ADULT SERVICES COMMITTEE AGENDA

HARTLEPOOL BOROUGH COUNCIL

Thursday 7 July 2016

at 10.00 am

in Committee Room B,
Civic Centre, Hartlepool

MEMBERS: ADULT SERVICES COMMITTEE

Councillors Hamilton, Loynes, Richardson, Sirs, Tempest, Tennant and Thomas.

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS**

3. **MINUTES**

   3.1 To receive the Minutes and Decision Record in respect of the meeting held on 16 June 2016 *(for information as previously circulated)*

4. **BUDGET AND POLICY FRAMEWORK ITEMS**

   No items.

5. **KEY DECISIONS**

   No items.

6. **OTHER ITEMS REQUIRING DECISION**

6.1 Access to Transport for People with a Disability – *Director of Child and Adult Services*

7. **ITEMS FOR INFORMATION**

7.1 Service Provision at the New Centre for Independent Living – *Director of Child and Adult Services*

7.2 Mental Health – Crisis Care – *Director of Child and Adult Services*

7.3 Direct Care and Support Services – Outcome of CQC Inspection – *Director of Child and Adult Services*

7.4 Quality Ratings for Commissioned Services – *Director of Child and Adult Services*

7.5 The Care Quality Commission: Strategy for 2016 to 2021 – *Director of Child and Adult Services*

7.6 Engagement with Older People – *Director of Child and Adult Services*

8. **ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT**

ITEMS FOR INFORMATION

Date of next meeting – Thursday 15 September 2016 at 10.00 am, Committee Room B, Civic Centre, Hartlepool

ADULT SERVICES COMMITTEE

MINUTES AND DECISION RECORD

16 June 2016

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool

Present:

Councillor: Steve Thomas (In the Chair)

Councillors: Lesley Hamilton, Kaylee Sirs, Carl Richardson and Sylvia Tempest

Members of the Public – Evelyn Leck, Sue Little, Stella Johnson and Gordon Johnson

Officers: Sally Robinson, Director of Child and Adult Services
Jill Harrison, Assistant Director, Adult Services
Denise Wimpenny, Principal Democratic Services Officer

1. Chair's Welcome/Expressions of Thanks

The Chair welcomed new and existing Members to the Committee and expressed thanks to Councillor Carl Richardson for the work he had undertaken as Chair of this Committee over the years and his future support as Vice-Chair of this Committee

2. Apologies for Absence

Apologies for absence were submitted on behalf of Councillors Brenda Loynes and John Tennant.

3. Declarations of Interest

Councillor Steve Thomas declared a personal interest in Minutes 5,6, 7 and 8 as an employee of Healthwatch.

4. Minutes of the meeting held on 23 March 2016

Received

5. Impact of the Better Care Fund (*Director of Child and Adult Services*)

Type of decision

No decision required – for information

Purpose of report

To provide the Committee with an update on the impact of the Better Care Fund in 2015/16 and plans for 2016/17.

Issue(s) for consideration

The report provided the background to the provision of the Better Care Fund (BCF) along with the associated criteria and performance measures for the Fund. BCF performance reports had been submitted to NHS England on a quarterly basis throughout 2015/16 with the final return submitted on 27 May 2016. Quarterly reports had been signed off by the Health and Wellbeing Board in line with national requirements.

In terms of the impact of the BCF during 15/16, Members were referred to the outcome of performance targets and key achievements as detailed in the report.

In the discussion that followed presentation of the report, the Assistant Director responded to queries raised in relation to the performance targets. Clarification was provided regarding the delayed transfers of care from hospital target, choice arrangements for permanent admissions to residential and nursing care homes and progress made to date with regard to weekend working service provision. In response to concerns regarding nursing bed provision, the Chair provided assurances that the Council as well as Healthwatch Hartlepool had highlighted this issue with Commissioners for a number of years and the Committee would continue to closely monitor this issue during the year.

In relation to the increase in use of assistive technology, whilst an increase in its use and the positive feedback from people accessing the service was welcomed, Members were of the view that such technology should not replace human contact. Some concerns were raised that some individuals were not aware that technology of this type was available and emphasised the need to increase awareness of such services. It was suggested that in addition to information being available via the Hartlepool Now website alternative methods of promoting the services available should be utilised including the Hartbeat magazine.

Emphasis was placed upon the need to monitor costs associated with the Better Care Plan. Whilst in support of the principles of the Better Care Plan, concerns were raised in terms of the financial impact on the Council as a result.

Decision

(i) That performance to date in relation to the BCF and plans for 2016/17 be noted.
(ii) That alternative methods of promoting services available to the public be utilised to include the Hartbeat magazine.
(iii) That the costs associated with implementing the Better Care Plan and financial impact on the Council be closely monitored.

6. Tackling Social Isolation (*Director of Child and Adult Services*)

Type of decision

No decision required – for information

Purpose of report

To provide the Committee with an update on work that was underway to tackle social isolation.

Issue(s) for consideration

The Assistant Director referred to the Committee's previous interest in what was being done within Hartlepool to tackle social isolation due to the potential impact this could have on vulnerable adults. The report provided background information in relation to research reported by Age UK and a research briefing by the Social Care Institute of Excellence (SCIE) regarding the effects of loneliness and isolation.

The Hartlepool BCF Plan included a commitment to help identify and combat social isolation, as a major influence on overall "health and wellbeing" and identified that an estimated 2,340 older people lived alone in Hartlepool. The recent national survey of users of adult services had been asked whether people had as much social contact as they would like and whilst the results for Hartlepool identified a significant improvement compared to the previous year there were currently some people who were not known to services who may be experiencing social isolation.

The Chair highlighted that this issue would be a high priority for this

Committee as well as the Health and Wellbeing Board in the ensuing year.

Members were pleased to note developments to date particularly the establishment of a befriending network, the benefits of which were discussed. A Member advised that social isolation was not just an issue for the elderly but also affected children and young people. The need to feedback this issue to the Chair of Children's Services was suggested.

In response to a request for clarification in relation to the level of interest that had been received on the befriending network contract, the Assistant Director advised that this was currently going through the quick quotes process, and an update on the outcome would be provided at a future meeting.

A lengthy discussion ensued during which personal observations/experiences were raised regarding social isolation and loneliness issues. Whilst it was suggested that social isolation appeared to be more prevalent in males, it was noted that demographically there were more older females living alone than males. The potential links between loneliness and alcohol related problems was also discussed. The need to increase awareness and promote the type of support services available as widely as possible was highlighted. The various methods of promoting services such as the "Men's Shed project" were discussed. The benefits of displaying leaflets in funeral parlours and supermarkets was also highlighted. The Assistant Director commented on the ongoing work with the CCG in terms of establishing better links with GP's in relation to early intervention and the wider BCF objectives.

In response to a request for clarification regarding engagement with older people, the Assistant Director outlined the various forums and groups that had been established to facilitate this. The Chair reported that effective communication and engagement was integral to the work of this Committee and referred to forthcoming community engagement events. Members were advised that luncheon club providers would be attending the next consultation event to facilitate a question and answer session.

Decision

(i) The Committee noted the current provision to tackle social isolation and developments that were planned, and receive a further progress update in six months.
(ii) The issue of social isolation in children and young people particularly those involved in providing care for a family member be reported to the Chair of Children's Services Committee.
(iii) That the various support services available in relation to social

isolation be promoted as widely as possible.

(iv) That an update on the befriending network contract be provided at a future meeting.

7. Impact of the Changes to the Independent Living Fund (*Director of Child and Adult Services*)

Type of decision

No decision required – for information

Purpose of report

To provide the Committee with further information regarding the impact of changes to the Independent Living Fund (ILF).

Issue(s) for consideration

The Assistant Director reported on the background to the transfer of funding and responsibilities relating to the Independent Living Fund (ILF) from July 2015. Details of how the Council had managed the new responsibilities were provided as set out in the report. The approach agreed in Hartlepool resulted in no impact on existing ILF users in 2015/16, through maintaining the status quo in terms of both expenditure and contributions.

The report set out the impact of the changes on local authorities. The Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS) raised a range of concerns about this situation in a consultation by the Department for Communities and Local Government earlier in the year, details of which were included in the report. There was an ongoing risk that the rate of reduction in funding from estimated attrition levels was greater than the actual reduction through attrition. This could result in insufficient grant funding being received to cover the cost of former ILF packages.

The Committee was advised that following the consultation, it had been confirmed that the former ILF recipient grant would be paid to local authorities as outlined in the consultation document. The Government's response to the consultation was attached at Appendix 1. Allocations for Hartlepool over the next four years had been confirmed and represented a 3% reduction year on year.

The Committee expressed a number of concerns in relation to the 3% proposed reduction in funding highlighting the impact on the most vulnerable groups as a result.

Decision

The Committee noted the outcome of the DCLG consultation regarding funding for former ILF recipients and the wider impact of the changes to the ILF.

8. Update: Care Homes for Older People (*Director of Child and Adult Services*)

Type of decision

No decision required – for information

Purpose of report

To provide the Committee with an update in relation to care home provision for older people.

Issue(s) for consideration

The Assistant Director, Adult Services reported on the background to the meeting on 12 October 2015, when representatives from the Care Quality Commission (CQC) and Hartlepool and Stockton on Tees Clinical Commissioning Group had provided a presentation to the Committee in relation to care home provision.

Attached as an appendix to the report was an update of CQC ratings of the care home sector in Hartlepool. Information in this format would be shared with the Committee on a regular basis. A range of actions were being taken to support and improve standards within care homes, details of which were included in the report.

Some concerns were raised in relation to out of borough placements. The Assistant Director advised that some out of borough placements were based on positive choices made by individuals and families. In response to a request for clarification the Committee was advised of the financial implications of out of borough placements. A Member referred to discussions at a recent meeting of this Committee in relation to the suggestion that in-house care provision be considered. The Assistant Director advised that work was currently ongoing regarding different models of provision, an update of which would be reported to the meeting in September. A Member was keen to receive an update on this issue at all future meetings.

Further concerns were reiterated in relation to the increased costs that the local authority would have to meet in relation to Adult Social Care

given the continued reduction in funding by Central Government.

In response to a query raised in relation to homes rated as "inadequate" by the CQC, details of the re-inspection process was outlined. Reference was made to the impact of care home closures resulting in a large intake of additional residents by one particular care home as reported at a previous meeting. Assurances were sought that arrangements were in place to prevent any reoccurrence of situations of this type.

Following a request from a Member, an update on the latest position on the former Admiral Court site was provided. A query was raised in relation to the number of nursing care beds available in Hartlepool which the Assistant Director agreed to provide details of the current position under separate cover following the meeting.

Decision

(i) That the contents of the report be noted and further updates be received on a regular basis.
(ii) That information on the current position in relation to the number of nursing care beds available in Hartlepool be provided under separate cover following the meeting.

The meeting concluded at 11.25 am.

P J DEVLIN

CHIEF SOLICITOR

PUBLICATION DATE: 23 JUNE 2016

ADULT SERVICES COMMITTEE

7 July 2016

Report of: Director of Child and Adult Services

Subject: ACCESS TO TRANPSORT FOR PEOPLE WITH A DISABILTY

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1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 Non-key decision.

2. PURPOSE OF REPORT

2.1 To seek approval from the Adult Services Committee to submit a referral to the Audit and Governance Committee regarding access to transport for people with a disability.

3. BACKGROUND

3.1 Hartlepool Borough Council is committed to supporting local citizens through effective consultation. Transport and access to transport within the Borough is regarded as one of the top three priorities when consulting with adults with a disability.

3.2 Consultation with community groups in recent years has highlighted a decline in the number of wheelchair accessible vehicles, a decline in the frequency and equality of access to private hire vehicles and bus journeys; and difficulties in access and conveyance.

3.3 The Equality Act 2010 came into force on 1 October 2010and most land transport is covered by the rules on services to the public in Equality Act Part 3, with greater exceptions for ships and aircraft.

3.4 The Disability Rights Commission (DRC) issued a statutory Code of Practice Provision on use of transport vehicles in 2006. This sets out in some detail how the DRC saw the transport rules working under the former Disability Discrimination Act 1995 (DDA).

3.5 Even though the DDA has now been superseded by the Equality Act 2010, it has been referred to in past cases and is likely to be taken into account by the courts where relevant

4. LOCAL POSITION & PROPOSAL

4.1 Transport should be accessible for everyone. Accessible buses, coaches, trains and taxis make it easier for people to visit friends, get to the shops or to work, enabling people to play an active role in their communities and reducing the risk of social isolation.

4.2 Following discussions with local citizens, including representatives from the New Hartlepool MS Support Group, it has become apparent that people are concerned at the reduction in opportunities for people to remain independent. Without access to good transport links, people are at increased risk of social isolation and are unlikely to be able to remain active citizens without opportunities to access education training and employment, sport and recreation.

4.3 As this issue cuts across a number of policy committees, and would benefit from further investigation, it is proposed that a referral is made to the Audit and Governance Committee to review the current situation. A copy of the referral is attached as **Appendix 1**.

5. RISK IMPLICATIONS

5.1 There are no risk implications identified associated with this report

6. FINANCIAL CONSIDERATIONS

6.1 There are no financial implications identified associated with this report

7. LEGAL CONSIDERATIONS

7.1 There are no legal consideration identified associated with this report

8. CHILD AND FAMILY POVERTY CONSIDERATIONS

8.1 There are no child and family poverty considerations directly associated with this report but it is recognised that access to transport is a key factor in enabling people with disabilities to access employment opportunities.

9. EQUALITY AND DIVERSITY CONSIDERATIONS

9.1 The Council is required to work within the principles of the Equality Act and where it procures, provides or promotes transportation within the Borough it must consider the impact of its services for people with a disability, ensuring equality of access to transport as prescribed within the Disability Rights Commission Code of Practice.

10. STAFF CONSIDERATIONS

10.1 There are no staffing considerations associated with this report

11. ASSET MANAGEMENT CONSIDERATIONS

11.1 There are no asset management consideration associated with this report.

12. RECOMMENDATION

12.1 That the Adult Services Committee agree to submit a referral to Audit and Governance to review access to transport for people with a disability.

13. REASONS FOR RECOMMENDATIONS

13.1 Consultation with community groups in recent years has highlighted a decline in the number of wheelchair accessible vehicles, a decline in the frequency and equality of access to private hire vehicles and bus journeys; and difficulties in access and conveyance.

14. BACKGROUND PAPERS

HBC Audit and Governance Committee: A Quick Guide to Referrals

15. CONTACT OFFICER

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Referral to Audit & Governance Committee: Access to Transport for People with a Disability

Referral from: **Cllr Stephen Thomas**
Chair of Adult Services Committee

Background

Hartlepool Borough Council is committed to supporting local citizens through effective consultation. Transport and access to transport within the Borough is regarded as one of the top three priorities when consulting with adults with a disability. Consultation with community groups in recent years has highlighted a decline in the number of wheelchair accessible vehicles, a decline in the frequency and equality of access to private hire vehicles and bus journeys; and difficulties in access and conveyance.

Statutory Requirements

The Equality Act 2010 came into force on 1 October 2010 and most land transport is covered by the rules on services to the public in Equality Act Part 3, with greater exceptions for ships and aircraft.

The Disability Rights Commission (DRC) issued a statutory Code of Practice on provision and use of transport vehicles in 2006. This sets out in some detail how the DRC saw the transport rules working under the former Disability Discrimination Act 1995 (DDA).

Even though the DDA has now been superseded by the Equality Act 2010, it has been referred to in past cases and is still taken into account by the courts where relevant.

Disabled Persons Transport Advisory Committee

The Disabled Persons Transport Advisory Committee (DPTAC) advises the government on transport legislation, regulations and guidance and on the transport needs of disabled people, ensuring disabled people have the same access to transport as everyone else. On 12 June 2013, it was decided to retain DPTAC to advise the Department for Transport on accessibility issues relating to disabled people.

Reasons for Referral

Transport should be accessible for everyone. Accessible buses, coaches, trains and taxis make it easier for people to visit friends, get to the shops or to work. Following discussions with local citizens it is apparent that they are concerned at seeing a reduction in the number of opportunities for people to remain independent. Without access to good transport links people are at increased risk of social isolation and are unlikely to be able to remain active citizens without the opportunity to access education training and employment, sport and recreation.

Objectives of Statutory Scrutiny Process
Hartlepool Borough Council is required to work within the principles of the Equality Act and where it procures, provides or promotes transportation within the Borough it must consider the impact of its services for people with a disability, ensuring equality of access to transport as prescribed within the DRC code of practice.

Useful Links
www.gov.uk/transport-disabled/cars-buses-and-coaches
www.drc.org.uk/services_and_transport.aspx

Timescales for Reporting Back to the Referring Body
The referrer requests that the Audit and Governance Committee consider this referral and if agreed, would suggest a report back within 10 weeks to enable sufficient time for members to consider the local position in relation to statutory duties under the Equality Act 2010.

This issue is not being dealt with by another committee.

ADULT SERVICES COMMITTEE

7 July 2016

Report of: Director of Child and Adult Services

Subject: SERVICE PROVISION AT THE NEW CENTRE FOR INDEPENDENT LIVING

1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 No decision required; for information.

2. PURPOSE OF REPORT

2.1 To provide Adult Services Committee with information on the range and type of services that will be delivered from the new Centre for Independent Living (CIL).

3. BACKGROUND

3.1 Members will be aware of the development of a new CIL which is due for completion in the autumn of 2016 following consultation and approval in 2014.

3.2 A report presented to members on 6 July 2015 provided an overview of the proposed process to implement a new service model and pricing framework from September 2016. The fairer pricing framework was agreed at a meeting on the 23 March 2016, and the Adult Services management team has been in discussion with staff side representatives through formal consultation in respect of the future delivery of services.

4. PROGRESS

4.1 A telephone consultation was conducted with 91 family carers on 17 and 18 September 2015. Family carers were given an update on the proposed changes within day services and the interim arrangements in the event of service disruption during the construction of the new CIL.

4.2 A presentation at the Hartlepool Learning Disability Partnership Board on 20 November 2015 gave people a brief overview of the existing pricing framework and provided information on some of the new proposed services.

4.3 The purpose of the engagement undertaken to date was to provide details of the proposed Fairer Pricing Framework and to put forward proposals for a new service model that could operate across 7 days over three sessions, namely 9.00am – 12.30pm, 12.30pm to 4.00pm and 4.00pm to 7.30pm. Delivery of services over seven days and provision of evening sessions would be developed incrementally over time, and subject to identified need.

4.4 In addition to this proposal was the consideration of how individuals deploy their resource allocation to meet their need for transport. The Council's Integrated Transport Unit (ITU) offers specialist support for those with specific mobility issues, as well as the 'Safe on the Move in Hartlepool' scheme.

4.5 All existing service users have individual transport plans. There is potential for people to travel using alternative transport with staff support, and these options continue to be explored on an individual basis.

5. FINDINGS FROM ENGAGEMENT WITH STAFF

5.1 Communication meetings have been held on 13 November 2015 and 15 January 2016 and a further staff development day took place on 3 May 2016 with the day opportunities staff. An outline of the type of services to be delivered from the CIL was presented and staff contributed to the suggestions put forward by the management team.

5.2 Formal consultation with staff commenced on 23 May 2016. This described the scope of service delivery, suggested a proposed restructure of the staff team and provided detail on services that will lease space at the new CIL.

6. PROPOSED SERVCE DELIVERY – CIL

6.1 The CIL is focused on supporting three distinct functions.

Meeting service demand – providing a range of day opportunities for people with learning or physical disabilities.

Increasing Income – making best use of the CIL as a community resource by encouraging the use of its facilities and leasing office space to local organisations.

Promoting Independence – providing information advice and guidance to Individuals and their carers to ensure they have the information they need, when they need it, by a route that meets their needs.

7. MEETING SERVCE DEMAND

7.1 The table below provides details on the reduction in the number of people with learning disabilities or physical disabilities attending HBC day services over the last 6 years.

Data	Sep 2010	Jan 2016	Predicted Sep 2016	Decrease Sep 2010-2016
Average Daily Attendance (PD)	36	6	9	75%
Average Daily Attendance (LD)	109	63	50	54%
Total Number of people supported (PD)	43	17	15	65%
Total Number of people Supported(LD)	179	97	79	56%
Average No of staff per day	26	25	20	23%

7.2 There are several factors behind this decrease over the last several years. The implementation of the Direct Payment Act which prohibited the use of direct payments for the purchase of Local Authority provision saw an initial reduction in attendance and marked a significant change in community care as people chose to exercise their rights to purchase more individualised support.

7.3 More recently since 2006 Child & Adult Services have supported people via personal budgets and this approach was further reinforced with the implementation of the Care Act 2014. Over the years there has also been an increase in the number of providers to the market offering alternatives to traditionally run day services.

7.4 Another factor of note is the increase in the number of people who are supported into employment. At present around 16% of people with a learning disability are in paid employment within Hartlepool; more than twice the national average.

7.5 **Appendix 1** provides an overview of the proposed model that will be delivered from the new CIL and the Waverley Terrace Allotment project.

7.6 The reduction in numbers also coincides with an increase in complex needs for some individuals, meaning that the service is now supporting a smaller number of people who have increasingly complex needs and / or autism. These individuals have significant support needs that can require high staffing levels and access to specialist equipment and resources.

7.7 The new facilities at the CIL will enable the service to offer more specialised services for adults with autism and the building will be designed to meet good practice standards for people with autism.

7.8 Due to the increase in numbers of people who present with complex physical needs, additional space and equipment will be available at the new CIL to meet service demands, including a new hydrotherapy suite, improved changing facilities, rebound therapy and a relaxation suite.

7.9 Dementia in older adults with a learning disability is increasing and the new CIL has also been designed to be dementia friendly

8. INCREASING INCOME

8.1 The new CIL will have increased capacity to facilitate both training and public meetings. The facility boasts 2 meeting rooms and a large conference hall equipped to support most community and private functions.

8.2 Child & Adult Services officers are discussing a range of options with Regeneration and Neighborhoods in respect of the catering and bistro arrangements with a view to ensuring effective use of resources.

8.3 At present the existing CIL provides a venue for a number of Adult Education and Child & Adult courses, it is envisaged this will increase as the venue will become a more attractive resource.

8.4 The service aims to encourage new business by promoting the services to a wider audience encouraging local businesses to use the resources to facilitate their own training requirements.

8. 5 In the months leading up to the opening of the new CIL there will be a number of events to market, support and communicate the range of amenities on site, with a view to maximising income.

9. PROMOTING INDEPENDENCE

9.1 The CIL will be host to a number of providers whose primary aim is to promote independence and citizenship. A number of services and organisations have already confirmed their intention to move to the new CIL.

9.2 At the time of writing this report the following organisations have confirmed their commitment to lease space in the new CIL:

- Incontrollable CIC- A disabled persons user led organisation
- Thirteen Housing - Telecare call monitoring
- Tees Esk & Wear Valley NHS FT - learning disability services
- Durham County Council - Occupational Health services (HBC)
- My Life Ltd - Provider of health and social care services in Hartlepool.

9.3 In addition to those services leasing office space, a number of services aimed at promoting independence will be delivered from the new site including.

- Direct Care & Support Services - Intermediate & Telecare services
- HBC Day Opportunities Provision - see **Appendix 1**.
- HBC - Trusted Assessor / Community Adaptation Service, providing people with practical support and assessments for aids to promote independent living.

10. WARREN ROAD

10.1 Services will cease to be delivered from Warren Road following the opening of the new CIL. The department is in discussion with Catcote Academy who have expressed an interest in using the site to meet demand for autism specific provision. A concordat is being drafted to ensure that the service complements the range of services being provided at the new CIL. It is envisaged that, if this development is supported, a lease agreement will be drafted with any services commencing from January 2017. Any such proposals will be presented to Finance and Policy Committee.

11. HANDPRINT ARTS

11.1 It is the intention of the service to end the lease agreement for the services delivered from Handprints Arts, currently based at Surtees Street, in November 2016. The lease agreement ends in November and the service will move to the new CIL.

12. WAVERLEY TERRACE ALLOTMENTS

12.1 On 8 June 2015 a report presented to Adult Services Committee provided an update to members on behalf of the Waverley Allotment Group (WAG) Promoting Change, Transforming Lives Project and informed members of recent success at the National Gardening Against the Odds awards and the Best of Hartlepool Awards.

12.2 The service remains an important part of the day opportunities offer and 12 months on from being awarded the grant the site has completed the building work linked to the capital element of the Big Lottery Grant. The capital element has seen the introduction of new accessible changing facilities and welfare suite, a new accessible classroom / teaching unit and improved car parking facilities on the site, as well as improved utilities (power and water).

12.3 A new project manager and volunteer coordinator have since been recruited and will lead on the ambition to develop the site and create employment, education and training opportunities for adults with disabilities and the wider community. An official opening is planned for August 2016

13. RISK IMPLICATIONS

13.1 There remains a risk with any proposed changes that people will choose to seek services from other trusted providers. The CIL and associated activities have been developed following extensive consultation over a number of years. Whilst they do not intend to meet the needs of all people with disabilities, the aim is to fill gaps in the existing market as part of a range of service offers for people with disabilities.

14. FINANCIAL CONSIDERATIONS

14.1 Adult Services Committee agreed on 23 March 2016 to implement a fairer pricing framework for day services and the new framework will be implemented from September 2016. This provides a fair and equitable model with a clear rationale for the cost of services, meals and transport.

14.2 There remains a risk, as with any service, that if prices are deemed too high some individuals may choose to use their resource allocation and purchase from other providers and cease to attend the day service. It is not anticipated that the fairer pricing framework will result in this happening. If there is any such impact, the service will need to respond by attracting new users and / or reducing overhead costs.

15. LEGAL CONSIDERATIONS

15.1 There are no legal considerations associated with this report.

16. EQUALITY AND DIVERISTY CONSIDERATIONS

16.1 The fairer pricing framework aims to provide a fair and equitable cost, based on the needs of an individual and the level of care and support they require.

16.2 All people accessing the service who meet the eligibility criteria set out in the Care Act 2014 will have an individual transport plan. This will provide a range of transport options for consideration and recommend the most suitable option, linked to greater independence where possible.

16.3 The new CIL is being purpose built and is compliant with existing legislation. The service will have an accessible changing place, specialist mobility equipment such as overhead hoists and is being designed to meet the needs of people with autism and dementia in terms of layout and interior furnishings.

16.4 Capital investment at Waverley Terrace Allotment has also focused on improving access and welfare whilst on site

17. STAFF CONSIDERATIONS

17.1 Formal consultation is underway in respect of proposed changes to day opportunities provision at the CIL, in light of potential extended opening hours and changes to the future service delivery (see **Appendix 1**).

17.2 A 12 month pilot is underway exploring the benefits of 7 day working for the Learning Disability Social Work team. The teams remain co-located with TEWV NHS FT staff and services will transfer across to the new CIL. TEWV NHS FT operate across 7 days providing community support with a view to preventing placement breakdown, and preventing hospital admissions.

17.3 Formal consultation has concluded in respect of changes to expand the telecare service, the service will operate from the new CIL and staff will be collocated with Thirteen Housing staff who provide equipment installation and call monitoring for the Telecare service.,

18. ASSET MANAGEMENT CONSIDERATIONS

18.1 The future use of the Warren Road site is being considered with a third party (Catcote Academy) that is interested in taking over the lease of the site. It is envisaged that a Memorandum of Understanding and lease agreement will be developed over the summer with a view to enabling Catcote Academy to commence the delivery of services from January 2017.

19. RECOMMENDATIONS

19.1 It is recommended that the Adult Services Committee notes plans for service provision at the new Centre for Independent Living

20. REASONS FOR RECOMMENDATIONS

20.1 Services for people with disabilities will be enhanced through the development of a new purpose built CIL and new facilities at Waverley Terrace Allotments.

21. CONTACT OFFICER

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Appendix 1

Proposed Provider Services Structure (September) 2016

DAY OPPORTUNITIES ACTIVITY OVERVIEW

Support to People with Complex Needs or Autism	Employment, Education and Training	Health and Independence (Condition Management) Leisure and Community Engagement
Provision of Therapeutic activities:- •Multi-sensory stimulation •Relaxation •Physiotherapy •Hydrotherapy •Music therapy) •National Autistic Society accreditation •Independent living skills •Community based opportunities •Communication skills •Positive Behavioural Support	**In partnership with Adult Education** •Employment preparation training •Independent travel training •Literacy and Numeracy programme •Voluntary work •Paid work support (in the workplace) •Horticultural and Social Enterprise •Entry Level NVQ •Improving communication	**In partnership with Public Health** •Healthy Heart programmes •Weight management •Cooking skills •Dementia support programmes •Relaxation techniques •Exercise and health promotion •Stress and Anxiety management •Accessing community activities •Short Breaks – Mini breaks

ADULT SERVICES COMMITTEE

7 July 2016

Report of: Director of Child & Adult Services

Subject: MENTAL HEALTH - CRISIS CARE

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1. TYPE OF DECISION/APPLICABLE CATEGORY

No decision required; for information.

2. PURPOSE OF REPORT

2.1 To provide an update to the Adult Services Committee on the progress in respect of Mental Heath - Crisis Care.

3. BACKGROUND

3.1 A number of key framework documents have been produced in recent years in relation to mental health services. These documents look at supporting improvement across all sectors and are heavily influenced by social inclusion perspectives.

3.2 Key documents include, but are not limited to, the following:-

- **NHS Outcomes framework** 2013/14 - Improving experience of healthcare for people with mental illness
- **Adult Social Care Outcomes Framework** 2013/14 – people who use services are satisfied with their care
- **Public Health Outcomes Framework** 2013/16 – Suicide rates
- **No Health without Mental Health** 2011 – most people will have good mental health
- **Closing the Gap** – improved access to Psychological therapies

- **Mental Health Crisis Care Concordat** 2014 – Access to support before crisis point

- **Five Year Forward view for Mental Health 2016 -** A report from the Independent Mental Health Taskforce to NHS England

3.3 This report provides an update on the work undertaken in Hartlepool in relation to the Mental Health Crisis Concordat and summarises the recommendations from a Crisis Care Summit.

4. PROGRESS

4.1 The Hartlepool Mental Health Forum aims to promote collaborative working across statutory, private and voluntary sector organisations in partnership with people who use mental health services, their carers and families.

4.2 The forum is tasked with monitoring progress against the Hartlepool Mental Health Implementation plan and is chaired by Healthwatch Hartlepool with representation from Hartlepool Borough Council, Hartlepool and Stockton on Tees Clinical Commissioning Group, Tees Esk & Wear Valley NHS Foundation Trust, local stakeholders from the private and voluntary sector as well as service users and carers.

4.3 On 25 February 2016 Hartlepool Healthwatch held an event at the Centre for Independent Living focused on Mental Health Crisis Care. The event was attended by over 70 people from a number of statutory and non statutory providers, all of whom had an interest in mental health crisis care.

5. CRISIS CARE CONCORDAT

5.1 The crisis care concordat makes reference to 4 key themes:

1. Access to support before crisis point
2. Urgent and emergency access to crisis care
3. Quality of treatment and care when in crisis
4. Recovery and staying well.

5.2 The Crisis Care Summit aimed to pick up the key issues in terms of what currently works well, areas for improvement and what was important to change in the future.

6. CRISIS CARE SUMMIT - FEEDBACK

6.1 The table below provides an overview of what people felt was working well:

Crisis	Access	Quality	Recovery
Quick response with Police and Street Triage	Charities working to support people	Mental Health Awareness Training	Fire Safety checks
A&E have Mental Health experts	Common Assessment Framework	Support networks, includes families views	Hartlepool Now
Urgent appointments within 4 hours	Voluntary organisations and signposting	Police – very polite, supportive and treat people with dignity	Improved accommodation for people
Links between acute and mental health trusts	GPs receptive to voluntary sector requests	Trained peers with Mindskills	Medication reviews
Reduction in arrest rates	Community are more helpful	TEWV purpose built facilities	Collaborative care plans
Police awareness of issues and ongoing referrals	Professionals know who can help	Police and NHS partnerships (street triage)	Multi-agency working
Good access to training	More talk about Mental Health in media	Bradley Report – equality of access	Information and Advice
Work of providers in Hartlepool	Better technology and information	Street Triage	NHS Trust values
24hr 7 day crisis team	Mindskills – reduce crisis use	Crisis Assessment Suite	

6.2 It was important to ensure that what was working well was captured and that progress made against the Crisis Care Concordat was acknowledged.

6.3 The table below provides a brief overview of what people in Hartlepool felt was not working well, the key themes and root causes:

Crisis	Access	Quality	Recovery
Awareness, access and Knowledge	**Lack of Awareness of provision**	**Consistency in provision of Assessment and Treatment**	**knowledge & Understanding**
Crisis centre is not local	Lack of awareness or services	Inconsistency of response	Placements are often out of area
What is a crisis	Managing crisis with no extra resources	Overstretched resources	Stigma of mental health
Implementing Concordat work	Poor or no response	More collaboration	Information and awareness
Information not available to everyone	People who experience poor mental health when substance misuse is linked	Police unaware of provision	Language and cultural barriers; hard to reach groups
Lack of support and funding	Consistency across services	GP reluctance to access Mental Health services	Support during recovery, isolation
Education in Schools	Lack of Collaboration	Can technology be used better	GP support

6.4 The key themes and root causes were discussed and priority actions to address what was not working were agreed as set out below:

Crisis	Access	Quality	Recovery
Awareness, access and Knowledge	**Lack of Awareness of provision**	**Consistency in provision of Assessment and Treatment**	**knowledge & Understanding**
Operational policy on self referrals to be reviewed	Develop a leaflet to be displayed in key facilities	Collaboration, multi agency approach and central Hub for signposting	Develop a one page info sheet for GPs

Ensure there are a variety of methods of communication with people including non IT solutions.	Mental Health Road show in popular venues, e.g. shopping centre, college	Expansion of Crisis Team, 24/7 dedicated crisis line, information, advice and signposting	Use data to better understand which services are having a positive impact
Revise the Crisis pathway	Awareness sessions in Secondary Schools	GP services to develop a 'mental health champion'	Families and cares support and information
Parity of provision across Tees	Lunch and Learn sessions for GPs	Street Triage / Crisis team, increase capacity cover 24/7	Awareness raising about staying well.
	Stigma – change our language focus on 'emotional wellbeing'		

6.5 The full report is attached as **Appendix 1**.

7. SUMMARY

7.1 **Appendix 1** (pages 23-27) provides a summary of progress against the Crisis Care Concordat and a number of actions will be incorporated into the Mental Health Forum action plan.

7.2 It is proposed that the Mental Health Forum will work with all agencies to monitor progress against the recommendations and this will form the basis of a response back to the National Concordat action plan, via the Tees Crisis Care Concordat Working Group.

8. RISK IMPLICATIONS

8.1 There are no risk implications identified associated with this report

9. FINANCIAL CONSIDERATIONS

9.1 The Crisis Care Concordat suggests that by identifying a crisis early, professionals can prevent further escalation and often costly and unnecessary interventions. This could support a constrain on future spend.

10. LEGAL CONSIDERATIONS

10.1 The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

11. CHILD AND FAMILY POVERTY CONSIDERATIONS

11.1 There are no child and family implications linked specifically this report although it is recognised that mental health issues can impact on an individual's ability to access and maintain employment. Supporting people in a mental health crisis is part of a wider agenda to support people with mental health needs to play an active role in their local community and to access and maintain employment.

12. EQUALITY AND DIVERSITY CONSIDERATIONS

12.1 Implementation of the Crisis Concordat should have a significant impact on groups of people who might be described as having protected characteristics. People will benefit from a more co-ordinated and efficient response in the event of needing assistance from a range of agencies in a time of crisis.

13. STAFF CONSIDERATIONS

13.1 There are no staffing implications within this report.

14. ASSET MANAGEMENT CONSIDERATIONS

14.1 There are no asset management implications within this report.

15. RECOMMENDATIONS

15.1 It is recommended that the Adult Services Committee;

- note the recommendations from the Crisis Care Summit and progress against the Crisis Care Concordat;
- note that the report will be presented to the Tees Crisis Care Concordat meeting for inclusion in the Tees action plan; and
- note that the Mental Health Forum will progress the implementation of recommendations from the report and monitor progress against the Crisis Care Concordat action plan.

16. REASONS FOR RECOMMENDATIONS

16.1 The Working Together for Change - Mental Health Crisis Care Concordat recommendations aims to improve services for people with mental health needs who experience a crisis.

17. BACKGROUND PAPERS

17.1 Hartlepool Crisis Care Concordat action plan

http://www.crisiscareconcordat.org.uk/areas/hartlepool

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Working Together for Change

Mental Health: Crisis Care Concordat

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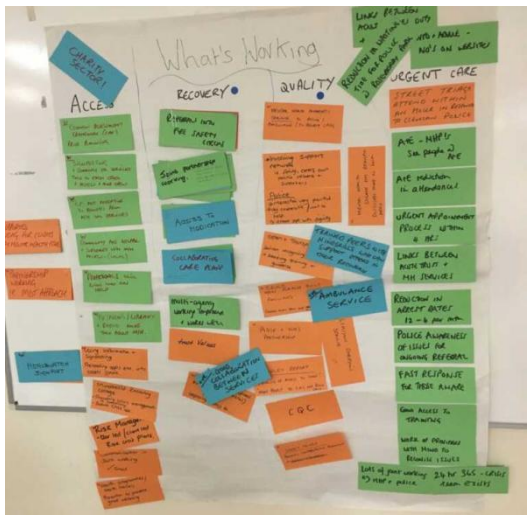
Summary

This report covers work completed in relation to understanding Mental Health Crisis Care, and is linked to the work already underway in respect of the Crisis Care Concordat. Using the Working Together for Change (WTfC) methodology we detail the activity undertaken so far against each of the eight steps of WTfC including a summary of key learning and outcomes and recommendations for next steps.

The report is written both to provide a record of work completed and to assist with local capacity building for using WTfC in Hartlepool. As such, it fits with our developing standards of best practice for delivering and reporting WTfC.

We wish to thank everyone who attended the event for their enthusiastic involvement in this work and for the time and energy people have committed to making this project a great success. In particular we would like to thank members of the Mental Health Forum and the speakers and facilitators on the day for their involvement throughout.



Background

About Working Together for Change

WTfC is a tried and tested approach to coproducing change with local people and harnessing the energy and intelligence from that process to drive commissioning and service development activity. It can help to make better use of scarce resources, improve productivity and lead to better outcomes for people by ensuring services provide the things people want and need in the way that makes most sense to them.

WTfC goes significantly beyond consultation, towards empowering people to play a leading role in determining the changes and improvements they want to see. It has been recognised as national best practice and is being used across the country in a wide variety of settings as well as internationally as a tool for delivering inclusive change in health and social care settings.

WTfC uses person-centred information, most commonly collected from reviews or action plans, to shine a light on what is working well for people, what is not working so well and what might need to change for the future. The process is structured, tightly facilitated and highly engaging. Commissioners, providers and people with support needs, their carers and families work together to analyse and understand what the information is telling them and to plan what actions they will take as a result.

The eight steps of WTfC

1. **Preparation**: Deciding the scope of work, how information will be collected and quality assured and who needs to be involved;
2. **Gathering information**: Collecting person-centred information from reviews, support plans or specially designed questionnaires;
3. **Recognising themes**: Working together to cluster information and identify common issues;
4. **Understanding why**: Thinking together about what the root causes might be for things that aren't working for people;
5. **Identifying success**: Agreeing what success would look like from different perspectives (people with support needs, commissioners and providers) if these issues were resolved;
6. **Planning for change**: Developing ideas, evaluating options and agreeing the actions that will make a difference for people;

7. **Making it happen**: Implementing plans and seeing them through;
8. **Learning and review**: Evaluating the impact, communicating the results and recording the outcomes.

The process is scalable, highly flexible and applicable at all levels of change. From a social enterprise using it for their business planning, to a commissioning authority using it for a service review, right through to a locality using it to plan how a range of partners can take action on a crosscutting issue. At each of these levels, WTfC has proven to be able to make a reality of commissioning and service design that is driven by people with support needs, their carers and families.

Our thanks to Groundswell

Groundswell works with health and social care organisations to transform support and improve people's lives. Groundswell provided the initial support and training to enable our facilitators to run reviews independently. Groundswell support sustainable change in organisations through personalisation and community based support and are committed to sharing learning and spreading innovation across the sector.

Groundswell Directors led the development of WTfC in partnership with HSA while in previous roles for the Department of Health and Association of Directors of Adult Social Services (ADASS) and are currently working with a range of organisations to further develop and refine the methodology, including councils, CCG's and providers.

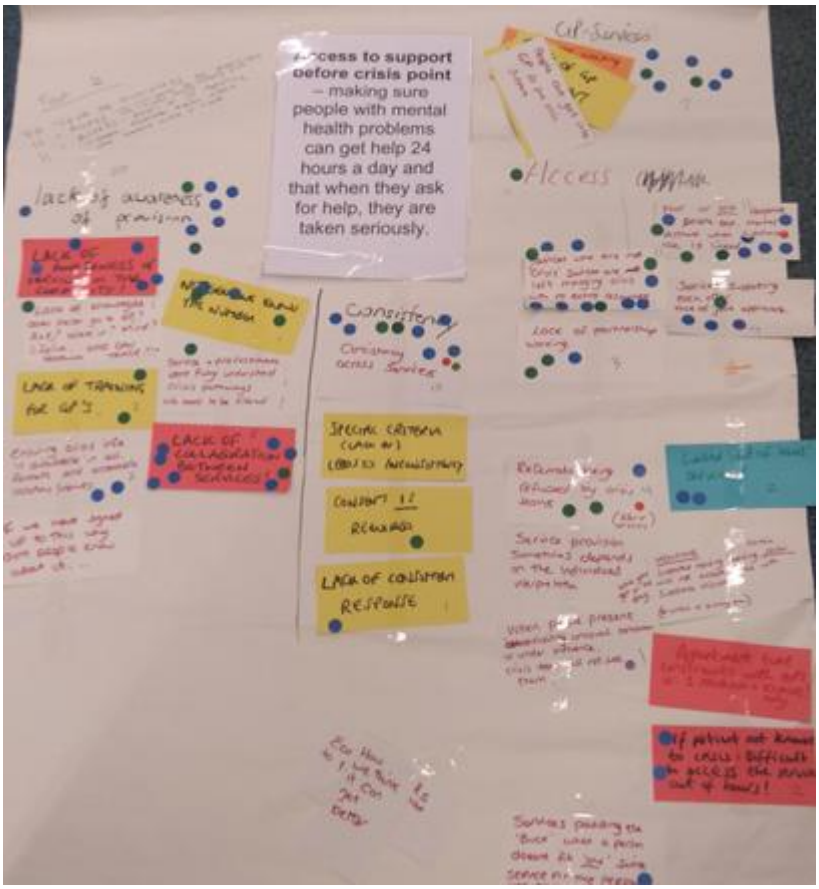
Using WTfC in Crisis Care

Hartlepool Borough Council were part of the Department of Health's National Provider Development Programme in 2009-2010 which used WTfC as a tool to drive change and improvement in provider services in response to the personalisation agenda. Following this experience, Hartlepool chose to use WTfC as the methodology underpinning the review of several key strategies including the Tees Autism strategy, Hartlepool Review of Day opportunities, and the Hartlepool Hearing Loss Strategy.

A key component of the Hartlepool work programme centred on supporting internal capacity building and skills development so that WTfC could be used in future without external support. This was in anticipation of Hartlepool embedding the process as a core tool for planning and engagement in local commissioning and service development.

Report structure:

This report works through each of the eight steps of WTfC in turn detailing key decisions taken and illustrating how the methodology was employed at each stage. We have also included some concluding thoughts and recommendations that we hope will inform further discussions about next steps for the Hartlepool Mental Health Forum.



Step 1: Preparation:

The first step of WTfC involves deciding the **scope of work**, agreeing how **person-centred information** will be collected and quality assured for the process and identifying **who will need to be involved**.

Scope of work

The scope of work was driven by the boundaries of the work already underway in the Borough, namely the Tees Crisis Care Concordat action plan and the Hartlepool Joint Mental Health Implementation plan. The scope of the work falls into level 3 (Service configuration)*, application of WTfC* (See below)

Level	Type	Description
1	Unit	A small number of people sharing a specific service or range of services, usually including accommodation e.g. a supported living arrangement for 4 people with learning difficulties.
2	Service	Support offered and provided by a single provider organisation, e.g. an independent sector residential care provider or in-house mental health outreach team.
3	Service configuration	Support offered and provided by a more than one provider where there is commonality of service type and/or outcomes expected, e.g. day opportunities or homecare.
4	Population	Support offered and provided by more than one provider to meet a range of needs and outcomes for a specific population, e.g. services for people with a learning difficulty in the north of the borough or mental health services across the town.

Person-centered information

Background

Successful WTfC processes stand or fall on the quality of the person-centred information available. Whilst it is often difficult for people who use services to express their feelings towards a particular service or person our process invited service users, commissioners, providers, and interested parties (eg Healthwatch, through its confirm and challenge process) to present their experiences throughout the day. Staff have a good grounding in person-centred thinking and practice and a number of people have received full person-centred review training in the past. In addition, since Hartlepool had used WTfC already through their involvement in the Department of Health programme, there was some recent experience of conducting reviews to feed this process to draw upon, including using an abridged process to collect person-centred information quickly and efficiently.

Sample

As part of the project initiation event in November commissioners and other stakeholders discussed what would be realistic in terms of a development day. A target of 50 – 80 people was set for attendance on the day with a net cast wide across both the statutory, independent and voluntary sectors. it was agreed that within each data collection efforts would be made to ensure the sample was broadly representative of all organisations on the day. Given that Hartlepool were also interested in gathering views of people not yet in contact with statutory services, it was agreed that some attempts would be made to canvas wider opinion though it was accepted that in practice this would necessarily be secondary to information relating to people with experience of accessing Crisis Care services.

Quality

As stated above, the starting position in relation to person-centred reviews in Hartlepool was relatively high. This meant that facilitation on the day was consistent and we already were able to include the 4 key themes as described in the Tees Crisis Care Concordat report and action plan.

Who needs to be involved?

At the project initiation day people identified a range of stakeholders that would need to be involved in the work and in particular the WTfC events themselves. Broadly, the learning from elsewhere is that any successful process must have three key perspectives represented at events in roughly equal ratios – commissioners, providers and most importantly, people with support needs, their carers and

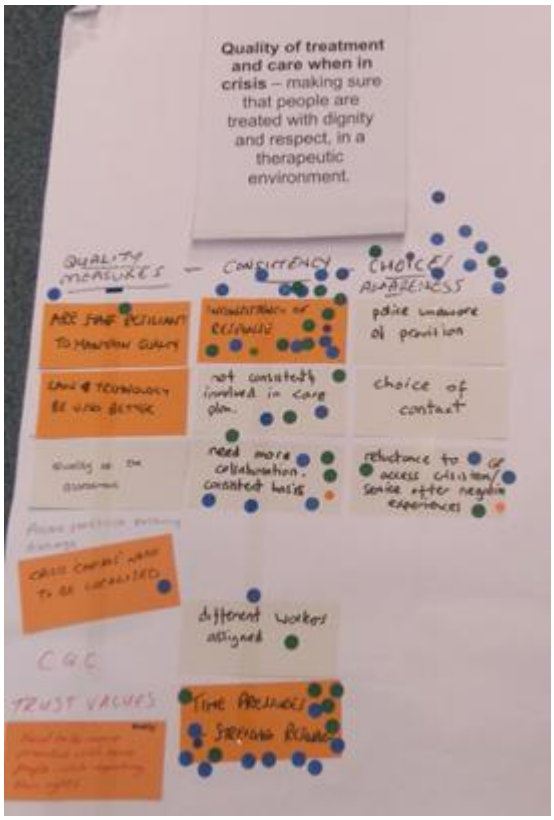
families. An optimum number of people can attend WTfC events, so it is very important to think carefully about who should attend and make concerted efforts to ensure that those who are listed to attend are able to priorities the sessions in their diaries.

Commissioners present at the project initiation session agreed to divide up attendance at the WTfC events on service area lines. Tasks were also allotted for identifying providers and people with support needs, carers and families that could attend. Learning from elsewhere suggests that the important thing is to be able to reasonably represent the perspective of the group or population under consideration, which does not necessarily mean having been part of the reviewed cohort of people.

A list of delegates for each event is attached at Appendix 2.

Where should the event happen?

Learning from elsewhere suggests that WTfC events work best where it is possible to use a community based venue. It is also important to think about access needs, acoustics and having ample space for pinboards and for people to move around freely. It was decided that the Centre for Independent Living would be an ideal venue for the events.



Step 2: Gathering the information:

The second step of WTfC is about collecting the person-centered data from people to drive the process.

The key information needed is statements in people's own words about what is working in their life, what is not working so well and what is most important to them for the future. People are then asked to prioritise the two most important things to them in each category, i.e. the top two things that are working, the top two that are not working and the top two most important things to change for the future

The raw data for this review was predominantly collected from people attending and contributing to the day.

Information was received from the following sources:

- Tees Esk & Wear Valley NHS FT (mental health trust)
- Cleveland Fire Brigade
- Hartlepool Borough Council – Adult Services
- Hartlepool Borough Council – Community Services
- Incontrol-able Disabled Persons User Led Organisation (DPULO)
- Healthwatch Hartlepool
- Hartlepool & Stockton Clinical Commissioning Group (NECS)
- Cleveland Police
- Hartlepool MIND
- Alliance Care
- Creative Support
- Hartgables
- HART (Hartlepool Action Recovery Team)
- Service Users and Family Carers
- Link Families
- Lynnfield School

Statements were then prepared for usage on the day in preparation for step 3.

Step 3: Recognising themes:

The third step of WTfC is about working with a diverse group of people, including commissioners; providers and people with care and support needs, their carers and families, to identify themes (or clusters) within the information. This happens by way of a facilitated "card call" and involves people hearing each individual piece of information and deciding if it is similar or different from the other information.

Once all the "data" has been worked through, there will most often be a number of clusters that emerge. The group then assisted in allocating to a key theme for each cluster. This process is completed for all of the 'working' information, all of the 'not working' information and all the information about what is "important for the future.'

It is always important to start with what is working well so that we can celebrate the things that are best about people's experience of services – something we do not do often enough! – before moving on to the things that are not working.

Information about what is working can be useful to give a rounded view of how well a service is performing and can be informative in relation to whether things are working better in some areas (e.g. geographical, different teams, client groups etc.) than others. The identification of "Working" themes should help to highlight what needs to be maintained and lead to consideration of what it would take to make some peoples' positive experiences into more universal outcomes of the service. Likewise, recognising themes about what is important to people for the future can be a useful way of identifying gaps in current provision and an invaluable resource when planning how things will need to change.

The remainder of the facilitated WTfC process focuses on the 'not working' themes, informed by the other clusters identified. This is so we honed in on things that would make the most difference to people if they were addressed. Experience has shown that there are often significant overlaps between what people have said isn't working and what they say they want for the future, i.e. when a "lack of social interaction" is what is not working, it is likely that "more social interaction" will be a future aspiration. So, focusing on what isn't working is not at the expense of the other themes identified. Rather, it provides a lense for building on what is working well, addressing what needs to change now and planning for the best possible future.

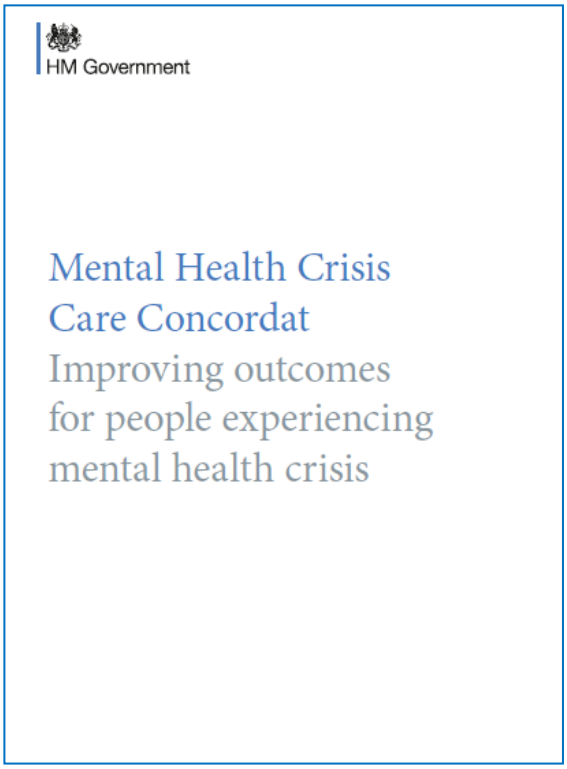
We supported the group to focus on the 4 key themes referenced in the Tees Crisis Care Concordat.

1. **Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.**

2. **Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.**

3. **Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.**

4. **Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.**



Step 4: Understanding why?

The next step of WTfC is for people to think together about what the various reasons might be for the top things that are "not working" for people. We do this to unearth the multitude of factors that can play a part in creating the problem.

Health and Social Care is rarely a straightforward environment of cause and effect and it pays to spend the time needed to develop a rounded understanding. It can feel difficult, almost counter cultural, for commissioners in particular (but also for others), when presented with a problem to hold back from jumping to solutions. But there are definite benefits to the discipline that the process imposes, from hearing each person's perspective, debating the root causes on equal ground and only developing an agenda for change once the full complexity of the issue has been considered.

We do this by forming mixed groups around each of the top "not working" themes with all of the different stakeholder groups represented and using a process called "five whys and a what." This is a thinking and planning aid developed by Toyota to help with problem solving and consists of continuous, systematic interrogation of a problem until all possible causes are identified. Think of when a child asks you "why?" something should be so, eliciting what you feel is a perfectly good explanation, only for the "why?" to be posed again as if that proved nothing at all and you'll get the picture. We seek to unearth as many reasons as we can as well as to dig into each of the individual reasons, i.e. when poor training is offered as an explanation we should ask why the training is poor.

We tend to ask people to conform to a couple of rules in doing this which both help to keep the conversation moving and signal for people when the end is in sight. Firstly, we ask people to avoid any mention of the reason being the inadequacy of the budget available for as long as possible. We do this to challenge people's thinking. It seems a reasonable guess that there will never be enough money to put everything right regardless of how much is in the pot and if we start with this kind of statement, however true it may be, we tend to back ourselves into a corner from where there's a danger we'll miss other equally plausible explanations that have nothing much to do with money. Secondly, we ask people similarly to stay away for as long as possible from broad brushstroke statements about the "nature of society" and such things. Though is may be an entirely legitimate part of the issue at hand that, for example, society does not value older people, this does tend to stymie the discussion somewhat. Once we've done this and are satisfied that we've identified as many of the reasons as we can, we ask people to vote again on their top root causes.

In Hartlepool, people worked in mixed groups to agree the top reasons for each of the "not working" themes. The outputs from these sessions are captured in Figure 2 on page 16, with the top root causes listed first and in bold.

Step 5: Identifying success:

The next stage of WTfC involves thinking about what success would look like if the top root causes and the things that were not working for people were addressed. We do this by getting people to think about the kinds of things people would be saying if what isn't working was put right and because we need to hear from all our stakeholders we ask people to do this from a range of different perspectives.

Commonly this means asking what commissioners would be saying, what providers would be saying and what people with support needs, their carers and families would be saying and gathering statements in the first or third person for each.

This stage helps to develop a clear vision for the future so we know what we're working towards and can picture what it will look like when we get there. It also helps us to set benchmarks for what we are trying to achieve and to begin unearthing the sorts of things we could measure to chart our progress. To this end, as well as asking, "What would people be saying?" we also ask, "and how else would you know?"

This prompts people to identify the sorts of measurable improvements we would see by addressing what isn't working. These are the tangible things we can track and report in addition to the qualitative improvements we are aspiring to deliver. In Hartlepool, identifying success happened at the beginning of the day rather than the end of day because of the quantity of data. **Figure 1** provides information on people's views of 'what works well'

Delegates were divided into mixed groups and provided with the information about root causes

Figure 1. Working Well

	Crisis	Access	Quality	Recovery
	Quick response with Police and Street Triage	Charities Working to support people	Mental Health Awareness Training	Fire Safety checks
	A&E have Mental Health experts	Common Assessment Framework	Support networks, includes families views	Hartlepool Now
	Urgent appointments within 4 hours	Voluntary organisations and signposting	Police – very polite, supportive and treat people with dignity	Improved accommodation for people
	Links between acute and mental health trusts	GPs receptive to voluntary sector requests	Trained peers with Mindskills	Medication reviews
	Reduction in arrest rates	Community are more Helpful	TEWV purpose built facilities	Collaborative care plans
	Police awareness of issues and ongoing referrals	Professionals know who can help	Police and NHS partnerships (street Triage)	Multi-agency working
	Good access to training	More talk about Mental Health in Media	Bradley Report – equality of access	Information and Advice
	Work of providers in Hartlepool	Better technology and information	Street Triage	NHS Trust values
	24hr 7 day crisis team	Mindskills – reduce crisis use	Crisis Assessment Suite	

Figure 2: Not working theme and root causes:

	Crisis	Access	Quality	Recovery
Theme	**Awareness, access and Knowledge**	**Lack of Awareness of provision**	**Consistency in provision of Assessment and Treatment**	**knowledge & Understanding**

	Crisis Centre's not local	Lack of awareness or services	Inconsistency of response	Placements are often out of area
	What is a crisis	Managing crisis with no extra resources	Overstretched resources	Stigma of Mental health
	Implementing Concordat work	Poor or no response	More collaboration	Information and awareness
	Information not available to everyone	People who experience poor mental health when substance misuse is linked	Police unaware of provision	Language and cultural barriers; hard to reach groups
	Lack of support and funding	Consistency across services	GP reluctance to access Mental Health services	Support during recovery, isolation
	Education in Schools	Lack of Collaboration	Can technology be used better	GP support

Step 6: Planning for change:

The next stage of the process is where we begin to stand back from the work people have done together to ask, “What does this mean for us?” and “what are we going to do about it?” The previous stages have helped us to recognise and explore a rich vein of person-centred information that tells us a great deal about peoples’ experiences of support. This is valuable in itself, but the reasons for doing it are greater than the acquisition of new knowledge and insight. This is about person-centred change, which means that we have to take the next step, beyond the co-identification of a problem towards the co-development of a set of actions that will push us in the direction of success.

It is very important that this stage is done well and that we don’t fall into the trap of prescribing the first solutions we think of without adequate consideration of the alternatives. To this end, we ask people to work through a tightly facilitated process to develop their ideas, identify the best ones and to evaluate which of them is worth taking forward

Once people have generated different ideas for all the “not working” themes, they are asked to vote on their top three solutions to each problem.

People need to be particularly careful with these votes because these ideas shape the final stages of WTfC and it is important to have the very best material to work with. Most importantly, we need ideas that can actually be made to happen!

In making their decisions, it helps to ask people to choose ideas that are:

- **Practical, possible and achievable within the time and resources available** – not forgetting the broad view of resources we have taken when generating the ideas;
- **Stretching and aspirational** – while we definitely need ideas that are workable, this is no excuse for only choosing things that are easy to do, deeply engrained problems are likely to require some fairly major solutions;
- **Clear and specific** – we do not need great detail at this stage, but we need to know the idea is grounded in something tangible;
- **Within the gift of the people in the room to do something about** – rather than a very broad aspiration that would require the world and her dog working in unison to achieve…world peace comes to mind;
- **New and not something that would happen anyway** – it can be tempting to see some ideas that emerge as a vindication of things that are already planned or happening, but this must be about new ideas rather than the endorsement of old ones if we are to get the most out of it!

In Hartlepool each delegate had three votes for the ideas against each "not working" theme. People could vote for whichever ideas they liked. See **Figure 3** "not working" ideas

The Top theme from each of the 4 areas were then developed as I statements

1. Crisis – I want better access, awareness and knowledge.

2. Access – I want to be better informed about local services.

3. Quality – I expect good quality when I need services.

4. Recovery – I want better information to help me stay well.

These 4 areas were further explored to identify projects that would be achievable and categorised as Major Projects, requiring resources and those that could be done with little or no additional resource 'Quick Wins'

Figure 3: Top ideas to address "not working" themes:

	Crisis	Access	Quality	Recovery
Theme	**Awareness, access and Knowledge**	**Lack of Awareness of provision**	**Consistency in provision of Assessment and Treatment**	**knowledge & Understanding**
	Operational policy on self referrals to be reviewed	Develop a leaflet to be displayed in key facilities	Collaboration, multi agency approach and central Hub for signposting	Develop a one page info sheet for GPs
	Ensure there are a variety of methods of communication with people including non IT solutions.	Mental Health Road show in popular venues, e.g. shopping centre, college	Expansion of Crisis Team, 24/7 dedicated crisis line, information, advice and signposting	Use data to better understand which services are having a positive impact
	Revise the Crisis pathway	Awareness sessions in Secondary Schools	GP services to develop a 'mental health champion'	Families and cares support and information
	Parity of provision across Tees	Lunch and Learn sessions for GPs	Street Triage / Crisis team, increase capacity cover 24/7	Awareness raising about staying well.

APPENDIX 1

		Stigma – change our language focus on 'emotional wellbeing'		

Figure 4: Crisis Care, Major projects and quick wins

Crisis " I want better access, awareness and knowledge "	
Major project	Self referral process will be accessible to all
Major project	Explore alternatives to IT in which to share accessible information
Major project	Map the existing Crisis Service against NICE guidelines
No decision	Ensure services across Tees offer parity
Access " I want to be better informed about local services"	
Quick win	Develop a leaflet, distribute the Beautiful mind Directory
Quick win	Hold the Mental Health Forum at different venues, market at local events
Quick win	Engage with Schools and promote good mental health
Quick win/ Major project	Dedicate a time out session with GP's on Mental Health
Quality " I expect good quality when I need services"	
Major Project	Develop a Multi Agency Support Hub for Mental Health
Major Project	Develop a dedicated crisis line (24/7)
Major Project	GP surgeries to have a named Mental Health Champion
Major project	Increase the Street Triage service

Recovery "I want better information to help me stay well"	
Quick win	Develop a one page wellbeing sheet for GP surgeries
Major project	Use data to find out which services offer the best outcomes
Major project	Ensure Carer's have the information they need to maintain their caring role
Major project	Provide more information on the importance of 'wellbeing'

Detailed action planning

Following the WTfC workshop, it was agreed that the data would be presented at a future Healthwatch Hartlepool Mental Health Forum.

We worked with people through a number of basic questions to develop outline plans for work in a several areas, building on the ideas developed through WTfC.

In addition, we followed this same process to help people think about the broader question of how to ensure that data gathered through WTfC would continue to inform the ongoing work of the Forum.

The Forum is also tasked with ensuring actions against the Joint Implementation Plan and Tees Crisis Care Action plan are realised.

Below shows a summary of progress

Tees-wide Crisis Care Concordat Update (October 2015)

Introduction and background

The Tees-wide Concordat Task and Finish Group was established to address issues emerging between local emergency services when dealing with people in a crisis. The group pre-dated the Mental Health Crisis Care Concordat, yet many of the areas of concern contained the Concordat were shared and experienced by members of the Group. The Group meets bi-monthly and enables a dialogue across commissioners and providers and users of crisis services.

An existing crisis action plan was in place before the national Concordat information emerged, so it made good sense to bring the two together. The local action plan has enhanced the national action plan, adding key deliverables, key tasks and lead person details, so monitoring and progress can easily be undertaken.

The Tees Valley Crisis action plan

Prioritisation and monitoring

The current action plan has been prioritised to reflect the key impact areas that the Group believes will make a significant positive difference to the lives of those people experiencing a mental health crisis and to the services providing support in a crisis.

A template is used for updating the action plan by the person responsible for that action, and a lead organisation (NEMHDU) was commissioned to support the Group

in delivery against its plan. NEMHDU, whilst also responsible for a number of actions within the local plan, collated all the action plan updates, maintained a master copy of the action plan and supported the Group to monitor implementation of the action plan

Progress against the action plan

The Group has developed a significant momentum over the last 12 months and has made good progress against the local action plan. The plan clearly address the main areas outlined within the crisis care review and prioritisation letter, and also the issues raised from the CQC reports: themed review of crisis care and places of safety. The plan takes these national issues and addresses them at a local level.

Key issues that the group has addressed thus far include:

1. Crisis Assessment Suite

Hartlepool and Stockton CCG and South Tees CCG have jointly commissioned a 24/7 open access Crisis Assessment Suite at Roseberry Park Hospital in Middlesbrough. The Mental Health crisis assessment suite aims to provide an alternative to attendance at Accident and Emergency Departments for individuals with urgent mental health needs by providing open access to mental health assessment. Anecdotally, one of the drivers behind the development of the 'CAS' was that people were turning up to Roseberry Park expecting to be seen. Previously, Roseberry Park had a '136 suite' but this was not publicly accessible.

2. Ambulance conveyance for people to the crisis assessment suite

Intelligence from the ground indicates that a discrete transport service would be beneficial in cases of mental health crisis, as traditional ambulances are often diverted to physical health emergency cases. As a result, a sub-group has been set up with the aim of putting a pilot service in place this winter to convey people to the Crisis Assessment Suite.

3. Frequent users of emergency services who need an alternative provision and service response

The Group has analysed the most frequent uses of all emergency services and found that certain Groups emerge(5 in total), all of whom consume significant emergency services resource, but have a distinct pattern. Usually one in which the person is using emergency services because they aren't able to access more appropriate community based services earlier, or as an alternative.

Some people in this group account for hundreds of 999 calls and A&E attendances, representing a hitherto unmanaged need in the system.

Further work is required in this area, identifying a detailed pathway for each of the 5 cohorts, but already recommendations have emerged to change services'

response, offer alternative services so use of emergency services reduces and improve multiagency planning and response.

4. Crisis Data gathering and sharing

This is a major action, as it underpins all the work involved. Good crisis data is required for intelligent commissioning and for monitoring service provision and access as well as outcomes.

The work on frequent users has required sharing of data within information governance protocols and clear agreements for data sharing across organisations.

Work is still progressing in this area but the progress is very encouraging.

5. Patient experience

User-led experience of crisis and crisis service has been commissioned and is a strong focus for the Group. The outcomes of this work will be incorporated in the pathways work identified above.

6. Crisis monitoring

The CQC Thematic Review data collection and report showed that it is possible to collect a range of data (mainly from the MHLD MDS) and distil in to a report specifically focusing on Crisis use and experience. We are in the process of developing such a report for the Tees area.

Conclusion

The Group is making significant progress against the local issues affecting the delivery of effective crisis response and user experience. The organisational structure and approach to delivery and monitoring of the Group crisis action plan has enabled the action plan to stay current, visible and on track.

The Joint Mental Health Implementation Plan for 2015-18

The plan was co-produced with the CCG. The plan incorporates the key national and local mental health outcomes and is refreshed annually to demonstrate progress and reflect any changing national and local priorities.

A summary of progress was reported to adult services committee on 9 March 2015 which included

http://www.hartlepool.gov.uk/egov_downloads/09.03.15_-_Adult_Services_Committee_Agenda.pdf

Objective 1: More people will have good mental health

- Hartlepool Borough Council workforce plan agreed to continue to commission Mental Health First Aid Course through MIND
- The North East Clinical Network agreed to support a regional approach to raising awareness of Mental Health as one of its 3 key objectives.

Objective 2: More people with mental health problems will recover

- Community Learning Pathway successful bid submitted to Skills Funding Agency for £80k via Adult Education
- Development day held at Hartlepool Marina

Objective 3: More people with will have good physical health

- Tees Commissioners meeting included Mental Health on the agenda
- Working party agreed to update the JSNA
- Newly appointed Hartlepool Locality Manager
- Hartlepool Borough Council purchased a system for its care act information advice and guidance requirements, Hartlepool Now – demonstration to Adult service committee and launched on World Mental health day (October)
-

Objective 4: More people will have a positive experience of care and support

- Mental Health Act Inspection – report presented to Adult services Committee
- CQC inspection of Mental Health Act – positive
- Healthwatch Hartlepool – hosted a mental health event at HCFE

Objective 5: Fewer people will suffer avoidable harm

- New Tees Safeguarding Board and Local Executive Group (LEG) established
- Hartlepool Borough Council and all key stakeholders have signed up to the Crisis Care

Objective 6: Fewer People will experience stigma and discrimination

- World Mental Health Day in Hartlepool focused on the topic of Dignity
- Healthwatch Hartlepool – provided public information at the Headland raft race.

Step 7: Making it happen

The next stage of the process is to do what it takes to respond to the information collected and analysed in steps 2-5 and to deliver the plans developed in step 6.

The Report will be presented at a future Mental Health Forum, it is important at this stage that progress against actions are monitored and aligned to existing key recommendations as described i.e. the Tees Crisis Plan and the Joint Implementation Plan. .

It is imperative that the learning and expertise from the event is not lost. The information provided at Figure 4 (page 19) will form the basis of a report to the next Mental Health Forum in May 2016.

Recommendations:

Crisis Care:

1. Healthwatch Hartlepool to agree and endorse the report
2. Following approval, report will be presented to the Mental Health Forum
3. Key members will monitor and take responsibility for the action plan
4. A report will be provided to the Tees Concordat Group for inclusion in the Regional action plan

Step 8: Learning and review

The final step of the process involves evaluating the actions and changes that have resulted from using WTfC to ensure we understand and evidence the impact we have had and can improve the way the process works in the future.

	Feedback from WTfC
General reflections	There was a lot if information Some people's thinking changed as a result of the process Using WTfC builds people's expectations which needs to be acted upon Getting the right people in the room is critical The process helped everybody to get involved what works for some people doesn't necessarily work for others balance between leading the process and letting it run by itself
What worked well?	The process helped to stretch people's thinking Good outputs we can use, went really well Good carers input It felt good to be taking ownership celebrate things that are working as well Good to have a range of different providers involved Providers recognised and appreciated that the process The process highlights what really matters to people
What didn't work?	People could do with more preparation before attending More users involved would have been good A few people couldn't manage the whole day There wasn't enough time or preparation for action planning

Recommendations for future use of WTfC:

- Use a smaller data set in future – themes were reinforced rather than new ones emerging
- Push people to be more specific when developing ideas for addressing things that aren't working
- Don't confuse roles – it will always be difficult to take part in an event as a commission.

Appendix 1: Work Schedule – March – May 2016

Key Dates	Group	Purpose
18/03/2016	Tees Integrated Commissioning Group	Monitor Tees action plan (LD/MH) Market Position Statement
21/03/2016	Local Health and Social Care Plan Working Group	Multi Agency discussion – key theme Mental Health
22/03/2016	North of Tees Locality discussion	Custody suite and diversion team (Middleborough, Ladgate Lane)
24/03/2016	CAMHS Transformation Multi Agency Information Group	Children and Young Person Mental Health plan
15/04/2016	Tees Integrated Commissioning Group	Monitor Tees action plan (LD/MH) Transforming Care update
28/04/2016	CAMHS Transformation Multi Agency Information Group	Children and Young Person Mental Health plan
05/05/2016	Hartlepool Mental Health Forum	Progress – Joint implementation plan, WTFC report, Tees Concordat
06/05/2016	Tees Esk & Wear Valley NHS FT – Locality Meeting	Monitoring of the Mental health Service Level Agreement

Appendix 2: Delegate lists

Crisis Care Summit

Neil Harrison	Hartlepool Borough Council
Jayne Gardner	Hartlepool Borough Council
Leigh Keeble	Hartlepool Borough Council
Ben Smith	Tees Esk & Wear Valley NHS FT
Rebecca O'Keefe	Tees Esk & Wear Valley NHS FT
Jeanette Willis	Hartlepool Borough Council
Margaret Yuill	Hartlepool Borough Council
Zoe Sherry	Hartlepool Healthwatch
Ruth Harris	Tees Esk & Wear Valley NHS FT
Jayne Wilson	Cleveland Police
Katie McIntyre	Hartlepool Borough Council
Jane Lane	Hartlepool Borough Council
Diane Spence	Hartlepool Borough Council
Kathleen Shaw	Hartlepool Borough Council
Michelle Howard	Hartlepool Borough Council
Stephen Thomas	Hartlepool Healthwatch
Michael Slimings	Incontrol-able
Sarah Leighton	Incontrol-able
Joanne Fairless	Hartgables
Anne Marie Hall	Alliance
Rob Smith	Hartlepool' & Stockton Clinical Commissioning Group
Nina Welch	Alliance Healthcare
Gemma Ptak	Hartlepool Borough Council
Evelyn Leck	Hartlepool Healthwatch
Steve Dougherty	Carewatch
Sheila Johnson	Hartlepool Healthwatch
Gordon Johnson	Hartlepool Healthwatch
Judy Gray	Hartlepool Healthwatch
Kirsten White	Tees Esk & Wear Valley NHS FT
Dominic Gardner	Tees Esk & Wear Valley NHS FT
Ruby Marshall	Hartlepool Healthwatch
Maureen Lockwood	Hartlepool Healthwatch
Paul Williams	Hartlepool Healthwatch
Carole Sherwood	Hartlepool Healthwatch
Kathleen Shaw	Hartlepool Borough Council
Caroline Adlam	Link Families
David Smyth	Hartlepool MIND
Elizabeth Henderson	Hartlepool MIND
Clare Andrews	Hartlepool MIND

Angela Sanders	Hartlepool MIND
Karen Kelly	Hartlepool Borough Council
Mary Green	Hartlepool Healthwatch
Susan Duffy	Street Triage TEWV
Gavin Spalding	Outreach TEWV
Shetha Jwad	Carer
Kate McIntyre	Lynnfield School
Joanne Ward	Cleveland Police
Kath Shaw	Hartlepool Borough Council
Michelle Chester	Hartlepool Borough Council
Marie Shout	Hartlepool' Borough Council
Michelle Banks	Carewatch
Melissa Wardle	Hartlepool Borough Council
Debbie Wright	Tees Esk & Wear Valley NHS FT

Special thanks to members of Hartlepool Healthwatch, whose determination and dedication to improve services led to the development of this report.

ADULT SERVICES COMMITTEE

7 July 2016

Report of: Director of Child and Adult Services

Subject: DIRECT CARE AND SUPPORT SERVICES – OUTCOME OF CQC INSPECTION

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1. TYPE OF DECISION/APPLICABLE CATEGORY

No decision required; for information.

2. PURPOSE OF REPORT

2.1 To inform Adult Services Committee of the outcome of a recent Care Quality Commission (CQC) inspection into the Direct Care and Support Service provided by Hartlepool Borough Council.

2.2 To provide assurance to Adult Services Committee regarding the steps taken to address issues highlighted in the report and details of the proposed improvement plan.

3. BACKGROUND

3.1 The CQC monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. The CQC ensure that health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve.

3.2 The Direct Care and Support Service, based at the Centre for Independent Living is registered with the CQC and regulated by the Health and Social Care Act (Regulated Activities) Regulation 2014.

3.3 The Health and Social Care Act 2008 established the CQC as the regulator of all health and adult social care services.

3.4 The CQC undertook an inspection of the Direct Care and Support Service provided by Hartlepool Borough Council on 10, 16 and 17 February 2016

4. REPORT FINDINGS

4.1 The Direct Care & Support Service (Hartlepool) is a domiciliary care service which provides reablement support (short term support, usually following a hospital discharge), a 'telecare' response services (responding to technology that helps people live at home longer) and an emergency respite care service for family carers to over 2,000 people in the Hartlepool area.

4.2 At the time of this inspection, 29 people were receiving personal care and reablement support.

4.3 CQC rated overall the service as follows:

Ratings	
Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

4.4 The full inspection report is attached as **Appendix 1**. This provides an overall summary of the inspection and detail for each of the domains, and describes the action that needs to be taken by the service to deliver the required improvements.

4.5 Good practice was identified within all five domains, as outlined in the inspection report. Positive feedback included:

- The service was responsive.
- People's needs were assessed before care was provided.
- Detailed care plans were developed which were specific to the needs of individuals.
- When people's needs changed this was discussed and care plans
- Were updated to reflect this.
- People were given clear information about how to make a complaint.
- People and their relatives spoke positively about care staff.
- People said staff were on time and they didn't rush them.
- Staff had a good understanding of safeguarding adults and their role in preventing abuse.
- Safeguarding concerns, accidents and incidents were reported by staff and dealt with appropriately by the management team.
- People told us staff sought permission before providing care.

- The service worked closely with health professionals to ensure people didn't stay in hospital longer than necessary.
- Staff completed appropriate training before working unsupervised.
- People were supported to meet their nutritional needs.
- People were supported to access other healthcare services when required.
- The service was caring.
- People told us they were happy with the care they received, staff were caring and helpful and staff put them at ease and reassured them.
- People were supported to be as independent as possible whilst retaining their privacy and dignity.
- People told us the service was well organised and they would recommend it to others.
- Staff told us there was a positive, open culture and they felt supported
- Where issues had been identified, these had been acted upon.

4.6 Improvements were identified as being required in three of the domains:

4.6.1 Safe

- The registered provider did not always have accurate records to support and evidence the safe administration of medicines.

4.6.2 Effective

- Staff had not received up to date training in a number of key areas.
- Some staff had not received regular supervisions.
- Observations of care did not take place regularly.

4.6.3 Well Led

- The provider did not have systems in place to identify and investigate issues with medicines records in a timely manner.
- There was no quality system in place to check care plans.

5. IMPROVEMENT PLAN

5.1 The Direct Care and Support Service has developed a detailed improvement plan to address the three areas identified in the CQC report as requiring improvement. A copy of the improvement plan is attached as **Appendix 2.**

6. RISK IMPLICATIONS

6.1 The service must meet regulations made under powers set out in the Health and Social Care Act 2008.

6.2 The CQC has a wide set of powers that aim to protect the public and hold registered providers and managers to account. In addition a new enforcement policy is in place enabling CQC to take action where they identify poor care, or where registered providers and managers do not meet

the standards required in the regulations. A service that repeatedly fails to deliver required improvements or is rated inadequate can ultimately have registration cancelled.

7. FINANCIAL CONSIDERATIONS

7.1 Additional resources will be required to ensure all actions of the report in respect to staff training are met. It will be necessary to provide refresher training for some staff, with backfill arrangements in place to ensure business continuity. Additional costs will be met from any underspend on staffing budgets supported by departmental reserves if required.

8. LEGAL CONSIDERATIONS

8.1 The CQC is not taking any enforcement action. The improvement plan aims to address the required improvements identified in the report.

9. EQUALITY AND DIVERSITY CONSIDERATIONS

9.1 There are no equality and diversity considerations associated with this report.

10. STAFF CONSIDERATIONS

10.1 Additional staff will be required to cover rosters in order for all staff to attend refresher training.

10.2 There will be changes to current processes to ensure that improvement are delivered.

11. ASSET MANAGEMENT CONSIDERATIONS

11.1 There are no asset management considerations associated with this report.

12. RECOMMENDATIONS

12.1 It is recommended that the Adult Services Committee notes the inspection report and the improvement plan that has been developed in response to the issues identified. A progress update will be provided in six months time to provide members with assurance regarding the delivery of the required improvements.

13. REASONS FOR RECOMMENDATIONS

13.1 Improvements to the Direct Care and Support Service will have a positive impact on the quality of care delivered to adults.

14. CONTACT OFFICER

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Hartlepool Borough Council

Direct Care and Support Team

Inspection report

Centre for Independent Living
Havelock Street
Hartlepool
Cleveland
TS24 7LT

Tel: 01429266522

Date of inspection visit:
10 February 2016
16 February 2016
17 February 2016

Date of publication:
28 April 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 10, 16 and 17 February 2016. This was an announced inspection. The last inspection of this service was carried out in March 2014. The service met the regulations we inspected against at that time.

Direct Care & Support Team (Hartlepool) is a domiciliary care service which provides reablement (short term support usually after people are discharged from hospital), 'telecare' services (technology to help people live at home longer) and emergency respite care for family carers to over 2000 people in the Hartlepool area. At the time of this inspection, 29 people were receiving personal care and reablement support.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found the provider had breached Regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider did not have accurate records to support and evidence the safe administration of medicines. We found gaps and inaccuracies in medicines records. Some staff had not completed up to date training in key areas, staff supervision records were not up to date, and direct observations of care did not happen regularly. The provider did not have audits in place for medicines and care plans.

You can see what action we told the provider to take at the back of the full version of the report.

People and their relatives spoke positively about the service, and told us there was enough staff to carry out visits. One person who used the service said, "The service is first class. The staff are excellent." Another person who used the service said, "They helped me stay in my own home which is fantastic."

Feedback to the provider from people who used the service was 100% positive, across all areas, in the last 12 months.

The service used an effective 'call confirm' system to monitor staff attendance at scheduled visits to people's homes. The majority of visits were on time and lasted for the allocated duration. Supervisors used this system to monitor visits on a daily basis so potential issues could be responded to promptly.

Staff knew how to report safeguarding concerns and were able to describe various types of abuse. Staff said they felt any concerns they had would be taken seriously. Safeguarding concerns, accidents and incidents were recorded and dealt with appropriately. They were also analysed so lessons could be learnt to prevent recurrence.

The service worked closely with health professionals to ensure people didn't stay in hospital longer than necessary. People were supported to attend medical appointments and social activities.

Staff had access to clear guidance about how to provide care and support to people, according to their individual needs and wishes. This guidance was set out in people's care plans which were reviewed and updated when people's needs changed.

People knew how to make a complaint, although all of the people we spoke with said they had never had to make a complaint. People told us if they had a concern they would speak to care staff or supervisors who were based in the registered office. People were confident their concerns would be dealt with appropriately.

Staff told us they felt supported by the management team and felt able to voice any concerns they may have. Staff told us there was a positive and open culture at the service.

People who used the service said it was well organised and they would recommend it to others.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. The registered provider did not have accurate records to support and evidence the safe administration of medicines.

People and their relatives spoke positively about care staff. People said staff were on time and they didn't rush them.

Staff had a good understanding of safeguarding adults and their role in preventing abuse.

Safeguarding concerns, accidents and incidents were reported by staff and dealt with appropriately by the management team.

Is the service effective?

Requires Improvement

The service was not always effective. Staff had not received up to date training in a number of key areas. Some staff had not received regular supervisions. Observations of care did not take place regularly.

People told us staff sought permission before providing care.

The service worked closely with health professionals to ensure people didn't stay in hospital longer than necessary.

Staff completed appropriate training before working unsupervised.

People were supported to meet their nutritional needs. They were also
supported to access other healthcare services when required.

Is the service caring?

Good

The service was caring.

People told us they were happy with the care they received, staff were caring and helpful and staff put them at ease and reassured them.

People were supported to be as independent as possible whilst

retaining their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before care was provided.

Detailed care plans were developed which were specific to the needs of individuals.

When people's needs changed this was discussed and care plans were
updated to reflect this.

People were given clear information about how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led. The provider did not have systems in place to identify and investigate issues with medicines records in a timely manner. There was no quality system in place to check care plans.

People told us the service was well organised and they would recommend it to others.

The service had a registered manager. Staff told us there was a positive, open culture and they felt supported.

Some systems were in place to assess the quality of care people received. Where issues had been identified, these had been acted upon.

Direct Care and Support Team

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 10, 16 and 17 February 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. The inspection was carried out by one adult social care inspector.

We reviewed other information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also contacted the local authority commissioners for the service, the local Healthwatch and the clinical commissioning group (CCG). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We did not receive any information of concern from these organisations.

We spoke with six people who used the service and two family members. We also spoke with the registered manager, a head of service (representative of the provider), six supervisors and four members of care staff. We looked at a range of care records which included the care records for 11 people who used the service, medicine records for 11 people, records for 10 staff, and other documents related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed in a safe way. During our inspection we viewed the medicines administration records (MAR) for 11 people who used the service. Three out of 11 medicines records were incomplete for the period October 2015 to January 2016. This was because staff had not signed to confirm prescribed medicines had been given. In some cases daily notes confirmed the medicines had been given, but the MAR did not correspond with the daily notes. Also, staff had failed to record a non-administration code when a person did not wish to take their medicines. Staff may have re-administered people's medicine as the MAR did not always evidence administration. Medicines risk assessments were not always signed and dated by staff. This meant people who used the service were at risk of medicine errors as the service did not have accurate records to support and evidence the safe administration of medicines.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we mentioned these issues to the registered manager and the representative of the provider they implemented a medicines quality assurance process and supervisors explained to staff what good practice was in relation to record keeping on MARs. The registered manager and the representative of the provider told us these incidents had been investigated as safeguarding incidents.

The service provided support to people from 7am to 10pm seven days a week. The service employed six supervisors who were based in the registered office, around 43 care assistants and one administrator. People and relatives we spoke with felt there were enough staff to carry out visits, and spoke positively about the service. One person said, "The service is first class. The staff are excellent." Another person said, "They helped me stay in my own home which is fantastic."

Staff rotas were done in groups according to location to try and ensure consistency of staff and to reduce travelling time. Most people we spoke with were happy with the continuity of staff that supported them but one person said, "It's been a bit erratic this week but previous weeks have been fine." Another person told us, "I actually prefer it when different people come as I like to see new faces."

The service used a 'call confirm' system which enabled supervisors who were office based to check staff were on time and to track the duration of visits. Each staff member had a hand held device which was linked to the provider's computer system. When staff attended people's homes they checked their device against an electronic 'tag' in people's homes. This was an accurate and effective system which alerted supervisors when staff had not turned up on time or visits had not lasted for the correct length of time. The registered manager told us how they used this system to measure compliance with people's scheduled visits. At the time of our inspection the service was 91% compliant which meant staff arrived on time and stayed for the correct length of time for the vast majority of visits.

People who used the service told us staff arrived on time. One person said, "Staff are as precise as a clock." Another person told us, "Staff are always on time." People told us staff stayed for the full duration of the

scheduled visit and they didn't feel rushed. One person said, "I like it that staff have time to chat to me."

When we asked the registered manager and the representative of the provider if the service had enough staff they told us they did, but they would like more so they could expand the service to provide care to more people. The registered manager told us they thought carefully before agreeing to provide more care as they had a commitment to existing clients. The registered manager told us staff worked well together as a team to cover sickness and leave.

Staff had a good understanding of safeguarding adults and their role in preventing potential abuse. Staff told us, and records confirmed, they had completed training in safeguarding vulnerable adults as part of their induction training and then at regular intervals. Staff knew how to report concerns and were able to describe various types of abuse. Staff we spoke with said if they had any concerns they would raise them immediately with supervisors or the registered manager. One staff member told us, "I know concerns are followed up properly, the supervisors are good at following up any issues that staff report."

Records showed safeguarding concerns, accidents and incidents were reported by staff and logged on the service's computer system. These were dealt with appropriately by the management team, for example they made safeguarding referrals to the local authority. These records were reviewed so that lessons could be learnt and action taken as necessary. For example a recent investigation resulted in staff being given further guidance on record keeping.

The service had an 'unable to gain access policy' if staff were unable to get a response at a person's home. Staff were able to explain the various steps they would take if such a situation arose. This meant staff were clear about their responsibilities to ensure people's safety in such situations.

Risks to people's health and safety were appropriately assessed, managed and reviewed. We looked at the care records of 11 people both in their own homes and in the office. Risk assessments included an assessment of the safety of the person's home and equipment, and any potential risks relating to falls, medicines, skin care and nutrition. The representative of the provider told us, "We try and mitigate risks to ensure people's safety." Staff we spoke with felt people who used the service were safe. One staff member said, "People are safe because we look after them well whilst helping them to regain their independence."

We were unable to view staff recruitment records during our inspection, as these were held by the provider (the local authority). Of the 30 disclosure and barring service (DBS) records we checked 30 staff had an up to date check. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

The provider had a business continuity plan in place to ensure the service could still run if emergencies arose.

Requires Improvement

Is the service effective?

Our findings

The provider did not have effective systems in place to ensure staff were given appropriate training. Some staff we spoke with said they felt they would benefit from up to date training on end of life care, emergency aid, mental health, the Mental Capacity Act 2005 and dementia. Records confirmed staff had received training in these areas but this had not been updated, and some staff had gaps in their training records. For example, some staff had not completed up to date moving and positioning training and training on emergency aid. This meant we could not be sure staff knew how to care for people in the right way. Supervisors told us there had been some difficulties sourcing appropriate training but they were working with the provider to address this. When we spoke to the provider about staff training, they gave a number of reasons why staff had been unable to attend training, but accepted that uptake of training could be improved.

Records confirmed staff did not receive regular spot checks of the care they provided. Supervisors told us they carried out spot checks but did not always record them. There was no clear policy in place regarding the frequency of such spot checks. Records confirmed some staff had not had a spot check in more than 12 months. This meant we could not be sure staff competencies were regularly checked. Supervisors said they would like more opportunities to carry out spot checks in people's homes. When we asked the registered manager about this they said this was an area for improvement and supervisors needed more time to do regular spot checks.

We viewed 10 staff supervision records. Supervisions are regular meetings between a staff member and their manager to discuss how their work is progressing and to discuss training needs. The provider's policy stated a minimum of two supervisions were required each year. All of the 10 files we viewed had a minimum of two formal supervisions recorded each year, however the provider agreed that the policy needed to be updated to ensure ad hoc supervisions were also recorded.

This was a breach of Regulation 18 health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notes of supervisions were detailed and well written. They recorded issues relating to people's care, policy updates and the personal development of staff. This meant supervisions were used as an effective method of communicating best practice when they happened regularly. Of the 10 staff records we checked annual appraisals were up to date.

People and relatives we spoke with said they felt staff had the right skills and training to provide the care and support they needed. They also told us staff sought permission before providing care or administering medicines.

Staff told us they had received appropriate training and opportunities to shadow established care staff before providing care on their own. Most staff told us they felt they had sufficient training, and if they wanted to do further training they would discuss this with their supervisors. Training records confirmed new staff completed a comprehensive induction programme which included training on moving and positioning,

food hygiene, health and safety and safeguarding adults. Records confirmed staff had also completed training on reablement, fire safety and medicines administration.

Staff told us they felt supported. One staff member said, "The supervisors are always there if we need to check anything. They're great."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

No one currently using the service was subject to any restriction of their freedom under the Court of Protection, in line with MCA legislation. Staff told us most people they supported had capacity to make their own decisions, although they did support some people living with dementia. Staff told us if they had any concerns about a person's capacity they would ask supervisors to contact the person's social worker and contact their family. This meant staff knew how to seek appropriate support for people if issues about their capacity arose. There was an up to date MCA policy at the service.

People's nutritional intake was monitored where appropriate. Care workers completed daily notes which recorded what meals they had prepared and how much people had eaten. People's food and fluid intake was monitored and recorded for every call where food or drink was prepared for the person. This helped staff check whether people needed increased support in this area. People's care plans contained specific guidance about people's nutritional wellbeing, for example,
'Carers to make sure they record how much [person] has eaten and to ensure they prepare and present food and encourage.' One person told us, "Staff encouraged me to eat and drink so I could get better."

People told us care staff supported them to access a range of medical appointments such as going to the hospital, GP and optician. People were also supported to attend social activities and go shopping. The service had access to the provider's vehicle so they could take people out.

The service worked closely with the local hospital discharge team to ensure people could return home with the right support as soon as possible. The representative of the provider told us "We have a good working relationship with health care professionals to enable people to stay at home."

People we spoke with told us how important it was for them to return home after being in hospital, some of them for extended periods. One person told us, "I had a bad time in hospital so coming home was top of my list." Another person said, "The staff have helped me get my independence back. I feel so much better about that."

Good

Is the service caring?

Our findings

People we spoke with were happy with the care and support they received. People told us care staff were caring, polite and professional. People and relatives told us they had a positive relationship with care staff. One person said, "I have enjoyed the carers coming in, they are very helpful." Another person told us, "The staff are brilliant. They do what's expected of them and more. They go out of their way for you like washing your hair. I now regard one of the carers as my friend." A relative told us, "The staff are very professional, friendly and always ready to help."

People told us staff treated them with dignity and respect. The service conducted satisfaction surveys when people's care came to an end. Records of surveys from the last 12 months showed 100% of people who responded said staff treated them with respect, promoted their dignity and independence, and respected their privacy. A relative told us, "They always treat [family member] with respect."

We asked staff how they promoted dignity, respect and independence. One staff member said, "I try and put people at their ease particularly when providing personal care. I cover the person up and keep talking to them. It's important to make that person feel valued. I feel I get on well with people who use the service." Another staff member told us, "I treat people with respect because I'm going into their home so it's what they deserve. We're also there to help people get back on their feet."

People we spoke with said initially they weren't looking forward to care staff coming into their home, as this was new to them, but they soon relaxed as staff were "very reassuring." One person said, "At first I found it unnerving when care staff used the key safe, but they always say hello when they let themselves in. They do a cracking job and make sure you're okay before they leave. For some it's a vocation. It's a difficult job but the staff stay cheery." This person described one of the staff members as "a phenomenal carer."

Another person told us, "I was wary before I had carers but I can't fault the lasses. They keep an eye on me while I cook and make sure I eat my meals. They're friendly and put me at my ease. It's like having one of your pals here. I'm glad the carers are here to prompt me to take my medicines as I can be forgetful. The lasses are down to earth and don't boss me about. I know if it wasn't for the carers I would be back in hospital".

Staff told us how they dealt with people's concerns when they started receiving care. One staff member told us, "I always try and reassure people and tell them to ask about anything." Staff told us they enjoyed helping people regain their independence, after a stay in hospital for example. One staff member said, "I enjoy helping people get back on their feet, increasing their confidence and improving the quality of their lives." Another staff member told us, "It makes my job worthwhile when people's health improves and their morale is boosted. This makes all the staff happy. I would recommend this service to my own family."

The registered manager told us, "They are all nice staff. They are very caring."

The service had received numerous thank you cards and letters from people who used the service and their

families. Comments included, 'The staff were excellent,' 'Carers have made me feel more secure in myself. Thanks for all the support,' and 'Staff were brilliant. They made me laugh when I was depressed.'

Each person who used the service was given a welcome pack which contained a guide to the service and the provider's statement of purpose. These were kept in people's homes so they could refer to them at any time. The welcome pack contained information about all aspects of the service, including how to access independent advice and assistance such as an advocate, although nobody who used the service had an advocate.

Good

Is the service responsive?

Our findings

People told us their individual care needs were assessed before the service was provided. Supervisors told us they had a good relationship with social workers, reablement staff and the hospital discharge team. This meant a number of health care professionals contributed to decisions about people's care. One supervisor said, "We work closely with social workers to decide how many visits people need and for how long. Social workers usually give us all the information we need". Supervisors told us that staff then go out to visit the person to discuss their care needs and preferences in more detail.

Each person's care needs were set out in a care plan before their care package was put in place. People kept a copy of their care plans in their own homes so they and their care workers could refer to them at any time. All of the 11 care plans we viewed contained clear guidance for staff about how to support people with their needs, such as personal care, medicines, and eating. Care plans also contained risk assessments about people's risk of isolation, self-neglect and abuse. This meant staff had access to information about how to care for people's specific needs in the right way.

Some of the care plans we viewed were not always completed fully in relation to people's life history and family background. When we asked the registered manager about this he said it wasn't always possible to get to know people that well in a matter of weeks for a limited amount of time each day, as most care packages lasted six weeks or less. They acknowledged this was something the service could improve and was looking at ways to address this.

People and relatives had been involved in their care planning, where capabilities allowed, and people had given their consent. One relative said, "[Family member] and I were fully involved in care planning." Records of surveys from the last 12 months showed 100% of people who responded said the service met their needs and 100% said the desired outcomes in their care plans had been achieved.

There were clear examples of the service responding to and acting on people's changes in needs. For example, we observed supervisors rearranging the timings and frequency of people's visits at people's request. Supervisors told us about specific occasions when staff were responsive such as when they contacted a heating engineer for a person whose heating had broken down. Supervisors also told us about how staff helped reunite a person with their missing dog by using social media, and how staff took someone for a sit down and a cup of tea when they got tired whilst shopping. Care plans showed clear evidence of people's changes in needs being acted upon. For example, one person needed additional support with their medicines after a minor operation and this was clearly reflected in their care plan.

A relative told us how a staff member noticed their family member was unwell and took them to the medical centre for treatment. They also told us how care staff had found a way of helping their family member remember to take their medicines. This meant the service responded to changes in people's needs promptly.

People were provided with a comprehensive welcome pack about the service and the standards they could

expect. This welcome pack included clear details of how to make a formal complaint to the provider. The registered manager told us people were encouraged to speak to staff first. He told us, "We try and deal with any issues informally first, so supervisors will call people to try and sort it out or I'll go out to speak to people who use the service." There had been no formal complaints received in the last 12 months.

People told us they had never needed to make a complaint, but they knew what to do if they did. People also told us they had confidence in staff to deal with complaints appropriately. One person said, "I've never had to make a complaint, but if I did I would contact the office by calling the phone number in my care file. I know I wouldn't have to make a complaint though." A relative told us, "I've never needed to complain but if I did I would go straight to the supervisors."

Requires Improvement

Is the service well-led?

Our findings

There was no documented quality assurance process in place to support the safe administration of medicines. This meant the provider had been ineffective in identifying and investigating errors on the MAR. When we mentioned this to the management team they began to investigate and address these issues immediately. They implemented a medicines quality assurance process and supervisors explained to staff what good practice was in relation to record keeping on MARs.

The registered manager reviewed care plans regularly but there was no documented quality assurance process in place. The registered manager said this was an area for improvement and he would ensure MARs and care plans formed part of his management checks in future.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's computer based management system was used to monitor the quality and safety of the service, for example missed calls, accidents and incidents. Safeguarding incidents were audited and analysed by the provider twice a year. This meant the provider was taking some action to help keep people safe.

People were asked for their views on the service when their care package came to an end. These quality assessments were conducted with people who used the service face to face. Feedback was recorded, analysed and acted upon. The registered manager told us, "If anything comes out of the quality surveys I go and visit the person to speak to them face to face, but there is rarely anything." Informal feedback via staff members was also acted upon, for example when people expressed their preferences for certain care staff this was accommodated wherever possible.

The provider had a registered manager and team manager who were responsible for the day to day running of the service. The registered manager was supported by six supervisors and an administrator.

People spoke positively about how the service was managed. They told us the service was well organised and they would recommend it to others. Staff told us there was an open and positive culture at the service and they felt supported. One staff member told us, "We work well together as a team because we back each other up. There are no problems with the registered manager or the supervisors. I feel I can discuss anything with them."

A supervisor said, "It's a team effort. I'm so proud of our staff". Another supervisor said, "We've got a good team without a doubt, we support each other. Staff rally round when we need them to cover extra shifts." The staff team at the service was stable; most people had worked there for several years.

Staff described the registered manager and supervisors as "very approachable." One staff member told us, "The manager is very understanding especially with family problems." Another staff member said, "The

manager was so lovely when I was off work. When things need doing he just quietly gets on with it and gets things done."

Staff meetings were held several times a year. The last staff meeting was held on 7 January 2016. Records showed staff discussed the care needs of people they supported and issues relating to the running of the service. Staff told us they felt able to raise any concerns at such meetings or informally with supervisors.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 safe care and treatment. People who use services were not protected against the risks associated with unsafe or unsuitable care and treatment because records and systems operated by the registered provider did not support the safe management of medicines. Regulation 12 (2) (g).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service's audit procedures did not always identify areas for improvement. Regulation 17(2)(a)(b)(c)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider failed to ensure staff received appropriate training and supervision to meet the needs of the people who used the service. Regulation 18 (1)(2)(a)(b)

Report on actions you plan to take to meet Health and Social Care Act 2008, its associated regulations, or any other relevant legislation.

Location name	Direct Care and Support Team

Regulated activity	**Regulation**
Personal care	**Regulation 12** **Safe care and treatment**
	How the regulation was not being met:
	Regulation 12 HSCA (RA) Regulations 2014 safe care and treatment. People who use services were not protected against the risks associated with unsafe or unsuitable care and treatment because records and systems operated by the registered provider did not support the safe management of medicines. Regulation 12 (2) (g).

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

As indicated in the inspection summary, actions have already been taken and a quality assurance process is now in place for the safe administration of medication. MAR sheets are now handed into the supervisors for checking and authorisation before they are scanned into the local authority data base system. Any recording errors or missed medication must be clarified at this point and safeguarding alerts will be raised if this cannot be done. Supervisors must sign MAR sheets to confirm they are correct before scanning. Staff/supervisors have been informed of the changes to medication guidance. Documentation for the safe administration of medication has been revised and training in relation to completion of the new documentation will take place in May 2016.

Plan

Update and change audit process - March 16

Update and change documentation - April 16

Provide staff training - May 16

Registered Manager to start auditing process - June 16

Who is responsible for the action?	Stephen Lennon

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Monthly checks will be made by the Registered Manager to ensure that documentation is completed correctly, and registered manager to check in supervisions if there has been any problems/concerns with the new process/protocol.

Who is responsible?	Stephen Lennon

What resources (if any) are needed to implement the change(s) and are these resources available?

Time for Registered Manager and supervisors and new documentation.

Date actions will be completed:	June 2016; monitoring ongoing

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Protocols have already been changed to ensure medication has been administered correctly, and revised documentation would be used to give greater clarification of any reasons why any medication cannot be administered this should now mean we can meet regulation 12 and therefore people using services will not be affected.

Regulated activity	Regulation
Personal care	**Regulation 17** **Good governance**
	How the regulation was not being met:
	The service's audit procedures did not always identify areas for improvement. Regulation 17(2)(a)(b)(c)

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
The areas where audit procedures were identified as requiring improvement related to the safe administration of medication and as identified for regulation 12 our response is as follows. As indicated in the inspection summary actions have already been taken and a quality assurance system is now in place for the safe administration of medication. MAR sheets are now handed into the supervisors for checking and authorisation before they are scanned into the local authority data base system. Any recording errors or missed medication must be clarified at this point and safeguarding alerts need to be raised if this cannot be done. Supervisors must sign MAR sheets to confirm they are correct before scanning. Staff/Supervisors have been informed of the changes in the medication guidance for Staff and Supervisors and documentation for the safe administration of medication has been revised and training for the completion of this new documentation will take place in May 2016. <u>Plan</u> Update and change audit process - March 16 Update and change documentation - April 16 Provide staff training - May 16 Registered Manager to start auditing process - June 16	
Who is responsible for the action?	Stephen Lennon
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
Monthly checks will be made by the Registered Manager to ensure that documentation is completed correctly, and registered manager to check in supervisions if there has been any problems/concerns with the new process/protocol.	
Who is responsible?	Stephen Lennon
What resources (if any) are needed to implement the change(s) and are these resources available?	
Time Registered Manager, Supervisors and new documentation (paper).	
Date actions will be completed:	June 2016, monitoring ongoing

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Protocols have already been changed to ensure medication has been administered correctly, and revised documentation would be used to give greater clarification for any reasons why any medication cannot be administered this should now mean we can meet regulation 12 and 17 and therefore people using services will not be affected.

Regulated activity	Regulation
Personal care	**Regulation 18** **Staffing**
	How the regulation was not being met:
	Regulation 18 HSCA (RA) Regulations 2014 Staffing *The provider failed to ensure staff received appropriate training and supervision to meet the needs of the people who used the service.* *Regulation 18 (1)(2)(a)(b)*

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
Identify and prioritise which staff require refresher training courses i.e. moving and handling, safeguarding, emergency aid, and enrol staff on next available course. Which are Safeguarding Refresher 14/6/16, 12/7/16, 13/9/16, 18/11/16 Moving and Handling Refresher 21/6/16 (am+pm), 30/6/16 (am+pm) First Aid at Work Refresher 16/5/16, 17/5/16, 8/8/16 and 9/8/16 Emergency Aid Refresher 7/6/16, 10/6/16 and 27/2/17 Introduce new audit process to ensure that supervisions and observations of all staff are undertaken regular. Review observation documentation to identify if it can be made easier to complete <u>Plan</u> Identify which staff require refresher training - April 16 Enrol staff on refresher training courses - May 16 Devise audit documentation for staff supervisions - May 16 Provide accurate records of staff training - May/June 16 Implement audit of supervisions/observations completed by supervisors - June 16 Review observation documentation - July 16	
Who is responsible	Stephen Lennon
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
Monthly audit by registered manager to ensure above actions have been undertaken by the supervisors. Training courses have already been arranged via Corporate Training Additional training to be arranged for any staff who are unable to attend identified courses.	
Who is responsible?	Stephen Lennon
What resources (if any) are needed to implement the change(s) and are these resources available?	
Registered manager/supervisors time, trainer and training budged	
Date actions will be completed:	June 16, training ongoing

How will people who use the service(s) be affected by you not meeting this regulation until this date?
All staff have received the necessary training and have the skills to provide the care needed for the service and we should be able to ensure that service users are not affected while further training and supervision is undertaken.

ADULT SERVICES COMMITTEE

7 July 2016

Report of: Director of Child & Adult Services

Subject: QUALITY RATINGS FOR COMMISSIONED SERVICES

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1. TYPE OF DECISION/APPLICABLE CATEGORY

No decision required; for information.

2. PURPOSE OF REPORT

2.1 Further to the report on care homes for older people in June 2016, this report provides the Adult Services Committee with an update on quality ratings for all other commissioned social care services that are regulated by the Care Quality Commission (CQC).

3. BACKGROUND

3.1 Care home provision for older people has been discussed by the Adult Services Committee on a number of occasions over the last twelve months and regular updates are provided, including the latest CQC ratings.

3.2 There are a number of other services commissioned for adults in Hartlepool that are regulated, inspected and rated by the CQC, which will be summarised in this report. These include;

- Domiciliary care services for older people;
- Non residential services for working age adults;
- Residential care for people with learning disabilities;
- Residential care for people with mental health needs; and
- Extra care support

3.3 In addition to services commissioned by the Council, there are some services that are regulated by the CQC and provide support to people in Hartlepool, where there is no contract in place with the Council. This includes services

purchased privately, services purchased using Direct Payments and services that are commissioned and funded by the NHS to meet health needs.

4. COMMISSIONED REGULATED SERVICES

4.1 All services commissioned by adult services are subject to contract monitoring and the Quality Standards Framework. Regulated services are also required to be registered by the CQC and are subject to regular inspection, which is followed by a published rating.

4.2 These services include:

4.2.1 Domiciliary Care for Older People

Domiciliary care (or homecare) for older people is commissioned from two providers, one covering the south of the town and one covering the north. There has been a significant amount of work carried out with both providers following the Healthwatch review of these services. The review identified that service quality was good but highlighted some issues relating to continuity of carers. Both providers have introduced protocols to ensure that wherever possible individuals can expect continuity of carers, where this is not possible good communication strategies have been employed to keep individuals informed of any planned or emergency changes to their care team. Older people also have the choice of using a Direct Payment to access alternative provision.

4.2.2 Non Residential Services for Working Age Adults

Services that support working age adults in their own homes or in the community (usually people with learning disabilities and / or mental health needs) are commissioned using framework agreements. There are currently two framework agreements; one for positive behavioural support and complex needs and one for autism. This means that a number of providers are accredited to provide these services and the person has a choice about which provider to use (as well as the choice to use a Direct Payment to access alternative services if they wish to do so).

4.2.3 Residential Care for People with Learning Disabilities

There are a number of providers of residential care for adults with learning disabilities within Hartlepool operating small group homes and a building based respite service (Greenfields Lodge). In addition to these services, a number of former residential care settings have moved to a supported living model over the last few years. This means that people have their own tenancies and receive care and support within their home. Supported living services are not regulated by the CQC as schemes in the same way as residential care provision, but are still monitored by the Council and the care and support provision is CQC regulated.

4.2.4 Residential Care for People with Mental Health Needs

Most people with mental health needs are supported in their own homes or in supported housing settings. In addition, there are a small number of

residential care settings that are regulated by CQC and support adults with mental health needs.

4.2.5 Extra Care Support

There a two purpose built Extra Care schemes in Hartlepool. Hartfields was built and has care services operated by Joseph Rowntree and Laurel Gardens was built by the Thirteen Group with care services operated by Comfort Call. There are also a number of virtual Extra Care Schemes where care is operated by Comfort Call; these are in existing Thirteen Group sheltered housing schemes - Richard Court, Albany Court & Bamburgh Court. All of these schemes have criteria for individuals with care needs to access and allocations panels to ensure there is the correct balance of care needs in each location to ensure that safe and effective care can be delivered. The majority of people accessing these services are aged over 55 but there are exceptions where those of working age with either learning or physical disabilities who meet specific criteria are having their care needs supported.

4.3 A summary of the current CQC ratings for these services is attached as **Appendix 1**. A number of services have not yet been inspected using the new CQC framework, but it is expected that all inspections will be complete by September 2016.

4.4 It is positive to note that the majority of services are rated as 'good'. Those services rated as 'requires improvement' have plans in place to deliver those improvements and are able to access support from the Council in terms of their action plans and monitoring of progress.

4.5 Both residential and non-residential providers have access to the training and support provided through the Commissioned Services Team and the wider Council. This includes enhanced support in relation to medication issues, which has been commissioned through the Better Care Fund and access to training regarding adult safeguarding. All providers are encouraged to attend regular forums for managers and proprietors to enable networking and the sharing of good practice.

5. RISK IMPLICATIONS

5.1 There are no specific risks associated with any of the existing services at the present time.

5.2 There is a potential risk that current services will not be able to meet needs of young people moving into adult services and people with learning disabilities who develop dementia in the future, and these issues are currently being explored. If appropriate places are not available within Hartlepool to meet the needs of local people, there is a risk that more people access of out of area placements, which can be costly and is not necessarily the best option to meet needs in the longer term.

5.3 There is also a risk of over provision of specialist residential provision for people with learning disabilities and complex needs, as a number of providers have shown an interest in developing services in Hartlepool without there being evidence that there is a local need or demand for these services. This could result in people from other areas moving into Hartlepool, which can then put increasing pressure on local health and social care services.

6. FINANCIAL CONSIDERATIONS

6.1 There are significant financial considerations associated with the sustainability of commissioned services, including calculating the fair cost of care and implementation of the National Living Wage. There are no financial considerations specifically linked to this report.

7. LEGAL CONSIDERATIONS

7.1 There are no legal implications associated with this report.

8. CHILD AND FAMILY POVERTY CONSIDERATIONS

8.1 There are no child and family poverty considerations associated with this report.

9. EQUALITY AND DIVERSITY CONSIDERATIONS

9.1 There are no equality and diversity considerations associated with this report. The regulation and rating of services is consistent across all ages and client groups in order to ensure an equitable and consistent approach.

10. STAFF CONSIDERATIONS

10.1 There are no staff considerations associated with this report.

11. ASSET MANAGEMENT CONSIDERATIONS

11.1 There are no asset management considerations associated with this report.

12. RECOMMENDATION

12.1 It is recommended that the Adult Services Committee note the contents of this report and receive further updates as required.

13. REASON FOR RECOMMENDATION

13.1 Commissioned services that are regulated by the CQC meet the needs of adults in Hartlepool with eligible social care needs, and the Council has a role in relation to commissioning good quality services to meet those needs.

14. CONTACT OFFICER

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QUALITY RATINGS FOR COMMISSIONED SERVICES

Domiciliary Care for Older People

Provider	Publication Date	Rating
Careline Homecare	19 January 2016	**Good**
Hartlepool Care Services (CareWatch)	24 May 2016	**Good**

Non Residential Care for Working Age Adults

Provider	Publication Date	Rating
Voyage	Awaiting inspection	
Pathways to Independence	Awaiting inspection	
Positive Support in Tees	17 June	**Good**
Real Life Options	Awaiting inspection	

Residential Care for People with Learning Disabilities

Provider	Publication Date	Rating
Voyage: Fivepenny House	3 July 2015	**Good**
Voyage: Glendale	17 July 2015	**Good**
Voyage: Greenfields Lodge	5 June 2015	**Good**
Voyage: South Highnam	9 June 2015	**Good**
The Crescent Care Home Ltd	23 March 2016	**Good**
Voyage: Belchford	18 November 2015	**Good**
My Life: Burbank Mews	Awaiting inspection	

Residential Care for People with Mental Health Needs

Provider	Publication Date	Rating
Seymour House	20 January 2016	**Requires Improvement**
Wordsley House	11 June 2015	**Good**

Extra Care Providers

Provider	Publication Date	Rating
JRF: Hartfields	28 January 2015	**Good**
Comfort Call	2 September 2015	**Requires Improvement**

ADULT SERVICES COMMITTEE

7 July 2016

Report of: Director of Child and Adult Services

Subject: THE CARE QUALITY COMMISSION: STRATEGY FOR 2016 TO 2021

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1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 No decision required; for information.

2. PURPOSE OF REPORT

2.1 To make the Adult Services Committee aware of the publication of the Care Quality Commission's strategy for the coming five years.

3. BACKGROUND

3.1 The Care Quality Commission is responsible for monitoring, inspecting and regulating a range of services, including adult social care services.

4. RECENT PUBLICATIONS

4.1 On 24 May 2016 the CQC published Shaping our future: CQC's strategy for 2016 to 2021. A supporting document was published alongside the strategy, identifying what the new strategy means for the different types of services that CQC regulates.

4.2 An overview of the strategy is attached as **Appendix 1.**

4.3 The document summarising what the strategy means for different services is attached as **Appendix 2**. The section relating to adult social care can be found on pages 17-20.

4.4 Officers from adult services have regular Information Sharing Meetings with CQC and will use these as an opportunity to explore in detail what th local impact of the new strategy will be.

5. RISK IMPLICATIONS

5.1 There are no risk implications identified. The strategy aims to improve partnership working between the CQC and Local Authorities.

6. FINANCIAL CONSIDERATIONS

6.1 There are no financial considerations associated with this report.

7. LEGAL CONSIDERATIONS

7.1 There are no legal considerations associated with this report.

8. EQUALITY AND DIVERISTY CONSIDERATIONS

8.1 There are no equality and diversity considerations associated with this report. The regulation and rating of services is consistent across all ages and client groups in order to ensure an equitable and consistent approach.

9. STAFF CONSIDERATIONS

9.1 There are no staff considerations associated with this report.

10. ASSET MANAGEMENT CONSIDERATIONS

10.1 There are no asset management considerations associated with this report.

11. RECOMMENDATION

11.1 It is recommended that the Adult Services Committee notes the CQC strategy for the coming five years.

12. REASONS FOR RECOMMENDATION

12.1 The Care Quality Commission is responsible for monitoring, inspecting and regulating adult social care services.

21. CONTACT OFFICER

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Shaping the future

CQC's strategy for 2016 to 2021




CQC 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.

Enter

OUR STRATEGY AT A GLANCE

Our ambition for the next five years is

A more targeted, responsive and collaborative approach to regulation, so more people get high-quality care.

We will achieve this by focusing on four priorities

1. **Encourage improvement, innovation and sustainability in care**
2. **Deliver an intelligence-driven approach to regulation**
3. **Promote a single shared view of quality**
4. **Improve our efficiency and effectiveness**

We will know we have succeeded when

- **People trust and use our expert, independent judgements about the quality of care.**
- **People have confidence that we will identify good and poor care and that we will take action where necessary so their rights are protected.**
- **Organisations that deliver care improve quality as a result of our regulation.**
- **Organisations are encouraged to use resources as efficiently as possible to deliver high-quality care.**

READ OUR STRATEGY

Foreword

David Behan
Chief Executive

Peter Wyman
Chair

We have radically changed our approach to regulating health and social care services over the last three years. Soon we will have completed inspections of all the services we rate, providing a powerful baseline understanding of the quality of care in England. We ask the same five questions of every service – Is it safe? Is it effective? Is it caring? Is it responsive? Is it well-led? – and publish our findings and ratings. We know that our work is leading to better care – providers tell us our reports help identify areas for improvement, and we regularly see improvements when we re-inspect.

Over the next five years the health and social care sector will need to adapt, and we do not underestimate the challenges that services face. Demand for care has increased as more people live for longer with complex care needs, and there is strong pressure on services to control costs. Success will mean delivering the right quality outcomes within the resources available.

We know providers are committed to addressing these challenges. Services are innovating, using technology and new ways of working to deliver care that is more person-centred. We will do all we can to encourage improvement, but we cannot do this alone. Providers, professionals, staff, commissioners, funders and other regulators need to work together, with people who use services, their families and carers, towards a shared vision of high-quality care.

Our strategy has been developed based on what thousands of people, providers, staff and partners have told us and what we have learned from more than 22,000 inspections. It sets out an ambitious vision for a more targeted, responsive and collaborative approach to regulation, so that more people get high-quality care.

As we move into this period of change, we will have fewer resources to deliver our purpose – so we need to use them as effectively as possible. We will always stay committed to our purpose, role and statutory objectives as we enter the next five years with energy, determination and passion.

Introduction

Health and social care regulation makes a real and practical difference to people's lives. There needs to be a strong, independent regulator that will always act on the side of people who use services. Our new strategy describes how we will build on what we have learned so we can continue to improve what we do. We will keep fulfilling our purpose to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve.

What we know

CQC's purpose and role remain of critical importance. Our assessments and inspections tell us that there is still significant variation in quality across different sectors and between services in each sector. In particular we are concerned about safety, which remains a serious challenge for those we have rated inadequate. Our assessments also tell us that effective leadership is very important to providing high-quality care – the overwhelming majority of good and outstanding services also feature good or outstanding leadership.

We are working in a challenging context. Demand for care has increased as more people live for longer with complex care needs. There is also strong pressure on services to control costs. To help meet these challenges, services are changing the way they organise and deliver care, and our approach needs to evolve too. We need to develop our monitoring to make best use of available information, especially from the public, who can be our eyes and ears in services. We must adapt to new models of care and work with others to support services to improve, particularly those with poor quality. We need to become more efficient in our operations, and reduce the process requirements we put on those we regulate.

Our ambition for the next five years

We are building a unique baseline of knowledge that provides critical insights into the quality of care people are receiving and we will soon complete inspections of all the services we rate. When we have finished, the answer is not simply to start again, but to use what we have learned – and what people tell us – to target our inspections where poor care, or a change in quality, is more likely.

We will focus on four priorities to deliver our ambition:

1 Encourage improvement, innovation and sustainability in care – we will work with others to support improvement, adapt our approach as new care models develop, and publish new ratings of NHS trusts' and foundation trusts' use of resources.

2 Deliver an intelligence-driven approach to regulation – we will use our information from the public and providers more effectively to target our resources where the risk to the quality of care provided is greatest and to check where quality is improving, and we will introduce a more proportionate approach to registration.

3 Promote a single shared view of quality – we will work with others to agree a consistent approach to defining and measuring quality, collecting information from providers, and delivering a single vision of high-quality care.

4 Improve our efficiency and effectiveness – we will work more efficiently, achieving savings each year, and improving how we work with the public and providers.

Our new strategy sets out an ambitious vision for a more targeted, responsive and collaborative approach to regulation, so more people get high-quality care.

We have produced an accompanying document, *What our strategy means for the health and adult social care services we regulate*, that describes how we will regulate and encourage improvement in each sector. As we work towards achieving our ambition we will develop the detail of our plans with people who use services and their carers, providers, staff and partners. We will also address the risks and opportunities for equality and human rights as outlined in our *Equality and human rights impact analysis*. We will consult, where appropriate, on changes to our inspection approach, and measure and report on whether we have achieved our ambition (see page 19).

What will stay the same

- Our purpose, role and operating model – inspections will continue to be central to our assessments of quality.
- Our work with the public to understand and focus on what matters to people.
- Our role in protecting and promoting equality and human rights, including for people being cared for under the Mental Health Act or the Mental Capacity Act Deprivation of Liberty Safeguards.

What will be different

We will develop our approach so that we:

- Put more of our resources into assessing the quality of care for services with poor ratings and those whose rating is likely to change, and less on those where care quality is good and likely to remain so.
- Better monitor changes in quality by bringing together what people who use services are telling us, knowledge from our inspections, and data from our partners.
- Make more use of unannounced inspections focused on the areas where our insight suggests risk is greatest or quality is improving – with ratings updated where we find changes.
- Have a more robust registration approach for higher-risk applications and a more streamlined approach for those that are low-risk.
- Focus more on the quality of care that specific population groups experience and how well care is coordinated across organisations.
- Learn alongside providers who offer new care models or use new technologies, to encourage innovation by flexibly and effectively registering and inspecting such new models.
- Develop a shared data set with partners, other regulators and commissioners, so providers are only asked for information about care quality once.
- Use online processes as the default to make interactions with providers and the public easy and efficient.
- Introduce new ratings of how well NHS trusts are using their resources to deliver high-quality care.

PRIORITY 1

Encourage improvement, innovation and sustainability in care

What we know

People's health and social care needs are increasing and changing, and there are limited resources to meet those needs. Some providers have found they cannot deliver services in the same way. Boundaries between hospital care, primary care, community care and adult social care services are blurring as providers look to new models and technology to efficiently deliver person-centred care.

There is a growing awareness that for care to be sustainable and meet people's needs, improvements have to be led by providers and commissioners, and planned across local areas with local communities. Across health and adult social care, local areas are developing plans, including through devolution, guided by the *Five Year Forward View*.

We expect to see some radical innovation and change, while some services will stay the same.

What we will do

We will continue to look for good care as well as poor care, and highlight examples of good practice and innovation, to enable learning and encourage improvement. We will do more to assess quality for population groups and how well care is coordinated across organisations, through our provider inspections and our thematic work. We will adapt our approach so we can effectively register and inspect providers who have new and innovative care models. With NHS Improvement, we will begin publishing ratings of how well NHS trusts and foundation trusts are using their resources to deliver high-quality care.

Learn how we will do it

How we will do it

When we register services, we will:

- Use a flexible approach that supports new ways of providing health and care, such as integrated care that cuts across organisational boundaries.
- Make sure that the person ultimately responsible for care can be held accountable for quality, for example registering a provider at a corporate level if it delivers care through subsidiary providers.

When we monitor quality, we will:

- Work more effectively to share information about how quality is changing locally, regionally and nationally. We will work with the Healthwatch network and other organisations that represent the public, with commissioners through our overview and scrutiny work, and with the Sustainability and Transformation Plan process.
- Use our information on a geographical basis to identify quality priorities and risks for local areas.
- Continue to use our market oversight function to monitor the financial health of difficult-to-replace adult social care providers.

When we inspect services, we will:

- Continue to encourage improvement by sharing what providers are doing well, and monitoring the impact our approach has on providers and staff, including incentives for improvement.
- Strengthen our assessment of how well providers work with others to share information and coordinate care.
- Assess how well providers deliver care for specific populations groups, for example whether end of life care is meeting the needs of different groups.
- Build our capability to inspect new models of care, such as care that is organised around conditions or population groups, or where hospitals, GP practices and care homes work together to deliver care.
- Make the most effective and efficient use of Experts by Experience to make sure we hear the views of people who use services and their families, and make clear how they have informed our judgements and ratings.

When we rate services, we will:

- Continue to publish ratings, incentivising providers to improve and recognising those who deliver high-quality care.
- Make our ratings available by area to inform planning and improvement.
- Work with NHS Improvement to publish ratings for NHS trusts and foundation trusts on how efficiently and effectively they use their resources.

When we need to enforce, we will:

- Inform and work closely with local organisations when we consider closing services, to ensure people can continue accessing their care.

When we use our independent voice, we will:

- Publish examples of good practice and innovative care to encourage improvement, for example through our *State of Care* report to Parliament.
- Continue producing national reports that support improvement by highlighting care quality for different population groups and pathways of care, such as *Right here, right now* our mental health crisis care review.
- Begin to publish estimates of the populations covered by good and outstanding care, to further encourage improvement.

PRIORITY 2

Deliver an intelligence-driven approach to regulation

What we know

We have powerful insights into the quality of health and social care and when we complete our comprehensive inspections we will be even clearer about the data that tells us most about quality. Technology has made it easier for people to leave instant feedback about services, and new tools to analyse data are constantly evolving. We are seeing this change across the health and care system, but there is more we can do to improve how we use and capture the views and experiences of people.

Inspections are critical to our work, as the factors affecting quality cannot be assessed from data alone. By bringing together information from people who use services and their carers, knowledge from our inspections, and data from our partners, we will be better equipped to monitor changes in quality.

What we will do

We will build a new insight model that monitors quality. We will inspect all new services, but then focus our follow-up inspections on areas where our insight suggests risk is greatest or quality is improving. We will update ratings where we find changes. By targeting our inspections, we will recognise improvement, and identify and act on poor care. We will make more use of unannounced inspections and focus on building a shared understanding of the local context and the quality of services between inspectors, providers and partners. When we register new services, we will look at risk levels and be flexible in our approach.

Learn how we will do it

How we will do it

When we register services, we will:

- Take a more robust approach for higher-risk applications and a more streamlined approach for those that are lower-risk, for example by considering the track record of a provider and who will be using the service.
- Strengthen the link with inspection by sharing information more effectively.
- Move all our interactions with providers online.

When we monitor quality, we will:

- Look at potential changes in quality by bringing together relevant information about a provider – our new insight model.
- Find new and better ways to encourage the public to tell us about their care and improve how we monitor, analyse and respond to their information.
- Use our insight model to make decisions about what action to take, such as responsive inspections triggered by information that highlights concerns or suggests quality has improved.
- Publish information about services so the public can access this between inspections.

When we inspect services, we will:

- Inspect all services that have not yet had a comprehensive inspection or who are newly registered with us.
- Continue to assess how well services meet the needs of those who may be more vulnerable due to their circumstances, including people being cared for under the Mental Health Act or the Mental Capacity Act Deprivation of Liberty Safeguards.
- Continue to inspect all services using a tailored approach driven by the data we gather and what people tell us.
- Change the frequency of re-inspections so that services rated good and outstanding are inspected less often than those that require improvement or are inadequate, for example moving to maximum intervals of five years for inspections of good and outstanding GP practices.
- Use the information we have about a service to focus our inspections on specific areas – such as maternity care – rather than the whole provider.
- Make more use of unannounced inspections in all sectors.
- Build an in-depth and shared understanding of the local context and the quality of services with inspectors, providers and partners.

When we rate services, we will:

- Update ratings on the basis of both comprehensive and focused inspections, for example we may inspect and rate a whole hospital or focus just on one or two core services.
- Publish ratings alongside shorter reports that make clear how we have come to our decisions.

When we need to enforce, we will:

- Continue to use the full range of our enforcement powers, such as restrictions or closure of services, fixed penalty notices or prosecution where we find poor care below the fundamental standards, to make sure people's rights are protected and those responsible are held to account.

PRIORITY 3

Promote a single shared view of quality

What we know

Care providers and other oversight bodies have welcomed the introduction of a clear way of assessing quality around the five key questions that we ask of every service: Is it safe? Is it effective? Is it caring? Is it responsive? Is it well-led? Some providers have aligned their governance processes around these questions. However, multiple definitions of care quality are still being used and we do not always make the best use of the information that services give us. As a result, providers are committing resources to meeting different information requests.

We know that regulation alone cannot improve quality, but requires the combined efforts of providers, professionals and staff, commissioners and funders, and regulatory bodies, all listening to the views of people who use services and their carers and working towards a single vision of high-quality care.

What we will do

We will work with our partners, providers and the public to agree a definition of quality and how this should be measured based on the five key questions. We will strengthen relationships with our partners to encourage improvement, and work towards a shared data set so that providers are only asked for information once. We will encourage providers to develop their own quality assurance based on the five key questions and to share this with us as part of an ongoing conversation about quality. We cannot achieve a single shared view of quality alone and we invite our partners to join us in delivering this ambition.

Learn how we will do it

How we will do it

When we register care services, we will:

- Improve the way we request information by using a consistent framework based around our five key questions.
- Work with newly registered services to embed the key questions at the heart of their understanding of high-quality care.

When we monitor care quality, we will:

- Work with providers and other system partners to make sure quality is measured transparently and consistently.
- Improve mechanisms for services to share information, including moving all transactions with them online.
- Develop systems for providers to make ongoing updates to information about their services – so we have an open flow of information in both directions.
- Expect providers to describe their own quality against our five key questions, including what has changed, their plans for improvement, and examples of good practice as part of annual reporting processes.
- Make use of relevant standards, such as National Institute for Health and Care Excellence (NICE) guidance, when defining what good quality care looks like.
- Share our monitoring data with partners to improve efficiency and reduce duplicate requests for information from services.

When we inspect services, we will:

- Build ongoing relationships between providers and CQC to have transparent conversations about care quality.
- Use information submitted by providers and from people who use services and their carers to inform what to inspect and where to inspect, but never use this alone to make a judgement about quality.
- Work with local partners to support services to improve after inspection, for example making sure the Healthwatch network is part of quality summits that follow inspections.

When we need to enforce, we will:

- Work closely with others to share information and align actions taken against services providing poor quality care.
- Make it clear how our enforcement against the fundamental standards relates to concerns under the five key questions.

When we use our independent voice, we will:

- Make sure that we put the five key questions at the heart of how we report quality issues.

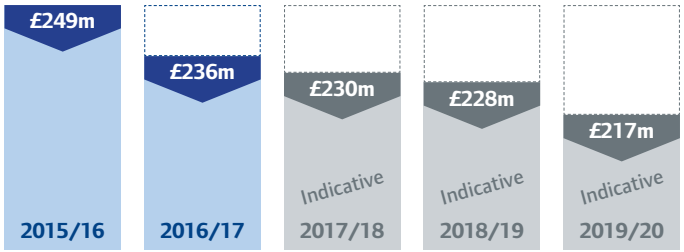
PRIORITY 4

Improve our efficiency and effectiveness

What we know

Our overall budget will reduce by £32 million by 2019/20, so we need to deliver our purpose with fewer resources. At the same time, the main source of our funding is switching from the Department of Health to fees paid by providers. We have a responsibility to use our resources as efficiently as possible, to make sure we deliver value for money for taxpayers and providers. The commitment of our staff has been critical to delivering our registration and inspection programme over the last three years and will continue to be fundamental to delivering our purpose, building on the foundations we have in place, and helping us to find innovative cost-saving measures.

CQC budget levels, 2015/16 to 2019/20



What we will do

We will work to keep our costs as low as possible as well as minimising the process requirements we have of providers. We will work more efficiently, delivering savings each year as identified in our business plans, to be a more effective regulator with a lower cost base by 2019/20. This means delivering a workforce strategy that ensures we have recruited, trained and retained the right level of skilled and expert staff. We will invest in our systems and in time-saving and online processes, so that we can improve how we work with the public and providers. We will continue to learn, share best practice, and

Learn how we will do it

collaborate with other regulators in the UK and internationally. And we will continue to regularly assess and report on our value for money to understand the impact of the changes we make on providers and partners.

How we will do it

We will develop our people by:

- Continuing to recruit the right people at the right time and developing the skills and knowledge of all employees through effective and tailored training programmes.
- Continuing to embed our values – excellence, caring, integrity, teamwork – to maintain and improve the culture we have worked hard to build.
- Promoting equality and celebrating diversity to get the best from our people and to ensure we are well-placed to identify equality issues when we monitor and inspect services.

We will ensure that we have the right systems and tools in place for our people and providers by:

- Building and improving quick and efficient systems for providers to submit information – such as our online provider portal.
- Improving the ways we make information available to the public, for example our website.
- Developing tools to support our regulatory activities and manage our resources – such as the national resource planning tool, which will improve how we schedule inspections.
- Supporting our people with the technology they need to work effectively and efficiently – for example by improving our IT infrastructure, our intranet and our flexible working.

We will save time and reduce bureaucracy by:

- Producing shorter, more consistent inspection reports more quickly.
- Removing and improving registration processes that are no longer required or are overly detailed.
- Continuing our work with partners to consider the impact of our regulation on business, including the Focus on Enforcement and Cutting Red Tape reviews for adult social care, the new Business Impact Target, and innovation and growth duties.

We will be more efficient by:

- Ensuring we are getting good value for money when we buy goods and services.
- Making the best use of the skills we have to deliver what we need.
- Ensuring we have robust financial management and reporting in place, with clear accountability and effective monitoring and escalation of risk.

What this strategy means for people who use services

We always act on the side of people who use services to make sure they get the right quality of care. Our strategy is clear that we will continue to work with the public to focus on what matters to people, to listen and act on people's views and experiences of care, and to protect people's rights, especially people in the most vulnerable circumstances. We will keep building public trust in our work and understanding of our role and purpose. And we will make sure people understand the quality of care they should expect and how to choose between local services. People will notice some changes as a result of this strategy, including:

- More information about the quality of services, that is easy for people to use and understand, and is up-to-date and available in-between inspections.
- Information from inspection that is accessible and available to the public more quickly after inspections.
- Better access to consistent and clear information about what quality care looks like – a single shared view of quality.
- Better use of information from the public to help us spot problems quickly, so we can prevent poor care and abuse happening to others in the future, and to celebrate improvements.
- Better customer service and online communications
- Close working with the Healthwatch network and our partners to hear about people's experience of care.
- More information in our reports on how well services deliver care for specific population groups, such as people with mental health needs in an acute hospital, and how new care models affect quality.
- New ratings of how well NHS trusts and foundation trusts are using their resources to deliver high-quality care.

We will renew and publish our Public Engagement Strategy towards the end of 2016.

Achieving our ambition together

We have set out a strategy for a more targeted, responsive and collaborative approach to regulation that ensures we continue to fulfil our purpose. We cannot do this alone and we will work closely with others to deliver our shared goal – that more people get high-quality care.

Our business plan each year will detail what we need to do to achieve our ambition over the five years of the strategy. For 2016/17, we will inspect, and where appropriate rate, all remaining services and locations at the same time as developing our approach. Changes to our inspections will come into effect from the start of 2017/18.

Over the course of the five years, we will improve our efficiency and effectiveness and develop new ways of working to adapt to the changes in the health and care sector.

We will work closely with the public, providers and our partners to develop our detailed plans for each sector we regulate, building on the approach set out in this strategy and the accompanying document, *What our strategy means for the health and adult social care services we regulate*. We will use a set of measures to check our progress and know when we have succeeded.

Working together

The **public and people who use services** have a crucial role to play in improving quality by sharing their experiences of care and speaking out when it needs to improve. We will:

- Co-produce our plans with people who use services, their carers and representative organisations.
- Work with the Healthwatch network, advocacy organisations and the voluntary and community sector to encourage people to share their experiences with us.

- Always speak to people who use services, their families and carers as part of our inspections.
- Make better use of people's experiences and views in our monitoring, inspections and ratings, including the expertise of Experts by Experience on our inspections.
- Build a culture that values public engagement throughout our work and equip our inspection teams to engage the public, and organisations that represent them, as part of our inspections and monitoring work.

Health and social care professionals and staff are the main drivers of innovation and improvement in the care that people receive. We will:

- Co-produce our approach with professionals and staff, and work with professional bodies.
- Involve professionals and staff in our inspections as specialist professional advisors.
- Always speak to staff as part of our inspections through focus groups and interviews.
- Draw directly on the expertise of our national professional advisors to inform our approach.
- Work closely with the National Freedom to Speak Up Guardian to support a culture of openness in the NHS, so that the concerns of staff are valued, encouraged, listened to and acted on.

Providers themselves must take responsibility for the quality of their services and drive continuous improvement and sustainable change. We will:

- Be responsive and make it as easy as possible for providers to work with us, for example through online systems.
- Co-produce our approach with providers, including through their trade associations and representative bodies.
- Reduce process requirements by streamlining data requests.
- Work together to encourage improvement at all levels, as well as holding services to account for the quality of care they deliver.

National regulators, oversight bodies and commissioners need to work to a single shared goal of high-quality care for people who use services. We will:

- Work through the National Quality Board and with leaders in the adult social care sector to agree and implement a single framework for defining and measuring quality.
- Contribute to the shared plans for delivering the *Five Year Forward View*.
- Continue to work with strategic partners, to ensure we are able to share information about risk quickly and effectively and work together efficiently.
- Work with NHS Improvement to develop a single view of success for NHS trusts and foundation trusts.

- Continue to work through the Future of Dental Regulation Programme Board to improve the system-wide approach to dental regulation.
- Build on the joint statement of intent with NHS England and the General Medical Council to improve how the system works with general practice by establishing a Future of General Practice Regulation Programme Board.
- Work with the Association of Directors of Adult Social Services and NHS England to find ways of creating greater consistency in how CQC, local authorities and clinical commissioning groups collect information from adult social care providers.
- Continue our current approach to joint inspections, such as the multi-agency work with HMI Prisons, HMI Constabulary, Ofsted and HMI Probation for children's services and in the criminal justice system, and look for opportunities to develop future joint inspection programmes.

Our measures for 2016 to 2021

In order to know whether we have achieved our ambition, we will need to measure how we are doing. We will keep these measures under review.

How we will measure whether we have achieved our ambition	
People trust and use our expert, independent judgements about the quality of care.	**Measure 1:** People reading our reports say they help them make choices.
	Measure 2: People tell us they trust that CQC is on the side of people who use services.
People have confidence that we will identify good and poor care and that we will take action where necessary so their rights are protected.	**Measure 1:** The number of newly registered services where a regulatory response is required.
	Measure 2: The range of ratings across all four rating categories (outstanding, good, requires improvement and inadequate).
	Measure 3: The number of services that are removed from the market where they fail to improve following enforcement action.
Organisations that deliver care improve quality as a result of our regulation.	**Measure 1:** The number of services that agree our standards, guidance and reports and inspections help them to improve.
	Measure 2: The number of services rated inadequate or requires improvement that improve on re-inspection.
Organisations are encouraged to use resources as efficiently as possible to deliver high-quality care.	**Measure 1:** (starting from 2017/18) The number of NHS trusts and foundation trusts that agree that the assessments and ratings we publish with NHS Improvement help them to improve the efficiency with which they use resources.
	Measure 2: (starting from 2017/18) The number of NHS trusts and foundation trusts rated inadequate or requires improvement for the efficiency with which they use resources that improve on re-inspection.

About CQC

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.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation.

Caring – treating everyone with dignity and respect.

Integrity – doing the right thing.

Teamwork – learning from each other to be the best we can.

Our statutory objectives

Our strategy is based on our main statutory objectives, which remain the guiding reason for doing what we do. These are: to protect and promote the health, safety and welfare of people who use health and social care services by encouraging improvement of those services; encouraging the provision of those services in a way that focuses on the needs and experiences of people who use those services; and encouraging the efficient and effective use of resources in the provision of those services.

How to contact us

Call us on **03000 616161**
Email us at **enquiries@cqc.org.uk**
Look at our website **www.cqc.org.uk**

Write to us at **Care Quality Commission**
Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA

Follow us on **Twitter @CareQualityComm**

Read more and download this report in other formats at **www.cqc.org.uk/ourstrategy**

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

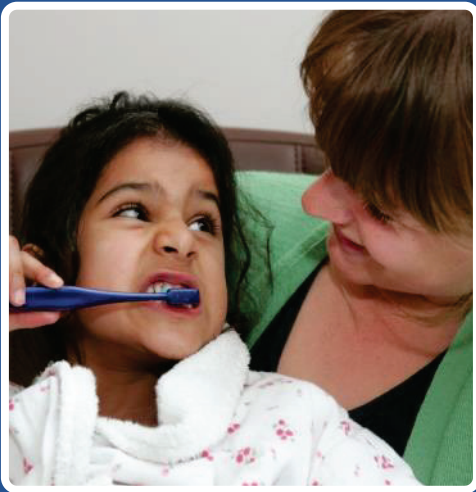
CQC-318-1400-WL-052016

Shaping the future

CQC's strategy for 2016 to 2021

What our strategy means for the health and adult social care services we regulate



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Foreword

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We have set out in our **accompanying strategy** our ambition for CQC over the next five years. We will focus on four priorities to deliver this – encourage improvement, innovation and sustainability in care; deliver an intelligence-driven approach to regulation; promote a single shared view of quality; and improve our efficiency and effectiveness.

In responding to our strategy consultation, care providers, the public and other stakeholders have been broadly positive about the changes CQC has made over the last three years. However, we cannot stand still. We know that there are still improvements to be made and these will have to be delivered with fewer resources.

This document signals how we will build on the strong foundations of our current approach across the sectors we regulate. We will soon complete comprehensive inspections of all services we rate. By using the baseline information that comes from this, and in particular ratings, we have an opportunity to improve and refine our key functions of registration, monitoring, inspection, rating, enforcement and national reporting in line with our new priorities.

Inspections will continue to be central to our assessments of quality, but we will complement this by developing our information and insight model to more effectively target our resources where the risk to the quality of care provided is greatest and where quality is likely to have improved.

People's health and social care needs are changing. Providers are meeting this challenge by changing the ways they deliver services, by breaking down the boundaries between hospital care, primary medical services and adult social care services, and by turning to new models of care and technology to efficiently deliver person-centred care. We will adapt our approach, and work collaboratively, within CQC and with providers and partners across health and social care towards a single shared vision of high-quality care.

People who use services, their carers and families remain central to all aspects of our work. We will continue to encourage and enable them to tell us about their experiences of care by working with our partners, including organisations that represent the public, and we will improve our ability to analyse what they tell us through the use of technology.

To help us implement the strategy, we will work with providers and their staff, with partner organisations, and with the public, people who use services and their families and carers. We will continue to learn from the completion of our current inspection programme this year, and consult where appropriate on changes we plan to make to our core methodology. This means that we can be confident that our work over the next five years responds appropriately to the challenges and opportunities that lie ahead.

New models of care

Summary of what we will do

- Learn alongside providers who offer new care models or use new technologies, to encourage innovation by flexibly and effectively registering and inspecting such new models.
- Build our capability to assess the quality of care from the perspective of people using services, particularly where services are organised by pathways or for particular groups of people across organisational boundaries.

We recognise that the way care is delivered is changing. The way CQC monitors, inspects, rates and reports on care providers will change to reflect new models of care and other changes in service structures. Innovative ways of organising health and social care are currently being tested, including through devolution – for example through the NHS *Five Year Forward View* vanguard programme and other initiatives, such as increasing access to primary care funded by the Prime Minister's Challenge Fund.

A central focus for many of these models is integrating services to improve how people experience care. This is achieved by making sure services are more joined-up and person-centred – for example, by encouraging better working between hospitals and care homes, or bringing together GPs and community-based services into a single organisation.

We will continue to assess individual services. At the same time we will do more to assess quality from the perspective of different groups of people and, where relevant, seek to understand their experiences of care across multiple services. As providers organise themselves in different ways we will increasingly tailor our inspections to changing models – making sure that we have the right combination of expertise on our inspections and that we register, report and rate at a level that is meaningful to the provider and the public.

We will build our capability so that we can inspect new models of care – for example, where care is organised by pathways and for particular groups of people, and where it crosses organisational boundaries. We will work alongside providers and partners such as NHS Improvement, NHS England, the Association of Directors of Adult Social Services and the Local Government Association, and learn from those providers that explore and offer new models. We have allocated an inspector to each of the vanguards across the country so that we can learn alongside them.

We will strengthen our assessment of how well providers work with others to share information and coordinate care, and assess how well providers deliver care for specific populations groups.

New models of care will be expected to deliver care that meets fundamental standards. We want to work closely with providers to understand what good and outstanding looks like in these new models.

Registration

Summary of what we will do

- Take a more robust approach for higher-risk applications and a more streamlined approach for those that are lower-risk, for example by considering the track record of a provider and the people who will be using the service.
- Use a flexible approach that supports new ways of providing health and care services, such as integrated care models that cut across organisational boundaries.
- Make sure the person ultimately responsible for care can be held accountable for quality – for example, we want to register a provider at a corporate level if it delivers care through a number of subsidiary provider organisations.

We will develop a more flexible approach to registration: an approach that is appropriate for how providers structure themselves now, as well as for future changes in ways of working and innovation in models of care.

A flexible approach means that we will focus resources where risk is the greatest. By 2020, all new registrations will be risk-assessed against set criteria. This will determine the process for the registration – for example whether we need to carry out an interview or a site visit. These criteria might include the nature of people using the service, the provider's track record on quality and whether individuals are professionally registered or subject to scrutiny by other bodies. Some applications, such as a change to an existing home-care agency branch office address, will be treated as an administrative change that providers can make through our more streamlined online process.

Where providers are delivering care through new, integrated and innovative approaches we will work with providers themselves, and with partners across health and social care, to understand their approach and how they are organised. This will help us determine the most efficient and appropriate ways of registering their services and how we will regulate them going forward.

We will also strengthen the link between registration and inspection by coordinating work between teams and sharing information more effectively.

We will move our registration processes online. This will allow us to set out clearly in one place, which providers deliver which services where and to whom – a digital register.

We will improve the way we request information from those registering with us by using a consistent framework, based around our five key questions that we ask each service: is it safe, effective, caring, responsive and well-led? We will

work with newly registered providers and managers to embed the key questions at the heart of their understanding of high-quality care.

We will consider whether we register providers at the right level when they are part of wider groups or organisations. This includes corporate groups, chains and federations. Our current approach is to register the body that directly runs local services, though we know these can be subsidiaries of larger companies or groups. So it may be the leadership of the parent company or group that is ultimately accountable for matters of quality in their services.

Where we find shortcomings, it is vital that we can hold leaders to account where we think this will protect people from poor care and ensure the improvements we need to see are made. Our enforcement powers only relate to providers that are registered with us. So we want to ensure that providers are registered at the level where ultimate accountability for quality sits.

Our plans for hospitals

Summary of what we will do

- Focus our inspections on core services (for example critical care, surgery), particularly those that require improvement or are inadequate and extend the intervals between inspections for those that are good or outstanding.
- Update core service ratings on the basis of smaller, focused inspections and make more use of unannounced inspections.
- Hold an annual review of each provider to determine where to focus our inspection activity for the year ahead.
- Expect providers to describe their own quality against our five key questions, and feed this information into the annual review.
- Produce shorter reports, more quickly, that make clear how we have come to our decisions.
- With NHS Improvement, give a new rating of how efficiently and effectively NHS trusts and foundation trusts use their resources.
- Develop approaches to inspect services that cross our current core service boundaries, like cancer and mental health services in an acute hospital.

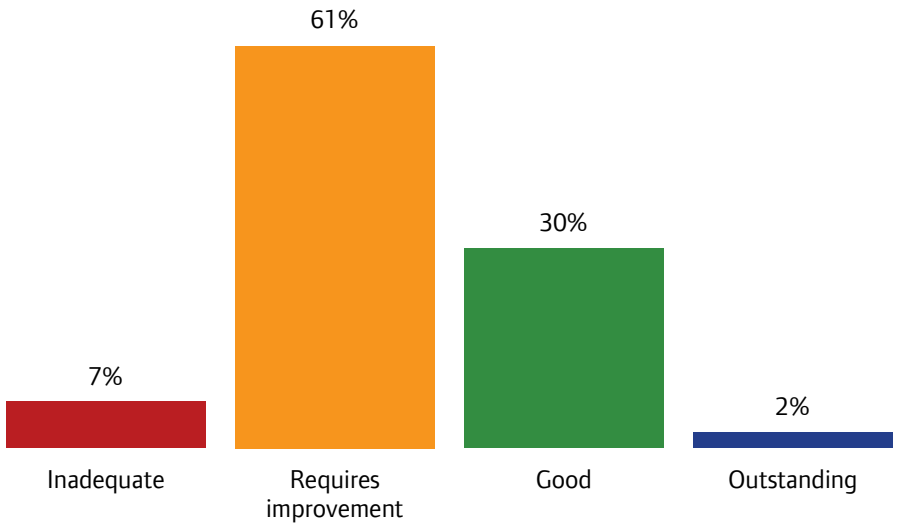
For all sectors, we will keep the experience of people who use services, their carers and families at the heart of everything we do and ensure that equality and human rights remain embedded in our approach.

Context

This section sets out how our functions of monitoring, inspection and reporting will evolve for acute, mental health, community and ambulance NHS trusts and independent healthcare services.

By the end of March 2017, we will have carried out comprehensive inspections of all acute, mental health, community and ambulance NHS trusts and independent hospitals, and all standalone substance misuse services. For the first time we will have a wealth of baseline information about the quality of all of these services across England. We already have a baseline for NHS trusts, where we have found a wide variation of quality across England, including good and also some outstanding practice. However, we have rated 61% of NHS trusts and foundation trusts as requires improvement, while 7% are inadequate. This

Ratings: NHS trusts and foundation trusts (May 2016)



demonstrates the need for continued oversight of quality by an independent regulator that can take action where necessary and encourage improvement.

During 2016/17, we will continue inspecting the independent sector to get an equivalent baseline picture of the quality of care for these services. We will use this baseline, and the insight that comes from it, to significantly improve and evolve our approach and the impact we have. We will continue to work with independent sector providers to improve the availability and quality of data about these services.

We also need to consider how we can work more efficiently – including with partners such as NHS Improvement and NHS England – as any changes will have to be delivered with fewer resources. The challenge of doing more, for less, but better, is one we share with providers.

We recognise the challenges that the sector faces: the financial pressures, recruitment issues and moves to develop innovative and efficient models for delivering care. We are committed to working with the sector to develop an approach that recognises these issues and is flexible enough to accommodate the changing environment. We also want to hear about people's experiences of care, both good and bad. Where people have concerns we want to be clear that they can raise them with us – this applies whether they are using the service themselves, have friends or families using services, or are members of staff.

To help us meet this challenge we want to build on the strong foundations of our comprehensive inspection programme and develop our future approach to inspecting hospitals to deliver a model that:

- takes account of the variations in quality that we have found
- uses a provider's own view of quality alongside information from other sources, particularly what people using services say
- incorporates an assessment of how efficiently and effectively acute NHS trusts and foundation trusts use their resources
- recognises and encourages improvements in quality
- is flexible to accommodate new and innovative models of care delivery
- is costed, rigorously evaluated and efficient in its use of CQC's funding and its impact on providers
- uses information more effectively in our work with both NHS and independent providers.

This development will build on the strong foundations of our comprehensive inspection programme and evolve over the next five years. While we will maintain comprehensive inspections for newly registered providers, and those we are most concerned about, we will move to a more targeted and tailored approach focused on core services. Our inspections will be smaller and more frequent, with a maximum interval between them based on previous inspection findings, our ratings and wider intelligence about the quality of care of providers. Where appropriate, we will adapt this approach for those services we do not currently rate, such as independent ambulances.

Efficient and effective use of resources

CQC has committed to a shared view of quality with NHS Improvement and other key system partners. We will work with NHS Improvement to develop a methodology for assessing efficiency and use of resources for NHS trusts and foundation trusts, beginning in the acute sector. We will ensure that both the quality and the use of resources assessments are clear, meaningful and relevant to providers and the public. Ratings should give providers an incentive to improve performance on both quality and use of resources and neither should override the other.

Development and testing of the assessment approach is underway, led by NHS Improvement. We will consult publicly on the model later in 2016/17, including on how the use of resources rating is brought together with CQC's existing quality ratings.

Monitor

We are committed to developing a single shared view of quality across providers, commissioners and regulators. This will ensure that providers can use the same information required by regulators and commissioners to assure themselves of the quality of services they provide. We will be working closely with the National Quality Board, in particular with NHS Improvement, NHS England and the National Institute for Health and Care Excellence, to define what good quality care looks like using the five key questions we ask of each service: is it safe, effective, caring, responsive and well-led? We will also work with NHS Improvement to develop an approach to assessing and rating efficiency and use of resources for NHS trusts and foundation trusts, alongside our five key questions on quality.

With our partners, we will bring together a common information set that is accessible to all. This will mean that providers only have to share information once, minimising duplication and reducing their administrative burden.

We will look at how we can work more effectively with our partners by using each other's information, such as accreditation schemes. We also recognise the importance of developing good relationships with providers and commissioners (including NHS England, clinical commissioning groups and local authorities), as well as statutory groups that represent the public, such as the Healthwatch network, foundation trust councils of governors and complaints advocacy organisations. Spending more time on relationship management will enable us to have a shared ongoing understanding of local issues and areas of risk. We also want to develop a more mature relationship with providers so that they are open and transparent with us and feel that they can highlight challenges as they occur.

We will improve the provider information request (PIR) submitted before a comprehensive inspection so it becomes an electronic submission, able to be updated regularly. We will expect providers to give their view of the quality of care they are providing against our five key questions, as part of annual reporting processes, including what has changed over the year, their plans for improvement and examples of good practice. This will help us decide what and when to inspect alongside the other intelligence we hold. We will explore this further with providers including whether some, if not all, of the information can be shared with commissioners and the public. We will also explore with providers how we can make this a core expectation of our regulatory relationship so that each provider's view of the quality they provide is transparent.

We will adopt a targeted and tailored approach to plan future inspections, using providers' regulatory history, our new insight model, information from providers and local knowledge to determine the scope of inspection (for example, which core services to review). We will develop a set of 'triggers', which will prompt us to investigate further, where we believe the quality of a service is poor or follow up where improvements are being made.

Through our new insight model, we will improve the information we have about local services and our ability to analyse and use this information to inform our inspections – for example, using information from our outlier programme and the metrics from our current 'Intelligent Monitoring' programme that correlate most highly to our inspection ratings. Our insight model will give our inspectors more timely information about providers' performance at core service and key question level, as well as overall provider level.

We will make improvements to our key lines of enquiry (KLOEs) and our assessment of core services so that we continue to assess aspects of quality that are most closely linked to good outcomes for patients.

Inspect

We will have a targeted approach to inspection that focuses our efforts both on areas of risk and where quality is most likely to have changed or improved. Although we will retain large-scale comprehensive inspections where we believe these are needed, we will move to a targeted and tailored approach focused on core services in most cases. This will mean more frequent inspections on a smaller scale and a greater reliance on unannounced or short notice visits. We will develop a regulatory plan for each organisation, based on the information we hold in our insight model – a combination of the existing baseline rating and ongoing data, information from a range of sources and local knowledge. Evidence from our work so far shows that a good predictor of the overall quality of care a provider delivers is how well-led they are.

For NHS trusts and foundation trusts we will carry out an annual inspection which, as a minimum, will be an inspection of how well-led they are and of one core service. We may also carry out an inspection to follow up a concern and to review ratings, where appropriate, including where care has improved.

We will prioritise the inspection of core services that have been rated inadequate or requires improvement. However we will also re-inspect a percentage of core services that have been rated good or outstanding to ensure quality is maintained. We will test and confirm the maximum interval within which all trust core services will be inspected as we develop our approach.

Where we have not rated independent providers (for example, standalone substance misuse services), we will use the findings from our previous inspections, along with our insight model (where available), information from providers, and local intelligence to determine our regulatory activity.

We will continue our regular visits to all places where people are subject to the Mental Health Act (MHA), and will use what we find to help inform our regulatory activities.

We will consider joint inspections where appropriate, for example, inspecting with NHS Improvement when making an assessment on the effective use of resources.

We will retain the ability to carry out comprehensive inspections where necessary – for example, where we have systemic or significant concerns, such as services in special measures. Where specific concerns about a provider are raised, we will also continue to carry out responsive, focused inspections (or MHA visits where appropriate). We will inspect newly registered services within 12 months to award a baseline rating.

The overall size of inspection teams will be considerably smaller by focusing on fewer core services. The roles in each team will depend on the scope of the inspection. Teams will include specialist advisors, Experts by Experience and MHA Reviewers (where appropriate), but they may contribute only to part of an inspection. The views of people using services and the public will continue to be an important source of information for our inspections.

We will work with new care models, such as hospital chains, and make sure our approach will be flexible enough to accommodate them. We will also target areas that we have not previously inspected to improve our understanding of their quality of care. These may be areas that are known to be at risk of poor quality, or that affect a large percentage of the population using services, and cross our current core service boundaries – for example, people with mental health needs in acute hospital settings, or people diagnosed with cancer.

Rate and report

In some cases, the information we hold will confirm the existing rating for a core service. Our smaller-scale inspections will review and, where appropriate, change the ratings for the core services we inspect. This may lead to a change in the overall rating for a provider. Factors we will consider in making changes to a providers' overall rating include:

- the findings of inspections carried out that year
- a review of leadership and governance within the organisation
- our insight model and other information we have gathered through local relationships.

We will produce shorter reports more quickly and that are more accessible to the public and will more clearly identify the evidence we gathered to inform our assessment. We will make clear in our reports where we are requiring that action be taken and where we are making a recommendation.

In 2016/17, we will start to publish the new assessments of the efficient and effective use of resources in NHS trusts and foundation trusts alongside our existing quality ratings, working together with NHS Improvement. We will also be developing options to combine these ratings from 2017/18, and consult on our proposed approach later in the year.

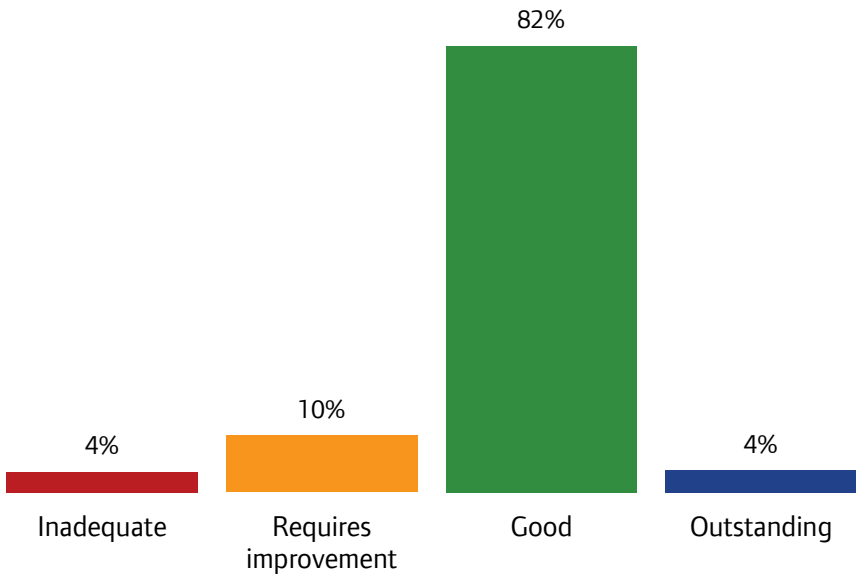
Our plans for primary medical services

Summary of what we will do

- Work with partners to reduce duplication for GP practices and dental providers, agreeing jointly what action should be taken by whom where there may be risks of poor quality care.
- Agree a data request with the General Medical Council and NHS England so that GP practices only need to provide a single description of their quality based on the five key questions.
- Move to a maximum interval of five years for inspecting GP practices rated good and outstanding – subject to general practices providing accurate and full data, and our confidence that quality has not changed significantly.
- Focus on areas where there may be emerging risks, or where we need to understand more about innovative models of care, for example independent doctors or digital health providers.
- For federations and other new care models, focus on how well-led they are at corporate level, and consider inspecting a sample of locations, alongside looking at local area data to understand potential risks.
- For urgent and emergency care – including out-of-hours and NHS 111 services – inspect related services at the same time and strengthen how we work with our hospital inspection teams.
- Continue our current approach to joint inspections, such as the multi-agency work with HMI Prisons, HMI Constabulary, Ofsted and HMI Probation for children's services and in the criminal justice system, and look for opportunities to develop future joint inspection programmes.

For all sectors, we will keep the experience of people who use services, their carers and families at the heart of everything we do and ensure that equality and human rights remain embedded in our approach.

Ratings: Primary medical services (May 2016)



Context

This section sets out how our functions of monitoring, inspection and reporting will evolve for GPs, dentists, urgent care, out-of-hours and 111 services, independent doctors and digital health services and inspections of children's services and of health and justice services.

By the end of 2016/17, we will have carried out comprehensive inspections and rated all GP practices, urgent care centres, out-of-hours and 111 services. We will have built on the initial round of inspections of dental practices we carried out in 2013/14, and inspected 20% of them. And we will have worked with partners to deliver a programme of reviews and inspections of children's services and health and justice services, and started comprehensive inspections of independent doctors.

For the first time, we will have a baseline of information that tells us about the quality of all general practices, urgent care centres, out-of-hours and 111 services across England. It is reassuring that so far we have found that the majority of practices (86%) are good or outstanding. However, we also have rated 4% as inadequate (affecting 600,000 patients) and 10% as requires improvement.

We will build on the aspects of our current approach that have worked well and driven improvements in the quality of care. We will rebalance our resources to focus on those areas where there may be unidentified or emerging risks, or where we need to understand more about innovative models of care – for example independent doctors, digital health care (such as online consultation services), some urgent care and new, more integrated care services.

We will invest in building local relationships and partnerships to help us move to a more intelligence-driven and targeted and tailored methodology, and also to ensure that collectively we have a better understanding of local issues and priorities. We also want to hear about people's experiences of care, both good and bad. Where people have concerns we want to be clear that they can raise them with us – this applies whether they are using the service themselves, have friends or families using services, or are members of staff.

The services we regulate are also going through a period of rapid change. We need to deliver a dynamic model that is both responsive to variations in the

quality of care and flexible to the new organisations that provide it, such as models that integrate both primary medical care and community health services, including those now emerging through the *Forward View* vanguard programme. We must ensure that we add value to the system, and work in the most cost-effective way possible.

We want to continue to encourage improvement and innovation in services. Crucially, we must strike the right balance between focusing on improving quality of care within a provider, such as an individual GP practice, and driving improvement across local and national systems – for example, the care of people with diabetes that needs to be coordinated across a number of services. We must ensure that we are also focusing on the priorities that matter most locally to the public and people who use services.

We recognise the challenges that services face over the next five years. We are committed to working more consistently with our partners to reduce unnecessary regulatory duplication experienced by services. This will be driven by our Regulation of General Medical Practice and Dental Practice Programme Boards, which provide a forum for regulatory bodies to tackle these issues together.

The next phase of regulation will evolve over the next five years. We will continue to carry out comprehensive assessments of quality, with comprehensive inspections being one element of a wider range of ways of working with services. We will move to a more targeted and tailored approach, with maximum intervals between inspections based on previous ratings (for those services we rate). We may inspect earlier than planned, depending on what our ongoing monitoring of wider intelligence (our insight) about a service is telling us.

We are currently piloting our approach to the regulation of independent doctors. We will publish our assessment framework and approach to regulating these types of services during 2016/17. We are currently developing our approach to regulating the provision of digital health care.

We will continue to deliver our joint health and justice services inspection work. Alongside delivering our children's inspection programmes (covering looked after children and safeguarding, joint targeted area inspections with Ofsted and special educational needs and disability), we will also consider how we can further embed assessing child safeguarding arrangements into our wider inspection activity.

We aim to begin implementing aspects of our new approach from April 2017, after we have completed our programme of comprehensive inspections. We will be co-producing and testing elements of our new model with patients and the public, and with partner organisations including NHS England, the General Medical Council, the Royal College of General Practitioners and the British Medical Association.

Monitor

For general practice, we will develop a single shared view of quality with providers, people who use services, and our partners, including NHS England, the General Medical Council, and the National Institute for Health and Care Excellence. We will structure a common framework according to the five key questions we ask of each service: is it safe, effective, caring, responsive and well-led? This framework will use consistent and transparent measurements to drive improvements at provider and local level and across the system.

We will introduce our insight model, which brings together all of the national and local intelligence we hold on practices, to support our decision making. This new model for ongoing monitoring will identify where good care has been maintained or improved, as well as where care has deteriorated. The development of our insight model will support an increase in the maximum interval between inspections for good and outstanding practices.

Our insight will be flexible to the changing provider landscape and new models of care. We will make improvements to our key lines of enquiry (KLOEs) and population groups, so that they continue to assess aspects of quality that are most closely linked to outcomes for patients, for example for people with mental health needs.

We will analyse general practice data across local areas, such as across clinical commissioning groups (CCGs). This will help us understand patterns in data that may not show up at individual practice level.

To underpin our monitoring we will enable GP practices to share up-to-date information with CQC and other regulators and expect them to describe their view of the quality of care they are providing against our five key questions, as part of annual reporting processes, including what has changed over the year, their plans for improvement and examples of good practice. We will explore this further with providers, and see whether some, if not all, of the information can be shared with commissioners and the public. We will also explore with providers how we can make this a core expectation of our regulatory relationship so that each provider's view of the quality they provide is transparent. We are working closely with NHS England and the General Medical Council to align our information requests and develop more integrated systems, so that we reduce unnecessary duplication.

We are currently piloting a GP Practice Leadership Assessment Tool (developed with the King's Fund) to evaluate if it will help practices and CQC to assess leadership and culture within a practice and identify areas for improvement.

In consultation with NHS England, CCGs and other partners, we will carry out a regular review to identify which providers are posing an enhanced risk, what actions should be taken, and who should take them. This knowledge will complement our insight and inform the development and delivery of the local area inspection plans.

Inspection teams will have dedicated time for strengthening local relationships and gathering local intelligence for their portfolio of providers. Depending on the level of risk or potential improvement that is flagged, inspectors will respond, using a range of interventions, which may include carrying out an inspection.

We will identify annual activity for dental services by reviewing the information we hold, including what providers tell us, and involving commissioners and other regulators, where possible. Developing a shared view of quality is a central feature of our monitoring and inspection activity. We will do this by building on the partnership work between system regulators and commissioners arising from the Regulation of Dental Services Programme Board.

As the data currently available for out-of-hours and urgent care services is more limited, we will continue to be more reliant on inspectors gathering local information.

Inspect

For general practice, the frequency and scope of each inspection will be based on the current level of concern that we have about a service, or their potential for improvement. We will inspect services that we have most concerns about more frequently than those where we have least concerns. Our level of concern will be based on previous ratings and up-to-date monitoring information. We will inspect a service earlier than planned if our insight identifies a level of concern that warrants it, or if we think quality has improved. With more effective monitoring information, more of our inspection activity will be unannounced. Our inspection programme will include a mix of focused, comprehensive and population or pathway assessments, reflecting national and local priorities.

We will inspect all newly registered locations within 12 months to award their baseline rating. Services rated inadequate will be inspected every six months, and those rated requires improvement at least every year.

For general practice, we will move to a maximum interval between inspections of five years for practices rated good and outstanding. This will be subject to practices providing accurate and full data, which is available to CQC and partner organisations, and also to CQC remaining assured that the quality of care has not changed significantly since the previous inspection.

We will carry out comprehensive inspections of all newly registered providers, and those that have been rated as inadequate. For other services, we may carry out a comprehensive inspection or an inspection focused on areas of concern or potential improvement, or with a particular focus on a population group or theme.

A core principle of our inspection approach is using specialist inspection teams and clinical expertise. This will continue to form an important element of our model. We will tailor the size and composition of the teams to suit the focus of the inspection and the nature and size of the service.

We will ensure that the level at which we inspect will be flexible to the type of provider. For many providers, this will remain at service level. For general practice, our approach for federations and other new care models will be informed by the structure and governance of the organisation. This could include inspecting a sample of locations, based on previous ratings and ongoing monitoring information. We may also focus on how well-led organisations, such as federations, are at a corporate level. For dental services, where appropriate (for example, large dental corporate providers), our assessment will be at headquarters level, with inspections of a sample of locations.

We will continue to inspect a proportion of registered primary care dental locations every year. Our current programme of inspections will provide a more comprehensive evidence base to identify the impact of our approach and how we can improve it. This will build on the findings of the Regulation of Dental Services Programme Board.

We will develop our model for regulating urgent care so that it can respond to the changes in national policy (for example changes to commissioning arrangements). Our approach will also be flexible to the changing models that deliver urgent care. Our Hospitals and Primary Medical Services inspection teams will collaborate more strongly to understand the quality of urgent care within a local area. This will build on our current urgent and emergency care

pilot, which is testing an approach for assessing care within an area and how providers coordinate care to produce a seamless experience for people who use services. Our future approach to inspecting care across pathways and populations will be informed by our findings.

As integrated out-of-hours and NHS 111 services are continuing to increase, we will continue to carry out inspections of both elements at the same time. We will also test joint inspections with commissioners. We will continue to inspect and rate at provider level.

Rate and report

We will continue to publish data, inspection reports and ratings for general practice and urgent care services. For many GP providers this will continue to be at practice level. An overall rating will normally only be updated on the basis of evidence from inspection.

We will develop consistent principles for the level at which we provide ratings for larger GP practices, federations, corporate providers and new care models such as the *Forward View* vanguards. The right level will reflect the different models of care, and will be meaningful for people who use services and that particular provider.

Our inspection reports will be concise and will highlight key findings, changes in quality since the previous inspection and areas for providers to address. We will produce reports more quickly, supported by data published at the most meaningful level for a provider and for the public.

Our plans for adult social care

Summary of what we will do

- Improve the information we have about local services and our ability to analyse and use this to inform our inspections – including expecting providers to describe their own quality against the five key questions.
- Respond to risk and potential improvements in quality through timely inspections.
- Once we have access to better information about services we will work with partners to agree and introduce longer intervals between inspections for services rated good and outstanding.
- Update ratings on the basis of inspection, and clarify where services are good with outstanding features and where services that require improvement are not meeting fundamental standards.
- For corporate providers, improve our local activity by better understanding the head office leadership and how this impacts on quality through culture and policies.

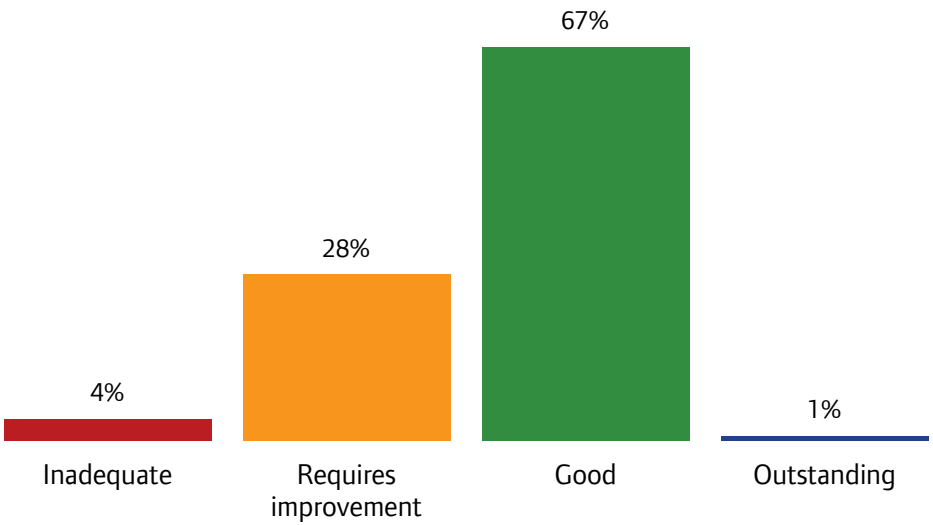
For all sectors, we will keep the experience of people who use services, their carers and families at the heart of everything we do and ensure that equality and human rights remain embedded in our approach.

Context

This section sets out how our functions of monitoring, inspection and reporting will evolve for adult social care.

By the end of 2016/17 we will have a comprehensive understanding of the quality of adult social care services across the country, following the introduction of our new approach in October 2014. So far we have found that the majority of services (68%) are rated as good or outstanding. However we have found that 4% are rated inadequate and 28% requires improvement. This understanding will give us a strong foundation from which to build and deliver the commitments set out in our strategy for 2016 to 2021, which we will start to develop from this year, alongside people who use services, providers, commissioners and other partners.

Ratings: Adult social care (May 2016)



The adult social care sector is large with over 25,000 locations, many of which are run by small providers. The financial pressures that the sector faces are well known, as are the difficulties in recruiting and retaining staff. In these circumstances, it is more important than ever that the quality regulator is on the side of people using services, identifying good practice, encouraging improvement in providers and holding them to account where they do not meet expectations.

In meeting this challenge, we want to be clear that we will build on what we have done over the last two years. The way we regulate will be different in 2020 and our approach will continue to evolve. We will draw on our understanding of the current quality of care, making better use of information from providers, people who use services, their carers and families and others, and focusing our efforts both where risks of poor care are greatest, and where we see significant improvements. We want to hear about people's experiences of care, both good and bad. Where people have concerns we want to be clear that they can raise them with us – this applies whether they are using the service themselves, have friends or families using services, or are members of staff.

Monitor

Although we do respond to risk now, the quality and availability of information is currently limited in adult social care and this is an important focus of improvement for us over the next few years. As more data and information become available, we will have a more comprehensive and sustained picture of the quality of care in individual services. This will allow us to respond more quickly and plan our inspections more proactively in response to possible risks to people, or where there has been significant improvement for people using services. This will give greater confidence that the regulator knows what is happening in local services throughout the year. We will encourage people who use services, their families and carers, as well as staff and other professionals, to pass information to us about the quality of care.

Through our new insight model, we will improve the information we have about local services and our ability to analyse and use this information to inform our inspections. We will also improve the provider information return

(PIR) so providers can describe their own quality based on the five key questions we ask each service (is it safe, effective, caring, responsive and well-led?), as part of annual reporting processes. This will include information to indicate what has changed over the year, their plans for improvement and examples of good practice. We will explore this further with providers, including whether some, if not all, of the information can be shared with commissioners and the public. We will also explore with providers how we can make this a core expectation of our regulatory relationship so that each provider's view of the quality they provide is transparent. Information will be submitted online and providers will be able to update it as and when they need to.

We will encourage more people to share their experiences of care with us and improve our ability to analyse what they tell us through the use of technology. This will help us to understand and respond better to the views of people using services – this is particularly crucial where people are looked after in their own homes, as we are less likely to be able to meet with them.

In order to promote a shared view of quality, we will work with local authorities and clinical commissioning groups to develop more consistent quality frameworks and expectations on providers, based on our five key questions. We will seek a common dataset that we can all access, so that providers only have to share information once, minimising duplication and reducing their administrative burden. We will improve our understanding of the quality of services delivered in people's own homes by requiring providers to share their call monitoring data – in particular, numbers of missed or late visits, length of stay and how many different carers are visiting individuals.

We will make improvements to our key lines of enquiry (KLOEs) so that they continue to assess aspects of quality that are most closely linked to outcomes for people. And we will monitor providers within a framework, based on our five key questions and KLOEs.

We will also continue to monitor the financial sustainability of the most difficult to replace providers of adult social care through our existing Market Oversight function.

Inspect

We will continue to inspect and rate all adult social care locations, asking whether the current rating is still accurate, so people using services can be confident that our judgements remain timely and appropriate. Where we inspect large providers with more than one location, we will improve our understanding of the effectiveness and impact of the overall leadership at head office. We know that the leadership can have an important bearing on quality through the culture it sets, its policies and procedures and how it monitors and ensures continuous improvement.

The length of time between inspections will be determined by the rating of the service and the likelihood of quality having changed. We will inspect all newly registered locations within 12 months to award their baseline rating. Services rated as inadequate will be inspected every six months, and those rated as requires improvement every year. Over the course of the strategy, we will move to longer intervals between inspections for services rated good and outstanding as we have access to better information, and in 2016/17 we will start to work with our partners and people who use services to agree appropriate timescales.

Where our monitoring activity suggests there has been a significant improvement or deterioration in the quality of care, we can and will inspect sooner.

Our inspections will always focus on the experience of people using services and they will also involve talking with, and observing, people using the service and staff. Our specialist inspection teams – particularly for services delivering poorer care or where we have concerns – will continue to benefit from Experts by Experience and specialist advisors.

Our inspections will be most resource intensive where the risk to people using services is greatest. Therefore, inspecting an inadequate service will normally be a longer inspection with a bigger team, compared to when we return to a good service where the information available suggests the rating remains accurate.

Rate and report

Given the currently limited availability of information about adult social care services, we will only change a rating on the basis of evidence from inspection, and this could be a comprehensive or focused inspection.

We will be clearer when services are good with outstanding features and where the rating of requires improvement does and does not entail a breach of regulations.

Drawing on information from our insight, from services and from our inspectors, our reports will be shorter and quicker to produce and publish, so that people using services will get to know our judgements more quickly and will be empowered to make choices about care using our information. We will work with national and local partners to share examples of good practice to encourage improvement.

Enforcement

Summary of what we will do

- Continue to use the full range of our enforcement powers, such as restrictions or closure of services, fixed penalty notices or prosecution where we find poor care below the fundamental standards, to make sure people's rights are protected and those responsible are held to account.

Where providers are failing to deliver the quality of care we expect, we will continue to take enforcement action against providers and individuals, to secure improvements in services and protect people using services from potential or actual harm. Where people are exposed to significant harm or risk of significant harm, we will take urgent enforcement action to prevent them being exposed to further risk. If appropriate, we will hold the provider to account using our powers to prosecute where fundamental standards have been breached.

We will continue to follow our enforcement policy and use the full range of our powers, from fixed penalty notices, to criminal prosecution, to closure or restrictions on services. We will share information about our enforcement action so that the public and good providers can be confident we are tackling poor care.

We will seek changes in the regulations so that we can share information during enforcement action we are taking, rather than at the conclusion.

We will review and adapt our current approach to special measures in all sectors, to ensure it is enabling services, commissioners, regulators and other stakeholders to act quickly and decisively where the quality of care is most poor.

About CQC

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.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation.
Caring – treating everyone with dignity and respect.
Integrity – doing the right thing.
Teamwork – learning from each other to be the best we can.

Our statutory objectives

Our strategy is based on our main statutory objectives, which remain the guiding reason for doing what we do. These are: to protect and promote the health, safety and welfare of people who use health and social care services by encouraging improvement of those services; encouraging the provision of those services in a way that focuses on the needs and experiences of people who use those services; and encouraging the efficient and effective use of resources in the provision of those services.

How to contact us

Call us on **03000 616161**
Email us at **enquiries@cqc.org.uk**
Look at our website **www.cqc.org.uk**

Write to us at **Care Quality Commission**
Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA

Follow us on **Twitter @CareQualityComm**

Read more and download this report in other formats at **www.cqc.org.uk/ourstrategy**

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

CQC-331-052016

ADULT SERVICES COMMITTEE

7 July 2016

Report of: Director of Child and Adult Services

Subject: ENGAGEMENT WITH OLDER PEOPLE

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1. TYPE OF DECISION / APPLICABLE CATEGORY

No decision required – for information.

2. PURPOSE OF REPORT

2.1 To update the Adult Services Committee on the outcome of an engagement event with older people and action taken as a result, as well as plans for further engagement on a regular basis.

3. BACKGROUND

3.1 During August and September 2015 discussions were held with the 50+ Forum, elected members and officers from Adult Services to review the way in which older people are able to contribute their views regarding issues that affect them. It was agreed that it is important for older people in Hartlepool to be able to influence and contribute to issues being considered by the Council and partnership agencies, to ensure policies and services meet the needs of local people.

3.2 Following a paper presented to the Council's Corporate Management Team a commitment was given by the Council to facilitate up to four events per year, and to feed the result from these events to Adult Services Committee, or other relevant policy committees, for consideration.

3.3 The second of these events was held on 14 March 2015. The event was less well attended than the first, but feedback from the older people in attendance remained positive regarding the way the event was facilitated. People said they appreciated the time they had to express their views and that they felt they were listened to.

4. EVENT THEMES

4.1 The event on 14 March 2016 looked at the following issues with a range of speakers attending to present information to the group.

- **Transport**
  Presentation from Regeneration & Neighbourhoods transport staff on current arrangements and developments in Hartlepool.

- **Community Safety**
  Presentation from Community Safety team on what the team does and how older people can make small changes to improve their own safety.

- **Hartlepool Now**
  Update on the website and how to use it.

- **iPads - is this the future?**
  Talk from Michael Slimmings of Incontrolable (local user led organisation) around the use of iPads and how this can be relevant in old age.

5. FEEDBACK

5.1 Transport

A presentation was delivered by Mike Blair, Technical Services Manager and Jayne Brown, Passenger Transport Services Team Leader. They set out what the functions of the team are:

- Passenger Transport Services – Responsible for the procurement, provision and management of a range transport services in Hartlepool
- More awareness on what activities are out there both day and night
- Home to school transport
- Extended school services
- Adult Services transport
- Educational visits
- Independent travel training
- Community Travel Clubs
- Teeswide Safe Places
- Courier services
- Public transport
- Concessionary Fares
- Safeguarding transport
- Private hire

They advised the group about Community Travel Clubs - these are bespoke transport solutions based on an individual group's needs. They can be used for any purpose i.e. shopping, medical appointments, social outings etc. The whole cost of transport must be met by the club members. They advised that they are predominantly utilised by individuals with a learning disability but the principle lends itself to any group of individuals including older people.

Issues around public transport were presented:

- Supported Bus Service Budget – ceased in 2010.
- Local bus operators reviewed services and withdrew services with low patronage.
- Use it or Lose it Campaign - Stagecoach reinstated some services but only service 7 had patronage to sustain following the campaign.
- Bridge card – If need any assistance from the driver.

There followed a lengthy debate about the position in the town around transport for older people particularly bus services. The following questions were asked and answered:

Q. Why were supported buses taken off?
A. As part of the savings strategy a number of years ago the Council voted not to continue to financially support bus routes. As discussed within the presentation, some routes were subject to a 'Use it or Lose It' campaign where bus companies paid to run the routes and evaluated whether the routes could remain. Many of them were not used and therefore ceased to operate.

Q. Do services have to be operated even if they are not profitable?
A. There is no legislation to enforce bus operators to run non-profitable services, the Council and community groups continue to work with the major bus companies.

Q. Combined Authority - will this mean more services especially after 6.30pm?
A. Mike Blair discussed the opportunities for the town as part of the Combined Authority. He explained the new 'Bus Bill' which was being introduced to ensure that information about buses, routes etc is more accessible, that local authorities and bus companies are encouraged to work in partnership and that the new legislation will help that. He reiterated that none of the legislation was about local authorities being able to make the bus companies implement changes but about working together with them and local communities.

Q. Who will put forward Hartlepool's views in the combined authority?
A. As leader of the council Christopher Akers-Belcher will represent the town.

Q. Who is responsible for flexibility of routes and can we suggest diversions?
A. Bus operators are responsible for routes but must take into account planning obligations such as the South West extension.

Q. Who trains bus drivers? (some discussion about the different experiences people have had; both good and bad)
A. Bus operators are responsible for training of drivers.

Q. Derwent Street residents - issues around changes to the bus stops and the issues that has caused?
A. Bus operators are responsible for where bus stops are - residents can canvas the bus operators.

Q. How does feedback get to bus operators?
A. Communities need to speak at meetings like this and there are also transport champions in the town and feedback can be passed to them. Feedback from this meeting will be passed through the Council's meetings with bus companies. Jayne Brown in particular has regular contact with colleagues within the industry.

5.2 Community Safety

A presentation was delivered by Ken Bennett, Community & Safety Engagement Team Leader and Lorna Hilton, Victim Services Officer. They set out what the functions of the team are:

- Mediation & Restorative Justice
- Prevention of anti social behaviour
- Victim support
- Environmental factors and how they impact on crime
- Prevent Strategy

With regard to Mediation & Restorative Justice Ken described how both victims and offenders are benefitting from meeting face to face and it is particularly helpful for offenders to understand the impact their actions have on others. Ken described how the Council employs different tactics to deter anti social behaviour working in partnership with other agencies such as the police, and also discussed victim support. The Prevent Strategy was discussed and Ken explained the statutory requirement placed on the Council to ensure that the local authority works with local partners and other statutory agencies to be aware of the anti-terrorism strategy.

Lorna Hilton followed with her presentation on the impact of crime on the individual. She described how being frightened as an older person can make people socially isolated. She discussed doorstep crime and talked about the practical steps everyone in the community can take to ensure they keep themselves from being targeted. She talked about stickers that can be placed in windows and using chains to ensure that people could check before they decided to answer the door. She reiterated that legitimate people will always have identification and people should feel confident to ask for it.

There as discussion around street lighting and the overall changes and it was reiterated that street lighting is for lighting the highways and not paths and driveways. Lorna described that people can have personal home safety visits following a referral to the service from another partner agency or organisation.

The home safety visit involves a risk assessment of the property, before advice is provided regarding crime prevention materials that can be installed to the property to improve security. This can include door and window locks, night lights and alarms, of which all are installed on a site specific basis. Any products installed on behalf of the Safer Hartlepool Partnership are undertaken by trusted sources.

Lorna advised the group that she could attend resident association meetings or make visits to anyone attending the group if they made arrangements with her at the end of the session.

Since the session Lorna has visited two residents and 'target hardened' their homes. She has attended two residents groups to give a talk on services available and has been invited to a further two groups.

5.3 Hartlepool Now

Rachel Hogg, Development Officer - Public Engagement (Child & Adult Services) gave a brief demonstration of Hartlepool Now, the department's information website. Rachel described how easily the website is accessed but reiterated that should anyone have difficulty with the internet, any of the information can be printed off and provided as a handout. It was discussed that providers of services keep the website up to date. It was described that the website can be used by lots of professional too, who can refer people to it but also print information should people need it.

Some members of the group expressed concern that websites are not always appropriate for older, vulnerable people - whilst others said they were confident with information technology. Rachel reiterated that this was just one way that people can access information and has the benefit of being easily updated and accessible twenty four hours a day, seven days a week.

5.4 iPads - is this the future?

A verbal presentation was provided by Michael Slimmings from Incontrolable - a local user led organisation. Owing to technical difficulties Michael was unable to show a presentation.

Michael described how technology had changed over the years and where a number of years ago we communicated via letter, in person and over the telephone there are now many different ways people interact and keep in touch. One of these ways is through digital technology in the form of iPads / tablets.

Michael talked about people getting transport information via mobile technology and explained how they could order taxis on their mobile phone, access wifi on the bus or check timetables on the internet.

He talked about various apps (applications) that can be accessed to help with day to day living - like reminders to do certain things like take medication or complete exercises.

Michael then told the group about various initiatives that his organisation is currently involved in:

The VIP (Visual Impaired People Project) was a six month pilot project that ran from January 2015 to the end of June 2015 and was funded by Northgate Community Fund.

The main purpose of the project was to support visually impaired people on a one to one, or group basis using tablet technology to enable them to access information, advice and guidance, to promote their independence and increase their knowledge base.

- Of the 20 people referred to the project, the majority stated that they felt competent in accessing digital media independently after spending time with the project worker.
- 8 men and 12 women accessed the service, with the age range varying from 35 to 86 years of age.
- As a result of the project, 60% of those referred purchased their own iPad or mobile device.

Ricochet - a free service enabling people to access information, advice and guidance. Mobile devices are provided with pre-loaded bookmarks to websites. Incontrolable can provide a basic introduction on how to use the device, if required. All people need is WIFI access in their home, or in community venues. The project worked closely with Hartlepool Blind Welfare Association and the Social Worker for People with Sensory Loss. The project had a positive impact on individuals increased their ability to access information independently.

In Your Dreams - a free service for people who have a diagnosis of dementia, their families and carers. Incontrolable provide 1:1 support to enable people to use digital technology and help re-ignite memories and share stories from their past.

Michael finished his presentation by encouraging people at the event to get in touch if they had any interest in discovering how mobile technology could help them.

6. FUTURE ENGAGEMENT EVENTS

6.1 The next engagement event is planned for 20 July at 10.00 at The Avenue, Masonic Hall, Avenue Road. Following a lower than expected turnout at the March event, a more central town centre location has been chosen.

The topics for discussion prompted by some of the issues raised at previous events are as follows:

- **Social Isolation** – introducing the new Befriending Network
- **Benefits Advice & Guidance** – presentations by the Council's Benefit Section and West View Advice & Resource Centre.
- **Luncheon Clubs** – question and answer session with Carewatch (facilitator of current service provision).

6.2 The event will be publicised in the local press and on the Hartlepool Now website and local groups will be contacted to encourage a wide range of people to attend and contribute. People requiring support to attend due to mobility issues will be supported by Adult Services.

7. RISK IMPLICATIONS

7.1 There are no risk implications associated with this report.

8. FINANCIAL CONSIDERATIONS

8.1 There are no financial considerations associated with this report.

9. LEGAL CONSIDERATIONS

9.1 There are no legal considerations associated with this report.

10. CHILD AND FAMILY POVERTY CONSIDERATIONS

10.1 There are no child and family poverty considerations associated with this report.

11. EQUALITY AND DIVERSITY CONSIDERATIONS

11.1 There are no equality and diversity considerations associated with this report.

12. STAFF CONSIDERATIONS

12.1 There are no staff considerations associated with this report.

13. ASSET MANAGEMENT CONSIDERATIONS

13.1 There are no asset management considerations associated with this report.

14. RECOMMENDATIONS

14.1 It is recommended that the Adult Services Committee:

- notes the feedback from this engagement event;
- notes plans for a further event in July, which Members are welcome to attend; and
- encourage older people from their wards to attend and make a contribution.

15. REASONS FOR RECOMMENDATIONS

15.1 To assure members that older people are being engaged about issues that affect them and have the opportunity to contribute and shape their communities and how they are supported within them.

16. CONTACT OFFICER

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