

Essex Health and Wellbeing Board	HWB/14/14
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Information and Signposting – proposal and outline plan

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Purpose of report and Decision Areas and Recommendations	<p>The purpose of this report is to set out a brief summary of current proposals and plans for the creation of a new Information and Signposting service for Essex, to be delivered by Healthwatch Essex in 2014-15. These proposals remain subject to continued discussion between Healthwatch Essex, ECC and wider stakeholders with health and social care.</p> <p><i>The Health and Wellbeing Board is asked to note the contents of the report, and is invited to comment on the proposals and to contribute to the planning and implementation of the proposals.</i></p>
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BACKGROUND AND CONTEXT

This report sets out a brief summary of current proposals and plans for the creation of a new Information and Signposting service for Essex, to be delivered by Healthwatch Essex in 2014-15. These proposals remain subject to final agreement between Healthwatch Essex and ECC, as well as continued discussion with wider stakeholders within health and social care.

The following section addresses considerations and background work that has been conducted to date, including:

1. the **policy framework** as set by the Health and Social Care Act 2012, as well as local initiatives such as the Who Will Care? Commission;
2. **people's experiences of finding out about health and social care** services, as captured by in an in-depth study undertaken by Healthwatch Essex, and;
3. a **stakeholder consultation** based on a wide variety interviews with people from statutory organisations across the health and social care economy.

1. Policy framework

The provision of a countywide Information and Signposting service across health and social care is a requirement of the Health and Social Care Act 2012. This sets out one of the functions of a local Healthwatch organisation as being to:

'provide advice and information about access to local care services and about choices that may be made with respect to aspects of those services'

This reflects part of the government's wider intentions in reforming health and social care – a position that is further elaborated in policy literature produced by the Department of Health and the Local Government Association. For example, in the LGA's publication, *Establishing Local Healthwatch: Advice, information and signposting* (2012), the role of local Healthwatch organisations is set out as follows:

'In addition to ensuring that the voices of service users, patients and the public are heard in the design, commissioning and delivery of services, the functions of local Healthwatch created by the Health and Social Care Act 2012 include providing a advice and information service to the public about accessing health and social care services and choice in relation to aspects of those services. Later policy documents refer also to a "signposting" service, so the assumption now is that the function should be described as 'advice, information and signposting'.

The Government's purpose in creating this function is "to enable people to take more control of their own health, treatment and care, and understand and use the increased choices available to them".

Local Healthwatch is intended to provide a single point of contact to help people find information about the choices they have or to put them in touch with the right advocacy organisation.'

This statutory framework is relatively clear, and, significantly, it also dovetails into the work of local initiatives, such as the Who Will Care? Commission. For example, in calling for the citizens of Essex to 'take control of [their] own health and that of [their]

families', the Commission put forward recommendations that aim to promote the empowerment of citizens through better access to information. The Commission's suggestion was for:

'An easy to navigate Citizen's Guide to Care in Essex showing how each aspect of care can be accessed and what the core offering to the citizen comprises. This will be supported by a communication strategy, which will support the desire to create a new contract with the citizen – the "SatNav" of care in Essex.

Funding for the Information and Signposting service is made available from the Department of Health Local Reform and Community Voices Grant, via Essex County Council.

2. People's experiences of finding out about health and social care

Whilst this policy framework provides a relatively clear exposition of the overall aim of any prospective information and signposting service, Healthwatch Essex believes fundamentally that any new provision should be oriented closely around people's needs and their lived experience of finding out about health and social care.

In Autumn 2013, Healthwatch Essex conducted an in-depth-study of people's experiences of finding out about health and social care. A series of focus groups were conducted, with a view to obtaining multiple perspectives and insights into local people's information and signposting experiences, preferences and needs.

Eight focus groups were conducted between October and December 2013 with a range of people, including young people, disabled people, informal carers and people with mental health conditions. A total of 59 people took part. The findings were as follows:

Experiences

- Participants described frequently only obtaining information or being directed to services in informal ways, for example 'stumbling across' information following chance meetings with people in similar situations to themselves.
- Health and social care professionals were perceived to be ideally placed to provide information and signposting to health and social care services but lacked time and knowledge to be effective in this role.
- Information and signposting by health and social care professionals was reactive and failed to take into account people's holistic needs, including, for example, emotional support needs and changing needs across key transition points in people's health and social care journeys.
- It was often down to luck that people received information and signposting from health and social care professionals, and sometimes only when they were in contact with professionals for a non-related reason.

- Written information was sometimes provided by professionals, but this was viewed as impersonal and unhelpful when not given in conjunction with personal communication and support.
- Use of the internet to seek information was popular, especially for personal or sensitive issues.
- Poor website design, accessibility issues, and finding information were all barriers to successful use of the internet.
- Conflicting, overwhelming, out of date and inaccurate information were all issues for people using the internet to find out about health and social care services.
- The internet was also perceived as less helpful for finding local information and personalised or individually-tailored information.
- Health and social care staff who responded to telephone queries for information were often lacking knowledge about services, listening skills and the ability to volunteer comprehensive information.
- People often had to make multiple phone calls in order to obtain information, or were passed on to other departments and services with no-one taking responsibility for answering queries and questions.
- Social Care Direct was experienced as being particularly difficult to obtain information from.
- There was a lack of information around mental health issues, including information about signs and symptoms of mental health conditions, and information about crisis support.

Suggestions for improvements

- Participants wanted a one stop shop for information and signposting to local health and social care services.
- A one stop shop should provide locally-specific and detailed information about statutory and voluntary and community sector services.
- A website and telephone helpline contact details should be extensively publicised to ensure broad awareness.
- Information should be available in multiple formats and be accessible outside normal working hours.
- Of particular importance was a physical presence where people could obtain face to face support with their information and signposting queries.

- Staff recruited to provide information and signposting should receive full training to ensure they have a sympathetic and empathetic attitude, and the skills and ability to gain a holistic understanding of an individual client's needs.
- Staff should take ownership of queries and ensure that clients are kept up to date with progress in obtaining information.
- Peers (who are paid and trained) were viewed as especially valuable in information and signposting roles.
- Information outreach, link and liaison officer roles within health and social care organisations would ensure that people's information and signposting needs are met at the point of care.

3. Stakeholder consultation

During the period October–December 2013, Healthwatch Essex conducted a stakeholder consultation with health and social care organisations across Essex. Senior level professionals (e.g. CEO, Chief Operating Office, Director of Nursing), as well as frontline patient experience managers, were interviewed.

In addition, we spoke to the Citizens Advice Bureau, although Healthwatch Essex has not yet undertaken wider or in-depth consultations with voluntary sector organisations. This was intentionally planned for a later stage, reflecting the view that the initial focus of any prospective service should be on providing information and signposting to services with the statutory sector.

In total, 16 interviews were conducted covering:

- CCGs - 5
- NHS Trusts - 5
- Other - 6 (including CAB, community providers, Essex County Council, NHS England)

The consultation took the form of a semi-structured interview, focussing on the following topics:

1. Demand
2. Supply
3. User groups
4. Organisational dimensions

1. Demand

There was clear consensus around the future growth in demand for signposting and information services. The majority of stakeholders saw demographic factors, such as an ageing population and improvements in the treatment of long-term illness, as key drivers in this context. The majority of those interviewed also noted that demand was localised in the sense that patients were often seeking solutions in their specific vicinity.

In addition, the growing integration between health and social care was widely identified as a key factor in an anticipated increase in the demand for signposting and information services. A number of stakeholders noted that what patients want is an “end-to-end service”. One senior CCG stakeholder said:

“Patients just see it as their care – not healthcare and social care.”

One stakeholder in a Trust spoke for many others when they said:

“Patients are looking for a solution, not just information.”

This was supported by a widely expressed view that demand from patients is becoming more sophisticated and this is, in part, driven by them being better informed (often by their own online research). This led to a further observation that many patients, having answered their own questions online, then seek reassurance and/or validation from speaking to a ‘real person’. However, a number of stakeholders (particularly those responsible for frontline patient experience work) did emphasise that patients were often looking for practical information such as the “who, what, where and how of services”. Stakeholders from the voluntary/provider sector noted that the question often asked was “what am I entitled to?”

A number of stakeholders pointed out that there was latency within the demand for signposting services that had an impact on both resourcing and on how the extent of a service is defined. One stakeholder in a CCG expressed the challenge as follows:

“People don’t complain because they either don’t know how to or think that nothing will get done.”

Closely allied to this was the dimension of expectation management raised by a stakeholder in the voluntary sector. Speaking for an organisation that handles around 10,000 requests for information and advice per year, this stakeholder felt it was essential for their organisation to set realistic expectations as to what clients could expect in terms of engagement and support.

In one NHS Trust, the focus was on the interaction of demand across health and social care, particularly in the context of mental health patients. It was highlighted that, within mental health, there is a historic ‘culture of dependency’ that can directly impact on what is expected of a signposting or information service. However, there was also recognition that building the capability of these patients to do things for themselves is part of a wider agenda.

Demand management was not an issue that was directly referred to by stakeholders. Attempts to prompt discussion of this mostly led to discussion of how organisations can be resourced and equipped to meet demand as it occurs. However, discussions around ‘self-service’ capabilities (particularly web based) did tend to focus on how this might help to reduce demand for person-to-person contact.

2. Supply

Across the range of stakeholders the issue of how increasing demand is and will be met was a consistent focus. A number of key issues were raised by many of the stakeholders.

Fragmented provision was highlighted as a particular concern in terms of meeting demand. Although a number of stakeholders spoke in positive terms about the provision of localised solutions – often facilitated by collaboration with voluntary sector partners - many also saw this as a major challenge. One stakeholder from the voluntary sector saw their role as:

“...trying to prevent bouncing clients.”

At the same time, it was recognised by some in the CCGs that organisational changes had exacerbated this problem and that this could lead to patients getting ‘lost’ in the system.

It became apparent from interviewing stakeholders that no one has a comprehensive picture of existing provision. Most stakeholders were clear about provision within their own organisation or area, but were less informed about what was happening elsewhere.

A number of stakeholders raised the topic of a centralised database to help ensure that the information that lay behind an improved ‘front end’ was accurate and up-to-date. However, it is clear that, across the commissioning areas and within individual organisations, many different solutions and platforms are in use.

One of the most unifying dimensions across the stakeholder base was the enthusiasm for creating a single point of access for signposting services. Most saw this as an overlay to existing provision enabling the current arrangements to work in a better, more consistent fashion. A number of stakeholders pointed out that a single access point would lend itself to marketing and promotion being undertaken in a consolidated fashion and would help to build universal awareness of the service.

Several stakeholders, particularly those outside commissioning organisations, were enthusiastic about developing a wider range of physical access points. Amongst these, GP surgeries, adult education centres, children’s centres, health centres, pharmacies and libraries were the most frequently mentioned. Some stakeholders noted that by developing outreach capabilities (for example using trained ‘navigators’ in libraries, developing the role of pharmacy staff or Village Agents), access to supported information provision could be improved.

The recognition of fragmentation in current provision led many stakeholders – particularly those in commissioning organisations – to suggest the need for a centralised data source. However, this was often tempered by a perception that there would be (possibly insurmountable) challenges around integration with existing data sources, the initial data harvesting and subsequent maintenance of such a database. As one stakeholder in a CCG stated:

“Primary care does not have the capacity to feed in data.”

In addition, several stakeholders noted that either data was concentrated around a small number of individuals (often in PALS teams) and was not stored in any systematic

or transferable format. It was also noted by one stakeholder that recent cuts in budgets had resulted in a “knowledge drain” in this area with many experienced signposting staff having left the service.

3. User groups

Some stakeholders highlighted levels of inconsistency that have resulted in patchy services that are inaccessible for some user groups.

One stakeholder (with a background in nursing) drew particular attention to this issue in relation to the following groups:

- English as a Second Language
- Deaf
- Blind

Another, again with a nursing background, emphasised the inconsistency that pervades the system, particularly in relation to carers who find it is they who have to chase the information they need. This was summed up as:

“They (carers) couldn’t get information, they couldn’t get through to Social Care. There was complete dissonance between health and social care. They had to do all the running around.”

This problem was highlighted as being particularly troubling in relation to patients (and their carers) in the following ‘high volume, high risk’ groups – dementia, stroke, stoma care, cancer (lung, prostate, breast).

4. Organisational dimensions

A common theme emerging from the stakeholder consultation was the need to look at how information and signposting provision might be streamlined, not just within the healthcare setting, but across health and social care.

One stakeholder in a CCG drew attention to their plans to create an integrated gateway for health and social care packages and saw this as a potential foundation that could underpin a more coordinated approach to providing information and signposting services. The critical dimension with this potential development is that it is focussed around a fundamental organisational realignment which includes elements that would directly impact on the provision of information and signposting service – including a single contact number, a directory of services and a centralised database.

Other stakeholders in CCGs were very aware of the impact of the lack of inter-organisational integration on information and signposting. Although a number of stakeholders referred to their organisation’s use of the Datix platform for managing patient feedback and complaints, these were fundamentally free-standing capabilities. Similarly, a number of stakeholders provided copies of the directory of services for their organisation, but with the caveat that this document is:

“Probably out of date the minute it is printed.”

Several stakeholders referenced their organisation's website as a key tool in providing information for patients. However, several highlighted the challenges they faced in keeping these up-to-date. One stakeholder offered the following assessment:

"our website is rubbish... actually, could we say sub-optimal?!"

Although others reflected the variable quality of the content on their organisations' website, they recognise the role they can and do play in providing better navigation through the system for patients. One stakeholder in the NHS highlighted the importance of providing online information, saying:

"[we] must do this.. it's part of our reputation management."

A significant number of stakeholders highlighted the complexity of the health service and the interface with the social care system as an important barrier to providing good information. Some stakeholders noted that it is difficult for professionals to understand every aspect on the two services and that cross-sector cooperation and collaboration was often pragmatic (for example around hospital discharges or support for cancer patients) and lacked any strategic dimension.

Looking to the future, a number of stakeholders pointed to a need to 'de-risk' engagement with patients so that information and advice could be provided without anxiety about litigation. However, it was recognised that accountability and helpfulness sometimes appeared to be difficult to reconcile.

Stakeholders in the CCGs were understandably concerned with any potential increase in workload that a new information and guidance service might create for their staff. This was commonly seen as a particular issue with the initial provision of data and the ongoing upkeep of it. One stakeholder suggested that the service start out on a small scale – "providing a directory enquiries type service" – building up in sophistication over a period of time.

PROPOSALS

This section addresses current plans for the proposed Information and Signposting, including:

1. the **definition and scope** of the service;
2. a **two-phased timeline** for the introduction and development of the service, and;
3. **Outcomes and benefits.**

The proposal remains provisional, subject to final agreement between Healthwatch Essex and Essex County Council, and dialogue with wider stakeholders as set out below. This includes a final sign-off by the Healthwatch Essex Strategic Body.

1. Scope and definition

Close dialogue between Essex County Council and Healthwatch Essex, as well as wider stakeholders, has underlined the importance of clarifying the scope and definition of the prospective service. It is clear from the policy framework that *information*, *advice* and *signposting* are intended to be at the core of the service. But what do these definitions actually mean, in practice?

Information

Definition: ‘the open and accessible supply of material deemed to be of interest to a particular population. This can be either passively made available or actively distributed’.¹

Implications (for Healthwatch Essex, for partners, and for the people of Essex): It is proposed that Healthwatch Essex develops a comprehensive repository of knowledge and facts about health and social care in Essex that can be shared with people via multiple platforms – including the telephone, the internet, printed literature, social media and other forms of outreach. This information base will contain details about services that have been supplied by service-providers themselves, as well as drawing upon existing sources of information (such as databases held by 111, NHS Choices, and voluntary sector organisations). This will necessitate close partnership working and co-operation, and the opportunity is for Healthwatch Essex to consolidate this existing information into one single place. Opportunities to integrate data and systems will be explored, to assess the merit of such an approach – but in the initial stages, it is the centralisation of knowledge (rather than systems) that will add value. Moreover, as the presentation of this information will be informed by the lived experience of people using and accessing the services themselves, Healthwatch Essex will be able to offer a more user-focussed or ‘customer-friendly’ service to the people of Essex.

Advice

Definition: ‘offers guidance and direction on a particular course of action which needs to be undertaken in order to realise a need, access a service or realise individual entitlements’

Implications: If the simple provision of information is insufficient to meet people’s needs, it is proposed that Healthwatch Essex provides ‘guidance or direction’ to individuals only so far as it relates to how they might further access the particular advice that they need. Healthwatch Essex will *not* provide specialist advice to people, but would instead offer signposting (see below) or perhaps a ‘soft handoff’ to an appropriate statutory agency or voluntary sector advice provider, such as Social Care Direct or Age UK. This will require establishing appropriate protocols between agencies, so that ‘soft handoffs’ can be achieved to smooth individual pathways.

Signposting

Definition: ‘the process of giving a client the details of other organisations that will be able to help them’.

¹ On definitions see, for example, Margiotta et al, 2003, *Are you listening? Current practice in information, advice and advocacy services for older people* (York: Joseph Rowntree Foundation).

Implications: If we accept that these definitions of ‘information’ and ‘advice’ form the basis of any new Healthwatch Essex service, then signposting will logically be at the heart of the work.

Healthwatch Essex recognises that many stakeholders have highlighted the risk that the proposed service may extend (intentionally or otherwise) into areas in which Healthwatch Essex would have neither the capability nor capacity to deliver. Such areas – which would be ruled categorically out of scope – include:

Advocacy

Definition: ‘the provision of support and encouragement, or representation of individuals’ views, needs or rights’.

Implications: Healthwatch Essex will *not* offer an advocacy service, but would be well placed place to signpost people to advocacy services when appropriate. A potential benefit to partners and individuals is that better and quicker access to information and/or advice, and hence better and quicker access to services, may help to reduce demand for complaints advocacy. More importantly, it should also ensure that people in need of advocacy are able to access the right kind of advocacy support at the right time. This will require close working between Healthwatch Essex and advocacy providers – which will also allow Healthwatch Essex to glean a system-wide picture of trends in advocacy provision, which will form a key part of Healthwatch’s evidence base to influence the commissioning and provision of health and social care services.

In the light of these definitions, Healthwatch Essex is suggesting that the terms ‘information and signposting’, and not ‘advice’, are most appropriately used to delineate the scope of the proposed service

In summary, consideration of the statutory framework, as well as discussions with Essex County Council, stakeholders and service users, have led an emerging consensus as to what the proposed service should – and should not – do. This is set out in the following tables:

The service *should*:

- Identify what information already exists and how to access it;
- Identify unmet needs so gaps in information can be plugged;
- Have its finger on the pulse of the latest information and news and know where to direct people;
- Fully understand and champion the NHS Constitution and the concept of Personalisation;
- Build people’s knowledge of local Healthwatch as an information and advice resource, ensuring visibility and ease of access;

- Develop relationships with commissioners and providers and provide them with information/intelligence about what issues individuals are requesting information or support around, and also unmet needs;
- Make sure people can get information in different formats that meets their need, e.g. electronic, hard copy, Braille, preferred language translations;
- Use a range of channels to distribute information including but not limited to face-to-face, telephone, web and email;
- Make full use of social networking, and other tools, to reach communities that are otherwise under-represented;
- Have the capacity and systems to direct people to services they require;
- Ensure that it provides feedback to individual members of the public;
- Have systems in place that can record and aggregate information requests for intelligence purposes that complies with the Data Protection Act 1998, and other relevant statutes and regulations.

The service *should not*:

- Tell people what to do, or what course of action to take, or give their opinions about what people should do;
- Give clinical guidance, or anything that could be thought to be clinical guidance or advice on medical interventions or conditions;
- Build up case work;
- Provide counselling;
- Undertake referrals (unless following agreed protocols with local organisations, or a potential safeguarding issue);
- Manage complaints;
- Be a replacement NHS Direct or 111 service.

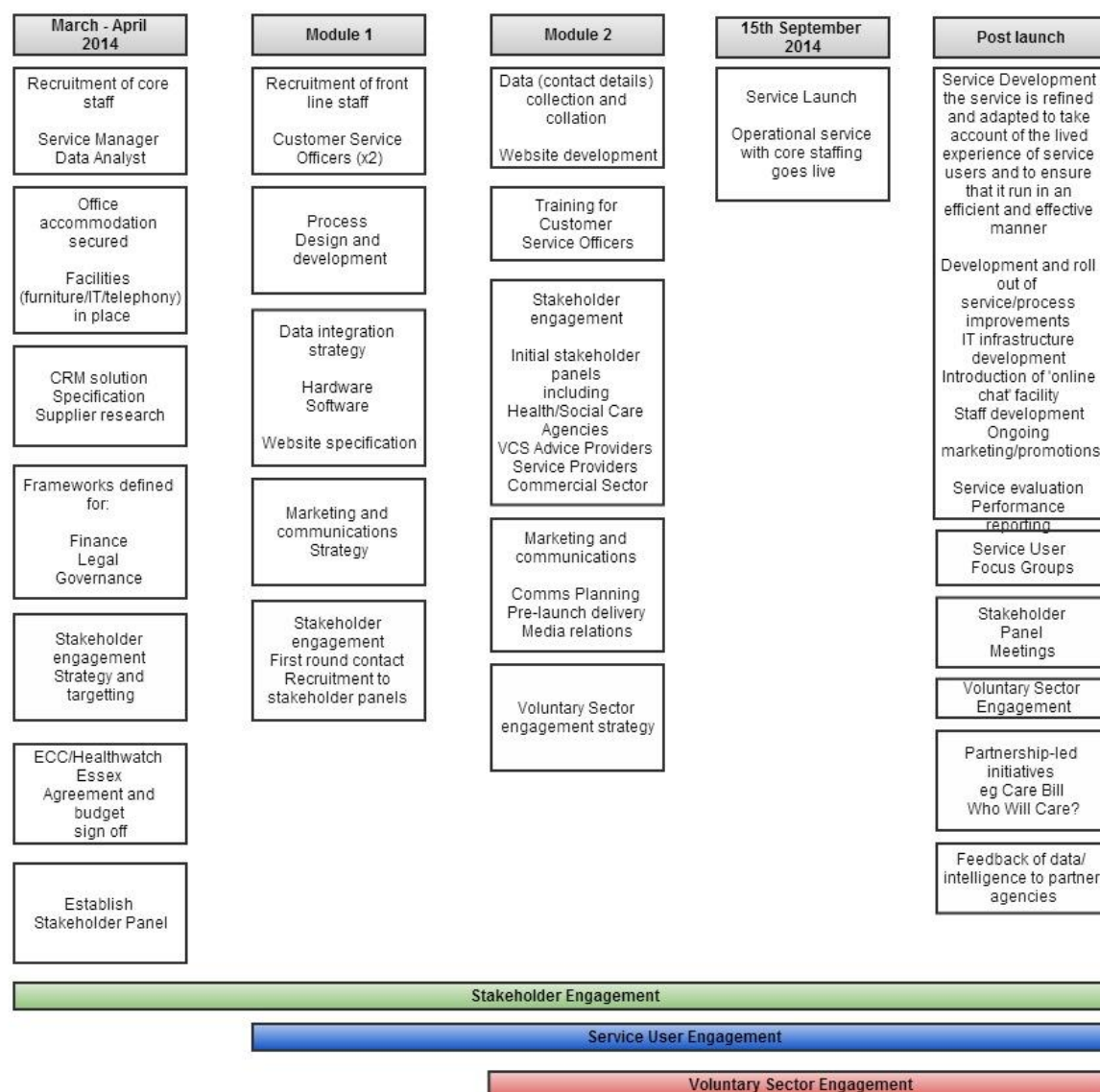
2. A two-phased timeline

The overall project timeline is framed around a proposed launch date for the Healthwatch Essex service in September 2014. A top level timeline is shown on the below.

Phase One covers the period up to September, with Phase Two commencing thereafter. Phase one is aimed at ensuring that a basic infrastructure is in place, and will cover:

- The basic infrastructure of an information and signposting service (staffing, technology, process design, data/information);
- Further stakeholder engagement (including continued service user engagement), so that the service meets initial needs/expectations. Engagement with the voluntary sector is a crucial and new component of this;
- Performance metrics;
- Protocols and processes in place to ensure that data/intelligence is feedback to partner organisations, as appropriate.
- Development of 'Citizens Guide to Care'

Phase Two will see the development and expansion the service, including marketing, exploitation of new technologies, partnership working, and development and implementation of the proposed 'Citizens' Guide to Care'.



3. Outcomes and benefits

Healthwatch Essex intends to create a service that will add value by increasing opportunities for coordination, consolidation and collaboration amongst existing providers and future partners, and with clear benefits for service users and the wider public.

For service users and the public, it offers the prospect of a better access via a single point of contact, a more seamless journey through the health and social care landscape and the potential for better outcomes. It is worth emphasising that a crucial underlying principle of the service proposed by Healthwatch Essex is that information provided by the service will be informed by the lived experience of service users and the public themselves, thereby creating a more 'customer-focussed' ethos.

In addition to providing this improved 'customer interface' to health and social care, Healthwatch Essex also believes that there are significant benefits that can accrue to the wider health and social care economy through the development of a strong set of partnerships across the health, social care and the voluntary sector. This will enable Healthwatch Essex to build higher levels of:

- *Coordination and consistency*: both at a strategic and operational level, across the county and between health and social care agencies.
- *Inter-agency sharing*: of knowledge, resources and best practice, including staff training and development.
- *Data collection, collation, analysis and reporting*: to inform the development of future policy and to underpin service improvement.

In summary, the new service is being designed to add value at both an individual and a system-wide, strategic level. In addition, the service will complement the core purpose of Healthwatch Essex – through significantly enhancing the capacity of Healthwatch Essex to consolidate evidence of people's voice and lived experience, and to use this to shape and improve the commissioning and provisioning of health and social care services.

FINANCIAL IMPLICATIONS

Essex County Council (ECC) receives funding through a variety of sources including Department of Health Local Reform and Community Voices Grant, with a requirement to support Healthwatch services. In 2014/15, £780,000 is budgeted for Healthwatch; £480,000 supports the annual operating costs and £300,000 is available to deliver the Information and Signposting service for health and social care.

No additional funding is sought or required from ECC or NHS partner organisations, and the operational structure of the service is designed to fit within the allocated £300,000 funding envelope. The two-phased approach to the introduction of the prospective service is intended to ensure that ECC and NHS partner organisations are fully involved in the design and implementation of the new provision.

As set out in this report, the initial focus of the service is upon improving citizen access to information and services, and to improve inter-agency handling and use of intelligence and management information. At this stage, there has been no modelling of the potential financial benefits of the service, although it is anticipated that this could include a reduction in unnecessary contacts between citizens and statutory agencies, and improved self-management of people's health and social care needs. These outcomes are in-line with the recommendations of the recent Who Will Care? Commission report, ECC's developing customer experience strategy, and the integration agenda between health and social care.

EQUALITY AND DIVERSITY

These proposals have been designed with a commitment to equality and diversity at their centre. For example, the user engagement conducted to date was designed to capture the lived experience of a diverse range of 'consumers' of information, reflecting differences based on age, geography, disability, health condition or a combination of these. This recruitment approach meant individual focus groups were reasonably homogenous, ensuring a constructive group dynamic with participants that were comfortable with each other, and that the experiences of a range of people were explored across the groups. A full description of this is set out in the accompanying report, *Exploring people's experiences of finding out about health and social care services*. (see Background Papers).

Enhanced and wide-reaching access to information is at the heart of the proposals. As the plans develop, Healthwatch Essex will ensure that the access needs of all citizens are met (thereby addressing deficits within the current system), including (for example) people with sensory impairments, or people with language or cultural barriers that prevent appropriate or meaningful access information about health and social care.

A full EIA will be completed as part of the planning process.

BACKGROUND PAPERS

None