Care Quality Commission

Coventry

Local system review report

Health and Wellbeing Board

Date of review:
22 – 26 January 2018

Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and for Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives the Care Quality Commission (CQC) the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we are able to understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that brings together key findings from across the 20 local system reviews.

The review team

Our review team was led by:

- Delivery Lead: Ann Ford, CQC
- Lead reviewer: Julia Daunt, CQC

The team included:

- Two CQC reviewers
- One CQC analyst
- One Pharmacy Inspector
- Two CQC Inspectors
- Four specialist advisors (one former Deputy Director of a local authority, one Director of Adult Social Services, one Deputy Chief Executive of a local authority, one Chief Nursing Officer)

Care Quality Commission

How we carried out the review

The local system review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on **older people aged over 65**.

We also focussed on the interface between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings.

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across three key areas:

1. Maintaining the wellbeing of a person in their usual place of residence
2. Crisis management
3. Step down, return to usual place of residence and/ or admission to a new place of residence

Across these three areas, detailed in the report, we have asked the questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?

We have then looked across the system to ask:

- Is it well led?

Prior to visiting the local area we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We asked the local area to provide an overview of their health and social care system in a bespoke System Overview Information Request (SOIR) and asked a range of other local stakeholder organisations for information.

We also developed two online feedback tools; a relational audit to gather views on how relationships across the system were working and an information flow tool to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care.

During our visit to the local area we sought feedback from a range of people involved in shaping and leading the system, those responsible for directly delivering care as well as people who use services, their families and carers. The people we spoke with included:

- Senior leaders and managers from Coventry City Council (the local authority), NHS Coventry and Rugby Clinical Commissioning Group (the CCG), University Hospitals

Coventry and Warwickshire NHS Trust (UHCW), and Coventry and Warwickshire Partnership NHS Trust (CWPT).

- Health and social care professionals including social workers, GPs, discharge teams, therapists and nurses and staff from West Midlands Ambulance Service NHS Foundation Trust (WMAS).
- Healthwatch Coventry and voluntary, community and social enterprise sector (VCSE) representatives.
- Representatives of health and social care providers.
- People using services, their families and carers. We also spoke with people in A&E, elderly care wards, the discharge lounge at University Hospitals Coventry and Warwickshire and during visits to intermediate care facilities.

We reviewed 15 care and treatment records and visited eight services in the local area including the acute hospital, care homes, domiciliary care providers, GP practices, extra care housing and the walk-in centre.

The Coventry context

Demographics

- 15% of the population is aged 65 and over.
- 74% of the population identifies as white.
- Coventry is in the 20%-40% bracket of most deprived local authorities in England.

Adult social care

- 61 active residential care homes:
  - 41 rated good
  - 15 rated requires improvement
  - One rated inadequate
  - Four currently unrated
- 17 active nursing care homes:
  - Six rated good
  - Eight rated requires improvement
  - One rated inadequate
  - Two currently unrated
- 96 active domiciliary care agencies:
  - One rated outstanding
  - 51 rated good
  - Nine rated requires improvement
  - 35 currently unrated

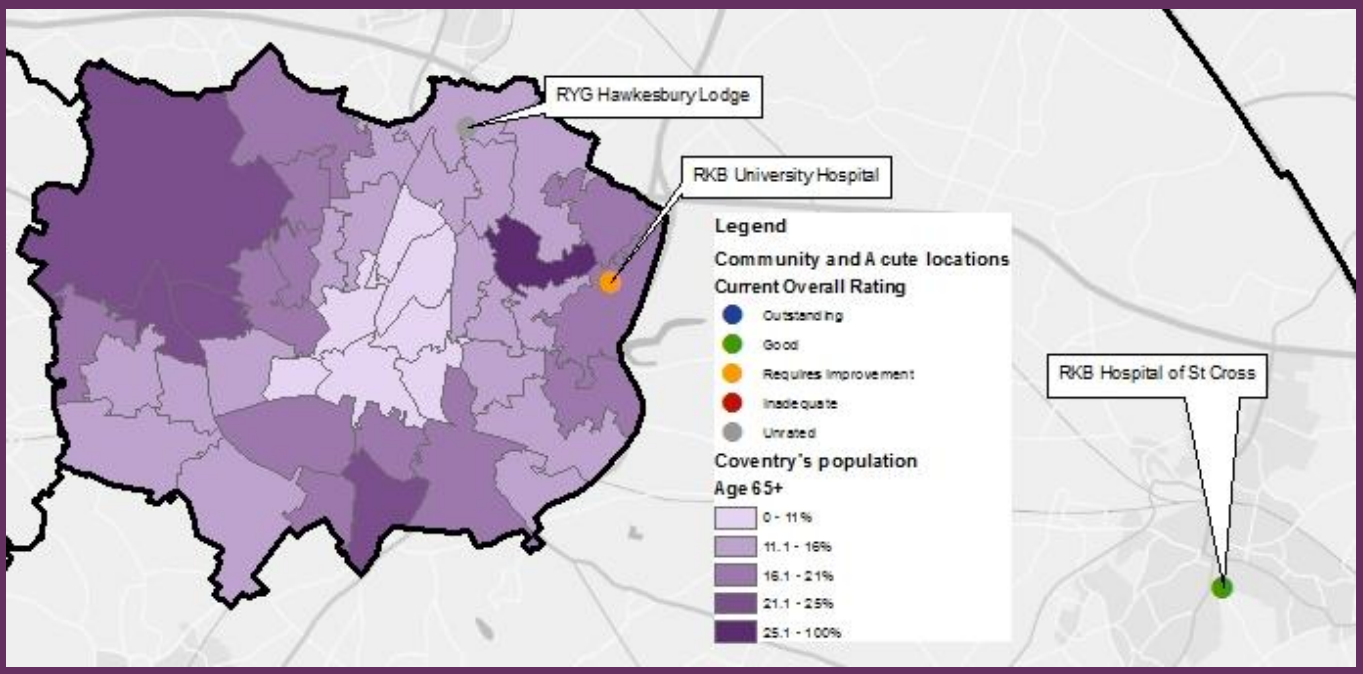
Acute and community healthcare

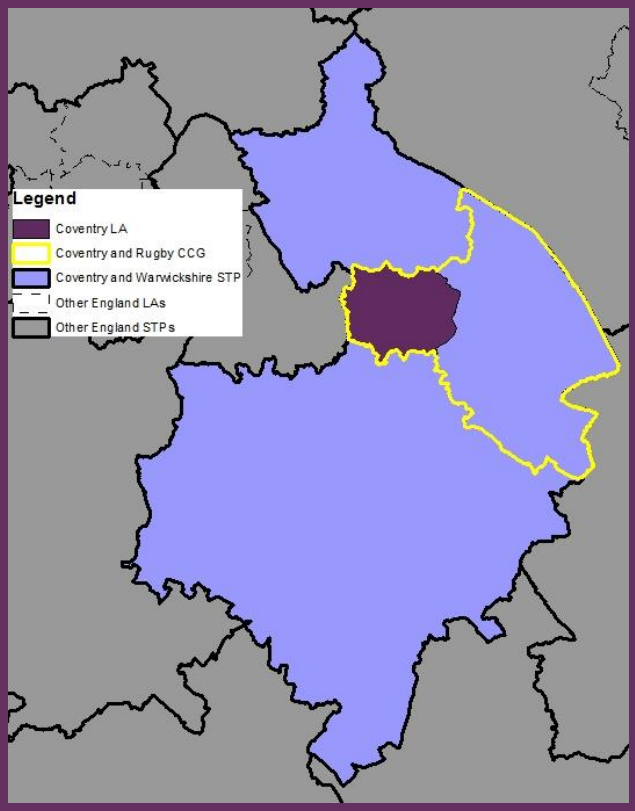
- Hospital admissions (elective and non-elective) of people living in Coventry are mostly to University Hospitals Coventry and Warwickshire NHS Trust
  - Received 92% of admissions of people living in Coventry
  - Admissions from Coventry make up 56% of the trust's total admission activity
  - Rated requires improvement overall
- Community services are provided by Coventry and Warwickshire Partnership NHS Trust
  - Rated requires improvement overall

GP Practices

- 56 active locations
  - Two rated outstanding
  - 48 rated good
  - Three rated requires improvement
  - Three currently unrated

All location ratings as at 08/12/2017. Admissions percentages from 2016/17 Hospital Episode Statistics.





Map one, above:
Population of Coventry shaded by proportion aged 65+ and location and current rating of acute and community NHS healthcare organisations serving Coventry.

Map two, left:
Location of Coventry LA within Coventry and Warwickshire STP.

Coventry and Rugby CCG is also highlighted.

Summary of findings

Is there a clear shared and agreed purpose, vision and strategy for health and social care?

- There was system-wide commitment to serving the people of Coventry well. Coventry was at the beginning of its journey towards transformation and integration.

- The Warwickshire and Coventry Sustainability and Transformation Plan (STP), renamed by the STP Board as the Better Care, Better Health, Better Value programme, was the overarching framework for integration between health and social care across Coventry and Warwickshire. However, there was not yet a shared articulated vision or strategy specifically for future service provision for older people living in Coventry.

- Coventry Health and Wellbeing Board (HWB) was where the priorities around the strategic direction of health and social care in Coventry were agreed. The Coventry Health and Wellbeing Strategy 2016-2019 was in place and provided an overarching plan for reducing health inequalities and improving health and wellbeing outcomes for Coventry residents. It was aligned with the Better Care, Better Health, Better Value programme.

- Coventry HWB worked closely with Warwickshire HWB. An Alliance Concordat between the boards had been set up in October 2016 to provide a foundation for more joined up working across Coventry and Warwickshire's health and social care systems. It was viewed by the system leaders as the cornerstone of joint working. However the impact of this alliance as a driver for change was not yet seen.

- The Joint Strategic Needs Analysis (JSNA) for Coventry developed by Coventry HWB reflected the priorities of the Better Care, Better Health, Better Value programme and was aligned with the health and wellbeing strategy. However, it was agreed by the system leaders and partners that the latest JSNA, having been completed in 2016, needed refreshing to ensure it accurately reflected current health and social care needs. The data on the local authority website was refreshed on 25 January 2018.

- There was an acknowledgement at a strategic level across partner organisations that a focus on preventing hospital admission was as crucial to the effectiveness of the health and care system as enabling safe and timely discharge.

- The annual Public Health Report 2016/17 focused on the needs of younger people and lacked insight into future plans for health promotion and prevention for the older people of Coventry. There was a risk that, as the numbers of older people in Coventry increased; the needs of this section of the population would be overlooked.

- There was an ambition to develop an accountable care system, but the system needs to focus on places and populations rather than organisations to achieve this. Overall there was a lack of collective decision making and governance structures that would support an aligned or shared purpose across partner agencies.

- A significant amount of 2017/19 Better Care Fund (BCF) investment was aimed at keeping people well and out of hospital. However there was not a clear transformational vision for the local provider market. There was a focus on keeping people well at home but it was not clear how system leaders were leading discussions with providers in the private and voluntary sectors to shape the market based on local needs.

Is there a clear framework for interagency collaboration?

- Much of what we saw during the review was still in early development. The leadership team were working towards integration but there was a lack of pace. System leaders lacked cohesiveness and their focus on working as a partnership rather than as individual organisations was underdeveloped.

- There was a commitment to be an integrated system but the structure was not in place to enable integration to happen effectively.

- Historically relationships had been challenging and there was little evidence of a joint approach to service design and delivery in the past. Relationships were more positive at the time of our review; however it was not yet clear how improving relationships and a shared commitment was being translated into comprehensive operational solutions to identify and manage gaps in the system.

- Closer working between providers and commissioners was evident however relations between community health providers and primary care were such that there was still no shared and agreed future focus. System leaders need to use the opportunity of integrated working as an accelerator for addressing any remaining relationship barriers between different parts of the system.

How are interagency processes delivered?

- The challenge for the system was to transform and integrate services while also delivering or maintaining improvements to ensure people were cared for in the right place, at the right time, by the right person.

- At the time of our review some frontline services remained fragmented. There were pockets of integrated working throughout the system but not a system-wide approach.

- A reliance on integration taking place organically and a lack of a shared strategic approach meant that the path to integration lacked pace and structure. There were some good initiatives emerging such as the discharge pathways to reablement and the Integrated Discharge Team (IDT). However, these initiatives were tactical responses to long standing issues rather than part of a shared strategic approach.

- The high impact change model was designed to offer systems an approach to effectively managing transfers of care. It identified eight system changes which would have the greatest impact on delayed discharges, including early discharge planning, seven-day services and discharge to assess. The high impact changes were being implemented in Coventry, overseen by the A&E delivery board.

- Local leaders were positive about the high impact change model and cited it as being one of the main reasons that Coventry had significantly reduced their delayed transfers of care over a relatively short period of time.

- The system undertook a self-assessment against the high impact change model and sent it to NHS England (NHSE) on a monthly basis. NHSE confirmed that Coventry was on track and the majority of plans were established or mature. We found that the discharge to assess model was well embedded and working well in terms of getting people out of hospital and into short term placements. However a lack of available long term placements could still result in delays. Seven day working was in place but not across the system and the trusted assessor role was not consistently utilised, therefore further work was needed to embed the model.

- Governance structures to support joined up working were not in place. There were individual system metrics and performance management frameworks but these were not brought together in way that would enable joint accountability for performance.

- Performance was not clearly used to drive change outside of individual organisations. This meant that it was difficult to identify which areas impacted on delivery of the overarching strategy. There was no shared view of risk outside of the STP.

- Coventry faced many of the workforce challenges that other systems faced nationally, regarding the recruitment and retention of nurses, care workers and GPs. There were good opportunities for Coventry, with the large student population attending universities locally and a wider young population, to build a robust workforce. However there were no clear local integrated workforce strategies in place. There was a workforce stream related to the Better Care, Better Health, Better Value programme but issues around workforce development were not being jointly addressed at a local level.

- There was not a circle of engagement with Coventry citizens around the development and monitoring of integrated services. It was not clear how people's feedback had impacted on integrated service development.

What are the experiences of frontline staff?

- While system leaders and managerial staff were visible and engaged there needed to be more emphasis on building trust and developing a collaborative approach to system integration. It was not clear how frontline staff could contribute to and influence integrated service design and delivery.

- Frontline staff were committed to providing high quality, person-centred care. We saw some good examples of multidisciplinary working, such as the Integrated Neighbourhood Team (INT). However, staff acknowledged that the system was not yet working in an integrated way across the whole health and social care interface.

- The degree to which frontline staff could articulate the system's direction of travel and plans for integration to the review team varied, and was often in the context of their own role rather than the wider system.

- The relationship between hospital and care home providers could be improved. There was a perception from both parties that communication was poor. Not all frontline staff had a shared view of risk. We were told by various staff groups that they felt professionals in other disciplines or parts of the system were too risk averse in their decision making. This meant that it could be more challenging to support people in their decisions while not compromising their safety.

- Frontline staff expressed frustration at the pace of change and the barriers to integration including the inability to share detailed information across the system.

What are the experiences of people receiving services?

- The experiences of older people receiving health and social care in Coventry varied.

- The numbers of people experiencing delayed discharges from hospital had reduced considerably during the latter part of 2017. Analysis of Department of Health and Social Care (DHSC) data showed a reduction from 22.8 days per 100,000 population in May 2017 to 11.5 days per 100,000 population in November 2017. However if people required long term care then there was an increased chance that their discharge from hospital would be subject to delays.

- If a person received a reablement service they usually achieved positive outcomes with a high percentage remaining at home 91 days after discharge from hospital. People's ability

to access reablement in a timely way had also improved. Analysis of DHSC data showed that delayed transfers of care waiting for further non-acute NHS care had decreased from 8.9 days per 100,000 population in April 2017 to 4.5 days per 100,000 population in November 2017. Delays owing to people waiting for completion of assessments had also decreased from 4 to 0.7 days per 100,000 population.

- If people lived in a care home they were more likely to be readmitted to hospital within 30 days of discharge. People in care homes were also at greater risk of an emergency admission from certain avoidable conditions such as pneumonitis and accidents and injuries. However, where community teams focused on prevention the results were very effective; for example the React to Red scheme had resulted in a significant reduction in admissions for the development of pressure ulcers. There were additional opportunities to expand the range of support to care homes more widely to further reduce admissions to hospitals and work was underway in this regard.

- Higher numbers of older people than the England average were admitted into hospital as an emergency. In A&E people often experienced long waits, some on trolleys in corridors. However once on the wards the overall feedback was that the care they received was good.

- Feedback from people and carers stated that navigation of the health and social care system was challenging. Analysis of Adult Social Care Outcomes Framework (ASCOF) data showed that there was an increasing proportion of older people living in Coventry who said it was difficult to find the social care information and support they needed.

- People living with dementia who were admitted into hospital and wished to return to their own home had access to effective bespoke support from the Carers Trust Heart of England (Carers Trust HofE), a voluntary sector organisation commissioned by the local authority. This service was proven to enhance people's wellbeing and allowed them to live as independently as possible.

- People's choice and control around care and support was limited. Availability of ongoing homecare support was restricted to a "geographical cluster" process although this did not apply to residential care or nursing home care. The implementation of the personalisation agenda was underdeveloped. Very few people were receiving direct payments or personal health budgets.

Are services in Coventry well led?

Is there a shared clear vision and credible strategy which is understood across health and social care interfaces to deliver high quality care and support?

As part of this review we looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system, joint working, interagency and multidisciplinary working and the involvement of people who use services, their families and carers.

The Warwickshire and Coventry Sustainability and Transformation Plan (STP), renamed as Better Care, Better Health, Better Value, was a high-level shared strategy, which was aligned to the Coventry BCF and the Coventry Health and Wellbeing Strategy. However, this strategy needed to be supported by detailed local evidence to inform the system how person-centred outcomes would be achieved for older people living in Coventry.

At the time of our review some key documents, which would be used to help inform and drive health and social care transformation on a local level, either needed refreshing or lacked the necessary detail.

*The workstreams within the Better Care, Better Health, Better Value p*rogramme *were well understood by system leaders. There was evidence of a developing commitment across system partners to deliver together through better integrated working within Coventry's health and social care system and across Coventry and Warwickshire.*

In the past there had been some challenging relationships and silo working, but these were improving and relationships across the system were, for the most part, positive. Staff across the system were committed to developing a more person-centred, joined up approach; however, although there was a willingness to work more collaboratively, frontline staff were frustrated by the lack of pace to secure change.

There were some integrated working arrangements in place. However, this needed to be strengthened and expanded at pace with a shift of focus towards integrated service delivery.

Strategy, vision and partnership working

- Coventry City Council's Health and Wellbeing Board (HWB) worked closely with Warwickshire County Council to provide a more integrated service across Coventry and Warwickshire. The Health and Wellbeing Boards of Warwickshire and Coventry had signed a Health and Wellbeing Alliance Concordat in October 2016. The aim was to create streamlined decision making, alignment and pooling of resources, putting the focus on people rather than on individual organisations. They also planned to meet regularly and take part in joint workshops to discuss topics such as joint commissioning between Coventry and

Warwickshire. The impact of this alliance for the older people of Coventry was yet to be seen. However recently there had been a renewed focus on utilising the Concordat as the key driver for transformation around the proactive and prevention workstream of the Better Care, Better Health, Better Value programme.

- Coventry and Warwickshire health and social care systems were part of the wider Sustainability and Transformation Plan (STP). The STP had been recently renamed by the STP board as the Better Care, Better Health, Better Value programme to better reflect the shared outcomes aspired to across the systems.

- The Better Care, Better Health, and Better Value programme was led by the Chief Executive Officer of UHCW. The programme was focused on three main areas: preventative care, urgent care and planned care. However there was not yet a shared articulated vision or strategy specifically for future service provision for older people living in Coventry.

- The Chief Executives and Accountable Officers of the health and local authority organisations within Coventry and Warwickshire Better Care, Better Health, Better Value programme footprint met twice monthly as a Board. Progress was reported to their respective HWB Boards. The Coventry HWB chair told us that while there was engagement at officer level and relationships and trust had developed over the last two years, he would like to see more political input into the Better Care, Better Health, Better Value programme.

- The Coventry HWB strategy, containing the board's three year vision for health and wellbeing in Coventry and the supporting strategic priorities, was aligned with the Better Care, Better Health, Better Value programme.

- Coventry and Rugby Clinical Commissioning Group (the CCG) was a key partner within the Better Care, Better Health, Better Value programme and was working with system partners on work streams related to areas such as urgent care and out of hospital care.

- We were told that there had been long standing "cultural differences" between health and social care system leadership partners. During this review, system leaders reported that relationships had improved and there was a commitment to improving health outcomes in a joined up way. The system benefitted from having stability at senior level for a number of years. However, we found that there was still some silo working within individual organisations resulting in a disconnect between approaches in delivery.

- System leaders were working together to implement the high impact change model, which was reported as having a significant influence on the recent large reduction in the numbers of delayed transfers of care (DTOC). However more needed to be done to ensure this improvement was maintained and the high impact change model embedded. Trusted

assessors were being utilised in places but not consistently. Discharge to assess pathways were in place and mostly had a positive impact on improving the speed at which people were being discharged from hospital but, at the time of our review, pathway three, (for people with long term care needs), was still subject to delays. Pathway three had recently been brought back under the management of the CCG and following our review, system leaders shared data that demonstrated improvements had been made. Weekend discharge rates were higher than many of Coventry's comparator areas but seven day services, although in place in some areas, were not operating across the system.

- Coventry's winter plan had been agreed at the A&E Delivery Board. While it was acknowledged by system leaders that Coventry, like systems nationally, had been under significant pressure this winter, they reported that this year there had been a more integrated approach to planning which had been more effective. However some system partners still felt the planning lacked timeliness and was not inclusive of all partners such as social care providers.

- Coventry's BCF plan was aligned to its Better Care, Better Health, Better Value programme. It was underpinned by strong values and there was a focus on addressing health inequalities and prevention; however there was a lack of an articulated vision of the future model for the older people of Coventry, in particular, the integration of community services delivery with primary care and social care.

- A network of local authorities in England including Coventry City Council worked to develop a 'Marmot approach' to tackling health inequalities, based on the Marmot Review Team publication: 'Fair Society, Healthy Lives (The Marmot Review 2010)'. Coventry became a Marmot city in 2013. Being part of the Marmot Network provided Coventry with access to the international expertise of the Marmot Team based at University College London. The Marmot principles of 'Fair Society, Healthy Lives' aim to reduce inequality and improve health outcomes for all. The local authority stated that these principles had been embedded into the core functions of the council and its partners. From our review of the Marmot City report we could see that there was a focus on greater collaboration, better partnerships, and evidence of impact and outcomes in some key areas, for example working with The Salvation Army on homelessness and the fire service on safe and well checks.

- We were told that there was an ambition to develop an accountable care system but this was in its infancy and had not yet resulted in a clear articulated plan for how this would be achieved.

Involvement of service users, families and carers in the development of strategy and services

- The response to the System Overview Information Request (SOIR) described the approach to public engagement. For adult social care there was a Stakeholder Reference Group that

included membership of people who were receiving care or caring for others. The main purpose of the group was to harness the knowledge and resources of people using services and their carers to develop and improve adult social care services. For example in the co-production of a new care home specification, there was family and resident involvement to shape the specification and develop person-centred I-statements There was also a national annual adult social care survey and bi-annual carers' survey, the responses to which helped inform the development of local strategies.

- However we were told by some system partners and leaders that engagement and involvement with the wide range of people who used services still needed to be improved. Coventry's growing population is currently made up of 26.2% people from Black, Asian, and Minority Ethnic (BAME) groups compared with 14.6% for the United Kingdom as a whole. There was not a clear strategy or plan to engage with older people who used services, particularly with people from a BAME background or seldom heard communities. Although there was some engagement with the BAME population it appeared to be focused on community relationships rather than engagement with transformation or identifying their needs regarding health and social care services.

- There was reliance from some system partners on complaints and compliments as the measure of how effective a service was, without consideration of engaging people in planning and seeking feedback on outcomes.

Promoting a culture of interagency and multidisciplinary working

- The staff we spoke with during the review expressed their commitment to working more collaboratively and we saw good examples of staff working in an integrated way. However staff told us about some of the barriers to interagency working. These included technological barriers, duplication of work and competing priorities between organisations.

- An example of a focus on multidisciplinary team (MDT) working at the operational level was the development of the Community Hub. The role of the hub was to discuss and jointly agree solutions to delays in hospital discharge, to identify problems and escalate them as needed.

- Other examples of excellent integrated working included the Integrated Discharge team (IDT). The team was made up of staff from across disciplines including social workers, nurses, therapists and the voluntary sector. They were co-located within the hospital and had been extremely effective at supporting people to have a safe and timely discharge from hospital as evidenced by the reducing numbers of delayed discharges and the positive feedback from people and families we spoke with. The Integrated Neighbourhood Teams (INT) also offered a MDT case management approach for the frail and elderly in their own homes, with the aim of ensuring people received the support they needed to stay well at home.

- For Coventry, while the latest winter plan was felt to have been undertaken in a more integrated way, some system partners reported that the culture was still very health focused and that there was lack of involvement from social care providers in the development of plans. We were told that the CCG and UHCW dominated the planning with a focus on trust information and data, and aiming to keep people out of A&E.

- CCG leaders described the attempt to better integrate the work of CWPT and primary medical services (PMS). There was a plan to form GP clusters which would be partly geographical; around 30-40,000 population areas. Community health services would then be centred on these new clusters with a view to providing more integrated preventative services and intermediate care. Success of this initiative would rely on improved links between PMS and CWPT. However there was no evidence of strategic planning around this, rather a reliance on 'organic' growth to develop the clusters. As a result of this there was not one aligned view across the system of what this approach would look like.

Learning and improvement across the system

- There were forums where quality and performance were monitored and discussed, such as the A&E delivery board, but more evaluation and sharing of lessons learned across the system was needed. The system needed to work at pace to collate and implement learning in order to drive improvement.

- The CCG provided a bi-monthly Quality, Safety and Performance report, where issues such as timeliness of continuing healthcare (CHC) assessments, the four hour target for A&E and CQC inspection results, were reviewed and reported on via a red, amber green (RAG) rated dashboard, an activity tracker and a risk register. Overall quality issues for social care providers were monitored through the Provider Escalation Panel. This was attended by a range of stakeholders and allowed the pooling of intelligence and coordination of activity to respond where quality may be falling below required standards, for example in a care home.

- Some system partners expressed their frustration at difficulties in getting access to specific health data. We were told that health partners could be very cautious about how data they supplied would be used.

- CCG leaders told us that historically Coventry did not have the strongest data systems for monitoring patient pathways. However they believed that this was improving through the implementation of the IDT and the access to data this would now provide. The CCG was at the time of our review formalising different pathway standards and relevant timeframes, and was optimistic that discharge performance would then be monitored against these by the IDT. Co-located teams in IDT could subsequently begin to flag issues with particular services within care package provision.

- Some system leaders lacked in-depth knowledge of overall performance outcomes. Aside from the bi-monthly reporting on system performance via the Quality Safety and Performance report, there was a lack of ongoing system-wide scrutiny of performance and an over-reliance on waiting for issues and concerns to be raised before any action was taken. We did not see clear system-wide ownership of system performance. There was a focus on metrics in individuals organisations but it was not clear how these were brought together to enable joint solutions.

- There were missed opportunities to ensure there was learning and improvement. The system could benefit from making sure there were opportunities to come together and discuss challenges, evaluate the effectiveness of initiatives and generate shared solutions. Learning regarding inappropriate safeguarding referrals for some partners such as West Midlands Ambulance Service NHS Foundation Trust (WMAS) was not shared as outcomes of safeguarding referrals were not always communicated. There was no method to facilitate feedback from the Carers Trust HofE to enable improvement in systems and services; for example we were told about a person who was discharged from hospital on five occasions over a short period of time and each time the discharge failed there was little or no evidence of learning from the previous episodes.

What impact is governance of the health and social care interface having on quality of care across the system?

We looked at the governance arrangements within the system, focusing on collaborative governance, information governance and effective risk sharing.

Across health and social care there were governance systems and processes in place to assess, monitor and mitigate risks for each organisation. However the system-wide focus was currently limited to the Better Care Fund and delayed transfers of care.
We found little evidence that data and intelligence monitoring was shared across the system and there was a lack of joint evaluation to drive system-wide improvements at pace. The chair of the Health and Social Care Scrutiny Board felt that the challenge and scrutiny function could be improved with better access to timely and accurate performance monitoring data.

Although risks were being escalated at every level, it was not always clear who held overall accountability and responsibility for mitigating them.

Overarching governance arrangements

- System-wide accountability for Coventry health and social care sat with the Health and Wellbeing Board. The Coventry HWB, working with Warwickshire HWB, also monitored the progress of the Better Care, Better Health, Better Value programme (STP) against a set of priorities for each workstream.

- Since the implementation of the BCF in 2015, the plans had been approved through the Coventry HWB supported by Section 75 partnership agreements between the CCG and the local authority.

- We were told that the final improved BCF narrative plan was ratified at the Coventry HWB to ensure local system oversight. Regular briefings were made as required to the HWB as the various aspects of the current BCF plan were finalised, developed and implemented.

- The Adult Joint Commissioning Board (AJCB), which comprised the local authority and the CCG, took ownership of the discussion on the progress of the BCF programme and the approval of specific business cases and new developments. It was the operational delivery and decision making body for the BCF programme. It also had a link to the A&E Delivery Board to ensure alignment with broader objectives and plans.

- The Coventry and Warwickshire A&E Delivery Board oversaw the implementation and monitoring of the A&E Improvement plan, including the DTOC plan based on the high impact change model, and was linked to the BCF plan and improvement and sustainability of the whole health and social care system.

- Although there was evidence of individual organisations monitoring and measuring performance, system-wide ownership and accountability was not evident. We were told by system leaders that to aid the transition to full integration there needed to be an acceptance by all board members of their joint accountability for certain targets, for example, A&E attendances.

- The local authority Health and Social Care Scrutiny Board's challenge function was underutilised. There was a perception of a lack of transparency and openness with data and performance sharing, in particular from the health sector. It was felt that the board would benefit from a performance dashboard to strengthen its oversight and challenge function.

- A Better Care, Better Health, Better Value programme risk register for Coventry and Warwickshire was in place and reviewed operationally and strategically at regular intervals through the AJCB. Major issues that impacted significantly on the BCF programme would be escalated through the appropriate governance channels. However there was limited evidence of a shared view of risk outside of the Better Care, Better Health, Better Value programme. Risk was managed in different forums depending on commissioning arrangements. System leaders told us that there was a commissioning intent to move towards risk sharing. Going forward a risk sharing agreement would be built into CCG contracts.

Information governance arrangements across the system

- Staff throughout the system reported that information sharing across the health and social care interface needed to improve and this was described as a key barrier to integrated working. We saw an example of this in a case file we viewed; A&E staff's lack of knowledge about a person's recent GP consultations led to several emergency attendances over a short period of time.

- The GP Alliance reported that information sharing between primary care and the acute sector was not in place. They told us that the new procurement for Electronic Patient Records still needed GP support. This lack of information sharing meant that people may undergo unnecessary assessment and admissions. For example, we saw from one person's case file that the lack of knowledge of the person's recent GP consultations by staff in the Emergency Department (ED) led to an unnecessary admission.

- In response to the SOIR we were told there was a Digital Transformation Board (DTB) in place, including representatives from all health and social care organisations across Coventry and Warwickshire. The Board had responsibility for developing and delivering the Local Digital Roadmap (LDR). There was an agreement that ten universal capabilities which formed the delivery requirement of the LDR should be delivered by 31 March 2018. These included access across the system to the Summary Care Record held by GPs and the ability for GPs to make electronic referrals to secondary care, both of which were in place at the time of our review. Some capabilities were not fully implemented at the time of the review such as whole-system access to people's end of life preference information. The longer term vision as set out in the Better Care, Better Health, Better Value programme was to produce an electronic citizen health record for Coventry by 2021/22.

To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?

We looked at how the system is working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource.

Coventry faced many of the workforce challenges that other systems faced nationally, in relation to the retention of nurses, care workers and GPs. There were good opportunities in Coventry, given the universities and a young population, to build a workforce however there were no clear strategies in place. There was a workforce workstream through the Better Care, Better Health, Better Value programme but issues around workforce development were not being addressed at a more local level for the residents of Coventry.

We saw some good work in individual parts of the system, for example the GP alliance proactively managing workforce capacity issues through physician assistants, nurse associates, apprenticeship programmes and links with the university.

We did not see consideration of digital solutions to manage efficiencies around workforce capacity.

System level workforce planning

- As one of the Better Care, Better Health, Better Value programme workstreams there was a workforce strategy for Coventry and Warwickshire. The aims of the workforce strategy were to tackle cross-boundary working, optimising contribution and integration of teams. However we were told that while there was collaboration on this strategy there was little formalised integration or joint strategic approaches in this regard.

- There was also a Coventry Adult Social Care Workforce strategy 2017-2019 in place but this only applied to the local authority's own workforce with no strategy for the whole of the adult social care workforce in Coventry and no connection to the broader system. Our analysis showed that staff turnover in UHCW was below the national average and similar to comparators. However estimates of staff vacancy rates in adult social care had increased between 2013/14 and 2016/17 from 4.3% to 7.9%. Therefore more work was needed to tackle the recruitment and retention of staff.

- A further push for better integrated working was taking place through the development of the Local Workforce Action Board (LWAB). The LWAB was focused on the whole work force and system. The Better Care, Better Health, Better Value programme group attended this board every quarter. There were numerous sub groups that were aligned to the Board. These were the project groups that would move work forward, for example skills for care, primary care and education. While we saw a LWAB action plan this comprised mainly statements around 'exploring' or 'identifying' issues. There was no evidence of a detailed delivery plan which would set out how the actions were to be achieved and set the pace of change.

- Some of the improvements regarding recruitment and retention cited included the development of Practice Facilitator roles. Coventry University was also part of a second wave of 24 test sites chosen by Health Education England to deliver the training for the new role of nursing associate. The nursing associate position has been designed to bridge the gap between health care assistants and registered nurses within the NHS, by focusing on hands-on care in hospitals and community settings.

- There was positive feedback from care home providers about the Health Trainer Service and its role in training and support for care home staff. The service emphasized the need to develop a better understanding of roles and responsibilities between hospital and care home staff. They also looked at the future workforce needs, highlighting care homes as good places to work and accessing placements for nursing students. Discussions were taking place with the local university and one of the team had been invited to form part of a working group.

- The workforce focus group told us that there were workforce challenges around retiring GPs and nurses in the city. They were keen to develop some innovative practices around this. For example engaging with nursing students and supporting their transition into community nursing services. Another example given was working with the Community Education Provider Network to help develop a sustainable community-based workforce supporting new GPs in the first year of practice.

- The GP Alliance had been proactive in its response to building workforce through initiatives such as the development of physician assistant role, apprenticeship programmes and developing links with the university.

- The emerging GP clusters would have a significant impact on workforce planning. Some work had been done mapping the design of a MDT workforce to the current workforce via the Design Board with the GP Alliance and LMC. However there was no evidence that a system-wide strategic response to addressing the significant challenges of this new way of working was in place at the time of our review.

Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?

We looked at the strategic approach to commissioning and how commissioners are providing a diverse and sustainable market in commissioning of health and social care services.

We saw that commissioners were working towards alignment but we did not see a clear joint commissioning strategy. The development of the collaborative commissioning board provided an oversight of activity on the ground but did not appear to be a decision making board regarding joint commissioning.

We saw some joint strategies for people living with dementia and the Out Of Hospital scheme. However, there were no clear timelines for delivery of some joint projects such as the development of GP clusters.

There were pockets and pilots of good practice, for example the Integrated Neighbourhood Teams worked effectively and the Integrated Discharge Team was co-located and effective in enabling people to be discharged with limited delays.

There was work to be done on developing relationships and improving communication between commissioners, GPs and other providers.

There was an opportunity to harness a market that appeared to have a good supply to enhance the care pathways of people living in Coventry.

Strategic approach to commissioning

- At the time of our review, Coventry's JSNA required some updating to better inform the market shaping and development of services for older people. The data on the local authority website was refreshed on 25 January 2018 however this was not shared with CQC until after our review. The Director of Public Health's annual report 2016/2017 made very little reference to what had taken place or was forecast to take place, from an adult perspective, through the public health agenda. It was focused on children and young people, and therefore did not address some of the key local issues for the older people of Coventry such as dementia, social isolation or falls prevention.

- The newly formed Collaborative Commissioning Board for Coventry and Rugby CCG and NHS Warwickshire CCG was in place to develop strategic commissioning, with the intention that the local boards of Coventry and Warwickshire would be overseen by this board. The impact of this board could not be measured at the time of our review.

- The Coventry AJCB oversaw a programme of joint commissioning. Commissioning across health and social care was done as a virtual joint team, with single agency leads. There were positive examples of where this worked to achieve effective outcomes for people using services. For instance there were the new long term home care arrangements in place. There were a number of joint commissioning posts established, for example a Joint Carers Lead and Joint Learning Disabilities Commissioner. However joint commissioning was in its infancy and accountability still sat within individual organisations. In the response to the SOIR we were told that the biggest challenge for Coventry was to move from collaboration based on positive relationships to a more formal structured arrangement.

- Pooled budgets were not in place but there was a move to alignment of budgets.

Market shaping

- The adult social care market position statement was dated 2015; it was out of date. We were told that a revised City Council Market Position Statement was due to be published in 2018 based on bespoke reporting tools that would interrogate information from the system as well as the performance dashboard. This would be used to inform the market about future opportunities for providing services, as well as where existing provision could be adapted to meet changing need.

- Leaders and staff working across the system told us that the focus of the system was on prevention and 'home first' for older people in hospital. This focus was supported by the involvement of Voluntary, Community and Social Enterprise Sector (VCSE), enablement, and re-enablement services. VCSE providers told us that they were already involved in a

number of successful schemes for discharge and enablement services locally but they were often very disjointed in their access and availability. However they were optimistic that the new local authority and CCG community-based preventative support grant would help coordinate this better. The grant was due to be available from 1 April 2018 and would end all existing contracts with VCSE providers and renew them for a new five-year term.

- Market shaping based on the 'home first' ethos was evident in our data which showed that between April 2015 and April 2017 there had been a 3% reduction in residential care home beds, a 13% reduction in nursing home beds and a 17% increase in the number of domiciliary care agency locations. Analysis of ASCOF data showed a reducing trend in the number of admissions of older people into care homes for long-term support, with the rate of admissions in 2016/17 being below the comparator group average and just below the England average at 608 per 100,000 population.

- Last year the system implemented joint commissioning of domiciliary care provider contracts with a significant reduction in the number of domiciliary care providers across Coventry. This meant a more streamlined service could be provided as there was continuous care from the same provider regardless of who was providing the funding. Commissioners told us that there was improved access to domiciliary care providers and reduced waiting time for people requiring home care packages.

- The quality of care home and care at home provision was monitored and reviewed regularly by the local authority and CCG joint quality assurance and improvement team, comprising nurses and contract officers, through clinical quality review meetings and supplemented by visits to services. Overall quality issues were monitored through the Provider Escalation Panel. This was attended by a range of stakeholders and allowed the pooling of intelligence and coordination of activity to respond where quality may be falling below required standards.

- The social care market in Coventry was not significantly challenged. From our data it could be seen that Coventry had much higher numbers of domiciliary care agency locations per population aged 65 and over compared to its comparator areas and the England average. Coventry also had a higher number of residential beds per population aged 65 and over. Therefore there was an opportunity to develop a strong adult social care provider market to sustain and enhance the care pathways of people requiring community-based services.

Commissioning the right support services to improve the interface between health and social care

- Commissioning plans in Coventry were focused on prevention, pathways and the person. While people living in Coventry could benefit from this person-centred approach, at the time of our review work was still needed to bring this together into a coherent system-wide commissioning strategy.

- Coventry residents had good access to GPs outside of normal working hours. Data from March 2017 on provision of extended access to GPs outside of core contractual hours showed that 55.4% of the 56 GP practices in Coventry surveyed offered full provision of extended access over weekends and on weekday mornings or evenings compared to the England average of 22.5% and the average across Coventry's comparators of 24.1%.

- Although there was good GP access and there were 'front door' services commissioned to support people to avoid hospital admissions, including the Frailty Service, the walk in centre and out-of-hours GP services; our analysis showed the rate of emergency hospital admissions for over 65s had been consistently higher than national and comparator rates over at least the last three years. In the final quarter of 2016/17 there were 7,883 emergency admissions of older people per 100,000 in Coventry compared to 7,144 across comparator areas, and 6,391 nationally.

- As part of commissioning services for prevention, community pharmacies were not well integrated into the health and social care economy. Very few services were commissioned from Coventry community pharmacies that impacted on the care of older people. The Local Pharmaceutical Committee (LPC) told us that there was good communication between themselves and the CCG but suggested that interventions such as identifying frail older people and offering enhanced medicine use reviews had not been agreed due to a perceived lack of funding, and this was managed by the CCG's own Care Homes Medicines Management Team. There was no specific care homes service commissioned from community pharmacy however system leaders told us that, in April 2018, pharmacists would be aligned to the new Care Home Enhanced Support Service (CHESS). Ad hoc arrangements for support, training or advice existed between some supplying pharmacies and their care homes however there was no formal agreement in place at the time of our review.

- The empowerment of people to take control of their own care and support through the use of personal health budgets and social care direct payments was not evident from the data. In the first quarter of 2017/18, the data showed that uptake of personal health budgets was very low at 0.88 per 50,000 population compared with the England average of 5.82. ASCOF data also showed that a lower percentage of older people using social care services received direct payments in Coventry (13.9%) compared to nationally (17.6%) or across comparator areas (16.5%). To address this and to improve the support available to people, the local authority and the CCG had worked with Improvement and Efficiency West Midlands and Think Local Act Personal to develop a 'Making it Real' personalisation plan. The plan included looking at the feasibility of an integrated personal budget system, developing clear performance indicator targets around the take up of direct payments and scoping the current provision for Personal Assistants (PAs) and shaping the offer for PAs.

- Some system partners expressed concern that communication and relationships between service providers, their representatives and commissioners was poor and at times led to a risk of poor or even unsafe service delivery.

- We were told that there was a lack of trust between the CCG and the GP Alliance and this impacted on their ability to work in partnership. The GP Alliance had no formal interface with the CCG leading to a risk of miscommunication. For example the GP out-of-hours service had been given notice in September by CWPT and we were told that there was an expectation that the GP Alliance would manage the contract and provide a solution. It was not clear how this was to be driven by the commissioners. When we discussed this with the GP Alliance they told us they were not aware of this.

- Care providers told us that strong commissioning relationships and good communication were essential and they would welcome better and timelier communications with the CCG, especially in relation to winter preparations. However we were also told that when planning for surges in demand such as winter the CCG block contract beds worked well. Commissioning support nurses were praised as an invaluable support for care homes.

- Managers of an extra care facility told us that they had taken time when the scheme opened to build these relationships to ensure commissioners understood the service and what they were contracted to provide. However they commented that the current commissioning model was restrictive in relation to their ability to be flexible to meet the changing needs of people in their care or being admitted to their service.

Contract oversight

- Commissioners across the system told us that there were already good governance arrangements around contract and quality monitoring. However this was still within individual organisations rather than as part of integrated governance arrangements.

- Most care home providers spoke highly of the CCG who they said they could call if they had any concerns, such as repeat problems with inappropriate referrals. NHSE in their annual assessment 2016/17 of the CCG awarded them a ‘good’ rating.

- In the response to the SOIR we were told that work was underway to develop a universal approach to care home commissioning. There was a joint quality management team which had established positive relationships with care home providers resulting in a number of improvement programmes. This had led to a significant reduction in the prevalence of pressure ulcers and avoidable admissions for norovirus. The CQC inspection team told us that they felt the local authority and social care quality team closely monitored poorly performing care homes and were proactive in their approach. However there was still work to do in supporting care homes to improve. Our CQC data showed that 60% of Coventry

care homes that had been re-inspected by the CQC and were originally rated as requires improvement or inadequate had not improved their initial overall rating, which was significantly higher than the England average of 30% and 32% for similar areas.

How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting peoples' independence?

We looked at resource governance and how systems assure themselves that resources are being used to achieve sustainable high quality care and promote people's independence.

We found that there had been some work to look at resource governance from a local authority perspective but there had been a lack of transparency between organisations which had hindered further development.

The BCF was the driver for any shared financial arrangement and this was where any risk sharing arrangements sat but otherwise assurance was provided within individual organisations.

There was an opportunity to be more challenging around how the system is assuring itself that there is investment in the right services through a comprehensive and up-to-date JSNA.

- The BCF narrative plan stated that a significant amount of 2017/19 BCF investment (£35.6M or 40.3% in 2017/18) was aimed at keeping people well and out of hospital. Agreement of the areas and services to be developed out of hospital had been driven through robust patient data and trend analysis to understand how and why the population used acute hospital services as opposed to other services available in the city and also through evaluation of the existing out of hospital services in place. Identification of gaps in services had led to prioritising investment in order to support the frail elderly population – who had a significant number of support needs and put the most pressure on Coventry's health and social care services – in the most appropriate settings.

- Between all partners there was one Better Care, Better Health, Better Value programme finance lead. The financial model for the Better Care, Better Health, Better Value programme was being updated at the time of our review. There was also a new role in providing benchmarking for cost saving opportunities. We were told that there were local Coventry and Rugby finance meetings; however these were informal and not documented. There was an acknowledgement that more could be done to better include system partners such as GPs.

- Within the local authority's leadership team there was a clear understanding of the organisation's financial position and the financial constraints aligned to demographic challenges.

- Some system leaders reported that they felt there was not sufficient synergy between finance and activity. They stated that there should be much bolder aspirations around integrated finance. It was acknowledged that moving to financial integration required a significant organisational shift.

- The local authority's Chief Finance Officer worked with the CCG to develop reports for HWB approval. This enabled closer working with health colleagues. However there was no formal process to look forward as a group based on their trajectory around joint issues.

- There was not a risk sharing agreement in place and we were told this was owing to a lack of capacity to develop one. The iBCF narrative plan stated that while no specific risk share was in place, the partner organisations worked closely together to mitigate against any financial impacts across the health and social care economy.

Do services work together to keep people well and maintain them in their usual place of residence?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: maintaining the wellbeing of a person in usual place of residence

Are services in Coventry safe?

There was a system-wide commitment to keeping people safe in their usual place of residence. There were a variety of services in place, that worked well together, keeping people safe and independent for as long as possible.

However, there were still some perceived shortfalls in support given to care homes and there was evidence of high numbers of people being admitted to hospital as an emergency from care homes.

There was an opportunity to enhance care home support further to reduce the number of people going into crisis.

- There were systems and processes in place to maintain people safely in their usual place of residence. There was support available when there were low level concerns through the local authority and Age UK. There was also some social prescribing in place by GPs. However the impact of this was yet to be seen in terms of any reduction in A&E attendances or admissions.

- People who were frail, had complex needs or were at high risk of deterioration and/or hospital admission were supported by a variety of services. The Coventry Falls Physiotherapy Service provided a specialist service to people who had fallen, or were at risk of falling. There was a telecare offer incorporating a 24-hour emergency response service, enabling people to stay safe in their own homes. Integrated Neighbourhood Teams (INT) offered multidisciplinary case management for frail and elderly people in their homes. The fire service was reaching out to 2,000 people each year to undertake safe and well checks in their homes. Safeguarding representatives spoke very highly of the work the fire service undertook for isolated elderly people. They were regarded as trusted figures and kept people safe by highlighting safeguarding issues early.

- Coventry residents had good access to GPs outside of normal working hours. Data from March 2017 on provision of extended access to GPs outside of core contractual hours showed that over half the GP practices in Coventry surveyed offered full provision of extended access over the weekends and on weekday mornings or evenings. This was much higher than the England average.

- From the case files we looked at during the review there was evidence of effective communication between services to keep people safe. For example, a person whose mental health had started to deteriorate was highlighted by the fire service. This led to the person being given a pendant alarm and meal delivery, organised via the Intermediate Care and Reablement team (ICaRe), and Age UK visited to make some changes to the home environment. This enabled the person to stay independent at home for longer.

- To support people living with dementia to be as independent as possible for as long as possible, Coventry had in place the Dementia Community Promoting Independence service. This service incorporated the first UK Community Dementia Locksmith service. Coventry had also been awarded Dementia Friendly Community status by the Alzheimer's Society. There was a dementia strategy in place for 2014 to 2017. It clearly identified some key outcomes for keeping people safe, including people knowing where to get advice and carers receiving support and training. Healthwatch Coventry told us that services for people with dementia had improved following the concerted focus on a dementia strategy linked in with the Alzheimer's Society.

- Front line staff across health and social care were able to describe the process for reporting safeguarding concerns and other incidents. CQC inspection colleagues also told us that they had no concerns with safeguarding processes and management throughout the system. The Coventry Safeguarding Adults Board had led work on 'Making Safeguarding Personal'. This was a toolkit for frontline staff working across the system to ensure safeguarding activity was person-centred. An evaluation of this approach had been completed showing that there was an increased awareness and confidence among staff about making safeguarding referrals and that staff felt that the new assessment form encouraged a more person-centred approach.

- However, some care home providers had expressed concerns that WMAS was overly zealous in making safeguarding referrals when being called to an emergency at a care home. Safeguarding representatives told us that they felt there were not many inappropriate ambulance safeguarding referrals from care homes and that they would prefer over reporting to under reporting. They told us that the conversion rate from referrals to Section 42 inquiries was 17-18%. They emphasized their commitment to ensuring there was good communication between themselves and care homes. Their aim was to achieve a balance between managing risk and putting unnecessary pressure on care homes. However there appeared to be a need to develop and embed a shared view of risk across all parties.

- Feedback from care home providers indicated support from GPs and community services was variable. Some care home providers described a lack of support from GPs. Others told us of the excellent support they had from GPs and district nurses. We were told that funding had been given to GPs to provide enhanced support to nursing (CHESS), which some nursing home providers described as supportive and helpful. However we were told by providers and the GP Alliance that take up by GPs had not been universal. We were told by system leaders after our review that the new CHESS was due to commence in April 2018 and would cover 66% of care home beds in Coventry.

- Data available at the time of our review suggested in the last quarter of 2016/17 the rate of older people that were admitted as emergencies from care homes in Coventry was higher at 959 per 100,000 people than the national average at 713 per 100,000 and their comparator group average of 831 per 100,000. The data also suggested that emergency hospital admissions from care homes had been consistently higher than national and comparator rates over the last three years. This data was based on postcodes where care homes were situated so could include some admissions from the general population.

- Hospital Episode Statistics (HES) data also showed that a comparatively low percentage of older people living in care were referred to A&E by a GP. In the last quarter 2016/17 only 2% of A&E attendances of older people coming from care homes were referred by a GP, compared to 6% nationally and 5% across comparator areas. This would indicate that the high levels of emergency admissions of people from care homes were happening without input from a GP. Our data and the feedback from care home providers supports the need to look at how further primary care support in care homes could help to decrease emergency admissions. Commissioners acknowledged the inconsistencies in support, high levels of emergency admissions and mixed feedback from care home providers. They shared information with us for plans to implement a revised CHES model, known as CHES 2, from April 2018. The plan would include delivering the service at increased scale; delivered by individual practices or consortiums with a dedicated named lead GP and weekly care home visits.

- An initiative that had already proven to be successful at reducing admissions from care homes was the React to Red skin pressure ulcer awareness and education campaign launched in Coventry in 2014. The success of this scheme appeared to be supported by our analysis of Hospital Episode Statistics (HES) data looking at admissions from care homes between October 2015 and September 2016 which showed that Coventry had a lower rate of people being admitted from care homes with diagnoses of pressure ulcers (83 per 100,000 population aged 65+) compared to the England average (161) and comparator average (217).

Are services in Coventry effective?

While the system had a range of services in place to keep people well and in their usual place of residence their effectiveness was not currently reflected in the data. However some of these services were quite new and/or underutilised and there was therefore an opportunity to promote and embed them into the system to improve their effectiveness.

There were good examples of ways to future proof the adult social care workforce and ensure staff and carers had the necessary skills.

People need to be able to navigate the health and social care system easily, and to access information and support in timely way in order to prevent unnecessary hospital admissions; this is especially true for older people. System partners, VCSE organisations, people using services and carers told us that information was not easily accessible and this needed to be given consideration as a priority.

There was a system wide focus on improving communication and collaboration between teams and evidence of a person centred multidisciplinary approach to keeping people well.

People's ability to have choice and control over how their health and care needs were met was underdeveloped with low numbers of personal health budgets and lower usage of social care direct payments however, the system was aware of this and plans were in place to improve the uptake.

- People and their carers' experiences of the effectiveness of support in their usual place of residence varied and they reported that the system was difficult to navigate and information about support was not easily accessible.

- The local authority provided an adult social care advice and guidance website, but despite this providers and voluntary sector organisations told us that information was not easily accessible or understood, particularly by people who funded their own care.

- Healthwatch Coventry told us that in their experience people often found it very difficult to

navigate services effectively, particularly when they were in crisis. ASCOF data for 2016/17 showed that only 69% of people over 65, who were using social care services in Coventry, found it easy to find information about support. This was lower than its comparator group average (73%) and national average (75%). This percentage had been decreasing for Coventry since 2013 however we were told by system leaders that this was not yet a priority as there were other priorities in the system needing more immediate attention.

- Carers told us that people wanted to stay in their own homes as did their carers. They expressed mixed views about people's understanding of options and services available to them as carers, for managing their own health and the health of people they cared for. ASCOF data for 2016/17 shows that only 59.5% of carers in Coventry found it easy to find information about support, compared to 64.2% nationally. It was clear that they relied on the Carers Trust HofE to provide advisory support to them. For example one carer told us about a person who had an eye condition and was frustrated that this was continuing but didn't know who to ask for support. The Carers Trust HofE signposted them to Vision Support Services who liaised with the hospital and they eventually underwent surgery. There was a dementia portal for people living with dementia and their carers to access information. The utilisation of this had increased by 25% in 2017.

- The Carers Trust HofE provided training and support to carers, to enable them to have the skills and resources to provide effective care. They also undertook carers' assessments on behalf of the local authority. Carers spoke highly of the Carers Trust HofE telling us that they were a bridge for hard to reach groups and unpaid carers who did not speak English as their first language. There was also an Admiral Nurse service to support carers to connect to local statutory and VCSE services.

- The lack of ability to share information was cited as a key barrier to providing effective support in people's homes. Staff across the system reported that the lack of digital interoperability impacted on their ability to share information effectively. Health and social care services used different IT systems which could often meant that services duplicated work.

- There were some examples of services designed to proactively maintain people in their own home that were underutilised and/or poorly communicated. The Coventry walk in centre (WiC) ran 8am to 8pm 365 days per year. It was staffed mainly by Advanced Nurse Practitioners and nurses, with some doctor presence. However a relatively small proportion of people using the WiC were aged 65 and over; we were told between 5% and 7%. When we visited on 22 January 2018 the service had only seen two older people. We were told by the centre that there were very few referrals from care homes and they would be keen to engage more with local services to discuss how older people could be better supported. There was also a lack of links and information sharing with the hospital or 111 service, meaning that if the person attending the WiC needed further treatment they would have to tell their story more than once.

- The development of the Integrated Neighbourhood Team (INT) was now in place as a MDT service for the frail elderly who needed care for more than one health or social issue. It was designed, in part, to make sure people only needed to tell their story once, so information was shared across the agencies providing their health and social needs. For example social workers and nurses went out together for assessment of people who were hard to reach and may only engage once. We were told that the INT was only impacting on a small number of people so far but they would be rolling out the approach as part of their new contract. However GPs told us that while the initial roll out of INT was positive the service had become diluted by the bureaucratic process and was no longer utilised by many GPs. They told us that this was because most referrals were rejected and in an urgent situation there would be too long a wait –up to two weeks – for the person to be seen.

- The Urgent Primary Care Assessment (UPCA) service was an Advanced Nurse Practitioner led service accepting referrals (including 'warm' handovers) from UHCW and WMAS. Its aim was to ensure people's health and social needs were met to avoid a hospital admission and support them within their own home. GPs, social workers and community staff told us that they thought this service was underutilised. An audit of acute admissions to UHCW undertaken in October 2016 demonstrated there was a lack of knowledge of UPCA service amongst ambulance crew and emergency department staff. Of the 50 people in the audit, 4% were suitable for current UPCA and 14% would have been suitable if UPCA had the additional capacity. It was not clear if the recommendations from the audit report had been put in place.

- People's access to Coventry GP services was good with a large proportion of GPs offering extended access outside of core contractual hours. To better manage this, GPs were trialling the use of the Black Pear System, an electronic referral and appointment system that aimed to increase patient access and choice. This system was also being trialled in UHCW as a platform to host GP and hospital records. Warwick University were evaluating whether this system was providing value for money.

- The personalisation agenda to empower people to take control of their own support was underdeveloped. Data showed from the first quarter of 2017/18 the rate per 50,000 population who received personal health budgets (PHB) was very low compared to the national average. ASCOF data also showed that the percentage of older people using social care services who received direct payments was also lower than national and comparator averages. The CCG's continuing healthcare (CHC) team were aware of the issue and were optimistic that this would improve. As the CCG was represented on the A&E delivery board they could feed their views upwards, and they told us that their suggestions for improvement were being listened to including a current project looking at PHB and how to improve their uptake. They told us their aim was to provide a seamless process for people between direct payments and PHB. This included an arrangement where social care continued to pay a

person's PHB and then claim back from the CHC. This meant that people did not have to change the provision of their care. They also reported that the joint assessments undertaken with CHC and social care had been very successful and they hoped to implement this process by the end of the financial year.

Are services in Coventry caring?

There was a commitment from staff at all levels in the system to provide person-centred care, reduce isolation and to empower people to make decisions. We found several examples of where people had been well supported and their preferences documented.

However improvements were needed in the information given to people about continuing healthcare (CHC) funding in order for them to make the appropriate decision about their care. The system also had to meet the challenge of ensuring that black, Asian, and minority ethnic (BAME) and seldom heard groups had equal access to tailored care and information that enabled them to make informed choices about their care and support needs.

- The system had invested in social prescribing and trying to reduce social isolation. Age UK were the lead provider for social prescribing and they aimed to integrate with INT service. They planned to work with the INT to see how they could support people's non-medical needs. This meant better support for people who may have been suffering from loneliness, encouraging them to become more independent in terms of socialisation. However Age UK told us that there was doubt about whether it was working. In the first two years of the programme the referral rate was very low because it was an immensely convoluted and unclear pathway. At the time of our review they were running a pilot to locate social prescribing services closer to GPs.

- A successful project for reducing people's isolation while improving their health was the Respiratory Innovation Promoting a Positive Life Experience (RIPPLE) project. Following consultation with people, an informal community based clinic for people with respiratory problems was introduced to act as a catalyst for increased community involvement. This group model blended an informal clinic/education session with a variety of social activities. A chronic obstructive pulmonary disease (COPD) consultant and supporting nurses were available to answer questions, give self-management advice and see patients more formally, if required. There had been approximately 114 attendances from new and repeat people each month, which ebbs and flows with seasonal health issues, such as winter pressures. The average monthly attendance has been anything between 23 and 45 people per week over the last year. On average 11 carers per month also attended and received support. As part of the RIPPLE project the UHCW chaplaincy and voluntary sector groups also provided a listening service and offered holistic support. The clinic had resulted in reduced social isolation for these patients, reduced anxiety, increased mental wellbeing, and improved confidence in the ability to self-manage.

- In the case files we looked at as part of this review we could see evidence of how people, their carers, families and advocates were supported to be actively involved in making decisions about their care and treatment. For example, one person – despite being very unwell with complex needs – wished to remain in their own home. The social worker worked with the community team and the person's family to support this wish.

- ASCOF outcome data for 2016/17 showed that 61% of older people who used adult social care services said they were satisfied with their care and support which was in line with comparators (averaging 61% also) but just below the national average of 62%.

- While we saw evidence of people and families being involved in aspects of decision making, several providers voiced concerns that people, carers and their families were not given the information they needed about CHC funding. This led to confusion about their eligibility and the assessment process itself. They suggested that better communication with families was needed, with a clear key point of contact for CHC funding.

- NHSE told us that one of Coventry's challenges would be ensuring that BAME groups within the community were accessing services and were being supported with tailored plans that put the person at the centre, in particular those that may be living with dementia. In Coventry's iBCF Narrative Plan this challenge was discussed in terms of setting equality objectives that sought to improve citizen engagement and consideration of policy impact on individual's needs.

Are services in Coventry responsive?

There were some good initiatives in place to respond to people's needs and prevent admission but the system was fragmented and not always easy for people to navigate.

There was some focus on a multidisciplinary approach to managing people's needs however the effectiveness of the initiatives were yet to be proven as numbers of hospital admissions and A&E attendances were still higher than average.

Good quality system wide performance data was needed to drill down into what was working and why and to support further decision making around how to ensure people were moving through the health and social care system, being seen in the right place, at the right time by the right person.

- There were plans to improve services and to ensure people were seen in the right place at the right time by the right person. A prime focus for 2017/19 was the implementation of the recently agreed Coventry and Warwickshire clinical model for out of hospital care, the impact of which has not yet been evaluated. A single point of access would provide a single referral route into all adult community services, with signposting into the most appropriate service. Place-based teams would carry forward the multidisciplinary approach started with

the Integrated Neighbourhood Team (INT) and expanding the positive outcomes achieved for a small amount of people by INT. The plan was that eight place-based teams would be organised around new GP clusters, although staffing for these teams was still to be established.

- NHSE told us that attention to improving dementia diagnosis rate for Coventry would be beneficial to ensuring people living with dementia got the care they needed when they needed it. The NHSE dementia diagnosis indicator for March 2017 showed that the Coventry and Rugby dementia diagnosis rate was 62.4%, a little below the national estimate of 67.6% and the national target for at least two thirds of people with dementia to be diagnosed. However this appeared to be an improving picture for Coventry; the iBCF narrative plan stated that their diagnosis rates for Coventry and Rugby increased from 48% in 2013 to 60% in 2017.

- There were some systems in place provided by CWPT to provide integrated services to people in the community so that they could stay at home. One example of this was the Intermediate Care and Reablement team (ICaRe).This service facilitated hospital discharge and prevented avoidable hospital admissions. Their aim was to work with partner agencies to provide people with quick access to nursing, therapy and support staff, providing short term interventions to reach maximum independence.

- There was a MDT approach to reducing the number of people being admitted into hospital from A&E. The frailty team, community nurses, matrons and social workers had daily lunchtime meetings to discuss any recent admissions into A&E. This also included Age UK. The meetings informed staff of people that did not require admission into hospital but would benefit from minimal intervention in order to return home. However, despite this, emergency admissions of older people were higher than average, suggesting a high conversion from A&E onto inpatient wards. There was no interface with the WiC and limited engagement with the GP out-of-hours service. This was a missed opportunity to engage with them and explore their role in prevention as part of the wider MDT.

- In the last four months there had been a pharmacist in the emergency department (ED) for two hours per day. There was a plan to increase this to eight hours per day although this would be from Monday to Friday only. There was some qualitative evidence of impact from this service, mainly around reviewing patients at risk of falls and taking away medicines that may have contributed to falls. At the end of March there would be an analysis of quantitative data so a business case could be made to the A&E delivery board.

- We were told that the frailty service at A&E had a good risk threshold; admissions were appropriately challenged by the team. This was a nine-to-five GP-led service. At the time of our review data was being looked at to see if the service had an impact on the turnaround of people at A&E.

- WMAS told us that they treated 35% of the people they saw within their own home. Our analysis of monthly data between August 2016 and July 2017 supported this, with WMAS regularly managing a slightly higher percentage of call outs without need for transport to A&E than the England average. However we were told by some care home providers and system partners that WMAS could be risk averse, and a cultural shift was required to ensure that hospital was always used as the last resort. To assist with this the Rapid Assessment and Triage service had recently been put in place. Led by consultants, people were assessed on ambulances to try and avert unnecessary admission in to hospital. We were told the service had helped to improve the turnaround at A&E and data shared with us from system leaders at UHCW supported the improvements in ambulance handover time.

- Despite all of the above services or initiatives in place the system continued to have a challenge around reducing the number of people attending A&E. HES data from the last quarter of 2016/17 showed that the rate of A&E attendances of people aged 65+ was just above both national and comparator averages.

Do services work together to manage people effectively at a time of crisis?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: crisis management

Are services in Coventry safe?

Systems, processes and practices were not always effective at keeping people safe at a time of crisis. Data showed that more older people in Coventry were attending A&E, being admitted to hospital and staying longer compared to people in similar areas.

Being unable to share information easily between services had made it more difficult to keep people safe.

Some risk-averse decision making may have contributed to more people experiencing emergency admissions than necessary. There was an opportunity to develop a system wide shared view of risk, where staff were empowered to develop a consistent approach to risk assessment and manage risk positively.

- The systems and processes in place across the health and social care interface to safeguard older people living in Coventry from avoidable harm were not always effective. A comparatively high rate of older people in Coventry was going into crisis and being admitted. Over 90% of admissions to hospital of people living in Coventry were to UHCW, and 31% of people admitted to the trust from Coventry were aged 65 and over. Our analysis of HES data in the last quarter of 2016/17 showed the rate of A&E attendances for people aged 65+ was 11,186 per 100,000 compared to the England average of 10,534 per 100,000 and the

comparator average of 11,151 per 100,000. The emergency admission rate for people aged 65+ in Coventry was 7,883 per 100,000 compared to a rate in comparator areas of 7,114 per 100,000 and the England average of 6,391 per 100,000. Performance had consistently remained higher than average since at least April 2014.

- Risks to people were not always assessed, mitigated and monitored to support them to stay safe when in a care home. Our analysis of HES data from October 2015 to September 2016 indicated that higher rates of older people were admitted to hospital with diagnoses for a range of conditions usually deemed to be avoidable. For example, diagnoses of pneumonitis due to solids or liquids were significantly higher than average at 112 per 100,000 aged 65+ compared to 66 per 100,000 nationally. The success of the React to Red campaign to reduce admissions for pressure ulcers needed to be analysed and emulated to provide similar outcomes for the other avoidable conditions.

- There was a perception of a risk averse culture reported by various staff groups. We were told that WMAS and A&E staff could be overly cautious in their decision making and this contributed to increased A&E attendance and hospital admissions. This perception was supported by the findings of our relational audit, for which we received 50 responses across the system, where one of the lowest scores was on the statement: people take organisational risks where it had the potential to serve wider system goals without fear of criticism or failure. There was also a perception among care home providers that safeguarding concerns were being raised inappropriately by ambulance staff. While this was not upheld by the safeguarding team it suggested a lack of shared understanding of risk across services, and the opportunity for building stronger relationships and trust across professional groups. We were told that feedback from safeguarding referrals was rarely received by ambulance staff, so there was limited opportunity to implement learning on their part.

- During one of our site visits to A&E we noted that 23 out of 25 beds were in use and there were up to 15 people on trolleys waiting lined up against the walls. The trolleys held mainly people over the age of 65. We were told by staff that the physical space in the department was not fit for purpose and some staff groups told us that there was a concern people were being admitted into hospital to move them on from A&E and free up space. There was a newly opened rapid assessment and triage unit but, although a good concept, this was also under strain as the unit was unable to move people through the system in a timely way.

- UHCW had a higher consultant led overnight bed-occupancy rate than the England average. In quarter one 2017/18, bed-occupancy was 93% which was above the national average of 87% and the optimal level of 85%. Bed occupancy at UHCW had also remained over 90% throughout each quarter of the previous year. Hospitals with average bed-occupancy levels above 85% risk facing regular bed shortages, periodic bed crises and increased numbers of healthcare acquired infections.

- Older people were exposed to greater risk of avoidable harm due to a longer length of stay in UHCW. Our analysis of HES data showed that in the last quarter of 2016/17, 35% of people aged 65 and over, admitted as an emergency, had a hospital stay lasting longer than seven days, which was higher than similar areas with an average 31%, and the England average of 32%. The quarterly trends for Coventry showed length of stay had been rising since quarter three of 2015 and had been consistently higher than national and comparator figures. From our site visits to the hospital we saw that there were some significant lengths of stay of up to 80 days and these tended to be experienced by people who were older. Analysis of data for reasons for people over 65 experiencing a length of stay over 20 days from April 2016 to June 2017, shared with us by the CCG, showed that the top three diagnoses were urinary tract infections, falls and pneumonia. The CCG stated that they were using this information to highlight where the focus was needed around pathway management. Consistently ensuring discharge planning was coordinated by the IDT and started early in a person's journey through the hospital would also be an important part of the strategy to reduce length of stay.

- Some system leaders told us that a significant issue in keeping people safe was the lack of a common information platform. They said that information not being available in a timely way had been a common thread in serious care reviews. However they cited the planned development of an Electronic Citizen's Health Record (ECHR) as way of resolving this. The ECHR was a plan in place at Better Care, Better Health, and Better Value programme level via the Digital Transformation Board (DTB). The long term plan was that the various electronic systems in health and social care would be joined up, with a projected completion date of 2021/22.

Are services in Coventry effective?

There were some effective streaming processes at the 'front door' of the hospital to ensure people were allocated to the most appropriate clinical pathways. However a lack of an urgent care centre meant extra pressure, in terms of numbers of attendees, on A&E. The walk in centre was not integrated into the wider health system.

There were examples of good collaborative working between staff teams and there was an obvious focus on moving people through the system more effectively. However there needed to be improved access to senior clinical decision makers at the weekends.

Information sharing was inconsistent and meant that work was sometimes duplicated.

- There were services in place designed to improve people's flow through UHCW. Entry into hospital was via three streams; emergency self-presenters, ambulance and GP referrals, who were streamed into the Medical Decision Unit. There was a nurse on the front desk for initial triage plus a GP that we were told saw 20% to 25% of patients. The GP-led frailty

service saw a small percentage of older people. There were also capacity managers who continually walked the wards to ensure they had up to date information on the bed state. However the rate of emergency attendances at A&E and emergency admissions for older people was higher than the England average and comparator sites.

- The ability to share information to ensure people's needs were met effectively while in hospital had recently been enhanced with the implementation of Genesis, an electronic tool for risk assessments which included a predicted date of discharge. However we were told that keeping it updated relied on staff undertaking a regular board round, which did not always happen due to staffing issues. There were also issues with difficulties accessing training for the system. Medical staff, therapists and nurses had access to the information held on Genesis; however social services did not have the same access. There was also duplication of work as the bed management team still recorded the information manually.

- Sharing key information about the health and care needs of people living in a care home who required attendance at A&E or admission to hospital was cited as an area of concern by care home providers. We were told that the majority of records sent in with the person were misplaced, either between the ambulance and the hospital, or between A&E and the ward. This meant that staff would have to spend time contacting the care home to review the person's care and support needs.

- Some hospital staff expressed concern that flow was compromised at weekends and during evenings and overnight as there were fewer senior staff available and more of a reliance on locum, bank or agency staff. There was a sense that this resulted in more admissions as there was a reluctance to make difficult decisions. We were also informed that there was a shortage of gerontologists which meant they could not be utilised in A&E to provide expert clinical decision making for older people at the "front door". Concerns were also raised that the number of medical outliers had an impact on the efficiency of flow; however within a few weeks prior to our review, matrons had begun to conduct a weekly review to try to understand and tackle the problem.

- The NHS Five Year Forward View set out the need to redesign urgent and emergency care services in England delivering care closer to home and out of hospital where possible. There was no urgent care centre in Coventry therefore all emergencies were dealt with at the hospital A&E. Coventry did have a walk in centre (WiC) which dealt with minor illnesses and injuries; sending people with more complex or severe conditions to A&E. At the time of our review, there was no evidence that the WiC was part of a wider clinical network or that there were transfer arrangements or shared clinical governance. System leaders told us that there were plans to address this in 2018/19.

Are services in Coventry caring?

Frontline staff understood the importance of involving people who needed support and their families in decisions in about their care. However, we received mixed feedback from carers and staff during our review.

Some staff were concerned that the wishes of people and their families were not always taken into consideration. Carers felt that, although they had access to support in a crisis, the level of ongoing support around their health and wellbeing could be improved.

- Our review of people's case files showed most care assessments were centred on the needs of the person. There was some documented evidence that the system informed and involved carers, families and advocates when making decisions about future plans. However ASCOF data for 2016/17 showed that 68.6% of carers in Coventry reported being included in discussions about the person they care for; this was below the England average of 70.6%.

- Some staff teams expressed concerns that hospital clinicians did not always listen to people or their families in terms of understanding their wishes and needs which meant that people were admitted to hospital unnecessarily and once there "over medicalised". However our review of case files did not find any evidence of this.

- When we spoke to a focus group of carers some were not positive about their experiences of care in a crisis. They shared examples of when the people they cared for had experienced poor care and not been treated with dignity. One carer told us that the person they cared for had been left in a hospital corridor for up to ten hours. However they went on to say that on the ward the care was excellent.

- Carers told us that there needed to be an improved system-wide approach to healthcare to include the care and support of carers in managing their own health and wellbeing as this may help to prevent the decline in the health of people receiving care, thus reducing hospital admissions and preventing readmissions. ASCOF data for 2016/17 showed that carers in Coventry reported lower quality of life scores and satisfaction rates than the national average. Carers had access to some support in a crisis. The Carers Trust HofE hosted the Carers Response Emergency Support Service which meant that carers could be provided with up to 72 hours of support during a crisis while other arrangements were put in place. We were told that in the first quarter 2017/18 there were 1309 carers registered with this service.

Are services in Coventry responsive?

- To improve the flow of patients through the hospital, UHCW were using improvement methodologies to imbed best practice with regards to board rounds. External coaches came in to train staff on the system called 'red and green bed days'; this was a visual management

system to assist in the identification of wasted time in a person's journey through the healthcare system. We were told that it had led to improvements on safety metrics such as discharge planning, for example it had resulted in medicines to take out of hospital (TTOs) being ready the night before. However for the case files we reviewed there was little evidence that discharge planning was started early on in the person's journey. Within two files we reviewed the discharge checklist was left blank despite the people having been in hospital for several weeks. From our site visit our findings were that the 'red and green bed days' system, where applied, was working well however it was not applied consistently across all wards and therefore there were pockets of people not experiencing good progress towards discharge.

- VCSE providers highlighted a concern that there were difficulties ensuring people and their families were able to have coordinated, regularly reviewed care as there was not one member of staff as a point of contact taking overall responsibility for a person's care. This was especially important because older people were often transferred several times between wards during their stay. They told us that families reported that this resulted in longer hospital stays and deterioration in people's health.

- Ensuring people were seen in the right place, at the right time by the right person in times of crisis often started with the ambulance service. Data we analysed for July 2017 showed that WMAS managed 39% of incidents they were called to without needing to transport the person to A&E – this was just above the England average. However during the same month only 5% of 999 calls received by WMAS were resolved by providing telephone advice; this was much lower than the England average of 10%. This meant that there may be an opportunity to further reduce the numbers of people requiring an emergency ambulance.

- The NHS Constitution set out that a minimum of 95% of people attending A&E in England must be seen, treated and then admitted or discharged in under four hours. Data showed that over 2016/17 the percentage of people who attended A&E at UHCW and met that target was 82.4%. Analysis from 2014/15 onwards shows performance against the A&E waiting times target had been declining at UHCW, and in each of the last three years had been worse than national performance.

Do services work together to effectively return people to their usual place of residence, or a new place that meets their needs?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: step down, return to usual place of residence and/ or admission to a new place of residence

Are services in Coventry safe?

While there were some excellent coordinated responses to ensure people were returned to their usual place of residence or new residence safely there were some inconsistencies in the safety of the discharge process.

Medicines were not always sent with the person on discharge and ward staff needed to ensure that they had sufficient information from people, their carers and family to provide a safe discharge.

Communication, written discharge information and relationships could be strengthened and improved between hospital staff, care homes and extra care facilities

- Staff involved in people's discharge told us that some of the basic safety concerns for people returning home were issues such as them not having heating or adequate provisions. In some of these cases West Midlands Fire Service (WMFS) was utilised to support them. WMFS, in partnership with UHCW, had an initiative called 'Back Home Safe and Well'. They took home from hospital, vulnerable people who otherwise would need to wait for hospital transport. They also checked that the home was safe for the person.

- Age UK were co-located with the IDT to coordinate support to people following discharge from hospital. As they were based in the hospital they were able to undertake some early engagement with the person while they were still in hospital and plan what support would be needed within one month of being discharged, such as befriending. They would also assist with transport following discharge and help to settle the person into their home.

- Safeguarding representatives spoke of the positive impact that the integrated discharge services in the hospital had on providing people with a safe discharge. Co-location also enabled better safeguarding monitoring because a complete service user picture was available due to the various health and social care professionals based in the same room. They told us that instances of unsafe discharge without the appropriate care package in place were now rare or non-existent.

- However representatives of extra care facilities expressed concern that hospital staff lacked understanding of the serious implications to the service and the safety of the person if their needs had changed significantly on discharge and this was not shared in a timely way with

the care facility. This meant that people could be discharged to a service that could no longer meet their needs and this had in the past resulted in another hospital admission for the person. They also stated that a safeguarding notification would then be raised against the provider due to concerns that staff had neglected the person. There was an opportunity to improve and strengthen relationships and communication channels between hospital discharge teams and extra care providers in order to keep people safe.

- Although we received a low number of responses from registered managers of adult social care organisations to our discharge information flow feedback tool, the responses received were very mixed regarding how frequently services received discharge summaries. There were mixed responses as to whether discharge information was sufficient to enable the service to make a decision about whether or not they could support the placement. Six respondents, out of the total of 14, said they received discharge summaries less than 25% of the time; while five respondents said that, when they did receive discharge summaries, they were rarely or never sufficient for them to make a decision about whether their service could support the placement. Four respondents felt they always or almost always were sufficient. One domiciliary care agency respondent said they had to "chase information" and that information was not shared between wards or agencies. From our site visits to care homes we saw three examples of people being discharged with no discharge information received from the hospital about people's ongoing care needs. The discharge plans seen were simply notes of any ongoing medicines or follow up appointment dates.

- Care home providers expressed their concern about people not receiving their medicines in a timely manner on discharge from the hospital. They told us that people could sometimes be discharged without their medicines, which would arrive later in a taxi. This meant that there was a risk people would not receive the medicine they required because if it hadn't arrived with them or shortly after, and care home staff were not aware of who to call to make enquiries. For example, a care home manager described an incident where a person who required specific emergency medicine as they were at risk of prolonged seizures arrived at the care home without the appropriate medicine.

- In Healthwatch Coventry's report on Effective Hospital Discharge (February 2017) concerns were found that hospital staff were not always eliciting the right information to ensure a safe discharge. Or that they were not being given the correct information because people wanted to go home despite the risk. This was particularly around the suitability of the home environment. However the report also stated that good work was being done by the Carers Trust HofE with their dementia reablement service to ensure there was a safe discharge.

Are services in Coventry effective?

Although there had been some marked improvement in performance around delayed transfers of care in recent months, the systems in place as part of the high impact changes needed to be properly embedded and monitored so that improvement could be sustained.

People who received reablement had good outcomes. The CHC team were able to demonstrate strong and effective joint working to manage discharge.

However improvements were needed in developing a joined up person centred approach for the discharge of people moving into or returning to a care home. Developing positive relationships between the hospital and care home teams, improving channels of communication and a willingness to see care home providers as part of the multidisciplinary team when discharge planning would all enhance the effectiveness of discharge for the person.

- Carers and care home providers had expressed concerns that people and their families weren't always given the information they needed to make informed decisions about their ongoing health care needs. CHC team staff told us that they were working with people to ensure they understand the options available to them. They told us that they worked with the same nurse assessors all the time which had enabled the development of positive professional relationships. This meant that they were able to have discussions and disagreements in a positive way. They stated that they currently had no active disputes and could normally resolve issues before funding requests went to panel. Their aim was to improve people's understanding about what funded health needs looked like. The CHC team demonstrated a commitment to driving a seamless pathway to discharge.

- The Integrated Discharge Team (IDT) had improved the process for effectively identifying appropriate care placements and packages for people by using a cluster approach for care home providers. Using this approach enabled the brokerage team to send out requests for care packages, residential and nursing beds through a clustered system in different geographical areas. This meant less work for the brokerage team around calling individual providers; streamlining the process to a cluster of providers who between themselves would establish which was the most appropriate provider. This has had a very positive impact in reducing time spent by the brokerage team trying to find placements. However it was not clear how this system enabled a person centred approach, empowering people to choose how they would be supported. System leaders told us that the residential care provision through the cluster approach enabled people to have their needs assessed after discharge from the hospital and from that setting people could make decisions about their long-term placements.

- As part of the system's implementation of the high impact change model to focus support on reducing delayed discharges, trusted assessors and discharge to assess (D2A) pathways were in place. However the utilisation of trusted assessors to facilitate speedy and effective transfer of people from hospital to a community or residential setting was not fully embedded throughout the system. Although there was a trusted assessor agreement between the IDT and some providers, the IDT felt that it was not always working effectively. Not all care

homes had trust that the assessment would be completed satisfactorily. We were told that the trusted assessor role was only utilised where there had been minor changes in a person's needs and the person was already known to the care home. If a social worker identified a provider for a new resident or there had been significant changes in need, then the care home would choose to come out and undertake the initial assessment themselves. Work was needed on developing and embedding the trusted assessor role so that care providers could feel confident in any assessment undertaken.

- D2A pathways were seen as mostly working well. There were three clearly defined pathways for discharge:
  - Pathway one – short term services to support at home
  - Pathway two – short term housing with care/care home
  - Pathway three – longer term nursing/residential care

- The IDT had an in-house brokerage team which were able to identify short term home care and care home support for people to be discharged quickly from hospital. This meant that pathways one and two were working well and enabling people to receive support in the community, which in turn enabled them to be discharged in a timely way from hospital. However pathway three was not seen as effective by some staff groups. Discharge staff told us that this was because pathway three was less integrated; the in-house brokerage team were not able to broker long-term placements, this was left to the CCG. They felt that if there was an in-house brokerage team for long term placements this would enable faster discharge. However this view was not held by CHC staff who felt pathway three was joined up and working well. NHSE data showed that there had only been a slight increase in DTOC due to awaiting residential or nursing home placement from April 2017 where it was 2.3 per 100,000 18+ population to November 2017 where it was 3.3 per 100,00 population.

- The ability to move people out of hospital and into short term reablement (pathway one and two) depended on the skills of the staff receiving them and the community support available. There were some mixed views from staff about their ability to support people's increasingly complex needs. Some care home staff with reablement beds told us about how well the short term pathways were working and that daily support from therapy staff meant that most people were discharged within six weeks. However extra care representatives told us that although they were being expected to take on people with more complex needs as short term placements, the support from local GP practices was not available. They told us GPs were reluctant to take on temporary patients with complex needs as they were not paid for short temporary registrations.

- A recurring theme around discharge appeared to be poor relationships and a lack of communication between hospital staff and care home staff. Ward staff had concerns that communication between the hospital and care homes was not effective around the outcome of assessments. Ward staff told us that although assessments were completed by care

homes often these outcomes would not be communicated in a timely manner. Staff said they had to contact the care home one to two days following the assessment to find out whether the person was accepted by the home.

- Care home and domiciliary care providers told us that there was poor communication between hospital staff and themselves when people they supported were in hospital. They stated that hospital staff did not involve them in discharge planning and did not contact them until the person was ready to be discharged. In order to check on the status of the person the care home staff said they would have to rely on the family or call the hospital ward themselves. This was supported by feedback from our discharge information flow tool. Respondents said their service was more commonly involved in the discharge process through visiting individuals in secondary health settings and through phone contact with the secondary health services than through undertaking pre-discharge assessments themselves.

- VCSE providers gave us examples of people falling through gaps because of miscommunication between services around discharge. For example they told us about a person found sitting on commode for hours because the care package had not been started as the discharge time had not been communicated to the provider. They were also critical of systems for not sharing people's support information adequately, with the result that people have to tell their stories over and over through assessment, either at various stages of care or at home.

- Despite the issues highlighted the effectiveness of these pathways on delayed transfers of care from hospital could be seen from the most recent data for DTOC. Analysis conducted by DHSC to select areas for this review showed that between February and April 2017 the reported average daily number of days transfers of care had been delayed per 100,000 population aged 18+ was 23 in Coventry. This was much higher than the comparator average of 12 and the England average of 14 days over the same period. However, Coventry had managed to drastically reduce the average daily number of delays throughout the rest of 2017, and by November 2017 the rate was 11.5 delayed days per 100,000. System leaders and frontline staff stated that the reason for the reduction in DTOC over a relatively short period of time was, in large part, due to the MDT approach to discharge with the introduction of the daily community hub, together with the successful implementation of the D2A pathways.

- The effectiveness of discharges, measured by readmission rates, appeared to be an issue for people living in care homes. The rate of older people being readmitted into hospital from their own home was in alignment with the England average. However, a higher percentage of older people living in care homes were readmitted, with 26% being readmitted to hospital within 30 days of discharge in the last quarter of 2016/17, higher than the national average of 20% and above the comparator average of 22%.

- However older people in Coventry who received reablement were more likely to have a good outcome with a high proportion remaining out of hospital. The percentage of older people who were still at home 91 days after discharge into reablement was 85% in 2016/17, which was better than the performance across comparators and also the national average which was 82.5%. For Coventry this figure had been steadily increasing since 2011.

- Managers of D2A reablement beds told us that it worked well. There was access to therapy staff seven days a week and the focus was on supporting people to be as independent as possible. Length of stay rarely went over six weeks.

- People's access to reablement in a timely way also seemed to have improved significantly. Analysis of NHSE data showed that DTOC due to awaiting further non-acute NHS care (which included reablement) had reduced from 8.9 days per 100,000 population in April 2017 to 4.5 days in November 2017.

- Analysis of ASCOF data from 2011/2012 to 2016/2017 showed that the percentage of older people in Coventry who received reablement services had decreased greatly over the years to just 1.5% in 2016/17. The England average in 2016/17 was 2.7%. However when this figure was presented to system leaders they confirmed that this was not an accurate reflection of the reablement numbers. They stated that a number of factors contributed to the recorded decline in performance, but it was considered that data capture and recording alongside market changes were the most significant factors. They stated that mechanisms were now in place to ensure the accurate recording of short term services. As a result of the review the system was confident that the figure for people receiving reablement in the first quarter 2017/18 was 4.3%.

Are services in Coventry caring?

There were mixed views about the extent to which people, their families, carers or advocates were treated as active partners. Where efforts were made to put the person at the centre, the extent to which they could make choices was limited to what care was available in their allocated 'cluster', particularly if they were not funding their own care. Staff were hampered in their ability to have robust discussions with people about care choices due to a lack of a choice policy. This risked delayed discharges.

The use of the Carers Trust HofE by the system to support people living with dementia to return to their usual place of residence resulted in people being enabled to leave hospital in a timely way achieving a level of independence and improved sense of wellbeing.

- The care of people living with dementia was well supported by the Carers Trust HofE; many people living with dementia were able to leave hospital in timely way and regain some

independence. Since 2014 the Carers Trust HofE, funded by the local authority, had been working with and providing support to people living with dementia and enabling them to return home and regain as much independence as possible after hospital admission. At the point of our review, 71% of people they had supported had remained in their own home, 48% had a reduced care package (compared with their needs prior to hospital admission) and 31% were independent with no care package. The Carers Trust HofE stated that the success of their work was down to well trained staff, good relationships with telecare and equipment services and most significantly having a flexible tailor-made service for each person they supported based on what the person wished to achieve. We were given several examples of the positive impact of this service on the people they supported. For example a person who had lost confidence with their mobility on discharge. Through intensive occupational therapy, and support and encouragement from the care staff, together with personalised goal setting the person gradually gained the confidence to mobilise and complete tasks independently. The Carers Trust HofE also routinely completed the MyCaw (Measure Yourself Concerns and Wellbeing) as a success outcome measure, which showed that the person had an increased sense of wellbeing.

- There were mixed views about how well people and their families were involved in discharge planning. We heard positive feedback from carers and staff about social workers. We were told that they always met with the person's family or advocate to ensure they were involved in the decision making where appropriate. Social workers told us that all their work was centred on the person. They said that they work well together as a team and felt comfortable with challenging each other if there were any concerns.

- However Healthwatch Coventry's report, Patient Centred Communication on Hospital Wards (October 2017), found that the majority of people spoken with were unsure or said they had not been told how long they could expect to be in hospital. They also found that the majority of people spoken with said they did not know if their family or carers had been spoken with about their discharge.

- People's choices for ongoing care were limited. Social workers told us that people had choice in terms of how they wished their care to be delivered such as direct payments or via the local authority. However choice was limited around the provision of services. This was because only a certain amount of care agencies were allocated within a geographical cluster. Some providers felt strongly that people (unless they were self-funders), had little or no choice. Ward staff told us that the policy around people's choice was still in the process of being finalised. They said that choice policies had been agreed and then changed. In two of the case files we reviewed we saw evidence of delays due to family disagreement around the care options offered. Nevertheless analysis of data between February and April 2017 showed that patient or family choice had not been a leading cause of delays to discharge. It would be beneficial to have and apply an agreed choice policy to ensure that robust discussions could be held about the options available promptly on admission to hospital.

The response to the SOIR stated that by March 2018 there would be better information for staff, patients and carers regarding choices available to them as part of our wider health and social care joint communications programme.

Are services in Coventry responsive?

Systems processes and services were in place to support and respond to the transition of people to their usual place of residence or alternative setting. However some people were still waiting too long in inappropriate settings. There were a variety of reasons given by staff about the cause of delays. The most recent data showed that the largest reasons for delays were awaiting further non-acute NHS care, and awaiting residential or nursing home placement. However the system had managed to reduce most of the reasons for delays significantly over the few months prior to our review, with the exception of awaiting residential or nursing home placements, which had risen slightly.

The system had made improvements in relation to delayed transfers of care, but there was an opportunity for further improvement with the implementation of clear channels of communication between health and social care providers and better integration of pathway three of the D2A model.

Seven day working was in place in parts of the system but there still remained some barriers to a system-wide seven day service.

- To ensure people experienced a responsive health and social care service, and as part of the system's implementation of high impact changes, some seven day services were in place. The hospital social work team was present in UHCW on Saturdays and bank holidays. However currently the hospital discharge teams were not present on the weekend. The response to the SOIR stated that other constituent parts of the system were now being put in place to facilitate discharges over the whole weekend. Ward staff told us that weekend discharge rates were lower as care homes would not receive people at weekends. Care home providers stated that they felt it was unsafe as they wouldn't have access to the person's GP and there were normally fewer care staff available at the weekends. There was a plan to include weekend admissions into care home contracts, as part of the D2A process, to increase weekend discharges from hospital by March 2018. Coventry as a system were doing better than many of their comparator areas for weekend discharges. DHSC analysis for April 2015 to September 2016 showed that the proportion of discharges over the weekend following emergency admission was at 21%, slightly higher than most of Coventry's comparator areas.

- Despite improving figures for numbers of people experiencing delayed transfers of care we still found pockets of concern where older people were delayed by a significant period. Frontline staff and discharge teams provided us with a variety of reasons for the delays. These included lack of communication, delays around commissioning long term placements

through pathway three, awaiting care home assessments, and waiting for CHC funding.

- At one of our visits to UHCW we observed, on the electronic bed management system, delays of 42 and 52 days. Staff told us there were issues with delays in CHC funding. However analysis of CHC data showed that the number of CHC referrals exceeding the standard 28 days per 50,000 was 11.3, which was only slightly above the England average of 10.3 days.

- At a hospital board round we attended we saw that of the 42 patients on the ward, 12 had been identified as medically fit for discharge, three had everything in place to go home that day and nine were delayed by waiting for assessments, decisions on funding or equipment. We were also told by ward staff that some delays occurred due to care homes not being able to conduct assessments in a timely fashion. However analysis of DHSC data showed that overall delays due to waiting for completion of an assessment had reduced from 4.0 per 100,000 population in April 2017 to 0.7 per 100,000 population in November 2017.

- Ward staff also told us about delays caused by a lack of communication between the IDT and themselves. For example, the care home manager would contact IDT with the outcome of an assessment but the IDT team would not pass on the information until the next board round; causing a delay. However, in general, utilisation of the IDT was seen by frontline staff to have considerably improved people's flow through hospital and reduced delayed discharges. They reported that they were not utilised for all complex discharges and where they were not involved this had a negative impact on speed of discharge.

- Pharmacy staff told us that the reason for delayed discharges related to waiting for medicines to take home (TTOs) had been extensively audited. The results were that delays were caused by waiting for TTOs to be written up by doctors. They stated that they needed to get TTOs written earlier in the day in order to process them in a timely way. Their audit showed that 33% were received into pharmacy for dispensing after 3pm, 29% before noon. It could then take up to two hours for the medicines to be dispensed, and then it may be a further two hours before being transported by porter to the ward. Volunteers had recently been recruited to transport TTOs back to the wards rather than wait for porters in order to speed up the process.

- Discharge teams told us that they thought the most common cause for delayed transfers of care was pathway three of the D2A model. They suggested there was a need for a review of this pathway. The main issue cited was the fact there was a separate assessment team from the CCG who had to commission pathway three user needs. This was far less integrated than the pathway two process. However this conflicted with the view of CHC staff we spoke with who told us that they felt pathway three was joined up and worked well. A review of this pathway had been undertaken in December 2017 and was shared with us. Key recommendations had been made and agreed by the A&E delivery board. This included

integration of CCG clinical assessors with out of hospital and case management teams into a single virtual team and the utilisation of a single reporting dashboard to monitor referral, length of stay and assessment timeframes. The impact of this review could not be measured at this time as it had only been implemented in January 2018.

- While there was a need to ensure delayed transfers of care continued to be addressed as a system, our data analysis showed that Coventry had made large improvements in most areas related to reasons for DTOC. Between February and April 2017 the main cause for DTOC in Coventry was 'awaiting further NHS non-acute care' (which included waiting for community and mental health care, intermediate care or rehabilitation services) which accounted for an average daily rate of 8.9 delayed days per 100,000 population. The second main cause of delays was 'awaiting care package in own home' which accounted for an average daily rate of 6.5 delayed days per 100,000 population. Later analysis of delays between July and September 2017 showed Coventry had managed to reduce delays against both of these reasons, as well as a number of other causes of delays. However, delays due to 'awaiting residential or nursing home placement or availability' had increased slightly.

Maturity of the system

What is the maturity of the system to secure improvement for the people of Coventry?

- We found that the system leaders in Coventry were working together and striving to improve the quality of care and the experience of older people. The leaders were focused on designing ways to improve how people moved through health and social care.

- The system did not have a clear and consistently articulated vision across health and care agencies for the older people of Coventry. The development of a joint strategy aligned with local commissioning intentions and the Better Care, Better Health, Better Value programme was in its infancy and just beginning to be tackled. There was an ambition to develop an accountable care system arising from the Coventry and Warwickshire HWB concordat but plans on this had only just begun.

- The governance structure that enabled partner organisations and the local community to hold to account performance and delivery of strategy was in place for separate organisations but underdeveloped as a joint system. Ongoing monitoring of performance was siloed.

- Relationships within all levels of the system appeared positive. There was commitment to working in a more collaborative way however we did not see how this translated into

comprehensive operational solutions to identify and manage gaps in the system. The wider work on integration lacked pace and structure.

- The plan for Coventry system leaders to work collaboratively and agree and shape a market supply that was sustainable and responsive was in its infancy. There was not a clear joint commissioning strategy. The development of the collaborative commissioning board provided an oversight of activity but decision making at board level around joint commissioning was underdeveloped.

- It was not clear if there was a shared understanding of where resource gaps were in the system. The Better Care Fund pooled budget was significantly above the minimum required and there was no financial risk sharing agreement in place.

- There was a lack of a cohesive risk sharing strategy across the system

- There was a workforce plan through the Better Care, Better Health, Better Value programme. However there was not a local system-wide approach to health care staff recruitment, retention and skills to deliver planned services for the older people of Coventry.

- The availability of shared records through digital interoperability was not in place. Health and social care used different record systems and within UHCW, two different bed management systems were in place, which were not able to share information. There was a shared use of NHS numbers and basic GP held information via the Summary Care Record was available across the system. There was an Electronic Palliative Care Co-ordination System that enabled the sharing of information across primary care, hospital, community and hospice services for patients at the end of their lives.

- It was not evident that system-wide multidisciplinary team working for effective outcomes was in place. There were emerging examples of good practice around prevention but more work needed to be done to become a truly integrated system.

Areas for improvement

We suggest the following areas of focus for the system to secure improvement

- Ensure there is effective joint strategic planning and delivery for the people of Coventry based on the current and predicted needs of the local older population, to include BAME and hard to reach groups, and which harnesses all the local assets available in the wider system.

- Ensure system-wide performance data is used to drive improvements, implementing solutions and setting targets in which all parts of the system have a shared responsibility, and providing opportunities for collaborative reflection and learning.

- While acknowledging that there is a concordat between Coventry HWB and Warwickshire HWB, the system leaders in Coventry need to build on the concordat and become more engaged with the development of the STP's Better Care, Better Health, Better Value programme.

- Develop a strategic plan for the health and social care workforce in Coventry linked to the STP's wider Better Care, Better Health, Better Value programme workforce plan and deliver it.

- Create and deliver a joint public engagement strategy which includes how the system will reach seldom heard groups.

- Accelerate the delivery of the Digital Transformation Board to provide digital interoperability and shared care records across the system.

- Provide a single point of access health and social care navigation system for people and carers to easily find the support and advice they need.

- Roll out and evaluate a programme of social prescribing.

- Reduce numbers of avoidable admissions from care homes by extending successful initiatives such as the React to Red scheme, introducing pharmacist led medication reviews and increasing coverage of GP input into care homes.

- Develop a shared view of risk across health and social care by identifying forums where staff groups can come together, build relationships and identify ways to establish a consistent approach to the process of risk assessment and positive risk taking.

- Ensure discharge planning is consistently started at the beginning of a person's journey through hospital and remains a key focus during their stay. 'Red and green bed days' to be implemented and embedded across all wards. Care home and home with care providers to be involved in discharge planning at an early stage of the person's stay in hospital.

- Improve the processes around medicines on discharge to reduce delays and improve the safety of those who have been discharged to care homes.

- Improve the ability to discharge patients from hospital at weekends by increasing senior clinical decision makers and ensuring the presence of the discharge teams at weekends. Identify and supply the necessary support needed for care homes to accept weekend discharges for new residents.

- Increase the utilisation of trusted assessors in each D2A pathway to improve the speed of transfers from hospital by increasing care home provider's confidence in assessments completed. Include in any jointly developed protocol for assessments and the review process, a clear feedback mechanism for learning and improvement when assessments are sub optimal.

- Improve the working relationships between the CCG and the GP providers.