Department of Health & Social Care

Department for Levelling Up, Housing & Communities

Local Government Association

NHS

Gloucestershire: Peer Review

Observations & Recommendations

June 2022

Integration and Better Care Fund

The Team

The peer team would like to extend their thanks to all the staff who participated in the review and for making us feel welcome, albeit virtually.

- Sarah Mitchell (Lead Peer)- Care and Health Improvement Advisor, LGA
- Katie Norton- Care and Health Improvement Advisor, LGA
- Natalie Jones- Senior Programme Manager – Better Care & Ageing Well (South East)
- Sarah Farragher- Home First and System Flow Coordinator, Cumbria County Council, North Cumbria Clinical Commissioning Group and North Cumbria Integrated Care Foundation Trust
- Jonathan Smith – Locality Director, Hampshire, Southampton and Isle of Wight CCG
- Ian Sturgess- LGA Associate
- Amie Witherspoon - Adviser, LGA
- Hannah Donnelly - Adviser, LGA
- Catherine Huby- Regional Discharge Lead North East & Yorkshire, NHS England

Virtual Methodology

What is a Peer Review?

- A peer review is a sector-led, constructive and supportive process which is based on the foundation of continuous system improvement
- Peer reviews are not inspections; they are designed to hold a mirror to the system to reflect on what is working well and where there are areas for development. No judgement rating or score is given. It is delivered from the position of a 'critical friend' to promote ongoing learning and improvement
- Peers are senior leaders from health and care with experience in leading and shaping integrated systems – they come as critical friends to support improvement and learn as much from the discussions as local colleagues taking part
- At a minimum, the peer team will include a lead peer from the LGA as well as other senior peers from health and care, typically council, CCG and hospital sectors; supported by an LGA adviser to coordinate activity

What did we do in the Gloucestershire peer review?

- A number of conversations took place with representatives of the Gloucestershire system between Oct 2021 and May 2022 to agree the required support including the scope and intended outcomes of the review. A proposal was put together by the LGA and signed off by the Gloucestershire representatives.

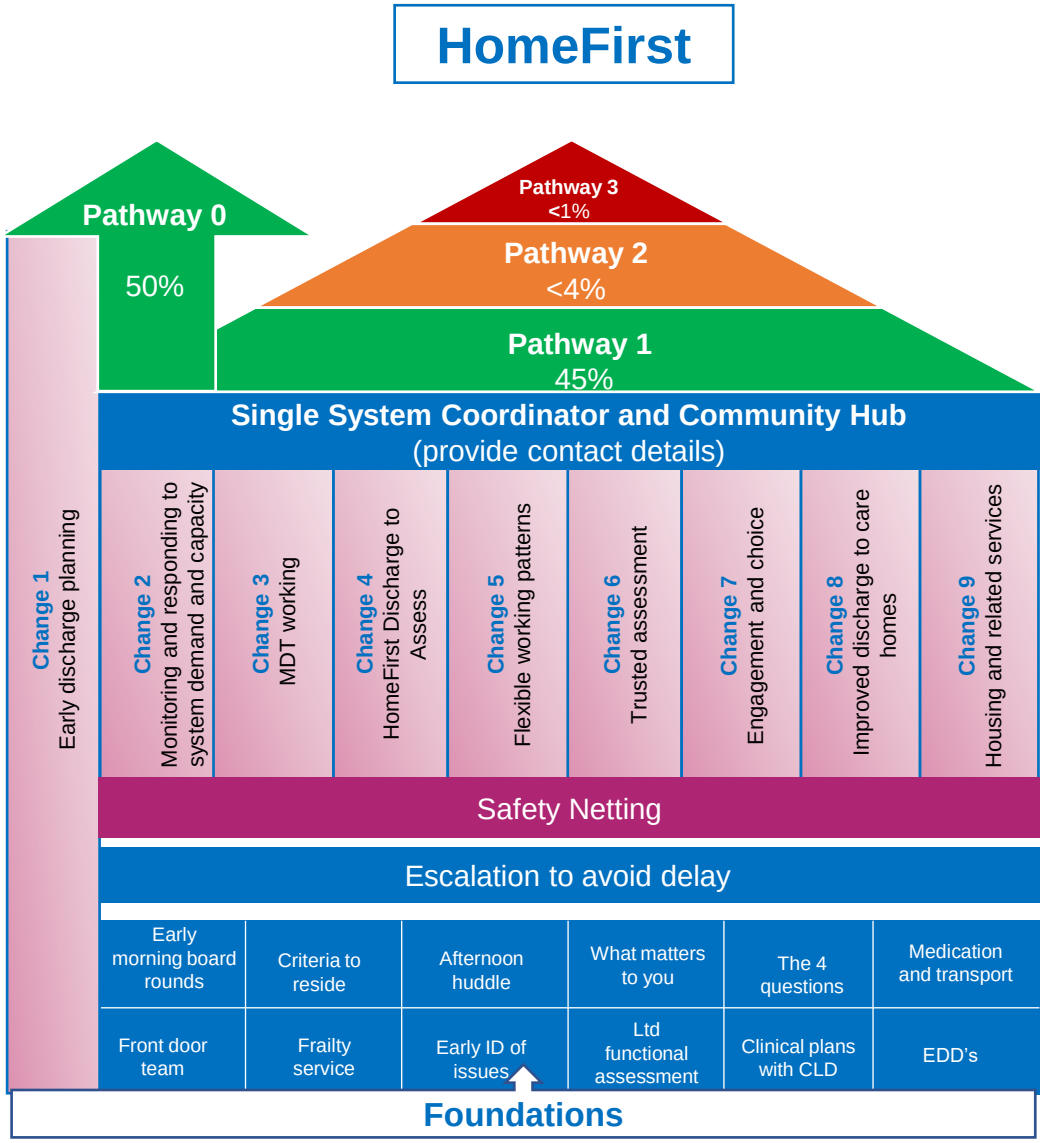
- A Discharge and Admission Avoidance Temperature Check survey was carried out prior to the review to gauge the systems assessment of the progress being made to implement D2A and the new Discharge Policy – see the slide below for the results.

- A virtual one day 'Peer Review' took place on 8th June 2022. The review included a series of interviews with staff and partners from across the health and care system, including both providers and commissioners. Teams spoken to included:
  - Front line staff from discharge teams, social workers, therapists
  - Executive leads, Commissioners and operational managers from Gloucestershire County Council and Gloucestershire CCG
  - Executive leads and operational managers from Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Health and Care NHS Foundation Trust

Improving hospital discharge

The LGA's sector-led improvement support programmes, in partnership with national NHS and BCF improvement teams, are underpinned by a range of evidence-based tools, which are employed as a framework in all peer reviews and support work:

- High Impact Change Models:
  - Managing Transfers of Care
  - Reducing Preventable Admissions to Hospital and Long-term Care
- Developing a Capacity and Demand Model for Out of Hospital Care, Professor John Bolton
- Implementing the Home First Discharge Policy Top Tips
- People First, Manage What Matters
- Implementing a Collaborative Commissioning Approach to Home First



Conditions for success

- Align system capacity to population need
- Increase the role of the third sector to improve community resilience
- Less reliance on bed based solutions is needed for home first models to succeed
- Co-produce the future market strategy and create flexible employment opportunities
- Agree pooled budgets and risk share arrangements underpinned by evidence

- Create a desire to make things better for local people
- Invest time to build relationships and trust
- Agree a collective ambition and vision
- Clarify lines of decision making and accountability
- Simplify and prioritise plans
- Create distributed leadership

- Simplify, standardise and streamline services, pathways and processes
- Agree shared system responsibility
- Use a single agreed dataset to drive system improvement
- Manage flow and capacity across the whole system
- Systematically and sustainably implement the Discharge Policy

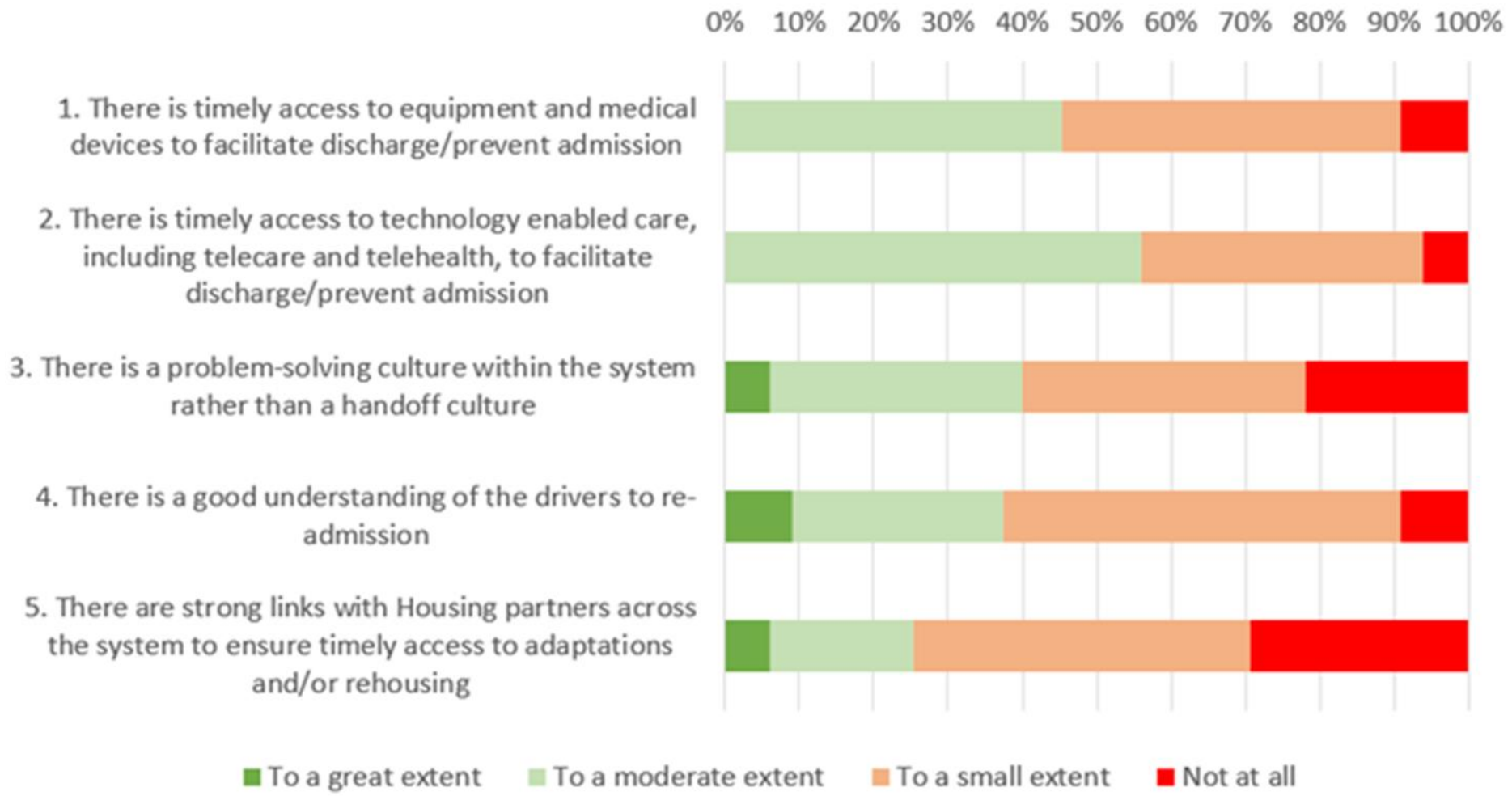
- Needs to be actively driven by system leaders
- Create a compelling narrative
- Develop a shared understanding of safe timely discharge
- Systematically learn about how the system works and support staff to be involved in continuous improvement
- Celebrate success

Discharge and Admission Avoidance Temperature Check Results

- Prior to the peer review we undertook a Discharge and Admission Avoidance Temperature Check survey to gauge perceptions the Gloucestershire workforce's of the different elements of discharge and admission avoidance
- 33 people completed the survey
- The breakdown of job roles of those who completed the survey is as follows:

Local Authority senior leadership	3%
Adult Social Care leadership including commissioning, performance and finance	9%
NHS Acute trust senior leadership	3%
Community Trust senior leadership	24%
CCG senior leadership	9%
Acute Trust Clinical Leadership	3%
Community Trust Clinical Leadership	9%
Primary Care	0%
Acute trust clinical teams including nursing, therapists, medical, mental health	0%
Community Health clinical teams including nursing, therapists, medical, mental health	3%
Discharge Hub / Transfer of Care hub staff / Discharge Coordinators	0%
Adult Social Care teams including Social Workers, Safeguarding, Quality Assurance	3%
Continuing Healthcare Teams	3%
Social care providers domiciliary, residential and nursing home care	9%
Voluntary sector providers	6%
Other (please specify below)	15%

General enablers of discharge and admission avoidance results



Survey results: Top successes and challenges

The results for the general enablers of discharge questions indicate the most successful element is timely access to Technology Enabled Care with just over 50% responding they agree with the statement to a moderate or great extent, however, there were a large number of people who responded that they agreed to a small extent or not all indicating mixed opinions about this element within the system.

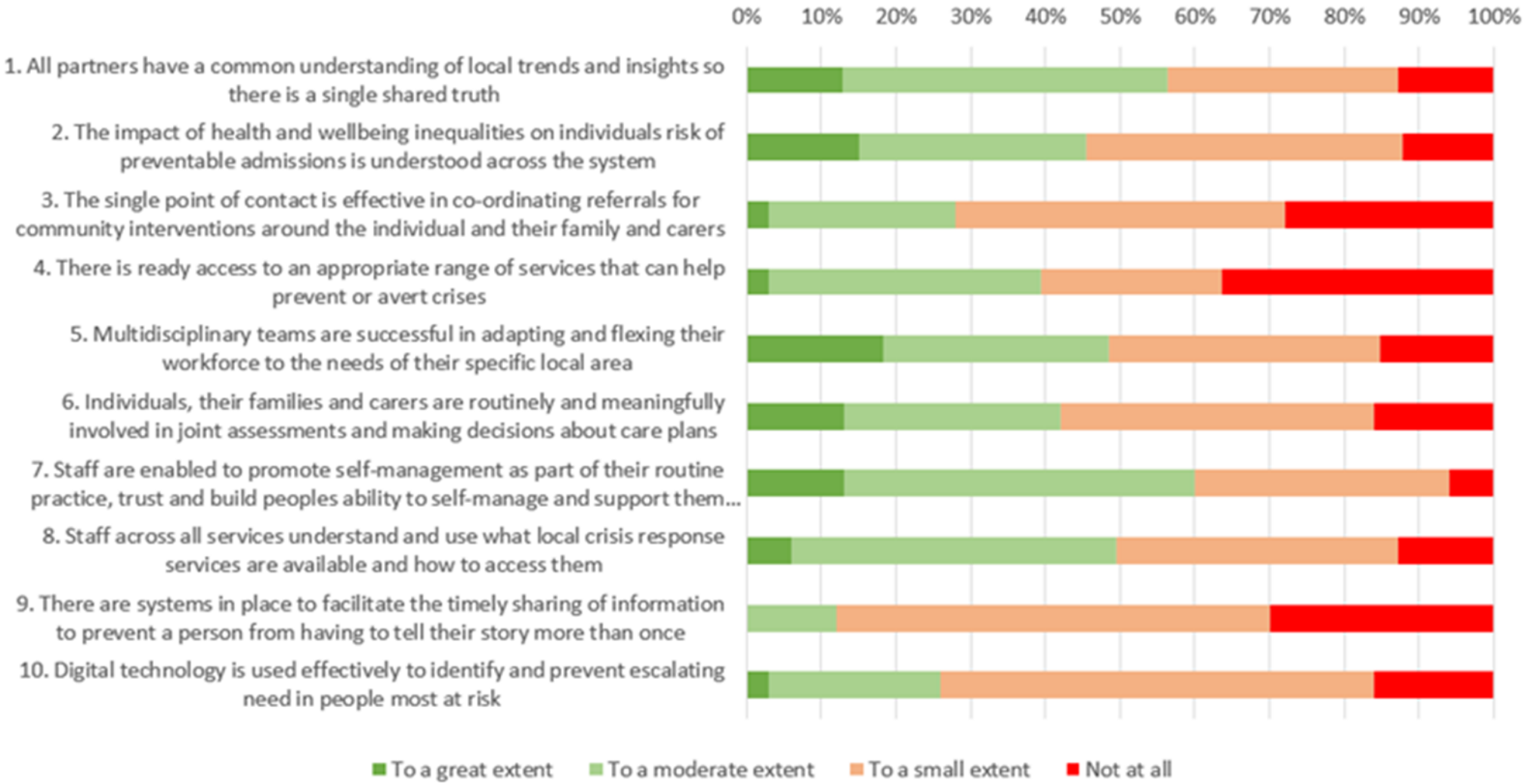
The results suggested the top 3 challenges are:

- Links with Housing partners
- Understanding of drivers to readmission
- A problem solving culture rather than hand off culture

Results of our national survey indicated the top 3 challenges are as follows:

- Links with housing partners
- Timely access to Technology Enabled Care
- Understanding of drivers to readmission

Reducing Preventable Admissions results



Survey results: Top successes and challenges

The results of the reducing preventable admissions questions indicate the most successful element is staff feeling enabled to promote self management with 60% of respondents saying they agree with the statement to a moderate or great extent, however, there were a large number of people who responded that they agreed to a small extent or not all indicating mixed opinions about this element within the system.

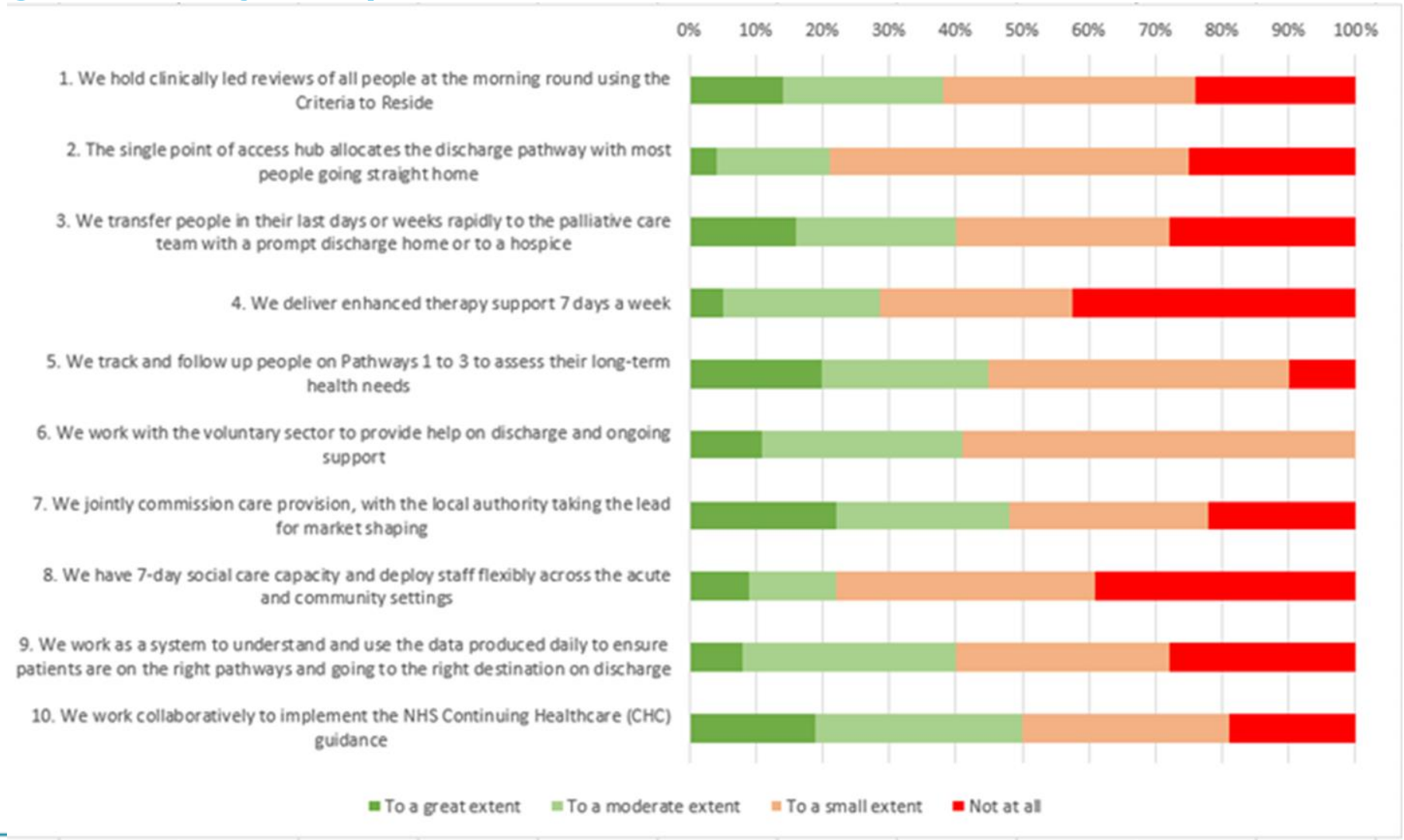
The results suggested the top 3 challenges are:

- Systems to facilitate timely sharing of information
- Digital technology used to identify and prevent escalating need
- The single point of access effectively coordinating community referrals

Results of our national survey indicated the top 3 successes and challenges are as follows:

Successes	Challenges
Staff are enabled to promote self-management	Digital technology used to identify and prevent escalating need
Individuals, their families and carers are routinely and meaningfully involved in joint assessments and making decisions about care plans	Systems to facilitate timely sharing of information
Multidisciplinary teams are successful in adapting and flexing / Understanding of local trends and single shared truth	There is ready access to an appropriate range of services that can help prevent or avert crises

Discharge Policy Implementation results



Survey results: Top successes and challenges

The results of the discharge policy implementation questions indicate the most successful element is working collaboratively with CHC however there were a large number of people who responded that they agreed to a small extent or not all indicating mixed opinions about this element within the system.

The results suggested the top 3 challenges are:

- The single point of access hub allocates the discharge pathway with most people going straight home7 day social care capacity
- 7 day enhanced therapy support

Results of our national survey indicated the top 3 successes and challenges are as follows:

Successes	Challenges
The single point of access hub allocates the discharge pathway with most people going straight home	We deliver enhanced therapy support 7 days a week
We hold clinically led reviews of all people at the morning round using the Criteria to Reside	We have 7-day social care capacity and deploy staff flexibly across the acute and community settings
We work collaboratively to implement the NHS Continuing Healthcare (CHC) guidance	We track and follow up people on Pathways 1 to 3 to assess their long-term health needs

Observations

Strategy and Vision

- We did not hear of a joint strategic vision for Gloucestershire. Organisations have their own organisational understanding and beliefs with little shared understanding of respective roles of partners in a HSC system including the important role of the VCSE sector. Reference was made to the 'One Gloucestershire' Strategy but staff were unsure where this had progressed to. We did however hear that the system are looking to select an external consultancy partner to help to develop a strategy which is encouraging however, this will require a very clear scope and consideration to ensure buy in from staff early on in the process.

- Staff were able to talk to some separate organisational strategies that are in place but they did not feel they were achievable with the current pressure and resources and felt that there needed to be more alignment. There is an opportunity to revisit existing strategies and ensure they all connect.

- We were pleased to hear about workshops being undertaken to understand the pressures amongst partners but there is a need to build on this to develop trust and commitment with and to each other in creating a system response. Understanding and supporting each others pressures will be key to developing that trust.

- We met some very committed, determined and passionate staff and saw a lot of desire to get this right with staff working together at lower levels seeking clarity around what system leaders want them to do to work together more effectively.

- We heard of lots of complicated rules and eligibility criteria causing unnecessary delays and confusion for staff. We also heard of lots of short term initiatives, pilots and moving goals with insufficient measuring of outcomes, or prioritising which also leads to confusion for staff and a sense of apathy regarding change. It is worth reflecting if there is sufficient resource allocated to embed change and develop clear communication with staff about changes, expected benefits and the long term goals.

Observations

Strategy and Vision

- It appeared to the peer team that Gloucestershire could commission on a more person centred basis rather than from organisational silos. We did not hear about a joint commissioning framework and feel this is needed to drive outcome based commissioning for outcomes but we did hear that good progress was being made in partnership working in the joint commissioning team and it may be a matter of timing of the peer review.
- It appeared to the peer team that the urgent operational work was crowding out the important strategic work and leaders might need to create time and space to come together and develop robust joint strategies and a shared vision and language now in the post covid time, thinking through taking the best of the joint working into those discussions but doing so in a way that recognises the pressures across all of the system and is based on achieving the best outcomes for people as part of a safe and timely discharge.

Observations

Leadership, Behaviour and Culture

- We commend Gloucestershire leaders for acknowledging the challenging time they are in and opening themselves up to scrutiny in the form of a peer review. It is clear there is a real desire to do things differently and a willingness to work together to do so.

- We heard positive feedback about progress made with population health management, work with frailty at the front door, developing locality based partnerships and the work of the joint commissioning team as well as the positive impact of the new system flow coordinator role. Reference was also made to the Rapid Response service being a very successful initiative.

- We felt that communication with staff and partners about how you work together could be improved as there appeared to be a disconnect regarding how collaborative the system and organisations are; leadership praised partnership working but as we spoke with people in more junior roles, perspectives were that working is siloed and the overriding opinion was "we are not an ICS". Communication was seen by staff as being a real barrier to effective collaborative working. This was particularly true of the Independent sector who did not feel as if they were treated as equal partners and felt they often were not treated with respect by health and social care staff.

- There appeared to be a view from ASC that their only role is to support the hospital and that their work overwhelmingly focused on the acute agenda at the expense of everything else. We heard of ASC staff being pressured to move people to D2A beds whom they didn't feel should be in a D2A bed to free up acute capacity. Work needs to be undertaken to ensure parity of esteem and mutual respect between all partners in addition to recognition of the significant amount of risk carried by the community and the important role they play in admission avoidance.

Observations

Leadership, Behaviour and Culture

- There is a risk-averse culture amongst staff, with a reluctance to discharge individuals in case something goes wrong. Nobody wants to risk recourse on themselves, their team or their organisation. Staff need to be empowered and understand the risk of keeping people in hospital, not just the risk of sending them home. Many of these concerns seemed to stem from a lack of confidence in community services so it is worth reflecting upon how staff are educated on the menu of services in the community and stronger links established between acute and community teams to relieve some of these concerns.
- We also heard of concerning reports of important information not being shared by acute staff regarding risk to the patient, staff or other patients. These incidents seem to be contributing to a feeling of mis-trust between partner organisations and indicate the presence of a hand-off culture rather than a collaborative culture.
- We heard of a culture of organisational blame and finger-pointing. There appears to be a fundamental issue of a lack of understanding, trust and support between partner organisations with no shared accountability being taken for the challenges the system is experiencing.
- We also heard about staff being discouraged from talking about the issues as these conversations were seen as too difficult or too awkward to have so heard reference multiple times to there always being an “elephant in the room”.
- We were concerned that we rarely heard about the person or outcomes for people during our discussions. A person centred approach appears to have got lost in the organisational and system culture within which staff are working.

Observations

Performance

- We heard of great ambitions for data capture and sharing and about the work with Amazon Web Services to build a dashboard which is soon to go live and is a positive step. There were however missed opportunities to involve adult social care in data capture and sharing, including the work undertaken to refine terminology so that everyone understands the language of the data captured. An agreed system wide set of metrics is required.
- There was a sense of preoccupation with the numbers. We heard a lot about the percentages on each pathway but very little about the outcomes or experience of people. It felt like there was a need for those working in the system to put themselves in the shoes of the people they serve and to truly listen to acknowledge the poor experiences people are having due to ineffective processes and lack of joined up working.
- We were very concerned about the significant issues raised relating to End of Life care and feel that these issues need to be addressed as a matter of urgency. We heard that Fast Track is not implemented effectively resulting in people dying in hospital due to lengthy bureaucratic processes. We heard of staff feeling they have exhausted the escalation route and that leadership are not taking action to address this issue. They are concerned about the potential for harm due to ineffective processes and concerned that they are in breach of their professional codes of conduct. We heard of the detrimental impact these processes are having on people and their families with reports of anger and violence directed at frontline staff because patients and their families were so frustrated about systems and processes which didn't work.
- Concerns were also raised regarding risk to and gaps in provision for people with dementia and about people who are non weight bearing being discharged to D2A beds with little to no therapy input resulting in significant deconditioning. We also heard of people being rehabilitated and ready to go home but due to lack of P1 capacity, being admitted to D2A beds and becoming deconditioned again whilst there.

Observations

Performance

- It is widely acknowledged amongst staff at all levels that the Gloucestershire system is over-reliant on beds and does not have a Home First ethos. Staff talked of “old fashioned ways of working” and a sense of helplessness and apathy as “flow is so poor that clinicians have disengaged from some of the process as they don’t see anything making a significant difference.”
- There is a need to restart implementation of the Hospital Discharge Policy, agree on pathway definitions and learn from systems where good progress is being made.
- An effective Transfer of Care Hub is required in addition to a single coordinator. The function of the Transfer of Care Bureau should be reviewed as we heard reports of it being ineffective and inconsistent since the permanent chair of the TOCB left.

Observations

Community Capacity

- We heard about a significant amount of wasted capacity in the system with lots of people getting too much care. There appeared to be several reasons for this; risk aversion of acute staff, staff intentionally over-prescribing care as domiciliary care agencies are reluctant to take on smaller packages, and patients not having the confidence in community services and worrying they will not get the care they require at home so opting to go into a Care Home bed. As a peer team we wondered if a greater understanding of the impact of over prescribing care and a risk averse culture on domiciliary care capacity is needed to get a system wide approach to making best use of a scarce resource.
- We heard a lot about workforce challenges across both health and social care partners but did not hear about any initiatives to begin addressing this issue. There appeared to be a learned helplessness. New initiatives are required to attract people into the health and social care workforce but the system must also take time to listen to their existing staff and consider how they retain them. Workforce challenges need to be seen as a shared issue and addressed in a collaborative way.
- We heard of serious concerns regarding the brokerage function, particularly in relation to the decision to subsume the CHC brokerage team within wider brokerage service which has had a significant impact on timeliness and effectiveness of Fastrack processes with waits of up to 21 days referenced. This has lead to staff effectively bypassing the process and brokering the care themselves in order to get their end of life clients out of hospital. Interestingly, these challenges were not recognised by the brokerage team suggesting a disconnect between the team and the wider workforce. These processes need to be reviewed as a matter of urgency.
- The VCSE sector is a formal part of the discharge pathway but VCSE partners do not feel valued or respected by health and social care staff. There is not parity of esteem and the inability to access care records, and share and receive information about discharge is a real challenge. We also heard of a mismatch of expectations and boundaries regarding what they could and should deliver. They feel there is an expectation to take on increasing acuity and complexity of clients but they currently feel very isolated and that they do not have access to support from statutory partners if they need it. They feel as if they have the same level of access as members of the public rather than as a partner within the system. Commissioning and Contracts could work with VCSE partners to understand their concerns and help to address them for the system to be able to maximise use of the VCSE sector to relieve pressure on domiciliary care.

Observations

Community Capacity

- The long standing voluntary sector network pulling partners together that input into UEC pathways offers a real opportunity for closer engagement and collaboration with voluntary sector partners. The use of the voluntary sector to support Pathway 0 and 1 discharges needs further exploration – we did not hear of them playing a large part in the process.
- We were pleased to hear about the collaborative work being undertaken to develop the home based rehabilitation and reablement service and heard of the challenges regarding the mixed management model and difficulties recruiting. The two stage Reablement model whereby people go through Home First for an assessment period of up to 10 days then on to Reablement seemed to be an unnecessarily complicated process – we would recommend this be reviewed.
- The eligibility criteria for Reablement would also benefit from a review as we heard of stipulations such as self-funders, those with dementia, those who have previously had social care and those who have recently had Reablement being deemed as not eligible for the service which will have a detrimental impact on Domiciliary Care capacity and also does not align with Care Act responsibilities. We also heard that the eligibility criteria tends to vary depending which coordinator is on duty. A clear and consistent approach is required to avoid confusion for staff referring into the service

Recommendations

- The senior leaders in Gloucestershire may wish to come together to reflect on the feedback from the peer review, particularly in relation to the lack of a person centred approach and the distress being caused by inefficient processes. The peer team has only interviewed a small number of people but the theme was consistent across organisations and staff are incredibly concerned about both their patients/service users but also their own registration. We would urge you to explore this further and believe that there is huge opportunity for change with the new ICS roles and new people in post. A good first step may be to share the learning from the mortality review of D2A patients.

- There is a need for the challenges in the system to become shared challenges for all partners – the care capacity difficulties, the workforce challenges and the discharge delays. None of these issues can be resolved by one partner alone – all organisations have a role in creating and resolving the difficulties faced. Whilst there are many national elements to these challenges there is more the system can do collectively to meet them locally but it will require senior leaders to commit to that approach – not just in terms of programme management but in terms of a shared culture of shared problem solving which staff see and believe to be real.

- System governance and escalation routes could be reviewed so that there is a clear route to escalate risks.

- There is an opportunity to review and rationalise the number of initiatives currently running. The aim at the moment should be long term, sustainable and system wide change rather than small scale pilots.

- In addition to the work on developing a system wide strategy due to be undertaken by external consultants, leaders could also review existing strategies and ensure they are achievable and aligned and that a clear communications plan is developed for all future strategies to ensure it lands with the workforce. A strategy and vision leadership group may be beneficial and this must include VCSE representation as an equal partner around the table.

Recommendations

- The Discharge Policy has not been fully implemented across the system and there are still processes and practices in place which relate back to DToC which are not helpful to embedding a D2A/Home First approach. Implementation of the policy should start with agreeing pathway definitions, terminology and metrics as a system and a good organisational development programme is required to embed the changes. Planning for discharge must start from the moment of admission and risk averse practices must be addressed.

- We heard some positive feedback about the beneficial impact the role of the system flow coordinator has had. We do however feel Gloucestershire would benefit from a single coordinator role as outlined in the discharge policy to address relationship challenges and ensure there is a single ambition, manage up to hold system leaders to account but also manage down

- The function of the Transfer of Care Bureau could also be reviewed. The creation of a truly integrated Transfer of Care Hub is key to the successful delivery of the Discharge Policy and the move towards the new way of working away from the previous DToC approach. An effective TOC hub can help to provide clarity to ward staff about the new Pathways and help to build new relationships with the wards through using the Criteria to Reside criteria. The hub should include representatives from the care market, housing and the voluntary sector.

- There is a need to undertake a capacity and demand modelling exercise to ensure that community capacity is developed with a view to reducing the over-reliance on D2A beds and community hospital beds, ensuring that the workforce is utilised effectively with a shift of assessment and therapy staff from the acute hospital to the community, an investment in intermediate care services in both bedded-based care and the community that will help support people's recovery and a focus on the outcomes for older people rather than their length of stay or speedy discharge.

Observations

"We have initiative-itis!"

"We are warehousing frail elderly people in community hospitals"

"We are not an ICS"

"How do we resuscitate ourselves".

"Clinical staff don't want to hang on to patients, they're just really worried about them "

"We are told 'don't go there' when wanting to talk about deficits in the system as it is too awkward to have those conversations"

"We get through the winter by everybody just running a little bit faster"