HALTON BOROUGH COUNCIL

Health Policy and Performance Board

Scrutiny Review 2024

NHS Community Health Services (non-GP)

Findings & Recommendations

Health Policy and Performance Board

Contents

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to summarise the evidence, findings and recommendations of the Health Policy and Performance (HPPB) Scrutiny Group in relation to the NHS Community Health (non-GP) Services topic brief (outlined in full in *Section 3)*.

1.2 The scrutiny review process provided Members the opportunity to gain an understanding of:

- Who uses the service and why.
- Referral/access pathways.
- How each of the services interact within the wider health and social care landscape.
- The key performance and quality indicators, including outcomes achieved by the service and service user experience.
- The level of capacity and demand within the services.
- Innovative work taking place to improve performance, outcomes and service user experience.
- Opportunities, current challenges or emerging issues faced by the services.
- Recommendations as to how services can further improve performance, outcomes and service user experience and how services manage any capacity and demand issues identified.

2.0 STRUCTURE OF THE REPORT

2.1 This report contains an introduction providing the topic brief and context, a summary of the evidence presented, conclusions reached by Members and recommendations to be made to Health PPB. Supplementary information such as presentations can be found in the appendices.

3.0 INTRODUCTION

Scope of the scrutiny topic review

3.1 This report was commissioned as a scrutiny committee of the Health Policy and Performance Board. The scope of the review is shown below:

The 2024/2025 scrutiny review for health policy and performance board will look at NHS Community Health (non-GP) Services, specifically;
Non-urgent services

- NHS Community Nursing
- Podiatry
- Therapy
- Musculoskeletal services

Urgent services

- Urgent Treatment Centres (Widnes & Runcorn)
- Northwest Ambulance Service
- Urgent community response.

The reason this scrutiny review was commissioned

3.2 Community health services play a key role in the NHS. They keep people well, often with complex needs, at home and in community settings close to home and support people to live independently. These services involve collaboration across health and social care teams, including professionals such community nurses, therapists, and social care workers. Moving more care out of hospital and into the community is an NHS priority and is one of the improvements outlined in the NHS Long Term Plan.

3.3 It is widely recognised that NHS community health services are critical to keeping the whole health system working effectively. From avoidable hospital admissions to supporting timely discharge, community services play their part in maximising capacity and managing demand across the system.

3.4 It is important that Members understand the community services' role in the health and social care landscape in Halton and how resources are mobilised to provide quality services that maximise capacity in both the health and social care system and meet or exceed agreed safety, performance and quality indicators.

3.5 **Membership of the Scrutiny Working Group:**

Members	Officers
Cllr Eddie Dourley - Chair Cllr Sandra Baker – Vice Chair Cllr Sian Davidson Cllr Chris Loftus Cllr Louise Nolan Cllr Tom Stretch Cllr Louise Goodall Cllr Emma Garner Cllr Mike Fry Cllr Victoria Begg Cllr Sharon Thornton	Damian Nolan, Operational Director Emma Bragger – ASC Service Development Officer

4.0 METHODOLOGY

4.1 This scrutiny review was conducted via:

- Monthly meetings of the scrutiny review topic group.
- Presentations by key Officers of services within the scope of the topic brief.
- Two site visits
- Provision of information both written and verbal.
- The evidence provided to Members considered:

✓ the key responsibilities of each service
✓ referral/access pathways and service user demographics

- ✓ key operational practices and interface with other services within the health and social care system in Halton
- ✓ performance and trend analysis in relation to key quality and safety indicators and patient outcomes/experience.

4.2 The presentations given to Members can be found in Appendix 1.

5.0 SUMMARY OF EVIDENCE, MEMBER CONCULSIONS AND RECOMMENDATIONS

5.1 Evidence Area 1: Cheshire & Merseyside Integrated Care Board (ICB) Context

5.2 NHS Cheshire & Merseyside is the statutory body responsible for the commissioning of most health services within the region, including primary, community, and hospital health services. Within NHS Cheshire and Merseyside ICB, there are nine places each of which is co-terminus with the local authority and has a place-based partnership. The place-based partnership in Halton is 'One Halton'. This is a collaborative partnership arrangement that comprises a range of stakeholders including health providers, children and adult social care, public health, housing, Healthwatch, and the voluntary and community sector.

5.3 The ICB is responsible for planning of services for the population, such as GP, Dental, Pharmacy, Optometry, community and hospital services. Cheshire and Merseyside has a population of around 2.7 million. Halton's place based partnership, One Halton, is co-terminus with Halton Borough Council footprint. The ICB allocates about £300m each year for health services for Halton's population of 130,000. Work continues on an on-going basis to improve patient services and access, as well as ensuring greater productivity and value for money. Health services, like some other public services, continue to recover from the effects of the COVID-19 pandemic. Demand for services continues with people generally living longer but with co-morbidities adding to the complexity of need.

5.4 Collaboration – Across NHS Cheshire and Merseyside there are two NHS provider collaboratives: Cheshire and Merseyside Acute and Specialist Trust (CMAST), the acute provider collaborative, and Mental Health, Learning Disabilities and Community Services (MHLDC), the mental health, learning disabilities, and community collaborative. These collaboratives work as groups of health providers at greater scale to drive improvements to services and increase productivity for the benefit of patients. More widely, all local agencies continue to collaborate and work in partnership to deliver for the residents of Halton.

5.5 Performance – NHS Cheshire and Merseyside Board receives regular performance and quality reports. Some of the indicators are monitored at Cheshire and Merseyside level whilst others are at Place level.

5.6 Quality and Safety – There is a continuous focus on the quality and safety of services which are monitored through rigorous ICB quality management

systems which seek to ensure the provision safe, high quality and effective services and improving patient experience.

5.7 Local quality and performance priorities for the ICB include:

- Maintaining/improving access to high quality and safe services, including Community Health Services.
- Working with partners such as the local authority children's and adults' services and Public Health in tackling disparities between communities in Halton who may be affected by wider determinants of health and wellbeing such as housing, social isolation, employment and financial, fuel and food poverty.
- Promoting the importance of the right service at the right time, including support to families 'upstream' to prevent escalation of issues later in life by adopting a multi-agency partnership approach.

5.8 Conclusions

5.9 Workforce, capacity and demand, increasing patient acuity and NHS estates continue to present challenges across the health service, including in community services in Halton.

5.10 National industrial action has had an impact on quality and performance in relation to capacity and patient experience in Halton. Whilst provider collaboratives are working to increase capacity, individual experiences do differ between services. However, Halton Intermediate Care and Frailty Service (HICaFS) and family hubs are examples of well used collaboratives that are working well.

5.11 Nationally and locally, there is a challenge to help people live longer, but in better health – highlighting the need to address the wider determinants of health such as poverty, housing and employment.

5.12 Locally, demand is continually high for community services and services are not seeing seasonal fluctuations that have previously been evident. This is compounded by workforce issues such as an unstable workforce in some services leading to vacancies, and the need for sufficient investment to address workforce retention issues.

5.13 Locally, bed occupancy in hospitals is consistently high, which has a knock on effect on community services in Halton, leading to high demand for packages of health and social care in the community. Provision in the social care market can also a challenge and often beyond the control of the local health and social care system.

5.14 Evidence Area 2: Urgent Treatment Centre (Widnes)

5.15 Bridgewater Community Healthcare NHS Foundation Trust deliver services from the Widnes Urgent Treatment Centre (UTC), which provides medical help for minor illnesses and injuries to all age groups. The centre is open 8am-9pm 365 days a year and supports primary care by dealing with acute, on the day illness and aims to prevent attendance at local accident

and emergency departments. The service has an onsite facility of x-ray imaging, plaster room and has the ability to book into the fracture clinic to ensure the process of care can be completed in one care episode.

5.16 The following list of injuries and illness are what patients can expect to be treated with at Widnes UTC:

- Slips, trips, falls, sprains,
- fractures (upper and lower limb)
- Wounds, grazes, dressings
- Burns, scalds,
- Allergies, rashes, bites, and stings
- Coughs, colds, sore throats, ear problems
- Headaches
- Back pain and strains
- Eye problems

5.17 The service is staffed by a range of health care professionals which include advanced nurse practitioners and prescribers, both adult and paediatric trained, GPs, health care assistants, who are highly skilled and able to triage, examine, diagnose and treat a variety of minor illness and injuries, and supporting administrative staff. As at August 2024 there was just one vacancy and the staffing base is reported as being stable.

5.18 Bridgewater Community Healthcare NHS Foundation Trust provides a number of other community services in Halton and refers patients from the UTC to these services if required, for example to the Halton Integrated Frailty Assessment Service (HIFCAS)/Urgent community response team. These established referral pathways are reported as working well and provide seamless transition for patients.

5.19 Average attendance is between 110-120 patients per day. Throat and cough symptoms account for the majority of attendances. The service averages 3500 contacts per month, with 130 follow up appointments (where patients have been invited to return). The majority of attendees at Widnes UTC are from Widnes, although people from Runcorn and out of borough can and do access the service. It is noted that there are instances of people from areas in which there is a UTC local to them are travelling to access the UTC in Widnes. This may be due to service availability, waiting times or previous positive experience of Widnes UTC.

5.20 The UTC national timeframe target for being seen, treated and discharged is within 4 hours. In the first 3 months of this financial year (2024/25) the service achieved 98.6%, 97.81% and 99.49% of cases seen within 4 hours. The service reported a key reason why someone may not be seen, treated and discharged within 4 hours as being due to additional treatment/s being required lengthening the episode of care. Some people who present at reception leave before they are triaged. Instances where people may not wait for triage is if the service is running at capacity, there are long waiting times or it is approaching service closing time and patients are advised on entry that it is a ‘triage only’ service.

5.21 Five visits were carried out by Healthwatch between Oct 2023 and March 2024. Each visit lasted between 2 and 3 hours and in total 98 people provide feedback on their experience.

5.22 **Feedback from Healthwatch visits** :

- The UTC offers an excellent alternative for patients who feel they need same day treatment and may have visited A&E if there wasn't a local UTC available.

- It supports patients attending from Halton and further afield, many of whom have been unable to access suitable appointments with their own GP practices and see the UTC as a viable alternative for treatment.

- During visits Healthwatch observed staff treating patients with dignity and respect and being, friendly, helpful and courteous to patients, which is also reflected in the comments from patients taking part in the survey.

5.23 **Recommendations from the Healthwatch visits:**

- Feedback highlighted a need for an improved way of keeping patients updated on waiting times – this will manage expectations and improve customer satisfaction.
- A review of the way patients are currently called in for triage or treatment to make it clearer and more accessible.
- Recommended the installation of a water cooler.
- Improved signage from both entrances to the Health Care Resource Centre to direct people to reception.

5.24 The UTC welcomed the audit as Healthwatch brings a unique, local perspective. The service has taken actions to implement previous Healthwatch recommendations relating to the waiting areas, and are considering how best to implement the recommendations from the most recent visits. It is acknowledged by the service that the building isn't always conducive to smooth and comfortable service delivery, but it is limited in options to increase capacity within the current building. The building is in an accessible location so there is no desire to move at this time. There are likely to be improvements to signage and waiting areas to improve patient experience.

5.25 Where there has been anecdotal evidence of inappropriate referrals from the UTC to Whiston A&E, the data does not appear to show that this is an issue. Through communication between the UTC and A&E's it is known that people will present at A&E and advise they have been told to attend by UTC even when this is not the case. The relationship between UTC and A&E's is positive and both services work together to maximise capacity, referring to each other where one has greater capacity.

5.26 In the NHS 'friends and family test', 89.9% rated the service as good or very good. There have been 3 complaints over the last 12 months, relating to clinical treatment and prescribing.

5.27 The service has identified a number of emerging areas to consider, including:

- A pilot to look at reviewing children who attend clinic and parents who need re-assurance . This aims to reduce A&E and GP attendance (Paediatric Assessment and Review Clinic (PARC)).

- Leg Dressing Clinic - Pilot to look at reviewing leg dressings , increasing the competencies and skills of the Health Care Assistants and using these staff to see lower leg dressings to free up the time of qualified staff to see more complex patients.

- 'Levelling up' the UTC offer across Widnes and Runcorn sites - As part of the integration work between Bridgewater Community Healthcare NHS and the Primary Care Networks (PCNs), the two UTCs in Halton (UTC Runcorn, Warrington and Halton Hospitals NHS Trust) will be moving towards working together. This may mean additional point of care testing or other diagnostic interventions so that more Halton residents can be cared for within their community.

- Musculo Skeletal Practitioners (MSK) - Pilot to look at the use of an MSK practitioner in the department. This will support any future skill mix planning.

- GP Connect - Work to re-instate the GP connect work undertaken in 2022. This was paused after initial pilot to enable an assessment to be undertaken of the benefits and to support a plan to widen this out across the GP patch.

- GP Coverage - Working with Commissioners and the Primary Care Network to look at how to meet the needs of the UTC in relation to GP coverage moving forward

- It was acknowledged that 'front of house' and the customer care experience of attendees can vary, but it is important to get the initial contact right to reassure patients and ensure they access the most appropriate service/signposting. Admin/reception is no longer managed by the clinical service, however previously it has been integrated within the clinical service and this provided more cohesion and opportunity to signpost, where appropriate. This will be an area of focus moving forward.

5.28 Conclusions

5.29 The UTC is a valuable resource for residents of Widnes, Halton as a whole and people in nearby areas. The service can treat a range of minor acute illnesses and conditions on the day, preventing the need for Primary Care intervention and A&E visits, maximising capacity across those parts of the health system.

5.30 Feedback about the service is largely positive, with negative comments mostly relating to waiting times. Work streams have been identified (noted above) to further improve patient experience.

5.31 There are processes and services within the Widnes UTC that differ from those offered by the Runcorn UTC as a result of different providers delivering the services. However, it is a priority across both UTCs to work closely together to level up the offer across Halton utilising the resources across both sites.

5.32 Recommendations

- **GP attendance**- There have been reported incidents of where there has not been a GP present within the service, an integral part of the service model. Availability of a GP should be a priority and steps taken to ensure that there is sufficient GP coverage in the service.
- **Patient experience** - The service should take steps to implement the recommendations of Healthwatch, where this is reasonable and practical to do so, in relation to waiting areas, signage and notice boards. Negative feedback on the friends and family test is largely around the waiting times, therefore, clear and up to date information about expected waiting times should be made available to manage people's expectations and improve patient experience.
- **Identified emerging areas** - The service should provide updates to the Health Policy and Performance Board on progress made in the identified emerging areas noted in this report.

5.33 Evidence Area 3: Urgent Care Response (UCR) – part of HICaFS

5.34 UCR is one component of the Halton Intermediate Care and Frailty Service (HICaFS), along with Oakmeadow Intermediate Care and Reablement.

5.35 HICaFS provides a whole-systems approach to proactively manage referrals safely and seamlessly for patients requiring urgent care response, intermediate care and frailty services by working in partnership with Halton Borough Council, Warrington and Halton Hospital Teaching Hospital NHS Trust, Bridgewater Community NHS Trust, general practitioners (GPs), the voluntary sector and other key stakeholders.

5.36 The service has office bases in Runcorn Town Hall, the Health Care Resource Centre in Widnes and Peel House Lane Children's Centre. The service is delivered in the patient's own home or care setting and is available 8am to 6pm Monday to Sunday with a maximum two-hour response time, with the aim of avoiding unnecessary hospital admissions.

The services inclusion criteria is:

- People over 18 years with complex health needs.
- People over 18 years who have experienced a rapid deterioration in health or function which does not need secondary care as a result.
- People over 18 years who require rapid intervention and a timely intensive care package.
- People over 18 years who require access to time-limited care and support.
- People who require a rapid Multidisciplinary approach to their care.
- Referrals from the Ambulance service to assist and assess patients who have fallen.

- Referrals from the Ambulance service for people who can remain at home with the correct support.
- Referrals from hospital for people who can continue their care at home with the correct support.

Main elements of the service are:

- Clinical triage
- Initial triage of presenting patients by an appropriate clinician
- Treatment and admission avoidance care plans
- Advanced care planning
- Clinical medication review
- Optimising physical function
- Discharge planning.
- Supporting self-care and patient education

5.37 There are around 350 referrals to the service per month. 69.80% referred for the crisis response element, 23.65% referred to intermediate/reablement care service and 6.55% referred to bed based intermediate care (Oakmeadow). Referrals mainly come from Hospitals GP practices, NWAS and district nurses. 85% of referrals are responded to within 2 hours.

5.38 Satisfaction with the service - In satisfaction surveys, 100% of respondents were very satisfied with the service, however, the cohort was small. Due to the emergency response nature of the service, it is difficult to get questionnaire responses completed at the time of intervention.

5.39 Admission avoidance work – The service is involved in the regional 'Newton' programme of work, which has identified opportunities for UCR to play a further role in admission avoidance. Within the Newton recommendations, the findings suggested there were 11 people a week going into hospital who could have been supported in the community by the Warrington/Halton UCR services. A group has been developed which brings together key stakeholders who can support the a review the UCRs in the context of the Newton findings and wider place-based systems. The group will review how UCR models are functioning and what needs to be developed or remodelled to increase UCR activity with specifically targeted groups to prevent unnecessary hospital attendance and admissions, specifically:

Mid Mersey and West Lancashire Urgent and Emergency Care Recovery Programme

The aims of the group are to:

- Increase NWAS → UCR referrals by having a co-located clinical navigator in the NWAS call centre (EOC)
- Understand the patient process from calling 999 to being conveyed to emergency departments → where are the opportunities for UCRs to intervene?
- Map service variation → understand where there are differences and whether those differences are barriers to increasing NWAS referrals

- ✓ Enhanced Care Home Model - No enhanced Care Home Service in Halton**.** There are plans to proposed a model to be developed
- ✓ When actively attending Care/ Nursing homes lots of patients are referred to the service at point of contact
- ✓ The service sits on NHSE Social Care Nursing Home Group.
- ✓ This area of work is where we could prevent admissions and reduce AED attendance

5.40 Conclusions

5.41 Anecdotal evidence suggested that there may be a problem with availability of care packages, but data does not show this. There are 'process' issues within the assessment and hospital discharge process that can slow down discharge. There is capacity within domiciliary care and intermediate care – the most common care types required on discharge. However, where people with dementia and other additional needs, some service providers are reluctant to accept the risk if they do not feel they have suitable staff numbers/skill mix or limited capacity within their service.

5.42 The UCR element of HICaFS is a fundamental part of the model with almost 70% of referrals to HICaFs being for this part of the service.

5.43 The Newton work has identified capacity for UCR to reduce hospital admissions, and Halton is part of a working group to consider recommendations on how to achieve this through closer working with stakeholders such as NWAS.

5.44 Recommendations:

- **Newton Recommendations** - UCR, and HICaFS as a whole, should continue to analyse the available data and work with stakeholders to maximise potential within the service and it's component parts, in line with the Newton recommendations. Progress should be reported to the Health and Wellbeing Being Board.

5.45 Evidence Area 4 – Nursing in the Community

5.46 Nursing in the community is made up of 3 service areas: District Nursing, Community Matron and Specialist Nursing (9 specialisms: Heart Failure, Palliative, IV Therapy, Tissue Viability, Stroke, Parkinsons, Intermediate Care, Wellbeing and Community Treatment Rooms). Each of the 3 service areas has different functions and are commissioned separately.

5.47 **District Nursing –** Has the aim of preventing hospital admissions and maintaining independence within the community. Referrals come predominantly from GP and Hospitals and is the biggest of the 3 nursing service areas in Halton.

5.48 Halton District nurses provide a 24-hour nursing service over 365 days a year providing nursing care and treatments to patients in their own homes, including residential homes, or sometimes from a GP Practice.

5.49 Care is for patients who have a short-term nursing need, require nursing care following a hospital discharge, have a long-term condition or a terminal illness.

5.50 The Halton District nurses work in partnership with patients, carers, GP's, Hospitals, Specialist Nurses, Community Matrons, Macmillan Nurses, Social Care teams and all other Health and Allied Health Professionals.

5.51 **Community Matron Service –** Community Matrons have additional qualifications than District Nurses enabling them to undertake higher level tasks, such as prescribing. There are 5 Community Matrons in Halton, aligned to the GP Practices.

5.52 Once referred into the service, the matrons aim to see patients within six weeks. They will create a care plan with the patient in order to promote patient autonomy and maintain patient independence.

5.53 Community matrons will keep patients on their caseloads for approximately 16 weeks, or until they are medically optimised, at which point they will be discharged back to the care of the GP.

5.54 **Specialist Nurses –** Specialist Nurses operate both from clinics in the community and also visit people's homes to support people at any/throughout all stages of condition progression. They work very closely with the hospitals/specialists and work is ongoing to further build on this. Specialist nursing teams' staffing is relatively small ie 4 specialist heart failure nurses.

5.55 The Specialist Nursing teams provide support to Urgent Care Response, and support the Virtual Wards model, in preventing hospital admissions through provision of specialist care in the community.

5.56 Service satisfaction rates are 92.7%, as at August 2024. It is rare for complaints to be about waiting times. Feedback tends to be around the length of the visit or not being able to tend to other nursing needs that fall under another part of the nursing in the community service. Whilst continuity of nursing staff is a priority, it is not always possible due to the small team numbers.

5.57 Conclusions

5.58 Patients may be in need of, for example, a District Nurse and also a Specialist Nurse, common for people with co-morbidities, yet services are delivered in silos and patients are referred to separate elements of community nursing. This may impact on the patient's experience ie having to 'tell their story' several times over multiple appointments and waiting for additional appointments.

5.59 Only Treatment Rooms have a waiting lists and Bridgewater have taken action to reduce this. Work is underway to look at how patient experience can be improved, potentially through changing the service opening hours

to outside of normal working hours. This may improve capacity within the Urgent Treatment Centre through offering a more accessible service so people don't need to attend the UTC.

5.60 Ongoing Virtual Ward development and expansion through enhanced links with the local acute hospitals will improve pathways for patients and ensure seamless care.

5.61 The specialist Wellbeing Nurses support people with severe mental illness, undertaking reviews and liaising with GPs. Members discussed a potential gap in accessibility of mental health services, and it was acknowledged that these specialist nurses play an important role in preventing people attending A&E and potentially resulting in an avoidable admission.

5.62 Some of the specialist services are extremely small, e.g. Parkinson's service which is one part time nurse. This makes building resilience for these services more difficult. Workforce planning is underway to look at the staff mix, for instance, in the Treatment Rooms and analyse what the demand is for specific treatments. This will help to modify the clinical treatments on offer to maximise capacity, in line with what the GP Practices need the service to deliver. The service has, in some areas, morphed into 'filling the gap', this then has a knock on effect on the wider healthcare system becoming saturated. People then attend the UTC seeking treatment which impacts on that services capacity resulting in people seeking UTC services then attending A&E.

5.63 It is recognised that there is a need to address the historical rational for nurses not dealing with a patient's multiple nursing needs in one visit. Nursing in the community has been very task orientated, with time allocated to attend to a specific task. This is further impacted by the fact that there is no single point of access for nursing in the community and the services are commissioned separately, fuelling a silo approach. A cultural shift may be required to move towards a more holistic nursing approach which, it is anticipated, will lessen 'another appointment on another day' and prevent escalation of patients' requirements. Positively, this is something that the newly qualified nurses in the teams are keen to develop and build on relationships with community partners, such as the voluntary sector to offer additional support to patients.

5.64 The impact of the bridge tolls has been evident across nursing in the community services, with nurses now generally working the patches on the side of the river in which they live. For nurses that reside outside of the borough, the toll costs have been prohibitive to recruitment if required to incur the toll cost. There is potential for Bridgewater to look at their expenses system and propose a similar approach to HBC staff bridge toll expenses reimbursement, separate from the car mileage system. Discussions with Merseyflow may also be considered to see if there is any potential discount for health services.

5.65 Recommendations:

- **Single Point of Access** - Consider how a single point of access and holistic approach to nursing in the community could maximise capacity across the 3 service areas and further improve patient experience.
- **Capacity -** Analysis of clinical practice/demand to identify opportunities to maximise capacity, particularly in the Treatment Rooms.
- **Impact of bridge crossings** - Explore solutions to mitigate the impact of bridge tolls on the recruitment and retention of nurses

5.66 Evidence area 5 – Podiatry

5.67 The Service aims to offer a wide range of clinical interventions primarily dealing with assessment, diagnosis, and treatment of the lower limb to patients deemed as having a clinical or medical need. This is done through the following:

- Basic foot care and routine podiatry for patients with medium to high clinical or medical need
- Specialist treatment to children via biomechanical (leg and foot function) clinics
- Biomechanical assessment and insole provision for adults
- Rapid access Diabetic foot ulcer clinic in Warrington Hospital
- Nail surgery clinics (i.e. when we remove all or part of a toenail under local anaesthesia) for all age groups.
- Emergency access clinics for acute/ infected/ painful foot conditions
- Domiciliary service for housebound patients

5.68 The service is offered at a range of community locations – all have the advantage of local transport stops nearby. Home visits are available for patients who are housebound. The service has 10 full time staff, trained to different levels, working closely with musculoskeletal services and acute hospitals.

5.69 Referral into the service has been via a referral form that can be completed by either the patient themselves, General Practitioner, or other Health Care Professional. An online referral form is replacing the previous referral form as there was previously no way that pictures can be sent as part of the referral to assist with the prioritisation of ‘urgent’ cases.

5.70 The service has an average of 1800 contacts with patients per month. Each month the service sees on average 200 new patients. There is a waiting list for this service, and waits at all clinics are monitored by clerical staff and the service lead. Patients are triaged on referral into the service in terms of medical priority. Staff are moved around clinics to provide more sessions at any particular venue where the demand has increased above normal.

5.71 There is a high level of satisfaction reported, despite the large waiting list, with 100% of participants satisfied with the treatment they received, waiting

times, dignity and respect and being listened to. Overall positive experience was 97.9%

5.72 Conclusions

5.73 The service is much in demand. The waiting list has reduced from over 1000 to 700 through the temporary use of locums. Work is underway to look across the ICB to mirror what other areas, such as Warrington, are doing to achieve smaller waiting lists. The service is working with commissioners to develop the eligibility criteria and the exploration of local provider offers.

5.74 There is a trial underway with a socially and medically 'risk score matrix' across Cheshire and Merseyside ICB that may help with eligibilities, referral, triage and prioritisation going forward.

5.75 Self-care web based and leaflet resources are areas for development, but often the cohort of people requiring podiatry struggle with self-care, hence their need for the service.

5.76 There are risks to the sustainability of the service as the current workforce profile is skewed towards older podiatrists. It is difficult to recruit podiatrist from university into the NHS as they are attracted by private practice. Bridgewater have done work with universities to develop and promote a flexible offer to newly qualified podiatrists whereby they can work for the NHS and Private Practice, to make recruitment into the NHS more attractive.

5.77 Recommendations:

- **Risk score matrix** - Monitor the results of the risk score matrix and implement recommendations resulting from the trial. Provide an update on the recommendations and impact of the trail/implementation of the risk score matrix in managing demand and prioritisation.
- **Information resources** - Explore what information resources and formats would be most appropriate ie preventative information and self-help, and the role of partner agencies in supporting prevention and self-help.
- **Recruitment and retention** - Continue with proactive relationships with universities to promote NHS podiatry as a career choice and provide updates to the Health Policy and Performance Board.

5.78 Evidence area 6 – Community Therapy and HICaFS Therapy (Warrington and Halton Hospitals NHS Trust)

5.79 The Halton Community Therapy Team (HCTT) offers therapeutic & rehabilitative assessment, triage, intervention and advice for adults within their home settings (including nursing and residential homes). Patients are mostly housebound and therefore unable to access therapy within the hospital environment; often therapeutic needs are best met in home environment as this reinforces functional aspect of their rehabilitation.

5.80 Halton Community Therapy Team is based at Halton Hospital and comprises of 12 staff: 5.65 whole time equivalent (wte) Physiotherapists, 2.71 wte Occupational Therapists , 0.55 wte Admin & Clerical staff.

5.81 Staff retention is reported as being stable. There have been a number of development posts introduced with opportunities for staff to work with colleagues across Cheshire and Merseyside which promotes retention of staff. There has been work done to attract people into the therapy professions, including links to colleges to promote apprenticeship routes and promote the different therapy roles, as well as links to universities.

5.82 The service accepts referrals from health professionals for any Halton resident with a Halton GP who requires Occupational Therapy or Physiotherapy in their own home environment. Referrals from GP's and community health care functions account for 75% - this includes: GPs, Practice Nurses, District Nurses, Community Matrons, Palliative Care Nurse, Halton Haven Hospice, Halton Intermediate Care & Frailty community services and Social services OTs, (anyone who is under the care of the GP at point of referral). Referrals from Hospital Consultants: account for 25% - including all hospital discharges, consultants, allied health professionals and nurses.

5.83 Waiting times have improved from a peak during the COVID-19 pandemic. At January 2020 (just before the pandemic) there was a 2 week wait for service. Post pandemic it peaked at 36 weeks. As at October 2024 it was at 8 weeks, against targets of routine referrals 8 weeks and urgent 48 hours.

5.84 New referrals per month average 133, with the split being around 33 for Occupational therapists, 100 for Physiotherapists. New patient contacts for 2023/24 totalled 1324 with 385 for Occupational therapists , 939 for Physiotherapists.

5.85 The Community Therapy service faces a number of challenges, including:

- Halton's Aging Population – 20% increase in over 65s by 2030 – therefore increase in referrals to the service for Falls Prevention/Management etc.
- Deprivation Index – Halton ranks at 39th out of 317 of the most deprived local authorities. Therefore the service has a clear role in contributing to quality improvement initiatives that tackle health issues such as obesity, cancer survival rates, diabetes related disease, smoking related disease.
- Implementation of Rolling Satisfaction Survey – Whilst service feedback is largely positive, participation rates are fairly low. The service is to investigate links with Experts by Experience/Halton Health Watch and implement a rolling satisfaction survey available to patients so that any issues can be identified and acted upon in a timely manner.
- The service attends Heads of Service & Clinical Leads Meetings ensuring quality of clinical care through research, audit, supervision, NICE guidance, patient experience; offering assurance to commissioners that the patient receives excellent evidenced based care. This involvement is to

be ongoing and forms an important part of the continuous quality improvement process.

Therapy in the Halton Integrated Care and Frailty Service (HICaFS)

5.86 HICaFS replaced the NHS services previously provided in Halton by the Rapid Access Rehabilitation Service (RARS), Capacity & Demand Team and the Halton Integrated Frailty Service (HIFS). The Therapy element of the service is made up of Urgent Care Response, Reablement (often referred to as intermediate care at home) and Oakmeadow Intermediate Care Response.

5.87 Access is through a referral by Health Professionals, Social Services, Voluntary Agencies and self-referral (if previously seen by the service). People have access to Dietetic, Physiotherapy and Occupational Therapists.

5.88 During quarter 1 of 2024/25 (April – June 2024) the average number of referrals was 325 per month. The majority of referrals came from the Hospital Discharge teams, then GPs. A small amount came from the Care Homes. Whilst a small amount of referrals came via Northwest Ambulance Service (NWAS) or NHS 111, there are plans to improve referral rates here through increased partnership working. There is an opportunity for the HICaFS Therapy team to work with the 999/111 calls service to triage and advise, where appropriate, to save an ambulance attendance where the HICaFS service can intervene.

5.89 Through the single point of access for HICaFS, the most demand for therapy is for Urgent Care Response (61%). Urgent Care Response have seen an increase in average number of referrals in comparison to 2023/24 by 18% (53 to 76). After Urgent Care Response, demand is then greatest for Reablement and then Oakmeadow Intermediate Care. Up to 29% of referrals result in no further intervention, due to either not being medically stable or referred to another service.

5.90 **Outcomes for UCR, Reablement & Oakmeadow Quarter 1 - April to June 2024**

- 65% of patients referred to the service were discharged has been independent, requiring no additional long term social care.
- 15% of patients were readmitted to hospital due to being medically unwell. Majority of this cohort of patients were seen by the UCR aspect of the service.
- 14% of patients required a new or revised package of care.

5.91 **Average length of stay Quarter 1 - April to June 2024**
Reablement - 33 days. A downward trend since 2023/2024.
Oakmeadow - 30 days. Average occupancy rate – 88%
Urgent Care Response - 7 days

5.92 **Service User Satisfaction Survey**
Latest results – as at October 2024
100% of people said they were treated with dignity and respect.

100% of people said agreed/strongly agreed they would recommend the service.
77% of people felt their condition had improved after they had received care.

5.93 Conclusion

5.94 An older person living with frailty is more likely to have a delayed transfer of care from hospital and it is recognised that people living with frailty often have their needs best met in settings outside of acute hospital care. Community Therapy plays a valuable role in the local health and social care system in both facilitating hospital discharge and preventing hospital admissions.

5.95 There may be opportunities within Community Therapy to maximise capacity in other parts of the health and social care system such as hospitals and ambulance service, with the appropriate levels of additional resourcing, through the flexibility and expertise within the therapy service.

5.96 Recommendations

- **Undertake a deep dive into service data** to identify potential opportunities for therapy services to support capacity and demand across the health and social care system and to inform future workforce structure requirements.
- **Urgent Care Response -** Pilot the use of lifting raisers to prevent unnecessary hospital admission, and example of therapies and nursing working in partnership.
- **Falls Prevention & Management -** As part of the aging well programme, continue to focus on ways to reduce the risk of people falling and going to hospital through assessment of their environment and provision of strengthening and balancing exercises.
- **Urgent & Emergency Care System Improvement Programme -** Maximise the use of alternatives to the Emergency Department, including Same Day Emergency Care. Where necessary, redesign and implement current alternatives to Emergency Department to ensure that they are optimised to reduce avoidable admissions. Provide updates to the Health Policy and Performance Board on any proposed system improvements.
- **NWAS** - Optimising referral pathways to community services.

5.97 Evidence area 7 – North West Ambulance Service (NWAS)

5.98 NWAS covers 5 counties; Cumbria, Greater Manchester (and Glossop), Cheshire, Merseyside and Lancashire, covering a population of 7.5 million across 5 Integrated Care System (ICBs).

5.99 Across the patch, there are 100 ambulance stations, and 10 contact centres handling 999, 111 and patient transport services, delivered by 7,074 staff with a budget of £493m. There are 1,019 vehicles in the fleet.

5.100 In the Cheshire and Merseyside region, there are 1,250 front line ambulance staff in operation working from 35 ambulance stations. Halton falls in the east of the sector (the sector also covers Warrington, St Helens, Newton Le Willows and part of Knowsley). There are 2 ambulance stations in Halton, one in Widnes and one in Runcorn.

5.101 Ambulance cover is matched to the 999 demand profile. Whilst there are two ambulance stations in Halton, emergency ambulances are dispatched on a 'next nearest' basis, not necessarily an ambulance that is based at a Halton ambulance station. Such is demand, it is very infrequent that ambulances are parked at a station during their shift.

5.102 Calls to 999 and 111 both use the same NHS Pathways triage system, so regardless of which service the patient calls they will get the most clinically appropriate response, or ambulance if required. There are clinicians based in the call handling centres to provide rapid phone assessment and advice to the patient and / or call handler.

Demand

5.103 Demand is returning to pre pandemic levels, with the greatest demand on the service being in 2020/21 and 2021/22.

5.104 During 2023-2024 in Cheshire and Merseyside there were the following number of incidents, by category. Category 1 is the highest level of medical acuity/emergency, category 2 is where there is most demand and category 5 calls no not require the dispatch of an ambulance.

	Category 1	Category 2	Category 3	Category 4	Category 5
No. of calls	35,610	188,641	73,134	4,823	30,269
Mean ambulance response time	8m24s (7m standard)	37m27s (18m standard)	2hr28m57s	2hrs44m27s	-
90th centile response time	14m21s	1hr20m51s	6hr45m	6hr41m11s	-

5.105 During 2023-2024 call response times to **Halton patients** for category 1 calls was 8m53s and category 2 calls was 40m35s. This was significantly higher than both the original national standard of 18 minutes, and the stop gap standard of 30 minutes for category 2 calls.

5.106 Across Cheshire and Merseyside, for 2024 – year to date (October 2024) there has been a slight improvement in the mean response time for category 1 calls from 8m24s to 8m2s and for category 2 calls from 37m27s to 35m59s.

5.107 Category 2 call response times for the year to date for **Halton patients** has shown some slight improvement, moving from 40m35s to 38m4s.

Outcomes

5.108 A little over half (56%) of the patients requiring an ambulance response result in the patient being conveyed to an A&E department. For Halton patients these are primarily Whiston and Warrington Hospitals.

Hear and Treat	14.4%
See and Treat	23.1%
See and Convey to A&E	56.1%
See and Convey to non A&E	6.4%

5.109 For 2024- year to date (October 2024) there are slightly higher numbers of people being conveyed to A&E, currently at 56.7%.

Performance

5.110 Delivery of performance against national response standards across Cheshire and Merseyside has been challenging. The national standard for category 2 calls (which make up the majority of demand) had been increased from 18 minutes to 30 minutes in a 'stop gap' response to unprecedented demand as a result of the COVID-19 pandemic. However, following the national trend, NWAS was falling short on attaining the revised standard of 30 minutes. As a result, significant investment has been made with an additional 1000 ambulance hours available per week than the same time last year. This investment has been incorporated in to the NWAS baseline establishment and is now permanent. Recruitment to these positions is now almost complete.

5.111 As a result, improvements in getting closer to attainment of the national response standards is showing this year, but NWAS still do not yet meet the standard.

5.112 Cheshire and Merseyside is somewhat of an outlier for response times compared to the north west. This is largely affected by the hospital transfer times affecting the availability of ambulance crews. 'Long waits' present a risk to patient safety and positive outcomes. Waiting over 60 minutes increases the risk of harm. In 2023 over 18,000 patients waited over 60 minutes for an ambulance.

5.113 In our area, Warrington Hospital currently is the best performing A&E department for handover times, but is still double the 15 minute target. Whiston A&E is 60 minutes, on average. It was noted by NWAS that ambulance crews queuing outside Whiston Hospital to do a handover has increased significantly this year compared to last year. NWAS has been held outside the A&E at Whiston 2000 times since April 2024. NWAS reported that across Cheshire and Merseyside 79,000 emergency ambulance hours have been lost this year to October, equivalent to 15 24hr emergency ambulances.

5.114 Conclusions

5.115 NWAS provide a vital front line service in the health and social care system. They work proactively with partners to maximise capacity within their own service and others.

5.116 The introduction of NHS Pathways across 999 and 111 works to ensure that ambulance dispatch is appropriate to the acuity of the patient, with other resources and tools available to call handlers to manage patient needs, such as clinical support and referral to other community services, such as pharmacy.

5.117 It is evident that the service is operating in very challenging times, despite significant investment to increase response capacity. Whilst demand for the service is great, it is relatively stable, but the ability to plan resources and work flow is hampered by the increasing issue of long hospital handovers.

5.118 The impact of long hospital handovers not only affects patient safety, but also operational aspects of the service in being able to free up crews and achieve the response standards, sometimes resulting in serious incidents and complaints, but also staff morale is being impacted.

5.119 Staff are highly educated, skilled and dedicated and their welfare has always been a priority of NWAS with things in place to support staff both on and off shift, however staff are becoming increasingly frustrated by the hospital handover delays and the impact it has on patients and operations.

5.120 NWAS raise the hospital handover issue regularly, with monthly newsletters to local MPs and regular meetings with hospital and Integrated Care Board (ICB) managers, but as yet there is no robust solution.

5.121 Recommendations

- **Hospital Handovers**: NWAS and ICB Halton should continue to work with health system managers to try and identify improvements to the hospital handover situation, taking learning from other areas that have managed to bring down the handover times, such as Greater Manchester. Analysis of differences in handover process between Warrington and Whiston Hospitals may provide insight as to how Whiston and NWAS can work together to improve their handover times.
- **Alternative to Hospital**: NWAS have identified that there may be more they can do with community health and social care partners to provide an alternative to hospital and negate the need for conveyance to hospital. NWAS should continue to explore potential with services, such as community therapy.

5.122 Evidence area 8 – Musculoskeletal Therapy Outpatient Service (Warrington and Halton Hospitals NHS Trust)

5.123 The Musculoskeletal (MSK) Therapy Outpatient Service comprises three teams;
• The Clinical Assessment and Triage Service (MSK CATS)
• The MSK Outpatient Physiotherapy Team Chronic Pain Management Service
• The Women's and Men's Health Physiotherapy team

5.124 **The Clinical Assessment and Triage Service (MSKCATS)** is made up of a team of highly specialised physiotherapists who diagnose muscle, bone and joint conditions, supported by an Admin and Clerical team. The service is available for people aged 16 years and over complaining of MSK conditions. There are a number of exclusion criteria, for which there are more appropriate services that people will be referred to i.e. condition management services or clinical intervention.

5.125 The service is made up of whole time equivalents (wte):

- Clinical Lead Physiotherapist- 0.63 wte (1 person)
- Physiotherapists- 8.6 wte (12 people)
- Admin and Clerical staff 3.37 wte (4 people)
- Medical Lead- 1 session per week with the team

5.126 The service operates out of:

- Clinic C Halton General Hospital: Mon- Fri core hours 8.30am-4.30pm Health Care Resource Centre, Widnes: Mon- Fri core hours 8.30am-4.30pm
- Halton Health Hub, Shopping City : Monday, Tuesday and Friday core hours 8.30am- 4.30pm
- Castlefields: Thursday 8am-4pm
- Brookvale: Friday 8.30am-4.30pm

5.127 The MSKCATS team work alongside GP colleagues offering appointments across primary care as part of the primary care workforce, which helps increase the capacity of primary care appointments across Runcorn and Widnes. This enables patients with MSK conditions to see the right clinician at the right time, freeing GPs to see more medically ill patients.

5.128 Patients receive a 30-minute appointment with a highly trained MSK physiotherapist, a significantly longer appointment than what they would have with a GP. Once assessed by MSKCATS clinician, the best course of management is discussed eg self-management advice, diagnostics, onward referral to treatment or onward referral to a consultant and referrals are made in a timely manner.

5.129 The service is commissioned service by Halton Place, Integrated Care Board (ICB) for Runcorn and Widnes offering a specific number of appointments to each GP practice based on practice population. Runcorn Primary Care Network (PCN) separately commission extra capacity for Runcorn GP practice patients using Additional Roles Reimbursement Scheme (ARRS) funding. Widnes PCN do not commission any extra

capacity from MSKCATS, they have commissioned a private company called 'Pure Physio' using the ARRS funding.

5.130 **Capacity and Demand**

- Runcorn ICB commissioned service capacity: 211 appointments per month
- Runcorn PCN commissioned service capacity: 412 appointments per month
- ***Total per month for Runcorn*** : 623

- Widnes ICB commissioned service capacity: 227 appointments per month

Performance

5.131 MSKCATS manage staff resources and work flow to match capacity and demand, wherever possible, to avoid long waiting times for patients. Waiting time is 5 working days, unless at holiday time where capacity and demand may not match. There is a 98% satisfaction rate for the service.

Runcorn June- Sept 24	**Widnes June- Sept 24**
Target appointments - 2494	Target appointments - 910
Actual appointments available - 2377	Actual appointments available - 751
Actual number of assessments carried out - 1952	Actual number of assessments carried out - 510

5.132 **The MSK Outpatient Physiotherapy Team Chronic Pain Management Service** sits within the MSK Physiotherapy Out Patient Department and currently has just over 1 WTE of physiotherapy, working across Halton Hospital MSK Physiotherapy Dept., Widnes Health Care Resource Centre Physiotherapy MSK Dept., GP practices and Halton Urgent Care Centre.

The service is staffed by:

- Clinical Specialists in spine, lower limb and upper limb - 2.4 WTE
- Clinical Team Manager - 1 WTE
- Advanced Therapists - 1.8 WTE
- Specialist static MSK physiotherapists - 4.2 WTE
- Band 5 Physiotherapist - 1 WTE
- Physiotherapy Assistants x3 – 2 WTE

5.133 The service offers triage, assessment, treatment advice, exercises and education relevant to the patient's condition and is available to adults and children (3years +, but excludes developmental MSK presentations).

5.134 The service offers:

- Musculoskeletal physiotherapy
- Rheumatology specialist physiotherapy
- Hydrotherapy
- Acupuncture
- Group therapy, including shoulder rehab classes, lower limb classes, post operative total knee replacement classes. Advance Lower limb class specialising in post operative of ACL Reconstruction with lower limb clinical specialists.
- Classes at Kingsway Leisure Centre and Brookvale leisure centre known as 'Escape Pain' for patients who suffer from Osteoarthritis (OA) of the Hip and/or Knee
- Back To Action class.

5.135 Demand for the service is high, with service demand against the available workforce capacity generating waiting lists. For example, 662 referrals in September 2024 with a capacity of 332 appointments. This is reflected in an increase in activity/attendances per month this year, from last year. In 2023-2024 there were 1014 activity/attendances on average per month, in 2024-2025 so far the average is 1165.

5.136 A number of strategies to support management of the high referral demand have been implemented, including introduction of a Virtual Engagement Group - inviting patients with similar pathologies to attend virtual clinics. However, poor attendance at the virtual class has facilitated a trial of group Face 2 Face for the first appointment which has shown an improvement in attendance, so referred this methodology for future groups. Escape Pain group for management of OA Hip and or Knee is well attended. Shoulder group classes in the gym at Halton Hospital have been introduced, along with Lower Limb gym classes in the gym at Halton Hospital and Hydrotherapy classes in the Community at Beechwood Community Centre twice per week. The clinical teams engage and refer to other community groups, including the HIIT Team and the Halton Healthy living team where appropriate.

5.137 **The Women's and Men's Health Physiotherapy team** offers general pelvic health, perinatal pelvic health and post operative breast cancer rehabilitation services. Referral is by health professionals for any patient with a Halton GP, with a self-referral access for Perinatal Pelvic Health branch of service to be available by the end of 2024. The services are available to people aged 18 year or older with the ability to access outpatient services.

5.138 The service is staffed by a Team Manager - 0.5 wte, Specialist Therapists - 2.98 wte, Pelvic Health Midwife - 0.4 wte and an Assistant Physiotherapist - 0.60 wte. A total of 4.48 wte staff.

5.139 The main aspects of the service are:

- Clinical triage
- 1:1 assessment and treatment
- Prescription of appropriate exercise programmes
- Supporting self-management and patient education

• Monthly multidisciplinary meetings for complex case discussions
• Referral into exercise / advice classes as appropriate
• Onward referrals as appropriate
•Training for Trust ward based staff and Bridgewater Adult Bladder & Bowel Continence Service.

5.140 Exercise and Advice Classes that the service provides:
• Antenatal pelvic health education class - online
• Pelvic Girdle Pain education and exercise class – Living Well Hub Warrington
• Postnatal education and exercise classes – Living Well Hub Warrington
• Pre-op gynae surgery education class referrals Total Referrals between

5.145 Referrals are shown below, with it being likely there will be a further increase in numbers with plans to open self-referral access for perinatal pelvic health by end of 2024.

	Total Referrals between April – October 2024	Total Referrals between April – October 2024
Breast	23	40
General Pelvic Health	148	272
Perinatal Pelvic Health	378	719

5.146 Conclusions

5.147 The range of therapy services available supported primary care capacity by enable patients to see MSK specialists to address, prevent and rehabilitate MSK problems.

5.148 The services work collaboratively with the wider health and social care system, adopting a holistic approach that helps ensure appropriate wrap around care for MSK problems. Referrals to other parts of the service, other health and social care services form a key part of the services.

5.149 Specialist MSK therapy services can reduce the number of diagnostic tests carried out, improve the appropriateness of referrals into secondary care (and reduce secondary care waiting lists) and improve conversion rate from referral into surgery.

5.150 Each of the services are made up of relatively few wte staff, so managing workforce capacity against demand can be difficult particularly during periods of holiday and sickness. This is further compounded by 'Did not attends' (DNAs) which continue to be a problem across the specialist MSK therapy services.

5.151 Recommendations

- **Improving patient uptake** to community services eg Health Improvement Team
- **Whilst management plans are in place to address DNAs, focus should remain on improving DNA** rates and understanding any barriers

to patients attending, such as accessing support from the Trust Knowledge and Skills Department to scope the reasons why patients DNA with a view to work with patients to identify ways to improve attendance.

- **Whilst patient satisfaction across the specialist MSK therapy services is high, further work on patient experience questionnaire is required** to gain greater insight into patient satisfaction, such as develop an annual comprehensive patient satisfaction questionnaire.
- **Continue with Evidence Based Practice** to ensure best treatment for patient and to provide excellence of care and to actively engage with Stakeholders in the planning of services.
- **Look for use of community settings** suitable to increase capacity for both more local groups and 1:1 appointments.
- **Raising profile of service** and pelvic health concerns Patient engagement events.

6.0 Summary of Recommendations to Health Policy and Performance Board

Evidence Area	Recommendation
1) Cross cutting across all evidence areas	1. Service areas within the scope of this scrutiny review should continue to provide update reports to the Health Policy and Performance Board on the outcomes of emerging workstreams identified in this report and any proposed service developments, emerging challenges or notable successes.
2) Urgent Treatment Centre Widnes	2. **GP attendance**- Availability of a GP should be a priority and steps taken to ensure that there is sufficient GP coverage in the service. 3. **Patient experience** - The service should take steps to implement the recommendations of Healthwatch.
3) Urgent Care Response	4. **Newton Recommendations** - UCR, and HICaFS as a whole, should continue to analyse the available data and work with stakeholders to maximise potential within the service and it's component parts, in line with the Newton recommendations.
4) Nursing in the Community	5. **Single Point of Access** - Consider how a single point of access and holistic approach to nursing in the community could maximise capacity across the 3 service areas and further improve patient experience. 6. **Capacity -** Analysis of clinical practice/demand to identify opportunities to maximise capacity, particularly in the Treatment Rooms. 7. **Impact of bridge crossings** - Explore solutions to mitigate the impact of bridge tolls on the recruitment and retention of nurses
5) Podiatry	8. **Risk score matrix** - Monitor the results of the risk score matrix and implement recommendations resulting from the trial. 9. **Information resources** - Explore what information resources and formats would be most appropriate ie preventative information and self-help, and the role of partner agencies in supporting prevention and self-help.

	10. **Recruitment and retention** - Continue with proactive relationships with universities to promote NHS podiatry as a career choice and provide updates to the Health Policy and Performance Board.
6) Community Therapy and HICaFS Therapy	11. **Undertake a deep dive into service data** to identify potential opportunities for therapy services to support capacity and demand across the health and social care system and to inform future workforce structure requirements. 12. **Urgent Care Response -** Pilot the use of lifting raisers to prevent unnecessary hospital admission, and example of therapies and nursing working in partnership. 13. **Falls Prevention & Management -** Continue to focus on ways to reduce the risk of people falling and going to hospital through assessment of their environment and provision of strengthening and balancing exercises. 14. **Urgent & Emergency Care System Improvement Programme -** Maximise the use of alternatives to the Emergency Department, including Same Day Emergency Care. Provide updates to the Health Policy and Performance Board on any proposed system improvements. 15. **NWAS** - Optimising referral pathways to community services.
7) NWAS	16. **Hospital Hand Overs**: NWAS and ICB Halton should continue to work with health system managers to try and identify improvements to the hospital handover situation, taking learning from other areas that have managed to bring down the handover times, such as Greater Manchester. Analysis of differences in handover process between Warrington and Whiston Hospitals may provide insight as to how Whiston and NWAS can work together to improve their handover times. 17. **Alternative to Hospital**: NWAS have identified that there may be more they can do with community health and social care partners to provide an alternative to hospital and negate the need for conveyance to hospital. NWAS should continue to explore potential with services, such as community therapy.
8) Musculoskeletal Therapy Outpatient Service	18. **Improving patient uptake** to community services eg Health Improvement Team 19. **Understand barriers to patients attending appointments to reduce DNAs**, such as accessing support from the Trust Knowledge and Skills Department to scope the reasons why patients DNA with a view to work with patients to identify ways to improve attendance. 20. **Undertake further work on patient experience questionnaire** to gain greater insight into patient

	satisfaction, such as develop an annual comprehensive patient satisfaction questionnaire. 21. **Continue with Evidence Based Practice** to ensure best treatment for patient and to provide excellence of care and to actively engage with Stakeholders in the planning of services. 22. **Look for use of community settings** suitable to increase capacity for both more local groups and 1:1 appointments. 23. **Raising profile of service** and pelvic health concerns Patient engagement events.

Appendix 1 – Site visits and evidence presented to Members

Site Visits

Theme	Attended by
North West Ambulance Service (NWAS), Estuary Point, Speke.	Cllrs Dourley, Baker and Loftus. Emma Bragger, Service Development Officer
Urgent Care Centre Widnes (Bridgewater)	Cllrs Dourley, Baker and Loftus

Presentations listed in the table below are available on request from the Policy, Performance & Customer Care Team – Adults Directorate:

Theme	Speaker	Presentation
Integrated Care Board (ICB) Perspective	Tony Leo, Place Director, Halton	Scrutiny Topic Review
Urgent Treatment Centre Widnes	Jillian Wallis, Associate Director of Halton Adult Community Services, Bridgewater Community Healthcare NHS Foundation Trust	Widnes Urgent Treatment Centre
Urgent Care Response		Halton Intermediate Care & Frailty (HICAF)
Podiatry		Podiatry
Community Nursing		Community Nursing
Community Therapies	Steve Hope, Clinical team Manager Community Therapies. Rachel Bold, Therapy Manager, Warrington and Halton Teaching Hospitals Hospital NHS Trust	Halton Community Therapy Team Halton Intermediate and Frailty Community Services - Therapy
Musculoskeletal Services	Lisa Horne, MSKCATS Clinical Lead, Warrington and Halton Teaching Hospitals Hospital NHS Trust	Halton Musculoskeletal Physiotherapy Outpatient Services
North West Ambulance Service (NWAS)	Ian Moses, Area Director, Cheshire and Merseyside, North West Ambulance Service NHS Trust	Halton OSC