

Older people's experiences of short term health and social care in Brighton and Hove February 2013



Patient and Service Users' Experiences of Short Term Care Services in Brighton and Hove

Age UK Brighton and Hove

February 2013

Part 1 Executive summary

1. In spring 2012, the Brighton and Hove Strategic Commissioning Group [BHSCG] set up a Short Term Care Partnership Board [STCPB] to work together to 'develop proposals for a new care pathway that ensured an integrated approach to short term care and rapid response services'. The partners are:

- Age UK Brighton & Hove Crisis Service [AUKBH]
- Brighton and Hove City Council, Craven Vale Intermediate Care Service [BHCC]
- South East Health Roving GP and out of hours district nursing services [SEH]
- Sussex Community NHS Trust Rapid Response Service and Intermediate Care Services [SCT]
- The Victoria Nursing Home Group, intermediate care beds [VNH].

2. The BHSCG have supported this piece of research:

'To find out the experiences of people who have recently used short term care services [both users and carers] to help inform the new provider service model for STC. The focus will be on processes, systems, user understanding and satisfaction with their care'.

3. AUKBH have led this piece of work. The fieldwork was undertaken in October and November 2012. Fifteen people were interviewed and 16 case files were reviewed from all partners except those people who had accessed SEH [who were unable to secure agreement from users]. At the time of the research, people were either current users of the services or had been so within the previous 6 months.

4. The majority of people were pleased with the care that they received from the individual services. This was evident from our interviews and an examination of previous patient and user satisfaction surveys carried out by STCPB partners.

5. This research adds detail to those surveys and patients/service users reports. Whilst many good experiences were reported, this report focusses on areas where improvements in the patient/user experience could be made. The headlines of the research have been verbally reported and incorporated into the STCPB new service model, which will start on the 1 April 2013. Some other issues have started to be addressed, such as medications and paperwork.

6. We have drafted this research so that it can inform the baseline information from which the partnership can evaluate whether the new STCPB model delivers improvements that will impact on patients/ service users. It identifies standards and markers that can be used to evaluate future changes.

7. The research was small scale and qualitative, so some issues will have not emerged. Nevertheless, some clear messages have emerged.

7.1 Information and access

7.1.1 One of the greatest concerns arising was poor information sharing between practitioners and their organisations; and between the practitioners and organisations and the patient/service users and carers. Patients/users highlighted:

- The number of handovers from one person (or agency) to others which often resulted in confusion for them - and for those delivering the service.
- Conflicting, unclear or untimely information.

7.1.2 This had led to a lack of understanding by some service users/patients about why they had been referred to the service, who had overall responsibility for their care and what was going to happen to them when the service ceased. In contrast, other people were given a plethora of written information, much of which was service related and not user friendly, and it could not be absorbed by people in crisis.

7.2 Referrals, assessments, admissions avoidance

7.2.1 In parallel, it was not always clear from both the interviews and file reviews why some people had been referred to and accepted by the STC services. This applied to all services routes including those admitted via SECamb paramedic services. There was evidence to suggest that many of service users/patients medical and social problems might have been predicted, addressed earlier, or differently. They may not have needed a rapid response service, especially the community based services.

7.2.2 One of the critical factors appeared to be how primary care practitioners intervened. There were a number of examples of people, unable to access primary care services, had turned to A&E; or they were waiting for a referral to see a specialist when a crisis occurred. Others had been seeing their 'own' GP on a regular basis, but had been changed to another GP who they did not know, and they had delayed getting help which had resulted in a crisis. There was a suggestion that some people were admitted to STC services mainly because routine services were not available at the point of need.

7.2.3 It is unclear how long term home care and support services interact with STC services. The experiences of the service users/patients suggests that more prominence to social and informal care solutions - as well as medical and health assessments and support- could be a better longer term solution to people's care needs. The pathway from STC to independence at home services and home care needs to be scoped; as well as the role of social care at home, in avoiding admission to STC.

7.2.3 For those people in bed based services, it was difficult to ascertain their current health or care status because of the plethora of separate assessments carried out by a range of different professionals, with no easily accessible summary. Notes were not patient/user centered. In particular, medication sheets were duplicated, sometimes differently, as well as having long lists of drugs. They had the potential for creating difficulties for staff administering medication: a serious risk area, given the importance of medication for the STC client group.

8. From the research, a number of specific areas for improvement have been identified:

- Clear written information about the care pathway and different services provision and interrelationships needs to be routinely provided
- Written information needs to be followed up with a conversation to clarify any outstanding issues.
- People need to know why they are receiving the STC service, for how long and who will be responsible for their care when this service ceases.
- Medication prescribing and management stood out as a risk area. Most people in bed based care appeared to be prescribed a great deal of medication, suggesting that pharmacy advice (medication review) needs to be factored into the new service.
- Clarity about how the long term care agenda relates to the care of older people, the role of screening, case finding and the active monitoring of older people at risk.
- Two areas that stood out as needing particular focus in respect of aligning care pathways were falls and people with diabetes.

9. The review also identified a range of other issues that have implications for STC partners and other agencies. These include:

- How data is recorded on patient/service users notes. This needs to be reviewed, especially the duplication of assessments, progress reviews and a summary of both clinical and care needs.
- The information recorded did not appear to take a holistic approach or to be person centered
- The criteria for referral to Rapid Response services need to be reviewed and clarified
- Care pathways need to be clarified - from hospital to bed based intermediate care and community based services needs to be clarified.
- The role of primary care in admission avoidance needs clarifying.
- The role of social care and support in admission avoidance and discharge from STC needs scoping and clarification.

10. Many of the issues raised above have informed the new service model. Some, particularly those that impact on other providers will require further consideration by commissioners. It is proposed that the information collected from this review could:

- Inform further work to improve the current service model;
- Provide a baseline to evaluate this current model;
- Provide an opportunity to develop benchmarks for the final STC model.

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Part 2 Full report

1. Background

1.1 In May 2012, the Brighton and Hove Clinical Commissioning Group [BHCCG] set up the Short Term Services Provider Partnership [STSP]. The remit of the group was to secure greater integration of services currently providing a rapid response or short term support for people who might otherwise be admitted to hospital or could be discharged from hospital with the right support. The STSP is a collective of the following organisations:

- Age UK Brighton & Hove Crisis Service [AUKBH]
- Brighton and Hove City Council, Craven Vale Intermediate Care Service [BHCC]
- South East Health Roving GP and out of hours district nursing services [SEH]
- Sussex Community NHS Trust Rapid Response Service and Intermediate Care Services [SCT]
- The Victoria Nursing Home Group, intermediate care beds [VNH].

1.2 The STSP and the BHCCG commissioned a small piece of research:

'To find out what experiences of people who have recently used short term care services [both users and carers] could help inform the new provider service model for STC. The focus will be on processes, systems, user understanding and satisfaction with their care.'

1.3 It was agreed that AUKBH should lead this piece of work. Patients/service users were interviewed and files reviewed of all partner organisations except those people who had accessed SEH. This work was not a comprehensive piece of research, but an evaluation of the impact of the service on patients/service users and their carers. Its intention was to capture, from different sources, information about patient and service user experiences that could inform future, improved service delivery. Many good and appropriate experiences were described, but the report concentrates on where improvements could be made.

The research looked at:

- * Access to the services
- * The assessment process
- * Service co-ordination and discharge processes, and
- * Any lessons from hand-overs from one service to another.

[See Appendix 1 for research outline and Appendix 2 for questions]

1.4 This report sets out the methodology used and identifies key messages and observations from interviews and data collection. For ease of reference these have been reported as follows:

- Methodology
- The people
- Paperwork, information sharing and communications
- Medication
- Admission avoidance, primary care
- Access to services, assessment processes

2. Methodology

2.1 The research took place in October and November 2012 and focussed on people currently using the services or those who had used them in the last 6 months. Each provider was asked to identify patients/service users willing to be interviewed and case files that could be examined. With the exclusion of SEH, who were unable to obtain permission from users, case files and names of interviewees were provided by members of the STSPP. The STSPP identified the following methods for capturing patient/service user experiences:

- Desk top review of existing pieces of research and evaluations of similar services [DT]
- Case examination exercises [DT]
- Interviews with patients/ service users [I]
- Focus groups [FG].

2.2 Some people interviewed were 'hazy' about their experiences, and their recollections sometimes muddled. Interviewers attempted wherever possible to clarify issues with patients/service users, to ensure that the reports were as accurate as possible. This shows how difficult it is to do qualitative research with older people in crisis and with memory problems. The researchers were volunteers and trained and skilled in this type of interview. [See Appendix 3]

2.3 A Stakeholder event was held on 2 November 2012. This included two patients/service users who had also been interviewed prior to the event. Their stories are used in this report.

2.4 Focus groups were also run by Pensioners Action [PA]. They leafleted blocks of flats housing older people in the West Hove, Ingram Crescent area, and engaged Wardens of neighbouring flats. They were assisted in this by the West Hove Forum and AUKBH West Hove Neighborhood Group to display flyers advertising the Focus Groups. In order to ensure full engagement, a simplified questionnaire was developed for group discussion. From this three people who

attended focus groups and had used STC services in the previous 6 months were interviewed.

2.5 Most of observations in this report are from face to face interviews with people who had used the service and the case files. In all, 16 people were interviewed and 15 people's case notes were reviewed.

2.6 Results of existing surveys were also reviewed, including:

- The ICS User Surveys undertaken by the Sussex Community Trust
- The Derby Outcome measure Survey [An Audit to measure the Effectiveness of the Intermediate Care Services (ICS) in Brighton & Hove using Derby Outcome Measure (DOM) by Saba Shanmughasundaram, Senior Physiotherapist, undertaken in 2011];
- South East Health Experience Questionnaire 2012
- Redesigning short-term services, a stakeholder event, 17th May 2011, 'Participant Post Event Briefing'
- Feedback from Short Term care Stakeholder Event 2 November 2011.

3. The people

3.1 There were four younger people in their 60's, and early 70s, who had complex medical conditions, including alcohol problems and needed bed based care. [A list of participants is in Appendix 2]

The youngest person was 55.

3.2 The prevailing picture was of older people in crisis, often due to a fall, an accident, or more frequently, due to underlying pathology.



Mr A who was an intermediate care resident . He was 66 and was chronically sick, having suffered 3 small strokes in 2006 and still had residual weakness on his left side. He was a diabetic, had stomach ulcers, depression, intermittent claudication, COPD, hepatitis A and prostate cancer. He had had to give up his job and was living alone though had local family support.[V: I and DT]

Many people had diabetes, even if this was not the immediate reason for short term care. A number of people had been managing relatively independently until they had a crisis and wanted to remain that way once they had recovered.

*11 people were in their 80s.
7 people were in their 90s
The oldest person was 97*

Mrs C. had been coping well and was able to get buses into town, until she suffered a chest infection, had a fall, which led to loss of appetite and back pain. The chest infection diagnosed during a GP visit triggered the admission to short term care.[V: DT].

Mr B. was admitted to hospital following a fall, with acute renal failure, dehydration, a urinary tract infection, type 2 diabetes, recent onset atrial fibrillation and heart block and heart failure. [V: DT]

There were few people with severe dementia in our research, probably because the people selected for interview did not have significant memory loss. So, we are not able to comment on dementia in respect of this cohort, though all research and intelligence indicates that this is a serious issue for the delivery of STC services, and more research may need to be done.



A number of the respondents appeared to have a level of depression or anxiety that was affecting their recovery.

Discussion points:

The prevalence of falls as a trigger for crisis, underlines the importance of the falls pathway now in place with the ambulance services, IBIS and CRRS; and the recently funded fast track falls pathway. Integration with the new STC model is imperative.

The new STC model needs to be well embedded into the Diabetes Pathway.

3.3 In many cases it was not clear why people had been referred to the STC rapid response service. In most cases, the patient/service user in a bed based service did not know or understand why they were in this type of provision; and an examination of notes did not always shed light on why the person was in this service rather than another mainstream service. Patients/service users were also unclear when they might be discharged or where to and who would arrange this. This does not mean that the discharge was not being arranged by staff, but users were in the dark or were not clear what was being planned for them - so they could not plan.

4. Paperwork, information sharing and communications

4.1 All the non bed based services appeared to avoid any additional paperwork. For instance, CRRS took referrals directly from DN's and roving GP's in order to speed up the assessment and intervention. Similarly in AUKBH Crisis, there is minimal paperwork.

4.2 Conversely, once admitted to a bed the paperwork becomes voluminous and duplicated. To the review team, it was not easy to see or understand chronologies and the current status of the patient/service user. Different professionals recorded in separate parts of the record. This may be because of demands on reporting standards by the Care Quality Commission but it is not easy to see at a glance the persons historic or current situation. The records did not appear to be holistic or person centered. The assessment process was clearly complex. Typically it included physiotherapy assessment, occupational therapy, prevention of falls, night care, continence management, vital signs monitoring, pain management, nursing care, social care as well as medication and medical assessments. The current format must be time consuming for staff to complete and to access relevant information. [We understand this issue is now being addressed with the new 'patient status at a glance' report at Knoll House.]

4.3 In the focus groups there was a great deal of discussion about problems with information sharing between agencies and with the way in which patient/service user or carers felt uniformed.

4.4 Some concerns have been raised in the STSPP that sharing of information may be difficult across agencies because of confidentiality. It was clear in notes that this already happens and most people had signed to agree to have their information shared.



Mrs P was suffering from high levels of anxiety and calling out services inappropriately, then turning them away on their arrival. The paramedics referred her to the Rapid Response Team and support was provided in a way which was described as 'excellent' especially as it happened over a weekend. Information was not shared well initially (which was especially important given Mrs P's the lack of insight), but followed up later. It would have benefitted Mrs P and the family if her son had been included more in the information-sharing, initially to help her take it in over a longer period [FG].

Mrs O had a fall, bruising herself badly after health service daytime hours. The lady rang her daughter who lives a long way away, and she spoke to a Roving GP, accessed with ease. She was admitted into hospital the following day. There was very poor information-sharing initially, then there was far too much information provided -and in print which was too small.

Discussion points:

Although there are discharge booklets, it was clear that people either had not seen them or were not able to assimilate all the information whilst ill. There is a need to ensure that patients/ service users understand the discharge process. It may be necessary, particularly where people do not have carers or friends to support them to provide an advocate or 'friend' who could help support their discharge, thus ensuring a better experience and making the best use resources.

Paperwork and consistent processes are a priority for the STCPP. This might include a clear chronology, same codes on data, including reasons for admission, disposition, how long the person has waited for the service, where they have come from, where they are going being discharged to.

If the STSPP is branded as a partnership entity, it needs to be clear how it will overcome concerns about confidentiality and have clear policies and protocols.

5. Medication

5.1 Most people in bed based services appeared to be on a plethora of drugs. Given the complexity of peoples health needs, this may be to be expected but, over 10 different drugs was common in those people in bed based care, though not all were prescribed for regular use. There are numerous examples of difficulties with medication throughout this report.

Mrs E. was admitted to a nursing home partly because was she was anxious about self medication. She had 16 medications prescribed [V, DT]

Mr F, who had 15 drugs prescribed and an alcohol problem had been admitted via A and E and ICS after a fall/collapse. [V, DT]



Discussion points:

The volume and complexity of medication taken by patients/service users indicates that the STSPP needs to include how medicines management can be incorporated in the new service model for STC.

Consideration needs to be given to a piece of research on how prescribing medication management can be improved for patients, staff and carers to reduce risks and improve outcomes for patients.

6. Admission avoidance, primary care

6.1 A number of people did not appear to have seen their GP prior to admission even though there were indications that a crisis was looming.

6.2 The ambulance service was a significant feature in people's admission to short term care and paramedics were highly commended. A number of people had successfully used their personal alarm when they had fallen.

6.3 Some of the issues that affect the use of STC services have emerged: relatives living a distance away, a number of different services needing to be accessed, differential responses by routine services over the weekend, the complexity of some of the users problems, and the variability of the severity and urgency of people's needs. The STC services appear to be used for variety of reasons, some of which are not simply to do with the needs of the patient. It is more to do with organisation of other services or the timing at which the person becomes ill or decides to seek help.

6.4 There was reluctance by some people to bother the doctor. This suggested that for a group of people with known complex or changing needs might mean regular monitoring or anticipatory care. This is in place for patients with COPD. There are other case finding and long term care models of continuing support. [See appendix 4.]

Mrs D. who was caring for her husband with dementia and was referred by HERMES to CRRS with severe back pain not being controlled by her drugs and she had been sleeping in a chair. However, she had been booked to go on holiday to Germany. After two visits, she decided she did not need the service. Mrs W needed help but along with a number of other people in this evaluation it was questionable whether there was the need for the rapid response service.





Mrs I. [CV, DT] had been in CV for 2 months. In August she had been admitted to hospital with leg ulcers, discharging pus. She had urinary retention requiring a catheter, blood pressure and heart problems and psychosis. She was known to the mental health services and ICAST. She lived in supported housing, where someone did her shopping. She had no other help at home. Mrs I had been struggling in general and with her mobility. She was prescribed 9 drugs (a number of these were psychotropic). Despite her difficulties, her notes show she was making a good recovery.

Mr K. 55, was referred by HERMES to CCRS. He had a number of serious problems: daily fits because of temporal lobe neuropathy and vertigo, he was under investigation for a brain tumour and was due to be admitted Hurstwood Park within the month. He was on a number of drugs, had alcohol problems, was depressed and had taken a number of overdoses. Carers attended 4 times a day but was still struggling. He had seen his GP 5 times since August. This man had one 30 minute visit as he did not feel he needed any more help.

Mrs H. [CRRS, DT] had been admitted to a bed from ICS. She had been found collapsed at home with acidosis, with incontinence and confusion. She had been fit and independent, until 2 weeks before admission but had declined to see 'her' GP. She was being moved from her regular GP to one she did not know and trust.

*Discussion point:
The criteria for access to the new STC need to be reviewed and clearly specified so that the short term care services are appropriately used.*



Mrs L, had been referred after fall. Feeling dizzy and shaky she had been seen by her GP and paramedics who had referred her to CRRS 2 months before. She was under investigation by her GP and had been to the falls clinic but was awaiting an appointment with a geriatrician. She had been offered, but declined, more personal care as she had help from her husband and daughter. [CRRS:

Mr G., admitted to hospital over a weekend, had been to his GP practice on the Saturday morning. As there was no GP working, the nurse at the practice said because of the severity of his pain he should go to A and E [V, I and DT].

Discussion point:

There was some suggestion that a number of people frequently used the STC services. This needs further examination to elicit whether this suggestion is correct, and whether this a separate, discreet group of people, whose needs may need to be addressed differently.

AUKBH are starting a small piece of work in their service as a way of investigating this suggestion.

Discussion point:

Crisis services are often required because there are delays in referrals to specialist services and investigations. The interactivity between rapid response services and general practice need to be rationised. Some consideration might be given to how the STC agenda links to preventive initiatives in the city, where people have longer term care needs. Case finding programmes may also have a place in avoiding crises. One example is the ' Anticipatory Care Model' in appendix 4.

Ms N broke her hip and was discharged from hospital to a nursing home. She returned home after a 6 month stay. She had input from the Rapid Response team to help her mobilize safely at the home. She seemed to be doing well initially but fell over again within 24 hours and had to be admitted to hospital. Information sharing was poor. The care home had changed her doctor to a Practice near them without Mrs N, her carers or family's knowledge or permission.



Discussion point:

A number of people had used personal alarms to get help, successfully. There may be a need to further promote this service and the key safe service; and to ensure that the community alarm response service is well integrated into the model.

Mrs M. had lost her balance and fallen approximately 3 weeks ago before this interview was carried out. She had pushed her 'call' button and two men came from the alarm service, picked her up, gave her a once over and said 'hospital'. She was diagnosed with a broken rib in A and E, and spent 2 days in MASU. She was well supported by her daughter, carers and her GP. She had not fallen before, but was taking a lot of medication [C V, I].

Discussion point:

It appeared that a number of people still believed that they has their 'own' GP who they had built a relationship with and who they had an understanding of their medical problems. If the GP was changed some patients would not seek help from another practitioner. Some consideration is needed as to how this can be resolved and to manage any necessary changeover of GP.

Discussion point:

Consider which patients, on discharge, need a named case/care manager [unless they already have one].

Discussion points:

In a number of cases, it was not clear where the distinction between long term home support services ended and special short term care services were needed because of a crisis.

There was some suggestion that enhancing regular home care services with some additional support from STC rapid response and crisis services, including clinical overview, might have prevented the need for longer term STC services. The pathways to and from home care needs to be clarified in the new STC model with the default position being flexible enough for people stay with their usual carers, unless this is unavoidable.

The threshold for access to community based STC needs some focus and possibly filtering of some people. Consideration might be given to the STS offering a 'consultancy' service. This might prevent admission to STC services and provide continuity of home care and general practice services for some service users.

7. Moving forward

Many of the issues raised above have informed the new service model. Some, particularly those that impact on other providers will require further consideration by commissioners. It is only a snapshot. However, the people's stories have highlighted that even when the services are good and where they have good clinical outcomes, that improvements can be made in the experience for them that could be better for both service providers and users. The answers are often in the detail, being more user focussed, communicating better, but other stories suggest the way some services are organised mediate against the best possible care.

It is proposed that the information collected from this review could:

- Inform further work to improve the current service model;
- Provide a baseline to evaluate this current model;
- Provide an opportunity to develop benchmarks for the final model.

Report written by Fran McCabe, Chair AUKBH, with help from Jane Simmons, Bunty Bateman, Ursula Robson and Bea Gahagan.

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Appendices

Appendix 1

**AUKBH: Proposal for User Participation
Towards a new service model for Short Term Services and Rapid
response Services
17 September 2012 Fran McCabe**

Purpose and objectives of the proposal

To find out what the experiences of people who have recently used short term care services [both users and carers] to help inform the new provider service model for STC. The focus will be on processes and systems and user understanding and satisfaction with their care.

Context

A number of pieces of evidence could inform the evaluation.

Existing research. Jane Lodge has been asked for this evidence and will also trawl public health [by end September].

Existing survey data from the partners, including clinical audits. This will need to be made available.

User files and case notes. A small number of recent files should be reviewed.

Questionnaires. Dealing with large numbers of questionnaires will create methodological and logistical problems so is not being considered at present.

Small number of qualitative interviews with recent service users and carers.

Focus groups with recent service users and carers.

AUKBH proposal

We are proposing a small scale evaluation combining 3, 5 and 6 as above. This is feasible in the timescale, which would be to produce a report by 1 December 2012. Trained volunteers would be used to do interviews and AUKBH has a track record and methodology to do this. We will work with Pensioners Action on focus group work. AUKBH would need resources to provide this training, setting up costs, management support, volunteer expenses and report writing. We estimate this will be about 20 days work and we are requesting £2K.

Focus of evaluation

To consider whether the care pathway of the person was effective in relation to helping to keep the person out of hospital or getting them home from hospital timely and safely.

To consider what difference 'a single point of access' might have had.

To consider whether a 'single assessment process' was used and what difference that might have made.

To consider the number and effectiveness of transfers to other services- within the provider group, and beyond- and what processes and protocols might improve them.

To consider what the users and carers are saying about their experience in respect of hospital admissions avoidance, early discharge, being listened to, making a difference to them, understanding and confidence in the system : and their views on what worked well and what might improve that experience.

Methods

Each partner organisation will identify 2 cases [10 in total] for the desk top exercise.

Each partner organisation will identify 2 people who have used STC services in the last 3 months.

AUKBH will set up 2 focus groups in collaboration with Pensioners Action and the Carers Centre.

AUKBH co-ordinate the evaluation and will provide volunteers but other people may wish to volunteer.

Confidentiality issues will be addressed.

The cases selected should be random but include people who have experienced at least one hand over. A particular day might be selected. The evaluation is qualitative and evidence will be cross referenced with existing research

evidence to provide indicators to the provider group so they can ensure their service design meets users and carers needs as well as service requirements.

Evaluation areas

A chronology: what happened, when: in interviews and focus groups, what it felt like as an experience.

Length of time in different parts of the service and speed of handover; and the result.

Observations about what would make difference.

The report

The report would be short and incisive and include:

Evaluation areas;

Observations about how the care pathways affected PI's and implication for different working practices, systems, processes and protocols;

Consistency of evidence from different information sources.

What the STC Provider Group can do itself in the new model;

Implications for other STC associated services.

These are the areas to be covered in a desk top exercise, in focus groups and individual interviews.

For use on people who have used the service in the last 3 months [less if possible, but may be a bit longer for focus groups]

Background

Some basis demographic details: gender, age, when used the service.

Access to the service

1. What were the reasons for using the service?
2. Could the reason be described as
 - Avoiding hospital admission
 - " " Readmission
 - Help getting out of hospital
 - Other
3. Who referred into the service.
4. What service was the entry point?

5. Did you feel that other services had given all the information about you to help the STC service be able to give you the right support?
6. How did [you] person experience first contact/access into the service?
7. What was good? What was bad? what might improve?

The service

8. Which service was used?
9. How long was it before a service contacted you?
10. How long did it take before a service was received?
11. What help did the person have? By whom?
12. What was good? What was bad? What might improve?

Handovers/transfers

13. Was the person referred on to another service?
14. What service? what help? How long did it take? Were there delays?
15. What was good? What was bad? What might improve?
16. What happened at the end of the STC/RR service? Do you still have service? what?

Overall experience

17. What was the best thing about the service? What was the worst? What could improve it?
18. Did you see a doctor at any time during receiving the service?
19. Do you think the service helped to avoid hospital admission, readmission; and speed up hospital discharge; or something else?
20. Did you feel more confident to manage by yourself having had the STC service?

Appendix 2

A profile for each service of service users who took part is shown below

CRRS

Desk Top reviews:

Mrs W	Age 87
Mr S	Age 55
Mrs CF	Age 87

Individual interviews:

Mr PP	Age 77
Mrs JB	Age 88
Mrs EC	Age 84
Mr SK	Age 61
Mr PP	Age 77
Mrs JB	Age 88
Mrs EC	Age 84
Mr SK	Age 61

Craven Vale [CV]

Desk Top reviews:

Mrs S	Age 90
Mr H	Age 79
Mrs BH	Age 83
Individual interviews:	
Mrs EC	Age 90
Mrs NB	Age 65
Mrs DM	Age 79

Victoria Nursing Home [V]

Desk Top reviews:

Mr A	Age 66
Mrs C	Age 91
Mrs D	Age 91
Mrs AD	Age 91
Mr D	Age 70
Mrs H	Age 88

Individual interviews:

Mr A	Age 66
RF	Age 70
MN	Age 95

AUKBH Crisis Care[AUK]

Desk Top Reviews:

Mrs EF	Age 95
DJ	Age 82

Individual Interviews:

Mr F	Age 88 (also took part in stakeholder event)
Mrs R	Age 82 (also took part in stakeholder event)
Mrs MG	Age 57

Focus Groups

Focus groups were organized by Pensioner Action (PA) on behalf of AgeUK

Mrs X	Age 84, had a fall,.
Mrs Y	Age 89, had anxiety and multiple infections,
Mrs Z	Age 97, broke her hip.

Appendix 3

Key points from a Stakeholder workshop held on 2 November 2012

- * Access to information (shared record amongst partners)
- * Standard documents / assessments. What does it look like?
- * Reduce number of systems.
- * Knowing who is working with someone "Patchwork" / Share My Care
- * Distinctive Number - people ringing wanting other services
- * *A Initial referrals should go through Access number not go direct to services. Must not bypass. But phone must be efficient so no delays.
- * Flow - taking on people leaving our services by new providers also needs to be slick too as we are blocked, slow.
- * Referrals need to be good; no wasting time assessing again as not good enough. Trusted assessment.
- * Repetition of work between teams: DNS do something. ICS go in and see need doing but don't know - so repeat action.

Appendix 4 Anticipatory Care

STAYWELL75+

Phoenix Surgery, Cirencester PRACTICE ACTIVITY at 25.5.2011

The figures are taken from a 'search' in EMIS that is used to create a 'Patients over 75 list' who are due to be sent their annual health questionnaire. The search picks up all patients in the practice over the age of 75 for the purpose of sending out the questionnaire. The data is formatted into 'birthday months' and then the month being studied is extracted. For the purpose of this exercise, the search was run at the end of April 2011 and the figures below are based on all patients over the age of 75.

There are currently 817 patients over the age of 75 registered with the Phoenix Surgery.

- 117 of these patients are non-compliant and do not respond to the annual health questionnaire.

Of the 700 compliant patients:

- 11 (1.5%) patients have requested to be 'exempted' from the scheme and are therefore coded as such.
- 34 (5%) patients have StayWell Volunteers.
- 40 (5.5%) of patients live in a nursing home. (All patients in a nursing home are sent an annual health review questionnaire which is completed with the nursing staff).
- 23 (3%) patients are due to be sent annual health questionnaires as they are currently coming into the scheme or have just joined the practice.

Overall response rate: **85%**

Benefits

- Phoenix Surgery; the only practice in South Cotswolds below indicative spending target out of eight practices: total weighted population 52,180;
- Partners have maintained programme over 22 years;
- Coordinated case finding on 36 hours per week – 12 administrative coordinator, 12 hours HV for the elderly and 12 hours Community District Nurse.
- Volunteer expenses, cost of postal questionnaires and training of volunteers provided by the Phoenix Charitable Trust, Cirencester and District (£5,200 per year).

There are approximately 18 – 20 visits generated from the returned annual health questionnaires per month.

A great deal of time is also spent working with/for volunteers, organising meetings and ongoing training. Volunteers often call in with concerns about their patients or for advice.

PRACTICE NUMBERS

There are currently 12029 patients registered with the Phoenix Surgery. The over 75's are broken down as follows:

Age Group	75-79	80-84	85-89	90-94	95-100	100-120	Total
Males	138	111	70	16	2	1	338
Females	176	139	115	38	8	3	479
<i>Total</i>	314	250	185	54	10	4	817

Stay Well 75+ outline – taken from www.staywell75.co.uk

Staywell team: Dr. Ian Simpson, lead GP; Tracey Lear, HV for the Elderly, Annabel McEune, Community District Nurse. (David Beales, Originator).

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