Oxfordshire

Local system review report
Health and Wellbeing Board

Date of review:
27 November to 1 December 2017

Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and for Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives the Care Quality Commission (CQC) the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we are able to understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that brings together key findings from across the 20 local system reviews.

The review team

Our review team was led by:

- Head of local system review programme: Ann Ford, CQC
- Lead reviewer: Karmon Hawley, CQC

The team included:

- Three CQC reviewers
- One CQC analyst
- Five specialist advisors; one former local government director, one chief executive officer, one director of adult social care, one with a background in clinical nurse governance and one with a general practice background.

How we carried out the review

The local system review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on **older people aged over 65**.

We also focussed on the interfaces between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings.

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

1. Maintaining the wellbeing of a person in their usual place of residence
2. Crisis management
3. Step down, return to usual place of residence and/ or admission to a new place of residence

Across these three areas, detailed in the report, we asked the questions:

- **Is it safe?**
- **Is it effective?**
- **Is it caring?**
- **Is it responsive?**

We then looked across the system to ask:

- **Is it well led?**

Prior to visiting the local area we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We asked the local area to provide an overview of their health and social care system in a bespoke System Overview Information Request (SOIR) and asked a range of other local stakeholder organisations for information.

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

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

- System leaders from Oxfordshire County Council (the local authority), NHS Oxfordshire Clinical Commissioning Group (the CCG), Oxford Health NHS Foundation Trust (OHFT),

Oxford University Hospitals NHS Foundation Trust (OUHFT), and South Central Ambulance Service NHS Foundation Trust (SCAS)

- Members of the Oxfordshire Health and Wellbeing Board (the HWB)
- Health and social care professionals including care home and domiciliary care agency staff, social workers, GPs, urgent care staff, reablement teams, and health and social care provider representatives.
- Healthwatch Oxfordshire and voluntary, community and social enterprise sector representatives
- People using services, their families and carers during our visits to day centres and support groups and in focus groups.

We reviewed 18 care and treatment records and visited services in the local area including OUHFT and OHFT sites, intermediate care facilities, care homes, a domiciliary care agency, a GP practice, an extra care housing scheme, out-of-hours services and the urgent care centre.

The Oxfordshire context

Demographics

- 16% of the population is aged 65 and over.
- 91% of the population identifies as white.
- Oxfordshire is in the top 20% least deprived local authorities in England.

Adult social care

- 60 active residential care homes:
  - Two rated outstanding
  - 45 rated good
  - Five rated requires improvement
  - 8 currently unrated
- 74 active nursing care homes:
  - Four rated outstanding
  - 51 rated good
  - Nine rated requires improvement
  - Two rated inadequate
  - Eight currently unrated
- 113 active domiciliary care agencies:
  - Five rated outstanding
  - 81 rated good
  - Seven rated requires improvement
  - One rated inadequate
  - 19 currently unrated

Acute and community Healthcare

Hospital admissions (elective and non-elective) of people of all ages living in Oxford were almost entirely to:

- Oxford University Hospitals NHS Foundation Trust.
  - Received 92% of admissions of people living in Oxfordshire
  - Admissions from Oxfordshire made up 73% of the trust's total admission activity
  - Rated good overall.

Community services are provided by:

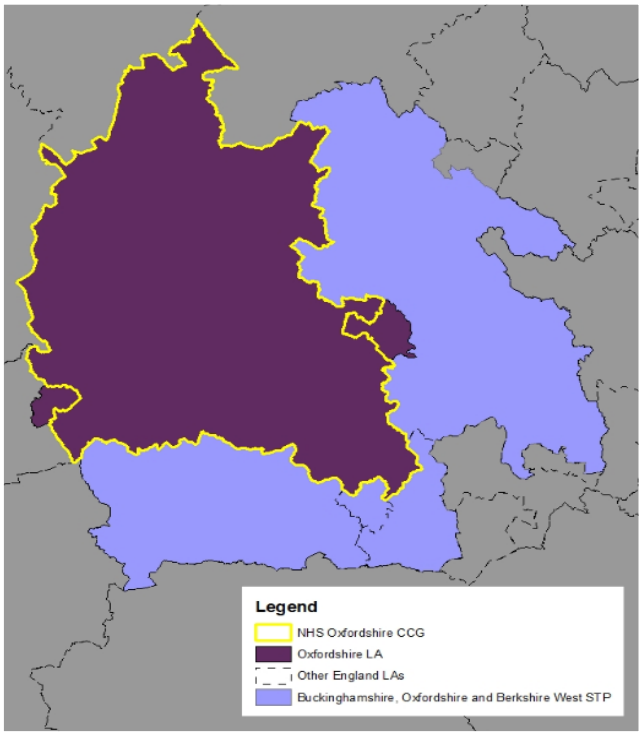
- Oxford Health NHS Foundation Trust
  - Rated good overall

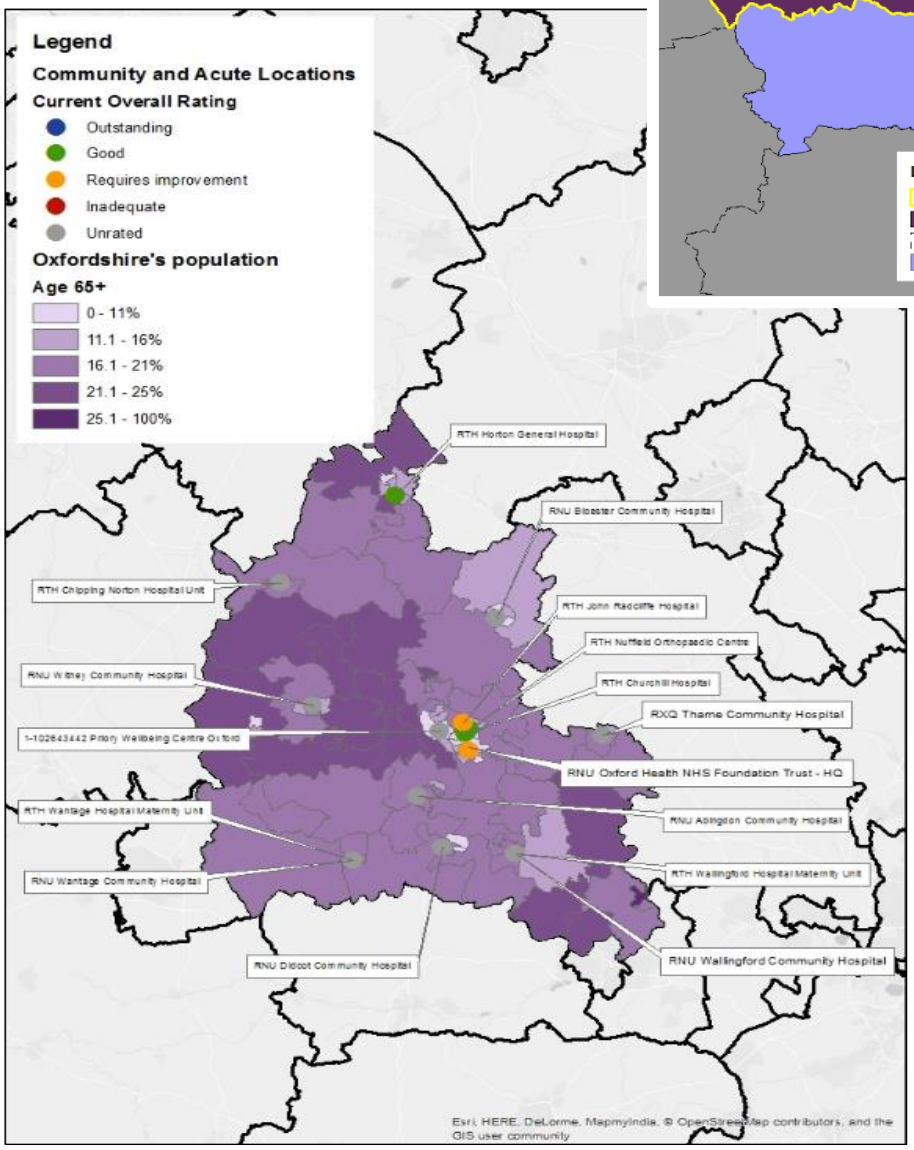
GP Practices

- 72 active locations:
  - Four rated outstanding
  - 64 rated good
  - Two rated requires improvement
  - One rated inadequate
  - One currently unrated

Acute location ratings as at 01/07/2017. ASC and GP ratings as at 29/09/2017. Admissions percentages from 2015/16 Hospital Episode Statistics.

Map one (right):
Location of Oxfordshire LA within Buckinghamshire, Oxfordshire and Berkshire STP.
NHS Oxfordshire CCG is also highlighted.





Map two (left):
Population of Oxfordshire shaded by proportion aged 65+. Also, location and rating of acute and community NHS healthcare organisations serving Oxfordshire.

Summary of findings

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

- In Oxfordshire we found that there was a lack of whole system strategic planning and commissioning with little collaboration between system partners. We could not find a compelling shared vision for the design and delivery of services. The significance of a shared vision is that it gives clarity to staff of all organisations and people who use services about what a system is trying to achieve and it is one of the fundamental building blocks to providing joined up care .

- Although there was increased ambition to work together system leaders continued to face significant challenges in coming together to formalise their ambitions through a joint strategic approach.

- Leaders were not able to provide a comprehensive strategy for the transformation and delivery of integrated services which would consequently impact upon effective commissioning and delivery plans.

- A lack of collaboration had led to a fragmented system where there was duplication of effort and at times, a reactive tactical response to embedded performance issues such as delayed transfers of care (DTOC). System leaders were considering national targets but not always applying them to their community and what is required to meet the needs of the people of Oxfordshire, for example, the strategy for older people was out of date and had expired in 2016.

- There was too much focus on service delivery when a person was at the point of crisis and little attention to prevention and early intervention services for older people with social inequalities, seldom heard groups and for those who may not be known to the system.

- The Buckinghamshire, Oxfordshire and West Berkshire (BOB) Sustainability and Transformation Partnership (STP) had little impact in delivering pan-Oxfordshire transformation. The development of local strategies to support older people who lived in Oxfordshire was a component of the Oxfordshire transformation programme. The first phase of that had concluded towards the end of 2017; the next phase of the transformation programme would be taken forwards in 2018, and so that process had not been completed at the time of the review.

- The Oxfordshire Health and Wellbeing Board (the HWB) did not have a clear role in influencing a strategic approach to support the joined up delivery of services. There was

recognition that the HWB required reconfiguration and a stronger sense of purpose. The chair and vice chair had a clear view for the development of the HWB and were keen to enact changes that would make it more effective and improve engagement with providers including the VSCE sector.

- The planned HWB review presented an opportunity for improved co-production, bringing together a full range of providers, and holding them to account for the delivery of the transformation programme, as well as providing clarity in respect of the interface with the wider STP.

- Relationships between Oxfordshire County Council (the local authority), Oxford Health NHS Foundation Trust (OHFT), NHS Oxfordshire Clinical Commissioning Group (the CCG), Oxford University Hospitals NHS Foundation Trust (OUHFT).and South Central Ambulance Service NHS Foundation Trust (SCAS) had been difficult over many years and although we found evidence that these had improved, feedback to our relational audit demonstrated that some cultural issues remained. For example, a few respondents described contrasting organisational cultures and the emergence of a blame culture in some organisations. Organisational development was required to address these barriers and create the required culture to enable better collaboration and service integration.

- The challenge for this system was to articulate its medium to longer term strategic ambitions while remaining focused on delivering continuous improvements against current performance pressures.

- Significant strategic effort is needed to ensure housing growth meets the demand of the much needed recruitment and retention of health and social care professionals and related key workers.

- Workforce challenges and the maintenance of a skilled and sustainable workforce were high on the agenda for the STP and also at local level for Oxfordshire. System leaders were working to develop the workforce through integrated working and initiatives including working with education institutes to enable innovative approaches to growing the workforce.

Is there a clear framework for interagency collaboration?

- There was no clear framework for interagency collaboration.

- There were some agreed overarching programmes aligned to the STP such as workforce planning and urgent care performance. However, the Oxfordshire system had not yet articulated a central, unified approach for the meeting of local needs aligned to the STP's strategic aims for the wider geographical BOB STP area).

- While each individual organisation within Oxfordshire had its own governance and reporting structures there were limited joint governance arrangements in place with unclear lines of accountability between system partners. The long history of pooled budgets jointly led by the CCG and the local authority was a good platform for the sharing of targets, outcomes, risk and reward. However, arrangements to support the management of wider risks to delivery were not jointly owned, which meant that different components of the system could, and sometimes did, focus resources on managing individual organisational pressures and targets rather than seeking joint solutions.

- The recent refresh of the pooled budget (Section 75) agreements between the local authority and the CCG had provided greater clarity and focus on older people. There were some good but limited examples of joint working which were having a positive impact on people.

- System leaders told us that at a strategic level, plans for Improved Better Care Fund (iBCF) spending were developed collaboratively, with discussions involving all major stakeholders. They acknowledged that while there were a range of initiatives from individual organisations and formal and informal partnerships and strategies, more work was required to improve the resilience and responsiveness of the system. They had begun to address this gap through the transformation programme and targeted work streams.

How are interagency processes delivered?

- There were some positive examples of effective partnership and collaborative working but it was widely recognised that some cultural and organisational barriers remained, which impacted on the ability to embed interagency processes. Organisational development work is required to address these issues if integration of service provision is to be realised.

- System leaders need to continue building cross-system relationships, articulating shared governance arrangements and jointly agreeing performance criteria.

- While we found some examples of staff working in an integrated way to deliver positive outcomes for people, the system remained fragmented and frontline staff reported multiple confusing access points into the system that impacted upon care delivery, and resulted in people who needed support having to fit into the system rather than receiving individualised care.

- System leaders acknowledged problems with information sharing systems and were committed to providing integrated care records by way of interfaces between platforms, rather than fully integrated systems due to a legacy of system challenges.

What are the experiences of front line staff?

- System leaders and senior managerial staff were visible and accessible. However some operational and frontline staff felt there was a need to improve and have effective conversations and co-production opportunities so that staff and people using services could influence and shape service design and delivery.

- Frontline staff were dedicated to providing high-quality, person-centred care and working in a seamless way with colleagues across the system. However they reported heavy workloads and recruitment challenges that did not support seamless care delivery. Workforce leads across the system cited work pressures at all levels as an inhibitor to integration.

- The incompatibility of IT systems was a common problem and frontline staff faced challenges when sharing information which impacted on the ability of staff to support people effectively.

What are the experiences of people receiving services?

- The experience of people receiving health and social care services in Oxfordshire varied. The Adult Social Care Outcomes Framework (ASCOF) measures for 2016/17 showed that the percentage of older people who were satisfied with their care and support was slightly above average. In addition, CQC's ratings of adult social care locations, which include feedback from service users, show that a higher proportion of locations in Oxfordshire are rated good and outstanding compared to the national average. However we received mixed feedback from people and carers we spoke with during the review.

- People, their family and carers told us that they felt well cared for and involved in making decisions about their care, support and treatment when moving through the health and social care system. The case files that we pathway-tracked demonstrated important relationships were acknowledged and the right people were involved in the person's care.

- People were treated with kindness and frontline staff were dedicated to providing person centred care, going the extra mile for people they cared for. Better Care Fund (BCF) plans supported personalisation and choice through the development of alternative models of care and investment in more flexible budgets.

- Some older people were not always seen in the right place, at the right time, by the right person. People using services, their families and carers reported multiple points of access and a fragmented approach to service provision meant that the system was confusing for people to navigate.

- People using services were complimentary about their interactions with staff and some services they received. However some people had very poor experiences of discharge from

hospital. For example, one person told us they had been discharged without the necessary care package in place and we saw a case study where appropriate support from a community healthcare professional had not been arranged on discharge. People using services also told us they had been discharged from hospital in the early hours of the morning.

- Although there was an increase in provision of primary medical services, some people reported varied access to services that meant they could wait for an appointment for up to 2 weeks. As a result, people sometimes relied on emergency services including A&E. On attending A&E people sometimes faced a long wait, especially if arriving by ambulance due to delays in handover to A&E staff.

- Although our analysis indicated that the rate of emergency admissions for over 65s in Oxfordshire had been consistently lower than the national average since 2014 and the average length of stay compared favourably against the national average, there were a significantly high number of delayed transfers of care. In addition the number of emergency readmissions was slightly higher than the national average.

- When people were admitted to hospital and needed a long term care package on discharge they were more likely to experience long delays, especially if they required complex support. People who experienced delays in moving to an appropriate care setting are at risk in terms of deterioration in their condition.

- The percentage of older people receiving reablement following discharge from hospital had decreased over the years in Oxfordshire and in 2016/17 was slightly below the national average. It also seemed that the effectiveness of these services had declined; in 2016/17 79.8% of people over 65 were still at home 91 days following discharge from hospital to a reablement service, while this performance was in line with Oxfordshire's comparator group it was below the national average of 82.5%,

- People who funded their own care experienced difficulties in accessing information in respect of support services available.

- While the ASCOF data and CQC provider ratings indicated that the percentage of older people who were satisfied with their care and support was above average, some carers we spoke with during the review felt the quality of domiciliary care was unsatisfactory, with staff not always appropriately trained to manage complex needs.

- People told us that they felt involved in their care and treatment but due to duplication in some roles and services some people had to tell their story more than once and were subject to multiple assessments.

- Some people experienced delays in social care needs assessments which impacted upon their health and wellbeing.

- The approach to co-production with people who use services, their families and carers was under developed. There were challenges engaging seldom heard groups and ensuring proactive engagement about things that mattered most to people living in the area.

- People who use services, their families and carers felt that the voluntary, community and social enterprise (VCSE) sector offered a good range of support services however concerns were raised by some carers that they were not receiving enough support and a reduction in day services had also impacted on this.

Are services in Oxfordshire well led?

Is there a shared clear vision and credible strategy which is understood across health and social care interface to deliver high quality care and support?

As part of this review we looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system, joint working, interagency and multidisciplinary working and the involvement of people who use services, their families and carers.

The alignment with the STP and the Oxfordshire transformation plan had contributed to delays in the development of local strategies to support older people who lived in Oxfordshire. The development of local strategies to support older people who lived in Oxfordshire is a component of the Oxfordshire transformation programme. The first phase of that concluded towards the end of 2017; the next phase of the transformation programme would be taken forward in 2018, and so that process had not been competed at the time of the review.

The HWB was not fully effective in its function and had not supported a clear shared strategic vision for the future of health and social care services in Oxfordshire. System leaders recognised some organisational development work was required and agreed that a joint vision and strategy was a priority. It was anticipated that the restructure of the HWB would provide the vision for integrated systems and structures.

Historical relationship issues were being addressed and relationships being rebuilt between system leaders and political leaders to enable change.

There were some good examples of the system working together to engage with people who used services, their families and carers; however a stronger approach to co-production was required.

While there was a shared commitment among system leaders to tackle challenges jointly this was not always translated into action at an operational level. There were missed opportunities to improve the system via lessons learned. Meeting the level of housing growth needed in the area to meet demand would require a significant strategic effort across all organisations.

Strategy, vision and partnership working

- There was a single local authority and a single CCG commissioning health and social care service for people in Oxfordshire and CCG commissioning services for people who lived in Oxfordshire was overseen by a single Health and Wellbeing board. There were five district councils which were responsible for services such as housing and waste collection.

- Oxfordshire was part of a wider Sustainability and Transformation Partnership covering the Buckinghamshire, Oxfordshire and West Berkshire (BOB) area footprint as a vehicle for wider system transformation planning and partnership.

- The Oxfordshire HWB was designated to provide the strategic oversight for the development of a strategy for health and social care services. The strategy at the time of our review covered the period 2015-19 and stated that it was "ultimately responsible for setting a direction for the County in partnership". At the time of our review the HWB was not working effectively and it did not set out a clear or compelling shared vision for the delivery of health and social care services. This would impact upon effective commissioning and delivery plans. Furthermore, a shared vision gives clarity to staff of all organisations and people who use services about what a system is trying to achieve and it is one of the fundamental building blocks to providing joined up care .A number of system leaders agreed that developing a joint vision and strategy, owned by partners was a priority.

- Given its statutory role for system leadership the HWB is the right body to set, agree and lead this vision, linked also to the STP. The review of the HWB governance and membership being conducted at the time of our review presented an opportunity to reshape the HWB so it took centre stage for driving a shared vision for older people in Oxfordshire and a shared case for change. It also presented an opportunity for the system to address the challenges it faced in order to focus simultaneously on what is happening to improve the current positon, and also the improvements needed for creating the right future system.

- System leaders were considering national targets but not always relating them to their community and the needs of the people of Oxfordshire. For example, we were presented with a strategy for older people which had expired in June 2016. While work was underway to review this, we were told this would not be completed until June 2018, which meant that services for older people in Oxfordshire had operated and would continue to operate for two years without a clear strategy.

- Elements of the health and wellbeing strategy, such as the integration of health and social care services, had not materialised. System leaders told us this was in part due to the development of the STP and the Oxfordshire transformation plan. 'The development of local strategies to support older people who lived in Oxfordshire is a component of the Oxfordshire transformation programme. The first phase of that had concluded towards the end of 2017; the next phase of the transformation programme would be taken forward in 2018, and so that process had not been completed at the time of the review.

- The CCG established an Oxfordshire Transformation Board in partnership with the local authority, OUHFT, OHFT, SCAS and the GP federations in 2015 to consider the transformation of services over five years. In the response to the System Overview Information Request (SOIR) system leaders indicated changes were already underway through the Oxfordshire Transformation Programme which was in two parts. Firstly, in working towards an accountable care system, and secondly, to better integrate primary, secondary care and social care services. At the time of the review there was no overarching vision for an accountable care system, and there was no evidence of commitment from partners to drive this, or a plan to achieve it.

- Work was needed to build positive relationships both politically and organisationally to reach agreement regarding transformational change. Phase one of the transformation programme could not be fully progressed because there was an ongoing judicial review of maternity services.

- System leaders recognised that there was a need to continue to improve relationships. We were told that recent changes in leadership had produced a more open culture that was more responsive to change and supportive of transformation. Although these were developing and system leaders were committed to serving the people of Oxfordshire well, feedback from 253 respondents in our relational audit showed some deep rooted issues in respect of organisational culture, trust, as well as communication and personnel challenges. For example, a lack of joint working created difficulties with communication across different organisations affecting the quality and continuity of care.

- Within Oxfordshire, leaders felt that the system was effective at addressing issues such as commissioning new services in response to the latest national initiatives. However we found that this reactive approach meant partners did not often have capacity to reflect, set plans and develop actions in a considered way to establish how they fitted with wider strategic objectives.

- There were some examples of good individual services in health and social care, and jointly commissioned services, including the Home Assessment Reablement Team (HART).

However, overall there was a lack of integration, and lack of a shared and understood joint workforce strategy.

- There were mixed views regarding the effectiveness of winter planning. Although system leaders were cautiously optimistic about their capacity to manage winter pressures, clinicians we spoke with were less so. Some of the measures put in place to manage discharges as part of winter planning such as 'one stop' ward rounds taking into account arrangements such as medicines to take home, were standard good practice and should be embedded in day to day discharge management rather than being seen as something new and innovative. Similarly, an improved approach to discharge planning was anticipated but far from embedded in the acute setting with limited evidence of the wider application of the high impact change model.

- Some leaders and front line staff we spoke with voiced concerns that planning for winter had been left too late and although bids for funding to support the management of winter pressures had been put in place there was little confidence in the system's ability to cope during this period.

- The recent refresh of the pooled budget between the local authority and the CCG provided greater clarity and focus on older people, and greater transparency regarding the overall spend. The review of the HWB, along with the existing pooled budget arrangements provided the system with a good opportunity to shape a shared vision, agree priorities and develop a communications narrative to galvanise the system into joint actions.

- The level of housing growth needed in the area to meet demand requires a significant strategic effort across all organisations, with the requirement for particularly strong partnerships between Oxfordshire County Council, the district councils and the Local Enterprise Partnership. This would help with the delivery of affordable and supported accommodation, which was much-needed to support older people, and the recruitment and retention of key workers in the Oxfordshire area.

- Local housing managers talked confidently about the initiatives to support this including extra care housing and efforts were predicated on the need for up to 100,000 additional new homes. A new project had started with a stock transfer partner to look at a bespoke model of "retirement living" to reduce costs and induce people into the area.

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

- Oxfordshire has a history of public engagement and co-production. However we received feedback indicating that it has not always been effective and local people felt that they had limited influence on the design and delivery of services.

- Challenges with public engagement were recognised by the system's engagement leads. The need to do more and to use new and proactive measures for working with underrepresented groups such as black and minority ethnic groups and travellers was recognised. This was corroborated as concerns were raised about ensuring engagement took place with underrepresented groups locally, to establish what mattered to them. System leaders told us there was a commitment by the local authority to embed a culture of co-production with people who use services, their families and carers across all adult services within the next two years. A dedicated team had been deployed to undertake this work which had been reviewed by the Social Care Institute of Excellence (SCIE) and which confirmed that positive work had been taking place and that the system were committed to the programme.

- There were some good examples of the system working together to engage with people who used services, their families and carers in the development of services, for example, around community beds (at Townlands Memorial Hospital), and carers, with – 'Oxfordshire commitment to carers' (Oxfordshire Carers' Strategy - 2017 to 2020). These examples involved working closely with the local community and ongoing engagement including stakeholder reference groups. System engagement leads felt they had made positive progress but there had been no formal evaluation or lessons learned review at the time of our review.

- The OHFT Dementia Strategy had been developed in partnership with people living with dementia, their families, the voluntary sector and OHFT staff. This strategy aimed to support OHFT to provide excellent and innovative specialist care to people with dementia and those supporting them throughout their journey. However, people's experiences differed with some people who use services and carers reporting a good service and others stating that insufficient support services were offered.

- SCAS representatives attended various patient forums and patient events including working with Oxfordshire Dignity and Dementia Champions Network. It had with an established dementia lead in post and a trust wide dementia strategy, which was underpinned by the clinical strategy 'Future opportunities and priorities to further care in the community'.

- The local authority worked closely with Healthwatch Oxfordshire to disseminate and cascade information and use feedback to inform how they designed, commissioned and delivered services. However, we were told that not all feedback was used to support service design and there were times when services such as daytime support had been reduced despite very positive feedback about its effectiveness in supporting carers.

- Providers had systems in place within their individual organisations to engage with people and obtain feedback. OHFT used a range of approaches to engage, involve and listen to older people as part of service delivery, which included patients, carers and public governors co-producing strategies. They had also made a five-year commitment to rolling out the online patient feedback tool 'IWantGreatCare' across all services which the system envisaged would provide rich, real-time feedback at service, team and clinician level. OUHFT had also undertaken a large number of engagement events, for example, the Quarterly Patient and Public Forum and Annual Quality Conversation with patients and members of the public.

Promoting a culture of inter-agency and multidisciplinary working

- System leaders recognised the need to improve the culture of interagency and multidisciplinary working. The Joint Strategic Needs assessment (JSNA) informed the vision and priorities of the Oxfordshire system towards new models of care, admission avoidance and discharging people from hospital as quickly as possible. The older people's strategy was being refreshed and would be completed in June 2018.

- Although jointly commissioned services were limited, there were some examples of good services in health and social care working together. For example the project groups working on DTOC and 'stranded patients'. However, many new initiatives were being developed without a shared approach, which resulted in silo working and a need to encourage a culture of inter-agency and multidisciplinary working to provide seamless care and avoid duplication of effort.

- In the response to the SOIR, system leaders told us that at a strategic level plans for iBCF spending were developed collaboratively, with discussions involving all major stakeholders. They acknowledged that while there were a range of initiatives from individual organisations and formal and informal partnerships and strategies, more work was required to improve the resilience and responsiveness of the system. They had begun to address this gap through the transformation programme and targeted work streams.

- While there was a shared commitment among system leaders to tackle challenges jointly however this was not always translated into action at an operational level.

- There was evidence of staff working collaboratively across some organisations to deliver care, for example in community hospitals/frailty units, staff worked with medical staff from OUHFT. There was also integrated health and social care provision for mental health services. The 'Joint Enterprise' was being created between Oxford Health and the County's GP federations to look to integrate neighbourhood multidisciplinary teams across primary and community care, informed by the National Association of Primary Care 'primary care home' model.

- More work was required to ensure all providers felt like system partners and that they had representation on decision making groups. While some social care providers were positive about their relationships with commissioners, concerns were expressed in respect of commissioners understanding the limitations of what their services were able to provide and about variance in support offered to providers.

Learning and improvement across the system

- Previous reviews of the problems of DTOC in Oxfordshire had included looking at complicated pathways, workforce and service provision, and some progress had been made to address these known issues. Some pressure points had been reviewed by various elements of the system, rather than by the system as a whole, which had encouraged a fragmented, reactive response. The system was frequently in escalation which had resulted in this becoming normalised among frontline staff who accepted performance levels as a consequence of a pressured system. There was a need for more evaluation of the contributing factors to the escalation and de-escalation processes so lessons could be learned, continuous improvements made and shared system wide.

- Each organisation had sight of their own incidents and incident management but there was no single, coordinated approach to ensure lessons were shared widely across the health and social care interface. Safeguarding and Serious Incidents were appropriately managed via the Oxfordshire Safeguarding Adults Board and the Care Governance Framework.

- Although governance arrangements were in place, there were mixed views regarding how well the system was learning and improving. Concerns were raised from some system leaders, political leaders and social care providers in respect of the transparency of the system, listening to concerns when they were raised and taking positive action in response. People we spoke with felt there was a lack of ownership and acceptance of some of the issues which impeded improvements. Furthermore people felt there were limited assurances due to the fragmented system and silo working. Staff reported that issues were discussed at so many different meetings and different decisions made, it was challenging to understand and maintain governance. The system had not explored what it could do differently to improve leadership, reduce over-prescribed care and bring people who used services to the forefront of service design, delivery and outcomes.

- There was evidence of joint learning in some areas, for example the sharing of best practice in the use of the electronic system (CERNER sites) and collaboration and shared care guidance for the Oxfordshire area prescribing committee.

What impact is governance of the health and social care interface having on quality of care across the system?

We looked at the governance arrangements within the system, focusing on collaborative governance, information governance and effective risk sharing.

There were governance arrangements across the health and social care interface to assess, monitor, share and mitigate risks but further development was needed. There were clear lines of reporting between organisations and up to system level arrangements and the STP. There was a strong demonstration of commitment in respect of the HWB and it was expected that once this had undergone reconfiguration it would become more effective in its role. Partnership boards such as the Joint Management Group had been established to encourage interagency working. A lack of digital interoperability was a barrier to providing fully integrated systems, however there was a commitment across system leaders to improve this.

Overarching governance arrangements

- The Oxfordshire Transformation Programme was the Oxfordshire component of the STP which was aligned with the HWB. The STP set out the strategic vision, delivery plans and provided an oversight of performance via the A&E Delivery Board.

- There were governance arrangements in place to support the planning and delivery of integrated care, particularly since the establishment of the Transformation Board. The Transformation Board existed to drive forward the long-term transformation of the health and social care system. The Transformation Board and A&E Delivery Board both benefitted from attendance by wider system partners including, Age UK, the Oxfordshire Association of Care Providers (OACP) and Healthwatch Oxfordshire.

- The HWB, together with its three sub-groups provided the joint forum for all aspects of the population's health and wellbeing and was chaired by the Leader of Oxfordshire County Council. Although the board was embedded in the wider system, it was due to undergo a restructure of membership. There were mixed views in respect of the effectiveness of the HWB, the level of challenge it provided and the ways in which it was aligned to and drove the system.

- The HWB had resolved to undertake a governance review with a view to exploring the potential of an Accountable Care System for Oxfordshire. This would be done in conjunction with other coordinating bodies such as the Transformation Board. The planned review of the HWB presented an opportunity to do this. Therefore the review should focus on setting a shared vision for the system and the relationship between the HWB, the Oxfordshire Transformation Programme and the STP. This would be particularly important if the HWB is to become the locus for the journey towards an Accountable Care System. This being the case, the review also offers an opportunity to co-produce and to engage care providers and the other stakeholders, such as VCSE sector organisations.

- System leaders told us that the JSNA and the health and wellbeing strategy provided oversight of further integration of health and social care, promotion of preventative services and re-shaping of NHS services outlined in the emerging Sustainability and Transformation Partnership. It also monitored related key outcomes and performance measures; however the older people's strategy was out of date.

- The long history of pooled budgets and the recent review of these was a platform for developing shared targets, outcomes, and risk strategies. The BCF Joint Management Group (JMG) monitored the resources that delivered the elements of the strategy that were within the scope of the pooled budget and provided assurance to the HWB. To provide the HWB with assurance around capacity and delivery, the revised scope of the pooled budget for 2017/18 had extended the reporting requirements of the JMG to include system indicators that were not strictly within the contracts commissioned from the pooled budgets but which the local authority and the CCG had responsibility for delivering in contracts outside of the pooled budget agreements.

Risk sharing across partners

- There were pooled budget systems and financial risk-sharing arrangements in place. However finance leads felt that should any unforeseen spending eventuality arise, there was not, at the time of our review, a robust contingency plan in place to manage overspend.

- There was evidence that the new iBCF monies had been spent on short-term solutions to target improvements against DTOC. Resources had also been used to offer incentives to care providers to enhance capacity however it was not clear that this spend was part of an overarching strategy to improve performance in the medium to long term. Although there was evidence that the more longstanding BCF had been structured strategically with financial risk sharing arrangements between the CCG and the local authority, there was less evidence on how these arrangements would be used to improve system integration or performance against DTOC under the remit of the Health and Wellbeing Board.

- All risks within the BCF were considered to be shared risks and while leaders were able to articulate how the system had responded to specific issues or pressure points, this approach was sometimes reactive and Oxfordshire was frequently responding to escalated risk. We were told these procedures did not always work and alleviate pressures as they ought. System leaders were aware of this and told us NHS England was imminently due to support an evaluation of escalation procedures to try and put a structure in place as well as address any identified gaps.

Information governance arrangements across the system

- The incompatibility of IT systems was the most common problem cited by the 97 respondents to our relational audit who supplied free-text comments. Frontline staff told us that the inability to share information electronically was a barrier to supporting people effectively. There was potential to streamline the system and improve flow and productivity through better use of technology. Some good work had been done with access to GP records but this needed to develop further to include providers such as 'hospital at home' teams, ambulance services and district nurses so that professionals have access to the same records and are enabled to assess and plan care and support needs effectively.

- System leaders told us they had established information sharing protocols as part of the Oxfordshire Information Sharing Framework. This was an overarching agreement which set the standards by which information could be shared, and it was developed by a multi-agency information governance steering group. All statutory organisations had agreed to the framework and in the past two years, all GP practices had also adopted this agreement.

- System leaders acknowledged the problems with information sharing systems and were committed to providing integrated care records by way of interfaces between platforms, rather than fully integrated systems due to legacy system challenges. However both OUHFT and OHFT had been awarded Global Digital Exemplar status [1] under the national NHS programme and were well-positioned to enable this integration.

- While much had been achieved to date in Oxfordshire to enable information sharing, further significant developments were planned as part of the Oxfordshire Local Digital Roadmap (LDR). A key strategic work-stream in the LDR is 'Records Sharing', with an improved Oxfordshire Care Summary being one of the first deliverables. The Oxfordshire Care Summary is a Health Information Exchange; a real-time view of information held in disparate clinical systems across Oxfordshire about patients registered at Oxfordshire GP practices.

To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?

[1] A Global Digital Exemplar is an internationally recognised NHS provider delivering exceptional care, efficiently, through the use of world-class digital technology and information. Exemplars will share their learning and experiences to enable other trusts to follow in their footsteps as quickly and effectively as possible.

We looked at how the system is working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource.

Oxfordshire was particularly challenged by workforce issues across the system and countless concerns about this were raised during our review. There were strategic plans at organisational level and STP level to align the workforce to future demand and collaborative work had taken place with an agreement to trial a combined recruitment campaign and to develop a single recruitment pathway. The current workforce challenges resulted in heavy workloads for staff and impacted upon seamless care delivery and integration of services.

There were some examples of innovative approaches to responding to workforce capacity and skill set, looking at new roles and models of care. System leaders were working to develop the workforce through integrated working and initiatives including working with education institutes.

However, at the time of our reviews this work had not yet had a positive impact and workforce remained a key risk to service delivery and the meeting of need. In addition some social care providers told us they did not feel engaged in the workforce strategy and felt this was a planning omission.

System level workforce planning

- The system in Oxfordshire was particularly challenged by the issues of workforce retention and recruitment across all professions and staff grades, especially acute hospital staff (with the exception of medical and dental staff, where the turnover rate was below the national average) and in the domiciliary care market. This resulted in staff shortages, heavy workloads and impacted upon seamless care delivery and integration of services. The system completed two comprehensive studies (in 2013/14 and in 2017) of Oxfordshire's adult social care workforce in order to better understand the fundamental cause of this issue. As a result, there was recognition among system leaders that the most likely route to resolving recruitment and retention issues was through joint working across the system, and through the Oxfordshire Transformation Programme aligned with the STP and the HWB. Models of care and the unqualified workforce were being jointly explored with the STP in a bid to address a potentially unsustainable workforce. At a more local level work had taken place between the local authority, OUHFT and OHFT to look at a joint workforce strategy, also linked in with the CCG and quality committee, and this was being tested.

- Collaborative work had taken place with an agreement to trial a combined recruitment campaign and to develop a single recruitment pathway led by Oxfordshire Association of Care Providers along with career structure pathways, accreditation and a bid to promote the image and profile of working in the health and social care sector. System leaders should continue to work with all partners to align and address the system-wide challenges and ensure that strategic plans are supported by data and timescales for delivery.

- Working with Health Education England, system leaders in health and social care had been trying to build on the skills of those already living in the community and work with local colleges and universities. They had also been working with district councils to address the issue of affordable housing in an attempt to encourage the workforce into the county.

- Social care providers were not always engaged in a meaningful and true partnership way. Some care providers told us they did not feel engaged in the workforce strategy and wanted to be more involved. System leaders told us they had regular contact with them and social care providers had named officers they could build links with. They felt this, along with regular meetings helped them keep up to date with the workforce strategy and oversight of workforce. Independent providers had also been able to advertise for staff on the local authority's website.

Developing a skilled and sustainable workforce

- Workforce challenges and the maintenance of a skilled and sustainable workforce were high on the agenda for the STP and also at local level for Oxfordshire. System leaders were working to develop the workforce through integrated working and initiatives with education institutes. We found positive examples of innovative approaches to growing the workforce by, for example, working with local colleges and universities to support those students keen to pursue a career in health and social care.

- However, countless concerns were raised in regard to recruitment and retention and the impact this had on developing a skilled and sustainable workforce. It was expressed that there was too much fragmentation and more needed to be done to increase professional development and the care industry becoming professionally recognised.

- Social care providers were working together to share what was working well in an effort to harness some of the skills about retaining staff and offering training and information. The system leads for Quality and Contracts had been matching poor performing providers and good performing providers to enhance the training of the workforce.

- There was a positive emphasis on training for staff across all sectors and there was evidence of joint training events taking place, although social care provider awareness of this service was variable. Workforce leads across organisations showed determination to work across the system and they should be encouraged by senior leaders to find the space and time to develop their plans. They all cited pressure of work at all levels as being an inhibitor to integration.

- Staff experienced heavier workloads due to recruitment issues. System leaders had been looking at capabilities and the competencies of the workforce for example, delegated health

care tasks and the use of passports to allow best use of resources and reduce pressure on staff.

- Electronic Staff Record data for 2016/17 showed that the staff turnover rate for NHS staff at Oxford University Hospitals NHS Foundation Trust was higher than the national average across all staff groups, with the exception of medical and dental staff. Adult social care workforce estimates from Skills for Care showed that staff turnover rates had previously been below England and comparator averages in 2013/14, at 20.5%, but then increased over the next two years to 31.2%; above the comparator group average of 28.9% and the England average of 27.4%. Staff vacancy rates in adult social care were at 7.3% in 2015/16, which was in line with comparator averages of 7.2% and England average of 7%. It was expressed by system leaders, frontline and operational staff that the workforce challenges, cost of living and housing all had a significant impact on staff recruitment and retention.

Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?

We looked at the strategic approach to commissioning and how commissioners are providing a diverse and sustainable market in commissioning of health and social care services.

Commissioning strategies, underpinned by the JSNA and future projections had supported a joint approach to managing the care market and commissioning services and this provided a good platform to move forward with service and operational integration. Oxfordshire faced significant social care market issues and the system needs to make sure there is sufficient capacity and resilience to cope with an anticipated increase in demand. Given that a larger proportion of people in Oxfordshire funded their own adult social care than across comparator areas and England averages overall, the system faced challenges when negotiating care fees on a county wide basis or individual care package basis.

The system had developed an integrated commissioning function with a pooled budget but there was little evidence that much more shared working was planned. System leaders were aware of the challenges they faced and as a result of this a number of developments had taken place in regard to market shaping and models of care.

Strategic approach to commissioning

- The BOB STP outlined the strategic vision, delivery plans and provided an oversight of performance across the STP footprint. While there were some overarching programmes such as workforce and A&E systems the strategic approach to commissioning was undertaken at a local level. However the HWB did not fully set out the strategic ambition of system integration, including integrated commissioning.

- The Oxfordshire Transformation Board which comprised system leaders from the local authority, the CCG, OHFT, OUHFT, SCAS, GP federations in Oxfordshire and Healthwatch was put in place in March 2015 to consider the transformation of services over five years and bring together health and social care partners with a focus on those programmes of work that will deliver significant improvements in the Oxfordshire health and care system.

- There were some positive examples of strategic approaches to commissioning which were effective, and had enabled some co-location of multidisciplinary professionals such as the 'virtual bed' (a specialist multidisciplinary team provided care in the person's own home, while an acute bed was held for a week to ensure if the person's health deteriorated there was an allocated bed space in the community setting for them to return to) and the admission avoidance services.

- While the absence of a specific focus on an older people's strategy made it difficult to articulate joint goals, commissioning plans were focused on the JSNA and projections about future demands on the profile of the population, which was incorporated into the joint Market Position Statements. There was an intended focus on prevention and place-based models of care designed to keep people well at home. However the preventative agenda was currently underdeveloped and leaders stated that the need for public consultation to had delayed fully integrated systems and structures.

- There was a commissioning model for domiciliary care and the system had reduced the number of providers. System leaders felt this gave a clear approach to providing assurances around income streams, ability to guarantee working hours as well as improving the terms and conditions of care workers. The CQC rating for quality for providers in Oxfordshire is higher than the national average; 88% of social care providers are rated as good or outstanding compared to 80% of providers nationally. However, during the review we found that social care providers felt there were some complex commissioning arrangements and contracts that were impacting upon their ability to provide a quality service. Commissioners should evaluate the commissioning arrangements to prevent agency failures.

Market shaping

- The response to the SOIR outlined that the local authority and the CCG worked jointly together and co-produced with providers to incorporate data in the JSNA and projection of future population demand into the joint Market Position Statements (first published in 2014). This outlined their understanding of the market, expectations about future demand, future purchasing intentions and represented the shared approach to purchasing and market pressures. However, the Market Position Statements did not fully set out a clear vision so commissioners and providers could use them to plan and deliver the services required to meet people's complex needs or ensure market shaping for capacity and workforce.

- Some social care providers felt they had not been involved in market shaping and they reported concerns of conflicts of interest and mixed messages in regard to building care home capacity when some care homes had more than 10% spare capacity.

- Oxfordshire had social care market capacity challenges as seen elsewhere in the country, particularly in regard to domiciliary care but there were differing views on how to address this, and continuing issues about affordability – pay was a common issue.

- The numbers of people being supported by the local authority for adult social care was comparatively low and a higher proportion of people funded their own social care compared to the comparator and England averages. This provided different challenges for commissioners who did not have as much influence when negotiating care fees on an individual care package basis. In light of the concerns raised by some social care providers and system leaders, commissioners needed to manage relationships and negotiations in a different and more collaborative way to secure the best rates for the local authority and best quality for people. This would ensure the system was fully assured of capacity and resilience in the market. This should be reviewed as a matter of priority to ensure there is clear view of capacity in the adult social care market.

- System leaders were aware of these challenges and the longstanding pooled commissioning budgets held by the local authority and the CCG had supported a joint approach to managing the care market and as a result of this, a number of developments had taken place in regard to market shaping. For example, the local authority and the CCG jointly fund a specialist dementia nursing home from the BCF pooled budget using social care and continuing healthcare (CHC) funding to create a 25-bed block.

- The local authority had also introduced a Dynamic Purchasing System for care homes to improve access to the care home market at more affordable prices, and the CCG had supported the development of this. The fragility of the domiciliary care provider market in Oxfordshire had partly been addressed through use of iBCF funding to improve provider prices. System leaders told us that fewer agencies had exited the market since March 2017 and there had been a realignment of providers on an approved list. However social care providers reported conflicts in respect of commissioning costs despite the local authority and the CCG paying the highest rates in the country for home care.

- To make best use of resources, there was a vision to move from a bed based model to the virtual beds and the service provided by the Integrated Liaison Team. Furthermore, although not a long term model, interim beds, hub and block beds to guarantee access to affordable and quality services, were available. This model had helped develop capability and capacity in the market, especially around the needs of people with the most complex

needs. System leaders acknowledged there was a need for further specialist capacity to support people with dementia. There were plans to increase capacity and a joint tender process put in place to create more specialist nursing care beds was set to conclude by January 2018.

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

- System leaders acknowledged the review of the pooled budget arrangements challenged the approach to market management and its efficiency to deliver the outcomes and objectives set out in the Oxfordshire health and wellbeing strategy and the BCF plans.

- This had led to a number of initiatives to improve the capacity and capability of the nursing home market, joint purchasing of complex care and hospital admission avoidance from care homes. However some of these initiatives were not fully embedded or working as effectively as they were intended; for example there were a variety of services commissioned with health and social care providers to prevent admissions to hospital and to facilitate timely discharges, such as the HART, Reablement Outreach Team and trusted assessor models. But the effectiveness of these was hindered by workforce challenges, complex pathways and delays in assessments.

- Although the analysis we undertook showed the rate of emergency admissions for over 65s in Oxfordshire had been consistently lower than the national average since 2014, there were a significantly high number of delayed transfers of care. System leaders were aware of the challenges and there was system wide recognition that the discharge pathway was complex. Therefore system leaders had mapped out the pathways in an expectation of streamlining the discharge pathway to offer the right support services and improve the interface between health and social care. The local authority and the CCG had jointly commissioned a Hospital Discharge and Reablement Service and a Community Reablement Service to bring several services together to provide a single pathway.

- There was a targeted, reactive approach to wider system pressures, resulting in preventative commissioning being under-developed. There was a lower uptake of direct payments and personal health budgets for NHS funded CHC, and a need to better utilise the VCSE sector, especially to support people ready for discharge from hospital.

- Although there were provider forums, communication between some social care providers and commissioners was reported as difficult at times and engagement was sometimes problematic. Social care providers felt they needed to be more involved in commissioning at an early stage, so that effective incentives could be discussed and for their concerns about commissioning to be listened to and responded to in a more proactive way. It was felt this would improve relationships, commissioning arrangements and service availability.

Contract oversight

- There were comprehensive systems in place to monitor the performance of commissioned services and a good response to quality issues. Commissioners were able to provide examples of how they evaluated the quality of service provision across the health and social care sector and how this helped improve activity and hold providers to account where required.

- System leaders monitored services to ensure care was appropriate and that providers delivered a quality service which met the contractual terms and conditions as well as the needs of people using services. Quality monitoring was risk based and there was shared quality monitoring between the CCG, the local authority and CQC. The system were able to demonstrate some positive outcomes as 50% of acute hospital core services, 47% of adult social care locations and 57% of primary medical locations within Oxfordshire had improved following a CQC re-inspection, which was better than both the comparator group average and the England average.

- The Oxfordshire Care Homes Association provided business intelligence and marketing information from across Oxfordshire to the system. This provided a mechanism to feedback any information or concerns. Information about people's experiences were also gathered from a range of national and local surveys, however system leaders acknowledged that they did not have the mechanisms to monitor and collate the total user experience through their pathways.

How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting people's independence?

We looked at resource governance and how systems assure themselves that resources are being used to achieve sustainable high quality care and promote people's independence.

Although there were clear lines of reporting between organisations with embedded risk sharing arrangements, due to system changes, governance arrangements were continuing to develop. There had been a long history of collaborative approaches and risk sharing arrangements, which were reviewed in line with system commitments to provide the necessary assurances.

- System leaders told us that due to a range of strategic challenges a formal review of the pooled budget arrangements took place in 2017 which concluded that the pooled budget arrangements should be re-framed. Therefore the pooled budget structure for 2017 to 2019 had been changed and system leaders set themselves strategic performance indicators relating to flow, user and patient experience and quality that would support system transformation. There was evidence of commitment from system leaders to join up their

commissioning and use resources flexibly for the benefit of people who needed health and/or social care and evidence there had been a move towards operational integration with a commitment to build multidisciplinary teams.

- The BCF pooled budget for 2017/18 had been reviewed and brought together key budgets in relation to care homes, hospital avoidance and prevention. Our analysis showed that there were far fewer residential care home beds per population aged 65+ in Oxfordshire compared to comparator areas and the England average (nearly 50% fewer - 1523 per population in Oxfordshire compared to 3049 across comparator areas and 3043 across England) with only a 1% increase in the number between April 2015 and April 2017. In contrast, there was a much higher number of nursing beds per population aged 65+ in Oxfordshire compared to comparator areas and the England average (3864 per population in Oxfordshire compared to 2750 across comparator areas and 2710 across England). The number of nursing beds had increased by 6% between April 2015 and April 2017. The number of domiciliary care provider locations per population aged 65+ in Oxfordshire was slightly above the number across comparator areas and the England average (113 compared to 99 and 110 respectively) and this number had increased by 4% between April 2015 and April 2017.

- Rates of admission to residential and nursing care homes to provide long term support for older people had been consistently lower in Oxfordshire compared with its comparator group and the England average and had reduced further in 2016/17 to 484 per 100,000 from 530 per 100,000 the previous year. Avoiding permanent admissions is a good measure of delaying dependencies.

- The system faced some significant financial challenges. OUHFT made a small surplus, but did not achieve its financial control total. The CCG was reporting a balanced budget for 2017/2018 and the local authority faced significant financial challenge across its whole budget, although social care as a whole was likely to break even. It is likely that further financial challenges will need to be tackled in future years.

- System leaders were realistic about how this would be managed. System leaders also acknowledged the difficulties faced due to a higher number of people funding their own social care and the changes in the care market with a need to manage relationships and negotiations in different and more sophisticated ways than in the past to secure the best rates for the local authority and best quality for all people.

Do services work together to keep people well and maintain them in their usual place of residence?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: maintaining the wellbeing of a person in their usual place of residence

Are services in Oxfordshire safe?

There was a commitment at all levels across the system to proactively maintain people in their usual place of residence; however services to prevent people from needing to access secondary care were underdeveloped and some people experienced delays in social care assessments. Systems and practices were working well for the majority of people, but more was needed to be done to ensure there was a shared view of who in Oxfordshire was at risk of hospital admission and that pilots and initiatives were fully evaluated and embedded.

- Some people experienced a delay in receiving social care needs assessments, resulting in a reliance on other services which were not best placed to meet their needs. Further concerns were raised about the effectiveness of the assessments and review processes in identifying people's complex needs. Case studies provided by local partners reflected these concerns and identified that some people in social housing were living in poverty or those with a social inequality were not identified early enough to prevent a crisis. It was only at the point of crisis that help and support was given which had a detrimental impact on people.

- A clear, in depth proposal to pilot a new frailty pathway to identify and support elderly and frail people to live well in their own homes had been drafted and was due to commence in December 2017. Oxfordshire GP federations and OHFT were also developing a joint enterprise to deliver joined-up primary and community care services through integrated neighbourhood teams. It was anticipated this would define a system wide frailty pathway, with a clear directives running through all parts of the system to care for people close to their homes.

- In an attempt to respond to system challenges, community based services such as care home support and an urgent visiting service (focussing on those at risk of admission to hospital) were available to identity those people who were frail, had complex needs or were at risk of deterioration.

- There was evidence within the case files we pathway tracked that some multidisciplinary assessments were undertaken and support put into place to keep people safe and maintain their health and wellbeing in their usual place of residence. There was universal positive feedback about these services from people, carers, families, system leaders and frontline staff.

- Care home and nursing home providers were supported to maintain people safely in their usual place of residence in a number of ways. Care Home Support Service nurses visited care homes and focussed on early intervention, prevention and improving quality of life. Formal structured teaching sessions were also offered focusing on subjects such as; recognising deterioration, falls prevention, prevention of dehydration, and pressure damage to the skin.

- A medicine optimisation initiative was in place to make more efficient the use of medicine and preventing admissions to hospital due to medication errors. The care home support service employed nurses specialising in medicines contributing to falls and pharmacists were offering additional support and training for GPs, nursing and residential home staff. GP surgeries employed pharmacists and further support was available from the CCG pharmacists. This included a pharmacist specialising in frail and elderly who was involved supporting care homes.

- Data from NHS England's Ambulance Systems Indicators showed that the SCAS routinely identified a higher proportion of calls to the ambulance emergency service as being from people for whom a locally agreed frequent caller procedure is in place than any other ambulance service in England. When these callers are identified, the SCAS team signposted them to the correct services so they received care at the right time, in the right place by the right person. The ambulance staff also worked with care homes staff who frequently used the service with a view to offering them training and support.

Are services in Oxfordshire effective?

Sometimes people did not receive a multidisciplinary approach when requiring additional support services. There were multiple and complex access points which caused confusion for people using services, carers and some frontline staff. There was some success with admission avoidance projects and services. There were widespread workforce issues across the system impacting on service delivery and staff workloads. Work was taking place in regards to recruitment and retention of staff. IT systems did not always communicate effectively which created additional workloads, reduced efficiency and put people at risk of avoidable harm as key information about their care and treatment was not easily accessible.

- A framework for an Oxfordshire Extra Care Housing Strategy for Oxfordshire County Council (January 2008) set out a commitment to invest in housing related support, extra care housing and assistive technology would support people to maintain their independence in their local community for as long as they were able and wished to do so. Although the framework had not been updated we found that investment had been forthcoming and when we visited a scheme, people using the service were positive about their experiences and told us that this enabled them to maintain their independence.

- Plans were in place to build and adapt properties that could remain a person's home for life and support longer term independence. Similarly plans to build affordable housing that would attract care and support workers in to the area were underway again with a view to providing a workforce that could support and maintain independence in a person's usual place of residence. It was important that this work continued at pace.

- Analysis of ASCOF data for 2016/17 identified that the number of people aged 65 and over entering care homes for support for long-term needs per 100,000 population was lower in Oxfordshire (484) than its comparator group average (525) and the England average (611) and had reduced over the last three years. Various pilots and projects had taken place or were underway as part of the admission avoidance work, for example, OUHFT and OHFT were running a pilot where cognitive behavioural therapy training was provided for professionals to improve medicines adherence. This pilot was in its infancy but early feedback suggested this was having a positive impact.

- Services designed to improve flow through the system and to keep people at home were evidence based but the service provision was fragmented, with multiple interfaces that increased the risk of delays in accessing services and confusion for people professionals and carers. There was not a single point of access for health and social care services, there was however a single point of access (SPA) for health services, which provided health professionals with an alternative referral route for patients needing community health services in Oxfordshire. We found that referrals were responded to in a timely way to provide support to people at risk of deterioration and avoid admission to hospital. The single point of access for health services took referrals from GPs, health professionals and more recently the general public but was separate to the social services access desk. There was a strong argument to make the single point of access more comprehensive and include adult social care services as people using services and some frontline staff, felt that there were multiple confusing access points.

- The SPA team was able to evidence positive examples of when they had utilised the trusted assessor model effectively across the system. But there was a need to work with other parts of the system to enhance the implementation of the model and fully integrate health and social care locality teams. For example, there were three Hospital at Home (H@H) services which operated to different specifications – frontline staff and social care providers felt it was sometime difficult to understand the different services offered by these teams and that further clarification was needed. This resulted in some people receiving an inconsistent multidisciplinary approach that was complex and disjointed. Case files that we pathway tracked and reviewed supported these findings.

- Access to primary care had been extended through the hub working approach, with all GPs

that were part of the GP federations working collaboratively to provide services to patients at the evenings and weekends. While this had yet to be fully stress tested, it enabled greater resilience and flexibility within the service and extended people's access to weekend and evening appointments. Our data analysis showed the provision of GP extended access was greater in Oxfordshire than in comparator areas and the England average. As at March 2017, only 2.9% of the 70 Oxfordshire GP practices surveyed offered no provision of extended access, while across comparator areas this was at 14% and across England was at 12.3%. Our analysis also showed that GP funding per patient in Oxfordshire had stayed above the England average from 2013/14 to 2015/16, and in 2015/16 was above its comparator group average (£145.76 compared to £143.67).

- There was an agreement in the BCF return for the delivery of a seven day service across the health and social care system. OUHFT was a national early implementer of seven day working and had facilitated system changes to extend routine working across a seven day week.

- The CCG had been working with the VCSE sector and OHFT to provide weekly falls prevention services to older people and was planning to extend services to begin focussing more on supporting people with long term conditions to improve health outcomes.

- System leaders and frontline staff reported widespread issues in respect of recruitment and retention across the system. In response to these challenges the local authority set out in the BCF plan that they had established a two year workforce programme, funded from the adult social care precept. There was a focus on job and career prospects and investment in additional long term staffing to manage and support the intermediate and acute care system, and to provide seven day prevention services. Despite this, staff in the acute setting continued to report heavy workloads with additional pressures of meeting targets. As the NHS England Five Year Forward View promotes a diversified skill mix in practices, some GPs had employed nurses or paramedics to do many regular reviews and some GP visits.

- Although frontline staff in health and social care services had the right skills and were provided with regular training and development, some social care providers told us they were unaware of training on offer from the local authority and CCG to support social care staff in reducing admissions to hospital.

- To some extent, staff were able to use computer systems or software to exchange and make use of information within the system; however these were not always effective, which impacted on the ability of staff to share information, especially between organisations as staff felt the risk of duplication and errors was too high to share cases.

Are services in Oxfordshire caring?

People living in Oxfordshire were involved in discussions about their care and treatment. People felt there was not enough support provided to people living with dementia and further information and support was required for carers. A commitment to personalisation was articulated in the BCF plan and the future strategic vision and staff at all levels demonstrated commitment to providing person centred care.

- People, their family and carers told us that they felt well cared for and involved in making decisions about their care, support and treatment when moving through the health and social care system. The case files that we pathway-tracked demonstrated important relationships were acknowledged and the right people were involved in the person's care.

- Age UK had methods to provide people with access to networking and keeping up to date with what was happening in the health and social care sector. Support was also offered to carers, families and advocates so they too could make informed choices about future plans. However representatives in the VCSE focus group told us that there were approximately 62,000 carers a year not receiving the support they required and they had recognised they needed to be more creative and reflective.

- People were treated with kindness when they moved between health and social care services. Frontline staff were dedicated and provided person centred care, going the extra mile for the people they cared for. BCF plans supported personalisation and choice through development of alternative models of care and investment in more flexible budgets.

- Funding for day centres and community support had been reduced. This impacted on some people's wellbeing as they felt these had provided a vital service, providing a sense of purpose and reducing social isolation. This had an additional impact on carers as some felt that they needed additional support, especially as they may have difficulty accessing respite services.

- Oxfordshire's ASCOF performance in 2016/17 compared well against the England average, with the exception of DTOC. A higher percentage of older people were receiving direct payments and a lower rate of older people was being permanently admitted to residential and nursing care.

- Integrated community care teams and the H@H service provided timely support to people with a long-term condition to effectively manage their health and improve their outcomes and experience. Our analysis of data from 2011/12 to 2016/17 measuring how successfully people with long-term conditions felt the NHS supported them demonstrated that a consistently higher percentage of people in Oxfordshire felt they received sufficient support

than across comparator areas and the England average. Furthermore, 2016/17 data for the health related quality of life score for people with long-term conditions in Oxfordshire was above both the comparator and England average (0.77 compared to 0.76 and 0.74 respectively).

Are services in Oxfordshire responsive?

System leaders and frontline staff had a shared vision that a person's own home was the best place for them. However, there were multiple confusing access points into the health and social care system and the VCSE sector were keen to develop networks and referral systems. Admission avoidance processes were in place, but further work was needed to embed them, as some were being developed in silos rather than strategically across the system.

- Social care providers reported variable experiences and outcomes and a lack of enhanced health care support. However, the GP federations were working well and being embedded. One of the aims was to try and maintain people in their normal place of residence and keep them out of hospital by use of various initiatives such as early visiting services.

- System leaders acknowledged that primary care was under significant pressure with a reduction in the number of practices and capacity challenges. People using services told us that it was difficult to get non-urgent access to GPs and they sometimes had to wait for approximately two weeks for appointments. However the GP hub now offered a seven days a week service, increasing access to a GP. The GP hub was working well and had resulted in better use of resources. Although not the only solution and professionals who may be able to help, this may address the concerns that people identified with access.

- Engagement between the VCSE sector, primary health services and acute health services was disjointed and difficult with no direct route to the hospital.

- Our data analysis of the rate of A&E attendances per 100,000 population aged 65+ who were referred by the GP without follow up showed that this was significantly lower in Oxfordshire than the England rate and had been consistently so for the past three years. Also the rate of A&E attendances from care homes per 100,000 population aged 65+ at 475 was lower than the comparator average of 878 and the England average of 979.

- Emergency admissions of older people were below the England and comparator averages. Analysis undertaken by the Department of Health showed that the rate of emergency admissions per 100,000 population aged 65 and over between March 2016 and February 2017 was lower than the national average at 22,112 in Oxfordshire compared to 24,092 across England.

- This hospital avoidance was also in part was due to initiatives such as the Emergency

Multi-Disciplinary Units (EMUs), H@H, ambulatory units and the Rapid Access Care Unit (RACU), which provided rapid support to people at risk of deterioration in their own homes to prevent avoidable admission to hospital.
    - The EMUs provided a 'one stop shop' seven days a week for patients with urgent sub-acute health and social care needs to avoid an acute admission.
    - H@H provided by OHFT aimed to improve the healthcare of patients registered with an Oxfordshire GP within the patient's own home to provide a community sub-acute alternative to non-elective acute admission.
    - The RACU and ambulatory services provided an integrated, multidisciplinary care to sub acutely ill patients.
    - The H@H team worked closely with the ambulatory units to support the safe transfer of care to the person's own home and avoidance of hospital admission.

- We found some good work in place around admission avoidance but some projects were being developed in silos rather than strategically across the system detracting from the effectiveness of services. There was an urgent need to review all services offered and arrive at a coordinated strategy for service design, delivery and outcomes.

- A Practice Care Navigator role was used to signpost people to services. This had been piloted and rolled out successfully as an effective way to improve, protect and maintain the health of older people and vulnerable patients through integration of care. People using services and multidisciplinary professionals offered positive feedback about this service as well as the community services.

- SCAS offers an accessible community-based First Aid Unit to people in the Chipping Norton area. There are similar units run by OHFT in Wallingford and Henley. These services signposted people to available services or advice. SCAS has also set up with OUHFT a service where gerontologists who were able to give advice to nurses and GPs supporting people in nursing homes.

- The Integrated Liaison Team facilitated person centred care in people's own homes. Care was delivered according to people's needs rather than them having to 'fit' to the services available. People using services provided positive feedback about this service. There was evidence to demonstrate that this team worked in a multidisciplinary way with other professionals to keep people at home wherever possible.

- Case files we reviewed demonstrated these services were effective and admission avoidance had taken place where possible by use of these services. GPs felt these services were useful for patients who would otherwise be admitted to hospital and frontline staff and system leaders spoke positively of these initiatives and felt the ambulatory care was a flag ship service.

- GPs felt that the care and support provided to people living with dementia was very positive. The Age UK website signposted people towards relevant information and identified service availability. The BCF outlined how the system intended to continue to build capacity for GP diagnosis and management of dementia, raising GP awareness of post-diagnostic support services, establishing strong links between primary and secondary care and developing a model of specialist nurse support in the community.

- Availability of ambulance transport impacted on the ability to discharge people in a timely fashion. Frontline staff told us transport arrangements were often a problem which meant people could not benefit from ambulatory care due to their discharge being delayed. This on occasion also resulted in staff having to wait with patients to return home after the service had closed.

Do services work together to manage people effectively at a time of crisis?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: crisis management

Are services in Oxfordshire safe?

Although there was a shared view of risk taking which was monitored closely, the escalation processes in the acute setting had to be used frequently. The handover times for ambulances in the A&E department impacted on the ability to respond to emergency calls. People were not always seen in a timely way once they had entered the A&E department, which meant longer waits for treatment.

- There was a system-level escalation procedure to manage risks to service delivery; the Operational Pressure Escalation Levels (OPEL) framework. This enabled a shared view of risks to deliver services to people in crisis and was monitored closely. Dashboards regarding flow, safeguarding and incidents were provided daily to system leaders and frontline staff who told us these helped with managing escalation and staffing. However frontline staff in the acute setting told us they had to use escalation procedures frequently due to system pressures.

- During November and December 2017 Oxfordshire was at level three OPEL escalation status for 47 of the 61 days (77%). Level three OPEL status indicates that the system is 'experiencing major pressures comprising patient flow and continues to increase and that further actions are required across the system by all A&E Delivery Board Partners.'

- During the same period the system was at level four OPEL status for 2 days (3%). Lever

four OPEL status is the highest escalation level and indicates that there is 'pressure in the system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety'.

- There were also significant handover delays at OUHFT and OHFT. Data provided from SCAS for November 2017 showed that in 1080 out of 3119 cases the 15 minute handover time had not been met, representing 34.6% of the total. This impacted on the ambulance turnaround time and the ability to respond to further emergency calls. Furthermore the A&E four hour target was also increasingly being breached. Our data analysis showed that the percentage of patients seen within four hours in Oxfordshire was 86.1% in 2016/17 compared to the England average of 89.1% and the standard target of 95%, and performance had been declining over the previous two years resulting in longer waits for patients to be assessed.

- Some staff we spoke with accepted escalation and sub optimal performance as being inevitable in a pressured system.

- Senior leaders within the acute setting had begun to look at patient flow in the context of providing assurance that internal resources were being effectively maximised during periods of escalation and pressure, however at the time of our review this work had yet to be evaluated and its impact was unknown.

Are services in Oxfordshire effective?

When a person was in crisis and transferred to hospital, systems and processes were in place to prevent unnecessary admission and long lengths of stay. There were multiple pathways at the point of crisis. The introduction and investment in these pathways was helping to prevent admissions to hospital but work was required to increase staff understanding and confidence in the capabilities of different services to ensure the whole system was working effectively during surges of demand.

There were known environmental issues which had an impacted on patient flow once in the A&E department at the John Radcliffe Hospital. The lack of digital interoperability sometimes impacted on information sharing and communication.

- Although there were complex and multiple pathways when someone experienced a crisis, there were effective admission avoidance systems in place, such as the Urgent Care Centres and Minor Injuries units triaging process.

- The Thames Valley Integrated Urgent Care Service (TVIUC) was launched in September

2017. System leaders told us the recent introduction of 'Enhanced 111', presented further opportunity for collaboration between 111, OUHFT and OHFT clinicians, delivering best patient outcomes, operational performance and value. Ambulance staff told us this had seen a reduction in referrals from 999 to 111 but it was too early to provide an in depth update of the effectiveness of this service. In July 2017 SCAS's percentage of 999 calls resolved with telephone advice was 13% and the percentage of patients seen by crew without transferring to hospital was 41%, both of which were above the England average.

- Admission avoidance services had been invested in such as the ambulatory assessment unit. Frontline staff told us that if a patient needed more support and rapid diagnostics, a referral to the Emergency Admissions Unit (EAU) or EMU could also be made with the intention that the patient would be treated within a day and returned home. However, bed occupancy for Oxfordshire was often at or above the England average level throughout 2016/17 and was at 90% in the first quarter of 2017/18.

- Our analysis of HES data showed that Oxfordshire had a good performance in regards to length of stay. The Department of Health's analysis of data between March 2016 and February 2017 showed that 90% of older people admitted as emergencies in Oxfordshire were discharged within 18 days, which was below the length of stay of any of its comparator areas and in each quarter of 20161/7 the percentage of emergency admissions of older people that lasted longer than seven days was significantly lower than the national average (25% in the last quarter of 2016/17 compared to comparator average of 33% and England average of 32%). If older people were admitted to hospital from a care home, they were also likely to have shorter lengths of stays than comparator areas or the England average with 28% of emergency admissions lasting longer than 7 days in the last quarter of 2016/17 compared to the comparator average of 37% and the England average of 36%. This meant that when people were in hospital, most were only in for short periods of time.

- Due to physical space and capacity issues, there were plans to make alterations to the environment at the OUHFT John Radcliffe A&E department. The current environment did not aid flow which resulted in overcrowding in the unit. SCAS told us they experienced frequent problems with capacity as it was not uncommon for multiple ambulances to arrive at the same time. During our visit to this unit we saw people who had been brought to the department by ambulance waiting to be moved to an appropriate space in the department.

- Services designed to improve flow through the health and social care system were evidence based. However, there were multiple pathways and access points, provided by different staffing groups. Frontline staff reported multiple confusing access points into the system and told us that which one they would use depended on individuals' knowledge of the options. This could mean that people do not receive individualised care, and could also mean more people are sent to A&E.

- Frontline acute staff felt the pathways and access points were clear, whereas some system leaders acknowledged getting specialist support such as general medicines was more difficult. If further treatment was necessary, there continued to be multiple pathways, such as the EAU, EMU and the RACU, hospital wards or transportation home with a care package. Therefore there is a need to ensure that these pathways and access routes are well defined and communicated across the system.

- OHFT trust figures between April and October 2017 demonstrated the effectiveness of the EMU units. For example, during October 2017 690 patients out of 729 required no further treatment. Data provided from the system also demonstrated the effectiveness of the EAU for those requiring medical care; on average only 60% of the people seen in EAU were subsequently admitted to a hospital ward. The Ambulatory Assessment Unit pathway enabled multidisciplinary professionals to seek clinical advice and avoid using A&E when this wasn't needed. Frontline staff confirmed the effectiveness of these services in reducing hospital admissions. The co-location of a social worker supported decision making with non-medical issues in these departments, and GPs were also working in ambulatory care, which the GP Federation and LMC described as having a positive impact.

- If admission to hospital was not necessary people may have been sent home with additional support from the acute H@H or HART. There were missed opportunities to streamline these services as staff told us that there were three hospital at home teams and these services sometimes overlapped and duplicate calls were a problem. We saw within one case file we reviewed that at the point of crisis this system had been utilised effectively and they had been supported by the hospital at home team and a relevant care package to prevent admission to hospital. Staff also felt that inappropriate referrals were sometimes made to the HART service and the criteria were circumvented. Figures provided by system leaders at the time of our review showed that the presenting needs of people using this service remained high with 43% of hours spent on complex cases and the average hours for completed packages remaining above the expected levels.

- There was some interoperability between health and social care to allow staff to share information across the system. However concerns had been expressed by some frontline staff about accessibility to these at the point of crisis. There were a number of meetings which enabled effective communication and information sharing at strategic and operational levels. However, some social care staff reported ineffective communication when people were admitted to or discharged from hospital. For example social care providers not being informed when someone was being discharged from hospital, or not receiving essential information at the point of discharge.

Are services in Oxfordshire caring?

Frontline staff understood the importance of involving people and their families in decisions about their care. People's experiences at the time of crisis did not always promote their health and wellbeing or protect their privacy and dignity. Carers faced additional challenges and required more support at the time of crisis.

- System-wide initiatives including a 'knowing me' passport across OUHFT and OHFT were completed for all patients with dementia and remained with the patient on discharge. Our review of case files while in the acute setting showed holistic assessments of people's needs and multidisciplinary input. There were examples of carers and relatives being involved in decision making at the time of crisis and that their views and opinions were taken into account in respect of any decisions made. This ensured that the person's best interests were established and the best outcome for the person achieved with minimal distress. However, people were undergoing multiple assessments which resulted in them telling their story more than once.

- Some people's experiences at the time of crisis did not always promote their health and wellbeing, for example, we saw instances where people's privacy and dignity were compromised in the A&E department at John Radcliffe Hospital; and one person told us that although they had been seen in A&E quite quickly, they had to wait a long while for their subsequent operation. A case file pathway tracked, showed a patient had a positive, patient centred episode of intervention when admitted to hospital but, they had a 15 day delay in hospital due to waiting for HART services.

- Carers were not always fully supported at the time of crisis. Although there was a five day emergency service they could access, carers told us this did not cover out of hours and this could result in challenges for them. Nevertheless positive feedback was received about this service.

- Carers of people who were funding their own care also faced challenges at the time of crisis in securing respite services. They told us there was a lack of support from the local authority in respect of navigating the system. System leaders advised that information was on the Live Oxfordshire website for people to access should this be required.

Are services in Oxfordshire responsive?

People living in Oxfordshire did not always receive the right services during times of crisis due to the multiple confusing access points. Triaging took place on arrival to A&E and there were some responsive community-based services, which people were referred to if required such as EAU, RACU and the ambulatory services which reduced some of the pressures on the hospital. However at times, people stayed on EAU for longer periods than expected and transfers to appropriate wards were delayed.

- System leaders and front line staff shared a vision of moving from bed based care to alternative models. There were systems in place to support this and prevent people being admitted to hospital at a time of crisis. For example, the H@H team could provide intravenous support at home and the SPA and the Integrated Locality Team could also help avoid admission to hospital. There was feedback from frontline staff that the SPA was dealing with calls in a timely way and making the necessary referrals to other services. Also the enhanced 111 service had employed more GPs and mental health care staff, along with pharmacists in the call centres to ensure correct streaming and advice was given.

- However due to multiple pathways at the time of crisis there were mixed views about how to access and navigate the admission pathways and the impact this had on patients, especially when someone required specialist care. The case notes we reviewed confirmed the multiple pathways and the impact these had on the patient.

- Nevertheless on arrival to A&E there were effective triaging systems and a frailty service to ensure appropriate support was sourced. The therapy team based at the John Radcliffe Hospital A&E worked with other multidisciplinary professionals to avoid admission wherever possible and accessed community beds if appropriate. Also at Horton General Hospital a coordinator managed and had oversight of the unit and the A&E nurse lead told us the impact of this was that assessments were rapid. The triaging practice at the John Radcliffe Hospital was due to change imminently and everyone arriving at the department would be triaged by a nurse who would signpost them to the different departments, such as minor injuries, Ambulatory Assessment Unit and GP streaming.

- We found when visiting the John Radcliffe Hospital that some people were staying in EAU for longer than the expected timeframe and there was a delay in transferring them to the relevant ward. While there was a reason for this in some cases, staff told us that sometimes people stayed longer if they felt they could discharge them home after the key performance indicator time rather than admitting them to a ward. We also found that people were sometimes supported at the end of their life on this unit. While in some cases this may not be avoidable, frontline staff and hospice staff based in EAU told us there were insufficient end of life beds in the community which resulted in people dying in hospital.

- System leaders told us they were investing resources in the ambulatory assessment units so they could stay open later and provide more capacity to move patients from A&E. System leaders must ensure when investing in this model that they consider the effectiveness of this service and to ensure this doesn't become another holding area.

- System leaders told us the local authority commissioned an urgent response service to provide social care for up to five days in emergency situations; including when a person

was at risk of hospital admission. In addition, the local authority contracted for a Telecare service for approximately 4000 service users; this also included an urgent response element.

Do services work together to effectively return people to their usual place of residence, or a new place that meets their needs?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: step down, return to usual place of residence and/ or admission to a new place of residence

Are services in Oxfordshire safe?

Some people had poor experiences on discharge home from hospital which impacted upon their health, safety and wellbeing. There were low levels of trust in discharge and medicine information due to widespread concerns in regard to its quality and timeliness.

- People did not always experience safe discharges home. People using services and social care providers raised concerns about people's experiences of discharge. We were told of examples of some people being discharged home late at night - between 02:00 and 03:00, which was unacceptable. Another person told us they were discharged home with a care package supposedly in place, only to find this was not the case when they arrived home and there was no one to provide the support they needed. They said eventually help arrived several days later but this had impacted on their confidence to be at home on their own.

- There were also widespread concerns regarding the quality and accuracy of discharge information, or about not getting any discharge data at all. This resulted in social care providers having to contact the hospital to gather more information and clarify if information was correct. Further concerns were also expressed about social workers providing information which was out of date, which provided an inaccurate picture of placement requirements. This sometimes resulted in a lack of risk sharing and responsibility and breakdown of care placements as people required more significant care than the service provider was led to believe. These findings were supported in the responses we received from registered managers of social care providers to our discharge information flow tool. Although we only received16 responses, just over half said they received discharge summaries on 50% or fewer of the occasions that people were discharged from hospital into their care, with registered managers of domiciliary care agencies in particular reporting that they rarely received discharge summaries.

- There were also concerns about medicine management and optimisation across the system with social care providers reporting concerns such as, lack of information, delays in

receiving medicines and prescription information detailed incorrectly. The medicine optimisation team also reported poor quality discharge letters from OHFT, and gave examples of when no indication had been given that medicines were being discontinued. This would impact upon medicines administered after discharge and could impact upon a person's health and wellbeing.

- Work had taken place in the acute setting with system leaders to facilitate more effective processes. Pharmacy leads told us that new processes were in place where the pharmacist drove the processes, drug-listing the discharge summary and preparing the prescription. Patients could only be discharged once the summary was checked by a doctor. They reported this had drastically reduced errors and also the time taken to process medicines for discharge had reduced by 90 minutes.

- While the length of stay was shorter, our analysis showed that emergency readmission rates for older people had been higher than comparator and national averages throughout 2016/17 and in the last quarter of the year, the percentage of older people in Oxfordshire requiring emergency readmission within 30 days of discharge from hospital was 19.5% compared to the England average of 18.6% and comparator average of 17.7%.

- Our analysis also shows that the percentage of older people receiving reablement services following discharge from hospital was lower than the England average in 2016/17 with Oxfordshire at 2.5% per 100,000 population and the England average of 2.7%. The percentage of older people receiving reablement following hospital discharge had reduced steadily over the previous five years from 4.4% in 2011/12. It also seemed the effectiveness of these services had declined; in 2016/17 79.8% of people over 65 were still at home 91 days after discharge from hospital to a reablement service, while this performance was in line with Oxfordshire's comparator group it was below the national average of 82.5%, and Oxfordshire's performance on this measure had worsened over the last two years.

Are services in Oxfordshire effective?

There had been considerable drive at a system level to address the issues of performance in relation to delayed transfers of care in the acute and community settings, but the number of delayed transfers of care remained high at the time of our review.

The workforce did not always collaborate and share information to meet the needs of the local population which led to inconsistency in starting the discharge process. Reablement services were usually achieving good outcomes for people although performance was declining. Although people's lengths of stay in hospital were shorter, readmissions to hospital were higher indicating that some discharges may have happened too soon and people experienced delayed transfers of care if they required longer term placements.

- Social care providers and frontline staff voiced concerns about the consistency in beginning the discharge process on admission and felt that the CHC assessments were a contributing factor to DTOC. Case files we reviewed demonstrated that the time discharge planning commenced was variable and the level of detail was inconsistent. We also found a case where a person was unable to be returned home as they were waiting for CHC funding, despite having undergone several assessments. The urgent care leads told us that although discharge information was discussed frequently it may not always be recorded and this was something they were looking to improve. They also told us that lengths of stay may vary on wards and there could be delays in discharge due to patient and family choice of available care packages.

- DTOC data we analysed covering February to April 2017 (the period of time used by the Department of Health in the DTOC analysis that was used to select areas for this review) did show that delays due to patient or family choice in Oxfordshire were higher than both the comparator (1.6) and national average (1.5) rates, accounting for an average daily rate of 2.9 delayed days per 100,000 population, although it was not one of the top three reasons for delays in Oxfordshire during this time period. Later analysis covering July to September 2017 showed that delays due to patient or family choice had increased in Oxfordshire to an average daily rate of 4.4 delayed days to be the third main reason for delays.

- Efforts had been made to improve system flow and reduce DTOC. For example, Oxfordshire System Flow Executive held weekly meetings to discuss issues with system flow, stranded patients, and lengths of stay and provided oversight of bed capacity. There were daily meetings to discuss transfers of care where ongoing support was required. The system was also trying to work more proactively with tertiary areas and there was to be a change in policy about managing these DTOC.

- However there were multiple out of hospital discharge pathways and our review of case files showed estimated discharge dates were not being discussed early enough and there was a lack of strategic oversight of the discharge process. The trusted assessor model, discharge coordinators and flow leads roles were not fully effective and people still experienced delays in their discharge, especially at weekends.

- Our analysis of DTOC between April 2015 and July 2017 showed that the rate of DTOC in Oxfordshire was consistently, and often significantly, higher than average. Delays reached their peak in June 2017 at an average daily rate of 39.9 delayed days per 100,000 population aged 18 and over (compared to national rate of 13.8) and while there had been a reduction to 34.7 delayed days in July 2017 (the most recent data analysed at the point of this review), this was still over double the comparator average of 16.1 and England average

of 13.5 delayed days. More recent DTOC analysis shows performance has continued to improve in Oxfordshire, with delays dropping substantially in August 2017 to an average daily rate of 26.3 delayed days and continuing at a much lower rate than in previous months, although still higher than national or comparator rates.

- System leaders were aware of the challenges the system faced. The CCG had undertaken site visits to OUHFT and Horton to assess the Safer, Faster, Better assurance and identify blocks in the system and in July 2017, pathway workshops were held. The System Flow Executive accepted the broad conclusions from the pathway workshops and authorised the development of a pathway programme on 4 August 2017; the programme was under development at the time of our review.

- The workforce did not always collaborate and share information to meet the needs of the local population which led to inconsistency in commencing the discharge process on admission and communication at the point of discharge. Social care providers and frontline staff expressed concerns and gave an example where a district nurse had not been informed of a medical need they needed to follow up and support the person with. This could have had serious consequences for the patient and resulted in readmission to the hospital.

- Systems leaders were aware that the HART needed further development and alignment and a recovery plan and mitigating actions had been discussed during recent A&E delivery board meetings. The HART staffing trajectory was not on track and there was a gap in the projection against what the service was able to deliver. The A&E delivery board performance dashboard showed that in September 2017, HART was performing consistently below the expected delivered hours which were 8440. In September 2017 HART achieved only 6848 hours. However delivered hours had increased in November 2017 to 7343 hours.

- A lack of digital interoperability did not support frontline staff to make timely decisions as IT systems were not compatible. Frontline staff told us the current IT systems were not fully effective in supporting communication and information sharing which impacted on the discharge process.

Are services in Oxfordshire caring?

People who use services, their families and carers were not involved early enough in the discharge process. People who were funding their own care experienced difficulties in accessing essential information and were therefore not always aware of what was available to them. While VCSE organisations were supporting people on discharge, more could be done if there were better links between the acute setting and the VCSE sector. Some people were not able to access hospices and as a result died in hospital rather than their place of choice.

- Our review of case files showed a person-centred approach was adopted and wherever possible people's preferences were documented and the right people were involved in conversations about their care. However, some records showed these discussions were not always started early enough and this had impacted upon their discharge and length of stay.

- People funding their own care faced barriers to accessing advice, information and guidance about services and costs and were not always at the centre of their care and support when moving through the health and social care system. Furthermore social care providers also told us there was a lack of support for financial assessments and costs of care were not always made clear.

- There were missed opportunities for the VCSE sector to be involved in the discharge process to make it more effective and person centred. The VCSE sector felt they could do more but there were barriers to them doing so due to insufficient links with acute hospital services.

- People at the end of their life who were admitted to hospital via A&E did not always experience a rapid transfer home or to a place of preference**.** Frontline staff we spoke with demonstrated compassion and a good understanding of support needed for people at the end of their life and stated there were good relationships with the local hospices and care homes. However they felt there was an insufficient number of hospice beds to transfer people to if this was their preference. This meant that people sometimes died in the EAU. Staff told us they did try to make this a peaceful and compassionate experience.

- Assessment and referral conversion rates for standard CHC assessments were above the England average in the first quarter of 2017/18 with Oxfordshire's conversion rate for assessments and referrals performing at 37% compared to the England average for assessments at of 31% and referrals at 25%. However the rate of assessment and referral conversion rates for Fast Track CHC (usually used for people at the end of their life) was lower, at 89%, than the England averages of 99% and 85% respectively, which may impact on the person being transfer to their preferred place to end their life.

Are services in Oxfordshire responsive?

There were multiple pathways to facilitate discharges from the acute setting and support people to remain as independent as possible. However, people experienced a high number of delayed transfers of care. Due to system challenges and conflicting information in regard to availability of care home packages in the community it was difficult to establish if there was sufficient capacity within the market to cope with the increase in demand. A higher number of CHC assessments were undertaken in an acute setting which could lead to delays and this needs addressing as a matter of urgency.

- The views of frontline staff in respect of CHC assessment varied; some felt the process worked well, whereas others felt this contributed to DTOC. Our analysis of NHS CHC activity in the first quarter of 2017/18 showed that 36% of decision support tools were completed in an acute setting in Oxfordshire compared to the England average of 27%. A higher percentage assessments being completed in acute settings can contribute to delays. Nevertheless, the rate of NHS CHC referrals exceeding 28 days was 5.87 per 50,000 compared to the England average of 10.27.

- There were discharge coordinators in post, a discharge assurance group, and daily multidisciplinary meetings to support patients to achieve rehabilitation goals. However, Oxfordshire had a long-term problem with DTOC. In 2016/17 over 51,000 beds days were lost to delays, which while a slight improvement on the previous year (59,000 bed days lost) meant that it still was the 4th highest rate in the country and nearly three times the national average. Our data analysis of DTOC per 100,000 population aged 18+ between February and April 2017 showed that the main responsible organisation for DTOC was the NHS, accounting for an average of 16.3 delayed days per 100,000 population aged 18+, while a further 13.1 delayed days were attributed to both the NHS and social care and 4.2 delayed days were attributed to just social care. By far, the main reason reported for delayed transfers of care in Oxfordshire over this time period was “awaiting care package in own home”, accounting for an average daily rate of 15.8 delayed days per 100,000 population aged 18+.

- System leaders felt there were not enough care packages, and dementia packages for those with moderate to high needs in social care settings and this lead to delays in transfers. Frontline staff were also of the same view and there was a consensus that there was a significant delay for people with complex or mental health care needs. There were also significant issues with care packages in the community and although there had been some reconfiguration of the commissioning of these, social care providers told us they had vacancies. This did not correlate with the data held by the system and therefore the delays could not be fully understood. Acute frontline staff also told us there were issues with care packages if they needed to start midweek.

- The Department of Health’s analysis of activity showed between October 2015 and September 2016 the proportion of older people discharged over the weekend in Oxfordshire was similar to its comparator areas at 20%. However, social care providers were less likely to accept discharges over the weekend, which meant this figure was unlikely to increase.

- Patient transport accessibility also impacted on people’s experiences and resulted in delayed transfers of care. A number of these issues were caused by the OUHFT and OHFT

discharging planning process as this caused an issue with the timeliness of discharge and use of resources. Although services such as the EMU were reducing the pressures on admissions to hospital, these services were short term and reactive and frontline staff told us this did not always work well as transport services required advanced booking. These delays meant that new patients could not be admitted to the service and could result in them being referred to emergency services.

- System leaders in the ambulance service stated there were challenges due to the number of unplanned discharges. Data supplied by SCAS showed that in October 2017, 28.6% of transfers were planned and 71.4% were short notice. When a 'breaking the cycle' week had been held from 6 to 12 November 2017 the figures were 29.5% planned and 70.5% short notice. The target for short notice discharges had recently been reduced to 30%, these figures corroborated that the majority of discharges were not planned in a timely manner. Also at times there was ineffective use of transport resources, for example, there had been occasions when the ambulance service arrived on the ward but OUHFT had also booked their own transport. Frontline staff at OUHFT advised this was to ensure the patient got transferred home; if there had been delays then they would also book their own transport , but this was unwarranted and an inefficient use of resources which added to the complications of the discharge system.

- System leaders told us there had been changes over the last 20 months as they were trying to move from bed based care. They had reduced bed base by 110 beds and invested in a range of ambulatory and home based services. This meant there were a variety of services available to support people to access reablement to help them to return home including step down, hub beds and the community reablement service, which followed a discharge to assess model. However people were getting stuck in reablement beds causing a holdup in the system. Frontline staff felt this was because these beds were used inappropriately which caused additional pressure and waiting lists in some areas. HART was commissioned to deliver a discharge to assess model. However, an increase in acuity and dependency had resulted in capacity issues due to increased episode hours. The system had put in place mitigating capacity in support of this and commissioners and providers were continuing to work jointly to address the acuity and dependency issue.

- The hospital at home teams for the north and south and the Acute Hospital at Home Team were in place to facilitate discharge. However these teams created some overlap in services and staff told us that sometimes more than one member of staff arrived from different teams to support the person. Also due to insufficient packages of care in the community, people could be using this service for months and staff within this team felt that the main reason for DTOC was waiting for care packages.

- Community rehabilitation pathway 'virtual beds' were being trialled on community hospital

wards to support early discharges. This enabled the person to go home with support from the multidisciplinary team while their bed remained open. This meant if the person was unable to manage at home they still had a rehabilitation bed to come back to if needed. During our visit we observed a multidisciplinary meeting where these people were discussed to ensure their needs were being met in the community or if they needed to return to the unit.

Maturity of the system

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

- There was a lack of whole system strategic planning and commissioning with little collaboration or a shared compelling vision for the design and delivery of services.
- Some strategies were not regularly refreshed and updated according to people's needs.
- We found that services for older people in Oxfordshire had operated for two years without a clear and current strategy. It was not evident that identified priorities from the JSNA were aligned with the STP and BCF priorities. The system had recognised this was a shortfall and were attempting to address this through the transformation plans and the refresh and refocus of the HWB.
- There were some positive examples of relational working and collaboration in the interests of the population's defined needs. However, overarching strategies had yet to be defined and co-production with the local population remained an area requiring further development.
- There was limited evidence of system-wide multidisciplinary team working for effective outcomes. There was some work in place regarding discharge from hospital and the community services, but there was little evidence of pathways across primary, community and secondary care that supported the wider objectives of health and wellbeing maintenance.
- A large proportion of decision making still sat separately within individual organisations but there was evidence of system wide approaches in respect of managing particular issues and challenges such as DTOC. In these instances there were shared metrics and systems for the oversight of performance and delivery.
- Historically relationships between leaders across the system had been poor, with a high

level of mistrust. Although these were developing positively the relational audit demonstrated that work was still needed to engage and include system partners, frontline staff and other key stakeholders.

- There had recently been changes in leadership in several organisations within Oxfordshire and this had encouraged an increased willingness to build trust and to work collaboratively going forward.

- The Oxfordshire Transformation Board had supported a joint approach in managing the local care market and commissioning services. The Transformation Board was seen to be providing a positive platform to support operational integration however; there was little evidence that a wider approach to full integration was planned.

- Oxfordshire was particularly challenged by workforce issues across the system. There were strategic plans at organisational levels and STP level to align the workforce to future demand and work had taken place with an agreement to trial a combined recruitment campaign and to develop a single recruitment pathway. However recruitment challenges continued to have an impact on the care market. There were challenges in recruiting staff in a number of key service areas with the high cost of housing and accommodation cited as a barrier to staff retention and recruitment.

- Strategic effort was required to provide more affordable housing at pace to support the supply and maintenance of a sustainable workforce.

- System leaders acknowledged that incompatible information sharing systems were a barrier to seamless working across agencies and were committed to providing integrated care records by way of digital interfaces.

- Both OUHFT and OHFT had been awarded Global Digital Exemplar status under the national NHS programme and consequently were well-positioned to enable this integration. Further developments were planned as part of the Oxfordshire Local Digital Roadmap.

Areas for improvement

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

Strategic priorities

- System leaders must improve how they work together to plan and deliver health and social care services for older people in Oxfordshire. While doing so a review of people's experiences must take place to target improvements needed to the delivery of health and social care services, bringing people back to the forefront of service delivery.

- System leaders must address and create the required culture to support service interagency collaboration and service integration.

- The older people's strategy must be reviewed and the results implemented into an updated Joint Strategic Needs Assessment. As part of the older people's strategy, the draft frailty pathway should be implemented and evaluated to include those underrepresented in society.

- System leaders should undertake more evaluation of the actions taken by teams and individuals during times of escalation and learning should be shared with system partners to encourage learning and continuous improvement.

- System leaders must evaluate their winter plans and pressures throughout the year to ensure lessons learned are applied when planning for increased periods of demand.

- System leaders should review and strengthen the approach to managing the care market so that providers are aware of future requirements, particularly in respect of domiciliary care, end of life care and care for people living with complex mental health issues. A proactive approach to market management is required to ensure a sustainable care market.

- System leaders must implement the STP's joint workforce strategy and work with the full range of care providers to support a competent, capable and sustainable workforce.

Operational priorities

- System leaders must review how people flow through the health and social care system including a review of pathways so that there are not multiple and confusing points of access. Pathways should be well defined, communicated and understood across the system.

- System leaders should ensure that housing support services are included within

multidisciplinary working, especially in relation to admission to and discharge from hospital, to enable early identification of need and referrals.

- System leaders should conduct a review of commissioned services to consider design, delivery and outcomes, to improve the effectiveness of social care assessments and reduce and avoid duplication. On completion, the criteria for each service should be circulated to system partners and social care providers to ensure resources are used effectively.

- System leaders should review methods used to identify carers eligible for support so that they are assured that carers are receiving the necessary support and have access to services.

- System leaders should ensure that better advice, information and guidance is offered to people funding their own care.

- Continue to embed the trusted assessor model.

Engagement priorities

- System leaders must continue to engage with people who use services, families and carers when reviewing strategies and integrated systems and structures to ensure these are co-produced.

- Engagement and partnership working with the VCSE sector should be reviewed to improve utilisation.