

Integration and continuity in Primary Care:

A patient-centred analysis of how organisation constrains care coordination

Between 2011 and 2014 a team of academics, led by Professor Rod Sheaff from Plymouth University, set out to explore the relationship between the organisation of primary (health and social) care services and the care experience of frail older people with multiple, complex needs. You were kind enough to give up your time to speak to us and in return we wanted to outline our findings.

1. What we did

We chose five areas in England where health and social care was organised differently. In each area we spoke to a number of older people with a wide variety of long-term health conditions (66 in total, together with their carers where appropriate). We also looked at their medical records in the GP surgery and spoke to those responsible for providing their health and social care (GPs, community nurses, physiotherapists, care managers and so on).

The aim of our research was to find out how the different organisational approaches adopted compared in terms of co-ordinating patients' care across the range of services. We wanted to know what factors helped services work well together and where people experienced difficulties.

2. What we found out

Our patient sample (average age 78) typically self-reported four chronic health problems. For many, such problems had increased over the last year and combined to limit mobility. 65% found difficulty walking outside on their own and fewer than half were able to drive (often because of declining health).

2.1 Similar Patient Experiences:

Despite the organisational differences, we found more similarities than differences in patient experience between our study sites.

Getting in touch

- Most found it easy to see *someone* about their health but not to see **a regular GP**, which was something which nearly everyone thought was important (80%). Telephone contact was

also partly replacing face-to-face contact. Relational continuity was thus patchy.

- Patients attributed this to practice policy, workload, working hours, size of practices and the urgency of the care required. Many also criticised the **one problem per visit policy** and the **time available within any one consultation**. These combined to leave them feeling they lacked the opportunity to talk things through, seek reassurance or experience holistic care.

Review

- Patients felt the best **overview** of their health was held either by their GP/GP surgery or (for 37% of them) by themselves or their spouse, a substantial proportion for a frail group. The medical records suggested patients had typically had multiple care coordinators in the last year.
- Most (86%) were unaware of any **plan for their care** but this was not an issue to which they attached a great deal of importance.
- In contrast, they were concerned about the **lack of a regular review** or 'a MOT check' with the GP. Most (77%) thought a regular review was important but many (61%) said they had had no review, no regular review or were reviewed only annually.
- Patients were also concerned about the **lack of follow-up** after any change in treatment or hospital care. The majority (84%) thought this was important but it was not always evident in practice. Of those who had been in hospital, many (58%) reported that they had not had a health professional check all was well once they were home.

Communication

- Communications was also an issue. Poor **transfer of information** meant staff were sometimes unaware of a patient's history, leading to incorrect care or medication being given and treatment being delayed.
- Only 58% of patients felt they themselves always had **sufficient information**.
- About a half (49%) reported **gaps or interruptions** in their care and a similar proportion thought (46%) it could be **better organised**.
- A contributory factor was the difficulty of being seen in the community. Patients tended to understate problems such as pain, impaired mobility and fear of falling but this understatement appeared to mean that many had problems accessing help, particularly attending repeat appointments.

Standard of care

- Overall, levels of **satisfaction** were relatively low. Only 59% of patients said they were satisfied with the care given.

- Perhaps surprisingly, given these reservations, 66% still felt they were sufficiently supported.

2.2 Some standard organisational responses

Organisations were responding to these challenges in broadly similar ways. We found an increasing number of **special initiatives, dedicated posts and multi-disciplinary care teams** focusing on frail older people. These included, for example, variants on the virtual ward model, acute care at home services, integrated primary care teams, and new roles such as primary care dementia practitioners. These were designed to reduce unnecessary hospital admissions and support the most vulnerable people when they returned home. They often included a single point of first contact and the use of integrated electronic records shared across organisations.

In all five of our study sites, **formally managed care networks** had been established to improve care across organisational boundaries. These were variously referred to as referral hubs, assessment centres, emergency intervention services, proactive care or virtual wards and often incorporated earlier informal inter-organisational teams. These too were typically aimed at admission avoidance (including the use of 'front-door' teams at hospitals to 'pull out' incoming patients whose admission could be avoided) and facilitated discharge, together with better long-term condition management. For individual patients, engagement with these networks was often time-limited, the focus being on swift assessment and triage. The need to address the continuing problems of occupational and organisational coordination was frequently a subsidiary aim.

Caseloads were also becoming increasingly stratified. All the studied community health services (CHS) identified **case managers** for patients with complex, long-term conditions, but which patients had a case manager, the criteria for having one and arrangements for assigning that role varied considerably across study sites and between services. Few of our patients, despite their complex co-morbidities, had access to this support or indeed a designated care co-ordinator. Rather, it was their GP(s) who acted as *de facto* care co-ordinators, with consultants also filling this role for some. Similarly, **care plans** existed only for a minority of patients, even in this frail group.

Provider organisations, irrespective of organisational structure struggled still with **information transfer**, and the degree to which their own records should be open to other services, such as GPs, Out of Hours, or CHS. Even within integrated organisations, discrepant IT systems for different care groups were evident and many practitioners continued to rely heavily on paper records. This was inimical to, for example, risk stratification and care planning. Understanding of individual roles and responsibilities also remained a common problem.

There was also a growing awareness that health and social services needed to work closely with

the voluntary sector to widen the breadth of services available. Initiatives encountered included day care, domiciliary care, care navigation services (both on an in-reach and out-reach basis), preventative interventions, hospital after-care and end-of-life care. Coverage was, however, often patchy and voluntary sector involvement was frequently reported as being under-developed, or under-valued and initiative-specific.

2.3 Some organisational differences

We also found some important differences between our case study sites. These often appeared to reflect **variations between GP practices** rather than system-level differences. For example, levels of community support, onward referral, home visits and care co-ordination by GPs tended to be higher in practices that either still operated patient lists or where the patient was predominantly seeing the same doctor. This suggested continuity of contact may produce higher quality of care, enabling a more complete assessment of need and more wide-ranging support.

We also found that what we would call '**network structures**', groups of independent organisations or teams, were good at working flexibly, that is adding in new services for small care groups in the short term. However these care networks were often limited by: incomplete information, referral and financial flows across organisational boundaries; capacity mismatches between the successive providers in a care pathway; and conflicting financial incentives and managerial targets. The expansion of **integrated organisations**, however, had advantages when adding new services on a longer term and larger scale. By 'integrated' we mean all staff – GPs, nurses and therapists – being employed by one organisation and for the same managers; in Sweden, where we explored this model of organisation, the managers are often GPs.

Differences in ownership affected the range of services to which patients had direct access; GPs' managerial responsibilities (relevant to care coordination because of their impact on GP workload); and the scope for doctors to develop special interests. We found little difference between integrated organisations and care networks in terms of managerial discretion and performance.

3. If you want to find out more

Our research was funded by the National Institute for Health Research - Service Delivery & Organisation Programme.

If you want to find out more our full report will soon be available in the Health Services and Delivery Research Journal: <http://www.journalslibrary.nihr.ac.uk/hsdr>

Or contact the Project Lead Rod Sheaff: Rod.sheaff@plymouth.ac.uk (01752) 586652