Qualitative evaluation of Focused Care
Final report
20 December 2019
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Director Version 2

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Summary

1. Focused Care emerged from grassroots general practice in Oldham over a period of eight years. It is a model of care developed in response to issues of clinical need and social complexity as they manifest in primary care in areas of deprivation.

2. In 2019 Focused Care was being delivered in seven localities of Greater Manchester (GM) through three different funding streams. GM Health and Social Care Partnership (GMHSCP) commissioned SQW, an independent research consultancy, to undertake a qualitative evaluation of Focused Care, focused specifically on the proof of concept programme financed by the GM Transformation Fund. The programme scaled up the Focused Care model from its original location in Oldham and ran from April 2018 to March 2020.

3. The evaluation used a mixed methods approach to explore the impact of introducing the Focused Care model into multiple new practices and areas of significant deprivation. Research included: interviews with Focused Care workers, GPs and stakeholders; focus groups with primary care and Focused Care workers; observations of Focused Care workers; and a review of documents.

4. Focused Care aims to support patients living in deprived communities and facing multiple interrelated clinical and social needs, to transition into more sustainable, less chaotic and healthier lives. The core components of the model are:
   - Senior and experienced Focused Care workers able to effectively support and work with a diverse set of complex patients
   - Provision of informal and formal training and support to Focused Care workers, which helps workers deal with complex cases
   - A set of core principles on referrals, the patient cohort and nature and duration of support, but with flexibility in operation, which allows application of professional judgement
   - Continuity of carer and care, which enables the development of the strong and positive relationship between the patient and their Focused Care worker that is fundamental to identifying the critical issues and implementing appropriate, effective co-produced solutions
   - Location of each Focused Care worker in a specific GP practice, to facilitate effective communication and information exchange between worker and GPs.

5. The evaluation found that Focused Care is widely considered to have generated tangible, significant outcomes for a range of chaotic/complex patients, particularly in terms of supporting them with mental health issues. Where outcomes were reported but not (fully) achieved or sustained, this was attributed to the chaos/complexity of the patients and the severe challenges of deprivation. The belief in the effectiveness and additionality of the Focused Care model for patients was extensive among patients, GPs and Focused Care workers. Outcomes were reported to be generated through a holistic approach to understanding a patient’s multiple, inter-linked needs and addressing them in a holistic way.
6. The Focused Care model is reported to have generated value for primary care in terms of reduced inappropriate appointments, the preventative value of improved physical and mental health for patients, and fewer DNAs; although there are also reports of increased demands on primary care through increased appropriate appointments such as for vaccinations and health checks. There are limited reports of the impact of the model at a system level, for example in reducing inappropriate attendances at A&E. However, support from Focused Care is reported to typically help a patient transition from accessing unplanned care to planned care, which should translate to a saving for the system. The quantitative evaluation may be able to provide quantification of these impacts.

7. Limitations and challenges identified regarding the Focused Care model included:
   - Evidencing and attributing impact with limited quantitative data
   - Reliance on short term and uncertain funding, which risks undermining collaborative relationships and the loss of key staff and their local knowledge
   - Integration between Focused Care as a primary care located service with other community organisations and within the social prescribing landscape
   - Reliance on (and interdependencies with) other services struggling with demand and limited resources such as social care, mental health services and employment support, to help patients address specific issues
   - The extent to which Focused Care can consistently and effectively influence strategic decisions.

8. The latter two issues are particularly important: the aim of Focused Care to ‘make the invisible patients visible’ should apply both at an individual level and a strategic level. The depth of engagement that Focused Care workers have with their patients offers potential for the programme to be a credible advocate for complex/chaotic people in areas of severe deprivation in Greater Manchester.

9. Current economic and social circumstances mean there is an increasing cohort of people living in chaotic and complex situations, with constrained public finances limiting capacity of services to meet demand. Focused Care has a particular offer for a particular cohort, which qualitative evidence indicates is effective and additional. Commissioners and others should therefore consider where Focused Care can add most value alongside other approaches. This is likely to involve careful consideration of levels of deprivation and the probable size of the Focused Care cohort. Crucially, Focused Care needs to be able to quantify the value of outcomes and demonstrate cost effectiveness, although funding may be justified on grounds of equity as well as overall reduction in service demand.
1. Introduction

Introduction to Focused Care

1.1 Focused Care emerged from grassroots general practice in Oldham over a period of eight years. It is a model of care developed in response to issues of clinical need and social complexity as they manifest in primary care in areas of deprivation.

1.2 At the time of writing, Focused Care was being delivered in seven localities of Greater Manchester (GM) through three different funding streams: the Greater Manchester Health and Social Care Partnership (GMHSCP) Transformation Fund; Oldham Cares, a partnership between Oldham Council, the NHS and the community and voluntary sector; and Heywood, Middleton and Rochdale Clinical Commissioning Group (HMR CCG). Figure 1-1 shows the coverage of each locality in terms of the number of Focused Care practices and Focused Care workers, shown against the level of deprivation across Greater Manchester. This evaluation concentrated on the Transformation Fund two-year proof of concept programme, covering April 2018 to March 2020, which scaled up the Focused Care model.

Figure 1-1: Overview of Focused Care localities and deprivation levels across GM

Source: SQW from GMHSCP documentation
Each practice receives a minimum of 0.4 FTE of Focused Care worker time.
Tameside district contains 19 LSOAs within High Peak, encompassing practices in Glossop which are outside of GM districts but within the commissioning area.
1.3 Focused Care contributes to the GM Population Health Plan and the GM Person and Community Centred Approaches programme (including social prescribing) and supporting complex people¹ and households. People with complex needs do not always fit easily into medical categories of care but are a population that have poor health outcomes in terms of life expectancy, morbidity and premature onset of multiple chronic conditions. Patients² in this cohort often engage poorly with services such as outpatient care or follow up appointments. The Focused Care model was designed to offer more flexible and holistic support to complex patients to better meet their needs and, in doing so, reduce pressures on primary care.

Introduction to the qualitative evaluation

1.4 In April 2019 GMHSCP commissioned SQW, an independent research consultancy, to undertake a qualitative evaluation of the Focused Care programme across Greater Manchester, focused specifically on the Transformation Fund financed element. The evaluation used a mixed methods approach to explore the impact of introducing the Focused Care model into multiple new practices and areas of significant deprivation.

Evaluation aims

The aims of the qualitative evaluation were to:

- Describe the Focused Care approach – what it aimed to do, who it was targeted at, how it was provided, the resources used, and the infrastructure that supported it.
- Identify how Focused Care complemented and linked with other models of Person and Community Centred Approaches (including social prescribing) that were in place within the integrated place-based neighbourhood model in GM.
- Evaluate how the Focused Care approach was spread – the reach to the target population, the efficacy, extent of adoption, consistency of implementation and maintenance of the effects in individuals and settings over time.

1.5 A separate quantitative evaluation has been undertaken, supported by the GMCA Research Team. The report is due to be provided to GMHSCP in January 2020. The scope of the quantitative evaluation will be commensurate with the data available.

¹ This report sometimes describes Focused Care patients as complex or as having complex needs because many of them have multiple, interlinking social and/or medical needs. It should be noted that the term complex is not used in a strictly medical sense. Individuals receiving support from Focused Care can also be chaotic in terms of the way they engage with primary care and other services, for example not accepting advice and support, or disengaging even when they need medical care.

² Individuals receiving support from Focused Care are referred to as patients because the model is located within primary care.
Introduction to this report

1.6 This is the final report at the end of the qualitative evaluation of Focused Care, and follows an interim report prepared for review by key programme leads and GMHSCP representatives in August 2019.

1.7 This report has been prepared for review by the GM Population Health Programme Board, Focused Care CIC, and others familiar with the Focused Care model across Greater Manchester. It is not intended for publication or wider dissemination.

1.8 The report contains:

- The evaluation methodology, including details of the documents and data that have informed this report
- A description of the Focused Care approach including details of aims, cohorts, activities, roles, resourcing, supporting infrastructure and variations on the model
- Evidence on outcomes including who benefitted, how they benefitted and to what extent, and how the effects were sustained
- A discussion of how Focused Care complemented and linked with other models of Person and Community Centred Approaches in GM
- Reflections on the implications of the findings for Focused Care.

1.9 This is a qualitative evaluation based on interviews, focus groups and observations, as well as a systematic review of documents. Findings and conclusions should be considered in this light. At the time of writing, there was no quantitative data to consider alongside the qualitative evidence.
2. Evaluation methodology

2.1 This chapter of the report presents the evaluation methodology, including details of activities and analytical approaches undertaken.

Overview

2.2 The evaluation methodology followed a three-phase approach, involving inception and scoping, data collection, and analysis and reporting at two points. This is the final report, bringing together all the evidence collected, full analysis and conclusions.

Figure 2-1: Overview of evaluation methodology

2.3 This research was structured by the work packages set out in the evaluation specification:

- **Work package 1**: description of the Focused Care approach (what it aims to do, who it is targeted at, how it is provided, the resources used, and the infrastructure that supports it).

- **Work package 2**: identification of how Focused Care complements and links with other models of Person and Community Centred Approaches (including Social Prescribing) that are in place within the integrated place-based neighbourhood model in GM.

- **Work package 3**: evaluation of how the Focused Care approach is being spread – the reach to the target population, the efficacy, extent of adoption, the consistency of implementation and maintenance of the effects in individuals and settings over time.
Data collection

2.4 Data collection activities included:

- **Consultations**: at scoping and then during the interim and final phases of fieldwork. Semi-structured consultations were undertaken with patients, GPs, Focused Care workers, members of Focused Care Community Interest Company (CIC), commissioners and staff from social prescribing schemes across GM, and strategic stakeholders. GP interviews were conducted at practices located in Bolton, Manchester, Oldham and Rochdale. The practices were randomly selected in conjunction with GMHSCP. Other consultees were identified by GMHSCP, Focused Care CIC or Focused Care workers.

- **Focus groups**: three focus groups were undertaken with primary care, one in Stockport and two in Manchester. Three only had GPs in attendance; in the fourth, a variety of practice staff attended. One of the primary care focus groups had only one attendee. One focus group was conducted with eight Focused Care workers from across Bolton, Manchester, Oldham, Rochdale and Tameside & Glossop.

- **Observations**: Focused Care workers were shadowed by a researcher for a day at two practices, one in Manchester and one in Oldham.

- **Document review**: a number of documents were systematically reviewed, listed in Annex C.

2.5 The numbers of individuals interviewed as part of the data collection process are presented in Table 2-1 below.

<table>
<thead>
<tr>
<th>Fieldwork type</th>
<th>Completed for interim report</th>
<th>Completed for final report</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focused Care worker interviews</td>
<td>6</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Focused Care worker focus groups</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>(8 attendees)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focused Care worker observation days</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>GP interviews</td>
<td>4</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Practice focus groups</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>(16 attendees, 2 attendees)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key stakeholder interviews</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Patient interviews</td>
<td>-</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Social prescribing commissioner interviews</td>
<td>-</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Social prescribing manager/staff interviews</td>
<td>-</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total interviews</strong></td>
<td>-</td>
<td>-</td>
<td>31</td>
</tr>
<tr>
<td><strong>Total focus groups</strong></td>
<td>-</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total observations</strong></td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
</tbody>
</table>

*Source: SQW*
The fieldwork covered all localities. The total number of interviews/participants for each locality was: 12 in Oldham, 5 in Rochdale, 50 in Manchester (due to high attendance at a focus group), 4 in Bolton, 3 in Tameside & Glossop, 3 in Stockport, and 1 in Salford.  

Analysis and reporting

The evaluation developed a Theory of Change (ToC) to describe how the Focused Care model was expected to function, from the inputs provided and the activities undertaken, to the generation of outputs and subsequently outcomes and impacts, including the context in which the programme was operating.

The ToC was supplemented with the use of the TIDieR checklist (see Table 3-1), describing the model under the following categories: why, what (materials), what (procedure), who provided, how, where, when and how much, tailoring, how well (planned and actual), context and voice. These items were used to structure an analysis of the Focused Care model based on the evaluation evidence collected.

The Re-Aim framework, which covers reach, efficacy, adoption, implementation and maintenance, informed the analysis of how the Focused Care model operated and the outcomes it generated.

Key considerations

GMHSCP commissioned separate qualitative and quantitative evaluations of Focused Care due to data availability and time constraints. This report presents findings and conclusions from the qualitative evaluation. As described above, data collection included interviews, focus groups, observations and a review of documents. The research encompassed the views and experiences of a range of groups and individuals, spread across all the Focused Care localities, and there was some rigour in identifying which practices to approach for interviewees. However, with the exception of the process for selecting GP practices for focus groups, consultees were proposed to the evaluation rather than being randomly sampled. All participants took part on a voluntary basis. For these reasons, some points of view may not be reflected in the evaluation.

Focused Care has been established in different localities for differing lengths of time. This may affect stakeholder experiences and perceptions of the model. All localities were covered by the fieldwork but the numbers of interviews and focus groups were not equal across localities (see 2.6).

The evaluation plan did not originally include patient interviews. These were added to the fieldwork after completion of the interim report and at the request of GMHSCP. For this reason, only six patients were recruited from a single practice in Oldham. Both the practice and the patients were proposed to the evaluators rather than selected as part of a sampling

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1 The number of interviews listed here by locality is slightly lower than in the table above as the majority of stakeholder interviews are not assigned to a locality and a small number of interviewees were interviewed twice.

4 The Invitation to Quote requested the use of the TIDieR framework. For more detail see BMJ 2014;348:g1687 at https://www.bmj.com/content/348/bmj.g1687.

5 The Invitation to Quote requested the use of the Re-Aim framework. For more detail see http://www.re-aim.org/about/.
strategy. Their experience is important in illustrating the real-world application of the Focused Care approach, but cannot be taken as representative of patient experience of Focused Care across GM.

2.13 The report considers how Focused Care fits into the landscape of Person and Community Centred Approaches (PCCA) but the evaluation scope did not include a detailed review of the GM social prescribing landscape, and the report does not seek to compare Focused Care against other PCCA models.

2.14 At the time of writing, there were no quantitative data on the scale, frequency and duration of outputs and outcomes to consider alongside the qualitative evidence.
3. The Focused Care model

3.1 This chapter describes the Focused Care model as it was designed and how it operates across localities. A detailed Theory of Change (ToC) of the Focused Care programme was developed during the scoping phase of the evaluation. The ToC maps out how the programme is expected to operate and the outcomes it is expected to generate. Alongside the step-by-step logic of how change is intended to be realised, it outlines the context in which the programme exists and the rationale for introducing the Focused Care model.

3.2 This section draws on the ToC and the TIDieR framework to understand the key elements of the Focused Care model, as well as any variations and the reasons, the value of different elements, and risks and challenges to the model.

The key elements of the model

3.3 Table 3-1 below depicts the key elements of the model, structured according to the TIDieR framework.

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6. The full ToC was contained in the interim report and is presented in Annex D.
Table 3-1: Key elements of Focused Care according to TIDieR framework

<table>
<thead>
<tr>
<th>TIDieR item</th>
<th>Brief description</th>
<th>Focused Care</th>
</tr>
</thead>
</table>
| Why         | Rationale, theory, or goal of the approach. This will include a 'logic model' which will also include detail of 'how' (see below) | - Some patients present to GPs with clinical symptoms alongside complex, multiple non-medical needs e.g. housing, relationships, employment.  
- GPs often unable to help with non-medical needs and consequently may then have limited ability to address clinical symptoms, leading to poor outcomes for patients, dissatisfaction for GPs, and inefficient use of GP time.  
- Other services are not picking up and supporting these patients.  
- The Focused Care model aims to:  
  ➢ address patients’ non-medical needs that are inter-related with their clinical symptoms  
  ➢ consider household and contextual factors rather than just the individual  
  ➢ undertake holistic, asset/strength based assessment to support sustainability of solutions  
  ➢ use specifically recruited Focused Care workers with the skills, experience and training to build relationships and work with patients to resolve complex situations. |
| What (materials) | Physical or informational materials used, and where they can be accessed. | A range of materials describe the model and how it is intended to be implemented. Please see Annex C: for details. |
| What (procedure) | Procedures, activities, and/or processes used in the approach, including any enabling or support activities. | One-to-one initial assessment following referral, to explore the patient's needs and assets, with follow up discussion to agree immediate priorities for focus. Review of GP records to inform decision making and support.  
The Focused Care worker is expected to take a patient-led approach whilst offering the patient appropriate challenge. A conversation about the patient’s needs, strengths, and goals outside of the usual formal, clinically focused consultation is intended to help build trust, empowers patients and helps them learn to self-manage and increase their resilience.  
The Focused Care worker provides support directly where appropriate or accompanies/labels patients to external support. Insights are shared via practice meetings and notes uploaded into EMIS and for Focused Care monitoring purposes. Focused Care workers on occasion set up community-based provision where gaps in services are identified. Significant events are reported to the Focused Care Board, and fed up strategically to the GM Population Health Board. |
| Who provided | Background, expertise of providers, and training given. To include details of workforce composition, size, background etc. | 0.4 FTE Focused Care practitioner allocated to each practice. 17 Focused Care workers currently in 29 practices funded by Transformation Fund monies, 18 practices with 8.5 FTE workers funded by HMR CCG and 10 practices with 9 (3 FTE, 6 PTE) workers funded by Oldham Cares.  
Range of backgrounds from social care, health care, criminal justice and community work.  
Workers graded at Band 6. |
<table>
<thead>
<tr>
<th>TIDieR item</th>
<th>Brief description</th>
<th>Focused Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>How</td>
<td>Modes of delivery, delivered to group or individual.</td>
<td>Training provided by Focused Care CIC. Initial two-week programme followed by buddying, shadowing, annual blue-stream CPD training and annual training from Focused Care CIC.</td>
</tr>
<tr>
<td></td>
<td>Patient referral from primary care / other services or self-referral.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-hour initial visit by the Focused Care worker (usually at patient’s home) where HNA conducted (assessment sheet with 5 categories).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient considered within context of their household.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient provided with action plan or leaves the service due to not requiring/being eligible for support.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cases taken to MDTs at practice including Focused Care worker and GPs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Care plans recorded on EMIS.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Further visits/appointments/calls to offer direct support to patient and coordinate the response to patient needs with other services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appropriate signposting/referrals to other services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Advocating with other statutory services for patients.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medication reviews.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minimum 3 month follow ups (depending on patient need).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient discharged, possibly to social prescribing.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monitoring through spreadsheet to record household and individual, good news, significant events.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data collection at start then quarterly.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>50 households assessed per 0.4 FTE worker per year.</td>
<td></td>
</tr>
<tr>
<td>Where</td>
<td>Type of location.</td>
<td>Varies according to patient need and worker judgement. May use space in GP practice, visit the patient at home or accompany them to appointments with other services.</td>
</tr>
<tr>
<td>When and How Much</td>
<td>Number of times, number of sessions, intensity and over what time period delivered.</td>
<td>Varies according to patient need and worker judgement and capacity. Patients typically receive support for six to nine months but there is limited consistency on the number, duration or frequency of support sessions provided.</td>
</tr>
<tr>
<td>Tailoring</td>
<td>What, why, when, and how of planned personalisation/adaptation.</td>
<td>Model is based on the principle of personalisation. The Focused Care worker flexes the duration, intensity and nature of the support according to the patient.</td>
</tr>
</tbody>
</table>
| How well (planned and actual) and context | Describe how and by whom fidelity to the approach was planned and assessed in practice. How did context affect the implementation? | Model originally designed by Hope Citadel CIC in Oldham. Further evolved by Focused Care CIC. Focused Care CIC provides training and supervision to workers to increase skills and monitor the quality of delivery. Implementation across areas and practices varies due to:  
  - extent of deprivation among the practice population (i.e. numbers of patients living in severe deprivation) |
## TIDieR item

<table>
<thead>
<tr>
<th>Brief description</th>
<th>Focused Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- capacity within other statutory services to meet patient needs</td>
</tr>
<tr>
<td></td>
<td>- the availability of other statutory/voluntary/community services to offer complementary or subsequent support</td>
</tr>
<tr>
<td></td>
<td>engagement and capacity of the patient’s GP.</td>
</tr>
</tbody>
</table>

### Voice

Who had input into this description, and to what extent are there different perspectives?

Evidence provided to complete this checklist included documentary evidence from GMHSCP and Focused Care CIC, interviews with commissioners, Focused Care CIC staff, Focused Care workers and GPs, focus groups with GPs and Focused Care workers and shadowing of Focused Care practitioners.

*Source: SQW*
Rationale

3.4 The Focused Care Project Implementation Plan of May 2017 described the rationale of Focused Care as trying to unpick complex situations, problems or needs, make the ‘invisible patients the most visible’, and support patients to transition into more sustainable, less chaotic and healthier lives by providing additional capacity and an alternative approach that would work more effectively than existing services. The model originated from primary care and remains located there, on the basis that target patients usually present to their GP (at some point), and primary care is the best place to jointly address interrelated clinical and social needs. Stakeholders and Focused Care workers broadly concurred with this rationale and expanded on it. Specifically, stakeholders report that the model seeks to:

- Engage with ‘hard to reach’ patients and improve access to services for patients with complex, interlinked social and medical needs
- Support patients to maintain a good quality of life following discharge from Focused Care, by equipping patients with the confidence and skills to manage a healthy lifestyle
- Improve health outcomes in areas of deprivation, through tackling social issues to increase life chances and opportunities for the most ‘disenfranchised’ in the community
- Alleviate pressure on primary care as well as urgent and emergency care and crisis response services, through reducing missed appointments and A&E attendances, leading to reduced cost to the healthcare system.

3.5 There were no significant differences evident in the understanding of the rationale or the aims of the programme across the localities or among different stakeholder groups.

Approach

3.6 The Focused Care approach is based on deployment of a skilled, experienced worker to work flexibly and holistically with patients, one-to-one, to address their specific needs. The unit of focus is the household rather than the individual, to ensure that all circumstances are considered and addressed, and to boost the sustainability of the solutions. Support is offered by the same worker throughout the patient’s time in the programme in order to build a trusting, positive relationship between the patient and the worker. This relationship, in conjunction with appropriate, meaningful challenge from the worker, is intended to help the patient work constructively with the Focused Care worker, and learn to self-manage and increase their resilience.

3.7 The personalised, patient-led approach meant a significant degree of variation in the duration, intensity and nature of the support was always anticipated. Research with a range of Focused Care workers indicated that they are applying the same fundamental principles and, in doing so, there was natural variation in the support provided.
Some patients go on the backburner, some are not ready to close but we don’t see them in a while. It's more about how often you see them. You might have them for 6 months but only see them once a month. You might see others once every week/fortnight.’ Focused Care worker

‘The approach gives us time to explore and do what [the patient] want[s].’
Focused Care worker

Staff

3.8 The Focused Care model is designed around skilled, experienced workers who are sufficiently senior and well-trained to handle the range and seriousness of issues and needs that patients have. The importance of this was underscored by both Focused Care workers and GPs. These interviewees talked about how the experience and seniority of Focused Care workers enables them to support patients with complex needs, including accessing patients who are hard to reach, negotiating and advocating on behalf of these patients, and the ability to ‘think on [their] feet’. Focused Care workers highlighted that their experience of working with this cohort allows them to recognise the ‘alarm bells’, such as indications of more serious issues, which less experienced workers may not identify and consequently not be able to tackle. GPs stated that previous experience was a key asset, as it supports the worker to have the right conversation with a patient and gives them the knowledge and the confidence to be able to challenge patients appropriately.

3.9 Some examples of the previous roles and experience of Focused Care workers include:

- A probation officer specialising in domestic violence support
- A support worker with experience in employment support, community development and youth work
- Adult social care, supporting those with dementia and adults with learning difficulties
- Working with people experiencing homelessness and substance misuse in the voluntary and community sector.

Training and support

3.10 To build on their previous experience, Focused Care workers undertake tailored training, which involves a two-week training programme to prepare workers with the tools and knowledge to undertake their roles effectively. The training includes sessions on systems, lone working, safeguarding and personal resilience, in addition to knowledge sessions on an array of topics. New recruits also ‘buddy up’ and shadow experienced workers to gain understanding of how the programme works in practice. Focused Care workers undertake annual blue stream CPD training (e-learning modules undertaken by healthcare professionals) and attend annual training days facilitated by Focused Care CIC.

3.11 All workers are assigned to a ‘hub’, which involves Focused Care workers who are members of a particular hub coming together for face to face meetings on a quarterly basis. There are three hubs:
Rochdale: covering 18 Focused Care workers
Manchester: covering 11 Focused Care workers
Oldham Plus (which covers Oldham, Bolton, Salford, Stockport and Tameside & Glossop): covering 19 Focused Care workers.

3.12 Hub supervisors are a source of ongoing support for Focused Care workers through one to one supervision sessions, and act as the first port of call for advice for workers. They intervene if there are any issues, and they offer cover for urgent patients. Hub supervisors also undertake performance management responsibilities. The supervisors are senior Focused Care workers by virtue of length of service and their level of qualification at appointment. They receive additional training and support to undertake the role.

3.13 Clinical supervisors are healthcare professionals who are external to Focused Care, who offer Focused Care workers the opportunity to discuss patient issues in one-to-one clinical supervision sessions. These sessions are anonymous and nothing is fed back to Hub supervisors or Focused Care senior management unless there are general trends arising which the clinical supervisor thinks could be addressed, for example with training or extra support. Focused Care workers also have access to counselling sessions if they feel they need them, such as when a long-term patient has passed away.

3.14 The quarterly face to face hub meetings include a professional development component. This is often bespoke to the needs of the workers in that hub, who can request training sessions based on their caseload or identified gaps in their knowledge. Recent examples include training on personality disorders, benefits and housing law. Professionals are sometimes invited to give talks about their area of expertise. Local services are also invited to speak about their offer; an example includes small community organisations that a Focused Care worker has come across which they think could be beneficial for other workers to be aware of. This allows Focused Care workers to keep up to date with the opportunities available in the local area for their patients. Focused Care workers are also able to request to attend additional, external training if they are working with a patient with a specific need they are unfamiliar with or are starting to encounter regularly. Examples of training topics requested and received include hoarding and suicide risk.

3.15 Overall, Focused Care workers were content that the training they receive is appropriate, effective and suited to what they need. One Focused Care worker noted that support and training has improved over time.

3.16 In addition, Focused Care workers report benefitting from a strong peer support network, which is an integral part of the model. Due to their varied previous experience, Focused Care workers share knowledge with each other, and are often in contact to ask each other questions on particular topics of need. WhatsApp is used by workers to communicate with multiple colleagues on a regular basis.

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7 As at time of writing based on information from commissioners and FC CIC.
In comparison to other types of health, social and community roles, Focused Care workers operate relatively independently. Some workers noted that the supervision and practice support does not substitute for working as part of a team day-to-day, and one reported that they ‘miss being able to unload’.

Management and governance

Focused Care operates as a CIC, which was established in 2016. Focused Care is governed by a board of trustees who meet every six to eight weeks and oversee the ‘integrity and development’ of the Focused Care approach across Greater Manchester. GMHSCP, the Shared Health Foundation and Hope Citadel Healthcare CIC are all represented on the board of trustees. The trustees provide performance management information and qualitative updates to the GM Population Health Board on a quarterly basis. There are also informal channels of communication between the Focused Care Board and the Population Health Board because of shared interests and, to some extent, shared membership including, at the time of writing, the same chair.

Operational delivery of the model is managed by the Operational Group, who meet weekly to manage the day to day programme development, discuss and confirm training needs and take care of any issues arising. The Operational Group includes the Focused Care Director (who sits on the board of trustees), the Focused Care Manager, the Focused Care Programme and Interface Manager and the three Hub supervisors.

Figure 3-1: Governance and management structure

Prior to Focused Care CIC, Focused Care was delivered by Hope Citadel Healthcare, a CIC that also delivered primary care services in Oldham.

Shared Health Foundation is part of Oglesby Charitable Trust which concentrates on reducing inequalities in the North West and specifically in the GM region. The Foundation invested in Focused Care to support the formation of a stand-alone Focused Care CIC, and funded the supporting infrastructure, start-up and mobilisation of the early roll-out to the 24 practices who began operating the service in early 2017.
Evidence from Focused Care workers suggests that the governance structure is broadly effective for them, allowing them to learn from others and access support when required. Stakeholders reported that the governance structure promotes accountability through collation of good news stories and significant event reporting, which are fed back to the GM Population Health Board. For example, when GM moved to an online system of bidding for social housing, several Focused Care patients fell into difficulties through being unable to access the system. The significant event reporting fed this information back to the Population Health Board and, along with other evidence, helped to inform the provision of a number of public locations at which people could access the system.

**Resourcing**

In general, Focused Care workers are **assigned to a practice for two days a week**, with just over half\(^\text{11}\) working in two practices (0.8 full time equivalent, four days per week). Practices vary in list size but to date this has not changed the allocation of worker time. In general, the model of 0.4 FTE is reported to feel sensible to workers and GPs, although there was some feedback that additional capacity would enable more patients to be supported.

There are a few variations on the model according to the local context. In one area, the practice the Focused Care worker was based in merged into a wider medical group practice; the worker now works across three practices. Another Focused Care worker is based in a large medical practice incorporating fifteen surgeries in one building, and therefore works with patients from this practice for four days a week.

Some Focused Care workers have opted to work 0.4FTE, and work two days per week in one practice. The Hub supervisors have full time roles, which allows them to undertake the role of a Focused Care worker in a single practice and use the remaining time to support the workers in their team and other management duties.

Although Focused Care workers are employed through Focused Care CIC, GPs from across GM reported that they are considered **valuable and integral assets to a practice team**. Interviewees commented that many are involved in formal practice meetings, attend safeguarding meetings and have access to internal systems (e.g. EMIS), and some have one-to-one meetings with a designated GP to discuss patients. GPs suggest that the direct communication on an informal basis with their Focused Care worker is particularly important, enabled by having the worker’s base within the practice, which allows quick responses to issues arising regarding patients and urgent referrals to support patients in crisis. This is seen as a key benefit by Focused Care workers too, who noted that they can take concerns to the practice team and work closely with GPs to support high need and/or urgent cases.

**Administration duties**

Focused Care workers typically allocate time at the end of their working day to administrative duties; patient notes have to be added onto their medical records within 24 hours. This is undertaken at the practice, with many practices using software such as EMIS. However, concerns were raised by GPs that Focused Care workers are expected to duplicate what they

\(^{11}\) 16 of 31. Focused Care (2019) Focused Care Surgeries, accessed on 11/07/2019
record on medical notes as part of the monitoring process. Focused Care workers have to input data into a Focused Care spreadsheet to record outcomes. One GP expressed concern that this takes time away from their worker’s patient supporting role, and called for a solution to be found to provide automated data to Focused Care CIC to minimise duplication of recording.

**Process**

**Target cohort**

3.26 The Focused Care model employs the ‘failure to thrive’ concept, adapted from paediatric care. It is intended to allow for professional discretion regarding entry to and exit from the pathway and to support a delivery model that is flexible enough to address a wide range of needs. Whilst ‘failure to thrive’ was not a term that some GPs had heard used in the context of Focused Care, one GP affirmed that it was a good definition for the type of patients they would refer.

> *‘We refer when we are anxious about someone’s general wellbeing.’ GP*

3.27 Some Focused Care workers reported using eight domains (set out by Focused Care CIC) of which a patient should meet at least two to be eligible for Focused Care: parenting, relationships, finances, housing, managing health, accessing services, management plan and/or mental health. These domains were not intended to be treated as a set of criteria or a checklist by the CIC, but there were some cases in which the criteria appear to have been used to guide identification of patients. Some practices have treated the criteria flexibly, allowing a patient presenting with one criterion to be accepted on the basis that there are often underlying issues that are not clear from the outset (patients may not fully disclose all issues upfront).

3.28 Some practices were unaware of the list of domains and relied on the Focused Care worker to define their own remit in discussion with the practice team. It was noted by some that the only apparent criterion was that the patient was registered at the practice, although Focused Care workers in other areas were reported to be still working with patients who were no longer registered at their practice.

3.29 Despite the **variations between practices in identifying suitable patients**, there was an overarching consensus that the target cohort is **patients who live in areas of high deprivation and present with multiple and complex needs**. This covers a wide range of issues, including mental health, addiction, homelessness (or the risk of homelessness), financial issues, dementia, domestic violence and language barriers. Focused Care was also used for **hard to reach patients** who do not attend (DNA) GP appointments (one Focused Care worker noted an example where it once took them three weeks to make contact with a patient with multiple medical and social needs who was not attending appointments) and **frequent attenders at the practice and sometimes also in urgent care settings**. GPs particularly welcomed the ability of Focused Care to support frequent attenders and regular DNA patients, with some reporting that it has had a positive impact on the practice by raising
attendance at appropriate appointments by these patients, for example at chronic disease reviews.

3.30 The **target cohort is not restricted in terms of age**: Focused Care workers have worked with children through to the elderly. While the model is intended primarily to assist adults, treating the household as the unit of support allows Focused Care workers to access patients who live with the original referred patient. As a result, children may be supported if it turns out the adult is struggling to care for them properly. In some cases, the child may generate the initial referral, for example for poor school attendance (see below for sources of referrals), and this will lead to identifying adults within the household who need support.

3.31 Both Focused Care practitioners and GPs identified a tension between the value of being able to refer a broad spectrum of patients to Focused Care, and the potential usefulness of refining referral criteria to provide greater clarity on which patients are most appropriate for Focused Care support. There was no clear consensus regarding this although the ability to exercise professional judgement in identifying patients was widely valued.

**Referrals**

3.32 Anyone can refer a patient to Focused Care, although Focused Care workers noted that referrals predominantly come from GPs and practice nurses. However, other common sources of referrals are the practice administrative team, housing officers, substance misuse services and schools. There have also been instances of patients being referred to Focused Care by a family member or self-referring after hearing about the programme from other patients.

3.33 The process of referral varies by practice. Some practices use a referral form to refer a patient to Focused Care, which includes criteria to help ensure the patient is an appropriate referral. In other practices, notes are put against medical records on EMIS, or referrals verbally passed on to workers via other modes of communication such as a phone call or informal meeting.

3.34 Whilst some Focused Care workers maintain that the referrals they get are appropriate for the service, others report receiving what they describe as **inappropriate referrals**. According to Focused Care practitioners, referrals can be 'hit and miss' when the practice is not clear on the criteria for Focused Care, or if a GP is unfamiliar with the Focused Care programme, for instance locum GPs. Focused Care workers have received referrals for patients who they consider would have been better suited to a social prescribing service, and workers have rejected referrals for patients who just need someone to listen or want to go on 'day trips'. One GP reflected that they had previously referred patients who were too complex and were now re-thinking the referral criteria, particularly after the introduction of High Impact Primary Care (HIPC) in the locality, which GPs felt was a more appropriate approach for patients with physical and/or medical needs. Where referrals are found to be inappropriate, these are identified at initial assessment by the Focused Care worker and re-directed to a more appropriate source of support, for example social prescribing services.

3.35 Occasionally, GPs have referred ‘quick wins’ to Focused Care workers, as reported by both GPs and Focused Care workers. These are patients who may need a small amount of support, for example a supporting letter written or a referral to another service, and then can be discharged soon after. Whilst this still supports GPs by freeing up their time, some Focused
Care workers considered that this may not be the best use of their time. However, it was implied by one GP that these referrals help their Focused Care worker to access households that might have needs that can be met by other part of primary care or other services, for example childhood vaccinations, or households that may need Focused Care in future.

Any uncertainty and variation in referrals may reduce over time as practitioners become more familiar with the model. By way of illustrating the routes into Focused Care, of the patients interviewed as part of the evaluation, two were referred into Focused Care by a medical professional (one by a GP and one by a practice nurse), one patient was referred by their housing association, and another through a local youth centre. One patient self-referred themselves into Focused Care after hearing about it through a friend and having recently lost access to employment support.12

**First assessment**

Following a referral, the Focused Care worker will make an appointment with the patient (or patient household) to undertake a needs assessment. This is a holistic assessment, using a standard form developed by Focused Care CIC, which takes into account personal, mental, physical health, social and spiritual factors. This assessment provides a baseline for further assessments and is completed on a household basis (encompassing all people within the household). Prior to the initial meeting, the Focused Care worker will read the patient’s medical records, so they are aware of any medical conditions and recent activity, and can adequately prepare documentation for the visit by gathering relevant leaflets, GDPR information or specific information that could be useful based on referral notes.

First assessments are reported to be mainly undertaken through a home visit. Many Focused Care workers reported a preference for a home visit, instead of doing the initial assessment within the practice, as it is where the patient typically feels most comfortable. It may also highlight needs with which the patient did not initially present. Some patients may have specific issues with attending the practice, for example entrenched mistrust in the system, or conditions such as agoraphobia.

> Patients can present in an ordered fashion, but if you go into their houses it can be very different. Focused Care worker

However, one Focused Care worker stated that, with the agreement of their practice, they hold their first assessment at the practice. It was noted that this approach takes up less worker time than home visits, which frees the worker up to spend more time with other patients.

> Patients have to be motivated enough to get help to change, and if they are motivated they will attend a meeting in the practice. Focused Care worker

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12 One patient could not remember how they had been referred into Focused Care.
Following the first assessment, the Focused Care worker will discuss the key issues identified by medical records and the holistic assessment with the patient. They will then ask the patient which issues they think need to be tackled first. The **person-centred nature of the programme** means a patient will always be given the opportunity to decide which issues need to be focused on most urgently.

**Support delivered**

Focused Care workers support their patients in a wide range of ways. The support was described as **personalised, flexible and tailored**, reflecting the broad spectrum of patients typically comprising a worker’s caseload. Generally, support is delivered through home visits, which enables Focused Care workers to understand the day-to-day lives of their patients and allows them to build up trust.

While lone working was considered a potential risk for workers, it was noted that this had not caused any issues to date. If a Focused Care worker did consider a home visit to be a risk, it would be undertaken in partnership with another agency, for example the patient’s social worker or the police. Some Focused Care workers will also spend time with their patients within the practice, with some holding drop-in sessions for their patients, and others attending GP appointments with their patients.

> ‘[Activity is] very varied because it’s very personalised.’ GP

Usually home visits are made by appointment. Making an appointment reportedly ensures that a professional boundary is maintained between the Focused Care worker and the patient. However, for some patients that are particularly chaotic or difficult to track down, Focused Care workers may undertake unannounced visits, sometimes in conjunction with another service such as a social worker, as otherwise they may not see these patients at all.

On average, Focused Care workers reported seeing about three to four patients per day, although this varied depending on the type of activity undertaken. For example, if a patient has a court appearance the Focused Care worker may attend with them, which could take a whole day.

A key activity that Focused Care workers reported was **giving patients the opportunity to access services**. This could be through attending appointments with them, which a patient may otherwise not attend, perhaps due to lack of funds to get to the appointment, fear or mistrust of the service, or forgetting the appointment due to mental health issues. Workers also arrange for other services to visit the patient as needed, for example, asking a nurse to undertake a smear test at home when a patient has agoraphobia. Focused Care workers often advocate on behalf of their patients to improve the likelihood of support from services. In addition, Focused Care workers may signpost patients to community services, such as referring an elderly patient...
who is socially isolated to a befriending service, and then attending the first event with the patient to alleviate any fear. Focused Care workers report that they will not attend appointments or services with patients if they think the patient can attend on their own, and sometimes will just attend the first appointment, to encourage independence.

3.46 **Focused Care workers provide practical support to their patients** such as providing food bank vouchers or parcels, or organising cleaning services to prevent patients from 'living in squalor'. Usually, **these are tasks that other services don’t have the time to do or are not able to do**. For other tasks, such as filling in forms, there are services who can offer support for this but they typically have limited capacity and long waiting lists. Waiting for form completion services could affect benefit payments or household circumstances for patients, and therefore Focused Care workers support them with filling in forms.

3.47 **Emotional support** is also provided to patients by Focused Care workers. This includes listening to patients and spending time with them, which GPs are not resourced to do. Workers refer patients on for counselling when needed. However, there is a risk that the provision of emotional support could influence dependency: one Focused Care worker had a patient who referred to the worker as ‘my only friend’. To alleviate this risk, some Focused Care workers report referring patients to an array of support services where possible, to limit their dependency, increase their independence and control over their situation, and improve their ability to self-manage in the future.

3.48 Due to the intensive nature of the support given, Focused Care workers report being able to easily recognise where there are gaps in the system for patients, and some report trying to fill gaps by **establishing new, bespoke groups**, for example, gardening clubs for socially isolated men, and craft groups for women experiencing domestic violence. Focused Care workers also work together to provide services. Examples reported include some Focused Care workers supporting patients with hoarding problems and creating a support group for these patients across practices.

3.49 Focused Care workers report **working closely with other services**, with multi-agency working a key aspect of the support they deliver. Focused Care workers report attending safeguarding meetings for both children and adults and liaising closely with other agencies on behalf of their patients. Focused Care workers will also refer their patients to an array of community or voluntary services which they feel are appropriate for their patients. Focused Care workers noted that their networks were an invaluable tool for supporting their patients. Networks are built up over time through referrals, word of mouth, speakers at Hub meetings or proactive searching when a patient needs a specific type of support.
Patient examples

3.50 Evidence from patients highlights the variety and flexibility of support offered by Focused Care and the extent to which workers are able to support patients to access support from other services.

Table 3-2: Support to Focused Care patients

<table>
<thead>
<tr>
<th>#</th>
<th>Time in Focused Care</th>
<th>Support directly from Focused Care worker</th>
<th>Support received from Focused Care referrals/advocacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>&lt;6 months</td>
<td>Debt management</td>
<td>Support with anxiety (GP, community group – not attended this yet)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support with mental health</td>
<td>Support with employment (two VCS organisations)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PIP form support</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>&lt;6 months</td>
<td>Support with mental health</td>
<td>Support with mental health (counsellor and GP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Travel to appointments</td>
<td>Support into temporary accommodation</td>
</tr>
<tr>
<td>3</td>
<td>&lt;6 months</td>
<td>Support with mental health</td>
<td>Support with long-term illness (GP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Debt management</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support with universal credit forms</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>2 years</td>
<td>Support with alcohol addiction</td>
<td>Support with alcohol addiction (addiction services)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support with mental health</td>
<td>Support with long-term illness/memory loss (GP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PIP form support</td>
<td>Support with mental health (VCS organisation and GP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support with long-term illness/memory loss</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>&lt;6 months</td>
<td>Support with mental health</td>
<td>Support with long-term illness (GP and heart specialist)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Travel to services (e.g. library)</td>
<td>Cleaning support (cleaning services)</td>
</tr>
<tr>
<td>6</td>
<td>5 years</td>
<td>Support with mental health</td>
<td>Support with mental health (psychiatrist, councillors and GP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support with drug addiction</td>
<td>Support with child safety/parenting (social services, parenting classes)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Travel to food banks and appointments</td>
<td>Support with drug addiction (addiction services)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support through family break-up</td>
<td>Support with child’s autism (speech and language specialist)</td>
</tr>
</tbody>
</table>

Source: SQW, based on patient interviews (6)

3.51 The most commonly raised issue that Focused Care workers supported these patients with was mental health. Patients reported that this involved the workers directly providing emotional support and consistent care, helping patients to access specialist support, and solving problems that were negatively affecting their mental health.

‘Being able to open up and have a chat with [Focused Care worker] and explain how I feel – she knows how I am. The support is a bit of a pain killer. I can fall back onto her if the doctor isn’t here.’ Patient

3.52 The table does not include the full range of practical and administrative support reported to have been provided by Focused Care workers, which included help to complete relevant forms.
such as personal independence payment (PIP) forms, making appointments, writing letters and making phone calls on their behalf, the latter of which was considered particularly helpful. Patients reported that they could not have completed these tasks on their own, as they were unsure of who to contact, or how to complete a form. Workers also reportedly provided the patients with material goods, for example safety gates, Christmas presents for children and food hampers\textsuperscript{13}.

Support to address financial difficulties is a clear example of how Focused Care workers have reportedly helped to unpick interrelated social and clinical issues: two of the patients interviewed reported previously being in debt and unclear on what action to take, which negatively affected their mental and physical health. The patients reported that the Focused Care worker negotiated a manageable payment plan for one and helped the other to resolve ongoing issues with Universal Credit claims.

\textit{The paperwork is very confusing and the situation I was in was difficult... Then it changed to universal credit... I was in arrears... everything was just being thrown at me.} Patient

Five of the six patients were supported with their housing situation. One patient with a young child reported being \textit{basically homeless} before being supported by their Focused Care worker to gain long-term temporary accommodation.

In addition to directly providing support, the Focused Care workers signposted or advocated for patients to receive support from medical professionals. This included signposting or making appointments on the patient's behalf with the GP. One patient reported that they previously had not attended a GP appointment due to their mental health issues despite having a heart condition that required regular monitoring. The patient described how the Focused Care worker organised home visits for them and accompanied them to appointments where possible. Examples were also provided of the Focused Care worker making appointments and advocating for support from medical professionals, such as heart specialists or speech and language therapists. The interviewed patients also reported being referred to psychiatrists, councillors or mental health charities and support groups by their Focused Care worker, which they felt they would not have known about or would not have attended otherwise.

\textit{I'm going to [a community mental health group] to talk about my problems. I haven't been yet, but I found out about that from [Focused Care worker].} Patient

\textsuperscript{13} Funds for these material goods or the goods themselves are sourced by Focused Care workers through their local networks e.g. local charities and churches. Focused Care may provide a very small amount of funds in exceptional cases to cover practical items.
There were also patient reports of the Focused Care worker referring to a range of other agencies for support depending on need, for example employment support (e.g. Job Centre Plus and Turning Point), addiction support, local housing associations and social services.

**Location**

Focused Care workers have a base within a practice, but a large proportion of their work is reported to be conducted outside the practice on home visits, supporting patients at appointments or meeting with other services. Practices are required to provide desk space to support their Focused Care worker\(^{14}\). Some practices have given their Focused Care worker their own room in the surgery, from which they can hold appointments with patients or conduct drop in sessions. Other practices have opted to give their Focused Care worker desk space at reception, so patients can talk with them more informally or arrange home visits and appointments. However, some Focused Care workers have reported not being given their own space at the practice, with one Focused Care worker asked to change desk three times during the day. Issues such as these are addressed by the Hub supervisor.

Nevertheless, the location of Focused Care within general practice gives the workers access to the relevant patient records, enabling them to improve their knowledge of the patient and share their insights with other primary care staff. This was reported to enable close communication between the worker and the GP(s), helping to improve referrals, unlock access to other clinical services, and benefit from the credibility of primary care in dealing with other services, for example to ensure referrals are picked up by other agencies.

**Timing and duration**

Typically, Focused Care workers report that they support each patient for six to nine months. This varies however depending on the complexity or chaotic-ness of the patient’s needs or the type of support needed. Some patients are reported to benefit from one visit: for example, they may need help with accessing a particular service or need a form filled in and so can be discharged after one month. Other patients may require housing support and therefore will stay on the caseload for a longer time whilst appropriate housing is secured. The longest duration cases are reported to be with the most complex/chaotic patients, and in some cases they can continue to receive Focused Care worker support for several years.

Of the six patients consulted as part of the evaluation, four had been working with their Focused Care worker for six months or less. Two had been working with their Focused Care worker for a considerably longer time; one for two years, and one for between five and six years.

‘Sometimes, we see people once or twice and then discharge [them] as it is straightforward, and then others we might have for a year. I’d struggle to average it out [in terms of average case duration].’ Focused Care worker

\(^{14}\) Greater Manchester Transformation Fund – Focused Care proposal, April 2017
3.61 Focused Care workers considered that intensity of support was more significant than the duration of support in terms of their own capacity and the level of need of a patient at a particular time. Duration of support is reportedly influenced by the number of issues a patient had to work through (and potentially the severity of those issues), but also by external factors such as access to and responsiveness of other services, particularly housing. Intensity of support was perceived to provide a clearer indication of how complex/chaotic a patient was and thus how much time they required on daily/weekly basis. Each worker is reported to typically have a combination of high and lower intensity patients on their caseload at any one time, and each patient may also fluctuate between being high and low intensity.

3.62 Most of the six patients interviewed stated that they typically saw their Focused Care worker once every fortnight and the Focused Care worker tended to 'check in' with them via a phone call between visits. However, patients described that the intensity of support depended on their need: one stated that, at the beginning of the relationship, they would call the Focused Care worker eight or nine times throughout the day due to their anxiety, but this frequency had reduced over time. Another patient stated that at one stage they didn't see their Focused Care worker for two months, however, when they needed support it was given more frequently.

'We don't spend loads of time together – but when we do, they are on it and they have dealt with it.' Patient

3.63 The discharge process was reported to vary between practices. Some Focused Care workers described liaising closely with GPs to decide when a patient should be discharged, whereas other workers reported more ownership over when a patient should be discharged. One Focused Care worker stated that she reviews her patients every three months to determine whether they should be discharged or kept on the programme.

3.64 **Focused Care workers can re-open cases they have previously discharged**, for example if a patient re-presents in crisis or with a different issue. Some GPs likened the discharge process to primary care: a patient can be discharged if they no longer need support with a particular medical issue, but the patient may present again with the same medical issue (or a new issue) at a later date.

**Caseload**

3.65 Caseload

Currently, the target number of households that Focused Care workers are required to assess per year is 50. Generally, Focused Care workers report having **20 cases per practice** open at any one time. This was considered the maximum capacity for Focused Care workers; having more than 20 open cases per practice was reported to be unmanageable. Some Focused Care workers stated they were at capacity and had waiting lists for when patients were discharged.

**Variations in the model**

3.66 While Focused Care supports a diverse range of patients in a highly personalised way, this was a consequence of the core principles of holistic, patient-led care. The evaluation found limited variations to the model itself. Those variations identified centred around:
• **Referrals** – some workers and practices reported only using perceived patient complexity/degree of chaotic-ness to identify patients, whilst others used the eight domains of need as a set of criteria for patients receiving support.

• **Location** – some Focused Care workers described choosing to undertake home visits whereas some tended to invite patients to the surgery for assessment and support.

• **Duration** – there was some evidence from interviews with Focused Care workers and GPs that some practices and workers were more focused on moving patients to independence and discharging them than others. However, this did not appear to affect how the workers engaged with their patients.

3.67 The variations identified were relatively minor and are not considered to represent different models. The differences appear to be influenced by:

• **The local context**: where Focused Care had been in operation longer, workers seemed more comfortable with the flexibility of the model and less concerned about issues such as duration of support and discharge.

• **The particular approach of different Focused Care workers**: different backgrounds and experiences also seemed to have an influence on how workers adapted to the flexibility of the model.

• **The infrastructure available to the Focused Care worker**: where there was more practice space available, it was easier for Focused Care workers to invite patients into the surgery. Where space was more limited, workers reported being obliged to do more home visits and external appointments.

### Value of the model

3.68 The core aspects of the model were considered by GPs, Focused Care workers and patients to offer particular advantages, as explored below.

#### Staff and training

3.69 The *experience, skillset, and seniority* of Focused Care workers was considered by GPs and workers to be a key enabler of the approach. Focused Care workers are required to be *'resilient and persistent, good at communicating and have tact and diplomacy'* and to know how to deploy these skills with chaotic patients. One Focused Care worker stated that the intensive nature of the model means that workers need to be aware of the fine line between support and dependency, which more experienced personnel can reportedly identify more easily than less experienced staff. Being able to share this learning and knowledge between Focused Care workers was also considered an enabler of success. As a group, the workers advise each other on their own speciality areas, as they bring and apply a variety of professional experience. The formal and informal training provided supplements worker skills and experiences and facilitates work with extremely complex patients. Some of the patients interviewed remarked

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15 No criteria are applied to patients referred through non-primary care routes.
on the skills and experience of their worker which the patients perceived as leading to workers providing high quality, appropriate support.

**Balance of core principles and flexibility in application**

3.70 Focused Care has some core principles in terms of cohort, referrals, and nature and duration of support. However, all of these allow for wide interpretation and professional judgement. This flexibility in the application of the approach is seen by GPs and workers as crucial to the ability of the model to effectively support complex patients. The Focused Care worker can spend an unrestricted amount of time unpicking issues for an individual patient and then support them in an entirely personalised way. They can do home visits to learn more about the patient’s circumstances, provide support and build a relationship. One worker described it as being able to ‘walk alongside’ their patient.

‘The biggest success factor is the relationship that the Focused Care practitioner builds with patients – she gets to know them which builds up their trust and confidence in speaking to her. She gets things done and has time to support patients, providing one-to-one support, and is personable and approachable.’ GP

3.71 The flexible and unrestricted nature and duration of support available through Focused Care is reported (by both professionals and patients) to enable patients to improve their confidence, address the issues most important to them, to become more independent and make sustainable changes to their lifestyle. Stakeholders report that this is further supported by the holistic and person-centred approach, which allows the patient to have control of their own ‘cycle of change’.

**Link with primary care**

3.72 Focused Care workers and GPs identified the practice-based approach as a distinct aspect of the model and a key enabler of success. It was seen as facilitating close working relationships between Focused Care workers and GPs in the practice. Both parties can refer the patient to the other when they have reason for concern. Co-location is reported to facilitate easy communication and information exchange. Being based in the practice also gives Focused Care workers access to the practice manager and reception staff, who can help to identify potential referrals.

‘[The Focused Care worker] is practice based, I can speak to her within a day or two even though we both work part time… It’s a close working relationship, she is incredibly reliable.’ GP

3.73 Furthermore, the Focused Care worker can access patient records in the practice, and therefore understand the history of the patient more effectively than they would otherwise be able to. Workers reported that there are sometimes important things in their medical history that a patient will forget to tell the Focused Care worker. Attending practice meetings also
enables workers to share information with practice staff quickly regarding any issues arising, how issues are being dealt with and what the outcomes are.

3.74 This model was praised by GPs and workers as allowing patients with interrelated social and medical needs to be supported with both types of need simultaneously via one consistent worker. Patients are reported to be less likely to get 'lost in the system' while they are being referred from one service to another that can only partially deal with their problems, as the Focused Care worker can track the progress a patient is making and the support they are receiving from other services.

**Partnerships**

3.75 The **multi-agency approach** is also considered an enabler of the Focused Care programme by GPs and workers. It was reported that close relationships with other services (e.g. housing, social work) means Focused Care workers can readily ask for support for patients. At some practices where other services operate, Focused Care workers can cross refer with other workers, which is credited with improving patient access to services.

**Risks and challenges to the model**

3.76 Table 3-3 shows the risks and challenges confronting the Focused Care model.
### Table 3-3: Risks and challenges for the Transformation Funded Focused Care programme

<table>
<thead>
<tr>
<th>Context</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Continued system and organisational change across the health and social care landscape in Greater Manchester.</td>
<td>• Limited capacity of Focused Care workers to collect data.</td>
</tr>
<tr>
<td>• Other new models of care or interventions potentially overlap/duplicate Focused Care e.g. in Manchester there may be a risk of confusion/overlap with High Impact Primary Care, Prevention (Be Well), Early Help and/or Crisis Response.</td>
<td>• Duplication of reporting; data entered onto EMIS and into separate tool for monitoring.</td>
</tr>
<tr>
<td>• The funds allocated to Primary Care Networks for social prescribing may complicate the PCCA landscape.</td>
<td>• Limited quantitative data because of difficulty in aggregating data across practices (due to different recording processes).</td>
</tr>
<tr>
<td>• Limited capacity within some services and across the system to meet identified needs, both for those who meet and those who fall below eligibility thresholds e.g. housing, VCSE, Universal Credit, and particularly for people with multiple and complex needs.</td>
<td>• Challenging to evidence and attribute impact because of multitude of factors affecting patients and limited quantitative data.</td>
</tr>
<tr>
<td>• Short-term funding can present challenges e.g. recruiting and retaining staff, gaining engagement from other parts of the system, supporting patients beyond funding limits (both for Focused Care and other relevant services). Focused Care workers and GPs in Rochdale and Manchester reported concerns. Uncertainty may affect morale of Focused Care workers and undermine trust amongst patients.</td>
<td>• Formalised scrutiny of the model (reporting, data collection) could become a barrier to innovation/flexibility of service to patients.</td>
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</table>

<table>
<thead>
<tr>
<th>Model</th>
<th>Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Flexible entry and exit criteria allows professional discretion in identifying, managing and discharging patients (including those ‘invisible’ patients that are not easily identifiable from data) but complicates planning, resourcing (balancing caseloads, waiting lists) and commissioning.</td>
<td>• Receiving appropriate patient referrals using concept of ‘failure to thrive’ applied to households, which depends on:</td>
</tr>
<tr>
<td>• The unit of focus is the household, which may yield more sustainable solutions but brings additional complexity.</td>
<td>o Focused Care being located in areas with sufficient patient population i.e. most deprived areas.</td>
</tr>
<tr>
<td>• Relies on GP and other practice staff engagement to ensure referrals generated and work supported e.g. MDT reviews of assessments.</td>
<td>o Engagement and capacity of GPs: workers reported referrals of patients who would be better suited to a social prescribing service and Focused Care being used like an ‘emergency service’. Practices with a high use of locum staff or new GPs had particular issues.</td>
</tr>
<tr>
<td>• Reliance on other services to meet needs of patients; some services may face resource constraints, entry/eligibility criteria, and/or competing demands.</td>
<td>• Lack of agreed duration and/or intensity of support for patients.</td>
</tr>
<tr>
<td>• There are issues with waiting times, particularly for housing and mental health services and criteria/thresholds for some services, which can mean patients remain in Focused Care longer than they would do otherwise.</td>
<td>• Barriers to engaging patients (e.g. trust, cultural differences, language, learning difficulties).</td>
</tr>
<tr>
<td>• Challenge of building trust with patients.</td>
<td>• Challenge of avoiding dependency or return to service.</td>
</tr>
</tbody>
</table>
• The Focused Care workers are employed by the CIC not the GP practice, which ensures all Focused Care workers have access to the same training, resources, supervision and peer support, but potentially positions Focused Care workers as external to practices, risking reduced engagement/commitment from GPs and other practice staff, and Focused Care being a low priority for practice space and time.

• Focused Care workers are Band 6, meaning they are skilled and experienced but relatively expensive compared to care navigators or social prescribing workers.

• Savings from the model are notional rather than cashable: the model is shifting resource from unplanned to planned care instead of making direct savings.

• Perceived exclusivity of model design: some GPs expressed interest in being more involved in the design and management of the programme. Lack of GP involvement may reduce their buy-in and willingness to engage in or fund the model.

• Capability of Focused Care workers to deal with diverse range of issues while working relatively independently.

• Capacity of Focused Care workers to deliver on all aspects of model e.g. admin/data collection as well as delivering a quality, personalised service.

• Retention, recruitment and availability of suitable Focused Care workers.

• Consistency between practices: value of standardised approach vs. flexible offer.

• Balancing caseloads – ability to meet the 50 households per year assessment target depends on complexity of patients.

• Worker safety and lone worker procedures.

Source: SQW
4. Outcomes

4.1 This section presents evidence on outcomes reported to have emerged as a result of Focused Care, including who benefitted, how they benefitted and to what extent, and the extent to which outcomes were sustained. Evidence was provided through interviews with patients\(^\text{16}\), GPs and Focused Care workers, who were variously able to comment on experiences of individual patients and the impacts on staff in primary care.

4.2 There were reports of outcomes for patients and GPs, and system level outcomes. However, the evidence is based solely on interview/focus group and documentary evidence, and impacts should therefore be understood as reported or perceived rather than quantitatively evidenced.

### Patient outcomes reported

4.3 **Improved mental health** amongst patients was reported by workers and GPs to be a common outcome of Focused Care, through improved access to mental health assessments, diagnosis and treatment for patients. Furthermore, Focused Care workers are reported to have supported patients with factors which affect their mental health, such as reducing social isolation, improved family relationships and reduced substance misuse, as well as tackling debt and financial issues.

4.4 Improved mental wellbeing was also the most common outcome reported directly by the six patients interviewed as part of the evaluation. Support from their Focused Care worker is reported to have made these patients feel stronger, more motivated, achieve a more positive outlook and manage their mental health more effectively. One patient noted that the Focused Care worker supported them to understand their diagnosis, which has allowed them to better manage their condition. Two patients stated that the support from the Focused Care worker has prevented them from ‘spiralling’. One patient reported that it has taken ‘a lot of my suicidal thoughts away’. It was noted by multiple patients that working with the Focused Care worker reduced their loneliness and social isolation, which positively affected their mental health.

> ‘My [reduced] anxiety is probably the biggest success. Not being able to leave my house, I wouldn’t go to the shop, I’m now able to take the kids to school. I’m now getting on buses and things. I didn’t understand my diagnosis or anxiety before I met [Focused Care worker], now I understand it, and I’ve got my medication sorted.’ Patient

\(^\text{16}\) Six patients were interviewed. All were currently receiving support from Focused Care from the same Focused Care worker at the same GP surgery. The patients were selected for interview by the Focused Care worker, who picked the interviewees to illustrate a range of need and duration of support.
4.5 Some patients were reported to have benefited from **improved housing stability**. Focused Care workers are reported to have advocated for patients at risk of homelessness and to have helped them to secure access to temporary or social housing. Focused Care workers were also reported to have supported patients with re-housing when their house has been not fit for purpose, for example due to a vermin infestation.

4.6 GPs and Focused Care workers reported that patients have experienced **improved financial stability**, with manageable payment plans being developed through facilitation by the Focused Care worker.

4.7 Three patients interviewed reported benefitting from improved finances. Two reported being supported out of or supported to manage debt, and one was supported to receive PIP support, which enabled them to purchase electric, gas and food. These patients highlighted that their improved financial position positively affected their mental health, and, in one case, the patient reported that it had also affected their physical health.

> ‘I had debt from 2007… Without [Focused Care worker], I would have spiralled again… it puts my mind at ease, it takes pressure off my shoulders and the stress off my heart.’ Patient

4.8 As a result of Focused Care, GPs and Focused Care workers reported that some patients have experienced a **reduction in chaotic behaviours**. This is reported to include reduced substance misuse.

4.9 Two patients interviewed reported drug or alcohol abstinence as a result of Focused Care. One patient reported being free of a cannabis addiction through their work with the Focused Care worker and addiction services. Another patient reported previously drinking more than a litre of spirits per day. However, support
from the Focused Care worker, alongside addiction services they were referred to, is credited with helping them become sober. This patient believed they would have died without this support.

'If it wasn’t for [Focused Care worker] giving me the inspiration to fight things, if I didn’t have the help of [Focused Care worker], I probably wouldn’t be here today.’ Patient

4.10 Focused Care patients are reported to have experienced improved safety, for both households and individuals. Through the support received through Focused Care, there were reports (from workers and GPs) of some households being removed from the Child Protection Register, houses having undergone pest extermination and deep cleaning measures, and helplines being installed for elderly patients. For individuals, it is reported that forced marriages have been prevented and patients have been protected from domestic violence.

'Women have been protected because of [the Focused Care worker]’. GP

4.11 In addition to mental health, Focused Care is reported to have resulted in improved physical health for patients, including encouraging patients to attend cancer screening appointments, reducing smoking, increasing child immunisation, improving diet and diabetes management.

Success factors

4.12 Patients commented on how Focused Care helped them to achieve outcomes. The most common enabler was reported to be the consistency of the Focused Care worker. Having a consistent point of contact for support was reported to generate trust between the Focused Care worker and the patient, which meant that patients were more likely to act on their advice and referrals, leading to better outcomes. Some patients reported that it was the first time they felt like a service had consistently cared about them, which improved their self-esteem and aspirations, and enabled their road to independence.

A patient reported their family has benefited from improved child safety. Due to the patient’s situation, social services were considering putting their two young children into care. However, through working with Focused Care, the patient reported improvements in their situation, and input from social services was no longer deemed necessary. The patient has also accessed parenting courses to support them to care for their children and keep them in the family home.

'I've been lucky. I never had this [support and care] growing up. Without it, I wouldn't have my kids any more. My eyes wouldn't have been opened to my selfishness. I would hate to think where I would be.’ Patient
The consistency meant that the patients felt that the Focused Care worker knew the issues they were facing, what support they were getting from other professionals, and therefore they did not have to repeat their stories to multiple people.

"When you’re seeing all these different people it can get overwhelming. But [Focused Care worker] knows where we are all up to. Like it used to be before when you had one doctor." Patient

Patients additionally identified other aspects of the model they thought were key enablers, such as the Focused Care worker being based at the GP surgery, the fact that Focused Care workers had access to their medical files, and the holistic assessment, which meant that patients could tackle a wide range of issues with the help of the Focused Care worker.

"I get appointments with the doctor and they know what is wrong already, because [the Focused Care worker] speaks to them first. It makes it easier, like I’ve got an appointment after this and [Focused Care worker] has put a note on my file." Patient

The experience, skills and knowledge of the Focused Care worker were also highlighted as key success factors in enabling patients to achieve their outcomes. This included Focused Care worker experience within the health and social care sector, as patients reported that the Focused Care worker had the right expertise and knowledge to help them understand their options, knew the right people to contact and was aware of all the options available to the patient. Patients also highlighted their Focused Care worker was patient, caring and kind, yet firm and straightforward, recognising the worker’s capability in working with complex patients.

"Being able to phone up and open up and have a chat with [Focused Care worker] and explain how I feel – they know how I am. The support is a bit of a pain killer. I can fall back onto [the Focused Care worker] if the doctor isn’t here. They can advise me because of their nursing background." Patient

**Sustainability**

Interviews with patients showed that the progressive unravelling of issues with the consistent support of the Focused Care worker was valued by patients. While the patients had been with Focused Care for varying lengths of time, and none had yet been discharged from the programme, they all reported that as issues had been tackled, their confidence had grown.
While some of them did not feel ready to leave the programme, they were comfortable with the level of support being reduced while they felt their circumstances were improving.

4.17 Patients commented that if they reached a point of crisis following their exit from Focused Care, or if they had any additional issues they needed support with, they would feel able to get back in touch with their Focused Care worker for support.

‘I know that if anything does come up [Focused Care worker] can help me, and I have someone to turn to.’ Patient

4.18 Overall, both GPs and Focused Care workers asserted that Focused Care has improved patients’ wellbeing and quality of life, and supported them to become more confident, independent and empowered.

4.19 There were two important caveats to keep in mind:

- Some interviewees reported that the approach had not worked for all patients. Some patients could not be engaged at all (for example they were not willing to accept the service or they could not be found) and others did not change their behaviour or quickly reverted to previous behaviours. This was attributed to the high levels of deprivation and multifaceted challenges faced by patients.

- There was limited evidence on the sustainability of outcomes, with awareness of the possibility of patients re-presenting. Interviewees were not unduly concerned that patients would return to the service because of over-reliance. Where unmet need had been identified and addressed, re-presentation was viewed as less likely. In the main, interviewees were concerned that some patients have complex needs which are unlikely to be fundamentally altered by Focused Care or that circumstances, particularly relating to deprivation, may tip an individual back into crisis, for example if a supporting service closed or the person suffered a setback in their relationship or employment.

GPs and practices

4.20 A key outcome perceived by GPs is a reduction in inappropriate appointments. GPs believed that there has been a reduction in patients making appointments with non-medical concerns they are unable to help them with, for example accessing benefits or not being able to feed their children. These are now issues they will take to their Focused Care worker, with patients reportedly being more likely to present at the GP when there is a specific medical issue. GPs considered that this has freed up their time to see other patients.

4.21 On the other hand, GPs perceived that in some cases Focused Care has led to an increase in appropriate appointments being made by ‘invisible patients’, with fewer DNAs. An increase in engagement can result in effective diagnosis and treatment, which may prevent a deterioration in health in the long-term for these patients. In addition, one GP stated that the Focused Care worker has taught the GPs in their practice a lot about how difficult patients can be engaged: they rely a lot on the worker’s experience and expertise.
4.22 GPs reported having a **better understanding of patient needs** as a result of Focused Care. Focused Care workers can spend time with patients, and as workers have access to medical records systems, GPs can gain a more ‘in-depth story’ about the patient, which reportedly enables them to work with that patient more effectively. In addition, GPs feel reassured that their patients are getting the support they need. As a GP, it is difficult to help a patient with all issues. As one GP stated, ‘there are some things we just can’t do’ in a ten minute appointment. Therefore, GPs reported that they can feel confident their patients are being helped and supported, which ‘makes a massive difference’.

> ‘We are seeing people [patients] we never saw before. Now there are people for whom we can put a face to a name.’ GP

4.23 Focused Care was considered to have resulted in outcomes at a system level. Focused Care was described as helping to ‘pull together different agencies’ and **improve partnership working**. Increased familiarity between staff in agencies and Focused Care workers was reported to facilitate improved and/or faster access to support for the most complex patients.

4.24 There were reports of a **reduction in inappropriate use of services** (such as emergency care) by some patients.

4.25 Focused Care is believed by stakeholders to have **filled a gap in the system** between primary care and social care. In the absence of Focused Care, GPs may have referred patients with social needs that do not meet thresholds to social care, putting additional pressure on social care in terms of having to assess those individuals. Focused Care has offered another, often more appropriate, option for GPs to refer their patients with social needs and improved GP understanding of what constitutes an appropriate referral to social care.

4.26 Some GPs and Focused Care workers highlighted the **preventative nature of the programme**. Focused Care workers prompt their patients to engage with services including smear tests, contraception, immunisation and so on. This was believed to be saving time for GPs and the system in the longer term by taking preventative action. Also, Focused Care workers take patients to appointments which they reportedly wouldn’t otherwise attend to enable pre-emptive medical treatment to happen: examples reported include pre-cancerous minor surgery and mental health treatment. Examples were also provided of workers encouraging lifestyle changes (exercise and diet) which are expected to relieve pressure on the healthcare system longer term.

> ‘I would be totally lost without it, I think its invaluable. [The Focused Care worker] is a vital part of our team, I can’t stress this enough.’ GP

**System level outcomes**

**One example cited was about a patient who attended A&E two to three times per week, fuelled by alcoholism. Following support from Focused Care, the patient is reported to have been sober for around four months and their A&E attendance drastically decreased.**
Unanticipated consequences

4.27 There have been limited reports of unexpected consequences as a result of Focused Care, predominantly because the programme has such a broad remit. However, it was noted by some GPs that Focused Care has uncovered additional needs of patients that they were unaware of, which has resulted in those patients receiving help and support from Focused Care.

Sustainability

4.28 GPs and Focused Care workers generally agreed that they expect many of the outcomes achieved by Focused Care will be sustained. By encouraging independence and empowering patients to ‘do things for themselves’, it was considered more likely that outcomes will be sustained by patients, who are reported to be better equipped to tackle any issues which arise in the future.

4.29 However, it was recognised by GPs and Focused Care workers that the cohort is made up of the most complex patients with a multitude of issues, and therefore there is an ongoing risk of them falling back into crisis. Furthermore, interviewees highlighted that issues such as domestic violence and mental ill health are not simple to solve, and may be likely to re-present, particularly during crisis. In addition, abstinence from addictive behaviours can be difficult to sustain. One GP discussed two hoarder patients: Focused Care enabled one of these patients to have a deep clean of their house, and has since improved their living conditions and behaviour, whereas the other did not make lasting changes and has ‘gone back to their old ways’.

\[\text{It is} \text{ worth bearing in mind that some of these cases are really complex} \]
\[\text{and Focused Care is not a silver bullet}: \text{GP}\]

4.30 It was also noted that outcomes can be partial: one Focused Care worker stated that a patient has cut their alcohol consumption in half, which had a massive positive impact on their mental health and significantly improved their life chances. However the individual is still reported to drink a bottle of wine a day.

Additionality

4.31 Patients themselves reported that the support they received from Focused Care was more effective than other services such as employment support or social services. GPs and Focused Care workers also felt that these outcomes would not have been achieved without the Focused Care support. As one Focused Care worker noted, for the most complex patients, they would not manage without Focused Care.
Without Focused Care they wouldn’t know where to go or what to do.  
Focused Care worker

4.32 Some GPs credited Focused Care with being more effective than other types of support.

This is one thing has been tried that is actually working. GP
5. The social prescribing landscape

5.1 Focused Care sits within a wider landscape of Person and Community Centred Approaches, including social prescribing, in GM. This section of the report considers the model’s alignment and integration with other services operating across GM, informed by interviews with commissioning staff, operational staff from social prescribing services, a review of ‘Social Prescribing in Greater Manchester’ (University of Salford, June 2019) and supplementary online research into social prescribing across the GM localities where Focused Care operates.

Interaction with other services

5.2 It is evident that Focused Care workers operate alongside a wide range of services to support their patients through advocacy, cross-referrals, multi-agency working, joint visits and signposting. Focused Care workers liaise closely with public sector agencies, such as adult and children’s social care, fire and rescue services, police, housing associations, the Department for Work and Pensions, Citizens Advice Bureau and wider local authority departments such as parks and gardens. In addition, Focused Care workers work with community and voluntary sector groups. Examples cited include local food banks, Crisis and Manchester Mind (for mental health), Turning Point (for substance misuse), Positive Steps (for youth offending) and community centres.

5.3 Focused Care workers work in partnership with organisations, with many reporting attending local multi-agency working groups and safeguarding meetings. They also are reported to work closely with services co-located in their practice, for example social prescribing services. However, it was noted by some GPs that there is potential for duplication or overlap with some services (with GPs mentioning services such as HIPC, social prescribers or community matrons), although stakeholders reported that there is no service which offers the same support as Focused Care.

Frameworks/schema for social prescribing

5.4 To conceptualise a framework for social prescribing, Kimberlee (2015) proposes the following categories:

- **Signposting**: the intervention receives referrals from a GP but does little more than signposting patients on to appropriate networks or groups, with little or no follow up and/or feedback with GP practice.

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17 Gibbons, A., Howarth, M., Lythgoe, A. (June 2019). Social Prescribing in Greater Manchester. [pdf] University of Salford. Available at: [https://static1.squarespace.com/static/57d2317e579fb3d5c12/ad5a/t/5d3b14523a2014001bc48fd/1564153006457/GM+Social+Prescribing+Research+-+Full+Report.pdf] (Accessed 26 November 2019). Note that while the report is dated 2019, the research was largely conducted over 2017/18. Changes in the social prescribing landscape since that time means the report may already be out of date in some respects. Focused Care was one of 78 schemes that provided evidence to the report.
• **Lite**: the most common form of social prescribing. Community and/or primary care based interventions refer to a specific programme to address a specific need. No direct links with GP services.

• **Medium**: a health facilitator sees referred patients to provide advice and signpost to voluntary organisations for specific disease areas or non-medical needs. Works within a geographically defined neighbourhood and is the product of joint partnership work, but does not obviously seek to address the beneficiaries’ needs in a holistic way.

• **Holistic**: usually evolves from the other models over several years, often co-located with GP practices. Direct, often formalised primary care referral; clear local remit and knowledge of local services and networks; developed and sustained jointly over time; addresses beneficiaries’ needs in a holistic way; no limits to the number of times a patient is seen according to their needs.  

5.5 According to the University of Salford (2019), social prescribing provision in GM ranges from signposting services to holistic provision. There are a variety of models and definitions which reflect organic development adapted to local assets and challenges. The Salford review found that many services in GM were trying to provide as holistic a service as possible within their constraints. Our research confirms that services vary according to local context and in terms of level of provision. The Salford review recommends adopting a ‘holistic approach’ to align and embed existing social prescribing with the wider GM context, devolved within each locality and building from the assets and activities which are already in existence.

'It is person centred, the Focused Care practitioner can work through a whole range of issues with a person – people have multiple complexities and challenges... They are very flexible to meet the needs of individuals in the whole context.' Consultee

5.6 From research conducted for the evaluation, using schemes or programmes proposed by GMHSCP, SQW mapped examples of GM social prescribing schemes by **target cohort**, demonstrating the level of user need and/or complexity and population size, and **service offer**, representing the flexibility of provision (Figure 5-1). The mapping is based on limited evidence, has not been validated with the social prescribing service leads, and is intended to be illustrative of some of the key differences between Focused Care and other PCCA models.

5.7 The figure demonstrates a broad correlation between the severity/complexity of need and the flexibility of support. All services had a variety of referral routes, including from primary care, public sector, voluntary and community sector organisations and self-referral. Focused Care appears to differ from other provision reviewed in offering a highly flexible service to highly chaotic/complex patients. Other services may deal with chaotic/complex patients (as cohorts are not discrete) and apply a holistic approach, but Focused Care does this as fully as possible for as many as possible.

Figure 5-1: Social Prescribing in Greater Manchester, mapped alongside Focused Care to present the service offer and target cohort details

Source: SQW consultations with operational staff and review of online material
How Focused Care compares to other schemes

5.8 While Focused Care has features in common with other services operating across GM in the Person and Community Centred Care landscape, there are also many ways in which Focused Care operates differently. Table 5-1 demonstrates an overview of the similarities and differences between Focused Care and GM social prescribing services.

Table 5-1: Focused Care’s alignment with social prescribing schemes across GM

<table>
<thead>
<tr>
<th>Social prescribing schemes across GM</th>
<th>Focused Care</th>
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<tbody>
<tr>
<td><strong>Cohort</strong></td>
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<tr>
<td>Patients with non-medical needs e.g.</td>
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<tr>
<td>social isolation, diet and exercise,</td>
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<tr>
<td>debt, housing, bereavement; long-</td>
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<tr>
<td>term health conditions; wellbeing</td>
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<tr>
<td>and relationships.</td>
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<tr>
<td>Often have parameters excluding</td>
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<tr>
<td>severe mental health or substance</td>
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<tr>
<td>misuse. Usually adult patients only</td>
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<td>(18+).</td>
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<tr>
<td>Patients who live in areas of high</td>
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<tr>
<td>deprivation and present with multiple</td>
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<tr>
<td>and complex needs – including</td>
<td></td>
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<tr>
<td>medical needs and non-medical needs.</td>
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<tr>
<td>‘Failure to thrive’.</td>
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<tr>
<td>Household model – no age restrictions.</td>
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<tr>
<td>Aligns with most GM social prescribing schemes in having a variety of referral routes.</td>
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<tr>
<td>Includes signposting, information giving and support to access other services, but in addition provides practical and emotional support, often attending support with patients or advocating for them in multi-agency work.</td>
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<tr>
<td>Some evidence of establishing new groups to meet need.</td>
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<tr>
<td><strong>Referrals</strong></td>
<td></td>
</tr>
<tr>
<td>Most have a variety of referral</td>
<td></td>
</tr>
<tr>
<td>routes, including from primary care,</td>
<td></td>
</tr>
<tr>
<td>public sector and voluntary and</td>
<td></td>
</tr>
<tr>
<td>community sector organisations, and</td>
<td></td>
</tr>
<tr>
<td>self-referral.</td>
<td></td>
</tr>
<tr>
<td>Nature of support</td>
<td></td>
</tr>
<tr>
<td>Most commonly signposting,</td>
<td></td>
</tr>
<tr>
<td>information giving and supporting to</td>
<td></td>
</tr>
<tr>
<td>access activities/other support/build</td>
<td></td>
</tr>
<tr>
<td>social networks.</td>
<td></td>
</tr>
<tr>
<td>For example, access to health and</td>
<td></td>
</tr>
<tr>
<td>wellbeing/lifestyle support,</td>
<td></td>
</tr>
<tr>
<td>befriending, volunteering, community</td>
<td></td>
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<tr>
<td>activity and social groups.</td>
<td></td>
</tr>
<tr>
<td>Some include asset mapping,</td>
<td></td>
</tr>
<tr>
<td>development of new services to meet</td>
<td></td>
</tr>
<tr>
<td>community need and support for local</td>
<td></td>
</tr>
<tr>
<td>community groups.</td>
<td></td>
</tr>
<tr>
<td><strong>Flexibility</strong></td>
<td></td>
</tr>
<tr>
<td>Some services flexible in length of</td>
<td></td>
</tr>
<tr>
<td>support based on need, but usually</td>
<td></td>
</tr>
<tr>
<td>with an upper restriction. Others</td>
<td></td>
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<tr>
<td>prescriptive in terms of the number</td>
<td></td>
</tr>
<tr>
<td>of sessions/length of support.</td>
<td></td>
</tr>
<tr>
<td>Can be flexible in location e.g.</td>
<td></td>
</tr>
<tr>
<td>meeting in neighbourhood/community</td>
<td></td>
</tr>
<tr>
<td>centres, sometimes GP practices or</td>
<td></td>
</tr>
<tr>
<td>via telephone. Rarely home visits.</td>
<td></td>
</tr>
<tr>
<td>No limitations of duration of support or amount of time.</td>
<td></td>
</tr>
<tr>
<td>Usually home visits; will also support in neighbourhood/community and/or the practice, and with attending other appointments.</td>
<td></td>
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<tr>
<td><strong>Staff/workers</strong></td>
<td></td>
</tr>
<tr>
<td>Navigators, link workers, connectors</td>
<td></td>
</tr>
<tr>
<td>or health trainers/coaches.</td>
<td></td>
</tr>
<tr>
<td>Skills and backgrounds of workers</td>
<td></td>
</tr>
<tr>
<td>unknown but tend to be between</td>
<td></td>
</tr>
<tr>
<td>Bands 3 and 5 (equivalent)</td>
<td></td>
</tr>
<tr>
<td>Skillset and experience of Focused</td>
<td></td>
</tr>
<tr>
<td>Care practitioners – Band 6 workers,</td>
<td></td>
</tr>
<tr>
<td>wide range of previous experience</td>
<td></td>
</tr>
<tr>
<td>working with people with complex</td>
<td></td>
</tr>
<tr>
<td>needs or chaotic lives, variety of</td>
<td></td>
</tr>
<tr>
<td>expertise shared across the service</td>
<td></td>
</tr>
<tr>
<td><strong>Where in system</strong></td>
<td></td>
</tr>
<tr>
<td>Usually community based, led by</td>
<td></td>
</tr>
<tr>
<td>external organisations. Some more</td>
<td></td>
</tr>
<tr>
<td>closely aligned with GP practices.</td>
<td></td>
</tr>
<tr>
<td>Involve GPs, other voluntary and</td>
<td></td>
</tr>
<tr>
<td>community sector organisations,</td>
<td></td>
</tr>
<tr>
<td>Practice-based – integrated with GP</td>
<td></td>
</tr>
<tr>
<td>systems. Multi-agency approach –</td>
<td></td>
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<tr>
<td>referrals, liaison and advocacy on</td>
<td></td>
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<tr>
<td>behalf of patient.</td>
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</tr>
</tbody>
</table>
Social prescribing schemes across GM

- Community health care professionals,
- Other public sector and frontline professionals to varying extents from referral only to closer partnership working.

Source: SQW consultations with operational staff and review of online material

5.9 This comparison demonstrates that some of Focused Care’s key enablers (expertise and experience of Focused Care workers, flexibility of provision to meet complex needs of individuals and close ties to primary care) appear to be distinctive to the model.

‘Focused Care workers are much more case workers than the other two social prescribing roles [in one particular locality in GM], they can go to people’s homes to support them and go with them to appointments, whereas the [social prescribing workers] don’t have that level of an offer – it is a very different approach... fundamentally the offers are different’. Consultee

5.10 Focused Care demonstrates many of the main enablers found by the University of Salford to provide the best outcomes for patients, in improving community connection and cohesion and in reducing demand on medical services:

- **Holistic model**, provided via face to face contact and home visits, with an absence of time limits
- Importance of **service relationships** (with funders, GPs, link workers, voluntary and community sector and community members); regular communication/feedback and continuous adaptation and improvement
- **Flexibility** of provision, referral processes and services provided, programme content and location
- (Reasonably) **long term resources** and secure staff with bespoke training offered regularly.

5.11 However, the service also experiences some of the main challenges found by the review across the GM social prescribing landscape:

- **Difficulties proving outcomes through metrics**: value of service, causality and patient journeys to improved wellness better demonstrated by qualitative research (a concern also raised by interviewees)

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• **Short term and uncertain funding**, with the risk of collaborative relationships, community knowledge and key staff being lost

• **Integration** between Focused Care as a primary care service and other community organisations, within the wider social prescribing landscape (examined in the subsequent section of this report).

5.12 A number of issues were raised by commissioning and operational staff from social prescribing schemes. First, the **sustainability of the model** was raised. Focused Care workers can only cover a small number of practices and patient groups compared to other models, due to the high level of need and complexity.

5.13 While the **location of Focused Care within Primary Care** was recognised as a benefit of the model, interviewees also questioned whether GP practices were the right location for supporting patients with social needs, with one consultee describing this as ‘trying to medicalise social intervention’. However, Focused Care is able to support patients with medical (as well as social) needs, as demonstrated by patient interview evidence, for example one patient reported showing his Focused Care worker some blood test results which she then followed up on his behalf. Focused Care also has close links with GPs as ‘gatekeepers’ to the medical system, with the influence and leverage required to access medical services needed by highly complex patients.

> [Focused Care worker] got me to a psychiatrist, they pushed for that.’
> Patient

5.14 Finally, interviewees stressed the importance of **good local knowledge and community assets and investment in voluntary and community services** for the success of social prescribing. Some interviewees questioned Focused Care worker knowledge of community assets due to the amount of time and effort needed to establish and maintain this, with asset mapping not a central element of the service.

> ‘Focused Care is being delivered in isolation. When they get into a practice, [the practice] refers less to social prescribing... [but Focused Care workers] don’t have access to the community... I just think social prescribing needs to be driven locally, with local intelligence.’
> Consultee

Integration of Focused Care in the local landscape

5.15 Commissioners and operational staff shared their perceptions of Focused Care’s integration with the local landscape. There was an **expectation that Focused Care should be integrated into the local Person and Community Centred model** at a locality level. For example, in

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20 Ibid.
Rochdale, the social prescribing system has been designed to range from Community Connectors, who signpost patients with low-level needs to other services, to Health Trainers and Coaches, who act as link workers for patients with medium-level needs by signposting and providing support and guidance, to Focused Care workers, who support the most complex patients with multiple needs.

5.16 However, evidence indicates that this local integration has been only partially achieved, with the commissioning consultees suggesting that Focused Care could be better integrated in the locality model. It was felt that there had been a greater focus on developing the Focused Care service offer and ‘a brand’ rather than linking up with existing provision and filling gaps, although there are reports that this is changing in some localities.

5.17 Part of the challenge to an integrated social prescribing offer within most localities is that currently the referrer has to determine the most appropriate service to refer into.

‘It’s hard enough for me to understand the other services, never mind locums and new GPs... GPs don’t know who is who, and who we should be referring to.’ GP

5.18 There were mixed perspectives regarding any degree of duplication of Focused Care with other services. While duplication was perceived to be an issue by some interviewees with roles external to Focused Care, others thought the lack of duplication is not obvious without being close to delivery on the ground. It was widely recognised that Focused Care’s navigation of clinical parts of the system is different to social prescribing models and that they work with the most complex patients.

‘There is little duplication, which you don’t see if you aren’t close to the offers, but the level of complexity is different. They help people leading chaotic lives... there are elements of that we can help with, with a different kind of support... but some are too complex.’ Consultee

5.19 Based on consultation evidence and our interpretation of the findings, the evaluation has identified a series of factors that affect the level of integration at a locality level, particularly in a rapidly changing landscape of provision. These include:

- How well established the service is. For example in Oldham, where Focused Care developed from grassroots practice, the service appears to be better integrated than it is in areas where Focused Care commenced in April 2018.

- Stakeholder and operational engagement and capacity: levels of buy-in to the approach and perceptions of its validity at all levels will affect the integration achieved in an area. This includes commissioners, primary care and public sector staff and other providers, who all have a role to play, whether explicitly or implicitly, in ensuring integration across the system.
• The scale of Focused Care: for example, the model operates in one practice only in Salford. Evidence from the evaluation suggests the model has a lower profile than in other localities which may hinder integration with other services compared to localities where it is operating on a wider scale, such as Oldham and Rochdale.

• The wider social prescribing offers in the area: where services are fragmented, with a large number of services operating, integration could be expected to be more difficult, at the very least there are a greater number of stakeholders for Focused Care to engage with and vice versa. Engagement and capacity of local stakeholders will play a role in how effective interaction and integration is in any particular place.

5.20 Integration varies according to location depending on these factors and how they interplay in the changing landscape. Social prescribing provision has been in a state of almost constant evolution since Focused Care was introduced and will be further influenced by how Primary Care Networks choose to spend their allocated social prescribing funds.

**Information aggregation and usage**

5.21 Externally, it is not clear that Focused Care practitioners or supervisors have routes to feedback information at a strategic level. The approach of Focused Care is viewed by some as meeting individual needs rather than influencing strategic change by feeding themes into the system: one commissioner described this as a mindset stemming from being based in primary care by thinking ‘How can we help this person?’ rather than ‘How can we improve this system?’ In addition, the current system of record-keeping within the patient record in EMIS means it is challenging to aggregate data.

5.22 However, there are mechanisms in place for feeding learning from Focused Care into the system at a strategic level, which have reportedly led to positive outcomes. For example, feedback from Focused Care workers about a special bus service for disabled and older people dropping off vulnerable individuals at the bottom of the path up to their home instead of taking them to their door was reported to the Population Health Board and remedial action was taken. Stakeholders reported that each month, forty to sixty significant events are reported to the Focused Care Board, from which themes are fed into the GM Population Health Board.

5.23 At a community level, there are some small examples of Focused Care workers addressing supply side issues, for example by setting up community assets, but capacity is a key limitation to this type of work. Being able to identify patterns of need or failure among local services and address them is fundamental to sustainability. Otherwise the service remains reactive.

> ‘But if we don’t invest in the voluntary and community sector, there won’t be anywhere to send these people to.’ Consultee

**Reflections on integration and alignment**

5.24 Elements of the Focused Care model are distinctive when considered in the context of the wider GM landscape of Person and Community Centred models. Often these are the key
enablers of the model, including the high levels of flexibility, skillset and experience of Focused Care workers and being based within primary care.

5.25 However, there is more work to do to fully integrate the service into the wider system. In areas where Focused Care operates at a larger scale, is well established and has buy-in from stakeholders, there are reports that integration is improving. However, this is not the case across all localities, which is likely to affect the impact that the service can have and levels of duplication.

5.26 Strategically, Focused Care has formal and informal routes to feed in themes and learnings at a GM level, namely reporting to the GM Population Health Board and close working relationships between Focused CIC trustees and the Population Health Board. However, more could be done to share learnings and influence systemic change at a locality level driven by Focused Care workers and supervisors working collaboratively with other services and professionals.
6. Reflections and conclusions

6.1 This section presents reflections on the Focused Care programme as funded by the Transformation Fund and offers some conclusions.

Outcomes reported

6.2 With the caveat that this report is restricted to reported and perceived evidence of outcomes, **Focused Care is widely reported to have generated tangible, significant outcomes for a range of chaotic/complex patients, particularly in terms of supporting them with mental health issues.** Where outcomes were not achieved, remain partial or may not be fully sustainable, stakeholders attributed this to the chaos/complexity of the patients and the severe challenges that many of them face through deprivation, rather than failings of the Focused Care model. The **belief in the effectiveness and additionality of the Focused Care model for patients** was extensive among patients, GPs and Focused Care workers **interviewed**, although limits and challenges to the approach were noted.

6.3 In addition to improved mental health, many other patient outcomes were reported, including reduced social isolation and loneliness, improved financial and housing stability, reduction in chaotic behaviour and addiction, improved safety (particularly for women and children), and improved physical health.

6.4 It is important to note that these outcomes are typically not produced independently by addressing a single issue. Instead **outcomes are generated through a holistic approach to understanding a patient’s multiple, inter-linked needs and addressing them in a holistic way.** The Focused Care worker may begin by tackling one small, practical problem (such as the installation of a child safety gate). The solution to one small problem is typically expected to generate an initial outcome (such as improved child safety) whilst also leading to other results such as improved trust between the Focused Care worker and the patient, the identification of other issues, and a reduction in patient anxiety. These results provide the basis for further work to address more serious or entrenched issues. The Focused Care model recognises the complex web of human lives and allows practitioners to exercise their professional judgement in supporting patients to untangle interlinked issues, with nothing excluded from consideration.

6.5 The review of social prescribing in GM by the University of Salford reached a similar conclusion, that considering the entirety of a patient’s circumstances and needs and dealing with any of them that are relevant, is most effective in improving outcomes (although the report also notes that there are significant challenges in measuring outcomes for social prescribing):

‘While signposting was adequate for certain patients, for the majority (particularly those patients with more complex needs who accessed services most often), the more holistic the service provision the better the outcomes.’ Social Prescribing in Greater Manchester, University of Salford, June 2019
The Focused Care model is reported to have generated value for practices; whilst outside of the remit for this evaluation, it is likely that this will not be easily quantified. Stakeholders reported that some time is likely to have been saved through reduced inappropriate appointments, the preventative value of improved physical and mental health of patients, and fewer DNAs. There are also likely to be increased demands on primary care through increased appropriate appointments such as for vaccinations and health checks (although these should have a preventative value). Equally difficult to precisely quantify is the satisfaction felt by GPs that their patients are receiving appropriate support for non-medical needs, and the extent to which this supports the effective delivery of primary care. These outcomes are important to understanding where the approach can deliver the greatest value.

There is limited evidence on the impact of the model at a system level, for example in reducing inappropriate attendances at A&E. More encouragingly, there were reports of improved partnership and multi-agency working due to the interactions between Focused Care workers and staff in other organisations. Over time, individual relationships offer the potential to lead to culture change among organisations. Examples of positive partnership working could be used to communicate the value of the approach to other potential practices or commissioners.

Core components

The evaluation evidence reveals that Focused Care is perceived to be delivering well against its aim to address patients’ non-medical needs that are inter-related with their clinical symptoms. Evidence indicates that there are a number of aspects of the programme viewed as crucial to its success, as shown in Table 6-1.

<table>
<thead>
<tr>
<th>Component</th>
<th>Perceived value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior and experienced Focused Care workers</td>
<td>Enables workers to effectively support and work with a diverse set of complex patients. Variety of experience drawn upon across the Focused Care workers via formal training and informal peer support.</td>
</tr>
<tr>
<td>Informal and formal training and support provided to Focused Care workers</td>
<td>Helps workers deal with complex cases; workers are able to request specific topics for training in response to emerging needs.</td>
</tr>
<tr>
<td>Core principles on referrals, cohort and nature and duration of support but flexibility on operation</td>
<td>Allows application of professional judgement. Apart from registration with a Focused Care practice, no specific patient needs or circumstances automatically lead to exclusion from the model. Home visits help to improve understanding of individual’s circumstances. Household as unit of focus facilitates holistic understanding of circumstances and needs and holistic approach to addressing needs.</td>
</tr>
<tr>
<td>Continuity of carer (the Focused Care worker) and care</td>
<td>Enables the development of a strong and positive relationship between patient and their Focused Care worker.</td>
</tr>
<tr>
<td>Location of Focused Care worker in a GP practice</td>
<td>Facilitates effective communication and information exchange between worker and GP. Access to primary care records improves Focused Care worker knowledge of patient circumstances.</td>
</tr>
</tbody>
</table>
### Component | Perceived value
--- | ---
 | Improves GP knowledge of patients’ non-medical needs
 | Allows support of patients with interrelated social and medical needs
 | Ensures patients receiving Focused Care support do not ‘get lost in the system’.

**Source:** SQW

#### 6.9
The necessity of some of these components has been questioned by stakeholders, in particular the seniority of the Focused Care worker. However, evidence from patients indicates that the relationship between the Focused Care worker and the patient is fundamental to identifying the critical issues for the patient and implementing appropriate, effective solutions. The relationship is created through both time, in terms of the frequency of meetings, length of appointments and duration of support, and effort, with patients highlighting their appreciation of the Focused Care workers’ willingness to tackle tasks as needed. There may be some value in using less senior staff to support patients with some of the more basic tasks (such as form filling or accompanying them to certain appointments) but this would have to be done carefully to avoid undermining the quality of the relationship between the Focused Care worker and the patient.

#### 6.10
The other key challenge raised by stakeholders relates to the length of time (duration) it takes to support some patients. This evaluation is not able to judge the cost-effectiveness of support. However, qualitative evidence suggests that the severity and complexity of the issues faced by some patients will take a considerable amount of time to resolve. This may be due to the length of time it takes to deal with a single issue, or because there are a number of issues that need to be tackled sequentially, or because a patient experiences additional needs or further crisis before they are discharged from the programme.

#### 6.11
Moreover, qualitative evidence indicates that, while the Focused Care worker is supporting them, patients are on a better trajectory than they would otherwise be. In one case, the support of a Focused Care worker was credited with helping a mother to improve her parenting and avoid her children being taken into care. In the main, support from Focused Care typically means that a patient transitions from accessing unplanned to planned care, which makes a saving for the system.

**Issues for future delivery**

#### 6.12
Any future delivery of the model faces some key issues:

- Capacity within other services and across the system to meet patient needs, as Focused Care is not able to address some topics without the support of other agencies. Important examples include housing, severe mental health issues and employment. Other practical support provided to Focused Care patients is not within the remit or capacity of other services.

- Retention, recruitment and availability of suitable Focused Care workers, as social prescribing and PCCA schemes become more common and compete for the same (or similar) staff.

- Evidencing and attributing impact with limited quantitative data.
• Continuing to manage the resourcing of the model (balancing caseloads, waiting lists) while using flexible entry and exit criteria.

• Capacity of GPs to engage effectively.

• Supporting harder to reach patients where there are specific barriers to engagement e.g. trust, ethnicity, language, learning difficulties.

• Continued system and organisational change across the health and social care landscape in Greater Manchester with potential for overlap/duplication or the perception of such in relation to other interventions.

Integration in the landscape

6.13 Given increasing demand and limited public resources, avoiding duplication and overlap is vital. One challenge made in respect of Focused Care is that it operates in isolation from other services. There is a danger that Focused Care could function entirely independently as it works with a specific, small cohort: it does not make a universal offer. However, in general Focused Care workers are engaged with other agencies and services in their locality to help their patients access other support, such as housing, welfare, and mental health. The real issues are twofold:

• How Focused Care operates alongside social prescribing schemes that seek to support people with non-clinical needs

• How Focused Care influences other services to improve the system for people beyond their caseload.

6.14 The evaluation mapping indicates that there is a low risk of overlap or duplication because Focused Care is aiming to support the most complex patients. The priority therefore needs to be ensuring that other services that may come into contact with possible Focused Care patients are aware of the model and know how to make a referral. Similarly, Focused Care workers need to be aware of where else to refer patients deemed not appropriate for Focused Care. This is happening, particularly where there is more stability and cohesiveness of social prescribing provision, plus greater buy-in from strategic and operational staff. But in a changing landscape, and where Focused Care has a smaller presence or lower profile, it needs to remain a priority. A single point of referral or a ‘no wrong door’ approach for all social prescribing offers could perhaps help to mitigate any issues associated with multiple services, alongside increased understanding across local systems of the available services.

‘The relationship could be tighter – Focused Care is more engaged to other parts of the system (i.e. GP surgeries). But we are all trying to do the same thing. The more we join up, the better we can achieve.’ Consultee

6.15 As a small service, Focused Care does not have much resource to put into mapping local assets. In most areas, this work is already been done so there is an onus on Focused Care workers to draw on these resources and link into others in their locality who are already doing this, as well as feeding local knowledge back in.
6.16 On the second issue, there is some evidence that Focused Care is providing intelligence at local and strategic levels through Focused Care workers sharing knowledge with local partners and the Focused Care CIC Board reporting into the GM Population Health Board. These efforts should be reviewed and, if necessary, strengthened. The aim of Focused Care to ‘make the invisible patients visible’ should apply both at an individual level and a strategic level. The depth of engagement that Focused Care workers have with their patients offers potential for the programme as a whole to be a credible advocate for complex/chaotic people in areas of severe deprivation in Greater Manchester.

The future for Focused Care

6.17 Current economic and social circumstances mean there is an increasing cohort of people with chaotic and complex situations, with constrained public finances limiting capacity of services to meet demand. At the same time social prescribing, personalisation, holistic, strengths-based and community-focused approaches are becoming mainstreamed. The future of Focused Care needs to be considered within this context.

6.18 Focused Care has a particular offer for a particular cohort, which qualitative evidence indicates is effective and additional. Commissioners and others should therefore consider where Focused Care can add most value alongside other approaches. This is likely to involve careful consideration of levels of deprivation and the probable size of the Focused Care cohort.

6.19 The value of the model could be enhanced by more explicitly drawing on asset mapping and the knowledge of other local practitioners, and committing to providing an aggregated picture of needs in a locality for review at a strategic level. Focused Care could also usefully become part of a ‘no wrong door’ approach to referrals.

6.20 Crucially, Focused Care needs to be able to quantify the value of outcomes and demonstrate cost effectiveness, although funding may be justified on grounds of equity as well as overall reduction in service demand.
Annex A: Acknowledgements

A.1 This report has been prepared by the SQW qualitative evaluation team, comprised of Lauren Roberts, Sarah Brown, Jane Meagher and Holly Waddell.

A.2 Our thanks go to the Focused Care Qualitative Evaluation Steering Group members, who have overseen the work of the evaluation. Group members were:

- David Boulger, Greater Manchester Health & Social Care Partnership
- Ben Squires, Greater Manchester Health & Social Care Partnership
- Giles Wilmore, Greater Manchester Health & Social Care Partnership
- Conor Dowling, Greater Manchester Health & Social Care Partnership
- Thomas Daines, Greater Manchester Health & Social Care Partnership
- Ruth Boaden, University of Manchester
- Laura Neilson, Focused Care CIC
- John Patterson, Focused Care CIC.

A.3 Thanks also to those who have contributed to this qualitative evaluation, by taking part in interviews and focus groups.

Table A-1: Consultees

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
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<tbody>
<tr>
<td>Ben Squires</td>
<td>Head of Primary Care Operations</td>
</tr>
<tr>
<td>Dave Boulger</td>
<td>Head of Population Health Transformation</td>
</tr>
<tr>
<td>Giles Wilmore</td>
<td>Associate Lead: People &amp; Communities</td>
</tr>
<tr>
<td>Dr Laura Nielson</td>
<td>Focused Care Director</td>
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<tr>
<td>Dr Mike Eeckelaers</td>
<td>Clinical Lead for Population Health</td>
</tr>
<tr>
<td>Angela Ouattara</td>
<td>Focused Care worker</td>
</tr>
<tr>
<td>Ann Murray</td>
<td>Focused Care worker</td>
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<tr>
<td>Emma Glover</td>
<td>Focused Care worker</td>
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<tr>
<td>Jayne Spotswood</td>
<td>Focused Care worker</td>
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<tr>
<td>Jenny Webster</td>
<td>Focused Care coordinator</td>
</tr>
<tr>
<td>Juliet Rose</td>
<td>Focused Care worker</td>
</tr>
<tr>
<td>Kelly Royales</td>
<td>Focused Care worker</td>
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<tr>
<td>Lisa Chattington</td>
<td>Focused Care supervisor</td>
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<tr>
<td>Liz O’Reilly</td>
<td>Focused Care worker</td>
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<tr>
<td>Matthew Frosdyck</td>
<td>Focused Care worker</td>
</tr>
<tr>
<td>Ruth Chorley</td>
<td>Focused Care supervisor</td>
</tr>
<tr>
<td>Name</td>
<td>Role</td>
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<td>-----------------------------</td>
<td>------------------------------------------------</td>
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<tr>
<td>Shahbana Hussain</td>
<td>Focused Care worker</td>
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<tr>
<td>Sue Tellet</td>
<td>Focused Care worker</td>
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<tr>
<td>Suzanne Atreides</td>
<td>Focused Care worker</td>
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<tr>
<td>Tim Royales</td>
<td>Focused Care worker</td>
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<tr>
<td>Tracey Johnson</td>
<td>Focused Care worker</td>
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<tr>
<td>Dr Charmarie Mullegama</td>
<td>GP</td>
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<tr>
<td>Dr Graham Watt</td>
<td>GP</td>
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<tr>
<td>Dr James Higgins</td>
<td>GP</td>
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<tr>
<td>Dr Jane Fernandez</td>
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<tr>
<td>Dr Michael McKernan</td>
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<tr>
<td>Dr Rachel Jesudas</td>
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<tr>
<td>Dr Rachel Young</td>
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<tr>
<td>Dr Rebecca Locke</td>
<td>GP</td>
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<tr>
<td>Dr Ruth Cammish</td>
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<tr>
<td>Dr Vishal Mehra</td>
<td>GP</td>
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<td>Phil Jordan</td>
<td>Operational Manager</td>
</tr>
<tr>
<td>Ruth Towner-Yates</td>
<td>Social Prescriber</td>
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Annex B: Re-Aim framework

B.1 The Invitation to Tender recommended the use of the Re-Aim framework to help evaluate how the Focused Care approach was spread, in particular the reach to the target population, the efficacy, extent of adoption, consistency of implementation and maintenance of the effects in individuals and settings over time.

Table B-1: Re-Aim framework

<table>
<thead>
<tr>
<th>Element</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach - The absolute number, proportion, and representativeness (in terms of the target for the approach) of individuals who are willing to participate.</td>
<td>Focused Care has been provided across seven localities across GM to a range of patients with diverse needs. Most patients are chaotic and have interrelated social and medical needs.</td>
</tr>
<tr>
<td>Efficacy - The impact of an intervention on important outcomes, including potential negative effects, quality of life, and economic outcomes.</td>
<td>Outcomes reported to be usually positive. Sometimes outcomes are reported to be partial/not sustained where patient has entrenched issues. Reported additionality is high.</td>
</tr>
<tr>
<td>Adoption - The absolute number, proportion, and representativeness of settings and providers (people who deliver the approach) who are willing to initiate the approach.</td>
<td>17 Focused Care workers currently in 29 practices funded by Transformation Fund monies, 18 practices with 8.5 FTE workers funded by HMR CCG and 10 practices with 9 (3 FTE, 6 PTE) workers funded by Oldham Cares. Transformation Funding provided for 2017/18 to 2019/20. Practices selected to receive Transformation-funding for Focused Care on basis of having a population within the 10% most deprived across GM and were willing to participate in the programme. Widespread acceptance of the Focused Care model in practices where it is delivered. Many other stakeholders welcoming of the approach.</td>
</tr>
</tbody>
</table>

Implementation - At the setting level, implementation refers to the providers’ fidelity to the various elements of the approach, including consistency of delivery as intended and the time and cost of the intervention. At the individual level, implementation refers to clients’ use of the support offered through the approach.

Setting: series of core elements but varies according to Focused Care worker’s individual approach, the local context/infrastructure and requirements of the patient

Individual: patients typically responsive to support offered.

Maintenance - The extent to which the approach becomes part of the routine organizational practices and policies. Within the RE-AIM framework, maintenance also applies at the individual level. At the individual level, maintenance has been defined as the long-term effects of an approach on outcomes after 6 or more months after the most recent intervention contact.

Setting: FC workers generally have effective relationships within practices and have become integral to the practices in which they operate. Focused Care is now a routine way of working in the majority of practices that have a Focused Care worker.
<table>
<thead>
<tr>
<th>Element</th>
<th>Progress</th>
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<tbody>
<tr>
<td>Individual:</td>
<td>least chaotic/complex patients can be helped more easily and discharged relatively quickly; perception that their changes and outcomes are sustained. More chaotic/complex patients need to work through various stages and typically take longer to achieve the desired outcomes. There are some reports of outcomes not being sustained or patients re-entering Focused Care, but it is not possible to quantify or verify this.</td>
</tr>
</tbody>
</table>

Source: Re-Aim framework [http://www.re-aim.org/about/](http://www.re-aim.org/about/) and SQW analysis
Annex C: Documents reviewed

Greater Manchester Transformation Fund proposal, April 2017
Focused Care Cost Benefit Analysis, April 2017
Project Implementation Plan, May 2017
Focused Care Communications Plan, April 2017
Board reports and minutes, March 2017 to March 2019
Focused Care Summary Report, September 2018
Focused Care CIC Scheme of Delegation & Governance
Focused Care Service Contract, November 2016
Focused Care worker person specification (undated)
Focused Care Practitioner Job Description (undated)
Focused Care Staff Handbook, February 2017
Focused Care Supervision record
Staff confidentiality agreement
Lone Worker Policy, February 2017
Focused Care Sickness Absence Policy, January 2019
Focused Care CIC Safeguarding Children, Young People And Adults At Risk Policy, July 2017
Focused Care Informed Consent form
Focused Care Significant & Adverse Incidents Policy, April 2017
Focused Care Significant & Adverse Incidents Form
Social Prescribing in Greater Manchester, University of Salford, June 2019
Annex D: Theory of Change

A Theory of Change

D.1 A ToC of the Focused Care programme was developed at the start of the evaluation as a description of the key elements of the model. A Theory of Change maps out how a programme or intervention operates, and the changes it is intended to generate. It aims to outline the logic of how X should lead to Y through depicting the main elements of a programme and how one aspects leads to another. A ToC elaborates on the core logic with explanation of the most relevant contextual factors, the rationale that underpins why the programme or intervention was needed (for example, why the problem was not self-correcting and why this intervention was required to change the situation) and the assumptions behind some of the steps in the logic. This additional detail gives a fuller picture of how and why one step is expected to lead to the next.

The context

D.2 The context for Focused Care has varied over time and across geographies. The ToC focuses primarily on the Transformation Fund Focused Care programme. In this respect, at the time of commissioning, the main policy drivers within GM were the Taking Charge strategy and Population Health Plan, alongside funding pressures on public services that meant GM had an anticipated £2bn gap between demand and funding for public services by 2021. The £450m Transformation Fund was intended to provide seed funding for new ways of working that could improve outcomes for citizens and reduce the expected funding gap.

D.3 The reasons behind the funding gap are presented in more detail in other documents. In summary, although health outcomes vary across GM, in general they are worse than the national average. Social determinants such as deprivation, poor housing, long-term unemployment and poor air quality are linked to public health outcomes such as high rates of excess weight in adults, high rates of alcohol consumption and smoking prevalence. These and many other similar factors lead to worse than average life expectancy rates for people in GM. However, there are local variations within GM, with some relatively wealthier areas experiencing better health outcomes, and more deprived areas having particularly poor outcomes.

D.4 The poor health outcomes noted above combined with pressures on all statutory services appear to result in increasing presentation to primary care, which is often people's first port of call for support. These issues are evident in the area of Oldham where the Focused Care model was first developed and are also noted in the GM Population Health Plan (2017/21).

D.5 The national policy context has changed since the Focused Care programme was commissioned: the Universal Primary Care strategy was published followed by the introduction of Primary Care Networks and the Personalised Care Guidance for local areas, which include a focus on social prescribing. These documents and policies seek to embed and deepen interventions that take a personalised, strengths-based approach to supporting and empowering patients. Overall, the focus remains on reducing inappropriate demand on healthcare services, although recently there has been a greater emphasis on delivering
sustainable health outcomes that will enable inclusive growth and improved wellbeing for individuals.

D.6 Structurally, the health and social care system has changed in GM during the period in which Focused Care has been delivered, even within the period of the Transformation Fund-financed element. The changes initiated by the health devolution settlement have meant that GM itself now has an overarching partnership body overseeing health and social care priorities in the area.

Rationale

D.7 Focused Care was originally developed and implemented in Oldham by Hope Citadel, a Community Interest Company (CIC) provider of primary care. Stakeholders involved in delivery of Focused Care in Oldham reported strong local support among commissioners and providers for the model despite limited formal evaluation evidence. The rationale that underpinned Focused Care as developed by Hope Citadel is fundamentally the same one that underpins the Transformation Funded model.

D.8 Those involved with the design of the original Focused Care model and the Transformation-funded model described how some patients present to GPs with clinical symptoms alongside complex and multiple non-medical needs, for example, related to housing, relationships, finances and employment. Alternatively, they may not access or comply with medical advice when needed because of non-medical issues (these are often referred to as ‘invisible’ patients). GPs are usually unable to help with non-medical needs, due to constraints of time and expertise. Consequently, GPs may find it difficult to support these patients to address clinical symptoms, leading to poor outcomes for patients, dissatisfaction for GPs, and inefficient use of GP time. Other services are typically not picking up and supporting these patients with their non-medical needs, partly because they are hard to engage, partly because they are hard to identify (from data), and partly because of limited capacity. The Focused Care programme was designed to remedy this gap by addressing patients’ non-medical needs when these are inter-related with clinical presentation. In doing so, Focused Care was intended to improve outcomes for patients, raise satisfaction for GPs and reduce inefficient use of their time, as well as increasing efficient use of other health and social care resources.

D.9 The Focused Care model employs the ‘failure to thrive’ concept, adapted from paediatric care. This is applied to households and is intended to allow for professional discretion regarding entry and exit of the pathway, flexibility to address a wide range of needs, plus time to access support elsewhere in the system and remedy complex situations sustainably. The unit of support is the household rather than the individual to ensure that all relevant circumstances affecting the patient are considered and addressed. The model uses specifically recruited Focused Care workers, intended to provide the skills, experience and training to build relationships and work with patients to resolve complex situations. Each Focused Care worker is intended to offer leadership and appropriate, meaningful challenge while taking a patient-led approach. They undertake a holistic, asset/strengths-based assessment with each patient, in the context of their household, to support the sustainability of solutions. The underpinning rationale is that a different conversation with a different kind of professional helps to build trust, empowers patients and helps them learn to self-manage and increase their resilience.
Ultimately it is anticipated that the resolution of cases should reduce pressures on GPs and other services. There is local support for the model in Oldham based on a perception that it is generating positive outcomes. It is expected that these outcomes can be replicated elsewhere.

The rationale for selecting practices to receive Transformation-funding for Focused Care (as set out in the Focused Care Project Implementation Plan, May 2017 and elaborated by commissioners) was that they have a population within the 10% most deprived across GM and were willing to participate in the programme.

**Objectives**

The specific objectives for the programme, as defined in the Focused Care Project Implementation Plan, May 2017, were to:

- Refine and scale the service offer (beyond practices using Focused Care in Oldham)
- Build and capture data, lessons and learning on the service and the consequential effects on GPs, Focused Care worker capabilities and patient outcomes
- Develop the service offer (product) as a clearly differentiated service methodology that can be systematically articulated.
- It was expected that this would generate the following outcomes:
  - Improved health outcomes for high chaotic patients
  - Increased levels of satisfaction for GPs, their staff and patients
  - Reduced cost to the system.

**A visual depiction**

A visual depiction of the ToC for Focused Care is presented below. It should be read from the bottom level (inputs) to the top (impact). The capital letters refer to assumptions in the logic.
Figure D-1: Theory of Change for Focused Care

Theory of Change for Focused Care

OUTCOMES

- Improved confidence, resilience and independence
- Improved physical health
- Improved mental health
- Improved employment
- Increased financial stability
- Increased social inclusion
- Increased positive relationships
- Personalised health and wellbeing outcomes, functioning households
- Reduced social isolation
- Increased positive health and wellbeing

IMPACT

- GP morale and wellbeing improved – improved retention
- Culture change - GPs and other services
- More appropriate use of services
- Reduced use of unplanned care
- Reduced inappropriate use of services e.g. GP, A&E
- Increased capacity for other patients
- Switch from urgent to planned care
- Preventative approach

ACTIVITIES

- Engagement with GPs practices
- Recruitment of FC workers and practitioners
- FC CIC (ex. 2018)
  - Strategic support and oversight from Board
  - Operational support from CIC team
  - 5 year experience from Hope CIC
- Focused Care staff
  - Skills, experience, specific expertise, local knowledge
  - Leadership team, data analysis, 3 Hub Supervisors, Focused Care Practitioners
- Shared Health Foundation
  - Knowledge and insight
- GP surgeries
  - Physical space for FC worker in practice
  - Access to patient records
  - Referrals and support to model e.g. local knowledge

INPUTS

- £2.4m Greater Manchester Transformation Fund investment
- £1.2m and Health Foundation contribution
- Both funding contributions from 2017/18 to 2019/20

OUTPUTS

- New pathway: standardised way of managing this cohort
- Patients referred, engaged and retained on pathway/discharged – 50 households per 0.4 FTE worker per year
- 12 months support
- Medication reviews, care plans
- Improved narrative captured by GPs in patient records

Source: SQW
The assumptions

- A – Improved management of demand will mean patients access more cost-effective support and lead to more efficient use of resources
- B – Addressing some patient needs will lead to reduced use of unplanned care or inappropriate use of services
- C – Helping patients to address specific needs will have a wider impact on their behaviour in terms of use of services
- D – Changing the behaviour of some patients will have a positive effect on others in their networks and community
- E – Other services/agencies are aware of and have capacity to engage with Focused Care and support patients referred to their services
- F – GPs are aware of and engage appropriately with Focused Care
- G – GP practices and localities require this service
- H – Patients in the target cohort will engage with Focused Care and want to increase their resilience and independence
- I – Identification of gaps in support may lead to new appropriate service offers
- J – Sufficiently skilled, knowledgeable, experienced and motivated Focused Care workers are recruited and retained by the service
- K – Evidence of outcomes for patients will change the culture and attitudes in primary care and other services
- L – Outcomes can be sustained, leading to longer-term savings.