
CONFERENCE ABSTRACT

Is care moving closer to home? A snapshot in England in 2014

16th International Conference on Integrated Care, Barcelona 23-25 May 2016

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Introduction: In view of the demographic change with its increasing demand for and cost of institutional care, current approaches to health care delivery are not sustainable. To meet future healthcare needs, the National Health Service (NHS) started an extensive transformation following the Health and Social Care Act 2012 in England, changing the structure, accountabilities, funding arrangements and working relationships within the care system. The goal is to improve the integration between different professions and in particular transitions between health and social care.

The aim of this transformation is to shift the balance from hospital to the community setting, providing holistic and patient-centric care.

The qualitative study described in this abstract examines if and how different stakeholders experience this transformation process.

Methods: The study design involved qualitative methods including reflection exercises, individual and focus group interviews, mapping of care network and trigger cards. Patients with a present chronic condition using one or more social and/or community service(s), professionals and representatives from service providers and informal care giver (ICG), were enrolled for this study. Both patients with and without ICG support were included.

Data collection and sample: The study involved semi-structured interviews in 22 subjects: six patients (age 70 ± 13 ; 4 female 4 COPD, 1 HF, 1 mental disorder), five ICG (age 55 ± 10 ; all female), eight NHS professionals (5 nurses, 1 service commissioner, 1 quality assurance and 1 rapid response team representative) and three representatives from care service (CS) providers.

Patients and ICG were asked about the support they received, social and community services they are using and the associated motivation/obstacles, means of communication with different providers and their vision of future care. Professionals and CS providers explained their professional background, tasks and responsibilities, amount and means of interactions with patients and ICG, role in arranging services, coordination, collaboration and follow-up with service providers as well as expected changes in the future.

Findings: Insights on integrated care.

Community and social service providers lack access to patient information (e.g. health condition). Data sharing and collaboration between health and care organizations is essential to enable holistic care, but currently not sufficiently in place as trust and clear responsibilities need first to be established. As a result, no single care provider oversees the whole picture of a patient.

Patients on the other hand interact with different providers, which causes a lot of dissatisfaction as the patient needs to repeat information from one care provider to the other.

Shifting care from hospitals into the community: There is a strong incentive to shift care out-of-hospital, closer to the home environment as health professionals are challenged by rising caseloads and limited patient time windows. The coordination of care is therefore shifting to district nurses and community matrons, linking up social services and community resources. However, the landscape of available community health and social care services is region-specific, fragmented and dynamic. As the service offer differs per neighborhood and is rapidly changing, navigating through the service landscape becomes challenging without a currently available up-to-date information supply chain. Care providers rely on their experience and exchange of such information from peers.

Empowering patients and ICG: The transformation of the NHS envisions patients to have far greater control of their own care (e.g. by means of shared budgets). However, patients and ICG lack awareness of available resources or benefits they are entitled to, and particularly mental services were mentioned to be lacking. Patients reported the obligation to be proactive and responsible in coordinating their care (e.g. paperwork). They raised concerns that not everybody is willing and/or capable to carry out these tasks. The selection of services should ideally be supported by a guiding professional.

Conclusions: Despite the ambition for integrated care, health and social services are still disjoint. This is reflected by limited collaboration, coordination, communication and data exchange between health and care professions. As social and CS are disconnected from the NHS, no professional has the overall picture of which treatment and care a patient can receive and is receiving.

Due to the strain on medical professionals, health and care services are increasingly shifted to the community. This process is supported by district and community nurses who coordinate care for patients with chronic conditions. However, these nurses lack information on what services are available.

Similar problems were reported by patients, who appreciate having a say in their care, but still need guidance from a medical professional. Patients will be expected to engage more and more in their care, but this may not be suitable for all.