Halton

Local system review report

Health and Wellbeing Board

Date of review:
21-25 August 2017

Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives CQC the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we are able to understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that brings together key findings from across the 20 local system reviews.

The review team

Our review team was led by:
Delivery Lead: Ann Ford, CQC
Lead Reviewer: Wendy Dixon, CQC

The team also included:

- Members of the executive team
- Three CQC reviewers,
- Two CQC strategy leads,
- One CQC analyst,
- One CQC Expert by Experience; and
- Three specialist advisors (two former local government directors of social service and one Clinical Commissioning Group board member).

How we carried out the review

The Local System Review considered system performance along a number of **'pressure points'** on a typical pathway of care with a focus **on older people aged over 65.**

We also focussed on the interface between social care, general medical practice, acute and community health services, and delayed transfers of care from acute hospital settings.

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across three key areas:

1. Maintaining the wellbeing of a person in usual place of residence
2. Crisis management
3. Step down, return to usual place of residence and/ or admission to a new place of residence

Across these three areas, detailed in the report, we have asked the questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?

We have then looked across the system to ask:

- Is it well led?

Prior to visiting the local area we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We requested the local area provide an overview of their health and social care system in a bespoke System Overview Information Return (SOIR) and asked a range of other local stakeholder organisations for information. We also developed two online feedback tools; a relational audit to gather views on how relationships across the system were working, and an information flow audit to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care[1].

During our visit to the local area we sought feedback from a range of people involved in shaping and leading the system, those responsible for directly delivering care as well as those who use services, their families and carers. The people we spoke with included:

- Staff members including social workers, GPs, discharge coordinators, therapists and nurses
- Senior leaders and managers in the local authority, the Clinical Commissioning Group (CCG), Warrington and Halton Hospitals NHS Foundation Trust, St Helen's and Knowsley Teaching Hospitals NHS Trust, Bridgewater Community Healthcare NHS foundation Trust, the North West Ambulance Service and North West Boroughs

- Local Healthwatch, voluntary and community sector (VCS) services
- Local Residents attending the Halton Direct Link service (the local authority's walk in advisory service)
- Service users in the acute hospitals in both A&E and the discharge lounges

We reviewed 26 care and treatment records and visited nine services in the local area including acute hospitals, intermediate care facilities, a hospice, a care home, a nursing home and 2 GP practices.

The Halton context

Demographics

- 15% of the population is aged 65 and over.
- 98% of the population is categorised as White.
- Halton is in the most deprived 20% of local authorities in England.

Adult Social Care

- 18 active residential care home locations:
  - 17 rated good
  - 1 rated requires improvement
- 8 active nursing care home locations:
  - 5 rated good
  - 3 rated requires improvement
- 5 active domiciliary care agencies:
  - 4 rated good
  - 1 rated requires improvement

GP Practices

- 12 GP practices rated good
- 1 GP practice rated outstanding
- 2 are currently unrated

Acute and community Healthcare

Hospital admissions (elective and non-elective) from Halton are largely split between two NHS acute hospital trusts:

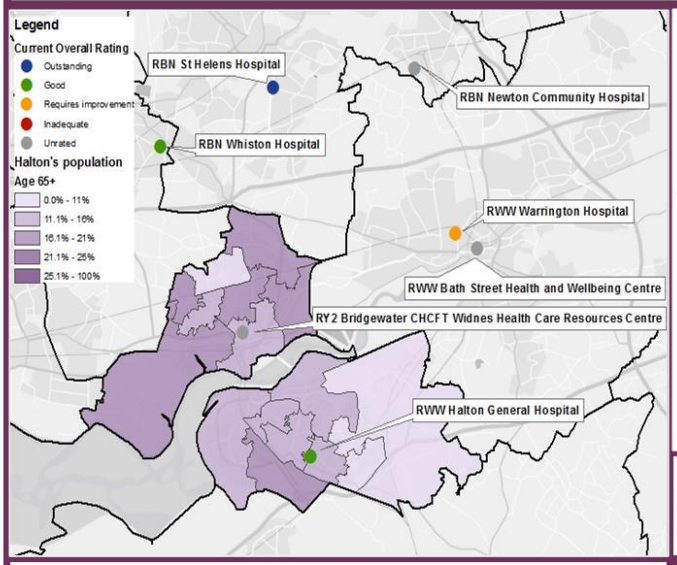
- Warrington and Halton Hospitals NHS Foundation Trust (RWW)
  - Receives 49% of Halton's admissions
  - Admissions from Halton make up 25% of the trust's admissions
  - Currently rated Requires Improvement overall

- St Helens and Knowsley Teaching Hospitals NHS Trust (RBN)
  - Receives 43% of Halton's admissions
  - Admissions from Halton make up 16% of the trust's admissions
  - Currently rated Good overall

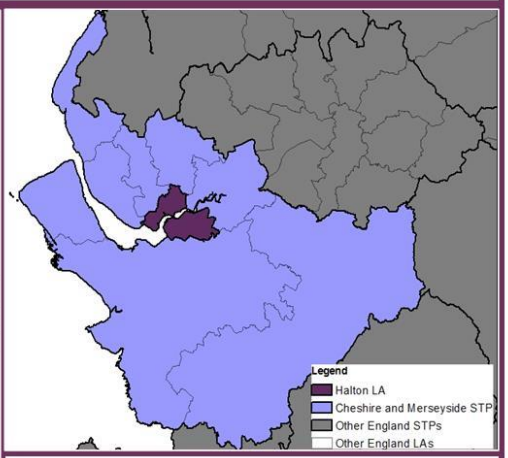
Community services are provided by:

- Bridgewater Community Healthcare NHS Foundation Trust (RY2) - currently rated requires improvement overall.

Acute and Community hospital locations as at 29/09/2017; ASC and PMS locations as at 29/09/2017
Admissions percentages from 2015/16 Hospital Episode Statistics.



Map 1: Population of Halton aged 65+ and location and current rating of acute and community healthcare organisations serving Halton.



Map 2: Location of Halton LA within Cheshire and Merseyside STP. Halton CCG and the HWB cover an almost identical footprint.

Summary of findings

Is there a clear shared and agreed purpose, vision and strategy for health and social care?

- Overall, there was a strong commitment from the local authority (LA) and the clinical commissioning group (CCG) to serve the people of Halton well.
- The local authority and CCG had a clear vision for the borough that had been shared with its strategic partners and was well understood by their staff at a managerial and operational level. There were also well established, positive relationships across the health and social care system with a shared dialogue between the CCG and the local authority underpinned by a high level of trust.
- Local NHS acute trusts, although not located in the borough, participated in the wider system planning.
- As there was not yet a cohesive interface or alignment between the local authority's and CCGs vision for the borough, the Local Delivery System (LDS), the Sustainability and Transformation Plan (STP), and a developing accountable care system, there were opportunities for system partners to think more widely and include the Local Delivery System (LDS) and the Sustainability and Transformation Plan (STP) in the overall system strategy to strengthen the position of the Halton community and give local partners a stronger voice within the system footprint.
- Work was required to develop a wider system vision for the STP footprint and develop a common framework for prioritising actions, and for specifying accountabilities and shared governance arrangements.
- This was recognised by the system leaders who were working towards a more robust approach to alignment at the time of our review.
- There was agreement across partners to develop an accountable care system (ACS) in the future, however this agreement had not yet manifested into detailed plans and actions. Discussions were ongoing at the time of our review.

Is there a clear framework for interagency collaboration?

- There were well established, positive relationships across the health and social care system with a shared dialogue between the CCG and the local authority, underpinned by a high level of trust.
- The Joint Strategic Needs Assessment (JSNA) was well thought out and had underpinned operational delivery plans and desired outcomes .All partners were sighted on what was important to older people and carers when moving through the interface of health and social care. There was a specific JSNA for older people and there was good evidence of partners meeting individuals'

needs in terms of health and wellbeing, social inclusion, social prescribing and transport. However, a joint commissioning strategy for older people's service provision had not yet been fully developed.

- There was evidence of robust analysis of need to support resource allocation and the setting of priorities within the local authority and the CCG. The local authority had a strong track record of financial management and delivering services for older people based on quality outcomes within budget.

- Joint preventative approaches were well thought through and embedded. There was a wide range of effective initiatives that were supporting people to remain socially included, maintain their own health and manage their long term conditions.

- There were some excellent examples of shared approaches and local agreements that supported local people in having timely access to services and support that met their needs in a person-centred way.

- The seven-day Rapid Access Re-ablement Service (RARS) and the five- day Rapid Clinical Assessment Team (RCAT) had been developed to reduce avoidable hospital admissions, which in 2016/17 had been above the comparator average. Similarly the numbers of delayed transfers of care were higher than the comparator average for the same period. System leaders were confident that the recently implemented RARS and RCAT teams' approach, coupled with the implementation of elements of the high impact change model, would secure improved performance in respect of avoidable admissions and further reductions in the numbers of delayed transfers of care.

- It was evident from the range of joint initiatives from the local authority and the CCG that there was a shared understanding and collective responsibility for meeting the needs of the local population. There was a strong commitment from partners to work collaboratively and efficiently for the benefit of local people.

- We found that the Health and Wellbeing board provided senior officers with high levels of support. However, as a forum to challenge and support the system's joint strategic approach, the Health and Wellbeing Board lacked rigour and required improvement to support and challenge the local system's transformation agenda and monitor progress more robustly.

- We found examples of poor monitoring of commissioned services which were having an impact on the quality of service provision, such as the intermediate care service provided at Warrington and Halton NHS Foundation Trust.

- Initiatives were not always connected and joined up to inform whole system performance. For example, GP practices were not always aligned with the system wellbeing strategies for example the enhanced care home model was not fully embedded with all GP practices

- Although recent DTOC figures were improving (figures for June 2017 indicate that the average daily rate of delayed transfers of care in Halton had dropped to 8.8 delayed days per 100,000 population,

below the England figure of 13.8 and below Halton's comparator average of 10.80), there were a number of challenges in the timely provision of appropriate rehabilitation services and intermediate care to support and maintain further reduction. Some people with complex needs were experiencing considerable delays.

- The local authority and CCGs had transformation plans for domiciliary care and care home provision in Halton. Both these elements of provision were challenged in terms of their capacity to meet demand

How are interagency processes delivered?

- The framework for interagency working was supported by separate organisational strategies; however we did not find evidence of this being co-ordinated into a system wide approach by the STP.

- There were shared performance metrics between the local authority and the CCG which were scrutinised at the Executive Partnership Board. However these were not aligned with all system partners.

What are the experiences of front line staff?

- Senior leaders were visible, accessible and approachable.

- Staff felt supported by their line managers and were encouraged to influence the design and delivery of services.

- There were systems and processes in place to support staff development and professional competence.

- There was work planned with staff in the independent sector in terms of promoting peoples safety and injury prevention.

- There was good support available to staff underpinned by regular training to manage adult safeguarding issues including issues of abuse and neglect.

- From interviews with system leaders and operational staff it was evident that leaders across respective agencies were working together to implement systems to support interagency and multi-disciplinary working and encourage staff to work in cohesive teams.

- We found a range of support services that encouraged staff to work across organisational boundaries to better provide holistic care to people requiring services

What are the experiences of people receiving services

- The experiences of people receiving services in Halton varied.

- We found a very positive approach to maintaining people's health and wellbeing in their own homes and services designed for older people to keep them socially included, active and able to manage their long term conditions.

- There were some excellent examples of social prescribing that helped people deal with bereavement, loneliness and concerns about their safety at home.

- We observed a number of assessments carried out by different teams during the course of the review. We saw good examples of person-centred assessments, including those for people experiencing memory loss. Clinical, social and cultural information was included in assessments which covered all aspects of what was important in people's lives. Care plans were developed with the inclusion of the person, their families and carers.

- Halton had a high uptake of personal health budgets and direct payments for all adults compared to the England average and Cheshire and Merseyside regional average. The Halton Disability Partnership delivered a service to support people through the process of accessing and using direct payments.

- The local authority provided good support to carers with input from the carer's centre that supported approximately 5000 carers, including 528 carers supporting people living with dementia.

- However, some older people from the Halton area had less satisfactory experiences when they were admitted to hospital; they were often experiencing long waits in A&E before being admitted to a ward.

- Once ready for discharge, some older people were subject to delays in their transfer home or to a new place of residence. In some cases people had suffered avoidable harm or detriment as a result of the delays, such as the development of a pressure sore. In the main, delays were attributed to the lack of provision of care packages in the community or the availability of long term care placements.
- In response there were a number of new initiatives planned to improve the experience of older people and at the time of our review performance in delayed transfers of care was improving. Nevertheless further work was required to maintain this improvement and ensure that delays did not increase as a result of winter pressures.

- Continuing Healthcare (CHC) was provided through a joint local authority and CCG budget that had been established for a number of years. Securing CHC funding was not considered to be a primary cause of delayed transfers of care. The NHS CHC figures for all adults showed that in Q1 2017/18 both the referral conversion rate (% of newly eligible cases of total referrals completed) and assessment conversion rate (% newly eligible cases of total cases assessed) were higher than the

England and Cheshire and Merseyside regional averages. This indicated that Halton's processes for identifying people eligible for CHC were working well. However, there were delays in completing the process as the data for all adults in Q1 2017/18 also showed that for Halton CCG 25% of referrals for standard CHC were completed within 28 days, lower than the England average of 57% and the Cheshire and Merseyside regional average of 73%.

Are services in Halton well led?

Is there a shared clear vision and credible strategy which is understood across health and social care interface to deliver high quality care and support?

As part of this review we looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system, joint working, inter-agency and multi-disciplinary working and the involvement of people who use services, their families and carers.

We did not find a cohesive interface between the local authority' and CCG vision for the borough, the Local Delivery System (LDS), the Sustainability and Transformation Plan (STP), and the emergent accountable care system (ACS).

The local authority and CCG had a clear vision for the borough that had been shared with its strategic partners and was well understood by its staff at a managerial and operational level. There was a strong commitment to joint working across the health and social care system. Leaders were visible and accessible, staff felt engaged and included in planning for the future. They were well supported by leaders in the development and design of services.

Strategy, Vision and partnership working

- We did not find a cohesive interface between the local authority's and CCGs vision for the borough, the Local Delivery System (LDS), the Sustainability and Transformation Plan (STP), and the emerging plans for an accountable care system (ACS).

- There were opportunities for partners to think more widely and include the Local Delivery System (LDS) and the Sustainability and Transformation Plan (STP) in the overall system strategy to strengthen the position of the Halton community and give local partners a stronger voice within the wider system.

- There were a range of plans across different organisations that were targeted at achieving the strategic aims in addition to the action plan within the wellbeing strategy.

- The local authority and CCGs had a clear vision for the borough. System leaders were working to promote a wider shared vision but there was a lack of clarity on the wider system interface; some leaders referred to the vision for the borough, others to the LDS and the STP.

- Interviews with system leaders indicated that partnerships and relationships at a local level were strong, particularly between the local authority and the CCG. Primary care engagement had previously been challenging but was seen to be improving, facilitated by the GP Federations. However, improvement was needed across the system in terms of understanding the role and potential of the federations.

- A review of the minutes of the Health and Wellbeing Board and discussions with senior leaders indicated that the function of the Health and Wellbeing Board could be improved as a forum to challenge and support the system's joint strategic approach and drive changes in practice.

- There was further work to be done to strengthen the HWB Board's challenge function to ensure the change agenda is developed and implemented in a timely way.

- Capacity and demand within the hospital system was overseen at an LDS and A&E Delivery Board level. This involved predictive modelling of activity, links to the A&E work streams and the wider out of hospital demand management work within the Local Alliance. The Local Delivery System (LDS) is the system that will deliver the Sustainability and transformation plans (STPs) developed for the area of Halton and make them operational.

- Planning for winter pressures was aligned with the North West boroughs and local plans had started via the A&E Delivery Board in the weeks prior to our visit. The local authority's divisional manager was also the urgent care lead for the local authority and the CCG, and was an active member of the Mid Mersey A&E Delivery Board, representing both organisations. This appointment was well received at an operational level and the divisional manager was seen as visible and supportive across the CCG, local authority and local NHS Trusts. There was an opportunity to replicate these joint posts at a more strategic level to better support the alignment of plans and the integration of services as well as establish joint governance and performance management arrangements.

- Winter planning was underway in all partner organisations however though we found a winter plan was being developed at a strategic level we found no evidence of this begin shared to system partners

- Winter plans across different organisations were collated at the A&E Delivery Board, however, operational staff in services felt that overarching plans were not fed back to them and consequently they were only aware of their own operational plans and not the wider support for winter pressures planned across the system.

Involvement of service users, families and carers in the development of strategy

- Halton OPEN (Older People's Empowerment Network) was a network of over 1000 older people that was established in 2001 and had become the collective voice of people aged 50 and over who live and work in Halton. The network was designed to support older people to influence and

encourage the development of services that can help to improve the quality of life and wellbeing of all older people in Halton.

- Halton OPEN members were engaged in new approaches and represented on boards for frailty pathway; Older People's Delivery Board and GP patient participation group boards. The network was also engaged in the process for transforming domiciliary care and will also have representation on the forthcoming Domiciliary Care Board.

- Halton OPEN has been engaged in discussions about health and wellbeing, finances, public transport, information provision, and reducing social isolation. The Director of Adult Social Services (DASS) met with the group regularly.
- Halton Carers Centre was used to gather carers' views and has fed into work such as the development of Halton's dementia strategy and associated implementation plan.

- Halton People's Health Forum was a key group supporting local engagement and involvement in service redesign. They have supported the development of the urgent care centres and aspects of enhancing healthcare in care homes, particularly with regard to GP realignment.

- The local authority started work on the development of an end-to end-pathway of care for frail older people, as part of the 'One Halton' approach.

- Older people have been involved in the development in the needs gap analysis for the older people's pathway, 'Living and Aging Well in Halton'.

- The Bridgewater Community NHS FT that serves the Halton area had undertaken engagement activities with local populations and staff on the future of community health services, which included a 'Big Conversation' event.

- North West Boroughs Healthcare NHS Foundation Trust undertook an engagement exercise in respect of changes to the bed provision for people with dementia. Plans were changed as a result of this engagement, ensuring better travel arrangements, improved community services as well as a more flexible approach to bed based service provision for older people.

- The information gathered as part of the consultation on 'Living and Aging Well in Halton', along with national best practice guidance was used to underpin the development of an overarching integrated 'Older People's Pathway'. This outlined the expected interventions, standards and aims to the approach for supporting older people across the whole system.

- It was evident that system partners understood the importance of including and involving people who use services, their families and carers in developing their strategic approach to managing the quality of the interface of health and social care.

Promoting a culture of inter-agency and multi-disciplinary working

- From interviews with system leaders and operational staff it was evident that leaders across respective agencies were working together to implement systems to support inter-agency and multi-disciplinary working.

  The framework for interagency working was supported by separate organisational strategies; however we did not find evidence of this being co-ordinated into a system wide approach. There were shared performance metrics between the local authority and the CCG which were scrutinised at the Executive Partnership Board. However these were not aligned with all system partners.
- We found a range of support services that encouraged staff to work across organisational boundaries. Examples included:

  ⇒ A new contract from the CCG that will see all GP practices aligned to individual care homes – every care home will now have a designated GP practice.

  ⇒ Social workers embedded within GP practices.

  ⇒ The continued development of the multi-disciplinary team (MDT) approach at primary care level offered a medical, nursing and a social care service as well as a multi-disciplinary prevention and wellbeing approach.

  ⇒ District nurses working together with local pharmacies to support effective medicines management and mitigate risk to safety to enable people to be maintained in their usual place of residence.

Learning and improvement across the system

- The CCG and the local authority are engaged with the STP and LDS and the Liverpool City Region Combined Authority which enabled them to transfer and apply learning from outside their local area.

- There was some evidence of learning being shared across agencies to improve quality and safety of care, for example, the CCG has worked with operational staff in hospices and hospitals to improve the quality of discharge information.
- We found evidence of learning at an organisational level regarding lessons learned however it was less apparent that this learning was being shared across organisations within the local area.

What impact is governance of the health and social care interface having on quality of care across the system?

We looked at the governance arrangements with the system, focusing on collaborative governance, information governance and effective risk sharing.

We found governance arrangements had been developed across the system to support partners to

collaboratively drive and support quality of care across the health and social care interface.

The overarching forum for system leaders to jointly plan how best to meet local health and care needs, and to commission services accordingly was the Health and Wellbeing Board (HWB). However there was little evidence of shared success criteria between the local authority and CCG commissioners and providers, underpinned by shared key performance metrics outside of the BCF

Overarching governance arrangements

- Governance arrangements had been developed across the system to support partners to collaboratively drive and support quality of care across the health and social care interface. Governance for the local authority and CCG's Section 75 partnership agreement was through a shared Executive Partnership Board (EPB) with an Operational Commissioning Committee (OCC) undertaking the detailed work of the agreement**.**

- The Health and Wellbeing Board was described as the overarching forum for system leaders to jointly to plan how best to meet local health and care needs, and to commission services accordingly. Partners were already engaged in system wide dialogue regarding the development of an accountable care system however these discussions had not yet manifested into detailed planning arrangements. Partners were committed to moving this work forward over the coming months

- Individual organisational governance arrangements were supported by well-developed committee structures in each of the system partner organisations. Strategic objectives were linked appropriately to organisational priorities. Organisational performance dashboards were shared and understood across partners and focussed on service quality and delivery.

- System partners acknowledged that pathways of care across organisational boundaries continued to challenge the system and required additional work regarding governance arrangements as well as future contracting and commissioning arrangements to ensure a truly collaborative and shared approach.

- There was a good process for agreeing Better Care Fund (BCF) allocations and responsibilities were agreed, shared and understood across the local authority and the CCG, and this was built on a pooled budget. However, the NHS trusts were not fully engaged

- There was not a collective governance framework that culminated in a series of agreed or shared performance metrics that were robustly monitored at the Health and Wellbeing Board. From the minutes of its meetings, and from our discussions with senior leaders, we found that the Health and Wellbeing Board had extensive membership and good rates of attendance. However the minutes indicated positive stakeholder engagement rather than a forum for strategic leadership and robust governance. There was a lack of challenge around performance for the system through the Health and Wellbeing Board.

- There was a history of joint working across health and social care, with some joint posts established, for example, the local authority's divisional manager is also the urgent care lead for the local authority and the CCG, and is an active member of the Mid Mersey A&E Delivery Board, representing both organisations. This appointment was well received at an operational level and the divisional manager was seen as visible and supportive across the CCG, local authority and local NHS Trusts. There was an opportunity to replicate these posts at a more strategic level to better support alignment and the integration of services as well as establish joint governance and performance management arrangements.

- In addition there was an agreement for a single executive lead for the development and delivery of older people's services supported by the chief nurse.

The governance of data collection systems were not always aligned to inform performance, which meant that information could not be effectively monitored across the system. For example, information from the discharge lounge at Warrington Hospital was not being used to improve the effectiveness of discharge lounge processes.

Information governance arrangements across the system

- Better Care Fund returns for 2016/17 indicated that the area was meeting the national conditions around data sharing. This included confirmation that they are using NHS numbers as the consistent identifier for health and care services. The local authority and the CCG are pursuing interoperable Application Programming Interfaces (APIs) – systems that can exchange and make use of information – with the necessary security and controls, ensuring appropriate information governance controls for information sharing, in line with national guidance. This approach supports people having clarity about how their data is used, who may have access to it, and how they can exercise their legal rights.

- The system has agreed to undertake work to improve information sharing and is transferring urgent care centres and community services onto 'EMIS Web' which will allow access to shared records with out of hospital services. This approach (due to be fully implemented in 2020) aims to promote seamless transfer of information across the system and reduce duplication of effort.

- All organisations within the system had robust policies regarding personal information and a person's right to confidentiality and privacy.

Risk sharing

- Work is required at a system level to articulate and mitigate wider system risks; this process was not yet fully developed across the STP and LDS or the emerging ACS

- We found no evidence (either during on site activities or through reviewing minutes from Health and Wellbeing Board meetings) of risk management arrangements across the system, however these were in place at an organisational level.

- All partners in the system were experiencing complex financial challenges. Partners were transparent and open with each other in sharing information about their own risks as to the impact this was having on decision making in respect of resource allocation and the setting of priorities.

- There was a shared understanding regarding risk mitigation in respect of the new approach to domiciliary care provision between the local authority and the preferred provider.

To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?

We looked at how the system is working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource. In Halton we found system leaders acknowledged a number of workforce issues across the health and social care system. Workforce challenges in the NHS were most prevalent in the availability of medical staff in hospitals, general practice and urgent care. In adult social care the biggest challenge was in the recruitments and retention of domiciliary care staff. Robust actions had been taken by each organisation to address vacancies however this had not yet resulted in a system-wide workforce strategy that supported the system to determine joint investment in a future workforce.

Workforce planning and development

- With the exception of the acute trusts we met with system leaders responsible for workforce planning. All participants indicated that there were strong personal relationships across the system and a shared understanding that workforce issues were a risk to high quality, timely service delivery. Most partners had an organisational workforce strategy however; we found little evidence of a cross sector analysis of workforce challenges or joint plans to address them.
- Individual partners in the system had an organisational workforce strategy. However, there was not a joint workforce strategy for the Halton footprint that was shared and governed across the health and social care system.

- System leaders acknowledged a number of workforce issues across the health and social care system. Workforce challenges in the NHS were most prevalent in the availability of medical staff in hospitals, general practice and urgent care.

- Actions had been taken by each NHS acute trust to address hospital-based nursing vacancies; however this remained an ongoing challenge and there were rolling programmes in place to secure nursing staff and manage turnover.

- Within social care, analysis of Skills for Care data from 2013-14 to 2015-16 indicated that staff turnover and vacancies in Halton were below national and comparator group averages. During our visit we found there were no social worker vacancies, the greatest challenges related to the recruitment and retention of domiciliary care workers.

- The increased skill expectation of care and nursing staff in the independent care sector was having an impact on capacity, demand and the delivery of high quality care. These matters also had an impact on the ability of community services to respond to the changing pattern of demand and the desire to deliver older peoples' care closer to and in their own home.

- The local authority and in some areas the CCG, had started work to support care and nursing staff in the independent sector through the transformation of domiciliary care and the support to care homes projects. This involved initiatives such as apprenticeships, and training and development programs to support staff development and retention in these areas.

- We found that there was a collaborative agreement across the whole system, including Health Education England, to work with the developing Health Academy to help address staffing challenges within health and social care and to adopt a more collegiate and strategic approach to manage workforce across the local authority footprint.

- Work was also underway to develop the skills of the existing workforce to help manage gaps. Partners were looking at ways to increase the numbers of advanced nurse practitioners and nurse prescribers to support timely interventions and improved access in both primary and secondary care.

- We found little evidence of a cross sector analysis of need regarding the workforce and no joint strategic action plan to support the anticipated increased demand as winter approached.

- However, there were positive steps being taken at an organisational level to support the maximisation of the existing workforce through work-related wellness campaigns and immunisation projects that included staff in the independent sector who were involved in direct care.

Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?

We looked at the strategic approach to commissioning and how commissioners are providing a diverse and sustainable market in commissioning of health and social care services.

There was evidence that the local authority and the CCG worked positively together to develop the JSNA over a number of years. Commissioning strategies were underpinned by the JSNA and were regularly reviewed and evaluated.

There was a specific JSNA for older people and good evidence of partners meeting people's needs in terms of health and wellbeing, social inclusion, social prescribing and transport; however a joint

commissioning strategy for older people's service provision had not yet been fully developed.

There was acknowledgement, particularly by the local authority, that work was needed to strengthen and diversify the range and nature of support services particularly domiciliary and care home provision to meet the needs of older people.

Strategic approach to commissioning

- Commissioners in the local authority and the CCG had carried out a comprehensive needs assessment and had used this to determine commissioning priorities at the interface of health and social care.

- To secure improved outcomes for older people commissioners had initiated several large-scale, long-term commissioning initiatives that were in the early stages of development and implementation. For example the 'Healthy New Town' project that aimed to improve peoples' experience by providing housing with health and wellbeing services that were easily accessible and co-located. This initiative also aimed to address staffing shortages in health and social care.

- A JSNA for older people had been completed however a joint commissioning strategy for Older People had not yet been formalised at the time of our review.

- There was evidence of consultation and inclusion of older people in the assessment process.

- One of the issues raised by users was they often felt unprepared for discharge from hospital and that the discharge process was not always well managed, especially for those older people who lived alone.

- Partners had responded positively to improving older people's experiences in this regard; this was one of the main areas identified to shape future service commissioning

- The local authority acknowledged that patients being able to exercise a choice regarding which care home to move to was leading to delays, patients were given the full range of care homes in the borough and not just a list of those care homes with vacancies. This meant that if a patient chose a home without vacancies their transfer of care could be delayed. The rationale for this was that the local authority wanted to provide information on all care homes within the area to ensure people in the borough received their care in a place of their choice. However there was a choice policy in place at Warrington and Halton NHS FT intermediate care unit that would have mitigated this issue, by a service user choosing there long term home but waiting in the interim in another care home however, we did not see evidence this was being implemented

- There were joint commissioning initiatives for older people based on robust analysis and evidence-based commissioning principles to keep people well and when they experienced a crisis, focussed on recovery. These were not yet fully implemented and embedded at the time of our review but included:

- ⇒ The development of multi-agency guidance regarding the early recognition of frailty across health and social care sectors
- ⇒ Rapid assessment 'close to home' and at hospital including management of frailty and improved discharge processes
- ⇒ Review of capacity, demand and models in intermediate care provision
- ⇒ Outcome-based domiciliary care commissioning and contracting
- ⇒ Strengthening of the existing primary and secondary falls prevention work

- There was one A&E Delivery Board for covering both St Helens and Knowsley NHS Trust and Warrington and Halton NHS Foundation Trust. The A&E Delivery Board met regularly and supported system resilience planning across the system including capacity planning and out-of-hours planning, however joint winter plans were still being developed at the time of the review. Pooled budgets had been in place since 2013, for example the continuing healthcare budget. Other initiatives included the use of embedded Social Care in Practice (SCIP) workers who worked across the primary care and social care interface.

- The joint commissioning of new services and the implementation of some key initiatives was already underway, for example the development of a frailty pathway.

- Changes to domiciliary care provision proposed by the local authority were agreed and due for full implementation by November 2017.

Market shaping

Our analysis showed that, per population aged 65+, there are fewer residential and nursing care home beds in Halton compared to comparator areas and the England average. Furthermore, our analysis identified that the number of residential care home beds had decreased by 9% since April 2015, meanwhile nursing home beds had decreased by 13%. However the vacancy rates in care homes was below the England average and that of comparator areas.

- There was an acknowledgement, particularly by the local authority, that work was needed to strengthen and diversify the range and nature of support services *particularly domiciliary and care home provision* to meet the needs of older people. Partners had an understanding of the changing environment of the adult social care provision and a subsequent risk assessment has been used to inform the 'Transforming Domiciliary Care' project.

- Commissioners were using long term contracts and risk sharing to address the challenges in the market. For example, through the Transforming Domiciliary Care project a long term contract was offered to a sole provider. The contract had an associated risk mitigation process, allowing the provider to sub-contract to meet identified and anticipated increased need, if required.

- The local authority had agreed to expand its in-house service provision by recommissioning long-term care beds for the provision of intermediate care.

- LDS partners had worked together to agree the key characteristics of a high performing out-of-hospital system, undertaking a baseline assessment and identifying the areas for improvement. Implementation of the following would commence in September 2017:

  ⇒ Halton's GP Forward View and the local strategy for primary care. These outlined the plans to manage the increasing demand for local medical services and primary care through service redesign.

  ⇒ Work to strengthen the domiciliary care and care home sector as part of Halton's BCF plan.

  ⇒ A single contract for care home provision was developed by the local authority and the CCG as part a Section 75 agreement, following a consultation on the cost of care.

  ⇒ The transformation of domiciliary care and the re-procurement of domiciliary care which sought to strengthen the market and plan for future demand. This would be done through using long term contracts, more efficient care delivery, and greater utilisation of the third sector to support older people in their own homes.

  ⇒ Developing existing multi-disciplinary teams, wrapped around primary care and supporting better self-care through technology.

- Developing an ACS will go some way to managing competitive elements with the health and social care system, however at the time of our review this work was in its very early stages.

Do commissioners have the right range of support services in place to enable them to improve interface between health and social care?

- An assistive technology program (telemedicine) was well established in Halton with approximately 3,000 people currently using the service that included a 24-hour response service.

- Community wardens responded to calls within approximately 30 minutes and were actively involved in the falls prevention programme.

- There was evidence emerging locally that the falls reduction programme was having a positive impact in reducing the number of domestic admissions to hospital as a result of falls.

- There was a single team approach in the falls team with good communication and support between teams and single senior management oversight of operational provision of this valued service.

- Halton Direct Link services, supported by partners in the voluntary sector, provided two centres in Widnes and Runcorn for people to access or be signposted to services that supported health and wellbeing and avoid medical intervention. Support was also available for people to access an appropriate assessment of need. People also had access to social prescribing and productive activities to maintain the wider determinants of health such as housing and social isolation.

- In addition, a member of the wellbeing service team was based at each GP practice; people could be referred directly to wellbeing services at the point of GP contact. Feedback from service users was very positive about these services and they felt valued and included as a result. Feedback from GPs indicated that this service was successful at preventing older people becoming lonely, demotivated and suffering from related conditions such as depression and anxiety.

Contract oversight

- The local authority had systems and processes in place to review the impact and quality of service provision through close working with the CCG in respect of contract renewal. This was particularly evident in the recent work regarding the transformation of domiciliary care and care home provision in the borough.

- More widely, all service commissioners had systems in place to review contractual arrangements as part of a rolling programme. However we found that some quality monitoring arrangements relating to commissioning contracts would benefit from a more proactive approach, for example in primary care and the performance of the intermediate care services provided by Warrington and Halton Hospitals NHS FT.

How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting peoples' independence?

We looked at resource governance and how systems assure themselves that resources are being used to achieve sustainable high quality care and promote peoples' independence.
We found that the assurance and governance process across the system would benefit from the addition of agreed performance metrics underpinned by a continuing challenge and scrutiny function from the HWB. Partners met regularly to share information, discuss key issues and adopt a problem solving approach. However not all partners felt fully involved in determining how resources were allocated, primarily the NHS trusts, and in particular with regards to the resource allocation for the Better Care Fund. We found performance dashboards in place to monitor resource capacity and predict demand. Performance metrics were shared and a problem solving approached adopted, particularly by the local authority and the CCG.

- The Health and Wellbeing Board had ultimate oversight of the work of the Operational Commissioning Committee, the forum undertaking the detailed work of the pooled budget agreement which included the BCF. Governance of this was through a shared Executive Partnership Board (EPB). However, not all partners felt fully engaged in this process, particularly the NHS Trusts.

- The assurance and governance process across the system would benefit from the addition of agreed performance metrics underpinned by a continuing challenge and scrutiny function from the HWB.

- The CCG and the local authority held monthly joint meetings of the Executive Board of the Council

and the Executive Management Team of the CCG, to share information and discuss key issues.

- There were a number of joint management team meetings that included the local authority, CCG and NHS Trusts that supported an open culture and problem solving approach.

- There were performance dashboards in place to monitor resource capacity and predict demand. Resource allocation and effective financial management was scrutinised through an embedded committee structure that called senior officers to account in their respective organisations.

- In respect of the BCF, joint consideration had been given and agreed by the local authority and the CCG as to where the investment of the fund would have the biggest impact on improving the care for older people and reducing DTOC.

- Work was planned and underway in respect of:
  - ⇒ Investment in re-ablement as the first approach on discharge from hospital, rather than a reliance long-term domiciliary care
  - ⇒ Investment in the transforming domiciliary care project
  - ⇒ The development of improved technology such as telecare
  - ⇒ The development of a social care Trusted Assessor model
  - ⇒ Improved information systems within the hospital to support discharge choices/ pathways
  - ⇒ Enhancing health in care homes, working with providers to develop an alternative commissioning and delivery model

- Expected outcomes were to:
  - ⇒ Meet adult social care needs in a timely way
  - ⇒ Reduce pressures on the NHS. There is an expectation that additional funding will reduce DTOC in accordance with national expectations
  - ⇒ Stabilise the social care provider market to support a wider range of support in the community

- Associated action plans had been developed to ensure that these initiatives would be implemented during 2017/18. A review of the outcomes and financial impact achieved was scheduled for completion at the end of 2017/18, and would form the basis of recommendations for further initiatives/developments for 2018/19 and 2019/20.

- The local authority worked with the CCG to complete the Urgent & Emergency Care Milestone Tracker that indicated positive progress in relation to the implementation of the high impact change model. However, the trusted assessor element of the model had yet to be implemented.

- We saw evidence of where resources were not being managed effectively. For example, some people being cared for in hospital were also being funded for a residential care home bed, when it

was apparent their needs had changed and they would require more intensive support ,for example a nursing home placement and consequently would not be eligible to return to their usual place of residence.

- Halton had one of the highest costs per patient with regards prescriptions in the country. To reduce the costs and optimise medication use in the system, the CCG medicine team were beginning to review cases where older people were prescribed large numbers of medicines in care homes. However this work needed a more system wide approach as the team were struggling to reach all GPs to identify cases for review.

Do services work together to keep people well and maintain them in their usual place of residence?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: maintaining the wellbeing of a person in usual place of residence

Are services in Halton Safe?

Strategies and initiatives have been developed and put in place to prevent avoidable harm.

- Each GP practice held monthly MDT meetings targeted at people with complex needs and those at risk of deterioration. These meetings were attended by a range of health and social care professionals to develop a person centred approach to case management.

- Systems were in place across the health and social care interface to safeguard people from avoidable harm, abuse or neglect. Halton's Safeguarding Adults Board was well established and was supported by its member agencies including the local authority, Halton CCG, North West Ambulance Service (NWAS), the local acute trusts, NHS England, Cheshire Probation Service, Halton Housing Trust and Cheshire Fire and Rescue.

- Providers were supported to identify people who were frail and with complex needs. A frailty pathway had been developed with input from all partners in the system. This included assessments being developed and rolled out across health and social care teams to facilitate the early identification of frailty, and timely access to support and interventions.

- Systems were in place to support the management of medicines. Pharmacy support was provided to reduce polypharmacy related risks, including falls prevention. The CCG medicines management team were working with the falls team to proactively address medication prescription and polypharmacy issues to support falls prevention for people living in care homes.

- Domiciliary care providers were working with their commissioners to assess risk to people using their services. Risk assessments were in place for each service user that could be reviewed on a regular basis. The domiciliary care provider proactively raised concerns to the local authority where there were mental capacity concerns that had not been communicated by the Acute Trust. In these instances a Mental Capacity Act assessment was subsequently completed, however we were told this could sometimes be delayed.

Are services in Halton Effective?

Halton had a high rate of attendance at A&E for older people. Joint initiatives had been developed across the health and social care system to maintain people in their usual place of residence. However these were not always fully coordinated and evaluated, meaning they might not always be used to their maximum benefit.

- Our analysis showed that Halton had a significantly higher rate of attendance at A&E of people aged 65+ than the England average and their comparator areas.[2] Analysis also showed a comparatively high number of hospital admissions from care homes, with a diagnosis associated with accidents and injury[3].

  A high number of falls in Halton had been identified as a challenge by the system, and a joint strategy involving public health, the CCG and the fire service had been put in place to prevent falls. There was multi-agency working to prevent falls including the falls team working with care homes to train staff, and the fire service conducting falls risk assessments in domestic premises. The system reported that the number of admissions to hospital as a result of falls has since reduced.
- The planned enhanced care home model, involving the CCG, local authority and GPs, will support care home staff to have the skills and confidence to make care decisions that avoid hospital admission. However this initiative will not be embedded to support the anticipated increase in service demand over this winter.

- An Older Peoples' Pathway had been jointly developed across the system with an emphasis on reducing the dependency culture for older people and supporting them to remain independent. The pathway had nine elements, including staying healthy, living well and rapid support to avoid admissions.

- We found that many older people had access to a range of services to help them remain healthy and socially included. Service user satisfaction rates remained high with over 90% of older people who responded to the local authority satisfaction survey saying the services were effective.

- Rapid and out of hours support in Halton included the Rapid Clinical Assessment team (RCAT) and

[2] Hospital Episode Statistics April 2015-March 2016.
[3] Hospital Episode Statistics October 2015- September 2016. Analysis based on attendances from postcodes containing a registered care home. Data could pertain to other addresses within the postcode. Postcodes containing more than one care home have been excluded from analysis.

Rapid Access Rehabilitation Service (RARS) services. Across stakeholders, the RCAT service was regarded as an effective and valued service; an unpublished exploratory study conducted locally identified that RCAT successfully avoided admissions for 85% of cases referred to it.

- However, the RCAT service was underutilised due to low referral numbers (196 in 2016/17). A recent (June 2017) report commissioned by the local authority identified the reasons for this as being gaps in GPs' knowledge of the service, inadequate communication between system partners, and a lack of shared understanding as to the capacity of the service and its availability out of hours. The recommendations made following the report were yet to be agreed and implemented by partners. The number of referrals to RCAT was being monitored as part of shared BCF Key Performance Indicators.

- In the RARs service there was historical evidence of a formal commissioning process and agreed performance criteria. However operational staff were unable to articulate this when asked

Are services in Halton Caring?

People and their carers are supported and involved in the planning and delivery of their care. There was good evidence of support services for carers that met their individual needs and preferences; however the assessment process for carers was duplicated.

- We observed a number of assessments carried out by different teams during the course of the review. We saw good examples of person centred assessments, including for people experiencing memory loss. Clinical, social and cultural information was included in assessments which provided all aspects of what was important in people's lives.

- Halton CCG had a high uptake of personal health budgets and direct payments. Cumulative activity through Q1 2017/18 showed their rate of personal health budgets for all adults was 27.7 per 50k, compared to the England average of 5.82 and the average across Cheshire and Merseyside of 7.44. Their number of direct payments for all adults was 11.18 per 50k, compared to the England average of 3.63 and Cheshire and Merseyside region average of 3.79. The Halton Disability Partnership delivered a service to support people through the process of accessing and using direct payments. Direct payments can empower people to make decisions about their future care and manage their health and wellbeing.

- Carers were well supported in Halton, with input from the Carer's Centre that reached approximately 5000 carers, including 528 carers supporting people with dementia. The centre had a carers support group specifically for people living with dementia which had 20 members. The centre considered the wishes and aspirations of carers and held a well-attended quarterly forum to seek feedback to ensure that they were meeting carers' needs.

- However, there was some duplication of assessments for service users between system partners and the local authority. There was an opportunity to streamline the assessment processes and reduce the number of times service users have to tell their story in order to receive support.

Are services in Halton Responsive?

People are assessed and receive care and treatment at the right place and the right time to maintain them in their usual place of residence. However, data showed that there were challenges in Halton in avoiding admission and readmission to A&E.

- Work was being undertaken to reduce A&E attendance by increasing the capacity within care homes to be more responsive to the needs of residents. The care home support team, and mental health care home liaison team supported care homes to prevent hospital admissions and improve the quality of care. There were plans to link each care home to a named GP, due to begin in September 2017 and be completed by December 2017.

- People in Halton could contact the local authority Contact Centre or attend the Direct Link services which were available to signpost and support people to make decisions about their care. Direct Link hosted health improvement and prevention programmes to keep people well, such as stop smoking groups and diet and nutritional advice.

- Direct Link could refer people to the local authority Contact Centre for pendant alert system services and blue badge applications, the Citizens Advice Bureau, and the Sure Start to Later Life service (offering information and activities for people over 55) . However, staff at Direct Link felt that by taking a greater role in referral process they could be more responsive to people's needs. Staff at the Direct Link centre had not received dementia training, meaning that there was a risk that people with dementia were not having their needs identified.

- Halton had a range of services designed to enable people to receive the right care in the right place at the right time to maintain them in their usual place of residence. This included:
  - ⇒ The 24-hour assistive technology service
  - ⇒ Community wardens working to a 30 minute response from referral time
  - ⇒ The Initial Assessment Team, RCAT and RARs services working to a same day response from referral target
  - ⇒ Community equipment provided within five days and emergency equipment available for teams as needed
  - ⇒ Strong and bespoke support for carers.

Do services work together to manage people effectively at a time of crisis?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: crisis management

Are services in Halton Safe?

Partners were working together to implement initiatives to assess risk and reduce avoidable harm, however there are still challenges in meeting the needs of older people at a time of crisis, particularly in relation to patients moving to intermediate care.

- There were systems and processes in place across the system to safeguard people from avoidable harm at a time of crisis. For example, NWAS had worked with the CCGs to reduce the number of A&E admissions from people who call the emergency services. NWAS deployed a 'falls care' process to incidents where an older person had fallen to give specific care and support to prevent a direct A&E admission.

- Our analysis of waiting times in A&E from 2014/15 to 2016/17 showed that both trusts were performing below the national expectation. In Whiston Hospital (St Helen and Knowsley Teaching Hospitals NHS Trust) an increasing percentage of people arriving at A&E had to wait longer than four hours year-on-year, with only 85% seen within four hours in 2016/17. At the two hospitals in Warrington and Halton Hospitals NHS Foundation Trust, 90% were seen within four hours in 2016/17.

- Risk assessments and escalation pathways were in place to mitigate avoidable harm for people who use services during a crisis. These included pressure area management and falls prevention. However, due to the extended waits for some patients to access intermediate care at Warrington and Halton Hospitals NHS FT we found evidence of avoidable harm to people.

- The CCG and local trusts had shared key performance indicators around quality, safety and experience of care, these look at recurrent trends for incidents and falls. Incidents were reported and discussed at the Quality Surveillance Group (QSG).

- Staff in A&E departments displayed an awareness of how to identify and manage safeguarding concerns, however further training in safeguarding awareness was identified as a need. Halton Adult Social Care was recognised in the system as providing high quality safeguarding training, and had been requested to deliver training to NHS staff.

- At Whiston Hospital GP streaming had been in place since June 2017 WHFT was due to have front door clinical screening provided by GPs in place by October 2017, this would allow the emergency departments to focus on caring for people with the highest needs, including older people.

Are services in Halton Effective?

We found evidence that the urgent care system was effectively managing the flow of people at a time of crisis, including through effective joint working in the emergency departments.

- There were good examples of effective system working at the Urgent Care Centres (UCCs) in Widnes and Runcorn. The UCCs were aligned in their approach, using a shared care pathway to deliver a consistently high standard of care across both sites.

- Systems were in place to support the effective collaboration and information sharing between professionals and organisations to meet the needs of the people who used services. Both UCCs had access to a record sharing system that included a summary care record, information about allergies, medications, and risk management.

- Diagnostic testing such as scans and blood tests could be carried out in the centres and the person's care and treatment plan was sent to their GP by 8am the following morning. Multi-disciplinary assessments were carried out by the appropriate professionals, as therapy staff were co-located at the centres. Referrals could be made to community services, district nurses, or when appropriate local safeguarding teams.

Are services in Halton Caring?

People and their carers are involved in their care and supported to make informed choices during a time of crisis. However people indicated that the discharge process could be more informative.

- In the discharge lounge people told us they had been given information about their care and treatment options and that the process had been explained in a way that they could fully understand. There was a wide range of information available in the departments for people to take away regarding the management of their condition and discharge options. However, there were also some people who indicated that the discharge process could be more informative.

- A survey carried out by the discharge teams at WHFT in 2016/17 was generally positive and people felt assessment and discharge was a smooth process, however, 10% of people and their carers who took part in the survey felt they weren't given enough time to prepare for the change in care arrangements.

Are services in Halton Responsive?

Services have been developed and planned in consultation with the local population. People are managed well through their admission and assessment in acute settings. However some people remain in acute care longer than necessary while waiting for intermediate and re-ablement services.

- Operational and management staff acknowledged that there was a challenge around delayed discharge due to a lack of care home placement and domiciliary care packages. During our site visit to Warrington hospital we saw examples of people who had been assessed as no longer requiring an acute bed remaining in hospital because an enablement /intermediate care bed was not available. There was evidence to suggest that one patient had suffered avoidable harm because of this.

- Data for 2016/17 showed an improvement in reaching the four hour treatment expectation at Warrington and Halton Hospitals NHS FT; however performance was still below the national expectation, and at St Helen and Knowsley Teaching Hospitals NHS Trust performance had been declining each year and in 2016/17 was below the expectation and the national average. The system attributes the improvement at Warrington and Halton Hospitals NHS FT to the RCAT and RARs services.

- At Q4 2016/17, 95.4% of the 718 available overnight beds at St Helens and Knowsley Hospital NHS Trust were occupied and throughout 2016/17 occupancy had remained above 90% at the trust. Although optimum occupancy rates for hospital beds may vary according to type of services offered, hospitals with average bed-occupancy levels above 85% are likely to face regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections. At Warrington and Halton Hospitals NHS Foundation Trust, 86.9% of the 613 available overnight beds were occupied in Q4 2016/17 and occupancy had stayed close to the optimal 85% level throughout the year.

- We found positive examples of effective discharge planning when we sampled records in Whiston hospital and Warrington hospital A&E and discharge lounges. There was evidence of people progressing through the system with a multi-disciplinary focus on assessment and discharge planning.

- There was a challenge around the sharing of relevant service user information in a timely way across organisations with different IT systems. This was identified as causing delays to the process, duplication of effort, and impacting effective decision making.

- Halton operated a borough based urgent care system review using daily information on capacity and demand in hospitals, intermediate care, and care home and domiciliary care provision. This information supported operational teams to identify gaps and direct existing resources (finance and staffing) accordingly. This also fed into longer term trend analysis used for the commissioning of additional capacity and alternative forms of care as well as for seasonal planning.

Do services work together to effectively return people to their usual place of residence, or a new place that meets their needs?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: step down, return to usual place of residence and/ or admission to a new place of residence

Are services in Halton Safe?

There was a shared view of risk management across staff, however there were sometimes difficulties with joined up working between health and social care when people are returned to their usual place of residence, or a new setting.

- Our analysis of emergency readmissions within 30 days of discharge during 2015/16 showed that Halton was in line with the England and comparator averages. However, the rate of emergency readmissions from care homes was significantly higher in Halton than the England average (28% in Q1 2016/2017 compared to 20%) and was also higher than the comparator group average (22%).

- A lack of communication between hospital social work teams and domiciliary care agencies during the discharge process was sometimes leading to people being discharged to their usual place of residence without all aspects of packages of care in place. The system in place for the domiciliary care provider to contact the social work team to address any issues was not always effective.

- There was an agreed view on risk across professions within the intermediate care team; that people should be facilitated to take ownership over their risk management plans. From a number of years of health and social care services working together a shared understanding of risk management had developed, this was well embedded and GPs trusted the system and used it to inform decisions as to whether a hospital re-admission was necessary.

Are services in Halton Effective?

There were a number of discharge pathways and plans in place involving partners across the system to effectively enable people to return to their usual place of residence. However these were not always able to be carried out effectively due to a lack of social care availability and poor information flow.

- We observed people experiencing delayed discharges on the review: one person waiting for a care home placement, one person waiting for intermediate care and another waiting for a domiciliary package of care. We saw the negative impact of delayed discharge; one person developed a pressure ulcer and another experienced an increase in clinical symptoms.

- Both our analysis and the analysis conducted by the Department of Health indicated that Halton

had comparatively longer length of stay in acute hospitals for older people. Across Halton's comparators, 90% of people aged 65+ who were admitted as an emergency were discharged within 19 days, however in Halton this figure was 23 days.

- At the time of our review the length of stay at the intermediate care unit at Warrington hospital was more than 50 days. The reasons cited by senior leaders and operational managers for these delays were the challenges in the care home and domiciliary care market including volume and capacity and quality issues.

- Analysis of Adult Social Care Outcome Framework (ASCOF) reablement measures for 2015/16 showed that Halton had a significantly lower percentage of people aged 65+ still at home 91 days after discharge from hospital into a reablement service (63.3%) compared to the England average (82.7%) and comparator areas (81%). Analysis of the longer term trend between 2011/12 to 2015/16 showed that the proportion had been consistently lower in Halton relative to the national and comparator averages and had decreased over that period. The rationale for this of the Local Authority was to respect people's choice if they wanted to return to their usual place of residence, sometimes against professional advice. This resulted in a higher percentage of people being transferred to a more suitable care environment.

- The quality of discharge summaries was raised as a concern across professional groups. Poor quality discharge summaries sometimes impacted on providers' ability to meet the needs of people when they return to their usual place of residence or a new setting. This was a particular issue with regard to quality of information around medications. It was acknowledged at a senior level that there was a lack of understanding about the importance of the quality of discharge information and actions were in place to help address the issue. These included the introduction of compulsory fields on electronic discharge forms.

- Our analysis showed there were fewer care home beds available in Halton compared to similar areas and recent care home closures had contributed to this. The local authority had worked with an external consultancy firm to assess the reasons for closures and develop early warning indicators before services closed. This had been fed into the care homes transformation programme and the local authority was also in the processes of purchasing a care home at risk of closure to secure these placements.

- Although both the domiciliary care and care home transformation plans appeared robust they were not in place at the time of the review. At the time of the review was that there were no new domiciliary care placements available and people had to stay in hospital until capacity became available. This meant that people were having extended length of stays in intermediate care. We also saw examples of people waiting in acute hospital beds to go into intermediate care.

- It was acknowledged across the system that there was a shortage of care home placements for people living with dementia. This was being addressed through the care home transformation programme, however this was not due to fully implement until 2018. It was not possible to assess if either of these programmes would be effective in dealing with the increased demand over winter.

Are services in Halton Caring?

People using serves, their families and carers felt included and involved in care planning. However the co –ordination of care and content of needs assessment was not always consistent across services

- Feedback from people in the Halton Borough Council satisfaction survey who had received a service (approximately 4,500) was positive overall with 58% of people responding:
  - ⇒ 96% of people said that they felt that staff treated them with respect and dignity all of the time.
  - ⇒ 100% of people outlined that they fully understood the information given to them about their care.
  - ⇒ .
  - ⇒ 96% of the people said they were either likely/extremely likely to recommend the service to a friend.
  - ⇒ 100% of people were either satisfied/very satisfied with the care they received.

- We reviewed eight assessments and discharge plans at Whiston, Warrington and Halton hospitals and found they varied in content and quality. There was evidence of people progressing through the system with a MDT approach to discharge planning. However in records reviewed at Halton hospital we found no evidence of involvement from people, their family or carers in terms of discharge planning and preferred place for discharge.

- In our review of case notes we saw examples of repeated assessments; in one case a person had received five assessments by different professionals in two weeks. The person had some cognitive impairment and had become distressed at the number of questions they were being asked and the number of people visiting them. This had also led to duplication of effort across professionals. The reoccurrence of such situations may be reduced by the planned implementation of the trusted assessor component of the high impact change model; however this had not been implemented at the time of our review.

- Case note review and dip sampling showed that people who used services and their relatives were involved in the development of care plans and discharge arrangements. We also saw evidence that GPs had discussion post admission with families about their choices and future planning, for example around further hospital admissions.

- However, involvement of people who use services, their families and carers was not consistent across Halton, and in some records we saw no evidence of their involvement in terms of discharge planning and preferred place of discharge. This was more significant in records reviewed from Warrington and Halton hospitals.

Are services in Halton Responsive?

Partners are working together to enable people to be discharged at the right time and to the right place, however, there are significant challenges with delayed transfers of care that had a negative impact on people.

- The capacity challenges in the care home, nursing home and domiciliary care market was widely recognised at operational and management levels at both hospitals as a key contributor to delayed transfers of care.

- The length of stay at the Warrington and Halton Hospitals NHS FT intermediate care unit (HICU/ B1) was at an average of 48 days for 2016/17, on the day we visited this had risen to 67 days. Staff dealing with discharges did not routinely attend the length of stay weekly meetings at Warrington hospital in person and any delayed transfers of care would be reported by phone.

- When reviewing six sets of case notes, the most common reasons for delayed discharge were people waiting for care packages, either domiciliary care provision or a care home placement.

- Senior leaders in the local authority and CCG had instigated the plans to transform provision in both domiciliary and care home settings, however these plans were untested and therefore the impact could not be measured as to see how they would increase capacity in the system and address the increased pressures during winter

- Analysis of DTOC figures from April 2015 to April 2017 showed that the rate of delays had been increasing within Halton and after October 2016 had remained higher than both national and comparator area averages. Although recent DTOC figures were improving (figures for June 2017 indicate that the average daily rate of delayed transfers of care in Halton had dropped to 8.8 delayed days per 100,000 population, below the England figure of 13.8 and below Halton's comparator average of 10.80), there were a number of challenges in the timely provision of appropriate rehabilitation services and intermediate care to support this reduction. Patients with complex needs were experiencing some considerable delays.

- Our analysis of delayed transfers of care showed that one of the main reasons reported for delayed discharges was 'patient or family choice', accounting for 35% of delays in the area. We were informed at the Warrington and Halton NHS FT intermediate care unit that people awaiting discharge to a care home were provided with information about all homes within the area, even those that did not have availability. This could result in delays if people and their families chose to wait for a bed in their preferred home. There was a choice policy in place at Warrington and Halton NHS FT intermediate care unit, we did not see evidence this was being implemented. The local authority acknowledged that people choice was leading to delays; however they wanted to provide the information to enable people to choose the right provision for them.

- Halton has comparatively longer lengths of stay in hospital for older people than the England average and that of its comparators. Analysis produced by the Department of Health showed that

across Halton's comparators, 90% of people aged 65+ who were admitted as an emergency were discharged within 19 days, however in Halton this figure was 23 days[4]. Additionally, our analysis showed that during 2015/16 33% of people aged 65+ who were admitted stayed in hospital for over a week, compared to the national average of 32% and comparator average of 30%.

- We held discussion with members of staff who dealt with discharges from the two acute hospitals and the intermediate care units. Staff from Whiston hospital had a good overview of how many delayed transfers of care they were managing that week. However staff covering Warrington and Halton were less clear because of a lack of robust managerial oversight.

- Continuing Healthcare (CHC) was provided through a joint local authority and CCG budget which had been established for a number of years. Staff did not recognise CHC as being a primary cause of delays. However, NHS CHC figures for all adults (NHS England) for Q1 2017/18 showed that for Halton CCG 25% of referrals for standard CHC were completed within 28 days, lower than the England average of 57% and the Cheshire and Merseyside regional average of 73%.

- The same data (NHS CHC figures for all adults for Q1 2017/18) showed that Halton CCG had a standard NHS CHC referral conversion rate (% of newly eligible cases of total referrals completed) of 43%. This was high compared to the England and Cheshire and Merseyside regional averages of 25%. Their assessment conversion rate (% newly eligible cases of total cases assessed) was also higher. This indicates that Halton's processes for identifying people eligible for CHC are working well and a lower proportion of people and their families entered the CHC process to be then denied CHC funding.

[4] Department of Health analysis of Hospital Episode Statistics - March 2016 – February 2017

Maturity of the system

What is the maturity of the system to secure improvement for the people of Halton?

- Relationships were strong with a high level of mutual trust and a culture of openness and transparency. There was a shared understanding of system challenges and a willingness to work together to achieve a solution, coupled with a strong commitment to serve the people of Halton well.
- Partners in the Halton system had a longstanding history of working together effectively for the benefit of the people living in the borough.
- There were some excellent examples of shared preventative approaches and local agreements that supported local people in having timely access to services and support that met their needs in a person centred way.
- However, there was still work required in relation to developing a wider system vision for the STP and ACS footprint and the development of a common framework for prioritizing actions, accountabilities and governance arrangements.
- Although managed well at a local level, the system had work to do to develop a strategic approach to workforce planning and development.
- In addition, the allocation of resources within a financially challenging environment and managing system wide performance would benefit from a more robust approach to risk sharing and shared success criteria.
- Work was underway to allow access to shared records with out of hospital services. This approach (due to be fully implemented in 2020) aims to promote seamless transfer of information across the system and reduce duplication of effort.
- This approach to records and information sharing should be part of a wider IT strategy that supports compatibility across partner IT systems to ensure that all parties have access to a full range of a person's record.
- Strengthening these key elements of system wide working would support the area to understand its future priorities and direction of travel more comprehensively and support improved outcomes for local people in a timely and effective way.

Areas for improvement

- The Health and Wellbeing Board would benefit from increased vigour in calling system leaders to account to ensure that agreed plans and service improvements are delivered at pace.
- A cohesive interface and robust alignment between the local authority's and CCGs vision for the borough, the Local Delivery System, the STP and planned ACS should be developed. This alignment should be underpinned by shared success criteria, key performance metrics and formal joint governance arrangements so that the all partners have a voice and appropriate recognition in wider system planning.
- While the local authority and the CCG work effectively together as commissioners in the borough, commissioning activity would benefit from increased care provider engagement including local NHS trusts and the GP Federations.
- The implementation of local strategies and plans to reduce avoidable admissions to hospital and improve delayed transfers of care should continue at pace.
- Plans to meet winter pressures should be aligned and coordinated at a system level to ensure that actions between key partners, staff, and people are effective and communications with the public to deter hospital attendance are clear, helpful and consistent.
- Further oversight and monitoring of commissioned services, particularly the intermediate care service provided at Warrington and Halton NHS FT should be put in place by both the service provider and the service commissioner so that poor performance is actively managed and patient experience improved.
- Data collection in different assessment processes across the system should be reviewed to avoid duplication this was particularly evident in assessment of people living with dementia and in the carer's assessment process.
- Now that strategic plans have been developed, strategic leaders should focus on delivery at the front line to improve outcomes for people in Halton.