

# Local system reviews

## Interim report

December 2017

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high quality care and we encourage care services to improve.

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## Message from the chief inspectors

The NHS and social care often work separately, but for people who use services, their families and carers, they need to work together. Older people tell us that they are concerned about the quality of the service, not its name or its brand, or who is providing the care.

When older people need these services, they want services to work seamlessly. People want to be treated as individuals, not as a 'package of care' or a collection of symptoms or problems, or a number on a delayed transfers of care (DTOC) list.

For some older people, they will not be able to tell the difference between whether the care they are receiving is from health or social care. This will be where health and social care services work together to provide a unified and joined up service where the person is always at the centre of their care.

For too many people, the experience of moving between health and social care services can be confusing. Care is too often fragmented and people are often uncertain about who is coordinating their care. Many people are worrying about what support will be in place when they return home from hospital, or who will be there to give their carer a break from looking after them full-time.

The local system reviews are designed to consider what it is like for older people in the system. In a fragmented system, circumstances can be created (unintentionally) that provide an experience that none of us would want our friends or family to endure. This is despite good intentions.

We have found examples of avoidable and unintentional harm.

We were told about Mrs Jones (not real name) who lived at home independently with the support of her son and services from a domiciliary care agency. Mrs Jones had dementia but was happy and safe. One Friday evening she fell over and bumped her head and was taken to hospital by her son. After a night in hospital she was ready to go home. But because the right staff were unavailable over the weekend she could not be discharged. As a result her home care was stopped. On the Monday morning she was ready to go home, but because her care was no longer available she couldn't go home. Mrs Jones stayed in hospital for over a month, her condition deteriorated and eventually she moved into a residential care home. She never saw her home again.

Although our work is not yet complete, we can already see some clear messages emerging:

- Without good relationships and a shared, agreed vision between system partners, achieving positive outcomes for people who use services, their families and carers is significantly compromised. Relationships between system partners play

a major role in the coordination and delivery of joined up health and social care services that meet the needs of the local population.

- More focused action is needed on keeping people well, with joined up processes to identify and support people to stay safe and well in their usual place of residence through effective prevention approaches, and to avoid secondary care admissions. This requires a continued drive towards integrated commissioning and changes in funding flows. The longer people are away from their homes the worse the outcomes tend to be especially for chronic rather than acute problems. The beds that people really want to be in are their own.
- The focus on individual organisational outcomes is distracting from the needs of the wider system to work effectively for the people it serves. Focusing on DToC in isolation will not resolve the problems that local systems are facing.

Tackling these issues will take strategic vision, good relationships and practical, deliverable solutions, especially in pressured times such as winter. A system's resilience during surges in demand is dependent on the organisations within it, working together to plan and deliver effectively, as a system.

We would urge everyone involved in health and social care to read this report, and the published reports of the individual reviews, and to think about what they can do differently so that a lady who bumps her head on a Friday night doesn't end up never seeing her home again.

We encourage all system partners to work together to:

- Create and clearly communicate a collective health and social care offer for people who live in their area, responsive to their local needs.
- Provide a stronger focus on maintaining health and wellbeing through preventative approaches to ensure support is available to enable people to be as independent as possible and maintain their own health and wellbeing at home.
- Address variation within systems so that everyone has equal access to high quality service provision when they need it.

We have more work to do to complete our remaining programme of reviews and look forward to continuing to meet leaders, staff and communities in local systems to learn more and to share our wider findings in the final report in the summer 2018.

**Steve Field**, Chief Inspector for Primary Medical Services and Integrated Care

**Andrea Sutcliffe**, Chief Inspector of Adult Social Care

**Ted Baker**, Chief Inspector of Hospitals

## Background to the review

Following the government's 2017 Spring Budget announcement of additional funding for adult social care, the Secretaries of State for Health and for Communities and Local Government asked CQC to carry out a programme of targeted 'system' reviews in local authority areas.

We are reviewing health and social care systems in 20 local authority areas to find out how services are working together to support and care for people aged 65 and older. This interim report summarises our findings so far.

The 20 areas we are reviewing have been identified by the Department of Health (DH) and Department for Communities and Local Government (DCLG) based on a [dashboard of metrics](#). These metrics, which were developed and agreed by the Secretaries of State, may indicate challenges with access and how people move between health and social care services (including delayed transfers of care).

As the independent regulator of health and social care services across England, CQC is in a unique position to provide an overview across the entire health and adult social care system and use our independence to provide an objective, trusted assessment of local situations and what improvements are needed.

### Reporting our findings from each system review

Each local system review addresses this question:

“How well do people move through the health and social care system, with a particular focus on the interface, and what improvements could be made?”

Following each review, a local system report is produced. This details our findings, and, highlights what is working well and where there are opportunities for improving how the system works for people using services, their families and carers. This includes an assessment of joined up working, the integration of systems, and how these are working for people in local authority areas.

In each local system report we make comment on the maturity, capacity and capability of the local system moving forward, and we share the data profile that we use to inform each review. A review is followed by a local summit, facilitated by the Social Care Institute for Excellence. This brings together system leaders from the local areas and representatives from national bodies, including the Local Government Association, NHS England and local Healthwatch.

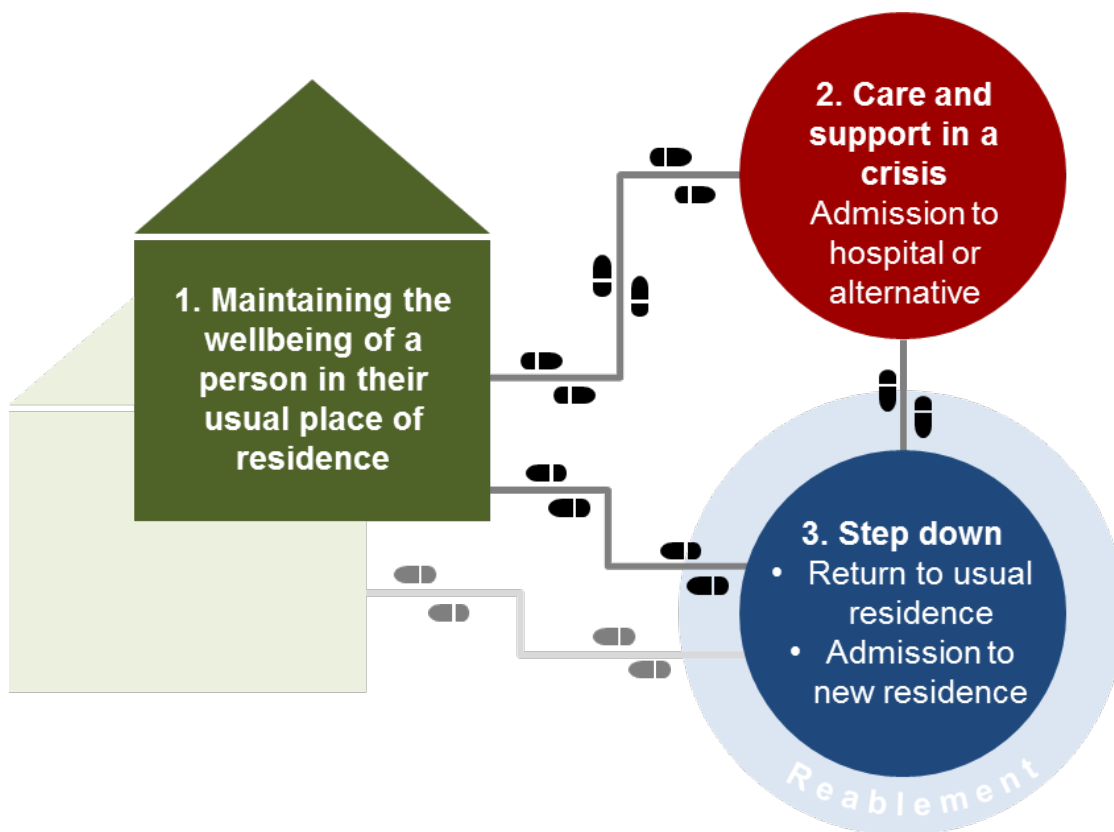
The summit is a forum to discuss the findings from the review and for system leaders to develop an action plan – and if appropriate, to work with national bodies to secure an improvement offer of support to enable leaders to implement changes at a system level in the local area.

## How are we carrying out these reviews?

We developed our approach to the local system reviews in co-production with a range of stakeholders including national bodies, health and social care commissioners and providers, voluntary and community sector organisations and people who use services, their families and carers.

The system reviews focus on the interface between health and social care, looking at the planning, commissioning and delivery of health and social care services. We are reviewing how each local area works within and across three key areas:

1. **Maintaining the wellbeing of a person in their usual place of residence**
2. **Care and support when people experience a crisis**
3. **Step down, return to usual place of residence and/or admission to new place of residence**



### Pressure points

Across these three areas we are looking at where there are pressure points that impact on the journey that people take across the interface of health and social care.

1. Maintenance of people's health and wellbeing in their usual place of residence

2. Multiple confusing points to navigate in the system
3. Varied access to GP / urgent care centres / community care / social care
4. Varied access to alternatives to hospital admission
5. Ambulance interface
6. Discharge planning delays and varied access to ongoing health and social care
7. Varied access to reablement
8. Transfer from reablement

## Key lines of enquiry

Within the three areas in the model above we are using our key lines of enquiry (KLOEs) to understand how **safe, effective, caring** and **responsive to people's needs** services are.

At a system level we are using specially developed KLOEs to understand how **well led** the system is to establish:

- If there is a **shared clear vision and credible strategy**
- The impact of **governance** on the health and social care interface
- The system approach to **workforce**
- The approach to **commissioning** within a local area
- **Resource governance** assurance

These key lines of enquiry bring to life the real experiences of people who use services, their families and carers, ensuring that they are the central focus.



## Key findings so far

We have now completed reviews of six health and social care systems. The reports from the following local system reviews are [published on our website](#).

- Halton
- Bracknell Forest
- Stoke-on-Trent
- Hartlepool
- Manchester
- Trafford

This interim report shares findings from the first six reviews, highlighting key findings and areas for focus from those areas only. The full programme of 20 local system reviews is due for completion this summer followed by a report which shares our findings from all of the reviews. In this report, we share some reflections on what we have found so far, and outline the next steps in the local service review programme.

Based on the first six reviews our key findings are:

### How systems work together

- We saw strong commitment and enthusiasm from organisations and staff working across health and social care services, but there are too many examples of people not being treated in the right place, by the right person at the right time. Unnecessary pressure is placed on services that are not designed to meet the needs of people who use them.
- While in most systems, we saw leaders working well together with a commitment to plans and achieving targets, the focus on individual organisational drivers is distracting from the ability of the wider system to work effectively for the people it serves.
- System-level leadership accountability is difficult to identify. Without a common understanding of where system leadership sits it is difficult for a system to achieve joint working and integration. The extent to which leaders are working effectively together across agencies is a key factor in the outcomes for people.
- Although all areas have health and wellbeing boards – the central forums for planning and coordination – their effectiveness as drivers of transformational change, or forums to hold wider system oversight is variable.
- Relationships between system partners play a major role in the coordination and delivery of joined up health and social care services that meet the needs of the local population. Without good relationships between system partners that work together to achieve positive outcomes for people who use services, outcomes for individuals, families and carers are significantly compromised.

- Coordinating and aligning strategies at local, regional and national levels is required. Alignment was at different levels of maturity in the systems we have reviewed. Instead of driving improvement, multiple and sometimes uncoordinated strategies can lead to fragmentation and confrontation between organisations across a system.
- Planning for surges in demand which occur throughout the year, including winter must involve all partners within a system including social care, primary care, voluntary, community and social enterprise (VCSE) providers. Winter planning was happening across all of the systems we visited (at A&E / urgent care delivery boards), but progress was at different stages and did not always involve wider system partners.

## Managing capacity, market supply and workforce

- People’s choice about their health and social care is limited in many of the systems we reviewed due to a shortage of capacity and range of options. Choice can only exist in a system where there is capacity and availability of high quality, safe, responsive, effective, caring and well-led care.
- The availability of social care was a challenge in the areas we have visited, especially in nursing homes, specialist care homes (for example, care homes specialising in dementia care), and in domiciliary care. Establishing the right amount and balance of social care provision for the needs of the local population was one of the most significant challenges in all of the systems we have visited. There is insufficient investment in the care home and home care workforce. There is also underutilisation of the voluntary, community, and social enterprise sector workforce.
- Health and social care commissioners do not consistently have robust systems in place to be able to predict demand and proactively shape the structure of the market supply (planning for capacity, workforce and skill mix, quality, and innovation).

“The council's approach to paying [domiciliary care] contractors a low price means that less contractors want to do the work. In an affluent area they cannot find enough carers. Due to the low rate they only offer the minimum wage and poor conditions, therefore retention of carers is poor. There are many other private care providers that will not contract with the council due to the poor rate.”

### Information flow tool response

Staff retention was an issue in each of the six areas we visited. Although workforce estimates from Skills for Care from 2013/14 to 2015/16 suggest that adult social care staff turnover and vacancy levels were below national levels across most of the areas reviewed to date, in all but one area staff turnover had increased.

- Workforce capacity has been a major issue in every system we have visited - we have not been assured of effective joint workforce strategies across systems in any of the areas to address this. While some local systems are working proactively to develop career pathways within the care sector, the competition from other sectors is making recruitment and retention of staff a significant challenge in a climate of austerity where it is difficult to attract and reward staff under current remuneration.

## **Moving beyond delayed transfers of care**

- There must be a whole system approach to tackling issues of flow at a local level. Focusing on DToC in isolation will not resolve the problems that local systems are facing. We have seen examples of where a focus on DToC has improved the speed at which people are moving between services, but this can also divert attention from important issues, such as initiatives to prevent people reaching crisis point, and addressing capacity issues across primary and social care which are impacting on the experiences of people who use services, their families and carers.
- A system that has established joined up processes to identify and support people to stay safe and well in their usual place of residence through an effective prevention approach, and implementation of initiatives to avoid unnecessary secondary care admissions, appears more likely to manage pressures well. Strong integration of primary and community care services in systems is essential for people to remain safe and well in their usual place of residence.

## Areas for priority action

From our early findings we have concluded that without a system wide focus that brings together partners from across health, social care, VCSE and independent sectors it is challenging to provide people with safe, effective, compassionate, high-quality care across the health and social care system. The whole person approach to flow of people through the system is being overshadowed by the drive to meet individual organisational targets. With a narrow focus on achieving their individual metrics and targets the ability for organisations and staff to collaborate and provide joined up care and support for people is hindered. Where we saw systems working well together we found that people had a safer and more caring journey.

We have identified initial suggestions that all local systems can take on board now. We encourage local system leaders to:

### How systems work together

- Agree and define cross-system leadership accountability (that can be articulated by all system leaders), agreed by all system partners, with planning and delivery monitored by health and wellbeing boards and associated governance mechanisms.
- Ensure there is a shared vision and system wide strategy developed and agreed by system leaders, understood by the workforce and co-produced with people who use services, their families and carers. Individual organisational strategies should be aligned and underpinned by a shared system wide vision.
- Ensure that time is invested in positive and productive system relationships, which deliver interagency and multi-disciplinary working.

### Managing capacity, market supply and workforce

- Establish risk sharing agreements so that there is a clear understanding of capacity and availability of services. Decisions that affect the provider market need to be communicated across all partners so there is an understanding of the impact this has on the system as a whole, and to enable effective risk mitigation, especially during surges in demand such as the wintertime.
- Develop clear and longer term arrangements with VCSE sector providers to ensure that the sector is utilised to establish capacity and availability of services, including in the management of surges, including winter pressures.

- Ensure ‘choice’ criteria for people moving between health and social care services is understood, agreed and implemented by all system partners so that there is a shared understanding of service provision and availability.
- Ensure that sufficient primary care capacity is commissioned by measuring available appointments, and ensuring commissioning response where there are gaps.
- Agree the [high impact changes](#) that will have the greatest impact on their system and prioritise implementation in accordance to the level of need.

## **Moving beyond delayed transfers of care**

- Ensure timely access to data to understand the needs of the population, understanding the interface between health and social care, informing joint strategic needs assessments (or equivalent) and to risk assess the needs of the population and to develop initiatives to support people during the winter months.
- Systems should access and apply [national guidance and support available](#) to address DToC.

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Although we are reporting at an early stage of the review programme and have only published reviews of systems in six local authority areas, common themes are emerging that we believe should be addressed at a national level. We will continue to keep these under review throughout the remainder of the review programme and make comment in our final report in summer 2018.

## **We encourage national leaders to:**

### **How systems work together**

- Enable and incentivise health and social care partners to establish aligned objectives, processes and accountabilities. The extent to which local leaders are working effectively together across agencies is a key factor in the outcomes for people. The metrics by which we measure system performance, and the funding flows, must incentivise this behaviour.
- Assess the impact of short-term funding initiatives. Currently the willingness of system leaders to collaborate is impacted by requirements attached to funding grants such as the Improved Better Care Fund.

- Establish IT systems that can connect across health and social care boundaries, and address continued local perceptions of information governance barriers. Effective use of technology plays a significant role in enabling services to share information in a timely way.

### **Managing capacity, market supply and workforce**

- Enable longer term contracts, as part of large scale transformation approaches.
- Ensure that there is a national focus on joint health and social care workforce strategies across systems that are flexible and what can predict future demand of services and collectively address challenges.
- Address the risks in the social care market as a matter of priority. The structure of supply in social care needs to be proactively shaped and supported.

### **Moving beyond delayed transfers of care**

- Create conditions that enable local systems to invest in out of hospital services to keep populations well through a wide range of preventative approaches and effective primary care supporting chronic and long term conditions, social isolation and wellness.
- Continue to follow the principles and commitments in '**Quality Matters**'<sup>1</sup> and the National Quality Board's, '**Shared Commitment to Quality**'<sup>2</sup> to ensure system delivery is person focussed.

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<sup>1</sup>[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/643716/Adult\\_Social\\_Care\\_-\\_Quality\\_Matters.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/643716/Adult_Social_Care_-_Quality_Matters.pdf)

<sup>2</sup><https://www.england.nhs.uk/wp-content/uploads/2016/12/nqb-shared-commitment-frmrwk.pdf>

## FINDINGS IN KEY THEMES

1. **System leadership**
2. **Maintaining people's wellbeing in their usual place of residence**
3. **Care and support when people experience a crisis**
4. **Step down, return to usual residence and/or admission to a new place of residence**

### 1. System leadership

- The maturity of relationships between organisations is different in different areas. Relationships between system partners play a major role in the coordination and delivery of joined up health and social care services that meet the needs of a local population. There are significant challenges where relationships are poor. Many strategies, plans and initiatives we reviewed were new and not yet embedded. Success will rely on a joint approach to reviewing their impact and making changes where needed. We could see that where there was a good level of trust and understanding of each other's roles and duties, system leaders tended to work more effectively and have common purpose.
- “There is a lack of understanding of what it takes to admit an individual to a care home and I believe all discharge co-ordinators should spend time in care homes seeing just what is involved in admitting an individual and how not having what we need impacts on both the individual and the care home”.

**Information flow response**
- So far we have found a lack of whole system-strategic planning and commissioning. To provide person centred health and care, leaders must work across systems in addition to focusing on organisational objectives. This should be locally and regionally determined. Where we found coordinated local, regional and national strategies there was a positive impact on promoting a culture of joint working across health and social care boundaries. The impact of sustainability and transformation partnerships on local strategies is variable across systems and they are at different stages of delivery.
  - In some places, the views of people who use services, their families and carers are informing local system strategies. However, there is little evidence of these strategies being co-produced with people who use services.
  - Systems for sharing information, and the information that is shared, varies significantly, between and even within organisations. Because of this, we found

that health and social care services can struggle to share information in a timely way.

- The [high impact change model](#) which aims to improve people's journey between health and social care services has not yet been fully embedded in any system we have visited. However there is awareness of the high impact changes – these have started in all of the areas we have visited and are being prioritised for implementation. For example, discharge to assess pathways and trusted assessor models have been developed in all areas but are in early stages of implementation. Enhanced primary care provision for care homes was also not evident in all areas.
- Governance arrangements are in place for the coordinated use of resources across local systems. However, it was not always clear if systems were in place to gain assurance on the impact of resources that are allocated to provide support at the interface of health and social care. Funding initiatives such as the Improved Better Care Fund are enabling investment in services but it is difficult for systems to plan long-term sustainable services because future funding arrangements are uncertain.
- High levels of demand for continuing health care (CHC) is having an impact on resource and capacity in the areas we visited. A lack of integrated CHC commissioning is also affected the timeliness of the decision-making and funding process for people who use services.
- Using different approaches, some areas are tackling reduced capacity and availability of nursing and residential home places and domiciliary care placements. These include supporting people outside of traditional health and social care provision, some authorities having to develop new in-house services alongside encouraging new providers into the market.

### **What does this mean for people?**

Mr H is from a Black and minority ethnic (BME) background and has recently been diagnosed with dementia. He is the main carer for his son who has a disability.

His condition had led to him lose some of his knowledge of English which was his second language and so he was referred to a BME advocacy service. He was supported by the local authority who carried out an assessment, taking into account his mental capacity and his ethnicity. As a result he received services to ensure support for both him and his son. He had been at risk of self-neglect, but the support he received helped him to maintain his role at home.

**VCSE submission, 2017**



## 2. Maintaining people's wellbeing in their usual place of residence

- When residential and nursing homes have strong integration with primary care and community care, it is less likely that people will need to access emergency services. We found a good example of enhanced primary care to care homes (particularly the multi-disciplinary team approach including dedicated GPs) in an area with fewer A&E attendances. We also saw effective nurse-led models of support to residential and nursing homes.
- Variable access to health and social care services in the community affects people's ability to stay safe and well at home. A lack of timely access to support services, social workers, therapists, community nursing and out-of-hours care seven-days-a-week means that people become reliant on emergency services.
- In all localities enhanced skills are needed among nursing and residential care home staff so that they are able to care for people's more acute needs in their usual place of residence, now and in the future.
- People who use services, their families and carers told us that good care means knowing that their support is coordinated and they know who to contact to get things changed. In one area, via the Sustainability Transformation Partnership, integrated decision hubs were being developed to support frail people who had complex conditions, using advance care planning and social prescribing to promote independence. Integrated decision hubs can support frontline staff to make informed decisions about people's care – they can be a single point of contact for care coordination across health and social care. New roles in care coordination and navigator roles were under development in some areas.
- Complex and fragmented referral processes are preventing people from accessing services quickly enough. In one area, ambulance services were unable to make direct referrals to intermediate care or falls services because these had to be made through a GP.

There is wide variation across systems in the rates of A&E and emergency admissions from older people living in care homes. Dedicated care home support teams can improve the rates and prevent admission of older people living in care homes.

Our analysis of data showed that one of the review areas had significantly lower rates of A&E attendance and emergency admission for older people living in care homes. This area also had lower than average rates of admission from care homes for a range of avoidable conditions including urinary tract infections and pneumonia.

- People who use services, their families and carers told us that good care means having access to a range of support to help them live the life they want and to remain

Feedback from CQC's relational audit indicated that in some areas, VCSE sector organisations felt that they were not used to maximum effect and that the health/care sector lacked awareness of their services.

a contributing member of the community. There are active voluntary, community and social enterprise sector providers in each of the areas we visited providing a wide range of support services to help people to stay well, independent and socially connected, however these are underutilised.

### **What does this mean for people?**

Mrs N is 92 and has multiple conditions which affect her mobility and mental health. She has a son who does not live locally so it can be difficult for him to keep an eye on her care.

After a recent visit to hospital, Mrs N's son got in touch with the hospital who told him that they were putting together a package of care for his mother at home so she could be discharged. However this was not done immediately after discharge, leaving Mrs N at risk without support she needed. This was not communicated to her son effectively leaving him feeling disappointed and let down, as he took their word that an appropriate package would be in place on discharge. After a welfare check was carried out by a voluntary sector organisation, they confirmed that Mrs N was discharged without a suitable care package in place.

Two weeks later, Mrs N was admitted back into hospital.

**VCSE submission, 2017**

### 3. Care and support when people experience a crisis

- People generally receive a good service at a point of crisis but too many people are admitted to secondary care when it is unnecessary. A lack of specialist out-of-hours support services for urgent care mean that people often have to use emergency services for their immediate needs.
- There is effective streaming in some urgent and emergency care services – this improves the pathway for frail older people, reducing the likelihood of people being admitted. By using skilled and trained staff, people aged 65 and over were more likely to be signposted to appropriate support than admitted to secondary care as a precaution.
- People who use services, their families and carers told us that good care means they tell their story only once. The ‘trusted assessor’ role aims to reduce the number of assessments and waiting times for people accessing services. It is at different stages of implementation across the six areas we have reviewed. Where this role is established, it is reducing the number of assessments, and subsequently reducing delays to accessing and being discharged from services.
- Information is not easily shared across organisations with the speed required – different IT systems cause delays to process, duplication of effort and have an impact on effective decision making. This is our view despite information in 2016/17 Better Care Fund returns, where health and wellbeing boards in all six systems said they met the national condition around better data sharing.
- Information sharing with social care and voluntary, community and social enterprise services at a point of crisis is generally poor. These services are sometimes excluded from information flow and communication. This is especially problematic when the service is the single point of contact for a person and they are unable to establish when a person may be discharged from hospital and if there is any change in their needs. People who use services, their families and carers told us that good care means having access to a care record that moves with them throughout the health and care system – a care record that everyone involved in a person’s care can access.
- At an operational level we have found that there are forums to share information and risks about people’s care and treatment. However risk strategies and protocols are not always aligned at a system level.
- People who use services, their families and carers told us that good care means their families and carers also having access to a good range of support. There is limited support for carers at a point of crisis. Many carers are worried about what would happen to the person they care for if they themselves became ill.

### **What does this mean for people?**

Mrs B is an 89 year old woman who lives alone at home after the recent loss of her husband.

Prior to Mrs B going into hospital for planned surgery, her GP liaised with her consultant to arrange reablement services. This triggered contact from the rapid access and reablement team who began formulating a plan for when Mrs B could be discharged from hospital. Putting a clear plan in place at this stage meant that equipment could be sourced and adaptations to Mrs B's home could be made while she was in hospital.

Following her surgery she was admitted to an intermediate care facility, preventing her from going home and needing to access emergency services if she became immediately unwell following discharge from hospital. At the intermediate care facility she received an assessment from the allied health professionals team and was discharge home after nine days with a package of care provided by the rapid access and reablement team for a further three weeks. The multidisciplinary approach taken to planning Mrs B's care enabled her to return home and regain her independence.

**Pathway review, 2017**

## 4. Step down, return to usual residence and/or admission to new place of residence

- In all areas we visited we saw dedicated, passionate staff, committed to supporting people to be discharged in a timely way so that they could return home and maximise their independence.

- There is limited availability of nursing and residential care home placements for people living with dementia across all areas and capacity in hospice care was also an issue in one area. We visited some people with dementia who were

There were fewer residential and nursing home beds per population compared to the England average in three of the systems we visited, and in four of the six systems the number of care home beds had decreased between April 2015 and April 2017 although there was evidence that capacity is now being addressed.

spending too long on medical wards that were not suitable for their needs.

- There is often a fragmented approach to medicines management. Community Pharmacists are not consistently involved in discharge planning. In all areas we were told that they, and local GPs, are not always provided with correct discharge information, which limits how they can support people following discharge. This also increases the likelihood of readmission.

- People who use services, their families and carers told us that they want clarity about next steps in their care – good care means they know in advance where they are

Although response rates have generally been low, responses to our discharge information flow tool in two areas indicated that ASC providers rarely received discharge summaries when a person was discharged into their care.

going, what they will be provided with, and who will be their main point of contact. The comprehensiveness, accuracy and timeliness of clinical information provided to nursing and residential care homes and domiciliary care providers at discharge is variable within the systems we visited. This can lead to inappropriate placements and delays to packages of care for people. It can also compromise the safety of the discharge. When hospital and adult social care staff work together it supports a smoother and more person centred discharge.

- People who use services, their families and carers told us that good care means that if they go to hospital, health and social care professionals work together to make sure they do not stay longer than

“We have to wait for the nursing home service to give us the account of the hospital stay information as they have access via the EMIS system. Depending on which day the resident comes back to us, we may have to wait three to four days for any relevant information. If we contact the ward they will never give information over the phone.”

they need to be. Social workers embedded in hospitals can improve the communication between health and social care. However, this role was underutilised in some of the areas that we visited. This could be strengthened so that hospitals work more collaboratively with social care providers to understand capacity and availability, and facilitate more timely and appropriate discharge.

- People who use services, their families and carers told us that good care means they can plan their care with people who work together to understand them, allow them control, and bring together services to achieve the outcomes that are important to them. Pressure to discharge people from hospital care is sometimes leading to inappropriate placements. In contrast, due to capacity and capability there is not always compliance with patient choice policies to avoid long hospital stays. This leads to delayed transfers. Patient choice policies need clarity and agreement across all organisations in a system in order to be embedded successfully.
- Availability of transport from hospital is an issue in some places. In the areas we visited, we saw examples of older people who were medically fit to be discharged, but they were waiting too long in hospital discharge lounges because of a lack of coordination.

DToC rates were higher than the national average between February and April 2017 in the six areas we reviewed in the first phase. By July, five of the six areas had managed to reduce their DToC rates and a reduction was also seen nationally over this period. However, in one area, rates of DToC rates continued to increase. "Awaiting care package in home" was a common reason for delay across four of the six areas. This includes, 'continuing healthcare' as well as social care packages.

## Next steps

We will publish our review of York in December 2017 followed by Oxfordshire, East Sussex and Plymouth in early 2018. In 2018 we will also complete the final 10 reviews and publish reports on the following local systems:

- Birmingham
- Coventry
- Bradford
- Cumbria
- Liverpool
- Sheffield
- Wiltshire
- Hampshire
- Northamptonshire
- Stockport

In summer 2018 we will publish a national report which will draw on the findings of all 20 reviews, once these have been completed.

# Appendix

## Review tools

We have developed a range of activities and tools for evidence gathering to supplement interviews and focus groups with system leaders, frontline staff and people who use services, their families and carers.

### **Data profile**

For each review we compile profiles with metrics covering a range of topics including demography, quality of service (CQC ratings), flow of service users into and out of acute hospitals (including from care homes), service user experience, system provision/ capacity, staffing and funding. The profiles use CQC's own data, data from national data collections as well as the Department of Health's "NHS social care interface dashboard" metrics that were used to select areas for this review. Analysis is being refreshed as we move through the review, so the profiles for areas reviewed later include more up to date figures. Please note that some of the analysis featured within the profile is developmental.

### **System Overview Information Request (SOIR)**

The SOIR is sent prior to on site fieldwork and provides and enables system leaders to give their own perspective on the challenges faced in their local area, as well as an opportunity to share what is working well.

### **Relational audit**

The relational audit comprises of a set of questions to gain an understanding of how relationships are functioning within and between health and social care systems. This audit is cascaded through local services in each area.<sup>3</sup>

### **Pathway tracking**

For each system, we review care records of people who have used primary and secondary care services to understand their experience and how well the system works together to provide joined up health and social care services.

### **Information flow**

This is a tool that helps us to understand what information is shared with social care providers following a person's discharge from secondary care services.

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<sup>3</sup> developed with the Relationships Foundation and Whole Systems Partnership



## **I Statements**

An “I” statement is a style of communication that focuses on the feelings or beliefs of people who use services, expressing what good care and support means to them. A list of 37 I statements were developed with the group, Think Local, Act Personal and are used within interviews and focus groups with system leaders as well as with people who use services, their families and carers.

## **Glossary of terms**

**For the purpose of these reviews we use the following terms. What we mean by:**

### **A system**

For the purpose of these local system reviews, a system is a group of organisations in a local authority area that collectively buy and provide health and social care services for people living in that area. (It is acknowledged that health and social care services and wellbeing of any population are affected by inter connected systems within and beyond local authority boundaries.)

### **Home**

‘Home’ means the place where a person normally lives, whether this is their own home – which might be supported accommodation or extra care housing, or a care home.

### **Step down services**

Step down services are the provision of health and social care outside the acute (hospital) care setting for people who need an intensive period of care or further support to make them well enough to return home.

### **A delayed transfer of care**

A delayed transfer of care is when a person moving through health and social care services is delayed even though they may be ready to move from one setting (for example, a hospital) to another (for example, a care home).

### **The high impact change model**

The high impact change model offers support to organisations that buy and provide services on how to better manage the way people move through the health and social care systems. This is so that people’s care and movement between services is not delayed. There are eight ‘high impacts’ which organisations can consider using.

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social care systems so that people's care and movement between services is not delayed. There are eight 'high impacts' which organisations can consider using.

### **Winter planning**

Winter planning is a process that people who buy or provide health or social care services should carry out every year to ensure that they are prepared for winter when there may be surges in demand for services.

### **Commissioning**

Commissioning is the process for buying health and social care services to meet the needs of a local population.

### **Governance**

Governance is how organisations and systems ensure that they are doing what is expected of them and achieving their intended outcomes. Resource governance is how organisations ensure that the money they have is used in the most appropriate way.

### **Health and wellbeing board (HWB)**

A HWB is a formal committee of the local authority charged with promoting greater integration and partnership between bodies from the NHS, public health and local government.

### **Joint Strategic Needs Assessment (JSNA)**

Each local authority area has a JSNA which identifies current and future health and care needs of the local population.

### **The Better Care Fund (BCF) and Improved Better Care Fund (iBCF)**

The BCF encourages integration by requiring CCGs and local authorities to enter into pooled budgets arrangements and agree an integrated spending plan. A BCF agreement is worked out each year. The iBCF was first announced in the 2015 Spending Review, and is a paid as a direct grant to local government, with a condition that it is pooled into the local BCF plan.

### **Sustainability and Transformation Partnerships (STPs)**

The NHS and local authorities have formed partnerships in 44 areas covering all of England, to improve health and care. Each area has developed proposals built around the needs of the whole population in the area.

### **Integrated decision hub**

An integrated decision hub is a single point of access for frontline staff and people who use services to access primary and community care advice and support.