
Older Persons Newton Abbot Hub

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Executive summary, Key Findings and Recommendations

Introduction

The PenCLAHRC Person Centred Coordinated Care Team were commissioned by the South West Academic Health Science Network (AHSN) following approval from the Joined up metric board (JUMEG) to provide a one-year formative evaluation of the Newton Abbot Older Persons (frailty) Hub. The hub commenced activity in January 2016, but following a slow in the recruitment of patients and the inception of a new local multi-agency team a decision was made to fold the service. This report details our findings from data collected from May-September 2016 when the frailty service was active.

Aims

This evaluation aimed to conceptualise the model of the Older Persons Hub, identify the barriers and facilitators to implementation and explore the experience of delivery and receipt of intervention. The evaluation also aimed to imbed an internal monitoring process with the expectation that this would facilitate the collection of metrics and measures to assess long term impact of the model.

Method

Mixed methods were used to meet the aims. This involved qualitative interviews with patients (n=7), key delivery staff (n=4), staff from feeder practices (n=8), and management (n=2). Quantitative interview data was also collected from patients (n= 7), carers (n=2), delivery staff (n= 10). There were no returns from feeder practice staff. The Person Centred Coordinated Care (P3C-OCT) tool was also completed to capture organisational level data. The low numbers of interviews and questionnaires collected reflect the low numbers of patients being treated by the service and its early folding.

Findings

Three elements of the planned model were implemented wholly. Seven elements were partially implemented due to a number of organisational barriers. Five elements were unable to be evidenced. The context within which the hub was developed, resourced and the loss of senior level support all contributed to the service failing to achieve its impact in terms of treating the planned numbers of patients. When the hub was planned in 2014 there existed a need for more intensive input into the health and social care needs of the top 2% most complex patients, with the expectation that the hub would fit into the existing complex and intermediate care services. However, barriers within the system; insufficient IT communications, lack of multi-level support and leadership, a lack of resource both from general practice and nursing, combined with a lack of contractual agreements for staff, all culminated in a mix of factors which ultimately led to the folding of the service.

Due to the early folding of the service we were unable to measure the impact of the model, but we were able to provide a glimpse of how patients and staff experienced the hub.

Overall, patients felt that their care was joined up and working. There was perceived to be a good level of communication between professionals, and their needs were communicated effectively between those involved in their care. All patients interviewed felt that they were treated as a whole person rather than a collection of conditions. Staff reported positive experience of Multi-Disciplinary Team MDT working and its ability to breakdown silo working. The ability to be able to communicate with colleagues and the input from a range of professionals was felt to give the opportunity for more creative ways of working.

Key learning and recommendations:

- Continued management and leadership need to be in place to ensure adequate resourcing to embed new models of care.
- Referral pathways need to be established and communicated very clearly and maintained with all services and organisations involved in the care pathway. Good communication links between the staff of the hub and those in feeder practices seemed to be vital to enable the smooth running of the hub and reduced anxiety about referring patients without adequate care. Representation at the Multi-Disciplinary Team meetings would have helped overcome this barrier, as would additional resourcing to facilitate an ‘open door’ policy whereby communication could be instantaneous in times of concern/ confusion.
- Clarity of responsibility with specific staff resourcing would ensure the updating of patient notes are relevant, clear and in real-time. Clarification/ additional training of the meaning of person centred coordinated care would facilitate staff understanding and professional development. This would also clarify patient and carer understanding, and improve their experience of the service. Acknowledging carers own healthcare needs in addition to supporting their role as carer was a strength of the service. However, organisational barriers meant that carer health needs were sometimes delayed whilst support for the referred patient was put into place. Staff acknowledging carers own healthcare needs in addition to supporting their role as carer was a strength of the service. Staff were committed to delivery good quality care and felt the concept of a specialist hub to organise care for this population was valid.
- Patient feedback largely reflected positive experiences of care and many were grateful of the extra support the service provided.
- Middle management leadership and support is crucial to provide the opportunity for new services to change and evolve.

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1. Introduction

There is now widespread recognition that the care provided by the NHS, social care and other associated community services should strive to be more person centred i.e. both centred around and responsive to the needs of the individual. For this to be achieved effectively services need to be better co-ordinated and in some circumstances integrated fully. However, the evidence base for integrated care is problematic and hampered by a lack of conceptual clarity. For example, evidence focusing on when it is better to strive for improved co-ordination rather than organisational integration is largely equivocal. There is also a lack of evidence about how best to achieve person centred coordinated care and which model is best. In spite of this, services are facing a real urgency to meet the health and social care needs of those with long term and complex health and social needs more effectively. This is represented in clinical policy (self-care, choice, care close to home) and financial imperatives (need to reduce emergency admissions) which are all demanding more integrated care for those with multi-morbidity and functional impairment, particularly for those individuals who are at risk of social isolation due to functional impairment or ill health.

Approaches therefore that involve support and empower people with long-term conditions (and potentially those in social adversity) play a role in improving outcomes (Wanless 2002; George Institute 2011). Research has also shown that individuals who are better informed and feel more involved in decisions about their care are more activated to self-manage (Hibbard 2004); and are more likely to experience good physical health and quality of life (Michie 2003; Schmittiel 2008). These features are important to person centred and coordinated care (PCCC) and often require the development of practical multi-disciplinary approaches (a single plan based on patients own goals, clarity about case management responsibilities and joint work supported by training).

To achieve a more person centred and coordinated care approach to service delivery a joint bid was submitted to the Department of Health for funds to set up two integrated care hubs within the integrated Pioneer site of South Devon and Torbay. This collaboration involved South Devon and Torbay CCG, South Devon Healthcare NHS Trust, Torbay and Southern Devon Health and Care Trust, Torbay Council, Devon County Council and Devon Partnership Trust (here on referred to as SD&TP). The bid was successful and in 2013 and SD&T received status as one of 14 Integrated Care Pioneers. These initiatives now form part of the wider context of integrated care work of Torbay Care Trust – considered as one of the most promising UK integrated care organisations (Ham, 2010). This joined-up integration programme is a key part of a cross-organisational strategic plan. The Better Care Fund further consolidates this plan, and the merger of acute and community provider trusts formed an Integrated Care Organisation and a local authority partnership. One of the two new integrated care hubs was the Older Persons Newton Abbot Hub and was orientated to address the Aging Well agenda of the wider programme.

The Older Persons Newton Abbot Hub aimed to provide a multi-disciplinary service providing holistic care for the frail elderly population of the locality. Newton Abbot was selected for the basis of the hub due to a higher than national incidence of frailty (5.2% vs 4.5% of those residing in care homes), and proportionally greater percentage of older

residents compared to England as a whole. Newton Abbot also shares a common primary care IT system, a high quality community hospital and benefits from an established multi-disciplinary crisis response process. The hub worked with six GP practices in Newton Abbot that are all using the same IT system which facilitates information and record sharing. The top 2% most vulnerable patients are identified by practices, using evidence-based predictive modelling with the Devon Predictive Model (DPM) and the local intelligence of health and social care Complex Care Teams. The hub also used the SystemOne Electronic Frailty Index to identify and risk-stratify the frail and pre-frail population.

Of the 2% identified as frail and at risk, the top 5% are highly-complex, likely to be very ill, possibly at the end of their life, and will already have had several unplanned hospital admissions. It was envisaged that these patients would be under the care of the GP-led older person's team, based at Newton Abbot Hospital, but supported to remain in their own home wherever possible. This built on the success of the community virtual ward model, taking it further to include more disciplines and holding the meetings daily in recognition of the complexity of the patients involved.

2. The Evaluation Team and Collaboration with Key Organisations

This study forms part of a programme of evaluations of service developments under the broad area of Person Centred Coordinated Care (PCCC) resulting from close working with local services and the South West Academic Health Sciences Network (SW-AHSN).

The evaluation team are: Dr Helen Lloyd (PenCLHARC) Principal Investigator, Dr Lynne Callaghan (PenCLAHRC) and Ms Jane Horrell Researcher. The team worked closely with Louise Witts (SWAHSN), Lisa Smith (RiPfA), Healthwatch and Senior Voice, Doug Haines (Public Health Team in SD&T), and the South Devon & Torbay CCG.

3. Aims of the Newton Abbot Older Persons Service Hub

The aim of the older person's service was to provide comprehensive, person centred, and multidisciplinary care for Newton Abbot's frail population. The Hub was originally termed the 'frailty' hub but due to negative connotations this name caused concerns with both staff and patients. Although the term frail has a defined meaning within the clinical groups, patients perceived it as meaning that they were perceived of little or no value. For this reason, this report will refer to the service as the Older Persons Hub. The hub also aimed to optimise health of the older population, manage their crises well whilst helping them plan for the future and provide good end of life care. To achieve this, it was visualised that a range of components should be put into place that might develop and change as the intervention grew. Based on the original logic model (see table 1), the following components were planned:

- GP Led Multidisciplinary approach (across 6 practices based in Newton Abbot)
- Multi-Disciplinary Team meetings (MDTs: meetings involving professionals from one or more clinical disciplines to make decisions regarding recommended treatment of individuals)
 - Teams/individuals involved in the Hub:
 - Complex Care Team/Hub Coordinators (x2)
 - Lead GP/ hub Manager
 - Registrars are present when working with lead GP
 - Pharmacist (moved to another post and not replaced)
 - Voluntary sector representative
 - Social worker/support worker
 - Therapies
 - Geriatrician
 - Community Matrons
 - Information and record sharing across GP surgeries and the Newton Abbot hospital
 - Risk stratification (the identification of those most suitable to be referred for care within the hub). Achieved through the identification of pre frail and frail through Integrated Electronic Frailty Index (2% most vulnerable identified).
 - Provision of crisis/ proactive care
 - Urgent complex care team with single point of access (SPOA: direct access to a single person/ team responsible for arranging and allocating hub caseload)
 - Care coordination (including admissions /discharge tracking)
 - Intensive care planning
 - Personalised care plans common to all practices
 - Proactive case management
 - Time patient allocated to hub care tailored to need
 - Mapping of local assets
 - Development of new workforce roles
 - Management support for staff to allocate time to hub work
 - Support at home (7/52 s

Table 1: Logic Model

Inputs	Activities		Outcomes -- Impact		
			Short	Medium	Long
<u>Hub staff:</u> Community Matrons, geriatricians, pharmacist, GP, nurses, community workers, Therapies, voluntary sector, coordinators <u>Staff skills:</u> Diverse <u>Resource allocation:</u> Lead GP 3 0.5 days per week All other staff to deliver hub care/services within current role (no additional resource) <u>Other organizations:</u> Care Direct Plus Community hospital Feeder Practices Voluntary sector	<u>Opportunities for communication to break down silo working</u> Generate an integrated care team to support the work of the hub Development of a shared vision of personalized and coordinated care from the perspective of the patient Map local assets Development of shared IT to support work of the hub Development of new workforce roles Management support for staff to: Allocate time to Hub work Work differently and across professional boundaries, centering resource and action on patient needs Innovate and exchange ideas MDTs	<u>Weekly MDTs</u> Multi-disciplinary decision making Embedding of medical care <u>Operation:</u> 6 weeks duration tailored to need and acceptance <u>Support at home (7/52 service)</u> <u>Advocacy</u> <u>Referral system:</u> SPOA Emergency referrals Routes: GP; IC1 Proactive/crisis referrals: Risk stratification: urgent input; complex; multiple needs that would benefit from multidisciplinary input <u>Care planning:</u> Personalised Care plan Intensive planning of care Carer and patient understanding of care Case management Crisis management <u>Care coordination:</u> Coordinating silos of care Mobilizing existing resources Tracking of admissions: handover; monitoring and discharge Key element of intermediate care team on discharge from hospital	<u>Patients:</u> Improved access to local services Improved patient experience of care More patient involvement Supported in managing own health (?) Can stay in own home where appropriate (?) Reduced feelings of loneliness (?) Improved mental wellbeing <u>Practitioners:</u> Motivated, flexible workforce	<u>Patients:</u> Improved access to local services Improved patient experience of health and social care More patient involvement Supported in managing own health (?) Can stay in own home where appropriate (?) Reduced feelings of loneliness Improved mental wellbeing (?) Reduced health inequalities People have a say in priorities and care provided in health and care system Reduced falls Reduced hospital admissions <u>Practitioners:</u> Motivated, flexible workforce	<u>Patients:</u> Improved access to local services Improved patient experience of health and social care More patient involvement (?) Supported in managing own health (?) Can stay in own home where appropriate (?) Reduced feelings of loneliness Improved mental wellbeing (?) Reduced health inequalities People have a say in priorities and care provided in health and care system Reduced falls Reduced hospital admissions <u>Service:</u> Financially stable health and social care system Reduction in waste and duplication across the system

Asumptions People's wellbeing is improved by staying healthy; breaking down organisational and professional barriers and boundaries will improve patient care; time limited (albeit tailored) intensive care package will impact on patient and service outcomes in longer term; that patients want more involvement and can engage in managing their own care.	Context: Newton Abbot was awarded pioneer status with a directive to target the frail population. The hub was set up without additional resourcing apart from the provision of single GP input for 1 1/2 days per week. Two other teams were already in place within the locality; complex and intermediate care.
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Key: GREEN: Implemented, Blue: Evidence identified for implementation but hampered by barriers, Red: no evidence of implementation.

4. Aims of the evaluation

The evaluation aimed to answer the following questions:

1. To what extent has the intervention model been implemented as planned?
2. What were the barriers and facilitators to this process?
3. Has the intervention model changed over the course of one year?
 - a. If so how and why did this happen?
4. How did service users experience the intervention, and did their experiences change over the course of one year?
5. . (a) Is there a relationship between patient and staff experiences and (b) How do these relate to process data and qualitative insights?
6. Are there observed changes in wellbeing, loneliness, and patient activation over the course of one year?
7. Are there observed changes in a range of service use variables over one year?

Due to the service being withdrawn, the evaluation was unable to ascertain (3), (5b), (6) and (7).

5. Methods

This evaluation used a mixed methods approach in an attempt to meet the aims and to answer the above questions. The overall approach was intended to be longitudinal mixed method and non-randomised design. A core feature of the proposed evaluation was the collection of three levels of data on a sub-set of patients from the main cohort of patients referred to the hub: qualitative data (level 1); structured questionnaire data on the experiences of care, patient activation, social isolation, mental health and carer experience (level 2); and system-wide service use data (level 3). The data was intended to be collected at baseline, 6 and 12 months. Structured questionnaires were aimed to be completed with all patients receiving hub care, with the experiences of care delivery and an organisational checklist (P3C-OCT) to monitor integrated activities completed by core staff. We were also intending to collect service use data tracing across health and social care by data linkage processes, contributing two levels of data for the entire cohort. This was intended to facilitate the long-term evaluation process with only resourcing for qualitative input and data synthesis required beyond one year. It was proposed that process data would be collected both qualitatively and quantitatively across all three levels providing a formative investigation of the core components of the intervention model, for example how and why it works (or is less effective than expected). The process evaluation also aimed to identify barriers and facilitators that influence the success of the intervention.

As mentioned above, level 3 data was not able to be collected, nor were 6 and 12 month follow ups.

The methods used are divided into qualitative and quantitative elements below. Ethical approval for the evaluation of hub model was obtained from Plymouth University Faculty of Health and Human Sciences and Schools of Medicine and Dentistry Research Ethics Committee.

5.1 Qualitative element:

Patients: Seven semi-structured qualitative interviews were conducted with patients who were discharged from the intervention between 1st July 2015 and the stepping down of the hub. Patients were first contacted by the hub co-ordinator by telephone to ask if they would be interested in talking with a member of the evaluation team about their experience, and verbal consent was sought. Twenty participants (1/4 of those treated by the hub) were potentially identified and thirteen of these agreed for their contact details to be forwarded to the evaluation team.

Of these, seven took part in an interview (two supported by carers). Of the remaining thirteen potential participants, reasons for non-participation were as follows: refused to take part on contact (n=2); relative refused over the telephone on their behalf (n=1); evaluation team unable to make contact on repeated attempts (n=1); hospital admission (n=1); interview was considered to put the participant at risk due to possible cognitive impairment (n=1); contact was not made due to the stepping down of service (n=2)

Interviews ranged between 25 and 60 minutes in duration. Participants were given an information sheet and consent form (see Appendix C). Interviews were audio recorded.

Topics covered included overall experiences of care, support for self-management, decision making and care planning, goals/ outcomes, and information & communication/ continuity of care.

Interviews followed a semi-structured schedule with questions developed to reflect the person centred nature of the intervention and model of care (see appendix G). Interviews were flexible to enable the flow of discussion of experiences to be guided by issues of importance to the participant.

Staff: Semi- structured qualitative interviews were conducted with two management level staff. Twenty-one information sheets and consent forms were sent out to key staff members (see Appendix B) and semi structured interviews were conducted with the four participants who consented (see appendix H). Of the six referral practices contacted, Practice managers and a team of GP's/ Nurses/ Community Matrons were interviewed (N=8) Interviews were audio recorded of 20-70 minutes' duration and followed a semi-structured interview schedule in order to ensure that data collected was both relevant to the needs of the evaluation and the experiences of the participant (see appendix I). Members of the research team also participated in direct observation of practice through attendance of Multi-disciplinary meetings (MDTs). Meetings also took place with two members of Care Direct Plus (described what this org does) in order to further understand locality teams and referral routes. Informal information gathering also occurred during the course of the data collection period and field notes were used in the evaluation.

5.2 Quantitative element:

Seven sets of questionnaires were completed by patients (see Appendix F). The questionnaires were: Short Warwick-Edinburgh Mental Well-Being Scale; Patient Activation Measure; De Jong Loneliness Scale; The Person Centred Coordinated Care Experiences Questionnaire. Two Carer Experience scales were completed by carers.

Twenty-one experience questionnaires were sent to key hub staff (see Appendix D). Of these, ten were returned.

The Person Centred Coordinated Care Organisational Change Tool (Horrell et al, 2016) was sent to the Hub plus the four of the six referral practices for completion. None were returned by the referral practices.

5.3 Analysis:

Qualitative: Interviews were audio recorded and transcribed verbatim. Framework Analysis was utilised to organise and analyse the qualitative data. The coding framework was developed within a wider framework of person centred coordinated care. It was formulated from the development of a modified patient experience measure for PCCC. Elements have been extracted from key policy and literature, mapped to the National Voices 'I' statements (2013) and have been initially validated through work with stakeholders. Mapping identified five domains central to patient experience of PCCC; (1) my goals/outcomes (2) care planning (3) transitions (4) decision making (5) information and communication. Twelve subcomponents supported these domains. Data was coded by a researcher with regular

double coding by a second researcher to ensure reliability and applicability of the coding framework. Any inconsistencies were discussed until agreement was reached.

Quantitative: Questionnaires were scored by a member of the evaluation team. Due to small numbers, no formal statistical analysis was conducted, but descriptive statistics have fed into the findings of the evaluation.

6. Findings

Findings are presented under the following categories: (6.1) quantitative and qualitative data/ observations with staff to identify core elements of the model including an assessment of the degree to which it was implemented, (6.2) process metrics, (6.3) qualitative and quantitative staff data, (6.4) qualitative and quantitative patient data, (6.5) summary /synthesis of findings.

6.1 Core elements of the model: Data from the P3C-OCT Tool, Observations and Discussions: Organisational systems and support

The following section details the core elements of the intended model from an organisational perspective. Data for this section has been gathered from observations, discussions with management concerning the key aims and components of the service, and the completion of the Person Centred Coordinated Care Organisational Change Tool (P3C-OCT). The P3C-OCT is a tool that has been designed to help organisations think about what they are currently doing to deliver Person Centred Coordinated Care (PCCC). Further sections will expand on specific areas in regard to patient and staff experience.

Key components of intended model:

Components that were implemented fully:

- GP Led Multidisciplinary (MDT) approach (across 6 practices based in Newton Abbot), with weekly meetings)
- Time patient allocated to hub care tailored to need
- Provision of crisis/ proactive care

Components that were identified for implementation but hampered by barriers:

- MDT input across key services
- Information and record sharing across GP surgeries (System1)
- Risk stratification to target patients most at need
- Urgent complex care team with single point of access.
- Care coordination (including admissions /discharge tracking).
- Intensive care planning.
- Proactive case management.

No evidence found for the implementation of:

- Mapping of local assets
- Development of new workforce roles
- Management support for staff to allocate time to hub work
- Support at home (7/52 service)
- Personalised care plans

6.2 Core components in operation as identified solely by the P3C-OCT

This section details the activities in operation within the hub and the specific enablers and barriers to the development and delivery of the new model.

Table 1 presents the activities in operation as identified from the completion of the P3C-OCT. A response count of 1 shows that an activity was part of hub practice, whilst the rating average is a subjective score rating how well the manager of the service considered that activity to be working (5= very well, 1= not working). The P3C-OCT was completed by the hub clinical lead in a telephone interview with a member of the evaluation team. Findings presented in the table are representative of those activities/ interactions that were identified as being present in the model. Questions/ response codes which were not being actioned in the hub are not reported.

Whilst it was intended to use findings from the P3C-OCT to facilitate and guide service development, for the purpose of this report the following key areas were identified. These were distinguished as relevant through comparison with the deductive and inductive themes resulting from qualitative analysis and are highlighted in the table in blue. A full copy of the (blank) P3C-OCT questionnaire can be found in Appendix 1.

Coordination and continuity of care

A single plan of care (an agreement within / across teams for an agreed approach to care) and the sharing of a care plan document (a formal written document that details the agreed approach) within the hub team supported the flow of information to avoid patients having to repeatedly tell their stories. However, patients did not have access to the care plan, so although it can be described as co-created in terms of multi-disciplinary staff input it is not co-created in the true sense of the term. Patients also lacked a named person responsible for coordinating their care

Patient Goals

The ability for the lead GP to provide longer appointment times enabled the setting of co-created goals, the discussion of treatment options and the discussion of support packages.

The eliciting of goals was achieved through conversations with service users, although the recording of these as an element of a written care plan was not felt to be working well.

Carers

The P3C-OCT identified that carers were offered support via respite care, and the provision of signposting to support services.

MDT working

Partnership agreements were in place between the Hub and Mental Health Services. However, they were not represented at MDT meetings.

Organisation of Care

The organisation of care was achieved through the lead practitioner taking the case management role. MDT meetings were central to achieving regular patient review and proactive assessment of case load.

The P3C-oct identified a number of interventions to reduce unplanned or inappropriate hospital admissions. These consisted of predictive modelling, case management (collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy) self-management strategies and advanced care planning.

The inclusion of a pharmacist in the MDT enabled procedures to be put into place to address polypharmacy and review medicines.

The above findings support the aim to provide an overall plan of care. **However, the lack of a single care plan which the patient took ownership of and a named person to contact may have hampered coordination and patient understanding.** The eliciting of patient goals was facilitated by the GP being able to provide longer appointment times when initially assessing patients. It is unclear if other staff were able to do this when responsible for assessments.

The offering of support to carers was a strength of the model, and this may have had a positive effect on keeping patients at home when safe to do so. The P3C-OCT also identified a number of other interventions to reduce unplanned hospital admissions including predictive modelling and increasing self-management skills. MDT working was also successfully implemented, although the lack of representation of adult mental health had a negative impact. However, the inclusion of a Pharmacist was felt to be a very successful component of the team.

Table 1: P3C-OCT

Individual/ practitioner interaction

What processes are in place to ensure that a person only has to tell their story once? (please indicate which processes you have in place)		
Answer Options	Response Count	Rating Average
A care coordinator	1	2
Sharing a plan of care/ appropriate information within your team	1	4
Sharing a plan of care/ appropriate information across teams	1	3
A shared care plan document within your team	1	4
A shared care plan document across teams	1	3
What type of additional activities do you provide that support PCCC?		
Answer Options	Response Count	Rating Average
Signposting to the 3rd sector	1	4
Referrals to other services	1	3
Pharmaceutical support	1	4
Do all people suitable for PCCC have a co-created personalised care plan?		
Answer Options	Response Count	
No	1	
Which of the following elements are included in the co-created plan of care? This can either be in the form of a written document or a plan of working).		
Answer Options	Response Count	
A contingency plan for crisis episodes or exacerbations of their condition	1	
An action plan to attain their health goals	1	
An action plan to attain their social goals	1	
Treatment planning (e.g. Physiotherapy)	1	
A medication plan	1	
A plan of support services, what they will do and when they will do it	1	
A date for review	1	
Treatment escalation plan	1	
How well are your care plans working?		Rating Average
Answer Options		3
Who takes the lead for care planning/ care coordination?		
Answer Options	Response Count	
GP	1	
Community Matron	1	

Other (please specify)	1	
How well is this working?	Rating Average	
Answer Options	3	
How is shared decision making with individuals supported? Individual and practitioner working together on:		
Answer Options		
Goal setting	1	
Treatment options	1	
Management and support packages	1	
Using:		
Longer appointment times	1	
How well is shared decision making working in general in your organisation?	Rating Average	
Answer Options	3	
How do practitioners specifically elicit goals related to people's health and social aims?		
Answer Options	Response Count	Rating Average
Personalised care plans structured around the identification of goals	1	3
Goals included as an element of a written personalised care plan	1	2
Longer appointment times	1	3
Using best interest (e.g. PoA/ advocacy)	1	4
How do practitioners ensure people are supported to achieve their goals?		
Answer Options	Response Count	Rating Average
Conversations with the service user	1	4
In what ways is consideration routinely given to understand how mental wellbeing affects peoples physical conditions, and of the role of physical wellbeing on mental health?		
Answer Options	Response Count	Rating Average
Personalised care plans structured to address this	1	3
Referral to other services	1	3
How are informal carers assessed and offered support?		
Answer Options	Response Count	Rating Average
Providing advice and signposting to support services	1	4
Provision of respite if required	1	4
How do you provide proactive case management?		
Answer Options	Response Count	Rating Average
Use of predictive models to identify who will benefit from PCCC	1	0
Where possible, appointments/ reviews are anticipatory rather than reactive	1	3
MDT working	1	3

P3C-OCT Practitioner/ practitioner interaction

What other teams do you have agreements in place with to enable partnership working and provide joined up care?		
Answer Options	Response Count	Rating Average
CCG	1	4
Primary Care	1	4
Mental health services	1	2
Voluntary sector (e.g. Age UK)	1	5
Social workers	1	3
Allied health professionals	1	4
Do multi-disciplinary team meetings take place to identify the most appropriate services and interventions for people suitable for PCCC?		
Answer Options	Response Count	
Yes	1	
Who attends these meetings?		
Answer Options	Response Count	
Primary Care	1	
Nursing specialists	1	
Voluntary sector (e.g. Age UK)	1	
Social workers	1	
Allied health professionals	1	
Pharmacist	1	
How often do these meetings happen?		
Answer Options	Response Count	
Weekly	1	
How well are your multi-disciplinary team meetings working?		
Are processes in place to allocate roles and responsibilities across and within teams?		
Answer Options	Response Count	
Yes	1	
Please identify from below:		
Answer Options	Response Count	Rating Average
Across team agreements to work together on a single care plan	1	3
Processes in place to ensure continuity of care/ care transitions (please specify in the comments box below)	1	3
Which practitioners act according to the personalised care plan?		
Answer Options	Response Count	
GP	1	
Community Matron	1	
Social Workers	1	

Nominated 3rd sector Providers	1
Allied Health Professionals	1

P3C-OCT Organisational systems and support

Are mechanisms used to measure and implement the experience of care of:		
Answer Options	Response Count	Rating Average
People receiving PCCC	1	4
Carers	1	4
What systems are in place to identify people suitable for PCCC allocation?		
Answer Options	Response Count	Rating Average
Case management allocation	1	2
Which approaches are used to organise the care of those identified for PCCC?		
Answer Options	Response Count	Rating Average
Lead practitioner takes case management role	1	3
People's treatment is reviewed regularly	1	4
People's needs are reviewed regularly	1	3
MDT meetings	1	4
Case load reviewed proactively	1	4
Are people who require PCCC offered longer appointment times, or a special appointment to review overall care?		
Answer Options	Response Count	Rating Average
Offered as part of routine contact	1	3
Crisis care	1	4
How is a person's ability and motivation to manage their own care embedded into routine practice?		
Answer Options	Response Count	Rating Average
Included in the assessment section of the care planning process	1	3
What systems are in place to support and confirm that shared decision making has been implemented?		
Answer Options	Response Count	Rating Average
Using a questionnaire/ tool to elicit people's experiences (please specify which measure)	1	3
To what degree is this information fed back into practice?		Rating Average
Using a questionnaire/ tool to elicit people's experiences		3
Which of the following activities/ resources are supporting culture change?		
Answer Options	Response Count	Rating Average
Change Champions	1	2
Informal bench marking	1	3
Auditing	1	4
What interventions are in place to reduce unplanned or inappropriate emergency admissions?		
Answer Options	Response Count	Rating Average
Predictive modelling to identify people most at risk	1	4
Increasing self-management skills	1	4

Regular case management reviews	1	3
Use of a virtual ward	1	2
Coordinated working between health and social care	1	2
Advanced planning (e.g. TEP, LPA)	1	4
What procedures are in place to address polypharmacy/ review medicine management?		
Answer Options	Response Count	Rating Average
MDT meeting (with Pharmacist)	1	4
Pharmacist review	1	4
Medicine reviews	1	4
Which of the following are in place?		
Answer Options	Response Count	Rating Average
A template/ record keeping system to bring together a single care plan within your organisation	1	3
A template/ record keeping system to bring together a single care plan across organisations	1	3
Across team agreements to access people's records	1	3
Across team agreements to amend people's records	1	3
Measurement of staff experience of care delivery	1	4
What are you going to change as a result of reading and completing this tool? It is clear that there are some structural changes that need to be put in place and we need to discuss how best to achieve this		

6.3 Process Metrics

The number of people being referred to the hub and the route by which this took place and the amount of people being treated by the hub were recorded during the period of operation.

6.3.1 Hub referrals and journeys

- 62 individuals were referred into the Hub from January 2015-September 2015.
- 23 of these referrals were in January and February 2015 with monthly referrals ranging between 3 & 7 in the months March-September.
- 21 referrals were emergency referrals and 41 referred proactively.

6.3.2 Referral routes

The following section presents the conceptualisation of the referral routes for the Older Persons Hub based on the qualitative interview and observational data collected. Graphical representations show the two identified referral routes (crisis/ proactive). Each referral route is presented with a narrative describing the core components and processes of each model.

Crisis Care (see Figure 2):

Referral

Emergency referral routes were established for those patients who were judged to require an immediate MDT intervention to avoid emergency hospital/care home admission. To a large extent, these followed previous protocol and were envisaged to come through Care Direct Plus:

The GP, at the same time, can contact the Service directly, and provide extra information on the patient's clinic system, to help with management.

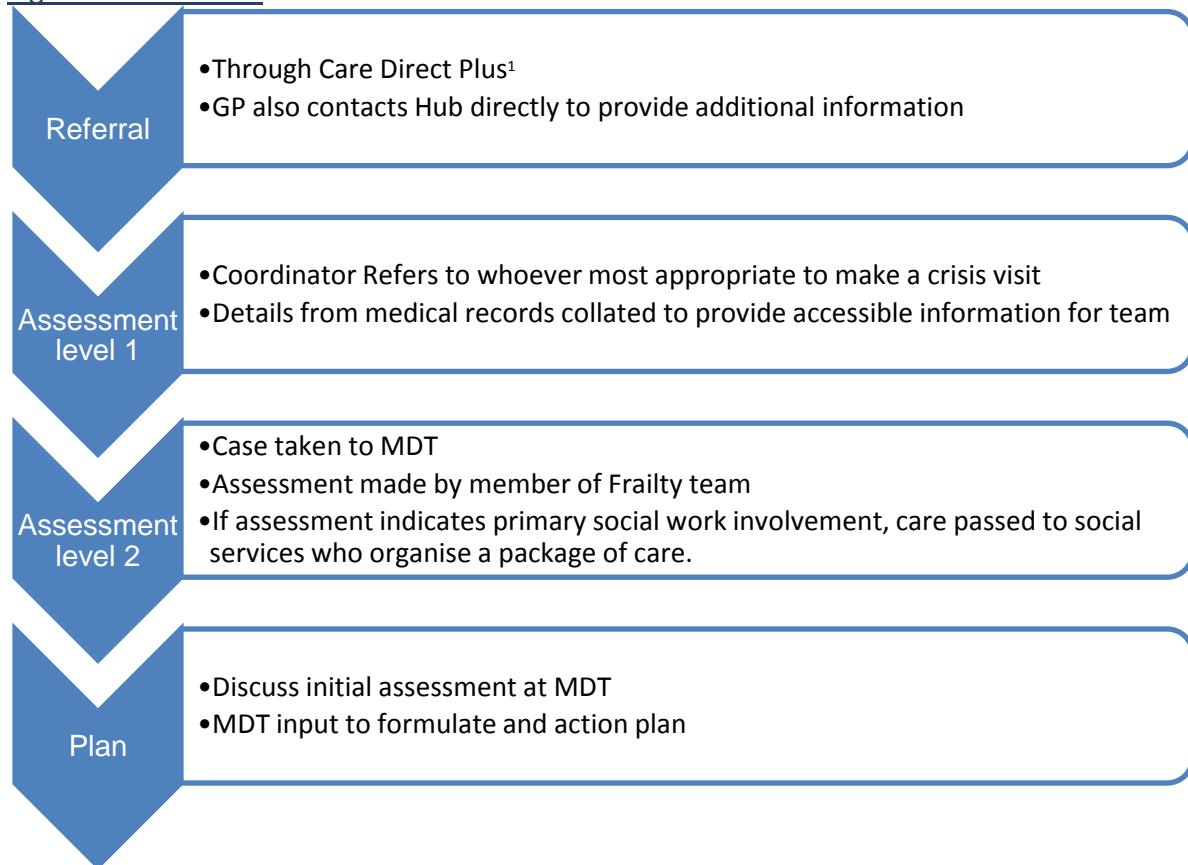
Assessment levels 1 & 2

Once the referral has been received, an assessment is made to decide who is the most appropriate person from the team to evaluate the situation and make contact. That Member of staff would then visit the patient on the same day of referral to make an initial intervention, with the aim to keep the patient at home if possible. Medical records are updated and collated, and the patient is discussed at the following MDT spell out first use in section meeting to agree next steps to continue the patient's stabilisation and to work with them on the goals that have been agreed.

Plan

These goals and interventions are then updated at the weekly MDT until it is felt that the patient is stable enough to be discharged from the hub and care passed back to their GP.

Figure 2: Crisis Care



¹. Care Direct Plus (CDP) is part of Devon County council service centre and uses telephone assessment. Most people will then have their needs identified and resolved through the provision of disability equipment, domiciliary care, arranging respite care, and so on. Referrals to CDP occur through three pathways: (1) via Care Direct (the ‘customer facing’ service for Adult Social Care that members of the public use) (2) via professionals on a separate contact number/email known by all professional teams (often used by occupational therapy services and hospital discharge teams but available to practices and pharmacy staff) (3) through the dedicated Social Services on line system

Proactive Care (see figure 3):

Referral

GP's refer in through email or via the clinical system.

Recruitment

Information is collated by the hub coordinator and added to the IT Spell out system. Patients then sit in the system ready to be reviewed at the next MDT meeting.

Assessment

Referrals are then discussed at the next MDT meeting, and the most appropriate practitioner/s are identified to conduct the initial assessment visit; this may be a joint visit between two disciplines if deemed appropriate.

Ongoing review

Subsequent to this initial assessment, information collected is then taken forward for discussion at the next MDT meeting. During subsequent meetings, patients receive ongoing review.

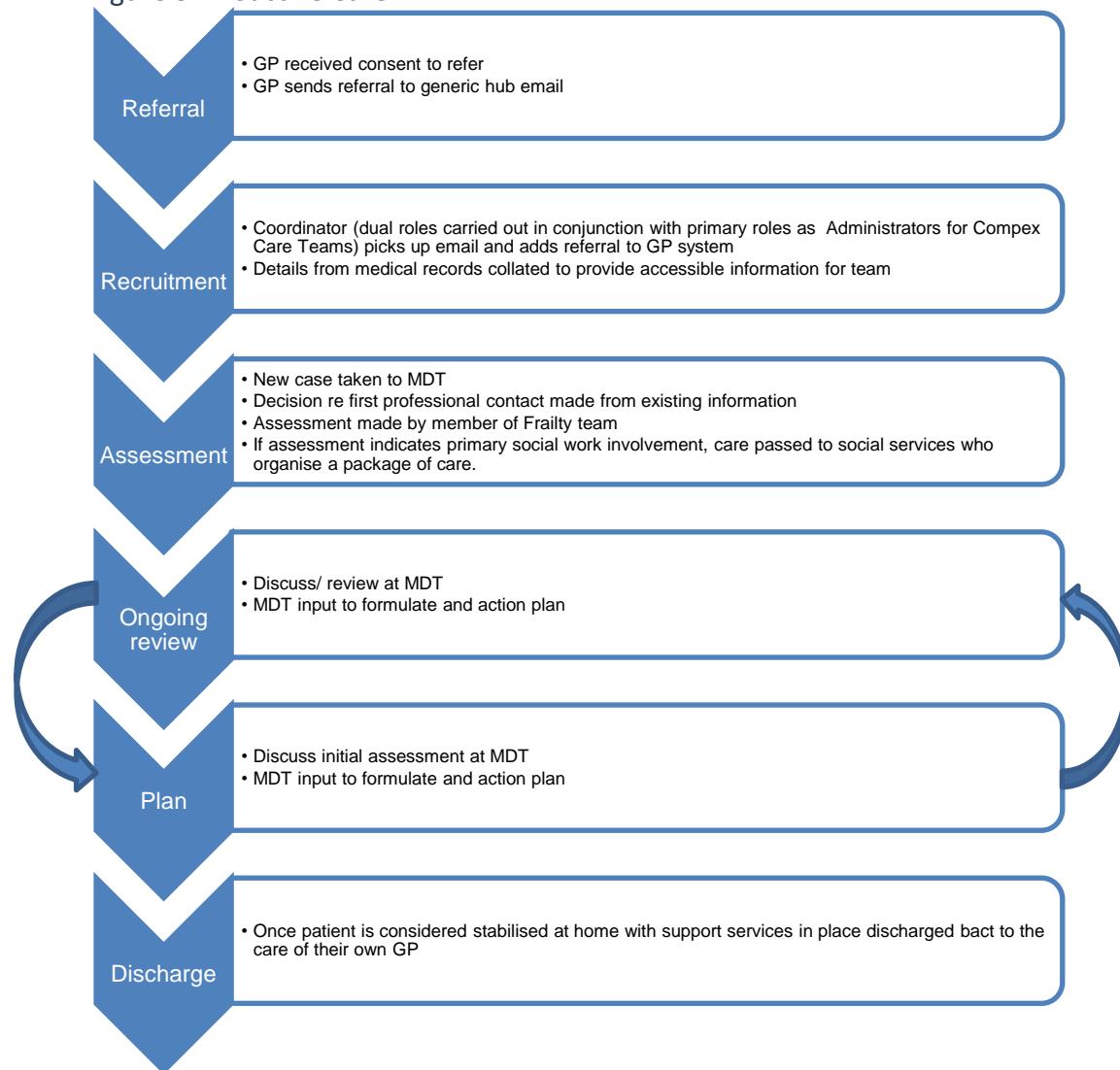
Plan

Assessment and ongoing reviews allow MDT input to formulate health and social care plans in agreement with the patient's goals.

Discharge

Once the patient is considered stabilised at home with support services in place, they are discharged back to the care of their own GP.

Figure 3: Proactive Care



6.4 Management experiences of the organisation of the Hub

The section below represents the findings from qualitative interviews with Practice Managers, GPs and nurses from surgeries referring into the Hub.

Lack of coordination between different services failed to create continuum of care

Management showed a clear understanding of how the Hub had been envisaged to fit in with existing services, but were also aware that the failure of this had resulted in a lack of communication and coordination between teams:

R: You'd try and bring them together so you'd actually have MDTs which would have the GP clinical lead, have the Complex Care Team and have the voluntary sector and have access to the GP notes to make those meetings more effective.

I: But we understand that that didn't happen...

R1: It didn't happen.

I:...so the Complex Care, Intermediate Care and Frailty seemed to be not working in a coordinated way.

R1: No (M2)

Resourcing and Leadership

Issues around leadership were also a concern for the two participants involved with the Hub at managerial levels. One spoke of how a lack of resourcing was impacting on the running of the service:

I'm kind of managing it as well as leading it, as being a clinical lead, so that it's more than just the clinical input that I'm providing at the moment, which is one of the limitations of where we've got to, I think, because I'm not a manager (M1).

Additionally, pressures on staffing levels, undertaking new service design within established ways of working and a lack of funding were also creating barriers:

In terms of taking over clinical responsibility and actually managing those patients on a day to day basis you need a greater level of GP/clinician input than we were able to fund (M2)

Uncertainty around the roles of the different teams meant that staff across interventions were potentially competing for patients rather than targeting clearly defined populations. Additionally, it appears that some staff were working across teams; adding to confusion:

...the complex care team and community nurse team were already hard pressed and despite the fact that this is the same patient group that they are looking after it was deemed at management locality level not to release those staff and embed them within that MDT. So they started coming and meeting collectively and then that option was withdrawn by the zone manager of the locality team (M2).

So no one else in on any extra resource. And the argument being that actually the proactive work is all new work. And therefore, it has to be prioritised in the same way as the other work that they've got to do. So often if we meet as a group, and we agree that someone needs a

therapist to go and see them, it will then get triaged in the same way as everything else, so these proactive patients, well we then have to put things on hold for several weeks, until the therapist then goes in and sees them(M1)

Participants suggested that better management buy-in was required to allow innovative interventions to develop and embed:

you need better buy-in, the more that are sort of involved, so if you've got people who are doing similar work it's not enough just to say, come on let's all work together, you have to have senior management buy-in and immediate line manager buy-in. I think we had strategic buy-in and I think we had some buy-in from the staff delivery, bearing in mind also that they have pressures on their own. What we didn't have buy-in was from the line managers. (M2)

However, a positive view of the Hub was that the staff delivering the care were adaptable and had a sense of what patients needed despite organisational constraints:

So those patients have had, I think, a really good service where it worked and I think that was mostly by clinicians, support staff and professionals behaving in an incredibly professional manner regardless of who manages them. They just saw a patient in need and delivered, which is exactly what you want – so it's about those permissions sometimes, I think, which I think we struggle with in the NHS to just give those permissions to do the right thing regardless of whether you're the OT or the physio or whoever it is that's going in (M2)

Referral practice view of the Hub

There was wide held support for the purpose of the Hub, and in particular the idea of supplying additional services for the targeted population:

'With the fact that it crosses over onto not just people who are frail but also other people who might well need to go to hospital, it does give you the scope of being able to bring mental health issues into it as much as you bring in simply frailty. So yes, it's focusing the resources in a good place'.

Understanding of Person Centred Coordinated Care

We found that some general practitioners held a view of a person centred care as a wraparound of timely provision, with continued communication between services. However, they did not mention the person having input into that care. As one GP put it:

Person centred care is 'I think ... it is about joined up communication, it is about having continuity of care, and it's about having timely response. So if somebody is poorly, you don't want to have a continuous chain of different people coming in'.

Although the process of supporting people within the home or community environment through a multi-disciplinary team was seen as a benefit to both the patient and the health service, there was concern about whether the Older Persons Hub really did provide evidence that this was effective:

'I'm completely on board with the idea of multi-disciplinary supporting people at home, not going into hospital, there's nothing wrong with that in principle, there's a lot right with it. It's just something about it didn't quite hit the spot in some respects' (FHF PM 001).

IT Systems

Several GP's within the practices felt that the ability to share information through a clinical IT system which is accessible to the GP practices and the local hospital was a good idea. It was felt that this system would enable patient notes to be kept more easily up to date and the sharing of information would be more rounded.

The Hub and all six referral practices used System One as their record keeping system. This ability for information sharing through IT was felt to reflect the way the hub was working across practices. This also gave them an overview of how the hub was supporting their patients.

'We're all on the same clinical system, system one. And that has brought us together as a locality, for one. And it's also allowed us to review the way which we work across the practices, and thereby allowing us to be able to decide locally whether or not we think it's a good thing to be able to share information across the frailty hub. Which we have agreed to do'. 'All the patients are on the system and we allow (the hub) Doctor to access notes, he's able to put the information on there. So basically, we don't do anything and the patients' records get updated as they go along. So it's a sort of real live time updating of the patients' notes' (FMF PM 001).

However, some practice staff stated that the patient information was not always placed on the system in a timely manner, and that some notes appeared confusing to some GP's. Although the intention was the hub would continue to update information and thus keep the practice informed, some GP's found that the system was not being updated in real time or that the information was confusing. An example of this confusion was highlighted when one GP was unaware of what the notes were asking of the GP in supporting the patient's needs. The GP's felt that this was a big flaw in the process which needed to be addressed to enhance seamless care for their patients.

There also there seemed to be a lack of continuity and coordination from one service to another.

'You might know about there being ambiguity about whose doing these jobs that are listed, because one of the patients definitely there was a list of changes to his medication. I wasn't sure if I was meant to do that or whether because I referred him that was going to get done miraculously, but it didn't get done, so we ended up doing...you sort of think, well it's this lack of clarity really about whether we've handed that patient over (FMF PM 002).

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Referrals

Issues were also present around the response times between referral and response. Of particular concern was the rate at which problems can escalate within the frail population,

leading to emergency admission. Although this may have been due to a number of issues outlined below, one GP suggested that he might not have referred patient soon enough for the hub to respond.

'Maybe that's as much my fault as who I referred in possibly was too late, you know, I was too late referring them in'.

The timescale of the Older Persons Hub to support the patient was seen as very problematic, and whilst this was not the only reason that some GP's mentioned, it did play a part in the decrease of referrals.

'Whether you're not [inaudible 12:01] sense, it's about the speed. So, it's almost sort of our total workload as it were, it's about the speed in which that could be coordinated and delivered. Where do things start to advance, they advance quite quickly'.

Another reason for problems around coordination and delivery was related to the working hours of the hub staff. It was suggested that due to the lack of continuous support from the Older Persons Hub the patient might go into crisis because no one who could give the right support was available at that time.

'I found that when you've reached that crisis point the meeting was the day after tomorrow that they were going to be seen, you know, that they were going to talk about it and then no one was going to see them until after that, and then by the time they had been seen the crisis had sort of escalated and they ended up going in'.

This outcome would suggest that the GP would consider putting in the support needed and not refer to the Older Persons Hub.

'If you find that actually it's going to be 48 hours before some of these things are actioned, you think, well it's quicker for me to just do it myself now and you never make the referral, you just sort the patients out with the things that they would have done on your behalf, but in 48 hours' time' (FHF PM 002).

Furthermore, there was an overarching feeling from some of the GP's that they had similar support services from other teams which added to the confusion around the appropriateness of referring a patient into the Older Persons Hub.

'it might be because they've got all these other schemes that are going alongside it, that going into the frailty service may not be identified as the main pathway in, because there's these other ways which all overlap. And the person ends up getting the same care, they may not be being referred in through the latest pathway... so the word frailty is being multi-used, if you like' (FHF PM 001).

I 'wasn't quite sure what the window was the frailty service gets involved in between what we are already do with rapid access services' (FMF PM 002).

Communication between teams

GP's within the feeder practices suggested that communication (or lack of) between services led to confusion. They felt they would get more immediate benefit if they were to have more verbal communication with the hub. Some feeder practice staff felt that a quick phone

call between services would improve both the rapid response of support and give the GP's an idea of what the Hub could do for their patient. This would provide a much more inclusive approach to support and prevent confusion around which service could provide the best support. One GP felt that this may have an impact on whether he sent his patients to hospital or not.

'think what would change our lives would be one phone call, you know just to make one phone call and, all right, I appreciate you need a proper referral with a list of things. Then somebody...it would be seamless, but there's rapid responses, public health, there's the frailty health, and in the end you just think, do you know what, it's easier just to send them in sometimes...' (FHF PM 002)

There were also concerns about the patients and family member's inclusion in decision making within the Older Persons Hub service; particularly in regard to patients and/or families not knowing who to speak to regarding on-going care.

'I think slightly the patients were a little bit confused as well that they didn't really know who to ring, so they rang who they always ring, which is us'.

Discharging from the Older Persons Hub should have been straight forward and follow guidelines and processes already in place:

'When discharging a patient from hospital or care service there should be a discharge form sent to the GP for that patient. Stating all the information of care given' (FHF PM 001).

'Where the patient's had continuity of care, there has to be a handing over, from a legal point of view, okay, we've done what we can now, this is where we are. It's over to you now and here's the information about how the patient has progressed, and this is the medication that they're currently on' (FHFP PM 001).

However, discharge information was not always clear on patient's notes and some families had told them that when they had tried to get more support from the hub they had been told that the patient had been discharged. Not only was the family unaware of this fact, but so was the GP

'The chap I referred for or was referred in, also they took on his care for a period of time, I presumed that then that was going to be ongoing, but when the family then rang them for some follow up, they didn't know he had been discharged. I wasn't aware that he had been discharged by them and nor at that point also was I aware as to what they had done for him either in the intervening period of time. So, that struck me as not being quite as joined up as it could have been'.

The GP's in one practice talked about a difficulty in finding the right person within the Older Persons hub, to talk about his patient's needs.

'I think it's just finding that right person, because I'm not quite sure who that right person is really anymore. You know, you sort of, I tried it with a few different ones and it hasn't really worked for any of them really, so I'm not, I'm not sure' FHF PM 002)

Coordination/ continuity of care

Some GP's found a lack in the information between services could be confusing; leaving the GP unaware of what patient had received within the hub and questioning areas of responsibility:

'The frailty service has been involved with him and they have written a number of recommendations down on that. They haven't actually recommended everything, and again where's the responsibility? Are these things that I'm supposed to do? Are these notes they're making for themselves in order for them to follow out these action points as we would do normally? No clarity, nothing's done. Well, I checked the notes, but at the moment nothing is being done, so who is responsible?'

Some GP's felt that a single point of access for support of the patient would be a good idea. Not only to highlight a patient in need but to identify sources for rapid support in order to hopefully prevent the reaching crisis point.

'The single point of access seemed to be a brilliant idea. You know, you tell us what the problem is and we'll decide who is best placed and who has got the time today to sort that out or tomorrow or whenever it is. But, I think the 24-hour response would be, you know, within 24 hours would be ideal really. Something happening rather than just somebody has a look at the notes and, you know, nothing else happens really'.

6.5 Hub staff experience of working within the Hub

The following section presents the experience of representatives of the key MDT members of the hub.

The concept behind the Hub

It was felt by some staff that the concept of a hub with specific responsibility for the frail population was a valid aim, with some mentioning how beneficial this model should be in facilitating the move from primary to secondary care:

I completely support the idea of Frailty, I think the multidisciplinary assessment, the, kind of, proactive case management is absolutely the right thing that we should be doing. I haven't got any doubt about it at all. (FHS03)

I think as a concept and as an idea it's very sensible and trying to improve and integrate primary and secondary care to get the smoothest journey for the patient makes a lot of sense. (FHS10)

However, the process of translating the concept into a working model was perceived to be more of a challenge with a lack of clarity on the effectiveness of this process in reality. As one staff member put it:

I'm not quite convinced that how it's working at the moment in Newton is as effective as it could be. (FHS03)

Understanding of Person Centred Coordinated Care:

We define PCCC as:

'Care that is guided by and organised effectively around the needs and preferences of individuals with complex needs'

Some staff interpreted person centred care as a holistic approach encompassing both social and medical needs, involving patients having informed choice, equal partnerships and staff attending to the whole person not just isolated working according to specialism.

I suppose, you know, in my mind we are all working for Person Centred Care, we all want informed care, we want the person understanding, you know, what's being suggested, why it's being suggested so that they can make an informed choice as whether that's what they want from their care. Yes, so it's an equal partnership. (FHS03)

However other staff spoke about a more ad hoc approach to person centred coordinated care which did not involve the patient thoughts and did not discuss the process within an equal partnership.

Actually dealing with the whole thing at once, because one tends to have a knock on impact on the other...That to me seems the definition there. (FHS14)

I think I would sum it up by ensuring that there is one question that you ask the patient, that actually shapes everything you try and do, which is, what do you want? (FHS15)

Identifying patients

In addition to the formally agreed referral routes of GP feeder practices, the hub adapted its referral routes to include other healthcare professionals. The benefit of this was that they could identify individuals who may not have accessed services otherwise.

...and they may find patients who would benefit, that may not come up on the GP's radar, and so, yeah, as I say, so any health professional, and the community matrons seem to be the ones who are picking quite a few up.(FHS15)

Identifying and supporting carers

When asked about the involvement of carers in assessments and health/ care packages, staff were keen to highlight the importance of this for two reasons.

Firstly, it supports patients who are also carers:

It is, and that's in either two, I suppose, different scenarios. One is when the carer is part of that, so the carer has been referred in as well, because we would look at their goals, as well, because they would be a patient in their own right. (FHS15)

And secondly, talking to carers may sometimes be the best way to understand what the patient themselves might want:

Often we've been in situations where the patient themselves can't express their wishes, and then that very much is discussing with the carers about what the goals might be. (FHS15)

At a service level, expanding the referral processes as detailed above meant that the partner of a patient could be considered in the care package even if their medical needs were less. In particular, carer's needs were being identified even though they might not approach either health or social care directly. As a result of this carers have been supported and arguably prevented from declining into a crisis situation themselves:

And in working with the patients, often you become aware of looking after the carers and how important that is. If you want to make a frail person's environment robust enough to be able to continue looking after them, then the carer is an element of that that needs to be addressed, looked after and supported as well. (FHS15)

Obviously the carers and their stresses and strains are a really important part of our assessment to make sure that, you know, whatever plan that is being, sort of, mooted actually is achievable. (FHS03)

Involving patients in decision making and goal setting

As part of delivering person centred coordinated care staff identified involving patients in decisions about their care as a core component: It was felt that the majority of patients were able to make their own decisions if given the right information, even if that sometimes contradicted with professional priorities:

We're not just there to say well actually our medical or social priority is this, therefore we do at all costs, and why doesn't the patient want the package of care? And it allows us to then have the discussion with the patient about okay what is, what do you want to be doing? Are you happy with your level of function at the moment? The way you exist at the moment, is that what you want? (FHS15)

Furthermore, this adherence to patient identified outcomes leads to better self-management and increases the likelihood of them following the co-created plan:

It's, kind of, a, it's the person involved having some responsibility but also a good understanding of what's going on and why it's being set up, so they, kind of, understand the goals and what's trying to be achieved. (FHS03)

But having those, having those conversations and developing some patient centred goals um, means that um, that they're appropriate for that individual and that individual is much more likely to comply because we're doing what they want us to do (FHS15)

Referral processes and communication between teams

Multiple teams

Staff were clear in that they felt that multiple teams were in operation within the locality with little guidance as to how they differed. This led to confusion as to the remit of the older

person's hub in conjunction with existing services, with some feeling that a virtual Older Persons service was already in place within the Intermediate Care team.

I think it's a bit muddled...Then Frailty, kind of, came in as a sort of, as an extra funded service but without the ties into really to what was already happening. (FHS03)

Additionally, familiar ways of working were sometimes preferred:

I suppose from a therapist's point of view we find it a little bit difficult in that we are used to working with the GPs with their own patients, so if we've got a complex patient we liaise with the GP attached to that person (FHS03)

Communication between teams

A further issue was communications between the Hub and outside/ referral agencies. Post-referral response times were expressed as one area of concern:

I think there was a delay in, there was a date, there was a delay in them getting medical response because there seemed to be that confusion as to who should be involved. (FHS03)

Concerns were also raised in regards to who held patient responsibility, as well as the effectiveness of communications between the hub and referring GP practices:

Yes, we've had circumstances where the patient has been confused and actually the patient's GP seems to have been confused as to who was taking medical responsibility, so that's a bit of a concern from a therapy point of view as to what the actual process is. (FHS03)

Furthermore, communication about who was under the care of the hub also posed problems:

Interestingly enough actually at my last virtual ward, the one person I had on Frailty the GP practice didn't know they had been admitted, so I don't know that it is completely linked up as well as it should be. (FHS03)

As conceptualised in the planned model, Hub staff talked of the discharge process without concerns:

Then, because we record it all on the patient's clinic system, that the GP uses, we send an internal task to the GP, to let them know they've been discharged, so that's effectively an internal message, but also everything, all the intervention that we've done, all the discussions that we've had are recorded on the system, so the GP can see what's actually happened in that process. (FHS15)

Referral processes and guidance of who should be referred to which service was problematic for staff:

...but it's not really clear from the therapy point of view as to when say (name) would go out and get involved and when the patient's own GP would get involved. (FHS03)

MDT working

MDT working was perceived as a positive aspect of the new model. Whilst accepting that this practice is common within other teams, a particular strength was perceived in that GP input was embedded and silo working reduced. In general, it allowed for an ease of communication amongst professionals outside of more formal referral routes and was perceived by staff to lead to a reduction in the need for patients to repeatedly tell their story. A key element was the involvement of the voluntary sector, particularly in regard to their focus on patient goals.

Benefits

Staff felt that MDT working enhanced patient care, particularly in regard to complex patients with multiple needs. Input was encouraged from a range of professionals and care was not necessarily medical led but embedded within the team:

Actually getting them together in one room can be very beneficial, um, and particularly these sorts of patients like I say that perhaps are the more complex um perhaps, um, a multidisciplinary approach would be the best way to treat them (FHS14)

Additionally, joint assessment visits were also seen as enhancing patient care:

...and we had some really good joint visits, and input with patients that I think worked very well (FHS15)

Patients were also able to receive input from specialist input from a pharmacist or geriatrician that may not have been easily accessible if care was organised externally to the Hub.

Maybe would benefit from um, but a lot of these patients perhaps could get multiple medicines, so it's very much looking at that and seeing if um there are any side-effects or adverse events (FHS10)

MDT working also enhanced staff experience, with staff feeling that opportunities for more informal communications benefited their working environment:

But, um, just looking at the relationship between the different professions that seem to be involved, seems to be going very well in terms that you've got these individuals that can just chat and access each other (FHS14)

However, a question was raised as to whether MDT meetings in their current format were the most effective use of time/ resources:

I guess...some of it, from my point of view, our availability and our time, what we could offer for that, whether our time was useful or whether that could be better done virtually through phone or videoconference or less frequent meeting. (FHS10)

A key contributor to successful intervention was the involvement of the 3rd sector, whose assistance was often more acceptable to the frail population than a formal package of care:

Are there any other things that you can't do at the moment that you'd like to do? And if there are, how do we help you to achieve that? and then we say well isn't one of the ways we could help you achieve that by getting some help in, or by getting the voluntary sector involved. Often people will say no to packages of care, but yes to the voluntary sector (FHS15)

In particular, acknowledgement was given to the role the 3rd sector can play in reducing older people's sense of social isolation:

I think there are a lot of aspects of patients' limitations and patients' sense of wellbeing that are linked with social isolation particularly. I don't think we, as clinicians, whatever our specialty, are very good at helping people with social isolation. I think the voluntary sector are excellent at it. (FHS15)

he's got like an eighty nine year old canoeing and two people linked up playing chess, so he's kind of their... because people don't want to go to day centres

Barriers

The most cited gap within the MDT was a lack of representation from the Mental Health Team:

Certainly better links to the Mental Health Service would be fantastic because I have to say that is an area we do struggle with locally, on top of obviously Social Care, Nursing, Matrons, or the Health Team. (FHS03)

Ah Mental Health teams are a huge barrier, we tried very hard to get them on board and uh, I think, I've not be successful um, and it's difficult because they're a separate Trust (FHS15)

Concerns were also raised about the lack of continuity around the staff members that attended the MDTs:

... because often, if we've got a therapist, it may not be the therapist who's seen the patient, or if we've got a community matron, it may not be the one who's been involved in the patient. So we sometimes get third hand knowledge, whereas it's much better to get that first...but to get that first-hand knowledge and that first hand sharing, of information, I think is the most useful thing, and to gain from each other's expertise (FHS15)

Embedding medical care into MDTs

Staff also talked about the value of embedding medical care through the addition of GP into MDTs which appears not to have been present in coexisting models.

I think maybe the links into the secondary care consultancies is better, so it's a good, the Frailty Hub is a good way of getting somebody at a, sort of, more thorough medical workup than perhaps the GPs can do, so I think that's been positive. (FHS03)

I think communication would be the key component, and inherent is that is the breakdown of silo working, and particularly, embedding medical care within the multi-disciplinary team. (FHS15)

IT systems

Staff identified shared IT systems as a fundamental enabler of coordinating care. These shared systems allowed communication between members of the MDT, and permitted team members to read and modify shared patient records:

there would be a summary that would go out from my clinic to their GP, and obviously I'd bring that back to the meeting, say I saw them in clinic, so that would then get put onto their electronic systems and be recorded. (FHS10)

Coordination/ continuity of care

Staff felt that a key positive aspect of MDT working was the influence it had on the patient's experience of joined up care:

But, the other thing is, and I think what the patients will benefit from, is that if they've told their situation to a member of our team, then if another one of us has to go and see them, we don't have to go through it all again, because we've heard it all, so there is that benefit from information sharing. (FHS15)

The service was also perceived as fulfilling a coordinating role toward keeping frail patients out of hospital:

They refer their patients from GPs from the surgeries around Newton Abbott, so then either the therapists or the nursing staff will go out, or the voluntary sector. So it's not people that have been discharged necessarily, its more people they're trying to keep at home and if there's any particular medical questions around that. (FHS10)

However, continuity of care was seen as being negatively impacted by problems within the referral processes/ multiple team issues as outlined above.

Lack of Leadership results in resource issues

Resourcing was named as a particular issue, with multiple roles and management layers identified as problematic. Agreements were in place, but these appeared to be informal rather than contractual arrangements:

I think, because I'm not a manager. Also the people within the team are not managed by me, with regards to their line management, their contract, their employer, or anything like that. But actually I still feel that I'm needed to manage the process. (FHS15)

As a result of this, a perceived lack of managerial buy-in was also seen as a barrier to the services development:

And I think that's where it needed someone within the organisation to lead it, from a management point of view, and I think we've lacked that. Certain people...there will be people

who will argue otherwise, but my experience is that there hasn't been that internal leadership of the organisation, to make it a priority. (FHS15)

Job satisfaction

Job satisfaction was reported positively when referenced to in regard to team working/working relationships and respect between professions. However, frustrations were expressed in regard to a perceived lack of managerial/ system support. Resourcing meant that the majority of staff were working within the Hub in addition to their contracted roles, resulting in a lack of formal agreements for time allocation and prioritisation.

Specifically:

Staff expressed satisfaction with the new model of working allowed by the Hub. One aspect of this was the increased time available to spend with patients:

And, the frailty hub, certainly from a medical point of view, if you look at it from a GP point of view, I've got time to see and go and spend with that patient, I've got, you know, I can go and sit with them for an hour, whereas if I was doing a GP home visit I'd have maybe fifteen to twenty minutes' tops (FHS15)

MDT working was also cited as contributing to increased staff satisfaction when relevant members were part of the team:

I think if you speak to anybody who is part of the MDT, if they feel that the right people involved and the persons getting Person Centre Proactive Care, they feel that they are doing a good job (FHS03)

And I've seen developments in those relationships within the team that have worked really well. And a respect that's grown for each other's skills and professional abilities, which I think is very good. (FHS15)

However, Staff were also feeling challenged by their roles within the hub as they were still required to fulfil their responsibilities within their parent organisations:

but I think that has been a challenge in getting everyone to want to change and carry it through when everyone's stretched and being pulled in all directions and they've got different priorities (FHS10)

the initial enthusiasm isn't quite to its height, and I think there's lots of things that have played a part in that. Part of that will be that the external jobs...the other roles that everyone else has to fulfil, naturally provides pressure. (FHS15)

As a result of this, staff also felt they were 'battling' the system:

You know, we all feel we are doing a good job, you know, we all feel motivated if we are doing a good job, we feel frustrated if you, kind of, feel that you are doing your best despite the system. (FHS03)

I think sometimes the difficulty you have is you've got different social service teams, different funding streams, different ways of working that kind of...remember or know all that becomes a bit more challenging. (FHS10)

Particularly the likes of having the voluntary sector there and though perhaps a little more and they can liaise with the carers (FHS14)

Yes, I think I do. Working as part of a team, is, for me, much more satisfying, and having more time to assess these patients is a luxury that I'm enjoying. The National Guidelines say, if you want to make a decent assessment of an older, frail patient, as a GP, you need between 45 minutes and an hour, with that patient, to be able to do it. We so rarely have that opportunity in primary care. And I have that opportunity with every patient I see within the Frailty Service. And that's great. And then you combine that with working as a team, being able to discuss patients, bounce ideas of each other, all of those benefits of being part of a team, yeah, it's a much more satisfying way of working. (FHS15)

6.6 Quantitative (questionnaire) data

Staff completed the Person Centred Coordinated Care – Practitioner Survey (n=10) Questions covered the following areas: Involvement in care/support planning; finding out goals; working environment; co-ordinated contact; meeting practical needs; communication; attitudes towards person-centred practice and getting to know the individual (see appendix D). These were completed at baseline.

From a practitioner's point of view, most users have an equal say in the development of support plans. Over half said they asked service users what their goals and needs were for their wellbeing, and over half said they usually or always asked carers about their goals and needs. Most also felt support plans were structured around these goals and needs. Similarly, staff felt patients usually had a say in their discharge plan.

Staff usually or always said they felt recognised and valued. The majority felt that the emotional and physical demands of their work were sometimes acknowledged and recognised.

The majority of practitioners said that the service user or carer usually knew who their key worker was, and had ready access to this person. The majority said they usually like working with the service users they care for, and that they always give service users recognition and allow time to talk and find out what is important to their wellbeing. The majority felt that once a patient was discharged they rarely had a follow-up phone-call to check on their welfare.

The majority of staff said they welcomed it when service users or carers questioned or challenged their advice. The majority also said they always put the service users' needs and preferences central to services.

6.7 Patient experience

Accessing care

Some patients also felt they should not go to the doctors with their concerns as they might be considered a nuisance.

When was the last time I went in to see the doctor...? There was something I was worried about...I forget, but I stopped going down to the surgery, because I don't want to be considered as being an old trouble maker. (FHP05)

Another patient felt that although they could do with support to prevent them from ‘bothering the doctor’, this might lead to conversations around going into hospital or care homes.

By getting someone in at night and getting someone that could come if I didn't feel well without having to bother a doctor. I wouldn't want to go into the hospital. I wouldn't want to bother the doctor perhaps, and I wouldn't want to go into a care home. So you can feel quite rough and you might not be able to get up' (FHP07)

Continuity of care/ care coordination

Patients largely felt that professionals were communicating with each other and providing a joined-up service:

Well the chap who fixed the rails, he must have known I'd had a couple of falls, but that was a long time ago, he must have known because he came to fit the handrail, so he must have known what he come here for. (FHP05)

However, one patient had experienced a lack of communication when admitted to hospital:

It wasn't accurate at all...So they came out in the middle of the night you see and took me. Well, the whole room, ambulance men, moving things around, the commode was...I'd been for a wee and that hadn't been emptied that time. And it was the first time I'd been on my own, no carer. And it was a struggle. In the middle of the night things were a bit adrift until you've tidied up a bit...And he put down as a bad assessment, said I couldn't keep the place in order. And that wasn't true. Wasn't strictly correct. They even put my age as ten years older than I was. And it was done by a trainee. (FHP07)

Another person encountered problems when one member of staff was absent due to illness, with apparently no systems in place to provide continuity:

...but his social worker went off sick and she's not back yet. So things are just a bit in limbo at the moment (FHP02)

Whilst another experienced an end in care that led to confusion:

There must be somebody that knows about me, I know the nurses, the ladies that used to come over more often, now nobody comes over to see how I'm getting on with the catheter, I don't know how to answer that question. (FHP05)

No single point of contact

None of the participants (patients or carers) knew of a named person who was specifically responsible for the coordination of their care.

However, even if they had no official point of contact, some patients seemed to have one health care worker who they relied or trusted in over others. Other patients seemed aware that there were a number of professionals involved in their care who could be contacted:

I could ask her (health worker) anything, I've found her so good. I could really talk to her, yeah...Oh yeah, she's been really good (FHP01)

Another patient was clear that the person responsible for coordinating her care was herself:

I: Do you have a single person that coordinates all your care, do you know?

R: Me. (FHP07)

Both carers who were interviewed spoke of the responsibility they felt to look after their family member. In the case of one carer, she felt that she was solely responsible for her Fathers care. She talked of not being able to find help from services when she herself was ill and unable to visit her Father:

From my experience if you need somebody you can call because there is an emergency on there's no one to help you. The reason that I'm not working at the moment is because I had an accident on my leg and had an operation on it, and dad had an accident here. I couldn't drive at the time. I could hardly get in a car so I was stuck. I had to get a taxi over here and crawl around on the floor trying to help him. I tried to get help, there was no one to help'.

I: Who did you contact?

R: I tried phoning anybody. Doctors, anybody, and I couldn't get anybody to come over (carer, FHP08)

Single plan of care

Patients were not aware of a care plan document that covered all their health and social needs:

And are you aware of a care plan for you, that takes into account all your health and wellbeing needs? Are you aware of anything like that?

No, I don't think so, no. (FHP01)

No, I don't think I do. (FHP08)

However, some patients had a sense that there was coordination between professionals happening in the background:

Maybe. I don't know. I think there might be but I can't be sure. (FHP07)

And that despite not having a care plan document, they were receiving enough information:

I: Okay, and do you think that would be useful to you or do you feel like you've already got enough information?

R1: I think I've got enough information. (FHP02)

Most patients also felt they had a good plan of care and that the various health services were either familiar with this or able to access relevant information to bring them up to speed. Most patients also said that due to this they did not have to repeat information to any service providers.

So we were just talking about to what extent the people involved in your care appear to be following the same plan for you, and you said that it seemed that everyone was kind of...?

Yeah, they all work together really (FHP02)

Support for self-management

Patients had mixed feelings as to whether they had received enough information about managing their own health and social care:

I: Have you had any information to help you manage?

Well, they don't ask those questions, really. (FHP06)

Always I think, yeah. (FHP02)

Yeah, I think that's fair. We've always made sure the options have been laid out for you. (Carer, FHP08)

However, some felt that they could manage their own health issues and could identify when they would require more support:

I'm one of those people that I have to make my own decisions in life and I accept things as a challenge and go as far as I can. And then if I really couldn't cope then I would have to say so. But until then I have to keep going (FHP07).

Shared decision making

Patients appear mixed in their view over whether they were involved in the decision making around their healthcare. Some said they were very involved:

While I'm capable and mind operating okay I'd prefer to make my own decisions because nobody can make that sort of decision for me. I'm too independent and fussy. (FHP07)

Others felt that they hadn't been involved in decisions about their care:

I: have you had a chance to tell someone and talk about what's important to you?

R: No, not really. (FHP01)

Contradicting staff opinion, one participant felt there were times when decisions had been made on this behalf; although this was not perceived as a necessarily negative event:

couldn't say...then again, you see, it's all these people that are doing things for me, I mean, like the carer...the, what you call it, the man who did the handrail and I never even asked for any of it, it was noticed by other people and done for me.' (FHP03)

However, he also talked of how the information he was given had worried him, and that perhaps he hadn't understood fully, or been involved in, the decision to go ahead with that aspect of his care:

Yes, although they've all caused me worries, these things caused me worried, but they have done what they think is right (FHP03)

Medication

Patients understanding of what their medication and when to take it were mixed. Some patients seemed to be unaware of what many of the medications they took were for:

I haven't got a clue (FHP05)

No, I have to disagree, because I don't really know, I don't, I don't really know what they do. (FHP03)

Whilst others were able to manage independently:

I: Do you 'know what each of my prescribed medications do?

R: Yes...I have to know them back to front and inside out...And I've got a proper chart I make out. (FHP07)

Other patients and carers state that they are concerned about which tablets to take and when:

No, because when I saw you last week you had a new packet, and you haven't taken the morning, afternoon and evening ones, you've gone down the week so you've taken the morning ones...(Carer, FHP08)

Support for carers

Carers spoke of their experience in a positive and supportive manner with regard to their involvement in the Hub. In particular, one carer spoke of how her own healthcare needs had been identified through her husband's referral:

R: Well it was me that...I'd got to the end of my tether, if you know what I mean? I got like screaming, I wanted to walk out, and...

I: Right, yeah, too much pressure?

R: Yeah. I mean I've been doing it for...well it'll be three years in November since he came out of hospital without a break. (FHP02)

Importantly, carers felt that their own health and social needs were being recognised through involvement with the Hub even though it was their partners who had been referred in to the service:

...and it's all these little things. She explained things. She asked about my weight and I said, I have lost weight. I said, I'm down to nine stone, and she explained why I'm losing weight, because I was starting to, you know, get a bit worried that there was something wrong. I am going for a chest X-ray on Friday, but...and she did explain it all that I've never had explained before. (FHP02)

Participants also articulated the understanding that making their health a priority would further support their ability to continue in the role of carer. There was however, an overall proportion of worry displayed. Whist this appeared to be about the health and wellbeing of the carer, it also highlighted that that if the support was not given it might impact on the health of the patient:

I: Do you think that the care for you, that you're receiving now, is better than it has been before?

R: Oh yes, they have. That's definitely...which I understand what they say; they've got to look after me so I can look after (name), yes. (Carer, FHP02)

Cause if she folds up, what about me? She takes care of me, more than I take care of her. She's the one that worries about me. She don't worry so much about herself, but she's always concerned about me. 'Cause we've been together for 60 years, so you can understand... (FHP01)

Furthermore, one carer appeared to be worried about the person they cared for and did not feel that services were in place to adequately support the patient. Also, whist the carers

healthcare was acknowledged, the support of that healthcare was impacted upon through the lack of necessary external support needed to support the patient:

It worries me that... Holidays are supposed to be relaxing, but if I go away it worries me who's going to care for you, and if I return to full time work, you're used to me coming over now definitely twice a week, and also if you need me, and it worries me what's going to happen if I'm not able to do that. (Carer, FHP08)

Well (name), the community matron, she was...she would say things, suggest things and yeah, that's fine. I mean they want me to go to...they've been wanting me to go to the rehabilitation clinic for my lung and I said, no, I can't because it's three times a week, I would have to get a sitter for three hours each time and I'd have to get a taxi there and back each time. I said, I just can't afford it. You know, it was just going to be too much. So it's been left and (name) said she thinks...the community matron, she thinks I ought to go but she said, we can't do anything about that at the moment until we get (name) sorted with his day care. (FHP02)

Social isolation

All patients talked of social isolation having an impact on their lives. As one patient stated, they went out of their way to try to get some type of company.

to get four pints of milk, so I've got the car there, I thought, I'll go down Sainsbury's, you know, what's the point, because instead of going shopping once a week I do it three times a week, I do it for the company, to be honest with you, I do it for the company, just to walk around the shop and if somebody recognises me, well, that's great, but I do it so I've got the company' (FHP05)

This feeling of isolation was viewed both in relation to a lack of family and/or visitors, and framed within the impact of reduced levels of mobility:

They were living in Torquay and my granddaughter and her other half were getting married last Saturday, I sent them money for a wedding present, sent them a card, and £100, but I haven't even had it acknowledged. And they said well, if you're coming you'll have to find your own way there and so forth, we can't help you. So I didn't go. I couldn't go. (FHPP07)

Well, I've bought myself a wheelchair that would go into a car; it would fold down and be light. But someone's got to push you in it, that's the trouble. (FHP07)

In some cases, visits by professionals were their main points of social contact:

I: Is that important to you though, when people stop and have a bit of a chat?

R: Oh yes, it does, yeah. Because you don't see anybody. (FHP01)

6.8 Quantitative (questionnaire) data

Patients completed four experience questionnaires (n=7). These were: Short Warwick-Edinburgh Mental Well-Being Scale; Patient Activation Measure; De Jong Loneliness Scale;

The Person Centred Coordinated Care Experiences Questionnaire. Two Carer Experience scales were completed by carers.

Wellbeing and social Isolation:

Patient scoring questionnaires found that whilst half said they didn't feel socially lonely, over half said they felt emotionally lonely. When compared to overall emotional wellbeing, the average score for our participants was slightly lower than the national average.

Patient experience of care:

Six out of seven respondents reported that what was important to them was only discussed to some extent or not at all. However, the majority felt they were considered as a whole person, and felt that families, friends and carers were involved in decisions about their care. Most people said they didn't have a named person overseeing their care or didn't know?. Most were also unaware of a single plan of care and did not know if it was available to them.

Patient activation:

More than half of the patients were at the lowest level of patient activation, and may not yet believe that the patient role was important. One patient lacked knowledge and confidence to take action. Two patients felt able to take action but lacked the confidence to maintain it over time.

Carer's survey:

Carers experienced some or little support from family and friends and the same levels of assistance from organisations/ government. However, they felt some fulfilment from caring, experienced some control over caring and mostly got on with the person they cared for.

7. Synthesis of Findings

The purpose of the Hub was to provide a multi-disciplinary means of working with patients to achieve agreed outcomes, particularly focusing on those who are frail and therefore vulnerable to deteriorating very quickly and requiring urgent care. It was envisaged that the Hub would fit into the existing intermediate and complex care teams by providing a clinical GP representative into the MDT group.

7.1 Extent to which the intervention model was implemented as planned

Analysis across data sources showed evidence for the implemented components but no evidence was found for four components detailed in the original model. Evidence was found for seven components but analysis showed that organisational barriers impeded their implementation. Individual components and their levels of implementation are shown in table 2.

Table 2: Implementation of model components:

Implemented:	Evidence identified for implementation but impeded by organisational barriers:	No evidence found for implementation:
Weekly MDTs	MDT input across key services	Mapping of local assets
Duration under hub care tailored to need	Information and record sharing across GP surgeries (System1)	Development of new workforce roles
Provision of crisis/ proactive care	Risk stratification to target patients most at need	Management support for staff to allocate time to hub work
	Urgent complex care team with single point of access.	Support at home (7/52 service)
	Care coordination (including admissions /discharge tracking).	Personalised care plans
	Intensive care planning.	
	Proactive case management.	

Components implemented but impeded by organisational barriers:

MDT input across key services

MDTs occurred regularly but were hampered by the lack of representation by adult mental health. The pharmacist involvement was also not contractual meaning that when he left his primary role, pharmacist input ceased.

Information and record sharing across GP surgeries (System1)

Information and record sharing across the six referral GP surgeries was implemented. However, record sharing with NA hospital was not formally put into place.

Risk stratification to target patients most at need

The aim to target the 2% most frail was expanded due to low patient numbers being referred in. Although this was advantageous in that it identified those who might not otherwise have accessed services, low referrals meant it was also not identifying all those in the 2% of most need. Barriers identified: lack of communication; confusion over referral pathways; multiple teams

Urgent complex care team with single point of access.

This was implemented but was hampered by a lack of resourcing; implementation would have been more successful if a new role had been created and sufficient time allocated.

Care coordination (including admissions /discharge tracking).

Care coordination was evidenced. However, no formal agreements were in place to track hospital admissions/ discharge. Involvement of the Geriatrician based at the hospital in the MDT was also not contracted so subject to change.

Intensive care planning.

Care planning was hampered by lack of resourcing; specifically staffing levels and the hub needing to work within previously established referral routes into other services (waiting lists).

Proactive case management.

This was evidenced but hampered by confusion of responsibilities for care and poor communication/ lack of IT updates.

7.2 Organisational factors

Analysis also showed evidence for the following barriers and facilitators at an organisational level:

Facilitators

Shared IT systems across practices

Shared It systems were felt to provide the opportunity to coordinate care across the locality. However, lack of resourcing meant that systems were not kept up-to-date. This led to confusions over responsibilities and ultimately resulted in its failure as a facilitator

MDT working

MDT working was a particular strength of the model, principally because in it allowed for health and social care to work together to support complex patients in their own homes. Dual assessment visits were also seen as productive amongst staff.

A further strength was that some of the key staff involved worked outside of their contractual remit to deliver care. These staff did not see their role/ managerial department as a barrier to care delivery and worked across boundaries to ensure complex needs were met.

Involvement of the 3rd sector

3rd sector involvement in the MDT was perceived as a particular strength, particularly as their main goal was to identify the goals of the patient and to work with them to make these achievable.

Support for carers

This was perceived as a central benefit of the model in keeping frail and complex patients in their own homes.

Barriers

Lack of Communication on Referral pathways

A lack of communication and/or clear managerial guidance on referral pathways led to confusion amongst feeder services. The two different pathways (crisis/ proactive) led to a sense of mistrust around response times for GP's and practice managers. This combined with key staff still having to use the traditional referral route within their own disciplines meant care could be delayed and perceived as unresponsive to situations that were liable to escalate quickly.

Lack of Clarity about Purpose of hub/ responsibility for patients & IT

Interview data suggests that referral practices found the processes of the hub confusing. The number of differing services resulted in uncertainty around which service provider would provide the most relevant support for their patient's needs. Also, a lack of clarity within patient notes resulted in a lack of clarity around actions and responsibilities.

In adequate Resourcing and contractual agreements stifles creativity and innovation

Overall it was felt that the Hub was pieced together as an add-on to existing services rather than forming part of a complete integrated service redesign.

Members of the Hub team were fulfilling their roles within the hub as an extra element to their contracted role rather than a dedicated team with allocated resourcing. The only extra resource was the funding of the lead GP for three half-days per week. It was felt by both management and referral practices that in order for the Hub to be sustainable and fit for purpose funding needed to be in place for a greater level of GP/clinician input.

A lack of formal resourcing and contractual agreements also meant that patient care was being delivered within established ways of working rather than innovative pathways. Therefore, the proactive work within the hub needed to be prioritised in the same ways as their other work. This meant that if, for example, a patient was identified as requiring input from therapies, they were then triaged through the same routes as all other referrals resulting in interventions being put on hold whilst they remain on waiting lists.

The lack of representation of Mental Health services was seen as a particular barrier to MDT working.

7.3 Service user experience

Referral practice experience:

Referral staff felt that although the concept of a hub taking responsibility for this population group was a good idea, confusion over responsibilities, referral pathways and a lack of communication led to mistrust.

Core Staff experience:

Staff reported positive experience of MDT working and its ability to breakdown silo working. The ability to be able to communicate with colleagues and the input from a range of professionals was felt to give the opportunity for more creative solutions for patients. However, staff did feel that organisational barriers and lack of resource impacted on their ability to deliver the planned service.

Patient experience

Overall, patients felt that their care was joined up and working. There was perceived to be a good level of communication between professional groups, and it was felt in the main that they did not need to keep repeating information. All patients interviewed to felt that they were treated as a whole person rather than a collection of conditions. Social isolation remains an issue for many in this population and was talked about by most participants. Questionnaire data supports the idea that social isolation is more of a problem than emotional loneliness. Both the interview and questionnaire data found that a number of patients did not experience continued and effective input into the decision making process. Patients also had no or very little idea of what the medication they were taking was for.

7.4 Relationships between patient and staff experience

Support for Carers

Both staff and patients felt in the main that support for carers was working well. The identification of patients who may not have accessed medical care otherwise was also a valuable element of the service. The ability to address the needs of carers whose spouses were on the hubs caseload was of particular value; not least because the support given was felt to have prevented them from possibly going into crisis. However, even if their healthcare needs were acknowledged by healthcare staff, they sometimes had to wait for the treatment of those they cared for to be organised before their own needs were met.

Single point of contact

This was an issue for both feeder practices and some patients. The ability to have a named person to phone may have helped communication between providers and provided patients/ carers with a better understanding of who was coordinating and responsible for their care.

Referral pathways need to be established and communicated more clearly.

Good communication links between the staff of the hub and those in feeder practices seemed to be vital enabling the smooth running of the hub. Representation at the Multi-Disciplinary Team meetings would have helped overcome this barrier, as would additional

resourcing to facilitate an ‘open door’ policy whereby communication could be instantaneous in times of concern/ confusion.

Clarity of responsibility with specific staff resourcing would ensure the updating of patient notes are relevant, clear and in real-time.

Clarification/ additional training of the meaning of person centred would facilitate staff understanding and professional development. This would also clarify patient and carer understanding, and improve their experience of the service.

Acknowledging carers own healthcare needs in addition to supporting their role as carer was a strength of the service. However, organisational barriers meant that carer health needs were sometimes delayed whilst support for the referred patient was put into place.

8. Recommendations

- **Leadership:**

The lack of multi-level leadership for the resourcing and embedding of the Hub also contributed to its breakdown. The setting up of the hub occurred without adequate knowledge of teams already in existence, meaning that staff worked between models with little guidance as to which patients should be accessing which service.

At the organisational level (i.e. across participating practices) confusion over roles and responsibilities for patient care led to mistrust and slow referral. Leadership and clarification over roles and additional training may have mitigated this, with a greater focus on coordination and the meaning of person centred care. This would also clarify patient and carer understanding, and improve their experience of the service.

- **Communication/IT**

Information and technology systems were not kept adequately up-to-date which meant referring practices lacked confidence in levels of patient support and care. This also impacted on care coordination and continuity between services. It is important to note, however, that this appears to have been ultimately caused by a lack of resourcing whereby staff were being asked to do additional work in addition to their primary roles.

Referral pathways for crisis/proactive care were not communicated clearly leading to around response time expectations not being met. This in turn affected confidence levels in those referring into the service.

Effective communication pathways/shared IT systems between primary and secondary care were not implemented. This had a detrimental effect on tracking care between services and added to staff burden.

- **Resourcing**

Individual staff appeared to struggle at times fitting hub work into their schedule. Some professions were represented at MDTs due to personal interest rather than their attendance being contractual.

The lack of representation of the Mental Health team at MDTs was felt to be a major barrier in the successful delivery of the service. Additional resourcing to facilitate an ‘open door’ policy whereby communication could be instantaneous in times of concern/ confusion may also facilitate confidence in referring. Clarity of responsibility with specific staff resourcing would ensure the updating of patient notes are relevant, clear and in real-time.

A lack of contractual agreements meant that the service operated as a ‘bolt-on’ rather than a new model of care.

- **Patient care and experience:**

Staff acknowledging carers own healthcare needs in addition to supporting their role as carer was a strength of the service.

Organisational barriers meant that carer health needs were sometimes delayed whilst support for the referred patient was put into place.

Summary:

The context within which the hub was developed, problems with resourcing and a lack of middle management support and ‘buy-in’ in the latter stages of the service all brought together a mix of factors which led to a slow in recruitment to the service, reduced impact and ultimately led to its folding.

At the time of the conception of the hub, it was envisaged that there existed a need for more intensive input into the health and social care needs of the top 2%, and that the hub would fit into the existing complex and intermediate care services. Staff were committed to delivery good quality care and felt the concept of a specialist hub to organise care for this population was valid. Patient feedback largely reflected positive experiences of care and many were grateful of the extra support the service provided. Middle management leadership and support is crucial to provide the opportunity for new services to change and evolve.

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Appendix A

NIHR CLAHRC
South West Peninsula

NHS
*National Institute for
Health Research*

**PLYMOUTH
UNIVERSITY
PENINSULA**
SCHOOLS OF MEDICINE & DENTISTRY

South West
Academic Health
Science Network

PenCLAHRC Plymouth University

The Person Centred and Coordinated Care Organisational Change Tool: (P3C-OCT):

Monitoring and Supporting Organisational Change for Person Centred and
Coordinated Care (PCCC)

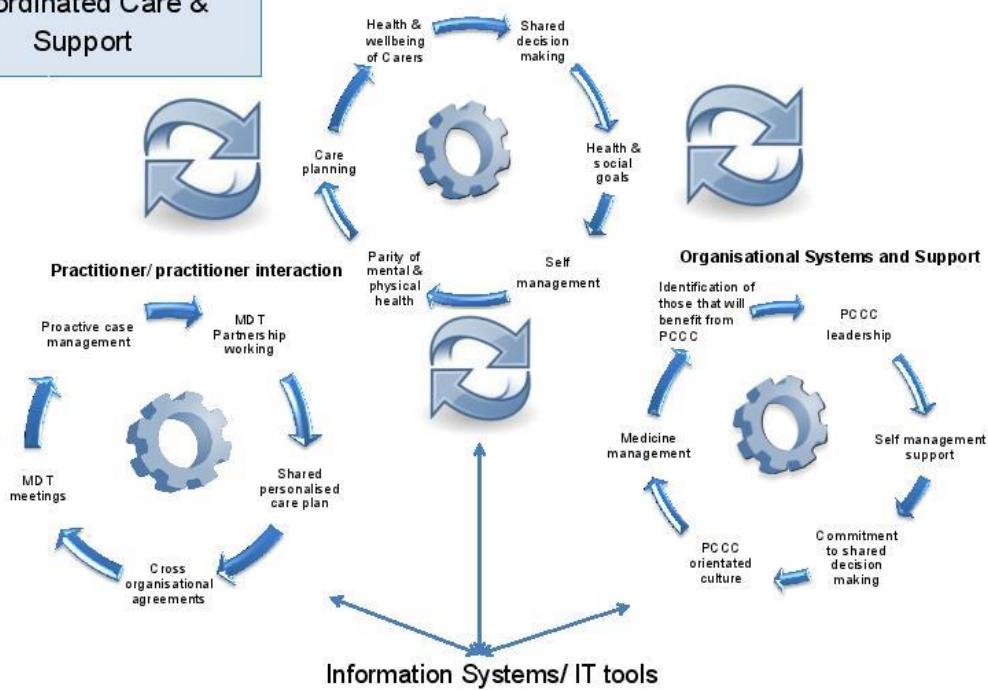


Jane Horrell, Richard Byng and Helen Lloyd
23/06/2015

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Person Centred and Coordinated Care & Support

1



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Introduction

This organisational tool has been developed to support organisations and individuals to deliver improved Person Centred Coordinated Care (PCCC), and to monitor change towards this aim. For the purpose of this tool we are defining PCCC as:

'Care that is guided by and organised effectively around the needs and preferences of individuals with complex needs'

Through the PCCC project we have identified a need for a tangible set of practitioner actions and organisational processes for which there is evidence that they might improve delivery of person centred coordinated care. To do this we conducted a critical examination of current policy, the key literature and NHS guidelines, and the National Voices 'I' statements. This tool focuses on your work with individuals with multiple or complex long term conditions (LT Cs) likely to benefit from input from several professionals.

We are a collaboration of academics and key stakeholders in the South West, consisting of the Peninsula CLAHRC and the Academic Health Science Network, and work closely with teams developing PCCC. We recognise that there is no one best established way to provide PCCC and not all options in the questionnaire will be needed for all localities.

The tool is arranged in the following order:

General information about you, your role, and your organisation.

Section 1: Questions 1-11 probe how practitioners (anyone working directly with people on their health/social care) are working with individuals to achieve PCCC.

Section 2: Questions 12-15 probe how practitioners are working together to achieve PCCC.

Section 3: Questions 16-27 probe how organisations support PCCC.

Section 4: Questions 28 and 29 investigate how information systems and IT tools are being used to support PCCC.

Section 5: Questions 30 and 31 provide a space for Managers and Practitioners to reflect on the use of this tool and assist in its further development.

Instructions for Use

This tool has been designed to help you and your organisation think about what you are currently doing to deliver PCCC. It is also designed to help you think about what you could be doing better and how this could be achieved. The data can be purely for internal use or collated as part of a system wide programme of change.

This tool should be completed by Practice Managers and/or Clinical/Service Leads, and although one person may take responsibility for its completion, they will need to gather information from several key professionals (e.g. GP's, nurses, community matrons, and members of other teams which come together to provide multidisciplinary care). For this reason, questions 1-15 (**aimed at practitioners**) and questions 16-29 (**aimed at managers**) may be circulated across the relevant professionals, or the tool may be completed as a team.

General Information (to be completed by the main person completing the tool)

You might be completing the tool with respect to:

1. A single general practice working with other community based teams to care for individuals with LTCs/ complex needs.
2. A locality team or whole locality approach to individuals with LTCs/ complex needs.
3. A community service provider (e.g. adult social care/ 3rd sector community support)

Name of Organisation:

Name of individual(s) completing: (1)

(2)

What is your role(s)? Please tick more than one if appropriate.

	Person 1	Person 2
Service manager/ lead	<input type="checkbox"/>	<input type="checkbox"/>
Practice manager	<input type="checkbox"/>	<input type="checkbox"/>
Lead clinician	<input type="checkbox"/>	<input type="checkbox"/>
Care coordinator / case manager	<input type="checkbox"/>	<input type="checkbox"/>
GP	<input type="checkbox"/>	<input type="checkbox"/>
Practice nurse	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>

What organisation(s) are you representing?

	Person 1	Person 2
General practice	<input type="checkbox"/>	<input type="checkbox"/>
Locality hub or similar	<input type="checkbox"/>	<input type="checkbox"/>
Social care	<input type="checkbox"/>	<input type="checkbox"/>
Hospital	<input type="checkbox"/>	<input type="checkbox"/>
Local authority	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>

Is your organisation(s):

	Person 1	Person 2
Rural	<input type="checkbox"/>	<input type="checkbox"/>
Suburban	<input type="checkbox"/>	<input type="checkbox"/>
Urban	<input type="checkbox"/>	<input type="checkbox"/>

Please tell us your key duties in this organisation:

Person 1	Person 2

Does your service target a specific group of individuals (e.g. people with complex needs, older people with long term conditions, general public)?
Please specify:

--

Which best describes your employment status within this organisation?

	Person 1	Person 2
I am a partner in this organisation	<input type="checkbox"/>	<input type="checkbox"/>
I am employed by this organisation	<input type="checkbox"/>	<input type="checkbox"/>
I am seconded/ contracted in to this organisation	<input type="checkbox"/>	<input type="checkbox"/>

How long have you worked within this organisation?

	Person 1	Person 2
Less than 1 year	<input type="checkbox"/>	<input type="checkbox"/>
1-3 years	<input type="checkbox"/>	<input type="checkbox"/>
4-6 years	<input type="checkbox"/>	<input type="checkbox"/>
Over 7 years	<input type="checkbox"/>	<input type="checkbox"/>

How many weeks/ months or years' experience do you have working in health/ social care organisations?

	Person 1	Person 2
1-3 weeks	<input type="checkbox"/>	<input type="checkbox"/>
1 month- 11 months	<input type="checkbox"/>	<input type="checkbox"/>
1 year- 3 years	<input type="checkbox"/>	<input type="checkbox"/>
4 years- 6 years	<input type="checkbox"/>	<input type="checkbox"/>
More than 6 years	<input type="checkbox"/>	<input type="checkbox"/>

For those completing as part of general practice:

What is your registered population?

--

Is the practice part of a wider group of practices or other organisation(s)?

Yes No

If yes, please specify:

Commissioning consortium	<input type="checkbox"/>
GP federation	<input type="checkbox"/>
Part of a larger provider organisation	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>

Do you allocate a named professional for PCCC?

Yes No

If yes, please specify:

Named GP	<input type="checkbox"/>
Practice manager within GP team	<input type="checkbox"/>
Named professional from within teams	<input type="checkbox"/>
Named professional from across teams	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>

In order to provide enhanced care for those needing PCCC which of the following staff are fully integrated (not necessarily employed but using the same records) into the general practice team?

Community Matrons/ District Nurses	<input type="checkbox"/>
Mental Health workers	<input type="checkbox"/>
Pharmacists	<input type="checkbox"/>
Community Therapy teams (OT/ Physio)	<input type="checkbox"/>
Third sector (e.g. Age UK workers)	<input type="checkbox"/>

How does your recall system for multiple LTCs work?

Each disease recalled separately	<input type="checkbox"/>
Joined up recall for diabetes and cardiovascular conditions	<input type="checkbox"/>
Recall and care for all conditions integrated	<input type="checkbox"/>

For those completing as part of a community hub/ locality service:

What is the approximate total population of the locality you cover?

What is the approximate total target population for PCCC in your locality?

What is your current caseload?

What is your planned/ target caseload?

Which of the following functions to support PCCC is your team designed to fulfil (tick more than one if appropriate)?

Promoting mental and physical health and wellbeing	<input type="checkbox"/>
Delivering whole person health care overtime	<input type="checkbox"/>
Delivering whole person health and social care overtime	<input type="checkbox"/>
Providing intensive short term (non-medical) care to prevent admissions	<input type="checkbox"/>
Providing short term medical care to prevent admissions	<input type="checkbox"/>
Providing integrated physical and mental health care	<input type="checkbox"/>

What medical support do you have?

Medical decisions made by GP's/ consultants outside this team	<input type="checkbox"/>
GP / medical input to locality team	<input type="checkbox"/>

Section 1: Person + practitioner interaction

Questions 1-15 are aimed at practitioners

1. What do you do to ensure that a person doesn't have to tell their story repeatedly and unnecessarily?
(please indicate which processes you have in place and how well you think they are working)

Note:

Plan of care refers to an agreement within / across teams for an agreed approach to care. This may or may not be in the form of a written document.

A Care plan document is a formal written document that details the agreed approach.

Process	How is this working?
A single person with responsibility for coordinating all care <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Sharing a plan of care/ appropriate information within your team <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Sharing a plan of care/ appropriate information across teams <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
A shared care plan document within your team <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
A shared care plan document across teams <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
MDT/ clinical meetings <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Discharge planning <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working

Question continued overleaf

Question 1 continued (What processes are in place to ensure that a person doesn't have to repeat them selves unnecessarily?)

Other (please specify) <input type="checkbox"/>	Working very well <input type="checkbox"/>
	Working well <input type="checkbox"/>
	Requires some improvement <input type="checkbox"/>
	Requires significant improvement <input type="checkbox"/>
	Not working <input type="checkbox"/>
Comments:	

2. Which of these is available to empower people?

Process	How well is this process working?
Providing information sheets <input type="checkbox"/>	Working very well <input type="checkbox"/>
<i>None</i> <input type="checkbox"/>	Working well <input type="checkbox"/>
<i>Not relevant</i> <input type="checkbox"/>	Requires some improvement <input type="checkbox"/>
	Requires significant improvement <input type="checkbox"/>
	Not working <input type="checkbox"/>
Signposting to 3rd sector support <input type="checkbox"/>	Working very well <input type="checkbox"/>
<i>None</i> <input type="checkbox"/>	Working well <input type="checkbox"/>
<i>Not relevant</i> <input type="checkbox"/>	Requires some improvement <input type="checkbox"/>
	Requires significant improvement <input type="checkbox"/>
	Not working <input type="checkbox"/>
Referrals to other services <input type="checkbox"/>	Working very well <input type="checkbox"/>
<i>None</i> <input type="checkbox"/>	Working well <input type="checkbox"/>
<i>Not relevant</i> <input type="checkbox"/>	Requires some improvement <input type="checkbox"/>
	Requires significant improvement <input type="checkbox"/>
	Not working <input type="checkbox"/>
Referrals to peer support groups <input type="checkbox"/>	Working very well <input type="checkbox"/>
<i>None</i> <input type="checkbox"/>	Working well <input type="checkbox"/>
<i>Not relevant</i> <input type="checkbox"/>	Requires some improvement <input type="checkbox"/>
	Requires significant improvement <input type="checkbox"/>
	Not working <input type="checkbox"/>
Pharmaceutical support <input type="checkbox"/>	Working very well <input type="checkbox"/>
<i>None</i> <input type="checkbox"/>	Working well <input type="checkbox"/>
<i>Not relevant</i> <input type="checkbox"/>	Requires some improvement <input type="checkbox"/>
	Requires significant improvement <input type="checkbox"/>
	Not working <input type="checkbox"/>

Question continued overleaf

Question 2 continued (Which of these is available to empower people?)

Process	How well is this process working?				
Other (please specify) <input type="checkbox"/>	Working very well <input type="checkbox"/>	Working well <input type="checkbox"/>	Requires some improvement <input type="checkbox"/>	Requires significant improvement <input type="checkbox"/>	Not working <input type="checkbox"/>
Comments:					

- 3a. Do all people who could benefit from PCCC have a co-created single personalised care plan in the form of a **written document**?

	Within teams	Across teams
All <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A few <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
None <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If no why not?
.....
.....
.....

- 3b. Are they given a copy of their care plan? Yes No N/a

4. In general, which of the following elements are included in the co-created plan of care (this can either be in the form of a **written document or a plan of working**)?

A lead coordinator	<input type="checkbox"/>	A List of medications and instructions for when to take	<input type="checkbox"/>
A contingency plan for crisis episodes or exacerbations of their condition	<input type="checkbox"/>	A date for review	<input type="checkbox"/>
A named person to contact in a crisis	<input type="checkbox"/>	Treatment Escalation Plan	<input type="checkbox"/>
An action plan to attain their health goals	<input type="checkbox"/>	Other (please specify)	<input type="checkbox"/>
An action plan to attain their social goals	<input type="checkbox"/>	<i>None</i>	<input type="checkbox"/>
Details of who is responsible for what	<input type="checkbox"/>	<i>Not relevant</i>	<input type="checkbox"/>

How well are your care plans working?	Comments (for example, which aspects are working particularly well/ not well):
Working very well	<input type="checkbox"/>
Working well	<input type="checkbox"/>
Requires some improvement	<input type="checkbox"/>
Requires significant improvement	<input type="checkbox"/>
Not working	<input type="checkbox"/>

5. Who normally takes the lead for care planning/ care coordination? Please tick as many as appropriate.

Type of Professional	How well is this working?
Managerial lead	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Clinical lead	<input type="checkbox"/>
Team coordinator	<input type="checkbox"/>
GP	<input type="checkbox"/>
District/ Community Nurse	<input type="checkbox"/>
Community Matron	<input type="checkbox"/>
Community Therapy teams	<input type="checkbox"/>
Social workers	<input type="checkbox"/>
Care workers	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/> <i>None</i> <input type="checkbox"/> <i>Not relevant</i>
	Comments (for example, which aspects are working particularly well/ not well): If dual lead, please specify:

6. How is shared decision making with individuals supported in your organisation?

Individual and practitioner work together on:	Using:
Individual and practitioner work together to set goals	<input type="checkbox"/> Personal budgets <input type="checkbox"/> <input type="checkbox"/> Other (please specify) <input type="checkbox"/>
Longer appointment times	<input type="checkbox"/> None <input type="checkbox"/> <input type="checkbox"/> Not relevant <input type="checkbox"/>
Decision aids	<input type="checkbox"/>
Information sheets	<input type="checkbox"/>
Measurements of patient experience of shared decision making	<input type="checkbox"/>

How well is shared decision making working in general in your organisation?	Comments (for example, which aspects are working particularly well/ not well):
<input type="checkbox"/> Working very well	
<input type="checkbox"/> Working well	
<input type="checkbox"/> Requires some improvement	
<input type="checkbox"/> Requires significant improvement	
<input type="checkbox"/> Not working	

7. How do practitioners specifically elicit goals related to people's health and social aims?

Process	How well is this process working?
Personalised care plans structured around the identification of goals <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> <input type="checkbox"/> Working well <input type="checkbox"/> <input type="checkbox"/> Requires some improvement <input type="checkbox"/> <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> <input type="checkbox"/> Not working <input type="checkbox"/>
Goals prompted in a separate section of the written personalised care plan <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> <input type="checkbox"/> Working well <input type="checkbox"/> <input type="checkbox"/> Requires some improvement <input type="checkbox"/> <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> <input type="checkbox"/> Not working <input type="checkbox"/>
Some practitioners trained to provide guided conversations <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> <input type="checkbox"/> Working well <input type="checkbox"/> <input type="checkbox"/> Requires some improvement <input type="checkbox"/> <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> <input type="checkbox"/> Not working <input type="checkbox"/>
Longer appointment times <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> <input type="checkbox"/> Working well <input type="checkbox"/> <input type="checkbox"/> Requires some improvement <input type="checkbox"/> <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> <input type="checkbox"/> Not working <input type="checkbox"/>
Using best interest (e.g. Power of Attorney or formal advocate) <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> <input type="checkbox"/> Working well <input type="checkbox"/> <input type="checkbox"/> Requires some improvement <input type="checkbox"/> <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> <input type="checkbox"/> Not working <input type="checkbox"/>

Question continued overleaf

Question 7 continued (How do practitioners specifically elicit goals related to people's health and social aims?)

Other (please specify) <input type="checkbox"/>	Working very well <input type="checkbox"/>
	Working well <input type="checkbox"/>
	Requires some improvement <input type="checkbox"/>
	Requires significant improvement <input type="checkbox"/>
	Not working <input type="checkbox"/>
Comments:	

8. How do practitioners ensure that people are supported to achieve their individualised health and social goals?

Processes and activities	How well is this process working?
Conversations with the individual to review goal achievement <i>None</i> <input type="checkbox"/> <i>Not relevant</i> <input type="checkbox"/>	Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working <input type="checkbox"/>
The auditing of the plan of care <i>None</i> <input type="checkbox"/> <i>Not relevant</i> <input type="checkbox"/>	Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working <input type="checkbox"/>
The use of additional support (for example health trainers, peer support, coaching, advocacy services or the voluntary sector) <i>None</i> <input type="checkbox"/> <i>Not relevant</i> <input type="checkbox"/>	Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working <input type="checkbox"/>
The use of tools to help people track whether they are achieving their goals (for example, a diary, checklist, charting changes such as weight, health apps) <i>None</i> <input type="checkbox"/> <i>Not relevant</i> <input type="checkbox"/>	Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working <input type="checkbox"/>
Other (please specify) <input type="checkbox"/>	Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working <input type="checkbox"/>
Comments:	

9a. How is support tailored to the person's ability and motivation to manage their own health?

Type of Support or Process	How well is this process working?
Use of a patient measure of activation (e.g. PAM)	Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working <input type="checkbox"/>
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Use of activation measure score as part of the care planning process	Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working <input type="checkbox"/>
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Health coaching to support self-management	Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working <input type="checkbox"/>
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Peer to peer support	Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working <input type="checkbox"/>
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Group based training for self-management	Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working <input type="checkbox"/>
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Disease specific training	Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working <input type="checkbox"/>
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Other (please specify)	Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working <input type="checkbox"/>
Comments:	

9b. How are self-management scores (e.g. PAM) fed back into practice?

Type of Support or Process	How well is this process working?				
Gathered externally and never included in records	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
	<input type="checkbox"/>	Requires significant improvement	<input type="checkbox"/>		
	<input type="checkbox"/>	Not working	<input type="checkbox"/>		
Gathered externally and included in records but rarely used	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
	<input type="checkbox"/>	Requires significant improvement	<input type="checkbox"/>		
	<input type="checkbox"/>	Not working	<input type="checkbox"/>		
Used informally in care planning	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
	<input type="checkbox"/>	Requires significant improvement	<input type="checkbox"/>		
	<input type="checkbox"/>	Not working	<input type="checkbox"/>		
Structured within the care plan	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
	<input type="checkbox"/>	Requires significant improvement	<input type="checkbox"/>		
	<input type="checkbox"/>	Not working	<input type="checkbox"/>		
Other (please specify)	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
	<input type="checkbox"/>	Requires significant improvement	<input type="checkbox"/>		
	<input type="checkbox"/>	Not working	<input type="checkbox"/>		
Comments:					

10. In what ways is consideration routinely given to understand how mental wellbeing affects peoples physical conditions, and of the role of physical wellbeing on mental health?

Type of Support or Process	How well is this process working?				
Through longer appointment times	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
	<input type="checkbox"/>	Requires significant improvement	<input type="checkbox"/>		
	<input type="checkbox"/>	Not working	<input type="checkbox"/>		
Personalised care plans structured to address this	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
	<input type="checkbox"/>	Requires significant improvement	<input type="checkbox"/>		
	<input type="checkbox"/>	Not working	<input type="checkbox"/>		

Question continued overleaf

Question 10 continued (In what ways is consideration routinely given to understand how mental wellbeing affects peoples physical conditions, and of the role of physical wellbeing on mental health?)

Type of Support or Process	How well is this process working?				
Mental health workers link into the team	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Other (please specify)	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
		Working well	<input type="checkbox"/>		
		Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Comments:					

11. How are informal carers assessed and offered support?

Type of Support or Process	How well is this process working?				
Identification of the carer population	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Carer health and wellbeing assessment	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Providing advice and signposting to support services	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Provision of respite if required	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Other (please specify)	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
		Working well	<input type="checkbox"/>		
		Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Comments:					

Section 2: Practitioner + practitioner interaction

12. With what other teams do you have agreements in place to enable partnership working and provide joined up care?

Team	How is this working?
Community based hub or team specialising in LTCs	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>Questionnaire completed by this team</i>	<input type="checkbox"/>
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
General practice	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>Questionnaire completed by this team</i>	<input type="checkbox"/>
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Nursing specialists (e.g. District/ Nurses/ Community Matrons)	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>Questionnaire completed by this team</i>	<input type="checkbox"/>
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Mental Health services	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>Questionnaire completed by this team</i>	<input type="checkbox"/>
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Community Therapy teams	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>Questionnaire completed by this team</i>	<input type="checkbox"/>
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Paid care providers (e.g. care agencies)	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>Questionnaire completed by this team</i>	<input type="checkbox"/>
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Voluntary sector providers	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>Questionnaire completed by this team</i>	<input type="checkbox"/>
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Social Work teams	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>Questionnaire completed by this team</i>	<input type="checkbox"/>
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>

Question continued overleaf

Question 12 continued (With what other teams do you have agreements in place to enable partnership working and provide joined up care?)

Team	How is this working?				
Emergency Department	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>Questionnaire completed by this team</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Community based admission avoidance teams	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>Questionnaire completed by this team</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Intermediate care team	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>Questionnaire completed by this team</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Residential/ care home providers	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>Questionnaire completed by this team</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Other (please specify)	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
		Working well	<input type="checkbox"/>		
		Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Comments:					

13. Do multi-disciplinary team (MDT) meetings take place to review and plan care for people suitable for PCCC?

Yes No

Who attends these meetings?

General practitioners	<input type="checkbox"/>
Practice nurses	<input type="checkbox"/>
District nurses/ Community Matrons	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>
Acute care providers	<input type="checkbox"/>
Social workers	<input type="checkbox"/>
Care workers	<input type="checkbox"/>
Voluntary sector (e.g. Age UK)	<input type="checkbox"/>
Physiotherapists	<input type="checkbox"/>
Occupational Therapists	<input type="checkbox"/>
Pharmacist	<input type="checkbox"/>
Medical Consultant	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>

How often do these MDT meetings happen?

Daily	<input type="checkbox"/>
Weekly	<input type="checkbox"/>
Fortnightly	<input type="checkbox"/>
Monthly	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>

How well are your multi-disciplinary team meetings working?	Comments (for example, which aspects are working particularly well/ not well):
Working very well	<input type="checkbox"/>
Working well	<input type="checkbox"/>
Requires some improvement	<input type="checkbox"/>
Requires significant improvement	<input type="checkbox"/>
Not working	<input type="checkbox"/>

14. Are processes in place to allocate roles and responsibilities across and within teams?

Yes No

Processes and activities	How well is this process working?
Processes in place for a single named person coordinating the support and care of each person suitable for PCCC within your team <i>None</i> <input type="checkbox"/> <i>Not relevant</i> <input type="checkbox"/>	Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working <input type="checkbox"/>
Processes in place for a single named person coordinating the support and care of each person suitable for PCCC across teams <i>None</i> <input type="checkbox"/> <i>Not relevant</i> <input type="checkbox"/>	Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working <input type="checkbox"/>
Across team agreements to work together on a single care plan <i>None</i> <input type="checkbox"/> <i>Not relevant</i> <input type="checkbox"/>	Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working <input type="checkbox"/>
Processes in place to ensure continuity of care/ care transitions (please specify) <i>None</i> <input type="checkbox"/> <i>Not relevant</i> <input type="checkbox"/>	Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working <input type="checkbox"/>
Processes in place for active Mental Health Team input <i>None</i> <input type="checkbox"/> <i>Not relevant</i> <input type="checkbox"/>	Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working <input type="checkbox"/>
Other (please specify) <input type="checkbox"/>	Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working <input type="checkbox"/>
Comments:	

15. Which practitioners act according to the personalised care plan?

Type of Professional	How well is this working?	
GP	<input type="checkbox"/>	Working very well
District/ Community Nurse	<input type="checkbox"/>	Working well
Community Matron	<input type="checkbox"/>	Requires some improvement
Mental Health Team	<input type="checkbox"/>	Requires significant improvement
Social Workers	<input type="checkbox"/>	Not working
Care workers (e.g. agency workers)	<input type="checkbox"/>	Comments (for example, which aspects are working particularly well/ not well):
Nominated 3 rd sector providers	<input type="checkbox"/>	
Physiotherapists	<input type="checkbox"/>	
Occupational therapists	<input type="checkbox"/>	
Consultant Specialists	<input type="checkbox"/>	
Other (please specify)	<input type="checkbox"/>	
Plans are used but not personalised	<input type="checkbox"/>	
Plans are not used	<input type="checkbox"/>	
Not relevant	<input type="checkbox"/>	

Section 3: Organisational Systems and Support

Questions 16-29 may be more easily completed by Practice Managers, Service Leads or GPs

16. How do you provide proactive case management (identification, assessment, planning, monitoring and coordination)?

Type of Support or Process	How well is this process working?	
Use of predictive models to identify who will benefit from PCCC	<input type="checkbox"/>	Working very well
None	<input type="checkbox"/>	Working well
Not relevant	<input type="checkbox"/>	Requires some improvement
	<input type="checkbox"/>	Requires significant improvement
	<input type="checkbox"/>	Not working
Appointments are available for crisis care	<input type="checkbox"/>	Working very well
None	<input type="checkbox"/>	Working well
Not relevant	<input type="checkbox"/>	Requires some improvement
	<input type="checkbox"/>	Requires significant improvement
	<input type="checkbox"/>	Not working
Appointments are available for proactive care	<input type="checkbox"/>	Working very well
None	<input type="checkbox"/>	Working well
Not relevant	<input type="checkbox"/>	Requires some improvement
	<input type="checkbox"/>	Requires significant improvement
	<input type="checkbox"/>	Not working
Multi-Disciplinary Team (MDT) meetings to discuss complex cases	<input type="checkbox"/>	Working very well
None	<input type="checkbox"/>	Working well
Not relevant	<input type="checkbox"/>	Requires some improvement
	<input type="checkbox"/>	Requires significant improvement
	<input type="checkbox"/>	Not working

Question continued overleaf

Question 16 continued (How do you provide proactive case management (identification, assessment, planning, monitoring and coordination?)

Systematic review of caseload/ list <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Allocation of an individual from MDT with responsibility to ensure ongoing care <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Other (please specify)	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Comments:	

17a. For which groups do you **measure** the experience of care:

Type of Support or Process	How well is this process working?
People suitable for PCCC <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Families of individuals suitable for PCCC <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Carers of individuals suitable for PCCC <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Other (please specify)	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Comments:	

17b. How do you use the measures from Q17(a) to inform the delivery of care/ support?

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18. What systems are in place to identify and allocate people suitable for PCCC?

Type of Support or Process	How well is this process working?
Risk stratification and automatic allocation	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Risk stratification and allocation by team agreement	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Agreement by team providing PCCC	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Routine discharge screening	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Ad hoc clinical complexity identified by practitioner	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
External practitioners/services refer in	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Comments:	

19. Which approaches are used to organise the care of those identified for PCCC?

Processes and activities	How well is this process working?
A lead practitioner takes on case management role for each individual	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
People's needs and treatment are reviewed regularly	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
The need to step up/ down intensity of input reviewed regularly	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
MDT meetings	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Regular review of case load allocation	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Comments:	

20. What contact/appointment arrangements are in place to support PCCC?

Processes and activities	How well is this process working?
Appointments specifically for PCCC planning <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Longer appointments available on request for routine care <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Home visits for PCCC planning <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Other (please specify)	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Comments:	

21. What systems are in place to assess the extent of shared decision making?

Processes and activities	To what degree is this information fed back into practice?
Care record audit Using a questionnaire to elicit peoples' experiences (please specify which measure) Other (please specify) <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Comments (for example, which aspects are working particularly well/not well):	

22. How are caseloads assigned to the following teams?

Practitioner	How is this working?			
Nursing specialists by area/postcode	<input type="checkbox"/>	Working very well	<input type="checkbox"/>	
by GP surgery	<input type="checkbox"/>	Working well	<input type="checkbox"/>	
<i>None</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>	
<i>Not relevant</i>	<input type="checkbox"/>	Requires significant improvement	<input type="checkbox"/>	
Not working	<input type="checkbox"/>		<input type="checkbox"/>	
Mental Health services by area/postcode	<input type="checkbox"/>	Working very well	<input type="checkbox"/>	
by GP surgery	<input type="checkbox"/>	Working well	<input type="checkbox"/>	
<i>None</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>	
<i>Not relevant</i>	<input type="checkbox"/>	Requires significant improvement	<input type="checkbox"/>	
Not working	<input type="checkbox"/>		<input type="checkbox"/>	
Care providers (e.g. agency workers) by area/postcode	<input type="checkbox"/>	Working very well	<input type="checkbox"/>	
by GP surgery	<input type="checkbox"/>	Working well	<input type="checkbox"/>	
<i>None</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>	
<i>Not relevant</i>	<input type="checkbox"/>	Requires significant improvement	<input type="checkbox"/>	
Not working	<input type="checkbox"/>		<input type="checkbox"/>	
Social Workers by area/postcode	<input type="checkbox"/>	Working very well	<input type="checkbox"/>	
by GP surgery	<input type="checkbox"/>	Working well	<input type="checkbox"/>	
<i>None</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>	
<i>Not relevant</i>	<input type="checkbox"/>	Requires significant improvement	<input type="checkbox"/>	
Not working	<input type="checkbox"/>		<input type="checkbox"/>	
Community therapy teams by area/postcode	<input type="checkbox"/>	Working very well	<input type="checkbox"/>	
by GP surgery	<input type="checkbox"/>	Working well	<input type="checkbox"/>	
<i>None</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>	
<i>Not relevant</i>	<input type="checkbox"/>	Requires significant improvement	<input type="checkbox"/>	
Not working	<input type="checkbox"/>		<input type="checkbox"/>	
Other (please specify) by area/postcode	<input type="checkbox"/>	Working very well	<input type="checkbox"/>	
by GP surgery	<input type="checkbox"/>	Working well	<input type="checkbox"/>	
	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>	
	<input type="checkbox"/>	Requires significant improvement	<input type="checkbox"/>	
	<input type="checkbox"/>	Not working	<input type="checkbox"/>	
Comments:				

23. Are there on-going efforts to ensure that support and training for staff in PCCC continues to be developed in the following areas?

Type of support/training	How is this support/ training impacting on practice?				
Person centeredness	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Self-management	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Empowering and activating individuals to be involved in self-care	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Coordinating care across teams	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Health coaching	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Shared decision making	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Supporting health promoting behaviours	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Managing polypharmacy	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Decision making in multimorbidity	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		

Question continued overleaf

Question 23 continued (Are there on-going efforts to ensure that support and training for staff in PCCC continues to be developed in the following areas?)

Type of support/training	How is this support/training impacting on practice?				
Promoting managed risk taking for individuals	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Other (please specify)	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
		Working well	<input type="checkbox"/>		
		Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Comments:					

24. Which of the following activities/resources are supporting culture change for PCCC?

Activity/resource	How is this impacting on practice?				
Change Champions for PCCC	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Formal benchmarking (e.g. reviewing performance indicators such as number of personalised care plans against internal performance or external organisations)	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Informal benchmarking (e.g. group reflections on practice)	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Auditing PCCC activities	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Other (please specify)	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
		Working well	<input type="checkbox"/>		
		Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Comments:					

25. What interventions are in place to reduce unplanned or inappropriate emergency admissions?

Processes and activities	How well is this process working?
Predictive modelling to identify people most at risk	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Support to increase self-management skills during crisis (e.g. medication/help seeking)	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Telemedicine (providing remote clinical services to patients via communication technologies)	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Hospital at home service (intensive community based treatment)	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Use of virtual ward	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Coordinated working between health and social care (e.g. joint assessments)	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Ward based health and social care coordinators to support discharge	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Individualised discharge plans	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>

Question continued overleaf

Question 25 continued (What interventions are in place to reduce unplanned or inappropriate emergency admissions?)

Processes and activities	How well is this process working?				
Implementation of specialist support services e.g. intermediate/ complex care teams (please specify)	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Advanced planning (e.g. Treatment Escalation plans (TEP), Lasting Power of Attorney (LPA))	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Community rehab/therapy teams	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Other (please specify)	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
		Working well	<input type="checkbox"/>		
		Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Comments:					

26. What procedures are in place to address polypharmacy/review medication management?

Processes and activities	How well is this process working?				
Pharmacist attending MDT meeting	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Pharmacist review for some or all patients	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Questions/ prompts about medicine taking for patients during reviews	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		

Question continued overleaf

Question 26 continued (What procedures are in place to address polypharmacy/review medicine management?)

Processes and activities	How well is this process working?				
Routine face to face medicine reviews	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Training for patients in medicine optimisation	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Medicine audit	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Other (please specify)	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
		Working well	<input type="checkbox"/>		
		Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Comments:					

27. What other systems are in place to support PCCC?

Processes and activities	How well is this process working?				
The pooling of budgets to be used flexibly by teams	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		
Use of tools and care plans to identify missing pathways	<input type="checkbox"/>	Working very well	<input type="checkbox"/>		
<i>None</i>	<input type="checkbox"/>	Working well	<input type="checkbox"/>		
<i>Not relevant</i>	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>		
		Requires significant improvement	<input type="checkbox"/>		
		Not working	<input type="checkbox"/>		

Question continued overleaf

Question 27 continued (What other systems are in place to support PCCC?)

Processes and activities	How well is this process working?
Measurement of staff experience of PCCC <i>None</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Paper based directory of services <i>None</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Other (please specify)	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Comments:	

Section 4: Information systems / IT tools

Note:

'**Telecare** involves continuous remote monitoring of patients in order to receive alerts about real-time emergencies and to track lifestyle changes over time. In this way, telecare helps manage a wide range of risks associated with a patient's independent living'.¹

'**Telemedicine** is defined as the use of electronic communications and information technologies to provide clinical services to patients in other locations. Examples of telemedicine include video consultations with specialists, remote medical evaluations and diagnoses and the digital transmission of medical imaging'.¹

'**Telecoaching** is a telephone based, self-care programme for people with long-term conditions. The aim is to improve the quality of care through empowering patients to self-care and promote a healthy lifestyle'.²

28. What kind of promotion is there to support self-care?

Processes and activities	How is this process working?		
Telecare	<input type="checkbox"/>	Working very well	<input type="checkbox"/>
None	<input type="checkbox"/>	Working well	<input type="checkbox"/>
Not relevant	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>
		Requires significant improvement	<input type="checkbox"/>
		Not working	<input type="checkbox"/>
Telemedicine	<input type="checkbox"/>	Working very well	<input type="checkbox"/>
None	<input type="checkbox"/>	Working well	<input type="checkbox"/>
Not relevant	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>
		Requires significant improvement	<input type="checkbox"/>
		Not working	<input type="checkbox"/>
Telecoaching	<input type="checkbox"/>	Working very well	<input type="checkbox"/>
None	<input type="checkbox"/>	Working well	<input type="checkbox"/>
Not relevant	<input type="checkbox"/>	Requires some improvement	<input type="checkbox"/>
		Requires significant improvement	<input type="checkbox"/>
		Not working	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	Working very well	<input type="checkbox"/>
		Working well	<input type="checkbox"/>
		Requires some improvement	<input type="checkbox"/>
		Requires significant improvement	<input type="checkbox"/>
		Not working	<input type="checkbox"/>
Comments:			

29. Which of the following IT based systems are in place?

Processes and activities	How well is this process working?
A template/ record keeping system to bring together a single care plan within your team <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
A template/ record keeping system to bring together a single care plan which is shared across organisations <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Electronic health/ social care plans accessible across team boundaries in real time <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
An electronic directory of services <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Individuals routinely have access to care plan/ records <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Individuals can add to their electronic care plan/ record <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Across team agreements to access people's records Across all teams Across some teams <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Across team agreements to add to people's records Across all teams Across some teams <i>None</i> <i>Not relevant</i>	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working

Question continued overleaf

Question 29 continued (Which of the following IT based systems are in place?)

Processes and activities	How well is this process working?
Across team agreements to inform others of changes to people's records	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Across all teams	<input type="checkbox"/>
Across some teams	<input type="checkbox"/>
<i>None</i>	<input type="checkbox"/>
<i>Not relevant</i>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/> Working very well <input type="checkbox"/> Working well <input type="checkbox"/> Requires some improvement <input type="checkbox"/> Requires significant improvement <input type="checkbox"/> Not working
Comments:	

Questions 30 and 31 are aimed at Practice Managers, Service Leads & Practitioners*Please answer the following questions in the boxes below:*

30. Is there anything you are going to change as a result of reading and completing this tool?

31. Is there anything you or your organisation is doing towards PCCC that has not been captured by this tool?

¹ <http://www.globalmed.com/additional-resources/telehealth-telecare-and-telemedicine-whats-the-difference.php>

² <http://www.peninsulacommunityhealth.co.uk/2014/15/documentsandPolicies/Publications/Services/Telecoaching-Patient-Leaflet.pdf>

Appendix B: Staff Information and consent form

Study Information Sheet: **Practitioner**

Early Help Hub Evaluation

You are being invited to take part in an evaluation of the *Early Help Hub*. The core aims of the hub are to create new ways of working that utilise and build community capacity, reduce dependency on health and care services, and increase the health and wellbeing of the communities served. This evaluation provides an interesting opportunity to assess and capture changes in processes and families care within the hub and support the development of the service.

This evaluation is being conducted by a team of researchers from the Peninsula Collaboration for Leadership in Applied Health Research and Care (PenCLAHRC) in collaboration with the South West Academic Research Network. This study forms part of a programme of evaluations of service developments under the broad area of Person Centred Coordinated Care (PCCC).

Why is this evaluation taking place?

To achieve a more person centred and integrated care approach to service delivery, the SWIFT project is supporting the set up and development of the Early Help Hubs.

The Hubs aim to serve families using a multidisciplinary team approach, facilitated by information sharing. It is essential that the service is evaluated to ensure that families are receiving optimal person centred care and that practitioners are appropriately supported to deliver this service. Further, it is vital that we capture what has happened to processes following these changes.

Please take time to read the following information carefully.

What do I need to do? There are three ways in which you can participate in the evaluation:

1. Completing questionnaires: You would be asked to complete a set of questionnaires at three time points: at the start of the evaluation and at 6 and 12 months after the start of the evaluation. Questions will focus on the delivery of person centred integrated care and should take no longer than 20 minutes to complete. All those taking part are required to participate in this element of the evaluation.
2. One to one interviews with a researcher: If you agree to take part in this element of the evaluation a researcher will contact you to arrange a convenient time and location for an interview. Interviews will be arranged to coincide with the

- questionnaire element above (3 interviews in total). Interviews should last no longer than 45 minutes and will be digitally recorded with your permission.
3. Observation of practice and meetings: Researchers will be making direct observation of practitioner consultations with individuals/families and staff meetings. If you agree for a researcher to observe consultations, informed consent will also be sought from the individual and/or family as appropriate prior to observation.

If you agree to participate, please complete and return the attached consent form, indicating the elements of the evaluation in which you agree to take part.

Do I have to take part? No. Participation is entirely voluntary. You are under no obligation to take part in this evaluation. Even if you consent to participate, you are free to withdraw from the study at any time until the data are analysed (ADD DATE HERE). You do not need to provide a reason for withdrawing from the study and neither participation nor withdrawal will have any impact on your relationship with the research team, the SW-AHSN or your employer. If you withdraw from the study all information provided by you will be destroyed.

Confidentiality and anonymity: Your information will be identifiable through a participant code known only to the research team. No individuals will be identified in any reports or publications.

How will my information be used? Information gathered from you will be used to inform the development of the Frailty Hub.

If you have any questions about the project please contact:

Dr Lynne Callaghan

Email: lynne.callaghan@plymouth.ac.uk

Phone : 07807966235

Dr Helen Lloyd

Email: helen.lloyd-1@plymouth.ac.uk

Phone : 07772 475423

Consent Form:

Practitioner interviews

Newton Abbot Frailty Hub Evaluation

Researchers: Dr Lynne Callaghan, Dr Helen Lloyd, Ms Jane Horrell

1. I confirm that I have read and understood the information sheet about the above evaluation dated dd/mm/yyyy.
2. I agree to take part in the evaluation and complete questionnaires at each time point specified in the information sheet.
3. I agree to take part in an interview about my perceptions of the impact of the Frailty Hub on patients, my practice and the organisation.
4. I understand that the interview will be digitally recorded.
5. I agree for a researcher to observe my consultation with patients with the on gaining informed consent of the patient/carer involved.
6. I agree for a researcher to observe team meetings in which I am involved. I understand that the researcher will introduce him/herself prior to commencing the observation.
7. I understand that I am free to withdraw from the study at any time without prejudice and that if I withdraw any information provided by me will be destroyed up until the point of analysis.

Name: _____ **Date:** _____

Signature: _____

Researcher: _____ **Date:** _____

Signature: _____

Preferred method of contact: _____

Contact details: _____

Appendix C: Patient/carer Information and consent form

Study Information Sheet:

Patient/Carer Participants

Newton Abbot Frailty Hub Evaluation

You are being invited to take part in an evaluation of the *Newton Abbot Frailty Hub*. The Newton Abbot Frailty Hub addresses the clinical and social care needs of the older population with complex needs. This evaluation provides an interesting opportunity to assess and capture changes in clinical processes and patient care within the hub.

This evaluation is being conducted by a team of researchers from the Peninsula Collaboration for Leadership in Applied Health Research and Care (PenCLAHRC) in collaboration with the South West Academic Research Network. This study forms part of a programme of evaluations of service developments under the broad area of Person Centred Integrated Care (PCIC).

Why is this evaluation taking place? To achieve a more person centred and integrated care approach to service delivery a joint bid was submitted to the Department of Health for funds to set up two integrated care hubs within the integrated Pioneer site of South Devon and Torbay. The Newton Abbot Frailty Hub addresses the clinical and social care needs of the older population with complex needs. It is essential that we understand what works and what needs improvement within the Hub to ensure the best possible care is being delivered to patients.

Why have I been asked to take part? You have been sent this information because you have responded with your interest to take part in the evaluation introduced by your care coordinator. As an individual or carer of an individual receiving care from the Hub, your experience is vital in developing our understanding of what works and what does not work in delivering good quality patient care for people within the Frailty Hub.

What do I need to do?

There are 3 ways in which you can take part in the evaluation:

1. **Questionnaires:** If you agree to take part in the evaluation a researcher will contact you to arrange a time to meet to go through some questionnaires about different aspects of the care provided by the Hub and your current situation. The researcher can meet you at a time and location to suit you. This should take no longer than 30 minutes. Questionnaires will need to be completed 3 times: (1) when you start receiving care from the Hub (2) 6 months after receiving care from the Hub (3) 12 months after you start receiving care from the Hub. Everyone who agrees to participate in this evaluation will need to complete the questionnaires.
2. **Interviews:** If you agree to take part in this element of the evaluation, a researcher will contact you to arrange a convenient time and place for a one to one interview. The researcher will ask you some more detailed questions about the care provided by the Hub. This will also be an opportunity for you to be able to highlight anything that you think is important about your experience of this service. You do not have to answer all of the questions and you are free to take

a break at any time. This can coincide with the questionnaire completion if that is convenient for you. You are welcome to bring a carer or friend/family member with you if you wish. If you need to travel you will be reimbursed your travel expenses. The interview should take no longer than 60 minutes and will be digitally recorded with your permission. Interviews will take place 3 times: (1) when you start receiving care from the Hub (2) 6 months after you start receiving care from the Hub and (3) 12 months after you start to receive care from the Hub.

3. **Observations:** In order to understand how the service is being delivered, researchers will be observing some sessions with practitioner and patients. The researcher would sit in on a consultation with you and the practitioner and take notes about the care that is being delivered. If you agree to being involved in this element of the evaluation, we would also ask your practitioner for consent before making any observations.

4.

Do I have to take part? No. Participation is entirely voluntary. You are under no obligation to take part in this evaluation. Even if you consent to participate, you are free to withdraw from the study at any time until the data are analysed (Date to be confirmed). You do not need to provide a reason for withdrawing from the study and neither participation nor withdrawal will have any impact on your relationship with the research team, the SW-AHSN or your care provider. If you withdraw from the study all information provided by you will be destroyed.

Confidentiality and anonymity: Your information will be identifiable through a participant code known only to the research team. No individuals or agencies will be identified in any reports or publications.

How will my information be used? Information gathered from interviews will be used to inform a wider evaluation of the Frailty Hub.

If you have any questions about the project please contact:

Dr Lynne Callaghan

Dr Helen Lloyd

Email: lynne.callaghan@plymouth.ac.uk

Email: helen.lloyd-1@plymouth.ac.uk

Phone : 07807966235

Phone : 07772 475423

Consent Form:

Patient /Carer

Newton Abbot Frailty Hub Evaluation

Researchers: Dr Lynne Callaghan, Dr Helen Lloyd, Ms Jane Horrell

1. I confirm that I have read and understood the information sheet about the above evaluation dated dd/mm/yyyy.
2. I agree to take part in the evaluation and complete questionnaires at each time point specified in the information sheet.
3. I agree to take part in an interview about my perceptions of the care that I receive from the Frailty Hub
4. I understand that the interview will be digitally recorded.
5. I agree for a researcher to observe a consultation with my practitioner.
6. I understand that I am free to withdraw from the study at any time without prejudice and that if I withdraw any information provided by me will be destroyed up until the point of analysis.

Name:

Date:

Signature:

Researcher:

Date:

Signature:

Preferred method of contact: _____

Contact details: _____

Appendix D: Practitioner survey

Person Centred Coordinated Care

– Practitioner Survey

(Modified from the Person-Centred Health Care for Older Adults Survey*)

About this survey

This survey aims to assess staff attitudes and practices in relation to person-centred care/support. **Person-centred care/support** has been defined as "*care/support that is guided by and organised effectively around the needs and preferences of the individual*" (Organisational Change Tool: Horrell, Byng & Lloyd, 2015; p2).

The survey will ask you to rate, on a 5-point scale, your attitudes and practices in relation to the following aspects of person-centred care/support: (1) Getting to know the individual, (2) Finding out goals/needs, (3) Attitudes towards person-centred practice, (4) Involvement in care/support planning, (5) Meeting communication needs, (6) Meeting practical needs, (7) Co-ordinated contact, and (8) Supportive working environment.

It is expected that the survey will take approximately 20 minutes to complete.

Throughout the survey, please tick the box that best corresponds with your opinion.

Service user /patient refer in this survey to clients or patients or families you work with.

Carer refers to parents (in case of children), or any family member or friend who provides care/support for the service user/patient.

Care/support may include personal care; emotional support; care management; help with activities of daily living, such as transport, financial management, shopping, and domestic help. It includes both primary (co-resident) and secondary carers (e.g. family members/friends who do not usually reside with the service user/patient).

1. Involvement in care/support planning

- 1.1 In my work area, service users/patients have an equal say with the rest of the team in the development of the support plan.

_____ _____ _____ _____ _____ _____

never rarely sometimes usually always not applicable

Comments:.....

.....

- 1.2 In my work area, service users/patients and carers have an equal say with the rest of the team in the development of the discharge plan or exit strategy from the service.

_____ _____ _____ _____ _____ _____

never rarely sometimes usually always not applicable

Comment:

.....

- 1.3 My/our support plans are structured around the service user's/patient's goals.

_____ _____ _____ _____ _____ _____

never rarely sometimes usually always not applicable

Comments :

.....

- 1.4 Where I currently work, we provide services in the location that best suits the needs and preferences of the service user/patient and their carers.

_____ _____ _____ _____ _____ _____

never rarely sometimes usually always not applicable

Comments:

.....

2. Finding out goals

2.1 I ask service users/patient what their goals/needs are for their well-being.

never rarely sometimes usually always not applicable

Comments:.....

.....

2.2 I ask the carer/s what their goals/needs are for the well-being of the person they support.

never rarely sometimes usually always not applicable

Comments:.....

.....

3. Your working environment

3.1 I am supported to develop the skills I need to work with the service user/patient and their carers.

never rarely sometimes usually always

Comments:

.....

3.2 Where I am currently working, I have been exposed to good role models in care/support for service users/patients.

never rarely sometimes usually always

Comments:

.....

- 3.3 Expectations of my role and how I treat the service users/patients I support are communicated clearly and consistently.

never rarely sometimes usually always

Comments:

.....

- 3.4 I feel that I work as part of a team with a recognised and valued contribution.

never rarely sometimes usually always

Comments:

.....

- 3.5 The emotional and physical demands of my work are acknowledged and recognised.

never rarely sometimes usually always

Comments:

.....

- 3.6 I feel that I am able to fully use my skills in my work with the service users/patients.

never rarely sometimes usually always

Comments:.....

.....

- 3.7 My work organisation values the care/support I provide to the service users/patients.

never

rarely

sometimes

usually

always

Comments:.....

.....

4. Co-ordinated contact

- 4.1 It is clear to the service user/patient or their carer who their key worker is.

never

rarely

sometimes

usually

always

not applicable

Comments:

.....

- 4.2 The service user/patient and their carer have ready access to a key identified worker (i.e. they are available by phone, messages are returned promptly).

never

rarely

sometimes

usually

always

not applicable

Comments:

.....

- 4.3 Where I currently work, we know how to direct the service user/patient or their carer to the most appropriate service without them having to make another call (single point of contact).

never

rarely

sometimes

usually

always

not applicable

Comments:.....

.....

- 4.4 After the service user/patient is discharged/leaves the service, they receive a follow-up phone call or visit.

never

rarely

sometimes

usually

always

not applicable

Comments:.....

.....

5. Meeting practical needs

- 5.1 Where I currently work, adequate transport and parking are provided to ensure access for service users/patients and their carers.

never

rarely

sometimes

usually

always

not applicable

Comments:.....

.....

- 5.2 Where I currently work, service users'/patients personal privacy is respected.

never

rarely

sometimes

usually

always

Comments:.....

.....

6. Meeting communication needs

- 6.1 I am able to meet the communication needs of the services users/patients and their carers when working with them.

never rarely sometimes usually always not applicable

Comments:

.....

- 6.2 Written materials are provided by my place of work to service users/patients and their carers in a language they can understand.

_____ _____ _____ _____ _____ _____

never rarely sometimes usually always not applicable

Comments:

.....

- 6.3 Information is provided in a variety of ways to ensure all service users/patients and their carers have access (e.g. written, verbal, visual).

_____ _____ _____ _____ _____ _____

never rarely sometimes usually always not applicable

Comments:

.....

7. Attitudes towards person-centred practice

- 7.1 I welcome it when services users/patients and their carers are informed and question or challenge my advice.

_____ _____ _____ _____ _____ _____

never rarely sometimes usually always not applicable

Comments:

.....

- 7.2 The needs and preferences of service users/patients should be central in all services.

_____ _____ _____ _____

never rarely sometimes usually always

Comments:.....

.....

- 7.3 I like working with the service users/patients I support or care for.

never rarely sometimes usually always

Comments:.....

.....

8. Getting to know the individual

- 8.1 It is an important part of my job to get to know my service user/patient (e.g. call them by their preferred name, remember and repeat something they have told me).

never rarely sometimes usually always not applicable

Comments:.....

.....

- 8.2 I give service users and their carers adequate time to talk to me (e.g. to discuss their concerns and their expectations).

never rarely sometimes usually always not applicable

Comments:.....

.....

- 8.3 I seek to find out what is important to service users/patients about their well-being (e.g. mobility, cognitive function, being part of the family, able to go to the gym, safety).

never rarely sometimes usually always not applicable

Comments:.....

9. About you

9.1 What is your current role?

9.2 What setting do you work in?

9.3 Have you identified any barriers or enablers to conducting your role?

Carer Experience Scale

PLEASE TICK ONE BOX FOR EACH GROUP to indicate which statement best describes your current caring situation.

1. Activities outside caring (Socialising, physical activity and spending time on hobbies, leisure or study)

You can do most of the other things you want to do outside caring1

You can do some of the other things you want to do outside caring2

You can do few of the other things you want to do outside caring3

2. Support from family and friends (Personal help in caring and/or emotional support from family, friends, neighbours or work colleagues)

You get a lot of support from family and friends1

You get some support from family and friends2

You get little support from family and friends3

3. Assistance from organisations and the Government (Help from public, private or voluntary groups in terms of benefits, respite and practical information)

You get a lot of assistance from organisations and the Government1

You get some assistance from organisations and the Government2

You get little assistance from organisations and the Government3

4. Fulfilment from caring (Positive feelings from providing care, which may come from: making the person you care for happy, maintaining their dignity, being appreciated, fulfilling your responsibility, gaining new skills or contributing to the care of the person you look after)

You mostly find caring fulfilling1

You sometimes find caring fulfilling2

You rarely find caring fulfilling3

5. Control over the caring (Your ability to influence the overall care of the person you look after)

- You are in control of most aspects of the caring1
You are in control of some aspects of the caring2
You are in control of few aspects of the caring3

6. Getting on with the person you care for (Being able to talk with the person you look after, and discuss things without arguing)

- You mostly get on with the person you care for1
You sometimes get on with the person you care for2
You rarely get on with the person you care for3

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Appendix F: Patient Questionnaires

Patient Activation Measure, 13-Item

If the statement does not apply to you, circle N/A.

1. When all is said and done, I am the person who is responsible for taking care of my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
2. Taking an active role in my own health care is the most important thing that affects my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
3. I am confident I can help prevent or reduce problems associated with my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
4. I know what each of my prescribed medications do	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
5. I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
6. I am confident that I can tell a doctor concerns I have even when he or she does not ask.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
7. I am confident that I can follow through on medical treatments I may need to do at home	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
8. I understand my health problems and what causes them.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
9. I know what treatments are available for my health problems	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
10. I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
11. I know how to prevent problems with my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
12. I am confident I can figure out solutions when new problems arise with my health.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
13. I am confident that I can maintain lifestyle changes, like eating right and exercising, even during times of stress.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A

De Jong Loneliness Scale (Short Version)¹

A very short questionnaire to explore your experiences of loneliness. (Please tick the box that best describes how you have felt lately, i.e. within the last two weeks). Scale:

YES! - Means a definite YES

YES - Means a YES (Most of the time)

MORE OR LESS – means sometimes (it's not more yes or no)

NO - Means a NO (Most of the time)

NO! - Means a definite NO

	STATEMENTS	YES!	YES	MORE OR LESS	NO	NO!
1	I experience a general sense of emptiness					
2	There are plenty of people I can rely on when I have problems					
3	There are many people I can trust completely					
4	I miss having people around					
5	There are enough people I feel close to					
6	I often feel rejected					

*Modified from: Department of Health. 2012. QIPP Long Term Conditions - Supporting the local implementation of the Year of Care Funding Model for people with long-term conditions.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215060/dh_133652.pdf

The Short Warwick-Edinburgh Mental Well-being Scale²

Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last 2 weeks.

	STATEMENTS	NONE OF THE TIME	RARELY	SOME OF THE TIME	OFTEN	ALL OF THE TIME
1	I have been feeling optimistic about the future	1	2	3	4	5
2	I've been feeling useful	1	2	3	4	5
3	I've been feeling relaxed	1	2	3	4	5
4	I've been dealing with problems well	1	2	3	4	5
5	I've been thinking clearly	1	2	3	4	5
6	I've been feeling close to other people	1	2	3	4	5
7	I've been able to make up my own mind about things	1	2	3	4	5

¹De Jong Gierveld & Van Tilburg 2006. A 6-Item Scale for Overall Emotional, and Social Loneliness.

² "Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS)

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Your Experiences of Health and Social Care: The Modified LTC 6 Questionnaire

This questionnaire is about your experience and understanding of the care you have received from your Health and Social Care team in the last

'Care' could be any treatment or support you received in relation to your health and well-being.

In the last, who did you receive care from? [Please tick all that apply to you]

GP	<input type="checkbox"/>	Nurse (community, practice)	<input type="checkbox"/>
Social Services	<input type="checkbox"/>	Mental Health Services	<input type="checkbox"/>
Hospital as an inpatient (i.e. admitted overnight)	<input type="checkbox"/>	Hospital as an outpatient (i.e. day visit)	<input type="checkbox"/>
Allied Health Services (e.g. Physiotherapy)	<input type="checkbox"/>	Agency Support Services (e.g. Care services)	<input type="checkbox"/>
Voluntary services (e.g. Age UK)	<input type="checkbox"/>	Others – please specify	<input type="checkbox"/>

For the questions that follow, please provide a response based on your overall experience if you have received care from more than one service.

Please use the comments section of each question to describe any stand out experiences in relation to the question.

1. Did you discuss what was most important for YOU in managing your own health and well-being?

Not at all	<input type="checkbox"/>	Comments:
To some extent	<input type="checkbox"/>	
More often than not	<input type="checkbox"/>	
Always	<input type="checkbox"/>	

2. Were you involved as much as you wanted to be in decisions about your care?

Not at all	<input type="checkbox"/>	Comments:
To some extent	<input type="checkbox"/>	
More often than not	<input type="checkbox"/>	
Always	<input type="checkbox"/>	

3. Were you considered as a ‘whole person’ rather than just a disease/condition in relation to your care?

Not at all		Comments:
To some extent		
More often than not		
Always		

4. Were your family/friends/carers involved as much as you wanted them to be in decisions about your care?

Not at all		Comments:
To some extent		
More often than not		
Always		
I did not want my family/friends/carers involved		
I have no family/friends/carers		

5. Were there times when you had to repeat information that should have been in your care records?

Not at all		Comments:
To some extent		
More often than not		
Always		

6. To what extent is your care joined up in a way that is working for you?

Not at all		Comments:
To some extent		
More often than not		
Always		

7. Do you have a single named person to coordinate your care?

Yes		Comments:
No		
Don't know		

8a. Do you have a care plan (or single plan of care) that takes into account all your health and well-being needs?

Yes <i>Please answer questions 8b, 8c and 8d</i>		Comments:
No <i>Go to question 9</i>		
Don't know <i>Go to question 9</i>		

8b. Is this care plan (or plan of care) available to you?

Yes		Comments:
No		
Don't know		

8c. To what extent have you found your care plan (or plan of care) USEFUL FOR YOU to manage your health and well-being?

Not at all		Comments:
To some extent		
More often than not		
Always		
Don't know		

8d. To what extent do all the professionals involved in your care appear to be following the same care plan (or plan of care)?

Not at all		Comments:
To some extent		
More often than not		
Always		
Don't know		

9. Have you had enough support from your care team to help YOU to manage your own health and well-being?

I have had no support		Comments:
I have not had enough support		
I have sometimes felt supported		
I have always felt supported		

--	--	--

10. To what extent do you receive useful information at the time you need it to help you manage your health and well-being?

I do not receive any information		Comments:
I rarely receive enough information		
I sometimes receive enough information		
I always receive enough information		
I receive too much information		

11. How confident are you that you can manage your own health and well-being?

Not at all confident		Comments:
Not too confident		
Somewhat confident		
Very confident		

How could your care be improved?

What would support you to feel more confident?

Any other comments:

Thank you very much for completing this questionnaire.

Appendix G: Patient qualitative Topic Guides

Baseline patient interview schedule

Frailty Hub

- Introduce who you are and reason for talking to them
- Gain consent

Introductory question:

- Could you tell me a little about the people/professionals that are regularly involved in your care/support you in your care. (GP, Care workers, Nurses, OTs, Social workers etc.)

Linking question:

- What do you consider are your main needs in terms of your health and social care?
- What events have led to you needing more support?
- We would now like to move on to ask you some questions about your most recent episode of care (add in date of referral to hub for orientation).....

Core questions/topics:

Patient experience:

- Could you tell me about your first visit from the [member of staff from FH]
 - What happened during that visit?
 - Was the purpose of that visit explained to you? Did you know why it was taking place?
 - Did you feel that you were listened to?
- Was this different to the care you were receiving before? If so how...
 - What has been helpful about this care?
 - Can you give me an example/s?
 - Have any aspects been unhelpful/ difficult?
 - Can you give me an example/s?

Support for self-management, decision making and care planning

- Are you aware of a plan for your care?
 - Have you seen a plan? If no, would you like to see it?
 - Were you asked about what you would like to be included in the plan?
- Is there one person that you contact if you have any questions about your care?
- Could you tell me about the ways you feel involved in making decisions about your care?
 - Is there anything you would change?

- Have you ever had a time of crisis?
 - Can you tell me about this time?
 - Did you know who to contact?

Goals/ outcomes:

- Were you asked about what you wanted in terms of your care?
 - Do you feel in control of your care?
- Do you think your carer has been offered support?
 - Can you give an example?
- Do you think your carer has been given the opportunity to be actively involved in your care?
 - Can you give an example?

Information & Communication/ continuity of care

- Do you have to tell your story over and over again to all the practitioners involved in your care?
- Can you tell me about a time when you felt professionals had shared information about you that helped improve your care?

Closing question:

- Is there anything that you would like to add that has not been covered in our discussion?

Thank you for your help.

Please check that the participant is okay

Appendix H: Staff qualitative Topic Guides

Baseline staff interview schedule

Thank you for agreeing to take part in the interview

I would just like to start with some introductory questions if that's ok

- Could you tell me about your role?
- So your role is Can you give me a brief outline of what you do within the service/intervention?
- What do you think of the intervention?
- What is your experience of being part of it?
- What does' person centred coordinated care' mean to you?

Processes and barriers/blocks within the intervention

- Could you describe to me the processes of the intervention?
 - PROMPT: If not already mentioned, ask about discharge decisions/ procedures
- What you do see is the aim of the intervention?
 - PROMPT: If not already mentioned, ask about the balance between providing proactive/ crisis care
- Could you give me an example of any barriers or blocks which might impede that process?
- Do you feel the process actively supports the person/patient to be involved within their own plan of care?
- Do people/patients have a care plan document that they can access/hold?
- Could you tell me a little about how partner organisations work with the service?
 - Are there any difficulties with partnership working?
- Do you have regular MDT meetings?
 - If yes, what do you think about the value of the MDT meetings in supporting the running of the hub?
- Do you think the MDT meetings should include any other people/services? If so who and why do you think this is not happening?
-

Working with a patient's/person's complex needs

- Can you briefly talk me through a person's journey after being referred to the service, what typically happens to them?

- To what extent do you think the service works proactively with the patients to achieve their goals?
- Could you explain how the patient/person is referred into the hub?
- Does the current referral system capture everyone who needs to be referred to the hub?
- Would you like anything to be changed within the referral system? If so what and why?
- What is your perspective about the way in which the hub tracks patients whilst in hospital and supports patients in discharge?
- In what respects do you think the intervention/hub is working that is different than before the hub appeared?
- In what ways do you feel the hub aids peoples complex care needs?
- In what ways do you think patients/people's requests are taking into account about their own care?
- What do you feel is the importance of the carer's involvement in the patient's/person's care plan or plan of care?
- In what respects do you feel the patients/people play a part in goal setting?
- Can you give me an example of continuity of care for a patient?

The satisfaction level of staff member

- Are you happier in your job within the hub?
- Do you feel a higher level of job satisfaction in this way of working?
- Could you explain in what respects this role as increased/decreased your job fulfilment
- Can you suggest any ways in which the intervention could be improved?

Are there any questions about the interview you would like to ask me?

Appendix I: Referral practices qualitative Topic Guides

Baseline referral staff interview schedule

I am *****, I am part of the PU team evaluating the NA (frailty hub), we are working closely with the hub as they develop and are really interested in your experiences in relation to working with them.

Thank you for agreeing to take part in the interview

I would just like to start with some introductory questions if that's ok

Could you tell me about your role?

So your role is Can you give me a brief outline of what you do in relation to the hub?

What do you think of the intervention?

What is your experience of being part of it?

Can I ask, what does person centred coordinated care' mean to you?

Processes and barriers/blocks within the intervention

Could you describe to me the processes of referral into the hub?

What you do see is the aim of the intervention?

Could you give me an example of any barriers or blocks which might impede that process?

Do people/patients have a care plan document that they can access/hold and that is shared across yourselves and the frailty hub?

Are you aware that the hub holds regular MDT meetings?

If yes, have you attended?

If no, what are your thoughts about attending the MDT?

If yes, can you tell us about your experience of attending?

Do you think the MDT meetings should include any other people/services? If so who and why do you think this is not happening?

The amount of referrals from the GP practices seem to have reduced, why do you think this might be?

In what ways do you work with the hub to provide joined up care?

Are there any difficulties with partnership working?

Could you describe if and how the care you provide to patients discharged from the hub is different to the care they received before referral?

Working with a patient's/person's complex needs

Can you briefly talk me through a person's journey into being referred to the service, what typically happens to them?

Does the current referral system capture everyone who needs to be referred to the hub?

Would you like anything to be changed within the referral system? If so what and why?

Are you aware about the ways in which the hub tracks patients whilst in hospital and supports patients in discharge?

Could you give me an example please?

The satisfaction level of staff member

Do you feel a higher level of job satisfaction in this way of working?

Could you explain in what respects this role as increased/decreased your job fulfilment

Can you suggest any ways in which the intervention could be improved?

Is there any questions about the interview you would like to ask me?

Thank you once again for agreeing to take part in the interview