

Wiltshire

Local system review report Health and Wellbeing Board

Date of review:
12 – 16 March 2018

Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and Social care, and for Housing, Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

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

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

The review team

Our review team was led by:

- Lead reviewer: Deanna Westwood

The team included:

- One CQC Chief Inspector
- Two CQC reviewers
- Two CQC strategy leads
- Two CQC analysts
- Two CQC inspector
- One CQC Expert by Experience
- Four Specialist Advisors (one Local Government Association representative, one Director of Adult Social Services, one former Director of Adult Social Services, one Director of Public Health and one Nurse Clinical Governance Lead)

How we carried out the review

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

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

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

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

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

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

We then looked across the system to ask:

- Is it well led?

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

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

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

- System leaders from Wiltshire Council (the local authority), Wiltshire Clinical Commissioning Group (the CCG), Salisbury NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust, Great Western Hospitals NHS Foundation Trust, Avon and Wiltshire Mental Health Partnership Trust, Wiltshire Health and Care LLP (WHC), the chair of the Health and Wellbeing Board (the HWB) and other elected members.
- Health and social care professionals including; social services staff, nursing and clinical staff, occupational and speech and language therapists, GPs, and health and social care commissioners.
- Healthwatch Wiltshire and voluntary, community and social enterprise sector (VCSE) services
- Independent social care provider representatives
- People using services, their families and carers at a Music for the Mind Group, a carers' support centre and an extra care housing scheme.

We reviewed 18 care and treatment records and visited six services in the local area including acute hospitals, intermediate care facilities, care homes and an extra care service.

The Wiltshire context

Demographics

- 18% of the population is aged 65 and over
- 97% of the population identifies as white
- Wiltshire is in the 20% least deprived local authorities in England

Adult Social Care

- 145 active residential care homes:
 - Four rated outstanding
 - 99 rated good
 - 31 rated requires improvement
 - One rated inadequate
 - 10 currently unrated
- 52 active nursing care homes:
 - Three rated outstanding
 - 21 rated good
 - 22 rated requires improvement
 - One rated inadequate
 - Five currently unrated
- 83 active domiciliary care agencies:
 - One rated outstanding
 - 46 rated good
 - 17 rated requires improvement
 - 19 currently unrated

GP Practices

- 49 active locations:
 - Seven rated outstanding
 - 40 rated good
 - Two currently unrated

Acute and community healthcare

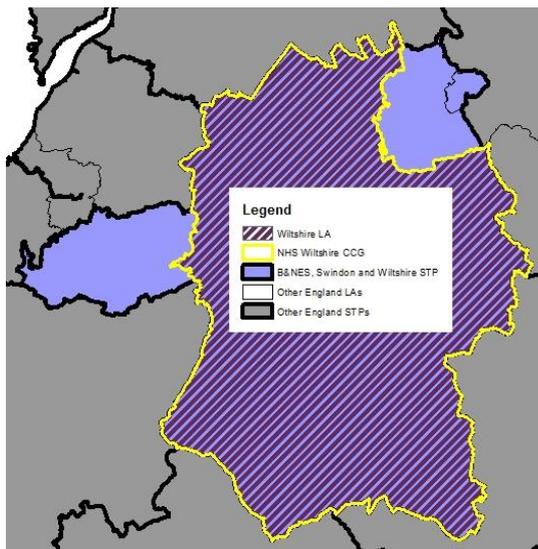
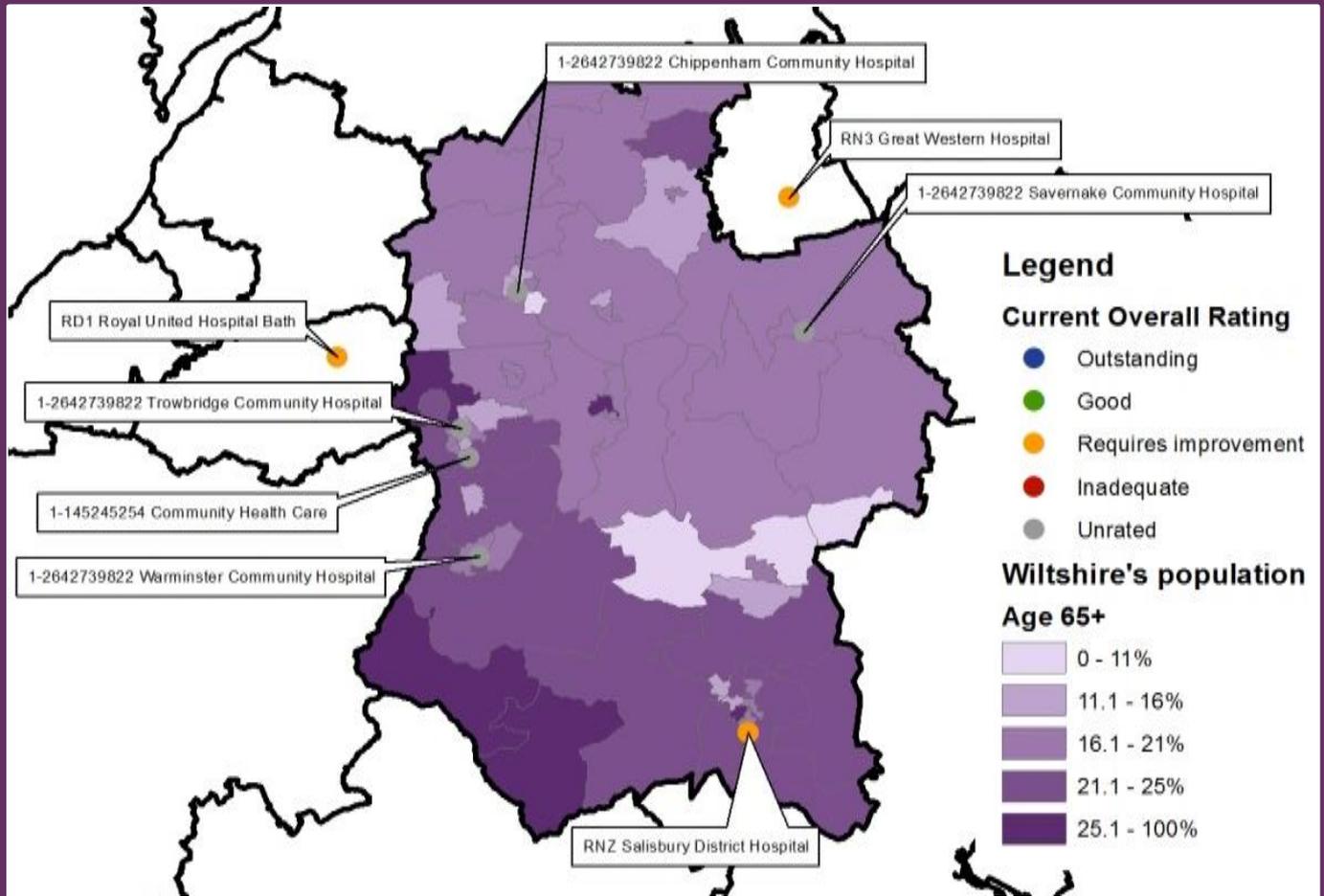
Hospital admissions (elective and non-elective) of people of all ages living in Wiltshire were to the following NHS acute hospital trusts:

- Salisbury NHS Foundation Trust
 - Received 34% of admissions of people living in Wiltshire
 - Admissions from Wiltshire made up 68% of the trust's total admission activity
 - Rated requires improvement overall
- Royal United Hospitals Bath NHS Foundation Trust
 - Received 32% of admissions of people living in Wiltshire
 - Admissions from Wiltshire made up 43% of the trust's total admission activity
 - Rated requires improvement overall
- Great Western Hospitals NHS Foundation Trust
 - Received 22% of admissions of people living in Wiltshire
 - Admissions from Wiltshire made up 29% of the trust's total admission activity
 - Rated requires improvement overall

Community services are provided by:

- Wiltshire Health and Care LLP
 - Rated good overall

All ratings as at 01/12/2017. Admissions percentages from 2016/17 Hospital Episode Statistics.



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

Map two (left): Location of Wiltshire LA within B&NES, Swindon and Wiltshire STP. NHS Wiltshire CCG is also highlighted.

Summary of findings

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

- Although there was a shared vision across health and social care which described the importance of preventative support that would enable people to stay healthy for longer, this had not translated into joint strategic developments and operational delivery. The vision for Wiltshire was articulated in the Better Care Plan which was developed in 2014. It was widely shared across the county and people who lived in Wiltshire, together with stakeholders such as VCSE organisations and the independent provider market, understood the vision. There was a lack of pace with regards to delivering the vision and shifting leadership and priorities within health and social services. As a result, all the groups of people we spoke with expressed frustration that the vision had not been applied to bring about change.
- There was no alignment between the STP and the health and wellbeing plan with little buy-in to the STP from Wiltshire Council's elected members. While some organisations within the Wiltshire health and social care system supported the STP, others did not see any value in engaging with the overarching plan.
- There were some individual strategies in place such as the dementia strategy, although this was four years old at the time of our review and this and other strategies were not aligned to an overarching vision.
- Organisations within the system had planned a focus on their immediate needs and improving their own ways of working. System leaders told us that they would be able to reshape the vision once this work had been done. However, this approach bore a risk that the vision would then have to fit around existing systems rather than shaping the system around a joint vision.
- There had been some progress in terms of building relationships within the health and social care system through the interim leadership in place at the time of our review. However the churn of leadership and a succession of interim posts was compromising the shared direction and pace of change. Many people we spoke with across all sectors and levels described the succession of interim leaders as a barrier to developing a vision and agreed strategic and operational plans. People we spoke with had been optimistic about the interim leaders of the CCG and local authority, and felt that relationships were improving however two weeks after our review the interim DASS left the local authority and the Director of Public Health was appointed as the new interim DASS. This came at a difficult

time for the local authority as, at the time of our review, the Director of Public Health was managing a major incident at Salisbury NHS Foundation Trust and Wiltshire had been affected by severe weather conditions.

- Although there were plans to appoint a joint corporate director/accountable officer, leading the CCG and local authority adult social services, the leadership of services in the meantime by interim roles meant that stability and authority of service leadership could be undermined. The scope of the joint post and what it was expected to deliver was not clearly defined at the time of our review. The management structure that would be required to support the joint post had also not been defined.
- There was a positive and proactive programme for the transformation of adult social care particularly around prevention, reablement and safeguarding. There was an acknowledgement, including from partners that this was an important step enabling the local authority to address immediate pressures but this needed to support the next phase of integration. It will be important to ensure that opportunities to shape integration at an earlier stage – for example reablement and Home First – are not missed.
- The Health and Wellbeing Board (HWB) was well-established with the majority of key partners involved. However the HWB was operating very much as a formal council committee with public meetings taking place on a bi-monthly basis. There were not opportunities for leaders to meet outside the formal settings of the Health and Wellbeing Board and the joint commissioning board to formulate direction and have opportunities to challenge and plan. There was not a clear forum for the local authority and CCG to work together and there was not a forum for providers including GPs, acute, mental health providers, social care providers and the voluntary sector to come together to shape the future delivery of integrated care.
- Energy and commitment had gone into the creation of the community health provider, Wiltshire Health and Care (WHC) and this created a strong platform to develop integration of community, health and social care on a locality footprint.

Is there a clear framework for interagency collaboration?

- There was not a clear framework for partners to work together on a routine basis at operational level. The alignment of services around the three localities provided a good opportunity to move this forward.
- Frontline staff wanted to work together in an integrated way. We found instances where people were relying on relationships to improve outcomes for people who use services

however this was not evident across the system. There was a clear message from frontline staff that a well-defined operational framework supported by a strategy would enable them to develop interagency collaboration further. While the direction of travel around the three localities was broadly agreed, the route map for operational delivery was still unclear.

- There were opportunities through the work being done with the localities to ensure that community support through Local Area Boards, GPs and community co-ordinators could be joined up to reduce duplication and provide clearer preventative pathways. There was a further opportunity to explore how the planned development of community care hubs could align to other services to provide integrated support in the community.
- Integrated discharge teams in the hospitals worked effectively to define the pathway of care out of hospital and to begin that process. However at the next stage of the person's journey there was a lack of integrated working between services which contributed to delays.
- Performance data was very good at describing past performance to the system but it was not clear how it could be used to describe the current position and direct work to relieve system pressures. There was reliance on daily calls and engagement and although this provided a more accurate picture it was resource intensive and there needed to be some robust cross system processes for sharing live data on real-time performance.

How are interagency processes delivered?

- Interagency processes were not embedded across the system and we found that interagency working was dependent on local relationships. For example, there was no alignment of GP communities and local wellbeing boards. Despite there being few formal joint working processes, many frontline staff told us that their teams worked collaboratively owing to knowing each other personally rather than via a systematic approach.
- The Wiltshire Integrated Command Centre (WICC) was managed by Wiltshire Health and Care to provide a single place where intelligence on capacity and flow in the system was centralised and allow the system to respond to multiple system pressures. Wiltshire Health and Care had been established as a limited liability partnership (LLP). This provided a legal framework for its existing activity but also for the future development of an integrated care model. At the time of our review, the partnership's focus was on achieving greater consistency of practice across the organisation. There were missed opportunities for all parts of the system to share learning and develop this approach together.
- There was effective interagency working between the VCSE sector and hospital services in emergency departments to help people to avoid admission and return home safely.

What are the experiences of frontline staff?

- Frontline staff were committed to achieving the best outcomes for people and were genuinely caring in their approach. We saw that there was some frustration that they could not always function in the integrated way that they would like, and it was clear that they would support the development of integrated services.
- Sometimes the support that staff provided to people was more traditional and some work was needed to help staff fully understand what a strength-based approach would look like. For example, one person who was receiving palliative care wanted to go home with a care package which they could fund themselves, but operational staff insisted that the person be assessed for a number of other services before eventually agreeing with the person's initial wishes. This delayed their discharge in the last few months of their life by a number of weeks. System leaders recognised that work was needed to help staff better understand person-centred care and opportunities for people to make their own decisions. In October 2017, a staff conference was held to support staff with a better understanding of this. Staff from a wide range of health and social professions attended but there was a missed opportunity to include staff from the independent care and VCSE sectors.

What are the experiences of people receiving services?

- People were able to access a number of services in the community to prevent social isolation and when they came into contact with services through their GPs there was good support from them to access other services and sign-posting. They were helped to stay well at home for as long as possible.
- However, people sometimes had difficulties accessing services directly, particularly people who funded their own care. Health, social care and social services staff provided support in a caring way however people often had to tell their stories many times as different professionals required different assessments, rather than using a single assessment approach.
- There was a risk that people could experience delays when being discharged from hospital. There was a shortage of care provision to support people at home. People who were at the end of their lives were not prioritised in terms of receiving a package of care.

Are services in Wiltshire 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.

There was a shared vision across health and social care which described the importance of preventative support that would enable people to stay healthy for longer. However, this had not translated into joint strategic developments and operational delivery. The vision was articulated in the Better Care Plan which was developed in 2014. It was widely shared across the county and people who lived in Wiltshire, together with stakeholders such as the VCSE sector and the independent provider market, understood the vision. Although system leaders relied on the Better Care Plan to articulate their vision, in practice it was not being delivered as the CCG and local authority were developing their own transformation programmes. There were some limited joint strategies but not a coherent strategic approach.

There was reliance on a new joint post of CCG accountable officer and Director of Adult Social Services but this was not clearly defined and there was an expectation that this post would develop the integration of services that were already going through a period of transformation.

There was a lack of stability at system leader level with the DASS and the CCG Chief Officer both interim. In the local authority in particular, leadership was not stable as the role of the chief executive was undertaken by corporate directors on a rotational basis and many of the key operational leadership roles in adult social care were also interim.

Strategy, vision and partnership working

System leaders had a vision for the delivery of services in Wiltshire and across primary and secondary health, and social care services there was agreement that there should be a focus on preventative services that enabled people living in Wiltshire to stay healthy for longer. However, this vision was not clearly articulated across, or within, the health and social care organisations. When we spoke with representatives of people who use services in carers' groups, the VCSE sector and independent provider organisations, people told us that a vision for Wiltshire had been unveiled some years ago but they expressed disappointment that it had not, to their knowledge, contributed to the transformation of services; they felt that it was difficult to engage with plans about the future as they did not always come to fruition.

We heard concerns about the functioning of the Health and Wellbeing Board. It was not perceived as a driver for change and was dominated by the local authority. It did not demonstrate effective system working. Although stakeholder partners attended the Health and Wellbeing Board meetings, they did not feel listened to. There was a joint commissioning board that met monthly but we heard that the clinical input into these meetings was not effective.

- There was not a clear system-wide strategy in Wiltshire. The Better Care Plan of 2014 described joined up services and integrated working across organisations with priorities which included supporting people to receive care at home and reducing delayed discharges of care from hospital. However, at the time of our review the CCG and the local authority were moving towards the transformation of services within their own organisations and it was not clear how their activity aligned to the Better Care Plan. Although leaders recognised that it was necessary to transform services to improve the experience of people's care and to make better use of resources, they were not supported by a joined-up overarching strategy that would enable integration to be delivered at pace.
- Leaders in health and social care organisations told us that there was a strategic focus on developing their own organisations before they could look at wider integration. This meant that there were missed opportunities to look at shared priorities and gaps in resources and design joint solutions. Senior leaders in the acute trusts and the community partnership also had visions and plans for their own organisations.
- System leaders had recognised that integration of health and social care services should be a priority and there were plans in place to appoint a joint CCG Accountable Officer and local authority Director of Adult Social Services towards the end of 2018. There was a risk, with the CCG and local authority undergoing their own programmes of transformation, that by the time the joint post was filled, there would be two systems running alongside each other, and potential for duplication of resource and a disjointed pathway of care for older people. The remit of the joint post and the underpinning structure was not clearly defined; this would be important to the post's success because of the significant statutory responsibilities that sit across both organisations.
- We undertook a relational audit that asked people to rate a set of 35 statements from 'consistently true' to 'consistently not true'. Across health and social care, 131 people responded from provider and commissioner organisations as well as the VCSE sector. Their responses reflected the impact of the lack of overarching strategy and one of the bottom five scoring statements was "We plan and implement change together, leading to understanding of the wider impact on other parts of the local system".

- Frontline health and social care staff and people working in the VCSE and independent care sectors told us that the changes in system leadership impacted on their ability to deliver strategies. At the time of our review, both the Director of Adult Social Services and the Chief Officer of the CCG were interim and there had been numerous changes in leadership in recent years. We heard that relationships between the CCG and the local authority had been difficult although under the interim leaders in post at the time of our review there had been improvements. The relational audit showed that senior executives appeared to rate the health of their relationships less positively than those who identified as having a different primary role.
- An “emergent” Sustainability and Transformation Plan’ (STP) for Bath and Northeast Somerset, Swindon and Wiltshire was published in December 2016. Although there were priorities in the plan that we recognised in the local area’s health and social care services, such as integration, prevention and workforce development, the plan was focused on health services. For example, the work around integration was based around primary care services and we heard that at the time of our review, the local authority was developing an integrated community model that was not aligned to GP localities.
- System leaders in health organisations had mixed views regarding the usefulness and purpose of the STP, with leaders from the CCG and one acute trust very much engaged with it while others did not see it as a driver for change. Initially there was little engagement from the local authority and we were told that the STP had been focused on the acute sector, however at the time of our review a Wiltshire County Council cabinet member was vice chair which enabled the local authority to be more involved in the development of the STP.
- The STP plan did not describe an active strategy for driving integration in the local areas. For example, priorities around prevention did not consider the role that social services played and how this could be better utilised. The STP stated a commitment to the integration of health and social care delivery however it did not shape a strategy for this. It described plans at a local level and stated that in Wiltshire there was a “well-established” Better Care Plan. This joint health and social care plan was published in 2014; as this predated the STP by two years there was not clear strategic alignment of the two plans.
- System leaders were not yet using the Better Care Fund (BCF) and the Improved Better Care Fund (iBCF) effectively to jointly shape services to reduce admissions to and improve discharges from, hospital. There were more than 50 separate schemes linked to the BCF. There had been investment in services such as Home First and Help to Live at Home but there had been very little investment in preventative services. The only joint funding through

the iBCF was spent on carers and there was a sense among system leaders that the strands of activity were operated quite separately across health and social care, with much of the fund going into protecting rather than transforming services.

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

- We saw that there was strong engagement with people who live in Wiltshire in terms of shaping priorities. The JSNA had been based on work with local communities through the local area boards and there were individual community plans. However, we did not see that work with people who used services included co-production in terms of the design and delivery of services.
- We saw that there had been an extensive programme gathering the views of people who used services about their health and social care needs and these were shared with system leaders to ensure an understanding of the impact of services on people's daily lives.
- Healthwatch Wiltshire was well-established and served as a voice for people using services. They engaged with local people around a series of thematic reviews that were commissioned by the local authority.

Promoting a culture of interagency and multidisciplinary working

- Views from staff about the culture of interagency and multidisciplinary working were mixed. There was a clear will across all organisations to improve and to work more effectively together however there was not a consistent strategic approach to this. Staff we spoke with told us that integrated activity took place when frontline staff worked to achieve it, but they felt that without strategic support it was not sustainable.
- There had been difficulties in relationships between primary care services, the local authority and the CCG. Although we heard that there was discussion at the Health and Wellbeing Board we also heard that there was a fear of challenging leadership. Leaders stated that there had been a lack of transparency. We saw that disputes about continuing healthcare had impacted on relationships and this was reported at the CCG Audit and Assurance Committee meeting January 2018. At the time of the review, the CCG and the local authority had been unable to agree a dispute resolution protocol and the committee reported that although relationships had been improving, the disputes had resulted in strain. In the meantime, this meant that disputes about funding could not be resolved as partners were reliant on agreeing a protocol before addressing these. There was a risk that people might not be receiving the care they needed while disputes about funding remained unresolved. We heard concerns that while the CCG was developing its 14 localities there was not

effective social care input.

- We heard that although there were pockets of interagency working, there was scope to improve communication between services and better support staff to undertake joint problem-solving to enable people to stay at home safely for longer. The Wiltshire Safeguarding Adults Board (WSAB) had recently completed two safeguarding adults reviews which were due to be published in April 2018. Two older people had died in different circumstances and their deaths might have been prevented. Among the recommendations of the WSAB, a need for a lead worker role was identified, and an agreed approach to shared care planning, when multiple agencies are working with an individual at risk. The board stated that a multiagency approach was required for managing risk in adults with care and support needs.¹
- There were some existing pockets of good practice. Care coordinators linked to GP practices supported people who were at risk of ill-health or losing their independence to access services which would enable them to avoid social isolation and hospital admission. Some care coordinators attended multidisciplinary team meetings and supported people on their journey through services, including hospital. However there was variation in how the role operated as it was not clearly defined, with some care coordinators employed by the community health provider and some directly by GPs. The benefits of this role could be more consistently applied across the county if there was a clear and defined remit.

Learning and improvement across the system

- We were told that the Health and Wellbeing Board was committed to continuous improvement and had participated in peer challenges. However, they did not demonstrate how learning from the peer challenges was disseminated and acted upon and there was not a culture of appreciative enquiry. System leaders and frontline staff agreed that communication could be better across the system to enable sharing of best practice. Staff described that across Wiltshire there was some good work in place but this wasn't linked to a system-wide approach. We observed this in focus groups where staff working in different parts of the county were unaware of initiatives undertaken by colleagues.
- We heard from independent providers that there was a lack of feedback following safeguarding referrals which meant that they could not determine whether the referrals were appropriate and if there was any learning to be taken from them. Safeguarding leads were

¹ Health and Wellbeing Board Agenda papers 29 March 2018

aware of this and a new multi-agency adults safeguarding team (MASH) was due to be in place at the beginning of May 2018; we were told that this would enable more prompt feedback to referrers. Following the safeguarding adults reviews, learning events had been held to support better understanding of safeguarding. Learning needs in areas such as the Mental Capacity Act 2005 had been identified and training was being rolled out. Frontline staff were positive about the difference that the safeguarding work had made and told us they would like to see greater transparency across the system.

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

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

We found that although there was a clear governance framework in place, in practice it did not enable robust system-wide challenge and monitoring. The Joint Commissioning Board was focused on particular areas that had pooled budget arrangements and the Integration Board was newly formed and had not yet had an opportunity to influence the strategic governance of the iBCF.

Information sharing was under-developed. Although there was a shared IT system between primary care providers and the community healthcare provider, there was a lack of sign up from some GP practices to information sharing which meant the benefits of a joint system were lost. Risk sharing was complicated by the development of three A&E delivery boards. Although the Wiltshire CCG led on only one of those, Wiltshire residents would be impacted by the governance processes of the other two that sat just outside Wiltshire boundaries.

Overarching governance arrangements

- There was a three-tier structure for governance of the health and social care system in Wiltshire. It was headed by three local governance groups: the Health and Wellbeing Board, the Wiltshire Cabinet and the Wiltshire CCG Governing Body. They had shared oversight of the Joint Commissioning Board and the Integration and Better Care Board, along with Children Trust Commissioning. The Wiltshire CCG Governing Body had oversight of the Primary Care Commissioning Board, the Clinical Executive and three A&E delivery boards.
- These arrangements had not proved straightforward. For example, the Joint Commissioning Board had oversight of strategies that were managed jointly such as the Dementia Strategy and Carers Strategy but it had not worked effectively to manage commissioning arrangements for the implementation of the Better Care Fund Plan. This had been recognised and an Integration Board had been put in place. The Integration Board was very

new at the time of our review and had not had an opportunity to develop relationships and governance infrastructure. Although the Joint Commissioning Board did meet regularly we heard that there was no significant clinical input into those meetings as stakeholder partners outside the local authority did not feel listened to, or able to challenge.

- Wiltshire was part of an STP which also included Swindon, Bath and North East Somerset. Although the Accountable Officer for the CCG sat on the STP board, the local authority was represented by the elected leader. While it was useful for elected members of Wiltshire Council to engage with and influence the strategic direction of the STP, there was a missed opportunity for system leaders in the local authority to be involved in shaping joint solutions for the region based on their operational knowledge of resources and pressure points.
- There were 18 local area boards with devolved executive functions from the local authority and they were able to engage with people to identify local priorities which fed into the JSNA. However there was a lack of clarity about how these fitted in with the wider health and social care system including the 14 health localities.

Risk sharing across partners

- Risk sharing across partners was not well established and although relationships were improving, there was a lack of transparency in the system that adversely impacted on risk sharing and robust risk mitigation. There were three A&E delivery boards, one for each acute trust, and the Wiltshire CCG led the A&E delivery board in Salisbury as this fell within CCG boundaries. System leaders described this arrangement as complex however they felt that they were “able to work with it”.
- The Health and Wellbeing Board monitored winter pressures but there were missed opportunities to engage with the wider provider market in winter planning. For example, independent care home providers told us that a number of beds had been commissioned to meet anticipated increased demand during the winter period however commissioners had block booked beds that were not being utilised.
- Not all risks identified were recorded on the corporate risk register. For example, the home care mobilisation plan was identified as a significant risk, but this was not cited on the corporate risk register.

Information governance arrangements across the system

- Information management and governance was organisationally based and there were not clear processes for sharing information at system level or operational level. There was still a traditional and siloed approach to information sharing and this reflected that organisations

were not working as one system. Although we acknowledge the importance of good information governance, professional silos around protection of information meant that staff were not focusing on the needs of the individual moving through the pathway.

- There were three different hospital information systems. GPs and the community provider used SystemOne and the three hospitals could access information from SystemOne through viewers. Social workers used CareFirst, as separate system, however the contract with CareFirst was due to end in March 2018 and the local authority was exploring options in line with the digital strategy. Information sharing from social care systems was being facilitated through a 'Single View' project which was designed to enable information sharing across most aspects of the local authority's business such as council tax and refuse collection, and including adult social care. This was in its early stages at the time of our review. Hospital staff we spoke with did not describe this and some frontline staff told us they could not access information when they needed it.
- All primary care services and Wiltshire Health and Care were using SystemOne which facilitated information sharing, but there was a low sign up from GPs to the sharing of information. The system required GPs to obtain patient consent for records to be shared and GPs were not always signed up to this. There was a risk when the out-of-hours provider moves to a new system, information will not be shared between the out-of-hours service and GPs which may mean that more people will be referred to A&E owing to a lack of access to relevant information.

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

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

We found that system leaders recognised workforce pressures as a significant risk; however despite some proactive work at STP level with the support of Health Education England, there was not a strong strategic local focus. The local authority and CCG were not working together or with the independent sector to develop solutions. Staff turnover and vacancies in the independent adult social care sector had risen sharply although the staff turnover rate was lower in two of the three hospitals that Wiltshire residents used. Although solutions were being sought these were not proactively driven and managed.

System level workforce planning

- There was no strategic workforce plan for Wiltshire and the connections between the STP and Wiltshire were rudimentary. The CCG and the local authority had representatives on the STP workforce action board, but they did not work closely together.
- System leaders told us in their response to the SOIR that workforce was recognised as the most significant issue facing Wiltshire. Capacity and skills development were described as an “enabler” within the STP and a work group was focused on this, with support from Health Education England. Although the governance structure was in place at STP level, and work looking at planning across the STP system partners had begun, it was still at an early stage of development.
- The workforce development lead (joint for the CCG and local authority) took reports regarding workforce strategy to the Health and Wellbeing Board and the Joint Commissioning Board to ensure that they were updated with issues and actions. These updates were well received by the boards but, given that workforce was described as a significant issue, we did not see how the reports were used to hold organisations to account with regard to workforce development or drive forward the workforce development agenda.

Developing a skilled and sustainable workforce

- The turnover rate of staff in the adult social care sector had sharply increased in 2015/16 and at 34% was higher than the England average of 27.8% and the comparator average of 30.5%. Although the vacancy rate had risen from 3.8% in 2013/14 to 6.8% in 2015/16, it was at the time of our review in line with the comparator average of 6.9% and slightly above the England average of 6.6%.
- The Wiltshire Workforce Action Group had developed a website, ‘Proud to Care’, but we heard that there was no clear partnership agreement of how this work would be taken forward. We tested the website and could see that to be effective it required further development. It was directed at encouraging care workers (sometimes referred to on the website as carers, which could cause confusion with people in unpaid caring roles) and provided links to the CCG, hospitals and local authority jobs sites. It was not clear from using the links how the advertised jobs related to the ‘Proud to Care’ website. There was a further missed opportunity given the shortage of care workers in the independent social care sector, to enable independent providers to link to the website.
- There was an initiative to develop workforce through apprenticeships across the STP footprint including funding support from Health Education England, and further positive initiatives to share training across health and social care. Some of this, such as health coaching and dementia awareness, was funded by the Better Care Fund (BCF).

- System leaders needed to ensure that the profile of workforce pressures was raised with stakeholder partners. For example, the workforce lead had drafted a letter to the Local Enterprise Partnership (LEP) via the Health and Wellbeing Board to request that health and care be included as one of the areas within its apprenticeship programme. No response had been received nor any action followed up.

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

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

We found that joint strategic commissioning was underdeveloped, particularly around the use of the BCF and iBCF. There had been some arrangements put in place, such as the formation of the Wiltshire Health and Care LLP, which could drive forward the delivery of integrated services; however this was not yet being used to its full potential. Although there were fewer services rated as inadequate, the care home and domiciliary care market overall was still of a lower quality standard than similar areas and commissioners needed to take a more proactive approach in improving the quality of services for people in Wiltshire. Contract management was underdeveloped and large contracts were at risk owing to a lack of collaboration between providers and commissioners.

Strategic approach to commissioning

- At the time of our review, joint commissioning was not well developed and system leaders agreed that it was limited. Although there was an ambition to develop this further the CCG and local authority were focused on dealing with their own financial issues and problems. The Joint Commissioning Board focused on strands of activity that were already jointly commissioned such as the Carers Strategy and the Dementia Strategy. There were also aligned budgets for carers' services and drug and alcohol services with aligned commissioning arrangements for intermediate care beds, community equipment, voluntary sector services and acute liaison services to support hospital discharge.

- Wiltshire had a Better Care Plan which was devised in 2014. There was not an updated strategic plan for the health and social care system. System leaders told us in the SOIR that joint commissioning structures and staffing arrangements had been developed for a range of discharge and intermediate care schemes which form the Better Care Plan. They told us that there were advanced discussions to recruit to a joint accountable officer and corporate director for Adult Social Services. This would be managed within a section 75 agreement, allowing services to be commissioned in an integrated manner.
- There were missed opportunities to jointly commission solutions such as packages of care at home, the lack of which was the largest cause of delayed discharges. Home First was a reablement service provided for 10 days by the community health partnership following discharge from hospital. After the 10 days reablement, it was intended that people would transfer to a new in-house reablement service which was due to transition from contracted services during the period of May to September 2018. This meant that people were transitioning between services and this could be streamlined. There was a lack of trust and transparency and this was highlighted when one of the benefits of bringing reablement in-house was described as “an ability to challenge any over-prescription of care by acute NHS colleagues and reduce demand for care at the point of hospital discharge”. People in Wiltshire would be served better if system leaders worked together at an earlier stage to determine criteria for people who would benefit from reablement.
- There was not a cohesive plan for the use of the BCF and iBCF, which provided an opportunity to develop integrated services; the BCF had been utilised to develop more than 50 different projects. The interim Director of Adult Social Services and the CCG Chief Officer had recognised this shortfall and appointed a portfolio delivery manager to rationalise the plans and align them to the high impact change model.

Market shaping

- Pressures on reablement services were recognised by system leaders and they planned to bring the reablement service in-house. This would be a significant mobilisation of services in a short period of time; we were not assured that there were contingencies in place should risks materialise, particularly owing to workforce challenges in Wiltshire.
- System leaders recognised that that market shaping and quality assurance required development. A market intelligence team had been put in place and the quality surveillance group focused on the quality of the care home market. Work was still needed to develop services in Wiltshire although CQC inspectors in Wiltshire told us that there had been improvements.

- Providers were not involved in the shaping of services. Some providers attended the Joint Commissioning Board meetings and the Health and Wellbeing Board. However, VCSE providers and independent health and social care providers were not engaged and their expertise was not used to develop market proposals.
- Social care providers told us that there was a lack of understanding of the services they were able to provide and felt that they were not engaged in discussions about the future of services. In addition, social care providers faced particular challenges owing to the rural nature of the county which impacted on travel. This in turn could impact on timeliness of visits and the quality of the experience for the person using services.
- CQC inspectors told us that their relationships with commissioners had improved and that there had been an improvement in quality monitoring of adult social care services. In March 2017, two per cent of community support and domiciliary care services and three per cent of residential and nursing care services were rated as inadequate. In March 2018, there were no community support and domiciliary care services rated as inadequate and one per cent of residential and nursing care services were rated as inadequate. However, quality in the market needed to be improved further. Our data showed that the percentage of nursing homes rated as requires improvement was, at 42%, significantly higher than the comparator average of 33% and the England average of 25%. The percentage of services rated outstanding was also higher at 6% than the England average and comparator average of 2%. Residential care home provision was also poorer with 21% of services rated as requires improvement compared to the England average of 15% and the comparator average of 13%. There were more domiciliary care providers requiring improvement with 17% of domiciliary care providers rated as requires improvement compared to the England average of 11% and a comparator average of 11%.

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

- There was no clear single strategic plan to address the interfaces between health and social care. Although system leaders advocated person-centred care and a strength based approach to delivery of services, they had not formally put operational plans in place to improve care provided at the interface. The Better Care Plan described a seamless transition between services based on support from a GP cluster approach. While there was good support for people from care coordinators working with GPs, the local authority was in the process of designing a community model that did align with the GP clusters. There was a risk that health and social care services would become more disjointed.

- The creation of the Wiltshire Health and Care LLP (WHC) as a legal entity was key to the development of integrated services between health and social care. However, services were not yet being jointly commissioned to manage this. For example, WHC provided the Home First service which supported people with rehabilitation on their discharge from hospital. This service was available for ten days and then people would transfer to the local authority commissioned provider of reablement, which it was planning to bring in-house. This was a missed opportunity to provide an integrated service and the services were being developed independently within each organisation, albeit with a stated ambition to ensure alignment.
- System leaders told us that there were 18 local area boards with devolved executive functions, and a local Health and Wellbeing Board with a dedicated budget for community based services as well as a dedicated champion for older people in the area. These forums used community area JSNAs and engaged on priorities and service changes. It was not clear how they interfaced with the 14 health localities.

Contract oversight

- We found that contract design and management was not robust. There was a variety of models in operation and no evidence of a systematic approach to evaluating different approaches. Contracts were awarded with a reliance on key performance indicators to demonstrate success rather than clear specifications about how the services would be delivered and how delivery would lead to success and improved outcomes for people.
- We saw a number of examples where contracts failed and providers could not meet key indicators. We saw that although there were clear indicators around delivery there was no implementation support to enable providers to deliver services in a different way. For example, the patient transport service had been contracted to cover Wiltshire and three other CCG areas (Gloucester, Swindon and Bath and North East Somerset), but the provider could not meet the key performance indicators (KPIs) owing to demand.
- There was acceptance by system leaders that KPIs were “unrealistic” and had not factored in the specific issues arising from the geography of Wiltshire, and issues such as peak times for discharges and appointments. As commissioners recognised this, they supported the provider by spot purchasing transport and one hospital had received funding to provide their own service. Although we were told that a single transport provider gave greater insight into the market regarding patient transport needs, this advantage was lost with the increase in funding other solutions.
- A Help to Live at Home service was commissioned from domiciliary care providers to provide short-term reablement and ongoing care packages of care at home. The work at the

time was seen as innovative as contracts for packages of care were intended to be outcome based rather than time and task based. Contracts were awarded to four providers across 14 geographical areas. At the time our review, contracts were only held with two providers who could not meet the demand on the service and there was a reliance on spot purchasing of care packages. A recent evaluation found that the spot purchased market had no commissioning performance framework or monitoring of outcomes which meant that the effectiveness of reablement could not be demonstrated. Following some serious concerns, the CQC had put an embargo in place with one provider in November 2014 and there were no commissioning contingencies to support new packages of care while this was in place.

- A recent review of the Help to Live at Home contract showed that commissioners recognised that a new commissioning strategy must have contingencies in place to safeguard against provider failure. However, the reablement service was being brought in-house to the local authority. This was planned as a phased approach so that people receiving reablement could continue with the existing provider and from May 2018, new packages of care would be delivered in-house. It was not clear that risks and contingencies had been identified, for example there was reliance on successful recruitment and transfer of staff across from provider organisations where the workforce was already challenged and system leaders did not demonstrate a clear understanding of the level of demand that would be placed on the service.
- Social care providers told us that intermediate care therapy contracts were more successful because there was a more collaborative approach. They described the contract management process as more streamlined with clear contacts so that if there were concerns about the contract, providers could easily identify who they needed to speak with and found that there was a willingness to deal with issues as they arose in a productive and proactive way.

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

We looked at resource governance and how systems assure themselves that resources are being used to achieve sustainable high-quality care and promote people’s independence. We found that resources were not being used to effect joint solutions to pressures in the system.

The development of the BCF planning and work was in its early stages and had not been addressed in a joined up and systematic way. There was a risk to this being embedded as it was being led by an interim post holder. There were missed opportunities to improve governance structures across the system in ways that would enable funds to flow to pressure points in the

system.

- There was no proactive approach to the joint funding of health and social care across Wiltshire. Although there had previously been some discussion with the Health Scrutiny Committee about the total spend on health and social care in Wiltshire, this had not been developed into a proactive approach to the joint management of spend in the county. There was a risk of duplication in the use of resources and the lack of a more streamlined and transparent approach meant opportunities to explore options for savings were missed.
- The local authority had updated their charging policy to reflect the national guidance and we heard that significant financial benefit had largely come from an improved process such as ensuring that people had up-to-date financial assessments. There had also been a positive initiative to support people to access benefits.
- System leaders in the local authority did not always use funding effectively. While budgets were managed so that there were no overspends, money that could have been used to tackle reablement problems had been returned to Central Government. With a clearer governance structure around the commissioning of services across health and social care, budgets could be used more effectively to address pinch points in the system.
- The BCF was being used to pump prime the ASC transformation agenda, including for example, the funding of a post that supported transformational change across adult social care and finance. When the iBCF was granted, the local authority developed a series of proposals which were shared with the CCG and WHC for discussion and agreement.
- The BCF plan had been very late in its development with no clear ownership until shortly before our review. At the time of our review there were over 50 work streams aligned to the BCF. Although this described many pockets of joint work, there was no system-wide foundation to underpin this or a clear structure. System leaders had recognised this and employed a delivery lead to rationalise the different strands and an Integration Board had been set up. The focus of the board was on reducing delayed transfers of care (DTC) which was a significant priority for Wiltshire but there needed to be wider work on system flow. The delivery lead was employed on an interim short-term contract, which posed another risk to achieving a more streamlined approach.
- System leaders did not always look to other areas to learn from best practice in relation to the management of resources. For example, in Wiltshire DTC were high but in a neighbouring authority they had decreased significantly. There was an opportunity to share learning as 30% of people living in Wiltshire used the same hospital as the neighbouring

authority.

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 Wiltshire safe?

People were supported to stay safely at home for as long as possible through the work of GPs and care coordinators. This enabled early warnings for people whose health may have been at risk of deteriorating. However, it was not always clear how these risks were managed once they were identified. Care coordinators supported people at risk of social isolation.

The management of safeguarding referrals needed to be improved. This was being addressed with the provision of additional resources and the formation of a multi-agency safeguarding hub to take effect from May 2018.

- GPs were key in supporting people to stay safe. GPs undertook risk stratification and system leaders told us that in their view this worked effectively. People were assessed when necessary using the Rockwood Clinical Frailty Scale to determine whether they would benefit from increased support and health monitoring. However we saw a case study that showed that although a person had been assessed and was identified as being at risk of falls, there was no clear action undertaken and they had multiple falls after the assessment, two of which resulted in attendance at A&E.
- There were systems in place to identify people who were frail or who were at risk of deterioration in their health or social situation. GP surgeries were linked with care coordinators who played a key role in identifying concerns early on. For example, we saw that a care coordinator had become concerned about the potential financial abuse of an older person. They raised a safeguarding alert and proactively supported the person through their pathway of care, liaising with other services. Care coordinators also played a role in signposting people to community services, reducing the risk of social isolation.
- We found GPs recognised the risks facing older people living in Wiltshire and that their interventions supported people to stay safe at home for as long as possible. Although there was not a consistent response from GPs if someone became unwell – for example some would prescribe without the need for a visit, some would do a home visit and some would send a district nurse – people told us that they could access support from GPs when they needed it. Care home providers told us that relationships with GPs were generally good and that their support was available when needed.

- Although our data showed that there were no GPs in Wiltshire offering full provision of extended access, 98% offered partial provision of extended access compared to the England average of 61% and 70% average in comparator areas. Only 2% of GPs in Wiltshire did not offer any extended access, compared to the England average of 12% and 14% in comparator areas. This meant that people could access pre-bookable appointments on at least one day of the week outside core contracted hours. CQC ratings showed that there were no GPs rated as inadequate or requires improvement, and 15% were rated outstanding, compared to the England average of 4% and 6% in comparator areas.
- The impact of the support from GPs was reflected in the data which showed that the rate of A&E attendances and emergency admissions for older people in Wiltshire was lower than the England average. The rate of A&E attendances per 100,000 population aged over 65 was 7,416 compared to the England rate of 10,534. The rate of emergency admissions per 100,000 population aged over 65 was 19,998 compared to the England rate of 25,009.
- People we spoke with told us that there had been some work in the past commissioned by the CCG to review people's medicines so that people could be assured that they were taking the right dosages of the right medicines for them. However, this was described as having "fallen by the wayside" which meant that the health benefits for people living in Wiltshire were lost and there was a lost opportunity to reduce costs.
- At the time of our review, system safeguarding processes were not always effective. We saw from a case study that although an alert was raised regarding potential financial abuse of an older person, there was a wait of five months before an investigation took place. In addition, we viewed an assessment of this person's needs and were not assured that the safeguarding matter had been considered; the care plan involved the support of some people who were subject to the investigation. Although this was ultimately resolved, the delay in investigation and communication about the concerns may have placed this person at risk of harm. We were told that system leaders understood that safeguarding needed to be addressed and additional resources were being put in place to improve this with additional staff and business support. A multi-agency safeguarding hub (MASH) was being rolled out with the local authority, CCG and police as partners and was due to be implemented in May 2018.

Are services in Wiltshire effective?

There was a focus on designing and delivering services that would maintain people in their own homes. However, design and delivery of services were disjointed and developed in local pockets that did not promote wider system learning or consistency. GPs led on work to enable people to

access community support and avoid hospital admissions with some innovative practice around the use of intermediate care beds in the east of the county. Staff missed opportunities to share good practice and there were no clear plans to promote skills that would enable integrated working although it was recognised as a need.

Although older people living in Wiltshire had the opportunity to inform the assessment of local needs, they were not given opportunities to be involved in the further development of plans.

- Services were intended to be holistic with support around the person to enable them to stay well at home. However we found that in many instances health and social care services worked separately. This included two separate “single” points of access. We viewed case studies where a number of professionals were involved in supporting people with different aspects of their lives, however from the case files we saw, and from people we spoke with, it was evident that people had to fit into the services available, rather than the services fitting around the person. The language of assessments and forms were professionalised and not easy for people who needed support to understand or navigate.
- There was some good practice arising from different parts of the local authority working together. For example, a decision had been made to consider the eviction of a social housing tenant owing to odours and clutter from the person’s property which had caused neighbours to complain. The housing team contacted the adult social care team who were able to work with the person, which improved their health and quality of life and meant that the person did not lose their home. However interagency working between health and adult social care services needed to improve and one of the safeguarding adults reviews found that health and social care agencies had not shared information which meant that the person had not received the support they needed and subsequently died.
- Our data showed that in 2016/17, 25.8% of people aged 65 or over who accessed long-term adult social care in Wiltshire received direct payments. This was much higher than the England average of 17.6% and the comparator average of 16.5%. This enabled people to manage their own packages of care in the way that they chose. There was a lower uptake of personal health budgets, 2.07 per 50,000 population, compared to the England average of 5.82. System leaders told us in the system overview information return that they were working to increase this with the support of a VCSE organisation.
- There had been significant consultation with people who lived in Wiltshire through the 18 Local Area Boards, and this had been used to develop the JSNA. This helped the local authority to identify system priorities and showed that most of the communities had concerns about health and social care.

- Elected council members told us that there would be a focus on universal services and support in the community, which they hoped would enable people to stay in their homes as long as possible. There was recognition that communities across the county would have different needs, however this meant that communities were developing services at their own pace without a clear strategic intent. For example, the CCG provided funding to GPs for a local enhanced service (LES) to care homes. This was at different stages across the county. Care home providers who received this service told us it worked well and that it enabled them to support people to remain out of hospital, while other areas of the county were still in transition. Although this was not fully embedded, data indicated that the LES was effective.
- Avoidable admissions to hospital from care homes in Wiltshire were low compared to similar areas and the England average, and significantly lower with regard to admissions resulting from pneumonia. However the numbers of people admitted as a result of accident or injury was higher than similar areas and the England average.
- There were plans to move adult social care contact centres from three localities to a single advice and contact team in May 2018, and these would include new information officer roles. This was expected to reduce the high rate of abandoned calls. However this development was limited to adult social services. System leaders told that a move towards better integration with the community health provider would improve the prevention focus but this wish had not been translated into plans for delivery.
- Funding streams were available to encourage local services to develop preventative support for people in their areas. GPs were receiving the Transforming Care for Older People fund. It was their responsibility to put forward proposals to show how the use of the fund would improve outcomes for older people in their area and if the proposal was approved, the funds would be allocated. Better Care Fund money was used innovatively in the east of the county where GPs jointly commissioned intermediate care beds so that people could avoid hospital admission. This was coordinated by a single practice manager. However, when we spoke with commissioners, those who commissioned intermediate care beds in other parts of the county were not aware of this arrangement, which meant an opportunity to share learning and resources had been missed.
- The relationships between care homes and the local pharmacies were also seen as key to keeping people safe and reducing hospital admissions. However these relationships were not formal and were dependent on individual care workers making contact with the pharmacies.

- Frontline staff told us that people were more likely to be admitted to hospital out-of-hours when their own GP was not available. They said that they had seen some improvement when an independent provider took on the out-of-hours contract, however this provider could not access people's GP records which meant that they did not always have the information they needed to support people to stay at home. The out-of-hours provider was unable to access support from district nurses after 10pm or palliative care teams after 9pm which again meant that people might be admitted to hospital when they could be better supported at home.
- The VCSE sector was granted "innovation funds" to develop local community services. Again, while this encouraged innovation, it showed that there was not a system-wide approach to working with the VCSE sector. Innovation funds were also granted to domiciliary care agencies to enable them to address workforce issues. Some agencies had put in place new ways of addressing the staffing shortfall such as offering to pay for driving lessons for newly recruited care workers. The local authority would pay half of the grant on approval of a proposal and the balance would be paid when results were achieved.
- System leaders recognised the areas that needed to be addressed to support an integrated workforce and work was ongoing through the workforce group to address this. However much of this was in very early stages of development; for example, system leaders were looking at how to develop the skill mix of staff but did not articulate what this meant in terms of timely plans and actions. Frontline staff missed opportunities to learn from each other as they were siloed within their own organisations or within communities. Frontline staff showed willingness to learn and improve and many groups we spoke with felt that learning opportunities such as those from safeguarding referrals were being missed.

Are services in Wiltshire caring?

Staff who supported people living in Wiltshire were caring in their approach. There was a clear will to put the person at the heart of services but health services did not always adopt an enabling approach. GPs played a prominent role in enabling people to access services, but people who tried to access services through different routes struggled to navigate the system. Families and advocates were involved in care planning but were not always listened to when people became unwell.

- Frontline staff in health and social care, including VCSE organisations and independent providers, were all clear that the person needed to be at the centre of their care. However, in practice, wanting what was best for the person sometimes manifested in a paternalistic approach with services being delivered to, or imposed upon, people. This was

acknowledged by staff we spoke with. Case studies showed that social services plans were more focused on people's needs and goals but health and therapy records tended to be time and task focused, maintaining a view of people as patients rather than taking a holistic approach.

- A VCSE organisation had undertaken some research in part of the county and found that in general, older people had a negative view of the services on offer to them – such as coffee mornings – and would prefer support to maintain normal community relationships, such as visiting the hairdresser and shops, and receiving simple forms of support within their community, such as someone helping them to put their bins out. People wanted to have a continued sense of purpose. For example, an older person who suffered from a disability was becoming depressed and socially isolated but did not want to attend the services on offer as they felt they had no purpose. A local church asked the person to sew squares for blankets and the person went on to run a sewing group that made items for the community.
- There was some good support from the CCG with regard to winter planning to ensure that people had information about flu immunisation and pharmacy support. More generally, people struggled to access information about services, particularly if they were funding their own support. People we spoke with told us they were reluctant to contact the local authority for advice as their experience of doing so felt more like a financial assessment than a discussion about, and signposting for their needs. Many of the focus groups we spoke with told us that GPs were most often the gateway to services for people. However GPs expressed frustration that when they tried to make referrals on people's behalf they were put in the same call centre queue as the general public; they could struggle to get through to services which caused frustration and was a poor use of their time.
- The local authority ran a website 'Your Care, Your Support' but it was not easy to use. It supplied a lot of information about what services meant, for example, what intermediate care was, but it did not help direct the reader to the right services for their needs. Rather, they would need to read a large amount of information about different services with different links to the CCG, Wiltshire Health and Care, NHS England, Department of Health and local authority websites.
- When people's needs were assessed, families and advocates were involved in supporting people to make choices about their plans. We saw in case studies that family members and friends were involved in assessments. People who used services told us that there was good support for them from VCSE organisations such as Alzheimer's Support. However some carers told us that they found themselves becoming service coordinators when supporting their friends or family as communication between agencies was poor. People

living in an extra care housing scheme relied on their housing officers to support them to navigate the system and we heard from people living at one of the services that the housing officers' support was paramount to enabling people to retain their independence.

- The dignity and respect due to people was compromised by poor communication. People felt that they had to tell their stories multiple times as they moved between services. Advanced care plans were not always considered when people were at the end of their lives. Occasionally ambulance services and GPs could be risk averse and admit people who were at the end of their lives to hospital despite their wishes not to go. We were provided with an example of a person who was at the end of their life and living in a care home, and who had an advanced directive that stated that they no longer wished to be admitted to hospital. They had a fall in the home at 9pm and were not seen by paramedics until 7am the following morning, at which point they chose to admit the person. The person ended up very distressed as they were moved five times in 24 hours before their family member was able to convince the hospital to allow them to return home. The carer felt that decision about their family member's care by clinicians was based on purely on the person's presentation at the hospital and did not take into account the carer's understanding of their family member's needs and wishes.

Are services in Wiltshire responsive?

Some services in Wiltshire were responsive to people's needs so that they could stay in their usual place of residence for as long as possible. Much of this was facilitated by GPs and the VCSE sector. In one part of the county there was a specialist geriatrician to support people and prevent hospital admissions, and the Urgent Care at Home Service provided 72 hours of care to help people to live at home. However the service was not always able to meet demand and this impacted on its success. Some services were only available at hospitals and there was a lack of reliable transport for accessing community services and outpatient appointments which meant that people were at risk of isolation and deterioration in their health.

- There were arrangements to ensure that people could be seen in the right place and by the right person to avoid hospital admission however these services were under pressure which meant that arrangements were not always timely. There was high intensity community support available through the Urgent Care at Home Service which provided 72 hours of care and support to people in their homes to prevent hospital admission. However, there was not enough capacity in the system to support this and people still had to wait for support which meant in the meantime they might require a hospital admission.
- We found evidence of innovation led by GPs which contributed to people staying at home and out of hospital. These included a community heart failure pilot which had led to a reduction in hospital admissions, and was due for roll out across the county during 2018.

Also, a dementia screening service with access to memory clinics, a psycho-geriatrician and referral to the Alzheimer's Support Centre. We heard that GPs in parts of Wiltshire had direct access to hospital consultants which helped prevent admissions.

- The system's own BCF performance dashboard for February 2018 showed that although there were more referrals to the Urgent Care at Home Service in 2017/18 than in the previous year, the service was less effective than it had been in previous years, and was not being utilised as widely as it had been in 2015/16. The system dashboard showed that, on average, fewer hospital admissions were avoided through the use of the service.
- There was increasing use of technology to support people in their homes. For example, the urgent care provider had a contract for aids such as falls alarms. We were also provided with an example of a person in a care home who needed to see a consultant dermatologist but became distressed when they needed to leave their room. The consultant was able to view the person through a video link which meant the person felt safe while still having their health needs attended to.
- Changes were being made to services to improve people's experiences and reduce admissions. For example, the independent urgent care and out-of-hours provider was due to link with the 111 service in May 2018. This was being commissioned by the three CCGs operating across the STP footprint. When the 111 service received calls about people over the age of 85, and once they had established that the person did not have an urgent life-threatening condition, the call would be transferred to the out-of-hours provider who could support people more appropriately according to their needs. However, there were risks to this as the out-of-hours provider did not have access to GP records and there was no overnight support from district nursing teams. The community health provider was considering implementing additional community based support such as enabling district nurses to administer intravenous antibiotics, but there were concerns about maintaining the levels of training required and if out-of-hours support was not available this could also impede the effectiveness of this scheme.
- In the north of the county a specialist geriatrician participated in multidisciplinary team visits to support older people and our case studies showed that there was often involvement from a range of health and social care professionals when people needed support.
- Wiltshire is a large rural county with the acute trusts near the north, west and south borders of the county. Transport was a significant problem which impacted on the ability of people to attend outpatient appointments and support services. People who attended support groups such as Music for the Mind told us that if they did not have their own transport they would

not be able to access services. Some basic services were not easily available without travelling long distances. For example, if people needed to have their hearing aids cleaned and maintained, they needed to go to one of the hospitals on the borders of the county. At one of the voluntary services that people attended, one person brought along equipment to help people with their hearing aids. This was a good example of people in the community supporting each other, but system leaders had not recognised and promoted this as a solution, despite it having a big impact on the quality of people's lives. One GP surgery had x-ray facilities which meant that people in area this would not have to travel large distances for appointments.

- The CCG coordinated the walk-in centres across the county. Local data showed that there were between 1,100 and 1,800 attendances per month at each minor injury unit (MIU). Opening times were 7am to 11pm daily, with support from a co-located x-ray department 9am to 5pm, Monday to Friday. Wiltshire Health and Care and the CCG published information online advising people what could be treated at the MIUs and when they should attend A&E.
- An engagement event was held in August 2017 with groups of people that included carers and people who used services. They identified a lack of continuity of care as they moved between services as a problem; they stated that frequent changes in social work staff meant that they had to tell their story often, information about them was stored on different systems, and requests for support were often slow to be managed. People felt that the requirement to undertake repeated assessments with different health and social care professionals reflected a lack of trust in the system as well as being burdensome to staff and the people who used services.
- People who attended the engagement event also fed back that the eligibility criteria for access to services was confusing and difficult to understand. There was a risk that people were deterred from contacting services for support and missed opportunities to access preventative services. Telecare services were provided by an independent provider as part of a reablement package to support people in their homes. However when the six week reablement period ended, people would be assessed and may need to pay for the telecare service that they had been receiving. This was not always clearly explained to people at the outset.

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 Wiltshire safe?

When people were in crisis and required support, there were systems and processes in place to ensure that they were safe. Staff across all sectors were appropriately trained to recognise risk, and generally knew how to escalate concerns. Teams worked collaboratively to support people at risk, and reduce any potential harm. Referrals for Deprivation of Liberty Safeguards (DoLS) were not routinely tracked or assessed by the local authority, with acute hospitals managing DoLS locally.

None of the three acute hospitals providing care for people in Wiltshire met the A&E waiting time target. All acute hospitals had front door teams who assessed frail elderly people on admission to identify the best treatment pathways, resulting in a large number of people being discharged home within 48 hours of crisis. However, bed occupancy was consistently worse than the recommended level in the three acute hospitals. The average length of stay in hospital for people from Wiltshire over 65 was higher than the England average.

Staff were able to access crisis support such as escalation beds or 72-hour care; however this was not consistent across the county. There was a disparity in the access to intermediate care or respite care beds according to people's location within the county

- People with complex needs or those who were at risk of deterioration, but did not need to stay in hospital were signposted to additional support mechanisms within the community. For example, someone admitted into A&E with a history of falls, would be referred to the falls clinic and the community occupational therapists on discharge from hospital. Staff reported speaking directly to community matrons, GPs and VCSE services to create links of support across the county for individuals.
- The local authority and the CCG jointly commissioned Urgent Care at Home, which provided up to 72 hours domiciliary care for people who require urgent support. This could be accessed through the GP who liaised with the care coordinators and Wiltshire Health and Care. If respite or an inpatient stay was required, GPs in the south of the county were able to directly access intermediate care beds or commission beds within a nursing home for up to two weeks. This service was only available within the south of the county.
- From May 2018, the Integrated Urgent Care service was planned to combine with NHS111

and the GP out-of-hours services to provide a single point of access for health and care. At the time of our review GPs did not have priority access to the service, using the same helpline phone number as the general public to make contact with services. To reduce time spent making referrals, the CCG was planning to commission improved access to the service for GPs from April 2018, with 100% coverage by October 2018.

- People in crisis were assessed on admission to hospital to determine what was needed to manage the person's clinical condition and maintain their safety. All acute hospitals provided a multidisciplinary team who assessed frail elderly people on admission, either within the accident and emergency department or acute admission areas. The teams comprised physiotherapists, occupational therapist and nurses. All were senior, experienced clinicians who were able to make decisions about people in care pathways. Working hours of this service varied according to the location, but all had a reduced service at weekends. Salisbury NHS Foundation Trust was the only front door team that reported direct links with a consultant geriatrician.
- All people were assessed on admission by the "front door assessment team" to identify any interventions that could have been implemented to facilitate discharge, for example, a person admitted following a fall, may require a walking aid for stability. These people could be assessed by a therapist and discharged the same day with equipment. The front door teams also referred people to the correct provider for ongoing care. Salisbury NHS Foundation Trust's team, were also able to directly refer people to intermediate care beds.
- There were systems and processes in place to ensure that people in crisis were supported through the health service. This included the escalation of concerns through a standardised safeguarding framework. All hospital nursing staff were familiar with safeguarding policies and referral processes, although some had not participated in any referrals. Staff were provided with mandatory safeguarding training appropriate to their role and responsibilities. Community care coordinators were also familiar with referral processes.
- We were told that safeguarding information was not available on the IT system, which meant that there was not a robust process for monitoring referrals. All acute hospitals reported that there were safeguarding leads who assisted with the tracking of patient concerns. They also provided support for ward staff for difficult cases.
- Deprivation of Liberty Safeguards (DoLS) referrals were not routinely followed up by the local authority. Nursing staff reported that they completed referrals and did not receive information back regarding safeguarding assessments or details of patient advocates. The community hospital reported that they had one patient advocate allocated in the four years

that they had worked within the department. Patients were tracked internally with DoLS maintained until the person was either discharged or their clinical condition changed.

- There were plans to introduce the National Early Warning Score (NEWS) into residential and nursing homes, although there was no timescale for completion of the project. The system is widely used in acute hospitals to identify people at risk of deterioration based on a point system allocated to clinical observations. It was thought that the introduction of NEWS would facilitate timely and appropriate referrals to hospital.
- The NHS constitution sets out that a minimum of 95% of people attending accident and emergency departments must be seen, treated and then admitted or discharged in under four hours. This is one of the core standards and often referred to as the four-hour target. Data showed that Salisbury NHS Foundation Trust met this target from April 2014 to April 2015, and performed better than the England average in 2015/16 and 2016/17 (90.8 to 94.8% compared to 89.1 to 91.9%). The Royal United Hospitals Bath NHS Foundation Trust and the Great Western Hospitals NHS Foundation Trust did not meet the 95% target in the same period (April 2014 to March 2017). Both consistently performed worse than the England average for the same period (83.3 to 91.9%). All trusts had declining performance.
- 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. Data showed that bed occupancy was consistently higher than the England average in the Great Western Hospital NHS Foundation Trust (92-95%) and the Royal United Hospitals Bath NHS Foundation Trust (91-97%), from April 2016 to June 2017. Data for Salisbury NHS Foundation Trust showed bed occupancy between 77 and 90% for the same period. During our review, we were told that bed occupancy remained an issue with occupancy frequently higher than 100% (between 95 to 112%).
- The average length of stay in hospital for people in Wiltshire aged over 65 years was 23 days from September 2016 to August 2017. This was worse than in 11 of the 15 comparator areas. Between the last quarter of 2016 and the first quarter in 2017, there was an upward trend in the proportion of emergency admissions for people over 65 years which lasted longer than seven days. Data showed 36% of admissions of older people from Wiltshire lasted longer than seven days in April to June 2017, compared to the England and comparator averages of 32%.

Are services in Wiltshire effective?

System leaders had supported the development of front door teams to reduce admissions to

hospital and data demonstrated that this was effective. However, hours of operation were not always aligned to activity. Admission pathways to acute hospitals did not always bypass the accident and emergency department, and were not always designed to meet the needs of people with dementia. There were systems in place to provide people with emergency care if they were discharged within 48 hours of admission to hospital; however after this time, a referral to the discharge team was required.

Health and social care teams were co-located on wards to assist with discharge planning. The IT infrastructure did not promote joined up working with different systems available to each service which limited ability to share information. Pathways for discharge were established; however, the capacity to deliver against each pathway was limited by resources. Community and acute hospital staff felt that there was little proactive in-reach from community staff relating to people admitted into hospital to promote early discharge. The introduction of the Wiltshire Control Centre had promoted a more streamlined approach to patient flow. Home First was able to buffer delays in long term packages of care to prevent inpatient waits. There were some delays in mental health assessments which affected people's length of stay in hospital. All hospitals used a red and green day system to identify how they could ensure timely discharge.

- Services were designed to improve flow through the health and social care system. The type and number of hospital admissions varied across all trusts. Salisbury NHS Foundation Trust saw the highest percentage of people who lived in Wiltshire with 25,119 people (approximately 70% of attendances), 38% of which were over 65 years. The Royal United Hospital Bath NHS Foundation Trust provided care for 23,836 people (approximately 40% of total numbers), of which 36% were over 65 years. The Great Western Hospitals NHS Foundation Trust saw 15,973 people (approximately 30% of total numbers), of which 39% were over 65 years².
- When people were in crisis at home, they were able to contact the clinical hub for advice and support. The hub provided direct access to on call GP services and community teams. The CCG was planning to develop the use of technology to include an online 111 service and eConsult. Most GPs were able to triage people remotely using similar IT systems.
- Salisbury NHS Foundation Trust provided a “consultant hotline” where ambulance services, GPs and nurses could contact the consultant directly to discuss people being reviewed in the community. This helped to streamline admissions.

² Figures represent 2016/17 data

- The Royal United Hospital Bath NHS Foundation Trust was supported by four minor injury units (MIUs) which impacted on the type of people attending the department. People with minor injuries made up 14% of attendances for Q3 2017/18 which was less than national average. Salisbury NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust were supported by local MIUs, but the balance of minor injuries to people requiring increased medical input, was higher for example 56% of Great Western Hospitals NHS Foundation Trust A&E attendances for minor injuries in Q3 2017/18. Royal United Hospitals Bath NHS Foundation Trust also had an urgent care centre co-located. A&E reception staff redirected people to the urgent care centre if the admitting symptoms had been present for over two weeks.
- The acute hospitals had varied admission pathways. Expected GP referrals were (where possible) directed to the acute assessment unit in Salisbury NHS Foundation Trust, bypassing A&E. In the other two trusts, people were usually admitted through A&E. Time spent within A&E varied according to activity and availability of inpatient beds. Patient records showed that people were in A&E for up to 20 hours, awaiting decisions on pathways or an inpatient bed.
- All hospitals recognised the importance of having a geriatrician “at the front door”, although this was not always provided. The Great Western Hospitals NHS Foundation Trust reported medical team vacancies, which resulted in delays in A&E. During our visit, we saw that there were some people waiting for up to 20 hours to be assessed by a doctor. The Royal United Hospital Bath NHS Foundation Trust also reported that they would like a geriatrician in A&E, with a dedicated admission area; however, this was not in place at the time of the review. Frail elderly people admitted to Salisbury NHS Foundation Trust were either seen in A&E or transferred to the acute medical unit which was staffed by a geriatrician 8.30am to 7pm, Monday to Friday, with a dedicated team outside of these hours. A&E had two cubicle spaces which were dementia friendly, with appropriate signage, lighting, clocks and decoration.
- People’s needs and choices were assessed holistically by the front door teams, to promote independence and plan discharge. On admission to hospital, people were assessed using a standardised framework (individual to each trust) and based on the activities of daily living. This process enabled the front door teams to identify people’s complaints, risks and determine treatment or care pathways. People were included in discharge planning, including discussions about any support networks.

- Salisbury NHS Foundation Trust had introduced a joint patient admission template which was completed by all staff. The aim of this template was to ensure that staff were not repeating unnecessary assessments. For example, the admitting doctor would complete a physical examination of the person and record a medical history. This assessment information would be trusted by speciality doctors when reviewing the person, preventing repeated assessments and discussions. Doctors would continue the patient record, stating for example, “physical examination, as above”. Similar templates were used at the other acute hospitals; however there was evidence to suggest that some assessments were repeated by clinicians.
- All A&E staff reported that they would like social worker input from the point of admission, preferably with a dedicated social worker based in A&E. This had been trialled for a short time at the Great Western Hospital NHS Foundation Trust, but had been withdrawn following completion of the trial. A&E staff reported that they did not know why the project hadn’t continued.
- People could be referred directly for support in the community within 48 hours of admission to hospital. After the initial 48 hours, people had to be referred to the discharge team for assessment of ongoing care needs. This meant that people who were fit to be discharged from hospital at for example on day four of admission, would have to wait for an assessment by the discharge team if a care package was required.
- Community hospitals reported that they received inappropriate admissions, with some people being admitted who were fit and could go home. However, the pathway chosen at the acute hospital did not facilitate this. The teams felt this was largely due to delays in beds being available and the consequential improvement in people’s baseline conditions while waiting and people not being reassessed before transfer.
- All trusts worked to similar discharge planning systems. Medical ward rounds occurred frequently according to the acuity of the inpatient area. For example, we saw that people admitted to the short stay frail elderly ward were reviewed twice daily by a consultant. Doctors clearly recorded when people were medically fit for discharge. Staff completed ward board meetings which identified people’s readiness for discharge. Discharge coordinators supported ward staff to complete any referrals and offered guidance on appropriate care pathways; although it was clear that the right pathway was not always followed. We were given examples of people who were discharged from hospital on different pathways to those originally planned as a result of limited capacity within the community to pick up care packages. For example, one person was discharged from

hospital with a live-in care worker, because a four times a day, two care worker package could not be provided.

- Social workers attended ward board rounds and worked closely with ward and discharge teams to promote a seamless transition of people's care.
- Services had the right skills to support effective transition between health and social care. There were effective working relationships between adult social care, GPs and housing teams which enabled people to access the right support to meet their individual needs.
- There were varied reports of effective collaboration and sharing of information. Community teams reported that acute providers did not always know where someone was located and community staff were often directed to the A&E reception. A&E staff would search for the individual on the electronic patient information system and direct the call accordingly. Acute hospital staff reported that community health staff and social workers rarely followed up people known to them and did not routinely seek to assist with discharge planning.
- The IT infrastructure did not promote joined up working. Community hospitals used a different electronic patient record (EPR) to the community teams and GPs. There were plans to change the community hospitals' system to one compatible with the community and GP EPR although the date for completion was not known as this was reliant of agreement of funding. The acute hospitals had different systems to each other and all community EPRs. Frontline staff within the acute hospitals reported having access to GP records, but this was not readily available and required assistance from the social work team. Social care teams used the same system, but this was not compatible with any of the health care EPRs.
- Although some EPRs were compatible (or the same), the sharing of information was not automatic. Consent needed to be authorised to enable another practitioner to view information. Staff reported that this process often needed repeated follow-up to enable access to patient records and hindered decision making.
- All inpatient areas used the red and green system to track people who were ready for discharge. This is a visual management system to assist in the identification of wasted time in a person's journey, used to reduce delays. Red days are those which are of no value for a person, for example, a day waiting for an investigation, or a care package to support discharge home. Green days are those of value to a person; the person receives care that can only be provided by an acute hospital. Teams were looking at how to reduce red days, to promote flow through the hospitals.

- Wiltshire Health and Care had implemented four discharge pathways:
 - Pathway 0 required no intervention.
 - Pathway 1, Home First, was for people who required some support but were safe to be left alone between visits.
 - Pathway 2 was for people who were not safe to be left alone at night or between visits, and/or did not have access to a normal place of residence.
 - Pathways 3, was for complex discharges that required ongoing support or placement within a residential or nursing home.
- People discharged on pathway 0 were not routinely referred to the Adult Social Care team, which meant that routine preventative intervention, information and advice could not always be shared with people who might benefit from this.
- The liaison between mental health and physical health teams was not always streamlined, with staff reporting delays in care as a result of lack of mental health input. Admission areas, were able to access mental health support without difficulty, however, once people were transferred to the inpatient ward areas, staff reported delays of up to three days for mental health assessments. We saw medical notes that confirmed this.
- Acute hospital staff reported a lack of in-reach from community teams, which was a separately commissioned function. This impacted on people's length of stay as their normal health condition was not always known. In addition, staff reported not fully understanding what community teams could offer to support a person's discharge. Wards had trialled a community matron attending the ward board rounds to identify people that could be discharged home with community input; however this was not consistent practice.
- Communication across all teams had improved since the introduction of the Wiltshire Winter Control Centre. This was a pilot initiative where all referrals were centrally reviewed by a team of clinicians. People were referred directly from the control centre to the most appropriate pathway, resulting in an increased flow of people through the hospitals. Data showed that the centre had assisted to reduce the number of delayed transfers of care by identifying the correct pathways and flexing the workforce to meet the demands. For example, Home First were able to extend the number of days that they assisted someone at home while waiting for a long term package of care to be introduced. Although this was not ideal, the process prevented a longer inpatient period.
- South Western Ambulance Service NHS Foundation Trust (SWAST) recorded the percentage of calls that were abandoned before they were answered. From August 2016 to

July 2017 between 1% and 4% percent of calls were abandoned, with an average of 1.7% monthly. June 2017 saw the peak at 4%.

- From August 2016 to July 2017 an average of 14.6% of call were closed following telephone advice. The figure for December 2016 was the highest in the period, with 17% of calls resolved without ambulance attendance. For the same period, between 49 and 51% of calls were managed without the person being transported to the accident and emergency department.

Are services in Wiltshire caring?

People received care that was assessed in a holistic way, and all people we spoke with felt that they were involved in decisions about their ongoing care. However, we saw missed opportunities to follow through on some people's preferences. Acute hospital staff felt that difficult conversations were not held early enough when people's conditions were deteriorating, which affected the ability to follow through treatment escalation plans in a timely manner. There were some discrepancies with knowledge in the acute hospitals of what was available within the community to support people and their carers. GPs provided carer support programmes. When ambulances were called, people were assessed before decisions made to transfer to hospital. Hospital treatment was advised for approximately 50% of ambulance calls. People were generally satisfied with the care and treatment they received.

- We found that the assessments of needs were not always coordinated effectively to ensure that people were at the centre of their care and support planning. There were reports of poor experiences within emergency care and poor communication between community and acute providers. For example, when someone was admitted to the acute hospital from a care home, information about the person was provided. However, care homes reported that they frequently received calls asking for information they had already provided. Similarly, when people were discharged from hospital, wards reported receiving multiple calls regarding treatments completed.
- There were concerns that discharge assessments did not pick up on individuals' needs and take into consideration the person's home environment. Domiciliary care staff reported that they would prefer people to have home visits before being discharged from hospital to ensure that all risks were identified before the person was discharged home.
- We saw that the discharge processes were not streamlined. There were no trusted assessors, which meant that people were frequently assessed by multiple professionals to obtain the same information. This was despite individual treatment plans being made in conjunction with the person and by a senior clinician.

- People and their loved ones were encouraged to be actively involved with decision making about their care. We saw patient records detailing conversations around discharge planning. Best interests meetings were completed for people who were unable to make informed decisions regarding discharge from hospital.
- GPs felt that information about services accessible to the acute hospitals did not always accurately reflect what was available within the community.
- Wiltshire jointly commissioned a carers service with GPs running carers programmes and prescription breaks. This is when GPs or practice nurses “prescribe” carers a social, leisure or health break which could include gym membership, sports activity, complimentary therapy or health and beauty appointments. This scheme was aimed particularly at carers who were suffering ill health as a result of their role, or those with long term conditions.
- Hospital staff felt that difficult discussions with people using the service and their loved ones should be completed earlier in the person’s journey. For example, we saw that people with a Treatment Escalation Plan cared for in the community were often admitted to hospital when their condition deteriorated. Staff felt that if the person using the service and their families were informed that they were nearing the end of their life, they may choose not to be admitted to hospital.
- We saw that people using hospital services and their loved ones were treated with dignity and respect. This was supported by results of Friends and Family Test surveys across the three acute hospitals.
- Royal United Hospital Bath NHS Foundation Trust had introduced a patient information leaflet which detailed expectations regarding discharge. The leaflet was introduced in February 2018 and given to all people who were admitted. Staff felt that clear information at the point of admission helped to “set the scene” and reduce delays in discharge planning.

Are services in Wiltshire responsive?

People who were in crisis could access support from a variety of settings, and this was provided in a timely way. Wiltshire performed better than the England average in preventing admissions to hospital for common clinical conditions. Hospital staff felt that some people admitted to hospital identified as requiring a package of care for the first time were encouraged to go home with support, rather than their preferred discharge destination of a residential placement. People were encouraged to maintain independence during their stay in hospital to promote early discharge and prevent deterioration of clinical conditions.

When ambulances were called, response times varied, however crews actively prevented transferring people to hospital wherever possible. People generally waited for less than 60 minutes for their care to be handed over to hospital staff when transferred to hospital by ambulance. Hospital choice policies supported staff and people using the services to identify discharge pathways although these were not always user friendly.

- People who were in crisis could access help from a variety of sources including, their GP, the clinical hub or acute hospitals. If assessed before presenting at A&E, action could be taken to prevent admission to an acute hospital. Community hospitals provided a step-up facility for people who required support, but were not acutely unwell. There was limited capacity to do this due to increased numbers of people requiring step down care from acute hospital.
- The out-of-hours services covered children and adult calls, with the unwell child taking priority over any adult calls. This meant that there was potential for delay in some assessments of adults.
- Capacity and workforce were the largest barriers to moving people through the health and social care system. We found and were told that people were often cared for in the wrong place, by the wrong people, due to lack of workforce capacity to manage referrals or cared for in the wrong location because of an inability to move people through the system. For example, we saw that all hospitals had a large number of medically fit people who were awaiting discharge home with packages of care or to a residential placement. There were between 40 and 80 people in each acute hospital waiting for some intervention to facilitate discharge.
- Residential and nursing home care workers told us that ambulance crews were sometimes reluctant to attend care homes, and response times varied. Although, when attending to people, crews endeavoured to prevent admissions to hospital where possible.
- Hospitals provided timely and effective processes for reviewing people's needs to ensure that they received care in the most appropriate areas. People referred to hospital usually required acute care for the initial period of admission. Care was provided in acute admission areas or speciality units depending on the person's clinical condition. All acute hospitals had short stay acute admission wards, which were designed to treat people and discharge them home within 48 to 60 hours. Once the person was clinically stable, if they were unable to be discharged home, they were moved to a less acute ward for discharge planning. This transfer was not always within the specified time frame, due to the lack of

capacity in non-acute wards. Medical records showed some people experienced delays of up to 52 days. Discharge planning continued throughout the person's stay in hospital irrespective of their location.

- We saw that hospital staff promoted wellbeing on wards to prevent deterioration in people's clinical conditions. This included encouraging people to get dressed and mobilise as much as possible. Some people were encouraged to continue to self-medicate during their inpatient stay; however, this was not consistent across all areas.
- Community hospital staff were not aware of admission criteria for people admitted to the community beds. Community ward staff did not know who was being admitted until the day of admission. People who were fit to be discharged from hospital to a community bed were referred through Medvivo. Beds were allocated on the day that they became available. There were examples of inappropriate admissions being accepted into community beds, with six patients reported to have been fit for discharge home within the month prior to our review.
- Where possible services ensured that people were able to make informed decisions, accessing support to promote independence. Assessments were focused on identifying any care needs, and people were involved with decisions regarding the level of care.
- People with Treatment Escalation Plans (TEPs) in place were at risk of decisions about their care not being inclusive of them, and their family. When the person's condition deteriorated, GPs and ambulance service crew would often refer them to the acute hospitals for further assessment or treatment. We saw an example of this during the review; a person's records confirmed that despite a TEP being in place, the person was admitted to an acute hospital for end of life care, which could have been provided within the community.
- Data showed that ambulance turnaround at all three acute hospitals was better than the national average; across all three trusts in January 2018, less than 2.3% of ambulances remained at the hospital for more than 60 minutes. The national average was 9.4%.
- Salisbury NHS Foundation Trust performed better than the national average for patients spending less than four hours within A&E. In January 2018, 86.6% of patients were discharged within four hours, compared to the national average of 82.9%. The Royal United Hospitals Bath NHS Foundation Trust and the Great Western Hospitals NHS Foundation trust performed worse than the England average with 72.3% and 77.3% respectively in January 2018.

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 Wiltshire safe?

There were systems and processes in place to ensure that people were safe when making the transition from a care setting to their homes. A standardised framework enabled the identification of risks and level of support needed when returning home. Ongoing care needs were monitored by GPs and community teams following notification of people's discharges home.

People's individual risks were usually identified prior to discharge from hospital; however system wide risks were identified by system leads. There were processes in place to record system wide risks; however these were not widely shared or utilised. Outcomes of concerns raised through safeguarding referrals were not usually shared with referrers which meant that they were unaware of any ongoing concerns or actions that had been taken. People in Wiltshire were less likely to be admitted to hospital or be readmitted following discharge from hospital.

- There were systems and processes in place to ensure that the transition between health and social care prevented any avoidable harm. Teams worked collaboratively to ensure that the discharge destination appropriately provided the right level of support to safeguard people.
- There was effective partnership working to ensure that people were discharged from hospitals safely. People in Wiltshire who were in hospital were assessed using a standardised framework to ensure that their needs would be met on discharge. This framework enabled the correct discharge pathway to be identified.
- Acute hospitals were focused on promoting early discharges, with front door teams assessing the majority of people over 65 years attending accident and emergency departments. Front door comprehensive assessments were designed to identify the reason for admission and senior clinicians were able to provide advice, equipment and if necessary referrals to community support teams to promote discharge as soon as possible.
- Data for the three acute hospitals showed that the front door teams were able to discharge between 70 and 75% of people within the first 48 to 72 hours of admission. This reduced the risk of people being admitted into wards unnecessarily.

- Within hospitals, discharge assessments identified the level of support needed for when a person left hospital. Staff were not always able to complete home visit assessments, but where possible ensured that people would be able to manage daily activities. If people were unable to perform daily tasks, packages of care or placements were arranged to ensure that people's needs were met. The Royal United Hospitals Bath NHS Foundation Trust had access to its own transport which was used by occupational therapists to provide home visits and equipment for high risk patients. The occupational therapist would accompany the person home and ensure that they were safe to be left in the property.
- There were processes in place to assess people's risks and mitigate these with actions to prevent harm; however, it was unclear how widely these were utilised; the acute commissioning lead referred to risk stratification being in place, but was not sure how widely this was used when planning services.
- Discharge letters provided key information to GPs and community services when people left hospital. Letters would contain details of the admission to hospital and highlight any ongoing concerns for follow up. This enabled people who remained at risk, or those who were frail to be monitored in the community. Hospital staff told us that they received multiple calls from GPs and community staff relating to hospital discharge letters and their content. This was usually due to information not being clear.
- In terms of people returning to their homes, risks associated with changes to medicine following an admission to hospital had been reviewed. Hospitals provided medicines for two weeks on discharge from hospital, an increase on the previous arrangement of one week's supply. This ensured there was sufficient supply of medicines until the discharge letter was received by the GP and any changes managed.

Are services in Wiltshire effective?

There was good working across the multidisciplinary teams to support people when being discharged from hospital. People were provided with estimated dates of discharge and were generally kept informed of any changes and included in decisions regarding discharge location. Health and social care services worked collaboratively to share information about delays and actively sought solutions to increasing numbers of delays. Four discharge pathways were established and the Wiltshire Winter Control Centre was helping to streamline people to the most suitable discharge location or pathway. There were staffing capacity issues across all areas which impacted on service delivery and some work was repeated as the trusted assessor model was not in place. There were community projects designed to reduce admissions to hospital.

- People’s needs and choices were considered at all stages when planning their return home. However, people were not always kept informed of plans or updated when plans changed. We saw that people took part in conversations about their discharge home and then decisions were sometimes made by clinical staff which were not always in line with the wishes of the person. For example, we saw patient records that confirmed that one person wished to be discharged home with an established package of care, however, due to concerns regarding their safety, the family were asked for their opinion which was that a residential placement was required. One week after being fit for discharge, the discharge location was still not agreed. This process also did not take into account the law regarding the Mental Capacity Act which states that if people are able to make informed decisions about their care these must be respected, even when they are considered to be unwise.
- Some people, who lived at home with no support until a crisis would prefer to be discharged to a residential placement but their preferences were not taken into account. Where they had not received a package of care prior to admission to hospital, nursing staff told us that the people were put under pressure by social care to be discharged home with a package of care. In their view, this resulted in readmission to hospital within a short period of time. Data showed that the proportion of older people aged 65+ who were still at home 91 days after discharge from hospital into reablement or rehabilitation services was, at 65.9%, much lower than the England average of 82.5%. However, system leaders told us that there were data quality issues which negatively affected this indicator.
- All the NHS trusts had a choice policy which included advice on engaging people who used services and their relatives in discussions around discharge planning. We saw that the choice policy was referred to as a tool to assist with difficult and complex discharges which involved senior nursing staff or the discharge teams. This supported staff to have difficult conversations with people about their next steps on leaving hospital and to support people to understand that the hospital was not the best environment for people while they were waiting for the residential service of their choice to become available.
- All hospital inpatients were provided with an estimated date of discharge (EDD) on admission. This date was determined by the underlying clinical condition and associated treatment. We saw that the EDD was reviewed daily as part of board rounds and changed if necessary. People were kept informed of dates for discharge.
- The details of the EDD varied according to the trust, and “medically fit for discharge” (MFFD) dates were also used. The Great Western Hospitals NHS Foundation Trust used the MFFD to record any delays, with the EDD changing according to where people were in

the discharge process. For example, The EDD would reflect the date that a package of care was expected to start. The remaining hospitals recorded the EDD as the date that the patient was MFFD. The difference in recording EDD would not have impacted on the number of delayed transfer of care patients; however, different terminology may complicate discussions across the county.

- There were delays in assessments for social care, continuing healthcare and nursing home placements. We saw that people were unable to be referred until they were medically fit, which meant that anyone awaiting an investigation or completion of treatment was unable to be discharged as soon as treatment was completed. There were also delays in accepting social care referrals. For example, we saw medical notes that detailed nursing staff faxed a social work referral seven days prior to the entry stating that the referral had been received by the social work department. This meant that the discharge home was automatically delayed by seven days, before any social care assessments had taken place.
- Delayed transfers of care (DTC) meetings were completed weekly and discussions completed across health and social care to identify the reason for delays and what actions could be taken to secure discharge from hospital. Acute hospital teams told us that although they understood why the meetings were required, they felt that the allocation “of blame” did not promote effective cross service working. They also felt that discharge was now so complex that the DTC measure did not accurately reflect the issues facing hospitals in regards to discharges.
- Community teams felt that hospitals were reluctant to discharge people who could be cared for or treated within the community. This was likely due to the limited understanding of people’s baseline conditions and what services could be provided in the community.
- When a person was to be discharged to a nursing or residential care placement, this affected the ability of hospitals to discharge at weekends or in the evening. We were consistently told that care homes did not accept people into a placement after 3pm or on a Friday, Saturday or Sunday. Staff reported that they were told that this was for safety; however, these delays placed people at risk of obtaining hospital acquired infections due to longer periods in hospital. Local authority leaders were working collaboratively to try and promote weekend discharges however this was not embedded across the county.
- All services were focused on improving flow through hospitals and care, with systems being designed and redesigned according to activity and performance. Health and social care workers felt that capacity was the main contributing factor to delays and that there had been a focus on delayed discharges for a number of years. Council meetings included discussions and updates on DTC and winter pressures.

- The introduction of the Wiltshire Winter Control Centre had assisted with the streamlining of people's discharges. Community hospital staff felt that acute hospital staff used them as a “default” for people being discharged from hospital, rather than assessing what was actually needed to support the person to go home. As the control centre assessed all referrals, they were able to ensure that people were sent to the right discharge location.
- The acute hospitals were located near or over county borders which meant that they provided care and treatment for people outside Wiltshire as well as those who lived within the county. This impacted on the processes used and available to staff. Each county and local authority had different processes for discharging people, including different referral systems and forms. Staff reported that they learnt which process was required according to the individual and their discharge destination; however, staff felt that generic forms such as continuing healthcare forms should be standardised. At the time of our review, staff needed to ensure that the generic template was appropriately identified as the relevant commissioning group’s version or the form would be rejected causing further delay.
- The four discharge pathways were established across the county, although the transition from the previous system had been slower in Salisbury NHS Foundation Trust and the Great Western Hospitals NHS Foundation Trust. This did not impact on people’s experiences.
- Discharge pathway 1 included the referral of people for reablement. Data showed that the proportion of people over 65 who were offered reablement or rehabilitation services was lower in Wiltshire (1.1%) than the comparator group (2.4%) and significantly lower than the England average of 2.7%. There was a decline in the provision of reablement from 2013/14 when the portion of people offered reablement or rehabilitation was over 10%.
- The proportion of people over 65 who were still at home 91 days after discharge from hospital into reablement or rehabilitation services was also significantly lower than the England average in 2016/17, with 65.9% of people in Wiltshire staying at home in comparison to 85% of the comparator group and 82.5% nationally. This figure had declined since 2015/2016. However, system leaders told us that there were data quality issues which negatively affected this indicator.
- There was not an established pathway for people with delirium. People who were admitted to hospital with a delirium were often treated in the acute hospitals until they were fit to return to their home, unless they were deemed unsafe. We saw one person’s records which showed that following an admission with delirium, they remained in hospital for several

weeks while decisions were made whether that person was able to go home. The person had stated that they wanted to go home, with a package of care, however, due to previous refusals of support, staff wanted to complete a mental capacity assessment, and best interests meeting with the family. The time to arrange this delayed the discharge by several weeks.

- All services had the right skills to support the effective transition of people between health and social care. However all services reported decreased numbers of staffing either through the inability to recruit or planned reduction in staffing numbers. Hospitals reported high nursing staff vacancies and difficulties in recruiting geriatricians and occupational therapists. Elsewhere, the falls service had been reduced and capacity with social care was limited.
- Teams generally worked collaboratively including some VCSE services. There was an apparent reluctance for some VCSE services to be involved, with no agreement on how to work together as partners. This affected the ability of people who were self-funding to access help or information. There was some ambiguity over what was commissioned within Wiltshire.
- There was no trusted assessor model used across any service. This meant that assessments were often repeated causing delays.

Are services in Wiltshire caring?

Although people spoke of the caring way in which staff supported them, particularly in the community and hospice teams, services were not always delivered in a caring way. Communication between services and family members about their needs was not always open. People who had continuing healthcare needs did not have their needs assessed in a timely way and they were less likely to receive funding after waiting for their needs to be assessed.

- Carers praised the support that they received for their loved ones from community and palliative care services. However, communication between services was often poor. We were told about a person who had presented to their GP and health professionals with increasing pain and were told they had a urinary tract infection. They were admitted to hospital and subjected to a number of tests but these were not discussed with the person or family members. The family did not receive any support or information on discharge from hospital and it was only when a family member was unpacking the person's bag and found a note which they queried with their GP, that they found their parent had only a week to live. The carer had to push for support services but once these were in place they received good support for the last few days of their family member's life.

- People did not always receive services that were delivered in a caring way on discharge. For example people often had to wait a long time for transport out of hospital and then might have long journeys while a number of people were delivered to various homes. People waiting in the discharge lounge were not always supported with food and drink while they waited. One hospital had commissioned their own transport to overcome delays. At the time of our review, the contracted patient transport service was responsible for assessing whether people were eligible for the service. If they were not, they were signposted to other voluntary community transport services. This would mean a further delay and distress for people waiting for transport. System leaders had recognised the difficulties this caused for people and providers and were transferring the assessment function to a commissioning support unit that was jointly managed by four CCGs.

Are services in Wiltshire responsive?

Insufficient provision in the community, nursing and residential care sector meant that services were not always responsive to people's needs. There were not clear systems across the county and different processes and timescales in services made the discharge process complicated and slower than it needed to be.

Independent care providers and hospitals did not support each other adequately which meant that hospitals were frustrated by independent providers' reluctance to accept residents throughout the week while providers felt that they were unable to do so because support around medicines was not always in place. People's hospital discharges were not prioritised according to their individual needs and people were likely to experience delays in hospital before they could return home.

- Community hospitals had different timescales for assessments from social care teams which meant that people were often delayed in being discharged with packages of care. Medical notes showed that, one person had been waiting for over ten weeks for a four times a day care package. Wiltshire Health and Care leads told us that they could negotiate timescales for assessments and packages of care; however this was not a robust agreed practice and was reliant upon individuals. There was no community hospital in the south of the county which meant that there was a reliance on nursing home beds.
- People who lived in nursing homes were usually accepted back by the nursing home care staff without the need for an assessment. However, nursing homes seldom accepted a people back after 5pm or at weekends. Data for April 2016 to March 2017 showed that 19% of people were discharged at weekends. This was worse than in 11 of the 15 comparator areas and better than in three comparator areas. We undertook a survey of care homes and domiciliary care agencies. We received a low number of responses however 12 respondents (41%) said discharge summaries 'rarely' or 'never' provided comprehensive

information on changes in the person's care needs, while 13 respondents (45%) said they 'rarely' or 'never' provided comprehensive information on future plans including escalation. Independent social care providers we spoke with told us that hospitals seemed to be unaware that care homes did not have a continuous supply of prescribed items and no pharmacy. Thursday and Friday can often be hospitals' busiest days for discharge, but this lack of awareness meant care homes were left to try to source medication and other prescribed items over the weekends, at a time when GPs were less available.

- Data from April 2014 to April 2017 showed that the rate of emergency admissions from Wiltshire care homes was consistently lower than the England average. However, for the same time period, more people would remain in hospital over seven days, up to 41% compared to the England average of up to 36%. Data for the same period showed that fewer people were readmitted to hospital in Wiltshire at 13-17% compared to the England average of 20%. Residential homes insisted that they reassessed people prior to their return home, which added a delay in discharge home.
- The daily rate of delayed transfers of care for people over 18 was higher than the England average in January 2018, with 17.7 people per 100,000 compared to 11.4 nationally. The majority of delays for people over 18 was attributed to NHS organisations with 9.9 people per 100,000 compared to 7.4 people nationally. The main cause of delay was attributed to "awaiting residential or nursing home placement" – 6.9 per 100,000 compared to 3.5 nationally. There was also a delay in the admission of people over 65 years to care homes with 41.1% of people waiting over seven days for transfer in comparison to 35.8% nationally. A framework contracting system was in place with two providers across the county which had been tasked with reablement and care at home. However at the time of our review commissioners told us that only 48% of packages of care were provided by the contracted suppliers and the rest were spot purchased. The local authority planned to address this by bringing reablement services back in house over a phased period during 2018.
- Staff across all hospitals told us that continuing healthcare (CHC) assessments were problematic, with minimal referrals being accepted. They told us that CHC referrals were completed for all patients, irrespective of whether clinicians felt that it was appropriate, as CHC referrals would need to be screened out before social care referrals would be accepted. There was a lack of interagency working which impacted on people waiting for support. Hospital staff felt that carrying out continuing healthcare assessments for all patients unnecessarily delayed social care input. This also meant that assessments were not completed in a timely way. NHSE data showed that in the quarter prior to our visit, 8% of assessments were completed on time.

- Referrals to the continuing healthcare team were completed by staff in inpatient areas. The number of people eligible for NHS CHC funding was lower for people living in Wiltshire than the England average with 18.2% eligible compared to 43% nationally. Wiltshire's performance for CHC assessment and referral conversion rates was also lower than the England average. The assessment conversion rate for standard CHC referrals was significantly lower than the England average, with 12% of assessments being completed in comparison to 31% nationally. The referral conversion rate was also lower than the England average of 25% at 11%. System leaders were unable to describe why the rate was so low but they were aware that CHC processes were not effective.
- There were significant delays in people receiving continuing healthcare assessments. The NHS Southwest CHC Activity Assurance report for Q3 showed that only 8% of referrals were assessed within 28 days. This was the lowest performance in the NHS Southwest region. There was a risk that people who might not be entitled to CHC were experiencing unnecessary delays in accessing support or conversely people might be paying for care for which they were entitled to support.
- We heard from independent social care providers that there was inequity in the provision of continuing healthcare and at one service we were told of a number of people who had almost identical health support needs however only one of them was receiving continuing healthcare funding.
- Data showed that in Q1 2017/18, fast track CHC assessment conversion rates were 100% compared to the 99% England average and referral conversion rates were 90% compared to 95% nationally. However the NHS Southwest CHC Activity Assurance report for Q3 showed that the fast track conversion rate had dropped to 90% and was the second lowest in the NHS Southwest region.
- Data showed that 0% of staff in acute hospitals were completing CHC decision support tool, however, acute hospital staff we spoke with told us that they were being asked to complete CHC referrals prior to referrals for social care. Some acute hospital staff also told us that they were unable to refer people with long term conditions or new onsets of conditions who would probably be eligible for CHC funding. This was because referrals were to be undertaken by community hospital staff as part of pathways 3 or 4. This meant that there was a delay in referral to CHC for people who were identified as being possibly eligible for funding. For example, those who had a life changing illness or accident.
- Acute hospital staff also reported completing fast track CHC referrals for people with life limiting illnesses. Staff reported that there were difficulties in fast track CHC referrals

relating to people with life limiting illnesses, but no diagnosis of malignancy. Palliative care teams reported that evidence to support diagnosis was often disputed. This was symptomatic of a system that did not have clear and agreed interagency protocols to support outcomes for people who used services.

- Funding approval following CHC assessment was considered to be speedy; however, people waiting to be discharged home with a package of care were placed on the same waiting list for care as all other patients. This resulted in delays of up to two weeks for people to be discharged home from hospital. At the time of our review we saw a person who had been assessed as being entitled to continuing healthcare funding as they were at the end of their life, but they remained in hospital awaiting a package of care along with people with less urgent needs. There was a risk that this person's life would end in a hospital bed away from home.
- There was not always a clear framework of support for people who funded their own care on discharge from hospital. Although reablement services were free of charge to all people who were discharged on a reablement pathway, conversations about fees and funding were not held at an early enough stage to enable people to understand what their options were when the package ended and if there was a delay in the process, there was a risk that people could find themselves owing money for a service they had been receiving.

Maturity of the system

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

- Although there was a clearly articulated vision with support and active engagement from elected members, this did not translate into an aligned strategy that was supported by joint commissioning intentions. Ambitions articulated in the joint Better Care Plan were being overtaken by separate developments in the health and social care systems and this was a source of frustration to frontline staff, VCSE and independent providers and people who lived in Wiltshire.
- The Health and Wellbeing Board had oversight of the delivery of services across Wiltshire and there was strong leadership from elected members. However the board was very much engaged in the operational and strategic planning for local services and was less effective as a forum to challenge system leadership and foster integration. System leaders needed to be able to work together independently of the HWB to use their strategic and operational expertise. This would enable the Health and Wellbeing Board and the Health Scrutiny Committee to constructively test plans for delivery against the system vision.
- There was a positive culture among frontline staff working in services in Wiltshire that valued joint working. Staff worked together to improve interagency approaches however there was a desire for this to be underpinned by a clearer strategic framework. System leaders had built relationships to further joint working although these were relatively new and there had been a period when relationships between the CCG and the local authority had been difficult. There were still some areas that required resolution such as the conflict around the continuing healthcare protocol and disputes. There was also a risk that interim leaders would change too frequently to allow cross organisational relationships to become embedded.
- There were pressures in the care provider market, particularly with regard to staffing, quality and the rural geographical spread of the county. System leaders were addressing this with the creation of an in-house reablement service and of the Wiltshire Health and Care LLP. However, while WHC LLP was strong in its support and delivery of services, the impact of an in-house reablement service would take time to be realised. There were missed opportunities to engage the market, particularly the VCSE sector and the social care provider sector in the design and delivery of services.

- There were pockets of joint commissioning but the use of the iBCF was not developed in a way that supported collaborative care and furthered joint working between the health and social care sectors. The targeting of resources at high-risk cohorts was very much led by GPs and the acute providers rather than through a system-wide approach.
- There was an integrated workforce plan through the STP but this did not translate into a local integrated workforce plan. Solutions to manage workforce pressures were being sought locally but these were not proactively managed by system leaders, and proposed solutions such as the apprenticeship scheme were slow in being taken forward.
- There was limited digital interoperability across the health and social care system. Primary care providers and the community health provider had a shared system which could facilitate better sharing of information however there had been limited sign up by practices to the sharing of information which meant that the benefits of a joint system could not be effectively realised.
- Although there were pockets of joint working, preventative services needed to be more streamlined. There was not clarity about how to access services, people were subjected to multiple assessments and the variety of services on offer differed across the county. There were some positive steps being taken to support people through services, such as the GP models with care coordinators and Wiltshire Health and Care, however this approach was not joined up throughout the system.
- GP and primary care services were a strength in the Wiltshire system and this could be built upon to support the vision of more preventative, coordinated and person-centred services.

Areas for improvement

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

- System leaders in health and social care must work more effectively together to plan and deliver an integrated strategy across Wiltshire which includes an updated Better Care Plan.
- System leaders must urgently agree the continuing healthcare dispute protocol and resolve outstanding disputes. Systems must be put in place so that services can work together to reduce the likelihood of disputes, increase the conversion rate of referrals and the timeliness of assessments.
- System leaders must work together to develop a culture that encourages joint planning, continuous quality improvement and integrated systems to deliver care for the people of Wiltshire.
- The system has experienced churn at senior leadership level. There should be a focus on developing stable leadership arrangements across the system. Further urgent consideration should be given to the proposed role of joint CCG Accountable Officer and Corporate Director for adult social services, to ensure this will provide sufficient capacity across the local authority and CCG, that the objectives for the role are clear and that there is a strong structure to support it.
- System leaders should create some space outside formal Health and Wellbeing Board meetings, to provide a forum for open debate and challenge. This will help partners further build trust, and an open and transparent culture.
- There appeared to be some lack of clarity and overlap of roles between elected members and senior officers in the local authority. System working would benefit from clearer differentiation between:
 - a) The role of elected members setting policy direction for the local authority and challenging system leaders via scrutiny, and;
 - b) Officers working with partners to develop and implement plans. There must be a clearer forum for senior officers across the system to plan, implement, support and challenge each other.
- System leaders should develop an integrated workforce plan for Wiltshire.

- System leaders should explore where transformation work streams across health and social care can be aligned to further integration and reduce duplication of resources.
- The system plan for Wiltshire, currently the Better Care Plan, should be refreshed and updated to reflect priorities aligned to the STP and the local transformation agenda.
- GPs, VCSE organisations and independent social care providers should be considered as partners in developing the transformation and integration of services so that there is assurance for leaders and buy-in from providers at the point of delivery.
- System leads should review the continuing healthcare referral and assessment process to improve the timeliness and appropriateness of referrals to improve people's experiences.
- A clearer, proactive approach to system-wide risk sharing should be developed supported by intelligence that enables a preventative approach to managing risk.
- There should be clearer access to support and sign-posting for people who fund their own care and systems need to work together to ensure that people who might become vulnerable as they lack support structures are identified at an earlier stage.
- There should be alignment and integration of localities and improved joint working to ensure effective integrated health and social care teams that meet the needs of people in Wiltshire.
- There should be contingency planning in place to manage the transition from block purchasing to in-house reablement so that leaders are assured that there will be sufficient provision of packages of care.
- Contracts with independent health and social care providers should have clear specifications and an outcomes framework that is understood and agreed by providers and commissioners. Realistic key performance indicators, that will demonstrate improved outcomes for people who use services, should be agreed.