Care Quality Commission

Bracknell Forest

Local system review report
Health and Wellbeing Board

Date of review:
4-8 September 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 was 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 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 will bring together key findings from across the 20 local system reviews.

The review team

Our review team was led by:
Delivery lead: Ann Ford, CQC
Lead reviewer: Julia Daunt, CQC

The team also included:
- One CQC reviewer
- Two CQC strategy leads
- One CQC analyst
- Three specialist advisors (with backgrounds in older people, primary care, and adult social care)
- Two Experts by Experience

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 delayed transfers of care from acute hospital settings.

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

1. Maintaining the wellbeing of a person in 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 have asked the questions:

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

We have 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 those who use services, their families and carers. The people we spoke with included:

- Senior leaders from across the health and social care system, including housing and public health
- Health and social care providers and commissioners
- Front line staff from acute, primary and community care providers including therapy specialists, bed managers, discharge teams, nurses and GPs
- Voluntary and community (VCS) sector representatives, Healthwatch Bracknell Forest, people who use services, their carers and people who are close to them

We also met people using services in the emergency departments and the discharge lounges of Frimley Park Hospital and the Royal Berkshire Hospital.

We tracked the journey of five people through the health and social care pathway by looking at their care and treatment records and we visited eight services in the local area including the out-of-hours GP service, an urgent care centre, a nursing home, a domiciliary care agency and a GP practice.

The Bracknell Forest context

Demographics
- 12% of the population is aged 65 or over
- 91% of the population identifies as white
- Bracknell Forest is in the least deprived 20% of local authorities in England

Adult Social Care
- 12 active residential care homes:
  - One rated outstanding
  - Eight rated good
  - Three currently unrated
- Three active nursing care homes:
  - one rated outstanding
  - two rated good
- 17 active domiciliary care agencies:
  - 12 rated good
  - one rated inadequate
  - four currently unrated

GP Practices
- 16 active locations
  - 15 rated good
  - one rated requires improvement

Acute and community healthcare
Most hospital admissions (elective and non-elective) of people living in Bracknell Forest are to Frimley Health NHS Foundation Trust:
- Receives 80% of admissions of people living in Bracknell Forest
- Admissions from Bracknell Forest make up 11% of the trust's total admission activity
- Currently rated outstanding overall

The second main trust used by people living in Bracknell Forest is Royal Berkshire NHS Foundation Trust:
- Receives 11% of admissions of people living in Bracknell Forest
- Admissions from Bracknell Forest make up 5% of the trust's total admission activity
- Currently rated requires improvement overall

Community services are provided by:
- Berkshire Healthcare NHS Foundation Trust - currently rated good overall
- The trust is also the main provider of mental health services for Bracknell Forest

All location ratings as at 29/09/2017. Admissions percentages from 2015/16 Hospital Episode Statistics.
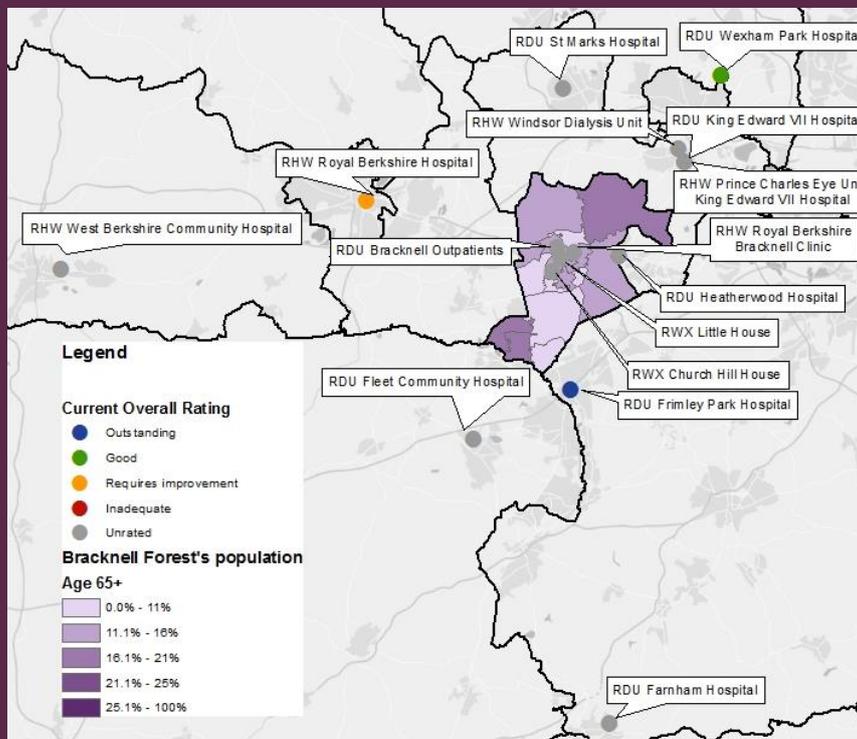
Map 1: Population of Bracknell Forest shaded by proportion aged 65+ and location and current rating of acute and community NHS healthcare organisations serving Bracknell Forest.
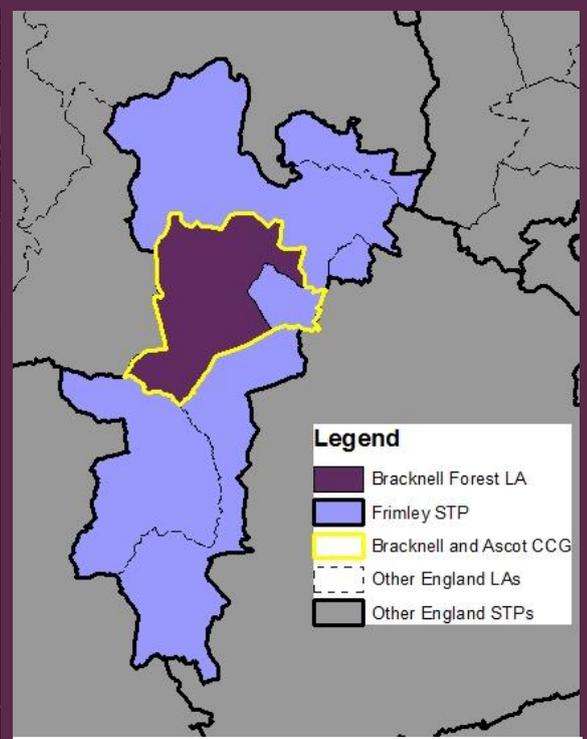
Map 2: Location of Bracknell Forest LA within Frimley STP. Bracknell and Ascot CCG is also highlighted.

Summary of findings

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

- There was a system-wide commitment to serve the people of Bracknell Forest well. There was a shared understanding across system partners of the challenges the system faced, and a willingness to work together to achieve solutions.

- Bracknell Forest was part of an agreed accountable care system (ACS) centred on the Frimley Health and Care Partnership and led by the Chief Executive Officer (CEO) of Frimley Health NHS Foundation Trust (FHFT). There was vertical and horizontal alignment of a system wide vision that was centred on the Sustainability and Transformation Partnership (STP) plans and the Better Care Fund (BCF) plans. The STP was recognised as a driving force for culture change across the system and instrumental in supporting integrated working.

- All staff within the system, from front line staff to the leadership teams, demonstrated knowledge of STP plans and voiced their commitment to its aims.

- The Health and Wellbeing Board (HWB) was well established, mature and functioned effectively by monitoring planning, delivery and outcomes for local people. The HWB was made up of representatives from across the system including the acute, community and voluntary sector. There were clear lines of responsibility and accountability.

- It was evident from our review that partners across the system were responsive to each other's challenges, while ensuring that responsibilities relating to their own organisations were not compromised by joint working.

- Aligned with the Bracknell Forest health and wellbeing strategy, there were joint strategic priorities in place. These focused on providing older people with preventative services and support to stay well, and on enhancing the capacity in the domiciliary and care home sectors to manage the current and projected shortfalls in these services.

Is there a clear framework for interagency collaboration?
- The Joint Strategic Needs Assessment (JSNA) was robust, well considered and underpinned by clear delivery plans and outcomes. All partners were sighted on what was important to older people, their families and carers when moving through the interface of health and social care.

- Governance arrangements, as set out in the BCF plan, included community, professional and clinical leadership and were collaborative with decisions made at local level. The BCF board had oversight on the alignment of the various strategies, including the joint commissioning strategy for intermediate care, joint commissioning strategy for people in an unpaid caring role, and the commissioning strategy for older people, together with the pooled budget and associated risks.

- The BCF plan built on a history of successful integration between Bracknell Forest Council (the

local authority) and Bracknell and Ascot Clinical Commissioning Group (the CCG). Intermediate care and reablement services were jointly funded through a Section 75 pooled budget agreement and had run in partnership between the local authority and the NHS for ten years. This integrated service was hosted by Bracknell Forest Council with Berkshire Healthcare NHS Foundation Trust providing supplementary community nursing and therapy.

- There were positive examples of shared approaches and initiatives that supported local people to have timely access to services and support that met their needs in a person-centred way.

- There was evidence of effective risk sharing across partners. For example, there were plans for the local authority to administer personal health budgets on behalf of the CCG. A shadow control budget was also in place.

- The system was willing to take collective risks to transform the provider market to meet the needs of the local population. For example, the local authority was using outcomes-based contracts that incentivised new domiciliary care providers to put reablement at the centre of their activities, and in turn challenge local people to rethink how care at home could be used.

How are interagency processes delivered?
- Partnership working across the system was supported through a range of joint partnership boards. Boards were well attended and encompassed a comprehensive range of stakeholders including housing, voluntary services and the out-of-hours (OOH) service. Key issues were discussed and actions agreed, implemented and performance monitored.

- A programme delivery board had been established to monitor and support STP delivery and progress which reported to the Frimley STP Board.

- As part of the STP, integrated decision-making hubs were being developed to support people who were frail or had complex needs through advance care planning and social prescribing to promote independence, wellbeing and social inclusion.

- Winter plans covering the resilience arrangements across the system had been formalised and agreed. While the CCG led on the plans, we found that all system partners including frontline staff across primary and secondary care were aware of the plans and had contributed to the planning processes.

What are the experiences of front line staff?
- Staff benefitted from strong visible leadership and clear direction. We found that a collaborative multi-agency approach was already embedded.

- Feedback from front line staff was, in the main, very positive. Staff felt that leaders were responsive and inclusive. Staff generally communicated well across agencies. However, some social care staff reported that they were not always kept informed when people in their care had been admitted to hospital.

- Workforce issues were identified across the whole health and social care system, and particularly in the recruitment and retention of carers that provided care to people in their own homes. There were comprehensive system-led plans in place to mitigate risks associated with these issues; however most of these had not been implemented at the time of the review and we were therefore unable to assess their impact. The plans in place to support the up-skilling of staff and the development of cross-boundary roles were welcomed by the staff we spoke with.

- Staff told us that there was an opportunity for improving the care and support to people with moderate to severe dementia within acute hospital settings.

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

- Local people benefitted from access to direct payments. We heard positive feedback from people and their carers about how this enabled them to have control over their care, and be more involved in their care planning.

- There was an agreement between the local authority and the CCG for the local authority to procure continuing healthcare (CHC). NHS and the Emergency Duty Service (EDS) CHC quarterly figures for April to June (Q1) 2017 showed that the CCG had a standard NHS CHC assessment conversion rate for all adults (percentage of newly eligible cases of total assessments) of 50%. This was high compared to the England average (31%) and the South Central regional average (35%).

- We found a multidisciplinary, integrated approach to delivering a number of key services including the assessment and discharge team who were proactive and solution-focused. The EDS was well integrated and worked well with the integrated intermediate care team. All these services were having a positive effect on reducing delayed transfers of care (DTOC). Our analysis showed that Bracknell Forest had an average of 14.5 daily delayed days in July 2017 compared with a peak of 22.5 daily delayed days in March 2017. Local system leaders were confident that this level of performance could be further improved.

- However, in both acute hospitals there were some issues around the timely provision of hospital transport and medicines and these were contributing to delayed transfers of care and a poor experience for some people.

- People who used services, their families and carers were engaged in developing and improving the health and social care interface. There was regular engagement and co-production with older people via a range of panels and groups.

- There was scope to increase the effectiveness of local engagement by working better with Healthwatch Bracknell Forest.

Are services in Bracknell Forest 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, multi-agency and multi-disciplinary working and the involvement of people who use services, their families and carers.

There was a collaborative leadership approach across all system partners with a coherent vision and strategy that could be articulated by people across the system. Public engagement and partnership working could be further improved, but there was a clear sense of shared endeavour. This was supported by the alignment of Bracknell Forest's BCF plans and the wider STP plans.

Strategy, vision and partnership working
- The health and wellbeing strategy, *Seamless Health 2016-2020*, was supported by an up to date JSNA and focused on providing joined up health and social care services to keep people well and to reduce the confusing multiple points of entry into the system when people become unwell.

- The local authority and CCG delivery plans and transformation programme were in alignment with the STP, BCF plans, and the health and wellbeing strategy. There was vertical and horizontal alignment of strategy and vision, centred on the STP. All staff working in the system, from front line staff to the leadership teams, demonstrated knowledge of STP plans and voiced their commitment to its aims.

- The STP was recognised as a driving force for cultural change across the system, supporting more integrated working.

- There was an effective multidisciplinary approach to delivering services. For example, the Frimley Park Hospital assessment and discharge team worked well with the local authority social care team.

- The CQC relational audit, completed by 18 people across the system, found that overall relationships were positive. While the number of respondents was small, the findings of the audit were corroborated during our review visit, where cross agency relationships were described positively.

- Partnership working across the system was supported through governance, where there was involvement and representation of a wide membership on a variety of partnership boards, for example housing, voluntary services and the out-of-hours (OOH) service.

- Front line interagency and multidisciplinary teams were supporting people to move through the health and social care system smoothly and seamlessly; evidence that joint working at leadership level was effective. For example, the local authority hosted a hospital equipment site on behalf of three councils, enabling people to gain access to equipment that supported timely discharge from hospital.

- There was a joined up approach to winter planning, using lessons learnt to inform this year's plan. Two-day workshops were held annually, where discussions took place between primary and secondary care and the CCGs based on the previous winter's outcomes.

- Partnership working could be further improved by ensuring all partners were kept informed and able to influence the strategic direction and share associated risks. Adult social care providers felt underrepresented at some forums. One of the acute trusts serving the area was unaware of the local authority's plans for reducing the number of domiciliary care agency providers and subsequent re-tendering of contracts and therefore was not prepared for the increased delayed discharges that took place in March 2017.

- The voluntary and community sector played a prominent role in supporting health and social care in Bracknell Forest and saw themselves as service partners. Although they felt they were currently engaged and included, they were also keen to ensure that the sector was fully utilised as part of future planning.

Involving people who use services, their families and carers in the strategic approach to managing quality at the interface of health and social care
- There was evidence that people who used services, their families and carers were engaged by partners in developing and improving the health and social care interface:
  - There was regular engagement and co-production with older people via a range of panels and groups, for example the Dementia Action Alliance, which included people with dementia;
  - There were examples of where engagement had informed service specifications. For example, the CCG commissioned a programme of stakeholder engagement to co-design the GP extended hours services, with service users defining key outcomes and priorities for the service;
  - A programme of engagement also informed the specification of the new domiciliary care contract.

- However, feedback from providers and Healthwatch Bracknell Forest indicated that engagement could be improved by ensuring their timely and consistent involvement in key meetings and by focusing on widening participation to a more diverse representation of residents.

- The Chief Executive of the local authority told us that the council received twenty times more compliments about services, than complaints. The 2015/16 ASCOF measure of 'Overall satisfaction of people using adult social care services with their care and support' showed that 69.5% of respondents in Bracknell Forest who were aged 65+ were satisfied with their care and support, higher than the national average of 61.7%.

Sharing learning and improvement across the system
- Learning and improvement took place and was shared across the system. For example, there was a clinical concerns system in place that enabled issues to be raised by GPs to the quality team at the CCG. Concerns were collated and common themes identified which resulted in shared actions and learning across wider partner organisations including though quality forums in the secondary

sector. There were plans to adopt this system in secondary care to feedback concerns to primary care partners.

- Best practice ideas were sought and implemented from elsewhere. For example, Frimley Park Hospital staff visits to other trusts resulted in the development of a frail elderly pathway involving rapid assessment in A&E and treatment within 48 hours.

- There was a longstanding GP council in place where GPs, practice staff and social workers came together to discuss concerns and share learning.

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

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

There was effective board leadership and information sharing so that senior teams were held to account for the delivery of their strategies and the management of risk to quality service delivery. Strong relationships supported the effective interface between systems.

Overarching governance arrangements

- There were local governance arrangements agreed by all partners through the HWB with clear lines of accountability. Partners across the system recognised their own duties and accountabilities to their own organisations, and ensured that these were not compromised through joint working.

- The governance arrangements, as set out in the BCF plan, included community, professional and clinical leadership and were collaborative with decisions made at local level. The BCF board had oversight of the alignment of the various strategies, including the joint commissioning strategy for intermediate care and the joint commissioning strategy for people in an unpaid caring role, together with the pooled budget and associated risks. The BCF steering group led the delivery of the strategies; and held the lead groups for each of the initiatives to account. The HWB chair stated that the board had oversight of the BCF plan and had a role in holding the organisations to account if targets were not being met. This was corroborated with the HWB vice chair and reiterated through the observed BCF steering group.

- Winter plans covering resilience arrangements across the system had been approved by NHS England. While the CCG led on the plan, we found that all system partners, including frontline staff across primary and secondary care, were aware of the plans and felt they had contributed to the planning. There was on-going scrutiny and challenge from the HWB and monitoring of hospital length of stay fed into the board to further support their overview.

- Quality monitoring and evaluation of impact throughout the health and social care system was undertaken through several audit activities. For example an audit of the effectiveness of seven day services in March 2017 undertaken by FHFT produced comprehensive recommendations. This included ensuring all Friday ward rounds resulted in a weekend plan.

- The Bracknell Forest Safeguarding Adults Partnership Board worked within a newly-developed quality assurance framework. Alongside this, a safeguarding sub group utilised a self-assessment audit tool to monitor performance and provide assurance to the board. The discharge and assessment team were clear that Bracknell Forest local authority had the best safeguarding adult board. They stated that the chair of the board was inclusive and ensured any actions taken were fed back to the board.

Information governance
- Improved information sharing was under development in Bracknell Forest. In the 2016/17 BCF return the HWB confirmed it was working towards better data sharing between health and social care, based on NHS number. The Berkshire Connected Care programme had started to provide a system for sharing information across health and social care, allowing for instant access to patient and social care information and enabling people to access their own records.

- Frontline staff, particularly those working across the community, gave us very positive feedback about this system. Bracknell Forest was the first social care service within East Berkshire to take part in the Connected Care programme.

Risk sharing
- Commissioners and the vice chair of the HWB told us that there was a well-developed process of scrutiny and quality assurance around joint working. This was led by clinical representation on the BCF board and the care governance board.

- The BCF plans were facilitating elements of risk sharing between partner organisations. The BCF Programme Manager maintained a risk register and monitored and escalated risks to the BCF Programme Board and HWB for consideration and action. Identified risks included workforce development and increasing demand for services. The HWB received a quarterly report on budget spend. A monthly report was produced for the BCF steering group and the BCF board with a Red Amber Green (RAG) rating for risk.

- There was evidence of effective risk sharing across partners. For example, the local authority was planning to administer personal health budgets on behalf of the CCG. A joint agreement was in place across health and social care to buy a dual registered care facility called Heathlands. A shadow control budget was in place.

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

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.

Developing the capacity and capability of the health and care workforce was recognised as a key challenge for Bracknell Forest, posing a risk to the future delivery of plans. However, there was a comprehensive system-wide strategy in place, as part of the health and wellbeing strategy, BCF and STP, to ensure the system had sufficient numbers of a suitably skilled staff.

- The recruitment and retention of sufficient numbers of health and care staff was widely recognised as a challenge for the system. Bracknell Forest is an affluent area with low unemployment and high cost of living and providers faced increasing competition for staff following the recent regeneration of the town centre, which created thousands of new jobs locally. A shortage of suitably skilled social care staff, together with a lack of therapists (e.g. occupational therapists), was impacting on people's discharge from hospital where they required support in their own homes.

- Our analysis of Skills for Care workforce estimates showed that between 2014/15 and 2015/16 staff turnover rates in adult social care reduced significantly from 28.8% to 19.8% and the proportion of vacancies also fell significantly from 6.5% to 1.7%. However, this may be attributed to the 58% reduction shown in our analysis of nursing home beds between April 2015 and April 2017, as well as a 5% reduction in residential care home beds.

- Within the BCF plan and linked to the Bracknell Forest health and wellbeing strategy for 2016 to 2020 there was a comprehensive plan to address workforce issues which had been developed by system partners.

- The STP plans had a workforce work stream that was focused on recruitment and retention, training and development, and supporting new ways of working; for example developing passports so staff could work across health and care. The plans also included a pilot project to develop a new Nursing Associate role. Nursing Associates would be equipped with the knowledge, skills and behaviours that would enable them to support the delivery of nursing care in and across a wide range of health and care settings. There were also plans to work with local colleges to develop the future workforce.

- These plans were at an early stage at the point of the review and work streams needed to be developed further. There was evidence of joint working to address recruitment challenges including a recent joint recruitment fair for health and social care. There was also work being carried out in relation to developing an agreement with neighbouring boroughs around managing recruitment from the same small pool of potential staff. The local authority was also in early stage talks with FHFT around the recruitment and training of staff who had been made redundant in another service and allowing them to rotate into domiciliary care.

- Plans were in place to change ways of working by increasing integration and focus on reablement and outcome-based commissioning. There was positive feedback from staff about this new way of working and the opportunity it afforded them to gain enhanced skills.

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.

There was a whole system collaborative approach to commissioning in Bracknell Forest. Partners saw the provision of high quality commissioning for local people as an ongoing process, and placed a significant focus on setting up systems that enabled them to capture accurate and meaningful data on the needs of the people they served.

- The health and wellbeing strategy focused on joint working to provide people with a seamless service and value for money. There was a history of effective collaboration around integrated commissioning which was embedded into the system. There had been joint commissioning posts that focused on integration, in place for seven years. The intermediate care and reablement services had been jointly funded (via a section 75 agreement), and delivered for ten years. This integrated service was hosted by the local authority with Berkshire Healthcare NHS Foundation Trust (BHFT) providing supplementary community nursing and therapy. This fully integrated team worked closely with the three acute hospitals used by Bracknell Forest residents.

- The BCF and STP plans demonstrated a focus on joint planning and working to commission services for people who move through the health and social care interface. The BCF plan set out the large number of joint commissioning strategies. Many of these strategies had been updated since the original BCF submission, following consultation with stakeholders, people who use the services and people working in health and social care. This included supporting people in an unpaid caring role, intermediate care and the strategy for dementia.

- There was a will to expand joint commissioning. However, commissioners were clear that identifying commissioning gaps would be an ongoing process and this would be supported by the development of a digital platform and by the data gathered from direct payment assessments.

- The voluntary sector was commissioned to provide support across the system, for example a BCF funded British Red Cross "Home from Hospital" service, operated from Frimley Park Hospital seven days a week. This service provided low level support, such as shopping and collecting prescriptions for people, for up to six weeks after hospital discharge. The team was co-located with the adult social care and hospital in-reach nursing, supporting an integrated approach with the wider hospital discharge team.

- The local authority had set out their future ambition to end grant funding to the voluntary and community sector (VCS) and develop the capacity and sustainability of the market through a digital platform. The digital platform would be used to generate data on unmet need in the community which could then be used by the VCS to develop services. The digital platform would also enable individuals with similar needs to pool direct payments and buy services collectively. However,

voluntary sector representatives expressed some concern that the plans to remove grant funding from local voluntary groups and ask people instead to use their direct payments to pay for services could mean people would be less willing to use them.

- There was an aspiration to move from commissioning criteria-based services to commissioning needs-based services and commissioners encouraging their community teams to think about how to meet people's needs using a whole system approach. This was also reflected in the focus groups held with frontline staff. For example, we were told about a bariatric patient that needed to be seen at a leg ulcer clinic; staff worked with other system partners such as South Central Ambulance Service (SCAS) to find the best way of achieving it.

- The CCG were clear that they needed to improve how they worked with acute services for the support of people with dementia and would benefit from strengthening the relationship with the adult mental health team. The Carers Forum also highlighted that acute care provision for people with dementia needed improvement. This was reflected as an action in the dementia strategy action plan.

- The local authority told us that commissioning for dementia placements in the community could be a challenge. This was corroborated by A&E staff at Frimley Park Hospital who told us that finding appropriate placements for people with moderate to severe dementia was difficult. However, the new model of joint funding with the three CCGs and local authority partners to finance a care home called Heathlands, which would have a number of Elderly Mentally Infirm (EMI) beds, was seen as a step in the right direction.

- The local authority aimed to stabilise the care market by reducing the number of domiciliary care providers and, through the contract, incentivising providers to put reablement at the centre of their activities. There was positive feedback about the retendering process; domiciliary care providers felt well informed throughout with clear objectives set around providing a needs-based service. However, the local authority need to ensure there is robust monitoring of quality to mitigate the risk of a failing service that would have a much larger impact given the smaller number of providers.

- The local authority included standards in their contracts and there were processes in place to monitor quality and take action if these standards were not met. For example, services were given a quality 'RAG' rating. Services with a red 'flag' would be reported to and monitored by the Care Governance Board. The local authority also worked with poor performing services to support improvement. The local authority Chief Operations Officer (COO) stated that the board would expect to see sustained improvement over a minimum of three months before the red flag was removed.

- Provider forum representatives expressed concern that the local authority could be over zealous in its approach to quality monitoring and slow in removing the 'red flag'. While acknowledging that this may have been the case in the past, the COO told us that they now worked well with providers but they needed to be confident that improvement was sustainable before removing the red flag. There was no evidence that poor quality care homes had an impact on delayed discharge. Our analysis showed that the CQC overall ratings score for adult social care locations in Bracknell Forest local authority was the best nationally. A focus group of providers were positive in their feedback about their relationships with the local authority and commissioners.

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

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

We found a shared understanding and whole system view of the challenges and priorities for using resources to achieve high quality care and promote people's independence. Key strategies focused on: prevention and support to stay well, availability of care home beds and homecare packages, provision of good quality dementia care and support in the community. There was joint working between the system partners to manage demand and govern resources. However, there was still a concern from front line staff and the older person's representative that capacity would not match demand, in particular for people with dementia. Many of the market stabilising plans were in their infancy, and their success could not be measured at the time of the review.

Effective use of information to prioritise improvement
- The system reported that the imbalance between supply and demand in long term care placements was such that placement costs were becoming unsustainable. As such, finding suitable care for people with complex needs, especially for people with dementia, was an increasing problem. An analysis of placements, undertaken as part of the JSNA between December 2016 and May 2017, indicated that the average cost of a weekly placement was now £801.89 for residential beds and £937.12 for nursing beds.

- To counteract this, the local authority developed a framework arrangement to stabilise the domiciliary care market (co-produced with providers and customers); reducing the number of domiciliary care providers whilst increasing the locations by 7% since 2015, and were working with new providers on a recruitment strategy.

- The SOIR stated that the iBCF additional grant was being invested to build on the DTOC 'deep dive' that the local authority undertook during June 2017, to look at the causes and factors associated with an increase in DTOC during 2016/17.

- The Department of Health's analysis of DTOC between February and April 2017 showed that the average daily rate of delayed days per 100,000 adults was higher in Bracknell Forest (18 days) than the England average (14 days) or comparator group average (15 days). Our monthly analysis of DTOC figures showed an increasing trend of delays in Bracknell Forest since April 2015, leading up to a spike in March 2017, (where the average daily rate of delayed days was 22.5). The main reason cited for this spike was the introduction of the new domiciliary care model and the invitation to tender in January 2017. This resulted in a period of uncertainty among providers and influenced their decision to accept new packages of care. Since March 2017, our analysis showed that DTOC had dropped in Bracknell Forest and at July 2017 were more consistent with England and comparator average rates.

Integrated commissioning arrangements
- The BCF plans built on a history of successful integration between the local authority and the CCG. The partners' next step would be developing a fully pooled budget and we were told that these

conversations were happening throughout the system.

- A Memorandum of Understanding (MoU) for the joint purchase of Heathlands had been signed by partners and a capital bid submitted to realise this ambition. There was also a proposal being considered to refurbish another site as a bridging venue until the new build was up and running. Extra iBCF money was being used to support this approach. The intended use of both sites was for an integrated community resource centre, with assistive technology showroom, sensory needs and group therapy clinics and to provide winter pressure capacity.

- The local authority had sought to address challenges with capacity in the provider market by commissioning a block contract of 20 beds with a residential care service, to include step up and step down beds. The CCG were also working collaboratively with the East Berkshire CCGs to ensure there was additional capacity available in the local area.

- The agreement of a shared control total was supporting the governance of resources between NHS community and acute services, and the commissioning and provision of services at the interface between health and social care at the right place and time. This was supported by the development of a high-level dashboard looking at mortality, satisfaction and service user outcomes.

Managing the market to ensure the system has capacity
- The Bracknell Forest BCF plan stated that they had operated a 'Home First' policy since 2010. Our analysis showed that the number of domiciliary care agency locations within the area increased by 7% between April 2015 and April 2017, (although the number of providers was reduced as part of the local authority's plans to stabilise the market), suggesting increased capacity in community-based care. However, this may not be sufficient to match demand as our analysis showed that the number of nursing home beds had reduced by 58% between April 2015 and April 2017 and the number of residential home beds had reduced by 5% over the same period. ASCOF data for 2014/15 and 2015/16 indicated that admissions to care homes in Bracknell Forest were increasing, (from 475 per 100,000 aged 65+ to 719 per 100,000 aged 65+), and as the percentage of Bracknell Forest's population aged 40-64 is above the England figure (34.2% compared to 32.7%), it is likely the area will face increased demand for social care services in the coming years.

- In recognition of this, the local authority have acknowledged in the BCF plan that as well as focusing on strategies to keep people well and in their usual place of residence they will also need to increase care home capacity to meet current demands and future projected shortfalls. The local authority increased council tax by 3% in 2017-18 through the adult social care precept. The additional 2017-18 funding for adult social care, (as announced in the Spring Budget 2017), will be used to increase capacity in adult social care by refurbishing a bridging venue until Heathlands is operational as well as spot purchasing.

- Despite the plans to fund a new care home with EMI beds there was still a concern among front line staff and the elected older person's representative that there would not be enough support in the community for people with dementia. It was felt that more needed to be done to provide a safe and secure home for people in the advanced stages of dementia. The voluntary sector felt that they could be better utilised in this area.

- System leaders acknowledged that relationships with the voluntary sector were not particularly mature however, the local authority was engaging with voluntary providers to develop a sustainable sector. For example, a voluntary sector partnership event was held in July of this year where the strategic plans were shared and the local authority set out its sustainability offer. Further events were planned to promote integrated working with the voluntary sector.

- The local authority had also put measures in place to engage with providers in the residential care home and the domiciliary care markets. This included a series of market shaping events that took place in association with the domiciliary care re-tendering exercise, as well as extensive discussions with providers within the residential, nursing and dementia care home market, with a view to entering into a block contract.

Maintaining people in their usual place of residence

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

Safe
There was a system-wide commitment to maintaining people in their usual place of residence and preventing avoidable harm. The evidence showed that people in care homes were supported to stay well and avoid hospital admission. However, A&E attendance for older people was higher than the national average. Plans were in place to further support people to be safe in their usual place of residence using falls prevention and frailty pathways; however, these plans were yet to be evaluated.

- There were joint strategies to support people to remain living in their usual place of residence safely. A local self-care strategy, based on the JSNA, was in its third year of delivery. This covered areas such as arrhythmia, blood pressure, chronic obstructive pulmonary disease and obesity. The East Berkshire Cardiology Update report (2017) outlined joint working taking place between the community trust and CCGs to improve detection and control of risk factors such as hypertension and atrial fibrillation. This included a campaign called 'Missing a Beat' to increase public awareness of symptoms. The CCG informed us that they were starting to see the impact of this in reducing hospital attendances.

- However, our analysis of A&E attendance rates between April 2015 and March 2016 for people 65 and over showed that attendance levels for Bracknell Forest residents were higher than the national average, and the average of their comparator areas throughout the year. The total rate in 2015/16 of A&E attendance for people aged over 65 in Bracknell Forest was 480 per 1000 people, compared to the average across their comparators of 385 per 1000, and a national average of 414 per 1000. More recent data provided by FHFT during the review showed that there had been no significant reduction in the attendance rate at Frimley Park Hospital since July 2016.

- Our analysis showed that during 2015/16 there were significantly lower rates of A&E attendance

from people aged over 65 living in care homes in Bracknell Forest compared to the England average (10 per 1,000 compared to 36 per 1,000). Of those older people in Bracknell Forest attending A&E from a care home, a significantly high percentage were referred there by a GP (21% compared to England average of 6%) and of those referred by a GP, a significantly lower percentage were discharged without follow-up, (i.e. not admitted), compared to the England average. This meant that GPs in Bracknell Forest were referring only those older care home residents that required acute care.

- Since 2014, the local authority had worked with the CCG to develop a Care Home Quality Programme, which reported to the BCF board monthly. Since May 2017, the three East Berkshire CCGs had collaborated to appoint an East Berkshire-wide Care Home Quality Lead. A specific aim of this programme was ensuring all homes had adequate GP availability and that good practice check lists for certain common conditions, such as urinary tract infections, were adopted.

- Bracknell Forest residents did not always have access to a full provision of GP services at the time of the review. Analysis of survey data from March 2017 indicated that a comparatively low percentage of GP practices in Bracknell Forest offered full provision of extended access to pre-bookable appointments outside of core contractual hours, (7.7% of the 13 practices surveyed, compared to 22.5% across England and 16.4% across comparator areas).

- The integrated care team produced a Crisis Escalation Plan when they undertook assessments of people referred to them. This aimed to mitigate against lifestyle or health risks for the individual, to reduce the occurrence and severity of crisis and prevent avoidable admissions. These plans were shared with acute and out-of-hours providers, GPs, social care and other relevant professionals to ensure an appropriate and informed response.

- Falls prevention and frailty identification was a key focus of the STP, Bracknell Forest Adult Social Care Transformation Plan and the health and wellbeing strategy. Our analysis of admissions from care homes between October 2015 and September 2016 indicated that admissions due to accidents and injuries were comparatively low in Bracknell Forest (135 per 100,000 aged over 65, compared to comparator group average of 367 per 100,000 and England average of 392 per 100,000). The Health and Wellbeing Development Programme (2016/2017) cited the development of a new integrated falls prevention pathway. An STP investment proposal through the Urgent and Emergency Care Transformation Fund was recently submitted. The proposal focused on a system-wide approach with an integrated specialty frailty team, safe and well home visits and extended GP access.

- There were systems in place to identify frail and complex people who were at risk of deterioration. Multidisciplinary team (MDT) meetings were held around clusters of GP practices, bringing together a range of professionals to discuss these cases and coordinate care and support. As part of the STP initiatives, integrated decision-making hubs were being developed to support people who were frail and suffering from complex conditions, by using advance care planning and social prescribing to promote independence.

- The Rapid Assessment Community Clinic (RACC) ran two days a week to provide assessment and

treatment for people with complex health and social care needs in times of mild to moderate health deterioration. There was some evidence of the effectiveness of this service; referral data shown to us on review from January to March 2017 showed that of the 26 people referred to RACC, 20 avoided admission to hospital. However not all GPs in Bracknell Forest used this service regularly.

- To develop a coordinated response to complex and challenging cases within the community, a multi-agency Community Problem Solving Group was in place. This was chaired by the police and brought together the ambulance service, social care, general practice and housing. We were given several examples of the positive impact of this group including one involving the coordinated effort between partners to enable a person with significant challenges to improve the quality of their life.

- The local authority was embracing the use of technology to keep people safe at home. Forestcare, a 24-hour telecare response service, provided Lifelines, care calls and emergency responders service to their subscribers. They could also supply a 'Pocket Pal'; a device which utilised GPS technology to locate a person and detect falls. There was buy-in for the service across the hospital discharge team and the intermediate care team, with the latter planning to recruit a technology specialist to increase awareness and uptake.

- There were initiatives in place to support the management of medicines so that people could medicate safely in the community. The CCG pharmacy team ran polypharmacy clinics in GP practices. We were also told that CCG pharmacy staff were working in care homes, some as independent prescribers, supporting care home staff with medicines management.

- However, carers of people who used services indicated that there were still areas for improvement in keeping people safe through effective medicines management in the community. Several people had experienced errors in the administration of medication, and delays in prescriptions at the community pharmacy.

Effective
Bracknell Forest had embedded systems as well as new projects and initiatives aimed at keeping people well in their usual place of residence. However, the full effectiveness of new initiatives could not be measured at the time of the review. There was an opportunity for the local authority to work with providers and community partners to further enhance the skills and confidence of the social care workforce.

- Our analysis showed that between 2014/15 and 2015/16 there was a sharp increase in the rate of admission to residential and nursing care homes for people aged over 65 in Bracknell Forest (from 475 per 100,000 to 719 per 100,000). This increase put Bracknell Forest at a higher rate of admission than their comparators and the England average.

- Bracknell Forest had multiple initiatives in place to keep people well at home. For example:

  ⇒ An integrated pilot project between community and mental health teams (2016) to provide trans-diagnostic cognitive behaviour therapy for people with long term conditions, depression and anxiety. People who accessed this service reported improved health and wellbeing with fewer visits to the hospital or GP. This service has been extended to the whole of East

Berkshire offering home visits to those who were housebound due to multiple health conditions or having mobility or communication difficulties.

⇒ A Patient Education Centre, based at the Berkshire Urgent Care Centre, provided health education information to people triaged at the service. While the management team did not have any evidence of how this impacted on people's health and wellbeing, they had begun to audit staff to confirm that people had been given written and verbal information.

⇒ The publication of an annual 'Helping you Stay Independent' guide.

⇒ The BCF funded Forestcare responder service – providing personal care and assistance in the event of a fall.

- Bracknell Forest had an active voluntary and community sector offering schemes to reduce social isolation and loneliness among older people and their carers. For example: Age Concern ran coffee mornings; the Alzheimer's Society hosted a memory café; the local authority funded Involve, a voluntary service, to run a befriending service; and a volunteer transport service enabled people to get out into the community.

- Plans were in place to develop the capacity and sustainability of the VCS through a digital platform and enhance the sector's role in keeping people well and independent. Through the BCF, 'community connector' roles were being funded and three posts were being advertised at the time of the review. Community connectors would sit within a connections hub and be co-located with the local authority's brokerage team, working closely with the VCS sector to identify support for people and their families. Work undertaken by public health to map the VCS sector, and the forthcoming digital platform also aligned with this work.

- There were initiatives to develop the workforce to have the right skills to support the maintenance of people in their usual place of residence. A new project entitled 'Conversations' had begun. By providing training to health and social care staff, 'Conversations' aimed to facilitate a culture change in the way that staff interacted with people, encouraging more meaningful interactions, driven by the needs of the person rather than what staff wanted to ask. Results from the pilot were encouraging, with 73% of the people who contacted the local authority having their cases concluded at the first conversation.

- Independent social care providers reported that the local authority was supporting their workforce through regular training and learning events. As part of the proposed enhanced frailty pathway there were plans to implement a competency framework and training programme to up-skill the workforce around frailty.

- However, there was still a concern from providers and the OOH service that some care home, nursing home and community staff lacked the skills and confidence necessary to make care decisions and provide support to people to avoid admission to hospital.

- The use of locum GPs at the OOH service was also cited as a factor for people being admitted to

hospital when they didn't need to be; GPs who were not familiar with the person and their needs could be more risk adverse in their assessments. The OOH service told us that they tended to use the same locum GPs each time so that they could become familiar with the area. From our analysis of the data there were low numbers of people being referred to A&E from care homes and of those who were referred the majority required hospitalisation.

- There was evidence of the workforce effectively collaborating and sharing information to ensure that people had the right care and support to maintain them in their usual place of residence. The integrated care team held virtual MDT meetings, including a link social worker, where they discussed people who were at high risk of deterioration and developed an action plan.

- The introduction of Connecting Care, a digital system that allowed the sharing of a person's information across professionals, was well received across the system and was supporting integrated working. To date the local authority, all GP practices, one acute trust and the community trust had signed up to this system. Use of Connecting Care had increased month-on-month, enabling the sharing of records across organisational boundaries and reducing the duplication of assessments.

Caring

Bracknell Forest had current initiatives and clear strategic ambitions to support people, their families and carers to take the lead in keeping themselves well and planning their care, with the support of statutory and VCS services. However, some of these plans were at early stages at the time of review.

- Bracknell Forest, through its health and wellbeing strategy, had a clear strategic direction to support people to remain in their usual place of residence. The focus was on empowering people to play the lead role in managing their own health and wellbeing and to be active decision makers in their care, support and treatment.

- A self-care strategy was in place to support people to manage their own conditions. For example, through the strategy, and in collaboration with system partners, a volunteer-led peer support scheme for people with long term conditions called 'Healthmakers' had been developed. The scheme offered support and advice on managing conditions and access to a six week self-management course.

- A programme of culture change was being initiated among staff, following the 'Making Every Contact Count' approach to encourage health and care staff to have conversations that empowered people to take responsibility for keeping themselves well.

- Representatives from the Support Care Workforce Board told us that Bracknell Forest had a comparatively good uptake of direct payments, which enabled people to take control over how their care was provided. The ASC Health and Housing Quarterly Service report for 2016-17 Q3 showed that the percentage of people using social care who received direct payments had increased from 21.9% in Q1 2016/17 to 24.2% in Q4. People and their carers who were using direct payments told us this enabled them to have a say and control over their care, and to be more involved in their care plans and reviews. Continuity of care across local authority and CCG funded care was supported by the ongoing promotion of personal healthcare budgets.

- This year the opportunity for people to make informed choices would be further enhanced through the release of the digital online marketplace. Here information on personal healthcare budgets, direct payments and groups and activities to promote independence and wellbeing would be made available via a digital platform. The marketplace would also provide a facility for individuals to pool their direct payments and jointly purchases services. A community asset map, produced by the public health team, was also available to direct people and staff towards services, activities and societies.

- Data collected by CQC suggested that Bracknell Forest had a high proportion of people fully self-funding their care home placement compared to the England average (66% compared to 37%), although the data collected for Bracknell Forest suffers from data completeness issues. There were mixed views as to whether self-funders received sufficient support to make decisions about their care. However, the introduction of the online market place would enable self-funders to have access to comprehensive information on services available.

- On review, we saw a person-centred approach to care and support planning being employed across staff groups. For example, the social work team tried to provide a consistent social worker point of contact from the point of assessment through to the planning and management of the case. The community multidisciplinary team used an 'I statement' approach to understand people's individual needs and ensure that their preferences were known and catered for.

- The Carers Forum was regarded as a strong community asset, providing a support network to carers and an information point for access to service and support. However, the Forum felt that there was scope to increase the number of referrals received from the local authority to their support group, which was local authority funded.

- Social work leads said that carers were offered separate carers assessments. A red card scheme for carers was also being promoted across the area.

Responsive
People's individual needs were assessed; their risks identified and proactively responded to in order to help maintain them in their usual place of residence. Signposting systems for people played a key part in enabling timely access to the right support in the right place.

- Services were in place to proactively maintain people in their usual place of residence. The self-care agenda in Bracknell Forest was playing a key role, as was the investment in preventative, community-based provision through the community asset mapping and online marketplace.

- Practices in the GP federation were pooling resources to ensure that the primary care system had the capacity to provide the services that kept people well, such as flu vaccinations. We were also told that flu vaccinations were being taken to carers at the carers groups. However, we received feedback from carers that annual health checks were no longer being routinely undertaken by their GP, and were difficult to arrange.

- There were processes to ensure people's needs were promptly identified and actions put in place to meet these across the health and care system. Integrated care teams, based around three clusters of GP practices, provided timely support to people with a long-term condition and frail elderly people to effectively manage their condition(s) and improve their outcomes and experience. People who were having difficulty in managing their conditions were referred to the team for a short period of time to stabilise their health. Data from the GP patient survey 2016/17 showed that 69% of people with long-term conditions in Bracknell Forest felt supported compared to the England average of 67% and the comparator average of 68%.

- To be more proactive in responding to those people more at risk of deterioration and hospital admission the OOH service supplied GP practices with cards displaying the OOH direct line number. GPs gave these cards to the people they felt were most at risk and asked them to ring the number if they needed medical advice or support out of hours. The impact of this initiative had not been measured at the time of the review.

- There was work being done to reduce the number of points of entry into the system for people, and signpost them to the right services and support. The recently established Berkshire Health Hub, provided by BHFT, gave a single point of access for the public and health and social care professionals and was streamlining the referral process by replacing multiple referral routes and points of entry. A voluntary organisation commissioned by the local authority called Bracknell Forest Signal 4 Carers was in place. Trained staff were available to signpost carers and offer them support and advice. The new community connectors' role would provide further signposting support.

Crisis

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

Safe

There was effective multi-agency communication during a health or social care crisis enabling people to be kept safe as they moved across the health and social care system. However, access to support for carers in a crisis could be further improved.

- As part of the STP plans for frailty management, an investment proposal had been submitted via the Urgent and Emergency Care Transformation Fund to establish an integrated frailty liaison service. This service aimed to ensure a comprehensive review of needs was undertaken, and enable a timely return to the community with support in place to avoid readmission.

- There were formal methods to share information around risks to people's care and treatment across the system through the Quality Surveillance Groups. Representatives from Bracknell and Ascot CCG alongside the neighbouring CCGs attended the meetings regularly, as did the HWB. We were told that local authority attendance was more sporadic and tended to be linked to when there was a particular issue around the Bracknell Forest system. It was confirmed that when concerns or a crisis occurred, the CCG worked closely with the local authority to resolve them.

- There were systems and processes to safeguard people from avoidable harm at the point of crisis. For example, we tracked a case where a person was unable to get out of bed, and used their Lifeline to alert the emergency services. The paramedic made a safeguarding referral; this was followed up at an MDT meeting and led to a homecare package being put in place.

- The Berkshire Health Hub provided a single point of access for people, their carers and professionals in times of crisis. For example, health and social care professionals could call the Berkshire Health Hub and ask for an urgent occupational therapy assessment and any equipment necessary to keep people who were at risk of deterioration safe in their home. A person who cared for their partner with dementia told us they had called the hub, on the advice of the Berkshire Carers Centre, following a crisis episode. A specialist team arrived to take the person to hospital and carried out a full assessment and medication review. The carer reported that they were pleased with the actions taken and the person in their care had not experienced a crisis episode since.

- However, concerns were expressed by a carers' focus group that when there was a crisis for the carer, and they may need hospitalisation, there were not sufficient respite services available. Bracknell Forest does have a carers' emergency respite scheme that carers can sign up to, taking an assessment to create an emergency plan; however, the perception was by some carers that this was not sufficient.

- Residents of Bracknell Forest received a better than England average emergency ambulance service. Our analysis showed that between June 2016 and May 2017 SCAS performance for Red 1 and Red 2 priority calls was above the England average and for the six months from December 2016 to May 2017 was consistently meeting the national target figure.

Effective

During a health or social care crisis people's needs were effectively assessed by a skilled workforce. Information was shared across the system to enable people the ability to make choices and maintain their independence. There was an opportunity to further improve dementia care in the acute setting through encouraging MDT working and ensuring a robust and disseminated dementia pathway in A&E.

- The Berkshire EDS provided an OOH crisis social care service to Bracknell Forest. The service had evolved over time and it now also provided intermediate care services to avoid people being moved into care homes and the trusted assessor role to assist with safe hospital discharges.

- There was a single assessment process in place during a time of crisis. Three trusted assessors were operating as part of the EDS. They could visit people in their home and undertake the necessary assessments. Reports from our interviews and focus groups suggested there was system-wide trust in these roles and the assessments produced.

- The effectiveness of the service was evident from the EDS referral outcomes audit in 2016/17, where it was found that out of 627 referrals, 325 avoided hospital admissions and 41 were supported to have a safe early discharge. We were also given a case study which described an

occasion when a person's behaviour had deteriorated due to their dementia and their carer needed support. Through the EDS a GP, community mental health specialist and occupational therapist visit was organised. A care package was put in place through the integrated care team and technology installed to support the carer and keep the person safe at home.

- There were multidisciplinary professionals, including a social worker, working in the A&E departments to prevent avoidable admissions and improve flow. Frimley Park Hospital had a senior nurse in place in A&E who would, alongside an initial assessment, also offer patient education with a focus on self-care.

- However, the team in Frimley Park Hospital did not appear to have strong links with the mental health liaison team. There was a lack of clarity around the pathway for dealing with patients who had moderate to severe dementia when they presented at the department. The A&E staff also told the review team that the mental health liaison officer was not involved in their MDT meetings.

- The hospital bed managers had a hub meeting once a month to which system partners were invited and there was a discussion about new strategies or initiatives being introduced. It was felt that this was a good way of networking and communicating and a means to meet people working in other disciplines and build relationships with them.

- People with minor illnesses or injury could attend the Berkshire Urgent Care Centre (UCC). Staff at the UCC could access people's key health information through Connected Care. There were still improvements to be made in the ease of accessing information as Connected Care was due to be fully embedded into their system later this year. To assess if people were being seen in the right place and by the right people, the UCC undertook regular audits of their performance looking at referrals to A&E and whether they were appropriate. The findings from the last quarter were that 77% of referrals were appropriate. Inappropriate referrals were collated and lessons learnt disseminated to the team.

Caring
People, their family and carers told us that they were at the centre of decision making during times of crisis. Support from the VCS was praised by all the people we spoke with.

- There were multiple points of entry to the system at a time of crisis, which could be confusing for people who used services, their families and carers. Work was being undertaken to streamline access through the Berkshire Health Hub. The hub provided people, their families and carers with a single point of entry to the system, from which their care could be coordinated, providing them with a joined up and seamless experience. However, some carers indicated that they would feel unsupported if they were to have a crisis.

- From our visits to carers groups the majority of people we spoke with felt that they had been included in decision making about their health during a crisis. This was corroborated by our review of a sample of case notes, which indicated that families were informed at the point of crisis.

- People told us that voluntary groups, such as the dementia alliance, were extremely helpful in offering a single point of access for support, signposting and advice during times of crisis.

- The introduction of a trusted assessor role as part of the EDS was reducing the number of assessments people received at a time of crisis, and the number of times they had to tell their story to different professionals.

Responsive

At times of crisis services and staff were in place to respond to people in a timely way. Both acute hospitals had systems in place to improve patient flow and reduce avoidable admissions.

- There were systems in place to ensure that people received care in the right place, at the right time and to avoid admission to hospital at a time of crisis. The Berkshire Health Hub single point of access, EDS, Forestcare assistive technology service for people at risk of falls, and the Urgent Care Centre all assisted in supporting people in crisis.

- The OOH provider told us that one of their biggest challenges in preventing people from requiring hospitalisation was that there was not an OOH catheter service. This was placing pressure on the OOH services and meant that people with specific catheterisation needs required hospitalisation instead of being able to stay in their usual place of residence. BHFT and the CCG informed us that they were currently looking at introducing a 'catheter passport' as a pilot. This would include having a detailed catheter care plan to support community nurses and avoid unnecessary hospital admissions.

- We saw that Royal Berkshire Hospital and Frimley Park Hospital had allied health professionals working at the front door to prevent people from being admitted unnecessarily and improve patient flow. BHFT had established a community matron that reached into FHFT. There had been investment in this role to improve the discharge flow and to prevent inappropriate admissions.

- In the last three years, both FHFT and RBFT had performed better than the England average in terms of the percentage of people being seen, treated and either admitted or discharged within four hours in A&E, although performance at both trusts declined in 2016/17 to 91.6% at Frimley Park Hospital and 92.3% at Royal Berkshire Hospital.

- FHFT had a higher occupancy rate than the RBFT. At Q4 2016/17, 95.1% of the 1390 available overnight beds at Frimley Health NHS Foundation Trust were occupied and throughout 2016/17 occupancy had remained above 90%. Although optimum occupancy rates for hospital beds may vary according to type of services offered, hospitals with average bed-occupancy levels above 85% are likely to face regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections. At Royal Berkshire NHS Foundation Trust, bed occupancy was in line with the optimal 85% level throughout the year.

- To improve the flow of people through the A&E departments and hospitals, the community discharge team met three times a week with partnership agencies to understand how the acute system was working, identifying people for discharge and where there were delays. Frimley Park

Hospital used historical data to model the predicted number of admissions, and planned their capacity accordingly.

- As part of the frail elderly pathway, the discharge and assessment team at Frimley Park Hospital had looked to other trusts to seek out best practice models in responding to people who were admitted through A&E. They were looking at implementing a rapid assessment and treatment strategy that could oversee treatment within 48 hours. There was a consultant allocated to this project who was responsible for developing the pathway and looking at the resources needed.

- Systems were in place to ensure people underwent a timely assessment and review seven days a week. FHFT undertook a seven-day service audit in March 2017. It showed that 95% of people were seen within 14 hours of admission, a figure maintained over the weekends. Also 100% of people received a twice daily review. A FHFT senior leader told us that they had increased the number of specialists working over the weekends.

Return

Are services working together to return people to their usual place of residence, or a new place that meets their needs?

Safe
When people returned to their usual place of residence or an alternative setting there were systems and processes in place to do so safely for the most part. However, further work was needed to ensure the relevant people had timely access to sufficient discharge information. Medicines management processes could be further improved to support a safe return home. People living with moderate to severe dementia needed to be able to access the right level of care and support when leaving hospital. Emergency readmission rates for Bracknell Forest's older people had improved and were now lower than the England average. However, the proportion of people still at home 91 days after reablement was significantly lower than England average.

- The number of older people in Bracknell Forest requiring emergency readmission once discharged had decreased. Our analysis showed that during 2015/16, Bracknell Forest's emergency readmission rates occurring within 30 days of discharge for people aged 65+ were slightly higher than the England average and comparator average at 17%. However, in the last quarter rates had dipped below comparator and England averages.

- The Forestcare assistive technology service provided 'takeaway bags' to support people with a safe discharge. The takeaway bag service was introduced two years ago and contained a Lifeline and instructions on installing the equipment. The service was provided as a six week free trial service, funded through the BCF. Following discharge a visit from an assessment and advice officer was provided to check for other assistive technology needs, such as an emergency response service.

- Frimley Park Hospital were piloting a scheme where they gave SCAS crew the direct number of the assessment and discharge team so that they could be informed if the crew arrived at someone's

home and found that there were safety concerns with their home environment. The team could then coordinate appropriate support for the person on discharge.

- Feedback around the quality and availability of discharge information was variable. A GP practice told us that while discharge summaries from FHFT and RBFT used to be of variable quality, they had recently improved due to feedback sent through the clinical concerns system, and most were now sent electronically. We heard from seven registered managers of social care providers, (care homes and domiciliary care), via our online feedback tool which asked about the quality of discharge information; four of seven respondents indicated that they received a discharge summary less than 75% of the time.

- The carers' forum told us that medication and discharge process concerns were a significant barrier against people returning home safely. Some reported that changes to medication had not been highlighted. Others stated that waiting for the discharge letter to reach the GP meant that there were delays in receiving the correct medication, or that people were left without a discharge letter and therefore social care was not able to be put a care package in place.

- These findings were supported by the responses to our online feedback tool around the discharge information flow, which found that while social care providers were largely positive regarding receipt of a discharge summary with 24 hours, some were less positive about receipt of discharge information that provided comprehensive information on details of medications and prescriptions.

- At Frimley Park Hospital processed were in place to support timely medicines management on discharge. When people were admitted, a log was made of what medication they were taking and passed to the pharmacy technician. The technician then liaised with the person's GP. A draft of any changes was made and reviewed throughout their stay with the aim to provide an accurate final medicine record on discharge.

- Availability of dementia placements in the community was an ongoing challenge and was compromising the safety of people in hospital at times. The Frimley Park Hospital assessment and discharge team had concerns that people with serious dementia needs were not having them met. This had led to safeguarding concerns when people with dementia and behavioural issues were cared for on a general medical ward. This was attributed to a lack of EMI bed availability. It was anticipated that the Heathlands project, which would have a number of EMI beds, should help with this.

- The percentage of people in Bracknell Forest who required readmission to hospital after discharge from reablement services was higher than the England average. The Department of Health's analysis of ASCOF reablement figures for 2015/16 showed that Bracknell Forest had a significantly lower percentage of people aged 65+ still at home 91 days after discharge from hospital into reablement services (58.2%) compared to the England average (82.7%) and comparator group average (85.1%). Our analysis of this measure showed a trend of declining performance in Bracknell Forest from a position in 2011/12 and 2012/13 where their performance was higher than the England and comparator average. The data also showed a decreasing trend between 2011/12 and 2015/16 in the percentage of people aged 65+ being offered reablement services in Bracknell

Forest.

- People discharged from intermediate care would receive a 91 day follow up appointment. The intermediate care team felt that there was scope to further safeguard these people from risk of readmission by carrying out reviews earlier, and were exploring ways to increase capacity in the service to enable them to do this as well as promoting the use of assistive technology to keep people safe at home.

Effective

There were some effective systems and processes in place to enable people to return to their usual place of residence. Market shaping, in the form of purchasing a care facility and agreeing a block contract of beds, was taking place to reduce delayed discharges

- There were multidisciplinary assessment and discharge teams in place to facilitate a smooth and timely transition of care. Social workers were linked into the hospital discharge teams through co-location and embedded into the discharge planning processes. The discharge team were clear that having a social worker in situ had improved the speed at which people could be assessed and sent home.

- Good working relationships between the FHFT hospital discharge team and the local authority social care team were seen to facilitate timely discharge from hospital. The discharge teams stated that there was a shared ethos of employing a solution-focused approach to getting people who were ready for discharge out of hospital as quickly as possible.

- There was mixed feedback about communication between care providers and hospital staff. Social care providers in a focus group stated that they had concerns about communication between themselves and secondary care staff when people's needs had changed. They felt that further work was needed regarding the assessment and communication of people's needs prior to discharge so that the person was moved into an appropriate setting with the support they needed in place.

- The discharge and assessment teams and social work teams we spoke with were clear that they felt they communicated well with social care providers, however conceded that there must still be room for improvement if a perception of poor communication was held by some providers.

- It was evident that people received seven-day care while in hospital. Analysis undertaken by the Department of Health showed the percentage of discharges of Bracknell Forest residents that took place at the weekend was 19% between October 2015 and September 2016. This was similar to the comparator areas**.** The availability of occupational therapists and access to equipment within the community was also given as evidence that seven day working was being supported.

Caring

We saw a strong commitment among operational staff to delivering a person-centred approach when managing how people returned to their usual place of residence or to step down care. However, transport delays meant that some people had a poor experience.

- We heard from operational staff that in addition to the trusted assessors in the EDS, a trusted assessor role was operating informally in some places, which reduced duplication of assessments and people having to tell their story multiple times.

- People were referred to VCS organisations to support their transition to their usual place of residence, for example the Red Cross support at home service. However, these organisations felt there was further scope to make use of them as a resource to support people to return home safely and support people's wellbeing.

- Staff across agencies displayed a willingness to discharge people home with a package of care when this was their wish, even if they were likely to require residential or nursing care in the longer term. Bed managers said that honest conversations with family took place early in the discharge process to ensure families were involved, and enable them to fully consider the options available with the person.

- Healthwatch Bracknell Forest's Hospital Discharge Survey June 2017 reported that the majority of people who responded felt that they were involved in decisions about their discharge and that the plan met their needs.

- However, delays to discharge from hospital meant that not all people were being treated with dignity, respect and compassion. We were told of some people with dementia having to wait for long periods in the discharge lounge. We were also given an example of transport delays leading to a poor experience for a person who was near the end of their life. The person had been scheduled to return to their nursing home in the early afternoon. Despite the nursing staff chasing up the issue several times the transport did not arrive until 17:30. The nursing home refused to accept the person after 17:00 and the person had to be readmitted to the ward, causing them distress.

Responsive

There were some systems and processes in place to enable a timely return for people to their usual place of residence or an alternative setting. However, a number of people experienced delays in their discharge due to medicines issues, transport delays and a lack of community health and social care support, including reablement beds, care packages and nursing home beds.

- Our analysis showed that, in contrast to the national picture and the average across comparators, fewer delayed transfers of care were attributable to the NHS than were attributable to social care in Bracknell Forest between February and April 2017. The main reason recorded for delayed transfers in Bracknell Forest over this period was 'awaiting care package in own home'.

- Lack of availability of adult social care beds and services was also a challenge for Bracknell Forest. Our analysis of data from July 2017 showed that provision of residential and nursing care home beds appeared to be lower per population in Bracknell Forest compared to comparator areas and the England average. The number of beds appeared to have decreased since April 2015, particularly in nursing care which saw a 58% reduction in beds.

- The local authority acknowledged that one of the capacity challenges they faced was a lack of access to local step up/step down beds to prevent admission and facilitate timely discharge. Beds were available in other areas such as Maidenhead and Slough but public transport links were poor, creating difficulties for family visiting. However, they were working with FHFT and the CCG to look at delivering an Integrated Community Hub at Bridgewell, incorporating step up/step down beds and discharge to assess (D2A) capacity. Bridgewell is a care home run by the local authority that currently provides short term care for people to support them returning to their home. The local authority was also negotiating a block contract of 20 beds to include step up/step down beds.

- Adult social care providers cited a concern that certain providers were not approached by social workers and commissioners when looking to discharge someone to a residential or nursing home from hospital, because of their higher price point. However, this was disputed by the commissioners and social workers who all explained that they would negotiate, and if the prices were deemed high, they would send this to panel for approval. They stated that this would not be a cause for delayed discharge. All agreed, however, that this difference of perception was evidence of a communication breakdown in the system.

- There were systems in place for the brokerage team to manage discharge issues raised by domiciliary care agencies. When there was a concern, the care home manager contacted the brokerage team and fed back to them. Case notes were updated to catalogue this, however there was little evidence that learning was taken from this.

- Aside from the primary reason cited in the data for delayed transfers of care (waiting for packages of care), two further issues were highlighted across stakeholders as contributing to delays; these were medicines management and transport.

- A social care provider said that medicines availability at both hospitals was a barrier to being discharged on time. We were told by social care providers and carers groups that a person could be ready to be discharged on one day but it might not be until the following day that the medication was available and they were able to leave hospital. In Healthwatch Bracknell Forest's Hospital Discharge Survey June 2017, 61% of respondents reported that their discharge was delayed, with the most common reason given as 'waiting for medication'. However, while waiting for medicines resulted in delayed discharge, evidence provided on the review from pharmacy staff suggested that the cause was more likely to be waiting for the doctor to write the prescription rather than waiting for the prescription to be filled by pharmacy.

- There were schemes in place to address medicines management. FHFT had a band 6 or 7 nurse and senior house officer undertaking 'ward rounds' to ensure medicines were written up in time for discharge, and a pharmacist independent prescriber had been employed to focus on prescribing for discharge.

- Issues with delayed transport at both hospitals were raised by stakeholders across the system. Once a SCAS key performance indicator (KPI) for collecting people with a planned discharge, (90% of people had a 45 minute or less pick up time), had been missed, frontline staff told us there was little incentive to go back to collect the person, instead they were 'bumped' down the list so that

they didn't impact on other people's wait times. However, we were told that a new KPI system was now in place that would prevent this.

- Transport for same day discharges were prioritised meaning that people with a planned discharge experienced a poorer service and delays. The SCAS transport KPI data for Bracknell Forest showed that, whereas same day discharge KPI was, on the whole, being met at 100%, those with planned discharge times had an average KPI of 70% between April and June 2017, increasing to 83% in July 2017.

- The scale and impact of transport issues was not being fully recorded which may have contributed to the fact that SCAS stated they were not aware of any significant concerns around delayed transport when the review team spoke with them. The hospital staff told us that they didn't always record their concerns because the system for logging and reporting them was too onerous and the number of delays too frequent. The relationship between transport and hospital staff was seen as needing further development and the monthly meetings held between the two groups could be at times adversarial rather than productive. However, it was reported that this had started to improve following some frank and open discussion.

- The local authority was working with Frimley Park Hospital to provide a D2A pathway. This would be a joint approach with the aim of addressing immediate need through practitioner autonomy. The planned outcome was a reduction in people remaining in hospital who were fit for discharge.

- In two of the people's records whose pathway we tracked, there was evidence that discharge planning started on admission.

- NHS continuing healthcare (CHC) quarterly figures for all adults (NHS England) for Q1 2017 showed that Bracknell and Ascot CCG had a standard NHS CHC assessment conversion rate for all adults (% of newly eligible cases of total assessments) of 50%. This was high compared to the England average (31%) and the South Central regional average (35%). Their referral conversion rate for all adults (percentage of newly eligible cases of total referrals completed) was also higher. This suggested that processes for accurately identifying people for CHC were working well and a lower proportion of people were entering into the CHC process to subsequently be denied funding. Front line staff told us that there were CHC specialists in all the discharge teams which helped them better understand the requirements of CHC and reduced the number of inappropriate referrals.

- In the same quarter, analysis for Bracknell and Ascot CCG showed that the 67% of referrals for all adults for standard CHC were completed within 28 days, higher than the England average of 57% and the South Central regional average of 33%. In our interviews, it was also confirmed that waiting for a CHC assessment and funding would not delay people's discharge. If an immediate care need was identified, the local authority would meet that need to get the person discharged while waiting for CHC funding to come through.

- However, we were told it was more challenging for people with mild dementia; people without a confirmed dementia diagnosis could find it challenging to obtain CHC funding. The discharge and

assessment team informed us that they spent a lot of time dealing with the funding issue and getting people with dementia discharged and supported in community. The integrated care team stated that people with mild dementia could stay in hospital for extended periods of time – for example waiting for a CHC funding decision which could take up to 28 days – and then spend further time in hospital for their care and support planning to be taken up by social services. There was no dementia specialist nursing post within the integrated care team which prevented them from taking on the more complex cases.

Maturity of the system

What is the maturity of the system to improve for the people of Bracknell Forest

- Overall, we found evidence of good strategic leadership supported by positive cross agency relationships that were strong enough to lead a whole system approach.

- System leaders were working collaboratively to agree and shape a structure of services that were sustainable and responsive to the needs of the local population and in particular to manage the needs of an aging population.

- The HWB had a well-developed health and wellbeing strategy. There were joint strategies aligned with local commissioning intentions and the STP and BCF.

- Within the BCF plan and linked to the health and wellbeing strategy for 2016 to 2020 there was a comprehensive plan to address workforce issues which had been developed by system partners. The resulting outcome for people is still to be tested given the early stage of the initiatives at the time of the review.

- There were well-developed joint processes for decision making, robust governance structures, and agreed performance measures that enabled partners to hold each other to account for the performance and delivery of the agreed strategies.

- The stabilising and shaping of the adult social care market through initiatives such as joint funding of a care facility, establishing a new domiciliary care agency contract and procuring a block contract of care home beds was either in the planning stage or just commenced and therefore at an immature stage.

- We found a very positive culture across the system with good use of shared learning and improvement opportunities. Leaders and managers provided encouragement and support for integrated and collaborative activities that improved outcomes.

- The Berkshire Connected Care programme had started to provide a system for sharing information across health and social care, allowing for instant access to patient and social care information and

the ability for people to access their own records. The local authority was the first social care service within East Berkshire to take part in the Connected Care programme.

Suggested areas for future focus

- Continue to ensure there is the right level of scrutiny and challenge in place across all partnerships. Consider the development of a partnership framework to support the governance of partnership working.

- Ensure there are robust and regularly evaluated plans to manage the current and projected shortfall of care home provision and the provision of high quality dementia care.

- Ensure there is robust contract monitoring and close partnership working with the newly tendered domiciliary care providers to mitigate risks during implementation and ongoing delivery.

- Prioritise workforce development and continue to work collaboratively to deliver an integrated, skilled and competent workforce.

- Ensure there is a consistent whole system and evaluated approach to best practice medicines management where medicine procedures are designed around a person's discharge needs from the point of admission.

- Continue to ensure that public engagement remains a priority alongside regular evaluation of effectiveness.

- Ensure there are robust and regularly evaluated plans in place with a whole system approach to reduce the number of people readmitted into hospital within 91 days post reablement.

- Ensure there are plans in place to reduce transport delays from hospital.