

Chells Way Surgery Long Term Conditions Audit Final Report

1. EXECUTIVE SUMMARY

The term “long term condition” has a broad definition. However, in this report it excludes people with dementia, mental health and learning disability and focuses on those people who are receiving long term care rather than short term intervention.

Health and Social care in Stevenage are facing a huge challenge in meeting the current health needs of the borough and will need to take account of projected growth. The audit focused on wards that have been identified as including some of the most deprived areas using information obtained from the Joint Strategic Needs Assessment.

The audit sought to identify potential preventative support for a person with a long term condition, which offered at an early stage may:

- assist a person with a long term condition to enjoy a better quality of life;
- prove to be cost effective i.e. by reducing the need for more intensive and costly services;
- help to inform a targeted prevention campaign particularly in the more deprived areas;
- could be funded and provided jointly by health and social care.

It also sought to identify where joint working could prove beneficial.

2. INTRODUCTION

The Joint Improvement Partnership (JIP) for the Eastern region commissioned an audit and identification project of people with a long term condition. The project was managed by Hertfordshire County Council and the work undertaken by Chells Way Surgery in Stevenage.

The overall aim of the audit was to understand and learn more about how to promote a joint approach across health and social care to support people with a long term condition.

The project aimed to clarify and inform for both the health and social care agencies involved, the extent of their knowledge or lack of knowledge about the people with long term conditions registered with the practice that they are individually or jointly supporting.

The project provides information on where there appear to be overlaps or gaps in support services. Learning from the project particularly sought to inform the development and promotion of targeted preventative support and the development of joint health and social care personal budgets for people with a long term condition who are supported by both health and social care.

3. DEMOGRAPHY

Chells Way Surgery is situated in Stevenage, Hertfordshire 25 miles north of London. It has a patient list size of 13,665 and the age profile of patients registered with the surgery is as follows:

Table 1: Age profile of Chells Way surgery

Age group	Male	Female	Total
0-4	411	378	789 (5.8%)
5-14	883	769	1652 (12.1%)
15-44	2866	2795	5661 (41.4%)
45-64	1886	1662	3548 (26.0%)
65-74	542	647	1189 (8.7%)
75-84	317	353	670 (4.9%)
85+	55	101	156 (1.1%)
Total	6960	6705	13655 (100%)

Stevenage's residents are younger on average than the regional and national populations. This factor may contribute to lower levels of chronic illness. They are also more likely to lead unhealthy lifestyles, be obese or a victim of violent crime than those in other areas of the region or in England. Average household income is less than neighbouring areas. Levels of unemployment are above the average for Hertfordshire but lower than those in the East of England and the UK. Overall the health of people in Stevenage is similar to the English average, however in a number of areas it is below average.¹

By comparing areas within Stevenage we can rank the level of deprivation.

1. Woodfield, Manor and the northern part of the old town (least affected by deprivation)
2. Symonds Green, Longmeadow, Chells
3. Bandle Hill and Martins Wood
4. St Nicholas, Roebuck, Pin Green and central parts of the old town
5. Bedwell, Shephall. (report worst deprivation)

Chells Surgery treats patients from **all** of the above areas apart from Roebuck and Longmeadow.

4. METHODOLOGY

The original intention was to extract data from the clinical IT system to identify those patients registered with the surgery who are receiving support from one or more care provider. However, this information could not be extracted from the computer system as agencies providing care are not linked, nor have any form of communication at present. Therefore, a questionnaire was sent out to all patients registered with a long term condition (Appendix A).

Questionnaires were analysed on return, and required entry onto spreadsheets and READ coding. A code is loaded onto the clinical record and then the system runs a report to search for that code. READ codes are used to be able to extract any information that requires audit or identification of clinical entry.

This approach encountered some obstacles as some patients assumed that GP systems were linked to other providers and that they therefore had no need to complete this information. Additionally, elderly patients and those with complex conditions required assistance in completing the forms. This led to a substantial increase in the volume of telephone calls received into the surgery. However, from the 5500 questionnaires dispatched **4042** were returned giving a high return rate of 73%. Of those returned 1996 were male, 2046 female and all resided within SG1 and SG2 postcodes.

¹ Sourced from APHO and Department of Health and from the Hertfordshire Joint Needs Assessment.

5. DATA ANALYSIS

5.1. LONG TERM CONDITIONS OVERVIEW

40% of the practice list size has a long term condition (5500 out of 13665 registered patients). The most common long term conditions are highlighted in **bold**. Some patients have more than one condition and so in areas are double counted. The system does not allow identification of these patients.

The following long term conditions were included in the audit:

Table 2: Long term conditions by type and prevalence

Condition	Number	Rank
Asthma	1310	2nd
Cerebral Palsy	9	
Coronary Heart Disease	427	4th
Chronic Obstructive Pulmonary Disease	168	
Cystic Fibrosis	0	
Diabetes	509	3rd
Heart Failure	82	
Motor Neurons Disease	0	
Multiple Sclerosis	20	
Muscular Dystrophy	4	
Parkinson's Disease	19	
Renal Failure	251	
Morbid obesity	288	
Stroke	157	
Atrial Fibrillation	161	
Cancer	86	
Hypertension	1571	1st
Hypothyroidism	349	5th
Epilepsy	89	

NB: This table includes data from all 5500 patients as it is extracted from the system

5.2. MULTIPLE CONDITIONS

From those who replied to the questionnaire (4042) over three quarters had multiple conditions.

Table 3: Number of long term conditions

% of people with one long term condition	% of people with two long term conditions	% of people with three or more long term conditions
21.8% (881)	37.3% (1508)	40.8% (1653)

This is also shown on a graph in Appendix B

5.3. AGENCY SUPPORT

It is worth noting that the questionnaire only asked about current support and therefore patients may have had other input from health and social care which is not included within these figures.

Definition of health support

All of the 4042 patients are accessing care from their GP (100% as shown in the table) – the other health providers included across the rest of the table are hospitals, intermediate care and district nursing.

Definition of social care support

Social care providers included are domiciliary homecare, direct payments, equipment provision, respite care, residential / nursing home care and other social care provided by adult care services.

Table 4: Type of support received by patients

% of people supported by Health (GP, Primary Care)
100% (4042)

% of people supported by Health and Social Care only	% of people supported by Health and family / friends only	% of people supported by Health, Social care and family / friends	% of people supported by Health only
6.3% (255)	24.4% (986)	8.6% (348)	60.7% (2453)

This is also shown on a graph in Appendix B

5.4. CHARACTERISTICS OF PATIENTS RECEIVING SUPPORT FROM BOTH HEALTH AND SOCIAL CARE

Approximately 15% of patients were receiving support from both agencies. It is likely that these patients have been in hospital with referral to social care upon discharge as a high proportion are receiving support in the way of equipment (see table in carers section) such as stair lifts, commodes and walking frames chairs. This may also indicate input from intermediate care and occupational health; further study would give a more robust picture.

5.5. DATA ANALYSIS SUMMARY

- No overlaps between health and social care have been identified as all service providers offer a completely different service provision.
- Gaps in support are evident as a high percentage of patients are seeking support from family, friends or voluntary organisations in addition to their GP (see figures above and in the carers section).
- Auditing of key data is restricted as health and social care systems are not compatible.

6. TARGETED SUPPORT

From the research it appears that the elderly (over 70) with a long term condition and patients with multiple conditions at any age have the highest level of need for preventative support. From the questionnaires 41 patients reported the need for additional input from social care, or both health and social care, and therefore required a review with the GP or targeted information on their condition(s) sending to them.

All of these patients were either 70 and over with a long term condition or are younger but have 3 or more conditions. It may be the case that more than 41 require further support, however did not choose to make such comments on the form.

6.1. A SAMPLE OF QUOTES FROM THE 41 PATIENTS IDENTIFIED

To aid an understanding of the type of targeted support identified a sample of comments made by patients is given below. These are coded to illustrate the type of comment as follows:

1. foot care
2. personal care

3. advice and information
4. carers support
5. health care

Table 5: Types of additional support highlighted

Comment	Type
<i>I have completed this form on behalf of my father who is unable to do so, any help with regard to taking tablets, food, drink, toilet features to aid would be a great help.</i>	2 and 5
<i>Can you let my daughter know what or who can help?</i>	3
<i>Assistance dressing and undressing, household chores, shopping and transport</i>	2
<i>Help with bathing, shaving and dressing</i>	2
<i>Could do with a podiatrist</i>	1
<i>Need help with my feet</i>	1
<i>A daycentre that specialises in Dementia would help us</i>	4 and 5
<i>I would like to receive care from an agency for shopping but I do not know how to go about it.</i>	3
<i>I am not aware of any care providers</i>	3
<i>I had help with equipment but no other visits; I have help from a very caring friend</i>	4
<i>My wife looks after me 24 hours a day</i>	4
<i>I have care from a relative or friend</i>	2,4 and 5
<i>I am paying someone to do my housework is there any other help? I also have to care for my disabled husband and I am disabled myself</i>	3
<i>I haven't seen a Parkinson's Specialist nurse for over a year</i>	5
<i>I need help with cooking, dressing filling in forms where do I go?</i>	3
<i>My wife cares for me but she is disabled too we have care for 2 hours a week but need more</i>	4
<i>Care of feet</i>	1
<i>We are on our own and need advice who do we go to? We receive help from nowhere</i>	3

6.2. CARERS (FAMILY AND FRIENDS)

Of those who returned the questionnaire 348 patients are receiving long term support from social care, friends, family and health services. They had not received information from the surgery on support services available such as Carers in Hertfordshire and had not been placed on the surgeries list of carers. The patients listed in columns 3 and 5 below in table 6 show a particular pattern. Their friend / family provide them with their main care needs and other support in place allows their main carer to have respite. Without the level of support from family and friends this group of people would need a higher level of care from elsewhere. The number of people reliant on their relatives or friends is possibly even greater as this study only concentrates on those that replied by questionnaire.

Table 6: Patients with carers by support

(1)Condition	(2) Family / Friend (all)	(3) Home Care only	(4) Equipment only	(5) Equipment and Home Care
Atrial Fibrillation	21	9	7	5
Cancer	30	10	11	9
Cerebral Palsy	1	0	0	1
CHD / Hypertension	89	41	29	19
Asthma /COPD	48	20	12	16
Diabetes	68	33	17	18
Epilepsy	15	8	4	3
Heart Failure	18	9	5	4
Muscular Dystrophy	3	0	3	0
Parkinson's Disease	10	4	3	3
Renal	45	21	15	9
Total	348 (100%)	155 (44.5%)	106 (30.5%)	87(25%)

6.3. TARGETED SUPPORT SUMMARY

- At the point of audit the practice was unclear on the type of targeted information that should be provided and to whom the patients should be referred to owing to lack of knowledge in relation to social care remit.
- A GPs view is that there is an educational need for both health and social care and that the findings indicate liaison and joint working must be improved. The GP also feels a liaison position would be valuable.

7. IMMEDIATE ACTIONS TAKEN BY THE PRACTICE TO IMPROVE CARE OF THOSE WITH LONG TERM CONDITIONS

The surgery has identified an area within the clinical computer system (System One) called groups and relationships. Within this area all details from the questionnaire will be entered on a template with their level of care, name, number of the agency providing this service, relative's information, etc. The benefits of this are:

- All doctors and nurses can see at a glance an overview of the patient's health and social care input at its current level. Where the level of input needs re-assessing, contact with the relevant multi-disciplinary agencies will be much easier and direct, as the information will be available on the clinical notes. For example, a home care agency can be contacted and updated when a patient whose number of falls in the home increases.
- The practice writes to all patients with long term conditions on an annual basis to invite them for a review of their condition with the practice nurse. The questionnaire used for this audit will be included in order to identify those requiring referral to adult care services for targeted / preventative support or those requiring re-assessment.
- The questionnaire also identifies carers and so the practice will send relevant and up to date information packs regarding access to support for carers for example, Carers in Hertfordshire. The carers identified from the audit have been placed on the surgeries list of carers and sent an information pack on how to obtain support.
- This template applies READ codes (see explanation on coding in methodology) to the care provider and so data can be extracted at any time for future auditing.

8. WIDER RECOMMENDATIONS

- Patients 70 and over with one or more long term condition and patients of any age with three or more conditions have been identified as a potential target group for early preventative support.
- A single point of contact in Adult Care Services to be maintained for GPs to refer to once a diagnosis has been made. This team should deal with both an early preventative assessment and crisis intervention.
- The referral management team to assess in detail their eligibility, etc. and signpost support services available specific to that condition. The reasoning behind this is that there are multiple criteria for eligibility and multiple social care / support services available, which primary care would not be able to match to the patient or be in a position to assess or keep updated.
- A feedback form to be sent to the GP detailing the outcome of the assessment and who the patient was referred to; this should also include details of any care package initiated.
- The referral management team to be able to take referrals from the prevention of admissions team. GPs currently refer patients to the prevention of admission team, by allowing this team to refer to the referral management team in Adult Care Services for an assessment of social care need will promote joint working across health and social care.
- With regard to budgets, perhaps a joint funding approach through Practice Based Commissioning Localities could be investigated. Practices will require additional funding to target those patients that would benefit from early intervention. Outcomes could be monitored by assessing numbers of patients admitted into intermediate care beds with 'Acopia' (unable to cope with everyday living) as either step up or step down. Figures currently available with regards to admission to intermediate care are as follows:

During 07/08 an audit was undertaken by West, East and North Hertfordshire PCT. The aim of the audit was to review existing intermediate care provision in order to consider location, suitability of facilities, clinical sustainability, and integration with social care. The intention being to provide intermediate care in local settings and inform the long term requirement for intermediate care beds on the local general hospital sites. The results of this indicates that across Hertfordshire 915 patients were referred to an intermediate care bed from hospital with "Acopia " (step down) and 353 were referred by the GP into an intermediate care bed for the same reason (step up). The total number of beds days was 35,683.

- A future piece of work should be undertaken to audit outcomes. Patients can be involved in this by undertaking a survey on how they have or have not benefited from preventive support.
- Any joint funding investment will need to show that it is based on validated need. Any targeted preventative support will need to be measurable.

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Appendix A

Name:	D.O.B:	Address:
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In order for the surgery to provide you with the best possible care we need the following important information to ensure your clinical records are up to date. This information also assists your doctor in assessing your health care needs.

Some sectors providing care do not communicate this information to the surgery.

Please take the time to complete the following survey and return it to the surgery, as soon as possible, in the enclosed stamped address envelope. If you are receiving care from more than one provider please tick all the relevant boxes.

Please tick where appropriate:

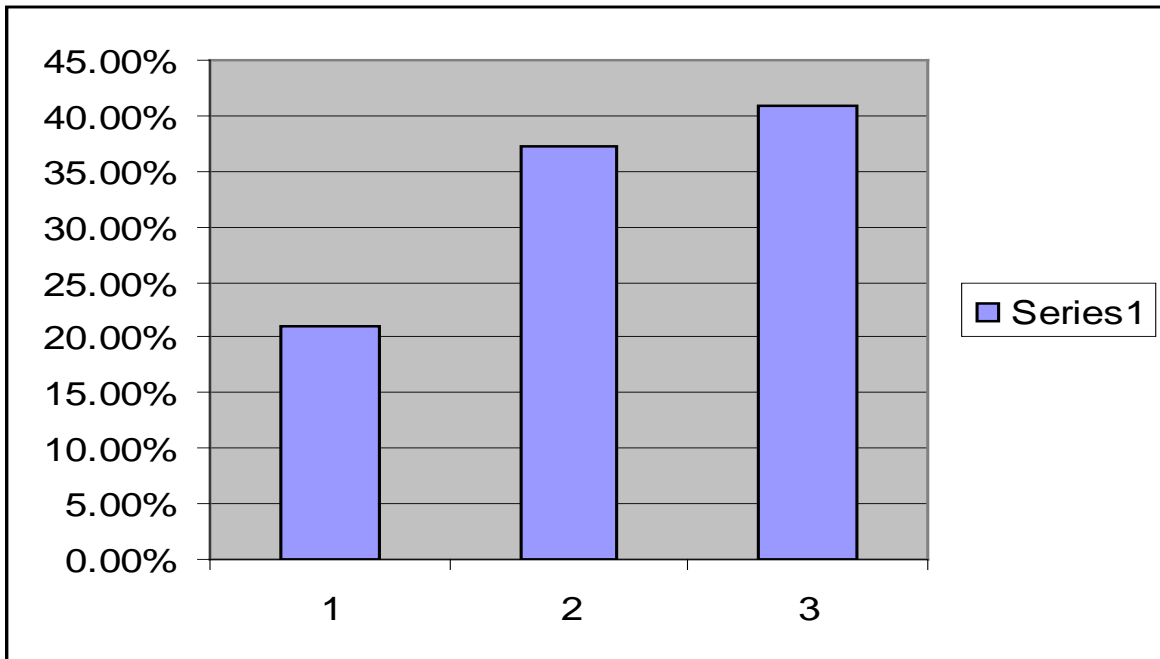
GP	
Hospital (please state which hospital(s))	
District Nurse (please state how many times they visit you – e.g. how many times daily / weekly)	
Community Matron (please state how many times they visit you – e.g. how many times daily / weekly)	
Podiatrist	
Adult / Children’s Care Services (please state how much input you receive - i.e. respite, day care, equipment provision, etc) how long have you / your child been receiving this support	

Home care (via agency). Please state which agency, in case we need to contact them, and how many times a day you are visited	
Care from a relative or friend	
Help from Age Concern or other voluntary organisation	
Other care provider (i.e. physiotherapy, occupational therapy, falls prevention team, rehabilitation teams, Macmillan Nurses, etc)	

Please try to state the level of care you are receiving from any of these providers.

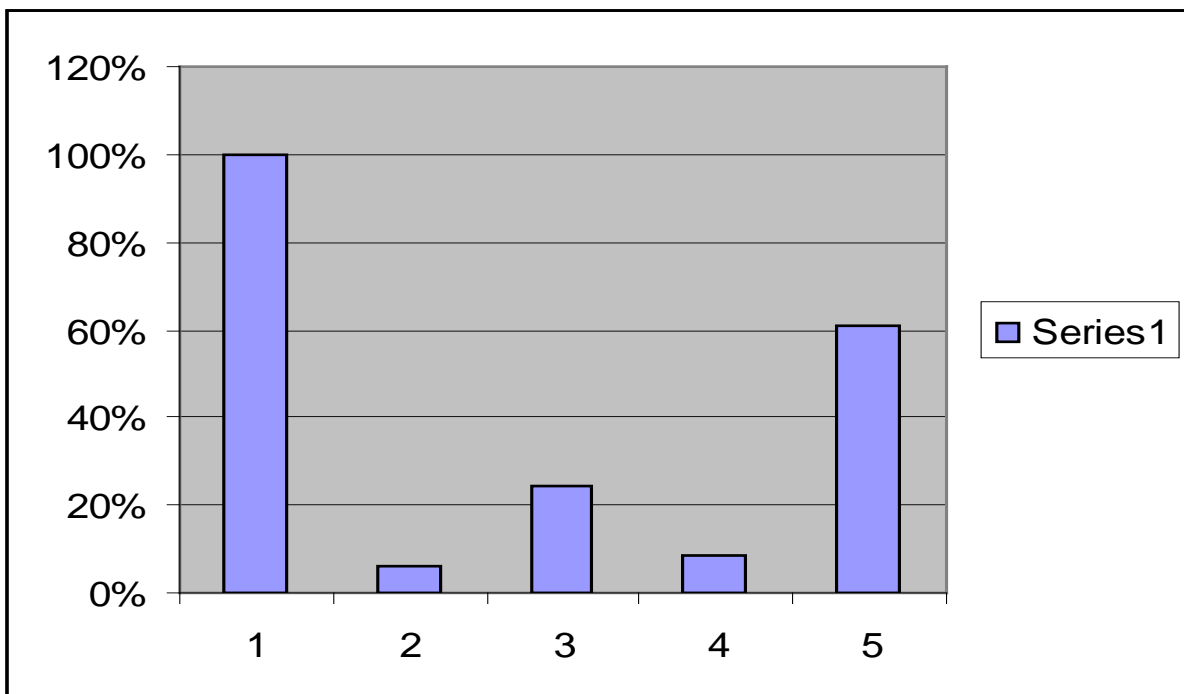
If there is any other care provider that you think could be of assistance to you, please list them below.

Chart 1: Number of long term conditions



Column 1: % with one long term condition
 Column 2: % with two long term conditions
 Column 3: % with three or more long term conditions

Chart 2: Type of support received by patients



Column 1: % supported by Health (GP)
 Column 2: % supported by Health and Social Care
 Column 3: % supported by Health and family / friends
 Column 4: % supported by Health, Social care and family / friends
 Column 5: % supported by Health only