healthwatch Cornwall

Ageing Well: Urgent Community Response Review

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Cornwall and Isles of Scilly Integrated Care System

healthwatch Cornwall

Contents

Introduction

About us

Healthwatch Cornwall (HC) is the independent champion for people who use health and social care services in Cornwall & the Isles of Scilly. We put people at the heart of care by listening to their experiences of health and social care services and sharing with people who have the power to make change.

HC was commissioned by NHS Cornwall & Isles of Scilly Integrated Care Board (ICB - formerly NHS Kernow Clinical Commissioning Group) to review the Urgent Community Response (UCR) a year after the post-implementation study published at the beginning of 2022.

Cornwall Partnership NHS Foundation Trust

Cornwall was one of the first areas in the country to implement an Urgent Community Response and, since the early days of its inception, it has evolved into an essential part of a system-wide partnership approach to delivering more care closer to home. Cornwall Partnership NHS Foundation Trust commissioned this report to capture the views of people who have received an Urgent Community Response, and of the frontline clinicians delivering the service. We are grateful to those who took the time to share their personal experiences and are delighted that it paints an overwhelmingly positive picture.

This report is one part of a wider programme of continual evaluation and improvement by the Trust, to ensure that Urgent Community Response continues to meet the needs of the people of Cornwall. It provides a valuable 'snapshot in time'. As such, it is important to note that some of the 'system' detail contained within it may not fully reflect the current situation, as we work with partners to deliver the responsive service that people tell us is important to them.

Acknowledgements

The Project Team would like to thank everyone who took part in this survey, including service users, carers and relatives who took the time to give feedback whilst they or their loved ones were experiencing serious health

issues. Thanks too to all the UCR staff who have taken time to give feedback during a time of unprecedented work pressure for the NHS.

Executive summary

The Urgent Community Response (UCR) is a key component of the NHS strategy to reduce hospital admissions whilst keeping people well, responding to urgent care and support needs in the place they call home. The UCR is a rapid response, aimed at clinician attendance within two hours of a call being received for urgent clinical needs, or within 48hours for reablement needs. The response is delivered by Enhanced Practitioners (Community - EPCs) and, where appropriate, community nursing staff. Integrated Transfer of Care Hubs (ITOCH's) triage referrals and ensure the most appropriate practitioner attends the call, delivering the right care and support at the right time, based on need rather than diagnosis or condition.

This study builds on a previous Healthwatch Cornwall study carried out in 2021 to review the UCR in Cornwall after implementation of the service as one of the accelerator sites for introducing UCR across England. The aim of this qualitative study was to determine how the Urgent Community Response was working for service users and staff, and whether the recommendations from the previous report had been implemented and, if so, had an impact.

We used an appreciative enquiry approach – what worked well/what could be improved – in structured 1:1 interviews with a small cohort of twenty service users, carers or relatives and nine UCR staff. A further five staff and four general practitioners (GPs) were reached via an online survey, with three staff and one GP participating in a semi-structured online seminar.

What works well

During the study period, just over 83% of referrals met the two-hour response target and it was clear from both service users, carers, staff and GPs that the UCR provides a fast, effective and person-centred response to a person's urgent support needs. In particular, both service users and staff singled out the ability for practitioners to carry out rapid on-site testing.

People appreciated both the multi-disciplinary team approach and the flexibility and skills of the UCR staff. Doctors felt they could rely on the Enhanced Practitioners' (Community – EPC) medical skills to carry out clinical assessments that would otherwise fall to the GP to complete. There was also a general sense of a high level of pride and job satisfaction from practitioners.

The UCR was intended to be primarily used by GPs, and the data from this study shows that this is the case. GPs represented approximately 51% of all referrals in the year to February 2023. The Integrated Transfer of Care Hubs have a hotline to facilitate referrals and this is effective, although some GPs preferred the detail of the electronic referral form.

What could be better

The main concern raised by both service users and staff was the lack of access to services and support through Adult Social Care (ASC) and the availability of continuing support beyond the urgent need. This was compounded by the perception of staff that there is no Adult Social Care representation in the IToCHs, meaning they do not have access to information that had previously been available when there was an ASC representative in each of the Integrated Transfer of Care Hubs (IToCHs). Staff feel that it has become more difficult to work with ASC representatives since a restructure in social care in autumn 2022.

The multi-agency approach, whilst popular with service users and practitioners, is hampered by the range of IT systems used by different agencies and teams. The impact of this is that practitioners do not always have access to the relevant information about service users, and often have to research and contact multiple teams to get the right information. This is time consuming and inefficient, often leading to the person having to relate their story multiple times.

Staffing was a concern, with a number of vacancies existing at the time of the study. At the time of the survey, we spoke with staff working in two of the three the ITOCHs who reported they often operated with only one prioritiser on duty, which impacted on the ability to triage effectively and safely. We have since been assured by senior managers that this is no longer the case. Staff reported that they have very little administrative support in their teams and they have to complete essential record keeping themselves, often at the end of a shift or out of hours.

Conclusions and recommendations

The feedback about Urgent Community Response, from both service users and health professionals, was principally very positive. People feel they receive good service and health professionals enjoy the flexibility and solution focussed nature of the work. There is no doubt that most of the people interviewed, or their loved ones, would have been admitted to hospital if UCR was not offered. This would inevitably have a knock-on effect to system pressures, as well as a potential deterioration in the person's condition.

There are still some issues that need attention, in particular the access to and sharing of information with adult social care. This was the single biggest issue for both service users and professionals and is a theme of feedback Healthwatch Cornwall hear about from the general public. Access to the different IT and patient records systems used by different teams and agencies was also of concern to staff.

The overarching theme of the recommendations is to smooth out the flow of both information and patient support and improve the awareness of UCR across the system. The recommendations from the 2021 report have been partly implemented, to varying effect, but the key themes of joined up working and access to support provided through ASC remain.

Background

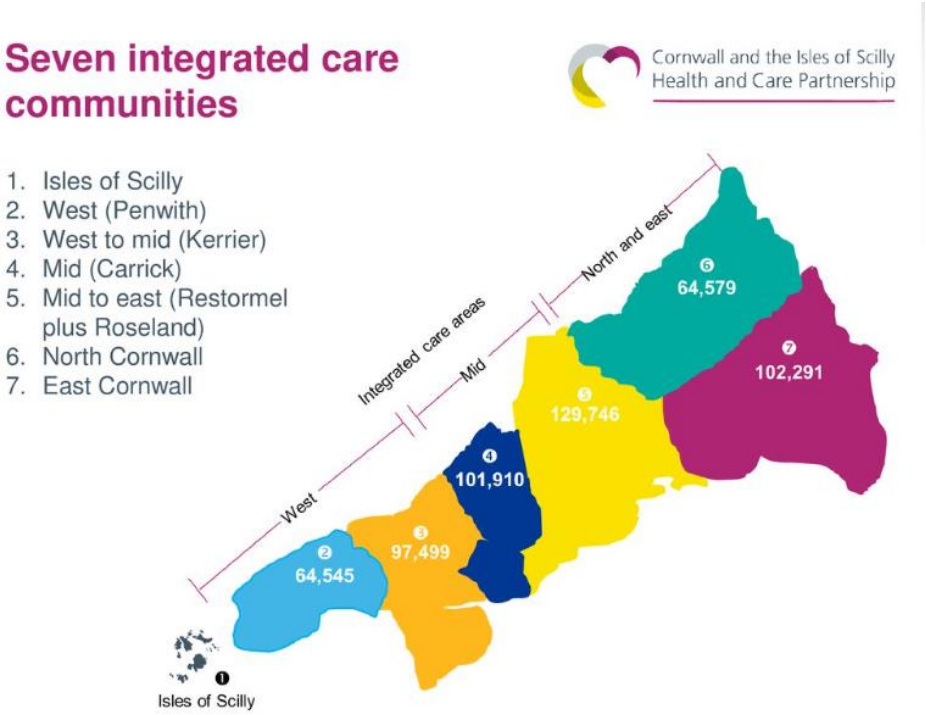
Ageing Well Urgent Community Response (UCR)

There is more pressure than ever before on health and social care services to deliver appropriate care and support to a growing population. With an ageing population and the residual impact of the Covid-19 pandemic on health and social care services, the NHS has introduced measures to try to avoid preventable hospital admissions, improve access to urgent health care and support.

The NHS long-term plan published in 2019 enshrined Ageing Well as a means of providing tailored support to help people live well and independently at home for longer. Ageing Well brings a multi-disciplinary approach, using doctors, nurses, health professionals and social care to allow people more control over their own care or that of their family or friends. More recently, the national COVID-19 response and ongoing recovery has also highlighted the importance of providing crisis care within the community to prevent avoidable hospital admissions and accelerate the treatment of people's urgent care needs closer to home.

The Urgent Community Response (UCR) is a crucial part of the Ageing Well plan, keeping people well at home and providing care and support at home, avoiding hospital admissions and enabling people and families to take charge of their own or their loved ones' care in the community. The aim of UCR is to give people the right care and support at the right time, based on need rather than to diagnosis or condition.

The national UCR standard requires that short-term intervention is provided to people in the place that they call home within two hours of the referral being received. Cornwall was selected as one of the accelerator sites for rolling out the UCR in 2020/2021 and the service has now been fully implemented in all Integrated Care Areas.



The integrated care areas of Cornwall, subdivided into care communities. (CIOS Healthcare Partnership, 2021)

Staff delivering the UCR across Cornwall

There is no dedicated clinical structure for UCR as the decision was made at the outset not to have a standalone service but to have it embedded within, and delivered by, existing community teams. However additional funding was secured to provide additional clinicians to enhance the existing skills provision. The decision on who responds to a UCR is based on which skill is required rather than on the basis of role. Referrals that are triaged to need enhanced assessment and clinical examination skills, differential diagnosis, prescribing and shared risk holding would be attended by a band 7 Enhanced Practitioner (EPC), formerly known as Advanced Community Practitioners (ACPs), or possibly a Community Matron (CM).

Enhanced Practitioners (Community - EPCs)

These are nurses and paramedics and allied health professionals (AHPs) with a robust clinical background who have the expertise to perform enhanced clinical assessments and examinations and take into account psychological, physical and social needs. They can order, execute and interpret common screening and diagnostic tests e.g. blood tests or x-rays. Each area should have at least one EPC and these [posts have been

fully recruited to, with the exception of one vacancy in the East of the county.

Community Matrons and Community Nurses

Other elements of UCR are also delivered by Community Matrons or Community Nursing teams. As well as providing nursing care, Community Matrons act as case managers. They are a single point of contact for the patients on their caseload offering support or advice. The advantage of having Community Nursing teams deliver UCR is that they often know the people they are visiting and have a wide range of skills and competencies.

2021 survey findings and recommendations

What worked well

People liked being able to address their immediate concerns quickly and appreciated the signposting given by UCR staff. Both service users and staff appreciated the quick access to mobility and support equipment. Staff also enjoyed the multi-disciplinary approach and having access to other practitioners and therapists, as well as direct access to social care to help provide support for people in their own homes.

What could be better

Both service users and staff cited the difficulties sourcing and securing ongoing care packages when needed. People were sometimes confused as to who had delivered their support, particularly if they regularly saw different practitioners, and they also felt that next steps were not always explained well. There was also a concern among service users over hospital discharge processes allowing people to go home before they were ready and generating the need for UCR visits.

Staff expressed the need for more detailed referrals at times, and for appropriate triage so that they were not going out unnecessarily. They also expressed the need for improved multi-disciplinary working across the board, particularly involving social care in decision-making and support planning.

Key 2021 recommendations

The survey made a number of formal recommendations, as well as some suggestions for further work. The key recommendations focussed on communications around referrals and with service users and carers and included:-

- GP Profiles on patient to be added to the SERF as standard and communicating with GPs about the impact of inaccurate/basic referrals.
- Enhanced training for employees to improve understanding of the urgent care response pathway and enable more accurate recording of information.
- UCR clinician to leave an information card detailing who carried out the visit and any next steps/signposting.

Other recommendations included:-

- Improved working with Adult Social Care
- Regular stock reviews of equipment stores

Details of the full findings and recommendations of the 2021 survey can be found in Appendix 2.

Aims of this survey

The aim of this survey was to understand a person's journey with the Urgent Community Response and their experience of community care across Cornwall. The research built on the learning from the Phase 1 survey carried out in 2021, exploring issues raised at that time and understanding whether the recommendations made then have been implemented and, if so, whether they have improved people's experience.

What we did and how

We used a qualitative and appreciative enquiry approach – what worked well/what could be improved – in 1:1 interviews with service users, carers, relatives and UCR staff. All except two interviews, one carer and one staff member, were completed by telephone or video conferencing. All interviews were conducted either by the Project Officer or one of two experienced volunteer interviewers who were engaged specifically for this survey.

The initial plan was to complete 18 service user/carer/relative interviews from all three Integrated Care Areas (ICAs) and then interview the corresponding staff member for each referral. We went direct to the teams providing UCR and asked them to refer service users to us for 1:1 interviews.

The interviewers used a structured questionnaire (See Appendix 3) to gain information about the experiences of service users and staff, from referral through the UCR visit to any follow-up and signposting. The interviews consisted of 12 questions in a combination of open and closed format, together with HC standard demographic monitoring questions. Interviewers repeated all answers back to participants to ensure sentiments were accurately recorded.

The difficulties gaining staff feedback led to a re-evaluation of the survey method in November 2022 in order to broaden the reach of the survey and make it easier for staff to respond. An online version of the survey was created, to enable staff to complete it in their own time. As a result of

specific feedback gathered during the survey, it was also decided to try to include GPs in the feedback and an online version of the survey was created to enable this to happen.

In addition to this, two webinars were held to gather group feedback from everyone involved in the UCR pathway. These were attended by administrative support staff, triage staff, UCR staff and a GP and the resulting discussion was a rich source of information about the use of the UCR.

We entered answers from face-to-face interviews onto an online survey platform for collation and data analysis. Video interviews were also contemporaneously recorded on MS Teams. The data from the online versions of the survey were collated on an online survey platform. The webinar was recorded and transcribed.

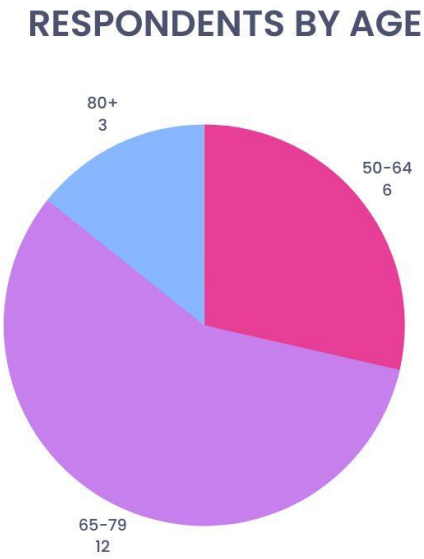
We then reviewed the data from the interviews, online surveys and the webinar, identifying themes in responses and grouping them to draw out conclusions and recommendations from the narrative or from quantitative responses.

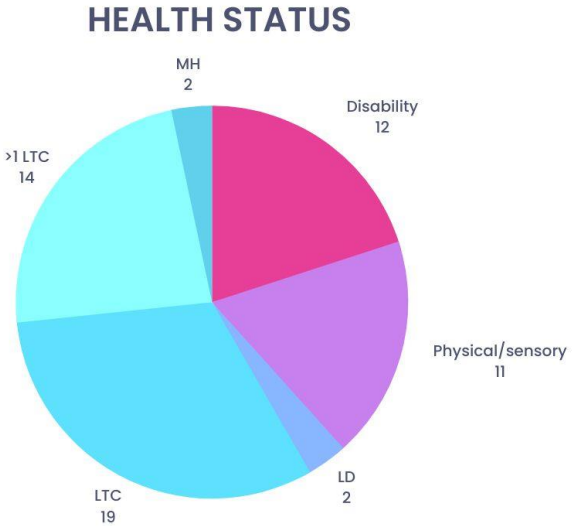
Who took part?

Service users

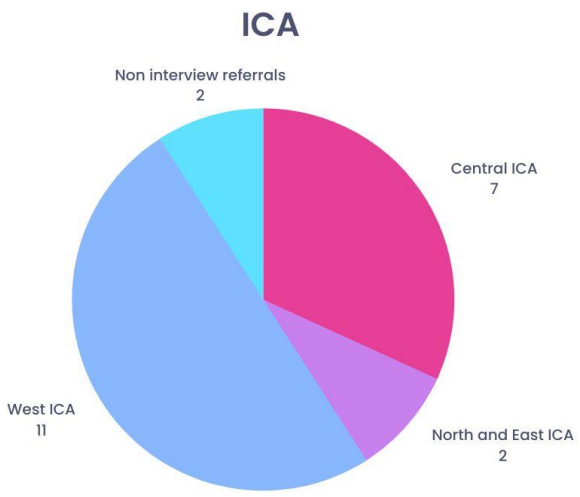
A total of 22 service users, carers or relatives were referred to the survey between July and November 2022, of which 20 were interviewed. Of the remaining two, one was too ill to interview and the second did not remember giving consent to participate and therefore the interview was cancelled.

Seven respondents were male and thirteen (65%) were female. Fourteen respondents (70%) were unpaid carers, of whom four had their own health issues. In all but one case where a carer was interviewed, the carer's condition was not the reason for the UCR visit.





Twelve (60%) had a physical or sensory disability, Nineteen (95%) had a long-term condition (LTC), of which fourteen (70% overall) had more than one LTC. Two 10%) had a mental Health diagnosis.

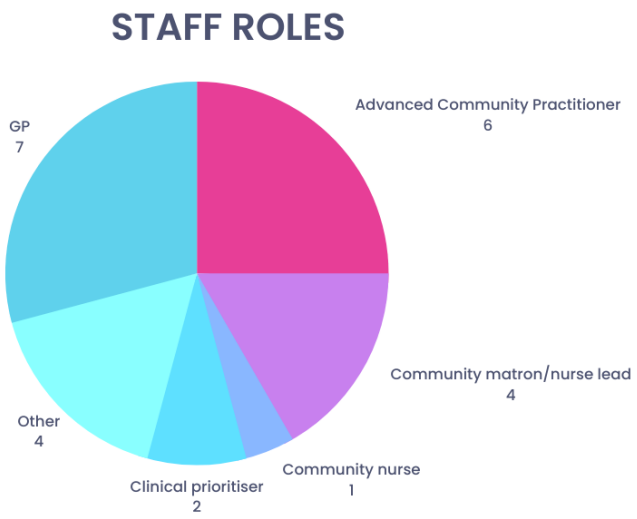


The most service user respondents came from the Western Integrated Care Area (ICA), whilst the North and East ICA produced the lowest number of respondents.

The lower number of respondents from the North area of the county was primarily due to the project team being unable to establish contact with the teams in that area. The project team was provided with contact details of new Integrated Care Managers, although recognising these posts were in transition over this period, with ongoing Enhanced Practitioner and Community Matron vacancies. Anecdotal evidence from staff in the East of this area suggest that, particularly towards the geographical centre of the area, East teams are covering calls.

Staff

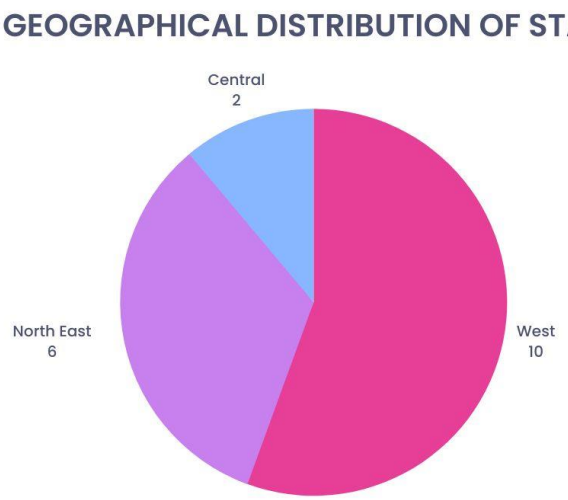
We completed a total of nine 1:1 interviews, with additional individual feedback from a further five staff via the online survey and three via the online focus group, together with one GP. A further six GPs completed an online survey.



Enhanced Practitioners and community nursing teams made up the majority of professionals spoken to during the study. The decision to widen the reach of the survey in the later stages meant that other staff, including clinical prioritisers and care co-ordination administrators were included.

The highest response from staff was in the West of the county, with responses fairly well distributed across the whole geographic area of the ICA.

There were only two staff responses from the Central ICA, both EPCs, but they related to a total of six service user referrals from across the Central area.



From the North and East ICA, the response has been limited to staff from the eastern teams.

Findings – what works well

"Sometimes this job is about not doing anything heroic, but having the guts to watch and wait and having a GP with the courage to do that too, and having the confidence to say when admission is right. Many of our patients are very old and infirm and admission is not always the best thing for them." (EPC, West ICA)

Speed and effectiveness of service

The overarching positive feedback from service users and staff related to the efficiency and speed of the response, either in terms of having someone attend quickly or in terms of accessibility to testing.

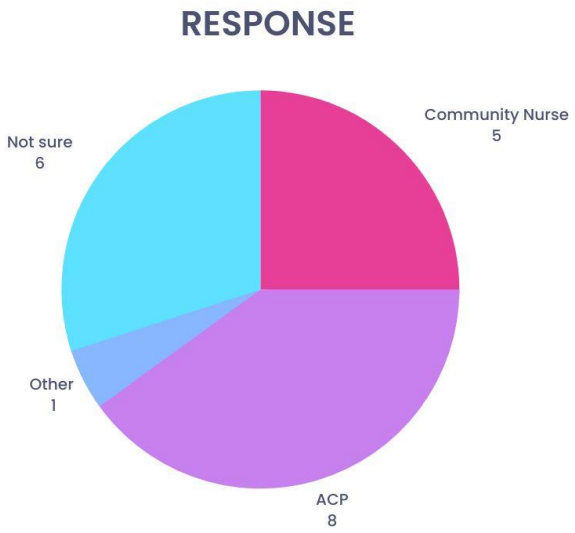
- Staff appreciate direct communication lines with GP surgeries and other services to get additional support quickly.
- Eight service users cited the availability of rapid testing and results improving their experience and making a difference to their care. The ability to carry out rapid testing speeds up the ability to prescribe and treat, removing the necessity for another visit, or for the person to go to their GP/hospital for further tests.
- The principle of having one person going in and sorting out the urgent support need from start to finish, carrying out tests and treatment if needed, rather than a series of professionals going in for different aspects of the need improves the patient experience.
- Staff are able to treat the person and deliver their support needs within the UCR visit. Occasionally, it is necessary to follow-up within 48/72 hours to ensure the support has worked.

People appreciated the skills, professionalism and compassion of staff. Multi-disciplinary working was a positive factor in this.

"A million times better than any experience I have had at RCHT I think care at home is 'the way to go'" (Service user, Central ICA)

- Eleven respondents (55%) praised the skills, knowledge, professionalism and compassion of the staff of the staff who attended as a plus. *"The ACP was 'so on the ball' that I am so pleased they were so sepsis aware. They phoned the ambulance several times while they stayed with me. I do not think I would be here if they were not so aware."* (Service user and carer, Central ICA)
- Nineteen of the twenty respondents felt fully (14) or partly (5) involved in decision-making about their care or the care of the person they were looking after.

- The multi-disciplinary nature of UCR support is popular with service users, staff and GPs. In terms of responders to the calls in the study, responders were predominantly Enhanced Practitioners (Community - EPCs), or Community Nurses.



- Service users and carers feel they are having to repeat their story less as the UCR provider can liaise with other services for them. Staff feel that having access to other services and an overview of what's need helps them to improve the patient journey. GPs find it easier to be able to contact the ITOCHs to make referrals.

- There is a good network of peer support between the EPCs, enabling them to exchange learning and experiences between teams across the county.

Fourteen of the eighteen respondents knew the name and/or role of the person who had completed the visit.

- Only four service users were not aware who had visited them, and in each case they had multiple practitioners coming in over a number of days.

Impact of recommendations from 2021 survey

A key recommendation to support service users' experience in 2021 was for practitioners to leave an information sheet/calling card that detailed who had visited, next steps, scaffolding information and signposting to any support organisations.

Prototype information sheets were sent out to some teams. However, staff seemed to be unclear as to what these were or when they should be used, and not all teams were aware of them. Most service users could not recall having seen a leaflet, although as stated, they did know who had visited them. At best, use seems to be patchy and not thought through. Teams who had received the leaflet were not sure of its intended use and it appears that it did not reach many of the teams spoken to in this survey.

The majority of visits are completed within the two-hour window for Urgent Community Response. Rurality, staffing and referral route could influence this.

- Eleven of the fourteen staff respondents completing interviews or individual surveys felt that they were able to meet the two-hour target for response. Performance figures for the period from April to December 2022 support this, showing that just over 83% of referrals met the two hour target.

Month	Total calls	Met target	Breaches	
April	215	182	33	15.35%
May	230	202	28	12.17%
June	281	230	51	18.15%
July	214	177	37	17.29%
August	228	196	32	14.04%
September	188	155	33	17.55%
October	180	153	27	15.00%
November	194	149	45	23.20%
December	74	61	13	17.57%

Exception reports do not go into detail, but evidence from the survey suggests breaches occurred when the practitioner was covering more than one area or when staffing was short. Staff in the East, responding on the online survey cited staffing shortages and the rural nature of their patch. The rural nature of all areas also means that it is sometimes not possible to get to a call within the timeframe, especially if the practitioner is already on another call.

If it's at the far end of my area, timing can be an issue, but that is more of an exception than the rule. We try and keep in our areas to manage distances better. The problem is that there are now more times when there are only one or two of us on, which makes things difficult as we have to cover a wider area. (EPC, Central ICA)

Logistically, to get from Hayle to Land's End within the two hours is hard and if I'm out on a call already it can be very hard. (EPC, West ICA)

- In all areas, where the initial referral comes into an Integrated Transfer of Care Hub it is extensively triaged before being received by the local team to carry out the visit. This may delay the practitioner receiving the call but improves the quality of information they receive. If the calls come into a district nursing team, the referrer and practitioner will discuss the case directly and the clock starts at the point of that call, rather than going through the hub.

Timely and appropriate referrals

The information from service users and carers about reasons for referral differed slightly from staff responses, with the staff offering much more detail about underlying health conditions, while service users tended to focus on the immediate need that led to the call.

- The main reasons given by service users and carers were:-
  - Acute illness - usually people with an underlying long-term condition who developed an additional illness or infection.
  - Catheter problems – usually blocked catheters or infection at the insertion site.
  - Non-fracture falls and loss of mobility.

- The main reasons given by staff depended on the role of the responder. Community nurses were more likely to be called for catheter problems, falls and loss of mobility, whereas EPCs were more likely to be called for acute illness because of the need for a medical assessment.

Summary of reasons for referral

Condition	Service users/carers	Staff
Catheter problems	5	1
Non-fracture falls	3	3
Dementia Crisis	0	0
Acute loss of independence/mobility	3	2
Acutely unwell	6	2
Wound care	1	0
Continence problems	1	0
Palliative or End of Life care	0	1
Other	2	8

*the figures above from service users and staff are an indication of the stated reasons for referral and do not necessarily relate to corresponding UCR visits.

- "Other" reasons for UCR referrals included taking long lie bloods after a fall, following up on hospital discharges at the request of the service user, who felt unsafe at home, reablement for patients who have become deconditioned or are not coping at home.

Referrals are usually timely, appropriate and promptly followed up with the referrer at the completion of the UCR visit.

Without us going in, she would have been sent to Treliske and would likely have been traumatised, as would her family be. The patient had a clear Treatment Escalation Plan (TEP) and had almost an acute set-up already in her home environment because of her MS. (EPC, West ICA)

- All staff who were asked (9) felt that the majority of referrals were appropriate and fitted with the stated aim of UCR to avoid hospital admission and care for people at home.

- The preferred referral route in all areas is through local Integrated Transfer of Care Hubs (ITOCHs), where they are triaged by prioritisers, who decide whether the response needs an EPC or other community nursing response. This means that the most appropriate responder is sent to the visit. Prioritisers are aware of the full list for each team member for the day and can redirect if a more urgent case comes up.

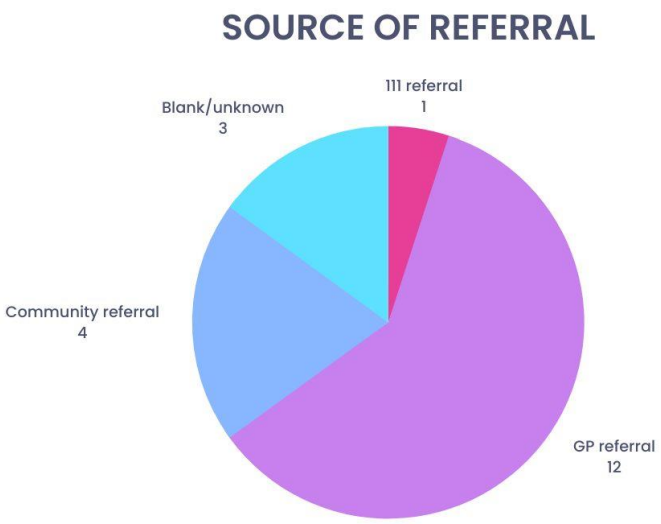
- In some cases where the patient already had a relationship with the community nursing team who could respond to the UCR need, they were able to self-refer direct.

- Most of the staff responders did not specifically list referrals from South Western Ambulance Service (SWASFT) as a source for UCR, however performance data shows that this was a source of around 2% of referrals in the year to February 2023.

- Referrals from SWASFT usually involve a crew on scene and the practitioners are able to discuss courses of action and the appropriateness of the call direct.

GPs are the predominant source of referrals.

- Service users and staff agreed that GPs were the primary referral source. 60% of service users said they had contacted their GP in the first instance, 20% were referred through community nursing teams and 5% by NHS 111. The chart to the right shows the staff responses about referral sources.



- Performance data for the year to February 2023 confirmed GPs as the main source, representing approximately 51% of referrals.

- GPs said that they tend to refer acute cases that have a mix of medical and social need, particularly where they may need a medical assessment and might otherwise need to go to hospital. The impact of this for the GP is that they do not have to visit the person themselves and the knock-on effect to their surgery lists is avoided.

- Practitioners do accept direct referrals from GPs or other professionals – i.e. not going through the ITOCH - as they want to promote UCR and to be a "service that says Yes".

- Each Integrated Transfer of Care Hub has a hotline, allowing doctors, NHS 111 and the South Western Ambulance Trust to call direct without the need for completing a SER form, although some GPs said they preferred the level of detail on the form as opposed to a phone conversation.

- As most calls either come into a hub or direct to the nursing teams, they are able to triage and direct the referral appropriately if needed.

- GPs said that in almost all cases they get to hear the outcome of UCR visits within the working day, and sometimes within hours. This is not necessarily through an established feedback process but through proactive contact from the UCR providers to update them.

Impact of recommendations from 2021 survey

One of the key recommendations of the previous report was to add GP profiles to the single electronic referral system (STRATAeF). This seems to have been done in part but practitioners still often contact GP surgeries for more details.

The 2021 survey also recommended more liaison with GP practices to promote the importance of completing the STRATAeF and making use of the support guide. This has been implemented to an extent but there are still some gaps and some surgeries that do not use the UCR or use it "on Friday afternoons" as an out of hours service (see P28).

Support for carers

In general, the carers we spoke to felt supported by the UCR providers at the time of the visit.

- As with the patients, carers were very happy to have had a quick response to their call, however some were disappointed at what they felt was a lack of follow-up.

- Twelve of the fourteen carers felt fully or partly supported. Of the two who felt they didn't receive support, one had a serious health condition herself and the UCR call related to her condition and she felt she was not well enough to look after her mother. The second was a man looking after his 96-year-old mother who had frequent contact with services due to falls and he felt nothing was being done to address the underlying causes.

Overall satisfaction with service

There was a general sense from all the practitioners that they take pride in what they do and get a high level of job satisfaction despite the intensity of the work and the pressures on health and social services.

- Staff enjoy the responsiveness and flexibility of UCR, along with the freedom to act and the appropriate skillset to take decisions during the visit. As one EPC described it, *"We aim to be a service that says Yes"*.
- In the West ICA, staff singled out daily huddles with local surgeries, Home First and adult social care increase effectiveness as the visit can be discussed in a multi-disciplinary team (MDT) prior to attending.
- Staff reported that they often join up dots in people's care, checking on progress 24/48 hours after a visit, and this was felt to improve both the service and people's experience. For example, UCR staff often liaise with family members to make sure that there is enough support available for them to be safe at home. If they are not able to check in with the patient, they try to find out progress from the GP or local nursing team.

Service users and families are generally happy with the easy and quick response that the UCR and community teams provide.

- Some respondents found the UCR provided easier and quicker responses than primary care, although in most cases the referral had come via their GP.
- Of the twelve respondents who had previously accessed UCR, seven said that this response was slightly (2) or significantly (5) better than before. Of those who qualified their response about their overall experience, two cited the speed of the response and a further two cited the skills and approach of the attending practitioner.
- Three respondents felt that everything about the visit was a positive experience for them.

Findings – what could be better

Staffing and service organisation

Urgent Community Response needs more staff both out doing visits and taking the calls.

Having experienced staff in the ACP posts is important, and the more experienced the practitioner, the better the service that can be offered. This will also lead to a build-up in professional confidence and trust from GPs. (GP, West Cornwall)

- There are a number of staff shortages across the county. Some of these are unfilled posts that managers have not been able to recruit to, while other shortages are down to short and long-term sickness amongst existing staff.
- Three respondents cited difficulties accessing their GP which led to the UCR visit. Performance data from NHS Cornwall suggests that, between April and December 2022, the number of referrals where the two-hour response target was breached ran at between 12 and 24%
- Appropriate staffing of IToCHs is essential. We spoke to staff working in the two of the three IToCHs, who said there was often only one prioritiser on duty. Senior managers recently (June 2023) provided assurance this would now be unusual. The hubs triage all calls that come in for UCR, Community Nurses and out of hours services, as well as calls from 111 call handlers and SWAST. The number of calls varies widely from day to day.
- There is little administrative support for EPCs. Administration from a visit may take several hours to complete and is often done at the end of a shift or out of hours.
- Getting basic performance data about the UCR has been very difficult for the HC Project Team. There is a national reporting framework, however there were ongoing issues with the national Community Service Data Set which was not set up to accommodate a UCR that is embedded in existing team structures rather than as a

standalone service. This meant that Cornwall was unable to record UCR in the same way as other authorities.

- Staffing levels and working alone. There are vacant posts and high levels of absence within teams, which leads to practitioners being stretched and having to cover wider areas.

Facilitating multi-disciplinary working

Working with Adult Social Care has become more difficult in the last year.

- The 2021 report recommended closer working with Adult Social Care, however in at least two of the ICAs, social care presence has been removed from the ITOCH due to a restructure in social care itself. Staff and GPs felt this was a backward step.
- Staff working in the ITOCH feel that the conversations that used to happen in the room when there were ASC representatives provided information that helped speed up responses, even when they were unable to source ASC support.
- GPs also said that removing ASC from the ITOCHs slowed up processes and felt less joined up than previously.

When ASC were in the hub, they used to deal with all the calls that had a social care element there and then. Now we have to do a referral and then we don't know what happens to it as it disappears into the ether. It feels like that level of integration has slipped over the last year. (Prioritiser, S Kerrier)

Impact of recommendations from 2021 survey

Improving working relationships with Adult Social Care (ASC) was a key recommendation of the 2021 report. The aim was to improve monitoring of care provision, giving patients a more accurate expectation of care availability.

One point that came out of the focus group, and is supported by evidence from 1:1 interviews, is that staff and GPs are disappointed at the removal of ASC staff input from the hubs. Until recently, there was an ASC representative in each hub most of the time. This enabled direct conversations with ASC at the time of a referral and, although social care might not be available, it enabled practitioners to have an accurate picture of any social care need related to the referral.

The removal of ASC from the hubs is leading to delays in getting social care information which means delays is organising care. All staff and GPs felt this was a step backward.

It was exactly that situation that helped general practice when we could call the SPOA so that the process was nice and streamlined. With social care coming out of it it seems like a decision was made to send one one way and one the other. A lot of patients have a bit of medical and a bit of social and they need dealing with at once. The whole point of having a hub was that it was all dealt with in one room. (GP, West Cornwall)

GP surgeries vary in their knowledge of the existence of UCR and when to use it. This can lead to delays and inappropriate referrals.

- One respondent, a GP whose knowledge of the system led to the UCR visit, felt that more work needs to be done to make surgeries aware of when they can access UCR support, as their relative's surgery did not appear to know about the service.

- UCR staff said that there are still some gaps and some surgeries that do not use the UCR or only refer to it "on Friday afternoons" as an out of hours service.

- Eight (47%) staff respondents said that the referrals they receive generally do not have enough information to carry out the visit. This is offset by the practitioners carrying out further investigation via electronic patient records systems (EPRS) and direct contact with GP surgeries. This is sometimes hampered by all the different IT systems involved for different areas of patient care.

- During a routine HC engagement, the Project Officer encountered an incident from the North of the county where, on the surface of the person's experience, UCR could have been implemented, however it was clear from discussions with surgery staff that they did not know about UCR.

The different services and teams involved in a person's UCR journey are all on different IT systems, making the sharing of information difficult.

- Practitioners do not have across the board access to systems such as EPRS and EMIS as different surgeries use different systems. Access to the MOSAIC system for adult care would also be of use, especially in the hubs. One single IT system for all the teams and agencies would help.

Impact of recommendations from 2021 survey

There were three key recommendations in the 2021 report relating to effective recording of information around UCR. The first of these related to staff understanding of the use of the Urgent Community Response. Interviews with staff show that they are clear about their roles and the function of UCR. Staff in the Integrated Transfer of Care Hubs also have a clear appreciation of when to utilise UCR.

The second recommendation referred to the importance of recording data accurately to identify further challenges. There was evidence in this survey that there are still issues with recording visits under the pathway, leading to difficulties in getting accurate performance figures for UCR. Further training and communication may be useful to support understanding among newer staff. There have been some recent (February 2023) changes to RiO (the electronic patient records system) to include appointment outcomes, which will improve the ability for managers to assess the effectiveness of UCR.

The third recommendation was to implement continued training for hub staff on how to triage incoming referrals to ensure patients are on the correct pathway for treatment or care. The hubs appear to be working well and triaging appropriately, allocating the correct practitioners to each case.

There is a lack of clarity for service users as to what happens at the end of and after a visit.

One of the things that happens is that mum gets visited by a lot of different people - the GP, community nurses, the emergency care people, plus STEPS and carers. You're never quite sure how everyone fits together or who to contact and it's confusing, especially for mum. A sheet explaining who everyone is and how they relate to each other would be helpful, with contact numbers if needed. (Relative, West ICA)

- Seven service users (35%) felt they were not informed or were unsure about what would happen after the UCR visit. Five of these said they would contact their GP in the first instance if they had any questions. There was some confusion amongst service users as to what constituted a UCR visit, as opposed to routine visits by community nursing teams, this was particularly the case if they had complex needs and had prolonged contact with community teams.

- All the staff said that they always signposted people and carers to other services or provided scaffolding information in the event of conditions deteriorating.

Impact of recommendations from 2021 survey

It was a key recommendation of the 2021 survey to review support offered to patients, carers & relatives, ensuring the support offered is effective and goes beyond signposting.

Feedback from patients and carers suggests that this is still an issue for around a third of them, although practitioners believe they are providing the right information.

Hospital stays and discharge

Hospital discharge processes do not always take people's social and domestic circumstances into account.

- We spoke to four service users who felt they or their loved one had been discharged prematurely from hospital.
- In one case, an elderly patient was discharged from a community hospital and provided transport that took five hours to get to them home. They were in a wheelchair for the whole journey, which resulted in pressure sores.
- One patient who provided care to a relative, was discharged back to their caring role while still in recovery from an acute admission to hospital.
- Hospital discharge processes do not always include effective liaison with community teams for ongoing care.

Impact of recommendations from 2021 survey

It was a recommendation of the 2021 report that 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. Both nationally and locally, Healthwatch England and Healthwatch Cornwall have undertaken extensive research into hospital discharge. Recommendations from previous research remain relevant and can be considered further by referring to these reports:

a. Discharge to assess: 590 people's stories (Healthwatch Cornwall, October 2020)

b. Delayed Transfers of Care: What it's like for patients and families. (Healthwatch Cornwall, August 2019)

Access to Adult Social Care services and ongoing support

Although not directly related to UCR, the most common concern raised by both service users and staff during the survey was the lack of access to Adult Social Care and the availability of continuing support beyond the urgent need.

- When asked what one thing could improve the provision of UCR, eight staff (40%) cited the need for a smoother system for referring to adult social care such as domiciliary care, and more Home First input and availability.
- There were concerns about out of hours care – i.e. after the UCR service stops as it is not 24/7 – particularly in relation to catheter blockages and end-of-life care.
- Only two of the eight respondents who were carers felt fully supported with the ongoing care of their relative. Five said that they were given little or no information about carer support or the care of their relative. This was not strictly related to the UCR visit, but some respondents felt that if information was more proactively provided, they might not have to access crisis support.
- Two of the carers had serious health conditions themselves but felt this was not taken into account in the caring for a relative.

"When I came out of hospital, I fell straight back into a caring role that I was not fully fit for." (Service user and carer, Central ICA)

- One respondent felt that the treatment she received in hospital overlooked an underlying condition that led to blood clots in her legs which led to the need for UCR after discharge.

Service users were concerned about ongoing care for themselves or their loved one, especially if the UCR had resulted in temporary support from Home First or STEPS.

These concerns were more in relation to general support from services than specifically relating to UCR.

Some carers felt they had little or no ongoing support and that there was very little proactive provision of information for them, so that they had to research options themselves.

To me what would be really important is that they don't just come and do their thing and then shut the door behind them. It was great they did the tests, but there was no follow-up and the problem wasn't solved. (Carer, Central ICA)

- Specific concerns were raised about the availability of respite care, especially for the carers with their own health issues.

- One 83 year old woman who was the main carer for her terminally ill husband had not had a care needs assessment for over a year, despite her husband being in end of life care and completely losing mobility and continence in that time. This person also experienced conflicting views and advice from nursing teams and carers.
- One man raised the issue of being asked to provide personal care for his elderly mother, which they both felt was inappropriate. This issue was resolved locally.

Conclusions

I think as things develop and hospitals see how potentially successful this service is, the more complex the patients will be that we're expected to manage in the community. This will need much more upskilling of primary care staff to do that. (GP, West Cornwall)

One of the things that the UCR are really good at is managing to pull together all those little bits of teams that need to be pulled together in order to keep the patient at home. What lets it down at the minute is that there is no package of care available because there are no carers around. (Prioritiser, West Cornwall)

There has been a sense throughout this project that service users, carers and staff like the Urgent Community Response. People feel that the UCR makes them safe and offers a quicker response than primary care. People accessing the UCR tend to be older, often with multiple complex medical and social care needs.

The sentiments expressed about the UCR and about NHS staff in general were overwhelmingly positive. People liked the personal contact and the fact that UCR staff were multi-disciplinary, whether they were EPCs or nursing staff and were very complimentary of the individuals they met, even when criticising overall services.

I really liked the fact that we had the community nurse. She knew what she was talking about and I felt I wasn't going to get 'fobbed off' (Relative, Central ICA)

People feel they have received a good service from UCR, which may be partly explained by this quote from an EPC in Central ICA:-

Sometimes it's just about listening to how things have been for them. Very rarely will I go into see a patient and the issue is purely clinical. If people feel valued and listened to, you can sort out a lot of challenges.

There is no doubt that if the service was not there, most of the people interviewed, or their loved ones, would have been admitted to hospital, possibly leading to a deterioration in their overall condition and adding pressure to an already stretched system.

Staff find the role rewarding and challenging and enjoy the freedom to act in the patients' best interests and sorting out people's needs. They value the additional time they can spend with people or working on a particular case, pulling together multi-disciplinary solutions to complex issues.

In general, the GPs we spoke to also like the service and find it a useful addition to their resources.

A quick 'yes we can see, or no we can't' really helpful to manage my workload. (GP, West ICA)

There are still some issues that need attention. In particular, access to and sharing of information with Adult Social Care has deteriorated in the year since full implementation. This was the single biggest issue for both service users and professionals and is theme heard by Healthwatch Cornwall's through its public feedback. The sharing of information between teams and agencies that support individuals is also made more difficult by IT incompatibilities and access issues.

During the course of the survey, it has been difficult to assess quantitatively how effective the UCR is at avoiding hospital admission. At the time of writing, there is no data available that covers the period of this report to show how effective the Urgent Community Response is at keeping people in their own homes and avoiding hospital admissions. There have been some changes to the electronic patient records system, RiO in February 2023 to enable this in the future.

Have the 2021 recommendations been implemented and has it made a difference?

Service effectiveness

The key recommendations to improve effectiveness of UCR and the systems through which it works have been partially implemented and have improved services. Some issues remain, particularly with the different IT systems and patient records systems used by the separate services. However, the practitioners have developed excellent working relationships with other services and agencies in order to help mitigate this.

Improving working relationships with Adult Social Care was a key recommendation of the 2021 report. However, this appears to have deteriorated, and all professionals thought this was a step backwards in respect of multi-disciplinary team working. Practitioners would like easier access to patient information held by adult social care, and reported that the lack of access to it is leading to delays in organising ongoing care.

Feedback from practitioners indicates that they are clear about their roles and the function of UCR. Both patients/carers and staff describe an effective and efficient service delivered by skilled, compassionate staff. Staff in the Integrated Transfer of Care Hubs also have a clear appreciation of when to utilise UCR. The hubs appear to be working well and triaging appropriately, allocating the correct practitioners to each case.

Patient experience

A key recommendation to support service users' experience in 2021 was for practitioners to leave an information sheet/calling card that detailed who had visited, next steps, providing information and signposting to any support organisations. The implementation of this does not yet seem to be consistent according to patients and families. However, what is positive, is that most people knew who had visited them and why.

Feedback from patients, relatives and carers suggests that there is an ongoing issue around the proactive provision of information about ongoing care/next steps and signposting support for them, although practitioners believe they are providing the right information.

The wider system challenges associated with hospital discharge remain an issue for some patients, carers and relatives – but this is not a reflection on the UCR service.

Recommendations

- To reinstitute ASC into the hubs and continue to improve collaborative working with ASC (this was a recommendation from 2021).

- To fill the staffing vacancies and ensure that recruitment strategy includes the right level of experience and skillset.

- To continue to improve marketing the Urgent Community Response to GPs and other services and to increase awareness of the pathway across the system.

- To standardise IT systems and/or facilitate systems for sharing patient information so that all can have access to the right records.

- To build on the relationships established during this research to provide an ongoing feedback mechanism through Healthwatch Cornwall.

- To enable better recording of UCR to make impacts more visible in terms of numbers of people seen/hospital admissions avoided.

- In order to help patients to remain in their homes and experience a safe and timely discharge, the Integrated Health and Social Care System should work together to address the concerns raised within this report about the lack of access to ongoing care provided through ASC and private care providers.

- The Integrated Health and Social Care System should also work together to address the lack of proactive ongoing information and support carers and patients have outlined as a significant concern to them.

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