

# Hampshire

## Local system review report Health and Wellbeing Board

Date of review:  
12 -16 March 2018

## 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 Social care, and for Housing, Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

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

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

## The review team

Our review team was led by:

- Delivery Lead: Ann Ford, CQC
- Lead reviewer: Wendy Dixon CQC

The team included:

- Two CQC reviewers,
- One CQC analyst,
- One inspection manager

- Two inspectors
- One strategy manager
- One business support officer
- Two medicines management inspectors
- Four specialist advisors; three with a local government management background and one with an NHS management background.

## How we carried out the review

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

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

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

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

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

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

We then looked across the system to ask:

- Is it well led?

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

We also developed two online feedback tools; a relational audit to gather views on how

relationships across the system were working, and an information flow tool to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care.

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

- System leaders from Hampshire County Council (the local authority); Hampshire Clinical Commissioning Group (CCG) Partnership (a formal agreement between Fareham and Gosport, South Eastern Hampshire, North Hampshire and North East Hampshire and Farnham Clinical Commissioning Groups) and West Hampshire CCG (referred to collectively in this report as the CCGs); Hampshire Health and Wellbeing Board (HWB); Hampshire County Council's Health and Adult Social Care Select Committee and elected leaders.
- System leaders from Hampshire Hospitals NHS Foundation Trust, University Hospital Southampton NHS Foundation Trust, Portsmouth Hospitals NHS Trust, Southern Health NHS Foundation Trust, and South Central Ambulance Service NHS Foundation Trust (SCAS)
- Health and social care professionals including social workers, GPs, pharmacy leads, discharge teams, therapists, nurses and commissioners.
- Healthwatch Hampshire and voluntary, community and social enterprise (VCSE) sector organisations.
- Providers of residential, nursing and domiciliary care.
- People who use services, their families and carers who attended focus groups. We also spoke with people in A&E, hospital wards and at residential and intermediate care facilities.

We reviewed 24 care and treatment records and visited 20 services in the local area including acute hospitals, intermediate care facilities, care homes, GP practices, hospices and out-of-hours services.

## The Hampshire context

### Demographics

- 18% of the population is aged 65 and over.
- 95% of the population identifies as White.
- Hampshire is in the 20% least deprived local authorities in England.

### Adult social care

- 369 active residential care homes:
  - 12 rated outstanding
  - 275 rated good
  - 49 rated requires improvement
  - Three rated inadequate
  - 30 currently unrated
- 146 active nursing care homes:
  - Five rated outstanding
  - 96 rated good
  - 37 rated requires improvement
  - One rated inadequate
  - Seven currently unrated
- 207 active domiciliary care agencies:
  - Eight rated outstanding
  - 112 rated good
  - 18 rated requires improvement
  - 69 currently unrated

### GP practices

- 127 active locations:
  - 116 rated good
  - Six rated requires improvement
  - One rated inadequate
  - Four currently unrated

### Acute and community healthcare

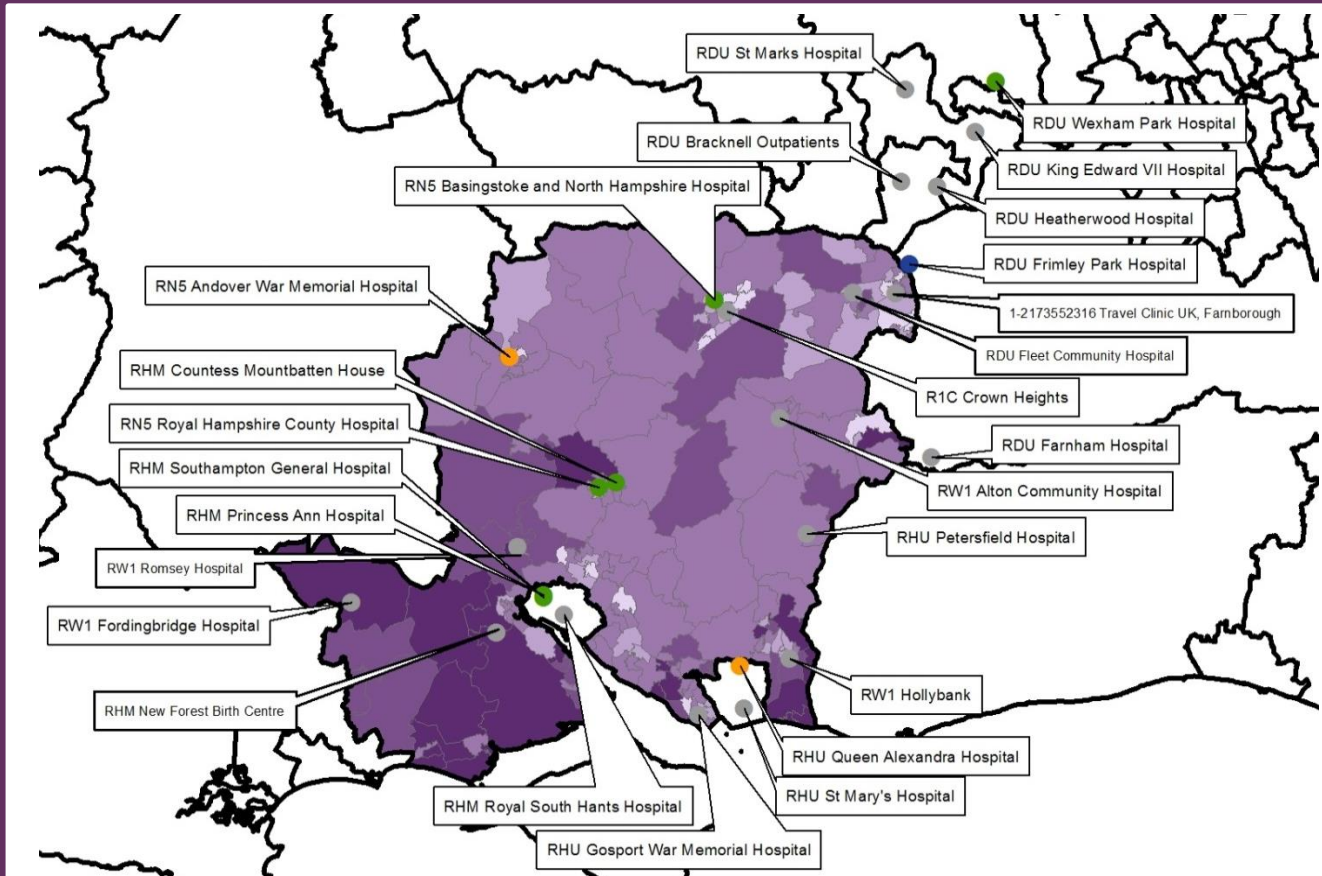
Hospital admissions (elective and non-elective) of people of all ages living in Hampshire were to:

- Hampshire Hospitals NHS Foundation Trust
  - Received 32% of admissions of people living in Hampshire
  - Admissions from Hampshire made up 93% of the trust's total admission activity
  - Rated good overall
- Portsmouth Hospitals NHS Trust
  - Received 24% of admissions of people living in Hampshire
  - Admissions from Hampshire made up 61% of the trust's total admission activity
  - Rated requires improvement overall.
- University Hospital Southampton NHS Foundation Trust
  - Received 20% of admissions of people living in Hampshire
  - Admissions from Hampshire made up 47% of the trust's total admission activity
  - Rated good overall.
- Frimley Health NHS Foundation Trust
  - Received 13% of admissions of people living in Hampshire
  - Admissions from Hampshire made up 22% of the trust's total admission activity
  - Rated outstanding overall.

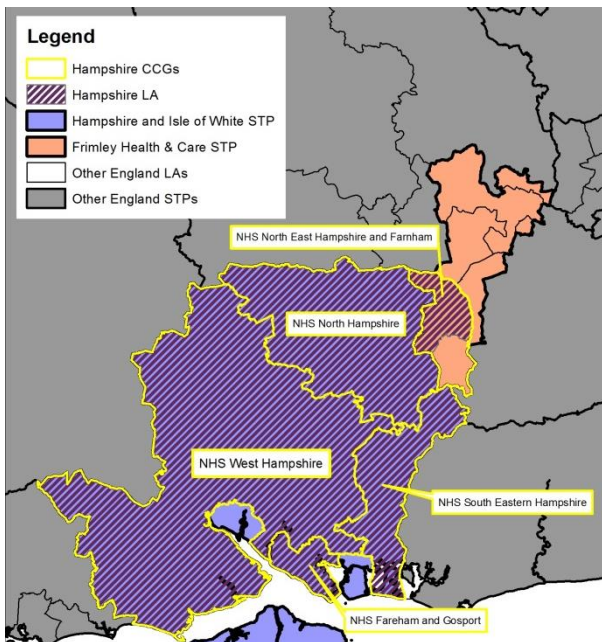
Community services were provided by:

- Southern Health NHS Foundation Trust, rated requires improvement overall
- Solent NHS Foundation Trust, rated as requires improvement overall

*All ratings as at 08/12/2017. Admissions percentages from 2016/17 Hospital Episode Statistics.*



Map one (above): Population of Hampshire shaded by proportion aged 65+. Also, location and current rating of acute and community NHS healthcare organisations serving Hampshire.



Map two (left): Location of Hampshire LA across the Hampshire & IoW and Frimley Health & Care STPs. The five Hampshire CCGs are also highlighted.

## Summary of findings

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

- There was a consistent shared purpose, vision and strategy for health and social care in Hampshire. The Health and Wellbeing Strategy included the vision of ‘ageing well’ and the system aimed to achieve this by integrating services for older people. This was interpreted in the Public Health strategy, Improved Better Care (iBCF) Plan, and in two sustainability and transformation plans (STPs).
- The leadership and delivery of services for older people were organised into four local delivery systems (north and mid Hampshire, Portsmouth and south east Hampshire, south west Hampshire, and Frimley), which were associated with the four main acute hospital trusts.
- Strategic planning and commissioning were informed by an analysis of local need. The Joint Strategic Needs Assessment (JSNA) was regularly updated and informed the Health and Wellbeing Strategy, iBCF plan and commissioning intentions. This resulted in clear action to address health inequalities in areas such as Gosport and Havant.
- At STP level a workforce planning team had been established but had not addressed the key system-wide problem of recruitment and retention of domiciliary and care home staff. This team at strategic level did not fully include all independent care providers or the VCSE sector, who would be significant to achieving transformation. Short term funded (iBCF) initiatives were being used to enhance core workforce activity with independent care providers to recruit and retain staff in care roles, for example the Partnerships in Care Training (PaCT) workforce development programme.

### **Is there a clear framework for interagency collaboration?**

- There was scope to improve the framework for interagency collaboration, which was complex. There was no single multiagency plan either at strategic level or at local delivery level. The STPs and Integrated Better Care Plans listed a range of key actions which would make a difference at local level, however some system leaders told us they found these difficult to track.
- The interagency HWB Executive, which reported to the Health and Wellbeing Board, monitored the progress of four work programmes; Joint Commissioning development, Help to Live at Home, New Models of Care and Intermediate Care delivery. This ensured a cross-sector overview of this work.

- Partnerships were becoming more cohesive. Stakeholders told us that relationships were improving and were more collaborative than they had been previously. The joint working within the partnership of four of the CCGs in Hampshire made Better Care Fund (BCF) planning easier. Partner organisations were involved in interviewing for each other's senior leadership roles, demonstrating a level of shared responsibility.
- Use of information technology in Hampshire could be a strong enabler of integration. The Hampshire Health Record, a shared record of personal healthcare, had existed for ten years; and the Digital Strategy aimed to build on this.
- Pooling of financial resources was in the early stages, although governance mechanisms for this were developed in the vanguard areas<sup>1</sup>.

#### **How are interagency processes delivered?**

- Implementation plans were not multiagency and were at differing levels of maturity; this meant that the experiences and outcomes for people using services varied.
- System leaders recognised that they needed to ensure consistency between plans and delivery models. Partnerships were becoming more cohesive and collaborative than they had been in the past. A county-wide Intermediate Care Board had been established to coordinate the delivery of intermediate care services in Hampshire.
- System leaders acknowledged that the plethora of delivery plans and accountability mechanisms made the system complex. Some told us that work was fragmented and there was a need to coordinate within STPs and standardise plans across geographical areas to become more outcome focused. It was sometimes difficult to demonstrate the impact of processes on the wellbeing of older people or on delayed transfers of care because of a lack of consistent measures.

#### **What are the experiences of frontline staff?**

- Staff from different health and social care organisations were delivering services together in some localities in Hampshire. For example, the jointly commissioned Bluebird domiciliary care service worked to prevent people being admitted to hospital.

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<sup>1</sup> Vanguard areas are new care models which will act as blueprints for future NHS service delivery

- Staff felt a common purpose in delivering health and care services. Our relational audit showed that staff felt they treated each other fairly, that they could be open and honest and they valued each other's contribution to services. On the other hand, they felt that organisational and personnel changes slowed progress and that financial pressures had a detrimental effect on relationships. They also said that poor communication created misunderstanding and ill-formed decisions and that people did not like to take organisational risks. The free text responses to our relational audit showed that frontline staff were concerned about recruitment and retention. Also, there was a lack of understanding in some areas of each other's roles which led to unrealistic expectations of each other.

### **What are the experiences of people receiving services?**

- People receiving services and their representatives and carers had opportunities to influence service development. Partners in the system had a variety of methods for consultation and co-production. This led to solutions which were tailored to meet the needs of local people, for example, GP community healthcare services in Gosport and Lymington.
- The health-related quality of life score for people with long-term conditions in Hampshire was 0.77 in 2016/17, according to the Adult Social Care Outcomes Framework (ASCOF). This was in line with comparator local authorities (0.76) and above the England average (0.74). People's experience of social care related quality of life in Hampshire was better than 13 of its 15 comparator areas in 2015/16.
- The percentage of people who felt supported to manage their long-term conditions was declining in Hampshire. In 2011/12, 70.4% of people felt supported but this reduced slightly to 65.8% in 2016/17. This was in line with the average for the comparator group but above the England average.
- The satisfaction with care and support services of people over 65 using adult social care in Hampshire in 2016/17 was in the middle of the comparator group and above the England average, according to the ASCOF Personal Social Services Adult Social Care Survey.
- Some people had experienced lengthy delays waiting for continuing healthcare (CHC) assessments to be completed; in 2016, this backlog had reached approximately 236 initial assessments, excluding people living with a learning disability. This meant that people were waiting a very long time for their assessments to be completed and for funding and care packages to be approved, including people who were at the end of their lives. This backlog of CHC assessments was being addressed at the time of our review.



- People told us they would like to see more signposting to services and more care planning before crisis events, such as falls or A&E visits, occurred. People also told us that care was not joined up enough and that they would like to see a single point of access for information about services. However, leaders informed the review team that there was a single point of access in place, referred to as 'Connect to Support'.

## Are services in Hampshire well led?

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

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

*Hampshire is a county in the south of England. It is bordered by unitary authorities in Portsmouth and Southampton. The area is mostly rural in the north where the neighbouring counties are Surrey and West Berkshire. To the south, the New Forest and some coastal areas attract tourism and retirees. Other neighbouring authorities include Wiltshire, Dorset and West Sussex. Although the county is relatively healthy and wealthy, there are pockets of significant deprivation and disadvantage, in particular in the coastal areas of Havant and Gosport where there is a higher than average population of over 65s. The population of Hampshire is predominantly white.*

*The Hampshire Health and Wellbeing Board (HWB) had a clear and consistent vision which was interpreted by two STPs and locality level planning. These incorporated some good practice on integrated care in the community. The system was aiming for joint co-production and some effective engagement mechanisms helped design services within individual organisations.*

*However, at a local level, plans were at different stages of maturity and work at strategic level had been constrained by frequent leadership changes. HWB governance arrangements were not always supporting partners to drive integration and tended to endorse reports without providing direction or leadership. The system appeared multi-layered and complex to some leaders. There was scope to develop strategic working with other public services such as housing services, to ensure that future provision for older people meets local needs. Hampshire had not fully developed a collaborative mechanism to share learning across organisations and between integrated local care initiatives, which limited the transfer of good practice.*

### **Strategy, vision and partnership working**

- The partners had a well-developed shared understanding of the vision and strategy for health and social care for the over 65s. Hampshire Health and Wellbeing Board's strategy for 2013 to 2018 and vision of 'ageing well' was widely understood and was reflected in the Public Health strategy. The HWB had strengthened its partnerships through a series of workshops and was refreshing its strategy at the time of our review. The HWB Executive which reported to the HWB monitored the progress of four work programmes: Joint Commissioning development, Help to Live at Home, New Models of Care and Intermediate Care delivery.
- Strategic planning was informed by a good analysis of local need. The Hampshire Integration and Better Care Fund narrative plan was based on the Joint Strategic Needs Assessment (JSNA). This plan was the high-level vision for integration in 2020 for the CCGs and local authority. The plan focused on prevention, strength-based delivery, new models of integrated care, access to high quality A&E services and effective flow and discharge from hospital. Plans around prevention were reducing admissions to some hospitals in Hampshire when we visited, but plans for crisis and step down care were leading to varied impacts across the county.
- Local clinical commissioning groups (CCGs) were combining efforts to give the integration agenda more impetus. There were five CCGs in Hampshire. Four of these CCGs collaborated under the Hampshire CCG partnership. The CCG Boards sought to combine and the Hampshire and Isle of Wight (HIOW) STP articulated their joint objectives for two million people in Hampshire. As a result, system leaders were gaining a better understanding of their shared challenges.
- The Frimley Health and Care STP planned services for the remaining population in the north east of the county.
- Partners within the system shared the same vision for integration of health and social care services for older people. Two STPs interpreted the aims of the HWB and the iBCF plan. Work towards STP objectives was detailed within local improvement plans, owned by four local delivery systems (north and mid Hampshire, Portsmouth and south east Hampshire, south west Hampshire, and Frimley) and linked with the four main acute hospital trusts.
- The partners accepted the shared challenge around delayed transfers of care. Among its objectives, the HIOW STP listed, "deliver a radical upgrade in prevention", "early intervention and care", and "address the issues that delay local people being discharged

from hospital". The Frimley Health and Care STP planned to focus on similar priorities for 2016 to 2021. The local authority's draft Adults' Health and Care Five Year Strategy 2018 was linked to the HWB strategy and was aligned with these objectives around prevention, maintenance and delivering new models of care. This consistency of approach made it more likely that the partners would deliver the transformation to services.

- The Hampshire BCF plan focused on developing a sustainable out of hospital system model for local communities within each CCG area. The two national demonstrator vanguard sites in north east Hampshire and Farnham and across Portsmouth and Southern Hampshire were consistent with this, developing locally integrated models of care. These involved developing out of hospital services, 'Better Local Care' and 'Happy, Healthy, At Home'. These projects were still in development at the time of our review but were having a positive impact on the accessibility of GP services in Gosport and Lymington.
- In 2017, monies from the iBCF were allocated to the out of hospital care transformation programme which included the delivery of the high impact change model. Parts of the model had been implemented across Hampshire including discharge to assess and trusted assessor. Outcome measures had been identified as part of the Integration and Better Care Fund plan but it was not possible to analyse the success of these due to a lack of data available at the time of our review. During our visits to acute hospital and community based services, we found that implementation of the model was at different stages and staff had very different levels of understanding. Where the model was well understood and there had been some initial successes, for example discharge to assess in the Portsmouth and Gosport area, this had not been extended consistently across the county.
- Strategic working with other public services was not comprehensive. System partners had similar financial constraints and avoided difficult issues such as pooled budgets. The partners worked well on operational issues such as supported housing and had plans to significantly increase extra care housing stock in Hampshire. However, health strategies did not always maximise the benefit of working with other public-sector services to achieve larger scale improvement, for example, through influencing housing strategies for key workers or housing design.
- A&E delivery plans aligned with system objectives. Each local delivery system developed a winter resilience plan which it shared with other systems across Hampshire. The four A&E Delivery Boards provided governance around delivery for system resilience and delayed transfers of care (DTC), with jointly owned DTC improvement action plans.

### **Involvement of people who used services, families and carers in the development of strategy and services**

- The Health and Wellbeing Co-Design, Co-production and Participation Sub-Group was launched in 2017 and had an overview of all consultation work and planned to lead on joint co-production in 2018. This laid the foundations for a shared and system-wide approach in future, although this had not been fully implemented at the time of our review.
- System leaders recognised the importance of carers. The Hampshire Joint Carers Strategy was in draft and due to be presented at the HWB in June 2018 with a planned launch soon after. It was the product of wide consultation beginning with a listening event in July 2016. Carers were actively involved in the governance and the editorial group established, so it was more likely to be tailored to their needs. Organisations within the system led various initiatives to involve local people and their relatives and carers in strategy and service design. CCGs consulted through engagement events throughout the community, focus groups, workshops, patient representative groups and groups who represented people who used services, such as advocacy and carers' groups. However, people we spoke to told us this was inconsistent and that North East Hampshire and Farnham CCG had a more advanced ethos of engagement than the others.
- Local people were involved in developing services. For example, through ambulance service led surveys, participation groups for people who use services in GP surgeries, forums and events in acute hospitals, and volunteer patient champions in north east Hampshire and Farnham. In Fareham the hospital Patients, Families and Carers Collaborative quality reviewed multidisciplinary teams. The Frailty Support Service and community phlebotomy service in the West New Forest was designed in conjunction with local people. This meant that people could influence health and social care decisions and service design.
- The CCGs consulted people about what they would like to see in place-based care. 'Your Big Health Conversation' launched by Portsmouth and South Eastern Hampshire CCGs in early February 2017 sought people's views on how services could and should change. The quantitative feedback based on 925 respondents showed that most people saw a benefit in a greater emphasis on community-based care. Most respondents thought that community care should be strengthened and access to GPs should be extended. The local partners had delivered some of the necessary changes and could demonstrate impact.
- Some stakeholders felt that system partners did not do enough to promote public understanding of the sustainability and transformation plans (STPs). One stakeholder group suggested that if the public did not understand these, they might assume the plans were

just about financial cuts. They told us nothing had been done to avoid this misunderstanding. There was an opportunity for the system to improve public understanding of the role and function of STPs and their plans.

- Engagement with VCSE organisations was inconsistent. Although some VCSE organisations felt very engaged in planning new services, other VCSE providers did not feel involved. There was a risk that only some of the VCSE sector was contributing effectively to the prevention and independence agendas.

### **Promoting a culture of inter-agency and multidisciplinary working**

- Partnerships across the Hampshire system were becoming more cohesive. Joint working between the CCGs over the preceding year made BCF planning easier. Stakeholders told us that relationships were improving and were more collaborative than they had been previously. Partner organisations were involved in interviewing for each other's senior leadership roles.
- However, partnership working had been hindered by recent churn at system leader level and the need to re-establish working relationships each time there was a change of senior personnel. The majority of people who responded to our relational audit thought that organisational and personnel changes had slowed progress to integration.
- System leaders told us that the plethora of delivery plans and accountability mechanisms around them complicated the system. Some told us that work was fragmented and there was a need to coordinate within STPs, standardise across patches, streamline reporting and to become more outcome-focused. Plans did not always set clear targets. As a result, it was difficult to demonstrate impact on the wellbeing of older people or on delayed transfers of care.
- Implementation plans were understood across partners but were not combined at multiagency level or at the same stage of maturity. The response to the SOIR listed these plans as: Hampshire and Isle of Wight Health and Care System STP Delivery Plan, Frimley Health and Care System STP Delivery Plan, Hampshire Integration and Better Care Delivery Plan, Portsmouth and South East Hampshire Accountable Care System Improvement Plan/Local Delivery System Transformation Plan, Urgent and Emergency Care Plans and Hampshire Integrated Intermediate Care Plan/Model. System leaders recognised that they needed to ensure consistency between plans. Multiagency operating plans for local delivery were not in place and this meant that people's experiences and outcomes for example, access to GPs or the frailty pathway, varied locally.

- Integrated intermediate care was not fully developed across Hampshire. The system had established a county-wide Intermediate Care Board for this purpose. An Intermediate Care Integration programme had been set up to develop a single intermediate care service provided by Adults' Health and Care (AHC) at the local authority and Southern Health NHS Foundation Trust for the population of Hampshire. Users of this service would mainly be older people who needed short term intermediate care.
- The pace of change within the four local delivery systems varied, reflecting prevailing local factors. For example, the North East Hampshire and Farnham vanguard new models of care programme 'Happy, Healthy at Home' launched in 2015 led to benefits for the local community. The new care models were designed to deliver more care at home and in the community, reducing hospital admission rates and enabling people to be discharged from hospital reducing duplication and improving efficiency and value for money. Other examples included improved access to care via a GP lead clinical team using new technologies to manage people who needed same day appointments seven days a week; this freed up GP time to support people with more complex needs. Likewise, 'Better Local Care', the community provider initiative across the south of the county, demonstrated similar elements of new models of care delivery. However, these approaches were not as advanced in other parts of Hampshire. Arrangements for extending good practice were not clear. This led to some inequity in service delivery across Hampshire.
- Some initiatives for older people had transformed service delivery at local level. For example, partners had a frailty pathway to avoid unnecessary admission, had introduced a GP-led hub at Gosport to take primary care out to the community and provide same day GP appointments, and jointly commissioned the Bluebird domiciliary care service.

### **Learning and improvement across the system**

- Groups, meetings and collaborative arrangements to promote learning were in their infancy. System leaders recognised that there was a need for transfer of learning and good practice on integration between organisations and across the county. At the time of our review, the Solent region had held workshops on collaborative working to encourage joint project ideas, with the idea of starting a shared learning hub. However, this was not fully implemented and was one of the "next steps" to follow from the workshops.
- Innovative joint funded approaches were beginning to support independence for older people. For example, the digital technology provider identified a need to support people living with dementia to stay at home. Their technology extended the ability to care for people living with dementia and kept people doing things they want to do. Early implementation was seen as very important so people would be able to understand how to

use equipment and was built into the dementia pathway; qualitative data demonstrated this had been successful. This initiative was used as part of a change programme to inform the workforce and change practice. The technology was funded from a combination of local authority and Better Care Fund monies.

- The lack of a systematic approach to learning meant that good practice around integration took longer to establish. However, learning had been shared at organisational level in order to extend some projects. For example, projects in nursing homes in Southampton to improve leadership, which had been rolled out across the adult social care system. The partners had responded positively to an assessment of the four local delivery plans produced by an independent expert. Recommendations included: a clearer narrative to engage the public and staff, more integration of health and social care resources at the locality level, collocation of integrated local teams which should include a range of health and social care professionals, pooled budgets and a single point of leadership. Partners were taking action to address these areas for improvement. For example, in Havant we saw a single point of access with primary care and social care professionals working together.
- Some organisations in the system did not treat mistakes as a source of learning for continuous improvement, in a culture of openness and candour. For example, learning from poor performance on safeguarding. We heard how there had been three serious case reviews and the points of learning had not been integrated into day-to-day working across the system.

### **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.*

*We found that governance was robust in some parts of the system but not others. Structures and delivery around integration were fragmented. Use of targets and clear outcomes measures was not systematic. Although the system had implemented some community-based transformation initiatives and prevention schemes, this did not appear to have led to a reduction in hospital admissions across the system, although this varied across the NHS trusts. Partners were unwilling to pool budgets because of risks to their finances.*

*However, the system had an established shared care record system and a strong base for developing shared information systems. There were effective information sharing arrangements for safeguarding. The Wessex Quality Surveillance Group (which included all public-sector partners in Hampshire and the Isle of Wight) met to share information about organisational and operational risks and poor quality.*

### Overarching governance arrangements

- Senior leaders and commissioners from the system monitored plans and their delivery through the HWB Executive Group. This reported to the HWB and oversaw progress against jointly agreed strategic objectives, integration and delivery plans at their monthly meeting. The HWB Executive Group also provided leadership to monitor the direct delivery and financial performance of iBCF schemes and operational detail of all section 75 (National Health Services Act 2006) agreements with specific work streams managed in local delivery systems. This ensured that system leaders were aware of progress and could take action on any difficulties.
- HWB governance arrangements were not always supporting partners to drive integration. The HWB was well attended and could hold organisations to account, but tended to endorse reports without providing direction or leadership. System leaders were unsure about what the HWB had achieved. They told us the HWB needed to align the multiple health and social care plans and systems across Hampshire. The HWB lacked a comprehensive work programme and did not actively influence the direction of services or monitor their impact. The role and responsibilities of the HWB in monitoring and supporting initiatives had not been defined. This limited the effectiveness of the HWB in achieving noticeable change.
- Below HWB level, governance arrangements were not integrated. System partners all had their own arrangements and some senior leaders wanted to see more coordination within STPs. STP leads told us that HWB chairs and deputy chairs from across the wider Hampshire footprint (including Hampshire, the Isle of Wight, Southampton, Portsmouth) had met twice so far to discuss common issues and align governance and practice, which meant that progress on internal and external coordination was in the early stages.
- Performance against agreed outcomes was reported at the four A&E delivery boards, which oversaw improvement work for A&E and DTOC. Each local delivery system had an A&E Delivery Board that monitored key performance indicators and projects based on: hospital to home; ambulances; urgent treatment centres; GP access; NHS 111; hospitals and mental health crisis. Monthly board meetings reviewed progress against the plan. The four A&E delivery boards monitored system resilience and DTOC, with jointly owned DTOC improvement action plans. They also monitored reports on high impact change model pilots such as discharge to assess. Because there were four separate boards, there was a risk that evaluation of individual initiatives was not always shared between them
- Local delivery systems monitored progress on their STP implementation plans. This included regular monitoring of progress against key objectives and national and local



targets. Key performance indicators were used to monitor progress on areas such as hospital admissions, delayed transfers of care, hospital bed days and GP referrals. Through close monitoring of systems, the partners were aware of each other's progress.

- Governance was starting to be effective in the accountable care systems. In North East Hampshire and Farnham, part of the Frimley Health Accountable Care System, which was among the first eight designated accountable care systems in England announced in June 2017, the Board began meeting in September 2016. This ensured local accountability of the vanguard project.
- The processes and governance around continuing healthcare (CHC) assessments across Hampshire had been ineffective. This had resulted in a backlog of 236 cases in 2016. West Hampshire CCG, which managed CHC on behalf of all Hampshire CCGs, aimed to clear the backlog by June 2018 by outsourcing the work. They were implementing a consistent approach to the CHC process and were aligning staff groups in relation to assessment, brokerage and procurement, so that performance would be better in the future.

### **Risk sharing across partners**

- The system had a mechanism to share information about risks. The Wessex Quality Surveillance Group was a forum to share intelligence about risks to quality and included public sector health and social care partners. It provided information and early warning of risks and poor quality. New terms of reference had been agreed for the forum in January 2018, so it was too early to assess outcomes from the joint approach at the time of our review.
- The CCGs were looking at new ways of monitoring and sharing intelligence about risk. The CCGs and specialised commissioners in HIOW were developing new ways of working with providers which included how to share intelligence about risk including utilisation risk, production cost risk and volatility risk.
- Otherwise, risk management arrangements were mostly based at organisational level. Healthcare organisations and the local authority had their own monitoring arrangements and risks were escalated where appropriate. Risks were identified at an operational level. Older people who were vulnerable were identified by their GP through use of risk stratification tools and the collective knowledge of health and social care professionals.
- Ambitions around financial risk taking and integration across the whole system were limited. System leaders recognised they needed to understand the whole system transformation plan because of the impact on their financial plans. However, they were under financial

constraints at organisational level and saw this as an obstacle. They did not want to risk investing in integrated services unless they saved money elsewhere. They preferred to work on specific projects to achieve better outcomes for people. This meant that the impact for people was restricted to specific localities until initiatives were rolled out on a county-wide basis.

- There were pockets of integrated risk management at local level in the system. The partners of the Solent Acute Alliance were starting to establish financial risk management to enable greater collaboration between them. In Gosport, part of one of the vanguard areas, GP practices had a model of clinical collaboration that allowed them to work together on initiatives such as same day urgent appointments.

### **Information governance arrangements across the system**

- System partners were overcoming barriers relating to information governance at system level. The Hampshire Health Record was a shared health and care record used to share key information between GPs, hospitals, ambulance services, care homes, out of hours services, NHS community services and local authority social care about people using services. This meant that the partners had a shared health and social care record system from which to further develop integrated information technology. However, this worked better in some areas than others.
- The Digital Strategy aimed to build on this by enabling real time passing or viewing of information between systems and the capability for clinicians to confer and coordinate their actions across organisation boundaries. It would also provide the basis for a HIOW Personal Health Record to enable people to access their full medical record and services like appointment booking and care collaboration.
- Information sharing arrangements were in place in key areas; for example, enabling effective multiagency information sharing about safeguarding. There were also pilot schemes such as sharing medical records between primary care and community health services, which enabled community teams to have the same picture of a person's care as their GP.
- There continued to be barriers relating to information governance at an operational level. Lack of access across health and social care to assessments and care records led to lost time and increased reliance on photocopying and sending records before transfers of care could be arranged.
- Partner organisations did not always share information to facilitate care or to promote the

best interests of people using services. For example, ambulance staff felt that providers did not want to share information following a safety incident. This was due to a mistaken belief that information governance arrangements prevented sharing. However, this could easily be overcome by anonymising the personal details on the record.

**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 its strategic direction and efficient use of the workforce resource.*

*We found that the system lacked a comprehensive strategic approach to workforce planning, for example, at HWB level. The HIOW STP Workforce Planning Team had completed the first phase of a project to map the future workforce needed in each local delivery system. Membership of this group included all the relevant public-sector bodies.*

*However, planning at strategic level did not include independent care providers or VCSE organisations who would be significant partners in achieving transformation. There was no system-wide recruitment of care staff, common approach to pay or strategies around staff development or retention.*

*There were some initiatives in place to train care home staff and to develop skills for new roles to meet the prevention agenda and short term funded programmes such as through the iBCF.*

**System level workforce planning**

- System-wide workforce planning was not inclusive of key partners at strategic level. The HIOW STP delivery plan had an Executive Delivery Group which oversaw a Local Workforce Action Board (LWAB). Working groups for Human Resources, Education and Development and Workforce Transformation reported to the LWAB. Representatives from primary care, mental health, prevention and out-of-hospital services had been seconded into the Workforce Transformation Group. Although the groups had made progress, the sub group leading on workforce transformation did not include the independent care providers or VCSE sector. This limited the influence these organisations could have on key issues affecting them, such as the availability of care workers.
- The public sector system partners were planning skills development for integrated health and social care. The STP Workforce Transformation Team was working with Health Education Wessex to review existing training placements, future trainees and new roles such as nursing associates and physician associates. For the domiciliary and residential

care providers who struggled to recruit and competed directly with each other for staff, social care and NHS partners launched 'Change Lives – Start with Yours'; a BCF funded scheme which aimed to raise awareness of opportunities and the value of working in adult social care and support for people of all ages considering career options. LWAB representatives were assessing the health and social care workforce needs of each local delivery system and establishing priorities. After this they planned a joint rehabilitation and reablement service, promotion and expansion of apprenticeships and were considering introducing a Homeshare programme. These plans were expected to be implemented from May 2018, with completion by October 2018 at the earliest.

- There was a plan to promote a shared culture. System partners planned to implement a job rotation scheme and organisational development measures such as portability of mandatory training and pre-employment checks for nurses and social care staff. These measures were likely to promote job mobility across sectors.
- The partners had no system-wide long-term approach in place for recruitment, or resolving the important issue of a shortage of care staff. They told us their campaign priorities were to address the shortage of domiciliary care staff, registered managers and to improve nursing capacity in social care settings. The workforce forum partners had not addressed difficult issues such as joint appointments although there was a focus on improving domiciliary care staff capacity. Their plans did not include how best to support the unpaid workforce of carers and volunteers or how to make best use of technology. This limited progress on increasing the staffing for domiciliary care, which restricted choices for older people for care at home or when they were transferred out of hospital.
- The system lacked any clear pay and reward strategies. Independent providers told us the local authority could pay their own care staff more and so they attracted staff away from the independent sector. The partners had not tackled pay harmonisation across public sector providers or included independent providers. Human resources professionals told us that they had tried to do this three years previously and it turned out to be too difficult to gain consensus; so, the issue had remained.
- Workforce retention was a significant unresolved challenge in Hampshire. Hospitals and social care services had higher turnover than the England average for most job types. The workforce programme included plans to address workforce supply and retention, but they were in the early stages. Commissioners had agreed to align specifications to promote a values-based approach in recruitment, aiming to retain staff more, but this was not effective at the time of our review.

- Independent providers were invited to some working groups. For example, to a sub-group related to Skills for Care and the HR Directors' Forum. The workforce forum told us that these groups were still defining outcomes, team definitions and looking at retention. They told us there was an action plan but financial resources to support the actions had not been defined.

### **Developing a skilled and sustainable workforce**

- The apparent lack of creative thinking around provision of skilled domiciliary care staff sometimes had the effect of delaying transfers of care out of hospital for older people. According to NHS mid-year 2017 figures, people in Hampshire were delayed in transferring out of hospital for 9.7 days owing to a lack of care packages compared to 3.8 days in comparable areas. Providers told us it was difficult to recruit staff and that there were delays while packages of care were organised. The system needed to address zero hours contracts and transport provision for care workers. There was full employment in Hampshire and London weighting in neighbouring counties which meant that care staff had considerable mobility of employment.
- Short term funding was used effectively to develop a more sustainable workforce. The iBCF was being used to provide dedicated resources through the established Partnerships in Care Training (PaCT) workforce programme to work with the independent care sector on three key workforce priority areas:
  - Values-based recruitment to attract and retain the right people; this was important because staff turnover in adult social care providers was higher than the national average.
  - Development of management and leadership capability and resilience including development of new skills linked to CQC standards; for example, innovation and entrepreneurial thinking.
  - Supporting new ways of working, for example; strength based working and exploiting digital opportunities such as the technology enabled care.
- Partners within the system were working to improve care and nursing skills. Joint working with Health Education England Wessex Local Team saw £1.7 million invested in workforce development activities to support the initiatives in Hampshire. The local authority's PaCT programme was a collaborative approach to support providers of adult social care in Hampshire to meet their workforce development and training requirements. The key focus was to promote leadership and develop sustainable approaches to build workforce capacity and capability. PaCT was a primary communication and engagement channel between system partners and the VCSE and independent sectors.

- The system was developing new roles and skills to better meet older people's needs. For example, the hydration programme which was designed to increase workforce skills in managing hydration in settings outside of hospital, new roles in west Hampshire including Care Navigators and Frailty Practitioners and implementation of the National Early Warning Score tools in social care. LAWB representatives told us about Skills for Frailty which was leading to quality improvement and social prescribing initiatives; however, the representatives felt these happened in isolated pockets and the knowledge had not been shared across the county.
- There was potential for system partners to extend their capacity by involving the VCSE sector more. Voluntary sector organisations told us that with more involvement and funding they could increase the level of support they offered older people and their carers.

**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 were providing a diverse and sustainable market in commissioning of health and social care services.*

*The joining of four of the five CCGs was seen as a positive step to integrated working; however, the impact on providing a whole system approach for the needs of the people of Hampshire had not been demonstrated at the time of our review.*

*It was not clear if there was a systemic approach to joint commissioning and associated governance. There were pockets of integrated working, for example the community reablement service.*

*There was work to be done on developing relationships and improving communication between commissioners, the voluntary sector and providers.*

**Strategic approach to commissioning**

- Commissioning across Hampshire was not fully integrated or comprehensive. System partners were taking steps to improve their commissioning capacity. From 31 March 2017, four of the five Hampshire CCGs formed a partnership and shared an Accountable Officer. The HWB told us that this facilitated leverage at scale with the local authority and providers, balanced with the need to retain a local outlook on commissioning decisions.

- A new five-year commissioning strategy and market position statement (MPS) developed by Adults' Health and Care (with input from NHS partners and providers) set the strategic direction for service commissioning. Flexibility in new AHC commissioning plans and frameworks would allow for joint commissioning approaches with partners.
- The local authority was working towards joint commissioning across the system with a focus on supporting independence and prevention. For example, AHC's community reablement service; a multidisciplinary team who worked with people to return them to, or maintain, their optimal independence following ill health or a diagnosis of a long-term condition.
- It was not clear if there was a systemic approach to joint commissioning and associated governance to ensure best use of joint resources. There were pockets of integrated working but they were not working at scale. However, there were some examples of joint commissioning for older people such as the joint hospital prevention service commissioned by South Eastern Hampshire CCG and the local authority. There was also intent to commission bed-based reablement jointly with the NHS through the recommissioning of some of the local authority's care home facilities and the creation of specialist dementia hubs by re-shaping some residential beds.

### **Market shaping**

- The market position statement (MPS) clearly set out the supply and demand issues and the business challenges and opportunities for health and social care across the system. The focus on promoting independence was articulated. The MPS was informed by the JSNA which had robust population analysis. The MPS used the JSNA to identify geographic and individual health conditions hot spots.
- Leaders and staff working across the system told us that the focus of the system was on prevention and "home first" for older people. This focus was supported by the involvement of the VCSE sector, enablement and re-enablement services. However, they acknowledged that sometimes the disparate and locally varied nature of the voluntary sector made it difficult for commissioners to deal with the sector as a coherent whole.
- Hampshire had a high number of nursing home beds. Although Hampshire had a lower number of residential care home beds per elderly population compared to England and comparator figures, this was more than compensated by the higher number of nursing home beds. Between April 2015 and April 2017, there had been small increases in the number of both types of beds in Hampshire and a noticeable 5% reduction in the number of domiciliary care agencies.

- Contracting arrangements for domiciliary care providers did not always work effectively. The County Council's Adults' Health and Care service (AHC) had revised domiciliary care contracting arrangements and reduced the number of providers, in order to guarantee them more work. This was done using AHC's Care at Home framework. However, the local authority recognised these arrangements were not working as intended, and planned to implement a revised approach from July 2018. The new approach aimed to improve capacity through a greater focus on promoting independence. It also aimed to improve terms and conditions for care workers to assist with recruitment and retention and reach into rural areas. This contract would provide support to the developing extra care housing services. It aimed to bring all the NHS commissioned domiciliary care services under one approach.
- There appeared to be a greater emphasis on bed-based solutions as a step-down approach. The system recognised this and planned to implement the Help to Live at Home framework from July 2018. System leaders told us this framework allowed more providers to contract with AHC and CCGs with consistent and more appropriate pricing, while they would continue to appoint lead providers within geographical zones across the county.
- The key commissioning focus on prevention and promoting optimal independence for the people of Hampshire was evident. The local authority had commissioned online resources, 'Connect to Support', to help adults identify a wide range of support to maintain independence. This was being rolled out widely across the county, including into GP practices with a target to increase the hits on the site from 5,000 to 10,000 within the 12 months following our review.
- Extra care housing was being developed to enable high levels of need to be supported in the community with care support on site. There had been a £70m investment to increase the number of units from 800 to 1,500 over a five-year period; details of how this would be achieved were planned for development during 2018.

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

- Commissioning plans from the CCG and local authority in Hampshire were person-centred and focused on prevention. While people living in Hampshire could benefit from this person-centred approach, at the time of our review, work was still needed to bring this together into a coherent system-wide commissioning strategy.
- People living in Hampshire had relatively good access to GPs outside of normal working hours although this could be improved. Data from March 2017 on provision of extended



access to GPs outside of core contractual hours showed that 6% of the 131 GP practices in Hampshire surveyed offered full provision of extended access over weekends and on weekday mornings or evenings compared to the England average of 23% and the average across Hampshire's comparators of 17%. However, 84% of practices offered partial provision which was significantly higher than the England average (61%) and comparator sites (63%).

- A growing number of people were empowered to take control of their own care. There had been an increase in the use of direct payments in Hampshire since 2014/15, and in 2016/17 20% of people aged 65+ using services were receiving direct payments. This was marginally less than the 20.2% in comparator areas, but more than the 17.6% across England.
- Some system partners felt that communication and relationships between service providers, their representatives and commissioners could be improved. Domiciliary care providers expressed concerns about the commissioning contract and the inequities inherent within it. Twelve providers had been awarded the latest Care at Home contracts. However there remained a number of domiciliary care providers who were contracted under older arrangements and a number that were spot providers for Hampshire. This meant that the 12 providers under the Care at Home contract had to abide by certain contractual requirements, such as staff pay. However, the other providers could pay their staff whatever they chose, which meant that they were more likely to have the staff they needed to offer packages of care that were required. This led to some difficulties in relationships with the brokerage team.
- VCSE organisations stated that there was a disconnect between the local authority's intention around strength-based approaches and capacity building and the actual services that Age Concern supplied that met those requirements. Age Concern felt their outreach services needed more financial support and that their services and those of the VCSE sector more generally were underutilised.
- System partners agreed that The Firs unit, a bed-based functional reablement service aiming to deliver a multi-professional response to transfer of care, could be commissioned more effectively to support a wider cohort of people coming out of hospital, or prevent people going in.

### **Contract oversight**

- Commissioners across the system told us that there were strong governance arrangements around contract and quality monitoring. However, this was still within individual

organisations rather than as part of integrated governance arrangements. In AHC, these assurances included a review of how personalised and appropriate the service was for the person, to ensure that care was person-centred.

- Hampshire health and social care partners worked together to ensure the delivery of high quality care and support. We reviewed evidence that the local authority and CCG quality leads met regularly to discuss providers and share intelligence. There were also joint quality visits undertaken with AHC and CCG colleagues.
- Adult social care providers told us that the local authority and social care quality team closely monitored poorly performing care homes and were proactive in their approach. However, there was still work to do to support care homes to improve.
- However, overall ratings of adult social care services within Hampshire were in line with national and comparator breakdowns. For example, 66% of residential homes were rated good compared to 65% in comparator areas and 62% across England.

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

*We looked at resource governance and how the system assures itself that resources are being used to achieve sustainable high-quality care and promote people's independence.*

*We found the system did not consistently carry out cost benefit or options appraisal work before schemes or evaluate them after completion. There was a risk that partners would not have clarity about what outcomes would be delivered for their investment.*

*However, partners were focused on using resources effectively within their individual organisations. Collaborative working and mechanisms for pooling resources were being developed in the vanguard areas.*

- System partners could demonstrate some effective use of cost and quality information to prioritise areas for improvement, but this was not applied systematically. For example, an aligned incentive contract was in place in this system aiming for cost benefit. The frailty model also applied an investment model before taking action, but this was not a widespread approach. Lack of cost and benefit information could deter the partners from allocating finance to a scheme.
- Not all schemes were evaluated for their impact on people's health and social care or their

scalability. For example, in west Hampshire there was a diabetes challenge which made services available as a one stop shop in the evening. This resulted in ten people joining the gym as a behavioural change. However, it was unclear to leaders how to extend the scheme across the county so that people living across Hampshire had equal access to the benefits.

- The system was not using benchmarking to test whether it was transforming services in the most cost-effective way. Although there had been some work at organisational level to identify good practice, there had been no system-wide cost or performance benchmarking or search for good practice elsewhere. This was a missed opportunity to learn from other systems.
- System partners reported some information on unit costs as part of their iBCF return. However, information about costs and outcomes was reported at different places and levels in the system. This was time consuming for system leaders to manage. Processes could be streamlined to give more impetus to transformation.
- Collaborative working and joint use of resources were being established in the vanguard areas. All partners agreed to move towards collective contractual accountability for achieving population health outcomes within a fixed budget and measured against a single performance framework. Portsmouth Hospitals NHS Trust and the local CCGs had agreed to replace payments by results with an 'Aligned Incentive Contract' from the beginning of 2017/18. This would be one of the foundations for a single multiagency operating plan from 2018/19, which would lead to integrated services focused on local people.
- Partners had achieved efficiencies within their own organisations. For example, Adults' Health and Care (AHC) had in 2016/17 been able to continue to meet the needs of the residents at the same cost level as 2011/12, while absorbing a higher level of demand and price increases. However, although a jointly funded Integrated Discharge Director post at Portsmouth Hospitals NHS Trust was being advertised, pooling resources and joint risk taking was in the very early stages.
- Progress on the Better Care Plan was reported and monitored. There were shared performance metrics and quarterly reporting. The partners planned to use independent evaluation in future to monitor and inform their developments, for example through the Wessex Academic Health Science Network. This would provide an independent assessment of outcomes and value for money.
- Short term funding was monitored at strategic level. The HWB Executive Group reviewed

the direct delivery of iBCF schemes and operational detail of all section 75 (National Health Services Act 2006) agreements with specific work streams managed in local delivery systems. This ensured joint reporting of transformation initiatives.

- Partners understood where resource gaps were across the health and social care interface. For example, the local authority had increased direct provision through county-wide reablement services. It directly funded provision in hospitals to support transfers to the community. The health and social care partners had set up a Public Services Summit to develop common approaches to financial pressures, which helped mutual understanding.

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

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

### **Are services in Hampshire safe?**

*There was system-wide commitment in Hampshire to keeping people safe in their usual place of residence. A number of initiatives had been introduced to promote this, including the development of frailty pathways, an intensive care home team where nurses identified those care homes that were struggling and worked directly with them, and GPs used a risk stratification tool to identify people at risk of hospital admission. All these initiatives were viewed positively by staff and people who used services.*

*Safeguarding processes were well embedded across the system and we saw good examples of multidisciplinary team (MDT) working to keep people safe. The digital technology enabled care service (DTECS) used in Hampshire was award winning, part of its function was to help people who had gone missing. The system enabled people to be found more quickly by tracking their movements. Since its introduction repeat missing events had been reduced by 66%.*

- Hampshire had effective systems to signpost people to appropriate support when needed. 'Connect to support' was the Hampshire-wide information point to signpost people to services. This website, initiated by the local authority, was designed to be used by the public, health and social care professionals and VCSE partners. There were hundreds of links and telephone numbers for people to use to access services to help keep them safe such as falls prevention and the silver line; this was a telephone line specifically to tackle loneliness in older people.

- One of the initiatives that had been introduced to promote keeping people safe in their own homes included the development of the frailty pathways across Hampshire.
- Frailty focus had been introduced in north and mid Hampshire to enable people to age well, an MDT approach to keeping well and plan for the future was key to the strategy.
- In west Hampshire, a frailty support service had been commissioned with the aim of avoiding unnecessary hospital admission. This was following a pilot where in a 12-month period; more than 300 frail elderly people were treated in their own home with only 75 of those requiring hospital admission. The frailty team would work as part of a team to prevent admission and readmission to hospital. People could be referred by GPs, community staff and the 'Connect to Support' service in Hampshire.
- There was an opportunity for both these frailty services, which were relatively new, to share learning and approaches to ensure pathways were well aligned and access was straightforward to hospital and community staff as we were told this could sometimes be confusing and led to duplication
- An intensive care home team had been developed in the Portsmouth and Gosport areas; nurses worked directly with care homes they had identified as struggling and where systems were not working well. The team then focused on nutrition, hydration and falls in homes and would arrange further training for staff to ensure homes improved standards.
- Hampshire had a lower rate of A&E attendances from care homes. In quarter four of 2016/17, Hampshire had a rate of 647 per 100,000 population aged 65+ which was less than in comparator areas (900) and England (947). This was a longer-term trend – Hampshire's rate had been consistently lower since at least 2014. Similarly, emergency admissions from care homes were lower; 561 in the same time period compared to 675 and 713 in comparator areas and England.
- Safeguarding processes were well established in Hampshire. The local authority provided training across the system including for the independent and voluntary sectors. Safeguarding referrals were taken from the Contact, Assessment and Resolution Team (CART), which was a front door service. Two social workers had been allocated to work with the ambulance trust with the aim of reducing inappropriate safeguarding referrals by offering advice and supporting referrals.

- GP practices were using the frailty index and maintained a register of people with complex needs that was shared with colleagues across health and social care using a MDT approach to monitoring and hospital avoidance.
- A&E attendances had been consistently lower in Hampshire than comparator areas and particularly the rest of England. In the fourth quarter of 2016/17, Hampshire had 8,498 attendances per 100,000 aged 65 compared to 9,595 and 10,534 in comparator areas and England respectively. A low proportion of GP referrals were discharged without follow-up suggesting that there were lower numbers of inappropriate GP referrals.
- Hampshire had a lower rate of emergency admissions than comparator areas and England. In the period that the Department of Health analysed (September 2016 to August 2017), Hampshire's rate was 21,192 which was lower than the 22,906 and 25,009 in comparator areas and England respectively.
- The digital technology enabled care service (DTECS) operated across Hampshire and had won a number of national awards for its service. This had been commissioned by the local authority. Care workers could refer people via the Contact, Assessment and Resolution Team (CART). DTECS also worked with Hampshire Constabulary and took referrals for older people who had gone missing. DTECS could then provide a method for tracking people to help them keep safe and find them quickly if they required. Since the service had been introduced repeat missing events had reduced by 66%.

### **Are services in Hampshire effective?**

*There were a number of services in Hampshire to prevent hospital admission and maintain people in their own homes, which worked well. Some of these were not Hampshire-wide and work needed to be done to fully evaluate these and determine which would be most effective. The process to order specialist equipment, particularly specialist beds, needed to be simplified and streamlined.*

- There were two out-of-hours providers in Hampshire, including North Hampshire Urgent Care (NHUC) and Partnering Health Limited (PHL). Both were valued by the system and had a focus on people's safety. Doctors used a "patient deterioration application" on their phone which helped decide whether to keep a person at home or to convey them to hospital. Early work with urgent treatment centres was seen as helpful, particular during the crisis flu, where support had been provided to GPs and had been linked to GP extended access.

- The rate of people being admitted to care homes had been consistently below the England rate. In 2016/17, 556 per 100,000 65+ population were admitted in Hampshire compared to 611 across England. This was slightly higher than the rate across comparator areas of 537.
- Frailty services were being developed across the Hampshire system with a strong focus on prevention and better support for this group of people. Since April 2016, a multidisciplinary Frailty and Interface Team had been sited at Queen Alexandra Hospital, Portsmouth. The service ensured admission avoidance for an average six older people daily and managed a further six supported discharges from the Acute Medical Unit. As well as admission avoidance, the service contributed to reducing length of stay with estimated avoided cost of £1.7 million.
- Across Hampshire people who thought they might need help and support were able to contact the CART team and an initial assessment would be carried out. Call handlers were able to carry out a wellbeing check and could authorise some things such as minor adaptations and refer on for assessment as required. We saw from records that, when people were assessed, they were assessed holistically.
- As part of the Hampshire falls prevention strategy and Better Balance for Life initiative, 'Steady and Strong' classes are delivered around the county. We attended a 'Steady and Strong' falls prevention class and observed the activities. People were visibly enjoying the class and the trainer worked carefully to adapt the exercises to individuals' capabilities. As well as physical strengthening, the class provided an opportunity for socialisation as people attended with friends, or made friends within the class.
- People attending the 'Steady and Strong' classes were asked to carry out a self-assessment of their confidence and risk of falling when they began attending the class and then periodically after they had been attending for a while. This data was submitted to the local authority, who coordinated the classes across the county, to measure the effectiveness of the sessions and adapt the content where needed. Self-assessments showed increased confidence levels of people who had attended a number of sessions.
- We saw examples of good working in A&E within reach into other clinical areas. Older person practitioners and the emergency community team were employed and working in the community to support placements in care homes. IT supported this as practitioners had access into other systems.
- A pilot to share notes with between Southern Health NHS Foundation Trust community

teams and primary care teams had been viewed beneficial by staff. This was not county wide at the time of our review but work was being done to spread this across Hampshire.

- Staff told us there was a complex system for ordering equipment, which caused them difficulties in the community and which could lead to delays. This was particularly when ordering specialised beds to maintain people at home. The process involved a number of steps and could lead to delays for people who were on an end of life pathway. Work needed to be done to streamline the service to prevent extended waits for equipment.

### **Are services in Hampshire caring?**

*People in Hampshire valued the services available to support them to stay at home. Generally, there was a view that there were a range of support services available, but people were not always aware of them.*

- Older people told us that there were a lot of services and support available for older people in Hampshire but these worked separately across the different localities in Hampshire and it was difficult to access information about what was available in your specific area. The 'Connect to Support' service provided a website with a directory of services for example, community activity clubs, nursing homes etc. Information about services in a particular area could be accessed using the person's postcode. Also, the Citizens Advice Bureau were working with Healthwatch to influence general information and advice services across Hampshire but this had not been fully developed at the time of the review.
- Some people we spoke with during the review were aware of services for carers, including carers' support workers and services commissioned from the Princess Royal Trust (PRTC) for carers in north Hampshire, who provided carers' hubs. People raised the point that this assessment service provided by PRTC was commissioned by north Hampshire and was giving good outcomes but this support was not available Hampshire wide.
- The county-wide services available in Hampshire to support older people included the fire service who provided what we were told was "great" support, carrying out safety checks and visits to people's own homes. National Trading Standards were offering a call monitoring service for older people who may be vulnerable to scams. The social prescribing service initiative though delivered by different organisations was county-wide using a recognised model. The model used was evidenced to deliver preventative results for health and social care.
- Not all older people told us they were as involved in discussions and decisions about their care, support and treatment as they wanted to be, this was particularly noticeable with



people who were funding their own care as they told us assessments were difficult to access. However, the records we reviewed during the review showed assessments were timely and holistic covering people's social and health needs. People using services, families and carers were involved in decisions about them.

- In Hampshire, the proportion of people feeling supported to manage their long-term condition has been consistently above the England average. In 2016/17, it was 65.85% compared to 64.0% across England. This percentage had been falling over the past few years as it had across England generally.

### **Are services in Hampshire responsive?**

*Some responsive services are provided in Hampshire that supported people to maintain their independence and remain in their own home. These services were not consistent and meant some people's experience were not as positive as others.*

- People were usually able to access same day urgent appointments with their GPs in Hampshire. Services operated differently across surgeries. Some offered "sit and wait" clinics; people told us that they could wait for a very long time to be seen at these clinics. The time taken to be seen was not as long in "sit and wait" clinics in located in hub locations, but these were not easy to access via public transport. The wait for routine GP appointments in some areas on Hampshire could be up to 6 to 8 weeks, and not all GP services offered a home visiting service, again impacting on people and or carers without transport. People were recognised as a carer by some GP surgeries, which meant they were flagged as a "priority alert" to ensure they had access to timely appointments.
- The provision of extended access to GPs was broadly similar to the national average and although only 6% of GPs offered full provision, only 8% offered no provision out of hours meaning most people did have some extended access from a GP from their own practice.
- While the percentage of A&E attendances that were referred by a GP were similar to England figures, a low proportion of those GP referrals were discharged without follow-up. This suggested that there were lower numbers of inappropriate GP referrals.
- There were care navigators in post across Hampshire to support people to access services and support, some of these based in GP surgeries. Care navigators told us they were not getting the number of referrals from GPs they would expect and they could be offering more to people. Not all GPs in Hampshire offered enhanced care into care homes which would involve regular 'surgeries' taking place in the care home.

- The Citizens Advice Bureau had a number of walk in centres across Hampshire where a Healthwatch lead was based to provide information and support for people. In parts of Hampshire (Solent) there were urgent response teams which included nurses, therapists and social workers. An urgent response domiciliary care agency service was also available that would support people to stay in their own home for short periods however these services were not county-wide, meaning the service was inequitable across Hampshire.
- Work had been carried out at the local authority, which identified that 40% of people caring for someone in Hampshire were doing so because the person was living with dementia. Technology enabled mechanisms, such as door alarms and pressure pads, were being provided county-wide to people to enable them to stay home. Early intervention was seen as key so people still had the cognition to use any necessary equipment.
- There had been an increase in direct payments in Hampshire since 2014/15 and in 2016/17, 20.0% of people aged 65+ using services were receiving direct payments. This was marginally less than the 20.2% in comparator areas but more than the 17.6% across England.
- The availability of community nursing services in Hampshire was different across the county. The majority of services operated until 22:00 or 23.000; in the Fareham area services were available until 04:00. The 04:00 service had been established recently and was particularly valued by people who were receiving end of life care and their carers. The service also provided support to GP and out-of-hours services.
- Community hubs had been set up across Hampshire to provide information to people and support them to stay independent and well. Not all people who attended the focus groups during the review were aware of these hubs and what support could be offered. There was an opportunity to improve communication with the public about hubs and what they could offer to ensure they were fully utilised.

## 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 Hampshire safe?

*The numbers of people attending A&E departments and then being admitted to hospital across Hampshire was lower than nationally and in comparator areas. This indicated overall GP referrals and services to keep people in their own home were working well.*

*People's experience differed once transported to A&E; people taken to Portsmouth Hospitals NHSFT could wait significantly longer to be seen and treated than those taken to Frimley Health NHSFT. None of the A&E departments had suitable areas to manage the care of people living with dementia.*

- The NHS constitution sets out that a minimum of 95% of people attending accident and emergency departments must be seen, treated and then admitted or discharged in under four hours. This is one of the core standards and often referred to as the four-hour target. Data showed that none of the four NHS trusts that served the people of Hampshire met the 95% expectation in 2016/17. However, this ranged from 91.6% at Frimley Health NHS Foundation Trust – which was above the England average of 89.1% – to 77.8% at Portsmouth Hospitals NHS Trust. For Hampshire, this meant that people were not always assessed in a timely way on admission by the front door assessment teams, who would identify any interventions or referrals that could be implemented to facilitate discharge or treatment by a more suitable provider of ongoing care. The percentage of admissions that lasted longer than seven days had been consistently, though only slightly, higher than the national average. However, 10% of people admitted were staying for 25 days or longer. This was worse than all of Hampshire's comparator areas. There was a perception of a risk averse culture reported by various staff groups. We were told that ambulance and A&E staff could be overly cautious in their decision making and this contributed to hospital admissions and lengths of stay. This perception was supported by the findings of our relational audit, for which we received 379 responses across the system, where one of the lowest scores was on the statement: "people take organisational risks where it had the potential to serve wider system goals without fear of criticism or failure".
- Bed occupancy varied across the four main acute trusts in Hampshire. During 2016/17 Hampshire Hospitals NHS Foundation Trust consistently had the lowest bed occupancy varying between 81 and 84%. The other three trusts serving Hampshire were all consistently at 90% or above bed occupancy, against the national recommended level of

less than 85% bed occupancy. Hospitals with occupancy levels higher than the recommended rate of 85% risk facing regular bed shortages and people not being admitted to wards that will specifically be relevant for treatment of their condition (for example, someone suffering from medical condition being cared for on a surgical ward) and potential increased numbers of hospital acquired infections.

- There was a perception among care home providers and hospital staff that safeguarding concerns were being raised inappropriately by ambulance staff. In response to these concerns two social workers had been allocated to work with the ambulance trust with the aim of reducing inappropriate safeguarding referrals by offering advice and supporting referrals
- South Central Ambulance Service NHS Foundation Trust confirmed that people's experience was different in Hampshire depending on the hospital location where they were taken to receive treatment. Overall, they reported having good relationships with all hospitals, trusts and staff groups although some hospitals were more effective partners. The Queen Alexandra hospital in Portsmouth was seen as having the most issues, these included difficulty for ambulance crews to handover patients to A&E staff.
- At Basingstoke Hospital within A&E there was no specific dementia friendly space identified which combined a visible and calm area for people living with dementia. Staff on the unit thought the area was not dementia friendly and caused people living with dementia and their families unnecessary anxiety while in the department. A band six nurse had been appointed who would work as a specific dementia coordinator for people who came to the department, helping by signposting to services and supporting staff.

### **Are services in Hampshire effective?**

*Assessments were holistic and contained MDT input but were not always timely. There were opportunities to improve communication, MDT working and the understanding of different roles between health and social care staff including independent providers in Hampshire. This would improve people's experience during a hospital stay, for example A&E staff spoken to at Basingstoke hospital were unaware of the frailty service located in the same hospital.*

*Several initiatives such as discharge to assess, frailty services and the SAFER bundle were being introduced in hospitals across Hampshire. These were at different stages of embedding in different hospitals and it was not always possible to measure success because of the relatively short time these had been operating.*

- Communication between independent care providers (domiciliary care agencies and care homes) and hospital staff often broke down. Independent care providers felt they were not

fully involved in discussions about the ongoing care of people. Domiciliary care and day care providers told us they were often not told that people they delivered a service to had been admitted to hospital and were informed by families rather than hospital colleagues.

- Communication within hospitals needed to be improved. Staff in the A&E department at Basingstoke Hospital talked to us about the difficulty of managing elderly frail people in the department but were not aware of frailty team based in the hospital.
- The red bag system had been introduced in parts of Hampshire; this was where transfer information, medication and basic information about a person would be transferred with the person, from their usual place of residence to hospital to ensure continuity of care. Staff and services who had used the system told us they found it valuable. However, this was not in place across Hampshire and the incidence where transfer information was not available to staff was increased where the red bag system was not used.
- Case files we reviewed showed people were holistically assessed and the assessments had MDT input. In our relational audit comments were made that demonstrated a lack of understanding between health and social care staff of what was involved in assessment processes by different disciplines, which caused frustration.
- The evidence based SAFER patient flow bundle was being used in acute and community hospitals across Hampshire to improve patient flow and avoid delayed discharge. The SAFER bundle comprises five main elements that should, to be most effective, be implemented together. We looked at patient records and spoke to staff in A&E and on a number of medical wards. In Basingstoke and Lymington hospitals we saw elements of the bundle not being fully implemented. At Lymington hospital, we were told by staff there were only monthly face to face MDT reviews for frail patients, which could delay decision making and therefore discharge. However, following review, senior leaders informed us that MDT review of frailty patients was undertaken as part of the consultant ward rounds, which took place twice a week. At Basingstoke hospital, although social workers were included in the MDT meetings, they were not starting discharge planning or setting an expected date of discharge until they received the assessment notification which built in unnecessary delays.
- In Southampton, there were older persons specialist practitioners (OPSP), these nurses were based on wards which were arranged in localities. The OPSP would go to A&E if someone was being seen from their locality, for example there were wards specifically for people who lived in Hampshire. The nurse would be able to route them to other services in that area such as hospital at home rather than being admitted. If the person was admitted on to the ward the OPSP would support them, their family and the discharge team to find

services in the person's locality and then visit them to ensure the new placement was fit for purpose.

### **Are services in Hampshire caring?**

*Frontline staff we spoke to understood the importance of involving people who needed support and their families in decisions in about their care, this was reflected in the records we reviewed which were person centred and considered the whole person not just their medical condition*

*Some staff were concerned that the wishes of people who were at the end of their lives and their families were not always met, because of a shortage of domiciliary care packages.*

- Our review of people's case files showed most care assessments were centred on the needs of the person. There was evidence that the system informed and involved carers, families and advocates when making decisions about future plans. ASCOF data for 2016/17 showed that 74.7% of carers aged 65+ in Hampshire reported being included in discussions about the person they care for; this was above the England average of 71.6%.
- A three-month pilot had started in January 2018, which involved a CHC assessor working with the discharge team at Portsmouth Hospital particularly looking at reducing delays for people at the end of life and being discharged with an advance care plan. This pilot had shown success, however problems accessing packages for people (particularly those who needed four times daily calls requiring two care workers) meant people were not always dying in their preferred place. We were informed following our review, that the trial had been extended and the CHC team were procuring dedicated fast track care at home and increasing nursing home capacity to improve the fast track sourcing times.
- ASCOF data for 2016/17 showed that carers in Hampshire reported quality of life scores and satisfaction in line with the national average. Carers had access to some support in a crisis; the Princess Royal Trust for Carers was commissioned to provide an emergency planning service for carers so support could be accessed quickly if needed. Hampshire Hospitals NHS Foundation Trust provided a carers' badge that meant carers could access parking and visit outside normal hospital visiting times.

### **Are services in Hampshire responsive?**

*Not all people in Hampshire received the right services delivered by the right people at the right time. This was dependent on the hospital they were transferred to. Ambulance crews experienced delays in handing over patients to staff in the A&E department in Portsmouth, and Portsmouth was the worst performing hospital across Hampshire with regard to people being seen within four hours.*

*At University Hospital Southampton, there was a strong commitment to people being seen by the right person at the right time and senior appointments had been made to DTOC transformation roles.*

- The NHS Constitution sets out that a minimum of 95 per cent of people attending an A&E department in England must be seen, treated and then admitted to or discharged from hospital in under four hours. This is one of the 'core standards' set out in the NHS Constitution and the NHS Mandate and is often referred to as the four-hour A&E target. NHS England data for 2014/15 to 2016/17 showed that acute trusts in Hampshire had consistently not achieved this target. In 2016/17 Hampshire Hospitals NHS Foundation Trust saw 86.6% of people within four hours, for Portsmouth Hospitals NHS Trust it was 77.8%, for University Hospital Southampton NHS Foundation Trust it was 89.6%, and for Frimley Health NHS Foundation Trust it was 91.6%.
- Ambulance staff they said that the time crews needed to spend in A&E departments before they could handover their patients to staff in the A&E department varied depending on the hospital. Queen Alexandra hospital in Portsmouth was viewed as having the most issues as it was very difficult for crews to access and handover patients. Ambulance staff told us delays in the year leading up to our review had been worse than ever before and there had been incidents as a consequence of this.
- The system's intention at a strategic level was to move forward based on prevention, strengths-based delivery, new models of integrated care, access to high quality A&E services and effective flow and discharge from hospital. This was broadly understood by frontline staff but the level of understanding and how embedded these were in practice varied considerably across hospitals.
- At University Hospital Southampton there was strong commitment to ensuring people were seen by the right person in the right place at the right time. A clinician and manager were in specific DTOC transformation roles to oversee and manage flow across the hospital. The frailty consultant had spoken to colleagues in the CCGs about the benefits of the virtual ward in relation to frailty. Communication was seen as a challenge in making this work especially because of the large geographical area; investment in ICT software and hardware was expected to help with this.
- At Basingstoke Hospital, we were told that people were often admitted to avoid a four-hour breach in A&E and staff were unable to admit a person to reablement services such as the Overton ward or The Firs unit direct from A&E, which meant people would not necessarily be admitted to the right place.

- We reviewed records across acute and community hospitals across Hampshire. The majority did not have estimated dates of discharge from hospital recorded until people had been transferred from A&E and had been admitted to wards. This sometimes led to confusion about the dates staff were working to and could cause delays.
- Safeguarding leads across Hampshire told us of good engagement between consultants and medical staff at acute trusts around mental capacity and best interests assessments for older people. However, at Basingstoke Hospital, staff told us there was limited access to social work support out of hours for people requiring mental health assessments which could cause delays in making decisions regarding further care and treatment.

## 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 Hampshire safe?

*Although people who returned home from hospital were less likely than in similar areas to be readmitted as an emergency, services did not always work together to ensure the continued safe care and treatment of people in their own homes. Medicines were not always available and understood when people left hospital, and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) documentation sometimes went missing. Work to ensure that the correct CHC processes were followed was underway.*

- Discharges from hospital were not always managed safely in Hampshire. We undertook an information flow survey with independent care home and domiciliary care providers. Some providers fed back concerns about the safety of hospital discharges with regard to medicines and DNACPR forms. They told us that DNACPR forms sometimes went missing when a person left hospital. This presented a risk as emergency staff attending a person would not know whether resuscitation was appropriate or against a person's wishes. In addition, information that went in to the hospital using the 'red bag scheme' was not always returned by ambulance staff. On some occasions medicines were not supplied when a person left hospital, or the wrong medicines were supplied. People did not always understand the changes in their medicines which meant that there was a risk these would not be managed safely.



- Some people who use services told us about experiences where discharges from hospital had been unsafe as there had not been services in place to support them when they returned. For example, one person was discharged to a home which had become uninhabitable. They had needed to be readmitted to hospital on an emergency basis while their home environment was made safe, however the person supporting them told us that there was no continued support in place and their home environment was once again deteriorating as they were unable to manage. Another person had to be supported to get into bed by neighbours on their return from hospital. In addition to the impact on the person's dignity, there was a risk that the person could have been left in an unsafe situation without the neighbour's goodwill and support.
- There were 75 responses in total from registered managers of adult social care providers in Hampshire to our information flow survey, and 30 respondents supplied free text comments. Nearly all of the 30 free text comments supplied raised concerns. The most common issues cited were a lack of information being provided when a person was discharged from hospital, and information provided being insufficient or incorrect. As a result of these issues, providers said they often undertook their own pre-discharge assessments and visits in order to ensure they had all the necessary information.
- Another common theme from the information flow tool was around medication issues; either lack of or incorrect information about medications (including changes), or wrong medication or insufficient medication being issued. Another theme was around discharges from hospital being unsafe and leading to risks in the community and/or people having to be readmitted.
- Systems were being put in place to ensure that hospital discharges were appropriate. For people requiring continuing healthcare there was a quality assurance process in place. Data showed that Hampshire consistently had a lower rate of readmissions than comparator areas and England during the period between April 2014 and March 2017. In quarter one of 2016/17, the rate in Hampshire was 17% compared to 18% and 19% across comparator areas and England respectively.

### **Are services in Hampshire effective?**

*People's needs after leaving hospital were not always holistically assessed and this meant that people often had to tell their story more than once. Health and social care staff did not always work together effectively to plan people's discharges from hospital and this meant that some people were unable to access further support when they needed it, particularly if they paid for their own care.*

*When people received reablement services these were effective in reducing the likelihood of a readmission to hospital and there were additional services in place to maintain their recovery*

*and improve their physical fitness. The trusted assessor model was not effective and was not used appropriately to support people to have their needs assessed in their usual place of residence.*

- People we spoke with did not feel that their needs and choices were assessed holistically. They felt that GPs and social workers did not work together or share information about their care needs and people had to tell their story more than once to professionals. The discharge process did not always take into account whether people's needs had changed following their hospital admission. For example, a person who was living with Alzheimer's had been managing to live independently at home and was admitted to hospital following a fall. They left hospital without additional support being put in place on their return home and were left to cope on their own. This resulted in a readmission to hospital and from there they were discharged to a residential care service which meant they were never able to return home or have an opportunity to plan for a change of residence.
- There were concerns raised by people who paid for their own care or were in receipt of direct payments as they did not know who to contact or where to get further support if their needs increased. Some people were anxious about taking up other options such as sheltered housing as they feared losing their property to cover costs and there was not sufficient support to help people navigate through this process. For example, one person told us that they had experienced difficulties in accessing interim funding for support while they were in the process of selling their property. There was a risk of further anxiety and ill-health as people in a vulnerable position attempted to manage their finances and were at risk of accruing debts.
- Staff we spoke with told us that additional referral processes had been put in place to access support such as the frailty service which delayed people's assessments. Although staff had received training, they felt pressured by other issues such as relationships between lower graded staff and consultants and the environment and place where assessments were to be conducted as staff felt unable to leave the wards. This showed that integrated working around the person's needs was not fully understood or embedded.
- Staff told us that continuing healthcare 'fast track' assessments could take up to three weeks. We were told that there had been a significant backlog in the completion of Decision Support Tools going back to 2016 however this had been addressed and was expected to be cleared by June 2018. In addition, the referral conversion rate for fast track referrals was 100% across the five CCGs which indicated that the referrals were appropriate.
- The percentage of older people who were discharged from hospital and then received

reablement had declined each year since 2012/13. In 2016/17, only 2.2% of people received reablement which though the same as comparator areas, was below the 2.7% across England. However, the reablement survey showed that not all the referrals had been appropriate and staff were working to ensure that the people who received reablement would be able to benefit from it. The proportion of older people who were still at home 91 days after discharge into reablement was in line with the England average and comparator average. In some areas, we heard that the criteria for referrals to reablement were too restrictive. For example, although people were staying in hospital longer than they needed to, one service provider we spoke with had capacity to support additional people but could not, owing to the referral criteria.

- A survey of the reablement service had been undertaken in the autumn of 2017 and the findings reflected some of what people told us. There was recognition that communication and advice was not always clear.
- The Community Response Team (CRT) was a non-chargeable service provided by the local authority which provided short term support for adults, for up to six weeks. The service supported people who had been discharged from hospital and/or required a period of enablement to help them to become as independent as they could be while living in their own homes. Where people required additional support following CRT intervention they would be supported to move onto another care agency that provided long term support to them in their own homes. This service was available across Hampshire.
- People who were recovering from an illness, or who had completed a programme of reablement could attend Steady and Strong classes. These physical activity groups were available throughout Hampshire and supported continued recovery. We received positive feedback from people who used the service. People enjoyed the service and many continued to use it for years.
- Other services were not easily accessed by people who were ready to be discharged from hospital. People who were at the end of their lives could not always get packages of care at home in a timely way and there were delays in obtaining equipment. There was a risk that people would not be able to die in their preferred setting because of these delays.

### **Are services in Hampshire caring?**

*Staff spent time with people and their families to explain services and find out their choices. The availability of some services – particularly domiciliary care – meant people could wait a long time for services and remain in a hospital setting longer than needed. The backlog of CHC assessments was being addressed at the time of our review and people needing a fast track service were having this met.*

- Data from NHS England showed that during quarter four of 2017/18, the referral rates across Hampshire for people to receive continuing healthcare care (CHC) funding was similar to the England average of 21% with the exception of South Eastern Hampshire CCG where the rate was 47%. This had been an improvement from the quarter one figures, when most of the Hampshire CCGs had lower than England rates for assessment and referral conversion.
- In 2016 there had been a backlog of fully completed CHC initial assessments that had reached 236; this was due to a lack of staff to complete these assessments. This meant that people were waiting very long periods of time for their assessments to be completed including those considered to need a fast track service. This had meant some people at the end of their lives were waiting funding and care packages to be approved for a number of months. We were made aware of examples where assessments had not been completed before a person had died.
- Staff told us that, previously, continuing healthcare ‘fast track’ assessments could take up to three weeks. The delays had been recognised as unacceptable by the system and resources made available to address this backlog. The performance for fast track CHC applications had subsequently improved and assessments were being completed within 48 hours consistently across Hampshire. In addition, the referral conversion rate for fast track referrals was 100% across the five CCGs, which showed that the referrals were appropriate. However, staff told us that although the approval for a package was timely, there were often delays in physically getting the equipment and staff to the person.
- Across the system there was a commitment to offer and involve people in choices about how and where they wanted to receive care and services. We saw staff spending time with people and their families to explain different types of services available and find out what they preferred. However, if a person had made a choice that they would like to receive care at home this was not always possible because of the shortage of domiciliary packages, particularly for people requiring complex packages of care.

### **Are services in Hampshire responsive?**

*People who were waiting to return home from hospital in Hampshire were at risk of experiencing significant delays in returning to their usual place of residence. Many people had to wait a long time, sometimes for three or four weeks for packages of care in their own homes. Some intermediate care services were underutilised while domiciliary care provision was stretched owing to workforce challenges.*

*There was added pressure to in-house services as the two independent providers*

*commissioned to provide reablement could not manage the demand. This meant that there was a risk of people becoming more unwell while in hospital and being unable to return home, or requiring residential or nursing home care.*

- People who were fit to return from hospital to their usual or a new place of residence were more likely to experience a delay in their return than people living in similar areas. This exposed people to further health risks such as a deterioration in their mobility and suffering from a hospital acquired infection. Delayed transfers of care had been significantly high in Hampshire since July 2017. They had been consistently higher than the national average going back even further. In January 2018, the average daily delayed rate per adult population was 22.7 in Hampshire compared to 12.6 in comparator areas and 11.4 across England.
- The largest reason for delays was given as awaiting care package in people's own home though there were also a large number of delays that were due to awaiting a nursing or residential home placement. Although awaiting completion of assessment wasn't one of the main reasons for delays in Hampshire, it was double the England rate. Independent providers we spoke with felt that hospital staff were not always aware or understanding of the services that they could provide and they felt that this contributed to delays. One provider told us that they visited their local hospital to meet with staff and to help them understand how they could support people, but a high turnover of hospital staff meant that this information was lost and needed to be repeated. There was not an integrated system in place to support health and independent social care professionals to understand how they could best support each other.
- Although most of the delayed days were as a result of activity at the main acute trusts, there were a number of delays that came from the community trust, Southern Health NHS Foundation Trust.
- Across the five CCGs in Hampshire there was variability in how much some CCGs were adopting discharge to assess in regards to Decision Support Tools for CHC. In quarter one of 2017/18, all had been completing at least 75% of these tools in an acute setting. As at quarter four of 2017/18, most had decreased with Fareham and Gosport, North Hampshire and South Eastern Hampshire CCGs all less than 50%. West Hampshire CCG however was still completing 95% of Decision Support Tools for CHC in an acute setting.
- The five CCGs had worked hard to reduce a big backlog in delays. However, in quarter four of 2017/18 the majority of referrals were still taking more than 28 days to complete in all CCGs.

- The proportion of discharges that occurred at the weekend was 21% in Hampshire which was in line with, or better than, all of its comparators.
- When people were discharged from hospital, they did not always receive care in the right place and at the right time. People who used services and their carers, as well as independent providers, told us that there seemed to be a reliance on residential care services to support people on leaving hospital. Our data showed that there had been an increase in residential care bed numbers which was higher than the England average and there had been a decrease in the number of domiciliary care agencies which was higher than the England average and comparator areas.
- There were intermediate care beds to support people in the transition from hospital to their usual place of residence; however the service was not joined up across Hampshire. System leaders recognised this shortfall and there were plans in place for an integrated intermediate care service. However, this was in its early stages with mapping of needs underway before an operational model could be agreed.
- There were seven care homes that provided discharge to assess where people could receive care on discharge from hospital. We saw that although occupancy was higher in the winter months these services appeared to be under-utilised and only one service achieving its target of 85% occupancy.
- Reablement in the community was provided by the Community Response Team (CRT) which was an in-house service provided by the local authority and by REACT which was provided by two independent providers across Hampshire. However, the REACT service was struggling to meet demand owing to workforce problems which then impacted on the availability of support from the CRT. Hospital staff told us that sometimes people had to wait for social work assessments and then delays were compounded by a three to four week wait for care packages. There were also delays owing to provision of equipment not being managed in a timely way. The rate of delayed transfers of care due to the reason 'awaiting community equipment/adaptations' in Hampshire was 1.4 days per 100,000 aged 18+, over four times the England rate of 0.3 days.

## Maturity of the system

### What is the maturity of the system to secure improvement for the people of Hampshire

- Although there was an emerging joint strategic vision for health and social care in Hampshire, we did not hear this consistently articulated at operational and implementation levels across all sections of the system.
- We found that work was taking place to develop relationships, but we did not find that they had reached the necessary level of maturity and sustainability to be truly effective in delivering for local people or organisations. This was evidenced by the variation in performance across Hampshire, underpinned by the absence of a shared risk approach; and – despite initiatives by individual partner organisations – the absence of a whole system financial strategy and joint budgets.
- Governance processes, joint decision making, risk sharing and performance management at a joint strategic level appeared under developed.
- Market shaping continued to be led by the local authority with good examples of engagement with partners on the development of a new commissioning framework for homecare.
- Public Health appeared well connected across the partnership and had a valuable contribution at strategic and operational levels.
- We found numerous examples across Hampshire of projects, pilots and initiatives that were working well to support people to remain independent at home, however there did not appear to be consistent and routine systemic approaches to evaluation and potential scalability of these projects.
- Engagement with the voluntary sector, the independent care sector and housing as strategic partners appeared underdeveloped, particularly in relation to workforce planning.
- Workforce challenges across the Hampshire footprint were clearly articulated throughout the review and workforce strategy and leadership sat at STP level via the LWAB. Representation of care providers at board level was absent.
- Information sharing and systems interoperability were frequently cited as barriers to progress.

## Areas for improvement

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

- The HWB must determine and agree its work programme, how to make the system more coordinated and streamlined and form stronger more coordinated links with the STPs.
- System leaders must develop a comprehensive health and social care workforce strategy for Hampshire in conjunction with the independent sector. This should work in synergy with financial, housing and transport strategies.
- The system must undertake further work to transform the trust and commitment in partnership arrangements and deliver tangible products that will improve services should be undertaken and developed at pace.
- The system must work with partners to develop a consistent approach to the evaluation of health and social care initiatives and their feasibility at a strategic and local level and communicate this information system wide.
- The health and social care system must work with the independent sector, nursing home, care home and domiciliary care to improve relationships and develop the market to provide services that meet demand across Hampshire.
- The system must ensure safe discharge pathways are in place and followed for people leaving hospital.
- The system leaders must revisit all service provision to ensure the delivery of more equitable services across Hampshire.
- The system must ensure that the enhanced GP offer is implemented to all care and nursing homes across Hampshire.
- The system must streamline discharge processes across Hampshire; this needs to include timely CHC assessment and equipment provision to prevent delayed discharges from hospitals.



- A comprehensive communication strategy must be developed to ensure health and social care staff understand each other's roles and responsibilities and all agencies are aware of the range of services available across Hampshire.
- All elements of the high impact change model must be introduced and the impact evaluated system-wide.