

NHS Providers On The Day Briefing: CQC *Beyond Barriers* local system reviews report

The Care Quality Commission (CQC) has completed a programme of targeted local system reviews in 20 local authority areas to assess how well services are working together to care for and support people aged 65 and over. The resulting report, 'Beyond barriers', summarises CQC's findings from the reviews. This briefing sets out the report's key findings and NHS Providers' response to the report.

We welcome CQC's system reviews and this report, which provides a valuable contribution to better understanding and improving system working. We recognise there is a need for legislative change in order to hold local systems to account for their performance. However, any plans for legislative change must be aligned with other developments currently happening at pace, including the new funding settlement and 10 year plan for the NHS. In addition, as responsibility and accountability for the provision of services remains with individual trusts, the regulators and national bodies must respect and support current and future institutional accountabilities.

Background

The 20 systems were identified by the Department of Health and Social Care (DHSC) and Ministry of Housing, Communities and Local Government (MHCLG), with 19 of the 20 systems described as 'comparatively challenged'. The systems were based on Health and Wellbeing Board (HWB) footprints. CQC reviewed how each local system works within and across three key areas: maintaining people's wellbeing at home; care and support when people experience a crisis, and step down, return to a usual residence, and/or admission to a new residence.

CQC carried out the reviews using a combination of observations, data analysis, focus groups, questionnaire tools, case-tracking and interviews. CQC spent two periods on site, speaking to people using services, their families and carers, and staff. After each review the CQC produced a local system report highlighting what worked well and opportunities for improving system working. The reviews were followed by local summits, which brought together local leaders and representatives from national bodies.

Report recommendations

- 1 Encouraging and enabling commissioners to bring about effective joined-up planning and commissioning

- Local leaders should create an agreed joint plan for how older people are to be supported in their own homes, helped in an emergency, and then enabled to return home safely. This plan must maximise the potential contribution from voluntary, community and social enterprise (VCSE) organisations.
- Local leaders must take a reformed approach to funding that allows and encourages local systems to align and pool their budgets.
- Sustainable funding reform must remove the barriers that prevent social care and NHS commissioners from pooling their resources and using their budgets flexibly. Consideration should 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. National leaders must work with the Local Government Association and the Association of Directors of Adult Social Service to support this.

2 A new approach to performance management

- There should be a single, joint, nationally agreed framework for measuring the performance of how organisations collectively deliver improved outcomes for older people. This would operate alongside oversight of individual provider organisations and use metrics that reflect outcomes for people – including from primary, community, social care and independent care providers – rather than relying primarily on information collected by acute hospitals.
- Local leaders should give more emphasis to investing in models of care that support prevention and avoid unwarranted admission to secondary care. To support this, local leaders must actively and effectively share information about people across organisational boundaries, with support from national leaders to make this possible and with the appropriate safeguards in place.

3 A move to joint workforce planning

- Local leaders should agree joint workforce plans, with more flexible and collaborative approaches to staff skills and career paths. These plans should reflect and work in tandem with Health Education England and DHSC workforce strategies, anticipated later this year.
- National health and social care leaders should design career paths that make it easier for individuals to move between health and care settings and gain skills in a variety of different settings.

4 Better regulation and oversight of local systems

- Government should consider new legislation to allow CQC to regulate local systems and hold them to account for how people and organisations work together to support people to stay well. This would also ensure that regulation looks at both individual organisations and quality of care across services.
- Regulators, including CQC, should work to agree a set of performance metrics and indicators for system performance that are used to inform all regulatory activity and oversight.

Key findings

System leadership and performance

- CQC sees the markers of mature relationships as collective goals, collaborative decision-making, and sharing of risk, underpinned by multi-disciplinary and multi-agency working on the ground.

- There were examples of cross-organisational leadership roles, but most senior leadership still sits within individual organisations. CQC also saw many instances where local managers and practitioners were leading change at an operational level through collaboration rather than formal structures.
- Feedback from CQC's relational audit highlighted that people felt most positively about treating each other fairly and honestly, and most negatively about their ability to take on risks that served wider system goals without fear of criticism or failure.
- Across all systems there were examples of silo working; pressures of performance targets and financial constraints often lead people to revert to protecting their own roles and organisational aims.
- The way performance is currently measured does not incentivise system working, which impacts negatively on relationships and collaboration. Delayed transfers of care (DTOCs) are an example of where improved performance in one part of the system places pressure on other parts and do not encourage shared accountability for performance.
- While system governance and accountability arrangements can be drivers for system working, their effectiveness varies from system to system.
- HWBs and STPs took different roles in different places, depending on their maturity and effectiveness, but both can provide effective accountability for local systems, although more commonly CQC found HWBs were not fulfilling their full potential.
- All systems had an ambition to move to joint commissioning but commissioning arrangements were collaborative rather than fully integrated, although progress was being made.
- Despite the positive impact that the Better Care Fund (BCF) has had on bringing together system partners to develop joined-up and integrated commissioning practices, the funding is only short term.
- Nationally, there is a need for national bodies to create the right incentives for integration and joint working, including aligned performance measures, oversight and regulation. CQC states that assessing the quality of individual providers in isolation from system outcomes is not maximising the potential improvement that might be driven by regulation.

Building sustainable systems

- Addressing the capacity and capability of health and care systems to support older people now and in the future is a priority. Part of this is developing a learning culture in systems; CQC saw learning taking place at an organisational level, but this was less apparent across a system.
- Having a stable and skilled workforce in place is also essential. Staff often went the extra mile to provide care. However, local systems are challenged to recruit, retain and develop their workforce.
- Health and social care leaders need to be innovative in how they recruit, train and utilise their workforce, and recognise the interdependencies of their sectors and address challenges collectively.
- Most systems had established joint workforce groups however CQC was not assured of effective joint workforce planning across health and social care. For example, these groups did not always include all system partners, such as independent adult social care and ambulance providers.
- Shaping the adult social care market was one of the most significant challenges across the systems. CQC did not find a culture of true collective responsibility for shaping health and care markets in any of

the systems, and health and social care commissioners do not consistently have robust systems in place to predict demand and proactively shape the structure of the market supply.

- All systems recognised the important role of the VCSE sector to support system-wide strategic aims and some systems are proactively working with VCSE organisations. However, the extent to which the VCSE sector organisations were included in the strategic planning and delivery of services was variable.
- Digital interoperability was an issue in all systems and information governance rules were often misunderstood. System leaders recognised the importance of information sharing and steps were being taken in some systems to build platforms for digital information sharing. However, no system had established platforms for information sharing across all health and social care organisations.
- Nationally, spending on primary prevention and early intervention is not being prioritised in BCF plans (total spend nationally was 2.73%). CQC concluded that instead of incentivising systems to reduce their DTOCs, systems could be incentivised to reduce pressures on hospital services by investing in admissions avoidance services and services that support people in the community.

Older people's experiences of moving between health and care services

- All the systems had a shared understanding of the importance of providing preventative services that promote health and wellbeing in the community. However, commissioning priorities were influenced by funding pressures and funding flows to support hospital care – as a consequence, the ability to invest in services that prevent people becoming unwell was limited.
- Local government resourcing, variable access to out of hours services and the unstable general practice workforce were leading people to rely on hospital services. CQC's analysis suggests lower rates of GPs and primary medical services care staff per registered patients may be associated with higher rates of attendance at A&E by older people.
- People working in care homes said it could be difficult to access GPs and community health support, which meant they were more likely to rely on emergency services. There was variation across the services in how well they had aligned community nurse teams, medicines optimisation and GP practices with care homes.
- CQC highlight the vital support that community health services provide to keep people well but point out that capacity in community health is challenged: between 2009 and 2017, there was a 40% drop in the number of community matrons and a 44% drop in the number of district nurses.
- People found accessing services complicated and confusing. CQC saw examples of how single point of access services could be effective in providing timely access to services. However they varied in terms of who could access them and in the range of services they could refer to.
- There was considerable variation in access to and availability of services, depending on where people lived. In systems with good access and support for personal budgets and direct payments people were being supported to take control of their care; however there was large variation in their uptake.

Care pathways

- CQC saw that having the right staff in place to assess and coordinate care was key to streaming people attending A&E into the most appropriate care and avoid unnecessary admissions. CQC analysis of

ambulance turnaround times at hospitals suggests that these times are longer when there are fewer senior staff to supervise and support junior staff.

- Allowing ambulance staff to refer people directly into community services can help reduce avoidable admissions, but the extent to which this was happening in the systems was limited and there were significant capacity issues in the ambulance workforce.
- There was some proactive work to identify frailty and treat people in appropriate frailty units, but people were often staying for too long due to lack of capacity in the main hospital or community.
- Pressure on local systems to reduce delays in hospital discharge has overwhelmed other health and social care priorities. While it was positive that this focus had led to reductions, CQC found examples where it had compromised the safety of people moving through services, for example where people were moved out of care settings before arrangements for equipment, medication or transport were in place.
- People did not always experience a consistent approach in planning for their discharge: discharge dates were not being discussed early enough; discharge planning did not always involve the relevant people and staff early enough; social workers frequently voiced concerns about not being involved early enough, if at all, and GPs frequently communicated that discharge planning was poor. Discharges were being delayed due to a lack of coordination in conducting assessments. People were frequently discharged without accurate or sufficient information about their hospital stay or care needs.
- There are different interpretations of the trusted assessor model in different systems and there was not the level of understanding of the model between services to implement it quickly and at scale.
- Lack of capacity in the adult social care market was a barrier to people moving smoothly between health and care and meant that, in some systems, people are not provided with genuine choice about what care they want to receive and where they want to receive it. People often had to make decisions about their long-term care while in hospital, leading to delays.
- There was wide variation and access to reablement and rehabilitation services and CQC saw people spending a long time in intermediate care beds.

NHS Providers' view

The CQC's report is an important starting point in building a picture of the quality of care in local systems. As the national policy agenda continues to support system working and collaboration, we welcome the steps CQC is taking to adapt its approach in response to the move to greater integrated working.

It is clear that strong relationships and a shared vision are crucial elements of any local health and care system. However there remains much to do to incentivise and remove barriers to system working. Some areas are devising ways around these disincentives, but national action is needed to remove these barriers and to set out a clear strategy to support the move to system working. We will continue to work with the arm's length bodies to ensure that the system architecture develops to enable leaders to collaborate.

Local health and care systems across the country are at different stages of development and while the front-runners are racing ahead, there are other local systems that will need more time and support to develop. This will mean that any approach to assessing systems will need to be iterative and take into account the history of local relationships and organisations, and see any progress within this context. We

are concerned that otherwise systems will be judged or even held to account for things that are beyond their control.

As the responsibility and accountability for commissioning and provision of services remains with CCGs and trusts' boards, trusts need to balance system working with meeting their own organisational accountabilities. In future it will be crucial that providers and their local system partners are not subject to 'double jeopardy' and multiple judgements. As CQC's oversight framework for assessing local systems evolves, it will need to ensure that the oversight of systems does not add an additional layer of performance management, duplication or burden. We understand that CQC is developing its relationships with two ICS areas and is working with them to develop a cross-sector, system-based approach to its regulatory work. We welcome this engagement with providers given the need for a clearer model of regulation and accountability to support and oversee the move to integrated care.

To support this, the national bodies must work together to align their approaches to supporting and overseeing local systems in order to avoid any unnecessary duplication and burden on health and care providers. For example, it would be helpful for CQC to consider how, when designing system-level assessments, it will work with NHS Improvement and NHS England to ensure its approach is aligned with the STP ratings. We believe that the national bodies can learn from CQC's experience of conducting these reviews and it is important that learning is shared at a national level too.

Press statement

"We welcome that the CQC has highlighted the importance of joined-up health and care services designed around the needs of local people.

"This report is an important starting point in the discussion about how we define the quality of care in local systems. However there remains much to do to incentivise and remove barriers to system working and we need a clearer national strategy to support the move to integrated care.

"This includes supporting local areas to flex the funding model and workforce planning to allow for the demands of the local area. Health and care systems also need support to plan strategically with a shared vision and shared accountability.

"We welcome the steps CQC has taken to adapt its approach in line with the changes that health and care systems are making towards delivering more integrated care. It is crucial that the national bodies work together to align their approaches to supporting and overseeing local systems in order to avoid any unnecessary duplication and burden on health and care providers.

"This report shows that whilst some systems are performing very well others will require further support. Any oversight approach for systems must take this into account so that local organisations are not held to account for things outside of their control."