Department of Health & Social Care

Ministry of Housing, Communities & Local Government

Local Government Association

NHS England

Solihull Delayed Transfers of Care (DToC) **Peer Challenge Report**

June 2019

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Background

1. The Solihull health and social care system took up an invitation for a peer challenge focused on the issue of Delayed Transfers of Care (DToC) from the national Better Care Fund (BCF) partners (Department of Health and Social Care, Ministry of Housing, Communities and Local Government, Local Government Association and NHS England). The clients for this work were representatives from Solihull Metropolitan Borough Council (SMBC), Birmingham and Solihull Clinical Commissioning Group (BSol CCG) and University Hospitals Birmingham NHS Foundation Trust (UHB). They were seeking an external view, comment and recommendations on what they do well on DToC and where improvements can be made. The exact scope of the work was:
2. To act as a 'critical friend', taking a system-wide view of Delayed Transfers of Care (DToC) and answering the following questions:

    - Are the practical processes for identification and sign-off of DToC robust or are refinements needed?

    - Given the extent of recent system change (merger of 3 CCGs across Solihull and Birmingham and the merger by acquisition of Heart of England Foundation Trust by University Hospitals Birmingham, and an STP across two council areas) is the STP system and associated partner organisations progressing arrangements which enable maintained understanding of performance and outcomes for populations at both 'STP' and 'Health and Wellbeing Board' level geographies and associated improvement progress?

    - What would be the most appropriate opportunities to take advantage of, to improve integrated working for the benefit of local residents, given our current local system position?

3. The benchmark for this peer challenge was the set of Framework Questions which are included as Appendix 1. Prior to the peer challenge exercise the Solihull health and social care system completed a self-assessment to give the peer challenge team a view with which to compare what they read, heard and saw while onsite. The headings provided by Solihull namely Delayed Transfer of Care, system change and strategic alignment and opportunities to advance integrated working were used to collate the team's thoughts whilst the feedback itself used the specific heading given to the team by the client in the scope.
4. A peer challenge is designed to help a system of partners assess current achievements, areas for development and capacity to change. The peer challenge is not an inspection. Instead it offers a supportive approach, undertaken by 'critical friends', with no surprises. All information is collected on a non-attributable basis to promote an open and honest dialogue. All advice and guidance is given by the peer team in good faith to help a system improve.
5. The members of the peer challenge team were:

    - **Cathy Kerr**, Local Government Association Associate, former Director of Adult Social Services

- **Martin Phillips,** Local Government Association Associate, former Clinical Commissioning Group Accountable Officer
- **Elaine Bradley,** Head of Care and Support Services, Central Bedfordshire Council
- **Lisa Christensen**, Improvement Manager, Emergency Care Improvement Support Team
- **Paul Grimsey**, Policy Manager, Devon County Council, Adult Care and Health
- **Rich Brady**, Advisor, Care and Health Improvement Programme, Local Government Association
- **Venita Kanwar**, Challenge Manager, Local Government Association Associate

6. The team were on-site from 18th–21st June 2019. The programme for the on-site phase included activities designed to enable members of the team to meet and talk to stakeholders across the health and social care system. These activities included:

    - interviews and discussions with staff, councillors and partners
    - meetings with managers, practitioners, independent care providers, frontline staff and carers representatives
    - reviewing documents provided by the system including a self-assessment of areas of strength and challenges the system faces.

7. The peer challenge team would like to thank all those involved in the review, across all organisations, for their open and constructive responses during the review process. The team was made very welcome and would in particular like to thank Roger Catley, Governance Lead – Adult Care & Support, and Ian Shakespeare, Programme Manager, SupportUHome for their invaluable assistance for the on-site support to the team in planning and undertaking this peer challenge which was exceptionally well planned and delivered.

8. Prior to arriving on-site the team considered over seventy-five documents including a self-assessment and had fifty meetings with at least one hundred and fifty different people. The peer challenge team have spent about 448 hours with Solihull health and social care system and its documentation, the equivalent of 64 working days.

9. The peer team provided high level feedback to Solihull health and social care partners on the last day of the on-site activity and gave an overview of the key messages. This report builds on the initial findings and gives a detailed account of the findings from the peer challenge.

Key Messages

10. The peer team met many dedicated staff working at different levels across the system involved in the discharge of patients from hospital settings. The peer team were hugely impressed by the committed and positive staff who

consistently demonstrated their enthusiasm for their work and the wellbeing of those in their care across the whole partnership.

11. The peer team agreed that the description of Solihull in the self-assessment provided a picture that we recognised during our week's visit and reflected an honest appraisal of the challenges and strengths in the system.

12. The peer team reflected that it is important to maintain the focus on enabling the people of Solihull to live 'healthy and happy lives' – only going to hospital when it is clinically necessary and coming "back home to Solihull" without any avoidable delays.

13. The peer team thought that what you were doing as a system in Solihull was good, with the potential to move from 'good to great'.

14. The foundations have been built. Now is the time for you to operationalise a consistent approach for all the partners involved in ensuring a safe, effective and timely journey from hospital admission to discharge. The report sets out recommendations aimed at helping you to achieve this.

Recommendations

The full set of recommendations is listed below. Further detail follows in the subsequent sections.

On DToC -

15. The system has addressed issues with recording and counting of DToCs which has provided a better understanding of the reasons why people experience delays. The system should now focus efforts on responding to the identified reasons for delays, and deliver practical responses across the system.

16. Action should be taken to provide assurance that the Patient Choice Policy is being applied consistently, including to self-funders. A broader piece work could be considered to increase public understanding and allow staff to better manage expectations about people's care at a time when individuals and families are unsure about the options available to them.

17. Action should be taken to quality assure the manual processes used to collect, validate and report DToC and reduce the likelihood of error.

On Strategic / system wide working -

18. Develop a clearly articulated framework / programme of work to ensure that the vision of 'Solihull Together' is understood and owned by staff working at all levels, and residents in the borough. Use your vision and five aspirations to make sure everyone in the system (and outside the system) is living, breathing, delivering and receiving them.

19. Ensure there are effective strategic arrangements in place which give parity to independent care sector providers, recognising them, like NHS Trusts, as key strategic partners in the system.

20. Publish the updated Health and Wellbeing Strategy and Market Position Statement as a matter of priority.

21. Review governance arrangements to ensure they continue to be fit for purpose and that 'Solihull Together' operates effectively to drive improvement locally. This could include a review of responsibilities and reporting arrangements to ensure there is clarity on where in the system decisions are taken.

22. From what the peer team have observed, Solihull is in a good place. It is the view of the team that the best way to safeguard the interests of Solihull in the wider system is to be bold, and to accelerate your plans and delivery. The peer team heard, ***"If we can't do it in Solihull, we can't do it anywhere".*** Compared to other areas, the arrangements for delivery and implementation in Solihull are neatly set out, and as such, should assist in ease of action and delivery.

On integrated working and pathways -

23. Undertake thorough system–wide demand and capacity modeling to ensure that you have the right services in place to meet the needs of Solihull residents in their own home, wherever possible. This would be in line with best evidence and practice and will, almost certainly, mean you re-shape your provision by reducing community beds and increasing reablement support at home.

24. Develop clear, defined and effective pathways out of hospital which are understood by staff working across the system, including care home and home care staff in independent sector providers. Ensure that there are clear pathways for Solihull residents who access hospital care in Birmingham and ensure that these are consistently applied across the system.

25. To support pathways, ensure there is a streamlined single, integrated, support at home service to enable people to remains in their own homes where possible, and leave hospital as soon as they no longer require acute hospital care.

26. Develop a programme of education and information so that staff across the system have a better understanding of both pathways and the range of service available. This should also be translated into a programme of awareness raising for partners and the wider public.

27. Include independent sector social care providers as equal partners in this work, and further build on early work with the Primary Care Networks to fully involve primary care.

28. Support people out of hospital while recognising the need to sit services within the wider context of the strengths of locality working, increasing the focus on supporting people at home, and including prevention of admission to hospital and long-term care as a whole system. Supporting people to leave hospital is not the end but one element within the system, of locality provision.

Solihull Themes

The peer team were asked to consider the following questions by Solihull during the peer challenge. These questions provided the peer team with their main areas of focus and the team used these as their framework for feeding back to the system.

- Are the practical processes for identification and sign-off of DToC robust or are refinements needed?

- Given the extent of recent system change (merger of 3 CCGs across Solihull and Birmingham and the merger by acquisition of Heart of England Foundation Trust by University Hospitals Birmingham, and an STP across two council areas) is the STP system and associated partner organisations progressing arrangements which enable maintained understanding of performance and outcomes for populations at both ‘STP’ and ‘Health and Wellbeing Board’ level geographies and associated improvement progress?

- What would be the most appropriate opportunities to take advantage of, to improve integrated working for the benefit of local residents, given our current local system position?

Q1: Delayed Transfers of Care

Are the practical processes for identification and sign-off of DTOC robust or are refinements needed?

Findings

29. The peer team were asked to look at the operational side of DToC and performance monitoring. We observed that in relation to the counting of DToC the system has been on an improvement journey. We were advised that in 2017- 2018 DToCs were not being recorded correctly and there was significantly under reporting. After a focused review this was corrected in April 2018. An adjustment was made through Better Care Fund (BCF) arrangements and national agreement given to a recalibration of the DToC targets for health and for social care. The peer team were requested to look at the operational process of discharge planning and whether the 'technical' process of identifying, agreeing and recording and submitting DToC figures was robust. We observed that there are now good systems and processes in place for counting and signing off the delayed transfers of care.

30. In the data collection process we were informed that there are occasions where data is transferred manually across systems – the system should be vigilant to ensure that this does not become a source of error.

31. While the peer team are assured that processes for reporting DToC have a level of robustness, the peer team did not hear a consistent narrative or understanding for the continued variation in performance. Although a range of reasons were suggested the absence of a shared understanding of the 'problem' will inhibit the effectiveness of any management action within organisations, and more so across the system.

32. Although DToC and other measures are reported through several governance routes, it was not clear where in the system responsibility lay and therefore where the accountability and drive for improvement was placed.

33. The issue of counting errors is now behind you, but it is important to remain vigilant. The task now is to get under the skin of the reasons why people are delayed and taking effective system action to address these in a consistent and sustained basis.

34. We heard that a major reason for delays is to do with the lack of understanding about the appropriate application of the patient choice policy to the many self-funders in Solihull. However, clear and consistent delivery of the choice policy can better enable you to take control of this obvious contributor to DToC. The peer team suggested contact with another area which has a high proportion of self funders but is performing well on DToC.

35. There may be cultural issues around expectations that people can go into social care homes following discharge, rather than a culture of establishing a "home first" option. There is a need to increase awareness and understanding of the purpose of the patient choice policy across all staff in the system. The

first communication should be a ‘welcome to the hospital’ letter that sets out plans and expectations around the patient’s care, treatment and discharge. This is the opportunity to set the expectation that people will return home as soon as they have finished their acute episode of treatment, with support as required. This letter should be given to ALL admitted patients within 24-48 hours.

36. As in most systems where there is any level of staff turnover, a level of knowledge is lost and it was evident that there was not a shared understanding of DToC within organisations or across the system, often compounded by the language used. The value of education and learning being refreshed should not be underestimated, particularly where the impact of action and inaction has such a direct impact of the care of local people.

Recommendations

37. The system has addressed issues with recording and counting of DToCs which has provided a better understanding of the reasons why people experience delays. The system should now focus efforts on responding to the identified reasons for delays, and deliver practical responses across the system.

38. Action should be taken to provide assurance that the Patient Choice Policy is being applied consistently, including to self-funders. A broader piece work could be considered to increase public understanding and allow staff to better manage expectations about people’s care at a time when individuals and families are unsure about the options available to them.

39. Action should be taken to quality assure the manual processes used to collect, validate and report DToC and reduce the possibility of error.

Q2:

Given the extent of recent system change (merger of 3 CCGs across Solihull and Birmingham and the merger by acquisition of Heart of England Foundation Trust by University Hospitals Birmingham, and an STP across two council areas) is the STP system and associated partner organisations progressing arrangements which enable maintained understanding of performance and outcomes for populations at both 'STP' and 'Health and Wellbeing Board' level geographies and associated improvement progress?

Findings

40. In April 2018, three Clinical Commissioning Groups (CCG's), Birmingham CrossCity, Birmingham South Central and Solihull CCG (the last of which covered a population of approximately 211k) merged into one new organisation, Birmingham and Solihull CCG, covering Birmingham and Solihull (population over 1 million). The patch covered now is therefore significantly larger. The organisation is still in the process of embedding new staffing structures and was reported as "still feeling new".

41. The team found nothing to suggest that a Solihull focus had been 'lost' within the recent system changes. We heard from many people that the integration of the CCGs, had actually brought a change for the better. The peer team were told about improved relationships at leadership level with a strong focus on delays as a system, and praise for SMBC by health partners to reduce discharge delays. Chief Officers spoke of Solihull Together for Better Lives (ST), chaired by the Chief Executive of SMBC, described as "the glue" and the "delivery vehicle" for driving the priorities for BSol STP and the Health and Wellbeing Board (HWBB) in Solihull.

42. The University Hospital Birmingham (UHB) and Heart of England Foundation Trust also merged in 2018 becoming a much larger organisation with multiple sites. Solihull is therefore only a small proportion of the total population it serves. UHB provides the community health services in Solihull. This is not the case in Birmingham which is served by a separate community trust.

43. The Birmingham and Solihull Mental Health Trust (BSMHT) has not restructured, but has a new Chief Executive following the retirement of the previous post holder. All in all, Solihull's health partners have experienced a great deal of recent change. Importantly, in addition to organisational turbulence described in the focus of the review, the Peer Team often met people who were relatively new to the Solihull system or new to their responsibilities.

44. Despite the amount of change across the health system, the peer team found evidence of strong and effective leadership across the system.

45. At a strategic level governance arrangements and shared aspirations set out in the 5 priorities for action are clear. These are:
    - Independence and resilience
    - Equity, equality and inclusion
    - Integration and simplification

- Promoting prosperity
- Creating social value

46. The STP, HWBB and Solihull Together have clear governance which was clearly articulated by system leaders. This is good practice which we would like to share. It will be important for the system to ensure that such arrangements are routinely reviewed so that they continue to be appropriate.

47. System leaders expressed an impressive commitment to partnership working, with high levels of trust making it possible to have 'difficult conversations' when needed. This gives Solihull a strong basis and platform to take opportunities forward.

48. Birmingham and Solihull CCG described being focused on "*commissioning with one voice*" which enables a greater ability to shape the market across the city-region (West Midlands). There was a clear consideration of commissioning decisions; which would bring greatest benefit from working at a regional level, through to those that needed to be more local. There were some examples of joint commissioning with the local authority though the peer team observed that this could be developed further.

49. While at a leadership level all partners understood the direction of travel, the peer team saw less evidence of how the shared vision and system aspirations permeated through to the rest of the system and at all levels, further work is needed to embed this throughout organisations.

50. There were well established arrangements which bring in wider system partners, (e.g. communities, housing, economy), resulting in a comprehensive focus on the wellbeing of the residents of Solihull. The peer team thought there was evidence of good work particularly with housing colleagues where the ALMO is central to strategic planning, and working with the CCG on Primary Care Networks. Data is being used from the housing waiting list to feed into development proposals. Evidence of effective leadership is demonstrated by the Joint Adult Social Care and Housing Board being co-chaired by the Director of Adult Social Care and Support and the Chief Executive of Solihull Community Housing.

51. The peer team heard about the development of three localities in Solihull. This was initiated by SMBC but is developing in partnership, and with co-terminosity with the newly developing Primary Care Networks (PCNs). The team considered this to be excellent work, focusing on the needs of particular localities, looking at ways to engage with local people and communities. This more qualitative work has the potential to increase resilience and make a significant contribution to enabling people to stay 'happy and healthy' at home.

52. The peer team noted that the role of primary care did not feature significantly in many of the interviews. However, the team were encouraged to hear about the developing PCNs and considered that these present an opportunity to increase the shift away from hospital to community, including a more preventive focus.

53. The peer team understands that the HWB Strategy is in draft form and has been presented at a HWBB meeting following the review, and we also understand that a Market Position Statement (MPS) is in draft form. It is important that these are published as soon as possible. The peer team believe that the publication of the MPS will be a good basis for engagement with independent sector providers on future commissioning priorities and could support beginning a new conversation with them.

Recommendations

54. Develop a clearly articulated framework / programme of work to ensure that the vision of 'Solihull Together' is understood and owned by staff working at all levels, and residents in the borough. Use your vision and five aspirations to make sure everyone in the system (and outside the system) is living and breathing, delivering and receiving them.

55. Ensure there are effective strategic arrangements in place which give parity to independent care sector providers, recognising them, like NHS Trusts, as key strategic partners in the system.

56. Publish the updated Health and Wellbeing Strategy and Market Position Statement as a matter of priority.

57. Review governance arrangements to ensure they continue to be fit for purpose and that 'Solihull Together' operates effectively to drive improvement locally. This could include a review of responsibilities and reporting arrangements to ensure there is clarity on where in the system decisions are taken.

58. From what the peer team have observed, Solihull is in a good place. It is the view of the team that the best way to safeguard the interests of Solihull in the wider system is to be bold, and to accelerate your plans and delivery. The peer team heard, ***"If we can't do it in Solihull, we can't do it anywhere".*** Compared to other areas, the arrangements for delivery and implementation in Solihull are neatly set out, and as such, should assist in ease of action and delivery.

Q3: Opportunities to advance integrated working

What would be the most appropriate opportunities to take advantage of, to improve integrated working for the benefit of local residents, given our current local system position?

Findings

59. There was evidence of strong leadership at system level as detailed in Q2. This provides a platform to launch improved integrated working and to take advantage of opportunities to develop further integrated systems to build on timely discharge from hospital for the benefit of local residents.

60. The peer team heard of some good examples of integrated working, for example Occupational Therapists (OTs) assigned to reablement services working on a six day basis within the reablement team to get people back home, this has been a great success in improving flow. The peer team also heard of good relationships between the brokerage service and care homes, with plans in place for brokerage to broker both health and social care referrals. The team thought this an excellent proposition, building on current positive work.

61. There is promising early work on locality development including engagement with the newly developing Primary Care Networks (PCNs), providing a strong platform for integrated working, albeit still at early days. We were told about excellent working between GPs and geriatricians. Localised working is of benefit to residents in providing tailored services based on need and prevents or minimises admissions to hospital and importantly provides a platform to engage with primary care, who do not seem to have been effectively engaged as partners and\or providers so far.

62. Positive steps are being taken to improve information sharing ~~a~~across the system. The peer team heard about the difference that the Council's implementation of a new Liquid Logic system is expected to make to the improvement of information recording and sharing. This system is primarily for recording social care information but has been designed with portals that NHS partners can use to facilitate integrated planning and information sharing. The system was due to go live on Monday 24th June, and despite the upheaval of installing a new system, there was a great deal of optimism from SMBC and NHS staff about the difference it would make.

63. At Heartlands Hospital we were told about delays in providing equipment which meant that some Solihull patients were being admitted due to delay in equipment provision – the team were told that this was not an issue for Birmingham patients. However, the team also heard about work to address this. The SMBC Equipment Service is a joint-funded service and has seen big improvements over the last 12 months following substantial changes. The vision is to use equipment to support independence and improve efficiency. The standard is to deliver anything required in 48 hours, but urgent items (including hospital beds) can be delivered on the same day. Customer responsiveness is a clear core value. Buffer stores have been created in hospitals to facilitate direct issuing by hospital staff; District Nurses have 'boot stores' of small, frequently required pieces of equipment in their cars. A Blue Badge clinic has been established in

the equipment demonstration centres and the Solihull Community Housing Service can prescribe equipment. A new induction training programme for drivers means they can deliver and install some pieces of equipment which brings greater efficiency. The ELMS system used by the service facilitates an 'Amazon-style' tracking and delivery system including texts to customers about delivery time slots. The service is over-spending its current budget. These were impressive and encouraging developments and an analysis of the cost-benefit of this service which aims to prevent hospital admission and facilitate prompt discharge would be beneficial.

64. We found evidence of some 'fragmentation' and 'silo' working and differing practices. The peer team saw services that were working hard but not joining up together. An example of this was the lack of integration of social work teams with the discharge hub teams. They operate separately which inevitably builds in unnecessary delay. We heard of a decision being taken to reduce the number of board rounds attended by the social work team which affected communication and timely action around patient discharge.

65. The team observed that there were multiple services often with differing access / eligibility. For example, it was difficult to understand why the Supported Integrated Discharge (SID) and reablement services were not integrated into one service that could support more people to go straight home with support. The peer team thought there was an opportunity to carry out some streamlining, and also heard from staff that it might be beneficial for them to carry out some awareness raising and education sessions about the services available for Solihull residents.

66. The peer team observed some lack of appreciation, knowledge and understanding of pathways, processes and out of hospital services. There was a lack of clarity around how all the pathways joined up for the benefit of Solihull residents which meant that people were not always getting services that might have benefitted them or they might not have been discharged earlier because of the lack of knowledge about the support that was available in community settings. The peer team have observed services in other systems where there are 3 clear discharge to assess pathways, with patients going straight home with reablement support and assessment for long term care happening once someone has gone home and recovered enough for an accurate assessment to be made.

67. The peer team did not identify evidence of systematic demand and capacity analysis and strategic planning to shape services to support people at home. Particularly in relation to discharge to assess pathways which were not clearly defined or adequately resourced. It was evident that some action had been taken to better understand capacity and flow (i.e. the SMBC capacity tracker) but that this was limited organisationally and if expanded system-wide would help dynamically understand the level and shape of local needs.

68. The peer team felt that there should be a piece of work to establish a clear understanding across the system of what your demand is, and what capacity you need to have in place to meet it, making sure that this is calculated on the basis of people being in their own homes wherever possible. This is the first step in determining where you want to be and the resourcing and implementation plan you need to get you there.

69. Some of the peer team's questions around demand and capacity are: Do you know how many people need to be discharged home? Do you have an understanding of what people need in order to be discharged home? Do you have the right pattern of services to be able to discharge people to their homes? The direction of travel should be that when hospital is no longer the appropriate setting that they should return to their home. This return should not be delayed whilst assessments are organised.

70. There was evidence that the system recognises that DToC is only one symptom of the underlying condition that sees patients staying in hospital unnecessarily, and acknowledgement that more could be done to develop other areas. For example, the development of trusted assessment – which the peer team heard as a positive opportunity, including from care home providers

71. The peer team felt that independent sector social care providers, specifically home care providers, are not seen or treated as strategic partners. There is a real sense of them "being outside of the loop". Social Care Providers are an integral part of ensuring that the residents of Solihull are supported to live well and be healthy in their own homes.

72. Independent care sector providers are a key piece of your jigsaw. It is often the frontline workers in these social care provider organisations who see people most frequently and know them best. They are a key measure of how your residents will view you, particularly at an operational\care delivery level. It is a missed opportunity for them not to be more fully included. We heard from care providers about the 'unprecedented move' in Solihull where fourteen independent providers collaborated to submit a joint bid but were rejected by the Council, without any understanding of why. We understand that some of these providers are now spot purchased at a higher rate than the bid pricing they originally submitted. The financial lift provided to them following the initial re-tendering process has been acknowledged by them. The system should acknowledge that the position independent care providers now find themselves in, and it being a difficult place from which to return. The peer team would encourage Solihull to make active and positive steps to engage with the independent sector as partners.

73. The peer team believe that further developing integrated working with independent care and support providers as part of the local system will help to improve capacity and partnership working for the benefit of local residents. We heard that commissioners are planning a "Winter Learning" event to improve preparations for increased demand on services during the winter. Independent care providers particularly care at home providers will play a key role in managing and responding to winter pressures and should be fully involved in planning this event as well as in the event itself.

74. Carers representatives spoke about wanting to take the opportunity to be involved in supporting people upon discharge but spoke about their involvement seldom occurring. Carers representatives spoke of future developments of having carer champions on every ward in Solihull hospital to pick up on carers support and work with them to prevent further admissions. The peer team were reminded that people have ended up in hospital due to carer breakdown and the peer team heard of a need for improving respite for carers in Solihull.

Recommendations

75. Undertake thorough system–wide demand and capacity modeling to ensure that you have the right services in place to meet the needs of Solihull residents in their own home, wherever possible. This would be in line with best evidence and practice and will, almost certainly, mean you re-shape your provision by reducing community beds and increasing reablement support at home.

76. Develop clear, defined pathways out of hospital which are understood by staff working across the system, including care home and home care staff in independent sector providers. Ensure that there are clear pathways for Solihull residents who access hospital care in Birmingham and ensure that these are consistently applied across the system.

77. To support pathways, ensure there is a streamlined single, integrated, support at home service to enable people to remains in their own homes where possible, and leave hospital as soon as they no longer require acute hospital care.

78. Develop a programme of education and information so that staff across the system have a better understanding of both pathways and the range of service available. This should also be translated into a programme of awareness raising for partners and the wider public.

79. Include independent sector social care providers as equal partners in this work, and further build on early work with the Primary Care Networks to fully involve primary care.

80. Support people out of hospital while recognising the need to sit services within the wider context of the strengths of locality working, increasing the focus on supporting people at home, and including prevention of admission to hospital and long-term care as a whole system. Supporting people to leave hospital is not the end but one element within the system, of locality provision.

On behalf of the peer challenge team June 2019.

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Immediate next steps

We appreciate the senior leadership in the health and social care system will want to reflect on these findings and suggestions in order to determine how the system wishes to take things forward.

As part of the peer challenge process, there is an offer of further activity to support this. The LGA is well placed to provide additional support, advice and guidance on a number of the areas for development and improvement and we would be happy to discuss this. **Rachel Holynska, Care and Health Improvement Adviser for the East Midlands** is the main contact between the system and the Local Government Association. Her contact details are, email: rachel.holynska@local.gov.uk Telephone: 07827083928.

In the meantime we are keen to continue the relationship we have formed with this system throughout the peer challenge. We will endeavour to provide signposting to examples of practice and further information and guidance about the issues we have raised in this report to help inform ongoing consideration.

Contact details

For more information about this Delayed Transfers of Care Peer Challenge with Solihull health and social care system please contact:

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For more information on adults peer challenges and the work of the Local Government Association please see our website https://www.local.gov.uk/our-support/peer-challenges/peer-challenges-we-offer/safeguarding-adults-and-adult-social-care

Read the Adults Peer Challenge Reports: https://www.local.gov.uk/our-support/peer-challenges/peer-challenges-we-offer/safeguarding-adults-and-adult-social-care-0

Appendix 1 – Framework questions for Solihull DToC Peer Challenge

Solihull's health and social care partners have collected and evaluated a substantial tranche of evidence, using the CQC's 'Key Lines of Enquiry' (KLOEs) as a template for an initial self-evaluation.

1. Is there a shared vision and system wide strategy developed and agreed by system leaders, understood by the workforce and co-produced with people who use services?

- Is there clear leadership, vision and ambition demonstrated by the CEOs across the system?

- Is there a strategic approach to commissioning across health and social care interface informed by the identified needs of local people (through the JSNA)?

- How do system partners assure themselves that there is effective use of cost and quality information to identify priority areas and focus for improvement across the health and social care interface including delayed transfers of care?

2. The people's journey: how does the system practically deliver support to people to stay at home, support when in crisis and support to get them back home?

- Does the workforce have the right skills and capacity to deliver the best outcomes for people and support the effective transition of people between health and social care services?

- How does the system ensure that people who are moving through the health and social care system are seen in the right place, at the right time, by the right person and achieve positive outcomes (will cover how people are supported to stay well in own homes - community focus, what happens at the point of crisis and returning people home which will include a look at reablement, rehabilitation and enabling people to regain independence)?

- How do systems, processes and practices in place across the health and social care interface safeguard people from avoidable harm