HEALTH & WELLBEING BOARD – 9 NOVEMBER 2017

Early Lessons from the CQC reviews of Health and Social Care Systems

The CQC has been asked by the Secretaries of State for Health and for Communities and Local Government to undertake a programme of local system reviews of health and social care in 12 local authority areas. Oxfordshire is one of these areas.

These reviews, exercised under the Secretaries of State's Section 48 powers, will include a review of commissioning across the interface of health and social care and an assessment of the governance in place for the management of resources.

The purpose of the CQC review is to understand how people move through the health and social care system. The CQC is focussing on the **interface between health and social care** systems during the review and looking at what improvements can be made. The **CQC want to understand the maturity, capacity and capability** of the Oxfordshire system.

The review will focus on **older people aged 65 and over**, they will not be looking at people who have a mental illness, but will review people who have a diagnosis of dementia.

The review will look at the Key Lines of Enquiry (KLOE) under the domains of **Safe, Effective, Caring, Responsive and Well-led**. There is an additional KLOE which covers **Resource Governance** that focuses on how the system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting people's independence.

Clearly the early learning from these reviews will be of importance to the Health and Wellbeing Board and the Board will want to take these into account as it embarks on its own review of governance. (see proposal elsewhere on this agenda).

The CQC has completed inspections of two areas. These are Halton and Bracknell Forest. The findings from these reviews provide useful early benchmarking for the health and Wellbeing Board to consider. The reports for these two areas are attached and the summaries are below.

Recommendation
The Health and Wellbeing Board are asked to consider these two completed reviews and what lessons might be learned for the Oxfordshire system in general and the review of Health Wellbeing Board Governance in particular.

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Summary of Findings: Halton

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

- Overall, there was a strong commitment from the local authority (LA) and the clinical commissioning group (CCG) to serve the people of Halton well.
- The local authority and CCG had a clear vision for the borough that had been shared with its strategic partners and was well understood by their staff at a managerial and operational level. There were also well established, positive relationships across the health and social care system with a shared dialogue between the CCG and the local authority underpinned by a high level of trust.
- Local NHS acute trusts, although not located in the borough, participated in the wider system planning.
- As there was not yet a cohesive interface or alignment between the local authority's and CCGs vision for the borough, the Local Delivery System (LDS), the Sustainability and Transformation Plan (STP), and a developing accountable care system, there were opportunities for system partners to think more widely and include the Local Delivery System (LDS) and the Sustainability and Transformation Plan (STP) in the overall system strategy to strengthen the position of the Halton community and give local partners a stronger voice within the system footprint.
- Work was required to develop a wider system vision for the STP footprint and develop a common framework for prioritising actions, and for specifying accountabilities and shared governance arrangements.
- This was recognised by the system leaders who were working towards a more robust approach to alignment at the time of our review.
- There was agreement across partners to develop an accountable care system (ACS) in the future, however this agreement had not yet manifested into detailed plans and actions. Discussions were ongoing at the time of our review.

Is there a clear framework for interagency collaboration?

- There were well established, positive relationships across the health and social care system with a shared dialogue between the CCG and the local authority, underpinned by a high level of trust.
- The Joint Strategic Needs Assessment (JSNA) was well thought out and had underpinned operational delivery plans and desired outcomes .All partners were sighted on what was important to older people and carers when moving through the interface of health and social care. There was a specific JSNA for older people and there was good evidence of partners meeting individuals'
- needs in terms of health and wellbeing, social inclusion, social prescribing and transport. However, a joint commissioning strategy for older people's service provision had not yet been fully developed.
- There was evidence of robust analysis of need to support resource allocation and the setting of priorities within the local authority and the CCG. The local authority had a strong track record of financial management and delivering services for older people based on quality outcomes within budget.
- Joint preventative approaches were well thought through and embedded. There was a wide range of effective initiatives that were supporting people to remain socially included, maintain their own health and manage their long term conditions.

- There were some excellent examples of shared approaches and local agreements that supported local people in having timely access to services and support that met their needs in a person-centred way.
- The seven-day Rapid Access Re-ablement Service (RARS) and the five- day Rapid Clinical Assessment Team (RCAT) had been developed to reduce avoidable hospital admissions, which in 2016/17 had been above the comparator average. Similarly the numbers of delayed transfers of care were higher than the comparator average for the same period. System leaders were confident that the recently implemented RARS and RCAT teams' approach, coupled with the implementation of elements of the high impact change model, would secure improved performance in respect of avoidable admissions and further reductions in the numbers of delayed transfers of care.
- It was evident from the range of joint initiatives from the local authority and the CCG that there was a shared understanding and collective responsibility for meeting the needs of the local population. There was a strong commitment from partners to work collaboratively and efficiently for the benefit of local people.
- We found that the Health and Wellbeing board provided senior officers with high levels of support. However, as a forum to challenge and support the system's joint strategic approach, the Health and Wellbeing Board lacked rigour and required improvement to support and challenge the local system's transformation agenda and monitor progress more robustly.
- We found examples of poor monitoring of commissioned services which were having an impact on the quality of service provision, such as the intermediate care service provided at Warrington and Halton NHS Foundation Trust.
- Initiatives were not always connected and joined up to inform whole system performance. For example, GP practices were not always aligned with the system wellbeing strategies for example the enhanced care home model was not fully embedded with all GP practices
- Although recent DTOC figures were improving (figures for June 2017 indicate that the average daily rate of delayed transfers of care in Halton had dropped to 8.8 delayed days per 100,000 population,
- below the England figure of 13.8 and below Halton's comparator average of 10.80), there were a number of challenges in the timely provision of appropriate rehabilitation services and intermediate care to support and maintain further reduction. Some people with complex needs were experiencing considerable delays.
- The local authority and CCGs had transformation plans for domiciliary care and care home provision in Halton. Both these elements of provision were challenged in terms of their capacity to meet demand

How are interagency processes delivered?

- The framework for interagency working was supported by separate organisational strategies; however we did not find evidence of this being co-ordinated into a system wide approach by the STP.
- There were shared performance metrics between the local authority and the CCG which were scrutinised at the Executive Partnership Board. However these were not aligned with all system partners.

What are the experiences of front line staff?

- Senior leaders were visible, accessible and approachable.

- Staff felt supported by their line managers and were encouraged to influence the design and delivery of services.
- There were systems and processes in place to support staff development and professional competence.
- There was work planned with staff in the independent sector in terms of promoting peoples safety and injury prevention.
- There was good support available to staff underpinned by regular training to manage adult safeguarding issues including issues of abuse and neglect.
- From interviews with system leaders and operational staff it was evident that leaders across respective agencies were working together to implement systems to support interagency and multi-disciplinary working and encourage staff to work in cohesive teams.
- We found a range of support services that encouraged staff to work across
- organisational boundaries to better provide holistic care to people requiring services

What are the experiences of people receiving services

- The experiences of people receiving services in Halton varied.
- We found a very positive approach to maintaining people's health and wellbeing in their own homes and services designed for older people to keep them socially included, active and able to manage their long term conditions.
- There were some excellent examples of social prescribing that helped people deal with bereavement, loneliness and concerns about their safety at home.
- We observed a number of assessments carried out by different teams during the course of the review. We saw good examples of person-centred assessments, including those for people experiencing memory loss. Clinical, social and cultural information was included in assessments which covered all aspects of what was important in people's lives. Care plans were developed with the inclusion of the person, their families and carers.
- Halton had a high uptake of personal health budgets and direct payments for all adults compared to the England average and Cheshire and Merseyside regional average. The Halton Disability Partnership delivered a service to support people through the process of accessing and using direct payments.
- The local authority provided good support to carers with input from the carer's centre that supported approximately 5000 carers, including 528 carers supporting people living with dementia.
- However, some older people from the Halton area had less satisfactory experiences when they were admitted to hospital; they were often experiencing long waits in A&E before being admitted to a ward.
- Once ready for discharge, some older people were subject to delays in their transfer home or to a new place of residence. In some cases people had suffered avoidable harm or detriment as a result of the delays, such as the development of a pressure sore. In the main, delays were attributed to the lack of provision of care packages in the community or the availability of long term care placements.
- In response there were a number of new initiatives planned to improve the experience of older people and at the time of our review performance in delayed transfers of care was improving. Nevertheless further work was required to maintain this improvement and ensure that delays did not increase as a result of winter pressures.

- Continuing Healthcare (CHC) was provided through a joint local authority and CCG budget that had been established for a number of years. Securing CHC funding was not considered to be a primary cause of delayed transfers of care. The NHS CHC figures for all adults showed that in Q1 2017/18 both the referral conversion rate (% of newly eligible cases of total referrals completed) and assessment conversion rate (% newly eligible cases of total cases assessed) were higher than the England and Cheshire and Merseyside regional averages. This indicated that Halton's processes for identifying people eligible for CHC were working well. However, there were delays in completing the process as the data for all adults in Q1 2017/18 also showed that for Halton CCG 25% of referrals for standard CHC were completed within 28 days, lower than the England average of 57% and the Cheshire and Merseyside regional average of 73%.

Summary of Findings: Bracknell Forest

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

- There was a system-wide commitment to serve the people of Bracknell Forest well. There was a shared understanding across system partners of the challenges the system faced, and a willingness to work together to achieve solutions.
- Bracknell Forest was part of an agreed accountable care system (ACS) centred on the Frimley Health and Care Partnership and led by the Chief Executive Officer (CEO) of Frimley Health NHS Foundation Trust (FHFT). There was vertical and horizontal alignment of a system wide vision that was centred on the Sustainability and Transformation Partnership (STP) plans and the Better Care Fund (BCF) plans. The STP was recognised as a driving force for culture change across the system and instrumental in supporting integrated working.
- All staff within the system, from front line staff to the leadership teams, demonstrated knowledge of STP plans and voiced their commitment to its aims.
- The Health and Wellbeing Board (HWB) was well established, mature and functioned effectively by monitoring planning, delivery and outcomes for local people. The HWB was made up of representatives from across the system including the acute, community and voluntary sector. There were clear lines of responsibility and accountability.
- It was evident from our review that partners across the system were responsive to each other's challenges, while ensuring that responsibilities relating to their own organisations were not compromised by joint working.
- Aligned with the Bracknell Forest health and wellbeing strategy, there were joint strategic priorities in place. These focused on providing older people with preventative services and support to stay well, and on enhancing the capacity in the domiciliary and care home sectors to manage the current and projected shortfalls in these services.

Is there a clear framework for interagency collaboration?

- The Joint Strategic Needs Assessment (JSNA) was robust, well considered and underpinned by clear delivery plans and outcomes. All partners were sighted on what was important to older people, their families and carers when moving through the interface of health and social care.
- Governance arrangements, as set out in the BCF plan, included community, professional and clinical leadership and were collaborative with decisions made at local level. The BCF board had oversight on the alignment of the various strategies, including the joint commissioning strategy for intermediate care, joint commissioning strategy for people in an unpaid caring role, and the commissioning strategy for older people, together with the pooled budget and associated risks.
- The BCF plan built on a history of successful integration between Bracknell Forest Council (the local authority) and Bracknell and Ascot Clinical Commissioning Group (the CCG). Intermediate care and reablement services were jointly funded through a Section 75 pooled budget agreement and had run in partnership between the local authority and the NHS for ten years. This integrated service was hosted by Bracknell Forest Council with Berkshire Healthcare NHS Foundation Trust providing supplementary community nursing and therapy.

- There were positive examples of shared approaches and initiatives that supported local people to have timely access to services and support that met their needs in a person-centred way.
- There was evidence of effective risk sharing across partners. For example, there were plans for the local authority to administer personal health budgets on behalf of the CCG. A shadow control budget was also in place.
- The system was willing to take collective risks to transform the provider market to meet the needs of the local population. For example, the local authority was using outcomes-based contracts that incentivised new domiciliary care providers to put reablement at the centre of their activities, and in turn challenge local people to rethink how care at home could be used.

How are interagency processes delivered?

- Partnership working across the system was supported through a range of joint partnership boards. Boards were well attended and encompassed a comprehensive range of stakeholders including housing, voluntary services and the out-of-hours (OOH) service. Key issues were discussed and actions agreed, implemented and performance monitored.
- A programme delivery board had been established to monitor and support STP delivery and progress which reported to the Frimley STP Board.
- As part of the STP, integrated decision-making hubs were being developed to support people who were frail or had complex needs through advance care planning and social prescribing to promote independence, wellbeing and social inclusion.
- Winter plans covering the resilience arrangements across the system had been formalised and agreed. While the CCG led on the plans, we found that all system partners including frontline staff across primary and secondary care were aware of the plans and had contributed to the planning processes.

What are the experiences of front line staff?

- Staff benefitted from strong visible leadership and clear direction. We found that a collaborative multi-agency approach was already embedded.
- Feedback from front line staff was, in the main, very positive. Staff felt that leaders were responsive and inclusive. Staff generally communicated well across agencies. However, some social care staff reported that they were not always kept informed when people in their care had been admitted to hospital.
- Workforce issues were identified across the whole health and social care system, and particularly in the recruitment and retention of carers that provided care to people in their own homes. There were comprehensive system-led plans in place to mitigate risks associated with these issues; however most of these had not been implemented at the time of the review and we were therefore unable to assess their impact. The plans in place to support the up-skilling of staff and the development of cross-boundary roles were welcomed by the staff we spoke with.
- Staff told us that there was an opportunity for improving the care and support to people with moderate to severe dementia within acute hospital settings.

What are the experiences of people receiving services?

- The majority of older people living in Bracknell Forest received good quality health and social care services in a timely way. Most people using services told us they felt included in decision making about their care.

- Local people benefitted from access to direct payments. We heard positive feedback from people and their carers about how this enabled them to have control over their care, and be more involved in their care planning.
- There was an agreement between the local authority and the CCG for the local authority to procure continuing healthcare (CHC). NHS and the Emergency Duty Service (EDS) CHC quarterly figures for April to June (Q1) 2017 showed that the CCG had a standard NHS CHC assessment conversion rate for all adults (percentage of newly eligible cases of total assessments) of 50%. This was high compared to the England average (31%) and the South Central regional average (35%).
- We found a multidisciplinary, integrated approach to delivering a number of key services including the assessment and discharge team who were proactive and solution-focused. The EDS was well integrated and worked well with the integrated intermediate care team. All these services were having a positive effect on reducing delayed transfers of care (DTOC). Our analysis showed that Bracknell Forest had an average of 14.5 daily delayed days in July 2017 compared with a peak of 22.5 daily delayed days in March 2017. Local system leaders were confident that this level of performance could be further improved.
- However, in both acute hospitals there were some issues around the timely provision of hospital transport and medicines and these were contributing to delayed transfers of care and a poor experience for some people.
- People who used services, their families and carers were engaged in developing and improving the health and social care interface. There was regular engagement and co-production with older people via a range of panels and groups.
- There was scope to increase the effectiveness of local engagement by working better with Healthwatch Bracknell Forest.