healthwatch Greenwich

Capturing patient experience on Eltham Test and Learn site

Summary

This report is presented to the Greenwich Coordinated Care (GCC) Project Board by Healthwatch Greenwich to evaluate the Eltham Test and Learn. 10 interviews were conducted with patients, and in some cases their families, to gain insight into their experience of having a Care Navigator to help coordinate their care. The report includes a case study which demonstrates how having a Care Navigator has impacted on a patient's care. Overall Healthwatch found there was a positive impact on patient experience with 91% of the patient's "I" statements either having been met or on their way to being met and a mean increase in coping score of 2.1. The success of the scheme means Healthwatch Greenwich welcomes the further testing of the initiative elsewhere in the borough before a wider roll out of the model. Healthwatch Greenwich have made some recommendations, particularly concerning increasing levels of communication which we believe should be addressed before the next phase of testing begins.

Background

Following the award of the status 'Integration Pioneer', partners across health and social care in Greenwich developed a model of the 'team around the person' targeting adults with complex needs who have been identified as being at high risk of ill health and hospitalisation. An individual Care Navigator was assigned to each patient to help establish their needs and to help coordinate their care. Based on the needs of the patients, the Care Navigator helped them to develop statements which specifically set out the outcomes the patient wanted. These statements known as "I" statements covered a wide range of outcomes with examples including "I want to be able to walk further" and "I would like help managing my episodes of low mood'.

The aim of the model is to provide proactive, efficient and effective and personally tailored care to a selected group of individuals, delivered by a highly functioning motivated professional and lay team. Before this model can be rolled out across the borough, in November 2013 Eltham was used as a Test and Learn site. Healthwatch Greenwich as members of the GCC Project Board were invited to facilitate at the evaluation stage of the Eltham Test and Learn by capturing patient experience.

Aims

The first aim of the evaluation process was to determine whether the model has improved patient's experience of care and has been able to meet all of their needs. A further aim was to be able to draw out any points of learning from the Test and Learn site and consider how they could be utilised going forward. The final aim is to

use the findings of the evaluation to inform further development of the model prior to it being rolled out across Greenwich.

Methodology

Healthwatch Greenwich carried out in-depth interviews with 10 patients who were randomly selected from those taking part in the Test and Learn.

Prior to the interviews with the patients, there was a discussion with the Care Navigator about the individual patients, their “I” statements and the progress made so far. The “I” statements, along with the coping score recorded by the Care Navigator formed the baseline for the evaluation. After this, in-depth semi-structured interviews designed around the “I” statements were conducted with the patients and in some cases family members. Nine of the interviews took place in person with one carried out by telephone. These interviews were recorded and then transcribed. After transcription the data was coded and analysed and this report produced to identify the main themes and learning points.

Findings

Of the 10 patients, there were in total 32 “I” statements. Of these, 18 had been met, 11 were on the way to being met and only 3 had not been met at all.

The starting and final coping scores are outlined below.

Patient	Coping score at the start	Coping score at the end	Difference
1	5	5	0
2	5	7	+2
3	4	9	+5
4	7	8	+1
5	8	8	0
6	6	7	+1
7	5	8	+3
8	6	8	+2
9	2	8	+6
10	7	8	+1

None of the patients experienced a decrease in their coping score and the mean increase of the coping score was 2.1. Two of the patients felt there was no change in their coping score and it was the patients with the lowest coping scores whose score improved the most.

Discussion

Overall, the findings demonstrate that the Care Navigator model has improved the patients' experience as there is an increase in coping scores and over 90% of the "I" statements have either been met or are in the process of being met. Almost all of the patients felt the Care Navigators had made a positive impact on how their care was managed and all of the patients were able to give at least one positive event which had occurred as a result of the Care Navigator's input.

There is a variety between the patients regarding how much contact they have had with their Care Navigator, with some having lots of contact and some having very little. There is also a difference in how patients use the service. Some patients use their Care Navigator as almost a sounding board to discuss ideas with while others rely much more heavily on the Care Navigator to arrange things on their behalf. Most of the patients felt supported by their Care Navigator, describing them as "*a shoulder to lean on"* and that having a Care Navigator took away some of the stress, particularly for family and other carers. The following were identified as the main themes following the interviews.

"I" statements

The majority of the "I" statements either had been met or were in the process of being met. Sometimes "I" statements were only in the process of being met because of delays in the service rather than because they had not been addressed by the Care Navigator. The majority of patients understood that it may take some time before all of their needs could be met and that they had worked with the Care Navigators to identify the "I" statements which should be prioritised.

Some patients raised the issue that their "I" statements were no longer relevant and that there were now other issues which were more pressing than those recorded in the "I" statements. Although the "I" statements are an important tool for the patients to express what they would like from their care, it is vital that the focus is not just on meeting those particular statements but also responding to the patient needs as they change over time.

Key Themes

Home visits

Many of the patients expressed that having a Care Navigator has made it easier for them to arrange home visits from other healthcare professionals such as district nurses and physiotherapists. There were also examples of the Care Navigator helping to arrange home visits from other services such as the opticians, which the patient was not aware was a possibility. As these patients have such complex needs and many have problems with their mobility, they commented on how helpful these home visits were.

Breadth of the Care Navigators' knowledge and assistance

One of the greatest successes of this project is the variety of ways in which the Care Navigators have been able to help their patients. Not only have they been able to

assist with the patients' medical needs but also with improving patients' overall wellbeing. This has included referrals to befriending services and suggestions of different clubs and online social sites patients could join. One patient's family member commented:

"[The Care Navigator] helps you become a bit more ambitious. Rather than just getting someone not to die and sit in their own squalor, you are thinking about their nutrition, their emotional and social needs. It means things are moving on and these other things are getting addressed".

Patients commented that the Care Navigators had a wealth of ideas of the different services they could access and introduced them to new avenues which they were not aware of before.

Contacting services for patients

Almost all of the patients felt that having somebody to contact different agencies on their behalf has improved their care. Patients commented that things moved more quickly, particularly within healthcare, because of the Care Navigator. Many patients expressed how confusing they found the different systems and pathways they encountered within health and social care and they found it much easier once the Care Navigator was involved to help coordinate their care. Some patients and their families felt that health care professionals were more likely to listen to the Care Navigator rather than to them, and that the Care Navigator was able to access services or information which had previously been denied to the patient.

Communication

Discussions on communication formed a large part of the interviews. On a positive note, all of the patients interviewed knew how to contact their Care Navigator by telephone. Most of the patients said they would be happy to call their Care Navigator if they had a problem with their care, and also if something were to go wrong. One patient's family member commented that he appreciated the Care Navigators and other agencies called him at a convenient time (after they had finished work at 5 o'clock), which meant that he could have a conversation regarding his father' s care, instead of having to rely on emails.

However, some patients felt that there was a lack of communication from the Care Navigator reporting back to the patient on any progress from meetings or their contact with other services. "*She never comes back and tells me what happens at that meeting. Well, I'm the person that should know"*. This lack of feedback leaves the patient feeling unsure about whether they are still being assessed and whether there has been any decision made regarding their care.

A minor point is that the patients who had met the Care Navigators expressed that they were very pleased to have done so and those who had not said they would have liked to have met them.

Recommendations

Before the scheme is replicated in another geographical area or rolled out across the whole borough, there are some recommendations Healthwatch would make in order for it to be as effective as possible.

1. **Keep patients up to date** - It is important that the Care Navigators ensure they are updating their patients regularly, even if there has only been very little progress made. This will keep patients fully informed about all aspects of their care and allow them to remain in control. The Care Navigator should also explain if there are any delays and try and offer a reason for this. If possible, it would be helpful to give a rough timeline of when they expected things to progress

2. **Keep in regular contact with patients** - Care Navigators should ensure they are being proactive and contacting their patients on a regular basis even if they feel there are no important updates. This will mean the Care Navigator will know how the patient is coping and whether other needs have arisen which need to be addressed. Patients may be more likely to disclose information if the Care Navigator contacts them, rather than if they have to contact the Care Navigator for fear of being a bother or not thinking the information is relevant.

3. **Be aware of changing patient needs** - The process regarding what happens when "I" statements are no longer relevant needs to be clearer. It is important that there is an opportunity to revise or add new "I" statements as circumstances and patients' needs change.

4. **Meet patients in person** - Although not a necessity, feedback shows that patients would like to meet their Care Navigator in person at least once. This would be useful at the beginning of the process to build a rapport between the patient and Care Navigator and perhaps mean the patient is more likely to contact the Care Navigator if they have a problem. Furthermore, as these patients have complex needs they meet and speak to people from lots of different agencies which can be overwhelming. Meeting a person face to face may make it easier for the patient to remember who their Care Navigator is and the role they play.

5. **Arrange home visits** – Healthwatch Greenwich recommends that care navigators continue to arrange home visits from other services where possible. As many of the patients have problems with their mobility, they find it difficult to leave the house for long periods of time so home visits mean they can access as many services as possible.

6. **Have a good knowledge of the variety of services available –** This model of care revolves around addressing all of the patients' needs and not just focusing on their physical health. So far patients have been able to access a wide range of services and organisations which can help to meet all of their needs and improve their overall wellbeing. The Care Navigator team should therefore ensure they continue to keep up to date with the services available in

the borough and the surrounding area which they feel may be beneficial to their patients.

Next steps

Healthwatch will be conducting follow up interviews in December with the same 10 patients. This will be to review whether these recommendations have been put into place and to establish the impact of those recommendations. The follow up interviews will also be to discern whether the patients are still part of the Care Navigator scheme and whether the positive effect has been sustained in the long term.

Conclusion

The patient feedback in these interviews has been overwhelmingly positive and the scheme has led to an improvement in patients' experience of their health and social care. It has led to an improvement in care for most patients and most of the patients' needs in terms of their "I" statements have either been met or are on the way to being met. Most of the patients have had an increase in their coping score and they feel their care has improved compared to before having a Care Navigator. Families and carers have also commented on how the Care Navigators have helped them and that it is easier and quicker to access services.

Acknowledgements

Healthwatch Greenwich would like to thank the patients and their families who agreed to be interviewed as part of the evaluation process. We would also like to thank the Care Navigator team for their help in recruiting patients and taking the time to share information and answer our questions.

Appendix

Case study

The following case study is an example of how the Care Navigator scheme has helped one patient, Mr E.

I was referred to the scheme through my GP after seeking help for my depression. My partner had recently died and the business we owned together had closed so I was both recently bereaved and had lost my job.

Due to the change in my financial circumstances, I asked for access to the food bank and for support with managing my finances. My Care Navigator was able to suggest different agencies I could access for financial advice and pass on their contact details. She referred me to the food bank and in addition to being able to access the service, I also started to volunteer there which helped with my depression.

I wanted access to social activities as I felt isolated from my friends. My Care Navigator gave me information about different groups and social sites that I could join and I've made new friends and expanded my support network.

My Care Navigator referred me to organisations who could offer me counselling, and I attended some sessions earlier in the year. She suggested lots of different ways I could get some help and although I did not contact every agency due to an improvement in my mood, I was very grateful for all of the suggestions she made.

I have a long standing problem with a squint in his eye and my Care Navigator suggested going to the opticians before getting the GP involved. Following my visit to the opticians, I was given new glasses which has helped alleviate my squint problem. She contacted the opticians to get their opinion on the problem and advised me that I should also contact my doctor who may be able to refer me to a specialist. I haven't made the appointment yet but I will be visiting my doctor soon.

I've now found employment which has helped both my financial situation and my low mood. I would say all of my "I" statements have been met and my coping score has gone from 2 to 8.

My Care Navigator was always full of suggestions of things I could do and several times when she phoned up I was feeling not a million dollars and she was kind enough to spend considerable time on the phone, suggesting things, always being very positive, which when you're in that situation is exactly what you want.

This case study demonstrates the wide reach of the Care Navigator and all of the areas they can provide support in. In this case the Care Navigator has provided advice on physical medical issues, mental health issues, financial issues and social issues, playing a very supportive role for the patient.

This also shows good practice with regards to good communication between the Care Navigator and the patient. The Care Navigator has taken a proactive approach to keeping in regular contact with the patient and ensuring they are fully informed about their care. Mr E commented that although they has regular telephone contact he would have liked to have been able to meet his Care Navigator face to face.