Independent evaluation of Case Management in Primary Care on the Isle of Wight

March 2018

Evaluation team

Sydney Anstee, Consultant Researcher, Centre for Implementation Science, University of Southampton

Dr. Andrew Sibley, Evaluation Programme Manager, Wessex AHSN

Philippa Darnton, Evaluation Lead, Wessex Academic Health Science Network (AHSN)

Joe Sladen, Evaluation Programme Manager, Wessex AHSN

Correspondence

Philippa Darnton, Wessex Academic Health Science Network Limited, Innovation Centre, 2 Venture Road, Chilworth, Southampton, SO16 7NP

Disclaimer

This report presents the findings of an independent evaluation comprising qualitative research methods for the Isle of Wight Case Management of Those Most at Risk Process. The findings and interpretations in this report were those of the author and do not necessarily represent the views of those working in the services.

Acknowledgement

We would like to thank the Case Management of Those Most at Risk Process participants for letting us letting us interview them and for their participation in this evaluation.

Contents

Executive Summary 2
1. Context and introduction 4
2. The CMoTAR process 6
4. Synthesised findings 9
5. Conclusions 14
Appendix 1 – MDT Logic Model 17

Executive Summary

Wessex Academic Health Science Network (AHSN), as the independent evaluation partner for the My Life a Full Life model of care, has evaluated the **Case Management of those at risk (CMoTAR) process** in primary care on the Isle of Wight.

The focus of this evaluation was the implementation of CMoTAR, to understand how well the process was being delivered, to understand the barriers and enablers to implementation, and to consider opportunities for improvement to the process.

The report addressed the following evaluation questions:

- What is the acceptability of this model?
- What are the implementation issues associated with delivery of the CMoTAR programme?
- What are the perceived effects of this approach to multi-disciplinary team (MDT) working on primary care and on people who receive care?
- What are the challenges and how could the service be improved?

The evaluation fieldwork was undertaken over a two month period from October to November 2017. This report presents the synthesised findings of this fieldwork.

Three coordinators of CMoTAR participated in a focus group in October 2017 about the day-to-day activities of their service. Five staff from GP surgeries adopting this MDT approach were interviewed about their experience in November 2017. Despite attempts, it was not possible to recruit staff from surgeries that did not adopt the MDT approach to take part in this evaluation.

Two main messages were apparent from the findings. Firstly, considerable disengagement by GP surgeries was observed. Only six of 16 surgeries participated in the CMoTAR programme. The reasons for this disengagement were sought but not obtained due to non-participating surgeries' disengagement with the evaluation work. From this finding, it must be concluded that adoption and spread was limited.

Secondly, participating surgeries were generally positive towards this approach to MDT working, however, a range of implementation problems were identified and improvements suggested. These findings offer possible reasons for why the majority of GP surgeries were disengaged.

Positive conclusions can be drawn from participating surgeries. On the whole, those engaged in this approach to MDT working were able to see that the purpose of CMoTAR was to improve care and reduce resource use. They were able to distinguish the programme as distinct from other initiatives and viewed it as worthwhile. They were also able to see positive effects of CMoTAR and were motivated to continue delivering this programme. The perceived outcomes for patients and the system included better coordination of health and social care, visible improvements for patients, a safety-net in case of crisis, reduced loss of complex patients, less duplication for both professionals and patients, less calls to out of hours services, 111, 999 and less hospital presentations. However, it should be noted that the scope of this evaluation did not objectively measure any of these outcomes. Any further evaluation work would benefit from a quantitative analysis of hospital and GP activity.

A wide range of operational issues affected the implementation of this approach to MDT working. Whilst some issues have been addressed during the course of the evaluation (e.g. consent by people to be discussed by the MDT team, assessment tool use), some continue e.g. lack of standardisation of systems, low numbers of patients and infrequent MDT meetings, insufficient time and capacity to deliver and confusion over possible duplication with the Integrated Locality Service (ILS) programme. With such a large range of challenges, it would be appropriate to address these prior to attempting further roll-out of CMoTAR.

1. Context and introduction

1.1. Brief purpose of this report

Wessex Academic Health Science Network (AHSN), as the independent evaluation partner for the Isle of Wight My Life a Full Life model of care, has evaluated the CMoTAR approach to multi-disciplinary team (MDT) working in primary care on the Isle of Wight. This report presents the results of a qualitative evaluation of this process.

1.2. Context

Like many areas of England, the Isle of Wight (IoW) has a number of pressures and challenges for its health and care services, including an increasing demand for service through increased life expectancy, financial pressures, and through more people living with long term health conditions. These challenges are further defined by the unique demographic make-up of the island's 140,000 residents and the way this demographic is changing.

The Island's population is older than the national average, with 27% being over age 65 - this is higher than the national average, and the 15th highest level of any local authority area in England and Wales[1]. The proportion of over 65's is expected to increase significantly in the coming decade, putting further pressure on the health and care services.

The Island has no fixed link to the mainland meaning that access to and from the Island is by ferry, or in emergencies, by helicopter. The consequence of no fixed link is that the Island can get cut off from the mainland during poor weather.

The IoW My Life a Full Life model of care has the goal of making changes to the way care is delivered on the Island to help address some of these challenges, and aims to:

- ***Prevent ill health*** – through information, advice and support to help people stay healthy and prevent them from becoming ill
- ***Coordinate care*** – by bringing different services together to work as an integrated team to work collectively for the person
- ***Improve access to services*** – by making the right care and support available the right time, and where possible, bringing care and support closer to home, or even in the home where possible
- ***Provide better quality services***, with the resources available

The development of the CMoTAR process in primary care was in response to the programmes goals of improving access to services by bringing care closer to a person's home and improving services for people who are most vulnerable. The new process commenced in 2016. It aims to identify those people most at risk of declining health and/or with a risk of a hospital admission, and through multidisciplinary team working and proactive case management of that cohort to reduce avoidable admissions and develop plans for such people to remain as well and independent as possible in the community.

[1] IoW Council – Joint Strategic Needs Assessment - Demographics and Population 2016/17, updated October 2017. https://www.iwight.com/azservices/documents/2552-Isle-of-Wight-Demographic-and-Population-factsheet-2016-17-Final-SS-v2.pdf

Further, the specific goals of the MDT process are for people to:

- remain at the centre of care planning
- have a personal wellness plan which, which wherever possible has been co-produced
- remain as well and independent as possible
- have a reduction in exacerbation of conditions
- decrease emergencies and unplanned hospital admissions
- decrease attendances at GP surgeries
- be supported to remain in their own homes or choice of residence
- reduce, or delay, enhanced care packages and or long term placements
- increased satisfaction from individuals, families and carers is reported

Multi-disciplinary professional case management is an established tool and method of integrating services around the needs of individuals who have complex and/or long-term conditions. Where such processes are implemented effectively, they have improved the experiences of users and carers, supported better care outcomes, reduced the utilisation of hospital-based services, and enabled a more cost-effective approach to care.

The intended outcomes of the CMoTAR process and longer term impacts are defined in the service Logic Model, provided at Appendix 1. The logic model was developed by the Vanguard.

1.3. Scope of the Evaluation

The focus of this evaluation is the implementation of the CMoTAR MDT model, to understand how well the process is being delivered, to understand the barriers and enablers to implementation, and to consider opportunities for improvement to the process. This report presents the findings from this evaluation.

The report addresses the following evaluation questions:

- What is the acceptability of this model?
- What are the implementation issues associated with delivery of this MDT approach?
- What are the perceived effects of MDTs on primary care and on people who receive care?
- What are the challenges and how could the service be improved?

The evaluation fieldwork was undertaken over a two month period from October to November 2017. This report presents the synthesised findings of this fieldwork.

2. The CMoTAR process

2.1. Delivery Model

At inception, the vision was for all 16 GP surgeries on the IoW to undertake this approach to case management of those at risk (CMoTAR), and a Local Incentive Scheme (LIS) payment was provided to all GP surgeries to facilitate the implementation of this. This LIS payment enabled each practice to release one administrator to act as a "MDT Coordinator" one day per week.

The MDT Coordinator has the responsibility of managing the CMoTAR process within their practice. Responsibilities include arranging the MDT meetings, generating the list of people to be discussed, facilitating actions and act to as the single point of access for the MDT process in their practice.

Under the designed CMoTAR model, meetings should take place every 6 weeks to allow time for actions and interventions to be completed between meetings, but be frequent enough to facilitate timely resolutions and interventions for individuals.

Any professional attending a meeting is able to nominate a person for discussion, however case finding is usually completed through the professional judgement of a MDT member, and/or by using the ACG risk stratification tool (now called IPA).

The desired MDT core team is listed below, however in some surgeries, attendance covers a narrower, or wider range of professionals:

- GP
- Nursing role
- Social worker
- Care Navigator
- Local Area Coordinator
- MDT Coordinator
- Physiotherapist/Occupational therapist

Despite the initial intention to implement MDTs in all 16 GP surgeries, only six surgeries had adopted this approach at the time of the evaluation and only these surgeries participated in the interviews.

2.2. Costs of providing the service

The total sum available for the 2016-17 LIS was £27,018.72, which was split equally across each of the sixteen IoW Surgeries. This amount is based on each Practice employing one Co-ordinator at the top point of Band 4 for 1 day (7.5 hours) per week for 17 weeks, and equates to £1688.67 per practice. For 2017-18, the payment is £3,875 per practice or £61,985 in total.

3. Evaluation Approach

3.1. Introduction – Data Collection

This evaluation study used the following methods to collect data from participants: a) semi-structured focus group discussions with MDT coordinators (qualitative data collection) and a quantitative questionnaire employing Normalisation Process Theory (NPT) at the end of the focus group session; b) semi-structured, one-to-one interviews (qualitative data collection). Further details are in the full Technical Report (available on request).

The NPT questionnaire was used to provide insights into behaviours associated with implementing new ways of working. Participants were asked to complete this questionnaire independently from each other. NPT proposes four constructs that represent different kinds of work that people do around implementing a new practice, comprising coherence; participation; action; and monitoring. (For further information on NPT, please see Prof. Carl May's work at http://www.normalizationprocess.org/).

The purpose of each evaluation activity:

- **Focus Group (FG)**: this session with MDT coordinators sought to explore the experiences of those directly involved with delivering the service on a day-to-day basis
- **NPT questionnaire**: sought to understand how the new MDT process has been embedded into practice and where service development may be required
- **Focus Group and NPT**: Additionally, these elements of the evaluation provided areas to explore further with MDT decision makers
- **Interviews with decision makers (programme leads, GP leads and specialist roles)**: sought to understand implementation issues (along NPT lines), to explore logistical issues in the FG and NPT questionnaire and gather views on the perceived effects of the MDT process. The interview added consideration of other programmes running on the IoW such as the Integrated Locality Service.

Evidence from all data sources has been brought together into a single synthesis in order to answer the evaluation questions set out at 1.3.

Participants were selected for each aspect of the study using the following methods:

- **Focus Group**: All those staff involved in delivering the MDT's were eligible to take part in the focus group. The MDT Programme Lead invited all such staff to the group meeting. Six eligible staff agreed to participate, three staff gave apologies, three attended
- **NPT questionnaire**: Those staff attending the focus group were invited to complete the NPT questionnaire
- **Staff interviews**: The MDT Programme Lead provided contact details for a variety of staff who are MDT decision makers in all the surgeries who are engaging with the MDT process to different extents: surgeries who have chosen to take part; have chosen to take part in MDT but are running the groups irregularly or not at all now; or those who have not implemented MDT at all. The latter two groups were invited to participate to explore surgeries' reasons for not adopting the MDT approach

- All participants were provided with Participant Information Sheets and asked to sign Consent forms before any activity took place

3.2. Data analysis and synthesis

Both the focus group and interviews were semi-structured sessions to promote open discussions and the ability to cover the topics or issues that were important to participants. The questionnaire was replicated and transposed to paper from the NPT online toolkit www.normalization.org/npt-toolkit. Data was collected via note taking, paper questionnaire and audio-recorded interviews. All were converted to Word and Excel files. This report has synthesised the series of data collection activities by using frameworks developed through commonality of themes following summaries of the findings; by extracting discrete elements from the NPT questionnaire and applying the NPT radar output; by recording more subtle observations in narrative form, such as holistic considerations, beliefs and attitudes.

It is important to note the limitations within the evaluation. The evaluation team had no ability to directly select participants to attend the focus group, or participate in interviews; however an inclusive sampling selection method was used to ensure that as many people were invited to participate as possible. All elements of the evaluation have a small number of participants and therefore the findings of this evaluation may be limited to the view of the limited number of participants.

It is also important to understand that capacity issues in primary care may have limited those who could attend. Similarly, those surgeries which are no longer using the MDT process may have chosen not to attend/participate – this evaluation acknowledges the importance of the opinions of this cohort and that these were not able to be represented in this report.

4. Synthesised findings

Three MDT coordinators participated in a focus group in October 2017 about the day-to-day activities of their service. Five staff from GP surgeries adopting CMoTAR were interviewed about their experience of the process in November 2017. Despite attempts, it was not possible to recruit staff from surgeries that did not adopt CMoTAR.

This section of the report separates findings into, firstly, those about implementation, and secondly, those about impact and challenges.

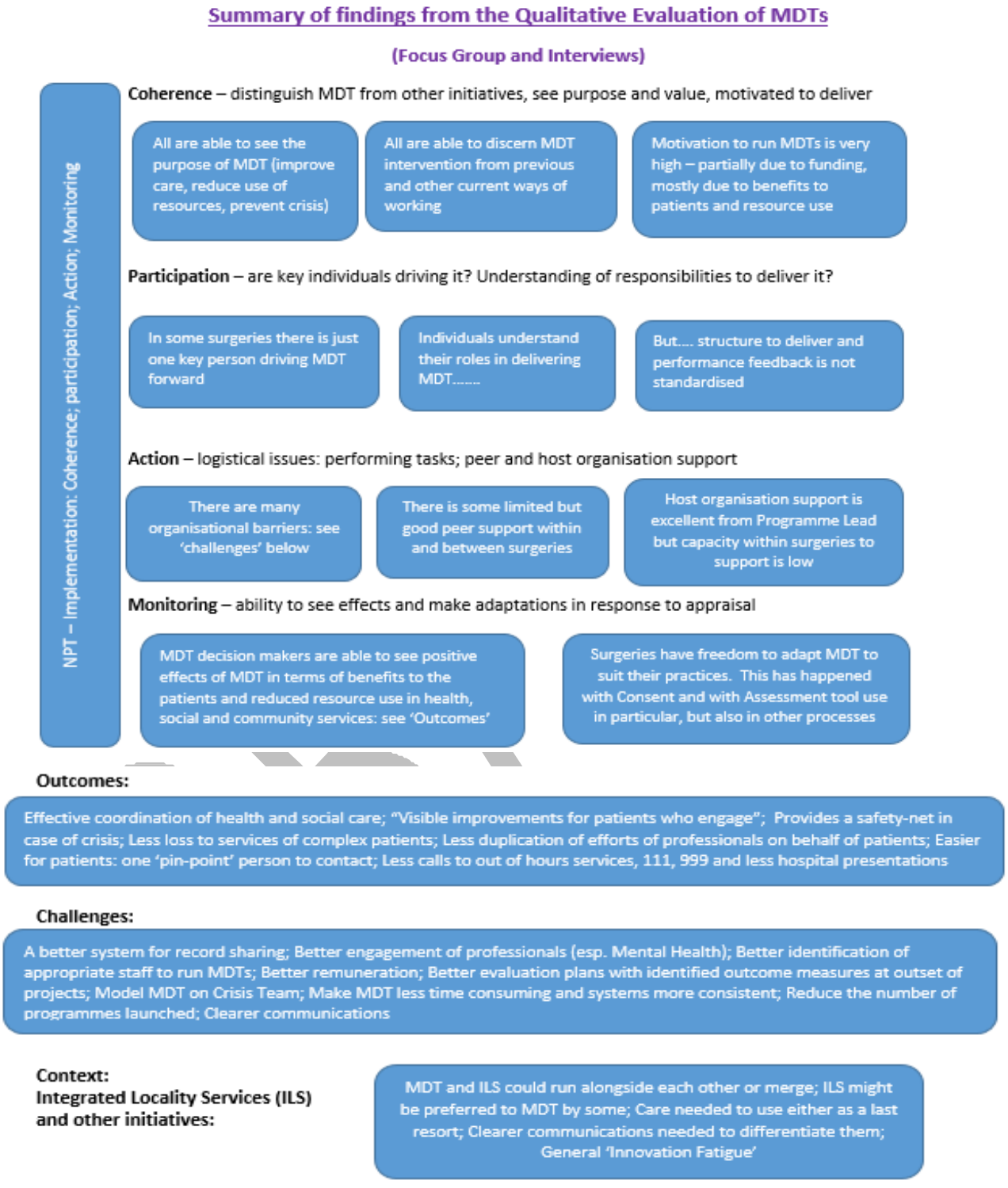
Figure 1 below is an illustrative description of the synthesised findings from all evaluation activities, organised into a framework that follows the four domains of NPT. It also presents findings about impacts, challenges and wider issues.

In the first section on implementation, NPT suggests there are important theoretical areas to assess whether a new innovation has been implemented into practice: coherence, participation, action and monitoring. Following Figure 1 is a summary of the key points raised by the focus group discussions and the focus group questionnaire with the participants who administer MDT, followed by the key points raised by interview participants who are MDT decision makers. All the available data is presented in full Technical Report (available on request).

Importantly, NPT was not used as a guiding framework to implement the MDT work or to support the MDT work as it developed. Its use here is to highlight what type of implementation behaviour was present or not present during the roll-out of this initiative. This was considered the best way to represent the data collected which was largely about implementation issues and challenges.

In the second section on impacts, challenges, and wider issues, a range of findings are highlighted by staff participating in MDT working. For example, they reported that the MDT approach was an effective coordination of health and social care leading to “visible improvements for patients who engage”, and for those who don’t engage with MDT a safety-net in case of crisis as “the door is still open”.

Figure 1: Synthesised findings about the implementation, impacts and challenges of MDT working on the Isle of Wight



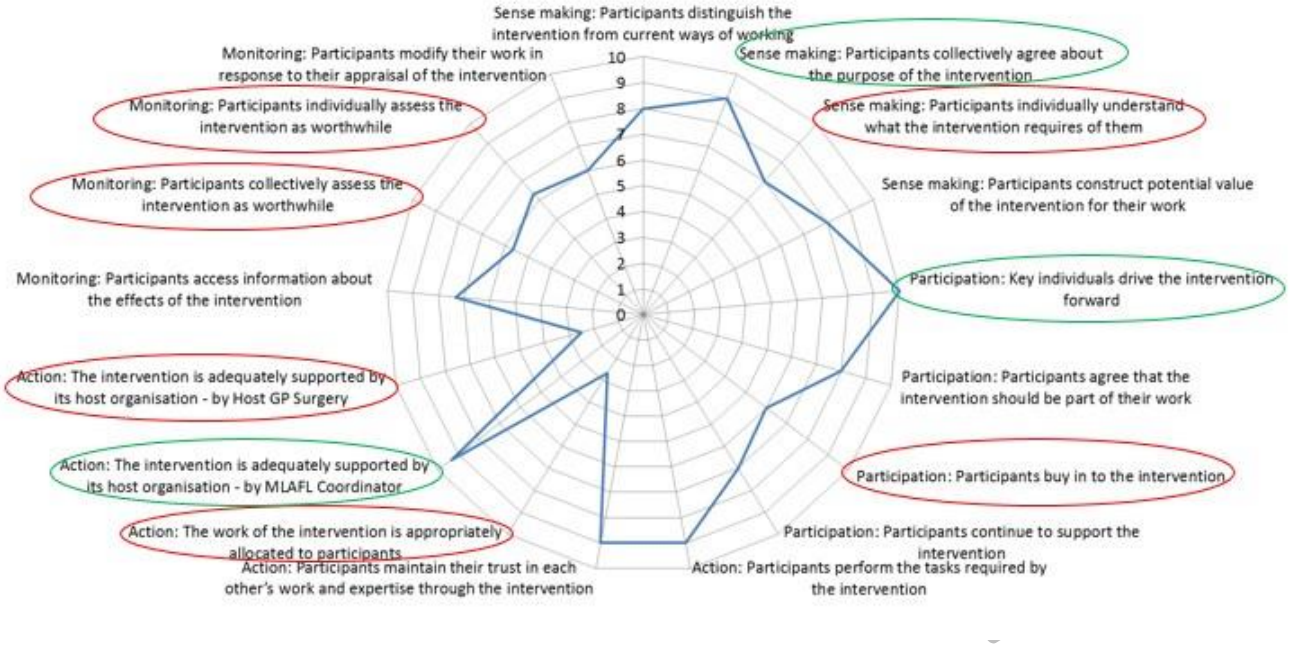
4.1. Implementation of the MDT approach in participating surgeries on the Isle of Wight

Findings from the focus groups and interviews regarding implementation issues were as follows:

- Participants could discern the intervention from previous ways of working, can see the purpose and view MDT as worthwhile to patients. Although it's important to state the group of participants were from an administration background and not involved in direct person care. This finding may be different for clinical staff.
- There was a lack of standardisation / structure – there was some dissonance between discussions and NPT surveys in that participants say they understand what the intervention requires of them, but also say there was confusion about forms, loose guidance and surgeries each running MDT differently.
- Peer support to deliver MDT was informal and between a limited number of surgeries.
- There was limited engagement from all GPs, mental health and social services.
- Low numbers of people were identified for MDT discussion: there were plenty who might be eligible for MDT but it was too difficult to gain consent, therefore the frequency of the meetings was low *(NB. Consent process has changed since).*
- The current scale of the service is at odds with the view of its value, but participants generally agreed it is worthwhile and should continue.
- Time to arrange MDTs was not protected by the surgeries and was less than budgeted/allocated.

Figure 2 shows the strength that participants assigned to each of the domains in the NPT questionnaire. The statements circled in green are those viewed most positively by the respondents. Participants collectively agreed about the purpose of the intervention, key individuals drove the intervention forward, and there was adequate support for the intervention. The least positive responses were for the statements relating to the extent of support provided by the GP practice, the appropriate allocation of work and the assessment of the work as worthwhile. Please see the full Technical Report (available on request).

Figure 2: Participants views on successful and less successful areas of implementation work



4.2. Impacts and challenges of working with the MDT approach

Interviews with five staff from participating surgeries reported a range of impacts and challenges from their experience of MDT working. The following outcomes were perceived by the staff (see Figure 1):

- ***Effective coordination*** of health and social care lead to "***visible improvements for patients who engage***", and for those patients who aren't involved with an MDT, it was a ***safety-net*** in case of crisis as "the door is still open". Participants said there was ***less duplication*** of efforts of professionals on behalf of patients and that there was a reduced loss of complex patients to services – i.e. "***less falling between the gaps of services"***.
- It was their view this programme made it easier for patients to have ***one "pin-point contact"*** to the team and this led to "***less calls to out of hours services"***, 111, 999 and "***less hospital presentations."***

The interviews also provided insight into some of the logistical challenges experienced by staff:

- For some staff it was part of their role to deliver MDT and not a problem but others ***struggled to find the time*** as an additional element to their usual role. Having the ***capacity*** and right staff to run MDT was a difficult challenge.
- ***Attendance and engagement*** was often a problem. Getting attendance from some groups such as mental health and social care was especially challenging. There were also difficulties with GPs engaging with patients with social issues. Participants reported there were ***enough patients eligible*** for MDT to run regular meetings and the ***assessment tool was not needed*** to identify them, but getting ***written consent was too burdensome*** and unnecessary (this has now changed to verbal or implied consent).

- ***Support and communications***: Participants reported there was good support from the Programme Lead but all stated communications from more senior leads had been confusing with regard to other new programs and whether or not the MDT programme would continue. There appeared to be a general feeling of ***'Innovation Fatigue'***. In addition, staff reported issues with ***computer systems not being suitable*** for staff requiring to access for MDT work.

Several wider issues were also elicited and are summarised below:

- Before MDTs: A couple of surgeries ran MDTs before the funded programme was introduced, but for others there was nothing similar except Community Watch. Usual care was for health and social care to operate separately.
- MDT purpose: all agreed on the aim of MDT to produce benefits for patients through streamlining care, reducing duplications, saving GP resources and saving patients from falling between services, being isolated and vulnerable.
- Motivation to run MDTs: whilst dedicated funding was identified for the set-up of some MDTs, staff confidence in the benefits to patients and surgeries appeared to provide the strongest motivation to continue with or without funding in future – at least in the case of the participating surgeries.
- Current alternatives to MDT: Other Island programmes, including Care Navigators, Local Area Coordinators and Integrated Locality Services, may provide similar benefits to the MDT model but the picture was considered unclear about which approach or combination of approaches would best suit the whole system.
- Evolution of MDT since inception: surgeries have now changed to 'Implied Consent' instead of written consent. All have abandoned the Assessment Tools and most have adapted their MDT to local needs.
- Considerable confusion about the differences between MDTs and Integrated Locality Services (ILS) and uncertainty about their future working relationship. (N.B. At the time of writing, a programme of Community Services Redesign is underway to bring together integrated working across the system).

Overall, participants felt the lack of adoption across the Isle of Wight and logistical challenges prevented the MDT approach from maximizing potential benefits. They suggested the following opportunities for improvement:

- A better system for record sharing (this applies to all projects)
- Better engagement of professionals (especially mental health) and less protectionism from GPs
- Better identification of appropriate staff to run MDTs
- Better remuneration
- Better evaluation plans and identified outcome measures at outset of projects
- Model MDT on Crisis Team (ILS also said this)
- Make MDT less time consuming and systems more consistent
- MLaFL – reduce the number of programmes launched at the same time and have clear communications about all of them from a central source

5. Conclusions

It was clear from the small number of primary care surgeries engaged in the MDT programme (six of 16 surgeries) that adoption and spread was limited. The small group of participating surgeries continued with the programme despite the implementation of other new care models with similar or overlapping objectives, or the option to return to usual care. Our evaluation made a concerted effort to examine and uncover the implementation, process and outcome issues that prompt engagement with and maintenance of this new care model initiative. A number of challenges, identified via the participating surgeries, provided insights into the how difficult it could be to operationalise the CMoTAR MDT process. They also represent possible explanations for the disengagement of other surgeries.

A good mix of participants (eight in total) engaged in our focus group, Normalisation Process Theory (NPT) questionnaires and one-to-one interviews (also employing NPT), in which a good range of data to illustrate collective and individual experiences, behaviours and views in relation to the enablers and barriers of this programme were collected. We also noted this programme was established at the same time as other new models of care. However, it's important to note that the insights described above only relate to participating surgeries. It was not possible to determine why many surgeries did not engage, despite repeated attempts to invite them to contribute their opinions.

Positive conclusions can be drawn from participating surgeries. On the whole, for those engaged in the CMoTAR process, participants were able to see that its purpose was to improve care and reduce resource use. They were able to distinguish the programme as distinct from other initiatives and viewed it as worthwhile. They were also able to see positive effects of CMoTAR and were motivated to continue delivering this programme – with or without funding, although improved funding was desired.

Participating surgeries highlighted a number of challenges to the CMoTAR process and suggested opportunities for improvements. Most notably, the process was considered time consuming and it was hard to find the right staff capacity to run it. Record sharing, systems and communications needed to improve MDT working were considered as sub-optimal. Similarly, more knowledge about funding and evaluation plans at the outset of the programme was desired. At the time of writing, we acknowledge some of these issues are being addressed, in particular assessment, record systems and communications.

A universally stated key challenge for the CMoTAR process was the simultaneous development of Integrated Locality Services (ILS) and a number of other new care models on the Isle of Wight. Participants expressed innovation fatigue in a confusing landscape of initiatives. Unfortunately, we were unable to include participants/surgeries who did not engage with the CMoTAR process. However, it was suspected that disengagement with the programme was related to these issues.

Of note, a circular argument appeared to serve as a key barrier to other professionals engaging with CMoTAR, that being that until they saw results there was no motivation to engage, but of course without engagement it would be difficult to know any potential benefits.

This sample of staff expressed determination to keep the programme running and reported good outcomes as a result of CMoTAR working effectively for them. The perceived outcomes included better coordination of health and social care, visible improvements for patients, a safety-net in case

of crisis, reduced loss of complex patients, less duplication for both professionals and patients, less calls to out of hours services, 111, 999 and less hospital presentations. However, it should be noted the scope of this evaluation did not cover such topics and did not objectively measure any of these outcomes. Any further evaluation work would benefit from a quantitative analysis of hospital and GP activity. Evaluation questions explored:

1) ***What is the acceptability of this model?***
   From the data collected here, which only included staff from six of 16 surgeries, the evidence suggested the concept of CMoTAR was acceptable, valued and desired – the purpose was believed in and the majority (of those limited surgeries engaged) wish it to continue. Importantly, with a large range of challenges and potential improvements highlighted by participating staff, these likely served to negatively affect the perceived acceptability of the model. Therefore, tacking these challenges would likely increase the acceptability of MDT working. In addition, it was our understanding that the remaining disengaged surgeries chose not to adopt the CMoTAR model, but they may have engaged with alternative models of care that have similar objectives (e.g. Care Navigation, Local Area Coordination, or Integrated Locality Services).
2) ***What are the implementation issues associated with delivery of CMoTAR?*** Significant operational issues affected the implementation of this model, as described within the report. Whilst some issues have been addressed during the course of the evaluation (e.g. consent by people to be discussed by the MDT team, assessment tool use), some continue e.g. lack of standardisation of systems, low numbers of patients and infrequent MDT meetings, insufficient time and capacity to deliver and confusion over possible duplication with ILS. With such a large range of challenges, it would be appropriate to address these prior to further attempts to roll-out MDT working.
3) ***What perceived effects does the CMoTAR process have on primary care and on people who receive care?***
   Staff reported a range of potential benefits, such as "visible improvements for patients who engage". For those who aren't involved with CMoTAR it still provided a safety-net in case of crisis as the "the door is still open". It was highlighted that there was reduced loss of complex patients between services and less duplication of efforts of professionals on behalf of patients. Also, it made navigating services easier for patients by providing one 'pin-point' person to contact, fewer calls to out of hours services, 111, 999 and less hospital presentations were reported. However, operational issues were felt to have prevented MDTs from maximising potential benefits.
4) ***What are the challenges and how could the service be improved?***
   The evaluation identified a number of ways in which the implementation of this service model was challenging. There was an inconsistency in approach between participating surgeries, confusion about the relationship with other new care models (particularly ILS), logistical problems across surgeries and confusion about whether or not ILS will replace or complement CMoTAR. It was highlighted there was unclear communication from senior leads on this issue. A range of improvements were suggested, including modelling the CMoTAR MDT process on the Crisis Team as participants felt this programme was a success.

Reflections on the CMoTAR process in relation to the My Life a Full Life (MLaFL) aims:

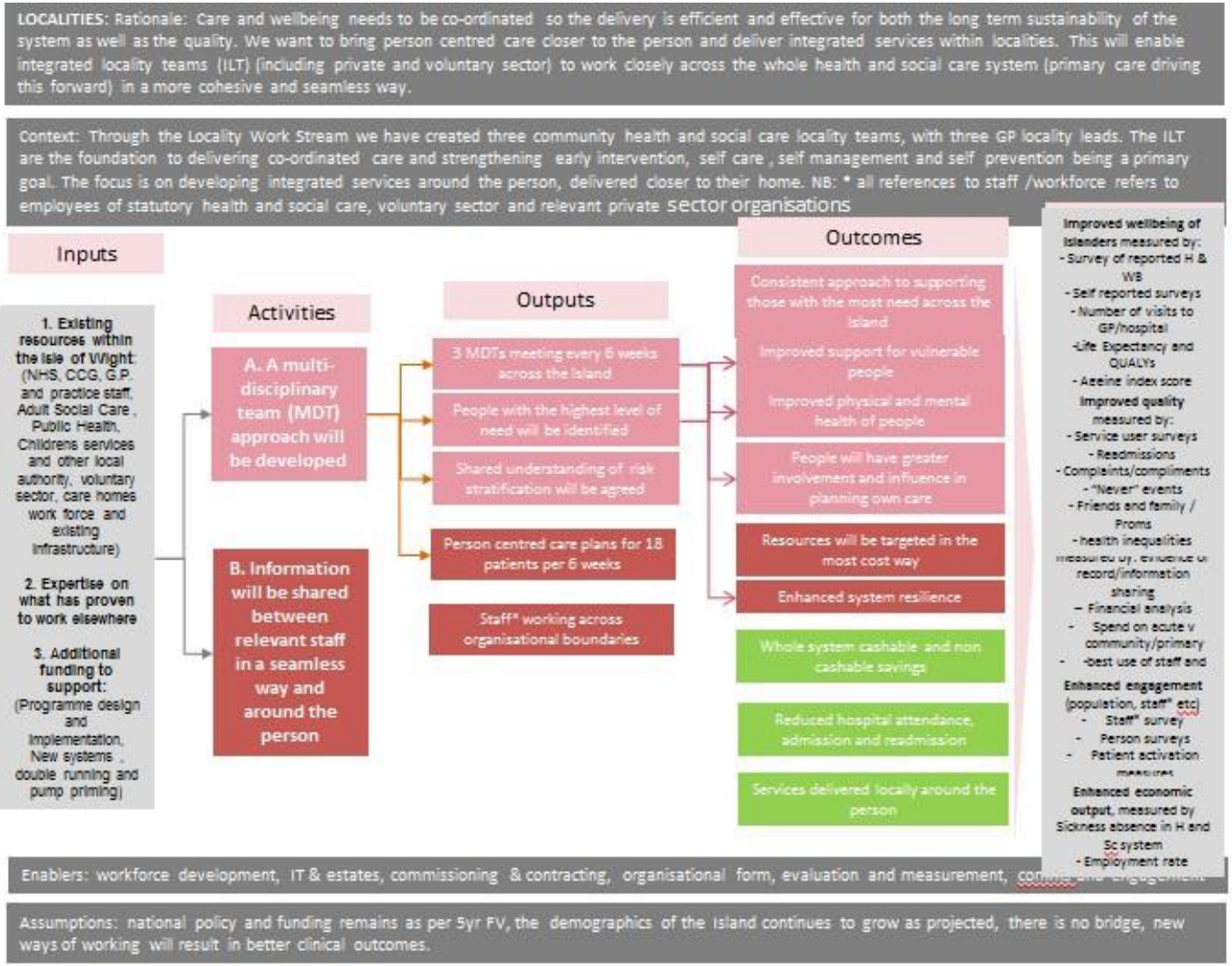
- ***Prevent ill health*** – through information, advice and support to help people stay healthy and prevent them from becoming ill
- ***Coordinated care*** – by bringing different services together to work as an integrated team to work collectively for the person
- ***Improve access to services*** – by making the right care and support available the right time, and where possible, bringing care and support closer to home, or even in the home where possible
- ***Provide better quality services***, with the resources available

Preventing ill health was a difficult aim to assess using this qualitative methodology. Only staff were involved with this evaluation, however, improvements in coordinated care were reported and this may have acted as a mediating factor to support prevention of ill health.

Participants in participating surgeries reported the CMoTAR process did improve integration between health and social care, suggesting coordinated care was successful. Participants reported effective coordination of health and social care led to visible improvements for patients who engage and a safety-net for those who are close to crisis.

Improved access to services was difficult to assess without an activity analysis of patient records. However, staff reported that there was less duplication of efforts by professionals and there was a reduction in complex patients being lost between services. Also, they reported that the CMoTAR process made it easier for patients to have one focus point of contact for the team and this led to less calls to out of hours services, 111, 999 and less hospital presentations.

All of the above suggested, that for participating surgeries, surgeries were providing better quality services. However, the large range of challenges and suggested improvements suggested the quality of services could be improved further or better optimised.

A final point on coordinated care must be made. Reasons for the large scale disengagement of many GP surgeries remain unresolved. Due to the inability of evaluators to speak to disengaged surgeries, it was unclear if implementation failures, internal MLaFL processes or external factors contributed to the limited roll-out of this programme. In order for CMoTAR MDT process on the Isle of Wight to reach is maximum potential, it is recommended that consideration is given to the challenges and disengagement revealed in this evaluation.

Appendix 1 – MDT Logic Model