

# Liverpool

## Local system review report Health and Wellbeing Board

Date of review:  
19 to 23 February 2018

### 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 for 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 the Care Quality Commission (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: Rebecca Gale, CQC

The team included:

- One CQC Strategy lead
- One CQC Chief Inspector
- One CQC Planner
- One CQC Analyst

- Two CQC Inspectors
- One CQC Senior Equality, Diversity and Human Rights Officer
- One CQC Public Engagement Manager
- One CQC Expert by Experience; and
- Four Specialist Advisors (one former Director of Adult Social Services, one current Director Adult Social Services and two Clinical Commissioning Group Governing Body members).

## 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 interfaces between social care, general medical practice, acute and community health services, and on 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 their 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 asked the questions:

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

We then looked across the system to ask:

- Is it well led?

Prior to visiting Liverpool, 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 asked the local area to provide an overview of their health and social care system in a bespoke System Overview Information Request (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 tool to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care.

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 people who use services, their families and carers. The people we spoke with included:

- System leaders from Liverpool City Council (the local authority), NHS Liverpool Clinical Commissioning Group (the CCG), Royal Liverpool and Broadgreen University Hospitals NHS Trust (RLBUHT), Aintree University Hospitals NHS Foundation Trust (AUHT), St Helens and Knowsley Teaching Hospitals NHS Trust (STHK), Liverpool Community Health NHS Trust (LCHT), Mersey Care NHS Foundation Trust (MCFT), Urgent Care 24 (UC24 - the out of hours GP provider), North West Ambulance Service NHS Trust (NWAAS), the Health and Wellbeing Board (HWB) and the Council's Social Care and Health Select Committee.
- Health and social care professionals including social workers, GPs, discharge teams, therapists, nurses and commissioners
- Healthwatch Liverpool, voluntary, community and social enterprise (VCSE) sector services, independent care providers (nursing homes, residential homes and domiciliary care agencies), the out of hours GP provider (UC24) and GPs
- People using services, their families and carers at the Liverpool Carers Centre, the Service User Reference Group (SURF) and Making it Happen group. We also spoke with people in A&E and hospital wards as well as managers and providers of residential and intermediate care facilities.

We reviewed 21 care and treatment records and visited 14 services in the local area including acute hospitals, intermediate care facilities, care homes, nursing homes, domiciliary care providers, GP practices, walk in centres and voluntary sector run activities.

## The Liverpool context

### Demographics

- 14% of the population is aged 65 and over.
- 89% of the population identifies as white.
- Liverpool is in the top 20% bracket of most deprived local authorities in England.

### Adult social care

- 49 active residential care homes:
  - One rated outstanding
  - 35 rated good
  - 10 rated requires improvement
  - One rated inadequate
  - Two currently unrated
- 41 active nursing care homes:
  - 16 rated good
  - 15 rated requires improvement
  - Six rated inadequate
  - Four currently unrated
- 72 active domiciliary care agencies:
  - Two rated outstanding
  - 34 rated good
  - 11 rated requires improvement
  - 25 currently unrated

### GP Practices

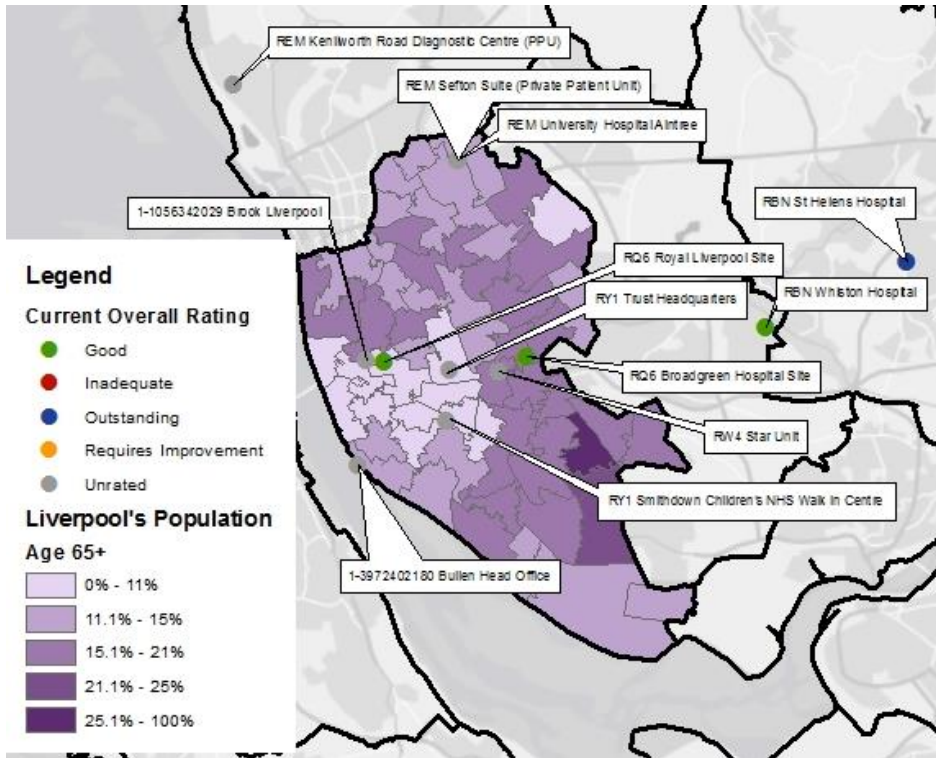
- 88 active locations
  - Two rated outstanding
  - 76 rated good
  - Three rated requires improvement
  - Seven currently unrated

### Acute and community healthcare

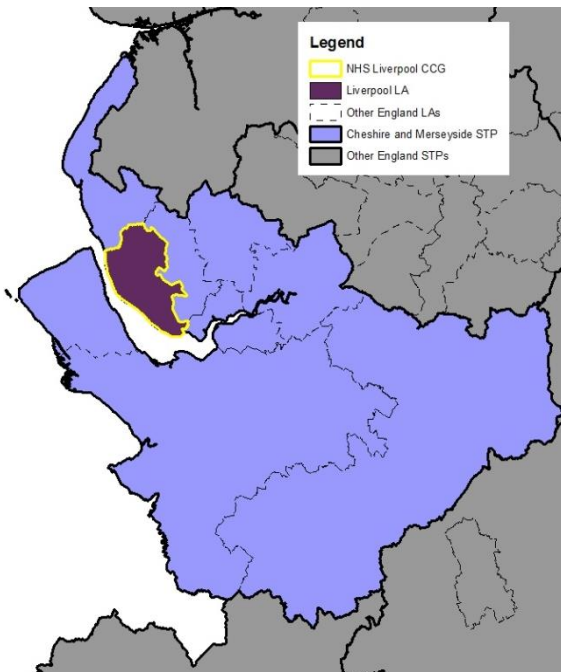
Hospital admissions (elective and non-elective) of people living in Liverpool are found at the following trusts:

- Royal Liverpool and Broadgreen University Hospitals NHS Trust
  - Received 61% of admissions of people living in Liverpool
  - Admissions from Liverpool make up 70% of the trust's total admission activity
  - Rated good overall
- Aintree University Hospital NHS Foundation Trust
  - Received 26% of admissions of people living in Liverpool
  - Admissions from Liverpool make up 32% of the trust's total admission activity
  - Rated requires improvement overall
- St Helens and Knowsley Hospital Services NHS Trust
  - Received 11% of admissions of people living in Liverpool
  - Admissions from Liverpool make up 9% of the trust's total admission activity
  - Rated good overall
- Community services are provided by Mersey Care NHS Foundation Trust, rated good overall

*GP and adult social care ratings as at 08/12/2017, hospital ratings as at 25/04/2018. Admissions percentages from 2016/17 Hospital Episode Statistics.*



Map 1 left: Population of Liverpool shaded by proportion aged 65+ and location and current rating of acute and community NHS healthcare organisations serving Liverpool.



Map 2 right: Location of Liverpool LA within Cheshire and Merseyside STP. NHS Liverpool CCG is also highlighted.

## Summary of findings

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

- We found that there was a clear strategic direction for health and social care, focused on the city of Liverpool. We also found that system leaders demonstrated a commitment to work with wider partners where it would be appropriate to meet the needs of the local population.
- Liverpool sat within the Cheshire and Merseyside Sustainability and Transformation Plan (STP) footprint, but this was not driving the future direction for the city, as partners felt the footprint was too diverse to capture the needs of Liverpool as a city. However, leaders were committed to a joint approach where there were benefits for Liverpool residents.
- In 2013 the Mayoral Commission made a recommendation for place-based, community care in Liverpool. Out of this was borne the *Healthy Liverpool* strategic plan, led by Liverpool Clinical Commissioning Group (the CCG). At the time of our review, this was undergoing a refresh, underpinned by a robust Joint Strategic Needs Assessment and a commitment by system leaders to address the wider determinants of health. Liverpool faces significant health inequalities and several public health indicators were considerably worse than the national average. System leaders demonstrated a clear intent to address these within the refreshed strategy, *One Liverpool*. This was in the early stages of development, so the shared strategic vision for the city needed to be translated into a jointly-owned deliverable plan and include a shared understanding among system partners about their roles and responsibilities in achieving it.
- The Liverpool Health and Wellbeing Board (HWB) provided challenge on the strategic direction for Liverpool and the Social Care and Health Select Committee was well-informed and provided a high-level of scrutiny in response to specific issues. The newly established Shadow Liverpool Integrated Care Partnership Group (LICPG), reporting into the HWB, provided tactical leadership to drive forward implementation of the strategic vision and address system challenges. Established in shadow form in November 2017, it brought together system leaders to lead on the development of an integrated health and social care system. At the time of our review, both the HWB and LICPG shared the same chair. However, it was intended the LICPG would be chaired separately soon. We were advised that a report would be received by the HWB in June 2018 recommending the formal establishment of the LICPG which would include a review of the chairing arrangements. We were assured by system leaders that each group had clearly defined roles and responsibilities and there was no risk of duplication.

- Provision for community health in Liverpool was due to be taken over by Mersey Care NHS Trust in April 2018. While the CCG had engaged the current and future community trusts in the neighbourhood model, it needed to further engage with the acute sector to include and strengthen its involvement and contribution. In addition, clarity in respect of the GP federation was needed to ensure it had a clear remit, forming a unified voice for the sector that could clearly articulate the collective offer.
- There was no system-wide workforce strategy or workforce planning. While there were pockets of innovation, these were not coordinated across the system. These need to be developed at pace to ensure there is alignment with *One Liverpool* and that resources are deployed in the most efficient way to support the transformation model.

#### **Is there a clear framework for interagency collaboration?**

- Liverpool had faced significant financial and system leadership challenges in recent years and this had been a barrier to truly integrated working. Relationships were improving at the time of our review and system leaders demonstrated a clear commitment to work more closely together to achieve better outcomes for people. It will be imperative for the system to work to embed improvements whilst at the same time harnessing new positive relationships.
- The neighbourhood model which aimed to bring together primary care, community care, social care and mental health provided a clear framework for interagency working within defined communities. System leaders hoped that the *One Liverpool* strategy would progress the integration agenda further. The transfer of elements of Liverpool Community Health NHS Trust to Mersey Care NHS Trust would see mental health and community healthcare come together. In addition, the planned merger of Royal Liverpool and Broadgreen University Hospitals NHS Trust (RLBUHT) and Aintree University Hospitals NHS Foundation Trust (AUHT) in 2019 were all seen as positive steps to achieving true integration.
- System-wide governance structures and been recently reviewed to ensure there was robust oversight and challenge of the strategic vision and the operational delivery of the transformation agenda. However, they were not yet embedded. The Integrated Care Partnership Board and Provider Alliance, established at the end of 2017, would be responsible for delivering the *One Liverpool* plan. However, the absence of independent care providers on the Provider Alliance membership was a missed opportunity. The care home and homecare market are integral to the delivery of good care and support for people of Liverpool, so leaders need to consider these services' role in strategic planning, including market shaping.

- Aside from the Better Care Fund (BCF) and a historic section 75 agreement in relation to learning disabilities, there were no examples of pooled budgets in place for the delivery of services across the health and social care interface. While there was a will to work together and examples of collaborative working at a system level, integrated commissioning remained underdeveloped with a focus on services rather than outcomes.
- There was a shared view of risks, but no evidence of formal risk sharing between partners. The system had taken learning from previous years to build robust system resilience in time for winter 2017/18, which had achieved positive outcomes. However, there was no evidence of collective evaluation and learning from the recently published Kirkup report into the systemic failings at Liverpool Community Health NHS Trust (LCHT) between 2010 and 2014.

#### **How are interagency processes delivered?**

- Our analysis showed that Liverpool faced challenges with higher than average A&E attendances, admission rates and readmissions from care homes. There had been multi-agency responses to these challenges, such as the Care Home Improvement Strategy which aimed to improve the quality within residential and nursing home services.
- Some ambitions set out by *Healthy Liverpool* had been achieved, most notably the development of 12 neighbourhoods and integrated Community Care Teams (CCTs). The neighbourhood model provided a framework for interagency collaboration, but there was not a shared understanding of roles and responsibilities to ensure there was consistency in how they operated. There was evidence of strong collaborative working in some parts of the city and fragmentation in others, particularly in relation to the engagement of primary care in the multidisciplinary model.
- It was widely recognised that the health and social care landscape was complex and difficult to navigate. Efforts had been made in recent months to redesign and simplify the pathway out of hospital. There was an agreed system of 'Discharge Lanes' and associated pathways under each, which had been bought together under the Integrated Community Reablement and Assessment (ICRAS) model. Data provided by the system showed there had been some improvements in recent months in relation to delayed transfers of care and reablement, but it was too early to determine if these improvements had been sustained.
- There had been considerable investment in the use of technology to support people as they moved through and between health and social care services and innovative use of data in predictive analysis to help inform commissioning decisions. Many people were receiving



telehealth to support them to remain in their usual place of residence and telecare had been rolled out to care homes for remote consultations. Primary care was now part of the electronic records system and plans were in place to do the same for secondary care.

- Mechanisms to work with voluntary, community and social enterprise (VCSE) sector organisations needed to be strengthened. Funding pressures had seen some services decommissioned and although VCSE sector organisations recognised the challenges faced by commissioners, some felt they were underutilised as wider system partners.

### **What are the experiences of frontline staff?**

- Staff we spoke with were committed, energetic and passionate about delivering high quality care to the people of Liverpool. There was a shared endeavour among staff across all sectors to work in a more integrated way.
- Staff we spoke with could articulate the future vision for the city and we saw multiple examples of effective multidisciplinary working. However, we also observed examples of where poor communication and a lack of shared understanding of services or each other's roles and responsibilities was potentially leading to unnecessary delays for people.
- Staff described the health and social care landscape as overly complex, particularly those staff working in services serving more than one CCG area with different processes and pathways. There was agreement that the 'Discharge Lanes' had gone some way to simplify the process for Liverpool, but the multiple number of services beneath them still created confusion and could be rationalised further.
- Although there had been considerable investment in technology within health and social care in Liverpool, staff continued to cite the lack of shared records as a barrier to providing truly integrated care.

### **What are the experiences of people receiving services?**

- The experiences of people using health and social care services in Liverpool varied. People were not always seen in the right place, at the right time by the right person; there were inconsistencies in commissioning and provision of services. There was some proactive monitoring of people most at risk of hospital admission, but this was not system-wide and service capacity limited the ability to be reactive. There were some services to respond to people in crisis, but if people presented at A&E they were more likely to be admitted.
- We spoke with carers at the Carers Centre and a dementia support group. They described

the system as confusing and complex and felt eligibility criteria was such that the statutory support available to them was minimal. Services such as the Carers Centre were described as a “life line” and there were some specific projects in parts of the city doing excellent work to prevent social isolation. However, these were not system-wide and available to all.

- People were not always supported to take control in making decisions about their care. The uptake of direct payments and personal health budgets was low. Carers and people we spoke with were keen to manage their own care, but there was confusion about how the system worked and they described how they had been given conflicting information.
- Performance in relation to continuing healthcare (CHC) was good. Very few people were waiting more than 28 days for assessments, which was significantly better than the England average. Furthermore, the conversion rate was higher than average meaning people referred for an assessment were more likely to meet the eligibility criteria for funding.
- Public engagement in shaping of the health and social care landscape for the future needed to be strengthened. System leaders acknowledged public engagement and involvement had fallen short of expectations, but this needed to be addressed at pace to ensure there was a bottom-up, collaborative approach to service design and delivery.

## Are services in Liverpool 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, interagency and multidisciplinary working and the involvement of people who use services, their families and carers.*

*There was a shared vision for the future for the city of Liverpool, with a clear commitment demonstrated by system partners to move towards community, place-based care, but this needed to be translated into a joint, deliverable strategy. There had been some advancement made to implement the community model, most notably with the development of 12 neighbourhoods and the multidisciplinary integrated Community Care Teams. However, this was not consistent across the system and examples of effective partnership working on the front line need to be system-wide and translated to the strategic level. We found that Liverpool had faced*

*significant financial and system leadership challenges, which had impacted on the degree to which the integration agenda had been progressed.*

*There was a commitment to involve people who use services, their families and carers in developing the future vision for the city. However, it was recognised public engagement had fallen short of expectations and system leaders needed to review how it ensured there was meaningful engagement with all stakeholders.*

### **Strategy, vision and partnership working**

- There was a shared vision for the future for the city of Liverpool, with a clear commitment demonstrated by system partners to move towards community, place-based care. Historically, relationships had been difficult and a barrier to effective partnership working and Liverpool had faced significant financial and system leadership challenges in its recent past. The local authority had experienced a 50% budgetary cut since 2010/11, health organisations were in deficit and there had been multiple changes in leadership across system partners. System leaders described how relationships were improving and were positive about the future direction of travel for the city. There were some joint posts to facilitate joint working, but these had not led to joint commissioning activities at the time of our review.
- Findings from our relational audit (there were only 67 respondents, so the sample may not be representative of all views) indicated there was a shared understanding of each other's challenges, an appreciation that each organisation contributed towards a shared purpose and that there were open and honest discussions between different stakeholders. Nevertheless, work needs to happen at organisational and system levels to embed the shared intent demonstrated by staff and stakeholders across the system and to build on improvements, particularly where there have not been pre-existing positive relationships.
- There has been a history of integrated planning across health and social care in Liverpool. In 2013 the Mayoral Health Commission recommended a neighbourhood model to deliver an integrated health and social care system. In response, *Healthy Liverpool* was developed in 2015 by the CCG in partnership with commissioners and statutory providers, and set out the strategic vision for a place-based integrated system of care. Implementation of the strategic vision had begun with the development of 12 integrated CCTs (multi-disciplinary health and social care teams) within 12 neighbourhoods across the city, increased capacity in bed-based reablement and the planned expansion of extra care housing. However, while some elements of *Healthy Liverpool* had been achieved, health inequalities within the city remained poor and healthy life expectancy had declined.

- It was widely accepted that *Healthy Liverpool* needed a refresh and a shared vision for the future needed to be developed. This shared strategy, *One Liverpool*, was in the very early stages of development and system leaders should take the opportunity to ensure this is a truly collaborative, bottom-up approach which involves providers from across the system (not just statutory providers) and meaningful engagement with the public. The care home and homecare market are integral to the delivery of good care and support for people on Liverpool, so leaders need to consider the role of these services in strategic planning.
- There had been a proactive and robust approach to building system resilience to winter pressures, overseen by the North Mersey and Southport A&E Delivery Board. Partners across the system could describe their involvement in developing a winter plan for Liverpool and there had been a collaborative approach to supporting each other in response to times of escalation within parts of the system. There was a shared view of activity and capacity across the system, enabling organisations to implement their specific ‘action cards’ and improve patient flow.
- Liverpool sat within the Cheshire and Merseyside Sustainability and Transformation Partnership (STP) footprint. We found there was a disconnect between Liverpool and the wider STP. The STP was not driving the future direction of health and social care within the city; Liverpool local system leaders were. Despite widespread concerns about the strategic approach for Cheshire and Merseyside, system leaders demonstrated a commitment to work across boundaries with wider system partners where it would have benefits for the people of Liverpool. They also recognised the role the Liverpool health system played in providing specialist services for the wider population.

### **Involvement of people who use services, families and carers in the development of strategy and services**

- As part of our review we spoke with people, families, and carers and attended a Making it Happen group and Dementia Service User Reference group (SURF) meeting. We also spoke with a number of voluntary sector organisations. In terms of their involvement in developing the strategic vision for the future of Liverpool, many described it as a “top-down” approach where they were asked to comment on proposals put to them, rather than a co-designed process. Others described how resource for communication, engagement and participation was stretched and told us the approaches to engagement needed to be reviewed. VCSE sector organisations felt they could do more to support the delivery of services and felt underutilised by commissioners.
- The response to the System Overview and Information Request (SOIR) stated that Healthwatch Liverpool facilitated public engagement about the health and wellbeing

agenda; and the Making it Happen groups formed the service user input into the Health and Wellbeing Board (HWB). Although there were mechanisms in place to obtain feedback from people, these were often focused at service or provider level. True engagement would enable local people to be active participants in service planning and delivery, by involving people at a much earlier stage and seeing their views about the entire health and social care landscape.

- System leaders were committed to involving people, their families and carers in developing the strategic approach and accepted they had fallen short in achieving effective engagement to date. It was recognised by system leaders that groups, such as Making it Happen and SURF, only reached a relatively limited number of people and at the time of our review, the local authority was in the process of reviewing and developing its engagement strategy.
- The Integrated All-age Carers Strategy was cited in the response to the SOIR as an example of how commissioners had used effective, meaningful engagement with carers to develop how their needs could best be supported by the system. In addition, the Director of Adult Social Services for Liverpool was the North West's Association of Directors of Adult Social Services (ADASS) strategic lead for carers. This experience provided a shared learning opportunity to support the development of public engagement strategies to involve and engage people in designing and shaping the future of Liverpool's health and social care landscape.
- The Joint Strategic Needs Assessment (JSNA) showed there was considerable variation across the city and the needs assessment for each of the 12 neighbourhoods showed their priorities and challenges differed. Therefore, the system needs to ensure its engagement strategy enables a flexible approach and considers how ward councillors and Locality Managers take a leadership role in public consultations.

### **Promoting a culture of interagency and multidisciplinary working**

- There was shared commitment from political leaders, system leaders and operational-level staff working within the system to develop the community model. The neighbourhood model, which aimed to bring together primary care, community care, social care and mental health care, provided a clear framework for interagency working within defined communities. System leaders said they believed that the *One Liverpool* plan would progress the integration agenda further.
- The 12 neighbourhoods set out in the *Healthy Liverpool* plan had become operational in April 2017. This saw multidisciplinary CCTs made up of social workers, therapists and

community health professionals working together to support people to remain well in the community. However, it was acknowledged by system partners that there was fragmentation with some neighbourhoods more advanced and working more effectively than others. At the time of our review this was leading to inequitable services for people in Liverpool.

- There had been considerable engagement between the CCG and the current and future community trusts in relation to the development of the neighbourhood model. Mersey Care NHS Trust was due to take over elements of LCHT which would see the bridging between community health and mental health. This coupled with the planned merger between RLBUHT and AUHT in 2019 was hoped to progress the integration agenda, improve consistency and promote a culture of multidisciplinary working. However, engagement with GPs needed to be strengthened to ensure there was system-wide agreement to the neighbourhood model. The GP Federation needed to work with its members and ensure it had a clear remit and coherent voice for the primary care sector.
- We observed multiple examples of effective multidisciplinary working, such as the Multi-Agency Discharge Event (MADE) held at the Royal Liverpool Hospital. Frontline staff we spoke with were aware of each other's challenges across the sectors and demonstrated a clear commitment to work together to deliver better outcomes for people. This was supported by the findings of our relational audit. This interagency working needs to be translated to the strategic level for the system. System leaders recognised that historical relationships and specific organisational challenges had been a barrier to integration, but recent improvements, such as the Integrated Care Partnership Group and Provider Alliance, need to be strengthened at pace to overcome these.
- We found not all independent care providers were positive about their relationships with commissioners and did not feel involved in developing the strategic vision for the future or the future service delivery model. Commissioners were not engaging with them in a meaningful way and more work was required to ensure all providers felt like system partners.

### **Learning and improvement across the system**

- There were some mechanisms in place to learn and improve as a system, but these were fragmented and there was an absence of independent care providers in forums to learn as a system. As relationships had improved and effective partnership working was becoming more apparent, so too had the sharing of information and escalation of concerns. A joint performance framework had been developed and eight joint priority measures were reported on, including delayed transfers of care and the utilisation, effectiveness and

outcomes of reablement services. It was widely recognised that the health and social care landscape was overly complex and not easy for staff or the people of Liverpool to navigate. Work had begun to streamline the discharge process using the Integrated Community Reablement and Assessment (ICRAS) model and Single Point of Contact (SPOC) to support admission avoidance.

- The system had learnt from periods of escalation in order to build system resilience, for example in relation to winter. At the time of our review, there were multiple examples of different work streams and pilots underway. A comprehensive evaluation needs to be carried out prior to system-wide roll-outs in order to demonstrate their effectiveness and the most efficient use of resources.
- Following concerns raised in relation to LCHT between 2010 and 2014, an external review had been carried out. The Kirkup report was published in January 2018 and concluded widespread failings and a culture of bullying within the organisation put the safety of people at risk. It also highlighted systemic failings within the Liverpool system which meant these concerns had not been identified and escalated sooner. At the time of our review, the report was being considered by individuals, but there was no evidence of a coordinated system-wide evaluation.
- There was a positive reporting culture within the system, but some staff and providers we spoke with reported they did not always get feedback from incidents and safeguarding concerns to provide assurance they had been dealt with in line with appropriate policies and procedures. We raised this with the local authority at the time of review and we were provided with evidence of a commitment to remedial action.

### **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 within the system, focusing on collaborative governance, information governance and effective risk sharing.*

*We found there was a clear governance framework in place to provide system level assurance, but system-level risk sharing was underdeveloped. Some governance arrangements had recently been implemented (such as the Liverpool Integrated Care Partnership Group and the Provider Alliance) and needed to be embedded. Furthermore, governance structures did not incorporate all stakeholders, most notably independent care providers, which was a missed opportunity considering the role they play in delivering support to the people of Liverpool.*

*There was a clear intent from system leaders to use information and technology to facilitate integrated health and social care and there were some innovative examples in operation at the time of our review. The single information sharing agreement in place was a considerable achievement and this had been built upon. For example, a single records system was now in place within primary care and there were plans for the two main acute providers to move onto a single system within the 12 months following our review. However, some digital advancements had negatively impacted on service delivery in other parts of the system, which is something for leaders to be mindful of moving forward.*

### **Overarching governance arrangements**

- There was a clear governance framework in place across the system to support partners to collaboratively drive and support quality of care across the health and care interface. The HWB provided challenge on the strategic direction for Liverpool, originally set out by the Mayoral Commission in 2013.
- The Social Care and Health Select Committee was well-informed and provided a high level of scrutiny in response to specific issues. The newly established Shadow Liverpool Integrated Care Partnership Group (LICPG), reporting into the HWB, provided tactical leadership to drive forward implementation of the strategic vision and address system challenges. Established in shadow form in November 2017, it brought together system leaders to lead on the development of an integrated health and social care system. At the time of our review, both the HWB and LICPG shared the same chair. However, it was intended that the LICPG would be chaired separately in the near future. We were advised that a report would be received by the HWB in June 2018 recommending the formal establishment of the LICPG, which would include a review of the chairing arrangements. We were assured by system leaders that each group had clearly defined roles and responsibilities and there was no risk of duplication.
- The Provider Alliance, also newly established, brought together statutory providers and VCSE sector organisations to create a 'one team' ethos to provide the best possible services to communities. In a positive step, this was led by the Chief Executive of Mersey Care NHS Foundation Trust, thus bridging the gap between acute and community care. However, at the time of our review, independent care providers were not members of the Provider Alliance. This was a missed opportunity considering the role the care home and home care market play in delivering support to the people of Liverpool. System leaders acknowledged this and should review the membership as a priority. There had been an established governance structure to oversee the five programme areas of *Healthy Liverpool*. With the refresh and development of *One Liverpool*, governance arrangements had been reviewed; some changes had been implemented shortly before our review and need to be embedded.



- All 12 integrated CCTs had been operational since April 2017 and there was a clear governance framework in place. However, we received mixed views from system partners and staff about how effective these governance structures were in ensuring there was equity in service provision and collaborative working within neighbourhoods. The response to the SOIR set out that Neighbourhood Leadership Teams (NLT) were responsible for taking the lead on integrated services based on their local defined priorities and any issues were escalated to the Community Programme Board which then reported to the HWB. However, it had been recognised the governance arrangements needed to be reviewed and MCFT was currently undertaking a stocktake of the development of the CCTs. MCFT needs to ensure this includes the perspective of primary care partners so there is a shared agreement of roles, responsibilities and each neighbourhood's geographical footprint moving forward.
- The A&E Executive Delivery Board, chaired by the Chief Executive of the Royal Liverpool and Broadgreen University Hospitals Trust (RLBUHT) was responsible for providing assurance in respect of the urgent care system in North Mersey and Southport. Beneath this sat a North Mersey sub-group which had overseen several schemes over the winter period to maintain flow. Staff from across the system attributed the resilience displayed this year to the efforts of the A&E Executive Delivery Board and sub-group.

### **Risk sharing across partners**

- System-level risk sharing was underdeveloped, both in terms of financial and operational challenges. The exception to this was the collective response to building system resilience for winter. However, there was transparency and openness about each other's challenges, such as the delays to the new Royal Liverpool Hospital as a result of the collapse of Carillion.
- Liverpool faced significant financial pressures; the local authority had seen a 50% reduction in funding and the CCG, RLBUH and AUH were in deficit. This placed people at risk of receiving care from poor quality services. These pressures were widely acknowledged by system leaders, but there was no sense these were managed as shared risks. Other than the section 75 agreement in relation to the Better Care Fund and learning disabilities, there were no pooled budgets in place. There was no shared risk register to appraise and assure partners these risks were being managed; the responsibility for dealing with them lay with individual organisations. The delay of the new Royal Liverpool Hospital site had wider implications for the rest of the health and social care system and a collective response was needed to mitigate any risks to future improvements.

### Information governance arrangements across the system

- There was a commitment to improve how information was used to facilitate seamless care for people as they moved through the system and Liverpool had made some considerable advances in overcoming barriers in relation to information sharing. For example, all primary health care was now on a single records system which could be viewed by health and social care partners and over 95% of records were searchable using an NHS number. This approach supported people to move safely through the health and social care system.
- In 2016, NHS England launched the Global Digital Exemplar (GDE) Programme whereby NHS organisations are recognised nationally and internationally for delivering high-quality and efficient care through digital technology and information; four of the 23 GDEs nationally were in Liverpool which recognised the system's early investment and progress.
- A Local Digital Roadmap had been produced and there was a single, overarching information sharing framework and agreement signed by all organisations in the local health and social care economy. The next step would be to rationalise the variety of systems in use within secondary care and create a single electronic patient record. The intention was for RLBUHT, AUHT and Liverpool Women's NHS Foundation Trust to move onto the same records management system within the 12 months following our review. This could be a potential step change for the system in terms of delivering truly integrated care.
- The response to the SOIR stated that the single information sharing agreement had resulted in more than 100 million shared records enabling integrated care. As part of our review, we found pockets of integrated records, but this was not system-wide and although system partners legally had access to each other's records, accessing them was not always straightforward in practice. Furthermore, advancements in some parts of the system had made information sharing harder for others. For example, the digitisation of all homecare records meant commissioners, providers and people could monitor the quality of service provision, but community health and social care teams were not equipped with compatible mobile technology to enable them to directly input into the same record. System leaders were aware of the issues and there was intent to overcome them. There was a plan to move to a single information exchange to join up systems through interoperability across Cheshire and Merseyside over the next 12 months. However, at the time of our review, a lack of compatible technology remained a barrier.
- Frontline staff throughout the system recognised there had been some considerable efforts made to improve information sharing capabilities, but still described technology as a key barrier to providing joined-up care.

- There had been significant investment within Liverpool in the use of technology for proactive health management. Approximately 5,600 people were signed up to telehealth, enabling health care professionals to monitor their health condition(s) remotely. According to the response to the SOIR, this was the largest deployment of telehealth in Europe and had contributed to a 22-32% reduction in emergency admissions for this cohort when compared to a control group. Plans were in place to expand the number to 10,000 people, including a process to support with early discharges.
- The system was not only committed to sharing information to facilitate joined-up care for people, but also for the planning of service delivery. Intelligence teams from the local authority and the CCG worked together closely to share activity and performance data to inform needs assessments, benchmarking and commissioning decisions. Digital leads demonstrated their innovative approach using predictive analysis to pre-empt where a person may end up following admission, based on their set of conditions or their journey so far. This approach has potential to support the choice agenda moving forward as there will be a better understanding of demand.
- Although we recognise the significant progress made to digitise the system, the lack of compatible technology between community care and domiciliary care may put people at risk of inappropriate care if key information or messages cannot easily be communicated between care partners.

**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.*

*We found there was not a single, strategic approach to workforce planning for Liverpool. Workforce strategies were based at organisational level and although some local initiatives were taking place to develop the future workforce, these were not coordinated. There was a shared view of what the workforce challenges were, but a coherent strategy for addressing them was needed. Liverpool was a place that attracted staff, but the system faced recruitment and retention challenges within the social care sector.*

**System level workforce planning**

- There was no single, coherent strategic approach to workforce planning for Liverpool nor for the Cheshire and North Mersey STP. We found that workforce strategies were based at organisational or sector level. The response to the SOIR described that a whole system

workforce needs review was undertaken as part of the *Healthy Liverpool* programme in 2016, which informed delivery plans for the integrated CCTs and design of the Home First service, but this had not been reviewed and updated since. The newly established Integrated Care Partnership Group and Provider Alliance provided the opportunity to address this. Without a workforce strategy to understand existing and future needs, the system puts itself at risk of failing to secure, train and sustain a competent workforce.

- The local authority sat on the regional Workforce Action Board, which was attended by Health Education England (HEE) and Skills for Care. Work was underway between these two national organisations to develop a nursing associate programme to improve quality and retention in the care home sector. In addition, there was an undertaking from HEE to support the development of the workforce to meet the needs of any transformation towards integrated working within Liverpool, however this was still to be described and defined by the system at the time of our review.

#### **Developing a skilled and sustainable workforce**

- There was a shared view of the workforce challenges faced by the system and there were some initiatives taking place, but they were not coordinated. For example, a joint venture between RLBUHT and the local authority to create a Health and Care Academy was in the early stages of development. The aim was to develop an apprenticeship; a standardised training programme to attract young people or those looking for a career change into the health and social care sector. It would provide a clear career pathway through the home care or care home sector towards a nursing qualification for those that wished to pursue it.
- Skills for Care workforce estimates for 2016/17 showed that the staff turnover rate for social care in Liverpool was 23%, which was lower than the regional and England averages (26% and 28% respectively). Vacancy rates in social care were higher than average at 6.9%, compared to a regional average of 5.7% and an England average of 6.6%. Commissioners recognised the challenge faced by the system and the need to make social care an attractive market to work in.
- The local authority had faced significant financial pressures and was aware the rate of pay for social care roles was low when compared to the retail sector. However, it was exploring the use of block contracts, tax levies and flexible working to support providers to recruit and retain staff. Similarly, independent long-term care providers were experiencing staffing and recruitment challenges and felt that within the current financial climate they could not compete with more favourable terms and conditions in other parts of the health and social care market.

- There were staffing shortages throughout the system, allied health professionals being one example. In the all sectors there were ongoing recruitment drives to secure suitable staff with varying degrees of success; however providers realised that they were all recruiting from the same group of potential employees and this was a challenge. A wider, shared approach to staffing challenges was required to enable the system to respond more proactively.
- Although there had been no reduction in the number of social workers despite significant funding cuts, people were experiencing delays in assessment. System leaders need to consider how to align the digital strategy with workforce requirements to maximise on the technological advances made and deploy staff most effectively.

**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.*

*We found there was an extensive use of data and a comprehensive JSNA to help inform future commissioning intentions. However, there was a lack of joint strategic commissioning and despite having some long-standing joint posts these had not translated into integrated commissioning activities. There was clear intent to shift towards outcome-focused commissioning, aligned to the strategic vision of place-based care. However, at the time of our review, commissioning remained predominantly traditional. Work was beginning to shape the market to meet future demand. Commissioners need to ensure they involve wider stakeholders in the refresh of the Market Position Statement to encourage providers to come together and agree how they can meet the desired outcomes.*

*Liverpool faced significant quality issues within the social care market, particularly in relation to residential nursing care. This was cited as a key priority by commissioners and there had been a robust, multi-agency response. At the time of our review, it was not possible to predict if this would lead to sustained improvements and better outcomes for people.*

**Strategic approach to commissioning**

- System leaders and staff across the system could articulate the strategic vision for the future: to shift from a focus on bed-based care to a focus on the principles of ‘right care’ which aimed to support people to remain independent in the community. If successful this approach would support admission avoidance.

- The local authority and the CCG carried out extensive analysis of data to identify priority areas and inform commissioning decisions. The JSNA provided a comprehensive view of the city's challenges and an area profile had been produced for each of the 12 neighbourhoods to provide a clear understanding of needs specific to a defined population.
- According to the response to the SOIR, the local authority and the CCG jointly spend about £232m each year on health and social care for older people. However, joint strategic commissioning between the local authority and the CCG was underdeveloped. Pooled budget arrangements had been in place since 2008 through a section 75 agreement and were overseen by the Joint Commissioning Group, which reported to the HWB. In addition, there were some joint posts, but these were historic and had not translated into integrated commissioning activities. It was recognised that further work was needed to develop integration at a strategic level and developing integrated commissioning was a key aim of the Integrated Care and Partnership Group. The potential for the local authority and the CCG to form a single strategic commissioning function was being explored, but no firm plans were in place for implementation. At the time of our review, the posts for the Director of Adult Social Services and Accountable Officer at the CCG were out for advert, rather than making this a joint post.
- Some partners reported there needed to be a greater focus on public health, looking at the causes rather than just trying to address the symptoms of poor health outcomes. This view was aligned with the aspiration of system leaders to move towards a proactive, earlier intervention model of commissioning which was outcomes-focused. However, at the time of our review this was in the early stages of development and the low uptake of direct payments and personal health budgets was illustrative of the traditional commissioning model adopted by the system. System leaders recognised the need to develop an asset-based approach to commissioning at pace. The *One Liverpool* plan will need to be underpinned by a strong joint commissioning strategy which sets clear objectives across the system

### **Market shaping**

- At the time of our review there was no active market shaping. CQC ratings for adult social care services were below comparator and national averages and commissioning had been traditional, service-level focused to address pressure points within the system. We heard there was intent to develop innovative new models of care, but the priority focus had been to address poor quality within the social care market. Attention needed to shift to working with system partners to look at new ways of commissioning to ensure there would be future capacity in service provision and workforce.

- There was a Market Position Statement (MPS) available on the local authority's website, but this was dated 2016 and required updating. Future market intentions included a reduction in residential beds enabled by increasing the supply of extra care housing and supported living, an enhanced community health and domiciliary care offer and an increase in dementia care provision through the development of three new dementia hubs (a total of 160 beds) with a mix of reablement and long-term care. Commissioners need to ensure the development of a refreshed MPS includes all stakeholders responsible for service provision, including independent providers and VCSE organisations. If the intention is to move to outcome-based commissioning, providers need to work together to determine how these outcomes can be determined and met.
- Analysis of Adult Social Care Outcomes Framework (ASCOF) data showed an increasing trend in the rate of admission of older people into residential and nursing homes for long-term support between 2013/14 and 2016/17. However, more recent data shared by the system showed progress had been made to prevent such admissions; in 2017/18 there had been a 4% decrease in permanent placements and the proportion of people offered long-term domiciliary care packages had increased from 27.6% in Q1 to 27.8% in Q3. Some people and carers we spoke with cited continuity of care as an issue; one carer described how their relative (who had dementia) had seen 42 different care workers across 56 time slots in one week. This is not acceptable and does not support continuity of care or a person-centred approach to service delivery.
- Commissioners described how they had used block contracting over the winter period to improve capacity and continuity in parts of the city where recruitment and retention were an issue. Retainers were also paid to domiciliary care providers for two weeks to keep packages of care open should a person be admitted to hospital. Commissioners were working to further expand capacity in the domiciliary care market as part of an expansion of the Home First service. However, these plans were in the development stage at the time of our review.
- Quality within residential and nursing homes in Liverpool was cited as a key risk by commissioners. Our analysis showed higher than average number of packages of care were funded by the local authority or NHS. CQC ratings data showed the quality of social care provision was worse than average, particularly in relation to nursing homes. This meant some people were receiving poor quality care.
- As of December 2017, 37% of nursing homes in Liverpool were rated as requires improvement and 15% were rated as inadequate which was worse than in comparator

areas (27% and 3%, respectively). The proportion of residential homes rated requires improvement was also worse than national and comparator averages. A higher percentage of domiciliary care locations than average was rated requires improvement, although two locations were rated as outstanding, which was more than across comparator areas. The local authority commissioned care from 14 domiciliary care providers (eight were rated as good or outstanding, three as requires improvement and three were yet to be rated).

- The variability in quality was a key market priority for the system and there had been a multi-agency response. The co-produced Care Home Improvement Strategy focused on improvement through education and development of staff; commissioners had worked with Edge Hill University to develop bespoke training packages and there was a leadership programme for Registered Managers of residential and nursing homes.
- Liverpool's iBCF submission statement for Q1 2017/18 stated it would use some of the additional monies to expedite some of the transformation plans to increase capacity and stabilise the care market. This included raising the rate of pay for domiciliary care from £13.06 an hour to £13.62 (for non-complex care) and average weekly cost of residential care from £488.72 to £516.17. A fee consultation had taken place with providers and they understood the financial constraints faced by the local authority; others felt the rate of pay impacted on their ability to provide a sustainable service and recruit and retain high quality staff. The system had seen some domiciliary care providers hand back contracts. The local authority advised us these services were of poor quality and they had been supported to leave the market. They felt continuity of care had been maintained by the transference of staff to the new provider. However, during our review we found examples of people receiving care from multiple different care staff and there was an acknowledgement by some commissioners that providers had become too big. Liverpool City Council has signed a tripartite agreement with their local authority colleagues in neighbouring Sefton and Knowsley to set a price for domiciliary care to provide consistency and ensure sufficient capacity across borders. The Association of Directors of Adult Social Services (ADASS) 2016/17 budget survey report highlighted there was national variation in the price paid for care and that local authorities overall had been unable to meet the desired 2016/17 UK Homecare Association (UKHA) benchmark of £16.70. Despite the rising pay rates in Liverpool, these are still significantly lower than the benchmark.

### **Commissioning the right support services to improve the interface between health and social care**

- Over the year prior to our review, Liverpool had developed the Integrated Community Reablement and Assessment (ICRAS) model, which aimed to improve safe and smooth movement through the health and social care system by bringing all intermediate services under one umbrella and providing a single pathway for 'step up' and 'step down' care. This



had led to the development of a single electronic referral process for the local authority's and LCHT's admission avoidance and discharge pathways (the local authority's Home First domiciliary reablement service, LCHT's bed brokerage system for residential reablement care packages and LCHT's Liverpool Out of Hospital Services therapy team).

- The development of the ICRAS model had impacted positively on the system's performance in relation to flow over recent months. However, it was recognised that the health and social care landscape was complex and difficult for staff and people using services to navigate with multiple teams offering similar services, but operating under different names. It was also recognised that there had been a reactive focus on pressure points within the system, notably delayed transfers of care, which meant that services designed for admission avoidance, were often at capacity from supporting timely discharges from hospital.
- The neighbourhood model provided an opportunity for a bespoke commissioning response based on the individual needs assessment or area profile. However, these were still in the early stages, and pilots and different ways of working had led to a perceived inequity in service provision. For example, a person in a care home in one part of the city may get fortnightly visits from an enhanced GP and consultant gerontologist, whereas a person in another neighbourhood may get no additional input.
- Financial pressures meant some services had been de-commissioned, which had had a negative impact for some people who had been receiving them. For example, funding had been withdrawn by the CCG for the Alzheimer's Society, and other VCSE organisations we spoke with described how funding cuts had meant many had left the market. System leaders and commissioners recognised more proactive work was needed to involve VCSE organisations in the delivery of services, particularly with the shift to building a community, asset-based approach to care.

### **Contract oversight**

- Addressing poor quality care within commissioned social care services had been identified by system leaders as a priority area and there had been a recent drive to ensure a multi-agency response. The joint Care Home Improvement Strategy and Safeguarding Standard Operating Procedure meant the local authority, the CCG and the Midlands and Lancashire Commissioning Support Unit (commissioned by the CCG to monitor performance and quality in care homes) had clearly defined roles and responsibilities. Nursing homes were jointly visited by the CCG and the local authority Quality Assurance Team and commissioners held regular contract monitoring meetings with providers. Any concerns were escalated and discussed at monthly multi-agency Quality Assurance Group meetings, attended by commissioners, the safeguarding team and other stakeholders including CQC.

- Sixteen per cent of adult social care services were found to have deteriorated following a CQC re-inspection (worse than the averages across comparator areas and nationally, at 14% and 12% respectively). Forty-two per cent were found to have improved, which was better than average (39% in comparator areas and 37% nationally), but this was from a poor quality base. It was hoped that the recently implemented Care Home Improvement Strategy would lead to further improvements.
- Most care providers we spoke with described positive working relationships with commissioners, particularly domiciliary care providers. CQC inspectors also described a collaborative relationship with commissioners and recognised the efforts that had been made to address some of the quality issues. However, they were concerned about providers that were persistently rated as requires improvement, had been subjected to enforcement action and were not improving. As a result, some people continued to be placed in poor quality services.

**How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promote 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 people's independence.*

*Liverpool faced significant financial pressures. We found there were robust controls and governance arrangements in place in relation to Better Care Fund monies to provide assurance that available resources were being used in the most effective manner. There was an aspiration to move towards greater pooling arrangements, but there were limited pooled budgets in place at the time of our review.*

- System leaders described a clear intent to working jointly and national stakeholders we spoke with were complimentary about how partners worked together in response to pressures within Liverpool. However, in practice, this had not been translated into pooled budgets or integrated commissioning except in limited ways; the section 75 agreements in place were limited to learning disabilities and the Better Care Fund. There was an aspiration to move towards a greater pooling arrangement, and eventually the whole Adult Social Care budget, but no work had been done regarding how to achieve this.
- Due to the late allocation of the improved Better Care Fund (iBCF) when the local authority had already set its budget, much had been used to fund several new sustainable and transformational initiatives rather than recurrent schemes. Therefore, careful monitoring is

required to ensure improvements achieved can be sustained and embedded in the future. There were robust governance arrangements in relation to the BCF and financial leads from the local authority and the CCG worked closely together.

- It was recognised there had been a historic lack of governance and evaluation around projects funded by the CCG. We were told that more than 120 projects were in operation and there was not a good level of assurance these were providing value for money. This was being addressed at the time of our review.
- There was a shared view of resource gaps within Liverpool and across the wider system. The local authority and the CCG both had challenging budgets, but had worked to protect adult social care and focus on health outcomes. NHS commissioners and statutory providers across Liverpool and the neighbouring areas of Sefton and Knowsley came together to “act as one” by agreeing fixed price contracts for 2017/18 and 2018/19, in order to share the risk of managing increased demand. This provided stability for acute hospital funding, but may mean the CCG have to make cost savings elsewhere.

**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 their usual place of residence**

**Are services in Liverpool safe?**

*There was commitment across all levels of the system to proactively maintaining people in their usual place of residence and protecting them from avoidable harm. The system had the capability to have a shared view of those people at greatest risk of admission and proactively manage those risks within a multidisciplinary model. However, there was not universal application of the tools available. Work had been undertaken by the system to address the higher than average A&E attendances and admissions, particularly from care homes and work needs to continue to ensure improvements are embedded and sustained.*

- There was a system-level commitment to support people to remain safe and well in their usual place of residence with a focus on proactive prevention, but initiatives were not always consistently applied. The local authority’s Healthy Homes programme helped people facing fuel poverty as well as identifying and addressing potential safety risks and Merseyside Fire Service conducted Safe and Well visits.

- Our analysis of Hospital Episode Statistics (HES) data covering 2014/15 to 2016/17 showed A&E attendances of people aged 65+ had been consistently higher than the national average. Between January and March 2017 there were 16,635 attendances per 100,000 population which was higher compared to comparator areas with a rate of 13,087 per 100,000 and significantly higher than the England average of 10,534 per 100,000. People aged over 65 were also more likely to be admitted to hospital; emergency admission rates had been consistently higher than average over the period of our analysis and between January and March 2017 there were 8,324 emergency admissions per 100,000 population in Liverpool compared to 7,570 per 100,000 across comparator areas and the England average of 6,391 per 100,000.
- Our analysis showed older people living in care homes in Liverpool were more likely to attend A&E compared to other areas and indicated they were more at risk of avoidable admissions. Our analysis of HES data showed that the rate of people aged over 65 who were admitted to hospital from a care home between October 2015 and September 2016 as a result of an injury or accident was significantly higher than the national average and also higher than the comparator average. Commissioners were aware and were working closely with providers and other system partners in response. For example, the Medicines Management Team within the CCG were supporting care homes by providing advice and conducting medicines reviews; Community Matrons and District Nurses assisted with training; and North West Ambulance Service NHS Trust (NWAST) had piloted the use of a triage tool by care home staff. Data from an evaluation report by NWAST published August 2017, showed that during the pilot phase, the tool was able to reduce inappropriate conveyance of people and potential admission to hospital by more than 50%, with no adverse incidents reported.
- System leaders felt the implementation of the integrated CCTs and other work going on in parts of the city had led to recent improvements in performance. Data provided by the system for RLBUHT showed a decline in A&E attendances since October 2017, but the numbers in January 2018 were similar to the previous year. Systems to support people to be safe in their usual place of residence needed a stronger, comprehensive focus.
- There was a city-wide risk stratification tool in place to enable GPs to identify people at most risk of hospital admission. With their consent, these people could then be referred to the multidisciplinary integrated CCTs within each neighbourhood for assessment and proactive monitoring of any identified risks. These people would be discussed at monthly multidisciplinary team (MDT) meetings. However, at the time of our review, only 50% of GPs were using the tool and participating in neighbourhood MDT meetings. For this targeted approach to be truly effective, there needs to be universal coverage and

commissioners need to work with partners to understand and address any barriers to achieving this.

- The system was using innovative technology to support people most at risk, to remain safe in the community. At the time of our review 5,600 people were receiving telehealth, enabling them to be remotely monitored in their homes and for any deterioration in their condition to be responded to quickly by health professionals. Data provided by the system showed this had contributed to a 22-32% reduction in avoidable admissions for this group of people. Telecare had also been rolled out across care homes in Liverpool to enable staff to access advice and support from a team of nurses and clinicians over video link. Providers we spoke with were mostly positive about this service.
- Frontline staff across health and social care providers and the VCSE sector could describe the process for reporting safeguarding concerns and other incidents. A Standard Operating Procedure (SOP) had recently been implemented across the health and social care landscape, clearly articulating roles and responsibilities. Although there was a multi-agency response to safeguarding, staff and providers across the system told us they received limited feedback, even if they followed up directly to ask for details of the outcome.

### **Are services in Liverpool effective?**

*There were some positive examples of staff working in a collaborative, proactive way to support people to remain well in the community, but this was fragmented across the city. Services designed to improve flow were evidence-based, but people and staff described the landscape as complex and difficult to navigate. There had been some considerable technological advances to enable better sharing of information, but some improvements had negatively impacted on other teams.*

- The MDT model, facilitated by the 12 neighbourhoods and CCTs, supported a holistic needs assessment to promote independence. However, this model was not consistently used and this led to inequity between neighbourhoods. Our review of case files showed people received comprehensive assessments, but these were often carried out by individual teams rather than through a coordinated approach meaning the person may have to tell their story more than once.
- Services designed to improve flow through the system and to keep people at home were evidence based, but not all were available seven days a week. There were multiple services, often with similar remits, and staff (and people) told us it was a difficult system to navigate. Careline was accessible to the public and professionals signposting or referring to the neighbourhood social work team for an assessment. People who required low-level

preventative support would be referred to the Prevention Early Intervention Service (PEIS) for further help, advice and signposting to support people and their carers to stay well at home.

- There was a Single Point of Contact (SPOC) for community health and social care professionals. This was a nurse-led call centre provided by LCHT, open daily from 8am to 9pm. Data collected by the system showed that between April 2017 and January 2018, alternatives to admissions were achieved for 28.4% of calls. It was not clear whether this was in line with expected performance. All frontline staff we spoke with were aware of the SPOC. Teams accessible via this number included:
  - Intensive Community Care Team (ICCT) – a multidisciplinary team working city-wide providing packages of care for up to six weeks.
  - Emergency Response Team (ERT) – providing packages of care in response to social crisis for 72 hours.
  - Medical Consultant Hotline – direct access to consultant advice at the Royal Liverpool and Aintree Hospital (including the frailty and ambulatory care units)
  - Community matrons and district nursing
  - Liverpool Out of Hospital Services – therapy services
  - Community IV therapy – IV antibiotics and blood transfusion
  - Bed brokerage and intermediate beds
- Despite the extensive list of services available to help prevent avoidable admissions, and the proactive approach of CCTs, many staff described GPs as a person's initial point of contact should their condition deteriorate. Independent care providers did not have access to the SPOC and so there was reliance on community health and social teams escalate concerns, which was a missed opportunity to prevent a delay in a person receiving treatment.
- Enhanced health care within care homes was not universally provided by GPs or pharmacists. We did see, however, a pilot in West Derby providing an enhanced MDT model, which included GPs. This was under evaluation at the time of our review.
- There were several examples of the health and social care workforce working in a collaborative way and sharing information to meet people's needs. For example, some care providers described how their positive working relationships with Community Matrons and allied health professionals, including pharmacists and therapists, was supporting people to remain well at home and prevent admissions. In some parts of the city, consultant gerontologists were working with GPs to increase their knowledge of elderly care and frailty. However, these examples were not illustrative of the whole system and people using

services and frontline staff raised concerns about inequity in service provision. This needs to be considered by commissioners when designing future delivery models.

### **Are services in Liverpool caring?**

*The case files reviewed demonstrated people received person-centred support and care, with a focus on maintaining their independence. However, this was not the experience for all people. Carers we spoke with described difficulties in accessing information and support, such as emergency respite; and nationally collected data showed people's satisfaction with adult social care services had deteriorated over recent years. During our review we heard about and visited some innovative groups providing support to older people in Liverpool and their valuable contribution should be harnessed by system leaders.*

- ASCOF data for 2016/17 showed people's overall satisfaction with adult social care services in Liverpool was the worst when compared with similar areas (a score of 50, compared to the national average of 62 and highest comparator area of 72). Satisfaction had declined year-on-year since 2014/15. However, there were some voluntary run groups and innovative pilots taking place providing invaluable support to people, their families and carers. These included the Happy Older Person Scheme, 'house of memories' events at Liverpool Museum and concerts provided by the philharmonic orchestra. There had also been some work in parts of the city looking at how inter-generational activities could prevent social isolation and improve older people's health and well-being. This was reported to have helped approximately 3,000 people with some excellent outcomes, which were presented to the Social Care and Health Select Committee during our review. Funding pressures had meant low-level support contracts had been withdrawn, but commissioners should harness the social capital potential within the community when developing the neighbourhood, asset-based model for the city.
- Our review of care records showed evidence of person-centred care planning; people's wishes were documented and any interventions were focused on maintaining their independence. However, people and carers we spoke with did not always feel appropriately supported or that their wider needs were met. One person, whose mobility was deteriorating, told us they had been waiting for suitable housing for them and their family for five years and felt the housing association was not taking into account their emotional and physical needs.
- During our review we spoke to a group of carers at the Carer's Centre, which they described as a "life line". However, they told us that the location of the centre, poor transport links, and strict eligibility criteria for support meant it was not always easy for them to attend groups and activities to prevent their own social isolation. This was supported by ASCOF data for 2016/17 which showed the proportion of carers in Liverpool who had as

much social contact as they would like was below the national average. Carers told us they told us they had to “push” and “be assertive” in order to get the support they needed and that arranging emergency respite was an impossible task. It was recognised by commissioners that there were respite capacity issues, particularly for people with complex needs. In one case file we reviewed respite had prevented a further hospital admission, but it had taken 20 days between the family requesting support and the placement starting.

- ASCOF data for 2016/17 showed 73% of people aged over 65 who were using social care services in Liverpool found it easy to find information about support. This had increased from 68% the previous year and was now more in line with the average for comparator areas of 76% and the England average at 75%. However, people we spoke with during our review told us they found it difficult to access the right information and that if they rang the central line at the local authority they might get conflicting advice.
- Healthwatch Liverpool managed the Livewell Directory which provided a comprehensive list of services and support available, including befriending services and statutory assessments for support. Staff and providers were complimentary, describing the directory as easy to use, but it was recognised it was only accessible to people if they were IT literate.
- ASCOF data for 2016/17 showed the proportion of people aged 65+ receiving funded care in the form of a direct payment was low at 12.1% compared to an England average of 17.6%. The same applied to those receiving a personal health budget (PHB); in the first quarter of 2017/18 a rate of 1.06 people per 50,000 were receiving a PHB compared to an England average of 5.82 per 50,000. The system needs to ensure people are supported to understand their options and be able to exert choice and control over how their care is delivered.

### **Are services in Liverpool responsive?**

*There was clear intent from system leaders to develop a system that was responsive to people's needs. Some initiatives were either in the early stages of development or were being piloted at the time of our review and there was variability in people's experiences across the system. There were effective day hospitals to help prevent a person going into crisis. There was also a proactive approach to identifying people most vulnerable to hospital admission, but the system's ability to be reactive to this work was hampered by capacity within individual teams, which meant people were not always seen in the right place, at the right time, by the right person.*

- GP Patient Survey data for 2016/17 showed 67% people in Liverpool felt supported to manage their long-term condition. This was above the England and comparator averages (both 64%). Performance against this measure had been slightly better than average in each of the previous five years.



- People who used services, their carers and care providers described GP access as variable. Nationally collected data indicated that people in Liverpool were less able to access GP appointments at evenings and weekends, compared to elsewhere in the country. Data from March 2017 on provision of extended access to GPs outside of core contractual hours showed that 1% of the 94 GP practices (there are now 92) in Liverpool surveyed offered full provision of extended access over the weekends and on weekday mornings or evenings compared to the England average of 23% and the average across Liverpool's comparators of 30%. Forty-four per cent of GP practices provided partial extended hours provision and 54% provided no extended provision at all. There was a city-wide out-of-hours GP service commissioned for the city and three walk in centres operating from 8am to 8pm. We were told these were well utilised and attendances had increased.
- Capacity within teams meant despite efforts to proactively identify those most at risk, people did not always receive a timely review of their support needs to ensure they continued to be met appropriately as they moved through system. Staff working within services designed to prevent admissions, such as the ICCT and ERT, told us that a focus on pressure points on the system meant their capacity was often taken up with supporting timely discharges from hospital rather than 'step-up' care. Data collected by the system showed that 2.31% of calls through the SPOC between April 2017 and January 2018 were picked up by the ICCT and 2.23% by the ERT. It was not clear whether this was in line with expectations.
- Older people in Liverpool had access to high quality multidisciplinary day hospital services. These acted as an opportunity to access specialists before a crisis occurred and to be seen at the right place at the right time. At Broadgreen day hospital, for example, there were a range of clinics from falls to dementia. The gerontologists worked effectively with the multidisciplinary team to maintain people in the community. During our visit to Broadgreen Hospital we were told by a carer that the service was "the NHS at its best".
- Health and social care providers and VSCE sector organisations reported there was not enough capacity within social work teams for rapid reassessment and preventative work and the onus was often on people to chase for these rather than them being carried out proactively. This had been recognised by commissioners who told us only 65% of reassessments were being completed within expected timescales. Plans were in place to assign named social workers to neighbourhoods and create a specialist team to undertake reassessments in care homes, but this had not been implemented at the time of our review.

## 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 Liverpool safe?

*People in Liverpool were more likely to attend A&E and be admitted. Data showed the average length of stay was comparable to other areas, but the 90th percentile length of stay for older people was higher than average. High bed occupancy rates coupled with higher than average A&E attendances meant people were at risk of avoidable harm. There were systems in place to safely triage people when they arrived at hospital and to provide a system-level view of capacity. However, more work was required to reduce the pressure felt at the hospital front door in the long-term and sustain any recent improvements.*

- Older people in Liverpool were more likely to attend A&E and be admitted compared to other areas. Unnecessary hospital stays put people at risk of avoidable harm, such as infections and reduced independence. Our analysis of HES data showed that between January and March 2017, 34% of people aged over 65 had a hospital stay lasting longer than seven days, compared to an average of 33% in similar areas and the England average of 32%. It was a similar picture for older people admitted to hospital from a care home; 36% stayed longer than seven days compared to the England average of 36% and comparator average of 38%. However, the Department of Health's analysis of the 90th percentile length of stay for older people admitted as emergencies between September 2016 and August 2017 showed that a higher percentage of people had longer stays in Liverpool than in many of its comparator areas. The 90th percentile length of stay (the point at which 90% of people had been discharged) was 25 days in Liverpool; only 3 of its 15 comparator areas had similarly long lengths of stay.
- During our review we visited A&E departments at the Royal Liverpool Hospital and Aintree University Hospital. People were risk assessed and triaged within 15 minutes of arrival to ensure they could be diverted to the most appropriate place of care. At the Royal Liverpool Hospital frailty nurses were based in A&E from 8am to 8pm to provide a more specialist assessment of their needs. At Aintree University Hospital frailty nurses could be contacted via a bleep system, but if the frailty unit was full they could not carry out any assessments in A&E.
- Overnight bed occupancy rates were consistently higher than the optimal target of 85% across all three acute trusts serving Liverpool during 2016/17 and the first quarter of 2017/18, peaking at 96% for both RLBUHT and AUHT. This meant people who medically

required a hospital bed may have been at risk of harm if none were available. Recent efforts by the system had led to some improvements in performance, but these need to be sustained to reduce pressure at the hospital front door in the longer-term.

- North West Ambulance Service NHS Trust (NFAST) reported that in 2017 they had faced significant ambulance handover delays at the A&E departments at both the Royal Liverpool Hospital and Aintree University Hospital. This had been escalated and they had worked collaboratively with both providers. The dedicated frailty unit at Royal Liverpool Hospital and rapid triage process was cited as having contributed to recent improvements. NFAST told us the average transfer time across the city was now 33-34 minutes. This was supported by data provided for the week preceding our review. However, across all three acute trusts there were some handovers taking more than two hours, the longest being over four hours at Whiston Hospital. Reports of five-hour handovers at Aintree University Hospital were received the week during our review when the trust was in a state of escalation.
- There was a system-level escalation procedure to manage risks to service delivery; the Operational Pressure Escalation Levels (OPEL) framework. Statutory providers uploaded twice daily capacity reports onto the shared Escalation Management System (EMS) to give a capacity overview. If parts of the system were in escalation, organisations could put the agreed mitigating actions in place to manage the risk and improve flow.

### **Are services in Liverpool effective?**

*Services designed to improve flow were evidence-based and staff had the right knowledge and skills to support people in crisis. However, there was not a consistent approach to manage people in crisis with the two acute hospital sites we visited operating in slightly different ways. This meant people were not getting a consistent, positive experience. There was effective multidisciplinary working and sharing of information, but records were not joined up or shared despite there being some capability within the system to do so.*

- When people went into crisis there was not a consistent approach across the city to effectively manage their care across the health and social care interface. In both the main acute hospitals serving the Liverpool population, older people received an assessment of their needs with the aim of diverting them to the most appropriate place of care. During our review we found the Royal Liverpool Hospital was maximising internal resources to support the flow of people. There was a similar approach at Aintree University Hospital, but it was not as effective because of the significant pressures on bed stock resulting in a potentially less positive journey for people.
- Services designed to improve flow were evidence-based and staff had the right knowledge

and skills, but capacity and staffing numbers impacted on how they supported flow in practice. At both acute hospitals people in crisis would either attend A&E or, following a GP or ambulance referral, be directly admitted to an ambulatory care unit, Medical Assessment Unit (MAU), Frailty Unit or hospital ward. The aim of the assessment units was to turn people around and facilitate a discharge within a short time period (72 hours for the MAU and Frailty Units and less than 24 hours for ambulatory care).

- The Frailty Unit at the Royal Liverpool Hospital had recently been co-located with A&E so it was part of the Emergency Department. The unit had consultant gerontology cover seven days a week and frailty nurses working in A&E to proactively identify and stream people through. At Aintree Hospital, consultant cover was only available five days a week and frailty nurses would attend A&E if 'bleeped' by staff. The unit was a 12-bedded unit, but had been running at 21 beds since 2016 and once the unit was full they would not carry out any additional assessments, meaning some people who attended A&E may not have received care in the most appropriate place.
- At the Royal Liverpool Hospital, therapists and social workers worked in A&E to proactively identify people who could be sent home with a package of care (provided by the Emergency Response Team or Intensive Community Care Team) or low-level support, such as equipment. At Aintree Hospital there was a therapy team working in A&E to prevent admissions. There was also a dedicated Liverpool social worker for A&E paid for by Liverpool City Council in Aintree, but not all Aintree Hospital staff appeared to be aware of this as those we spoke with told us there was not one on site.
- There was system capability for staff working in secondary care to access a person's GP records. However, this was not happening in practice due to a restriction on which grade of staff had access and the time it took to do so. At the time of our review, there was not a single records system and staff completed different documentation depending on which organisation they worked for. Our review of case files showed effective communication between staff, despite the technological challenges they faced.

### **Are services in Liverpool caring?**

*Frontline staff understood the importance of involving people and their families in decisions about their care. Our review of case files demonstrated staff considered more than just the person's medical condition and recognised the importance of the 'whole person'. However, we received mixed feedback from people who used services, carers and independent care providers during our review in terms of their experiences when in crisis.*

- Staff were committed to providing person-centred care and demonstrated understanding of

the need to look at the whole person, rather than treat the condition. Our review of case files and completion of assessments showed this was happening in practice and people's social needs as well as their health needs had been considered.

- We received mixed feedback from people, carers and independent care providers we spoke with. Some described having to repeat their story multiple times and others felt people were not always supported with personal hygiene on some hospital wards. During our visit to the Frailty Unit at the Royal Liverpool Hospital we spoke with people and their families. One person described how they had been admitted to the unit following a referral from their GP. They had felt like health staff in the community had not been communicating effectively, but were complimentary about the care on the unit and now fully understood their plan of care. Specialist frailty nurses working on the unit had specialist training in dementia care to facilitate high quality care.

### **Are services in Liverpool responsive?**

*Older people in crisis in Liverpool who ended up attending A&E were more likely to be admitted and not necessarily be seen in the right place, at the right time, particularly at Aintree University Hospital which faced significant bed pressures. All three acute trusts failed to meet the A&E expected waiting time of four hours and some people experienced delays in assessment for ongoing support due to lack of clarity about what services were available and also capacity within those services.*

- When an older person went into crisis, they did not always receive the care in the right place, at the right time, by the right person. Our review of case files showed examples of early referrals to alternative services to wrap care around the person, but delays in assessment and placement meant people often spent too long in inappropriate settings. At Aintree University Hospital this was due to capacity within services and high demands on beds. However, at the Royal Liverpool Hospital we were impressed with the proactive team of consultant gerontologists who worked across the site, at Broadgreen Hospital and in the community to support people to receive timely and appropriate care.
- NFAST paramedics and Urgent Care 24 (the out of hours GP provider) used a 'pathfinder' to support people in crisis and find alternatives to transferring them to hospital. Data showed that in July 2017 the ambulance service managed 32% of the 999 calls they attended without transferring the person to hospital, which was below than the England average. NFAST staff we spoke with told us that capacity issues within community-based services had impacted on the service's ability to prevent a transfer to hospital. There had been an increase in 999 activity this winter, but the referral rate to Liverpool's SPOC had remained the same as the previous year; NFAST had expected this to rise.

- Between 2014/15 and 2016/17 all three of the acute NHS trusts serving Liverpool residents failed to meet the national four-hour A&E target of 95%. Performance mirrored the England average and had fallen year-on-year to its lowest in 2016/17 where less than 90% of people were seen within four hours (the lowest being 84.9%).
- Once people in crisis arrived at hospital they were not always treated in the most appropriate place to meet their needs. This was particularly apparent at Aintree University Hospital where there was a high demand for beds (the trust had needed to open an additional 100 beds to cope with winter pressures). During our visit to the Frailty Unit, there were three people who had been there for over two weeks, thus breaching the hospital's 72-hour target. One person had no plan of care and another was awaiting an assessment by the community therapy team. Data provided by the trust showed the average length of stay for January 2018 was 3.6 days, a decrease from 5.8 days in September, but the unit had only met its target twice since opening in 2016. Data provided by RLBUHT showed that length of stay at the Frailty Unit at Royal Liverpool Hospital had reduced since it had been co-located with A&E in March 2017. However, average length of stay was still higher than the trust's 72-hour target, ranging from four days most months to a peak of six days in January 2018.
- Staff cited delays in assessment and capacity within the community teams – particularly the capacity of therapists – as impacting on flow and supporting people in crisis to return home rather than be admitted. There was also confusion between staff at Aintree University Hospital around the availability of social work staff; some told us they were not based on site and others told us they were there Monday to Friday. Social work staff and the local authority told us there was a dedicated social worker for Liverpool based on site seven days a week. It would help to avoid any potential for confusion around social work availability if plans to centrally locate Sefton and Liverpool social workers with Aintree hospital discharge staff were expedited, as well as there being some immediate additional communication about recent changes.

## 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 Liverpool safe?

*Variability in processes and practices across the system meant people were not always protected from avoidable harm when they were ready to be discharged from hospital.*

*Readmission rates of people from care homes were significantly higher than average. System leaders were aware of this and had put some measures in place to try and address it. However, the quality of information flows between secondary and community care, including to independent care providers was inconsistent.*

- There were some systems in place to ensure people were kept safe and prevented from avoidable harm when they were ready to return to their usual place or residence or new place of care. A jointly commissioned integrated discharge ward had been established at the Royal Liverpool Hospital. People admitted to the ward were medically fit for discharge and usually awaiting a package of care. They continued to receive therapy input to prevent deconditioning and a loss of independence while they were waiting to be transferred.
- Some hospital wards had dedicated pharmacists which prevented delays in people receiving their medication or being sent home without it. However, people who used services and care providers did give us examples of where people had been discharged without their medication. Aintree University Hospital had been selected to pilot the Electronic Transfer of Care to Pharmacy which had begun in February 2018. The aim was for all local hospitals to send discharge information direct to the pharmacy by the end of March 2018 to support safer discharges and prevent readmissions, which was a priority area for the system.
- Analysis available at the time of our review showed that the percentage of older people in Liverpool requiring emergency readmission once discharged between 2014/15 and 2016/17 was broadly in line with the comparator averages and just above the England averages. Between January and March 2017, the percentage of emergency readmissions of people aged 65+ within 30 days of discharge was 21% in Liverpool, compared to the England average of 19% and comparator average of 21%. This indicated people were only discharged from hospital when they were medically fit and were less likely to be readmitted due to inappropriate discharges.

- However, the percentage of people readmitted to hospital from care homes increased over January to March 2017 to be significantly higher than average. Our analysis of HES data showed that 26% of people aged 65+ discharged to a care home were readmitted within 30 days as an emergency, compared to 21% in comparator areas and 20% nationally. Community and secondary care staff felt there were several reasons for this, including the increasing complexity of people's care needs, the confidence and skills of care staff and the quality of providers' assessments. Commissioners hoped that the Care Home Improvement Strategy would improve performance, but at the time of our review, it was too early to judge its impact.
- The quality of information flows between NHS organisations and independent care providers may also have contributed to emergency readmissions. Seven out of the 14 Registered Managers of care providers who responded to our online feedback tool reported they received discharge summaries at least 75% of the time, mostly in paper format. However, three respondents (two from domiciliary care providers and one from a supported living facility) received discharge summaries less than 50% of the time. Eight respondents reported receiving discharge summaries within 24 hours, but four stated they rarely or never received summaries within 24 hours (three of these related to domiciliary care providers). GPs we spoke with during our review also described inconsistencies in relation to receiving discharge information. Not receiving timely discharge summaries puts people at risk of unsafe and inappropriate care, which may lead to readmission.
- During our visit to Aintree University Hospital, staff told us the discharge lounge was open five days a week until 7:30pm, but that it had been used over night during times of escalation and the longest length of stay had been three days, which is highly inappropriate and a poor experience for people. AUHT leadership needs to assure itself that during times of escalation people continue to be cared for in the most appropriate place that meets their needs and prevents them from avoidable harm.

### **Are services in Liverpool effective?**

*The system had undergone some recent changes in an attempt to streamline and simplify the discharge pathway. Some of these had been implemented just shortly before our review, but improvements in performance had been recognised by national stakeholders as well as the system. There were some very positive examples of multi-agency working to facilitate timely discharges and some of the high impact changes had begun to be implemented. However, more work was required to ensure there was consistency in practices and processes and shared understanding among staff across the system to improve levels of trust and communication.*



- System leaders had recognised the challenges faced within parts of the system, particularly in relation to flow. Efforts had been made in recent months to redesign and simplify the pathway out of hospital, acknowledging it was complex and difficult to navigate. There was an agreed system of 'Discharge Lanes' and associated pathways under each, which had been bought together under the ICRAS model. These were seen as a positive by most staff we spoke with, but some working at Aintree University Hospital told us the three CCG areas they covered all had different pathways and processes which needed to be simplified.
- The high impact change model for managing transfers of care identifies a series of changes that can help reduce delays and while the system had begun to implement some aspects, much of the model was underdeveloped. The SAFER discharge bundle and use of 'red to green' days had been implemented across secondary and intermediate care to improve flow and reduce length of stay. Although our review of records showed some early discharge planning, it was not consistently applied.
- During our review we observed and were impressed with a Multi-Agency Discharge Event (MADE) at the Royal Liverpool Hospital where all people with a length of stay over seven days were discussed. Facilitating timely discharges was considered a shared responsibility and these events took place twice a week at the Royal Liverpool Hospital and once a week at Aintree University Hospital. These events should be encouraged to continue more frequently if they are proving to be effective at reducing length of stay and supporting people to return to the community.
- The MADE meetings were viewed positively by frontline staff, but further organisational development work was needed to ensure there was effective communication across the system. There was not a shared understanding among staff working in the acute sector about the services available within the hospital and in the community, including the availability of equipment and availability of social work staff and occupational therapists.
- Any person who was expected to need some additional support on leaving hospital was put on a discharge to assess pathway; Home First (home-based) or 28-day beds (residential or nursing care). There was a trusted assessor model in place for the Home First pathway, but staff told us independent care providers would carry out their own assessments for 28-day bed placements, which sometimes caused additional delays. There was no trusted assessor model for new packages of long-term care.
- Independent care providers we spoke with told us they were not always involved early enough in the discharge planning process. Some reported they were only informed once a

person was medically fit or if they had phoned the ward to check on the person's progress. Six out of the 14 Registered Managers of care providers who responded to our online feedback tool reported they were never or rarely involved in the discharge process by carrying out pre-assessments, but 10 reported the information they received was usually enough to determine if their service could meet the person's needs.

- The rate of delayed transfers of care (DTC) was above comparator areas and in line with the England average. The average daily number of delays had decreased between March 2016 and September 2017 from a peak of 17.4 days per 100,000 population (aged 18 and over) to 12.6 days per 100,000 population, but there had been fluctuations in performance during that time. This compared to an average in September 2017 of 11.1 days in similar areas and 13 days nationally. It is important to note that the largest contributor to delayed transfers of care was the mental health trust, Mersey Care NHS Foundation Trust. In September 2017, the trust had a daily rate of six delays per 100,000 compared to three for Aintree University NHS Foundation Trust and two for Royal Liverpool and Broadgreen University Hospitals NHS Trust.
- At the time of our review we were told by the system and by national stakeholders that performance had improved further and that Liverpool had met the 3.5% DTC trajectory in January 2018. Data provided did not give a system overview, but data from NHS England showed that in December 2017 the DTC rate for AUHT was 3.96% and the rate for both RLBUHT and St Helens and Knowsley NHS Trust was 1.88%, a significant decrease from November 2017. Our analysis of data from December 2017 showed that the average number of daily delays had reduced, but remained higher than national and comparator averages (11.5 days per 100,000 aged 18+ compared to 10.9 and 10.6 respectively).

### **Are services in Liverpool caring?**

*Performance in relation to continuing healthcare was very good compared to average. However, people we spoke with described varied experiences of the discharge process. Some felt they had not been involved early enough and there was acknowledgement by commissioners that the VCSE sector could be better utilised. A comprehensive information pack had been produced by RLBUHT to support people to understand their options and make decisions, which should be adopted by the wider system.*

- People we spoke with and their carers described mixed experiences of being discharged from hospital. A group of carers we spoke with felt they had not been involved early enough in the process to support decision making, but to also determine what would be expected of them and whether they would be able to cope with any additional responsibility. Our review of case files documented discussions with people and those important to them about their options and preferred place of care, but there was a lack of involvement of VCSE organisations.

- To support people to make informed decisions, RLBH had produced a publication, 'Options', which was given to every older person on admission to hospital. It was easily accessible and provided a comprehensive overview of what to expect during their hospital stay and the services available to support them to return home. This sort of publication should be adopted by the system and made widely available to increase understanding and consistency in messages.
- Commissioners acknowledged there was a lack of involvement of the VCSE sector to facilitate discharges unless a person was on the Home First pathway, which was a missed opportunity. However, we were also told some VCSE organisations were involved in the provision of "hospital boxes" which supported older people on discharge from hospital by providing them with some nutritional basics. However, frontline staff did not refer to these, nor did people or carers we spoke with. Therefore, further work is required by system leaders to ensure this is well communicated to those who are eligible.
- Performance in relation to continuing healthcare (CHC), which is often used to support people towards the end of their life, was good. Data relating to Liverpool CCG for the first quarter of 2017/18 showed that people's eligibility was assessed in a timely way with 96% of referrals being completed within 28 days. This was significantly better than the England average. Furthermore, there had been a decline in the number of assessments done in an acute setting, which meant people were not having to wait unnecessarily or make long-term decisions while in a hospital bed. One hundred percent of people referred for Fast Track CHC received it, meaning people at the end of their life were supported to be moved to their preferred place of care.

### **Are services in Liverpool responsive?**

*Recent changes to the discharge pathway had facilitated improvements in performance in relation to delayed transfers of care and reablement outcomes. More people were being seen in the right place, at the right time. However, some initiatives were short-term to increase capacity over the winter period and system leaders need to ensure improvements are sustained. The pathways had increased volume and flow, but people were experiencing delays in reviews and assessments following discharge due to staffing capacity which placed them at greater risk of readmission.*

- Published data in relation to delayed transfers of care between July and September 2017 showed that more delays were attributable to the NHS compared to adult social care (7.4 days per 100,000 people aged 18+ compared to 5.0 days per 100,000), but the figures were in line with comparator and national averages. The main reason recorded for the

delays was 'other,' which may include public funding, person or family choice, disputes and housing. This accounted for 4.1 days per 100,000, which was higher than the comparator and England average of 2.6 days. There was a system-wide choice policy in place to encourage people and their families to understand the options available to them. Staff we spoke with described how it had been used effectively.

- Recent system changes and re-modelling of pathways meant more people were discharged from hospital and transferred to the most appropriate place of care, ensuring they were seen in the right place, at the right time. The pathways available to support people to return home and remain as independent as possible included; bed-based reablement in one of three hubs, home-based reablement provided by the local authority's Home First service and discharge to assess 28-day care home beds for people likely to require long-term residential or nursing care. It was hoped consistency would be further enhanced by the establishment of the new community care provider.
- System leaders told us resources were used in a flexible way to support flow. For example, the intermediate care hubs were used to provide interim placements for people needing a Home First or 28-day care home placement. Block contracts had also been established with a preferred list of domiciliary care providers (Help to Live at Home providers) to provide packages of care in areas of the city where recruitment was more challenging. According to the response to the SOIR, the expansion of the Home First service and increased capacity in bed based reablement had resulted in an initial 8% reduction in overall delays from Q1 to Q2 2017/18. However, some of these initiatives had only been implemented over the recent winter period so it was too early to determine if improvements were sustained.
- Published ASCOF data from 2016/17 showed access to reablement for older people post-hospital discharge in Liverpool was similar to the national average (2.8% compared to 2.7% respectively), although it was below the average across comparator areas (3.8%). However, since 2016/17, Liverpool's Home First service has been implemented and subsequently expanded, and three intermediate care hubs have been developed. Overall, throughput had increased; data provided by the system showed that between 2016/17 and 2017/18 there had been a 24% increase in the number of people receiving reablement (1370 to 1700 people). Data provided by the system showed that when people received reablement they achieved positive outcomes; in Q3 2017/18, 94% of people aged over 65 were at home 91 days after discharge from hospital. This was a significant improvement from 76% in 2016/17, coupled with the fact the system had seen an increase in demand in hospital services during the same period.

- Transport was not cited by staff as a barrier to timely discharges. However, transport capacity had been increased over the winter period at Aintree University Hospital on a short-term contract with Chloe Care which was due to finish at the end of March 2018. Staff were very complimentary about this service and were concerned about the impact of it stopping.
- There was variability within the system in terms of ensuring people received timely reviews and assessments of their support needs upon discharge from hospital. As well as improving the outcomes for people who received a reablement service, the system had also improved efficacy of the intermediate care hubs to facilitate flow. The average lengths of stay had decreased from over 40 days to 24-25 days. People using services and staff spoke positively to us about the availability and timeliness of equipment to facilitate discharges. There were equipment hubs based at hospital sites and mobile delivery vans provided equipment within 24 hours. Some additional capacity had been provided over the winter period and staff hoped this would continue.
- However, we received mixed feedback from frontline staff working in healthcare and social care settings about the availability of community therapy staff and social work staff, particularly in the north of the city, to carry out timely reviews and support people to remain independent. Commissioners were aware of where there were capacity issues, but this needs to be addressed at pace to ensure equity in geographical coverage and to prevent unnecessary readmissions to hospital.
- The high impact change model for managing transfers of care identifies seven-day services as one of the changes that can support health and social care systems reduce delays. The Department of Health's analysis of activity between April 2016 and March 2017 showed that the proportion of older people discharged over the weekend in Liverpool was slightly higher than similar areas at 20%. Intermediate care hubs admitted people seven days a week, but social care providers were less likely to accept discharges over the weekend and some services across the system were not operating seven days a week. Therefore, this figure was unlikely to increase significantly.

## Maturity of the system

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

- Liverpool's vision for integration dated back to 2013 and although some work had begun within the two years prior to our review and there was clear commitment from system leaders to work more collaboratively, this shared intent needed to be operationalised at pace. Performance showed Liverpool was on the right trajectory but sustained improvement may be hampered if system leaders do not involve wider partners and the public in strategic planning (*One Liverpool*), planned organisational changes are delayed, or system risks are not addressed collectively.
- For the system to move forward it needs a clear strategic vision. This is now in place with *One Liverpool*, but this is only in its embryonic phase and the system needs to ensure this becomes a co-produced plan. Furthermore, joint commissioning arrangements remained underdeveloped and long-standing, jointly-funded posts had not translated into integrated commissioning activities.
- Governance structures had historically been organisationally based. Moves towards system-level governance had gained momentum with a framework put in place shortly before our review, but this needed clear terms of reference to avoid duplication. The system needed to ensure governance structures included wider system partners and that there were shared controls and processes to manage risks and to learn as a system. There was a culture of piloting with limited evaluation to demonstrate cost-effective outcomes and high-quality service provision.
- There was a strong commitment to partnership working among frontline staff. There was some evidence of positive relational working among system leaders and collaboration in the interests of meeting defined needs for the people of Liverpool. It was widely acknowledged that recent system challenges had been a barrier to effective partnership working, but it was clear relationships were improving. However, this had not yet resulted in true service integration or a joint strategic approach to commissioning and provision.
- There was a traditional approach to shaping the health and social care market. System leaders need to be more innovative and inclusive by working with the local care market, recognising the role the independent care sector plays in service provision. The city faced significant quality issues within residential and nursing care provision and there had been a multi-agency response via the Care Home Improvement Strategy. A tripartite agreement

was in place between Liverpool and neighbouring local authorities to set a price for domiciliary care, but it was acknowledged there needed to be a shift in focus to outcomes rather than the traditional time and task focus.

- At the time of our review there was no evidence of formal risk sharing agreements in place. There was good tactical use of the Better Care Fund (BCF) to reduce pressures, but more needed to be done. Pooled budget arrangements were limited to the BCF and historic section 75 agreements and there was low uptake of personal budgets.
- The positive trajectory for the system may be further hampered if there is no integrated, coherent workforce strategy. This was not in place at the time of our review and could impact on care now and in the future.
- Liverpool was making good progress in relation to technology and shared records. There was universal use of the NHS number and considerable investment had seen primary care adopt the same records system and plans were in place to develop a single patient record between RLBUHT and AUHT within the 12 months following our review. Efforts had also been made to digitise domiciliary care, which was a positive step. However, this had negatively impacted on community health and social care teams who did not have compatible mobile technology. System leaders need to ensure future technological advances to not destabilise other parts of the system.
- There was a shared commitment to pursue the prevention agenda, but service delivery and the development of an asset-based approach was underdeveloped. Although we saw evidence of strong MDT working, this was not system-wide and there was inequity between neighbourhoods. There was a proactive approach to identifying people at risk and remote monitoring through technology, but the ability for the system to respond reactively was hampered by service capacity and a focus on facilitating discharges.

## Areas for improvement

### We suggest the following areas of focus for the system to secure improvement

- The shared strategic vision for the city needs to be translated into an operational plan that is co-produced with all system stakeholders to ensure developments, are well understood and all partners agree about how it should be delivered.
- Strategic planning needs to be system-wide, recognising the role of all partners, including the private and voluntary sector across the health and social care and includes a comprehensive understanding of future workforce requirements, set out within a coherent workforce strategy.
- Organisational development work needs to be undertaken to strengthen relationships, improve communication and ensure there is a shared understanding among staff of the services available including each other's roles and responsibilities in achieving the strategic vision.
- System leaders need to work with providers to shape the market, recognising independent providers and VCSE sector organisations as system partners, ensuring they are involved in strategic planning and market shaping, to determine how desired outcomes can be effectively met.
- System leaders should develop a comprehensive public engagement strategy as a priority in order to facilitate meaningful public involvement in shaping the future direction of the city. There needs to be a review of the role neighbourhood political and officer leadership play in public engagement and representation of local views.
- Work needs to continue to strengthen relationships and ensure effective partnership working with wider system partners to improve people's experiences as they move through the health and social care system, ensuring geographical boundaries do not become a barrier to seamless care. For example, Liverpool CCG should work with its partners in Sefton and Knowsley to streamline out of hospital pathways.
- System-level governance arrangements need to be strengthened to address performance and quality issues and facilitate risk-sharing as well as encouraging learning and evaluation between partners. Outcomes from safeguarding investigations should be shared with referrers to provide assurance concerns have been managed in accordance with agreed



policies and procedures.

- The local authority needs to ensure it continues to fulfil its statutory obligation under the Care Act 2014 to provide assurance there is appropriate capacity of good quality services within the social care market to ensure people receive person-centred, safe, high-quality care.
- Joint strategic commissioning intentions between the CCG and the local authority need to be operationalised. Work to rationalise the complex health and social care landscape needs to continue so it is easier to navigate and ensure staff are deployed effectively to enable services to be more responsive. System leaders need to address the inconsistencies in commissioning and service provision. For example, only 50% of GPs were participating in MDT meetings and other initiatives were not available in all neighbourhoods.
- The GP Federation needs to ensure it works with its member organisations to present a unified voice and to help deliver a coherent offer in the context of neighbourhood model proposals.
- System leaders need to ensure future technological advancements do not destabilise other parts of the system. Community-based teams should be equipped with compatible mobile technology to access domiciliary care records in people's homes.
- The personalisation agenda should be developed with more people supported to access personal budgets and direct payments.
- Information flows between services, including independent care providers, need to improve to facilitate safe and timely discharges from acute hospitals. Specifically, the early involvement of community services and care providers, quality of discharge information and the sharing of discharge information.
- We found many examples of good practice, such as the Options publication and MADE meetings; these should be rolled out across the system.