Paper C

Title: CQC Review on Integration

Sheffield Accountable Care Partnership ACP Board

Date: 19 June 2018

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1. Purpose

To provide an update to the ACP Board from the recent CQC Review.

2. Introduction / Background

The final CQC report is now in the public domain. The key themes include improving flow for Older People; workforce; the importance of the voice of older people; building on pilots and scaling up; strengthening links between those developing strategy and those delivering services; working better with VCS partners and working as a system as opposed to individual organisations.

After publication, the CQC came to Sheffield to present their findings. They were clear in their feedback that they recognise there are some problems but also some strong foundations. This was clear from the constructive tone of the verbal feedback provided by the team at the end of the inspection week and at the summit and we feel this is a good sign for future improvement in Sheffield. In our response when they launched the report to the Sheffield system we recognised the key themes as valid.

Stakeholders in Sheffield set out that they welcomed the outcome of the review and the positive nature of the discussion at the summit. They felt that this was an opportunity to improve services at operational level whilst developing better strategic and operational links. All stakeholders have committed to working to produce a plan to improve the care outcomes and experience for those older people and this will be ready in draft form in approximately one month. The plan will directly pick up the themes identified in the CQC review. This is being led by the Director of Adult Social Services with support from all stakeholders. Once completed, this will be publicly available.

3. Is your report for Approval / Consideration / Noting

Noting

4. Recommendations / Action Required by Accountable Care Partnership

N/A

5. Other Headings

N/A

Are there any Resource Implications (including Financial, Staffing etc)?

N/A

Paper prepared by: Greg Fell

On behalf of: John Mothersole

Date: 14 June 2018

Sheffield

Local system review report
Health and Wellbeing Board

Date of review:
5 – 9 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: Karmon Hawley

The team included:

- One CQC Reviewers,
- Three CQC Inspectors,
- One Chief inspector

- One Deputy Chief inspector
- One CQC Expert by Experience; and
- Three Specialist Advisors, two with local authority backgrounds and one with a health governance 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 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 Sheffield City Council (the local authority), Sheffield Clinical Commissioning Group (the CCG), Sheffield Teaching Hospitals NHS Foundation Trust (STHFT), , Sheffield Health and Social Care NHS Foundation Trust, Primary Care Sheffield, Yorkshire Ambulance Service NHS Trust, Sheffield Health and Wellbeing Board and Healthwatch Sheffield.
- Health and social care professionals including care home and domiciliary agency staff, social workers, GPs, urgent care staff, reablement teams and health and social care provider representatives.
- Voluntary, community and social enterprise (VCSE) sector representatives.
- People using services, their families and carers during our visits to day centres and support groups and in focus groups.

We reviewed 18 care and treatment records and visited services in the local area including STHFT sites, intermediate care facilities, care homes, a domiciliary care agency, GP practices, out-of-hours services and the urgent care centre.

The Sheffield context

Demographics

- 16% of the population is aged 65 and over.
- 84% of the population identifies as White.
- Sheffield is in the 20-40% bracket of most deprived local authorities in England.

Adult social care

- 72 active residential care homes:
  - 60 rated good
  - Eight rated requires improvement
  - One rated inadequate
  - Three currently unrated
- 47 active nursing care homes:
  - One rated outstanding
  - 25 rated good
  - 16 rated requires improvement
  - One rated inadequate
  - Four currently unrated
- 93 active domiciliary care agencies:
  - 42 rated good
  - 17 rated requires improvement
  - One rated inadequate
  - 33 currently unrated

Acute and community healthcare

Hospital admissions (elective and non-elective) of people living in Sheffield are mainly to:

- Sheffield Teaching Hospitals NHS Foundation Trust
  - Received 96% of admissions of people living in Sheffield
  - Admissions from Sheffield make up 71% of the trust's total admission activity
  - Rated good overall

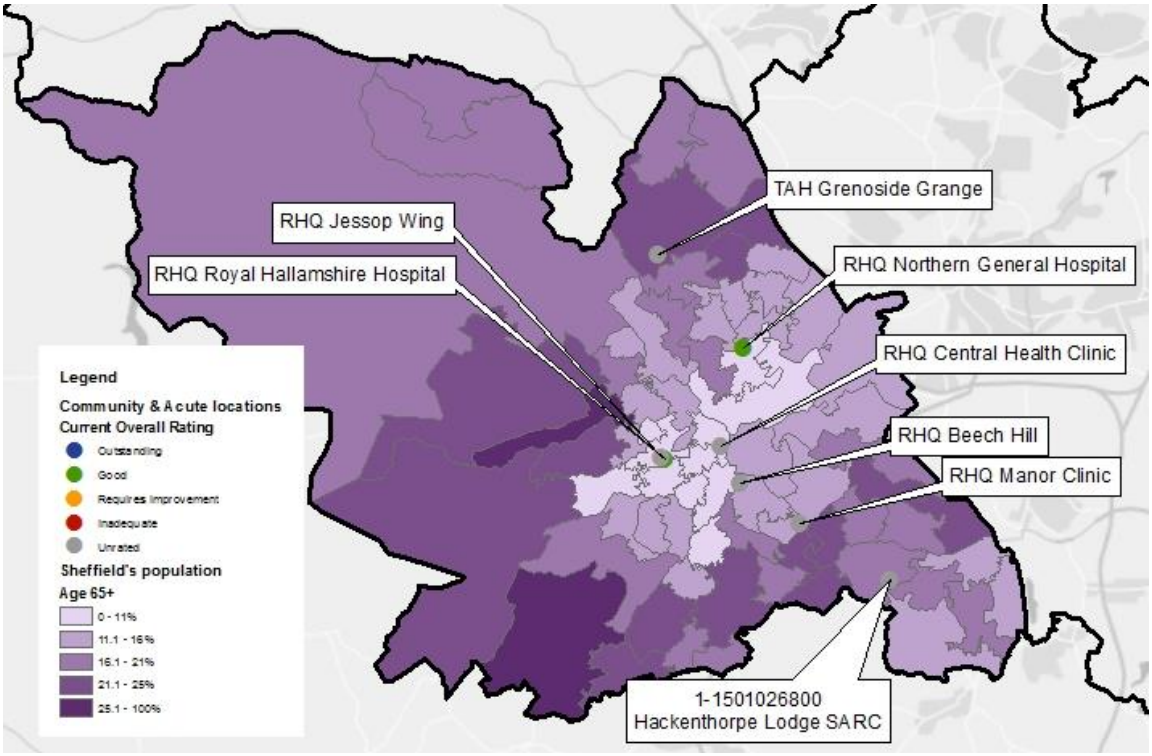
Community services are provided by:

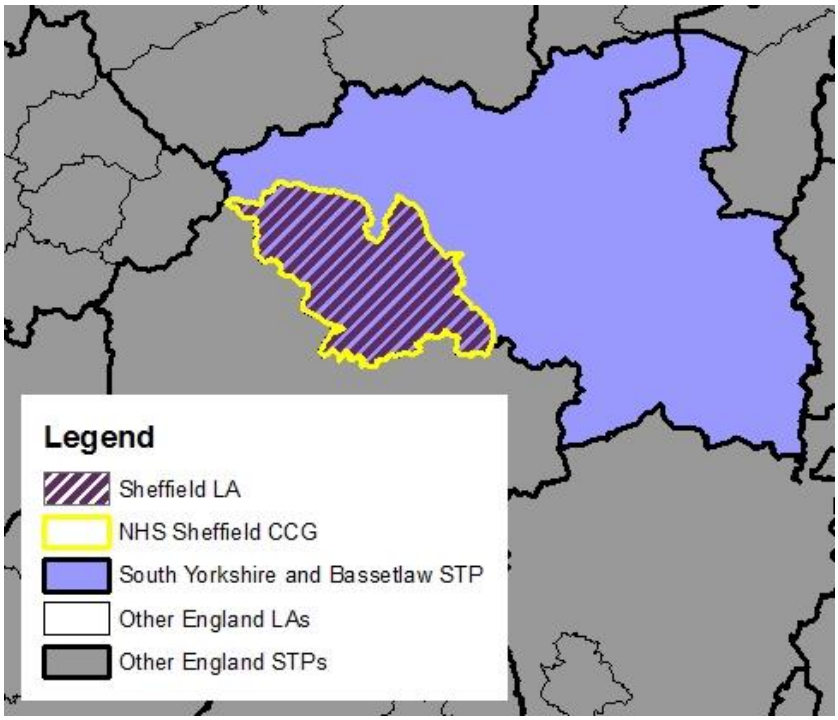
- Sheffield Health & Social Care NHS Foundation Trust
  - Rated good overall

GP practices

- 88 active locations
  - 78 rated good
  - One rated requires improvement
  - Two rated inadequate
  - Seven currently unrated

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





Map 1 (above): Population of Sheffield shaded by proportion aged 65+. Also, location and current ratings of acute and community NHS healthcare organisations serving Sheffield.

Map 2 (left): Location of Sheffield LA within South Yorkshire and Bassetlaw STP. NHS Sheffield CCG is also highlighted.

Summary of findings

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

- The Health and Wellbeing Board (HWB) had previously been ineffective in driving system delivery and transformation. System leaders had acknowledged this and responded with a refresh of the purpose and focus of the board. The 'Shaping Sheffield' plan and the accountable care partnership (ACP) were reflective of the wider aspirations and work programmes of the system; however a lack of alignment of these strategies prevented a clear overarching system vision. It was anticipated that the restructure of the HWB would align strategies and drive the vision for integrated services and drive the transformation programme through the ACP. This would present a good opportunity to give assurances that system leaders were focusing on the right areas and involving the right people in developing and progressing service transformation.

- System leaders had developed a Joint Strategic Needs Assessment (JSNA) according to the needs of the population but this was due to expire in June 2018. The JSNA and the Health and Wellbeing Strategy was being refreshed and developed. This was in order to underpin the needs of the local population and to bring about the necessary changes to deliver on the work programmes and outcomes in line with the ACP.

- This work had resulted in a vision among system leaders for the transformation and delivery of services in Sheffield. However, this had not yet been clearly articulated as a strategy that was understood across all partners in the system. At an operational level, staff understood that there was a desire to move towards a preventative approach but were not clear on the plans for achieving this. This lack of clarity had an impact upon the pace of the system journey and the interagency working between health and social care.

- Sheffield is part of a sustainability and transformation partnership (STP) called the South Yorkshire and Bassetlaw Integrated Care System (ICS) which covered South Yorkshire and Bassetlaw. This had little influence on the Sheffield system as Sheffield had developed its own vision and strategies based on the assessed needs of the local population. However the partnerships and strategies in place in Sheffield were reflective of the wider aspirations and work programmes of the ICS.

- There were opportunities for increasing the scale of positive innovations being tested, such as the virtual ward. However; the desire to scale up innovations was compromised by weakness in the system's approach to evaluation and clearly evidencing the impact of pilot

and test projects. As a result, commissioning decisions were not being supported by robust evaluation.

- We found strengthening relationships and a strong commitment to achieve the best outcomes for the people in Sheffield. We heard that Sheffield was “at its best when facing a crisis” and the system worked well together to address related challenges. However in making positive tactical responses to system pressures and crises, this had sometimes diverted attention from looking at the bigger picture and in particular, delivering the transformation required to meet the needs of people using services in a holistic way.

- System leaders acknowledged that relationships had improved over the twelve months prior to our review and they were working collectively. Engagement from NHS England and support from external consultants had helped the system move away from a perceived blame culture through constructive conversations and agreeing “a single version of the truth” regarding data . System leaders felt that = cultural change was “filtering through”, however some comments received in response to our relational audit suggest there is still a perception of a blame culture; so further work is needed to fully embed and sustain positive perceptions about the emerging culture for all staff.

- Workforce challenges and the maintenance of a skilled and sustainable workforce was recognised as an ongoing challenge for Sheffield. Partners had developed organisational-based workforce strategies and system leaders were working to develop the workforce through a range of initiatives. However workforce leads were not collaborating to develop an overarching system workforce strategy or approach.

Is there a clear framework for interagency collaboration?

- The Joint Health and Wellbeing Strategy and the ACP provided a framework for interagency collaboration with an agreed memorandum of understanding setting out the relationship between the ACP Board and the Better Care Fund (BCF). System leaders felt this was providing a stronger framework for delivering the Shaping Sheffield Plan and BCF aims. A programme director had recently been appointed to oversee the delivery of the ACP work streams.

- Each work stream being delivered under the ACP had senior level sponsorship and brought together systems partners to share risk and delivery. The Active Support and Recovery work stream within the Accountable Care Partnership had a primary focus on older people.

How are interagency processes delivered?

- The delivery of interagency processes was based around localities referred to as

"neighbourhoods" serving areas of between 30,000 and 50,000 people. In parts of the city there are differences in the geographical boundaries used by health and social care organisations which resulted in some challenges to the delivery of interagency working in these neighbourhoods.

- A lack of integrated working and co-location impacted on service delivery and the ability of staff to be aware of changes across the system.

- There was a lack of joint plans to deliver services but some examples of shared agreements and approaches, such as the Active Recovery integration project under the ACP and the joint NHS and local authority community intermediate care services (CICS) were having positive outcomes on people's experiences.

- The VCSE sector did not feel integrated with statutory service delivery. There were a number of forums for the VCSE sector organisations to meet, form relationships and improve joint working. VCSE sector organisations felt that links between them and system partners were underdeveloped this lack of inclusion meant they were unable to influence the strategic direction of the local system based on their understanding of the needs of people who use services.

- Although there had been improvements in information sharing and joint working, most social care providers felt that they were not meaningfully involved or included in market shaping or service development.

- Health and social care integration was being driven with a top down approach and system leaders recognised that this had not filtered down to all staff. System leaders needed to continue building cross-system relationships, and develop and embed shared governance arrangements and jointly agreed performance criteria to provide staff with clarity regarding expectations.

What are the experiences of frontline staff?

- Some staff reported disconnection between health and social care services and told us that the leadership strategy was very different to the frontline reality. These kinds of sentiments were echoed in responses to our relational audit with some respondents describing feeling that social care and VCSE sectors were undervalued within the system, which has led to the health sector monopolising joint working decision-making. Frontline staff were dedicated to providing high-quality, person-centred care. However they reported heavy workloads and recruitment challenges that did not support seamless care delivery.

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

- System leaders and senior managerial staff were visible and accessible. However some operational and frontline staff felt more effective conversations and engagement opportunities were needed for them to feel part of the vision and able to influence and shape service design and delivery.

What are the experiences of people receiving services?

- Most people were treated with kindness and the majority of frontline staff provided person centred care, going the extra mile for people they cared for. Most people were positive about individual staff and their kindness and compassion.

- Some people who use services, their families and carers told us that they did not always feel well cared for and involved in making decisions about their care, support and treatment when moving through the health and social care system. Some people we spoke with reported a lack of trust in the system with a lack of transparency, openness and engagement. Specific concerns were raised in relation to the bullying and oppressive nature of some staff towards people using services and carers when they were in vulnerable circumstances.

- Some older people were not always seen in the right place, at the right time, by the right person. People using services, their families and carers reported multiple points of access and a fragmented approach to service provision. This resulted in people having to tell their story multiple times and on occasion with a lack of privacy and dignity. The system could do more to ensure that activities and services were easier to navigate and easier for people to find out about; this would improve access and use.

- Multiple concerns were raised in respect of the continuing healthcare (CHC) process and the timeliness and accuracy of social work assessments. This resulted in a lack of support to carers, inappropriate placements, placement breakdowns, hospital admissions and risks to people using services.

- People were not always communicated with effectively when there were delays in their care and treatment and they didn't always experience a seamless and safe discharge to their usual place of residence. Decisions were sometimes made without consulting people, their spouse and/or family members. Also because of the quality of discharge information, GPs were not always notified of the need for follow up appointments which impacted on people's follow up care.

- People faced delays when waiting for a long term care package on discharge from hospital, especially if they required complex support.

- The proportion of older people receiving reablement or rehabilitation upon discharge from hospital in Sheffield was significantly higher than the England average in both 2015/16 and 2016/17. However, the effectiveness of these services, as measured by the proportion of people still in their own homes 91 days later, had decreased in recent years and in 2016/17 was below both the comparator and England averages.

- Carers felt that they did not always receive the help and support they needed. Adult Social Care Outcomes Framework (ASCOF) data for 2016/17 showed the percentage of carers (of all ages and those aged 65 and over) in Sheffield who were satisfied with their experience of care and support was below the England average.

Are services in Sheffield well led?

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

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

The Health and Wellbeing Board (HWB) had previously not been fully effective in its function and had not supported a clear shared strategic vision for the future of health and social care services in Sheffield. It was anticipated that the restructure of the HWB would align strategies and drive the vision for integrated services and the transformation programme through the ACP. The 'Shaping Sheffield' plan and the ACP were reflective of the wider aspirations and work programmes of the ICS however the ICS did not directly influence the system transformation programme.

Relationships across the system had not previously been productive however there was recognition that these had developed in recent years resulting in greater maturity between system leaders to enable change. While there was a shared commitment among system leaders to tackle challenges jointly this was not always translated into action at an operational level. There were missed opportunities to improve the system through lessons learned.

There was a need for stronger engagement and coproduction with people who use services, their families and carers in the development of strategic priorities.

Strategy, vision and partnership working

- The Sheffield Health and Wellbeing Board did not at the time of our review appear to be effective, as key decisions were not being made to support the strategic approach. It was not driving transformation nor did it undertake robust scrutiny. This was recognised by the new HWB chair who was working to get the right stakeholders to the board. However the recent change in leadership and the refresh of the HWB was enabling system partners to work with a stronger focus on wellbeing and prevention, and shift investment to medium and long term care, working alongside the ACP.

- System leaders had developed a JSNA which although due to expire in June 2018 was in the process of being refreshed. The Health and Wellbeing Strategy had also recently been refreshed to reflect the needs of the local population. Alongside this was the ACP and the Shaping Sheffield plans, which while similar, need to be aligned to represent the vision that system leaders want to achieve in their transformation and delivery programmes.

- 'Shaping Sheffield' was the city's commitment to a single plan for improving health and wellbeing in the city. Although this plan linked into the Health and Wellbeing Strategy, the Better Care Fund (BCF) and Sheffield Accountable Care Partnership (ACP), the system was at the beginning of its journey and this vision and strategy needed to be fully aligned and embedded to become a reality. This presented a further opportunity to drive change using co-production with health and social care professionals and with people using services, their families and carers.

- Because the Health and Wellbeing Strategy, Shaping Sheffield and the ACP were not fully aligned the joint overarching strategic vision was not clear. It was not well understood by all frontline and operational staff which impacted on the culture of the wider system and interagency working between health and social care.

- There was an increased ambition to work together as a system, face system challenges and formalise ambitions through a joint strategic approach. Leaders within Sheffield were developing an ACP to provide a whole system strategic planning and commissioning approach across system partners. This offered a shared approach for the design and delivery of services however; this was not yet fully aligned or embedded or translated into actions which would provide clarity for staff in all organisations and people who used services about how the transformation of integrated services would be delivered.

- Sheffield was part of an STP called the South Yorkshire and Bassetlaw Integrated Care System (ICS), covering South Yorkshire and Bassetlaw. The ICS appeared to have had little influence on the Sheffield system as Sheffield had developed its own vision and strategies based on the assessed needs of the local population. However the partnerships and strategies in place in Sheffield did reflect the wider aspirations and work programmes of the ICS.

- The need to develop individual organisations had led to delayed transformation and delivery of integrated services. This led to a fragmented system where there was duplication of effort and, at times, a reactive tactical response to entrenched performance issues such as delayed transfers of care (DTOC).

- Historical relationships between system leaders were described as “tense” by system leaders, however there was consensus that these had improved through the development of the Shaping Sheffield strategy and a wider commitment to system-level working. Despite improvements it was evident that not all system partners were working together as effectively as they could, and this was recognised by system leaders.

- We received 230 responses to our online relational feedback tool. Although the 98 free text comments supplied as part of this feedback were mixed, various respondents described an increase in partnership working, and a will to work collaboratively to improve care for older people in a person-centred way. However, a few respondents noted that some cultural issues remained including the perception of a blame culture and social care and voluntary sectors feeling less valued than the health sector. Organisational development was required to address these barriers and create the required culture to enable better collaboration and service integration.

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

- The engagement and inclusion of people using services, their families and carers was not consistent across the system. Although there were mechanisms in place, the strategic approach to co-producing services was underdeveloped and people felt they had limited influence on the design and delivery of services.

- People who use services, their families and carers felt that there was a lack of dialogue and consultation between themselves, providers and commissioners when making decisions about service delivery. People did not feel listened to despite public consultation which caused them concern and anxiety. For example, people felt a decision had been made to close an Urgent Care Centre before a formal consultation had been undertaken.

- System leaders recognised there was more to do in respect of listening and using people's views and aspirations in the development of services and were keen to improve people's inclusion and engagement. Leaders also acknowledged there was an opportunity to work more closely with the VCSE sector to explore positive involvement and use the learning to develop a more inclusive approach.

- There were some examples where co-production had worked well, such as the Sheffield Young Carer, Parent and Adult Carer Strategy, the Dementia Care Pathway Review and the first point of contact with social services. All were developed in consultation with people who used services to determine what would meet people's needs.

- Feedback from people who use services had been used to assess the impact and developmental needs of the 5Q process (this is a person-centred process asking five questions to assess what is better for the individual), which was currently under evaluation. An example of where public involvement and feedback had resulted in change was the 15 Step Challenge undertaken in response to Friends and Family Test for community services. This improved the quality and quantity of feedback received from local people and a short video for staff was produced to encourage staff to respond to people's wishes and feelings.

- Although there were good levels multidisciplinary working within organisational boundaries these did not always translate across the system. System leaders and operational staff recognised the need to improve interagency and multidisciplinary working at pace.

- The external review commissioned by the Better Care Fund to explore the challenges in DTOC had encouraged system developments to improve relationships and promote the culture of interagency and multidisciplinary working. However the system still faced key challenges to resolve those issues. There were multiple first points of contact which were not fully understood by some professionals and resulted in some staff being detached from the overall system vision and how this influenced their work, making it difficult for everyone to work together in a unified way. The restructuring of social care, the reduction in resourcing of operational groups and a disconnect in discharge planning between frontline acute and social care staff had led to disjointed relationships between some health and social care partners. However, system leaders told us that social care staff were consistently involved in all discharge meetings which included the task group meeting (daily), flow meeting (weekly), and director level escalation meeting (twice weekly).

- New initiatives were being developed, sometimes without a shared approach, which resulted in silo working and potential duplication of effort. Staff at all levels acknowledged

that there was a lack of joined up working between health and social care and there had been issues in the past which had negatively affected relationships.

- We found that the lack of coterminosity between organisations and systems was a barrier to integration, particularly between social care and primary medical care services, where there was a lack of multidisciplinary team discussions and the existing referral systems. The alignment of the workforce across different sectors and around smaller locality-based population bases was also recognised as a system wide challenge. The advent of the ACP presented leaders with an opportunity to address these challenges in a coordinated and collaborative way.

- The local authority and the CCG were not working as effectively with social care providers as they could. Social care providers did not feel they were considered as system partners or involved in service design and delivery in a meaningful way.

- Although jointly commissioned services were limited, there were some examples of good individual services in health and social care working together. For example, the Short Term Intervention Service Team (STIT) and the Community Intermediate Care Service (CICS) were developing joint rostering and management approaches to improve shared use of resources.

- Yorkshire Ambulance Service NHS Trust works flexibly with primary and secondary care partners, using paramedic capacity to avoid transfers to hospital and facilitate A&E handovers at periods of peak demand.

- In a crisis, there was a collaborative response to support system resilience and risk mitigation. However, this was indicative of a reactive culture and further development was needed to plan effectively for the longer-term.

- There were good foundations for further development on a system-wide basis as some relationships and joint working were strong across and between the different organisations.

Learning and improvement across the system

- Learning worked well at operational level, as learning outcomes from pilots and projects were shared; however there was limited shared learning outside of organisational boundaries. There were some good pilot initiatives but there was a lack of appropriate strategic oversight, monitoring or in depth evaluation of these, which meant opportunities to influence commissioning and strategic development were missed. A more coordinated approach to developing pilot schemes and innovations is required to ensure they will

support strategic planning and commissioning. The First Contact service had been developed and implemented with clear aims and measurable indicators for delivering improvements, so this may be a good practice example for considering how other innovations and pilots could be evaluated and rolled out.

- Each organisation had sight of their own incident management but there was no single, co-ordinated approach to ensure lessons were shared widely across the health and social care interface. Despite the external review and improvements made to DTOC, the system had not been able to sustain this. The system was frequently in escalation which had resulted in sub-optimal performance being accepted as a consequence of a pressured system. There needed to be more evaluation of the contributing factors to the escalation and de-escalation processes so lessons could be learned, continuous improvements made and shared across the system.

- There were mixed views regarding how well the system was learning and improving. Concerns were expressed by some frontline staff that they didn't feel they had a voice and when they expressed concerns these were not always acted upon.

- There were examples of ambition to learn from best practice and develop systems and processes within individual organisations. For example, staff in A&E had recently been researching successful care plan methods which reduced people having to tell their story more than once.

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.

The Health and Wellbeing Board was responsible for overseeing the delivery of the transformation programme through the ACP which was responsible for the delivery of individual work streams identified by the HWB. Due to structural changes and new developments, more work was needed to strengthen and drive the collaborative delivery of health and social care services in Sheffield through the ACP board.

The newly formed ACP was the key governance arrangement in overseeing the delivery of the transformation work streams, driving collaborative working across the system. The HWB and the ACP shared the same joint chairs which provided consistency; however this arrangement meant that scrutiny of decision making may not always have been objective.

The lack of integration and continued silo working made it difficult for the system to analyse and assess the impact of services at a system level.

Overarching governance arrangements

- The HWB was designated to provide the strategic oversight for the delivery of health and social care services in the city. At the time of our review the Health and Wellbeing Strategy had been refreshed but structural changes and governance arrangements were being made to the HWB. Previous arrangements had not fully supported partners to collaboratively drive and support quality care across the health and social care interface.

- There was recognition by system leaders that the HWB required reconfiguration and a stronger sense of purpose. The HWB had recently been restructured with an aim to fulfilling its statutory functions and holding leaders to account as to how the system was working in the interests of the people of Sheffield.

- The ACP had recently been established to deliver the strategic vision and outcomes for the city, defined by the HWB through seven work streams. The ACP was in its infancy but was the key governance arrangement across the system to support collaborative working and to promote integration.

- The HWB was responsible for overseeing the ACP, however the HWB and the ACP were co-chaired by the same people – this was not a clean governance arrangement and it did not necessarily allow for true scrutiny of process and accountability. At the time of our review the governance arrangements between the HWB and ACP were still to be clarified and scrutiny arrangements finalised to ensure accountability and responsibilities were defined appropriately.

- A lack of scrutiny of decision making was also evident in the governance of the Healthier Communities and Adult Social Care Scrutiny Committee. The Committee was not sighted on discussions at the Health and Wellbeing Board and was therefore unable to provide any scrutiny to decision making.

- A Programme Director had been recruited to oversee the delivery of the seven transformation work streams of the ACP, each supported and sponsored by a Chief Executive and Chair. Progress of the work streams is to be reported into the HWB.

- The Sheffield Better Care Fund (BCF) was one of the largest in the UK with a combined budget of £364m. The BCF was steered by an Executive Management Group that included

leads from the CCG and the local authority focused on developing a joint commissioning approach to support the ACP.

- As part of Sheffield's BCF plan, there was focus on the delivery of initiatives jointly agreed between providers and commissioners. This promoted and had developed joint decision making and risk sharing arrangements to establish effective shared responsibility and governance of the pooled budget. All risks within the BCF were considered to be shared risks and while leaders were able to articulate how the system had responded to specific issues or pressure points, this approach was sometimes reactive and Sheffield was frequently responding to escalated risk.

- The lack of integration and continued silo working made it difficult for the system to analyse and assess the impact of services at a system level. For example, The End of Life Strategy was not integrated into the system governance arrangements. In addition there were no formal mechanisms for end of life professionals to report to the wider system the impact of this important service and consequently include end of life care in system wide planning.

Information governance arrangements across the system

- Use of, and access to IT systems was fragmented and varied both between and within organisations. There was a need for a clear centralised information plan the arrangements in place did not allow the seamless transfer of people's information. The information systems were not integrated, and were not allowing for the complete sharing of information; system partners were not able to access and see records across sectors. For example, health staff from the Active Recovery service and Integrated Care Therapy (ICT) could not access social care records which impacted upon assessment and meeting people's needs.

- There was a lack of digital interoperability. Frontline staff told us the IT systems were not fully effective in supporting communication and information sharing which impacted on the discharge process. For example, use of PharmOutcomes (an online system) to transfer discharge information was very low. Since the platform was launched last year there had been 18 referrals to community pharmacies, three from STHFT and 15 from community services. Frontline staff told us that this system was duplicating work and was time consuming to use. This could be improved if the referral system was integrated with the hospital system so that sending the information to community pharmacies became routine practice.

- Sheffield Hospice and other VCSE organisations developed their own Sheffield Palliative Care Communication System, it was hoped that this would develop into something that would support coordination with other services, but again, there were issues with different

systems collaborating. Sheffield Hospice was developing a system for regularly assessing people and feeding information through to the Single Point of Assessment system to enable greater oversight of a person's health in their usual place of residence

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 was working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource.

Sheffield was particularly challenged by workforce issues in the acute and community sectors and a number of concerns were raised during our review. There was not a strategic plan at system level to align the workforce to future demand. Collaborative work had not taken place to tackle recruitment issues or to develop a single recruitment pathway. The workforce challenges resulted in heavy workloads for staff and impacted upon the delivery of care and integration of services.

There were some examples of innovative approaches to responding to workforce capacity and skill set, with workforce leads exploring new roles and models of care.

System level workforce planning

- Although there was recognition of pressures in each sector, there was no overarching workforce strategy that covered all of the systems in Sheffield. There was limited strategic oversight, an underdeveloped approach to joint workforce and limited future planning across the system. Frontline and operational staff were concerned that services were trying to recruit from the same pool of staff and this impacted on recruitment and retention of staff.

- There were staff shortages across the system and staff told us workloads were heavy which impacted upon the delivery of care and integration of services. Workforce challenges and the maintenance of a skilled and sustainable workforce were high on the agenda for Sheffield and there was recognition of the need to develop more proactive approach to recruitment and retention of staff. The system had invested more in secondary care because of the pressures of reactive work; however there were plans to invest in the community workforce to build preventative capacity.

- Electronic Staff Record data from July 2016 to June 2017 showed that the staff turnover rate at STHFT was lower than the national average across all staff groups. However the workforce in adult social care was less stable as estimates from Skills for Care showed that staff turnover rates had been rising year-on-year and in 2016/17 were above the England

and comparator average. Nevertheless, while estimates for adult social care staff vacancy rates in Sheffield have fluctuated in recent years but they have remained below the England average.

- Although there was no joint workforce strategy there were a number of separate workforce development plans including a primary care workforce strategy to address the potential shortages of GPs. STHFT were hosting training placements for physician associates to integrate into GP services.

- The local authority was producing a Workforce Development Strategy, operational from April 2018 and South Yorkshire Region Excellent Centre (SYREC) was supporting an educational initiative to reach the people working in care homes and within domiciliary care services in Sheffield. The ACP also had a specific workforce development stream and this should provide opportunities to better consider workforce planning and new employment models.

Developing a skilled and sustainable workforce

- Although there was a lack of strategic workforce plans that brought all the individual organisational work streams together, system leaders had been looking at capabilities and the competencies of the workforce within their own sectors For example, in primary care, GP practices were employing nurse practitioners and paramedics to undertake home visits.

- Workforce leads in the CCG had also been looking at moving on from traditional roles between the acute and community settings. STHFT had responded to system challenges in the A&E department to match flow, staffing numbers and skill mix, restructuring staffing to make sure they had the optimum staff working at the right times.

- The virtual ward brought together a multidisciplinary skilled team that were working together effectively to meet the needs of neighbourhood population groups. The virtual ward was having a positive impact on maintaining people's wellbeing in their usual place of residence and preventing unnecessary admissions to secondary care. While staff in health services and the VCSE sector were working well and collaborating effectively, social care representation was absent from the team.

- There was a positive emphasis on training for staff across all sectors and there was evidence of joint training events taking place. However, workforce leads told us that the Developing People Improving Care framework did not involve social care and there was a gap in primary care. The Hospice had provided CCG funded sessions to educate the public, primary care professionals and other health and social care professionals about end of life

care. The Hospice also ran Project ECCO, which provided tele-mentoring to support practice and learning communities within 20 nursing homes.

- There was extended use of Community Matrons, Clinical Pharmacists and Physiotherapists in general practice to support with medical staff vacancies. Other roles including Care Navigators, Advanced Clinical Practitioners, Physicians Associates, Nursing Associates, Assistant Practitioners, were also being developed.

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 the commissioning of health and social care services.

Commissioning strategies, underpinned by the JSNA, had supported a joint approach in managing and commissioning services. The JSNA had provided a platform to move forward with new models of care and service integration; however transformation strategies were not fully aligned. . Sheffield faced significant social care market issues, including in extra care housing capacity; the system needs to make sure there is sufficient capacity and resilience to cope with an anticipated increase in demand. The system had developed an integrated commissioning function with a pooled budget based around areas of need but there was little evidence that much more shared working was planned.

Strategic approach to commissioning

- The JSNA informed the Health and Wellbeing Strategy, the Shaping Sheffield plan and the ACP plan and defined what the system wanted to achieve for Sheffield, however these plans were not fully aligned to bring about the necessary changes to deliver on work programmes and resulting outcomes.

- At the time of our review the system had submitted a bid for an £80 million innovation fund to direct additional resources towards supporting frail older people and older people with long term conditions. In line with the Health and Wellbeing Strategy, it was intended that funding would be used to increase provision in preventative services.

- An executive management development group had been tasked with looking at what preventative services worked best. There was consensus among system leaders about what was working in terms of preventative services and keeping well, some of which

underpinned how long term conditions were managed. However some of these services, were not well managed, and there was a lack of integration. Commissioning leads were unable to articulate what the impact of individual services would mean in terms of outcomes for local people and there was limited oversight and evaluation of pilots and initiatives which meant that commissioners did not have extensive information to inform commissioning decisions.

- The BCF steered by an Executive Management Group included leads from the CCG and the local authority. There was also a Deputy Director overseeing the pooled budgets. There was commitment from leaders of STHFT to move towards more integrated commissioning with the local authority and the CCG, who were responsible for joint commissioning under the ACP. Some positive work had been undertaken to pool resources around the dementia pathway.

- Commissioners reported pressures as boards were still held to account for the financial position of the individual organisations but the ACP and Shaping Sheffield had provided them with a mandate for managing finances to meet the expectations of these system strategies. Despite being a large joint fund, integrated commissioning arrangements were not well developed. In 2013 the system agreed a single budget for health and social care but in reality they were not operating a single budget, although they were working towards a total resource model for 2020.

- The independent sector was vulnerable owing to financial and workforce challenges, although these had improved following a recent cost of care exercise which resulted in an uplift in fees to give fair price for care, and increase capacity in homecare. Social care providers needed to be more involved in strategic conversations and a number of issues still needed to be resolved in order to benefit from a unified commissioning strategy and workforce plan.

- The system had begun commissioning services through a neighbourhood working approach, based on analysis of the needs of the populations of the local area; there were varied levels of health needs identified in different parts of the city. Commissioning through neighbourhood working should bring together multidisciplinary team working, however concerns were raised in respect of the geography and staffing resources.

- Sheffield Integrated Commissioning Programme (April 2015) presented an overview of the redesign of the health and social care system, aimed at reducing reliance on hospital and long term care. It was evident that although there had been challenges, progress had been made in respect of the some of the work streams such as Active Support and Recovery.

Sheffield Integrated Commissioning Programme acknowledged that more detailed design was needed in regard to models of care, as well as addressing provider sustainability, efficiency and mixed economy provision.

Market shaping

- System leaders had a good understanding of the social care market but further work was needed to address the continued challenges the system faced owing to financial and workforce pressures.

- Sheffield had a Market Position Statement. It had recently been refreshed and was due to be presented to Sheffield City Council's cabinet shortly after our review. This had set out the ambition for the type and volume of care provided to support the overriding strategy of their three sphere model; keeping people at home, at home with enhanced support, or to another place for assessment.

- There was a commitment to prevention and building family resilience to enable people to stay at home with care wrapped around them. However, there were concerns in respect of the decision to map commissioning strategies to the three sphere model, rather than undertaking an in-depth evaluation of the market position to influence commissioning or strategic development.

- Care home bed modelling had been carried out to inform future commissioning; taking account of the growth in service demand, population needs and forecasted available supply of care beds. To support people being cared for at home, system leaders decided to expand the domiciliary care market and fee rates were increased by 8% in 2017/18 to support providers to increase their capacity. There was also planned investment in residential care through the introduction of a fair fee rate in April 2018. However system leaders were aware that there was much more work to do to ensure future sustainability and sufficient supply to meet demand.

- Our analysis showed that at September 2017 there were fewer residential care home beds per population aged 65+ in Sheffield (1848) compared the average across comparator areas (2215) and the England average (2223) and this number had decreased by 8% over the preceding two years. However, there had been a 3% increase in the number of nursing home beds over the same period and there were more nursing beds per population aged 65+ in Sheffield compared to comparator areas and the England average (2669 in Sheffield compared to 2200 across comparator areas and 2075 across England). The number of domiciliary care provider locations per population aged 65+ in Sheffield had increased by 5% and was higher than the comparator and England averages (89 compared to 86 and 79

respectively). Despite this there were specific challenges in commissioning non-bedded social care and care services such as extra care housing.

- We saw limited engagement with housing services at a strategic level; there seemed to be no direct link to the HWB and we saw little evidence of alignment of Planning Policy and Housing Policy with the Shaping Sheffield Plan, the Health and Wellbeing Strategy, or the ICS. There was a very limited amount of extra care housing for a city of Sheffield's size and no mention of housing based services for intermediate care (step up or step down). Housing services and the support from housing professionals was talked about favourably and well regarded by primary care and those involved in social prescribing. Housing staff and services were sometimes involved in discharge arrangements but housing services still thought there was more they could do and were keen to be more involved.

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

- Through the development of Shaping Sheffield and the ACP there was a shared vision and strategy. While senior leaders knew what they wanted the system to achieve, strategies were not fully aligned, understood and owned by all organisational staff. The local authority and the CCG were responsible for joint commissioning under the ACP. Senior leaders in the CCG and local authority met and discussed plans and there was buy-in from STHFT to move towards more integrated commissioning.

- The local authority's housing service had changed its operating model to create a single point of contact; housing staff are aligned to and working within designated neighbourhoods to improve collaboration with health and social care partners. The housing strategy was developed with a good level of strategic interaction with health and social care and was informed by modelling to understand how services need to evolve to meet the changing needs of the population.

- The VCSE sector provided a range of services that were valued by people who used them, however these were underutilised and concerns were expressed by the sector in regard to the sustainability of some of their services, for example the advocacy support and advice provided to people claiming direct payments.

Contract oversight

- STHFT is rated as good by CQC. CQC data from December 2017 showed that 96% of GP practices in the area were rated good, none were rated outstanding and two practices were rated inadequate. Adult social care locations across Sheffield were more poorly rated than average. Although residential care homes in Sheffield were rated similarly to comparator

areas, a higher percentage (34%) were rated requires Improvement than the national average (25%). Nursing homes were performing well in their ratings, with 83% rated good compared to 74% and 75% across comparators and England respectively; however a higher percentage of domiciliary care and other community adult social care services were rated requires improvement in Sheffield compared to comparators and nationally.

- Where services had been re-inspected a higher percentage of adult social care services had improved in Sheffield compared to comparator areas and the England average (40% compared to 36% and 37% respectively), higher percentage of GP practices had kept the same rating (79% compared to 64% and 56%).

- The local authority and the CCG had started to jointly commission to better manage the quality of the care market and improve market management. Care home bed modelling had been carried out to inform future commissioning; taking account of the growth in service demand, population needs and forecasted available supply of care beds.

- Enhanced health care was one of the initiatives that had worked well and rationalised health care across the city. However the system encountered problems with this due to the ever increasing number of care homes and also those care homes which had been rated poorly by CQC. This had resulted in a mixed economy; some care homes were not receiving enhanced health care and the number continued to decline. Concerns were expressed in regard to the financial impact of this service and the benefits as there had been no uplift in fees for eight years.

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.

There had been a long history of collaborative approaches and risk sharing arrangements. System leaders were committed to joining up their commissioning and using resources flexibly for the benefit of people who needed health and/or social care. Resource leads across the system collaborated well in times of crisis. However there wasn't a good understanding of what worked well and a lack of evaluation and oversight meant that we could not be assured about the impact of resources.

- The HWB which was responsible for ensuring services met the needs of the population was being refreshed and we heard the Overview and Scrutiny Committee (OSC) had recently

also been refreshed. The OSC had oversight of system challenges, but we heard it was not fully performing the scrutiny aspect of its role and gaining assurance that there was effective use of cost and quality information to identify priority areas and focus for improvement.

- We noted the ACP was being developed to take on more responsibility and oversight across health and social care in Sheffield but this was more strategic at the time of our review and still in development.

- As part of Sheffield's BCF Plan, there was focus on the delivery of initiatives jointly agreed between providers and commissioners to promote and develop joint decision making. There were risk sharing arrangements to establish effective shared responsibility and governance of the pooled budget. Finance leads had developed strong relationships and worked together to balance the system's finances and had developed a strong understanding of each other's' financial issues.

- There was evidence that BCF monies had been spent on solutions to target improvements against DTOC and support the social care market to enhance capacity. However it was not clear that this spend was part of an overarching strategy to improve performance in the medium to long term. Although there was evidence of financial risk sharing arrangements between the CCG and the local authority, there was less evidence of how these arrangements would be used to improve system integration.

- Although relationships were strong, there was not a shared understanding about what their priority areas were for funding prevention services at scale. Finance leads did not have collective oversight of what was working and how they would prioritise resources for particular services. However there were strong links from finance departments across the local authority, the CCG and STHFT into all of the accountable care work streams. The BCF budget was steered by a system leads' Executive Management Group focussed on developing a joint commissioning approach to support the newly developed ACP. To give better oversight, system leaders told us there had been improved joint working through the development of pooled budgets and fully integrated commissioning was beginning to gather pace. The BCF pooled budget for 2017/18 had been reviewed and brought together key budgets in relation to themes such as people keeping well, Active Support and Recovery and Independent Living Solutions.

- There was joint agreement between the CCG and the local authority to use additional social care funding made available from the iBCF to support the provider market. There had been a bid to the National Life Chance Fund, which had been successful in the first stage, which had a significant focus on frailty and long term conditions for older people.

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

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

Are services in Sheffield safe?

The system was committed to supporting older people to remain well and to live independently at home. However preventative services were underdeveloped and some people expressed concerns in regard to social care assessments. Systems and practices were not working well for the majority of people we spoke with. More was needed to ensure there was a shared view of who in Sheffield was at risk of hospital admission and that pilot initiatives were fully evaluated and embedded.

- People who were frail, had complex needs or were at high risk of deterioration in their health or social situation were not always safeguarded from harm as systems, processes and practice across the health and social care interface were not fully established and embedded. Although system leaders saw admission avoidance as part of the prevention strategy, admission avoidance services were under developed and there was a lack of integration of health and social care. People at risk of deterioration were falling through the gaps and they reported not being listened to and experiencing a crisis before they received the support they needed.

- Some people were not effectively supported to stay in their usual place of residence. Not all of the care and nursing homes had access to enhanced GP support. There had been a plan in place to support all care homes but as the number of care homes had increased this had not been expanded and GPs had reduced their support due to the extra resources needed to invest in these services, especially in poorer rated care homes. This resulted in a lack of focus on early intervention, prevention and improving quality of life in a number of care homes. The previous impact this had on reducing hospital admissions had been apparent and recognised by the Local Medical Committee. To further support care home staff, formal teaching sessions from the system were offered to care homes focussing on subjects such as recognising deterioration, falls prevention and prevention of dehydration.

- System leaders were aware that the preventative agenda was underdeveloped and they were responding to this with development work; for example, with risk stratification and case management in primary care and the digital care home project. Risk stratification and case management promoted the early identification of the frailest people within GP practices who would benefit from an enhanced approach to care. The digital care home

project was using a range of digital devices to help individuals or their carers to keep a regular check on their health. The data was then sent live to the health Single Point of Access (SPA, an interface with a focus on admission avoidance) which identified any irregularities and followed up on potential concerns enabling preventative measures to be put in place earlier.

- Some people were exposed to risk of harm due to inaccurate and delayed social care assessments. We were told of examples where people's complex needs had not been identified, resulting in hospital admissions, inappropriate placements, a lack of support and removal of care packages. Missed reviews meant that people's changing needs were not always being identified. For example, a lack of timeliness and communication in a social care assessment resulted in a domiciliary care provider not being able to respond with the immediate change to the care package. This resulted in the person's health and wellbeing being compromised and ultimately a change in their social situation and usual place of residence.

- People using services, carers and frontline staff experienced multiple confusing access points as there was a lack of effective signposting to services and no comprehensive single point of access. Although there was a SPA for health and the First Contact team for social care, we received varied feedback about the effectiveness of these services from people using services, carers, and multiple professionals.

- The Active Recovery scheme reduced people's reliance on hospital and long term care and prevented people from going into hospital by responding rapidly to individual needs and undertaking assessments to provide the necessary support for a short period of time across seven days a week. If a GP felt that someone was at risk they could contact the team for support.

- Medicine optimisation took place as part of the Active Recovery scheme and there was also CCG-led support for social care providers which included education and training. However there was no formal, joined-up approach to support medicine optimisation and concerns were expressed in regard to the lack of oversight in regard to de-prescribing as part of routine practice.

- Our analysis of quarterly A&E attendance rates between 2014/15 and 2016/17 showed that A&E attendances of older people in Sheffield had reduced slightly but were still above the national average, although not significantly so. In the last quarter of 2016/17 there were 10,821 A&E attendances of older people per 100,000 in Sheffield compared to 10,534 nationally. The A&E attendance rate of older people living in care homes was also just above the England average.

Are services in Sheffield effective?

People did not always receive a multidisciplinary approach when requiring additional support due to fragmentation and silo working within the system. There were multiple and complex access points which caused confusion for people using services, carers and some frontline staff. There was some success with admission avoidance projects; however these had not been fully evaluated to measure success. There were widespread workforce issues across the majority of the system, which were impacting on service delivery and staff workloads. Staff reported concerns with IT systems not communicating effectively which reduced efficiency as key information about people's care and treatment was not always available.

- ASCOF data showed an increasing trend of older people being admitted to residential and nursing homes for long-term support in Sheffield. In 2015/16 the rate of admissions of older people to care homes in Sheffield was significantly higher at 988 per 100,000 compared to the comparator average of 772 and England average of 628. Care home admissions reduced in Sheffield in 2016/17 to 824 per 100,000 but remained above both the comparator and England average.

- People were not fully supported to maintain their health and wellbeing in their normal place of residence due to under-established preventative services. This had resulted in silo working and a lack of adequate community and primary care services. System leaders told us they were focussed as a collective on proactively supporting older people to remain well and live independently at home. To do so they had commissioned services and pilot initiatives around prevention, however these were early in inception and there wasn't a shared, evidence-based understanding of what prevention services worked best, or consistent evaluation of impact.

- People using services were at risk of not receiving consistent enhanced health care. Although there had been an evaluation report for community-based support in July 2017, this evaluation only looked at the effectiveness of one component of the People Keeping Well Programme. Furthermore, the people keeping well outcomes framework identified the function and outcome indicators but lacked key information in regards to how this would be fully achieved, monitored and measured.

- The enhanced health care in care homes (EHCH) implementation plan identified that Sheffield had successfully implemented some of the care model elements from the EHCH framework and were in the process of implementing others. It offered a number of initiatives such as medicine optimisation, providing intravenous antibiotic therapy at home and a range of training such as end of life care. The plan stated that all residential and nursing

homes in Sheffield were covered through the Locally Commissioned Service apart from four care homes. When we spoke with social care providers, GPs and the LMC, it was apparent that the reality did not reflect what was stated in the plan as they all expressed concerns in regard to the management, availability, sustainability and effectiveness of the service. More work needed to take place with social care providers with regards to the preventative agenda, focussing on early intervention, prevention and improving quality of life.

- The system had begun commissioning services through a neighbourhood working approach, based on analysis of the needs of the populations of the local area. It was anticipated that this approach would bring together multidisciplinary teams and integrated models of care. An example of this was the pilot called The Virtual Ward which covered four neighbourhoods. This was testing out an integrated approach to supporting people in their own home and reducing the need for hospital admissions and preventing unnecessary delays in hospitals. This model brought together community health professionals and the VCSE sector, to work in a person-centred and holistic way, although social care staff were not involved. Positive feedback was received about the service and the impact this was having on people's health and wellbeing. However the future of this initiative was unclear as there was the potential for the funding for the pilot being removed.

- People remained at risk of not receiving consistent care due to a lack of integrated working between health and social care. For example, frontline community health care staff told us they had become less integrated with social care and found this difficult to access, especially as social workers were not often assigned to people. This impacted upon relationships and information gathering about people they were providing care for. Furthermore, community health professionals found interacting with some social care providers challenging as they did not always know who to contact. This was highlighted as particularly problematic when helping people to remain at home towards the end of their lives.

- There was an agreement in the BCF return for the delivery of a seven day service across the health and social care system. Primary care access had been extended through a hub working approach and extended access, with GPs working collaboratively to provide services to people at the evenings and weekends. Data collected in March 2017 showed the provision of GP extended access was significantly greater in Sheffield than across comparator areas and the England average, with only 4% of the 82 GP practices surveyed in Sheffield offering no provision of extended access. The GP collaborative also supported GP surgeries and the A&E department out-of-hours so that there was 24 hour access to a GP if required. While this had yet to be fully stress tested, it enabled greater resilience and flexibility within the system and extended people's access to appointments and other

professionals such as physiotherapy. Positive feedback was provided about the extended access services.

- As the NHS England Five Year Forward View promotes a diversified skill mix in practices, some GPs were looking at different ways to meet people's needs, such employing advanced practitioners and using social prescribing. Frontline staff told us that people's understanding of their own health was improved and they were enabled to engage in activities to promote their health and wellbeing through the social prescribing. This supported the preventative agenda, however dementia was not considered an ongoing health need and therefore people with very complex needs were being managed by social services and independent care providers.

- Services designed to improve flow through the system and keep people well at home were fragmented, with multiple interfaces. This increased the risk of delays in accessing services and confusion for people, carers and professionals; they reported it was difficult for them to navigate the system and understand the services on offer. They didn't feel listened to or supported in the way they the needed.

- Frontline and operational staff felt the SPA was pivotal to frontline services. There had been improvements in the way the SPA and First Contact worked over the preceding 12 months but it was more difficult to respond to demands out-of-hours when social care was involved, and concerns were raised from operational staff in respect of information sharing between health and social care. There was evidence that the SPA was dealing with and responding to calls and making the necessary referrals to other services but data also showed that there were some abandoned and inappropriate calls made to the SPA. There was a strong argument to make the single point of access more comprehensive and integrated to combine health and social care to reduce the risk of an inconsistent multidisciplinary approach that was complex and disjointed.

- There were time consuming layers to access step up services to avoid hospital admission. Social workers could not access the Active Recovery team or dementia rapid response team and they had to go through GPs who were not always aware of the pathways. There were missed opportunities to integrate these services to provide joint up care with more effective outcomes for people.

- System leaders and frontline staff reported widespread issues in respect of recruitment and retention of staff across the system and staff in the acute healthcare and community health and social care settings continued to report heavy workloads with additional pressures of meeting targets. Although there was no system-wide workforce strategy in place there had

been focus on job and career prospects and investment in additional long term staffing to manage and support the intermediate and acute care system. Initial discussions had also taken place with Skills for Care and Skills for Health which has highlighted that significant work was required. A project lead had been appointed who would pick this up as a priority for the 12 months following our review.

- To some extent, staff were able to use computer systems or software to exchange and make use of information within the system; however these were not always effective, which impacted on the ability of staff to share information, especially between organisations. BCF returns for 2016/17 showed that the NHS number was not being used as the consistent identifier for health and care services.

Are services in Sheffield caring?

People living in Sheffield were not always involved in discussions about their care and treatment. There was not always enough information and support provided to people and their carers. A commitment to personalisation was articulated in the BCF plan and the future strategic vision and staff at all levels demonstrated commitment to providing person centred care.

- System partners had committed to taking forward a city-wide commitment to person centred care and coordination. BCF plans supported personalisation and choice through development of alternative models of care and investment in more flexible budgets. Examples of this commitment were the five year programme in primary care; 'Specification Person Centred Care Planning', as well as a local authority programme, 'Three Conversations', and the ACP work streams. The aims of these services were to spend more time listening to people to understand their strengths and goals, improve outcomes for people, and empower staff to feel more confident about the advice and support they give; ultimately helping to avoid unnecessary unplanned admissions.

- However, most people, their family and carers told us that they felt neither listened to nor empowered to be involved in their assessment of care, support and treatment. At times they did not feel well cared for. This resulted in some very poor experiences; for example, one person described the inadequate support they had received to help them remain well and independent, which resulted in them experiencing an acute crisis and a subsequent long period of recovery in hospital and a reablement service.

- Analysis of GP survey data between 2011/12 and 2016/17 showed that the percentage of people who felt supported to manage their long term conditions was similar in Sheffield to the national average and average of its comparator areas. However, the health related quality of life score for people with long term conditions had been consistently below the national average over the same time period.

- Despite the poor experiences that people shared with us, most told us that individual staff were kind and caring when encountered. Frontline staff were dedicated to providing the best service they could for people.

- People were supported to remain socially included and connected through community support workers, carers' groups and social groups within the community. People valued these groups and the way in which they enriched their lives and helped them remain in contact with people.

- Carers we spoke with felt there was a lack of effective support. Most carers we spoke with were not aware of the support that was available for them and told us that during difficult times, there was a lack of communication and that their needs were not always considered. ASCOF data for 2016/17 showed only 30% of carers surveyed in Sheffield were satisfied with their experience of care and support compared to 39% nationally.

- The local authority and NHS partners', Young Carer, Parent and Adult Carer Strategy (2016-2020) set out six "carer principles" which defined the key actions and services that were required to improve carers' lives, which included ensuring that carers were identified. GPs were trying to encourage people to identify if they are a carer.

- Healthwatch Sheffield and VCSE organisations had methods to provide people with access to networking and keeping up to date with what was happening in the health and social care sector. However the VCSE sector felt they were underutilised and undervalued and they could offer more support to people, their families and carers.

Are services in Sheffield responsive?

System leaders and frontline staff had a shared vision that a person's own home was the best place for them, articulated as "Why not home, why not today?" We found some good work in place around admission avoidance but some projects were being developed in silos rather than strategically across the system, detracting from the effectiveness of services. There was an urgent need to review all services offered and arrive at a coordinated strategy for service design, delivery and outcomes.

- Social care providers reported variable experiences and outcomes with enhanced health care support, resulting in a lack of focus on early intervention, prevention and improving quality of life in a number of care homes. However the Virtual Ward project set up and running since 2016 within four neighbourhoods in central Sheffield was described by system leaders, operational and frontline staff as having a positive impact on the early

detection of deterioration and admission avoidance; data provided by the system confirmed this. However the evaluation of the Virtual Ward had not been fully completed to establish its full effectiveness. Frustration was expressed by some frontline staff and system leaders that this had not been rolled out to other localities as MDT work would have supported admission avoidance. This project brought together staff from primary care, district nurses and the voluntary sector and enabled a MDT approach. Despite this joined up approach, there were missed opportunities as there was no representation from the social care sector to ensure truly integrated working.

- GPs could access timely support from hospital consultants via the SPA to determine if hospital admission was required. This promoted conversations to determine appropriate care and treatment with a view to supporting people at home when previously this had not been possible. Frontline staff spoke positively with regards to the effectiveness of the SPA and the advice and clinical guidance they were able to gain. However concerns were expressed about the two-phased response before being passed to the appropriate person; frontline staff felt this was frustratingly long and that the process could be streamlined.

- Our analysis of hospital admissions from care home postcodes for a range of conditions deemed to be avoidable between October 2015 and September 2016 indicated that Sheffield had higher admission rates for pneumonia, pneumonitis and other lower respiratory tract infections compared to comparator areas and the national average.

- People using services told us that accessing the system was confusing and it was difficult to get non-urgent access to GPs. However, the GP hub working and extended access was being embedded with an aim to maintain people in their normal place of residence and keep them out of hospital by use of various initiatives such as early visiting services. The GP collaborative supported GPs out-of-hours and were able to make referrals between A&E and hospital wards to promote a more streamlined process and making sure people were seen at the right time, by the right people in the right place. Frontline and operational staff told us this system was working well and had resulted in better use of resources. Although not the only solution and professionals who may be able to help, this may address the concerns that people identified with access.

- Out-of-hours and minor injuries offered an accessible, community-based first aid unit and signposted people to available services or advice where needed.

- Hospital admission avoidance was in part achieved by initiatives such as the Clinical Decision Unit, Medical Assessment Care (MAC), ambulatory assessment units, front door frailty response team (FDFRT), the community Care Coordinator and the Active Recovery

service. Case files we reviewed demonstrated these services were effective and admissions had been avoided through the use of these services. Frontline staff and system leaders spoke positively of these initiatives.

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 Sheffield safe?

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

- People using services were not always seen in a timely way and they sometimes had to wait for treatment. However the system was responsive to surges in demand and there were some solid examples of when the system had rallied to maintain capacity. Senior leaders had been responsive to system flow. Within the acute setting they had begun to look at flow of people in the context of providing assurance that internal resources were being effectively maximised during periods of escalation and pressure. Senior operational staff had also begun developing and using alternative pathways for specific conditions to promote a seamless transfer, rapid assessment and treatment.

- People experiencing a social care crisis rather than a health crisis were not always supported to remain safe and well. Part of the difficulty was the lack of step up beds. Although the Active Recovery service team told us they tried to support in these instances and data provide by the system was reflective of this, there were no specifically commissioned services for this requirement. Frontline and operational staff confirmed it was difficult to access this type of service and this impacted upon admissions to hospital.

- Some residential homes provided some block contract beds for emergency respite to support carers in a crisis. However carers and the VCSE sector reported a need for more respite beds and that there was a lack of crisis plans for carers of older adults with learning disabilities.

- Some people using services reported poor experiences of emergency services and

treatment. Staff did not always have a good knowledge of people's needs, due to insufficient staff resources and at times insufficient communication. This resulted in inconsistent and at times unsafe support.

- People were able to access effective frailty assessments via the A&E department or GP collaborative and where possible supported to return home when appropriate and safe to do so.

- Sheffield had a predictive risk and analytics system which informed direct care and planning by primary care, community care and social care services. There were plans in place to extend e-record sharing as part of the predictive risk system under which care providers, gated by role-based access controls, would be able to access named excerpts from NHS and social care records.

- There was a system-level escalation procedure to manage risks to service delivery; the Operational Pressure Escalation Levels (OPEL) framework. This enabled a shared view of risks to delivering services to people in crisis and was monitored closely. Dashboards regarding flow were provided daily to system leaders and frontline staff who told us these helped with managing escalation and staffing. In the acute setting, clinicians could refer to assessment units and the system portal for urgent advice, preventing admissions if possible. Frontline staff in the acute setting told us they had to use escalation procedures frequently due to system pressures but these processes worked well at times of extreme pressure and that they were listened to. Systems such as the Hospital Ambulance Liaison Officer (HALO) roles, reducing handover delays for the ambulance service and improving patient care during handover processes could be activated to support the A&E and system flow at these times.

- The handover times for ambulances in the A&E department impacted on the service's ability to respond to emergency calls. People were not always seen in a timely way once they had entered the A&E department, which meant longer waits for treatment. Our analysis of A&E waiting times showed that during 2016/17 only 86.9% of people attending A&E were seen within four hours, below the England average of 89.1% and the target of 95%. Data supplied by the system for the 15 minute handover times, showed during the period from 1 January 2018 until 19 March 2018 the department did not achieve 100% on any day. During this period, there were only eight days where more than 50% of the target was achieved and 70 days were below 50% of the target. The lowest figure achieved on one day was 15%, but on this day the 30 minute handover time was 21.8%, which meant that 67.2% of people waited less than 30 minutes for handover over to the department. Trolley waits in A&E for the same period of time showed that there was only one day where

everyone waiting on a trolley was seen within four hours. On seven days 25% of people waited over four hours and on five days 50% of people waited over four hours.

Are services in Sheffield effective?

Some people had poor experiences at the time of crisis and felt that the pressures of the system impacted upon the quality and effectiveness of the service they received. Admission avoidance systems had been invested in to try and prevent unnecessary admission to hospital. However high numbers of people were admitted to hospital in an emergency and they experienced longer lengths of stay. There were multiple pathways and access points, provided by different staffing groups to increase flow; however the criteria for some of these pathways would benefit from being redefined.

- Sheffield performed worse than all but two of its fifteen comparator areas for the Department of Health and Social Care measure looking at the 90th percentile length of stay for emergency admissions of older people between September 2016 and August 2017. Our analysis showed that, throughout 2014/15 to 20161/7, Sheffield consistently had a higher percentage of older people admitted as emergencies staying in hospital for more than a week, compared to both national and comparator averages. In several quarters, Sheffield's performance was significantly higher than the national average. In the last quarter of 2016/17 for example, 37% of older people admitted to hospital as emergencies in Sheffield stayed in hospital for more than a week; this was significantly higher than the national average of 32%.

- Some people shared significant concerns about their perception of the quality and range of services available to them at a time of crisis and felt that the pressure in the system affected their experiences.

- Our analysis showed that between August 2016 and July 2017 the percentage of 999 calls resolved by Yorkshire Ambulance Service NHS Trust (YAS) with telephone advice and the percentage of 999 calls attended and managed by YAS without transferring to hospital was consistently below the England average. In July 2017, only 9% of emergency calls received by YAS were resolved with telephone advice (below the England average of 10%), while 31% of calls attended by YAS were managed without transferring to hospital (below the England average of 38%). This impacted upon the number of people using alternative services and attending the A&E department.

- Ambulance handover times at A&E did not always meet their targets which impacted upon turnaround times to respond to other emergency calls. This had been recognised and over the three months prior to our review there had been a change in practice and a new rapid

assessment process to enable smoother and more effective triage. Frontline staff told us that relationships between the ambulance crew and A&E staff were building so they could work on the “fit to sit” handovers, which in turn would improve handover times.

- Analysis of quarterly overnight bed occupancy figures showed that STHFT had bed occupancy figures consistently higher than 90% throughout 2016/17 which was also higher than the England average. In the first quarter of 2017/18, bed occupancy was at 95% while the England average was 87%. National guidance suggests that optimal bed occupancy levels in hospital are around 85%. Hospitals with an average bed occupancy above 85% risk facing regular bed shortages, periodic bed crises and potential increased numbers of hospital acquired infections. The hospital flexed its bed base according to demand, opening and closing surge capacity as required. System leaders told us the apparent high occupancy levels were owing to their approach of staffing occupied beds well, rather than keeping open capacity which is not in use.

- Investment had been made in admission avoidance systems to prevent unnecessary admissions to hospital with the intention that people are treated quickly and returned home. Multidisciplinary working in the A&E department promoted integrated working. For example, there was mental health care support twenty four hours a day in the A&E and EAU, however capacity for this service was sometimes an issue. Staff in the FDFRT had undertaken core competencies in other roles to offer consistent care and reduce the need for people having to tell their story more than once. The FDFRT were effective in reducing hospital admissions as this helped with the assessment process and getting people home quickly and safely. However the system could be more streamlined if the system alerted the team to people suitable for this service, rather than staff needing to check the system and departments to see if there was anyone suitable for the service. Data supplied by the system showed that between 19 February and 4 March 2018, the team received 145 referrals from urgent care services; 91% of these referrals were processed for discharge, of which 75% were discharged on the same day.

- Services designed to improve flow through the health and social care system were evidence based. However, there were multiple pathways and access points, provided by different staffing groups, such as the MAC, Emergency Assessment Unit, the frailty unit and ambulatory care and there was an opportunity to redefine the criteria of the MAC unit. Although the multiple assessment units allowed a quicker turnaround time the multiple pathways created capacity and flow issues. System leaders and frontline staff were aware of this and were trying to make improvements at operational level. Some frontline staff reported concerns about the length of stay and the impact this had on people’s health and wellbeing, with reports of people becoming more unwell and staff requiring different skills mixes to support them.

- People's experiences were impacted by capacity issues and the number of pathways. This resulted in some people moving departments and wards numerous times, including during the night.

- There was some interoperability between health and social care to allow staff to share information across the services. However concerns had been expressed by some frontline staff about accessibility to information at the point of crisis. There were a number of meetings which enabled effective communication and information sharing at strategic and operational levels.

Are services in Sheffield caring?

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

- Generally people were positive about the care and treatment they received but their experiences varied depending upon the complexity of their needs and the service they were using. For example, one person shared their experience of waiting in a corridor in A&E and said, "It is very distressing to be asked the same thing over and over again; you question if people know what they are doing, they asked for the same information five times and this was in front of people; there was no privacy." And a relative caring for their spouse told us frontline staff were not considerate of their needs as they wouldn't allow them to travel to the hospital with their spouse. This resulted in them not being with their spouse at the time of their death.

- People had to tell their story more than once because of multiple assessments. Carers and relatives were not always involved in the assessment process and their views and opinions were not always taken into account. This caused people and carers distress and impacted upon their confidence in the system to deliver care and support to them appropriately.

- People's health and wellbeing was not always promoted due to inconsistency in communication and the attitude of some staff. We were told of dismissive and patronising staff, contributions not being valued during consultations, and not being listened to. This was supported by frontline social care staff who reported a lack of sensitivity and understanding of needs of people living with dementia and gave examples of derogatory language being used by paramedics attending the service.

- Staff in STHFT were responsive to the needs of people living with dementia, and there was a quiet space allocated in A&E which promoted a calmer environment, and the frailty ward had a dementia friendly environment.

- People at the end of their lives were supported by collaborative working to die in their preferred place wherever possible. Systems and processes were in place to support this.

Are services in Sheffield responsive?

People living in Sheffield experienced multiple confusing access points and experienced long waits for treatment. Triaging took place on arrival to A&E and there were some responsive services which people were referred to if required which reduced some of the pressures on the system.

- People told us of long waiting times for ambulance transport and being treated in A&E which impacted upon their health and wellbeing. There had been some new initiatives in A&E where specific pathways had been defined for a number of conditions to achieve better outcomes for people, and staff were working on making pathways more person-centred.

- Ambulance turnaround times were not always responsive as hand over times in A&E sometimes exceeded an hour, which impacted upon the department and ambulance crew. In response to this there had been a recent change in practice and a new rapid assessment process had been implemented which enabled a more effective triage system. There was also a self-handover for people who had been assessed as “fit to sit2 to make handover time more effective and responsive.

- System leaders and frontline staff shared a vision of “why not home, why not today?” There were some systems in place to support collaborative working and prevent people being admitted to hospital, such as, the GP collaborative, Active Recovery service and the FDFRT. The SPA and First Contact team were also making referrals to other services to ensure correct streaming, advice and support was given. However there was a lack of step up beds and community based beds for people to use if they needed which impacted upon lengths of stay in hospital.

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 Sheffield safe?

The majority of people had poor experiences on discharge home from hospital which impacted upon their health, safety and wellbeing. There were low levels of trust in the discharge process due to widespread concerns about its quality and timeliness.

- People did not always experience safe discharges to their usual place of residence because of a lack of communication and coordination, adequate assessment and provision of services. Significant concerns were raised by people using services, carers, social care providers and the VCSE sector. For example, we were told that some people were being discharged home late at night from the wards and the A&E department between 02:00 and 03:00. System leaders told us this was infrequent it was a matter of responding appropriately to the individual needs and wishes of each person. People would not be discharged between these hours without having been appropriately assessed and unless they wished to go home. We also heard of an example of a person who was discharged from hospital and left at home sitting in a wheelchair without any support. Owing to transport and communication issues, domiciliary care agency staff were not at the person's home when they arrived home at 9pm. It wasn't until the following day that this person was found by their neighbour; they had been left sitting in the wheelchair all night.

- There were also widespread concerns regarding the quality and accuracy of discharge information, or about not getting any discharge information at all. This sometimes resulted in a lack of risk sharing and responsibility and at times resulted in placement breakdown as people required more significant care than the service provider had been led to believe.

- We received 16 responses from registered managers of adult social care services in Sheffield to our discharge information flow feedback tool. Responses were polarised with regards to whether or not services received discharge summaries from secondary healthcare services, with domiciliary care services rarely receiving them while care homes more commonly receiving them. Responses were mixed in regards to the timeliness, accuracy and comprehensiveness of discharge summaries. Eight respondents supplied free text comments in which the most common themes were having to chase for information, and receiving incomplete or incorrect information. One respondent noted how this could impact on service delivery and lead to readmissions. Other issues noted included poor discharge planning and processes, unsafe discharges at weekends, medication errors and

a lack of trust in assessments. One respondent noted that they felt the discharge process had deteriorated over the preceding six to 12 months.

- Analysis of weekend hospital discharges between April 2016 and March 2017 undertaken by the Department of Health and Social Care showed that Sheffield was among the lowest of its comparators for the percentage of people discharged at the weekend, at just 18%.

- On discharge from hospital people did not always get the adequate follow up care they required to remain safe. For example, a carer described their experience of intermediate care and the lack of support received prior to discharge under the 5Q process. This resulted in the person not being safe for discharge home, despite the process being started.

- On discharge from hospital, people's medicine information was not always correct resulting in risks of contraindications and potential ill health. There were opportunities for community pharmacists to be involved in planned hospital admissions and the discharge process which would help to reduce such incidents, and prevent readmission to hospital as a result.

- Most people were able to obtain equipment and adaptations before care packages started. The VCSE sector could support safe discharge home from hospital by taking referrals for emergency discharge equipment from the occupational therapists, STIT, community matrons and support workers.

- Our analysis showed that emergency readmission rates for older people were consistently higher than the England and comparator averages in each quarter between 2014/15 and 2016/17. In the last quarter of 2016/17 the percentage of older people in Sheffield requiring emergency readmission within 30 days of discharge from hospital was 22% compared to the England and comparator averages which were both 19%. Emergency readmissions to hospital for people living in care homes had broadly been more in line with the comparator group average, but above the national average.

Are services in Sheffield effective?

Although there had been considerable drive at a system level to address the issues of performance in relation to delayed transfers of care, the system had not been able to sustain this due to pressures over the winter period. People had poor experiences throughout the discharge process and experienced delays. To address DTOC there had been a greater focus on discharge to assess which had led to more people accessing reablement services. The drive to reduce DTOC had meant people were perhaps leaving reablement services too soon, which was why there was such a high number of people being readmitted.

- People experienced delays being discharged from hospital especially at weekends, due to waiting for medicines, availability of staff and transport issues. They also experienced inappropriate discharges. We were told of examples where people were discharged without care packages, medicines and equipment and to inappropriate settings. We received reports of poor joint working with a lack of communication with and involvement of the people, their carers, families and care home providers.

- Medicine data supplied in relation to STHFT demonstrated the mean turnaround time of take home medicines from September 2017 to February 2018 were in line with the expected 60 minutes. The percentage of take home medicines completed in less than 120 minutes had a target of 95% and the system was achieving above 90%. However, the process of monitoring medicine turnaround times was not consistent across the system, which impacted upon each individual organisation being able to integrate performance data and make any improvements if needed.

- There was a lack of strategic oversight of the discharge from hospital process and discharge dates were not being discussed early enough. Case files we reviewed demonstrated that the point at which discharge planning began varied and the level of detail was inconsistent. Frontline staff had differing views about when the discharge process would start and told us that although discharge information was discussed frequently it would not always be recorded due to work constraints.

- System leaders were aware of the DTOC challenges the system faced; following an external review recommendations were made. The system adopted a “single version of the truth”, held three joint summits to engage staff and stop a blame culture and developed and agreed the “Why not home, why not today?” approach. System leaders acknowledged these changes had not been fully embedded due to the winter pressures and that they needed to evaluate their effectiveness once the winter pressures had settled. This would present an opportunity to review the current pathways and discharge process, evaluate their effectiveness and gather feedback from people using services and their carers in order to embed and communicate a comprehensive and structured discharge process.

- The system had focussed on reacting to extreme pressures over winter rather than planning ahead, however efforts were being made to improve system flow and reduce DTOC. For example, the senior leaders held weekly meetings to discuss issues with system flow, stranded patients, and lengths of stay and provided oversight of bed capacity. There were also daily DTOC meetings to discuss transfers of care where ongoing support was required. The attendees for these meetings could be tailored to make it a more solution focussed meeting, for example by having the Active Recovery service team present.

- The discharge process was confusing, ineffective and unclear to some staff, and the 5Q process could not be clearly and consistently articulated. The 5Q discharge process was in the pilot phase and midway point reviews were showing a third of people were going home as first port of call with wrap around support and social intervention. The pilot has been extended until the end of March 2018 to obtain further data. Comments in our relational audit cited a lack of consultation between staff and decision-makers in regards to the creation and implementation of the 5Q process. They described the 5Q process as being poorly considered, and that a lack of communication had continued following implementation of the pilot.

- The trusted assessor model would complement the discharge to assess and 5Q processes but this was not currently functioning well which was impacting upon this being individualised for the person. The development of this model is essential to facilitating timely discharge from hospital.

- There were constraints with the discharge process such as a lack of choice and people waiting for placements, for example, when there was no capacity in social care, intermediate beds and the active recovery team. There were also issues in respect of capacity to undertake CHC assessments. This made the discharge process more difficult for staff in the acute setting as they were not able to determine how long a person would be waiting. There was a divide between health and social care and some therapy teams worked in isolation which impacted upon proper coordination of those agencies involved in the discharge process. This resulted in people receiving inconsistent support on leaving hospital. For example, one person told us they had no support to find their relative long term residential care upon discharge from hospital, in contrast they said that when their relative needed nursing care the NHS were more helpful and supportive. They felt this was due to a divide between health and social care. Frontline reablement and intermediate care teams felt that acute hospital staff needed more knowledge of the different criteria and pathways of where to discharge people to, to support the process.

- There was a lack of joined up assessments and information systems with different services carrying out their own assessments. Community frontline staff told us that this resulted in people having to repeatedly tell their story and this was not the best use of resources as it was duplication in work. However the information systems in use meant that it was hard to get a complete picture or chronology of people.

- Capacity issues also caused delays in discharging people from intermediate care and consequently accepting people from hospital. Frontline staff told us they were behind the

principle of getting people home but there were delays in people's onward journeys e.g. three week waits for STIT services.

- Analysis of ASCOF data showed that the percentage of older people receiving reablement services following discharge from hospital had risen over recent years in Sheffield (in contrast to the national trend) and was significantly higher than the England average in 2016/17 with Sheffield at 6.3% against the England average of 2.7%. While a higher percentage of older people were receiving reablement in Sheffield, the percentage who received reablement and were still at home 91 days after discharge from hospital was below both the comparator average and England average at 74.7% compared to the comparator average of 83.3% and the national average of 82.5%. Sheffield's performance on this measure had declined in recent years.

- In June 2017 the CHC process changed and no CHC assessments were to be undertaken in hospital. People would be transferred to an interim care bed where the assessment would take place; this was to reduce the length of stay. Some people using services, carers, social care providers and frontline staff told us the discharge process impacted upon CHC assessments and the quality and accountability of this process with concerns about it not being person-centred. Specific issues were raised regarding reassessment and withdrawal of CHC funding for some individuals at specialist dementia nursing homes.

- People did not always receive effective support after leaving hospital and there was inconsistent and insufficient access to rehabilitation. Some people experienced difficulties finding care for their complex needs which resulted in failed placements. Carers and social care providers told us this sometimes led to readmission to hospital. The trusted assessor workforce and project team were looking at the development of pathways when a person was discharged from hospital and referred to the Active Recovery service to promote a seamless transition.

- Despite these challenges, some people had some good experiences of support from the GP, community health teams and social care providers to enable them to rehabilitate. These services provided care, help and advice with a practical approach, for example the community physiotherapist, twice managed to get a person walking in their own home after being left in bed during two hospital admissions.

Are services in Sheffield caring?

People who use services, their families and carers were not always involved in the discharge process or involved early enough. Sometimes there was insufficient coordination and communication which resulted in a lack of continuity of care. Support services were available for people without family or friends available at the time they were ready to leave hospital.

- People and their carers were not always involved in the discharge process, or if they were, this was not always timely. For example, one carer told us they felt the hospital had forced them into taking their family member home when they felt their relative was not well enough to go home alone. Soon after discharge they returned to hospital. The carer stated the doctor was angry with them for returning to the hospital but the carer managed to convince the hospital staff they were not fit for discharge and they were readmitted.

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

- Sheffield Churches Council for Community Care, a charity working in partnership with STHFT, the local authority and the CCG, delivered a highly personal service to support people on their return from hospital. They provided a rapid response to support those people without family or friends available at the time they are ready to leave hospital. We received positive feedback about this service.

- Some people had poor experiences in respect of discharge from hospital or follow on services due to a lack of continuity in care and a lack of an individual approach. For example, one person who used the Active Recovery discharge to assess service felt that the team was so large there was very little continuity of care. Despite raising concerns about this, continuity of care was never provided. This person and their relatives found the whole process stressful rather than helping their recovery, which did not improve until they got continuity of care through a different care service.

- The 5Q discharge process was not well understood and had not been effectively embedded. This resulted in several failings relating to a lack of choice and control, multiple assessments and inappropriate placements resulting in placement breakdown. These failings were substantiated by the experiences of people using services and carers and some frontline and operational staff. Comments in our relational audit specifically noted that the 5Q process was not person-centred, with one respondent describing the process as "undignified".

- Staff across the system were not aware of a choice policy and told us they would try to negotiate with people and carers wherever possible but this was not always successful. An up to date choice policy would support this process and ensure that the system's vision of person centeredness was more fully recognised.

Are services in Sheffield responsive?

There were multiple pathways to facilitate discharge from the acute setting which caused some confusion for people using service, carers and frontline staff. People experienced a high number of delayed transfers of care. Data showed a higher number of CHC assessments were undertaken in an acute setting which could lead to delays and this needs addressing as a matter of urgency.

- Some people experienced delayed transfers of care and there was evidence within records we pathway tracked that discharge planning was not always starting early enough. Frontline staff had differing views as to when the discharge process would start and who would take the lead and responsibility for this.

- System leaders recognised the improvements needed in regard to DTOC and had begun to implement changes following an external review by Newton Europe. An operational multidisciplinary task team was developed. As the team had become embedded the size of the team had reduced but its scope remained the same. Changes had been made to systems and processes, however, there had been insufficient time to embed these changes before the winter period. This impacted upon the sustainability of these new processes and DTOC increased again. It was acknowledged that system pressures had been very significant and this had affected multidisciplinary working as teams did not work as well in sustained pressure. An analysis of this had taken place so the system could begin to address some of the issues. As a next step the system needs a focussed capacity plan which is planned over the longer term.

- STHFT had invested in predictive analytics hour-by-hour systems, for winter predicted admissions and discharges on a day-by-day basis and fed this information back into the system. It was evident that staff were utilising this information and it was being discussed in the MDT and bed management meetings across the system.

- Staff were aware that there had been a focus on reducing delays and felt there had been some small improvements, mostly communication between services and systems to make sure the relevant stakeholders were engaged in the process especially in regard to equipment and housing.

- As part of the home first principle, emphasis had been place on simplifying multiple discharge routes to three pathways. System leaders told us this had improved hospital discharge rates but acknowledged that more needed to be done to mapping and cascading this across STHFT. As there was a lack of clarity and focus around the discharge process

and the trusted assessor model was still evolving, this had resulted in the three routes to discharge not being fully embedded and utilised across the system. The system needs to make better use of the discharge to assess model and also assess weekend discharges to see if there are any themes and trends which are impacting upon this.

- Our analysis of the average daily rate of delayed transfer days per 100,000 population aged 18+ in each month between June 2015 and November 2017 showed that Sheffield's rate of delayed transfers increased sharply at the beginning of 2016 and remained much higher than the national average throughout the year, but then steadily reduced from a significantly high rate of 34.7 average delayed days in March 2017 to be much more in line with comparator and England averages by September 2017 with an average of 14.3 delayed days. Delayed transfers were also in line with national and comparator rates in October and November 2017. However data for December 2017 and January 2018 showed the rate of delayed transfer days increased again demonstrating that some improvements had not been sustained. The system has acknowledged that while its capacity to manage complex discharges improved significantly during 2017/18 these improvements were not able to keep pace with demand levels in December and January.

- Between July 2017 and September 2017 the NHS accounted for more delays than social care, with an average of 11.3 daily delayed days per 100,000 population aged 18+, compared to 5.2 days attributed to social care (a further 1.3 delayed days were attributed to both). By far, the main reason reported for delayed transfers of care in Sheffield over this time period was "awaiting care package in home", accounting for an average daily rate of 7.3 delayed days per 100,000 population aged 18+. Awaiting completion of assessment was also a more common reason for delay reported in Sheffield than across comparator area or England.

- There were differing views in regard to the availability of a domiciliary care packages, and the length of time to set these up. There was increased social care capacity but this was not always being used as well as it could be.

- The CHC assessment process was not always person-centred and there were issues with the quality of assessments and a lack of accountability for who would lead on this process. Some people reported concerns about not being listened to and bullying approaches with a lack of choice and control. Data from the first quarter of 2017/18 showed that more than half of decision support tools were completed in an acute setting (compared to 27% nationally), which could be contributing to delays. However following the introduction of the 5Q process the number of assessments completed in an acute setting fell to 0% in Q3 and Q4 of 2017/18.

- Based on data for the first quarter of 2016/17, Sheffield CCG had high rate of people receiving personal health budgets and direct payments for NHS CHC. ASCOF data for 2016/17 also showed that a comparatively high proportion of older people in Sheffield who were accessing social care services were also receiving direct payments (20.2% compared to 17.6% nationally and 14.5% across comparator areas).

- Patient transport accessibility also impacted on people's experiences and resulted in people being delayed in leaving hospital on the day of their discharge. A number of these issues were caused by the discharge planning process and the timeliness of discharge from hospital, use of resources and medicines. Ambulance discharge performance data supplied by the CCG on 22 March 2018 showed that patient transport services were consistently missing the target levels for all transfers definitions. The lowest performing being people collected no more than 60 minutes after Ready Time which was significantly below the target between September 2017 and February 2018.

- There were capacity issues with reablement and stepdown services and a lack of restrictive access criteria in regards to who would benefit from these services. At times this resulted in delayed transfers of care. These staff felt that they could do more to aid flow if they had more capacity and staff.

Maturity of the system

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

- The system has been in a period of transformation over the last 12 months. Although this had enabled better joint working, more coordination of system changes and service delivery was needed.
- The roles of the HWB and the ACP were developing but further development is needed to ensure the HWB undertakes its statutory responsibilities and drives the system transformation programme alongside through the ACP.
- Relationships have improved and there is evidence of more collaboration but this is not mature and embedded to improve outcomes for the people of Sheffield.
- The ICS had little influence on the Sheffield system as Sheffield had developed its own vision and strategies based on the assessed needs of the local population.
- Whole system strategic planning and commissioning was developing with the Shaping Sheffield plan and the ACP. Although this provided a vision for the design and delivery of services, this need to be further embedded to ensure complete alignment and success of integration. More effective communication with staff at all levels and people using services was needed to make the vision a reality and improve outcomes for people using services.
- System leaders were attempting to align services to scale up integrated working and implement new models of care through transformation plans. This was being addressed through the ACP work streams and was in the early days of implementation.
- There were some positive examples of joint working and collaboration in the interests of the population's defined needs. However, overarching strategies had yet to be defined and co-production with local population needed further development.
- There was some evidence of system-wide multidisciplinary team working for effective outcomes; the virtual ward and community services, but there was little evidence of pathways across primary, community and secondary care that supported the wider objectives of health and wellbeing maintenance. There was a vision for full integration, but there was a long way to go to actualise this.

- A large proportion of decision making sat separately within individual organisations but there was evidence of system-wide approaches in respect of managing particular issues and challenges such as DTOC. In these instances there were shared metrics and systems for the oversight of performance and delivery.

- Relationships between leaders across the system had continued to develop over the previous two years with a move away from a blame culture. Although these were developing positively the relational audit demonstrated that work was still needed address longstanding cultural and communication issues.

- Sheffield was particularly challenged by workforce issues across the system. There were workforce plans at organisational level but no agreement to trial a combined recruitment campaign and develop a single recruitment pathway.

- System leaders acknowledged that incompatible information sharing systems were a barrier to seamless working across agencies but were committed to providing integrated care records and shared access wherever possible.

Areas for improvement

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

Strategic Priorities

- System leaders must continue to engage with people who use services, families and carers and undertake a review of people's experiences to target improvements, bringing people back to the forefront of service delivery.

- System leaders must work together to create the required culture and conditions to support integrated care delivery.

- Health and social care leaders across Sheffield should work together to align their transformation delivery programmes and strategies. Health and social care be must equal partners in the system transformation programme and strategic direction.

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

- System leaders should plan more effectively for winter and demand pressures throughout the year, ensuring lessons are learned and applied when planning for increased periods of demand.

- System leaders should continue to implement the recommendations of the Newton Europe review and evaluate their effectiveness. This needs to inform strategic planning and delivery.

- System leaders should develop a more proactive approach to market management in adult social care. They should continue to focus on domiciliary care to ensure that the proposed changes are effective. Strategic conversations must take place with people delivering services when these services are being recommissioned to establish the impact on service delivery.

- System leaders should develop a workforce strategy across health and social care and include providers in the VCSE sector to ensure a competent, capable and sustainable workforce.

- To ensure there is robust evaluation supported by data to inform commissioning decisions, system leaders should have a more coordinated approach to running pilots and developing innovations; it should be clear how they will fit in with the wider strategic plan and how quality information will be used to evaluate them against identified focuses for improvement.

- The discharge process should be evaluated incorporating the views and experiences of people using services, their families and carers. During this process system leaders must consider the multidisciplinary approach, clarity of the process, the three routes to discharge from hospital, the choice policy and the quality and consistency of the information provided. Following this evaluation, revised processes must be implemented and evaluated.

Operational Priorities

- There must be a review how people flow through the health and social care system, including a review of pathways so that there are not multiple and confusing points of access. Specific focus should be given to prevention, crisis and return. Pathways should be well defined, communicated and understood across the system.

- There must be an evaluation of health and social care professionals' skills in communication and interaction with people to establish where improvements are needed.

- Housing support services should be included within multidisciplinary working, especially in relation to admission to, and discharge from, hospital, to enable early identification of need and referrals.

- There should be a review of commissioned services to consider outcomes, design and delivery to improve the effectiveness of social care and CHC assessments.

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

- The trusted assessor model should continue to be embedded.

- The criteria for the reablement services should be evaluated and reviewed.

- There should be a specific focus to bridging the gap between the single point of access and First Contact, community and acute preventative services and rehabilitation. Social care providers should also be part of this process to align services and develop collaboration between all system partners.

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