Northumberland
County Council

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HEALTH & WELLBEING BOARD

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Learning & Recommendations from the Initial Twenty CQC Local System Reviews

Report of: Dr Deborah Freake, Director of Integration NHCFT

Cabinet Member: Councillor Veronica Jones, Adult Wellbeing and Health

Purpose of the Report:

This report seeks to appraise the Health and Wellbeing Board (HWB) of the key issues and recommendations in the Care Quality Commission (CQC) report "*Beyond Barriers How older people move between health and social care in England*" which sets out the lessons learned from the first twenty Local System Reviews (LSRs). It highlights the potential contribution of the HWB for consideration by members and updates the Board on the Northumberland approach to LSR.

Recommendations

It is recommended that the HWB:

- Notes the findings, learning and recommendations from the initial twenty CQC LSRs;
- Considers the role of the HWB in further supporting system integration;
- Note and comment on the local arrangements in preparing for an LSR including use as a framework for system improvement.

Link to Corporate Plan

This report contains details of a whole system review, which links to the Councils philosophy of ensuring Northumberland residents feel safe, healthy and cared for. By scrutinising our local health and social care system and working with service users and stakeholders, systematic plans can be implemented to ensure improved patient experience, more creative workforce planning and a more effective use of resources.

Key issues

The CQC Report found that organisations intended to work together but mostly focused on their own goals. Although there was good planning between services, the way services were funded did not support them to work together. Organisations were prioritising their own goals over shared responsibility to provide person centred care, did not always share information with each other which meant they were not able to make informed decisions about people's care, were not prioritising services which keep people well at home and planned their workforce in isolation to other services. It was further noted that the regulatory framework focuses only on individual organisations.

The CQC Report made a number of recommendations for local and national partners including:

- Reform of planning and commissioning of services,
- An agreed joint plan, funded in the right way, to support older people in their own homes, help them in an emergency, and return home safely,
- A new approach to system performance management, measuring how organisations collectively deliver improved outcomes for older people,
- Joint workforce planning to allow flexible and collaborative approaches to staff skills and career paths,
- Better oversight of local system performance, as well as new legislation so the CQC can regulate how people and organisations work together to support people to stay well.

Local LSR preparation arrangements are designed to take into account the learning from this report and to facilitate existing work on service improvement.

Background

The CQC carried out an initial series of targeted reviews of local health and social care systems, to consider how services met people's needs, focusing on those over 65 years of age. The overall findings from the initial twenty reviews were published by the CQC in July 2018 in their report '*Beyond Barriers: how older people move between health and social care in England'*.

Implications

Policy	The learning from the initial twenty LSRs should shape Northumberland County Council policy and that of its partners across health and social care.
Finance and value for money	Not applicable at this stage
Legal	Not applicable at this stage
Procurement	Not applicable at this stage
Human Resources	Joint workforce planning across health and social care partners is recommended
Property	Not applicable at this stage
Equalities (Impact Assessment attached) Yes ☐ No ☐	Not applicable at this stage

N/A ☐	
Risk Assessment	Not applicable at this stage
Crime & Disorder	Not applicable at this stage
Customer Consideration	Not applicable at this stage
Carbon reduction	Not applicable at this stage
Wards	Not applicable at this stage

Background papers:

Care Quality Commission. *Beyond Barriers: how older people move between health and social care in England*, July 2018.
https://www.cqc.org.uk/sites/default/files/20180702_beyond_barriers.pdf

Report sign off.

Authors must ensure that officers and members have agreed the content of the report:

	initials
Monitoring Officer/Legal	
Executive Director of Finance & S151 Officer	
Relevant Executive Director	CM
Chief Executive	
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Northumberland County Council

Learning & Recommendations from the Initial Twenty Local System Reviews

1. Purpose

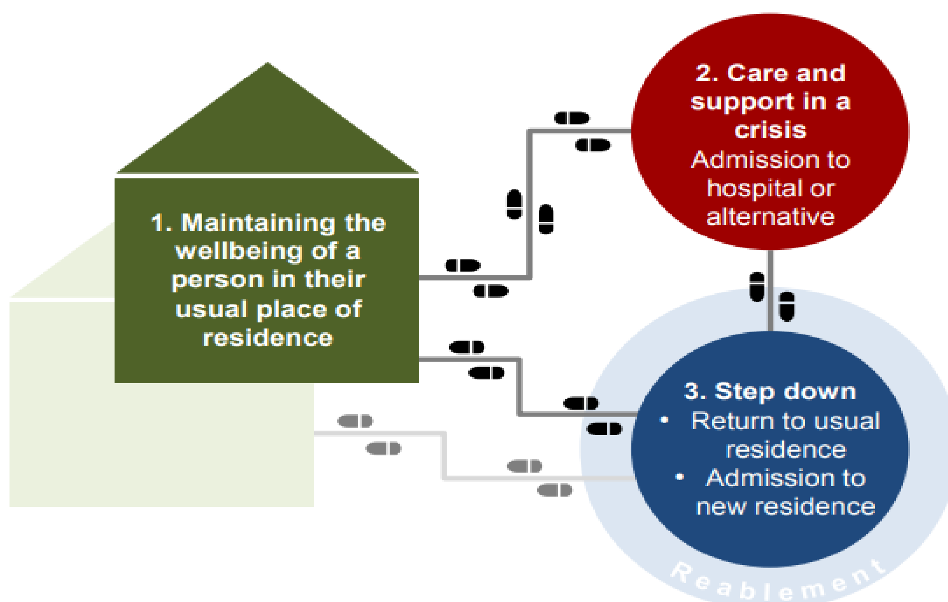
1.1 This report summarises key issues and recommendations as set out in the Care Quality Commission (CQC) report "*Beyond Barriers How older people move between health and social care in England*". It considers the lessons learned from these first twenty Local System Reviews (LSRs) and the potential contribution of the Health & Well Being Board (H&WBB)for consideration by members. Finally, it updates members of the Board on the Northumberland approach to Local System Review.

2. Background

2.1 The CQC was tasked in 2017 by the Secretaries of State for Health and for Communities and Local Government Care to carry out an initial series of targeted reviews of local health and social care systems, to consider how services met people's needs, focusing on those over 65 years of age.

2.2 Twenty areas were identified for review (see Appendix 1), principally based on a dashboard of metrics, although also intended to ensure reasonable geographical spread and potential for demonstration of good practice.

2.3 Each LSR sought to answer the question: "*How well do people move through the health and social care system, with a particular focus on the interface, and what improvements could be made?"* The LSRs each considered these interfaces, looking at the planning, commissioning and delivery of health and social care services, and reviewing how each local area works within and across three key areas:



2.4 Appendix 2 outlines the methodology used by the CQC to date. Each of the Local Review Reports have been published and reported to their local authority area's H&WBB, highlighting what was working well and where there were opportunities for improving how the system works for people using services.

3. *'Beyond Barriers'* – Findings & Lessons Identified

3.1 The overall findings from these initial reviews was published by the CQC in July 2018 in their report '*Beyond Barriers: how older people move between health and social care in England*'[1]. It is important to note that 19 of the 20 systems were selected as comparatively challenged systems, and the following over-arching comments need to be considered in this context.

"*In some areas, different parts of the system are working well together. In other areas, the system was less joined-up and not working as well for people. In the systems we reviewed, we found individual organisations working to meet the needs of their local populations. But we did not find that any had yet matured into joined-up, integrated systems.*"

"Organisations intended to work together but mostly focused on their own goals

Although there was good planning between services, the way services were funded did not support them to work together. Organisations:

- were prioritising their own goals over shared responsibility to provide person-centred care

- did not always share information with each other which meant they weren't able to make informed decisions about people's care

- were not prioritising services which keep people well at home

- planned their workforce in isolation to other services

The regulatory framework focuses only on individual organisations."

3.4 The Report noted that the quality of relationships, within and across organisational boundaries, and at all levels, had a significant impact on effective system-working and the quality of care people received. Collective goals, collaborative decision-making, and sharing of risk were markers of mature relationships and underpinned multi-disciplinary and multi-agency working on the ground.

Some staff spoke negatively about their ability to take on risks that served wider system goals without fear of criticism or failure. The CQC also observed silo working at all levels, such as decisions taken in one organisation without consideration of wider system implications.

3.5 There was generally good intent amongst organisations to work together to a common plan, but a reality where most were focused on their own goals. Where good joint working

[1] Care Quality Commission. Beyond Barriers: how older people move between health and social care in England, July 2018. https://www.cqc.org.uk/sites/default/files/20180702_beyond_barriers.pdf

was observed, relationships were characterised by aligned vision and values, open communication, trust and a common purpose to meet the needs of local people. However, in the majority of systems, local health and social care leaders were not working together effectively enough to fully address the needs of the people they serve.

The CQC commented on a culture where organisations prioritised their own goals over the whole system's shared responsibility to people using health and social care. They considered that none of the areas visited had a fully joint, system-wide accountability framework, which meant that leaders were not accountable for the outcomes of their wider system, beyond the accountabilities of their individual organisations.

3.6 Even in places where good planning was evident, there was a disconnect between those plans and the funding to support them. Although every system had an ambition to move towards integrated health and social care commissioning, the extent to which this could be realised was inhibited by the ability of local leaders to align and pool their budgets to best serve their local populations.

This, in turn, was compounded by the fragmentation of commissioning responsibilities of local authorities and clinical commissioning groups. It was noted that separate funding streams and different payment processes (for example different approaches to eligibility for care between NHS care and social care) could cause organisational divide. The dominance of tariff-based funding was considered to have acted as a barrier to more effective integration.

3.7 It was observed that performance management was based on the specific responsibilities of each organisation, rather than outcomes for older people, with ways of measuring performance of individual organisations not encouraging system working.

The CQC considered that most senior leaders sitting as they were within individual organisations, were judged on their individual organisational measures, not by system success. It was found that where leaders in systems had an understanding and appreciation of each other's roles and responsibilities, this helped to build relationships and improve outcomes for people.

3.8 The Report considered that information was not always available in the right place at the right time leading to delays, with people having to tell their story multiple times, and a risk-averse approach to decision-making. Information about individual users was collected by each organisation for its own purpose, preventing important information being shared effectively.

Information sharing was noted to be a significant barrier to effective decision making and to seamless working across health and social care. Where information was being shared effectively across organisational boundaries, staff were able to access each other's notes and people's records, helping them to make more informed decisions on people's care. A misunderstanding of information governance rules sometimes led to information not being shared between health and social care services when it was legitimate to do so and in the users interests.

3.9 The CQC considered that individual organisation approaches to workforce planning operated in isolation to others in their area, despite every system visited struggling in some areas to maintain a sustainable health and social care workforce. Many organisations were facing substantial challenges in recruiting and retaining staff to meet demand, with different local services competing with each other to recruit from the same pool of skilled and qualified staff. While some areas had established joint workforce groups, the CQC rarely saw strategic workforce planning between health and social care.

The CQC observed that staff will increasingly need to work across boundaries and take on new responsibilities beyond people's specialisms, for example in relation to care coordination and assessment. This will require knowledge and understanding of other health

and care services that can meet people's needs in the community, and will be crucial in reducing pressures on hospitals.

3.10 Some specific challenges and barriers were noted including amongst (numerous) others:

- difficulties in access to a GP in and out of hours, leading to reliance on hospital services
- lack of capacity in the adult social care market
- domiciliary care pressures leading to poor continuity of care and compromising peoples independence
- access to services being complicated and confusing for both users and professionals
- variation in availability and access to services dependent on where people lived
- perceived lack of understanding by hospital staff about social care services, and of the needs of social care providers to ensure appropriate admissions

3.11 As well as noting areas of concern the CQC also identified examples of good practice including:

- staff such as health care assistants and domiciliary care staff undertaking clinical duties that might traditionally have been done by district nurses
- extra care housing schemes
- 'single point of access' services
- general practice care navigation systems
- social prescribing initiatives
- assets-based approaches to supporting people building on available personal and community resources
- multi-disciplinary teams using risk stratification tools to identify people at highest risk
- 'virtual' wards in the community
- provision of effective support to care homes
- high use of personal budgets and direct payments
- 'hospital-at-home' services
- streaming services in the emergency department
- ambulance 'see and treat' responses
- frailty assessment & management services
- early discharge planning, including social care and primary care
- dedicated hospital ambulance liaison officer roles
- co-ordination of assessments and trusted assessor models at discharge
- good communication and information sharing at discharge
- 'home first' and 'discharge to assess' models

It is encouraging to note that the majority of these are key features of local arrangements.

3.12 The CQC also made a number of observations in relation to national issues such as short-term and activity-based funding models and the regulatory and oversight framework being currently focused only on individual organisations.

4. *Beyond Barriers'* – Recommendations

4.1 The CQC concluded that a new type of leadership approach is required, where leaders are supported and encouraged to drive system priorities collectively, through system-based, shared and well-understood performance measures and accountabilities,

4.2 The CQC recommended that local leaders create an agreed joint plan for how older people are supported in their own homes, helped in an emergency, and then enabled to return home safely, maximising the potential contribution from voluntary, community and social enterprise organisations (VCSEs).

4.3 It was recommended that local leaders take a reformed approach to funding that allows and encourages local systems to deliver this plan by aligning and pooling their budgets.

4.4 Local leaders should give more emphasis to investing in models of care that support prevention and avoid unwarranted admission to secondary care, with local leaders actively and effectively sharing information about people across organisational boundaries. (National leaders were urged to provide the support to make this possible, with the appropriate safeguards in place to maintain public confidence.)

4.5 Local leaders were recommended to agree joint workforce plans, with more flexible and collaborative approaches to staff skills and career paths, working in tandem with Health Education England and Department of Health and Social Care workforce strategies.

It was noted that systems will need to be innovative in how they recruit, train and use their workforce, so that staff have the ability to provide seamless care. Health and care commissioners and providers, including the currently under-used VCSE sector, were urged to share risk and work together as a unified system.

Important factors identified to enable system-working:

- A shared and agreed vision that is signed up to by all system partners
- effective and robust collaborative leadership, and a shared endeavour across a system
- clear governance arrangements and clear accountability for how organisations contribute to the overall performance of the whole system with agreed system performance measures
- strong relationships, at all levels, characterised by aligned vision and values, open communication, trust and common purpose
- joint funding and commissioning
- the right staff with the right skills
- the right communication and information-sharing channels
- a learning culture

5. Beyond Barriers – National Recommendations

5.1 The Report recommended sustainable funding reform to removes the barriers that prevent social care and NHS commissioners from pooling their resources and using their budgets flexibly to best meet the needs of their local populations. It proposed consideration be given to a move from short-term to long-term investment in services, and from an activity-based funding model towards population-based budgets that encourage collaboration between local systems.

In support of this, the national leaders (NHS England, NHS Improvement, the Department of Health and Social Care, and the Ministry of Housing, Communities and Local Government) were urged to work with the Local Government Association and the Association of Directors of Adult Social Services.

5.2 The CQC asserted that national health and social care leaders should make it easier for individuals to move between health and care settings – providing career paths that enable

people to work and gain skills in a variety of different settings so that services can remain responsive to the needs of local populations.

5.3 The Report argued that better alignment between system regulators (NHS England, NHS Improvement and CQC) is needed so that contradictory actions are not reinforced by regulation. It was proposed that the government consider new legislation to support the improved planning and reformed commissioning at a local level, which would allow CQC to regulate local systems and hold them to account for how people and organisations work together to support people to stay well, looking not just at individual organisations, but focusing on the quality of care experienced by people across the services they use. The Report recommended that the regulatory oversight be aligned to a new national performance management framework, so that regulation supports local leaders in their focus on improved outcomes.

5.4 Finally, it was recommended that regulators, including the CQC themselves, work to agree a set of performance metrics and indicators for system performance to be used to inform all regulatory activity and oversight.

In summary CQC recommendations were for:

Reform of planning and commissioning of services: an agreed joint plan, funded in the right way, should support older people in their own homes, help them in an emergency, and then to return home safely.

A new approach to system performance management which would measure how organisations collectively deliver improved outcomes for older people.

Joint workforce planning. This would allow flexible and collaborative approaches to staff skills and career paths.

Better oversight of local system performance, as well as new legislation so the CQC can regulate how people and organisations work together to support people to stay well

6.0 The Role of the Health & Well Being Board

6.1 The Report considered the role of H&WBBs as well as local Sustainability & Transformation Partnerships (STPs), noting that these can be important drivers for system working. It noted that with a statutory role in the leadership of a place, H&WBBs were well positioned to oversee the vision for health and care, the strategy for delivering it, and to hold organisations to account for meeting the needs of people in that area.

6.2 However, the Report noted that there could be a disconnect between an STP, HWBs and the local systems, depending on their maturity and effectiveness: H&WBBs (and STPs) took different roles in different places. Commonly H&WWBs were not fulfilling their role to full potential; some H&WBBs lacked representation across the system, and as a result, collective buy-in for a strategic vision. Whilst there were examples of H&WBBs having clarity of role and purpose, a strong and committed leadership, and providing scrutiny and challenge, some were functioning more as a forum for engagement, or a place where papers or proposals were taken to for sign-off rather than scrutiny.

6.3 The CQC sees further potential for H&WBBs to provide effective collective leadership for the system, holding organisations in a system to account by setting out clear accountability between partners for the delivery of shared goals, and governance arrangements that assess, monitor and drive performance in the quality of services, and the quality of experience for people using them. With established vision, local buy-in, and a place where decisions can be made on behalf of the system, this is where local leaders can be held to account for system performance at leadership level.

6.4 The Report argues that local system leaders should be informed by a comprehensive understanding of the population's health and wellbeing needs, typically identified by the Joint Strategic Needs Assessments (JSNAs) for which H&WBBs are responsible for developing in partnership between local authorities, heath and other members. JSNAs should include a specific focus on addressing the needs of older people.

In addition system leaders should have a shared understanding of the existing capacity, availability and quality of care providers, understanding the business environment of the providers offering services in their area. The CQC advocates well-developed and up-to-date Market Position Statements (MPS) summarising supply and demand in a local area, and signalling future capacity requirements and consequent business opportunities to the market.

6.5 To establish a sustainable health and social care system, the CQC notes that systems need to be able to invest in services which keep people well at home and reduce reliance on hospital services. Local authorities are responsible for public health that supports wellbeing and prevention, but cannot achieve this alone: this was recognised in the Department of Health & Social Care's mandate to NHS England for 2018/19 which includes a responsibility for the NHS and social care as equal partners in collaboration with the VCSE sector to lead a step change in the NHS in preventing ill-health and supporting people to live healthier lives.

6.6 Member of Northumberland's H&WBB will wish to consider these recommendations and how it can further facilitate effective local collective system leadership.

7.0 Local Approach

7.1 There is not as yet formal confirmation but it is fully expected that further LSRs will follow these initial twenty. It is very possible that extension of the programme may see translation into a formal inspection regime with accompanying system ratings in the future; it would be hoped that this would be integrated with other regulatory aspects rather than in addition to existing arrangements. Appendix 2 provides an overview of the current LSR process. Any future reviews could be expected to start with an older person's experience of a system and be shorter and more focused.

7.2 Whilst there is no certainty about any future date for review it is agreed that the local system should start to prepare for an LSR now on the basis that:

- the task of adequately preparing for any CQC inspection is considerable, with added complexities in an LSR of preparation across multiple organisations
- early preparation will ensure the System is viewed by Reviewers/Inspectors in the best possible light with opportunity to showcase examples of good practice
- systematic and early preparation will in itself help expose weaknesses in current arrangements, enabling them to be addressed in a considered manner – thus strengthening delivery of integrated services to our communities

7.3 Further to discussions at officer level across Northumberland and North Tyneside and at a joint meeting of the Health & Well Being Boards for Northumberland and North Tyneside in June 2018, it has been agreed to additionally use the national LSR approach as an opportunity and lever for long-term system service improvement. It provides a useful framework for system transformation and integration, potentially expanding in the future beyond a remit around older people to encompass other client groups or service areas.

Given the commonality of providers across the Northumberland and North Tyneside patches, where possible officers are working together to reduce duplication of effort, and provide peer challenge and critical friend support.

7.4 Objectives for the Northumberland work reflect the dual nature of the work in both preparing the system for an external Review and as a lever for service improvement, and have been separated into two distinct phases. It is expected that an evidence-based report detailing findings of baseline review and gap analysis, and with recommendations for work in Phase 2 will be produced for consideration by the Health & Well Being Board at the end of Phase 1:

Phase 1: Preparation – by 31st March 2019:

1. To ensure that the local Northumberland health and care system (including stakeholders) is comprehensively prepared for a CQC Local System Review.
2. To identify deficiencies and best practice in current commissioning and/or provision of services for those over 65 years across the Northumberland health and care system.
3. To learn from identified deficiencies and best practice (locally and beyond)
4. To ensure that stakeholders are fully engaged in preparation and review work.

Phase 2: Improvement – by March 2020:

1. To work with system partners to jointly and systematically address identified deficiencies and spread best practice, making best use of system-wide resource to achieve transformational and continuous service improvement
2. To ensure that stakeholders are fully engaged in improvement and transformation work
3. To consider if the approach could/should be extended to other client groups.
4. To implement a system of compliance and performance management against LSR requirements across the whole system.

8. Programme Management

8.1 In Northumberland formal programme management arrangements have been put in place, with director level leadership and dedicated project capacity taking responsibility for co-ordination of preparation requirements as well as of associated improvement work. Standard programme documentation is in place and fortnightly roject meetings established.

8.2 The Project Board will meet for the first time at the end of January with senior stakeholders including:

- Debbie Freake, Director of Integration, Northumbria Healthcare NHS Foundation Trust (Project Executive)

- Cath McEvoy-Carr, Director of Adult & Children's Services
- Liz Morgan, Director of Public Health
- Helen Mason, Senior Manager Governance NCC/NHFT
- Vanessa Bainbridge/Siobhan Brown, Accountable Officer, Director of Transformation, Northumberland CCG
- Russell Patton, Deputy Chief Operating Officer, Northumberland, Tyne & Wear NHS foundation Trust
- Birju Bartoli, Director of Performance & Improvement, Northumbria Healthcare NHS Foundation Trust

Board membership is likely to expand as the project moves from Phase 1 into the improvement phase.

8.3 Rather than create new governance arrangements running in parallel to other improvement work, and in keeping with the CQC Report recommendations, it is planned to use existing mechanisms for partnership and service improvement, with the Northumberland Transformation Board providing cross-system leadership to oversee the work.

This will ensure the right level of leadership with clear linkage through the Transformation Board to the H&WBB as the responsible body for the LSR. It is envisaged that the Transformation Board will be responsible for oversight of "well-led" elements, ensuring shared vision, strategy, targets and objectives, and a clear understanding by leaders of the whole system with shared ownership of risks. In line with its existing remit, the Transformation Board would be anticipated to take responsibility for proposals for, and delivery of, system improvement with timescales extending beyond anticipated inspection dates.

8.4 Learning from systems that have participated in Reviews to date underlines the criticality of early and on-going engagement of users, staff, community leaders, wider system partners and other stakeholders. Likely LSR interviewees/participants will benefit significantly from having an understanding of the Review process, and will also be invaluable in co-production of plans for, and execution of, service improvements. A robust communications plan therefore forms a core part of programme planning.

9. Baseline Assessment & Gap Analysis

9.1 An approach to Phase 1 self-assessment and gap analysis against service requirements and recognised best practice, has been developed based on three distinct but inter-related components. Prominence is placed on a strong user/carer voice:

9.2 User Experience:

- **User and carer surveys:** use of an already validated and piloted survey based on 'I' statements[2] covering both Northumberland and North Tyneside, will be conducted in January with results anticipated in early March. Using an approved CQC contractor, the survey will be sent to approximately 1000 users in each area with expectation of an approximate 20% response rate.
- **Linking user experience to professional case reviews:** early discussions with Healthwatch Northumberland and Healthwatch North Tyneside seek to enlist support to explicitly link individual user and/or carer views with those of professional in the cases considered in the Professional Case Review (see 9.3)
- **Shadowing selected patients by trained patient leaders:** 'Patient leaders' will be identified, trained and support to use a shadowing framework to track a small number of actual patient journeys across the system. It is planned to focus this work on 'hot-spots' identified through surveys and other baseline work to derive maximal value.

9.3 Professional Case Review

Two multidisciplinary individual user case review exercises have been conducted to date with partners from across the Northumberland and North Tyneside systems. Using a jointly developed audit methodology, senior professionals have discussed what happened during actual user journeys across the health and care systems, considering aspects against *Institute of Medicine*[3] quality domains at each 'interface' of care between agencies.

The exercises have been found valuable by participants and it is intended to continue the approach, expanding to engage front line teams across agencies, address issues identified and to spread the learning across system partners.

[2] National Voices, Think Local Act Personal, A narrative for person-centred coordinated care, May 2013

[3] Institute of Medicine (IOM). Crossing the Quality Chasm: A New Health System for the 21st Century, D.C: National Academy Press 2001

Institute of Medicine Quality Domains:

- **Safe**: Avoiding harm to patients from the care that is intended to help them.
- **Effective**: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Patient-centered**: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely**: Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient**: Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable**: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status

9.4 Well-Led Review

Recognising the importance of local system relationships, the CQC uses a relational audit[4] as part of its initial information gathering exercise. The Northumberland LSR Team and North Tyneside partners have commissioned the CQC provider to undertake a local Relational Audit in early 2019. The first to be undertaken outside of the formal CQC process, this will provide the system with a shared understanding of its relationship strengths and areas for improvement, give legitimacy to areas that may otherwise be considered as 'soft', and provide the basis for regular reflection.

Work is also underway to gather some of the data that will be needed in the event of a formal LSR to comply with the CQC System Overview Information Request (SOIR). This will help identify gaps within current documentation, and highlight areas where work is required such as in development of shared strategies and plans, or in relation to system governance arrangements such as those to support decision-making, and/or shared risk management.

There is also potential to create a shared information repository extending beyond the life of LSR preparation, with opportunity for a new approach to system performance management in line with national recommendations.

10. Summary & Recommendations

10.1 The CQC Report, *Beyond Barriers: how older people mover between health and social care in England* highlights a number of integration deficiencies and a lack of maturity in the systems reviewed to date. It makes a number of recommendations, which include the role of the local H&WBB in facilitating effective collaborative leadership.

[4] Developed by *Whole Systems Partnership* & the *Relationships Foundation*

Local arrangements have been put in place to both comprehensively prepare for a future LSR, and to use the process as a lever for system improvement. Arrangements take into account learning from LSRs to date, and deliberately build on existing governance for transformation with an explicit link to the H&WBB.

10.2 Health & Wellbeing Board colleagues are asked to:

- Note the findings, learning and recommendations from the initial twenty Local System Reviews
- Consider the role of the H&WBB in further supporting system integration.
- Note the local arrangements in preparing for an LSR including use as a framework for system improvement

Dr Debbie Freake, Director Integration, Northumbria Healthcare NHS FT
January 2019

Appendix 1

20 Local System Review Reports published as at July 2018:

- Birmingham
- Bracknell Forest
- Bradford
- Coventry
- Cumbria
- East Sussex
- Halton
- Hampshire
- Hartlepool
- Liverpool
- Manchester
- Northamptonshire
- Oxford
- Plymouth
- Sheffield
- Stockport
- Stoke on Trent
- Trafford
- Wiltshire
- York

Individual reports can be accessed at: www.cqc.org.uk/localsystemreviews

Appendix 2

National LSR Methodology

The standard methodology used aims to

- listen to older people who use services, their families, carers and communities
- listen to people who commission and provide health and social care for older people
- analyses data about the quality of care services and outcomes for people

A number of ‘pressure points’ are identified on a typical journey that people take across the interface of health and social care:

- Maintenance of people’s health and wellbeing in their usual place of residence
- Multiple confusing points to navigate in the system
- Varied access to GP / urgent care centres / community care / social care
- Varied access to alternatives to hospital admission
- Ambulance interface
- Discharge planning delays and varied access to ongoing health and social care
- Varied access to reablement
- Transfer from reablement

Key lines of enquiry (KLOEs) are used by the Review Teams to understand the degree to which services across the three areas are: safe, effective, caring and responsive to people’s needs. At system level specific KLOEs seek to understand how ‘well led’ the system is:

- If there is a shared clear vision and credible strategy
- The impact of governance on the health and social care interface
- The system approach to workforce
- The approach to commissioning within a local area
- Resource governance assurance

The end-to-end Review process is 12-14 weeks. Local systems are given six weeks advance notice of the specific dates of their review. Each CQC Review Team spends 5 days on patch, and is made up of 2 CQC staff, and 1 ‘health’ plus 1 or 2 local government Specialist Professional Advisors. Review components are:

- Pre-Preparation Weeks 1-6: Call for evidence, attend local events for residents, meeting with wider local partners; System Overview Information Request (SOIR) expected Wk 5.
- Preparation Week 7: analysis of qualitative and quantitative data; liaison with statutory bodies (eg NHS England/Improvement, Health Education England).
- Review Week 8: Day 1 Focus Groups; Days 2-3 interface pathway interviews with case tracking and dip sampling; Day 4 well-led interviews; Day 5 Final interviews, mop-up and feedback
- Report writing (Weeks 8-9) and Quality Assurance (Weeks 10-14): concludes with written advice to the area H&WBB and a local summit