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Monday 29 November 2021

Notice of Meeting

Dear Member

Health and Adult Social Care Scrutiny Panel

The **Health and Adult Social Care Scrutiny Panel** meeting will take place remotely at **2.00 pm** on **Tuesday 7 December 2021.**

This meeting will be webcast live and will be available to view via the Council's website.

The items which will be discussed are described in the agenda and there are reports attached which give more details.

Julie Muscroft
Service Director – Legal, Governance and Commissioning

Kirklees Council advocates openness and transparency as part of its democratic processes. Anyone wishing to record (film or audio) the public parts of the meeting should inform the Chair/Clerk of their intentions prior to the meeting.

The Health and Adult Social Care Scrutiny Panel members are:-

Member

Councillor Habiban Zaman (Chair)
Councillor Aafaq Butt
Councillor Bill Armer
Councillor Vivien Lees-Hamilton
Councillor Lesley Warner
Councillor Fazila Loonat
David Rigby (Co-Optee)
Lynne Keady (Co-Optee)

Agenda
Reports or Explanatory Notes Attached

Pages

1: Minutes of previous meeting

1 - 10

To approve the Minutes of the meeting of the Panel held on 11 November 2021.

2: Interests

11 - 12

The Councillors will be asked to say if there are any items on the Agenda in which they have disclosable pecuniary interests, which would prevent them from participating in any discussion of the items or participating in any vote upon the items, or any other interests.

3: Admission of the public

Most debates take place in public. This only changes when there is a need to consider certain issues, for instance, commercially sensitive information or details concerning an individual. You will be told at this point whether there are any items on the Agenda which are to be discussed in private.

4: Deputations/Petitions

The Committee will receive any petitions and hear any deputations from members of the public. A deputation is where up to five people can attend the meeting and make a presentation on some particular issue of concern. A member of the public can also hand in a petition at the meeting but that petition should relate to something on which the body has powers and responsibilities.

In accordance with Council Procedure Rule 10 (2), Members of the Public should provide at least 24 hours' notice of presenting a deputation.

5: Public Question Time

The meeting will hear any questions from the general public.

Questions should be emailed to richard.dunne@kirklees.gov.uk no later than 10.00 a.m. on 6 December 2021.

In accordance with Council Procedure Rule 51(10) each person may submit a maximum of 4 written questions.

In accordance with Council Procedure Rule 11(5), the period allowed for the asking and answering of public questions will not exceed 15 minutes.

6: Care Quality Commission - Quality of Care in Kirklees

13 - 76

Representatives from the Care Quality Commission will be in attendance to outline the activity and scope of work that has taken place across the district and provide an overview of the results of the inspections.

Contact: Richard Dunne Principal Governance Officer Tel: 01484 221000.

7: Reconfiguration of bed base resources across LA care homes and proposals for an improved Intermediate Care offer

77 - 100

The Panel will consider the proposal to reconfigure Local Authority dementia and Intermediate Care Beds.

Contact: Saf Bhuta, Head of Service for In House Care Provision

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8: Work Programme 2021/22

101 - 110

The Panel will review its work programme for 2021/22 and consider its forward agenda plan.

Contact: Richard Dunne Principal Governance Officer Tel: 01484 221000

Contact Officer: Yolande Myers

KIRKLEES COUNCIL

HEALTH AND ADULT SOCIAL CARE SCRUTINY PANEL

Thursday 11th November 2021

Present:	Councillor Habiban Zaman (Chair) Councillor Bill Armer Councillor Lesley Warner Councillor Fazila Loonat
Co-optees	David Rigby Lynne Keady
In attendance:	Michelle Cross – Kirklees Council Simon Baker – Kirklees Council Chris Porter – Kirklees Council Vicky Dutchburn – Kirklees CCG Julie Oldroyd – Kirklees CCG Jane Close – Locala Helen Duke – Locala Rachel Foster - Locala
Observers:	Councillor Elizabeth Smaje Peter Bradshaw
Apologies:	Councillor Aafaq Butt Councillor Vivien Lees-Hamilton

1 Minutes of previous meeting

The minutes of the meeting held on the 10 October 2021 were approved as a correct record.

2 Interests

Cllr Lesley Warner declared an interest as a member of the Calderdale and Huddersfield NHS Foundation Trust Membership Council.

Lynne Keady declared a pecuniary interest as a Healthwatch Kirklees and Calderdale Volunteer, and as a carer representative advising Kirklees Council on projects relating to (i) the integration of the Gateway to Care and Locala Single Point of Contact Service (ii) direct payments and (iii) protocols of co-production.

3 Admission of the public

All items were taken in public session.

4 Deputations/Petitions

No deputations or petitions were received.

5 Public Question Time

The Panel received a question from Councillor Alison Munro regarding concerns around obtaining a same day GP appointment. Cllr Munro explained that as some GP practices had a system whereby you were expected to phone the surgery at 8am, this was causing long queues to speak to a receptionist. Some systems cut the caller off after half an hour of waiting, after which they would need to call again after which time they may not get a same day appointment. Cllr Munro advised that 8am was an inconvenient time for many people, as they were juggling work and getting children ready for school. Many people become so frustrated with attempting to get through to their GP practice that they give up. Cllr Munro questioned whether systems at GP practices could be reconsidered and new ways identified for obtaining same day appointments?

Cllr Munro was informed that the Panel would seek a formal written response from the Clinical Commissioning Group (CCG).

6 Care Homes Programme Board Update

The Panel welcomed Michelle Cross, Service Director Mental Health and Learning Disability, Simon Baker Head of Commissioning Partnerships and Market Development and Chris Porter Service Development Manager Integrated Commissioning to the meeting.

The Panel also welcomed Julie Oldroyd Lead for Transformation for Kirklees CCG to the meeting.

Mr Baker presented an update on the Kirklees Care Home Programme Board which outlined the issues and challenges of the care home sector and the work planned to address these.

Ms Oldroyd informed the Panel of the Ageing Well Governance Structure and explained how the Ageing Well Board flowed into the Heath and Care Leadership Board and ultimately the Health and Wellbeing Board.

Ms Oldroyd advised that care homes was one of a number of programmes that sat beneath the Ageing Well Board, along with Anticipatory Care, Frailty, End of Life, Urgent Community Response and Discharge to Assess.

Ms Oldroyd explained that the benefit of having these together under the Ageing Well banner was the cooperation that could take place between the programmes given the interdependencies across areas.

Mr Baker stated that across Kirklees there were 131 care homes operating with 3,500 beds of which 2760 were for older people with care needs within 64 homes.

Of the 64 care homes in Kirklees, Mr Baker explained that 39 of them supported people with nursing care.

Mr Baker informed the Panel that the last 20 months had been difficult for the care home sector with occupancy rates being impacted by residents passing away due to Covid and a lack of new placements.
Mr Baker confirmed that the aim for the social care sector was to keep people at home and independent for as long as possible, and this in turn had also impacted on occupancy rates within care homes.

Ms Oldroyd advised the Panel of the impact that Covid had on the Care Quality Commission (CQC) ratings of care homes and there were less care homes within Kirklees that were rated as 'good', and several more that now 'required improvement'.

Ms Oldroyd explained that there were robust quality processes in place, along with a good relationship with the CQC, and the Programme Board were in touch with the CQC on a weekly basis to discuss any emerging issues within care homes.

Mr Baker informed the Panel that there were just over 4,000 people working across the care sector which were typically part-time roles, with approximately 85% of the roles being filled by women.

The Panel heard that there was an increasing focus now on the skills required in the workforce and keeping the residents of care homes well was of paramount importance.

Mr Baker explained that the funding remained an important consideration and was now a key challenge that faced the care home sector.

Mr Baker confirmed that a sustainable funding model approach for the care home sector remained a challenge with central government announcing some changes to the way that social care would be funded in the future, but the detail of that was yet to be clarified.

Mr Baker explained that there was a risk that the combination of finance needed to create a pay and conditions offer that attracted and retained the right workforce; funding required for more complex care; and reductions in the amount that people were required to contribute to the cost of their care could exceed the resources currently identified nationally.

The Panel heard the benefits that digital advancement had brought to the care home sector, increasing connections with partners to facilitate joined up care, reporting being completed once and used across varying reporting systems and opportunities for residents to connect digitally with their family and friends.

Mr Baker informed the Panel that feedback from the care home sector suggested that the negative portrayal of the sector in the media had significantly impacted interest in new care home placements from both LA funded and privately funded care.

Mr Baker advised that it was anticipated that there would be a small increase in demand as carers started to struggle to support people in their homes as their

needs became more complex. Overall the demand was expected to be lower than in previous years although there was an expectation that it would increase to pre-pandemic levels.

Mr Baker confirmed that future demand was expected to be for shorter more complex packages of support in a care home and population predictions showed an increase in demand after 2025 when the baby boomer generation reached a point where care home support may be required.

Mr Baker explained that future demand had implications for buildings, staff skills and funding that reflected the complex nature of future support needed which in turn created an opportunity for the LA to reflect on its role as a provider and key stakeholder.

Ms Oldroyd advised the Panel that the Care Home Programme Board had a large programme of work, some of which came about from the closure of Oxford Grange and the framework for enhanced care homes, and the strategy within the programme of work reflected the outcomes identified.

Ms Oldroyd explained that the Programme Board had assisted in building relationships and trust with care home providers and partner organisations, and those relationships had strengthened throughout the past 20 months of the pandemic and provided opportunities to discuss issues and improve the way that the various organisations in the sector worked together.

The Panel was informed that there were five key work areas that the Programme Board reported on and Ms Oldroyd provided the Panel with a summary of the workstreams that included Quality Improvement Assurance & Contracting, Workforce, Data & Dashboards, Enhanced Health in Care Homes and Market Management & Sustainability.

Mr Baker gave the Panel an overview of the key findings from the Cordis Bright report which had been jointly commissioned by Kirklees and Rotherham Councils to look at the short, medium, and long-term challenges across the care home sector, and used their expertise, to advise on what future demand might look like.

Mr Baker advised that recruitment remained a challenge within the sector and along with the impact of Covid had meant that as some care homes struggled with occupancy rates, this impacted on their viability.

Mr Baker explained that the number of care home beds per 100 people had dropped slightly and that was something that continued to be monitored.

Mr Baker confirmed that a positive step within the care sector was the ability to keep people at home for longer which had been made possible by the increased capacity in the community, and support with equipment and adaptions at home.

Mr Baker informed the Panel that when people did enter the care sector, their needs were more complex, but they stayed for a shorter period of time, which in turn had an impact on the way care was managed and supported.

Mr Baker outlined the work of the Programme Board in relation to Market Management and Sustainability and key areas of work within that included Care Association, Contracting, Fees and Funding and Strategic Assets and Diversification.

Ms Oldroyd provided the Panel with an update regarding the training and support provided to the care home sector that included the Verification of Expected Death, End of Life Care Plans and Testing and Swab Taking.

Mr Baker explained that the work and structure of the Care Home Programme Board and its plan of work had continued to evolve and be shaped by issues in the local market and advised the Panel that a representative of the sector would have a permanent seat on the Board.

Mr Baker concluded by advising the Panel that the Programme Board was working closely with the care home sector and with an integrated approach across health and social care.

A question and answer session follow that covered a number of issues that included:

- Confirmation that the LA had done several pieces of work to ensure the market position statement and forecasting had been shared with and shaped by the sector with consideration being given to what long-term contracts and fees should look like.
- Details about how the Board was working across other LA areas on a regional approach to consider the most appropriate level of intervention, of those suggested by Cordis Bright, given providers often worked across varying local authority areas.
- A question around the interrelationship between the residential home market and the domiciliary care market and confirmation from the service that although a similar report concerning domiciliary care hadn't been commissioned, the service was working closely with the domiciliary care partners.
- Information regarding the number of care hours provided in a person's home which had increased from 8,000 hours in 2019 to currently 17,000 hours, confirming that the aspiration to keep people at home was progressing well.
- Confirmation that there were some challenges within the domiciliary care market, but the service was trying to support all key markets with the aim of keeping people in their own homes for as long as possible.
- A question around the key challenges and issues in the sector with bed occupancy and bed vacancies, and in noting that nursing dementia care vacancies remained low, whether families were left facing challenges when loved ones required nursing dementia care.
- Confirmation that there were some gaps with complex dementia care and individuals who needed a speedy discharge from hospital, and consideration was being given to current provision and discharge to Kirklees in-house provision.

- Details regarding the take up of vaccines for care home staff with 96 percent of independent sector staff having received their first vaccines, and 92 percent having received both doses which had equated to a loss of 200 people working within the care sector in Kirklees.
- Confirmation that for Kirklees in-house staff, the vaccine take up was almost 100 percent, following an intensive period of interaction with staff members, including myth busting sessions with GP's.
- A question regarding attrition and whether engagement was taking place with the staff who had not left the profession to learn lessons to avoid staff members leaving the sector in the future.
- Details regarding the recruitment campaign to attract workers to the sector with a regional workforce group considering how to recruit workers into the sector to make the role attractive for individuals.
- Confirmation that the LA was working with other authorities in the area to ensure parity of pay scales and to ensure that young people could choose a caring role with a clear career pathway for both LA carers and those in the independent sector.
- A question regarding pay rates and only receiving pay for hours worked with travel time often not being payable.
- Confirmation that the domiciliary care providers had a diminishing pool of workers as other service industries could offer better rates of pay.
- A question regarding care homes for people with learning disabilities and in noting that Kirklees had the highest rate of provision for people with learning disabilities in Yorkshire and Humberside, but a high number of out of area placements for people with learning disabilities, whether there was a strategy looking at what future provision would be needed.
- Details of how those with learning disabilities could be brought back into area, and although there had been some success, obstacles remained due to the complex nature of some of those disabilities.
- Details that it could take three to four years to identify and provide the most appropriate accommodation and care for those with complex learning disabilities.
- Confirmation that there was a reduction in the number of people with learning disabilities being placed out of area with only those with very complex needs being placed out of area following a robust review of the needs of these people at a system level.
- Details of the work being done with NHS England and the West Yorkshire ICS around whether those with the most complex needs could be placed within a West Yorkshire footprint, even if placement in Kirklees was not appropriate.
- A question whether other authority areas were meeting the care needs of those with learning disabilities in a different way, rather than in care homes, given that the number of care home beds was lower than in Kirklees.
- Confirmation that engagement continued with the families of those with learning disabilities to support the development of services either in hospital or the community.
- Details that other local authority areas were using the available capacity within Kirklees to place people in facilities within the area, but that it was

important for the service to ensure that these other authorities maintained responsibility for their own population.

RESOLVED –

1. That officers and partners be thanked for attending the meeting.
2. That the information presented to the Panel be noted.
3. A request that further information be provided to the Panel around the capacity within care homes and current occupancy taking into account the impact of the Covid-19 pandemic.

7 Community Care Services

Due to the pecuniary interest declared by Lynne Keady, she took no part in the discussion on this item.

Jane Close, Helen Duke and Rachel Foster from Locala were welcomed to the meeting.

Ms Close advised the Panel that Locala and the LA had moved towards a more integrated Health and Social Care service and development work had seen the introduction of one health and social care integrated referral route for the Kirklees Independent Living Team services.

The Panel heard that progress had been made to ensure that a single discharge form would be completed which had reduced some administration.

Ms Close outlined the work programme that Locala were progressing regarding adult community services and the work that was being done to support admission avoidance, the immediate care service, an update on the community response pathfinder and the discharge to assess pathway.

Ms Close explained that from an acute perspective there was a same day emergency response ward and Locala were looking to replicate that within the community which would be trialled over winter in the Mid Yorkshire area.

Ms Close advised that the report provided to the Panel gave an update on the proposals to merge the Gateway to Care Service and the Locala Single Point of Contact Service.

A question and answer session followed that covered a number of issues which included:

- A question whether the same day urgent emergency response model in the community, in conjunction with primary care networks, intended to include GP's.
- A question around that response model and where the patients would come from and how they would be able to access the scheme.
- Confirmation that since the report was written which identified GP practices triaging patients that needed same day response, it was also now envisaged

that to ease pressure on the ambulance service, category three and four patients would be triaged through the emergency community response along with referrals from the 111 service.

- Confirmation that the same day urgent emergency response model would be based at the walk-in centre in Dewsbury with some locum GP support, with a close working relationship with the emergency department, and it would provide for patients who needed diagnostics such as a blood test or an x-ray.
- Details around patients who needed intravenous antibiotics and that the response model would provide for patients to have the canular inserted at the hospital and then to return home for ongoing treatment.
- A question as to whether the same day response model would be rolled out across primary care.
- Confirmation that the development of the Same Day Emergency Care service was work in progress as a pilot, and that it would develop as it progressed to ensure that services were available throughout the winter period.
- Details of the structured training programme for staff around the merger of the Gateway to Care Service and the Locala Single Point of Contact Service to ensure that a single person could answer a query about either service.
- The initial merger would be trialled until January with learning being taken on board for the training of the remainder of staff to ensure that as much as possible would be answered within one call.
- A question as to whether there would be collaboration with SWYFT to ensure consistency.
- A question around additional capacity when the pilots completed, and how much demand would be taken from hospitals and primary care.
- Confirmation that the model for the Same Day Emergency Care service, would provide for 240 appointments across five days with the GP element running from Monday to Friday for 12 hours per day.
- Confirmation that the pilot would be closely tracked to see what difference it made and would run from the end of November until the end of March.
- Details that the key performance indicators and the learning and intelligence gathered from the merger of the Gateway to Care Service and the Locala Single Point of Contact Service would be monitored to ensure that patients experience was of only having to tell their story once.
- The discharge to assess to model had supported around 900 people who had got health and or social care needs and the urgent response service supported 1400 patients in a 12 month period.
- A question around the dependencies on primary care and community services on hospital reconfigurations and whether this had been fed into the business cases for Calderdale and Huddersfield Foundation Trust.
- A question around access to GP services and face to face versus telephone appointments, and a concern around the elderly in particular being missed through the complexity of change.

RESOLVED –

1. That Locala be thanked for attending the meeting.
2. That the information presented to the Panel be noted.

3. That the section 'How it Feels' within the Gateway to Care and Single Point of Contact Integration Blueprint, include the addition of i) as a carer and ii) as a community partner.

8 Work Programme 2021/22

A discussion took place on the Panel's agenda plan with a focus on the items scheduled to take place at the December and February meetings.

A general discussion took place on the focus of items for future meetings;

- Confirmation that the Care Quality Commission (CQC) would be attending the December meeting to give an update in relation to the overall state of care in Kirklees and would include a specific focus on adult social care and the impact of the pandemic on the quality of care.
- Confirmation that the Panel would consider proposals to reconfigure the dementia and Intermediate Care Beds across Moorlands Grange, Castle Grange, Ings Grove House and Claremont House to include a temporary decant of The Homestead Day Service at the December meeting.
- A request that the Mental Health and Wellbeing item which would be considered at the February meeting focus on suicide prevention, young people's mental health and support for unpaid carers.
- A request for information around access to GP services with a particular focus on the difficulties that some patients find when in a long telephone queue.

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KIRKLEES COUNCIL			
COUNCIL/CABINET/COMMITTEE MEETINGS ETC **DECLARATION OF INTERESTS** Health & Adult Social Care Scrutiny Panel			
Name of Councillor			
Item in which you have an interest	**Type of interest (eg a disclosable pecuniary interest or an "Other Interest")**	**Does the nature of the interest require you to withdraw from the meeting while the item in which you have an interest is under consideration? [Y/N]**	**Brief description of your interest**

Signed: …… **Dated:** ……

NOTES

Disclosable Pecuniary Interests

If you have any of the following pecuniary interests, they are your disclosable pecuniary interests under the new national rules. Any reference to spouse or civil partner includes any person with whom you are living as husband or wife, or as if they were your civil partner.

Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner, undertakes.

Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses.

Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority -

- under which goods or services are to be provided or works are to be executed; and
- which has not been fully discharged.

Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

Any tenancy where (to your knowledge) - the landlord is your council or authority; and the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -
(a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and
(b) either -

the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or

if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

Name of meeting: Health and Adult Social Care Scrutiny Panel

Date: 7 December 2021

Title of report: Care Quality Commission

To provide members of the Health and Adult Social Care Scrutiny Panel with the context and background to the discussions with representatives from the Care Quality Commission (CQC).

Key Decision - Is it likely to result in spending or saving £250k or more, or to have a significant effect on two or more electoral wards?	**No**
Key Decision - Is it in the Council's Forward Plan (key decisions and private reports)?	**Not Applicable**
The Decision - Is it eligible for call in by Scrutiny?	**Not Applicable**
Date signed off by Strategic Director & name **Is it also signed off by the Service Director for Finance?** **Is it also signed off by the Service Director for Legal Governance and Commissioning?**	**No – The report has been produced to support the discussions with CQC.**
Health Contact	**Helyn Aris Inspection Manager – Kirklees and Wakefield North Region Adult Social Care Directorate Care Quality Commission**

Electoral wards affected: None Specific

Ward councillors consulted: Not Applicable

Public or private: Public

Has GDPR been considered? Yes. The report does not include any personal data that identifies an individual.

1. Summary

1.1 The work of the Health and Adult Social Care Scrutiny Panel includes a focus on the quality of care in local health and adult social care services. A key objective of regulators of health and adult social care is to provide people with safe, effective, compassionate and high quality care and to encourage care services to improve.

1.2 The CQC is the independent regulator of health and adult social care and its role is to monitor, inspect and regulate services to make sure that they meet fundamental standards of quality and safety.

1.3 Before a care provider can carry out any of the activities that are regulated by CQC, they must register with CQC and demonstrate that they will be able to meet a number of legal requirements.

1.4 Activities regulated by CQC include the treatment, care and support provided by hospitals, GP practices, dental practices, ambulance services, care homes and home-care agencies.

1.5 CQC have recently introduced a new strategy in response to what it describes as a changing world of health and social care. The new strategy strengthens its commitment to deliver on its core goal to ensure health and care services are providing effective, compassionate, and high-quality care.

1.6 CQC has stated that its strategy is purposefully ambitious, and to implement it CQC have highlighted the need to work closely with others to make it a reality. CQC has also committed to review the strategy regularly so it can adapt to changes and be prepared for what the future holds.

1.7 Details of the new strategy is attached.

1.8 The work of CQC has been included on the Health and Adult Social Care Scrutiny Panel Work Programme for a number of years and has helped the Panel to gain a good understanding of the state of care that is being provided across Kirklees.

1.9 Representatives from CQC will be in attendance to provide the Panel with an overview of the state of care across the district that will include an overview of ratings for Adult Social Care (ASC), Primary Medical Services (PMS) and Mental Health (MH) Services. A presentation that will be used to help inform discussions is attached.

1.10 CQC has also been asked to provide an overview of its views on the impact that the Covid-19 pandemic has had on the quality of care.

2. Information required to take a decision

N/A

3. Implications for the Council

N/A

3.1 Working with People

No specific implications

3.2 Working with Partners

No specific implications

3.3 Place Based Working

No specific implications

3.4 Climate Change and Air Quality
No specific implications

3.5 Improving outcomes for children
No specific implications

3.6 Other (e.g. Legal/Financial or Human Resources)
No specific implications

4 Consultees and their opinions
Not applicable

5 Next steps and timelines
That the Overview and Scrutiny Panel for Health and Adult Social Care takes account of the information presented and considers the next steps it wishes to take.

6 Officer recommendations and reasons
That the Panel considers the information provided and determines if any further information or action is required.

7 Cabinet Portfolio Holder's recommendations
Not applicable

8 Contact officer:
Richard Dunne – Principal Governance and Engagement Officer
richard.dunne@kirklees.gov.uk

9 Background Papers and History of Decisions
Not applicable

10 Service Director responsible
Julie Muscroft – Service Director, Legal, Governance and Commissioning

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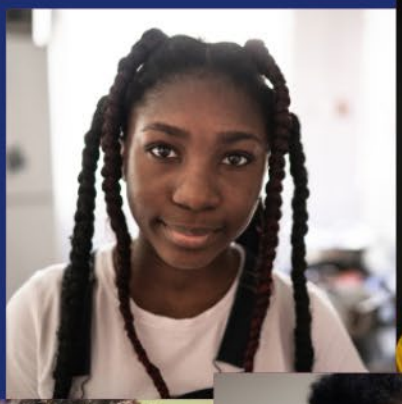
Care Quality Commission

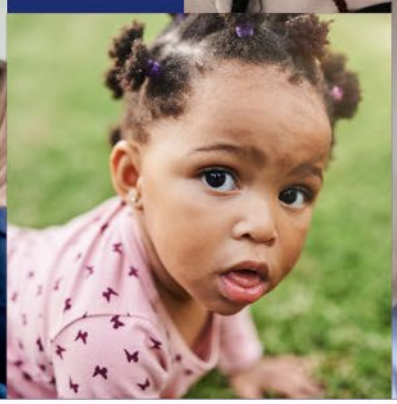
A new strategy for the changing world of health and social care

Our strategy from 2021










Introduction

We're changing how we regulate to improve care for everyone.

What we've learned from the past five years puts us in a better position for the future. Our new strategy combines this learning and experience and we've developed it with valuable contributions from the public, service providers and all our partners. It means our regulation will be more relevant to the way care is now delivered, more flexible to manage risk and uncertainty, and will enable us to respond in a quicker and more proportionate way as the health and care environment continues to evolve.

This new strategy strengthens our commitment to deliver our purpose: to ensure health and care services provide people with safe, effective, compassionate, high-quality care and to encourage those services to improve. Our strategy is purposefully ambitious, and to implement it we will need to work closely with others to make it a reality. We'll review this strategy regularly so we can adapt to changes and be prepared for what the future holds.

Our purpose and our role as a regulator won't change – but how we work will be different. We set out our ambitions under four themes:

- **People and communities**

  Regulation that's driven by people's needs and experiences, focusing on what's important to people and communities when they access, use and move between services

- **Smarter regulation**

  Smarter, more dynamic and flexible regulation that provides up-to-date and high-quality information and ratings, easier ways of working with us and a more proportionate response

- **Safety through learning**

  Regulating for stronger safety cultures across health and care, prioritising learning and improvement and collaborating to value everyone's perspectives

- **Accelerating improvement**

  Enabling health and care services and local systems to access support to help improve the quality of care where it's needed most

Running through each theme are two core ambitions:

- **Assessing local systems**

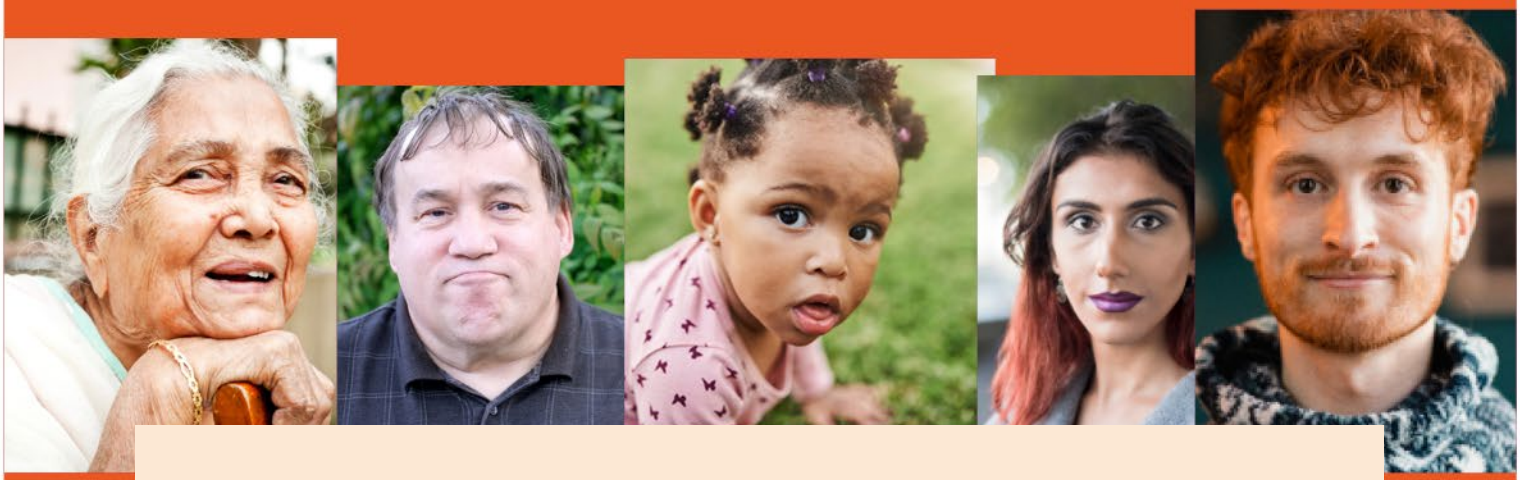
  Providing independent assurance to the public of the quality of care in their area

- **Tackling inequalities in health and care**

  Pushing for equality of access, experiences and outcomes from health and social care services

We'll look at how the care provided in a local system is improving outcomes for people and reducing inequalities in their care. This means looking at how services are working together within an integrated system, as well as how systems are performing as a whole.

We're committed to our ambition of regulating to advance equality and protect people's Human Rights. Everyone in health and social care has a role to play in tackling the inequalities in health and care for some people. This strategy sets out our ambition for how we can help influence change.



People and communities

We want to be an advocate for change, with our regulation driven by people's needs and their experiences of health and care services, rather than how providers want to deliver them.

This means focusing on what matters to the public, and to local communities, when they access, use and move between services. Working in partnership with people who use services, we have an opportunity to help build care around the person: we want to regulate to make that happen.

Listening and acting

People need to see how their voice can make a difference to the safety and quality of the services they use and how we reflect their experience in our work. We want to hear both positive and negative experiences when people access, use and move between services.

- We'll make it **easier for people, their families and advocates to give feedback** in the most convenient and suitable ways for them whenever they want. We'll also enable those who act as trusted intermediaries to share feedback with us. Working with local communities, we'll make the most of existing sources of feedback so people don't have to repeat themselves.

- **We'll identify more and better ways to gather experiences from a wider range of people** and develop the skills and tools that we need to do this. We'll reach out to people whose voices and experiences we don't often hear: people who are the most disadvantaged in our society, have had distressing or traumatic experiences, and those who are more likely to experience poor outcomes and inequalities. This includes people with a learning disability, people with communication needs, people living in poverty, those whose voices are not often heard, those who are detained under the Mental Health Act, and people who are at risk of abuse or other human rights breaches.

- A priority will be improving our capacity and capability to get the most out of feedback. **We'll change the way we record and analyse people's feedback** so it's easier for us to quickly identify changes in the quality of care – both good and bad. We'll be clear about the value and weight we give to quantitative and qualitative information when using it with other evidence.

People's feedback is vitally important. It's important to build trust with the public and motivate people to share their experiences.

- When we publish information about quality, **we'll be clearer about how we've used what people have told us** – both good and bad. We'll explain what action we and others have taken as a result.

- When people take the time to share their experiences with us **we'll provide a response in the way people need it** and explain how their feedback has informed our view of quality.

People are often afraid to speak up. We want to help build a new culture among the public, health and care providers, and all our partners, that welcomes, values and acts on feedback.

- **We'll improve the way we assess how services and local systems encourage and enable people to speak up**, and how they act on this feedback. It will be unacceptable if they are not doing this – where they are not, we will make sure they take action to address it. We'll also focus on this when we look at how local systems are listening to their communities. This is so they can improve access to services that meet people's needs, in particular people who are most likely to have a poorer experience of care or who are less able to speak up.

People are empowered

We know care is better when it's developed through the eyes of people who use services and delivered in partnership with them. We think the same of regulation. When we talk about the quality of care in our work we will have people at the centre.

- To empower people to drive change, it's important for them to know who we are and understand what we do. **We'll proactively raise public awareness of CQC and be clear about our role as a regulator.** We'll invest in the most effective ways to reach different groups of people.

- We'll work closely with people who use services and those that represent them to understand their needs, and to co-design and develop how we work and our services for the public. Any changes we make will start with understanding what people expect and need from care services and pathways, and from CQC. **We'll involve people in a more equitable, targeted and meaningful way and enable them to engage with us in ways that best suit them.**

- We'll work with all our partners and people who use services to develop an agreed and shared view of quality that makes clear what standards people can expect from their health and care services. **We'll provide a clearer definition of what good and outstanding care looks like for everybody, based on people's lived experience of care and what matters to them.** Everybody will be able to easily access, understand, and use these definitions. We'll use them as the basis for assessing services and the information that we collect as evidence.

  This shared view of quality will enable a joined-up approach that's applied to individual services, corporate providers, and across system boundaries in health and social care.

Providing independent, trusted and high-quality information about the quality of care is a fundamental part of our work.

- We'll change how we provide information so that it's more relevant, up to date, and meaningful for people who use services, and reflects their experiences. **We'll ensure people have easy access to information in the way they need it**, and use clear and accessible language.

- **We'll encourage people to use our information in ways that are relevant to them.** Our up-to-date view of the quality of care in a service will help people and their families make informed decisions, where they can, about where to go for their care. It will also give people confidence that our information reflects the quality of care that they can expect.

Prioritising people and communities

- **We'll look at how effectively a service works with others, and in partnership with local communities, to involve people in designing and improving services.** This includes how services embed equality, diversity and inclusion, and corporate social responsibility in everything they do, such as improving local health and wellbeing, and environmental sustainability.

Working collaboratively as a local system is essential to improving the quality and safety of care. Health and care services and commissioners need to understand the diverse needs of their local populations and where there are inequalities in how people access and experience care, and in their outcomes.

- When assessing individual health and care services, we'll look at how they work together in an area, as one system, to deliver better and more coordinated care. **We'll focus on how well local systems perform against the important things that matter to people in that community** – such as being able to move easily between services. We'll work to build our understanding of the needs of a local population so we can hold services to account effectively.

  Our work in this area will be through legislation in the Health and Social Care Bill and we'll align with other regulators to encourage a shift towards more integrated services.

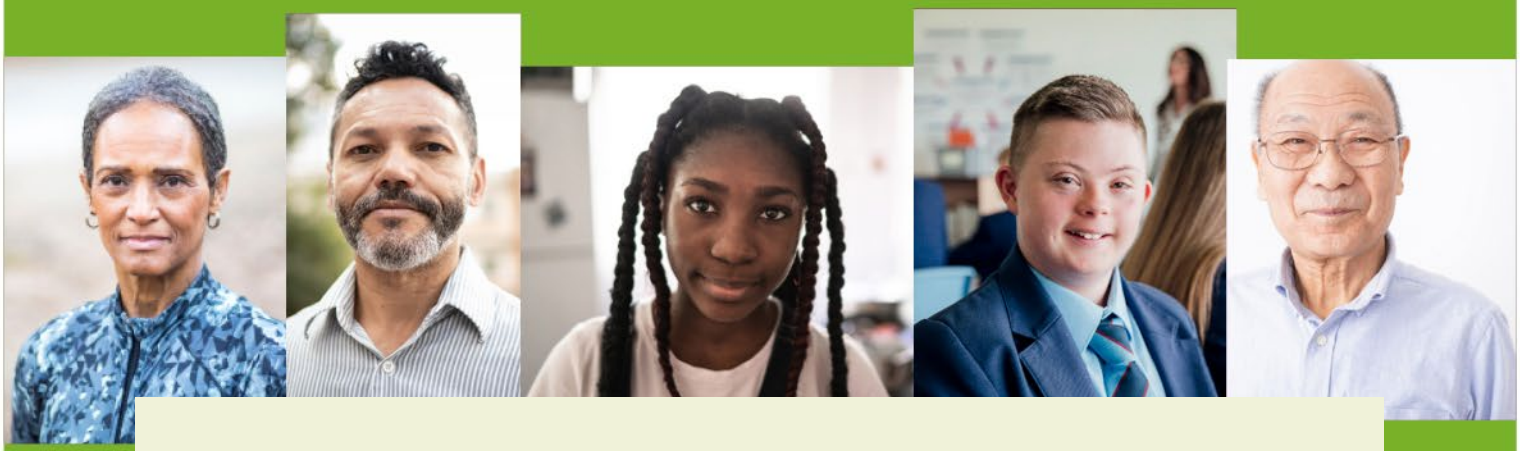
- **Our assessments of local systems will provide independent assurance to the public of how they are working together to deliver high-quality care.** We'll ensure our people have the right skills and capability to assess at both a service provider and a system level.

- We'll publish what we find about the performance of a system. **If we see good practice, we'll highlight this and share examples so that others can learn from it and adapt it to their own area.** We'll also make recommendations to improve where we find issues or concerns.

We will identify and call out unwarranted variation and inequalities in how people experience health and care services. But we also know that a person's health and wellbeing is significantly affected by factors outside health and care.

- **We'll assess how local systems understand the needs of their local populations**, especially people who face the most barriers to accessing good care and those with the poorest outcomes, enabling them to proactively address inequalities.

- We'll work with other appropriate agencies, voluntary and community organisations, and other regulators to develop a **shared understanding of the factors that contribute to inequalities in people's access and experiences and how this affects their outcomes** from using care services. Together, we'll identify the levers that we can all use to tackle these inequalities.



Smarter regulation

We will be smarter in how we regulate. We'll keep pace with changes in health and care, providing up-to-date, high-quality information and ratings for the public, providers and all our partners.

We'll regulate in a more dynamic and flexible way so that we can adapt to the future changes that we can anticipate – as well as those we can't. Smarter use of data means we'll target our resources where we can have the greatest impact, focusing on risk and where care is poor, to ensure we're an effective, proportionate and efficient regulator.

Taking the right action at the right time

We have a baseline understanding of quality across health and social care. But we know that the quality of care can vary from day to day. We'll use our regulatory powers in a smarter, more proportionate and consistent way to make the right decisions and take the right action.

- Our assessments of quality will be different. **On-site inspections are a vital part of our performance assessments and essential to observe the care people receive.** But they are not the only way to assess quality: we want to move away from relying on a set schedule of inspections to a more flexible, targeted approach. To do this, we'll use all our regulatory methods, tools and techniques to assess quality.

- **We'll build stronger relationships with services and with local systems.** This includes having ongoing conversations about quality, which will give us a better insight and enable us to tailor our approach to be more proportionate.

- **We'll visit when there's a clear need to do so.** For example, this could be when we're responding to risk, where we only have limited data or we need specific information, where we need to speak to people using the service face-to-face, or to ensure that our view of quality is reliable. For some types of service, we'll need to visit more often to observe care.

  Our continuous insight and monitoring activity mean that rather than spending time looking at paperwork when we're on site, we'll be able to make the most of our time – **we'll have better conversations with people who live in or use the service, and their families and advocates, and more time to talk with staff.**

- We'll build digital platforms that will better integrate the data we hold, which will enable us to interpret data in a more consistent way. **We'll use innovative analysis, artificial intelligence and data science techniques proactively to support robust and proportionate decision-making, based on the best information available.**

  Combined with the experience, knowledge, and professional judgement of our inspectors, this means we'll be alert and ready to act quickly in a more targeted way and tailor our regulation to individual circumstances.

More meaningful ratings

Our ratings will be more dynamic – we'll update them when there is evidence that shows a change in quality. We won't always need to carry out an inspection to do this.

- **Ratings will evolve to reflect how people experience care so they're more meaningful and focus on things that matter to them.** We'll be clear about what information we use and how we use it in our judgements and decisions about ratings.

Making it easier to work with us

We all have a common drive to improve people's care. From the point of registration, we'll develop ongoing, collaborative relationships with services, built on openness and trust. We want this to enable effective and proportionate regulation so we can focus our work where quality needs to improve and minimise any unnecessary workload.

- We'll work with service providers and other regulators and partners to coordinate data collections. To reduce the duplication and workload for services in collecting and submitting data to us, and to other organisations, **we'll only ask for the information we need and that we can't get elsewhere.** We'll use information from other sources and share the information we gather ourselves through data-sharing agreements. We'll collect data once and use it many times. We want this to help staff to focus on providing care safely and finding opportunities to improve.

- We'll improve the way we connect with services digitally. Starting from the point of registration, where we do need to collect information directly **we will make it easier for services to give us the information we need and simpler to update what they've already told us.** We'll also make it easier for services to access more of the information we hold about them by having it in one place.

We want everyone we work with to benefit from our regulation. The way we regulate will become more constructive and supportive – using what we know to help services to tackle problems early and providing up-to-date, high-quality information and ratings.

- **We'll share the data and information we hold on services** with organisations that represent or act on behalf of people who use services, and with our partners and others where it will help them in their own work to improve people's care.

Adapting to changes

Like the services we regulate, we're evolving and adapting to changing models of care, such as integrated care systems and digitally-enabled care. The move to looking at how services work together in a local system is a change in our approach that better reflects how people experience care – we think this is a smarter way to regulate.

- We'll work with service providers, partners and other regulators to align our activity, understand how care is changing and **ensure that our regulatory model keeps pace with changes.**

- By improving the way we register services, **we'll be better able to hold organisations to account for people's care.** We'll expand our definition of what we consider to be a provider of care and what it means to carry on a regulated activity. This will make sure that we register all the parts of an organisation that are responsible for directing or controlling care; and importantly, this will make sure they can be held accountable.

- Our assessments will always **focus on what matters to people as they access, use, and move between services.** We'll also look more closely at aspects that we know have a positive effect on quality such as the culture of a service, how it works with other services in a local system, and how it drives improvement.

- We'll focus our assessments on how services and local systems are working to ensure equal and appropriate access to good health and care services for everyone. The information we gather will enable us to **better understand the risks of inequalities in people's experiences of their pathway through care and their outcomes.** We'll take action where we see a need for improvement.

Relevant for all

We want our ratings and information to help people to make informed choices about their care, and to give services an assessment of their quality to encourage them to improve.

- **We'll use our clearer definition of quality as a reference for what good and poor care looks like.** We'll explain clearly how we use this to assess the quality of services and how we decide what information to collect as evidence. This definition will be at the heart of our regulatory processes and will help us improve consistency in what we do – so people can be confident that good means good wherever they are in the country and whichever service they are using.

- We'll move away from long reports written after inspections, and instead provide information and data to better meet the needs of all audiences, including people who use services. **Information will be easier to understand and more accessible.** We want people to be able to get information in ways that suit them.

Safety through learning

We want all services to have stronger safety and learning cultures. Health and care staff work hard every day to make sure people's care is safe. Despite this, safety is still a key concern for us as it's consistently the poorest area of performance in our assessments.

It's time to prioritise safety: creating stronger safety cultures, focusing on learning, improving expertise, listening and acting on people's experiences, and taking clear and proactive action when safety doesn't improve.

The importance of culture

Having the right organisational culture is crucial to improving safety. This means safety must be a top priority for all – regardless of seniority or role. A strong safety culture needs everyone working in health and care, as well as people who use services, to play their part. In a strong safety culture, risks aren't overlooked, ignored, or hidden – and staff can report concerns openly and honestly, confident that they won't be blamed.

- **We'll work with others to agree and establish a definition and language about safety** and how this could apply in different health and care services. This will create a better understanding of risk across all health and care – so that we all know what's not acceptable – and therefore help to reduce avoidable harm, neglect, abuse and breaches of human rights. When we talk about safety we'll make sure it reflects what's most important to people when they use services. More clarity will enable services to prioritise the essentials and have clearer expectations when we assess them.

- We'll be looking for cultures that have learning and improvement at their core. In a good safety culture, it's accepted that all incidents – positive, negative, or wholly avoidable – provide opportunities to learn and improve. It's important that **we also embody a learning culture and demonstrate this in our relationships with providers and all our work.**

- Our assessments of safety will have a sharper focus on checking for open and honest cultures. We'll encourage health and care staff to speak up about safety issues where they work, including where there may be safeguarding issues. We'll expect all services to have stronger safety and learning cultures and that learning and improvement should be the primary response when anyone speaks up. **We want staff to feel confident that we'll also listen and act when they raise concerns with us, and we'll intervene quickly where appropriate.**

- We can do more to help services improve safety by sharing the insights, learning, and exemplary practices that we've identified. **We'll use our independent voice to highlight the changes and improvement that services have made to improve safety as a direct result of our regulatory actions.**

Building expertise

Knowledge is crucial to having the right safety cultures, but there are different levels of knowledge and expertise in different types of service and sectors.

- **We'll look at how services and systems assure themselves that they have the right knowledge and expertise,** and how they are investing in improving safety.

- **We'll improve and increase our own safety expertise in CQC** to ensure our approach is in line with the latest safety thinking. Together with our unique data and insight, this will enable us to challenge and highlight failures in services and in systems.

Involving everybody

People should be able to influence the planning and prioritisation of safe care and be truly involved as equal partners in their care at all levels. This collaborative approach has the potential to transform safety and to ensure that people's human rights are upheld.

- In our assessments we'll look for processes to show that leaders and staff are committed to involving people in their own safety throughout their health and care journey, and the impact this has on their outcomes. **We'll check that services actively take into account people's rights and their unique perspectives on what matters to them in the way they choose to live their lives and manage risk.** This includes having the information they need to help them be equal partners in their care and play a part in their own safety.

Regulating safety

We know that some of the greatest safety risks – both physical and psychological – happen when people struggle to access the right care, when they're transferred between services or after they're discharged. We also know that some services are more likely to have greater safety risks than others.

- **We'll focus more on the types of care setting where there's a greater risk of a poor culture going undetected.** We'll develop ways to understand what's happening in these services, as we know that people are often afraid or unable to speak up for themselves and more likely to be failed by a poor culture.

- We'll review how effectively we are assessing and monitoring safety – from registration through to enforcement. We'll use our improved safety expertise to make sure we're taking the right approach. As part of this, **we'll review how we gather data to ensure greater consistency across sectors regardless of who it is reported to.**

- Learning and improvement must be the primary response to all safety concerns in all types of service and local systems. **Where we have concerns, we will direct services and systems to respond and show us – and people who use the services – what action they'll take to learn and improve.** We'll share this information with the public as part of our up-to-date view of quality.

- Services that are not open to learning can't be safe. **We'll use our powers and act quickly where improvement takes too long, or where the changes won't be sustainable.** We'll take action where services are unable to identify systemic issues in their own organisational culture or fail to learn lessons from widely publicised failures happening across health and care.

- **We'll change how we regulate safety in all services to reflect new ways of delivering care and as more services work as part of a local system.** We'll check how well services work together – those that are truly focused on safety will be determined to ensure a safe journey of care for people moving on to a different service, or when being transferred between services for ongoing care.

- Where we see systemic safety issues in a local area, we'll speak out to encourage meaningful change. **We'll share the learning from our insight on themes, trends, and best practice to help services and local systems improve their safety.** We'll also share with regional organisations our data and information about safety in local systems, to support their oversight of safety in their area.

Consistent oversight and support

To improve safety, service providers may need support and guidance. In some sectors, there's a national team of experts who provide guidance and alerts about safety. But this type of national support and oversight doesn't exist in all sectors.

- It's crucial that all health and care services have consistent access to the right support and insight to help them build strong safety cultures, learn from safety and safeguarding incidents, and improve their practice. **We'll work with others to develop solutions to ensure that all services have support and leadership** during difficult times, and that they have the right tools to always provide safe care. We'll need to understand where this oversight is best placed and develop the right frameworks as needed.

- **We'll use our insight and independent voice to promote a national conversation on safety across health and care sectors and systems.** We can use this to drive improvements in safety cultures and reduce harm.

Accelerating improvement

We will do more with what we know to drive improvements across individual services and systems of care. We'll use our unique position to spotlight the priority areas that need to improve and enable access to support where it's needed most.

We'll empower services to help themselves, while retaining our strong regulatory role. The key to this is by collaborating and strengthening our relationships with services, the people who use them, and our partners across health and care.

Collaborating for improvement

The support that's available to improve the quality of care varies between and within health and care sectors and across England. We'll work collaboratively to support all parts of a local system to focus on improvement.

- Where there are gaps in improvement support, **we will facilitate national improvement coalitions with a broad spectrum of partners within both health and adult social care**, including those representing people who use services. These coalitions will work collaboratively to improve the availability of support, both nationally and at a local system level. This will **build on existing partnerships and programmes around improvement** rather than duplicate efforts. We'll champion consistent access to direct, tailored, hands-on support for all services who need it.

- Local systems need to drive improvement in their areas. We will support these efforts and assess how well they are doing this, including how well they are ensuring everybody has fair and equal access to care, an equally good experience and good outcomes. **We'll strengthen our ongoing relationships at a local level to promote collaboration on improvement** across areas, working with local and national partners from the relevant improvement coalitions.

Making improvement happen

We want to see improvements that benefit people. We'll play an active part in this by setting clear expectations and empowering services and local systems. But we're clear that while enabling access to support, we will retain our core regulatory role, which means using our powers to act where we see poor care.

- **We'll encourage continuous improvement in quality by being clearer on the standards that we, and people who use health and care services, expect.** Services and local systems will need to demonstrate a culture of improvement and contribute to improvement in their local area. As part of this, we'll expect them to address inequalities in access, experiences and outcomes.

- We'll develop collaborative relationships with services, helping them to find their own route to improvement. This will involve facilitating access to improvement support and pointing services to sources of guidance, best practice, and other providers and organisations that can offer advice and support. **We'll hold improvement conversations with services and offer a range of resources to support them to decide for themselves the best way forward** rather than telling them what to do. We will develop our skills, capability, and culture to enable this shift.

- In collaboration with others **we'll identify the areas that need to improve as a priority – both at a local and national level.** Using our independent voice, we'll deliver a programme of activity to drive change in these areas, based on evidence of what works. We'll share good practice and examples of the factors that drive improvement, and the findings from our in-depth reviews. We'll prompt action through events and workshops, and by publishing guidance, tools, and frameworks that support improvement.

- **We'll empower services and local systems to improve themselves by offering analysis and benchmarking data.** This will enable them to self-assess how they're performing against similar services and areas. Our benchmarking information will also show us where we need to focus our work to drive improvement.

Encouraging innovation and research

Innovative practice and technological change present an opportunity for rapid improvement in health and care. We have a role in creating a culture where innovation and research can flourish.

- **We'll encourage and champion innovation and technology-enabled services where they benefit people and where the innovation results in more effective and efficient services.** We know the path to innovation can be difficult; we want to use what we know as a regulator to create an environment where services can try new ways to deliver safe, high-quality care. We'll aim to support their efforts to innovate through clear advice and guidance.

- We'll understand and keep pace with changes, both in new technology and new ways to deliver care. **We'll work in partnership with services and other stakeholders to develop a coordinated, effective, and proportionate approach to regulating new innovations and technology.** When we do this, we'll consider where the use of new technology to deliver care might not suit some people, and what services need to do to make sure that nobody is disadvantaged.

- Research can help improve the quality of care, and people often value the opportunity to participate in research, whether clinical trials or other studies. **We'll encourage services to play an active part in research to improve care for all, foster innovation and enhance people's experiences of care.**

An approach based on evidence

We have valuable knowledge and insight about improvement – we'll use this to inform our regulatory approach.

- We want to promote an improvement culture across health and social care. Through our assessments of services and local systems, and across all our work, **we'll identify and investigate the things that are most important to ensuring good quality care.** We'll use the evidence we collect to support improvement.

We'll invest in research and make better use of external evidence to have a better understanding of the conditions that drive quality improvement, including evidence and best practice from other industries. We will also strengthen our evidence on the extent and nature of inequality in people's experiences of care, and the good practice to help reduce this.

We'll use the best available evidence to inform our approach to regulation. We'll develop and extend our own internal improvement activity and capability. As part of this **we will embed a culture of learning and evaluation in CQC to maximise our impact on the quality and outcomes of care for people.**

Outcomes from this strategy

By delivering this strategy, we will achieve 12 outcomes:

People and communities

1. Our activity is driven by people's experiences of care.
2. We clearly define quality and safety in line with people's changing needs and expectations. This definition is used consistently by all people, and at all levels of the health and social care system.
3. Our ways of working meet people's needs because they are developed in partnership with them.

Smarter regulation

4. We are an effective, proportionate, targeted, and dynamic regulator.
5. We provide an up-to-date and accurate picture of quality.
6. It is easy for health and care services, the people who use them and stakeholders to exchange relevant information with us, and the information we provide is accessible, relevant, and useful.

Safety through learning

7. There is improvement in safety cultures across health and care services and local systems that benefit people because of our contribution.
8. People receive safer care when using and moving between health and social care services because of our contribution.

Accelerating improvement

9. We have accelerated improvements in the quality of care.
10. We have encouraged and enabled safe innovation that benefits people or results in more effective and efficient services.

Core ambitions

11. We have contributed to an improvement in people receiving joined-up care.
12. We have influenced others to reduce inequalities in people's access, experiences and outcomes when using health and social care services.

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Follow us on Twitter @CareQualityComm

Download this document in other formats at
www.cqc.org.uk/Strategy2021

Please contact us if you would like this document in another language or format.

CQC-471-052021

Overview and Scrutiny Committee CQC ASC update

Helyn Aris
Inspection Manager Kirklees and Wakefield
Dec 2021

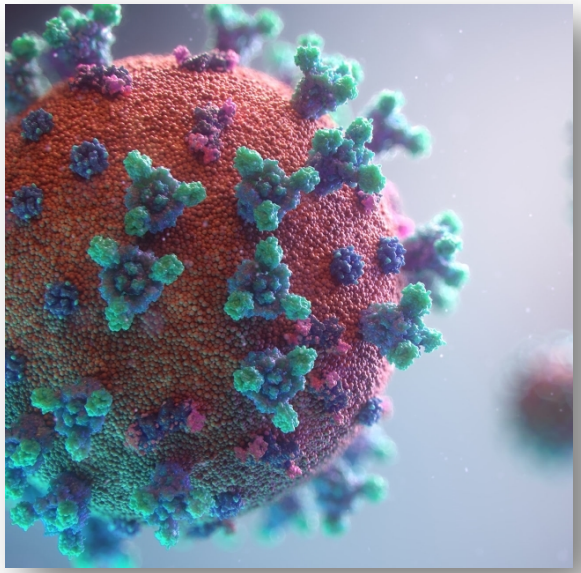
Our role and purpose

The Care Quality Commission is the independent regulator of health and adult social care in England

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve

CQC and COVID-19

- Forced us to **adapt how we work** so we could support providers, allowing them to **focus on the emergency**
- While routine inspections were paused, **we never stopped regulating**
- Deliver our purpose by:
  - Gathering and analysing information
  - Working with providers and partners
  - Acting on what we know
  - Developing new monitoring tools
  - Sharing learning



Learning from the COVID-19 crisis

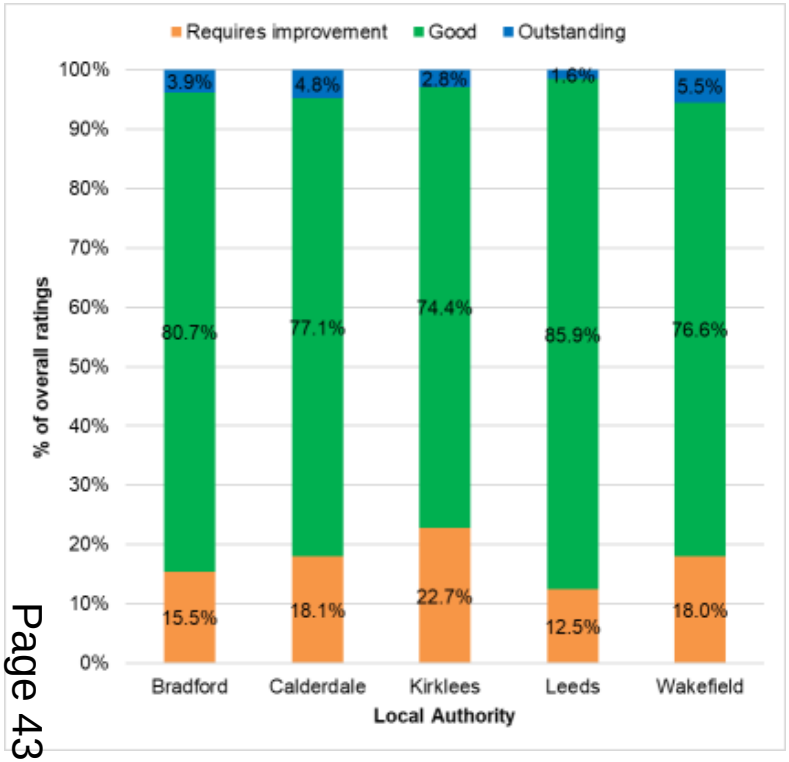
- **What's important?**
  - Voice of people
  - Voice of care providers
  - Information sharing

- **Local systems –** peoples outcomes are significantly impacted by the way health and social join up

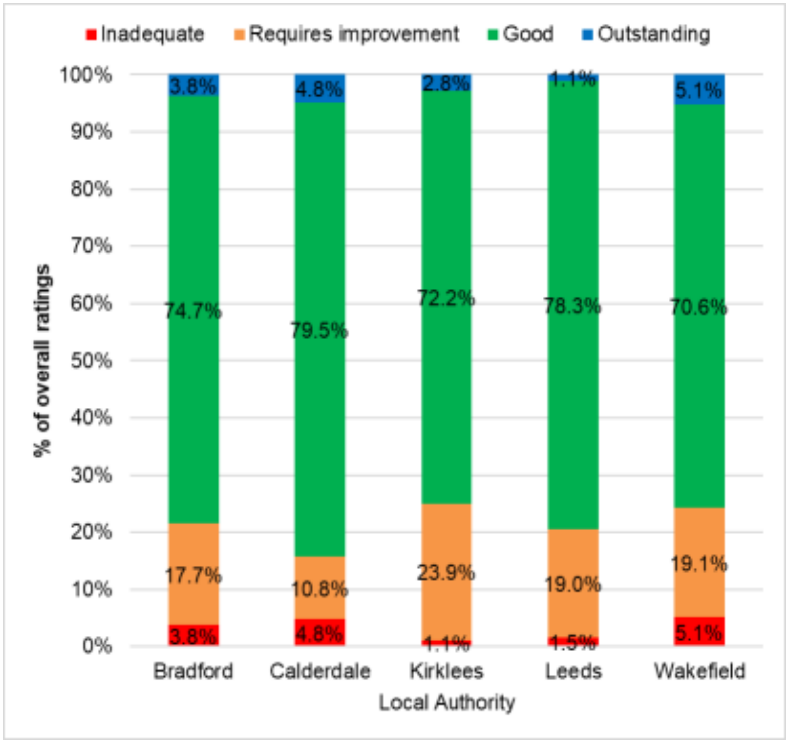
Overall ratings – pre and post COVID -19

When comparing the breakdown of overall ratings 16/03/2020 with the breakdown on 11/10/2021:
The majority of services are rated good pre and post-COVID, followed by requires improvement.
There is a higher percentage of services rated inadequate post-COVID.

Overall Ratings Breakdown Pre COVID-19
Ratings profile as of 16/03/2020



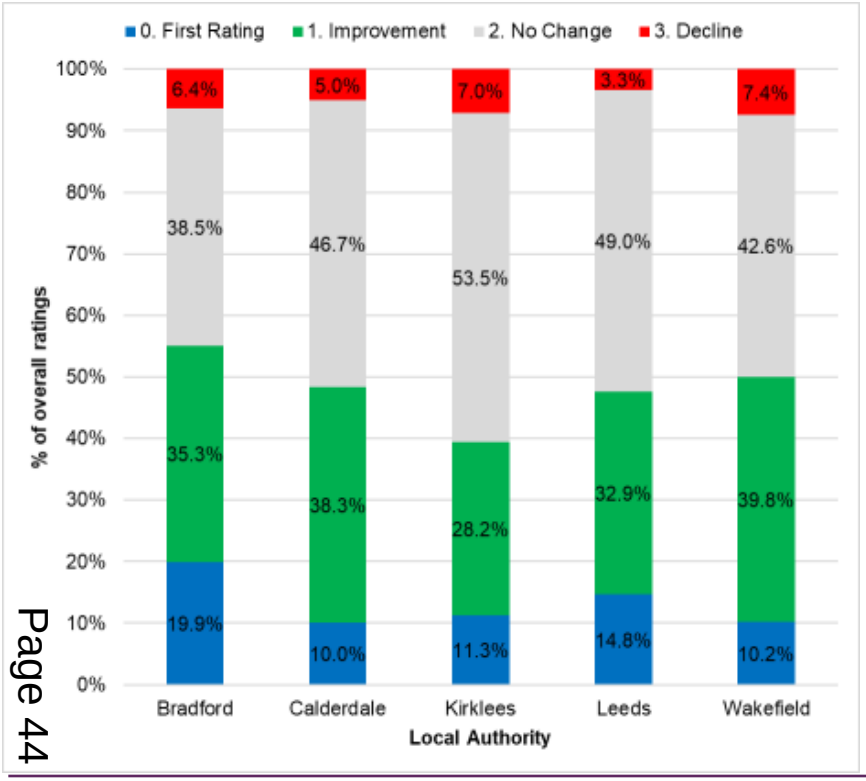
Overall Ratings Breakdown Post COVID-19
Ratings profile as of 11/10/2021



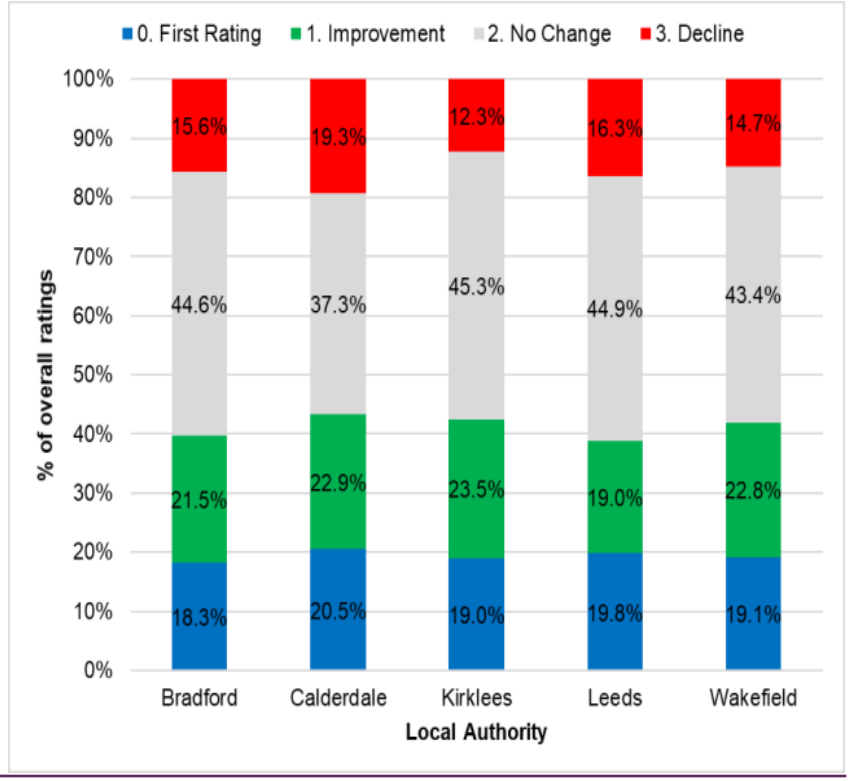
Overall rating change – pre and post COVID-19

This slide compares the direction of travel to the current overall rating as it was on 16/03/2020 with 11/10/2021.
The amount of decline in ratings has increased in all five local authorities post COVID-19, and the amount of improvements has decreased.

Rating Change Breakdown Pre COVID-19
Profile as of 16/03/2020



Rating Change Breakdown Post COVID-19
Profile as of 11/10/2021



Kirklees Locations verses National Picture

All ASC services in Kirklees: 215
181 of these are rated:

Outstanding	2.8 %
Good	72.4 %
Requires improvement	23.2 %
Inadequate	1.6 %

National Picture:

Outstanding	4.6%
Good	80%
Requires improvement	14.4%
Inadequate	1%

The state of health care and adult social care in England 2019/20

Name, Title
Event title - Date

@CareQualityComm
#StateOfCare

An overview

- **In adult social care**, failure to agree funding solution continues to drive instability.
- Staff turnover is high = difficult to improve
- COVID has exposed and exacerbated problems – funding, staffing, operational support, PPE – less readily available than the NHS
- **In the NHS,** acute care now faces winter - treatment, diagnosis and screening for patients fell, leading to a backlog
- Pre-existing pressures combine with COVID pressures
- There was a fall in GP appointments = risk that there is pent-up/delayed demand going into winter

Our new strategy: key themes

- Regulation that's driven by people's needs and experiences
- Smarter, more dynamic and flexible regulation that provides up-to-date and high-quality information and ratings
- Regulating for stronger safety cultures across health and care
- Enabling health and care services and local systems to access support to help improve the quality of care where it's needed most

We'll implement our new strategy over the next five years so we can be flexible and adapt to changes in health and care.

Our new strategy: core ambitions

Assessing local systems:

- Providing independent assurance to the public of the quality of care in their area.

Tackling inequalities in health and care:

- Pushing for equality of access, experiences and outcomes from health and social care services

Developing our approach to monitoring 2021/22

Since March 2020, driven by a need to adapt to the pandemic, we made real progress in using data and insight to monitor services.

Since June 2021 we have continued to make progress in how we monitor services in three key areas:

- Being more targeted in our regulatory activity
- Bringing information together in one place
- Developing elements of how we want to work in the future

Our communication with services and the public statement

Public Statement:

A public statement is published on our website for services where our information review does not indicate anything of concern. An email is also sent to the Service Provider

Enhanced monitoring – Direct Monitoring Activity

If once we have completed our monitoring activity, we are assured of the quality of care, then the service may be eligible to have a ***public statement published in the next monthly information review***.

If our monitoring leads to an inspection
No statement on the website, but an inspection report will be published.

Further information is available on our website.

https://www.cqc.org.uk/guidance-providers/how-we-inspect-regulate/our-monitoring-approach-what-expect

Thank you, and any questions?

Helyn Aris
Inspection Manager

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Kirklees Health and Adult Social Care Scrutiny Panel December 2021

MH & CHS- Jo Walkinshaw

State of Care 2021- national
Rising demand for mental health care

- The impact of the pandemic on people's mental health is well recognised. The Centre for Mental Health has estimated that up to 10 million people, including 1.5 million children, are likely to need new or additional mental health support as a direct result of the crisis.
- Through our Give Feedback on Care service between April and December 2020, we heard that when some people sought help for their mental health from primary care services, they reported issues including feeling ignored by the GP or not having their symptoms taken seriously. People with mental health needs also felt that they could not get a referral to a specialist from their GP because of a lack of capacity in community mental health services.

State of Care (continued)

- Our inspection teams have raised concerns about people being admitted to mental health services with more severe mental ill-health. They have also told us about people presenting in emergency departments and acute trusts struggling to find appropriate places for them due to a lack of suitable provision.
- As with other areas of health care, we saw that the increased use of digital technology had a positive impact for some people. This included for example, the use of online mental wellbeing apps. Video calling was also beneficial as it made it easier for people, for example those with chaotic lifestyles, to keep scheduled appointments. However, the use of digital technology was not accessible or suitable for everyone, and excluded some, with the importance of face-to-face appointments still recognised.

Community Health Service - Locala

- Locala is a not-for-profit social enterprise that provides a variety of NHS community healthcare services to people in Kirklees, Calderdale and Bradford. The head office of Locala is Beckside Court (1st Floor) which sits with Kirklees Local Authority. It has 20 registered locations with CQC
- They were last inspected in November 2019, with the report published in 2020. The overall rating and all the domains were Good.

The services included in that inspection were:

- Community dental

- Community health services for children, young people and families

- Community health services for adults

- Community sexual health services

Locala (continued)

- Locations never inspected are:

- 2nd Floor, Howard House

- Bingley Medical Centre

- Bowling Hall Medical Practice

- Farfield Group Practice

- Windhill Green Medical Centre

- We have no current concerns regarding Locala, we have a good working relationship with the senior leadership team and they are responsive.

- During the Covid 19 pandemic Locala engaged in a transitional monitoring call with the CQC to gain assurance regarding the quality of care they were able to offer and no concerns were highlighted.

Mental Health Services- SWYPFT/ Kirklees

Inpatient

- Enfield Down Holmfirth - MH - Long stay/rehabilitation mental health wards for working age adults. This is a 30 bedded recovery unit for adults in the Huddersfield area offering recovery in a community setting.

Long stay rehab received a rating of good in 2017.

SWYPFT (continued)

MH - Community-based mental health services for adults of working age

- Calderdale and South Kirklees SPA - Single point of access team to manage referrals in Kirklees
- Kirklees Dual Diagnosis - Service providing substance misuse support in Kirklees
- Kirklees South Enhanced- Community Mental Health Team for working age adults with mental health problems
- Kirklees South Enhanced 2 - Community Mental Health Team providing support for working age people with more complex mental health problems in Kirklees

SWYPFT (continued)

- North Kirklees Enhanced 1- Community Mental Health Team for working age adults with mental health problems
- North Kirklees Enhanced 2 - Community Mental Health Team to support working age adults with more complex mental health problems
- South Kirklees Core - Community Mental Health Team for working age adults with mental health problems
- North Kirklees EIP - Early interventions services for people with psychosis
- South Kirklees EIP - Early interventions services for people with psychosis
- Last inspection good

SWYPFT (continued)

- There has been a number of suicides within the teams. Themes from serious incidents include issues relating to care plans and risk assessments not being up to date. This is being discussed at engagement and the Trust have plans in place to try and improve this.

<u>MH - Mental health crisis services and health-based places of safety</u>

- Kirklees IHBTT - Home based treatment team for working age adults with mental health problems

Last inspection – rating good

- Patient suicide– still under investigation.

SWYPFT (continued)

MH - Specialist community mental health services for children and young people

- Kirklees CAMHS Team - Community services for children and young people with mental health problems

Last inspection requires improvement – no current concerns raised.

MH - Community mental health services for people with a learning disability or autism

- Kirklees Community LD service - Community team to support people with learning disabilities

Last inspection good (requires improvement in well led).

SWYPFT (continued)

Other specialist services

- Perinatal service - The service will be able to offer a range of different interventions depending on need and current involvement with our services

Other

- Kirklees recovery college- Education and support for people with mental health problems and carers
- Kirklees IAPT - Community Mental Health Team for working age adults with mental health problems
- Mirfield Day Centre (Pathways) Carer Support service- Carers support service

Mental Health Services- Priory Hospital Dewsbury

- The Priory Hospital Dewsbury is situated in a community location in West Yorkshire.
- The hospital provides a specialist inpatient service for adults and older age males with severe and enduring mental health conditions, who may also have an undiagnosed memory related illness.
- The service was last inspected in March 2020 and was RI overall and in all domains apart from Caring which was Good. This was a comprehensive inspection.
- The MHAR completed a remote visit of Jubilee ward in March 2021 and Hartley ward in August 2021. There were no major issues found.

Mental Health Services- Priory Hospital Dewsbury (continued)

- However, in April 2021 we did have some serious concerns raised by the CCG. These concerns included no falls risk assessments in place and notification of a serious injury not being sent to CQC (this was the break of a patients hip after falling multiple times). The issues seemed to be specifically related to Jubilee ward and the CCG have created an action plan with the service. The service has also replaced the previous ward manager on that ward.
- The service is currently on our risk register and are on monthly engagement.
- We inspected the Priory Dewsbury in October 21 and rated the service RI.

CHART Kirklees

- CHART Kirklees provide substance misuse services to around 4000 clients per year. Services provided include prescribed opioid substitution therapy, alcohol detoxification, psychological therapies, and social and harm reduction interventions.
- The service is coming up for tender in November 21.

Locations

- 3 Wellington Street, Dewsbury is a new registered location this year having previously been registered at 12 Station Street, Huddersfield. As well as 3 Wellington Street, Dewsbury, they also run satellite locations at Princess Royal Community Health Centre, Huddersfield and a new location at 20 Manchester Road, Huddersfield.

CHART Kirklees (continued)

Latest inspection and current rating

- The location is currently unrated (new location) but was rated requires improvement at their previous location during an inspection in November 2018. There were two breaches of regulations:
- Regulation 9 – Person-centred care
- Regulation 12 – Safe care and treatment
- These breaches were predominantly due to a new client record system that staff didn't know how to use properly.

CHART Kirklees (continued)

Monitoring and COVID-19

- A transitional monitoring call was carried out with the registered manager on 31 January 2021. No regulatory action was required following the call as the service had systems and processes in place to monitor safety and effectiveness, and to ensure care and treatment was caring and responsive to individual needs.

CHART Kirklees (continued)

- The service reported an increased demand during COVID-19 due to illicit supplies not being available. Contact has significantly increased to provide additional support to service users. This is initially twice weekly and contact frequencies can be flexed up or down based on needs/risks, combined with home visits and ensuring referrals to external agencies for specialist support. Most appointments were virtual during the restrictions however there was a choice of appointment times and frequency of contact. The service extended their opening hours to enable virtual evening appointments to accommodate those service users who work during the day. Mobile phones were provided for vulnerable service users to help them engage.

CHART Kirklees (continued)

- No concerns were raised during the monitoring call in relation to infection prevention and control procedures. Regular premises risk assessments are carried out. Cleaning has increased, particularly of high touch areas, and is recorded on daily checklists and monitored via monthly audits. PPE and hand sanitiser stocks have remained high. Appropriate checks are carried out on all visitors and weekly testing is in place for all staff. Signage and guidance is in place and social distancing is observed.
- Engagement meetings take place between CQC and the registered manager every three months. There are no current issues or concerns.

Primary Medical Services

Jill Taylor

Inspector

State of Care

- Like all health and care services, GPs and their teams have had a crucial role to play in supporting the health needs of their communities throughout the pandemic, as well as keeping people safe.
- GP practices, following national directives and drivers from government, had to accelerate innovation, such as moving rapidly to remote consultations.
- A remarkable achievement since December 2020 has been the rollout of the COVID-19 vaccination programme.

Primary medical services

State of Care

- After dropping considerably in April 2020, the total number of GP appointments started to pick up from June 2020, and by September 2020 was broadly in line with figures for the previous year.
- The pandemic had an impact on patient behavior, the proportion of respondents (to National GP Patient Survey) spending more than a year without attending a GP appointment more than doubled to 27%.
- This was reflected in a Healthwatch report, which found that people were worried about “overloading” services and not speaking to their GP practice unless they felt their health issue was of extreme importance. This was especially prevalent in feedback from older people.

State of Care

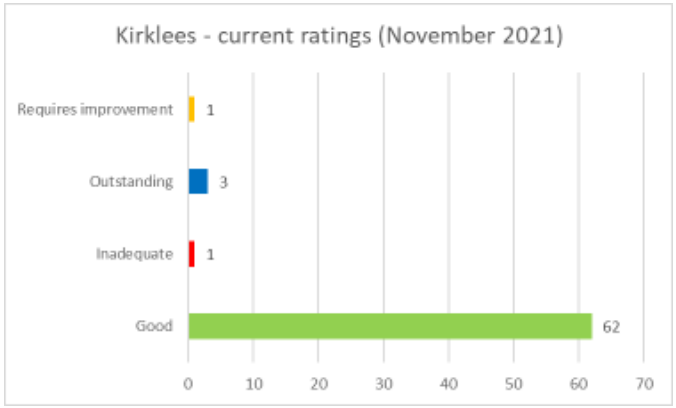
Access

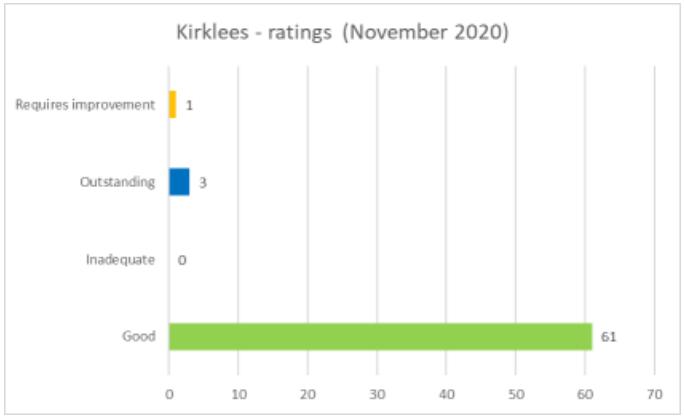
- In line with guidance, practices moved to a triage model for anyone seeking an appointment. This generally took place by telephone.
- Results from the 2021 GP Patient Survey show that the proportion of remote appointments increased substantially. Face to face appointments have continued to be offered when appropriate.
- All systems have recognised the challenges using remote consultations, including digital poverty, language, poor access to the internet and variation in digital literacy.
- The sector needs to think about the future impact of remote or digital appointments, to make sure everyone gets appropriate access to meet their needs safely.
- We are currently developing an inspection methodology so we can inspect those practices where we have concerns about access.

Primary medical services

Primary Medical Services – Summary of current overall ratings in Kirklees

- There has been a slight deterioration in ratings overall across primary medical services in Kirklees over the last 12 months.





Outstanding	4.6%	Kirklees – November 2020
Good	93.8%	
RI	1.5%	
Inadequate	0%	
Outstanding	4.5%	Kirklees – November 2021
Good	92.5%	
RI	1.5%	
Inadequate	1.5%	
Outstanding	4.8%	West Yorkshire – November 2021
Good	93.6%	
RI	1%	
Inadequate	0.6%	

Source: CQC ratings data extracted Oct-20 and Oct-21. Ratings reflect primary care services most recent inspection rating overall

Developing our approach to monitoring 2021/22

Since March 2020, driven by a need to adapt to the pandemic, we made real progress in using data and insight to monitor services.

Since June 2021, we have continued to make progress in how me monitor services in three key areas:

- Being more targeted in our regulatory activity
- Bringing information together in one place
- Developing elements of how we want to work in the future

Name of meeting: Health and Adult Social Care Scrutiny Panel
Date: 7th December 2021
Title of report: Beds Remodelling

Purpose of report: To consider proposals to reconfigure the dementia and Intermediate Care Beds across Moorlands Grange, Castle Grange, Ings Grove House and Claremont House to include a temporary decant of The Homestead Day Service

Key Decision - Is it likely to result in spending or saving £250k or more, or to have a significant effect on two or more electoral wards?	**Not Applicable**
Key Decision - Is it in the Council's Forward Plan (key decisions and private reports)?	**No** **Private Report/Private Appendix – No**
The Decision - Is it eligible for call in by Scrutiny?	**Not Applicable**
Date signed off by Strategic Director & name **Is it also signed off by the Service Director for Finance?** **Is it also signed off by the Service Director for Legal Governance and Commissioning?**	**Richard Parry 26/11/21** **N/A** **N/A**
Cabinet member portfolio	**Cllr Musarrat Khan**

Electoral wards affected: Mirfield, Crosland Moor and Netherton, Newsome, Heckmondwike

Ward councillors consulted: N/A

Public or private: Public

Has GDPR been considered? N/A

Page 2 of the report

1. Summary

The proposals presented in this paper outline both short and medium-term implications of the Council's in house residential (IMC) homes, facilitated through strategic developments with Locala and pressures through the Adults Capital Development strategy, with a proposal to reconfigure the Council run bed base. The proposals set out how this would be facilitated, through an improved model to utilise a 10-bed wing at Moorlands Grange for dementia respite (currently at Castle Grange) and using a wing at Castle Grange for The Homestead (LD Day Services) decant. A wing at Castle Grange is required as a temporary decant for The Homestead day service for approximately 14 months to enable successful delivery of the capital programme within projected costs.

Intermediate care (IMC) services are delivered jointly by Locala and Kirklees Council through the KILT (Kirklees Independent Living Team) approach. The care provided includes residential support, based across three sites, with a service capacity of up to 63 beds across Kirklees and wider community services including reablement.

Over the years demand for beds has been falling. Occupancy has fallen 13.5% in the last 24 months, current demand is, on average, for 48 beds (it should be noted that occupancy will have been impacted by Covid19). The events over the last 20 months have resulted in some use of these beds for non-intermediate care use, meaning true IMC usage is lower than reported levels

At the core of the proposal is a reduction in the number of IMC beds to 50 (reduction from the current 60 beds), these to be concentrated with 40 at one site (Ings Grove), with the flexibility of using an addition 10 IMC beds at Moorlands during system pressure – this together with the creation of a community based therapy team that will provide an in-home alternative for those patients who will safely benefit from that approach. This has been approved by the oversight / governance arrangements across the Council, Locala and the Kirklees Integrated Health & Social Care Business Meeting.

It is proposed the new model be implemented during December to support with winter resilience with phase one operational changes running from December 2021 to April 2022, followed by phase two based on our learning from this approach. It should be noted that contingency support is in place until March 2022.

The proposals presented would make the most of the opportunity to: (a) proactively influence the future of bed based IMC with a view to realising the benefits of the Home First model, (b) facilitate a decant opportunity for The Homestead to ensure service continuity using an existing local asset, and (c) present the Council with the opportunity to consider a flexible bed base model of care in the future at Moorlands Grange

2. Information required to take a decision

Intermediate Care Services underwent a review of the operating model in summer/Autumn 2020 including the IMC beds across Kirklees. In addition, there was the introduction of new pathways relating to Discharge to Assess (D2A) and Urgent Community Response (UCR)

The review was required to ensure the current service offer meets the needs and demand of these changes, ensuring a home first approach is taken with an ambition to reduce the length of stay (LOS) within bed settings therefore requiring more Intermediate Care support offered in the community, where service users improve more within their own home.

Intermediate care as a service has clearly established, nationally accepted parameters

> "Bed-based intermediate care aims to prevent unnecessary admissions to acute hospitals and premature admissions to long-term care, and to support timely discharge from hospital. For most people, interventions last up to 6 weeks" NICE, 2017

However, as IMC is delivered within the wider context of discharge management, there is constant pressure on the service and a need to regularly refocus the service upon its intended population. Pressures that have occurred over the last year, which have affected this, include,

- The initial impact of Covid, and the pressure to urgently free up secondary care beds
- The introduction of other schemes, e.g., Discharge to Assess, and the consequent need to clearly define each service
- The introduction of parallel community based services, e.g. Urgent Community Response, the Home First model, aimed at providing supplementary and alternative pathways for patients, and reducing the number of ICM beds required

During the last 18 months different ways of working have been tested with the introduction of a flexible bed model during the summer of 2020 to help respond to Covid19 pressures. This has been updated earlier this year and a bed modelling report was produced to model the proposed changes required in order to understand variations in demand and capacity, improve the quality of care provided and enhance the community support to ensure patients can receive the service within their own home

The table below shows the outline timeframe for the proposed changes to the profile of beds in preparation for winter resilience, to meet current demand and meet projected demand for the future

Establishment	**Current Bed Base**	**Improved Model (December 2021 onwards)**	**Apr 2023 review** (desired model, following review and evaluation)
Moorlands Grange	30 IMC 10 transitional	10 IMC 10 dementia respite 20 transitional / flexible (includes respite and transitional capacity from Ings Grove)	20 dementia respite (mix of Specialist and Non-Specialist) 20 Flexible Beds
Ings Grove House	30 IMC 7 transitional 3 respite	40 IMC	40 IMC
Castle Grange	30 long term dementia 10 dementia respite	30 long term dementia 10 bed (Hstd Day Care, based on moving respite beds to Moorlands Grange)	40 long term dementia (mixed provision of EMI residential)
Claremont House	30 long term dementia 10 dementia respite	30 long term dementia 10 dementia respite/dementia D2A beds (to support with acute hospital pressures)	40 long term dementia (mixed provision of EMI residential)

Key changes:

- *Temporary reduction of 10 beds at Castle Grange during Homestead decant*
- *Extra 20 x long stay dementia beds as a longer term offer in line with commissioning activity*
- *IMC: reduction from 60 to 50 IMC beds by Dec 2021, in the medium term a further reduction to 40 IMC beds*
- *Dementia respite, no changes still 20 beds but at a different location*
- *Above reflects demand for dementia beds and reduction in IMC linked to Home First agenda.*

Our learning from the improved model will help inform our joint plans for winter pressures and inform the next steps in readiness for 2023. We are already working with Locala to develop new specifications and operating procedures for each bed type and we will continue to work together to shape the longer term model in line with our understanding of demand, capacity and outcomes

This proposal for IMC also fits well with the Council's Capital Programme objectives, offering options within both the strategic capital programme plan and service redesign priorities. The consolidation of IMC beds into Ings Grove allows for a review of the released capacity and will facilitate developments across linked services in line with anticipated service models.

This includes a realignment of the current respite offer within the dementia care homes - using bed capacity in Moorlands Grange to facilitate a broader respite/transitional offer aligned with patient need, thus enabling space to be created within the dementia care homes for an enhanced dementia day service as a temporary decant solution to support with the Adults Social Care capital schemes

The reconfiguration of the bed base is one component of a wider strategy for resilience across IMC and KILT related services, with the Council exploring additionality of funding within its Short Term and Urgent Support services (Rapid Response, Reablement etc.) to meet our ambitions for care which is closer to home. We remain engaged with commissioning colleagues across the system to ensure these proposals remain consistent with strategic commissioning analysis and plans

3. Implications for the Council

- **Working with People**
  The experiences of service users/patients and staff is at the heart of these proposals, with families consulted as part of the proposed changes to the dementia bed base, service users/patients consulted as part of the proposed improvements to the IMC bed base and staff teams (including trade unions) across the Council and Locala consulted on the holistic changes and what this means for them. Our messaging to staff has been clear, that the proposed improvements do not place their employment at risk, however, staff may be requested to work with a different profile of service users as we progress towards the proposed changes to the service offer.

- **Working with Partners**
  Locala and Kirklees Council in consultation with the CCGs and hospital trusts have been working to maintain and promote independence for people, reduce the length of time people are in hospital (or in short stay beds) and that they are the centre of all future care planning. Joint meetings and shared objectives have helped to underpin the future model of the services that the Council and Locala offer, with these proposals coming to fruition following a planning timeline of almost 10 months during which a range of

partners have been consulted and engaged through their respective governance arrangements. We have also engaged with Primary Care to ensure the appropriate medical cover arrangements in place to respond to the improvements across the bed bases and respond to an increasingly complex service user/patient profile

- **Place Based Working**
  The proposals presented are based on:

  maintaining a core resource of 40 IMC beds as the offer across Kirklees and to concentrate these on one site on the border of North and South Kirklees (Ings Grove, Mirfield). This is based on our analysis of the site (opportunities for strategic capital investment), the geographical location of the site (central to Kirklees, good transport links) and the limited asset maintenance required to the site to support the improved model for intermediate care.

  Transitioning the model of care at Moorlands Grange to provide a mix of short term / respite beds, flexible beds to support acute hospital pressures alongside a temporary decant solution for an existing dementia day service.

- **Climate Change and Air Quality –** no assessed impact

- **Improving outcomes for children –** no impact

- **Other (eg Legal/Financial or Human Resources)**

  This proposal is in line with the whole system H&SC approach and the move away from bed based intermediate care into a Home First approach which gives improved outcomes for service users.

  This proposal enables continuation of day services which is a critical part of the system, enabling families to keep loved ones at home for as long as possible before they may need residential care.

  This proposal 'buys time' to enable in-house services to revisit their new flexible offer post Covid as more data becomes available on trends.

  There is some financial risk to the Council through loss of income with the proposed 10 IMC bed reduction at Moorlands Grange. However, in the short term this mitigates against the cost of finding an alternative decant solution for The Homestead service. In the mid to long term, it is anticipated that this risk can be mitigated through additional income in increasing the long term dementia bed capacity

Do you need an Integrated Impact Assessment (IIA)?

Equality Impact Assessments and Quality Impact Assessments have been completed to support these proposals

4. Consultees and their opinions

The proposals have been through interagency and individual governance arrangements with endorsement.

5. Next steps and timelines

There is an interim phase of the work to change the offer of the IMC beds as well as supporting winter pressures/resilience and discharge to assess. This is planned in for December 2021.

- 10 IMC beds, 10 dementia respite and 20 transitional/flexi beds at Moorlands Grange
- 40 IMC beds at Ings Grove
- 30 Long term dementia beds at Castle Grange and 10 bed unit is being used for Homestead day centre whilst the building is being refurbished.
- 30 Long term dementia beds and 10 dementia respite at Claremont House.

Next steps:

- Work with the operational teams in Locala and Kirklees to understand and implement the new model
- Recruitment to new positions
- Identify any staff learning and development
- Implement a communications plan for internal and external stakeholders
- Work closely with any affected individuals and families to ensure that they continue to receive respite services.

6. Officer recommendations and reasons

The Overview and Scrutiny Panel receive these proposals and provide feedback on any further actions or next steps required

7. Cabinet Portfolio Holder's recommendations

The Cabinet Portfolio Holder has endorsed these proposals

8. Contact officer

Saf Bhuta – Head of Service for In House Care Provision
Saf.bhuta@kirklees.gov.uk

Helen Duke – Head of Operations, Locala Community Health Services
Helen.duke@locala.org.uk

9. Background Papers and History of Decisions

N/A

10. Service Director responsible

Michelle Cross – Service Director – Mental Health and Learning Disability
Rachel Foster – Assistant Director of Operations, Locala Community Health Services

Reconfiguration of bed base resources across LA care homes and proposals for an improved Intermediate Care offer

Helen Duke – Locala Health and Wellbeing
Saf Bhuta – Kirklees Council

Overview and Purpose

- To explain the current configuration of Local Authority (LA) owned care homes and the arrangements across integrated health and social care services delivering intermediate care (IMC)

- To outline the challenges and pressures these services currently face

- To propose a reconfiguration of the LA led bed based support offer, based on learning through Covid19, which offers more resilience, flexibility and offers opportunity for greater investment in community support in line with our strategies for discharge to assess and Home First

- To consider how the proposals for reconfiguring the IMC bed base enable the system to identify commissioning gaps which existing LA residential care services could respond to

Strategic Drivers

- The reconfiguration of the beds within Kirklees care homes is not being done in isolation. This is one component of a wider change programme within Adult Social Care to offer flexible and responsive options to the residents of Kirklees in maintaining their independence and community involvement as well as offering long term solutions where needed.

- The proposals are also a key part of the integrated partnership with Locala in developing the Kirklees Independent Living Team (KILT) Partnership project, the Discharge to Assess approach and broadening the services to include Urgent Response, Short Term response, D2A outreach and Hospital Support.

- Linking with Commissioning colleagues across Kirklees Council and CCGs to understand commissioning strategies for Integrated Health and Social Care and alignment with current and projected market demands/pressures.

Timeline to date

- August 2020: IMC bed modelling work and review regarding capacity and demand
- Sept / Oct 2020: Proposal for bed modelling presented at KILT Board and CCG at contract Board
- March 2021: Review of proposal and relevant data analysed and the model and proposals updated
- May 2021: Bed modelling report completed. LA Capital Development Report impacting on IMC homes approved via internal governance
- May 2021: Integrated planning commence in preparation for an implementation
- June 2021: Report discussed and agreed at the KILT management meeting and KIHSC Business Meeting
- July 2021: Proposed model, implementation plan and QIA updated for commencement of the planning 1st August 2021
- 11th August 2021: bed modelling proposal presented at Contract board meeting
- September 2021: Commence patient engagement , Colleague engagement, Union reps and stakeholder engagement
- October 2021: Colleague consultation ended
- 18th October: LA/Locala present proposals and seek endorsement via Portfolio Briefing (Approved)
- November: Patient / stakeholder engagement conclude
- October / November 2021 – Engage with H&SC Scrutiny Panel and/or Overview and Scrutiny Committee
- December 2021: Phased approach to improvements being made

Improved IMC service Offer

The national agenda for Home First enables the improvement of Kirklees IMC service offer by:

- Taking a *flexible* approach to the service locations
- Strengthening our flexible and *integrated* approach to workforce capacity, development and planning
- Enabling an approach to support *Home First* models to succeed through reducing the reliance on bed-based IMC solutions
- *Compliment* other services in place (Reablement/Enhanced, START, HAT, D2A, UCR, 7 day service offer)

This will consist of:

- Maintaining a core resource offer of 40 IMC beds at Ings Grove House (Mirfield – border of North and South Kirklees, good transport links)
- Access to additional beds (10) in Moorlands Grange
- An improved integrated health and social care model using best practice from both existing sites
- An increased nurse presence within the bed base to meet the increased acuity needs of the patients
- A flexible therapy team who will provide support in the bed base and follow patients home
- A single CQC Registered Manager working alongside the Locala Team Leader providing management oversight and ensuring compliance with CQC requirements

Kirklees Council Current Model

Kirklees Council have four 40 bed in-house care homes for older people. These homes currently provide the following:

1. **Castle Grange** in Newsome and **Claremont House** in Heckmondwike are both 40 bed establishments - 30 beds in each are used for long term dementia care and the remaining 10 beds in each home are used as short term dementia respite.

2. **Ings Grove House** in Mirfield and **Moorlands Grange** in Netherton are 40 bed establishments - 30 beds in each home are Intermediate care beds with therapy delivered by Locala to people who need a rehabilitation service and are unable to receive this in their own home. The remaining 10 beds in each home provide transitional and respite beds to people in need of a short stay placement.

Bed Types and Definitions (LA Care Homes)

Intermediate care beds

To avoid admission to hospital (step up) and facilitate early discharge from hospital (step down). Using a rehabilitation and therapy approach before returning home.

Transitional Beds

Whilst awaiting a community package being set up or a long term placement in residential care. There are different types of beds depending on funding streams e.g. non weight bearing and choice and recovery.

Respite beds

Beds that are used following assessment to give family carers a break from supporting their loved ones at home. Some establishments provide respite only for people with dementia and other establishments for other older people.

Long Term dementia beds

For people with advanced dementia that following an assessment have been deemed as not being able to continue to live in their own homes safely.

What the data tells us

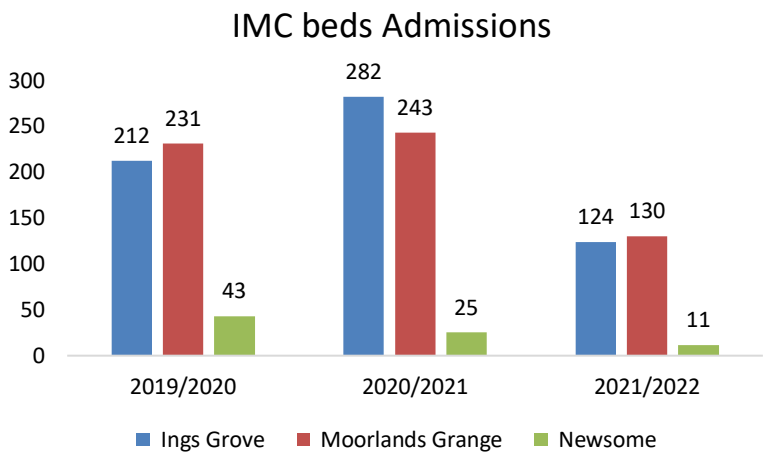
Dementia

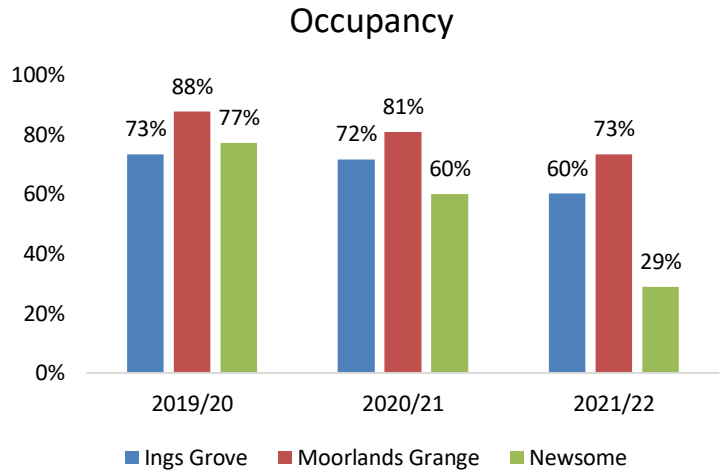
- Those living with a dementia diagnosis locally is expected to increase by 11% (600 people) by 2025.
- There is demand for placements that support those living with dementia who have more complex needs.
- As confidence in placement infection control systems, and sadly carer fatigue increases there is likely to be increased demand for dementia provision across Kirklees.
- Demand for dementia placements over the past 18 months is relatively flat, this is thought to be because of a reluctance amongst families to place relatives in care homes. It is also due to a year of higher rates of excess deaths amongst those living with long term conditions such as dementia.

Intermediate Care

- COVID-19 and the last 20 months have enabled us to utilise bed based support in flexible ways showing less dependency on the current service offer
- Patients want to return home rather than go into a transitional bed based placement.
- Bed modelling analysis shows variations in demand and capacity, this has helped inform the model of the delivery of Intermediate Care services taking a home first approach.
- Occupancy has fallen 13.5% in the last 24 months, demand has been on average for 48 beds
- The events over the last 20 months have resulted in some use of these beds for non-intermediate care use, meaning true IMC usage is lower than this

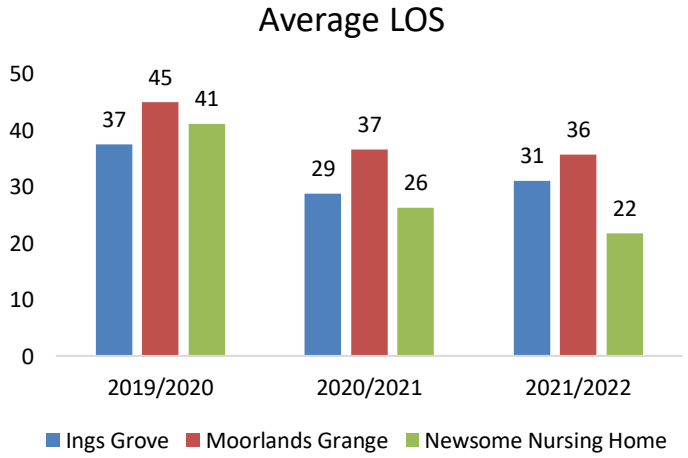
Performance monitoring





An increase in referrals to IMC during COVID (flexi beds in summer 2020) then reduced again to 265 to date this year

This years referrals in line with new model of 53 beds



Reduced occupancy year on year, supporting the new model

The Average LOS reduced with a slight increase at Ings this year. Some developments include moving patients more quickly on who have finished their IMC

Increased activity into community reablement since 2019: 12% in referrals, 15% Overall patient contacts, 13% monthly caseloads

Key Risks / mitigations

Risk	Mitigation
Potential delays to LA building works / capital programme	• Managed via capital board / S151 officer aware and advised
Demand may exceed capacity of remaining IMC beds	• Enhanced capacity in community / reablement • Retain the option of spot purchasing IMC beds • Bed numbers have been carefully calculated against past and current usage • Changes will be made on a staged basis and usage monitored
IMC services will not be optimally structured for the anticipated winter pressures	• Closer working with Locala / ongoing work via KILT programme improving the quality of care
Some of community may feel 1 site is geographically inaccessible to them (IMC in Ings Grove and transitional / flexible / respite in Moorlands	• Ings Grove has been chosen in part as the most accessible location for the majority of the population • The site is well served by public transport • Spot purchasing beds, with in reach therapy, will be available for where there are geographical challenges to accessing services
Stakeholders may not be aware of the new model of service and fail to understand benefits to patients and for themselves	• All arrangements will be approved by partnership governance bodies and information disseminated through partner organisations • Locala and Kirklees managers will design and deliver a full explanatory communication programme with all stakeholders to ensure effective relationships continue

Engagement and feedback

As part of the IMC bed modelling process colleague, stakeholder and patient engagement has been included in the development of the model and how this is put into practice. This includes;

- Colleagues across both Locala and Kirklees Council
- Colleague Unions
- Internal departments to Kirklees Council including Adult Social Care
- Patients currently accessing services within the bed bases
- Attendees of the Enhanced Health and Care Home meetings
- Local Primary Care Networks
- Acute Trusts (CHFT & Mid-Yorks)
- Kirklees CCG

Case for Improvement

The overarching purpose of the homes have not changed, however there is a compelling case for a shift in how the bed capacity is used to meet changing demands in the market.

Intermediate Care Beds Proposals

- In line with the KILT approach, both the Council and Locala are investing in **increasing the resource capacity in the community** to support with the 'home first' approach, this will enable people where possible, to return to their own homes safely following a hospital stay.
- We recognise however that for some, they may still need a bed based offer with a reduced length of stay.
- Our modelling highlights a requirement for **fewer** intermediate care beds in the system, we are therefore proposing to **reduce** the number of IMC beds with an enhanced flexible offer at home

Transitional Beds Proposals

- We know that when people are 'medically fit for discharge' from hospital, it is inappropriate for them to remain in an hospital bed.
- To assist the 'home first' approach – we want to provide **more** of these beds, as **flexible bed capacity** responding to need
- This will support the 'discharge to assess' capacity in the system in readiness for post March 2022
- To give flexibility in the system to accommodate respite for people without complex dementia

Respite Beds Proposal

We are **retaining** the dementia respite beds to ensure families can have regular breaks to enable them to continue to support their loved ones at home.

Long term dementia beds Proposal

To meet the demands needed for additional capacity for people with advanced dementia needing admission into long term care homes.

To respond to variation in demand and supply of specialist Dementia beds

We are proposing to **increase** the number of beds.

Moorlands Grange, Netherton

Pen Picture

- Owned by Kirklees Council, the home has capacity for 40 beds and specialises in short term intermediate support .
- It has 2 floors - each with 2 wings and 10 beds each
- The Registered Manager and care staff are employed by Kirklees Council, Locala provide therapy staff (OTs, physios etc)
- Locala purchase 10 beds for IMC from the Council, with the CCG funding 20 beds at a Council subsidised bed rate
- The Council and Locala team work together promote people's independence prior to returning home
- Medical cover provided through New Street Practice

Current Bed Configuration

- **30 Intermediate care beds (IMC)** - these are short-term rehabilitation beds for 'step up and step down' (in and out of hospital to assist with reducing hospital beds being occupied)
- **10 transitional beds** – for those that need further assessment or those awaiting package of care start date or a home adaptation to be completed or those awaiting final destination care home

Proposed Changes

- Host **10 dementia respite beds** from other LA establishments (Castle Grange/Claremont House), move towards this being mixed provision to include specialist (EMI) respite beds
- **Reconfigure** the Locala IMC bed capacity to **10 beds in Moorlands** – this 10 bed reduction will be based on the beds purchased by Locala directly from the Council (i.e. CCG funded beds (20) will remain, see point below)
- **Reconfigure** the 20 CCG funded beds as '**flexible**' beds to support with transitional and D2A bed capacity across the system
- Locala will continue to provide input to the bed base on an 'in reach' basis
- Engage with current aligned GP practice to explore medical cover, including exploring other options

Ings Grove House, Mirfield

Pen Picture

- Owned by Kirklees Council, the home has capacity for 40 beds and specialises in short term intermediate support .
- It has 2 floors - each with 2 wings and 10 beds each
- The Registered Manager and care staff are employed by Kirklees Council, Locala provide therapy staff (OTs, physios etc)
- Locala purchase 10 beds for IMC from the Council, with the CCG funding 20 beds at a Council subsidised bed rate
- The Council and Locala team work together promote people's independence prior to returning home.
- Medical cover provided through North Road Practice (Ravensthorpe)

Current Bed Configuration

- **30 Intermediate care beds (IMC)** - these are short-term rehabilitation beds for 'step up and step down' (in and out of hospital to assist with reducing hospital beds being occupied)
  7 transitional beds – for those that need further assessment or those awaiting package of care start date or a home adaptation to be completed or those awaiting final destination care home
- **3 respite beds** – these provide short term respite to enable family carers to have a break

Proposed Changes

- **Transfer** the 7 transitional beds Moorlands Grange
- Engage with LA commissioners to explore market options for the **3 respite beds**
- Use this capacity of 10 beds to enhance the IMC offer at Ings Grove, so that all 40 beds are IMC beds
- An improved integrated health and social care model using best practice from both existing sites
- **Increased** nurse presence within the main bed base to meet the increased acuity needs of the patients
- **flexible** therapy team who will provide support in the bed base and follow patients home
- Medical cover to be provided through Locala – further engagement to be undertaken with existing aligned practice to explore options within existing GP contract

Castle Grange, Newsome

Pen Picture

- Owned by Kirklees Council , the home has 40 beds specialising in dementia care
- 2 floors each x 2 wings x 10 beds each
- The Registered Manager and care staff are employed by Kirklees Council.

Current Bed Configuration

- 30 beds are used for long term placements for people with dementia (permanent)
- 10 beds provide short term respite for people with dementia to enable family carers to have a break

Desired Model by 2023/24

- Transfer the 10 dementia respite beds to Moorlands Grange
- Reconfigure this 10 bed capacity to provide 40 beds as long term dementia beds
- Consider opportunities to take a 'mixed economy' approach to these beds to meet current/anticipated levels of need for complex/specialist dementia

NB: Prior to above, 1 x 10 bed wing will be used to provide day care to people with dementia whilst the new Homestead Day Centre is being built

Claremont House, Heckmondwike

Pen Picture

- Owned by Kirklees Council , the home has 40 beds specialising in dementia care
- 2 floors each x 2 wings x 10 beds each
- The Registered Manager and care staff are employed by Kirklees Council.

Current Bed Configuration

- 30 beds are used for long term placements for people with dementia (permanent)
- 10 beds provide short term respite for people with dementia to enable family carers to have a break

Desired Model by 2023/24

- Transfer the 10 respite beds to an alternative establishment (medium/long term – Moorlands Grange)
- Reconfigure this 10 bed capacity to provide 40 beds as long term dementia beds
- Consider opportunities to take a 'mixed economy' approach to these beds to meet current/anticipated levels of need for complex/specialist dementia

Summary of reconfiguration

The table below shows a summary of the improvements
The improvements will be managed via a phased approach to ensure we take account of capacity to change with the least possible disruption.

Establishment	Current Bed Base	Improved Model
Moorlands Grange	30 IMC 10 transitional	10 IMC 10 dementia respite 20 transitional / flexi (enhanced community based offer)
Ings Grove House	30 IMC 7 transitional 3 respite	40 IMC (enhanced offer at home)
Castle Grange	30 long term dementia 10 dementia respite	30 long term dementia 10 beds for Homestead Day Services (based on moving respite beds to Moorlands Grange) (note proposals to move towards 40 long term beds as the desired model for 2023/24)
Claremont House	30 long term dementia 10 dementia respite	30 long term dementia 10 dementia respite (note proposals to move towards 40 long term beds as the desired model for 2023/24)

Summary

- Intermediate Care is currently concentrated around residential care, demand for which has been impacted by several factors
- The clarity of purpose of IMC services requires a refresh grounded in the principles of Home First with a more flexible approach resulting in a better patient experience
- The proposed bed reconfigurations, and the improved model for IMC makes for a better patient experience, more efficient use of resources, responds to commissioning objectives and creates the opportunity for strengthened community therapy and care
- Proposed usage of LA sites acts as an enabler on the wider LA capital development plans
- Opportunities to refresh commissioning needs analysis to inform commissioning gaps which could be responded to through available bed capacity (e.g. EMI/Specialist Dementia Beds, Stroke Rehab Beds - April 2023 onwards)

HEALTH AND ADULT SOCIAL CARE SCRUTINY PANEL – WORK PROGRAMME 2021/22

MEMBERS: Cllr Habiban Zaman (Lead Member), Cllr Bill Armer, Cllr Aafaq Butt, Cllr Vivien Lees-Hamilton, Cllr Fazila Loonat, Cllr Lesley Warner, David Rigby (Co-optee), Lynne Keady (Co-optee).

SUPPORT: Richard Dunne and Yolande Myers, Principal Governance Officers

FULL PANEL DISCUSSION		
THEME/ISSUE	**APPROACH AND AREAS OF FOCUS**	**OUTCOMES**
1. Financial position of the Kirklees Health and Adult Social Care Economy	Maintain a focus on the finances of the local health and social care system to include: • An update on the impact of Brexit and Covid-19 to include exploring the implications on staff numbers/shortages. • Assessing the local approach to developing a workforce strategy. • A focus on the implications of the financial pressures on services provided and commissioned by Adult Social Care.	
2. Impact of Covid-19 on the Health and Adult Social Care Sector	To look at the impact of Covid-19 on the local health and adult social care sector to include: • Considering the capacity of the system • Monitoring the impact on planned surgery waiting lists • Considering planned changes to service delivery as a consequence of the pandemic. • Assessing the impact of the "health debt" due to delays in health screening, cancer treatments, vaccinations etc. • Looking at the local plans for catching up with delayed treatments. • Lessons learned to include looking at how services across the health and adult social care sector have adapted practice to take account of the impact of the pandemic.	<u>Panel meeting 19 August 2021</u> Representatives from Calderdale and Huddersfield NHS Foundation Trust and Mid Yorkshire Hospitals NHS Trust provided an update on the impact of Covid-19 on Acute Hospital Trust. The update was noted and the panel requested a written update on the suspension of the provision of planned inpatient surgery at Dewsbury Hospital.

	• Assessing the broader impact on adult social care including the increased social care needs for older people as a consequence of reduced mobility and access to services and activities during the pandemic. • The impact of long Covid	

3. Integration of Health and Adult Social Care	An overarching theme that covers the move to increasing the integration of services across the health and adult social care sector to include:
	• Looking at the progress and effectiveness of Community Care Services (CCS) in Kirklees.
	• Reviewing progress of the Primary Care Networks (PCNs) to include the effectiveness of their integration with other key services and agencies across the local health and social care network.
	• Assessing the impact of CCS in Kirklees in reducing avoidable A&E attendances; hospital admissions; delayed discharges; and reducing avoidable outpatient visits.
	• To consider the implications of the changes from legislative proposals that are intended to integrate care within the NHS and encourage greater collaboration between the NHS and local government and other agencies to include:
	  ○ How the changes will impact on local commissioning and delivery of service.
	  ○ Considering the changing health and care landscape to include a focus on the progress of collaboration between local providers.
	• To consider the proposals to merge the Gateway to Care Service and the Locala Single Point of Contact Service
		<u>Panel meeting 11 November 2021</u>
		Representatives from Locala provided an update on services delivered by them, including reducing unnecessary hospital admissions and delays in discharge. Locala updated the Panel on the development of the same day urgent/emergency response and the integration of Gateway to Care Service and Single Point of Contact Service.
		
		The Panel requested that the blueprint regarding the integration of services reflect how it felt as a carer and as a community partner.

4. Digital Technology	An overarching theme that looks at the impact of the use of digital technology in the delivery of health and adult social care services.	

5. Mental Health and Wellbeing	An overarching theme that looks at services that focus on providing support in areas that cover mental health and wellbeing to include: • Reviewing progress of the work being delivered through the Kirklees Integrated Wellness Service. • Suicide prevention • Looking at the Council's work in supporting mental health provision across the various localities in Kirklees. • To look in more detail at the services provided by South West Yorkshire Partnership NHS Foundation Trust (SWYPF) to include redesign of services and any post pandemic new initiatives. • Looking at the wellbeing and support for unpaid carers including working carers.	
6. Quality of Care in Kirklees	Receive an annual presentation from CQC on the State of Care across Kirklees to include: • A focus on Adult Social Care • The impact of COVID-19 on the quality of care in Kirklees.	
7. Kirklees Safeguarding Adults Board (KSAB) 2019/20 Annual Report	To receive and consider the KSAB Annual Report to include consideration of the Impact of Covid-19 on safeguarding adults during periods of lockdown.	<u>Panel meeting 7 October 2021</u> The Panel received a presentation on the proposed approach to developing the Kirklees Joint Health and Wellbeing Strategy. The Panel requested that its comments and views on the proposed approach to the Strategy and the high level aspirations and ambitions for the health and wellbeing of the residents of Kirklees be noted.

8. Yorkshire Ambulance Service (YAS) Response Times	To receive an update on performance and demand across all areas of Kirklees to include: • A focus on response times for categories 1 and 2. • Looking at the variances of performance across Kirklees.	Panel meeting 8 July 2021. The Panel received an update on performance, demand and quality in Kirklees. The information provided was noted and the Panel requested that for future updates the data should also include the ambulance pick-up and drop-off times.
9. Kirklees Public Health	An overarching theme that looks at the work of Public Health Kirklees to include: • Continuing to receive regular updates on the impact and response to Covid-19 (to be kept under review) • Assessing the performance of the Immunisation Programmes in Kirklees to include any future coronavirus programmes. • To review the work being done on population health management.	Panel meeting 8 July 2021 Kirklees Public Health presented an update on the local position and response to Covid-19. Actions agreed included: • A request for information on the current rates of covid-19 hospitalisations including the trend in Kirklees; and the current assessment of the impact on people who have been diagnosed with long Covid. • That a further update be scheduled for the August meeting to include a focus on the impact of the proposed removal of national restrictions. Panel meeting 19 August 2021 Kirklees Public Health and Public Protection presented an update on the local position and response to Covid-19. Actions agreed included: • Reviewing the approach to receiving future covid-19 updates.

		• A request for information on the uptake of financial assistance to qualifying individuals who have to self-isolate.
10. Update on Winter Planning	Update on winter preparations 2021/22 from the Kirklees Health and Adult Social Care sector to include: Receiving details from key organisations across the local health and adult social care section on preparations for winter to include the key areas of focus. • lessons learned from the winter period 2020/2021. • feedback and experiences of service users from last winter period.	<u>Panel meeting 7 October 2021</u> Representatives from organisations across the Kirklees Health and Adult Social Care system presented an outline of the work that was being done to prepare for the winter period 2021/22. The information provided was noted. In addition the Panel requested that partners across the local health and adult social care system continue to review risks during the winter period and notify the Panel should any major issues affecting the provision of services occur.
11. Effectiveness of smoking cessation arrangements in Kirklees.	To review the effectiveness of smoking cessation arrangements in Kirklees to include a review on how people with complex mental ill health are supported.	
12. Kirklees Care Homes Programme Board including analysis of the home care market	Receiving an update on progress of the Board to include: • Looking at the key issues and challenges identified by the Board and the actions taken to address them. • Details of the training and support that will be provided to care homes on the verification of expected death, end of life care plans and testing and swab taking.	<u>Panel meeting 11 November 2021</u> Representatives from Kirklees and the CCG attended to update the Panel on the work of the Programme Board which included some of the challenges following Covid affecting how the care home market operates. Agreed actions included:

	• Continue monitoring the outcomes of the analysis of the home care market to include receiving a copy of the final report from Cordis Bright and implementation plan.	• A request for further information relating to current bed occupancy.
13. Healthwatch Kirklees	To develop the working relationship with Healthwatch Kirklees to include sharing of work programmes and identifying local areas of concern to inform the work of the Panel.	<u>Panel meeting 7 October 2021</u> Representatives from Healthwatch provided an update on their workplan. The Panel noted Healthwatch's key areas of work and agreed to continue to share work programmes and monitor local areas of concern.
14. Air Pollution	To assess the health risk associated with air pollution.	
15. Rainbow Child Development Unit at Calderdale and Huddersfield NHS Foundation Trust (CHFT)	To consider proposals to relocate the Child Development Service (CDS) and create a central community hub for families to include co-location with specialist nursing input and community therapies.	<u>Panel meeting 8 July 2021</u> Representatives from CHFT presented the plans to relocate the CDS. The Panel supported the proposals including the Trust's preferred location and requested that the outcomes from the engagement work be presented at a future meeting.
16. Reconfiguration of Bed Capacity in Kirklees supporting with Intermediate Care and Dementia Care	To consider proposals to reconfigure the dementia and Intermediate Care Beds across Moorlands Grange, Castle Grange, Ings Grove House and Claremont House to include a temporary decant of The Homestead Day Service.	

LEAD MEMBER BRIEFING ISSUES	
ISSUE	**AREAS OF FOCUS**
1. Mid Yorkshire Hospitals NHS Trust (MYHT) Ambulatory Emergency Care (AEC) Services and Services provided at Dewsbury and District Hospital (DDH)	Update on the closure of the AEC unit at DDH.
2. Transforming Outpatient Care at Calderdale and Huddersfield NHS Foundation Trust (CHFT) and Mid Yorkshire Hospitals NHS Trust (MYHT)	Receive an update on progress of: • The programme of change at CHFT. • The work being done by MYHT on its Outpatient Care.

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Health & Adult Social Care Scrutiny Panel – Outline Agenda Plan – 2021/22

MEETING DATE	ITEMS FOR DISCUSSION
8 July 2021	1. YAS performance and demand update 2. COVID-19 update 3. Setting the work programme for 2020/21 4. Child Development Service
19 August 2021	1. Impact of Covid-19 on the Health and Adult Social Care Sector 2. COVID-19 update
7 October 2021	1. Healthwatch Kirklees sharing of work programme 2. Update on Winter Planning 3. Health and Wellbeing Strategy
11 November 2021	1. Community Care Services (CCS) in Kirklees 2. Kirklees Care Homes Programme Board Update
7 December 2021	1. CQC – Quality of Care in Kirklees 2. Reconfiguration of Bed Capacity
9 February 2022	1. Mental Health and Wellbeing (details tbc) 2. Review of PCNs (Confirmed) 3. Direct payments (tbc)
10 March 2022	1. Kirklees Public Health (tbc)
14 April 2022	1. Financial position of the Kirklees Health and Adult Social Care Economy (tbc) 2. Review of the Work Programme

All meetings have been scheduled to start at 2:00 pm with a pre-meeting at 1:30 pm

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