Care Plans for Vulnerable Adults at Hounslow GP Practices:

A review by Healthwatch Hounslow

Healthwatch Hounslow
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Contents

A word from our CEO

I am delighted to present another Healthwatch Hounslow review identifying the impact and efficacy of service provision within the borough.

Healthwatch reviews are reflective and don't present a particular view or perspective but are rather a simple reflection of what we are being told by the general public.

As an independent scrutiny body our only agenda is to ensure that the community which we serve receives the best possible health and social care provision.

Where possible we will aim to make recommendations and incorporate alternatives for better service provision.

As always Healthwatch is grateful to those that take the time to help us with our reviews and we are always available to support our recommendations and meet with our health and social care partners.

Tim Spilsbury

CEO, Healthwatch Hounslow

Acknowledgements

On behalf of Healthwatch Hounslow, I would like to thank all those who helped to complete this report.

Since obtaining assistance from local GP Practices was vital for this review, we would like to begin by thanking Hounslow CCG staff who not only supplied us with useful background information on Care Plans, but also joined us in making an appeal to a selection of local GP Practices to give us feedback on Care Plans and help us by providing us with access to a cross section of vulnerable adults in Hounslow for whom they had developed Care Plans to help them stay out of hospital.

Next, we must thank those GP Practices who responded to our joint initiative for collaboration by providing us feedback on their experience of Care Plans through face to face interviews or via a structured questionnaire. Some Practices were kind enough to also agree to mail out our patient/user questionnaire to relevant patients within their Practices. GP Practices who deserve special mention include: the Hatton Medical Practice, Crosslands Surgery, Albany Practice, The Manor Practice, Firstcare Practice, Grove Park Surgery, Dr Sood's Practice in the Heston Health Centre, Blue Wing Family Practice, Firstcare Practice and Dr Burbidge and Partners. Among the GP Practice Managers we wish to convey our special thanks to Vijay Jambulingam, Saira Juma, Meera Sood, Dr Sheila Hunt, Bobby Bahra, Jade Taylor and Susanne Bauer. Among the GPs who helped us were Dr M H Muzafer and Dr Shuaib, Dr Tal Mahmud, Dr Sood, Dr Annabel Crowe, Dr Nicola Burbidge, Dr Mendel, Dr Perera, Dr Julia Chalmers-Watson and Dr Drewery.

Besides GP Practices, other health and social care professionals also helped. Martha Moran of Park Lodge House went out of her way to obtain GP feedback for us. Similarly, from within the local voluntary/community sector, we were helped in obtaining user/patient feedback by Lyn Hammond, Care Navigator Manager and Carol Hopkins, Interim CEO, both from Integrated Neurological Services (INS); Scarlet Sarksan, Health and Care Support Worker, Centre for Armenian Information & Advice; Aldona Zywicka-Thornton of the Hounslow Parent Carers Forum (PCF) and Patricia Sale of the Hounslow Disabled Community Forum (DCF).

Within the London Borough of Hounslow, Celia Golden, Head of Equality and Human Rights, Corporate Governance, Chief Executive Department and Sarfraz Kherdin, Principal Equalities Officer, Corporate Resources, London Borough of Hounslow, provided us with useful links to carers in the community. Last, but not the least, a committed community worker with wide experience of running local health groups, Vijay Rai, also helped us in accessing patients.

Within HWH, I am grateful to Tim Spilsbury, our Chief Executive Officer, for his leadership, guidance and timely interventions to help the research team in surmounting the barriers we encountered on our way. I also must thank my research assistant, Sangnuma Rai, for help with collating data from GP Practices as well as from patients. As always, Mystica Burridge, our committed Engagement and Volunteer Manager, and her volunteers assisted in data collection. Finally, our versatile Corporate Relations Officer, Namrata Pandey, helped to finalise the report by adding some useful and easily comprehensible graphs and enhancing the document's aesthetic appeal.

We hope our readers will find our report of interest and utility.

Dr Kusum Pant Joshi

Research Manager, Healthwatch Hounslow

Introduction

This review will examine the progress that local Practices in the London Borough of Hounslow have been making towards achieving the Hounslow Clinical Commissioning Group's (HCCG) aim to introduce proactive Care Plans for some of the more Vulnerable Adults in each of the Practices with GPs as pivotal points[1] in the care and management of the health of these patients to help them stay out of hospital, maximise patient involvement and reduce unnecessary admissions.

Background

Hounslow is one of the most rapidly growing boroughs in London with a predicted growth rate of 12% by the year 2020. Within the same time frame, the age profile of the borough's population is also anticipated to undergo change with an anticipated 18% growth of its over-65 age group.

At the start of the year 2015, Hounslow's 54 GP practices had a registered patient population of 299,928. Although, life expectancy at birth for men and women is 79.5 and 83.3 years respectively, healthy life expectancy at birth for men is 60.8 years, making it significantly worse than England as a whole. For women, 63.2 years of healthy life is expected at birth.

The main causes of early death in Hounslow are recognised to be cancer, heart disease and stroke. Between 2010 and 2012, around 1,674 premature deaths among people aged below 75 years occurred in the borough. In many instances, these early deaths occurred after several years of provision of health and social care.

The scale of the work to be done with patients in Hounslow is significant. At present, there are approximately 14,000 people with diabetes in the borough and an estimated 5,000 undiagnosed cases of diabetes, with a high proportion linked to obesity. Increasing healthy life expectancy (in relation to life expectancy) will help improve wellbeing in the borough and decrease health and social care costs. It is clear that without major changes, preventable ill-health and early deaths will continue and may even rise in the borough. [2]

It has been increasingly evident that fragmentation and lack of coordination in the provision of health and social care in the borough are the root causes of serious gaps between services and jeopardise the health and wellbeing of patients and that of their carers. They also add to the burden on the National Health Service (NHS) because vulnerable adults tend to be hospitalised.

To improve the quality of life of patients, providing better and more holistic and integrated out of hospital community-based health and social care services to vulnerable adults has been recognised to be essential by providers and commissioners of both health and social care services.

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[1] According to Health Secretary Jeremy Hunt, "General Practice is uniquely placed in the health and care system to oversee the care of vulnerable and older people."

[2] The information and statistical data in this section is from a letter under the signature of Nicola Burbidge Chair, Hounslow CCG, dated 23 February 2015.

A significant step towards achieving this goal was taken in 2014 when GPs in England took responsibility for developing Care Plans for 2% of the most vulnerable adults in their Practices. A local CCG document of 2013-2014, says that one of the three actions for improvement of local health and wellbeing is to "*Ensure [that] everyone with a long-term health condition has an action plan for their care*." In February 2015, a report titled, *Hounslow - Summary of Progress under Shaping a Healthier Future*, the CCG had said: "*In 2015/ 2016 we are aiming to offer care plans to 7,000 local patients; supporting people more effectively and treating problems earlier to avoid hospital admissions*."

Their holistic vision for the future is clearly summarised and publicised on their website by the Hounslow and Richmond Community Healthcare (HRCH) NHS Trust[3] in the following words:

> *"Our plans to deliver better care out of hospital are outlined in our out of hospital strategy. Hounslow CCG has already made considerable progress in delivering this … GPs are starting to identify patients at highest risk of unscheduled admission to hospital. Practice nurses will co-develop a care plan with the patient and carer (where appropriate), ensuring that all the services the patient needs are working together helping to prevent the patient attending hospital when they do not need to. They are supported by a Care Navigator who will work with the GP, the community matron and the social worker to support the highest risk patients to ensure they can access all the services they need, self-manage their conditions and proactively ask for help, and that their family carer is supported."*

Objectives of this Review

This review of Care Plans in Hounslow aims to connect with a cross-section of General Practices in various parts of the borough to directly obtain their response on developing proactive Care Plans for vulnerable adults, to understand how they have been working to achieve this aim, what challenges/difficulties they have been facing, what progress they have made so far, what their expectations are regarding outcomes and what suggestions or ideas they might have for the future to improve this initiative.

The review also attempts to establish links with relevant patients whose Care Plans have been developed by their GPs to ascertain if and in what way/s they had been involved in the development of their Care Plans and to gather any useful suggestions/ recommendations for improvement based on their experience of the Care planning process and its execution.

The overall aim was to focus on the experience of Care Planning and implementing Care Plans from relevant patients/users and from local Practices; to find out what they understand about Care Plans and also gain feedback from both patients/users and local Practice GPs on how they might like to improve or change in how Care Plans are developed and implemented.

[3] See the HRCH website: http://www.hrch.nhs.uk/

Through this investigation, our aim is to help support the implementation of Shaping a Healthier Future (SaHF) for patients by promoting more integrated health and social care services for vulnerable adults and enabling safer and more economical Out of Hospital Care in the community. In addition, by reflecting patient views and experiences and aiding their move towards self-care and self-management of their health, HWH feels we will be empowering patients/their carers and encouraging them to speak up for themselves and those they care for.

Scope and information sources for our review

We came to the conclusion that the best way to identify the relevant target group of Vulnerable Adult patients in Hounslow for whom their GPs had developed Care Plans, was to approach some local GPs and their staff and request them to identify such patients/users. We also reached out to Locality Managers in Hounslow to help us with accessing GPs and winning their collaboration in gathering data for our review.

After explaining the aims of the review and requesting their collaboration, we contacted about 20 local GPs and offered them a choice of three options:

1. To agree to mail out a short HWH questionnaire for completion by their Vulnerable Adult Patients for whom they e had developed Care Plans along with a covering letter explaining what the review was about and a Self-Addressed Envelope (SAE) for them to return their completed questionnaires to us; **or**

2. To agree to invite some of their Vulnerable Adult Patients for whom they had developed Care Plans to attend a forum at their surgery facilitated by HWH so that we could get their feedback; **or**

3. To agree to them selecting some of their Vulnerable Adult Patients for whom they had developed Care Plans by SMS/Email/Telephone to explain our survey and seek consent for HWH to contact them to carry out the survey.

After a good deal of perseverance, some local GPs agreed to help us and about seven practices selected option 1 as it perhaps appeared to be the least time-consuming to them.

To add to the richness of our data and to make sure we hit the target number of patient/user respondents we had set for ourselves, we also used our links with local voluntary/community groups for patient/user feedback for this survey. This gave us access to patient feedback from a couple of voluntary/community organisations including one catering for patients from so-called BME groups in Hounslow.

We decided to analyse the feedback received from the voluntary/ community sector by merging it with the overall data generated by our review. Nevertheless, we have also scrutinised the data received from the voluntary/community sector as a separate data set, to see if doing so might help provide insight into the way Care Plans impact on vulnerable adults from Black and Minority Ethnic (BME) communities in the borough.

Chief Tools for our Review

We prepared **2 Questionnaires** for gathering data for our survey:

- One questionnaire was for gathering information from local GPs/ GP staff involved in preparing Care Plans for patients registered in their Practice; and

- the other questionnaire was for collating information and views from Patients/Users of Care Plans for whom their GPs had worked out Care Plans to help them manage their health and keep them out of the hospital.

Each questionnaire had six questions. Both were checked and approved by staff from the CCG before we started the review.

From the **Questionnaire for GPs**, we aimed to find out from a cross section of local GPs in Hounslow:

- Whether they were able to meet the targets they had agreed to achieve[4];

- What process they were following for developing Care Plans for their vulnerable adult patients;

- Whether they were periodically reviewing their Care Plans; and

- How they perceived their patients with Care Plans were managing their health.

From our **Questionnaire for Patients/Users** we wanted to ascertain:

- Whether Patients/Users had a copy of their Care Plan from their GP;

- Whether Patients/Users were in the habit of using their Care Plans on a daily basis;

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[4] According to Hounslow CCG: "Across CWHEE, the out of Hospital service case finding, care planning and case management specification for Out of Hospital services requires practices to identify an additional 2% of the over 18 population to be case managed on top of the 2% already paid for by the Enhanced service.

As part of the Enhanced service for avoiding unplanned admissions, practices already maintain a case management register of at least 2% so it has been agreed that the difference between this register and 4% of the practices over 18 population will need to be referred in and case managed in addition to current activities for the enhanced service.

There have been some key changes in the enhanced service for 2015/16 which are also included within the OOHs specification and managing these registers as one should simplify the process and ensure that the same case management is applied to both registers. It will also mean that for those practices that have more than 2% of the population included within the enhanced service they would be able to refer in fewer additional patients to achieve the 4% minimum requirement."

- Whether their Care Plans are reviewed regularly;

- How they perceive their management of their health; and

- Whether they have any ideas/suggestions for improving the implementation of Care Plans.

Limitations of our review

Practices in Hounslow responded to our request to collaborate with us by responding to our questionnaire for GPs/GP staff only after considerable perseverance from our side. A number did not respond or suggested that they were unable to help us since they were too busy. As a result, we received responses to our GP /GP Staff questionnaire from a smaller sample than we had originally desired.
Likewise, we would have liked to gather feedback from a higher number of patients but for the following factors:

a) Engagement issues with some local GP practices;

b) Care Plans being developed by GPs for only a very small percentage of local patients;

c) Patients sometimes not being aware whether they have a Care Plan or not; and

d) Even if patients are aware of their Care Plan, not always knowing whether it is managed by their Social Worker, the hospital or their GP.

It became clear that we would not be able to identify patients relevant for our survey on our own by talking to people in random locations such as libraries, the High Street, in GP surgery waiting rooms, the Heart of Hounslow or in hospitals. We, therefore, decided to access them in **three** ways:

1) By requesting GPs to help us reach out to their vulnerable patients with Care Plans;
2) By approaching some key voluntary /community sector organisations for help; and
3) By requesting help from the CRS and ICRS.

Although this helped us to obtain feedback from patients/users of Care Plans, we became totally dependent on if, when and how far various health and social care providers were willing or able to help us. Despite these issues we successfully achieved our target of speaking to over one hundred patients.

Our Respondents and Responses

We obtained feedback from 16 GPs on our questionnaire for GPs/GP staff in Hounslow. In addition, we also interviewed five GPs and three Practice Managers.

We also obtained feedback from 105 Vulnerable Adult patients/ users of Care Plans. Due to the constraints of maintaining patient confidentiality and anonymity, we were unable to gather personal information about any of these respondents.

Breakdown of Respondents to our review

Number of GPs /GP Staff respondents to our Questionnaire for GPs/GP staff	**16**
Number of GPs /GP Staff interviewed	**8**
No. of respondents to Patient/User Questionnaire (via GPs)	**75**
No. of respondents to Patient/User Questionnaire via voluntary/community groups	**30**

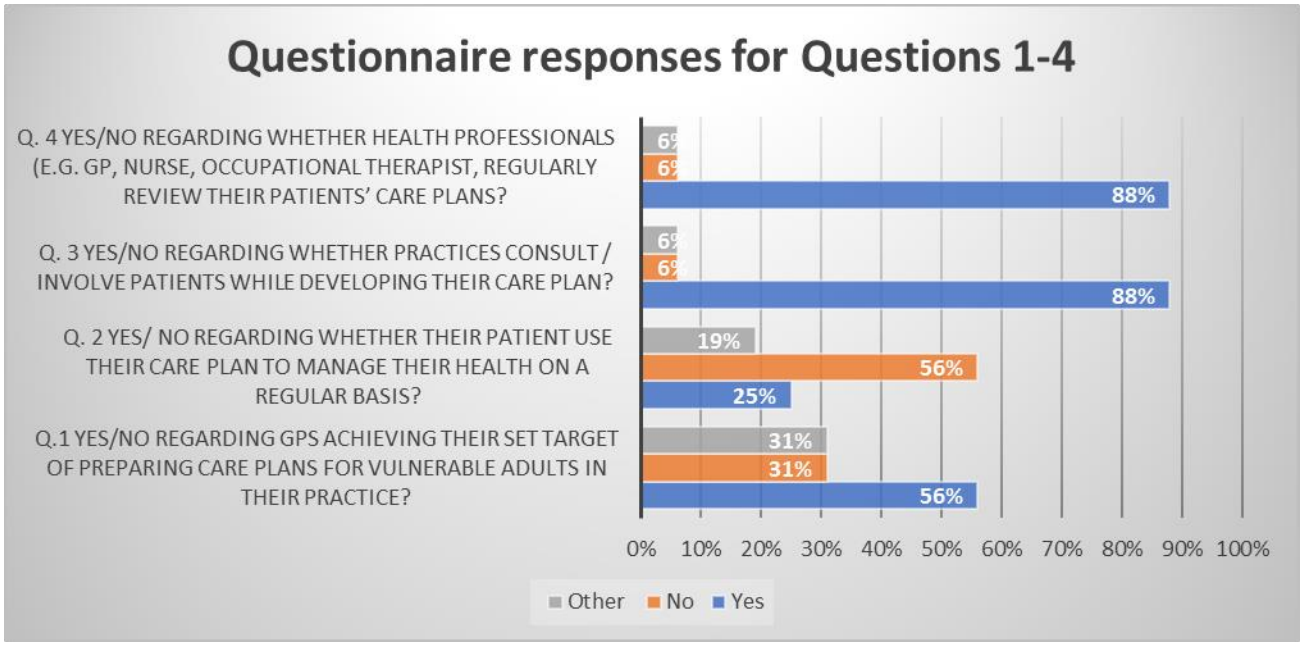
The responses received to the above-mentioned questionnaires from both GPs and GP staff on the one hand, and from and local Patients/users of Care Plans on the other, are presented below separately:

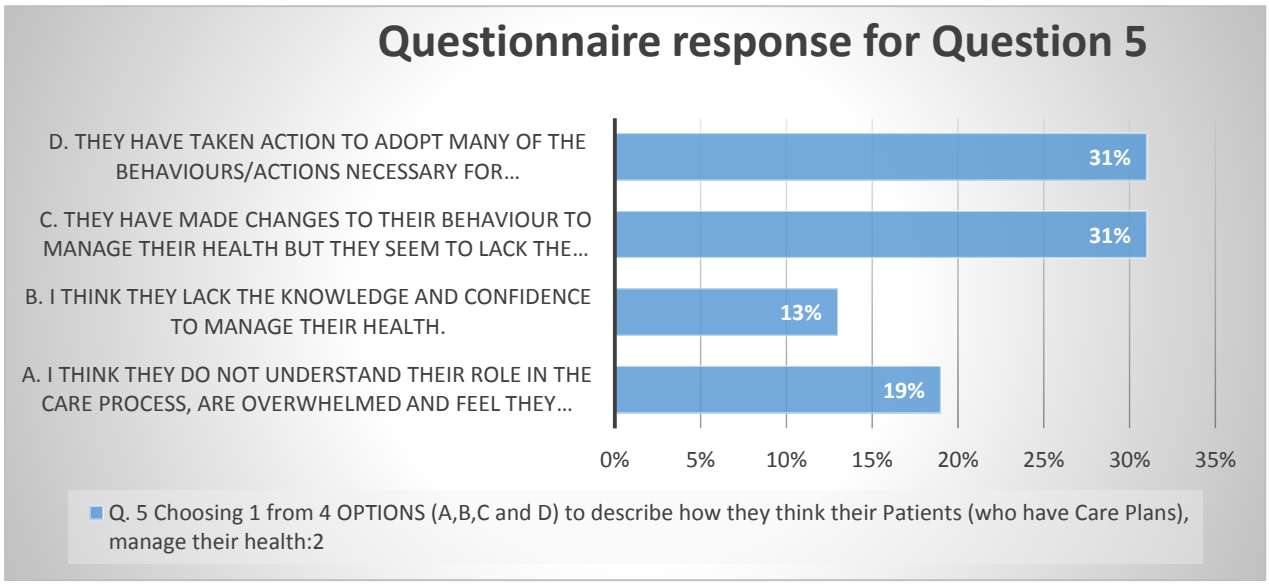
1. Questionnaire for GPs/GP staff and a summary of their responses

A summary of our questions and a breakdown of the total of 16 responses received to the six questions posed in our questionnaire, are given below:

Summary of Questions	Yes	No	Other
Q.1 Yes/No regarding GPs achieving their set target of preparing Care Plans for Vulnerable Adults in their Practice?	9 56%	5 31%	2 13% (Unclear or Did Not Respond (DNA))
Q. 2 Yes/ No regarding whether their patients use their Care Plan to manage their health on a regular basis?	4 25%	9 56 %	3 19% (Said they were not sure as there were variations within patients depending on whether they were passive about their health or not)

Q. 3 Yes/No regarding whether Practices consult / involve patients while developing their Care Plan?	14 88%		1 6%	Other: DNA:1 6%
Q. 4 Yes/No regarding whether health professionals (e.g. GP, Nurse, Occupational Therapist), regularly review their patients' Care Plans?	14 88%	1 6%	Other: DNA:1 6%	
Q. 5 Choosing 1 from 4 options (A,B,C and D) to describe how they think their patients (who have Care Plans), manage their health: **A. I think they do not understand their role in the care process, are overwhelmed and feel they don't have control in managing their health.** **B. I think they lack the knowledge and confidence to manage their health.** **C. They have made changes to their behaviour to manage their health but they seem to lack the confidence and skill to support these changes of behaviour.** **D. They have taken action to adopt many of the behaviours/actions necessary for managing their health but they still lack the confidence and skill to maintain them.**	Option A 9 19% Option B 2 13% Option: C 5 31% Option: D 5 31%		Other 1 6% Did not choose any of these options because different patients respond differently. In addition, two other respondents who had chosen from options A, B, C, D also said the same about their patients.	
Q. 6 Suggestions/ ideas to improve the planning and implementation of Care Plans for Vulnerable Adults			Various ideas/suggestions were given that we have included in various parts of the report.	





Conclusions evident from interviews and responses from Local GP's/GP Staff

Most GPs/GP staff that we interviewed, started by saying that under the Direct Enhanced Services[5], they had begun preparing Care Plans about two years ago, for a small section of the patients registered in their Practice who they had identified as being among the

[5] Directed enhanced services (DESs) - schemes that PCTs were required to establish or to offer contractors the opportunity to provide, linked to national priorities and agreements.

top 2% of their Vulnerable Adult patients. They added that they had later increased this to between 2-5% of their registered patients to help with the local CCG's Out of Hospital strategy.

When asked whether they determined or identified their vulnerable patients on the basis of their age e.g. those aged over 75 years or those affected by long-term illnesses, they generally said that age was not the prime determinant factor. [6] Instead, it was other factors such as the frailty of patients, the severity of their health condition or its complexity, and the frequency with which they tended to go in and out of hospital,[7] that determined whether they needed to be included among their most vulnerable patients for whom Care Plans were necessary.

GP /GP staff responses to our questionnaire, indicated the following:

- The majority of Practices (56%) had achieved their set target of preparing Care Plans for Vulnerable Adults in their Practice.

- The majority of Practices (56%) said their Patient did not use their Care Plans to manage their health on a regular basis.

- The majority of Practices (88%) said that they involved/consulted their patients while drawing up their Care Plans.

- The majority of Practices (88%) said that health professionals (e.g. GP, Nurse, Occupational Therapist), regularly carried out reviews of their Patients' Care Plans.

- Regarding Patient Activation or patients managing their heath, 19% of Practices supported option A. In other words, they said that according to them their patients do not understand their role in the care process, are overwhelmed and feel they don't have control in managing their health; and

- Another 13% chose option B, that they thought their patients lack the knowledge and confidence to manage their health.

- An equal number (31%) chose options C and D, they said they believed their patients have made changes to their behaviour to manage their health but they seem to lack the confidence and skills to support these changes of behaviour; or that they have taken action to adopt many of the behaviours/actions necessary for managing their health but they still lack the confidence and skill to maintain them.

From the above percentages, it can be concluded that the **Patient Activation level** according to feedback from GPs/Practice staff is presently not very high and though 61%

[6] Only one Practice Manager that we spoke to said they had at one point in time tried to develop Care Plans for their patients who were aged 75 and over.

[7] Some Practices wanted HWH to convey to hospitals that they found their patient discharge forms to be running into several pages with the information they needed scattered all over them. They complained that this problem made them far too unwieldy and time-consuming for them to extract the information they required from the forms. They wanted shorter forms so that the information therein, could be quickly identified.

are reported to have moved towards changing their behaviour for improving their health, they lack the confidence and skills to support and maintain these changes.

- It is apparent that among some Practices, there is a lack of clarity about the meaning of "Vulnerable". The uncertainty comes across strongly from the following remark made by a local GP: "What is a vulnerable adult? If it is the frail, then please use this term. [Or] is it someone who you might be concerned about safeguard [ing]?"

- It is evident that GPs and their Practice staff feel they are already under severe pressure in the workplace and Care Planning is useful but nonetheless an additional and difficult task that adds to their burden of work. *"It has unfortunately come at a time when we already have so much work."* said a local GP. "*We are expected to have monthly reviews by MDTs but quarterly reviews are more realistic* "said another GP.[8]

- Practice staff expressed concern or fear that due to the practical difficulties of hitting their targets or otherwise failing to receive payment for their Care Planning work, Care Planning, which had so much positive potential, should not become yet another exercise in "*Ticking the correct boxes*" instead of achieving and helping patients to achieve real targets or goals.

- For developing and implementing Care Plans effectively, Practices need staff who:

  a) are engaged by the Practice for the necessary number of hours; are

  b) suitably trained for Care planning work; and very importantly, they require

  c) continuity of health advice /care to be provided to their vulnerable adult patients through their own GP/GPs and not a sequence of different locum GPs who neither know their patients nor are known to them.

These three essential preconditions do not seem to be present. Thus, besides receiving a general impression from local Practices that Care Planning is not regarded as something that is easy for them to implement, we also gathered that among the practical hurdles that confronted them were: **difficulties in having suitably trained staff** who could work on Care Plans for the adequate number of hours; problems created by the **inability to retain staff even after investing in staff training** and a **shortage of regular GPs** that makes it necessary for Practices to depend on various locum GPs for their Care Plan work.

A local Practice Manager we interviewed, for example, clearly illustrated how their Care plan work had suffered. He explained in detail about how their GP Practice had provided

[8] MDT meetings held every month are listed among the four Key Performance Indicators (KPIs) for GP Practices. The remaining three KPIs are: Number of patients with a care plan as a % of expected population prevalence; 100% review of patients who have had an unplanned admission and have been reviewed within three working days and Patient Satisfaction Survey.

training to a Healthcare Assistant (HCA) who then started doing good work on Care Plans. However, as this HCA suddenly left the Practice not long after completing the training, the Practice's Care Plan work had suffered a severe setback. The Practice Manager added that in the absence of their trained HCA who used to remind the busy GPs at the Practice to review/update Care Plans at regular intervals, this crucial work had not received enough attention. "*Now, unless I remind our GP or a newly trained staff member is in place, our Care Plan reviews will get delayed*." A GP at another Practice reiterated the same point when he/she said: "*We need to have a recall system for reviews."*

Likewise, GPs spoke of the disadvantages of not having regular GPs for their vulnerable adult patients and the need for using locum GPs instead. "*Ideally there should GP continuity*" said a young GP, "*so that he/she knows the patient thoroughly and who the patient also trusts and has a rapport with."*

- Local Practices said they have used different measures to identify vulnerable patients in various Practices.[9] Some Practices mentioned having used a special tool called BIRT (Business Intelligence and Reporting Tool) for some time as well as the Frailty Index.[10] Some mentioned that recently a new method called the Patient Activation Measure (or PAM) had been implemented.

- Practices also said that besides reviews of Care Plans at set intervals, they were often having to review Care Plans because they received information from the hospital that the patients concerned had to be hospitalised unexpectedly.

- Some GPs said that local Practices should have a smaller number of registered patients to make their care of Vulnerable Patients more effective and to have adequate capacity to cater for their needs. The following statement from a local Practice staff typifies the pressure they presently face: "*We have about 10,000 registered patients and still, though some patients do move out or might go back to their country of origin, we still have about 20 new patients wanting to register almost each day. It's a time-consuming*

[9] This seems to be in accordance with what GPs were expected to do as described in a document produced by NHS England: "The GP practice will use an appropriate risk stratification tool or alternative method, if a tool is not available, to identify vulnerable older people, high risk patients and patients needing end-of-life care who are at risk of unplanned admission to hospital. If a risk stratification tool is used, commissioners should ensure that a suitable tool has been procured for GP practice use". From: *Enhanced service specification: Avoiding unplanned admissions: proactive case finding and patient review for vulnerable people 2016/17*, NHS England.

[10] According to information provided by the Hounslow CCG: "The electronic frailty index (eFI) is available to help practices to identify the top 2% of vulnerable patients as part of the Avoiding Unplanned Admissions Enhanced Service (AUAES). The eFI has been developed by the University of Leeds, the Care of the Elderly team at Bradford NHST, the National Clinical Director for Frail Elderly at NHS England and TPP ResearchOne. The tool relies upon routinely-collected data from General Practice. It has been derived and validated on the ResearchOne database and is currently undergoing external validation on the THIN research database." Emphasising the importance of clinical judgement, the same document goes on to say: "As with all risk assessment, the calculation of a patient risk score does not remove the need for clinical judgement and is considered advisory only."

process in itself."

The work pressures on local GPs also found expression in some of them saying that they should be spared from involvement with Care Plans. Upholding their point of view, they said: "*This work should be carried out by other health professionals. Care Plans should be done by the visiting Nurse Team rather than by GPs wasting their time. The community staff is well placed in assessing and delivering the necessary service rather than the GPs*."

- Care Planning was perceived by some Practice staff as "*a clunky vessel and some of the questions are quite intrusive."*
- Not all patients identified for Care Plans, respond promptly. It takes time and effort.

- Sometimes there are language issues that act as barriers to the communication and implementation of Care Plans. This was mentioned in a few responses collated by us via local ethnic minority organisations.

- People with Learning Disabilities sometimes have specific communication needs which is an additional barrier for Practices to cross.

- The background of patients also creates barriers. Hounslow is such a multicultural borough. According to one GP, *"Patients from some cultural backgrounds are more passive in their approach towards self-care than others. Because of their passivity, such patients might not get actively involved in the management of their care."* Stressing the excessive dependence of some local patients on GPs, another GP spoke of their preference for a: "*doctor-centred or paternalistic approach" instead of self-dependence or self- care.*

- Feedback from Practices seems to indicate that it is predominantly GPs and Practice Nurses in Practices who are involved with Care Plans and Social Workers are involved when there are specific goals to be achieved by a patient/user. Thus, it generally appears that only some health and social care professionals are involved in Care Plans. Voluntary/ community groups were not mentioned.

- Care Navigators are not involved in all Care Plans. However, some GPs believe that having Care Navigators for some of their vulnerable adult patients is an excellent idea and is very useful.

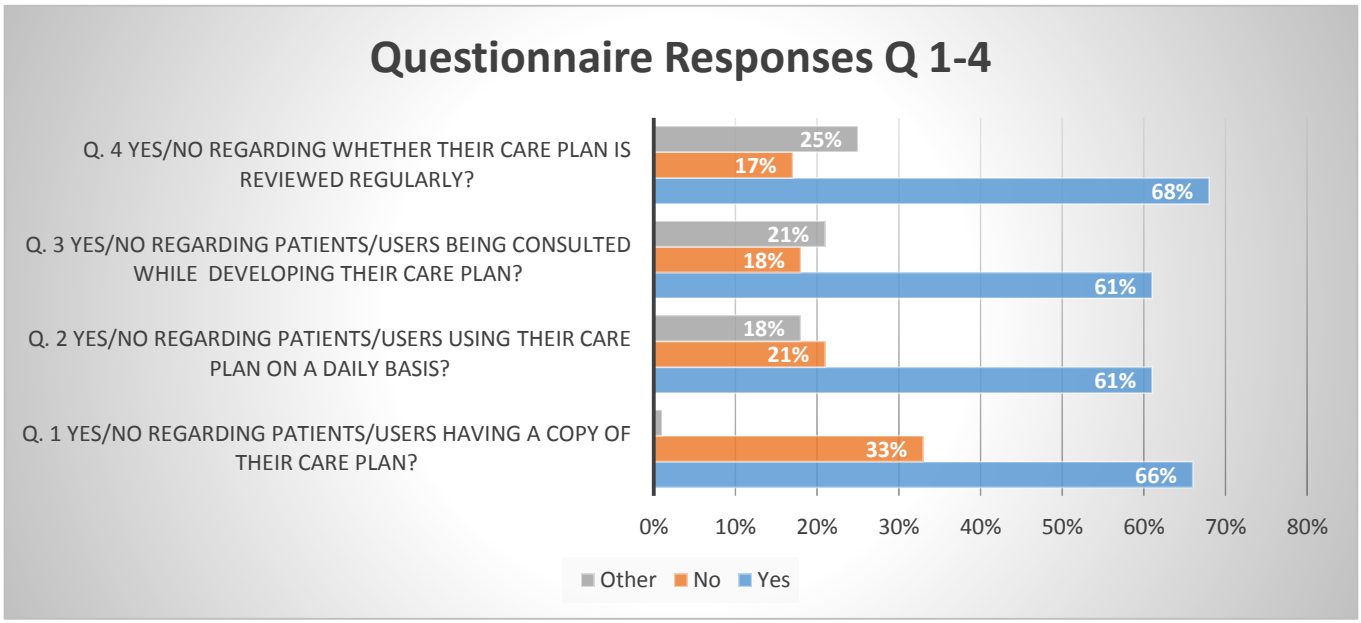
- Some Practices regretted that there were delays in receiving remuneration for their Care Plan work if they failed to tick the right boxes or did not submit their responses in a certain fixed manner.

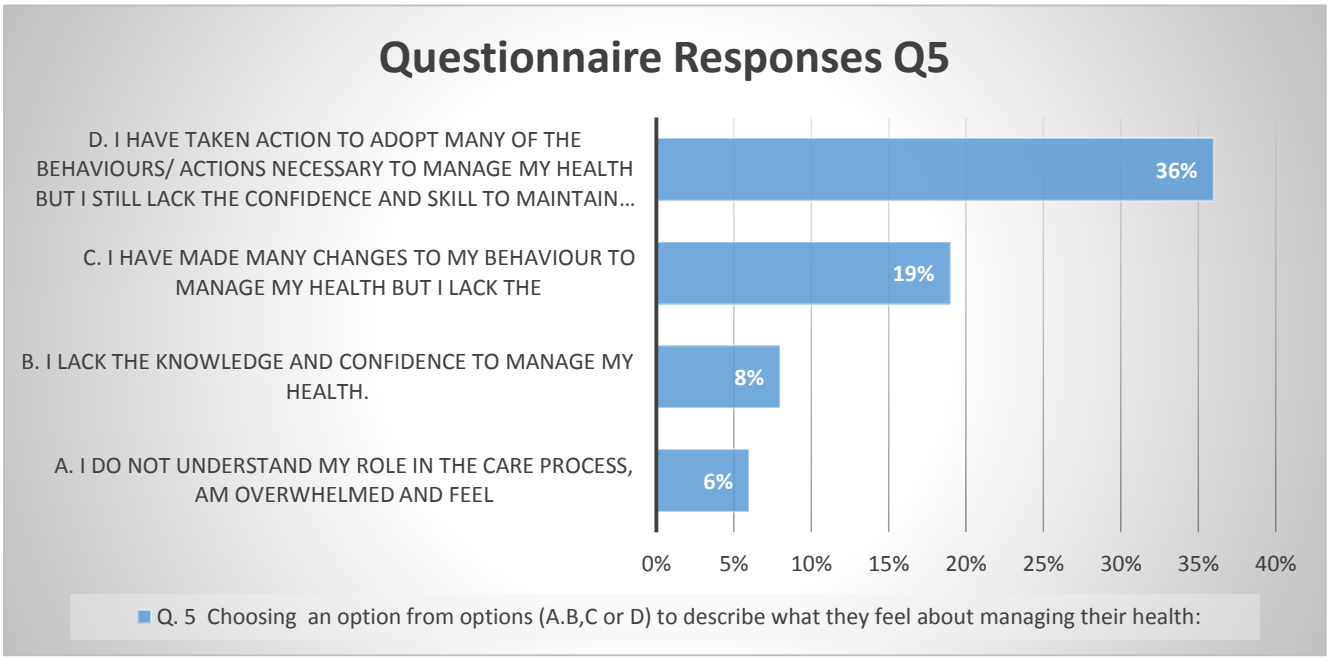
- Some GPs said because of the way they identified vulnerable patients, it was possible that some of their vulnerable patients fell through the net, i.e., were not being selected for Care Plans.

2. Questionnaire for Patients/Users of Care Plans and Summary of responses

Summary of Questions	YES	NO	OTHER
Q. 1 Yes/No regarding patients/users having a copy of their Care Plan?	69 66%	35 33%	Not Applicable (N/A):1 1%
Q. 2 Yes/No regarding patients/users using their Care Plan on a daily basis?	64 61%	22 21%	DNA:18; N/A:1=19 18%
Q. 3 Yes/No regarding patients/users being consulted while developing their Care Plan?	64 61%	19 18%	DNA: 22 21%
Q. 4 Yes/No regarding whether their Care Plan is reviewed regularly?	61 68%	18 17%	DNA:24; Don't know: 2 26 25%
Q. 5 Choosing an option from options (A.B,C or D) to describe what they feel about managing their health: **A. I do not understand my role in the care process, am overwhelmed and feel I don't have control in managing my health.** **B. I lack the knowledge and confidence to manage my health.** **C. I have made many changes to my behaviour to manage my health but I lack the confidence and skill to support these changes of behaviour.** **D. I have taken action to adopt many of the behaviours/ actions necessary to manage my health but I still lack the confidence and skills to maintain them.**	Option A: 9 6% Option B: 8 8% Option C: 20 19% Option D: 38 36%		None of the options: A,B,C or D: DNA :20; N/A: 9; and 1 patient who said: "I'm confident about managing my health." 28%

Q. 6 Suggestions/ ideas to improve the development and implementation of Care Plans.			Various (These have been included in our recommendations)





Conclusions evident from Patients/Users of Care Plans

Responses to our questionnaire from --- patients/ users of Care Plans, indicated the following:

- The majority (66%) of our patient/ user respondents said they had a copy of their Care Plan.
- The majority (61%) of patients/users said they used their Care Plans on a daily basis.
- The majority (61%) of patients/users said they were consulted in the development of their Care Plan.
- The majority (68%) of patients/users said their Care Plans were reviewed regularly.
- Regarding Patient Activation or management of their health condition, 6% of users/patient respondents chose option A or said they did not understand their role in the care process, are overwhelmed and feel they don't have control of managing their health.
- 8% chose option B or said they lack the knowledge and confidence to manage their health.
- 19% chose option C or said they have made many changes to their behaviour to manage their health but lack the confidence and skills to support these changes of behaviour.
- 36% chose option D or said they have taken action to adopt many of the behaviours/ actions necessary for managing their health but still lack the confidence and skills to maintain them.
- 28% did not choose any of the options, said they did not know what to say or that these options were not applicable to them.
- Only about 1% of our respondents felt confident enough to emphatically write that they were confident about managing their health.

From the above percentages, it can be concluded that the Patient Activation level, according to the patients themselves, has considerable scope for improvement.

- There is a communication gap between some patients and providers. For instance, a patient said: "It would help to know if I have one [Care Plan] and if so what it says." "There are cultural and language issues and barriers", remarked a local GP at a local Practice.
- 33% of patients said they do not have a copy of their Care Plan. "I would love to have a copy of my CP. It will help me look after my health" wrote one of them.

While it is possible that some of the patients who we approached through the voluntary/community sector might really not have had Care Plans from their GPs, it is clear that we received such responses from patients who we had contacted via GPs.[11] Last month Healthwatch Hounslow staff also noticed they had received several calls from patients asking us what Care Plans were after they had presumably received a covering letter on our letter-headed paper along with our Patient Questionnaire despatched to them.

- Not all patients know what a Care Plan is and what Care planning is all about. "I'm not aware of Care Plans" said one patient; "I do not know what the plan includes", said another and "Patients need to be made aware of the existence of Care Plans" said yet another. A GP Practice nurse added that while developing Care Plans, she noticed that some younger vulnerable adult patients were not comfortable being asked questions about their End of Life Care. Their dependence on their GP and not their Care Plan or their lack of understanding of their Care Plan and its relevance was perhaps also evident from statements such as: "I visit my GP regularly and take his/her advice" and "I consult my GP for my care."

- Not all patients are familiar with or know what is included in their Care Plan. "Someone needs to explain it [my Care Plan] to me", said a patient. On the other hand, GPs too were aware of this as evident from what a busy GP from the Heart of Hounslow said: "There should be classes for patients to make them understand what Care Plans are for and how they can benefit patients."

- Patients/users feel that GPs do not spend enough time with them to explain the system to them fully. This was evident from statements such as the following: "I don't understand how the system works." "For the care and support I need, I must understand how the system works. They must inform me about my rights, describe the free services available and if there is any change or contribution involved." "I don't know my rights and what I am entitled to." "GPs need to spend more time with elderly patients like me and explain everything in detail".

- It was mentioned that instead of being seen by the same GP every time a patient needed a doctor, each time they were seen by different GPs. In other words, there was a lack of continuity when a patient needed to see his/her GP.

- There seems to be scope for more partnership between local Practices and other health and social care professionals, especially those in the community/voluntary sector, so that the benefits of working according to the principles of Whole Systems Integrated Care (or WISC) and through Multi-Disciplinary Teams (or MDTs) have a salutary impact on vulnerable patients who have Care Plans from their GPs. [12]

[11] GPs are the surest way to identify and connect with vulnerable adult patients with Care Plans because GPs have a pivotal role in identifying, initiating and developing Care Plans for some of their most vulnerable adult patients.

[12] This will help make Care Plans in Hounslow closer to the specifications expected from Out of Hospital (OOH) services. Referring to Care Planning and care delivered by MDTs, a CCG document on Care Plans says as follows: "The OOH specification requires the service to be provided in a setting where the patient is also receiving other aspects of care at the same time. Individuals will experience coordinated, seamless

Our Recommendations

The data generated and analysed for this review, conjures up a picture of the prevailing Care Plan scenario at Hounslow that prompts us to conclude that, despite the benefits inherent in Care Plans and Care planning, it presently has gaps and areas of concern that need to be addressed.

We feel it is only after essential steps have been taken that health and social care providers will start moving closer to the holistic and well-integrated services desired by Hounslow's CCG; and vulnerable adult patients, empowered with information, will begin to take better charge of their health and start reaping the benefits anticipated through proactive Care Plans.

We would, therefore like to make the following recommendations:

Implement Essential Changes within Local Practices

- To help local Practices to have greater impact through Care Plans for vulnerable patients, Practices will need to make sure:

  - That there is clarity regarding the definition of "Vulnerable Adults" among GPs and that they are given absolute clarity by the commissioning authority from within the CCG/NHS so that they can confidently identify their target population for Care Plans;

  - They get help and resources to overcome their lack of capacity due to a shortage of permanent GPs and other staff[13]. This will help them:

  (a) In their struggle to carry out their Care plan work with a large number of locum GPs and enable them to provide continuity of care (and hence better care) to their vulnerable patients through regular GPs, not Locum GPs who keep changing constantly and with whom patients are unfamiliar, have no rapport and regard as being unfamiliar with their needs; [14] and

  - (b) To recruit other Practice staff and provide them with the necessary training, e.g., appoint Health Care Assistants with adequate staff hours to carry out their Practice's Care plan work [15] and also retain staff in whom they invest resources;

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and integrated services using evidence-based care pathways, case management and personalised care planning where their primary care clinician has access to their results through SystmOne. Effective care planning and preventative care will anticipate and avoid deterioration of conditions."

[13] It has been reported this month that, according to a major poll, surgeries in UK are facing "a recruitment crisis".

[14] Stressing the importance of continuity of care provided by professionals known to patients for ensuring success of the Care Plans initiative, a local GP remarked: "Continuity of care is needed for all our patients to maintain for many years the relationship with their key clinician."

[15] "GPs want the best care for their most vulnerable and frail patients. This requires a coordinated whole system approach spanning general practice, community services, acute and social care. It is vital that CCGs provide additional resources, as set out in the NHS England planning guidance, to support practices to play their part in this wider programme." Chaand Nagpal, Chairman, General Practice Committee (GPC)

- They build upon the model of MDTs working in a holistic, collaborative manner to plan and deliver health and social care services to their vulnerable adult patients;

- They liaise and build links with health and social care providers from **all** sectors by seamlessly crossing over the artificial boundaries or borders that have tended to divide providers from the statutory, the local government and the voluntary / community sectors to proactively develop, implement and review Care Plans and also involve, support and inform patients about them; [16]

- They work with local schools and voluntary /community organisations to seek suitably skilled volunteers who could come into GP Practices and help them in various ways so that their burden of work is eased[17]; and

- To impress upon over-stretched local Practices the practical value of Care Plans, it will be useful to identify and collate Good Practices with regard to Care Plans at various Practices in England so that the benefits that accrue to GPs through Care Plans are clear.

Promote Patient Education

- The lack of adequate information among patients/their carers needs to be investigated and improved through **patient education**.[18] As demanded by some of our patient respondents, they must be informed about:

  - the health and social care system, how it works and how to use and not misuse it;

  - the latest changes in the health and social care system and how patients might be affected;

  - their rights and entitlements as patients as well as their responsibilities;

  - the services available to them from the statutory, voluntary and community sectors and how to access them;

  - the various ways in which they can provide feedback about services received and influence service provision;

  - how and where they can raise issues about service provision or register complaints about service received.

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[16] This is supported by the following statement made by Dr Martin McShane, former GP and NHS England lead for Long Term Conditions: "To build this new, proactive approach, we need to involve patients, carers and families – and we need to mobilise the full range of services – community mental health, pharmacy, social care, voluntary/ charitable providers – who can help people stay independent for longer"**.**
From NHS England, Publications Gateway Reference 01414.

[17] HWH has developed and is presently delivering a project at GP Practices involving work with volunteers.

[18]

Since knowledge is power, the above will help to both inform and **empower patients.**[19]

Increase awareness about Care Plan & Self-Care among patients

- Besides general information, vulnerable adult patients with Care Plans and /or their carers will need to be provided with:

  - a copy of their Care Plan that is short, to the point and easy for them to understand so that they can access, comprehend and use it regularly; and

  - a full explanation about what their Care plan is, what its various sections are about, what have they to do or not do, why it has been developed, what its benefits are for them or their carers, how and why they/their carers can/ should contribute towards developing their Care plan, why and when the plan will be reviewed.

Increase Patient Activation

To activate patients so that they become proactive and start moving with self-confidence towards taking charge of their own health, they will need to be given the following:

- complete information about their health condition that they can easily comprehend; and

- accessible support towards which patients can turn to rapidly clear any doubts or fears that might arise while looking after themselves.

Besides increasing patient activation or moving patients away from passivity towards taking their health into their own hands, the above will help bridge the "communication gap" between patients and providers.

Reduce Health Inequalities & Access Vulnerable/ Emerging Communities

To reduce health inequalities and reach out to so-called 'difficult to reach' and 'emerging communities', special efforts will need to be made to provide easily comprehensible information in suitable formats and languages so that those whose first language isn't English as well as those with learning difficulties and other kinds of disabilities, are not excluded.

We hope our recommendations will contribute towards making care planning and Care Plans for vulnerable adults, more effective in achieving the aims for which they have been initiated.

[19] Empowering individuals, carers and families is one of the underlying principles of Out of Hospital Services.

Appendices

QUESTIONS FOR PATIENTS/THEIR CARERS WITH CARE PLANS

1. Do you have a copy of your Care Plan? **Yes/ No**

2. Do you use your Care Plan to manage your health on a daily basis? **Yes/No**

3. Were you consulted and involved in developing your Care Plan? **Yes/No**
If yes, please briefly describe how you contributed to planning it.
……..
……..

4. Is your Care Plan regularly reviewed by health professionals (e.g., GP, Nurse) **Yes/No.**

5. From the 4 descriptions (**A,B,C,D**) given below, please the one that best describes what you feel about managing your health *(From options A, B, C & D, please **tick** √ **only ONE)*:**

A. I do not understand my role in the care process, am overwhelmed and feel I don't have control of managing my health.

B. I lack the knowledge and confidence to manage my health.

C. I have made many changes to my behaviour to manage my health but I lack the confidence and skill to support these changes of behaviour.

D. I have taken action to adopt many of the behaviours/actions necessary for managing my health but I still lack the confidence and skill to maintain them.

6. Do you have any suggestion about how making and implementing your Care Plan can be improved?

Thanks for your time and valuable input.

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QUESTIONS FOR GP PRACTICE STAFF

Have you been able to achieve your set target of preparing Care Plans for vulnerable adults in your GP Practice? **Yes/ No.**
If your answer is **No**, can you briefly explain why? ……
…….

Do you think your Patient's Care Plan is used to manage their health on a regular basis? **Yes/No**

Did you consult and involve patients while developing their Care Plan? **Yes/No**
If **Yes**, please briefly describe how they contribute to planning it.
……..
……..

Do you and other health professionals (e.g. GP, Nurse, Occupational Therapist, regularly review your Patient Care Plans? **Yes/No.**

From the 4 descriptions given below, please tick the one that best describes what you think your patients feel about managing their health *(From options A, B, C & D, please **tick** √ **only ONE)**:*

A. I think they do not understand their role in the care process, are overwhelmed and feel they don't have control of managing their health.

B. I think they lack the knowledge and confidence to manage their health.

C. They have made changes to their behaviour to manage their health but they seem to lack the confidence and skill to support these changes of behaviour.

D. They have taken action to adopt many of the behaviours/actions necessary for managing their health but they still lack the confidence and skill to maintain them.

Do you have any suggestions and ideas to improve the planning g and implementing of Care Plans for vulnerable adults?

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Thanks for your time and valuable input.