



Connecting Care in Wakefield

Evaluation report January 2017



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SUMMARY

This report concludes a three-year evaluation of the “Connecting Care” initiative in Wakefield.

Three “hubs” have been established in three areas of the district of Wakefield, as bases for multidisciplinary health and social care teams:

- the Waterton Hub, in Lupset
- the Civic Centre Hub, in Castleford
- the Bullenshaw Hub, in Hemsworth

This report presents: the results of almost 1000 interviews with service users, carers, and staff of the services involved; quantitative data about the activities of Connecting Care, and of services on which it was hoped it would have an impact; over a period of nearly three years, from 2014 to 2016. Our overall summary findings are that:

- The Connecting Care programme has not been implemented as originally intended. It was originally over-ambitious, and has struggled in a challenging context, and with less management focus than it required
- Staff have, however, hugely valued the experience of working in Connecting Care, and have developed and improved relationships across teams as the programme has progressed
- The programme has led to improvements in the co-ordination, responsiveness, and quality of services experienced by many patients and (some, but not all) carers
- The programme has not had any clear impact on use of bed-based services, and therefore no clear overall financial impact

Improvements to patient experience and responsiveness must be a key objective of any service. Also, in a context where recruitment and retention of staff are increasingly difficult, it is essential to provide services in a way which provides a good working environment for staff. The evidence for both of these conclusions is clear and compelling, and all involved should take satisfaction from them. They provide an equally clear justification for continuing the initiative, rather than retreating from it.

The improvements seen have been achieved without actually moving on to fully implement any of the originally intended objectives:

1. Community-based teams able to provide a crisis response within two hours, 24 hours a day, 7 days a week
2. Open access to both health and social care services, via a single triage point
3. Care co-ordination for complex cases
4. A team whose purpose is to go into the acute hospital, and assess the opportunity for facilitated early discharge
5. Common electronic care records across health and social services, using the NHS number as a common identifier.

These remain important and relevant objectives. From the platform which has been built over the past three years, we hope that work can continue to be taken forward to ensure their full implementation.

1. INTRODUCTION

This report concludes a three-year evaluation of the “Connecting Care” initiative in Wakefield.

“Connecting Care” is a complex initiative, with several contributing elements; as this evaluation was first launched, towards the end of 2013, it was known as “Care Closer to Home.” The elements of what was then known as Care Closer to Home which were agreed in February 2014 as relevant service changes to be evaluated were:

1. introduction of community-based teams able to provide a crisis response within two hours, 24 hours a day, 7 days a week
2. open access to both health and social care services, via a single triage point
3. introduction of care co-ordination for complex cases
4. introduction of a team going into the acute hospital, and assessing the opportunity for facilitated early discharge
5. common electronic care records across health and social services, using the NHS number as a common identifier

The fifth of these proposed service changes (the introduction of common electronic care records) was, however, agreed during the course of the evaluation process no longer to be regarded as a measure of the implementation of Connecting Care.

Over the period April 2014 to October 2016, many changes have happened in local services in Wakefield, some directly linked to the implementation of Connecting Care, and others (as would be expected) arising for other reasons. The core change process is, however, very quickly and simply described. Three “hubs” have been established in three areas of the district, as bases for multidisciplinary health and social care teams:

- the Waterton Hub, in Lupset
- the Civic Centre Hub, in Castleford
- the Bullenshaw Hub, in Hemsworth

Waterton hub is based in an old care home/day care setting with many individual offices; Bullenshaw and the Civic Centre have more open plan designs. However, the integrated staff teams at each site included the same types of health and care professionals from the various participating organisations.

A range of work has been undertaken over that period to develop the policies and practices of those teams. This evaluation is therefore intended to evaluate the impact of that change.

In March 2015, the research questions for this project were agreed to be:

- a) Has the CC programme been implemented as intended? What have been the reasons for departure from the intended plan?
- b) What is the impact of CC on the quality and experience of services, in the opinion of staff providing services?
- c) What is the impact of CC on the quality and experience of services, in the opinion of people receiving services?

- d) How does the health status of people using the CC service change over the evaluation period?
- e) What has the experience of working in the CC teams been like for their members? What has been the impact of CC on perceived opportunities for career progression, clinical leadership, and internal communications? Has a common sense of purpose developed?
- f) During the implementation period for CC, what has been the change in the number of admissions to hospital? To what extent, and why, is the CC programme considered to have contributed to that change?
- g) During the implementation period for CC, what has been the change in the number of admissions to residential and nursing home care? To what extent, and why, is the CC programme considered to have contributed to that change?
- h) During the implementation period for CC, what has been the change in the length of stay of hospital admissions? To what extent, and why, is the CC programme considered to have contributed to that change?
- i) During the implementation period for CC, what has been the change in the number of readmissions to hospital? To what extent, and why, is the CC programme considered to have contributed to that change?
- j) What are the financial impacts of (f) to (i), net of the cost of the CC programme itself, and taking account of excess bed day payments?

Following this introduction, this report presents evidence from the three main methods adopted by the evaluation:

- interviews of staff involved in the delivery of Connecting Care
- interviews with patients/service users in receipt of Connecting Care, and carers of service users
- analysis of relevant and available local data

The report concludes with a set of summary assessments against the agreed research questions, and recommendations arising.

2. STAFF INTERVIEWS

2.1 Findings from final set of interviews

This section details our findings from the fifth and final wave of interviews with 35 staff (from the three Hubs) and their managers conducted during August and September 2016.

All but one of the interviews were conducted on an individual and face to face basis; one interview was conducted via the telephone. The staff interviewed came from a range of different professional backgrounds and positions. Interviewees included:

- Staff from the Community Matron Service
- Physiotherapists, Occupational Therapists and Technical Instructors
- Pharmacist
- Social workers
- Support workers from Carers Wakefield and Age UK
- Administrative staff
- Managers

The breakdown of the number of interviews conducted per Hub is as follows:

- Bullenshaw: N = 10
- Waterton: N = 5
- Castleford Civic Centre: N = 8
- Managers: N = 12

We then used thematic analysis to identify the key themes arising from the qualitative data collected via the staff and managers' interviews.

2.1.1 Views on the main impact of Connecting Care (CC) on service users / patients and their carers

As in previous sets of interviews, staff were able to describe a number of significant, positive effects of Connecting Care for patients/service users and their carers. Staff members described how Connecting Care has made it much easier to make patient referrals to other teams. They said that, before Connecting Care, it was difficult to refer to other agencies. It was difficult to make a telephone referral. One staff member described the change as dramatic - how they are now a multi-agency team and no longer need to make a telephone referral as they are all sitting together in one room. She said:

"It's amazing! No emailing or writing referrals.....it's all there".

The benefits of being able to refer patients to colleagues in Connecting Care on a face to face basis rather than over the telephone were summarised as follows:

"Before it was like referral to a black hole. You made a referral and never heard the outcome...there is more negativity when you refer over the phone. We are more united here".

Several staff highlighted that they cannot make internal referrals to social workers. All referrals need to be made via Social Care Direct which was seen as a hindrance and not the most cost effective way of doing things. One Social Worker said

"...they can't refer to us directly...we are not working as a team."

One member of staff described the impact that Connecting Care has had on patients as follows:

"Having all the services in one place has had the biggest impact. Everyone is used to us here. They know we can deal with more than one issue. The number of Age UK referrals have gone right up. There is more awareness now of what they do. We are now working together and we know what each other does".

One staff member described how they were much more responsive. He said:

"We are nearer patients and more local. In an emergency we can respond quicker. I took a frame to someone within an hour".

A staff member described how it was beneficial having everyone together within the hubs as this enabled them to share their knowledge and experience. However, they also said that the issue of funding always raises its head at some point:

"All aspects that a patient might need are all under one roof. If we don't know someone else will. The drawback is separate budgets and who pays for what. At some point that question is asked".

One staff member said that Connecting Care had been "a Godsend".

Another said:

"It is easier to converse and to organise packages of care with social workers".

Another said:

"When staff go out on a visit and come back they can refer onwards to colleagues in the office when they get back. Before they had no idea what they did (other colleagues and organisations)".

Staff said that they were more aware of what Age UK and Carers Wakefield can offer and that this has had a positive impact on patients and carers. Staff reported that they were referring more to them. Staff said that Age UK were now expanding and offering more services. For example they have been working with MyTherapy staff and managers to develop a falls pathway which includes a locally developed quality impact assessment which uses trained Age UK staff to do detailed assessment, and give out sticks.

Several staff spoke about the benefits of having a pharmacist in the hubs. They are seen as a valuable asset. Staff said that they are able to ensure that patients are compliant with their prescribed medication and that they are taking their medication safely. However, some staff raised concerns about the fact that the pharmacy input into the hubs has been reduced.

In relation to the impact Connecting Care has had on carers, there is widespread agreement that this has been very positive. Including Carers Wakefield within the hubs has raised the profile of carers' needs and so they are more likely to be addressed. Carers Wakefield report a 50% increase in referrals since the beginning of Connecting Care, and say that it is still increasing.

Staff said:

"...carers are now on people's radars..."

"We are working together...working in the best interests of the client to not have duplication. We can be clear now. Carers know there is support out there".

A staff member summarised the impact on patients and carers as follows:

"It's opened communication and broken down barriers. Before we were separate and isolated and insular. We were never the twain shall meet. Now it's open but not as open as it could be. We talk to one another but we are not integrated. It's pretty good. It's good for patients as they don't know who they need to talk to and I will tell them. Support for carers is a lot better".

Managers interviewed had slightly different views. No one felt that clients were getting a worse service, but there were a number who felt that, for most patients/service users, the service was largely the same, with just minor improvements; whilst others felt it had significantly improved. Those in the first group said that, essentially, the way they worked and the service they offered had not changed, although the referral pathway for staff was quicker and easier. Patients/service users were still having to tell the same story to different members of staff when they came to assess and the staff would have referred them on to the other services (when needed) anyway.

Managers said:

"..All the services were there before but didn't always work well together. Not so many gaps now in terms of delays. Could be up to 10 days for internal referral previously, now usually we can pass them over on the same day."

"...It has streamlined processes and prevented admissions for some people..."

2.1.2 Views on the impact of Connecting Care on staff and the organisations involved

Staff were universally positive about working within the Connecting Care teams. One staff member described their experience as follows:

"It's been positive working with different agencies....if we are not sure what to do, if we have a query we can ask. We go to meetings where we all talk about cases. We get together and discuss cases and everyone can ask questions. Connecting Care has built my confidence"

Another staff member described how they like being part of a small team within a larger team. They said it was the *“best of both worlds”*.

Other examples of positive comments include:

"It's a nice place to work"

"We can chat to social workers about packages of care. We have a greater understanding of each other's roles".

There remain some practical difficulties and concerns. The suitability of the physical work environment, particularly at Civic Centre, remains a concern.

The importance of having an administrator within each hub was raised. They were described as the "linchpin" of each hub. When all staff are peripatetic, this is particularly important to the smooth running of the Hubs. Having a full time, dedicated administrator was felt to be vital to the success of the project – with an impact on staff, service users and referrers. Even where a full time administrator was available there was, however, no cover for sickness or holiday leave which meant that an inconsistent service was provided.

Managers generally felt that the biggest impact of CC to date has been on their staff and that this had been a very positive impact, for similar reasons given by staff above (e.g. developing relationships with colleagues and a real understanding of each other's roles.)

Managers recognised the pressures this had put on staff and were full of praise for the way that staff had made co-location work. In particular, they felt that moving this forward so positively in the face of the issues and challenges they had faced was worthy of particular recognition and praise and was *"a huge achievement"*.

Managers said

"...CC is not a new way of working or a new approach. It is the old way with better communication, less frustration, better understanding and better trust. ..."

"...in the face of ongoing work pressures and now budget and resourcing pressures, the staff have continued to push hard to make this work..."

"...The front line staff have shown real tenacity to keep this progressing. The forces within our workforce are incredible and we should recognise that..."

Managers also identified the positive impact of CC on the organisations involved. Whilst it is not a new thing for health, social care and third sector organisations to work together in Wakefield, managers felt that these closer links had improved their relationships with colleagues, at management level, in other organisations involved in CC. This had forced more honest and transparent discussions regarding some of the difficulties which were impacting on them (whether within or outside CC). This seems to be picking up pace, with a Joint Operational Delivery Group now in place. Managers felt that it was now much more likely that they ask, not just "what can I do to help my own organisations?", but "what can I do to help the whole system?" They felt that working in this way has had clear benefits on the whole service pathway for patients and service users and the organisations which serve them.

The inclusion of Age UK and Carers Wakefield within the Hubs was noted to have had positive benefits both for the organisations themselves and for the system as a whole. The organisations involved felt that their profile had increased significantly with other organisations who are now much more trusting of them and recognise them as being able to make a real positive contribution and impact on the health and social care of service users and their families. The numbers of referrals to each of those organisations had increased significantly as a direct result of their work within CC teams. They had also been involved in more related work outside of Connecting Care, as an indirect benefit.

Managers said:

"...the system is under pressure and we must respond to pressure together. CC is helping us to do this more effectively and cohesively. I feel we no longer work in isolation. I don't feel that would have happened three years ago....."
"..by joining up resources, it can help all of us..."

Third sector managers said:

"...we have been able to showcase the work that we can do..."
"..progress has ebbed and flowed as the system has ebbed and flowed. You have to see it all as part of a system but staff often don't see this and therefore become frustrated. At staff level it looks quite simplistic but at organisational levels it's very complex with huge barriers to overcome"

2.1.3 Views on the impact of Connecting Care on external organisations

There were mixed responses to this question. Some staff thought that Connecting Care has facilitated people to contact them and enabled them to sign post people onto the right service.

"They know how to get in touch with us".

One staff member thought it was definitely now much easier for external organisations. She said:

"It's made their lives easier. We can deal with multiple problems....before they would have had to call lots of different services. Now they just call one number. We can say that we will take it from here. Sometimes they think they need a social worker but we might think that they might be better with Age UK. They ring us and we deal with it".

With regard to the impact on GPs, staff and managers agreed that whilst some GPs are engaged with Connecting Care others are not. They said:

"I don't know if they understand what we do despite us promoting it. GPs just want one telephone number - they say can't we just have a telephone number? They want to delegate (to us)".

"We do get referrals from GPs but not as much as before".

“GPs are enormously influential in the number and type of people referred and seen”

One staff member did not think that Connecting Care had had a great impact on other professionals or organisations. They were of the opinion that GPs are not getting involved in Connecting Care and that they never would get involved. They noted that the networks linked to the hubs were about to change and did not think the changes would help GP engagement.

Managers also felt that the impact on GPs had been limited, and shared the staff view that the experience and understanding (of CC) seems to differ from GP to GP. GPs remain a crucial group to get on board and involve, and several managers felt that, in hindsight, this was not given enough support or focus from the CCG. They felt that CC had been “oversold” to GPs before everything had been put into place e.g. they were told there would be a single point of contact, and a single assessment, and the lack of this two years down the line is an ongoing practical issue which is likely to continue to limit GP support.

Managers and staff said

“..engagement and involvement of GPs has been very variable. Only yesterday one asked me to explain what goes on in the hubs and how CC works! In early days we did lots of engagement and meetings, but GPs are still not properly engaged/informed etc. This is crucial as they are the main referrer into the service and to have true impact they need them fully on board...”

“...the impact on GPs has been very limited. It was over sold to them. They did not get anything tangible. They were given positive messages prematurely which were not delivered. For GPs its feels more or less the same. Same referral patterns and same response...”

“...it could have been so much more effective with GPs on board...”

“...GPs should really be part of CC. They influence so much of who gets access to/referred to the service but despite so much work with them, they are still on the outside.....”

2.1.4 Views on the impact of Connecting Care on reducing A&E attendances, hospital admissions, readmissions and length of stay in hospital

A clear aim of Connecting Care from the beginning was to keep people well and safe at home for longer; it was hypothesised that emergency admissions and re-admissions and A&E attendances might reduce. It was also hypothesised that working in this way might impact positively on shortening length of stay, by facilitating earlier supported discharge. Views differed significantly amongst those we interviewed as to whether or not Connecting Care had been able to significantly impact on these elements and why. The quantitative activity data shows little impact, but it is of course unclear whether, without Connecting Care, the position might have been worse.

Whilst staff could identify many individual examples where they felt they had definitely been able to keep patients/service users at home for longer (and support carers to care for longer), there was also a strong feeling that, for a variety of reasons, Connecting Care (in its present form and with current resources) would only ever be able to have a limited impact on this. There was no consensus as to why the impact of Connecting Care on these figures appears to be limited. A wide range of reasons was suggested by staff and managers:

1. CC is not a 24 hour emergency service, and was not planned or resourced as such.
2. Staff are working with the same cohort of patients, on the whole, with the same kind of staff offering the same kind of interventions, just based somewhere different.
3. Reduced resources within MyTherapy and the Community Matron service
4. Increased complexity and acuity of service users and patients
5. Lack of robust GP involvement in referring people to CC who could benefit, particularly as a viable alternative to sending patients into hospital
6. A lack of good quality data and analysis which would help to really understand where the pressure come from – e.g. what areas, kinds of patients/service users, drivers of referrals
7. A lack of work with Yorkshire Ambulance and 111/OOH GP services to offer a consistent service (from CC) across Wakefield which is easily available in and out of hours to divert patients from A&E
8. The number of people whom CC teams see is “a drop in the ocean” compared to the overall population of elderly or infirm people in Wakefield. The majority of people who attend A&E, for example, have never been in touch with Connecting Care, therefore they cannot impact on their behaviour
9. Commissioning drivers for individual services are not configured to incentivise an integrated approach across organisations.
10. A lack of resources (including Community Matrons, but also other staff groups) to proactively inreach into hospitals and assist with earlier discharge.
11. A lack of step down beds
12. The fact that Connecting Care is just one part of a much more complex and multi-faceted set of interlinked services and circumstances.
13. Patient / service users sometimes expect to be admitted to hospital

Of course, it may be that the reality is due to a combination of these factors – it is not possible to distinguish their individual effects with certainty in an evaluation of this nature.

Several managers and staff felt that a flat line (i.e. no sharp increase or decrease in emergency admissions) should be seen as a positive in the face of increasing demand -both acuity and numbers. Some felt that the impact of their work would be evident in the longer term (keeping people at home safely for longer, supporting carers to care for longer) and would not be directly evident after such a relatively short time.

In relation to efforts to reduce discharge delays, there was a suggestion that the data quality on reasons for delayed discharges had often been poor in the past. Work has now been undertaken to improve this and to ensure meaningful data is available which can give a much better picture of the real reasons for discharge delays within or outside the hospital and a clearer picture regarding where demand is coming from.

Some staff mentioned how they attend GP meetings on a regular basis to discuss hospital admissions and what could be done to prevent them. However, they said that there was usually nothing they could do to prevent admissions to hospital. One staff member suggested that, whereas they felt that they had previously been preventing hospital admissions, this was no longer the case. They said this was due to the change in referral criteria for MyTherapy. They said:

“At the beginning of CC we were preventing admissions....we struggle now...there is a risk we can't prevent admission because we can't use MyTherapy. Now people need to be at crisis point (to be seen by them). If they got their funding back we could prevent admission”.

Another said:

“At the beginning of CC we prevented admissions. We struggle now”.

Some staff shared examples with us of where they had been able to offer emergency visits on the day and arrange whatever support the person needed to stay at home straight away. One staff member described how they had been able to organise joint home visits to try to prevent hospital admissions, but the patients have still needed to go into hospital:

“I've had a couple of admissions, people with long standing infections. I have rung their GPs and raised concerns, then there has been a joint visit with the Community Matron or District Nurse”.

One member of staff spoke about how it was difficult to prevent admissions as the patient often does not meet the criteria for any of the services which could support them to remain at home. As a result the person will end up being admitted to hospital.

One staff member spoke about how people expect to be admitted to hospital when they are ill. They said:

“There is a culture of if you are ill you go to hospital. It's what people do”.

The same staff member thought that people could be prevented from being admitted to hospital if there were more staff working within the Connecting Care teams. They said:

“There is a massive lack of staff to do what is expected within Connecting Care. Staff have left and not been replaced. If they had increased staffing levels within the hubs that might have had an impact on admissions to hospital”.

They also highlighted how the hubs had not been given any additional posts since they were established. In contrast, however, another staff member spoke about having better connections working within the hub to be able to prevent admission:

“If I was trying to prevent an admission I now have a lot more contacts”.

The role that Age UK plays in preventing admission to hospital was highlighted. Age UK deliver meals to people and they can let carers know if the person is not eating or seems unwell. This is an early intervention which could prevent admission. Age UK also involve the pharmacist when they think someone needs help with their medication, which is another way of preventing admission.

One staff member said that they had always tried to prevent admission prior to the establishment of Connecting Care and still do. The staff member therefore did not think that there would be any difference in the numbers of people being admitted:

“Before CC we always tried to avoid admissions...we were doing it before anyway”.

Another staff member said that they undertake home visits in order to try and prevent hospital admission, but sometimes admission is necessary. They said that, although they do home visits, they have to call an ambulance sometimes as, despite all the support they could potentially put into place at home, the patient *“will still need to go in”*. One staff member gave an example of patients with COPD who are on their own, breathless and anxious, saying *“You can’t leave them. It’s difficult in that situation”*.

One staff member observed that people have to pay for respite care whereas admission to hospital is free. Wakefield are currently undertaking a pilot project which offers access to two beds in a care home to avoid hospital admissions. The staff member thought that this could help avoid some admissions, providing the patient meets the admission criteria. Another staff member said that people now need to be at crisis point in order to be admitted to hospital. They described how many elderly people tend to fall and then end up being admitted. This staff member thought that more should be done to prevent falls and admission. The same staff member highlighted how Age UK now undertake assessments for walking sticks, and patients are now charged £10 when they were previously not charged.

Some staff said that they liaise with the Discharge Co-ordinators in hospital to help plan discharge. One staff member described the difficulties of facilitating discharge from hospital as follows:

“Our focus has always been to prevent admission. This is what we work towards. Helping people to come out of hospital is difficult as beds are closing. There are less beds. They are closing step down beds”.

One staff member’s explanation as to why there had not been a reduction in Accident & Emergency attendance rates was as follows:

“The culture is if you are unwell you go to hospital. We are not an emergency service. We can’t respond when people are in crisis”.

Another staff member said:

“There are so many frail people. The last person I sent to Accident & Emergency had a recurrence of an infection. They needed hospital. They had a long admission. We couldn’t do anymore than we did”.

The same staff member also said that many frail people have multiple medical problems so they often end up in Accident & Emergency or being admitted. Another staff member said that it was often the patient's GP who had referred the patient to Accident & Emergency. She said that staff in Connecting Care have regular meetings with GPs in order to remind them of Connecting Care and their role in preventing admission.

The links which Connecting Care have with other teams working to prevent admission were described as follows:

"There is the new team in Accident & Emergency called REACT. They assess people there and then try and avoid admissions. If they are sent home they are referred to us. We get more referrals from them. We follow them up on the phone. We are taking them on".

It was reported to us that recent work by other services in Wakefield has recently, it is believed, shown an impact on admission/attendance/re-admission rates and length of stay:

- Improved, proactive discharge liaison work within Pinderfields on targeted wards has resulted in greatly increased numbers of discharges and shorter lengths of stay. We heard that there had been 68 extra discharges on one ward in a month
- Care Home Vanguard work has resulted in reduced emergency admissions and A&E attendances and shorter lengths of stay for targeted care home residents
- Age UK's hospital to home scheme, following up all clients, has resulted in reduced re-admission rates.

2.1.5 Views on gaps within the Connecting Care teams

There remains a recognition that mental health support to both staff (to inform their practice) and for some service users and carers, would have been helpful. However, managers recognise that it may not be as easy as just putting someone in the Hub. Several mentioned that the mental health nurse working with the Vanguard was doing some really useful work, particularly with elderly patients, and that this might be a useful model to look at in terms of how mental health staff could best add value to the CC teams. It was also mentioned that the link person who was already in place could usefully be more pro-active in ensuring staff understood what their role was and what they could offer.

One staff member said:

"We were given the name of a mental health link worker but when we contacted her she said she was unaware she was the link worker. Management were adamant she was the link worker. The mental health link worker has been to a meeting once in the hub two years ago".

Another staff member thought that, whilst it would be helpful to have a mental health worker in the hub, funding is an issue. They said:

"Mental health....they can't afford three mental health workers...mental health has been put on the back burner. We come across a lot of depressed elderly people. It would be good to have a mental health nurse here".

Managers said:

“it would have been good to have mental health staff involved to transfer their knowledge and skill to staff and aid understanding of each other’s roles, as well as to help service users...”.

“Mental health works very differently and will always be a more difficult pathway”

“Mental health is a commissioned service, so they are trapped by this too...”

“We expect mental health to be able to do something amazing and the reality is that they just can’t”

Both staff and their managers felt that the reductions in the Community Matron service had impacted negatively on the CC service, particularly in facilitating effective and earlier discharge, where they had not had the resources to work pro-actively. Work is ongoing regarding the roles of Community Matrons and other community nurses, and any developments will need to be viewed within the context of these changes. There was still some concern that, with the changed role of the Community Matrons to a more acute one, some patients with long term conditions who had previously had ongoing support from a Community Matron were now unsupported, and more likely to use A&E or to be admitted.

We also heard concerns from some staff about perceived reductions in other staff groups. We are conscious that staff’s understanding of service changes, and their implications for staff numbers and organisation, may not always have been accurate, but we heard a range of different perceptions from staff about these changes.

Other ongoing gaps included a lack of administrative support for the CC teams. Administrative staff were not originally included in the teams for the Civic Centre and Waterton, and qualified staff have to provide administrative cover when staff are on leave. A staff member suggested it would be helpful to have some main telephone answering system at Bullenshaw which said “Press 1 for Social Care, 2 for MyTherapy etc”.

One staff member raised the issue of access to equipment, and said that, whilst they now keep equipment on site, they cannot store everything. Whereas previously, if they needed to order equipment in, they waited a couple of days, they are now having to wait four weeks.

Several staff shared their views on what additional services they thought would be helpful to be based within the hubs. Suggestions included:

- Alcohol worker
- Speech & Language Therapist
- Dentist (able to undertake home visits)
- Podiatrist
- Chiropodist
- Staff from Alzheimer’s Society
- Staff from Stroke Association

One staff member said that if there were more voluntary sector organisations working within the hubs she would be more likely to refer to them and use them.

In relation to gaps in general service provision, staff thought access to 24 hour step down beds is needed.

2.1.6 Views on communication and information sharing

All staff reported that Connecting Care has enabled them to be able to communicate more effectively with other colleagues in the hub from health, social care and the voluntary sector. They were clear that this was beneficial and had enhanced their knowledge of each other's roles and the ways in which they work. They often overheard discussions in the office about patients and work related matters which were also beneficial to them in their role. Staff said it was good to be able to come back to the office and talk to colleagues about a patient and get their views on next steps. Staff found it much easier to discuss possible referrals face to face with a colleague in the hub rather than via the telephone.

There was a mixed response in relation to the different patient / service user information systems. One staff member said:

"We just get on with it. It's difficult if you want information but you can go and ask them...it's not too difficult...it's accessible".

Another staff member thought it was a problem. There had been one occasion where a patient with a history of violence had had this clearly recorded on the social care information system. However, other staff were unaware of this as they are not on the same patient information system. Another example mentioned was where a social worker had organised care for someone with dementia at home, as their carer had been admitted to hospital, but Carers Wakefield were unaware that this was the case since they do not have access to the same patient information system.

The Administrator at Bullenshaw (who takes referrals by phone) has access only to the NHS patient information system. As a result she has to wait until the relevant social care worker is back in the hub to ask them to look up a patient / service user on their system. She is also unable to enter information on the social care system about any calls she has received regarding specific patients.

There was widespread agreement amongst managers that the lack of shared access to electronic records had impacted on their ability to deliver CC successfully. In particular, the ambition for patients and service users to have to tell their story only once could not be met until shared IT systems are in place. Assessments may have to be repeated. And it also prevents having a proper single point of access. On a positive note, several managers felt that the work now ongoing to develop a single assessment document, which can be accessed by all systems, was at last making positive and tangible progress, which should deliver a workable solution for staff.

2.1.7 Management of the Connecting Care Teams

Both staff and managers agreed that it was the determination of the staff which had made the hubs work. This was especially the case at Bullenshaw, the first pilot site who had had to start this “from scratch”. Staff said:

“We weren’t given any guidance. There was no project manager. We were the first pilot. As front line staff we knew we had to make it work. We had a common goal. We worked as a team...we get on. Being in the same room was helpful. If you are in different offices you don’t know them (other staff from other agencies). It’s not them and us. We are the same team. They are a good bunch of people”.

“At the start Bullenshaw had lots of meetings with the leads for each service where they would argue with one another about things like what triage is....but we had a room full of staff who went off and without any decent guidance thought that they needed to make this work and we did. We brought it together. That’s what made it. These workers know what their patients need. Managers are not in touch with the real world. They are not in touch as they are not in the field. The workers know what works”.

Some staff within the three hubs said they have had little contact with managers since the hubs were established. Examples of what staff said include:

“I don’t know who the managers are...we don’t meet them which is a good thing as we can get on. It’s been ok. Initially there was too much red tape but now it has died down”.

“I have only seen managers 1 – 2. I have not seen them that often. They are not involved. I am sure they are out there in meetings”.

“We all did it together..... services learning and inputting. We had control over how it has been developed. The other hubs had a Project Manager...they took it away from staff.”

“This hub manages itself. There is no one overall manager”.

Several staff in the other two hubs thought that Bullenshaw was the hub which is working the best. Some had worked in more than one hub. One staff member in another hub said:

“Management has lost the vision. The pot of money has dried up...no managers come to hub meetings. No one visits here”.

Some staff felt that managers felt that they (the staff) have been perceived as not being committed to making Connecting Care work or resistant to change. One from the Civic Centre said:

“Staff are committed to make it work but somehow there is a view we are not committed”.

Another staff member from Bullenshaw said:

"We have been told we are resistant to change but we are not. We have shown us to be successful"

One staff member said, due to withdrawal of funding for some services within the hubs, the team thought that the hubs were being run down. Other staff members said they had heard the hubs were being reduced from three to two. However, one stakeholder said they recently attended an event and learnt more about what is planned for the future such as the establishment of Gateway to Care and a "One Stop Shop". This made them feel as though there has been an overall lack of communication with staff within the hubs.

Some of the managers that we interviewed also expressed frustration and disappointment with the level of communication. One said:

"Communication has been appalling. Staff will say this too. Managers have tried hard to communicate, but they have not always been made aware of things. Same with the vanguard work – no one has explained this to the staff"

and:

"there was a complete lack of a "make it happen message" from the top"

2.1.8 Factors outside Connecting Care which have had an impact on its success

A number of factors outside of Connecting Care have impacted on the success of the project. Staff from the social care team in particular felt that a key negative external factor was the Care Act. One staff member said:

"Prior to the new Care Act it felt like more of a team".

Another staff member said:

"The Care Act has impacted on our work and what we can provide".

Also during the latter 12 months or so of the Connecting Care implementation, two local Vanguard projects have been established: one to offer enhanced support to care home residents; and one in West Wakefield (the MCP Vanguard) aimed at redesigning care around the health of the population, irrespective of existing institutional arrangements. Many staff are not clear what the impact of the Vanguards on the Connecting Care programme is likely to be. One staff member said they were surprised that they didn't come and ask the staff in the hubs for advice about this new initiative given their experience. One staff member was concerned about the impact the MCP Vanguard could have on the work of the hubs. They said:

"It felt like they were starting from scratch but they didn't come and ask us. They have a bigger voice. They have the money. Are they going to influence what we do here? What impact is that going to have on us?"

An ongoing programme of service cuts being carried on at the same time as CC was being put in place and developed has also, undoubtedly, affected its ability to deliver. In particular, managers felt that large budget cuts within Adult Social Care (and some of the services they had previously had available to them such as day centres, interim care beds) and some areas of health (such as community nursing), as well as reductions in the number of Community Matrons and therapy staff (within the CC teams) have undoubtedly affected the quantity as well as the quality of the services offered. More recently, the reductions in the MyTherapy service have concerned both staff and managers.

A number of factors within CC organisations, but outside the control of local teams or management, have also impacted on the ability to deliver.

Managers we interviewed spoke of their frustration and inability to get senior people within their own organisation to engage with and fully support developments. This appeared more common from health managers. Some managers felt that they had been left to get on with it, with very little guidance and support, and that it was a credit to their staff that they had managed to move things forward. All of the managers that we spoke with felt that supporting their staff through times of uncertainty had caused an extra burden on them, but equally they recognised it as a vital part of their role. Having the Joint Operational Delivery Group in place now provides cross sectoral and very senior leadership, and all of the managers that we spoke to expressed optimism and support for the work that this group was now moving forward and the impetus it had managed to develop.

2.1.9 Do staff think that Connecting Care has been a success overall?

Nearly all staff and managers thought that, overall, Connecting Care had been a success, particularly given the challenges that had had to be overcome. They felt that it was the right thing to do and that lots of positives have come out of it. Staff had benefited from the closer working relationships they had developed with their colleagues from other teams and from the faster and smoother internal referral pathways that were now in place - whilst still recognising there was some way to go. Service users had benefited from staff having a wider "offer" to them, including faster access and access to more support from Age UK and Carers Wakefield. All of the other roles and services within the CC team were also felt to be vital to its success.

Managers said:

"...it's been very positive and the qualitative feedback from the evaluation has been really useful in proving it..."

"...given the challenges that had to be overcome, it is amazing..."

Staff said:

"Yes definitely. It's been really good. I'm pleased to be part of it".

"It's opened communication and broken down barriers. Before we were separate and isolated. Insular...never the twain shall meet. Now we are open...not as open as could be...we talk to one another. Not as integrated as we could be, but it's pretty good".

"It has had a valuable impact on people's health and wellbeing. It has brought agencies together....let's hope it goes further".

"For patients it's the speed that they get services. There is also less duplication. It's been a success for staff. We have a better understanding of each other's roles. It is easier to make referrals or we don't refer at all as they help us think about what could help".

Amongst this positive feedback, however, were concerns about the future of Connecting Care:

"We need more finance to do it well. We are not integrated as much as we could be"

"It has brought community teams together but preventing admissions to hospital it's not like we were a new team brought in to do that. We are the same staff as before. We did not get any new posts. It's existing staff and services who were put together. We just work as one team and talk to one another, that's what makes it a success. We have less staff than before".

"My main worry is that it started off great ...but I am really worried we have lost MyTherapy.....We have shown us to be successful".

2.1.10 What enabled Connecting Care to work well?

Bullenshaw was described by many staff from all three hubs as being the most successful of the three. Staff in Bullenshaw and from the other hubs thought that the reason that Connecting Care has worked "better" in Bullenshaw is because they are a smaller team, covering a smaller area and because they are based on one room. In addition they have had dedicated, proactive administrative support from the start. Staff from Bullenshaw said:

"It's worked because we are a smaller team. We are in one large room and everyone can consult one another. We treat each other like we are in one team (not lots of different teams sitting in one room). At the beginning it was us and them but..... forced them to play nice with one another. We have a nice team here. If we were not together in one room it would be us and them. There are also other services in the building here like reablement. They are in the same building but it would be good if they were in the same office".

"The room really helps. We have a nice mix of services here. It's different in other hubs as they have lots of people. We are in one room. The on call social worker comes down and we get to know the social workers better".

A staff member from Civic Centre described why they thought it works better at Bullenshaw:

"At Bullenshaw they are in one room and it was the pilot and works well. It works better as you can overhear conversations (colleagues are having). At Civic we cover a larger geographic area".

A manager said, of the staff at Civic Centre,

“that initial group of staff could have dug their heels in and refused to work until they had a proper work place but they didn’t . They got on with things and worked together to sort things and they deserve much credit for this”

A couple of staff thought that the Civic Centre was more co-located as opposed to integrated. One staff member said:

“...it’s easier to communicate with other professionals now we are co-located. However, there is no joint referral point”.

The same staff member thought things have plateaued and went on to say that they did not think that anything has progressed since April.

2.1.11 What has held back the progress of Connecting Care?

There was a lot of common ground in terms of the reasons given as to why the Connecting Care programme had not moved forward further past the initial successes of co-location. The commonest reasons we heard were:

1. Lack of a clear project plan, or clear milestones for implementation
2. Lack of senior guidance and input
3. Lack of common governance structures or lines for escalation
4. Differing contracting and commissioning drivers including targets and KPIs.
5. National payment and reward systems can be barriers to change. For example, if a service gets paid to admit people to hospital but not if it prevents an admission; or if one service’s resources are used to support a patient/service user but savings accrue to another.
6. Differing pay rates, policies and procedures
7. Differing approaches to payment from client/means testing
8. No shared access to electronic information
9. Increasing workload and complexity of client need
10. Budget cuts and resource pressures across health, social care and third sector
11. Poor infrastructure to support co-location
12. Lack of full GP involvement and buy in
13. Lack of common assessment processes
14. Lack of Single Point of Access
15. Lack of changed, agreed pathways for patients/service users
16. Lack of clarity regarding the Community Matron role

During the final set of interviews, managers were more optimistic about the future of Connecting Care than staff. This may be because they are more aware of the current positive developments which are driving this forward. Primarily the Joint Operational Delivery Group which appears to be starting to address some of the above issues, and the work coming out of the MCP Vanguard around developing an accelerated approach to developing an accountable care organisation which can commission services in a different and more integrated way.

“Overall it’s been a bumpy ride because at first not everyone was signed up, particularly top level health. If that had been in place, we could have been a lot further forward. However everyone is now on board and the next six months will be really interesting!”

One manager concluded:

“I would be devastated if CC did not continue. We don’t want to go backwards. Yes there are challenges ... but there is a real appetite to continue to improve and move forward. We have developed really good relationships and can move forward a lot better now”

This echoed the words of a staff member who said:

“We are so proud of ourselves. We would be devastated if it winds down.”

2.2 Tracing changes in opinion and staff experience over time

To ascertain staff opinion regarding the progress made via Connecting Care, we interviewed a sample of staff from each of the Connecting Care hubs plus managers on a 1:1 basis at six monthly intervals over a two year period. We commenced the interview process at Bullenshaw, in the summer of 2014. At this point the team had only recently started working together and the project was still called Care Closer to Home (CCTH). The second set of interviews included staff at Bullenshaw and at Civic Centre. The subsequent three sets of interviews included staff from all three hubs. In addition, we interviewed managers from all of the services involved in the teams, twice during the evaluation.

Many themes which emerged during the first set of interviews continued to be raised throughout the following two years. Staff were both insightful - which shouldn’t be a surprise as they are the ones delivering the services - and consistent in their views about both what worked well and what did not work well throughout the five sets of interviews. There was slightly more variation in their views regarding why things have worked, or not worked.

2.2.1 Benefits of co-location and internal referral

During the first set of interviews staff were already able to describe the benefits which they had found through their co-location with other staff groups – including better working relationships and better understanding of each other’s roles, issues and pressures. They felt that this enabled them to refer patients/service users more appropriately, and to find out information directly from their colleagues, giving them a more holistic view of a person’s situation and needs and the services that would best be able to help them.

They told us that co-location had enabled quicker, easier and more appropriate referrals to colleagues in other disciplines. This has continued to be the development which has driven most real improvement for both staff and service users, in the views of the staff we have interviewed. Staff consistently reported that this was leading to better outcomes for many of their patients/service users.

The inclusion of Age UK and Carers Wakefield in the Hubs was valued by other members of the team right from the first set of interviews. Both organisations have delivered on that initial optimism with team members consistently praising the value that these services have added for clients in areas where statutory services may not be able to help.

Staff at each set of interviews told us that these services have been very significant in supporting service users and carers to manage for longer in their own homes. The pharmacist role was also welcomed and valued right from the start, and throughout all sets of interviews both in terms of a resource for staff and patients/service users. In addition to ensuring that patients/service users were taking their prescribed medication in the correct manner, we found evidence via our staff interviews of the pharmacists reducing waste via ensuring that patients/service users are given a repeat prescription for the medicines they have run out of, rather than all their medication.

It was a big change for many staff to work in this way and some were suspicious about the motives for the changes. Initially there was some reluctance to meet with the evaluation team. This changed over time, as staff came to understand more about the evaluation and its benefits, and at subsequent interviews they gave their time willingly.

2.2.2 Processes and support needed to make this work

Staff quickly realised that, if they wanted this to work, they would have to come up with their own systems and processes, and set about designing these. By the second set of interviews, staff at Bullenshaw had implemented an internal referral system which was subsequently taken up by the other Hubs. There was common agreement that this was a big step forward and meant that internal referrals were dealt more quickly and appropriately than before. This was a paper based system. The project has continued to be impacted by the lack of electronic access to records across the different agencies. Staff became more dissatisfied by this as time went by.

There was also widespread frustration from staff across the hubs when Social Care pulled out of the internal referral process and it was widely felt that this was a backwards move. More latterly, referrals to MyTherapy have been affected by tighter referral criteria, due to a limited resource available to meet increasing demand. This has meant that people with lower level needs can no longer be seen by the service, which may influence the ability of therapists to prevent some longer term deterioration.

Whilst the internal process improved significantly with the full implementation of Connecting Care, this was not true of the external referral process. The teams worked hard, particularly in the early days, to ensure that GPs were aware of the service, but despite early concerns raised regarding the need for better engagement of GPs, this has continued to be a source of concern to staff and managers. This was not helped by the lack of progress with the key service changes originally intended, particularly the single point of access.

In the final set of interviews, managers reported that relationships with Care Homes had improved, which they felt was a result of the Care Homes Vanguard work, however, rather than of the Connecting Care work.

2.2.3 Senior management support

Staff were frustrated by the lack of senior guidance and operational support to the work. Whilst individual team managers were very supportive and worked really hard to make Connecting Care work, the lack of project planning, support for a huge change management project and senior drive to make this work have consistently been raised by staff as concerns. An unforeseen positive consequence of this, however, has been that the staff themselves have taken the initiative to shape the project and shown a real determination to make this work, in the face of many hurdles. The impact of this should not be underestimated. If the staff had not adopted this positive attitude it is likely that the project would not have achieved as much as it has. Staff throughout the sets of interviews have demonstrated a common purpose in wanting to achieve the best service they can for their patients/service users and have continued to focus on this as a goal, despite all the difficulties.

There were and are, however, some much bigger and more intractable issues which staff themselves cannot tackle which have hampered the progress of the project. These include:

- separate managers and management structures,
- separate budgets,
- separate accountabilities and governance arrangements and
- separate contracting/commissioning arrangements and KPIs/targets

At the start, and to some extent throughout the project, staff have reported being frustrated by the practical implications of some of the above limitations. Much time was taken on issues such as who paid for and organised supplies and support services to the team, and this has continued to rear its head throughout our programme of interviews. We understand that there is now a Joint Operational Delivery Group in place which is starting to look at some of these areas.

2.2.4 Referrals

During early interviews, staff reported increasing numbers of referrals, as referrers found out about the service and internal referral processes were set up. There was some frustration and stagnation of this process in the first year, with third sector staff reporting that they should be getting many more referrals. Over time, however, these have increased and from quite early on (and on a continuing basis) there was a recognition that having Age UK and Carers Wakefield within the hubs was a real asset and enabled support to be provided to service users and their carers in a better way. Staff reported that they were referring to these services in a way that they might not have done before – for example, by the final set of interviews, Carers Wakefield reported that referrals had increased by 50%.

Pharmacists and Community Matrons told us quite early on that they felt that, due to these being new roles, they were not getting enough referrals passed onto them. Again, other staff in the team valued these roles and felt they were really important and able to have significant impact. The role of the Community Matron has continued to be an issue of debate throughout. Reductions in the Community Matron staffing levels have meant that this service has not been able to take as many referrals as originally hoped.

During the period of Connecting Care implementation, referrals to Social Care were affected by the introduction of the Care Act, which meant that referral criteria changed. Towards the end of year two, changes in MyTherapy which introduced acceptance criteria for patients following sustained levels of high demand, are expected to change the acuity of patients which the service can support, with those with lower levels of need no longer eligible. And of course this work programme has been taking place during an increasing period of “austerity” within the public sector with Council services hit particularly hard by budget cuts of up to 30%.

2.2.5 Gaps within the service

In early interviews staff complained that lack of quick access to short term respite care was a limiting factor in helping them to keep people out of hospital. A service was introduced during the second year of the project which helped to plug this gap and this became much less of a concern following this.

Staff and managers continued to identify mental health expertise as an area that the teams needed better access to, from the first to the last set of interviews. During the earlier interviews staff identified a lack of administrative support at Waterton and Civic Centre. Although administrative staff were eventually appointed, this continued to be an area of concern as there was no cover provided when these staff were on leave. In addition, staff identified a fairly wide range of other services (including third sector services such as Alzheimer’s Society and health services such as Dietetics and Speech Therapy) which they felt should be included within the Hubs. However, there was no particular consensus regarding which of these other services would be of most use, with responses tending to vary depending on the background of the staff member who suggested it.

In the final set of interviews, therapists and others identified a gap in the ability of the therapy services to help clients in the light of tightened access criteria which they had had to implement to manage demand.

2.2.6 Impact on career progression and development?

During the first two sets of interviews staff were unable to identify any clear benefits in terms of career progression and development from working in this way. During later interviews, however, they were much more positive regarding the impact which they felt working in this way was having. Many felt they had developed new confidence and skills in working with their colleagues from other teams and had developed a deeper understanding of other roles which had enhanced their own practice. They felt that this would be very valuable to them if/when they moved on with their own careers and that this had been a developmental process.

2.2.7 Focus of Connecting Care

The focus of the Connecting Care service has been largely on supporting people to stay well and safe for longer within their own homes. A few staff have occasionally mentioned that facilitating safe and early discharge is a key aim, but this has not been a major focus of the work.

Promising early plans to involve Community Matrons in working more proactively with the hospital to facilitate more timely discharge had to be stopped due to lack of staff available to do this.

The interface with the discharge service at Pinderfields Hospital has not always been effective, and this has been highlighted by recent developments. Over the last six months, discharge structures and processes have been reviewed and some key improvements put into place. At present these are limited to a small number of wards. However evaluation has shown them to be very effective in discharging patients more quickly and safely and there is potential for this work to impact significantly. Whilst this is very positive for patients, it will be vital that the Connecting Care services are ready and able to cope with this potential enhanced workload. The hospital discharge team had some reservations as to whether the Connecting Care (and other community services such as community nursing) are resourced and structured adequately to be able to cope with significantly increased numbers of patients discharged earlier.

3. PATIENT / SERVICE USER INTERVIEWS

3.1 Background

Healthwatch Wakefield was commissioned in 2014 to provide an independent evaluation of the Connecting Care service from the point of view of the person receiving the care. The evaluation was conducted alongside the development of the Connecting Care service itself.

The evaluation survey was designed to capture people's experience of integrated services (rather than their care in general) based on the National Voices "I" statements. The results from the survey were captured and fed back to form part of the formal evaluation. They were also used to create the patient metric for the Better Care Fund and form part of the high level integration "Assurance Framework" on a quarterly basis. Patient experience metrics have been displayed beside more conventional quantitative metrics such as those measuring reductions in hospital attendances and admissions.

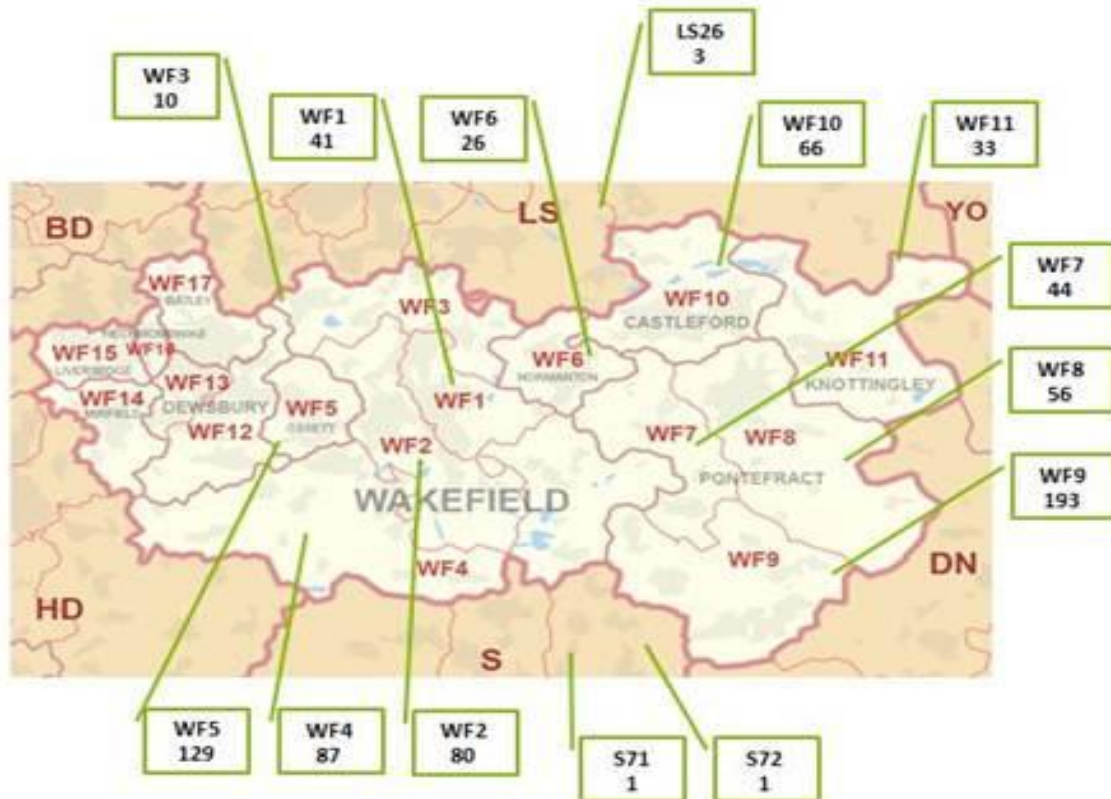
The approach was one of participatory appraisal, using local lay people as volunteers to conduct the interviews, which combine qualitative interviewing techniques with a quantitative scoring system. The interviews took place in people's own homes, with consent being obtained by frontline Connecting Care staff to enable Healthwatch Wakefield to telephone to arrange for a visit. The three hubs referred people from all over the district for interviews.

A combination of staff, sessional workers and volunteers were used to complete the surveys. They conducted interviews in pairs as this helped with more accurate recording of the findings, and offered some mutual support and safety. It was also felt to be good practice in relation to safeguarding, not just for the interviewers but for the person also. Full training was provided, which included a detailed briefing on Connecting Care, the interview method, safeguarding, personal safety and dementia awareness.

There were a number of challenges during this process. The referral process was difficult to maintain as frontline Connecting Care staff had to obtain consent from individuals then pass that consent and contact details through hub administrative staff to Healthwatch Wakefield. The administration function within the hubs struggled with capacity and their ability to pass referrals to us was variable. The provider of the administration function also changed hands during the evaluation which caused delays. As a result, there were a number of times when months went by without sufficient referrals being obtained.

The target for the number of interviews was 1000 and we reached 680. We noticed that, as numbers rose, the variation of responses overall became less marked. In addition, with the target being so high, there was a need to maintain constant awareness of the quality of interviews as opposed to the quantity. We chose to abort interviews on several occasions when realising that people had only received one service from the Connecting Care team as this would not be a true integrated care experience.

By the time the evaluation came to an end, we had interviewed 680 service users and 53 carers about their experiences of receiving Connecting Care. The distribution of service user interviews across the district was as shown on the map below:



The interviews with carers were depth interviews, and a separate much fuller report is available on their findings. In brief summary, these interviews with carers found that the Connecting Care services which were most frequently mentioned as helping and supporting them were Age UK and Carers Wakefield. It is clear that having these two services within the Connecting Care teams is enabling a greater and more comprehensive service to be offered to carers. The fact that Carers Wakefield could develop an ongoing relationship with carers was something which carers who had experienced this, particularly valued and found helpful.

We met other carers where the picture was mixed. Maybe the services delivered to the service user/patient were good, but the carer felt isolated and unsupported personally. Or the carer had found it difficult to access services, which were good once accessed, but the process of trying to organise things had taken their toll. Around half of the carers we spoke to, fell into this middle group.

There was an additional group of carers (around 25%) who had received very poor support and services. In some cases, this was around difficulties in accessing the services in the first instance - both finding out about and locating services and waiting (e.g. on a waiting list) for access. For other people it was really not clear why, despite very clear needs (both for service user and carer), they had not been offered the support which they obviously required. Several of these stories related to end of life care. The carer was not always clear why they had not been able to get the help that they needed.

The remainder of this section relates to the interviews with patients / service users.

3.2 Findings from the full sample
















The data presented here are based on 680 interviews, of which 43% were conducted with the carer present, either supporting the person through the interview or answering questions on behalf of the person who had been receiving Connecting Care services. If the person being interviewed had a significant lack of cognitive understanding then the interviews were generally conducted with the carer, although being inclusive of the person involved as far as possible. In these cases the focus was on the experience of the person from the carer's perspective, rather than the carer's experience of the service.

97% of people interviewed were white British and 62% were female. The majority (79%) were over 65, with and 69 people were over the age of 90. 42% of people interviewed live alone.

There were 22 questions in the survey which have been grouped under four main themes:

1. Overall experience of health and care services
2. Co-ordination of care and services
3. Understanding and wellbeing
4. Carers, friends and family

3.2.1 Overall experience of health and care services

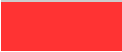





What care or help have you received in your own home in the last few months?				
			Response Percent	Response Total
1	Nursing		45.95%	312
2	Physiotherapy		54.05%	367
3	Occupational Therapy		63.33%	430
4	Seen GP		50.66%	344
5	Help with shopping/cleaning/food preparation etc		20.91%	142
6	Assistance at home with personal care (eg washing self, continence care, getting dressed etc)		23.12%	157
7	Help from Mental Health services		8.10%	55
8	Social worker		22.83%	155
9	Housing staff		26.07%	177
10	Age UK staff		25.18%	171
11	Carers Wakefield		10.75%	73
12	Going to day care centre		8.98%	61
13	Help from family, friends or neighbour		40.06%	272
14	Pharmacist		2.21%	15
15	Other (please specify):		43.30%	294

From the beginning of the evaluation, referrals to the Healthwatch team came predominantly from the Connecting Care staff employed by Mid Yorkshire Hospitals Trust, including the MyTherapy team. It was only in the last year or so that referrals from social services and the voluntary sector started to increase. This might have some implication on the number and type of services that people have reported receiving.

When people ticked the 'other' box this mainly included care and help from family, friends or neighbours. Other responses included private home care, community matrons, health and wellbeing worker, privately paid cleaner and gardener, vicar, Macmillan. Later months showed an increase in help from housing/Occupational Therapy (OT) services although we noted that OT is provided through more than one organisation in Connecting Care.






We noticed that the options relating to help with shopping, cleaning and assistance in the home were often answered in relation to the care and help provided by friends and family, rather than by Connecting Care services.

“Age UK transport service is great. So glad for what we have - all these people help us live better and we are not alone.”

How have these services helped you? (Tick as many as you want)				
			Response Percent	Response Total
1	It helped me to come home from hospital more quickly		25.00%	162
2	It helped me to stay in my own home rather than go into a nursing home/hospital/elsewhere		56.79%	368
3	It helped my family/carers		50.00%	324
4	It helped me to recover more quickly (from ill health)		36.88%	239
5	It helped me to stay more independent		62.81%	407
6	It helped me to cope better		66.67%	432
7	They have not really helped me		13.27%	86

The majority of people reported some positive outcomes in relation to their experience of Connecting Care. The highest positive responses were that Connecting Care had helped them stay more independent and cope better in their own home.







“GP wanted her to go into hospital but by having the nurses round to care for her at home she was able to stay at home which is what she wanted.”

Did you get the help and care when you needed it, or did you have to wait?			Response Percent	Response Total
1	I had to wait too long		14.75%	99
2	I had to wait, but not too long		23.40%	157
3	I didn't have to wait at all		56.63%	380
4	Not sure or can't remember		2.83%	19
5	Not applicable		2.38%	16

Most people felt that the waiting period for Connecting Care services was acceptable, with 57% of people saying that they didn't have to wait at all. 15% of people felt that they had to wait too long, but their responses to the other questions in the survey were generally positive, with 74% rating the service overall as quite good or very good. Some of the comments about waiting times were in relation to specific services. Although not captured in the data, it is likely that sometimes the waiting times were affected by the fact that all three hubs were not fully operational from the beginning of the evaluation, with two hubs starting much later than the first and teams being relocated from elsewhere.

“I have been waiting for mental health services for over 6 months which I feel is far too long, the services need to be available sooner.”

“Would be helpful having physiotherapists earlier - it was 5 or 6 weeks after I came out of hospital. Also someone to explain what would happen to my rehabilitation and how I would progress etc. after I left hospital.”

If you had to rate the health and care services you have received overall (in your home) in the last month, would you say it was;			Response Percent	Response Total
1	Very Good		54.92%	363
2	Quite Good		29.65%	196
3	Neither Good nor Poor		6.05%	40
4	Quite Poor		2.27%	15
5	Very Poor		2.72%	18
6	Don't Know		4.39%	29

85% of people interviewed felt that the health and care services provided through Connecting Care are very good or quite good. From our conversations with people we feel that this reflects a strong endorsement of the proactive and committed frontline staff in the Connecting Care teams. We often heard praise in relation to individual staff who had gone out of their way to ensure that people were looked after well and referred to services that they needed.

From what we have observed, integrated care works well not only when the organisations involved are committed to work together, but when the frontline staff are empowered and supported to be flexible and person-centred in their approach.

“Daughter reports that dad has had good care, has been offered services which he hasn't accepted, the staff are brilliant and flexible and she says she cannot praise them enough, they have been lovely.”

People rating the service overall as quite poor or very poor

Of those people (5%) who reported the service as quite poor or very poor, 60% felt that people did not work together well and 10% felt they hadn't been treated with kindness and compassion. 38% said they felt they had to wait too long before services were offered to them. 60% said their family or friends who care for them had received little or no support from Connecting Care services.















57% of this cohort reported that they had not enough social contact or none at all. They felt that they would benefit from help to get out and about (42%), more help from therapists such as physiotherapist / occupational therapist / speech therapist (42%) and better aids and adaptations for their home (32%).

“Patient said if he wanted support from social services he would have had to stay in hospital longer because they had not done a care package for him quickly enough – he wanted to be at home. All his care he has paid for privately.”

There did not appear to be any linking factor between the people who rated the Connecting Care service poorly; they came from a wide geographic spread and generally followed the same demographic picture as the average.






Occasionally there was disagreement between the person being interviewed and their carer/ family about the rating of the service.

“The interviewee rated the service as quite good but the family did not agree – they felt there were gaps in the service. The interviewee felt everyone worked well as a team and shared information but the family did not. Generally it was felt that the services were not joined up and the communication was inconsistent between the service providers.”

Thinking about your care over the last few months, are there other services that would have been of benefit to help you regain your independence more quickly and/or feel better able to cope at home? (Select all that apply)			Response Percent	Response Total
1	Help/more help from nursing staff		6.46%	42
2	Help/more help from my doctor		7.85%	51
3	More help from therapists such as physiotherapist / occupational therapist / speech therapist		14.31%	93
4	Better access to aids and adaptation for my home		8.15%	53
5	Help from mental health staff		2.62%	17
6	Help with eating/drinking/diet		2.46%	16
7	Help with continence needs		3.69%	24
8	More information about my medication or condition		5.23%	34
9	More information about financial support or benefits		7.69%	50
10	Help to get out and about		15.54%	101
11	More help for my family or carers		6.77%	44
12	No		49.08%	319
13	Don't know		3.69%	24
14	Other (please specify):		17.23%	112

For this question, the people interviewed were talked through the list so that they were given the option to think about whether these extra services might be helpful. Nearly half the people interviewed didn't think there were other services that would help them. The highest answer was 16% of people who said they'd like more help to get out and about.

Answers to 'other' include help with housework, cooking and shopping etc, getting medication from pharmacy, support with transport, help to get to church, counselling, memory clinic, Macmillan support and more social contact. People also suggested that more information on 'what's out there' would be useful.

Have all the staff who care for and support you at home treated you with kindness and compassion?			Response Percent	Response Total
1	Yes definitely		85.78%	567
2	Yes most of the time		11.04%	73
3	Not really		1.21%	8
4	No definitely not		0.30%	2
5	I am not sure / can't remember		1.66%	11

The vast majority of people interviewed (97%) felt that they had been treated with kindness and compassion by the Connecting Care staff.








“They have been brilliant, nothing but praise.”

From an analysis of the open-ended comments from those few people who said they had not been treated with kindness and compassion, or were not sure, we heard stories related to poor discharge practices and not enough support being put in place on their return home from hospital. Some of the stories were in relation to poor experiences in hospital or with paid home care support (it was often difficult to keep people focused just on Connecting Care services). Many people also mentioned long waits for aids and adaptations in their homes. This appears to suggest system failings rather than individuals not being kind and compassionate.

3.2.2 Co-ordination of care and services

One of the main Connecting Care aims is to provide a more joined up service to people receiving health and social care support, whether it is from the NHS, council or voluntary sector. The co-location of professionals within three integrated care teams, or hubs, is part of the way that this joined up approach is being delivered. The following questions were designed to find out whether people who are receiving these services have benefited from the new ways of working.

If several different people were involved in your care and looking after you, did you find that everyone worked well together?

			Response Percent	Response Total
1	Yes always		43.18%	288
2	Yes mostly		22.64%	151
3	Neither well nor poorly		2.85%	19
4	Not really		9.30%	62
5	Not at all		4.50%	30
6	Myself or my family had to co-ordinate everything		2.70%	18
7	Not sure or not applicable		14.84%	99

66% of interviewees reported that people mostly or always worked well together. When people felt that this hadn't happened it was often in relation to communication issues, often not the fault of individual staff.





“The people are brilliant but the systems are at fault.”

“One bit of the hospital system does not talk to another so that the patient is left in the middle and messed about. So sort out the communication.”

“Be more open and communicate better with each other. We had to repeat ourselves every time someone came. They should know the history.”

It was noted that problems were also related to the fact that although Connecting Care is itself an integrated service, it still has to interact with other health and care systems around it, for example domiciliary care and hospitals. We saw a definite need for a solution to support people to co-ordinate their health and care provision, to be aware of what is out there for them and how to access it.

An important element of Connecting Care was to ensure that if people need other services staff were able to refer them internally, for example a district nurse recognising that help with shopping from Age UK might be useful for someone, or that a carer could do with some support from Carers Wakefield. We found that just over half of people we interviewed did feel that they had been given information about other support that they might need.

Have the staff who are supporting you given you information about other services that are available to you, including support organisations?				
			Response Percent	Response Total
1	Yes, definitely		33.63%	225
2	I have had some information		19.88%	133
3	I have not had any information		35.28%	236
4	I am not sure/I can't remember		11.21%	75

From our more detailed interviews with carers we found that support was often not felt necessary at the time of first contact with the Connecting Care service, but that if leaflets or information had been left that they were able to follow up later if necessary. As Healthwatch Wakefield interviewers were going into people's homes after Connecting Care services had finished, they sometimes picked up situations where people were getting worse and were able to refer back into Connecting Care for further support.

We felt that a more consistent way of providing information about the services available under Connecting Care might help people feel better supported. We also felt it would be useful for people to know if and how they could refer themselves back in to the service if they needed help later on.

“Instead of waiting to be asked can we have help, they should be offering help not try to find out what people can get. People don’t know about services. People need to be made aware.”



If you need to ask questions about your condition or treatment or support, who would you contact/ask? NB: don’t prompt an answer here.

		Response Percent	Response Total
1	Community Matron	1.93%	13
2	Another health/social care professional	13.20%	89
3	My GP	50.45%	340
4	Don't know/can't remember	5.64%	38
5	Family or Friend	11.87%	80
6	Other (please specify):	16.91%	114




Despite the efforts of Connecting Care and other primary care interventions aimed at diverting people to other sources of support than primary care, most people told us that they would still contact their GP to ask questions about their condition, treatment or support. For those who ticked the ‘other’ box, answers included social worker, Stonham, health and wellbeing worker, carers, 111, internet, Carelink, Social Care Direct and Age UK.

If you needed advice or help out of normal working hours who would you contact?

		Response Percent	Response Total
1	My GP	6.52%	32
2	111 Service	17.11%	84
3	I would go to A&E	3.46%	17
4	I have another number to ring out of hours	3.67%	18
5	Community Matron	1.43%	7
6	Care Link	13.24%	65
7	Family member	19.55%	96

If you needed advice or help out of normal working hours who would you contact?				
			Response Percent	Response Total
8	Not sure/Don't know		11.20%	55
9	Other (please state):		23.83%	117






Fewer people would contact their GP out of hours, most choosing a family member or 111. Care Link was also a high answer although not all people we interviewed had access to this service. Answers to 'other' include neighbours, 999, social workers, health and wellbeing workers, Stonham, palliative care contact, the warden at sheltered housing, friends and family.

Do you have a named health or care professional, or other support person, who co-ordinates your care and support?				
			Response Percent	Response Total
1	Yes, definitely		23.27%	155
2	Not really sure		9.91%	66
3	No, not a clue		66.82%	445

Having a named professional to co-ordinate your care was one of the key aims of the Connecting Care service in 2014, but proved to be one of the most difficult to achieve. Just under a quarter of all people interviewed felt that they had a named health or care professional. The majority of people however said that this person was their GP. Although general practice is an essential element of care in the community, GPs do not form part of the integrated Connecting Care hubs so this statistic is somewhat misleading.






When people did feel that they had a Connecting Care health professional as a named person to co-ordinate their care and support, they reported higher levels of satisfaction in relation to how involved they felt in decisions about their care (92% as opposed to 57% of those people who said they didn't have a clue if anyone co-ordinated their care). When asked who these named professionals were, people mentioned occupational therapists, social workers, Age UK, district nurses, mental health workers, consultants and matrons as some examples. Some people didn't know the person's occupation only their name.

Of those people who thought they had a named professional, 84% felt that person definitely understood them and their condition.






When it comes to making decisions about your care and support - are you as involved as you want to be?			Response Percent	Response Total
1	Yes, definitely		64.06%	426
2	Yes, to some extent		22.26%	148
3	Not really		6.02%	40
4	No, definitely not		3.91%	26
5	I am not sure		3.76%	25

86% of people interviewed felt they were definitely or to some extent as involved as they wanted to be in making decisions about their care and support, but 10% said not really or they definitely weren't and 4% said they weren't sure.

3.2.3 Understanding and wellbeing

Do you understand your medication (medicines and tablets) – why you need them and the side effects you might have?			Response Percent	Response Total
1	Yes, definitely		60.03%	392
2	Yes, to some extent		21.44%	140
3	Not really		8.12%	53
4	No, definitely not		8.58%	56
5	I am not sure		1.84%	12

Most people felt that they understood their medication and its possible side effects, although 56 people saying they definitely do not understand is a thought-provoking number of people, even though they are in the minority in this survey.






Would you say that you feel safe living at home?			Response Percent	Response Total
1	Yes, definitely		82.23%	546
2	Yes, to some extent		10.99%	73
3	Not really		3.92%	26
4	No, definitely not - I would rather be looked after somewhere else		1.36%	9
5	I am not sure		1.51%	10

The majority of people said that they felt safe living at home. The negative responses were often not necessarily connected with health and social care services but more about people's vulnerability in relation to the local environment, neighbours or other issues. Where appropriate, Healthwatch Wakefield alerted relevant support agencies for those people who said they did not feel safe, for example raising the issue with Wakefield District Housing who then made a visit to the property. However, it is also very possible that people might have told us they felt safe when they didn't because they don't want to leave their homes and go into a care home setting.






Do you have as much social contact as you would like?			Response Percent	Response Total
1	Yes, definitely		32.59%	218
2	I have some, it's OK		28.40%	190
3	Not really		20.33%	136
4	No, definitely not		16.89%	113
5	I am not sure		1.79%	12

This question shows that 37% of people (249 individuals) interviewed don't feel as though they have enough social contact. An analysis of their other responses shows that 32% of this cohort feel they are less able to cope with their situation than a month ago compared with 14% of those people who say they definitely have enough social contact. 40% feel worse in themselves compared with 13% of people who definitely have enough social contact.

Not really or definitely not enough social contact	Definitely enough social contact
40% feel worse in themselves	13% feel worse in themselves
32% feel less able to cope	14% feel less able to cope

Compared to a month ago how do you feel you are coping?				
			Response Percent	Response Total
1	Much more able to cope with my condition/situation		18.61%	123
2	A bit more able to cope with my condition situation		19.36%	128
3	About the same		37.67%	249
4	A bit less able to cope with my condition/situation		14.67%	97
5	A lot less able to cope with my condition/situation		9.68%	64

The reasons that people give for how they are coping and how they feel in themselves can vary according to their specific circumstances. Many people supported through Connecting Care are elderly with multiple long term conditions and they do not expect to feel significantly better or more able to cope within a month. This is reflected in the fact that the majority of people report that they are about the same.







Compared to a month ago how do you feel in yourself?			Response Percent	Response Total
1	Much better in myself		19.82%	131
2	A bit better in myself		17.70%	117
3	About the same		35.70%	236
4	A bit worse in myself		18.61%	123
5	A lot worse in myself		8.17%	54

3.2.4 Carers, family and friends

There were two questions in this survey that related to the carers, family and friends of people receiving Connecting Care services. There is acknowledgment that unpaid carers provide a significant amount of support and care to people, enabling them to stay in their own home for longer rather than go into hospital or into care home settings. Often those people wouldn't describe themselves as carers and therefore don't access much needed support. As our more detailed report about their experience shows¹, this can result in a detrimental impact on their own physical and mental health. The questions in this survey were designed to elicit information about the level of involvement of carers, and also how much support they were offered in their caring role.

Most people we interviewed (79%) said that they felt that friends and family who cared for them had been as involved as they wanted them to be in decisions about their care and support, even when they disagreed about what was the best for them.

“I don't like putting on my family - they don't want me in a home but it is for the best. They agreed with me eventually.”

When it comes to making decisions about your care and support are your family and friends as involved as you want them to be?			Response Percent	Response Total
1	Yes, definitely		63.64%	154
2	Yes, to some extent		14.88%	36
3	Not really		9.09%	22
4	I am not sure		2.07%	5
5	Not relevant - no involved family/friends		6.61%	16
6	I didn't want them involved in those decisions		3.72%	9

Only a very few people said that they did not want their family and friends who cared for them to be involved in decisions about their care.

Thinking about your family and friends who care for you, do you feel that they have had as much support from health and social services as they needed?

¹ *Evaluation of Connecting Care in Wakefield – Carers' Experiences of Connecting Care*, August 2016, Niche Health and Social Care Consulting and Healthwatch Wakefield

			Response Percent	Response Total
1	Yes they have had as much support as they needed		17.23%	41
2	They have had some support but not as much as they needed		10.08%	24
3	No they have had little or no support		34.87%	83
4	They did not want/need support		17.65%	42
5	There are no family members or carers to support		6.30%	15
6	I am not sure		13.87%	33

Only a small percentage of people interviewed (17%) felt that their family and friends have had as much support as they needed. The highest responses (45%) said that they had had little or no support, or not as much as they needed. This indicates a significant level of unmet need within this group.

"I don't cope, I struggle. Don't know what to say."

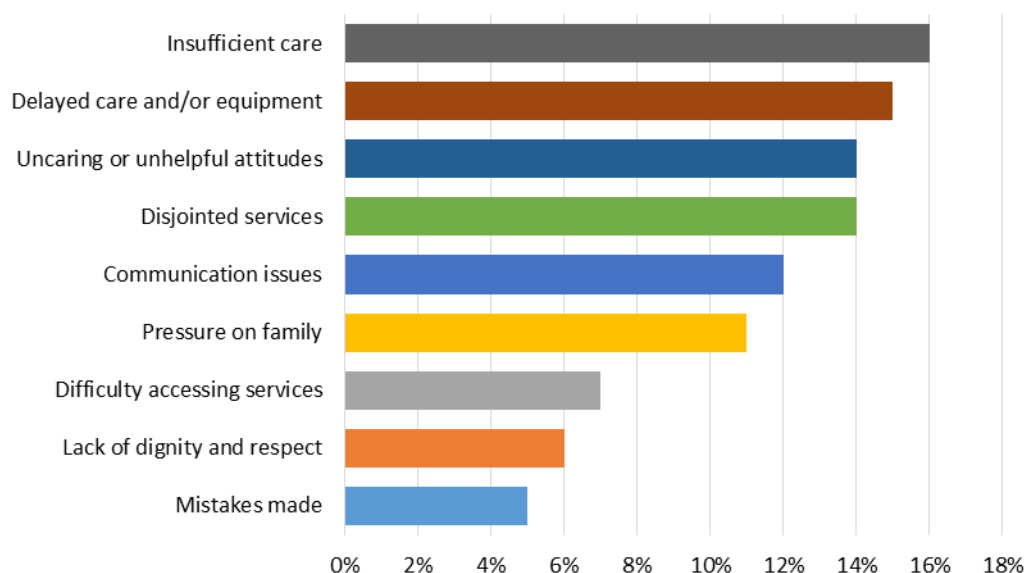
3.2.5 Qualitative comments

The final question of the survey asked people to share any additional comments about the care/services which they had received which could help to improve them in the future. 613 comments were recorded, including many very detailed histories, some spanning decades. A significant proportion of the stories we heard were not directly in relation to Connecting Care, but to discharge issues, previous hospital visits, mental health interventions, domiciliary care support etc. We found that lots of people enjoyed the opportunity to chat to our interviewers, particularly those who were not able to leave their homes very often.

Of those comments that were relevant to the Connecting Care service, we found there was a fairly even mix of positive and negative comments. The negative comments, as one would expect, exemplify the instances when Connecting Care has failed to deliver a joined up service.

Her daughter reported during the interview that the family were confused about who does what - they felt the service was disjointed.

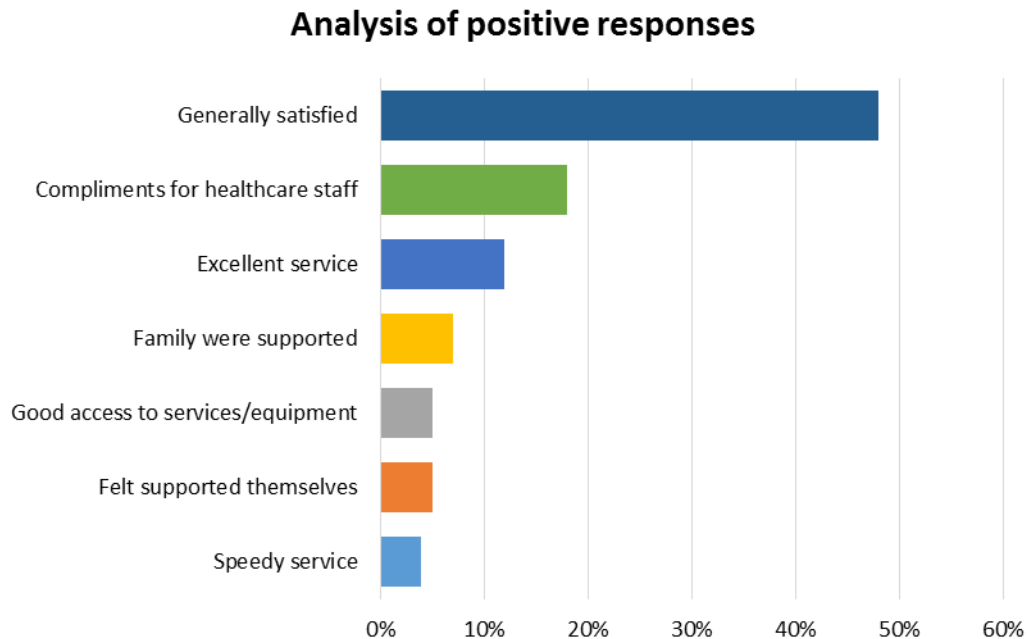
Analysis of negative comments



Those people who had some negative experiences primarily felt that their care had been insufficient. Some of the people who felt services were inaccessible were those who were expected to finance care themselves, one person with very little notice and experiencing great financial loss due to delays in the system. Delayed care and disjointed services were also seen as negative issues.

Those who had mixed views often involved comments by or regarding family. One family member had felt that care had been better previously but since more serious illness has occurred, this was no longer the case for their loved one. There were also comments that the system seems to rely perhaps too heavily on family members - for time and finances.

The themes from the positive responses are as follows:



It seems evident from our interviews with people receiving Connecting Care, that when staff are able to turn the aims of the integrated service into a reality on the ground, the outcomes for people are better and they are very satisfied with their care.

We conclude this section with case study examples from our conversations with people who have used the Connecting Care services. All are provided with permission of the patients/service users involved, and all names have been changed.

“..When Dad was ill the Community Matron AB organised short term carers so we could keep Dad at home rather than go into hospital... CD from Social Care helped too ... the services work very well together ... AB is amazing ... if she is not there I contact her colleague who is really good, they are both very helpful ... there is no better care, the team are fabulous.

Dad was very reluctant to have help and AB helped me coax him ... AB put me on the right track ... I can contact her anytime and if I ring they are out to him within the hour! ... My aunt was having health problems and like dad she was very reluctant to have any help but AB got her on the list and now she says it is the best thing she has ever done and wished she would have done it years ago... AB really gets in touch with the patients and chats to him about sports etc ... his face lights up when she comes in ... 11/10”

Additional comments “it is a shame more people cannot access this service. Before we had to ring 999 when he became ill and he was in hospital getting anxious and it was an unnecessary burden for the staff at the hospital as we were there nearly every week but now we have the Community more staff, we need more Community Matrons”

Alf was referred to Age UK Connecting Care from the Age UK hospital to home scheme. He is 83 years old and has diabetes, arthritis and poor mobility. He wanted help to get a walking aid. He was seen and assessed by an Age UK using the LEAF assessment. His assessment identified that, in addition to his mobility problems, he was feeling quite socially isolated.

He was referred to MyTherapy for further help with his mobility and Age UK addressed his need for more social contact. Alf is now attending a local reading group every Monday and is using the access bus to do this, he has better walking aids now and feels a lot happier that he can now access the community and is back doing what he loves which is reading in large groups.

Alf said that he is very happy with the service that he has received from Age UK and that he didn't think it was possible for him to improve his life at his age and he couldn't have done it without the help from Age UK.

Elsie is 75 and lives alone. She has recently had a second heart attack and becomes short of breath when walking. Her family referred her to Age UK as they felt she was struggling to manage at home and was now living downstairs due to being too weak to manage the stairs.

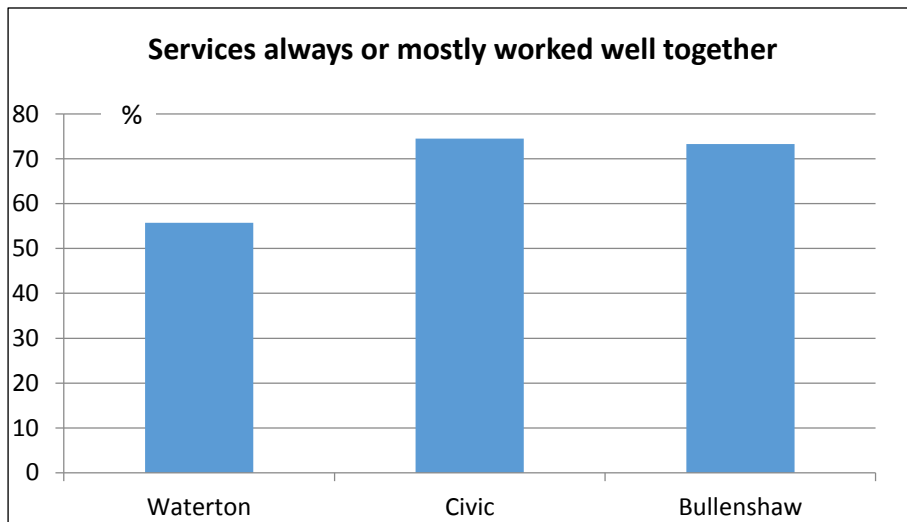
Following assessment Age UK give information and advice as well as making a successful referral to DWP for attendance allowance. Additional referral was made to MyTherapy for a kitchen and bathroom assessment which resulted in a stair lift being fitted and bathroom adaptations. MyTherapy also provided physiotherapy services to assist with the client's mobility.

Betty is in her late seventies and has COPD. She was referred from the district nursing service as her husband was struggling to cope looking after her, as he too was elderly. At that time they had no other services involved.

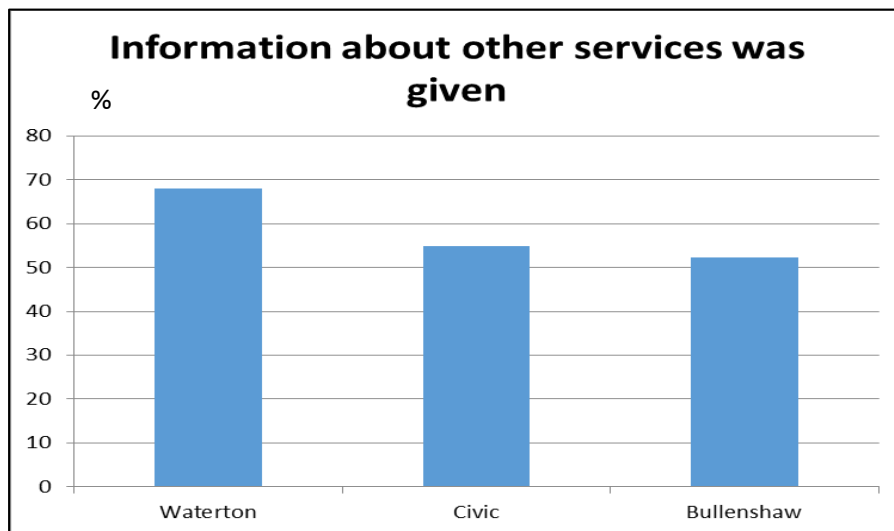
Betty's niece had originally rung district nursing in desperation as she knew someone who worked there. The Community Matron saw and assessed Betty and started working to improve her management of COPD. It was clear that Betty's mobility was also poor, and so the matron referred her to MyTherapy. She also identified that Betty and her husband were not receiving any benefits. Betty was also taking 2 to 3 hours to get herself dressed in the morning and was then so exhausted she could not do anything for the rest of the day, so she was also referred to Social Care to assess and provide carers to help in the morning and look at benefits. As the lady was elderly the matron also asked Age UK to assess her and her husband was referred to Carers Wakefield. "And all on one referral form!"

3.3 Tracing differences between hubs

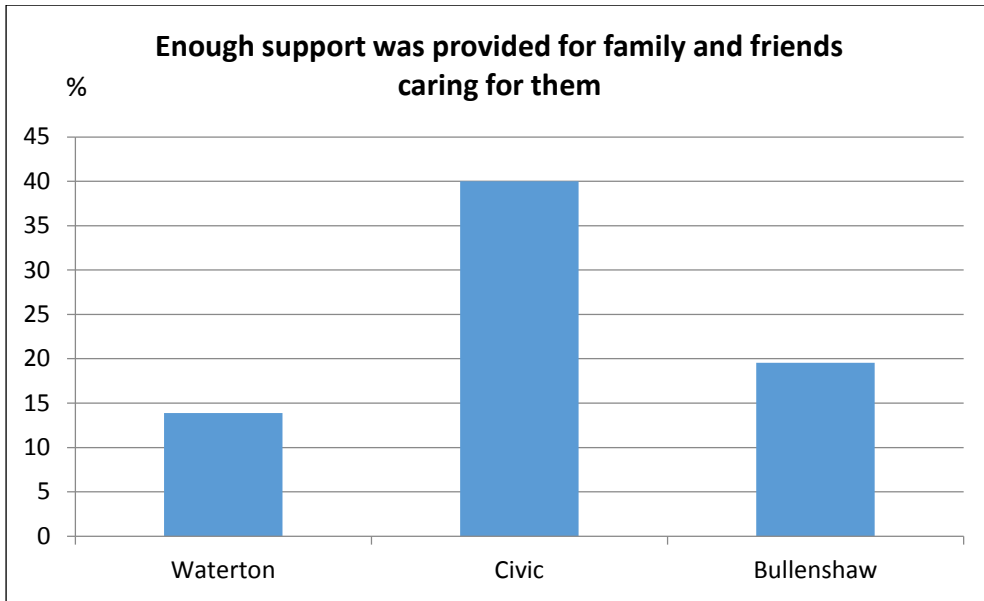
Analysis of the data from the three hubs shows that, on most of the indicators, there is not a significant amount of difference between the three. There are, however, also some interesting variations. Fewer people said that services from Waterton hub worked well together than the other two, which might suggest that the staff, although co-located in one building, are not working in a truly integrated way because of the layout of the environment.



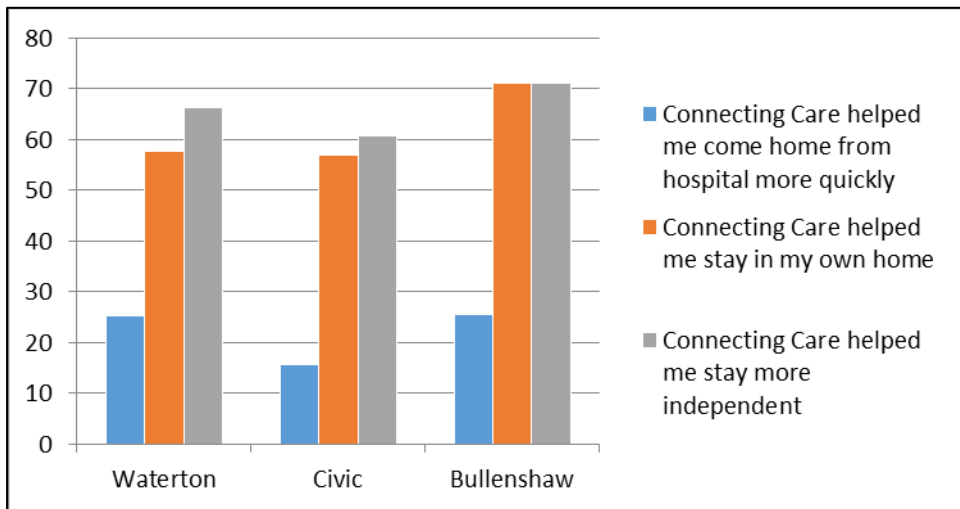
Interestingly however, more people said that Waterton hub staff had given them information about other services. This is a key indicator of whether or not Connecting Care staff are identifying additional needs that could be met through other colleagues within the integrated teams.



The most significant variation between answers in the hub was in relation to support offered to family and friends. As seen below, people being supported through the Civic hub were far more inclined to say that their family and friends caring for them had received enough support.



Most of the reported outcomes from the Connecting Care service were roughly similar across the three hubs. The chart below shows the three outcomes that had some variation in response. On these measures, the Bullenshaw Hub appears to have been more effective.



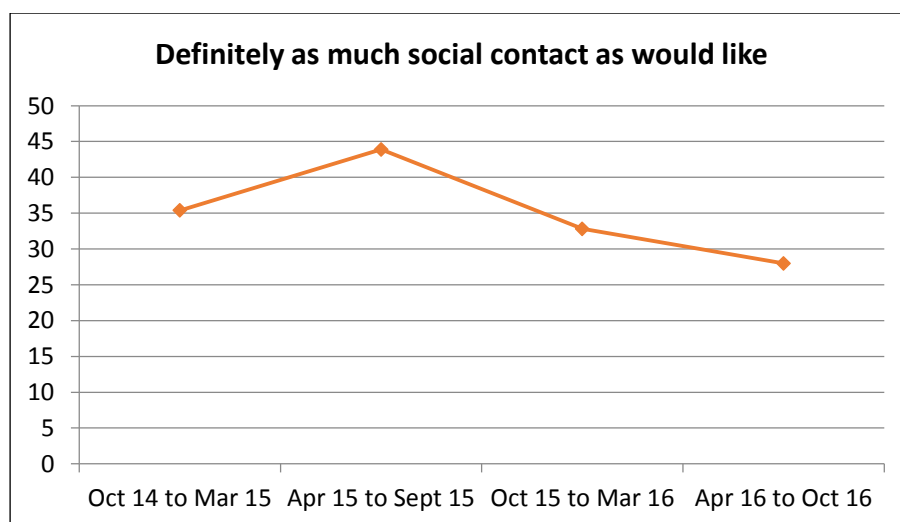
3.4 Tracing differences over time

The data collected over the two years has not been collected in a regular fashion due to issues such as the intermittent nature of the referrals to the evaluation team, the phased start-ups of the hubs and the occasional setback in relation to administration of Connecting Care. However, for the purposes of determining if any differences over time can be traced, the 25 months of data were divided into roughly six month sections, as follows:

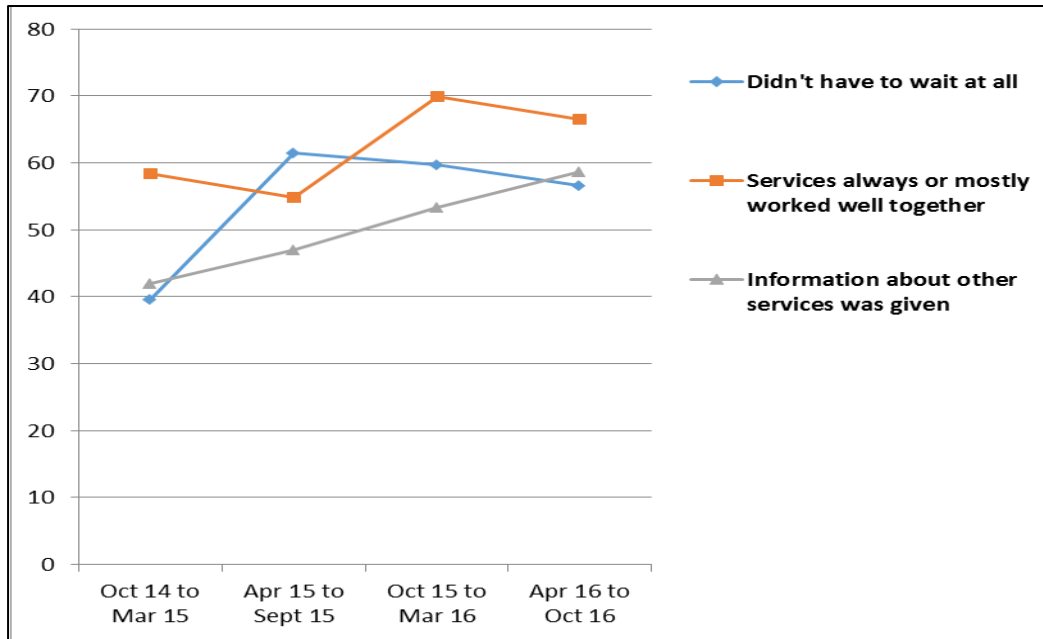
Timescale	Number of interviews
October 2014 to March 2015	66
April to September 2015	84
October 2015 to March 2016	252
April to October 2016	274

Some questions showed very little difference over time, but there were a few questions that did demonstrate a change in people's experience of Connecting Care from October 2014 when the service started, to 31 October 2016 when the evaluation came to an end. The majority of the change was positive.

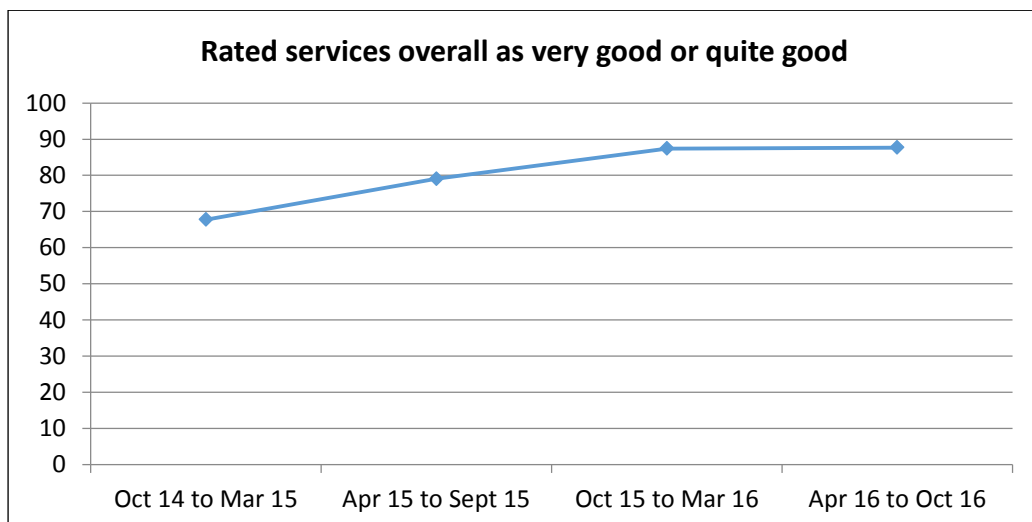
There was one question that showed a negative trend and this was not really related to the Connecting Care service; this was the question about whether or not people felt they had as much social contact as they would like. From our observations during the 680 interviews, this often related to the fact that many people were either very poorly or unable to leave the house as often as they would like for various reasons. From another question in the survey, 'Help to get out and about' was the most often identified service that people said would have been of benefit to them to help them regain their independence more quickly and/or feel more able to cope at home. This appears to be an unmet need for many people.



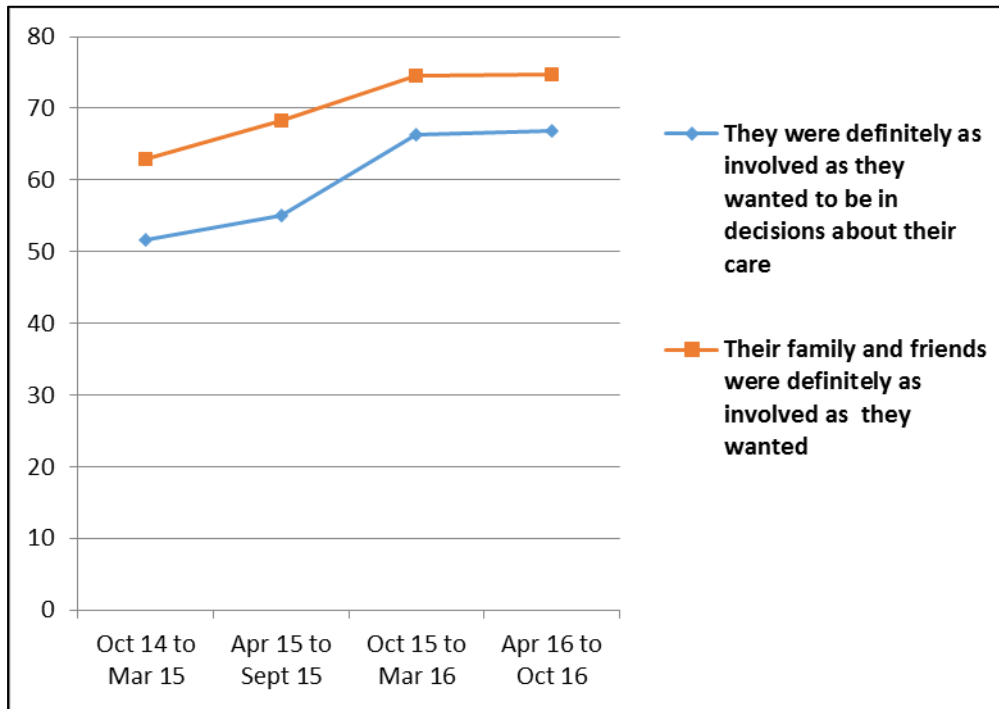
The questions that measured the integration of the service have shown improvements over time, albeit with a few peaks and troughs along the way. Overall, by the end of the evaluation period more people were reporting that they haven't had to wait for the service, that services always or mostly worked well together and that where appropriate, information has been given to them about other services that might be helpful.



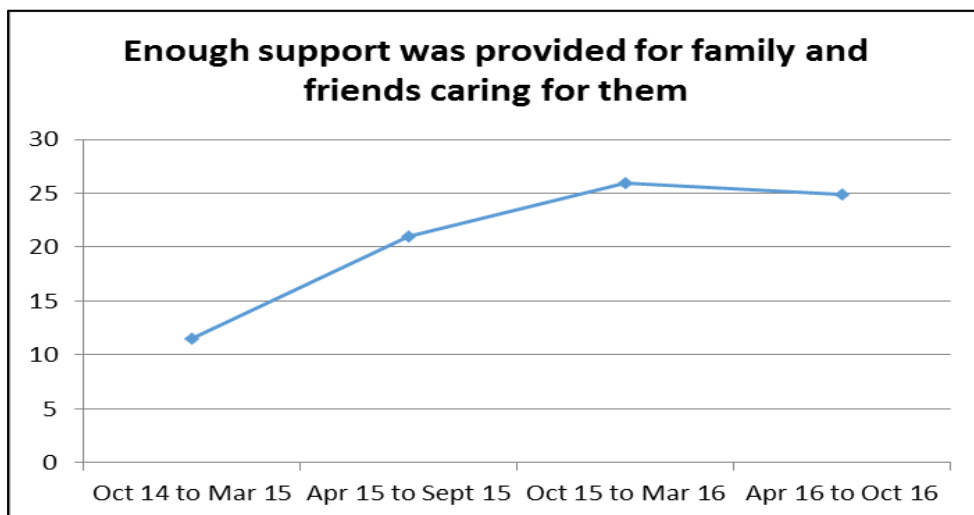
In addition, from 2014 to 2016 a gradual improvement in people's rating of the service can be traced, from 68% to 88% saying Connecting Care was very good or quite good overall.



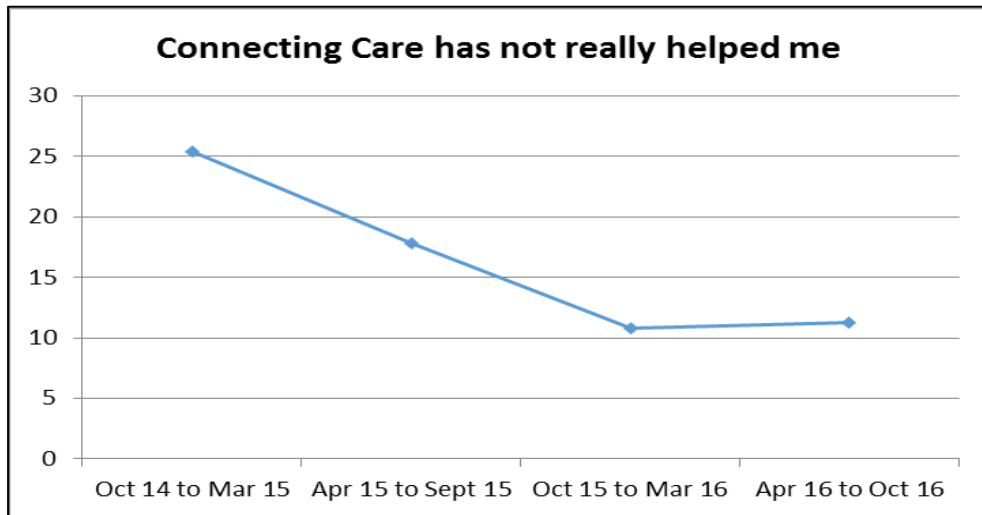
People also reported more as time went on, that they definitely felt involved in decisions about their care and that their family and friends who were caring for them were involved as much as they wanted them to be. This is a positive trend both in the experience of the service, but also in the move towards supporting people to take more control over their own health and wellbeing.



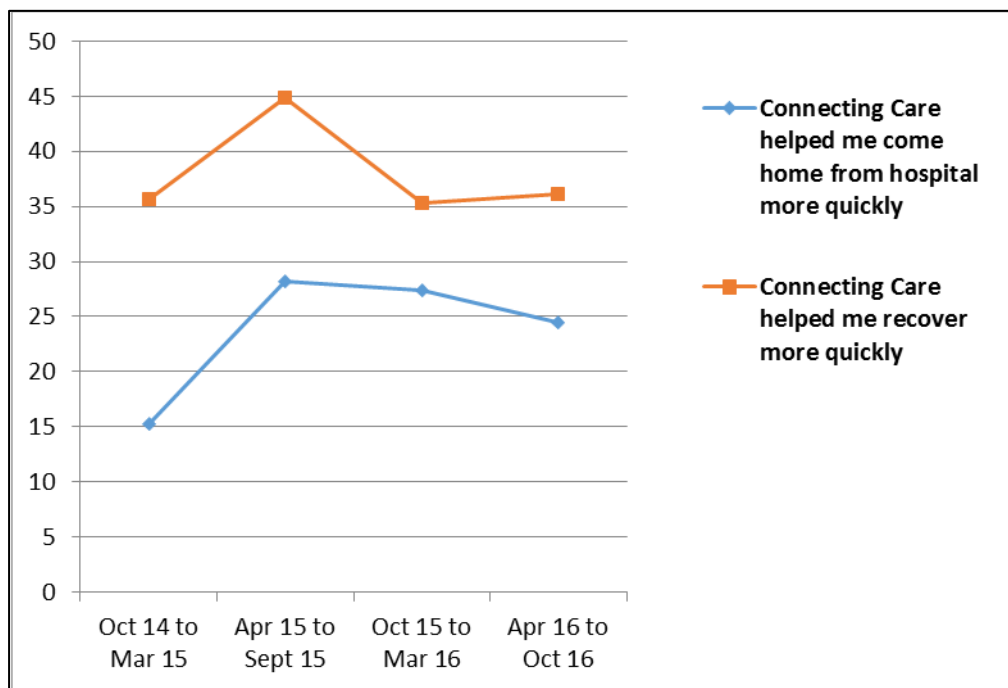
In relation to family or friends in caring roles, there was a positive trajectory over time, with 11% of people in 2014 saying that enough support had been provided increasing to 25% in 2016.



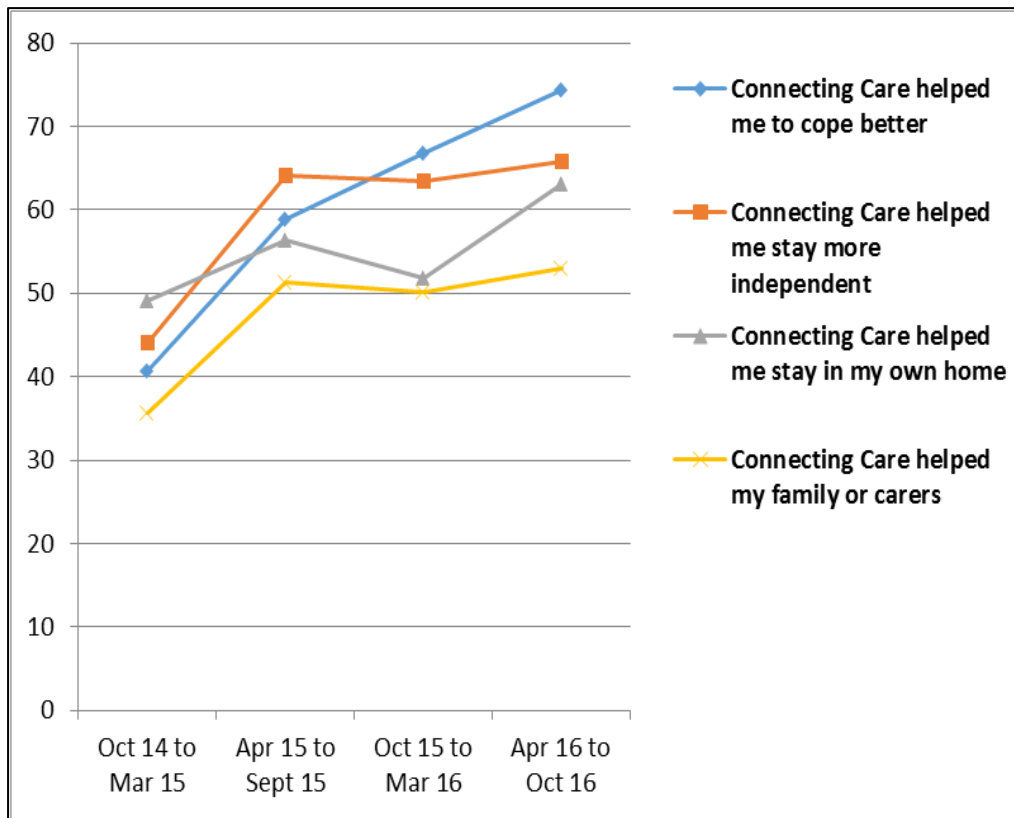
One could argue that the most important question of the evaluation was whether or not people felt the Connecting Care service had achieved the right outcomes for them. We measured seven outcomes that the service aimed to achieve, six positive and one that stated the Connecting Care services ‘had not really helped me’. The graph below shows the downward trend of the answers to this final outcome.



The outcome ‘Connecting Care helped me to come home from hospital more quickly’ showed an initial increase from the first period, but then began to dip towards the end of the evaluation. ‘Connecting Care helped me recover more quickly’ has reverted to the same average response at the beginning, albeit with a large peak in the second period.



Four of the indicators, again with some peaks and troughs, show an improvement in reported outcomes from the beginning of the Connecting Care service in 2014 to the end of the evaluation in October 2016. In particular, the outcome 'Connecting Care helped me cope better' increased from 41% to 74% over the two years.



On the following pages, we present an analysis of the movements over time, with 95% confidence intervals. This suggests that there has been statistically significant change from the first to the last survey period on 15 of the 26 indicators in this survey. Of these changes, fourteen are in a positive direction; only one has been in a negative direction.

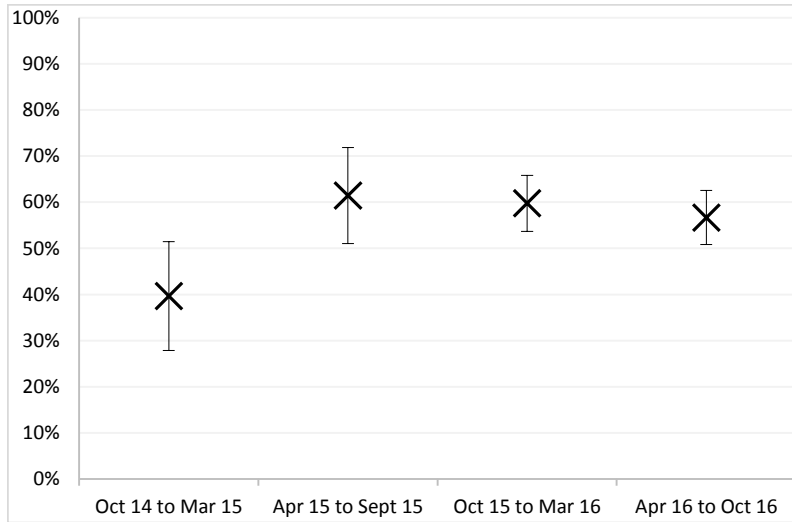
	Survey Question <i>*Results have been omitted where no improvement has been found.</i>	Oct 14 to Mar 15 Result	Apr 16 to Oct 16 Result	Improvement Trend
1.	Didn't have to wait at all	40%	57%	↑
2.	Services always or mostly worked well together	*	67%	—
3.	Definitely or mostly treated with kindness and compassion	*	98%	—
4.	Info about other services was given	42%	59%	↑
5.	Would ask GP about condition/treatment/support		50%	—
6.	Definitely has named health or care professional co-ordinating their care and support	14%	26%	↑
7.	This person definitely understands me and my condition	86%	78%	↓
8.	Definitely or to some extent understands medication		78%	—
9.	Definitely as involved as they want to be in decisions about their care	52%	67%	↑
10.	Family and friends definitely as involved as you want	63%	75%	↑
11.	Enough support was provided for family and friends caring for them	11%	25%	↑
12.	Definitely feels safe living at home	*	83%	—
13.	Definitely as much social contact as would like	*	28%	—
14.	Definitely not as much social contact as would like	*	18%	—
15.	Much more able to cope compared to a month ago	*	18%	—
16.	A lot less able to cope compared to a month ago	17%	10%	↑
17.	Feel much better in themselves compared to a month ago	*	18%	—
18.	Feel a lot worse in themselves compared to a month ago	*	10%	—
19.	Rated services overall as very or quite good	68%	88%	↑
20.	Connecting Care helped me come home from hospital more quickly	15%	24%	↑
21.	Connecting Care helped me stay in my own home	49%	63%	↑
22.	Connecting Care helped my family or carers	36%	53%	↑
23.	Connecting Care helped me recover more quickly	*	36%	—
24.	Connecting Care helped me stay more independent	44%	66%	↑
25.	Connecting Care helped me to cope better	41%	74%	↑
26.	Connecting Care has not really helped me	25%	11%	↑

Improvement Trend Key	
↑	Improvement
—	No movement
↓	Negative movement

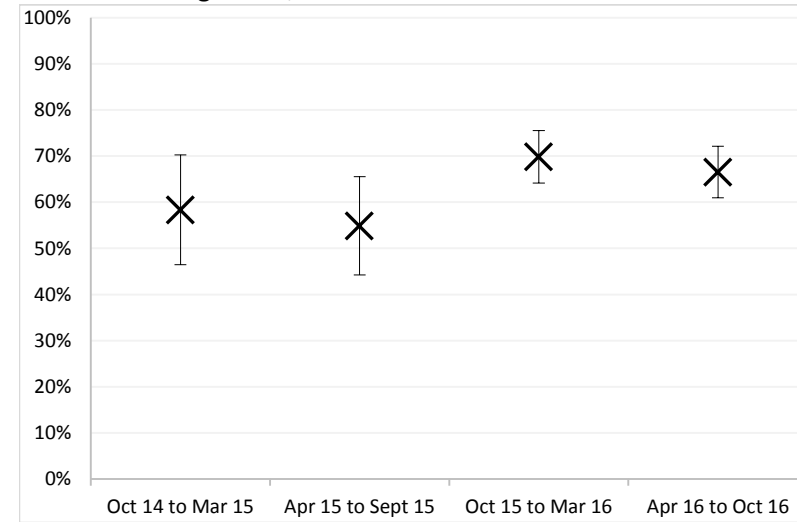
1. Proportion of respondents who agreed with “Didn't have to wait at all”,

2. Proportion of respondents who agreed with “Services always or mostly

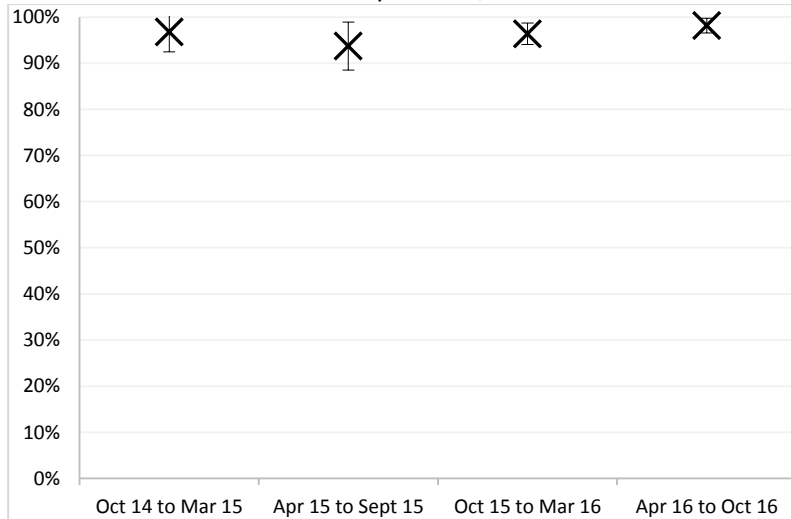
with 95% confidence intervals.



worked well together", with 95% confidence intervals.

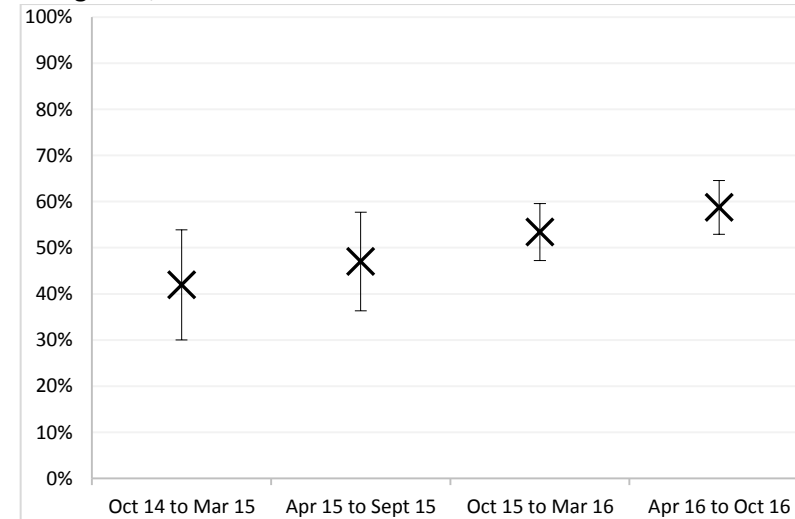


3. Proportion of respondents who agreed with "Definitely or mostly treated with kindness and compassion", with 95% confidence intervals



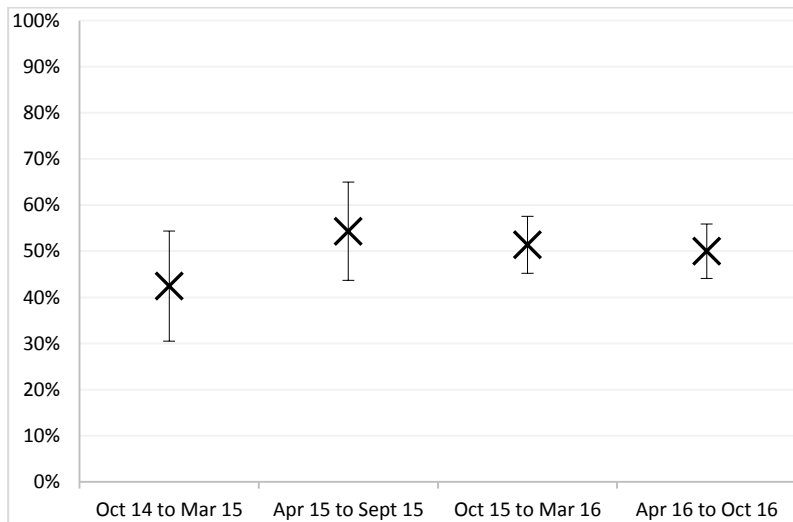
5. Proportion of respondents who agreed with "Would ask GP about

4. Proportion of respondents who agreed with "Definitely has named

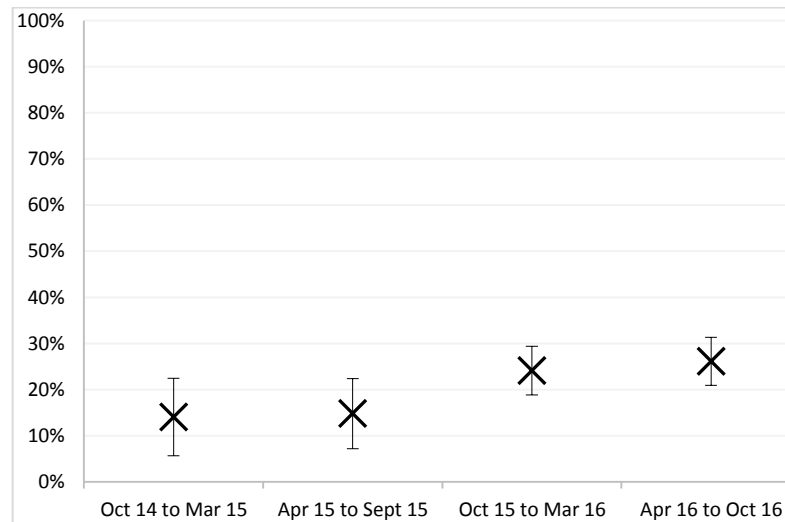


6. Proportion of respondents who agreed with "Definitely has named

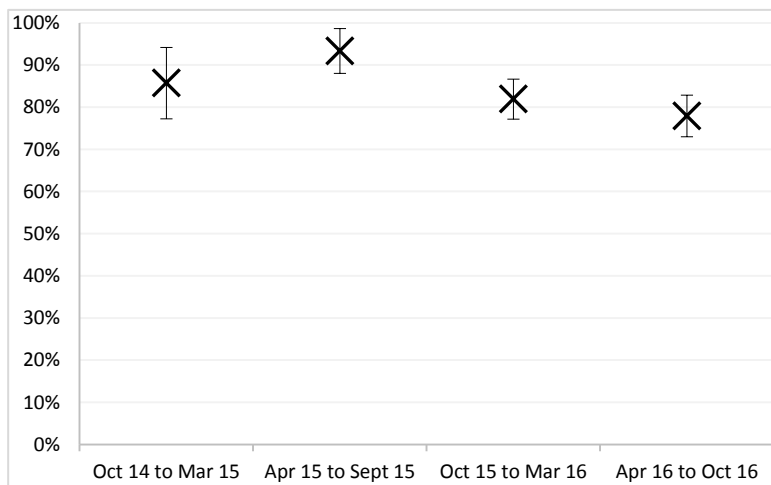
condition/treatment/support”, with 95% confidence intervals.



health or care professional co-ordinating their care and support”, with 95% confidence intervals.

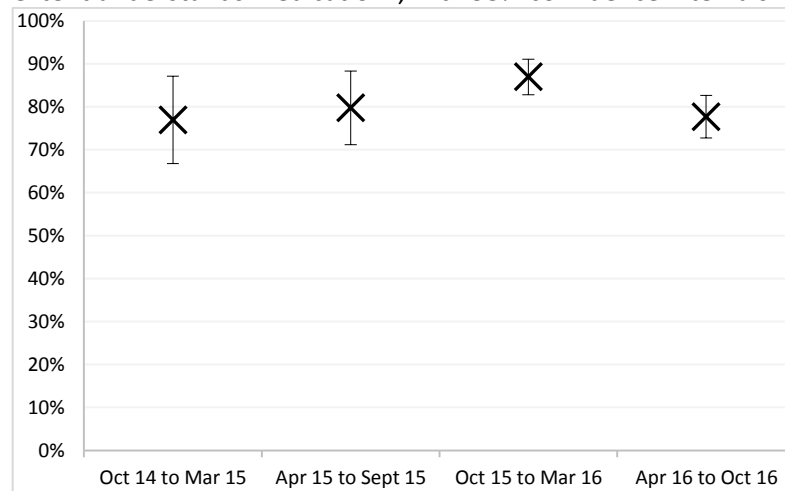


7. Proportion of respondents who agreed with “This person definitely understands me and my condition”, with 95% confidence intervals.



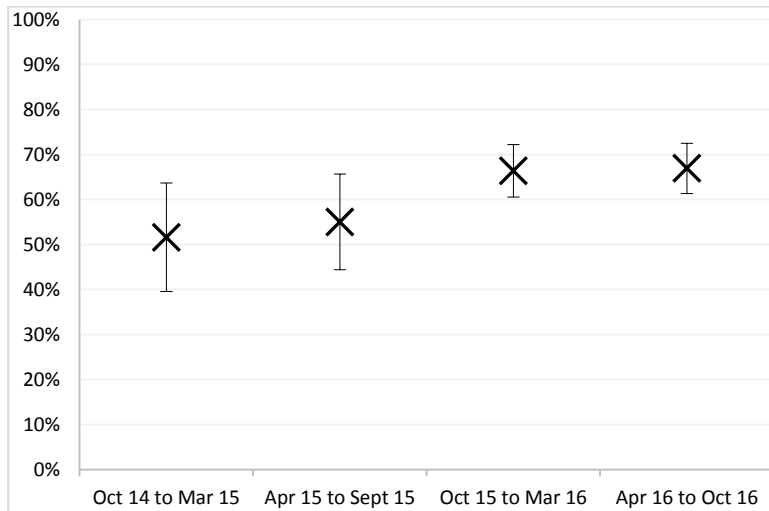
9. Proportion of respondents who agreed with “Definitely as involved as

8. Proportion of respondents who agreed with “Definitely or to some extent understands medication”, with 95% confidence intervals.

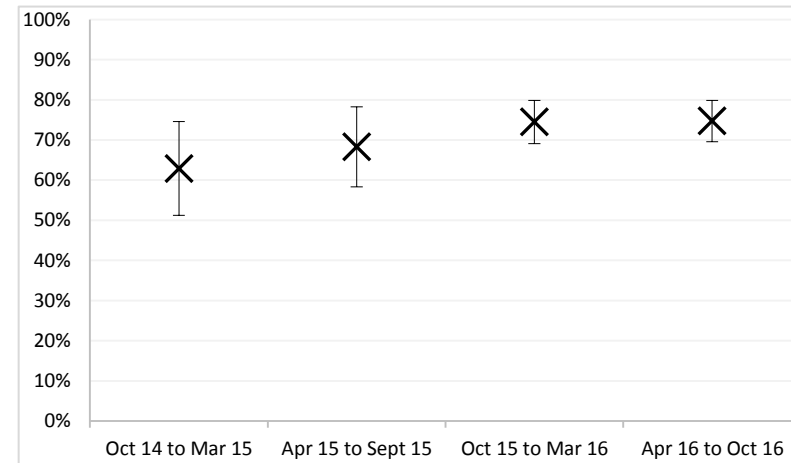


10. Proportion of respondents who agreed with “Family and friends

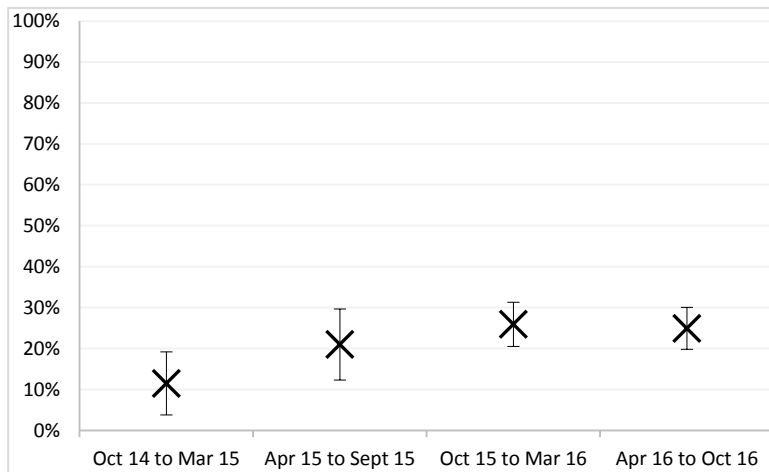
they want to be in decisions about their care”, with 95% confidence intervals.



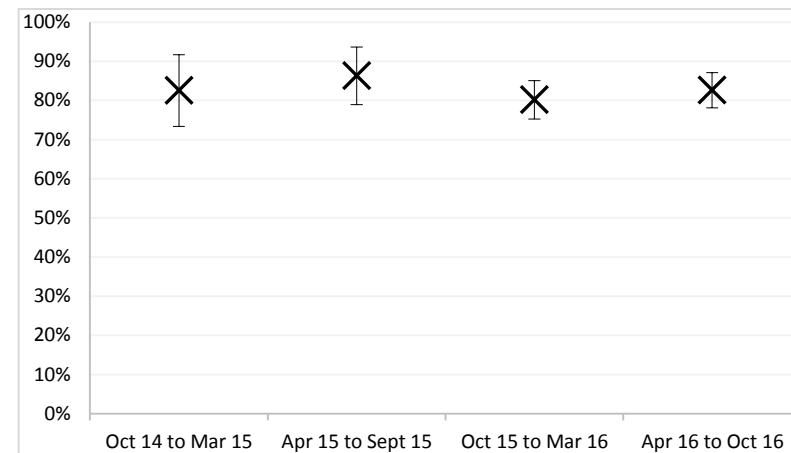
definitely as involved as you want”, with 95% confidence intervals.



11. Proportion of respondents who agreed with “Enough support was provided for family and friends caring for them”, with 95% confidence intervals.



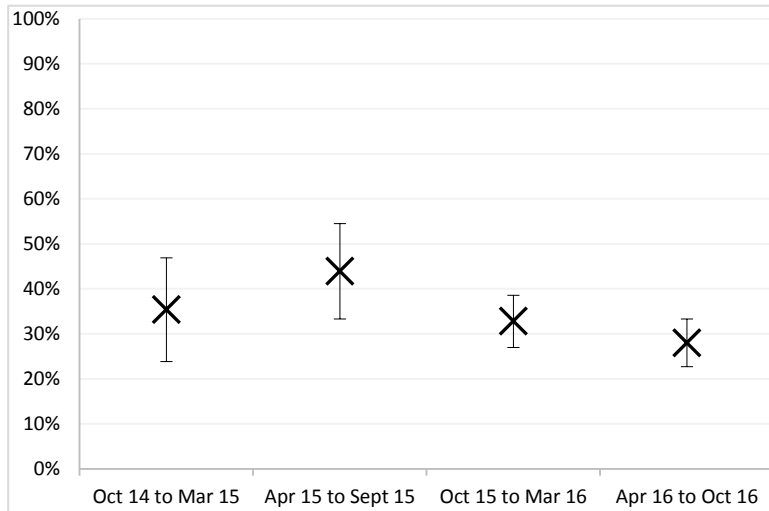
12. Proportion of respondents who agreed with “Definitely feels safe living at home”, with 95% confidence intervals.



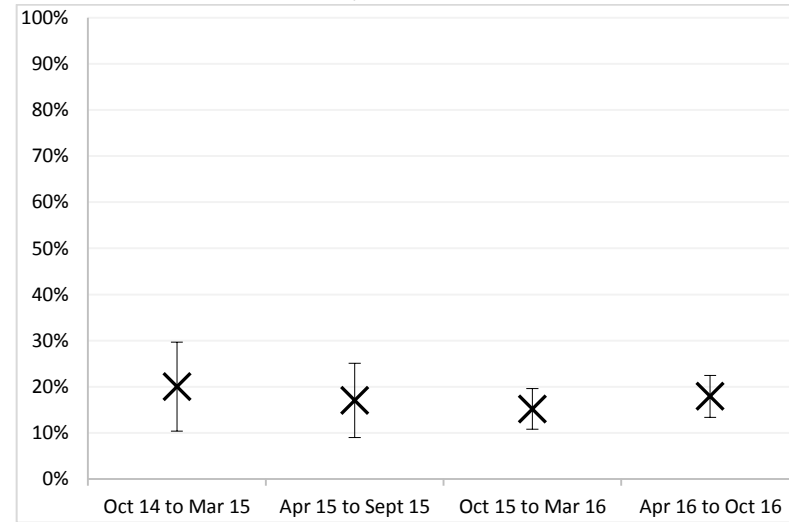
13. Proportion of respondents who agreed with “Definitely as much

14. Proportion of respondents who agreed with “Definitely not as much

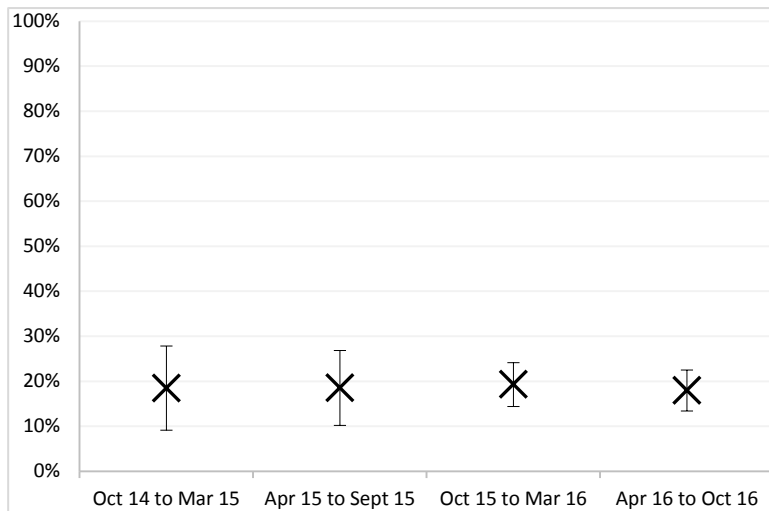
social contact as would like”, with 95% confidence intervals.



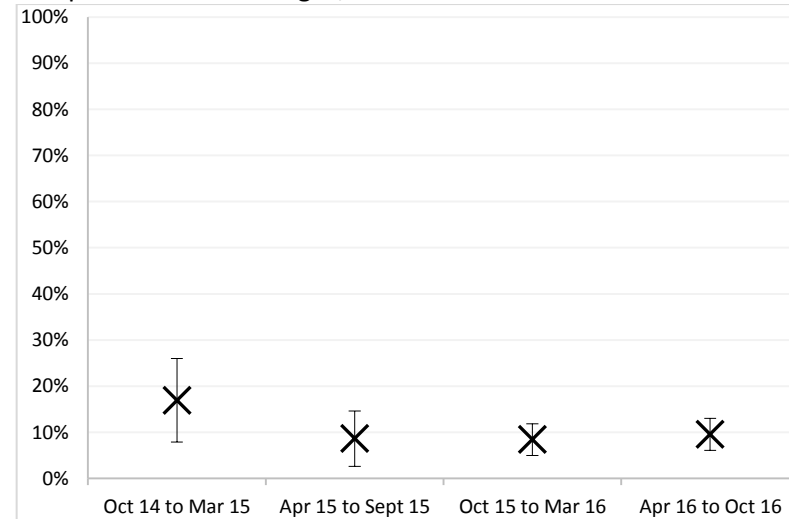
social contact as would like”, with 95% confidence intervals.



15. Proportion of respondents who agreed with “Much more able to cope compared to a month ago”, with 95% confidence intervals.



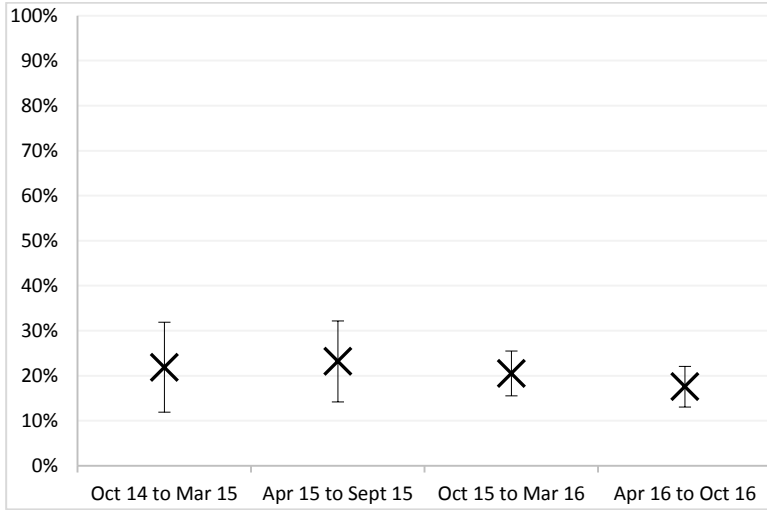
16. Proportion of respondents who agreed with “A lot less able to cope compared to a month ago”, with 95% confidence intervals.



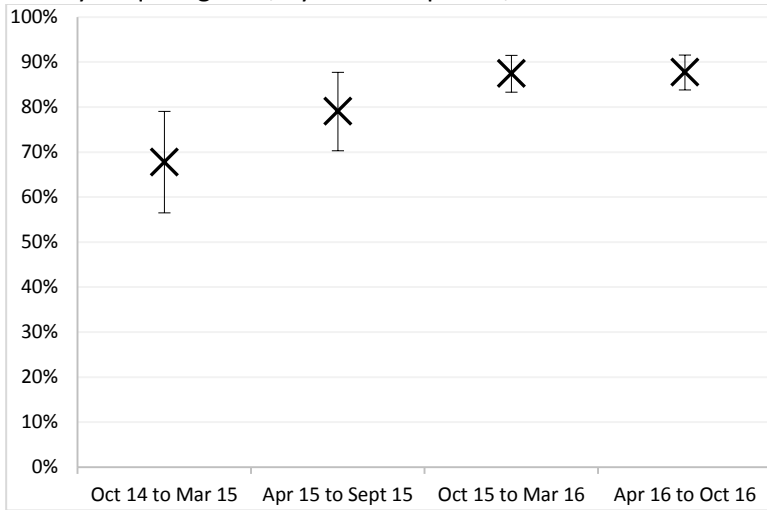
17. Proportion of respondents who agreed with “Feel much better in

18. Proportion of respondents who agreed with “Feel a lot worse in

themselves compared to a month ago”, with 95% confidence intervals.

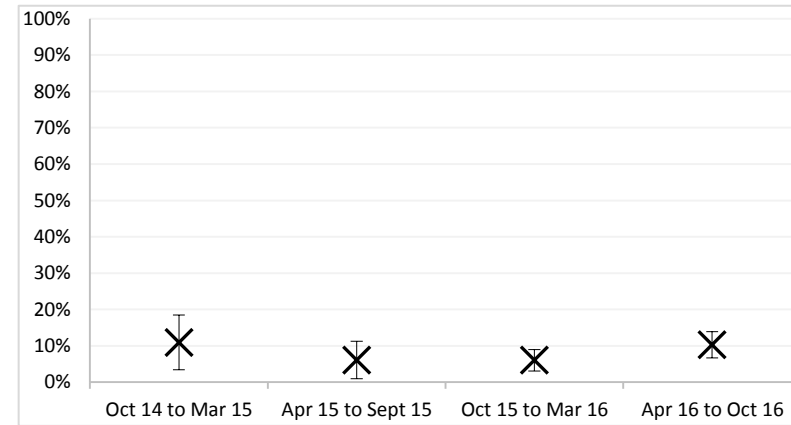


19. Proportion of respondents who agreed with “Rated services overall as very or quite good”, by 6 month period, with 95% confidence intervals.

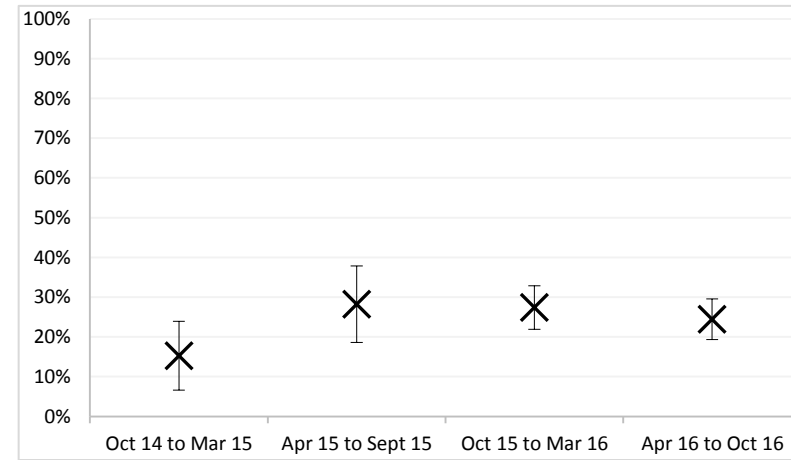


21. Proportion of respondents who agreed with “Connecting Care helped

themselves compared to a month ago”, with 95% confidence intervals.

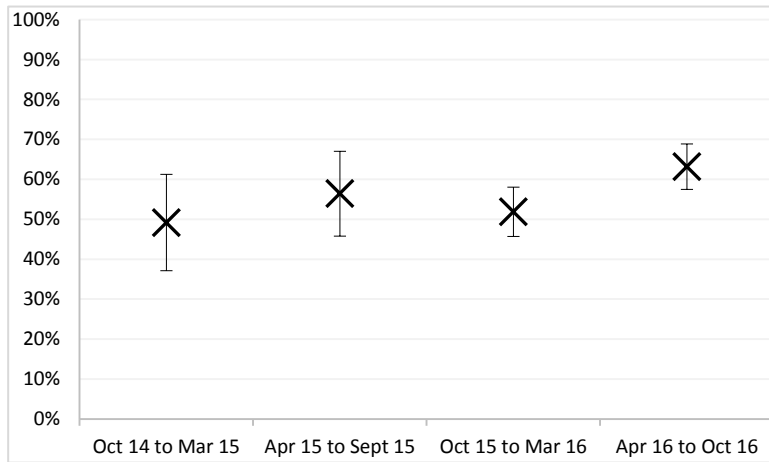


20. Proportion of respondents who agreed with “Connecting Care helped me come home from hospital more quickly”, with 95% confidence intervals.

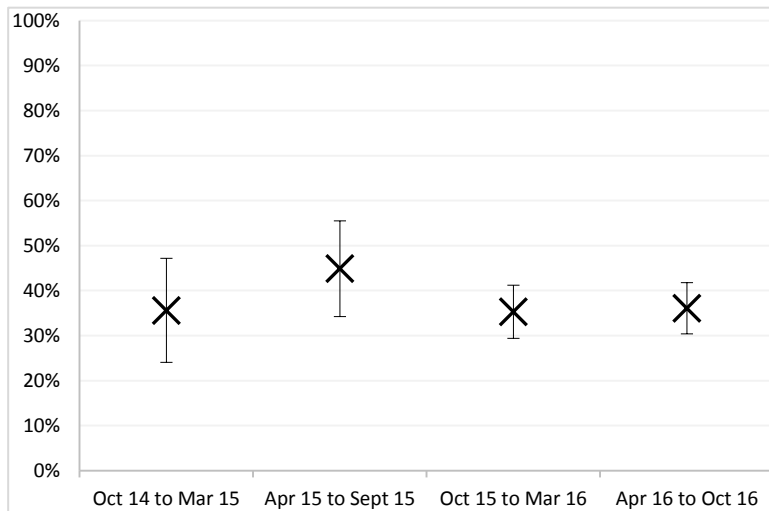


22. Proportion of respondents who agreed with “Connecting Care

me stay in my own home”, by 6 month period, with 95% confidence intervals.

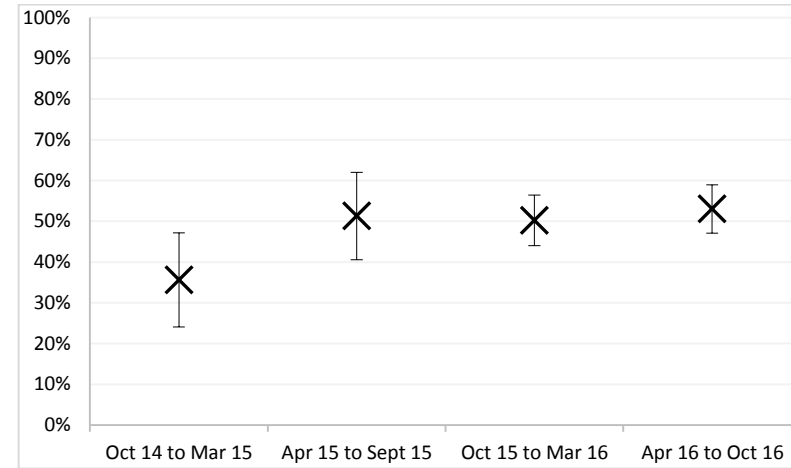


23. Proportion of respondents who agreed with “Connecting Care helped me recover more quickly”, by 6 month period, with 95% confidence intervals.

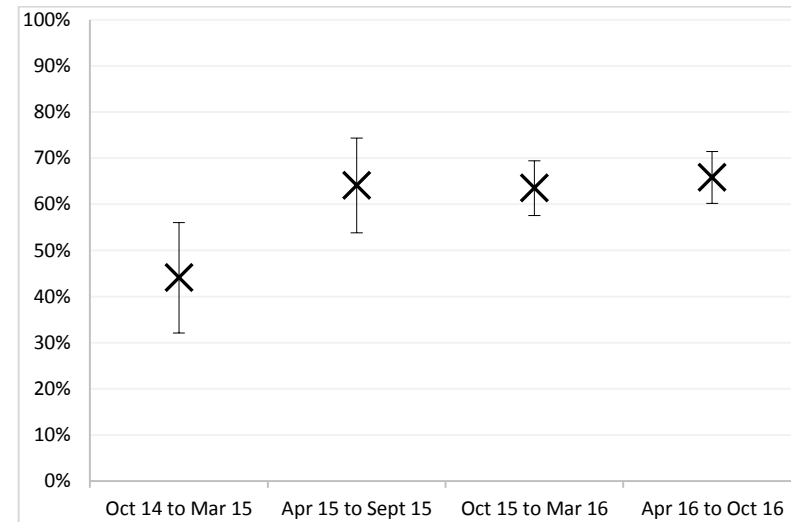


25. Proportion of respondents who agreed with “Connecting Care helped

helped my family or carers”, by 6 month period, with 95% confidence intervals.

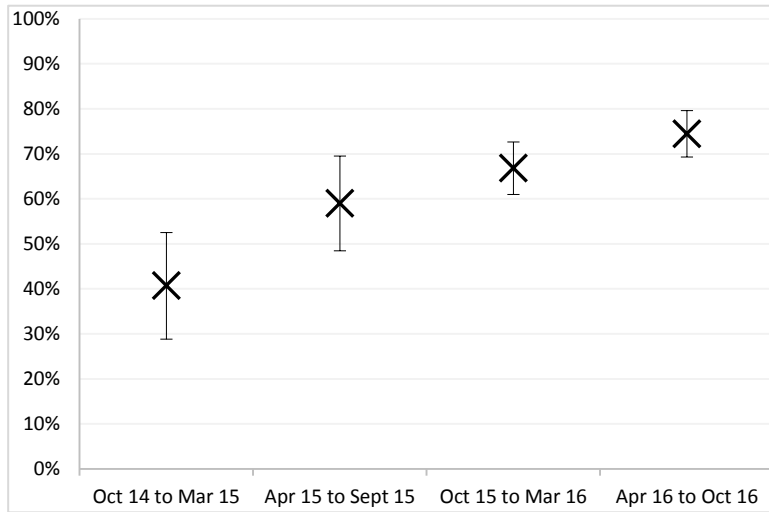


24. Proportion of respondents who agreed with “Connecting Care helped me stay more independent”, by 6 month period, with 95% confidence intervals.

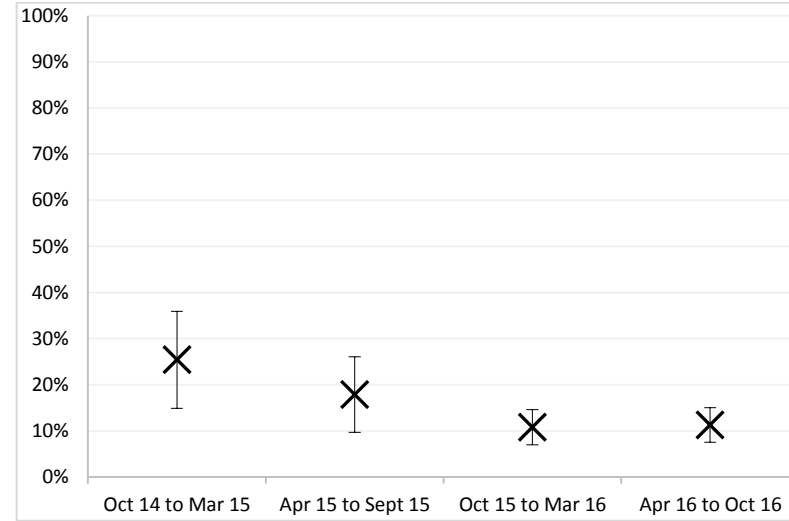


26. Proportion of respondents who agreed with “Connecting Care has

me to cope better", by 6 month period, with 95% confidence intervals.



not really helped me", by 6 month period, with 95% confidence intervals.



4. DATA ANALYSIS

We have analysed data from various sources in Wakefield to monitor the activity of the Connecting Care service, along with other elements of the Wakefield health economy;

- Non-elective admissions to acute hospital inpatient wards (excluding maternity);
 - Emergency admissions
 - Non-emergency admissions (repatriations of Wakefield patients from outside the area)
- Admissions to residential and nursing homes
- Presentations to acute hospital accident and emergency departments

Where possible, we have analysed overall activity, along with demographic factors which sit behind the overall activity. There have been challenges in the recording of data from Connecting Care, due to the different data systems used by the various services within it. We have received the monthly performance reports provided by the service, which give headline data on contacts and referrals, along with some data on the source of referrals. In these reports, “South East” is Bullenshaw, “East” is the Civic centre, and “Central” is Waterton.

The data relating to inpatient admissions and emergency department presentations has consisted of a regular data feed of episode level data from Mid Yorkshire Hospitals from the beginning of 2013 onwards. This has allowed us to look at trends in this data from prior to the introduction of the Connecting Care service, through to the present time. Similarly, we have received a regular feed of the number of admissions to care homes from Wakefield MDC.

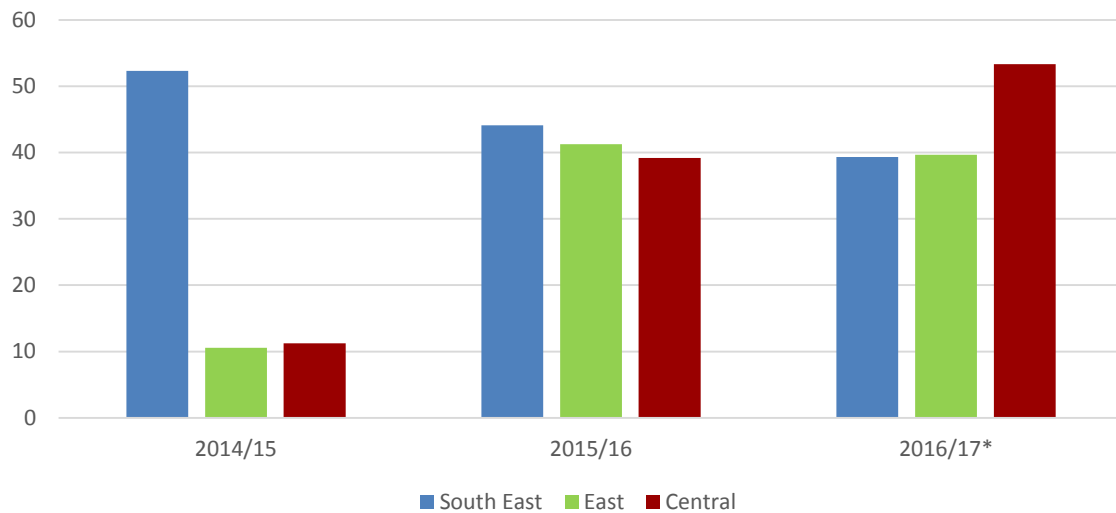
Local confidence in the quality of data submissions has not been high, throughout this evaluation project. Responses to drafts of this final report included suggestions that:

- The data on connecting care team activity is of too low accuracy to warrant inclusion in here at all
- The criteria for counting nursing home admissions have changed, such that returns on this topic should be regarded as non-standard
- Forms of ambulatory care presentation via A&E have been counted as inpatient admissions in an inconsistent way over the data period, such that the numbers of full inpatient admissions may now be over-stated

We have therefore considered the option of presenting very little data activity at all in this report. We have, however, decided that it is on balance preferable, and in the interests of transparency, to present the relevant data as supplied over the course of the project, but to precede it by this strong caveat. The data in this section are secondary data to this evaluation, gathered locally, and not directly by the evaluation team. We cannot therefore provide any assurance as to its reliability, and we advise readers of this report to interpret all data in this section with caution, and not to rely on it for decision-making purposes.

4.1 Connecting Care Activity by team and speciality

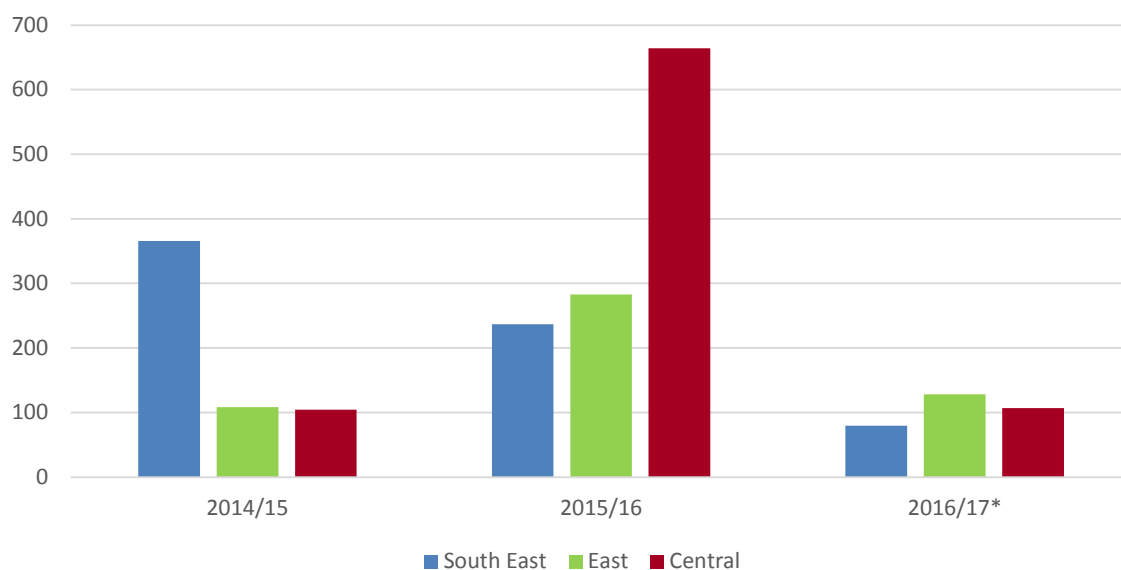
Figure 4.1 – Average number of referrals to community matron service per month, by hub



* - to Jun 2016

Whilst there was variation in 2014/15 between the hubs, this largely equalised in 2015/16. In each hub, an average of 40-45 referrals per month were received by the community matrons. In the first months of the current financial year, there has been a slightly higher average in the Central hub.

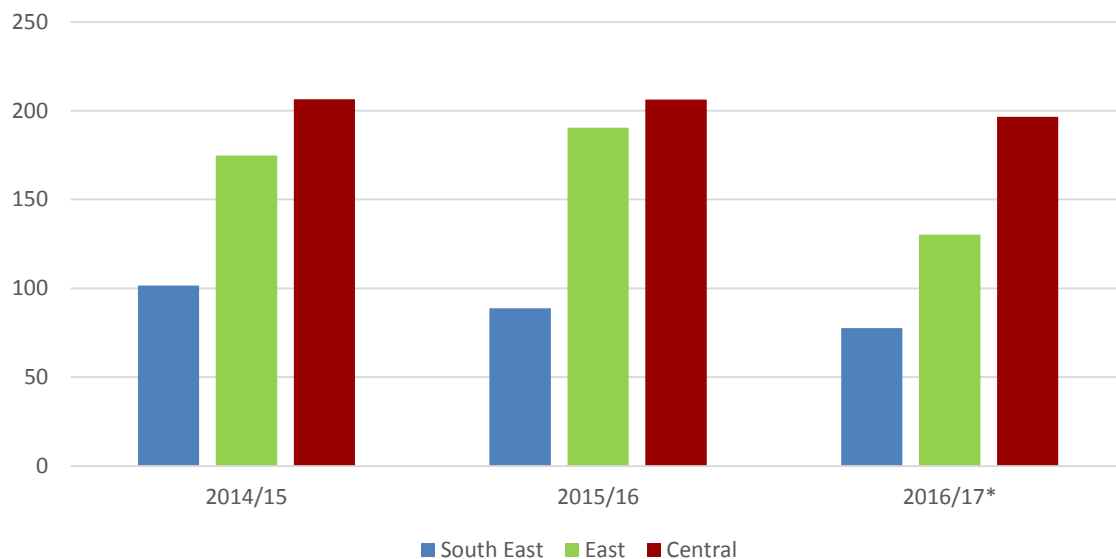
Figure 4.2 – Average number of community matron contacts per month, by hub



* - to Jun 2016

In the East and Central hubs, the average number of contacts per month in the current financial year has settled back roughly at the level seen in 2014/15, after increases in 2015/16 (particularly notable in the case of Central). The average number of contacts in the South East hub has fallen year on year.

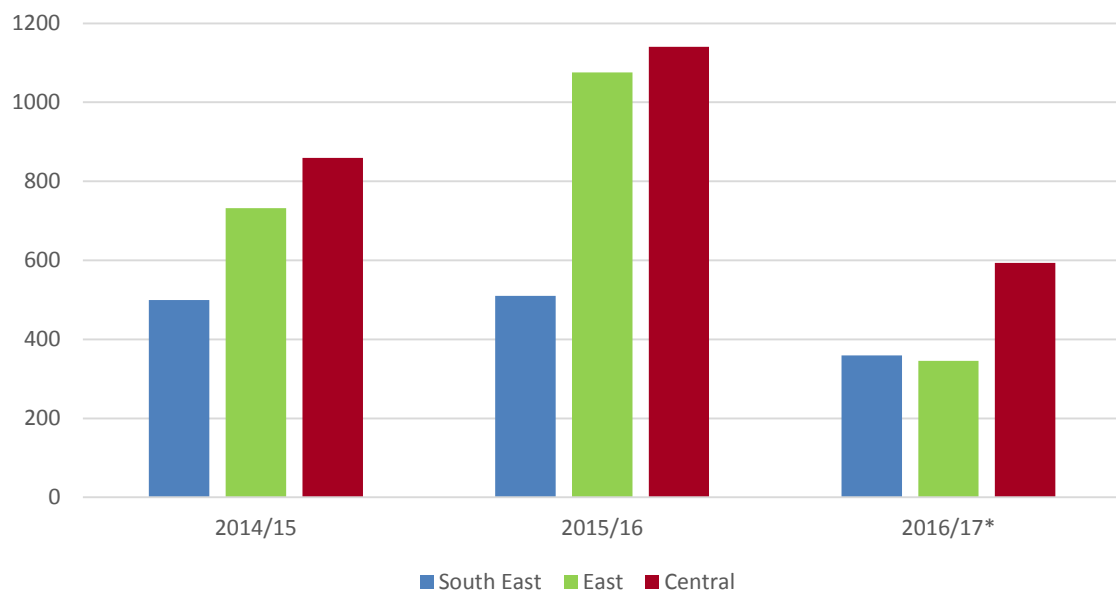
Figure 4.3 – Average number of referrals to MY Therapy per month, by hub



* - to Jun 2016

The Central hub has seen the highest number of referrals to MY Therapy in each of the three years of data, averaging around 200 per month. The numbers for South East and East have fallen year on year.

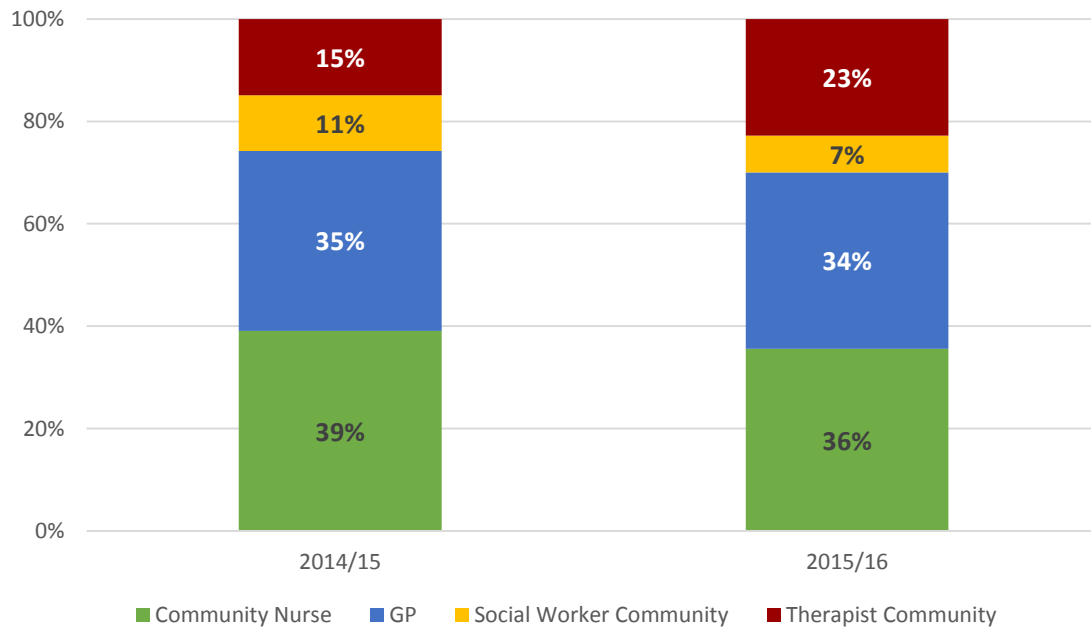
Figure 4.4 – Average number of MY Therapy contacts per month, by hub



* - to Jun 2016

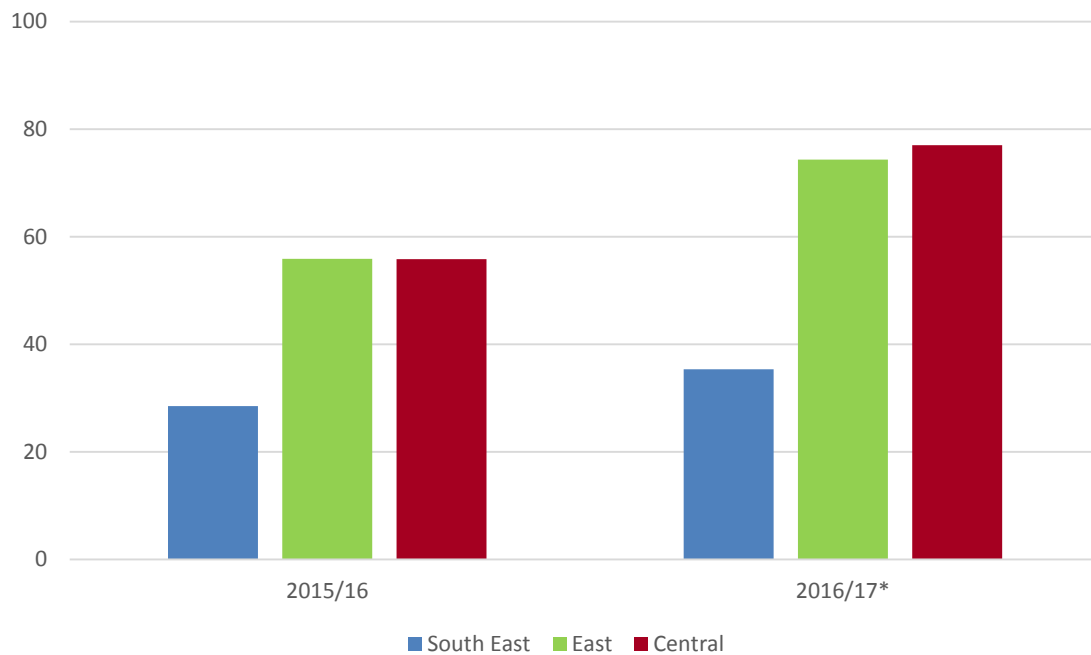
From 2014/15 to 2015/16, there was an increase in the average monthly contacts delivered by MY Therapy in each of the three hubs. However this appears to have fallen significantly in the current financial year to date.

Figure 4.5 – Source of referral to MY Therapy



There has not been a great variation in the pattern of referral source to MY Therapy from 2014/15 to 2015/16, though an increase in the proportion of referrals from therapists has been observed.

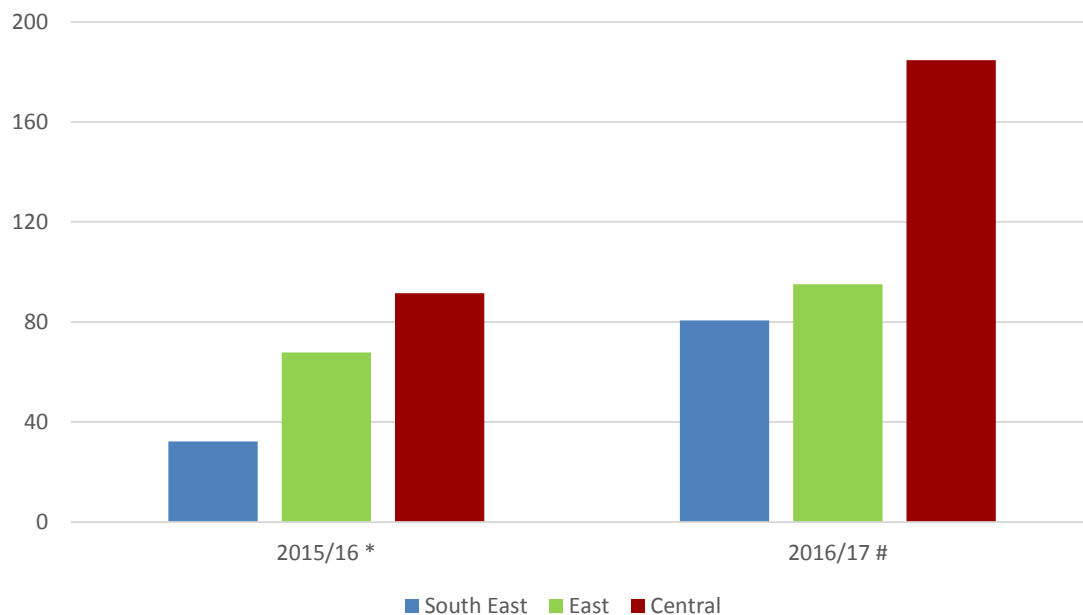
Figure 4.6 - Average number of referrals to Age UK per month, by hub



* - to Jun 2016

The average number of referrals per month to Age UK has increased year on year in each hub. More referrals are seen from the East and Central hubs than from South East.

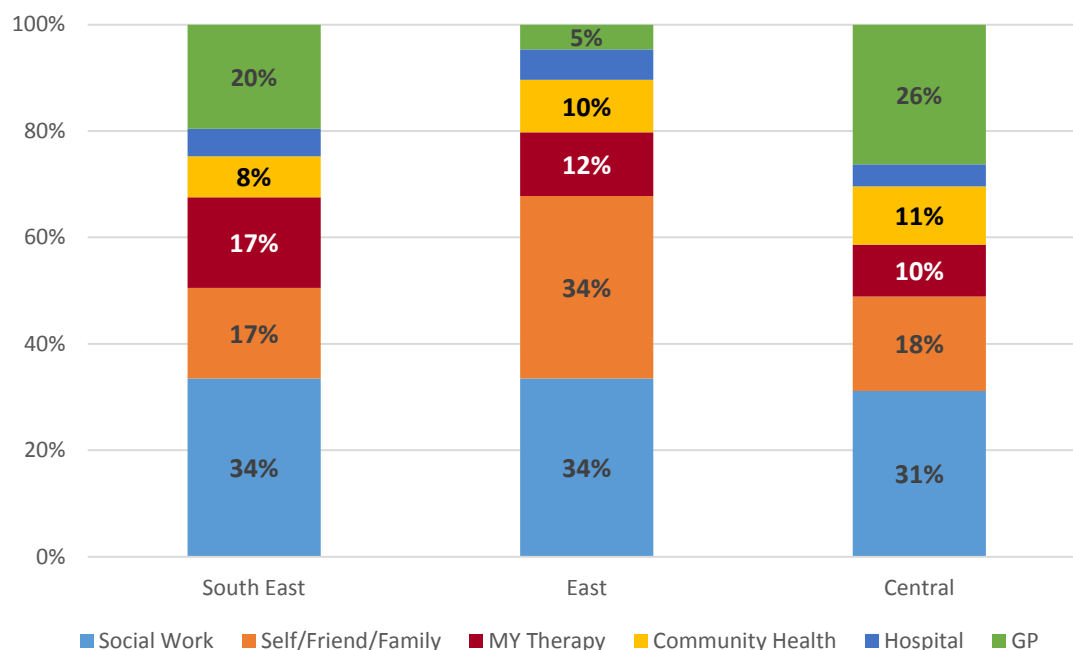
Figure 4.7 – Average number of Age UK contacts per month, by hub



* - from Dec 2015, # - to Jun 2016

The average number of contacts per month delivered by Age UK has also increased year on year across Wakefield, with the majority being delivered in the Central hub area.

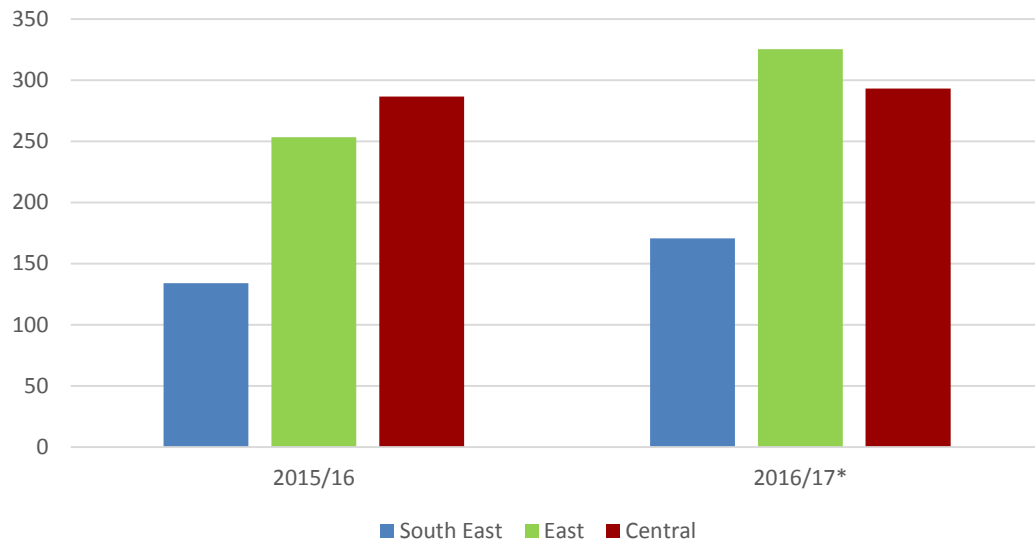
Figure 4.8 – Source of referral to Age UK, by hub*



* - from Aug 15 to Mar 16

For the short period that this data has been available, the one notable variation appears to be the higher proportion of self-referrals (including by family and friends) to Age UK in the East hub, compared to the other two hubs.

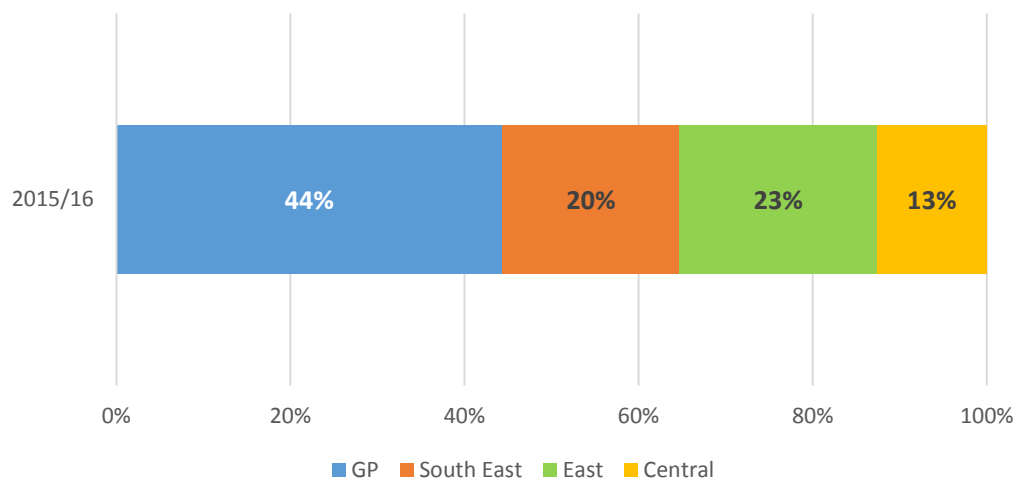
Figure 4.9 - Average number of Carers Wakefield contacts per month, by hub



* - from Aug 15 to Mar 16

Carers Wakefield have delivered an increased average number of contacts per month in each hub in the current financial year, compared to 2015/16. A slightly higher number is observed in the East hub so far this year.

Figure 4.10 – How users heard about Carers Wakefield (2015/16)



Just under half of users of Carers Wakefield were told about the service by their GP. The remainder were given the information from the hub in their area of Wakefield.

4.2 Bed-based Activity

Non-Elective Emergency Admissions

Figure 4.11 - Emergency admissions to hospital (Wakefield patients, aged 18+)

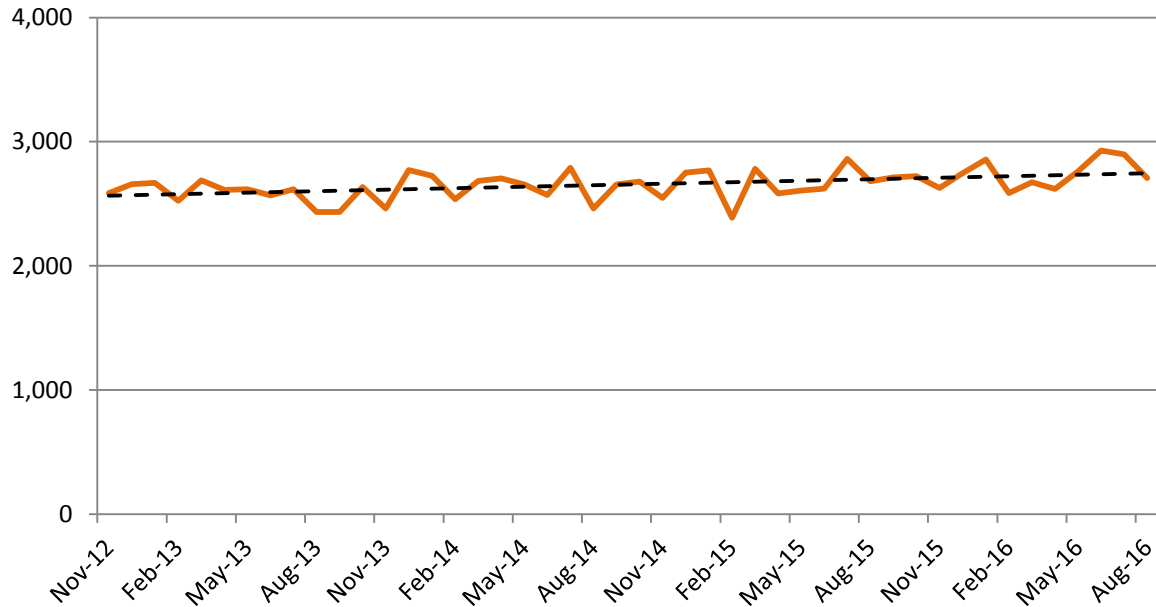
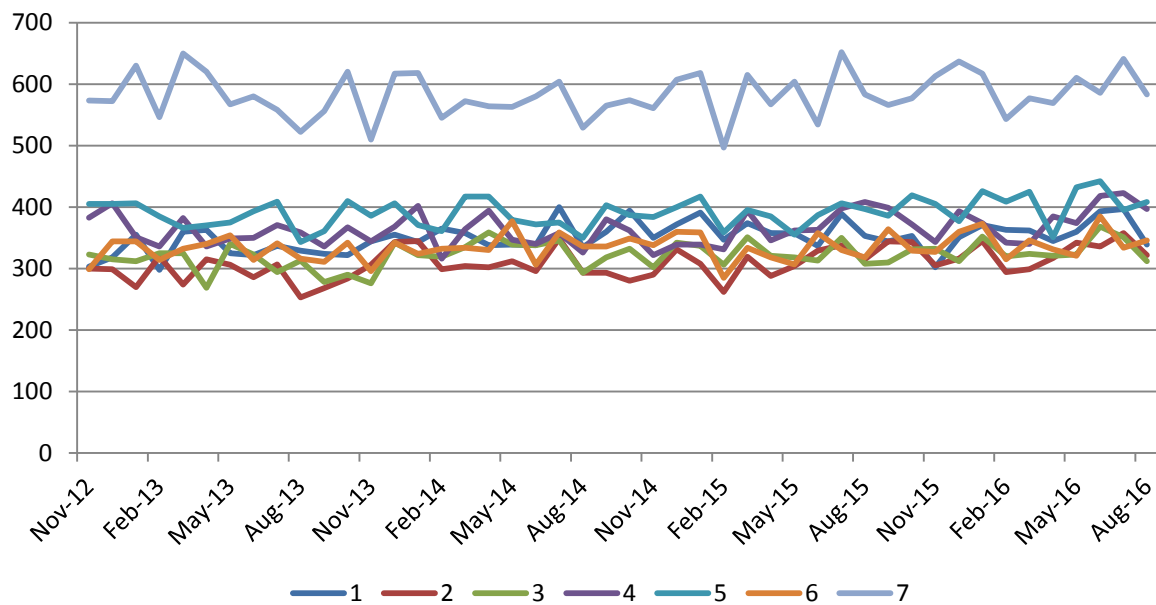
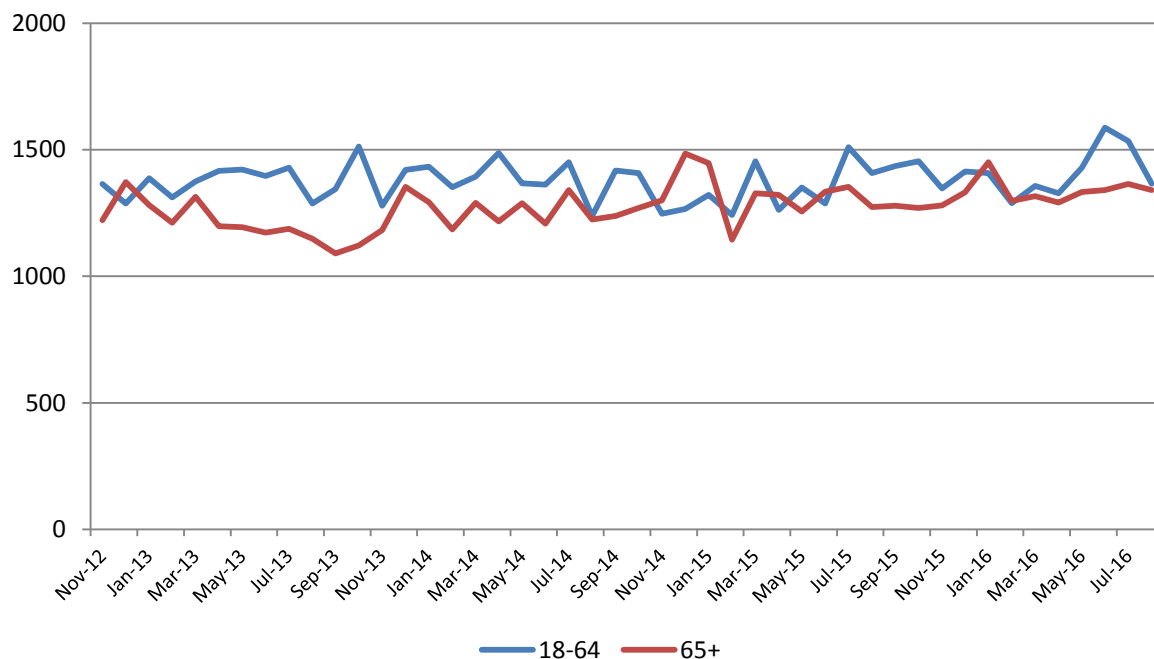


Figure 4.12 - Emergency admissions to hospital – by network (Wakefield patients, aged 18+)



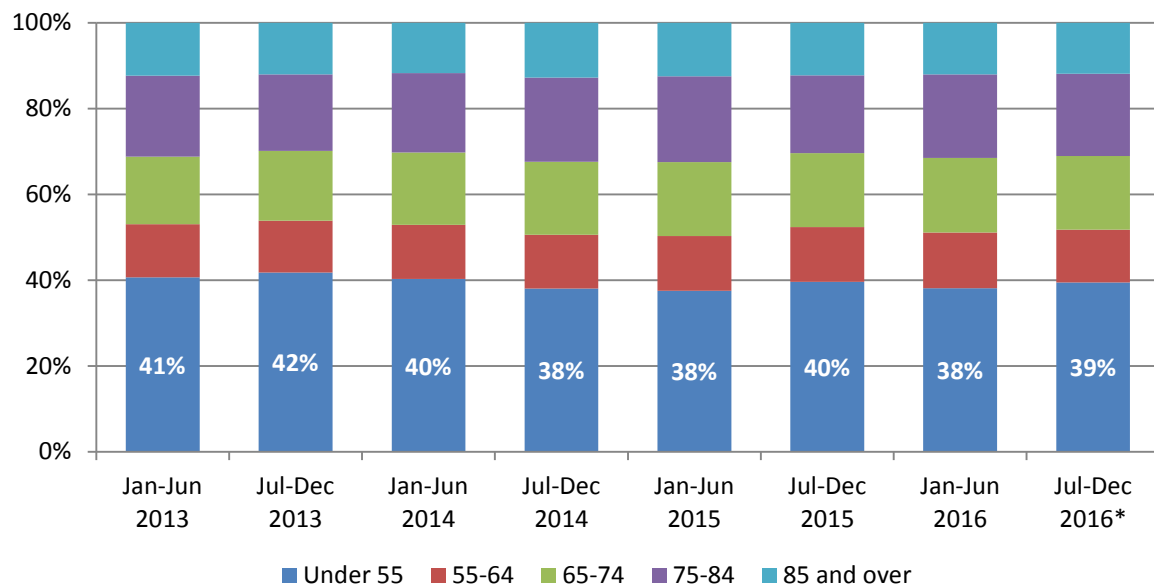
The number of emergency admissions to hospitals in Wakefield has shown a slight increasing trend across the period, with between 2,500 and 3,000 per month. Network 7 sees a higher number of admissions than other networks, due to population size, but there is no particularly notable variation between networks.

Figure 4.13 - Emergency admissions to hospital – by age group (Wakefield patients, aged 18+)



Admissions are roughly evenly split between working age adults and older adults. There has been a slightly larger increase in the number of admissions of those aged 65 and over, than those under 65.

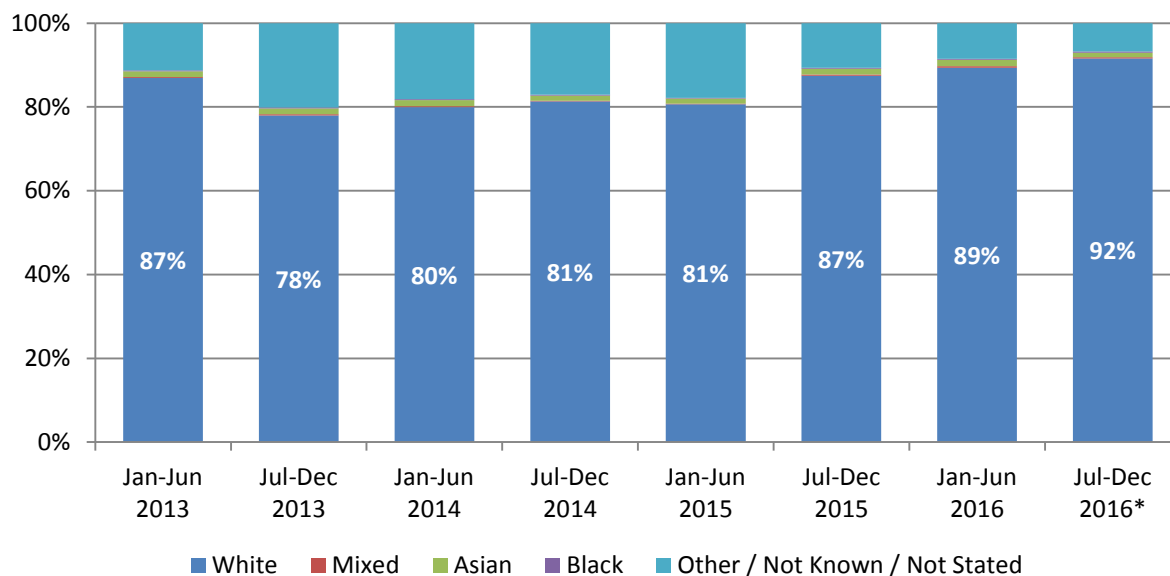
Figure 4.14 - Age profile of emergency admissions (Wakefield patients, aged 18+)



* - to Aug 2016

There appears to be a slight reduction in the proportion of admissions of those in the Under 55 age group over time, but any differences are small.

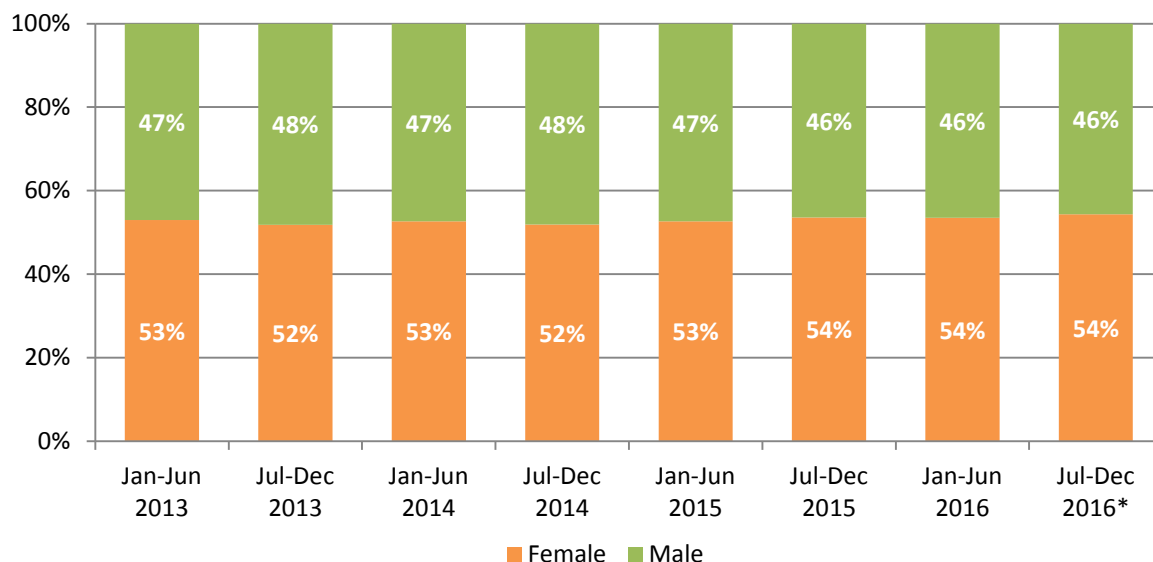
Figure 4.15 - Ethnicity profile of emergency admissions (Wakefield patients, aged 18+)



* - to Aug 2016

Any variation over the period appears to relate to the number of admissions where the ethnicity is recorded as not known or not stated, and can therefore be attributed to issues around data quality.

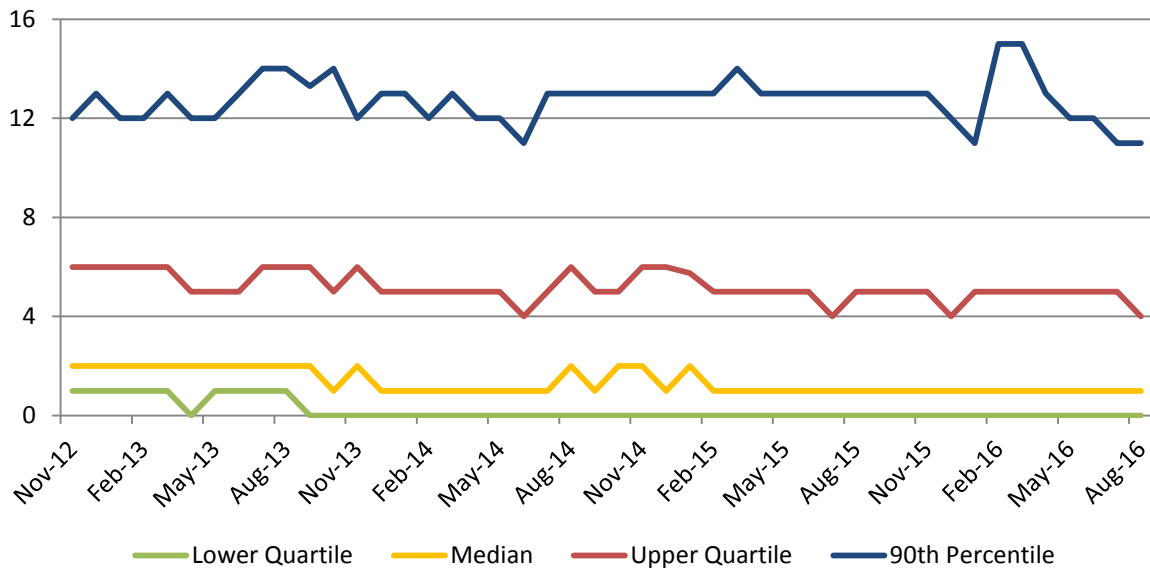
Figure 4.16 - Gender profile of emergency admissions (Wakefield patients, aged 18+)



* - to Aug 2016

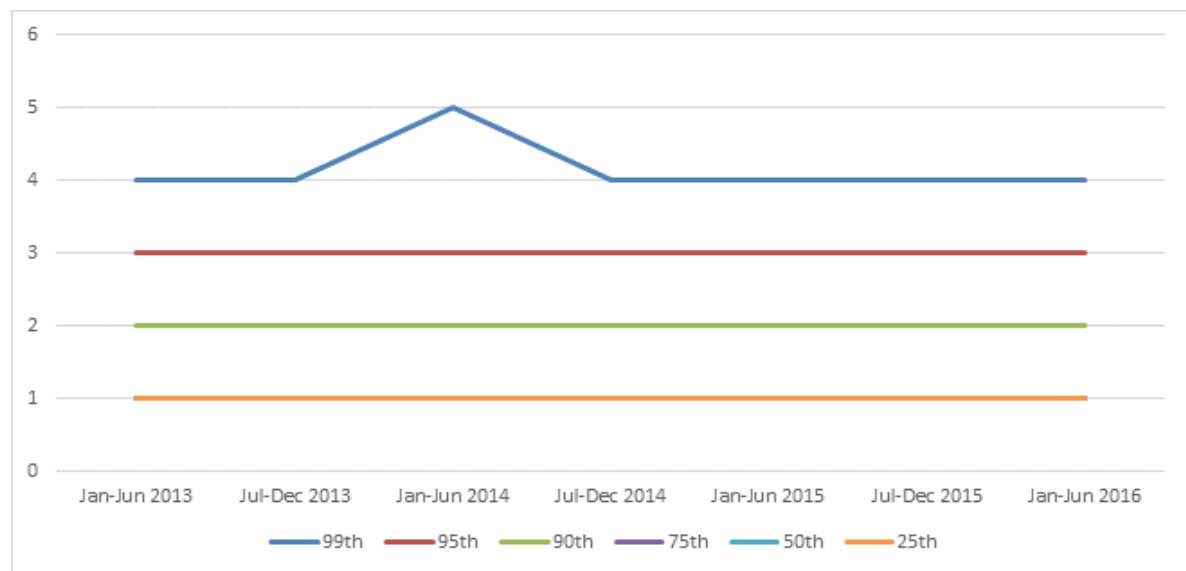
There is a slightly greater proportion of females admitted than males. It seems likely that this is related to the age profile, with older adults forming a relatively larger proportion of admissions, and the difference in life expectancies between males and females.

Figure 4.17 - Length of stay of emergency admissions (Wakefield patients, aged 18+)



The median length of stay of emergency admissions is 1-2 days. 75% of patients are discharged between 4 and 6 days. However, 10% of patients generally stay upwards of 12 days. There has been little variation in this pattern over the period, although possibly emerging signs of a downward trend towards the end of the period.

Figure 4.18 – Number of readmissions per patient in 6 month period (Wakefield patients, aged 18+) (percentiles)



There appears to have been no change in the pattern of readmissions over the period.

Non-Elective Non-Emergency Admissions

These admissions represent Wakefield patients who were initially treated outside of Wakefield, before being repatriated.

Figure 4.19 - Non-elective non-emergency admissions (Wakefield patients, aged 18+)

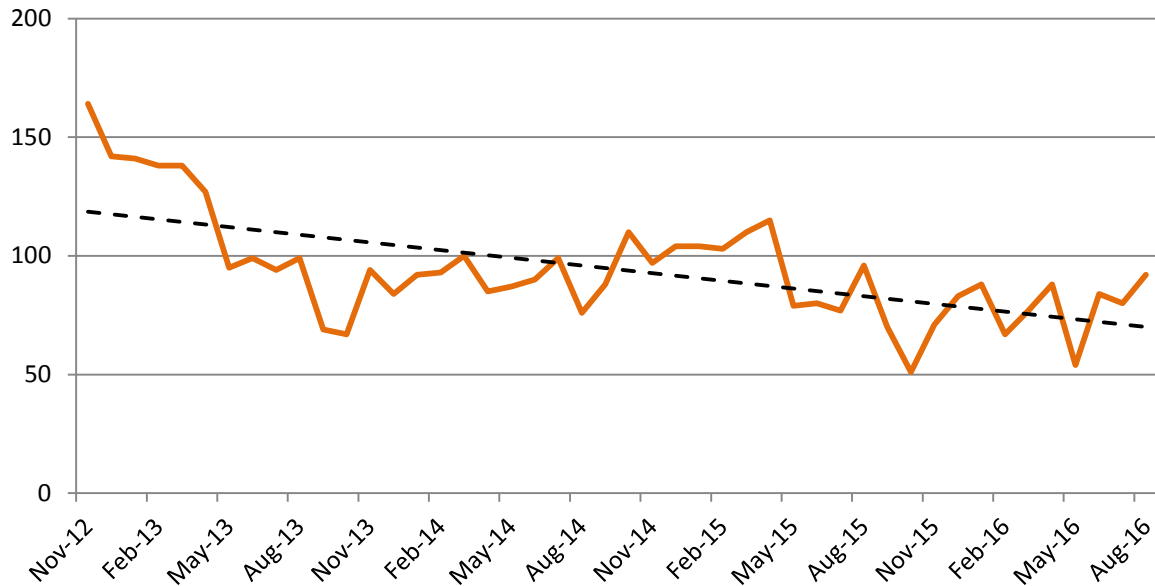
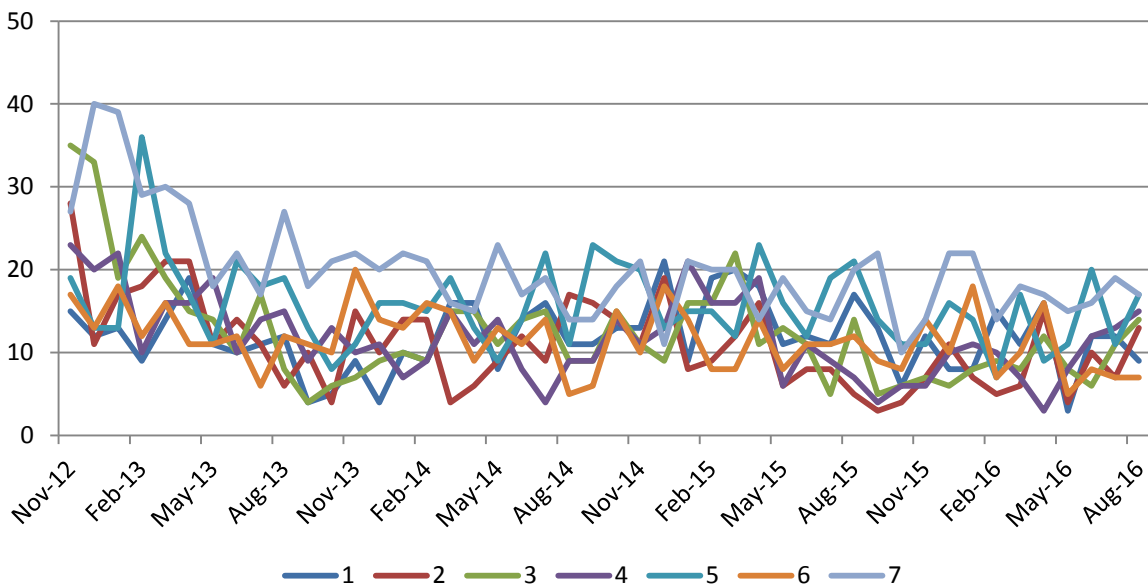
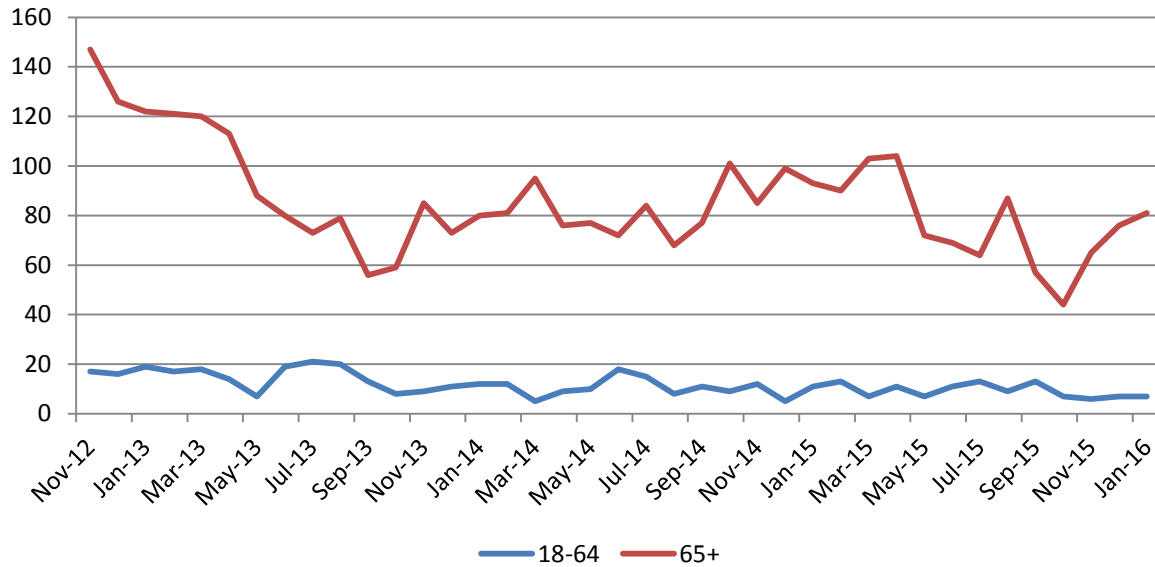


Figure 4.20 - Non-elective non-emergency admissions – by network (Wakefield patients, aged 18+)



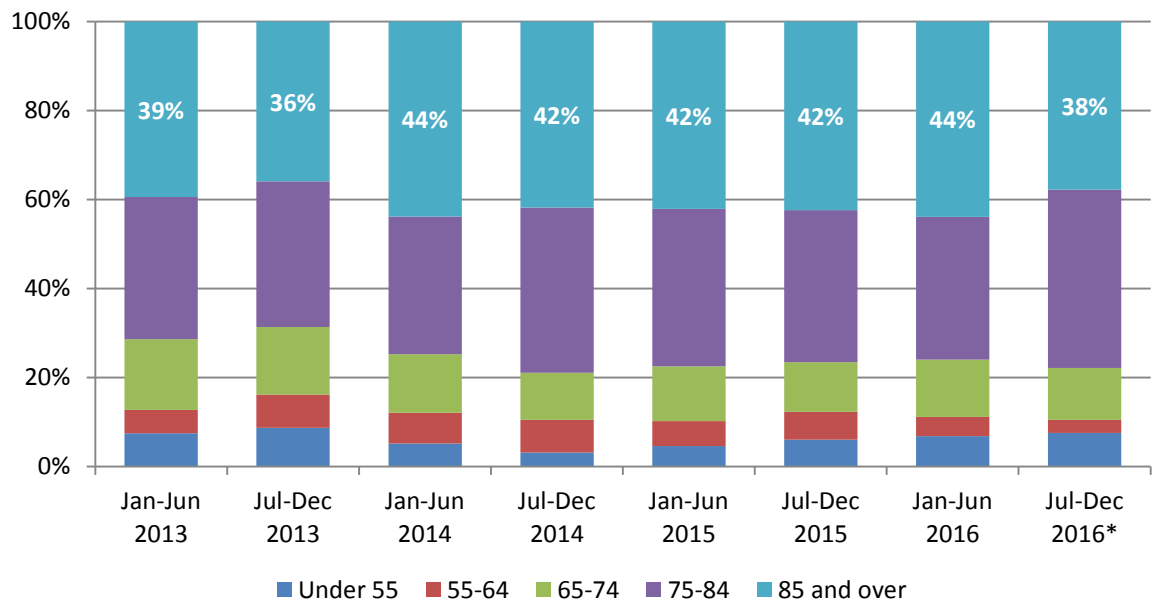
There has been a persisting downward trend in the numbers of non-elective non-emergency admissions. As the number of this type of admission is significantly lower than that for emergency admissions, any trend may be more susceptible to natural variation, however given the persistent nature, it may be the case that this is a real trend.

Figure 4.21 - Non-elective non-emergency admissions – by age group (Wakefield patients, aged 18+)



The majority of admissions are patients over the age of 65. Whilst a downward trend has been observed in both working age adults and older adults, it has been more pronounced in the latter group.

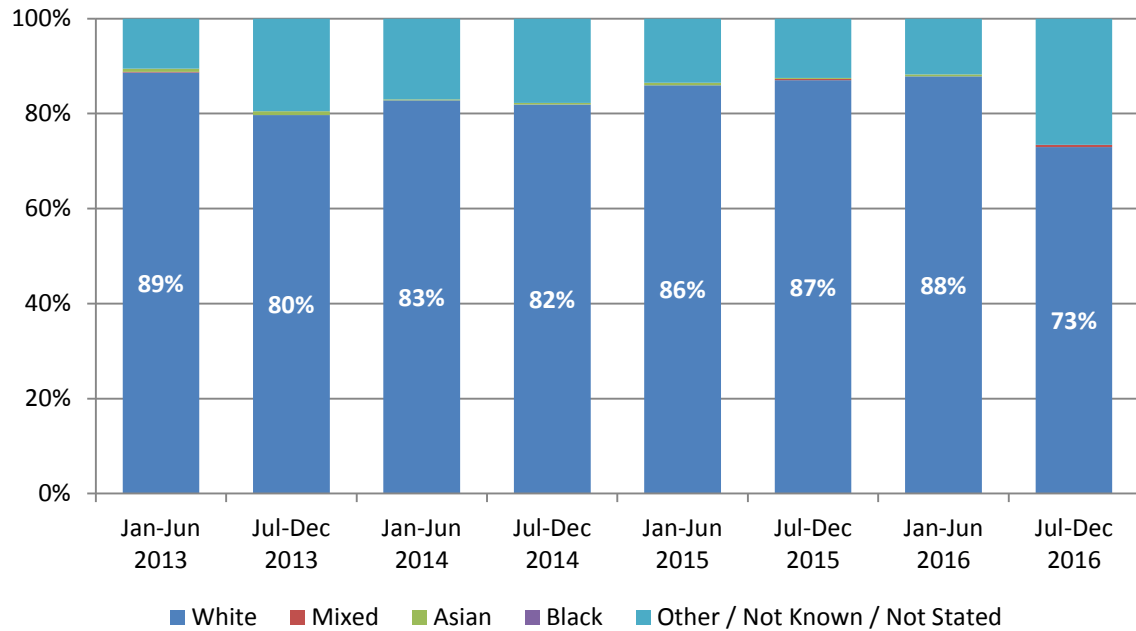
Figure 4.22 - Age profile of non-elective non-emergency admissions (Wakefield patients, aged 18+)



* - to Aug 2016

Approximately three-quarters of such admissions are service users who are aged 75 and over, which shows a much older age profile than that of emergency admissions.

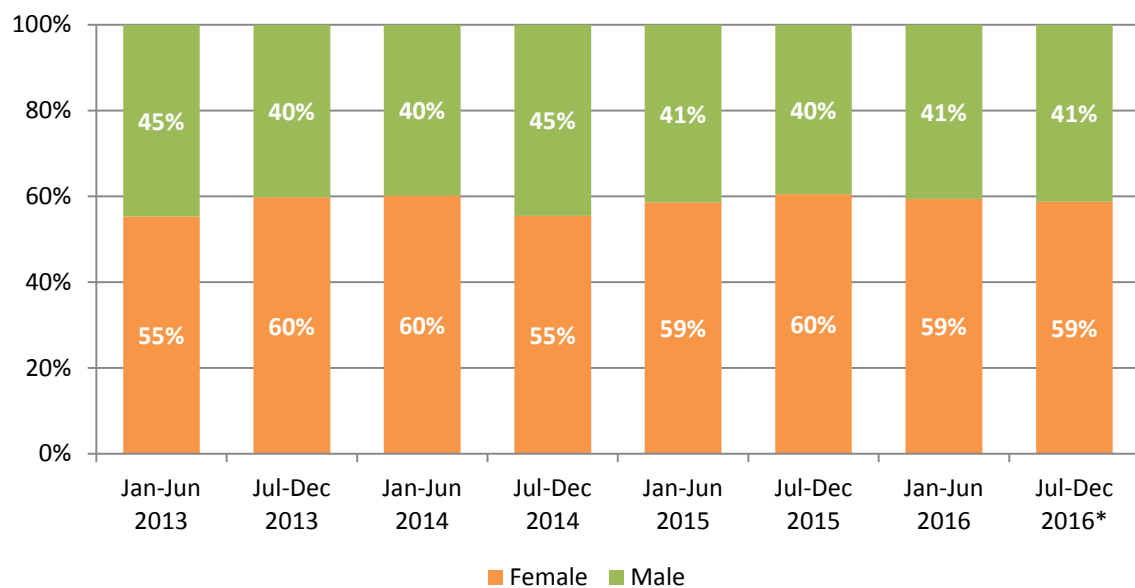
Figure 4.23 - Ethnicity profile of non-elective non-emergency admissions (Wakefield patients, aged 18+)



* - to Aug 2016

As is the case with emergency admissions, the issue regarding the number of 'Not Known' records is present here too, and therefore it is difficult to draw any conclusions regarding a trend in this data.

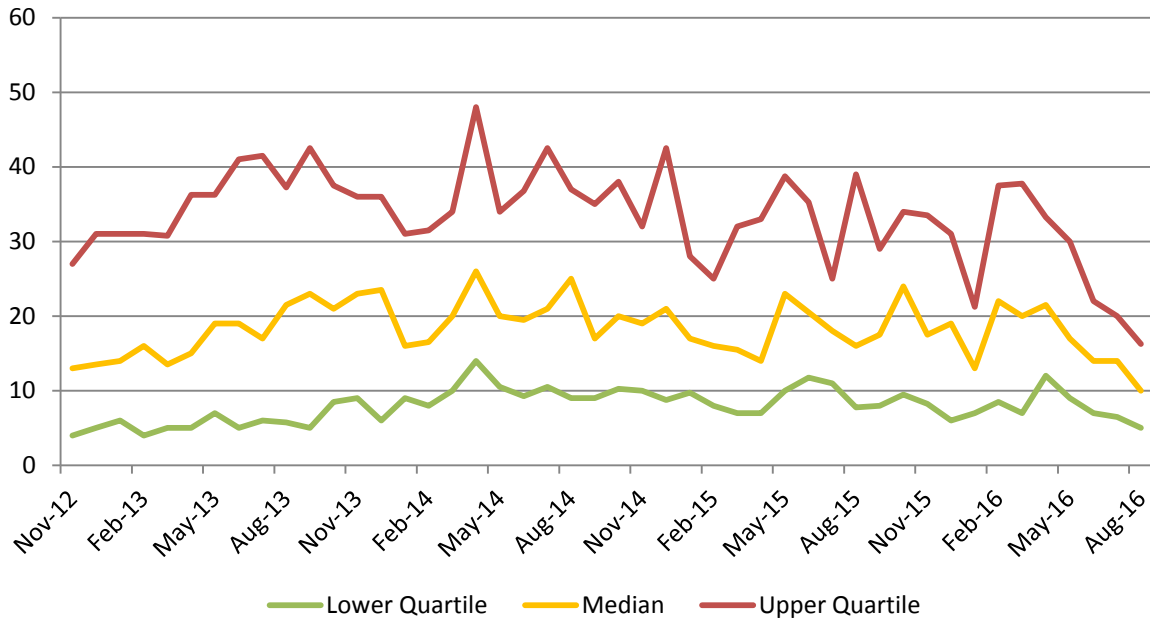
Figure 4.24 - Age profile of non-elective non-emergency admissions (Wakefield patients, aged 18+)



* - to Aug 2016

Female admissions make up a greater proportion of these admissions. This is again likely to be linked to the older age profile of the admissions.

Figure 4.25 - Length of stay of non-elective non-emergency admissions (Wakefield patients, aged 18+)



The median length of stay of these admissions has generally been between 15 and 25 days, with no real upward or downward trend visible. Lengths of stay in excess of one month has been seen for a quarter of patients, though there is a slight decrease in this figure over time.

Residential and Nursing Home Admissions

Figure 4.26 – Number of admissions of Wakefield patients to residential and nursing homes



The majority of admissions to care homes are to residential homes than nursing homes. There has been a slight increase in both of these, though more so in admissions to residential homes.

4.3 Accident and Emergency Activity

Figure 4.27 – Number of presentations to accident and emergency departments (Wakefield patients, aged 18+)

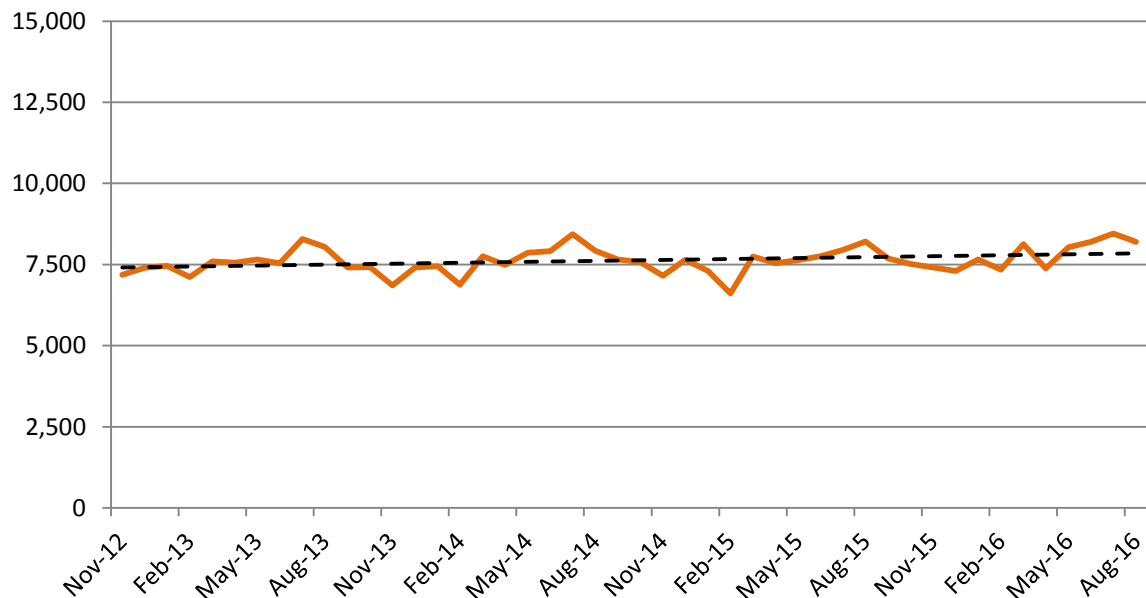
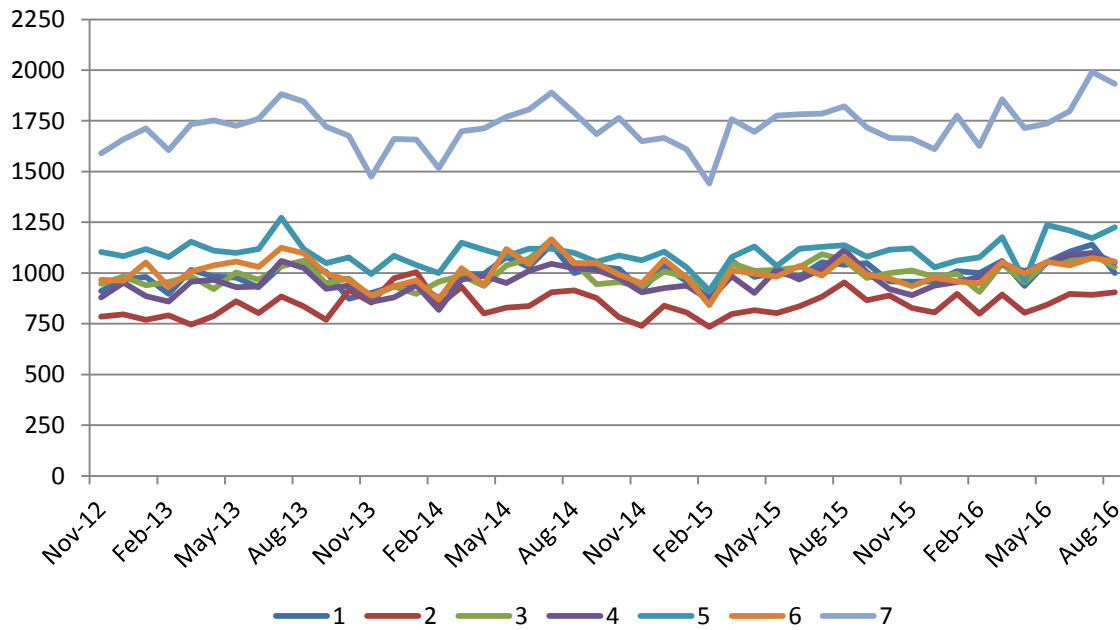
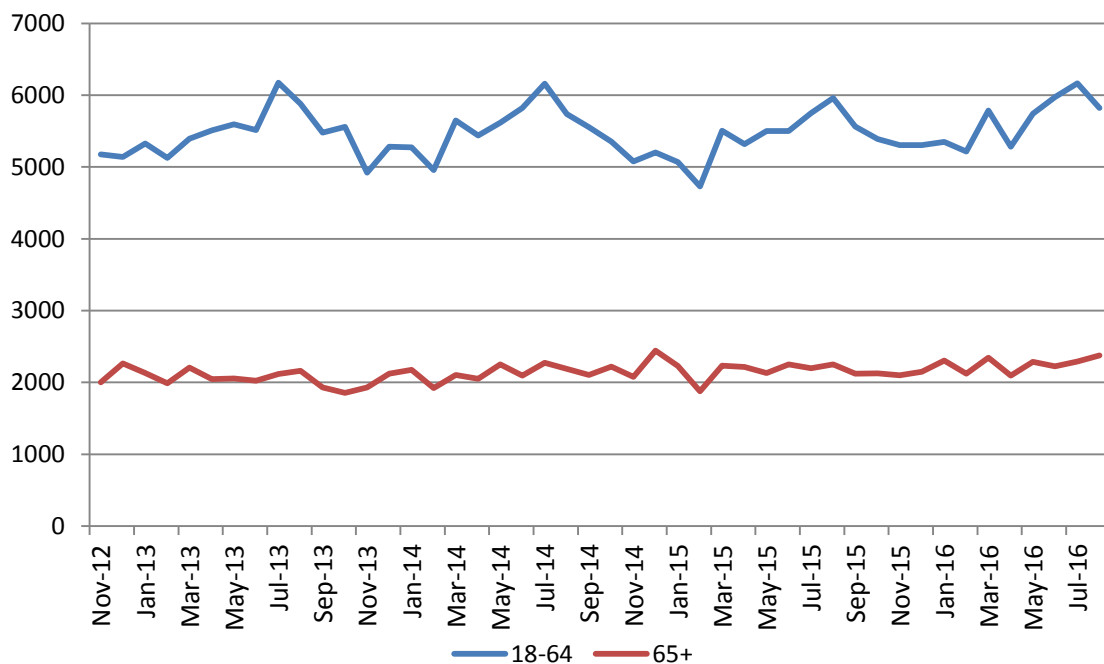


Figure 4.28 – Number of presentations to accident and emergency departments – by network (Wakefield patients, aged 18+)



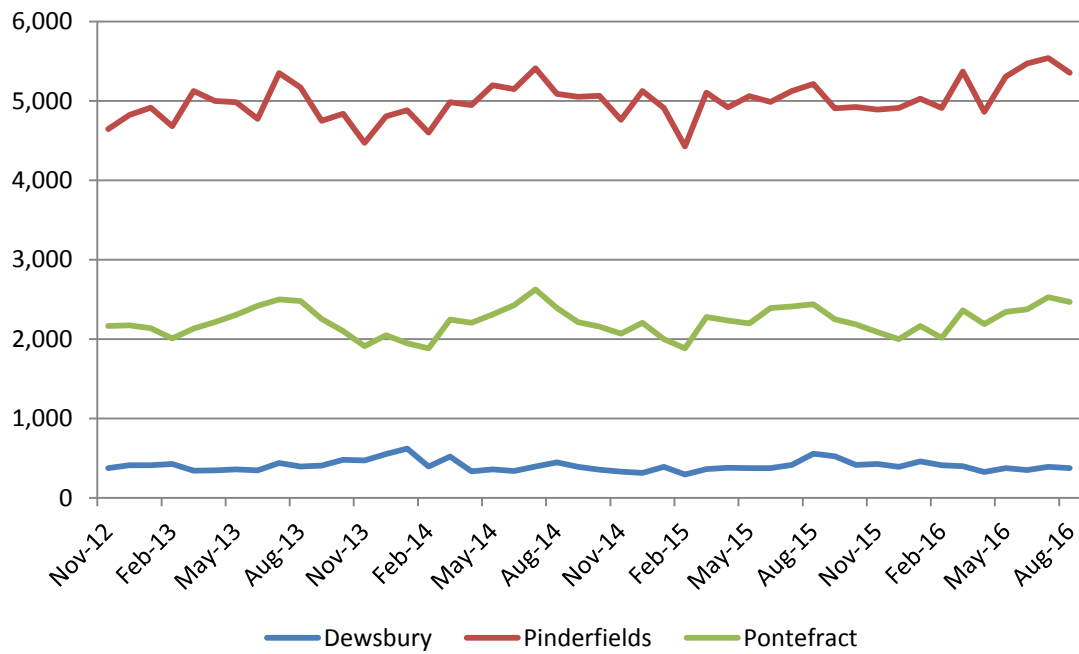
There has been a very slight increase in the trend of A&E presentations over the period, but no particularly notable variation between networks. There are approximately 7,500 presentations per month.

Figure 4.29 – Number of presentations to accident and emergency departments – by age group (Wakefield patients, aged 18+)



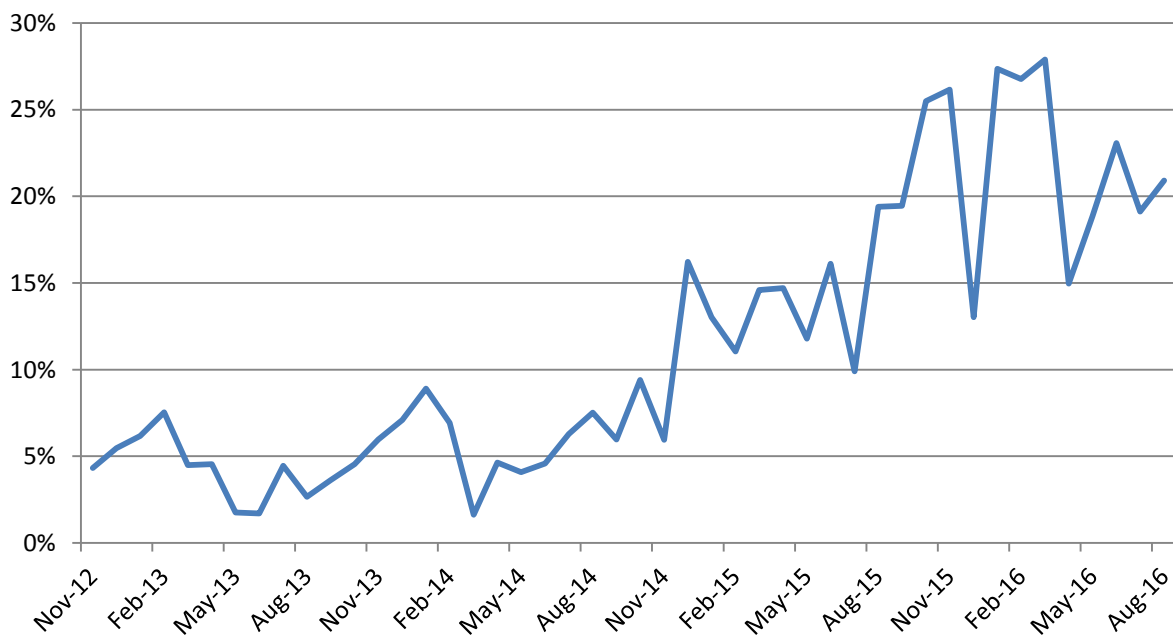
The majority of presentations are from working age adults. There does appear to be a slight increase in the trend of this figure, whilst the trend for those over the age of 65 is essentially flat.

Figure 4.30 – Number of presentations to accident and emergency departments – by hospital (Wakefield patients, aged 18+)



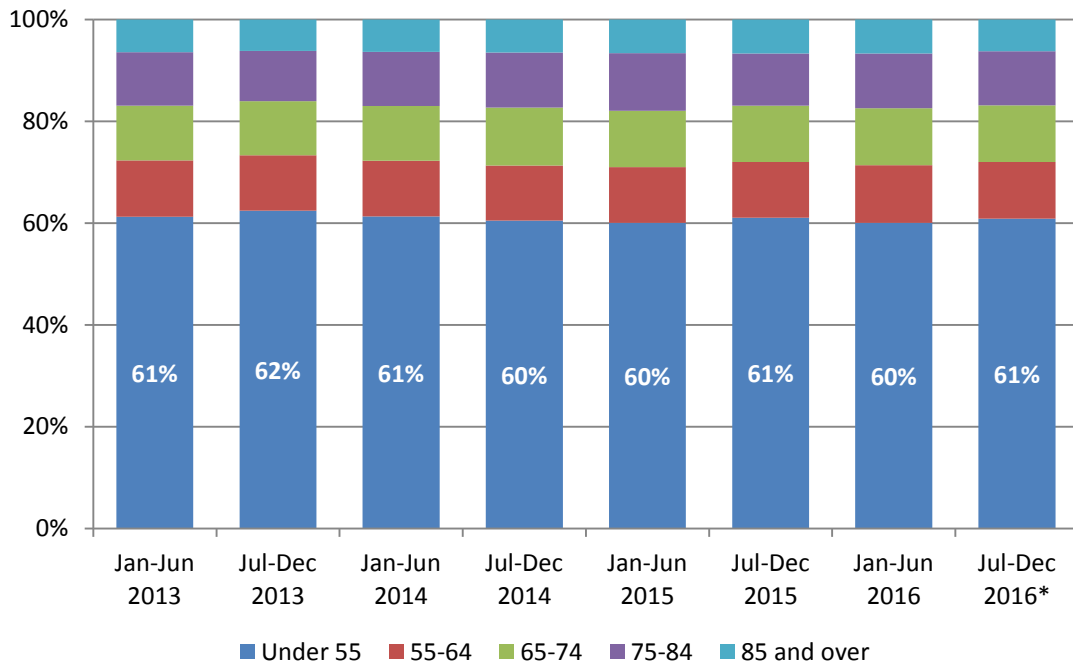
Pinderfields is responsible for the majority of A&E presentations across Wakefield.

Figure 4.31 – % of A&E presentations breaching 4hr target (Wakefield patients, aged 18+)



There has been a steady increase in the percentage of presentations where the four hour waiting time target has been breached. It remained in excess of 10% since the beginning of 2015, and peaking at 25%. There does appear to have been a slight drop again during the middle of 2016.

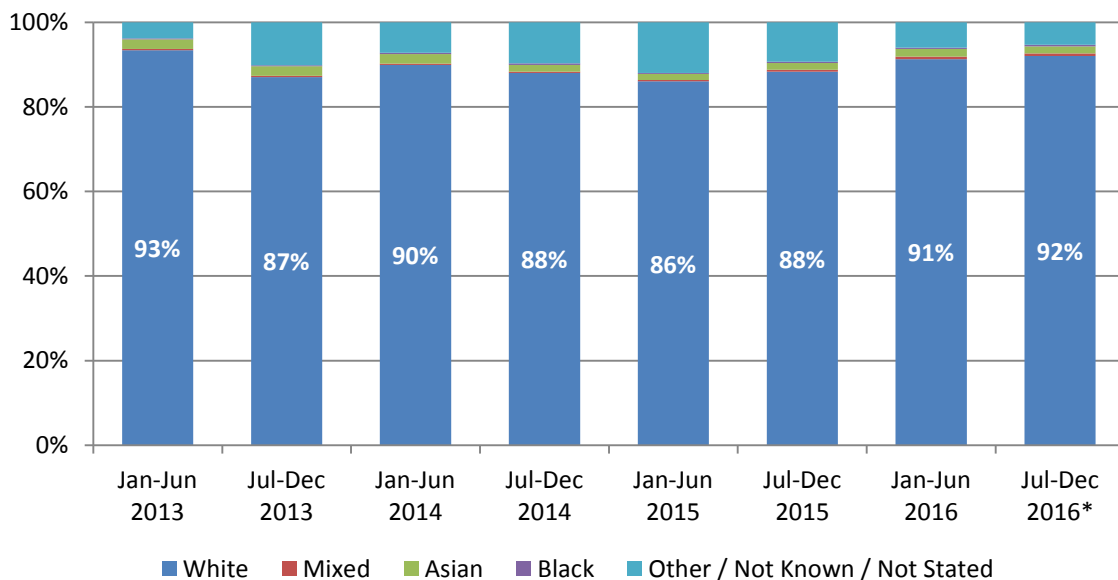
Figure 4.32 – Age profile of accident and emergency presentations (Wakefield patients, aged 18+)



* - to Aug 2016

Approximately 60% of people presenting to A&E are under 55, which is lower than is observed for admitted care. There has been a slight increase over more recent months, but not significantly so.

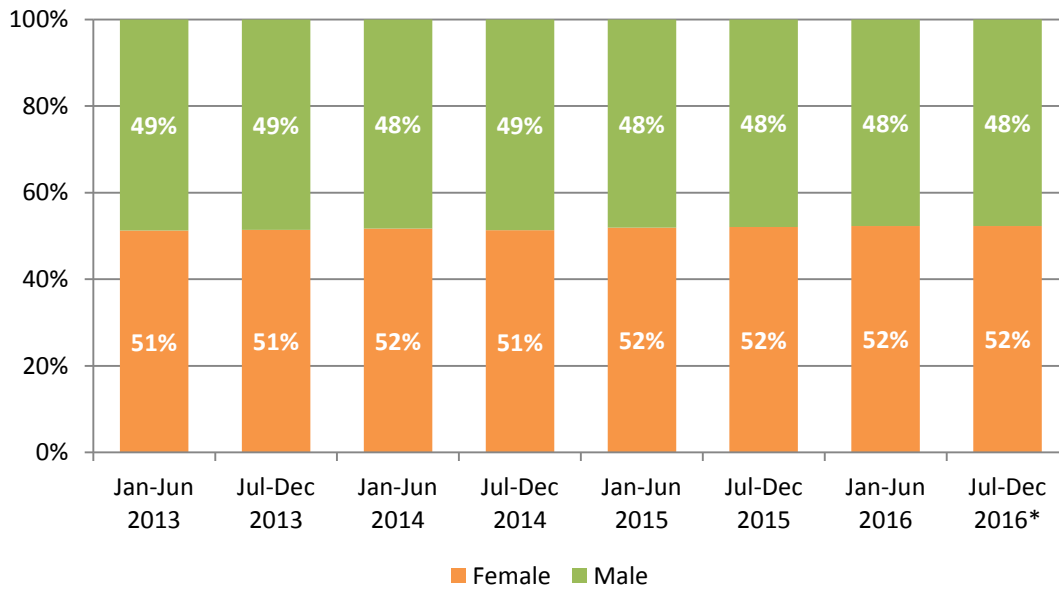
Figure 4.33 – Ethnicity profile of accident and emergency presentations (Wakefield patients, aged 18+)



* - to Aug 2016

There has been some variation in this data, but drawing conclusions is again made difficult by the level of 'Not Known' records in the dataset.

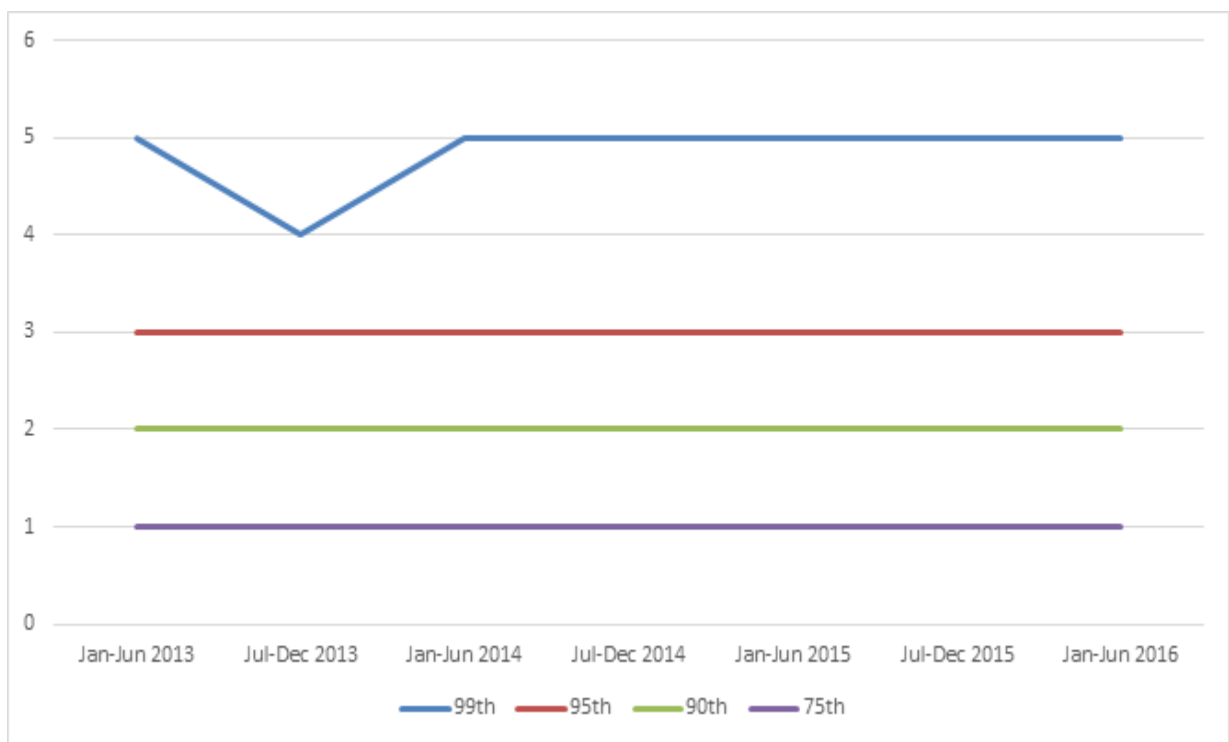
Figure 4.34 – Gender profile of accident and emergency presentations (Wakefield patients, aged 18+)



* - to Aug 2016

There is a slightly higher proportion of presentations by females, but the pattern remains essentially in line with the overall population split.

Figure 4.35 – Number of re-presentations to accident and emergency departments (Wakefield patients, aged 18+)



There has been no change in the pattern of representations to A&E over the period.

5. CONCLUSIONS AND RECOMMENDATIONS

This has been a long and complex evaluation, which has gathered a very large volume of data: qualitative data from almost 1000 interviews with service users, carers, and staff of the services involved; quantitative data about the activities of Connecting Care, and of services on which it was hoped it would have an impact; and all of this over a period of nearly three years. Four formative reports have been provided to services in Wakefield over the course of the evaluation.

For our conclusions, we return to the questions we were originally asked to consider:

a) Has the CC programme been implemented as intended? What have been the reasons for departure from the intended plan?

The only realistic answer to the first part of this question must be “no.” The ambition of the original care closer to home programme was to provide:

1. The introduction of community-based teams to provide a crisis response within two hours, 24 hours a day, 7 days a week
2. Open access to both health and social care services, via a single triage point
3. The introduction of care co-ordination for complex cases
4. The introduction of a team whose purpose was to go into the acute hospital, and assess the opportunity for facilitated early discharge
5. Common electronic care records across health and social services, using the NHS number as a common identifier.

In amending and renaming the programme to “Connecting Care” the fifth of these ambitions was agreed no longer to be regarded as a measure of the programme’s implementation. In reality, however, none of these ambitions has been delivered by the end of the evaluation period. There is no 24/7 crisis response, no single triage, no structured care co-ordination system, and little inreach via the Hubs to offer facilitated early discharge. There remain no common care records, electronic or otherwise.

What has been delivered is three co-located health and social care teams, with some additional resources to those teams, and additional third sector input from Age UK and Carers Wakefield; teams which have spent considerable time thinking about and working on new ways of working with each other. This evaluation is therefore, in reality, evaluating the impact of creating such co-located teams, with some additional or reallocated resources and third sector input, rather than evaluating any of the programme’s original intentions. In the rest of these conclusions, when we refer to Connecting Care, we are therefore referring to what has actually happened, not what was intended to happen.

Why has the intended plan not been delivered? There are many possible answers to this question, but we suggest that they boil down to three core reasons:

1. The intended plan was always over-ambitious. Given the resources of time and money at Wakefield’s disposal, and the very substantial complexity of these tasks, it was always going to be very difficult to achieve this plan within the intended three year period.
2. The context quickly became more challenging than local managers had hoped. Financial resources to invest in Connecting Care were more constrained, and other initiatives attracted attention. These included initiatives in overlapping and related areas, such as new Vanguard programmes.

3. Until relatively recently, when new processes and structures have begun to be established, there was far too little serious management attention given to the implementation of Connecting Care. The original intentions were not pursued with any real vigour, and it was quickly accepted that Connecting Care would be a much more limited initiative than early ambitions had intended. There was insufficient attention paid to routine disciplines of project planning and project management, and busy staff with other day jobs simply could not devote the attention to Connecting Care's ambitions.

Other reasons were material – difficulty in engaging GPs, continuing differences in national policies for health and social care most notably – but these three are, we suggest, the fundamental reasons why Connecting Care has not been implemented as intended.

b) What is the impact of CC on the quality and experience of services, in the opinion of staff providing services?

This question has a clear and positive answer. Staff have, throughout, been very clear that service users have benefited from the changes which Connecting Care has brought, in particular having a wider “offer,” faster access to services, and access to more support from Age UK and Carers Wakefield. All of the other roles and services within the CC team were also felt to be vital to its success. Staff thought duplication had been reduced, as their understanding of roles had improved. There is very clear staff support for the continuation and development of increasingly integrated services.

c) What is the impact of CC on the quality and experience of services, in the opinion of people receiving services?

As with (b), this question has a very clear and positive answer. The evidence from this evaluation's survey of service users is clear that there have been positive movements, across the majority of indicators, over the implementation period. There have been particularly positive movements in service users' views as to services helping them to cope independently, and in their overall rating of services.

The interviews with carers were depth interviews, and a separate much fuller report is available on their findings. In brief summary, these interviews with carers found that the Connecting Care services which were most frequently mentioned as helping and supporting them were Age UK and Carers Wakefield. It is clear that having these two services within the Connecting Care teams is enabling a greater and more comprehensive service to be offered to carers. The fact that Carers Wakefield could develop an ongoing relationship with carers was something which carers who had experienced this, particularly valued and found helpful. Around a quarter of carers reported very poor experience of services.

d) How does the health status of people using the CC service change over the evaluation period?

Our patient survey process asked two questions which give a perspective on this. We asked if people felt more or less able to cope, and felt better or worse in themselves. Consistently over the evaluation period, more people reported improvements than deteriorations after contact with Connecting Care. 38% reported themselves as better able to cope, as against 24% who reported themselves as less able to cope. 37% reported themselves as feeling better in themselves, as against 27% who reported themselves as feeling worse in themselves. These proportions did not change significantly over the evaluation period. It therefore appears that

use of the Connecting Care service may have consistently led to net improvements in health status, but that this did not change as the service was implemented.

We do not know how this compares to services available prior to Connecting Care; the lack of change over the implementation period may be a significant contributor to the lack of change on other activity indicators, such as hospital admissions.

- e) What has the experience of working in the CC teams been like for their members? What has been the impact of CC on perceived opportunities for career progression, clinical leadership, and internal communications? Has a common sense of purpose developed?**

Staff overwhelmingly report working in the CC teams as a positive experience. During later interviews, they were increasingly positive regarding the impact which they felt working in this way was having. Many felt they had developed new confidence and skills in working with their colleagues from other teams and had developed a deeper understanding of other roles which had enhanced their own practice. They felt that this would be very valuable to them if/when they moved on with their own careers and that this had been a developmental process. Our assessment would be that the Connecting Care process has clearly been material in developing a common sense of purpose across a large number of staff in local Wakefield teams.

- f) During the implementation period for CC, what has been the change in the number of admissions to hospital? To what extent, and why, is the CC programme considered to have contributed to that change?**

The hoped-for fall in admissions to hospital appears not to have happened during the implementation period for Connecting Care. The formally reported numbers have in fact slightly risen, although the overall trend is small and fluctuating. We cannot, of course, know what would have happened had CC not been implemented in its current form – whether admissions would have risen more, or fallen. We are aware that there had been earlier projections suggesting 3% growth in non-elective secondary care per year to continue from 2014/2015 onwards; there have also been local projections for an overall reduction in secondary care activity.

We are conscious that it has been identified very recently that some forms of ambulatory care may have been incorrectly coded as inpatient admissions for all or part of the data period. It is not, however, clear to what extent this has been consistently the case, and it is therefore difficult to interpret the overall effect this may have had on the data as reported. It should, however, be kept in mind that these remain clinical presentations at a level of severity sufficient to warrant treatment akin to inpatient care; and that decisions not to admit may therefore reflect changes in hospital policy more than changes in community-generated demand.

In answering this and subsequent questions, we are conscious that the majority qualitative judgement arising from our interviews was that Connecting Care had not significantly affected services' ability to prevent admissions. We are also conscious that there have been many other initiatives taking place over the same period, and that disentangling the specific causality of any single initiative is very difficult.

Given the lack of either clear quantitative or qualitative evidence of an impact on admissions to hospital, and the lack of implementation of those measures most intended to reduce hospital admissions, our conclusion is that Connecting Care, in its current form, has not materially

affected the number of hospital admissions in Wakefield. Others may of course draw different conclusions from the findings presented here.

- g) During the implementation period for CC, what has been the change in the number of admissions to residential and nursing home care? To what extent, and why, is the CC programme considered to have contributed to that change?**

There has been no material change in the number of admissions to residential and nursing home care over the implementation period. For very similar reasons to those in (f) above, we conclude that Connecting Care, in and of itself, has not materially affected the number of residential and nursing care home admissions in Wakefield.

- h) During the implementation period for CC, what has been the change in the length of stay of hospital admissions? To what extent, and why, is the CC programme considered to have contributed to that change?**

There are emerging signs that the length of stay of hospital admissions may be beginning to fall. However, it does not appear likely that this can be attributed to Connecting Care: the initiatives which were intended to achieve this objective have not been implemented, and there was no qualitative view from staff interviewed that this effect had been achieved. It appears likelier that these emerging effects are the result of separate initiatives led from within the hospital setting.

- i) During the implementation period for CC, what has been the change in the number of readmissions to hospital? To what extent, and why, is the CC programme considered to have contributed to that change?**

There has been no material change in the number of readmissions to hospital, or in re-presentations to A&E, over the implementation period. For very similar reasons to those in (f) above, we conclude that Connecting Care, in and of itself, has not materially affected the number of readmissions in Wakefield.

- j) What are the financial impacts of (f) to (i), net of the cost of the CC programme itself, and taking account of excess bed day payments?**

Given the lack of observed effect, it is not possible to calculate financial impacts of Connecting Care on other services. Our conclusion is that there has not been a significant financial impact arising from this initiative.

In summary, we therefore conclude that Connecting Care:

- has led to improvements in the co-ordination, responsiveness, and quality of services experienced by many patients and (some, but not all) carers
- is a change welcomed by staff providing the services
- has not had any clear impact on use of bed-based services, and therefore no clear overall financial impact

The first two conclusions are important ones. Improvements to patient experience and responsiveness must be a key objective of any service. Also, in a context where recruitment and retention of staff is increasingly difficult, it is essential to provide services in a way which provides a good working environment for staff. The evidence for both of these conclusions is clear and compelling, and all involved should take satisfaction from them. They provide an equally clear justification for continuing the initiative, rather than retreating from it.

As regards the lack of clear wider impact, we suggest that the original ideas behind Connecting Care (with apologies to G.K. Chesterton) have not been tried and found wanting; they have been found difficult and not tried. The improvements seen have been achieved without actually moving on to fully implement any of:

1. Community-based teams able to provide a crisis response within two hours, 24 hours a day, 7 days a week
2. Open access to both health and social care services, via a single triage point
3. Care co-ordination for complex cases
4. A team whose purpose is to go into the acute hospital, and assess the opportunity for facilitated early discharge
5. Common electronic care records across health and social services, using the NHS number as a common identifier.

Our formative reports have provided ongoing feedback on matters of detail arising from our evaluation; we do not repeat that detail here, given the purpose of this report is to stand back from the overall process of three years' implementation of Connecting Care.

Our concluding recommendation is therefore a simple one. From the platform which has been built over the past three years, we hope that work can continue to be taken forward to ensure the full implementation of the five objectives originally agreed. They remain relevant, and their delivery will require the integration at greater depth which staff are clearly seeking: team leadership, budgets, referral systems, training. It will need the project management and project planning which have not been sufficiently applied to date; there is new learning about the physical facilities of the Hubs, and the detail of team composition. The platform is definitely there, and can be built on – all involved remain very keen for this to happen – and the opportunity is now there to be taken. We hope it can be.