Health and Wellbeing Board

27 November 2017

Integration Update

Report of Lesley Jeavons, Director of Integration, North Durham Clinical Commissioning Group, Durham Dales Easington and Sedgefield Clinical Commissioning Group, Durham County Council

Purpose of the Report

1 The purpose of this report is to provide an update to the Health and Wellbeing Board on developments in relation to the integration of health and social care which includes the following areas:

- Developments within the Accountable Care Network, Primary Care Home and Teams Around Patients
- An overview of the new approach being taken to the delivery of community services across County Durham as well as work currently taking place with Price Waterhouse Coopers on developing a Health and Care plan for County Durham
- Our approach to Prevention
- The North East and Cumbria Learning Disability Transformation Programme including the development of an Accountable Care Partnership.
- Better Care Fund and the Improved Better Care Fund

Background

2 The Five Year Forward View and the Care Act 2014 outlined the need to design and implement services around individuals and their communities to further enhance pathways and joint service provision across health and social care.

3 Sustainability and Transformation Plans support the development of services outside of acute settings with a view to preventing admissions and facilitating effective discharge.

4 Many adult health outcome measures within County Durham fall significantly below the national average presenting a challenge to the local health care system. There are a rising number of people with multiple long-term conditions including respiratory, cardiovascular disease and diabetes. Demographic pressures also place emphasis on the need to manage demand for social care more effectively.

5 At present, distribution of spend is very focussed on the acute and there is a need to move away from using existing organisations spend in secondary care as the basis of determining spend patterns in community services.

Health and Care organisations need to review how they can redistribute resources appropriately at a community level in response to local population needs to ensure best use of the "public pound". Continuing with current patterns of funding and delivery is not an option.

6 Further details in relation to national policy can be found in Appendix 2.

7 The Health and Wellbeing Board has received regular updates in relation to integration. The last update were received at the meetings on 16 March 2017 and 22 June 2017.

County Durham Accountable Care Network (ACN)

8 Integration of health and social care services is a key consideration for County Durham and work is being undertaken in conjunction with NHS partners, facilitated through the joint appointment of the Director of Integration. Our vision for integrated care is to bring together health, social care and voluntary organisations to achieve improved health and wellbeing for the people of County Durham.

9 In County Durham agreement has been reached that the new integrated models of care will progress as part of an Accountable Care Network arrangement. An Accountable Care Network is a group of organisations which are not formally enshrined, but work as a network to deliver joined up care. Its work, including progressing opportunities for further integration is overseen by the Integration Board which provides strategic leadership to the integration of health and social care for County Durham.

10 A Memorandum of Understanding (MoU) for the County Durham ACN has been agreed by the Integration Board and an update provided to the HWB. The Memorandum of Understanding establishes a framework for collaboration between the following organisations with regard to integrated care in County Durham:

- Durham County Council (DCC)
- North Durham NHS Clinical Commissioning Group (ND CCG)
- Durham Dales, Easington and Sedgefield CCG (DDES CCG)
- County Durham and Darlington NHS Foundation Trust (CDDFT)
- Tees, Esk and Wear Valley NHS Foundation Trust (TEWV)

11 Organisations within the ACN will work together to ensure the delivery of efficient, high quality care which meets the needs of the population. These organisations retain their own governance arrangements, but work as a network to improve flow into Primary Care Home (PCH) and deliver joined up care into Primary Care Home and Teams Around Patients (TAPs).

Primary Care Home (PCH)

12 PCH encompasses Teams Around Patients. It has a focus on all activity, both elective and non-elective, across primary care. DDES CCG has modelled its clinical leadership in line with PCH and a launch event took place in May 2017.

13 In the DDES area support of the PCH TAP model, an MDT approach is being applied across three levels:

- GP practice-based MDT (micro level)
- TAP level MDT (intermediate level)
- Primary Care Home meeting (macro level)

14 North Durham CCG will consider PCH in due course but have expressed a view that their preference is to ensure TAPS are fully operational and working effectively in the first instance.

Teams Around Patients (TAPs)

15 An approach which promotes a total of 13 Teams Around Patients, covering 69 GP practices is currently being rolled out across County Durham. Five TAPs are in the North Durham area with the other eight across the Durham Dales, Easington & Sedgefield area. Team configurations and staff alignment have been confirmed.

16 Given the different size and scale of TAPs across County Durham it has been easier for some areas to mobilise more quickly than others.

17 Development sessions have been held across DDES and North Durham, in recognition of the need for colleagues in primary care to have an opportunity to shape the operational delivery of a multi disciplinary approach.

18 The core workforce elements of TAPs consist of GPs, Community Nurses, Vulnerable Adults Wrap Around Services Nurses (VAWAS), Community Matrons, Social Work, Therapy Services, Voluntary and Community Services which provide a wide range of care, from supporting patients to manage long-term conditions, to treating those who are seriously ill with complex conditions. Most of this community healthcare takes place in people's homes or in community clinics or health centres.

19 TAPs will:

- Focus on people who are frail/have complex long term health conditions who are at risk of emergency admission to hospital.
- Deliver more care in a community setting/persons own home.
- Strengthen care delivery at GP practice level (named care coordinator).
- Take responsibility for coordinating care over a longer timeframe regardless of the number of episodes of ill health.
- Deliver stronger joined up working and collaboration across people and

organisations.

20 Both DDES and ND CCG's have recognised the importance of clinical leadership in supporting the development of TAPS and have appointed GPs to champion the model and liaise with colleagues in primary care to ensure that implementation is timely and effective.

21 The TAPs model will directly contribute to improving the following outcomes:

System Outcomes	**Person Centred Outcomes**
Effective use of Discharge to Assess approach	People who use services have positive experiences of care.
Less presentation at Accident & Emergency (A&E)	Maintaining or improving the quality of life for people.
Improved Primary Care access	People with disabilities or long-term conditions are supported to live at home for as long as possible.
Reduced admissions and readmissions to hospital	People are helped to look after and improve their own health and wellbeing.
Reduction in hospital bed days	People who use services are treated with dignity and are safe from harm.
Less people in residential and nursing care	Helping people to recover from episodes of ill health or injury.
Prevention through risk stratification	People who provide unpaid care are supported to look after their own health and wellbeing.

22 The TAP toolkit which includes a statement of common purpose, operating principles, terms of reference, clinical scenarios, agenda templates, staffing lists, multi-disciplinary team levels and frequently asked questions will be reviewed and updated to meet the needs of all partner agencies

23 In order to ensure that the voluntary and community sector (VCS) are engaged in the development of the TAPs, a VCS Delivery Plan is being implemented. Priorities include supporting the VCS in influencing commissioning decisions on a locality basis and identifying commissioning issues for consideration by TAPs, with a specific focus on frail elderly people and those with long term conditions.

24 Through the Advice in County Durham Partnership, the Advice Referral Portal will be tested to ensure a 'no wrong door' policy for clients. In effect this will simplify referral routes for front line health and social care practitioners into the voluntary sector, making the best use of partnerships and networks.

25 To help familiarise health and social care professionals with the work of the VCS across County Durham and to introduce them to the Advice Partnership network four workshops were held over summer 2017. More detailed consultations will be held with the TAPs during the autumn to help inform and

shape engagement between VCS providers and health and social care professionals.

Community Integrated Service Model

26 It is recognised that a new approach is needed to bring positive benefits in terms of improving people's health, wellbeing and experience of care, particularly delivering services in partnership by wrapping services around people's needs and shifting the focus to keeping people well and happy at home with reduced demand for hospital and other health and care services. NHS Commissioners have been clear on the revised service requirements and as a consequence intend to procure a new service, through a formal process, in line with the principles referenced above. A new specification for the NHS community services contract has been developed and views on service delivery have been sought to identify improvements to be made.

27 The development of a Community Integrated Service model across County Durham supports a shared commissioning vision to improve access, continuity and coordination of community-based health care services for the local population.

28 These improvements as such would not constitute significant changes to service delivery, but aim to reduce duplication, improve patient experience and to ensure services operate at maximum efficiency, which will help to enable the service to be sustainable in future years. Currently community services are delivered by a number of different providers which in some cases leads to fragmentation of care.

29 As part of this process the CCGs and DCC have been working together to ensure that governance arrangements for community services will support the future integration of health and social care services. Given the important role that community services play in avoiding admission and supporting discharge from hospital at as early a point as possible, the inclusion of integrated community services in any model of health and social care will be vital.

30 Building on the integration work to date we want to further develop the strategic direction for the future of integrated services and in doing so develop a Health and Care Plan for County Durham.

31 To facilitate this work, Price Waterhouse Cooper (PwC) have been engaged to considered three areas of work as follows:

- Stage 1 – Undertaking a current stage review to assess the maturity of our plans for health and social care integration taking into account what they have seen work well elsewhere in the country.
- Stage 2 – Developing options for an integrated strategic commissioning function. Bringing together elements of the CCG and local authority commissioning functions would be an important step in the journey towards an Accountable Care System. Joint commissioning functions

are better placed to deliver better health and wellbeing outcomes for the local population.

- Stage 3 – Developing a governance framework for future integrated services in County Durham. Having clear processes and governance in place would help partners to progress with this transition at pace.

32 The findings from this work will be brought back to a future meeting.

Prevention

33 The County Durham Partnership (CDP) has agreed to develop a more proactive approach to prevention across the Partnership and drive a decisive shift in all parts of the system through a Prevention Steering Group and three workstreams:

- Building on Best Practice
- Maximising Funding
- Preventing Demand for Services

34 In addition, the County Durham Partnership Forum and Thematic Partnerships have held discussions in relation to identifying three or four areas for focused prevention work.

35 The Local Government Association (LGA) Prevention at Scale offer provides 20 days of a Support Manager and expert advice and support focused on supporting a local area to deliver at scale a preventative approach for a particular condition or risk factor that will have a significant impact on health improvement for the local population and add value to existing interventions.

36 Timescales for the LGA project are from September 2017 – September 2018. There are 10-15 sites chosen for this prevention at scale work and it is an opportunity for Durham to share best practice with other areas, following completion of the project.

37 The chosen prevention area will be evaluated to see what impact on health outcomes there has been and will be required to produce two outputs:

- A report on the effectiveness of the logic model to deliver prevention at scale, (effective logic models make an explicit statement of the activities that will bring about change and the results expected for the community and residents).
- Case studies providing a commentary if there has been any measurable impact on outcomes and any financial benefit, as well as capture any other social and economic impact.

38 An outline planning form was submitted to the LGA in relation to mental health as a key prevention priority that cuts across a number of partnerships. The project sponsor for this work is the Director of Adult and Health Services as chair of the Prevention Steering Group.

39 The Health and Wellbeing Board leads the work on mental health and wellbeing, as a priority within the Joint Health and Wellbeing Strategy and regular updates on progress on the prevention at scale work will be reported to the Mental Health Partnership Board through to the Health and Wellbeing Board.

40 The LGA attended the Prevention Steering Group on 19 October 2017 to discuss the prevention offer in further detail.

North East and Cumbria Learning Disability Transformation Programme

41 Nationally the Learning Disabilities Transforming Care Programme aims to reshape services for people with learning disabilities and/or autism with a mental health problem or challenging behaviour, to ensure that more services are provided in the community and closer to home rather than in hospital settings. The programme arose as a result of Sir Stephen Bubb's review of the Winterbourne View concordat.

42 North East and Cumbria is one of five fast track sites selected because of high numbers of people with learning disabilities in hospital settings. Fast track areas have access to a share of a £8.2 million transformation fund to accelerate service redesign. An overarching North East & Cumbria (NE&C) plan was submitted with each of the 13 Local Authority areas presenting their own plans alongside it, which outline local initiatives that reduce the need for admission to hospital.

43 Representations have been made regarding the financial barriers to delivering the new Transforming Care Programme, particularly from the North East Region, led by Adult Social Care in County Durham. Limited capital funds have been made available and a bid for £1.2m Transformation Funding for 2017/18 and 2018/19 has been submitted for the North East Region. Regional representatives are currently in discussion regarding the affordability of the overall programme including the level available for individual care dowry payments. An interim dowry proposal has been identified and is currently being reviewed and considered via the relevant approval streams within each partner authority.

44 Across the North East and Cumbria there are a number of different commissioning arrangements that are being reviewed with the aim of establishing further pooled budget arrangements, joint contracts and alternative commissioning models to support delivery of this transformation plan.

Accountable Care Partnership (ACP) for Health Funded Learning Disability Services across Durham and Teesside

45 An Accountable Care Partnership (ACP) is being developed between CCG's in the region and Tees, Esk and Wear Valley Foundation Trust for NHS funded learning and disability services across County Durham and Teesside to improve the lives of people living with learning disabilities.

46 The Partnership brings together expertise from providers and commissioners with the aim of enhancing the quality of care packages and services, maximising and controlling spend on these packages and services and delivering the Transforming Care agenda. This will be delivered through a phased development of the ACP for learning disabilities across Durham, Darlington and Teesside Clinical Commissioning Groups (CCGs) allowing greater ability to influence and manage the specialist learning disability hospital bed configuration and deliver better quality outcomes.

47 The phased introduction of an ACP model will initially include services and packages delivered through Tees Esk and Wear Valleys NHS Foundation Trust (TEWV), Northumberland Tyne and Wear NHS Foundation Trust (NTW) and specialist packages in the Independent Sector, expanding to all other learning disability services provided for people within the CCGs' responsibility.

48 There is an option for further expansion with CCGs including Mental Health Services into the ACP project, while there are benefits for this to be across the full Durham/Tees areas it could be delivered on a different footprint.

49 The development of the ACP will be undertaken through a series of key stages delivered over the course of 2017/18, essentially a soft launch that will demonstrate that new ways of working are in place and this will lead to full development of the ACP by March 2018.

50 Throughout 2017/18 the intention will be to look to expand the scope to include Continuing Health Care (CHC), joint funded packages, Section 117 (After Care) agreements and mental health services in general; the range of this development will be dependent upon the size of the geographical footprint based on the number of CCGs included. Engagement with local authorities is a critical factor in this expansion of scope and this has already begun.

51 The Accountable Care Network will oversee the work of the ACP for County Durham residents.

Better Care Fund (BCF) Plan 2017/19 / Improved Better Care Fund

52 The BCF is the only mandatory policy to facilitate integration through a pooled budget and provides a mechanism for joint health and social care planning and commissioning bring together ring fenced budgets from CCG's and funding paid directly to local government.

53 The BCF Plan complements the approaches taken by the ACN, PCH and TAP's identifying how pooled funding will be utilised to enhance the range of community services the Council commission in conjunction with the NHS to achieve savings associated with keeping patients out of hospital.

54 An update on the BCF Plan 2017/19 was presented to the Health and Wellbeing Board in September 2017.

55 In the current year, the BCF allocations have been augmented with additional resources – the Improved Better Care Fund (iBCF) – initially announced in the Autumn statement last year and augmented in the March budget. The iBCF allocations are additional monies payable to Councils to support the adult social care budget.

56 The iBCF consists of two elements – a planned allocation included in the Local Government Finance Settlement 2017/18 (£2.378million), and additional funding for adult social care announced at Budget 2017 (£13.112million) for 2017/18. Future year allocations for the iBCF have also been published, and projected income streams are set out below:

£m	**2017/18**	**2018/19**	**2019/20**
Initial iBCF Allocation	2.378	13.378	23.078
Additional iBCF Allocation – March Budget 2017	13.112	8.068	3.993
Total iBCF Allocations 17/18 to 19/20	**15.490**	**21.446**	**27.071**

57 Available funding for 2020/21 and beyond has not been determined.

58 The initial planned iBCF amounts, which increase to c£23million by 2019/20, have already been built into the Councils Medium Term Financial Plan (MTFP) to support adult social care-related activity. The additional monies announced at Spring Budget 2017 offer further opportunities to utilise funds to support social care and health priorities, and defer future savings pressures.

59 Whilst the additional iBCF allocations were announced in March, the grant conditions were not received until 24 April, 2017 and the detailed BCF planning guidance was not received until July 2017.

60 Due to the late notification of these additional funds, received after the Council and the local CCG's had set their 2017/18 budgets, and the delay in receiving the planning guidance, plans have only recently been finalised.

61 This has required detailed discussions between the Council and local CCGs. Given the nature of this funding, which is non-recurrent, the following criteria has underpinned planning:

- Whether the planned investment is one-off or recurrent;
- Whether the investment generates savings;
- Whether the investment is preventative and how the impact of this can be measured, including financial impacts within the care system;
- Whether the investment is capital or revenue;
- Whether the investment supports MTFP objectives

62 In terms of the 2017/18 iBCF additional funding allocations, the areas identified for focus are outlined below as indicative figures being overseen by a small working group. The intention being work will support overall health and social care priorities across County Durham:

iBCF Planned Spend – 2017/18 Grant Allocation	£'000
Supporting the Market:	
- Residential Care in Reach Service (1:1)	0.750
- Workforce Development in Care Sector	1.500
- Transitional Arrangements – Quality Band Assessment (QBA) Changes	1.500
Prevention:	
- Dementia Care Advisors Contract	0.735
- Social Isolation / Mental Health (AAP Allocations)	1.050
- Income Maximisation - Benefit Take-Up	0.375
Alleviate NHS Pressures:	
- Community Based Services Support	4.500
- Enhancing Reablement	1.500
System Support:	
- Deep Dive Reviews	0.084
- Commissioning Resource - Backfill	0.300
- Project Management	0.150
- ICT Resource (Integration)	0.150
- ICT Resource (e-Brokerage)	0.481
- Contingency	0.037
Total	**13.112**

63 In terms of the additional allocations for 2018/19 (c£8m) and 2019/20 (c£4m), these amounts have been built into MTFP and will be utilised to delay adult care-related MTFP savings.

Recommendations

64 The Health and Wellbeing Board is recommended to:

a) Note the contents of this report.
b) Agree to receive further updates in relation to Health and Social Care Integration on a six monthly basis.

Contact: Paul Copeland, Strategic Programme Manager – Better Care Fund and Integration Tel: 0300 265190

Appendix 1: Implications

Finance
Existing and future financial challenges facing the NHS, local government and public health, increased demand for health and social care and rising costs of delivering services will make integration health and social care services increasingly difficult. The Better Health Programme framework of care will have to be implemented within current financial resources.

Staffing
A critical element of delivering an integrated model of care will depend upon a suitably trained and skilled workforce.

Risk
Failure to transform and integrate services will result in reputational damage for the Council and its partners. If transformation and system wide reconfiguration is not achieved this will result in services aimed at improving results for patients, life expectancy and quality of life not being delivered efficiently and effectively.

Equality and Diversity / Public Sector Equality Duty
Equality Impact Assessments are carried out as part of the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy.

Accommodation
No direct implications.

Crime and Disorder
No direct implications.

Human Rights
No direct implications.

Consultation
Proposals for integration would be the subject of consultation with stakeholders.

Procurement
A new specification for NHS community services has been developed.

Disability Issues
Addressed under Equality and Diversity

Legal Implications
There are a number of key legislative and policy developments/initiatives that have led the way and contributed to Adult Care Transformation and further integration with Health and Social Care Services. All changes must be compliant with legal requirements.

Appendix 2: Policy Context

Learning Disabilities Transforming Care Programme – January 2015 - The Learning Disabilities Transforming Care Programme aims to reshape services for people with learning disabilities and/or autism with a mental health problem or behaviour that challenges, to ensure that more services are provided in the community and closer to home rather than in hospital settings. It arose as a result of Sir Stephen Bubb's review of the Winterbourne View concordat. The Transforming Care guidance highlights the importance of local partnership working between commissioners from local government and the NHS with an emphasis on the oversight and support of Health and Wellbeing Boards.

Social Care – Queen's Speech – June 2017 - The Government will consult on options to improve the social care system and to put it on a more secure financial footing, supporting people, families and communities to prepare for old age, and address issues related to the quality of care and variation in practice.

Adult Social Care: Quality Matters – July 2017 - sets out a single view of quality and a commitment to improvement, an initiative which is co-led by partners from across the adult social care sector. The summary action plan sets out 6 priority areas to make progress on improving quality in the first year:

1. Acting on feedback, concerns and compliments
2. Measuring, collecting and using data more effectively
3. Commissioning for better outcomes
4. Better support for improvement
5. Shared focus areas for improvement
6. Improving the profile of adult social care

As the plan develops, updated versions will be published so everyone can see how partners are working to translate the ambition of *Quality matters* into real action.

Your Data: Better Security, Better Choice, Better Care – July 2017 - is the Government's response to the National Data Guardian for Health and Care's Review of Data Security, Consent and Opt-Outs and the Care Quality Commission's Review 'Safe Data, Safe Care'. A response to the National Data Guardian Review was submitted by Adult and Health Services in December 2015.

The Government accepts the recommendations in both the National Data Guardian Review and the Care Quality Commission Review. The commitments made by the Department of Health and its partners to ensure the health and social care system in England realises the full benefits of sharing data in a safe, secure and legal way, and, that complements the existing Caldicott principles include:

1 **Protect information through system security and standards:**

- The Government agrees to adopt and promote the 10 data security standards, as proposed by the NDG's review.
- The Government also agrees to adopt the CQC's recommendations on data security.

- Boost investment in data and cyber security above the £50 million identified in the Spending Review to address key structural weaknesses, such as unsupported systems. The Government will target an initial £21 million of capital funding to increase the cyber resilience of major trauma sites as an immediate priority, and improve NHS Digital's national monitoring and response capabilities.
- The NHS Standard Contract 2017/18 requires organisations to implement the NDG review recommendations on data security.

2 **CQC will enable informed individual choice on opt-outs:**

- By December 2018, people will be able to access a digital service to help them understand who has accessed their summary care record. By March 2020, people will be able to use online services to see how their personal confidential data collected by NHS Digital has been used for purposes other than their direct care.
- NHS Digital will develop and implement a mechanism to de-identify data on collection from GP practices by September 2019.
- Give people the choice to opt out of sharing their data beyond their direct care, which will be applied across the health and social care system.
- In moving to the national opt-out, honour existing type 1 opt-outs (the option for a patient to register an objection with their General Practitioner, to prevent their identifiable data being released outside of the GP practice for purposes beyond their direct care) until 2020 and consult with the NDG before confirming their removal.

3 **CQC will apply meaningful sanctions against criminal and reckless behaviour:**

- Implement the UK data protection legislation in May 2018, which will provide a framework to protect personal data and also impose more severe penalties for data breaches and reckless or deliberate misuse of information.

4 **CQC will protect the public interest by ensuring legal best practice and oversight:**

- Put the National Data Guardian role and functions on a statutory footing.
- The Information Governance Alliance (IGA) will publish anonymisation guidance based on the Information Commissioner's Office (ICO) Code of Practice on Anonymisation in 2018.
- Clarify the legal framework by working with the Confidentiality Advisory Group (CAG) to ensure its approvals process under Section 251 of the NHS Act 2006 enables organisations to access the information they need, for example for invoice validation.

Shaping the Future – Care Quality Commission's Strategy for 2016 to 2021 - The Care Quality Commission (CQC) recently published two consultations on its future strategy for 2016 to 2021. Responses to these consultation were submitted by Adult and Health Service in March 2016 and August 2017. These follow a series of consultations on Shaping the Future (March 2015) and Building on Strong

Foundations (October 2015), in which CQC asked for views on their approach to the quality and regulation of health and social care services.

The focus of CQC's strategy 2016 to 2021 is to build on the current regulatory approach and further improve efficiency while adapting to changes in the health and care sectors. CQC's ambition for the next 5 years is to deliver a more targeted, responsive and collaborative approach to regulation, so more people receive high quality care. CQC will achieve this by focusing on four priorities:

- **Priority 1: encourage improvement, innovation and sustainability in care** - work with providers to support improvement.
- **Priority 2: deliver an intelligent driven approach to regulation** - use intelligence and information to more effectively target resources to where the risk to the quality of care provided is the greatest.
- **Priority 3: promote a single shared view of quality** - work with organisations to agree a consistent approach to defining and measuring quality.
- **Priority 4: improve efficiency and effectiveness** - achieve savings each year while improving the quality of service to the public and providers by working more efficiently.

Registered services will still be required to meet the fundamental standards of quality and safety which will be achieved through CQC's registration, monitoring, inspection and rating of services. CQC will also continue to work with the public to understand and focus on what matters most to them and will continue to use a full range of enforcement powers, such as restrictions or closure of services, fixed penalty notices or prosecution where poor care below the fundamental standards is found. CQC's role in protecting and promoting equality and human rights, including for people being cared for under the Mental Health Act or the Mental Capacity Act Deprivation of Liberty standards will also remain.

CQC will:

- Improve information and analysis of local services to inform inspection, including self-evaluation by providers and encouraging more people to share their experiences of care.
- Respond to risk and improvements in quality through timely inspection which will be determined by the rating of the service and the likelihood of quality having changed:
    - newly registered locations inspected within 12 months;
    - services rated as inadequate inspected every 6 months;
    - services rated as requires improvement inspected annually;
    - over time CQC will move to longer intervals between inspections for services rated as 'good' or 'outstanding' as CQC develop better access to intelligence and information; and
    - during 2016-17 CQC will work with partners and people who use services to agree appropriate timescales for inspections.
- Update ratings on the basis of inspection, and clarify where services are 'good' with 'outstanding' features and where services that 'require improvement' are not meeting fundamental standards.

- Work with local authorities and Clinical Commissioning Groups to develop more consistent quality frameworks and expectations on providers, based on the five key questions.
- Improve understanding of the quality of services delivered in people's own homes by requiring providers to share their call monitoring data, in particular, numbers of missed or late visits, lengths of stay and how many different carers are visiting individuals.
- Inspection reports will be shorter and produced and published more quickly.
- For corporate providers, improve local activity by better understanding the head office leadership and how this impacts on quality through culture and policies.

Local system reviews of health and social care – July 2017 - The Secretaries of State for Health and Communities for Local Government have asked CQC to undertake a programme of local system reviews of health and social care in 20 local authority areas. These reviews, exercised under the Secretaries of State's Section 48 powers, will include a review of commissioning across the interface of health and social care and an assessment of the governance in place for the management of resources.

CQC will look specifically at how people move between health and social care, including delayed transfers of care, with a particular focus on people over 65 years old. This is a review of the interface across the whole system with all partner organisations, primary and secondary health care, CCGs, and the local authority in an area involved. The reviews will not include mental health services or specialist commissioning but, through case tracking, will look at the experiences of people living with dementia as they move through the system.

The purpose of the reviews is to provide a bespoke response to support those areas facing the greatest challenges to secure improvement. On completion of the review CQC's findings will be reported to each local authority area's Health and Wellbeing Board.

The first tranche of reviews includes the 12 local authority areas of: Birmingham, Bracknell Forest, Coventry, East Sussex, Halton, Hartlepool, Manchester, Oxfordshire, Plymouth, Stoke, Trafford, York, and are expected to be completed by December 2017. The first local authority area under review is Halton. These areas have been chosen from a ranked list and determined through a 'dashboard' set of Department of Health metrics. The remaining 8 areas, which have yet to be announced, are scheduled to be completed by April 2018.

Whilst the metrics that have been used to populate the dashboard and draw up the list are more narrowly focused, in the lead up to CQC undertaking the reviews a much broader set of metrics from the geographical area subject to the review (as part of the 6 week lead in time) will be gathered. This is to support the focus areas of; people being maintained in their usual place of residence, crisis management (admission to hospital or alternative response), and, return to usual residence and the interface between those areas, for example, access to GP, ambulance transfers, discharge planning. Relationships across the system will also be 'measured'.
Once all 20 reviews have been completed CQC will publish a national report of their key findings and recommendations.