

# Staffordshire

Local system review report

Health and Wellbeing Board

Date of review:

22 to 26 October 2018

## Summary of findings

Published: December 2018

### What are older people's experiences of care in Staffordshire's health and care system?

- Older people living in Staffordshire had varied experiences of health and social care services. There were local variations in what was available and as a result people's experiences of care and support were inconsistent. Access to preventative services was also variable. Some people were aware of what services were available to support them in their local area, others were not.
- We spoke to people in a range of health and social care environments. The people we spoke to were mainly satisfied with the quality of services provided once they received them.
- People were being supported to remain in their own home and as part of the community through a number of services coordinated through a GP practice hub model. This was more developed in some parts of the county, for example in Lichfield.

- Our analysis showed that A&E attendances for people over 65 (January to March 2018) were similar to the national average but higher than comparator area averages ('comparator areas' are nationally determined and refer to areas of a similar geographical size and population as Staffordshire). A&E attendances for people over 65 living in care homes (January to March 2018) were higher than both national and comparator areas.
- There had been some recent improvements. However, people living in Staffordshire were still more likely than people in comparator areas to be delayed coming out of hospital, and older people with complex needs were more likely to experience long delays in accessing suitable care and support.
- Some people we spoke with during the review told us that they felt their choice was restricted when choosing a care home placement following the introduction of a new care home brokerage system by Staffordshire County Council (SCC). People we spoke with said the choice of home was based mainly on cost and did not consider, for example, their existing community networks or how their friends and family might travel to visit them.
- The quality of care homes varied. Staffordshire had higher than average numbers of care homes rated as requires improvement or inadequate. The quality assurance team was doing good work to improve the quality of care and that was having a positive impact, however people still had a limited choice of care homes rated as good.

**Is there a clear shared vision and common purpose, underpinned by a credible strategy to deliver high-quality care that is understood across the health and care system?**

- The Sustainability and Transformation Partnership (STP) had a clear vision which was underpinned by the Health and Wellbeing Board's (HWB) Joint Strategic Needs Assessment (JSNA). There was strong commitment at system leader level to deliver the vision, and good political support at county level. The vision was supported by Staffordshire's Health and Wellbeing Strategy.
- At senior leader level there was a strong sense of a shared vision, maturing relationships and improved partnership working. At different operational levels of the health and care system, the vision became less understood.
- There were opportunities to include involve, and engage with frontline staff, the voluntary, community and social enterprise (VCSE) sector, local people and communities to help deliver the strategy and improve understanding of the vision for Staffordshire.

## Are there clear governance arrangements and accountability structures for how organisations contribute to the overall performance of the health and care system?

- The STP was the driver for transformation in Staffordshire, and the forum where the strategy would be agreed rather than the HWB. This was acknowledged by the HWB. Staffordshire's Health and Wellbeing Strategy for 2013 to 2018 did not contain an overarching set of indicators to measure the progress of the whole system against its strategic aims.
- New governance arrangements had recently been introduced to support collaboration between partners. As well as recent trust mergers, a combined accountable officer management team had been put in place combining six CCGs (five from Staffordshire plus Stoke on Trent CCG). Delivery mechanisms included three new provider alliance boards and 23 integrated care teams.
- However, there was not yet a clear thread between the strategy for the system, and the individual roles of the organisations and people involved in commissioning and delivering services.

## Are there arrangements for the joint funding, commissioning and delivery of services to meet the needs of older people?

- There was no joint commissioning strategy in place at the time of our review. There were limited joint commissioning arrangements in place other than the Better Care Fund (BCF) arrangements for winter planning.
- Steps had been taken to make commissioning system-wide with the recent development of a joint strategic commissioning board, however a joint commissioning strategy had not yet been developed. There was limited joint commissioning of services and a transactional approach meant that commissioning largely remained organisational and contract-based.
- At the time of our review there was a draft market position statement to provide information to partners regarding the current and future care needs of people in Staffordshire. A joint approach to care market management and development was in its early stages. There was some system-wide working to address problems regarding service provision across the county, however activity remained fragmented.

## Are people who work in the system encouraged to collaborate and work across organisational boundaries to meet the needs of older people?

- We saw some good examples of collaborative and joint working at both senior leader and operational level. The STP's strategy and vision had brought together organisations through a number of workstreams to tackle system issues.
- The workforce workstream was using a system-wide approach to look at redeployment. A system was in place to offer redeployment and retraining to those at risk of redundancy. The aim was to retain a skilled and valued workforce and avoid redundancies.
- The quality assurance team was made up of SCC and CCG staff with a specific safeguarding focus. The team was working together to improve the quality and safety of care homes in the independent sector. This work was targeted and well-managed, and there were already encouraging signs that it was leading to improved outcomes and positive experiences for local people.
- The new frailty hub in Lichfield was an example of good primary and secondary care working together to improve outcomes for people. A Lichfield GP, who was also a Consultant Geriatrician, had developed a new service after seeing high numbers of patients being admitted to hospital due to falls. The service hub brought together resources already available to local health and care organisations, and included 'community connectors' who helped signpost and connect individuals with local community activities and groups. The service also included staff members, such as a care navigator and an elderly fare facilitator, to coordinate care for those referred to the service.
- There was an opportunity to increase collaboration between services in the north and south of the county. For example, the Home First Integrated Team, a team that provides resablement and rehabilitation services, was more developed in the north than the service in the south. The team was able to share good practice across other teams and locations, and improve the consistency of all the services.
- The VSCE and independent sectors were not included in a number of workstreams and in the development of transformational strategies. If VCSE groups were included more in the co-production of initiatives, it would help support the implementation and embedding of the initiatives as all parties would feel involved and equally valued.

## Key areas for improvement

At the time of our review, the Staffordshire health and social care system was in the early stages of transformation. Although there was a clear vision and strong senior leadership in place, there was potential to improve services and outcomes for local people. Provision of health and care was fragmented and people's experiences were dependent on where in the county they lived.

There was a lack of involvement of people using services in Staffordshire in the design and development of services. Work is required to include local people in the co-production of services for the future so that their needs and aspirations are met and supported.

The system is not fully using the range of potential sources of support in Staffordshire, particularly VSCE organisations and independent care providers. Including VCSE organisations as full partners is under-developed.

# Background to the review

## Introduction and context

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 targeted reviews of local authority areas. The purpose of this review is to understand how people over 65 move through the health and social care system in Staffordshire with a focus on the interfaces between services.

This review was 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 regulatory activity. By exploring local area commissioning arrangements and how organisations are working together to meet the needs of people who use services, their families and carers, we can understand people's experience of care and what improvements can be made.

This report follows a programme of 20 reviews carried out between August 2017 and July 2018. The reports from these reviews and the end of programme report, [Beyond barriers](#) can be found on our [website](#).

## How we carried out the review

Our review team was led by:

- Ann Ford, Delivery Lead, CQC
- Wendy Dixon, Lead Reviewer, CQC

The review team included: two CQC reviewers, a CQC Expert by Experience; and three specialist advisors, two with experience as a senior system leader in a local authority and another with experience as a commissioner and clinical nurse advisor at a senior level in the health system.

The Staffordshire 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 65 and over**.

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

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

- supporting people to maintain their health and wellbeing in their usual place of residence
- care and support when people experience a crisis
- supporting people to return to their usual place of residence and/or admission to a new place of residence following a period in hospital.

Across these three areas, we asked the questions:

- Do people experience care that is safe?
- Do people experience care that is effective?
- Do people experience care that is caring?
- Do people experience care that is responsive to their needs?

We then looked across the health and care system to understand:

- Is the system well-led?

Before 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 local system leaders to provide an overview of their health and social care system in a System Overview Information Request (SOIR) and asked local stakeholder organisations for evidence.

We used two online feedback tools: a relational audit to gather views on how relationships across the system were working, and a discharge information flow tool to gather feedback on the flow of information when older people are discharged from hospital into adult social care.

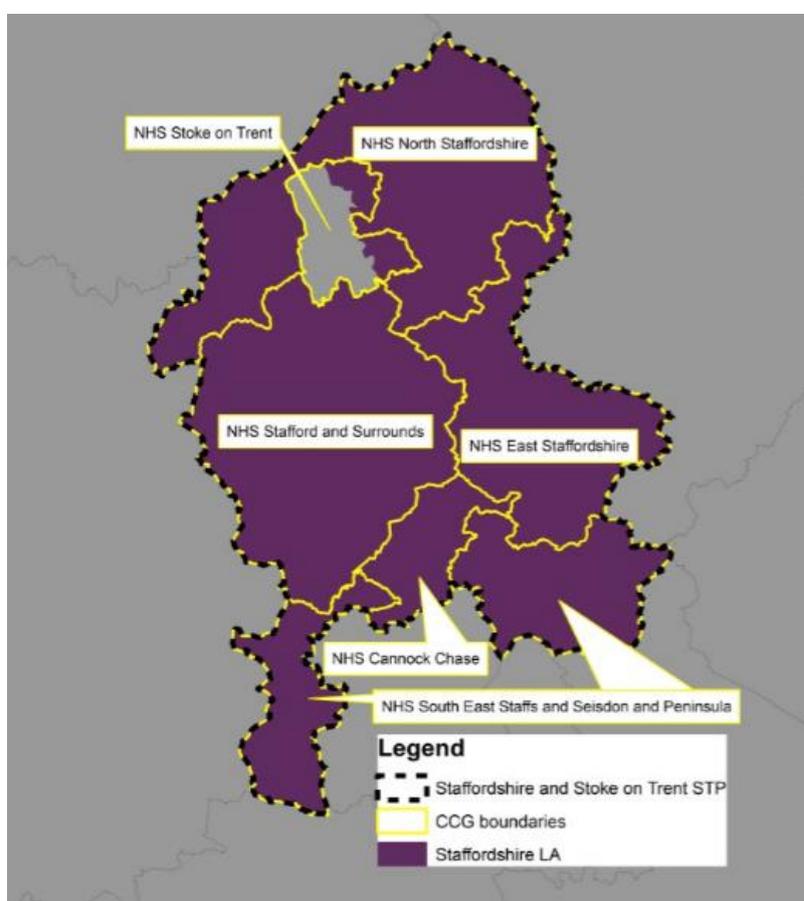
We reviewed 18 care and treatment records and visited 21 services including acute and community NHS services, care homes, GP practices, extra care facilities, out of hours services (OOH) and a hospice.

We sought feedback from people involved in shaping and leading the system, those responsible for directly delivering care, as well as people who use services, their families and carers. The people we spoke with included:

- System leaders from Staffordshire SCC, including the chairs of the HWB.
- The management team with overall responsibility for the CCGs covering Staffordshire: North Staffordshire; Cannock Chase; Stafford and Surrounds; South East Staffordshire and Seisdon Peninsula; and East Staffordshire.

- Senior leaders from University Hospitals North Midlands (UHNM), University Hospitals Derby and Burton (UHDB), Royal Wolverhampton NHS Trust, Midlands Partnership NHS Foundation Trust (MPFT) and North Staffordshire Combined Healthcare NHS Trust (NSCHT).
- Staff including members of the workforce, quality, commissioning, market shaping and brokerage teams. We also met staff working in the community, care homes, A&E departments, frailty services, medical wards and the discharge lounge.
- Local Healthwatch.
- Provider representatives from adult social care and VCSE services.
- People who use services, their families and carers.

## Staffordshire context



Map 1: Geographical location of each of the five CCGs that cover the Staffordshire health and care system.

[Note that Stoke on Trent CCG appears on the map but was not included in this review].

# Detailed findings

## Are services in Staffordshire 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?**

We looked at the strategic approach to delivery of care across the interface of health and social care services. This included looking at strategic alignment across the system and the involvement of people who use services, their families and carers. We found that the Staffordshire and Stoke-on-Trent STP was the system driver of transformation and there were good relationships and a good understanding between senior leaders and the STP. A new Health and Wellbeing strategy has been developed from 2018 for five years which takes a 'life course' approach to the population's health and wellbeing and is focused on addressing health inequalities as identified in the JSNA. The delivery of this plan was yet to be developed. People working in the Staffordshire health and social care system, both at a senior and operational level demonstrated that they were proactive and willing to work together across organisational boundaries, however this did not always translate into consistent delivery and outcomes for people. There was limited evidence to demonstrate how system partners involved people who use services, their families, carers and representative organisations in the strategic approach to planning and delivering services.

- The Staffordshire health and social care system was complex, made up of a number of non-acute and acute providers. Some providers were not located in the county of Staffordshire, for example the Royal Wolverhampton NHS Trust, which had created additional complexity and differences in delivery of services. There were five CCGs across Staffordshire that had recently joined and established one accountable officer. In 2017, the STP was set up to include SCC, NHS trusts and CCGs.
- Rather than the HWB being the forum where the system was to be held to account, this took place at the STP board with the HWB's agreement. There were good relationships between senior leaders in the STP and they demonstrated a strong understanding and consensus regarding the issues and challenges in Staffordshire. The STP's Together We're Better Strategy had a plan for transforming the health and care system. There were not yet detailed comprehensive delivery plans in place to implement the changes as the strategy was relatively new.
- There was strong political support from SCC for the STP. This was confirmed in our conversations with leaders and demonstrated in the drafting of the HWB manifesto in May 2017 as, the SCC cabinet included the delivery of the STP in that manifesto.

Senior leaders met fortnightly as an STP executive forum; chairs and chief executives met monthly to consider strategic issues. The HWB met bi-monthly.

- At the time of our review, the Staffordshire Health and Wellbeing Strategy (2013 to 2018) was coming to an end and a revised strategy had been developed for 2018 to 2023. The new strategy took a life course approach to the population's health and wellbeing and was focused on addressing health inequalities as identified in the JSNA.
- As the 2018 to 2023 Health and Wellbeing Strategy was new, there were no plans in place yet to describe how it would be delivered. Documentation outlining the strategic ambition, challenges and way forward for 2018 to 2023 did not fully address equality and diversity. For example, the documentation did not reference the faith sector or set out how the needs of minority groups or those with protected characteristics would be met.
- We found that the people working in health and care in Staffordshire demonstrated a willingness to work together across organisational boundaries for the benefit of people. We saw this in frontline staff, at leadership level and across community and hospital services.
- The willingness to work together did not always translate into consistent delivery and outcomes for people. We found that the Home First initiatives operating in the north and south of the county were at different stages of development, yet the learning was not being shared across the system to drive consistency and better outcomes for people.
- We found examples of good joint working, for example the quality assurance team that monitored the quality and safety in care homes across Staffordshire. This team comprised members from SCC and the CCG. The work they had done together had seen quality and safety outcomes for people improve. There were opportunities for leaders to build on this good practice and create a collaborative environment that would enable people to work together proactively. That supported a shift of focus from being tactical and reactive, towards long-term, multidisciplinary work and strategic planning.
- There was evidence of proactive approaches to clinical leadership in facilitating cross-sector working, as identified in the STP vision. We found that the integrated care teams were becoming established and staff told us that they could deliver better outcomes through adopting a multidisciplinary team approach to supporting people.
- There was limited evidence to demonstrate how health and care system partners involved people who use services, their families, carers and representative organisations in the strategic approach to planning and delivering services. Recently there had been significant organisational change across the CCGs and the NHS trusts. Information about the changes was communicated by the relevant organisations, however a true co-production approach to developing services based on the views of people had not been used.

## 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 in the system, focusing on collaborative governance, information governance and effective risk sharing. We found that governance arrangements for organisational changes across the system were understood but needed to be embedded. The STP with the agreement of the HWB was the forum where the system was to be held to account to ensure the delivery and the embedding of plans. There was limited evidence of organisations sharing learning across the system. Organisations had systems to reflect on issues and implement learning but these were based within organisations and were not system-wide.

- Significant work had taken place to reconfigure organisations across the system. In 2018, the five CCGs covering the Staffordshire area joined with the Stoke on Trent CCG with a single accountable officer and management team, managing across all of the six CCGs. Three Alliance Boards were formed to provide professional accountability and clinical governance for the integrated care teams, with arrangements overseen at the STP level. There had also been structural changes in provider arrangements with the reconfiguration of acute and community NHS trusts.
- Governance arrangements had recently been introduced to support collaboration and consistency across the system. There was not yet a strong understanding of how system governance fitted within the new organisations.
- The system was working to evolve clear governance arrangements at system level which included the newly merged CCG, the Alliance Boards, the local integrated care teams and NHS providers. There was not yet a clear thread between the strategy for the system, the individual roles of the organisations and the people involved in the delivery of services.
- Rather than the HWB being the forum where the system was to be held to account, this took place at the STP board with the HWB's agreement. The Staffordshire Health and Wellbeing Strategy for 2018 to 2023 did not contain measures to determine the success of progress of the whole system against its strategic aims.
- There was limited evidence of organisations sharing learning across the system, however there were some informal discussions on a daily basis across the system which involved looking at lessons learned. Different organisations had formal systems to reflect on issues and implement learning but these were not system-wide. There had been a more collaborative approach to the development of 2018/19 winter plan following learning from 2017/18, which was spoken about very positively. System leaders and frontline staff were more confident that this approach would lead to a more resilient system and better outcomes for people.

- There were opportunities for closer working and sharing of practice, for example in the way that complaints were reviewed across the system. There was some collaboration between SCC and health providers, but there was a need to establish formal joint working and to carry out monitoring to determine if complaints disproportionately affected people with protected characteristics (as defined in the Equality Act 2010, for example race, disability, sexual orientation) with the CCG. This would help to identify themes across organisations and address them through a whole system approach.

**How is the system working together to develop a health and social care workforce that will meet the needs of its population now and in the future?**

We looked at how the system is working together to develop its health and social care workforce, including workforce planning and effective use of the current workforce. We found that there were workforce pressures across Staffordshire with vacancies in areas such as urgent and emergency care, primary care and domiciliary care. System-wide workforce arrangements were in place at STP level, and a STP Workforce Programme Board had been developed to move this forward. The strategy proactively articulated the drivers and immediate pressures such as an ageing workforce, recruitment and retention, and the culture needed to move to new ways of working. The system and STP Workforce Programme Board were not as sighted on the workforce pressures in the independent care sector and the VSCE sector.

- Workforce was one of five 'enabler' projects within the STP plan. There was a system-wide workforce strategy to ensure there were sufficient staff with the right skills across health and social care to meet the needs of older people, now and in the future. The work to develop a health-based workforce was more developed than in adult social care.
- An STP Workforce Programme Board had been developed to move this forward. The board met monthly and all key system partners were represented. They included Health Education England, NHS Improvement, NHS England, three universities and Skills for Care. The strategy articulated the drivers and immediate pressures such as an ageing workforce, recruitment and retention, and the culture needed to move to new ways of working. The three areas of the workforce strategy were clear with risks identified.
- Partner organisations including UHNM, NSCHT, SCC, MPFT and the CCGs were collaborating to implement an innovative approach to redeploying and retraining staff across the system. People at risk of redundancy in one organisation were made an offer to be retrained to work in another, saving on redundancy as well as retaining a skilled and valued workforce.
- There were workforce pressures across Staffordshire with vacancies in areas such as urgent and emergency care, primary care and domiciliary care. Initiatives to address workforce pressures over winter included increasing the use of bank and

agency staff to cover additional hospital wards that were planned to be opened over the winter period. We heard that there had been some success in recruiting hospital staff from other countries but the turnover of staff meant that vacancies continued to be challenging.

- Work had started with Health Education England to recruit and retain GPs across Staffordshire. Posts were developed that provided GPs with the opportunity to work across both primary and secondary care. This was designed to make general practice a more attractive profession and encourage staff retention.
- The system and STP Workforce Programme Board were not as sighted on the workforce pressures in the independent care sector. A domiciliary care workforce review was being undertaken at the time of our review by the STP workforce team. A steering group was in place with key partners to take forward the actions as a system.
- Skills for Care estimates for 2017/18 showed that Staffordshire's adult social care staff turnover rate was 30.7%, slightly below its comparators and England averages. The adult social care vacancy rate was 7.2%, again below England and comparator averages, although rising.
- While adult social care recruitment and retention in Staffordshire overall was better than its comparators, Skills for Care data provided to us showed that there were approximately 50% more vacancies within the independent domiciliary care sector than those in care homes and that recruitment was a challenge.

### Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population?

We looked at the strategic approach to commissioning and to what extent commissioners are providing a diverse and sustainable market of health and social care services. We found that in Staffordshire there was not a well-developed approach to joint commissioning or joint funding commitments between SCC and the CCGs. The merger of the CCGs had been a priority over the past 12 months and the development of a joint commissioning strategy for Staffordshire had not taken place. This was now seen as a priority by the STP. There was only true joint funding through the BCF for specific commissioning activities including those focused on relieving winter pressures. Steps had been taken towards the integration of commissioning with the recent development of a joint commissioning board. The management and development of the adult social care market was in the early stages, but there were examples of positive system working to address quality and capacity issues across the county.

- There was not a well-developed approach to joint commissioning or joint funding commitments between SCC and the CCGs. There was only true joint funding through

the BCF for specific commissioning activities including those focused on relieving winter pressures. At the time of the review, commissioning in Staffordshire was fragmented and it was felt that without a more joined up approach the STP vision could be hard to achieve.

- Some steps had been taken towards the integration of commissioning with the recent ongoing development of a joint commissioning strategy. However, a joint strategy, informed by a joint strategic needs assessment process, was not yet agreed.
- The joining of the six CCGs (five Staffordshire CCGs and one Stoke CCG) through a single accountability and management structure had potential to improve outcomes through improving the consistency of commissioning and reducing variation in people's experiences. The three Provider Alliance Boards attended by commissioners were planned to be developed to be contractors and to then undertake population-based commissioning. The services commissioned should then be responsive to the local needs of the local populations
- A joined up urgent and emergency care commissioning strategy, including out-of-hours and extended access was being developed and was acknowledged to be needed. However, this now needs to develop at pace to ensure people in Staffordshire receive a more equal service.
- There was evidence available for specific commissioning areas, including the current provision, gaps and future requirements across different service environments (such as extra care, domiciliary care and care homes) as well as service types (such as day services, community equipment services and reablement). However, the market position statement was in draft at the time of the review and was not able to fully inform providers of the current and future adult social care needs of people in Staffordshire.
- System leaders told us there was a lack of good quality independent providers, particularly those providing nursing home beds. Only 65% of residential care homes in Staffordshire were rated as good, lower than the comparator areas (76%) and England (77%) averages. The quality of nursing homes was even more challenging, with 46% rated as good compared with 69% across comparator areas and 66% across England.
- Market management and oversight teams were closely linked in with the work of the quality assurance team through management structures. This included joint working with all system partners such as acute providers. The team prioritised addressing unsafe and poor-quality care and worked with providers to either improve or exit the market. The team was being expanded to enable it to focus on improving the capability and capacity of registered managers in domiciliary care, care homes and nursing homes. In Staffordshire, 44% of nursing homes are rated as requires improvement.
- The Market Oversight Team were working with the Public Health team to identify adult social care needs. The Public Health team were tracking the ageing population in Staffordshire and had modelled future needs and gaps. For example, the team identified a lack of domiciliary care and respite provision in Newcastle-under-Lyme. In response, the Market Oversight Team approached local independent providers to increase their

capacity and recruited a rapid response team to provide 315 additional hours of care. This additional capacity was due to be available from November 2018. This was a tactical response to a specific issue rather than part of a joint commissioning strategy to ensure sufficient services to meet people's needs. In the interim, some people had faced a limited choice of high-quality local services. One service users' daughter said, *"I had been given very limited options which meant I couldn't visit as it was too far away."*

### How do system partners assure themselves that resources to support the interface of health and social care are achieving sustainable high-quality care?

We looked at how the local health and care system can have assurance that resources are being used to achieve sustainable high-quality care and promote people's independence. We found that the local financial position was challenging in Staffordshire. The system was anticipating a £157 million overspend (£100 million of which was related to UHNM). The newly formed CCG management team acknowledged it was also financially challenged. Although the system partners understood each other's pressures, they agreed that cost-saving schemes should be balanced with quality and assessed need, and should not be focused just on the financial position of the system.

- The system was anticipating a £157 million overspend (£100 million of which was related to UHNM). Leaders across Staffordshire acknowledged that the system was financially challenged and had recently undergone a significant restructure of the CCGs to help address this. There were also future plans to look at reconfiguring community hospital services. However, leaders were clear that the financial position was not the main driving force for the introduction or withdrawal of services and any change had to be balanced with quality and assessed need.
- BCF and Improved Better Care Fund (iBCF) spending primarily focused on the 'out of hospital' part of the STP Work Programme and particularly supported the Discharge to Assess (D2A) model. The BCF/iBCF was the only area that was truly subject to joint commissioning processes. BCF/iBCF spending was aligned to the STP strategy.
- System leaders had been in discussions with the Department of Health and Social care (DHSC) because DHSC had not agreed the BCF for the last two years. In the 2016/17 plan, a sum of around £15 million was in dispute, and for the 2018/19 plan, discussions were related to system leaders not agreeing the NHSE-imposed delayed transfers of care (DTC) target. It had finally been agreed with NHSE that changing (lowering) the target was considered achievable by the system. However, the monitoring report for quarter 2 stated 'not on track' but with a comment that DTCs had reduced by 25% since the start of 2018 and would be close to target by the end of September 2018. CQC data showed that the Staffordshire DTC rate was 15.2 average days delayed per 100,000 population and that the overall delays in September 2018 amounted to

3,084 days. This meant that they were not on track but were close to the target. All other areas of the BCF were reported to be on target.

- SCC's adult social care sector had a challenging savings target and had already made substantial savings in previous years; however, they were confident that this year they would meet their budget or deliver a small underspend. System leaders said that system transformation was making a difference to financial outcomes through NHS initiatives that reduced people's use of hospital services. These included: the 'Exemplar Front Door' model to reduce emergency hospital admissions; additional D2A beds; Home First services; the Enhanced Primary and Community Care model; and support for care homes, including therapy input and community support for people who are frequent service users.
- SCC had taken a number of measures to ensure financial sustainability. It had reduced support for people whose needs fall beneath the eligibility criteria set out in the Care Act 2014. They had increased productivity which had reduced spend on adult social care assessments and case management for people with eligible needs. They had also increased charging for services in line with the Care Act 2014. Services were being recommissioned to improve the productivity of the market.
- The arrangements for Disabled Facilities Grants (as part of the BCF) were well developed with a consortium of six of the eight district councils working with SCC to deliver a consistent and flexible approach. Two district councils remained independent of the consortium and there was an opportunity to strengthen the approach by involving them.

## How are people in Staffordshire system supported to stay well in their usual place of residence?

Using specially developed key lines of enquiry, we reviewed how safe, effective, caring and responsive the health and care system is in the area in terms of maintaining the wellbeing of a person in their usual place of residence. We found that across Staffordshire there were a range of services to support people to be safe at home although access was not equitable across the county. Access may be addressed by the establishment of The First Contact Centre which plans to support people with signposting to services and community support. There was a phased introduction of integrated care teams in the community to effectively support early identification and prevention approaches. Risk stratification was being implemented in some primary care settings. The system told us that the CCG had achieved 100% extended access to GP services across Staffordshire as at October 2018. We saw some improvements to access to primary care and general practice where services were responding to need by increasing the extended access available in primary care hubs for routine appointments. Further work was needed to fully embed this approach so that people are not attending A&E as an alternative, and have the same access to services regardless of where they live in Staffordshire. The role of the VCSE sector as a strategic partner in the prevention agenda was underdeveloped and there were missed opportunities to make the most of the VCSE resources available in the community.

- There was a range of services to support people in their own homes and to keep people included and engaged in their community, for example a 'dementia café' and a carers support group. There were also plans to introduce social prescribing across Staffordshire. At the time of the review these services were not available in all parts of Staffordshire and people told us about difficulty accessing preventative services.
- People who accessed preventative services spoke about them in a positive light, however access points were not always clearly understood across the county, for example how to access services (such as the dementia café) or rapid response services.
- People told us about difficulties they had experienced with the Staffordshire Cares service. Staffordshire Cares is a service provided by SCC and comprises a team of call handlers who provide information, advice and guidance, and process social care enquires. We were provided with data that showed the average waiting time for people was 1.5 minutes. During the review we were told by some people that it took a long time to get through to the service, and that when people were promised a call back this did not always happen.

- A new service, the First Contact Centre, was being introduced to support older people at the time of our review and is due to be fully operational as of November 2018. The First Contact Centre supports people with signposting to services and support in the community. The service was built on a successful pilot supporting people with learning disabilities. At the time of the review, the service was expected to alleviate pressure on Staffordshire Cares and ensure that referrals to operational teams were appropriate.
- First Contact had worked with the NSCHT outreach team to reduce duplication using a joined up approach to triaging referrals. An example of this was the autographer project. The project involved a camera that is worn by the service user and takes real-time pictures throughout the day that can be played back to support memory recall and assist with the assessment process.
- There was a phased introduction of integrated care teams in the community to support early identification and prevention approaches. We saw, for example the frailty hub and the early work going on around early identification of those at risk. Risk stratification was being implemented in some primary care settings and we attended a multidisciplinary team meeting that was being used effectively to arrange services around the individual to keep them safe at home. This approach had seen some early success, but due to Staffordshire's integrated care teams being at different stages of maturity it was not available to all people.
- Frailty services were also being developed in the community to prevent people going into crisis; the Lichfield hub was a good example of this. The hub included Community Connectors who helped signpost and connect individuals with local community activities and groups. It also included staff, such as a Care Navigator and an Elderly Care Facilitator, to coordinate care for those referred to the service. There were plans to develop similar facilities but at the time of the review this service was only available to people from the Lichfield area.
- System leaders told us that the CCG had achieved extended access to GP services across Staffordshire. The Staffordshire CCGs had been required to commission extended access to GP services, including at evenings and weekends for 100% of their population since 1 October 2018. At the time of the review, our data showed that extended coverage for the 112 surgeries in Staffordshire in March 2018 was available to 42% of the population, which is below comparators (49%) and England averages (62%). Fifty nine per cent of the 112 Staffordshire GP surgeries offered partial provision and 21% offered no provision. We heard that a large number of additional primary care appointments had been commissioned for the winter period. However, these were not urgent out-of-hours appointments and this could mean that people would not be able to get appointments at times of increased demand.
- There was not a consistent approach to the delivery of rapid response services across Staffordshire. Different CCGs had historically commissioned different types and volumes of services. At the time of the review there was a move to improve standardisation. However, in the south of the county people could access intravenous antibiotics in their own home, preventing hospital admissions, whereas in the north of the county, digital technology was being used and community pharmacists, GP

practices and consultants were able to access care home records to review people's care and treatment. Both these initiatives had had some success in keeping people well at home but had not been adopted across the whole county.

- We also saw examples of people attending A&E where wraparound care in the community would have prevented this. In one instance a person was admitted to hospital and the documented reason was that their daughter had gone on holiday and was no longer able to support them. This was a planned event and if respite care or additional home support had been arranged beforehand then the hospital admission could have been avoided.
- There were different models of GP practice support for care homes across Staffordshire which meant that there was variation in the primary care support for the people of Staffordshire who were living in a care home at the time of the review. Each CCG had had a different commissioning strategy for care homes and so people's experiences were different depending on where they lived. We were told these different models were being tested now that the CCGs had merged. This variation was occurring despite national evidence of best practice in how to commission GP practices and pharmacy services that are effective in keeping people well and preventing hospital admission.
- The Mental Health Liaison Service provided by NSCHT operated 24 hours a day, seven days a week. The team used a cluster approach where each practitioner was linked to a group of wards or the A&E department in order to develop strong working relationships with colleagues at the Royal Stoke University Hospital. This piece of work had demonstrated positive results in the early diagnosis of delirium and addressed identified training needs. This service was not available across the whole of Staffordshire.
- There was no whole system dementia strategy in place at the time of review. In north Staffordshire a dementia strategy existed and reflected national guidance by considering how to create dementia-friendly communities and the importance of shaping the market and providing high-quality dementia services. The strategy included rapid access to memory services; ways to avoid admission to hospital; and a focus on how to promote personal, family and community resilience with positive outcomes for people with dementia. The strategy had not been adopted across the whole of the county.
- The latest Adult Social Care Outcomes Framework (ASCOF) data (2017/18) showed the proportion of people aged over 65 using adult social care services who received a direct payment had increased from 13.7% in 2016/17 to 20.5%, making performance in Staffordshire better than the England average (17.5%) but slightly lower than the comparator areas (20.9%). This indicated that more people in Staffordshire could use direct payments to manage their own care choices in a way that supported their independence. There is still more that can be done to support more people to have choice and control as Staffordshire was still not as good as comparator areas.

## How are people supported during a crisis?

Using specially developed key lines of enquiry, we reviewed how safe, effective, caring and responsive the health and care system was in Staffordshire in providing support to a person in a crisis. We found that across the county there were multiple points of access to urgent care and out-of-hours primary care services. Staff needed a greater understanding of services available in the community. Access to acute services differed depending on where people lived in the county. Staff indicated that access is improving with recent initiatives being implemented. Services were in place to specifically support and be responsive to people with dementia or frailty. However, hospital providers in the north and the south were not implementing consistent approaches to assessing and managing discharges and the patient choice policy was not being consistently applied across trusts. We found that people had different experiences of discharge, and processes were not always effective at supporting people to be discharged as soon as they were ready.

- There were multiple points of access for people who needed urgent care and out-of-hours primary care services in Staffordshire depending on the area they lived because of the large size of the county. The major problems related to County Hospital (Stafford) and Burton Hospital at acute sites. We were told that there were ongoing conversations between system leaders about the provision of emergency and urgent care however for people living in Staffordshire at the time of our review, provision was inconsistent.
- The two main acute providers that serve the people of Staffordshire were experiencing an increase in attendances. These providers are: University Hospitals North Midlands (UHNM) with acute sites at the Royal Stoke University Hospital, the County Hospital (Stafford); and University Hospitals Derby and Burton (UHDB) which also has an acute site in Burton. Surrounding providers of acute services for the people of Staffordshire are The Royal Wolverhampton, Telford and The Russell Hall (Dudley) Hospital. They were also experiencing the same issues.
- At the County Hospital (Stafford), out-of-hours GP practices were situated in the A&E department throughout the night. The A&E department closed at 10pm, however there were no shared processes if a person had to be seen by a GP when the A&E department was closed, members of staff or the person themselves had to dial 111 to arrange a hospital admission.
- Access to primary care and general practice was improving with increased extended access available in primary care hubs for routine appointments. There were still instances where people were attending A&E because they could not get GP practice appointments. Between April 2016 and March 2017, the proportion of discharges in the local area at the weekend following emergency admission (19%) was similar to the England average (19.6%). While on a site visit to the Royal Stoke University Hospital, we met a person who had attended the A&E department, eight times in nine months. The person had contacted

their Staffordshire-based GP practice with shoulder pain but was unable to gain an appointment for two weeks. They had then been referred to the 111 service where they were transported to hospital (five other admissions for this person had been for similar reasons). None of the agencies involved, primary care services, acute hospital services or ambulance services had looked at the pattern of these admissions until the day of our review to consider if other services could have prevented further hospital admissions.

- Hospital managers did not always know what services were available in the community to prevent people being admitted to hospital or to support their discharge from hospital. This risked people being admitted to hospital when more appropriate support might have been available in the community. It also meant that people might stay in hospital too long receiving treatment that they could have received at home.
- Although emergency admissions to hospital for people over 65 were in line with the comparator average, A&E attendances from care homes were higher. There were plans to work with the ambulance service to provide a service where a paramedic could treat a person in their own home or refer them on to community-based service, such as the falls team, to prevent hospital admission, however this service was not yet in place.
- Front door services at the Royal Stoke University Hospital had recently been reconfigured to facilitate a better experience for people through the department. The Acute Medical Rapid Assessment team had been set up three weeks before the review to assess where the most appropriate place was for people to be seen and treated in order to avoid admissions.
- Services available seven days a week included: the front door service at UHNM; GP practice streaming; daily consultant-led ward rounds and hospital social work input. Discharge to assess processes involving Home First and including fast-track end of life and community nursing were available. However not all acute or community hospital trusts provide the same level of service at the weekend. Also, not all independent domiciliary care providers would restart home care and new packages of care at the weekend. Falls services in some areas of the county are not available on a seven-day basis. Over the winter there were plans to extend the hours of the brokerage service to cover seven days a week. Between April 2016 and March 2017, the proportion of discharges in the local area at the weekend following emergency admission (19%) was similar to the England average (19.6%).
- We spoke to staff who worked across the front door services at the Royal Stoke University Hospital who told us that over recent months, the service offered to people was much improved. They thought the department was better managed and people did not wait as long. The A&E four-hour wait performance at UHNM over a lengthy period of time had been below the England average, although this had recently improved from the 69% reported in January 2018, to more than 84% in July 2018.
- When people who were living with dementia came into the A&E department there was a separate dedicated room where they could wait with family and carers. There were distraction tools such as 'twiddle mits' to help people remain calm.

- There were frailty assessment services located at each acute site where people's needs would be assessed and after a short stay, usually 48 hours, they would be referred on to either services in the community such as Home First (short term intermediate care and reablement) or admitted into a longer-term hospital bed.
- When people were admitted to County Hospital (Stafford) and Burton Hospital, some people had a poor experience of moving through the hospital, for example experiencing multiple ward moves and delays in leaving hospital. There were examples of people being delayed owing to lack of capacity in block contract arrangements in care homes and domiciliary care. We noted that delayed transfers of care were improving, albeit from a low base.
- Hospital providers in the north and the south of the county were not implementing consistent approaches to assessing and managing discharges. The patient choice policy was not also not being consistently applied in either of the Staffordshire trusts. This meant that people had different experiences of discharge, and processes were not always effective at supporting people to be discharged as soon as they were ready.
- At the County Hospital (Stafford), people were being transferred from the Royal Stoke University Hospital without staff at the County Hospital being made aware of a full patient history. There was a lack of urgency regarding discharge planning. Expected dates of discharge were not being worked towards and the 'red and green discharge boards' were not kept up to date on all wards.
- There was no clear risk stratification of people who were waiting for discharge at any of the acute sites, and there were examples of people who experienced avoidable harm, such as the hospital-acquired infections, pneumonia and Clostridium Difficile.

## How are people supported to return home or to a new place following an admission to hospital?

Using specially developed key lines of enquiry, we reviewed how safe, effective, caring and responsive the system is in Staffordshire in providing support to a person returning home or to a new place of residence. We found that partners in Staffordshire were effectively adopting the high impact change model to support people returning home. Progress with this model was being overseen by a single Urgent Care Board. Although some parts of the model were being addressed proactively, other parts, such as Trusted Assessors, were being implemented inconsistently. While systems were in place for integrated discharge planning we found that there was scope for these multidisciplinary teams to be more assertive in how they planned people's discharge to get them home as soon as they were ready. Home First teams had been introduced to support people to stay well in their own homes where possible. Home First offered a suite of integrated prevention and D2A services including intermediate care, reablement, palliative and end of life care, for up to six weeks. There were also bed-based solutions for discharging people from hospital, and this has been replicated in the winter plan. However, we found that discharge teams did not routinely involve the VSCE sector therefore not always making the most of the resources already available in the community.

- The high impact change model is a national good practice model for improving transfers of care. It was developed in 2015 by national partners including the Local Government Association, the Association of Directors of Adult Social Services, NHS England and the Department of Health. Partners in Staffordshire were adopting the high impact change model with progress overseen by a single Urgent Care Board.
- The system's self-assessment of their progress against the model demonstrated that all eight areas had been considered and were at different stages of maturity. There was variation across Staffordshire in how the model was implemented. There was inconsistent application of the Trusted Assessor scheme. We found some independent providers were carrying out their own assessments as a Trusted Assessor was not in place. This contributed to delays to people's discharge from hospital.
- While systems were in place for integrated discharge planning (one of the high impact changes), we found that there was scope for these multidisciplinary teams to be more assertive in how they planned people's discharge to get them home as soon as they were ready
- The system had experienced some success with the D2A element of the high impact change model particularly in the north of the county. At the time of the review the CCG had commissioned 363 beds within the independent sector. People could be discharged to these beds for their assessment to be completed rather than remain in hospital. Further BCF funds were being invested into D2A to support the system over winter.

- At both UHNM sites a track and triage system was used to manage discharges to assess. This involved ward staff completing a patient profile once a person was medically fit and ready to be discharged from hospital and sending this to the track and triage team based at the Royal Stoke University Hospital, who if needed visited the person on the ward. Track and triage was done remotely at the County Hospital (Stafford) site using an electronic patient profile proforma. Face-to-face assessments were only done by exception which could lead to an extra step in the process if a reassessment was required at home.
- The track and triage system had been operating for approximately 15 months and had improved the time people waited to be assessed and discharged. When sampling people's care records and when speaking to staff it was clear that the system was not fully embedded or being implemented consistently by ward staff at the Stoke and County Hospital sites.
- There was an outreach service provided by NSCHT for people with dementia. They could work with the track and triage team as part of the discharge to assess model at the Royal Stoke University Hospital. The service provided specialist assessment for older people with mental health needs to ensure that they were supported in the correct environment. As a result, the impacts had been: a reduction in the number of patients with dementia need waiting at The Royal Stoke; a seamless patient journey with fewer handoffs and moves around the system; and patients picked up early who may have had a delirium rather than a dementia. A crisis service was also provided to the CCG beds within care homes so that they were supported to accept admissions at weekends.
- UHDB hospital sites had more traditional discharge processes in place which included an assessment being carried out by a care manager under the, now historic, Community Care (Delayed Discharges) Act 2003 by a Care Manager. Only once this process was completed could discharge planning start in full. At the Sir Robert Peel Community Hospital, we saw examples of good multidisciplinary team working to facilitate discharge, but this was limited in effectiveness in part due to the availability of community care, but also due to the appropriateness of admissions. For example, one person had been in the hospital for 95 days in addition to 179 days in Burton Hospital when a community placement would have been more suitable. With both trusts we saw that the discharge process did not start until either the patient profile or the section 2 (assessment by a care manager) had been completed, meaning a delay in both cases in the start of the discharge process. For the month of September 2018, data provided by the trusts showed there were 154 days of acute delays attributed to adult social care and 231 days attributed to non-acute delays at UHDB. This compared with 16 days of delay attributed to adult social care at UHNM. This indicated the track and triage or patient profile system being used at UHNM had more success in arranging timely discharges.
- Discharge teams did not routinely involve the VSCE sector therefore they did not make the most of the resources already available in the community.

- We saw instances where the patient choice policy was not being fully implemented. For example, when people did not want to return home with their existing provider of domiciliary care because of safeguarding concerns. In one instance the person had developed a grade four pressure sore where the care provider had not carried out the required visits. In a second example, a property had been left insecure when a domiciliary care provider had left. The case tracking notes reflected that in both cases they had felt bullied by the discharge team to continue receiving care from their providers. The drafting of the choice policy at UHNM had started 12 months earlier but at the time of the review it was still in draft.
- Home First teams had been introduced to support people to stay well in their own homes where possible. Home First offered a suite of integrated prevention and D2A services including intermediate care, reablement, palliative and end of life care, for up to six weeks. The service was commissioned jointly by the CCGs and SCC and additional capacity in the service had been commissioned in the last year as part of winter planning, using BCF funds. The service was more developed and established in north Staffordshire as it had been operating for a longer time. There was an opportunity for sharing learning and best practice across the north and south teams to offer a more consistent quality service.
- Data provided by organisations in the system showed that the number of people discharged from hospital and then going on to receive rehabilitation services at both University Hospitals North Midlands sites was 70% of those discharged at University Hospitals Derby and 50% of those at Burton Hospitals. National data showed that the percentage of people over 65 during 2017/18 receiving reablement within Staffordshire had reduced since 2016/17 from 1.3% to 0.7%. This was significantly lower than the comparator (3%) and England (2.9%) averages. System leaders told us that this data was not accurate and they were taking this up nationally. Data provided by the system showed that the percentage of people over 65 during 2017/18 receiving reablement within Staffordshire had increased since 2016/17 from 1.3% to 7%, which is significantly higher than the comparator (3%) and England (2.9%) averages. The effectiveness (91.1%) of these services, as measured by the proportion of people over 65 still at home after 91 days, remained better than the comparator and the England averages.
- Haywood Hospital provides rehabilitation for people living in Staffordshire, however during our review we found that 40% of people on the wards were there inappropriately and were not receiving rehabilitation but instead were waiting for a long-term care placement. When speaking with staff they told us that the system often filled beds with inappropriate referrals. A number of people told us they had been in an acute setting for at least four weeks before arrival at Haywood Hospital and had been moved several times.
- There were bed-based solutions for discharging people from hospital, and this had been replicated in the winter plan. There were some pilot schemes to support discharges away from a hospital setting, for example a virtual ward set up in the east of the county,

however this seemed to be an isolated example. There was a lack of an innovative approach across the county to increasing opportunities for care in people's own homes.

- The average Staffordshire DTOC rate for people over 18 in July 2018 was 16 days. That had continued to remain worse than the comparator (10.1 days) and England (10.3 days) averages. Local performance had however improved since April 2018 when the rate was significantly worse at 18.6 days. From April 2017 to March 2018, the majority of delays were attributed to the NHS, although rates attributed to adult social care were much higher than comparator and England averages. During this period, the majority of delays were categorised as either, awaiting a care package in a person's own home or awaiting community equipment/adaptations; or awaiting completion of an assessment.
- The CCG brokerage system (ADAM) was used to source care and nursing home placements for people requiring continuing healthcare (CHC) both as a fast track process, usually for people at the end of their lives, and long-term. The time people waited for assessments and accessed a care home placement had recently improved and at the time of the review nobody was waiting for a fast track placement. There was a strong record for assessments taking place in 28 days. The rate at which local CHC referrals were concluded was better than the England average in all five Staffordshire CCG areas, and at the time of the review there were no incomplete assessments.
- There were more Decision Support Tools (DST) for CHC completed in a hospital setting in south east Staffordshire as there were less D2A placements available in that part of the county. Plans were being developed to introduce a model where community hospitals were used to complete DST, rather than acute hospitals. The use of DST in an acute setting during quarter two of 2018/19 varied across the five CCG areas. Just two met the national target of 15% and performed better than the England average. This was: 12% in north Staffordshire, 1% in Stafford and Surrounds, 3% in south east Staffordshire. Seisdon Peninsula was the worst performing of the five local areas at 36%. The data showed considerable differences in the conversion rates for CHC across the county. However, the system did not recognise any outliers with regards to the high variation, the numbers involved were low and the percentages were misleading as there was no obvious explanation for the variation.
- There was a heavy reliance on a bed-based approach and the way to help reduce this was to increase the Home First model to reduce bed use in care homes.

## Maturity of the system

What is the maturity of the system (direction of travel) to secure improvement for the people who use the Staffordshire health and care system?

- System leader relationships are good in Staffordshire, with a willingness from all system partners to work around a shared agenda. As relationships mature further, a proactive rather than reactive approach needs to be developed.
- There was a good plan in place and clarity about the vision for Staffordshire. Implementation was at an early stage and there was a risk that the resources needed to deliver this were not in place. Most of the deficit was held within one organisation, UHNM. Their plan for rectifying this and generating income from planned activity was not aligned with the STP plan.
- The system would benefit from joint mapping of resources with a clear delivery plan that all stakeholders are signed up to, along with wider engagement. This transformation would require highly developed, sustained and mature relationships.
- The challenges regarding workforce were being addressed through the STP workstream. More emphasis needs to be given to the adult social care workforce. At the time of the review, there was some improvements but more work needed to be done to attract people to certain roles for example domiciliary care roles.

# Areas for improvement

## We suggest the following areas for improvement

- The Staffordshire health and care system is in the early stages of transformation. Although there was a clear vision and strong leadership at a senior level, services delivered remained fragmented and dependent on the area of Staffordshire people lived in. A whole county joint commissioning strategy needs to be developed so that there is consistency of provision throughout Staffordshire, including detailed delivery plans.
- The Health and Wellbeing Strategy for 2018 to 2023 should refer to how people with protected characteristics will be included in the development of services.
- A whole county dementia strategy needs to be developed to ensure that people with dementia have their needs planned for and are consistently supported across Staffordshire.
- The market position statement needs to be finalised and work started across the system to address the findings. Areas of particular need should be prioritised.
- The system needs to develop a co-production strategy that ensures services are developed with input from the people who will use them.
- Nationally validated models of GP practice support for care homes need to be rolled out more quickly as at the current pace means these models will not impact on services and people in winter 2018/19.
- Work needs to be done to ensure people living in Staffordshire have equal access to services such as the intravenous antibiotics administered in their own home and the falls prevention services.
- All elements of the high impact change model should be implemented to the same level across Staffordshire.
- There is a reliance on bed-based solutions to discharge. A system-wide approach is needed to look at more innovative solutions to manage the market, for example developing options such as virtual wards.
- Learning from serious incidents and complaints currently takes place at an organisational level and should be shared across the health and care system.