



Kent Academic Repository

MacInnes, Julie, Jaswal, Sabrena K., Mikelyte, Rasa and Billings, Jenny R. (2018) *Service Evaluation of the Acute Response Team (ART)*. CHSS: Canterbury (Unpublished)

Downloaded from

<https://kar.kent.ac.uk/71421/> The University of Kent's Academic Repository KAR

The version of record is available from

This document version

Publisher pdf

DOI for this version

Licence for this version

UNSPECIFIED

Additional information

Versions of research works

Versions of Record

If this version is the version of record, it is the same as the published version available on the publisher's web site. Cite as the published version.

Author Accepted Manuscripts

If this document is identified as the Author Accepted Manuscript it is the version after peer review but before type setting, copy editing or publisher branding. Cite as Surname, Initial. (Year) 'Title of article'. To be published in *Title of Journal*, Volume and issue numbers [peer-reviewed accepted version]. Available at: DOI or URL (Accessed: date).

Enquiries

If you have questions about this document contact ResearchSupport@kent.ac.uk. Please include the URL of the record in KAR. If you believe that your, or a third party's rights have been compromised through this document please see our [Take Down policy](https://www.kent.ac.uk/guides/kar-the-kent-academic-repository#policies) (available from <https://www.kent.ac.uk/guides/kar-the-kent-academic-repository#policies>).

Julie MacInnes, Sabrena Jaswal,
Rasa Mikelyte and Jenny Billings

SERVICE EVALUATION OF THE THANET ACUTE RESPONSE TEAM (ART)

Report: December 2018



Centre for Health Services Studies (CHSS), University of
Kent, George Allen Wing, Canterbury, CT2 7NF

CHSS
University of Kent

TABLE OF CONTENTS

<i>Acknowledgements</i>	3
1. Executive Summary	4
2. Introduction	9
2.1 Background and Rationale	9
2.2 Centre for Health Services Studies (CHSS), University of Kent.....	10
2.3 Evaluation Aims.....	11
3. Methods	12
3.1 The Evaluation Design	12
3.2 Analysis	14
3.3 Evaluation Timescale	15
3.4 Management and Governance	15
3.5 Ethical Considerations	15
4. Results	15
4.1 User and Carer Characteristics.....	16
4.2 P3CEQ Survey results.....	18
4.3 Staff Characteristics.....	19
4.4 User and Carer Experiences	19
4.5 Staff Experiences	36
5. Recommendations	53
6. Evaluation Challenges and Limitations	55
7. Conclusions	56
8. References	57
9. Appendices	58

List of Tables and Figures

Table 1	Evaluation timescale
Table 2	Summary of data sources and sample sizes
Table 3	Age and living situation of users
Table 4	Age and living situation of carers
Table 5	Medical conditions of users
Table 6	Scores for individual items on the P3CEQ
Table 7	Professional groups of participants
Figure 1	Gender of users
Figure 2	Gender of carers
Figure 3	Carers relationship to users
Figure 4	Place of first contact with the ART

Acknowledgements

The University of Kent have enjoyed working with the Acute Response Team (ART) service and being part of the evaluation. We are particularly indebted to **Ged Timson** (ART and IACO Delivery Lead, Thanet Clinical Commissioning Group), **Nicola Davies** (Senior Clinical Decision Maker, ART, Kent Community Health NHS Foundation Trust) and **Sarah Wolf** (Senior Clinical Decision Maker, ART, Kent Community Health NHS Foundation Trust) who gave us valuable insights into the ART. Also Mary Dutton (ART, Kent Community Health NHS Foundation Trust) and **all members of ART** for their support in recruiting participants. Thanks also to the steering group, **Sheena Healy** (Locality Organiser, Kent Enablement at Home, Kent County Council), **Claire Young** (Team Manager, Thanet Adult Community Team, Kent County Council), **Eryl George** (County Service Manager Social Work, Older Persons and Physical Disability, Kent County Council), **Julie Jones**, (Senior Practitioner, Thanet Adult Community Team, Kent County Council) and **Alison Mills** (Project Manager, Design and Learning Centre Programme Team, Kent County Council) for their ongoing support and direction. Finally, **Anne Tidmarsh** (Director of Older People and Physical Disability, Kent County Council), for initiating this evaluation.

Above all, we like to express our sincere thanks to the **service users, carers and professionals** who took the time to take part.

I. Executive Summary

Introduction and Aims of the Evaluation

This report details the findings of a service evaluation of the Acute Response Team (ART), in Thanet. The ART service was developed in November 2016, piloted until March 2017 and continues to be commissioned. Key drivers for the implementation of the ART were that patients were not always seen by the most appropriate practitioner in the most appropriate place. Some patients were being admitted to hospital who could have been cared for in their own home and some patients were taken to hospital by the ambulance service because there was no alternative option. The primary aims of the ART service are to enhance the level of integration of a range of primary, community and acute services specifically to ensure a more timely and appropriate service response for patients who are in the community and at risk of attendance or admission to hospital, and patients who have arrived in the Emergency Department (ED) and could be cared for in the community.

An internal evaluation in 2017 revealed a significant impact on hospital admissions and an associated reduction in costs. To supplement this largely quantitative data, there was an identified need to investigate patient outcomes and perceptions, and assess staff experiences and perceptions of the impact of the ART. Therefore, the aims of this independent evaluation were:

- 1) To investigate the extent to which the ART has impacted upon the patient experience with respect to person-centred care, co-ordinated care, and wellness.
- 2) To explore the experiences and perceptions of a wide range of professionals and managers of the ART service and external stakeholders, including aspects of communication, roles and relationships, co-ordinated and person-centred care, the nature of impacts and effectiveness, and sustainability.

Methods

The overall evaluation design was a mixed methodology using predominantly qualitative but also quantitative methods. To determine the experiences and impact of the ART on users and carers, semi-structured interviews were carried with users (N=16) and carers (N=13). In addition, users completed the P3CEQ (N=21), which is a questionnaire measuring the degree to which care is perceived to be person-centred and co-ordinated. To determine the perceptions of the ART and external stakeholders on the processes of care and outcomes of the service, two focus groups (N=16) and individual interviews (N=5) were carried out. External stakeholders included GPs, paramedics, hospital consultants, CCG employees, care agency staff and members of the KEaH team. Quantitative data were analysed using descriptive statistics. Qualitative data were analysed thematically.

Results

The following results relate to the two main aims of the evaluation.

- 1) The extent to which the ART has impacted upon the patient experience with respect to person-centred care, co-ordinated care, and wellness

Strengths

- The **overall impressions** of the ART were overwhelmingly positive from both users and carers with individuals feeling fortunate to have received the service.
- Users were satisfied with the **time from referral into the service** and first contact with a member of the ART, with most receiving care within one to two days.
- The **high level of skill** of the ART team was commented upon.
- The **support of carers** was highly valued in terms of practical support and information, reassurance and being involved in decision-making.
- Carers unanimously reported **knowing who to contact and how to contact them** and valued the accessibility and responsiveness of the team.
- Overwhelming, a **person-centred approach to care** was described by both users and carers. Users felt they were listened to and treated with respect throughout the care process. Carers felt the person they cared for were treated with friendliness, respect and patience, especially those with dementia.
- There was a perception by both users and carers that the **ART worked together collaboratively**, for the benefit of the user with information being shared between the team.
- Carers were very positive about the **consistency of information** they received from the ART.
- Most users experienced **smooth transitions in care**, with information shared with relevant providers.
- Some users felt their **physical and emotional health** was improved as a result of the ART service.

Areas for further consideration

- Occasionally, there was **some miscommunication around referrals** where the ART did not arrive at the time they were expected or users and carers were unaware that they had been referred to the ART.
- The **time the ART spent with users** was generally felt to be brief. For some, this was seen as efficient, although there may also be a suggestion that some users felt the care could be rushed.
- In general, those users who received predominantly nursing and medical input received ART input for a short period of time (5 days or under), while those also receiving personal care (such as assistance with washing and dressing) were likely to be part of **the ART caseload** for several weeks. Interestingly, those that received ART for just a few days would have liked input for longer.
- Users and carers felt that there was **some lack of communication with primary care**, at times, with GPs and practice nurses not always being aware that the user was being cared for by the ART.
- Users and carers reported **delays in receiving new services** or needing to follow-up services themselves.
- Occasionally, services **ceased their input following their initial assessment**. For example, in terms of enablement the user may have either improved and no longer needed the service or had deteriorated more than expected and so enablement was no longer appropriate.
- **Suggestions for improving the service** centred around communication including the need to explain the purpose of the ART service, that it was time-limited, and that care would be 'handed back' to usual care providers.
- Some users felt their **physical and emotional health** was improved as a result of the ART service. However, there was a recognition that this improvement was, at times, limited in the presence of long-term conditions.
- **Action planning** and preparing for setbacks in the future was less apparent with few reporting this. However, as this was not an aim of the ART service, this was not an unexpected finding.

2) To explore the experiences and perceptions of a wide range of professionals and managers of the ART service and external stakeholders, including aspects of communication, roles and relationships, co-ordinated and person-centred care, the nature of impacts and effectiveness, and sustainability

Strengths

- The **purpose of the ART** as described by external agencies, was generally consistent and described as a service which could support people at home with acute and complex health needs, prevent hospital admissions, and provide a smooth transition between hospital and home at discharge.
- A number of **facilitating factors** were identified in setting up the ART service; that the core team developed from an existing service (Rapid Response), enabled the team to be involved in the development of the service; financial support from the CCG was essential as was the engagement and support from other service providers.
- **Care co-ordination and information sharing** with the ART was highly effective and facilitated by frequent handovers.
- All staff within the ART were **valued for their contribution to the team** and listened to.
- **Skill-mix** within the team was also highly valued.
- **Benefits for the ART staff** included access to training and education, skills development, and increased levels of responsibility, especially for support staff.
- The development of **trusted, personal relationships** between members of the ART team and other service providers was key to successful team working and care co-ordination. Ways in which information was shared were various, but the value of personal communication and feedback was of paramount importance.
- Working closely with other health and social care professionals led to greater understanding of each other **roles and responsibilities**.
- For **social care**, the involvement of the ART led to more rapid enablement primarily due to the input of the ART therapists and the provision of equipment provided by the ART.
- **Active ingredients for success** related to the personal qualities and skills of the staff involved and effective multi-professional team working.

Areas for further consideration

- **Early challenges to implementation** were around referrals from primary care, ambiguity around roles and responsibilities, the anticipated nature of the work and lack of input from some services.
- The number of **referrals into the ART** was seen as sub-optimal. This was a perception both within the ART service and external agencies. The main reason for this was lack of awareness about the existence of the service, as well as specific challenges for different providers.
- There was a recognition within the ART service that a **re-launch or education** was needed for referrers.
- There were challenges around **transitions out of the ART** which again, were different for different providers, including lack of capacity in social care and replication in the process of referrals.
- **Lack of capacity** was identified within the ART due to lack of staff and patient turnover. Lack of capacity in the wider health and social care economy, particularly social services was a significant factor influencing the turnover of patients within ART, impacting on their ability to take new referrals. The medical needs of some users also meant they some needed to stay in the service for longer than 5 days.
- **Digital information sharing** was problematic due to a lack of a shared IT system, although this was believed to be improving.
- There was a desire among the ART to **expand the service** in terms of taking referrals from care homes and expanding the type of patients served by ART, particularly patients with frailty and more complex health and social care needs. Increasing the hours the ART was available was also an ambition.

- There was also an ambition amongst the ART and external service providers to **increase the geographical area** of the ART, although this would require additional resources.
- **Suggestions for improving the service** included access to GP beds, formalisation of procedures and protocols, a single referral system into social services, and into the ART.
- Going forward, increasing the **establishment of staff and succession planning** were seen as important.

Recommendations

A number of recommendations are made in relation to the evaluation aims:

1. Recommendations for Users and Carers

a) Improve communication and information giving. Clearer communication is needed by those referring into the service and the ART themselves so that users and carers are aware they will be receipt of the service. The ART should explore with users what information is to be shared with carers who do not live with the user, and how this might best be achieved, for example, telephone calls or written information left with the user at home, if requested. More effective communication is needed about the rapid and time-limited nature of the service. Clarity is needed about the nature of some ongoing services, such as enablement which are not part of a 'rapid response' service.

b) Prepare for discharge. A greater emphasis on communication around action planning, preparing for setbacks in the future and self-management support might be considered.

2. Recommendations for Service Delivery

a) Maximise referral rates. The development of an effective information strategy is needed to disseminate knowledge about the service to organisations who refer into the ART. This may include face-to-face meetings or written information, targeted at different organisations. GPs and the Ambulance Service would benefit from feedback on the impact the service has on patients. Consider concentrating on specific referral sources that have the greatest potential for impact. Monitor referrals from care homes to assess the impact on overall referral rates.

b) Ensure smooth transitions to other service providers. Streamline the process of referral to social services so that a single referral from the ART is passed on to the appropriate team.

c) A shared IT system. Implement access to EMIS and normalise its use to facilitate information sharing.

3. Recommendations for Sustainability, Scale and Spread

a) Invest in staff. There is a need to continue to develop the skills of staff and plan for succession, especially for those in key leadership roles. If the service is to expand, investment in additional staff and other resources will be necessary.

b) Formalise policies and operating procedures. To ensure sustainability, policies and procedures should to be developed, agreed and documented so that all staff work in a consistent and safe way. In addition, a clear governance structure needs to be established with all provider organisations.

c) Focus on key aims and outcomes. Articulate the primary purpose of the service and develop a shared vision going forward. To realise the ambition of scale and spread, there needs to be buy-in from other CCGs and all relevant service providers.

Evaluation challenges and limitations

The main challenges to the evaluation were the recruitment of users and professionals and the administration of the P3CEQ. Recruitment of users was more difficult and took longer than anticipated. The reasons for this were various but included the fact that users in receipt of the service were generally elderly, frail and unwell, with some only recently discharged from hospital. This made it less likely that they would want to participate. As a result, the sample consisted of a greater proportion of informal carers than expected. In addition, recruitment took place at the point of discharge from ART, which was also challenging given that many users remained in receipt of the ART service beyond 5 days and often for many weeks, as described in the findings of this report. This made the turnover of users lower than anticipated. As a result, the decision was made to include some users who had not yet been discharged from the service which in hindsight, added to the richness of the data as the sample then included those with more complex health needs and those in receipt of personal care. The recruitment of professionals external to the ART was also challenging, and was likely due to heavy workloads. As a result some professional groups and organisations were not represented. Most notably, there was no representation from staff based in the ED which was unfortunate given the pivotal role this department plays in referrals to the ART.

During administration of the P3CEQ, two other surveys were also taking place. This meant that users were being asked to complete three different questionnaires all evaluating the service. This was overly burdensome and confusing for users. The small sample size meant that limited sub-group analysis of the P3CEQ could be carried out with only a total mean score and scores for individual items being calculated. Qualitative data from the P3CEQ data was used to supplement the interview data on the themes of person-centred and co-ordinated care.

Conclusions

In conclusion, this evaluation has considered the extent to which the ART has impacted upon the patient experience with respect to person-centred, co-ordinated care, and wellness. The ART delivers a high standard of care which is valued by users and carers alike. Users are treated with dignity and respect and carers are supported emotionally and practically. There is good collaboration and care co-ordination within the ART and with other service providers. Although users experience an improvement in their health and wellbeing in the short term, for many this is within the context of deteriorating long-term conditions. The evaluation has also explored the experiences and perceptions of professionals and managers of the ART service and external stakeholders. Personal relationships are key and facilitate effective communication. There is a unique understanding of each others roles and responsibilities which enhances integrated working. There is effective leadership and a team climate of trust, respect and shared decision-making. As a result, the ART has a number of key ingredients in place for successful integrated intermediate care, going forward. Although, some improvements to the service are recommended, overall the ART is well-placed to deliver a service which is both sustainable and transferable, given adequate resources.

2. Introduction

2.1 Background and Rationale

The Integrated Acute Response Team (ART) was developed with local stakeholders building on the work of the Primary Care Homes in Thanet. The service was piloted between 14th November 2016 and 31st March 2017. Following an internal evaluation, the service continues to be commissioned (Timson et al, 2017).

Key drivers for the implementation of the ART were that patients were not always seen by the most appropriate practitioner in the most appropriate place. Some patients were being admitted to hospital who could have been cared for in their own home and some patients were taken to hospital by the ambulance service because there was no alternative option (Thanet ART pilot proposal, 2016).

The primary aims of the ART service (Thanet ART pilot proposal, 2016), are to enhance the level of integration of a range of services including Primary Care, Rapid Response, Intermediate Care Team (ICT), South East Coast Ambulance Service (SECAmb), Age UK Thanet, Kent Enablement at Home (KEaH), East Kent Hospitals University Foundation Trust (EKHUFT), Pharmacy, Integrated Discharge Team (IDT) and the Acute Medical Model, to ensure a more timely and appropriate service response for:

- (i) Those patients who are in the community and at risk of attendance/admission to hospital
- (ii) Those patients who have arrived in the ED and could be cared for in the community

The clinical criteria for referral into the ART (Thanet ART pilot proposal, 2016), are:

- Exacerbation of long term conditions - COPD, Asthma, Heart Failure
- Exacerbation of neurological conditions or any long term condition making patient more frail – e.g. MS, Motor Neurone Disease
- Worsening Frailty – needing more support for a short period of time.
- End of Life Care – crisis management
- Infections – excluding sepsis
- Recent onset of recurrent falls
- Poor mobility /unable to cope at home due to medical condition

Exception criteria are:

- Acute abdominal pain
- Chest pains
- Medically unstable or time critical patients
- Mental health patients in crisis
- Obstetrics
- Paediatrics

The Operational Model (Timson et al, 2017):

- All referrals to the ART are made direct to the Senior Clinical Decision Maker via a single telephone number, or face-to-face in the Emergency Department (ED) and Clinical Decision Unit (CDU).
- SECamb have direct access to the Senior Clinical Decision Maker via a pager system.
- The ART has two bases, one at QEQM which is adjacent to the ED, and one in the community at Westbrook House. Integrated health and social care support is provided by the ART. In addition to the clinical team, Age UK Thanet, and All Seasons (domiciliary care) provide personal and social care support.
- A package of care and support is put in place for a maximum period of 5 days. Any ongoing needs for support are met by mainstream services.

An internal evaluation of the ART pilot (Timson et al, 2017), revealed:

- The cost of providing the ART for the four and half months from 14th November 2016 to 31st March 2017 was £0.13m. The expected annual cost of the ART for an entire year was forecast to be £0.47m.
- The reduction in Health Care of Older People category (HCOOP), non-elective (NEL) admissions, for patients aged over 70 years, for the 4 and half month period was forecast to be in the range of 153 and 260, which at a rate of £1,527 per episode of care, equates to cost avoidance of between £0.23m and £0.4m.
- The net savings for the four and a half month period were forecast to be in the range between £0.1m and £0.27m. The annual forecast savings for HCOOP NEL admissions for patients over 70 years old could be expected, for Thanet CCG, to be in the range between £0.15m and £0.59m.
- If the ART continues to follow the same pattern, then it may be possible to close between 2 and 4 beds at QEQM.
- As the pilot progressed, since November 2016, the ratio of community referrals to ED/Acute referrals was increased.
- The level of GP activity during the morning QEQM sessions was contingent on the level of referrals from the ED and CDU during that session, and the number of requests for home visits and referrals from SECamb. The level of activity was therefore variable and there are times when the potential GP input was underutilised.
- There was a clear need to define the management and leadership of the GP workforce.
- The ART would benefit from utilising an integrated electronic patient care record.
- There was a need to extend the multidisciplinary educational sessions to include the ED/CDU clinicians.

Given the predominantly quantitative evaluation that has already taken place to date, there was a need to investigate patient outcomes and perceptions, and assess staff experiences and perceptions of the impact of the ART on a range of factors. This information will provide an in-depth and objective analysis of what is working well and what aspects warrant improvement going forward. This one-year evaluation of the ART service was funded by the East Kent Partnership Consortium.

2.2 Centre for Health Services Studies (CHSS), University of Kent

The Centre for Health Services Studies (CHSS) is a well-established and thriving international centre of excellence for health service research and research training. It is one of three major research units within the School of Social Policy, Sociology and Social Research. The centre has a wide range of research and disciplinary experience. It undertakes commissioned research and has a large portfolio of competitively funded studies. CHSS has specialist groups for its research including health psychology, integrated care, health economics, public health, clinical trials, and addictive behaviours.

2.3 Evaluation Aims

The aims of this evaluation were:

1. To conduct an investigation of the extent to which ART has impacted upon the patient experience with respect to person-centred care, co-ordinated care, and wellness.
2. To undertake an exploration of the experiences and perceptions of a wide range of professionals and managers of the ART service and external stakeholders, including aspects such as communication, roles and relationships, co-ordinated and person-centred care, the nature of impacts and effectiveness, and sustainability.

3. Methods

3.1 The Evaluation Design

The evaluation was formative (assessing processes) and summative (measuring outcomes) of the ART service over a one year period from October 2017 to September 2018. It focused on understanding the impact of the ART on patients, carers, staff delivering the service, staff referring to the service, managers, commissioners, GPs and other key informants as identified by the steering group. The approach was a mixed methodology using both qualitative and quantitative methods. Data sources consisted of demographic questionnaires, the P3CEQ (Sugavanam et al, 2016), interviews with patients and carers, and focus groups and interviews with staff. The evaluation aimed to create a better understanding of the outcomes for patients, and the processes and ‘success factors’ of implementation, as well as reporting on areas for improvement.

The methods of each aim of the evaluation are now discussed:

I. An investigation of the extent to which ART has impacted upon the patient experience with respect to person-centred care, co-ordinated care, and wellness

This consists of quantitative (questionnaires) and qualitative (interviews) methods.

(i) Questionnaires

Patient demographic information was collected in relation to age, gender, the nature of any long-term conditions, and where the patient received initial contact with the ART, namely the ED at QEQM, Westbrook House or in a home setting.

The Person-Centred Co-ordinated Care Experiences Questionnaire (P3CEQ) (Sugavanam, 2016) was used (*Appendix 1*). Each item on the original 17-point questionnaire was discussed with the ART steering group. As a result of this process, 6 individual items were omitted, largely those related to long-term care planning which were not perceived to be relevant in terms of the ART service, which is time-limited. The final P3CEQ consisted of 11 items scored on 4 or 5-point response scales, and three open-ended questions to elicit a broader picture of patients’ opinions on how the service could be improved. Three additional questions were included which captured information about whether services new to the patient were accessed either as part of the ART or in transitioning to mainstream services.

A total population sample of eligible patients fulfilling the inclusion criteria were targeted. It was anticipated that approximately 80 questionnaires could be completed over the eight month data collection period. The questionnaires were completed either over the telephone or face-to-face depending on the preference of the participant, and audio-recorded with permission.

(ii) Interviews

Following the administration of the questionnaires, participants were invited by the researchers to take part in a follow-up interview up to a week later. The aim was to recruit 30 patients with a diverse range of conditions and demographic characteristics. The interview explored overall experiences of care, the extent to which needs were identified and met in an holistic way, participation in care, quality of care, the extent to which care was co-ordinated, effects on health and wellbeing, comparisons with previous service contacts, maintaining independence at home, crisis avoidance and illness prevention, and care transitions following discharge from ART (*Appendix 2*).

If patients were too unwell, frail or lacked capacity to give informed consent, interviews were carried out with family members or informal carers in order to gain their perception of the service (*Appendix 3*). Demographic data was also collected from carers.

Interviews were carried out either over the telephone or face-to-face depending on the preference of the participant and audio-recorded with permission.

The clinical inclusion and exception criteria for ART (see page 9) were applied. Further criteria were added in terms of eligibility to take part in the evaluation:

(iii) The inclusion and exclusion criteria

- The patient/carer was cognitively able to participate
- The patient/carer was able to understand and converse in fluent English
- The patient was based at home (their own home, in care facilities, or sheltered housing)

(iv) Recruitment

All patients fulfilling the inclusion criteria, or their carers were told about the research and given an information sheet by an ART professional at the point of discharge from the service. If they were willing to take part, their contact details were passed to the research team securely using an expression of interest form. Participants were then contacted directly by a researcher to arrange a suitable time to complete the questionnaires or interview.

2. An exploration of the experiences and perceptions of professionals and managers of the ART service and external stakeholders

This evaluation was qualitative in nature, using focus groups and interviews, in order to fully explore the processes that appeared successful and those that warranted improvement.

(i) Focus groups

Two focus groups were conducted. A total population sample of the ART and a focus group with social care managers and team leads from adult social care and the enablement team. It was requested by the steering group that the focus groups were carried out separately as there was loose integration between the two teams

so separate perspectives would be more informative to the evaluation. The focus groups explored key themes such as how communication worked, roles and relationships including trust, co-ordinated and person-centred care, what quality care looked like, the nature of impacts on patients and the service, and the effectiveness and sustainability of service delivery (*Appendix 4*). The focus groups took place at the workplace and were audio-recorded, with permission.

(ii) Interviews

Individual staff interviews were conducted with key stakeholders, external to the service, as identified by the steering group. The purpose was to explore a range of perceptions about the impact of the service to provide depth of data. Topic areas mirrored the main themes of the focus groups (*Appendix 5*). The interviews were conducted over the telephone and audio-recorded, with permission.

(iii) Recruitment

Participant information sheets were sent to members of the ART and social care team. The focus groups were arranged by the individual teams. The contact details of external stakeholders for individual interviews were provided by the ART and members of the steering group and the research team contacted individuals directly. Participant information sheets were sent to the external stakeholders.

3.2 Analysis

Demographic characteristics were analysed using descriptive statistics of means, standard deviations and percentages. The mean total score, range and standard deviation on the P3CEQ were calculated. Quantitative data analysis was carried out using SPSS v 24.

The audio-recordings of interviews and focus groups were transcribed and analysed thematically using Flick's (1998) approach. This required bringing predetermined templates to the data, in this case the interview and focus group schedules. Quotes were sorted into categories and coded according to the origin of the quotes. Each category was then analysed into themes using the quotes to justify interpretation. The qualitative data analysis software, NVivo 11, was used to facilitate this process. Data from users, carers and professionals were analysed separately. Users, carers and professionals were assigned a unique identification number, with 'U' representing a user, 'C' representing a carer and 'P' representing a professional. Individual members of the focus groups were not identified individually, rather 'FG1' represented the focus group consisting of ART team members and 'FG2' represented the KEaH focus group. Qualitative data obtained from the open questions on the P3CEQ were added to the analysis.

4. Results

3.3 Evaluation Timescale

Table 1: Evaluation Timescale

Activity	Month
Development and co-design of the evaluation framework; University ethics approval; Setting up the management and monitoring function; Development of dissemination methods.	October – December 2017
Questionnaire distribution and recruitment for interviews; Contemporaneous data collection and analysis; Monitoring meetings two monthly with briefing reports on progress and findings.	January-August 2018
Completion of data collection and analysis; Co-production of recommendations; Write and deliver report.	August - November 2018

3.4 Management and Governance

Dr. Julie MacInnes and Professor Jenny Billings was responsible for the management of the evaluation. A research steering group was set up to support, advise and monitor progress. This consisted of the research team, a CCG representative, ART members and social care leads. Meetings took place approximately every 2 months either face-to-face or by telephone with individual team members. Terms of reference were co-produced and agreed with the steering group.

3.5 Ethical Considerations

Ethical approval was gained from the University Research Ethics Committee, School of Sociology, Social Policy and Social Research (SRCEA 195). Ethical principles of anonymity, confidentiality, and non-maleficence were adhered to. All data relating to participants was anonymised using an identification coding system that only the research team had access to. Although the ART is identifiable as it is unique in the local area, individuals within it cannot be identified. Informed consent was gained at the point of data collection. For those taking part in the focus groups or face-to-face interviews, written consent was obtained. For those taking part in telephone interviews, consent was verbal and audio-recorded. Data was collected and stored according to GDPR regulations and will be destroyed after 5 years.

Table 2: Summary of data sources and sample sizes

Data collection method	Sample Size
Demographic questionnaire (user)	22
Demographic questionnaire (carer)	13
Interview (user)	16
Interview (carer)	13
P3CEQ (user)	21
Focus group (ART)	11
Focus group (KEaH)	5
Interviews (external stakeholders)	5

4.1 User and Carer Characteristics

There was a broadly equal number of men and women users in this sample. Nearly half were over 80 years old and around a third lived alone. The average number of medical conditions was five. This sample therefore, represented a particularly frail and vulnerable population. Most users first came into contact with the ART at home although around a quarter met them in hospital.

Most carers were women and were the partner/spouse of the cared for person. Not surprisingly, then, many were themselves elderly. The following figures (1-4) and tables (2-5) elaborate on the above information.

Figure 1: Gender of Users

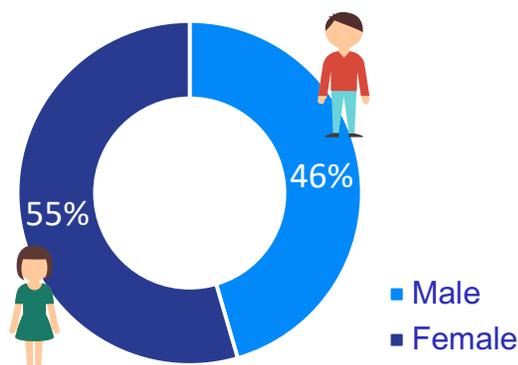


Figure 2: Gender of Carers

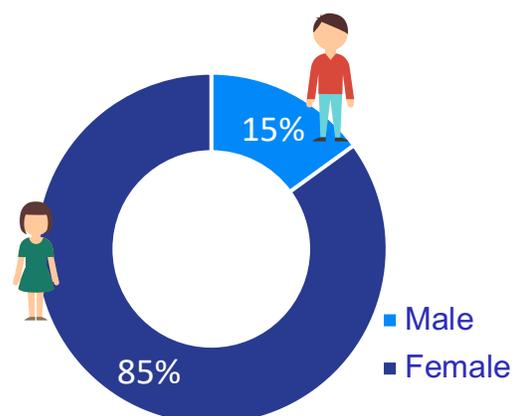


Table 3: Age and living situation of Users

Age group (years)	% (N=22)
51-60	9.1
61-70	18.2
71-80	27.3
81-90	36.4
90+	9.1
Living situation	
Lives alone	33.3
Lives with spouse/partner	57.1
Lives with carer	4.8
Other	4.8

Table 4: Age and living situation of Carers

Age group (years)	% (N=13)
51-60	7.7
61-70	23.0
71-80	69.2
Living situation	
User lives alone	15.4
User lives with carer	69.2
User lives with someone other than the carer	7.7
User lives in a care home	7.7

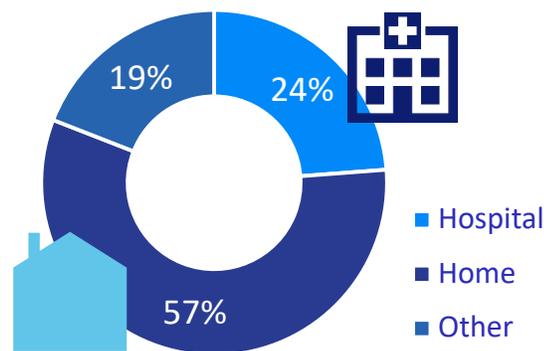
Figure 3: Carer Relationship to User**Table 5: Medical Conditions of User**

The mean number of medical conditions was 5.09 (range 1-12, SD±2.67)

Medical condition	% (N=22)		
Wearing of joints	54.5	Cancer	22.7
Respiratory condition	50.0	Depression	22.7
Broken bones (other than hip)	40.9	Vision problems	22.7
Back pain	36.4	Anxiety/panic attacks	18.2
Diabetes	31.8	Hearing problems	18.2
Dizziness	31.8	Prostate problems	12.6
Heart failure	27.3	Incontinence	9.1
Stroke	22.7	Other condition*	52.2

*Other conditions, as defined by users, included problems with blood clotting, coeliac disease, amyloidosis, cellulitis, peripheral vascular disease, hypertension, hyperthyroidism, difficulty in walking, neuralgia, burns, Sjogren's syndrome, varicose veins, water retention.

Figure 4: Place of first contact with ART



4.2 P3CEQ Survey results

The P3CEQ measures the extent to which care is perceived to be person-centred and co-ordinated. Person-centred and co-ordinated care is defined here as “care where individuals’ values and preferences are elicited to guide all aspects of their health care, supporting their realistic health and life goals”. The mean total score on the P3CEQ was 21.52 out of a maximum 33 (range 10-31, SD±5.49) which indicates a moderate to high degree of person-centredness and co-ordinated care.

Scores for individual items ranged from 0.62 to 2.62 (out of a maximum score of 3). The lowest score was for the item relating to the availability of single professional co-ordinating care. This is consistent with the ART procedures and user and carer interview data which suggests that users and carers were given a telephone number for the ART service rather than a named individual. The availability of a care plan item was also a low score, which again is consistent with the interview data where there was limited written information available to the user and carer and limited forward planning, which was not an aim of the ART service. Highest scores were for involving family and friends in decision-making, which was also evident in the interview data and experiencing ‘joined-up’ care. Items relating to person-centredness also scored highly.

Table 6: Scores for individual items on the P3CEQ

		(N=)	Mean	Std. Deviation (+/-)
Individual P3CEQ item	1. Most important in managing health and wellbeing	21	2.00	1.26
	2. Older person involved in decision-making as much as wanted	19	2.42	1.17
	3. Considered as a 'whole' person	21	2.43	0.92
	4. Necessary to repeat information	21	2.52	0.93
	5. Extent to which care is joined up	19	2.58	0.90
	6. Availability of a single coordinating professional(s)	21	0.62	1.20
	7. Availability of care plan	21	0.71	1.30
	8. Extent to which received support is sufficient to older person	20	2.40	0.88
	9. Extent to which information when needed is useful	16	2.25	1.12
	10. Confidence in managing health and wellbeing	20	2.20	0.69
	11. Family/ friends involved in decision-making as much as wanted	21	2.62	0.97

4.3 Staff Characteristics

Overall, a broad range of health and social care professionals were represented in the analysis. The exception was ED staff (see section 6, Evaluation limitations and challenges).

Table 7: Professional groups of participants

Focus group (ART) (FG1)	N=11	GPs, nurses, allied health professionals, support workers
Focus group (Social care) (FG2)	N=5	KEaH
External stakeholder interviews (P1-P5)	N=5	GP, CCG member, paramedic, hospital consultant, care agency worker

4.4 User and Carer Experiences

4.4.1 Overall impressions of the service

The overall impressions of the ART were overwhelmingly positive from both users and carers with individuals feeling fortunate to have received the service:

“From the time I had my accident to the time I [was] signed off from ART, I would like...to say how delighted I was, I’ve written to them but please write and let everybody know what a wonderful team they are” (U3)

“I just wish more people would be quicker to praise this service, what they’re getting, seeing that we don’t do too badly, as opposed to people knocking the service all the time and complaining, I think it’s very unjustified a lot of the time” (U13)

“Well, if this is what the National Health offers then it's an excellent service” (U14)

“I've said to all my family, we couldn't have had better care” (C11)

Carers hoped the service would continue to operate and wished it was available in other areas:

“I think the whole service is fantastic, it should be all over the country” (C4)

“I hope this service keeps going and they don't sort of give it up because it's absolutely brilliant” (C5)

There was a recognition that the service kept people out of hospital, which was appreciated:

“The idea of keeping people who want to be at home out of hospital is an excellent idea. I think it's a proactive idea and I hope it continues the service” (U20)

“What a good idea it is to keep such vulnerable people out of A&E” (C7)

“Previously, when I've been to the hospital with the same thing a month prior I sat for sixteen hours in A&E, they did exactly the same as what they did this time and then just sent me home. There was no support. There was nothing. Again, it was borderline whether I was going to be admitted or not. So the fact that there was the support...was really good” (U10)

Carers stressed the benefit of the ART, not just for the user, but also for themselves:

“They really make it easier for me, because then I know I've got someone on the other end of the phone and I'm not stuck here on my own wondering if he's alright” (C5)

4.4.2 Referral into the service

Users were referred to the ART via a number of routes including paramedics, GPs, care co-ordinators and hospital staff. In one case, a request for the service was initiated by a family member:

“The doctor actually phoned for an ambulance and the ambulance people, when they came out said, ‘This might be the ideal candidate for the ART team coming out’” (C1)

“My husband actually went down to the GP surgery and said ‘We've been told about the emergency response team, we need somebody out now to help us’” (C6)

The triggers prompting entry to the service were diverse, including sepsis, breathing difficulties, low blood oxygen levels, poor nutrition, falls and pneumonia. Several carers identified the main reason for referral to the ART was to keep the user out of hospital:

“Because he was out of hospital for such a short time before he had to go back in, they referred him to the ART team... because they thought that would save him going back into hospital” (C4)

Speed of response

Users were satisfied with the time from referral into the service and first contact with a member of the ART, with most receiving care within one to two days:

“I came out on the Monday and, I think, Tuesday morning [Name] from the acute team rang me up and said who he was and what their team did, could he come and see me and I said, ‘Yeah, no problem’, he said, ‘Half an hour fine?’, I said, ‘Yeah, no problem whatsoever’, so bang on half an hour he was here” (U23)

Although one user attributed this prompt response to their geographical proximity to the ART:

“I think maybe because they operate from QEQM, and I only live probably, what, ten minutes from the hospital” (U23)

This rapid response was also echoed and appreciated by carers:

“Within a couple of hours! I mean, where else can you get a nurse and a doctor in the afternoon” (C9)

“They arrived the next day and I couldn’t believe the speed...I was imagining that it would take a long time before they arrived, but they arrived the very next morning and just took everything off my shoulders. It was great” (C1)

However, at times there was some miscommunication where the ART did not arrive at the time they were expected based on the information given by the referrer:

“[The paramedic] said they would call in the afternoon, because it was about lunch time when the paramedics came, but nobody came and I thought, ‘oh well, wait and see’, but the following day they phoned up by 11 o’clock to say that they would be there and it was about 12.30/1pm, just after lunch [when they came]” (C2)

On another occasion, the carer did not know a referral had been made to the ART:

“I didn’t expect them, so...I just accepted that they came...I wasn’t really expecting anything to be honest” (C10)

4.4.3 Care received

Users and carers described the type of care that was received, who delivered the care, whether the needs of the service user were met, and whether the care was delivered in a timely and co-ordinated manner.

The type of care provided by the ART varied but predominantly involved bloods tests and clinical observations and monitoring.

“They just took my blood pressure and that was it, that's all they could do, and they probably took my temperature and all that sort of stuff...but they didn't do any care as such because they didn't think I needed it probably” (U7)

“They just came to take blood, temperature and blood pressure” (C11)

One user would have liked to have been more involved in their care by having these results shared with them:

“The only thing I would have liked to have was a recording of the figures that they used” (U20)

In many instances, interventions also involved personal care:

“All I asked them to do is just mainly fill up my two kettles with water because I'm non-weight bearing on my foot, I can't, because I'm on crutches...and they emptied my commode every day and they do my washing up for me and that's all I needed really” (U12)

“Every morning they gave her a wash. Sometimes they'd get her dressed - it depends how she felt on the day. They put cream on her legs and her bottom to make sure she doesn't get sore, they [emptied] her commode and they'd always ask if there's anything else they can do” (C4)

Carers felt particularly reassured that any problems identified by the care team would be fed back to the nurses:

“Washing and dressing him...but of course when they do that, if they see something's wrong they will tell me and they will speak to the chief nurse about it” (C1)

Carers reported the ART tailoring their input to meet both the needs of the user and that of the carer and also described advocating on their behalf with social services:

“They'd make him a cup of tea as well, or if he hadn't had any dinner, they'd help as well as waiting for his carers to come in” (C6)

“They contacted the continuing care people to come and assess...apparently I'm not going to get it, but...the ART team are going to try again, because they feel I should get it and they don't agree with the decision” (C1)

Helping with obtaining medication and ensuring adequate nutrition was also areas of support:

“They looked after her medication, the doctors have been out to see her, which her own GP doesn't” (C4)

“The [ART] doctor said he needed stronger antibiotics so they put him on something really strong and then gradually the blood pressure started to reduce” (C2)

“They've got a prescription sorted for me...one of the carers, she got the prescription, took it home with her, got it filled and brought mum's tablets the next morning” (C4)

“They were...enabling my mum to have her meals, made sure she’d had enough nutrition. There was no necessity whatsoever to be aiding her with her personal care... it was just making sure that she was consuming enough” (C13)

Users also valued the support with shopping provided by Age UK when they were most vulnerable and unable to leave the house:

“Whenever I need some shopping doing, I just type out a list on the computer, print it and hand the list and some money...ask them to let the lady know I need some shopping doing, she turns up, I give her the list and some money and a few hours later I’ve got my shopping back” (U11)

Time spent with users

The time the ART spent with users was generally felt to be brief. For some, this was seen as efficient, although there may also be a suggestion that some users felt the care could be rushed:

“They just sort of like get on with it, and it’s all matter of fact and as I said, it’s lovely, they turn up and 10, 15 minutes later I’m washed, clean and they’re off again” (U11)

“They came in for about quarter of an hour each day I suppose. It doesn't take long to check, you know, with the automatic things they have these days, like temperature and blood pressure and so forth, to do it, so they were probably in and out within a quarter of an hour I would say” (U20)

“They didn't stay long really, they were gone in less than fifteen minutes or something” (U7)

Length of time in the service and frequency of visits

The length of time users received care from the ART varied; some users received a brief intervention lasting 2 to 5 days, while others had input from the team for a number of weeks or had yet to be discharged at the time of the interview:

“They came out for five days” (C3)

“Oh, it must be about five or six weeks...I can't tell you the exact date...they're still coming at the moment” (C4)

Some carers mentioned that the period of ART involvement could not be set at the start:

“It was day-by-day” (C2)

In some cases, user deterioration (or fluctuations in health) led to a longer than planned input from the ART.

“They came in extra, a couple of extra days, because [the user] hasn't been that great at one point” (C2)

In general, those users who received predominantly nursing and medical input received ART input for a short period of time (5 days or under), while those receiving personal care (such as help with washing and dressing)

as well, were likely to be part of the ART caseload for several weeks. Some users in receipt of care for a short period would have valued input for longer:

“They checked her tablets, blood pressure and monitored her pulse every day [for] 5 days. If anything, I’d probably say it would have been nice to continue a few more days...I probably would have liked 5 to 8 days or 5 to 10 days, that would be good, but I know time is tight and people are busy” (C3)

The majority of cared for individuals received one visit a day although some received calls more frequently if personal care was also needed:

“They were coming three times a day: morning, lunch and teatime” (C12)

“It was personal daily care and three meals a day: morning, lunchtime and evening” (C6)

Staff involved and skill level

Nurses, support workers and doctors (including a trainee doctor) were identified as part of the ART although some carers were less sure of staff identities:

“A lady came first to assess what mum would need...then we just got five different ladies that come and do mums washing in the mornings” (C4)

“I think they were healthcare assistants. I’m not sure, they were wearing blue tops and I don’t really...They could be nurses”(C10)

One user commented on the level of skill of the ART team, comparing this favorably to hospital staff:

“The nurses that took the blood samples, they were, probably the nicest nurses for taking blood I’ve had over the whole treatment in the hospital, because quite a few in the hospital were like struggling to find veins...whether they were bigger needles or not, I’m not sure, but the ladies, the two nurses did say they use a colour coded needle... and she said, ‘No, we use a finer one’, and so I couldn’t feel the needles going in and the blood coming out whatsoever” (U23)

4.4.4 Overall views of the ART service

Aspects seen as successful

Carers, in particular, mentioned a diverse range of aspects that they felt went well. Intensive clinical monitoring and the reassurance this provided was identified as a clear strength, as was the ability to build rapport with the user and the carer, and the help and support provided to the family or the couple as a unit. Relational aspects were particularly important to carers as were regular visits and ‘keeping promises’ in relation to calls:

“If they said they were coming, they came, and when they said they were going to phone, they phoned, so you were never left not knowing what’s happening” (C5)

Practical help and support was highly valued and was compared to the input received from other services:

“They’ve done more for mum in a few short weeks than her GP has done for the last three years” (C4)

Relaying important information to the GP or other professionals outside the ART, as well as a positive relationship with these services, was also important:

“[They] also kept the our doctor informed...it was so helpful all round” (C11)

Signs of getting better or improvement of symptoms was seen as an aspect of the ART success, but this was not frequently mentioned:

“What was working well was the fact that it was obvious to me mum was eating...she was getting back into a routine of eating food...she seemed to be brighter and slightly more alert” (C13)

Lastly, keeping the service user out of hospital or the ED was seen by many carers as an indicator of success:

“Just the fact of keeping her out of A&E really, because...we’d been there earlier in the week and it was horrific there...it’s like landing in a war zone” (C7)

“I’ve found that having the ART team put my mind at rest, because they were coming every day and I didn’t need to call...the paramedics again” (C2)

Less Successful Aspects

In terms of what did not go so well, most users or carers did not express any criticism of the service. However, some issues were identified in terms of communication. This centered around not being aware that ART were coming and lack of communication with primary care:

“We weren’t actually told at the hospital that we were going to have anybody from the ART team and when they actually turned up I thought they were from my surgery...it wasn’t until the second time they came, about an hour after, a nurse came from our surgery for blood, and I said he’s already given it. And she went, ‘who to?’ and I went, ‘the ART people, didn’t that come from the surgery?’ She said ‘no’...there was a miscommunication somewhere, I presume it was the hospital that should have told us that we were going to have the ART team” (C10)

“I don’t think the surgery knew I was having [the ART], because I had to take him [to the surgery], and a nurse that saw him seemed to be surprised that the ART team were coming” (C2)

There was also some lack of communication with the ART team and a carer who did not live with the user:

“There was no communication so that I would know for sure that they’d visited and what had been achieved as a result of the visit. So there was no diary or anything to tell me that she’d had a visit in the morning at 9 and had taken her breakfast and at lunch she had her lunch - there was nothing like that to

reassure me, I was just hoping for the best. So there was, in fact, a lack of communication with myself being her main carer with obvious concerns about her welfare” (C13)

The same carer was also unsure what communication had happened between ART and other services:

“I’m on the outside, so I couldn’t tell you what communication ART has with KEaH and I couldn’t tell you what communication ART has with Age Concern. It was only at the end that [ART team member] phoned me and said, ‘I just wanted to let you know that we have been coming in every day, three times a day, and that we are going to be handing over to KEaH” (C13)

4.4.5 Care co-ordination and information sharing

There was a perception by both users and carers that the ART worked together collaboratively, for the benefit of the user. This finding is consistent with the P3CEQ.

“They very much came over as having common aims, and supporting each other, you know, not just supporting me, because you see different people and I felt they were very much supporting each other as well” (U17)

Information was believed to be shared within the team, which compared favourably to experiences with other care services:

“A girl can turn up and I’ve never seen her before but she knows what my needs are because somebody else has told her, that’s because of the fact that they work together as well as working on their own out in the community...whereas the private ones, I think they probably get the jobs for the day sent to them on their phone and they probably don’t see somebody from one week to the next unless they need to get supplies and bits from their headquarters” (U11)

“They all had their books with everything they did and that was written down so I assume they shared the information (with the team)” (U2)

“They had good background information...they seemed to have done their homework” (U17)

Some carers commented specifically about good teamwork during visits carried out by two or more ART professionals:

“They were both so friendly and...made you feel comfortable” (C12)

“They all worked well together, they explained everything they were doing as they did it, what was needed” (C8)

Others reflected on team members sharing information and knowing the case well even if a particular professional had not visited for a while:

"[She] said, 'oh, that's the chair that's going back, but the occupational therapist is going to come over and see if there's another option that they can find' and this is the girl that I hadn't seen for a week, and yet she knows everything about what's going on" (C1)

"It seems as though they've read notes...they didn't seem [like] they didn't know what to do...so they obviously knew what was needed" (C3)

"They've got it all written down, so there must be a central office that puts it all together and passes it on. When they said the nurse wasn't particularly happy that particular day, I got a phone call... saying that, 'oh the nurse is a bit concerned about your husband today so a doctor will be coming out, one of our doctors from our team will be coming out to see your tomorrow...and if you've got any worries between now and then, you've got our number and phone us" (C9)

Carers were also very positive about the consistency of information they received from the ART:

"Very consistent, very much so" (C9)

"I think that was what was quite reassuring about the ART team that things didn't change much" (C3)

Information and advice was shared with carers about how to care for the user, and carers were actively involved in decision-making, which was appreciated. This was consistent with the findings from the P3CEQ where the involvement of family and friends in decision-making was the most highly scored item.

"They would make suggestions that I didn't know [about], [that] he would need to put his feet up...they actually gave me a few information leaflets and things to help me, they were really good" (C2)

"I feel that they're sharing with me any information that they've gleaned from elsewhere. I haven't been excluded just because I'm not a professional" (C1)

Carers unanimously reported knowing who to contact and how to contact them:

"They gave us some information all about them, they told us if we needed help we could always ring them for advice...most people don't do that, you know?" (C12)

However, many carers stressed that aside from knowing who to contact, the accessibility and responsiveness of the team were crucial:

"They were very good and I could speak to the doctor as well. They were on call. They are there from 8 in the morning until 8 at night" (C2)

"I know they are at the end of the phone if I'm worried about anything and I don't feel I have to hesitate twice to phone them. I know their phone number off by heart. I don't use it that much, I've only phoned them perhaps once or twice, but I know I can" (C1)

4.4.6 Person-centred care

Overwhelming, a person-centred approach to care was described by both users and carers. This was consistent with the P3CEQ survey results. Users felt they were listened to and treated with respect throughout the care process:

“There’s an awful lot of people, they don’t listen to you and they just treat you like you’re a what’s-name in the works, [but] they’re very understanding and intelligent, do you know what I mean? And it’s sort of like I trust them. That’s the word I need, trust!” (U11)

“You can get people that come in, it’s almost like you’re talking over their heads, you know, they don’t really listen to you, but these people absolutely do” (U17)

Carers reported that the person they cared for were treated with friendliness, respect and patience:

“He wasn’t very keen on them coming and washing and dressing him in the past...he’d lock himself in the bathroom if he did not like the look of the [carers] and then the ART team came in and I know initially he wasn’t keen, but he allowed them, and now he’s putty in their hands...They go in so lovingly and wake him up gently and just get him along in his own time, don’t rush him” (C1)

The ART team, every single person who’s come to look after [husband] has been really good and have got on with him...I can hear them when I’m downstairs, talking to him, and it’s exactly the way he’d like to be talked to” (C1)

“They tended to make her relaxed...very friendly, very positive and quite reassuring” (C3)

“Each one, they respected him. Very friendly people” (C11)

“They looked at her as a whole, they were very kind to her, very gentle with her, the doctor was absolutely charming, we couldn’t have received nicer care from nicer people to be honest” (C7)

Some carers stressed the importance of genuine connection and humanness of the professionals:

“They’re so kind, they really are kind and, I mean, it’s like having a visitor in the house” (C4)

“Very friendly, in fact the last one, she said ‘ooh, I feel like one of the family!’” (C5)

“They were lovely lovely people and they were very good with my stepmother - and that’s all you can ask, is they’re treated how you’d like to be treated” (C6)

The care of those with dementia, was also stressed as a particular strength of the ART:

“The patience they gave him was second to none...they asked his opinion and they didn’t talk over his head or ignore him as a person...they had patience, they had time, there was no, ‘hurry up you’re inconvenient’” (C9)

“They have been so pleasant to my husband...we’ve had carers before, but these are a different caliber completely” (C1)

“I don’t think some people know how to treat people with dementia and they were very, very kind...and they actually had quite a sense of humour” (C10)

However, one user felt that the ART, much like many other health and social care services, did have a tendency to talk to older people in a certain manner:

“One of my beefs is when you get to a certain age, people are inclined to think you’re...a bit silly and they have to go into a lot of detail and shout or something like that, you know. But that’s general, you get that in hospitals as well. I’d say they were OK...I wouldn’t say they were wonderful or anything like that, but they were OK” (U7)

In one situation, the terminology used may not have been most appropriate, despite the user seemingly not being offended:

“The idea was ...for the service, they explained to me, was to stop me going into hospital and bed-block, bed-blocking as they call it!” (U20)

In terms of how the ART team treated the carers, most stressed the friendly and accessible nature of the team:

“It’s like having new friends” (C4)

“I felt when they came into the house, I felt I wanted to welcome them because they were so nice” (C12)

Ability to speak to the team and being listened to in relation to the users care were also frequently mentioned by carers:

“You could talk to them and they understood what you were talking about” (C12)

“If I say anything, they listen” (C9)

“They’ve been open to my suggestions as well and they understand that I know him and know how to get round him because I’ve practiced [laughs]. They will listen if in the end something’s not working and they will try my way, and they’re happy to, and it works” (C1)

Practical input and sharing the caring tasks was also highlighted:

“They looked at absolutely everything...I didn’t have to do anything apart from when they left” (C8)

“When the ART team stepped in, it was another pair of shoulders to lean on and they’ve given me so much support that it’s just been wonderful...They can go straight to the occupational therapy, the medical, the doctors, everything...I just feel as if it’s a burden shared now” (C1)

Helping to liaise with other services, and in so doing enabling the carer to look after the user, was also important:

“It’s taken a bit of pressure off me because I’m her sole carer...I phoned the ART team and I said look, I’ve got a bit of a problem, mum’s run out of some tablets and I can’t get to the surgery, and they got it sorted straight away” (C4)

The importance of considering the carer and the service user as a unit, and appreciating their interdependence, was apparent:

“They said ‘we’re also concerned about you, how you are, and because if you go down, he goes down so you’ve got to look after yourself” (C5)

“[My husband] feels safe with them, because he knows that I feel that he’s safe with them” (C1)

“We are more independent [now]” (C8)

“They met all the needs, my needs, his needs, without us even realising that’s what we needed” (C1)

4.4.7 Health and well-being and maintaining independence

Some users felt their physical and emotional health was improved as a result of the ART service. However, there was a recognition that this improvement was, at times, limited in the presence of long-term conditions:

“There’s very little that they can do to solve the (health condition). What they’ve done is they’ve made it a lot more comfortable for me and psychologically, I feel a lot better because if they weren’t there I’d be completely up the wall” (U11)

“They dressed the wound, made it comfortable, so that made a difference to me and I got better in myself quicker, my wellbeing came back quicker and obviously because I was taking the antibiotics as well, it all came together quite well, because of the ART team and their attendance on me, it helped a great deal” (U9)

Some carers also reported an improvement in service users’ health and wellbeing, which was related to be cared for out of hospital:

“When he came out of hospital [his health and wellbeing] greatly improved. What [ART] did was amazing” (C8)

“Probably the medication and just relaxing at home I’d imagine, it’s far better than being in hospital” (C3)

However, as echoed by users, there was a recognition that improvement may be temporary due to the nature of a long-term condition, with most carers feeling that health and well-being was more variable. Nonetheless, ART were adept at reacting to any changes in health:

“Yeah, but it [improves] each time before he goes down” (C5)

“To be honest it’s a bit of a rollercoaster, it goes up and down. She did improve and then she became ill again a couple of days ago, but now she seems to be improving again” (C7)

“He has a chest infection every winter...His walking is not very good. His chest is still not... his breathing is not good, but I just calm him down, and you know he’s 89 so he’s not doing too bad really” (C2)

“It varies every day, but the way she’s treated - the [ART workers] will react to whatever is going on” (C4)

Some carers felt that the service user’s health had stayed the same:

“So really nothing changed, it’s just the benefit of not going to A&E really and having medical attention at home” (C7)

“I think the reason they were coming was they do blood pressure, etc etc - that has improved, but the rest of his health hasn’t” (C11)

Lastly, some of the carers felt that the service user’s health has deteriorated during and/or since ART input. Some felt that while deterioration was inevitable, this would have been quicker without ART input.

“Actually it has just got worse last night...he has been asked to go into hospice” (C12)

“I think if it wasn’t for the team coming in, he’d be much much worse, much much worse than he is. I think he’s deteriorated, because he’s going to deteriorate...I don’t think I’m being over dramatic when I say that he could have been dead by now had it not been for the constant help” (C1)

Importantly, when a deterioration was expected, one of the carers stressed the importance of the ART workers helping them prepare for that deterioration:

“But [ART worker] said to me, ‘He’s not always going to do this, he’s not always going to bounce back’, and she’s absolutely right to do this, to keep our feet on the ground about it” (C1)

In terms of maintaining independence, one carer remarked on a particular instance when ART helped a service user to gain confidence and consider going out:

“Well, he doesn’t want to go out, he’s frightened to go out, but he’s had a word with the nurses yesterday, just before they discharged him, and she said, ‘there’s no reason why you can’t go out, only do as much as you feel you can, but there’s no reason why you can’t go out. And now he’s thinking he’s going to try to go out”

For some users a needs assessment resulted in equipment being installed and a care package being implemented, to ensure they could continue to carry on with their everyday activities as independently as possible:

“It was wonderful...they arranged for me to get things that would help me like a bed, a stool for the shower, a cushion and they arranged for carers to come to look after me” (U1)

“They helped me with equipment, when I needed some equipment, and they also helped me with, just running through what was the best strategy for me to improve” (U17)

Many carers reported that they already had all the equipment they needed from other sources such as KEaH or local hospitals although did mention getting equipment from the ART, including beds, wheelchairs, grab rails and pressure mattresses or cushions. However, some remarked that getting the equipment was not quick:

“A grab rail for my husband which they came and measured up about 3 or 4 weeks ago...so I don't know who long that's going to take, but they did measure up” (C8)

Carers mentioned the importance of flexibility and person-centeredness when offering new equipment:

“She suggested perhaps having a ‘wheeler’ that would help him to walk and I had borrowed one from a neighbour downstairs, but it was a very old one, so she ordered a new one which I've got in the bedroom at the moment” (C2)

“The electric reclining chair...they tried it and it could have worked had it not been for the fact that he would wake up from the recliner and then try and get out of the chair in the wrong position and go straight onto his face three times, so that's going back. But everything else - great. They tried and been successful in everything except for the chair, it's not their failure” (C1)

However, one carer felt that ART discouraged independence by microwaving the meals for a user, instead of encouraging her to do this herself:

“I don't think that they should be there to do things for the person if they are able...It seems at the moment mum is tending to depend on somebody coming to put the meal in the microwave, whereas she could be doing it, but I think it's become a habit now to perhaps expect somebody to come around in the middle of the day. So rather than it being an enablement for her to become more independent, I think she's beginning to depend on them more” (C13)

Action planning and preparing for setbacks in the future was less apparent than day-to-day independence. Some carers reported that the team did not help to plan for the future:

“Not really, no....I would have actually repeated the thing I did in the first place with me phoning 111 and an ambulance” (C3)

“No, we haven't really discussed it but, you know, they have said I can phone them any time and talk to them” (C4)

However, there were also a couple of cases where future action was already planned outside of the ART input:

“We've already got that in place with the hospice and our GP” (C11)

Where the team have discussed preparing for the future this was seen as highly beneficial:

"I think it's been a comfort... to know that they're open...the possibility is getting closer and closer of him [whispers] dying, and I think it's a comfort, because it's what I've been feeling...that he's not going to get better. In fact some of [the ART team] have mentioned this in the most gentle way, and not coming out with it bluntly, it's when I've ventured something towards it...You feel they understand and we're on the same wavelength and they're not trying to kid me that he's going to be alright, they're treating me like an adult, and you have got to have a plan for death" (C1)

4.4.8 Moving to other services after the ART

Some users were still receiving the ART service at the time of the interview, however, most had been discharged from ART and care transferred to other providers, including their GP. Although most users experienced smooth transitions in care, there was lack of clarity, for some, around where referrals for new services originated:

"I've got a home visit tomorrow and I've got a sneaking suspicion it was originated by them [ART]" (U13)

At times, co-ordination between the services was excellent:

"I think they [ART and hospice nurses] worked together...they seemed to be sort of joined in some way together" (C12)

"[ART] assured me that at no point in time would she be left without care [KEaH] and she wasn't and it was seamless" (C6)

In most instances, carers felt information about the user had been shared with the relevant providers:

"Relatively seamless...everyone sort of knew what was going on" (C6)

"Yes, they did [have information about the user]. So I don't know where they would have got that from" (C3)

However, this was not always the case and at times, there was some lack of information sharing between the ART and other providers:

"I don't think they told the Intermediate Care Team anything" (U14)

Where a lack of information was felt, one carer attributed this to the type of the new service, rather than insufficient handover from ART:

"I don't know if they [KEaH] know all of his problems, no, because they are just carers, aren't they? They're not nurses or anything like that" (C11)

When asked about the length of time it took to receive the new service, some carers reported a quick handover:

"[ART] finished on a Friday and I think the following Monday, the District Nurses came" (C3)

"I've had somebody phone up from the falls prevention and we start exercising next Monday" (C2)

While others spoke of a lack of service, delays or a need to follow-up services themselves:

"[ART member] was supposed to get in touch with the respiratory people because they also do a physio side, but I don't think that ever happened" (C5)

"I spoke with the ART team, this was on the Thursday, they did say to me that the District Nurse will...they'll contact the District Nurse and I should expect a visit on the Saturday...I didn't see anybody from the District Nurse on the Saturday, so I contacted the ART team, spoke to them and they were surprised that nobody had been and that was when they gave me the information that if I wanted to get contact, for me to contact the District Nurse... I'd need to go through 111. And that's what I did, and I did get through to the District Nurse and they came out on the following day" (U9)

Some carers remarked that the new services were fairly basic and non-intensive, perhaps when compared to the intensive intervention provided by the ART, and a lack of medical input:

"I think it was very rudimentary. I think it was just somebody calling in and just making sure she was alive and breathing more than anything else" (C13)

"Well, they've dwindled down now, it's just the District Nurses were having a few problems with, sometimes they turn up, sometimes they don't" (C8)

"The care that she's getting now is...it's care rather than medical help....ART team took blood tests, monitored her blood pressure" (C7)

There were also occasions when the new services ceased their input following their initial assessment, either because the service user has improved or because they deteriorated more than expected:

"Kent Enablement came in for a few days but [user] can now walk on a Zimmer around the room, so there wasn't really a lot they could do" (C8)

"Kent Enablement came [and] said, 'I'm really sorry there is nothing we can do to help at the moment because you're too poorly', but they will come back at a later date if things improve" (C4)

4.4.9 Improving the service

Most users and carers could not suggest ways in which the service could be improved:

"Personally, I think it's excellent. I think if it's keeping people out of hospital it's improving their health because, especially older people, who've got this terrible fear of going into hospital...and this is keeping people out of hospitals, and its freeing up a bed for somebody" (C9)

"There's been no circumstance where I've thought, 'oh, I wish I had a little extra from them'" (C1)

However, there were suggestions around issues of communication, especially the need to explain the purpose of the ART service, that is was the time-limited, and that care would be 'handed back' to the usual care providers:

"I'm still not 100% what their role is to be quite honest" (U7)

The lack of clarification with regard to the ART's remit, including the length of the service may have resulted in potential misunderstandings of the service:

"They're more of a community type service, so I think they could do more and find out more and give more assistance if they had a broader scope...I don't quite see what they do to make it worth their while and whether they're good value for money, I'm a bit uncertain about that, as an outsider. See, I might only be seeing a little part of what they do, I don't know" (U7)

A small number of service users expressed confusion over how the service ended. This user felt an explanation of why they no longer needed care from the ART was needed:

"It just seemed to peter out, I don't know whether they were satisfied with what they'd done and there was nothing more to do but somewhere along the way communication seemed to have failed, not the service itself because I was well pleased with them...I wasn't too sure whether they'd just run out of time or whatever. I didn't know why they'd stopped, put it that way, but I presumed there was nothing too dramatically wrong with me otherwise it would have kept on the case, so to speak" (U13)

"When I come out of the hospital, they come in the next day and the day after that...and then they sort of left, but the two days was reassuring"(U7)

It is difficult to ascertain whether in some instances this was the result of the purpose of the ART service not being effectively communicated or whether service users were unable to recall such details:

"The second time they turned up, but after that, as I say..., it just seemed to have died a death (the service) and it's either my memory sort of serves me badly and they did tell me something but I can't recollect that they did" (U17)

It was also felt that the time of visits or delays to appointments could have been more appropriately conveyed:

"I knew they were coming but they never...they just come and knocked on the door...I do appreciate the phone call to say roughly what time they're coming, you know" (U7)

"They could be consistent on time of visits...when someone says they're coming in the morning, but actually come in the afternoon...if there was a regular AM visit or a regular PM visit, I think the users probably get to know that" (C3)

"Only a slight hiccup, nothing major, but it would be useful for them...communication really...sometimes there was a delay...All I needed was a telephone call or a text of some sort to say they've been delayed, that's the only thing" (U9)

Other suggestions made by carers involved quicker test results and written notes in the service user's house that could be read by carers, especially those who did not live with the user. The lack of written information and care planning is also apparent from the P3CEQ results.

“One thing that could be improved was the speed of the blood test, because she had blood tests we were waiting for results...that could have been sped up a little bit” (C7)

Several carers mentioned wishing the service was available in the past when they were in similar circumstances:

“I wish I had this years ago”(C1)

“It’s a shame they didn’t do it before, because I had my husband, my first husband died ten years ago and there was nothing, I had no support whatsoever” (C5)

In summary

The overall impressions of the ART were overwhelmingly positive from both user and carer perspectives with individuals feeling fortunate to have received the service from staff who were seen as highly skilled. Most received a very prompt service from the time of referral. Occasionally, there was some lack of awareness that users had been referred to the ART. In addition, some felt that there was a lack of communication with primary care. Carers experienced a high level of practical support, received consistent information and were involved in decision-making. Care co-ordination was seen as effective with users and carers knowing how to contact the ART if they needed to. There was a perception that the ART worked collaboratively and shared information between team members for the benefit of the user. Overwhelming, a person-centred approach to care was described by both users and carers - they felt they were listened to and treated with respect throughout the care process. Some users felt their physical and emotional health was improved as a result of the ART service. However, there was a recognition that this improvement was, at times, limited in the presence of long-term conditions. Most users experienced smooth transitions in care, with information shared with relevant providers although some reported delays in receiving new services or needing to follow-up services themselves. Action planning and preparing for setbacks in the future was less apparent with few users or carers reporting this. However, as this was not an aim of the ART service, this was not an unexpected finding.

4.5 Staff Experiences

4.5.1 External agencies understanding of the purpose of the ART

The purpose of the ART as described by external agencies (GPs, paramedics, hospital consultants, CCG members, care agency workers and KEaH staff) was generally consistent and described as a service which could support people at home with acute and complex health needs, prevent hospital admissions, and provide a smooth transition between hospital and home at discharge:

“Someone that’s got a higher need than just a basic level of care... if someone needed emergency medications, that potentially a care company would struggle with...they’ve got people that can give those medications, and it’s more the higher risk patient” (FG2)

“To reduce the number of admissions that would have been passing through the hospital ward had the service not been there” (P1)

“The service was set up to support patients on discharge who needed some kind of support early after the discharge process to try and remain safe at home, to continue their recovery at home and have a smooth transition between the hospital and home” (P5)

However, for one participant, the ART was used when as an alternative service to the GP:

“I’ve had one service user that was in a lot of pain and the GP wasn’t actually doing a lot about it, so we asked the GP if they could refer to the ART team, see if they could help” (FG2)

4.5.2 Facilitating factors and challenges to implementation

A number of facilitating factors were identified in setting up the ART service; The core team developed from an existing service (Rapid Response) which was beneficial in terms of recruitment. This also enabled the existing team to be involved in the development of the service which meant there was an early commitment to its implementation and delivery:

“We have had the luxury of being able to redesign an existing team, we haven’t had to go out to recruit new posts” (P1)

“The core clinical team who’ve actually led the delivery of the service, were completely on board from day one...in terms of designing and developing the model pre-October 2016. So, there wasn’t a hard sell, if you like, having to be made to the clinicians who were going to be providing the service” (P1)

The team felt supported in trying out new ideas and were allowed to find creative solutions:

“We’ve got the ability to say, “Right, okay, I think this might work, can we try it?” and 100% the CCG and the GPs are behind us, they’re happy for us to trial anything, as part of our role, so that’s really beneficial to us” (FG1)

Financial support from the CCG was essential:

“There was financial support from the CCG, because there were some, you know, significant additional costs. I mean quite a bit of the team has been created within existing resources, so it was about redesigning what some of those staff were already doing, but the GP input into the team has had to be paid for as an additional cost. So, there were those sorts of commitments” (P1)

“We’ve been saying for years that we would be able to do this, but without that backing and that support [from the CCG] it was really difficult to get it on its feet, so that kind of really was the game changer” (FG1)

Engagement and support from other service providers was also instrumental to successful implementation early on:

“There was virtually whole system sign up to the idea of testing the model so it wasn’t a question of having to go out and persuade other stakeholders” (P1)

“All Seasons and Age UK and their engagement in the project, that’s been 100% since day one and never wavered...In fact they’re continuing to look for opportunities in terms of developing their own organisations to be more supportive to the team” (P1)

“Thinking about it from the hospital’s perspective, I mean they continued to be challenged in terms of their performance in relation to waiting times and the four-hour standard in A&E etc. So, there was support from that quarter to see it work” (P1)

Support from a key individual (GP) was highly valued by the team in the early stages of implementation:

“Without [Name], it would have been extremely difficult to get the service established in the way it has been...it’s about his passion for the service and for the local hospital and the health system and in primary care” (P1)

“When we did Rapid Response we always knew that the service could be a lot more and we were fortunate that the GP kind of helped to set it up, came in and actually took time to see what the team was doing at that point, and listened to where we thought we could take it” (FG1)

However, there were some early challenges to implementation around referrals from primary care, ambiguity around roles and responsibilities, the anticipated nature of the work and lack of input from other services:

“In the early stages, and it wasn’t unexpected...there was some reluctance in terms of primary care, primarily GPs being reluctant to refer into the service” (P1)

“There might have been a bit of confusion in the early weeks of the service between the Age UK and the All Seasons input, but that was one of those niggles that was just sorted out” (P1)

“I don’t think that we thought we would have as much a personal care aspect of the job...it was meant to be sort of 40% personal care, and 60% medical, however, there isn’t any other service out there that can deal with personal care patients that have a health need” (FG1)

“In the original concept it was meant to be a larger team with social services and mental health being in there as well” (FG1)

4.5.3 Processes of care – referrals in and transitions out of the ART service

Referrals in

There was a perception that the number of referrals into the ART was sub-optimal i.e there was a significant number of patients meeting the inclusion criteria that were not being referred. This was a perception both within the ART service and external agencies. The main reason for this was lack of awareness about the existence of the service, however, the reasons for this lack of awareness varied according to the referrer.

Hospital –The ED and wards:

Lack of awareness of the ART service was seemingly related to staff turnover and internal hospital policies and procedures:

“They sort of operate in splendid isolation and that’s not a criticism, but there are other parts of the system. So, if I think about the integrated discharge team in the hospital, both services, whilst the clinicians speak to each other, both services are managed and provided completely separately and there isn’t, if you like, a joined up patient pathway” (P1)

“The hospital end of the service, it’s quite difficult when you’ve got a rotating...particularly the medical workforce, a rotating medical workforce which changes every four months” (P17)

In the ED once patients are triaged, there was a reluctance to transfer eligible patients to the ART:

“Often if it’s in the afternoon you’ve gone back here [Westbrook House] so you’re no longer in the hospital, and then again that’s a delay for the patient because then they have to stay there overnight and we pick them up in CDU the next day...there doesn’t seem to be a quick flow in A&E, and therefore I don’t think it’s effective for us” (FG1)

“In A&E as we’ve tried to almost assess patients on trolleys, once they reach A&E they have to have their full investigations, they’ve got to have bloods, they’ve got to have whatever” (FG1)

“We in-reach into A&E and CDU, in my opinion A&E isn’t really the most best place to in-reach into, I think you get more patients on the CDU, and a respiratory ward in a hospital, and often I feel that we’re going around in circles...wasting time trying to find patients, when we shouldn’t be finding patients, they should be finding us. And I think that that’s a fault of the consultants and the doctors at the hospital, because I think that there at least should be five patients a day that they’re able to put our way, so I almost feel that we’re pulling them out of their hands, rather than them actively giving them to us” (FG1)

Pick-up from the ward(s) seemed to be more effective:

“The ART team has focused on specific areas of the hospital. They could not go to every single ward to meet to every single patient so they focused in areas who are discharging much more eagerly where they can have an impact because we noticed that the readmissions were a problem” (P5)

“The patients that were identified for ART and were from Thanet, almost all of them were sent” (P5)

GPs:

Referral from GPs was slow at first, perhaps simply due to lack of awareness of the service, but has become more commonplace. This finding supported the previous audit data:

“When we first started, the be all was the hospital. I think that a good 70% of our patients now come from the community, the hospital is a small proportion of patients, which I think is a really good thing, because ultimately if we were to get the patients whilst they’re in the community from an ambulance, from their own GPs, that we’re preventing them from getting into hospital in the first place” (FG1)

Ambulance service:

Referrals from the ambulance service seemed to be most problematic:

“All I know is they don’t get as many referrals from us as they probably could” (P3)

“If a paramedic goes out to a patient’s home either via a 999 call or a call from a GP practice, then the theory is that if the paramedic thinks that with the support of the ART that patient could be kept at home rather than being transported to hospital then that’s what should happen. And whilst the referrals from the ambulance service have increased significantly, certainly over the last six months, we still don’t believe we’ve reached the potential. There are still patients being transported to hospital that don’t need to be” (FG1)

The main reason for this seems to be the mis-match between the geographical footprint of the ART service (Thanet) and the Ambulance Service (South East Coast). There is significant variation in services across the region making it difficult for crews to know what is available, especially if they are based outside the area:

"[Crews] go to Herne Bay, Canterbury, Maidstone, Ashford, Pembury Hospital, there's so much geography, we are going to miss patients that potentially would be suitable because someone could be out of area and won't even have the phone number" (P3)

"We cover such a vast area, I've got crews that are in Maidstone, Ashford, all over the place, obviously, if they come into Thanet and they don't know the area, they're not going to refer to the ART team, and there's no real way of me pushing that because every areas different. I mean, actually, the battle the ART team have is that every area we go to has a different pathway" (P19)

Coupled with this is the fact that GPs may call an ambulance with the expressed intention of taking the patient to hospital, which then created an unacceptable level of risk for the paramedics:

"Generally, I think we would take them to hospital, if the doctor said, 'Go to hospital'. I'd be surprised why any crew [would] put themselves at risk by going against that, because sod's law that would be the patient that deteriorates. You might get a crew that are very comfortable, if I was there, I potentially could call the ART team and say, 'This might be suitable', but it's very unlikely" (P3)

Interestingly, one of the users interviewed was referred to ART by an ambulance crew who was asked to take them to hospital by the GP.

As a result of this of this variation in referrals, the ART recognised that they may need to consider where they can be most effective:

"Maybe we need to re-evaluate ART and say look where it is more effective, is it more effective in the community or is it more effective in the hospital?"(FG1)

There is a recognition without the ART service that a re-launch requiring an investment of time, is needed to increase awareness of the service:

"Almost every four months we need to re-launch...we have it all the time in hospital, you'll speak to a consultant one day and say, "Hello, is there any patients for us?" and you can have the same conversation every single day of the week with that same consultant, because, you know, we think that we're important, we know we're important but they've got so many things to think about, and everybody just needs re-reminding that we're out there, and I think that by having posters made up, by having sort of regular meetings, and going to regular meetings with everybody..." (FG1)

"If we were sort of to educate, including the hospital staff...if we were to do that on a regular basis that they would know who we are, they'd know what we do... I think that that's possibly something that we need to do rather than they need to do really" (FG1)

For GPs:

"You need to show them the figures, how much money you've saved them, you can save this amount of money, or this number of hospital days, because that's generally what they think of" (FG1)

"It helps that some of our GPs are local GPs, so they also work in their local surgeries but there's still some surgeries that may need to be a bit re-educated" (FG1)

For the Ambulance Service:

"The ambulance crews as well I think need another re-launch, because the thing with the ambulance crews, they cover such a big area, they won't necessarily be Thanet based" (FG1)

Transitions out

“The missing link is how we pass these patients over, once we’ve finished with them really” (FG1)

As with referrals into the service, challenges with transitions out of the ART were different depending on the service provider.

Discharge to GPs:

There was a sense that some GPs were more prepared to take patients back from ART sooner than others. However, there was a view that the payment scheme needed to reflect that:

“Some surgeries are very proactive and they would like to look after their own patients once they are discharged...the question is who funds that? if it comes from the CCG then that’s fine but the surgeries who are a bit proactive need somehow to be rewarded versus the surgeries who are not. So for instance, X surgery who says we’re happy within 72 hours after the discharge to relieve ART and to take our patients has to have a different financial contribution to the ART service” (P5)

Transfer to social care services, including KEaH:

There was a number of barriers identified by the ART in relation to handing over patients to social services. The main difficulty for ART was the need to make a number of referrals to different services which caused some frustration about whose responsibility this was:

“When we may refer to KEaH [they] go out and say it’s not appropriate for KEaH, it needs a long-term care package, and then that gets pinged to us to then refer the same paperwork to refer for a long-term care package...why can’t KEaH pass that on, as it’s under the same umbrella? that’s quite frustrating” (FG1)

“A single point of access really, somebody who works with Social Services, be it KEaH or long-term conditions, to take responsibility once a referral ends up in front of them to then decide from our assessment what’s needed, instead of having to do it twice, it’s just crazy” (FG1)

The speed at which social care could be instigated was a frustration for the ART team. This was recognised by KEaH as a difference between the types of service offered:

“You could be waiting weeks really, you know, I mean the difficulty is we’re trying to work acutely, quickly, best for the patient...it does seem that it’s a very slow process when it comes to Social Services, and obviously fast track isn’t as fast as we would like it to be...the whole social aspect of patient care is just a lot slower” (FG1)

“We go out and assess but we might not be able to start that person for a week because we’re not that sort of emergency service, whereas the ART team are more, ‘yes, we can go today’ or ‘yes, we’ll go tomorrow” (FG2).

The speed at which new services, not just social services, were initiated was also a concern of users and carers.

From a social care point of view, the involvement of the ART led to more rapid enablement primarily due to the input of the ART therapists, the provision of equipment provided by ART, and the advance notice of patients transferring to social care:

"We're only given a few weeks to actually come with an outcome for this individual, so we need the physio in, we need the equipment in, we need this there to be able to work with that person... had the ART team not been involved we would wait three or four weeks for a physio" (FG2)

"One of the positives is that we'll get a referral perhaps four or five days beforehand. Often we can go out and do an assessment before they actually hit our service, which can deem whether somebody's appropriate for our service, whether they need three calls or two calls and things like that" (FG2)

Capacity and Turnover

Lack of capacity was identified within the ART due to lack of staff and patient turnover:

"I get really concerned when we're running to full capacity, that at the end of the day there's possibly more patients out there that need support" (FG1)

"At the moment we're lucky enough to have extra staff but that's a temporary measure, we're still over capacity" (FG1)

"Sometimes they haven't got capacity to take. We had a gentleman a fortnight ago, bypassing catheter, poorly in bed, hospital bed, hadn't been mobile, declined any support from OTs. I immediately phoned the ART team, unfortunately they didn't have capacity otherwise they would have taken him" (FG2)

"Because we're health providers, in our mind we can't say no, so we will always try and make space, especially End of Life patients" (FG1)

Interestingly, there was a suggestion that social care would take on patients in situations when the ART was full:

"If they haven't got capacity then we might put a service in because obviously we can't leave vulnerable people with nothing" (FG2)

Lack of capacity in the wider health and social care economy, particularly social services was a significant factor influencing the turnover of patients within ART, impacting on their ability to take new referrals:

"We've got people waiting for care packages that have been requested, it's a knock-on. If we could get those people off now...some requests have gone through last week and we still haven't got a care package. We've identified their needs, we've got it agreed that this is their needs, let's move them on and then we can take more, ART can take more and it's a knock-on effect" (FG2)

"we should have almost a seven day turnaround, but obviously our personal care patients can be on there for about 12 weeks sometimes, so that blocks us really, because we've only got a certain amount of capacity in our personal care side" (FG1)

At times, patients with medical needs also need to stay in the service longer than 5 days. This was also echoed in the user and carer data.

"Our medical ones are much more of a quicker turnover, but sometimes they can be longer than five days, if there's a change in antibiotics or something that needs continually reviewing" (FG1)

"The aim when we started ART was to stick to a certain period of time, but there are certain people who [need] longer than that because their personal circumstances or their recovery is not improved in that timeframe" (P20)

There may also be reluctance at times for the ART team to 'let go':

"So many of our End of Life patients who go over to fast-track, continuing care, the feedback that we've got is, 'Why can't we stay with you, why do they have to go to another agency?'...we know that we're a short-term service and we know we've got to pass them on, but it is difficult for us as well as the patients" (FG1)

4.5.4 Team working and care co-ordination

Team working, communication and co-ordination was described within the ART team and with external service providers.

Team work and co-ordination within ART

Frequent handovers between members of the ART was a significant activity deemed necessary for effective care co-ordination:

"Handover is quite a substantial part of our day really, it's at least an hour in the morning, plus another one at three o'clock in the afternoon, as well as the sort of mini ones at lunchtime. We have a GP that should be at the handover every morning, and in the afternoon, so you've got direct feedback and direct liaison" (FG1)

"We have handover twice a day, obviously we have All Seasons carers with us and they tend to work a lot of split shifts so they will hand over to the nurse in charge before they leave at 12, and then that nurse will then make sure any issues between 12 and 4 are sorted before All Seasons come back in the evening" (FG1)

"Our communications have had to get a hell of a lot better, we have to keep handing over all the time because obviously we're not all on every day and we see different patients every day, you have to hand over everything, [and] your written information has got to be good" (FG1)

The perception amongst users and carers was also that the team worked collaboratively and information sharing was effective within the team.

There was a sense that all staff were valued for their contribution to the team and listened to:

"If we bring back something really important, for example, a significant change in somebody's pressure areas, we get listened to, it's really important that everyone listens and they do, and then they make a decision on that" (FG1)

The skill-mix, within the ART was highly valued by the team. The perception of users and carers was also that the team were highly skilled.

"With the GP in the team, we've also got Age UK and All Seasons. Age UK has been a real help for the domestic tasks and things, people that need...to get their money out to pay various bills, any domestic support if they're in this acute phase, that's been really helpful" (P17)

"We also have a therapist from rehab as well to cover weekends, we cover a day or at least a day or weekend of therapy, that could be OT or physio" (FG1)

“That’s a good thing about this team, being multidisciplinary, because we’ve all got our aspects of expertise, but they’re not all the same, even as nurses my background’s respiratory, [Name’s] is endoscopy, we’ve got somebody else that’s a heart specialist nurse previously... and it’s the same with the support workers, we’ve got a Band 4 that knows everything about equipment, we’ve got staff that’s come from the hospice...we’ve got a rehab support worker...we’ve got a really, really good skillset here, and as I say our GPs are amazing, we couldn’t wish for better GPs” (FG1)

Team work and co-ordination with external service providers

The development of trusted, personal relationships between members of the ART team and other service providers was key to successful team working and care co-ordination. Ways in which information was shared were various, but the value of personal communication and feedback was of paramount importance.

Personal relationships

“It’s not about having people like social workers or care staff based in the same building, it’s about having really good relationships with that team, wherever they’re based, so that things like referrals get processed efficiently, so that the people in each of the respective teams trust each other in terms of assessing patients, that they trust each other to make accurate assessments” (P1)

“I think both teams have grown and now we’ve got this relationship, this partnership” (FG2)

“We just pick the phone up. We’ve got to know each other...we’ve got a really good relationship with them (FG2)

Information sharing

This was highly personalised and achieved over the telephone or face-to-face, especially with social services:

“We update GPs, we go in person to the hospitals, so you’re not just referring, we’re talking with the consultants, the nurses, face-to-face, we’re part of the ward round...We pick up the phone and speak to hospices, we pick up the phone and speak to the GPs, nurses in the practice, we speak to the heart failure team, the respiratory team...” (FG1)

“I’ve just come off the phone to [clinical decision-maker] and she said, ‘well, you know, don’t forget...’, so we’ll be updating each other, because at the end of the day we want the best for the person we’re going in to, the service user” (FG2)

“Even if you say to them ‘oh, I didn’t think about that’ or ‘this is what I was thinking, do you agree?’ It’s just sharing it isn’t it for the individual at the end of the day” (FG2)

“You can speak to the people that are involved with their care, which is really important... I you can speak to the actual person, the physio that went out or the GP that went out” (FG2)

“So ART...will come and discuss the patients with the team on the ward while they are in hospital, then they will visit the patient on the ward and obviously understand from the patients and explain to the patients what they are going to do...so they knew exactly what are the challenges” (P5)

Communication and information sharing with GPs external to the ART was problematic initially but may now be improving. Some lack of communication between the ART and primary care services was also described in the user and carer data.

“Initially, to start with we were not sure which patients were under ART or when they were going to be discharged, but we do now get a notification that they’re under ART so that kind of avoids the duplication of work so professionals from the surgery don’t get involved with them, and the same when they’re discharged. And when they come to the end of it, for example, if any medications are stopped or if any blood tests need to be repeated or anything, that information will be communicated to the GP” (P4)

Information sharing digitally was more problematic due to a lack of a shared IT system:

“What is missing in co-ordination is shared records, you know, if we had shared records across all systems, if we could have more integration with the care teams” (FG1)

“Fairly imminently people like [clinical decision-maker] and the rest of the clinical team will be able to see the patient’s live GP record and the patient’s GP back in the patient’s practice will be able to see what the ART team has been doing with the patient. But we’ve not had that to date” (P1)

“Our IT systems can be a bit of a problem, I think EMIS is definitely on the horizon and we’re waiting for our training, but if one system could be used it would be an awful lot easier, but we will still remain on CIS with being able to access EMIS” (FG2)

Interestingly, social care staff valued being able to gain access to digital information, vicariously through the ART team:

“Because ART are part of health, if we are talking about somebody they can get information up on their screen to tell us when they last saw a doctor, for example, so they’ve got access to the medical records as well, which has been useful” (FG2)

In hospital, the ART team were able to influence the information that was sent to GPs at discharge:

“Information that was deemed important to be included on the DN [discharge notification] by the ART team was included by the junior doctors and therefore their GPs have more information available which were pertinent to them and to the patient’s care” (P5)

However, there was a perceived lack of communication and feedback to the ambulance service:

“Once we leave we get no feedback on that patient, so if we make a referral, good or bad, once we’ve left and it’s been agreed, that’s it...I’m assuming, if there was a major issue, we would get a complaint or something” (P3)

“I haven’t put any new stuff up about the ART team for quite a while, and I don’t know if they’ve had any changes, there’s not been a meeting” (P3)

“We would like more feedback, we would like an honest answer of how many referrals they’re making, how many of those patients they’re dealing with and able to keep at home and any negatives so we can feedback to staff, ‘this didn’t work because of this’. I think they’re currently just trying to get us to use it more and more and more without any real sU17stance behind it. There’s nothing for the Ambulance Service, we don’t get anything out of using them, they’re the ones that get the funding if they’re used more and make their case, we don’t get anything” (P3)

Social care staff described situations where care was shared with the ART:

“We’ve got a gentleman, we’re trying to get him onto continuing healthcare but there’s a change in circumstances. His main carer has gone away. We’re now working with the ART team, so they’re covering part of the calls because it is more of a health thing and we’re covering some of the calls” (FG2)

“We’re both of the opinion, you know, that for this particular gentleman, a hoist isn’t needed, I’ve been and done the moving and handling assessment this morning, she’s been out at lunchtime, so we’re both, to coin a phrase, singing from the same hymn sheet” (FG2)

Sharing extended to the ordering of and use of equipment which had an impact on the outcome for the user:

“I needed a 2” raised toilet seat which we didn’t have in stock in our peripheral stores, they did, so they allowed us to take that and then they re-ordered it back to their store...it’s been helpful” (FG2)

“We had a gentleman who had a fall and bent his Zimmer frame and this was on a Friday night. There was no way that he could have used his Zimmer frame to mobilise at all and without it he was immobile and he would have been hospital and they said, ‘we’ve got a Zimmer frame’”(FG2)

Working closely with other health and social care professionals has led to greater understanding of each other roles:

“The integration of social care and health working together has been quite an eye opener. I think health didn’t really understand what social care did to a certain extent or the enormity of what they did and the context work that we do, and we didn’t understand all the protocols and the sheer hard work that goes into working within the hospital” (FG1)

4.5.5 Impact of the ART service on patients and staff

Impact on patients

Benefits for patients were described in terms of quality of care including more holistic care, timeliness of care delivery and effective communication. Improved health and well-being was evidenced by being cared for at home through avoiding admission or being supported after discharge.

Better quality of care

Quality of care was cited as a key outcome for ART in terms of providing more holistic care, delivered at the time when patients needed it:

“We’re used to doing that holistic assessment and being able to pick up those other things and signposting, so although yes, this is very much medically led, if a patient is poorly you still have that scope to look wider across the whole patient” (FG1)

“This team does look at the overall situation of someone...so if someone’s unsafe, safeguarding, any of those issues, anybody who works within ART is trained to look out for those things, pressure relief, pressure sores, you know, all those things are flagged all the time, so we’re not just going in and giving someone a quick wash, you know, we’re flagging up if someone’s not eating, if someone’s not drinking, if someone hasn’t had their bowels open, if someone hasn’t passed urine for 24 hours” (FG1)

“If you look at the depth at which we’re working it’s far more than I do if I was having my GP hat on in the practice later in the week, not because I am less caring, it’s just that’s what ART is supporting” (FG1)

“They take the patient’s care immediately after the discharge, so some of them, if they are discharged in the morning they would be seen by ART in the afternoon, some of them will be seen first thing the following morning” (P5)

The ART are able to communicate directly with patients about what services will be provided, when:

“My gentleman that was started last week, he knew the physio was going because they said to him, ‘a physio will come tomorrow and will do this with you’. It’s not ‘oh I will refer through anthey may phone you’ So they know, they’ve been told directly who’s coming and when they’re coming” (FG2)

Improved health and wellbeing

The ability of ART to care for patients at home by avoiding admission and supporting them on discharge was believed to result in a more positive experience for patients. This was also the perception of users and carers:

“They are responding better at home and recovering better at home, they’re not getting sucked into another pathway” (P1)

“A patient needed more monitoring, more acute trained staff to go in because their blood sugar was a bit high...there was nothing to gain from going back to hospital, and the ART team came in, were able to make sure the antibiotic meds were taken, they were able to come in and give that extra level of care, that you wouldn’t have been able to get from a care company, you’d have to go to hospital, and these are the normal stories of people avoiding A&E” (P3)

“With End of Life patients, even if we don’t necessarily keep them right till the End of Life, you go in and you set them up and make them safe so that they can stay at home, and they don’t have to go into the hospital, they can be nice and comfortable where they are, and then obviously fast track comes and picks them up, or hospice” (FG1)

“I just feel that the individual has got every service concentrating on them, in their own environment, in their own time, and I think it’s that which I think is invaluable” (FG2)

The rehabilitation services, available as part of the ART also supported more rapid recovery:

“We’ve got a gentleman that’s just come on to us from the ART team. The ART team have been supporting him for two weeks...the physio was going out there from the ART team to say, ‘yes this gentleman can now get out of bed and slowly begin to mobilise round his property’. I mean from somebody that was in bed for two weeks, he is now going out on his mobility scooter” (FG2)

Impact on ART staff

Being a member of the ART had a number of perceived benefits for staff including access to training and education, skills development, and increased levels of responsibility, especially for support staff.

There were opportunities for regular training and education both in-house and provided externally:

“We’re having joint education...we have our own five weekly education here” (FG1)

“We’re lucky enough to have a GP tutor who works with us as part of ART and he’s given us regular training sessions” (FG1)

“We’re also lucky to be involved with any training the CCG put on, we’re also now allowed to go on that training as well, so that’s really useful for us” (FG1)

Up-skilling was described across different professional groups:

“For me I’ve just up-skilled so much and I never thought I’d ever do it at my age so it’s been great for me” (FG1)

“This is the first time that we’ve actually dealt with acutely unwell patients, so it’s quite a learning curve for all of us, from nurses to support workers, we had to almost up-skill and learn different roles and responsibilities” (FG1)

In addition to skills development, support staff valued the added responsibility of being part of the ART service and described gaining confidence in their roles:

“We’ve all been given the opportunity to do a lot more than we did when we were Rapid Response, and it’s not just about the skills, it’s about the responsibility as well, because you’re dealing with very sick people and if you don’t notice something, or you don’t bring it back to the team...that’s the responsibility that you want” (FG1)

“Working with these medically unwell people every day, you’re more aware of what to pick up on, what to feedback on, compared to the Rapid Response days, I’m sure that we’re all a lot more confident in that sort of thing now” (FG1)

4.5.6 Sustainability of the ART service and moving forward

Sustainability was described in terms of what is needed to continue the service as it is, but also increasing the scale of the service such as extending the target patient group, extending the hours of the service and expansion into care homes as another sources of referrals. As well as the scale of the service, implementation of ART in other geographical areas (spread) was noted.

Sustainability

In order to continue the existing service, ongoing funding based on hospital admission data and workforce issues, linked to funding and succession planning, were highlighted as issues to be addressed:

“Funding that has been invested is based on the rationale that certainly for Thanet CCG, the service is delivering savings. So, the less people going into hospital, costing the CCG less for those patients not to be in hospital, the money is being reinvested in the ART team. That’s the sort of crude rationale in terms of the funding model” (P17)

A shared understanding of the quantitative audit data was seen as essential for ongoing commitment of providers:

“Because of issues around what the data’s telling us, until we’ve got a shared understanding of that then, you know, organisations I don’t think are going to be able to give 110% commitment” (P17)

Both the establishment of staff and the need for succession planning were seen as important:

“The only thing is that we’re lacking permanent staff, because obviously at the moment our capacity is based on the staffing that we’ve got at the moment. We’ve been lucky enough to have a little bit of winter pressure money so we’ve been able to temporary source two nurses and another two support workers from All Seasons, however, it is only a temporary source of funding, and we are waiting for the CCG to approve more staff for us, we have been waiting quite a considerable amount of time” (FG1)

“From a workforce perspective, in terms of the sustainability of the service...making sure that the service... isn’t as fragile as potentially it could be. It is very reliant on three or four individuals in terms of the clinicians...we need to be planning anyway for those people, for when those people are no longer around, either through retirement or they leave and get another job” (P1)

Working at Scale

There was a desire, among the ART to expand the service in terms of more patients, with the recognition that this would require additional resources:

“We have to be very careful as to what is the purpose of ART... if you’ve got to expand a little, so you’re going to take in more patients, we need to be careful, because then we’re just going to be like any other service, so it’s a balance, we want to be cost effective but equally the reason it works well is because you can spend that time and expertise...” (FG1)

Expansion into care homes as a source of referral was an ambition which would require extra capacity.

“Being the first point of contact for care homes, that’s going to require an increasing capacity and it’s not necessarily new additional posts and new additional investment, it might be about re-designing the way some existing services work and operate” (FG1)

The recognition of this lack of capacity led to this expansion being implemented in a smaller geographical area, as a starting point:

“I was happy to do it with all of the nursing homes, but was told, ‘Hold on a minute, just reign yourself back, just do it in a little area first’...so we’re just trialling it in Westgate, Birchington area” (FG1)

There was also a desire to expand the type of patients served by ART, particularly patients with long-term conditions and more complex health and social care needs:

“The next step really is also to try and take over some of the frailty patients, you know, I don’t see why a 90 years old patient...who lives alone, if he has falls, cannot be more supported by ART...because don’t forget the population is elderly. Frailty is certainly something that needs to come out and we need to deliver it because the population is requiring it” (P5)

Increasing the hours ART is available was also an ambition:

“It would be really useful to have a GP till eight o’clock, and also with the staffing that we’ve got at the moment, other than obviously the little bit of winter pressures money, we don’t have enough staff for nurses to be on a late seven days a week, and obviously we want to have a cohesive service where we can offer the same service 12 hours a day, seven days a week, so that’s where we want to go...maybe even a 24 hour service if you’re looking at the best possible care that we can support” (FG1)

Spread

There was a desire within the ART and external stakeholders from social care, hospitals, and the Ambulance Service to implement ART across a wider geographical area outside Thanet CCG boundaries. This was also the view of users and carers. There was multiple reasons for this, namely, to have greater impact on admissions and therefore, produce greater cost savings; to disseminate a model that is seen to be 'best practice'; to reduce variation across the system making it easier for services to refer into:

"It is difficult at times, you want to help every single patient, but it almost feels a bit like a postcode lottery, where we will help our patients, but not help any others" (FG1)

"Strategically the whole of East Kent has to implement the model, because one of the downsides of the current model is, it's great that it's happened in Thanet, but it's only available for patients who are registered with a Thanet GP and it's only available for patients who are admitted or at risk of being admitted to QEQM. And obviously from an Acute Trust perspective they're looking at the other two sites in terms of Kent and Canterbury and the William Harvey. There's lots of interest from the other CCGs, particularly GPs, about wanting to roll out the model in other parts of East Kent" (P1)

"For it to be sustainable in Thanet, it has to be a sustainable model across the whole of the East Kent system. It just doesn't make sense, in the long-term anyway, to have it just for Thanet patients. [For] example, what we found in the early review of the data was that 'it's great, we appear to be keeping all these Thanet patients out of beds at QEQM' and all that was happening was the beds were being filled by patients from Canterbury" (P1)

"ART is not mapped to the hospital...and that means that if ART can only take, let's say out of 15 patients, if 4 of them are from Thanet then only 4 would be supported, the other 11 we need to find another way, which is either to discharge them at risk or to try and get other services to come in which is really not working very well. Currently the geography in East Kent, the hospitals are having a totally different overlap to ART, equally I understand that ART needs to start from somewhere but sadly the other CCGs have not bought into that service" (P5)

However, there was also a recognition that there needs to social care services and capacity elsewhere in the health and social care economy:

"if you're thinking about say setting up an ART team say, in Dover, then you need to make sure that Dover's got a good KEaH team to follow" (FG2)

4.5.7 What is needed to improve the service

Going forward a number of suggestions were made to improve the service including access to GP beds, formalisation off procedures and protocols, further education and training and a single referral system for the Ambulance Service:

"Having access to beds, somewhere where we can get somebody in to have some fluids, or some IV antibiotics, instead of going to the acute sector, that could be a direction" (FG1)

"It'd like for it to be more formal, more things written on paper, more standard operating procedures, more flowcharts. If somebody new came in, I'd like them to be able to know exactly what to do, when to do it, who to contact" (FG1)

"Build up the framework of governance, the clinical aspect, the protocols...reporting incidents like any other organisation, if anything happens in their day-to-day work. If anything happens then you know there are proper systems in place for a complaint or a significant event, that all needs to be sorted" (FG1)

“The education and training of the staff who are there currently and also the people who are going to come in the future” (FG1)

A single telephone number for referrals across the region was seen as beneficial in order to streamline the referral process and maximise the number of patients that could be passed on to ART, especially by the Ambulance Service:

“We would like take a kind of consistent approach in every area...if we could have one phone number for each area, so wherever I am I can phone that phone number and that call handler will be able to pass me on to the correct team” (P19)

Better integration of services, aligned to patient pathways, was also highlighted:

“The pathway that patients move along through all these services has to be joined up. What we can’t have is all these separate services like the ART, like the integrated discharge team, like the service that Hilton provide, you know, we can’t continue to operate in that disjointed way. Because it’s not good for patients and it’s not an efficient use of resources and the workforce” (FG1)

4.5.8 Active ingredients for success

There was a number of active ingredients for success identified, mainly relating to the personal qualities and skills of the staff involved and around multi-professional team working:

“I think GPs - having that extra resource, for patients to avoid admission, would be really important” (FG1)

“Passionate GPs, that’s the first thing, you’ve got to get GPs involved before you even look at anything else, they’ve tried to look at it in other areas, the staff want to do it, but ultimately this is a GP led service, and without GPs on board you can’t even move forward” (FG1)

“The clinicians who are delivering the service have to be absolutely passionate about doing it and have to believe that what they’re doing is the right thing. Because without that it would just be another admission avoidance service” (FG1)

“We couldn’t have done anything without our staff and the way we integrate together, everybody’s moved at the same pace with the same enthusiasm and I think if we didn’t have that then it wouldn’t work” (FG1)

“Skilled staff I think, a group of people with lots of different skills. If we go and do a visit you can bring something back and everyone’s in there, it’s really good, it’s a good feeling to have, to make decisions, because they have the skills” (FG1)

“It’s multi-professional, so it’s not one person or it’s not one kind of professional who is running it, so there is social services, nursing, GPs. It’s more like a mini MDT who are able to look after the patient when they need them the most” (P20)

A bottom-up approach to implementation was also highly valued:

“It wasn’t decided by ‘this is what NHS England want you to do’ and it comes down that way, it was very much decided here, this is what this team can provide, this is what we feel we can do, this is what our

staff do, and it was built on that, and I think that's why it's been so successful, because it's very much this is what we can do, so this is what we're going to do, rather than 'you need to do this'”(FG1)

In summary

In setting up the service, a number of facilitating factors were identified including the benefits associated with developing from an existing team (Rapid Response), and CCG and key stakeholder support. Challenges were around the mechanisms for referrals into the service and the lack of anticipated input from some service providers. Referrals into the ART remain sub-optimal primarily due to lack of awareness of the service but other provider-specific factors. There was a recognition within the ART service that a re-launch or further education was needed. Similarly, there were challenges around transitions out of the ART related to lack of capacity in other services, particularly social care. Lack of capacity was also identified within the ART due to lack of staff and lower than expected patient turnover. Care co-ordination and information sharing within the ART was highly effective and facilitated by frequent handovers. Staff were valued for their contribution and reported up-skilling and increased levels of responsibility, which was welcomed. Staff valued having access to training and education both within the team and externally. The ART developed trusted, personal relationships with other service providers which was important for successful team working and care co-ordination. Information shared was mostly by personal communication which was valuable. Digital information sharing was more problematic due to the lack of a shared IT system. Working closely with other health and social care professionals led to greater understanding of each other roles and responsibilities. For social care, the involvement of the ART led to more rapid enablement primarily due to the input of the ART therapists and provision of equipment. Going forward, there was a desire to expand the service in terms of taking referrals from care homes, expanding the type of patients served by ART, and increasing the hours that the ART was available. There was also an ambition to increase the geographical area of the ART. Suggestions for improving the service included access to GP beds, formalisation of procedures and protocols, and a single referral system into social services, and ART. Increasing the establishment of staff and succession planning were seen as important to achieve these aims.

On reflection overall, the ART service has made substantial strides towards integrated intermediate care working. The service has managed to transcend many of the difficulties associated with integrated care through an ability to stay focused on providing an acute rapid response which has brought about real impact in reducing hospital admissions. Despite some improvements that are needed regarding communication, system processes and digital information sharing, for example, the ART have all the essential ingredients for successful integrated care including: good co-ordination and collaboration both within the team and with the other agencies, assisted by the team's intrinsic influence in the early stages of implementation and the co-creative way this was operationalised. This collaboration extends to knowledge transfer and a true understanding of different roles and responsibilities; Integrated care is all about relationships and this is a strong feature in this analysis. There is effective leadership provided by key individuals, namely the Senior Clinical Decision Makers and GPs in leadership roles which are central to swift decision-making. There is a desire to scale-up and spread the initiative and there seems to be an appetite to do this from all agencies. The features above suggest the team are well-placed to do this but need to remain focused on the purpose and expected outcomes of the initiative so as not to try and be 'all things to all people'.

5. Recommendations

A number of recommendations are made in relation to users and carers, the process of delivering the service and the requirements for sustainability, scale and spread.

Recommendations for users and carers

Overall, users and carers experienced a service which was highly person-centred with good care co-ordination, especially between the ART but also with other service providers. Recommendations largely relate to the communication and information needs of users and carers. At times, users and carers were unaware that they had been referred to the ART. Clearer communication is needed by those referring into the service and the ART themselves so that users and carers are aware they will be receipt of the service. Similarly, on some occasions staff in primary care were unaware that users are being cared for by the ART which resulted in some duplication of services for the user. For some users, knowing the approximate time the ART would be visiting would be appreciated. Communication and information sharing with carers was effective, especially for those carers who lived with the user. However, those who did not live with user did not know if the ART had visited and what was being done. The ART should explore with users what information is to be shared with carers who do not live with the user, and how this might best be achieved, for example, telephone calls or written information left with the user at home, if requested.

For some users, the purpose of the ART was unclear and they required more consistent verbal and written communication about the remit of the service. This also related to discharge from the ART with some users feeling the service ended unexpectedly and abruptly and they were not clear about the reasons for this. For some, more effective communication may be needed about the time-limited nature of the service and should include preparation for discharge. This preparation may also include action planning and preparing for setbacks in the future, including self-management support and planning for gradual deterioration and death where appropriate. Although, this is not necessarily within the remit of the ART service, it was highlighted as a need, especially by carers.

Whilst most users experienced a smooth transition to other services after the ART, some experienced time delays and lack of follow-up. Part of this may relate to a lack of understanding about the nature of some services, such as enablement which are not part of a 'rapid response' service. Delays may also be being brought into sharper focus when comparing the speed at which the ART service was initiated after referral. This may require managing user and carer expectations.

Recommendations for service delivery

Recommendations focus on processes of care specifically referrals into the service and transitions out, and care care co-ordination.

The ART takes referrals from a wide range of service providers in primary, community and secondary care. There is recognition within the ART and amongst external stakeholders that many patients who meet the eligibility criteria are not being referred. The reason for this is largely lack of awareness of the service. To address this the

ART needs to increase the profile of the service through the development of an effective information strategy which may include face-to-face meetings, or written information for example, targeted at different organisations. GPs and the Ambulance Service, in particular would value feedback on the impact the service has on patients. The ART may need to consider focusing their efforts in specific areas that have the greatest potential for impact. For example, primary and community providers. Referrals from the ED seem particularly problematic in that once patients arrive they are unlikely to be referred until after completion of tests and investigations. The pilot to include referrals from care homes needs to be monitored to assess the impact on overall referral rates.

Transitions out of the service are also challenging largely due to lack of capacity in the health and social care economy as a whole, but specifically lack of available care packages which impacts on the turnover of patients within ART, which in turn impacts on their ability to take new referrals. This is of course, no simple solution to this. However, streamlining the process of referral to social services i.e one referral from the ART which can then be passed on to the appropriate team within social services may speed up the transition process.

Overall, care co-ordination and information sharing was effective and built on trusted, personal relationships. At the time of writing this report the lack of a shared IT system accessible to all, inhibited care co-ordination although access to EMIS is now being made available to the ART which may go some way to address this.

Recommendations for sustainability, scale and spread

Going forward, to ensure sustainability continued resources, especially skilled staff are necessary and there is a need for succession planning as the service is reliant on a small number of key staff. There is also a need to formalise policies and operating procedures and a clear governance structure needs to be established with all provider organisations. To ensure the ART is sustainable, its needs to remain focused on its main purpose to avoid being 'all things to all people". There are ambitions to scale-up the service such as extending opening hours and extending the eligibility criteria to older, frail people. However, in order to do this, again, additional resources are necessary. There is also a desire to extend the service to other geographical areas, outside Thanet which will require buy-in from other CCGs and all service providers.

6. Evaluation Challenges and Limitations

Recruitment of users and professionals for interview

Recruitment of users was more difficult and took longer than anticipated. The reasons for this were various but include the fact that users in receipt of the service were generally elderly, frail and unwell, with some only recently discharged from hospital. This made it less likely that they would want to participate. As a result the sample consisted of a greater proportion of informal carers than expected (N=13). In addition, recruitment took place at the point of discharge from ART, which was also challenging given that many users remained in receipt of the ART service beyond 5 days and often for many weeks, as described in the findings of this report. This made the turnover of users lower than anticipated. As a result, the decision was made to include some users who had not yet been discharged from the service which in hindsight, added to the richness of the data as the sample then included those with more complex health needs and those in receipt of personal care. However, despite these challenges, the recruitment target of 30 users and carers was almost met (N=29).

The recruitment of professionals external to the ART was also challenging, and was likely due to heavy workloads. As a result some professional groups and organisations were not represented. Most notably, there was no representation from staff based in the ED which was unfortunate given the pivotal role this department plays in referrals to the ART. Similarly, there was no representation from community nursing or mental health services.

The P3CEQ

It was the intention to administer the P3CEQ to 80 users. The actual number was just 21. The Meridian Survey is a questionnaire administered to patients by KCHFT, including the ART, as the time of discharge. During the design phase of the evaluation it was hoped that this survey could be temporarily stopped during data collection for this evaluation, however, this was ultimately not possible. In addition, in March 2018 a national intermediate care survey was also introduced within the ART population. Overall, this meant that users were being asked to complete three different questionnaires all evaluating the service. This was overly burdensome and confusing for users, many of whom told us that they already completed the questionnaire (P3CEQ). The small sample size meant that limited sub-group analysis of the P3CEQ could be carried out with only a total mean score and scores for individual items being calculated. Qualitative data from the P3CEQ data was used to supplement the interview data on the themes of person-centred and co-ordinated care.

7. Conclusions

In conclusion, this evaluation has considered the extent to which the ART has impacted upon the patient experience with respect to person-centred, co-ordinated care, and wellness. The ART delivers a high standard of care which is valued by users and carers alike. Users are treated with dignity and respect and carers are supported emotionally and practically. There is good collaboration and care co-ordination within the ART and with other service providers. Although users experience an improvement in their health and wellbeing in the short term, for many this is within the context of deteriorating long-term conditions. The evaluation has also explored the experiences and perceptions of professionals and managers of the ART service and external stakeholders. Personal relationships are key and facilitate effective communication. There is a unique understanding of each others roles and responsibilities which enhances integrated working. There is effective leadership and a team climate of trust, respect and shared decision-making. As a result, the ART has a number of key ingredients in place for successful integrated intermediate care, going forward. Although, some improvements to the service are recommended, overall the ART is well-placed to deliver a service which is both sustainable and transferable, given adequate resources.

8. References

Flick, U. (1998) *An Introduction to Qualitative Research*. Sage Publications: Thousand Oaks CA.

Thanet CCG (2017) *Integrating Health and Social Care in Thanet. Thanet Acute Response Team Pilot Proposal* (14th Nov 2016 to 31st March 2017). (Unpublished).

Sugavanam, P., Byng, R. and Lloyd, H. (2016) Identifying and modifying a measure to tap individuals experiences of person centred and coordinated care: The development of P3CEQ. In, review. *BMC Health Services Research*.

Timson, G., Emery, E., Halse, A. and Jones, L. (2017) *Acute Response Team Evaluation*. Thanet CCG (Unpublished)

9. Appendices

Appendix I

The Person Centred Coordinated Care Experiences Questionnaire: P3CEQ

This questionnaire is about your experience and understanding of the care you have received from your Health and Social Care, Acute Response Team (ART).

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

The following questions ask you who you have received care from and when [Please tick all that apply to you]

- a) Who have you received care from for a long period of time that is for 3 months or more? [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"/>

- b) Who have you received care from whilst in the ART service – this is the team that you met at home, at Westbrook House or the Emergency Department at the hospital, and who provided care for you for a few days? [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"/>

c) Who are you now receiving care from that is new for you? [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 wellbeing?

[0]	Not at all	<input type="checkbox"/>	Comments:
[1]	To some extent	<input type="checkbox"/>	
[2]	More often than not	<input type="checkbox"/>	
[3]	Always	<input type="checkbox"/>	
	Not relevant	<input type="checkbox"/>	

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

[0]	Not at all	<input type="checkbox"/>	Comments:
[1]	To some extent	<input type="checkbox"/>	
[2]	More often than not	<input type="checkbox"/>	
[3]	Always	<input type="checkbox"/>	
	Not relevant	<input type="checkbox"/>	

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

[0]	Not at all	<input type="checkbox"/>	Comments:
[1]	To some extent	<input type="checkbox"/>	
[2]	More often than not	<input type="checkbox"/>	
[3]	Always	<input type="checkbox"/>	
	Not relevant	<input type="checkbox"/>	

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

[3]	Not at all		Comments:
[2]	To some extent		
[1]	More often than not		
[0]	Always		
	Not relevant		

5. Is your healthcare joined up in a way that works for you?

[0]	Not at all		Comments:
[1]	To some extent		
[2]	More often than not		
[3]	Always		
[3]	I only use one healthcare service (e.g. GP)		
	Not relevant		

6. Do you have a single professional (or several professionals) who takes responsibility for coordinating your care across the services that you use?

[3]	Yes		Comments:
[0]	No		
[0]	Don't know		

7. Do you have a care or support plan (or a single plan of care or support) that takes into account all your health and wellbeing needs?

[3]	Yes		Comments:
[0]	No		
[0]	Don't know		

8. Have you had enough support from the healthcare staff to help YOU to manage your own health and wellbeing?

[3] I do not need support		Comments:
[0] I have had no support		
[1] I sometimes have enough support		
[2] I often have enough support		
[3] I always have enough support		
Not relevant		

9. To what extent do you receive useful information at the time you need it to help you manage your health and wellbeing?

[0] I do not receive any information		Comments:
[1] I sometimes receive enough information		
[2] I often receive enough information		
[3] I always receive enough information		
[2] I receive too much information		
Not relevant		

10. How confident are you that you can manage your own health and wellbeing?

[0] Not at all confident		Comments:
[1] Not too confident		
[2] Somewhat confident		
[3] Very confident		
Not relevant		

11. Did the healthcare staff involve your family/friends/carers as much as you wanted them to be in decisions about your care?

[0] Not at all		Comments:
[1] To some extent		
[2] More often than not		
[3] Always		
[3] My family/friends/carers did not want to be involved		

[3]	I have no family/friends/carers		
-----	---------------------------------	--	--

How could your care be improved?

What would support you to feel more confident to help manage or maintain your health and wellbeing?

Any other comments?

Thank you very much for completing this questionnaire.

Appendix 2

Patient Interview schedule V1

Evaluation of the Acute Response Team Service

1. Experience with receiving the service

You recently received a service from a team of people called the 'Acute Response Team' that helped you for a short period when you became ill. They may have assessed you at home or in the Accident and Emergency department and organised some care for you. The aim of these questions is to get your feedback on this service and the care you received, particularly in relation to what did and did not work.

I. Please give us your thoughts on:

- a) *Your overall impressions and experiences of receiving the service*
- b) *What sort of care was organised for you?*
- c) *What went well and what didn't go so well?*
- d) *Thinking about any care you received before this particular service, have you noticed any difference in the way your care needs are now being met?*
- e) *If there are changes, are they better or worse? Please give me an example.*

2. Effects on health and well-being

These next questions ask about whether the care you have just received has made a difference to your health and well-being.

I. Thinking about your general health and well-being:

- a) *Do you feel your health and well-being has improved, stayed the same or got worse?*
- b) *In what way has it improved, stayed the same or got worse, and why do you think this has happened?*
- c) *How do you feel about looking after yourself and being independent? Did the care you received make a difference? In what way?*

II. Thinking about avoiding setbacks to your health and well-being:

- a) *Have you been offered any home safety improvements or been given any equipment to help you? If yes, what were you offered and did it help you or not?*
- b) *If your health should take a turn for the worse, what would you do? Has the care team helped you with a plan of action?*

3. Care received

Now I would like you to think about how the staff work to give you the care you need.

I. Thinking about the recent care you received

- a) *Who has been involved in your care?*

- b) Do you feel your needs were met? If yes, in what way? If no, please explain why.*
- c) How did you feel about the time it took the ART to respond to your needs when you were first taken ill?*
- d) How about during your illness – do you feel they met your needs in good time, or could it have been faster?*
- e) How would you describe the way that the people involved in your care treated you? (respect and dignity, listening, friendliness)*

II. How did all the different workers treating and caring for you work together?

- a) How would you describe the way that they worked together?*
- b) Do you think that the workers shared information with each other about you and your care plan/treatment, or did you find yourself having to repeat your story?*
- c) Was the information you got from workers consistent?*
- d) Did workers know all the important information about you that keeps you as independent as possible at home?*

III. Did you know who to contact (and how to contact them) if you need to ask questions about your condition(s) or care?

4. Improving the Care

These questions are all about how we can make improvements to the service.

I. Thinking about the care you have received, what could we do to make the service better?

5. Moving between Services

These questions ask about what happened to you when you were discharged from ART

I. Did you receive any other service(s) after the ART? Please describe this/these to me.

- a) Who is involved?*
- b) Was this a new service(s) or one that you were already receiving?*

II. Tell me about the length of time it took to get this service(s) and how you felt about that.

III. Do you think that the workers shared information with each other about you and your care plan/treatment, or did you find yourself having to repeat your story?

IV. Did the workers know all the important information about you and your needs that keeps you as independent as possible at home?

Final question: Is there anything else you would like to add?

Thank you for your time

Appendix 3

Carer Interview schedule V1

Evaluation of the Acute Response Team Service

1. Experience with receiving the service

A person you are caring for [*insert patient's name*] recently received a service from a team of people called the 'Acute Response Team' that helped them for a short period when they became ill. They may have been assessed at home or in the Accident and Emergency department, and had some care organised for them. The aim of these questions is to get your feedback on this service and the care they received, particularly in relation to what did and did not work, from your point of view.

I. Please give us your thoughts on:

- a) *Your overall impressions and experiences of the service*
- b) *What sort of care was organised for them?*
- c) *What went well and what didn't go so well?*
- d) *Thinking about any care they received before this particular service, have you noticed any difference in the way their care needs are now being met?*
- e) *If there are changes, are they better or worse? Please give me an example.*

2. Effects on health and well-being

These next questions ask about whether the care [*insert users name*] has just received has made a difference to their health and well-being.

I. Thinking about their general health and well-being:

- a) *Do you feel their health and well-being has improved, stayed the same or got worse?*
- b) *In what way has it improved, stayed the same or got worse, and why do you think this has happened?*
- c) *How do you feel about how they are looking after themselves and being independent? Did the care they received make a difference? In what way?*

II. Thinking about avoiding setbacks to their health and well-being:

- a) *Have they been offered any home safety improvements or been given any equipment to help them? If yes, what were they offered and did it help them or not?*
- b) *If their health should take a turn for the worse, what would they do? Has the care team helped them with a plan of action?*

3. Care received

Now I would like you to think about how the staff work to give *[insert users name]* the care they need.

I. Thinking about the recent care they received

- a) *Who has been involved in their care?*
- b) *Do you feel their needs were met? If yes, in what way? If no, please explain why.*
- c) *How did you feel about the time it took the ART to respond to their needs when they were first taken ill?*
- d) *How about during their illness – do you feel they met their needs in good time, or could it have been faster?*
- e) *How would you describe the way that the people involved in their care treated them? (respect and dignity, listening, friendliness)*
- f) *How would you describe the way that the people involved in their care treated you? (respect and dignity, listening, friendliness)*

II. How did all the different workers treating and caring for *[insert users name]* work together?

- a) *How would you describe the way that they worked together?*
- b) *Do you think that the workers shared information with each other about *[insert users name]* and their care plan/treatment, or did you find *[insert users name]* or yourself having to repeat their story?*
- c) *Was the information they got from workers consistent?*
- d) *Did workers know all the important information about them that keeps them as independent as possible at home?*

III. Does *[insert users name]* or yourself, know who to contact (and how to contact them) if *[insert users name]* or yourself need to ask questions about their condition(s) or care?

4. Improving the Care

These questions are all about how we can make improvements to the service.

- I. Thinking about the care *[insert users name]* has received what could we do to make the service better?

5. Moving between Services

These questions ask about what happened to *[insert users name]* when they were discharged from ART

- I. Did they receive any other service(s) after the ART? Please describe this/these to me.
 - a) *Who is involved?*
 - b) *Was this a new service(s) or one that they were already receiving?*
- II. Tell me about the length of time it took to get this service(s) and how you felt about that.

- III. Do you think that the workers shared information with each other about their care and treatment or did *[insert users name]* or yourself, have to repeat their story?
- IV. Did the workers know all the important information about them and their needs that keeps them as independent as possible at home?

Final question: Is there anything else you would like to add?

Thank you for your time

Appendix 4

ART – Focus Group Schedule V1

Evaluation of the Acute Response Team service

1. Experience with the implementation of the ART service

- I. Since the service has been put in place, give us your thoughts on:
 - a) Your general experience of the service – what has been easy and what has been challenging?
 - b) Which aspects of the service were, in your opinion, implemented successfully? What facilitated this success?
 - c) Which aspects of the service were, in your opinion, less successfully implemented? What particular things got in the way?
 - d) Are there any changes to the way that patient care needs are now being met and looked at? What are your views about these changes?

2. Coordination and impacts on patients

- I. In your opinion, what effect has the service had on the way you now work together in a coordinated way, as ART members and with other services and professionals?
 - a) What has or has not changed?
 - b) How would you describe the way you now work together? How does the skill mix work? (*clear roles and responsibilities; shared goals, decision-making, working as a democracy*)
 - c) What are your perceptions of how information is now shared between yourselves and with other agencies (*data sharing agreements*)
 - d) What are your views on how the service has impacted on patients receiving care? (*outcomes – hospital admission prevention, crisis avoidance, health and wellness, self-management, positive experience, seamless care*)
 - e) What are your experiences of working with other teams and professionals? (*health and social care, communication*)?

3. Sustainability

- I. In your opinion, what is needed to ensure the service continues to move forward?
 - a) What are the ‘active ingredients’ that could be passed on to other areas to help them succeed?
 - b) What personal attributes do you think you need to succeed?
 - c) Are there any stumbling blocks that still need to be overcome? (*politics, workforce changes, working environment, culture, relationships, resources*).

- II. Are you able to draw some conclusions about what works better in the ART model and why? (*co-ordination, leadership, engagement, information sharing, care planning, culture, relationships*).

If negative – what might have led to this?

4. Issues of staff engagement and retention

- I. How has the rollout of the service affected your engagement within the team?
 - a) Have there been any changes to relationships in or outside of your team – if so, what were they and why might they have happened?
 - b) How has it impacted on patient pathways (*right referral at the right time*)?
- II. Thinking about staff motivation and satisfaction, could you answer the following?
 - a) How would you rate your overall job satisfaction since the rollout of the service – what might have affected it?
 - b) Have you been more or less motivated to undertake work in the service?

Final question: Is there anything else you would like to add?

Thank you for your time

Appendix 5

Staff Focus Group/Interview schedule V1

Evaluation of the Acute Response Team service

1. Experience with the implementation of the pilot

- I. Since the service has been put in place, give us your thoughts on:
 - a) Your general understanding of what the service is there to achieve
 - b) Your experience of managing/being involved with/commissioning/ leading the service – what has been easy and what has been challenging?
 - c) Which aspects of the service were, in your opinion, implemented successfully? What facilitated this success?
 - d) Which aspects of the service were, in your opinion, less successfully implemented? What particular things got in the way?
 - e) Are there any changes to the way that patient care needs are now being met and looked at? What are your views about these changes?

2. Coordination and impacts on patients

- I. In your opinion, has the service had any effect on the way professionals now work together in a coordinated way?
 - a) What has or has not changed?
 - b) How would you describe the way professionals now work together? (*clear roles and responsibilities; shared goals*)
 - c) What are your perceptions of how information is now shared? (*data sharing agreements*)
 - d) Are you able to draw some conclusions about what works better and why? (*leadership, engagement, information sharing, care planning, culture, relationships*)
 - e) What are your views on how the service has impacted on patients receiving care? (*outcomes – admission avoidance, health and wellness, self-management, positive experience, crisis management, seamless care*)
- II. What are your views about transitions of care to other services when patients are discharged from ART? (*smooth/or smooth, rapid/slow, how information is shared, duplication of assessment*)

3. Sustainability

- I. In your opinion, what is needed to ensure the service continues to move forward?

- a) What are the 'active ingredients' that could be passed on to other areas to help them succeed?
- b) Are there any stumbling blocks that still need to be overcome? (*politics, workforce changes, working environment, culture, relationships, resources, funding/finance*)

Final question: Is there anything else you would like to add?

Thank you for your time.