

Northamptonshire

Local system review report Health and Wellbeing Board

Date of review:
9 – 13 April 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. We have also published a national report for government that brings together key findings from across the 20 local system reviews.

The review team

Our review team was led by:

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

The team included:

- Chief Inspector of Primary Medical Services and Integrated Care
- One Deputy Chief Inspector of Primary Medical Services and Integrated Care
- Head of Public Engagement
- Three CQC reviewers

- Two assistant reviewers
- One CQC strategy lead
- One adult social care inspection manager
- Two CQC pharmacy inspectors
- One CQC Expert by Experience; and
- Six specialist advisors; one chief executive of a local authority, one clinical commissioning group governing body member, one former director of adult social services, one head of adult care and support services, one former director of social care, one former national director of health and social care improvement programmes.

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

- Senior leaders and managers from Northamptonshire County Council (the local authority), NHS Nene Clinical Commissioning Group and NHS Corby Clinical Commissioning Group (referred to collectively in this report as the CCGs), Kettering General Hospital NHS Foundation Trust, Northampton General Hospital NHS Trust, Northamptonshire Healthcare NHS Foundation Trust and East Midlands Ambulance Service NHS Trust.
- Health and social care professionals including social workers, GPs, discharge teams, therapists and nurses and paramedics.
- Healthwatch Northamptonshire and voluntary, community and social enterprise sector representatives.
- Representatives of health and social care providers.
- People using services, their families and carers. We also spoke with people in A&E, elderly care wards and the discharge lounges of both trusts and during visits to intermediate care facilities.

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

The Northamptonshire context

Demographics

- 15% of the population is aged 65 and over
- 91% of the population identifies as white
- Northamptonshire is in the 20-40% least deprived local authorities in England

Adult social care

- 190 active residential care homes:
 - Four rated outstanding
 - 157 rated good
 - 17 rated requires improvement
 - 12 currently unrated
- 63 active nursing care homes:
 - 45 rated good
 - 11 rated requires improvement
 - Two rated inadequate
 - Five currently unrated
- 153 active domiciliary care agencies:
 - Two rated outstanding
 - 90 rated good
 - 12 rated requires improvement
 - 49 currently unrated

GP practices

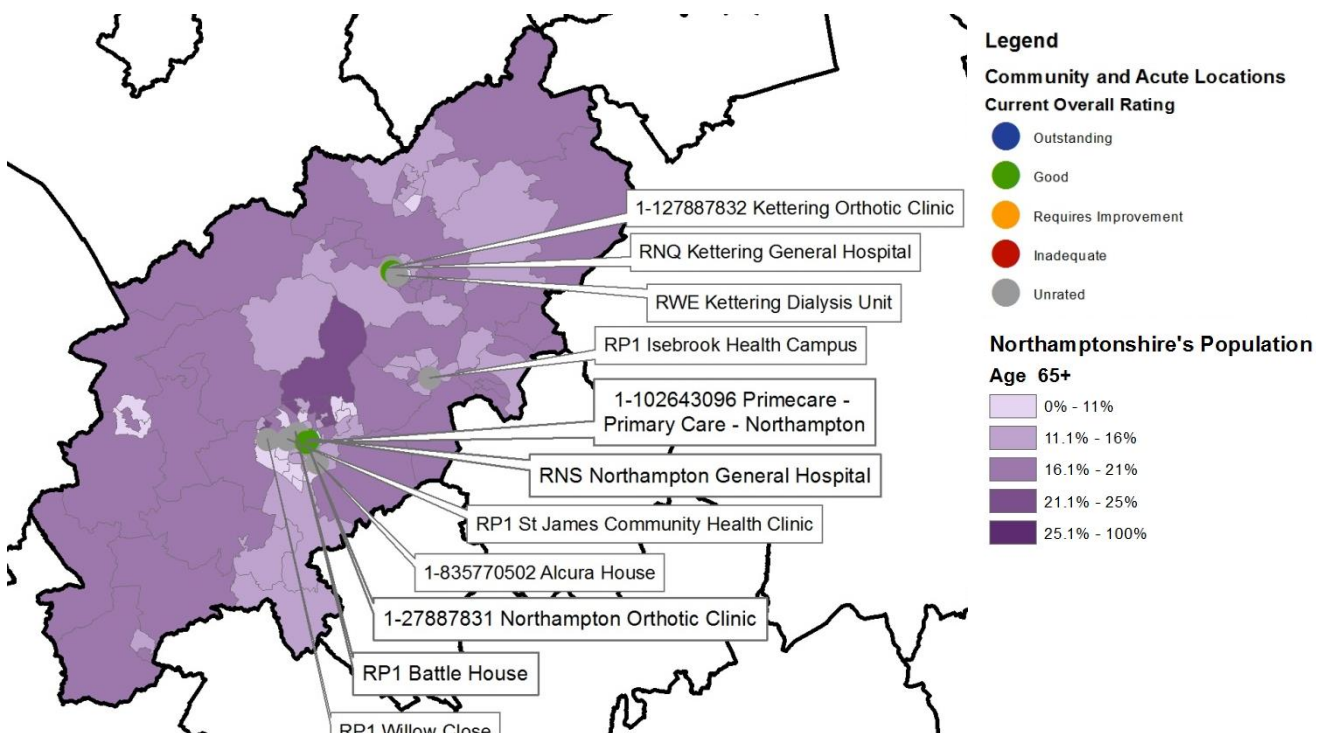
- 79 active locations:
 - 2 rated outstanding
 - 64 rated good
 - 7 rated requires improvement
 - 6 currently unrated

Acute and community healthcare

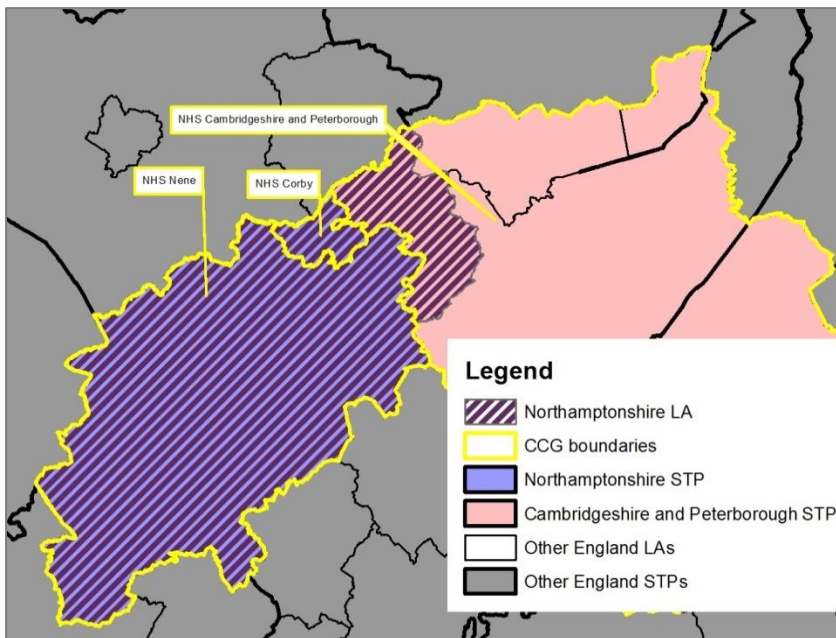
Hospital admissions (elective and non-elective) of people of all ages living in Northamptonshire were to the following NHS acute hospital trusts:

- Northampton General Hospital NHS Trust
 - Received 45% of admissions of people living in Northamptonshire
 - Admissions from Northamptonshire made up 96% of the trust's total admission activity
 - Rated good overall
- Kettering General Hospital NHS Foundation Trust
 - Received 39% of admissions of people living in Northamptonshire
 - Admissions from Northamptonshire made up 92% of the trust's total admission activity
 - Rated requires improvement overall
- Community services were mainly provided by Northamptonshire Healthcare NHS Foundation Trust, rated good.

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



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



Map two, left: Location of Northamptonshire LA within the Northamptonshire STP as well as Cambridgeshire and Peterborough STP.

Nene CCG, Corby CCG and Cambridgeshire and Peterborough CCG are also highlighted

Summary of findings

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

- There were significant barriers to progressing a shared vision and strategy for integrated health and social care. These included severe financial pressures, and a history of siloed working and poor relationships between organisations.
- While there was a strategy for integrated, community, place-based care, arising from the Sustainability and Transformation Partnership (STP), this had not been developed into a single, coherent vision for Northamptonshire which could be clearly articulated by all staff. There was not a shared use of language by staff across the health and social care system to describe the strategic direction for the future; demonstrating plans were at an early stage of development and often remained at organisational level.
- The recently reset STP plans had not been translated into a local deliverable plan for Northamptonshire. However, system leaders were all clear that the STP was the vehicle by which to deliver their objectives.
- Northamptonshire's health and social care system was in the embryonic stages of integration. However, with the resetting of the STP plans and some new leadership roles in place there was renewed optimism and commitment from system leaders that the transformation agenda would drive significant changes to better meet the needs of people living in the county.

Is there a clear framework for interagency collaboration?

- There was not a clear framework for interagency collaboration. It was widely acknowledged that relationships had been challenging and a barrier to change. Recent changes in the system, including a renewed focus on the STP and some new senior appointments across the system, had created a renewed sense of motivation which was a positive step. However, in order to sustain and drive forward the necessary organisational changes there needs to be good quality support in place for leaders.
- There were still a significant number of uncertainties within the system which could severely

test the professed unanimity of purpose. The recent developments at Northamptonshire County Council following the Best Value inspection report¹ and the appointment of two Government Commissioners, had led to further concerns about the availability of resources to address some key issues in relation to collaborative working.

- Aside from the Better Care Fund (BCF), there were limited examples of pooled budgets in place for the delivery of services across the health and social care interface for older people. Although there was a will to work together and examples of collaborative working at a system level, there was a lack of truly integrated commissioning arrangements at the time of our review.
- In the past governance arrangements had an organisational rather than system focus. However, as part of the resetting of the STP, governance structures were aligned with the STP vision and provided a more solid foundation for promoting collaborative working.
- While individual organisations had risk management processes in place and a shared view of system-level risks was emerging, there was not a single, coherent risk register for the system. Northamptonshire faced significant financial pressures and despite leaders showing a willingness to work together to address them, there was not a full understanding of the financial position between health and social care. Risks were spoken about in the context of health or social care, rather than a system wide context.

How are interagency processes delivered?

- The challenge for the Northamptonshire's health and social care system was to push forward with its transformation agenda while also delivering improvements in the flow between services to ensure people were cared for in the right place, at the right time, by the right person. This all needed to be achieved within a framework of significant financial constraints and external regulatory oversight and scrutiny. While there had been some improvement in performance shortly before our review, including a reduction in the numbers of delayed transfers of care, this was from a low base and the system's ability to sustain and build on improvements remained uncertain.
- There was opportunity for the system to implement and embed more of the high impact change model, (the suggested national model for the management of transfers of care), across the system, including seven day services and the use of trusted assessors.

¹ *Northamptonshire County Council best value inspection* published 15 March 2018:
<https://www.gov.uk/government/publications/northamptonshire-county-council-best-value-inspection>

- The role of the Health and Wellbeing Board (HWB) as a forum for system leadership was not being fully met. The relationship between the STP and the HWB needed to be reviewed and strengthened to ensure the HWB was holding the system to account on behalf of the people of Northamptonshire. We were told that this was being addressed at the time of our review.
- There were some good examples of multidisciplinary team (MDT) working within parts of the system, for example the Crisis Response Team, Short Term Assessment and Reablement Team (START) and the Intermediate Care Team. However, further work was needed to reduce duplication of efforts and to evaluate and upscale those MDT services that had the biggest impact on improving the flow of people through the health and social care system.
- Mechanisms to engage with wider system partners, including health and social care providers and voluntary, community and social enterprise (VCSE) sector organisations needed to be strengthened. At the time of our review, there was limited evidence to demonstrate how VCSE organisations were involved in developing strategic commissioning intentions and those we spoke with felt they were underutilised. It was widely recognised by system leaders that they needed to work more proactively with the VCSE sector

What are the experiences of frontline staff?

- Frontline staff were committed to delivering high quality and person-centred care. However, there was a risk that because of prolonged working in health and care settings where there was continued sub optimal performance in areas such as delayed transfers of care from hospital, staff expectations would lower and sub-optimal performance would become normalised and accepted.
- All staff we spoke with agreed that integrated working was the way to improve services for people and enhance their own working arrangements. However, most frontline staff were not engaged in or able to articulate the long-term strategic vision for the Northamptonshire's health and social care system.
- We found examples of staff working well in an integrated way to improve outcomes for people, such as through multidisciplinary discharge teams. However, most staff on the front line were working towards their own organisation's targets and performance measures which created barriers to integrated working.
- There were significant workforce pressures in a number of health and social care disciplines across services. This was having an impact on areas such as the number of unallocated social care cases and Deprivation of Liberty Safeguards referrals.

What are the experiences of people receiving services?

- Older people in Northamptonshire had a varied and sometimes unsatisfactory experience of health and social care services. While there had been some improvements shortly before our review, people were not always seen in the right place at the right time by the right person.
- There was a dedicated VCSE sector that provided older people, people living with dementia and carers with support, information and advice.
- If an older person living in Northamptonshire went into crisis and was admitted to hospital, data showed they were more likely to experience longer lengths of stay. People's experience of being discharged from hospital was not always timely or person-centred.
- Data showed that people who lived in care homes in Northamptonshire were at a greater risk of avoidable conditions such as urinary tract infections and of being admitted into hospital, than people living in similar areas.
- There was not a systematic and joined up approach across the county to using feedback from people, their families and carers, or to public involvement in the development of strategy and services.

Are services in Northamptonshire 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.

There were some significant barriers to the progress of the transformation agenda in Northamptonshire including poor relationships, financial constraints, issues of capacity in the acute trusts and the adult social care market, and imposed changes in the structure of the Northamptonshire County Council. The government had appointed commissioners to oversee financial management activity in Northamptonshire County Council and made a recommendation for the local authority to be replaced with two unitary authorities.

However, we were told that there was a commitment across system partners to deliver integrated health and social care, and this was supported by a clear strategy arising from the

recently reset Sustainability and Transformation Partnership plan. However, how this approach translated into a vision for better outcomes for the people of Northamptonshire was less well articulated and work was needed to embed it across the system.

Strategy, vision and partnership working

- In January 2018 the Secretary of State for Housing, Communities and Local Government appointed inspectors to undertake an inspection of Northamptonshire County Council's (NCC) compliance with the requirements of Part I of the Local Government Act 1999 in relation to the authority's governance functions, particularly those functions under Section 151 of the Local Government Act 1972. This was due to Northamptonshire County Council having failed to comply with its duty to provide best value in the delivery of its services. In the light of their findings the inspection team recommended the creation of two new unitary authorities; one covering the areas of Daventry, Northampton and South Northamptonshire and the other encompassing Corby, East Northamptonshire, Kettering and Wellingborough. It was recommended that these should be established following elections to be held in May 2020. It was also recommended that government commissioners be appointed to take over functions associated with NCC's financial management and budgetary control. Subsequently two commissioners were appointed in May 2018. The local system review had initially been paused due to the serious issues identified for NCC.
- At the time of our review the Health and Wellbeing Board (HWB) had no chair and there was some dissension about who the new chair would be. We were not assured that the HWB was acting as a system leadership forum or had the necessary strategic oversight. The HWB needed to use the opportunity of appointing a new chair to refresh and reframe the board as the place where system leaders came together, at a strategic level, to lead and influence a whole system approach to service transformation and delivery.
- This was supported by the Sustainability and Transformation Partnership (STP) lead who told us they were keen to work with the HWB to review their role and function in relation to the STP and suggest ways it could add value to the transformation agenda. There was a plan to review the terms of reference of the HWB with the Director of Public Health. As part of these plans the STP lead had given a presentation to the HWB outlining the main issues that needed to be reviewed, such as membership of the board, role of the chair and managing differing priorities.
- System leaders acknowledged that effective partnership working and a strong vision was integral to improving health and wellbeing outcomes for the people of Northamptonshire. We were told that, historically relationships between organisations had been poor. The system leaders we spoke with were open in their view that this had led to siloed working and a fragmented system with sub-optimal performance. There had been some recent changes to

the system leadership together with changes to the STP plan; relationships were reported to be improving as a result.

- In December 2016 the Northamptonshire health and social care system published its five year STP plan to reshape and improve the way that care was delivered within the county. However, this plan was subject to criticism from NHS England (NHSE). Subsequently the planning process was paused leading to the appointment of a new STP lead in September 2017 and an agreement to undertake a STP reset process. This reset process included developing a more clearly articulated STP vision, rebranded as the Northamptonshire Health and Care Partnership strategy, through a shared governance framework underpinned by an agreed set of principles. These principles included delivering improvements in the quality and integration of services and focusing on outcomes and prevention. Since the reset of the STP, performance against the metrics used by NHSE to measure its effectiveness had improved and there had been positive feedback from NHSE in this regard.
- We found that the STP plans were aspirational with a strong focus on collaborative working. There were key work streams in areas such as operations, finance, and frailty but they were all at the very early planning stages.
- Most system leaders reported that there was greater optimism about the STP's potential for success at the time of our review. However, there was a risk that, given the number of major immediate pressures in the system such as the financial constraints and the plans for restructuring the local authority, the system leadership would not be able to move away from past behaviours of siloed working and focus on what was required to deliver the transformation in an integrated way. The STP lead was aware of the risks but was optimistic that given the necessary support and a focus on developing aligned values and behaviours, system partners could move forward with the integration agenda.
- The Northamptonshire Joint Strategic Needs Analysis (JSNA), developed by Northamptonshire HWB, reflected the principles of the STP strategy and was aligned with the HWB strategy for 2016 to 2020. The JSNA was updated on a three year cycle.
- The JSNA contained a specific section for older people entitled 'Older People's Needs Assessment'. This summarised some of the key challenges for Northamptonshire, which included; delayed transfers of care from hospital, shortages of residential care provision and the limited nature of housing options across the county. The document was largely descriptive in nature setting out the variations for older people across the county based on their place of residence with some analysis against statistical neighbours. The data used appeared to be drawn from 2013 to 2014 with some data, (for example the emergency

readmissions within 30 days of discharge information), dating back to 2011/12. It was acknowledged by system leaders that the JSNA needed to be strengthened and updated with regards to frailty, dementia and the needs of the older population. We were told that the sections in the JSNA related to lifestyle factors most responsible for disease burden were being refreshed as a priority, and that there would be a clear and updated analysis of the needs of people aged over 65.

- Some system leaders expressed concern that the vision for Northamptonshire's health and social care system was still not strong enough to drive the changes needed. In response to this we were told by the STP lead that the next step would be to engage staff in the vision for the STP. They reported that the foundation of a more robust STP had needed to be put in place, together with addressing the values and behaviours of the leadership teams, before they could focus on sharing with, and engaging staff in, a well-articulated vision about the transformation agenda.
- We saw evidence of a good aspiration to improve outcomes for local people through an integrated health and care agenda. However, we found that there remained a lack of trust between organisations, in particular between providers and commissioners, which was hampering progress towards system integration. This was supported by our relational audit which found that some staff felt the system was reluctant to take risks to serve wider system goals.

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

- Engaging people and system partners living in Northamptonshire in a meaningful way was seen by system leaders as a vital part of producing effective service improvement and system transformation. However, there was limited evidence of people's engagement and involvement in developing Northamptonshire's strategic approach to managing the quality of the interface between health and social care. System leaders agreed that more could be done in terms of public engagement.
- In response to the System Overview Information Request (SOIR), system leaders stated that the local authority's adult social care department utilised a wide range of customer and service user groups who informed service provision and future strategy. Engagement across acute healthcare services involved the voluntary sector, charitable organisations and Healthwatch Northamptonshire, with events within local communities across various towns which informed service planning.
- System partners agreed that committing to meaningful co-production helped to provide a greater sense of ownership among people using services which could in turn help moderate

demand for healthcare resources. However, Healthwatch Northamptonshire told us that genuine public consultation and co-production in the strategic approach was very limited. They reported that people were sometimes having plans imposed on them rather than any real consultation taking place; for example, the stroke pathway had been developed without any engagement with the Stroke Association. This was a missed opportunity for meaningful consultation and meant that there was a risk services may not be fit for purpose or as effective as they could be.

- Healthwatch Northamptonshire also informed us that their ability to support key engagement activities with the public was limited given that their funding had been significantly reduced.
- Some evidence of a more robust approach to engagement was provided by Corby Clinical Commissioning Group (CCCG), with regards to Corby Urgent Care Centre. Although no formal consultation took place, activity to gather the opinions of the public around shaping their urgent care service included presentations to community groups, website and social media content and a presence in public places with a high footfall. It was acknowledged by CCCG that the residents of Corby expressed strong support for retaining as much of the urgent care facility as possible. Therefore the decision was made to preserve the core function but change to an appointment only service. There was an opportunity for the system to ensure that the learning and success from this form of public engagement was built upon when designing the future health and social care landscape to ensure service design reflected the views of the local people.
- The local authority undertook an annual survey of how people felt about services, the quality of care received and how the care made them feel. It reviewed the results to inform annual planning and improvement cycles. Data from the Adult Social Care Outcomes Framework (ASCOF) measuring over 65 service users' overall satisfaction with adult social care and support showed that in 2016/17 people over 65 living in Northamptonshire were scoring slightly lower than most comparator sites but in line with the England average for satisfaction.
- There was some evidence of good carer engagement around shaping the carers' strategy through the Interagency Carers Partnership. The chair of the partnership told us that their monthly meetings were attended by staff from health and social care along with carers. The focus of the group was co-producing the carers' strategy. However, we were told that getting the right membership from the statutory bodies had been challenging and although elected members of the council had attended they were, "not necessarily the decision makers".
- As part of the STP a new Collaborative Stakeholder Forum had been developed. This comprised representatives of a wide group of community organisations. The focus of this

forum was to develop frameworks for public engagement. System leaders told us there were plans for this forum to be jointly used by the Health and Wellbeing Board so that public engagement links were formed across both bodies. However, this forum was relatively new and therefore its impact on improved public engagement could not be evaluated at the time of our review.

Promoting a culture of inter-agency and multidisciplinary working

- There had not been a history or culture of joint working or interagency collaboration across the health and social care interface in Northamptonshire. There had been little evidence of cooperation between primary care services and the acute trusts and joint working between commissioners and providers was also under developed. System leaders acknowledged that services and commissioning had historically been fragmented and relationships poor.
- In the past health and social care plans had gained little or no system-wide traction and therefore had limited impact. This seemed to be a reflection of the lack of trust and cohesion among senior leaders and between organisations, which was still in evidence during our review.
- We were told that there was, at the time of our review, more of a drive towards greater interagency and multidisciplinary working, but in practice this was embryonic. The STP lead told us that agreeing a set of principles, values and behaviours as part of the reset of the STP was key to promoting a more collaborative way of working.
- System partners reported that although integrated meetings were being held regularly through the STP, these were not translating into integrated operational delivery and organisations remained focused on their own priorities. This was exacerbated by a perceived lack of understanding of the differences between the local authority and health colleagues with regards to pace of change and working with elected members. While we found that some joint working had been undertaken, for example the joint contract for community equipment; this area needed further strengthening and commitment.
- System partners acknowledged that in the past there had been a lack of transparency between organisations, creating some blockages to agreeing mutually beneficial plans. This was corroborated by our discussions with system leaders about winter planning. In 2017 the system had not undertaken winter planning in a coordinated way. Each organisation had developed their own plans and then submitted them individually. These plans were then assimilated into a whole system plan without any cross-organisational input or challenge. However, the system aspired to take a more joined-up approach to winter planning. We were told that in 2018 system leaders had established the Urgent Care Working Group where the development of winter plans would be coordinated as a whole system.

- Further progress towards an integrated way of working could be seen from the recent instigation of weekly chief executive officer (CEO) meetings. This was attended by CEOs across the health and social care system. The aim was to provide a cross organisation forum to discuss and manage escalations and reflect and act on system priorities through a joined up approach. System leaders told us that this had resulted in messages being consistent and a more supportive culture. The chief operating officers from across the system also met weekly. Both groups provided an operational focus for tackling issues that arose and allowed for visibility of each other's pressures. This encouraged shared understanding and commitment to solutions.
- The chief executive of East Midlands Ambulance Service NHS Trust reported that operational interactions and relationships were excellent between their operational managers and managers in the acute trusts; we were told that their clinical and quality managers were well integrated and seen key partners in redesigning care pathways.
- While relationships were improving at the system leadership and management level, the impact had not been felt on the front line. Frontline staff we spoke with across the system reported that there was a lack of integrated working between secondary and primary healthcare and social care services. Staff told us that although there were some good relationships, for example between district nurses and the community mental health team, they were all aware that each group had different budgets and the component parts of each organisation had different processes. This led to different agendas and priorities. They reported that the impact on people could be seen through unsatisfactory outcomes such as a lack of timely support. For example, the Intermediate Care Team reported that, as they did not have direct links to the local authority and no longer had a care manager working in the team, they found it challenging to establish who was offering what element of what service at any given time. This could lead to delays organising the right support for people.

Learning and improvement across the system

- System leaders told us that historically there had been a fragmented, individualistic approach to learning and improvement, based within separate organisations rather than across the system as a whole.
- The A&E Delivery Board scrutinised performance in relation to flow through the system. Meetings were attended by system leaders across health and social care, but indicators used to measure performance were traditional and activity-focused rather than outcome-focused.
- Due to concerns around Northamptonshire's health and social care performance, the system had been the subject of some external reviews, such as the Emergency Care Improvement

Programme (ECIP), which provided a clinically led programme offering practical advice and support to improve patient care and flow. The ECIP identified, through a system wide gap analysis of the system, what the system should focus on to realise improvement; this included the interface between hospital admission and discharge.

- A business management consultancy company had also been commissioned by NHS England to identify and help address some of the key concerns around the flow of people through Northamptonshire’s health and social care system. At the time of our review the initial diagnostic had been completed. This had led to the identification of some key areas for focus, which included:
 - Capacity planning
 - Delayed transfers of care from hospital caused by waiting for a decision
 - Duration of social care assessment in community setting.

The consultancy team told us that after developing action plans the next stage would be supporting the system through implementation planning. It was their intention that recommendations arising from our review would feed into the action planning.

- System leaders told us that they had established a Discharge Quality Assurance Board that reviewed any issues related to unsafe discharges from or readmissions to hospital, to ensure that as partners they understood what went wrong and where they could improve. However, this was a relatively new board and therefore the impact could not be measured at the time of the review.
- More evaluation and sharing of lessons learned across the whole health and social care system was needed. We did not see system-wide ownership of system performance. There was a focus on metrics in individual organisations but it was not clear how these were brought together to enable joint solutions.

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 oversight and challenge functions of the Health and Wellbeing Board and the Scrutiny Management Committee were not being used effectively.

Governance arrangements had been traditional, with an organisational rather than system focus. However the governance structures had been reviewed shortly before our review and were more aligned with the Sustainability and Transformation Partnership and an integrated way of working.

There was no shared view of risks and mitigating actions, and no formal risk-sharing agreements were in place. This meant that system leaders were unable to appraise and assure themselves of risks across the health and social care interface. Data used to monitor flow was based on traditional performance indicators rather than outcomes for people.

While there was intent by system leaders to share information to provide seamless pathways of care, the lack of a system-wide integrated records system was a barrier to this.

Overarching governance arrangements

- The Health and Wellbeing Board (HWB) had overall responsibility for ensuring that health, social care and wider wellbeing services were effective and met the needs of people living in Northamptonshire. At the time of our review the HWB did not have a chair in place. System leaders acknowledged that the HWB would benefit from strengthening its oversight and challenge function in relation to the delivery of the transformation agenda. We were informed that work was underway to facilitate this, including a review of the Terms of Reference to enable the HWB to become more of a driver for system transformation.
- The Scrutiny Management Committee was responsible for managing the overview and scrutiny function at Northamptonshire County Council. Scrutiny members told us that they had a large agenda with a lack of democratic support making their role difficult to manage. There was a perception of a lack of transparency and openness around data and performance. We found that the Committee's challenge function was underutilised in terms of the Northamptonshire's Sustainability and Transformation Partnership (STP) agenda.
- Individual organisations had assurance of their own performance, but objectives were linked to their individual priorities rather than a shared, system approach.
- The system-level governance arrangements developed as part of the reset STP were embryonic and not embedded. The governance structures reflected STP agreements with the STP work streams feeding into the Strategic Executive Board which reported to the STP Board. However, the governance structures appeared complex and it would therefore be important when developing the work streams that system partners had a shared understanding of the structure.

Risk sharing across partners

- We found no evidence of sharing of risks across the system. System leaders and partners at all levels acknowledged they needed to respond to risks more collaboratively.
- Although organisations had their own systems and processes to identify and monitor risks,

there was no shared risk register at a STP or Northamptonshire system level. Data used to monitor flow was based on traditional key performance indicators rather than outcomes for people. System leaders agreed they needed to ensure they were able to appraise and assure themselves of those areas that presented current and potential risks across the system in order to fully mitigate them.

- Northamptonshire's health and social care system faced significant financial pressures. The planned move from the existing two-tier local government structure to two unitary authorities also brought inherent risk. While this was widely acknowledged by system leaders, there was no sense it was considered a shared risk.

Information governance arrangements across the system

- Although there was some good evidence of information sharing, overall it needed further development. There was an acknowledgment that systems needed to come together in order to provide more integrated, joined-up care. We were given several examples of where information sharing between organisations was in place and had already proved beneficial by ensuring staff had access to timely information. This included the expansion of SystemOne, (an electronic clinical system allowing access to shared records), at Northampton General Hospital NHS Trust to include local authority colleagues including those working in adult social care.
- There was some duplication of work being undertaken, for example the Intermediate Care Team and Short Term Assessment and Reablement Team (START) each undertook their own assessments of people's needs. This meant that people often had to tell their story more than once. Staff felt that the lack of an effective way to share information had an adverse impact on the quality of service delivery.
- As part of the STP, a work stream for Information Computer Technology (ICT) and Information Governance Local Digital Roadmap (LDR) had been developed. Outlined in the LDR were plans to roll out an interoperability initiative called the Northamptonshire Care Record. Funding had been allocated for the procurement of the software and equipment required to deliver the Care Record and for the project management resource to deliver this work. However, ICT leads told us that despite this funding there would be further stages in the development of the LDR plans at which significant investment would be required. Given that the system is in significant financial deficit there may be a risk that this investment will not be achieved.
- During our review a number of issues about information sharing and ICT emerged. These included, several different ICT systems in use across Northamptonshire's health and social care system; and significant usage of paper communication, for example Kettering General

Hospital NHS Foundation Trust's (KGH) referrals to the Single Point of Access for discharge planning, and discharge notes to GPs. Also Northamptonshire County Council's social care case management system was no longer fit for purpose and required replacement.

- Plans to resolve these issues included re-provision of the social care client system, continued development of the Medical Interoperability Gateway system (a system that enabled sharing of people's health information between providers), and addressing the issue of hand written discharge notes. In addition the work stream was also addressing the issues relating to information governance; agreements were in development and Caldicott Guardians met regularly.

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 was working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource.

There was no single, coherent workforce strategy for Northamptonshire; workforce planning remained at an organisational level. There was a workforce strategy at Sustainability and Transformation Partnership level, but this needed to be translated to the local level to ensure it was aligned to the vision for new models of care. Independent providers were also facing workforce challenges which had not been addressed as part of a system-wide approach

System level workforce planning

- There was no single strategic workforce plan for Northamptonshire's health and social care system. As part of the STP, a work stream had been developed to deliver a system wide workforce strategy. This was led by the Northamptonshire Workforce Transformation and Education Group, which was a sub group of the Local Workforce Action Board, sitting within the STP governance structure. However, this work was in its infancy.
- System leaders acknowledged that Northamptonshire had some significant challenges in relation to workforce. These included difficulty in recruiting geriatricians within the acute sector, recruitment of GPs and community nurses.
- A significant workforce challenge for Northamptonshire was in the adult social care sector. Analysis of Skills for Care workforce estimates up to 2017 showed that adult social care staff turnover in Northamptonshire was much higher than in comparator areas and the England average. In 2016/17 turnover rates were at 40.4%, compared to 28.7% in similar areas and the England average of 27.8%. The proportion of vacancies in Northamptonshire in 2016/17 was 11.4% which was higher than comparator sites at 6.6% and the England average at

6.6%. Northamptonshire's adult social care vacancy and turnover rates had been increasing since 2013.

Developing a skilled and sustainable workforce

- Workforce leads from across the system informed us that they needed to map existing workforce provision against the emerging service models to try and align workforce with demand projection. They told us they were trying to innovate to create initiatives in parallel with the development of new models of care to inform commissioning decisions. This would be an opportunity for the system to reflect the importance of supporting a preventative agenda with a focus on primary and community care staff leading to a change in work patterns and types of working environment as well as in staff numbers and skills.
- There was little or no shared learning or training across health organisations for professionals, for example, physiotherapists or nurses. In focus groups with frontline staff they reported that rotational posts across health organisations had ceased.
- There was an opportunity for more leadership and management development in the system. Senior leaders, who were in key roles for supporting the transformation agenda, would need the support of proactive and committed leaders and managers, who were focused on a more collaborative approach to meet the needs of people living in Northamptonshire.
- Adult social care providers we spoke with said that they were not involved in workforce planning or recruitment. They told us that they were offered little support with their recruitment needs and upskilling of staff. Prospective staff were being recruited from the same pool by health and social care services. However, workforce leads from across the system told us that there were opportunities to collaborate in order to increase staff skills and experience, for example through nursing staff providing training and upskilling for independent care providers. They were also looking at working with providers to improve their staff recruitment.
- Social care leads told us that the local authority leadership team were very supportive of social work as a profession. The local authority had committed to increase the number of qualified social workers and reduce the use of unqualified staff. The local authority was also supporting newly qualified social work staff through the Assessed and Supported Year in Employment (ASYE) programme. This was a twelve month employer-led programme of extra support and assessment for social workers. This was perceived as very positive in terms of future workforce development.
- In the acute healthcare sector, NHS trusts were managing nursing vacancies at an organisational level. There was no shared workforce strategy across the two trusts.

- External partners and system leaders raised concerns about the staffing capacity within the local authority; given that historically Northamptonshire County Council (NCC) had significantly reduced the number of staff, for example, in the commissioning team and care manager roles. We were told by staff and local authority leaders that a lack of capacity was having an impact on areas such as the number of unallocated social care cases. There was an opportunity for NCC to undertake a more sophisticated analysis of the scale of the problem in order to understand the actual resourcing requirements. In addition it would be important to be clear about the skill set of the teams in relation to their efficiency in working practices and throughput. Without a detailed analysis of the scale of the issue and making any required changes in working practices, there would be a risk that any additional resource would have minimal impact.

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.

Commissioning activity for health and adult social care had historically been reactive and short term. The prevention agenda was underdeveloped and there was an over-reliance on bed-based care for people who could be better cared for at home.

There were very limited examples of joint commissioning. There was also limited evidence of commissioners using strategic commissioning intentions to shape the market and work collaboratively with providers and voluntary sector organisations.

Commissioners agreed that the focus should be on a system-wide integrated approach to ensuring the best outcomes for the people of Northamptonshire.

Strategic approach to commissioning

- There was no strategic approach to integrated commissioning. System leaders acknowledged that the system had not achieved integrated commissioning across pathways of care. Commissioning activity had historically been reactive to pressure points within the system and preventative commissioning strategies were embryonic. There were limited examples of jointly agreed services such as community equipment, community beds and care home improvement. The prevention agenda was underdeveloped and there had been an over-reliance on bed-based care for people who could be better cared for at home.

- In response to the System Overview Information Request (SOIR) system leaders stated that 'Commissioning Development' had been identified as a priority work stream under the strategic executive of the Sustainability and Transformation Partnership (STP) Board. However, it was not clear where commissioning linked with each of the other four priority work streams of the STP, and how the commissioning agenda was going to be taken forward.
- We were told that the commissioning plans would utilise the latest Joint Strategic Needs Analysis (JSNA) information and the NHS Five Year Forward View ensuring that market offers would address future population trajectories and likely demand for the care needs of older people. However, some specific areas of the JSNA needed to be reviewed and updated, for example the sections on frailty, dementia and the needs of the older population in order to better inform commissioning intentions.
- Social care leaders told us there was a gap in the strategic impetus behind commissioning. The role of Director of Commissioning had not been backfilled when the last person in this role became the Director of Adult Social Services. This gap meant that there was a risk that opportunities were lost and provision carried on based on historical needs or was fragmented. However, we noted that Northamptonshire County Council was looking to recruit a Director of Commissioning at the time of our review. This could provide an opportunity for a joint post with the Clinical Commissioning Groups (CCGs). Although a joint post would be a positive step towards integrated working, such a post would need clear objectives and governance to be effective
- GPs told us that the two CCGs in Northamptonshire commissioned separately. This had led to issues such as variation in services offered across the county, for example the GP alignment to care homes offer. However, the CCGs had published their commissioning intentions for 2018-19 as a joint endeavour. In this, they set out their intention to change their approach to one of joint planning and integrated commissioning delivery, with a focus on keeping people well and at home. The commissioning intentions aligned with the Northamptonshire STP; however, they were new and therefore not implemented.
- The CCGs' primary care lead spoke about the need to commission and deliver primary care at scale. Work to develop new models of care was in its infancy. There was a two year contract to bring some of the GP federations into a devolved multidisciplinary team model. However, we were told that money in the system was "locked in secondary care". They reported that despite a system-wide agreement that commissioning by patient pathways was the right approach, it was not actioned.

- We found that primary care commissioning was transactional rather than transformational. GPs told us they could do more in terms of helping to develop the market, but felt that the CCGs were “ticking boxes” with contracts rather than being innovative around how to better meet the needs of people.
- Health and social care commissioners were not driving an innovative approach to commissioning, and some providers were considering their own short term fixes. For example, the end of life providers group explained to us that strategic work on integrating their services had started two years ago and then stopped because of financial and organisational imperatives. They had started to investigate an end of life coordination hub. Discussion around these ideas had recently re-started, and providers told us there was more of a will to work together. However, this provider led approach was not conducive to creating the market needed.
- System leaders told us that transparency of commissioning arrangements remained a key challenge for the system. They were fully aware of the deficit in commissioning and had committed to developing this area, but the detail of how this would be achieved had not been clearly set out.

Market shaping

- There was limited evidence of effective market shaping to ensure sufficient capacity, quality and innovation in system-wide service provision and the workforce. Commissioning had been traditional and reactive, focused on the services provided by individual organisations in response to pressures within the system rather than outcomes for people. Health providers were commissioning their own services in an attempt to manage system pressure in the acute trusts. For example, Kettering General Hospital NHS Foundation Trust had commissioned step down beds in Claremont Parkway Care Home. System partners reported that there was a need to understand their system wide capacity requirements and where the gaps were in service provision in order to shape the market effectively with an integrated response.
- Mechanisms to engage with wider system partners, including providers and voluntary, community and social enterprise (VCSE) sector organisations needed to be strengthened.
- There was limited evidence to demonstrate how VCSE organisations were involved in developing strategic commissioning intentions and those we spoke with felt they were underutilised. It was widely recognised by system leaders that they needed to work more proactively with the VCSE sector. Adult social care providers told us that there were no forums where they could come together with commissioners and meaningfully engage in strategic planning. GPs also told us that they were not involved in any activity around shaping the market.

- The adult social care market position statement was out of date. However, in response to the SOIR system leaders stated that the local authority was about to publish a refreshed Statement setting out its future needs, population trajectories and priorities in terms of market commissioning and shaping. People's choices over how their needs were met in Northamptonshire were limited and therefore commissioners needed to ensure that there were plans in place to provide a more diverse range of care and support services.
- Housing organisations were well placed to work with health and social care partners in their prevention strategies. Each of the seven districts and boroughs of Northamptonshire had their own housing strategy. However, to provide a more system-wide approach to housing, an 'Accommodation Market Position Strategy for Living and Ageing Well in Northamptonshire' had been produced. This set out key messages for providers, informing them of potential future opportunities and enabling them to consider where existing provision could be adapted to meet changing needs. Some housing support plans we were made of aware of included a housing development underway which consisted of 80 one-bedded units designed for older people needing housing with care. There were also plans for four flats, available from September 2018, to be used by the CCGs for step-down support.
- Northamptonshire faced significant challenges in relation to the social care market, in terms of capacity. Data indicated this was adversely affecting delayed discharges from hospital, with social care being one of the main organisations responsible for older people experiencing a longer length of stay in hospital. Commissioners also told us that they were facing a shortage of nursing home places with costs rising sharply due to the level of demand.
- However, overall numbers of older people needing admission to a care home for long term support had reduced. Analysis of data showed the number of admissions of older people into care homes in 2016/17 being below the comparator group average and the England average at 479 per 100,000 population. Nevertheless people did still wait for extended periods of time for suitable placement and support.
- Our data showed that as of April 2018, the number of residential care beds had increased by 4% over the previous three years. The number of nursing care beds had decreased by 11%. The number of domiciliary care agencies () however had increased by 36% since 2015 and numbers of DCAs per population ages 65+ was at 122 compared with the England rate of 87. There was an opportunity for commissioners to recommission a much smaller number of providers. This would not only ensure a more sustainable market in financial terms but enable the local authority to work more collaboratively with social care providers in relation to quality. Commissioning leads told us they recognised that they had too many providers so lacked economies of scale. We were told that there were plans to rationalise the market.

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

- System leaders agreed that there was a need to develop new models of care, taking bold action to drive transformation efforts across the system. As part of this transformation there was an opportunity for clinical commissioners to engage better with GPs by embedding clear and open lines of communication while collaborating effectively with local authority commissioners.
- The shared ambition for Northamptonshire's health and social care system was to implement a model of integration that wrapped services around the person and maintained them in their own home with the support of multidisciplinary teams, including staff from health and social care, and the voluntary sector.
- Commissioning leads from health and adult social care acknowledged that many solutions had arisen to address problems in the short term but these had not solved root causes or led to an effective and sustainable approach to prevention or step down care. Commissioners needed to focus on and prioritise a system-wide integrated approach to achieving the best outcomes for people, rather than delivering a tactical approach to each individual issue.
- Local authority commissioners told us that they were commissioning a new contract for home care. Providers were being sought for 15 zones across the county and rates would be based on comprehensive analysis of the market and economic sustainability. One of the key challenges for the local authority would be the recruitment and retention of staff with the right aptitude to deliver care services to vulnerable older people.
- GPs felt that innovation was being stifled by bureaucracy. For example; three years previously they had drafted a submission for a vanguard aimed at supporting frail elderly people with geriatricians working in community settings and 30-minute appointments. They felt that this service would reduce significantly the number of people attending A&E. However, the CCGs would not agree. System leaders acknowledged that there needed to be a change in mind-set as well as culture. Commissioning needed to act as an enabler and be transformational rather than transactional, with the person at the centre of every decision.
- Data showed that, in the main, there was a focus on empowering people to take control of their own care and support through the use of personal health budgets and social care direct payments. In Q4 2017, the data showed that, for Nene CCG, (which served the majority of the population of Northamptonshire), uptake of personal health budgets was higher than the England average at 12.65 per 50,000 adult population compared with the England average of 9.73. Data also showed that a higher number of people 18+ using social care services

received direct payments in Northamptonshire (9.49 per 50,000 population) compared to nationally (5.10 per 50,000 adult population). However, for Corby CCG the figures were not as high. Uptake of personal health budgets was significantly lower than the England average at 5.80 per 50,000 adult population. The number of direct payments was slightly lower than the England average and lower than Nene CCG at 4.97. This meant that people living in Northamptonshire had an inconsistent offer in terms of having greater control and choice over their health and care needs.

Contract oversight

- The quality of care homes and domiciliary care providers, as rated by CQC, was better than comparator averages. However, system leaders told us that recent issues with small and poor performing services had led to capacity issues for Northamptonshire's social care market.
- CQC ratings indicated that the overall quality of care homes in Northamptonshire was relatively good. For example, CQC data for December 2017 showed that 71% of nursing homes and 83% of residential home were rated by CQC as good. However, system leaders told us that the combined effects of low payment rates and the large number of smaller providers had led to significant provider failures with 100 beds being lost in the north of the county in 2017. They told us that they needed to invest in improving quality as they had faced significant challenges with embargoes on commissioning from poor quality services and failing providers when they could not afford to lose the capacity.
- The CCG's quality team reviewed domiciliary care providers where agencies provided care for people with continuing healthcare funding. At this time there were 61 domiciliary care providers commissioned and reviewed with an average quality monitoring score of 90%. It had also been noted by the quality team that many of the providers commissioned were new, recently registered and therefore not yet inspected by CQC. These providers were being commissioned to provide fast track and end of life care to people in the community. The quality team identified this as a risk, and to mitigate it monthly meetings had been arranged between commissioners and new domiciliary care providers to seek further assurance from them.
- Care home providers told us that there was limited support around education and training from the local authority. However, they said that commissioners were very supportive when they were in a challenging situation and needed help. We were told that there were no provider forums where they could come together and share ideas and best practice. However, the local authority quality team told us that they had held five forums and learning events for care home providers in the previous year. The aim of these events was to disseminate the most recent guidance, legislation and education to ensure continued

learning and good practice. Topics included medication management, end of life care and nutritional assessment. System leaders also told us that the CCGs and local authority quality teams had been working together to support care homes with advice and support to help them feel confident in managing health concerns and avoiding unnecessary hospital admissions. Adult social care providers we spoke with were not all aware of this support.

- There was an opportunity for commissioners and quality teams to expand on these learning events and to provide a regular commissioner led provider forum where quality concerns could be reviewed and addressed.

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 the system assured itself that resources were being used to achieve sustainable high quality care and promote people's independence.

Northamptonshire faced significant financial pressures and the system's ability to develop a joint solution and effective risk-share arrangements had been hampered by historical poor relationships. The system had faced national scrutiny due to a lack of system-level agreement.

Owing to Northamptonshire County Council having been found to have failed to comply with its duty of Best Value, a Best Value Inspection had recently been undertaken with the report published 15 March 2018. Recommendations made included a move to a two unitary authority model and government commissioners being appointed with a specific remit around strategic financial management.

System leaders were open and transparent about their financial challenges and articulated a clear intent to work more jointly to address them. However, at the time of our review it was widely acknowledged that work had been siloed due to individual organisational targets and this had led to reactive spending rather than focusing resources on pathways and ensuring older people received high-quality, sustainable care.

- Due to the severe financial challenges faced by Northamptonshire County Council (NCC), in February 2018 a section 114 notice was issued, meaning that no new expenditure would be permitted other than for the statutory services for safeguarding people. A Best Value Inspection was also undertaken between January and March 2018. The report found systematic failure of NCC to comply with its duty of Best Value. The report's recommendations included that the county, borough and district councils should be replaced with two unitary authorities, and that government commissioners should be appointed with a specific remit around strategic financial management. Subsequently two commissioners were appointed to NCC on 16 May 2018.

- It was acknowledged by the financial leaders we spoke with that work had historically been siloed, with people “retreating into their own organisations” due to their own internal pressures. At the time of our review both acute trusts, the Clinical Commissioning Groups and NCC were dealing with significant financial deficits. Financial leaders for health told us there was an anticipated system gap of £111 million for 2018/19, but only if they met their own individual cost improvement plans. Twenty-two million pounds would be met by making system-wide savings and the remainder was to come from the acute trusts. This was described as “ambitious” by financial leads. NCC had increased council tax by 4.98% in 2017/18 to fund adult social care services and the improved Better Care Fund (iBCF) plans described how it had to make savings of £26 million following an overspend of the same amount the previous year. The significant financial pressures felt by the system meant the focus had been on organisational financial targets and reactive spending rather than achieving sustainable, high quality care for older people.
- System leaders were open and transparent about the fact that their ability to agree an approach to overcome financial challenges had been partly hindered by poor relationships between system partners. Northamptonshire’s Better Care Fund had been in national escalation in the past because of a lack of agreement around the financial elements of the plan and effective risk-share arrangements. These issues had been exacerbated by many changes in key personnel and the continued financial pressures experienced by all partners.
- Financial leaders told us relationships were beginning to improve and they had been encouraged to come together by NHS England; the first meeting took place the week before our review. However, it was apparent that the financial situation within NCC was a cause for concern and presented an “unknown risk” for the system. At the time of our review, both acute trusts were funding out-of-hospital services in order to improve flow and address high hospital occupancy levels. Leaders told us there needed to be longer-term financial planning with a shift to funding transformational projects and services rather than focusing on short-term solutions. However, due to financial pressures and large amounts of money being spent on servicing debt, along with other national restrictions on funds, organisations were financially risk-averse.
- Relationships with the Voluntary, Community and Social Enterprise (VCSE) sector were underdeveloped and appeared to be seen in terms of financial contracts rather than with an understanding of the intrinsic value of the sector and its ability to utilise volunteers to help address and support some of the challenges in the system. There was an opportunity for NCC and NHS bodies to jointly consider the development of a Northamptonshire compact with the VCSE sector in order to maximize the benefits of this relationship for residents.

- Our analysis showed that there were slightly more residential care home beds per population aged 65+ in Northamptonshire compared to comparator areas and the England average, although numbers of nursing homes beds were lower than the England average. Rates of admission to residential and nursing care homes to provide long term support for older people had decreased by 2016/17 to 479 per 100,000 from 750 per 100,000 in 2013/14, and were below the England average and lower than in all but one of its 15 comparator areas. Avoiding permanent admissions can be a good measure of delaying dependencies and system leaders described a clear intent to support people to remain in their own homes. However, despite higher than average numbers of people receiving personal health and social care budgets, service provision and capacity meant people were not always supported to remain well, at home. With high numbers of people waiting to be discharged from hospital, the system needed to assure itself that resources were being used most effectively to ensure good outcomes for people.

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 Northamptonshire safe?

There were systems and processes in Northamptonshire which had been designed to support people safely through health and social care services and to prevent avoidable harm. However, these were not always effective and people we spoke with raised concerns about high safeguarding thresholds and processes which did not provide assurance that referrals were understood and managed appropriately.

There was a significant backlog of Deprivation of Liberty Safeguards referrals which meant that there was a risk people were being unlawfully placed in settings they would not otherwise choose.

Organisations within the system had processes in place to identify emerging risks to people's health and manage long-term conditions resulting from frailty, however these were not joined up or system-wide.

- Although there were systems and processes in place to safeguard people from avoidable harm, we heard some concerns from staff about how effective they were due to the way they were managed and the high threshold for investigation. The safeguarding team managed the

complex cases only. They had been reduced to a core team based in the local authority. All other aspects of safeguarding referrals, including issues such as best interests meetings and safeguarding assessments, were undertaken by care managers. However, we also heard that the numbers of care managers had been reduced and there were unallocated social care caseloads. This increased the pressure on staff who were trying to manage priorities and posed a risk that potentially serious concerns could be missed.

- There was a three-stage assessment test for a safeguarding referral which would be triaged by the local authority's customer service centre. If a referral met the threshold it would be passed onto the locality social work team. Staff we spoke with recognised that this was a risk as customer service staff were making these decisions. We looked at the decision-making framework which showed there were some complex decisions to be made by customer services staff, particularly around issues such as mental capacity, social isolation and mental or physical illness. Staff told us that nearly three quarters of all referrals were deemed as not meeting the threshold. However, one social care provider service we spoke with told us that 75% of their referrals were accepted as they had experience and were better able to explain the circumstances of the referral in relation to the Care Act and people's rights. There was a risk that other people who made referrals, such as members of the public, may not be able to frame their concerns in such a way that would enable them to be managed appropriately through the triage process. The Safeguarding Adults Board's annual report for 2016/17 analysed "abuse types" against comparator local authority areas and showed that apart from "neglect and other acts of omission", the recorded cases were lower than the England average and comparator areas.
- There was a risk that people were being unlawfully deprived of their liberty. The Safeguarding Adults Board report showed that at the beginning of 2016/17, there were 1,967 outstanding Deprivation of Liberty Safeguards (DoLS) referrals. At the beginning of 2017/18 the number carried forward was 3,042. Of a total 4,723 referrals that required assessing during the year, 1,681 (36%) were shown as completed. However, a significant proportion of those had been "abandoned" as a result of the person moving on, action no longer being necessary or the person having died. Only 509 (11%) had been assessed with an outcome agreed.
- There had been work undertaken to try and reduce the backlog of DoLS referrals, including outsourcing the work to an independent agency; however this had not proved successful. At the time of our review, we were told that the number of assessments outstanding had increased to around 3,500. Representatives of people who used services told us of their concerns that health and social care staff did not fully understand DoLS, which meant that people's human rights could be infringed upon. The Director of Adult Social Services acknowledged the significant backlog but told us that each case was risk assessed.

- Systems were being put in place to assess, monitor and mitigate risk as early as possible so that people could stay safe in their usual place of residence for as long as possible. In response to the SOIR system leaders stated that First for Wellbeing (a social enterprise company jointly run by Northamptonshire County Council, Northamptonshire Healthcare NHS Foundation Trust and the University of Northampton) supported people with emotional wellbeing, social isolation, managing long term conditions and supporting people to stay independent in their own homes for longer. It included GP-based wellbeing advisors supporting those at risk of needing future care or managing existing conditions. System leaders told us that frailty would be a key focus of the service going forward. Their 2016/17 annual performance report showed that they had managed 973 referrals regarding support to reduce falls. However, the focus on support available for older people with frailty issues was not evident from information on the service's website. Consequently people and their families looking for support with managing frailty might not have accessed the service. In addition, we heard from the VCSE sector and health and social care staff that there was not a single frailty pathway across the system. System leaders recognised that this needed to be addressed in order to be effective.
- Pharmacy leads told us that there was medicines support for people living in care homes. The pharmacy care home team were employed by Nene and Corby Clinical Commissioning Groups. The team worked with GPs and care homes to undertake medication reviews and helped care homes by auditing their medication systems. However, we were told that there was no medicines support for older frail people supported to live in their own homes. They told us that there had, in the past, been community pharmacy support for older people who needed to manage medicines in their own homes, however this was no longer funded.

Are services in Northamptonshire effective?

A number of systems had been developed to help people maintain their independence in their usual place of residence. There were some community facilities where people could get step up care to avoid a hospital admission and a Holistic Intermediate Care service had been commissioned for people living with dementia. However, many of the services available were not offered consistently across the county, such as GP support for care homes. We found that some initiatives had been withdrawn and contractual arrangements sometimes made it difficult to use services to best effect.

Frontline staff and people who used services felt that assessments were not always undertaken in a holistic way with a focus on independence. There was potential to improve this through further development of work with GPs and ambulance staff and there was an appetite from staff across the system to work in a more integrated way through more streamlined processes and information sharing.

- Frontline staff, system leaders and people who used services told us that when people's needs and choices were assessed this was not always undertaken in a holistic way with a focus on keeping people well and independent. We were told that the preventative agenda was underdeveloped and there was not a system wide approach to prevention work being undertaken. For example, some GPs were working on measures to support people to stay healthy at home, but this work was being developed in pockets. There was not shared best practice and learning across the system.
- One of the preventative services available to people living in Northamptonshire was the Holistic Intermediate Care Team (HICT). This was a dementia specialist service that provided home care and reablement for older people supported by Admiral Nurses. Its aim was to avoid unnecessary admissions, support transition home and keep people in their own homes.
- System leaders described commissioning intentions that would support people in care homes to access out-of-hours primary care support. However, these were not embedded or effectively rolled out across the county. For example, we heard that there was a pilot in place regarding paramedic support to care homes, but people using services and those that supported them were not always benefitting from this approach. Impact assessment data from this pilot showed that between February and April 2018 of the 693 people who were visited by a paramedic, 86% stayed home and 13% were conveyed to A&E. Although this data supported the positive impact of the pilot, paramedic crews told us there was more that could be done to avoid hospital attendance. However, there were limited alternative pathways to A&E. They were able to access support from the Crisis Response Team and the Intermediate Care Team but could not access community beds if people would have benefitted from step up care as an alternative to hospital admission. A 'falls ambulance' had been withdrawn owing to funding.
- Step up specialist care was available but could not be accessed in an emergency to prevent a hospital admission. The contract with the provider had been set up in such a way that people could not be admitted on the basis of a phone call which meant that, particularly out of hours, people who needed urgent support would require a hospital admission. There were no alternative services to provide treatment via intravenous (IV) antibiotics. People could receive IV antibiotics in their homes up to twice a day but if they needed this treatment more often, they would need to be admitted to hospital.
- There was a lack of clear commissioning intentions and understanding between the CCGs and GPs in relation to providing effective preventive services. We found that relationships were poor and primary care partners were sceptical about what commissioners would

achieve. They felt innovation was stifled because of a lack of collaborative relationships and a lack of trust. For example, GPs told us that they had offered to provide full extended access but this had not been commissioned; three years before our review they had offered to work 8am to 8pm seven days per week and felt that their offer had been “blocked”.

- People who were at the end of their lives were enabled to stay at home with the support of a specialist service commissioned from an independent care provider. However, some frontline staff felt that the service lacked capacity to manage people’s needs effectively and that district nurses and the provider were advising people to contact the Intermediate Care Team service when they were unable to meet people’s needs. This placed pressure on other parts of the system. GPs told us that they had not been informed about the service by the CCG. If GPs were not aware of end of life services there was a risk that care or advice could be disjointed or duplicated at this critical stage in people’s lives.
- While health and social care staff had the knowledge and skills to undertake their roles, a lack of integrated working sometimes prevented them from effectively supporting the transition of people between services. Frontline staff told us that, although there were some good relationships between social workers, district nurses, GPs and community mental health workers, there was a clear sense that they worked within different organisations with separate processes and funding structures. They felt that this prevented the services working well together and impacted adversely on the experience of people using services as they experienced different outcomes in different parts of the system.
- Staff in the VCSE sector and independent provider sector also faced some difficulties in supporting people to move through the system effectively. VCSE sector staff told us that there was a lack of communication from healthcare professionals which meant that there were potential gaps in their knowledge with regards to people’s support needs. For example, if people were taking medication to thin their blood or had a Do Not Attempt Cardiopulmonary Resuscitation instruction in place. In order to safely maintain support for people in their own homes, the VCSE care and support workers would have to spend time actively seeking out information.

Are services in Northamptonshire caring?

We saw some examples of people being supported in a caring and compassionate way to maintain their independence and continue living in their communities for as long as possible.

There was good support for carers who received assessments and support to manage their lives. However care was not always coordinated in a way that put people’s needs and wishes at the centre of their care. Care planning, particularly around end of life care, did not always

address people's future wishes and choices which meant that there was a risk that people might be subjected to treatment that they would not choose. Some people felt that a focus on the financial aspects of case management meant that health and social care staff lost sight of the person at the heart of the matter.

- Care was not always effectively coordinated in a way that put people at the centre of their care and support planning. We heard from frontline staff that long-term condition plans and advance care plans were not always completed by GPs for people living in care homes. This meant that in an emergency, staff did not always have clear or up to date information which could result in unnecessary hospital admissions or treatment being given against the person's wishes. Some frontline staff felt that independent care home providers were not having conversations with people about their end of life choices which meant that when they became very ill there was a risk that they would be moved to services that were not suitable for them, or what they would have wished for.
- People were not always supported to make decisions about their care and treatment. Representatives of people who used services felt that factors such as choice and whether the service met people's needs were not always being considered and that services were offered on the basis of convenience for commissioners and availability. This was reflected by some system leaders who felt that outcomes for people were not discussed at system level.
- There was good support for carers. We heard from representatives of people who used services that the local authority was committed to supporting carers and there was a carers' support group in every locality. Northamptonshire Carers Association was commissioned by the local authority to undertake carers' assessments. However, they told us that the assessments they were undertaking were becoming increasingly complex and they were struggling to meet key performance indicators with regards to the 28-day target.
- There were examples of older people living in Northamptonshire being supported in a positive and compassionate way. We spoke with frontline staff in the Short-Term Assessment and Reablement Team (START) and the Crisis Response Team (CRT), services. These services enabled people to be supported in their own homes, to avoid hospital admissions and also be supported on discharge from hospital. We heard how a person who had played an instrument with a local community group had developed dementia and no longer attended. They recognised that social isolation was impacting on their happiness and wellbeing and worked with the community group to help them understand the person's condition. As a result, the person re-joined the group and this had made a "marked difference" to his wellbeing.
- However, there were times when people did not always feel supported. We heard that

sometimes people felt that care managers lacked compassion when discussing case management with people who need support. They felt that care managers sometimes forgot about the person and focused on financial issues.

Are services in Northamptonshire responsive?

System leaders had put in place a number of schemes to support people in their usual place of residence. However, high numbers of people in care homes were attending A&E or being admitted to hospital and despite this there was no system-wide arrangement to provide GP or pharmacy support to care homes.

Technology was used to help people to maintain their independence for as long as possible. There was short-term care available in the community to help people avoid hospital admissions.

Support workers were able to provide basic equipment which would enable people to remain independent. However, assessments and referrals were not managed in a timely way which increased the risk of people entering a crisis.

There was support for people from Black Asian and minority ethnic communities from the VCSE sector. However, there needed to be more information about services across the county to enable people and staff to understand which options were available.

- Work had been undertaken to enable people to receive support in their own homes. A pilot over the three months prior to our review aligned paramedics with a GP practice to undertake home visits for them. Calls were triaged to a paramedic who could assess the person as calls came in, which meant that people would not have to wait until the end of the clinic for a visit. System leaders felt that this had enabled people to avoid hospital admissions and the pilot was being evaluated at the time of our review.
- Despite the evidence of benefit, and given the high numbers of people attending A&E from care homes, there was not a system-wide contractual arrangement to provide GP support to care homes.
- There were a number of initiatives that would enable people to receive support at the right time and the right place that met their needs. Social care teams supporting older people included the Crisis Response Team (CRT), the Short-Term Assessment and Reablement Team (START), the Community Occupational Therapy (COT) team and the Holistic Intermediate Care Team (HICT), a specialist dementia intermediate home care service. They told us that these services supported the “home first” principle as well as supporting admission avoidance. Longer term needs were overseen by the Older Persons Teams.

- Assistive technology was used to enable people to stay at home for as long as possible. The local authority provided a system called the Canary Monitoring System. This was a sensor monitoring and notification system. Sensors were put into a person's room to measure light, temperature and movement and could provide live reports on what was happening in that person's own home. There was the ability to set up a 'safe zone' – for example the local shops – and if a person with memory problems travelled beyond their 'safe zone' people could be alerted. Family members could be kept informed and receive assurance where this was agreed. We heard how one person who had been at risk of getting lost was able to continue living at home as a result of this technology. We also saw an example in a case file we looked at that showed how the ambulance service had engaged the support of the CRT who used assistive technology to support the person which meant a hospital admission had been avoided.
- Assessments of people's needs were not always timely and responsive. For example, we heard about a carer who was supporting someone living with dementia and had asked for a referral for day services as they were struggling to cope. The referral process had taken too long and the person being cared for had gone into crisis necessitating an emergency admission to hospital. One person told us that they had struggled to get appointments and the necessary tests for their spouse who had been diagnosed with cancer.
- Independent homecare providers told us that if a person's needs changed they would refer to the social worker but there could be up to two weeks' wait for an assessment and in the meantime people were at risk of not having their needs met. Sometimes homecare providers felt they needed to "fill the gap" to ensure that people were adequately cared for and had to spend considerable time chasing up referrals.
- Voluntary sector workers from Black, Asian and minority ethnic communities supported people from similar ethnic backgrounds through the social care assessment processes to help them make informed decisions about the care and support they needed. However, generally we heard that there needed to be improved communication about what services were available in the county. This would support people who needed to make choices about services, but would also assist health and social care workers and providers to better support people through their pathways of care.

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 Northamptonshire safe?

The systems and processes in place across Northamptonshire were not always effective at keeping people safe and preventing them from going into crisis. Inconsistencies in processes and service provision meant that once an older person went into crisis, they were more likely to be admitted to hospital and stay longer. We found examples where avoidable harm had been caused as a result of long lengths of hospital stay.

Risks were not always identified and people living in care homes were more likely to be admitted to hospital for treatment of conditions deemed avoidable, such as urinary tract infections.

- The systems and processes in place to safeguard older people living in Northamptonshire and prevent them from going into crisis were not always effective. Our analysis of Hospital Episode Statistics (HES) data for September 2016 to August 2017 showed that although the rate of A&E attendances for the area was in line with the England average, the rate of emergency admissions was higher than the England average at 27,260 compared to 25,009 per 100,000 population 65+. Emergency admissions had been consistently higher than the average since at least Q2 2016. This indicated that there were weaknesses in the health and social care system around early identification, prevention and management of people at high risk of emergency admission. This was contributing to an increased demand for secondary care.
- People living in care homes in Northamptonshire were more likely to be admitted to hospital as an emergency compared with similar areas and the national average. GPs were not consistently aligned with, or commissioned to provide enhanced care to, care homes to help with early identification and monitoring of people who were frail or at risk of deterioration. Data for Q1 2017 indicated that the rate of older people admitted as emergencies from care homes in Northamptonshire was 838 per 100,000 people 65+, which was higher than the national average of 713 and the comparator group average of 688. The data also suggested that emergency hospital admissions from care homes had been consistently higher than national and comparator rates over the preceding three years. However, it should be noted that this data was based on postcodes where care homes were situated so could include some admissions from the general population.
- HES data also indicated that the percentage of A&E attendances of people aged 65 and

over living in care homes and referred by a GP was almost three times higher than in comparator areas. In Q1 2017, 15.1% of A&E attendances of older people coming from care homes were referred by a GP, compared with 6% nationally and 5.3% across comparator areas. Care home providers told us that a lack of access to GPs outside of normal working hours resulted in them having to use 111 services. As the unwell person was not known to the 111 service this could result in more risk averse decision making.

- People living in care homes in Northamptonshire were also more likely to be admitted to hospital with diagnoses for a range of conditions usually deemed to be avoidable. For example, our analysis of admissions between October 2015 and September 2016 indicated that the hospital admission rate for urinary tract infections (UTIs) was significantly higher than comparators and England averages with 316 per 100,000 population compared to 182 (average across comparators) and 190 (average across England). This provided further evidence to suggest that systems were not in place to monitor and provide early intervention for those people deemed to be at higher risk of hospital admission. System leaders told us that training had been put in place to ensure early recognition and management of UTIs however they felt that the high turnover of care home staff and use of agency staff meant it was not as effective.
- Once admitted to hospital as an emergency, older people in Northamptonshire were more likely to have an increased length of stay than people in comparator areas, with 10% of emergency admissions lasting 24 days. Although hospital staff used national tools to assess and monitor people while in hospital, we saw that people were at risk of harm from long stays. For example, in two case files we reviewed we saw that people had experienced avoidable harm as a direct result of a prolonged hospital stay. One person developed a hospital acquired infection and another fell, resulting in the need for 24-hour care. This further delayed the discharge process as the social worker would not start to plan the discharge until the person had fully recovered.
- Both Northampton General Hospital NHS Trust (NGH) and Kettering General Hospital NHS Foundation Trust (KGH) had clear oversight of performance in relation to avoidable harm experienced by people when in hospital, such as falls and pressure ulcers. This was through red, amber and green (RAG) rated performance scorecards or dashboards. NGH's scorecard appeared to be more comprehensive and included flow; not only A&E waiting times, but information on length of stay and discharge. At NGH length of stay had been consistently rated red since December 2017. Causes documented included, insufficient capacity in the care home and home care market with a reliance on bed-based solutions. NGH data showed that 54.6% people aged over 75 in April 2018 had a length of stay over seven days, which was higher than their set target of 45%.

- System leaders from both acute trusts acknowledged that length of hospital stay was a concern. One of the key actions arising from the commissioning of an external consultancy team to review patient flow was to implement an action plan, as a system, around managing delayed transfers of care and 'the stranded patient', which refers to someone who has been in hospital for more than seven days.
- According to hospital performance indicators, ambulance handover times were consistently failing to meet their target. At KGH there had been 203 ambulance handovers that had taken longer than 60 minutes in December 2017, up from 92 the month before. At NGH there had been 56, but the number had steadily declined to 11 in April 2018. Long ambulance handovers put the person waiting to be admitted to A&E at risk, and also those in the community as it impacted on the ambulance service's capacity to respond to further calls.

Are services in Northamptonshire effective?

People who went into crisis in Northamptonshire had varied experiences depending on which hospital they attended. Although there were streaming processes in place to ensure that people were allocated to the right clinical pathway, there was no system-wide approach to emergency care.

Hospital occupancy rates were high and both acute hospitals were failing to meet the national A&E target for time taken to be seen, assessed and treated. Some recent service design changes at Northampton General Hospital NHS Trust had led to improvements in performance, but it was too early to determine if these could be sustained. Older people continued to stay longer in hospital and bed capacity issues meant some people were not cared for in the most appropriate place by the most appropriate staff.

- Pressures on hospital capacity impacted on people's experiences and the care they received. Data from NHS England showed that bed occupancy at the two acute hospitals was consistently higher than the England average from Q1 2016/17 to Q1 2017/18. Kettering General Hospital NHS Foundation Trust (KGH) had an occupancy level over this period of 96% to 97% and Northampton General Hospital NHS Trust (NGH) had an occupancy level over this period of 88% to 91%. Data provided by the system for NGH showed that occupancy levels were even higher over the same period, (93.71% to 95.68%, with an average of 94.66%). Although optimum occupancy rates for hospital beds may vary according to type of services offered, hospitals with average bed occupancy levels above 85% risk facing regular bed shortages, periodic bed crises and increased numbers of healthcare acquired infections.
- The system had commissioned an external review from a business management consultancy organisation to look into the reasons people were spending too long in hospital.

This work was still ongoing at the time of our review, but initial findings presented showed that, on average, people in Northamptonshire had spent 115 more days in hospital than they needed to over the past year. We were told by the consultancy team that the next step was to devise and implement action plans for key areas identified as causing delayed discharges from hospital. For example, they had found that 40% of delayed transfers of care were due to awaiting some sort of decision.

- When hospital capacity was stretched additional clinical areas were opened to increase bed capacity, which meant that people were not always cared for in areas designed to provide inpatient care. For example, case files we reviewed showed that people had been cared for overnight in the discharge lounge in NGH, while waiting for transport home the following day. Care and safety could be compromised in these escalation areas. For example, we saw evidence from records that one person had become unwell while in the NGH discharge lounge. They were not reassessed by the medical team and their monitoring was poor. They were discharged home the same day, and as a result they were readmitted to hospital several days later.
- There was no evidence to show that A&E departments in the two acute trusts worked jointly to address the county-wide pressures of high referrals and admissions to hospital and share learning. There was not a system-wide approach to providing emergency care.
- Although both acute hospitals had 'front door' frailty teams who assessed older people on arrival at A&E with the aim of promoting early discharge, the teams worked in isolation from each other and did not share processes or have a common frailty pathway. This meant that people had different experiences depending on which hospital they attended. Furthermore, these frailty teams could only be accessed via A&E rather than direct referrals from the community and some GPs we spoke with were not aware of them.
- The aim was for people assessed by the frailty teams to be discharged from the frailty unit within 72 hours. Data provided by KGH showed they had failed to meet the target length of stay since June 2017. The average length of stay had been consistently longer than 100 hours since July 2017, peaking at 168 hours in March 2018 – over double the expected target. We were not provided with the equivalent data for NGH.
- Between 2014/15 and 2016/17 both acute hospitals failed to meet the national four-hour A&E target of 95% and their performance was consistently below the England average of 89.1%. Performance at both hospitals had deteriorated over time; between 2014/15 and 2016/17 at NGH there had been a decline in performance from 90.9% to 87% of people being seen within four hours. At KGH there had been a decline from 92.4% to 83.4% over the same time period.

- To improve people's experience and improve performance, in November 2017 NGH had opened an Urgent Treatment Centre (UTC). This GP-led service was open 15 hours per day, seven days per week, and was equipped to diagnose and manage most common ailments for which people had previously attended A&E. Streaming practitioners based in A&E directed people to the most appropriate pathway. Data provided by NGH showed that by opening the UTC, A&E attendances had reduced and people were receiving timely care with 100% of people attending the UTC being seen within four hours. A&E performance had also improved with 90% of people being seen within four hours in April 2018. It was too early to determine if these improvements could be sustained, but system leaders needed to continue to evaluate performance and, if the service model proved consistently effective, consider rolling it out to KGH.
- People being supported in hospital often had to tell their story more than once due to limited information sharing. Communication and information sharing across the system was not as effective or safe as it could be. There was a reliance on traditional methods of communication, and a lack of shared records which necessitated repeated assessments and duplication of work. There was also the risk of information not reaching the right person; for example, in one case file reviewed we saw internal referrals at NGH for urgent consultant reviews being sent by fax.

Are services in Northamptonshire caring?

When people were in crisis their views, along with those of their families and carers were not always taken into account when planning care. People were not always supported to be involved in making decisions about their care.

People were generally treated with respect and dignity by staff. Data provided by the system showed that patient satisfaction results were improving across Northampton General Hospital NHS Trust, but there was no recent data available for Kettering General Hospital Foundation Trust.

- Our review of case files and feedback from people we spoke with provided a mixed picture regarding people being involved in decisions about their care. Some did not always feel that they, their families or carers were involved in making decisions about their care or support needs while in hospital. Although some files reviewed referred to speaking with family members about plans, the majority lacked documented detail of any discussions held with people. In one case file we reviewed it was documented that a family had expressed dissatisfaction with the lack of communication from medical staff in relation to their relative's condition. There were no follow-up entries to demonstrate this issue had been resolved and the onus had been placed on the family to telephone the ward for updates.

- People in Northamptonshire did not always have access to the support they needed when making decisions about their care. We were told that the local authority had made cuts to funding for advocacy services. Advocacy representatives said that because of the reduction in service provision they were concerned that vulnerable older people, in particular those living with dementia, would be more at risk of being left unsupported when having to make critical decisions about their care.
- Some care homes used care passports which contained information about people, including their preferred choices and medical history. These were used to convey key information to hospital staff in the event of an admission. Although care home staff felt these were well received by staff within the acute hospitals, it was not clear if there were plans for them to be used across all care homes.
- Northampton General Hospital NHS Trust (NGH) provided us with details of their A&E Friends and Family Test² (FFT) results from April 2018. NGH's results showed that 87.2% of people were happy to recommend NGH A&E services to their friends and family, which was an improvement from 84.2% in March 2018. The A&E FFT data for Kettering General NHS Foundation Trust for March and April 2018 was not available when reviewed on NHS England's FFT website.

Are services in Northamptonshire responsive?

There were variable levels of responsiveness to people's needs in a time of crisis. There were some planned initiatives to ensure people were seen in the right place by the right person however, they had not all been implemented across the system at the time of our review

NHS Improvement's Emergency Care Improvement Programme was in place to support with improving patient flow through the system. However, at the time of our review there was a lack of focus on discharge planning from the point of admission in both acute trusts, although we found that discharge processes were more established in Northampton General Hospital NHS Trust.

- A service providing GPs with direct access to consultants at Northampton General NHS Trust (NGH) was in place to help reduce unnecessary referrals to A&E and prevent admissions. This service had been operating for about 16 months and data shared with us showed 62% of calls had prevented an admission. Plans were in place to expand this

² The Friends and Family Test, run by NHS England, gives people who use services the opportunity to submit feedback to providers of NHS funded care or treatment.

service across the county, but no timescale for this had been agreed. The Intermediate Care Team was also planning to introduce a telephone service to allow GPs to speak directly to senior clinical staff to discuss the possibility of additional support for people in their homes who were at risk of deterioration. However, at the time of our review there was no date for implementation.

- Ensuring people were not unnecessarily taken to hospital was a priority for East Midlands Ambulance Service (EMAS). Although some key performance areas were managed well, others could be improved. Analysis of data showed that EMAS had consistently performed better than the national average from August 2016 to July 2017 in resolving 999 telephone calls by providing advice. In July 2017, 20% of calls had been resolved at the telephone stage in comparison to the national average of 10%. However, EMAS performed consistently worse than the national average for managing incidents they were called out to without the need for transferring people to hospital for the same period. Data showed that only 23% of people EMAS attended were not taken to A&E in July 2017 compared to the national average of 40%. However, it should be noted that this data referred to performance across the whole of the East Midlands, not just in Northamptonshire.
- NHS Improvement's Emergency Care Improvement Programme (ECIP), a clinically led programme offering practical advice and support to improve patient care and flow, was working with the two acute trusts at the time of our review. They told us that as part of this programme they were working with the trusts to embed the 'red and green bed days' system, a visual management system to assist in the identification of wasted time in a person's journey while in hospital.
- System leaders agreed that a focus on discharge and discharge planning, started on admission to hospital, can help to reduce people's length of stay and allow for a smoother transition into another care setting or to their home. However, we found variation in the level of focus on discharge between both acute trusts. At NGH, progress towards embedding the 'red and green bed days' system was starting to work well. Patient flow and capacity was monitored daily, lunch time board rounds took place to ensure actions were followed up, and there were in-depth reviews of people who had been in hospital for longer than 21 days. Kettering General NHS Foundation Trust (KGH) also had regular discharge planning meetings however the 'red and green bed days' system was not embedded. An ECIP representative told us that it remained challenging to get all staff at the acute trusts to engage with the process. We also saw variation across the two trusts in the use of Estimated Dates of Discharge (EDDs). They were used from admission at NGH and the community hospitals. However, during our site visit to KGH we observed that EDDs were not consistently used.

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 Northamptonshire safe?

Systems and processes did not always support people to return to their usual place of residence, or a new place, safely. Older people living in Northamptonshire care homes were more likely to be readmitted to hospital than people living in other similar areas.

We found evidence of unsafe and inappropriate discharges from hospital as a result of poor communication and insufficient discharge information between secondary care, independent providers and community health and social care teams.

- Older people living in Northamptonshire were more likely to be readmitted to hospital. Our analysis of HES data showed that between the Q2 2016 and Q1 2017, 21% of people aged over 65 were readmitted to hospital within 30 days of discharge in Northamptonshire, which was higher than the England and comparator area averages of 19% and 18%, respectively. Readmission rates from care homes were also higher at 23% in Q1 2017 compared to the England average of 20% and comparator average of 19%. There was a perception among some professionals in community and residential settings that pressure within the acute system was resulting in some people being discharged from hospital before they were medically ready, and were therefore more likely to be readmitted.
- People being discharged from hospital were at risk of unsafe ongoing care and support due to inconsistent levels of communication from Northampton General Hospital NHS Trust (NGH) and Kettering General Hospital NHS Foundation Trust (KGH), with families, care providers and health professionals in the community.
- We reviewed eight safeguarding referrals from January and February 2018 relating to hospital discharge. They highlighted issues such as lack of communication about a person's end of life needs, the management of a pressure sore and a general concern with a lack of information sharing with a person's carer and family members.
- Care home providers and VCSE sector representatives told us that people were sometimes discharged from hospital without an assessment, enough medication or without necessary aids such as incontinence pads. There was also no 'red bag' scheme in place, which would ensure that important information about the care home resident's health and support needs accompanied the person on transfer.

- People were also at risk of unsafe discharge because some discharge summary letters lacked all of the necessary information. We reviewed summaries of discharge audits carried out by Nene and Corby CCGs. An audit of 110 KGH discharge summaries sent to eight GP practices carried out in April 2018 showed that only 42% of patients had an accurate discharge summary. An audit of 146 NGH discharge summaries sent to seven GP practices conducted in February 2018 showed that 67% of discharge summaries were accurate. In both cases the contractual expectation of accuracy was 85%. The reasons for the summaries not meeting the audit criteria included omissions of regular medicines, apparent stopping of medications without explanation and incorrect alterations of medications.
- Pharmacy representatives told us that the pharmacy team at KGH had, until recently, been supporting people to have a safe discharge by checking their medicines discharge information for accuracy. For example, we were told about these checks identifying a discharge letter that told a person to stop taking their blood pressure medication. This had been flagged as a potential error and the person had been contacted and underwent a medicines review where it was clear this medication had been incorrectly stopped, and the pharmacist was able to rectify this. These checks had been stopped due to a lack of resource, which meant people were more at risk of an unsafe discharge.
- The reported lack of accurate or detailed information on discharge from hospital was supported by feedback from adult social care providers to our survey on discharge information flow. The majority of the 49 providers who responded to the survey told us they received discharge summaries more than 50% of the time; however 14 responded that they received them less than 25% of the time. These responses were mainly from domiciliary care agencies. The feedback on the timeliness and detail supplied in discharge summaries varied. Respondents also described a number of other issues including out of date or incorrect information, having to chase hospitals for information, relying on verbal handover and care providers having to undertake their own assessments in order to ensure they had the correct information.
- In order to help keep older people safe on discharge, an overnight Carers Sitting Service was provided by the VCSE sector. This service supported people for up to three days following discharge from hospital. Criteria were set around needs such as mobility and frequency of needing the toilet, to reduce likelihood of falls. A reassessment of the person's needs could also be requested if there were ongoing concerns about their ability to remain safe at home. Staff felt that this had a positive impact on enabling people to settle in again at home.

Are services in Northamptonshire effective?

System leaders acknowledged that pathways out of hospital needed to be simplified and communication improved to facilitate effective sharing of information. There had been efforts to design services to support timely transfers of care and provide holistic assessments of people's needs but some were disjointed and this led to the risk of duplication of work.

Some elements of the high impact change model had begun to be implemented, but were not embedded system-wide. More work was required to ensure there was consistency in practices and processes and to improve levels of trust and communication among staff.

- System leaders told us that they were aware that too many people were admitted to hospital and they stayed longer on average than people in national comparator areas, worsening their prospects for positive outcomes. They agreed that the pathways for people leaving hospital were not always smooth and their approach was not sustainable. Our review of case files supported this. We found several examples of people experiencing delayed transfers of care and for some it was not always clear why. For example, in one case file we reviewed the person had been declared ready for discharge with some ongoing support, but the necessary referral form was not completed for a further five days.
- Some services and initiatives designed to facilitate flow had been implemented and were evidence-based. However, at the time of the review they were not fully effective. For example, Multiagency Discharge Events (MADE) had been held with the support of the Emergency Care Improvement Programme (ECIP). These meetings brought together the local health and social care system to support improved patient flow, unblock delays and streamline discharge processes. System leaders told us that these events had helped to improve flow and release some beds in the short term. Partners had also held a workshop on complex discharge planning which highlighted issues around capacity and demand planning, data sharing, early joint planning, simplified processes and commissioning. However, a representative from ECIP stated that challenges of work pressures and conflicting demands meant staff could not always maintain and embed decisions and processes agreed at a MADE to facilitate timely discharges from hospital.
- Northamptonshire's health and social care system had a single point of access (SPA) to manage discharges from hospital with a multidisciplinary team who were not located at the hospital.
- The Short Term Assessment and Reablement Team (START) was able to access and provide simple equipment and aids to support people to regain their independence. The Short-Term Enablement and Prevention Service provided short-term reablement services and community occupational therapy as well as supporting intermediate care and step down

following a period in hospital. The team also provided mental health crisis support with health partners, utilising crisis cafés and other community-based solutions.

- Variability in the sharing of information across the health and social care interface also impacted on the effectiveness of services at facilitating timely discharges from hospital. The Patient Discharge Notification Assessment (PDNA) form, which notified the local authority's social care team of any ongoing needs, was sometimes contributing to delays. Although recent improvements, led and facilitated by NGH and supported by the system, had seen the length of the form reduced, hospital staff told us that they were often completed over several days by the different professionals involved in a person's care. This sometimes led to the document containing conflicting assessments of people as their needs had changed over that period of time. They told us it was not reviewed or updated before submission to the SPA. SPA staff therefore had to ask further questions to clarify a person's needs, leading to potential delays in discharge from hospital.
- Care home and domiciliary care providers told us that when people they supported were in hospital, communication with hospital staff was poor. They stated that hospital staff did not involve them in early discharge planning and often did not contact them until the person was ready to be discharged. In order to check on the status of the hospitalised person the care home staff said they would have to rely on the person's family or call the hospital ward themselves.
- Some stages of the discharge process were duplicated. For example, the Intermediate Care Team (ICT) and Crisis Response Team (CRT) undertook rehabilitation assessments while the START team undertook their own assessments which resulted in duplication. In one case file we reviewed, the person received care from the CRT for the allotted time of two weeks following discharge from hospital and then had a further assessment from START to provide care for two more weeks. This meant the person not only had to tell their story more than once, but it also impacted on continuity of care as they experienced an additional handover of staff.
- The high impact change model for managing transfers of care identifies a series of changes that can help reduce delays. While the system had begun to implement some aspects of the model, much of the work in this regard was underdeveloped. For example, the Intermediate Care Team and community hospitals were using a trusted assessment model by accepting referrals based on the information included in a person's PDNA. This was not without its challenges as some staff told us the information included in the PDNA did not always accurately reflect the person's needs. In addition, care home providers did not accept the idea of a trusted assessment and would carry out their own assessment once a person was fit discharge. This contributed to further delays in the person's journey.

- Discharge lounges were not used in the most effective way to support flow of people through the hospital. There was an opportunity to improve flow by anticipating the time of a person's transfer out so people could be there at the right time for this.
- Pharmacy representatives told us that care homes could be overly cautious about medication which led to delayed discharges from hospital, some stockpiling and increased waste. They would only accept a 28-day supply of medicines when a person was transferred to them. This meant that supply had to be revised at the point of discharge and added to the delay for a person's return to their usual place of residence.

Are services in Northamptonshire caring?

People were not always supported to be involved in making decisions about their care when they were ready to be discharged from hospital. Capacity issues within the social care market meant availability of placements were prioritised over choice even if they were not appropriate and the person had to be moved.

Carers and families were not always involved in the discharge planning process and there was not always a holistic assessment of the person's needs to ensure their wellbeing needs were also addressed.

While those referred for continuing healthcare (CHC) did not have to wait long for an assessment, the proportion of people who received CHC support at the end of their life was significantly lower than average.

- The discharge process from hospital was not always person-centred which could lead to increased readmission rates. There was little evidence in the case files we reviewed of meaningful involvement of people, their relatives or carers in decisions regarding their ongoing care needs. One advocacy organisation told us that the drivers around discharging people from hospital were "convenience and availability". They told us that hospitals were using discharge to assess to avoid the need for a best interests meeting and advocacy. As a result, they felt that a number of people were transferred out without proper oversight. This lack of oversight and a person-centred approach could lead to people being readmitted. Data showed higher hospital readmission rates 30 days after discharge for older people in Northamptonshire compared to other areas.
- We were told that choice for people around their care and support needs was often an aspiration rather than a reality. In response to capacity pressures at the acute hospitals and to improve flow, an external company had been commissioned to find discharge to assess placements for people. Initially set up to support self-funders only, this service had been

expanded to local authority funded placements in order to meet a 48 hour deadline for supporting people out of hospital once they were deemed fit for hospital discharge. We were told by system partners and frontline staff that the priority for this service was to find a placement as quickly as possible, which could impact on a person's choice. Placements could not be progressed by the local authority until a social care assessment was completed. This was done after four weeks. A significant proportion of people stayed in the initial placement. Data provided by the local authority from May 2018 showed that of the 90 people placed only 22% of them were moved from their initial placement. This meant that there was a risk people and their families "chose" to stay where they were because after four weeks they had become used to the care setting or did not want the upheaval of the move. This was a concern because frontline staff told us that sometimes the initial placement was not the most appropriate.

- We spoke with a group of carers who told us that they were not always involved in discharge planning and sometimes felt that communication was poor. In one case file we reviewed a person had suffered a stroke and their carer was expected to take the person home. There was no evidence in the file that staff had considered the carer's needs and what support they required to be able to care for the person at home.
- Performance in relation to CHC, which is often used to support people towards the end of their life, was mixed. Data relating to Nene and Corby CCGs for the last quarter of 2017/18 showed that people's eligibility was assessed in a timely way with fewer than average people waiting 28 days or more for an assessment. Furthermore, very few people had assessments completed in an acute setting; 6% for Nene CCG and 0% for Corby CCG, compared to the England average of 14%. This meant that people did not have to wait unnecessarily or make long-term decisions while in a hospital bed.
- If a person's condition was deteriorating and they may be approaching the end of their life, a fast track CHC assessment may be applicable to allow an appropriate care and support package to be put in place as soon as possible. Most people who were referred for fast track CHC in Northamptonshire received it, (96% for Nene CCG and 92% for Corby CCG). This meant that people at the end of their life were supported in a timely way to be moved to their preferred place of care.
- However, the number of people deemed eligible for both standard CHC and fast track CHC was lower than average for both CCGs. As referral conversion rates were high, the lower eligibility rate may indicate staff were not identifying enough people who needed the support of CHC funding. NHS data for Q4 2017/2018 showed the England average for the number of people eligible for standard CHC was 39.5 per 50,000 and 18.4 per 50,000 for fast track CHC. In Nene CCG it was 30.1 per 50,000 people for standard CHC and 6.5 per 50,000 for

fast track and for Corby CCG it was 26.5 per 50,000 people for standard and 1.6 per 50,000 for fast track. Eligibility rates, therefore, were significantly lower than average for fast track CHC.

Are services in Northamptonshire responsive?

People were not always seen in the right place, at the right time by the right person.

The NHS acute trusts in Northamptonshire had a history of delayed transfers of care well in excess of the England average and although there had been some significant improvements between September 2017 and March 2018, performance continued to be sub-optimal. A large proportion of older people were in hospital for more than 21 days and they were more likely to be readmitted.

People who received a reablement service achieved good outcomes and we received positive feedback from people about step-down intermediate care services. However, there was an over-reliance on bed-based intermediate care in response to capacity issues both within the acute and community setting. This model of care did not align with the Sustainability and Transformation Partnership's 'home first' principle.

- Older people in Northamptonshire were more likely to experience delayed transfers of care (DTC) from hospital than people elsewhere. The Department of Health and Social Care's analysis of NHS England's data showed that between October 2017 and March 2018 Northamptonshire consistently had a higher rate of DTC from hospital than the England average. There had been a peak in October 2017 of 25.2 days per 100,000 adult population. System leaders had recently implemented short term measures to address DTC. More resources had been put into acute hospitals, the capacity of reablement centres had been increased and Multi-agency Discharge Events were helping to improve understanding between system partners and facilitate more timely discharges from hospital. As a result, considerable improvements in performance had been made. Data showed that the rates of DTC had reduced over the following months to 16.3 days in February 2018. However, in March 2018 the rate had increased again and was at 18.3 days compared with the England average of 11.4 days and comparator average of 13.1 days. It was too early to determine if the measures implemented would lead to further and sustained improvements.
- Data provided by the system showed that between 1 April and 30 April 2018 there were 838 people from Northamptonshire whose transfer of care from Kettering General Hospital NHS Foundation Trust (KGH) was delayed, (54% of discharges). During the same period there were 723 delayed transfers of care at Northampton General Hospital NHS Trust (NGH), (46% of discharges). There was an almost equal split between those delays that were attributable to social care and those attributable to health. The most significant reasons for

delay were awaiting completion of social care assessment, residential care home placement, nursing care home placement or awaiting further non-acute NHS care. We were also told by staff across the system that waiting for transport and medication were common reasons for delays on the day a person was due to be discharged from hospital.

- There were also DTOC from the community provider, Northamptonshire Healthcare NHS Foundation Trust (NHFT). Over the same period (1 April to 30 April 2018), there were 629 delayed transfers of care, 447 (71%) of which were classified as social care delays with the main reasons being: awaiting completion of a social care assessment, residential care home placement or domiciliary care package.
- A pilot scheme that supported people with complex housing needs to be discharged from hospital in a timely way was in place. The Health and Housing pilot commissioned jointly between KGH and NHFT began in July 2017. A Housing Options Advisor was based on site, split between KGH and community hospitals in the north of the county over each week. Their focus was on avoiding or resolving accommodation related DTOC. Data shared with us from the pilot showed that of the 118 cases referred to the Housing Advisor, 96 were closed with 88% of those cases successfully assisting a person to be discharged from hospital. The main reason for referral was homelessness or the property no longer being suitable due to a medical condition. The pilot was due to finish the end of June 2018 however a business case had been put forward to Nene CCG to consider continuing the service. There was an opportunity to share learning with NGH if the pilot was deemed to be successful.
- It was widely acknowledged among system leaders and frontline staff that capacity within the social care market impacted on how quickly a person could be discharged from hospital, particularly if a person required more intensive support at home, such as multiple visits a day with two care workers. Capacity issues within other community-based services also contributed to delays. Anyone who was assessed as needing reablement support would be discharged via the Crisis Response Team (CRT). However, we were told that the CRT did not have capacity to ensure they saw everyone in a timely way, which meant some people's discharge from hospital was delayed.
- It had been recognised that people living with dementia or delirium experienced delays waiting for suitable care to be found for them. A specific team was in place to support the discharge of older people living with dementia; the Holistic Intermediate Care Team (HICT). They offered same day discharge from hospital and up to eight weeks of support. They had access to care staff who could stay with someone 24 hours a day for up to 72 hours, which enabled a thorough home assessment. Data shared with us from the team showed that since February 2016 over 640 people had received intermediate care in their own home. However, the CCGs identified that HICT had limited capacity to meet demand and had

recommended within the Joint Northamptonshire Dementia Strategy 2016-2019 that there was a 30% increase in capacity in HICT.

- Although there were undoubtedly capacity issues within the community which meant people were waiting for packages of care, we also found delays were accepted among health and social care staff. This was a symptom of long term working within a challenged system and therefore staff often lacked any sense of urgency around discharge. For example, in one case file we reviewed a person had been deemed medically fit by clinical staff on 4 January 2018 and ready for discharge on 9 January 2018 by the hospital therapy team. However, a Patient Discharge Notification Assessment was not completed and sent to the Single Point of Access for a further five days. The person was eventually discharged home with support from the Crisis Response Team and their family. However, despite being classified as a “non-complex” discharge, this person spent over a week longer in hospital than was necessary.
- Older people in Northamptonshire who received reablement were likely to have a good outcome with a relatively high proportion remaining out of hospital. The percentage of people who were still at home 91 days after discharge into reablement was 81% in 2016/17, which was higher than comparator sites and only slightly lower than the national average of 82.5%. However, the percentage of older people in Northamptonshire benefitting from reablement was decreasing, and was below the England average. Analysis of ASCOF data showed that the percentage of older people who received reablement services had decreased over the years from 3.6% in 2011/2012 to 2.3% in 2016/17.
- The high impact change model for managing transfers of care identified seven-day services as one of the changes that could support health and social care systems to reduce delays. Northamptonshire’s health system was doing better than average on providing seven day services as indicated by the Department of Health and Social Care’s analysis of activity between April 2016 and March 2017. This showed that the proportion of older people discharged from hospital over the weekend (a measure of seven day working) in Northamptonshire was 21% and was in alignment with comparator sites and the England average. This needed to be built on and reflected in social care and the independent sector services. For example, putting in processes whereby care home and homecare providers felt confident and comfortable to receive people from hospital over a weekend.
- Some bed-based intermediate care was available for older people. The local authority had a 25 year contract of ‘block booked’ beds with Shaw Healthcare to provide some step down intermediate care. However from our review, and from feedback from CQC inspection teams, it would seem that this resource was not always effectively utilised. For example, we found that on 22 May 2018, only 25 of the 51 available beds were occupied. Hospital staff told us that this was because the high admission criteria made the service very difficult to access.

- KGH had commissioned 46 'outflow' beds at Claremont Nursing Home. This service was for people that were medically stable and awaiting further assessment, discharge home or to another placement or rehabilitation setting. Of the 46 beds, 15 were dedicated therapy beds. People in the therapy beds had more complex needs and were seen daily by the therapy team with an aim to return home sooner.
- KGH had commissioned these beds in response to the capacity pressures at the acute hospital. Evidence provided by the system showed the 15 therapy beds were achieving good outcomes for people. The Claremont Therapy March 2018 report showed that of the 301 people discharged from the service in the previous six months, the average length of stay was 22 days. Forty-eight per cent of people had been discharged home, (77% of those discharged home required additional support from intermediate care services or a package of care), and 27% had been transferred to an inpatient rehabilitation setting. The remaining 25% of people had returned to KGH, needed 24 hour care, or died. The feedback received from people and their families about the service was excellent.
- Although bed based intermediate care was helping to relieve the pressure in the acute hospitals and provide a more timely discharge from hospital for some people, a focus on more targeted community services, developing capacity for a multi-agency approach to supporting people in their home, would align better with the 'home first' principle as set out in Northamptonshire's STP.

Maturity of the system

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

- The review took place at a time of significant pressure and financial challenge within the system and followed a report that was likely to lead to significant change in Northamptonshire.
- There was a clear intent from the system's leadership to improve how people moved through and between health and social care. However, historically poor relationships and financial challenges meant people's experiences of health and social care was variable. The system was at the very start of its journey to integration and for improvements to be realised at the front line, considerable work was needed to translate embryonic strategic plans into operational delivery.
- At the time of our review there was not a single, shared vision that could be consistently articulated across health and care agencies. Although there was willingness to create a joint vision through the recent refresh of the Sustainability and Transformation Partnership (STP), there was no clear narrative that was owned and understood by the whole system.
- There were signs of increased partnership working and intent to develop shared processes and decision-making, which was a positive step. However, at the time of our review, system-level governance arrangements were newly established and not understood by all system partners. The STP was described as the vehicle through which system-level transformation would be implemented. However, there lacked clear lines of communication and reporting between the STP and Health and Wellbeing Board, with the latter not fulfilling its oversight and challenge function to hold the system to account. Performance was measured on traditional key performance indicators rather than a set of shared metrics, so remained transactional rather than transformational.
- We were impressed by the commitment demonstrated by frontline staff to work in a more integrated, joined-up way and there was some evidence of joint-working. However, these examples appeared to be provider rather than commissioner-led and needed to be translated to system leadership level. System leaders were open and honest about the fact that relationships had been poor and a barrier to integration. However, there was also a renewed sense of motivation and commitment among leaders to move forward with transformation together. The level of work required to build positive relationships and develop effective partnership working should not be underestimated. There needed to be more proactive engagement with the Voluntary, Community and Social Enterprise sector,

health and social care providers, and the public to ensure there was collaborative working in the interests of the population's defined needs.

- There lacked a strategic approach to system-level workforce planning with organisations and sectors working in silos. There was no single, integrated, coherent workforce strategy for Northamptonshire which looked at future staffing needs to deliver service transformation which wrapped care around a person.
- Information sharing between services, although improving, remained underdeveloped. Plans were in place to progress digital interoperability across the system, including the expansion of SystmOne into the local authority. As part of the STP work stream for Information Computer Technology, an Information Governance Local Digital Roadmap had been developed. However, concerns were raised that the significant investment necessary to see all of these plans to fruition would not be forthcoming given the financial constraints on the system.
- There was not a strategic approach to managing and shaping the market. Northamptonshire faced significant market challenges, but to date a traditional approach to shaping the health and social care landscape had been in place. There were very limited examples of joint commissioning. The prevention agenda was underdeveloped and there had been an over-reliance on bed-based care for people. There was scope for longer-term gains for local people if system partners jointly made the investment to actively shape the market.
- There was a shared commitment to pursue the prevention agenda, but integrated service delivery was underdeveloped. Although we saw examples of some multidisciplinary team working, these were not embedded to ensure they were system-wide. Pathways could result in duplication of work and there was evidence of silo initiatives which were not leading to system-wide learning and communication around good practice.

Areas for improvement

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

- System leaders across health and social care in Northamptonshire must work together to strengthen relationships, working collaboratively to address the significant challenges in the provision of integrated health and care services for older people living in Northamptonshire.
- The delivery of the Sustainability and Transformation Partnership strategic plans must be accelerated in order to secure positive outcomes for the older people of Northamptonshire. A clearly articulated vision of the transformation agenda should be known and understood by all health and social care staff.
- The challenge and oversight functions of the Health and Wellbeing Board and Scrutiny Management Committee should be strengthened.
- The Clinical Commissioning Groups (CCGs) and local authority commissioners must work together to develop joint commissioning and manage the social care market more effectively with an increased focus on prevention; improving people's flow through the health and social care system.
- The CCGs should work to improve relationships between themselves and GP providers.
- System leaders should ensure that there are regular and system-wide opportunities to come together and discuss challenges and risk, evaluate the effectiveness of initiatives and generate shared solutions.
- System leaders should use system-wide performance data to drive improvements, implementing solutions and setting targets in which all parts of the system have a shared responsibility, and providing opportunities for collaborative reflection and learning.
- System leaders must ensure there is a Northamptonshire-wide workforce approach, articulating a clear system-wide action plan to provide a competent sustainable workforce. Independent adult social care providers should be included in the development of the workforce strategy so that recruitment and retention across all health and social care sectors can be improved. Consideration should be given to the development of joint posts or new roles to support integrated care by working across organisational boundaries.

- System leaders should develop comprehensive engagement strategies, including working with Healthwatch Northamptonshire, to facilitate effective engagement with the public and with frontline staff to ensure they are appropriately involved in the transformation plan.
- System leaders should continue to implement the high impact change model approaches to facilitate more timely discharges from hospital.
- System leaders must ensure discharge planning is consistently started at the beginning of a person's journey through hospital and remains a key focus throughout their stay. Care home and care at home providers should be involved in discharge planning at an early stage of the person's stay in hospital.
- System leaders must improve the processes around medicines on discharge to reduce delays and improve the safety of those who have been discharged to their usual place of residence.
- System leaders should aim to reduce numbers of avoidable admissions from care homes by increasing coverage of GP and pharmacy input into care homes.
- System leaders should review the Management and Technology strategy, including the Local Digital Roadmap to ensure that actions are funded and risk assessed; working towards interoperability of systems and shared health records as a priority.