Leeds

Local system review report

Health and Wellbeing Board

Date of review:

15 to 19 October 2018

Summary of findings

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What are older people's experiences of care in Leeds?

- Older people who lived in Leeds were supported by well-established multidisciplinary Neighbourhood Teams to remain well at home. The focus of the Neighbourhood Teams was on rehabilitation, promoting independence, preventative care and supporting self-management to keep older people out of hospital. There was a commitment to build on the model to include a wider range of disciplines and partners. These are called Local Care Partnerships (LCPs) and were not fully developed with inconsistencies across the city. However, frontline staff were very positive about their development.
- There was a vibrant voluntary, community and social enterprise (VCSE) sector in Leeds with many opportunities for people to receive support to keep them well, particularly for people at risk of social isolation and loneliness.
- There was also long-standing investment in Neighbourhood Networks. These are 35 community based, locally led organisations that enable older people to live independently and pro-actively participate within their own communities by providing services that reduce

social isolation, provide opportunities for volunteering, act as a “gateway” to advice/information/services promote health and wellbeing and thus improve the quality of life for the individual.

- We found positive work going on in relation to asset-based community development that enabled people to develop responsive services to support local communities, meet local need and encourage people to remain included and involved. Some people we spoke with were not always aware of the services available; there was an opportunity to raise awareness of the services available so the services were accessible to all.
- There was limited support in primary medical services to support people living in care homes to remain there when they became acutely ill. Admissions to hospital from care homes were higher than the national average.
- When older people attended hospital, admission rates were higher than the England average and once people were admitted it was difficult for them to return home. At the time of our review, delayed transfers of care were significantly higher than national and comparator averages. We did not find that a ‘home first’ culture was embedded across the system and early discharge was not always prioritised.
- Some older people had poor experiences when they were in hospital. They were often moved to, or placed in, a setting that was not suitable for their needs. For example, the clinical decision unit based in A&E was being used as a medical admissions unit due to a lack of capacity on the wards.
- When people were due to return home, the discharge process was not always well planned or coordinated. Discharges from hospital could take place at inappropriate times of day and people did not always have access to medicines or transport in a timely way.
- When older people were discharged from hospital, reablement services were available to help them regain independence. This provided people with good support towards regaining their independence. National data confirmed that once people were discharged and in receipt of reablement services, they were less likely to be readmitted to hospital and more likely to remain in their own homes.
- We also found good support put into care homes caring for people with dementia. A specialist support service was available from the mental health trust for care homes caring for people with complex needs - the service provided support for up to six weeks to support care home staff in settling a person in to their new home.
- Carers that we spoke with found that access and communication with services could be difficult. For example, they were not always informed if plans or appointments relating to the people they supported were changed or rescheduled.
- Carers did not always feel that there were opportunities to have their say in the shaping of services. Their support organisation, Carers Leeds, captured views and fed back into the system, but carers themselves were not always aware of the outcomes or how effectively they were being listened to.

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

- System leaders in Leeds had a shared vision that was supported and understood across health and social care organisations. The 2016 Health and Wellbeing Strategy was built on the joint strategic needs assessment (JSNA) developed in 2015. Representation of health and social care organisations on the Health and Wellbeing Board (HWB) meant that the vision was clearly shared and understood by all partners.
- The Leeds Plan (the delivery plan for transformation within the Health and Wellbeing Strategy) was well developed and reflected the needs of the population, supported by operational delivery plans.
- There was a shared understanding across partners of system-wide issues. A review by an independent consultancy in July 2018 had established 'one version of the truth' with regard to the issues around discharges from hospital that system leaders were working collectively to address. The Leeds Health and Care Plan had not yet been updated to reflect some of the findings. There were not strategies in place to address issues such as continuing healthcare (CHC).
- Healthwatch and representatives from the VCSE sector were represented on the HWB, and were partners in the system. Independent social care providers were not included and did not always feel they were fully recognised as partners in the system.
- There was long-standing investment in Neighbourhood Networks which enable proactive support to be delivered in local communities. System leaders were aligned in prioritising investment in preventative services. For example, a five-year funding agreement was in place with the Neighbourhood Networks which provided the stability to transform services in a sustainable way.
- Although the strategy and direction of travel for Leeds was understood by system leaders, it was not always understood at different levels within the organisations. For example, there were 13 Neighbourhood Teams which system leaders described as 'evolving' into 18 Local Care Partnerships. However, this was not always understood by operational staff.
- The Partnership Executive Group (PEG) brought together chief officers across the system and was established as a decision-making group for the Leeds system; however, it did not have executive decision-making powers.
- Collaboration between system leaders took place across the local authority, the clinical commissioning group (CCG), the trusts and the VCSE. While there was GP representation on the PEG, some GPs still did not feel engaged in the design and delivery of strategy.

System leaders told us that there was a Strategic Directions Forum to enable engagement with the care home sector.

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

- There were clear governance and accountability structures which flowed from the HWB. Reporting into the HWB was the PEG, which was formed in 2015 to enable a 'one system approach' to leadership. While this was not a statutory body, its members held executive decision-making powers. Its membership included system leaders across health and social care, including the VCSE sector. The HWB had oversight of the Leeds Plan, which was reported into the PEG through the Leeds Plan Delivery Group.
- There were strong relationships between leaders in the PEG which provided the foundation needed for them to collectively take forward the findings from the external review and drive improvements for the system. The PEG was the locally agreed forum where system leaders came together to hold each other to account.
- There were accountability structures within organisations, such as the Operational Discharge Group and an understanding of performance. However, it was not clear how this effectively translated into planning and strategy across the system. For example, on the wards, regular meetings were held to monitor bed numbers and where the blockages were, but when we interviewed staff we did not feel that there was a sense urgency about enabling people to return home. There was a lack of bed management and oversight on the wards which meant that there was not always an understanding about people whose discharges had been significantly delayed.
- Monitoring, evaluation and learning were not strongly embedded across the system. There were elements of shared learning within the system but this was driven by individual organisations rather than by the joined-up governance framework across health and social care. We heard from community health staff and other frontline staff how learning was shared. Although system leaders had an outward-facing approach where best practice could be learned from neighbours, this learning was not yet embedded. There was a reliance on external diagnosis; for example, when we asked system leaders what the issues and barriers were, they referred to the findings of an external consultancy.

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

- The last JSNA was published in 2015 and was being updated at the time of our review. On completion it would be used as a live document to inform strategic and commissioning decisions. The commissioning of some community health and social care was based around neighbourhoods that reflected the needs of the local population; other services are commissioned on a city-wide basis. Local Care Partnerships (LCPs) had been developed with GPs that also reflected communities. Public Health at the local authority described a good understanding of population need and commissioning of adult social care services reflected this.
- There was not an integrated commissioning strategy for the Leeds system; but there were good building blocks in place to address this. We were told that a strategy was in development at the time of our review. Three previous CCGs had combined to form one organisation. There was a (recently recruited) single Director of Strategy employed by the Leeds CCG and a Deputy Director for Integrated Commissioning who worked across the CCG and local authority. A single GP confederation had formed. We saw some good examples where health and social care budgets had been pooled to support local needs, for example, to support people living with dementia. However, there was not yet a clear plan as to how the system would commission health and social care services in an integrated way.
- There was a lack of market management which was recognised by system leaders as an area for development. There was a high number of independent residential providers but a shortage of providers providing nursing care. The standard contract did not address variations in need such as the additional support required for people with complex needs. Although system leaders told us there were processes to address this, they were complex and providers we spoke with were not aware of this. The CCG and LA were working together improve the quality of nursing and residential care, reporting to the HWB and the Overview and Scrutiny Committee. The Care Quality Team had worked to improve the quality of older people's care homes and there had been an improvement over a two-year period.

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

- Collaboration between frontline staff was a real strength in the system. We heard that communication and relationships had improved when social workers, community nurses, therapists, pharmacy technicians and community geriatricians worked together in shared offices as part of Neighbourhood Teams. This was a strong model of collaborative working to build the Local Care Partnerships upon.
- The Leeds Care Record was a well-developed information sharing system which facilitated collaborative working. Frontline staff could access detailed information about different aspects of care including diagnosis, therapies that were already in place for people using services, as well as contact details for relevant professionals. Work was underway to allow citizens to access and share their own information with those relevant to their care
- There were many strands of activity to address workforce issues but not a clear joint workforce strategy across health and social care in Leeds. We heard about pockets of practice where staff supported other professionals such as GPs training paramedics (Health Education England pilot scheme) to support admission prevention and podiatry staff training GPs to recognise issues with diabetic footcare. There were good relationships with the local universities and work being undertaken to develop a joint understanding of the skills needs for students coming through. There was a citywide workforce strategy in development however this work was recent and had not yet being rolled out.

Key areas for improvement

- The HWB should continue to maintain oversight and hold system leaders to account for the delivery of the health and wellbeing strategy.
- The remit of the ICE should be further developed so that it extends more widely to underpin the development of wider integrated working.
- There is a recognition from system partners that hospital pressures should be addressed as a system. This should be reflected in system-wide strategic plans.
- The culture of ‘home first’ and moving people away from hospital needs to be embedded throughout the system, especially in the hospital setting where there remains a risk averse approach to discharge and a lack of understanding of community support.
- Communication between health and social care professionals and their leaders needs to be addressed across the system. Although there are good relationships at system leader level,

and where multidisciplinary working is embedded, this can become fragmented at other levels leading to a breakdown in communication which can impact on people's care.

- The workforce strategy for Leeds should be developed at pace, pulling together the different strands of activity to develop deliverables and timescales which include the independent social care sector.
- There should be improved engagement with GPs and adult social care providers in the development of the strategy and delivery of services in Leeds.
- A clear process should be implemented so that health and social care professionals can be assured that they are able to identify and support the members of their communities who are most at risk.
- Signposting to services in the community needs to be clearer so that people can access the wide range of services on offer and get the support that they need.
- There should also be consistent and proactive input from GPs to support care homes.
- Specific pilot schemes were helping people to receive support in the community. There should be evaluations and exit plans in place to reassure or inform people who benefitted from good support about what their future options were.
- Wards for people who are medically fit for discharge should have a plan in place to reduce the numbers of beds on these and to reduce the reliance on these as part of the discharge process.
- Systems should be put in place to ensure that people who go into hospital are seen in the appropriate wards and remain there until they are medically fit for discharge without multiple moves.
- System leaders should continue the work to reduce hospital admissions as admissions are higher than the England average.
- The patient choice policy should be rolled out as a priority and leaders should have a system to gain assurance that this is understood and implemented.
- The system should ensure that staff, particularly hospital staff understand and respect the dignity of people who use services and to understand the impact that issues such as multiple ward moves can have on people's wellbeing.

Background to the review

Introduction and context

This review has been carried out following a request from the Secretaries of State of 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 move through the health and social care system in Leeds 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 are able to 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
- Richard Brady and Deanna Westwood, Lead Reviewers, CQC

The review team included: 2 CQC Chief Inspectors, 1 CQC Reviewer, 3 CQC Inspection Managers, 2 CQC Analysts, 1 CQC Expert by Experience, 1 CQC Specialist Pharmacist, 1 CQC Clinical Fellow; and 3 Specialist Advisors from health and local government.

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 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 is functioning within and across three key 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, detailed in the report, 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 system to understand:

- Is the system 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 requested the local system provide an overview of their health and social care system in a System Overview Information Return (SOIR) and asked local stakeholder organisations for information.

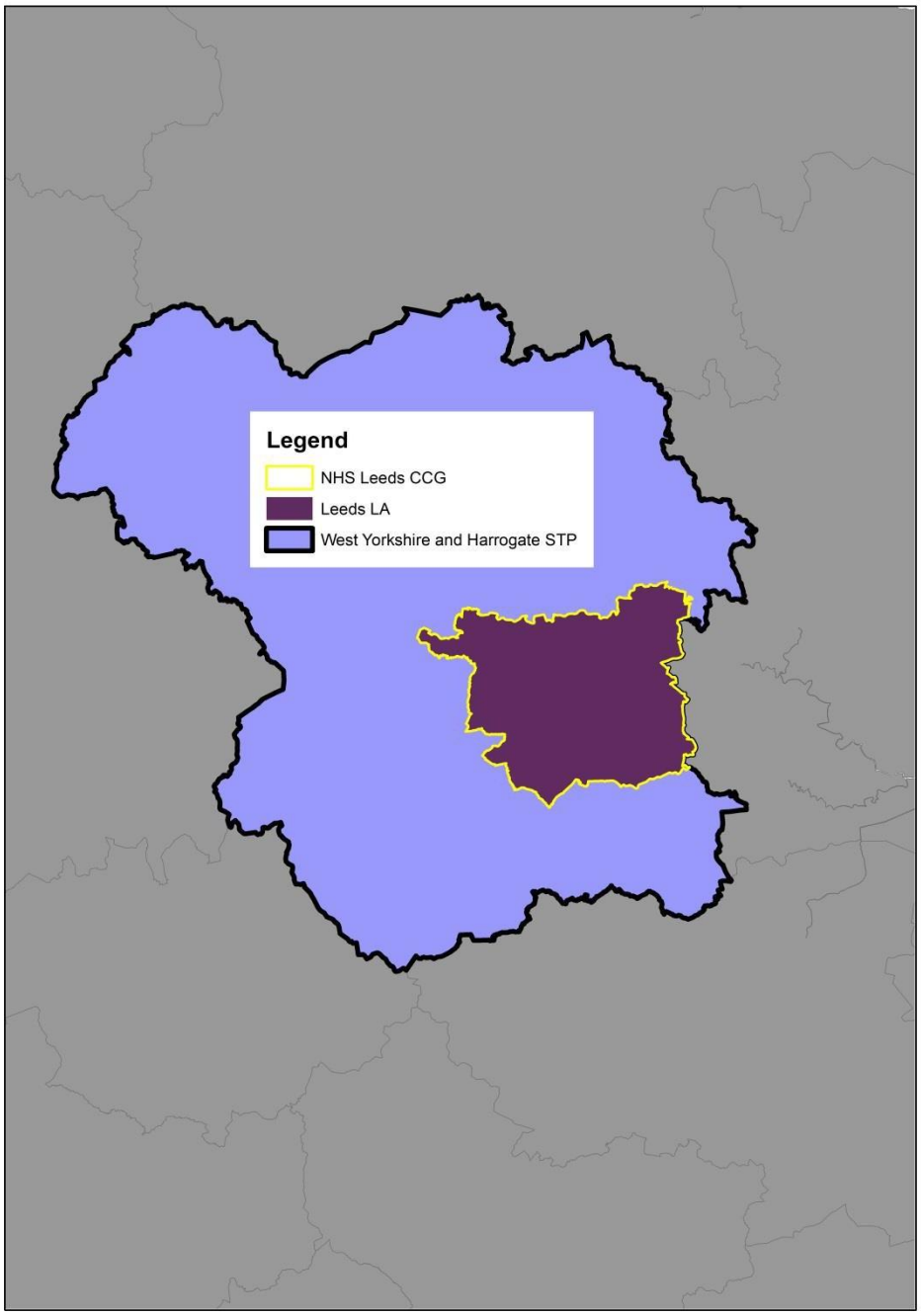
We used two online feedback tools; a relational audit to gather views on how relationships across the system were working, and a discharge information flow tool to gather feedback on the flow of information when older people are discharged from hospital into adult social care.

During our visit to the local area 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 the local authority, the Leeds Clinical Commissioning Group (CCG), the Leeds Teaching Hospitals NHS Trust, GP Confederation, Leeds Community Healthcare NHS Trust, Leeds and York Partnership Foundation Trust, the Health and Wellbeing Board and elected members.
- Staff members including GPs, social workers, occupational therapists, nursing staff, care workers, allied healthcare professionals and pharmacy professionals from across all sectors
- Local Healthwatch, voluntary, community and social enterprise (VCSE) services
- Provider representatives
- People who use services, their families and carers

We reviewed 18 care and treatment records and visited 11 services including acute hospitals, care homes, recovery hubs, GP practices, neighbourhood offices, and an out-of-hours urgent treatment centre.

Leeds Context



Leeds is the second largest city in England and overall has a lower proportion of older people than the England average.

Acute care is predominantly provided by Leeds Teaching Hospitals NHS Trust (85% of local people requiring hospital admission are treated by the trust). When last inspected, the trust was rated good overall by CQC.

The area is also served by the Leeds Community Healthcare NHS Trust, which is also rated good overall.

Further information can be found in the local area data profile on the CQC website.

- Leeds is part of the West Yorkshire and Harrogate Integrated Care System (ICS) which is overseen by the West Yorkshire and Harrogate Health and Care Partnership.

Detailed findings

Are services in Leeds 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. This included strategic alignment across the system and the involvement of people who use services, their families and carers.

There was a clear strategic approach which aligned the West Yorkshire and Harrogate sustainable transformation partnership, the Leeds Health and Wellbeing Strategy and the Leeds Care Plan. This was shared and understood by system leaders across health and social care although it was not fully developed through all levels of service delivery. The voluntary, community and social enterprise (VCSE) sector and Healthwatch were members of the Health and Wellbeing Board and were able to influence the development of services. Independent adult social care providers did not have a seat at the board and were not able to influence service development in the same way. People who used services and their carers did not always feel that they were engaged with and their voices heard. Relationships between system leaders were strong and trusting and provided a good platform for future development.

- The Sustainability and Transformation Plan, formed in March 2016 was known as the West Yorkshire and Harrogate Health and Care Partnership (WYH HCP) which Leeds was a part of. In May 2018 the WYH HCP was selected as one of four areas to be part of the Integrated Care System Development Programme which will enable decisions about health and social care to be taken locally. System leaders were working towards a partnership agreement and ensuring that this reflected the priorities outlined in the health and wellbeing strategy. Leeds was an active member of the Integrated Care System (ICS) and feeds into and aligns with this wider system planning.
- Leeds was two years into the Health and Wellbeing Strategy (2016-21) in which system leaders set out the vision that “Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest”. This strategy set a clear

direction for the system and good representation on the Health and Wellbeing Board (HWB) meant that this vision was clearly articulated and owned across system partners.

- The Leeds Health and Care Plan was developed in 2017 with actions aligning to the Health and Wellbeing Strategy. It set out priorities to reduce inequalities, improve outcomes and maintain financial sustainability.
- The Leeds Health and Care Plan was one of six place based plans that contributed to Yorkshire and Harrogate Health and Care Partnership. However, some system leaders felt that the plan needed a review and a refresh. There was not a clear link between strategies and operational delivery plans. There were a number of pilots in place and we heard from frontline staff and system leaders that these were not always properly evaluated. This meant that delivery of care for older people could be disjointed and lack continuity.
- Leeds benefits from having coterminous footprints across its main system partners - the local authority, (recently merged) CCG, and NHS trusts. These system partners were focused on working towards a single vision for Leeds and developing a place based approach for the city. Relationships between partners were effective and system leaders we spoke with were aligned in their understanding of where the system pressures lay with a determination to work together to address issues.
- There was good engagement with Healthwatch and VCSE sector in developing the health and wellbeing strategy. They were seen as system partners and work with the voluntary sector was a strength in the system in terms of the development of services. Age UK Leeds was involved in winter planning and the external consultancy assessment work.
- Long-standing investment in the Neighbourhood Teams had fostered a strong and collaborative approach to strategic development in the system. There was a clear recognition of what the system referred to as a ‘left shift’, which was a move towards preventative care and services. However, this vision was not clearly understood through all levels of the organisations. For example, although there was shared understanding in the Neighbourhood Teams of the need to keep people well at home for as long as possible, there was not the same awareness and understanding within acute services.
- People who used services, their families and carers did not feel that they had the same opportunities to shape the delivery of care in Leeds. There was a need to find ways to engage with the wider population. Organisations such as Carers Leeds and Age UK Leeds worked with the system to gather people’s views. We heard that people who use services and their carers who were not connected to those organisations felt that they did not have a voice in shaping services.

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.

There was a clear governance structure at system leader level with oversight from the Health and Wellbeing Board. Governance structures were designed to support integrated working. These had not yet become embedded in a systematic way. Risk and information sharing was in place, but it did not proactively drive developments.

- System leaders had developed a governance structure designed to support collaboration between system leaders. It clearly articulated the levels of governance throughout the system. This was enabled by a geographical alignment of the local authority, the merging of three CCGs into the Leeds CCG and a recently formed single GP confederation. This enabled the development of a consistent approach to governance and contracting. We saw that, in terms of governance structures, this was taking effect and there was an opportunity to build the governance around integrated commissioning.
- The HWB had governance oversight, leading on the citywide health and wellbeing strategy. The Leeds Health and Care Plan supported the delivery of the health and wellbeing strategy and fed into the work of the local authority, the CCG, the acute trust, the mental health trust and the community trust. However, this needed to be reviewed. A shared vision that translated the strategy into delivery needed to be described because it was not clearly understood across all levels of the system.
- The Leeds Health and Care Partnership Executive Group (PEG) brought together chief executive officers of the CCG, the local authority and the trusts. The HWB delegated oversight and governance of the Leeds Health and Care Plan to this group. This was not a statutory body and was dependent on the commitment, relationships and trust of its members.
- There were a number of sub-groups sitting below the PEG. The role of the Integrated Commissioning Executive (ICE) was to support and develop integrated commissioning. However, at the time of our review, the focus was on Better Care Fund (BCF) commissioning. Although there were some pooled budgets around services such as services for carers, community-based mental health support and learning disability services, there was a risk that limiting wider joint commissioning to the BCF might result in other opportunities for joint commissioning being missed.
- The Leeds Plan Delivery Group (LPDG) was put in place to have oversight and manage delivery of the health and care plan. It also provided management and oversight of the BCF. There were other leadership groups such as the Leeds Clinical Senate, which

supported clinical and professional leadership, and the Committees in Common, which was the mechanism for all the NHS providers - including the GP Confederation - to work together to integrate service delivery. Many of these boards had shared members and there was a risk of duplication and fragmentation without a clear forum for challenge and accountability.

- Urgent care performance, resilience planning, and winter response was overseen by another sub-group, the Leeds System Resilience and Assurance Board (SRAB). We were told after our visit that the findings of the consultancy report were being discussed at the Overview and Scrutiny Committee. PEG and the SRAB were accountable for monitoring the actions from the external consultancy report.
- There were accountability structures within organisations and a clear understanding of data, but it was not clear how this effectively translated into planning and strategy across the system. For example, the hospital was involved in regular calls and monitoring of bed numbers (and where the blockages were) but when we spoke with frontline staff, there was no sense of urgency to enable people to return home. There was a lack of case management for people whose discharges had been significantly delayed. We saw data that showed that the numbers of people had been delayed in hospital for a long time were reducing; but there were no clear exit strategies around wards that had opened to care for people who were waiting to be discharged from hospital.
- There were elements of shared learning within the system but this was driven by individual organisations rather than by a joined-up governance framework across health and social care. There were pockets of good practice; community health staff and other frontline staff demonstrated how learning was shared with each other. System leaders had an outward-facing approach where best practice could be learned from neighbours, but this learning was not yet embedded. There was a reliance on external diagnosis - for example, when we asked system leaders what the issues and barriers were, they referred to the findings of the recent external consultancy. While detailed diagnostic work was helpful and important, system leaders needed to have a structure in place to identify emerging issues or provide assurance.
- Monitoring and evaluation was not strongly embedded across the system. Pilots and initiatives were developed but it was not always clear how decisions were made on taking forward or decommissioning these schemes following robust evaluation. There was also evidence of initiatives that were not seen through to completion. While this can be supported by a clear rationale, if it was not clear to frontline staff what the outcomes of evaluation were that supported the decision-making process, there was a risk that staff would become frustrated or disengaged, which could impact on future development opportunities.
- The Leeds Care Record was well-developed and had been having a positive impact. Professionals we spoke with described it as a “game changer” as it enabled them to access people’s shared records in a way that facilitated faster and safer decision-making.

At the time of our review, not all partners were accessing it, and some professionals needed to act as a personal interface between systems. Where staff had access - such as in the recovery hubs and the local community services - we heard that it was very effective in supporting people with a wide range of information and detail about a person's pathway, and it was available to community health and social care professionals. There was a recognition that this is a phased roll out. There was still a disconnect with mental health systems and not all GPs were accessing systems.

- Community pharmacists did not have access to shared information and there was a reliance on staff in Neighbourhood Teams to review the medicines, identify and raise queries with the pharmacists or consultants if there were prescribing issues. However, it is acknowledged that there was a phased roll-out in progress, and plans were in place to provide access across health and social care organisations.

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.

System leaders had developed a workforce plan that would provide staff with the right skills to support people as services developed in a more integrated way. However, this plan was in its infancy and timescales for the implementation had not been agreed. Meanwhile, there were different strands of activity that needed to be managed more cohesively. Some specific challenges were being addressed, such as the training of paramedics to support GPs, and there were opportunities for system leaders to harness some of the work being delivered by operational staff to support and train each other.

- Workforce planning for Leeds was underdeveloped. There was an overarching West Yorkshire workforce strategy that the Leeds system contributed to. Locally, the One Leeds and ICS strategic workforce plans set out aspirational work with strategic commitment. It described the staffing and skillset needed across health and social care to meet demand. It identified a broad range of partners in the system who would support the strategy and areas of key focus. At the time of our review, agreed deliverables and timescales had not yet been determined. None of the areas of key focus considered the independent social care sector, where recruitment was also problematic. If the right staff were not recruited to this sector, this would impact on the quality of care people receive.
- There were many strands of activity to address workforce issues, but there was not a clear, overarching workforce strategy across health and social care, setting out immediate priorities. There was a citywide strategy in development, to bring together existing

strengths across the city, and develop areas of new capacity. However, this work was recent and had not yet been rolled out. A staffing strategy was much needed.

- The system held a workforce conference in August 2018 to assess Leeds priorities and evaluated what was needed in line with Leeds demographics. This resulted in a list of priorities and an increase in membership of the working group to include universities and colleges.
- There were challenges around having enough staff with the correct skills. We heard about examples of using the existing workforce more effectively and developing skills and knowledge. For example, there had been a focus on upskilling the workforce building on a strength-based approach. This was important in the recovery hubs, where previously staff were accustomed to maintaining people long-term and needed to focus on people regaining their independence. We heard about staff supporting other professionals to develop new skills, such as GPs training paramedics - a Health Education England (HEE) pilot scheme - to support admission prevention. Podiatry staff were training GPs to recognise issues with diabetic footcare.
- Skills for Care's adult social care workforce estimate for 2017/18 showed that Leeds performed well on staff vacancies (4.7% compared to the England average of 8.1%) but rates of staff turnover were similar to the England average. Organisations outlined concerns about the availability, retention and turnover of staff. Some system leaders felt that staffing was one of the biggest concerns and we heard that one provider handed a contract back because nurses were leaving. This was cited as one of the pressures impacting on the availability of nursing homes.
- System leaders were working hard to address workforce issues. Recruitment of health and care staff was being supported through the commissioning of a joint health and social care jobs website and joint recruitment fairs. The university and colleges were engaged with supporting entry level recruitment. Apprenticeships and nursing places had increased across education and care organisations. School visits were taking place to educate young people about the roles available in health and social care. To support this further, system leaders were exploring the development of system-wide training so that staff working in different organisations would have a common skillset. This would further promote the development of single care pathways for people using services.
- The HEE pilot had enabled paramedics to be more closely aligned with primary care. This enabled them to develop their skills and knowledge of primary and voluntary sector services. It meant that, where appropriate, paramedics could refer people to support in the community and a hospital admission could be avoided. At the time of our review, attendances at A&E were slightly above the England average, but it was expected that these initiatives would have an impact and reduce the pressures on the hospital workforce.
- Staff with specialist skills in the community trust had done work to train or embed skills with generic staff. However, this has not been strategically driven, and system leaders would

benefit from harnessing this goodwill among frontline staff to extend people's skills in a more formalised way.

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 how commissioners are providing a diverse and sustainable market in their commissioning of health and social care services.

System leaders were working together to ensure that they understood the needs of the local population and were in the process of updating their joint strategic needs assessment at the time of our review. The move to a place based approach would enable them to commission services that meet the needs of local populations and target people with particular needs. There was some joint commissioning and integrating working particularly with regard to the Better Care Fund. There were opportunities to develop this further. The care home and homecare market needed further development and leaders had recognised this.

- The JSNA was last published in 2015 and was being updated at the time of our review. We heard that the new JSNA would be used as a live resource, making intelligence and analysis visible through the online Leeds Data Observatory and Data Mill. This would inform strategic and commissioning decisions based on the needs of the local population. The commissioning of some community health and social care was based around neighbourhoods, that reflected the needs of the local population; other services are commissioned on a citywide basis. Local Care Partnerships had been developed with GPs that also reflected communities. Public health described a good understanding of population need.
- Leeds was working towards a place-based and bottom-up approach to commissioning. Eighteen LCPs were established in 2018 to deliver a population health management approach. System leaders told us in their SOIR that inequalities in health were a key issue for older people, and that the poorest people in the city were affected disproportionately. Some of this would be addressed by the implementation of outcomes frameworks which had been agreed for the first two population cohorts to be addressed through this work: 'frailty' and end-of-life pathways.
- Health and social care commissioners were brought together through the ICE. Leeds had a Deputy Director of Integrated Commissioning who worked across the CCG and local authority. An Integrated Commissioning Framework was in development at the time of our review, but there was not yet a clear plan as to how the system was going to commission in an integrated way. We heard that not all parts of the system were fully signed-up to an integrated commissioning strategy and much of the work focused on the BCF. Commissioning was still mostly undertaken at organisational level.

- Market-shaping in the independent care sector was underdeveloped. At the time of our review, system leaders were developing a joint market position statement. There was a shortage of nursing home provision in the city. Our analysis showed that between April 2015 and April 2017, there had been an increase in residential care beds in Leeds and a decrease in nursing care home beds. However, the position had not changed since then. We heard that one person with complex needs was 'trapped' in hospital, having been refused by 14 care homes. Independent residential care providers informed us that the Leeds Care Association served as an effective conduit for discussions with the local authority. But domiciliary care providers did not feel that they had opportunities to be involved in service development.
- A two-week retainer to enable packages of care to remain in place when people needed to go into hospital had ended. This impacted on delayed transfers of care as new packages had to be set up. The retainer had been reinstated shortly before our review and this would support improvements to the flow of people from hospital. However, some frontline staff and providers were not aware that this had been reinstated, and communication from system leaders was required to ensure that it was effective.
- Neighbourhood Networks were supported by a strong funding model which was commissioned in five-year cycles. This enabled stability and time for services to embed and grow. This approach would be strengthened by extending to other services, particularly those in the voluntary sector that relied on grants which were coming to an end. Succession planning around these contracts would provide further stability for the sector and give assurance to people using services.

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 systems assure themselves that resources are being used to achieve sustainable high-quality care and promote people's independence.

System leaders were working to ensure that resources were used effectively. Nonetheless, pressures in the system meant that resources were being diverted to manage areas of pressure as and when required. This hindered the system's ability to use resources effectively in a streamlined way that was in line with the strategic vision. Although there was oversight of the use of resources, it was managed in pockets and in line with different priorities and projects rather than in a coherent way which would enable resources to be directed more strategically.

- The system was in a sound financial position and the acute trust had moved from a significant deficit to a surplus position over a four-year period. However, patient flow issues were still impacting on the use of resources. System leaders recognised this and

were open about the challenges required to deliver the transformational change programme while managing pressures around care. There have been some pragmatic solutions around management of resources, such as the co-location of health and social care staff in the Neighbourhood Teams (for example, district nurses and social workers, which enable better integrated working). The acute trust had entered into an aligned incentive contract in 2018/19, for the first time. The purpose of the contract was to incentivise the correct system behaviours and support the movement of resource across the system.

- The local authority had protected adult social care spending. However, there were pressures elsewhere in the system, such as in public health and other services that impacted on the overall provision of services that supported the wellbeing of people who lived in Leeds. Local authority spending on preventative services had increased and system leaders were considering how services could be commissioned more flexibly.
- The CCG was also reviewing areas to make efficiencies, for example, through the use of technology. However, system leaders told us in the SOIR that areas that were under pressure were often supported with non-recurrent resources in an ad hoc way.
- Oversight and the challenge to the use of resources could be further developed, and there was a role for the overview and scrutiny to develop its work around holding the system to account. There were shared strategic indicators, but these were limited to particular areas around system resilience plans for winter pressures and the BCF programme. The SRAB had a set of metrics that monitored indicators to measure improvement on the findings of the external consultancy. The Leeds Plan had its own set of metrics. There were other indicators that the system used to measure the wellbeing profile of people who lived in Leeds. It was not clear how these indicators and metrics were all brought together in a coherent format to enable system leaders to manage resources in a coherent way that gave a clear picture of how resources were used across the system.

How are people in Leeds 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 system is in the area: maintaining the wellbeing of a person in their usual place of residence.

Older people in Leeds who were most at risk of becoming unwell were not yet supported by a joined-up system-wide approach. Some of this was being addressed through the development of 'frailty' and end-of-life pathways. At the time of our review, there was not a widely understood system in place that enabled community staff and social workers to target earlu support to people most at risk. When risks were identified, there was a 'frailty' service that could respond quickly. Some people found the number of care pathways confusing to navigate, which meant there was a risk that opportunities to support people were being missed. Some pilot schemes were in place – this added complications and instability to both people receiving services and staff providing them, as there was a risk that pilot schemes could be discontinued.

People who lived in care homes were not always well-supported. There was a higher number of care homes that required improvement in Leeds and people in care homes were more likely to have unplanned admissions. Although the wide range of support in the community and access to health care meant that fewer people attended A&E, once they did attend they were more likely to be admitted.

Well-established Neighbourhood Teams enabled people who lived at home to be supported by multidisciplinary teams that were co-located. In addition, Local Care Partnerships, building teams around cluster of GP practices were being developed building on the strength of the neighbourhood model. This approach enabled people to have their needs and choices assessed holistically. There was a focus on independence, building on people's strengths and developing communities to support people to live their lives to the full.

Through the Neighbourhood Team model, frontline professionals across health and social care worked together in a joined-up way and they were able to collaborate and share information.

- There was not a joined-up approach to managing people in the community who were at risk of hospital admission. The system did not have a risk stratification tool across the LCPs and the hospital. The Neighbourhood Team provided a coordinated approach to people in the community at high-risk of hospital admission. For example, they were able to facilitate access to a 'frailty' service that could respond within four hours. However, as this

used a reactive referral system supporting people to avoid crisis, there was a risk that people may fall through gaps unless they had previously used the service.

- The system had multiple pathways. Trying to navigate this, especially when care was not joined up, was difficult for people and caused some confusion. This was further complicated by the number of pilot schemes taking place, which were often short-term and stopped when the funding ran out. This affected staff's ability to further develop skills and progress gained during the pilot, and their continuity of care for people.
- There were variable experiences in the level of communication between the system and carers. Some did not feel they were kept up to date, whereas those who accessed voluntary provision, such as Age UK Leeds and Leeds Carers, saw these services as a lifeline as they were good at signposting to services and support. The Leeds Commitment to Carers Campaign recognised that unpaid carers were crucial, both to the community and to the sustainability of health and social care in Leeds. It emphasised that if Leeds was to be the best city for health and wellbeing, they would have to be the best city for carers. A variety of activity had taken place since the HWB endorsed the Leeds Commitment to Carers campaign in February 2017 to support this.
- Some people using services and carers told us there was an absence of culturally sensitive provision, and at times this had affected the choices they had to make. For example, we heard about a family that had to place a relative in a neighbouring area because of a lack of provision in the city where their relative could be supported by staff who spoke their language. Nevertheless, a service called the BAME Hub to support people from black and minority ethnic backgrounds acted as both an information hub and provided ongoing care support, connecting people to support and services. This was a good example of good partnership working. They identified common goals to work well with their partners, such as Touchstone and Feel Good Factor, which were voluntary organisations providing community support. They also worked well with the project development worker at Leeds City Council, who worked with social services and the CCG to identify gaps in services and fix them.
- Despite engaging with a wide range of partners to raise awareness, it was still a challenge for VCSE services to access people in the community, especially where people were already isolated and not connected to other support.
- People told us they faced barriers to accessing GP services, which affected their health and wellbeing. System leaders told us that extended access to GPs had reached 100% from October 2018. This meant that opening hours when people could access GPs started earlier and finished later. But older people did not always benefit from this arrangement. Older people who relied on senior bus passes could not use them to access appointments before 9.30 - and some people told us this was a barrier.
- We looked at some people's care records and saw that, where appropriate, their relatives were being involved in discussions about their care. There was evidence of multidisciplinary support from the Neighbourhood Team to try and keep people at home. If a person's health deteriorated, there were triggers for support and this information was

shared with social workers and relevant multidisciplinary team (MDT) professionals. In most cases, assessments were coordinated and relevant adaptations were made to the home following assessments. There were close working relationships with housing colleagues and a strong focus on use of assistive technology to enable people to stay in their own homes.

- People living in care homes were not always well supported. And people living in care homes in Leeds were more likely to have an unplanned hospital admission. Our analysis showed that emergency admissions from care homes per 100,000 population (aged 65+) was also higher in Leeds at 3,279 compared to 2,794 in England. An enhanced offer for support to care homes was underdeveloped across the system. Frontline staff in these settings gave examples of challenges with trust and communication with the MDT which impacted upon people's health and wellbeing as this delayed them getting seen by the right people at the right time. This was reflected in the rate of A&E attendance and emergency admissions to hospital from people living in care homes.
- Our analysis showed that January to March 2018 the rate of A&E attendances from people living in care homes (65+) per 1000 population was higher than the England and comparator area averages (1201 in Leeds; 1027 England; 1131 comparators). Data taken from the Adult Social Care Outcomes Framework (ASCOF) experience measures for satisfaction with adult social care, showed a decline from 69% in 2014/15 to 60% in 2016/17. However, although this had declined, it was in line with the England average (Leeds 60% and England 62% in 2016/17).
- There was an increase in the numbers of people receiving direct payments, but fewer people in Leeds received direct payments than in comparators areas and the England average. In 2016/17, 13.2% of people over the age of 65 who used services received direct payments in Leeds, compared to a 17.6% average for England. Direct payments would enable people to have more choice and control over their own care. We heard from staff that the system for direct payments could be burdensome, and consideration was being given to the use of payment cards to make the process easier.
- Analysis of ASCOF data showed that people (aged 65+) whose long-term support needs were met by a change of setting to residential or nursing care had declined for the last three years. It had gone from being higher than the England average in 2015/16 to in line with the England average in 2016/17 and 2017/18. Avoiding permanent placements in care homes is a good measure of delaying dependency, and this measure supports local health and social care services to work together to reduce avoidable admissions.
- Emergency admissions per 100,000 population (aged 65+) in Leeds were higher at 28,052 than the England average of 25,568, whereas A&E attendances per 100,000 population (aged 65+) in Leeds was lower than the England average (Leeds 43,295 and England 44,225. This analysis is based on Hospital Episodes Statistics (HES) data from April 2017 to March 2018.

- Leeds Neighbourhood teams brought together multidisciplinary teams around clusters of GP practices to provide community support to thousands of older people throughout the city. Their focus was on preventative care and supporting self-management with an aim to reducing hospital admissions. They had undoubtedly impacted on the resilience, health and wellbeing of local older people and provided opportunities for people to engage with local services, including utilising the vibrant voluntary and community sector. However, there were some inconsistencies across the Neighbourhood Teams in the MDT working and the input of primary care was not consistent across the city. The neighbourhood model was a strength to build on. There was an opportunity with the LCPs to establish consistency, and this should be a priority in the development and delivery of the new care model. Frontline staff were positive about the Neighbourhood Teams and told us that work with the Neighbourhood Teams enabled them to support people more quickly and effectively.
- The system was developing a response to people's needs in the community via the Asset Based Community Development. This was supporting a move towards a strengths-based approach to assessment and building individual and community resilience to result in more person-centred conversations with people using services. This had led to some strong community projects that were not financially dependent on system resources and which were having a strong impact. There were some good examples of community activities, charities and neighbourhood schemes. We saw examples of how these projects evolved as the community embraced them. For example, a pub landlord brought people together for a Christmas dinner and encouraged those on their own to share dinner at the same table. Other initiatives, such as walking groups, enabled people to maintain their health and fitness.
- However, community contributions statistics showed that the uptake of volunteering was lower in areas of deprivation, which could influence development of this approach. In addition, the closure of some day services meant that people who needed this support were not able to access it and were consequently at risk of social isolation. Nevertheless, there were some good examples of the use of the voluntary sector to reduce social isolation, such as befriending services and One Digital, a service that supports older people to use online services. Where needed there was a real multi-agency response including police and fire services as well as health and social care professionals. We heard an example of someone who was struggling with social isolation and making frequent contact with emergency services. Services worked together to ensure the person was safe and to address their social care issues.
- Although this work was positive and steps were being made to respond to the needs of the community, further development and communication of the strategies and services were needed. Despite these initiatives, many people using services - and their carers - were not aware of services or support on offer to them. It was extremely difficult for people using services and carers to know how to access what was available to them or what rights they had, especially those who had not previously engaged with systems. This sometimes

resulted in a lack of support for those most in need and people and carers often reaching crisis point before they got the help they needed. There had been a reduction of support services in Leeds owing to reduced financial resources - or example, day centres where older people could have an active social life.

- Frontline staff told us that it was helpful for service users and their families to have a single contact centre phone number for the local authority. They said that the call handlers had good experience in terms of giving advice and that there were six social workers from the Rapid Response Teams (RRTs), one team manager and access to a service delivery manager. Their function was to triage safeguarding and rapid response referrals to ensure a speedy response
- Within two days, the RRT could pick up referrals for people who needed support. They worked well with the neighbourhood social work teams who would take referrals if needed to support people to receive a rapid service. They could facilitate a step-up service at home or people could be referred to the recovery hubs for an intermediate care bed. However, frontline staff felt that despite them having capacity to support people a lack of case worker capacity to do the initial assessment delayed access to support.
- The VCSE sector had undertaken work to signpost people to services which better met their needs. For example, there was VCSE sector work on engaging with people to become aware of where to go when they need help and encourage them not to go to A&E for example, the Migrant Access Project. There was also engagement between the system and the VCSE sector around therapeutic activity, such as dementia cafes, Age UK Leeds and Carers Leeds groups.
- Social workers and GPs could refer people to other services, such as occupational therapy, reablement and the equipment service to enable them to remain at home. However, some independent adult social care providers found issues with accessing some services such as physiotherapy which meant that not all people could be supported and the level of support they could receive depended on the availability of particular specialists.
- Leeds prided itself on being a World Health Organisation age friendly city and as a result had looked at initiatives beyond health, such as falls prevention, funded by the Improved Better Care Fund. Health promotion campaigns helped support people to remain well at home. For example, there was a health bus during mouth cancer awareness week, visiting hard-to-reach groups and offering mouth cancer screening alongside healthy living and dental advice. However, we found there was a lack of dentists taking on NHS patients and training for care home staff on oral health.

How are people supported during a crisis?

Using specially developed key lines of enquiry, we reviewed how safe, effective, caring and responsive the system is in the area: support to a person in a crisis.

There were some systems in place to maintain people's safety and enable them to avoid hospital admission when they become unwell. The Rapid Response Team was an example of this, supporting people at home for up to 72 hours. There was also a crisis team to support carers if they became unwell. There were opportunities to improve people's experiences, particularly with regard to improved working between care homes and the ambulance service where different professional boundaries could cause conflict and impact on people's care.

The hospital was under pressure and far more people stayed in hospital than needed to. Hospital wards were full and the average length of stay was the highest in the country. Some areas were crowded and offered little privacy and dignity. People who used services told us there were times when people were waiting on trollies while there were comfort rounds to ensure people were safe and hydrated, patients and their families were not kept informed about what was happening to them or their relatives.

This also impacted on the delivery of services as some wards were being used to hold patients that they were not designed to support. People were moved between wards multiple times and there were examples of failed attempts at discharge because a recent patient choice policy was not yet understood or used by staff.

There were independently run hospital wards to support people who were medically fit for discharge. The wards had become an accepted part of the discharge journey and there were no plans for reducing the reliance on this. This alleviated the urgency to get people home from hospital and a 'home first' culture was not embedded.

- When people became unwell and needed urgent support, we found that people using services may not always be seen in the right place at the right time and by the right person. Systems to manage crisis response out of hospital were underdeveloped. There was only one urgent care service which allowed direct access to NHS 111 and 999 emergency patients. System leaders told us in their SOIR that there were four more urgent care centres planned, although they did not describe timescales for this.
- We were told that more people were using the out-of-hours service and frontline staff felt this was taking the pressure off GPs - but probably not from A&E. A GP was co-located in each hospital, to reduce pressures at A&E and admissions. At the time of our review, this was taking time to embed and it was too early to demonstrate an impact on numbers. People we spoke with were not aware of the out-of-hours service and because of this they would go straight to A&E.

- People living in care homes needed better levels of support to prevent hospital admission when they became acutely unwell. There were inconsistencies in services offered to independent social care homes. The Leeds Care Home Project focused only on eight council-managed care homes - and system leaders told us that 250 residents had improved responses with reduced falls and unnecessary 999 calls. Attendances to A&E from care homes was higher than the England average, while A&E attendances from the general population were slightly lower than the England average.
- Some people's experiences at the time of crisis were poor due to relationships between some care home staff and Yorkshire Ambulance Service (YAS) paramedics. A lack of clarity of roles and accountability at the point of crisis resulted in challenges in understanding the responsibilities of each professional. This resulted in negative experiences for people when arguments between professionals took place in front of them. It was also the impression of some staff that safeguarding was used as a threat by the different sectors, to force others to act and provide care when they felt this was not their responsibility.
- A range of services were in place to support people who required a rapid response to keep them in their usual place of residence at a time of crisis. For example, the RRTs enable someone to obtain social work support within four hours. Social workers in the rapid response service could arrange support for people in their own homes for up to 72 hours. If people required further ongoing support, they could be referred to the Neighbourhood Teams, which could access a range of services including reablement, dementia liaison, community nursing and therapy. The RRT was also able to directly refer people to reablement services. The reablement service had been developed and expanded to increase efficiency and capacity but the step up offer for people continued to require improvement.
- System leaders told us in their SOIR that the Single Point of Access (SPA) for mental health services and an Intensive Community Support (ICS) service provided home-based treatment. There were plans to implement a new community mental health and crisis service model operational from March 2019. This would provide home-based treatment specifically for older adults working to prevent hospital admission and facilitate early discharge.
- System leaders told us in their SOIR that the YAS had one of the most effective 'hear and treat' rates in the country, with an average of 6.6% of calls being dealt with via telephone treatment (the current average for England is 4.67%) supporting people to avoid unnecessary hospital admission. The role of the ambulance service in 'see and treat' could be further developed. However, it is recognised that work was underway in upskilling paramedics through the HEE pilot.

- People could follow various pathways once in the hospital to prevent admission. Initiatives were in place to try and improve the flow through the hospital, but these require further development and services were not available 24 hours a day. For example, in the A&E reception, a nurse was on duty 12 hours a day to stream people. The JAMA (a short stay assessment unit) was staffed by advanced practitioners, nurses and healthcare assistants. It was open until 10pm seven days a week. We heard that this had a positive impact on reducing hospital admission with only 20% of people who were assessed here subsequently being admitted to hospital. There was positive feedback about this service from people and relatives.
- There was a frailty unit at St James's Hospital, which provided a multidisciplinary response to meeting the care and support needs of older people. Frontline staff were positive about the impact of the JAMA and the frailty unit in supporting a reduction in the admission of older people to hospital wards. The 'frailty unit' was particularly beneficial for people living with dementia as it was quieter and calmer.
- People's reablement and discharge could begin from the point that they attended hospital if they were referred to The Early Discharge and Assessment Team (EDAT) based in A&E or the frailty unit. This team could assess what services a person needed to return home, avoiding admission. Frontline staff felt that this unit was effective with people who were referred seeing a geriatrician and returning home, meaning that the people admitted to the ward needed to be there.
- Despite these options, when people attended hospital, there was a higher chance of them being admitted than across England (analysis of 2017/18 hospital admissions for people aged 65+). And once they were admitted, it was more difficult to get out. Leeds had a pressured hospital system that was working at a high capacity. Our analysis found that Leeds Teaching Hospitals NHS Trust had high bed occupancy (91%) in January to April 2018. Its performance in relation to the four-hour emergency care standard targets throughout 2018 was consistently worse than the England average, meaning people had to wait longer to be seen and treated.
- The clinical decision unit, which was meant to be providing ambulatory care with rapid turnaround, was being used inappropriately with people staying for up to seven days. Frontline staff told us this was because there were no suitable beds in the hospital wards. This impacted upon people as the area was very crowded with little privacy and dignity. It also impacted on performance as the service was not able to function as intended to create flow through the hospital or discharge home.
- People could experience long delays and extended waiting time on a trolley due to the high bed occupancy levels. Some people and carers reported poor experiences and gave examples of waiting in A&E in excess of eight hours on trollies. Some people who used services told us there were times when people were waiting on trollies while there were comfort rounds to ensure people were safe and hydrated, patients and their families were not kept informed about what was happening to them or their relatives.

- Others told us of their poor experiences of discharge from A&E and some people were discharged during the night. One person told us that when they were discharged after midnight, they had no relatives with them and no way of getting home. They had to book a taxi for themselves and had found this experience extremely distressing.
- There were multiple examples of people having a poor experience while in hospital. We heard of examples including people not having their privacy and dignity respected, a person being moved five times in two months, we saw another person had been moved at five in the morning prior to an operation.
- People who were admitted to hospital were staying there for too long. Leeds's length of stay for people over 65 who were admitted as an emergency was the highest amongst its comparator areas (April 2017-March 2018). Thirty-four percent of admissions of people aged over 65 lasted longer than seven days compared to an England average of 30.2%. At the time of our review, the average length of stay in the hospital was the highest in the country. Leeds has a 90th percentile length of stay of 28 days (April 2017-March 2018). This means 10% of patients (65+) within Leeds have a minimum length of hospital stay lasting 28 days. This was the worst performance out of its comparator areas and worse than the England average (19.7 days).
- To manage risk, system leaders used OPEL (operational pressures escalation levels) grading, daily. Every organisation had escalation processes in place and a need for a conversation at certain points across the system which were identified through this process. We did not see examples of risk stratification on the wards to know who was where and how long they had been there for. We were told that, while there were regular catch-ups between staff, there was a not a system to monitor patients and multiple moves were not being registered as incidents.

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 the area: support to a person returning home or to a new place of residence.

When people were due to return home, the discharge process was sometimes unplanned and uncoordinated. Discharges could take place at inappropriate times of day and people did not always have access to the medicines or transport that they needed. Discharges processes were complex and staff struggled to understand them. When we spoke with staff we felt there was a lack of urgency around discharge planning which meant it often started too late and this impacted on the timeliness of discharges, particularly where care packages and equipment needed to be put in place.

Although the numbers of people receiving reablement services had reduced, there were fewer people being readmitted to hospital. There were systems in place to ensure that when people were able to leave hospital, professionals shared information and ensured the right support was in place.

People were more likely to get better support at the end of their lives, as professionals worked together to facilitate this. There was an opportunity to develop this work more widely so that people's experiences throughout their care pathways improved.

- People using services, relatives and frontline staff reported concerns with the discharge process, which at times was not well coordinated. People experienced delays due to waiting for medicines and transport. People were sometimes discharged at inappropriate times. Sometimes people were discharged inappropriately dressed. On the day of our visit to the hospital we saw four people waiting in the discharge lounge in pyjamas and one was in a hospital gown. There were issues with the quality and availability of discharge notes and information about medicines. People were sometimes discharged without alerting or coordinating with care home and home care staff over discharge planning.
- Although there was community support for people being discharged from hospital, discharge processes were complex. Frontline staff we spoke with struggled to describe the process and found it difficult to understand the range of community services available or pathways for elderly people. They suggested that it would be even more difficult for people using services to understand the process.
- There was no risk stratification tool to help with identifying people that needed to be prioritised for discharge. There was a need to focus on discharge earlier because planning was not always timely, resulting in delayed referrals to ongoing services. We heard that

discharge coordinators were not familiar with the pathways for an elderly person, which sometimes resulted in people getting lost or stranded in the system.

- Staff had become accustomed to having wards filled with people ready for discharge. The system had tried to respond to delayed discharges and the pressure of bed occupancy and short-term initiatives were put into place. For example, there were 227 community care beds in seven sites across the city.
- Transition beds were operated by an independent provider in Wharfedale Hospital in response to pressures in 2016 and subsequent delayed discharges. These were six wards, including two off-site, providing a total of 150 beds which were used by patients who were medically fit to leave hospital but who were waiting for arrangements for care to be put in place. Frontline staff said that the aim was for patients to be there a maximum of 21 days but people could be there longer. We found examples of this occurring as on one ward one patient had been there since January 2018 and one from mid-August 2018. There were no plans to reduce this provision which meant that allowing people to wait in hospital when they were well enough to leave had become normalised.
- Frontline staff believed that significant delays in discharge were caused by there being a limited availability of services and arrangements to restart care packages. Some people who were in receipt of a home care package experienced a delayed discharge because their package of care had been stopped when they were admitted to hospital. We also heard about people experiencing delays because they were waiting for care home placements. For one person it took three weeks for a new package of care to be arranged. We were told by system leaders that a two-week retainer paid to homecare providers to hold the person's package of care open while they were in hospital had been reinstated. However not all staff and providers were aware of this so the benefit was yet to be fully realised.
- The Leeds Integrated Discharge Service (LIDS) provides a trusted assessor model to access reablement services, but there was not an established pathway for people moving into care homes. A trusted assessor model, whereby the assessment of one professional is trusted by another to facilitate smoother discharge, was not fully established. Frontline staff displayed varying levels of trust in the assessments undertaken by other professionals. Where trust was improving, this was leading to better confidence in social workers assessments which increased the likelihood of social care providers accepting a person discharged to them on a Friday afternoon or weekend. This was not yet consistent across the system and some assessments were repeated by care home staff which caused delays in discharge.
- The new patient choice policy was not yet being used by staff to help people to understand their options once they were medically fit for discharge. Some people refused to leave hospital if they were unable to secure a bed in their preferred place, which led to a delay in their discharge. Our analysis showed that when reasons for delayed discharge were categorised, 'other' was the largest reason for delays. Patient choice was categorised as

'other' and in Leeds this was the highest category of reasons for delay. In Leeds 7.8 people per 100,000 (aged 18+) were categorised as 'other', compared to the England average of 2.5 people, and the comparator average of 2.2 people. At the time of our review, this was being addressed and a patient choice policy had been written but was not yet operationalised.

- Frontline staff told us, that there was multidisciplinary team input in the discharge process, and records we viewed supported this. In addition to this, specific discharge co-ordination roles were utilised to optimise take home medicine turnaround times and discharge. Responses to our information flow tool supported these findings. While the majority of respondents said they felt discharge summaries were regularly sufficient for them to make a decision on whether they could support the placement, some respondents disagreed. Some 38% of respondents told us they were 'sometimes' sufficient, and nine percent said they were 'rarely sufficient. A range of issues were detailed in these responses, however the most common theme raised was around a lack of discharge summaries/information or the discharge information provided being insufficient or incorrect. Often because of this, respondents said they undertook their own pre-discharge assessments/visits to ensure they had all the necessary information. Another common theme was around medication issues; either lack of or incorrect information about medications (including changes), or wrong medication/insufficient medication being issued.
- Joint working processes to support people to move home required more development to promote an understanding of what was on offer to patients. The LIDS was the trusted assessor for the community care beds receiving referrals from hospital social workers and referring on to community care beds. This should provide easy access to social workers, community beds, Neighbourhood Teams and specialist health services. We were told that housing gets involved in discharge planning however, this is often at the last minute and if adaptations are needed this could delay someone's return home.
- In some cases, a lack of understanding of the services' criteria impacted upon people's expectations and experience. For example, operational leads told us that people leaving hospital had different expectations of the recovery hub and work needed to be done with hospital staff to ensure that people understood that the support would be short-term aimed at getting them home. If people did not understand and were reluctant to leave the recovery hub, there was a risk that beds could not be freed to enable people to be discharged from hospital. The same pressures around expectation were felt in the community care beds.
- Relationships between health and social care staff were not always effective enough to support the smooth transition of care. A lack of communication and understanding of the roles and services offered created delays in discharge. For example, care home and nursing homes refused to admit new residents to the home after 5pm and not at a weekend. Hospital staff found this frustrating as it created delays and they did not knowthe reasoning for this. On speaking with care home providers, they advised that the lack of an

enhanced service and access to GPs was a concern at weekends and this influenced this decision.

- Communication between the multidisciplinary team was sometimes lacking during the discharge process and the MDT was not always invited to discharge meetings. A blame culture was evident and there was little indication of partnership working to solve problems. For example, someone who was discharged from hospital at the end of their life was invited to a hospital appointment to undertake a walking breath test. This could be frustrating and upsetting for the person and their family and was also an appointment that could have been allocated to someone more appropriately.
- There was not consistent support for people who had problems impacting on their mental health, such as those living with dementia. Frontline staff felt that where people lacked capacity or there was a query about their capacity to make decisions that there was a delay in getting Independent Mental Capacity Advocates (IMCA's) or legal representation for financial decisions. This could delay people being able to come out of hospital. There was limited capacity in the nursing care market to support people living with dementia. As a result, people could remain in hospital, which was inappropriate setting. For example, one person received 14 different assessments for care homes; all were unable to meet the person's needs. To address some of these problems, the CCG, along with the mental health trust, had established a six-week package of one to one care for patients experiencing mental ill health with challenges to behaviour to try to get them into nursing care. But there was no plan for longer-term sustainability to maintain the placement and it was therefore likely that in the long term those placements would struggle when the funding ceases.
- While the Leeds Care Record had a positive impact on the ability of staff to ensure they had all the information they needed to put the right packages of care in place for people when they came out of hospital, it was not always being used effectively. Access to discharge planning and information still showed variability in this depending on the strength of local relationships and local leadership.
- There were a number of services that people could access to support them in their discharge journey. For example, the SPUR (Single Point of Urgent Referral) team reviews and passes referrals from the hospitals, clinicians, community beds and community providers (e.g. GPs, Neighbourhood Teams, and adult social care) to the Neighbourhood Teams or directly to adult social care to get people back into the community. This was for people who would benefit from additional care on discharge. However, SPUR staff found that there were challenges in working with many different referrers whose processes were changing so it was difficult to keep up to date.
- Analysis of our data showed that the percentage of people aged 65+ discharged from hospital who received reablement/rehabilitation had reduced from 4.4% in 2015/16, above comparators and the England average, to 2.9%, below comparator areas although still above the England average. System leaders told us that their subsequent data showed this

had since improved to 3.3%. There were 227 community care beds across Leeds, offering recovery step-up, step-down and discharge to assess functions, comprising of recovery hubs for step down and reablement. Three places were provided through a partnership between Leeds City Council and Leeds Community Healthcare Trust and were referred to as recovery hubs, offering 109 beds. There were positive developments in the reablement hubs with good MDT working and therapists on site to provide support for people to enable them to go home. Staff in the recovery hub were able to describe a very clear model for stepdown with an active involvement in a journey to recovery. When people were in receipt of reablement, they were less likely to be readmitted to hospital. 89.2% of people aged 65+ who received reablement/rehabilitation were still at home 91 days after discharge compared to 81.8% in comparator areas and an England average of 82.5%.

- Frontline staff who supported people when they left hospital told us that the recovery hub service was effective because they were able to provide support based on people's individual need in terms of the length of stay although a 28-day stay was more common. We also heard that people's experience of rehabilitation in hospital varied and if this was not provided in hospital it meant that people needed longer in the recovery hub.
- The VSCE sector services were used at the point of discharge. For example, good use was made of a 'hospital to home' initiative run by Age UK which provided transport to people to go back home, provided them with some shopping and also the option of an additional welfare check the next day. Frontline staff felt that this will have played a positive impact on reducing the numbers of people readmitted to hospital after their discharge.
- Seven-day working was supporting discharge. In addition to the 227 community care beds in eight sites across the city, Neighbourhood Teams, the recovery hub and reablement team were able to support discharge seven days a week. Frontline staff felt this was enabling patients to be discharged more quickly.
- GPs, nurses and other frontline staff worked well together to support people at the end of their lives. There was a palliative care network to support people living in Leeds, and St Gemma's Hospice was a teaching hospice working with the University of Leeds. Fast-track continuing healthcare funding (CHC) was arranged in a timely way. Staff were trained to discuss people's needs at the end of their lives at the appropriate time. Care was wrapped around the person and we were given an example of someone who had received this care for the last three months of their life. They were involved in decisions about their care and were able to die peacefully at home.
- We heard concerns from frontline staff about instances where CHC fast-track funding was removed and this was causing families distress when supporting their loved ones at the end of their lives, particularly as often it would need to be reinstated anyway. While some of these funding decisions may be appropriate, families needed better communication and support to enable them to understand the financial implications and the other avenues of support available.

Maturity of the system

What is the maturity of the system (direction of travel) to secure improvement for the people of Leeds?

- We were encouraged by the aligned structures, the commitment and the system-wide shared agreement of areas for development. This meant the system was well-placed to improve the health and social care pathways of people living in Leeds and there was an opportunity to develop their plans at pace.
- A 'single version of the truth' agreed by system leaders and leaders in the VCSE sector, following an independent consultancy review, meant that processes had begun to be implemented which should improve the flow of people through the hospital setting and reduce delays.
- The system had a clearly articulated vision that aligned local strategic intent with the wider West Yorkshire and Harrogate Health and Care Partnership. The local authority, the CCG, the acute trust, the Leeds Community Healthcare Trust, the Leeds and York Partnership Trust and the GP federation were co-terminus, which gave system leaders an advantage in terms of developing integrated services to improve the health and care experience of people living in Leeds. System leaders had a shared understanding of the barriers to delivering good pathways of care and were committed to improvement. However, integrated commissioning and working was very much confined to the Better Care Fund Plan, and this needed to be further developed.
- There were strong relationships between leaders in the PEG which provided the foundation needed for them to collectively take forward the findings from the external review and drive improvements for the system. The relational audit showed that respondents felt that they treated each other fairly, were open and honest in their dealings with each other and supported each other's organisational goals. However, the audit also showed that poor communication was perceived as a problem. Respondents felt that organisations did not plan and implement change together, leading to understanding of the wider impact on other parts of the local system.
- Workforce planning to support integrated working and resolve recruitment challenges was in its infancy and timescales had not yet been agreed. However, specific challenges, such as paramedic support for GPs, were being addressed.
- Although system leaders were working together to ensure that they had a shared understanding of the needs of the population, work to shape the market collaboratively

was underdeveloped. Leaders recognised that the care home and homecare market needed further development and a market position statement was under development at the time of our review. At the time of our review, the market was not sustainable in its current form.

- At the time of our review, despite a strategic intent to focus on maintaining people at home, resources were being diverted to manage areas of pressure. There was joint funding and commissioning through the BCF but this was limited to this area. There was scope for the ICE to develop this further.
- Digital interoperability, although still in progress, was well-developed through the Leeds Care Record. There were numerous examples of how this facilitated integrated working between health, primary and social care professionals. It was being developed further however not all professionals across the system had fully engaged with it and this will take some time to embed.

Areas for improvement

We suggest the following strategic areas for improvement

- The HWB should continue to maintain oversight and hold system leaders to account for the delivery of the health and wellbeing strategy.
- The remit of the ICE should be further developed so that it extends more widely to underpin the development of wider integrated working.
- There is a recognition from system partners that hospital pressures should be addressed as a system. This should be reflected in system-wide strategic plans.
- The culture of 'home first' and moving people away from hospital needs to be embedded throughout the system, especially in the hospital setting where there remains a risk averse approach to discharge and a lack of understanding of community support.
- Communication between health and social care professionals and their leaders needs to be addressed across the system. Although there are good relationships at system leader level, and where multidisciplinary working is embedded, this can become fragmented at other levels leading to a breakdown in communication which can impact on people's care.
- The workforce strategy for Leeds should be developed at pace, pulling together the different strands of activity to develop deliverables and timescales which include the independent social care sector.

- There should be improved engagement with GPs and adult social care providers in the development of the strategy and delivery of services in Leeds.

We suggest the following operational areas for improvement

- A clear process should be implemented so that health and social care professionals can be assured that they are able to identify and support the members of their communities who are most at risk.
- Signposting to services in the community needs to be clearer so that people can access the wide range of services on offer and get the support that they need.
- There should also be consistent and proactive input from GPs to support care homes.
- Specific pilot schemes were helping people to receive support in the community. There should be evaluations and exit plans in place to reassure or inform people who benefitted from good support about what their future options were.
- Wards for people who are medically fit for discharge should have a plan in place to reduce the numbers of beds on these and to reduce the reliance on these as part of the discharge process.
- Systems should be put in place to ensure that people who go into hospital are seen in the appropriate wards and remain there until they are medically fit for discharge without multiple moves.
- System leaders should continue the work to reduce hospital admissions as admissions are higher than the England average.
- The patient choice policy should be rolled out as a priority and leaders should have a system to gain assurance that this is understood and implemented.
- The system should ensure that staff, particularly hospital staff understand and respect the dignity of people who use services and to understand the impact that issues such as multiple ward moves can have on people's wellbeing.