AVOIDING ADMISSIONS

SCRUTINY REVIEW

A report produced by
THE FORMER FAMILIES AND WELLBEING POLICY & PERFORMANCE COMMITTEE

July 2016
FINAL REPORT

WIRRAL BOROUGH COUNCIL

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Page

APPENDICES

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1. INTRODUCTION AND ORIGINAL BRIEF

On 2nd February 2015, Members of the Families and Wellbeing Policy & Performance Committee received a report entitled 'Commissioning community services, managing the market and reducing reliance on residential and nursing care'. Members were informed of a change of commissioning practices aimed at strengthening community based services in order to keep residents, particularly older people, at home for longer and consequently reduce the reliance on the residential care sector and the need for avoidable admissions to an acute hospital setting. Budget priorities had been changed in order to reflect the change in priorities.

As a result, members agreed that an item should be added to the committee's work programme in order to undertake a detailed scrutiny review. It was hoped that the review would give members the opportunity to gain assurance that adequate plans are in place to further develop community-based services with the aim being to reduce unplanned admissions to acute hospital. Members would also be able to assess the effectiveness of the integration of social care and health and also the effectiveness of ongoing partnership working in delivering community-based services. As a result, a task & finish group comprising five Members was formed. The group was also been strengthened by the addition of a representative from Healthwatch Wirral. The Scope Document for the Scrutiny Review is attached as Appendix 1 to this Report. The key issues for the review were identified as:

- Understand the demand for both acute and community based services in Wirral
- Understand the reasons for the increased demand for admission to acute services
- Assess the levels of readmissions and unnecessary admissions to acute services
- Appreciate the mechanism for the allocation of funding
- Understand the services that are already in place or being planned
- Assess whether the resources and capacity are available to support the service provision
- Consider whether the transition from acute to community based services is achievable within a realistic timescale
- Consider whether community based services are provided on a person-centred basis

The task & finish group has held a range of meetings in order to obtain appropriate evidence. Sessions were planned with representatives of a significant number of health and care provider organisations, including some care homes as well as carer and patient representative groups and third sector organisations.

The remainder of this report provides details of the Panel membership followed by an overview which includes the recommendations proposed by the Members and the reasoning behind those recommendations. This is followed by the main body of the report which provides contextual information and details the key findings of the Review.

2. MEMBERS OF THE SCRUTINY PANEL

Councillor Moira McLaughlin (Chair)

 That people are living longer is a fact, but that increased life expectancy should also mean people live longer and healthier lives which they are able to enjoy. That means having a health and care system which is able to cope with the extra demands and play its part in achieving better health.

Nationally, our health and care services are struggling to meet the present demands and that struggle is replicated here on Wirral. It is clear that this pressure on frontline services will only increase without radical changes to the way services are delivered.

Those responsible for planning and delivering services locally recognise this. Our review was undertaken to look at what is being done to help relieve the pressure on front line services, develop newer community-based services and promote services which prevent ill health. We have been impressed by the way health and care services are working together to tackle this increasing challenge. However, it is an uphill struggle and we hope our recommendations will complement their effort in meeting that challenge.

Councillor Alan Brighouse

 There are 3 factors I would highlight from the scrutiny review.

First, the delivery of successful health and social care requires a coordinated response from a range of services. For this to be achieved, a clear single high standard leadership structure needs to be established. Secondly, the importance of domiciliary care and the recognition of the vital contribution it makes. This will require additional resources to ensure that pay rates are acceptable and to provide further training. Finally, there is the vital role of public health and the preventative agenda, neatly summed up by the heart transplant specialist, Christian Barnard: “I have saved the lives of 150 people from heart transplantations. If I had focused on preventive medicine earlier, I would have saved 150 million”.

Councillor Bruce Berry

 This was a very in-depth piece of scrutiny covering all aspects of health and care. We all recognise that the system is under immense pressure and it was interesting to review the alternative ways to deliver services within our communities. Education and preventative measures are equally important to encourage healthy life styles and it was pleasing to hear of newly developed services to deliver this outcome.

To deliver a service fit for a modern society will be challenging but we are encouraged by the joint efforts of health and care services to bring about that change.

Councillor Treena Johnson 	***Councillor Denise Roberts*** 	***Karen Prior Healthwatch Wirral*** 	***This Scrutiny Panel was supported by:*** Alan Veitch Scrutiny Officer 0151 691 8564 alanveitch@wirral.gov.uk

3. OVERVIEW AND RECOMMENDATIONS

The NHS Five Year Forward Plan, published in October 2014, highlighted the challenges facing the nation's health services and provided a vision for the delivery of services in the future. Demographic changes have seen the growth of an ageing, increasingly frail population with a rising prevalence of chronic disease. The plan states that long-term health conditions now take 70% of the health service budget. There are increasing opportunities for better health through increased prevention and supported self-care. Technology is also transforming the ability to predict, diagnose and treat disease. However, funding pressures continue, particularly in the aftermath of the 2008 global downturn.

The Forward View argues:

- the need for a radical upgrade in prevention and public health
- when people do need health services, patients will gain far greater control of their own care including the option of shared budgets combining health and social care
- the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals; between physical and mental health; between health and social care.

Subsequently, in December 2015, new guidance outlined an approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England was required to produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years. Wirral is part of the Cheshire and Merseyside footprint. The health and care organisations within this geographic footprint are working together to develop an STP which will help drive genuine and sustainable transformation in patient experience and health outcomes of the longer-term. Therefore, there are national and local drivers for change.

At a local level, it had already been recognised that there was a need for greater emphasis to be placed on avoiding admissions to acute services in addition to minimising discharge delays. This has resulted in an increasing focus on investment in a range of community-based services that will be able to provide alternative pathways to acute care where appropriate. Commissioners and providers are putting in place cost-effective, community-based services, which can both prevent the need for hospital admission and safely reduce length of stay for older people. It is anticipated that this will enable savings to be made from hospital-based services.

The introduction of the Better Care Fund has been important to this change of emphasis towards service provision. The Better Care Fund currently sets a target of an annual 3.5% reduction in unplanned acute hospital admissions. During 2015/16, this target was achieved in Wirral with a reduction by 5% in non-elective admissions. However, this has to be balanced, during the same period, against a 4.2% increase in A&E attendances. In addition, those patients who need to be admitted are costing more as the number of complex cases, particularly among older people increases. This has led to continuing financial challenges across the health economy.

The Panel Members have concluded that although many positive steps have taken place, further work is required to ensure that the right services are provided in the right place at the right time. During this review, much detailed evidence was gathered relating to specific services and this evidence is recorded in section 4 of this report. However, as the review has taken place, change to service provision and the introduction of new care pathways have continued at pace. Therefore, in developing their recommendations, the Members have chosen to focus on strategic issues:

3.1 Governance and funding

Members support the existing concept of collaboration and strengthening partnership working. The discussions at both a national and local level provide strong evidence for ever closer relationships leading towards the development of a single health and care system. It is intended that Wirral will move towards the goal of becoming an Accountable Care System, which will promote place-based working. Under such a system, NHS organisations and their partners collaborate in order to meet the needs of the populations they serve. There is, therefore, an intention for pooled budgets to be expanded by April 2017, with the planned introduction of more coordinated commissioning procedures within Wirral. It is also envisaged that, as the delivery of the Sustainability and Transformation Plan for Cheshire & Merseyside develops, underpinned by the Local Delivery Plan for Wirral, arrangements across a variety of footprints for different services are likely to emerge.

Although existing oversight for the Better Care Fund lies with the Health and Wellbeing Board and partner organisations, Members do envisage the need for more effective governance arrangements with clear lines of responsibility and accountability. The Panel Members appreciate the importance of strengthening the levels of collaboration and urge steps to be taken as quickly as feasible. It is suggested that progress should be reported to the appropriate scrutiny committee on an annual basis as a minimum.

Recommendation 1 - Developing one system with shared governance
Wirral will move to be an Accountable Care System by 2020 in line with national requirements. Wirral Clinical Commissioning Group, in conjunction with all partners are encouraged to continue to strengthen the culture of collaboration and partnership working which will lead to the ultimate development of a single health and care system for Wirral, the achievement of which will require a single pooled budget. This will require the establishment of appropriate governance arrangements with clear lines of responsibility and accountability and robust pathways minimising duplication. Opportunities should be taken to achieve incremental steps towards achieving an Accountable Care System by 2020 and report on progress to scrutiny on an annual basis.

Although second year funding for Wirral's Vanguard programme has been effectively removed with an announcement by NHS England in May 2016, it is intended that the ethos of the programme will continue through the delivery of the Healthy Wirral programme. During this scrutiny review, as detailed further in section 4.2.2, Members were informed of the ways in which the priorities of the health economy are influenced by the funding arrangements, which includes the use of the payments by results tariff. This means that commissioners pay healthcare providers for each patient seen or treated. As a consequence, the funding arrangements increase payments to hospitals based on the number and complexity of admissions. Members welcome the progress that has been made by Wirral CCG and the major partners to move to the concept of cost envelope funding (that is a block contract) from April 2017 and would like to see this initiative progressed.

Recommendation 2 – Funding of acute hospital services
In order to further develop services in the community, Wirral Clinical Commissioning Group and partners are requested to continue to explore the opportunities arising from commissioning within a cost envelope as an alternative to the Payment by Results tariff model.

3.2 Service quality

During the review, Members were informed by practitioners that there is capacity in the system to find a community bed if one is required. However, there was also evidence that the pressure to discharge patients from acute hospital can lead to priority being given to those patients. Members were told that this can lead to occurrences of difficulties finding a bed in a community-based setting for a client who is not already hospital-based. It is essential that there is adequate system capacity. It was noted during the review that there is a real aspiration that there should be no waiting lists for access to community-based services.

The quality of provision of commissioned services has been raised throughout this scrutiny review. As an example, Members are aware that four of the five homes currently commissioned to provide the intermediate care service have been assessed using the Care Quality Commission's (CQC) new assessment regime and have been rated as 'Requires Improvement'. (The remaining care home has been rated as 'Good'). In addition, the home commissioned to provide additional 'step-down' capacity during the period of winter pressures in spring 2016 has also received a CQC inspection rating of 'Requires Improvement'. The members believe that service quality, in addition to the provision of person-centred care and system capacity, must all be an integral part of future commissioning decisions. In particular, service quality should be further embedded within the commissioning processes.

Recommendation 3 – Service quality and a person-centred approach for community services
The Director of Adult Social Services and Wirral Clinical Commissioning Group, as commissioners of community services, are requested to ensure that adequate system capacity, service quality and a person-centred approach are embedded within all such contracts. An effective monitoring measure of the integrated care system should continue to be developed, appropriate to the changing commissioning structures.

3.3 Developing the right services

The Kings Fund document, Transforming our health care system, stated that "the ageing population and increased prevalence of chronic diseases require a strong re-orientation away from the current emphasis on acute and episodic care towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated and integrated". The Panel Members fully support the direction of travel towards developing a greater emphasis on the preventative agenda and the promotion of self-care. Initiatives such as Think Pharmacy, reablement and the Helping People Home scheme are welcomed as they encourage residents to seek to further self-care.

Recommendation 4 – Admission prevention
Wirral Clinical Commissioning Group and Wirral Borough Council, as commissioners of services, will continue to further develop the concept of preventative services to reduce unplanned admissions through the improved outcomes of public health initiatives, the development of robust community services and the encouragement to promote self-care. Annual feedback is requested from the Joint Strategic Commissioning Group.

It is understood that further work is required to review the unplanned and urgent pathways for care as there is some apparent confusion among the public regarding where to go to receive particular services. It is suggested that further steps are required to explain the most effective pathways to both professionals and the wider public. It would be beneficial to agree an effective communication strategy allied to a targeted approach to reach those parts of the community whose attitudes and behaviours are most required to change. It will, therefore, be most effective if the right message and mode of communication is chosen depending on the target community.

Recommendation 5 – Promotion of community services
Wirral Clinical Commissioning Group and Wirral Borough Council, as commissioners of services, will place greater emphasis on promoting community services among the public and professionals. Increased priority will also be given to changing the awareness and behaviours of the public and professionals in order to encourage greater usage of the range of services aimed at preventing unplanned hospital admissions.

It is appreciated by the Panel members that the development and implementation of patient pathways takes time, especially for those pathways to be followed in a consistent way. However, during this review, evidence did occur of examples where the new pathways were not always being applied consistently. One such example was the approach employed by the 111 service towards community-based care. It is anticipated that, as the 111 service is now being delivered by the North West Ambulance Service, a more consistent approach is developing which should lead to fewer unplanned acute admissions.

The engagement of GPs in the delivery of the new service models is essential to the successful delivery of the programme to enhance the use of community-based services. The increased use of alternative community-based services, as an alternative to sending patients to A&E, is dependent on the full engagement of GPs. It is fully recognised that significant effort has already been made by GPs who are champions of change. However, further steps are required to progress consistent application of the new pathways.

Recommendation 6 – Implementation of alternative referral pathways
Wirral Clinical Commissioning Group and Wirral Borough Council, as commissioners of services, will work with all service providers, including North West Ambulance Service, the 111 service and GPs, in order to ensure full engagement in the new referral pathways.

The evidence-base for commissioning decisions is improving as lessons are being learned from the progression of existing services and the development of newer community-based services. As an example, the demand for domiciliary care and Mobile Nights services has resulted in more resources being made available to develop capacity. It is essential that the use of customer insight data and demand analysis in addition to learning from best practice from elsewhere are all used as a basis for future commissioning decisions. As demographics change and demand for different services moves to reflect those changes, it is important that services are able to respond quickly and imaginatively.

Recommendation 7– Responding to changing requirements for services
Wirral Clinical Commissioning Group and Wirral Borough Council, as commissioners of services, will ensure that community services are introduced on the basis of best practice, insight and analysis of need. This will ensure that services will remain responsive to changing community needs, reinforced by the use of formal contract mechanisms to expand or reduce contracts as appropriate.

During the review, Members heard many comments relating to the effectiveness of joined-up working across the different partner organisations responsible for delivering health and social care, often to the same patient. The effectiveness of patient care will be improved by the efficient sharing of data by the different providers. It is fully understood that robust safeguards regarding data privacy must be in place allied to a patient opt-out if so desired. Members heard that the Wirral Care Record will enable the effective sharing of data which will enable the multi-disciplinary teams to better develop integrated care plans for patients. The Panel Members endorse the development, in principal, of the Wirral Care Record and urge its full implementation at the earliest opportunity.

Recommendation 8 – Communication of data
The Healthy Wirral programme's work to improve the communication of patient data between health and care providers in order to create a single patient record is fully endorsed. The Wirral Care Record will ensure that the use of the single patient record is spread to as many providers as possible at the earliest opportunity. Feedback on the implementation and the impact of the Wirral Care record is requested to a future meeting of the People Overview & Scrutiny Committee.

3.4 Evaluating the effectiveness of services

Performance data is already available for the various services which form the current community-based service offer. However, it is also important to be able to judge the impact of the various elements of the integrated provision. A greater emphasis on integrated reporting across organisations would help to achieve this. Members suggest that greater emphasis should also be given to the measurement of service quality as well as capacity and quantitative data across the different services that make up the community-based service delivery. It is also suggested that further thought be given to the opportunities for public scrutiny of the performance of these services across the wider partnership.

Recommendation 9 – Performance management of community services
Wirral Clinical Commissioning Group and Wirral Borough Council, as commissioners of services, will give a high priority to the effective performance monitoring of the various community services, including the use of both qualitative and quantitative data. The monitoring will include performance comparisons with geographical and statistical neighbours. Opportunities will also be explored to report across organisations in an integrated way and consideration will be given to the wider role of scrutiny across partners.

4. KEY FINDINGS

4.1 Local context

On 2nd February 2015, Members of the Families and Wellbeing Policy & Performance Committee received a report which described that Wirral has traditionally had a relatively high level of reliance on the residential sector for older people's care. In comparison to other Local Authorities, the proportion of the adult social care spend in Wirral on residential care was one of the highest in the region at 38% of the whole budget. Conversely, the high spend on residential care services reflected a position where the expenditure on community based services had been low. It was necessary for transformation to take place in order to re-shape the market to provide capacity in local communities. A commissioning strategy was developed to ensure that the principles of personalisation and the transformation of adult social care were fully embedded in commissioning processes and practices. Budget priorities were changed from 2013 onwards to reflect the shift in strategy.

Although the previous focus was on ensuring the right community offer and minimising discharge delays, it was recognised that greater emphasis on avoiding admissions was required. The introduction of the Better Care Fund has been important to this change of emphasis. An increasing focus on investment in a range of priority services that will be able to respond as alternatives to acute care where appropriate has followed. The following initiatives and community-based services are in place in Wirral:

Domiciliary care and reablement
New contracts were awarded in November 2013 relating to the domiciliary care and reablement services, the focus of which was to provide Wirral-wide services in order to better support people at home and reduce the reliance on bed-based capacity. The new contract expanded the capacity to deliver domiciliary care, enabling a same-day response to new packages of care. The commissioning of fewer, zone-based providers also aimed to deliver best value for money as well lead to an improvement in quality and contract management. These services enable older people, people with disabilities and people recovering from an illness or hospital stay, to continue living at home by supporting them with home-care and services that help them to stay mobile.

Reablement is the use of focussed intensive therapy and care in a person's own home in order to enable them to remain or return to living independently. This approach focusses on optimising client's independence with the lowest appropriate level of on-going support and care. DASS retain responsibility for assessing and commissioning reablement packages through the STAR Team.

Mobile Nights service
The Wirral Mobile Night Service is provided by Local Solutions and delivers a Wirral-wide overnight mobile domiciliary care service between the hours of 10pm and 8am, 365 days a year. Between one and four visits per night can be arranged depending on the requirements of the client.

Home from home service
The Home from Home service, available in four properties, provides temporary furnished, adapted accommodation (with support where required) for people who are temporarily unable to return to their own home. This could be because they are waiting for an adaptation to their home. Three of the Home from Home properties are located in Extra Care or Sheltered Housing developments.

Single Point of Access
From January 2016, the Single Point of Access has operated as an effective gateway and point of contact for all referrals, sign posting to the correct service and ensuring the best pathway and range of options are considered for the individual. This is seen as an important step towards providing more effective care navigation. As there are so many more services other than hospital-based services, it is important to encourage all referrers, including GPs, to use them more.

Integrated Care Coordination Hubs
The Integrated Care Coordination team will provide wrap-around services aimed at keeping clients at home and strengthening the focus on admission prevention, particularly for complex cases. Based on the constituency footprint, four hubs will cover the borough. Any professional can refer into the multi-disciplinary team hub regarding a particular patient. The core team in each hub consists of social workers, community nurses / matrons, multi-disciplinary coordinators, occupational therapists, physiotherapists and mental health practitioners. The most appropriate lead professional will be allocated to the client depending on the primary patient requirements. This coordinated approach will result in more proactive care and will reduce admissions.

Rapid Community Service
Commencing in September 2015, the Rapid Community Service has, as its primary function, the prevention of admission to hospital or facilitation of discharge from hospital through a rapid, coordinated response, 365 days a year. Enabling referrals from partners including GPs, North West Ambulance Service and the acute hospital, the service provides integrated health and social care assessments on a four hour turnaround, leading to people being supported either within their own home or coordinated community bed based provision. The service, which operates from 8.00am to 8.00pm, incorporates referrals to reablement, intermediate and transitional care. The community bed base now exceeds 110, with additional funding allocated to enable beds to be purchased on a spot purchase basis in order to respond to the additional demands of winter pressures.

Intermediate and Transitional Care
Intermediate Care is targeted at people who would otherwise face unnecessary prolonged hospital stays or inappropriate admission to acute inpatient care or long term residential care. People accessing intermediate care have a structured, integrated, individual care plan which involves active therapy, treatment or opportunity for recovery. It has a planned outcome of maximising independence and typically enabling service users to resume living at home. Stays in an intermediate care home are time limited, normally no longer than six weeks and frequently as short as one to two weeks. Transitional Care provides a bed-based service for those patients who may need further assessment and / or some level of rehabilitation input.

From September 2015, this service has been enhanced by increasing capacity. Wirral currently has 110 intermediate and transitional care beds spread across five providers:

Daleside (Birkenhead)	21
Grove House (Birkenhead)	20
Leighton Court (Wallasey)	25
Hoylake Cottage (Hoylake)	20
Elderholme (Clatterbridge)	24

In addition, funding has been in place for additional winter pressure beds to be commissioned when appropriate. For 12 weeks, in the spring of 2016, additional capacity of 28 beds was commissioned at Charlotte House to enable speedier discharge from Arrowe Park hospital.

Helping people home 72 hour service
This is a service provided by Local Solutions, which offers up to 72 hours support at home, including overnight, 7 days a week, either to prevent admissions to hospital whilst longer term arrangements can be made or to facilitate discharge (but only where a care package has been arranged and will start within 72 hours). This service is designed to complement services such as Home from Hospital. The Helping People Home service assists in the admission prevention and the discharge from hospital by:

- Ensuring supplies are available including medication by liaising with the relevant professional
- Ensuring the person needing support is either welcomed at home or visited at an agreed time
- Providing overnight and mobile support
- Ensuring the person has adequate food

Home from Hospital
Provided by Age UK, the Home from Hospital Service provides an enablement service designed to help with client's rehabilitation after a stay in hospital. The service encourages people to regain their independence and successful rehabilitation on returning home by providing social and practical support such as shopping, collecting pension or paying bills, collection of prescriptions, help with correspondence that may have built up and light housework. This service provides short-term low-level support to anyone over 16 years of age, leaving hospital and living in Wirral. It is recognised that a significant number of hospital admissions are because individuals do not have an informal support network at home.

4.2 Organisation and Funding

4.2.1 Organisational issues

What the Members welcomed:

- Members welcome the principle of reducing the demand for admissions to acute hospital by investing in robust alternative services provided in the community. The development of new services such as the Rapid Community Support team, the Integrated Care Coordination Hubs, the 72 hour overnight service (Helping People Home) and the introduction of the Mobile Nights service are all positive steps.
- The enhancement of previously existing services, such as the provision of intermediate and transitional beds in addition to the domiciliary care services are also welcomed.
- The new approach to service delivery is resulting in more integrated service provision between DASS and other partners, linked to the Healthy Wirral agenda.

Where the Members found challenges:

- In preparation for the introduction of the new community-based services, officers had difficulty in specifying the initial requirements as there was not sufficient performance data available, especially from the Council. However, at that time, it was recognised that there was not a diverse menu offer and the commissioning arrangements needed to be reviewed. Although performance data for the new services is now being provided it is understood that further work needs to be done to ensure that the right services are being provided in the right place at the right time.
- The introduction of new services at pace has led to pressure on resources, both financial and people. It has, therefore, been necessary to prioritise the transformation programme. It is recognised there has been a period of considerable change within the health and care sector for some time, amplified in Wirral by the introduction of both the Better Care Fund and the Healthy Wirral programme. While welcome, the service transformation has had to be delivered at speed, creating its own pressures.
- The move to more flexible joint working by the partner organisations is breaking down some barriers but further progress is required in order to reduce costs but, most importantly, provide a more coordinated and effective service for the patient. There was anecdotal evidence that, although in some areas staff from different organisations are being brought together in single locations, more needs to be done to ensure true joint working. Professionals told the Members:

  "There are advantages of practitioners from different specialties co-locating. Integrating staff together leads to better communication".

  "The relationship with social work is good within the team. The relationship between the nurses and social workers within the hospital has also been good".

"It is hoped, in the future, for all partners to start behaving as a single organisation without structures necessarily having to change".

- Across the health and care sector, Members were informed that there are too many patient assessments, with each provider undertaking their own assessment. As a result, duplication of work can occur.
- A significant complication arises from the different footprints covered by the various service providers. As an example, while the Healthy Wirral programme applies to Wirral only, NWAS provides services for the whole of the North West. With the advent of the Sustainability and Transformation Plan across Cheshire and Merseyside plus the possible extension of devolution powers to the Liverpool City Region, the complexity of footprints is likely to increase.

4.2.2 Funding and resources

What the Members welcomed:

- The Better Care Fund had led to shared budgets, which was likely to develop further. This will encourage the ethos of joint working, as evidenced by the establishment and growth of multi-disciplinary teams across the sector.

Where the Members found challenges:

- Funding for service enhancements is extremely limited. Although the emergence of the Better Care Fund is enabling Wirral CCG and Wirral Council to join budgets and jointly commission services, there is no additional funding available from the Council. It is essential that services are developed on a borough-wide basis involving effective partnership working; not concentrating on Council-provided services only. Members heard warnings regarding the consequences of the strict financial outlook, being told by a representative from the third sector:

  "The direction of travel is correct but funding is putting pressure on the ability of the system to deliver the required outcomes".

- Members were informed of staff shortages in some areas, with the availability of trained therapists and paramedics being raised as concerns.
- Members were told, on a number of occasions, that there are incentives within the funding formula to encourage too great a focus on acute care, rather than looking system-wide. Members heard that Hospital trusts are paid through payments by results, which is the system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs. Therefore, when someone goes into hospital, the Trust will be paid via the payment by results tariff. Members were told that:

  "The tariff system needs to be changed to provide disincentives for readmissions and long hospital stays".

  "There tends to be too great a focus on acute care, rather than looking system-wide".

  Recent developments are enabling greater flexibility and the introduction of some block contracts with providers.
- It is anticipated that the financial implications of the introduction of the Living Wage will have a significant impact on care provision, particularly for care home providers.

4.2.3 Data and Intelligence

What the Members welcomed:

- A major aim of Healthy Wirral is for the whole system to become more intelligent about the requirements of individuals and the community. It is intended that population health data will be used to help design the appropriate services and where those services should be placed geographically. This improved system intelligence is enabling community provision as an alternative to hospital provision.
- It is recognised that the availability of data will enable a better understanding of the prevalence of particular conditions, resulting in improved service planning.

Where the Members found challenges:

- Although a process is being established to ensure that patient records can be shared by the different health and care partners, further progress is required in order to develop fully integrated care plans for patients. Issues of information governance and technical issues such as incompatible computer systems have presented barriers to progress. While recognising the need to maintain patient confidentiality and the necessity to enable patients to opt out of the system, Members welcome the development of the Wirral Care Record. It was anticipated that, during 2016, GPs and the acute hospital trust (WUTH) will be able to share patient records. Wirral Community Trust will follow by being able to access the same data later in 2016.
- Further to the Health & Social Care Act 2012, the Clinical Commissioning Group (CCG) no longer has access to personal information held by the hospital. As a result, patient identifiable information is removed before any data is sent to the CCG. This leads to a timelag of approximately 6 weeks.

4.3 Admission prevention

4.3.1 Admission Prevention

What the Members welcomed:

- There was widespread agreement that, in the future, Wirral needs to increasingly focus on keeping people at home. Admission avoidance is key to that ambition.
- There has been a significant investment in the 7 day Rapid Community service, enabling staff to provide a same-day response. An ambition for the future is also to see mental health practitioners included as part of the Rapid Community Service team.
- The OPAT service (Outpatient Antibiotic therapy) is hosted by WUTH and works in partnership with Wirral Community Trust and the local Clinical Commissioning Group. It is estimated that the service, since its implementation in early 2015 has saved in excess of 2000 bed days. However, it is anticipated that more admissions can be prevented in the future.
- The Think Pharmacy scheme now enables local participating pharmacies to prescribe for certain conditions, providing advice and also issuing of prescriptions.
- Street triage is a scheme which has been developed with the support of the Better Care Fund. Mental health nurses work alongside Merseyside Police in providing mental health support to incidents where the police are called. The scheme has been very successful in reducing A&E presentations and acute admissions.

Where the Members found challenges:

- Although Members were informed by practitioners that there is capacity in the system to find a community bed if one is required, there was also a strong impression that the pressure to discharge patients from acute hospital can lead to priority being given to those patients as opposed to patients from the community (that is, admission prevention).

- The Paramedic Pathway is an approach to patient prioritisation implemented by North West Ambulance Service. Although the Paramedic Pathfinder encourages the use of alternative responses, where appropriate, other than the delivery of a patient to A&E, there was evidence that the referral rate to GPs could be improved, particularly in relation to referrals to the Out of Hours GP service. It was suggested to Members that it may be possible for the CCG to further encourage GPs to accept paramedic calls. However, it was also accepted that a culture change among patients as well as among service providers is required before referrals to urgent care services (including GPs) will be fully accepted. Members were informed that, in the future, it is planned to develop increased access in the community around GP surgeries. If the patient does not need seeing in A&E it may be feasible to fix an appointment with a GP for the following day.
- In general, it was reported that there is some reticence, particularly among older crews, to use alternative responses as recommended by the Paramedic Pathfinder. Members were informed that paramedics follow the pathways supplemented by their own judgment. As a result, referrals to alternative services are not always happening consistently. As a comparator, Members were informed that, in East Cheshire, up to 12% of all ambulance activity was referred into the Primary Care Early Response Visiting Scheme. The equivalent diversion rate for Wirral is 4%.
- It was noted that the performance of NWAS is measured on times; not on patient outcomes. Data based on patient outcomes is currently not available for NWAS. From an NWAS perspective, currently a successful outcome is when the GP or hospital has accepted the referral. It is planned for data on outcomes and whether the intervention was successful to become available in the future.
- There is anecdotal evidence that, particularly during daytime hours, some patients are more likely to ring the ambulance service because they cannot get a GP appointment.
- Members were informed that a greater emphasis should be placed on preventative measures, such as reducing the risk of falls. Greater attention should be given to reducing the level of risk in the home, especially for people who live alone.
- Members were told that there continue to be too many admissions of frail elderly people, especially from care homes. There was anecdotal evidence that clients are more likely to be admitted to hospital from some care homes than from others. In addition, there is an apparent tendency with some homes for a patient to be admitted to hospital and then the home arguing that they are no longer able to care for the patient as their acuity level has increased.
- A representative of the third sector commented:

  "There is a danger of disinvesting in services which are currently preventing people from going into hospital. The optimal approach is to avoid people getting into hospital through more effective prevention strategies".

4.3.2 Integrated Care Coordination Hub (ICCH)

What the Members welcomed:

- In the future, it is planned that the Integrated Care Coordination teams will provide wrap-around services to keep the client at home and thereby close the revolving door of repeated admissions to hospital. It is accepted that admission prevention needs to be strengthened to keep people out of hospital. The multi-disciplinary approach being developed within the Integrated Care Coordination Hubs is welcomed by Members.

Where the Members found challenges:

- Resources for the Integrated Care Coordination Hubs have, to date, been limited. Time will be needed to enable them to grow and manage people with complex needs effectively. To date, the work of the Integrated Care Coordination Hubs has been predominantly reactive. However, it is intended that the work will become more proactive by becoming more sophisticated in engaging effectively with GPs. This relates to better use of data in order to identify those people who are most likely to benefit from early intervention.
- The number of referrals from GPs to the Integrated Care Coordination Hubs is few but it is recognised as a priority for future development.
- Members were informed that there are currently adequate resources to coordinate reactive cases. However, for the more proactive work the capacity is not yet available. It was suggested that involvement of mental health professionals in the hubs would be a positive development in the future.

4.3.3 Access to services for GPs

What the Members welcomed:

- A service index has been developed which is easy for GPs to access. The introduction of the single point of access should also make it easier for GPs to refer in to any of the community-based services.
- A series of meetings have been held to discuss ways in which the Community Trust and GPs could work better together. The aim is specifically to encourage GPs to refer more patients to community services rather than to WUTH. In addition, the Urgent Care Recovery Group monitors a dashboard relating to emergency admissions by GP practices.
- Members were informed that the primary care Quality Outcomes Framework (QOF) exists to give financial incentives to practices in order to achieve pre-determined goals. This includes reducing non-elective admissions and reducing the level of prescribing. Therefore, GPs are being encouraged to look at how they manage patients and achieve quality outcomes.

Where the Members found challenges:

- The increased use of alternative community-based services, as an alternative to sending patients to A&E, is dependent on the full engagement of GPs. This requires behavior change, which can be very difficult. Although some GPs are champions of change, many practices have very high workloads. As demand is great and there is much face-to-face clinical contact it is often difficult for GPs to attend meetings.
- The engagement of GPs in the provision of the new service models was widely viewed as key to the successful delivery of the programme to enhance the use of community-based services. Doctors are held in high esteem by many residents and patients. It is, therefore, important that GPs give advice to patients which includes alternatives to bed-based services.
- Wirral GP Out of Hours service, managed by Wirral Community Trust, provides emergency medical care to patients who are unable to wait for their GP practice to re-open. Although the use of local doctors by the GP Out of Hours service is encouraged it cannot be guaranteed. Therefore, local knowledge can be lost.

4.4 Non-elective stays in hospital

4.4.1 Unplanned admissions

What the Members welcomed:

- The Better Care Fund sets a target of an annual 3.5% reduction in unplanned acute hospital admissions. During 2015/16, this target was achieved with a reduction by 5% in non-elective admissions. However, this is not all good news because during the same period there has been a 4.2% increase in A&E attendances. In addition, those patients who need to be admitted are costing more as the number of complex cases, particularly among older people increases. This has led to continuing financial challenges across the health economy.
- Commencing in December 2015, a single front-door to A&E has been developed whereby experienced staff triage patients on arrival at A&E and, if appropriate, patients are sign-posted to alternative services. As a result, between December 2015 and March 2016, 420 patients were re-directed to alternative services such as a GP surgery or the Think Pharmacy service.

Where the Members found challenges:

- Although there has been an overall reduction of 5% in non-elective admissions, further work is needed to monitor funding, staffing and activity in order to provide better data to demonstrate where the difference is coming from. As a number of complimentary services have been introduced or enhanced on a similar timescale, the direct impact of each individual service is not easy to monitor.
- Members were informed that next-day appointments at an acute hospital may be a feasible pathway for some patients. If a patient requires hospital intervention, it may be better for the patient to be given a next-day appointment rather than them being sent to A&E and potentially having an overnight stay.
- It was reported that there has been a significant increase in the number of arrivals by ambulance. The new 111 service was implemented in October 2015. Since that time, the number of patients delivered to A&E by ambulance had increased significantly compared to the same period last year. Further work is taking place to understand the reasons behind that increase in arrivals by ambulance, given the introduction of the Paramedic Pathway described earlier.

4.4.2 The Discharge process

What the Members welcomed:

- A significant amount of work has taken place to review and improve the discharge process. Members were informed that there is now a much better relationship with partners and that there have been significant improvements in the awareness of ward staff regarding the mechanisms to follow in facilitating speedy discharge.
- In recent months, there has been an improved rate of weekend discharge; albeit still lower than the weekday rate of discharge. This has been facilitated by enhancements such as the ability for care packages to restart at the weekend and also for funding arrangements to be agreed at the weekend.
- The introduction of the SAFER patient bundle flow on specific wards at Wirral University Teaching Hospital has shown promising results. In particular, the drive to ensure more discharges before mid-day is having a positive effect. All Safer wards are hitting the targets for discharge by lunchtime. Key to this development is earlier preparation, preferably the previous day, of take home medication. The process is monitored by the daily board rounds, which include a presence from pharmacy.
- It is noted that closer working is also being developed between the acute hospital trust and the Integrated Care Coordination Teams, who particularly provide support to patients who are discharged with complex needs. A robust plan can then be placed around the client to prevent readmission.

Where the Members found challenges:

- Although the proportion of delayed discharges in Wirral is one of the best in the North West, the actual target is still not met. Average monthly bed days lost due to delayed transfers of care per 100,000 population has increased from 79.3 days in 2014-15 to 93.6 days in 2015-16. However, Wirral does remain 3rd best in the Northwest region in terms of delayed transfers of care. Work continues through the Urgent Care Board to review the systems and processes to achieve more timely and appropriate discharges. Members were told that earlier planning for discharge is likely to provide the key to reducing delays.
- Members were informed that practicalities can cause delays to the discharge process, for example, the provision of a Keysafe. As home care providers will not hold a key, access to a property may not be available until the Keysafe is fitted. A further example of delays can relate to waiting for furniture to be moved, such as a bed to be taken downstairs. It was reported that adaptations, such as the fitting of a stair lift can take a significant period to install. Delays were also reported in the discharge of patients from intermediate care beds caused by waiting for minor adaptations, such as the fitting of a grab rail or the provision of equipment.
- It is sometimes the case that providers respond quickly to set up a care package but families can reject the package or equipment is not ready to enable the patient to be discharged from hospital. During the review, Members were told that a man was recently discharged but the equipment, such as a hoist and a commode, were not available from hospital. As he could not be safely handled at home, the man had to be readmitted to hospital for a further two and a half days.
- Members were informed that there can be communication issues between wards and other departments within the hospital as the discharge processes are complex.
- There continues to be anecdotal evidence relating to discharge delays being caused by the availability of medication at the time of the patient's discharge from hospital to an IMC bed. In particular, this was reported as "a fairly common" occurrence by the care home providers. Members were informed that a working group was reviewing the provision of pharmacy medication.
- The development of the Integrated Discharge Team process has been recognised as a high priority because it is understood that, in the past, the discharge process has not worked as well as it might, with a significant amount of paperwork being required.
- Feedback from carers representatives suggest that some delays to discharge are caused, at least in part, by waits for assessments and subsequently the availability of care packages.
- It was pointed out that living alone can be a factor in the discharge process because of little potential support being available at home.

4.5 Discharge and step-down services in the community

4.5.1 Relationship between Discharge and Intermediate care homes - IMC (including bed allocation)

What the Members welcomed:

- It was confirmed that, prior to the new contract in April 2015, the care home manager was able to assess the patient in hospital to confirm that the placement was appropriate. However, that assessment was removed from the process as it was responsible for delaying some discharges. The decision is now taken by the Intermediate Care Duty Nurse and therapist.
- Members were told that a placement will be made hopefully within hours although on occasions it may take longer. Members were reassured to hear that, where possible, if a patient or a relative requests a specific location for an IMC placement the request will be met if at all possible.

- The relationship between the Intermediate Care Duty team and the Integrated Discharge Team at Arrowe Park was described as robust and improving but "not confrontational", given an understanding that the hospital is often operating under extreme pressure to discharge patients efficiently, effectively but when safe to do so. Members were told that a more integrated and robust relationship would continue to be developed between the Intermediate Care Duty team and the Integrated Discharge Team.

Where the Members found challenges:

- Some concern was expressed by care home proprietors that, at the time of a patient being discharged from hospital to an Intermediate care Home bed, either incomplete or inaccurate information were sent to the home regarding the patient's medical condition. However, subsequently members were informed that an electronic form, based on the Millennium system, had been implemented. Members were reassured that it is now less likely that relevant information will not be passed to the care home.
- Members were informed that the majority of clients in IMC beds have been discharged from hospital, although some cases are admissions from the community in order to avoid admission to hospital. Although Members had been informed that, on occasions, access to IMC beds for the Rapid Community Support team had proven problematical, reassurances were given that the community-based pathway is robust.
- There were suggestions that the pressure from Arrowe Park to discharge patients can create pressure for "inappropriate placements". Examples of such placements included patients with high cognitive impairment and some end of life patients. Some clients in IMC beds were described as "heavily dependent complex people". Concerns were expressed that this can lead to a higher risk of falls, which means client safety is difficult to ensure.

  "There continues to be significant pressure for speedy discharge from Arrowe Park".

  "Arrowe Park is under a lot of pressure to discharge patients. The hospital is aware that IMC beds are available and that the criteria for the use of transitional beds are wide".

4.5.2 Staying in an Intermediate Care Home (IMC)

What the Members welcomed:

- Members welcome the principle of enabling patients to readjust to their new circumstances by the free provision of intermediate care beds for up to 6 weeks, supported by a care plan and on-site therapists. The aim of the IMC service is for the client, at the end of the stay, to be ready to go home and continue to live relatively independently.
- On arrival, the IMC client will be assessed within 24 hours and a treatment plan will be developed. The progress of a client is discussed in a weekly multi-disciplinary meeting, which includes therapist and social worker reports. Therefore, any potential problems with discharge should be flagged up in advance.

Where the Members found challenges:

- The quality of provision of commissioned services has been raised throughout this scrutiny review. This issue has been raised on numerous occasions outside the evidence-gathering sessions, for example, at WUTH's Quality Summit and as a result of work carried out by Healthwatch. The issue is also highlighted by the outcome of CQC inspections. Four of the five homes currently commissioned to provide the IMC service have been assessed using CQC's new assessment regime and all four have been rated as 'Requires Improvement'.
- There was evidence from care home providers that some clients have been through the IMC bed cycle more than once during the previous year because they had been e-admitted to hospital, resulting in "a revolving door".

4.5.3 Post-hospital Community Services

What the Members welcomed:

- There have been only a very small number of cases when it has not been possible to facilitate community support in the required timescale.
- Members welcome the range of community-based services which are available across the borough, such as domiciliary care and reablement, Mobile Nights, the Helping People Home service and the Home from Hospital service. However, Members are also conscious of the difficulties for providers in recruiting and retaining staff with appropriate skills. It is essential that suitable working conditions and salaries are developed.
- As sicker people are now being cared for in their own homes, there is an increased risk of accidents and incidents at home.
- Members heard that it is becoming increasingly beneficial for the domiciliary care providers to develop relationships and shared work agreements with district nurses in order to jointly plan care. In particular, this can help to focus on skin care and pressure ulcers.
- Domiciliary care providers confirmed that there are very few requests from the commissioner for fifteen minute visits. It was also confirmed that when they do occur it will usually be as part of a wider package.
- It is the intention to not have a waiting list for community-based services. This was corroborated by care home providers who agreed that the availability of care packages for clients leaving an IMC bed was considered to be acceptable.

Where the Members found challenges:

- There is a general understanding that clients now being cared for in the community are often sicker and more complex cases. Consequently, the care plans for such clients are often more complicated to put in place. The manager of a service provider informed members:
  "The level of need and complexity of those being supported at home is far higher than it was even just 5 years ago".
- Although the current clients are older people there is a possibility of expanding the Mobile Nights service in the future to cover people with disabilities rather than paying someone to stay overnight.
- It was reported that the community-based service providers have detected an increasing demand for such services. As a result, it is becoming more difficult to recruit staff, particularly for night-time work.
- A suggestion was made that the Home from Hospital scheme could be expanded to provide a role in preventing admissions as well as its current role in providing support to discharged patients.

4.6 Specialist Requirements

4.6.1 End of Life Care

Where the Members found challenges:

- Criticism of WUTH's end of life processes were highlighted in the Care Quality Commission report which emanated from the inspection which took place in September 2015. Members were informed that an action plan is being created which will show separate pathways for those patients at end of life (for example, with hours or days of expected life) and those patients undertaking palliative care who have a longer life expectancy in the range of 3 to 6 months. Although, in the past, WUTH has combined the two into a single pathway, two separate pathways will be developed in the future.
- Members were informed that a small number of end of life clients have, in the past, been allocated to the IMC beds, despite an IMC bed being not seen as an appropriate placement for an end of life client.

4.6.2 Dementia and mental health

What the Members welcomed:

- The members welcomed that the Better Care Fund has been able to fund four dementia outreach nurses. In particular, the 2 nurses based at Arrowe Park work to facilitate early discharge and provide support to the individual to avoid readmissions.
- Third sector partners, such as Alzheimer's Society, provide a range of services aimed at keeping people with dementia living in the community for as long as possible. Examples include the dementia cafes and the new Side by Side project.
- The successful introduction of the street triage scheme, with mental health specialists working alongside the police, to identify and support patients with mental health issues is warmly welcomed.

Where the Members found challenges:

- Members were informed that admission avoidance often depends on the support network of the family. There is statistical evidence to show that people with dementia are more likely to be admitted to A&E as, in a crisis, some simply cannot manage. A service manager told members:

  "The truth is that there is little support available in the community (for people with dementia".
- Stays in hospital for people with dementia are typically longer than for other patients. The Alzheimer's Society Report, 'Fix Dementia Care – Hospitals', issued in January 2016, states that "on average, people with dementia in hospital stay more than twice as long as other patients aged over 65". The report also states that at least 25% of hospital beds are occupied by people with dementia. As people with dementia are slower to discharge, many can become more disabled quickly as they become de-skilled. For those with lengthy stays the consequences can be to become increasingly de-skilled and, as a result, needing to go into full-time care.
- It was reported that there is a shortage of one-to-one support for early intervention provision to prevent the onset of crises, specifically aimed at supporting people in their own homes and preventing admission to hospital.
- There is a perception that there are some residential homes who feel that they cannot cope with people with dementia. Therefore, once a person is admitted into hospital there can be a tendency for the home to say that they can no longer meet the person's needs.
- Members were told that there is a shortage in provision for people with dementia with complex needs, for example, those patients with challenging dementia. The specific dementia ward commissioned by Cheshire & Wirral Partnership Trust, is reserved for challenging and complex cases; clients often displaying aggressive behavior. In general, EMI nursing homes are not equipped to cope with such patients. This has resulted in having to look further afield for available beds.

Appendix 1: Scope Document for the Avoiding Admissions Scrutiny Review (Final version)

1. Contact Information:	
Scrutiny Panel Chair: Cllr Moira McLaughlin moiramclaughlin@wirral.gov.uk **Panel members:** Cllrs Bruce Berry bruceberry@wirral.gov.uk Alan Brighouse alanbrighouse@wirral.gov.uk Treena Johnson treenajohnson@wirral.gov.uk Denise Roberts deniseroberts@wirral.gov.uk Karen Prior, Healthwatch Wirral Karen.prior@healthwatchwirral.co.uk	**Scrutiny Officer(s):** Alan Veitch 0151 691 8564 alanveitch@wirral.gov.uk **Departmental Link Officers:** Jacqui Evans (Head of Transformation, DASS) 0151 666 3938 jacquievans@wirral.gov.uk
Other Key Contacts: Andrew Cooper (Head of Strategy and Outcomes, Wirral Clinical Commissioning Group)	
2. Review Aims:	
Which Wirral Plan Pledge does this review relate to? This review will support the Wirral Plan Pledges: • 'Wirral residents to live healthier lives' • 'Older people live well'	
What are the main issues? • Understand the demand for both acute and community based services in Wirral • Understand the reasons for the increased demand for admission to acute services • Assess the levels of readmissions and unnecessary admissions to acute services • Appreciate the mechanism for the allocation of funding • Understand the services that are already in place or being planned • Assess whether the resources and capacity are available to support the service provision • Consider whether the transition from acute to community based services is achievable within a realistic timescale • Consider whether community based services are provided on a person-centred basis	
The Panel's objectives in doing this work: • To understand the current position regarding admissions to acute services • To understand the actions being taken to divert service provision towards community based services in order to reduce the demand for acute hospital services. • To understand the impact that the transition away from acute services towards community based services may create	

The desired outputs/outcomes:

- an assessment of the current service provision in relation to the current and planned demand for services
- a view on the Wirral health economy's ability to respond to increasing demand for services
- an indication of any perceived gaps in service provision

an appraisal of the effectiveness of decision-making in order to prioritise resources on an economy-wide basis

What specific value can scrutiny add to this topic?

Scrutiny will give members the opportunity to gain assurance that adequate plans are in place to further develop community-based services with the aim being to reduce admissions to acute hospital. Members will also be able to assess the effectiveness of the integration of social care and health and also the ongoing partnership working.

3. Review Approach

How will the Panel engage with the Executive?

The scope document will be shared with the relevant portfolio holder at the start of the review, requesting any comments. The draft report will also be discussed in advance of being finalised by the task & finish group, before being presented to the Families and Wellbeing Policy & Performance Committee for approval.

Who will the Panel be trying to influence as part of its work?

- Appropriate Cabinet members
- Senior Leadership Team, Wirral Borough Council
- Health partners, in particular Wirral Clinical Commissioning Group

Duration of review?

Aim to complete the review by January 2016

Extra resources needed? Would the investigation benefit from the co-operation of an expert witness?

The review will be conducted by councillors with the support of existing officers, from within the Council and external partners as appropriate. Healthwatch Wirral has offered to provide feedback from patient / public input during Healthwatch Week (9th – 13th November)

4. Sources of Evidence:

Secondary information (background information, existing reports, legislation, central government documents, etc).

- Relevant Committee reports / briefing papers
- Relevant Government reports
- Briefing papers provided by national bodies, for example, NHS England, Kings Fund, LGA, LGiU
- Reports from other Councils relating to the same topic
- Outcomes from Wirral Care Model public engagement process
- Outcomes from Questionnaire re Urgent Care (due in Nov 2015)

Primary/new evidence/information

- Interviews with key officers from the Council, partner organisations and service user representatives
- Documentation regarding current processes, services and funding arrangements. This will include:
  - Funding streams and how the money is allocated
  - Statistics and the monitoring process relating to admissions, avoidable admissions and re-admissions
  - Capacity in the system
  - The process to determine appropriate services for a patient
- Healthwatch to acquire patient / public input during Healthwatch Week (9th – 13th November 2015) and provide feedback on the findings prior to January 2016

Who can provide us with further relevant evidence? (Cabinet portfolio holder, officer, service user, general public, expert witness, etc).

Sessions to include:

- Jacqui Evans (Head of Transformation, DASS, Wirral Borough Council)
- Andrew Cooper (Head of Strategy and Outcomes, Wirral Clinical Commissioning Group)
- Chris Oliver (Director of Operations, Wirral University Teaching Hospital)
- Jackie Howard (Deputy Director of Operations, Wirral University Teaching Hospital)
- Possible visit to A&E, Medical Assessment Unit and Pull Team at Wirral University Teaching Hospital
- Rapid Community Service at Wirral University Teaching Hospital
- Possible visit to Integrated Care Coordination Hubs (Eastham), via Jason Oxley (DASS) and Val McGee (Wirral Community Trust)
- Val McGee, Wirral Community Trust
- Suzanne Edwards, Cheshire and Wirral Partnership Trust
- Jason Oxley, DASS, Wirral Borough Council
- North West Ambulance Service
- Dr Paula Cowan, GP Lead for Unplanned Care
- Domiciliary care providers (via Julie Walker)
- Reablement service providers (via Julie Walker)
- Third sector representatives, for example, Age UK (Home from Hospital)
- Patient Voice Group (via Andrew Cooper)
- Carers Partnership Forum (via Carol Jones, DASS)
- Intermediate care home providers (via June Walsh)
- Integrated Discharge Team (via Jason Oxley / Sarah Alldis)
- Representatives of front-line staff, including community workers and social workers
- Healthwatch Wirral

What specific areas do we want them to cover when they give evidence?

- How effective are current and planned services?
- Suggestions for any improvements?
- How person-centred is the local approach to service provision?
- Are any funding priorities causing perverse outcomes?

What processes can we use to feed into the review? (site visits/observations, face-to-face questioning, telephone survey, written questionnaire, etc).

- Meetings with witnesses as listed above
- Desktop analysis / research
- Appropriate site visits

In what ways can we involve the public and at what stages? (consider whole range of consultative mechanisms, local committees and local ward mechanisms).

- Service user representatives will be included in the interviews
- Advocacy agencies such as Healthwatch Wirral will also be involved in the review. Healthwatch will provide feedback from the patient / public input which is due to take place during Healthwatch Week (9th – 13th November)

Should we involve the Press & Public Relations Team at any stage of the review? (Homepage news release, press releases etc)

The scope document will be sent to the press office on approval.

The Panel has employed the following methods to gather evidence:

5.1 Meetings

A series of individual meetings has taken place at which the Scrutiny Panel Members could discuss relevant issues with the following:

- Thursday 1st October 2015
  Jacqui Evans (Head of Transformation, Department of Adult Social Services, Wirral Borough Council)
  Andrew Cooper (Head of Strategy and Outcomes, Wirral Clinical Commissioning Group)

- Wednesday 14th October 2015 – Rapid Community Support, Claughton Medical Centre
  Anne Cartwright (Manager, Integrated Community Commissioning Team, Wirral Community Trust)
  Maggie Johnson (Manager, Rapid Community Service)
  Sharon Barry (Nurse Practitioner, Rapid Community Service)

- Monday 2nd November 2015 – Grove House care home, Claughton
  Simon Shaw (Manager, Grove House care home)
  June Walsh (Market Transformation and Contracts Lead, DASS, Wirral Borough Council)

- Monday 2nd November 2015 – Daleside care home, Rock Ferry
  Kate Armstrong-Shone (Proprietor, Daleside care home)
  June Walsh (Market Transformation and Contracts Lead, DASS, Wirral Borough Council)

- Monday 2nd November 2015 – Hoylake Cottage care home, Rock Ferry
  Lynn Cooke (Manager, Hoylake Cottage care home)
  June Walsh (Market Transformation and Contracts Lead, DASS, Wirral Borough Council)

- Monday 9th November 2015 – Integrated Care Coordination Hub, Eastham
  Jason Oxley (Acting Head of Delivery Services, DASS, Wirral Borough Council)
  Anne Cartwright (Manager, Integrated Community Commissioning Team, Wirral Community Trust)
  Helen Lundy (Manager, Integrated Care Coordination Hub, Wallasey)
  Jeanette Hughes (Acting Senior Manager, DASS, Wirral Borough Council)

- Wednesday 18th November 2015 – Wirral Community Trust
  Val McGee (Director of Integration and Partnerships, Wirral Community Trust)

- Thursday 19th November 2015 – Admissions Prevention team
  Karen Thomas (Manager, Admissions Prevention team, DASS, Wirral Borough Council)

- Thursday 19th November 2015 – Lead GP for unplanned care
  Dr Paula Cowan (Lead GP for Unplanned Care, Wirral Clinical Commissioning Group)

- Monday 30th November 2015 – Domiciliary care providers (Local Solutions, Mears Care plus Amanda Kelly (Senior Manager, Market Transformation and Contracts, DASS, Wirral Borough Council
  Julie Walker (Market Transformation Lead, DASS, Wirral Borough Council)
  Paula Bell (Director, Local Solutions)
  Jenny Smedley (Project Manager, Local Solutions)
  Simon De Brabander (Care Coordinator, Mears Care)

- Monday 7th December 2015 – Cheshire & Wirral Partnership Trust
  Suzanne Edwards (Service Director, CWP Wirral, Cheshire and Wirral Partnership Trust)

- Thursday 21st January 2016 – Age UK
  Jamie Anderson (Chief Executive, Age UK Wirral)
  Ray Collings (Senior Manager, Age Uk Wirral)
  Claire Thomson (Home from Hospital Coordinator, Age UK Wirral)

- Monday 25th January 2016 – North West Ambulance Service
  Paul Walton (Urgent Care Development Area Manager, Cheshire & Merseyside, North West Ambulance Service NHS Trust)

- Thursday 11th February 2016 – Visit to Wirral University Teaching Hospital at Arrowe Park
  Amanda Farrell (Divisional Director, Medical & Acute Specialties Division, Wirral University Teaching Hospital)
  Dr Ranj Mehra (Divisional Medical Director, Medical & Acute Specialties Division, Wirral University Teaching Hospital)
  Holly Middleton (Head of Urgent Care, Medical & Acute Specialties Division, Wirral University Teaching Hospital)
  Helen Morris (Matron, Wirral University Teaching Hospital)
  Alison Quinn (Clinical Lead, Integrated Discharge team, Wirral University Teaching Hospital)
  Becky Mazier (Deputy Manager, Integrated Discharge team, Wirral University Teaching Hospital)

- Monday 15th February 2016 – Carers
  Pat Ward, Judith Varley, Jenny Ebb, Peter Sampson, Edwin Stanley, Joan Stanley

- Monday 15th February 2016 – Alzheimer's Society
  Sue Newnes (Services Manager, Alzheimer's Society Wirral)

- Wednesday 23rd March 2016 – Patient Voice Group representatives
  Wendy Sheen, David Bowe, Terry Sullivan, Philip Barton
  (Note: All Patient Voice representatives attended the meeting in a personal capacity and were not representing the views of their Patient Representative group or other Patient Voice members).

5.2 Written Evidence

The Review was also informed by written evidence including committee reports, Government documents and briefing papers from officers.

APPENDIX 3 - RECOMMENDATIONS

Governance and funding

Recommendation 1 - Developing one system with shared governance
Wirral will move to be an Accountable Care System by 2020 in line with national requirements. Wirral Clinical Commissioning Group, in conjunction with all partners are encouraged to continue to strengthen the culture of collaboration and partnership working which will lead to the ultimate development of a single health and care system for Wirral, the achievement of which will require a single pooled budget. This will require the establishment of appropriate governance arrangements with clear lines of responsibility and accountability and robust pathways minimising duplication. Opportunities should be taken to achieve incremental steps towards achieving an Accountable Care System by 2020 and report on progress to scrutiny on an annual basis.

Recommendation 2 – Funding of acute hospital services
In order to further develop services in the community, Wirral Clinical Commissioning Group and partners are requested to continue to explore the opportunities arising from commissioning within a cost envelope as an alternative to the Payment by Results tariff model.

Service quality

Recommendation 3 – Service quality and a person-centred approach for community services
The Director of Adult Social Services and Wirral Clinical Commissioning Group, as commissioners of community services, are requested to ensure that adequate system capacity, service quality and a person-centred approach are embedded within all such contracts. An effective monitoring measure of the integrated care system should continue to be developed, appropriate to the changing commissioning structures.

Developing the right services

Recommendation 4 – Admission prevention
Wirral Clinical Commissioning Group and Wirral Borough Council, as commissioners of services, will continue to further develop the concept of preventative services to reduce unplanned admissions through the improved outcomes of public health initiatives, the development of robust community services and the encouragement to promote self-care. Annual feedback is requested from the Joint Strategic Commissioning Group.

Recommendation 5 – Promotion of community services
Wirral Clinical Commissioning Group and Wirral Borough Council, as commissioners of services, will place greater emphasis on promoting community services among the public and professionals. Increased priority will also be given to changing the awareness and behaviours of the public and professionals in order to encourage greater usage of the range of services aimed at preventing unplanned hospital admissions.

Recommendation 6 – Implementation of alternative referral pathways
Wirral Clinical Commissioning Group and Wirral Borough Council, as commissioners of services, will work with all service providers, including North West Ambulance Service, the 111 service and GPs, in order to ensure full engagement in the new referral pathways.

Recommendation 7– Responding to changing requirements for services
Wirral Clinical Commissioning Group and Wirral Borough Council, as commissioners of services, will ensure that community services are introduced on the basis of best practice, insight and analysis of need. This will ensure that services will remain responsive to changing community needs, reinforced by the use of formal contract mechanisms to expand or reduce contracts as appropriate.

Recommendation 8 – Communication of data
The Healthy Wirral programme's work to improve the communication of patient data between health and care providers in order to create a single patient record is fully endorsed. The Wirral Care Record will ensure that the use of the single patient record is spread to as many providers as possible at the earliest opportunity. Feedback on the implementation and the impact of the Wirral Care Record is requested to a future meeting of the People Overview & Scrutiny Committee.

Evaluating the effectiveness of services

Recommendation 9 – Performance management of community services
Wirral Clinical Commissioning Group and Wirral Borough Council, as commissioners of services, will give a high priority to the effective performance monitoring of the various community services, including the use of both qualitative and quantitative data. The monitoring will include performance comparisons with geographical and statistical neighbours. Opportunities will also be explored to report across organisations in an integrated way and consideration will be given to the wider role of scrutiny across partners.