Health and Adult Care Scrutiny Committee

Rapid Response Spotlight Review

November 2018

1. Recommendations

The spotlight review asks the Health and Adult Care Scrutiny Committee and Cabinet to endorse the recommendations below, with a review against progress of the recommendations in 12 months time.

	Ambition	Specific recommendations
1	Continue to develop Rapid Response service.	1.1 Consideration of joint teams to provide both Rapid Response and social care reablement, enabling the team to have more flexibility to respond to need.
		1.2 Explore the feasibility of GPs as part of the Rapid Response team as a standardised approach across Devon.
		1.3 Record all calls and Rapid Response teams take a proactive approach where there is no help available, calling back health professionals when care is available, if not already done.
2	Support the system to work.	2.1 The Scrutiny Committee continue to scrutinise other aspects of system flow to ensure that appropriate care is available when needed and avoid bottlenecks.
		2.2 Scrutiny to celebrate the successes of Rapid Response and receive a yearly report on the number of people being kept out of hospital because of the service.
		2.3 Consideration to be given to a review of the geographical limitations that may be placed upon a service – where a patient can only be treated where they are registered in area.
		2.4 A review of all intermediate care provision across the County with a view to reopening some community hospital beds on a flexible basis to ease pressure on the system and Devon to see no further community hospital bed closures.
		2.5 Write to the Secretary of State for Health to request a review of pay structures within Rapid Response and Social Care Reablement.
3	Increase GP and other agency's confidence.	3.1 Publish % patient satisfaction on website including a 'you said – we did' response form (possibly online with the Rapid Response pages in Kent https://www.kentcht.nhs.uk/service/rapid-response/).
		3.2 Review the phraseology used to describe patients in the Rapid Response service.
		3.3 Publicise the 'yellow card' scheme where GPs are able to feedback on systems that are not working as well as they could.
4	End of Life Care Support	4.1 Review of Hospiscare's role in end of life support with a view to increasing public sector funding.

2. Introduction

2.1 The Health and Adult Care Scrutiny Committee heard representation in January 2018 under public participation from a GP in East Devon. Dr Slot shared his concerns about how the Rapid Response service was working. A full transcript of the address in in Appendix 1.

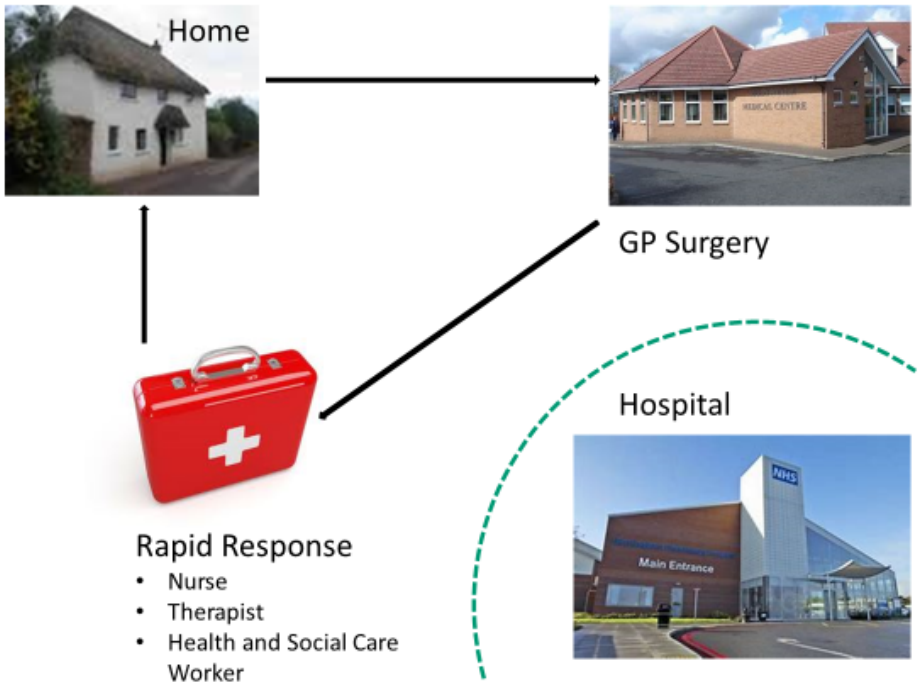
2.2 Whilst it is unusual for the Committee to establish a review group following public participation, listening to the voice of the public is a crucial part of scrutiny work. Subsequently the spotlight review was established to ascertain whether these concerns were shared across Devon. The scope was set as:

- To understand how the Rapid Response system should work and how it is working
- To carry out a survey among GPs in Devon to ascertain if the concerns raised are typical of other primary care practitioners.
- To identify pressure points in the system and understand what action might be taken to ameliorate them.

2.3 The spotlight review was conducted over two sessions which took place on 6 June 2018 and 25 July 2018. The review spoke to nine witnesses over these two sessions. This report is the conclusions that the review group have drawn from these witnesses sessions, triangulated with other collected data.

3. What is Rapid Response?

3.1 The Rapid Response service provides care for a person in their own home when they are experiencing deterioration in health or if there has been a breakdown in care arrangements. The service is a short term intervention for up to seven days, designed to support people to remain in their own home instead of being admitted to an acute hospital or nursing home (community hospitals).



3.2 Most of the referrals are made by GPs, but they can also be made by GP out-of-hours service, community health and social care services and Ambulance crews. The agency referring rings the Rapid Response Intervention Centre which co-ordinates care.

3.3 Care needs are assessed by a member of the Community Health and Social Care Teams This is provided by Rapid Response support workers employed by NHS Healthcare Trusts or by care staff provided by local agencies and is co-ordinated by the Rapid Intervention Centre. Care can be provided up to four times a day and overnight if required.

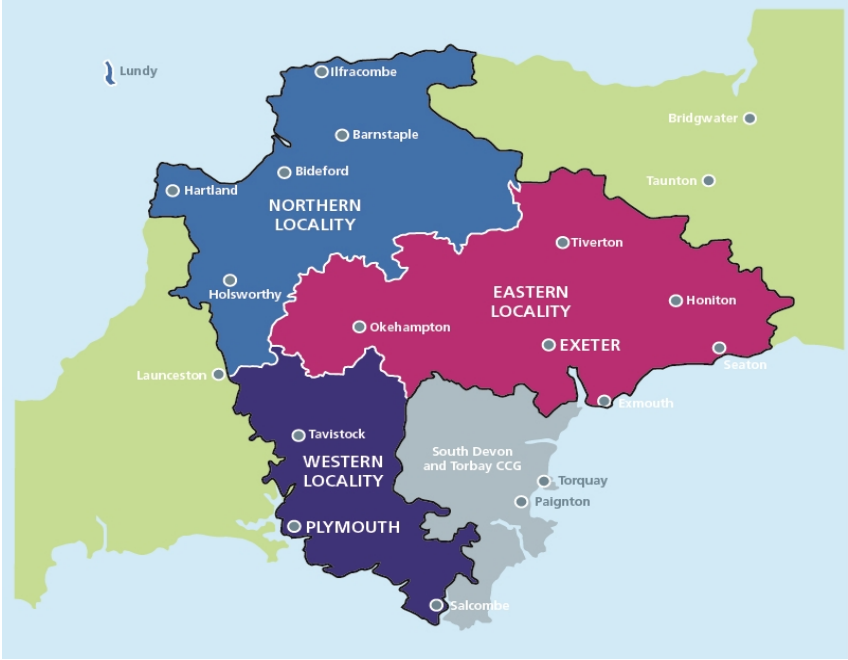
3.4 Avoiding a hospital admission where possible can be of significant benefit, minimising disruption, improving recovery, and reducing the risk of possible complications that can be associated with hospitalisation. Most patients treated through Rapid Response in Devon say that they would prefer to not go to hospital[1].

3.5 The DCC Social Care Reablement service provides a corresponding community-based service to support successful transition in 'step down services' when people are discharged from hospital. These teams work on similar interventions to support independence.

Recommendation 1.1 Consideration of joints teams to provide both Rapid Response and social care reablement, enabling the team to have more flexibility to respond to need.

How is Rapid Response organised in Devon?

3.6 Across Devon health and social care is managed at an area level, with Northern, Eastern and Western Devon making the 'NEW' in NEW Devon CCG. South Devon and Torbay CCG covers this remainder of the County. These areas are demarked on the map below:



3.7 The areas can have different approaches as appropriate to match the needs of the local population. See Appendix 2 – leaflet from the Northern Locality. The spotlight review has been informed of the following local approaches:

In the Western locality the Rapid Response Care Service is comprised of 'band 4' co-ordinators and 'band 3' support workers, providing the intervention together with the Intermediate Care Service and in conjunction with local community hospitals. Co-ordinators will receive referrals, allocate work, collect data and arrange duty rotas. Rapid Response staff receive training from Livewell South West, and are able to draw on the resources of the Intermediate Care team.

In the Eastern locality the Rapid Response teams are complimented by the Eastern Urgent Community Response working to help people living in Exeter, Mid Devon and East Devon on discharge from acute hospital. However, the team includes nurses, community matrons, physiotherapists, occupational therapists, social workers, social care assessors, co-ordinators, support workers and therapy assistants.

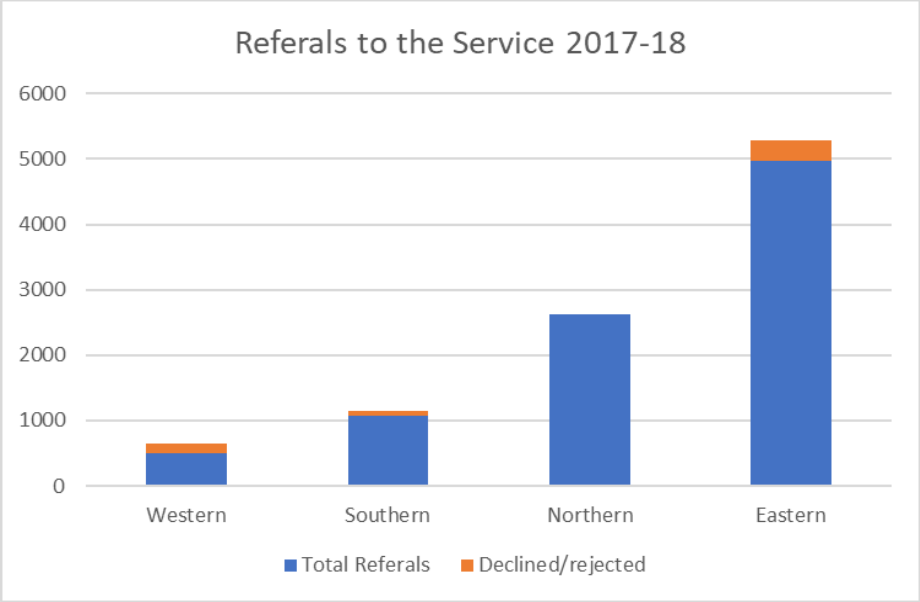
[1] Information provided to the spotlight review

South Devon and Torbay CCG organise care differently again, ensuring that qualified GPs are part of the team. Many of the witnesses that the task group spoke to felt that this was a very positive development.

Recommendation 1.2 Explore the feasibility of GPs as part of the Rapid Response team as a standardised approach across Devon.

Referrals to Rapid Response

The chart below shows the number of referrals made and the number declined or rejected over the period from April 2017 to March 2018. In North Devon no referrals were declined during this time.



3.8 As demonstrated here the number of referrals declined or rejected is a very small proportion (less than 6%, approximately 300 people, on average) of the total number of cases that are referred. However, the spotlight review does have concerns about inconsistencies in recording calls that are not referred. Hearing from some witnesses, it became clear that calls may not be recorded if care was not available at that time. This could lead to the figures looking lower, or even higher – if unsuccessful referrals are double counted because they have recorded more than once. GPs and Hospiscare also expressed concerns about whether all of the calls were being logged. Within the figures the number of calls logged does not differentiate between patients, and a patient could be referred more than once if there was no capacity.

Recommendation 1.3 Record all calls and Rapid Response teams take a proactive approach where there is no help available, calling back health professionals when care is available.

3.9 **Reasons for Rapid Response intervention not being possible:** This broadly breaks down into either capacity, or a referral whose needs cannot be met by the service:

Capacity not available	**Patient needs support beyond what can be offered**
Capacity of team due to, staff sickness/leave	Needs of the individual being over and above what Rapid Response can support, (i.e. related to medication management
Timings or location of incoming referral and/or not compatible with scheduled rota or capacity for night sit	Increasing number of inappropriate requests to breach gaps to cover for a lack of packages of care in the locality.
When RR capacity is supporting wider personal care demands in the system, where people may wait for personal care package (closely monitored)	

3.10 For those referred, the service is able to care for the majority in their own home, figures below have been supplied to the spotlight review. (no data was available for Northern Devon)

locality	looked after at home
Eastern	73%
Southern	72%
Western	82%

3.11 For those not able to be cared for at home, they were either taken to a hospital, or another care setting for example hospice, residential or nursing care. The dedicated system would also include:

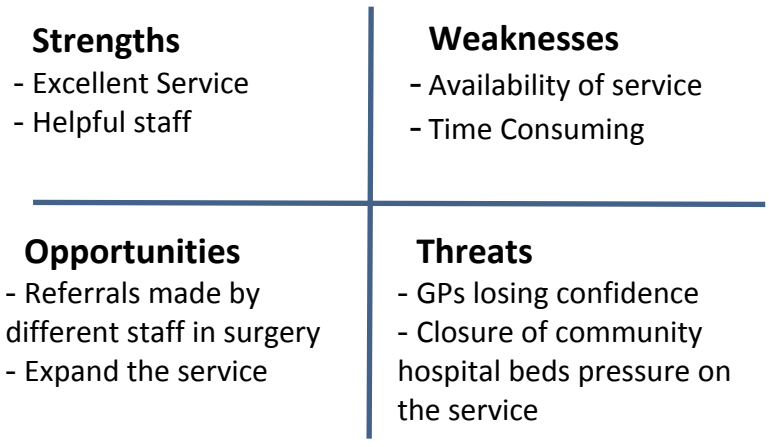
- For admission avoidance cases, locality teams would be asked if they could support the referral either by going out to do an assessment to see if the level of requested care was appropriate or whether an alternative could be considered, e.g. by the provision of equipment or telecare.
- Where possible, the local community health and care team would support any gaps in care visits and joint support with the Social Care Reablement for a double handed care package.
- The commission of additional capacity from local personal care providers who are part of the joint personal care framework contract.
- Potential to use spot purchase intermediate care beds where appropriate and available. If out of hours, then the urgent care nursing service could be approached to support until day time teams could pick the case up.

4. Listening to Primary Care

4.1 The spotlight review considered how best to understand the views of GPs across Devon, this was particularly important considering how the topic was raised by a concerned GP at public Committee. The review began by identifying large surgeries and clusters of Surgeries to contact directly. The surgeries were chosen to give a mix of practices across all localities in Devon. They were then invited to share their views electronically, unfortunately, this approach yielded no results.

4.2 The spotlight review then decided to speak to the Local Medical Council, which represents the views of GPs, to also ask the LMC if GPs could share experiences with the spotlight review. The spotlight review also spoke to a representative from Exeter Patient Participation Group (PPG) to triangulate information and hear from patients. The spotlight review also contacted Healthwatch, but there was no information that they had collected specifically on this subject.

4.3 The spotlight review did gather written qualitative data from nine GPs on their experiences of Rapid Response. These were provided through the LMC and Dr Slot, with the majority being GPs in East Devon. Whilst no statistical inferences can be drawn from this group, the responses are striking in their consistency, and each makes similar comments – these have been analysed on the SWOT chart below looking at the current situation:



- Many respondents spoke of how the service is excellent, with staff who try to help.

- The majority detailed problems with the availability of Rapid Response, which in some cases led to the GP needing to admit/re-admit the patient to an acute hospital.
- Many had concerns over the time-consuming nature of making a referral as well as the need to call back if there was no availability.
- These two factors are leading many of the GPs who responded being hesitant to use the service and a couple to state that they will not use the service.
- A minority mentioned community hospitals and increased pressure.

(See Appendix 3)

Recommendation 3.1: Publish patient satisfaction on website including a 'you said-we did response form.

4.4 There were also two standalone comments that the spotlight review felt were worth highlighting:

> ***'Disappointed that there is an unwillingness to take referrals from admin staff who have been delegated to call by the GP…They also won't accept referrals directly from the social care reablement team, which increases GP workload in terms of the healthcare professionals in the team referring back to the GP to refer on to Rapid Response.'***

The spotlight review did receive a different view to this – where a community matron made referrals on behalf of the GP and this was working well. However, it was felt that this possible inconsistency required further investigation and clarity on what was required of the person making the referral.

> ***'One case I can remember in the past 2 months - wife had to be admitted and no care available for husband with dementia so he had to be admitted to residential care.'***

This view point was also identified by the Exeter PPG, where care for one person also had a significant impact upon their partner. The spotlight review would expect to see this aspect considered where a support package was being developed for one person. In theory, the Rapid Response service should help to support both members of a couple staying at home.

4.5 GPs are encouraged to use the Yellow Card[2] process to report when things are not working so that a review can be undertaken by the CCG. The scheme has been operating in South Devon and Torbay CCG since 2014 and has recently been rolled out across Northern, Eastern and Western Devon CCG. However, the evidence that the spotlight review received would suggest that this is not being uniformly used.

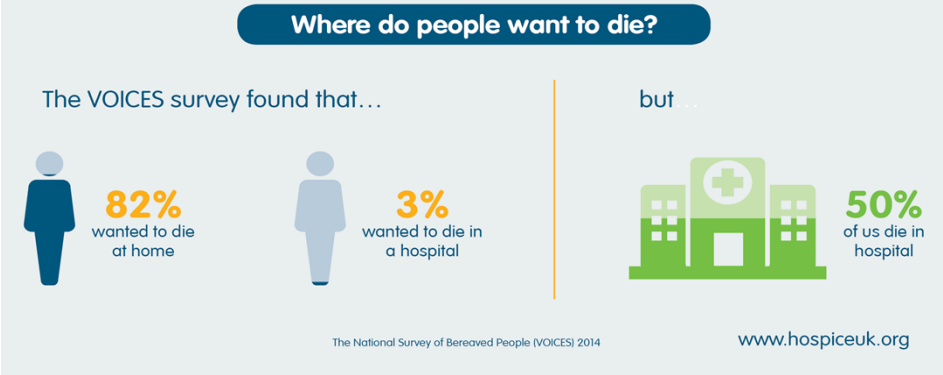
Recommendation 3.3 Publicise the 'yellow card' scheme where GPs are able to feedback on systems that are not working as well as they could

[2] https://www.newdevonccg.nhs.uk/contact/yellow-card-for-healthcare-professionals-103551

5. End of life care

5.1 Rapid Response may be called to support someone to stay at home for end of life care, this may be because they have chosen to die at home.

5.2 A large proportion of patients prefer to remain at home for the end of their life. Hospiscare work alongside NHS colleagues, together with inpatient and community teams to co-ordinate packages of care to prevent unnecessary admissions. If patients cannot be supported, the Hospiscare@Home team will step in and try to provide the care needed. Hospiscare cover the area of Exeter, East and Mid Devon, including Tiverton, Crediton, Okehampton, North Dartmoor, Dawlish, Exeter and the Coast to Seaton, Axminster and Honiton, in effect, the Eastern area.



5.3 Hospiscare log as many instances as they can where patients need access via Rapid Response and, in the last 3 months, around 40 people have been unable to access Rapid Response.

5.4 The number of people who retire to Devon can often mean there is a lack of social support from families being at times geographically spread, or when this is not the case, families taking on the carer role which can result in a post-bereavement risk. Trajectories of illness currently seem to be that the patients are stable for longer but then deteriorate rapidly at the end of life, which can result in crisis needing urgent support which is not available.

5.5 The Hospiscare representative had invited comments from colleagues about the Rapid Response service and received the following:

- Clinical nurse specialists can make phone contact 3-4 times a day to the Rapid Response service because there is NOT support available. This is very time consuming and has a significant impact on community teams.
- Several instances have occurred where families are waiting for Rapid Response to arrive, only to be phoned and told that it has been delayed and as a result it may be that sometimes pressure is exerted to not come at all.
- A further situation arose when the Service was phoned about a Mid Devon patient who was registered with a GP in Crediton, but lived closer to Tiverton, although there was a carer available in Tiverton, the Rapid Response Service could not access that carer because of the patient being registered in Crediton and not Tiverton.
- There have been instances in times of no capacity when the term 'reject list' has reportedly been used. To use this phrase is very poor practice.

Recommendation 2.3 Consideration to be given to a review of the geographical limitations that may be placed upon a service – where a patient can only be treated if they are registered in area.
Recommendation 3.2 review the phraseology used to describe patients in the Rapid Response service.

5.6 The spotlight review was incredibly concerned to hear written testimony from one Hospiscare nurse that reported in the last month there were eight instances where no care was available.

5.7 Statistics show that Hospiscare@Home teams keep over 90% of their patients at home if that is their preferred place of death and nearly 90% of these patients would otherwise have been admitted to an acute setting. The spotlight review was informed that there has been significant pressure on the service provided, ultimately affecting people's option of where they would like to die. Hospiscare have seen a large increase of patients dying in their 12-bed Inpatient Unit over the last 12 months.

5.8 Funding challenges are a particular risk area for Hospiscare. Around £1m of funding is provided by the NHS each year, but an additional £7m is needed to be raised from funding events, charities etc. Hospiscare can choose where to invest these monies, but strains are becoming more intense.

6. Pressure on the system

Recruitment and Retention

6.1 Recruitment and retention of staff are large challenges facing the service. Some of the conditions of contract are specified at a national level, others are local. The service works to make Rapid Response a desirable area to work, including paying above National Minimum Wage. All staff are salaried and do not have zero-hour contracts. Benefits include basic level training with opportunities to work towards a qualification and for career progression, with some staff eligible for salary sacrifice car loans.

6.2 The NHS does not carry out exit interviews when staff leave, but one of the recurring themes cited for leaving NHS employment is the amount of travel involved for the role and the reduction in mileage allowance rates, after the first 3,500 miles. The first 3,500 miles is paid at 56p per mile reducing to 20p per mile for the remainder of the year.[3]

6.3 Establishment is a term used to describe recruitment to the optimum level of staffing designated for each area. Recruitment is mixed across Devon. The RD&E has two localities that are operating at establishment and four that are below. Generally, across the board there is 80-85% establishment. Recruitment is difficult in Exeter as it competes with much larger employers and retention of staff at the RD&E is challenging while South Devon and Torbay experiences problems where teams have grown due to the care market changing locally. The outer rural edges of Mid Devon are particularly challenging to recruit to. However, recruitment in Northern Devon is good.

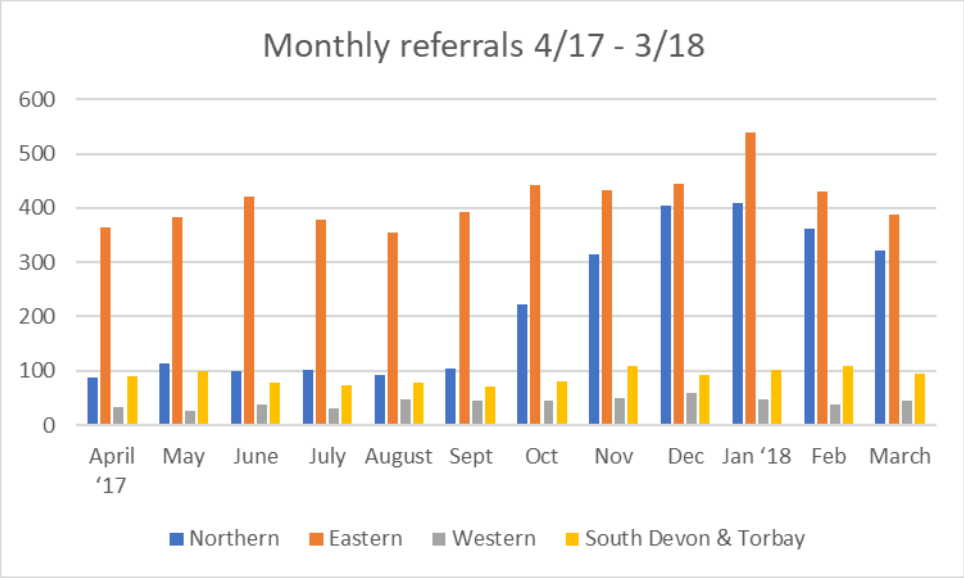
6.4 The graph below sets out comparable salaries from other large employers in Devon, based on basic rates with no enhancements:

	from £
Sainsburys (average)	8.00
IKEA, Customer Services representative	8.55
Rapid Response support worker (NHS)	8.79
Lidl, Customer Service Assistant	8.83
Reablement support worker (DCC)	8.90
Rapid Response support worker (DCC)	9.78

[3] http://www.nhsemployers.org/your-workforce/pay-and-reward/agenda-for-change/nhs-terms-and-conditions-of-service-handbook/mileage-allowances

Winter pressure

6.5 Inevitably when considering NHS and social care services the winter cycle does have an impact. The graph below demonstrates the variation in referrals by month from April 2017 to March 2018. In Southern (the light green bars) there are small peaks across the winter months from November, Eastern (Red bars) also sees an increase, peaking in January 2018, with almost 50% more referrals than in August, however the most notable increase is in Northern (light blue bars) with up to 150% increases for December and January.



6.6 Whilst winter pressure is to some extent inevitable, when a service is already stretched, additional pressure on the system will lead to failure. One of the witnesses to the spotlight review said that hospitals work to optimal capacity of 85%, leaving enough capacity for flex across the system, however the community service feels like it is working at 100%.

Closure of Community Hospital beds

6.7 Treating people in their own homes is a positive move when it is safe and appropriate to do so. The closure of community hospital beds is a controversial area but was brought up by several of the witnesses that the spotlight review spoke to.

6.8 With the reduction in bed-based step up/step down care, the spotlight review has heard concerns that additional pressure has been put on the system from several witnesses including the LMC and Hospiscare. This in turn has made it more difficult to cope in times when the service is already stretched.

6.9 The Spotlight Review heard from Hospiscare, who have seen an increase in acute setting deaths in some areas, with a corresponding decrease in home deaths. Further community hospital closures last autumn created an increase in Hospiscare patients being referred to their Inpatient unit due to a lack of social care available. The spotlight review heard that they system worked well up until community hospital bed closures began to have a 'huge impact'. Patients say they prefer to be at home or in a community hospital but there are now not enough care packages to support this.

Recommendation 2.4 A review of all intermediate care provision across the county with a view to reopening some community hospital beds on a flexible basis to ease pressure on the system and Devon to see no further community hospital bed closures**.**

Conclusion

This short investigation has focussed solely on the Rapid Response service, looking at how it is working in practice and trying to ascertain if the concerns raised by Dr Slot were replicated across Devon. The spotlight review has consistently heard that the Rapid Response service is a well-designed intervention with dedicated and helpful staff working to deliver the best service for the people of Devon. However, the pressures on the system have meant that at times the service has not been available and in some instances, this has led to a lack of confidence among GPs and other health service staff.

There are lessons to be learnt both from good practice within Devon and other local authorities. The service has the structure to continue to be effective, but additional pressure has demonstrated its limitations. In particular the reduction in community hospital beds for both step up and step down care has inevitably required more from both Rapid Response and social care reablement teams.

This report's recommendations should help to alleviate pressure on the local health and social care system and also ensure a county wide consistent approach in call handling, to ensure that all calls are recorded and not just those that have successfully provided Rapid Response.

It is clear that some GPs have lost faith in a system that works to the laudable aim of treating people in their familiar environment and supporting them to be independent and have the best outcomes but is not currently achieving this. This lack of faith is leading to more admissions and needs to be urgently remedied if the system is to become effective once again.

The spotlight review was particularly concerned about end of life care and the recommendations in this report are intended to help reduce pressure on Hospiscare, a charity which receives a relatively small portion of NHS funding, yet provides a significant service to terminally ill people that the NHS would have to otherwise provide.

The spotlight review concluded that additional workforce is needed across all sectors. There is currently a large recruitment drive taking place in Devon to try and recruit both nationally and internationally. However, this has had limited success. Recruitment for domiciliary care and back-filling in the Eastern and Southern CCG areas have a knock-on effect for Rapid Response.

The spotlight review has heard from the service about the ambition to continue to grow and improve. The Rapid Response Service has been largely funded through the Better Care Fund. With more investment expected in this area, it was hoped to continue recruiting into the service. The aim is to make the service available for everyone, especially those with dementia or young people with disabilities. There is a strong commitment to work creatively including looking at possibilities with working collegiately with the reablement team. The spotlight review strongly welcomes these developments.

Sources of evidence

Witnesses

The Task Group heard testimony from a number of witnesses and would like to express sincere thanks to the following people for their contribution and the information shared.

NAME	ORGANISATION	ROLE
Dr M Slot	Sid Valley Practice	GP
Dr P Hynam	Devon LMC	GP and Medical Secretary
Mr R Westlake	Exeter PPG	Chair
Ann Rhys	Hospiscare	Assistant Director of Care
Jo Turl	South Devon & Torbay CCG and NEW Devon CCG	Deputy Chief Operating Officer
Keri Storey	Devon County Council	Head of Adult Care Operations - Health
Jane Cawthorn-Weaver	Royal Devon & Exeter NHS Foundation Trust	Rapid Intervention Centre Manager
Tracey Morrish	Northern Devon Healthcare NHS Trust	Urgent Care Services Manager
Suzanne Skelly	Torbay & South Devon NHS Foundation Trust	Community Services Manager

Membership

Councillors Claire Wright (Chair), John Berry and Nick Way.

Contact

For all enquiries about this report or its contents please contact:
Camilla de Bernhardt Lane, Head of Scrutiny Cam.debernhardtlane@devon.gov.uk

Bibliography

- Health & Wellbeing *Scrutiny* Committee – Sustainability and Transformation Plan Model of Care, Joint Spotlight Review – November 2016
- Nursing in Practice; *'Delivering a Rapid Response service in the community'* https://www.nursinginpractice.com/article/delivering-rapid-response-service-community
- Introduction of the yellow card system for GPs https://www.newdevonccg.nhs.uk/contact/yellow-card-for-healthcare-professionals-103551
- *http://www.nhsemployers.org/your-workforce/pay-and-reward/agenda-for-change/nhs-terms-and-conditions-of-service-handbook/mileage-allowances*

Appendix 1

Transcript of address given by Dr Slot at the Health & Adult Care Scrutiny Committee on 25 January 2018.

"I've come to you as a local GP practising in Sidmouth.

As we're all aware we lost a lot of community beds recently over the last year or so and the loss of community hospital beds was intended to be offset by increasing the capacity of community care so that patients could be cared for in their own homes. This may or may not have been realistic since many of the patients in the hospital system cannot be managed in the community even with excellent community services.

However, with or without community hospital beds, it's an excellent idea to expand community services so that those patients who can be cared for out of hospital can remain at home. Unfortunately, there is not sufficient capacity in the home care services to do this job. When GPs ring the single point of access number asking for Rapid Response or night sitting, the carers are not available. This is partly due to lack of resources and partly due to difficulty with recruitment. I suspect that part of the difficulty with recruitment may be due to the terms and conditions. If the carers only get paid when they are required, then this may not be a particularly attractive option for them.

Now, it's well understood that a hospital only functions well with a maximum of 85% bed occupancy and similarly with home care services we need to accept that there will be some unused capacity otherwise the service is never able to accept unexpected cases, thus we need to allocate enough resource so that we can offer both an attractive rate of pay and attractive terms and conditions.

The importance of this should not be underestimated because this is in fact an essential part of the answer to the problem that the entire NHS is experiencing. If the level of water in a reservoir is steadily rising and then overflows, you can either try and build the banks higher, in which case it will just overflow a bit later, or you can look at the streams going in and going out of it. Similarly, when you see an overflowing accident and emergency or hospital, you can buy more accident and emergency or acute beds - very expensive - or you can increase community capacity to prevent people going in and facilitate people coming out - relatively much cheaper - but you do have to pay a proper rate for it."

Northern Devon Healthcare
NHS Trust

Appendix 2 Rapid Response Service

Other formats

If you need this information in another format such as audio tape or computer disk, Braille, large print, high contrast, British Sign Language or translated into another language, please telephone the PALS desk on 01271 314090.

About the service

The Rapid Response service can provide care for you in your own home when you are experiencing deterioration in your health or there has been a breakdown in your care arrangements. This will prevent you going in to hospital or a care home unnecessarily. This service is available for you if you have no other people to support you at a time of crisis.

This is a short-term service for up to seven days. Care can be provided up to four times a day and overnight if required. During this time your care needs are reviewed. Should you require any longer-term care, a further social care assessment will be undertaken with your consent.

Who will provide the care?

Your care needs will be assessed by a member of the health or social care community team. This could be a nurse, therapist or social care worker.

Your care will be provided by skilled Rapid Response support workers employed by Northern Devon Healthcare NHS Trust or by care staff provided by local agencies.

We are able to help you with your health and personal care needs, including daily living tasks such as washing and dressing. The Rapid Response service is free of charge, but if you need services after this you might need to pay towards the cost of them.

Care is coordinated by our Rapid Intervention Centre to make sure that the appropriate professionals are involved in your care as quickly and seamlessly as possible.

Who can refer?

Rapid Response referrals are welcome from:

- GPs
- GP out-of-hours service
- Community health and social care services
- Ambulance crews

We are sorry but we do not accept direct referrals from the public.

PALS

The Patient Advice and Liaison Service (PALS) ensures that the NHS listens to patients, relatives, carers and friends, answers questions and resolves concerns as quickly as possible. If you have a query or concern call 01271 314090 or e-mail ndht.pals@nhs.net. You can also visit the PALS and Information Centre in person at North Devon District Hospital, Barnstaple. Alternatively, it may be possible for us to arrange an appointment in your area.

Have your say

Northern Devon Healthcare NHS Trust aims to provide high quality services. However, please tell us when something could be improved. If you have a comment or compliment about a service or treatment, please raise your comments with a member of the ward staff or the PALS team in the first instance.

'Patient Opinion' comments forms are on all wards or online at www.patientopinion.org.uk.

Northern Devon Healthcare NHS Trust
Raleigh Park, Barnstaple
Devon EX31 4JB
Tel. 01271 322577
www.northdevonhealth.nhs.uk

Appendix 3: written feedback received from GPs

comments have been altered slightly where necessary to anonymise.

AREA	*GP FEEDBACK*
EAST	In my experience the staff handling the calls are very helpful, the main issue is whether the care is available or not. Sometimes it can take some time to get a call back informing you that they cannot get the care requested, meaning the patient needs to be admitted much later in the day.
EAST	'Good service when they have capacity. Most often though they cannot help esp at the end of the week' 'just one for me re inadequate physio provision following a discharge of a patient. He required readmission. I have already reported through the requested RD+E link & they are looking into this '
EAST	Our allocated care agency handed back their contract and we have been left with very little support for care. Hence, when we need Rapid Response to support patients and prevent admission we cannot link into subsequent long-term care packages. I had one chap with a neurological condition who had Rapid Response for over a year! This then further destabilises the Rapid Response teams and so often find Rapid Response are unable to support when needed. When it works it is on the whole an excellent service. Since the closure of community beds and supposed reallocation of funds, the service seems worse rather than better. Clearly its multifactorial and difficult from this end to know how much extra was provided. I take the view when with a patient that I won't be able to access Rapid Response, but if I can it's a bonus.
EAST	Sadly, SPOA sounds great, but in reality, it's a time-consuming referral with low probability of delivering the service you want
EAST	I have had 3 recent episodes where I have called SPOA in recent months and they have been unable to put in appropriate care. Patients have been sent to RD+E for admission. It is a frustrating process - often not staffed well enough so details at the point of contact cannot be taken. Most cases seem to involve 2-4 calls backs to speak to the right person. GPs under pressure are tied up for too long by the service. So long in fact it has made me not want to use the service. It would be easier to admit patients than it is to call SPOA and arrange care -or try to arrange the care. Having said that, lately, I have found our community support Matron ET incredibly helpful in being an intermediary to help prevent admissions and arrange care at home promptly. With my clinical guidance she can work as an intermediary and can deal with SPOA on my behalf which works better. This works well - a bit like the system we had prior to SPOA
EAST	One case I can remember in the past 2 months - wife had to be admitted and no SPOA care available for husband with dementia so he had to be admitted to residential care.

AREA	***GP FEEDBACK***
EAST	I'm in the same boat having dropped off SPOA referrals because they can't usually deliver. ET replied to a task for me yesterday too and sorting the patient today.
EAST	Disappointed that there is an unwillingness to take referrals from admin staff who have been delegated to call by the GP; it was intended that referring to them would take no longer than speaking directly to a consultant, however they are asking many questions which the GPs cannot always answer and which increase the length of time to make the referral; please could they explain why they feel it is inappropriate for informed, delegated staff to make these referrals on the GPs behalf? They frequently do not have anything to offer once the referral has been made. They also won't accept referrals directly from the social care reablement team, which increases GP workload in terms the healthcare professionals in the team referring back to the GP to refer on to Rapid Response.
NORTH	Over the last 3-4 years had approximately 4 problems (2 cases were out of hours and 2 cases were in hours), where Rapid Response were unable to provide the adequate care provision so had to admit the patient. Don't have a problem with the Rapid Response service and that they all deserve a pat on the back.