healthwatch Cornwall

Ageing Well Report

December 2021

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Introduction

Healthwatch Cornwall (HC) is an independent, publicly funded health and social care champion commissioned by Cornwall Partnership Foundation Trust to review the Urgent Care Response pilot they are delivering as part of the Ageing Well Programme. We listen to what works well for people and what could be improved about Health and Social Care services in Cornwall and share our findings to guide NHS Leaders and other decision makers in improving standards of care.

Ageing Well Programme Overview

The Ageing Well Urgent Community Response programme's (UCR) primary objective is to develop effective expert rapid response teams who will be on hand within two hours to help support older people to remain well at home and avoid hospital admissions in Cornwall and provide reablement services within two days.

Older people and adults with complex health needs who have a very urgent care need, including a risk of being hospitalised, will be able to access a response from a team of skilled professionals within two hours to initiate the care they need to remain independent.

A two-day standard will also apply for teams to put in place tailored packages of intermediate care, or reablement services, for individuals in their own homes, with the aim of restoring independence and confidence after a hospital stay.

The operating model, pathways and processes to deliver these objectives are being tested as part of a pilot across Cornwall's Primary Care Networks. As part of this pilot, it is essential to understand how these pathways and processes are working for patients, families and staff delivering the service.

An overview: Ageing Well Programme

Urgent Community Response	Enhanced Health in Care Homes	Anticipatory Care
2 hour standard for UCR, 2 day standard for reablement and a single point of access for UCR utilizing 111	Enhanced support & better co-ordinated care, reablement and rehabilitation	Helping people with complex needs stay healthy and functionally able
#AgeingWell	@AgeingWellNHS	#NHSLongTermPlan

Ageing Well Urgent Community Response Programme Objectives:

National:

- Deliver clearly defined crisis response services within two hours of referral to avoid unnecessary hospital admissions.
- From 2020/21, have primary care networks assessing local populations at risk and working with local community services to support people where it is needed most through targeted support.
- Support the expansion of the existing community dataset and intelligence base.
- Support the commitment to greater recognition and support for carers.

Local:

- Provide 24 hour offer which includes the 2 hour UCR and 2 day reablement therapy response.
- Understand the right skill set to achieve the Urgent Community Response model.
- Explore potential for integrated primary and community care urgent response service.
- Reduce risk of acute admissions.
- Following COVID Community Response – review lessons learned from establishing Community Coordination Centres (CCC) and Primary Care Network (PCN) alignment.
- Improving the interface between community services and D2A Bedded Pathways.

Aims & Objectives Of The Study

1. Explore patients' and families' experiences of their care and support in the circumstances of their referral. Referrals will focus on two patient groups:
   + Urgent Care
   + Reablement
2. Explore patients and families' needs and priorities and ascertain what good quality care and support looks like from patients' and families' perspective.
3. Understand more about the successes and challenges staff experience when providing 2 hour UCR or 2 day Reablement services.

Objectives

- Identify areas of care and support that are working well from patient and family perspectives.
- Identify areas of care and support that could be better and ideas for improvements.
- Identify priorities for patients and families for remaining independent and at home, and any gaps in care and support.
- Understand the role of the Urgent Community Responder, including Advanced Community Practitioners, and their impact on experiences of care and support.

What we did

Methodology and Interviews

During the development phase of the study, HC and the Ageing Well Programme Team cocreated two sets of structured interview questions, one for patient experience in receipt of the Urgent Care Response and one for employee experience in delivering the Urgent Care Response to patients.

Using an appreciative inquiry approach, the interviews consisted of 13 open and closed questions, in addition to HC standard demographic monitoring questions. All answers given were repeated back to participants to ensure sentiments were accurately recorded.

Throughout August, September, October, and November HC undertook 1-2-1 interviews with employees and patients across Central, North & East and West Integrated Care Areas (ICA).

Due to Covid-19 restrictions, interviews were undertaken either via telephone calls or Microsoft Teams video calls.

In addition to the project team, HC enlisted the help of three volunteers to undertake some of the interviews to ensure patients and employees had a wide choice of times and dates to participate. Patients typically spent 42 minutes discussing their experiences. By comparison employees took 48 minutes to complete the interview and were willing to give a candid view of their experiences.

Who took part?

A total of 36 people took part in the interviews.

Patients/Carers

We spoke with 18 people who identified as a patient, relative or carer.

39% of respondents were patients, whilst 56% of respondents participated on behalf of their relative, and 5% of participants identified as a carer. Upon further investigation, it became evident some relatives were carers to their spouses or parents, however they chose not to identify as a carer.

67% of participants were female and 33% were male. Most participants were either aged between 65-79 (39%) or aged 80 years and over (39%). We found that 61% of participants considered themselves to have a disability. 83% of participants were from a white British background, the remainder identifying as either white Cornish or white other.

Employees

We spoke with 18 UCR employees, with a variety of roles including:

- Advanced Community Practitioner (ACP)
- Occupational Therapist
- Physiotherapist
- Home First Nurse Assessor
- Home First Therapy Support Worker
- Student Nursing Associate

89% were female and 11% male. Most employees who took part were between the age of 29 and 49 (61% of 18). We found that 18% of respondents had a long-term condition, and overall, 95 % were from a white, British background.

A full breakdown of demographics of the respondents is provided in the appendix.

Summary of findings

Methodology and Interviews

- The majority of patients, carers & relatives in all ICAs initially contacted their GP with their concern. This result is expected as the UCR pilot is not yet heavily promoted amongst all services who can refer across all areas.
- There were conflicting results from patients, carers & relatives regarding time responsiveness of Urgent Community Response, compared with the views of employees.
- Acute loss of self-independence or mobility were the main reasons for requiring a UCR.
- Results of patients, carers & relatives getting the help or care they needed at the time of the UCR intervention are encouraging in most areas.
- Results of patients, carers & relatives feeling partly or fully involved in care decisions are encouraging in most areas.
- The majority of patients, carers & relatives felt they were not advised of next steps or aware of who they had received treatment or care from.
- Sourcing and securing care is a concern across all areas, as is the impact of this on carers of patients.
- In the main, patients, carers & relatives were very satisfied or satisfied with the care received at the time of UCR intervention.

What worked well?

Patient Perspective	Employee Perspective
Able to address the immediate concern for patients at the time of Urgent Community Response intervention with high praise for most employees	Timely referrals
Mobility equipment availability & demonstrating techniques	Well stocked mobility equipment stores
Providing interim care	Joint employee visits
Signposting for domestic support (i.e meals on wheels, lifeline)	On hand, inhouse therapists
	Securing care when available

We asked patients, carers, relatives and employees an open-ended question about what or who has been helpful and what worked well. Participants had a wide range of views. A number of patients, carers & relatives referred to their support network (mentioning specifically family & friends) as the most helpful aspect of their experience. A small number of patients, carers and relatives were able to recall specific teams and individuals who had been helpful. Other comments were generalised but praised technique demonstrations, the arranging of mobility equipment and the same day response.

Relative comment *"Helpful to have a quick response the same day...the physical examination provided confidence that my father's needs were being addressed".*

Relative comment *"The first two ladies who came showed me a technique for getting my wife more mobile, using demonstrations which was very helpful".*

Relative comment (when discussing interim care) *"Carers coming in, making sure [mother] gets showered, dressed etc, and when she refuses to take her tablets for me or to drink enough water".*

When employees were asked the same question 'who or what worked well?' The most common themes across all ICAs included joint visits, readily available equipment from local stores and securing ongoing care.

Employee comment *"It was helpful to have conducted the visit with our OT to help to get [the patient] off the floor, ... Equipment was readily available after order and collection which was smooth - no hitches. Health buyer was able to get the care package in place relatively quickly i.e., within a week (better compared with usual standards)".*

Employee Comment *"The timely fashion which the referral was sent was helpful, access to equipment on that particular day was good (this was due to the early timing of the referral)".*

Employee Comment *"Volunteer Cornwall were brilliant, the patient needed help with domestic duties, and this is outside our remit".*

What could be better?

Patient Perspective	Employee Perspective
Sourcing and securing ongoing care package	Sourcing and securing ongoing care package
Communicating next steps	More informative referrals
Communicating who has provided the Urgent Community Response at the time of intervention	Appropriate triage of referrals
Support for carers	Fully resourced teams
Improved discharge	Improved Multi-Disciplinary Team working across the board

Initial responses were positive when discussing the patient Urgent Community Response intervention and whether additional support was needed, however at a later stage, concerns around sourcing and securing ongoing care were raised by a number of carers and relatives and mirrored by some employees. The impact of this for carers and relatives is worrying.

Carer comment *"[we need to get] adult social services package of care secured for mother - very challenging due to no staff"*.

Carer comment *"would be nice to have a care plan in place"*.

Carer comment *"This is what I'm worried about. I've spoken to 2 care agencies but there's none available... GP referred me to Adult Social Care [for mother], but no one has got back to me yet and that was two weeks ago...I don't know what happens at the end of 6 weeks ... (mother) still needs daily care after that. We were looking for carers even before her Urgent Community Response"*.

Employee comment *"Having better access to social care or care provision would be more helpful. Availability of care is poor"*.

Employee comment *"We have referred to adult social care too, although it doesn't seem to have progressed"*.

Furthermore, a small number of employees mentioned frustrations with team operations. Specifically, teams mentioned being under resourced or challenges with part time working patterns, annual leave, and unplanned sick leave.

Employee comment *"... part time working can be a challenge, and unable to rely on overstretched teams with competing priorities"*.

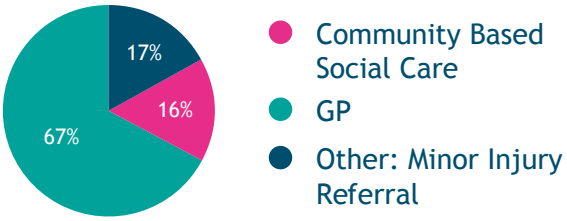
We understand this challenge has been acknowledged and recruitment has taken place (at the time of writing this report) to increase the number of ACPs across all ICAs. It would be remiss to assume the new recruits have addressed this challenge in its entirety and it would be beneficial to review the impact on the service once the ACPs are settled in their roles.

Full findings by locality

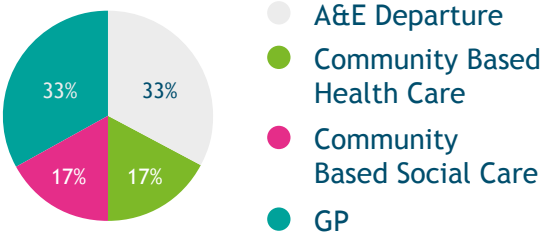
Patient referral pathway

As identified in the key themes, most patients, carers & relatives recall initially contacting their GP with their Urgent Care need. Whilst this result was expected, patients, carers & relatives identified a small number of referrals via a different route. The data from employees suggest a high number of GPs across Cornwall's ICAs are cooperating with the AW UCR pilot and patients' circumstances meet the criteria to justify a response by the AW UCR service.

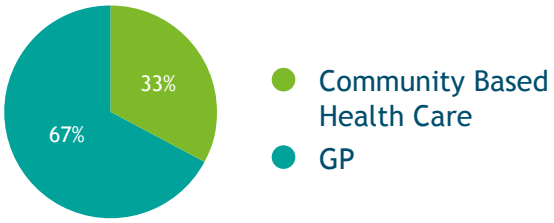
Central Employee Referral Pathway



North & East Employee Referral Pathway



West Employee Referral Pathway



Responding to patients within the 2 hour or 2 day standard

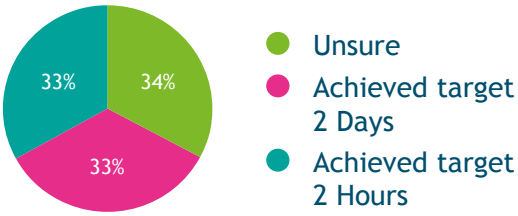
All employees across all areas were confident they achieved the 2 hour or 2 day standard in responding to the UCR referral.

Patients, carers & relatives however had conflicting views.

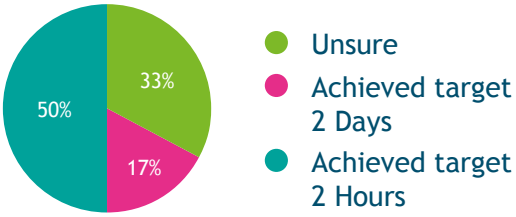
34% of participants in the West said they received a UCR or reablement visit within the AW standards, whereas 49% advised the time went beyond the standards, and the remaining 17% couldn't recall the time frame.

In comparison, 33% of participants in both the North & East and Central ICA, also reported a level of uncertainty when recalling time frames. This recurrent theme of uncertainty across all ICA could indicate challenges with time frame reporting on RIO compared with actual care or treatment in the field. Alternatively, it may be that participants do not accurately recall the time frame due to the urgent care need of the patient taking a priority.

Central Patient UCR Time Frame



North & East Patient UCR Time Frame

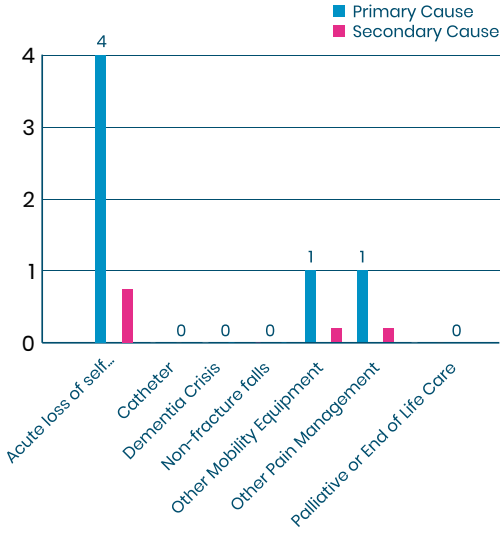


West Patient UCR Time Frame

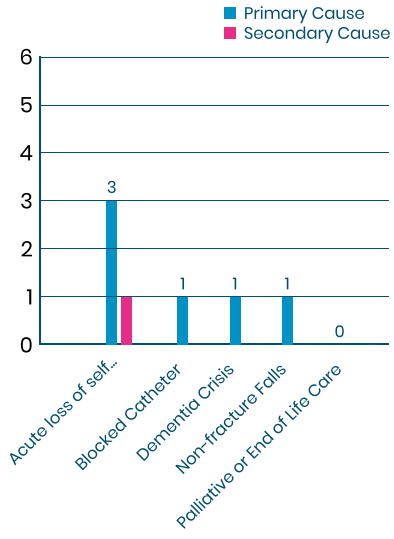
Patient need for UCR/ Reablement intervention

61% of participants across all ICA reported acute loss of self-independence or mobility as the primary reason for requiring a UCR or reablement intervention. In the main, employees' views mirrored that of participants. A small number of patients, carers & relatives included additional reasons for their intervention. Upon further exploration of this question, 28% of participants referenced poor hospital discharge as an influential factor when requiring a UCR.

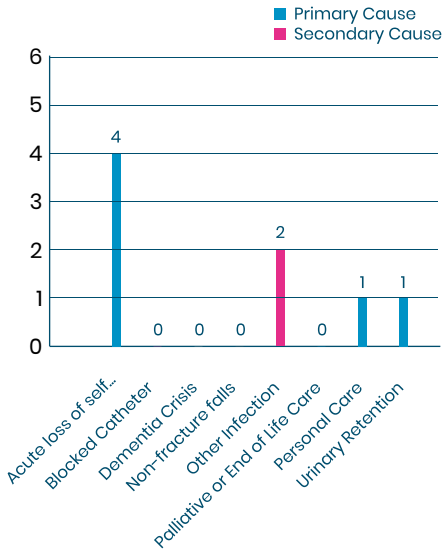
Central Patient UCR Need



North & East Patient UCR Need



West Patient UCR Need



Carer comment *"At hospital, the patient was checked over (not put on ward), given antibiotics for UTI and released without package of care, despite clear loss of mobility"*

Employee comment *"[when discussing patient need, following hospital discharge] … the info was difficult to believe. Usually, a patient would stay in hospital for a period of time following total hip replacement … however (the patient) was discharged much earlier than expected. We saw the patient on Wednesday, (the patient) wasn't feeling well… and had followed all advice re medication regime. Patient and wife shocked to find they were by themselves and left to own devices, so soon after such a large operation".*

Relative comment *""[when discussing sequence of events, leading to Urgent Community Response need] I am not happy that (patient) was discharged from RCHT without any care package into the care of a 91-year-old relative with Parkinson's disease".*

Carer comment *"was told by hospital on patients discharge that they would need physio support that they are not receiving. Feels that they have just been left".*

Relative comment *"She was discharged to us the same day, by the receptionist, but we were given no information on after-care such as washing, showering".*

Patient recollection of who provided UCR / Reablement service

28% of all participants were unsure who treated them at the time of their intervention. A further 28% of patients, carers & relatives' accuracy is questionable as they identified the treatment as being provided by community nurses or doctors. The remainder of patients, carers & relatives identified either ACPs or Home First as attending their needs. The uncertainty was higher in the Central region.

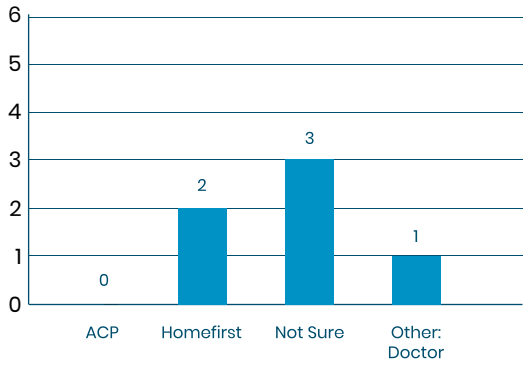
Again, it is important to acknowledge participants may not accurately recall who provided the treatment due to the patient being more focused on the treatment or care than the person attending, however when patients are unaware of who has treated them it can impact negatively upon the continuity of care. Continuity of care contributes importantly to patient experience, particularly when coordinating individuals' care across the wider health care system.

Carer comment *"I was told who attended but I can't recall who it was. A calling card would've been helpful as I was more concerned about my wife at the time".*

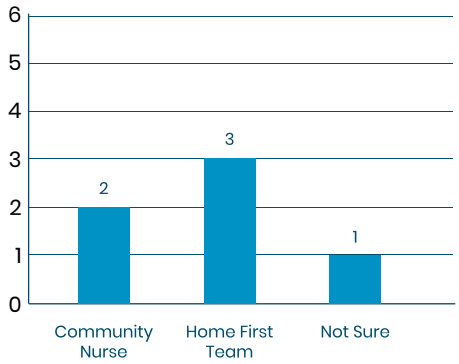
> **Relative comment**
> *"Have seen so many people, can't recall name or role of person who attended".*

Relative comment *"We had lots of people coming and going but no-one seemed to know what was going on".*

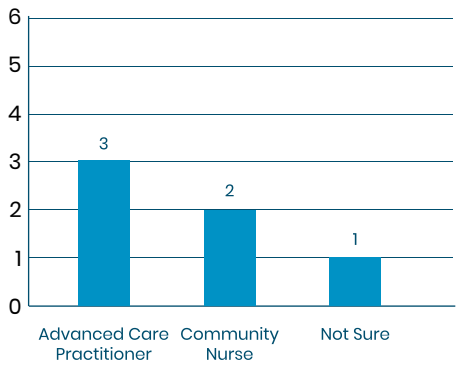
Central Patient Recollection of UCR Responder



North & East Patient Recollection of UCR Responder



West Patient Recollection of UCR Responder



Referral detail

We asked employees whether the referrals detailed enough information about the patient prior to the intervention.

Whilst the Central and West ICAs had an initial encouraging response, the North ICA reported that 83% of referrals in their area had insufficient details. Upon exploring the question further with employees across all areas, it became evident that there were two recurrent themes, inaccurate referrals and insufficient detail. Both the UCR and Home First teams alluded to valuable time being spent researching patient history or attending interventions with an inaccurate expectation of patient condition. However, whilst employees raised this issue, they still reported achieving the time standards.

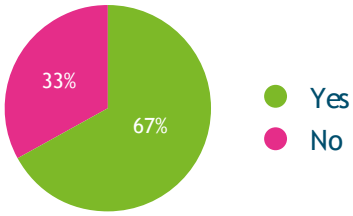
There is an easily accessible, comprehensive SERS Support Guide [1], with a detailed example of a completed SERS which would be a useful reminder to GPs on the level of detail required. Whilst the detail on a referral can be addressed (see recommendations), it would also be beneficial to continue monitoring this process and question if it is the most efficient way for patients to access a UCR.

Employee comment *"Very brief info. Needed to dig around at the patients' profile, looking at bloods and admissions prior to attending patient's needs".*

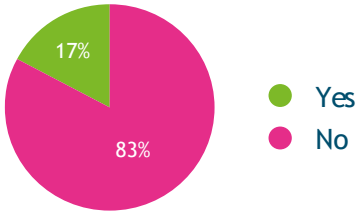
Employee comment *"Mixed, no details about the patients living situation, no medical history, no staff safety concerns or next of kin details given. Enough info about the reason for referral".*

Employee *"Basic info of name and phone number. Referral stated patient lives alone but patient lives with son. Didn't detail any info about patients' functional mobility or health related information/ history or diagnoses".*

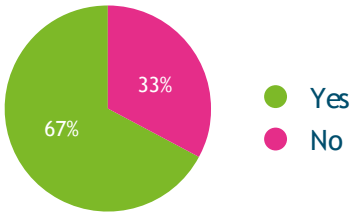
Central Employee Referral - sufficient detail provided?



North & East Employee Referral - sufficient detail provided?

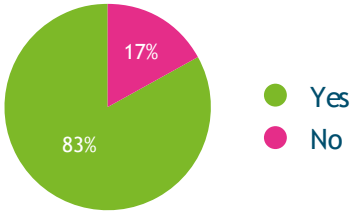


West Employee Referral - sufficient detail provided?

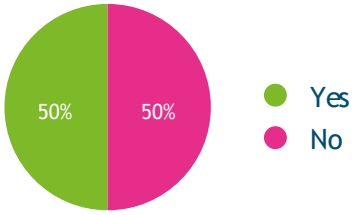


Most employees (except North & East) considered referrals to be justified with a shared goal of treating or providing care for patients to avoid unnecessary hospital admission. The North & East reported a 50/50 balance in terms of referrals being appropriate or not appropriate. The main reason for this was identified as patients not in as dire need as the referral suggested. Upon further investigation it is apparent that the triage pathway via the CCC may not be effectively triaging patients to the right team, however they could be erring on the side of caution. Some employees reported upgrading or downgrading referrals on receipt of the SERF. This would suggest that the triage team would benefit from further training ensuring patients are on the correct pathway for treatment/ care.

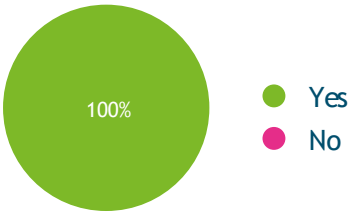
Central Employee Appropriate Referral



North & East Employee Appropriate Referral



West Employee Appropriate Referral



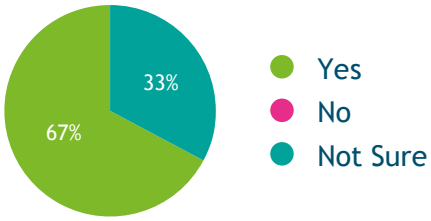
Employee comment *"patient independently mobile, fully independent transfers and able to provide self-care and manage home life well enough. I don't feel this required an urgent care response".*

Patient receiving help or care they need

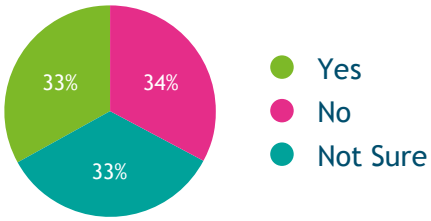
We asked patients, carers, relatives and employees if they feel they or the patient received the help or care they need. 100% of patients, carers & relatives in the Central ICA were confident they received the help or care they needed at the time of the intervention. 67% of patients, carers & relatives in the North & East were also confident they received the help or care they needed at the time of the intervention, whilst the remainder of participants were unsure. 67% of patients, carers & relatives in the West were either unsure or certain they did not receive the help or care they needed. Further exploration of this sentiment suggested patients, carers & relatives main concerns were around the ongoing care requirements, following the UCR. Employees across all ICAs in general, believed patients did receive the care or help they needed. A small number of employees who commented on patients not receiving the help or care they needed related to patient compliance, and unwarranted referrals.

Central Patient Help or Care Needed

North & East Help or Care Needed



West Patient Help or Care Needed



Employee comment *"we can't keep patients out of hospital if we don't have the care to support them".*

Involved in decision making about your care

All employees were confident they fully involved patients, carers & relatives in decisions about their care and treatment. An encouraging number of patients, carers & relatives also felt they were fully involved with decisions made about their treatment and care; however, this varies from area to area. Leading the way was the Central ICA, where 100% of patients, carers & relatives reported being fully involved. The majority of patients, carers & relatives reported being fully or partly involved in the North & East, whereas the West have a 50% response rate of patients, carers & relatives who did not feel involved in the care or treatment decisions.

Central Patient Involved in Decisions About Care

North & East Patient Involved in Decisions About Care

West Patient Involved in Decisions About Care

Patient comment *"Everything (the employee) did was discussed with me".*

Patient comment *"I feel like they are discussing us without our involvement. We were not involved in a discussion about adaptations - we were told".*

Advising patients about next steps

83% of employees in both Central and West ICA were confident they were able to advise patients, carers & relatives of the next steps in terms of care or treatment. In the North & East employees were able to advise patients of next steps or identified that no further intervention was required. In a small number of cases plans were already in place for the patient, or patient compliance hindered discussions around next steps.

Furthermore, 100% of employees who were able to advise patients, carers & relatives about next steps did so verbally either during or at the end of the intervention.

In contrast, the majority of patients, carers & relatives in the North & East (83%) and the West (67%) reported not being advised of the next steps and the Central ICA had a 50/50 balance. Upon further exploration, patients, carers & relatives highlighted other areas of uncertainty with:

- Who is responsible for what?
- If there is a follow up from initial visit?
- How long the Urgent Community Response or interim care lasts for?

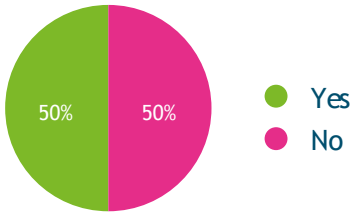
As with patients' recollection of who provided treatment or care, patients, carers, & relatives may cast doubt on being accurately informed of next steps, due to the discussion happening verbally at such a stressful time. As previously noted, continuity of care is important, therefore exploring ways to improve patients' understanding would be helpful.

Patient comment " *Home First haven't said if there will be anymore contact*"

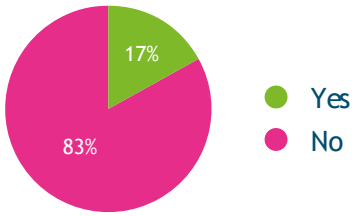
Relative comment *"The staff member did not explain what will be happening next... GP surgery spoke to Social Services about the arrangements for the carers and was told the Home First team would be dealing with it".*

> Relative comment *"I'm not aware of any follow up visits or further interventions to check my father's condition going forward".*

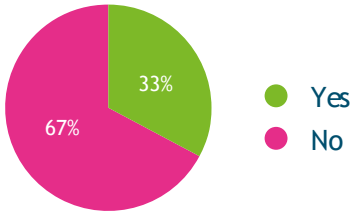
Central Patient Advised About Next Steps



North & East Patient Advised About Next Steps



West Patient Advised About Next Steps



Carer's experience

With regards to carers support, 83 % of carers in the Central ICA reported being fully supported, 33% of carers in the North & East also felt fully supported with the remainder of responses falling within the 'not applicable' category. In the West however, only 33% of carers felt partly supported and 67% said they were not supported.

The NHS Long Term Plan AW Web page [2] refers to a pledge to '*offer more support for people who look after family members, partners or friends because of their illness, frailty or disability*'. Evidence collected suggests more could be done to fulfil this duty, ensuring it is consistent across all areas. The need of carers & relatives often goes beyond signposting, requiring active support and not just suggestions.

Carer comment "*I feel I have to organise everything myself and I'm not aware of any support available to me*".

Carer comment "*I'm not sure what I need... Care needs will be assessed by the local council, but I'm not sure about when this will happen or what it entails*".

> Carer comment "*As support for myself and husband, I would have liked someone to talk to. I go into the garden and cry*".

Central Carer Support

North & East Carer Support

West Carer Support

Patient signposting

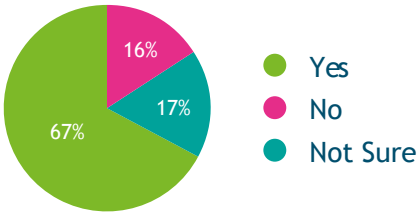
When asked about signposting, all employees referred to a variety of services to which they regularly signpost patients, carers & relatives. Some employees mentioned leaving leaflets on services such as Lifeline, meals on wheels and benefit payments. Many employees also mentioned referrals onto other services and reiterated to patients the importance of contacting their GP, NHS 111, or 999 should symptoms worsen.

Employee comment "*Signposted back to GP ... re pain and symptom management. Wound healed well however we advised what to do should that change*"

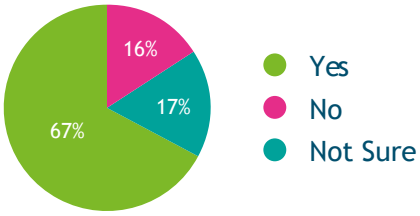
Employee comment "*I identified Lifeline would be useful and gave a leaflet and [the patient] was very interested. I explained the importance of a friend as a local contact also, a key safe and to have her sofa raised which I referred via the council*".

Continuing the theme of signposting, 67% of patients, carers & relatives in both the Central and North & East ICA reported to have been signposted to other services, referring to their GP as their first port of call should they need to access further help or support. This either suggests verbal signposting given by employees has been effective or it could suggest contacting a GP is the conventional pathway known to them. Only 17% of patients, carers & relatives in the West know where to access further support which suggests signposting requires improvement in this locality.

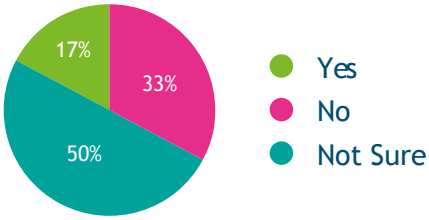
Central Patient Accessing Further Support



North & East Patient Accessing Further Support



West Patient Accessing Further Support



Patient comment *"Any numbers that I have been given take me through to a central location, but they know nothing about continuing care of the long-term situation".*

Patient comment *"GP would be first contact for support".*

Patient comment *"I have been advised about claiming Carer Allowance and have been signposted to the Age UK Website".*

Treating patients within Ageing Well Pathway

There was a resounding yes when we asked employees if they felt they were able to treat patients within the Ageing Well pathway. The commitment and passion of employees working toward the common goal of addressing patient needs was clear.

Employee comment *"We had the resources around us to do so. It was done within the designated time frame and ongoing plan in place as discharged from our service for a seamless transition into other services".*

There were, however, comments on daily challenges which hinder the efficiency of providing the service, particularly when referring to the Ageing Well Pathway [3]. It would be beneficial to reiterate the patient pathway and the criteria with employees on a regular basis.

Employee comment *"...could have been better after my Urgent Community Response re social care. Too many teams working in silo rather than an integrated service...family very frustrated with...inconsistent communication between teams and patient".*

Employee comment *"Although I'm not 100% sure what the pathway is, I know I was able to treat the patient appropriately and I was happy the patient was safe, and no further intervention needed".*

Employee comment *"Would be helpful to know more about the AW Criteria to enable a better use of resources".*

Delivery of the UCR compared to delivery prior to the introduction of Ageing Well standards.

Reassuringly, there were no reports from employees of the AW UCR service being worse compared with delivery of a similar service prior to the introduction of AW standards. Despite challenges mentioned throughout this report, 67% of employees in the West, 50% of employees in the North & East and 17% of employees in Central ICA felt the service was better and many employees from across all areas referred to being more reactive to patient needs.

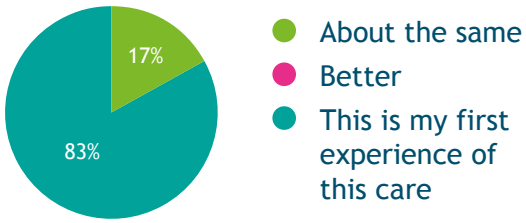
Employee comment *"Patient would've potentially had a long wait from the GP (in pain) had this service not been available. Service could be improved if all services are on-board with Ageing Well".*

> Employee comment *"It's about the responsiveness and being available to respond to the situation with resources (when readily available) ...".*

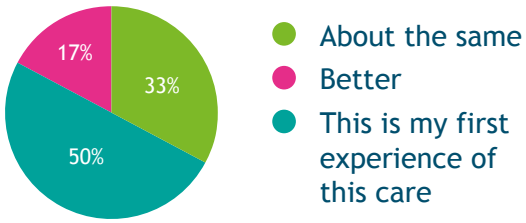
Employee comment *"I did the assessment and was able to involve the integrated team and set up a key worker, the patient pathway was more streamlined and effective, one person able to deliver the majority of care rather than lots of different professionals trying to individually deliver parts of care".*

When patients, carers & relatives were asked how this experience of care compares to previous experiences, the majority of participants (61%) reported that this was their first experience of treatment or care at home and therefore didn't have anything to compare this experience with. 22% of participants reported the service to be the same whereas an isolated participant identified the service as being worse (but chose not to comment further) and 12% described the service as better.

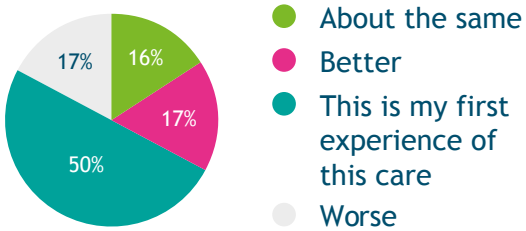
Central Patient Comparative Experience



North & East Patient Comparative Experience



West Patient Comparative Experience



Patient satisfaction

Despite the challenges mentioned throughout this report, most patients, carers & relatives reported being very satisfied or satisfied with the treatment or care received. 83% of patients, carers & relatives in the Central ICA reported being very satisfied, with the remainder being satisfied.

In North & East 67% of participants reported being very satisfied, with the remainder being satisfied.

In the West 67% of participants also reported being very satisfied, however two patients, carers & relatives in the West (33%) reported being dissatisfied with the care they received from the Home First Team. These patients, carers & relatives gave reasons that the intervention was completed too quickly, not thorough in assessment, and needs of the patient were not listened to. As with 'advising patient of next steps', exploring ways to improve patients' understanding of what happened during the intervention would be helpful to patients, carers & relatives.

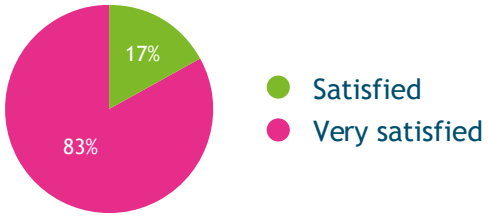
Overall, this is very encouraging, and employees can be commended for the positive impact they have had on patients' quality of life.

Patient comment *"community team have been brilliant"*.

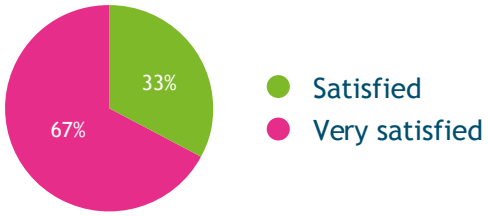
Patient comment *"everyone's been excellent"*.

Patient comment *"felt I was listened to and given all the information and help needed"*

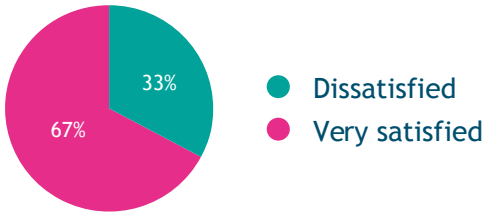
Central Patient Satisfaction



North & East Patient Satisfaction



West Patient Satisfaction



Recommendations

Recommendations to support employees in providing an effective UCR and Reablement service

1. GP Profiles on patient to be added to the SERF as standard. This will make more effective use of UCR / Home First time and easily identify patient needs by having access to patient medical history. Additionally, GP's would benefit from further training when completing referrals via SERS. This should also be extended to other services who will be using the SERS in future.
2. Communicate with all GPs the challenges associated with inaccurate or basic referrals, reiterating the importance of a complete SERF and making better use of the SERS Support Guide. Further consideration could be given to introducing compulsory boxes in the software, to ensure information about the patients' current circumstances (i.e living situation, support network etc) is not overlooked.
3. Improve working with Adult Social Care to help monitor care provision, giving patients a more accurate expectation of care availability. Furthermore, it would be beneficial to monitor the number of patients exceeding interim care (six weeks) and consider whether six weeks is long enough, and how extended interim care can be provided where needed.
4. Implement regular reviews and stock checks of equipment stores, ensuring they are adequately stocked. Effective management of equipment will result in fewer delays, supporting patient recovery and time taken to locate and deliver equipment by team members.
5. Check employees' understanding of the AW Pathway and provide up to date criteria for employees.
6. Enhanced employee training on the importance of recording data accurately on RIO, even if outside of AW standards, to identify further challenges.
7. Continued CCC training on SERF triage ensuring patients are on the correct pathway for treatment or care.

Recommendations to support patient experience of UCR and Reablement service

1. UCR to leave patient with information card, advising patient (when well enough to process), relative or carer, to include:

    a. Healthcare Professional providing UCR and/or Healthcare Team name

    b. Next steps (follow up required and by whom, time frame of interim care provided)

    c. Reiterate who to call if patient deteriorates

    d. List and provide literature on signposting to other services

    This will provide patients and health workers on future interactions with verification of treatment and care provided, supporting continuity of care. It will also allow patients to understand the treatment or care given when they are in a better frame of mind.

2 Review support offered to patients, carers & relatives, ensuring the support offered is effective and goes beyond signposting. Leaving the Age UK Checklist for Carers' [4], with carers would provide more detail on what help they could get, and where.

3 Further consideration should be given to the wider system challenges associated with early discharge from hospital without package of care or information on where patients, carers & relatives can source further support. HC has undertaken extensive research into hospital discharge in the county. Recommendations from previous research remain relevant and can be considered further by referring to these reports:

- Hospital discharge report October 2020
- Delayed Transfers of Care: What it's like for patients and families. 2019

Considerations and thoughts for the future

There are a few aspects of this work we feel are worthy of a note. Preliminary conversations took place with employees prior to the official interviews commencing during which the following points were noted:

- Although there was very little mention throughout the interviews of challenges with communication between teams, preliminary conversations identified it as a barrier to providing efficient care to patients. It was also mentioned there is not a universal understanding of the Ageing Well UCR / Reablement service between district nursing teams, and employees would benefit from regular updates to promote the service internally.
- Consideration should be given to the marketing of UCR / Reablement services for patients when the service delivery has progressed from the pilot phase to the fully operational phase of the programme.
- In an isolated case, an employee raised concerns on a referral that should have been addressed by a GP visit. Employees need to be supported to challenge such referrals, and processes need to be in place to monitor future cases.
- Reviewing the additional ACP provision should help to alleviate staffing concerns around part-time working patterns and adequate cover for annual leave and unplanned sick leave. It will also help to identify further gaps in service provision. It would be helpful to mirror this exercise for the Home First Team, which has previously been mentioned during Aging Well programme meetings. This will ensure effective use of healthcare resources and be conducive to patient recovery.

Lessons Learnt

Whilst conducting this study we have identified a few areas for improvement. Where possible, some of these improvements will be carried forward to the potential second phase of the study.

- HC were introduced to Integrated Care Managers (ICM) early in the study; however, their cooperation (due to competing priorities) was lacking. It also became evident some ICMs hadn't fully processed the purpose of the study or communicated this to their team leaders.
- This did not filter down to frontline employees which led to a considerable delay in patient referrals and employee interviews. Going forward, ICMs will need to cooperate and encourage employee participation.
- The role of HC, had not been cascaded to frontline employees. This meant a considerable amount of time was used to explain HC role and why the study was important to the Ageing Well Programme.
- Some frontline employees resisted involvement due to workload pressures, therefore it would be beneficial to have support from top down to encourage involvement, ensuring employees see the interviews as a priority and understand the impact of their involvement.
- It would be worth considering introducing a limit of characters for open ended questions and comments to focus the responses given and aid data analysis. Further training with HC volunteers could explore recording verbatim responses and extracting key points. Whilst a limit of characters for responses would aid data management, there is a risk this approach could negatively impact the depth of responses given.
- Some patient consent forms were completed retrospectively and not by the employee who provided the original UCR, which HC knew would be the case for some patients. This meant the employees who completed the form did not identify who provided the original UCR which caused some delays in speaking to the right employee. A minor adjustment to the consent form will easily address this issue.
- Online Microsoft Teams interviews worked well with employees, allowing HC to be reactive to employee availability. Sadly, this is not the same with patient, carer & relative interviews. These interviews were conducted over the phone and were less personable. Due to the pandemic, it's still unlikely we will be able to conduct face to face interviews for phase two.

Acknowledgements

Our sincere thanks go to:

- CPFT Ageing well employees from the AW Programme management through to front line staff
- Cornwall Council for the use of their facilities at Chy Trevail
- Patients, relatives and carers, who participated in the interviews
- HC volunteers

References

1 SERS (Single Electronic Referral System) Support Guide (2020) Available online at: How-To-Guide ---SERS-Full.pdf (kernowccg.nhs.uk)

2 Ageing Well, NHS Long Term Plan webpage. Available online at: https://www.longtermplan.nhs.uk/areas-of-work/ageing-well/

3 Ageing Well Pathway, Healthwatch Cornwall Ageing Well Interim Report. Published September 2021.

4 Age UK, Checklist for Carers

https://www.ageuk.org.uk/globalassets/age-uk/documents/information-guides/age-uk-carers-checklist.pdf

Appendix

Please note, HC own and process the data shared in line with current GDPR guidelines. As some participants wished to remain anonymous, and with such a small sample, it is important to respect these views.

Demographics of patients, carers & relatives in the Central ICA

1. Identity	Value
Patient	3
Relative	3
Grand total	**6**

2. Age	Value
65-79	3
80+	3
Grand total	**6**

3. Gender	Value
Female	3
Male	3
Grand total	**6**

4. Same gender from birth	Value
Yes	6
Grand total	**6**

5. Sexual orientation	Value
Heterosexual/Straight	6
Grand total	**6**

6. Ethnicity	Value
White: British (English/Scottish/Irish/...)	5
White: Cornish	1
Grand total	**6**

7. Religion or belief	Value
Christian	3
Not known	1
Other religion	1
Prefer not to say	1
Grand total	**6**

8. Marital status	Value
Married	3
Widowed	3
Grand total	**6**

9. Disability	Value
No	1
Yes: Long term condition	2
Yes: Physical or mobility impairment	3
Grand total	**6**

10. Long term health condition	1st cause	2nd cause	3rd cause	4th cause
Asthma, COPD or respiratory condition	2			
Blindness or severe visual impairment		1		
Cardiovascular condition (including stroke)	1			
Chronic kidney disease	1	1		
Deafness or severe hearing impairment	1	1	1	
Diabetes	1		2	
Epilepsy		1		
Hypertension				1
Grand total	**6**	**4**	**3**	**1**

11. Carer	Value
No	5
Yes	1
Grand total	**6**

Demographics of employees in the Central ICA

1. Identity	Value
ACP	3
Home first Therapy Support Worker	1
Occupational Therapist	2
Grand total	**6**

2. Age	Value
25-49	1
50-64	5
Grand total	**6**

3. Gender	Value
Female	6
Grand total	**6**

4. Same gender from birth	Value
Yes	6
Grand total	**6**

5. Sexual orientation	Value
Heterosexual	6
Grand total	**6**

6. Ethnicity	Value
Prefer not to say	1
White: British (English/Scottish/Irish/Welsh)	5
Grand total	**6**

7. Religion or belief	Value
Christian	5
Prefer not to say	1
Grand total	**6**

8. Marital status	Value
Married	5
Single	1
Grand total	**6**

9. Disability	Value
None	6
Grand total	**6**

10. Long term health condition	1st cause	2nd cause
No	4	
Yes: Asthma, COPD or respiratory condition	2	
Yes: Diabetes		1
Grand total	**6**	**1**

11. Carer	Value
No	6
Grand total	**6**

Demographics of patients, carers & relatives in the North & East ICA

1. Identity	Value
Carer	1
Patient	4
Relative	1
Grand total	**6**

2. Age	Value
50-64	1
65-79	3
80+	2
Grand total	**6**

3. Gender	Value
Female	4
Male	2
Grand total	**6**

4. Same gender from birth	Value
Yes	6
Grand total	**6**

5. Sexual orientation	Value
Heterosexual/Straight	5
Prefer not to say	1
Grand total	**6**

6. Ethnicity	Value
White: Any other White background	1
White: British (English/Scottish/Irish/Welsh)	5
Grand total	**6**

7. Religion or belief	Value
Christian	5
No religion	1
Grand total	**6**

8. Marital status	Value
Married	2
Single	1
Widowed	3
Grand total	**6**

9. Disability	Value
No	1
Not known	1
Yes: Long term condition	3
Yes: Mental health condition	1
Grand total	**6**

10. Long term health condition	1st cause	2nd cause
Musculoskeletal Condition	3	
Hypertension	1	
Asthmas, COPD or respiratory condition	1	
Diabetes		1
Other: Arthritis		1
Other: Underactive Thyroid		1
Grand total	**6**	**3**

11. Carer	Value
No	3
Yes	3
Grand total	**6**

Demographics of patients, carers & relatives in the North & East ICA

1. Identity	Value
Advanced Clinical Practitioner (ACP)	3
Physio Therapist (Home First)	2
Student Nursing Associate	1
Grand total	**6**

2. Age	Value
25-49	6
Grand total	**6**

3. Gender	Value
Female	4
Male	2
Grand total	**6**

4. Same gender from birth	Value
Yes	6
Grand total	**6**

5. Sexual orientation	Value
Heterosexual/Straight	3
Prefer not to say	3
Grand total	**6**

6. Ethnicity	Value
White: British (English/Scottish/Irish/Welsh)	6
Grand total	**6**

7. Religion or belief	Value
Christian	1
No religion	4
Other religion	1
Grand total	**6**

8. Marital status	Value
Cohabiting	3
Married	1
Single	2
Grand total	**6**

9. Disability	Value
No	5
Yes: Long Term Health Condition	1
Grand total	**6**

10. Long term health condition	Value
No	5
Not Known	0
Yes: Crohn's	1
Grand total	**6**

11. Carer	Value
No	6
Grand total	**6**

Demographics of patients, carers & relatives in the West ICA

1. Identity	Value
Relative	6
Grand total	**6**

2. Age	Value
50-64	3
65-79	1
80+	2
Grand total	**6**

3. Gender	Value
Female	5
Male	1
Grand total	**6**

4. Same gender from birth	Value
Yes	6
Grand total	**6**

5. Sexual orientation	Value
Heterosexual	6
Grand total	**6**

6. Ethnicity	Value
White: British (English/Scottish/Irish/Welsh)	5
White: Cornish	1
Grand total	**6**

7. Religion or belief	Value
Christian	2
No religion	3
Prefer not to say	1
Grand total	**6**

8. Marital status	Value
Married	5
Widowed	1
Grand total	**6**

9. Disability	1st cause	2nd cause
No	3	
Yes: Long term condition		1
Yes: Mental health condition		1
Yes: Physical or mobility impairment	3	
Grand total	**6**	**2**

10. Long term health condition	1st cause	2nd cause
No	3	
Not known	1	
Yes: Cancer	1	
Yes: Mental health condition	1	
Other (possible dementia)		1
Grand Total	**6**	**1**

11. Carer	Value
No	4
Yes	2
Grand total	**6**

Demographics of employees in the West ICA

1. Identity	Value
Advanced Clinical Practitioner (ACP)	3
Home First Nurse Assessor	1
Home First Team Lead	2
Grand total	**6**

2. Age	Value
25-49	4
50-64	2
Grand total	**6**

3. Gender	Value
Female	6
Grand total	**6**

4. Same gender from birth	Value
Yes	6
Grand total	**6**

5. Sexual orientation	Value
Heterosexual	6
Grand total	**6**

6. Ethnicity	Value
White: British (English/Scottish/Irish/Welsh)	6
Grand total	**6**

7. Religion or belief	Value
Christian	2
None	4
Grand total	**6**

8. Marital status	Value
Divorced	2
Married	4
Grand total	**6**

9. Disability	Value
None	6
Grand total	**6**

10. Long term health condition	Value
None	6
Grand total	**6**

11. Carer	Value
No	6
Grand total	**6**

Patient, Carer & Relative Questions

1. Can you recall who you initially contacted when you first sought help? [Explore details of how help was obtained]

2. Can you recall how long it took for your needs to be responded to? [Explore time frame i.e. 1 hour, more than two hours]

3. Can you tell us more about why you asked for help? [Patient to advise of reason for needing Urgent Care Response]

4. Who have you received support and care from? Select one option. [Explore role of Advanced Care Practitioner/ Community Nurse/ Home First team]

5. Do you feel you are getting the help or care that you need?

6. What or who has been helpful/what has worked well?

7. What additional help or support would you have liked? Is there anything you would like to have happened differently?

8. Have you/your family felt involved in decision making about your care?

9. Have you been told about what will happen next in terms of treatment and care? Select one option.

10. [If speaking to a carer, we'd like to know about their experiences of caring for the individual] Are you receiving the support you need to care for them?

11. Do you know how to access more support/healthcare if and when you need it?

12. Overall, how satisfied have you been with the care you've received?

13. How does your experience of care compare to previous experiences?

Employee Questions

1. Can you tell us how this patient was referred to you for Urgent Care?

2. Did the referral detail everything you needed to know about the patient prior to attending? [explore communication between teams on patient pathway]

3. Were you able to comfortably respond to the patient within 2-hours/ 2-days?

4. What was the urgent care need of the patient?

5. Did you consider this to be an appropriate referral?

6. Do you feel the patient is getting the help and care they need? [Explore What more would you like to do? Is there anything that you often think 'if only we could do x' for our clients, it would make a difference?]

7. What or who has been helpful/ what has worked well in responding to the Urgent Care need of the patient?

8. What additional help or support would have helped you deliver the care?

9. Were you able to involve the patient/ family in decision making about their care?
[Explore if patients interested to be involved in their care choices?]

10. Were you able to advise the patient what will happen next in terms of their treatment? How were you able to do this? [Explore Verbally/ Written and when]

11. What signposting do you offer to patients to enable them to access more support and healthcare if they needed it?

12. Overall, do you feel you were able to treat the patient within the Ageing Well Pathway? [refer to pathway below]

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Cornwall
TR1 2RP

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t. 01872 306 033
e. enquiries@healthwatchcornwall.co.uk