Responding to a risk or priority in an area

London Borough of Sutton

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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 how well care is coordinated across organisations, 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.

We tested this model in two areas during 2017: the London Borough of Sutton and the area covered by NHS Kernow Clinical Commissioning Group (CCG) in Cornwall.

The model 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 with stakeholders and will help to encourage improvement across the area (Cornwall) and share good practice where systems are working well (London Borough of Sutton).

These reviews pre-dated the request from the government for CQC to carry out 20 reviews of local health and care systems. While the experience of conducting the Cornwall and Sutton reviews has helped to inform the development of the methodology for the 20 reviews, the Cornwall and Sutton reviews are separate and should not be seen to reflect how the local system reviews are being carried out or how they will be reported.

This report focuses on our review of health and social care in the London Borough of Sutton. The area was selected because local CQC teams identified that it had improved care for older people in care homes in order to both reduce hospital admissions and to enable rapid and safe discharge from hospital. Sutton is one of the NHS 'vanguard' areas and along with other information, the review also included information from the Sutton Homes of Care Vanguard Programme.

We used our unique position to look across health and adult social care in Sutton and to test our approach in order to understand where there is emerging good practice and how this can be shared more widely.

Scope and activity

Our activity in the London Borough of Sutton is in the area covered by both the Sutton Clinical Commissioning Group (CCG) and the London Borough of Sutton. The London Borough of Sutton covers a population of 203,000 and of this, approximately 15,000 people are aged over 75 and 5,000 people are aged over 85. There are 81 care homes in the area covered by the CCG with 594 people in NHS funded nursing home placements. There are a total of 1,299 care home beds, 47% in care homes providing nursing care, 22% in care homes providing personal care only and 31% in homes for people with mental health needs or a learning disability. There are a further five care homes (144 beds) supported by GPs from outside Sutton CCG, but within the London Borough of Sutton. These five homes do not currently receive interventions provided by Sutton Community Health Services.

The vision of the vanguard programme has been to have vibrant, high-quality care homes in Sutton. Between 2015/16 and 2016/17, the number of care home beds for care homes supported by GPs in Sutton CCG increased by 14%. This was due to two big care homes opening. However, as a result of the programme there has been a reduction in emergency presentations. Between 2013/14 and 2016/17, A&E attendances and non-elective admissions per care home bed reduced by 17% and 11% respectively. The greatest impact was seen in nursing home activity but this does include an increase in emergency activity from mental health and learning disability care homes. This shows that in spite of an increase in care home bed numbers, there has been a reduction in A&E attendances and non-elective admissions. This is believed to be as a result of better coordination of care, enhanced training of care staff and better health care support for older people in care homes.[1]

We wanted to understand the scale of the impact of the changes for people in Sutton, identified through CQC's unique local knowledge in order to support providers, our partners and stakeholders in order to identify how particular points of practice can be shared more widely.

Our review focused on how services and other agencies work in partnership to support service development and joined-up care for people in care homes in Sutton.

We set out to collect information on what was working well and what challenges there were; whether there were any obstacles to improvement; and what the system collectively, or as individual elements, could do more of or do differently to ensure that people in care homes can move across services and have their health and care needs met.

[1] Information based on the Sutton CCG Metrics Dashboard (Measuring the Impact of Our Interventions: tracking outcomes and activity through metrics, updated 23 May 2017).

We also considered the sustainability and progression planning in place to ensure that the identified changes would continue once the targeted funding for the vanguard programme was no longer available, as well as whether the changes could be replicated in other areas.

What did we do?

We collated information from across adult social care, primary medical services and hospitals). We then reviewed:

- information held by CQC systems and local teams and data available regarding area demographics, CQC enforcement activity, service provision, staffing, funding, and activity relating to patient flow in and out of hospital
- ratings and findings from inspection reports for hospitals, primary medical services and adult social care services
- reports and reviews already undertaken by CQC about services in Sutton.

We also looked at plans for the future development of services in Sutton and we spoke to the South West London Sustainability and Transformation Partnership (SWL STP) lead who provides a link with the health and wellbeing board for the area. We explored the changes that have taken place across the area and looked at improved partnership working. To do this we:

- looked at information from the Sutton Homes of Care Vanguard Programme, with a particular focus on the enhanced health in care homes (EHCH) aspect of this, including material on the Sutton CCG vanguard website. The information included reports, updates and videos describing the approach in Sutton. We also gathered information on specific processes such as Sutton's Hospital Transfer Pathway (known as the 'Red Bag' pathway) and how this impacts on people in care homes when they transfer in and out of hospital.

- attended meetings, such as the Sutton Homes of Care Vanguard Programme Steering Group, Managers Forum and the Joint Intelligence Group (JIG).

- used four planned adult social care inspections to ask some additional questions in order to assess what care homes knew about the work of the Sutton Homes of Care Vanguard Programme.

- undertook some specific visits to care homes, outside of the inspection programme, to speak to staff, residents and family members to gain their views of the impact of joint working on the care of people living in care homes.

- had discussions with NHS England and other stakeholders, such as Health Education London and Healthwatch.

- held a number of telephone interviews with key leaders, care home providers, GP practices, partners and stakeholders. This helped us to understand how partners and services work together across health and social care to improve the experience of people living in care homes.

Framework

We designed a framework for our activity to explore how well the different elements of the health and social care system work together in Sutton to deliver joined up care, and how we could share examples of good practice more widely. We set out to answer the following questions:

1. What is the strategic framework that brings together inter-agency work and multidisciplinary work?
2. Is there a clear operational planning framework that shapes the work of operational managers?
3. Is the planning framework clearly communicated into an operational delivery framework for professionals and practitioners?
4. Are there effective arrangements for evaluation?
5. What is working well to ensure people can move between services through improved inter-agency working?
6. What is working well and what is planned that will ensure people can move between services and providers through improved inter-agency working?

It is important to note that the review and the questions explored were not an inspection. The work was undertaken 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 people who use services. We carried out this work using our powers under Section 48 of the Health and Social Care Act 2008. We requested and collected information from CCGs and local authorities to enable us to comment on the commissioning of services.

Key findings

- There is a clear framework and strategic approach to collaborative working in Sutton overseen by the vanguard steering group, the Sutton CCG and overseen by the South West London Sustainability and Transformation Partnership (SWL STP) team.
- The framework is clear in relation to delivery and there is clear leadership, investment and support from the Sutton CCG to implement change and progress partnership working, to improve care for people living in care homes in Sutton.
- There is a strong commitment to partnership working across the majority of organisations and stakeholders in Sutton.
- All stakeholders, staff and people using services that we spoke with stated that they felt included, valued and listened to.

Detailed findings

1. What is the strategic framework that brings together inter-agency work and multidisciplinary work?

The strategic framework for the Sutton vanguard is comprised of the value propositions, supported by the logic model for the NHS England Vanguard Programme.

The development of the joint health and social care work in Sutton, supported by the NHS England Vanguard Programme is also sponsored by The National Institute for Health and Care Excellence (NICE). The partners working together as members of the Sutton Homes of Care steering group are:

- NHS England
- New Care Models Programme
- CQC – represented by the local adult social care inspection manager
- Health Education South London
- Sutton CCG
- Sutton Council
- Epsom and St Helier University Hospitals NHS Trust
- South West London and St Georges Mental Health NHS Trust
- London Ambulance Service NHS Trust
- St Raphael's Hospice
- Alzheimers Society
- Sutton Age UK
- CVS – Sutton centre for the voluntary sector
- All care homes in Sutton

These partners also work in collaboration (meaning that representatives are not regular members of the steering group but are consulted and have input into proposed changes and developments) with:

- South West London Collaborative Commissioning
- Health Innovation Network
- Other Care Home Vanguards

There is a clear framework and strategic approach to the collaborative working in Sutton overseen by the Sutton Homes of Care Vanguard Steering Group that then gives information to the SWL STP team. Preparatory work, such as joint meetings and sharing of information, was well established before the vanguard programme was set up. This helped to establish ways of working that meant Sutton could develop a very clear proposal for the vanguard selection process.

The work in Sutton, supported by the vanguard, is monitored by the CCG and feeds into the NHS England New Care Models Programme. The SWL STP has five key priorities and one of them is to embed the outcomes of the Sutton Homes of Care Vanguard and the EHCH framework across South West London. In South West London there are four local delivery units (LDUs), one of which is Sutton. Each LDU has its own local transformation board that reports into the SWL STP team.

The work of the Sutton Homes of Care Vanguard includes supporting the SWL STP with one of its five key priorities – the spread of the EHCH framework to all CCGs in South West London. In addition, as part of being awarded vanguard status, Sutton, with the other five care home vanguard sites, has been instrumental in developing the EHCH framework with NHS England. The challenge now for Sutton is to meet all elements of the EHCH framework. Evaluation, embedding and progress of the vanguard programme is reported formally on a quarterly basis to NHSE, and the NHSE account holder for new care models attends the steering group meetings where monitoring and evaluation updates are part of the agenda.

The vision of the Sutton Homes of Care Vanguard is to have **'**vibrant, high-quality care homes in Sutton' delivering care that embraces the national nursing values of patient care – care, compassion, competence, communication, courage and commitment (the '6Cs'). The vision is implemented through three 'pillars':

- Integrated Care
- Care Staff Education and Development
- Quality Assurance and Safety

There is good representation and participation at the Sutton Homes of Care Vanguard Steering Group from health and social care providers and stakeholders, and the voluntary sector. There are open and honest discussions at these meetings to consider how to support organisations in moving forward to provide the best

approach to care. This support includes access to relevant training and support from link nurses, as well as resource packs for referral. The support helps to ensure that admissions and conveyances to hospital are steadily reducing.

Commissioners

Sutton CCG is very clear about its remit in supporting and driving change as well as monitoring and evaluating partnership working in Sutton. The CCG has clarity of purpose as well as plans that are wider than the vanguard, for example employing pharmacists and pharmacy technicians with specific care home responsibilities.

There is clarity in the vanguard programme about how the different agencies work together to provide care for people in care homes across health and social care. The programme stipulates access to training, and there has been investment in providing training opportunities for all care staff that are accessible to every care home in Sutton. In order to upskill staff, the CCG has invested in a care home support team that includes:

- link nurses to support care home staff – they provide training and updates as needed to ensure that they all have the same approach, and the capacity and capability to provide person-centred care to a high standard
- end of life care specialist nurses who provide training, liaison, support and role modelling to enhance the end of life care in care homes
- care home pharmacists who provide medication reviews for residents and advice and support to care home staff
- dementia support workers who provide advice and support to staff, family members and residents about dementia
- a care home dietitian who provides training and advice to care home staff to facilitate a ‘food first’ approach.

Additionally, a physiotherapist and occupational therapist for care homes will be piloted later this year.

There is a clear process for evaluating the progress of organisations against the criteria for the EHCH framework and monitoring change. There is a prioritisation process for working out how best to invest time in those that need support.

At the steering group and JIG meetings, the different agencies are brought together to plan and review the health and care needs of their local population, progress is discussed and support offered where needed. This support may be in the form of additional training or additional visits by the care home support team.

Care homes and partners are informed about the work that is taking place to enhance collaborative working across Sutton through updates at the meetings and the circulating of the minutes and newsletters.

Key system leaders in partner agency and providers are aware of and support the plans in place and the work of the vanguard as well as the CCGs long term plans for greater integration and working together across health and social care to improve outcomes for people in care homes.

Although there is a clear reference in the SWL STP to the need for developing enhanced primary care in line with the EHCH framework, this is viewed as a challenge and the overall approach to enhanced primary care is not fully developed or clear at present. Although there was positive feedback following a pilot that took place to support GPs being linked to care homes and carrying out ward rounds, this has not been implemented as standard practice due to limited funding. Funding for this is currently being reviewed by the SWL STP team and the CCG. The CCG is aware that there is a need to have a clear strategy for all care home residents to have access to enhanced primary care. It is in discussions with the local GP federation to find ways to achieve this.

2. Is there a clear operational planning framework that shapes the work of operational managers?

There are clear responsibilities and role definitions for leaders and operational staff in the EHCH framework. Care home managers' forum meetings are used to discuss concerns and gain support and this is viewed very positively by those that attend. Although some of the care home managers are unable to regularly attend meetings, all of the care homes in Sutton receive a regular newsletter following each meeting that directs them to any changes or training in place and explains how to access it. Those we spoke with said that this was helpful to them. Part of the SWL STP team strategic approach is to consider ways of sharing good practice across the whole of south west London. However, this is not limited to EHCH. Joint workshops to look at this further started in July.

Forum meetings are chaired by a senior member of the CCG at the CCG's headquarters. Some care home managers said that the venue was difficult to access by public transport and that it would be helpful to consider rotating meetings around the care homes. This would help facilitate attendance and enable managers to better understand and implement the vanguard's overarching framework as directed by the CCG working in partnership with the providers.

Since 2014, time has been spent developing strong and trusting relationships across health and social care. This, along with the commitment of individuals, and a strong desire among health and social care staff to improve the experience of people living in care homes, has supported the development of the EHCH Vanguard in Sutton.

(Sutton Homes of Care) This has then supported the delivery of the overarching framework.

Sutton's Hospital Transfer Pathway (Red Bag) has demonstrated the benefits of having relevant information about a person when they need to attend hospital or other appointments. This not only assists staff in understanding the person's needs and medical history, but also reassures people using the service that staff are aware of their needs. The Red Bag has been adopted nationally in various areas, and has been discussed and reviewed in professional journals and by the King's Fund, as well as recognised internationally. It has also been shared across the vanguard programme and with other CCGs and providers. However, in speaking with staff, it was clear that the work in Sutton is much more than the Red Bag pathway. Establishing strong relationships, and mutual trust and respect are imperative if the process of working more closely together to deliver an integrated health and social care service is to be achieved.

The hospital staff we spoke to were either aware of the system in place for people being admitted from care homes in the area or had access to the information. This was due to good representation at meetings. Representatives from the acute, mental health, community and voluntary sectors, the local hospice and the London Ambulance Service attended the steering group, as well as the representatives of people who use services and CQC. The JIG, meetings were attended by all statutory agencies across the health and social care sector, including the London Ambulance Service and safeguarding leads from all agencies. Information from these meetings was then shared with staff to ensure that everyone was aware of the way services need to respond to meet people's needs. The attendance of safeguarding leads, who share information and support the analysis of findings, helps to make sure that people are kept safe. They ensure that incidents and unnecessary admissions or conveyances are investigated and challenged with steps taken to address any issues. They do this by supporting particular staff or care homes and investing in additional training where needed.

The Sutton Homes of Care Vanguard Programme communications strategy had been implemented. As a result, health and social care staff understood how to work with other agencies. They also understood the processes in place to support them to provide person-centred care that gives people a choice of where they have their treatment. This included end of life care where a specialist nursing team supports adult social care staff and residents in care homes. This specialist team provided training to develop the confidence in staff to care for people receiving end of life care in their place of choice.

All adult care providers in Sutton had been made aware of the work involved in the EHCH Vanguard. They were encouraged to participate in meetings, discussions and forums. The ECHC work initially targeted nursing homes in Sutton and then expanded to all older people's care homes. In the second year of the programme this

extended further to all residential homes. The third year of the programme will take the learning to homes for people with a learning disability.

Some care home staff found it more difficult to fully engage with meetings but commented that having the link nurses (part of the care home support team) visiting and providing support and training had been very helpful. They also mentioned that having access to minutes of meetings and newsletters meant they were aware of what was happening in the area. Some adult social care staff raised concerns about the use of the Red Bag pathway and thought it could be viewed as labelling people who are going into hospital. They thought it could have an impact on people's dignity. However, all of the people spoken to agreed that the experience of using the Red Bag was positive for them.

Due to the success of the Red Bag pathway, the steering group is looking at widening its use to include people who are receiving care in their own home. This is currently being delivered as a pilot for people with long-term conditions who are on a tele-health pilot (using IT to support access to medical professionals without people having to attend hospital). The pilot is on the same basis as the Red Bag pathway, but with all relevant information contained and accessible in a purple bag. Once the pilot has been completed and evaluated, the Purple Bag pathway will be included in the overarching framework.

We were only able to speak with five GPs. However, due to the way the communication plan had been implemented, they all demonstrated a clear understanding of how to work with other agencies and the processes to support them to do this. Some were concerned that those involved in delivering the Sutton Homes of Care Vanguard work were spending a lot of time speaking to others about what had been achieved. Instead the focus needed to be on embedding the work and ensuring its sustainability and continuation. There remained some challenges in developing the enhanced primary care processes and ensuring that all care homes were linked to a specific GP or GP practice. This was due to the number of small practices in the area and was recognised by Sutton CCG as a challenge. Work is taking place to manage this.

Staff in all areas of health and social care said that the CCG's implementation of the strategic framework relating to improving medicine management was beneficial. A pharmacist with specific care home responsibility has been employed and widening the team in this way was seen as a positive way to help reduce risks and concerns around medicines and their use by people living in care homes or older people more generally. The pharmacist works very closely with staff to make sure that medicines are regularly and appropriately reviewed. They also liaise with hospital staff and GPs to reduce identified risks associated with this group of people.

Overall, the Sutton Homes of Care Vanguard Programme was viewed as positive by staff, stakeholders, and people using the services. The additional funding from the programme has given people the time and resources to further develop the work.

The majority of staff felt that the work had now become a part of routine daily practice and that it was sustainable. We repeatedly heard that the vanguard had enhanced what was already happening. The importance of strong relationships and working in an atmosphere of trust and mutual respect were rated as the main reasons for the success of the work.

3. Is the planning framework clearly communicated into an operational delivery framework for professionals and practitioners?

The framework is clear in relation to delivery. There is clear leadership, investment and support from the Sutton CCG around implementing change and progressing partnership working to improve care for people living in care homes. This is being widened to include people living in their own home who require medical or social support.

Meetings where staff from across the health and social care network (including the voluntary sector) could come together to openly discuss any concerns or challenges as well as ways to improve care, had been initiated before Sutton was awarded ECHC Vanguard status. These meetings included the JIG and the care home manager's forum. The staff we spoke with felt that the setting up of these meetings was the key in moving towards more integrated working. Adult social care staff said that they no longer felt as if they were viewed as less important than health care staff. Health care and ambulance staff said they had gained a better understanding of how people work in care homes. All staff felt that being able to openly discuss and challenge in a supportive atmosphere where the aim is to find solutions rather than apportion blame is to the benefit of the people in their care.

Part of the CCG's strategic approach is to involve the community in the care of people in care homes. The council had supported local young people to give their time to work in care homes and to deliver specific outcomes. These included activities such as building a fish pond or setting up a drama group and they had been welcomed by staff, people using the services and their relatives.

To help improve care for people with specific needs, there was a programme to support people with hearing or sight difficulties and care home staff were being supported to gain a better understanding of the impact of sensory loss on people's overall wellbeing. In addition, dementia support workers from Alzheimer's Society were spending time in care homes, not only to help people with dementia but to support staff to do the right things for people with dementia.

One of the priorities for delivery of the strategy is making sure that there is open and honest dialogue. All staff stated that they felt they could ask senior leaders involved in the vanguard programme anything and that the whole approach was supportive. They recognised that senior leaders would have to act if any serious concerns were

highlighted, but they felt speaking to them openly and raising any concerns early was a way of ensuring that more serious issues or incidents did not occur.

Sharing information across all sectors at an early stage and identifying changes or outliers at JIG meetings meant staff could get the relevant support and input promptly. In addition, plans could be developed to avoid future difficulties, challenges or problems. Examples included the fact that through the JIG, system leaders were made aware of an application for planning permission for a very large care home in an area where there were few GP practices. This was communicated to the CCG clinical lead and enabled the CCG and GP practices to work together to look at developing or expanding one or more of the practices to ensure that support would be available for the new home. Another example was where data metrics identified that a sudden increase in unexpected conveyances from one care home might be linked to a change in manager and staff. This was addressed by increasing link nurse attendance and training opportunities. This made sure that all new staff were aware of the processes and services in place to support the health care needs of residents and therefore reduced unnecessary admissions.

The meetings encouraged open and frank discussions and demonstrated a shared view of priorities and risks as well as ways of dealing with them. Staff, particularly care home staff, said they felt respected and supported and that the access to training increased their confidence and ability to make decisions. This was also reflected in the comments from people using the service and relatives. Overall, by sharing information and supporting each other, staff were able to be responsive to people's needs.

Support and training for staff was being further reinforced by the strong links in Sutton to Health Education England. Access to training previously viewed as aimed at healthcare workers was being made more widely accessible to all care staff. In addition, placing student nurses in nursing homes for part of their training was giving them a greater understanding of the needs of this group of people.

As part of the monitoring and review, the steering group noted that there were some care homes and staff who had not accessed the full support of the programme. The steering group is considering ways of addressing this and increasing support and engagement for those not fully involved. In addition, some people raised the issue about the need for formal, written and agreed progression planning and ongoing support for the continuation of the work once the vanguard programme finishes in 2018, and once a senior member of staff (who has been instrumental in a lot of the work and relationship building) retires.

4. Are there effective arrangements for evaluation?

At the monthly JIG meetings, a dashboard covering agreed areas of pressure or risk is presented. Any flags are discussed and solutions considered.

As part of the vanguard programme, the NHS England evaluation team supports Sutton in developing appropriate evaluation tools and ways of monitoring their progress. The support includes helping Sutton to progress local metrics for all care homes to report against. They also ensure Sutton has the right systems to collect data and looks at the right metrics to make sure they are making progress against their plan and compared with other vanguards. The process is based on self-reporting. NHS England do not check on them but support their self-assessment. NHS England helped Sutton CCG to draw up a logic model that clearly laid out their plans, what they were doing and how to assess progress against their initial value proposition.

NHS England has regular meetings with the vanguard. There are also quarterly meetings to see how Sutton is progressing and where they are in relation to their plans and progress against the agreed metrics. The metrics are a mix of information from the national dataset and local metrics that have been agreed. The meetings consider how much this accords with what NHS England think should be in place, for example the impact on non-elective admissions and delayed discharges from hospital. In addition, the quarterly meetings consider Sutton's commitment to the EHCH framework and are a two-way conversation around support needs and how NHS England can respond as part of the national programme.

As part of the vanguard programme, the CCG has employed staff to support the evaluation of their work. These staff work with NHS England as well as an external company that provides evaluation reports on the progress of the work in Sutton. The evaluation reports are discussed and challenged at the steering group meetings. The people working on the programme are held to account in relation to the performance of those involved in the work. This includes the performance of those care homes that have been a challenge to engage.

Medicine protocols have been developed by the CCG medicines team in conjunction with GPs. The medicines optimisation team reviews and monitors medicines management in care homes on a monthly basis. Training is provided if required and the medicines optimisation team's information feeds into the dashboard for review at the JIG and for overview and scrutiny at steering group meetings. Since the introduction of these reviews, there has been a reduction in issues related to polypharmacy and also to medicines management costs in the area.

London CCGs have a contract in place that spans the whole of London. The Any Qualified Provider (AQP) initiative, along with the London procurement programme, is used for continuing healthcare placements in nursing homes. There is a self-reported dashboard used by CCGs for quality monitoring. It is recognised that the

demographics in Sutton have changed over time and that this has led to a change in the number of services and the way care is delivered. The AQP allows the STP and the council to see where things are going well and less well and to put in measures to address concerns promptly. If there are any outliers then these can be explored further to see if support is required. Essentially, they look for spikes around particular issues and then discussion takes place around the cause and how this is to be addressed. They also look at the data from the JIG meetings, especially around reasons for admissions and they can then target these for increased input from the care home link nurses. The dashboard also allows commissioners to look at the whole picture, as well as staffing and any particular issues, such as an increase in falls. Data is collated from individual care homes on a monthly basis and comparisons are made across the whole of London, for example performance against urinary tract infections, falls and healthcare-associated infections and admissions.

Challenges have been identified by the steering group through the evaluation and by the ongoing operational delivery team as follows:

- Replication and spread – SWL STP and beyond.
- Adoption and adaption from other care home vanguards.
- Embedding learning from 2016/17 into business as usual, for example care home support staff and pharmacy.
- Sustainability of the programme beyond March 2018 – embedding practice into contracts.
- Meeting the EHCH framework in full. An EHCH moves away from traditional reactive models of care delivery towards proactive care that is centred on the needs of residents, their families and care home staff. Such care can only be achieved through a whole system, collaborative approach. The specific aims are to provide continuity of care for residents, timely medicines reviews, access to hydration and nutrition support, and streamlined referral to out-of-hours services and urgent care.
- The primary care element of EHCH (section 2.3 of the EHCH framework). As part of the programme, Sutton piloted a care coordinator role to strengthen nursing leadership in some of the care homes and to maximise the input they have into the way GPs review the care the residents receive. At the time of the review, this was only in place in some of the care homes and needed to be spread across all of the homes. In addition, not all of the people in the care homes had access to a consistent named GP who provided regular ward rounds.

These challenges are similar to those identified by this review with the addition of the need for formal progression planning and future ownership due to senior staff retirement.

5. What is working well to ensure people can move between services through improved inter-agency working?

Attendance at steering group meetings by representatives from Healthwatch, Alzheimer's Society, Age UK, the Sutton Volunteers Association and service user representatives, ensures that the views of people using the services and their families are considered. In addition a number of discussions take place with residents and their families during any quality monitoring review and as part of evaluation.

There is good attendance from all relevant stakeholders and providers at the steering group meetings where issues around improving integration and joint working take place.

All the meetings around the work in Sutton, which include the vanguard, have consistently been described as being honest and where open challenge and conversation can take place. These meetings include the JIG, the care home manager's forum and the Sutton Homes of Care Vanguard Steering Group. All stakeholders, staff and people using services we spoke with said that they felt included, valued and listened to.

Staff from a number of organisations in Sutton, as well as people using services have been involved in creating videos to explain the how the work in Sutton has supported integration and coordinated care. These are available on the Sutton Homes of Care Vanguard website.

A number of care homes and staff involved in the changes and development of greater integration have discussed their work at national events and hosted visitors from other areas and countries to view the work.

6. What is working well and what is planned that will ensure people can move between services and providers through improved inter-agency working?

The vision of Sutton Homes of Care, through their three pillars of integration, education and quality, has been demonstrated in a number of ways. There is a strong commitment to partnership working across the majority of organisations and stakeholders in Sutton. The time taken to build trust and strong relationships across the sectors meant that people could work together in a way they had not done before. This meant that a strong submission, based on the work in place as well as future plans, enabled Sutton CCG to engage with NHS England and become one of the vanguards.

The care homes manager's forum was given as an example of people working better together across care homes. The forum has meant that managers understand better how people and organisations work. They can now ask for help from each other in a

way they never felt they could before as previously they felt they needed to compete for people, services and staff.

Staff in hospitals and those working in the care sector felt a strong partnership and commitment to working together to provide the best care they can for people. Access to training and support has increased the confidence of many care workers to provide the care that people want. Open discussion and good partnership working has increased people's understanding of the way different sectors work and encouraged discussion around how to overcome challenges together. For example, reducing non-elective admissions and reducing the length of stay have both been influenced positively by the work in Sutton.

Sutton's performance is measured on clear metrics. These are coordinated by the vanguard evaluation lead, SQW (an external evaluation company) and the NHS England vanguard evaluation team. The reports show that there have been a number of achievements in the way care is supported and delivered by staff in Sutton. The achievements demonstrate a desire to work together, integrate care and make sure people living in care homes have a seamless journey when care is provided from more than one sector. These achievements include:

- On the second release of NHS England's national dashboard, Sutton's impact was significantly better than other vanguards, although there was recognition that there remain some data issues.
- The local dashboard for the Sutton Homes of Care vanguard has shown a £138,000 reduction in medicine costs since September 2015 when medicine reviews were started by the medicines optimisation team.
- Since the start of the programme there has been a reduction in ambulance call outs and conveyances per care home bed, particularly for nursing and residential care homes.
- 2013/14 to 2016/17 shows an 11% reduction in average A&E attendances per bed and a 2% reduction in average non-elective admissions per bed. For care homes specifically supported by GPs in Sutton CCG the impact is greater: a 17% reduction in average A&E attendances per bed and an 11% reduction in average non-elective admissions per bed.
- In nursing homes, many of the residents have been offered and taken up the opportunity to have a 'Coordinate my Care Record'. This, in combination with training and resource packs, has led to an increase in people being able to stay in the place of their choice when receiving end of life care.
- There is good liaison with communities, patient groups and the public. One impact is that young people have participated in a volunteer training programme in care homes to increase their knowledge and understanding of the needs of people in this group in their society.

- The initial results from the evaluation of the Hospital Transfer Pathway demonstrate a four-day reduction in length of stay in hospital.
- The resource packs used by care staff to assess people have led to overall reductions in urinary tract infections, pressure ulcers and falls.
- All staff we spoke to said that there is good joined up working and information sharing. This was supported by people using the services and their relatives.[2]

Future plans

Plans going forward include:

- The active involvement and participation in the programme of all care homes, homes for people with a learning disability and homes for people with a mental health condition.
- Replication and spread of the learning across the SWL STP.
- Further work on the primary care element of the EHCH, linking all care homes to one GP practice where possible.
- Further development of training and resource packs for care staff as required.
- Ongoing work with Health Education England to enhance the training for nurses working in care homes and other care staff.

Key system leaders in London are keen to use this work to help inform the work of the SWL STP team as they continue to develop plans for improvement. More information is available in the *South West London Five-Year Forward Plan* (pages 15, 16 and 24)

CQC will continue to work with national and local partners to support improvement by sharing information and working together to agree a shared view of quality.

Areas for improvement

Continue to develop and share the information around the Hospital Transfer Pathway (Red Bag)

There is recognition both nationally and internationally that the use of the Red Bag pathway has positively impacted on the care of care home residents, their families and their carers in the London Borough of Sutton. It is important that information shared emphasises that for the pathway to work, there is a need for underpinning documentation, as well as collaborative working and open and honest relationships across health and social care.

[2] All information in bullet points is based on the Sutton CCG Metrics Dashboard (Measuring the Impact of Our Interventions: tracking outcomes and activity through metrics, updated 23 May 2017).

Progression planning

There is a need for:

- Clarity of roles and ownership going forward in the light of individual retirements.
- Clear guidance and plans to ensure the buy-in of all care homes in the area.
- Ways to support attendance and representation of all care homes at meetings.

Clear support and planning around enhanced primary care

It is important to make sure that there is a clearly documented plan and way of monitoring and evaluating progress around enhanced primary care in the Sutton CCG, as well as across the whole area covered by SWL STP.

Spread of the work and learning across the SWL STP area

- There is a need to identify and document the plan for the Sutton scheme to continue beyond 2018.
- There is a need to document and put a clear plan in place to ensure the spread of the vanguard work across the STP area, supported by a process of evaluation and monitoring.

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