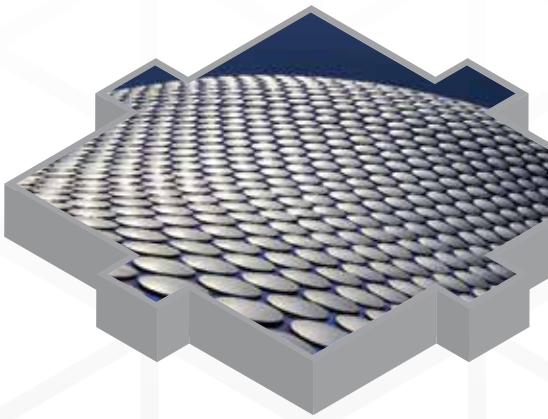
Appendix 1

Care Quality Commission

Beyond barriers

How older people move between health and social care in England

JULY 2018



About the Care Quality Commission

Our purpose

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

We register health and adult social care providers.

We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.

We use our legal powers to take action where we identify poor care.

We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can

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Foreword

In the 70 years since the National Assistance Act and the new National Health Service established the modern welfare state, our health and care needs have changed and grown.

We are living longer into older age. Women born today can expect to live 11 years longer than those born in 1948. As healthy life expectancy has not kept pace with life expectancy, more people are living longer with complex health problems. Increasingly, our care must be delivered by more than one person, and more than one organisation.

Alongside these demographic changes there have also been changes in our understanding of what high-quality care looks like. In 2018, we expect people to experience personalised care that is tailored to their individual circumstances and joined-up to meet their needs. And we understand that people should be active partners in decisions about their care.

For people working in health and social care, the task has rarely been more challenging, complex and uncertain. Trust and collaboration between health and social care organisations have never been more important.

This means that a system designed in 1948 can no longer effectively meet the needs of increasing numbers of older people with complex health and care needs.

In our review of care for older people in 20 local systems in England, we found that people experience the best care when people and organisations work together to overcome the fragmentation of the health and social care system and coordinate personalised care around individuals. This is already happening in some places, but if we are to turn these examples of good practice into standard practice everywhere, then we must remove the barriers to collaboration at a local and national level and incentivise joined-up working.

If we are to make integrated care a reality, we need to change the way we measure performance, approach funding, plan the workforce, and regulate services.

The NHS and social care are two halves of a whole, very often providing support for the same people. We must create an environment that drives people and organisations across health and social care to work together, rather than driving them apart.

We need to move away from efforts to measure the performance of individual organisations working separately. Local and national leaders need a single, shared approach to measuring how well their whole system meets the needs of people using health and social care services.

We also need long-term funding reform, supported by long-term investment and greater flexibility that allows local systems to make the best use of their resources to meet the needs of local populations. We need an approach that supports collaboration, rather than imposes limits on how far local government and NHS commissioners can align or pool their budgets.

Joined-up care also requires a workforce equipped to move between health and social care. Workforce planning needs to create the skills and career paths that allow people to work flexibly across the system as services evolve over time to meet the population's changing needs.

And efforts to join-up a fragmented health and social care system must be recognised and reinforced by an improved regulatory framework that looks at the whole system, as well as the individual organisations within it. For CQC, this means we want the power to look at the quality of care across a system, as well as in the individual organisations that provide health and social care services.

These are difficult problems to solve. There have been attempts to integrate health and social care since the 1970s. None has yet fully succeeded in overcoming fragmentation and achieving joined-up, personalised care for individuals. But it is clearer now than ever before what needs to be done to address this great unresolved challenge. The question that remains is whether leaders working locally and nationally have the bravery and conviction to lead the charge.

Sir David Behan CBE
Chief Executive

Summary

Most older people in England, particularly those with complex needs, will receive care at some time. Their experience of care will often depend on how well different services work together for them, their families and carers.

CQC has reviewed 20 local health and care systems, to understand how services are working together to meet the needs of people who move between health and care services. Our focus was people aged over 65. In some areas, different parts of the system are working well together. In other areas, the system was less joined-up and not working as well for people.

In the systems we reviewed, we found individual organisations working to meet the needs of their local populations. But we did not find that any had yet matured into joined-up, integrated systems.

Health and care services can achieve better outcomes for people when they work together. Joint working is not always easy. The health and social care system is fragmented and organisations are not always encouraged or supported to collaborate.

An effective system which supports older people to move between health and care services depends on having the right culture, capability and capacity. We have looked for effective system-working and found examples of the ingredients that are needed. These include:

- A common vision and purpose, shared between leaders in a system, to work together to meet the needs of people who use services, their families and carers.
- Effective and robust leadership, underpinned by clear governance arrangements and clear accountability for how organisations contribute to the overall performance of the whole system.
- Strong relationships, at all levels, characterised by aligned vision and values, open communication, trust and common purpose.
- Joint funding and commissioning.
- The right staff with the right skills.
- The right communication and information-sharing channels.
- A learning culture.

Health and social care organisations should work together to deliver positive outcomes for people and ensure that they receive the right care, in the right place and at the right time. In the local systems we saw, people were not always receiving high-quality person-centred care to meet their needs, or getting their care in the right place.

We have met hundreds of dedicated staff who are committed to providing the highest quality of care possible. Many regularly go beyond the call of duty. Some exceptional professionals we met are working across organisational boundaries to provide high-quality, personalised care and support to people, despite the barriers to joint working.

As a starting point, there should be greater emphasis on keeping people well at home. Investment in preventing health problems and keeping people out of hospital where possible will be better for people and for the health and care system. Bed occupancy in hospitals is higher than ever. Local leaders need to be able to invest in the prevention measures that will help keep people well.

If older people have to go to hospital they should only be there for as long as necessary. If they are ready to go home, they should not be delayed. A recent focus on tackling these delays has led to some improvements for people. This is important because older people, particularly frail people, can suffer harm and distress if they stay in hospital too long. Care providers need to work together to achieve the best outcomes, to ensure that people who need care and support are receiving it in the place that is best for them.

People are not usually concerned with who is providing their care. What they want to know is that the care they are getting is right for them. We have seen examples where joined-up working between health and social care services can achieve this.

We have seen that health and care staff are committed to helping people. And where we have found that there is one strategic vision, shared by leaders working across a local system, this provides clarity and a common purpose for organisations and individuals working within it.

To build on these strong foundations, overcome the fragmentation of the system, and ensure that more people experience high-quality, personalised care, we need to see changes to:

- the way the performance of health and social care is measured;
- the funding arrangements for health and social care;
- the way the future shape and skills of the workforce are planned; and
- regulation and oversight of health and social care.

Better health and care outcomes for people rely on good relationships at all levels of services – the best ones are characterised by aligned visions and values, open communication, trust and common purpose.

Currently, people working within systems are not always incentivised to work together. Most senior leadership sits within individual organisations, requiring good working relationships and collaboration to deliver joined-up services for people. Organisations answer to their own organisational objectives, commissioners and regulators. Leaders are judged on their success in terms of individual organisation performance measures, not outcomes for people cared for by a system.

Senior leaders report a culture where organisations prioritise their own goals over the whole system's shared responsibility to people using health and social care services. We heard about tensions in organisations and across health and social care, influenced by system pressures and accountability against performance measures, such as delayed transfers of care. This behaviour hinders joint working. Where we have seen that leaders in systems have an understanding and appreciation of each other's roles and responsibilities this has helped to build relationships and improve outcomes for people.

A new type of leadership approach is required, where leaders are supported and encouraged to drive system priorities collectively, through system-based, shared and well-understood performance measures and accountabilities.

None of the systems we visited had a fully joint, system-wide accountability framework. This means leaders are not accountable for the outcomes of a wider system, beyond the accountabilities of their individual organisations. Individual governance and accountability structures are well established at the level of organisations, however, across the review programme we have found that accountability for the performance of a system, in how organisations work together to meet the needs of people in a place, has not been universally established. Forums such as Health and Wellbeing Boards, Sustainability and Transformation Partnerships and the Urgent Care Delivery Boards can all be drivers for system-working. We found varying effectiveness of these from system to system.

To drive collaboration, there needs to be a transformation in the way the performance of health and social care services is measured. Currently, performance is measured in individual organisations, working separately. We need to see a shared approach that measures how well

a whole system is working to meet the needs of people using health and social care services.

Funding flows are also a challenge across systems and financial pressures have affected joint working.

Separate funding streams and different payment processes can cause divides between organisations in a system. This is seen in the different approaches to eligibility for care, with NHS services provided for free at the point of delivery and based only on clinical need, while social care delivery is means-tested. The dominance of tariff-based funding has acted as a barrier to joined-up commissioning across health and social care, and to investment in prevention and out-of-hospital provision.

The Better Care Fund was a catalyst for joint funding in most systems, bringing together system partners to commission and deliver services across health and social care. Despite limitations in scope in some places, it has shown what is possible when health and social care organisations are able to commission services from a unified budget.

In June 2018 a long-term NHS funding plan was announced. This promises that by 2023/24 the NHS England budget will increase by £20.5 billion in real terms compared with today. For health and social care to plan collectively as a system for the long-term, funding security is required across both health and social care. At the time of writing there is no long-term funding solution for adult social care. A long-term financial plan for adult social care is expected as part of the forthcoming Spending Review, following the publication of the social care Green Paper.

We need to see long-term funding reform that addresses social care and the NHS together, and removes the barriers that prevent social care and NHS commissioners from pooling their resources and using their budgets flexibly to best meet the needs of their local populations.

National bodies have an important role to play in overseeing the performance and quality of health and care services and encouraging improvement. CQC has a role through its regulation of the quality of care. It is clear from our reviews that assessing the quality of individual providers is important to ensure people experience safe, high-quality, compassionate care. But if we are to encourage and recognise efforts to collaborate across the health and social care, then we also need regulation to look at the quality of care across whole systems. In reviewing systems, we are able to clearly understand what the journey through health and social care is like for people who use services, their families and carers and the safety and quality of this journey.

The key to building sustainable improvements in the quality of care for people is through collaboration across the health and social care system. Health and care systems face an unprecedented challenge in meeting the increasing needs of their populations within available resources. For systems to be sustainable they need to have the right provision in place and sufficient capacity to support people to stay well in the community or move smoothly through the system. This all depends on having staff with the right skills, in the right place.

There are significant challenges in recruiting and retaining frontline health and social care staff and we have seen the impact this has had on the quality of care people experience. This will get even more challenging over time, as an ageing population that has more complex long-term conditions increases the demand for health and social care services.

We found particular challenges in the care home and domiciliary care workforce. Years of funding reductions and the growth of competing job markets in some local areas have left the care home and domiciliary care market less able to attract a workforce. There are issues for the health and social care leaders to address. People working in health and social care are not always seen as equal partners.

As we move towards more integrated models of care, staff will increasingly need to work across boundaries and take on new responsibilities beyond people's specialisms, for example, by undertaking care coordination and assessment. Knowledge and understanding of other health and care services that can meet people's needs in the community will be crucial in reducing pressures on hospitals. Systems need to be innovative in how they recruit, train and use their workforce, so that staff have the ability to provide joined-up care that is seamless for people who need it.

Workforce planning as a system will be central to this. Currently these issues are addressed within individual organisations, not as a whole system approach. Organisations need to work collaboratively to develop a health and care workforce that will meet the needs of people now and in the future. An integrated national and local approach to health and social care workforce planning is essential to provide sustainability in local labour markets, and high-quality, personalised care for people using services.

Establishing the right health and care provision for the needs of a local population was one of the most significant challenges in all the local systems we visited. We have found that the voluntary, community, and social enterprise (VCSE) sector are under-used in the planning and delivery of services and often not seen as partners. Health and care commissioners and providers, including the independent sector, must share risk and work together as a unified system.

Another significant challenge to health and social care integration is the ability to share information to inform effective decision-making. This problem is not new. Poor information governance or a lack of understanding of rules and regulations of sharing information can prevent joined-up care and support.

Information is not always available in the right place, at the right time – this leads to delays, people having to tell their story multiple times, and a risk-averse approach to decision-making.

Health and social care services are already under significant pressure, and demand for care is likely to increase. We cannot solve this problem by continuing to work in the same way. We must make collaboration across health and social care the default option. This means removing the barriers to collaboration and changing the way we measure performance, fund the system, build our workforce, and regulate services. Only by working across the health and social care system, recognising that health and care services are very often caring for the very same people, can we possibly hope to see the significant and sustainable change that is required.

Introduction

CQC has completed a programme of targeted local system reviews in local authority areas. This work followed the government's 2017 Spring Budget announcement of additional funding for adult social care and a joint request from the Secretary of State for Health and Social Care and the Secretary of State for Housing, Communities and Local Government.

We were asked to find out how services are working together to support and care for people aged 65 and over – people who experience the interface between health and social care services. This report pulls together our findings.

CQC is in a unique position to provide an overview across the entire health and adult social care system and provide an independent, objective and trusted assessment of local systems and what improvements are needed.

Each local system review addressed the following question:

How well do people move through the health and social care system, with a particular focus on the interface, and what improvements could be made?

We have identified what makes it easier and what makes it harder for local services to work together to make sure older people have a timely, high-quality and safe journey through the health and social care interface. In this report, we confirm and expand on what we published in our **interim report** to the Secretaries of State (December 2017). We also set out the action that needs to be taken to improve the quality of the journey for older people who move between health and social care services.

The 20 systems we reviewed were identified by the Department of Health and Social Care (DHSC) and the Ministry of Housing, Communities and Local Government (MHCLG). They are based on a **dashboard of metrics** indicating challenges with access and how people move between health and social care services, including delayed transfers of care.

In every system reviewed we found good practice. This has led to good outcomes for people who use services, their families and carers. The systems we reviewed were facing significant challenges – 19 of the 20 systems were selected as comparatively challenged systems and the findings should be considered in this context.

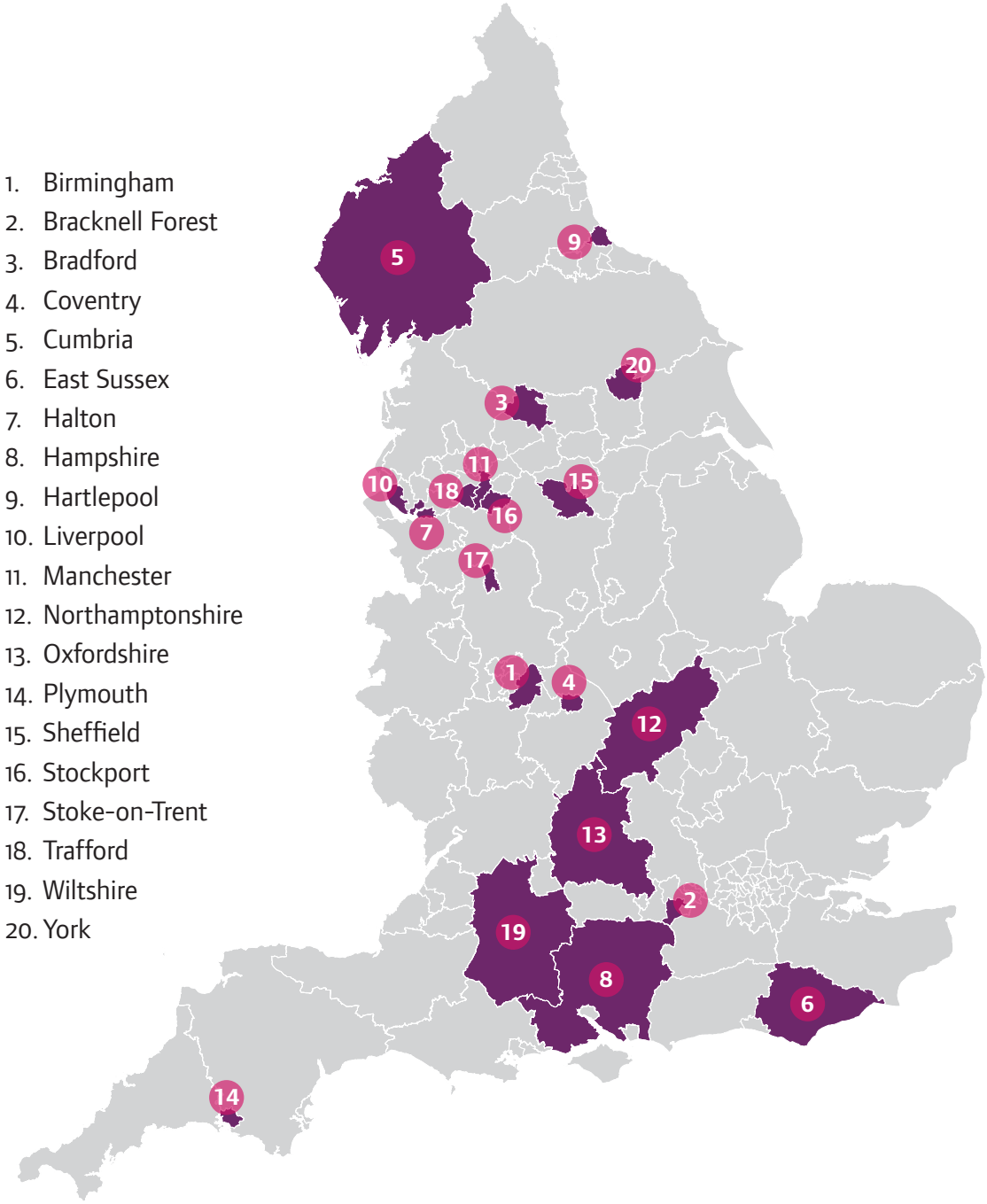
This report makes recommendations for national and local leaders, to suggest the scale and pace of improvement needed for people to have better experiences when they use a combination of health and social care services.

There are two supporting documents for this report that provide more detail on the findings from two evidence-gathering tools we used in the reviews:

- the relational audit examining the quality of relationships between people working in health and social care systems;
- the discharge information flow tool seeking perspectives from providers of social care about the information they receive when older people are discharged from hospitals and into their care.

Within this report, we have included the experiences of the some of the people we have met and heard about in the systems we visited. We have not used their real names.

FIGURE 1: THE 20 SYSTEMS

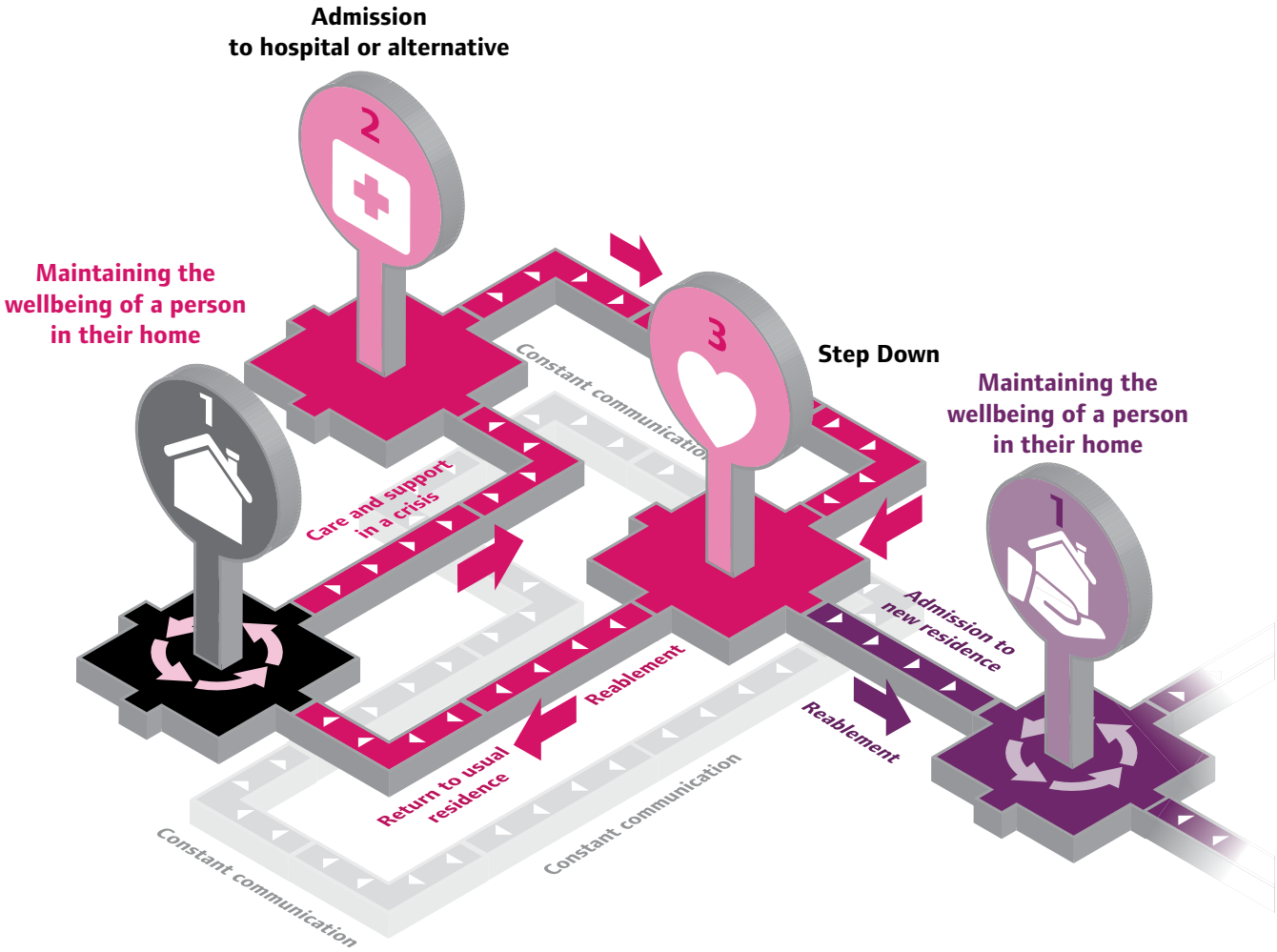


What we did

Starting in August 2017, we have undertaken 20 local system reviews, using data analytics, observation, case-tracking, interviews, focus groups and questionnaire feedback tools. The detailed findings from each system are in the local system reports published on our **website**. We collected qualitative and quantitative data and supporting observations, which are explained in this publication.

We developed our approach to the local system reviews in co-production with a range of stakeholders, including national bodies, health and social care commissioners and providers, voluntary and community sector organisations, and people who use services and their families and carers.

FIGURE 2: HOW OLDER PEOPLE MOVE BETWEEN HEALTH AND SOCIAL CARE SERVICES



The system reviews focused on the interface between health and social care, looking at the planning, commissioning and delivery of health and social care services. We reviewed how each local system works within and across three key areas:

1. **Maintaining people's wellbeing at home**
2. **Care and support when people experience a crisis**
3. **Step down, return to a usual residence, and/or admission to new residence**

Each review involved:

- Analysis of available data and the production of a local system data profile
- A system overview information request (completed by the system)
- Evidence submitted by local stakeholders, including organisations that represent people who use services, their families and carers
- Two questionnaire feedback tools completed by people working in the system (a relational audit and discharge information flow tool)
- 'Pathway tracking' for a small sample of people who use services.

During the review we spent two periods on site in each local system:

- In the first period we spoke with people who use services, their families and carers, and organisations that represent people, including local Healthwatch. We were supported by experts-by-experience, who have personal experience of using health and/or social care services, or caring for someone who uses health and/or social care services.

- During the second period, we took a team on site for a week to hold focus groups with staff, carry out interviews and visit services. The review team included CQC staff and support from specialist advisers, including current and former directors of adult social services, chief executives of local authorities and senior health professionals.

A local system report was produced after each review, showing findings, highlighting what was working well and where there were opportunities for improving how the system works for older people using services, their families and carers. Each local system report has an assessment of joined-up working, the integration of systems, and how these were working for people in the area.

We commented on the maturity, capacity and capability of the local system, and we shared the data profiles used to inform each review with the system. Reviews were followed by local summits, facilitated by the Social Care Institute for Excellence (SCIE). These brought together system leaders from the local areas and representatives from national bodies, including the Local Government Association, NHS England and local Healthwatch.

The summits were to discuss the findings from the reviews and for system leaders to develop action plans. Sometimes this might lead to work with national bodies to help enable leaders to implement changes at a system level.

SCIE was asked by the DHSC to provide independent support to local system to assist with the development of plans that addressed the findings and recommendations from CQC's local system report.

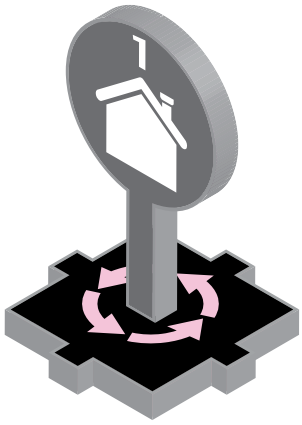
Local system reviews report

This report is mostly based on analysis generated by CQC:

- Qualitative analysis of local system reports
- Quantitative analysis of CQC and national data
- Quantitative and qualitative analysis of questionnaire feedback tools completed by people working in the systems (a relational audit and a discharge information flow tool).

Where other data is used it is referenced in the report. The analytical findings have been corroborated and in some cases supplemented with expert input from our local system review team, specialist advisers and analysts to ensure that the report represents what we saw during the reviews. The report was developed with the support and challenge of an external expert advisory group.

1. Older people's experiences of moving between health and care services



We saw many examples of good practice at individual organisations within systems. We also saw the way that systems are not working in the best interests of people who use services, their families and carers, because organisations in a system are not joined up.

Older people often need to move between different kinds of care. When they do, all services involved in their care have a role in keeping them safe and helping them move smoothly between different aspects of their care – so they must work together. This is especially important when people are being discharged from hospital to return home, or if as a result of their health and care needs changing, they move somewhere else, such as a care home.

Across the reviews we heard many people compliment and praise the work of health and social care staff and the organisations they represent. We also heard many stories from people who were admitted to hospital but were unable to go home when they were ready because health and social care services were not joined up. For some older people, the consequences of this are severe and life-changing.

Avoidable admissions and delayed transfers of care – why do they matter?

People told us that when they are admitted into hospital, they only want to be there for as long as they need to be – when they are ready to go home, that is what they want to do.

There is strong evidence that when an older person unnecessarily spends time in hospital, it can be detrimental to their health and wellbeing. Being inactive means older people are more likely to lose their ability to perform everyday tasks. A length of stay in hospital for one week is associated with a decline in muscle strength in older people. The additional and unnecessary burden this places on health and care services is also significant.

NHS guidance states that people should be discharged from acute settings as soon as it is clinically safe to do so.[1] Many things can stop this happening and lead to a delayed transfer of care (DTOC). Delayed transfers of care are widely

recognised as a national challenge – far too many people stay in hospital beds for too long. Analysis has shown that many people might get more appropriate care outside a hospital – this applies to 20-25% of all admissions and up to 50% of bed stays.[2]

Delayed transfers of care were common across the systems we visited. Of the 20 systems, 17 had higher rates of delayed transfers for older people than the national average and six had more than double the national average rate.[3] Thirteen systems also performed worse than the national average against the DHSC's assessment of the length of stay for older people admitted to hospital as emergencies.[4]

Ensuring effective transfers of care is also more than discharging someone from hospital in a timely way. If the right support and provision is not in place when a person returns home, this can lead to a breakdown in care, deterioration of their health and wellbeing, and readmission to hospital. Services need to work together to ensure that when a person moves from one setting to another, they have the right care in place and at the right time to meet their needs.

CASE STUDY 1
END OF LIFE CARE

Mrs Foley began to experience mobility problems and she funded her own social care. As a self-funder, Mrs Foley was not offered support or sign-posting to services and her daughter felt the only options available were for her to become a full-time carer to her mother or for her mother to be admitted to a care home.

Having opted for a care home, Mrs Foley's experience was poor. Staff did not follow district nurses' instructions, but equally the district nurses did not fully understand Mrs Foley's care needs, which included mental health support. The focus for treating her mental health needs was with medication. But there was little mental health support between her crises.

The local authority and GPs disagreed over whether Mrs Foley had capacity to make decisions for herself and it was left to her daughter to try to coordinate the various services. Her daughter raised concerns about her mother's care, but she felt that she was labelled 'a nuisance' and the local authority disregarded the fact that she had power of attorney for her mother's health and welfare.

Following a fall, Mrs Foley was admitted to hospital despite an advance directive (where the decision is made in advance) that she did not want to be treated in a hospital. Her daughter was told the hospital admission was to improve her mobility and hydration. In hospital, Mrs Foley was moved five times within a 24 hour period, causing her distress. Her daughter described her mother as being in an "uncared for state". Mrs Foley's daughter recognised her mother was at the end of her life and requested she be allowed to return home. After an initial disagreement, the hospital allowed this.

Medicines to make Mrs Foley comfortable at the end of her life were to be administered via a syringe driver, but some district nurses would not agree to administer this. Mrs Foley's daughter felt that she best understood her mother's needs, and yet decisions were made on her mother's immediate presentation without asking her.

Note: The names of people in our case studies in this report are not their real names.

CASE STUDY 2
GETTING WELL IN THE COMMUNITY AND AT HOME

Mrs Arthur was shopping with her daughter when she had a fall and an ambulance was called.

At hospital, Mrs Arthur was seen promptly and an x-ray showed she had a fractured hip. She was appropriately admitted as an inpatient and within 24 hours of admission, she had surgery.

Staff on the ward had an in-depth understanding of Mrs Arthur's health and social care needs, as well as Mrs Arthur's preference for returning home as soon as possible, post-surgery. These discussions had taken place within 24 hours of Mrs Arthur being admitted, so staff could help to plan her discharge and make the necessary arrangements as soon as possible.

Multi-disciplinary meetings took place between health care, social care and therapy staff to arrange a suitable package of care to enable Mrs Arthur to go home. Within 48 hours of surgery, Mrs Arthur was supported to move around by therapy staff, and 14 days later she was transferred to a reablement bed in the community where she was supported to further regain her confidence and independence.

Once Mrs Arthur felt she was ready, she returned home with a single, daily visit from a domiciliary care provider, which she had requested. However, Mrs Arthur cancelled this support herself after a week at home because she felt she no longer needed support and had regained her mobility and independence.

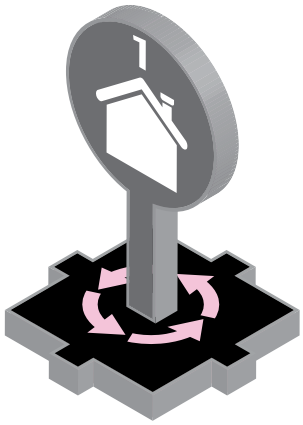
Note: The names of people in our case studies in this report are not their real names.

Alongside the challenges of delayed transfers of care the number of older people attending and being admitted to hospitals has increased. Our analysis shows 4.3 million attendances of older people at accident and emergency departments (A&E) between September 2016 and September 2017, an increase of 11.3% from the same period two years before. The number of emergency admissions of older people increased by 4.8% over the same period to nearly 2.5 million. Fourteen of the 20 systems we reviewed had emergency admission rates above the national average.[5]

Reducing avoidable admissions through supporting people in the community should be a priority for local systems. Our review methodology looked at how systems were supporting people to maintain their health and wellbeing in their home. We have seen that a proactive approach to preventing the need for hospital care is best for the person, their families and carers, and the system.

2. High-quality care pathways: barriers and enablers to providing safe, timely and high-quality care

2.1 Maintaining health and wellbeing in the community



Where possible, people want to be supported in the communities they live in. People told us that having access to support at home helps them to live the life they want and continue to contribute to their community. In our reviews we looked at how people are supported to remain healthy and well at home. This could be in their own home, or in a care home. Preventing people from reaching a crisis and needing to use hospital services is important for the person and the system.

The need to move towards a more preventative approach has been recognised nationally in health and social care through the *Five Year Forward View*[6] and the *Care Act (2014)* respectively. Locally, in all of the systems we have visited we found a shared understanding of the importance of providing preventative services that promote health and wellbeing in the community.

Local leaders (e.g. chief executives of councils or clinical commissioning groups) can commission a wide range of services in their communities to provide support to people and help them to maintain their health and wellbeing at home. We saw many services and initiatives across the reviews that were helping people to access care and support when they need it and in the communities they live in, preventing them from needing to go to hospital.

"IT PROVIDES COMPANY FOR ME..."

In Plymouth, the public health prevention budget was small, but the system had continued to fund a befriending service. Professionals recognised the role it played in preventing social isolation and loneliness.

The service provided support to over 1,100 people at the time of our review – all were referred by partner organisations, GPs or people and their families and/or carers. The service proactively followed-up people who failed to attend regular sessions, to ensure they were safe and well.

People we spoke with were extremely positive about the service; some had been using it for over 15 years and stressed the important role it played in maintaining their health and wellbeing. One person told us, "It provides company for me, with bingo and trips out. It's a part of our local community and integrates with other things like the church and the theatre."

Research has shown that investment in lower-level preventative services can lead to a reduced need for care and support and cost saving equivalent to £880 per person.[7] While the benefits of prevention are well understood, there are barriers to systems having the right preventative services and support in place. Across the reviews, we found that commissioning priorities were influenced by funding pressures, and funding flows to support hospital care. As a consequence, the ability to invest in services that prevent people becoming unwell (from social care, primary care, community care, or the VCSE sector) was limited.

Local authorities are responsible for ensuring people receive care and support services that prevent their needs from becoming more serious.[8] Local government leaders told us that resourcing is a barrier to supporting people to remain healthy and as independent as possible at home. It is reported that reductions to public health grants, announced in December 2017, will see a 3.9% real-terms reduction each year between 2015/16 and 2019/20.[9]

The health and social care services that support people to stay well in the community (primary, community health, social care and VCSE sector services) are facing significant pressures in demand. For a person with one or more long-term condition or frailty, the availability and quality of primary, community health and social care are critical in preventing hospital admissions or A&E attendances and maintaining quality of life.

In the face of these challenges, we saw organisations working well together to identify and support people in their own homes and in care homes. However, difficulties and inequalities in accessing support meant that people were not always able to access care and support when they needed it. This can have a significant impact on people's health and wellbeing.

Access to general practice, community health and social care at home

General practice

General practice is usually a person's first point of contact for general healthcare, and provides the majority of contacts between the NHS and people. Across our reviews we saw how general practice can play a central role in the early identification and management of health problems and preventing people from needing hospital care.

Quality in general practice is generally high.[10] However, the general practice workforce is stretched, and this was impacting on people's access to their GP. In some systems, the GP workforce was unstable, and in a few systems, this had led to the closure of GP practices.[11]

Across our reviews people told us it could be difficult to access their GP. Not being able to access the GP was a barrier to getting the right support at the right time, and could lead to people relying on hospital services. Access

to primary care support out of hours was also critical to this, but we found that people's access to this support varied, and in some areas was not adequate.

"Sometimes you can have a 50-minute wait for them to answer the phone. As a patient with chronic health issues it's very difficult to get appointments to see a doctor or a nurse, to have bloods taken or have health reviews. I often go to the hospital for my bloods, instead of waiting for weeks for an appointment."

Personal experience described to CQC

Our analysis[12] suggests lower rates of GPs and primary medical services (PMS) care staff per registered patient may be associated with higher rates of attendance at A&E by older people.[13] Data also shows that while the majority (over 80%) of older people have good experiences making GP appointments, this has declined in recent years[14] and our analysis indicates poorer experiences making GP appointments may be linked to higher rates of older people attending A&E.[15]

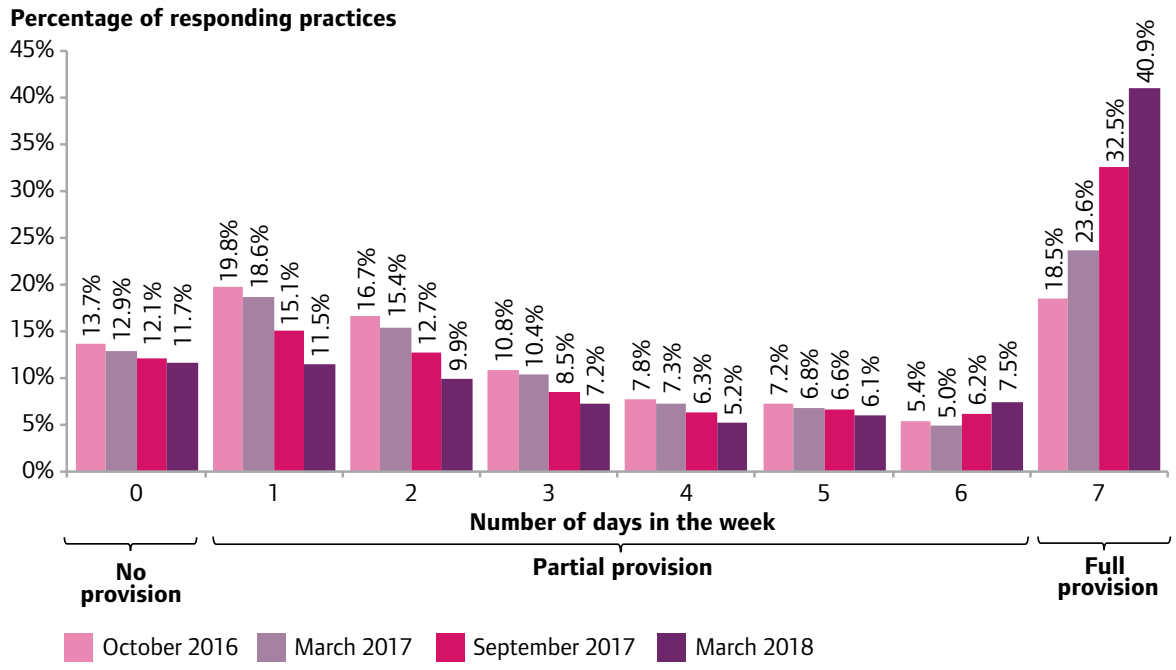
Throughout the review programme, we were told about examples of people presenting to hospital when they could have accessed out of hours primary care support. To prevent this from happening, and raise awareness of the out of hours service, in Bracknell Forest, GP practices supplied cards displaying the out of hours contact details to people who were at highest risk of hospital admission.

The national drive to provide seven-day services[16] has been recognised in general practice and extended access is rising substantially. Clinical Commissioning Groups (CCGs) are required to provide extended access to GP services for 100% of their populations by October 2018.[17] In March 2018, 40.9% of GP practices across England that responded to NHS England's survey of extended access said they offered full provision[18] outside of core contractual hours, an 8.5 percentage point increase on the previous survey in September 2017 **(FIGURE 3)**.

This means that almost four in every 10 (22.6 million) people registered with a general practice have access to a GP appointment outside of core working hours. While extended access is rising, in some of the systems we reviewed there was still a need for improved commissioning in primary care to maximise the potential of general practice's impact on improved outcomes for people.

In the face of capacity challenges, we saw that collaboration and innovation in general practice were helping GP services to meet the needs of people in their communities. For example, we saw general practices working as a collaborative hub to provide evening and weekend access. In one system we saw that through a neighbourhood team model, GPs were starting to proactively work together around prevention to ensure more people were treated in the community.

FIGURE 3: NUMBER OF DAYS OF EXTENDED ACCESS TO GP PRACTICES



Source: NHS England; Extended access to general practice – March 2018

Community health services

General practice is well known for its role in supporting people in the community, but the contribution of community health services (e.g. community nursing and therapy services) is also key. We saw that when primary and community care work together, along with social care, to join up their services around the person, they can effectively meet people's needs.

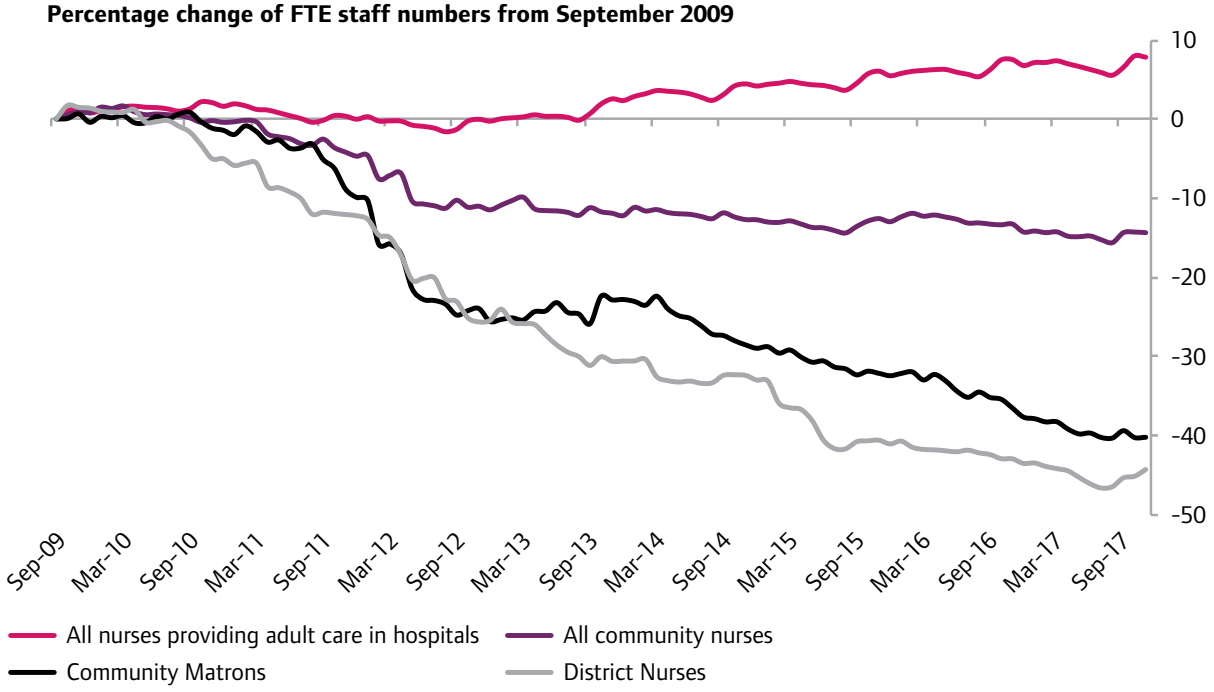
> We found community health services providing vital support to keep people well. In Bradford, a special district nurse health team had been established to focus on people with complex and long-term conditions and who were isolated and unable to access their GP easily – it reduced the need for them to access care in hospital.

Nationally, capacity in community health is challenged. Between 2009 and 2017 there was a 40% fall in the number of community matrons and a 44% drop in the number of district nurses **(FIGURE 4)**. At the same time, the number of nurses caring for adults in hospitals increased by 8%.

A reduction in the availability in district nursing was having an impact on people and across sectors. We heard about people going to hospital to receive catheter care when this could have easily been addressed in the community. We also heard about other paid care staff such as health care assistants and domiciliary care staff undertaking clinical duties that might traditionally have been done by district nurses, such as providing catheter or wound care. We also heard about other paid care staff such as health care assistants and domiciliary care staff undertaking clinical duties that might traditionally have been done by district nurses, such as providing catheter or wound care.

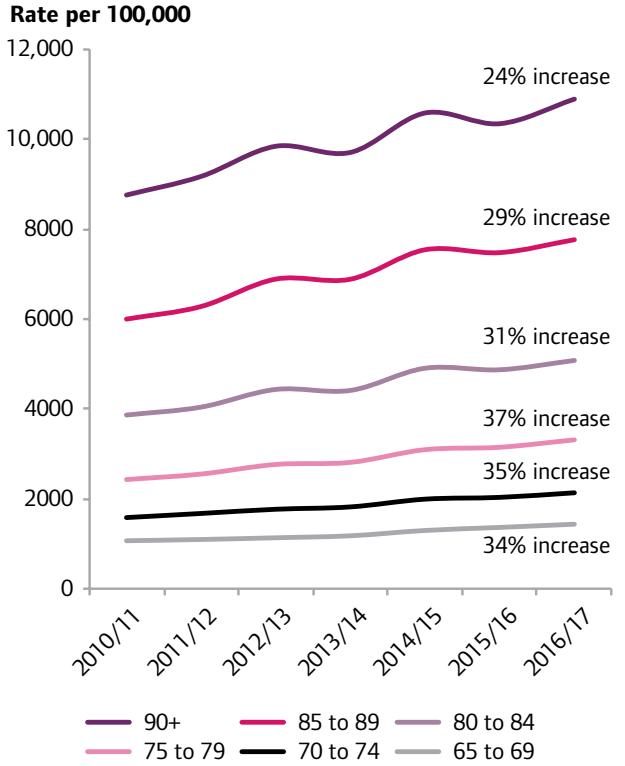
From 2010/11 to 2016/17, the rate of emergency hospital admissions for older people has steadily increased for conditions (e.g. kidney and urinary tract infections, flu, pneumonia, upper respiratory tract infections and angina) that would not usually require hospital admission **(FIGURE 5)**. Each age group over 65 years showed at least a 24% increase over this time period.

FIGURE 4: CHANGE IN STAFFING LEVELS SINCE SEPTEMBER 2009



Source: NHS Digital, NHS Workforce statistics, September 2009 – November 2017

FIGURE 5: RATES OF AVOIDABLE EMERGENCY ADMISSIONS FOR OLDER PEOPLE



Source: Source: NHS Outcomes Framework 3a – emergency admissions for acute conditions that should not usually require hospital admission. Rate has been indirectly standardised to take into account demographic differences.

Our analysis shows that in 2016/17 there were 110,178 emergency admissions of older people to hospital for kidney or urinary tract infections (UTIs) – this cost over £289 million in care in acute settings. Kidney infections and UTIs are seen as avoidable admissions because with the right community and clinical support they can generally be treated outside of hospital.

These admissions might have been avoided if people got the right care in the community.

Social care at home

Social care provided in people's homes plays a key role in supporting older people to remain independent. The role of domiciliary care is becoming ever more important – while the number of older people grows, system leaders want to reduce the number of people receiving care in a care home and increase the amount of care people receive at home.

CASE STUDY 3

CONFUSED BY ALL THE PEOPLE

Mrs Singh lives with her husband at home. Mr Singh has dementia and recently stayed in hospital because of a chest infection, and he had reduced mobility.

Mr Singh was able to leave hospital and return home with the offer of domiciliary support, receiving 56 visits from paid care workers every week.

In the week before we met Mrs Singh, she told us that she had counted the number of different individuals visiting her husband in one week – there was a total of 42 different paid care workers, many of whom had not visited her husband before.

Mrs Singh said that this was very distressing for her husband because he got very confused by all the people. She also said it was stressful for her because she had to tell her husband's story multiple times. This took up a lot of the carer's time and was reducing the time they had to care for her husband. Discussing this issue with the local leaders, they said that this situation was not uncommon.

Note: The names of people in our case studies in this report are not their real names.

Skills for Care, the strategic body for workforce development in adult social care in England, estimates that there are currently 90,000 job vacancies in adult social care at any one time. Domiciliary care agencies continue to report higher job vacancy rates than care homes. In 2016/17, the overall staff vacancy rate in adult social care was 6.6%, rising to 10.4% specifically for domiciliary care staff.[19]

We found that the challenges faced by domiciliary care are affecting people's ability to access care and support in their own homes – their independence is compromised and it puts pressures on other parts of the system. We also saw how pressures and challenges could damage continuity of care – we heard about one person who had been seen by 42 different care workers in one week.

Across the reviews, systems were investing in building housing that is specifically designed for older people to support them to live independently at home. Extra care housing allows older people to live independently while having access to care and support when they need it. We visited extra care housing schemes as part of our reviews and saw that they could provide people with good support in their homes including access to on-site general practice services. The people living there told us that they felt safe and supported, while being able to be part of a community.

Helping people to access the right support, at the right time, in the community

Navigating services and support

All the systems we reviewed had a range of services to promote the health and wellbeing of people and their carers in the community. Yet people were not always able to access the support they needed because they didn't know where to go.

People sometimes found accessing services complicated and confusing. Even professionals working in a system were not always knowledgeable about the services available in their area to make referrals to the right service, in a timely way.

People told us that having access to information about services helped them to maintain independence and control.

The challenge of navigating health and care services is well known. Many systems had

developed specific services to help people navigate the system called single points of access. These services provided one point of contact for people and professionals, from which they could be referred to the most appropriate team, based on the person's needs. We saw that these could be effective in providing timely access to services, including in a crisis.

Single point of access services varied in terms of who could use them – some could not be accessed by members of the public directly, and some could not be accessed by all health and care professionals. They also varied in the range of services that they could refer a person into – it was rare that these services could make a referral to the full range of health and social care support available in an area.

SINGLE POINT OF ACCESS

The Health and Social Care Connect (HSCC) service in East Sussex was an integrated contact centre providing a single point of access to services.

The HSCC could be accessed by health and social care professionals, who could then refer people to HSCC to access health, social care and community services. People who use services, families and carers could also contact the service directly for support.

HSCC staff were able to make immediate assessments and referrals, accessing a number of services directly, such as safeguarding, meals on wheels, life line (support technology), or a carers assessment arrangement.

The service could also refer people to teams within the system, such as occupational therapy clinics, rehabilitation services, frailty services and the crisis response team.

We know that some people do not necessarily see themselves as having a health need or a social care need. If systems can go further in removing the boundaries between services, by developing one point of entry that is based around the person rather than services, this can improve people's experiences and outcomes.

Alongside the development of single point of access services, the role of general practice in providing signposting and information is still critical. We saw systems successfully embedding signposting within practices. There was the introduction of specialist coordinator roles (sometimes called community connectors or care navigators) to help people access support and services in the community.

We found social prescribing initiatives in various stages of development. Social prescribing is a means of enabling GPs and other frontline healthcare professionals to refer people to services in their community instead of offering only medicalised solutions.[20]

People who use services have told us that by having health and social care professionals that have the time to talk and understand their needs and aspirations, they build confidence in managing their own health and wellbeing. Some systems were moving towards an assets based approach to supporting people. This approach encourages staff to have conversations about people's care and support needs that are led by their personal ambitions, and build on the personal and community resources available to them.

FEWER LONELY PEOPLE

In Cumbria they were trialling the use of health and wellbeing coaches (HAWC) to support anyone aged over 16 years to remain well at home by providing a point of contact and showing them where to find advice.

People could either refer themselves to a health and wellbeing coach or get referred by agencies across the system. Early data collected by the system about the outcomes for people who received a service from the HAWC service showed some early success. Prior to working with the HAWC service, 37% of people were identified as being very lonely. This had reduced to 16% following contact with an HAWC.

Also, the number of people needing to visit a GP or nurse had reduced. Much of the team's focus had been on people with mental health concerns and it was too early to validate the impact this service was having for older people.

Working together to meet people's needs

When care from different specialisms is co-ordinated in the community it supports people to stay well at home. In the systems we reviewed, we found many examples of effective multi-disciplinary working to identify people who are at risk of hospital admission, and wrap care and support around them to meet their needs. This included GPs, social workers, therapists, the VCSE sector and co-ordinator roles (described previously). Multi-disciplinary teams used risk stratification tools to identify people at the highest risk of attending hospital.

One example we saw in systems was a hospital-at-home services, sometimes referred to as virtual wards, that were aimed at people at high risk of admission and were having a positive impact on preventing people from relying on the hospital. Evidence shows that there is a potential reduction in elective hospital admissions and outpatient attendances in the six months after a virtual ward intervention is used.[21, 22]

THE VIRTUAL WARD

A virtual ward was being tested in a neighbourhood in central Sheffield, providing support to people in the area for 18 months.

The virtual ward comprises a multi-disciplinary team (MDT), bringing together staff from primary care, district nurses and the voluntary sector, including an advocacy service and Age UK. It aims to support people at home.

Through a weekly multi-disciplinary team meeting, staff from across organisations meet at the coordinating general practice and discuss the needs of people at highest risk of hospital admission, using a risk stratification tool. Everyone registered with the virtual ward is risk-rated, for possible hospital admission.

The MDT links with community support workers and voluntary sector workers, who have an in depth knowledge and understanding of people's needs, and through this can access information that would not usually be available to statutory services. The virtual ward has been successful in targeting the people most at risk of hospital admission and by providing wrap around support this may stop unnecessary hospital admissions.

CASE STUDY 4

A VIRTUAL WARD AND THE CORRECT DIAGNOSIS

Mr Peters is 81 years old and lives alone, and he has been diagnosed with chronic obstructive pulmonary disease (COPD). His other conditions included diabetes and arthritis, and he had previously suffered a stroke.

For two years Mr Peters struggled with respiratory problems and exacerbations of COPD. After a number of visits to hospital he had a series of follow up appointments which were either cancelled or could not happen because he had been readmitted to hospital.

He was regularly feeling breathless and started experiencing anxiety attacks. He lost his confidence and was calling the emergency services because the only place he felt safe was in a hospital. He attended hospital frequently and was regularly admitted.

Mr Peters had been prescribed multiple courses of antibiotics and steroids. They had little effect on his disease but added to his overall health risk, especially as he has diabetes and not very mobile.

Mr Peters was referred to a 'virtual ward' where his coordinator was able to quickly secure him an appointment at a community COPD clinic. It was identified that he did not have COPD after all. He was diagnosed with 'asthma with fixed airways obstruction' and he was then provided with the correct medication. He no longer needed to take steroids or antibiotics.

A year after his appointment at the COPD clinic, Mr Peters had not been back to hospital. His quality of life had improved and he was been able to go away on holiday, which he had not been able to do for a long time.

Note: The names of people in our case studies in this report are not their real names.

Across our reviews we heard lots of examples of people like Mr Peters, who were relying on hospital emergency departments at a time of crisis. Initiatives such as the virtual ward shows the impact that multi-disciplinary teams working in a community can have on enabling people to maintain their health and wellbeing in their own homes.

Support to people living in care homes

Between September 2016 and September 2017, there was approximately 380,000 attendances at A&E by older people living in care homes.[23] across England, and nearly 270,000 emergency admissions [to hospital]. Of the older people admitted to hospital from care homes during this period, 35% stayed in hospital longer than a week. Providing effective support to care homes can help to avoid unnecessary admissions to hospital – we have seen good examples of primary and community care support provided to care homes in some of the areas we have visited.

People working in care homes told us that it could be difficult to access their GPs and community health support, which meant that they were more likely to rely on emergency services.

Some care homes had commissioned their own support from GPs, such as weekly ward rounds, where GPs would visit residents. In some systems where there were well established relationships between GPs and care homes, care home staff could contact GPs for information and advice. These arrangements meant that care home staff had access to support so they would not need to rely on emergency services when they had concerns about their residents' health.

Some systems had plans to put these arrangements in place at scale, so that all care

homes have access to GPs, for example by having a linked GP to each home.

In addition to GPs, we saw a range of other community professionals such as community matrons, therapy staff, nurse prescribers, clinical pharmacists, intermediate care teams and care home support teams providing a comprehensive range of support in care homes (such as developing the skills and confidence of staff, conducting reviews and prescribing medication). Alongside this approach in some systems we found care homes and local GPs supported by community gerontologists who were proactively working to maintain people in the community and avoid admission to hospital.

Timely access to support in care homes is recognised as a national issue. Providing enhanced health in care homes (EHCH) is one of the high impact changes for managing transfers of care.[24] This sets out the importance of aligning community nurse teams, medicines optimisation and GP practices with care homes. It aims to reduce unnecessary hospital attendances, admissions and bed days, while ensuring the best continuity of care for people. While this was having a positive impact in some systems, the extent to which EHCH had been implemented varied across systems. At a system wide level, where enhanced support to care homes initiatives were in place, these were not always consistently available.

Equal access and choice

Variation in the access to and availability of services was a major finding in our reviews. We found people experiencing variation in availability of services and good and poor access to services. This was dependent on where people lived and could be the result of disjointed organisation, funding and delivery of health and care services.

Some people living in large rural systems did not have access to services, and had to travel long distances, with poor transport links. In urban systems we also saw that the availability of services could differ from one part of a city to another. Where you lived could determine the type of preventative support you received, such extended access to GPs or enhanced GP support to care homes.

> "Where I live, the colour of your bin can tell you which services you'll be able to access! Having a blue bin is bad news!"
>
> **Comment to CQC in a focus group**

Personal budgets and direct payments are a mechanism to allow people to have choice and control over the support and services they receive. We found that in systems where there was good access and support to manage direct payments, this allowed people to take control of their care. We found examples of people using personal budgets and direct payments for dementia day services and other community-based support.

Nationally, personal budgets and direct payments for social care and health are not widely accessed. In 2016/17, only 17.6% of older people accessing long-term social care support across England were receiving direct payments, while just 9,127 adults received a personal health budget (an amount of money to support a person's health and wellbeing needs) in 2017/18 (of which 4,784 received direct payments).[25]

There is huge variation in uptake of direct payments and personal health budgets across the country. This variation was apparent in the systems we visited. In several systems, as many as one in four older people received direct payments for social care. In others it was as few as one in 20.

Conclusion: Access to preventative support in the community

Even when the capacity of general practice, community health care and social care support available to people at home is challenged, we have seen how systems are ensuring that people still receive the right care, in the right place at the right time. By working together, services can identify those people most at risk and provide the support they need. We have seen the impact that a strong multi-disciplinary approach, good use of community assets, and community

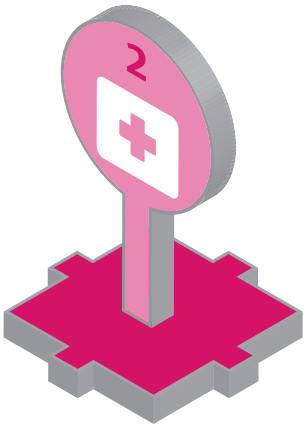
support to people living in care homes have on people's health and wellbeing. These approaches also reduce pressures on hospitals.

Across the review programme systems have shown an understanding of the importance of keeping people well at home – there has been a collective aspiration to provide services that enable people to access the care and support they need, when they need it, in the communities they live in.

However, while good initiatives are in place, there is still significant inequality in access to preventative services. People are not receiving consistent support to keep them well at home and often people do not know where else to turn but to their local A&E department at a time of crisis.

2.2 Care and support in a crisis

Sometimes people experience a health crisis and might need urgent support from a variety of services – this might be a physical or mental health problem or a social crisis, but it is something that profoundly affects a person's ability to function or to remain independent.



Many social crises manifest as health crises and many mental health crises manifest as physical or social crises. In 2018, we are still finding the term 'social admission' in notes in acute hospital trusts- this means a person was admitted to hospital for a social rather than an acute medical need.

Hospital treatment may be necessary for a range of problems, planned or urgent, to address a medical need, but it is often in people's best interests to try to get well outside hospital if possible. However, services and support in the community to address a social or mental health crisis can be limited.

NHS hospitals are under continued strain. The percentage of beds occupied in acute hospitals is higher than it has ever been. Our analysis estimates that in April 2018 only 16 of the 152 local systems in England had bed occupancy rates below the optimal 85% level. This strain is felt further during surges in demand, such as the winter months.

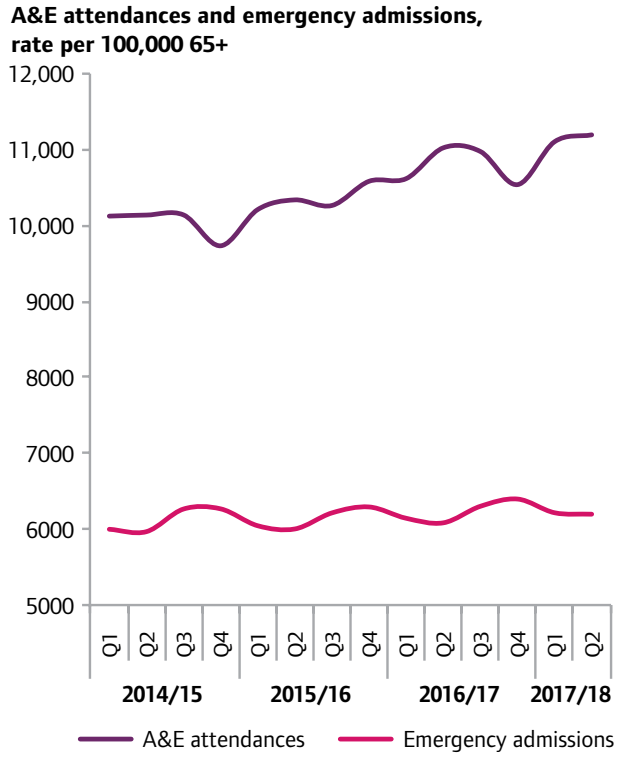
Leaders in some systems told us that planning for surges in demand is now needed all year round, not just for winter. Regardless of the time in which a system comes under pressure, a system's resilience is dependent on the organisations within it, working together to plan and deliver effectively, as a system. In May 2018 we published, *Under pressure: safely managing increased demand in emergency departments,*[26] a report providing practical solutions from staff working in emergency departments.

Preventing unnecessary admissions

In response to pressures in hospitals, the systems we visited have implemented various approaches to reducing avoidable admissions. These varied from introducing community based rapid responses services (e.g. hospital-at-home services) to streaming services in the emergency department, set up to point people to the right support when they do not require emergency admission.

Our analysis shows that nationally, the rate of emergency admissions for older people has not increased as much as the rate of A&E attendances over the same period. It suggests that initiatives based at the hospital front door to prevent admissions may be having some effect, although there may be other factors which contribute to this, such as difficulties accessing services in the community.

FIGURE 6: A&E ATTENDANCE AND EMERGENCY ADMISSION RATES FOR OLDER PEOPLE



Source: Hospital Episode Statistics April 2014 – September 2017, ONS mid-year population estimates 2014, 2015 and 2016

To stream people attending A&E into the most appropriate care and avoid unnecessary admissions, we found that having the right staff in place to assess and coordinate care was key. We saw examples of staff taking a risk-avoidance approach to hospital admission in some emergency departments (this sometimes resulted in people being admitted as a precaution).

Our preliminary analysis of ambulance turnaround times at hospitals (as a proxy for pressures in emergency departments) suggests that these times are longer when there are fewer senior staff to supervise and support junior staff.[27] Ensuring sufficient support for junior staff in emergency departments can enable decisions to be made decisively and efficiently. In some hospitals, we saw GPs in emergency departments and A&E consultants stationed on reception to ensure people were seen in a timely way by staff with appropriate skills – this helps prevent unnecessary admissions.

We found that having a multi-disciplinary approach established in emergency departments can help. Many systems had multidisciplinary staff such as social workers and therapists based in emergency departments to support assessment and decision-making.

Some systems had established links between hospital front door staff and VCSE services, helping people to quickly access social support. We also saw 'care navigators' in emergency departments, and community matron in-reach services that could point people to appropriate community care. Links between emergency departments and community based services are important – we saw people being admitted to hospital with social needs, such as a breakdown in support at home, rather than medical reasons because support was not available in the community.

As well as ensuring people are not admitted to hospital unnecessarily, improved decision-making in emergency departments can reduce pressures on hospitals.

Ambulance interface

Ambulance services are often the first point of contact when someone is in crisis and we saw the positive impact that they had in preventing inappropriate admission to hospitals in some systems.

Ambulance staff can treat people at home (sometimes referred to as 'see and treat'). Capacity issues in the workforce sometimes prevented this from happening. In one system there was a two-year waiting list for training for an enhanced care paramedic role that aimed to contribute to preventing avoidable admissions.

Ambulances can also play an important role in reducing avoidable admissions through referring people to services in the community as an alternative to hospital. There were well established processes in some systems to allow ambulance staff to refer people directly into community services.

The extent to which this was happening in all systems we reviewed was limited. In one system, the ambulance service felt that capacity issues in community-based services were affecting their ability to prevent hospital attendance. In another, advice and support for ambulance staff and direct access to a falls team had been withdrawn.

Pressures experienced by emergency departments affect ambulances' ability to get to people in time. The NAO reported that in 2015/16 58% of ambulance transfers to A&E met the 15-minute handover expectation and 65% of ambulance crews were ready to respond to another call within the next 15 minutes. This resulted in approximately 500,000 ambulance hours being lost due to turnaround times exceeding 30 minutes.[28]

Delays in handovers were being experienced in the systems we visited. We saw systems making efforts to reduce delays through improved coordination, including the introduction of dedicated hospital ambulance liaison officer roles.

Flow through the hospital

Congested hospitals struggle to deliver their best care. Our analysis shows that the average overnight bed occupancy trend at NHS trusts is increasing, with quarterly figures consistently above the optimal level of 85% in recent years. National Institute for Health and Care Excellence (NICE) recommends that healthcare providers should monitor total acute bed occupancy and plan capacity to minimise the risks associated with occupancy rates exceeding 90%.[29]

Bed occupancy figures change throughout each day and vary between different wards and units however quarterly averages show the England average has peaked during January to March in each year since 2014/15, reflecting winter pressures.

CASE STUDY 5
RESOLVED IN THE COMMUNITY

Mr Robinson has Parkinson's disease and he lives at home.

On one occasion, his mobility deteriorated and he had a fall at home that badly bruised his hip and shoulder. He called an ambulance and following a see-and-treat, the ambulance team referred him to the community rehabilitation on-call team, instead of taking him to hospital.

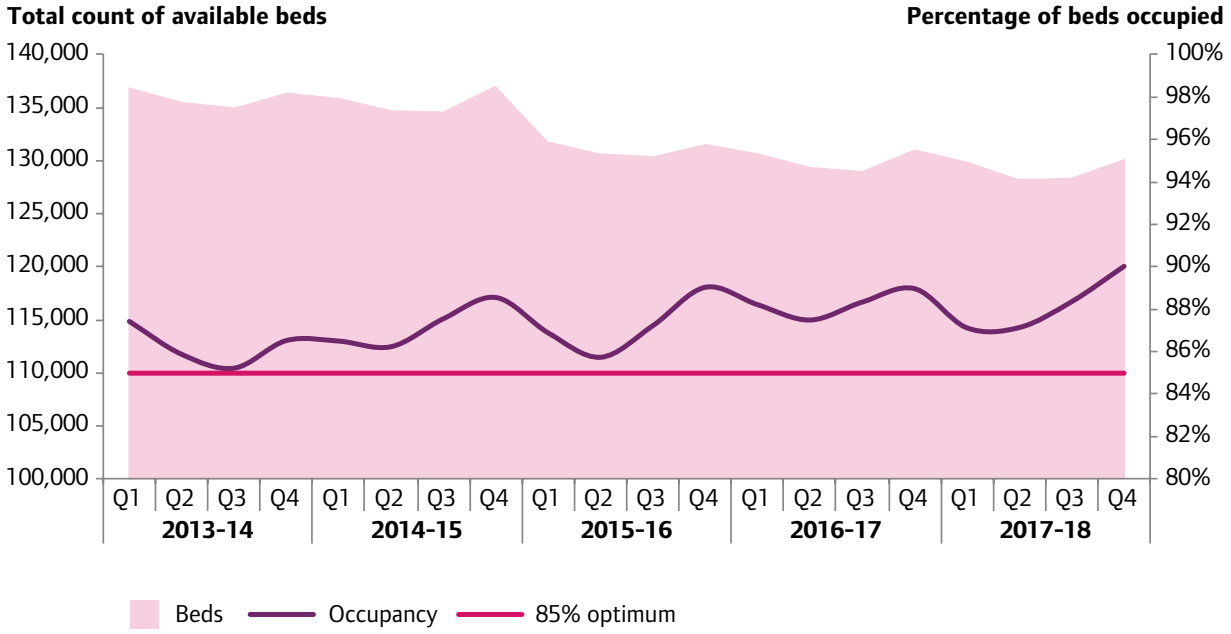
The team visited Mr Robinson within two hours and did an assessment of his needs. He was referred to a reablement team and a package of care began immediately. This team worked with Mr Robinson for two weeks, including an assessment for assistive technology and an occupational therapy home assessment.

Mr Robinson received weekly visits from the community Parkinson's nurse and his mobility improved. As someone paying for his own social care, he was offered a flexi-care package to support him.

Mr Robinson's needs were resolved in the community. If the community services had not been available, then he might have been taken to hospital in these circumstances, which would not have been the best care for his needs.

Note: The names of people in our case studies in this report are not their real names.

FIGURE 7: ACUTE TRUST BED AVAILABILITY AND OCCUPANCY



Source: NHS England, quarterly KH03 overnight beds

In our reviews, we found that people mostly experience good quality care when in a hospital and people were usually treated with compassion, dignity and respect. However not all older people were moving through the hospital at the right times. This meant that they could spend time in beds when they didn't need to be there, or could be moved multiple times to create space on wards.

Frailty units

We saw services that were designed to ensure that when frail older people attend hospital, they are treated in the place that is most suitable to their needs – not in hospital unless necessary. In some systems we saw proactive work to identify frailty, and the use of dedicated assessment and short-stay units that meant that older people were treated in an appropriate environment.

We also found some people staying in frailty units for too long, when it would be better for them to be moved to a hospital ward or the community (usually due to a lack of capacity in the main hospital or in community provision).

CASE STUDY 6

HE EVENTUALLY WENT HOME ONE MONTH LATER

Mr James, 72, was admitted to a frailty unit after he fell while getting out of a taxi.

He had a mental capacity assessment after two days in the frailty unit. And although Mr James was medically fit for discharge, a Deprivation of Liberty Safeguards application was made.

A decision was not received until four days later. During this time, Mr James was also assessed by an occupational therapist, who concluded that he needed a walking frame to be able to move around at home.

Mr James also required a home visit from the occupational therapist (OT) in the community team to make sure he was coping. But there were no OTs available to conduct an assessment at his home in the following days.

Due to these delays, Mr James ended up staying on the frailty unit for 15 days. The average length of stay was 72 hours.

On day 15, when Mr James was finally ready and able to go home, he fell again and fractured his hip. Mr James was then admitted onto a ward and eventually went home one month later.

Note: The names of people in our case studies in this report are not their real names.

Conclusion: Joined up care and support from the point of admission

When a crisis occurs and a person is admitted to hospital, a joined-up approach is required to coordinate their care and support so that they can return home as quickly as possible, and when it is clinically safe to do so. This is best for their recovery.

People should be discharged from hospitals as soon as they are ready in order that they do not experience a delay. It is important to achieve the correct balance between minimising delays and not discharging a person from hospital before they are ready or before the required ongoing care and support in the community has been arranged. Otherwise a readmission to hospital is likely.

The analysis and evidence we have gathered as part of this review suggests that emphasis on shortening lengths of stay in hospital may be resulting in increased emergency readmissions.

Problems can occur if services and support are not integrated, resulting in delayed transfers of care, readmissions and poor care. Examples of poor transitions include discharge problems (such as when people are kept waiting for further non-acute NHS care or for their home care package to be finalised), uncoordinated hospital admissions and avoidable admissions to residential or nursing care from hospital.

NICE Quality Standard 136[30]

Our analysis of national data showed that reductions in the percentage of older people staying in hospital longer than a week between 2014/15 and 2016/17 are correlated with increased emergency readmissions for older people over the same period.[31] For example, this could be as a result of poor discharge planning or people being discharged before they are medically ready. It is important to note that this analysis does not control for other variables that could influence this association and there are likely to be other issues influencing increased emergency readmissions (such as an increasingly ageing population living with multiple co-morbidities). This finding is corroborated by feedback we collected from our discharge information flow tool, as well as what we were told on the reviews, regarding unsafe discharges that led to readmissions..

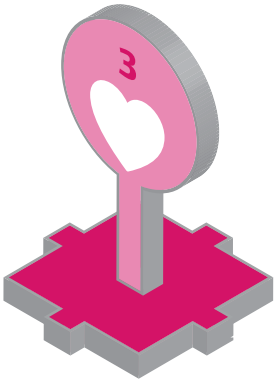
Across England, around 434,000 people aged 65 and over were readmitted to hospital within 30 days of discharge between September 2016 and September 2017 – almost one in five (18.8%) people being readmitted to hospital. Recent analysis from QualityWatch[32] shows that both the number and rate of emergency readmissions within 30 days increased between 2010/11 and 2016/17, including potentially preventable readmissions which have increased at a faster rate than readmissions for other conditions.

In particular, the QualityWatch analysis identified that readmission rates for pneumonia, pressure sores and venous thromboembolism increased more compared to other conditions. The NAO estimated that emergency readmissions (all ages) cost the economy more than £2.4 billion in 2012/13.[33]

Reducing the incidence of readmission not only avoids poor outcomes and experiences for people, but also represents considerable saving opportunities for the health and social care system.

2.3 Step down

When an older person is cared for in hospital, for their wellbeing and the best opportunity for recovery, services must be joined-up in the way they support them to return home. There are challenges to getting this right, but care providers can begin by ensuring the person is at the centre of their care.



Delayed transfers of care

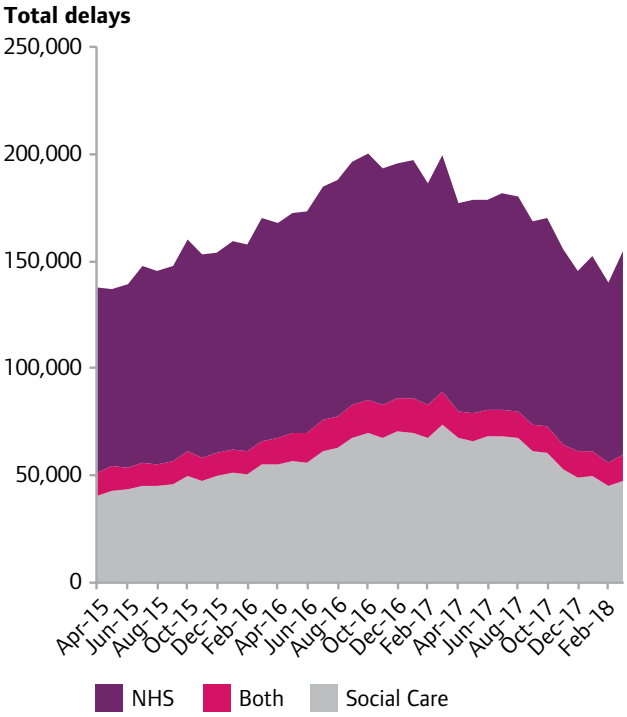
The impact of delayed transfers of care has been well documented and nationally there has been a drive to reduce delays. The DHSC required the reduction of DTOC to 3.5% of occupied hospital beds by September 2017.[34] Guidance has been issued around how to support the reduction of delayed transfers of care through the *High impact changes for managing transfers of care*[35] model.

Data shows that nationally, delayed transfers of care fell throughout much of 2017 (following the 3.5% target). At the close of 2017/18, 18 of the 20 systems we reviewed had managed to reduce their rate of delayed transfers from the level they were at when they were selected, and two had fallen below the national average. There is still wide variation across England in the rate of delayed transfers.[36]

While both social care and the NHS managed to reduce the rate of delayed transfers attributed to them over the course of 2017, social care delays reduced faster than NHS delays during this period.

Throughout the reviews, we were told that the pressure on local systems to reduce delays in hospital discharge has almost overwhelmed other health and social care priorities. We saw that system leaders had implemented various measures to achieve this, and front line staff were working hard to reduce delays.

FIGURE 8: TOTAL DELAYED TRANSFERS OF CARE ACROSS ENGLAND, BY RESPONSIBLE ORGANISATION



Source: NHS England, delayed transfers of care: April 2015 to March 2018

While this reduction in delayed transfers of care is positive, we found examples where the focus on DTOC had compromised the safety of people moving through services. This included people being moved out of care settings before arrangements such as equipment, medication or transport were in place for the person to return to their home.

There are many different reasons why people experience delays to the discharge process. For example:

- availability of staff;
- availability and coordination of medication;
- availability of care provision (including care at home as well as in care homes);
- coordination of assessments;
- availability of transport; and
- access to equipment and adaptations.

Much of the health and care system delivery is already in operation 24 hours a day and seven days a week. But this is not uniformly implemented or coordinated. A lack of seven-day services creates delays. For example:

- social care providers are less likely to accept discharges at weekends;
- there could be a lack of seven-day access to equipment and medication; and
- community health services may not be available to support people in their own homes.

Throughout a person's journey between health and care services, everyone involved in their care has a part to play in helping them to move to the most appropriate place for them – as soon as they are ready.

It is important that discharges are timely, safe and tailored to people's needs. This includes ensuring joined-up planning and sharing of information with services in the community to ensure the right ongoing care is available and in place for the individual.

Planning for transfers of care

Where we found effective planning for transfers of care there was a strong multi-disciplinary approach, effective monitoring/oversight of people moving through the hospital, and early involvement from a range of different professionals and people who use services, their families and carers. Having ward-based social workers, dedicated integrated discharge teams and strong coordination with community and primary care teams enables early and effective planning for discharge.

The high impact change model for managing transfers of care recommends that planning for discharge takes place at the earliest point possible. This means prior to admission for elective care and as soon as possible for emergency admissions, to enable an expected discharge date to be set within 48 hours of admission.

However, we found that people did not always experience a consistent approach in planning for their discharge. Our review of case records and discussions with people and staff indicated that the point at which discharge planning began was varied across areas and did not always involve the relevant people and professionals early enough in the process. While there was evidence in places of discharge planning at the point of admission, more often we found that discharge dates were not being discussed early enough.

Social care professionals frequently voiced concern about not being involved early enough, if at all, in discharge planning. GPs frequently reported that communication about discharge was poor. This is important because social care providers and GPs may have a better understanding of a person's needs and can play a key role in informing a person-centred approach to care planning, enabling a person to be discharged as soon as possible.

It was clear on our reviews that to prevent delayed transfers of care, a focus on discharge was needed not only to be established early in the process, but maintained throughout the person's time in hospital. This involves all professionals working towards a culture that focuses on getting the person home as soon as they are ready and where it is unacceptable for people to be in beds longer than they need to be.

CASE STUDY 7

MR BHARAT'S END OF LIFE CARE

During one review we were told about a distressing story where a person was not always treated with dignity and respect at the end of their life.

Mr Bharat had dementia and a brain injury and he was living in a care home.

His daughter had power of attorney for his health and welfare. However when Mr Bharat was admitted, she did not receive any contact from the hospital. Mr Bharat's hospital stay was a poor experience for him and his daughter – there were multiple ward moves and there was poor communication about what was happening to him.

Staff were not sensitive to Mr Bharat's needs – they had not recognised his dementia – and did not recognise the importance of his daughter being with him and advocating for him when decisions about his care needed to be made.

Doctors at hospital told Mr Bharat's daughter that her father was at the end of his life. The decision was made he should be discharged back to the care home, which was his preferred place to die. However, hospital ward staff were unaware of this and failed to make the necessary arrangements to ensure Mr Bharat was placed on the palliative, end-of-life care pathway.

Despite requests for a conversation about Mr Bharat's end-of-life care plan, no one had a discussion with his daughter. On the day he was due to be discharged (10 days after his hospital admission) staff told Mr Bharat's daughter that discharge was going to be delayed because they were waiting for medicines and for a funding decision to be made regarding his care.

Administrative processes delayed Mr Bharat's discharge by a further day. He passed away in the care home, six days after his discharge. Care home staff treated Mr Bharat with dignity and his family with compassion. There was a clear advance plan in place for Mr Bharat, but the out-of-hours GP who came to certify his death notified his daughter that because he had not seen his own doctor, there would be an inquest and he would be removed to a public mortuary.

This was highly distressing for Mr Bharat's daughter, who had discussed her father's wishes with him. The GP ignored information about the end-of-life care pathway and the hospital admission and referred the matter to the police. The police subsequently confirmed that they should not have been contacted.

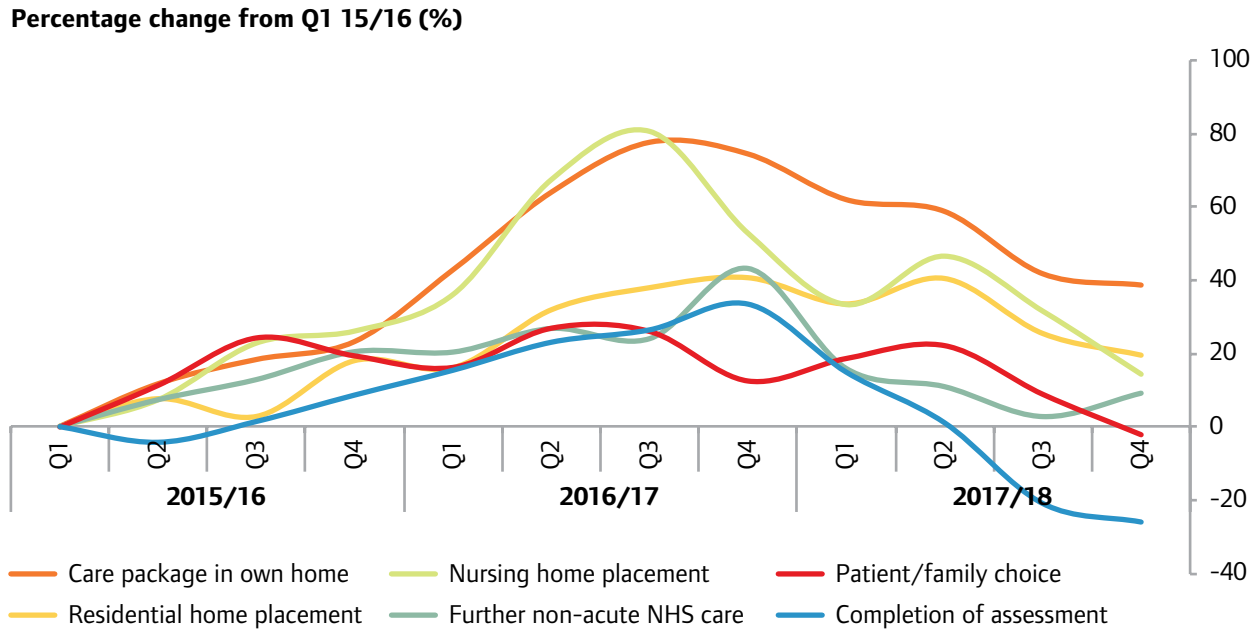
Note: The names of people in our case studies in this report are not their real names.

Co-ordinating assessments of need at discharge

Co-ordinating assessments to enable a person to be discharged as soon as they are ready can be complex. One person may require assessments from occupational therapists, social workers, financial eligibility assessments, social care providers and clinical staff. We saw good co-ordination of assessments through the use of integrated discharge teams which included multi-disciplinary professionals who were able to conduct assessments at the same time.

Nationally there are signs of improved co-ordination of assessments. Of the reported reasons for delayed transfers of care, 'awaiting completion of assessment' reduced the most throughout 2017 and by the end of 2017/18 had decreased by 26% compared to the first quarter of 2015/16.

FIGURE 9: PERCENTAGE CHANGE IN MOST COMMON REASONS FOR DELAYED TRANSFERS OF CARE ACROSS ENGLAND SINCE APRIL 2015



Source: NHS England, delayed transfers of care: April 2015 to March 2018

However, in the systems we visited, we saw that people's discharges were being delayed due to a lack of co-ordination in conducting assessments. In one system there were over 200 people waiting in hospitals for an initial assessment for continuing healthcare at the time of our review.

To reduce delays and duplications of assessments, implementing a trusted assessment scheme is recommended as a key element of best practice in the high impact change model for managing transfers of care.

Trusted assessment

There are several models of trusted assessment, but at its core is the principle that a, "trusted assessment is carried out by a trusted assessor, who is authorised by the parties involved to carry out an assessment on behalf of others".[37]

We saw different interpretations of the trusted assessor model in different systems. Some systems had dedicated trusted assessor roles, whereas in other systems there were agreements between services to share assessments.

Fundamental to the success of the model is confidence in the assessment. The person carrying out the assessment must have knowledge and understanding of the service about which they are conducting an assessment, and the risks associated with transferring into their care. In the systems we reviewed, the model was in early stages of development and there was not the level of understanding between services to implement this model quickly and at scale.

From feedback we received from social care providers in our discharge information flow tool[38] and in our reviews, it was clear that some providers lacked confidence in the assessments undertaken in hospitals.

"We would never accept anyone on a summary from a third party as we have had too many occasions when information is incorrect."

Registered manager, nursing home

"We do not use the hospital's trusted assessors as they don't know our home, current dependencies and how we work, so they are in no place to make that decision for us."

Registered manager, nursing home

From our reviews we have seen the trusted assessor model has the potential to reduce delays for people. For the potential for the trusted assessor model to be realised, trust and understanding between health and social care providers must be established.

Information sharing and communication on discharge

Good communication and information sharing underpins safe and effective transfers of care. The timeliness and accuracy of the information provided is important for ensuring that the person being discharged understands what will happen next – and also for anyone providing ongoing care to know how to support them.

When someone is discharged from hospital, it is the responsibility of clinical staff to provide a discharge summary to ensure safe transfer of care from a hospital to those providing ongoing care in the community.

> The discharge summary is one of the most critical documents in medical settings, but often [it is] the least experienced, most junior clinicians [who] are entirely responsible for its completion with little or no training and supervision.
>
> **NHS England (2016)**[39]

We heard that people are frequently discharged from hospital to their home without accurate or sufficient information about their stay in hospital or their care needs. We heard about people returning home or being moved to a new home only to get unsafe care and/or get readmitted to hospital because of a lack of information.

As part of each review, we distributed an information flow tool questionnaire to all registered providers of social care for older people, to get an understanding of the timeliness and level of detail of information they receive when a person is discharged from hospital. Across the 20 systems, we received 449 responses from registered managers of social care providers.

Some 29% of registered managers said they receive discharge summaries less than a quarter of the time when a person is discharged into their care. Registered managers from domiciliary care services were more likely to not receive a discharge summary than to receive one. Sixty percent of registered managers from domiciliary care services told us that they receive discharge summaries less than a quarter of the time.

> "Unless we specifically chase for information we are very rarely provided with completed discharge paperwork. It seems that freeing up a bed space is often valued more than a safe discharge."
>
> **Registered manager, domiciliary care provider**

Nearly a quarter (23%) of care providers told us that the quality of discharge information was 'rarely' or 'never' sufficient to make decisions about whether or not they can provide care to a person being discharged to them. Domiciliary care providers were less likely to receive sufficient discharge information than other service types, affecting their ability to do assessments to support timely transfers of care.

Social care providers told us that sometimes people were discharged home from hospital without sufficient information about their medication. Discharge documentation did not always highlight changes to medications or detail when the person had last taken their medication. This meant that social care staff did not know how to administer the person's medication safely. We saw that there was potential in new technologies to support the transfer of medicines information across organisations – one system was piloting electronic sharing of discharge information directly from the hospital to the community pharmacy.

We also heard of people being discharged without their medication which was a risk to their safety.

CASE STUDY 8

DISJOINTED CARE

In one system we were told about a person who died shortly after returning to a care home after a visit to hospital.

This person was taken to A&E with a life threatening condition. After discussion with close family, the decision was made not to operate and the person returned to the care home in the early hours of the morning, at the family's request.

The resident arrived back at the home with no paperwork or 'end of life' medicines. The home called the out-of-hours provider, but it took around four hours for morphine and other necessary medicines to be prescribed, delivered to the home and then administered by the community nurse.

This person died shortly afterwards.

"Often medication doesn't come with the person.. Recently a person arrived without medication and was [at the] end of [their] life.. Due to these concerns we do not accept residents Friday to Sunday."

Registered manager, nursing home

We found that social care providers felt that hospital staff did not always demonstrate an understanding about social care services, and the needs of social care providers to ensure appropriate admissions.

Things work well for people who need care when health and social care professionals understand each other's roles, and they are aware of the pressures and challenges in each other's role and services, as well as how the actions of one impacts on the other. This helps effective joint working for smooth and successful transfers of care.

"The discharge team are keen for us to place individuals appropriately, and subsequently we want to help ease the demands on the hospital and are keen to free up beds on the wards. In recent months [the] information we have been given is accurate and honest. This builds for better relationships between the hospital and care home."

Registered manager, nursing home

Supporting choice in ongoing care

A lack of capacity in the adult social care market is another barrier to people moving smoothly between health and social care.

Since March 2016, the most common reason reported for a DTOC (nationally) has been, 'Awaiting care package in own home'. We saw that people were staying in hospital longer than they needed because there were not the appropriate services in place to care for them in the community.

In a focus group, a relative told us that her mother had been kept in what she described as a "holding pen" in hospital with around 40 people with similar needs. There was nowhere for her to be discharged to. She later died in hospital while waiting to be discharged.

The Care Act (2014) sets out that "the core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life". Local authorities must actively promote people's wellbeing. A key part of this is enabling "control by the individual over day-to-day life, including over care and support and the way it is provided"[39].

TABLE 1: MOST COMMONLY REPORTED REASON FOR DELAYED TRANSFER OF CARE 2017/18

Reason for delay	Number of areas where this is the most common reason	Number of CQC review areas where this is the most common reason
Care package in own home	45	10
Further non-acute NHS care	38	3
Completion of assessment	23	2
Nursing home	20	3
Patient or family choice	16	2
Residential home	9	0
Total	**151**	**20**

Source: NHS England, delayed transfers of care: April 2017 to March 2018

Choice and control is particularly important when people are moving between health and social care services. An older person's discharge from hospital can be a time of life-changing decisions.

The ability for people to choose what care they want to receive and where they want to receive it can be limited by availability: in some systems there are not enough places and what is available does not always provide care of the right quality. People are therefore not provided with a genuine choice, especially in terms of high-quality care.

People could be offered poor quality services, or placements that were far away from their families. Ideally, people should not be making decisions about their long-term care while in hospital. We saw this occurring often, and this can lead to delays while people and their families make decisions about future care.

Policies and practices should ensure that choice is managed sensitively and consistently, and people are provided with information and support to make decisions about their care.[40] This does not always happen.

In Liverpool, a hospital produced a magazine with comprehensive information on what would happen next after discharge, providing easy to understand information on the range of options available once someone returns home. This included information on how to access personal budgets, continuing healthcare assessments, signposting to other services in the community and other benefits such as carer's assessments.

Out-of-hospital assessments

Traditionally, people have been assessed for their ongoing care needs while in hospital. However, it is now recognised that a person should not stay in hospital for longer than they are receiving acute medical care just to wait for an assessment.

In line with the requirements of the high impact change model for managing transfers of care, systems are implementing a 'home first' or 'discharge to assess' model to facilitate a person moving out of hospital as soon as they no longer need acute care. We saw different types of this model in operation during our reviews. For example, people could be discharged into an intermediate care facility where they are assessed for the short or long-term support they need to stay living independently. People could also be discharged directly back to their own home, where they are met by a team of specialists to assess their needs and coordinate their ongoing support.

We saw that where 'discharge to assess' pathways were well established and understood by staff across health and social care, this enabled people to be discharged in a more timely way. However we also saw that capacity and co-ordination issues could mean that people who were discharged home did not receive an assessment quickly enough, which caused distress and risk of harm.

Access to intermediate care and reablement

Intermediate care and reablement services play a key role in preventing people from going into

hospital or staying in hospital too long. They provide people with care and support that focuses on helping them to be as independent as possible.

Intermediate care

We saw that people could spend a long time in interim beds that were only intended for short-term use. While people had been moved out of hospital, this was only to be transferred to a different form of bed-based care.

The National Audit of Intermediate Care 2015[41] found that, when accessed and used appropriately, 70% of people who received intermediate care after a hospital stay would then return to their own home; 92% maintained or improved their dependency score; and 72% did not move to a more dependent care setting.

Reablement

Our analysis shows that 82.5% of older people who received reablement following discharge from hospital in 2016/17 were reported as still being at home 91 days later. Nationally, only 2.7% of older people discharged from hospital received these services in the first place.[42] Reablement services are effective in providing the right support to people, but these services are not widely accessed.

There is wide variation and access to reablement and rehabilitation services.[43] Our analysis showed that in the local authority area with the highest level of provision of reablement/rehabilitation in 2016/17, nearly one in 10 older people discharged from hospital received reablement or rehabilitation. In the area with the lowest level of provision, just one in every 160 older people discharged from hospital accessed these services.

The role of carers across the health and care journey

The contribution of unpaid carers to supporting older people is significant. We spoke to unpaid carers in each of the 20 systems. They were taking pivotal roles in supporting their families and loved ones to remain independent and well.

Aside from providing care, unpaid carers are navigating systems and coordinating care and support around the person they care for.

Many unpaid carers are not identified or receiving support, representing a growing invisible and unaccounted for group of people that is vital in supporting the health and social care system. In 2015, Carer's UK estimated that the value of care provided by unpaid carers was £132 billion per year, far exceeding expenditure on formal social care and nearly equalling spend on healthcare.[44] The Office for National Statistics estimated that the cost of replacing unpaid carers with paid carers would be £56.9 billion per year.[45]

Carers told us about the challenges of their caring role. It could be difficult to know where to go for information. They could feel unsupported and that they had to fight to access services. They told us they worried about what would happen if there was a crisis.

> "I am concerned about what would happen to my wife who has Alzheimer's if I had a stroke – there is no clear care planning."
>
> **Told to us at a carers focus group**

We saw systems taking proactive steps to identify and support carers. We heard about GP practices that gave carers priority access to appointments and that flu vaccinations were offered at carers groups. In one system, GPs and practice nurses could 'prescribe' carers a social, leisure or health break.

When speaking to carers we were told that VCSE sector organisations and carers centres provided what was described as 'invaluable guidance and support'. Working as the key point of contact for carers, they helped people to navigate the system to access carers assessments, services, practical and financial support. These services also provide places for unpaid carers to meet people with similar experiences. Where VCSE support specifically targeted for carers of people with dementia, it was highly valued.

3. Incentivising system working

Strong, collective leadership is the single most important enabler for success in providing high-quality health and social care for people. In our programme of reviews, we saw the impact this has on providing joined-up care for people.

We met leaders at all levels who are rising to the challenge of meeting the needs of the people in their communities, at a time when there are significant constraints on resource.

It is widely recognised[46] that people working in health and social care should work in a more joined-up way. Yet people who use services, their families and carers tell us that from their experiences this is not always the case. As a consequence, their needs are not always met and their health and wellbeing can be badly affected.

We have met people at all levels working in health and social care who have successfully developed strong relationships, driven by a shared strategic vision for doing what is best for the people in their communities. Sometimes we have seen good relationships and yet individual organisational drivers can act as a barrier to joined-up working.

Important factors to enable system-working are:

- Establishing a shared and agreed vision that is signed up to by all system partners;
- collaborative leadership and a shared endeavour across a system;
- relationships built on trust;
- agreed system performance measures;
- accountability for system performance;
- joint funding and commissioning; and
- effective and joined-up regulation.

Across our reviews we saw where these factors have enabled and driven collaborative working for the benefit of people who use services, their families and carers. We did not find all of these factors embedded in any of the systems we reviewed. Nationally and locally, the right conditions have not yet been created to allow joined-up systems to flourish for the benefit of people who use services, their families and carers.

3.1 System level vision

All the systems we visited had a strategic ambition to move towards more integrated, joined-up health and care for the people they served. Local systems aspired to support older people to stay well in their communities, with access to high-quality, person-centred services, when they need them.

Alongside our programme, the national drive for more joined up health and care services has progressed. Transformation is taking place at different levels, including Sustainability and Transformation Partnerships (STPs), local authority areas and neighbourhoods.

More recently, some of the reviews took place in an integrated care system (ICS), where additional flexibilities in managing the operational and financial performance of services in the area will help drive integration. Some of the systems we reviewed also had a legacy of vanguard

involvement and three were in a devolution area and governed by a local mayor.

We looked at the vision articulated by the local systems (CCGs/local authorities), Health and Wellbeing Boards (HWBs) and STPs. We looked at the extent to which these strategic visions were aligned, and the extent to which the vision was translated into delivery plans in provider organisations, people's experiences, and the buy-in of staff. We also looked at whether the system vision was responsive to and matched the needs assessments for that population.

We found that the clarity of the local vision for health and care, and the extent to which this was jointly articulated across the health and care agencies in a system was variable. Some STPs were driving the vision for the local system. In other systems we saw tension where a well embedded local strategy had been held up or overridden by the emergent STP. But we have also seen systems with a clear vision that spans the level of STP/ICS/and local commissioning and delivery footprints. Three reviews were undertaken in Greater Manchester Devolution Area, there was a clear line of sight on the vision at STP/ICS level through to the local levels.

Across the programme we have found that where there is one strategic vision which is signed up to and agreed at all levels, this provides clarity and a common purpose, setting the foundations for system working.

3.2 System leadership

In all systems we talked with leaders across commissioning and provider organisations, local political leaders, and leaders with cross sector responsibilities, all working towards a common purpose to providing high-quality care to the people they serve.

There are some cross-organisational leadership roles, such as joint appointments and roles where accountability sits across health and social care organisations (such as directors of integrated commissioning). Most senior leadership, however, still sits within individual organisations, requiring high levels of relational working and collaboration to deliver joined up services for people. Leaders are judged on their success by individual organisational measures, rather than by system success. Leaders in cross-system roles have a challenging job, often without mandate and ownership of resources for the task.

System leadership happens at all levels. We found many instances where local practitioners and managers were leading change at an operational level, through high levels of relational working, rather than formal structures. Staff could feel frustrated by the rigidity of the system, which affected their ability to meet the needs of the people they cared for.

Systems leadership has been described as "a necessary response to volatility, uncertainty, complexity and ambiguity, and to resource pressures".[47] The challenge to achieving success in systems leadership practice is significant; most senior leaders in health and care organisations progressed in a system that was based on competition rather than collaboration.

A new type of leadership approach is required, where leaders are supported and encouraged to drive system priorities collectively. It will require a shift in mind-set, skills and practice. To incentivise this, the way in which leaders' success is judged should be different – through system-based shared and understood performance measures and accountabilities.

Effective system working relies on relationships. In the systems we reviewed, leaders that invested in building relationships and forming a consensus through a shared vision were able to address difficult issues through collaborative problem solving with openness and honesty.

3.3 Building relationships

Good relationships are the heart of good local systems – we know this from our reviews of local systems for this report and from our wider inspection work and analysis. In our annual *State of Care*[48] report to Parliament in October 2017, we pointed to some great achievements in exceptionally challenging circumstances. We also made clear that for consistently good quality care, where the person is at the centre of their

care, everybody's focus must now be on working more collaboratively.

We saw that the quality of relationships, within and across organisational boundaries, at all levels, has a significant impact on effective system-working and the quality of care people received. Collective goals, collaborative decision-making, and sharing of risk were markers of mature relationships and underpinned multi-disciplinary and multi-agency working on the ground.

Feedback from our relational audit highlighted that across the systems, people felt most positively about treating each other fairly, and in being open and honest in their dealings with one another. People told us that trust and openness facilitated joint-working, and we saw in our reviews how trust between partners enabled practical solutions to be developed to resolve system problems.

In senior leaders, collaboration was evident where partners demonstrated a shared understanding of system challenges and a shared responsibility for system performance. For example, leaders in one system had a shared view of the reasons for rising A&E attendances, agreeing 'one version of the truth' from which they could collectively act. In another system, partners jointly commissioned an independent review into their pathways; this meant that the findings from the review and responsibility for addressing them were jointly owned.

In response to the relational audit, people responded negatively about their ability to take on risks that served wider system goals without fear of criticism or failure. We observed silo working at all levels in our reviews, such as decisions taken in one organisation without consideration of wider system implications.

"[We] react to pressure without always giving due consideration to the impact of decisions made on the longer term goals or needs of the system, or without supporting enough of a preventative approach. I think this can have an impact on positive outcomes for people."

Operational manager, working in multiple sectors

Rather than working to common goals for the benefit of people who use services, people could revert to protecting their own roles and organisational aims. People told us about defensive behaviours and 'blame cultures' that sharpened divisions between partners. The pressures of performance targets and financial constraints could exacerbate feelings of 'them and us'.

Despite conditions and pressures in the local system, we also saw and heard about collaborative working in the face of challenges. New cultures were emerging that enabled people to work towards collective goals, focused on the needs of people.

"Our organisations have worked hard to develop a culture of closer working and embed a 'no blame' ethos. There is still much to do to break down historical thinking and ways of working. This is not without challenges and there is still a long way to go, however, relationships are being built and ideas tried and tested."

Operational manager, working for a health provider

Changes in leadership could slow progress in the development of the mature relationships required to set out a long-term vision and drive change. Some systems were also working to overcome deep-rooted relational fractures and cultural differences between their organisations. We saw that new leadership could reset previously difficult relationships, although these relationships needed time to embed.

"In the last two years we have made huge steps forward as a system to work together towards a shared goal which is patient-centred and organisationally agnostic. We know we are not perfect but there is a real will to work collectively to overcome what are often complex challenges."

Senior executive, working in a health care provider

We have seen that where time is invested in relationships, there is a greater chance of success. Where there was a good level of trust and understanding between system partners, and where they could look beyond organisational priorities and performance, this created a positive platform for system working.

3.4 Measuring performance

The importance of relationships on effective system working is clear. In the systems we reviewed, we found that relationships and collaborative working are also affected by the way in which success is measured.

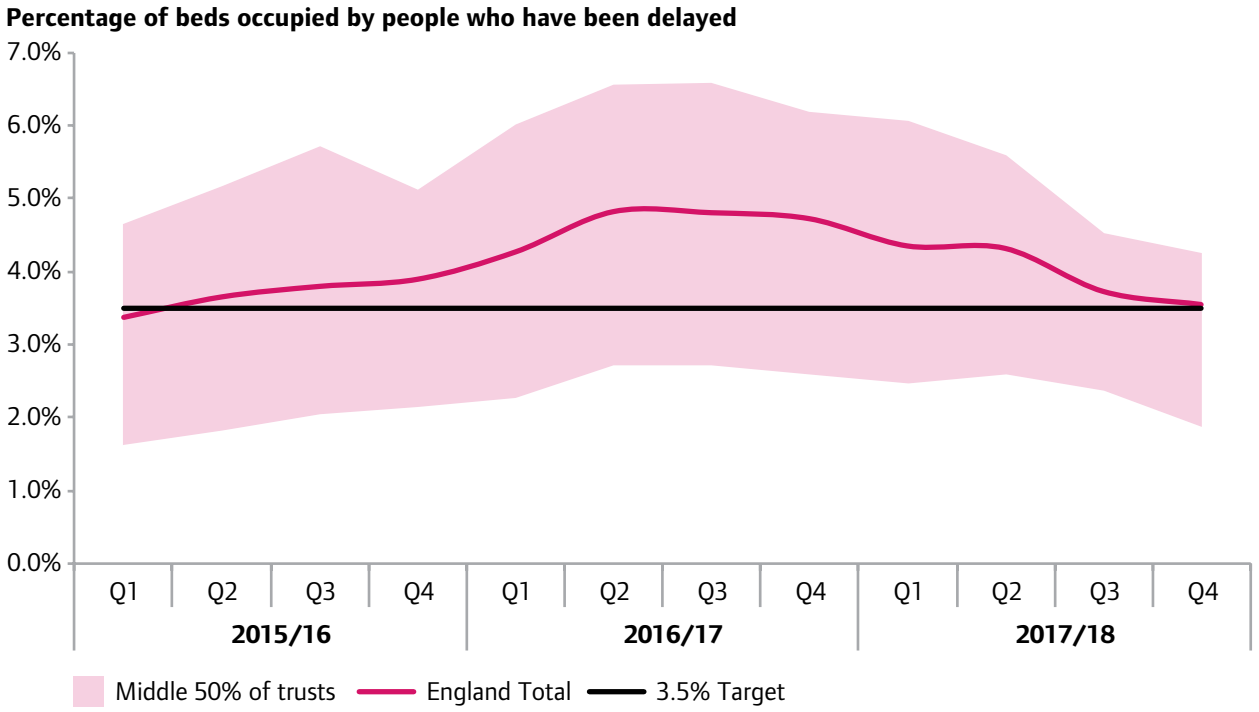
The way in which success is measured has the power to drive organisational and system priorities. While system leaders expressed a commitment to working together to best meet the needs of the people in their communities, their performance is still largely measured at an organisational rather than system level.

We produced a data profile for each system, based on CQC and nationally available data. The data profiles highlight performance across primary and secondary healthcare as well as adult social care, and include data on ratings, activity, provision, workforce, funding and the experiences of people who use services. This was a departure in usual practice from looking at individual provider performance, to looking at the system as a whole.

Indicators are an important barometer for understanding system performance and where improvements are needed. However, indicators are not able to show the whole picture. While delayed transfers of care were higher than the national average across most of the systems we visited, this did not necessarily indicate a common systemic issue across systems of similar demographics and size.

We have seen that measuring performance does contribute to improvement. In 2017/18, the Department of Health and Social Care's mandate to NHS England was to reduce DTOC nationally to 3.5%[49]. Our analysis shows that, in quarter 3 of 2017/18, the percentage of acute NHS beds that were occupied by an acute delayed transfer of care was 3.72% (figure 5)[50]. The target was missed, but there had been a fall from 4.35%. This was however, part of a longer term trend of a reduction in delays.

FIGURE 10: OCCUPIED ACUTE BEDS DELAYED



Source: NHS England; Delayed transfers of care and KH03 NHS Bed availability and occupancy, April 2015 – March 2018

We saw that measuring DTOC is an example of where improved performance in one part of the system may not have a positive impact on the system as a whole. In some systems, the focus on improving DTOC performance placed pressure on other parts of the system. Consequently, people were not always receiving care in the right place, at the right time and from the right person. We also found that the pressure to reduce DTOC, and the requirement to report delays by social care or health responsibility could contribute to divisions between health and social care.

The current way to measure DTOC does not encourage shared accountability for performance. They are routinely attributed to the responsibility of either health or social care, not to both as a system.

The way that performance is measured should incentivise system working and consider whole system performance.

3.5 Clear accountabilities

Accountability for the performance of a system involves holding to account how organisations work together to meet the needs of people in a place. This is important as it provides assurance for how resources within a system are being used.

We saw that system governance and accountability arrangements, such as Health and Wellbeing Boards, Sustainability and Transformation Partnerships, and Urgent Care Delivery Boards, can be drivers for system working. This varied from system to system as to which was most effective. We have found that accountability for the performance of a system, in how organisations work together to meet the needs of people in a place, has not been universally established. While organisations work towards shared system priorities, they are ultimately not accountable to the same authority.

Health commissioners are accountable to NHS England, NHS trusts to NHS Improvement, local authority officers to their councils and elected members, all of which we have seen can create tensions and some competing accountabilities.

The health and care system includes a wide range of individual providers, each with their own, and sometimes competing corporate accountabilities.

Health and Wellbeing Boards / Sustainability and Transformation Partnerships

Health and Wellbeing Boards were established in 2013 and have a statutory role in the leadership of a place. They are well positioned to oversee the vision for health and care, the strategy for delivering it, and to hold organisations to account for meeting the needs of people in that area.

Sustainability and Transformation Partnerships were established in 2015 with the intention of helping to ensure services are joined up and planned across local areas rather than around institutions. STPs have added an additional dimension to system accountability without formal powers to require changes.

Across the review programme we found that HWBs and STPs took different roles in different places, depending on their maturity and effectiveness. We found that differing geographies and leadership behaviours could create a disconnect between an STP, HWBs and the local systems we reviewed.

STP's are encouraged to bring together local leaders to develop a shared vision with the local community[51]. The extent to which STP plans were aligned to a local system's vision, strategy and delivery plans was variable.

We saw how STPs could be a positive driving force. In one system the STP had brought together leaders in a way that had not happened previously. We found examples of the HWB providing scrutiny and challenge, including over Better Care Fund (BCF) and STP progress.

Smaller systems situated within large STPs could struggle to find their voice and influence the decisions that would impact locally. The extent to which the STP had understood the functions of councils, the responsibilities of their staff and the extent of engagement with local elected leaders could also be a barrier.

We saw the potential of the HWBs to provide effective collective leadership for the system. We found examples of this where the HWB had clarity of role and purpose, representation from across the system, and a strong and committed leadership. HWBs could hold organisations in a system to account through setting out clear accountability between partners for the delivery of shared goals. We found examples of the HWB providing scrutiny and challenge, including over Better care Fund (BCF) and STP progress.

More commonly the HWBs are not fulfilling their role to full potential. Some HWBs lacked representation across the system, and as a result, collective buy-in for a strategic vision. Some HWBs were functioning more as a forum for engagement, or a place where papers or proposals were taken to be signed-off, rather than scrutinised.

In some systems, implementing sustainability and transformation plans provided a timely opportunity to refresh membership and strengthen the role and function of the HWB. This could ensure that it had a prominent and appropriate role in overseeing and influencing the strategic direction, setting the relationship between the HWB, transformation programmes and the STP.

Local systems need accountability and governance arrangements that assess, monitor and drive performance in the quality of services, and the quality of experience for people using them. Both HWBs and STPs can be effective in bringing together local leaders to plan and deliver services. What is most important is that there is an established vison, local buy in, and a place where decisions can be made on behalf of the system. This is where local leaders can be held to account for system performance at leadership level.

During the course of these reviews, the first integrated care systems (ICSs)[52] have been announced. Over time, some STPs will become ICSs. With greater flexibility of the management of operational and financial performance, they offer potential opportunity for improved system accountability.

3.6 Joint commissioning

Joint commissioning between health and social care gives local systems the opportunity to design and deliver services around the needs of people rather than organisations. We have seen the positive impact that joint commissioning has had on investing in services based around people's needs. In one system health and care organisations were pooling budgets around a dementia pathway.

Health and social care services are funded differently. Health services are funded by NHS budgets from general taxation, and are non-means tested. There are rules around how funding is distributed, which makes it difficult for health commissioners to change the balance of investment. Social care services are means-tested and influenced by local authority budgets. The contrast in the way in which funding flows into health and social care is a barrier to working together for the benefit of the whole system. Financial challenges and funding flows were having an impact on joint working at all levels.

"I don't feel we work together enough to achieve the best outcome for the patients. It seems to come down to budget restraints and who is prepared to pay for what, especially when trying to safely discharge a patient into the community"

Frontline staff member, health provider

Commissioners are required to ensure they are maintaining the quality and delivery of statutory services, while getting value for money and driving improvement. The need to move towards new integrated ways of working, while maintaining current delivery within their financial context, adds another dimension to the challenges faced by systems.

All systems had an ambition to move to joint commissioning, with the aim of improving health and wellbeing and providing better value for money. At the time of our reviews, the commissioning arrangements in most systems were collaborative rather than fully integrated, but progress was being made.

When organisations are financially challenged they are less incentivised to share financial risk. For example, in one system we saw how a difference in the financial position between health and social care organisations was a barrier towards progressing joint commissioning.

The BCF has been the primary lever in recent years to bring health and social care organisations together to plan, fund and commission services through a pooled budget. The BCF and the iBCF have had a positive effect on system working across the systems we visited. Some systems used governance established through the BCF as a platform to further joint commissioning beyond BCF requirements. Some supplemented BCF and iBCF funding with core funding, demonstrating a commitment to sharing resources.

Despite the positive impact that the BCF and iBCF have had on bringing together system partners to develop joined up and integrated commissioning practices, the funding is short term (see section 4.4). Recently there were moves to align funding across different parts of a system. Capitated budgets or whole population budgets are a potential driver for more population-focused and preventive approaches. The recently announced ICSs may be enabled by system control totals. We saw these being implemented in a few systems that were moving to an ICS.

Funding flows need to be seen as enablers of system working. A system-based approach to planning and an ambition to move to integrated commissioning represents an important acknowledgement that to meet the needs of people who use services in the future, this will require health and care commissioners and providers to work together as a unified system. Trusted relationships and risk-sharing are key features of this approach.

3.7 Performance oversight and regulation

National bodies have an important role to play in the oversight of performance and quality of health and care services and encouraging system working.

There are national commitments to align regulation and progress on developing shared views of quality. The role of regulators in driving system behaviours that are counter to collaborative working is still significant.

In CQC's role in regulating quality, it is clear from our reviews that assessing the quality of individual providers in isolation from the system outcomes for people is not maximising the potential improvement that might be driven by regulation.

An intention to align NHS England and NHS Improvement in regions may address some of these issues if there is alignment of purpose towards integration.

Conclusion: Incentivising better joint working

We have seen that system working relies on people working within health and care organisations to have a common vision, purpose and shared endeavour. Relationships are fundamental to joint working. Collective goals, collaborative decision-making, and sharing of risk are indicators of mature relationships, underpinned by multi-disciplinary and multi-agency working on the ground.

For this to happen there needs to be effective system leadership both locally and nationally.

Locally, there needs to be a shared understanding of local needs, clear agreements about the roles of different partners, clear priorities and action plans which will make it easier for local leaders to collaborate across the system. Local services can provide better and more joined-up care for people when different organisations work together across in a system.

Nationally, there is a need to create the right incentives for integration and joint working in local systems. Leaders need to have the ability to work across organisational boundaries and prioritise system outcomes, and look beyond what they are accountable for at an organisational level. System accountability is required. Future system working will need to include aligned performance measures, aligned oversight and regulation, and funding to incentivise joint commissioning across health and social care.

4. Building a sustainable system

Addressing the capacity and capability of health and care systems to support older people now and in the future is a priority. We highlighted this in our interim report last December and it remains a priority.

In every system we saw examples of staff across health and social care working together, often going the extra mile, to provide the care and support that people in their local area need.

For systems to be sustainable they need to have the right provision in place with the capacity to support people to stay well in the community and move smoothly through the system. Having a stable and skilled workforce in place is essential to achieve this.

Resources need to be targeted towards what is effective. Part of building a sustainable system is developing a learning culture in systems. We saw learning taking place at an organisational level, but this was less apparent across a system. There was opportunity for organisations to learn from one another, to understand system issues, learn from incidents, and implement good practice and innovation at scale.

In this section we report on the key challenges to system sustainability that impact on the ability for organisations in a system to work together, to ensure that people get the right care, in the right place and at the right time:

- **Workforce** – having enough staff, with the right skills in the right place
- **Supply** – having the right services and support to meet people's needs
- **Information sharing** – having the infrastructure, cultures and practices to support joined up care
- **Funding** – having the resources to plan and deliver, now and in the future

4.1 Workforce

Health and social care bring together the two biggest workforces in England, combining to make the country's largest industry. In 2016/17, it is estimated there were 1.34 million jobs in adult social care[53] and 1.2 million people working in the NHS[54] in England.

Creating a workforce that is fit for the future is a complex challenge that requires action at both national and local level. Local systems are challenged to ensure they have enough staff with the right skills in the right place. To address these challenges, health and social care leaders need to recognise the interdependencies of their sectors, and plan together for a sustainable system workforce.

Capacity in the workforce

Capacity within the health and social care workforce is a significant and ongoing challenge – many health and care organisations were struggling to recruit, retain and develop their workforce to meet the needs of people they provide care for. (In Chapter 2 we addressed in detail the challenges in the availability of health and social care services for people in the community.)

There are challenges across the health and care workforce. The nature is specific to each system we reviewed (influenced by factors such as geography, the local economy and housing market).

Sector	Issue and impact
Adult social care	Challenges recruiting and retaining care workers and nursing staff were common, and impacting on systems' ability to meet people's care needs in care homes and in the community.
General practice	An ageing workforce, coupled with challenges recruiting and retaining newly qualified GPs meant that the workforce was unstable in places and impacted on people being able to access their GP.
Acute medical care	Shortages were reported across staffing groups and could particularly affect urgent and emergency care.
Community health	Shortages in community nursing was impacting on the delivery of responsive, seven day care. Shortages of allied health professionals were impacting on the timeliness of people's discharge from hospital and step down care.
Social services	Shortages of social workers meant that they were working with high case-loads of people with complex needs, impacting on the timeliness of support for older people.
Ambulance services	The shortage of paramedics was affecting the ambulance services' ability to respond to emergencies in a timely way.

Different local services are competing with each other to recruit from the same pool of skilled and qualified staff. While some local systems were working proactively to develop career pathways and raise the profile of the health and care sector, the competition from other sectors, such as retail or hospitality, was making recruitment and retention of paid care staff a significant challenge.

Flexibility in skills and roles

'One of the biggest challenges for today's professional workforce is that it was trained and developed to work in a model centred around single episodes of treatment in hospital. However, those placing the greatest demand on services, both now and in the future, are older people with multi-morbidities (both mental and physical), who need integrated, long-term health and social care.'

King's Fund (2013)[55]

Mobilising a workforce to work together to provide seamless joined-up care is a significant challenge when they work for different employers, answering to different commissioners and regulators, and have been trained with different professional standards and practice boundaries.

For too many people, the experience of moving between health and social care services and their workforce can be confusing and disjointed. Care is often fragmented and people are uncertain about who is coordinating their care.

Delivering joined-up care has significant implications for the workforce and how they are deployed and trained. As we move towards more integrated models of care, staff will increasingly need to work across boundaries and take on new responsibilities, for example co-ordinating care and undertaking assessments, beyond their specialism. Knowledge and understanding of

other health and care services that can meet people's needs in the community will be crucial in reducing pressures on hospitals. This will need to be underpinned by culture change, improved communication and relationships across professions.

To enable health and care staff to build skills, knowledge and experience, some systems were developing accreditation style 'passports' that were recognised across health and social care organisations, allowing staff to easily move across health and social care roles. Nursing associate roles were being developed in several systems, some allowing for the rotation across the hospital, community and social care.

We saw examples of staff working safely beyond the boundaries of their traditional roles. For example, paramedics supporting out-of-hours primary care services to provide home visits, reducing pressures on general practice. Through the effective deployment of advanced nurse practitioners in urgent care centres, medicines could be prescribed without having to wait for a general practitioner, significantly reducing delays. With reduced resources and availability of staff, some areas were able to maximise the potential of their workforce and enable more people to receive the right care in the right place at the right time.

Some local systems were contracting with the fire service to good effect, where they were providing transport home from hospital, doing minor adaptations in people's homes and undertaking 'safe and well' visits when people returned home from hospital.

To meet the needs of people now and in the future, systems need to be innovative in how they recruit, train and utilise their workforce, so that staff have the ability to provide joined up and seamless care. Having staff with the appropriate skill mix that are able to undertake duties outside of traditional roles, with appropriate training, will help to reduce the pressures on services while meeting people's needs at home.

System workforce planning

In the recent *Health and Care Workforce Strategy Consultation*[56], Health Education England (HEE) stated that the current gap between workforce demand and supply has occurred partly as a result of a historic disconnect between service planning, financial planning and workforce planning.

It is acknowledged that workforce issues are being addressed through the HEE and Skills for Care work on a new strategy for the health and care workforce - the first to cover the care workforce since the former Department of Health's previous strategy published in 2009.

Workforce challenges were mainly addressed within individual organisations, rather than through a whole system approach. Most systems had established joint workforce groups, with governance and programmes of work to address issues. However these groups did not always include all system partners, such as independent adult social care and ambulance providers. Work to develop comprehensive, integrated system-level workforce plans was still at an early stage in most places. Across the review programme we have not been assured of effective joint workforce planning across health and social care to meet current and future demand.

National workforce strategies need to set the tone, ensuring that health and care staffing has parity and is joined up.

4.2 Supply

Shaping the adult social care market to establish the right amount and type of social care provision for the needs of the local population was one of the most significant challenges across the systems we reviewed. The care market is complex and fragmented. There are more than 25,000 active adult social care locations in England registered with CQC. With more than 400 local organisations responsible for commissioning different types of services[57], there is a challenge in commissioning, providing and monitoring consistently high-quality health and care services.

The availability of adult social care is a national challenge, especially in nursing homes, specialist care homes (for example, care homes specialising in dementia care) and domiciliary care. We have seen that the description, 'awaiting package of care in own home', is the most common reason recorded for DTOC, but when combined, delays due to awaiting residential or nursing home placement or availability are even more common.

There is a need to develop a wide and diverse adult social care market to enable people to have their needs met at home and in their local communities.

The needs of an ageing population with more illness and frailty is creating pressure on services across the system, especially during surges in demand where there is an increased reliance on urgent care services at a point of crisis. There is also a recognised need for a wide and diverse adult social care market to enable people to have their needs met at home and in their local communities.

The Care Act (2014) places a duty on local authorities to shape their local care market based on the needs of their population, taking into account those who are eligible for care and support, as well as those who pay for their own care. Statutory guidance says that market shaping and commissioning should be focused on outcomes and wellbeing, support sustainability, ensure choice and meet local needs. Local authorities are also required to integrate their approach with local partners, including NHS providers and commissioners[58].

Systems are struggling with these principles. When we spoke to care providers, there was a common frustration that commissioners did not engage with the sector in a productive way to help resolve the challenges.

Shaping the social care market in most areas remains the primary responsibility of a local authority, and shaping the health provider market remains the primary responsibility of NHS commissioners. The health of the adult social care market has consequences for the whole system. However, we did not find a culture of true collective responsibility for shaping health and care markets in any of the systems we reviewed.

Understanding the market

Market-shaping activity should be informed through Joint Strategic Needs Assessments (JSNAs), which HWBs are responsible for developing in partnership between local authorities, heath and other members. Local system leaders should be informed by a comprehensive understanding of:

- the population's health and wellbeing needs (typically identified by a Joint Strategic Needs Assessment); and
- the existing capacity, availability and quality of care providers, understanding the business environment of the providers offering services in their area.

HWBs are responsible for developing the JSNA, and statutory guidance is clear that shared responsibility must be taken across all HWB members[59]. We found that the level of understanding of the needs of older people varied across systems. JSNAs were not always adequate to inform commissioning decisions. In some areas JSNAs were underdeveloped, outdated or did not include a specific focus on addressing the needs of older people.

Where systems had good insights into the needs of their populations, we saw this driving a strategic approach to commissioning for populations and the place they live. For example, in some areas, understanding the needs of their diverse communities underpinned and informed the transition to commissioning at the neighbourhood level.

A Market Position Statement (MPS) summarises supply and demand in a local area and signals business opportunities to the market. Not all areas that we visited had well-developed and up-to-date MPSs to signal future capacity requirements to providers to encourage innovation to meet the future needs of the population.

In the absence of a well-articulated MPS, it is difficult for care providers to predict and plan for the long-term and give assurance

to commissioners of availability. One system described plans to move away from a static MPS to an online market position tool that would provide commissioners with real time intelligence of current market needs.

Across the review programme we found that health and social care commissioners do not consistently have robust systems in place to be able to predict demand and proactively shape the structure of the market supply.

The capacity and capability of the provider market

Capacity issues in the community are contributing to delays in accessing suitable care. Another issue is finding care at a price that is both acceptable to commissioners and meets individual/family choice expectations. Some systems were forced to commission poor quality care due to a lack of alternative provision meaning that for some people the only choice was in providers rated as requires improvement. Where this was the case, we raised this issue with system leaders and discussed their plans for improvement.

We saw how a lack of quality provision could generate a two-tier care system and inequitable access for people who need care. In one area, care providers were using their CQC rating as a way of negotiating higher fees. People who received local authority funding were required to pay a top-up fee to be placed in a service rated as good by CQC.

Across systems, domiciliary care providers were usually the most challenged providers in recruiting and retaining a sustainable workforce. Local authorities recognised this; some were increasing rates of pay to providers to enable them to offer more attractive employment conditions. This was seen to make a difference in some places – increasing the pay rates in one system led to a reduction in the shortfall of available domiciliary care hours.

A number of systems were reforming their domiciliary care markets to increase quality and capacity. This included reducing the number of providers on the commissioning framework to support more stable and high-quality provision. One system had implemented a new domiciliary care contract that was co-produced with providers, coupled with a workforce recruitment strategy.

Some systems were providing people with better access and continuity of care by paying retainers to domiciliary care providers to keep packages of care open if a person they cared for was admitted to hospital. One system paid a 30-day retainer to domiciliary care providers; this had been effective in minimising delayed transfers of care and providing continuity of care as the same care provider would still be available when the person is ready to be discharged from hospital. This approach also provided greater stability to the domiciliary care market, enabling providers to recruit and retain staff at reduced risk. We also saw examples where this did not happen, and where a hospital episode resulted in the cancellation of a care package, preventing people from being discharged when they were medically fit to return home.

In contrast to the NHS, the social care market is dominated by independent providers who, like any other health and social care organisation, need financial assurance to be able to plan for the future. Without local authorities being able to adequately compete with self-funders (people who pay for their own care), this can lead to a two-tier care system where people who are not able to contribute financially to their care may not be able to access the same quality care home as those who do. Due to financial constraints, independent providers are not incentivised to prioritise local authority placements over those who fund their own care.

In a recent Public Accounts Committee session on the adult social care workforce, it was acknowledged that self-funders are "subsidising people whose care is paid for by their local authorities". While local authorities are able to negotiate lower costs through block contracts, self-funders pay on average 41% more for care home placements than local authorities[60].

The social care market is under strain and the systems we have reviewed were challenged to provide joined up, person-centred care in the

community. Services in the community help support people at home, preventing the need to use hospital services. Systems need to be supported to provide services that keep people healthy and well at home.

Using the voluntary, community, and social enterprise sector

Across the reviews we met passionate and committed people working within the voluntary, community, and social enterprise (VCSE) sector who were collaborating with health and care partners to support older people. In the systems we reviewed the VCSE sector was providing services to promote wellbeing, reduce social isolation and prevent people's physical and mental health from reaching crisis point. These services also supported people who had been admitted to hospital to return home safely.

The VCSE sector has a long history of providing support to people in communities. It is recognised in the NHS Five Year Forward View as having a significant role to play in meeting the needs of local populations; this was clear from our reviews too. The sector is large and diverse, often working with marginalised, harder to reach groups and engaging with people that statutory services are sometimes unable to reach. People who use services, their families and carers told us how important these services were to them.

Some older people become reliant on these services and when funding for these services are cut this can impact on access to "life-lines" of support for the most vulnerable people. In 2016/17, less than half of older people using social care services had as much social contact as they would like (43.2%) and this percentage had fallen slightly from the previous year (43.7%)[61].

All systems recognised the important role of the VCSE sector and we found good examples of systems proactively working with VCSE organisations to develop and commission services to support older people in the community and as they move between health and social care. The inclusion of the VCSE sector in strategic groups such as the HWB increased their visibility and influence.

However, this was not common practice in all systems and the extent to which the VCSE sector organisations were engaged and included in the strategic planning and delivery of services was variable.

Throughout our reviews we encountered a frustrated VCSE sector that felt undervalued in the planning, commissioning and delivery of services. In response to our relational audit, people working in the VCSE sector generally rated the health of their relationships with partners more negatively compared to the rest of the system.

We found there was scope to improve the commissioning of VCSE sector services. There could be disjointed commissioning approaches across health and social care. The VCSE sector were often underutilised within commissioning and delivery arrangements, with missed opportunities to develop the market to address the capacity challenges in the system. Funding cuts, short term contracts and uncertainty impacted on the sustainability of VCSE organisations and their ability to plan.

There were signs of systems working more closely with and supporting the sustainability of the VCSE sector. One system was developing a digital platform that would capture information on unmet needs which could, in turn, be used by VCSE sector providers to develop responsive, sustainable services. Another system supported the creation of a VCSE alliance that enabled VCSE organisations to take on larger contracts in partnership that supported longer term financial and service planning.

The VCSE sector has significant value in the system. If system leaders work with the VCSE sector as partners, this could support system wide strategic aims to keep older people well in their communities and improve their personal outcomes and experiences.

4.3 Information sharing

Effective information sharing across organisational boundaries means that staff working in different organisations are able to access people's records to make informed

decisions about people's needs and care requirements. We saw some good practice in some systems however in the main, information sharing remained a significant challenge for systems.

Digital interoperability was an issue (to varying degrees) in all systems – there could be many different IT systems in operation in one system which prevented professionals from sharing information in a timely way. Even services using the same IT system could struggle to share information well. For example, in one system, the urgent care centre could not access the records of the people they were treating, even though they used the same IT system as the general practices in the system, meaning that they were making decisions about individuals without information that could have a direct bearing on their care.

A misunderstanding of information governance rules also sometimes led to information not being shared between health and social care services when it was legitimate to do so and in the best interest of people receiving care.

These issues meant that information was not available in the right place and at the right time. This caused people delays, risks to their safety and people telling their story multiple times.

System leaders recognised the importance of information sharing and steps were being taken in some systems to build platforms for digital information sharing, such as Local Digital Roadmaps. However, no systems yet have established platforms for information sharing across all health and social care organisations.

In the absence of fully integrated record sharing and to improve communication and co-ordination, we saw examples of systems co-locating multi-disciplinary staff from across health, social care and the VCSE sector. By having different information systems in the same room, this enabled quicker and easier information sharing. We heard of multi-disciplinary teams working with access to multiple computers, to log into different provider systems to access and cross-reference information to help with care coordination.

STEP CHANGE FOR A SYSTEM

There is progress in Liverpool, where there was a single, overarching information sharing framework and agreement signed by all organisations in the local health and social care economy.

This had resulted in more than 100 million potentially shared records. However, the ability to for staff across the system (particularly hospital staff) to access them remained fragmented and was acknowledged by system leads.

Community health and social care professionals could access a shared record and primary care was on a single records system. The next step was to create a single electronic patient record within secondary care and the intention was for three of the system's acute trusts to move onto the same records management system within the next year.

This could be a potential step change for the system in terms of delivering truly integrated care. The system's early investment and progress in digital technology and information had been nationally recognised by NHS England's Global Digital Exemplar (GDE) programme.

These challenges and barriers to information sharing are not new. Five years ago, an information governance review, *To share or not to share?*[62] found that, "a culture of anxiety permeates many health and social care organisations from the boardroom to frontline staff. This leads to a 'risk-averse' approach to information sharing, which prevents professional staff at the front line cooperating as they would like". We found that the same challenges still exist.

The information governance review found that there was also a lack of trust between the NHS and local authorities and between public and private providers, due to perceived and actual differences in information governance practice.

This creates tension among health and social care professionals and further limits information sharing. The review concluded that it is clear that information governance is both part of the cultural impediment to sharing [in the interests of] the care of people who use services, their families and carers, and is used as an excuse for other impediments to sharing.

Having access to information in the right place at the right time contributes significantly to safe and person centred care. While there are challenges with digital interoperability, information governance should not always be a barrier to record sharing across organisations, as with appropriate safeguards information can be better shared to the benefit of people who use services.

4.4 Funding for sustainability of health and care services

Incentivising prevention and admissions avoidance

All systems recognised the importance of investing in services that prevent people from relying on hospital care. However, funding and target pressures continue to drive attention to hospitals rather than services in the community. We saw examples where due to funding pressures, commissioners had taken a reactive approach to achieving savings by decommissioning services and support that prevent people needing to use services in the longer term.

Local authorities are responsible for public health that supports wellbeing and prevention, but this cannot be achieved alone. This is recognised by the Department of Health and Social Care in its mandate to NHS England for 2018/19, which includes a responsibility to lead a step change in the NHS in preventing ill-health and supporting people to live healthier lives. This needs to be led by the NHS and social care as equal partners in collaboration with the VCSE sector.

Health and social care organisations were given joint funding through the BCF and iBCF. It was one of the requirements of the BCF that funding was used to reduce hospital delayed transfers of care and implement the high impact change model for managing transfers of care[63]. The consequence of having such a strong focus on one aspect of system performance can mean that attention is diverted from other important areas, such as prevention.

In a review of BCF spending plans for 2017/18 by the BCF team, funding dedicated to 'primary prevention and early intervention' varied drastically between the 20 systems we reviewed. One system we reviewed allocated just 0.1%, of spend to primary prevention and early intervention while the system that dedicated the highest proportion of resource allocated 16.5% of their total BCF spend. It is important to note that these local plans may have been influenced by variation in local demographic need and other joint pooling budgets arrangements, and some spend classified under different headings (such as care co-ordination and multi-disciplinary teams) may contribute towards prevention.

Analysis by the joint BCF team shows that nationally spending on primary prevention and early intervention is not being prioritised in BCF plans. Across England, in 2017/18 the total BCF spending allocated to primary prevention and early intervention was just 2.73%. Spending plans for 2018/19 show that allocated funding will reduce further to 2.61%.

While delayed transfers of care numbers have been steadily declining since the introduction of the 3.5% target, the trend in emergency admissions continues to increase. Instead of incentivising systems to reduce their delayed transfers of care, systems could be incentivised to reduce pressures on hospital services by investing in admissions avoidance services and services that support people in the community.

To establish a sustainable health and social care system, systems need to be able to invest in services which keep people well at home and reduce reliance on hospital services. All systems recognised the importance of this. However current funding flows, and short term funding cycles, as they currently exist in most systems, can make it very difficult for commissioners to move money across organisational boundaries

and invest in services outside of core commissioning responsibilities.

Long-term sustainability

Systems have been and are still required to make cost savings. We saw that current financial pressures have affected systems' ability to invest in services for the longer term. At the time of publication of this report, there is widespread analysis and debate on future funding for health and social care. In our State of Care reports (October 2016 and October 2017) we reported that adult social care was approaching a tipping point and that without a long-term solution the quality and availability of adult social care may not be sustained[64].

From our reviews we have seen that long-term planning is challenging without the security of longer-term funding measures. The funding provided through the Better Care Fund and improved Better Care Fund has supported investment in services, however this funding is short-term. From the iBCF plans we have reviewed, if this funding is not continued, many of these services may not be sustained.

The sustainability of health services has previously been supported by funding made available through other grants such as the Sustainability and Transformation Fund. However, the National Audit Office reported that financial pressures experienced by services meant that the funding made available through this grant in 2016/17 was directed towards services under current pressures rather than planning for long-term sustainability. While the development of preventative services were inclusive in most sustainability and transformation plans, the NAO found that progress in developing these services had been insufficient and that in a bid to make short–term savings, preventative services were often overlooked[65].

In June 2018 a long-term funding plan for the NHS was announced, where the NHS will receive an extra £20bn a year by 2023. For health and social care to plan collectively, as a system for the long-term, funding security is required across both health *and* social care. At the time of writing there is still no long-term funding solution for adult social care. A long-term financial plan for adult social care is expected as part of the forthcoming Spending Review, following the publication of the social care Green Paper.

Without longer term security of funding, commissioners cannot plan for the future, when demand for health and social care services is likely to increase even further.

Conclusion and recommendations

Many older people in England have complex care needs that usually require more than one professional and more than one service. Their experience of care depends on how well different services work together with and for them, their families and carers.

In our review of 20 local authority areas, exploring how older people move between health and adult social care services, we found examples of organisations working well together for the benefit of local people. But, too often, barriers to effective co-ordination of health and care services meant that people's experience of care was fragmented. They were not receiving the right care, in the right place, at the right time.

Across our reviews, we have seen the positive outcomes that can be achieved when those working in local health and care organisations have a clear, agreed and shared vision, strong leadership and collaborative relationships. We met some outstanding professionals, working across organisational boundaries to provide high-quality care. But their efforts were often despite the conditions in which they are working, rather than because of them.

The conditions to enable systems where joined-up working across organisational boundaries can flourish are not yet in place. We need incentives that drive local leaders to work together, rather than push them apart.

Our reviews found:

Good intent among organisations to work together to a common plan, but a reality where most were focused on their own goals. Where we saw good joint working, relationships were characterised by aligned vision and values, open communication, trust and a common purpose to meet the needs of local people. However, in the majority of systems, local health and social care leaders were not working together effectively enough to fully address the needs of the people they serve. We found a culture where organisations prioritised their own goals over the whole system's shared responsibility to people using health and social care. None of the areas we visited had a fully joint, system-wide accountability framework, which meant leaders were not accountable for the outcomes of their wider system, beyond the accountabilities of their individual organisations.

- **In places where good planning was evident, there was still a disconnect between those plans and the funding to support them.** Every system we visited had an ambition to move towards integrated health and social care commissioning. The extent to which this could be realised was inhibited by the ability of local leaders to align and pool their budgets to best serve their local populations. This, in turn, was compounded by the fragmentation of commissioning responsibilities of local authorities and clinical commissioning groups. Separate funding streams and different payment processes can cause divides between organisations. This can be seen in the different approaches to eligibility for care between NHS care and social care. The dominance of tariff-based funding has impacted widely and, in many of the areas we

visited, acted as a barrier to more effective integration.

- **Performance management that was based on the specific responsibilities of each organisation, rather than outcomes for older people.** The way in which the performance of individual organisations is currently measured does not encourage and incentivise system working. Most senior leaders still sit within individual organisations; they are judged on their success on individual organisational measures, not by system success.
- **Information about people was collected by each organisation for its own purposes, which prevented important information being shared effectively across all those involved in a person's care.** Information sharing was a significant barrier to effective decision making and to seamless working across health and social care. Where information was being shared effectively across organisational boundaries, staff were able to access each other's notes and people's records, helping them to make more informed decisions on people's care. A misunderstanding of information governance rules sometimes led to information not being shared between health and social care services when it was legitimate to do so and in the best interest of the person receiving care.
- **An approach to workforce planning by each organisation that operated in isolation to others in their area.** Maintaining a sustainable health and social care workforce was a challenge in every system we visited. Many organisations were facing substantial challenges in recruiting and retaining staff to meet demand, with different local services competing with each other to recruit from the same pool of skilled and qualified staff. While some areas had established joint workforce groups, we rarely saw strategic workforce planning between health and social care.
- A regulatory and oversight framework that **focuses only on individual organisations.** The legal framework underpinning regulation could do more to enable a focus on the quality of care experienced by people across services they use. Regulators, including CQC, have until now looked at the quality of care within organisational boundaries. Better alignment between system regulators (NHS England, NHS Improvement and CQC) is needed so that contradictory actions are not reinforced by regulation. Similarly, a single agreed performance management and oversight framework will encourage cooperation between organisations.

Our reviews have highlighted both the barriers that prevent local systems from working together and the impact this has on people. We are calling for those barriers to be broken down.

The following recommendations to local and national leaders and government – on funding flows, performance measurement and regulation – will incentivise local systems to work together more effectively in the interests of the people who use their services, and encourage improvement in the way agencies and professionals work to support older people to stay well.

We recommend:

1. Encouraging and enabling commissioners to bring about effective joined-up planning and commissioning

Local leaders should create an agreed joint plan for how older people are to be supported in their own homes, helped in an emergency, and then enabled to return home safely. This plan must maximise the potential contribution from voluntary, community and social enterprise organisations.

Local leaders must take a reformed approach to funding that allows and encourages local systems to deliver this plan by aligning and pooling their budgets.

There must be sustainable funding reform that removes the barriers that prevent social care and NHS commissioners from pooling their resources and using their budgets flexibly to best meet the needs of their local populations. Consideration

should be given to a move from short-term to long-term investment in services, and from an activity-based funding model towards population-based budgets that encourage collaboration between local systems. In support of this, the national leaders (NHS England, NHS Improvement, the Department of Health and Social Care, and the Ministry of Housing, Communities and Local Government) must work with the Local Government Association and the Association of Directors of Adult Social Services, who should be involved as equal partners, to encourage and enable this change.

2. A new approach to performance management

There should be a single, joint, nationally agreed framework for measuring the performance of how organisations collectively deliver improved outcomes for older people. This would operate alongside oversight of individual provider organisations and use metrics that reflect outcomes for people – including from primary, community, social care and independent care providers – rather than relying primarily on information collected by acute hospitals.

Local leaders should give more emphasis to investing in models of care that support prevention and avoid unwarranted admission to secondary care. To support this, local leaders must actively and effectively share information about people across organisational boundaries, with support from national leaders to make this possible and with the appropriate safeguards in place to maintain public confidence.

3. A move to joint workforce planning

Local leaders should agree joint workforce plans, with more flexible and collaborative approaches to staff skills and career paths. These plans should reflect and work in tandem with Health Education England and Department of Health and Social Care workforce strategies, anticipated later this year.

National health and social care leaders should make it easier for individuals to move between health and care settings – providing career paths that enable people to work and gain skills in a variety of different settings so that services can remain responsive to the needs of local populations.

4. Better regulation and oversight of local systems

To support the improved planning and reformed commissioning at a local level, government should consider new legislation to allow CQC to regulate local systems and hold them to account for how people and organisations work together to support people to stay well. This would also ensure that regulation does not just look at individual organisations, but focuses on the quality of care experienced by people across the services they use. It is important that the regulatory oversight is aligned to a new national performance management framework, so that regulation supports local leaders in their focus on improved outcomes.

Regulators, including CQC, should work to agree a set of performance metrics and indicators for system performance that are used to inform all regulatory activity and oversight.

Glossary

Avoidable admission

An avoidable admission is a potentially *preventable* hospital *admission, when a condition could have been successfully treated elsewhere or prevented*.

Bed occupancy rate

Bed occupancy rate is a statistic which looks at the amount of beds that are occupied by people who use services at a moment in time. The statistic is expressed as a percentage of time that beds are occupied. It is calculated by multiplying 'average daily occupied beds' by 100 and dividing by 'average daily available beds'. For wards open overnight, an occupied bed day is defined as one which is occupied at midnight on the day in question. This measure indicates the capacity of the system to manage inpatients and to enable patient flow.

Better Care Fund (BCF) and Improved Better Care Fund (iBCF)

The Better Care Fund encourages integration by requiring CCGs and local authorities to enter into pooled budgets arrangements and agree an integrated spending plan. A BCF agreement is worked out each year. The iBCF was first announced in the 2015 Spending Review, and is a paid as a direct grant to local government, with a condition that it is pooled into the local BCF plan.

The Care Act

The Care Act (2014) makes clear that local authorities must provide or arrange services that help prevent people developing needs for care and support, or delay people deteriorating such that they would need ongoing care and support.

Carer (to make clear the distinction from care worker)

A carer is anyone who looks after a family member or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without that support. They are not paid for the care they give.

Carers' assessment

A carer's assessment looks at the support and help an unpaid carer might need from their local council to meet their own needs while caring for a family member or friend.

Case tracking

Case tracking was a process undertaken during the local system reviews for reviewing the health and social care notes of a persons who has used services so a picture can be built of the care they received and how effective, responsive and safe this was across their whole health and social care journey.

Commissioning

Commissioning is the process for planning and buying health and social care services to meet the needs of the local population.

Commissioning cycle

Good commissioning requires commissioners to follow a cycle of activity. There are various definitions but most include analysis of population needs, deciding priorities, designing and procuring services, development of the market to meet need, procurement of services, monitoring and evaluation of the quality and impact of services on the needs of the population.

Community assets/assets based approach

An assets-based approach considers people's skills, networks and community resources (their assets) alongside their needs to improve their care and support.

Community health services

Community health services provide care for people with a wide range of conditions, often delivering healthcare in people's homes. This care can be multi-disciplinary, involving teams of nurses and therapists working together with GPs and social care. Community health services also focus on prevention and health improvement, working in partnership with local government and VCSE services.

Co-produce/co-production

Coproduction describes the voluntary and intentional, individual and collective involvement of citizens in the production of services (either co-design and co-delivery or co-delivery of professionally designed services), with the support of public officials and using public resources.

Crisis

Sometimes people experience a crisis and might need significant support. A crisis may be a physical or mental health episode, or a social crisis – anything that impacts profoundly on a person's ability to function or to remain independent.

Delayed transfer of care

A delayed transfer of care is when a person moving through health and social care services is delayed even though they may be ready to move from one setting (for example hospital) to another (for example back to their own home or a care home).

Devolution

Devolution is the transfer or delegation of power to a lower level, especially by central government to local or regional administration.

Digital interoperability

Digital interoperability describes the extent to which different information and computing systems can interact. In health and social care, this usually relates to how well information systems used by different agencies can share and use information, for example being able to view data from a person's GP record via a computing system used in the acute hospital, or vice versa.

Direct payments and personal budgets

A personal budget is a sum of money to meet a person's care and support needs. The amount a person requires is agreed in an assessment process (usually by a local authority or a joint health and local authority panel). The personal budget can be used for an arranged service, where the council manages the budget on behalf of the person, or as a direct payment, where the person has direct access to their budget to arrange their own care and support. A third way personal budgets can be used is through an Individual Service Fund, where an independent agency manages the budget on behalf of the person.

Extended access

Extended access is where people have access to pre-bookable GP appointments outside of core contractual hours, either in the early morning, evening or at weekends. This might be through a GP practice or a group of which the GP practice is a member.

Five Year Forward View

The NHS Five Year Forward View was published in October 2014 and set out a shared vision for the future of the NHS based around more integrated, person centred care.

Frailty

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. People living with frailty take longer to recover from illnesses or accidents. Frailty leads to increased risk of poor outcomes, even after seemingly minor health challenges such as an infection or new medication.

Funding flows

Funding flows means the rules by which funds are allocated through the health and care system. Examples include short term funding, conditions applied to funding such as iBCF, and funding flows into hospitals through tariff arrangements or 'payment by results'.

Governance

Governance is how organisations and systems organise and make decisions, to ensure that they are doing what is expected of them and achieving their intended outcomes. Resource governance is how organisations ensure that the money they have is used in the most appropriate way. Governance is a term that includes legal aspects and ensuring accountability in organisations.

Health and Wellbeing Board (HWB)

A Health and Wellbeing Board is a formal committee of the local authority charged with promoting greater integration and partnership between bodies from the NHS, public health and local government.

High impact change model

The term in this report refers to the Local Government Association high impact change model which provides improvement advice to organisations that buy and provide services to better manage how people move through the health and social care systems so that people's care and movement between services is not delayed. There are eight changes which have been identified as those with potential for a 'high impact' on reducing delays.

Home

'Home' means the place where a person normally lives, whether this is their own home – which might be supported accommodation or extra care housing, or a care home.

Integrated care system

An integrated care system is a type of close collaboration between NHS organisations, local councils and other partners. In an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.

Single point of access

A single point of access is a single route for frontline staff and people who use services to access primary and community care advice and support.

Joint Strategic Needs Assessment (JSNA)

Each Local Authority area has a Joint Strategic Needs Assessment which identifies current and future health and care needs of the local population.

Market Position Statement (MPS)

A Market Position Statement is a document produced by a commissioning authority. It describes the types of support and care services people need, what is available and what needs to be put in place, now and in the future. It also considers what the future might look like in terms of care and support and how this can be planned for and shaped by commissioners. The main aim of a Market Position Statement is to encourage commissioners, people who use services, carers and provider organisations to work together to explain what care services and support is needed in the area and why.

Medicines optimisation

Medicines optimisation is a person-centred approach to ensuring people get good value from their medicines, both in terms of health outcomes and cost-effectiveness.

Mental capacity assessment

The Mental Capacity Act states that a person lacks capacity if they are unable to make a specific decision, at a specific time, because of an impairment of, or disturbance, in the functioning of mind or brain. A mental capacity assessment is a process of professional assessment of someone's capacity to make decisions.

Multidisciplinary

Multidisciplinary teams bring together staff from different professional backgrounds to support the needs of a person who requires more than one type of support or service. Multidisciplinary teams are often discussed in the same context as joint working, interagency work and partnership working.

Multiple comorbidities

Comorbidity is the presence of more than one diseases or disorders co-occurring. For example a person's primary disorder may be a stroke and comorbidity may be urinary incontinence. A person may have multiple comorbidities.

NHS Continuing Healthcare

HS Continuing Healthcare (CHC) is a package of care for adults aged 18 or over who have been assessed as having significant ongoing healthcare needs. It is arranged and funded solely by the NHS.

Person-centred approach

A person centred approach is about ensuring *a person who is receiving health and social care is* at the centre of decisions which relate to their health and social care needs.

Prevention

In the context of the Local System Reviews, prevention refers to a range of approaches to supporting population health and wellbeing with a view to maximising health status and preventing crisis and admissions. Prevention approaches include expanding access to primary and community services, active case management, social prescribing, health coaching, and care coordination.

Primary care

Primary care services are the first step to ensure that people are seen by the professional best suited to deliver the right care and in the most appropriate setting. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services.

Reablement

Reablement is a form of support that helps people to learn or regain daily living skills after deterioration in health and/or increased support needs. It can include different types of interventions and focuses on physical ability, with active reassessment while the support is ongoing.

Risk sharing

Risk sharing is a management method of sharing risks and rewards between health and social care organisations by distributing gains and losses on an agreed basis. Financial gains are calculated as the difference between the expected cost of delivering care to a defined population and the actual cost.

Secondary care services

Secondary care services are usually based in a hospital or clinic rather than the community. Sometimes '*secondary care*' is used to mean 'hospital *care*'. However, not all *secondary care* professionals work in hospitals, such as psychiatrists, geriatricians and occupational therapists.

Silo working

Silo working is commonly used to describe the practice of individual health or care organisations working to their own organisational agendas in isolation rather than working together collaboratively around the needs of the population.

Step down

Step down services are the provision of health and social care outside the acute (hospital) care setting for people who need an intensive period of care or further support to make them well enough to return home.

Structure of supply

Shaping the structure of supply is the process within a commissioning cycle involving stimulating provider interest, ensuring that there is a choice of providers to commission services from. The process involves exploration of gaps in current service provision against population needs, working with current and potential providers to develop innovative solutions for service delivery and specification, and deciding when to tender and placing contracts with providers.

Sustainability and Transformation Partnerships (STPs)

The NHS and local authorities have formed partnerships in 44 areas covering all of England, to improve health and care, known as Sustainability and Transformation Partnerships. Each area has developed proposals built around the needs of the whole population in the area.

System

For the purpose of these local system reviews, we reviewed the system as a group of organisations in a local authority area that collectively buy and provide health and social care services for people living in that area. It is acknowledged that health and social care services and wellbeing of any population are affected by interconnected systems within and beyond local authority boundaries. The defined characteristics of a complex system when applied to health and social care are a series of connected interdependent components, where action on one part of the system changes the context for another.

Vanguard

A vanguard is the term for an innovative programme of care based on one of the new care models described in the NHS Five Year Forward View. There are five types of vanguard, and each address a different way of joining up or providing more coordinated services for people. Fifty vanguard sites were established and allocated funding to improve care for people in their areas.

Voluntary, community, and social enterprise (VCSE) sector

A term referring to the wide range of organisations providing services to people encompassing voluntary services, community groups and initiatives, charities and social enterprises.

Appendix A: Membership of our Expert Advisory Group

To ensure that the voices of stakeholders (including commissioners, providers and people who use services) were heard and informed the development of this report, we established an Expert Advisory Group, where members contributed expertise and insight. Experts by Experience were present at each Expert Advisory Group to represent the voices of people who use services, their families and carers. Experts by Experience are people who have personal experience of using or caring for someone who uses health, and/or social care services

- ADASS (Association of Directors of Adult Social Services)
- Age UK
- British Red Cross
- Care England
- Carers Trust
- Department of Health and Social Care
- Healthwatch England
- Hertfordshire County Council
- Leadership centre
- Local Government and Social Care Ombudsman
- Local Government Association
- Ministry of Housing, Communities and Local Government
- National Care Forum
- NHS Clinical Commissioners
- NHS Confederation
- NHS England
- NHS Improvement
- NHS Providers
- NICE (National Institute for Health and Care Excellence)
- Public Health England
- Richmond Group of Charities
- Royal College of General Practitioners
- Royal College of Occupational Therapists
- Skills for Care
- Social Care Institute for Excellence
- The King's Fund
- TLAP (Think Local, Act Personal)
- UKHCA (United Kingdom Homecare Association)
- Volunteering Matters

References

1 NHS England, **Transforming urgent and emergency care services in England – Safer, Faster, Better: good practice in delivering urgent and emergency care. A guide for local health and social care communities**, August 2015

2 NHS Improvement, **Guide to reducing long stays**, June 2018

3 The Department of Health and Social Care analysis of total rates of delayed transfers of care undertaken in two phases. In the first iteration (used to select the first 12 areas for the local systems review) the national average daily rate of delayed bed days was 14 between February and April 2017. In the second iteration (used to select 7 of the final 8 areas for the local systems review) the national average daily rate of delayed bed days was 13 between July and September 2017.

4 Department of Health and Social care analysis of the 90th percentile length of stay for older people admitted to hospital as emergencies. This is the point at which 90% of older patients have been discharged from hospital. DHSC analysis undertaken in two phases, in the first iteration (used to select the first 12 areas for the local systems review) the average 90th percentile length of stay across England was 21 days between March 2016 and February 2017, in the second iteration (used to select 7 of the final 8 areas for the local systems review) the average was 20 days between September 2016 and August 2017.

5 Department of Health and Social Care analysis undertaken in two phases. In the first iteration (used to select the first 12 areas for the local systems review), the national rate of emergency admissions for people aged 65+ between March 2016 and February 2017 was 24,092 per 100,000. In the second iteration (used to select 7 of the final 8 areas for the local systems review) the national rate of emergency admissions for people aged 65+ between September 2016 and August 2017 was 25,009 per 100,000.

6 NHS England, *Five Year Forward View*, October 2014

7 Dixon J and others, *An Analysis of the Economic Impacts of the British Red Cross Support at Home Service*, Personal Social Services Research Unit, LSE, January 2014

8 Care Act (2014) **www.legislation.gov.uk/ukpga/2014/23/section/2/enacted**

9 British Medical Association, *Funding for ill-health prevention and public health in the UK,* May 2017

10 Care Quality Commission, *The state of care in general practice 2014 to 2017*, September 2017

11 NHS Digital data from September 2017 shows the number GPs in England reduced by 1.6% over the previous year (a 2.2% decrease in terms of full-time equivalent GPs). Nearly a quarter (22.7%) of GPs are aged 55 or over

12 GP and PMS staff per weighted registered patient calculated at LA level using NHS Digital, General and Personal Medical Services England data for September 2017 and applying NHS England's CCG Improvement and Assessment framework methodology for indicator 128d – Primary care workforce. A&E attendance rates calculated using Hospital Episode Statistics between July and September 2017 and ONS mid-year population figures for 2016.

13 Spearman correlations: GPs per patient and A&E attendances of people 65+ ($\rho = -0.41$, $p<0.0001$). PMS care staff (GPs, nurses, other direct patient care) per patient and A&E attendances of people 65+ ($\rho = -0.63$, $p<0.0001$). Please note this analysis does not control for other variables that could influence the observed associations.

14 NHS Digital, NHS Outcomes Framework Indicator 4.4.i – Access to GP services 2011/12 – 2016/17 **https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current/domain-4-ensuring-that-people-have-a-positive-experience-of-care-nof/4-4-i-access-to-gp-services**.

15 Spearman correlations: Access to GP appointments and A&E attendances of people 65+ ($\rho = -0.43$, $p<0.0001$. Please note this analysis does not control for other variables that could influence the observed associations.

16 NHS Improvement, Seven day services in the NHS, February 2017 **https://improvement.nhs.uk/resources/seven-day-services/**

17 NHS England, Improving access to general practice **www.england.nhs.uk/gp/gpfv/redesign/improving-access/**

18 People have access to pre-bookable appointments on Saturdays, and on Sundays, and on each weekday for at least 1.5 hours: in the early-morning before 8am, in the evening after 6.30pm or both in the morning and evening; through the practice or a group of which the practice is a member

19 Skills for Care, **State of the adult social care sector and workforce**, September 2017

20 NHS England, Social Prescribing **www.england.nhs.uk/personalised-health-and-care/social-prescribing/**

21 Sonola L, and others, *South Devon and Torbay Proactive case management using the community virtual ward and the Devon Predictive Model*, The King's Fund, 2013

22 Oliver D, Foot C, Humphries R. *Making our health and care systems fit for an ageing population*, The King's Fund, 2014

23 Analysis of hospital activity from care homes residents is a proxy based on matching the postcodes of residence of those attending/admitted with an active, registered care home. However, data could pertain to other addresses within the postcode.

24 Local Government Association and partners, High impact change model, **www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model**

25 NHS England, NHS Continuing Healthcare and NHS-funded Nursing Care 2017-18 Quarter 4, **www.england.nhs.uk/statistics/statistical-work-areas/nhs-chc-fnc/2017-18/**

26 Care Quality Commission, Under pressure: safely managing increased demand in emergency departments, May 2018

27 Care Quality Commission, *Under pressure: safely managing increased demand in emergency departments*, May 2018

28 National Audit Office, **NHS Ambulances**, January2017

29 National Institute for Health and Care Excellence, **Emergency and acute medical care in over 16s: service delivery and organisation**, March 2018

30 National Institute for Health and Care Excellence, **Transition between inpatient hospital settings and community or care home settings for adults with social care needs**, December 2016

31 Hospital Episode Statistics 2014/15 and 2016/17. Spearman correlation: ρ = -0.41, p<0.0001. Please note this analysis does not control for other variables that could influence the observed associations.

32 QualityWatch, Emergency readmissions: Trends in emergency readmissions to hospital in England, May 2018 **www.qualitywatch.org.uk/blog/emergency-readmissions-trends-emergency-readmissions-hospital-england**

33 National Audit Office, *Emergency admissions to hospital: managing the demand*, October 2013

34 Department of Health, *The Government's revised mandate to NHS England for 2017-18*, March 2018

35 Local Government Association and partners, High impact change model, **www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model**

36 Coefficient of variation (a measure of the extent of variability in relation to the average) at January 2017 = 57%, compared to 49% at January 2018.

37 NHS Improvement, Developing trusted assessment schemes: essential elements, July 2017, **https://improvement.nhs.uk/resources/developing-trusted-assessment-schemes-essential-elements/**

38 This is a short questionnaire, designed specifically for the Local Systems Review, which was emailed to the registered managers (RMs) of adult social care services registered within the 20 local authorities. The questionnaire was designed to gather feedback from adult social care providers on their involvement in the discharge process and the quality of discharge summaries they receive from hospital services.

39. Care Act 2014, **www.legislation.gov.uk/ukpga/2014/23/section/2/enacted**

40 NHS England and partners, **Quick Guide: Supporting patients choice to avoid long hospital stays**, 2016 National Institute for Health and Care Excellence, Transition between inpatient hospital settings and community or care home settings for adults with social care needs, December 2016

41 NHS England and partners, **Quick Guide: Supporting patients choice to avoid long hospital stays**, 2016

42 NHS Digital, Measures from the Adult Social Care Outcomes Framework, England – 2016-17, **https://digital.nhs.uk/data-and-information/publications/clinical-indicators/adult-social-care-outcomes-framework-ascof/current**

43 Coefficient of variation 2016/17 = 59.3%

44 Carers UK, **Valuing carers 2015: The rising value of carers support**, 2015

45 Office for National Statistics, Unpaid carers provide social care worth £57 billion, July 2017, **www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/articles/**

46 NHS England, *Five Year Forward View*, October 2014

47 Ghate D, Lewis J and Welbourn D, **Systems Leadership: Exceptional Leadership for Exceptional Times**, Leadership Forum and Virtual Staff College 2013

48 Care Quality Commission, State of Care 2016/17, October 2017

49 Department of Health, *The Government's revised mandate to NHS England for 2017-18*, March 2018

50 Our analysis focused just on acute delays in acute beds in order to overcome data quality issues arising from the list of trusts submitting data on delayed transfers not matching the list of trusts submitting data on beds to the KH03 collection. These

issues mostly relate to mental health and community health trusts. Further, this analysis aligns better with the scope of our review for which mental health trusts were out of scope. It should be noted that there is no clearly stated definition of how the target to reduce delayed transfers nationally to 3.5% of occupied bed days by September 2017 was constructed or how it should be measured. As a result, figures quoted elsewhere are likely to differ from our analysis.

51 NHS England, **Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21**, 2015

52 In an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.

53 National Audit Office, *The Adult Social Care Workforce in England*, February 2018

54 NHS Digital, NHS Workforce Statistics – July 2017, Provisional statistics, **https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/nhs-workforce-statistics-july-2017-provisional-statistics** .

55 Imison C and Bohmer R (2013) **NHS and social care workforce: meeting our needs now and in the future?**, The King's Fund, July 2013

56 Health Education England, Workforce Strategy, **https://hee.nhs.uk/our-work/workforce-strategy**

57 Humphries R and Wenzel L, *Options for integrated commissioning: Beyond Barker,* The King's Fund, June 2015

58 Deaprtment of Health, **Care and Support Statutory Guidance: Issued under the Care Act 2014**, June 2014

59 Department of Health, **Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies**, March 2013

60 Public Accounts Committee, The adult social care workforce in England, May 2018 **https://publications.parliament.uk/pa/cm201719/cmselect/cmpubacc/690/69006.htm**

61 NHS Digital, Measures from the Adult Social Care Outcomes Framework, England - 2016-17, **https://digital.nhs.uk/data-and-information/publications/clinical-indicators/adult-social-care-outcomes-framework-ascof/current**

62 Caldicott, F, **Information: To Share Or Not To Share? The Information Governance Review**, 2013

63 Local Government Association and partners, High impact change model, **www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model**

64 CQC, (2017) **State of Care** 2016/17

65 National Audit Office, *Sustainability and transformation in the NHS*, January 2018

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