

Responding to a risk or priority in an area

Partnership working to deliver health and social care in Cornwall

October 2017

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Introduction

The Care Quality Commission's (CQC's) strategy for 2016 to 2021, *Shaping the future*, commits CQC to do more to assess quality for population groups and consider how well care is coordinated across organisations in an area, through our provider inspections and our thematic work.

In 2016 we tested different approaches in three areas: North Lincolnshire, Salford, and Tameside. We published three prototype reports that looked at how we might assess the quality of care in a local area in order to encourage improvement.

We have now developed this approach further. We have designed a more flexible model that enables local inspection teams to respond to a local risk or priority in an area that crosses traditional provider or sector boundaries.

This model was tested in two areas: the London Borough of Sutton and in the area covered by NHS Kernow CCG in Cornwall. It looked at a local health and care system where there appeared to be challenges (Cornwall) and one that appeared to be functioning well (Sutton). The findings will inform our discussions and influence with stakeholders, in order to encourage improvement across the area (Cornwall) and share good practice where the systems are working well (Sutton).

The experience of producing the Cornwall and Sutton publications has helped us to inform the development of a programme of local system reviews that we have been asked to carry out by the government. However, the Cornwall and Sutton reports are separate do reflect how the local system reviews are being carried out, or how they will be reported.

The Cornwall and Sutton reviews were carried out mainly to help us develop a methodology that local teams might use when they identify risks or priorities that are system-wide, rather than linked to any particular sector or provider.

This report sets out our activity and findings in Cornwall.

During inspection activity and engagement in the area, the local CQC teams in Cornwall had identified ongoing and significant challenges. These included concerns about the community and adult social care provision, including sustained challenges faced by the clinical commissioning group (CCG), an acute trust (including the emergency department and urgent and emergency care) and delayed transfers of care. The review aimed to explore the reasons for concerns and to understand the factors contributing to issues affecting the system, so we could focus interventions and work with national and local stakeholders.

Scope and activity

We wanted to understand the scale of the concerns identified by our local teams and the underlying causes of the ongoing problems, as well as the impact on people using services, staff, strategic partnerships and the system more generally. We did this by looking at the strategic, operational and planning frameworks for inter-agency working, by talking to people who use services and their families, and staff and system leaders.

We set out to collect information on what was working well and what was not; where the obstacles to improvement lay; and what the system collectively, or as individual elements, could do more of, or do differently.

We did this work by reviewing the information we hold in our inspection reports, as well as analysing data from national data collections to see what this told us about the local area. A cross-sector team of inspection staff, supported by the CQC integration team, did this work. It included visits to 25 independent sector adult social care providers and discussions with GPs and patient and voluntary groups.

We also carried out a four-day visit to the area with a cross-sector inspection team, supported by specialist advisers, and spoke with staff in the acute, community and mental health trust, as well as system leaders across the health and social care community.

We were aware that Cornwall had a persistent and significant problem with delayed transfers of care (DTC) from the Royal Cornwall Hospitals NHS trust (RCHT) to other health or social care services. During our initial review of information and discussion with our local teams, it became clear the DTC continued to be a major challenge, and was causing significant tension between providers of health and social care and also between providers and commissioners. Our analysis showed there was a higher rate of DTC in Cornwall than across comparator areas. This includes delays attributable to the NHS as well as delays attributable to adult social care.¹ We were also aware, through our ongoing work with local providers in the area, that there was considerable effort to address this issue, to ensure people could move more easily across services and have their health and social care needs met. These efforts included support from the emergency care improvement programme and an independent external review of the existing discharge planning process in the acute trust.²

As a result, and as a means to better understand some of the key elements of partnership working, we focused on how partners in the area work together to manage the discharge and transfer function for people who require ongoing care following treatment in the acute trust.

Patients in Cornwall local authority with a delayed transfer of care (DTOC), April 2016 to October 2016

	Cornwall local authority	Comparator group of local authorities
Total patients with a DTOC per 100,000 population aged 18+	193	129
Patients with a DTOC attributable to the NHS per 100,000 population aged 18+	102	80
Patients with a DTOC attributable to Adult social care per 100,000 population aged 18+	82	42

Framework

The framework for our activity was designed to explore how well the different elements of the health and social care system were working together to deliver joined-up care. There was a particular focus on DTOC and how that affected people’s movement between and across services. We set out to answer the following questions:

- Is there a clear shared and agreed purpose and vision for health and social care?
- Is there a clear framework for inter-agency collaboration?
- Is there a shared strategy for the delivery of the purpose through the framework?
- Is there an implementation plan with clear roles, responsibilities and accountabilities?
- How are inter-agency processes delivered, and what are the experiences of frontline staff?
- What are the experiences of people receiving services?

This work was carried out to test how CQC can use its unique perspective of health and social care services in an area to support improvements across the system for patient care. It was not a CQC inspection. The work was done using powers under Section 48 of the Health and Social Care Act 2008. We requested and collected information from CCGs and local authorities, as well as providers, so that we could comment on the system.

Key findings

- The sustainability and transformation partnership (STP) was largely seen as the plan for inter-agency working. While it sets out the vision for six key programmes of work, it was in its infancy and was not presented as a cohesive, collaborative plan with clear purpose and a vision by all system leaders.
- All the relevant agencies were working to improve the systems and processes to support inter-agency working. However, we found the current arrangements lacked a cohesive approach and remained fragmented and lacking in ownership, and had lost sight of the needs of people using services.
- There was no clear picture of the demand and capacity of adult social care services shared by system leaders. This made it difficult to develop robust plans for the future social care services needs of local people.
- The key system leaders acknowledged the difficulties in the past and that there has been considerable effort to bring about some improvement to partnership working.
- Engagement with all sectors, staff and the local community was acknowledged by system leaders as having been poor during the STP consultation. People did not feel involved, listened-to or respected. It was striking that co-production with people who use services was not mentioned as part of any agenda by the system leaders other than the CCG.
- There was a lack of confidence in the system (from providers, staff, and community groups) that the plans for inter-agency work would deliver. Many people across the system, and at all levels, told us they saw that initiatives for partnership working had started, but that they were abandoned when new staff were appointed – or where plans had been started but failed to lead to sustainable improvement.
- The systems in place for discharging people from the RCHT to other health and social care were confusing, despite the efforts of frontline staff and the onward care team. The processes and direction provided to them to manage the DTOC were incomplete, duplicated and not aligned to an agreed operational plan or strategic vision for inter-agency working.
- People's experience of moving out of hospital – to a care home or their own home with social care support – was often poor. People identified lack of choice, poor information sharing and a lack of home care packages. The delays people experienced had affected their recovery, rehabilitation and wellbeing, and the negative impact extended beyond individuals to family, friends and to the staff involved in delivering care.

Detailed findings

1. Is there a clear shared and agreed purpose and vision for health and social care?

We spoke with leaders across the health and social care system in Cornwall. This included Cornwall County Council, NHS Kernow CCG, RCHT, and the Cornwall Partnership NHS Foundation Trust. It was clear from our meetings with them, and documents we saw, that people were committed to transformation and change. However, it was not clear how they had come together to agree the priorities for delivering health and social care to meet the needs of the local population. There was no cohesive and aligned shared vision or agreed purpose that was clearly articulated by all system leaders.

The four key system leaders (chief executive, RCHT; chief executive, Cornwall County Council; interim chief officer, NHS Kernow CCG; and chief executive, Cornwall Partnership NHS Foundation Trust) sent a letter in December 2016 to local partners, setting out the plans for health and social care in Cornwall. This letter set out the ambition to ‘move with pace to establish an accountable care organisation (ACO) for Cornwall and the Isles of Scilly and one focal point for the strategic commissioning of health and care’.

The letter also acknowledges that relationships in the past had been difficult – and the success of the planned transformation would be ‘dependent upon the quality of collaboration among those bodies that are party to the process of convergence’. In the letter, the key leaders commit to work in closer partnership to achieve a ‘functioning, responsive and effective health and care system for the people of Cornwall’.

However, talking with senior system leaders, it was clear that the acknowledged historical differences, together with numerous changes in key leadership roles over several years, had taken their toll on partnership working and relationships. Some leaders were very focused on the ‘long game’, and this included working with an external strategic partner with a view to transformation that would lead to automation and digital solutions in the future. Other senior leaders were more rooted in transforming current fragmented systems. When we asked to see the plans or scoping documents for the digital solutions work with the external partner, we were told these were not yet available and that work would be ‘starting in the summer’ (2017).

One system leader commented on the tension between the ‘visionary accountable care organisation versus on-the-ground issues such as DTOC.

We were told by another senior leader that there were different levels of engagement with the inter-agency forums. They went on to say "...we are a relatively small system, which is a benefit, but the downside is if one partner is lagging that is a quarter of the system lagging."

There were discussions about the development of a cohesive inter-agency leadership team with a collaborative approach to joint working, but these seemed immature. One senior manager told us: "Getting over historical lack of trust is the real challenge."

We spoke with a number of people in management roles in different parts of the system in Cornwall, including NHS Kernow CCG, Cornwall Council, local health trusts and independent social care providers. However, there was no evidence of a consistent shared understanding, agreed purpose or vision for how different agencies and services should work together to deliver health and social care across the area.

Some staff told us of their frustration that there was no agreed strategic vision for how partners should work together. Teams and staff involved with the discharge processes for people who required onward health or social care when they left hospital, described multiple and confusing systems and sometimes poor working relationships between health and social care staff.

We spoke to groups representing people using health and social care services and asked them how they were involved in discussions for delivery of health and social care in the area. A charity told us: "There is little collaboration in adult services. There are examples of excellent working relationships on an individual level, but system and leadership-wide, we lack consistency, trust or mutuality in our discussions."

We were told that overall, there had been limited meaningful engagement with people and their carers in the area. One group told us there had been 'little or no genuine engagement', and that they had seen 'no evidence to indicate that health and social care providers are shaping their own teams and commissioning contracts around outcomes and relationships with people'.

Another community group felt that its involvement in planning for people's care reflected local health and social care organisations' merely paying 'lip-service to public engagement' and that they were 'another box to be ticked'.

2. Is there a clear framework for inter-agency collaboration?

There was agreement among the system leaders that their framework and strategy for inter-agency working was linked to the Cornwall and Isles of Scilly STP's³ *Shaping our Future* health and social care plan. Alongside the STP framework, the Cornwall health and social care leaders have set out their ambition for 'developing the ACO approach'.

We were told that one of the ways they are moving towards an accountable care system was the plan to form a joint board between the Cornwall Partnership Foundation Trust (CPT) and the RCHT. The first meeting was scheduled for after our visit. We were told the aim was to create an overview board that pulled the two organisations closer together, with a view to sharing joint policies and procedures and a more flexible workforce. We heard that plans had already been made for the finance director at the Royal Cornwall Hospital Trust to move from the trust role to focus on the STP, and that the CPT finance director will become a joint role across CPT and RCHT.

The planned joint provider board may be a lever for greater collaborative working between the two provider organisations in the area. However, it was communicated to us via interviews with senior leaders and did not appear to be part of any documented framework, vision or plan. Those documents may exist, but none of the leaders could point to them or how this had been communicated to any wider audience as part of the vision for transformation. It was also not clear how this joint board would work with other partners, such as the CCG and Cornwall Council. There were no clear plans at the time of our visit about the inclusion of adult social care services in the ACO.

We asked about the existing framework for inter-agency collaboration across all sectors in the area. We were told that this occurred through the Shaping our Future Programme Board, the decision-making board which reports to the Shaping our Future Transformation Board. This includes the chief executive officers of the four key players (council, CCG and the two NHS trusts) plus the chair of the clinical cabinet and the chair of the local medical committee.

There was widespread agreement that the A&E Delivery Board was the forum for system decision-making in relation to patient flow, including hospital discharge. The delivery board was accountable to the Cornwall STP Transformation Board; however, there was a lack of agreement between system leaders about the level of people's seniority among the group's attendance. At the time of our visit there was an assumption by one partner that chief executives of all key agencies (CCG, council, NHS trusts) should and would attend. However, other agencies were either not aware of this or felt the attendance at this forum was better suited to operational director level representation.

This disconnect around expectations of attendance at the board was an example of the lack of cohesive approach among leaders in the area to address challenges within the system. This is a critical forum with a core purpose to address discharge and the delays to transfers of care. The issue affected not just RCHT but also the CCG, the local authority, the community hospitals run by the CPT and independent sector adult social care providers.

It also affects neighbouring areas, such as Plymouth and North Devon. Both neighbouring areas' acute trusts treat patients from East Cornwall and report that while the numbers of patients with a DTOC were low, a disproportionate number of those were waiting to transfer back to care in Cornwall.

A chief executive in Devon told us it was important when defining a footprint of an STP that it doesn't become another boundary, and that consideration should be given to how they 'combine so that it benefits the patients at the edges' of STP areas. It was not clear that the Cornwall STP leads had considered the needs of those people in East Cornwall in this way, or that they had actively managed the people whose transfer from hospital back into East Cornwall. Given the challenges faced by the CCG and acute trust in Cornwall, there did not appear to be any routine contact at chief officer level to share experience and good practice.

At the time of our visit, there was no shared sense of how the framework for inter-agency working would develop collaboration and cooperation between different partners, agencies and support inter-agency working groups, to promote solutions to identified problems.

The council was observed to have been less proactive in its approach to date, in developing adult social care in terms of inter-agency working, partly due to changes in the senior leadership posts. There were indications that this was changing with the use of a model for an innovative approach to needs assessment and care planning. Most people we spoke to believed there was a will to move forward and deliver a more joined-up approach to health and care delivery for people using services in Cornwall.

Relationships between the council and CCG had not been strong in the past, but again there were signs of an increasing collaborative leadership approach. The CCG recognised the challenges associated with being placed under legal directions in 2016 had meant they were behind where they should be. There was a view from some that the CCG was not a strong enough presence in holding the acute trust to account, so that they were assured of the quality of services they commission. This relationship becomes more complex when considered in the context of the STP, led by the chief executive of the trust, who the CCG must hold to account. However, we saw the CCG was making progress over recent months, with improved governance and quality reporting.

We saw some positive steps in relationships between the council and the CCG – working together on joint initiatives such as the Short Term Enablement Planning Service (STEPS),⁴ and the development of a joint commissioning framework for ‘Care Closer to Home’ and most crucially developing joint strategic commissioning.

While key leaders in Cornwall were aware of, and generally agreed the common issues and challenges, they did not demonstrate a shared view of the causes and solutions. There was a tendency to try to attribute the cause of the problem, rather than to approach the systems challenges as a collaborative leadership team.

3. Is there a shared strategy for the delivery of the purpose through the framework?

It was acknowledged by system leaders that some elements of the STP needed strengthening, such as services for people with mental health needs and adult social care, as well as input from the community. One senior leader told us the STP “was not what it should have been in terms of inter-agency working,” but we were told this was being addressed through the programmes to deliver the plan.

The strategy for delivery of the STP was through six programmes of work that aimed to transform health and social care delivery in Cornwall. The programmes appeared to address a number of issues highlighted as barriers to inter-agency working. They included:

- an integrated place-based approach to care in the community
- improved pathways across the system to ensure the future delivery of services is viable and sustainable
- joined-up commissioning arrangements
- a single digital record for people using services that can be shared across services as required.

This work was very early in its the planning stage and while it contained key high-level milestones, it was too soon to see how the early plans would successfully bring together the different agencies and multidisciplinary teams to deliver change.

On PMS leader told us: “STP is the main document but [it is] aspirational at the moment.”

In addition to the STP programmes of work, there were multi-agency groups working on three priority work streams, agreed by the A&E delivery board and set out in its terms of reference:

Priority 1: reduce ambulance arrivals

Priority 2: implement discharge to assess pathway 1

Priority 3: increase capacity in council-funded providers

Despite the plans to support delivery of the STP programmes of work and the priority work streams overseen by the A&E delivery board, it was too soon to see how all the different elements would come together under the overarching plan and deliver improvements for people using services.

For example, staff at the Royal Cornwall Hospital told us the discharge processes needed to be simplified and streamlined as a priority. We were told there have been various initiatives to tackle the end-to-end process and produce a sustainable model for the future, but which had resulted in multiple processes and caused confusion.

We were provided with policies and other documents to support the discharge processes but none appeared to be a fully integrated document with all parties signposting it as the agreed and implemented process. The RCHT adult discharge and transfer policy (May 2016) directed staff to use a related process that was still in draft and with letter templates that were not available. There was frustration at an operational level that there appeared to be no agreed strategic vision for how partners should work together to ensure effective discharge and transfer of care.

Generally, adult social care providers understood the pressures the trust was under to ensure that people who did not need to be in a hospital bed were transferred out of hospital. However, they did not feel their contribution to the multi-disciplinary health and care team work was valued. Despite this, people told us of their willingness to engage with other parts of the system.

Cornwall Partners in Care told us: “There needs to be better engagement with the provider sector. They need to be seen as part of the solution, not as part of the problem.”

And one domiciliary care agency told us: “We need a proper liaison system between commissioners and care providers...with shared experiences so everybody understands each other’s roles. I would be happy for staff to work with discharge staff so they could understand what we need to know.”

Commissioning of adult social care beds

We heard conflicting views about the capacity of social care services and whether there was sufficient provision of services. There was no evidence that work has been undertaken to fully understand and agree the gap between the social care needs of

the local area and the current capacity. We were told there was no regularly updated data that was shared, trusted and respected, and used to inform commissioning. Senior managers told us that “there is a lot of data in the system, but this isn’t distilled into usable information.”

One manager said: “There are increasing issues around use of data [and] more needs to be worked on to see if current capacity [in adult social care services] is sufficient or being effectively used. There’s a lack of usable data at the moment. So the changing scope of capacity in the market can’t be ascertained without a great deal of hard work and phone calls.”

Cornwall is a relatively deprived area, with an average deprivation ranking of 50th out of 152 local authorities.⁵ However, analysis of data that CQC collects as part of its comprehensive inspection programme indicated that a larger percentage of residential care home beds are fully or partly self-funded in Cornwall, compared with the national picture.

This means a smaller percentage of beds in adult social care homes in Cornwall are fully funded by the local authority.⁶ In addition, data collected as part of CQC inspections suggests that the south west of England has the highest proportion of domiciliary care agencies with no local authority funding, i.e. used by people who were able to fund themselves.⁷

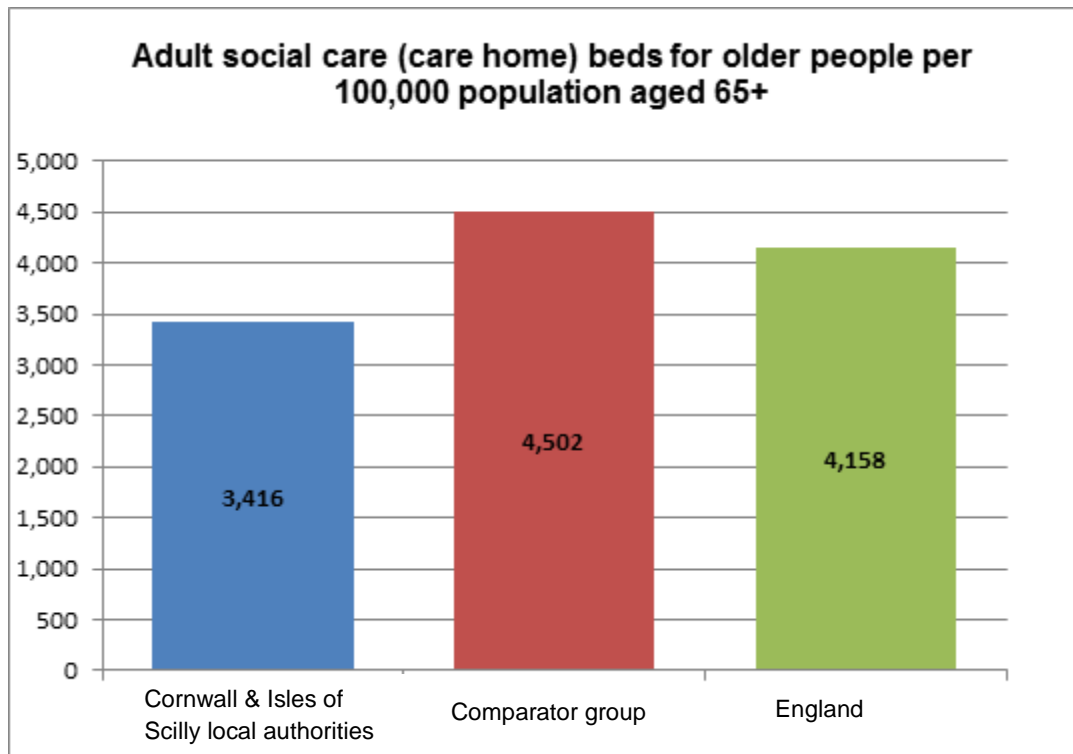
Our analysis showed that there were fewer adult social care beds per 100,000 people aged 65 and over in Cornwall, compared to its comparators and nationally.⁸ Our analysis also showed that more adult social care beds have closed than opened in Cornwall over the last few years. While this is also true of its comparators, the percentage decrease has been greater in Cornwall than across comparator areas.⁹

Some people we spoke with cited a lack of modelling for adult social care provision as a key barrier to change. There was a lack of shared awareness of the needs for social care services versus capacity in the system, although most people we spoke with did believe there was a lack of social care capacity to meet local needs. This included the availability of care home places, but particularly the provision of packages of home care.

We were told that some people who wanted to go home were not always able to access packages of care to meet their needs. This meant for some, rather than stay in hospital they had been transferred to a care home. Others remained in hospital having been assessed as medically fit to go home, but unable to leave until a home care package was found.

The impact of the delayed transfers on patients was described to us by the Cornwall Partners in Care:¹⁰

“Patients are moved from one service to the next, not in their best interests but in order to free the service’s bed...for example, an acute hospital discharge to lengthy community hospital stay without effective reablement.”



The hospital and other healthcare staff referenced the lack of home care packages as the most significant cause of people being delayed in their discharge from hospital once they had been assessed as physically fit to leave. Managers said:

- “Patients are waiting for a package of home care, they get stepped down into residential beds, but they then don’t move on.”
- “Provision for patient needs just isn’t there... just waiting for a patient to pass away, a bed or package of care to be available or the family to step in.”

People talked to us about the factors that influence the use of social care beds. One commissioning manager told us: “You can have 100+ available beds but there were still delayed discharges.”

We were told the factors affecting this could be that beds are not available in the right location, or beds are unavailable to safeguard patients with additional needs – or there is a lack of wider awareness of bed availability. Some people we spoke with said that there was capacity in the system, one person commented: “It is a provider – led market – you can always find a bed but it depends on what you want to pay for it’.”

The adult social care providers told us the current system was poorly organised, with people ringing them up, sometimes several times a day, to find out about bed availability. They told us that funding was a challenge with several people saying they were owed large sums of money and were waiting months for payments from the commissioners.

One provider described their frustration with the system: “No one speaks to us with any accurate information. Brokerage send us information on screen... I call it ‘eBay for people’... they are posted online and people bid for them. There is just ‘How many visits they need’, according to the person who has supposedly assessed them... trouble is, no one has really assessed them.”

Another talked about the delays in payment from the local authority: “Funding is a nightmare... we have to wait months and months for payments. We were owed tens of thousands of pounds until recently, ridiculous. They still expect you to take people though.”

However, some hospital staff said that they believe the care homes have ‘all the power’ and can ‘pick and choose’ their residents.

While the capacity within the social care system was considered a concern, there was also a widespread belief within the system that the hospitals were risk averse – over-prescribing packages of care for people whose level of fitness was the same as when they were when admitted from home without a package of care in place.

This was a view shared by some of the GPs we spoke with. One told us: “There’s a view that hospital teams are risk averse in willing to discharge patients, as they don’t speak with the GP to find out how the patient has previously managed or what the home environment is like.”

A manager at the council had a similar view: “[We have a] hospitals system that is risk averse. The three-conversation model (Partners for change) builds on respecting social care and health care perspectives and informed conversations with people who use services. Community health colleagues really get this but pace in the acute sector can hamper them.”

One comment from a manager at the CCG again suggested there were some assessments for home care services that may not be necessary. They saw ‘over-prescribing home care services’ as one of the causes of the high numbers of DTOC, along with a lack of home care capacity, inefficient use of resource, increasing demand and the lack of capacity in hospital to move people out quickly.

We also heard similar concerns from people at the council, NHS England, independent social care providers, and the CCG. The staff that we spoke to from community hospitals supported this view. One manager said: “The acute hospital

sees the community as a safe route. They need to get better at managing risk – they want people to come to the community hospitals rather than home-based care.”

The concerns from some about the current capacity of social care services does not seem to have been considered together with conflicting concerns about the perception of the risk averse behaviour of hospital teams resulting in over-prescribing home care packages.

On CCG manager said: “More needs to be worked on to see if current capacity is sufficient or being effectively used. There’s a lack of usable data at the moment. So the changing scope of capacity in the market can’t be ascertained without a great deal of hard work and phone calls.”

As well as the concerns about capacity in social care services, there was much criticism of the ‘incredibly cumbersome’ council brokerage system. Many providers told us they were called daily to find out about bed availability. We heard there were plans for joining up health and social care brokerage systems, and from the council that they were in the process of expanding the brokerage service to be more responsive. However, there was little confidence in the providers we spoke with that the plans would result in improvement. One voiced criticism was: “We just enter into dialogue then the person leaves and it’s all up in the air again.”

We spoke with a number of independent social care providers. They told us there was little incentive for them to enter into a block-booking contract with the commissioners. The fee per person in this sort of contract was less than the rapid discharge health-funded process. The other incentive was an assured income from block contracts, but we were told the usage rate for nursing homes on individual contracts was so high that the security of block contracts was of less importance. One provider told us they were part of a ‘discharge to assess’¹¹ project, which meant they had three beds block-contracted from the end of 2016. They commented: “However, as there is no understanding of demand, these beds have only ever been used at 50% capacity.”

We also spoke with neighbouring areas in Devon, where residents in East Cornwall receive their acute care but who need to return to onward care in East Cornwall. We heard that patients in hospital in Devon were often given the option of a community hospital bed, but could have gone home if they had worked better with social care in Cornwall. It was acknowledged that the NHS community hospitals were supportive and responsive, but this was not always the case with social care because patients were getting ‘stuck’ waiting for a package of care.

The arrangements for funding onward care were reported as a persistent challenge when managing the discharge and transfer of care for people. One hospital manager told us there was a ‘funding war, and the provider takes highest bidder.’ There was much confusion in the system about how these problems were being addressed. We saw the plans for the STP and for the A&E Delivery Board for Priority 3 –Increase

capacity in Council funded Providers – yet there were very differing views about progress against the plans. On the one hand we were told there was confusion and delays in the system and were told the CCG were paying for packages of domiciliary care that it shouldn't be, and also that there are regular occurrences where health and social care were 'bidding against each other' and 'chasing the same beds'.

The continuing health care (CHC) funding was described as cumbersome and slow. Patients, families and staff were frustrated that decisions were taking too long for patients at the end of their life. Discussions with hospital staff at RCHT identified concerns about long waits for decisions on end-of-life care funding, and poor engagement from CHC in the discharge planning process.

One manager told us the CHC process was "clunky". They told us they believed "people are dying in hospital as a result, when they could have been at home."

However, we were told by the CCG that the processes for same-day decision-making for fast-track CHC applications for end-of-life care were in place. They told us that some of the difficulties arose when the referrals were not appropriate, and it was suggested that sometimes hospital staff would use the fast-track system to move people out of hospital more quickly, rather than based on clinical need.

We were told: "If it [the application for fast-track] is appropriate, the decision will be made on the same day."

The CCG told us that training had been offered to the hospital staff to raise awareness of the requirements for consideration for CHC funding.

Some staff we spoke with were able to describe the plans that were already starting to have an impact. We heard about work to develop the joint commissioning and joint brokerage arrangements. And we were told the plan would address some of the identified concerns around funding and those situations we had been told about where the CHC were chasing the same care packages as the county council, as well as individual people who were self-funding.

Changes to funding arrangements were being led by a jointly funded role, the director of joint commissioning and integrated care. We were told that after a year of working together there was the start of a joint understanding of the different positions and cultural differences in the two organisations which was providing the basis to take forward joint commissioning. However, the person in the jointly funded role had left and the post was not being reappointed as a joint post, which could lead to a loss of momentum in partnership working and joint commissioning. The venture was too new to identify the impact it would have on the system.

An ambition for improvement was evident when speaking to all leaders across the different agencies. However, the strategies for improvement were in their infancy and the lack of progress to understand the capacity of social services provision against

the needs of the people meant there remained differing views about priorities for improvement at all levels in the system.

4. Is there an implementation plan with clear statements of roles, responsibilities and accountabilities?

We saw numerous plans from the CCG and from the council. And we were shown joint plans submitted from inter-agency working groups to the A&E delivery board, all with the aim of improving commissioning, the way people move between services and for managing the demand for services. The effort and commitment to improvement plans was evident in all parts of the system.

However, all the plans were in the very early stages of implementation. It was too soon to see how these plans would shape the work of operational managers and become clear frameworks for the staff managing the current systems and processes. As a result, at the time of our visit, the operational plans and processes for inter-agency teams to work together to manage discharge were confusing, fragmented, and poorly communicated. By their own admission, and from analysis of the significant efforts to date, the A&E delivery board had not had the impact on delayed discharges from hospital that was anticipated.

One person commented that the A&E delivery board can sometimes feel “bullish”, while they acknowledged attitudes were possibly due to frustration with other stakeholders failing to deliver, it still meant that sometimes people do not feel listened-to, and we were told of a perceived lack of respect at the meetings. One GP said: “People are fed up with hearing about the ‘latest new thing’. There’s a disinterest and weariness amongst the practices.”

There was little mention within RCHT senior manager interviews of how they were making best use of the support and advice offered by the emergency care improvement programme (ECIP), a clinically-led programme that offers intensive practical help and support to urgent and emergency care systems across England, leading to safer, faster and better care for patients. This support had been available in the trust for 18 months but it was felt that while they were working well with operational teams, it was more difficult for the team to engage at strategic level.

A core responsibility of the A&E delivery board was to oversee work to address the ongoing and significant issues around patient flow in the RCHT, including the delays to transfers of care. A comprehensive external review of the Cornwall health and social care system discharge process was commissioned by RCHT, Cornwall Partnership Foundation Trust and Cornwall Council. It was completed in November 2016. The report set out the very complex discharge processes, identified key areas for prioritisation and improvement, and made a number of recommendations.

However we were not provided with any documented action or impact as a result of the recommendations. When asked, we were told there was deliberately no action plan developed to take forward the recommendations, but the reasons for this were not clear. It was also unclear where the findings of the report had been discussed– or how the system was going to benefit from the insight provided in the report.

The report of the external review was mentioned at different levels within the hospital management structure, but we heard clear frustration from teams and wards who were still coping with a multitude of forms and different processes as part of the trust’s discharge system.

The ongoing challenges for the system managing the discharge processes were evident. During our activity in Cornwall, there were two occasions where we saw how partners come together for ‘GOLD calls’¹² in response to the numbers of people delayed in being discharged from hospital. The escalation process in the system states that Gold calls take place if there is a major incident or crisis, when chief officer level decision-making was required. However, the calls we witnessed were erratically attended by key agencies and not consistently at chief officer level. We were told this was not unusual and often meant some attendees did not have the authority to make decisions required.

We were told by different agencies that these meetings were called at very short notice– sometimes as little as 10 minutes’, and as many as four in a day. People told us the requests to attend GOLD calls were made inappropriately. The result was significant frustration in all agencies and a lack of effective action to support a crisis in the trust.

The lack of demonstrable implementation of the plans for inter-agency working was evident throughout the system. There was frustration at an operational level that there appeared to be no agreed strategic vision. Several people shared with us the *System wide patient choice and equity framework*, which was regarded as the overarching means of supporting inter-agency working for discharge planning and reducing delays in discharge. The document was produced by the CCG but owned by all the organisations with the A&E delivery board. However, this document has been in draft format since 2013. The latest revisions were made in February 2017, but there was no indication of when it would be signed off, and at least one director with a role in managing hospital discharges told us they had never seen it.

Despite a willingness to change and improve among senior leaders, it was clear across the system and at all levels that there was a lot of talk but little action. One senior manager told us: “Cornwall has suffered from doing lots of pilot projects but not embedded anything – now need to do a small number of things well that have an impact.”

Use of information and data

All the provider groups we spoke with raised the subject of the collection and use of data as a concern and barrier to better inter-agency working. There were multiple IT systems operating within and across the providers. These were not integrated across providers and sectors. We were told that “accessing patient information requires time-consuming searches across numerous systems.”

In primary care there were different IT systems in practices and very poor links to community care services, making auditing activity difficult. District nurses couldn't input into GP practice systems, and there was no shared care plan. One GP told us the current lack of information made “decision-making difficult without the right data/information.”

The hospitals had multiple information collection systems that were not compatible with each other. We heard there was a lack of confidence in the data or agreement on how the trust was counting delays in discharge from hospital care. A council manager said: “There needs to be local agreement about when the clock starts ticking for when it is a delay. The trust recognises this is an issue and this needs addressing.”

There was also a lack of available ‘live’ data to allow teams to see where there was capacity was in adult social care services. We were told that sometimes care home beds were empty and available, but staff capacity wasn't available to match a person with high-level needs. We were told improvements in the live data could make a difference, if it was known what the problems were and where, so that people could be better matched to the services that met their needs and were available. One CCG manager told us: “There isn't a bed bureau. Lots of time [is] spent ringing round homes.”

Many of the GPs and social care providers we spoke with highlighted information-sharing as a major barrier to good inter-agency working. Sometimes this was attributed to data protection issues, resulting in a reluctance to share information between agencies; this was also raised with us by the social care providers as a barrier to joined-up care provision. One GP told us: “Patients discharged from hospital without paperwork remains an ongoing problem. Finding who was involved in the patient's care and treatment takes a huge amount of time. Often, GPs have to consult with the patient's family members to find out who saw the patient so that the paperwork can be asked for.”

There was a programme for information management and technology as part of the planning portfolio for the STP. The vision for this part of the programme plan was that by 2020/21 the local digital roadmap would have achieved its vision of ‘One Person, One Digital Record’, much of the detail was still to be worked out and there were varying levels of confidence across the system that this work was on track to

deliver the improvements required. We were told that there is a good digital roadmap ambition but it is not very far forward.

5. How are inter-agency processes delivered– and what is the experience of frontline staff?

Delivery of the plans for better inter-agency working appeared to be aspirational, and there was little evidence of support for staff and teams managing the existing processes. One senior leader referred to this as a “mess” and “very convoluted”.

We looked at a sample of 41 hospital records for people whose discharge from hospital had been delayed (taken from a list of over 100 people who were counted in the hospital figures as having a delayed discharge on 4/5 January 2017).

The patient records should set out the discussion with the patient through the discharge planning process, and any delays or problems with discharge. However, the records that we saw did not always contain all the relevant information about the discharge process – and it was sometimes difficult to determine the cause of the delay from the hospital records.

This would make any audit of the effectiveness of discharge processes difficult. For example, in one case we looked at, a patient was assessed as being ready for discharge but was still in hospital 37 days later. It appeared that the right steps had been taken to progress the person’s discharge, such as:

- discharge planning commenced within 48 hours of admission
- a recorded medication review with documentation
- best-interest meetings to ensure the placement was appropriate and in the best interests of the person
- appropriate involvement of teams, such as occupational therapy and physiotherapy
- involvement from the dementia specialist nurse.

Yet despite this activity, there was still a significant delay and the person was unnecessarily in hospital for a number of weeks. No reason for the delay was recorded in the records.

Other records for patients who experienced a delay in their transfer of care did not include a clearly set out discharge plan, showing how discharge was being coordinated or where people were going to go. One record included entries indicating a person was going both home and to a community hospital. There was inconsistent information in the records we saw, regarding how staff monitor individual

patients who have a delay in their transfer of care, and any action taken to reduce the length

We were told the ability to monitor and audit the discharge processes was hampered by multiple IT systems. Reports were produced by the onward care team to capture key information that was used to monitor the numbers of delayed discharges. However, we were told that to carry out more in-depth exploration to monitor quality and evaluate impact would be difficult and time-consuming. The systems used to collect information were described to us and confirmed through case reviews.

Progress with planned discharges was maintained on a relatively simple database that had no interface with other systems, such as the 'SwiftPlus' ward dashboard system. Patient information was captured by the onward care team following review of each ward dashboard in SwiftPlus at least once and usually twice a day to capture the patients' discharge status. We were told this was time consuming and reliant on manual data entry. It did not appear to be a sustainable method and relied heavily on the goodwill of the team to ensure that happened.

The database used by the onward care team recorded a variety of useful information about the history of patients' progress towards discharge. This database was not part of the patient history and the information was deleted three months after the patient had been discharged, and was therefore not available for any audit or quality monitoring purposes. We looked at the records of some patients with delayed discharges, to track their journey through the process, but the information stored on the onward care team temporary database was not routinely recorded in the paper records— and in some cases it had already been deleted.

As well as looking at records and discharge monitoring processes, we spoke to a range of staff in independent providers of adult social care, hospital staff in the acute trust, the community and mental health trust and in primary medical services. There was a great deal of frustration with the end-to-end process of securing the right onward care for people ready to leave hospital.

Hospital staff

The hospital established the onward care team to support the discharge processes. This brought together a multidisciplinary team of social workers, nurses and the hospital management lead for patient flow. The team was clearly committed to improving the processes to reduce the delays in transfer of care.

However, the individuals involved report to different line managers in different directorates or agencies. They come together as a group but were not supported to work as a fully integrated team. At the time of our visit the team had started to make a difference, but it was too soon to be able to demonstrate consistent improvement in the overall confusion on wards regarding the discharge processes. One senior nurse told us: "Discharge is a very complicated process...we on the wards don't

have ownership of this, it's been taken off us and now feels impenetrable... [I am] not sure I even understand how it all works."

Apart from the frustration with their own internal processes, some of the hospital staff we spoke to expressed concerns about the lack of agreed criteria for discharging patients to community hospital beds. This was equally a frustration for the community hospital teams, who believe the hospital teams see the transfer of people to community beds as the 'safe option'.

The lack of system-wide agreement on the use of community beds was a persistent concern at all levels, from system leaders to frontline staff. One member of staff at RCHT told us: "Moving people into community hospitals? Every day it's a debate about who they can take... for example, a patient with [a specialist neck collar] – the community hospital wouldn't admit but promised to get staff trained [and] every time we checked, the training had not been done. [The patient] does not need to have been in an acute bed for 77 days."

Hospital staff told us of other concerns linked to the delays to transfer of care. We were told the adult social care staff and social workers did not trust information supplied by nursing staff and insisted on carrying out their own assessments of people's needs. This view was supported in neighbouring areas. In Devon, where there was not the same pressure of DTOC, a disproportionate number were people waiting to return to ongoing care in Cornwall. We were told the social care teams did not accept the hospital assessments of people's needs and they have to do their own, meaning the assessment would be repeated. We were told the Devon acute trusts work very collaboratively with Devon social care, but that it was different with Cornwall social services.

There were frustrations expressed to us that care homes were less likely to accept people for discharge on a Friday, and would not visit wards at weekends to carry out assessments.

We spoke with hospital staff about the range of initiatives and efforts by individuals and teams to improve the discharge processes. The teams expressed frustration at the range of different information recording systems being used, including 'RiO', 'MOSAIC' and 'SwiftPlus', as well as the paper records – and how difficult this made it to collect robust discharge information to better understand the delays and to target improvement. We were told of different assessment forms being used, even within the same team, and that these need to be standardised to create consistency. We were told of the frustration at an operational level that there appeared to be no agreed strategic vision for how different agencies should be working together.

One hospital manager had a view that the system had "suffered from different ways of working, different IT systems, different discharge forms [and there was a] need to sort out the way through it." The manager added: "Packages of care in the community is what needs to be right – the basic capacity needs to be right. Roughly

45% of complex discharges go through community hospitals because other routes are blocked.”

Adult social care services staff

The majority of the 25 services we spoke with reported a generally poor relationship with the RCHT. The main reasons for this were the lack of information provided by the hospital about people transferring to their care. One adult social care service provider told us: “Discharge arrangements from Royal Cornwall Hospital to care homes and domiciliary care agencies were abysmal.”

While there were isolated comments about good processes experienced by the service providers we spoke to, the overwhelming message was that the hospital was under such pressure to free-up beds that the assessment process for ongoing social care was unreliable. The staff told us that frequently the information received was incomplete, inaccurate or missing— and there was an urgent need for improvement. One adult social care provider told us that ‘they will tell you anything you need, mostly untrue, just to get the person out’.

Another adult social care provider told us: “If you can work with people at the hospital you know and trust, nine out of ten [times] they are ok. Good assessment by us of new people is essential as we don’t trust hospital information provided under pressure.”

The adult social care providers talked about their frustration in trying to meet people’s needs and their choice, but that the current system does not allow them to do so.

One provider of home care services told us: “People do not get to make choices in the current system. For example, today we have been dealing with one person who we previously supported who is due to be discharged. The package went out to open tender on the council system and was given to another provider. The person is really unhappy about this and we have spent the morning trying to sort out the situation.”

A manager at an adult social care service told us that “people are herded around like cattle.” We also heard from a number of independent providers of adult social care that they did not feel respected by the RCHT staff. They told us they found staff dismissive or rude, and they felt ‘talked-down to and avoided.

Another comment from an adult social care provider was: “When I arrange to go to RCHT for an assessment of a new person, I tell the ward I am coming but still no one knows I am coming when I arrive... no one knows why I am there. Once I explain, they are dismissive, unhelpful and often rude.”

We asked where there were examples of the processes working well. Again the community hospitals were highlighted, with several providers telling us that the

communication and information-sharing was much better from the local community hospitals.

One adult social care provider told us about their experience of community hospital discharge: “If you look at Bodmin Hospital’s processes and practice, that is the gold standard – really good discharge summaries, good communication and liaison and supportive staff who listen and work with us.”

Another said: “The information provided by these smaller hospitals is excellent. We receive detailed information about patients, proper transfer letters with medication and they actually know the patient and you can talk to physios, occupational therapists and everyone involved in the care of that person, to get a clear and honest picture of the person’s needs.”

Primary medical services staff

The GPs we spoke with told us there was ‘a lot of talk about integration’ with other health and social care colleagues, but little evidence of any change. They talked about a lack of consistency in attendance at meetings, which made decision-making difficult. We were told there was a lack of an overarching system of governance to support ongoing inter-agency working, and with a perception that there was still a culture of working in silos and ‘managing individual businesses first’. As a result, the systems for inter-agency working were underdeveloped.

CQC inspection reports show GP practices in Cornwall are rated highly, in line with comparator areas and national performance. At the time of our review, 88% of GP practices in Cornwall were rated as good, which was the same percentage as in comparator areas, while nationally 84% of practices were rated as good.¹³ Our analysis also showed that GPs in Cornwall receive more funding to deliver services compared to comparators and the national average, even when taking into account differences in the services provided.¹⁴

GPs we spoke with did not feel engaged and part of an overarching strategic plan for better inter-agency working. One told us there poor oversight meant that sometimes the focus was on system capacity, rather than being patient-centred.

We were told that out of hours, people were admitted from care homes because there was nothing in place to support the staff, such as out-of-hours district nurses who had additional nursing skills and expertise. A GP told us “it’s easier to admit to hospital rather than set up community or residential packages.”

In contrast, we also heard there was now a perception of more openness than previously existed across the sectors. The GPs we spoke with shared aspects of the work they were involved in that was having a positive impact on the care of people in their area. One GP told us their practice had got together with another local practice to try and set up improved services. They told us: “We’re currently trying to get

resilience funding for nurses to shadow community nurses... to improve integrated working. We have verbal buy-in but there's been a lack of funding to support this."

Another GP told us 'the community matron works well' and that 'she joins things up successfully'. They said the acute care at home service also works well, assisting with preventative work as well as crisis work. But it was acknowledged that the service needed to expand.

6. What is the experience of people receiving services?

In order to understand how the health and social care system worked together for people using services, we spoke to the local Healthwatch and voluntary groups, as well as 25 people (or families and friends of people) currently receiving social care services and who had been recently discharged from hospital.

People told us there was little choice in the current system; no choice of care home or of which domiciliary care agency would provide services.

A care home resident, following discharge from hospital, told us: "I was not given a choice. I was told these people were available so that is who we have."

Some people told us they had wanted a different home or one nearer to where they used to live, so friends and family could visit more easily, but this option had not been available to them.

Many of the concerns related to lack of discharge information and a reluctance by hospital staff to share information with care home staff. This caused delays to ongoing care and treatment. The son of a person in a care home told us: "I had to do all the liaison work between the hospital and the service as the hospital refused to speak to the service."

The impact of lack of choice on one woman and her husband

“They told me on the on [a date in February 2017] that my husband was ready for discharge but that they were finding it difficult to arrange the four-visits-per-day home care package that was necessary. The social worker then went off sick and subsequently I have very little involvement in the discharge process.

I would normally have wanted to visit the service to have a look around before the move. To see what the room was like and things like that. I had no involvement in the decision and the move did cause [my husband] some distress as it was a new environment and still over 20 miles from home, so I remained his only visitor.

There was a room available in the care home in our village and it was cheaper than [the care home my husband was in]. They did not tell us what they were doing and we were being billed £100 per week... and this combined with the cost of visiting and traveling twenty-plus miles every day since November has had a significant impact on our household budget.”

Where we were unable to speak to people directly, the staff providing care gave examples of people being discharged from hospital without information about the treatment they had received– or ongoing care requirements.

Some of these people required readmission to hospital or phone calls to find out what care they should be receiving as a result of their hospital admission. One person returned to their care home following a surgical procedure with no information about the procedure, including whether any sutures were present.

Another person returned from hospital with no after-care information. The care home rang the hospital to find there was a problem with the person’s sodium levels, and the person needed to be restricted to one litre of fluid each 24 hours. The person also needed a blood test a week after discharge. This had not been communicated to the care home staff.

We heard of several cases of people being discharged with cannulas still in their arms. This caused avoidable visits from district nurses. We were told of three separate cases where a person had been discharged home with a package of care to be provided by a home care agency, but without informing the agency. This left people at home without the required visits until either the agency made enquiries or the family told them, or asked why visits had been missed.

In one example, the service told us about a person discharged without them being told, and the person “missed three potential visits by us before we knew they were there.” In another case, a provider told us “it was sheer luck that the visit was not missed.”

The impact of the lack of a home care package

A care home manager told us: “One relative was so disheartened with the delay in picking up a package of home care that she put her needs on Facebook and asked everyone if there was a carer that would be willing to accept direct payments and provide the support her parent needed at home.

This worked well and she got several offers and checked them all out thoroughly and now all is well she is home with support. What a sad reflection of the system that is though.”

During a discussion about the pressure to discharge people who were assessed as medically fit, we asked how the patient’s choice was considered. One member of hospital staff told us there was very little choice for people in the current system. They said: “It is hard to hold the line on professional values and principles in the context of the competing priorities.”

We were told of some experiences that showed good practice for discharge management. We heard from one relative who told us that when their parent was ready for discharge from the RCHT and back to a care home, a doctor rang them at home to explain what was going to happen.

The examples of good practice more frequently related to discharge from community hospitals, which were considered by social care staff as better than the acute trust. The community hospitals are managed as part of Cornwall Partnership NHS Foundation Trust, which is rated good by CQC. In particular, discharges from Bodmin Hospital were mentioned as good examples.

However, among the people we spoke to, good practice examples were mentioned less often than concerns. In some cases people were put at risk due to poor discharge practices such as lack of information shared about ongoing care requirements.

Conclusion

There is no doubt that there is a determination and will to move forward and improve services for the people of Cornwall. This was evident from discussion with staff across the different agencies and providers that make up the health and social care system in the area.

However, the combination of a challenged acute trust and a CCG rated inadequate by NHS England may have led to an increased focus on improvement activity within those organisations when the national drive was to look outward at integration. This has led to competing demands for senior leaders of those organisations.

There are still some difficult decisions to be made around configuration of services. Senior leaders must have a common view and understanding of the current social care service provision, and a clear picture of the scale and scope of any unmet needs. There needs to be trust in the senior leadership team that makes those decisions. The senior leadership teams from all agencies will need to work together to build a culture where differences, concerns and risks can be aired and challenged.

There is a challenge for the leaders to build a responsive team that inspires trust, works with the community and delivers effective change. The frequent changes in leadership may be the reason for so many comments at all levels and across all sectors about initiatives starting but not resulting in any change or improvement. We were told that it was always the same: people move on and someone different comes in with new ideas – “nothing changes” and the initiatives just fall by the wayside. However, whether people move on or not, good plans, well designed and focused on a common purpose should survive changes in leadership.

There has been little purposeful engagement and co-production with staff and the local community when developing plans for improved service delivery. This has to be in place before implementation of the vision for the future can achieve any real traction. Also, there appears to have been little collaboration with neighbouring areas that are willing to work together to ensure STPs do not create new boundaries, and to share good practice.

The experiences of people moving between services are unacceptable and require urgent and significant change to improve. An increase in the pace and commitment to change is essential to deliver effective and focused action on agreed priorities. This is necessary to ensure people in the local community receive the best quality care in the right place when they need it.

One senior leader told us: “The system is beginning to understand itself but not in terms of outcomes.”

Many of the challenges and issues identified in our work with the partners in Cornwall were not unique to Cornwall – they are national issues. However Cornwall has a history of frequent changes in leaders, resulting in less well-developed relationships. As a result, some of the building blocks in place in other areas – at a time of great change and transformation – have been missing. This means there may be an increased challenge in ensuring the ambition of the STP is realised operationally.

Areas for improvement

National health and social care services across the country are coming together to identify ways of providing care more flexibly and efficiently, to meet the changing needs of an ageing population and increasing financial pressures. It is more

important than ever that local authorities – and adult social care in particular– as well as acute, community and primary medical services NHS colleagues work together in mature, purposeful and trusting relationships.

This will increase the likelihood that the communities those organisations serve are provided with good quality care. This is particularly important for those people living with long-term conditions – people who may need to move between health and care services and providers as their care needs change.

This report has identified that the components of the health and social care system in Cornwall are not working well together. The experience is poor for patients who need to leave hospital but require ongoing care. It is clear that partnership working is better than it has been historically, but there is little confidence in the system that improvements will be made.

There has been a lack of oversight, accountability and ownership to implement initiatives and evaluate activity based on patient experience. We have five recommendations intended to build on a willingness to improve and ensure different parts of the system work together, focused on people using services.

Recommendations

1. The system leaders must focus on building and presenting a cohesive, visible leadership team with a full-time leader, to take forward the STP's plans. They must ensure leaders across health and social care have the capability and capacity in each part of the system to improve inter-agency working for the benefit of people using services– especially in those areas with existing known concerns.
2. Arrangements for inter-agency working must be clarified, strengthened, and consistently implemented. System leaders responsible for commissioning and delivering care should set out and communicate widely, their agreed framework, structure and governance for coming together to:
 - align and regularly review the key priorities for inter-agency working
 - develop and implement the early work started on a joint commissioning agenda to improve access to care in the community to meet the needs of local people
 - Immediately make use of the joint strategic need analysis– this information must be shared and owned by all system leaders to develop a set of priorities to jointly manage and plan for the current and future health needs of the local population.
3. Leaders must re-engage with the community and staff and establish a programme of co-production across the area. This must include:

- engagement across the system to better understand the problems and action needed for improvement. This must feed into the collective development of the strategic plans
 - ensuring the public has meaningful opportunities for participation in the decision-making process
 - staff involvement to agree the two or three key priorities that will align the work programmes for the STP and the A&E Delivery Board. These must be communicated and actioned immediately to increase confidence and challenge the Culture that ‘nothing changes’
 - prioritisation of engagement with Devon providers and commissioners to ensure East Cornwall people’s interests are considered when they are receiving care in Devon.
4. There is an urgent need to refocus on the experience of people moving between services and those who need ongoing support. This must include:
- development of person-centred, individualised care plans– these must be agreed, owned and shared across the system to ensure people’s needs are better met as they move from secondary care to receiving social care and care services
 - reviewing and streamlining of all plans and initiatives involving discharge and the transfer-of-care between services
 - development of jointly agreed patient-focused discharge processes and pathways – these must be communicated clearly
 - establishment of a coherent, inter-agency leadership and management structure for the onward care team
 - establishment of a coherent system of jointly commissioned reablement services
 - arrangements for monitoring and evaluation of effectiveness of all plans.
5. All recommendations must have an accountable person or group to oversee action, implementation, monitoring and evaluation.

¹ NHS England, Delayed Transfers of Care, April 2016-October 2016

² The Cornwall Health and Social Care System Discharge Process Review GE Healthcare Finnermore, November 2016 – commissioned by RCHT, Cornwall Partnership Foundation Trust and Cornwall Council

³ The STP is an initiative covering all aspects of the NHS in line with the NHS England Five Year Forward View – final versions of the STP plans were produced in October 2016

⁴ STEPS/Corcare– service is jointly commissioned by NHS Kernow CCG and the Council focused on re-ablement

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- ⁵ Department for Communities and Local Government, 'Indices of multiple deprivation' 2015
- ⁶ CQC Provider Information Returns for Residential Care Homes as at 28/11/2016. Analysis based on valid returns from 44% of active residential care homes in Cornwall.
- ⁷ CQC provider information returns for community adult social care providers as at 09/01/2017. Analysis based on valid returns from 65% of active domiciliary care agencies in the South West.
- ⁸ Adult social care home bed numbers based on CQC HSCA Register data as at 01/12/2016, population figures from ONS mid 2015 population estimates
- ⁹ CQC HSCA Register data January 2013 and May 2016
- ¹⁰ Cornwall Partners in Care, a trade organisation for care providers,
- ¹¹ Discharge to assess is a process for assessing people who do not require an acute hospital bed, but may still require care services are provided with short-term, funded support to be discharged to their own home (where appropriate) or another community setting.
- ¹² GOLD calls are intended to be the highest level of escalation, as set out in the trust escalation process, held on an exception basis and only when chief officer decision-making is required.
- ¹³ CQC ratings data as at 25/11/2016
- ¹⁴ NHS Digital 'NHS Payments to General Practice', England, 2015/16

The Care Quality Commission is the independent regulator of health and adult social care in England.

Our purpose

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

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CQC-386-102017