

Cumbria

Local system review report Health and Wellbeing Board

Date of review:
12 - 16 February 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 Social Care and for Housing, 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: Wendy Dixon, CQC

The team included:

- Two CQC reviewers,
- Three inspectors from our directorate teams (Primary Medical Services, Adult Social Care and Hospitals)

- Two medicine management inspectors
- One inspection manager (Hospitals)
- One CQC analyst,
- Four specialist advisors; two with a local authority background and two from a health background.
- One assistant inspector
- One business support assistant

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 interfaces 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 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:

- System leaders from Cumbria County Council (the local authority), NHS North Cumbria Clinical Commissioning Group (NCCCG), NHS Morecambe Bay Clinical Commissioning Group (MBCCG), North Cumbria University Hospital NHS Trust (NCUHT), University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT), Cumbria Partnership NHS Foundation Trust (CPFT) and the Health and Wellbeing Board (HWB)
- Health and social care professionals including social workers, GPs, discharge teams, therapists, staff from North West Ambulance Service (NWAS), nurses and commissioners.
- Healthwatch Cumbria and voluntary, community and social enterprise (VCSE) sector services
- Representatives of health and social care providers

We spoke with people using services, their families and carers. We also spoke with people in A&E, the discharge lounges and during visits to community hospitals and hospices.

We reviewed 21 care and treatment records and visited 14 services in the local area including acute hospitals, intermediate care facilities, care homes and GP practices.

The Cumbria context

Demographics

- 21% of the population is aged 65 and over.
- 99% of the population identifies as white.
- Cumbria is in the middle 20% bracket local authorities in England in terms of deprivation.

Adult social care

- 126 active residential care homes:
 - Two rate outstanding
 - 99 rated good
 - 16 rated requires improvement
 - Two rated inadequate
 - Seven currently unrated
- 35 active nursing care homes:
 - One rated outstanding
 - 24 rated good
 - Seven rated requires improvement
 - One rated inadequate
 - Two currently unrated
- 67 active domiciliary care agencies:
 - One rated outstanding
 - 51 rated good
 - Four rated requires improvement
 - 11 currently unrated

Acute and community healthcare

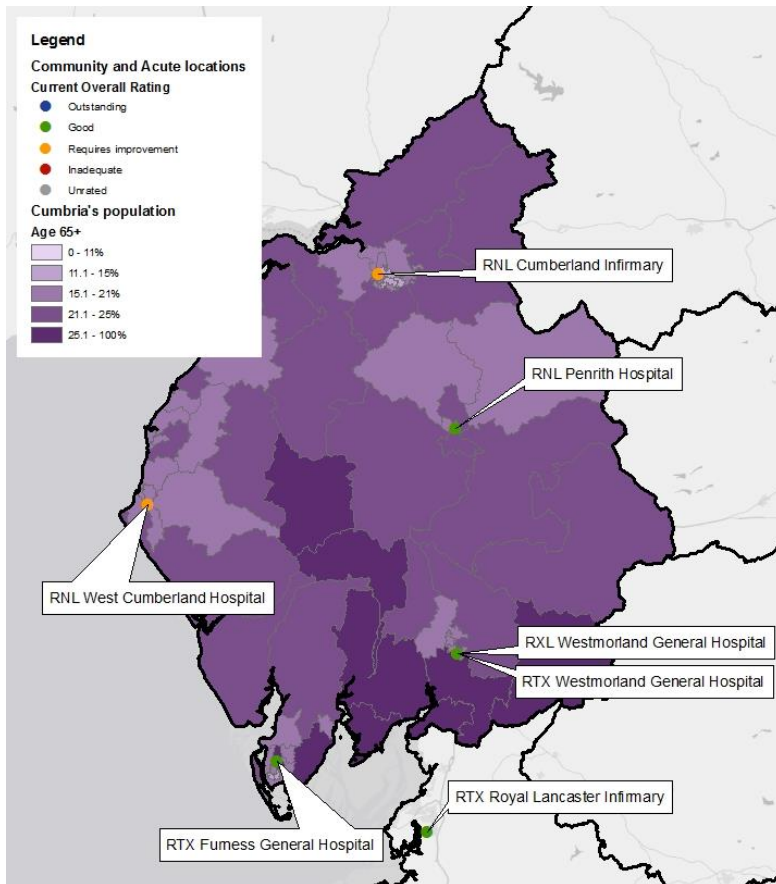
Hospital admissions (elective and non-elective) of people living in Cumbria are found at the following trusts:

- North Cumbria University Hospitals NHS Trust
 - Received 51% of admissions of people living in Cumbria
 - Admissions from Cumbria make up 97% of the trust's total admission activity
 - Rated requires improvement overall
- University Hospitals of Morecambe Bay NHS Foundation Trust
 - Received 35% of admissions of people living in Cumbria
 - Admissions from Cumbria make up 56% of the trust's total admission activity
 - Rated good overall
- Community services are provided by Cumbria Partnership NHS Foundation Trust
 - Rated requires improvement overall

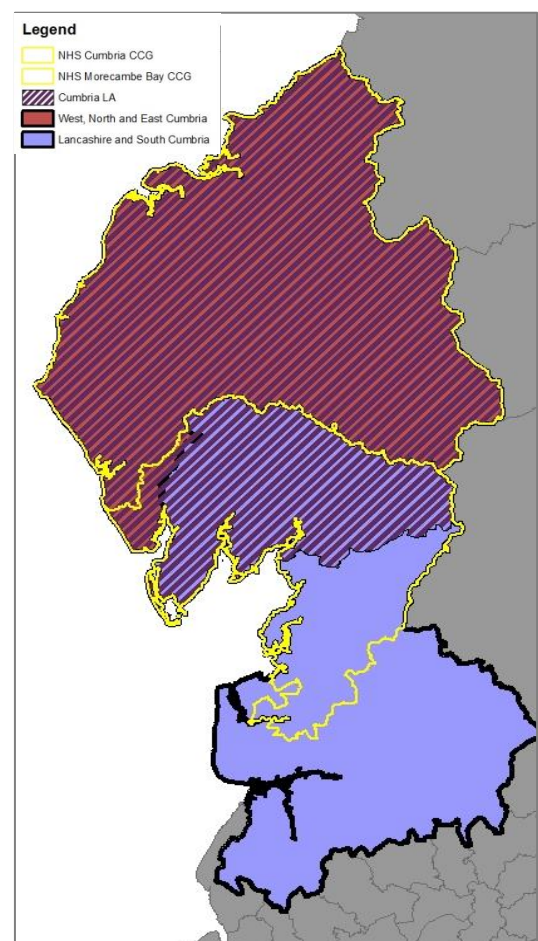
GP Practices

- 73 active locations
 - 12 rated outstanding
 - 57 rated good
 - Four currently unrated

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



Map 2, left: Population of Cumbria shaded by proportion aged 65+ and location and current rating of acute and community NHS healthcare organisations serving Cumbria.



Map 1, right: Location of Cumbria LA within the West, North and East Cumbria STP and Lancashire and South Cumbria STP. The North Cumbria and Morecambe Bay CCGs are also highlighted.

Summary of findings

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

- There is a single Health and Wellbeing Strategy for Cumbria with the vision to improve health and wellbeing and reduce health inequalities across Cumbria. This is shared and being implemented through two Integrated Health and Care Systems (IHCS) – North Cumbria Integrated Health and Care System (NCIHCS) and Bay Health and Care Partners (BHCP - covering south Cumbria and north Lancashire).
- The County Council area covers the whole county, and the two strategic transformation plans being delivered by the IHCS cover the north and south of the county. A local place based approach of Integrated Care Communities, (ICCs) was a key element in delivering the Health and Wellbeing Board's vision in both IHCS across Cumbria.
- There were two separate Sustainability Transformation Partnerships (STPs) covering Cumbria; the West, North and East Cumbria STP and the Lancashire and South Cumbria STP. The CCGs that were nested within the STPs were NHS Morecambe Bay CCG (MBCCG) covering north Lancashire, South Lakeland and Barrow in the south of Cumbria; and NHS North Cumbria CCG (NCCCG) covering Allerdale, Carlisle, Copeland and Eden in the north of Cumbria. Each STP is guided by the overarching objectives of the Health and Wellbeing Strategies that cover their area and coterminous objectives established via national STP planning guidance and the NHS Five Year Forward view. This means that improving outcomes link directly to the Health and Wellbeing Strategy and delivery of the national NHS Five Year Forward View in the respective IHCS.
- There were common overarching principles set out in the respective STP plans which were being implemented and operationalised differently across the two areas.
- The implementation of the Health and Wellbeing Strategy was leading to variable and sometimes limited progress in initiatives preventing people from being admitted to hospital unnecessarily and taking a proactive approach to discharging people home from hospital. The implementation and interpretation of the strategy had led to variation between each ICC due to differences in local circumstances such as recruitment challenges, geography, history and whether they were early adopters. Significant work was being undertaken to ensure robust planning, governance and performance measures supported further implementation and development across the county.

- The Health and Wellbeing Strategy focussed on high-level system changes required to address the challenges set out in the Five-Year Forward View and, by moving towards a population health system, aimed to improve long standing issues such as hospital avoidance and maintaining people at home.
- A review of the Health and Wellbeing Strategy was planned during 2018 and this opportunity should be used to ensure that it meets the needs of very diverse and often rural communities. The implementation of ICCs should also support more proactive focus on “place” as well as co-production with local populations and key risk groups.
- The two IHCS have invested in structures and programme governance arrangements in order to operationalise the respective system based transformational plans and associated programmes of work. These arrangements align to the respective individual organisations internal governance, monitoring and decision making structures.
- Reporting and oversight on the implementation of plans in the respective systems are not routinely reported to the Health and Wellbeing Board. Consideration should be given to how transformational plans are monitored in relation to outcomes, in order to show demonstrable improvement as part of the Health and Wellbeing Board’s overall programme of work. Many of the strategic intentions and solutions were in development system wide, but at the time of the review, plans were mainly organisationally based.
- The two IHCS have started work to focus on aspects of workforce planning, however it is recognised that progress to date had not resolved the key challenge of ensuring that a suitably skilled workforce was available in sufficient numbers to meet the needs of local people across the County.
- Other barriers to integration, such as separate ICT systems, have led to difficulties in information sharing and duplication of effort. for example, the STRATA electronic referral system and the Medical Interoperability Gateway.
- The two IHCS have their own programme management structures, performance monitoring and risk management arrangements. These frameworks set out how partners within the IHCS come together and have collective oversight for delivery. However, the Health and Wellbeing Board, in conjunction with the IHCS, needs to develop more robust oversight mechanisms to provide demonstrable assurance that the Health and Wellbeing Strategy is being implemented and the expected outcomes are being delivered by the respective IHCS.

Is there a clear framework for interagency collaboration?

- The Health and Wellbeing Board had an established development process that enabled discussion between system leaders to address strategic issues and common areas of work across the respective IHCS.
- IHCS had developed arrangements that involve all health and care organisations, which had dedicated leadership and development time to focus on how relationships and all parts of the system work together. It is important that the leadership and development work continues across the county and respective IHCS.
- There were examples of where IHCS were looking externally to learn from others including expert support which had been commissioned to support system wide development.
- The two IHCS have their own programme management structures, performance monitoring and risk management arrangements. However, these frameworks for interagency and multidisciplinary working were better developed in some areas than others.
- In some localities teams were still forming, and in others they were more established. We reviewed care pathways and talked to stakeholders, which confirmed that some multidisciplinary teams were working well but that the approach was at varying stages of implementation.

How are interagency processes delivered?

- The ICCs and a place based model were seen as one of the main vehicles for delivering interagency processes and services. The system had made progress towards some key changes identified in the high impact change model however the model remained underdeveloped in some areas. Some localities were discharging to assess, using trusted assessors and using multidisciplinary discharge support. There were other examples where interagency working was becoming more effective however this was inconsistent and at different stages.
- There was joint ownership of the patient flow, discharge and DTOC challenges across the system led by the STP leads. Daily early morning calls between senior leadership members sharing concerns across a variety of sectors had a positive impact on reducing delayed transfers of care (DTOC) However, there was still much to be done to reduce delays to an acceptable level and promote timely and positive transfers for older people.
- There were separate A&E delivery boards, based in the north and south of the county, who reviewed hospital discharge problems. These had been designed to reflect natural patient

flows including travel routes and the nature of the Cumbrian geography for access to emergency care. However, there is an opportunity to increase learning across the whole of Cumbria and between the A&E delivery boards linked to the developments for enhanced flow that improve the experiences of patients.

What are the experiences of frontline staff?

- Staff were not always able to articulate a system wide vision and spoke of a lack of strategic planning to give them direction and focus. Staff reported that they were beginning to see the emergence of shared goals and objectives with the creation of the ICCs. We found that while system wide metrics for the two IHCS were in place, further work was required on delivery and service plans so that staff understood the meaning, impact and their individual contributions.
- We found examples of staff working in an integrated way to improve outcomes for people, such as a multidisciplinary approach to the needs of people who were frail or who had complex needs.
- Detailed joint plans had not been cascaded through organisations to form a basis for joint team planning for service delivery. Frontline staff were working towards their own organisations' budgets and targets which also created barriers to integrated working.
- There were specific programmes of improvement and engagement which were supported by both Bay Learning and Improvement Collaborative (BLIC) and Cumbria Learning and Improvement Collaborative (CLIC) around the development of ICCs and wider system reform involving staff from all parts of their systems. However, there were still areas where staff were not sufficiently aware of the development of proposals and more work was required to ensure that staff were pro-actively engaged in shaping proposals and developing a common culture.
- There were good examples of collaborative working with the VCSE sector. Compass Cumbria maintained by Age Concern provided a directory of services where people could access services and was valued by staff in social care, primary, community and secondary care.

What are the experiences of people receiving services?

- People's experiences of services depended on the type of service they received. Experiences varied across the county with some people's experience of care being similar to or better than national comparators, however other people had a poor experience that did not meet their needs in a timely or person-centred way.

- In the hospital setting, some frontline staff did not always understand the importance of involving people and their families in decisions about their care. Some case files we viewed documented the discussions had with people; however, staff we spoke with were not always familiar with the contents or nature of the discussion. We were told by some people who use services and their carers that they were not always aware of what their plan of care was and that they were not part of the decision-making process. Communication with people using services, their families and carers was not always open, timely or helpful.
- In step up and step down services, choice was often an aspiration rather than a reality. This was mainly due to shortages of domiciliary care capacity and the scarcity of step down beds in the community. Acute hospitals often tried to discharge people to any available community hospital bed. This therefore meant that the person's preferences, or the wishes of the family could not be met. Access to supported discharge for stroke patients was unequal across Cumbria. Supported discharge existed as a pilot from Furness General Hospital, but did not happen in the South Lakes or the north of the county.
- System leaders acknowledged that the assessment process for continuing healthcare (CHC) was serving people poorly and there was also a backlog of 79 outstanding checklists for review and determination of eligibility for movement to a decision support tool completion at the time of our review in north Cumbria. This meant that people eligible for CHC funding did not receive their assessment or care package in a timely way. There was a risk that the assessment process was not applied consistently or fairly.
- People who received services in their usual place of residence were given choices about how care and support was delivered. We found that people at the end of their lives had advanced care plans in place to give them more control regarding how and where their care was delivered.

Are services in Cumbria well led?

Is there a shared clear vision and credible strategy which is understood across health and social care interface 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.

Despite operating across two CCG areas and across two STPs, effective partnership working was seen as key to improving outcomes for people of Cumbria by system leaders. The strategy of the Health and Wellbeing Board and the newly formed integrated approach should support this but there will need to be an integrated approach for this to succeed.

Strategy, vision and partnership working

- The vision for Cumbria, agreed by the system and detailed in the Health and Wellbeing Board (HWB) strategy, is “Everyone in Cumbria will have improved health and wellbeing, and inequalities in health and wellbeing across the county will be reduced”. The Health and Wellbeing Strategy listed five desired outcomes, among them “older people are enabled to live independent and healthy lives”, with the aims of reducing falls and tackling social isolation. A local place- based approach of establishing of Integrated Care Communities, (ICCs) was a key element in delivering the system vision across Cumbria. However, this did not give rise to a specific multiagency strategy for older people.
- There were two separate Sustainability Transformation Partnerships (STPs) within Cumbria; the West, North and East Cumbria STP, and the Lancashire and South Cumbria STP. The CCGs within the STPs were NHS Morecambe Bay CCG (MBCCG) that covers north Lancashire, South Lakeland and Furness in south of Cumbria; and NHS North Cumbria CCG (NCCCG) which covers Allerdale, Carlisle, Copeland and Eden in the north of Cumbria. There were common overarching principles set out in the respective Sustainability and Transformational Partnership Plans which were being implemented and operationalised differently across the two areas.
- System leaders acknowledged that effective partnership working was integral to improving health and wellbeing outcomes for the people of Cumbria. In the year prior to our review there had been changes to the system leadership which included new CEOs at the local authority and the combined acute and partnership trusts as well as senior appointments to adult social care. These leaders had invested in relationship building and reinvigorated efforts to work collaboratively to achieve service integration.
- Not all places in the county of Cumbria were at the same stage of implementing the ICC model. The two systems aimed to provide place-based care through Integrated Care Communities (ICCs), tailored to the needs of individual local communities. Foundations were in place but progress was at different stages, because of the two different STP approaches, and because some ICCs were set up as “early accelerators”. The Morecambe Bay and North Lancashire area had received funding from Better Care Together which had led to some timely improvements. The seven ICCs in the south of the county were developing specific

initiatives in the community which had achieved up to a 12% reduction in unplanned hospital admissions. The eight ICCs in the north were at different stages and while some were achieving results, others were still building capacity. Due to the different stages of implementation and maturity of ICCs, significant work was being undertaken to ensure that these differences did not result in inequalities in health and social care across Cumbria which would impact on people's experiences.

- The Health and Wellbeing Strategy was ineffective in removing some barriers to good healthcare in Cumbria and there was no system-wide workforce strategy. Although work had started through the Cumbria LEP to link to economic and housing strategies to overcome barriers to attracting relevant health and social care staff to Cumbria, more needed to be done. There was a shortage of suitable accommodation for care staff or projects for supported housing. The lack of care staff persisted and this led to older people being delayed in hospital while they waited for domiciliary care packages to be arranged. As a result, the system continued to be fragile.
- The place-based approach had moved forward without sufficient mapping of provision against the needs of the county as a whole. The system planned for the ICCs to base action on 'mini' joint strategic needs assessments (JSNAs) which applied to their locality, including an overview to how the local needs could be compared between ICCs and where population growth was likely to take place. However, the mechanism for deciding how resources could be prioritised for those most in need was unclear.
- GPs interpreted the place-based vision as an opportunity to tailor services to local need, for example, to create a range of community health services to serve isolated and rural communities. They emphasised that there needed to be a shift of resources from community hospital bed provision which they saw as abundant, to local multiagency services.
- Development of integrated working across the system remained fragile. System leaders recognised the need for a baseline of provision across the county and this led to the development of a frailty pathway. They had worked jointly to co-design this. However, detailed IHCS governance arrangements, performance measures, longer term strategic action plans, and funding strategies were being put in place to support implementation.
- Partners did not have a track record of joint commissioning or risk management. Joint delivery plans on which to base SMART action plans at system, directorate or service level were new and unspecific about the source of funding. The lack of organised funding frustrated some initiatives. For example, staff told us about recruitment processes for joint ICC posts which due to lack of funds, did not result in offers to successful candidates as

funding had not as yet been released. This inhibited service development and demotivated staff.

- Leaders, frontline staff and stakeholders we interviewed as part of our review welcomed the new organisational arrangements. It was widely anticipated these changes would help the system to overcome the silo based working of the past. Some comments provided through the relational audit (responded to by 144 people) indicated that while people working in the county wide Cumbria health and social care system generally felt they treated one another fairly and could be open and honest with each other, respondents were unwilling to take organisational risks to improve the system due to fear of criticism or failure. Respondents also flagged up practical barriers such different ICT systems, poor understanding of different roles and responsibilities and a lack of equality in relationships. Respondents from the third and voluntary sector organisations described feeling under-acknowledged and sometimes excluded.
- Winter plans were produced on an IHCS basis by the two A&E Delivery Boards that cover Cumbria. However, not all frontline staff we spoke to were aware of these. There was an A&E board for each of the IHCS areas, the local authority attended both meetings, and the CCGs attended their respective A&E Boards. They block contracted for winter pressures so older people, when medically fit, could be transferred from hospital into care homes. There was some joint planning between the local authority and CCGs. Contingency plans were in place to respond to a flu outbreak. Daily reviews of the model led to GPs responding to increased demand. However, the GPs and voluntary sector were separate from other approaches and system winter planning was not joined up. Staff worked to their organisation's winter plan. This meant there were risks of duplicating resources or not prioritising them in the best way for people using or needing a service.

Involvement of people who use services, families and carers in the development of strategy and services

- System partners sought feedback from users of individual services. One example of a service led strategy was the local authority's Commissioning Strategy for Care and Support delivered by Adult Social Care 2016-2020. This was based on feedback from providers, partner organisations and the wider public, which contributed to key commissioning intentions. The local authority also consulted on a range of individual services. These included the recent consultations on day service provision, care and support services for people who were deaf or hard of hearing and carer support services, but there was no mechanism to gain feedback on a person's experience of their journey through the system.
- The county did not have a systematic joint approach to involving people using services,

families and carers in strategic development. Involvement was initiative, locality or service based. In addition, although changes had been made as a result of consultation, there was a perception that public engagement lacked true co-production, for example changes to service provision were shared; even though the feedback provided had resulted in changes to delivery intentions. Some people felt that they were informed of changes rather than being actively able to influence and co design service transformation and delivery.

- In the north of the county, feedback and involvement from communities in Alston, Wigton and Maryport led to a 'place based commissioning approach'. This identified some gaps in service which informed ICC development in these localities. The North Cumbria IHCS adopted a 'you said, we did' methodology following on from the engagement done in Appleby, which it planned to apply more widely.
- There was a different approach in the south of the county. 'Better Care Together' was the focus for extensive engagement with people who use services and the wider public. This engagement included focus groups, roadshows, online surveys and public drop in events. Regular engagement and involvement events focused on care in and out of hospital, women's services, children's services and health service planning. Feedback concluded that better integration was needed between in and out of hospital services. However, consultation feedback and learning was not shared across the north and south. This was a missed opportunity for wider learning and sharing good practice.
- Engagement and involvement of local people had coalesced around local issues in some places, for example, the Millom Alliance and Alston. This facilitated the development of the ICCs within which these areas sit.
- There were efforts to capture feedback from specific groups. North Cumbria CCG and Cumbria Foundation Partnership Trust developed a joint survey to gather people's experiences at an orthopaedic clinic, including their travel time and any costs incurred. Findings were not yet available at the time of our review.
- However, the two IHCS were moving towards more effective system-wide involvement of local people and stakeholders. They were using Cumbria Learning Improvement Collaborative (CLIC) and Bay Learning Improvement Collaboration, local learning partnerships to facilitate delivering coproduction of the plans with the community and people using services were involved in recruitment panels and decision making. Stakeholders welcomed this and anticipated development of a conversation with the public on what was needed in the health and social care system.

Promoting a culture of inter-agency and multidisciplinary working.

- The Health and Wellbeing Board has an established development process that enables discussion between system leaders to address strategic issues. In addition, both IHCS have developed arrangements that involve senior leaders from all organisations in system wide discussion and decision making, including dedicated development time for system leaders. This was supported by both BLIC and CLIC implementing programmes of staff engagement around the development of ICCs and wider system reform involving staff from all parts of their systems. However, there were still areas where staff were not sufficiently aware of the development of proposals and more work was required to ensure that staff were pro-actively engaged in shaping proposals and developing a common culture.
- The two IHCS have their own programme management structures, performance monitoring and risk management arrangements. These frameworks set out how partners within the IHCS come together and have collective oversight for delivery. However, the Health and Wellbeing Board, in conjunction with the IHCS, needs to develop more robust oversight mechanisms to provide demonstrable assurance that the Health and Wellbeing Strategy is being implemented and the expected outcomes are being delivered by the respective IHCS.
- There are two A&E delivery boards covering Cumbria. There were no formal links between them. The North Cumbria A&E Delivery Board regularly invited participants from other parts of the system and the local authority director of adult services was the vice chair of the board. The Morecambe Bay A&E Delivery Board (based in the south) included good cross sector representation including the local authority and North West Ambulance Service at all strategic and operational meetings. Leaders acknowledged that capacity was a challenge in respect of leader's capacity to support improvement work, and there was an opportunity to look at this jointly across the two boards.
- The framework for interagency and multidisciplinary working was better developed in some areas than others. For example, Morecambe Bay CCG and Age UK had designed and promoted the Multi-Agency Referral Scheme for GPs to refer people to voluntary sector provision available locally, which was piloted in Kendal ICC. Other areas, such as Keswick and Solway were resolving internal organisational issues. We heard how a social worker was working alongside health professionals in the GP practice in Eden. We reviewed care pathways and talked to stakeholders and this showed that multidisciplinary teams were working well in some localities but were at various stages of implementation.
- During our review staff told us scope existed to improve system wide communications around the transformation. NHS organisations had staff communication mechanisms but

local authority staff told us they did not receive updates about integrated joint working and felt there was a case for a joint communications strategy. All staff we spoke with expressed a will to work more collaboratively, but they did not feel informed about plans and priorities for the future.

- Interagency working to address delayed transfers of care was starting to yield results in both parts of Cumbria. An example of interagency working was the joint ownership of the hospital discharge problems within the system. Daily early morning calls between senior leadership members sharing concerns across a variety of sectors had a positive impact on delays. Separate A&E delivery boards, north and south, reviewed hospital discharge problems. The two A&E Boards covering Cumbria linked into their regional urgent care forums to enable learning. However, they should also ensure that they share learning with each other.
- Progress had been made across the county on key changes identified in the high impact change model. Some localities were discharging to assess, using trusted assessors and using multidisciplinary discharge support. There were other examples where interagency working was becoming more effective:
- A multiagency rapid response model, based around ICCs, was developed to ensure that wrap around care was delivered to prevent unnecessary admissions either to acute settings or residential care. This responded to urgent calls for assistance or facilitated discharge from hospital. The clinician of the day, in consultation with appropriate professionals, ensured that the most appropriate professionals assisted the older person. All relevant professionals, for example, district nurse and/or reablement staff would intervene to deliver a comprehensive care package. The ICCs and the aligned MDT working were effective in some locations. However, as implementation was progressing differently across the north and south of the county, greater cross area working was required to limit the risk of inconsistent outcomes for local people.
- The Integrated Discharge Team in the north of Cumbria comprised an MDT approach with acute, community and adult social care team members working together to facilitate effective discharges from hospital for people with more complex needs. Discharge Navigators provided a link between all three providers, freeing up nurse capacity for patient care.
- Age UK and the NHS had developed a multiagency referral system to receive and allocate people requiring a service based on the specialty. In addition, Age UK provided a hospital to home service to help people get home from hospital quicker.
- Locally tailored plans such as in Appleby, promoted prevention services such as Telecare,

support for carers; and commissioned services differently for day opportunities and extra care housing.

- Recent partnership working had taken place around palliative care. This facilitated fast tracked packages of care, this involved liaison with health clinicians such as district nurses, out of Hospital care teams, Short Term Intervention Team providing rehabilitation (STINT) and Hospice at Home teams, and with social care teams such as domiciliary care agencies.
- Although these examples were positive, they were place-based and not consistent across Cumbria and there was a lack of quality monitoring with some of these initiatives to demonstrate that they were achieving good outcomes for local people and therefore good value for money.
- Partnerships were becoming more collaborative in Cumbria. Leaders told us that mutual understanding within the HWB had benefitted from a series of sessions with an independent facilitator. Staff were positive about future joint working, especially with senior leadership having an open-door policy and leaders who understood the pressures of creating and maintaining an integrated system. Previous health and social care initiatives had left people feeling nervous about 'top down' change implementation. Staff had become protective of their local services and were appreciative of the possibility of reversing some recently taken decisions with the beginnings of a more collaborative approach.
- Although relationships were improving at the system leadership level, frontline staff did not feel the positive impact of improved focus or clear prioritisation. Frontline staff told us they felt uninformed about future plans and priorities. They also needed solutions to day to day operational matters such as better communication between agencies when people were discharged from hospital into a community setting.
- Social care and the community health trust memory services were developing joint working. This aimed to wrap care around people's needs locally, including joint approaches to best interests meetings, routine care planning, and safeguarding. As a result the partners would have a better shared understanding of how to tailor services to vulnerable older people.
- System partners were not engaging with voluntary, community and social enterprise (VCSE) sector services to maximise system capacity. Although relationships were improving, the VCSE sector was not consistently involved in multidisciplinary discharge planning, or in supporting older people to make care choices. There was an opportunity to involve these services more in strategic discussions and in local service development and planning.

- However, good examples existed of collaborative working with the VCSE sector. Compass Cumbria maintained by Age Concern provided a directory of services where local people could access services and that was valued by staff in both primary and secondary care.

Learning and improvement across the system

- There were constraints to learning across the county. Cumbria Learning Improvement Collaborative (CLIC) working in the north of Cumbria, and Bay Learning and Improvement Collaborative (BLIC) working in the south, were both recognised as leaders in staff training. However, there was little joined up or system working across the two systems to share learning. This limited the beneficial effect that the organisations could have in sharing learning, developing joint objectives and measures to evaluate any success.
- The two learning collaboratives had differing approaches to learning and improvement. In the north CLIC believed they could be at the forefront of care. They recognised there were issues for example, DTOC and financial challenges but were implementing a plan to address these. This involved working with teams to look at how their behaviours were slowing them down and teaching middle managers to look at their processes. They acknowledged there was still a need to assist people to work on team development and leadership skills to transform service delivery. They saw the ICCs as part of the solution and a fundamental building block to respond to need.
- Across the south of Cumbria, with BLIC, the focus was to develop a culture of collaboration and improvement. They had held 75 events over the nine months prior to our review for all grades of health service and voluntary services to develop and improve practice. These events had been well attended and had a theme of 'prevent, detect and treat'. However, the opportunity to include staff from across the whole county was missed and meant staff were unable to access the wider range of skills development offered across the two collaboratives.
- There were limited mechanisms to bring providers together to learn and share. Hospice providers told us that Morecambe Bay CCG developed a Bay-wide palliative care focus that complemented and supported the work already going on in Cumbria, shortly before our review. There were several discussions but no finances to support actions so this had not led to any improved outcomes.
- Innovation was not shared across the system. For example, the Health and Wellbeing Coaches (HAWCs) had been employed after a value based and participative recruitment process. This sought to ensure that successful candidates for the HAWC positions had personal resilience as well as client facing competencies, so that they were happy and effective in the role. This was successful, because only one HAWC out of 22 had left after

recruitment, for reasons unrelated to the job. Although this success was recognised at directorate level, there were no system-wide mechanisms to share this learning.

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.

The Health and Wellbeing Board (HWB) had an overview, which included the financial governance of the Better Care Fund (BCF). The two IHCS have both invested in system structures in order to implement specific system based programmes such as ICCs, co-production and engagement, supported by their own system wide programme management structures, performance monitoring and risk management arrangements. The HWB had not undertaken a formal review of its governance needs, and it, in conjunction with the IHCS, needs to develop more robust oversight mechanisms to provide demonstrable assurance to the Board that the outcomes of the Health and Wellbeing Strategy are being delivered by the IHCS.

Overarching governance arrangements

- The HWB had an overarching strategic leadership function across Cumbria and set the strategy. The HWB provided challenge to the strategic direction for the county and had an overview of the financial governance of the Better Care Fund.
- In 2017, two STPs were created, one in the north, one in the south. The STPs set out the strategic vision and delivery plans and provided an oversight of performance via the two IHCS.
- Each of the two CCGs had their own governance structures which fitted into the HWB governance arrangements; these arrangements had been recently reconfigured to support better governance. In 2016/17 NHS Cumbria CCG was rated as Requires Improvement by NHS England. This resulted in a realignment of the CCG boundaries between NHS Cumbria CCG and NHS Lancashire North CCG and the introduction of a new NHS Morecambe Bay CCG. These changes were intended to make local commissioning arrangements simpler and more efficient and to lead to greater integration of health and social care services in the respective areas.
- Both IHCS are using work stream governance. For example, in the north of Cumbria where there was a primary and community services work stream with a nominated senior responsible officer and clear lines of reporting to the system leadership board. A steering

group chaired by a GP oversaw four key projects; rapid response, integrated teams, mental health commissioning, and community hospitals. Enabling groups worked alongside this to develop HR, IT, and communications requirements.

- Other than this, governance arrangements were based at an organisational level and there was a lack of fully developed system-level governance structures or an agreed Cumbria governance framework across the interfaces of health and social care. Individual organisations had an assurance of their own performance, but objectives were linked to their individual priorities rather than a shared, system approach. Partners needed to be clear about what progress was being made across the system and problems which needed to be addressed.
- The HWB and the partner organisations had not undertaken a formal review of their governance needs. System leaders told us there was no memorandum of understanding, accountabilities or a decision-making structure which met the needs of all partners. This meant there was a risk of misunderstanding legal obligations surrounding board, cabinet or full council decisions, which could adversely affect implementation timescales.
- Governance around providing assurance at strategic level was incomplete. The A&E Delivery Boards monitored a set of key performance indicators for delivery of the urgent care programme. The development of ICCs was monitored through the two IHCS with reports providing assurance being presented to the HWB.
- Budgetary integration and financial governance were in the early stages of development. System partners had experience of joint management of the Better Care Fund and the Learning Disability Pooled Budget. However, the system had not defined responsibilities around arrangements to pool, manage and monitor budgets for the ICCs. Staff on the front line were working towards their own organisations' budgets and targets which created barriers to integrated working.
- There was a lack of clarity about shared communication arrangements and assurances that better outcomes and financial efficiencies would be achieved.
- The delivery group of the South Cumbria A&E Board oversaw performance in relation to avoiding admissions to, and discharges from, hospital and ensured that partners delivered the programme of work for the A&E Delivery Board. The group committed to meeting weekly to progress pieces of work requested by the A&E delivery board, and to jointly identify and address system wide issues. The focus of the group when we visited was supporting the development and implementation of pathways for discharge to assess models, which

included iBCF (Improved Better Care Fund) schemes to establish a bed based rehabilitation service, and expansion of the hospital home care services.

Risk sharing across partners

- Although IHCS had their own systems and processes to identify and monitor risks, there was no shared risk register at a county wide level.
- Cumbria County Council and the Cumbrian health trusts faced significant financial pressures; they all had cost improvement programmes. Although these risks were widely acknowledged amongst system leaders, there was no sense of shared risk. Other than the section 75 agreement in relation to the BCF and iBCF there were no pooled budgets in place. At the time of the review, financial managers told us that budgets had not been transferred from the hospitals to the community, so there was a funding gap.
- Some joint financial risk sharing was being developed. For example, in Morecambe Bay, the CCG and UHMBT agreed to work towards a system control total, creating joint financial arrangements. Local partners had moved their transformation plans forward to make progress against the national activity indicators for Vanguard. North Cumbria partners NCCCG, NCUHT and Cumbria Partnership Foundation Trust (CPFT) had agreed a system control total for 2017/18 onwards, to promote trust and ensure joint action.

Information governance arrangements across the system

- Although work had been undertaken to improve commonality between the different ICT systems, frontline staff told us that lack of interoperability frustrated their approach to delivering person-centred care. They told us that the inability to share information electronically was a barrier to discharging older people from hospital. Community nurses had to enter information on three different systems to book in a person requiring the service. This took up unnecessary time and there was potential to streamline the systems and improve flow and productivity through better use of technology.
- Professionals told us that in multidisciplinary team (MDT) meetings there were as many as four IT systems to navigate depending on stakeholders attending. Health professionals spoke of a rich vein of social care information which they could not tap into and social care colleagues expressed similar frustrations about tracking older people once they were admitted to hospital.
- We received 25 responses from registered managers of adult social care services in Cumbria to our online feedback tool regarding the provision and quality of information provided when older people were discharged from secondary care services into adult social

care. These responses painted a mixed picture of the handover of information on, with responses from domiciliary care agencies indicating that they rarely or never received a hospital discharge summary. Responses were also mixed about the timeliness of discharge summaries, their accuracy and comprehensiveness, which indicated there was scope for improvement in these areas.

- Several digital strategy projects to integrate health and social care working were in the early stages of development. These aimed to meet the operational needs of integrated ICCs across Cumbria. For example, a pilot in GP services and adult social care in south Cumbria showed that digital care records could be shared with the GP record. This meant clinicians could have records of continuity of care, district nurses could access records in the home and community hospitals, and occupational therapists could also use these.
- Further developments were planned as part of the Cumbria Digital Roadmap 2016-21. The roadmap referred to the health needs of the community – in particular health inequalities and rural isolation – and plans had been based on an audit of existing digital infrastructure. The CCGs' ICT commissioning strategies set out short to medium term plans such as; capturing all clinical activity electronically in an interoperable way; creating an underpinning platform of devices and connectivity between health and social services; and the ability for all health and social care staff to access relevant knowledge at the point of care and to track transfers of care. However, these were not yet in place across the system, but were listed among 2016/17 commissioning intentions.
- The system still had to overcome some key barriers to implementation. BCF returns for 2016/17 indicated that Cumbria was not meeting some of the national conditions that would facilitate better sharing of information; including not using the NHS number as the consistent identifier and not pursuing open application programme interfaces (APIs) that would allow IT systems to speak to one another.
- Healthcare and ICC teams were starting to gain access to GP records, on a need to know basis. They identified those staff with responsibilities integral to assessing and supporting customers with care and support needs

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.

We found employing and retaining staff at all levels in Cumbria was very much a challenge for all parts of the system and played a significant part in the delays in Cumbria to ensuring people receiving services received the right care in the right place at the right time. There were several initiatives looking at how to tackle this issue. However, there was no unified system wide approach to addressing workforce challenges in the health and social sector in Cumbria.

System level workforce planning

- The two IHCS had started work to focus on aspects of workforce planning, however it is recognised that progress to date had not resolved this key challenge. There were shortages of care staff which meant that providers were competing for the same pool of locally based staff, for care workers at domiciliary care agencies and care homes. In addition, the population of Cumbria aged 65+ was set to increase by 25% by 2020, with 12.7% more falls and nearly 14.7% more people with mobility difficulties, so there was an urgent need to attract and retain new care staff.
- Historically, workforce planning had not encompassed the independent sector in Cumbria which had difficulty finding suitable staff. Between July and September 2017 independent social care providers reported 179 FTE care staff vacancies that they were not able to fill. The difficulty in attracting staff was a major issue for domiciliary care agencies whose numbers decreased by over 10% in Cumbria between April 2015 and April 2017, which was contrary to the trend in most of the country. This was a major risk to future plans because domiciliary care agencies played an important role in ensuring older people could remain at home safely. However, despite this, the number of hours delivered increased by 28% in a similar period.
- Any mapping of existing workforce against need was done on a countywide basis. The North Cumbria Integrated Health and Care system and Bay Health and Care Partners had individual workforce plans. These plans included some relevant actions such as establishing a GP Recruitment Collaborative to explore how best to attract and retain GPs. The local authority's Workforce Plan 2016-2019 identified some of the system wide issues including developing the Cumbria 'brand' to help attract and retain talent within the county and working with Cumbria Local Enterprise Partnership to develop a skills plan for the Cumbrian workforce. However, this plan was not yet in place.
- The system had not resolved inequity of pay rates. Staff told us that there was no consideration of relative pay rates for the same job which meant that care staff were more attracted to working in NHS jobs, because they offered better pay and conditions. However, although this was recognised, insufficient progress had been made to address this issue. There had been problems with recruitment for ICCs because although the posts were paid

more, the funding was not in place at the time of the review to offer the jobs. These issues and inequalities were demotivating for staff.

- There had been ad-hoc initiatives by individual organisations within the system to solve workforce shortages. Commissioners told us they funded a recruitment campaign for domiciliary care providers, which included a website and radio advertisements. This led to some recruitment in Carlisle but was not as successful in other areas of the county. The system did not have a shared approach to supporting the volunteer workforce. There was no joint planning around involving volunteers and VCSE sector organisations effectively in service delivery, or around how best to support unpaid carers.

Developing a skilled and sustainable workforce

- There were no system wide strategies to develop a sustainable workforce. The Cumbrian health and social care workforce was ageing at the same rate as the local population, which presented challenges for sustainability and succession. Representatives from the acute hospital trusts told us there was a large number of nurses approaching retirement age, and the same was true of district nurses working in GP practices. The local authority representatives we met expressed concern about their experienced social workers and adult social care managers also reaching retirement. However, although there were initiatives to attract a range of professionals to the area, these had not fully addressed the underlying issues.
- Initiatives to give local people professional training had helped secure new social workers. The local authority had a social work academy and since its launch in 2015, more than 60 newly qualified social workers obtained professional accreditation. The local authority was a member of Cumbria Local Economic Partnership's Health and Social Care Employers Panel, which worked to develop education and employment pathways and secure funding for investment into employment initiatives.
- The local authority was training its workforce on future skill sets needed for joint working. Leaders told us that the workforce was gaining the right skills to support the effective transition of people through the system including generic supervision and critical analysis training and roles.
- There were some initiatives aimed at making the workforce more stable. Financial incentives were being offered to workers to encourage them to stay in the Cumbria area long term, and local authority staff told us that these initiatives had been effective in the past. NCUHT representatives told us about a plan for a nursing loyalty premium that was being finalised for approval. There was also a joint bank of healthcare assistants between the acute and community trusts in the north of the county.

- System organisations were working in partnership with local universities and colleges. NCUHT was working to develop the workforce through partnerships with further and higher education institutions. The trust attended 12 university careers fairs in the last year and promoted a career in nursing in Cumbria based on how far the salary would go locally. They also had campaigns to recruit internationally, the latest resulting in three new staff members from Poland.
- The trust also worked with the Department of Work and Pensions to offer job shadowing for long term unemployed people and offer a job interview as a minimum. These schemes provided students and local people with access to Cumbria health and social care jobs. The nursing apprenticeship (RNA), was attractive to many but the criteria excluded some motivated individuals. This was because of the need to have GCSE maths and English, or equivalent. The RNA qualification pathway was open to all providers, including hospital, community services, ICC and regulated care homes and will have an intake of up to 100 places twice a year. The RNA pathways were being developed to work across all parts of the healthcare economy. However, some staff told us they thought that the training was narrow and that trainees did not have the opportunity to experience different activities in different settings.
- In some instances, local charities were funded from non-recurrent monies to test initiatives. This is not always easy for those organisations to manage. However, we found that these initiatives have since been made recurrent which should enable improved delivery of prevention and social support agendas.

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 were providing a diverse and sustainable market in commissioning of health and social care services.

We found a strategic system wide approach to commissioning that was in its early stages in Cumbria. A Joint Commissioning Board with system-wide responsibilities was in place but its work had been confined to countywide joint initiatives for example overseeing the delivery of the BCF and iBCF and the plans to develop joint commissioning through the Integrated Commissioning Group in north Cumbria and through the STP in south Cumbria were still being developed. It was unclear how the visions of the two STPs were informing commissioning intentions across Cumbria.

The Joint Strategic Needs Assessment (JSNA) facilitates comparisons between relative inequalities between districts of Cumbria. The system was not at a stage to commission services to balance the local health economy or take a wider view of cause and effect.

The system had not been sufficiently proactive in shaping the market. The independent sector was fragile in Cumbria particularly with regard to specialist dementia nursing care and domiciliary care. The shortage of domiciliary care provision had contributed to reablement services provided by the local authority needing to provide care on a longer-term basis and restricting the number of people they could accept. A review of the reablement services was required to ensure adequate provision was available to those requiring the service.

Strategic approach to commissioning

- A strategic partnership-wide approach to commissioning across the whole of the county of Cumbria was in its early stages. While the county of Cumbria had a joint commissioning board with system wide responsibilities there was no strategic commissioning approach across the whole of Cumbria. There was no county-wide urgent care strategy and older people's strategy on which to base commissioning. The joint commissioning board included representatives from the local authority, MBCCG and NCCCG. Its work had been confined to specific joint initiatives. It oversaw the delivery of the BCF, iBCF, and the Learning Disabilities Pooled Budget. System leaders saw the Section75 and iBCF funding as very useful in the short term. Plans to develop joint commissioning through the Integrated Commissioning Group in north Cumbria and through the STP in south Cumbria were still being developed.
- It was unclear how the visions of the two STPs were informing commissioning intentions across Cumbria. For example, the West, North and East Cumbria STP strategic plan reflected the intentions of the HWB which aligned drivers of behaviours. It was broadly based on the JSNA (published January 2016) though this did not appear to be used to prioritise commissioning activity. The lack of collaborative commissioning posed a risk that the split of the CCGs in the north and south would result in inequity of provision.
- The local authority's strategy for Adult Social Care 2016-2021 was based on knowledge of local need as outlined in the JSNA, on population projections, predicted demand, existing and future models of service – it was then consulted with the public, providers and user groups. It followed recommendations to consider barriers to ageing well, to ensure future assets and services were sustainable and to identify risk groups and prioritised prevention. The JSNA however did not facilitate comparisons between relative inequalities between the ICC areas of Cumbria. Subsequently, mini-JSNAs for each ICC had been produced.

However more work was required to ensure that resources were prioritised to where they were most needed.

- Local planning was not sufficiently informed by detailed knowledge of the needs of the local population.
- The system was not at a stage to commission services to balance the local health economy or take a wider view of cause and effect. For example, the HAWCs were originally intended to be a universal and targeted prevention service. Instead they had been diverted to deal with mental health crises and address unmet need, dealing with shortages in professional staff elsewhere. Although they were trained to deal with this, they became neither targeted nor universal because their focus had become mental health. In a situation where there was much demand for their services, they could not be sure that they were prioritising those most in need.
- System partners had not systematically involved VSCE sector organisations in a collaborative approach to planning and delivering services. For example, there was no regular forum for VCSE organisations to feedback to commissioners what needs they were seeing on the ground, or for commissioners to tell them where the gaps in services were. This meant that the system was not benefitting from their knowledge of local people or using voluntary capacity to help deliver a more person-centred approach.
- Carers told us they were not included in service design, and that their role was not built into the hospital discharge planning process. These issues were recognised by system leaders and commissioners who described a clear intent to address them.

Market shaping

- The local authority had not been sufficiently proactive in shaping the market. We found that independent care home and domiciliary care provision was fragile across the county. This was because of the shortage of care workers and registered nurses. The lack of domiciliary care capacity was contributing significantly to the delays in getting people out of hospital and freeing up capacity in reablement services.
- Commissioners recognised the risk of market failure, which could result in providers leaving the market, particularly those in domiciliary care. A local authority professional told us that some care providers who provided placements in care homes or in people's homes were only able to remain in the area due to additional financial support from the local authority, through the iBCF.

- The system acted in the short term by using iBCF funding to provide an increase in the rate paid to residential and nursing care homes and a backdated increase to providers of domiciliary care services. It also planned to use funding to stabilise social care staffing to maintain current staffing levels in 2017/2018; fund additional packages of care required in 2017/18 above the approved budget; and provide intermediate care beds to facilitate discharges from hospital. In the medium to long-term revised arrangements for residential, nursing and domiciliary are required to put the system on a sustainable footing.
- Adult Social Care Outcomes Framework (ASCOF) data showed that the numbers of local authority-supported older people (aged 65 and over) who were admitted to a care home in Cumbria was 669 per 100,000 in 2016/17, although it remained above national (611) and comparator averages (599).
- Strategic relationships with providers needed to be improved and there were weaknesses in market provision. Changes in the boundaries of the CCGs had slowed down discussions around integrated shared commissioning. Although there was recognition of the potential benefits, there was a lack of clarity about how this would be achieved.
- Market constraints, especially workforce, made it difficult for the local authority to commission the care services needed. This was true for residential and nursing care homes as well as domiciliary care.
- Commissioning had not been effective in aligning service provision to demand for different services or addressing nursing home capacity. While Cumbria had a higher number of registered residential care beds per 1,000 population than the average for England and the North West region, there were significantly fewer nursing care beds per 1,000 population than these comparators. This meant there was a relative shortage in Cumbria of nursing home beds, which put pressure on community and acute hospitals.
- There was some unmet need within the Cumbria market. There was demand for extra care housing across Cumbria, with 699 units in place, however more units were required to be developed to ensure that wider demand had not been met. We also heard how in some areas dentistry was difficult for residents in care homes to access, especially for residents living with dementia. Hospice provision was underdeveloped in the east of the county.
- Cumbria lacked sufficient independent sector extra care housing and had no retirement villages offering leisure and wellbeing facilities alongside a range of health and social care packages. This was a missed opportunity to ensure that older people had quality of life related choices.

- A key consequence of the market's failure to provide adequate care home and domiciliary care provision was the adverse effect on community reablement services. Because there was a lack of domiciliary care agency provision, service users had to rely on reablement to continue care arrangements, when reablement should have been a short-term intervention. We heard how reablement provision was extended in some cases up to a year beyond the initial reablement period, because no other care support was available. The local authority provided the majority of reablement through Cumbria Care; joint commissioning would reduce the pressure on reablement due to the lack of domiciliary care resources.
- The system acknowledged that commissioning was not yet effectively preventing people from being admitted to hospital and maintaining people safely in their own home. There was generally too much focus on the health system and people coming out of hospital rather than early intervention and prevention and keeping people safe at home.

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

- System leaders acknowledged there was an absence of ongoing joint commissioning discussions at a senior level. The creation of the Integrated Commissioning Group in North Cumbria and work through the Lancashire and South Cumbria STP were beginning to explore this.
- Health commissioners were using commissioning support units (CSUs) to procure on their behalf. There had been insufficient focus from a system point of view regarding continuing healthcare (CHC). The NCCCG CHC lead understood that local leaders had to review and improve commissioning of CHC and this would include negotiating a new standard operating procedure. NCCCG and social care leaders were also refocusing the CHC steering group. However, at the time of our review the delays were still detrimental to people's care.
- Provider forums were not fully effective or well attended. This was attributed to providers not having the capacity to release staff. Without effective engagement between commissioners and independent providers it will be difficult to shape an effective future market.

Contract oversight

- Joint commissioning and joint contract oversight arrangements were in the very early stages. There had been some joint specification work, for example the south Cumbria STP plan work stream for regulated care was linked to the CSU framework contract.
- Commissioning arrangements did not ensure transparency and fairness around financial support for continuing healthcare. System leaders told us that no one had a real understanding of the criteria and there were delays in the systems.

- Continuing healthcare assessments were not timely. The NCCCG CHC lead told us there was a backlog of 79 outstanding checklists for review and determination of eligibility for movement to a decision support tool completion at the time of our review. This was an increase from 30 in few months prior to our review, due to differing lists of outstanding checklists in the CHC team and the local authority. The commissioners did not have effective arrangements in place to cover leave arrangements with the result that more assessments were delayed. NCCCG had been reviewing the system for some months with no estimated date of completion, so quality and performance were unlikely to improve in the short term.
- The system had social care provision which compared well against the national average. Some providers needed support with quality; NCCCG had a quality framework in place, and was working with the local authority on a revised joint framework which would focus on early notification, and subsequent intervention. We were told that domiciliary care contracts needed strengthening to ensure they were performance and quality led. The plan was to use ICCs to be part of the early notification for the system.
- CQC ratings across adult social care organisations were also comparatively good, with a higher percentage of nursing homes, residential homes and domiciliary care locations receiving a CQC rating of 'good' compared to the national average. GP services were rated more highly than the national average. NHS acute hospital services were improving from a relatively low base.

How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting people’s 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 the system did not have appropriate mechanisms in place to measure whether resources were used effectively in joint initiatives. There were no arrangements in place to demonstrate where investments and benefits were fairly balanced between partners. Establishing new shared working arrangements was partially based on the BCF being focussed on ICCs. There was short term spend on winter planning allocated to bolstering capacity, particularly for intermediate care to get people out of hospital in cases where they were not completely fit to return home. However, major elements of the integration agenda were focused on redeploying existing base budgets and more work was required to ensure that sustainable financial arrangements to support integration were in place

- The HWB had oversight of BCF reporting and monitoring. However, the architecture of governance and financial monitoring for partnership working around integration had not been decided. At an operational level, the BCF was reviewed through the Joint Commissioning Board on a quarterly basis.
- Financial leaders told us that they recognised their low position in the local area performance metrics but they believed that their financial position was directly related to transfers of care and flow issues within the system. They told us it would take further funding and ambitious pilots to remedy this situation.
- They told us that re-allocating resources from existing provision, without disrupting flow would be challenging and need careful discussion.
- Establishing new shared working arrangements was partially based on the BCF being focussed on ICCs. There was short term spend on winter planning and bolstering capacity, particularly for intermediate care to get people out of hospital in cases where they were not completely fit to return home. However, major elements of the integration agenda were focused on redeploying existing base budgets and more work was required to ensure that sustainable financial arrangements to support integration were in place.
- There was a need to free up resources to enable transformation at pace. The system had not combined existing programme offices, meaning that capacity for change was not maximised.
- The system was on track to deliver on its control total. There had been efforts to be more disciplined and stay within the control total, and a real desire to maintain grip on finances. However, there was still tension around delegating budgets to meet business needs. The system had not aligned financial issues and established governance for how partners would support each other and ensure that no organisation was disadvantaged.
- The system was not making sufficient use of benchmarking to test whether it was transforming services in the most cost-effective way. CCG and social care commissioners told us that they benchmarked with the ten most similar CCG areas, for example Lincolnshire and Cornwall. There had been cost and performance benchmarking, but more needed to be done to investigate the integrated models being used by other systems.
- We were told that that the local authority was in the process of re-shaping resources to services, for example, ensuring criteria were in place for access to HWACs, so that they could take targeted action.

- The system did not have the governance to assess how spending was reflecting joint priorities. It also needed to develop the data to measure against its specific goals relative to prevention. Mechanisms to correlate outcomes to joint investments were limited to ad-hoc initiatives or attached to specific funding streams. This prevented the system from measuring the added value of joint working.

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 their usual place of residence

Are services in Cumbria safe?

There was system-wide commitment to keeping people safe in their usual place of residence. A number of initiatives had been introduced to promote this, including the development of the frailty pathway, MDT working based on risk and the introduction of the HAWC role. All these were viewed positively by staff and people who used services.

Safeguarding processes were well established. Frontline staff received training and told us they were supported to address any safeguarding issues.

- Our analysis of Hospital Episode Statistics (HES) data showed that the rate of A&E attendances per 100,000 population aged 65+ in Cumbria had been consistently in line with its comparator average and below the England average from 2014/15 to 2016/17. However, a significantly high percentage of A&E attendances of older people in Cumbria were being referred by a GP (15% in the last quarter of 2016/17 compared to 8% nationally).
- Analysis of emergency admission rates for older people also showed Cumbria to have a lower rate than the national average between September 2016 and August 2017 (21,204 per 100,000 population aged 65+ compared to 25,009) and rates were broadly in line with Cumbria's comparator areas from 2014/15 to 2016/17.
- Systems and processes had been developed in Cumbria so that people could be safely maintained in their usual place of residence. With the development of the frailty pathway and the ICCs, a risk stratification tool had been introduced to provide a single view of those who were at most risk of a hospital admission.

- GP practices and federations aligned to ICCs were using the frailty index and maintained a register of people with complex needs; these were shared with colleagues across health and social care using a MDT approach. MDT meetings were held at varying intervals depending on need – from daily to twice weekly to weekly to discuss any emerging issues, review medication and to look at different approaches to avoiding hospital admission.
- The post of Health and Wellbeing Coaches (HAWCs) had been established in January 2017. The HAWCs operated county wide and could offer support to anyone 16 and over. Part of the role involved enabling people to stay safe at home. Referrals came from agencies across the system, though predominantly through the adult social care single point of access, people could also self-refer.
- The HAWCs told us there was some information sharing on risk with other agencies and they could access the local authority IT system to see if any risks had been flagged. They also received risk assessments from the referrer, and assessed risks through conversations with the person or the referral agency, documented on their own risk assessment document.
- Early data collected by the system about the outcomes for people who received a service from the HAWC service showed some early success. For example, prior to working with the HAWC service 37% of people were identified as being very lonely; after contact this had reduced to 16%, and the average number of people needing to visit a GP or nurse in the previous three months had reduced to 1.68 compared to 2.35 before working with the HAWC.
- Our analysis of HES data for October 2015 to September 2016 suggested that the rate of admissions from care homes in Cumbria was lower across a range of conditions usually deemed to be avoidable, including urinary tract infections, pneumonia and pressure sores.
- Day centre and care home staff knew people who used services well. They were responsible for identifying any signs of changes or deterioration in people's health and then contacting the necessary health support or care services to help prevent a crisis from developing. However, we were told there could be difficulties making referrals to the right services in a timely way as the process was bureaucratic.
- Cumbria Safeguarding Adults Board had made the delivery of a person-centred approach to safeguarding one of its key priorities in its strategic plan. The partnership had developed a guide for practitioners and user information guidance to support the effective delivery of Making Safeguarding Personal. At the start of an enquiry, adults were asked what outcomes they wished to achieve as a result of the safeguarding intervention; at the closure of the

intervention they were asked to comment on whether they believed these outcomes had been achieved. A further questionnaire was used to capture how involved and in control of the process they felt, through a series of specific questions. The responses were reported on a quarterly basis as part of the performance framework to aid learning and continuously improve the service. A person-centred approach to safeguarding helps ensure that people are kept safe and informs practice so that it can be more tailored to people's needs.

Are services in Cumbria effective?

Services had not been fully integrated across Cumbria and though steps had been taken to deliver services as a system with the setting up of the ICCs, further work was needed to make services easy to access, consistent and available seven days a week.

- Across Cumbria people who thought that they might need help and support were able to contact the single point of access which covered social care in their local area. This had different telephone numbers dependent on the area. The contact centres operated across the county and were available 9am to 5pm, five days a week with emergency duty cover available outside these times. Staff at the centres could signpost people or health care professionals to services or arrange for an assessment. We saw from records that, when people were assessed, they were assessed holistically.
- The vision outlined by system leaders for place-based care in local communities delivered by the ICCs, was already in operation though at different stages across Cumbria. For example, the East ICC, which incorporated six GP practices, held weekly MDT calls to discuss frail and complex patients to avoid admission to acute services where possible and this had proved successful. Other ICCs used the Electronic Frailty Index risk stratification process to identify and discuss frail and complex patients.

Are services in Cumbria caring?

People who received services that supported them to be maintained in their usual place of residence were given choices about how care and support was delivered. Most people at the end of their lives had advanced care plans put in place to give them more control over how care was delivered. Overall people in Cumbria were satisfied with the services they received.

- From 2011/12 to 2015/16 the percentage of people who said they felt supported to manage their long term conditions in Cumbria was similar to the average across comparator areas and performance was consistently better than the national average. In 2016/17, performance improved even further in Cumbria, with 69.5% of people saying they felt supported to manage their long term conditions, compared to only 64% nationally and 66.6% across comparators.

- Performance in Cumbria was consistently better than national and comparator averages between 2013/14 and 2016/17 in relation to the percentage of older people using adult social care services who said they were satisfied with their care and support. In 2016/17, 71% of people using adult social care services in Cumbria aged 65+ said they were satisfied with their care and support, compared to the national average of 62% and Cumbria's comparator average of 65%.
- Information we received from people who used services was positive overall about the degree of choice they were offered about how and where care was delivered. Staff told us choice was well embedded, was linked to the local community where people were based, and covered a wide range of wellbeing, health, care and community services that maintained people's independence.
- NCCCG leaders spoke about the increased success of advanced care planning for people at the end of their lives. At the time of our review, 55% of people who use services who were aged 65 and above in north Cumbria and who were at the end of their lives had their own plan in place. This showed that the system supported the end of life wishes of just over half of local people, to be in their usual place of residence.
- People felt they had choice about how much support they needed and this was reviewed regularly. There was evidence at MDT meetings observed of people and their families being involved in decision making.

Are services in Cumbria responsive?

Initiatives to prevent people attending A&E had had some success. GPs were conducting telephone consultations and patients could email about symptoms when they had concerns and a GP would call them back to discuss the issues they raised.

However, preventative services were not uniformly available on a Cumbria-wide basis; for example, in certain areas of Cumbria respite care was difficult to source meaning carers were under pressure, and in some situations this led to hospital admissions for the people they cared for. Also, there was a lack of clarity about the role of some services and confusion between managers and frontline staff regarding when and who could access the services, for example the primary care assessment units (PCAS).

- Analysis of extended access to GP appointments outside of core contractual hours (as at March 2017) indicated that Cumbria had a similar level of provision to its comparator average; however, provision was below the national average. Only 1% of GP practices surveyed in Cumbria said they provided full provision of extended GP access on weekends

and weekday mornings or evenings, compared with the England average of 23%. Full provision of extended hours of GP opening is not mandated until 1st October 2018. In addition, work was being undertaken through Cumbria Health on Call (CHoC) in south Cumbria to ensure access to primary care.

- Out-of-hours GP services were provided by CHoC across Cumbria. Out-of-hours GP services were accessed via the 111 service and telephone advice or a home visit service would be offered depending on clinical need. CHoC also ran the telecare service which had a dedicated care number for care homes and providers who needed to access support and avoid a crisis episode. This service was well received and the CHoC service was rated as outstanding by CQC in 2017.
- Seven-day access to services was patchy. There was seven-day access to district nursing and the adult social care urgent care service, but not to community physiotherapy and falls prevention services. BCF returns for 2016/17 indicated that Cumbria was not meeting the national conditions around agreement for delivery of seven-day services across health and social care to prevent unnecessary emergency admissions and facilitate transfer to alternative care settings when appropriate. This limited the extent to which people could receive the right treatment at the right place at the right time.
- Attendances at A&E by older people living in care homes in Cumbria had been consistently below the national average between 2014/15 and 2016/17 and had also been below comparator averages. In the final quarter of 2016/17 there were 713 A&E attendances per 100,000 population aged 65+ compared to the average across comparator areas of 905 and the England average of 979.
- Our analysis of HES data showed that the rate of emergency admissions of older people in care homes had been reducing over time. At the beginning of 2014/15 the rate in Cumbria was in line with comparator and national averages, however it had since reduced and been significantly lower than the national average in several quarters featured in our analysis, including the last quarter in 2016/17 where there were 399 emergency admissions per 100,000 aged 65+ compared to the England average of 713.
- The system had a commitment to implementing the changes identified in the high impact change model; however, these were at different stages of implementation. The Home First scheme had been established in south and north Cumbria and the enhanced health in care homes initiative which involved offering training to care home staff and a community matron buddy up with nursing and residential homes to offer support was again patchy across Cumbria.

- To prevent people attending hospital we saw some positive examples of GPs conducting phone interviews when face to face appointments were not available. People with concerns could email about their symptoms and a GP would call them back to discuss the issues raised. However, we saw examples where people could have stayed at home with support but this was not available.
- There was unequal service provision around falls in Cumbria. The Barrow in Furness area had no falls team or pathway. North West Ambulance Service (NWAS) told us there had been a “falls car”; a paramedic would attend an incident and refer on to the rapid response team. Funding for this service was withdrawn. Also there was no ambulance pathway for patients with a skin tear. Subsequently people were conveyed to hospital and then became part of the acute system instead of being treated at home and kept at home.
- There was a lack of clarity in articulating the role of PCAS and confusion between managers and frontline staff regarding the purpose of PCAS and when and who could access it. Staff were not clear about how different services could work together as a whole system and there was some tension between acute and community services. We were given an example of when primary care had been told they could not access the unit to deliver IV antibiotics; however, when the acute hospital in Carlisle needed additional bed capacity, the unit was opened. This meant that it was not always used in the best way to maintain people’s independence.
- People receiving end of life care could be referred by a GP, community nurse, specialist nurse or a hospice for a period of pain control or respite. They could then decide with the support of their family how they would like to receive the service going forward, either as an inpatient or from the hospice at home. However, any crisis after 5pm was difficult to manage in the community for people at the end of their lives as not all services were available out of hours. The availability of equipment was noted as a difficulty.
- In certain areas of Cumbria respite care for people was difficult to source meaning carers were under pressure, reaching crisis, and in some situations this was leading to hospital admissions for the people they cared for. The VCSE sector provided lunch clubs and home visits commissioned by the local authority. These often provided the only respite carers got and were very valued. There were some day centre places available – these were predominantly in more urban areas so rural users required additional transport.
- NHS continuing healthcare data from NHS England showed that in the first quarter of 2017/18 the uptake of personal health budgets in north Cumbria was just below the England average (with a rate of 4.93 per 50,000 in the NCCCG area compared to the England

average of 5.82), however uptake was slightly higher than the England average in the newly formed MBCCG area at 6.08 per 50,000.

- Uptake of direct payments in both CCG areas was slightly above the England average during this time period. ASCOF data also showed that Cumbria had a higher percentage of older people accessing long-term social care support in 2016/17 who were receiving social care direct payments than the national average. By supporting people to use personal budgets the system was supporting a responsive and personalised approach to people's needs.

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 Cumbria safe?

There were several initiatives to improve the experience and safety of people in a crisis, including assessing people more quickly and diverting them away from A&E. The integrated Home First team worked to avoid admissions to hospital and there were good relationships between paramedics and GP services, with GPs responding to paramedics when they were on site.

Information about the person using services was not always consistently transferred between health professionals. Lack of process and communication about discharges in some hospitals meant that ward staff did not have the full picture regarding discharge arrangements for older people.

- In crisis, treatment for people varied between north and south Cumbria. Morecambe Bay hospital dealt with people effectively. However, during our visits to several wards at Cumberland Infirmary it was evident from discussions that ward staff had minimal understanding of the people within their care. It was unclear how any risks were being identified and how concerns had been escalated to other members of the team, particularly the discharge team. Staff on the wards based treatment on printed handover notes but it was clear that their level of knowledge over and above this was limited. This meant that while basic nursing care needs were being met, staff on the wards were not managing patients' discharge from hospital proactively. They relied on the discharge team and there was a risk that communications with families and carers could be missed.

- At West Cumberland Hospital the A&E department had no designated area for people living with dementia. We were told of plans to make up to three cubicles more dementia friendly, including using colours to identify areas.
- At West Cumberland Hospital, we saw evidence that board rounds were still not focussing sufficiently on getting people home. Not all patients had an expected date of discharge noted on admission to hospital. Social workers no longer routinely attended the board round which had been the case before Christmas, however, the discharge navigators attend the board rounds daily and fed back to the social workers several times a day. Without effective board rounds, people who use services could be put at risk. There were several 'front door' initiatives used by the ambulance service and the A&E departments in Cumbria to treat people quickly and prevent them from being admitted to hospital. For example, following assessments, paramedics could refer people to the rapid response service. However, the lack of transport provision when people were ready to go home and the lack of equipment for people were delaying their discharges from hospital.
- The Home First service in Cumbria was established in summer 2015 to reduce admissions into hospital. This service was made up of a range of health, social care and voluntary sector workers and had reduced the number of people admitted to hospital from Cumberland Infirmary's A&E department. Between May 2016 and November 2016, data showed that 600 people, who would have been admitted into the Cumberland Infirmary from the A&E department, had been able to go home supported by the Home First service. 350 of these people then received additional support from the team. We received very positive feedback from staff and people using the service about the programme, showing that it had been effective in preventing unnecessary hospital admissions.
- Department of Health and Social Care analysis of emergency admissions for older people between September 2016 and August 2017 showed that the 90th percentile length of stay (the point at which 90% of people were discharged from hospital) in Cumbria was above 10 of its 15 comparator areas at 21 days. Our analysis showed that throughout 2015/16 the percentage of older people from Cumbria whose hospital admission for an emergency lasted longer than seven days was above England and comparator levels, however this had dropped during 2016/17 and by the last quarter of the year was in line with England and comparator averages at 32%.
- NHS England data on quarterly overnight bed occupancy rates in acute trusts showed that bed occupancy had reduced at both of the two main acute trusts serving Cumbria during 2016/17 (considerably so at UHMB, where occupancy had been at 96% in the first quarter of 2016/17). By the first quarter of 2017/18 overnight bed occupancy was below the England average at 85% in NCUH and 80% at UHMB.

- There were good systems in place for NWS to share any safeguarding concerns with the local authority. However not all staff in community hospitals were familiar with safeguarding procedures and did not always involve the local authority safeguarding team when investigating serious incidents.

Are services in Cumbria effective?

During a crisis, frontline staff demonstrated an awareness of assessing a person holistically, but a lack of digital interoperability impacted on how effectively they could share information with colleagues. There were multiple pathways available once a person was in crisis and work was required to increase staff understanding of different services to ensure the whole system was working effectively. A shortage of mental health provision was reported to us causing a strain on staffing and facilities within A&E departments in Cumbria which impacted on other patients.

- Our review of case files showed holistic assessments of people's needs and multidisciplinary input. However, there was a lack of knowledge of exactly what was involved in different professional assessments and why some would take additional time, particularly for best interests and mental capacity assessments.
- Services designed to improve flow through the health and social care system were evidence based. However, there were multiple pathways, provided by different staff groups and a lack of knowledge by staff meant they were not always being used effectively. Also, we saw a lack of forward thinking from some ward based staff at West Cumberland Hospital. For example, someone had been assessed as requiring support in a community hospital, a bed became available but the person was refused the place as they were on IV antibiotics. The next day the person's antibiotics were changed to being administered orally but the bed in the community setting was no longer available. This delay could have been avoided if medical staff had been consulted and the antibiotic route reviewed earlier.
- People in crisis could be routed to the Hospital at Home team or the acute assessment unit where they could be seen by a GP or advanced nurse practitioner, or referred to the frailty service to prevent their admission.
- It was recognised that work was required to increase staff knowledge of services available and what they could offer. Findings from our relational audit showed there was poor understanding of roles and responsibilities between different organisations.
- In A&E departments across Cumbria, older people with mental health needs were

sometimes delayed because they had to wait to be assessed. In Cumberland Infirmary A&E there was only one designated suitable area for older people living with dementia. PCAS also lacked space for people in a crisis, because there was a gap in mental health beds and services, and length of stay was a problem. This meant that older people with mental health needs often stayed in hospitals longer than those with purely physical problems.

- In Cumbria relationships between UHMB and CPFT demonstrated good partnership working. This was highlighted in the rapid response service and community care teams. There were some effective admission avoidance initiatives between the acute trusts, NWAS and GPs. In UHMBT discharge planning began on admission to hospital and all patients had an expected date of discharge.
- There was limited interoperability between records systems to allow staff to share accurate, real time information. Although there were plans in place to address this and staff reported it was better than it had been, it remained disjointed.
- The ambulance service reported that they had good access to GPs who would generally respond well to calls from paramedics. However sometimes GPs would not leave notes with the person after they had requested conveyance to hospital and the ambulance would arrive on scene with no information to refer to. The GP would make the referral direct to the hospital but this did not support the paramedic team on site who had no information and no access to records.
- While NHS England data showed that between August 2016 and July 2017 the proportion of 999 calls resolved with telephone advice by NWAS was in line with the England average, the proportion of 999 calls that were seen by an ambulance crew and managed without needing to be taken to A&E was consistently lower than the England average, at 32% in July 2017 compared to 38% nationally. This may indicate that there is an opportunity for more work to be done in relation to seeing and treating people on scene.

Are services in Cumbria caring?

Frontline staff did not always understand the importance of involving people and their families in decisions about their care. Case files we viewed documented the discussions had with people; however staff we spoke with were not always familiar with the contents. During our review some people and their carers told us that they were not always aware of what their plan of care was and were not part of the decision-making process.

- On speaking to staff and people using services at Cumberland Infirmary, it was evident that ward staff had minimal understanding of the plans for people in their care.

- There appeared to be a fragmented approach between ward staff and the Integrated Discharge Team.
- People were not always transferred to the community hospital nearest to their home as there was not always capacity to accommodate them there. To avoid longer unnecessary acute hospital stays referrals were made to more than one hospital.
- Although people's experience of care in Cumbria was similar to or better than national comparators, the choices of people receiving care and their families were not always considered and decisions were not always person centred. In the cases where this happened, lessening people's involvement in decisions about their care made them unequal partners in something very fundamental to them.
- There was variable involvement of families and sometimes where families had been involved in discussing plans for discharge from hospital, the nurse in charge of the area was not fully aware of what had been involved in these discussions.

Are services in Cumbria responsive?

People living in Cumbria did not always receive the right services during times of crisis because of delays in moving people from acute to non-acute care, sometimes due to a lack oversight and planning by staff. Triage took place on arrival to A&E and although both trusts did not meet the national performance indicator for people to be seen, treated and then admitted to or discharged from hospital in under four hours, performance had improved. There were some responsive community-based services, for example Home First and the rapid response team that were available for people to be referred to rather than being admitted to hospital, but these were not Cumbria wide.

- The NHS Constitution sets out that a minimum of 95 per cent of people attending an A&E department in England must be seen, treated and then admitted to or discharged from hospital in under four hours. This is one of the 'core standards' set out in the NHS Constitution and the NHS Mandate, and is often referred to as the four-hour A&E target. NHS England data for 2014/15 to 2016/17 showed that both acute trusts in Cumbria had consistently not achieved this target. In 2016/17 NCUHT saw 87.3% of their A&E patients within four hours and for UHMB it was 85%.
- The system's intention to move towards care being based in the community and preventing people being admitted to hospital was supported by the Home First policy and the rapid response service which was understood by frontline staff based in A&E across the hospitals

in Cumbria. Referral to these services by staff completing the triaging process was well embedded but services were not accessed in the same way Cumbria-wide. GPs could refer patients directly into the medical assessment unit at UHMB and NCUH meaning they would avoid an extended wait in A&E.

- When reviewing case records, we saw examples of when hospital discharge plans were not routinely started on admission in the north of Cumbria, though there was evidence of people's social circumstances being documented to support planning when discharge from hospital was started.
- Staff on the PCAS at Penrith had difficulty transferring people by ambulance when they had arrived at the department and then required onward referral to an acute hospital; this was usually to Carlisle in the north of Cumbria. Some people needing routine care had to wait for four hours or more to move to an appropriate care setting.
- Transfers of care from the wards at Cumberland Infirmary were delayed because of limited oversight by nursing staff and discharge teams. We saw examples of when people's discharge plans had been delayed, particularly those with complex or multiple needs who were outliers on wards not specific to their condition.

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 Cumbria safe?

Cumbria had a history of poor performance on delayed transfers of care. There were several system constraints to older people being discharged from hospital to the right place at the right time, which had not been resolved. Some people using services in north Cumbria were not discharged with the right information to ensure their safety. Readmissions were lower than the national average despite these risks. There was an inconsistent approach to providing mental capacity assessments and Deprivation of Liberty Safeguards documentation, which limited communication about the person's needs.

- Cumbria had a history of poor performance on delayed transfers of care. It had the highest rate of delayed transfer of care of any local authority in England between July and September 2017 at an average daily rate of 36.5 delayed days per 100,000 population aged

18+. Our trend analysis showed that delayed transfers in the county had been significantly higher than average since November 2015 with an increasing trend overall. Though analysis for November and December 2017 showed a reduction in delays compared to previous months, in January 2018 the figure rose again and was still significantly higher than the national average at 30.7 delayed days per 100,000 population aged 18+ compared to the national average of 12.

- The transfers of care process varied across the county. Community hospitals and care providers told us that transfers of care from Cumberland Infirmary appeared disorganised and sometimes happened late on a Friday afternoon. Discharge planning started early in Furness General Hospital and in NCUHT.
- Not all transfers of care from the hospital to the community in Cumbria were safe. In north Cumbria, we heard how the acute hospitals discharged people with new medications but without any instructions as to how to take them. Information about the transfer of care sometimes did not include essential details about how people could mobilise safely. Home care providers told us they spent considerable time finding out the correct information to ensure that people were safe. We also heard accounts of older people who were transferred out of hospital with cannulas left in, feeding pegs badly fitted, or discharged home with no support or without their discharge letter. Older people were not always signposted to relevant services after a major operation. These events made it more likely that the person would be readmitted to hospital with a related deterioration in their health and quality of life.
- We reviewed case notes at Cumberland Infirmary and West Cumberland Hospital. There was an inconsistent approach to ensuring that mental capacity assessments, Deprivation of Liberty Safeguards and best interests meetings happened, and these were not in place for some older people with mental capacity issues.
- Our analysis of HES data between April 2014 and March 2017 showed that the percentage of emergency readmissions (including those from care homes) within 30 days of transfer of care had been consistently lower than comparator sites and the England average since the beginning of 2015/16, and in the last quarter of 2016/17 was at 16% compared to 17% across comparator areas and 19% nationally.
- There was scope to improve communication around transfers of care in the north of the county. We heard of people being discharged from hospital to care homes or community hospitals in the early hours of the morning, without any communication in advance. We were told of failed discharges because care packages were not in place. Communication about reablement packages was sometimes ineffective for people who used services. Ambulance

crews told us that if this was the case, some older people would become anxious and ring 999. There was no risk assessment approach around this.

Are services in Cumbria effective?

Multidisciplinary discharge teams were effective in some places but not others. In Carlisle and Furness, key professionals did not always attend the meetings. The discharge navigator position was welcomed by nursing staff as helpful in ensuring flow, but was only funded in the short term.

Reablement resources were not used effectively because staff continued to give care after the initial reablement period. This limited access to reablement for people newly discharged from hospital. Where reablement services were delivered, they helped older people to live independently and to stay out of hospital.

The lack of interoperability of ICT systems and teamwork and communication issues generally made the discharge process more difficult and time consuming than it needed to be. However, local authority brokers for packages of care were beginning to work well.

- The quality of multidisciplinary processes around transfers of care varied. Some were effective, but at Cumberland Infirmary, medical staff often did not attend. Instead, doctors informed people that they were fit to be discharged from hospital, and told their families, sometimes without consulting nursing and therapy staff. This fell short of a holistic approach to transfer of care and considering all the person's needs.
- The system had schemes to facilitate transfers of care but in some cases, they were not fully embedded or permanent. In West Cumberland hospital, we heard about the role of the discharge navigator who completed the paperwork for a transfer of care, booked transport, talked to and made arrangements with family members. However, funding for these posts was short term and we did not see discharge navigators at all hospitals we visited.
- Data shows there is strong evidence that reablement services are helpful in leading to improved health and social care outcomes and value for money. However, in Cumbria fewer people benefitted from this compared with elsewhere in England. In 2016/17 only 1.4% of older people (65 and over) living in Cumbria received reablement or rehabilitation services upon discharge from hospital compared to the comparator group average of 2.2% and the England average of 2.7%. However, for the small percentage of older people who did receive reablement in Cumbria, it appeared to be beneficial because the proportion who were still at home 91 days after discharge from hospital was 85%, above the comparator and England averages of 82.

- In Cumbria, reablement resources were not always used effectively. Sometimes no alternative packages of care such as domiciliary care were available to be put in place after the initial agreed reablement period. Therefore, reablement staff continued to deliver the service as having no package of care in place would have posed a risk to the person in the community receiving the service. Staff told us this happened regularly. The system was not structured or well developed enough to prevent this happening. This meant the service was not available to people who were ready to be discharged from hospital.
- At Cumberland Infirmary, staff told us there was no consistent teamwork across the hospital to ensure that people were discharged in a timely way. Staff felt that the Integrated Discharge Teams did not work with wards effectively and did not visit the ward daily. The working process for the Integrated Discharge Team should ensure that they are fully aware of ward issues via the 8.30 huddle that is attended by all ward leads. This forum is used for the escalation of discharge issues that are then owned by the appropriate member of the MDT. The discharge navigator could not access social care IT systems. Ward staff are dependent on other departments which did not seem to be focusing on the same priorities. They told us that issues including waiting for tests such as MRIs and delays to continuing healthcare assessments were common reasons for delay. However, a process was in place to ensure that the radiology team proactively prioritised patients needing tests before discharge from hospital.
- Transfer of care related IT processes were time consuming. Community hospitals needed to use three IT systems (RIO, STRATA and EMIS) to book people in to their services. They had no access to acute IT systems, and they were concerned about the quality and safety of information received in written handover notes. There was a DNA CPR (Do Not Attempt Cardiopulmonary Resuscitation) alert system but information about new people using services was not always complete. Transfers of care were also complicated by the lack of information provided by the acute hospital to community hospitals, which meant nursing staff had to make phone calls to follow up. Domiciliary care providers told us important information about a person was not always passed on, for example around numbers of required staff or safeguarding. This put older people at risk.
- Feedback from our information flow survey supported this, since 40% of respondents felt hospital discharge summaries were only 'sometimes' or 'rarely' or 'never the case' sufficient for services to make a decision on whether they could support the placement. Responses were even less positive with regards to whether discharge summaries were accurate.
- Some aspects of the transfer of care process were becoming more effective. Working with

the local authority brokers for new packages of care worked well. This reduced some delays in parts of the county. Generally, domiciliary care providers received fuller care plans with more information on what the person's needs were.

Are services in Cumbria caring?

Choice was limited by shortages of domiciliary care workers and community beds. Shortages were more severe in some places than others which led to inequalities across the system. There was a backlog of 79 continuing healthcare outstanding checklists for review and determination of eligibility for movement to a decision support tool completion at the time of our review in north Cumbria, and the system was reviewing the process for this. The differing assessment conversion rates for this pointed to potential inequalities in access to healthcare funding.

- Choice was an aspiration rather than a reality for some people. This was mainly due to shortages of domiciliary care and other care for people in the community. For example, some people had waited several months for a package of three or four daily visits to be arranged. In addition, there was a scarcity of step down beds in the community.
- We saw examples at Cumberland Infirmary of when staff tried to discharge patients to any available community hospital bed. This meant that the person's preferences or the wishes of the family could not be met. Some community hospitals tried to ensure they only received people living locally so they were in familiar surroundings and near to relatives.
- Access to supported discharge for stroke patients was unequal across Cumbria. Supported discharge occurred in north Cumbria and existed as a pilot from Furness General Hospital, but did not happen in the South Lakes.
- Families were not always involved in discussions around discharge from hospital. We reviewed patient notes from hospitals across Cumbria and found little evidence of this. At Carlisle Infirmary, the nurse in charge could not give us complete information about care decisions or action taken about discharging patients, meaning they could not act as the patients' advocate.
- System leaders acknowledged that the assessment process for CHC was serving people poorly. This was particularly in the NCCCG area; the CCG was conducting a long-term review of its processes. In the meantime, there was a risk that the assessment process was not applied consistently or fairly. There was also a backlog of 79 outstanding checklists for review and determination of eligibility for movement to a decision support tool completion in the north of the county at the time of our review. These delayed assessments would have been a source of anxiety to people waiting for assessment and their families and carers.

- Local people did not appear to have equal access to continuing healthcare funding. NHSE data for the last quarter of 2017 showed that the assessment conversion rate for standard NHS CHC was lower than the England average of 31% for both CCGs. For MBCCG, it was 24%; however for NCCCG it was a lot lower at 9%. Fast track conversion rates were at 100% for both CCGs. Referral conversion rates for standard NHS CHC were also a lot lower for NCCCG at 9% compared with the England average of 25%. For MBCCG, this was only slightly lower at 24%.
- The views of health professionals sometimes delayed independent living. For example, we reviewed one set of case notes which included a referral for the person to the Copeland Unit for rehabilitation. Case notes showed that reablement at home was not considered, although the person was only just 65. We were told that therapists preferred to keep people on the unit to reduce risks.

Are services in Cumbria responsive?

The process of returning home or to a new setting was not responsive for some people and this was due to awaiting placements or care packages, or awaiting assessment. There were delays in completing CHC assessments across Cumbria. The most significant delays in discharges were from North Cumbria University NHS Trust and the community hospitals. The most recent figures for November 2017 showed an improvement but it was unclear if this was sustainable without fundamental problem solving and a system wide approach. There were signs of an improved oversight of delayed transfers in pockets of the system, which was driving more timely discharges from hospital, particularly in the Morecambe Bay area.

Seven-day working was not implemented across the system and this limited the extent to which organisations could integrate.

- Processes for discharges from hospital in Cumbria were not timely and when we conducted our review, Cumbria had the worst DTOC rate in England. November 2017 data showed that although there was an overall downward trend in DTOC across Cumbria, the south of the county appeared to be making better progress. However, both the north and south were not achieving the trajectories in their BCF plans and were significantly worse than their neighbours and other local authority areas.
- NCUHT was the main acute hospital provider contributing to delays, although CPFT contributed a similar number of delays. A much smaller number of delays were recorded at UHMBT.

- The delays were due to three main reasons. Between July and September 2017 (the time period used in the Department of Health analysis used to select areas for this review) the largest proportion of Cumbria's delayed transfers of care were attributed to social care provision, equally to 'awaiting residential or nursing home placement', and 'awaiting care package in home or community or adaptations'. The next main cause of delayed transfers of care was 'awaiting assessments'
- We were told by frontline staff in north Cumbria that people were waiting in hospital for CHC assessments. NHSE data for the first quarter of 2017/18 showed that the proportion of CHC decision support tools completed in an acute setting was 14% within NCCCG. This figure was much higher in MBCCG at 28% although this was not much higher than the England average of 27%.
- Although recent DTOC data for November 2017 did show a reduction in delays, it is not clear whether these initiatives were sustainable or effective in improving flow or how they have stood up to winter pressures.
- Improved oversight of delayed transfers in pockets of the system was driving more timely discharges from hospital. UMBHT had a system of meetings to monitor DTOC. There was a meeting every two hours to determine action needed, supported by real time technology and an escalation process. We also heard that acute hospitals within the system were implementing a system of 'red and green days' to monitor DTOC and using a trusted assessor approach to facilitate discharge.
- People were not always treated in the right place at the right time to optimise discharge from hospital. Some people who were transferred out of their designated ward due to demand for beds did not necessarily receive the best treatment to facilitate their fitness to return to their usual home. We heard how in Cumberland Infirmary, people were sometimes transferred to a different ward for a few days and only received personalised treatment when they returned to their original ward. All patients who are transferred received a daily senior medical review. This was inequitable and had the effect of delaying discharge more than if the person had remained in the most suitable ward.
- The system approach to seven-day working was not cohesive. Acute hospitals were trying to discharge people seven days a week, but many care homes would not accept transfers of care over the weekend. This was because they did not receive full details of the person's issues and were not aware of how to access mental health support over the weekend. Other information flows did not always work smoothly. The single point of access carried out the adult social care assessment for reablement, but only worked Monday to Friday. There were

some electronic referrals happening on a 7 day basis but these were limited. This slowed the process down at a key stage. The reablement service operated seven days a week and told us they were busy at the weekends.

- Better Care Fund returns for 2016/17 indicated that Cumbria was not meeting the national conditions around agreement for delivery of seven day services across health and social care to prevent unnecessary emergency admissions and facilitate transfer to alternative care settings when appropriate.

Maturity of the system

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

- There was a high level, system wide vision for the provision of health and social care in Cumbria. However, the county was part of two separate STPs and two separate CCGs. There was a definite divide between approaches to delivery in the north and south of the county. Although the development of the ICCs was seen as a positive step in delivering place based care there were significant variances in implementation and development that led to an inconsistent experience and sometimes poor quality experience for local people.
- The Health and Wellbeing Board (HWB) had an overview, which included the financial governance of the Better Care Fund (BCF). The two Integrated Health and Care Systems have both invested in system structures in order to implement specific system based programmes such as ICCs, co-production and engagement, supported by their own system-wide programme management structures, performance monitoring and risk management arrangements. The HWB had not undertaken a formal review of its governance needs and it, in conjunction with the IHCS, needs to develop more robust oversight mechanisms, so that it can gain demonstrable assurance that the outcomes of the Health and Wellbeing Strategy are being delivered.
- There was a commitment to partnership working and evidence of positive relational working among system leaders in the county of Cumbria. Recent system changes including the creation of STPs and reorganisation of CCG boundaries had affected partnership working. However, relationships were improving and we saw some examples of strong leadership tackling some deeply rooted issues.
- Within the county, there were two nested systems in the north and the south, which meant there were some missed opportunities to develop a common approach and share learning. The development of the ICCs was a positive step towards integration. Nevertheless, this had not yet resulted in true service integration or a joint strategic approach to commissioning and provision.
- There remained some longstanding cultural challenges between organisations and these need to be addressed if true service integration is to be achieved. Organisational development work was required to engage and include all staff groups and ensure that staff were clear about their contribution and the direction of travel. In addition, further work was required in respect of public engagement as this was inconsistent across the county.

- There was a traditional approach to shaping the health and social care market. System leaders need to be more innovative and work inclusively with the local care market, recognising the important role the independent care sector plays in service provision. The independent sector was fragile in Cumbria and there were quality concerns both in residential and domiciliary care that required a proactive approach. In addition, the desired shift to prevention-based services had not led to any analysis of independent sector provision. A joint strategic approach to managing the care market was required to ensure a responsive and sustainable service provision.
- There were no arrangements in place to demonstrate where investments and benefits were balanced between partners. Establishing new shared working arrangements was partially based on the BCF being focussed on ICCs. There was short term spend on winter planning allocated to bolstering capacity, particularly for intermediate care to get people out of hospital in cases where they were not completely fit to return home. However, major elements of the integration agenda were focused on redeploying existing base budgets. More work was required to ensure that sustainable financial arrangements to support integration were in place.
- The two IHCS had started work to focus on aspects of workforce planning, however it was recognised that progress to date had not resolved the key challenge of ensuring that a suitably skilled workforce was available in sufficient numbers to meet the needs of people across the county. A strategy for the medium to longer term was required. However, there were examples where significant progress had been made in areas such as A&E consultant positions in the north of Cumbria.
- There was a lack of system-wide digital interoperability across the county. Information technology system incompatibility frustrated frontline staff in their efforts to deliver person-centred care and share information electronically when discharging older people from hospital. Professionals told us that in MDT meetings there were as many as four IT systems to navigate depending on stakeholders attending. Health professionals spoke of a rich vein of social care information that they were unable to access and social care colleagues expressed similar frustrations about tracking older people once they were admitted to hospital.
- There was a shared commitment towards the prevention agenda and we saw some good examples of MDT working in the ICCs and positive work to prevent hospital admissions as well as good primary medical services, including out-of-hours (CHoC). In addition, we saw responsive advanced care planning for people at the end of their lives and a growing use of the frailty pathway. However, initiatives were at different stages of implementation and the development of an asset-based approach was underdeveloped in some areas.

Areas for improvement

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

- System leaders within Cumbria must work together to develop implementation plans for delivery of their county wide strategy. The implementation plans should include agreed joint outcomes and financial protocols, relevant ICT support, a communications strategy and a co-production approach to ensure that feedback from local people results in changes to delivery intentions.
- System leaders should develop a coherent health and social care workforce strategy for Cumbria to work in synergy with financial, housing and transport strategies.
- System partners should develop risk sharing and governance mechanisms to measure whether they are using resources in the best way possible to achieve intended outcomes for people in Cumbria.
- System leaders within Cumbria should develop robust governance arrangements for implementation within the ICCs, which include a monitoring and review structure, defined roles, responsibilities and accountabilities.
- System leaders should develop system-wide commissioning arrangements, including market shaping.
- System leaders should work with people who use services, carers, VCSE organisations and independent care providers to co-design services.
- System partners should extend GP hours so GPs are more accessible for local people.
- The system should review reablement provision and services across Cumbria.
- The system should review continuing healthcare assessment processes to ensure assessments are timely and there is equality across Cumbria.
- Cumberland Infirmary should ensure that staff communicate relevant and reliable information to partner organisations when people are discharged from hospital, for example ensuring that discharge summaries are comprehensive and using the red bag system.