REPORT TO:	Health Policy and Performance Board
DATE:	14th February 2023
REPORTING OFFICER:	Executive Director, Adults
PORTFOLIO:	Adult Social Care
SUBJECT:	Integration: Health & Adult Social Care
WARD(S)	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To summarise progress to date on the integration of Health and Adult Social Care services across One Halton.

2.0 RECOMMENDATION: That:

i) The report is noted.

3.0 SUPPORTING INFORMATION

3.1 ***Background***

Two key pieces of legislation have supported the implementation of integration of across Health and Social Care. In February 2021 the Department of Health and Social Care published the White Paper "Integration and Innovation: working together to improve health and social care for all" - the paper detailed proposals for NHS and social care reform, with a focus on integrated care and services adding value for end-users. In February 2022, they published the White Paper "Joining Up Care for People, Places and Populations".

3.2 Following the publication of the first White Paper, all areas across England implemented Integrated Care Systems from 1st July 2022 (replacing NHS Clinical Commissioning Groups with Integrated Care Boards (ICBs).

3.3 ***One Halton Sub-Committees***

In Halton, a number of One Halton Board sub-committees were formed to progress aspects of the integration agenda. The main sub-committee focussing on the integration of health and adult social care is the Operations and Delivery Sub-Committee (ODSC). The ODSC is responsible for overseeing the operational delivery of the integrated local health and adult social care system in Halton. This was the first sub-committee to be established and has now been running for just over a year.

3.4 The ODSC is chaired by the Director of Adult Social Services and membership of the group includes a breadth of representation across the Health and Social Care system, including acute trusts, primary care, adult social care, the voluntary sector and a domiciliary care provider.

3.5 ***Priorities***

There are two priority aims which will help inform the ODSC Work Streams to be undertaken. These aims are to support people to:-

- live an independent life; and
- regain independence following a change in circumstances

3.6 ***Delivery Plan***

The ODSC has a Delivery Plan which sets out the key areas of opportunity to move forward with an integrated pathway approach. It focusses on how the ODSC will deliver on its priorities, through a whole-system approach. The areas identified are those in a shared space across health and social care, where there is a clear interface between health and social care. If there is no interface within a particular work area, these are to be retained by the relevant partner organisation and dealt with under statutory duties. The Delivery Plan continues to be a live/working document which is updated following each meeting of the sub-committee.

3.7 **Work Streams – Progress and Achievements to Date**

Three Work Streams of the ODSC have already made significant progress, as detailed below. The work streams have been aligned to the One Halton Health and Wellbeing Strategy themes of Living Well and Ageing Well, as well as linking in to Health Inequalities. Each Work Stream has a detailed Work Stream brief setting out the aims, key deliverables, risks, digital requirements, financial requirements and communication requirements, ensuring all projects are fit-for-purpose and relevant to the overall aims of the ODSC.

3.7.1 ***Halton Integrated Care and Frailty Service***

The Halton Intermediate Care and Frailty Service (HICaFS) has been operating within the Borough since December 2021. The Service replaced the services previously provided in Halton by the Rapid Access Rehabilitation Service (RARS), Capacity & Demand Team and the Halton Integrated Frailty Service (HIFS). One of the key elements of the Service has been the introduction of a Single Point of Access (SPA) for Intermediate Care and Frailty referrals (from Hospital and the Community), both for those requiring support within the community and those requiring an Intermediate Care bed. The aim for the service, as a whole, is for all referrals received by the SPA will have been reviewed, assessed and appropriately actioned within 72 hours of receipt. To date, the majority of referrals come from hospital teams, followed closely by GP Practices and Health care professionals. The majority of referrals have been dealt

with within the 72 hour target, with some referrals being actioned within 2 hours, and some 24 hours (dependent on the decision of triage). A review of the service model for HiCAFS has begun and outcomes from this will be reported back to the ODSC next year.

3.7.2 ***Hospital Discharge***

The aim of this Work Stream is to define and review the current Hospital Discharge pathways, associated processes and performance in respect to Halton residents, to ensure that Service Users receive timely and appropriate discharge from Hospital and that the systems and processes in place to support the Discharge pathways are fit for this purpose. Any improvements to current Hospital Discharge pathways would support the best outcomes for people leaving hospital, it would further reduce the length of stay of acute admissions and aim for a higher proportion of people to be discharged on the day that it is determined they no longer need the support of an acute hospital. Benefits include improved patient care, experience and satisfaction and overall efficiency and effectiveness of the Hospital Discharge process. The final report and recommendations will be presented at the ODSC in January 2023.

3.7.3 ***Care Homes***

There are a number of strands of work within the Care Homes Work Stream. Examples of progress to date includes:

Environment - Plans have been finalised for a refurbishment programme across all in house care homes, starting in 2023.

Training - An on line platform is now operational across Care homes to support the care home nurses to continually develop their skills and expertise.

Recruitment - Work with St Helens and Knowsley Teaching Hospitals NHS Trust to support the recruitment to the Clinical Development Lead Nurse lead is progressing. Successful recruitment to this position has been made which will support the drive to improve standards across the borough-wide nursing homes. This approach has been welcomed and would be beneficial to explore further in the nursing recruitment drive.

MDT Team - Ongoing work is required to embed MDT working across the sector, not simply as one-off meetings but a recognition of the importance of delivering quality care to residents within care homes, in line with any other resident of the borough (see Case Study example).

Digital - The recently published White Paper has propelled the need to digitalise care homes to the forefront of any development plans. Introducing digitalised care records will benefit residents, staff and managers and work is underway to procure up-to-date systems across the homes.

Care Homes Case Study – MDT Working

Mrs X resides in a nursing home in Widnes. She has, over the last twelve months, had a number of hospital admissions. After her latest discharge from hospital she returned home requiring long-term catheter care.

The nurses working within the nursing home had not cared for a person requiring long-term catheter care for some time so required some support. They were concerned that if they did not provide the correct care and support Mrs X would be at risk of requiring further episodes of acute care.

The Nursing Home nurses discussed their concerns at the weekly Multi-Disciplinary Meeting (MDT) and it was agreed that the District Nursing team would in reach into the home to provide the care until care home nurses could undertake the necessary training.

Further discussions took place between the managers of the two services, District Nursing and Care homes to support the services, ensuring Mrs X received the care she needed within her home and the District Nurses offered further support to Care Home nurses. Care Home nurses have the opportunity to shadow District Nurses to gain confidence and competence in the task ensuring they will be in a position to meet the needs of Mrs X and other care home residents if required in the future.

3.7.4 **Future Work Streams**

There are a number of other work stream areas to be considered, as detailed in the table below, aligned to the priorities within the Health and Wellbeing Strategy. These will be influenced by the development of and priorities established within the One Halton Plan.

Living Well	Living/Ageing Well	All themes
• Therapy and Equipment provision • Transition	• Single Point of Access • Mental Health • Learning Disability (Board and Groups in place) • Out of Hours Provision • Voluntary Sector – including Core20Plus5 and Social Prescribing** • Palliative/End of Life Care – scope wider • Safeguarding (Board and Groups in place) • Quality Assurance • Housing	• Carers (Strategy Group in place) • Prevention Framework • Public Health • Neighbourhood working

4.0 **POLICY IMPLICATIONS**

4.1 N/A

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 N/A

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**

6.2 **Employment, Learning & Skills in Halton**

6.3 **A Healthy Halton**
Integrated working at different levels across the local system is vital to ensure that the residents of Halton have a smooth and efficient health and social care service.

6.4 **A Safer Halton**

6.5 **Halton's Urban Renewal**

7.0 **RISK ANALYSIS**

7.1 System challenges, including financial stability, appropriately skilled workforce to address the increases in demand across health and social care, will be considered when approving new work stream briefs.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified.

9.0 **CLIMATE CHANGE IMPLICATIONS**

9.1 Environmental and climate change implications are considered through each individual work stream delivery project group and the over-arching Delivery Plan for the ODSC.

10.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

10.1 None under the meaning of the Act.