CareQuality Commission

Stoke-on-Trent

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 is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives the Care Quality Commission 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 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: Deanna Westwood, CQC

The team also included:
Two CQC reviewers,
Two CQC strategy Leads,
Two CQC analysts,
One CQC Expert by Experience; and
Three specialist advisors (two former local government directors of social service and one Nurse Clinical Governance Lead).

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 focused 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 is functioning within and across three key areas:

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

Across these three areas, detailed in the report, we 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 requested the local area 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 audit to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care[1]. As part of 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:

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[1] Only 42 responses to the relational audit were received from people working across the health and social care system in Stoke-on-Trent and 12 in response to the information flow audit. The low number of responses means the findings from these sources are not representative. As such, these sources are only used as evidence where they corroborate with other sources of evidence.

- Senior leaders and managers at Stoke-on-Trent City Council (the local authority), Stoke-on-Trent Clinical Commissioning Group (the CCG), University Hospitals of North Midlands NHS Trust, Staffordshire and Stoke-on-Trent Partnership NHS Trust, and North Staffordshire Combined Healthcare NHS Trust.
- Health and social care staff, including social workers, GPs, discharge coordinators, and nurses.
- Healthwatch Stoke-on-Trent and voluntary and community sector (VCS) representatives.
- Local residents in Carelink, a support organisation and a 'dementia café'.

We also met people using services at the Royal Stoke Hospital in both A&E and the discharge lounges as well as at an after-hours walk-in centre.

We reviewed 16 care and treatment records and visited ten services in the local area including community hospitals, intermediate care facilities, care homes and GP practices.

The Stoke-on-Trent context

Demographics

- 16% of the population is aged 65 or over.
- 87% of the population identifies as white.
- Stoke-on-Trent is in the most deprived 20% of local authority areas in England.

Adult social care

- 68 active residential care homes:
  - one rated outstanding
  - 47 rated good
  - 13 rated requires improvement
  - seven currently unrated
- 19 active nursing care homes:
  - one rated outstanding
  - six rated good
  - nine rated requires improvement
  - three rated inadequate
- 46 active domiciliary care agencies:
  - 20 rated good
  - 11 rated requires improvement
  - one rated inadequate
  - 14 currently unrated

Acute and community healthcare

Hospital admissions (elective and non-elective) of people living in Stoke-on-Trent are almost entirely to University Hospitals of North Midlands NHS Trust:

- Receives 97% of admissions of people living in Stoke-on-Trent
- Admissions from Stoke-on-Trent make up 38% of the trust's total admission activity
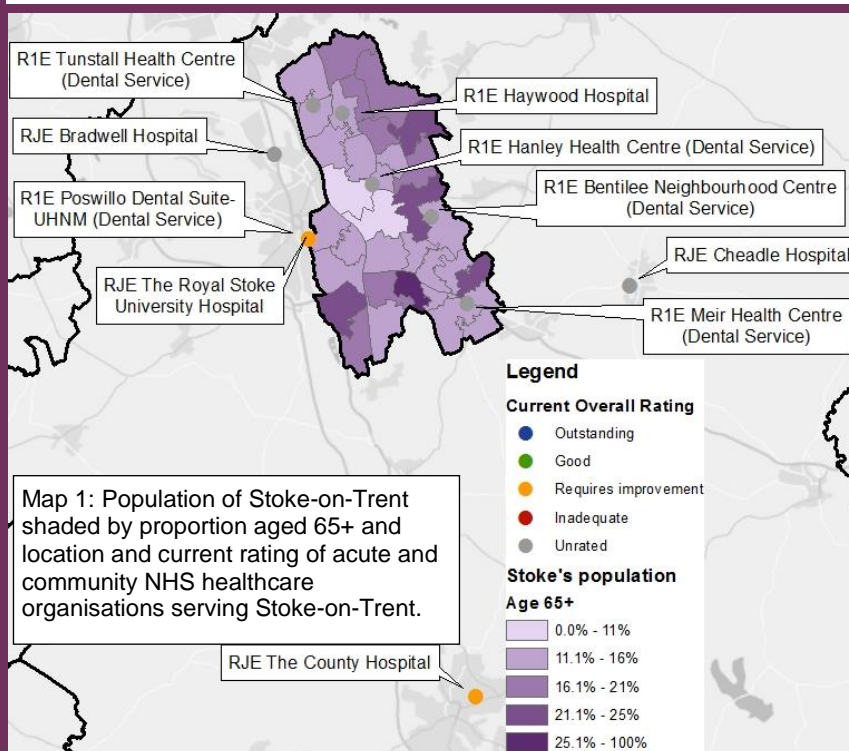- Rated requires improvement overall.

Community services are provided by:

- Staffordshire & Stoke-on-Trent Partnership NHS Trust - currently rated requires improvement overall
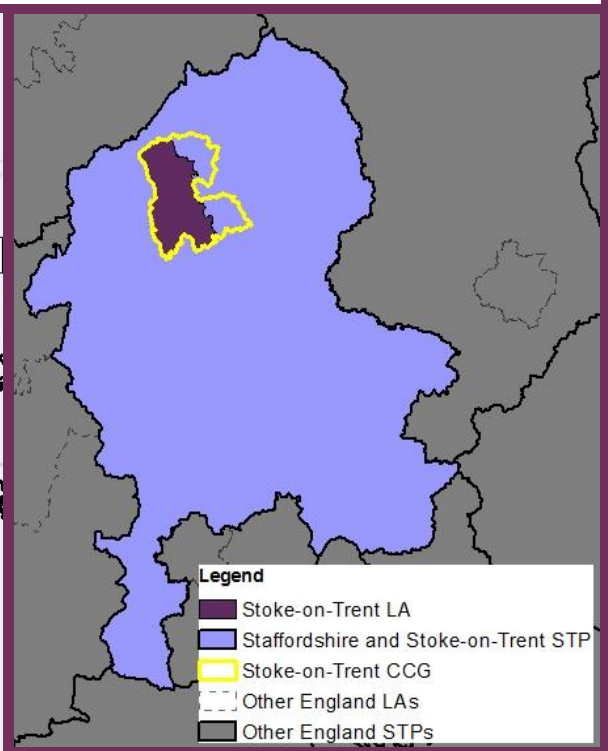
GP Practices

- 46 active locations
  - two rated outstanding
  - 37 rated good
  - two rated requires improvement
  - one rated inadequate
  - four currently unrated

All location ratings as at 29/09/2017. Admissions percentages from 2015/16 Hospital Episode Statistics.

Map 1: Population of Stoke-on-Trent shaded by proportion aged 65+ and location and current rating of acute and community NHS healthcare organisations serving Stoke-on-Trent.

Note that Poswillo Dental Suite UHNM is at the same location as The Royal Stoke University Hospital. The Requires improvement rating refers to RSUH; PDS is currently unrated.

Map 2: Location of Stoke-on-Trent LA within Staffordshire and Stoke-on-Trent STP. Stoke-on-Trent CCG is also highlighted.

Summary of findings

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

- Historically relationships across the system had been poor with a high level of mistrust and very limited joint working.

- More recently there had been a number of changes to the senior leadership across the system and relationships had begun to improve. There was political will and acceptance that a shared vision was required with leaders across the system beginning to work together to improve services, however this was very new and there was still much to be done in terms of building trust and developing a collaborative approach. There was a willingness to work collaboratively going forward, however relationships remained fragile.

- The sustainability and transformation plan (STP) for Staffordshire and Stoke-on-Trent provided a good coherent narrative that had potential for being a driving force for change across the wider system and being instrumental in supporting integrated working if translated to local levels. However, there was no evident line of sight to local plans for Stoke-on-Trent. Many of the plans and initiatives recently agreed were very new and far from embedded.

- Although there was a joint strategic needs assessment (JSNA) that had been developed into Stoke-on-Trent's health and wellbeing strategy, it was not clear how the priorities identified in the plan were aligned with the STP vision and Better Care Fund (BCF) priorities.

- There was a lack of joined-up whole system strategic planning and commissioning with little collaboration or the articulation of a shared endeavour in designing and delivering services. The existing JSNA was due for a review. Plans to carry out a JSNA for older people had been agreed, and a draft version was produced shortly after the review visit.

- Strategies were not regularly refreshed and updated according to people's needs and there was duplication which could impact on delivery.

- Discussions were underway in respect of the BCF, and an initial joint agreement signed during our review. However the BCF agreement stalled shortly afterwards and required further discussion before the local authority and CCG reached agreement.

- Joint arrangements, in the main, tended to be reactive with a reliance on short-term solutions. This prevented the system from implementing long-term commissioning arrangements encompassing a preventative agenda. Market oversight and management

was under-developed and a high number of services had been rated as inadequate, which limited commissioners' ability to assure themselves that people received high quality care.

- There were joint commissioning arrangements between the CCG and the local authority for learning disability, dementia, mental health and carers' services. This involved joint funding, strategy development and service reviews. In relation to support for people living with dementia the joint approach had had positive outcomes in terms of preventing hospital admissions. There were elements of this positive approach that could be replicated to secure improvements across other services.

- There was an agreement for a 50/50 contribution from health and social care commissioners for Section 117 arrangements and this had been described as having positive outcomes for people using services. Staff we spoke with felt that financial arrangements could be a barrier to person-centred care and that pooled budgets were a positive way forward.

Is there a clear framework for interagency collaboration?

- The challenge for this system was to both deliver and transform services while building an effective guiding coalition. The system and its approach to joint working remained fragile although it was encouraging that there was an acceptance of the challenges ahead and a willingness to work together to improve service quality and people's experiences.

- There was little evidence of system wide multi-disciplinary team working for effective outcomes. There was some work in place in relation to improving effective and timely discharge from hospital; however it was not fully integrated.

- Much of what we saw was still in early development, partnership working was still underdeveloped and relationships – although improved – remained fragile. There was little evidence of a joint approach to service design and delivery historically, and the system had experienced significant leadership churn. There had been very 'siloed' working across the system coupled with cross-organisational tensions. This was particularly evident in relation to the local authority and the CCG, although the City Director (CEO equivalent at the local authority) and the Accountable Officer at the CCG were now personally committed to working collaboratively.

- We were not provided with any evidence of cross-system collaborative plans for the anticipated increase in demand during winter. The CCG have since submitted their draft plan for winter however there was no evidence of a system-wide approach to winter planning and work in this regard was underdeveloped.

How are interagency processes delivered?

- There was no effective clinical engagement with primary medical services (PMS) which had resulted in a lack of confidence from GPs in the CCG, despite it being a GP membership body.

- There was no dedicated primary care delivery model for care homes, and a previous attempt to commission an enhanced service for care homes had not been brought into operation.

- There was a shortage of GPs with GPs managing large caseloads. In addition there were variances in surgery opening times and significant variances in people's access to primary care. Access to out-of-hours support was a particular concern with local people experiencing difficulty in gaining a GP appointment in a timely way.

- As a consequence, many people attended A&E; people were often referred to A&E directly by their GPs, either from care homes or their own homes.

- There was good support placed at front-of-house at the A&E to help to prevent avoidable admissions and this had potential for a positive impact. It will be crucial to monitor conversion rates in respect of the numbers of admissions in order to evaluate the impact of this approach.

- Once people were admitted to hospital there was potential for the track and triage system to support people to plan for their discharge and the new discharge to assess (D2A) plans have the potential to consolidate the discharge arrangements and improve people's experience in this regard.

- Leaders expressed confidence that the roll out of D2A would reduce delayed transfers of care (DTOC), which at the time of our review were among the highest nationally. During the period February 2017 to April 2017 the total delayed days per 100,000 18+ population averaged at 32 for Stoke-on-Trent compared to the England average of 14, and 11 in similar areas. However, we did not find evidence of a coherent, cross-sector delivery plan or that there were robust mitigations plans should D2A not deliver as anticipated.

- It was clear that the system had made efforts to address homecare delivery but there was still nervousness in the system in respect of the capacity to meet demand as a result of increasing operational pressures, particularly in the winter.

- Hospital occupancy rates were high – above the England average – so the effective management of patient flow will be essential over the coming months as demand increases. There was potential to improve patient flow by the planned expansion of track and triage.

- The housing directorate within the local authority was a willing partner to improve the experiences of older people. There has been some positive work around extra care housing schemes and working with housing, waiting times for aids and adaptations had reduced. There is potential to achieve further benefits by building on this good work with housing.

What are the experiences of front line staff?
- The workforce across the local authority and the CCG had a clear will and enthusiasm to do the right thing for people; however they were not clear about the direction of travel. They expressed frustration at the lack of engagement and confusion regarding expectations and service planning. Staff told us that changes were badly implemented and there was little support during periods of transition.

- Front line staff felt supported by their line managers however felt they would benefit from visible and clear senior leadership that enabled them to fully understand priorities and support improvement.

- There was very limited evidence of staff being enabled to work across organisational boundaries. Some community staff reported that working across boundaries in the North Staffordshire CCG area, which had more cross sector working between social care and health compared with Stoke-on-Trent, was different.

- There was not a single strategic workforce plan across the system. It was anticipated that the workforce strategy would align with the STP vision as it emerges. In the meantime, a system-wide workforce board met on a monthly basis and included representation from all system partners including the GP federations and NHS England.

- There were recruitment challenges in many parts of the system. In the community there were difficulties recruiting home care staff. There were difficulties recruiting nurses and medical staff both in primary and secondary care. Each organisation individually had taken steps to address vacancy rates; however there was no evidence of a collaborative approach to workforce planning to address immediate staffing pressures. The system needed to do more to understand, plan for, and secure a confident, competent workforce – particularly with winter approaching.

What are the experiences of people receiving services?
- The experiences of people receiving services in Stoke-on-Trent varied and services were not always provided in a timely and effective way.

- People who contacted social services for the first time received assessments that considered their needs holistically and also considered what support their carer family members might need.

- However, some older people had less satisfactory experiences when they were admitted to hospital; they were often experiencing long waits in A&E before being admitted to a ward.

- Once ready for discharge, older people were often subject to delays in their transfer home or to a new place of residence. In some cases people had suffered avoidable harm or detriment as a result of the delays. In the main, delays were attributed to the lack of provision of care packages in the community or the availability of long term care placements.

- Staff informed us that at weekends people were remaining in hospital due to the lack of seven day support services to enable people to return to their homes safely.

- Continuing healthcare (CHC) funding was provided by the CCG. The NHS CHC figures for all adults showed that in Q1 2017/18 both the referral conversion rate (% of newly eligible cases of total referrals completed) and assessment conversion rate (% newly eligible cases of total cases assessed) were much lower in Stoke-on-Trent than the England and North Midlands regional averages. This indicated that Stoke-on-Trent's processes for identifying people eligible for CHC were less effective, which could contribute to delayed discharges. However, the timely completion of referrals was more effective as the data for all adults in Q1 2017/18 also showed that in Stoke-on-Trent 67% of referrals for standard CHC were completed within 28 days, higher than the England average of 57% and the North Midlands regional average of 57%.

- Reviews of care packages and people's needs were not done in a timely way. This was a missed opportunity to release service capacity and meet people's needs appropriately. There were plans to improve performance in this area but we were unable to assess the impact at the time of the review. In the meantime, people were at risk of not having their needs met if they required more support. The local authority's monthly data showed that in June 2017, 61% of review activities due had been completed compared to 72% in June 2016. There had been a steady downwards trend month-on-month.

- There was little evidence of system-wide multi-disciplinary team working for effective outcomes. There was some work in place around discharge and the use of the track and triage team, but it was not fully integrated or fully embedded.

- There was little evidence of pathways across primary, community and secondary care that supported the wider objectives of health maintenance. People living in Stoke-on-Trent encountered barriers to maintaining their health and wellbeing through inconsistent access to services.

Are services in Stoke-on-Trent 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, inter-agency and multi-disciplinary working and the involvement of people who use services, their families and carers.

Although there was a clear shared vision across the health and social care system, the health and wellbeing of people who lived in Stoke-on-Trent was placed at risk by the lack of a deliverable joined up strategy. Partners had agreed that a joint approach would improve outcomes for people and demonstrated a willingness to commit to this, but in practice there were fissures in the system which had not been overcome and critical plans such as winter planning and the Better Care Fund had been delayed. There had not been a period of stability in Stoke-on-Trent to enable relationships to embed, particularly in the last year where there had been numerous changes in leaders across the commissioning and secondary care systems.

Strategy, vision and partnership working

- System leaders acknowledged that close partnership working would be integral to resolving the health and social care issues in Stoke-on-Trent. There had been a difficult period when relationships between health and social care partners were strained but all system leaders told us that relationships were improving based on a shared vision. Within the last year, there had been changes in leadership in health and social care organisations and this was seen as an opportunity to reset relationships and work together.

- Many staff and representatives of the private and voluntary sector were aware of historical relationship issues and the lack of trust between system leaders. Leaders described a willingness to work together and that lessons had been learned around communication; for example, the need to engage with political leaders. Relationships were also fragmented within the system, for example there had been a breakdown in relationships between the CCG and GPs. We also found frontline staff felt that a lack of transparency between the CCG and local authority was a hindrance to building trust and integrated working.

- In practice, there was limited partnership and joint working across the system for the planning and delivery of services and poor relationships remained a key barrier. We saw that health and social care partners had made significant changes that had negatively impacted on each other. For example, widespread closure of community beds had taken place which impacted on the local social care market provision and social care leaders had not been involved in the decision making. A provider had been commissioned by health services to provide care to people at home as they had identified a shortfall in this provision

which was contributing to delays. Social care staff reported that this had destabilised the market as they lost staff to the provider commissioned by health. The local authority had responded by extending its own in-house domiciliary care services.

- Although the winter plan had not been formalised at the time of our review, subsequent to our review a draft plan was submitted to NHS England via the West Staffordshire A&E Delivery Board. Frontline staff advised they were not aware of any winter planning that was being put in place although managers across both systems reported they had been asked to contribute to plans. Voluntary sector providers were not involved in the winter planning and felt they had a role to play, offering initiatives to ensure people in communities lived in warm and safe environments and were supported to reduce their sense of social isolation which in turn could impact on their health. Staff across the system told us it was not clear to them what learning had been put in place following past winter pressures; they felt the system was reactive and crisis-driven.

- Partners had been unable to agree and sign off a joint plan for the Better Care Fund (BCF) within the final deadline. The BCF plan was subsequently agreed and submitted on 28 September 2017. System leaders were not transparent with regard to financial arrangements and this lead to a breakdown in joint working. This posed a significant risk to the health and wellbeing of older people living in Stoke-on-Trent. Plans to implement the D2A scheme which would enable people to return home from hospital in a safe and timely way were dependent on the BCF plan being approved. System leaders did not have alternative plans in the event that the D2A scheme could not proceed or became delayed. System partners were not working together to implement the changes in the High Impact Change Model which was one of the national conditions for the BCF; for example, there was no trusted assessor scheme in place, D2A had not been agreed and seven day services were not operating across the system.

- The local system created a clear vision within the wider STP with a clear narrative about local priorities but it was not clear how this would translate into delivery. The local leads had started to set up systems to get line of sight on plans to delivery level, such as the STP chair's meetings. STP leads had begun the process of looking at deliverables with the A&E delivery boards. They understood the difficulties system leaders had had in the past in terms of planning and working together and recognised that a period of stability in leadership was required to enable cross-system relationships to develop and for strategies to become embedded.

- System leaders reported that working collaboratively with partner organisations and within communities was a core element of the Stoke-on-Trent strategic plan, 'Stronger Together', however this plan did not describe the involvement of health services and although one of the indicators of success would be measured against the numbers of older people who

were still at home 91 days discharge from hospital to reablement service, there were no objectives that addressed the pressures in the health system or support for older people specifically. This disjointed approach to managing pressure points ultimately impacted on the lives of older people who were more likely to be admitted to hospital if they become unwell and then stayed longer than they needed to in hospital.

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

- There were systems in place to enable people who lived in Stoke-on-Trent to share their views and inform strategic planning. A patient and public involvement structure was in place and included a number of strands that enabled older people, their families and carers to be involved in developing the strategic approach including lay representation on boards, patient congresses and a Citizens' Jury which was a call for evidence on thematic subjects that could make recommendations for change.

- System leaders told us partners engaged people living in Stoke-on-Trent through the Older People's Engagement Network (OPEN) which was jointly commissioned by the local authority and the CCG. We saw examples of engagement meetings that had been held. Reports with recommendations had been put forward by OPEN with suggestions and views from people about what support would enable them to manage their health and independence better. These forums were well-attended, for example an engagement forum held in October 2016 to discuss the topic 'Older People's Health' had more than 150 attendees and the report compiled represented the views of more than 300 people. We could see that representatives from the local authority and the CCG attended these meetings.

- There was however frustration from representatives of the voluntary sector engagement networks that although they provided feedback, they did not receive any response to this, which impacted on the credibility of their organisations as they were unable to demonstrate that changes had been made as a result of people giving their views. An example of this was the suggestion of mass flu vaccinations at places such as retirement villages. This was seen as a pragmatic and efficient approach to maintaining people's health. There had been no response to this suggestion or acknowledgement that it had been considered.

Promoting a culture of inter-agency and multidisciplinary working

- There was not a clear framework for interagency collaboration across the health and social care interface. There were examples of joint working such as the dementia strategy and there were some systems in place, for example the interface around the track and triage and reablement teams, that worked collaboratively. The Meir Partnership Care Hub which has been operational since October 2016 consists of a core team of co-located adult social care and mental health practitioners and won an award from the Positive Practice in Mental Health Awards 2017. These areas of good practice are not being taken forward in a coherent strategically and operationally integrated way.

- Frontline staff across the system reported that there was a lack of integrated working between health and social care. However all staff we spoke with during the week of our review expressed a will to work more collaboratively. Some staff described a lack of transparency between the health and social care sectors that was a hindrance. Frontline staff were without exception focused on the needs and welfare of people who lived in Stoke-on-Trent and expressed a desire to improve outcomes for people through more collaborative working. They felt systems could be streamlined to enable this through joint contracts and commissioning.

Learning and improvement across the system
- There was no coherent structure to describe learning from best practice across the system. Some staff were concerned that learning from the last winter had not been used to inform planning for the coming winter. System leaders described some processes in place to learn from specific safety incidents and complaints supported by reporting mechanisms. They described how changes in practice had come about as a consequence of lessons learned from safeguarding board reviews.

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

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

There was no collaborative governance framework that culminated in a series of measurable agreed or shared performance metrics that were robustly monitored at the Health and Wellbeing Board. The metrics that were in place had not been refreshed to reflect the gaps in the system. There was a lack of challenge around performance for the system through the Health and Wellbeing Board.   We found that data and intelligence was not routinely shared across the health and social care system.

Overarching governance arrangements
- Although there were governance structures in place for health and social care organisations with oversight by council leaders and the overview and scrutiny committees, there was little evidence of the boards influencing operational delivery. The Health and Wellbeing Board (HWB) was considering its role in terms of governance and reshaping the board to enable it to focus on challenging and monitoring cross-system priorities and performance. There was little evidence of the HWB carrying out this function at the time of our review. There was recognition that the right people needed to attend board meetings if changes and progress were to be facilitated. In practical terms, stakeholders used it as a forum for reporting progress on service delivery and it did not function as a driver for change.

- Information governance was not joined up across the system and this meant that there was potential for strategies that duplicated or worked against each other in an already pressured system. Information sharing worked well in some limited areas; however, some partners felt that a lack of trust hindered transparency

- Individual organisational governance arrangements were supported by committee structures in each of the system partner organisations. Objectives were linked to individual organisational priorities rather than a system-wide approach.

- We did not find evidence of shared management information that would identify emerging risks and gaps. System leaders had not developed common datasets and did not routinely share information about each other's activities.

- There was system-wide acknowledgement that improved performance in a number of key areas was required, particularly the management of patient flow in the acute setting including:
    - Reducing unnecessary admissions to hospital
    - Delayed transfers of care
    - The provision of intermediate care and long term care provision.

- System partners acknowledged that pathways of care across organisational boundaries continued to challenge the system and required additional work in terms of governance arrangements as well as future contracting and commissioning arrangements to support a collaborative approach.

- Council leaders were actively engaged in monitoring progress and had a strong voice in representing the interests of the people of Stoke-on-Trent. There had been tensions in the past between political leaders and leaders in the health system. However, both acknowledged that there were benefits in working together as they had a shared interest and common goals for people in living Stoke-on-Trent.

Information governance arrangements across the system
- There were information sharing agreements in place to support people who moved through the health and social care system. The HWB's BCF submissions for 2016/17 indicated it was meeting the national conditions around better data sharing between health and social care, based on the NHS number, including pursuing interoperable application programming interfaces (APIs) (i.e. systems that speak to each other). However, we found that data and intelligence were not routinely shared. There were no integrated care records which was a further barrier to supporting people in a joined-up way.

- System leaders had not developed common datasets and did not routinely share information about each other's activities. Instead there was mistrust and a lack of transparency. Leaders and frontline staff across the health and social care systems described feeling that management information tended to be guarded, when sharing it would enable partners to engage in joint problem-solving. There was recognition that information sharing would improve delivery of services and system leaders told us that the A&E delivery board was in the process of developing a dashboard to enable monitoring of agreed key performance indicators.

Risk sharing

- There were some arrangements for identifying and sharing risk however these were not widespread. We did not see evidence of shared management information which would identify emerging risks and gaps. We saw data collected by the local authority which enabled them to track the delivery of their services, including information about delayed transfers of care. Where there were processes for sharing information across systems (for example, the Quality Safeguarding Information Sharing Meeting where multi-agency discussions were held to review quality and safety in local services), partners involved in this work found it effective as a driver for improvement. There were also daily reports between the acute trust and the local authority with regard to numbers of people awaiting discharge. System leaders needed to consider a joined-up approach to identifying and sharing information about potential risks to enable them to respond in a proactive rather than a reactive manner.

- Strategies were not regularly refreshed and updated according to people's needs and there was duplication which could impact on delivery. For example the CCG had its own care home strategy which had not been refreshed since 2015. A care home matron had been appointed and this role was not reflected in the strategy. The strategy was updated following the review describing what progress and been made and what the outstanding issues were, however it did not identify a strategic plan for addressing outstanding issues, such as support for care homes to manage the care of people at the end of their lives. The housing strategy for older people addressed issues that had the potential to overlap with other parts of the system such as the provision of aids and adaptations. Frontline staff and providers told us that different contracts and a lack of joined up commissioning meant that key performance indicators could be conflicting and placed an additional burden on providers.

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.

There was a well-attended, integrated workforce board but there was no collaborative system-wide workforce strategy because leaders were waiting on new models of care to be developed. In the meantime system leaders were working to address shortfalls, particularly around the recruitment of domiciliary care workers and GPs.

Workforce planning and development

- System leaders told us that workforce planning was a priority within the STP and that plans needed to be developed by assessing system-wide capacity. The STP had prioritised a number of strategic workforce issues:
    - Urgent and emergency care
    - Enhanced primary care (distressed environment for recruiting GPs)
    - Domiciliary care (including reablement)
    - Redundancy management

- There was not a single strategic workforce plan. The STP was still working to articulate what new models of care would look like and the workforce strategy was dependent on this outcome. In the meantime the workforce board met on a monthly basis and included representation from all system partners including the GP federations and NHS England.

- There were significant pressures in the system with regard to GP and domiciliary care recruitment. Analysis of Skills for Care workforce estimates for 2015/16 showed that although social care vacancies in Stoke-on-Trent were below the England average, staff turnover had increased to 31%, above the national average of 27%. The local authority had recently recruited in-house domiciliary care workers to alleviate some of the pressures in the system caused by difficulties retaining care workers in the private sector. GPs felt that they were in crisis owing to the shortage of GPs and the demands placed on them. A strategy had been developed to address gaps in the medical workforce including the recruitment of GPs from abroad and the introduction of physician associates, however there were mixed views on the sustainability and appropriateness of these appointments.

- System leaders were working to develop the workforce through partnerships with local further and higher education institutions, which were offering placements with the aim of converting students into the workforce. An Integrated Therapies Apprenticeship was developed by University Hospitals of North Midlands NHS Trust and Stoke-on-Trent City Council to train individuals to support occupational therapists (OTs) in achieving timely discharge. In the meantime, OTs were considering practical ways of supporting people, such as through changing hoisting techniques to extend the support they could offer with limited capacity.

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.

The JSNA had led to the development of a health and wellbeing strategy but this strategy was not aligned with the STP and BCF priorities. Commissioning arrangements tended to be reactive with a reliance on short-term fixes that prevented the system from implementing long-term commissioning arrangements built around a preventative agenda. Market oversight and management was under-developed and there was a high number of inadequate services that limited commissioners' ability to assure themselves that people received safe care.

Strategic approach to commissioning

- The HWB produced a JSNA and published an 'outcomes' report in October 2015 based on 2013-14 data. This informed the 'Stoke-on-Trent Joint Health and Wellbeing Strategy 2016-2020'. The data in the outcomes report showed that there was a low uptake of direct payments by people living in Stoke-on-Trent[2]. Data on NHS continuing healthcare from NHS England shows that during Q1 2017/18 the rate of people receiving direct payments in Stoke-on-Trent was very low; 0.22 per 50,000 people compared to the England average of 3.63 per 50,000 and the rate for the North Midlands region of 2.93 per 50,000.

- The outcomes report also told leaders that people in Stoke-on-Trent experienced more falls[3]. The HWB analysed the number of emergency hospital admissions due to falls in persons over 65 and found that Stoke-on-Trent had the tenth highest rate among all local authorities of falls for women and the seventeenth highest rate for men. In addition, the outcomes report showed that there was a steady year-on-year decline in the uptake of flu vaccinations for people over 65 years of age. In 2014/15 Stoke-on-Trent was the sixty-fourth worst nationally[4].   However, since the publication of the data, there had been an increase in the uptake of vaccinations and the rate in Stoke-on-Trent was slightly above the England average.

- The joint health and wellbeing strategy identified seven priorities for people living in Stoke-on-Trent, one of which was 'keeping older people safe and well'. This highlighted plans to improve outcomes for people to ensure that they were able to live at home independently, had access to support and information to enable them to manage their care needs when they arose, had experienced less social isolation and were able to live in a warm and safe environment. The joint health and wellbeing strategy linked to other strategies such as the

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[2] JSNA Outcomes report p.71
[3] JSNA Outcomes report p.65
[4] JSNA Outcomes report p.68

dementia strategy, the carers' strategy and the Staffordshire frail elderly strategy. The JSNA had looked at a wide range of data and demographics. Older people living in Stoke-on-Trent might benefit from an older people's JSNA so that system leaders could ensure that their priorities for older people were more targeted and used more recent data to ensure the design of systems to improve the flow through the health and social care system was evidence based. A draft older people's needs assessment was produced in October 2016 but it has not been published to date.

- The JSNA had been signed up to by leaders across the system however many of the signatories were no longer in post and commissioning arrangements were now expected to be influenced by the development of the STP and BCF plans. These new plans were based on local needs. However where health and social care systems were not integrated, conflicting commissioning priorities – particularly around reablement – had resulted in a fragmented system. System leaders told us that proposals for a fully integrated health and social care model were being developed following detailed modelling and evidence review.

- Commissioning arrangements were often reactive in order to meet demands and agencies told us they often had short notice of when contract arrangements were due to begin. Pilot schemes were implemented dependent on short-term funding and would cease at the end of the funding period rather than being developed in a way that would enable them to become business as usual at the end of the pilot period.

- We spoke with staff and voluntary sector agencies who were part of schemes where the short-term contract was coming to an end within three months and they did not know if their work would be continuing. Commissioners across health and social care felt that short-term funding arrangements created more problems in the long-term for the workforce and people who use services, as systems did not have time to bed-in before they changed. The in-house provision of domiciliary care services was described by leaders as a 'short-term fix' to ensure there was enough provision but was not a long-term option. They had not yet developed a strategy for alternative long-term provision.

- There were joint commissioning arrangements between the CCG and the local authority with regards to learning disability, dementia, mental health and carers' services. This involved joint funding, strategy development and service reviews. Staff we spoke with felt the joint work with regard to dementia had positive outcomes in terms of preventing hospital admissions. There was an agreement for a 50/50 contribution from health and social care commissioners for Section 117 arrangements and this had been described as having positive outcomes for patients. Staff we spoke with felt that financial arrangements could be a barrier to person-centred care and that pooled budgets were a positive way forward.

- The focus of commissioning was on getting people out of hospital. Although there were

'front door' services commissioned at the A&E department that were successful at redirecting some people, emergency admissions for over 65s in 2015/16 were significantly higher than the national average for much of that year at 91 per 100,000 population compared to 63 per 100,000 population in quarter one of 2016. The Department of Health's analysis of data spanning March 2016 to February 2017 shows that rates of emergency admissions for over 65s were still considerably higher in Stoke-on-Trent than they were across comparator areas or the England average.

- The reactive nature of commissioning decisions meant that there was less focus on prevention in the community. Issues arising from shortages in the GP workforce were considered as a separate workforce issue. We saw no evidence that the impact this was having on the health of people was being addressed. When we spoke with staff, providers, and people who use services, the lack of access to GPs was cited as a reason for using emergency services. Data from March 2017 on provision of extended access to GPs outside of core contractual hours showed that only 6.5% of the 46 GP practices in Stoke-on-Trent surveyed offered full provision of extended access over the weekends and on weekday mornings or evenings. This is considerably lower than the England average of 22.5% and the average across Stoke-on-Trent's comparators of 37.1%.

Market shaping
- There was little evidence of market oversight and management and a large number of care and nursing homes were rated inadequate. Initiatives to work with the independent sector to improve local services occurred once a service was in crisis. More positively the CCG had appointed a care home matron (on a temporary contract at the time of our visit) to help staff improve their knowledge and skills and meet people's needs more effectively. However, only services that were contracted by the CCG were required to work with the care home matron.

- The local authority had appointed a commissioning manager for responsibility for market shaping and development and there was a care market steering group but these initiatives were too recent to demonstrate outcomes. System leaders needed to engage with providers more actively to ensure the right balance of provision in Stoke-on-Trent. One provider expressed frustration that they had a number of beds ready for use and had tried to have conversations with commissioners to determine what their needs were before registering them but had been unsuccessful.

- Commissioners across health and social care told us that they had good relationships with market providers and appeared confident in their arrangements. However, the care market in Stoke-on-Trent was challenging. Our analysis in July 2017 showed that 16% of nursing homes in Stoke-on-Trent were rated inadequate and 53% were rated as requires improvement, both of these figures were much higher than the comparator averages (4% and 21% respectively) and national averages (3% and 28% respectively). The percentage

of community social care providers rated inadequate (3%) or requires improvement (36%) was also much higher in Stoke-on-Trent than across comparator areas (1% and 16% respectively) or England (1% and 15% respectively). This meant that people were at risk of receiving unsafe care and it limited the capacity in the market.

Do commissioners have the right range of support services in place to enable them to improve interfaces between health and social care?

- Voluntary sector providers had not been given the opportunity to be involved in commissioning arrangements such as winter planning, despite their ability to support people with initiatives aimed at maintaining their independence and wellbeing. There had been a recent review of voluntary sector contracts by the CCG and commissioners acknowledged they had not properly engaged voluntary sector providers in these decisions. There were plans to address this and engage more fully with the sector but in the meantime there were missed opportunities to develop this element of the market and support increased capacity.

- Commissioning tended to be reactive rather than based around long-term strategic plans. During our review much of the focus was on the implementation of the Home First and D2A model. Both health and social care system leaders felt this would resolve many of the problems for people in Stoke-on-Trent however there were no contingency plans and the system was described as commissioning different pieces of work rather than dealing with the whole picture. In addition the development of commissioning in relation to the frailty pathway required further development.

Contract oversight
- There was not a clear strategy for managing quality in care services unless they were in crisis, at which point there would be joint quality visits and safeguarding meetings. Although this was a good example of joined up working, data did not show that it was effective in driving improvement. Only 37% of adult social care services were found to have improved following a CQC re-inspection compared to 48% in similar areas.

- Commissioners across health and social care were building relationships with providers through contract monitoring approaches and regular forums such as the domiciliary care and extra care forums. It was intended that the intelligence gathered and shared through these networks was used to shape services however we did not see evidence to demonstrate how this worked in practice.

- There were different contracts for health and social care provision and a lack of joined up quality monitoring indicators. We found that some quality monitoring arrangements and robust interventions relating to commissioning contracts would benefit from a more proactive approach.

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

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

System leaders did not have a cohesive system-wide strategy to ensure that people were supported to remain independent. There was a disproportionately high number of poor services in Stoke-on-Trent and no cohesive strategy to manage this.

- Spending in the health and social care systems did not reflect joint priorities. Although there was a shared vision that was articulated in the draft BCF plan and the STP, this did not translate into shared granular operational plans. System leaders dealt with financial pressures by engaging in commissioning strategies to support their own priorities and failed to consider how priorities could be addressed jointly to achieve the best outcomes for people using services. Voluntary sector providers told us that cuts to services would take place with the expectation rather than the agreement that other partners in the system would pick up shortfalls in provision.

- System leaders reported in the System Overview Information Request that commissioners across health and social care were building strong relationships with providers through contract monitoring approaches and regular forums such as the domiciliary care and extra care forums. They told us that the intelligence gathered and shared through these networks is used to shape services however we did not see evidence to demonstrate how this worked in practice. Providers told us that although they had good working relationships with individual officers, they did not feel engaged in commissioning developments.

- Some commissioning arrangements were costly when they were applied in a reactive way to address gaps in the system. For example, the pressure to move people out of hospital had resulted in a costly contract between the CCG and a private provider that some leaders argued had destabilised the market. In turn, the high volume provision of in-house domiciliary care by the local authority was recognised as unsustainable and other models should be explored to secure quality and stability.

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

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

Are services in Stoke-on-Trent safe?

There were limited systems and processes in place across the system which could enable people to stay at home and to safeguard them from avoidable harm. The voluntary sector was underutilised. Some people were unable to access primary care services and support in a timely way which meant that they would rely on emergency services and were at risk of being admitted to hospital unnecessarily.

- We spoke with voluntary sector stakeholders and saw some of their initiatives to support people in the community. They gave examples of support around wellbeing checks and calls on people to reduce social isolation. They described how they might be the only point of contact for some older people who did not have families to support them and gave us an example of an instance where, following a conversation with a carer, they had identified that a person needed further support. They were able, with the carer's permission, to contact the social worker. The social worker responded straight away and the support that was put in place ensured that the family's needs did not reach crisis point.

- System leaders told us in their System Overview Information Request that partnership work was well established with regard to safeguarding adults at risk of harm. When we spoke with frontline staff across health and social care, independent providers and the voluntary sector, they confirmed this. Where there were concerns about a service that could impact on the safety of people using the service, staff from the CCG, local authority and hospitals would work together to ensure that issues of quality and safety were addressed. Information would be shared with each other and with CQC. Representatives of the voluntary sector told us that they felt that social services staff were responsive when they flagged concerns.

- However, there were some areas where people were at risk of avoidable harm which had the potential to place them is in a crisis situation and a possible hospital admission. There was some confusion, particularly among private residential, nursing home and domiciliary care providers about who to contact if a person they cared for became unwell. GP services designed to support care homes had been replaced by a 'hub' model with support from intermediate care teams. However there was confusion about the purpose of the hub and some providers reported that when they contacted the hub they were referred back to the person's own GP, which caused delays. There were some elements of the hub which worked effectively as a nurse on the team could make prompt referrals to services such as

occupational therapists. In addition, referrals could be made to the intermediate care team so that people could receive the care they needed in the community without having to go into hospital.

- Some voluntary sector and social care providers indicated that some GPs were reluctant or unable to attend to people in their usual place of residence and would advise them to contact emergency services. Frontline staff felt that there was a variation across Stoke-on-Trent with regard to the responsiveness of GPs and their understanding of and engagement with preventative services. Some GPs were effective in contacting intermediate care teams and social services but there were missed opportunities for others. Our analysis of Hospital Episode Statistics data showed that in the last quarter of 2015/16 the percentage of older people that attended A&E as a result of being referred by their GP was in line with similar areas at 5% and slightly lower than the national average of 8%. The percentage of those people who were then discharged from A&E without being admitted to hospital was lower in Stoke-on-Trent (12%) than similar areas (14%) and the England average (16%), which suggests those referred to A&E by GPs in Stoke-on-Trent were more in need of acute care.

- The low availability of GPs out-of-hours services was cited as a reason for people attending A&E services. We attended an out-of-hours walk-in centre which was nurse-led. Staff at the centre and people who were using the centre described the difficulties they had in getting a GP appointment which had led to them relying on the walk-in centre. While the walk-in service was effective as a means of diverting people from emergency services, it was operating over and above its planned capacity. Again, there was a risk that if people could not be seen here, they would use A&E as an alternative. Data from March 2017 showed that full provision of extended access to GPs was much lower in Stoke-on-Trent, with only 6.5% of the 46 GP practices surveyed offering full provision of access to GPs at weekends and on weekday mornings or evenings, compared to the England average of 22.5% and the average across Stoke-on-Trent's comparators of 37.1%.

- We spoke with a care home provider who had a paid arrangement with a GP service that entailed regular 'ward rounds' in which the GP attended the service on a regular basis to check on people who lived at the service. They told us that out of a population of 150 residents, there were on average only two urgent admissions to hospital each month and that regular visits and support from the GP had been an effective way of enabling people to stay out of hospital. However, this arrangement was made independently of NHS commissioners.

- Frontline staff across the health and social care systems including ambulance service and hospitals also reported concerns about the impact that a lack of GP access was having on people, increasing use of A&E.

- The CCG had worked to prevent admissions to hospital from care homes with the appointment of a care home matron in January 2017. This role was a temporary 12-month contract at the time of our visit. Part of this role was to undertake preventative work with care homes to reduce admissions to hospital as a result of people experiencing emergencies caused by issues such as falls or urinary tract infections. However this role was still fairly new and was combined with other responsibilities and will require further time to embed.

- The reach of the care home matron role could only extend to services which were commissioned by the CCG. The care home matron could not insist on engagement from other services which meant that there was still a large population of people living in care home settings who might not benefit from this preventative measure. Analysis of admissions to hospital from care homes for a range of avoidable admissions between October 2015 and September 2016 showed that the rate of admissions per population aged 65+ was higher in Stoke-on-Trent than the national average for each condition. In particular, the rate of admissions for pneumonia was significantly higher at 617 per 100,000, than the England average of 264 per 100,000

- There was a pilot initiative underway with eight GPs using video technology to enable them to support people who live in care homes more promptly. It was too early to determine the impact of this approach in terms of preventing hospital admissions.

- No dedicated GP provision for care homes was commissioned outside of normal GMS and PMS; a previous attempt to commission a dedicated Stoke-on-Trent-wide service had not been implemented.

Are services in Stoke-on-Trent effective?
Although there were arrangements in place to support people with maintaining their health, wellbeing and independence, these were not joined up across health and social care systems and there was a risk that people would require hospital admissions as a result of falling through gaps in service provision. There was not a seamless approach to information sharing.

- People who thought that they might need help and support were able to contact social services contact centres. Staff would be able to signpost them to services or arrange for an assessment. We saw from records, and heard from frontline staff we spoke with, that when people were assessed by the local authority, they were assessed holistically taking into account all their needs, and their carers' needs. However, the local authority's management information for July 2017 showed that there was a downward trend in the number of people who were able to receive assessments and there was a continuous growth in the number of overdue reviews.

- Telecare services such as Lifeline pendants and sensor mats were important to people and these services which would enable people to continue to feel safe while living at home showed the greatest uptake. However the data also showed a declining trend in the uptake of new domiciliary care packages and direct payments which meant that people needing more complex care may not be receiving it. Some of the decline in the provision of domiciliary care packages was attributed to the reduction in contracts allocated to a private provider as the local authority moved towards in-house provision and the use of reablement services. Department of Health analysis of ASCOF data for the period 2011/12 – 2015/16 showed that the percentage of people who received reablement services and were still at home after 91 days was low at 74.5%, much lower than the England average of 82.7% although the local authority's own monthly data shows an increase to 87.9% in June 2017.

- There was an older people's housing strategy and we saw action plans that were regularly updated. As a result of this work 470 supported housing units had been built and three extra care schemes had been developed. There were plans to review housing options for older people with specialist needs such as dementia and a contract with a voluntary sector organisation, including holistic assessments considering energy efficiency and fuel poverty, had been extended to spring 2018. These were some of a number of initiatives that were designed to enable people to stay independent for longer and in a safe environment.

- Although frontline staff in acute and social care services had the skills and knowledge to support the transition of people between health and social care services, there was a risk that people could fall through the gaps in other areas, particularly in primary care and residential and nursing care services. Staff we spoke with in the voluntary sector told us that very few of their referrals came from GPs as GPs were not always aware of voluntary sector services which could support people at home. Our relational audit also showed that voluntary sector providers felt that those working in the public sector lack understanding of the role and value of the voluntary sector.

- There was recognition from some health and social care staff that we spoke with that there was a need to ensure that training of staff in care homes was coordinated and monitored to improve quality and check competency of staff. There was no coordinated overview of this with care home providers being responsible for the delivery and checking of competencies themselves. There was a risk that not all providers would have the skills to ensure that the training they commissioned was sufficient to enable staff to make the right decisions about people's care and to keep them in their usual place of residence.

- Health and social care commissioners in Stoke-on-Trent were signed up to a 'One Staffordshire' information sharing protocol. The protocol had a wide range of signatories including hospitals, CCGs, the local authorities, some voluntary sector organisations and the police. Among the benefits listed of information sharing was the opportunity to keep people safe and to provide joined up services across agencies. There was clear guidance

in the protocol about the management of confidential personal information and issues around consent. However, in practice, information sharing was not built into processes around assessment. Some people who used services told us that they had to tell their story numerous times to facilitate people working together to support them in their homes. Some frontline staff felt that the quality of referrals into the system needed improvement and that minimal information would be received to help them support people in the right way.

Are services in Stoke-on-Trent caring?

People living in Stoke-on-Trent did not always experience a seamless transition between services that would help them to stay at home for as long as possible. There were missed opportunities to involve the right people in discussions about their care and treatment and people were more likely to get better outcomes if they had people to advocate on their behalf.

- Some people felt that they were dependent on family members or friends to advocate for them and we spoke with someone who described that there was not one person in charge of their care in terms of a single point of contact. This could make it difficult for people to navigate through the various health and social care systems and get the right information at the right time. We saw an example of a person who had 'slipped through the net' with regard to communication and had been left at home unsupported, in a urine-soaked bed for a number of days. The voluntary sector played a significant role in supporting people to get referrals to social care and other services which would support them at home and activities to reduce social isolation. They stated that successful communication was often dependent on individuals within the organisation rather than robust processes to enable this.

- Domiciliary care providers often felt that their staff knew people's needs well and that they would be able to support people more effectively when they were being assessed, particularly with regard to issues around continence and pressure ulcer management which could result in a person going into crisis in addition to issues around their privacy and dignity. Better coordination of assessments would alleviate some of these issues. We were told by providers and representatives of people who use services that people often had to wait for care packages to be arranged while agencies worked to agree funding. We also saw evidence of this in care files that we looked at.

- We saw some completed social care assessments and could see that the person's holistic needs were considered. System leaders described in the System Overview Information Request that there were community wellbeing teams in place to assess and support identified needs. There were missed opportunities; for example paid carers were often not involved in assessments when people's needs changed.

- Where health and social care agencies worked together, staff told us there were improved outcomes for people, for example with the carers strategy and the dementia strategy.

Frontline staff and management across the health and social care system exhibited a strong desire and a willingness to work together however the system structures did not always enable this. They told us that a perceived lack of openness and transparency between health and social care systems impacted on their ability to support people in a more integrated way.

Are services in Stoke-on-Trent responsive?
There were some good initiatives in place to respond to people's needs and prevent admission to hospital, particularly at the A&E 'front door'. However the focus on prevention needed to become embedded in the provision of community services and work with the voluntary sector to enable people to maintain their own health and independence.

- When we spoke with people who lived in Stoke-on-Trent and who relied on health and social care support, some people described positive experiences. For example one person described how they were supported at home and had not had any hospital admissions despite having complex health needs. GP Patient Survey aggregated data collected from July to September 2015 and from January to March 2016 showed that the percentage of people living in Stoke-on-Trent who felt supported to manage their long-term condition figure was 57% compared to 56% across England. Case files we reviewed showed that packages had been arranged to support people to remain at home.

- Frontline staff and voluntary sector staff told us about some services designed to enable people to avoid hospitals admission that were subsequently withdrawn. A service that enabled ambulance staff to contact an advanced nurse practitioner to seek advice rather than take people to hospital was withdrawn in January 2017. A previous 'hub' model that had enabled people to directly obtain support from services such as occupational therapists had been decommissioned in December 2016 as it was not considered effective following an evaluation. Since then, referrals for these services had had to come via the GP. This placed added pressure on GPs and frontline staff described it as an 'extra layer' in the process.

- Some social care providers told us that when they had concerns about people living at their services, some GPs would not visit patients at the service. GPs told us that this was because they had to manage high workloads. In addition, GPs felt that a recent reduction in community hospital beds and community nursing meant that they had no alternative but to send people to A&E.

- The ambulance services reported that they received a high volume of calls from older people who had fallen and this was also reflected in data[5] which showed that admissions

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[5] HES admissions October 2015-September 2016. Analysis is based on admissions from postcodes containing a registered care home.

from care homes in Stoke-on-Trent as a result of accidents and injuries were much higher than similar areas and the England average at 562 per 100,000 aged 65+ in Stoke, compared to 439 per 100,000 aged 65+ across comparator areas and 392 per 100,000 aged 65+ across England.

- Ambulance services told us that they were no longer able to refer people directly to the falls team or the intermediate care team. Frontline staff in other services also told us that people were at risk of admission to hospital as a result of falls and that support in the community to manage this could be improved. We were told that there was a falls service however frontline staff across the system stated that it was difficult for people to access and this was confirmed by system leaders who told us that only GPs could refer people into the service. This created a barrier to access and also placed an additional pressure on GPs. We were told that a more 'fit for purpose' falls service was planned for spring of 2018.

- System leaders told us that their key preventative services were placed at the A&E 'front door' owing to the high numbers of people presenting there. However, our analysis showed the rates of A&E attendance for over 65s in Stoke-on-Trent were lower than comparators and in line with England average through 2015/16, although rates of A&E attendance were greater than England average (although similar to comparators).

- We saw that the 'front door' system engaged effectively with voluntary sector providers to enable people to return home from A&E rather than be admitted. They were able to ensure that people's homes were safe and warm for them to return to and to check that support services were available. The mental health trust worked with the acute trust to ensure that there were services to support rapid assessment, intervention and discharge at the hospital. At the time of the review these services were limited to 7am to 11pm but there were plans to extend this to a 24-hour service in 2018.

- Concerns were raised across a range of people we spoke with, from system leaders and frontline staff to voluntary and private sector representatives, that services could not meet the needs of the population in a responsive way. We were told by people who used services that they relied on voluntary sector organisations to provide some support. An example was given to us by a person who told us they had to change their neighbour's catheter bag as district nurses could not attend daily to support the person with this. District nurses found themselves supporting people with tasks other than nursing because care packages were not yet in place, and where care packages were in place, domiciliary care providers felt that they were being expected to undertake nursing tasks that their staff were not trained to do.

- Staff working in all sectors across the system demonstrated that they wanted the best support and outcomes for people, but they felt they were not always able to manage this. Staff in the voluntary sector told us that they perceived the biggest issue for people in

Stoke-on-Trent to be access to community care. They indicated that there was not a problem with funding of care but finding placements and providers. GPs also felt that the lack of community beds and community nursing was an issue.

- When people first needed services, systems were designed so that their needs could be assessed and reviewed to enable services to be implemented as soon as possible. When a referral to services was made, a visit should take place the same or the following day with the social worker undertaking the first assessment. There would then be weekly reviews of the care packages to assess people's ongoing needs. The local authority's monthly data return showed that the numbers of assessments being undertaken were on a downward trend. In addition the number of reviews that were overdue was steadily increasing. Although the local authority monthly management information analysed this, their report did not show the reasons for this. This presented a risk that there might be missed opportunities to support people whose needs might have changed. If their needs had increased and the support packages were not reviewed, they might be risk of entering into crisis as a result of issues such as falls or mental health related needs. There was also a missed opportunity to divert support more appropriately elsewhere when people's conditions might have improved.

- System leaders did not provide evidence of analysis to show whether the declining trend in new packages of domiciliary care support and direct payments was a result of reduced need, people not having their needs assessed or reviewed in a timely way, or the result of an increased focus on enabling people to return from hospital.

- Accessing help for older people was confusing. The local authority website directed people to arrange an assessment and it was only by choosing this option that people could find more information about what services they might be able to access. There was a link to the 'Staffordshire Cares' website but this took people to the Staffordshire County Council's website, which could prove confusing. Although there were also links to the Lifeline pendant service and telecare services, there was no signposting to other ways of support such as carer support groups and services such as befriending and handyman services which would enable people to maintain their independence for longer. Documents we reviewed showed us that when people did come into contact with social services and assessments were undertaken, a wide range of options were discussed with people that considered their individual needs. The 'What Matters Review' form asked the question "What matters to the adult?" and based plans and goals on the response to this question.

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

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

Are services in Stoke-on-Trent safe?

Risks were not managed strategically which meant there were too many people in crisis being admitted unnecessarily to hospital. Risk aversion in the primary and private sectors contributed to this and this was not being addressed by system leaders.

- When services entered into crisis and were unable to provide high quality care, partnership working across the system in Stoke-on-Trent was effective. Partnership working was well established in the area of safeguarding adults at risk of harm and neglect. Partners described how changes in practice occurred as a result of lessons learned from Safeguarding Board reviews. When CQC was required to take urgent action with regard to care home failings there was a robust response from local authority and CCG staff to ensure that people were moved safely and promptly.

- Ambulance services reported that there was a lack of alternative provision for people who became unwell and needed support. This was supported by our analysis, which showed that emergency admissions for older people were significantly higher in 2015/16 in Stoke-on-Trent than the national average and comparator areas. The Department of Health's analysis also showed that the rate of emergency admissions of older people was still higher in Stoke-on-Trent in 2016/17 than across comparator areas or the national average. This meant that although the numbers of people presenting at A&E were lower, people were more likely to be admitted.

- Once people were admitted to hospital the percentage of older people who stayed longer than 7 days in 2015/16 was lower in Stoke-on-Trent than similar areas and it was not clear whether leaders had explored whether this means that a higher number of people were admitted to hospital who might have benefitted from services in the community.

- Frontline staff and commissioners expressed concerns that many admissions from other services were owing to social care providers being 'risk averse', for example if people had falls they would always ring for the emergency services. Social care providers told us that they felt that they would be subject to frequent safeguarding investigations if people became unwell. These conflicting views indicate a lack of trust and transparency in the system. This is supported by findings from our relational audit which showed some low scores relating to trust, particularly in regard to people feeling like they could take organisational risks where this has the potential to serve wider system goals without fear of criticism or failure.

- Further analysis of these issues would enable system leaders to ensure that people aren't admitted to hospital unnecessarily as a result of issues that could be resolved by closer working and transparency between commissioners and providers. We did not see systems that would flag risks at an early stage and prevent the need to continuously manage crisis.

- The CCG had published a risk management strategy, which had been due for review in July 2017, that described the process for identifying and escalating risks in its area. This included operational risks that impacted on people such as clinical quality and safety. The local authority also had a protocol for the management of risk. Although information sharing protocols enabled frontline staff to work together to address risks, the protocols did not describe how the system could jointly identify and manage risks in a proactive way. They were not aligned to each other and relied on internal escalation procedures. This presented a risk that partners might attempt to address the same issues independently of each other with duplication of resources or by implementing solutions that negatively impacted on other parts of the system.

Are services in Stoke-on-Trent effective?

People in Stoke-on-Trent had mixed experiences when they were in crisis with outcomes often depending on the skills and knowledge of staff managing their particular condition. Information was not shared effectively across the system and this led to poor outcomes for some people. There were missed opportunities to work with people who supported the person at home, who would be familiar with the person's needs and could support discharge planning while the person was in hospital.

- Frontline staff told us that when people presented at hospital, the effectiveness of their care pathway would depend to some extent upon their condition. For example if people presented with an orthopaedic condition their pathway would be straightforward but if they had complex needs for such as a urinary tract infection and had comorbidities it would become a "minefield". Analysis of these admissions would enable system leaders to determine whether the admissions were related to the condition that had resulted in the person going into crisis or whether frontline staff were admitting people for treating or monitoring conditions that people had been managing at home.

- We were told that there were blockages in A&E due to high attendances and that the numbers of people using A&E was increasing. This led to high waiting times and in 2016/17 only 78.3% of people at University Hospitals of North Midlands NHS Trust (UHNM) were seen within four hours which is considerably lower than the 95% target rate and also the England average for 2016/17 of 89.1%. Our analysis of HES A&E data (which specifically looked at A&E attendances of people aged 65+), showed that, per 1,000 population aged 65+, the rate of A&E attendance from both Staffordshire and Stoke-on-Trent was lower than the England and the comparator group averages over 2015/16. When older people

living in Stoke-on-Trent did attend A&E, the rate of admission was significantly higher than the England average at 91 per 100,000 compared to 63 per 100,000 for England. This data suggests that older people did not attend A&E unless they were in crisis and reflects feedback from providers and voluntary sector organisations who told us that older people were reluctant to attend A&E unless they were in crisis.

- System leaders and frontline staff told us that people were supported during trolley waits to ensure that their needs were met in terms of hydration and safety however this could still be a distressing experience for people who were left in these conditions.

- System leaders did not work together to ensure that the workforce had the right skills to support people across services. Frontline staff expressed concerns that owing to pressures, there were missed opportunities to ensure that newly qualified staff were fully inducted to local systems and ways of working.

- We found several examples of people who had had poor outcomes as a result of professionals not sharing information effectively. Voluntary sector representatives felt that they were often excluded from information sharing when they were sometimes the only point of contact for an older person using services. This view was shared by frontline staff in health services. Domiciliary care providers also felt that they could be of assistance on wards particularly with regard to supporting people who live with dementia. They were familiar with the person's needs and their home environment and would be able to provide information such as equipment needs to support the planning of people's care while they were still in hospital.

- A patient profile was designed to build a picture of a person's care needs and support them as they progressed through services. There was no 'trusted assessor' system and the system was dependent on ward staff to ensure the information was completed correctly. Social work staff told us that they had relationships with ward staff and were able to liaise with them if information was missing or there were other queries about the person's care.

Are services in Stoke-on-Trent caring?

Frontline staff understood the importance of involving people who needed support and their families in decisions about their care. The dementia strategy was designed to enable person-centred care and hospital feedback mechanisms had been designed to better collate the views of people. In practice, people who used services and providers felt that decisions were often made without their involvement.

- People we spoke with did not always feel that they were at the centre of care and support planning. For example one family told us that they had not been involved in life-changing decisions about their loved one. They felt that consultants did not listen to their concerns and that their relative had been placed on a palliative care pathway owing to their diagnosis of dementia.

- System leaders told us that the Dementia Steering Group was working to coordinate activities to improve person-centred care for people living with dementia. There was a dementia strategy 2015 – 2019 on the local authority's website however this was last updated 2015 and was marked as draft.

- The system relied on the completion of a patient profile to ensure effective coordination of services, but residential, nursing home and domiciliary care providers felt that the patient profile was not always kept up to date while the person was in hospital. They found it could be misleading when it came to providing information for discharge and the most commonly recurring theme they found was around people's mental health needs. We saw an example of a completed profile and saw that the person completing the form did not understand or apply the requirements of the Mental Capacity Act 2005. This meant that the person had been unable to be involved in discussions or decisions about their care, and there were not safeguards to ensure that decisions made on their behalf were done so legally.

- Frontline staff that we spoke with acknowledged the importance of involving families in decisions about people's care. There could be additional pressures as there was a perception that some families tended to be risk averse and their expectations of what services should provide did not align with what was available.

- In the System Overview Information Request, system leaders described the difficulties they experienced in getting feedback from carers so they had incorporated questions into the hospital feedback mechanisms.

Are services in Stoke-on-Trent responsive?
People living in Stoke-on-Trent did not always receive the services they needed at the right time and in the right place. A shortage of available hospital beds meant that people could spend too long waiting in A&E and people were also more likely to stay in hospital for too long because of a shortage of care packages and beds in the community.

- People who were in crisis were not always able to have their needs met at the right time and place. A shortage of available hospital beds meant that people could not be discharged from A&E as quickly as they needed to be and there were occasions when people were nursed in corridors. Data showed that bed occupancy at UHNM was higher than the England average, consistently above the optimal 85% level and was steadily increasing over the last three quarters of 2016-17. Hospitals with average bed-occupancy levels above 85% are likely to face regular bed shortages, periodic bed crises and increased numbers of healthcare associated infections.

- Although there were step up and step down beds commissioned in care homes to enable people to receive care and treatment in the community rather than in hospital, front life staff

reported that there was reduced availability of beds and that people's needs were too complex to enable them to use this type of provision. This meant that people weren't always receiving care they needed in the right place and that when they experienced a health crisis they were more likely to stay in hospital.

- Frontline staff told us that there was pressure to move people out of hospital as soon as possible owing to the pressures coming through the A&E system. However data showed that the proportion of people who were offered a reablement service was significantly lower at 0.7% compared to the England average of 2.9%.

- Some providers and frontline staff reported that the brokerage system for the arrangement of care packages could be inefficient. To increase capacity staff would also have to commission from outside the framework to find providers to support people.

- System leaders had processes to gather people's views and feedback and to ensure that complaints were addressed. They reported that feedback and learning from complaints was shared at team meetings and provider forums.

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

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

Are services in Stoke-on-Trent safe?
Discharges from hospital were not always managed safely as people were sometimes discharged inappropriately. Social care providers were not always given discharge information to enable them to meet people's needs and community pharmacists were not given information which would enable them to ensure that people's medicines were safely managed on their return from hospital.

- The systems for discharging people from hospital to their usual or new place of residence did not always protect people from harm. Although system leaders told us in their System Overview Information Request that the guiding principle was "understand me enough to discharge me safely", providers of residential and nursing services expressed concerns about the timeliness of discharges for people who were on end-of-life care pathways. Providers told us they had experienced times when people had passed away during the move from the hospital to the care home or shortly after arrival at the care home. This would

be an undignified and distressing experience for a person who is at the end of their life. We saw the brokerage system which during one day on our visit had put out requests for end of life care placements for a number of residents which then were withdrawn within hours.

- Five of the 12 registered managers of adult social care services in Stoke-on-Trent who responded to our online request for feedback on the flow of information during the discharge process said they rarely received discharge summaries when an older person was discharged from hospital into their care. However, when they did receive discharge information, this tended to be comprehensive and gave them the information they needed about people's needs such as diagnosis, medicines and mobility.

- Social care providers told us that they could wait seven to eight weeks for a medicines review for someone who had been discharged into their care which could place people at risk if they were not getting the right medicines to manage their condition or they were experiencing problems owing to the medicines they were taking. Community pharmacies did not receive discharge information and felt that if they were involved in the patient's care pathway they would be able to support people better. We were told by pharmacists that there was a planned project due to start before the end of the year which would ensure that they received discharge information and medicines reviews could be undertaken more promptly using video technology.

Were services in Stoke-on-Trent effective?
Rates of readmission to hospital were increasing. Services across health and social care did not work jointly to support the effective discharge of people from hospital to their usual or new place of residence. There were not enough reablement beds and there was limited access to services such as occupational therapy and speech and language therapy.

- Readmission rates to hospital were increasing. At the time of our review, there were new systems being put in place and 'discharge to assess' (D2A), was due to launch shortly after our review. Analysis of ASCOF data for 2015/16 showed that the percentage of older people who received a reablement services was significantly lower in Stoke-on-Trent than in similar areas and the England average at 0.7% for Stoke-on-Trent, 2.9% for England and 3.1% for comparators. For the D2A scheme to work it will require close working across the health and social care system which was not embedded at the time of our review. For example social workers were not always part of multi-disciplinary team discussions about a person's care. Local authority processes required a separate referral which would enable them to undertake an assessment. Frontline staff felt that social workers were key to ward rounds but sometimes they were under resourced and professionals such as social workers and speech and language therapists would need to prioritise which meetings they could attend.

- Providers and voluntary sector representatives told us that there were occasions when people indicated in hospital that they were ready to manage at home, but found when they were at home that they were unable to cope. Again, this was something the system leaders were expecting D2A to address; if people had their needs assessed at home, then professionals would be able to determine more accurately what people's needs were.

- The design of services to improve the flow of people through health and social care services was not joined up across the system. There were some areas of good practice with a 'track and triage' team at an early stage within the acute hospital. This was intended to be the 'one stop' for step up or step down expertise enabling people to move through the system smoothly.

- Following the closure of some community hospital beds, the CCG commissioned reablement beds from some private providers. These were commissioned as step down beds so that people could receive reablement support which would enable them to return to their own homes. Providers raised concerns about the volume of admissions, for example on the day of our visit one provider had received three new service users although the contract specified that they should take up to two admissions per day. This meant they had difficulties keeping up with their own assessments of people's needs and there was a risk that important information might be missed.

- There were pressures across the system in the workforce to support people to return from hospital. The local authority had begun a recruitment programme to employ staff to undertake domiciliary care to support people at home however the private sector was experiencing problems with the recruitment and retention of staff. Data from Skills for Care showed that vacancies were lower than average but turnover was increasing, above comparator and national levels.

- Occupational therapists reported that they could not keep up with demand and were having to prioritise urgent referrals on their waiting lists. This, coupled with pressures on social workers and speech and language therapists, meant that people were not able to get timely access to services and there was a risk that they may need to be readmitted to hospital. Our analysis showed that emergency readmissions for people aged 65+ in Stoke-on-Trent increased during 2015/16 and in the last quarter of that year were significantly higher than the national average at 22%, compared to 18%.

- There were concerns that information was not shared in a way that would enable people to be properly supported once they had been discharged from hospital. We saw an example of someone who had been admitted to a reablement unit on the basis of their physical support needs but their mental health needs related to their diagnosis of dementia had not been considered. The service had been unable to get support from a community psychiatric nurse for four weeks. In the meantime, this person was not only in distress and

at risk of harm, but also a reablement bed could not be used by someone who might have benefitted from the service.

- Pharmacists and other frontline staff also described how a lack of integrated systems and clear information sharing impacted on their ability to support people effectively.

Are services in Stoke-on-Trent caring?
The CCG's system for purchasing care packages for people with continuing healthcare could limit people's choices of nursing home placements and this sometimes resulted in delays. Further delays could be encountered when people left reablement services but were not able to return home. Both issues contributed to delayed transfers of care.

- System leaders reported in the System Overview Information Request that the enablement service supports people to be actively involved in making decisions about their care with an assessment and service delivery plan completed at the start of the service and we saw files that reflected this.

- Whether assessments of need ensured that the person was at the centre of support planning could differ depending on where the person was placed and the situation they were in. There was a brokerage system for people with continuing healthcare needs that involved inviting providers to make an offer of a care package for people who were leaving hospital. However, providers raised concerns that this limited the choices that people were able to make and people were subject to a number of assessments. At the time of our review the discharge to assess scheme had not started and people had to wait in hospital for these assessments to be completed.

- We saw examples showing that where people were not able to return home from reablement or rehabilitation services they were supported to make decisions about where they wanted to live. In some cases this caused further delays as the particular service that they wanted was not available. Providers also told us that some people chose not to use the services allocated through the brokerage system. This could cause delays, particularly if there were disputes over the funding of care packages.

- Our analysis of reasons for delayed transfers of care between February and April 2017 showed that 'patient choice' was reported as one of the main reasons for delay in Stoke-on-Trent, accounting for an average daily rate of 7.3 delayed days per 100,000 population. In contrast, over the same period this reason was only reported as contributing to an average of 2.1 delayed days per day across similar areas and 1.5 delayed days per day across England.

Are services in Stoke-on-Trent responsive?
The need to discharge people quickly from hospital sometimes meant that people were

discharged to places that could not manage their individual needs. There were also delays in enabling people to return home because there was a shortage of domiciliary care provision which the local authority had tried to address by building an in-house service. There was no trusted assessor to support discharge from hospital and delays in assessments impacted on delayed discharges. Some people were inappropriately placed on palliative care pathways to enable them to be fast-tracked out of hospital.

- System leaders reported that work had been undertaken to support early discharge from hospital and the local authority had created in-house domiciliary care provision. The discharge to assess model had been implemented in the North Staffordshire CCG area but at the time of the review it had not yet been implemented in Stoke-on-Trent. This meant that secondary care providers had to work within different structures and frontline staff reported that the integrated discharge to assess model they worked with for another area enabled people to move through the system more quickly.

- Staff at all levels were optimistic about the pending implementation of the D2A model and felt that people would benefit from this. Staff we spoke with across the systems felt that the paucity of domiciliary care provision and reablement beds were a cause of delayed discharges.

- Our analysis of reasons for delayed transfers of care between February and April 2017 showed that 'awaiting care package in own home' was reported as the main reason for delayed transfers of care in Stoke-on-Trent, accounting for an average daily rate of 9.3 delayed days per 100,000 population. Across comparators this reason for delay accounted for an average of 1.3 delayed days per day per population and 3.1 delayed days per day across England. 'Waiting for further non-acute NHS care', which includes community and mental health care, intermediate care and rehabilitation services, was also one of the main reasons reported for delayed transfers in Stoke-on-Trent according to our analysis. The local authority had employed care workers to build an in-house domiciliary care service but this was not yet having an impact.

- There was an expected offer of on-site support at care homes that were commissioned to provide reablement beds so that people could receive services such as physiotherapy but because of capacity in the system this support could be limited and people weren't always able to receive the services in a timely way.

- The continuing healthcare brokerage system also caused delays as providers needed to be given a window to apply and then three providers would be invited to assess people for themselves. A trusted assessor scheme which is recognised in the High Impact Change Model as good practice would alleviate some of this delay. Providers were concerned about the information that was supplied in advance of their assessments and felt that they

relied on their own assessments which meant that there was a reluctance to consider a trusted assessor scheme.

- Patients who required rehabilitation could be transferred to a ward in the community trust. However, staff we spoke with told us that some of the people who were placed on the ward had needs that needed to be addressed by other services such as care packages or social needs. This meant that people were not in a place that best suited their needs and in addition to the delays this caused, led to a poor patient experience. These 'bottlenecks' in the system with reablement and rehabilitation beds meant that hospitals would experience increased difficulty in discharging patients in a timely way, putting patients at risk of further deterioration in their health.

Maturity of the system

What is the maturity of the system to secure improvement for the people of Stoke-on-Trent?

- Relationships between leaders across the system had been poor with a high level of mistrust for many years and significant churn in leadership across the system partners.

- There has been a recent change in leadership across several organisations in the system. More recently, relationships had begun to improve and there was a willingness to build trust and to work collaboratively going forward, however relationships remained fragile overall.

- System leaders did not demonstrate positive relational working and collaboration in the interests of the population's defined needs. However they recognised this as a shortfall and were addressing it through the implementation of plans around the BCF and discharge to assess.

- There is little evidence of system-wide multi-disciplinary team working for effective outcomes. There was some work in place regarding discharge from hospital and the use of the track and triage team, but it was not fully integrated. There was little evidence of pathways across primary, community and secondary care that support the wider objectives of health maintenance, and people living in Stoke-on-Trent encountered barriers to maintaining their health and wellbeing through inconsistent access to services.

- There was a good understanding of challenges to the local health and social care system. While there was a system-wide health and wellbeing strategy it was not clear how the priorities identified in the plan were aligned with the STP and BCF priorities. Through the BCF, system leaders had worked together to agree and shape a structure of supply that would be sustainable and responsive to the needs of this population group. However, this was at its early stages in terms of planning and will need to build on a history of individual commissioning arrangements that originally brought system leaders into dispute.

- Funding flows through the BCF are designed to improve collaborative care around discharge and make it easy for health and care sectors to work together. However resources are not jointly targeted at high-risk cohorts to prevent crises and maintain wellbeing. The use of personal budgets was low and there was little integrated commissioning. Health and social care leaders had different systems for identifying and managing risk.

- The majority of decision making still sits separately within organisations with little evidence of there being a system-wide approach. There were some limited shared processes, measurements and systems for effective oversight of delivery for the defined population; for example around support of people with dementia.

- The governance structure did not always enable system partners and the local community to hold each other to account regarding performance and delivery of strategy as health and social care organisations operated as very separate entities.

- While operational delivery was supported by controls, processes and policies to manage risk, these were also managed separately and were not always effective in preventing poor quality of experiences for people in Stoke-on-Trent. System leaders were in the very early stages of developing an integrated approach and there was no evidence that as a system they provided encouragement, support and reward for integrated and collaborative activities.

- Systems did not share records through digital interoperability or use of NHS number although since our review system leaders have secured funding to progress this.

Areas for improvement

- There must be better and effective communication between leaders of the system.

- There must be effective joint strategic planning based on the needs of the local population with clear shared and owned outcomes.

- Attention should be given to long-term strategic planning across the system within an agreed performance framework.

- System leaders should ensure effective delivery of their integrated strategic plans.

- Strategic commissioning should be aligned to the agreed strategic plans and must include primary care

- System leaders should ensure an integrated approach to market development which should include the monitoring of quality in the care and voluntary sectors.

- An effective system of integrated assessment and reviews of the needs of people using services should be introduced urgently.

- There should be integrated delivery plans which include resources and workforce.

- The trusted assessor scheme should be implemented as soon as possible.