

# Report of SIMTEGR8 Project Workshops:

## Help to Live at Home Service

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## 1. Introduction

This is the second phase of the Simulation to Evaluate Great Care (SIMTEGR8) project. The first phase was undertaken in 2015 collaboratively between Leicestershire County Council, Healthwatch Leicestershire, Loughborough University and SIMUL8. It evaluated four patient centric service integrated admissions avoidance schemes being piloted through the Leicestershire Better Care Fund (BCF).

Evaluation of up to four further schemes has been built into the BCF Plan for 2016/17.

These schemes are:-

- a) Ambulatory pathway at CDU (Glenfield) hospital admissions avoidance scheme for cardio/respiratory patients.
- b) Lightbulb Programme (a Leicestershire housing support service hosted by Blaby District Council).
- c) Help to Live at Home
- d) The intensive community support (ICS beds) scheme.

The evaluation is undertaken using facilitated simulation modelling, to support the development of patient centric integrated services aimed at reducing emergency hospital admissions and improving the user experience.

A crucial part of the assessment process is a set of workshops held with project leads. The purpose of the first workshop was to develop an agreed process map (i.e. conceptual diagram) of the pathway with the project leads. The second workshop used the computer model built as a result of the first workshop to facilitate a discussion on how the intervention can be improved. This report sets out the outcomes of these two workshops in relation to the Help to Live at Home Service.

These workshops were conducted as a partnership between staff of Loughborough University and Leicestershire County Council, with support from SIMUL8. The workshop participants included staff from Leicestershire County Council, both in terms of project management and the Adults and Communities Department. This report is structured using the methodology designed for the workshops, which will be outlined below. The discussions in these workshops were particularly interesting and the following observations were made as a result:

- The need for localities to consider and model what needed to be included in their local offer was identified;
- The workshop stimulated collaboration between participants for future work on HTLAH.

## 2. The Help to Live at Home Service

The Help To Live At Home (HTLAH) Programme is an essential component of the 5 year plan to transform health and care in Leicester, Leicestershire and Rutland and provides domiciliary care targeted to two specific groups of people:

- Those in need of support at home following a hospital stay
- Those in the community whose needs have changed meaning they need more support to stay at home

The HTLAH Programme has been designed to help service users achieve maximum possible independence at home, by moving to a service model which is focused on reablement and maximising independence.

This service sees a significant reduction in the number of providers of domiciliary care services following a procurement process which concluded in July 2016. The domiciliary care provision has been currently divided into 14 geographic lots, whereas the previous fragmented arrangements meant there were over 150 providers of domiciliary care in Leicestershire. The process was conducted in partnership between Leicestershire County Council, West Leicestershire Clinical Commissioning Group and East Leicestershire and Rutland Clinical Commissioning Group.

The HTLAH Programme was launched on 7 November 2016 and the evaluation took place within the first few months of the programme going live. There are 8 providers of the service; three of the lots are currently being retendered following the withdrawal of one of the providers just before the service went live.

## 3. Methodology

The *SimLean Facilitate* approach described in Robinson et al (2014) and the PartiSim approach described in Tako and Kotiadis (2015) have been adopted and modified to be used for the purpose of this study.

Simulation models are developed after discussing the pathways with relevant stakeholders in a facilitated workshop. These models are subsequently used in a facilitated workshop environment to generate understanding and discussion around the effectiveness of the pathway and how the user experience can be improved, and to identify potential improvements.

In order to analyse whether the patient pathway is the most efficient for service users and the service the methodology follows a set of specific steps:

- Stage 1: Initial Pathway Briefing. This involves developing an initial understanding of the pathway and the data needed to inform the process map. The data, including referrals, staffing and use of the Disabled Facilities Grant, are then interpreted as an initial process.
- Stage 2: Workshop – Conceptual Modelling. This includes discussion of the planned pathway and reflections on its efficiency. The discussion serves as a basis for developing the simulated computer model in order to evaluate the intervention.

- Stage 3: Model Development. This is a quantitative representation of the qualitative conceptual diagram developed during the previous workshop. Data in the model may be adjusted to generate a representative behaviour of the system. The detailed complexity of the model is deliberately kept to a minimum to ensure stakeholder and patient participation in the next stages. The model developed aims to provide a good enough representation of the service to show the basic processes involved and to show the capacity and use of resources within the system.
- Stage 4: Workshop – Project Leads’ Perspective. This workshop uses the model to facilitate a discussion on how the intervention can be improved. The discussion involves the following four phases:-
  - Model Understanding, the simulation model developed is presented and shown to the participants to allow them to understand how the simulation works;
  - Face Validation, the participants are asked to consider whether the simulation model reflects what actually happens;
  - Problem Scoping, by taking a helicopter view of the pathway, participants are asked to identify issues which have previously remained hidden because they are normally involved in the detail of only their part of the process;
  - Improvement, during this session the group is encouraged to identify changes that can be introduced to the service to reflect on the ideas produced throughout the session.
- Stage 5: The Service Users’ Perspective. Although a workshop with service users was scheduled to take place on 17<sup>th</sup> February and then rescheduled for 24<sup>th</sup> February to allow for more time for the service lead to identify and engage service users, it was decided that a workshop with service users would not be pursued. It became apparent when the service lead contacted service users, that they were not able to attend a workshop due to their health. It was instead decided to schedule home visits to gain a full overview of the service users’ opinion and experience. The discussion with the service users involved the following themes:
  - Treatment at home
  - Experience & care at home
  - Standard of care at home
  - What could be improved based on their experience
  - Quality of care

## **4. Workshops**

In the next sections, the structure and the outcomes of each workshop are presented separately.

### **4.1. Workshop 1: Conceptual Modelling**

#### **4.1.1. Introduction**

The workshop was held on 9 December 2016 at Leicestershire County Council's County Hall. It was facilitated by the project investigator (Dr Antuela Tako) and the post-doctoral research associate (Dr Anastasia Gogi).

The workshop participants were 4 Leicestershire County Council employees involved in the HTLAH Programme (i.e. Senior Project Manager in Transformation Unit LCC involved in the back office integration of HTLAH and Information Adult Social Process and System Manager involved in the back office of HTLAH, Business Analyst working on the HTLAH Finance processes, Financial System Support Officer). Despite the efforts made on the part of the Health and Care Integration Team to invite appropriate members of the team, these workshops were only attended by a small number of professional staff who contributed to the work of the HTLAH Programme, largely focusing on the back office processes developed for the new service. However people, who were looking after the day to day processes of the service such as the project lead did not attend any workshops, apart from the project briefing meeting to kick start the project. It should be noted that on the day, the workshop ran successfully and participants expressed a vivid interest in the study and productive conversations took place. A consultant from SIMUL8 (SIMUL8) also attended this workshop.

The sessions were managed within a tight timeframe of 2 hours to impact minimally on service delivery. Two particular participants (i.e. Senior Project Manager in Transformation Unit LCC involved in setting up the back office integration of HTLAH and Information Adult Social Process and System Manager involved in setting up the back office processes of HTLAH) were able to provide relevant information and comment about the processes involved in the service.

#### **4.1.2. Participants' anticipated expectations for the workshop**

At the beginning of the session the facilitator briefly introduced the overall aims of the SIMTEGR8 project and the four phases of the study followed by a short presentation of the sessions included in this workshop. Participants were then asked to express what they hope to gain from this workshop. All participants agreed that they hoped to gain a clear understanding of how the evaluation process is undertaken and can assist the team to meet the following aims:

1. Test the ability of the Help to Live at Home Service to cater for service users under different levels of provider capacity, including in the case of provider failure;
2. Test flow through the system and whether processes were streamlined.

The format of the workshop was as follows:-

#### **4.1.3. The Process Map**

This part of the session involved the creation of a process map on paper, to which the workshop participants were invited to contribute their understanding of their process.

At the beginning of this session, an initial process map developed based on information provided at Stage 1 (Figure 1, Appendix 1). The participants were then asked to comment on whether this was an accurate representation of their system. Participants noted that this was a high-level process map, which simplified the process, and that there was more detail in the process maps which sat underneath this high-level map. There were some elements of the process map which required amending or clarifying. Participants were asked to join the facilitators and explain what amendments were needed so that the facilitators could amend process map, which was drawn on a large piece of white paper stuck on a wall. After a few iterations, an agreed process map was produced. It was confirmed that, although there were six different entrance points to the service for service users, depending on how their care was funded and whether they were being discharged from hospital or already in the community, once they entered the service the process was the same. During a follow-up meeting with the analyst of the service, some further changes and simplifications to the process map were identified, due to lack of data and the refined aims of the evaluation (see section 4.1.4 below) (Figure 2, Appendix 1).

#### **4.1.4. Aims of the Evaluation Revisited**

After having drawn the process map, the participants reconsidered the aims of the evaluation which they had put forward at the beginning of the workshop. The revised aims focused more on business continuity than testing how streamlined the processes were, given the context of a fragile domiciliary care market both nationally and locally. The following scenarios that could be used to evaluate the service using the model were identified:

- The impact of one or more of the providers or the Home Assessment and Reablement Team (HART) was not able to deliver a service (i.e. failure of a provider);
- The impact of a partial failure of a provider;
- If a provider did not fail but its capacity was reached;
- The creation of a contingency provider arrangement to provide the service in the event of the existing providers not having enough capacity;
- Failure in more than one provider to provide services.

With all these scenarios, the intention was to see when the rest of the service would be affected and also how quickly it could recover.

#### **4.1.5. Performance Measures**

Next the group was asked to identify performance measures that could be used to identify the success of their service. It was confirmed that the overarching target was that all service users received a service. The following more detailed performance measures were also identified:-

- Provider performance;
- Number of cases delivered by each provider;
- Number of cases where the provider is unavailable;
- Service Waiting times

The facilitator explained that these performance measures could be plotted as one of the outcomes of the model.

#### **4.1.6. Learning from the Service**

After discussing service performance measures, the participants were then asked to discuss learning acquired so far from the HTLAH service, acknowledging that it had only been in place for a month, from the service users and the projects leads perspective.

##### ***The Project Leads Perspective***

It was felt that, where the HTLAH service was working as expected, it was an efficient model. Where work-arounds were in place it was not possible to see whether processes were effective. It was acknowledged that the processes currently in place were likely to evolve as the service developed.

The withdrawal of a provider which had been awarded three lots had had a significant impact on the capacity of the service and its ability to deliver. This resulted in the need for the model to focus on testing how failure of a provider or HART affected the system, to help inform contingency planning.

It was noted that the risk of providers failing was much higher now there was a significantly reduced number of domiciliary care providers used by Leicestershire County Council and the Leicestershire Clinical Commissioning Groups.

##### ***The Service Users' perspective***

31 official complaints had been received following the launch of the service, these all related to the provider withdrawing from the contract shortly before the launch and the effectiveness of the contingency arrangements that had been put in place. Unfortunately, there had been a small number of late or missed appointments.

Participants advised that, from the service user perspective, the HTLAH service should not be any different to the service that they had previously received, as the majority of the changes were to the back office functions. One change that service users might see could be that they were receiving care from a different person.

#### **4.1.7. Alternative process map**

When asked about what changes to the process map could potentially improve the service and therefore would be worth testing using the simulation model, it was agreed by all participants at the workshop that there would be no benefit in testing an alternative process through this evaluation.

#### **4.1.8. Participants' Actual Outcomes from the workshop**

At the end of the workshop participants were thanked for attending and were asked to express their actual outcomes from the workshop. These are summarised below:

- An agreed scope for the evaluation and the model creation
- A better understanding of the process to be undertaken
- An expectation that the simulation model will be useful for meeting aims of the evaluation<sup>1</sup>

#### **4.1.9. Reflections on conceptual modelling workshop**

The discussion during the workshop was lively with all participants contributing and engagement during the development of the process map and discussion of potential scenarios with the model was high.

Expectations that were stated at the beginning of the workshop showed that participants generally understood that the workshop could help them to achieve an agreed process map of the HTLAH project. However, some of the participants' anticipated expectations were more relevant to the purpose of the Project Leads workshop rather than to this one.

Based on the comments provided in the feedback forms, at the close of the workshop the participants generally appreciated the chance to hear the views of others. They thought that it was useful, informative and a helpful way to gain a better understanding of the HTLAH service operational pathway and what will be evaluated by the project. Comparing participants' anticipated outcomes for the workshop to their actual outcomes at the end of the workshop, it can be concluded that their aims had generally been met.

#### **4.1.10. Conclusions from the conceptual modelling workshop**

The concept of adopting a facilitated mode of practice to stimulate discussion on and create an agreed process map was effective. On reflection, the workshop was attended by a relatively small number of participants. Although all participants contributed to the discussion and the development of process map and identifying scenarios to test during the model, it might have been more productive if participants representing all elements of the pathway were present. For example, participation of other employees involved in the service such as those covering the contract management side of the service as well as those responsible for back office functions, would have been useful to represent their views of the service. Nonetheless, participants were pleased with the focus on business continuity as this was felt to be an important aspect that needed to be understood going forward.

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<sup>1</sup> It should be noted that the participants were shown an example of a simulation model of the LightBulb service, one of the services evaluated as part of this project, to give the participants an idea of what the simulation model looked like.

At the end of the session, participants demonstrated a shared understanding of the entire pathway, Despite the limited attendance, using facilitated simulation modelling as a means of conceptual modelling has been successful.

## **4.2. Workshop 2: Discussing the simulation model with the Project Leads**

### **4.2.1. Introduction**

The workshop was held on 17 February at Leicestershire County Council's County Hall. It was facilitated by the project investigator (Dr Antuela Tako) and the post-doctoral research associate (Dr Anastasia Gogi).

The workshop was attended by 4 participants (the Manager in Commissioning and Market for Development Area for Adult Social Care, Portfolio Analyst in Business Intelligence Service, IAS Systems and Process Manager involved in the back office integration of HTLAH, Senior Project Manager in Transformation Unit LCC involved in the back office integration of HTLAH). Out of the 4 participants, two had not attended the first workshop and had limited involvement in the HTLAH service. The workshop was also observed by a member of the Healthwatch Leicestershire team and a postgraduate researcher from Loughborough University, the latter was not affiliated to the project.

### **4.2.2. The simulation model**

A screenshot of the model used for the project leads workshop and outputs page can be seen in Figure 3 and Figure 4 respectively. The model had been built to analyse the resilience of HART in case one or more providers fail. The service has been designed to help people achieve maximum possible independence at home. In brief, individuals following hospital discharge, or who need more support in the community are referred to the HTLAH service to avoid an admission to hospital. LCC Customer Support Centre reviews referrals and place an order to a Provider or HART to deliver care services in the home of individuals depending on individuals' locality and needs (i.e. reablement or maintenance) as well as providers' real time capacity. Once the order has been completed, the provider or HART delivers their services in the home to individuals on a regular basis according to service users' needs. When a care package has been completed, the case is reviewed and then the user can be either discharged or referred to a provider if his/her needs have been changed (i.e. from reablement to maintenance care package). The model examines one contingency plan: when a provider reaches its capacity, the case is referred to HART. Although the model does not examine alternative contingency plans when a provider reaches its capacity (e.g cases being referred to a new private provider and not to HART), it provides the service with useful insight into current capacity levels of providers and whether the demand is met.

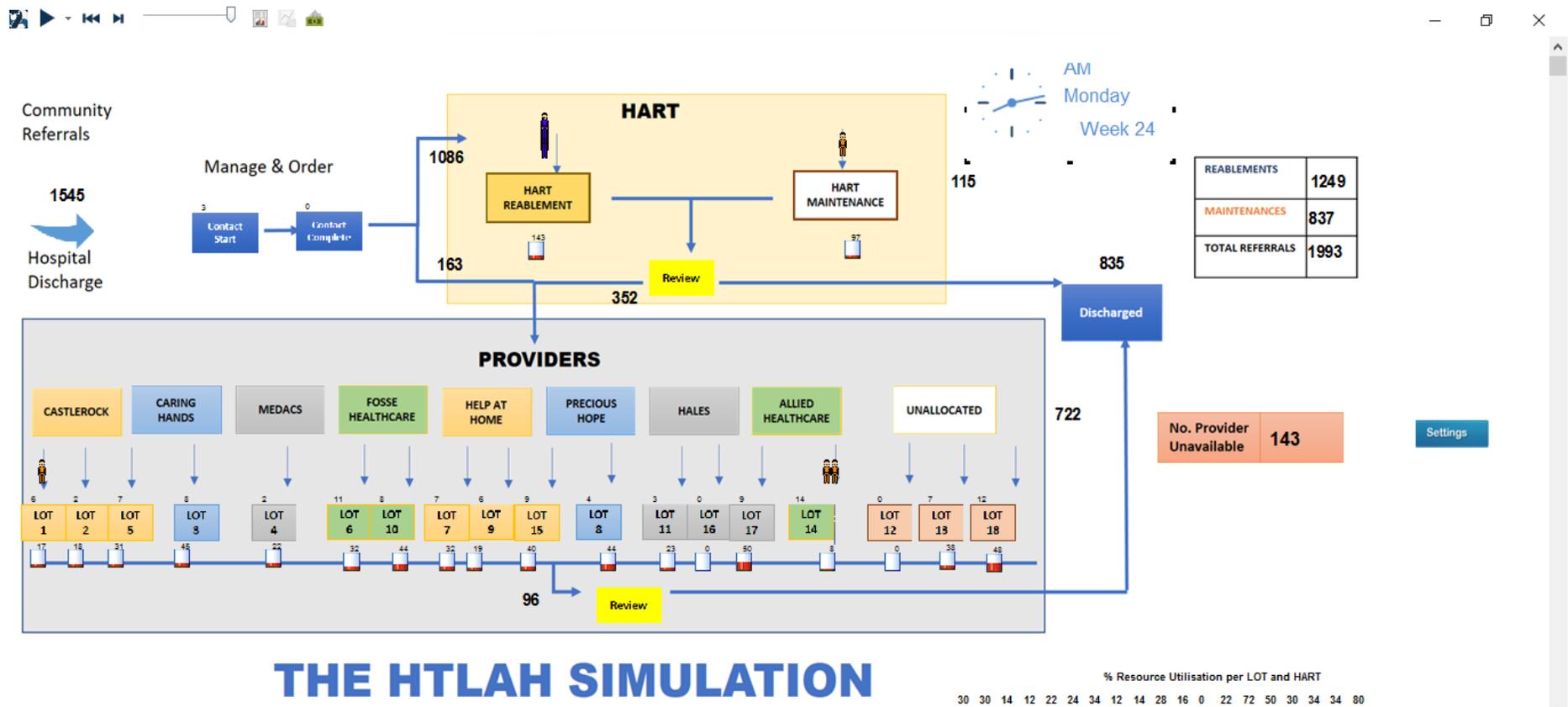


Figure 3. A Screenshot of the model used for the project leads workshop

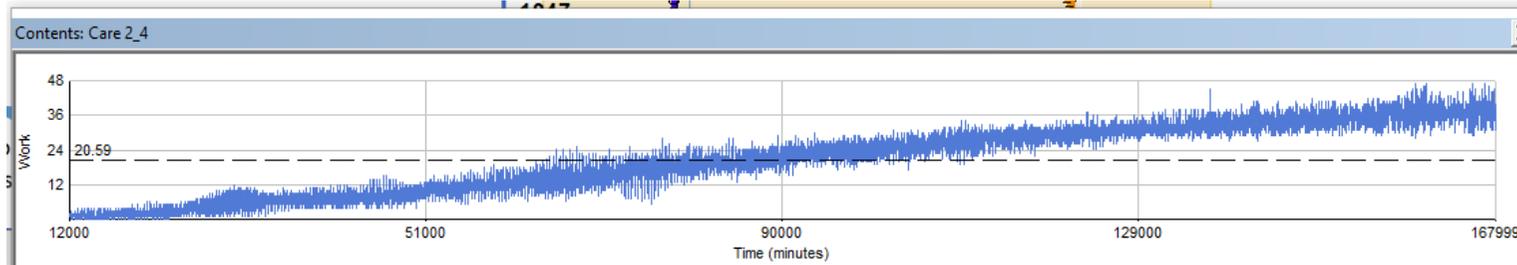
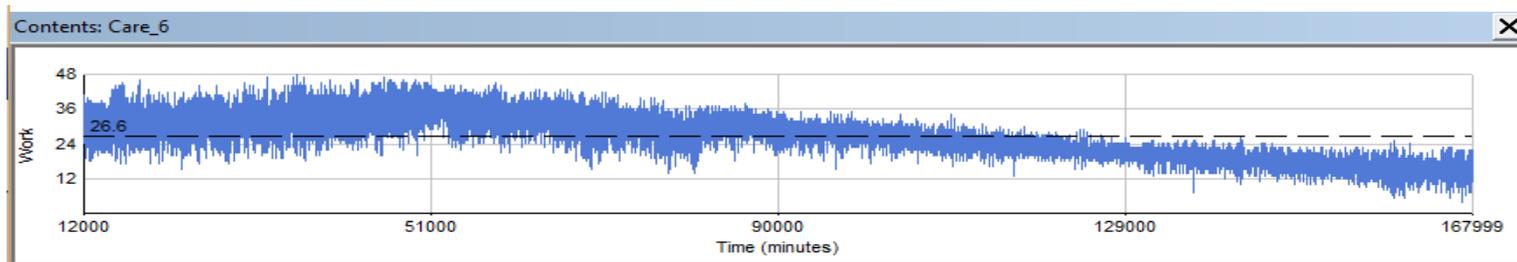
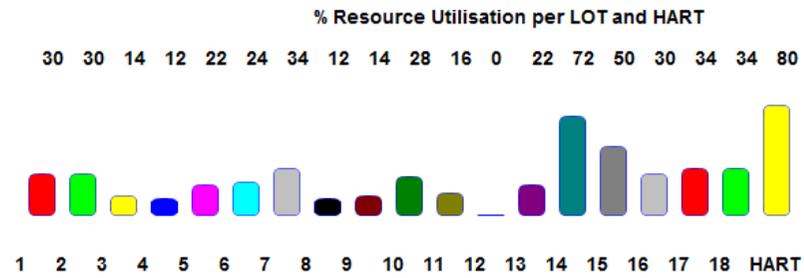


Figure 4. A screenshot of model outputs: provider and HART utilisation per LOT (top), HART Reablement activities over 1 year (middle), HART maintenance activities over 1 year (bottom).

#### **4.2.3. Participants' anticipated expectations for the workshop**

At the beginning of the session the facilitator briefly reminded the participants of the aims of the SIMTEGR8 project and the four phases of the study. She then explained that the purpose of the second workshop was to use the simulation model as a basis for the analysis of the intervention and the participants to work together to find ways for ensuring business continuity arrangements for the HTLAH service. After introducing the sessions included in this workshop, the participants were asked to express what they would like to gain from this workshop. The aspects of the HTLAH service that the delegates hoped to resolve through the workshop were:

- To understand how the model works
- To gain an understanding of how the model can be used to test different scenarios under different capacity levels.

It is noted that all participants' expectations in the list above were relevant to the purpose of this workshop and were captured in the model.

The workshop session was structured as follows:

#### **4.2.4. Model understanding**

The approach taken to address model understanding was to check that both the basis for building the simulation models was considered accurate and that the participants understood how it had been transferred into the simulation software. This involved an initial "walk through" of the process map which had been developed at the previous workshop. It continued by demonstrating how this was built into a SIMUL8-based model and then the outputs were presented in the form of number of cases and number of different types of outcome (e.g. number of referrals, number of discharges, number of hart reablement cases, total number of providers maintenance cases etc.) to familiarise participants with the model. The following assumptions are needed to be taken into account when considering the results of the model:

- The working hours of the service are Monday to Friday, 8am-6pm.
- HART reablements that next go on to maintenance services serve 33% of cases whereas for non-HART reablements the rate is estimated to be at 56%
- All providers operate similarly.
- When a provider of a LOT fails, new cases of that LOT are referred to HTLAH.
- The activities for reablement purposes start quite high (i.e. 45 minutes 4 times per service user per day) but reduce quite quickly ( 30 minutes 2 times per service user per day)
- Each activity for maintenance purposes takes around 30 minutes and occurs twice a day per service user.
- The model did not show interaction with other services (due to lack of data).

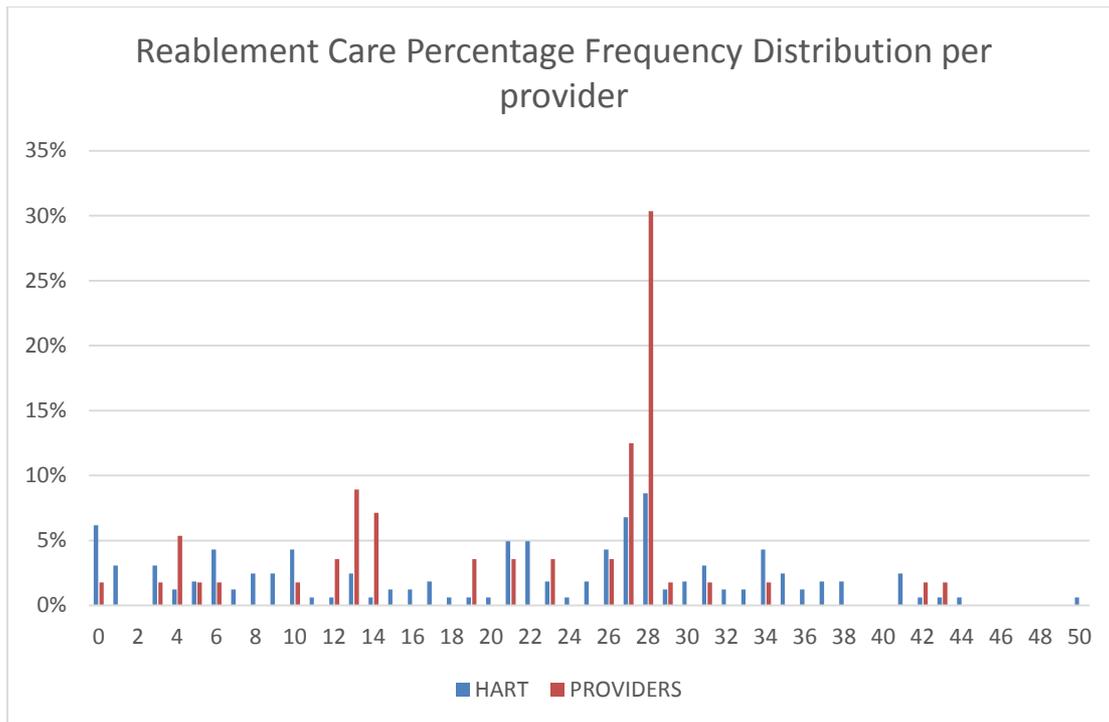
The general conversion of these process maps into a simulation model appeared to be understood by all participants and the process map was confirmed as accurate.

#### **4.2.5. Face validation**

Having confirmed the understanding of the processes within the system the simulation was run through for one month with infinite capacity for each provider, which was clearly not realistic but allowed the participants to view a top-down perspective and to study model outputs. The aim was to validate that the simplified simulation model was acting along the same lines as the real system. This wasn't intended to be a detailed validation to assess statistical accuracy, but instead for the participants to gain trust in the model, that it was performing as expected.

With regard to the key data used to inform the model, it was noted that the 344 referrals came from both hospitals and the community. Although initially the reablement number of 63% looked low, it was advised that this did not include the people who had gone through reablement into maintenance. The actual number of people accessing the reablement service was nearer to 85%.

Participants then considered a graph (Figure 5) which showed the reablement case duration per provider. This showed a spike for private providers at two weeks and again at 28 days. This was in line with contract requirements to have undertaken a review within 2 weeks with the possibility to extend by a further two weeks and review again. The HART service undertook constant reviews so the figures were more level across the period.



**Figure 5. Reablement case duration per provider**

There were some difficulties in collecting reliable data regarding the capacity of the HTLAH providers. Actual capacity figures for several providers were not available. As a result these were not possible to enter into the model. While the expected capacity figures included in the tender document could have been used, it was not possible to access those by the date of the workshop. It was also noted that the model did not take account of seasonal variation. However, the model depicts data collected for the busiest period of the year (December and January). It was suggested at the workshop that if the providers are able to cope with the busiest period, then they are able to cope with quieter periods.

When the model was run based on participants' estimations about current providers' capacity (acknowledging that in some cases capacity was significantly under-estimated), graphs showed that over the year the number of reablement cases decreased and the number of maintenance cases managed by HART increased. This was because there was not enough capacity in the system so HART capacity was used to support maintenance rather than reablement. Given that the service had only been operational since 7 November, and still was not at full capacity, it was not possible to validate at this stage whether this finding was accurate; however it did demonstrate an issue which the service would need to undertake further evaluation.

It was noted that the model assumed that all cases were going through HART either into maintenance or discharge. It did not pick up service users who opted for a Direct Payment. This was due to relevant data not being provided by the service.

#### **4.2.6. Problem scoping**

The facilitators and participants were keen to understand whether any scenarios could be tested using the model to estimate providers' capacity levels in which the service could be improved.

The model was therefore tested with all providers being set at a capacity of 860 hours per week (except HART, because the capacity of that service was known to be accurate). This was an estimate, based on the capacity figures provided by the providers. The results graphs were much more consistent, with reablement remaining fairly consistent for the first eight months. However, without changing the weekly capacity from 860 hours per provider, the graph showed that after approximately 8 months the number of maintenance cases increased significantly.

The model was also tested on an almost infinite capacity basis, i.e 1960 hours of capacity per week. This showed that for most providers the utilisation was around 30% indicating that the demand of the service could be met, if most providers were set at a capacity of between 860 and 1960 per week.

A scenario then tested the case where one lot failed and the capacity of all other providers was set at 860 hours per week. This showed 299 cases where no provider was available and 206 cases being maintained by HART. The reablement pattern was still fairly constant, not dissimilar to that where all providers had 860 hours capacity. It took about 10 months for the number of reablement cases to decrease, despite steady growth in the number of maintenance cases taken on by HART. This suggested that the HART service had a good level of resilience. The discharge rates used were the normal discharge rate from the HART service and for the private providers was based on 2-month period.

It was requested that a scenario whereby HART did not provide any maintenance be tested. However, it was not possible to do this without amending the model. In addition, it was noted that it would never be possible to test the impact of waiting for domiciliary care on admissions and readmissions to hospitals.

The main constraint to the service was identified to be the provider's capacity.

#### **4.2.7. Improvement**

The final part of the workshop focused on action planning, a summary of next steps and a discussion around access to the simulation product for future use, including any modifications needed to the model. The following learning points and suggestions for further work with the model were identified:-

- The resilience capacity of HART was good and could be built on during future reviews of the reablement service in Leicestershire;
- It would be useful to refine the model to include service users with Direct Payments;

- It would be useful to calculate the cost of holding cases within the HART service based on the cost of an average package of care. This would show that although the service was working it was costing more than it ought to;
- It would be good to update the model with more data once that is available.

When asked what they would use the model for and how it would impact the service, participants suggested the following:-

- It would help to understand where the tolerances were, the likely capacity and what contingencies needed to be put in place;
- Likely scenarios that could be tested in case any of the three unallocated lots not being successfully procured;
- Timescales for putting contingencies in place in case of provider failure or a lack of capacity in the market could be identified;
- It would help to test assumptions during the upcoming review of the reablement pathway/offer.

Regular meetings were already held, particularly with struggling providers, supporting them to maximise capacity. The knowledge gained from the model could be used to support providers further to improve capacity planning and could be used by commissioners of the service to help with business continuity arrangements.

It was felt that action needed to be taken in the future to address likely shortfalls in capacity. The model suggested that this would start to appear after about 10 months.

The model would be made available to participants to enable them to make changes to the model with respect to providers' capacity levels to see how it would affect the flow of service users through the pathway.

#### **4.2.8. Participants' actual outcomes and their feedback on the workshop**

At the end of the workshop, participants were thanked for attending and asked to express their actual outcomes from the workshop. Participants' actual outcomes from the workshop are presented below:

- Better understanding of the model
- Saw opportunities for modelling
- Have a model that is representative of the HTLAH service and can model different provider capacity scenarios.

The participants were also asked to complete a questionnaire stating in a scale of 1 to 5 whether they agreed or disagreed with a number of statements about the workshops'

communication, commitment, consensus and usefulness. Four participants completed the questionnaire. The results of the questionnaires are presented below:

<b>Communication</b>	<b>Average Score</b> 1 = Strongly Disagree 5 = Strongly Agree
1. The workshop provided me with an improved understanding of the HTLAH service	3.50
2. The model helped me gain a better understanding of the HTLAH service	4.00
3. There was open communication in the workshop sessions	4.25
4. I understood the model findings	4.50
5. I understood the opinions of others	4.50
6. The session leaders paid attention to my ideas and opinions	4.50
<b>Commitment</b>	
7. I was personally willing to involve myself in the interactive sessions	4.25
8. I had ample opportunity to participate in the workshop sessions	4.50
9. The topics discussed at the workshop are of importance to me	4.00
10. Providing a timely service is important to me	4.25
11. I identified activities that I could change as part of my day-to-day job	2.67
<b>Consensus</b>	
12. An integration of opinions was reached in the workshop sessions	4.25
13. The workshop sessions built a shared vision	4.00
14. Consensus about the next actions to be taken was reached as a result of the workshops	4.00
15. I agree with the conclusions reached	4.33
<b>Workshop usefulness</b>	
16. The workshops had a clear focus	4.25
17. All in all, I found the workshops useful	4.00
18. The model gave me a different perspective of the HTLAH service.	3.50

**17. What did you learn from the discussions in the workshops?**

- *That this approach would have been useful at the start of planning for the service.*

**18. In your opinion, what do you think should be the next steps/changes to be taken within HTLAH and explain why do you think this is important?**

1. *Not applicable to my role.*

**4.2.9. Reflections on the project leads workshop**

The discussion during the workshop was lively with all participants making contributions and engagement with the model was high. The participants focused their discussion around the model and its ability to show different outcomes from changing variables. The opportunities presented by the model in terms of business continuity featured prominently in the discussions as well as the service as a whole.

At the close of the workshops the participants generally thought that the sessions had been useful and that their expectations had been met. One participant mentioned that s/he appreciated the model's potential in addition to its immediate uses.

The results from the survey given at the end of workshop were generally very positive with respect to Workshop usefulness and Communication. In more detail, they all agreed that the workshops had a clear focus; the model helped them gain a better understanding of the HTLAH service; they understood the model findings as well as the opinions of others; and the session leaders paid attention to participants' ideas. One participant stated that the workshops did not provided him/her with an improved understanding of the HTLAH service and the model did not give him/her a different perspective of the service. As a result, s/he remained undecided on whether the workshop was useful for him/her. However, it should be mentioned that this participant did not attend workshop 1 and his/her involvement in the HTLAH service was rather limited.

In terms of participants' commitment, almost all agreed that they were willing to involve themselves in the sessions, the topics discussed at the workshops were of importance to them but they did not identify any activities that they could change as part of their day-to-day job.

Finally, all participants agreed with the conclusions reached from the workshops and that an integration of opinions was reached in the workshop sessions. However, one participant was not sure whether a consensus about the next actions to be taken was reached as a result of the workshop.

#### **4.2.10. Conclusions**

The concept of using a computer simulation of a patient pathway in order to stimulate discussion on and test the model set out in the business case was effective. It would have been useful if the same participants attended both workshops, to ensure continuity of the discussions between the two workshops. It would have been more productive if more participants were present at the workshop, covering the contract management side of the service as well as the front office part of the service. The discussion in this workshop revolved around testing the ability of HTLAH Service to cater for service users in case of provider failure and the representation of the pathway in the simulated model.

Actions were identified which could further refine the model and make it even more useful as an ongoing tool for the HTLAH service to use when planning changes in the future. Participants demonstrated a shared understanding of the entire pathway, despite most participants only being involved in the back office part of the service. Therefore, it can be concluded that, in this case, using a computer model of a patient pathway as a vehicle for testing business continuity arrangements as well as improvement, change and development has been successful.

## **4.3. The Service Users' Perspective**

### **4.3.1 Introduction**

Due to the nature of the HTLAH service, which supports elderly people with varying levels of need, it proved to be problematic for the service lead to identify service users that would agree to attend a workshop. This made it difficult for the project to engage with service users and gather experiences of the service as envisioned. It became clear that alternative methods to acquire user experience would be required, such as home visits. Hence home visits were scheduled to gain a full overview of the service users' opinions and experiences. The service lead and Healthwatch team undertook to organise the home visits over a period of two days where service users could share their experiences. The new service lead that started in the post on the 1 April 2017, organised and scheduled these visits.

### **4.3.2 Home visits and metrics identified to measure service users' satisfaction with the service**

Eight service users in two different areas of Leicestershire (four in North West Leicestershire and four in Charnwood) were identified as potential users that could be interviewed as part of the home visits. These service users were all receiving support from either Precious Hope or from Caring Hands, care providers commissioned by Leicestershire County Council. Consent for the home visit was obtained by phone via the service lead on behalf of the Adult Social Care department. This included the service users' consent for Healthwatch to visit their homes.

Six out of the eight service users identified responded to our request. We did not get a response from two of the users (one from North West Leicestershire and one from Charnwood) that had a home visit arranged. (Due to time constraints, we were not able to follow up as to the reasons for this). Healthwatch Leicestershire and a member of the service team visited the remaining six service users in their homes on Friday 21 April and Tuesday 25 April 2017 to gather feedback about the service they were currently using or about the service they had recently used.

On average, approximately 40 minutes to an hour was spent at the service users' homes discussing various aspects of their care. A set of questions along with using the Leicestershire County Council 'I Statements' for the integrated health and social care outcomes was developed. See Appendix 1 for the full list of questions.

Below is a summary of the questions and a summary of responses that were asked and gathered from visiting and listening to service users in their homes.

#### Do you know the name of your Home Care Provider?

All 6 service users remembered or partly remembered the name of their care provider.

Before your care support started did staff from Caring Hands explain your care was to support you to live as independently as possible?

The home visits found that the providers, in general had explained to the person or their carer, about the support that had been put in place. In many cases, service users mentioned that their family member (son or daughter) normally handles the information exchange between the provider on their behalf. In some cases, users were on heavy doses of medication, for example Morphine, around the same time that providers explained their package of care.

Was the meaning of reablement/maintenance fully explained to you at the start of your care support?

In general, users were not familiar with the terminology of reablement and maintenance. There was an understanding of the 4/6 weeks' free care when leaving hospital, which once explained, they understood this to be reablement.

- “Didn’t understand what they were saying. It went straight over my head”.
- “No one talked to me about the blue folder (care plan folder)”.
- “They explained to my daughter”.

How well has your care support enabled you to live independently? Does your carer support you to do tasks as independently as possible?

From the perspective of the users that we spoke to, we found that the support of the provider alone, did not enable them to live independently. Users told us that they could not manage without the support of providers and family members. In the case where no maintenance was required, the service user was very strong willed and would often do things before the carer arrived.

The carer support did try to encourage the user to be independent, at times, but this varied dramatically depending on how mobile the cared for person was or how confident the carer is. For example, there were three users that had the desire to want to achieve moving around the house independently and that were physically able to do so. However, there were three other users that physically could not manage assert themselves in anyway.

We learnt that there were a range of packages provided to service users, including packages that allowed for care staff to visit services users at home twice a day. For example, there were two users that were helped onto their sofa in the mornings and who then remained there for the rest of day, as well as users that could answer the front door unassisted. It is worth mentioning that the mental attitude of users varied enormously. Some were very

positive, either about making a recovery or about living life in general, others were less optimistic.

Are your carers arriving at your home at a time that is/ was suitable for you?

Initially, service users responded positively to this question and seemed happy with the allotted times. However, as we got further into the conversation, some (four) users would have preferred a slightly earlier morning visit and less time between the morning and afternoon visit. Also, the last visit in some cases could be as late as 10.30pm which for some (at least three) was too late.

Timings of the visits were very sporadic, for example, a 9am – 10am calling slot could have carers attending as early as 8.30 am and as late as 10.30am. Users that were more independent tended to get on with their day in terms of having breakfast, instead of waiting for the carer to arrive. The less mobile user, would have little choice but to wait. This had major knock on effects such as changing a colostomy bag.

In all cases, users mentioned that timings of the care staff would vary outside of the parameters, and that they were told it would be looked in to by the providers.

Have you noticed any changes in your service since November 2016?

One user had moved from one care provider (My Life) to another provider (Precious Hope). It was at this point the person being cared for realised that many of the carers that visited her spoke 'broken English'. We were told that it took a bit of time to be able to communicate in an effective way. This effected the 'small talk' that service users often like to have with visitors in order to help their day go quicker. The quality of the care was not directly affected by this but their experience is.

What did you find good about the care support you are/ were having?

Users mentioned that it was the little things that made the difference. For example, plugging in a charger for a mobile phone. It was difficult for service users to articulate and explain what they thought was good about the support received, although in general the service users were happy with the care they received.

How could the quality of your care support be/have been improved?

A common theme that emerges is the arrival times of carers for their visits.

A user was told that their number of visits per day would be slowly reduced. However, this was reduced/ stopped without proper communication, leaving the user expecting a call. Communication could definitely be developed further to better inform the family.

Hygiene was mentioned as something that needed to be improved. A user mentioned that the carer would wear gloves to empty his colostomy bag, but then make him a drink and carry the mug whilst wearing the same gloves. The service user is very uncomfortable with practice.

A user commented that once when it snowed, the provider called them by phone and notified them that they would not be visiting that day. The service user had to call a family member to help her with day to day routines.

### **4.3.3 Conclusions**

There were some reoccurring trends during the home visits, which were:

- inconsistent arrival times of care staff – users commented that care staff would arrive at various times outside of the agreed plan.
- lack of continuity of care of care staff – users commented that it would be better to have the same carers on set days so that a relationship can be built.
- communicating key information with the cared for person – users often commented that they were not sure about certain things surrounding their care as this was something that their main carer (son or daughter) took care of. For example, receiving important information from providers or financial information.

From the qualitative feedback and analysis of emerging themes, there are some clear issues that need to be addressed regarding packages of care to be more responsive to the needs of the service user.

### **4.3.4 Reflections on the service users' input in the evaluation**

As explained above, service users' engagement through the medium of workshops proved to be infeasible for this project, hence home visits were organised in order to obtain their views and opinions about the service. The identification of service users suitable for this study took more time than anticipated and caused delays in the project. Obtaining consent and securing engagement again proved to be problematic with the cohort of service users for this study. We were able to gain insights from 6 of the 8 service users identified and they have provided rich insights into their experience of the care service they receive as part of the HTLAH programme.

# Appendices

## Appendix 1 – Initial and Final Process Map of the HTLAH Project

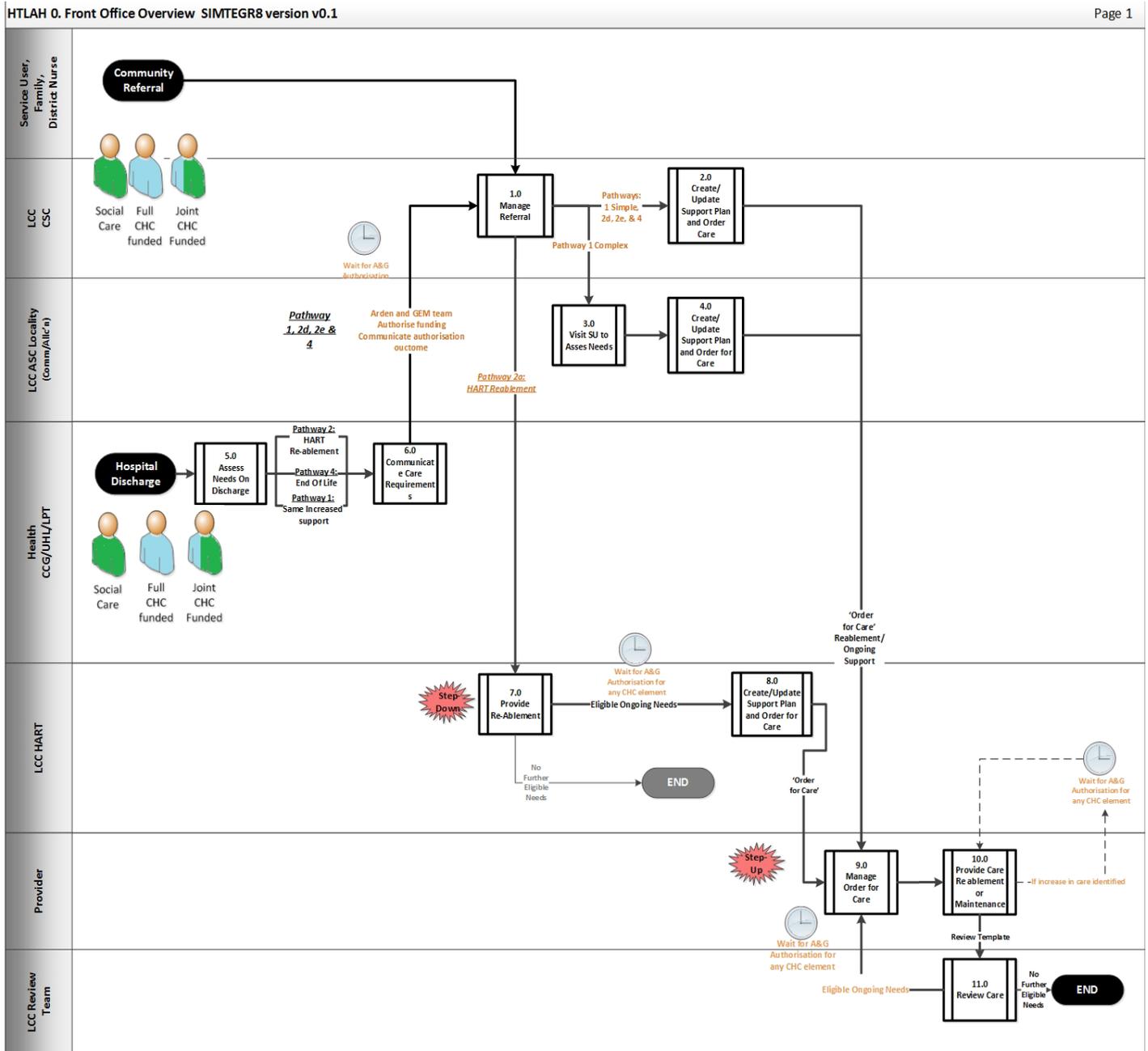


Figure 1. The draft process map showed to the participants at the beginning of the workshop.

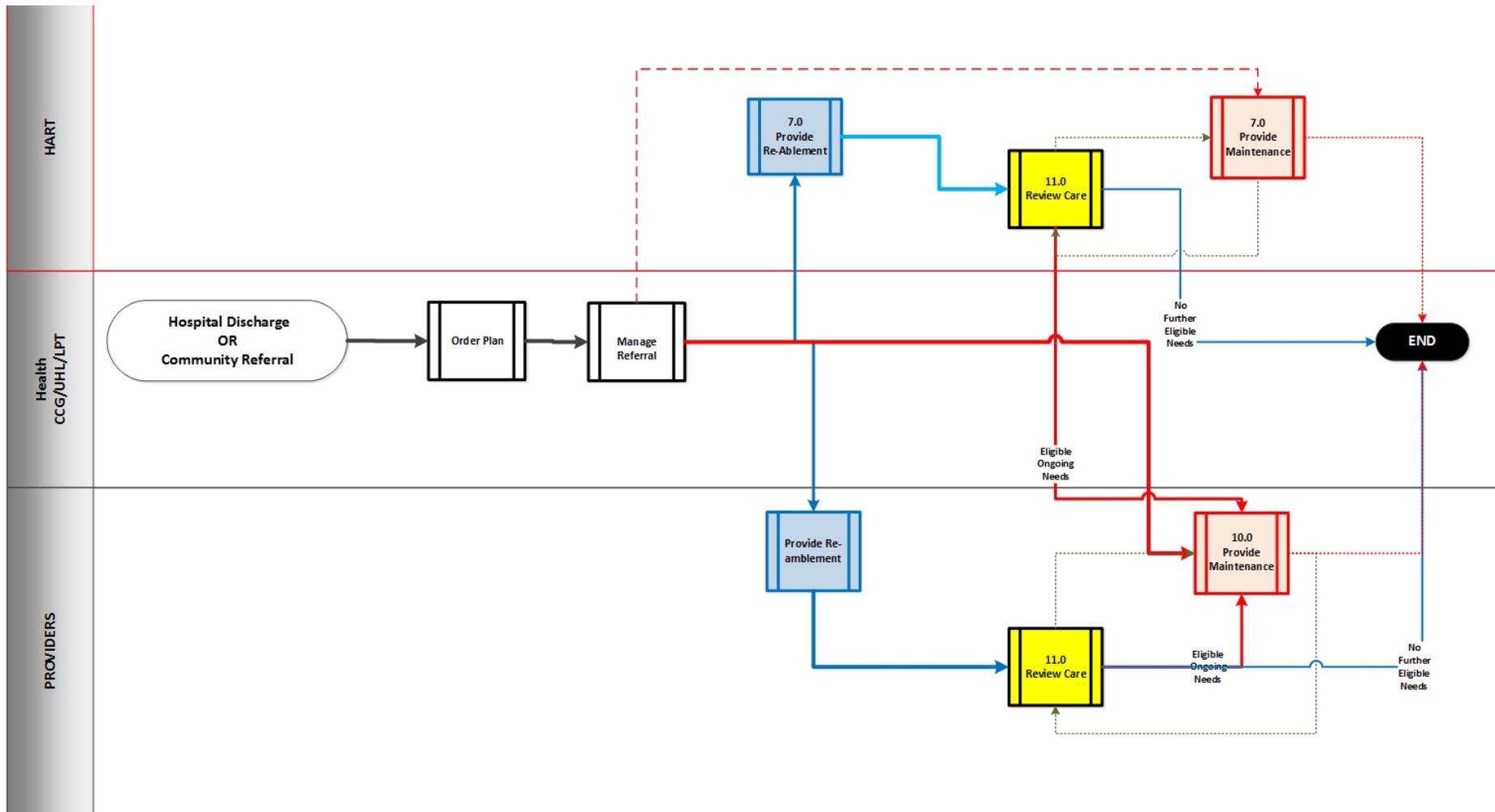


Figure 2. The final agreed process map.

## Appendix 2 – Questions for HTLAH Visits to Service Users who have had a Reablement Package of Care

### Questions about your Care and Home Care Provider

<b>1.</b>	How long have you been receiving a home care service?						
Response							
<b>2.</b>	Do you know the name of your Home Care Provider? (Caring Hands/Precious Hope)						
Response							
<b>3.</b>	Have you noticed any changes in your service since November 2016? (if applicable)						
Response							
<b>4.</b>	Before your care support started did staff from Caring Hands/Precious Hope explain your care was to support you to live as independently as possible?						
Response							
<b>4a.</b>	Was the meaning of reablement/maintenance fully explained to you at the start of your care support?						
Response							
<b>4b.</b>	Did you understand the information you were given?						
Response	Yes		No		Sometimes		Not Sure
<b>5.</b>	How well has your care support enabled you to live independently?						
Response							
<b>6.</b>	Does/Did your carer support you to do tasks as independently as possible?						
Response							
<b>7.</b>	Are/were your carers arriving at your home at a time that is/was suitable for you?						
Response	Yes		No		Sometimes		Not Sure

<b>8.</b>	What do/did you find good about the care support you are/were having?							
Response								
<b>9.</b>	Did/Do you find that each member of staff provides a consistent standard of care?							
Response	<table border="1"> <tr> <td>Yes</td> <td></td> <td>No</td> <td></td> <td>Sometimes</td> <td></td> <td>Not sure</td> </tr> </table>	Yes		No		Sometimes		Not sure
Yes		No		Sometimes		Not sure		
<b>10.</b>	Do/Did care staff show you respect and provide care in a dignified manner?							
Response	<table border="1"> <tr> <td>Yes</td> <td></td> <td>No</td> <td></td> <td>Sometimes</td> <td></td> <td>Not sure</td> </tr> </table>	Yes		No		Sometimes		Not sure
Yes		No		Sometimes		Not sure		
<b>11.</b>	How could the quality of your care support be/have been improved?							
Response								
<b>12.</b>	If you could make/could have made any other changes or improvements to the care support you receive/d, what would they be/have been?							
Response								

**Questions about the Local Authority and Health Authority**

<b>1.</b>	Were your options for paying for your care provision fully explained to you before you started receiving care?
Response	
<b>1a.</b>	Reablement? (where applicable) (the first six weeks?)
Response	
<b>1b.</b>	A Personal Budget?
Response	
<b>1c.</b>	A Managed Service?
Response	
<b>1d.</b>	A Direct Payment/Personal Health Care Budget?
Response	
<b>2.</b>	How long did you wait for Home Care to be available?
Response	