NHS

Yorkshire and Humber
Commissioning Support

NHS Doncaster
Clinical Commissioning Group
Qualitative Framework

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Contents

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Summary

NHS Doncaster CCG commissioned the Health Economics, Evidence and Evaluation Service to provide a qualitative framework for use within their intermediate care review.

The journey of 30 patients through the intermediate care services was reviewed by a multidisciplinary team and summarised by the project team. This data was analysed using a pragmatic adaptation of content analysis to provide a framework of frequently occurring topics.

This framework can then be applied to other findings as part of the wider project.

Background

Intermediate care covers the range of integrated services which promote faster recovery, prevent unnecessary acute hospital admission and premature admission to long-term residential care, and support timely discharge from hospital whilst maintaining and maximising independent living. These services are crucial to frail older people who can rapidly lose mobility and functional independence in the face of acute illness or injury.

Young (2014 suggested that one in twenty report negative aspects of care and that the current provision of intermediate care is around half of that required to avoid inappropriate admissions and provide adequate post-acute care for older people – and capacity has not changed from 2012. However, there are opportunities for services such as re-ablement to become better integrated with intermediate care and for new ways of working to be developed.

NHS Doncaster Clinical Commissioning Group (DCCG) has identified a range of strategic ambitions and work programmes relating to care out of hospital, care of the frail and co-ordinated care. DCCG aims to maximise independence and improve quality utilising resources effectively to get best value for money whilst improving and simplifying the system for patients and healthcare professionals. As part of this, understanding the experiences of patients in the intermediate care services is required.

The Health Economics, Evidence and Evaluation Service (HEEES) has provided qualitative analysis of data previously summarised by a multidisciplinary review of patient journeys within the intermediate care service in Doncaster. The frequently occurring topics arising in the data are collated into a framework through which the project team will then be able to examine the remaining data generated as part of the wider project. This will allow the project team to evaluate the effectiveness of a patient's journey through the current intermediate care system from admission to discharge and help commissioners and providers to understand the issues that arise in the current service / system.

Methods

Data collection

The project team collected text based data through a retrospective desk-top study of 30 patients selected from across the five GP localities in Doncaster. A total of 6 patients were reviewed from each locality across 6 days at Doncaster Royal Infirmary. These patients had received intermediate care services in the past 6 months or could have benefitted from intermediate care and all agencies involved with the patient were reviewed.

Patients were identified by one or more GPs from each locality according to the following criteria:

- Patient is identified using the top 2% high risk patient's profile during the past 6 months
- Patient has had an unplanned attendance at A&E in Doncaster and Bassetlaw Hospitals NHS Trust (DBH)

  OR
- Patient has had an admission directly onto DBH MAU by a GP
- Patient has capacity to consent or there is someone able to make a best interest assessment on their behalf

Each patient was contacted by the GP and asked to consent to inclusion in the review. The GP noted their consent in the patient notes and a letter was sent to the patient confirming what had been discussed with them and detailing how to withdraw from the review should they wish to.

The review team was made up from across the health and social care services who had been involved in the care of the patients included. Table 1 details the key members of the review team.

Methods

Table 1. Key members of the review team.

Team Members	Provide Experience in:
Geriatrician/ Care of the Elderly team member	Elderly Care Special interest in Intermediate care services
General Practitioner	General practice, special interest in Intermediate care services
Community Matron/ Nursing	Step up and discharge processes from community and /or Hazel/ Hawthorn/ MMH wards
Community Therapist	CICT/ +Steps/ Hazel/Hawthorn
Social Care Assessment representative	Social Care processes across intermediate care and re-ablement services
IDT representative	Assessment of patient IC need

Representatives from mental health and ECP services were also present where possible and each team was asked to ensure they had access to the relevent paper or electronic notes / records on the patient for review.

In the review sessions the review team explored the patient's need from first touch point, initial assessment, treatment and on-going care through the system to discharge. The team identified key patient needs, possible unmet patient needs, barriers encountered, what worked well or issues that occurred through consideration of the following:

- First point of contact from any source.
- Referral to intermediate care and whether it was appropriate
- Intermediate care pathways, how well did they serve the patient need?
- Hospital Discharge Pathway and associated discharge pathways.
- Were there any gaps in service?
- Is there a better way?

The focus was on process, the effectiveness of the patient journey and the impact / issues / outcomes / benefits for the patient.

Each patient journey was reviewed, discussed, and evaluated by the review team, and the patient's journey was also recorded by the project team. A list of the key findings from the session was recorded by the project team, then reviewed and agreed by the whole team at the end of the session.

Data analysis

The textual data generated by the review process was analysed using a pragmatic adaptation of content analysis. Content analysis allows systematic scrutiny of textual information, (Corner et al, 2013), giving insight into the frequency and variety of messages, themes and concepts within it. Content analysis allows for a rapid review of the material, can identify trends in the information and allows conclusions to be drawn about the presence or absence of issues and characteristics within textual material (Hsieh and Shannon, 2005; Vaismoradi et al, 2013).

The accepted methodology of content analysis was adapted for the more pragmatic approach required here, for example the data to be analysed was already summarised by the project team rather than the 'raw data' available in the patients notes being provided for analysis.

The following steps were taken in the analysis of the summarised data:

- Analytic approach selected: a manifest analysis was used. This takes the meaning of the recording unit at face value

- Unit of analysis selected: individual sentences within the data were selected as the recording unit

- Coding of the data: each patient summary was reviewed and codes manually assigned to each meaning unit. These codes were developed inductively based on their manifest meaning

- Coding categories: codes were grouped into broader categories which then form the basis of the qualitative framework to be applied to data generated within the wider project.

Findings

Table 2 shows the framework of frequently occurring topics identified from the content analysis of the summarised data. Examples of each category can be found at Appendix 1.

Table 2. Qualitative framework and structure of categories within it.

Overarching category	Sub-category	Further sub-category
Poor communication		
	Records are inaccurate	
	Information is not easily accessible	
	Information is not shared proactively	
	GPs do not receive the up to date information they need	
Quality of care is affected		
	Referrals are delayed	
	Discharge is delayed	
	Inappropriate referrals are made	
	Adverse impact on patient	
		Social care needs are not met
		Psychological needs are not met
	Adverse impact on processes of care	
		Care is not co-ordinated or planned
		Opportunities missed
	Unnecessary stay in hospital	
System working well		

Conclusion

A qualitative framework was developed from the content analysis of summaries of patient notes reviewed by a multidisciplinary team and provided by the project team. This framework may be applied to the information generated within the wider project.

References

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Vaismoradi, M., Turunen, H and Bondas, T. (2013). Content analysis and thematic analysis: implications for conducting a qualitative descriptive study. Nursing and Health Sciences: 15: 398-405.

Young, J. (2014). The National Audit of Intermediate Care Summary Report 2014. [Internet]. Available from http://www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/NAIC/NAICSummaryReport2014.pdf Accessed on 26/06/2015.

Appendices

1. Examples of categories included in qualitative framework.

Table 2. Qualitative framework and structure of categories within it.

Overarching category	Sub-category	Further sub-category
Poor communication		
	Records are inaccurate: *Discharge dates wrong* *Discharge destination not correct.* *Notes not updated with death.* *Discharge summaries are incomplete or inaccurate.*	
	Information is not easily accessible: *Records are written that are then not routinely available to other teams.* *Records are not available to all services.* *Notes held in several places and in different systems.* *Copy of assessment not shared in records.* *Notes from Falls service not available on S1.*	
	Information is not shared proactively: *DNAR not shared.* *Copy of assessment not shared in records.* *Care plans not shared with all services who support patient e.g. ambulance service.* *Alcohol liaison services do not routinely share records.* *Community services not communicating effectively.*	
	GPs do not receive the up to date information they need: *Information on pattern of falls not shared with GP.* *Results of scan not sent to GP.* *No discharge letter sent to GP*	

	GP not aware of referral to Positive Steps. And no discharge summary received.	
Quality of care is affected		
	Referrals are delayed: *Referral not made until day of discharge then not picked up by team (3 weeks).* *Referral for falls assessment delayed.* *Other professionals not making referrals – sending back to GP.* *Delay to referral to MMH rehab.* *Delays to access Positive steps.*	
	Discharge is delayed: *Discharge delayed by 23 days because patient was slept out.* *Patient could have been discharged earlier.* *Discharged delayed for several weeks as home visit required.* *Discharge delayed due to wait for NOMAD.*	
	Inappropriate referrals are made: *What else would FALLS clinic been able to offer after all input patient had received?* *Referred to MMH rehab but not appropriate for rehab.* *Referrals unchallenged.*	
	Adverse impact on patient	
		Social care needs are not met: *Housing and family situation not made clear in records.* *Housing services needs integrating.* *Social care needs not accounted for.* *Needs a social worker appointing.*
		Psychological needs are not met: *MH team not involved.* *Emotional needs overlooked.*

		Psychological needs overlooked and now a significant problem. *Anxiety not addressed.* *Patient would have benefitted from psychological therapy but not received.*
	Adverse impact on processes of care	
		Care is not co-ordinated or planned: *Pharmacy not involved so unable to ensure dressings / meds available.* *Duplication of services e.g. referrals to OT.* *Care planning for EOL needed.* *Care coordination would have been beneficial for patient.* *Would benefit from an advanced care plan.* *Care only provided reactively not proactively.*
		Opportunities missed: *Telehealth could have benefitted patient but not offered.* *RAPT could have picked up patient but missed as only 58.* *Direct access to ECP instead of calling ambulance.* *GP can no longer access care offered in Sheffield.*
	Unnecessary stay in hospital: *Care could have been given in community not as inpatient.* *Urology investigations could have been done as outpatient.* *Frailty assessment could have been done at home.* *Could have had anaemia investigated as outpatient.* *Patient could have been managed at home.*	

Appendices

System working well:

Whole system worked for patient.
Early Stroke Discharge Team worked well.
Telehealth worked well to reduce admissions.
Social Prescribing worked well.
Discharge plan from respiratory ward worked well.

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