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Encompass Vanguard: Evaluating Staff & Manager Perceptions

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University of Kent

April, 2018

CHSS
University of Kent

Centre for Health Services Studies



encompass

Working together for better health and care

Background



Research & Evaluation Team

- ▶ Professor Jenny Billings and her team from the Centre for Health Services Studies (CHSS) at the University of Kent



Prof. Jenny
Billings



Dr. Melanie
Rees-Roberts



Sabrena
Jaswal



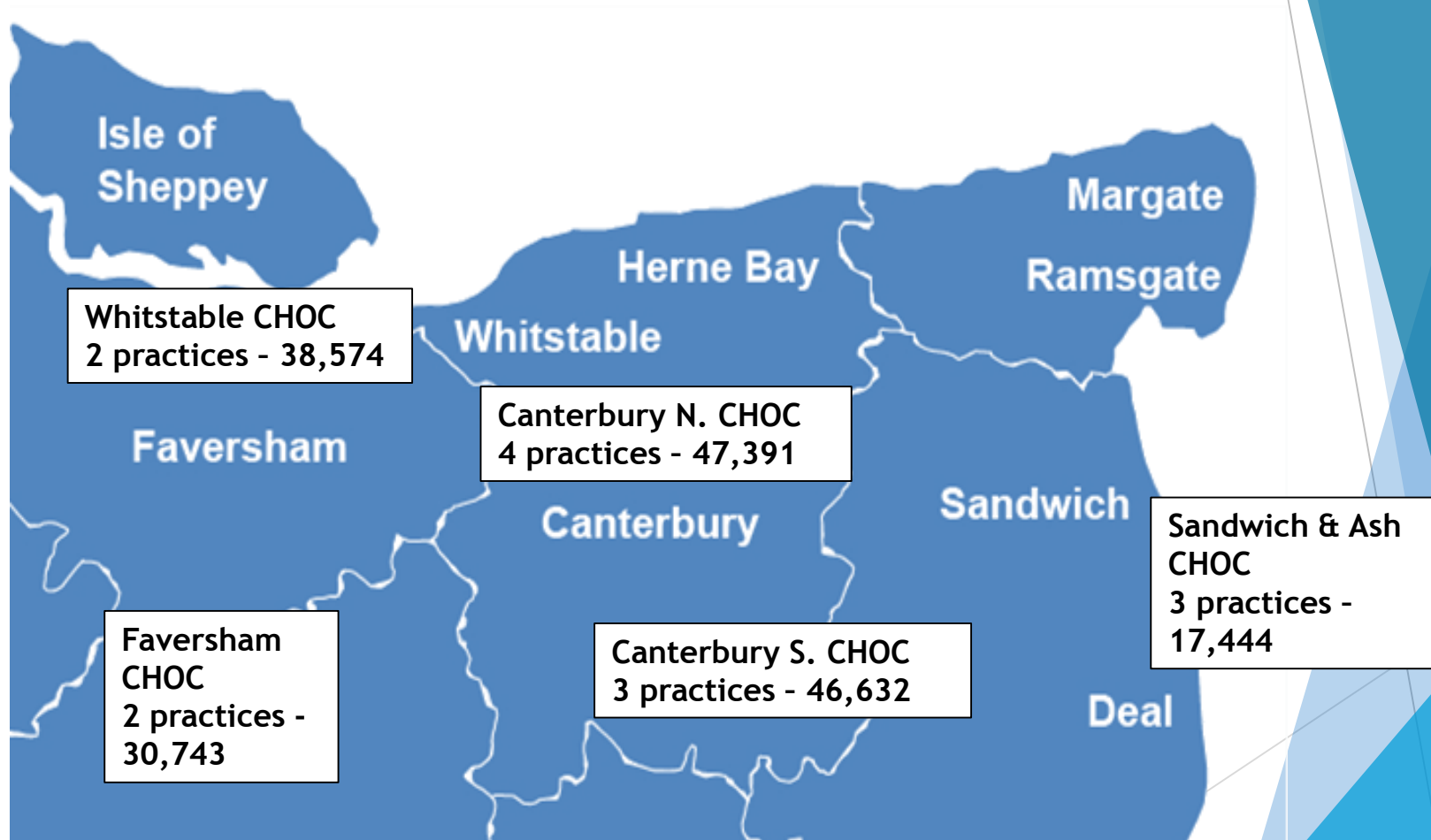
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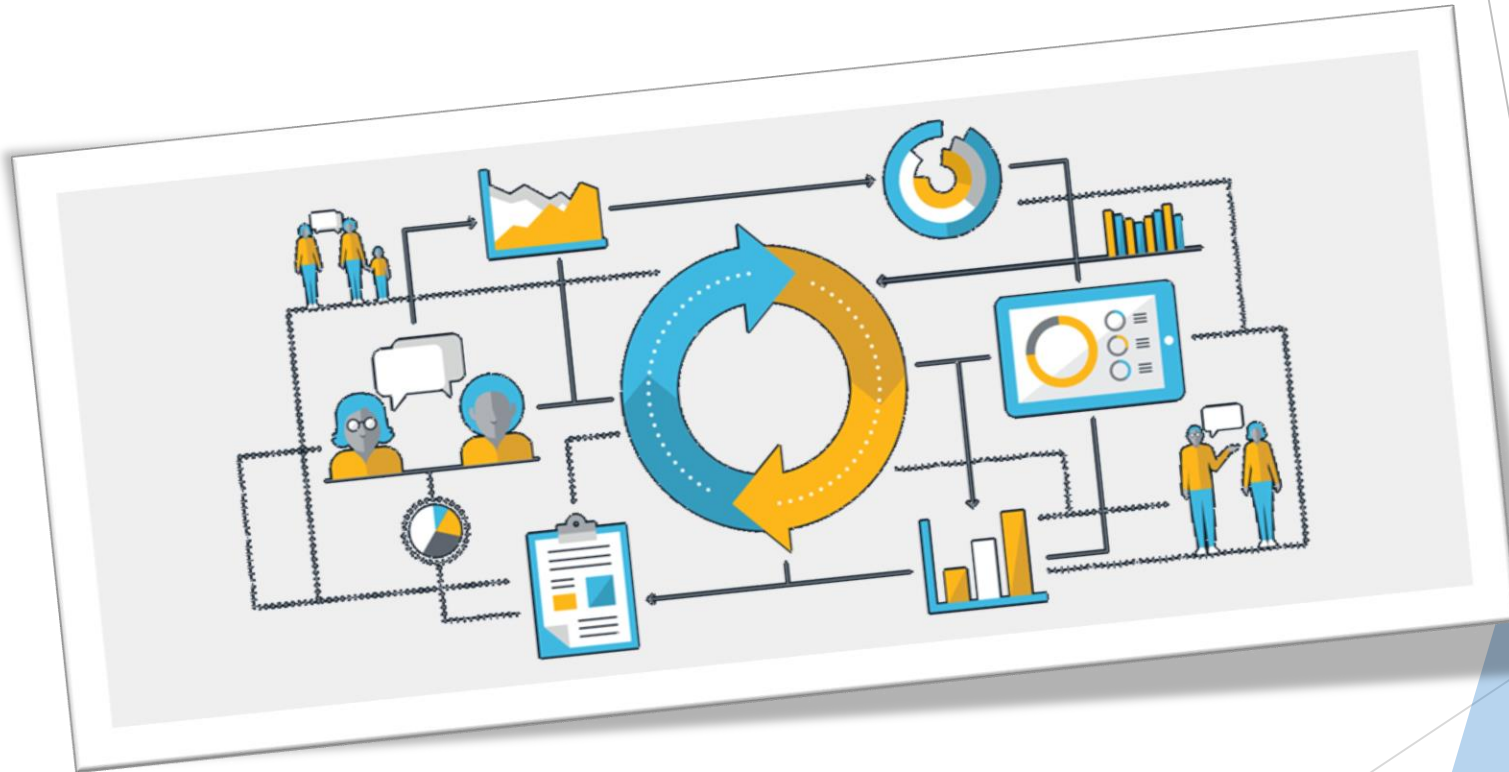
Community Hub Operating Centres in Kent (CHOCs)

- ▶ The objective of the CHOC is to support system sustainability through the creation of a holistic community based model of integrated service delivery. They commenced in 2016 and have now been rolled out in Canterbury, Faversham, Whitstable, Ash and Sandwich. They represent a fully integrated health and social care team; offering primary, community and social care services.
- ▶ Aims of the CHOC:
 - ▶ To improve user experience of co-ordinated care and self-management at home
 - ▶ To contribute to a reduction in A&E demand and onward admission in the short term
 - ▶ To reduce pressure on acute services and long term care home placements in the longer term

CHOC Localities



The Evaluation



Local Evaluation Research Questions

- I. What impact are the CHOCs having on user outcomes and experience?
- II. What are the components of the care model delivery (or 'active/successful ingredients') that are really making a difference?
- III. What are the influencing contextual factors and how have they affected implementation and outcomes?
- IV. What changes to the use of resources and activity in the local health system have taken place and to what costs?
- V. What could be improved, replicated and sustained?

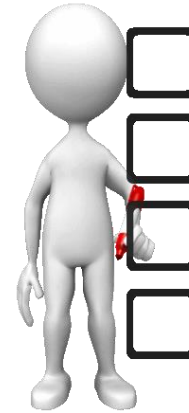
Data Collection



Patient Interviews



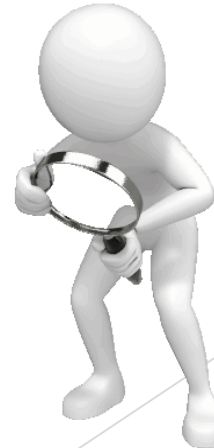
Staff Interviews



Staff Questionnaire

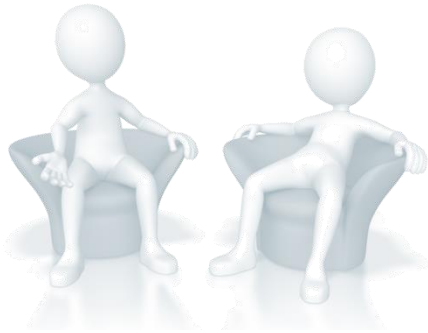


Patient Survey



MDT Observations

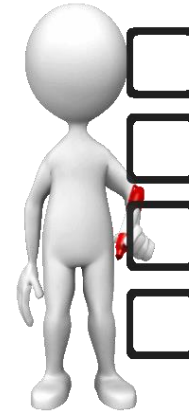
Data Collection: Staff & Managers



Patient Interviews



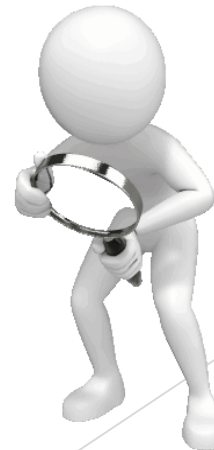
Staff Interviews



Staff Questionnaire

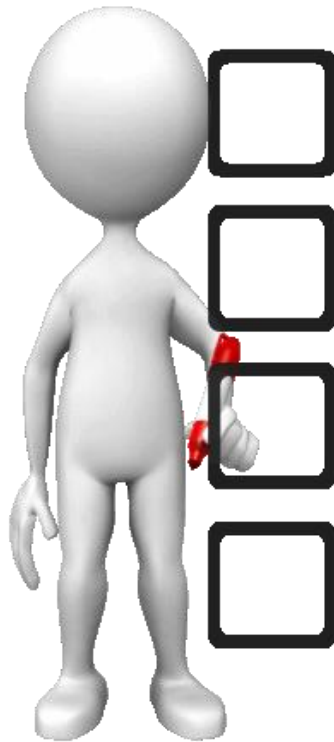


Patient Survey



MDT Observations

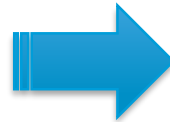
Interprofessional Collaboration Scale



A Closer Look...

▶ The scale looks at:

- ▶ Experiences of working relationships
- ▶ Reported perceptions
- ▶ Teamwork



▶ Themes

- ▶ Communication
- ▶ Accommodation
- ▶ Isolation

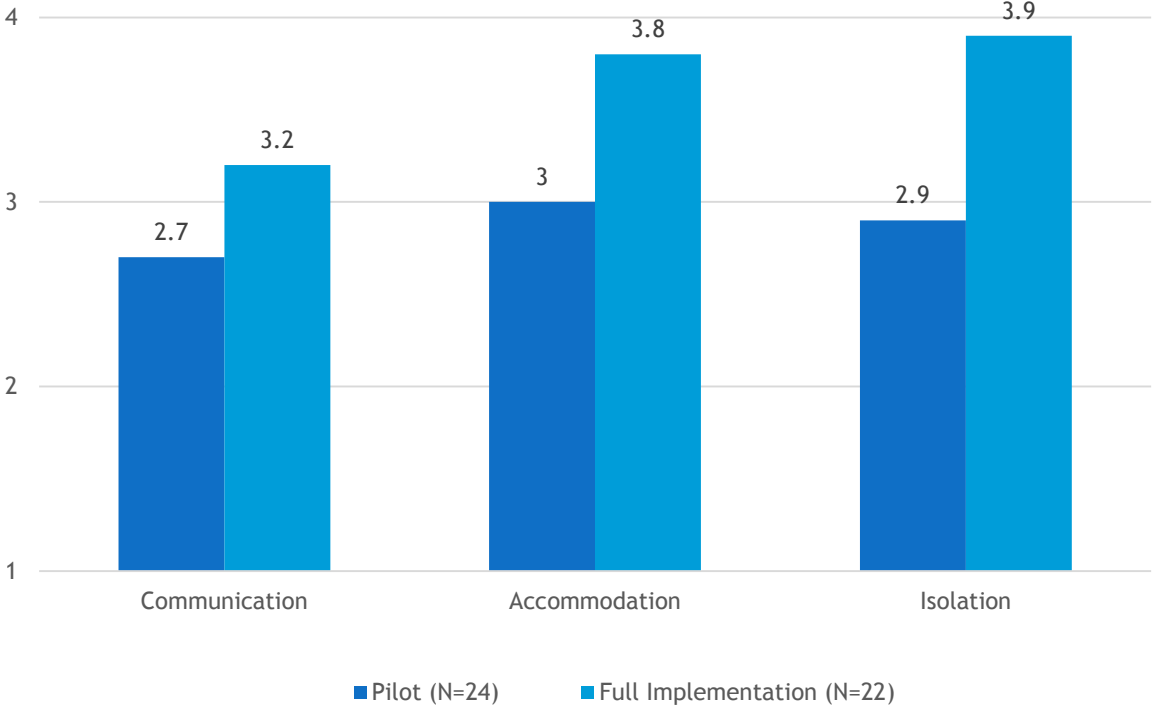
Question	Themes
<i>I feel that patient treatment and care are not adequately discussed between and among team members</i>	C
<i>Team members cooperate with the way care is organized</i>	A
<i>Individuals are not usually asked for their opinions</i>	I

¹ Kenaszchuk C, Reeves S, Nicholas D, Zwarenstein M. Validity and reliability of a multiple-group measurement scale for interprofessional collaboration. *BMC Health Services Research*, 2010; 10.

Collaboration and the CHOCs

Interprofessional Collaboration Scale

1 = Strongly Disagree, 2 = Disagree,
3 = Agree, 4 = Strongly Agree



Staff & Manager Interviews



Staff/Manager Interviews to Date

Staff role	Target Recruitment Number	Interviews Completed
Managers	26	8
CHOC GPs		2
Nurses		1
Other Allied Health Professionals		8
Other roles within CHOC		1
Other roles outside CHOC		2
Total		22

Experience with the Implementation of the CHOC

- ▶ *You have a bit more confidence in your care plans because you know it's had that MDT approach, so you know all basis have been covered (SM1)*
- ▶ *How you can be integrated and not be able to share that information was challenging to begin with...it's better and developing and with the integration of EMIS and the MIG we've been able to move that forward (SM10)*
- ▶ *There's an element of trust that "yes you know this is going to get done" because people are committed for this to work (SM6)*

Coordination and Impact on Patients

- ▶ *I think we've avoided quite a few crises from patients (SM11)*
- ▶ *Medicines management were the hardest people to get referrals through to and now they're at our meetings it's fantastic (SM2)*
- ▶ *The voluntary sector has been hugely helpful in stepping in; the Red Zebra team are often picking up little gaps where social services can't really help or have been very slow too (SM13)*
- ▶ *You have a face-to-face conversation around the table about this patient and you - not always - but you can get a solution or an action right then and there so you're not waiting (SM3)*

Sustainability of the CHOCs

- ▶ *People needed to be afforded the time and the availability to be able to do it alongside their normal role (SM1)*
- ▶ *Need access to the systems during the meetings [i.e. EMIS and CIS] (SM4)*
- ▶ *Have a representative from each organisation [not everyone from health and social care organisations attend] (SM4)*
- ▶ *We do not have a sustainable workforce with the skills required to continue (SM3)*

Professionals Working Across CHOCs

- ▶ *The relationships between the providers has gone from non-existent and full of animosity to respectful, open, honest, supportive (SM3)*
- ▶ *It's helped beyond the CHOC in understanding who is out there, what other services are there, particularly the voluntary services (SM5)*

CHOC MDT Observations



Observations

- ▶ The observations involved
 - ▶ 3 CHOCs
 - ▶ 4 consecutive MDT meetings
 - ▶ 2 observers
 - ▶ **12 CHOC MDT meetings observed in total**
 - ▶ Observers were non-participatory members at the meeting
 - ▶ Focussed Ethnographic Observations
 - ▶ Observations were handwritten and included sections for free text and sections which were more structured

- ▶ **Aim:**
 - ▶ To identify what elements of the process are leading to what outcomes for service users
 - ▶ To better address our objective: What are the components of the care model delivery or “active ingredients” that are really making a difference?

INPUTS	National policy directives	Mention of national policy directives or guidelines.
	Local Guidelines	Mention of local guidelines/rules/regulations.
	Resource issues	Mention of resource issues (e.g. staff, time, money). How do these factors affect decision making? Evidence of resources being pooled?
	Other services	Mention of other individuals/services/team within organisations that impact on options/decisions made.
	Context	Other broader contextual factors influencing decision making.
	Presenters	Who presents cases up for review? How? How are agenda items framed?
	Targeting of Patients	Who are they targeting? How? Any particular health conditions? Is there a formal approach (risk stratification)?
	Patient characteristics	Patient characteristics – any variation?
	Voluntary Sector Input	What input does the Voluntary Sector Organisation representative give (if they attended)?
	Missing info	Mention of missing information? How does this impact on decision making?
PROCESS	Leadership style	Is there a clear role or several competing leaders? Do they encourage involvement or limit contributions?
	Team dynamics	Does everyone contribute to discussions/actions and decision making? How?
	Overall Purpose	What appears to be the overall purpose of the MDT?
	Case Management & Review	How is the case management and patient review managed? What information is provided? Who provides the information? Who takes action?
	Performance Measures	What measures are they using to measure performance of the MDT?
	Mediators	Other mediators, processes influencing decision making.
OUTPUTS	Ongoing & new cases	How many cases are discussed in the meeting? Number of new cases/ongoing cases.
	Actions agreed on	What actions are agreed? Are actions from previous meetings reviewed?
	Decision making & recording patterns	Who records the decisions made? Is there a verbal summary and rationale? Is responsibility for implementation discussed? Any other outputs by the MDT
OUTCOMES	Outcomes/end result	Patient experience, service utilisation, clinical, patient-reported and wider outcomes
	Cost Savings	Evidence in the meeting of cost savings in terms of changes to staff input in patient care
	Identifying problems	Did they identify delays or doubling up of care, patient problems, other problems in care?
	Remedying problems	Did they remedy delays or doubling up of care, patient problems, other problems in care?

Analysing the Observations

- ▶ The information recorded on the structured part of the schedules has been analysed thematically within the main categories of:
 - ▶ INPUTS
 - ▶ System & Organisation Factors
 - ▶ Team & Task
 - ▶ PROCESS
 - ▶ Leadership & Team Dynamic
 - ▶ Purpose & Performance
 - ▶ OUTPUTS
 - ▶ ‘Actioning’ & Decision Making
 - ▶ Outcomes
 - ▶ Patient, Clinical and Wider outcomes
 - ▶ Health Economics

Findings: INPUTS

▶ System & Organisation Factors

- ▶ Safeguarding Vulnerable Groups Act 2006 and Mental Capacity Act 2005 were most relevant and commonly mentioned **national policy directives**
- ▶ **Local Guidelines** mentioned less frequently; mostly to do with mandatory assessments required prior to decision-making
- ▶ CHOC MDT prepare and plan ahead for **resource issues**; e.g. closure of voluntary services and NHS staffing over Christmas
- ▶ Involvement of other services or availability of informal carers related to CHOC discharge; CHOC MDT unlikely to take over from or 'top up' other care provision

Findings: INPUTS

▶ Team & Task

- ▶ Good skill mix for each CHOC MDT observed, but notable lack of **Mental Health Services'** representation
- ▶ If no representatives from a service are present (e.g. no pharmacist), at times handing actions to them becomes more difficult and less effective
- ▶ **Information sharing** before and during the CHOC MDT works well within the team, but is considerably complicated by fragmented access to various systems across organisations (which often results in **missing information**)
- ▶ Caseload is characterized by older adults, multimorbidity and either the patients refusing assistance or family members complicating access

Findings: PROCESS

▶ Leadership & Team Dynamic

- ▶ ‘De Facto’ leadership of highest status and most outspoken professionals (e.g. GPs, geriatricians). The chair for the meeting changes each time, but they are rarely ‘leaders’; leadership is stable
 - ▶ This means that if the ‘natural leaders’ are absent during a given MDT, the process changes considerably (often more collaboration and discussion)
- ▶ Dominance of the medical model. Non-medical professionals or those of lower banding less likely to take part in decision making; usually feed back knowledge and/or take on actions
 - ▶ Overall, a smaller platform given to Social Care and Voluntary sector professionals to raise questions or suggest action

Findings: PROCESS

▶ Purpose & Performance

- ▶ Overall observed purpose of the CHOC MDT appears to be to pool resources and distribute actions most efficiently with the knowledge of other attendees (i.e. avoiding double-up)
- ▶ Performance measures not overtly discussed, but some indication from team discussions that the aim is to prevent a crisis, stop preventable deterioration and getting appropriate and speedy input from relevant health and social care professionals
- ▶ Patients of the **caseload** discussed each week, to ensure frequent **review**
- ▶ Absence of a pre-defined and finite caseload size
- ▶ Action is handed out depending on suitability and (at times) availability of staff

Findings: OUTPUTS

▶ 'Actioning' & Decision Making

- ▶ 15-20 cases in *most* CHOC MDTs, but variation likely, and differences between locations present.
- ▶ In each of the 12 observed MDT meetings there were new cases accepted, and existing cases closed
- ▶ Commonly agreed **actions** were visits by CHOC members either for assessment, or treatment or both
- ▶ Assigned actions from previous week **reviewed** at each meeting, but in some cases the professional fed back not having had enough time to address the given action / visit the patient
- ▶ Administrators record overall agreements, but attendees make personal notes, too
- ▶ **Responsibility** implicitly left with the action holder, who is expected to feed back the following week / make electronic records.

Findings: OUTCOMES

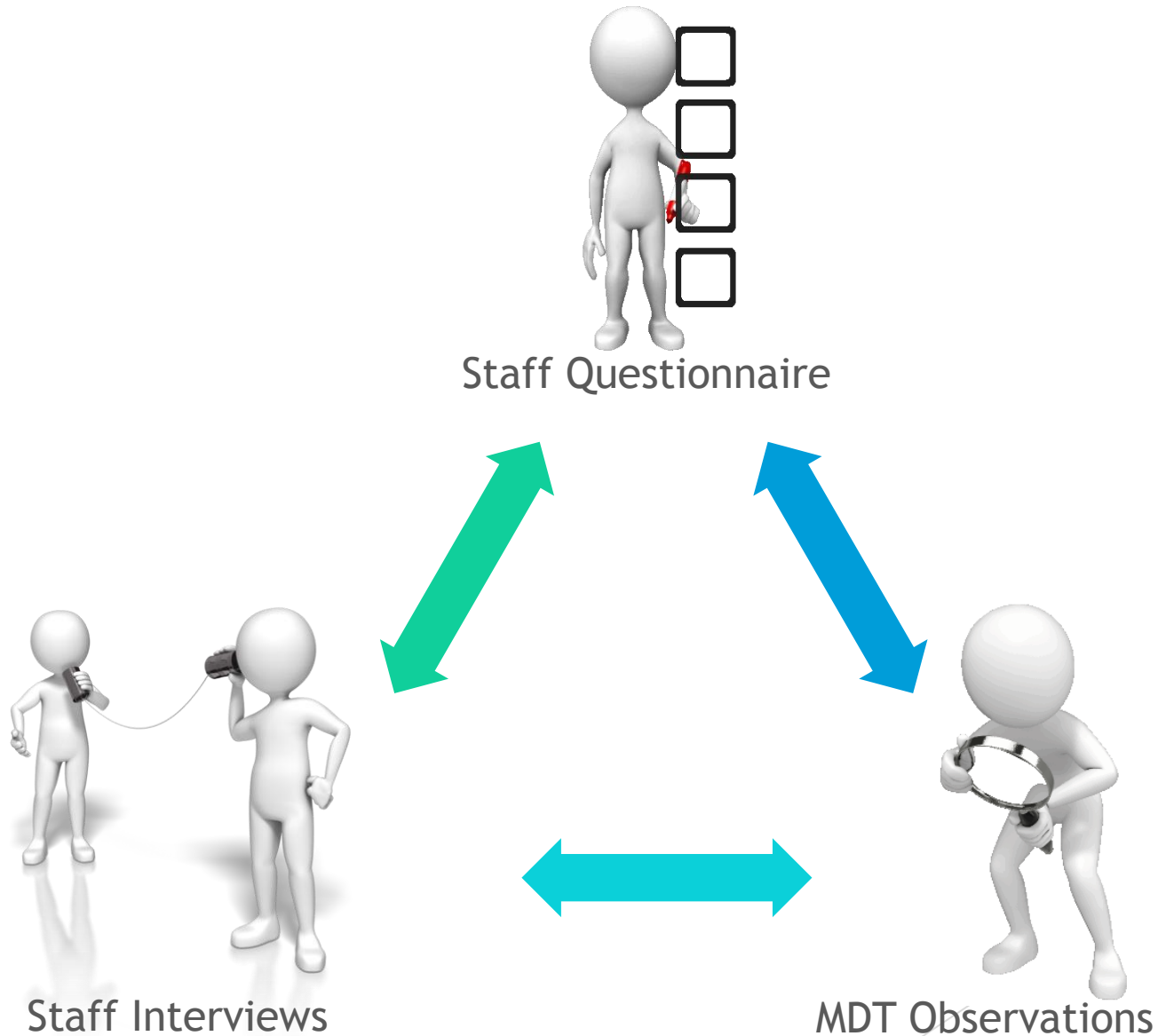
▶ Patient, Clinical and Wider Outcomes

- ▶ Patient outcomes not discussed overtly during the MDT meetings
- ▶ Decrease in demand on acute services/hospital admissions not evident directly from the CHOCs, but some discussion on avoiding inappropriate admission has taken place
- ▶ Clinical outcomes also not discussed overtly in many cases and not standardised. Individual clinical outcomes (e.g. absence of infection, vital signs' indicators sometimes discussed)
- ▶ Wider outcomes only discussed as reducing duplication of services

▶ Health Economies

- ▶ **Delays** in providing a service often **identified**, but seen as **irremediable** and a result of insufficient resources
- ▶ **Problems in care** (such as service previously needed but not accessed) identified effectively. Resolution, however, is rarely straightforward or quick due to complexity of cases (either multimorbidity, unmet social care needs or refusal of services)
- ▶ **Quick and appropriate response** to patient problems affected by patient eligibility and staff capacity, but attempted whenever possible

Triangulating Findings



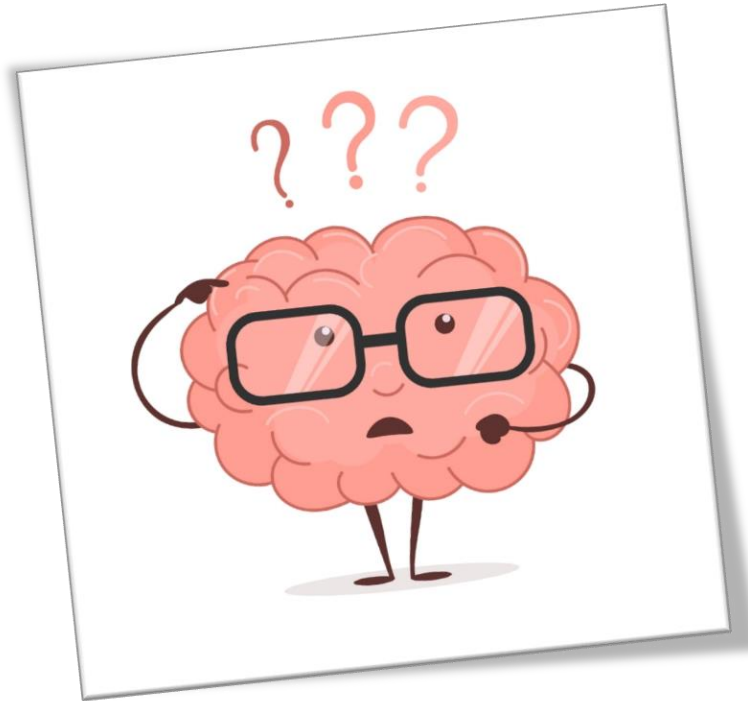
What Works Well?

- ▶ Good MDT skill-mix, high attendance numbers
- ▶ Voluntary Sector involvement to provide social prescribing and befriending services
- ▶ Dedicated geriatrician involvement to provide specialist medical knowledge on the ageing process (due to high proportion of older adults in the CHOC population)
- ▶ Dedicated administrative support to pool, update and distribute information
- ▶ Face-to-face format of the CHOC MDT meetings (according to interviewees, teleconferencing would not have resulted in sufficient rapport and trust among attendees)
- ▶ Cross-organisational relationship and partnership building within the MDT format (respondents often spoke of newly developed trust and confidence in colleagues from partner organisations attending the CHOC)
- ▶ Tailoring for the needs of the local population (e.g. inviting fire and rescue services where appropriate)

What Could Be Even Better?

- ▶ IT and information sharing between organisations (to allow for more joined-up working both within and outside CHOC meetings)
- ▶ Intra-organisation delegation at CHOC meetings (even if regular attendees are away, a colleague would represent the discipline) to ensure action points relevant to the agency are undertaken
- ▶ Greater participation of Mental Health professionals
- ▶ More equitable participation in decision-making across attendees from different professions and organisations (notably, this would increase the length of CHOC MDT meetings)
- ▶ More upskilling of staff to further improve performance and skill-base
- ▶ Staff workloads re-evaluated to ensure retention (so professionals are able to attend the CHOCs / avoid cancellations due to workloads)
- ▶ Speedier investigation of patients and implementation of action (if the overall workload is more manageable)
- ▶ Funding arrangement (continued funding crucial)

Thank You



**Any Questions? Not right now?
Then please e-mail:
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