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**Health Policy and Performance Board
Supplementary Appendix to Item 5 (D)
Tuesday, 23 February 2021 at 6.30 p.m.
To be held remotely, contact Clerk for
access**

A handwritten signature in black ink, appearing to read 'David W R', positioned above a faint rectangular stamp.

Chief Executive

BOARD MEMBERSHIP

Councillor Joan Lowe (Chair)	Labour
Councillor Sandra Baker (Vice-Chair)	Labour
Councillor Lauren Cassidy	Labour
Councillor Mark Dennett	Labour
Councillor Eddie Dourley	Labour
Councillor Pauline Hignett	Labour
Councillor Chris Loftus	Labour
Councillor Margaret Ratcliffe	Liberal Democrats
Councillor June Roberts	Labour
Councillor Pauline Sinnott	Labour
Councillor Geoff Zygadlo	Labour

***Please contact Ann Jones on 0151 511 8276 or e-mail
ann.jones@halton.gov.uk for further information.
The next meeting of the Board is to be confirmed.***

**ITEMS TO BE DEALT WITH
IN THE PRESENCE OF THE PRESS AND PUBLIC**

Part I

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5. DEVELOPMENT OF POLICY ISSUES	
(D) INTERMEDIATE CARE SERVICES IN HALTON - APPENDIX 2	1 - 21

In accordance with the Health and Safety at Work Act the Council is required to notify those attending meetings of the fire evacuation procedures. A copy has previously been circulated to Members and instructions are located in all rooms within the Civic block.



Halton Borough Council Peer Review Report on Intermediate Care

October 2019

Feedback Report

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Executive Summary

Halton Borough Council (HBC) asked the North West region of the Association of Directors of Adult Social Services (NW ADASS) to conduct an Adults' Peer Review focussing on the arrangements for adult intermediate care. The work was commissioned by Sue Wallace-Bonner, Director Adult Social Services who was seeking an external view to consider how effectively the intermediate care arrangements were currently operating in Halton. The council intend to use the findings of this peer review to link with other work commissioned to consider improvements to the pathways through intermediate care, both pre and post hospital admission. The review team was asked to concentrate its efforts on:

The Intermediate Care service user experiences and outcomes. It will look to understand the current approach taken and impact of that on the people who receive services. It will then look to make recommendations for how service user experiences and outcome could be improved; specifically in the areas of:

- Intermediate care options prior to hospitalisation
- Reablement
- Service user experience, both bed-based and community.

The team spoke with representatives from a wide range of organisations and the findings in this report are based on the evidence that was obtained from the meetings undertaken whilst on site and the documents presented. The main findings are:

Service users told the team that they experienced services to be very responsive. However, this did depend on capacity being available. Service users also told the team that they felt safe, well cared for and were able to influence what happens next. However, this was not necessarily reflected in the care plans that the team saw.

There were examples of staff who go over and above what is contractually required in order to deliver services, sometimes using creative solutions to meet the needs of the people in their care. However, the criteria for accessing intermediate care is too wide, leading to high numbers of people requesting services and the pathway to access these services is unclear.

The workforce is committed to providing the best care that they can for residents. They held a good value base that respected individuals and tried to balance support with independence. The team also experienced them to be honest and candid in the way that they engaged with the review process, sharing experiences and ideas about how they currently operate and how improvements could be made. The team was impressed with how the reablement assessment process includes service users in setting their own goals. However, service user engagement in goal setting was not evident earlier on in the process. If assessments were undertaken prior to receiving care rather than once people had entered the system, the approach would then be in line with the National Institute for Health and Care Excellence (NICE) guidelines

There are structures in place to provide direction and governance for intermediate care services. However, these need to be strengthened to ensure that the right membership, with sufficient seniority, are in place to make decisions and hold each other to account, so that meaningful change can occur. The team was aware that plans are in place to align some of the structural arrangements. This needs to happen at pace and across the system.

The team noted that there was a capacity and flow issue across reablement and domiciliary care. The lack of capacity in the domiciliary care market needs to be addressed, both through increasing the number of carers available and by greater management of demand.

It was clear to the team that the Peer Review was not happening in isolation and that Halton is actively engaged with other reviews of the intermediate care pathways. The peer team's work should be taken as part of the whole system approach to determining what changes are required.

Report

Background

1. Halton Borough Council (HBC) asked the North West region of the Association of Directors of Adult Social Services (NW ADASS) to conduct an Adults' Peer Review focussing on the arrangements for adult intermediate care. The work was commissioned by Sue Wallace-Bonner, Director Adult Social Services who was seeking an external view to consider how effectively the intermediate care (IMC) arrangements were currently operating in Halton. The council intend to use the findings of this peer review to link with other work commissioned to consider improvements to the pathways through IMC, both pre and post hospital admission. The review team was asked to concentrate its efforts on:

The IMC service user experiences and outcomes. It will look to understand the current approach taken and impact of that on the people who receive services. It will then look to make recommendations for how service user experiences and outcome could be improved; specifically in the areas of:

- IMC options prior to hospitalisation
 - Reablement
 - Service user experience, both bed-based and community.
2. Peer review is designed to help an authority and its partners assess current achievements, areas for development and capacity to change. The peer review is not an inspection. Instead it offers a supportive approach, undertaken by friends; albeit 'critical friends'. It aims to help an organisation identify its current strengths, as much as what it needs to improve. But it should also provide it with a basis for further improvement.
 3. The members of the peer challenge team were:
 - **Hazel Summers:** LGA Regional Care and Health Improvement Advisor
 - **Sarah Alldis:** Associate Director for Social Care, Wirral Community Health and Care NHS Foundation Trust
 - **Catherine Jones:** Operational Director Adult Social Care, Warrington Borough Council
 - **Paul Walsh:** Head of Integrated Commissioning, Salford City Council/Salford CCG (Lead Commissioner for Intermediate Care)
 - **Rebecca Maidment:** PSW, Head of Adult Safeguarding, Blackpool Council
 - **Lia Chelminiak:** NW ADASS Programme Manager
 - **Jonathan Trubshaw:** Peer Review Manager

4. The team was on-site from Monday 7th – Wednesday 9th October 2019. To identify the strengths and areas for consideration in this report, the peer review team reviewed over 40 documents, held over 17 meetings and met and spoke with over 100 people during the three on-site days and collectively spent more than 220 hours to determine their findings. The programme for the on-site phase included activities designed to enable members of the team to meet and talk to a range of internal and external stakeholders. These activities included:
 - interviews and discussions with service users, carers, officers, partners and providers
 - focus groups with managers and frontline staff
 - collecting information from those who access services
 - reading a range of documents.
5. The NW ADASS would like to thank; Sue Wallace-Bonner, Director Adult Social Services for welcoming the team into their organisation. The team would also like to thank; Louise Wilson, Commissioning and Development Manager and Damian Nolan: Divisional Manager, for the excellent job they did to make the detailed arrangements for a complex piece of work across key partners with a wide range of staff and those involved in the access to services. The peer team would like to thank all those involved for their authentic, open and constructive responses during the review process and their obvious desire to improve outcomes; the team members were all made very welcome.
6. Our feedback to the Council on the last day of the review gave an overview of the key messages. This report builds on the initial findings and gives a more detailed account of the review.

Key Messages

7. The team talked with a wide range of people, including; nurses, therapists, social workers, integrated discharge teams, the Rapid Assessment and Referral Service (RARS) team, Reablement and representatives from the Voluntary and Community Sector (VCS). All the members of staff that the team met were passionate, caring and committed. The team recognised that these people are a significant resource for Halton and partners and can provide a strong base for making changes and improvements to the system. However, the team also heard evidence that these staff can feel overwhelmed by what they have to do. Whatever changes are put in place to improve the IMC arrangements will require a whole system approach, support by all partners.
8. There is an awareness and commitment to getting people home as soon as possible once they have been admitted to hospital. Staff recognise that this is generally the right thing for people and work from the moment of admission to make this happen. There is also a recognition that this is not always achieved and that there are delays and people become 'stuck' in bed-based care.
9. Staff are ready and willing for change. There are good relationships between staff at the frontline, both within specialisms and organisations and wider with those in different disciplines, who also engage with the patient.
10. The service users whom the team met were very complimentary about the care that they received in B1, Oakmeadow and Reablement. They spoke highly about the staff and how they perceived that their needs were being met.
11. The team recognised that Halton is aware that the intermediate tier faces a number of significant challenges. It is also acknowledged that there are challenges around the capacity to deliver within the current model. However, the team believes the right ingredients are in place for the development of the intermediate tier.
12. There was little evidence of a whole system commissioning framework, across both the Clinical Commissioning Group and the Council. There is a need for a clear joint approach and framework for IMC with clear roles and responsibilities and also for the wider out of hospital services. This should set out clearly the approach and what is available across the system, to meet the needs of individuals.
13. There is insufficient capacity of community services in both the health and care systems. What resources are available are not always in the right place to provide for the needs of individuals.
14. Although staff were aware of the pathways that are in place to support individuals there is not always the capacity to ensure that these are consistently delivered. Where the pathway prescribed services are not available people look elsewhere to get needs met and this can on occasions make solutions complex and convoluted. There was also evidence that

reablement may keep some people too long, which also has an adverse impact.

15. Individual assessments are being undertaken and evidence from the files reviewed showed that individuals might receive numerous assessments. However, these were seen to be more functional and clinical, resembling a hospital plan rather than a holistic care plan. Files contained specialist care plans, including those for physiotherapy, mobility and gait but did not appear to have an overarching care plan with the person at the centre. The team also had concerns that social workers were not engaged at an early enough point in the person's care or that this was not clearly enough demonstrated in the files seen.
16. From the cases that the team were aware of some people are in the wrong place at the wrong time. Staff have the best intentions and are keen to be responsive to people's requests for help. There is a tendency to use what is available at the time and to do something quickly for the individual, which may not be the right response to best address need. In some cases, people deteriorate because they are in the wrong place and are "desperate" to go home. This can drive additional demand; as the person's condition worsens so the need for further or higher need care increases. This could be alleviated by addressing the capacity issues within the domiciliary care market.
17. The tripartite arrangements for delivering IMC involving; Halton, Warrington and Bridgewater, does not appear to share responsibility evenly. There was accountability and clarity from the therapeutic nurses within Warrington, whereas there was less clarity on the arrangements for mental health across the system. There would be benefit in ensuring that Community Psychiatric Nurses (CPN) were available and engaged at an early, pre-admission stage in the patient's treatment and to support the bed-based provision where necessary in a crisis. This was also available and involved (where needed) in discharge planning.

Intermediate Care is Responsive to Individual Needs

18. There is a Single Point of Access, which is provided through the RARS. The other social work teams spoke of positive relationships between themselves and RARS with positive joint working and effective relationships. A Single Point of Access provides a simpler access route to a range of services for referrers and enables a more consistent triage and response. Without capacity constraining options, it should enable better and more appropriate use of the services available. However, to ensure that this operates effectively there needs to be clear widely supported criteria applied so that the correct level of service can be accessed. This needs to be adopted on a systematic basis across all those involved in providing and a supporting the IMC arrangements.
19. Service users told the team that they experienced services to be very responsive. However, this did depend on capacity being available. These reflections took place sometime after the care had been received and experience may have been viewed positively depending on the outcomes for the individual. More could be done to gather the views at the time of service use; recognising the difficulties and sensitivities of this work.
20. The team heard evidence that the current Multi-disciplinary teams (MDT) work well. Professionals come together to support individuals who require a range of support. However, not all people will need more than one professional's input. For some, community nursing may be all that is required and there is not the need for a routine assessment through a MDT, which causes a blockage in the system.
21. The team saw some good and thorough assessments by Occupational Therapists (OT) and Physiotherapists, which were evidenced in case files.
22. Service users told the team that they felt safe, well cared for and were able to influence what happens next. However, this was not necessarily reflected in the care plans that the team saw. Case files contained a variety of assessments from a range of therapists and other professionals. The 'paperwork' reflected these individual assessments rather than presenting a coherent story of the person receiving care. This siloed representation of review and action undertaken is not helped by organisational IT systems not being able to 'talk' to each, other, which forces duplication and separation of information. On the whole assessments and care plans that the team saw were not strengths based; they appeared to be functional and clinical, with little evidence of forward planning. The plans reflected what had taken place and did not focus on what needed to be done to achieve agreed goals.
23. The team heard that delays in receiving out of hospital care, which could help prevent admission/readmission were caused through a lack of capacity in the community. The capacity issue affects a number of areas including; community health services, Domiciliary Care packages, dementia nursing and Reablement. The peer team heard that if Reablement team stuck to their core tasks (and were not through necessity pulled into the Domiciliary Care function) that there would have sufficient Reablement capacity. By increasing

the capacity within the community and more widely promoting where options are available more people could benefit from receiving care where they need it and not having to rely on being admitted into hospital.

24. The allocation of services was seen to not always have been made on the evidence of need but rather on resources available. Staff said that try not to only allocate what is available and often shared with the team that they were “frustrated” in not being able to meet an individual’s need. However, they also wanted to make sure people were able to receive care and realised that this might be most readily available in hospital. It was noted that this particularly happens when there is pressure from the hospital. There appears to be a lack of concentration on the preventative services available in the community. The capacity of the therapeutic services, including; physiotherapy, domestic care and occupational therapists is used to facilitate people moving out of hospital rather than the focus being directed on preventing them needing to enter hospital in the first place. When people are in hospital, including B1 and Oakmeadow, they are provided with high levels of care. However, this level of therapeutic care may need to be continued in hospital beyond the point of recovery if the person cannot be allocated the care in the community that need to live at home, so as to maintain their level of fitness. This ties resources to in-hospital provision and necessitates an on-going commitment to prevent deterioration.
25. The team heard that there was inconsistent and variable information available on the IMC pathway and criteria for accessing services. Service users did not always know what was available to them, what they were receiving and where this to be provided. Although information does exist there needs to be greater emphasis on finding out how people want to receive information and what are the most accessible places for them to go to when they want to know more; whether this is a physical location or on-line.
26. Evidence from the case audit indicated that currently there is no lead professional model in place. Case notes in the individual’s file provided a partial story, with a number of assessments from a variety of professionals. However, there was not one person who took the lead regarding the individual’s care and was able to articulate the care journey. There does not have to be a prescriptive model for who assumes the lead professional role and could be any one of those professionals who has most significant influence on the individual’s care. Once the lead professional is in place, they can take responsibility for ensuring where and when the most appropriate care is provided, based on need.
27. Although there is a single point of access, provided through the RARS, this presents an open and revolving door for those wishing to access care. There are definite benefits for the individuals in knowing that there is a place for them to go, whatever help they may need. However, this ‘wide’ approach means that, due to the caring nature of the RARS staff, people are accepted and held within the service regardless of whether reablement is what they need and who could potentially be looked after elsewhere if the capacity in the system were available. Therefore, because individuals receive a caring service, they return either when something new develops or there has been a slight change in their personal circumstances. This creates a bottle neck in the system, which needs to be released by better signposting to other out of

hospital services. The criteria for accessing services through RARS needs to be considered in light of the above and then robustly maintained, supported by referrals to other services. There also needs to be a commitment from other services and organisations to accept cases that may not fit a revised RARS criteria.

Effectiveness of Intermediate Care – Independence

28. Service user needs for discharge are identified early in treatment process, particularly through the RARS. The team heard evidence that as patients are admitted onto the IMC wards their needs for discharge are assessed and treatments planned so that they are ready to go home as soon as possible. This approach should be applauded and all those involved in the provision of IMC should systematically ensure that people are progressed to independence as quickly as possible.
29. The team heard evidence from service users that they thought highly of the physiotherapy service. People said that they received an excellent care; it was responsive and met service user aspirations, helping them to recover well and get back on track with their lives. Service users praised the level of care they received with some saying; “*without the people there [B1] I wouldn't be here today*” and “*they [RARS and Reablement] are complete stars for what they've done for me*”.
30. Some service users said that they felt in control of the services that they received, being able to say and agree what they needed and when. They also recognised that the service they received enabled them to achieve positive outcomes in the way in which they lived their lives.
31. The team heard examples of staff who go over and above what is contractually required to deliver services. They also heard of some creative solutions to meet individual needs. The team heard of staff who were supporting a service user with low-level mental health issues so as to build up their self-confidence. This was also recognised in the comments received from some of the service users that the team met. However, where staff were putting in extra effort this was often to cover a gap in provision in some other pathway.
32. Reablement staff said that they were well trained and recognised that they were supported by the OTs, which was important to them.
33. The criteria for accessing intermediate care is too wide, leading to high numbers of people requesting services and the pathway to access these services is unclear. One of the reasons for the lack of clarity is that staff are having to find innovative solutions (which may be over-protective as the least restrictive option or best fit option is not available) because services are not there if the pathway is followed. Staff reported that there is insufficient capacity within the system and that care packages, both pre and post admission, are not always available at the time they are required. More could be done to assess the individuals needs before they enter an IMC setting so that those who could be best helped in their own home have the packages of care provided there and not admitting them to hospital as a way of ‘forcing’ some care to be made available.
34. There were varying views from within each discipline that the “*wrong people are being referred*”. Although this was not universally the case there was evidence to suggest that more needs to be done to develop the market so that there is more capacity and choice in the provision available. The team heard

that people are not necessarily in the right services. However, there was also evidence that the decision making processes were sound and focussed on the individual's best interest when sourcing what provision was available at the time of need.

35. The hospital IMC environment (B1) needs to do more to focus on promoting independence. The care is nurse led and operates as a traditional hospital ward; exemplified by displaying 'Intermediate Care Ward' signage. The style of the case notes seen by the team demonstrated the clinical approach being taken. The team saw limited evidence of opportunities to reacquire independent living skills, with some patients remaining in bed or in their bed clothes. The environment was one of a sub-acute ward rather than IMC. However, some patients spoke very highly of the care that they received, stating that they felt; "*cared for and safe*" and that, "*the staff are lovely, they look after me*".
36. The team heard from patients that they want to go home as soon as possible. However, having received reablement care whilst on B1 and developed the capacity to go home they have to be maintained functionally and medically optimised as the care packages needed to maintain them in their own home are not yet available. Patients are therefore deteriorating when they remain in hospital as this is the wrong place to fully utilise their independent living skills. Staff clearly want to do the best for the people in their care, which translates into people can stay for as long as they need. Evidence from some of the cases reviewed was that this can be for up to seven months and the team heard anecdotally that in certain cases this was up to 14 months.

Caring – Compassionate, High-quality, Seamless

37. The team experienced the workforce to be committed to providing the best care that they could for residents. There was strong evidence that they held a good value base that respected individuals and tried to balance support with independence. The team also experienced them to be honest and candid in the way that they engaged with the review process, sharing experiences and ideas about how they currently operate and how improvements could be made. There was a clear sense of awareness and ownership, by staff and managers, of the challenges that the IMC system faces. They also appeared to be ready and willing for change and were open to working differently.
38. The team heard that there were generally good relationships and communication/feedback with General Practitioners (GPs). There was evidence of a local GP working in Oakemeadow who was highly regarded by staff and service users.
39. The team was impressed with how the reablement assessment process includes service users in setting their own goals. However, service user engagement in goal setting was not evident earlier on in the process. By engaging people early in the process, they may be better signposted to other, community provision that best meets their needs. The reablement assessment model should be rolled out to other areas of the system, so that service users experience a consistent approach and relieve pressures/bottlenecks elsewhere. If assessments were undertaken prior to receiving care rather than once people had entered the system, the approach would then be in line with the National Institute for Health and Care Excellence (NICE) guidelines.
40. Service user feedback is collected but not always used to inform decisions on service. More analysis of the data that is collected and an assessment of how this collected would help ensure that future developments are based on what people say they need and that it is delivered in ways that they want. This would help ensure that the right services are provided in the right places at the times that people want. The timeliness and the ways in which feedback is collected will also impact on the quality and content of the feedback. Analysis of data collected should take into account the length of time after receiving care that the feedback is given and whether it is through face-to-face or written response.
41. The team found little evidence that the Trusted Assessor (TA) model is fully utilised, both in Domiciliary Care and in hospitals. Consideration could be given to implementing a TA model within Domiciliary Care to promote flow and enable quick responses to changes in need. More should be done to establish the model, so as to reduce duplication in assessments, save time and resources and to provide a more coherent picture of the care being offered to the individual.
42. The team recognise that there is quality assurance (QA) framework in place. However, from the meetings with staff it was clear that this is not fully understood and more needs to be done to promote the processes involved

and what staff are required to do so that a consistent approach and application is maintained.

43. The team heard from staff that service users were told in the hospital that; “*Reablement is a free, 6 week service*”. There is a lack of clarity on the service offer, which can lead to unrealistic service user expectations that can in turn cause frustration and discontent. Hospital staff need to be made more aware that reablement is not a free service but a rehabilitation programme that is tailored to meet individual need, which is time limited and may or may not last up to six weeks. It needs to be made clear to staff and service users what the specific reablement package is, what the follow-on steps are and whether or not there is a charge for what is being offered. Some service users said that they were not told when discussing what the offer was that there was a charge and this led to disputes when a bill was presented after the programme had concluded. Reablement may not be appropriate for all those leaving hospital, with some needing to be discharged to resume a package of care that was already in place and has not materially changed in value or task prior to their in-patient stay. There is also a need to be clear on perceptions of ‘entitlement’ to reablement, particularly if individuals are paying for an existing package of care and could consider reablement as a way of reducing personal expenditure.
44. The case files that the team reviewed showed little evidence of Social Work voice. Various other professionals were seen to contribute, albeit in a variety of different ways and using multiple styles of reporting. These mainly focussed on assessing people’s ability to undertake the functional tasks of day to day living. However, there was often clear evidence that wider issues were affecting the individual including; mental health and wellbeing, housing and other high vulnerability factors. More needs to be done to include social workers’ involvement, where appropriate; although this does not necessarily require social workers to take on the lead professional role. There is a need for a systematic response that considers the complex housing, social, long term conditions and mental health factors.

Well Led – Vision, Governance and Partnership

45. The team recognised that there were a number of documents in place that clearly set out the ambitions for Halton residents, including; the One Halton Vision and the Vision for Adult Social Care. There are also a number of governance structures that maintain the focus on how Halton cares for residents, including; the Operational Commissioning Committee, the Executive Partnership Board and the Intermediate Care Steering Group. Although these structures are in place, they need to be strengthened to ensure that the right membership, with sufficient seniority, are in place to make decisions and hold each other to account, so that meaningful change can occur. A whole system approach to IMC needs to be established and robustly monitored to ensure that all those in the wider workforce understand how they interlink with each other. The team was aware that plans are in place to align some of the structural arrangements. This needs to happen at pace and across the system, with each organisation recognising its responsibilities to act in a coordinated way with partners. More could be done to encourage providers to become more involved in the decision making structures, so that services can be appropriately expanded and capacity can be addressed at all stages on the pathway.
46. Although there are documents setting out the vision some of the people and staff whom the team met were not able to describe the offer or vision. More needs to be done to communicate to staff about what their work is aiming to achieve, so that they can understand and personalise the changes that are planned and those that have already been implemented. Messages need to be ongoing and use mechanisms that engage staff in a dialogue so that they participate in the process of communication.
47. The development of the Community Hubs offers an opportunity to co-locate. This should bring health and social care colleagues closer together, enabling them to better share information and to provide more locally based solutions to care needs. The team was aware that the Hubs were deciding operating mechanisms for themselves, without the need for a formal commissioning process. However, it is not widely understood how the Hubs will operate and more needs to be done to ensure that staff and partners are aware of potential developments.
48. The team was unsure about how current IMC services are commissioned and where do these arrangements fit with future planning for out of hospital care. More needs to be done to articulate how the development of Hubs contributes to future IMC service delivery and there needs to be a clearly understood timetable that sets out when services are going to change, so that staff and service users are kept informed with accurate information. This would help manage expectations and would keep attention focused on producing the necessary changes.
49. The team saw evidence that there are good relationships with third sector partners and that there are regular meetings to discuss how organisations can best work together. However, the team also heard that the good strategic

level relationships do not always translate to frontline staff working well together.

50. There was a lack of clarity regarding the relationship with Bridgewater going forward and how the tripartite relationship was going to function. There was a lack of clarity regarding accountability, with a recognition that the council could not hold it all. More needs to be done to work with partners to ensure the lines of accountability are clearly understood and accepted.
51. The team understands that an integrated Workforce Strategy for staff that sit within the services, as well as the independent sector, is being developed as part of the overall One Halton vision. This also takes into account the developments coming through the Sustainability and Transformation Partnership (STP). This is an opportunity to consider the capacity can be developed to meet the future needs of Halton residents and not just how more/different services could be provided to meet current demands.

Resources used to Promote Independence

52. The team heard that there was good access to equipment to help people maintain their independence, including service user feedback that community equipment was responsive when they needed it. The recent pilot to promote equipment to facilitate single handed care, 'moving with dignity', was very well regarded within the teams. Bariatric equipment is no longer seen as 'specialist' and is available without going through a funding 'panel'. Equipment can be provided within a few hours if required, to prevent a hospital admission, due to good working relationships between frontline staff and stores staff.
53. There is a fully integrated hospital discharge between St Helen's and Halton at Whiston, which is an effective use of resource whilst maintaining a focus on the services that are pertinent to Halton residents. There are also good relationships at Warrington, with staff reporting very positive working relationships and positive joint working and that in times of particular pressure they said that, "*everyone pulled together*".
54. The team heard evidence from staff and service users that some residents are looking for their own solutions. Not only does this demonstrate that residents are independent it is also a rich source of information that can be passed on to others and so help promote a culture of resilience and not having to rely on the council to provide for every eventuality. This needs to be supported by a whole system vision for IMC with clear links between partners and information made widely available to residents so that are able to see how the system joins up.
55. The team noted that there are good relationships with Premier, who have stated that there is potential to release capacity. There was some evidence of over commissioning, which if reviewed could reduce the requirement for the number of visits and/or double-handed visits, therefore enabling staff to be available elsewhere. Building on this relationship could help relieve some of the capacity issues currently experienced with the Domiciliary Care offer; working together to address any concerns about the perception of stepping-down the care provided. Premier also reported some under capacity as a result of recruitment challenges, which impact on both long-term and reablement responses.
56. Staff and service users said that their overarching sense was that IMC services are in place but that there was lack of capacity on prevention and in the community for when patients are discharged. This included a low level of capacity in fall prevention and intervention. Investing in the capacity to help prevent the issues that lead to admission would reduce the bottlenecks in hospital care. The team acknowledges the difficulties in focusing on prevention activities when capacity to provide the services that are enquired now are already stretched.

57. The team noted that there was a capacity and flow issue across reablement and domiciliary care. The lack of capacity in the domiciliary care market needs to be addressed, both through increasing the number of carers available and by greater management of demand. Some reablement staff reported that they undertake home care work, rather than reabling. Although this is another example of staff going above and beyond to provide what is needed for the people in their care it is also an indication of the lack of domiciliary care capacity, which in turn creates bottlenecks for specific reablement services that are then not able to look at minimising future need.

Recommendations

The following are the team's recommendations for HBC, together with partners, to consider further and determine what action is required to:

58. **A whole system response is required:** Creating an integrated IMC offer is not the sole the responsibility of any one organisation. All those partners involved, with a particular focus on those from Health and Mental Health, need to identify the wider leadership and commit to full engagement (including for periods when nominated individuals may not be available). A plan needs to be produced that includes specific workstreams with identified people who are responsible for ensuring delivery
59. **Implement a Joint Commissioning approach:** Involve all partners, including service users, families and carers, in designing, developing and commissioning an integrated service. All partners' inputs should be based on a robust, up to date needs assessment. The offer should encompass all out of hospital provision as well as those interventions that are currently being developed or planned for in the future, e.g. Hubs
60. **There is an opportunity to re-specify a new model for IMC:** These services should be based on a Lead Professional model that is asset based, holistic and that takes the social context into account as well as clinical need. Although there are examples of this happening by default there now needs to be a formal and systematic approach to adopting the Lead Professional model for all cases. There should also be an increased focus on therapeutic and recovery led services and the Trusted Assessor model needs to be accelerated around Domiciliary Care and hospital discharge
61. **Define how in-hospital care fits within the IMC offer:** The care currently provided in Ward B1 is not IMC and consideration needs to be made about the Ward's future use and resources within it. More needs to be done to clarify what community health services are available to support what happens both in the community and to provide support for discharge from hospital
62. **Review the criteria for accessing IMC services:** IMC is accepting people with too an acute level of need to benefit from recovery interventions at the point of access. Alternative service criteria might need to be considered for other services, for those who do not meet IMC services criteria. When doing this consideration also needs to be given to how capacity in the wider community is developed to ensure that care offers are available, so as not to rely on RARS workers undertaking Domiciliary Care duties. In order to do this the Social Work capacity in the RARS team also needs to be reviewed
63. **Define the system response to shape and sustain the market:** Out of hospital community services need to be developed so that people do not fall back on Home Care because other services are not available. This requires a whole system response from all partners, including addressing the capacity issues within Domiciliary Care and should not be considered as a Social Care issue

64. **Re-commission the End of Life service out of Reablement:** Reablement is focussed on getting people better and equipping them for independent living. This philosophy does not sit well with that of end of life care
65. **Consider single line-management arrangements for RARS and Reablement:** Having clear management arrangements for both RARS and Reablement would help in taking forward any planned changes that these services need to go through and would provide a clear point of contact for discussions with partners when developing the wider IMC offer
66. **Revisit the Mental Health offer within a wider review of the MDT and partner offer:** Cases had to be escalated to get the help that was needed. Evidence from case files showed that where individuals did not receive the appropriate and timely mental health interventions there was not a good outcome.
67. **Map the range of services required:** There is guidance readily available on what services are required, including that from; SCIE, Halfway Home, Royal College guidance and NICE guidelines. With partners, consider what is already available and jointly adopt what is relevant for the local circumstances given the system capacity and what resources might need to be increased to meet the agreed need. This will include more integrated ways of working with the voluntary and community sector
68. **Consider separate (but aligned) short term change and long term transformation plans:** There are a range of activities that could be undertaken by one or more stakeholders to support better use of the IMC services in the short-term. However, a more substantial transformation programme, supported by all the key stakeholders, is also required to deliver the whole system response to ultimately deliver better outcomes for residents and make significantly more efficient use of resources. Delivery of short term change while planning and initiating a longer-term transformation programme will require capacity and agility to be undertaken simultaneously.