How does Focussed Care work address missingness in healthcare?

Overview

We are a team of researchers based at the Universities of Glasgow, Oxford and Bath, who are undertaking an NIHR-funded project exploring 'missingness' in healthcare, placing focus on the causes of missingness and interventions to address it. On 10th July 2024, two of our project team, Andrea Williamson and David Baruffati, visited Oldham to spend a day shadowing four Focused Care Workers (FCWs) to understand how the work undertaken by Focused Care (FC) can help to reduce missingness in healthcare. By 'missingness' we refer to:

> "the repeated tendency not to take up offers of care, such that it has a negative impact on the person and their life chances"(1).

Previous epidemiological work has shown that people who experience missingness tend to experience multimorbidity, socioeconomic deprivation and far higher premature mortality than the general population (2, 3). Missingness therefore represents a significant public health issue, and one that should be a focus of attention for policymakers, practitioners and all those responsible for the health our population (4). While the wide-ranging work that FC undertake is not specifically targeted towards, or limited to addressing missingness, reengaging people experiencing missingness with care is an integral part of the work they undertake. Drawing on our knowledge of the drivers of missingness and what may work to address it, this brief report explores how the FC model provides invaluable support to people affected by missingness.

Applying a 'Missingness Lens'

During our visit, it became apparent that FC apply a **'missingness lens'** to their work with people facing barriers to accessing and engaging with healthcare. By this, we refer to **several important principles** which underpin the work that FC undertake, and which cut across specific interventions. Firstly, FC moves far beyond the predominant understanding – still apparent across policy, research and, practice – that missed appointments are primarily a problem *for* services*, caused by*, and are the sole responsibility of, individual patients. FC's work is instead underpinned by an understanding that a range of unmet material and social needs in addition to clinical needs can make engaging in care hugely challenging for many people. As a service, they **take responsibility** for **addressing these, and the array of service-side barriers which are so often overlooked**. Second, rooted in this understanding, FCWs work closely with people who have been referred to them by GPs or other health and social care services to determine, in a person-centred fashion, what social and clinical issues people are facing, which of these are priorities for each individual, and provide intensive support to

address them **using transparency collaboration and communication**. In doing so, they **work collaboratively with other services** more suited towards addressing specific needs; and establish a knowledge base of local operating conditions and ongoing relationships with these external services. Third, their work is rooted in the principle of **'proportionate universalism'**(5): providing support proportionate to need. This is true of the service as a whole – in providing **targeted support to those facing poverty, marginalisation and exclusion and the wider social determinants of health** – but also in relation to day-to-day decisions made regarding immediate priorities for support work. Fourth, the ethos of FC is one rooted in empathy and knowledge of the **importance of strong, stable and psychologically safe relationships with professionals**. Finally, interventions were aimed **towards patient empowerment**. While FC interventions were often intensive proportionate to need, offering direct support with often basic needs, this support was actively designed to encourage people to **develop the agency and capacity** to engage more fully in healthcare and other aspects of life over time.

Interventions

Our study has been developing a flexible suite of interventions, guided by the principles described above, which healthcare services can draw on to address missingness. During our visit, we found that many of what we have developed thus far overlapped with components of the FC model. These are explored in turn below.

Embedding a missingness lens as usual practice

The FC approach uses a missingness lens and missingness interventions as applicable to their setting. They report influencing attitudes and behaviours about missingness amongst the wider GP practice staff and wider colleagues they work with. However, their remit is not specifically to bring about systems change.

Proactive and ongoing identification of patients at risk of missingness

Clearly, an important first step in providing targeted support to individuals who are experiencing missingness is to identify these individuals. In FC, this work is typically undertaken by a member of practice staff (often a receptionist or a GP) who identify a patient as 'missing', or vulnerable to 'missingness' and provide an onward referral to FCWs. At this point, FCWs use a range of tactics to engage individuals in care.

Contact and outreach

Our research has highlighted that effective communication around what appointments will involve, emphasis regarding the importance of each appointment, the provision of reminders to attend and inquiry as to barriers which may have arisen to attendance each help to address missingness. If a patient has not attended by around 5-10 minutes into an appointment with a FCW, they contact the patient. The tone is not punitive, but seeks

to encourage people back into care; 'Are you OK? You had an appointment but don't worry about it, we can reschedule. When would suit?'. Sometimes, FCWs have to rearrange a visit with a patient because a crisis has arisen with another patient. A similar approach is used: honesty and empathy, establishing with the patient that this is okay, and rearranging for a time that would suit that patient.

Conversations with FCWs on our visit highlighted the persistence that was often needed for positive outcomes. One worker spoke of a patient who hadn't responded having been contacted eight times, through phone calls, text messages, emails, letters, door-knocking, leaving notes. The worker described passing her house on her way to see another patient, and she wrote and delivered a hand-written letter through the door encouraging, in an open and empathetic way, the individual to get in touch with her if ever she felt in a position to. This person presented at the GP practice the next day, asking for this worker and is now engaged in care. One FCW highlighted that home visits form a particularly valuable component of their work in allowing them a fuller view of the contexts within which people are living, and the needs they are facing. Specific reengagement tactics are devised and deployed on a person-centred basis, rooted in an understanding, developed by the FCW through engagement with the patient, of what their needs are and what might work to encourage them to reengage in care.

Flexible Scheduling

Mainstream, and often specialist, healthcare services typically offer little flexibility regarding when appointments will take place, show little understanding of the barriers which people face in presenting on time, and often act to exclude those who face challenges in presenting in this manner. During our visit, it appeared that FCWs will arbitrate for flexible appointments with the GP practice and other services to ensure that appointments were at a time which suited the patient. FCWs themselves do not have set time or days and accommodate patients whenever they can attend.

Transport and Logistics

Accessible provision of practical support to attend appointments is key to attendance for people experiencing poverty and other forms of marginalisation. As part of their comprehensive assessment of social needs, we saw FCWs assessing whether people would be practically able to travel to their appointment. During our visit, this involved the FCW offering the patient a lift in her car to an important appointment. He highlighted that he would be able to travel to an appointment at his practice, which was two miles away from his home, on his mobility scooter. To support this, the FCW looked online to check the range of the scooter and ensured that it was able to cover the journey.

Relational Communication changes

The establishment and ongoing maintenance of positive caring relationships is a vitally important part of addressing missingness and is an essential facilitator for other interventions to be put into place successfully and sustainably. Relationships are typically established with one FCW, enhancing the relationship through allowing trust and rapport to develop.

FCWs also attempt to map and develop an individual's support network. The initial consultation with new patients includes clearance to get in contact with family members where this would improve the care and support provided to the individual. On one of the home visits, this involved asking someone if they would be able to provide their son's phone number and permission to get in touch with them. Following this visit, the FCW highlighted that they would be able to ask the patient's son for an assessment of his wellbeing, and to use him to identify further needs which he had not disclosed.

Communication with patients was informal and flexible: asking patients how they prefer to be contacted, and using their preferred means of communication – WhatsApp, texts, phone calls – appeared to be standard. While writing up case-notes, one FCW received a phone call from a patient facing a crisis and wanting to 'get things off her chest'. The FCW signed off by saying 'you know you can contact me whenever you need'. This worker suggested that the extent of contact from patients varied, with some not calling at all and others phoning almost daily. They suggested that sticking to any promises made, and not building up false expectations about achievements and timelines for change, were important in establishing trust with individuals. Reflecting the graded model of support described previously, patients are not rigidly 'discharged'. Instead, the patient and worker come to a mutual agreement to scale down and withdraw support when they feel the time is right, with an agreement that they can get back in touch whenever needed.

Use of Proxy Candidates

Within our research, what we term 'proxy candidates' – those working as 'wayfinders' identifying and providing practical support to attend services and working to develop pathways for individuals where they usually don't exist – are hugely valuable in helping to addressing missingness. This forms a central part of the FCW role, with these workers acting as proxy candidates across primary and secondary healthcare, social care, housing and other services. The visits highlighted a number of practical aspects of this role. FCWs tend to have a caseload of around 30-40 patients. Within this, patients vary widely in the level and intensity of support required, with this often fluctuating over time.

While the work undertaken by FCW is similar to the community link worker (CLW) role in Scotland, in that the CLW will seek to proactively address issues which patients face, the FCWs highlighted that the role is dissimilar to those (such as the 'social prescribing' role

in England) which are limited to passive signposting to services and wider support. During the visit, one FCW described some crossovers with CLW in England. Given this, they suggested that they contact any services already supporting an individual to determine what support they were providing, avoiding the duplication of work while assisting in the coordination of these services around the individual.

With our research having demonstrated that people experiencing missingness often face multiple, overlapping social and clinical needs, working to identify and address this array of needs is vital to improve people's capacity to engage in healthcare. In assessing a patient's structural vulnerability, we heard that FC take a 'failure to thrive' approach, which seeks to identify people who are facing multiple unmet social and, often, clinical needs. With a range of agencies – GPs, schools, housing offices, criminal justice organisations for example FCWs then undertake an evaluation to assess these needs. This assessment involves building up an understanding of the individual's social needs – including assessment of caring roles, abusive relationships, asylum status, housing needs – and clinical needs, including physical and mental disabilities, mental health conditions, problem substance use, long term physical conditions (and their management), current medication and screening history for various conditions. FCWs work to update their knowledge on these evolving needs throughout their relationship with the patient.

Addressing these needs often requires involvement from multiple agencies with different specialisations. FCWs work proactively to help to address these through collaboration with other team members (FCW are recruited from different professional backgrounds, offering a wide range of knowledge and expertise) and through contacting other services to engage the individual in different forms of support. Building ongoing relationships with a range of services is essential to this.

During the visit, we saw a FCW attempting to map all of the services already tied into an individual's care and suggest linking in other services where necessary. The FCW, with the patient's permission, read their case-notes from a social care visitor and said that they would phone the care worker to inquire regarding the person's request to reduce the number of social care visits per day. Through such work, FCWs play a vital role in coordinating care between what can be a complex array of services involved with the individual.

One of the workers highlighted that the FCW role requires key attributes: being a 'people person' and a good listener; being an effective problem solver; having empathy and compassion, and having tenacity. Importantly, FCWs provide pastoral support for FCW colleagues on a regular basis to allow workers to maintain their own wellbeing in what is often a challenging role.

Conclusions

From what we understand, while the work that FC undertakes was not explicitly designed to address missingness when it was set up; it is such a central component of the challenges patients have that this forms a core element of what FC does. Strategies FC use apply a missingness lens and embody all the patient and service delivery orientated aspects of what our research has found. FC is a best practice exemplar to address missingness in healthcare.

Dr David Baruffati and Professor Andrea Williamson

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References

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