Northumberland
County Council

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HEALTH & WELL BEING BOARD

Date: 11 April 2019

Local System Reviews: Phase 1 Report

Report of: Deborah Freake, Director of Integration NHCFT

Cabinet Member: Councillor Veronica Jones, Adult Wellbeing and Health

Purpose of Report

This report details the progress made on the Local System Review project, following the report to Health and Wellbeing Board entitled *Learning and Recommendations from the Initial Twenty CQC Local System Reviews*, in January 2019.

A process of self-assessment and baselining has taken place, analysing the effectiveness of the health and care system in Northumberland, based on the Local System Review (LSR) framework developed by the Care Quality Commission (CQC). This report outlines the findings of this process and makes recommendations for a programme of system improvement.

Recommendations

Health & Wellbeing Board (H&WBB) colleagues are asked to:

- Note the findings, learning and recommendations from the process of base-lining and self-assessment.
- Consider the role of the H&WBB in further supporting system integration.
- Approve phase 2 of the project to implement recommendations.

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 user experience, more creative workforce planning and a more effective use of resources.

Key issues

The project assessed the system of health and care in Northumberland across three work-streams:

- User experience
- Professional case reviews
- Well-led review

This approach has allowed analysis and assessment of the system from different key perspectives, culminating in a holistic view of how well the system is functioning. The process reveals a system working comparatively well to provide patient-centred, integrated care but when the findings of the three work streams are triangulated, provides evidence of the opportunity for system improvement in a number of key areas:

- **Coordinating Care**
  The most repeated theme across all review processes was that for complex users who required care from multiple agencies, there was a danger that they 'fell through the gaps' due to the lack of clear approach to the broad coordination of care. Whilst the most appropriate solution will be different depending on the user in question, there is a need to develop and embed system-wide approaches for ensuring robust co-ordination and establish frameworks for agreed escalation triggers and responses.

- **Communication, technology and data sharing**
  Across all three work streams, communication difficulties, use of technology and IT interoperability were highlighted as significant barriers to providing person-centred integrated care. Even sharing of information for improvement purposes proved arduous and a potential disincentive to system-wide working.

- **Organisational relationships, integration and risk management**
  Relationships between the agencies which make up the system are generally good but there is opportunity for further development, investment and improvement in relational health across participating organisations. A perception exists amongst staff system-wide that the aims and objectives of the organisation (or indeed section within an organisation) one works for can take priority over those that are system-wide, potentially resulting in a lack of system perspective and consequent broader population benefit. Evidence demonstrated that at times staff can find it difficult to take risks which might benefit the system and the integration of a patient's care, but might not benefit the host organisation.

- **System-wide shared strategy & planning**
  More work is required to adequately assess the strategies, planning, policies and ways of working which underpin the health and care system in Northumberland. That said, and in noting CQC feedback to localities which have already undergone formal LSR, whilst governance at an organisational level is good, Northumberland is yet to fully develop the maturity of system-wide governance that the CQC would hope to see. New arrangements for the System Transformation Board provide an

excellent opportunity to drive transformation of care for older people through comprehensive strategic approach to aspects such as commonly agreed pathways and service priorities, co-production, and workforce planning.

The evidence amassed through phase 1 of the Local System Review Project justifies an ongoing programme of system improvement considering and acting upon the following recommendations which, if approved can form the basis of phase 2 of this project:

RECOMMENDATION 1 –CLINICAL INFORMATION SHARING

- **The System Transformation Board partners should review their processes for information sharing in order to facilitate joint learning and quality improvement. In particular efforts should be made to ensure that individual organisational processes can be streamlined and integrated with those of others whilst continuing to adhere to highest principles of information governance.**

RECOMMENDATION 2 –INTEROPERABILITY & SHARED RECORDS:

- **The System Transformation Board should monitor and where appropriate drive local IT improvement work as a system priority, facilitating the move towards full interoperability and shared electronic patient/client records.**

RECOMMENDATION 3 –CROSS-SYSTEM USER SURVEY:

- **The Health & Well Being Board should sponsor annual cross-system user survey and other mechanisms for feedback, ensuring that results are actively used to inform system-wide planning and delivery.**

RECOMMENDATION 4 –MULTIAGENCY PROFESSIONAL CASE REVIEWS:

- **The process devised for multiagency Professional Case Review should continue, adapting methodology, and approaches to dissemination of learning as appropriate, and ensuring the work complements and builds on learning from related individual agency/organisation work.**

RECOMMENDATION 5 – SYSTEM-WIDE LEARNING & SERVICE IMPROVEMENT

- **System Transformation Board should consider inter-organisational improvements in communication, care coordination, and triggers for & responses to escalation.**
- **Principles of co-production should be used with the expectation that this can be evidenced in this as with all other future service improvement work.**

RECOMMENDATION 6 –FINDINGS OF RELATIONAL AUDIT

- **System Transformation Board should consider the finding and recommendations of the WSP Relational Audit including:**
    - **Feedback to staff & partners**
    - **Actions to address issues raised**
    - **Ongoing Relational Audit at regular intervals**
    - **Systematic use of the R^{v} Tracker survey within quality routines.**

RECOMMENDATION 7 – SYSTEM GOVERANCE & CULTURE

- **System Transformation Board should consider specific formal mechanisms and supporting OD approaches that can address an "organisation first" mind set. This may include development of common system pathways, joint planning including system workforce planning, shared decision-making and financial risk-share mechanisms.**

RECOMMENDATION 8 – METRICS AND DATA

- **System Transformation Board should develop system-wide performance metrics for integrated care for older people, and consider their routine use within and between organisations as a lever to drive improvement.**
- **Consideration should also be given to the establishment of a shared data repository to facilitate standardisation of measures with commonly-owned data, and improve use of resources.**

RECOMMENDATION 9 – SYSTEM OVERVIEW AND STRATEGY

- **The Health & Well-Being Board and System Transformation Board should ensure full completion of the CQC System Overview Information Request (SOIR) by the end of 2019 noting that this requires significant input and resource.**
- **This should include a developmental workshop for local leaders, externally facilitated if appropriate, to jointly assess system-wide working arrangements in line with SOIR format by September 2019.**

Implications

Policy	The learning from this system review process 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

LSR Phase 1 Report – Supporting Material.

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	
Chief Executive	CMC
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Northumberland
County Council

Local System Reviews: Phase 1 Report

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1. Background & Purpose

The Care Quality Commission (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. Each Local System Review (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 CQC has now reviewed 20 local health and care systems and returned to re-review three of these. Each Local Review Report has been published[1], and reported to the local authority area's Health & Wellbeing Board (H&WBB) highlighting what is working well and where there are opportunities for improving how the system works for people using services.

'Beyond Barriers: how older people move between health and social care in England'[2] was published by the CQC in July 2018 summarising their work to date with the following key findings:

- "*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*."

Whilst it was never certain that Northumberland would be chosen to undergo a CQC LSR, following 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 18, it was agreed to use the national LSR approach as an opportunity and lever for long-term system service improvement as well as to prepare the local system for a possible LSR.

This decision was made on the basis that the LSR provides a useful framework for system transformation and integration, and could potentially expand beyond an older people's remit to encompass other client groups or service areas in the future.

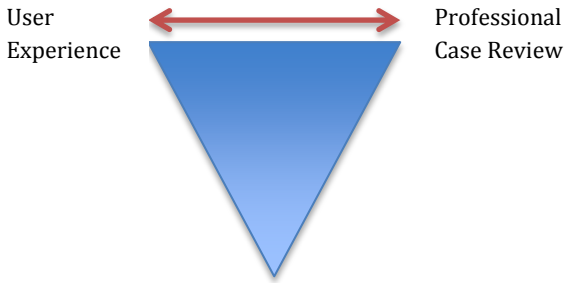
In Northumberland formal arrangements were put in place, with director level leadership and project management able to take responsibility for co-ordination of preparation requirements as well as for co-ordination of associated improvement work. A formal Project Board was established comprising senior officers from Northumbria Healthcare NHS Foundation Trust (NHFT), Northumberland County Council (NCC), Northumberland Tyne and Wear NHS Foundation Trust (NTW), Northumberland CCG and Healthwatch Northumberland. The Project Initiation Document is available in section 1 of the supporting material. Objectives for phase 1 were as follows:

[1] Care Quality Commission, reports of local health and social care systems, 2017-18
[2] Care Quality Commission. Beyond Barriers: how older people move between health and social care in England, July 2018

- To ensure that the local Northumberland health and care system (including stakeholders) is comprehensively prepared for a CQC Local System Review.
- 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.
- To learn from identified deficiencies and best practice (locally and beyond)
- To ensure that stakeholders are fully engaged in preparation and review work.

Whilst separate arrangements are in place in North Tyneside, given the commonality of providers across the patch, where possible officers have worked together to reduce duplication of effort, and provide peer challenge and critical friend support.

A key first step for any improvement work is to undertake systematic self-assessment and gap analysis against service requirements and recognised best practice. An approach based on three distinct but inter-related components was adopted, with prominence placed on a strong user/carer voice in line with LSR emphasis:



Well-Led Review

This paper provides H&WBB members with an initial system assessment to form the basis for the next phase of work. For a full report into the context, and process used by the CQC and the initial baseline methodology adopted by the Northumberland Project Board, see section two of the supporting material.

2. Update on Status of CQC Local System Reviews

On 1st February 2019, it was reported that the CQC had been 'forced to abandon its local system review programme after the Department of Health and Social Care ignored a request for approval to continue.'[3]

On 13th February 2019 however, a further announcement was made, confirming that the Health and Social Care Secretary had written to the CQC stating his intention for continued inspections of local health systems. . The report noted that 'details on the exact number of system reviews and the level of funding the government would make available were yet to be determined.'[4]

There is no indication yet as to which localities will be selected but it is assumed that the CQC will resume its Local System Reviews in 2020 having refined the framework. It should be noted that those selected for initial reviews were generally those with particular system challenges – this approach may alter in the future making it impossible to predict when Northumberland may be reviewed.

The Northumberland LSR Project Board met on February 27th and agreed that the work being undertaken in Northumberland should continue.

3. User Experience

3.1. User Survey

3.1.1. Methodology

A user and carer survey, based on the nationally adopted 'I' statements which defined the goals of integrated care [5], was developed tailored to focus on the service interfaces. Work was led by Northumbria Healthcare Foundation Trust (NHFT) Patient Experience Team and Patient Perspective, a trusted collaborator and approved contractor for the CQC National Patient Survey Programme in England. To view the full survey, please see section 3 of the supporting material.

The survey was distributed to 1000 users and carers across the health and social care system in Northumberland. In order to establish a representative system-wide sample, a number of criteria were set:

- Over 65 years old
- Resident in Northumberland
- Have had an episode of care in the last three months
- Appears on more than one of our health and social care data systems i.e.
    - SWIFT (social care, also indicating mental health need through contact with Northumberland Tyne and Wear NHS Foundation Trust (NTW).

[3] https://www.hsj.co.uk/policy-and-regulation/disappointed-cqc-forced-to-drop-system-inspections/7024302.article
[4] https://www.hsj.co.uk/policy-and-regulation/cqc-given-green-light-for-more-local-system-reviews/7024413.article
[5] National Voices, Think Local Act Personal, A narrative for person-centred coordinated care, May 2013

- PAS (acute admission)
- SystmOne (community care)

A sample of users from across the system was extracted from the various relevant data systems ensuring as many users as possible were represented from all agencies. The final sample was therefore made up of the following user profiles:

- Social Care + NTW – all 25 out of 25 in total
- Social Care + Acute Admission – all 166 out of 166 in total
- Social Care + NTW + Acute Admission – all 4 out of 4 in total
- Social Care + NTW + Community Nursing – all 42 out of 42 in total
- Social Care + NTW + Acute Admission + Community Nursing – all 15 out of 15 in total
- Social Care + Community Nursing – random sample of 226 out of 754 in total
- Acute Admission + Community Nursing – random sample of 268 out of 1777 in total
- Social Care + Acute Admission + Community Nursing – random sample of 254 out of 456 in total

1000 total users

3.1.2. Results

Of the thousand users surveyed, a total of 204 responses were received, which represents a healthy response rate for surveys of this nature. The results are generally positive and suggest that from the user perspective the system is working well on the whole to provide integrated care. For example:

Has your care felt coordinated to you?		
Yes, definitely	Yes to some extent'	No
69%	24%	6%

Were all the people involved in your care always aware of your medical and care history?'		
Yes, definitely	Yes to some extent'	No
64%	26%	10%

Another positive response displayed evidence of 'person-centred care':

'Were your views taken into account when deciding on any care you might need'		
Yes, definitely	Yes to some extent'	No
72%	25%	4%

Whilst there is room for improvement, the results of these two questions from a range of users, all of whom have had contact with at least two agencies for their care, are encouraging. However, there were some questions where the responses were a little less positive:

'Have you felt able to manage your own care at home and avoid any unnecessary trips to hospital?'

Yes, definitely	Yes to some extent'	No	Not Sure
52%	34%	22%	3%

Whilst this still represents a positive outcome, it also indicates that there is still work to be done in supporting people to manage their care at home rather than being admitted to hospital unnecessarily.

The full survey results are available in section 4 of the supporting material.

3.1.3. Respondent Comments

Comments have been analysed using an experience based themes framework which assesses whether the comment relates to a relational or transactional aspect of care. Transactional care refers to processes, the things done to and for people by the system. Relational care refers to the strength of relationships and interactions with people. The comments have then been categorised under each heading as to whether they are positive or negative. The framework can be found in section 5 of the supporting material.

As with the quantitative results, the qualitative free text comments from users are broadly positive about their experience of integrated care. Indeed, 86% of comments are positive with 26% being relational and 60% being transactional. The highest proportion of positive relational comments (19%) came under 'quality of staff/professionalism'. The highest proportion of positive transactional comments (42%) came under 'general/quality of care'.

There are however, some negative comments which highlight some of the same system issues revealed elsewhere in this report. Only 2% of comments were negative relational, 12% were negative transactional. Tellingly, the majority of negative transactional comments came under the heading 'coordination and integration of care':

No care plan put in place
Nothing joined up. Retelling the same story and symptoms at least 15 times, often within a couple of hours. Main objective is to move you onto someone else's budget.
Since my treatment in hospital I have not been approached by anyone offering any help or care whatsoever.
The care I have received whilst in hospital subsequent to my heart attack has been excellent. However, no one has approached me to ask (at 70+ years of age) whether or not I can manage domestically. I live alone.
At the moment we do not know who her care manager is and we have had no communication with anyone in the care system. We have not seen a care manager for about 2 years. The carers from Age UK do a very good job.
I have been my mum's sole carer for 6 years. Now in desperate need of support for my and mum's wellbeing. As a carer I feel let down by the system. Although the care manager was fine, there were major failures in the system. The care organisation 'cold called' my 90 year old vulnerable mum to discuss care. I should have been involved and present, and mum should have had been contacted prior to the visit for safety! This took place before care costs were discussed and agreed. Carer still attended my mum the following day. Result, my mum was angry, frightened, and has refused care, which has impacted on me picking up the pieces. Disappointedly, when I rung the care manager to explain she failed to try and reassure or offer support or show concern despite her failure to manage. Appalling!
Communication between social care and health care needs to be improved. People should not have to attend GPs for unnecessary appointments just to have boxes ticked. Dementia care has to be improved.

Talked down to because you are old. Talking to themselves in medical jargon. Not informing patients of the terrible side effects of the drugs they are administering. Waiting endlessly then being forgotten about. Not being kept informed of waiting times. Too quick to prescribe drugs rather than looking into the background. Obvious healthcare rationing for those in their late 90s. There is no patient centred care.

The comments above demonstrate that in a minority of cases, there are issues where services and organisations are not always linking appropriately with one another, or proactively providing person-centred support to provide an integrated patient experience.

The majority of comments however were positive; a selection below particularly highlights evidence of integrated care at a system level helping to keep patients out of hospital.

The service is great, we have great support. I have the extra time in my own house with all my family and friends. Thank you very much for all you have done for me.
All services joined up and communication first class.
I have received excellent personal care, twice in the last 16 months when I was in circumstances where I needed help to cope with basic living requirements re mobility, dressing and food.
The care managers [name removed] is absolutely amazing. Always follows up issues promptly, and keeps everyone informed. CCHS generally brilliant. Very thoughtful, caring bosses readily available on phone to deal with minor concerns. Go above and beyond to help. Wheelchair services most difficult to get hold of and need to be chased to give appointments. Generally feel delighted with care we receive.
Wansbeck Hospital Clinics were very good. Cramlington Hospital was excellent. Short term care was very good. Ambulance service good.
The mental health crisis team were exceptional. I wholeheartedly commend them.
I suffer from rheumatoid arthritis, spinal sclerosis, Parkinson's disease, failing eyesight, and have recently had a complete shoulder joint replacement. As a result I see a wide variety of health professionals and have nothing but praise for the attention and care, which they all provide.
I am amazed at all the help I have been given already - I could have been required to stay in hospital for my rehab but I live in a beautiful part of Berwick and I am so glad I managed to get home for my rehab.
Both my husband and I have needed to use health services and social care in the past few months. The service was amazing and has made a difficult time much easier.
The service and care I received from everyone concerned, ambulance, Cramlington, aftercare and therapy were all 1st class.
There was no way I could have managed to stay in my own home without the excellent help from carers etc.

For a full list of comments, see section 4 of the supporting material.

3.1.4. Discussion

Acquiring a sample of users across the various systems was a challenging process. It required the cooperation and support of multiple teams representing different parts of the health and social care system, in meeting Caldicott and other Information Governance (IG) requirements in each area. Indeed, this project was only successful in gathering a sample of system users from within NHFT managed agencies. A full system-wide approach involving other organisations such as NTW would be preferable and would have provided an even more representative sample. Having been successful in procuring this sample is a positive example of cross-system working but it is nevertheless recommended that work is

undertaken to improve cross-system information sharing, and work towards full inter-operability and use of shared electronic records.

It is worth noting that a consistent message in the CQC's Beyond Barriers report is that *"another significant challenge to health and social care integration is the ability to share information to inform effective decision-making. This problem is not new. Poor information governance, or a lack of understanding of rules and regulations for sharing information, can prevent joined-up care and support."*

RECOMMENDATION 1 –CLINICAL INFORMATION SHARING

- **The System Transformation Board partners should review their processes for information sharing in order to facilitate joint learning and quality improvement. In particular efforts should be made to ensure that individual organisational processes can be streamlined and integrated with those of others whilst continuing to adhere to highest principles of information governance.**

RECOMMENDATION 2 –INTEROPERABILITY & SHARED RECORDS:

- **The System Transformation Board should monitor and where appropriate drive local IT improvement work as a system priority, facilitating the move towards full interoperability and shared electronic patient/client records.**

The survey has been a useful exercise in gathering user opinion from across the system. Having established a data-flow which allows us to extract a cross-system user sample and the necessary IG arrangements, it would be beneficial to continue to survey users on a system-wide basis.

With a longer lead in time, the survey could perhaps be refined further, ensuring that all agencies making up the system have been able to input.

It was noted that a number of users would have been unable to complete the survey unaided due to conditions such as dementia. With this in mind, a section was added to the survey allowing the respondent to make clear whether they were completing the survey themselves, on behalf of someone else or as a carer with their own experience in mind. 2% of responses came from carers giving their own views.

RECOMMENDATION 3 –CROSS-SYSTEM USER SURVEY:

- **The Health & Well Being Board should sponsor annual cross-system user survey and other mechanisms for feedback, ensuring that results are actively used to inform system-wide planning and delivery.**

4. Professional Case Reviews

Three multi-disciplinary Case Review Meetings have been carried out to date, each of which considered in depth the journeys of users who have moved across a number of different aspects of the health and care system. Attending the reviews were representatives from the relevant agencies including NHFT (Acute, Community, Social Care), North Tyneside Council and NTW.

A standard audit methodology was devised to jointly consider a user's experience of a journey through the system. Whilst there are no universally recognised framework(s) for quality assessment across health and social care, the *Institute of Medicine*[6] framework was considered by colleagues in both health and social care to be suitable for use by parties across public and private sectors. Its domains clearly indicate meaning and relevance of quality measures, with research showing that a framework such as this is helpful for users/consumers in understanding a range of quality indicators across the breadth of services. It is of course fully consistent with CQC 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

Aspects of the individual's journey were considered against each of the Institute of Medicine framework domains and at each 'interface' episode i.e. at points where the individual moved from one part of the health and care system, and/or or physical location, to another.

A number of patient profiles were established and patients fitting these were then selected for a case review. It should be noted that this exercise took place in collaboration with colleagues at North Tyneside Council and therefore some patients were resident in North Tyneside rather than Northumberland. Learning from the case reviews is still applicable however, across both health and care systems. Patient profiles were as follows:

- Profile 1 – Multiple admissions to acute care
- Profile 2 – Multiple ward/hospital shifts
- Profile 3 – Complex health and social care
- Profile 4 – End of life or palliative care
- Profile 5 – User of Mental Health Services for Older People (MHSOP)
- Profile 6 – Regular attender to A&E
- Profile 7 – Frequent presenter to Social Services emergency duty team
- Profile 8 – Mixed mental health and physical health issues where there have been major carer (coping issues)

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

To date, 8 individual case reviews have taken place covering profiles 1 (2 patients), 2, 3 (2 patients), 4, 6 and 7. The audit tool has been completed for an additional patient meeting profile 8 but a system-wide review meeting has not yet taken place for this patient.

Many examples of good practice in delivering person-centred integrated care were apparent; however each professional case review also revealed issues in how the system delivers care for complex patients and opportunities for improvement.

Full details of each patient journey and specific learning outcomes can be found in section 6 of the supporting material.

4.1. Overarching findings from professional case reviews

Whilst there were many learning outcomes specific to individual cases of complex users who required care from multiple organisations within the system, a summary of the recurrent issues is below.

4.1.1. Coordinating Care

The most common theme across the case reviews was the lack of a clear approach to the broad coordination of care. In many cases this led to a disconnect between agencies and a lack of joined-up care for the user in question who then inevitably 'fell through the gaps' in the system. These 'disconnects' potentially caused – or at least strongly influenced – some unnecessary admissions, less than ideal clinical outcomes, poor user/carer experience, and wasted user and professional time. Whilst each user reviewed was very different, there is a clear need to develop frameworks for coordinating system-wide care for complex users, in particular identifying a named care coordinator, key worker or lead professional; critical to this will be clear definition of roles and responsibilities and appropriate levels of professional support.

4.1.2. Communication

Related to the point above, another common theme was the need to ensure consistent and clear communication between agencies, staff within large organisations (e.g. community and acute elements of NHCFT), the user themselves and the user's family. Each user's circumstances were different and appropriate communication could take many forms including multi-agency MDTs, written handovers, use of better systems and shared electronic records or direct conversations in person or by phone. Wherever there were break downs in communication, it led to less joined-up care and a deterioration of the user's condition. For instance, in the case of profile 1, patient B she attended A&E and was admitted on 8 separate occasions, and was transferred an additional 5 times in the 5 months before her death; better communication between acute, community and primary care teams and the family of the patient could potentially have significantly improved this user's experience.

4.1.3. Trigger points

Due in part to the points above, it was often the case that there was no clear trigger point at which a user was identified as requiring escalation of care including a system-wide response. Whilst dependent on each individual case it was suggested that some suitable generic triggers and escalation responses could be developed to assist professionals and users for example, after a certain number of repeat admissions, or a certain number of contact points with a given team. For example, profile 7, patient A, a frequent presenter to social services emergency duty team (EDT) in Northumberland would have benefitted from a multi-agency

meeting to agree a single approach to management but this was never triggered: the user fell through gaps between services with individual presentations not deemed significant enough to require an ongoing agency response.

4.2. Links with other audits

The findings of the professional case reviews align with other related work. For instance, a recent Northumbria Healthcare audit which took an in-depth, system-wide view of the last 1,000 days of the lives of 5 patients drawn randomly from 100 in Summary Hospital-level Mortality Indicator (SHMI) during 2016/17. This audit exposed the same three key issues as listed above: coordinating care, communication and trigger points.

It is intended to ensure that further audits taking place across the system are linked up to triangulate learning, reduce non-value adding duplication of effort and re-enforce actions and learning.

It is important to note that the professional case reviews which have been undertaken here as part of the LSR process are unique in their system-wide approach including representatives from all agencies involved in the user's journey.

4.3. User experience across case reviews

It is intended that user experience and professional case reviews are explicitly linked at individual user level to challenge and test professional assumptions. Due in part to the nature of the cases reviewed to date and confidentiality concerns, it has not been possible to involve users directly from the outset. However, representatives of Healthwatch Northumberland and North Tyneside are invited to attend future case review sessions. Discussions are in train with Healthwatch to develop a sensitive approach to inclusion of the user of user's family members experience in case review. Adding the user's voice will lend greater weight to the evidence for system improvement, helping pinpoint changes to prioritise, potentially offering new solutions & ideas, and opening up subsequent improvement processes to concepts of co-production, with the intention that this becomes the norm for all system service improvement work

4.4. Disseminating findings and learning from case reviews

At each Professional Case Review meeting, the group has discussed ways of ensuring the lessons learnt are communicated to the right parts of the system and that action is taken by the appropriate agencies or staff involved. A number of recommendations have been made:

- Establish a responsibility matrix for completion following each case review identifying parties responsible, accountable, consulted and informed at each level of seniority and in each part of the system, for identified actions.
- Present user journeys and key findings at appropriate forums both system-wide (e.g. System Transformation Board) and within organisations (e.g. NHCFT Clinical Policy Group).
- Create accessible storyboards summarising the user journeys and recommendations which can be disseminated to appropriate teams.
- Consider how the LSR Clinical Case Review methodology could be adapted for use by front-line inter-agency clinical/professional teams.
- Incorporate the user voice into case reviews (see above).

Participants have proposed that the system continues to hold regular, multi-agency case reviews for the identified profiles.

RECOMMENDATION 4 –MULTIAGENCY PROFESSIONAL CASE REVIEWS:

- **The process devised for multiagency Professional Case Review should continue, adapting methodology, and approaches to dissemination of learning as appropriate, and ensuring the work complements and builds on learning from related individual agency/organisation work.**

RECOMMENDATION 5 – SYSTEM-WIDE LEARNING & SERVICE IMPROVEMENT

- **System Transformation Board should consider inter-organisational improvements in communication, care coordination, and triggers for & responses to escalation.**
- **Principles of co-production should be used with the expectation that this can be evidenced in this as with all other future service improvement work.**

5. Well – Led Review

Two key aspects were proposed to baseline 'well-led' review components, both based upon the CQC LSR framework:

- A Relational Audit conducted by the Whole System Partnership (WSP), the company which undertakes these on behalf of the CQC.
- The System Overview Information Request (SOIR) used by the CQC in the event of an LSR, to be completed in draft, compared to those of other systems and analysed for gaps.

5.1. Relational Audit

The Relational Audit was carried out across the health and care system in Northumberland between 1st February and 6th March 2019 by WSP. The audit was sent to individuals working within an organisation in the Northumberland footprint with a request to cascade to other colleagues. . The exercise was also undertaken in North Tyneside, with those working in both footprints completing patch-specific audits. The full report can be found in section 7 of the supporting material. A summary of the methodology, key issues and recommendations is below.

5.1.1. Introduction to Relational Audit

The value of relationships within systems of care is something that WSP has championed through an innovative piece of research and development in partnership with the University of Leeds School of Healthcare Studies. This has led to the production of a tool for the assessment of relational value (R^v) underpinned by evidence that the presence of behaviours described in the R^v tool lead to effective and sustainable services, and improved outcomes in a variety of settings.

Building a picture of how the system is perceived as a relational entity by those working within it enables an understanding of the factors helping (or hindering) the delivery of services. These factors can then be addressed in any future improvement work, as well as providing evidence for quality assessment and in describing the benefit they bring to the client group, carers, and wider health and social care system.

5.1.2. Relational Value Methodology

An effective system, where particular goals were being achieved, would demonstrate appropriate levels of 5 attributes:

- System integrity (how things interconnect and function, all pulling together)
- Respect (how we treat each other, recognising everyone's contribution)
- Fairness (how equity is achieved)
- Empathy (how we understand each other)
- Trust (how much we put ourselves in other people's hands)

Together, these attributes combine to form the 'relational value' of the system. The output of the online R^v tool is a metric for R^v for a whole system and/or different parts of the system. This metric provides a view of how the system is experienced relationally from all perspectives and may point to practices and behaviours that contribute to, or hinder, a well-functioning system of care.

The assessment consists of 30 statements about relationships within the local system which respondents are asked to assess on a scale from 'consistently not true' –rating 0, to 'consistently true' – rating 5, in the respondent's experience. People were asked to respond to the statements in the following way: '*Please reflect on the statements and the extent to which they are true in your recent experience of the local system of health and care for older people, choosing the rating that best fits your overall experience*. The survey tool is included in section 8 of the supporting material. Following the rating of the statements there is an opportunity to capture 'freeform' responses regarding the respondent's perception of the relational health of the system they are engaged in. This can provide an additional and rich set of views on the quality of relationships that adds to that gathered through the statement ratings.

5.1.3. Key Findings of the Relational Audit

A total of 174 individuals responded with breakdown as follows:

Respondent	**Number**
Social Care Commissioner	9
Other Health Provider	3
Community Health Provider	19
Community Mental Health Provider*	12
Acute Health Provider	27
Other	7
Social Care Provider	73
Third or Voluntary Sector	9
Other Organisation	8
Health Commissioner	3
Acute Mental Health Provider*	2
N/A	2
Total	**174**

*NB due to issues with browser functionality, a number of staff from NTW were not able to respond.

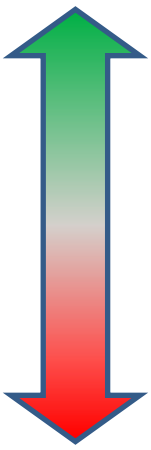
The overall score for relational value for the Northumberland system of integrated care from this assessment is 3.29 out of a possible 5. This indicates that the system of care is working reasonably well from a relational point of view, a score of '3' representing 'often true' on the rating scale, but that there is room for improvement. Northumberland compares favourably with similar services assessed recently as part of the CQC Local System Reviews where average scores for relational health ranged between 2.7 and 2.9 across the 20 integrated systems. (Note that 19 of the 20 Local Systems reviewed were chosen because they were assessed as 'challenged' by CQC with regard to their services for older people). However, WSP also have experience of overall R^v scores as high as 4.5 for integrated system working.

Whilst the overall average R^v score gives an indication of how the local system is working, it is important and perhaps more revealing to consider the scores for individual statements in order to obtain a clearer picture of the system under scrutiny, especially when there is little variation in the above. The table below shows where the highest and lowest scoring statements fall, followed by the statements themselves.

	Socio-technical dimensions					
Relational value attribute	**Culture**	**Infrastructure**	**People**	**Process**	**Technology**	**Vision**
Integrity	3.52	3.06	3.49	3.29	3.01	3.57
Respect	3.44	3.41	3.53	3.52	2.80	3.24
Fairness	3.67	3.37	3.52	3.26	2.82	3.45
Empathy	3.24	3.19	3.09	3.08	2.87	3.55
Trust	3.69	3.57	2.72	3.52	3.14	3.14

Highest /lowest scores for individual statements

Best scoring	We can be open and honest in our dealings with each other	Trust/Culture
	We treat each other fairly	Fairness/Culture
	The buildings we use provide a safe place to engage with others in as open a way as possible We experience a common purpose across the organisations in meeting the needs of our clients	Trust/Infrastructure and Integrity/Vision
	Any limitations in the ability to use particular technology in parts of the care system are understood and accommodated	Empathy/Technology
	Decisions about how we use technology takes into account the needs of all parties	Respect/Technology

 Worst scoring	People take organisational risks where this has the potential to serve wider system goals without fear of criticism or failure.	Trust/People

The findings suggest that system relationships are reasonably good but there is potential for further development, investment and improvement in relational health across participating organisations.

- Positive findings include:
    - Highest ratings given were for elements of fairness and trust attributes ('We can be open and honest in our dealings with each other' and 'We treat each other fairly');
    - There is some satisfaction with the quality of joint working across the system (e.g. Submitted comment: 'Organisations have shared high-level aims and objectives in relation to system integration, and individuals within organisations work effectively together to further those aims');
- Challenges include:
    - A perception that the aims and objectives of the organisation one works for take priority over those that are system-wide, resulting in a lack of system perspective (e.g. The lowest overall rating for an individual statement was for the Trust/People statement '*People take organisational risks where this has the potential to serve wider system goals without fear of criticism or failure*');
    - Relational factors associated with Technology are perceived as a barrier to joint and integrated working (e.g. 4 out of 5 of the lowest rated statements were in the Technology domain).

5.1.4. Respondent Comments

At the end of the assessment respondents were given the opportunity to add free text comments about the relational aspects of their experience of working within the local system for older people. 13 such comments were received from across a range of organisation types. A full set of respondent comments can be found in section 9 of the supporting material.

1 comment was entirely positive:

The system wide approach to delivering population health in the area is very strong and has been highlighted as an example of good practice

9 were entirely negative, and references include Technology, communication, and lack of shared vision:

We feel as a provider that we stand alone with little or no support and providers are the first to be accountable despite failings elsewhere. Every one appears to close ranks at the expense of providers. Transparency only exists from the provider side in most cases
Estate not all fit for purpose and can restrict service delivery. IT systems do not talk to each other and can lead to repetition of data collection throughout the patients journey.
We are sometimes constrained by poor technology, non-interoperability of systems across primary, acute and social care systems e.g. Google hangout is not accessible to NHS staff and poor video conferencing facilities make engaging with the whole system more difficult.
As a system we struggle to learn from the past. Constant change often erases organisational memory and IT divides rather than unites.

If we concentrated on our clients rather than the cost these days then everything would run effectively regardless. All problems are due to costs. You cannot put a cost on someones life therefore do not use money as an excuse.
Each of our service users has a care manager, and we feel increasingly that care managers have a very different organisational culture, and have different objectives to us when meeting the needs of adults with learning disabilities.
We have to interface with Social care frequently and often on very high risk cases. There is no shared understanding or planning in this and they do not accept our assessments or opinions. It has been Social Care I have had in mind when completeing this survey. However it is also difficult to communicate with Primary care you can only talk to the GP on call who will probably not have the information required. And Northumbria Healthcare A & E have taken our clients off medication and are far too quick to discharge our clients.
In the geographical area where I work, the health and social care interface is difficult at times. This is more complicated too with people placed in care in England from the Scottish side, as there are no cross-border protocols. I think we do our best as professionals.
One computer system for health and social care would be helpful as status of care package etc could be accessed without multiple telephone calls for the same client.

3 comments held both positive and negative views, the positive relating to effective working across organisations whilst the negative relates to lack of shared agendas/goals:

Organisations have shared high-level aims and objectives in relation to system integration, and individuals within organisations work effectively together to further those aims. However, individual organisational agendas, drivers and restraints still restrict the ability to deliver a truly integrated system across the health and social care environment.
There is already much integrated working but huge further potential for increasing shared perspectives and goals which are dependent on increasing trust, in particular between commissioners and providers. There is a huge opportunity also for embracing the third pillar of population interventions, namely the Voluntary and Community Sector, and getting to the point that we stop saying ‘how will we solve this problem?’ and start asking the question: ‘who is best placed to address this problem?’
Mostly true, though I find that staff shortages can make it very difficult to provide the best care for our service users and pressure on staff.

5.1.5. Discussion and Conclusions - Summary

An overall relational value score of 3.29 out of a possible 5 suggests that relationships between those organisations and services in the Northumberland system are reasonably satisfactory. The fact that the average ratings vary little across the range of relational attributes reflects a balanced system without any glaring issues at the interface of organisations. However, given that good system relationships are strongly linked to better outcomes and experience for service users, these findings also suggest that there is room for improvement in general, and in specific areas as detailed below.

Whilst acknowledging the limited variation in average ratings in general, it is worth noting that responses were the most positive around specific issues of fairness (‘We treat each other fairly’) and trust (‘We can be open and honest with each other’), both of which are key foundational behaviours for future improvement in integrated working.

One of the key issues highlighted as a barrier to inter-organisation working in this assessment is Technology, with 4 out of the 5 Technology domain scores featuring in the lowest 5 scores in the survey, alongside several references to IT issues in negative comments submitted. The impact of lack of interoperability between systems is commonly highlighted as an issue across systems of integrated care in general, and often surfaces as an issue in relational value assessments. Whilst some action towards alleviating this situation is the remit of national bodies, attention should be given locally to this barrier to integrated working to both acknowledge its impact and find local solutions where possible.

Enabling issues identified include the overarching population approach and the sharing of vision at a high strategic level. It is possible that the key strategic leaders of the system have a vision and intention to work together as one but that there is a disconnect between that intention and the everyday working practices within the system.

The lowest overall score in the survey, also alluded to in comments made, is for the 'Trust/People' domain, in response to the statement 'People take organisational risks where this has the potential to serve wider system goals without fear of criticism or failure'. This might suggest that, in spite of all endeavours to share vision, aims and objectives, there exists an insecurity around being free or able to take action that might be best for the overall system but not reflect well on the individual organisation. Feedback of this nature suggests that there might be limited leadership accountability for the outcomes of the wider system, the main concern being for one's own organisation. If that is the case then development towards a joint approach to funding, finances, shared risk taking and whole system performance is needed to encourage joined up working.

5.1.6. WSP Recommendations

The findings noted above give a baseline position for the relational health of the system in question. They can now be used, in conjunction with findings from other evidence such as service user feedback, to plan improvement and development. WSP recommend that:

- "Positive feedback from this survey is celebrated and shared to encourage staff at all levels;
- An agreed set of actions is devised and systematically implemented to address the issues raised;
- There are ongoing relational health checks at regular intervals (between 6 months and a year) to identify trends, new areas of focus, or impact of any intervention or suggestions made as a result of this assessment;
- That an 'R^v Tracker', a much simplified 5 question survey, be embedded in ongoing quality routines to give speedy feedback on the relational health of the system and act as an early warning system."

5.1.7. Comparison with Carnall Farrar Report

In July 2018, Northumberland CCG commissioned a system review report by consultancy Carnall Farrar. Whilst the majority of this report is focussed on the system's financial plans and capacity, Carnall Farrar undertook more than 45 interviews with system leaders and conducted a survey to which 152 individuals responded, representing organisations across the system.

Whilst, the questions asked were different, the Carnall Farrar report notes similar findings to the Relational Audit undertaken here. In particular it notes under the 'system leadership and relationships' section, the need to overcome an "organisation first" mind-set, echoing the results above. Further key findings of the Carnall Farrar report include:

- A need to translate a strong history of integration between health and social care into transformation plans and delivery.
- The need to improve the alignment of partners to organisational strategy with appropriate system-wide strategic planning and pathway thinking, including better stakeholder engagement.
- System imbalance driving more organisation-led financial decision-making.

The relevant summary findings of the Carnall Farrar report can be found in section 10 of the supporting material.

RECOMMENDATION 6 –FINDINGS OF RELATIONAL AUDIT

- **System Transformation Board should consider the finding and recommendations of the WSP Relational Audit including:**
    - **Feedback to staff & partners**
    - **Actions to address issues raised**
    - **Ongoing Relational Audit at regular intervals**
    - **Systematic use of the R^{v} Tracker survey within quality routines.**

RECOMMENDATION 7 – SYSTEM GOVERANCE & CULTURE

- **System Transformation Board should consider specific formal mechanisms and supporting OD approaches that can address an "organisation first" mind set. This may include development of common system pathways, joint planning including system workforce planning, shared decision-making and financial risk-share mechanisms.**

RECOMMENDATION 8 – METRICS AND DATA

- **System Transformation Board should develop system-wide performance metrics for integrated care for older people, and consider their routine use within and between organisations as a lever to drive improvement.**
- **Consideration should also be given to the establishment of a shared data repository to facilitate standardisation of measures with commonly-owned data, and improve use of resources.**

5.2. System Overview Information Request (SOIR)

Prior to visiting a local area for a system review, the CQC ask the local area to provide an overview of their health and social care system in a bespoke System Overview Information Request (SOIR). The SOIR contains 15 questions and provides an opportunity to describe how the system works for older people moving between health and social care.

In addition to answering the questions themselves, there is an expectation that all underlying strategic evidence is provided. In Northumberland, it was agreed that drafting a response to

the SOIR and gathering the relevant strategies together would provide a good opportunity for internal gap-analysis.

This task was approached by seeking appropriate expert leads for each of the SOIR sections and asking them to complete a draft response.

Whilst some information has been forthcoming and an element of gap-analysis has taken place, it has become apparent that completing the SOIR is a challenging task, requiring input from leaders across the system and investment of significant time and effort. This is reinforced by discussion with those in systems which have undergone a formal LSR.

It has not been possible to complete a suitably system-wide, representative version of the SOIR thus far. Responses gathered have an organisational rather than system orientation and include significant gaps.

5.2.1. Learning from other localities

In order to learn more about the LSR process, two local authorities which have undergone the CQC review process were contacted for information. These were Cumbria County Council and Leeds City Council.

In order to complete the SOIR, both organisations required significant input from system leaders and went through multiple (up to 52) iterations before all agencies and the CQC were content with the information supplied. In addition to the SOIR, the CQC requires submission of all underpinning strategies cited in the SOIR. In Cumbria's case, 34 additional documents needed to be submitted, ensuring each was up-to-date. Gathering and reviewing this information required significant time and resource.

Both localities suggested that, given more time, it would be of benefit to run a developmental workshop for system leaders to confront the questions asked in the SOIR in a cross-system manner, allowing for open discussions between decision makers on existing system-wide strategies.

This would be a challenging exercise but may prove very beneficial in identifying areas of disconnect as well as common ground on which to build. The SOIR itself however, is designed to inform LSR reviewers at a point in time so would not necessarily all be useful as early preparatory work.

Consideration should be given to the value of the exercise, and potential modification, as well as other options. The SOIR template including all questions can be found in section 11 of the supporting material.

RECOMMENDATION 9 – SYSTEM OVERVIEW AND STRATEGY

- **The Health & Well-Being Board and System Transformation Board should ensure full completion of the CQC System Overview Information Request (SOIR) by the end of 2019 noting that this requires significant input and resource.**
- **This should include a developmental workshop for local leaders, externally facilitated if appropriate, to jointly assess system-wide working arrangements in line with SOIR format by September 2019.**

6. Readiness for Inspection Plan

Alongside our internal review process described above, and in line with expectation of Phase 1 of the LSR Project a plan has been drawn up for use in the event that the CQC announce a Local System Review in Northumberland. This plan addresses the logistics and personnel required to prepare for and host a LSR. The plan requires the identification and appointment of an inspection coordinator and administrative support who would need to be dedicated to the LSR for 9 weeks (the lead-up and duration of the review).

This plan has been developed based on the existing Local System Review framework. It is understood however, that this is under review by the CQC so the plan may need to be updated and revised if new frameworks are published.

Actions required in the lead-up to the review include:

- Identify and contact leads from each participating organisation
- Instigate completion and submission of SOIR document
- Identify stakeholders for relational audit and distribute accordingly
- Identify venue for initial meeting
- Co-ordinate system overview presentation for initial meeting with Inspectors
- Identify and brief staff to attend focus groups
- Co-ordinate the identification of user pathway examples (good and bad)
- Commence gathering of internal intelligence (SUI's, high risk complaints etc)
- Identify suitable base during inspectors for inspection/inform reception
- Carry out gap analysis/quality check of SOIR submission
- Co-ordinate the venues for focus groups and final feedback session
- Prepare Inspectors room & resources (IT, telephone, refreshments, briefing packs/story boards, protected parking)
- Organise conference call facilities for 2 x daily feedback sessions

During the review itself, the team would be required to carry out the following tasks:

- Check and replenish Inspectors room
- Meet and greet Inspectors
- Carry out induction to building
- Escort Inspectors to meetings and focus groups
- Lead feedback conference calls twice daily
- Co-ordinate well led interviews
- Co-ordinate final feedback session

Whilst the prime driver for the LSR work has been to enable system-wide improvement in health and care, the efforts in consideration of preparatory requirements place the system well to respond swiftly and effectively should a formal LSR be announced.

A full timetable of the Local System Review preparation plan can be found in section 12 of the supporting material.

7. Conclusion and Recommendations

Phase 1 of this project has allowed analysis and assessment of the system from different key perspectives, culminating in a holistic view of how well the system is functioning. The process reveals a system working comparatively well to provide patient-centred, integrated care but when the findings of the three work streams are triangulated, provides evidence of the opportunity for system improvement in a number of key areas:

- **Coordinating Care**
  The most repeated theme across all review processes was that for complex users who required care from multiple agencies, there was a danger that they 'fell through the gaps' due to the lack of clear approach to the broad coordination of care. Whilst the most appropriate solution will be different depending on the user in question, there is a need to develop and embed system-wide approaches for ensuring robust co-ordination and establish frameworks for agreed escalation triggers and responses.

- **Communication, technology and data sharing**
  Across all three work streams, communication difficulties, use of technology and IT interoperability were highlighted as significant barriers to providing person-centred integrated care. Even sharing of information for improvement purposes proved arduous and a potential disincentive to system-wide working.

- **Organisational relationships, integration and risk management**
  Relationships between the agencies which make up the system are generally good but there is opportunity for further development, investment and improvement in relational health across participating organisations. A perception exists amongst staff system-wide that the aims and objectives of the organisation (or indeed section within an organisation) one works for can take priority over those that are system-wide, potentially resulting in a lack of system perspective and consequent broader population benefit. Evidence demonstrated that at times staff can find it difficult to take risks which might benefit the system and the integration of a patient's care, but might not benefit the host organisation.

- **System-wide shared strategy & planning**
  More work is required to adequately assess the strategies, planning, policies and ways of working which underpin the health and care system in Northumberland. That said, and in noting CQC feedback to localities which have already undergone formal LSR, whilst governance at an organisational level is good, Northumberland is yet to fully develop the maturity of system-wide governance that the CQC would hope to see. New arrangements for the System Transformation Board provide an excellent opportunity to drive transformation of care for older people through comprehensive strategic approach to aspects such as commonly agreed pathways and service priorities, co-production, and workforce planning.

The evidence amassed through phase 1 of the Local System Review Project justifies an ongoing programme of system improvement considering and acting upon the following recommendations which, if approved can form the basis of phase 2 of this project:

RECOMMENDATION 1 –CLINICAL INFORMATION SHARING

- **The System Transformation Board partners should review their processes for information sharing in order to facilitate joint learning and quality improvement. In particular efforts should be made to ensure that individual organisational processes can be streamlined and integrated with those of others whilst continuing to adhere to highest principles of information governance.**

RECOMMENDATION 2 –INTEROPERABILITY & SHARED RECORDS:

- **The System Transformation Board should monitor and where appropriate drive local IT improvement work as a system priority, facilitating the move towards full interoperability and shared electronic patient/client records.**

RECOMMENDATION 3 –CROSS-SYSTEM USER SURVEY:

- **The Health & Well Being Board should sponsor annual cross-system user survey and other mechanisms for feedback, ensuring that results are actively used to inform system-wide planning and delivery.**

RECOMMENDATION 4 –MULTIAGENCY PROFESSIONAL CASE REVIEWS:

- **The process devised for multiagency Professional Case Review should continue, adapting methodology, and approaches to dissemination of learning as appropriate, and ensuring the work complements and builds on learning from related individual agency/organisation work.**

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