An Evaluation of the Supporting People in Hospital Project

Final Report

Prepared for:
NHS Greater Glasgow and Clyde

SUBMITTED BY AXIOM

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1. **Introduction and research objectives**

1.1 **Introduction**

Holistic needs assessment (HNA) and care planning was first introduced by the National Cancer Survivorship Programme to help identify the concerns and needs of people living with cancer. The HNA and care plan aimed to ensure that people's physical, emotional and social needs are effectively identified, prioritised and met appropriately, targeting resources where they are needed most. The information gathered from the HNA was also shared with the multidisciplinary teams (MDTs) to help improve the management and delivery of an individual's care.

The HNA aimed to provide a more personalised approach to care planning and to facilitate the development of appropriate interventions for each individual, which would also support self management and could include support and information and signposting or referral to other services. A review of the HNA approach identified a range of benefits including a more effective identification of specific problems, enhanced communication between staff and patient, improved staff competency and satisfaction and improved co-ordination of the care pathway.

In recognition that many of the issues faced by people living with cancer are similar to those for people living with other life changing and/or deteriorating conditions, the Acute Health Improvement Team in NHS Greater Glasgow and Clyde (NHS GGC) liaised with frontline staff to identify areas where a similar approach could be tested. HNA and care planning has already been introduced in cancer services in Glasgow (Improving the Cancer Journey) and in children's services (a Parent/Carer needs assessment).

Three further areas were identified as offering the potential for effective HNA and care planning - people undergoing lower limb amputation, people attending the Physical Disabled Rehabilitation Unit (PDRU) and people attending for renal dialysis. The tool used with cancer patients was then modified and designed to be used by a range of health care professionals and support workers.

1.2 **Research objectives**

NHS GGC wanted to explore the application of Supporting People in Hospital in the three new clinical areas, determine its suitability for long term conditions other than cancer and use this evidence to inform any changes required to the approach to support a future, wider roll-out. This research aimed to establish:

- Whether the modified approach worked in all three areas
- If it was appropriate for all its stakeholders (i.e. patients and health care professionals/support workers)
- The benefits were resulting from its introduction
- To what extent it was being applied consistently across all three areas and by all health care professionals and support workers using it
- The factors were supporting its successful implementation
• The type of needs identified, how they were being addressed and any implications for the referral support service pathways
• Any factors preventing the approach working and how these were addressed
• To what extent it was contributing to key health service outcomes such as person centred care and support and self management
• Any lessons learned from its implementation
• Any improvements which would ensure that the needs of patients are being identified and met
• Key recommendations for the future roll out of Supporting People in Hospital in NHS GGC.
2. Methodology

2.1 Research location

Three locations were selected by the NHS GGC project team for inclusion in this research. These were:

- The Physical Disabled Rehabilitation Unit (PDRU) in the Queen Elizabeth University Hospital in Glasgow
- The Renal Dialysis Unit at Inverclyde Royal Hospital
- Ward 11A/11D Vascular (lower limb amputation) in the Queen Elizabeth University Hospital in Glasgow.

Each of the selected areas support patients with complex needs. Patients in the Renal Dialysis Unit attend for dialysis three times per week, whilst those in PDRU and Wards 11A and 11D have a length of stay which is generally around four weeks. In some cases however, the complexity of the patient needs results in patients remaining in the ward for several months.

It had been intended that this research would follow a process evaluation approach and would seek to explore the early outcomes arising from the implementation of the Supporting People in Hospital approach. However, unforeseen delays in the implementation of the project has meant that this evaluation has adopted a formative approach, focusing on the learning generated from its initial implementation in each of the three areas.

This research has therefore been conducted in three stages:

- Establishing the background to its introduction
- Pre-launch development
- Engaging with the stakeholder groups

2.2 Establishing the background to the introduction of the project

In order to better understand the rationale for the project and the reasons for choosing the three test locations, a discussion group was held with the project planning team and individual interviews with team members to explore the project's history and the key decisions taken which would inform its implementation.

2.3 Prelaunch development

Individual interviews were conducted with senior management in each of the three locations selected for piloting the Supporting People in Hospital project. In addition to this our research consultant also attended an information session conducted by Macmillan Cancer Support for staff who would be implementing the project in each of the three locations.
2.4 Stakeholder groups

In order to explore the approach taken to implementing the Supporting People in Hospital project, the research engaged with the following stakeholder groups, using in-depth face to face interviews, in each of the three locations:

- Ward/unit management to explore how the project should be implemented in their service areas, how staff would engage with patients in the assessment and care planning process, any pre-implementation concerns and how these might be addressed, how the implementation process was working in practice and what issues were arising from this (3 individuals interviewed during several visits to the locations)
- Staff in each of the three locations to explore their expectations of how the approach would be implemented and their role in this, any pre-implementation concerns, how the implementation process was working in practice and what issues were arising from this (8 individuals interviewed during several visits to the locations)
- A sample of patients to explore their experiences of the needs assessment and care planning approach and the extent to which it was their needs (10 patients).

The feedback from the research stakeholders is set out in Sections 3 - 5 of this report.
3. Implementation planning and pre-launch training

3.1 Background to implementation

The Improving Cancer Journey’s pilot in Glasgow was the first time non-clinical staff had conducted needs assessments with cancer patients. It was found that during the assessments, which were conducted by support workers, a range of non-medical and nursing issues were raised by the patients, particularly in relation to concerns over money, employment and family relationships.

It was felt that this might also be applicable to other types of patients who experience life changing conditions. As a result, three locations were chosen, reflecting patients who were experienced permanent changes to their lives as a result of health conditions or traumatic events:

- Renal Dialysis Unit, Inverclyde Royal Hospital
- Physically Disabled Rehabilitation Unit (PDRU), Queen Elizabeth University Hospital, Glasgow
- Ward 11 A (lower limb amputees), Queen Elizabeth University Hospital, Glasgow.

Each location chosen was allocated a member of the health improvement team who would liaise with them to facilitate the introduction of the process in their location. This was in recognition of the fact that the implementation process was likely to be different in each location, reflecting the differing patient groups and staff experienced of conducting health behaviour change discussions.

The health improvement team liaison spent time in each of the locations observing how the units/wards operate and the type of issues facing the patients in these locations. This identified several issues relating to money advise, benefits and financial entitlements, fuel costs, housing adaptations, employment concerns and transportation and it was anticipated that these issues would feature heavily in the assessment and care planning discussions.

3.2 Assessment tools

The documentation was amended from the documents used with cancer patients in Improving Cancer Journeys. Discussions were conducted with management and staff in each of the three pilot locations in relation to the issues to be included in the assessment documentation. This resulted in some changes to the issues detailed under the 6 categories – Medical Matter, Practical Matters, Family/Relationship Matters, Emotional Matters, Spiritual Matters and Health Behaviours. Whilst there were some changes made to the content of the form the layout remained the same as that used with cancer patients.

From the assessment form patients were to be asked to rate the level of concern they have for their issues using a stress thermometer (creased by NHS Ayrshire and Arran). The Action Plan records their top three concerns based on this rating and is reviewed with the patient to explore progress and any further needs to be addressed.
It was agreed that a copy of the completed and prioritised care plan should be given to the patient, a copy held within the patient's notes and a copy held centrally. No decision had been taken at the pilot stage as to whether the information would be recorded on TrakCare.

3.3 Assessment completion

The focus of the needs assessment is the patient and therefore it was expected that family/carer involvement in the process would only be in circumstances where the patient was unable to complete the documentation e.g. where there was cognitive impairment etc.

3.4 Pre-implementation information

NHS GGC has an electronically based Health and Wellbeing Directory which details out information and support available in communities across the Glasgow and Clyde Health Board area. It was expected that this would be used by the locations as one source of information on community support available for patients. In recognition that the Renal Dialysis Unit accepts patients from Argyll and Bute, local services in that area were mapped out by the Health Improvement liaison to be given to staff in the Unit prior to launch.

3.5 Patient information

An information leaflet was developed for patients to explain the purpose of the holistic assessment and care planning pilot. It was intended that this would be given to patients by ward staff as an introduction to the assessment and that patients could use this information to decide if they wanted to take part in the assessment process.

3.6 Pre-launch training

All staff who would be conducting the assessments were to have undertaken training in Health Related Behaviour Change, designed to help facilitate sensitive discussions with patients regarding lifestyle issues affecting their health and encourage them to adopt healthier behaviours. The training sessions are available as:

- A 1 hour introductory session where participants can gain a basic understanding of how to raise the issue of health behaviour change, the difficulties and barriers around raising the issue of health behaviour change and know how to direct clients to specialist support services that can provide ongoing support to individuals
- A 4 hour sessions which introduces health behaviour change approaches and encourages practitioners to develop their brief negotiation skills to support individuals to address specific health and wellbeing needs.

Training sessions were organised for staff who would be conducting the assessments and who had not previously received this training and all staff had received this training prior to the launch of the pilot.

In addition to this staff who were to conduct the assessments were invited to attend a half day training session on the assessment process from Macmillan Cancer Support. The training session covered the background to the introduction of the process for cancer
patients, the rationale for the inclusion of the range of issues in the discussion, the process used by the cancer link workers to conducting the discussions and recording and prioritising the issues raised. Participants were also given the opportunity to participate in role play to practice conducting the assessments.

The training was attended by the team from the Renal Dialysis Unit (including the Unit ward manager), the staff member from SIS (and SIS management) and 5 staff from PDRU.
4. Delivery models

The delivery model for implementing the Supporting People in Hospital approach varied amongst the three locations as follows:

- Nurse led - Renal Dialysis Unit
- Key worker led - PDRU

The service delivery model adopted in each of the three locations is set out below.

4.1 Renal Dialysis Unit, Inverclyde Hospital

The Renal Dialysis Unit provides care and support for up to 55 adult patients with renal failure. The patients attend for dialysis three times each week for between 4 and 6 hours each session. Dialysis is offered through 16 haemodialysis stations which are set up as (beds) over 3 shifts and patients can attend during the day or overnight. The day shift starts at 7am and the overnight option is popular with patients who are still working.

The Unit cares for NHS GGC patients from Inverclyde area and provides a service to NHS Ayrshire and Arran patients in North Ayrshire and NHS Highland patients from Dunoon and Rothesay. Care is provided by a mix of medical staff, nurses and healthcare assistants.

Staff conducting assessments
In this model, nursing staff would be conducting the holistic assessments and care planning. Four members of the nursing team were selected to conduct the assessments, based on their interest in the issue of holistic patient health. The staff were selected on the basis of their participation in Health Behaviour Change training – all four staff had attended the 1 hour session and 2 had attended the more in-depth 4 hour session. Three out of the four staff selected had an interest in palliative care, which was regarded by ward management as closely linked to the supporting people in hospital ethos.

All nursing staff who would be conducting the assessments attended the half day information session on the background to the HNA ethos and approach to conducting assessments and care planning provided by Macmillan Cancer Support.

Implementation plans
All patients who attend from dialysis were to be offered the holistic assessment. As renal failure can create memory issues for many patients, ward management planned that the nurse would work through the assessment form and care plan with the patients. Once completed a copy of the form would be given to the patient, one copy would be kept in the patient’s folder in the unit and another sent for data analysis as part of the evaluation process.

Information on support services (organisations, helplines etc) was to be made available in a folder kept in the ward. Other services, such as the Live Active Co-ordinator, I-Heat and Your Voice, met with staff before the launch of the project to outline support available in
the local area (including grants) to help patients and to set out the referral process for services.

4.2 Physical Disability Rehab Unit, Queen Elizabeth University Hospital

PDRU provides a rehabilitation service for adults with a range of physical disabilities including patients with MS, stroke and brain injuries. Some of the patients also have cognitive impairments as well as mobility issues.

The Unit includes a rehabilitation gym area, 20 in-patient single rooms and 6 day case spaces and 3 break out rooms. The service is available for patients from NHS GGC and NHS Lanarkshire and supports patients for an average of 5 to 6 weeks.

The Unit includes consultants, 40 nursing staff and 12 allied health professionals (OTs, speech therapists and physios). Difficulties in recruiting consultants to the Unit has resulted in limited availability of medical cover and a subsequent restriction on new admissions.

Staff conducting assessments
On admission, patients are allocated a key worker, a nurse or AHP, who is responsible for co-ordinating their care throughout their stay in the Unit. The holistic needs assessments and care planning would be conducted by the responsible key worker.

Key workers already conduct in-depth discussions with patients in PDRU and the holistic assessment was seen as an extension of this discussion. The AHPs receive in-depth training in the key worker role and have undergone the Health Behaviour Change training (a combination of 1 hour and 4 hours sessions). In addition to this the psychology service and speech therapists run training sessions on care planning and being a key worker which all AHPs have received.

Five AHPs attended the information session from Macmillan on HNA and Care Planning. None of the nursing staff were available to attend. Train the Trainer sessions are planned with AHPs and nurses who could not attend the session to explain how the approach works.

Implementation plans
Unit management intended to offer assessment to all newly admitted patients (in patients and day patients). The discussion would form part of the "clerk in" process which is conducted normally by the key worker (sometimes nursing staff) to ensure that every new patient is offered the opportunity. The documentation would be included in the key worker pack which is used to assess new patients.

The Unit already had access to information on support services available to staff conducting assessments and staff also routinely refer to services outwith the NHS GGC area. The Unit regularly refers patients and carers to the Support and Information Service located in the QUEUH and arranges visits from local organisations such as Money Advice, carers groups, fuel support. There are also good links with hospital based psychiatry and psychology services.
Information on the support services (organisations, helplines etc) is accessed through a combination of online/electronic portals and paper based leaflets in the Unit. Once the assessment and care plan has been completed a copy of the form would be given to the patient, one copy would be kept in the patient’s folder in the unit and another sent to the Support and Information Service.

4.3 Ward 11A, Queen Elizabeth University Hospital

The ward admits patients who require lower limb amputation through a combination of elective and emergency surgery. Ward 11A has 28 beds in single rooms (14 are normally designated for vascular surgery, however at the time of the evaluation 24 patients were currently admitted). Patients admitted to Ward 11A can be transferred to Ward 11D, which has 12 beds for amputees. Average length of stay for patients is 30 days and care is provided by medical, nursing and allied health professionals (OTs and physios).

Staff conducting assessments

The needs assessment and care planning would be conducted by a member of the Support and Information Service (SIS) in the hospital based on the ground floor of the Queen Elizabeth University Hospital. SIS provides health information and support for patients, relatives, visitors and staff on a range of issues including money advice, support for carers and young carers, lifestyle issues and links to community services and organisations. The staff are not ward based and are not part of the multi-disciplinary ward/unit team.

SIS staff conduct in-depth discussions with patients, carers and families about a range of concerns and issues they have and the holistic assessment is seen as an extension of this discussion. It could also provide an opportunity to develop the SIS role in directly supporting patients, releasing health practitioners to concentrate on clinical issues. SIS staff have been received the 4 hour health behaviour change training and the representative also attended the information session from Macmillan on HNA and Care Planning.

Implementation plans

The assessment was to be offered to all newly admitted patients, one week after admission. This was to allow the patient to have received surgery before the discussions took place.

The SIS team member would visit the ward one half day per week and meet with patients who had been identified by the ward physios as potentially benefitting from the assessment. The physios were to leave a list of potential patients in a folder at the nursing station in the ward. The SIS team member would then meet with the patients, explain the process to them and then arrange to conduct the assessment at later stage – either through self completion by the patient or through assisted completion with the SIS team member, depending on the patient’s preference.

Based on their existing knowledge and experience of supporting people in their information needs, the SIS team member would discuss options for solutions to the issues raised in the assessment with the patient at the time of the assessment and record these in the care plan. A follow up meeting would be arranged with the patient around 5 weeks later to discuss progress and any further support needs,
5. Implementation feedback

The discussions with the stakeholders in this evaluation focused on establishing learning from the early stage implementation of the Supporting People in Hospital Project in each of the three locations. Feedback was obtained from ward/unit management, the staff conducting the assessments and a sample of patients.

The staff interviewed included Charge Nurses, physiotherapists, nursing staff and a member of the Support and Information Service. The patients interviewed were males and females, aged between 30 and 85. They included people who had lived with their health condition for many years and were regular service users as well as those who had only recently experienced their life changing condition.

The discussions with the stakeholders in each of the three locations focused on the following issues:

- Understanding of the project background and what it was trying to achieve
- The pre-implementation planning process
- The assessment and care planning tools
- Selection of patients
- Pre-launch training
- The assessment process.

5.1 Understanding of the project background

Feedback from the ward and unit management in the selected locations confirmed that there had been extensive discussions with them over a period of time about the rationale for introducing the assessments and the selection of their wards/units for piloting the process. All had a clear understanding of the potential benefits to patients in their care from having the opportunity to discuss issues which are affecting their lives or which are giving them concern. As interviewees explained:

"Our patients go out of here different to when they come in. They usually come in mobile and leave in a wheelchair. It’s a huge psychological as well as physical change and it affects every part of their lives. Nothing is the same for them anymore and this is a great opportunity for them to talk to someone about more than just their medical condition"

"Coming in here is a massive part of their weekly lives and they are exhausted. We talk to them about how they feel physically but they have many other issues - particularly money, so this is a really good way of helping them deal with things which are affecting them and their families"

The process was regarded in PDRU as a natural extension of the key worker assessment process used to explore the needs of each new admission into the Unit and as a support to the home assessment undertaken by OT’s in Ward 11A.
Patients coming in for dialysis are first assessed by a nurse who visits their home to review the issues associated with renal dialysis and the Supporting People in Hospital assessment was also seen as an extension of this. Indeed, discussions with ward management suggested that it may have, on reflection, been beneficial to have included the pre-dialysis nurse in the assessment process as it was felt that it may help them tease out some of the concerns at an earlier stage, particularly those in relation to family/relationship and practical matters.

5.2 The pre-implementation planning process - ward/unit communication

Several visits to each of the three locations were made by the health improvement team liaisons prior to the launch of the process. The wards/units were asked to review the assessment and care planning documentation used by the Improving Cancer Journeys Link Workers to highlight any amendments needed to address the likely issues faced by their patients and identify key information messages that should be included in the patient information leaflet. It was then expected that the ward/unit management would cascade any relevant information on the process to ward/unit staff.

Feedback from staff suggested that communication from ward/unit management to the rest of the ward team varied. Whilst communication and updates were regular with those staff members who were to conduct the assessments, the extent of involvement of other staff in the locations was more limited. As a result of this some challenges arose just immediately prior to the launch of the pilot.

In the Renal Dialysis Unit, the medical consultants were reluctant to discuss medical issues with patients where these issues had already been reviewed and therefore advised nursing staff not to refer any patients with previously discussed issues to them.

In PDRU the assessments were to be conducted by the key workers, who include nursing staff. However the Charge Nurse for the area had not attended any of the discussions and, as a result, most of the assessments were being conducted by the Unit AHPs resulting in few in-patient clients being offered the opportunity to receive an assessment.

In Ward 11A, the person conducting the assessments (the SIS staff member) is not based in the ward. Identification of patients interested in taking part in the needs assessment would therefore be reliant on liaison with ward team members. Discussions with ward management suggested that the ward physios would take on the role of identifying the patients. On the day the pilot was due to go live, the physios had indicated that they did not wish to do this, expressing concerns with the skills and knowledge of the SIS staff in addressing patient emotional wellbeing issues, given that the ward does not have access to psychology services, as well as concerns about how patients with cognitive impairment would be approached and how discussions with these patients would be facilitated.

In addition to issues with patient identification, it also became apparent just before the launch that the patient journey in Ward 11A can often result in the transfer of patients to beds in Ward 11D within the first few after admission. This meant that some patients who would be eligible for assessment would not be resident in Ward 11A when the assessments
were being conducted. Ward management in Wards 111D were not involved in the initial discussions about the project and were unaware of its objectives and benefits, resulting in a slower uptake of referrals for assessment.

5.3 The pre-implementation planning process - patient and staff information

Whilst ward/unit management and the health improvement liaisons had spent a considerable amount of time discussing and agreeing the content of the patient information leaflet, delays in Medical Illustrations meant that the leaflet was not ready for the pilot launch. Staff conducting the assessments were asked to verbally explain the purpose of the assessments, its benefits and the process which it would follow until the leaflets became available. The delays in Ward 11A, however, meant that the patients there were all able to be given a leaflet introducing the assessment as planned.

Those patients who had received a leaflet were able to confirm its purpose. As these interviewees commented:

"It's about helping me if I have anything that is worrying me"

"It gives me the chance to tell someone if I need help with things at home".

However, several of the patients spoken to in this evaluation and who had not received the leaflet could not recall what they had been told about the assessment. Some of these patients had memory problems - either from their medication or from their health condition. These patients struggled to remember why the staff wanted to speak to them about their situation and often could not recall the content of the assessment discussion.

Information was made available to staff in the NHS GGC Health and Wellbeing Directory which can be accessed electronically. Whilst staff in PDRU and SIS were experienced in signposting clients to other services for support, this was a relatively unfamiliar approach for staff in the Renal Dialysis Unit.

Feedback from ward management and staff in the Renal Dialysis Unit suggested that, despite the support provided from the health improvement liaison, they had concerns about the availability of information supporting information for patients outwith NHS GGC. As one staff member explained:

"We have people from the Islands and we really only know what is available in the Inverclyde area. We don't know what else is out there, what support they will provide, who would be eligible to get this support and how to refer them there".

Whilst PDRU were more familiar with referring people to community support and do signpost to community services in the NHS Lanarkshire area, they also expressed concern about the extent of information on, and knowledge of, these services. Unit management felt that this might present issues in supporting non-local patients, depending on their needs.
5.4 The assessment and care planning tools

The content of the forms was amended following discussions with ward/unit management and staff in each of the three pilot locations. Feedback from the patients who had participated in the assessments indicated general satisfaction with the issues listed in the documentation and could not think if any other issues which were not listed. Three patients had decided not to participate in the assessment having reviewed the forms. These patients felt that they did not require any support at this stage.

Whilst patients were generally happy with the forms, there were some concerns expressed with the layout of the assessment form. As these interviewees explained:

"It's was a wee bit overwhelming. There is such a lot of things on it I thought it would take a long time to complete"

"I was a bit surprised to see so many medical things on the form - I had thought the assessment was about other things".

These concerns were also highlighted by staff completing the assessments. They also commented on:

- The medical matters list, which is the largest of all the matters raised. They felt that this placed a visual emphasis on medical issues in the form
- Some patients being unclear that the list of medical issues was suggestive and not meaning that people were likely to develop these conditions in the future. This was of particular concern amongst patients new to renal dialysis

Concern was also expressed at the extent of medical issues which were being identified as opposed to other factors. As these staff commented:

"I really thought there would be more practical and emotional issues raised but it is nearly all medical related - and we discuss this with them during our own assessment anyway"

"I am finding elderly patients run of out of steam during the assessment and are tending to skip over the columns at the end of the form (emotional and health matters)"

Feedback from the patients indicated that they were not clear on what was meant by the heading - Spiritual Matters and found this difficult to identify. As one patient commented:

“What do they mean by not being at peace? At peace about what?”.

Some staff also found it awkward at the listing of Sexuality under medical matters, particularly with elderly patients who were not sure why they were being asked this. Patients commented on this area as well:
“I’m 83. I don’t bother with that now (laughs)”. 

Whilst the design intention had been for patients to review the form themselves and then discuss their prioritised issues, staff felt the need to complete the form with some of their patients, particularly those who were elderly, had literacy challenges or who had any form of cognitive impairment.

PDRU staff already had time set aside for their initial assessment process and assessments in Ward 11A/11D were conducted by the SIS staff member, ward management in the Renal Dialysis Unit recognised the potential time implications of conducting a nurse led assessment. Whilst four staff had been trained to conduct the assessments, the Unit needs to cover sickness/absence, holidays and shifts and ward management were unclear how sustainable this would be in the longer term.

The feedback from the ward/unit management and staff interviewed in each of the locations suggested some confusion over the timing of the care planning follow up and the distribution of the completed forms. As a result of this each of the location was planning to follow up with patients at different lengths of time after completion of the care plan. Follow up timetables ranged from five weeks to three months.

Ward/unit management also suggested that it would be beneficial if the forms stated on them where each of the coloured carbon copies were to be sent.

5.5 Selection of patients

All patients in the Renal Dialysis Unit were to be offered the assessment and all new patients in PDRU and Ward 11A/11D were to be given the opportunity to assess their holistic needs. The feedback from the staff completing the assessments suggested that selection of patients was operating as intended in the Renal Dialysis Unit.

However, problems in identifying patients in Ward 11D and in the in-patient section of PDRU meant that not all eligible patients were being identified. In both cases, the managers in these areas were not involved in the pre-planning processes and were not as familiar with the rationale for the process. In addition to this, the SIS team member conducting the assessment was not a ward team member and therefore not able to ensure that the assessment process maintained a high profile in the ward. As a result, the identification process was less embedded in these areas.

As a means of addressing this, ward management in Ward 11D suggested that the SIS team member attend the multi-disciplinary team meeting. However, it was recognised that this solution would require additional time being allocated by the SIS management to the project pilot to facilitate this.

Staff in the in-patient section of PDRU appeared to be only selecting patients who they thought would be interested in completing an assessment and, as a result, some eligible patients were not being offered the opportunity of an assessment. It should be noted that
these staff were not involved in the pre-planning discussions and did not attend the MacMillan information session.

5.6 Pre-launch training

Prior to the introduction of the Supporting People in Hospital project, only AHP’s and SIS staff were experienced in conducting discussions with patients to explore non-medical issues and how these were impacting on their lives. Whilst nursing staff in PDRU participate in client assessments, at the time of the pilot launch their training in the key worker assessment role had been more limited than their AHP colleagues.

Health Behaviour Change training was arranged for all staff who would be conducting assessments in this pilot. In addition to this staff were invited to attend the information sessions from MacMillan Cancer Support which explained how they applied the process.

Initial feedback, following the training and prior to the launch of the process in PDRU and the Renal Dialysis Unit suggested two issues:

- A recognition that the implementation would be different from the one used in the Improving Cancer Journeys but a lack of clarity of how the process was expected to work in their own locations
- Concerns amongst some staff in relation to discussing the full range of issues in the assessment. The staff who were less experienced in conducting these assessments appeared happy to discuss the physical health related issues but were not as confident in how to address the more emotional issues raised such as guilt, even after the training.

As these staff explained:

"It was interesting to hear how MacMillan had used it but it would have been more useful to have done the training on this process as opposed to theirs. I came out of the training still unsure what we were supposed to do"

"I am worried about how to deal with something that comes up that I am unfamiliar with. I don’t want to let the patient down".

After conducting a few assessments most of the staff appeared much more confident in talking to patients about the range of issues on the form, even in cases where they the support they could provide would be very limited. As one member of staff commented:

"One of our patients has childcare issues. They need out of hours support which is difficult to get. However, we have talked it through with them and they know it is not an easy fix but we will keep trying"
5.7 The assessment process

5.7.1 Who conducts the assessment
In designing the process, it has been intended that the patient should own the process and that the role of the staff would be to facilitate the discussion. Feedback from the ward/unit management indicated that decisions on how the process would be facilitated was dependent on:

- Whether the patient had any cognitive impairments
- The patient’s preference.

Ward/unit management recognised that some patients in their care had cognitive issues and would need staff assistance in completing the forms. These patients include those with vascular dementia (Ward 11A/11D), brain injuries (PDRU) and poor memory due to medication (PDRU) or side effects of dialysis (Renal Dialysis Unit). Staff feedback confirmed that the assessments were conducted on site by staff with these patients.

It was also recognised that some patients would prefer to complete it themselves, with staff discussing the priority issues and their solutions. The feedback from the patients suggested that this happened in all three locations, irrespective of the delivery model, particularly amongst younger patients. As these interviewees explained:

“*I wanted to discuss it with my family first and then talk to the staff about how best to deal with the issues so I took it home*”

“*I felt I needed time to think about the issues and didn’t want to take up the nurses’ time so I took it home and did it over a couple of days*”.

The only concern raised by staff at this approach is that patients often forget to bring their forms back, resulting in a delay to the assessment or preventing it taking place altogether.

Other patients wanted assistance in completing it. These patients tended to be elderly (Renal Dialysis Unit) or people who had just experienced their life changing event (Ward 11A and PDRU) and who were still trying to adjust to what was happening to them. As one patient commented:

“*I really needed someone to go through it with me. I had so much going on in my head and I found it really useful. XX made sure I thought about everything without putting words in my mouth*”

5.7.2 Where the assessment is conducted
All the assessments in PDRU and Ward 11A/11D were conducted in-situ. Although PDRU has day patients, the assessment is facilitated by key workers as part of the unit “clerk in” process and therefore is conducted on-site. Both these locations have single rooms or private areas where discussions can take place without being overheard.
The assessments in the Renal Dialysis Unit could be conducted at home or in the Unit. However, the ward environment was considered to be potentially problematic prior to the launch. Spacing between the dialysis beds is limited making it highly probable that conversations between the patients and nursing staff could be overhead - creating potential issues with confidentiality and also disturbance for patients who attend overnight as the discussions could be disruptive on patients’ ability to sleep.

However, the patients who conducted their assessments in the ward were unconcerned at being overheard and this did not prove to be a barrier to uptake. As one patient explained:

“Most of the time we have headphones on listening to the radio or to the TV so we can’t hear each other”.

5.7.3 When discussions take place
In PDRU the assessment is built in to the assessment process for all new admissions and takes place as part of the “clerk in” process when the person comes to the Unit. The forms have been placed in the assessment documentation for all AHPs conducting assessments. However, whilst this approach was working effectively for day patients, it was not as well imbedded for newly admitted in-patients who should be assessed by nursing staff. The documentation was not highly visible and did not appear to be part of the admission pack.

All patients in the Renal Dialysis Unit were offered an assessment and this was arranged for one of the days the patient attended for dialysis. The discussion took place, bed-side, during the 6 hour visit.

All new admissions to Ward 11A (and Ward 11D) were to be offered an assessment within the first week of surgery. The SIS team member had a half a day allocated to conduct assessments each week. However, after the pilot launch it was discovered that during this window of opportunity patients could be attending for further surgery or, more often, could have people visiting them - making it difficult to conduct the discussions.

5.7.4 The time taken for discussion
The time taken to complete the discussions varied from 5-10 minutes to almost two hours. This depended on the complexity and number of issues raised, the age of the patient and their cognitive functioning and the stage of the life changing condition.

Elderly patients and those patients with some form of cognitive impairment took the longest to complete. Staff had to spend longer explaining the issues and probing for how they impacted on the patients' lives.

Patients who had only just experienced the life changing event/condition also took longer to complete (around 45 minutes to an hour). Staff found they had a number of concerns which took some time in exploring to determine priorities. As one patient explained:

"I had no idea what I was facing but was worried about everything - me, my family, my job, how I would cope. It was good to talk to someone about it"
The shortest discussion time tended to be with patients who had taken the form home and who were really using the discussion time to talk about the priorities and the next steps. However, staff were keen to highlight that the duration of the assessment is driven by the patient:

“Elderly patients are very chatty and they want to talk to you about all the things that are going on in their lives and that can take a while but it is very important to listen”

“If someone had just gone through a really traumatic event you need to take your time with them – they have a lot to deal with and you don’t want to rush them”.

5.7.5 Issues raised
It had been anticipated that the assessment discussions would encourage patients to raise issues relating to non-medical matters, particularly practical, emotional and family/relationships. The feedback from the ward/unit management and staff interviewed suggested that many of the issues raised in fact related to medical matters, irrespective of the location of the pilot. Feedback from the patients suggested three reasons for this:

- A reluctance amongst some patients, particularly males, to discuss issues relating to family, emotional and spiritual issues. The male patients would only discuss non medical issues when probed to do so by staff
- A perception amongst patients that they had received little information on their medical conditions or a need to discuss the conditions further. This was a particular issue amongst patients who had been living with their conditions for longer
- A lack of understanding of what the topic meant. This was a repeated issue with Spiritual Matters

“I have had problems for a few years and I have spoken to the GP and the consultant before but I was worried it was getting worse so I wanted to speak to someone again”.

“I have been like this for years. When I had the stroke at first the doctors spoke to me about my condition then but that was 20 years ago and no-one has really talked to me about it since”.

According to the feedback from patients, people who were experiencing the life changing condition for the first time or had been living with it for a short time tended to be more likely to want to raised matters other than medical with staff. They had a particular focus on practical matters related to impact on employment, housing and money and family matters relating to impact on relationships.

"My life has changed forever and I don’t know what that really means yet. I guess I can’t work and I don’t know if I can stay where I currently live. I don’t want my wife to see me like this so I have tried to laugh it off. XX has suggested a few things which I hope will help"
Whilst the staff feedback and a review of the forms suggests a focus on medical issues, it should be noted that the feedback from some of the patients indicated that a reluctance to discuss other issues and that these were only highlighted as a result of probing by the staff member. This was a particular issue with male patients as these interviewees demonstrate:

"I am always uncomfortable talking about how I feel. I am scared and I am worried about what happens when I go home. How will I get out and about, how will I cope? I would never have said this had XX not talked to me about it"

5.7.6 Developing the care plan

Given that this evaluation was conducted at the early implementation stage of the project it has only been possible to review how staff have gone about developing the action plan from the assessment. In PDRU and Ward 11A/11D the care plan is developed with potential solutions immediately following the assessment discussion, allowing the patient to have the completed form on the same day. As staff explained:

"Unless it is something very unusual we pretty much know from previous experience who can help so we talk to them about solutions as we go along".

In the Renal Dialysis Unit the finalisation of the care plan is done after the assessment process to allow staff time to research potential solutions for issues. This means that there is a delay between the patient raising the issue and the discussion over its solution.

"We need to take time to research what information and support is out there and, unless it is something health related, that can take a little while to do. For example, one patient had issues with tiredness and loss of independence. We spoke with the Live Active Co-ordinator and have arranged for them to go to local exercise classes. However, the loss of independence is more complicated and we are not quite sure how to deal with this".

Patients in Ward 11A/11D tended to have a better understanding of what actions were being taken because of the development of the care plan and were more able to discuss the follow up process.

"Mark will be back in 5 weeks to speak to me about how things are going and if I need anything else".

Patients in PDRU and in the Renal Dialysis Unit were less aware of what the next steps were and, in some cases, were not sure what was happening with their care plan. It should be noted that some of the patients have memory issues which may well be affecting their ability to recall what they have been told by staff.
6. Conclusions and learning to date

This evaluation was conducted in the weeks prior to and immediately following the launch of the Supporting People in Hospital Project. Its purpose was to review the implementation of the three delivery models and highlight any learning as a result.

Whilst the three models are very different in their application, none of them were without initial implementation issues, some of which were common to all three and some which were specific to the delivery model. The learning resulting from these issues is outlined below.

6.1 Common themes

6.1.1 Pre-launch engagement with ward/unit staff
Whilst there had been considerable discussions with ward/unit management and the staff who would be conducting the assessments, lack of understanding of what the project was trying to achieve did create difficulties in the early stages of implementation in each of the locations. Lack of awareness and understanding gave rise to concerns amongst medical staff about increased demand on their services to discuss previously addressed medical issues and problems in identifying eligible patients.

It would appear to be beneficial in any future roll out to involve all ward staff in the early discussions about the process.

6.1.2 Patient information
Delays in producing the patient leaflet were outwith the control of the health improvement team, however patients who had received the leaflet were more familiar with what the process was aiming to achieve and had a better recollection of the discussions which followed than patients who had received a verbal only explanation from staff. It may be that receipt of the patient information leaflet raised the profile and importance of the process with patients, resulting in them giving the outcome more credence.

It would appear to be beneficial to provide patients with written information on the process and what it is aiming to achieve.

6.1.3 Staff information
The NHS GGC Health and Wellbeing Directory has a wealth of information on support available in the Health Board area. However, it does cover areas outwith Greater Glasgow and Clyde and therefore does not cover the information and support needs of patients from other Health Board areas. This information gap did create concerns for staff who were less familiar with talking to patients about support needs, other than healthcare needs.

Whilst it is recognised that it is difficult to provide staff with all the information sources they need, there may need to be greater emphasis given in the planning stage to guiding staff as to how best to deal with support requests outwith the Health Board area.
6.1.4 Assessment forms
Each of the locations expressed issues with the layout of the forms and the fact that the list of Medical Matters was very extensive and the first column of issues listed on the form. Staff perception is that this is focusing too much attention on medical issues and preventing patients from considering other non-medical issues which may be of relevance. The internal analysis of the completed forms which provide further detail on the extent to which medical issues feature in the process.

Feedback from some of the patients suggested that they found the amount of issues on the form overwhelming. Whilst staff can guide the patients in situations where the form is being completed in the ward or unit to ensure other issues are considered, this is more difficult if the patient takes the form aware – which is an option for patients in PDRU and the Renal Dialysis Unit.

Some patients did want to discuss Medical Matters and therefore they should remain on the form, however it may be beneficial to consider changing the order in which the topics are presented so that issues such as Practical and Emotional are discussed at an earlier stage.

It may also be beneficial to consider providing some explanation of some of the topics such as Sexuality and Spiritual Matters as patients were not clear on why these were included in the form.

In order to improve clarity and ensure consistency, it would also be beneficial to provide some written guidance on where each of the carbon copies should be sent after completion and when staff should consider organising the follow up discussion with the patient to explore progress.

6.1.5 Pre-launch training
Pre-launch training on Health Behaviour Change and the use of the process with cancer patients was found to be of benefit by all staff. However, they considered the half day session from MacMillan to be an information sharing session as it did not appear to help staff understand the issues in implementing the process in their area.

Staff felt that it would have been more beneficial to have had a training session on how to implement the Supporting People in Hospitals project and it may be that it that had been available it might have addressed some of the confusion staff had over paperwork and timings.

6.1.6 Assessment process
The feedback from staff and patients suggested that implementation of the process was affected less by the type of staff conducting the assessment. All locations were experiencing a perceived emphasis on medical issues from patients and the time taken to complete assessments was broadly similar, varying only by type of patients.

The key issue appeared to be more related to staff experience, knowledge and confidence in sourcing and referring, particularly outwith NHS GGC. It may be that increased project
specific training and guidance on how to deal with support needs from people outwith the Health Board area would address this.

Two of the models adopted involved conducting the assessments in the ward/unit which prevented one of the issues faced by staff in the Renal Dialysis Unit, whereby some patients took the form away and forgot to bring it back. At this stage of the evaluation it is not clear how best to address this issue as completing it on the ward has time and staffing implications and probably requires further monitoring to see to what extent this issue continues in the Unit.

PDRU and Ward 11A/11D could offer patients the opportunity of discussing their issues in private. Whilst none of the patients in the Renal Dialysis Unit appeared to consider the lack of privacy to be an issue, this may not always be the case. It would be beneficial to discuss this with other patients once the pilot is more established as this could be a barrier to completion in ward areas where single rooms are not available.

6.1.7 Issues raised
Staff had raised concerns about the inclusion of medical matters in the form as the key messages to patients have been that the process is about more than medical issues, a fact raised by a few interviewees. However, feedback from some of the patients suggests that Medical Matters are relevant depending on where they are on their care journey.

It may be that re-positioning of the Medical Matters list on the assessment form addresses these concerns without removing the topics completely. It may also be beneficial for the patient information to contain an explanation of why medical matters are included, if analysis of the completed forms continues to demonstrate greater “demand” for these topics as opposed to other issues.

6.1.8 Developing the care plan
One of the common issues at the care planning stage was patients’ awareness, and staff understanding, of when the follow up discussions where to take place. Lack of clarity had resulted in considerable variations in the timing of the follow and in patient awareness of the next stages. These issues could be addressed through additional guidance to staff and inclusion in any future training on the process.

6.2 Specific Issues
The feedback from the patients in each of the three locations suggested general satisfaction with the approach taken. However, the initial evaluation has identified some factors which should be considered in the future application of the model. These are outlined below.

6.2.1 Training
The key worker and SIS model benefit from the experience the staff have in talking to patients about non-health related issues. This allows patients to discuss solutions to most of their issues during the assessment process, minimising the delay in developing the care plan and providing quicker access to the identified solution.
The nursing led model has nurses conducting the assessments. The nurses are highly experienced in their topic area but have less experience in conducting non-health related discussions on sensitive issues affecting patients. They also have less experience in sourcing and referring people to community based, non-health related, information services and support which was resulting in delays to the care plans.

These skills are more specifically covered in the 4 hour Health Related Behaviour Change training and consideration should be given, when using this model, to providing the 4 hour course for all staff conducting the assessments.

6.2.2 Numbers of staff trained
The key worker model benefits from the numbers of staff who can conduct the assessments, giving Unit management greater flexibility during times of peak demand and in dealing with staff sickness/absence and sick. It also has enabled the discussions to be built into the Unit assessment process, giving it potentially greater sustainability.

There were issues in the nursing led model and the SIS model related to the availability of trained staff to conduct the assessments, which have the potential for delaying the assessment process for some patients. This suggests that where there are large numbers of eligible patients there may need to me a greater number of staff trained to conduct the assessments to cope with demand without compromising the patient experience.

6.2.3 Establishing the patient pathway
Given that the SIS model has someone that is external to the ward conducting the assessments, it is essential that the pre-implementation discussions for this model includes a review of the patient pathway. This would have established that patients can be transferred to another ward within the time period for the assessment. This information is also essential to determine when the assessment is done and how much time should be allocated from the SIS staff working week to conduct assessments.

6.2.4 Identification of eligible patients
The key worker model and the nursing led model benefit from staff being based permanently in the location, enabling easy identification of eligible patients (assuming staff do not self-select the patients to be offered the assessment opportunity). The SIS model is based on an external member of staff visiting the ward at agreed times. This approach relies on the commitment of ward staff to identify eligible patients, provide the SIS team member with appropriate information on the patient and on all staff having a full understanding of the project and what it is trying to achieve.

Problems in identifying patients led ward management to suggest that it might be beneficial for the SIS team member to attend the Multi-Disciplinary Team meeting so that they could be fully aware of which patients were coming into the ward and when they would be available to be approached. Whilst this raises the profile of the project, it has a significant time element for the SIS team, adding a further half day per week to the project resourcing. Longer term review of the project would determine the sustainability of this approach.
6.2.5 Flexibility
With staff permanently based in the ward/unit, the key worker model and the nursing led model benefit from staff being able to conduct the assessment discussions at times which suit both the patient and the ward/unit activity. The SIS model had set days and times when the staff member would visit the ward(s) to speak to patients. Unfortunately, the nature of the ward(s) meant that patients were not always available at these specified times, either due to having to leave the ward for further treatment or from patients receiving visitors. With a once per week visiting rota, patients might have to wait longer for their assessment to be arranged, resulting in subsequent delays to the care planning development.

6.3 Conclusions

It is recognised that this evaluation was conducted at a very early stage. However, the initial feedback suggests that each of the models has the potential to be successful, after some minor amendments. The key worker and nursing led models appear particularly appropriate for wards/unit where the patient day is highly structured and where activities/care needs to be completed at particular times. The SIS model, because it is conducted by an external presence who needs to visit at prescribed times, is less flexible and requires locations where the patient does not need to leave the ward/unit for additional treatment or where the activities/care can be more flexibly organised.

It is recognised that some of the issues have happened at an early stage and a further evaluation conducted later in the project lifecycle will confirm to what extent they have impacted on the project’s outcomes and effectiveness and require to be addressed in any future roll out of the process.