NHS Warrington and Warrington Borough Council

Intermediate Care Services

COMMERCIAL IN CONFIDENCE

An outline solution submitted by Halton Borough Council and NHS Halton and St Helens

24th June 2009

Contents

1. Introduction

1.1. Overview

This outline solution has been prepared in response to an 'Invitation to Submit an Outline Solution' received by Halton Borough Council and NHS Halton and St Helens from Warrington Borough Council and NHS Warrington.

A competitive dialogue process was instigated following a joint review of intermediate care in Warrington in the Autumn of 2008 where it was agreed to procure a redesigned, integrated, singly managed intermediate care service for the Borough.

Our outline solution has been broken down into the following sections:

- In this section we summarise the key features of our proposal describing why we believe we are ideally placed to manage and deliver this service.
- In section two we demonstrate our understanding of both the context of the service and your requirements.
- In section three we describe our proposed service model.
- Governance and management arrangements are outlined in section 4 of the document.
- In section five we outline the indicative costs of delivering the service and the measures in place to assess performance and value for money.

1.2. Executive Summary

There are a number of key features within our outline solution that we wish to highlight and emphasise:

- The service model proposed will deliver an integrated intermediate care model within a transparent single management structure. This model is based on best practice and has been tried and tested within Halton and St. Helens.
- The whole system model we have adopted will ensure that handovers are kept to a minimum, response times are quick, capacity is built in the community setting and that focus is maintained on preventing unnecessary hospital admissions, reducing the length of hospital stays and reducing the number of long term care placements.
- The effectiveness of our model can be illustrated by our achievements in Halton and St Helens over the past 5 years, this includes: a steady reduction in emergency admissions and acute hospital bed admissions (the reduction being greater in the over 65 population); a halving of the number of people living in care homes; a tripling the number of people over 65 supported at home; a reduction in the size of on-going care packages so that people are able to live more independently with lower levels of support.
- A single point of access will be adopted to ensure that the service is easy to enter and capacity can be more effectively managed.

- In the acute setting the creation of a high profile front of house service with a presence in EMU, GPU and A&E will ensure that alternatives to hospital admission are pro-actively and systematically considered. Integration of intermediate care staff onto ward rounds / discharge team will be also be used to identify opportunities for earlier discharge.
- Adopting the same intermediate care system for Halton and St Helens and Warrington patients will make it easier for staff at Warrington Hospital to process and promote intermediate care.
- The integration of intermediate care onto the elective pathway and the involvement of the team in pre and post operative assessments will be used to ensure that community based recovery and rehabilitation is built into care plans.
- Multi-disciplinary intervention teams will provide a flexible and responsive resource that will integrated with emerging models of locality based working in Warrington and ensure robust co-ordination of episodes of care.
- The solution we have outlined represents value for money for Warrington. In addition to reducing emergency admissions, length of stay and long term care placements we will reduce intermediate care bed capacity to 55 beds.
- Robust governance arrangements are proposed that will ensure continuous improvement against performance standards and the on-going development of the intermediate care service in line with changing needs.

2. Context and Requirement

2.1 The Warrington Context

2.1.1 Warrington's health measures are slightly below the average for England, although there are wide variations in health outcomes at a neighbourhood level. Healthy and wealthy communities live side by side with much more disadvantaged and less healthy communities. Health in Warrington is improving, for example, life expectancy continues to increase and premature deaths from heart disease are falling; cancer death rates are similar to the national average; there is evidence from lifestyle surveys that smoking in adults has reduced; the population is eating more fruit and vegetables and exercising more regularly; and the conception rate amongst teenagers continues to fall.

2.1.2 Deprivation is largely concentrated in the inner town centre areas, where eleven super output areas (SOAs) fall within the most deprived 10% nationally. Residents in these areas will have higher levels of chronic diseases, and consequently more pain, disability and premature death. Life expectancy at 65 is lower in Warrington than the England average. The major contributors to reduced life expectancy in Warrington are circulatory, respiratory, and digestive diseases.

2.1.3 Levels of obesity and alcohol are rising steeply in Warrington and current health improvement programmes on diet, alcohol, smoking and exercise are not meeting the local needs. The population is ageing and the health of older people is worse than the national average. There are predicted to be large increases in the prevalence of cardiovascular diseases, long term conditions and dementia. This has serious implications for health care, mental health and social care. Early detection and effective management are crucial if Warrington is to reduce use of health services.

2.1.4 The rate of unscheduled/emergency hospital admissions in Warrington is significantly higher than the England average. There is a clear correlation between deprivation and emergency admissions at Ward level. Within Warrington, the issue of higher rates of emergency hospitalisation amongst more deprived populations is complicated by the fact that this is where both the hospital and deprived populations are located. However, the level of deprivation experienced is a more significant factor in determining likelihood of emergency admission than proximity to the hospital.

2.1.5 Warrington PCT has successfully addressed a number of these significant challenges over the past two years. They launched a programme of public and stakeholder engagement that underpins the way NHS Warrington does its business. "A Healthy Warrington" and will continue to build on this work through a Public Engagement Plan which aims to engage hard to reach communities in greater depth and ensure that the population as a whole have the opportunity to comment and influence the direction of health services. As a result of this work the PCT has established the following strategic goals:

- Improve healthy life expectancy & life expectancy for all
- Prioritise earlier interventions in care pathways to keep people well

- Improve the quality, safety and patient experience of all commissioned services
- Optimise health outcomes whilst achieving sustained financial balance

2.1.6 Given the current analysis of health in Warrington, it is likely that it will experience an increase in the demand for intermediate care services.

2.1.7 A recent study at Warrington Hospital[1] identified non-elective admission statistics roughly in line with National studies, including:

- 45% of admissions had a zero or night length of stay – indicative of those who could potentially have remained at home or a community setting with appropriate care.
- 16% of patients were identified as appropriate for discharge the day after the survey, but it did not happen.
- 40% of non elective admissions in medicine and care of the elderly were inappropriate for an acute trust setting.

2.1.8 In Autumn of 2008 the PCT and Local Authority undertook a joint review of intermediate care. The review concluded that,

"*The current service is very fragmented as Intermediate Care is currently provided by three agencies within Warrington. There are a number of advantages to the Council and the service if the procurement method outlined above is adopted. One lead provider is more likely to achieve a fully integrated, seamless pathway for the service user, and there may be potential economies*".

2.1.9 Service users and carers were consulted as part of this review with a number of strong themes emerging, these were:

- The wish to avoid hospital admission where possible.
- Information sharing at all stages is important.
- 'Kindness and caring' is highly valued at all stages of service delivery.
- Prevention is integral to the service.
- Co-ordination across the whole system is essential.
- Intermediate care at home should be a real alternative.
- Recognition of the needs of carers.

2.1.10 The joint review led to the publication of the Joint Intermediate Care Strategy and Commissioning Intensions in March of this year on which this procurement process is based.

2.2 Policy and Drivers Relating to Intermediate Care

2.2.1 As well as local imperatives which are promoting the development of intermediate care in Warrington there are a number of national drivers which are pushing in the same direction.

2.2.2 The Department of Health is encouraging the provision of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living. In particular they have issued a standard which makes it clear that older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils. This is designed to prevent unnecessary hospital admission and effective rehabilitation services and to enable early discharge from hospital. It also aims to prevent premature or unnecessary admission to long-term residential care.

2.2.3 The direction of policy is explicit within Strong and Prosperous Communities, Our Health, Our Care, Our Say; Ambition for Health and the Darzi Report. Central to meeting this aspiration is the creation of services close to home utilising partnerships across the public, private and third sectors. Within the World Class Commissioning framework services should be based on an assessment of needs, evidenced based to make the intended health impact / improvement, be developed with all stakeholders, ensure improvement and innovation, stimulate the market and, as a result ensure sound financial investment.

2.2.4 Nationally a variety of services developed or were redesigned that had crisis response and / or rehabilitation and reablement components. Bed based services were set up in NHS, local authority and private sector provision. Research and evaluations from a variety of sources have demonstrated the efficacy, safety, user satisfaction and efficiency of a range of community and bed based services) although there are gaps in relation to bed based provision in nursing and residential homes and some crisis response services. Furthermore, a strength of intermediate care is identified as its development in the context of local circumstances thus meeting local need.

2.2.5 The NHS Plan set out a major new programme to promote independence for older people, through developing a range of services that are delivered in partnership between primary and secondary health care, local authority services, in particular social care, and the independent sector. One of the critical elements in this programme is to develop new intermediate care services. The NHS Plan announced an extra investment of £900 million annually by 2003/04 for intermediate care and related services to promote independence.

2.2.6 Among the extra services required nationally are more intermediate care beds and supported intermediate care places. Capital funding has abeen provided to Health commissioners to expand capacity and to support the development of intermediate care services and in particular a growth in bed numbers. The national agenda also seeks to increase the level of quality of provision. It aims to promote a wide range of new and innovative services, including intermediate care services, established to promote people's independence.

2.2.7 The *Community Care (Delayed Discharge etc) Act 2003* has removed social services' ability to charge for community equipment and intermediate care services. This means that these services are free of charge to users and removes a barrier to local authorities providing these services jointly with the NHS, which does not charge and will help make access to services easier.

2.2.8 National research has promoted the need for a number of key services in order to sustain the objectives of the policy agenda. The needs are likely to include

rehabilitation / therapy social and personal care and nursing. There is likely to be relatively little need for medical support. Most rehabilitation need is for physiotherapy or occupational therapy. The intensity of need can vary: need for nursing and medical support tends to be low intensity, and need for social and personal care tends to be high intensity whilst need for rehabilitation / therapy varies with the care type.

2.2.9 Department of Health commissioned research has shown that the great majority of patients could receive care at home with some of those needing minor adaptations. Only a very small minority would require community hospital beds. This research has provided robust results which will determine the future provision of intermediate care and influence other services across the health economy.

2.3 Effectiveness of Intermediate Care

2.3.1 Recent national studies have suggested that:

- Bed based intermediate care services probably achieve similar outcomes for patients who are assessed as no longer requiring acute medical care, as those who remain in acute hospital beds. However, there does not appear to be a definitive definition of when acute care is no longer required though there are clinical tools available to support this; the evidence is based on 'sub-acute' NHS (or similar) bed based provision, not residential or nursing home bed provision where further research is required.

- Admission avoidance schemes (rapid assessment nurse, social work, therapy or MDT teams, hospital at home schemes) do divert people from admission and have the potential to reduce costs, though the clinical effectiveness of various types of services needs to be established.

- Services that provide comprehensive geriatric assessment / multi-disciplinary interventions are more able to deal with the complex needs of the user group and may therefore achieve better outcomes. Models vary in localities.

- Outcomes for users of intermediate care services are probably related to the severity of their illness and it's trajectory at admission, the amount of social support and networks they have and the support they receive in undertaking self care.

- Satisfaction levels with intermediate care and related service are consistently high.

- There are no prescribed formulas that identify how much and what types of intermediate care services need to be provided in a locality. The availability and use of hospital and community health and social care services as well as population and health predictions need to be factored into the equation. In addition work would need to be undertaken to agree thresholds and thus criteria for various services.

- Local circumstances have been the main predictor of resultant services and pathways.

- Issues in relation to the efficacy and safety of existing and newly commissioned services can be addressed through governance and performance management frameworks.

- Care and case management systems, though not traditional intermediate care services, have the potential to affect admissions and discharges and therefore warrant further exploration in the locality to identify the most appropriate systems.

2.4 Experience in Halton and St Helens

2.4.1 Intermediate care services have played a significant role in achieving improvements in overall outcomes for people in Halton and St Helens over the past 5 years. This has been reflected in a steady reduction in emergency admissions and acute hospital bed utilisation, the reduction being greater in the over 65 population. The number of people living in care homes has more than halved. Over the same period of time the number of people over 65 supported at home has tripled. This approach has also reduced the size of on-going care packages so that people are able to live more independently with lower levels of support.

2.4.2 Following a recent review of Intermediate care services a 'Gold Standard' was introduced to underpin service delivery. The standard incorporates the criteria for assessment that encourages referrers and staff within intermediate care to adopt a person centred approach. In addition a performance management framework was developed to ensure that current and future provision delivers high quality efficient services linked to outcomes for users.

2.4.3 All intermediate care services across Halton and St Helens are managed within a partnership agreement across health and social care. A pooled budget is operational and utilised flexibly to enable the services to be responsive to local need.

2.4.4 Access to all Intermediate Care services is through a single point of access and is aligned with assessment provision. Following assessment the person will be placed in the most appropriate intermediate care service. This ranges from community placement to the sub acute unit according to assessed need.

2.4.5 We deliver a comprehensive intermediate care services that uses a range of expertise, services, interventions and assistive technologies. These are widely available not just to those at risk of hospital admission or on leaving hospital. This is in line with out philosophy of providing care closer to home and supporting people to remain independent in their own homes for as long as possible.

2.4.6 The service adopts an "inclusive" approach with equitable access for people with long-term conditions, mental health and palliative care needs. Length of stay is dependant on clinical need and not length of time in the service. Discharge is planned on admission and a goal orientated plan of care including expected date of discharge agreed.

2.4.7 The service is comprised of:

<u>An Intermediate Care Assessment Team</u>

This team consists of nursing staff and is available from 8am to 10pm. This assessment team attends A&E/Medical Assessment Unit at the North Cheshire Hospital Trust (NCHT) at the identified peak times and proactively case finds to

prevent admission/reduce length of stay and assists with early discharge. The out of hours service is integrated with district nursing.

Rapid Access Rehabilitation Service (RARS)

This is a key Intermediate Care Service in Halton providing multidisciplinary assessment and intervention to people in their own homes and those in designated Intermediate Care Beds through which programmes of rehabilitation, treatment and care are implemented.

Residential Intermediate Care Beds

There are 13 beds located in Oakmeadow in Widnes (local authority residential home). Access is generally through RARS assessment, however Community Matrons and the ICAT service in St Helens also admit directly to these beds. Medical support is provided by a designated GP. Pharmacy support within the beds supports the team to work with people to self medicate and remain as independent as possible with their medications.

Sub-Acute Unit

22 beds commissioned from NCHT. Access is through the Intermediate Care Assessment Team. A service specification includes the provision of GP and consultant cover.

Domiciliary Re-ablement Service

The Halton Reablement Service aims to provide a short term time limited service to support people to retain or regain their independence at times of change and transition, which promotes the health, well being, independence, dignity and social inclusion of the people who use the service. At times of change in circumstances, the service will offer a timely, equitable and flexible response, which ensures appropriate support by the right person, at the right time and in the right place to facilitate the most positive outcome for the service user.

2.4.8 Research undertaken as part of the Department of Health Care Services Efficiency Delivery (CSED) programme demonstrated that the use of short-term re-ablement care achieved an overall 28% reduction in the number of long term hours commissioned with approximately 70% of users continuing to benefit for more than 2 years. These figures are consistent with a local evaluation undertaken by the re-ablement team in Halton.

2.4.9 Halton BC has a clear set of values that defines our service ethos and underpins all aspects of service delivery, these are:

a) As professionals we should respect and promote the autonomy of the individual.

We should: -

- Safeguard and promote the interests of service users and carers.
- Strive to maintain the trust and confidence of service users and carers
- Support people's right to control their lives and make choices about the services they receive.

- Facilitate listening to, respecting and where appropriate, prompting the views and wishes of service users and carers.
- Value and treat each person as an individual.
- Respect and maintain the dignity and privacy of service users and carers.
- Be non-judgmental.
- Aim to support and treat people in the same way, as you would like to be supported yourself.
- Provide a process to enable people to exercise their right to self determination.
- Listen to the views of people about their needs and wishes for care.
- Empower service users to make decisions about their care and the level acceptable.
- Provide opportunities for service users to exercise choice in how the service is delivered.

b) We should ensure that all service provision is perceived by the user to be a single package of care.

We should: -

- Work openly and co-operatively with colleagues and Professionals, recognising their roles and expertise and treating them with respect.
- Front-line Professionals should be supported to take responsibility for planning and providing the care for individual older people.
- Where an older person requires the help of more than one agency, agencies should co-ordinate service delivery in the best interests of the older person.
- Access to services should be via assessment that is co-ordinated and straightforward, with duplication kept to a minimum.

c) Informed consent is a pre-requisite to every element of the assessment and the care package

We should: -

- Provide realistic options of how persons needs can be met***.***
- Ensure that where there is no risk to others, people should be (and feel) empowered to determine the level of risk they wish to take. Consent includes: - informing the service users of the level of risk associated with a particularly course of action. Informing service users of the implications of that risk. Informing service users of the implications of not avoiding that Risk
- Focus on achieving realistic goals.

- Ensure that people being assessed have every opportunity to consent to the assessment process, it outcome and the plan for providing care.
- Carers should be made aware of their right to a separate and confidential assessment.
- Seek a service user/patients consent to share information at all stages.

d) Age, itself, should not determine how services are accessed or provided.

We should:-

- Be aware of the impact of age, gender, race, living arrangements, lifestyle choices and disability on older people and their needs but not make assumptions about its impact and be prepared to respond appropriately.

e) Where individual older people lack capacity to make decisions or give their agreement, agencies should have procedures in place to secure the maximum possible participation and safeguard the older person's interests.

We should:-

- Ensure that the service users interests are represented when it is not possible to attain their informed consent.

f) We should promote individual health and well being and optimise independence.

We should: -

- Respect the independence of service users and protect them as far as possible from danger and harm.
- Promote independence and care at home as far is feasible and desired.
- Identify the service users strengths and weaknesses.
- Ensure that service provision is based on assessed needs.
- The assessment process and services should enable people to maximise their potential for independence.
- Promoting health and well-being is as important as reacting and responding to needs as and when they arise.
- The potential for rehabilitation should be explored at assessment and subsequently kept under review.

g) Service information should be both understandable and accessible.

- Information should be readily available.
- Information on how to access services should be clearly understandable.
- Older people should be appropriately informed, in clear language about suitable methods of assessment and services and how to access them. Their

comments on assessment arrangements and services should be actively sought.

h) Professionals should be competent to work with older people and should be active in Continuing Professional Development.

- Professionals who work with older people should be properly trained and developed to do so.

i) Care providers will promote and maintain good practice and adhere to legal requirements and the relevant standards of practice.

We should: -

- Balance the rights of service users and carers with the interests of society.
- Adhere to legal requirements and relevant standards of practice and promote and maintain good practice.
- Challenge dangerous, abusive, discriminatory and/or exploitive behaviour.
- Recognise the potential for power imbalances in working relationships with service users; carers and other Professionals and using authority in *a* responsible manner the principles underpinning 'Direct Payments' should apply to all services.

j) Communication will be honest open and straightforward.

We should: -

- Take complaints seriously and respond to them.
- Ensure that service users and care workers have a mutual understanding of the service users needs.
- Not ask for people's comments unless we genuinely intend to take them on board and do something about them.
- Involve people in decisions about their care and help them to understand their involvement.
- Respect confidential information and gain permission from those it concerns to share it for specific reasons.
- Ensure that at all times the service user will know who to contact to discuss any respect of their care plan.
- Ensure that service users find it easy to comment on their experiences of services
- Effective information sharing between professionals, where confidentiality is respected, can be crucial for effective person-centred care.

k) A holistic approach to assessment will incorporate the whole picture of individual needs.

We should: -

- Endeavour to understand the service users' situation from their perspective in all situations.
- Recognise and support the contribution of family and other carers, ensuring their contribution and needs are considered – either as part of the service users assessment or as part of a carer's assessment in their own right.
- Recognise that each of the following can impact on the range of service provision which can be provided: - age (however service should not be denied solely on the basis of age); race; living arrangements; relationships; disability; culture; lifestyle choices; agencies should acknowledge the role that many carers and family members play in the care of older people, and be prepared to offer necessary support.

2.5 The Requirement

2.5.1 Following the joint review of intermediate care services and the subsequent publication of the Joint Intermediate Care Strategy and Commissioning Intensions in March 2009, NHS Warrington and Warrington Borough Council has embarked on a procurement process for a redesigned intermediate service that will comprise of the following components:

- An integrated, singly managed, multi-disciplinary assessment and care co-ordination team that will work across all settings and will directly support the most complex cases (LOT 1).
- Integrated locality based teams that reflect different needs across the Borough and to ensure integration with other local or neighbourhood services (LOT 2).
- Sufficient beds to provide a local bed based service for intermediate care where this service cannot be provided in someone's own home due to risk or level of need (LOT 3).
- The estate and facilities management to support the bed based services above (LOT 4).

2.5.2 In order to realise all of the benefits you have identified within your intermediated care strategy we believe that it is essential to consider the service as a whole system of integrated intermediate care. In section 3 we present a service model that we believe would meet all of your requirements efficiently and effectively. In order to ensure the service does not become fragmented and all aspects of provision are fully integrated we have presented this as a whole patient journey which we have signposted to the appropriate Lot.

3. Service Model

3.1. *Introduction*

3.1.1 Halton and St Helens have a tried and tested intermediate care model founded on a gold standard that is delivering the following benefits to the communities served:

- A reduction in emergency admissions to the acute trust.
- Reduction in the length of stay for appropriately assessed patients.
- A reduction in the intensity of domiciliary care packages of 28%.
- Increased elective capacity within acute.
- Allowing the patient to be cared for at, or closer to home
- Reduction in overall costs
- Contributing to achieving accident and emergency access targets
- Reduction in elective admission cancellations
- Cost savings to the PCT
- Reduction in demand for long term care placements;
- Streamlined and informed patient pathway
- Greater patient satisfaction

3.1.2 This model encompasses the best practice principles that are highlighted within the 'Invitation to Participate in Competative Dialogue', including:

- Sufficient capacity in community based settings to respond to need.
- Integration with models of case management being developed.
- Complements and promotes the range of services that support independent living.
- Encourages collaboration with other aspects of provision.
- Case finding in the community.
- Iterative assessment of need to help balance home and bed based provision.

3.1.3 The approach is based on a whole system model that places the patient at the centre of service design. It seamlessly integrates the pathway ensuring the patient has the right care, in the right place at the right time. This approach helps us to ensure:

- Services are easily accessed.
- The pathway is uncomplicated with the number of handovers kept to a minimum.
- The service can respond rapidly and flexibly to demands.
- Clear management and co-ordination for each episode of care.

- Easy integration with other aspects of service provision.
- Focus on the wider benefits and outcomes are maintained.

3.1.4 As stated in section 2.5, the invitation to submit an outline solution is broken down into four lots, these are, the provision of an integrated assessment and care co-ordination team; provision of integrated locality based teams; local bed based services; estates and facilities management. In order to realise all of the benefits you have identified within your strategy we believe that it is essential to consider the service as a whole system of integrated intermediate care. We have therefore presented our service model in this way and have signposted how the model fulfils your requirements.

3.1.5 Overall our service model can be represented as:

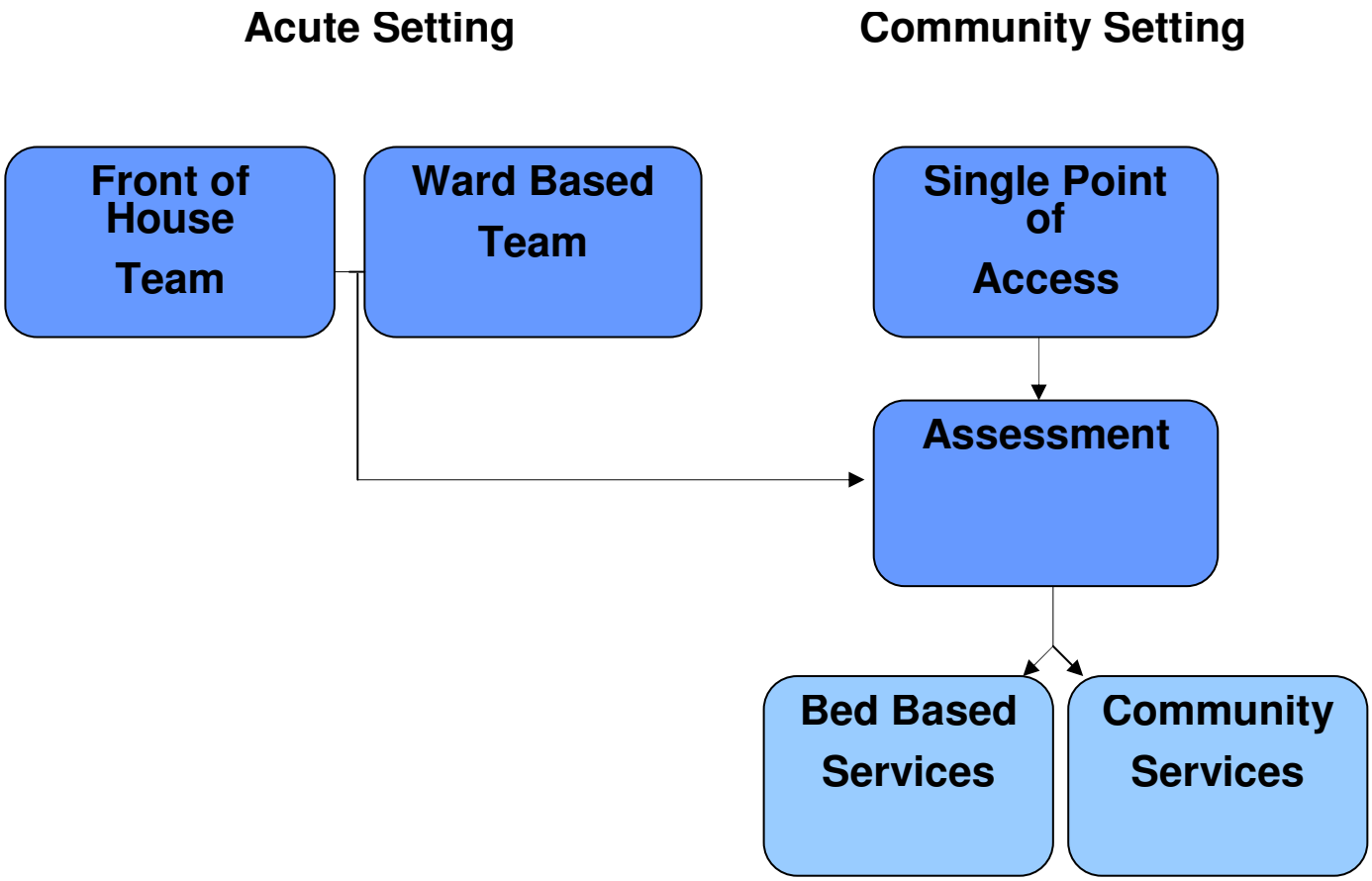


Figure: Service Model Overview

3.2. *Access and Assessment*

This section addresses part of the requirement outlined within Lot 1.

Single Point of Access in the Community Setting

3.2.1 An essential feature of our model is that access to service is as easy as possible. We would establish a **single point of access** that would be the entry point for anybody entering the system. The referral could be made by: GPs, health and social care professionals, self-referral or carers. The referral could come into the

single point of access either by telephone or through e-mail / web enabled access channel.

3.2.2 The service is available to anybody over the age of 18 and we would allow any number of re-referrals of patients as access to the service is based on health need.

3.2.3 An initial assessment would be undertaken over the phone with one of three possible actions recommended:

- Signpost / referral to another service or agency.
- An appointment is made with the assessment and care co-ordination team.
- An urgent or emergency response is triggered.

3.2.4 There are five options on the structure and operation of this single point of access that we would wish to explore in further detail with you. Each has relative advantages, disadvantages and cost implications:

- **Option 1** is that the single point of access is purely an administrative function that simply collects information, retains this information in a central repository and then passes the information to a member of the assessment and care co-ordination team to make a decision on what happens next.
- **Option 2** places a member of the assessment team with the administrative staff who can make an immediate decision on what happens next over the phone.
- **Option 3** involves the telephone call to the single point of access being diverted to a member of the assessment team to pick up.
- **Option 4** would be to integrate this function within any existing single point of access being developed in Warrington. In this model the administrative staff would be employed by Warrington PCT and would be supported by a member of the assessment and care co-ordination team.
- **Option 5** would involve integrating the function into an existing single point of access operating within Halton and St. Helens.

Model	Advantages	Disadvantages
Administrative Model (option 1)	• Accessible during advertised times • Can gather many of the information domains quickly.	• Passing information onto a member of the assessment team will slow down response time.
Administration and Assessment Model (option 2)	• Rapid decision making • Clinician making the referral is able to speak to a clinician • Can provide patient with immediate assurance	• Additional Cost
Direct Access to Assessment Team Member (option 3)	• Reduced cost of service	• Many patients do not like leaving messages • Slows down decision making.
Integration with existing single	• Closer integration with other	• Management of the function

point of access (option 4 and 5)	services / less confusion for patients • Cost reduction	sits outside of the intermediate care service.

3.2.5 For options 1, 2, and 3 we would provide a 7 day a week service between the hours of 8am and 10pm. Options 4 and 5 would operate on a 24/7 basis.

3.2.6 A key responsibility of the single point of access would be to provide up to date information on bed capacity to the assessment team in order to assist with planning and decision making.

3.2.7 A full set of protocols and comprehensive training would be provided when developing the single point of access.

Assessment

Community Setting

3.2.8 An integrated assessment function would be established and integrate with the Single Assessment Process in Warrington.

3.2.9 A number of mechanisms would be adopted to get the information from the single point of access to the assessment function in the community. This could include: a telephone call; assessment team chooses to visit the patient first; the information is transmitted through mobile technology (depending on systems in place at Warrington).

3.2.10 A clear set of assessment domains that must be covered prior to agreement for an admission into any of the services will be outlined. These will include:

1) Bio-Graphical Information

2) Presenting condition / situation / plans

the current situation and any precipitating factors e.g. Mrs X had a fall yesterday whilst getting off the bus and presented to A&E today complaining of pain in left hip.

investigations and results completed

impression of causes of any residual issues e.g. diagnosed as soft tissue injury affecting mobility. Mrs X has lost confidence with mobilising. Transfer ability is affected by pain

immediate treatments / interventions e.g. Mrs X has been prescribed analgesia, assessed using zimmer frame, requires support to transfer and mobilise

any instructions for ongoing care / treatment at the receiving service

any follow up planned

3) Previous medical / health conditions (including mental health)

4) Current medication

for community patients a complete list of current medications needs to be gained from GP surgery

injections, controlled drugs, oxygen should all be highlighted

5) Known allergies and sensitivities

6)Communication

This should include:

language used e.g. English, sign, Cantonese

difficulties experienced e.g. memory problems, expressive dysphasia, passive mood, hearing and vision issues

ability to express needs, wants preferences

7) Functional ability

Where relevant a comparison of ability prior to the current situation should be included for:

self care ability e.g. assistance required with washing and dressing, unable to prepare food or drinks

tranfers e.g able to transfer independently from chair / bed / wheelchair

mobility e.g. unable to mobilise at present, previously used a wheeled zimmer frame. Unable to climb stairs, has a stair lift

diet and fluids e.g. able to eat and drink, has dietary supplements

affect of existing long term conditions e.g. has copd / heart failure and is breathless on exertion; had stroke 4 years ago with left side hemiparesis; has bilateral leg oedema affecting mobility

8) Copies of specialist assessments completed

This could be capacity assessment, home visit report, tissue viability assessment. Anything that will assist continuation of assessment / care / treatment.

9) Consent

This should include:

documented confirmation that information about the proposed service has been given to the patient and that they have consented.

documented confirmation that the patient's next of kin or similar is aware of the proposed intervention and any comments they have (where patient consents to this contact)

10) Intervention(s) recommended

This should describe what services are needed and when they need to commence e.g. requires sub-acute intermediate care bed for IV anti-biotic management of cellulitis; will need assistance with daily activities at home and further rehabilitation commencing today; for admission to residential intermediate care bed to manage pain and improve mobility and self care ability – will need physiotherapy review of mobility on admission.

11) Risk Assessment

Information on any risks and actions to ameliorate these should be included. Risks from health status, environment, behaviour etc should be clearly documented.

12) Medical stability / predictability / appropriate environment of care

Where there are new or exacerbations of medical conditions a copy of the medical assessment and proposed / continuation of a treatment plan must be provided. This should include documentation that the need for an acute hospital admission / continuation of stay is not required to complete the medical intervention. Where information is transcribed then this should be made explicit noting where the information is from.

In order to ensure the process is as efficient as possible we would seek to:

- Get each GP surgery to sign up to the process ensuring we have access to medical records.
- Use any assessment information already available so as to not duplicate processes.

3.2.11 The assessment process would further be sped up if part of the assessment function sits within the single point of access (see options in 3.2.4) as some of the assessment process could be undertaken over the phone.

3.2.12 We offer two options for operating hours of the assessment function in the community setting, these are, 8am-10pm (option 1) or 24 hour access (option 2) depending on further conversations as part of the competitive dialogue. In our experience the number of referrals after 10pm is minimal and would not justify the additional cost of the service. The assessment team would be made up of a core group of staff (six band 6 clinical staff with 2 administrators for option 1 or ten band 6 clinical staff with 2 administrators for option 2). Additional staff can be added on a rota basis from the intervention and hospital teams to meet periods of high demand.

3.2.13 Members of the assessment team would also work closely with locality based teams in Warrington and seek to use predictive modelling and discussions with other professionals to case find in a community setting.

3.2.14 Targets for response times will be agreed as part of the contracting process as a guide our existing standards are outlined in section 5.4.1.

Acute Setting

3.2.15 We have already highlighted a study in Warrington that found: 45% of admissions had a zero or night length of stay (indicative of those who could potentially have remained at home or a community setting with appropriate care); 16% of patients were identified as appropriate for discharge the day after the survey, but it did not happen; 40% of non elective admissions in medicine and care of the elderly were inappropriate for an acute trust setting.

3.2.16 We would therefore propose a pro-active approach in hospital to identifying patients who are suitable for discharge and intermediate care services. This would be comprised of two options:

Option 1

- A '**front of house' team** that would be based at the hospital and would have a high profile presence in accident and emergency, the emergency medical unit (EMU) and GP unit (GPU). This team would trawl these areas at key times to coincide with consultant rounds. This team would be available from 8am to 10pm and would be available 7 days a week.
- A **'ward based team'** that would undertake a systematic trawl of wards to identify opportunities for discharge. This service would be available from 8am to 10pm.

Option 2

- A 'front of house' team that would be based at the hospital and would have a high profile presence in accident and emergency, the emergency medical

unit (EMU) and GP unit (GPU). This team would trawl these areas at key times to coincide with consultant rounds. This team would be available from 9am to 10pm and would be available 7 days a week.

- Integrated discharge team to proactively identify and drive people though the hospital system. This team would plan and arrange the full range of primary care services required for discharge..

3.2.17 These teams would be made up of:

- Front of house team – six band 6 clinical staff.
- Ward based team – four band 6 clinical staff.
- Discharge team – eight band 6 clinical staff.

3.2.18 In periods of high activity at the hospital additional staff could be brought in from the community setting to ensure we have sufficient resource to meet the overall need.

3.3.19 We would also propose that our work is integrated into the elective pathway and will undertake pre-operation and post-operation assessments to plan for rehabilitation and recovery in a community setting.

3.2.20 The assessment function (whether in a hospital or community setting) will have the following options open to them following an assessment:

- Setting up an episode of care and handing over to the intervention team.
- Referral or signposting to another agency.
- Discharging with information and advice.

3.3. *The Intervention Team*

This section addresses the requirement of Lot 2 and some of Lot 1.

3.3.1 There are a number of service features that we would wish to build into our model of service delivery, these include:

- Fostering closer working across professional groupings.
- Locality based MDT.
- Robust co-ordination of each episode of care.
- Offering maximum flexibility of resources.
- Responsiveness to local needs.

3.3.2 We propose the creation of a large singly managed intervention team. Staff within this team will be allocated to virtual multi-disciplinary teams comprising of occupational therapists, nurses, social workers, physiotherapists and home support workers.

3.3.3 Each of the multi-disciplinary teams would be allocated to a different locality / localities in order that we build a presence within and can respond to the different needs of neighbourhoods served. We would wish to explore how these teams might

integrate with emerging models of case management within Warrington and/or practice based commissioning clusters.

3.3.4 Where-ever possible a single person (the allocated case manager) from the intervention team will be responsible for delivering the entire episode of care in order to reduce the number of handoffs. Multi-skilling will therefore be a core component of our approach. The episode of care could incorporate re-ablement, recovery and support for the management of sub-acute illnesses.

3.3.5 The intervention team will operate 7 days a week from 8am to 10pm.

3.3.6 The allocated case manager will be responsible for discharging the patient at the end of the episode of care based on an on-going series of review and assessment. The options at discharge are: discharge with commencement of another service; discharge with admittance to hospital; discharge without services. The case manager will be authorised to place patient direct into long term provision.

3.3.7 We would be keen to integrate the promotion and provision of telecare into the work of the intervention team and would welcome the opportunity to discuss this further. In our experience we have found that it is an effective mechanism for: speeding up discharge to the home; getting assistance quickly to a service user at risk; helping to build confidence that the person can continue to live independently.

3.3.8 The intervention team will comprise of:

Staffing	Scale Point	FTE
Multi-Disciplinary Team		
Occupational Therapist	Band 7	1
Occupational Therapist	Band 6	2
Occupational Therapist	Band 5	1
Physiotherapist	Band 7	1
Physiotherapist	Band 6	2
Physiotherapist	Band 5	1
Therapy Assistant	Band 4	2
Dietician *	Band 6	0.5
Community Psychiatrist Nurse	Band 6	1
Social Worker	SCP 37	0.5
Community Care Worker	SCP 29	1
Nurse **	Band 7	1
Nurse **	Band 6	2
Nurse **	Band 5	1
Speech & Language Therapist *	Band 7	0.25
Administration	SCP 15	2
Home Support Team		
Senior Care Assistant	SCP 25	4
Care/Support	Cons 15	20

3.4. *Local Based Bed Service*

This section addresses the requirement of Lot 3 and Lot 4.

3.4.1 Our initial calculations shows us that we believe that a capacity of 55 beds is sufficient based on the size of the population of Warrington. Depending on a better understanding of need and demand this would either be made up:

Option 1

- 35 residential beds at Padgate House and 20 nursing beds purchased from the independent sector.

Option 2

- 35 nursing beds at Padgate House and a further 20 residential beds purchased from the independent sector

This would provide a higher level of sub-acute work at Padgate House in order to facilitate earlier hospital discharge and prevent admission. Padgate House would be registered as an NHS facility.

3.4.2 The approach that we have outlined for integrating with discharge teams at the hospital would help reduce the numbers of patients requiring step down beds as we would proactively seen recovery and rehabilitation in the community.

3.4.3 We would also look to reduce the number of people in Warrington who are in transitional beds not provided in Padgate or Houghton. This would be done through proactive trawling by the assessment team / intermediate care co-ordinators.

3.4.4 In relation to facilities management we would be happy to explore the following options as the competitive dialogue develops:

- **Option 1:** We would lease[1] Padgate House from Warrington BC taking responsibility for the management of the facility. This would include: building insurance; heat, light and power; health and safety; communication media; telephony; visitor access; urgent repairs and routine maintenance; grounds keeping; cleaning; security and incident management.
- **Option 2:** We would purchase 35 bed places at Padgate House to deliver bed based services.

3.4.5 We would also seek to lease appropriate office accommodation for staff working within the service to operate from. This could be from Warrington BC, NHS Warrington or through a private landlord.

[1] This would be subject to due diligence and a full survey of the facility.

4. Governance and Management

Robust Governance Arrangements

4.1 Halton BC will provide overall governance and management of the service. The approach is underpinned by out 'Performance Management Framework' (see appendix 1) that addresses the following areas:

- Business probity
- Governance
- Promotion and marketing
- Activity monitoring
- Outcomes reporting

4.2 Robust and effective clinical governance for the service will be provided by Halton and St Helens PCT. The clinical governance strategy in place (see appendix 2) covers the following 9 components:

- Pro-actively identifying clinical risks to patients and staff
- Improving services based on lessons learned from patient safety incidents/near misses
- Improving services based on lessons learned from complaints
- Ensuring effective clinical leadership
- Maintaining the capability and capacity to deliver services
- Ensuring the quality of the patient experience
- Involving professional groups in multi-professional clinical audit
- Involving patients and public in the design and delivery of CHS services
- Collecting and using intelligent information on clinical care.

4.3 A formal Partnership Agreement and a Partnership Board is in place to oversee joint working between Halton BC and NHS Halton and St Helens and provides an additional level of assurance and governance.

4.4 Based upon our experience of promoting partnership working we would propose the following governance arrangements are put in place for the contract:

- A small strategically focussed strategic management board comprising of senior managers from Warrington BC, Halton BC, NHS Warrington and Halton and St Helens PCT. The Board would meet on a 6 monthly basis to discuss opportunities for the on-going development of the intermediate care service.

- A joint operational improvement board comprised of operational managers and contract managers across the four organisations that would meet on a bi-monthly basis to discuss and resolve issues in relation to the delivery and performance of any aspect of the service.

4.5 The management structure proposed (see 4.12) would establish a clear intermediate care lead, the Divisional Manager that would provide day to day accountability for the service provided and can be reached daily to respond to issues that arise.

4.6 A Director level contact at both Halton BC and NHS Halton and St Helens would also be provided to whom issues can be escalate issues to should you feel that a higher level viewpoint is required.

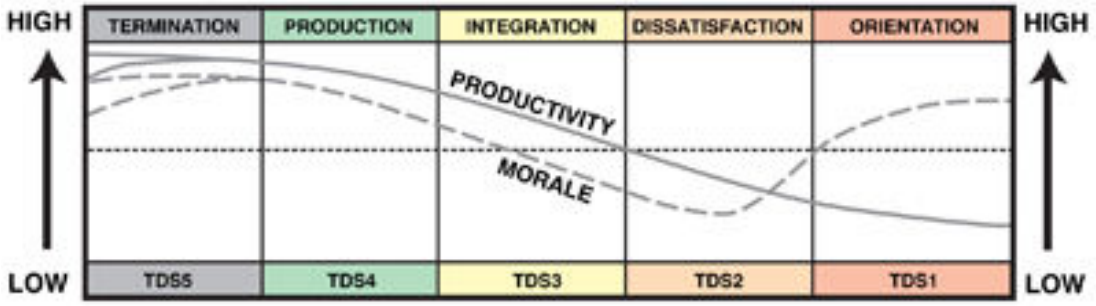
4.7 Systematic, timely and accurate performance and activity level information will be provide to Warrington in line with contract management, performance reporting and governance procedures.

Promoting Effective Partnership Working

4.8 We are committed to developing effective partnership working with NHS Warrington and Warrington BC in relation to the governance, management and delivery of intermediate care services. We have extensive experience of partnership working across health and social care including:

- The joint provision of a multi-disciplinary intermediate care team across Halton and St Helens since 1999.
- The joint provision of bed based intermediate care services across Halton and St. Helens since 1999.
- The joint provision of re-enablement services.

4.9 Studies show that all partnerships go through a series of distinct development phases (shown right to left) before they achieve their full potential, these are:



4.10 To move quickly through the orientation (honeymoon) and dissatisfaction stage a number of building blocks need to have been put in place. These are:

- Clarity of shared vision and objectives signed up to by both partners
- Well understood roles and responsibilities agreed across the partnership structure
- Open and honest reporting to build trust between partners

- Mechanisms for two way dialogue and joint problem solving
- Resolving any perceived inequalities in level of risk and reward of either partner
- Devolving decision making to the front line so that the partnership can make a difference on the ground.

4.11 In order to ensure these building blocks are quickly put in place and built upon we propose a series of 'away days' involving key managers from Halton and commissioning / contract managers from Warrington. This sessions will take place on a 3 monthly basis for the first year of the contract and will focus on the how the partnership is working and what could be done to improve the partnering arrangements.

Management Structure and Arrangements

4.12 The following management structure would be established[2]:

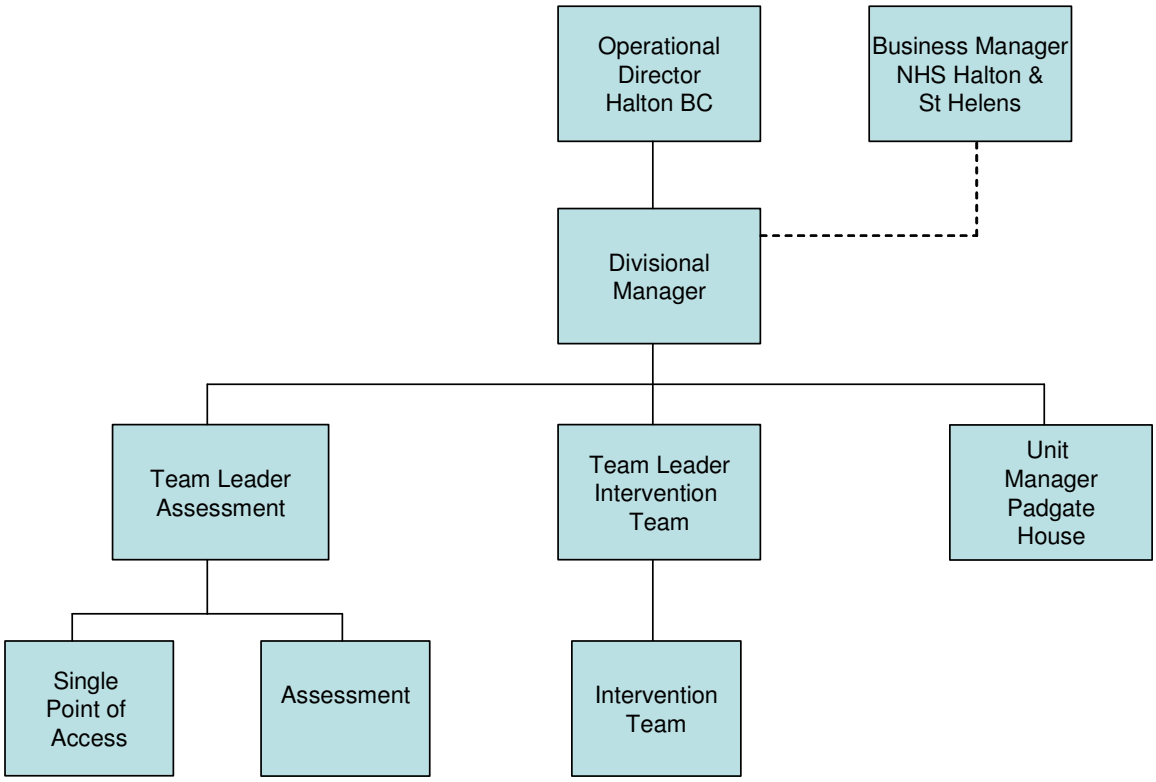


Figure: Management Structure

4.13 This structure offers a number of distinct advantages including:

- Clear responsibilities and accountabilities.
- Appropriate spans of control.
- Minimal hierarchy to ensure decision making is not held up.

[2] Subject to further discussion and TUPE requirements

4.14 The team leaders / unit manager will work hard at ensuring communication and co-ordination across the 3 areas ensuring the focus on the patient and overall outcome is maintained.

Arrangements for Implementing the Proposed Model

4.15 A rigorous approach will be put in place to ensure a smooth transition to the new service model. This will incorporate:

- The establishment of a project board chaired by a senior manager of Halton Borough Council that will oversee the process.
- The appointment of a full time project manager that will have day to day responsibility for managing the transition arrangements.
- The project manager will be responsible for the creation and updating of the following management products that will be used to co-ordinate the transition: a detailed project plan and schedule outlining milestone dates, deliverables, responsibilities and resources; a risk register that will be used to identify mitigating actions and counter measures to reduce the likelihood and potential impact of the major risks materialising; an issues log that will be used to quickly resolve problems that arise; a communication and engagement plan to ensure that key stakeholders are kept informed and carried through the project; a project status report to ensure rigorous reporting of progress.
- The project plan will incorporate the following work streams: management structure; business process design specification; performance reporting; recruitment / transfer; induction and training; communication; finance; procurement; facilities management; information and communications technology; governance; information migration.

4.16 We have substantial capacity within the organisation to help us manage and deliver the proposed changes and innovations, this includes a partnership board that focuses solely on intermediate care services.

4.17 The project structure will be set up immediately following the contract award decision (December 2009) and will remain in place until all elements of the phased transfer are complete and new business processes in place.

Transfer Arrangements

4.18 TUPE transfer would apply in these circumstances and terms and conditions of work and continuity of employment for all employees employed before transfer.

4.19 We have extensive experience of managing TUPE transfers. NHS Halton and St Helens has been involved in transfers of services and staff in and out of the organisation. Recent examples have included Oral Health Promotion, Dental Services, Informatics, GP Out of Hours Services and Learning Disabilities. The latter required the facilitation of a 'Hub' and 'Spoke' model where the LD Service was split for delivery between Halton Borough Council (the Hub) and 5 Boroughs Partnership (the Spoke). A number of employees, including clinical staff were transferred to the Local Authority. As part of the consultation process we worked with staff, unions and

the local authority to obtain a Section 31 Pensions Agreement. This enabled NHS Halton and St Helens employees to transfer to the local authority with their NHS Pension. The scheme is now operating within the local authority for the transferred Staff. Furthermore, we have ongoing links and close working relationships with the HR Department to assist with NHS related terms and conditions of employment which include, but are not limited to: agenda for change, job evaluation, KSF, CPD and clinical governance matters.

4.20 Similarly, Halton Borough Council has well established TUPE processes that have been developed through numerous TUPE transfer including both transferring staff and services into and out of the Authority. A recent example of this was the successful transfer of the Borough's Trading Standards service to Warrington Borough Council in December of 2008. This transfer was designed to achieve a comprehensive integrated trading standards service delivering all the statutory functions mandatory and discretionary) undertaken previously by Halton. The project involved transferring a number of staff from their base in Halton Lea Runcorn to Warrington Town Centre. As part of the process we consulted regularly with the staff and their Union representatives, keeping them informed of the process throughout by both formal and informal means.

4.21 The best practices we have developed across both organisations take account of the requirement to inform and consult those affected by the transfer process. This includes the establishment of project boards, one to one advice, induction, due diligence and employment liability declarations. All these have staff-side involvement and Unions are kept informed at a Regional level.

4.22 We would conduct full and meaningful consultation with employees at the earliest practicable time, noting that a failure to conduct consultation results in liability for the payment of compensation which may be up to 13 weeks' pay (full pay) per employee. We recognise that the transferor and transferee are both liable for any award of compensation made by an employment tribunal for failure to inform and consult. We would therefore work in partnership to plan the transfer.

4.23 In terms of public sector transfers, we acknowledge and apply the Cabinet Office Statement of Practice and the Code of Practice on Workforce Matters in Public Sector Service Contracts which states that most public bodies should operate as if TUPE applied even if it otherwise may not. It is also states that we must offer new recruits terms which are, overall, no less favourable than those of transferred staff in order to avoid a two tier workforce.

4.24 Strictly speaking, obligations relating to provisions about benefits for old age, invalidity or survivors in employees' occupational pension schemes do not transfer under TUPE. However, the provisions of the Pensions Act 2004 sections 257 and 258 do apply to transfers taking place after 6 April 2005. In effect, this means that provisions equivalent to the TUPE regulations apply to pension rights from that date. In essence, if the previous employer provided a pension scheme then the new employer has to provide some form of pension arrangement for employees who were eligible for, or members of the old employer's scheme. It does not have to be the same as the arrangement provided by the previous employer but will have to be of a certain minimum standard specified under the Pensions Act. There are a number of possible pension options on a transfer of staff as outlined in 'A Fair Deal for Pensions' documentation, that we would be happy to explore:

- Offering broadly comparable pension arrangements
- Continued access to the NHS Pension Scheme
- Secondment
- NHS Contract Service Provider
- Direction Employer
- NHS / Local Authority Section 75 Partnership

4.25 The Council is currently a member of the same pension fund as Warrington Borough Council (Cheshire Pension Fund). Therefore existing Warrington BC staff can remain with their current pension provider and any new staff will have the opportunity, if they wish, to join the same local government scheme as existing staff.

4.26 We would be happy to host site visits or attend meetings with staff and trade unions prior to transfer to address any concerns they have raised. We would also support NHS Warrington and Warrington BC to meets its statutory obligation to provide information about the transfer.

4.27 We would undertake robust due diligence in order to assess the full potential costs of transfer, this will include: terms of conditions of employment; currency of job descriptions; salary bands and increments due; enhanced benefits; notice periods; issues that could lead to employment tribunals; staff appraisal and competency levels; outstanding discipline and grievances.

5. Costings and Value for Money

5.1. *Outline Staffing Costs*

The following are an estimate of staffing costs based upon our outline solution. These will be refined through the competitive dialogue process as we build a better understanding of activity levels and undertake due diligence.

5.1.1 Single Point of Access

	Grade	FTE	Salary	Additional Employee Costs	Total Cost
Option 1.					
Administration	SCP 15	2	40,531	0	40,531
Total			**40,531**	**0**	**40,531**
Option 2.					
Administration	SCP 15	2	40,531	0	40,531
Nurse Assessor	Band 7	2	98,134	4,000	102,134
Total			**138,665**	**4,000**	**142,665**
Option 3. Incorporated as Part of Assessment Team					
Option 4. Part of Integrated SPA - to be determined as part of larger SPA					
Option 5. Integrated across Halton & Warrington - to be further explored if required					

5.1.2 Assessment Function

	Grade	FTE	Salary	Additional Employee Costs	Total Cost
Option 1. Community 8am to 10pm					
Clinical	Band 6	6	249,990	12,000	261,990
Administration	SCP 15	2	40,531	0	40,531
Total			**290,521**	**12,000**	**302,521**
Option 2. Community 24/7					
Clinical	Band 6	6	249,990	12,000	261,990
Clinical includes 20% enhancement	Band 6	4	199,992	8,000	207,992
Administration	SCP 15	2	40,531	0	40,531
Total			**490,513**	**20,000**	**510,513**
Option 1. Hospital					
Accident & Emergency	Band 6	6	249,990	0	249,990
Wards	Band 6	4	166,660	0	166,660
Total			**416,650**	**0**	**416,650**
Option 2. Hospital					
Accident & Emergency	Band 6	6	249,990	0	249,990
Discharge Team	Band 6	8	333,320	0	333,320
Total			**583,310**	**0**	**583,310**

5.1.3 Intervention Team

	Grade	FTE	Salary	Additional Employee Costs	Total Cost
Multi-Disciplinary Team Capacity 60 Placements (at any one time)					
Occupational Therapist	Band 7	1	49,067	2,000	51,067
Occupational Therapist	Band 6	2	83,330	4,000	87,330
Occupational Therapist	Band 5	1	33,300	2,000	35,300
Physiotherapist	Band 7	1	49,067	2,000	51,067
Physiotherapist	Band 6	2	83,330	4,000	87,330
Physiotherapist	Band 5	1	33,300	2,000	35,300
Therapy Assistant	Band 4	2	52,600	4,000	56,600
Dietician *	Band 6	0.5	20,833	1,000	21,833
Community Psychiatrist Nurse	Band 6	1	41,665	2,000	43,665
Social Worker	SCP 37	0.5	19,700	1,000	20,700
Community Care Worker	SCP 29	1	31,375	2,000	33,375
Nurse **	Band 7	1	49,067	2,000	51,067
Nurse **	Band 6	2	83,330	4,000	87,330
Nurse **	Band 5	1	33,300	2,000	35,300
Speech & Language Therapist *	Band 7	0.25	12,267	500	12,767
Administration	SCP 15	2	40,531	0	40,531
Total			**716,061**	**34,500**	**750,561**
Home Support Team Capacity - Operating 8am to 10pm					
Senior Care Assistant	SCP 25	4	109,329	8,000	117,329
Care/Support	Cons 15	20	445,836	40,000	485,836
Total			**555,165**	**48,000**	**603,165**
Intervention Team Total			**1,271,227**	**82,500**	**1,353,727**

** Subject to revision due to specialist provision requirements*

*** Dependant on negotiations of nursing functions to be undertaken*

5.1.4 Bed Based Services

Costings are provided for options 1 & 2 (see 3.4.1).

	Grade	FTE	Salary	Additional Employee Costs	Total Cost
Option 1.					
Nursing Beds Capacity 20 beds					
Care Home	Per bed/ per week		640		665,600
GP Medical Cover	Per bed/ per week		100		104,000
Community Care Worker	SCP 29	0.5	15,688		15,688
Social Worker	SCP 37	0.25	9,850		9,850
Dietician *	Band 6	0.25	10,416		10,416
Speech & Language Therapist *	Band 7	0.25	12,267		12,267
Occupational Therapist	Band 6	1	41,665		41,665
Physiotherapist	Band 6	1	41,665		41,665
Total				**0**	**901,151**
Residential Beds Capacity 35 beds					
Care Home	Per bed/ per week		590		1,073,800
GP Medical Cover	Per bed/ per week		100		182,000
Registered General Nurse	Band 6	1	41,665		41,665
Community Care Worker	SCP 29	0.5	15,688		15,688
Social Worker	SCP 37	0.25	9,850		9,850
Dietician *	Band 6	0.25	10,416		10,416
Speech & Language Therapist *	Band 7	0.25	12,267		12,267
Occupational Therapist	Band 6	1.5	62,498		62,498
Physiotherapist	Band 6	1.5	62,498		62,498
Total				**0**	**1,470,681**
Option 1. Total Bed Based Services				**0**	**2,371,831**

	Scale Point	FTE	Salary	Additional Employee Costs	Total Cost
Option 2.					
Nursing Beds Capacity 35 beds					
Care Home	Per bed/ per week		800		1,456,000
GP Medical Cover	Per bed/ per week		100		182,000
Community Care Worker	SCP 29	1	31,375		31,375
Social Worker	SCP 37	1	39,400		39,400
Dietician *	Band 6	0.25	10,416		10,416
Speech & Language Therapist *	Band 7	0.25	12,267		12,267
Occupational Therapist	Band 7	1	49,067		49,067
Occupational Therapist	Band 6	1	41,665		41,665
Physiotherapist	Band 7	1	49,067		49,067
Physiotherapist	Band 6	1	41,665		41,665
Therapy Assistant	Band 4	1	26,300		26,300
Total				**0**	**1,939,222**
Residential Beds Capacity 20 beds					
Care Home	Per bed/ per week		590		613,600
GP Medical Cover	Per bed/ per week		100		104,000
Registered General Nurse	Band 6	1	41,665		41,665
Community Care Worker	SCP 29	0.5	15,688		15,688
Social Worker	SCP 37	0.25	9,850		9,850
Dietician *	Band 6	0.25	10,416		10,416
Speech & Language Therapist *	Band 7	0.25	12,267		12,267
Occupational Therapist	Band 6	1	41,665		41,665
Physiotherapist	Band 6	1	41,665		41,665
Total				**0**	**890,816**
Option 2. Total Bed Based Services				**0**	**2,830,038**

5.2. *Other Costs*

5.2.1 Management Costs

	Grade	FTE	Salary	Additional Employee Costs	Total Cost
Service Lead	8A	1	57,084	2,000	59,084
Team Leader	Band 7	2	98,134	4,000	102,134
Total			**155,218**	**6,000**	**161,218**

5.2.2 Support services

10% - 15% of the total cost of the service would be added to cover the cost of support services including: finance, human resources, information technology support.

5.2.3 Management Fee

A management fee of 10% of total cost would be added.

5.2.4 Facilities

The costs of facilities as detailed in section 3.4.4 and 3.4.5 will be explored as part of the competitive dialogue.

5.3. *Value for Money*

The outline solution that we have proposed in this document will deliver financial, performance and outcome benefits across the whole system.

Comprehensive intermediate care services utilise a range of expertise, services, interventions and assistive technologies which can be made available to many more people, not just those at risk of hospital admission or on leaving hospital, thus supporting the overall direction of providing care closer to home and supporting people to remain independent in their own homes for as long as possible.

As the competitive dialogue progresses we will be able to better quantify the financial and performance benefits across the system arising from our proposed approach relating to:

- The savings we can deliver on residential and nursing long term care placements, including continuing health care.
- The savings on longer term domiciliary care packages, including continuing health care.
- The increased numbers of people supported to remain in their own home.
- The savings realised through a reduction in excess bed days past the trim point (£100 per day).

- The reduction in emergency admissions to hospital. The average PBR cost per patient per admission in the acute hospital is £1,500, for a 5-day stay.
- The achievement of the 18-week target for elective admissions.
- The reduction in non-elective admissions.
- The savings realised from a reduction in readmission rates. The additional costs for readmissions could increase the PBR costs by £1,500 per readmission.
- The savings realised through a reduction in A&E attendances. The additional costs per A&E attendance, £85 per attendance.

5.4. *Performance Levels*

5.4.1 The performance management framework that oversees the delivery of services in Halton and St Helens outlines the following reporting requirements, standards and performance targets. These are provided as an illustration we would adapt according to the requirements of the contract.

Activity Monitoring

- Promotion and marketing activity.
- Referral data that can be aggregated to show trends in the following domains (this will vary depending on intensity of service): Bio-graphical information including GP surgery and postcode; Source of referral; Reason for referral; Primary diagnosis / presenting condition (categories to be determined); Secondary diagnoses / long term conditions (categories to be determined); Date and time of referral; Number of people 'screened out' prior to referral and outcome (categories to be determined); Number of referrals leading to a screening assessment; Screening Assessment data that can be aggregated to show trends; Time from referral to the commencement of assessment; Time from commencement of assessment to decision (admit or discharge); Number not admitted to service following assessment and reason; Time from decision (to admit) to commencement of service (by service type); Number of assessments leading to a service
- Service activity data that can be aggregated to show trends, in the following domains: Number of specialist assessments completed per episode (by type); Number of discharge dates set within 48 hours of admission (%); Number of care / treatment / rehabilitation plans completed within 48 hours of admission (%); Length of stay per episode; Delayed discharges coded (to agree codes); Destination at point of discharge; Services commissioned / arranged at discharge; Coded explanation of hospital admissions; Reviews of unexpected deaths in Intermediate Care beds; Number of critical / adverse incident reviews undertaken and outcomes.

Outcomes

The following are routinely collected and reported upon:

- Service user satisfaction

- Self care ability / activities of daily living
- General health status / quality of life using EUROQOL
- Non-elective admission to hospital within x days of discharge from service
- Number of attendances at A&E within 28 days of discharge from service
- Admission into long term residential / nursing home care within 28 days of discharge from service
- Number of attendances at GP surgery's within 28 days of discharge from the service
- Number of attendances at Urgent Care / Minor Injuries / Walk in Centre within 28 days of discharge from the service Section Six:

Targets

The following targets apply for all services in Halton and St Helens. These could be adapted according to the requirements of the contract:

- 90% of screening assessments are commenced within 48 hours of referral (all categories) with a 2% increase year on year. this doesn't tie in with the response targets in the gold standard e.g. crisis response within 4 hours, urgent within 24 and non-urgent within 5 days
- 95% of 'crisis' interventions are commenced within 24 hours of referral (need to define 'crisis') – as above
- 80% of all screening assessments lead to the provision of a service. Codes for variance to be agreed
- 80% of services are commenced within 48 hours of decision to admit with a 2% increase year on year.

Appendix 1 Performance Management Framework

Section One: Business Probity

1.1The provider will be able to demonstrate that they have sufficient business processes in place to ensure the operation of the business.

1.2 The provider will be able to demonstrate that robust financial systems are in place for the conduct of the business.

1.3 The provider will have in place systems of audit and monitoring that facilitate the measurement of inputs, process, outputs and outcomes in line with the strategic and operational objectives of the services commissioned.

Monitoring Framework in development by PCT will provide additional information.

Section Two: Governance

2.1 The provider will have a clear organisational structure that identifies lines of responsibility and accountability. As a minimum this should include:

2.1.1 Clinical Lead

2.1.2 Chief Executive / Agency Manager

2.1.3 Professional Leads (appropriate to service commissioned)

2.1.4 Where services are provided through a 'partnership agreement' or similar then the associated agreements will clearly identify lines of accountability and management of the services commissioned.

2.2 The provider will have risk management systems in place to cover the following areas:

2.2.1 Identification and management of clinical risks.

2.2.2 Identification and management of adverse / critical incidents.

2.2.3 Identification and management of potential budget deficits / surplus.

2.2.4 Identification and management of (potential) events that compromise the ability to deliver the services commissioned.

2.2.5 Identification and management of health and safety requirements.

2.3 The provider will have in place a range of policies and procedures that comply with statutory and the respective commissioning bodies requirements in relation to the following areas:

2.3.1 Recruitment, selection and retention of personnel.

2.3.2 Discipline and grievance

2.3.3 Bullying and harassment

2.3.4 Supervision of personnel

2.3.5 Protection of vulnerable adults / children procedures

2.3.6 Confidentiality and information sharing

2.3.7 Personnel development

2.3.8 Equality and diversity

2.3.9 Exclusion and service withdrawal

2.3.10 Medication

2.3.11 Charging for services

2.3.12 Reflective practice

2.3.13 Whistle blowing

Section Three: Promotion and Marketing

3.1 The provider will have in place a strategy for the promotion and marketing of the service to key stakeholders and the public. Information will include the range of services offered, access arrangements and performance information.

Section Four: Activity Monitoring

Providers are required to monitor activity in the following areas and provide regular reports to commissioners on such activity.

4.1 Promotion and marketing activity.

4.2 Referral data that can be aggregated to show trends in the following domains (this will vary depending on intensity of service):

4.2.1 Bio-graphical information including GP surgery and postcode

4.2.2 Source of referral

4.2.3 Reason for referral (categories to be determined)

4.2.4 Primary diagnosis / presenting condition (categories to be determined)

4.2.5 Secondary diagnoses / long term conditions (categories to be determined)

4.2.6 Date and time of referral

4.2.7 Number of people 'screened out' prior to referral and outcome (categories to be determined)

4.2.8 Number of referrals leading to a screening assessment

4.3 Screening Assessment data that can be aggregated to show trends, in the following domains:

4.3.1 Time from referral to the commencement of assessment.

4.3.2 Time from commencement of assessment to decision (admit or discharge)

4.3.3 Number not admitted to service following assessment and reason.

4.3.4 Time from decision (to admit) to commencement of service (by service type)

4.3.5 Number of assessments leading to a service

4.4 Service activity data that can be aggregated to show trends, in the following domains:

4.4.1 Number of specialist assessments completed per episode (by type)

4.4.2 Number of discharge dates set within 48 hours of admission (%)

4.4.3 Number of care / treatment / rehabilitation plans completed within 48 hours of admission (%)

4.4.4 Length of stay per episode

4.4.5 Delayed discharges coded (to agree codes)

4.4.6 Destination at point of discharge

4.4.7 Services commissioned / arranged at discharge

4.4.8 Coded explanation of hospital admissions

4.4.9 Reviews of unexpected deaths in Intermediate Care beds

4.4.10 Number of critical / adverse incident reviews undertaken and outcomes

Section Five: Outcomes

5.1 Outcome measures that are valid and reliable need to be used by providers. These should be used routinely in the following domains:

5.1.1 Service user satisfaction (can be sample) (await PCT document)

5.1.2 Self care ability / activities of daily living (to agree tools)

5.1.3 General health status / quality of life using EUROQOL (can be sample)

5.2 System wide measures of outcomes need to be collected in the following domains these would be the responsibility of the Commissioners:

5.2.1 Non-elective admission to hospital within x days of discharge from service

5.2.2 Number of attendances at A&E within 28 days of discharge from service

5.2.3 Admission into long term residential / nursing home care within 28 days of discharge from service

5.2.4 Number of attendances at GP surgery's within 28 days of discharge from the service

5.2.5 Number of attendances at Urgent Care / Minor Injuries / Walk in Centre within 28 days of discharge from the service

Section Six: Targets

The following are domains for which data should be collected to provide information on service delivery to assist the future development of targets. These will be reviewed annually.

6.1 Assessments:

6.2.1 90% of screening assessments are commenced within 48 hours of referral (all categories) with a 2% increase year on year.

6.2.2 95% of 'crisis' interventions are commenced within 24 hours of referral.

6.2.3 80% of all screening assessments lead to the provision of a service. Codes for variance to be agreed.

6.2 Service Provision:

6.2.1 80% of services are commenced within 48 hours of decision to admit with a 2% increase year on year.

6.3 Finance: providers will incorporate annual savings required by the commissioning agencies into their budgeting

Appendix 2 Clinical Governance Strategy

Community Health Services

For use in:	All areas of CHS
For use by:	All CHS Staff
Used for:	All CHS staff
Document Owner:	Head of Clinical Governance
Board approved:	Completed by Policy Administrator
Policy Indexed:	Completed by Policy Administrator
Controlled Document No:	Completed by Policy Administrator
Version Number:	1
Status:	Corporate Strategy

Statutory and legal requirements:	None
Implementation Lead:	Head of Clinical Governance
Implementation Process:	Implementation of this strategy will be managed via the individual clinical governance action plans of each service providing health care through or on behalf of the PCT. Awareness of the Clinical Governance Strategy will be raised through publication on the Trust's web-site and intranet site.

The Trust is committed to an environment that promotes equality and embraces diversity both within our workforce and in service delivery. This document should be implemented with due regard to this commitment.

1. Introduction

Clinical Governance is an essential part of quality health care and must form an integral part of the daily working lives of all clinicians, service leads and health care staff. It must also be embedded in the culture of health care organisations; in the philosophy, business planning and delivery of care at all levels within them and across the boundaries of care with commissioned and provided services.

Clinical Governance is the framework through which healthcare organisations demonstrate that they are meeting their statutory 'duty of quality', it was described by Sir Liam Donaldson in 2004 as:

> "*A unifying concept for quality which provides organisations with a systematic means for ensuring that they comply with their statutory duty. It aims to effect …. a culture in NHS organisations where; openness and participation are encouraged; education and research are properly valued; people learn from failures and blame is the exception rather than the rule; good practice and new approaches are freely shared and willingly received."*

2. National Drivers

The Annual Health Check gives an annual performance rating for healthcare organisations based upon a range of data sources. The Trust's statutory duty of quality is monitored through this assessment. The Health Check assesses healthcare organisations against Standards for Better Health Core Standards and against National priorities and targets as published by the Healthcare Commission (2008).

3. Background

Halton & St Helens PCT Clinical Governance Strategy: 2007-2009, produced in April 2007, has clear lines of responsibility and accountability. The strategy outlines committee structures and details how the Trust will implement and monitor Clinical Governance activities.

Due to the development of autonomous working of Community Health Services (CHS) there is a requirement to identify how the Trust's overarching Clinical Governance Strategy: 2007-2009 will be implemented within CHS to ensure robust Clinical Governance arrangements. The proposed reporting structure can be seen at Appendix 1.

The Trust's Clinical Governance Strategy: 2007-2009 outlines the approach to be taken to meet the 9 components of Clinical Governance, as detailed within the document; Improving Quality and Safety published by the National Audit Commission in January 2007.

These 9 key components are:

- Pro-actively identifying clinical risks to patients and staff
- Improving services based on lessons learned from patient safety incidents/near misses
- Improving services based on lessons learned from complaints
- Ensuring effective clinical leadership
- Maintaining the capability and capacity to deliver services
- Ensuring the quality of the patient experience
- Involving professional groups in multi-professional clinical audit

- Involving patients and public in the design and delivery of CHS services
- Collecting and using intelligent information on clinical care.

Community Health Services (CHS) will:

- Name a lead member of staff for each component
- Define clear structures and processes designed to demonstrate effective governance activity
- Implement and maintain effective governance activities.

The next section of this document describes the approach that Halton & St Helens PCT CHS will adopt to address the 9 components in terms of the above.

4. Community Health Services Clinical Governance Strategy

4.1 Pro-actively ***identifying*** Clinical risks to Patients and Staff

Clinical risk management is not, primarily, a reactive process. While it is obviously necessary to respond swiftly and efficiently to incidents as they happen, and appropriately disseminate the lessons to be learned, it is also essential that potential risks are identified and evaluated to minimise their frequency and impact.

The **Lead Members** of staff for this activity are the **Risk Manager** who reports to their appropriate Manager who will report clinical risk issues by the Structures and Process below.

The structures and processes for pro-actively identifying clinical risks to patients and staff encompass:

- Risk Management: Develop and review the PCT's risk management strategy and strategic framework in relation to CHS. This will support the development of CHS assurance framework, which will be monitored by the Business Management and Finance Committee and report to the CHS Board
- Risk Registers: The development of working risk registers for all clinical services is ongoing across the CHS. The registers form part of the risk management structure of the organisation. Reviews of the registers take place regularly throughout the year, with the identified local Risk Team in each service.
- Local Commitment: Divisional Managers and Service Leads will ensure that members of their service's Team have time to fulfil their individual responsibilities, by factoring agreed amounts of time into the management structure of their service.

Implementation and Training: will be provided by the CHS in:

- **Risk Management** to enable the local Risk Teams to fulfil their role in the process.
- **The Reporting of Accidents, Incidents and Near Misses** for all staff, to ensure that awareness and reporting levels are maintained appropriately across the whole organisation.

Training will be provided by a combination of an e-learning package and face-to-face training.

4.2 Improving services based on lessons learned from patient safety incidents/near misses

Where patient safety incidents and near misses do occur it is essential that the appropriate conclusions are drawn and the lessons learned are disseminated across the organisation in order to improve services, enhance patient care and reduce the likelihood of repetition in the future.

The **Lead Member** of staff for this activity is the **Health and Safety Manager** and **Risk Manager** who report to the Senior Risk Manager.

The structures and processes for improving services learned from patient safety, incidents and near misses:

- To ensure continuous development of high quality, safe patient care across the whole CHS all reports of all accidents, incidents and near misses will be reviewed by the Risk Management Team. Divisional Managers and Service Leads will be key personnel in assuring appropriate action plans are devised and implemented.
- Full details of the process are contained in the PCT's Accidents, Incidents and Near Misses Policy

Implementation and Training:

- Will be provided by the Risk Management Team in the reporting of accidents, incidents and near misses for all staff, to ensure that awareness and reporting levels are maintained appropriately across the whole organisation.
- The lessons learned will be disseminated across service boundaries through attendance at team meetings, and also via the development of a regular governance newsletter.

Training will be provided by a combination of an e-learning and face-to-face training programme.

4.3 Improving services based on lessons from complaints

The **Lead Member** of staff is the **Complaints Manager** who reports to the Director of Clinical Standards and Quality.

The structures and processes for improving services based on lessons from complaints:

- All complaints are managed via individual action plans. Where the complaint is of a clinical nature in relation to CHS, the action plans will be monitored by the Quality and Clinical Governance work stream. A quarterly report on the complaints received is presented to the Quality and Clinical Governance Work-stream, and progress with the clinical action plans is monitored and reviewed. The Risk Management work-stream also receives a full complaints report each quarter.
- Full details of the process are contained in the PCT's Concerns, Comments and Complaints Procedure

NB: All the activity defined in sections 4.1, 4.2 and 4.3 above are supported by the use of information entered and stored in an electronic Risk Management System (Datix).

Implementation and Training:

- Will be provided by the Complaints Manager, to ensure awareness and reporting levels are maintained appropriately across the whole organisation.

4.4 Ensuring effective clinical leadership

Clinical engagement is critical to the organisation's fitness for purpose in the discharge of its responsibilities and the Clinical Services Committee is a vital element of this. As the clinical conscience and challenger to CHS, its purpose is to drive intelligent and effective clinical services.

Clinical Leadership of CHS is embodied jointly in

- Deputy Chief of Operations Clinical
- The Head of Clinical Governance
- The Medical Director (PCT's Halton & St. Helens)
- The Executive Nurse (PCT's Halton & St. Helens)

The structures and processes for effective clinical leadership:

Operational responsibility for the duty of care is devolved throughout the organisation via the committee structure which incorporates Community Services Committee, Management Team and the Community Health Service Board. The Quality and Clinical Governance work-stream and its feeder groups for clinical audit, clinical policies, and national guidance will support the above committees.

This document is the definitive statement of corporate and clinical responsibility for effective clinical leadership in CHS.

Implementation and Embedding:

- Will be provided by the Governance structures to ensure effective clinical leadership in CHS.

4.5 Maintaining the capability and capacity to deliver services

In this context the capability and capacity to deliver services recognises the knowledge and skills of individual clinicians to provide high quality, safe patient care.

The **Lead Members** of staff are the **Chief of Operations** and the **Deputy Chief of Operations Clinical**

The Structures and Processes for ensuring capacity and capability to deliver high quality, safe and effective patient care include:

- Continuing Professional Development for Clinical Staff - There is a robust ongoing CPD programme for clinical staff supported by the Professional Development team and the Learning and Development Department to ensure staff have the necessary skills and knowledge to carry out their roles effectively. Training plans are completed annually for each service identifying and prioritising service and individual development needs. These are met either through evidence-based, in-house programmes or via local universities with which the CHS has strong links
- Clinical Supervision - For full details see the PCT's Clinical Supervision Policy
- Performance Monitoring - This process is managed via Performance Development Reviews (PDRs) through a supportive and facilitative approach. Any clinical professional whose performance gives cause for concern, or whose knowledge and skill fails to reach an acceptable level, is referred, as appropriate, either direct to their professional body or more usually in the first instance, to the PCT's Professional Performance Advisory Group (PPAG) which provides support and monitoring to improve.

All these activities are reported via the appropriate work-streams to the CHS Board.

Implementation and Training:

- Will be provided by the professional development team and Head of Clinical Governance.

4.6 Ensuring the quality of the patient experience

Capturing data on patient expectations and experience is a key element in quality improvement. Routine collection of such information should be used to influence service changes and commissioning decisions. Patient satisfaction surveys and ad hoc consultations with patient groups are the most usual, but not exclusive, means of gathering such data.

The **Lead Member** of staff is the **Clinical Audit and Quality Manager**.

The Structures and Processes for ensuring quality of patient experience.

- Service providers routinely conduct patient satisfaction surveys on all - or specific - aspects of the care they provide and, where appropriate, respond to findings. Increasingly, and in line, with national initiatives
- Patient expectations should be measured together with or separately from actual experiences
- Patient panels will be involved in the choice and planning of areas for review.
- New and existing patient groups will be convened to influence the development of new or redesigned health care services.

Full details of these processes are contained in the Trust's Clinical Audit Strategy.

Implementation and Training:

- Will be provided by the Clinical Audit and Quality Manager.

4.7 Involving professional groups in multi-professional clinical audit

Clinical Audit has been described as 'the basis of assurance about Clinical Governance in a Trust,' which underpins its function as a key tool to demonstrate that local health services are providing quality assured care.

The **Lead Member** of staff is the **Clinical Audit and Quality Manager**.

The Structures and Processes to involve professional groups in multi-professional clinical audit.

Clinical Audit is carried out across the organisation under a number of headings:

- National audits (e.g. diabetes, falls, continence, etc)
- Organisational audits to ensure the implementation of nationally or professionally defined best practice (e.g. NICE Guidance; record keeping, medicines management, infection control)
- Organisational audits to ensure the implementation of local quality standards (e.g. chaperoning)
- Service specific audits to monitor and improve the quality of care where clearly defined external standards do not exist (e.g. many primary care or community based services) to improve outcomes
- Patient satisfaction surveys
- Audit activity to monitor the impact of service changes and commissioning decisions where they directly affect patient care.

All strands of this activity are connected via the Clinical Audit Sub-group, which meets monthly to:

- Support the development and delivery of annual audit programmes within each service
- Receive prior notice of individual audit project plans and approve them on behalf of the CHS
- Monitor the progress of plans and programmes, providing facilitation and support where necessary and appropriate
- Supervise the delivery of audit training to staff across the organisation
- Arrange the dissemination of audit reports and lessons learned
- Provide frequent and regular up-dates to the Clinical Governance work-stream, and the wider organisation.

Full details of this process are contained in the Trust's Clinical Audit Strategy.

Implementation and Training:

- Will be provided by the Clinical Audit and Quality Manager.
-

4.8 Involving patients and public in the design and delivery of CHS services

The CHS has a legal duty to carry out patient and public involvement (PPI) activity. Section 242 of the Health and Social Care Act (HSCA) requires that actual or prospective users of services are involved in or consulted on:

- The planning and provision of those services
- The development and consideration of proposals for changes in the way those services are provided
- Decisions to be made affecting the operation of those services.

The **Lead Member** of staff is the **Business Manager**.

The responsibility for this activity rests with the business manager and service leads of the services under review. However, the CHS's PPI Manager has a responsibility to ensure that CHS Staff are aware of the organisation's duty to engage and consult with patients and the public, and to give guidance and support for this.

There is no set system for how people will be engaged as it depends on the nature of the client group e.g. children will need a different approach to older people etc. However, a set of principles for engagement have been defined and a PPI resource produced that gives guidance on 'how to' involve people appropriately.

The PCT has a LINKS (Local Involvement Networks) group, which represents local patient involvement.

A PPI manager will attend the Quality and Clinical Governance Work-stream meetings. The LINKs group will report into the clinical services committee. Details of the accountability structure and processes are contained in the Involvement and Communications Strategy.

Implementation and Training:

- Will be provided by the PPI Manager and team.

4.9 Collecting and using intelligent information on clinical care

The CHS looks after the health of around 300,000 people and aims to ensure that they find it easy to access the best possible services when they need them. The CHS also aims to support people in Halton and St Helens to improve their overall health and wellbeing to enable them to lead healthier, happier lives. With the introduction of choice and plurality in the market, and the increased focus on commissioning, the collection, processing and use of intelligent information on clinical care is essential to ensure the CHS is able to demonstrate and deliver high quality, safe patient care.

The **Lead Member** of staff is the **Deputy Chief of Operations Business Management**.

The Structures and Processes for collecting and using intelligent information for clinical care require the following information:

- A brief description of services provided
- Contact details
- Care streams involved
- Existing national and /or local Key Performance Indicators
- Current contract arrangements
- Current governance arrangements
- Reporting of outcomes
- Level of contact, frequency and purpose

Implementation and Training:

- Will be provided by the service reviews of the individual services.

5. Responsibility and Accountability

5.1 Responsibility of the Trust Board

The Trust Board is responsible for reviewing the effectiveness of financial, organisational and clinical systems. The Board are also required to produce statements of assurance that it is undertaking its 'reasonable best' to manage the Trust's affairs efficiently, effectively and safely.

5.2 Responsibility of the Chief Executive

As the Accountable Officer of the organisation the CEO is responsible for the overall delivery of CHS's strategic and operational business, including Clinical Governance.

5.3 Responsibility of the Community Health Services (CHS) Board

The CHS Board is responsible to ensure that community health services have effective and robust systems to monitor financial, organisational and clinical systems.

5.4 Responsibility of the CHS Clinical Service Committee

The CHS Clinical Service Committee is responsible to provide robust assurance that CHS is providing effective, safe clinical care to the population it serves.

5.5 Responsibility of the Chief of Operations

The Chief of Operations has overall responsibility for the delivery of the Clinical Governance arrangements of CHS reporting into the Chief Executive.

5.6 Responsibility of the Deputy Chief of Operations Clinical Services

The Deputy Chief of Operations Clinical Services is one of the four key roles providing effective clinical leadership in the organisation and provides clinical information and support to the Chief of Operations on clinical practice.

5.7 Responsibility of the Deputy Chief of Operations Business Management

The Deputy Chief of Operations Business Management is responsible to provide effective integrated governance and performance management arrangements for CHS that affect clinical services.

5.8 Responsibility of the Head of Clinical Governance

The Head of Clinical Governance is one of the four key roles in providing effective clinical leadership in the organisation and will provide information and support to the Chief of Operations on all issues of clinical practice within the CHS. Also has the overall operational responsibility to ensure clinical governance is delivered across the trust.

5.9 Responsibility of the Medical Director

The Medical Director is one of the four key roles for providing effective clinical leadership across the PCT and will provide information and support to the Chief of Operations and the Deputy Chief of Operations Clinical Services on all clinical and medical practice within CHS.

5.10 Responsibility of the Executive Nurse

The Executive Nurse is one of the four key roles for providing effective clinical leadership across the PCT and will provide information and support to the Chief of Operations and the Deputy Chief of Operations Clinical Services on clinical practice within CHS.

6. Accountability

6.1 Clinical Services Committee

The remit of the Clinical Services Committee is to report key risks identified via the work streams and task and finish groups to the CHS Board. The Clinical Services Committee will also monitor the implementation of the Clinical Governance Development Plan.

6.2 Quality and Clinical Governance Work-stream

The key forum for accountability in Clinical Governance activity is the Quality and Clinical Governance work-stream, which reports to the Community Services Committee.

6.2.1 Functions of the Quality & Clinical Governance work stream:

To discharge the delegated responsibility of the Community Services Committee with regard to Clinical Governance by:

- Ensuring compliance with the annual health checks, Standards for Better Health and all other external inspections,
- Developing and maintaining robust Clinical Governance structures and processes
- Monitors the delivery of the Clinical Governance programme through devolvement of responsibility to its sub groups.

6.2.2 Sub Groups of the Quality & Clinical Governance work stream

Clinical Policies and Guidelines Sub-Group

To ensure dissemination of best practice throughout the Trust by the identification of areas of practice that require clinical policies and guidelines, and through the review, adoption and monitoring of policies and guidelines that have been created in a consistent way, reflect current evidence and are accessible electronically from a central database.

Clinical Audit Sub-group

To ensure the CHS's Clinical Audit Programme is established, prioritised, implemented and monitored through facilitation and support for clinicians and their teams across the CHS

National and NICE Documentation Sub-group

To ensure the organisation is compliant with its responsibilities regarding the implementation and monitoring of all National Confidential Enquiry into patient outcome and Death (NCEPOD), NICE Guidance and National Services Frameworks(NSF's) published documents. The group will also ensure that actions plans are developed in order that services reflect current evidence based practices

Task and Finish Groups

Will be developed as required to react to any alerts or national directives that may affect the delivery of clinical care within CHS e.g. National Patient Safety Alerts (NPSA) or changes in regulatory inspections

6.3 Resources for Clinical Governance Activity

The Trust is committed to providing sufficient, appropriate resources to ensure the delivery of its statutory duty of care.

The Head of Clinical Governance manages a budget and a team of staff to lead, support and facilitate all aspects of the organisation's activity in relation to:

- the approval and implementation of local policy and guidance
- Clinical Audit
- National and NICE Documentation

Heads of Clinical Services and individual clinicians will be able to draw on this central resource to ensure that they are able to fulfil the Clinical Governance responsibilities which apply to the care they provide but will also create capacity for appropriate activity within the structure of their service.

The Clinical Governance Team will offer skills and awareness training in all aspects of clinical governance, at scheduled times and by individual arrangement, at induction, and as part of the on-going professional development of all individuals, teams, departments, services and directorates.

7. Implementation of the Clinical Governance Strategy through the Clinical Governance Development Plan

The Clinical Governance Strategy sets out the Clinical Governance arrangements for Halton & St Helens CHS, including individual and corporate responsibility, accountability, systems and processes.

The Clinical Governance Development Plans are intended to be living documents, which embed the principles of Clinical Governance into every aspect of CHS activity. Clinical Governance has no defined end-point and will evolve as the CHS and services develop, and in response to new initiatives and lessons learnt from implementation. Utilisation of the *Standards for Better Health* demonstrates the CHS commitment to continuous performance improvement and establishes the level of quality of care to be received by all service users.

7.1 Establishment and Monitoring of the Clinical Governance Development Plan

The Clinical Governance Toolkit, and associated Service Review Proforma was introduced in April 2008 as the mechanism for identifying the content and related actions that make up the Clinical Governance Development Plan and the development of service review programme for all services.

The Clinical Governance Development plans will use the Standards for Better Health as its structure and will be used as an ongoing monitoring process to assess governance arrangements within all Community Health Services.

This process will give internal Board assurance and external assurance of compliance with Standards for Better Health.

Following the collection of base-line information, from the clinical governance tool-kit individual clinical governance plans for each of the seventy-six services within CHS will be developed along with an overarching Clinical Governance Plan including the following:

- General Clinical Governance activities
  (care pathways, policies, patient information leaflets, benchmarking referral pathways, safeguarding procedures, service redesign)

- Clinical Audit
- Implementation of National documents
- Research governance
- Medicines management
- Complaints and litigation
- Risk management
- Patient experience
- Professional development and education

8. Structure of the Clinical Governance Development Plan

The Clinical Governance Development Plan, which can be seen at Appendix 2, reflects the Domains within *Standards for Better Health*. These are:

Domain	Domain Outcomes
Safety	*Patient safety is enhanced by the use of health care processes, working practices and systematic activities that prevent or reduce the risk of harm to patients*
Clinical & Cost Effectiveness	*Patients achieve health care benefits that meet their individual needs through health care decisions and services based on what assessed research evidence has shown provides effective clinical outcomes*
Governance	*Managerial and clinical leadership and accountability, the organisation's culture, systems and working practices ensure that probity, quality assurance, quality improvement and patient safety are central components of all activities of the health care organisation*
Patient Focus	*Health care is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient well-being*
Accessible & Responsive Care	*Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or of the care pathway*

Care Environment & Amenities	*Care is provided in environments that promote patient and staff well-being and respect patients' needs and preferences. They are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients*
Public Health	*Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas*

9. Monitoring

The monitoring of the Clinical Governance tool-kit will be the responsibility of the quality and clinical governance work stream.

A programme of service reviews will be developed following the collation of information from the clinical governance tool-kit.

The service reviews will be monitored by the community services committee, which is led by the Deputy Chief of Operations, Clinical Services.

10. Training

Training in all aspects of Integrated Governance (including clinical) is offered at induction for all new employees. This will be rolled out to existing staff along with all the training identified within this strategy. This training may be through E learning packages or by instructor led training.

11. External Monitoring

The Trust is required to make a declaration of levels of compliance with the Standards for Better Health to the Healthcare Commission annually. The implementation of the Toolkit and its associated Service Review process will provide evidence to inform future declarations and also to assure commissioners of the quality and safety of services provided by CHS.

Mersey Internal Audit Agency (MIAA) provides the Board and the Audit Committee with an independent opinion on the degree to which the risk management and governance arrangements support the achievement of the organisation's objectives. The Trusts Clinical Governance arrangements are, therefore, monitored by MIAA.

In early 2008, MIAA undertook a Clinical Governance Baseline Review. The assurance level for this review was given as 'Limited Assurance' the definition of which was given by MIAA as:

'*There are weaknesses in the design and/or operation of controls which could have a significant impact on the achievement of the key system, function or process objectives but should not have a significant impact on the achievement of organisational objectives.'*

An action plan is to be developed against the MIAA report to address each of the recommendations.

12. Supporting Documents

This strategy should be read in conjunction with the following documents:

- Halton & St Helens PCT Accidents and Incidents Policy
- Halton & St Helens PCT Risk Management Policy and Strategy
- Halton & St Helens PCT Information Governance Strategy
- Halton & St Helens PCT Comments, Concerns and Complaints Procedure
- Halton & St Helens PCT Clinical Audit Strategy
- Halton & St Helens PCT Clinical Supervision Policy
- Halton & St Helens PCT Involvement and Communications Strategy 2007 – 2010
- Halton & St Helens PCT Medicines Management Policy
- Standards for Better Health
- NHS Litigation Scheme

13. References:

The Annual Health Check 2008/9: Assessing and Rating the NHS (Healthcare Commission 2008)

Standards for Better Health (Department of Health 2004)

Improving Quality & Safety Processes in Implementing Clinical Governance in Primary Care: Lessons for the new Primary Care Trusts (National Audit Commission 2007)