Hartlepool

Local system review report

Health and wellbeing board

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 that will bring together key findings from across the 20 local system reviews.

The review team

Our review team was led by:
- Delivery lead: Ann Ford, CQC
- Lead reviewer: Karmon Hawley, CQC

The team included:
- Two CQC reviewers
- One CQC analyst
- One CQC strategy lead
- One CQC Expert by Experience
- Three specialist advisors: one former local government director, one with a background in clinical nurse governance and one with a general practice background.

How we carried out the review

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

We also focussed on the interface between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings. Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across three key areas:

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

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

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

We have then looked across the system to ask:

- **Is it well led?**

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

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

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

- System leaders from Hartlepool Borough Council (the local authority), NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (the CCG), North Tees and Hartlepool NHS Foundation Trust (NTHFT), Tees Esk & Wear Valleys NHS Foundation Trust (TEWV)

members of the Hartlepool health and wellbeing board

- Health and social care staff including social workers, GPs, discharge teams, reablement teams and the integrated discharge team
- Healthwatch Hartlepool and voluntary and community sector (VCS) representatives
- Health and social care provider representatives
- People using services, their families and carers during our visits to day centres and support groups and in focus groups

We also met people using services from North Tees and Hartlepool NHS Foundation Trust in both A&E and the discharge lounge as well as at the urgent care centre.

We reviewed 16 care and treatment records and visited 11 services in the local area including Hartlepool and North Tees Foundation Trust, intermediate care facilities, care homes, domiciliary care agencies, GP practices, an extra care housing scheme, out-of-hours services and the urgent care centre.

Hartlepool context

Demographics
- 17% of the population is aged 65 and over.
- 98% of the population is categorised as White.
- Hartlepool is in the most deprived 20% of local authorities in England.

Adult Social Care
- 18 active residential care homes:
    - 11 rated Good
    - 6 rated Requires improvement
    - 1 currently unrated
- 8 active nursing care homes:
    - 4 rated Good
    - 2 rated Requires improvement
    - 2 currently unrated
- 13 active domiciliary care agencies:
    - 9 rated Good
    - 3 rated Requires improvement
    - 1 currently unrated

GP Practices
- 17 active locations
- 13 rated Good
- 4 currently unrated

Acute and community Healthcare
Hospital admissions (elective and non-elective) of people living in Hartlepool LA are almost entirely at one NHS acute hospital trust:

North Tees and Hartlepool NHS Foundation Trust (RVW)

- Receives 76% of admissions of people living in Hartlepool LA.
- Admissions from Hartlepool make up 28% of the trust's total admission activity
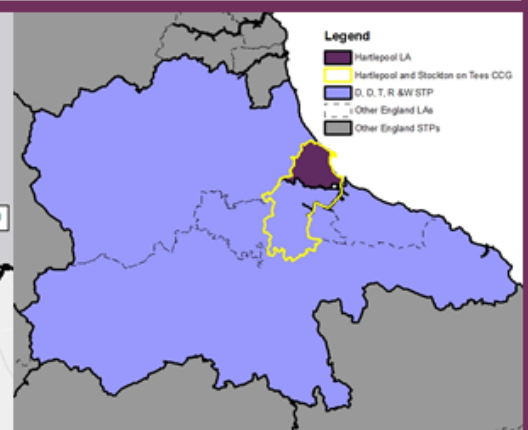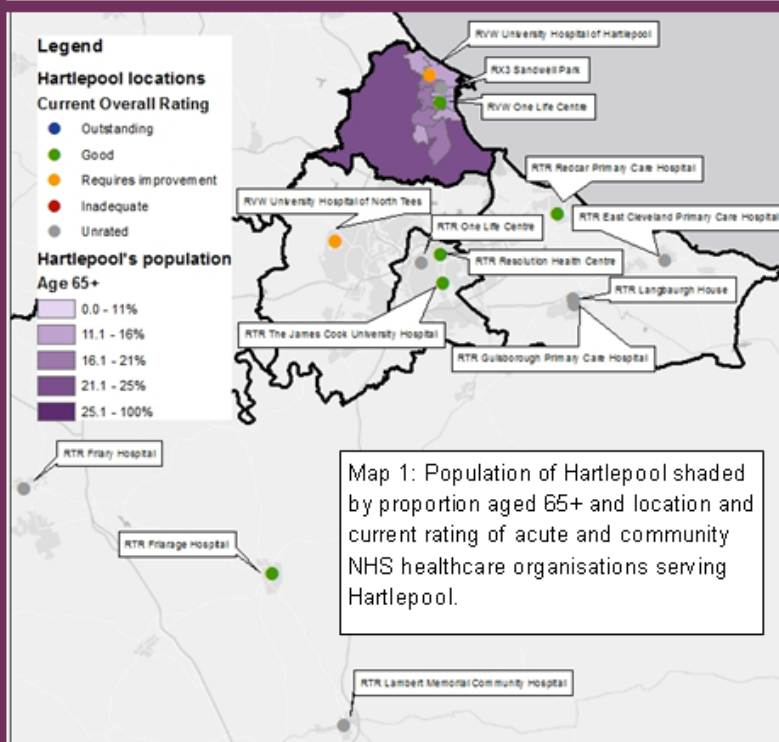- Rated Requires Improvement overall

The second main trust is South Tees Hospitals NHS Foundation Trust (RTR)
- Receives 15% of admissions of people living in Hartlepool LA.
- Admissions from Hartlepool make up 3% of the trust's total admission activity
- Rated Good overall

Community services are provided by:
- Tees, Esk and Wear Valleys NHS Foundation Trust (RX3) - currently rated Good overall.

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

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

Map 2: Location of Hartlepool LA within Durham, Darlington, Teesside, Richmondshire and Whitby STP. Hartlepool and Stockton-on-Tees CCG is also highlighted.

Summary of findings

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

- The sustainability and transformation plan (STP) 'Working together to improve health and care' for Durham Dales Easington and Sedgefield, Darlington, Teesside, Hambleton, Richmondshire & Whitby was undergoing restructure and realignment for the geographical area. The plan provided a comprehensive account that had potential to be a driving force for change across the wider system and support integrated working at a local level within Hartlepool. The Hartlepool Matters report, which describes a model for the integration of health and social care services in Hartlepool, was incorporated within the STP vision and delivery plan and would support the STP being translated at local level.

- Historically relationships across the STP footprint had been compromised. System leaders in Hartlepool acknowledged that in the past relationships across the wider system had been poor and there had not been a high level of trust but more recently this had begun to improve. There was an acceptance among system leaders that a shared vision was required with leaders working collaboratively to improve and develop sustainable services across the STP footprint.

- Relationships had improved between system leaders from Hartlepool Borough Council (the local authority), NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (the CCG), North Tees and Hartlepool NHS Foundation Trust (NTHFT) and Tees Esk & Wear Valleys NHS Foundation Trust (TEWV). Aligned with the jointly developed health and wellbeing strategy there was a strong commitment from the local authority, the CCG and NTHFT to serve the people of Hartlepool well. The health and wellbeing board (HWB) was recognised as the vehicle for progressing this, and work was underway to strengthen its challenge and support functions.

- There was a shared understanding across system partners of the challenges that each organisation faced and a willingness to work together with a solution-driven approach without compromising their own organisational responsibilities. There was evidence of joint working in respect of the Better Care Fund (BCF) initiatives which were supported by system partners.

- The BCF had resulted in positive outcomes for people in terms of social inclusion, hospital admission avoidance and timely discharge.

- Local priorities were focussed on keeping people well in their normal place of residence by

providing them with preventive services and support and also enhancing the capacity within the care home sector and extra care housing schemes.

Is there a clear framework for interagency collaboration?

- The Joint Strategic Needs Assessment (JSNA) was robust, well considered and underpinned by clear delivery plans and outcomes. This had been translated into the Hartlepool Matters report and the Hartlepool Matters implementation plan 2017 as a joint local strategy overseen by the health and wellbeing board. All partners were sighted on what was important to older people, their families and carers.

- The BCF plan built on the early integration between the local authority and the CCG and had interdependencies with the JSNA and the Hartlepool Matters report. The BCF plan was facilitating elements of risk sharing between partner organisations. For example both the CCG and the local authority had agreed plans set out in the BCF that needed full investment to pooled budgets in order to achieve the desired outcomes. Both parties agreed to manage the risk of increased emergency admissions to hospital and increased admissions into residential services. It was encouraging to see that there was an acceptance of the challenges ahead and a willingness to work together to improve people's experiences and the quality of services.

- Governance arrangements, as set out in the BCF plan, included community, professional and clinical leadership and were collaborative with decisions made at local level. The BCF board had oversight of the various strategies, including the joint commissioning strategy for intermediate care and the joint commissioning strategy, The Great North Care Record (API).

- There were positive examples of shared approaches and initiatives that supported people in Hartlepool to have timely access to services and support that met their needs in a person-centred way. The joint approach for people living with dementia had positive outcomes in terms of diagnosis and longer term support. Cross-system collaborative plans for the anticipated increase in demand due to winter had been submitted and there was evidence of a system-wide approach to winter planning.

- Care home closures locally had resulted in a substantial loss of long-term care beds in Hartlepool and the lack of capacity had led to increased numbers of delayed transfers of care (DTOC).

- There had been proactive attempts to stabilise and improve capacity in the care market. The local authority had worked well with local providers to encourage the development of

new care facilities and improve availability to good effect. Recently there had been a significant increase in care home bed numbers that was supporting improved patient flow and a reduction in DTOC.

- Additionally, a joint and collaborative approach had been adopted to improve the quality of long-term adult social care services following poor CQC service ratings. The majority of providers that we spoke with said that they felt well supported by the local authority and the CCG to secure service improvement.

How are interagency processes delivered?
- Partnership working across the system was supported through defined governance, and there was involvement and representation of a wide membership on a variety of partnership boards such as the North of Tees Partnership Board, BCF Pooled Budget Partnership Board, BCF Delivery Group and BCF Project Implementation Group. Within these forums, key issues were discussed and actions agreed for implementation and performance monitored.

- Frameworks for interagency collaboration across the health and social care interface were developing positively, an example being the integrated discharge team.

- System leaders and frontline staff across the systems reported good integrated working between health and social care professionals. However, social care providers expressed a desire to work more collaboratively with the local authority. Partnership working could be further improved by ensuring all partners and stakeholders were kept informed of pilot projects and initiatives so these could be utilised to their full potential.

- Frontline staff were clearly focused on the strategic direction, needs and welfare of people who lived in Hartlepool and they expressed a desire to improve outcomes for people through collaborative working. Some community based teams felt systems and processes could be streamlined to enable this further.

- A self-assessment against the high impact change model undertaken and provided to the Local A&E Delivery Board (LADB) in June 2017, identified that significant progress had been made in relation to early discharge planning, monitoring of patient flow, multi-agency discharge teams, discharge to assess, seven day services, focus on choice and enhancing health in care homes.

- Frontline interagency and multidisciplinary teams were supporting people to move through the system smoothly and seamlessly; there was good support placed at 'front of house' in

A&E to help to prevent avoidable admissions. Once people were admitted to hospital their journey was tracked via the patient flow coordinators and the integrated discharge team. This was having a positive impact and reducing DTOC. Our analysis showed that the percentage of older people staying in hospital for 7 days or longer reduced in 2016/17 to be more consistent with national and comparator averages.

- System leaders had developed winter plans covering the resilience of the system to support increased demand. Frontline staff were aware of the plans across primary and secondary care.

- There was an active voluntary and community sector (VCS) that played a positive role in supporting older people to remain at home and to be socially included.

- A number of support services were commissioned through the BCF including carers support, day services for people living with dementia, a dementia advisory service, advice and signposting, and a handyperson service.

- Further work was being undertaken to improve the coordination of services and to ensure the voluntary sector felt engaged and included in service design and delivery.

- Thirteen Housing Association was a willing partner to improve the experiences of older people and there had been some positive work around the development of extra care housing schemes.

What are the experiences of frontline staff?
- Health and social care professionals in Hartlepool were highly dedicated to supporting people using services, their family and carers. Staff that we spoke with felt that leaders were visible, responsive and inclusive. Frontline health and social care staff reported that staff generally communicated well across agencies. However, some social care staff reported that they were not always kept informed when people in their care had been admitted to, or discharged from hospital.

- We found that a collaborative multi-agency approach was establishing well as a result of new initiatives that supported networking and the building of relationships. Social care staff welcomed the opportunity to be more involved in people's care when in hospital and in the discharge assessment process.

- Feedback from frontline staff was, in the main, very positive, although they identified issues about workforce; particularly about the recruitment and retention of nurses in nursing

homes and paramedics. There were system-wide plans in place to mitigate risks associated with these issues and new models of care, which would promote integrated working and best use of resources, were being considered.

- In the main, staff felt supported with their professional development and career opportunities; however some specific concerns were expressed with regard to the lack of opportunity for ambulance staff to undertake the advanced practitioners training due to waiting times for places.

What are the experiences of people receiving services?
- Most older people living in Hartlepool received health and social care services in a timely way. However some concerns were expressed in respect of access to GP services. Most people using services told us they felt included in decision making about their care, treatment and support. However, some people had to tell their story more than once due to duplication of assessments as they moved through the system.

- There were a number of extra care housing schemes which supported people to remain independent in their own homes for longer. People living at these schemes were extremely positive about their experiences and the benefits this brought.

- Local people benefitted from access to direct payments and data for Q1 2017/18 showed the rate of direct payments per 50,000 people was 8.13 in Hartlepool and Stockton-on-Tees, above the regional average of 4.73 per 50,000 and above the national average of 3.63 per 50,000. While continuing healthcare (CHC) data for Q1 17/18 showed that the number of standard CHC referrals exceeding 28 days was 0.64 per 50,000 in Hartlepool and Stockton-on-Tees CCG (far below the England average of 10.27), we did speak with some people who reported long waiting times for their direct payments. Where applications had been successful, we heard positive feedback about the impact of this in respect of the person having control and involvement in their care planning.

- We found a multidisciplinary, integrated approach to delivering a number of key services including the single point of access, which provided a proactive and solution-focused service that improved people's experiences.

- There was effective involvement of people using services, their families and carers, who were engaged in developing and improving health and social care. People living with dementia were being identified earlier and they, their families and carers were well supported. There was a range of community support groups that provided advice, support and guidance.

- Reported levels of overall satisfaction with adult social care and support were above national and comparator averages in 2015/16 (ASCOF) and in our more recent analysis of 2016/17 data, at 64% for Hartlepool in 2016/17 compared to the comparator average of 63% and England average of 62%.

Are services in Hartlepool well led?

Is there a shared clear vision and credible strategy which is understood across the 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 multidisciplinary working and the involvement of people who use services, their families and carers.

There was a collaborative leadership approach between system leaders and a coherent vision and strategy that could be articulated by people across the system. System leaders were committed to working together and further developing strategies for working more collaboratively with the STP. There was evidence that people who used services, their families and carers were engaged by partners in developing and improving the health and social care interface.

Strategy, vision and partnership working
- We found there was a strong commitment from local partners to serve the population of Hartlepool well. Historically there had been tensions between system leaders following the closure of the A&E at University Hospital of Hartlepool in 2011. Following the recommissioning of the urgent care service in the town and a change in senior leadership, local system-wide relationships had improved. Over the last 12 months there had been a recognition that leaders needed to work together to provide sustainable high quality services for the people of Hartlepool.

- Local leaders worked well together and the Hartlepool Matters report had been jointly developed and published. The Hartlepool Matters report and the subsequent implementation plan was informed by the JSNA and aligned to the local vision, the health and wellbeing strategy and the BCF plan. The alignment of these strategies and plans resulted in a cohesive vision and implementation plan for the area.

- The Hartlepool BCF plan set out a system-wide approach to provide solutions to local issues. There was an acceptance that a shared vision and approach was crucial for the

provision of sustainable services and to address associated risks.

- The STP for Durham Dales Easington and Sedgefield, Darlington, Teesside, Hambleton, Richmondshire & Whitby had been established following the merger of two smaller STPs. Local systems leader felt disconnected from the STP and felt unable to influence decisions made by the STP that would impact on Hartlepool. Local leaders acknowledged that more productive engagement with the STP was needed.

- Partnership working between the CCG, the local authority, NTHFT and TEWV was supported by good governance; partnership boards held organisations to account and enabled innovative and collaborative working.

- Partnership working between CCG, the local authority, NTHFT and TEWV had continued within the past 12 months. The urgent care centre (UCC) had been established as well as collaborative working initiatives such as the Integrated Discharge Team and integrated discharge pathways, a discharge to assess and trusted assessor pilot project for the elective orthopaedic pathway, and development of the Home from Hospital service (the latter had impacted positively on DTOC).

- There was a joined up approach to winter planning, using lessons learned from the previous year's performance to inform the plan for 2017/18. Primary and secondary care providers had been able to input into plans through workshops facilitated by the CCG.

- Adult social care providers told us they were not always able to influence the strategic direction and the implementation of plans. Many adult social care providers were under-represented at some fora; however, we found that a domiciliary care provider attended a A&E Delivery Board event in October 2017 which meant that they could feed provider perspectives into planning. The local authority acknowledged engagement with providers had reduced and they told us they had plans to improve this.

- The voluntary sector felt engaged by the health and wellbeing board and the CCG's locality board meetings and were able to represent the views of communities and contribute to the wider strategy.

Involvement of service users, families and carers in the development of strategy and services
- We found there were many opportunities for local people to be engaged in the development of services. Local people were involved in the Hartlepool Matters report and implementation plan through local fora and engagement events to influence and participate

in service design and delivery. The health overview and scrutiny committee indicated that there should be even more public consultation in respect of local changes to health and social care services. People living in Hartlepool were encouraged to take an active role in influencing service design and delivery through groups such as the 50+ Forum, Hartlepool Carers Strategy Group and Dementia Friendly Hartlepool. There was targeted engagement during Dementia Awareness Week, Carers Week and World Mental Health Day, and people had strong links with Healthwatch.

- Healthwatch Hartlepool was represented on executive committees across ten themed areas that spanned all dimensions of health and social care. It was also a member of the locality meetings and was represented on the CCG's primary care co-commissioning joint committee.

- In developing the Hartlepool Matters report and implementation plan an engagement event with older people was held to gain feedback on what worked well, how services could be improved and what they felt were the priorities for the future. The feedback from this event had been incorporated in BCF plans, and had influenced developments across the system. For example, to address reducing social isolation, there had been investment in a 'Befriending Network' and a home library service for people who were housebound.

- A 'Family Leadership' course for people living with dementia and their carers was delivered in 2016. This course, delivered in partnership with In Control, drew on the Partners in Policymaking model and created shared understanding of dementia alongside offering people information and support.

- There was regular engagement and co-production with older people. The CCG had developed Community Health Ambassadors and had led a range of engagement projects and formal public consultations including a frail elderly summit and ongoing engagement regarding the regarding the Better Health Programme.

- Qualitative feedback from people who use services, their families and carers was gathered by system leaders and Healthwatch through public consultation and surveys and this information was used to improve services.

Promoting a culture of inter-agency and multi-disciplinary working
- Frontline staff we met were consistently focused on the needs and welfare of people who lived in Hartlepool and expressed a desire to improve outcomes for people through collaborative working. Some community based teams felt systems could be streamlined to enable this further as they described duplication in assessments that created unnecessary

workloads and meant that people had to tell their story more than once.

- There were good examples of interagency and multidisciplinary working. A multiagency group consisting of the CCG, NTHFT, TEWV, Hartlepool Borough Council and Stockton-on-Tees Borough Council had been successfully working together to promote dementia awareness. The integrated discharge team won the Best Integration Project of the Year at the North East, Cumbria, Yorkshire and Humberside Commissioning Awards facilitated by the NHS North of England Commissioning Support Unit.

- Frameworks for interagency collaboration were developing to improve outcomes for people; an example of this working well was the collaborative dementia strategy. Health and social care organisations in Stockton-on-Tees and Hartlepool were collaborating to improve the experiences of people living with dementia, their families and carers.

- In addition, the integrated discharge team was working effectively to reduce DTOC and a single point of access worked to reduce the multiple points of entry in to the system for people who required care and support and enable timely access to services.

- All GP practices in Hartlepool were members of the GP federation. The GP federation had a well-established relationship with the CCG and undertook joint working with them, for example in the development of the care coordinators role. The Local Medical Committee (LMC) and the GP federation described how this had improved joint working across GPs and told us that the federation was now looking to develop cluster working strategies. Responses about the impact of this care coordinator role from people using services was extremely positive; all 20 people who received the service in the previous six weeks had provided very positive feedback, including describing the service as making a "vast difference" and "life-changing".

- A self-assessment against the high impact change model had been undertaken and provided to the LADB in June 2017. This identified that significant progress had been made in relation to early discharge planning, monitoring of patient flow, multi-agency discharge teams, discharge to assess, seven day services, focus on choice and enhancing health in care homes. However, it was acknowledged in the response to the system overview information request that further work was needed to develop and embed trusted assessor models.

- The Hartlepool BCF Delivery Group was reviewing the high impact change model in light of the new BCF plan for 2017-2019, highlighting areas of good practice and agreeing actions for areas that required further improvements.

Learning and improvement across the system

- System leaders and frontline health and social care staff told us there was openness to being innovative and to trying new approaches to enable learning and improvement. An annual review of the Hartlepool Matters report had taken place to understand what was working well locally and to share learning. The Hartlepool Matters implementation plan followed this to secure future improvements.

- There were various fora to share best practice at an organisational level, including:
    - A recent "practice month" in adult services in the local authority, gave managers the opportunity to strengthen links with frontline staff and people using services. During practice month, case audits and observations were completed alongside the social worker. There were observations of social work interaction with other relevant professionals as well as the service user and/or carer (where achievable). The approach provided assurances that services were person centred and well-coordinated.
    - The GP federation and the LMC had been exploring cascading learning to get practices to share good practice and protocols to save time and effort. They told us this was starting to work and practice managers had regular meetings to network and share good practice.
    - The ambulance trust director told us there was a forum for sharing important messages with frontline staff. However social care providers told us that whilst there had been fora for them to share good practice, these were not taking place as frequently.

- However, it was less clear how learning and sharing of best practice was fostered across the system. Some social care providers told us that they felt opportunities for them to be involved in sharing good practice and learning new skills had diminished recently.

- Following a Healthwatch investigation about the hospital discharge process, a system wide action plan was put into place. This resulted in changes such as establishing daily huddles and the development of an integrated discharge team. System leaders told us that as well as excellent feedback from patients and staff, recent performance data had shown that the number of delayed days had reduced by 41% between Q3 and Q4 2016/17. This fed into the BCF plan and was monitored through the local authority's Adult Services Committee. Our analysis indicated these changes had resulted in reduced delays with the average daily delayed days in July 2017 below the national average.

- Quality monitoring and evaluation of impact was undertaken by the CCG through several

audits. The CCG Operational Plan outlined the care and quality gaps across the STP area and also outlined the health and wellbeing, funding and finance gaps for the system overall. The local authority's Local Account of Adult Social Care Services in Hartlepool 2016/17 outlined areas where they were doing well and areas where there was room for improvement and plans for the future.

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

Overarching governance arrangements

- The STP lead told us that governance arrangements of the STP were currently being reviewed due to the restructure and realignment to the geographical areas. There was good engagement between the CCG, the local authority, NTHFT and TEWV but not all partners felt engaged with the STP.

- The BCF board had oversight of the BCF Delivery Group and the BCF Project Implementation Group which oversaw delivery of the BCF plans and development of new pathways and models of care. It also ensured that decisions were made using correct processes so that each organisation was accountable for the successful implementation of the BCF plans. Alongside this they also had oversight of alignment of the various strategies, including the intermediate care joint commissioning strategy and the joint commissioning strategy The Great North Care Record (API).

- The North Tees Partnership Board acted as the unit of planning to provide strategic leadership and oversight to the development and delivery of the Hartlepool BCF. This was aligned with wider strategic plans across health and social care to improve health and social care outcomes for people.

- Four local authorities, including Hartlepool Borough Council, plus Hartlepool and Stockton-on-Tees CCG and Cleveland Police formed the wide range of statutory partners who had committed to work together through a single Teeswide Safeguarding Adults Board. Frontline staff in primary and secondary care stated that safeguarding was taken seriously

and raising any issues of concern resulted in action.

- The LADB aligned partners across health and social care and provided an effective forum for system leaders to monitor key strategic aims and objectives. The LADB had oversight of and responsibility for improving A&E performance, and for monitoring performance and progress of discharge to assess and delayed transfers of care. Our analysis suggested NTHFT's A&E was performing well, with better than average performance against A&E waiting times targets and the trust nearly meeting the 95% target in 2016/17.

Risk sharing across partners
- There were established risk sharing arrangements between the CCG and the local authority and well-developed scrutiny processes in place with quality assurance at a local and regional level. System leaders across the system were working collaboratively and were actively involved in the HWB which addressed areas of risk and issues relating to health and social care in Hartlepool.

- The BCF plan was facilitating elements of risk sharing between partner organisations. For example, the CCG and the local authority had agreed plans set out in the BCF that needed full investment to a pooled budget. Both agreed to manage the risk of increased emergency admissions to hospital and increased admissions into residential services.

- As part of the BCF a risk register was maintained and monitored with mitigating actions identified. One of the risks specified was insufficient data at the correct level and quality to effectively monitor outcomes and ensure overall delivery of the BCF plan.

- The North Tees Partnership Board addressed areas of risk, agreed contingency and risk management plans and arrangements; and oversaw the Care Quality Improvement Programme which brought together all the initiatives that were underway to support care homes.

Information governance arrangements across the system
- Hartlepool and Stockton-on-Tees Local Digital Roadmap Narrative 2016/17 outlined the vison to empower the public, patients, care providers and commissioners to improve health and care through digital transformation.

- There was no current unified care record, however, systems leaders informed us that the development of a fully integrated digital care record remained a priority to inform the best decisions at the point of care and for the person to only have to tell their story once.

- GP practices, hospitals, community and mental health trusts were leading a project called The Great North Care Record to develop a specification for a system to provide integrated digital care records across the North East. All partners had been involved as part of the BCF and system leaders were very positive about its potential impact and had worked hard to overcome the technical and governance challenges.

- In the 2016/17 BCF return the HWB confirmed it was working towards better data sharing between health and social care. All GP practices in Hartlepool were signed up to data sharing through the Medical Interoperability Gateway (MIG). This enabled clinicians in 15 providers (within acute and mental health trusts and out-of-hours services) across the North East to access relevant records at the point of care. This had been initially rolled out in A&E and the UCC, with plans to implement this throughout NTHFT.

- There were also plans to make health records available to social care providers; it was evident that processes towards this had already been started, and people in the local area had been invited to meetings to discuss the implications of the proposals.

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

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

Developing the capacity and capability of the health and care workforce was recognised as a key challenge for Hartlepool. There was a system-wide strategy in place as part of the BCF and STP to ensure the system had sufficient numbers of suitably skilled staff. However social care providers felt there was no system-level support for, or oversight of, long term requirements of the workforce; and ambulance staff were concerned about staff shortages.

- From the STP and CCG operational plans we reviewed it was clear that the development of a sustainable workforce that was suitably skilled and experienced to support the needs of local people was a priority for system partners. The BCF and the STP plan outlined a comprehensive strategy to address workforce issues. There was a focus on recruitment and retention, training and development and supporting new ways of working.

- One example of a new way of working was the McKenzie House community integrated service pilot. The primary purpose of this pilot was to provide more timely access to assessment, treatment and support for the frail elderly by facilitating closer communication and collaboration between health and social care practitioners working in the community.

By sharing relevant information, improving coordination and more proactively engaging with identified people, the aim was to maximise community based health and social care resources so that people would receive a more targeted and responsive service.

- The local authority and the CCG had actively engaged with social care providers and had developed a bespoke North Tees Education and Training Alliance programme led by NTHFT, which was available to all care homes in Hartlepool and Stockton-on-Tees. The programme started in February 2017 and by mid-August 2017, 780 members of staff had attended training, and at the time of our review, 64% of care homes in Hartlepool and Stockton-on-Tees had confirmed or booked training.

- System leaders were committed to continuing to work with Health Education England (North East) and the BCF plan acknowledged that future challenges could not be met by any single organisation and reflected the importance of working with all stakeholders and providers. Consideration had also been given in the BCF plan to succession planning through supporting new employees and working with local colleges to develop the future workforce.

- System leaders confirmed that partners were working collaboratively across health and social care to better understand the implications of proposed STP workforce plans with a particular focus on primary and community care.

- However, social care providers reported that recruitment of nursing staff was a significant issue, with providers competing with each other for staff. They felt there was no system level support or oversight of the workforce requirements in long term care.

- To tackle the difficulties of retaining staff in the single point of access team, the service had developed progression opportunities by introducing band three and four supervisory roles. The innovative work at the McKenzie Practice (a GP Practice) was having a positive impact and attracting new GPs to the practice. Health Education England and system leaders told us there was investment in the primary care workforce with an increased number of staff being attracted to Hartlepool through a range of recruitment, retention and education initiatives. Partners were also introducing some new roles, working to change the skill mix of staff, and expanding roles such as the advanced practitioner role.

- The reablement and rehabilitation services were well staffed and there were good opportunities for career progression within the team. Community Matrons identified that more training was needed for care home staff, but they felt they didn't have the necessary resources to be able to facilitate this at the time of our review. They also reported having to

provide staffing cover at the Holdforth Unit when it was short of staff, and described that this impacted upon the availability of skilled staff to undertake work in the community.

- Ambulance staff were concerned about staff shortages and even though there were plans to recruit additional staff there was a consensus that these plans were not sufficient. They reported that a number of measures had been put into place to recruit staff and they were also working with Health Education England, the CCG and GPs in Hartlepool via the A&E delivery board to help categorise calls better and make more efficient use of resources.

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

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

Commissioning frameworks enabled a coordinated and strategic approach to commissioning across the health and social interface, which was informed by the identified needs of local people though the Hartlepool Matters report. System leaders were working jointly towards developing a diverse and sustainable market and the Care Quality Improvement Programme would enable resources to be effectively targeted where there was likely to be the greatest impact. Although capacity in the adult social care market had increased, so was the complexity of people's needs increasing, which would impact on bed availability and resources in the community.

Strategic approach to commissioning
- Work had been ongoing to establish a strategic commissioning approach across the local authority and with partners. These joint approaches led to the Hartlepool Matters report and implementation plan which was the agreed strategy between system leaders and was driving local authority and CCG commissioning. Partners acknowledged that the BCF process had been a challenge but it was evident that this was now working well through pooled budgets between the CCG and the local authority.

- A detailed and comprehensive report which looked into current commissioning frameworks was presented to the Adults Services Committee on 5 October 2017. The committee noted the complexity of the commissioning framework for adult services and the requirement for flexibility to ensure there was a vibrant and sustainable care market in accordance with the statutory duties set out in the Care Act 2014.

- The CCG's annual report 2016/17 demonstrated a commitment to ensure a coordinated approach to the delivery of the STPs locally, plus their two year operational plan, efficiency programmes, BCF plans; as well as a number of service improvement and related activities and initiatives developed by member organisations.

- Winter plans covering resilience arrangements across the system had been approved by NHS England. We found that all system partners were aware of the plans and had contributed to their development and they were committed to implementing these. While frontline staff across primary and secondary care stated they hadn't contributed to the planning they were always informed about the plans and were aware of the key themes and wider system preparation.

- The local authority had good working relationships with social care providers and worked with them closely in relation to the support provided to their employees. This included paying the national living wage, which was a stipulation of all Council contracts, and requirements regarding continuity of carers. Social care providers indicated that they had an effective relationship with local commissioners.

Market shaping

- The local authority undertook a feasibility study for Alternative Service Delivery Models in March 2017, which identified three key options for change as the current model of adult social care was not seen as financially sustainable. These were evaluated against the objectives the local authority and partners had highlighted as important and fed into the BCF plan and Hartlepool Matters implementation plan. The BCF plan clearly articulated these challenges and set out funding arrangements to enable the local authority (and CCG) to support the local care market and invest in initiatives that supported the integration agenda and promoted new ways of working.

- Our analysis showed that the provision of adult social care beds was lower per population in Hartlepool compared to comparator local authority areas and the England average. While the number of residential beds had increased by 1% between April 2015 and April 2017, there was a 20% reduction in the number of nursing home beds in the same period. There were more domiciliary care agency locations per population in Hartlepool than in comparator areas.

- The provision of adult social care beds was a concern as the key issue over the last two years had been a shortage in nursing home capacity, following the closure of a number of care homes. The local authority had worked with potential providers of social care to

encourage them to develop services in Hartlepool and to support new providers to develop sustainable services. System leaders anticipated this would further reduce the numbers of DTOCs.

- Our data demonstrated a continuing rise in CHC funding agreements, evidence of the increasing complexity of people's needs. This will impact on demand for beds and resources in the community. It had been acknowledged by system leaders and frontline staff that there was a deficit in the number of specialist beds for mental healthcare of older people and for end of life care beds for people requiring palliative care. There had been an increase in the number of long term end of life care beds at the hospice, and a new nursing/residential home had been opened, with another planned, which would increase capacity and help reduce the system's deficit, but further measures would be needed to resolve the overall deficit and to meet growing demand.

- The local authority had invested in housing related support, extra care housing and assistive technology that supported people to maintain their independence. The local authority was building positive relationships with social care and housing providers in order to reshape the market to suit the needs of older people in Hartlepool.

Commissioning support services to improve the interface between health and social care
- System leaders and frontline staff were working closely with the voluntary and community sector for example with The Community Hubs, The Bridge, and Home from Hospital services. Healthwatch Hartlepool told us that they felt the voluntary sector were underutilised within commissioning arrangements. However, system leaders informed us that links with VCS services would be further developed with the Community Engagement and Cohesion Strategy 2018-2021 to support the admission avoidance agenda and recognising the role of all local providers in delivering a more holistic approach to person centred care planning.

- To increase funds to meet social care demand, the local authority raised council tax by 1.9% for 2017/18, plus 3% to cover the Government's Adult Social Care precept. The additional 2017/18 funding for adult social care, (as announced in the Spring Budget 2017), would be spent on adult social care services which include supporting older people (aged 65 and over), adults with learning and physical disabilities, adults with mental health issues, helping people to access residential care and supporting people to live in their own homes.

Contract oversight
- Our analysis showed that the majority of GP services in Hartlepool were rated by CQC as

good and NTHFT was rated as requires improvement following its last inspection. Hartlepool also had a high percentage of adult social care services rated by CQC as requires improvement. System leaders had worked with social care providers to make improvements by utilising the Responding to and Addressing Serious Concerns Policy & Procedure. The local authority also proactively monitored the quality of care provision in care homes through the Quality Standards Framework (QSF) and fed back concerns to providers following monitoring visits.

- The iBCF was being used to address key local priorities around the sustainability of the local care market. As part of this, the Care Quality Improvement Programme would enable resources to be effectively targeted where there was likely to be the greatest impact,

- We received positive feedback from a newly opened care home about the support that commissioners had given them during the process of opening, and on an ongoing basis.

- Both of the main domiciliary care agencies felt that they had an open and transparent relationship with their commissioners and felt supported through their contract. However some social care providers said that although they had good working relationships with individual officers, they did not feel engaged in commissioning developments.

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

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

We found a shared understanding and whole system view of the challenges and priorities for using resources to achieve high quality care and promote people's independence. There was some joint working between system partners to manage demand and govern resources; evident in Hartlepool's Health and Wellbeing Strategy 2013-18 and the BCF plans.

- System leaders told us that the delivery of a sustainable financial position across the health and social care economy, while managing the needs of an ageing and growing population within available resources, was proving a significant challenge. As a response, savings proposals had recently been approved by the local authority, with further savings to be identified over the next three years. Considerable work had taken place to continue to protect frontline services in the context of budget cuts over the last five years.

- New models of care had been explored and system leaders were encouraged to think

differently about using resources to best meet the needs of the local population. The BCF pooled budget had supported this, and had played a key role in protecting frontline services and in providing additional investment in services focused on promoting independence and wellbeing including information and advice, low level services, enhancements to the early intervention model and further growth of assistive technology.

- A pilot programme, the McKenzie House community integrated service, was using a multidisciplinary approach to provide timely access to assessment, treatment and support for the frail elderly by facilitating closer communication and collaboration between health and social care practitioners working in the community. This was identifying ways that services could make efficiencies and this learning could be implemented at other practices. However there were concerns expressed from the LMC and GP federation about the challenges of having short term pilots and the importance of collecting quantitative data to evidence impact to ensure continuation of the projects.

- Our data analysis showed the number of people eligible for standard NHS CHC per 50,000 adults in Hartlepool on the last day in Q1 was slightly below the level across the Cumbria and the North East region (63.73 compared to 65.20); however it was higher than the England level (43.04). The rate eligible for Fast Track CHC (usually used for end of life care) was significantly lower in Hartlepool than across the region (16.68 compared to 26.75 across the Cumbria and the North East region). It was also lower than the England level of 18.45. System leaders acknowledged that the uptake of continuing healthcare funding would continue to present a risk and identified there had been a 16% increase in spending on CHC between 2013/14 and 2015/16.

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

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

Are services in Hartlepool safe?

There was a system-wide commitment to maintaining people in their usual place of residence with joint working arrangements for assessing, mitigating, monitoring and managing risks to prevent avoidable harm. Systems were in place to identify people who were frail, with complex needs or who were at a high risk of deterioration in their health or social situation and there was support for them to stay well and avoid hospital admission. Although there had been initiatives put in place, some concerns remained in respect of access to primary medical services.

- Statutory partners had committed to working together through a single Tees Safeguarding Adults Board formed across four local authority areas. The board had developed a Serious Concerns Protocol to enable a multi-agency response to serious safeguarding concerns. The board had engaged with the public and provided information through informal opportunities, for example awareness campaigns in local libraries. This helped to increase the number of people accessing the board website and information. The number of reports about concerns arising in people's own homes increased last year. Cleveland fire brigade also worked with health partners across Tees to help keep people safe and well in their own homes.

- Frontline staff, across health, social care and voluntary services demonstrated effective partnership working to safeguard people from avoidable harm. Staff told us there was a responsive approach to safeguarding referrals and these were always investigated. However, the outcome of safeguarding referrals was not always fed back to the referrer, particularly when referrals crossed organisational and local authority boundaries. There was also scope to further involve social care providers in strategy meetings to share system learning.

- There were systems in place within primary care to identify and support people who were frail, with complex needs or at high risk of deterioration. The McKenzie House community integrated service pilot used a multidisciplinary approach to provide timely access to assessment, treatment and support for the frail elderly, identified through the 2% Direct Enhanced Service and fragility registers. The formal evaluation of the pilot is pending and will inform decisions about future developments and potential roll out of the model across all GP practices.

- A care coordinator pilot programme was also in place, funded through the LADB. All GP practices had a linked care coordinator who worked proactively with the practice's most frail and complex patients to coordinate a social response to their needs to prevent deterioration. We received extremely positive feedback about this service from frontline staff and care providers.

- Hartlepool residents told us that they did not always have access to primary care services and support in a timely way, which meant they would rely on emergency and urgent care services. Concerns were also expressed by GPs, social care providers and people using services that the lack of capacity within primary care for GPs to conduct home visits to people who were housebound, was a risk to monitoring and maintaining people within their own home. The GP federation and LMC were aware of the capacity issues within primary care.

- Analysis of survey data from March 2017 indicated that a comparatively low percentage of GP practices in Hartlepool offered full provision of extended access to pre-bookable appointments outside core contractual hours (15.4% of the 13 practices surveyed, compared to 22.5% across England and 19.6% across comparator areas). However, access to primary care had been extended through joint local strategies and LADB funding, and the Improved Access Scheme had been commissioned to deliver seven day access, provided at hub level, for all registered patients. This to enable greater resilience and flexibility within service delivery, included extending GP access at evenings and weekends. A 24/7 GP facility was also provided at the UCC.

- There were initiatives to provide rapid support to people at risk of deterioration in their own homes to prevent avoidable admission to hospital. People with chronic obstructive pulmonary disease had access to a Hospital at Home service. People who accessed this service reported that it had prevented them having to go into hospital.

- The total rate of A&E attendance in 2015/16 for people aged over 65 in Hartlepool was lower than the national average (351 per 1000 people, compared to 414 per 1000). However, analysis undertaken by Department of Health showed that the rate of emergency admissions per 100,000 populations (65+) between March 2016 and February 2017 was also higher than the national average at 29,006 compared to 24,092.

- Our analysis of rates of avoidable admissions from care homes from October 2015 to September 2016 showed that the rates of avoidable admissions for pneumonia, decubitus ulcer and urinary tract infections (UTIs) in Hartlepool were higher than both the England and comparator averages. More recent data provided in the response to the System Overview Information Request indicated that recent initiatives such as the Hospital at Home service had impacted on these avoidable admissions; the overall non-elective admissions report for Q1 2017/18 (all over 65 admissions from Hartlepool and Stockton) showed a 41% decrease in UTI activity and a 38% decrease in cost. Although the admission rate for diseases of the respiratory system had not reduced, the average length of stay decreased from 16.4 days in 2015/16 to 14.7 days in 2016/17.

- Care home and nursing home providers were supported to maintain people safely in their place of residence in a number of ways. The BCF had been used to launch a training and education programme to support providers in maintaining and improving quality. The ambulance service also told us that they had offered training to care homes with regard to falls and manual handling manoeuvres. A medicine optimisation initiative was in place and each adult social care home had a link pharmacist who undertook reviews. A care home

confirmed this service took place and that it was helpful in streamlining use of medicine and preventing admissions to hospital due to medicine errors.

- Care homes and nursing homes felt well supported by community services. A community rapid response team was available to people and professionals via a single point of access. The single point of access contact centre could provide advice and rapid referrals as an alternative to admitting people to hospital. A community matron service linked community matrons (who were also prescribers) directly to residential and nursing homes. This aimed to mitigate against health risks, reduce the occurrence and severity of crises and prevent avoidable harm and admissions to hospital. However, although community matrons told us although their role was working well, they didn't have the necessary resources to spend as much time as they would like on education in care homes as they were very busy and they also had to provide cover at the Holdforth Unit when it was short of staff.

Are services in Hartlepool effective?

Hartlepool had embedded systems alongside new projects and initiatives aimed at improving population health and integration of care delivery. The reconfiguring of hospital based services and technology was being used to strengthen care delivered outside of hospital with a focus on early intervention and prevention.

- Delaying dependency was a key priority for the area and there was a local commitment to investing in improving population health, early intervention and prevention. Over many years, the local authority had invested in housing related support, extra care housing and assistive technology that supported people to maintain their independence in their local community for as long as they were able and wished to do so. Hartlepool Borough Council Housing Strategy 2015 - 2020 outlined the housing options and priorities for the future and BCF investment has enabled these approaches to be maintained and further developed.

- The local authority had successfully opened three community hubs in the areas of greatest need. These provided access to information, health education and advice and services to promote wellbeing. Furthermore, the Enhanced Early Intervention Model had increased focus on prevention of hospital and care home admission through proactive partnership working between health and social care services.

- Our analysis showed that average GP funding per patient had increased from being below England and comparator averages in 2013/14 to being above England and comparator averages in 2015/16 (£145.94 compared with the England average of £142.63 and comparator average of £132.37). There was an improving picture regarding access to seven day primary care services.

- In addition, there was an agreement for the delivery of a seven day service in the BCF submission, and this was currently being provided through the community hub approach and the UCC 24 hour, seven days a week provision.

- The McKenzie House community integrated service pilot was leading the way in embedding a multidisciplinary coordinated approach to maintain people's health and wellbeing in their usual place of residence. The pilot was seen to be effective because of the high level of buy in across agencies to attend multidisciplinary meetings. The Care Coordinator also attended the meetings, to support a holistic approach to planning care and support to frail people. All 20 people who received the service in the previous six weeks had provided very positive feedback, including describing the service as making a "vast difference" and "life-changing."

- The UCC had been highly successful in recruiting GPs to the service to assure continuous cover 24 hours a day seven days a week. Triaging by the North East Ambulance Service (NEAS) out of hours visiting service was effective in ensuring people received services in a more timely way as staff reported that they were managing to see the vast majority of people in their own home without GP input and rarely needed to call out a GP for issues they couldn't address.

- A seven-day single point of access for NHS community services (provided by NTHFT) was facilitating a coordinated rapid response between agencies. The service had been enhanced through BCF investment to add a clinical triage nurse. This ensured that a holistic assessment and timely response was provided across community services, linking in to other key services like the out of hours provider, the rapid response team and physiotherapy in order to keep people at home. This system was working well and received positive feedback from frontline staff.

- Our analysis showed that in 2014/15 the rate of admissions to residential and nursing care homes in Hartlepool was significantly higher than the national average (1056 per 100,000 people aged 65+ compared to 669 per 100,000 people aged 65+). In 2015/16 the rate of admissions dropped considerably to 688 per 100,000 aged 65+, and although the rate then increased again in 2016/17 (to 922 per 100,000 aged 65+) it remained below its previous peak in 2014/15.

- As outlined in the North Tees Education and Training Alliance Q1 report February - April 2017, residential and care homes received a range of support to develop the skills and knowledge of staff to maintain people in their place of residence. Ambulance staff provided

training in respect of falls and manual handling. Tees, Esk & Wear Valley NHS Trust promoted an ongoing training campaign to spot delirium. Through the BCF, enhanced pharmacy support was provided, along with a training and education programme that incorporated piloting National Early Warning Scores (NEWS) to support early identification of deterioration or changing needs. Care homes had signed up to a forthcoming programme of free training offered by the CCG.

- Systems leaders had worked to reduce social isolation and loneliness based upon research by Age UK and the Social Care Institute for Excellence (Adults Services Committee report, 23 November 2017). Hartlepool's BCF plan included a commitment to "help identify and combat social isolation, as a major influence on overall health and wellbeing".

- There were initiatives in place to reduce social isolation and loneliness, supported by Hartlepool's vibrant voluntary and community sector, such as 'Hartlepool Getting Out and About'. A befriending service (funded by the local authority until March 2019) was commissioned in 2016 from Age UK. Outcomes for individuals using the service had been very positive with a high level of satisfaction. However, the Age UK befriending service felt they were not linked into wider systems as they didn't get any referrals from hospital discharge teams or GPs, despite having promoted the service.

- The local authority and the CCG had undertaken work with Cleveland Fire Brigade to make the most of contact with isolated older people through their rolling programme of Fire Safety Checks. Data collected indicated that the Fire Brigade had completed approximately 470 screening tools for Hartlepool residents since November, 330 of whom had been identified as the most vulnerable using GP data.

Are services in Hartlepool caring?
People living in Hartlepool were empowered to manage their health and wellbeing so that they were able to stay at home for as long as possible. The right people were given opportunities to be involved in discussions about people's care and treatment; however people sometimes had to tell their stories more than once and carers wanted more information and support in respect of direct payments.

- BCF plans supported personalisation and choice through development of coordinated alternatives to hospital and residential care, including investment in personal health budgets, which allow a more person-centred approach to meeting people's health needs. NHS England's NHS continuing healthcare data shows that in quarter one of 2017/18 the rate of people (all adults) receiving personal health budgets in Hartlepool and Stockton-on-Tees CCG area was above the England average (9.62 per 50,000 compared to 5.82) and

also above the rate across Cumbria & the North East (8.16). The rate of care direct payments per 50,000 was 8.12 – above the regional average (4.73) and the England average (3.63). People and their carers who were using direct payments told us this enabled them to have a say and to be more involved in their care plans and reviews.

- Hartlepool Matters set out a clear implementation plan to maintain people in their usual place of residence by empowering them to play a lead role in managing their own health and wellbeing. Hartlepool's integrated care and support strategy supported this as well as ensuring people worked with staff who understood their needs and desired outcomes.

- Our analysis of data measuring how successfully the NHS supported people with long term conditions to live as normal life as possible demonstrated that people's health related quality of life in Hartlepool had been below the national average for the six year period from 2011/12 to 2016/17 and was often below its comparator group average as well.

- In 2016/17 the quality of life score for people with long-term conditions in Hartlepool was 0.70, just above the comparator average of 0.69 but below the national average of 0.74. Initiatives had been implemented to ensure people's needs were promptly identified and actions put in place to meet these across the health and care system. Integrated community care teams and the Hospital at Home service provided timely support to people with a long-term condition and frail elderly people to effectively manage their condition(s) and improve their outcomes and experience.

- Despite the comparatively low quality of life score data from the GP patient survey 2016/17 showed that 70.5% of people with long-term conditions in Hartlepool felt supported compared to the England average of 64% and the comparator average of 64%. Furthermore, our analysis of ASCOF data showed that reported levels of overall satisfaction with ASC care and support were also above national and comparator averages in 2015/16 and in our more recent analysis of 2016/17 data (64% in 2016/17 compared to comparator average of 63% and England average of 62%) this demonstrated services were achieving the outcomes that mattered most to people.

- A CCG funded project with GPs had increased the number of people identified as carers. The Carers Forum was regarded as a strong community asset, providing a support network to carers and an information point for access to services and support. For example, every carer registered with the service was referred for a carers' emergency respite care card and would be given advice about direct payments. The Carers Forum would also contact the person's GP to inform them that they were a carer.

- Although some carers told us they had been offered direct payments, there was a view that these needed to be requested, and were not automatically offered; they felt that if people were not members of the Carers Forum they may not have access to information about direct payments. The Local Account of Adult Social Care Services in Hartlepool showed that in 2016/2017, 78% of carers (all, not just older people) were satisfied with the support or services they and the person they cared for had received from Social Services in the last 12 months and the proportion of people who used services and carers who found it easy to find information about services (carer-element only),' performance for Hartlepool for 2016/17 was 80.6%.

- While CHC data for Q1 17/18 showed that the number of standard CHC referrals exceeding 28 days was 0.64 per 50,000 in Hartlepool and Stockton-on-Tees CCG (far below the England average of 10.27), we did speak to some people who reported long waiting times for direct payments. Data from Q1 2017/18 data showed that 39% of Decision Support Tools for CHC were completed in an acute setting, above the England average of 27% and far above the target of 15%.

- The Bridge centre was providing invaluable advice, support and social interaction for people living with dementia and their carers. Since The Bridge opened in 2015, its Dementia Advisors had supported more than 500 carers and people living with dementia to ensure they lived life to the full. Positive feedback was received about this service stating that the friendly approach of the team had enabled people to be involved in decisions about care, that their wishes were listened to and that they were able to discuss their diagnosis and find out what support was available in a relaxed and welcoming atmosphere.

- Frontline workers we spoke with demonstrated a strong commitment to supporting people to reach their maximum level of independence. They took a person-centred approach and told us they would flex their services to ensure people's individual needs were met in a timely way. However, there was scope to better coordinate the use of resources as there was duplication in some assessments which resulted in people having to tell their story more than once.

Are services in Hartlepool responsive?
People's individual needs were assessed and risks were identified and proactively responded to in order to help maintain them in their usual place of residence. Signposting systems for people played a key part in enabling timely access to the right support in the right place. Access to primary medical services remained a concern, although it was anticipated that the reconfigured services and hub models would address this.

- There were processes to ensure people's needs were promptly identified and actions put in

place to meet these across the health and care system. Work had been done to reduce the number of points of entry into the system and signpost people to the right services and support. The single point of access was streamlining the referral process by replacing multiple referral routes and points of entry. Positive feedback was received about the single point of access, stating that it worked well and was a responsive service which had prevented admissions to hospital. Although community based staff told us that referral records could sometimes lack detail and cause some inappropriate visits there was evidence within the Pooled Budget Partnership Performance report Q4 - Single Point of Access Clinical Triage Nurse evaluation report – January-March 2017 that these had been acknowledged and analysed.

- There was a system-wide awareness of capacity challenges in primary care and how this impacted on access to GP services. The GP hub approach, the out-of-hours service and the UCC had been initiated to reduce the burden on primary and secondary care services and to cope with increasing demand. This was part of the CCG's vision for an integrated seven day service to prevent patients attending A&E because they hadn't been able to access a GP appointment. Further pressures had been taken away from GPs through the community matron and care coordinator roles. However, community matrons had reported they were extremely busy and were called to provide cover at the Holdforth Unit when it was short of staff.

- The focus on prevention was embedded in the provision of community services to enable people to maintain their health and wellbeing and independence. A Community Integrated Assessment Team (CIAT) included therapy and rapid response nursing to provide responsive care, supporting admission avoidance and hospital discharge. Care Coordinators along with other community based staff provided timely support to people with a long-term condition and/or the frail elderly to effectively manage their condition(s) and improve their outcomes and experience. People who were having difficulty in managing their conditions were referred to the team for a short period of time to stabilise their health.

- People using services and carers had mixed experiences of accessing GP appointments and reported that challenges accessing a GP created additional pressures on carers supporting people living with dementia. The BCF return for Q4 2016/17 stated the system's performance was 1% below the target for dementia diagnosis at the year end, which represented 12 fewer people being diagnosed with dementia than was aimed for. Primary care stakeholders said that they were conducting more mental state checks, and felt there was a good dementia service they could refer into at The Bridge. Overall people who used services told us that strides had been made in recent years to increase awareness of dementia and make Hartlepool a dementia friendly place to live.

- Additionally, some providers indicated that some GPs were reluctant or unable to attend people in their usual place of residence if it was a care home, but they would refer them to the older person's team who had nurse prescribers or offer telephone appointments instead.

- Our analysis of A&E attendance rates between April 2015 and March 2016 for people 65 and over showed that attendance levels for Hartlepool residents were lower than the national average, and the average of their comparator areas throughout the year. More recent updates to our analysis showed that A&E attendance rates remained consistently below national and comparator averages throughout 2016/17 as well. During 2015/16 the rate of A&E attendances of people aged 65 and over from care homes in Hartlepool increased, and although they were below the comparator averages, by the last quarter of the year they had increased to being above the England average (11 per 1000 compared to 9 per 1000). Updated analysis for 2016/17 shows that A&E attendances from care homes for older people decreased again below both comparator and national levels.

- The GP federation and the LMC were aware of people's concerns and it was expected that the new seven day service and the UCC access would help alleviate some of these challenges. Frontline staff in health and social care reported that GPs were responsive and understanding of preventive services and were effective in contacting the single point of access, Care Coordinators and other community based teams.

- There were initiatives in place to promote older people's independence and access to information. In response to feedback from people living in Hartlepool, three community hubs were opened in July 2017 to provide information, advice and services that supported and promoted wellbeing. There had also been investment in the 'Hartlepool Now' website, a project to support older people to access the internet (Project 65) and the home library service for people who were housebound. People using services welcomed these initiatives and the impact these services were having. Our analysis of ASCOF data showed that Hartlepool performed significantly better than comparators and the England average in 2015/16 in respect of the proportion of people aged 65 and over using ASC services, who said they found it easy to access information and advice about social care (87% compared to 76% and 75% respectively), which is a key factor in early intervention and reducing dependency.

- The local authority invested in extra care schemes and sheltered housing, which provided community villages for older people. When we visited one scheme, people told us how this enabled them to remain independent and safe and well in their own home.

- People were given support to make adaptations to their homes to enable them to remain in their usual place of residence. The Disabled Facilities Grants figures in year 2016/17 showed that 65% of total grants were given to people aged 65+ (stair lift and level access shower were the most common adaptations) and waiting times had reduced. Improved performance in waiting times for adaptations had been achieved through BCF pooled budget investment. The disabled facilities grants waiting list and budget position 2016/17 Q3 evidenced that the waiting times had decreased from 202 days in the previous quarter and at the time of our review, the average time from first contact to certified date was 127 working days.

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 Hartlepool safe?

Risks were managed operationally to prevent people at time of crisis being admitted to hospital. There was effective multiagency communication during a health or social care crisis enabling people to be kept safe as they moved across the health and social care system. However the falls management process was impacting upon workloads for the emergency response services and the wellbeing of people using services.

- There were formal methods to share information around risks to people's care and treatment across the system through the Quality Surveillance Groups. It was confirmed that when concerns or a crisis occurred, the CCG worked closely with the local authority to resolve them.

- NTHFT had undertaken a lot of work to ensure systems, processes and practices were in place across the trust to reduce avoidable harm. Emergency frontline staff could feed into and obtain advice from safeguarding panels attended by trust staff and the community safeguarding team. A triaging system ensured urgent matters were addressed within the hour and emergency frontline staff told us this was effective and they received the necessary advice and feedback. Case records we reviewed confirmed safeguarding referrals were made and investigated in a timely way, and a multidisciplinary approach had been taken.

- The single point of access was available to people, their carers and professionals in times of crisis. For example, health and social care professionals could call the single point of

access and ask for an urgent occupational therapy assessment and any necessary equipment to keep people who were at risk of deterioration safe in their home. The single point of access and the CIAT team could mobilise staff quickly and make referrals in a timely way and respond when people were at risk by following crisis escalation plans. The single point of access's key performance indicators demonstrated a consistently high performance had been achieved over the last year in responding to both urgent and non-urgent calls.

- There was a system within A&E to identify frail older people. A&E staff were completing frailty assessments for all people over 65 which the therapy teams followed up so people did not go home without the support they needed. Furthermore, A&E staff were completing falls risk assessments for anyone over the age of 65 so that appropriate referrals could be made to other services.

- Concerns were raised in respect of falls prevention following changes in service provision, providers felt this was less effective and that the falls service for people living with dementia was difficult to obtain. Community rehabilitation staff told us there was a clear criterion of 'one fall and then refer in' but the bulk of their referrals came in from ambulance or emergency care service.

- The telecare system made people feel safe and confident about being able to access appropriate support at a time of crisis. Support was also in place for carers as a red card scheme gave them information about who to contact in a time of a crisis.

- Once people were admitted to hospital the percentage of older people who stayed longer than seven days in 2015/16 was higher in Hartlepool than similar areas. Our analysis showed that the percentage of older people whose admission lasted longer than seven days in 2015/16 was higher in Hartlepool than across similar areas and England (34.4% in Q1 2015/16 compared to 32.7% across comparator areas and 32.3% across England). However our updated analysis for 2016/17 showed that the percentage of older people staying longer than seven days reduced to be more in line with similar areas and the national average, as a result of recent initiatives to improve patient flow. Despite this, analysis undertaken by the Department of Health covering the period March 2016 to February 2017 showed that in Hartlepool, 10% of older people admitted as emergencies stayed in hospital for more than 24 days.) This was longer than most of Hartlepool's comparator areas, so while more older people may have been discharged within seven days of their admission in 2016/17, a small percentage of people were still staying longer than in comparator areas.

Are services in Hartlepool effective?

During a health or social care crisis people's needs were effectively assessed by a skilled workforce. Information was shared across the system to enable people to make choices and maintain their independence. However vital information could be missed as transfer documentation didn't always follow people though their journey and people also had to tell their story more than once to a range of professionals. Ambulance performance data was consistently below the England average for Red 2 and Red 19 responses.

- Effective systems were in place to support people at a time of crisis. The single point of access offered a centralised MDT approach and specific pathways for people's needs. Furthermore, the CIAT could be mobilised quickly to attend at times of crisis and offer an MDT approach to assessment, treatment and support. If people did get 'stuck' in the system or there were transferal issues, the principal social worker said they would be informed so that pathways could be clarified and appropriate professionals involved.

- Urgent care services and the emergency department had effective triaging systems in place so people were seen at the right time, by the right person in the right place to avoid hospital admissions whenever possible. Although there was limited joint information sharing systems, the single point of access team had access to many different systems and the UCC had access to 'System1'. This supported effective multiagency communication during a crisis, enabling people to be kept safe as they moved across the system. 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.

- Our analysis shows that the percentage of A&E attendances of older people that were referred there by a GP was significantly lower in Hartlepool throughout 2015/16 and 2016/17 at around 2% in each quarter, compared to an England average of 7%-8%.

- A rapid assessment unit has been established to ensure effective flow through A&E, which would enable NTHFT to flex capacity during winter.

- Multidisciplinary working prevented avoidable admissions and improved patient flow. Patent flow facilitators worked closely with doctors in A&E and the Emergency Assessment Unit (EAU) and with the emergency care therapy team to ensure flow was maintained and people were discharged in a timely and appropriate way. MDT meetings with the A&E and patient flow facilitators, including social workers and the Integrated Discharge Team took place. There were also good links with the mental health liaison team and there were clear pathways for supporting people who had moderate to severe dementia when they presented at the department. Frontline A&E staff told us that as a consequence the flow of people through the system had improved and it was very rare to get people arriving at the

department who only had social care needs.

- Staff in the EAU had been trained to conduct mental health capacity assessments and the majority had been on dementia training which led to the creation of the area designated for people with dementia. They had also had interaction with the delirium team who offered specific advice about the best medicines to prescribe when someone was in crisis. Staff on the EAU could complete the first few pages of the CHC and mental health referrals and assessments were being completed in a timely way.

- A workforce review had taken place in A&E to ensure that staffing levels were fit for the winter period by changing some shift patterns so more staff were available at the time of highest need.

- Ambulance staff expressed concerns in respect of staffing levels, especially at the weekend and frontline ambulance staff felt that more paramedics were needed as people were waiting on the floor too long following a fall. Impacting on this was the number of 111 referrals which were not appropriate, and which they had fed back to the department.

- Ambulance response time data for North East Ambulance Service NHS Foundation Trust between December 2016 and May 2017 showed that response times for Red 2 (types of potentially life-threatening incidents) and Red 19 (how quickly ambulance services get a vehicle to the scene able to transport a patient) were consistently below the England average but Red 1 (assigned to patients in cardiac arrest) response times were in line with or better than the English average. Our analysis also showed that the proportion of 999 calls resolved by telephone advice was consistently lower than England average as was the proportion of 999 patients who were seen by an ambulance crew and the incident was managed without need for transport to A&E (The NHS England Ambulance System Indicators, June 2016-May 2017).

Are services in Hartlepool caring?
Frontline staff understood the importance of people, their family and carers being at the centre of decision making during the time of crisis. People that we spoke with, their family and carers confirmed this was the case. Although streamlining of systems had taken place in Hartlepool and is continuing, some people using services and some carers felt there were multiple confusing points of access and issues with access to GP services.

- Although systems had been streamlined to avoid multiple confusing entry points into the system, some people using services and carers still reported issues accessing services. GPs and care coordinators had been working with older people to identify those most frail

and vulnerable so they knew who to access in the time of a crisis.

- Carer's Emergency Respite Cards were given out by social services which gave details of services to contact in a time of crisis. However there was a sense from carers that the support they received was sometimes insufficient and carers' assessments were not widely offered unless asked for. In addition, carers felt the threshold for support was too high; for example, one carer said that the person they care for had caused a fire in the house and it had not been deemed necessary to provide support.

- To encourage patients, family and their carers to play an active role in making decisions about their care the EAU had an open visiting policy and the Integrated Discharge Team and MDT held drop in sessions three times a week. While there were a number of assessments resulting in people having to tell their story to different professionals, the integrated discharge team had worked to try and reduce this by completing one overarching assessment as part of the CHC assessment. It was evident that this system had worked well in the case files we viewed and that people and their family had been involved in this process and were listened to when deciding upon outcome.

- Frontline staff acknowledged the importance of involving families in decisions about their care and understood the importance of informed decision making based on people's wishes at a time of crisis. Staff held review meetings and reassessed care needs to ensure that appropriate decisions could be made in future. We saw an example of where this had resulted in a positive outcome for a person when following a review of their needs they were able to secure a placement at a nursing home of their choice.

- The North of Tees Dementia Collaborative strategy promoted person-centred care and people told us that voluntary groups, such as the Dementia Action Alliance, were extremely helpful in offering a single point of access for support, signposting and advice. Carers spoke positively of the support they had received at hospital and in the community when the person they care for experienced a mental health crisis.

- Some providers expressed concern at the support and availability of skilled staff for people living with dementia when they attended the A&E at a time of crisis. However, from reviewing care records of people living with dementia who had attended A&E, we found that people were cared for and supported well. Staff across the A&E department had received training and there was also an adapted space in the EAU for people living with dementia. Furthermore, mental health assessments took place in a timely manner and once on the hospital wards there were care coordinators to support people and prevent distress. Volunteers were also available in the discharge lounge to ensure people had

someone to talk to or ask questions if they had concerns.

Are services in Hartlepool responsive?

There were systems in place to ensure that people received care in the right place; however, the ambulance response times impacted upon people's experiences. Triaging systems were effective in ensuring people were seen in a timely manner and there were also systems such as the emergency care therapy team to improve patient flow.

- There were systems in place to prevent people being admitted to hospital at a time of crisis. The Hospital at Home service provided responsive care for people with chronic obstructive pulmonary disease, usually within two hours of referral. People using this service told us it was excellent and it had been successful in avoiding hospital admissions.

- Responsive services, such as the single point of access, CIAT, care coordinators and community matrons also all helped avoid admissions to hospital. There was evidence that the single point of access team were dealing with calls in a timely way and making the necessary referrals to other services. The CIAT team received a high number of referrals to enable people to be supported at home in the community. The total number of internal referrals in 2016/17 was 405 people and the number of community referrals during this same period was 1471 people.

- The use of enhanced care paramedics also prevented avoidable admissions. Ambulance staff told us that they were having a significant impact and if they were not part of every crew there was a higher chance that a person would be admitted to A&E. The ambulance staff told us more people would like to undertake the advanced paramedic training; however there was a two year waiting list.

- Care home staff reported that delays occurred in transferring people to hospital due to a lack of trust in their assessments when they called the emergency services. The care home staff didn't feel there was a formal route through which they could feedback their concerns. Ambulance staff told us that as trust in their assessments of people's needs was developing, ambulance staff were able to take people straight to hospital wards rather than going through A&E.

- Ambulance staff told us there were staffing issues which impacted upon response times, they were aware there was funding for seven more crews but they felt this would have little impact on staffing numbers.

- Although there was ongoing work to improve the triage of emergency calls, workforce

issues continued to impact on ambulance response times, resulting in social care providers reporting widespread issues of waiting for non-emergency cases which had led to distress when people had experienced a fall.

- In each of the last three years, NTHFT had performed at or slightly below the 95% target in terms of percentage of people being seen, treated and either admitted or discharged within four hours in A&E with scores of 95.2, 94.6 and 94.2%. This was better than the England average in each year. Since the establishment of the new UCC in April 2017 there had been a review of the flow for people attending A&E. The department took an admission avoidance approach and used a triaging system to ensure people were seen in the right place, by the right person at the right time. This meant that people with primary care needs and minor injuries were seen by the GP led units, supporting a better flow of people through the system.

- Positive feedback was shared with us about the support people received from the mental health care team; their timeliness and commitment to providing a service and educating staff, people using services, their families and carers. There was a crisis team who were able to respond to concerns in the community or at the UCC or A&E. A&E staff told us they had access twenty-four hours a day to a mental health and frailty team who were very active in preventing admissions if there were signs of dementia.

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 Hartlepool safe?

When people returned to their usual place of residence or an alternative setting, systems and processes were not always in place to enable them to be supported to do so safely. Further work was needed to ensure the relevant people had timely access to sufficient discharge information and ensure people's experiences were monitored and any lessons learned undertaken.

- We received mixed views from people using services, carers, social care providers and the VCS about the safety of discharge processes from hospital and heard that they did not always protect people from harm. Social care providers told us they did not always receive feedback after they raised safeguarding referrals about delayed and inappropriate discharges, which was a missed opportunity to learn when things went wrong. System

leaders acknowledged this and said that the integrated discharge team would be exploring further ways to improve systems, reduce duplication and intervene more proactively at the earliest possible stage to facilitate safe and timely discharge.

- Social care providers reported good relationships with the integrated discharge team and stated that this process worked really well, but there were instances when the discharge team had been bypassed by the wards and out-of-hours services and that this had resulted in poor discharge planning. They cited issues with trust regarding the quality and validity of discharge assessments and that some people were not as well as reported on discharge.

- People using services and carers reported issues about medicine information not being passed to GPs, leading to inconsistent advice. Some GPs confirmed discharge information could be improved and although they received information in a timely way there was often confusion about medicine information. The chief pharmacist at NTHFT told us collaboration and communication with the medicines optimisation team in the community could be improved.

- Further concerns were expressed about the timeliness of discharge, especially for those people requiring an end of life care pathway. The impact of these discharges had been a lack of clarity in medicine administration times resulting in numerous calls being made and safety concerns as staff would not be able to contact the pharmacy team until the next day. These findings were supported by the responses to our online feedback tool about the discharge information flow. This had a risk of impacting on readmission and poor experiences for people returning home.

- The BCF performance report Q4 2016/17 showed that the system was not achieving against the BCF plans for DTOC, and our trend analysis showed an increase in delays above national and comparator levels from April 2016 onwards, resulting in a significantly high spike in October 2016. The HWB reported that the main reason for delays in Q4 2016/17 was 'awaiting nursing home placement' (accounting for 345 delayed days or 30% of delays). To address this, a new nursing home was opened in May 2017. We found that this had reduced the pressures and it was anticipated that the imminent opening of a further nursing home would reduce pressures further, especially for specialist beds for mental healthcare of older people. Analysis of DTOC for July 2017 showed that daily delayed days in Hartlepool had reduced to 12.3, below the England average of 13.6.

- The bed manager in the discharge lounge told us that waiting for prescriptions for medications in the discharge lounge could cause delays. However to prevent long waits for medicines, we were told that, a "man in a van" initiative was used to deliver patients'

medicines to them after they had been discharged, if this was required.

- Although the timeliness and availability of medicines had been reported as a barrier against people returning home safely, we found that processes at NTHFT were in place to support timely medicines management on discharge. Data showed that medicines dispensed from the remote dispensary location were processed in a timely manner with 25% of discharges in under 30 mins, 50% in under 60mins and 75% within 90mins; all were processed on the day requested.

- Our analysis of the percentage of older people readmitted to hospital within 30 days on discharge showed that Hartlepool's performance was in line with the England average in 2015/16 (18.3% compared to the English average of 18.4%) and was lower than comparator areas. The percentage of emergency readmissions of older people in care homes within was also similar to the national average (19.4% compared to 19.8%). This indicates that more than 80% of people aged over 65 had been discharged at an appropriate time with support as needed in the community.

- However, our updated analysis suggests that emergency readmissions increased in the last two quarters of 2016/17, and by the last quarter of the year were above national and comparator averages (22% compared with comparator average of 20% and England average of 19%). There was an even sharper increase in emergency readmissions of people from care homes in the last quarter of 2016/17, increasing to 27% which was significantly higher than the England and comparator averages of 20%. It is possible that this could relate to the reductions in length of stay during 2016/17 having a perverse outcome in increasing emergency readmissions, as some people may be being discharged too early. This is an area of provision that requires prompt analysis and appropriate action.

Are services in Hartlepool effective?
There were some effective systems and processes in place to enable people to return to their usual place of residence. However the Holdforth Unit's admission criteria and expected length of stay was not clear, which resulted in inappropriate placements and extended lengths of stay.

- Local arrangements such as Daily Discharge Planning Meetings and the Integrated Discharge Team were very effective in ensuring that older people received an integrated response, concentrating on the longest DTOC and "stranded patients". We saw daily huddle meetings taking place during our visit to NTHFT and evidence within patient records showed that the Integrated Discharge Team held meetings with a range of professionals and that discharge planning started as soon as possible so there were fewer delays. Any delays in discharges were monitored through a board report and analysis of performance took place to drive system improvement. The length of stay had reduced in 2016/17

demonstrating the impact of these initiatives. While this is to be commended, the system should note the increasing emergency readmissions and take action to ensure that patient flow and discharge is both efficient and safe.

- The Emergency Care Therapy Team (ECTT) facilitated rapid discharge of returning care home patients if their needs hadn't changed and they had been in hospital for less than 72hrs and had no need for an acute medical bed.

- Trusted assessors had been piloted for elective orthopaedic surgery and the results from this had shown that the pilot had reduced length of stay by 61% with the average length of stay at 3.06 days at the time of our review. We received positive feedback about this service from people using services. There were plans to roll this programme out at West View Lodge.

- Since May 2017 a bed manager had worked in the discharge lounge to improve patient flow and reduce lengths of stay. They told us the flow had also improved since the opening of a new care home. Data demonstrated that there had been improvement in patient flow since this role had been initiated. For example; the percentage of patients through the lounge in under 90 minutes in 2016/17 was 37.21% and during 2017/18 to date was 53.45%; the number of patients discharged before 15:00 hours in 2016/17 was 35.76% and in 2017/18 this had increased to 43.88%. During our visit it was acknowledged that more work needed to be done to ensure the discharge lounge was effective and there was a need to identify if the lounge was an area/unit to wait for transport or if it should be a more integrated unit which had links to the community.

- From reviewing care records it was evident that continuing healthcare assessments were taking place as a matter of routine, however some community based staff felt that CHC assessments were being used a tick list rather than enabling a holistic approach. They cited incidents where assessment had begun before the person was medically fit for discharge which had a significant impact for the CIAT.

- The Home from Hospital service was a new service which had been in place for less than six months. It was used to enable people to be discharged in a timely way. The organisation supporting the delivery of this service expressed that there was a need for greater recognition of the service and they had looked again at the criteria for eligibility in a bid to increase referrals. We received positive feedback about this service and the impact this was having on people when discharged from hospital.

- Frontline staff took collective responsibility for identifying people in need of reablement and

rehabilitation services and systems were in place to support people on discharge from these facilities. A multidisciplinary approach was taken and a specialist practitioner for reablement for people living with dementia supported the reablement team.

- The percentage of people in Hartlepool who required readmission to hospital after discharge from reablement services was lower than the England average. The Department of Health's analysis of Hartlepool's reablement figures for 2015/16 showed that Hartlepool had a marginally higher percentage of people aged 65 and over still at home 91 days after discharge from hospital into reablement services (82.9%), compared to the England average (82.7%) and comparator group average (82.5%). System leaders reported that 78.4% of people had no ongoing social care needs after a reablement intervention, and 94.1% of reablement goals had been achieved at the end of the period of reablement. If there were any residual needs, telecare or telehealth could be arranged as could a personal budget or a longer term package.

- Our updated analysis of ASCOF returns for 2016/17 showed the percentage of people offered reablement who were still at home 91 days after discharge had continued to decline in Hartlepool to 76.2%, below the England (82.5%) and comparator averages (83.6%). This was below their target of 89.2%, as reported in the BCF performance report for Q4 2016/17. System leaders explained this was because the target set had been too challenging and was unrealistic given the complexities of people's needs. Therefore an audit was undertaken to understand the reasons for this and actions would be agreed following a findings paper.

- We raised concerns about the range and nature of services provided on the Holdforth Unit as the admission criteria and expected length of stay was not always clear. This had resulted in people being admitted to the Holdforth Unit when an alternative and more suitable environment was required; for example people at the end of their life. There was also an issue with the flow in the step down on this unit which had resulted in extended length of stay for some people. The Holdforth Unit was unable to cite length of stay data or bed occupancy rates and appeared disconnected from the main hospital campus at NTHFT. It was acknowledged that there was a need for greater clarity as to the purpose of the unit. We were given assurances that work would begin urgently to address the matters raised.

Are services in Hartlepool caring?
We saw a strong commitment among operational staff to delivering a person-centred approach when managing how people returned to their usual place of residence or to step down care. Despite this we found that some discharge processes from hospital meant that not all people were being treated with dignity, respect and compassion.

- There was a lack of multidisciplinary assessments meaning that people would need to tell their story more than once. The rapid response team told us if the person was discharged home without their paperwork, they would have to repeat the assessment again. Significant work had already been undertaken to make the assessment more personal so as to better understand the underlying reasons for an admission, through using a 'my voice my choice' care and support plan.

- The CIAT worked closely with other multidisciplinary professionals to support discharge and therapy staff were very passionate and focused on helping people reach their full potential. There was evidence of a person centred approach to reablement and involvement of people, families and carers.

- Staff across agencies displayed a willingness to discharge people home with a package of care when this was their wish, even if they were likely to require residential or nursing care in the longer term. Drop in sessions were held three times a week for people, carers and their family to spend time discussing discharge options and needs. We saw this had a positive impact on ensuring people were involved in the plans for their ongoing care and that they were listened to in terms of their wishes and aspirations.

- Our analysis of reasons for delayed transfers of care between February and April 2017 showed that 'patient choice' was reported as a one of the main reasons for delay in Hartlepool, accounting for an average daily rate of 3.5 delayed days per 100,000 population for aged 18+. 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. The CIAT team told us they had introduced a robust patient choice policy. Prior to this they had been dependent upon people telling social workers where they wanted to go and there had been difficulties due to reduced services in Hartlepool. This policy was now managed by the CIAT team and they held MDT meetings with people and their relatives to explore options. We saw within care records that these meetings were taking place.

- We found that some discharge processes from hospital meant that not all people were being treated with dignity, respect and compassion. We received reports of discharges that had caused people distress through a lack of communication and planning to check if anyone was at home to support them. We were also informed of examples of people sometimes returning from hospital with missing aids and equipment which impacted on their health and wellbeing.

- Social care providers and VCS organisations reported concerns with transport and timing of discharges. Providers also reported that they were not invited to discharge planning meetings and they felt that there was limited family involvement at discharge resulting in a lack of choice and families finding out about decisions after they had been made. It was felt that communication could be improved, as the staff who provided the day to day care could be the only point of contact for some people.

Are services in Hartlepool responsive?
System leaders were working collaboratively to improve systems and processes to enable people to return to their usual place of residence or an alternative setting in a more timely way. Although these had been effective, some people still experienced delays or poor experiences on discharge.

Although CHC assessments were taking place, the process was not working as well as it should be, resulting in a higher proportion of people entering into the CHC process to subsequently be denied funding.

- The primary reason cited in our data for delayed transfers of care was 'waiting for packages of care'. System leaders acknowledged that one of the capacity challenges they faced had been a lack of access to nursing home beds, particularly specialist beds for mental healthcare of older people to facilitate timely discharge. Our analysis of data from September 2017 showed that provision of nursing care home beds was lower per population in Hartlepool compared to comparator areas and the England average (300 per population in Hartlepool, compared with 409 across comparator areas and 391 across England). The number of beds appeared to have decreased between April 2015 and April 2017, particularly in nursing care which saw a 20% reduction in beds. However a new residential/nursing home had opened in April 2017 and another service was expected to be registered with CQC in the very near future which would give the system more capacity. This would also enable people using services to have more choice when looking for a suitable placement.

- People using services, their carers and family and social care providers raised further concerns about timeliness of assessments, involvement in discharge arrangements and transport home following discharge, and particularly regarding the time of day people were arriving home.

- System leaders had been working collaboratively to drive improvement and this had resulted in a number of initiatives such as The Perfect Week' As a result, changes in the system took place and initiatives such as the daily huddles had begun in an attempt to resolve system issues. Also on a day-to-day basis local arrangements such as daily discharge planning meetings with representatives from health and social care took place to focus on people's journeys and facilitate a timely discharge and effective follow on care. We saw evidence of

these planning meetings taking place and the positive impact they had on people using services.

- According to the HWB's BCF submission for Q4 2016/17, 20% of delayed transfers were due to 'awaiting completion of assessment'. The CCG CHC team were responsible for eligibility assessments (including fast track process), decision making process, case management and reviews (including out of area placements), appeals, and restitution.

- NHS CHC quarterly figures for all adults (NHS England) for Q1 2017 showed that the CCG had a standard NHS CHC assessment conversion rate for all adults (% of newly eligible cases of total assessments) of 21%.This was low compared to the England average (31%) and the Cumbria & the North East region average (26%). The referral conversion rate for all adults (percentage of newly eligible cases of total referrals completed) was also lower (21% compared with 25% for the region and England respectively). This suggested that the processes for accurately identifying people for standard CHC were not working as well as they should be and a higher proportion of people were entering into the CHC process to subsequently be denied funding.

- Frontline staff told us that they understood the CHC process and CHC assessments were undertaken as part of the integrated discharge team assessments. They didn't indicate any delays or issues with applications being denied. In the applicable case notes we viewed whilst at NTHFT we saw that CHC assessments were taking place and there was no indication that applications were being refused. Therefore it was not clear why the process was not working as well as it could be.

- A pilot for trusted assessors had been taking place and this had supported discharge to assess for those patients undergoing elective orthopaedic surgery. This encouraged timely discharge and received positive feedback from people using services.

- It was evident that people received seven-day care while in hospital. Analysis undertaken by the Department of Health showed the percentage of discharges of Hartlepool residents that took place at the weekend was 18% between October 2015 and September 2016. This was similar to other comparator areas, but lower than a few who were achieving 20% or above. The availability of the rapid response team, single point of access and the GP hub approach was evidence that seven day working was being supported and developed.

- Social care providers, the reablement and rehabilitation services team manager and the Head of Patient Flow confirmed the main reasons for delays were a lack of nursing home beds and a lack of rehabilitation beds. However, transitional/rehabilitation beds to enable

people to receive care and treatment in the community rather than in hospital were available. Local measures indicated that 583 reablement packages commenced in 2015/16 with 78.4% of people having no ongoing social care needs after a reablement intervention, and in 2016/17, 94.1% of reablement goals had been achieved at the end of the period of reablement.

- Assistive technology services such as telecare Lifeline pendants (sensors/detectors that automatically send a signal to either a carer, community alarm or monitoring service) and GPS trackers were highly valued by the people who used them for supporting them or a person they care for, to feel safe.

Maturity of the system

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

- Hartlepool Matters and the Health and Wellbeing Strategy presented a clear and consistently articulated vision locally which all system partners had signed up to. Overall there were positive cross agency relationships in Hartlepool. There was an acceptance among system leaders that a wider shared vision was required with leaders working collaboratively to improve and develop sustainable services across the Sustainability and Transformation Plan footprint.

- System leaders were working collaboratively to agree and shape a structure of services that were sustainable and responsive to the needs of the local population and in particular to manage the needs of an ageing population and the associated risks, although some adult social care providers would welcome more involvement in this process. There were effective escalation processes to work proactively with service providers in maintaining and developing performance and delivery.

- The governance arrangements, as set out in the BCF plan, included recognition by system leaders that more collaboration and a system-wide approach was required to provide solutions for local issues. Although frontline staff were aware of the local vision, not all were aware of the BCF and STP and how the system aligned to this. System leaders and frontline staff were focussed on the needs and welfare of people who lived in Hartlepool and expressed a desire to improve outcomes for people through collaborative working.

- System leaders were working collaboratively in stabilising and shaping the adult social care market through the Feasibility Study for Alternative Service Delivery Models and integrated working initiatives. The local authority has supported new care home providers by offering to block book a proportion of nursing beds on a fixed term basis, which has been welcomed by providers. Resilience planning had been taking place with all system partners involved.

- There were clear processes in place for how system leaders were using the BCF funds. There was a good approach to using the money to address priority needs and pooled budgets supported this, protecting frontline services. New models of care had been explored and system leaders were looking at the resources available and how best to use them to meet local needs.

- The BCF, STP and CCG plans outlined a comprehensive plan and priorities regarding the development of a sustainable workforce that was suitably skilled and experienced to

support the needs of local people. There was a focus on recruitment and retention, training and development and supporting new ways of working. Various fora took place to share best practice at an organisational level; how these were shared across the system was unclear.

- A fully integrated digital care record remained a priority and the Great North Care Record project was at the time of the review developing a specification for a system to provide integrated digital care records across the North East. There was data sharing by way of the MIG and System1 records within primary medical care and urgent care services.

- There was evidence that integrated working was developing and where this was in place it was effective in supporting pathways and integrated systems across health and social care. System leaders recognised the benefits of this approach and secondary care that supports the wider objectives of health maintenance.

Areas for improvement

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

- System leaders including those representing the STP in Hartlepool must continue to improve their working relationships and engagement to enhance a system wide focus and commitment.

- Develop the partnership framework to support the governance of partnership working.

- Continue to embed the Hartlepool Matters implementation plan.

- Ensure that there is effective use of the patient choice policy across the system.

- Review the purpose and function of the Holdforth Unit. Include in the review the criteria for admission and plans for patient flow, and also the use of community matrons on this unit and the impact this has on the skills and workforce available in the community

- System leaders should ensure there are robust and regularly evaluated plans to manage the complexity of commissioning to ensure a flexible and sustainable care market to address the current shortfall of care home provision for specialist beds for mental

healthcare and end of life care beds.

- Evaluate CHC funding to aid better understanding of why a higher proportion of people who were entering into the CHC process were subsequently being denied funding.

- Promote the use of pilots and initiatives system-wide to ensure these resources are used to their full potential. Continue to evaluate the effectiveness of these on completion to ensure best practice is promoted and shared.

- Explore people's experiences of discharge through follow up by the integrated discharge team, so any changes in methodology or services can be considered. During this review evaluate the effectiveness of the discharge lounge and quality of discharge information particularly in respect of medicine administration.

- Undertake an assessment of people's experiences in respect of access to primary medical services to evaluate the effectiveness of hub working in resolving issued identified by people.

- Continue to develop integrated working to support effective use of resources and people only having to tell their story once.

- Continue to develop relationships with social care providers so they play an active part in service provision and strategy, maintenance of people's health and wellbeing, managing crisis and the return from hospital.

- Continue to develop and embed the trusted assessor scheme.

- Work with Health Education England and Skills for Care in respect of challenges with the recruitment of nurses and ambulance staff and further develop a contingency plan while this work is underway.

- Evaluate the increasing emergency readmissions and timeliness of discharge to establish if there is any correlation between the two and take action as required to ensure that patient flow and discharge is both efficient and safe.