REPORT

Item No:

SUBJECT:	Intermediate Care Review
TO:	**Integration Joint Board**
Lead Officer for Report:	Chief Accountable Officer
Author(s) of Report	Head of Planning, Performance and Quality Assurance
DATE:	16.05.18

1. PURPOSE OF REPORT

This paper is coming to the IJB

For approval	☒	For endorsement	☐	To note	☐

2. ROUTE TO THE IJB

This paper has been:

Prepared	☒	Reviewed	☒	Endorsed	☐

The paper was prepared by the Head of Planning, Performance and Quality Assurance and reviewed at the extended Senior Leadership Team meeting.

3. RECOMMENDATIONS

3.1 The IJB is asked to:

1. Approve the new model of Intermediate Care outlined in Appendix 1 (section 5)
2. Monitor the delivery of the approach and satisfy due diligence in governance by asking the fora (noted below) to implement the model in a timeous manner:
    a. North Lanarkshire Support, Care and Clinical Governance Committee
    b. NHSL Healthcare Quality Assurance and Improvement Committee,
    c. NHSL Area Partnership Forum,
    d. North Lanarkshire Joint HR Forum and
    e. North Lanarkshire Council Social Work Committee
3. The Social Work Intermediate Care facility at Monklands House is deemed surplus to requirements by October 2018 and associated operational matters are dealt with in a timely and sensitive manner

4. Note that a review of Muirpark Social Work Intermediate Care Home be undertaken in 2018/19 to ascertain the potential for expanding its service model in line with the proposed model and, where appropriate, any future recommendations be brought back for approval
5. Seek future assurance through the PPA Committee that Long Term Conditions and Frailty teams in Localities are appropriately sized against the additional requirements for providing in-reach for assessment, rehabilitation and discharge planning to sites within their boundaries, in line with the outcomes to be achieved and safety.
6. Request a suitable workforce plan be created by September 2018 from partners to identify the future requirements for Consultant, Nursing, Social Work and AHP input
7. Request that an appropriate programme of training and development be created for ward staff on active reablement and rehabilitation to support a change in culture by September 2018
8. Note that a future report on the local provision of respite and adult support and protection placements will be developed in 2018/19 and will be incorporated within the partnership's upcoming Market Facilitation Plan.

4. BACKGROUND/SUMMARY OF KEY ISSUES

4.1 In 2016, a pan-Lanarkshire bed modelling steering group was formed to review the future bed requirements in line with the direction set out within Health and Social Care North Lanarkshire's Commissioning Plan 'Achieving Integration', NHS Lanarkshire's Healthcare Strategy 'Achieving Excellence' and North Lanarkshire Council's Business Plan.

4.2 In the partnership's 2017/18 Strategic Commissioning Plan, two key actions were identified around bed modelling:

- Repatriation of out of area Low Secure Forensic Mental Health patients to Beckford Lodge, improving outcomes for patients by maintaining closer links with friends and family (completed in 2017/18)
- Undertake a review of Intermediate Care, including NHS off-site beds, Cottage Hospitals and Social Work Intermediate Care to create a single proactive, preventative and anticipatory model for North Lanarkshire.

4.3 An Intermediate Care Short Life Working Group was established in 2017, featuring broad representation from acute services and the Health and Social Care Partnership, with a remit to review the community bed-based model of intermediate care for North Lanarkshire. The report from the group is included in appendix 1.

4.4 It is important to realise that intermediate care covers a much wider scope than just bed-based services, spanning a range of community-based initiatives such as Reablement, Rehabilitation, Hospital at Home and multi-disciplinary Locality offerings. Recent IJB decisions around integrated Locality teams and the new model of Home Support are an integral part of the partnership's developments around intermediate care.

4.5 A proposed new inpatient model has been developed, which covers four core functions:

- Active Rehabilitation
- Complex Assessment
- Hospital Based Clinical Complex Care
- End of Life Care

4.6 The case for change is twofold 1. cultural shift and 2. bed numbers. The former involves a cultural shift within the inpatient setting towards active rehabilitation and reablement, supported by in-reach from Locality teams to support reablement, rehabilitation, assessment and discharge.

4.7 The introduction of a Discharge to Assess approach will provide an alternative pathway for acute hospitals for those currently unable to go directly home, which will have a direct impact on the need for Social Work intermediate care. It is anticipated that the new model will result in the facility at Monklands House being deemed surplus to requirement, while a review of Muirpark will be undertaken in 2018/19 with the aim of bringing the facility in line with the agreed new model.

4.8 There are currently three long-term residents within Monklands House, who will require to be supported into a new care environment. Officers within the service are well experienced in managing such transitions and individual plans will be developed in conjunction with the service users and their families.

5. CONCLUSIONS

5.1 Following the Integrated Service Review Board report, the Health and Social Care Partnership has set a direction of travel that significantly alters the service landscape, creating integrated Locality teams that will in-reach to Hospital sites, offer rapid community response, support the Hospital at Home model and create a model of discharge to assess. These developments fundamentally change both the interface with and demands placed on the off-site facilities in future.

5.2 Inpatient intermediate care can play a crucial role in supporting individuals to regain function to support a discharge home. At present, however, there is inconsistency in model between sites impacting on both performance and patient outcomes.

5.3 Implementation of the new model will improve the outcomes that the service is able to deliver to people, providing far greater consistency between sites and continuity of care between inpatient facilities and the community. Ultimately, the aim is to create a genuine focus on reablement and rehabilitation, shortening hospital stays and supporting people home earlier, reducing the risk of deterioration and maximising the chance of independent living.

6. IMPLICATIONS

6.1 NATIONAL OUTCOMES

6.1.1 This work has implications for all nine national outcomes, but particularly outcomes 3, 4 and 5.

6.2 ASSOCIATED MEASURE(S)

6.2.1 The plan will impact on national outcome measures 13, 14, 15, 16, 18, 19, 20, 21 and 22.

6.3 FINANCIAL

6.3.1 This paper has been reviewed by Finance:

Yes	☒	No	☐	N/A	☐

6.4 PEOPLE

6.4.1 The associated workforce plan sets out the implications of the implementation of the commissioning intentions.

6.5 INEQUALITIES

EQIA Completed:

Yes	☒	No	☐	N/A	☐

6.5.1 An EQIA has been completed.

7. BACKGROUND PAPERS

8. APPENDICES

Appendix 1: Intermediate Care Review, April 2018

9. DIRECTIONS

9.1 Subject to IJB approval, a direction will be sent to North Lanarkshire Council to enact the closure of Monklands House intermediate care facility and manage the key operational considerations around existing residents and families, staffing and continued provision of respite and Adult Support and Protection support.

9.2 Subject to IJB approval, a direction will be sent to North Lanarkshire Council and NHS Lanarkshire to implement the new inpatient model of intermediate care during 2018/19 financial year.

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CHIEF ACCOUNTABLE OFFICER (or Depute)

Members seeking further information about any aspect of this report, please contact Ross McGuffie on telephone number 01698 858293

Health&Social Care
North Lanarkshire

Intermediate Care Review

April 2018

1. Introduction

1.1 The Scottish Government's Health and Social Care Delivery Plan of 2016 set out a range of key ambitions, noting "*Integration of health and social care has been introduced to change the way key services are delivered, with greater emphasis on supporting people in their own homes and communities and less inappropriate use of hospitals and care homes… …Too often, older people in particular, are admitted to institutional care for long periods when a package of assessment, treatment, rehabilitation and support in the community – and help for their carers – could better serve their needs."*

1.2 Health and Social Care North Lanarkshire's Commissioning Plan 'Achieving Integration', NHS Lanarkshire's Healthcare Strategy 'Achieving Excellence' and North Lanarkshire Council's Business Plan set a vision of an integrated health and social care system focused on prevention, anticipation and supported self-management.

1.3 Local patient census exercises have identified that up to two-thirds of patients in off-site facilities could be cared for in a community setting. In addition, the introduction of the updated Hospital Based Clinical Complex Care guidelines further support a shift towards community service provision, based around the core criteria of *'Can this individual's care needs be properly met in any setting other than a hospital?'*

1.4 In addition, over 50% of Delayed Discharge bed days take place within the off-site beds (e.g. Wester Moffat, Coathill etc) and initial enquiries highlighted significant variance in practice and outcomes between the sites.

1.5 Set within this context, a pan-Lanarkshire health and social care bed modelling steering group was initiated in April 2016 to review the future bed requirements and actions required to facilitate change. It is clear that the utilisation of beds is rapidly changing and will continue to do so over the next decade, necessitating whole system planning on the future direction of travel with a clear focus on maximising health and social care at home, thereby reducing reliance on hospital and care homes (both nursing and residential care homes).

1.6 Within phase one of this programme, a number of aspirations were agreed, including reviews of intermediate care (off-site NHS beds), social work intermediate care and cottage hospitals. Within North Lanarkshire, it was agreed to undertake this as one process, with the aim of creating a single vision and service model for implementation in 2018/19.

2. Background

2.1 Intermediate Care is an 'umbrella' term describing an approach involving a collection of services working to common, shared objectives and principles. It provides a set of 'bridges' at key points of transition in a person's life, in particular from hospital to home (and from home to hospital) and from illness or injury to recovery and independence; helping them achieve their personal outcomes.

2.2 By its nature in acting as a bridge between locations, sectors and personal circumstances, there must be close connections with mainstream services – whether the acute sector or community based services.

2.3 Intermediate Care covers a much wider scope than just bed-based services, spanning a range of community-based initiatives such as Reablement, Rehabilitation, Hospital at Home and multi-disciplinary Locality offerings. In this context, there is a role for all including health, social care, housing, the third and independent sectors, families, carers, neighbours and the wider community.

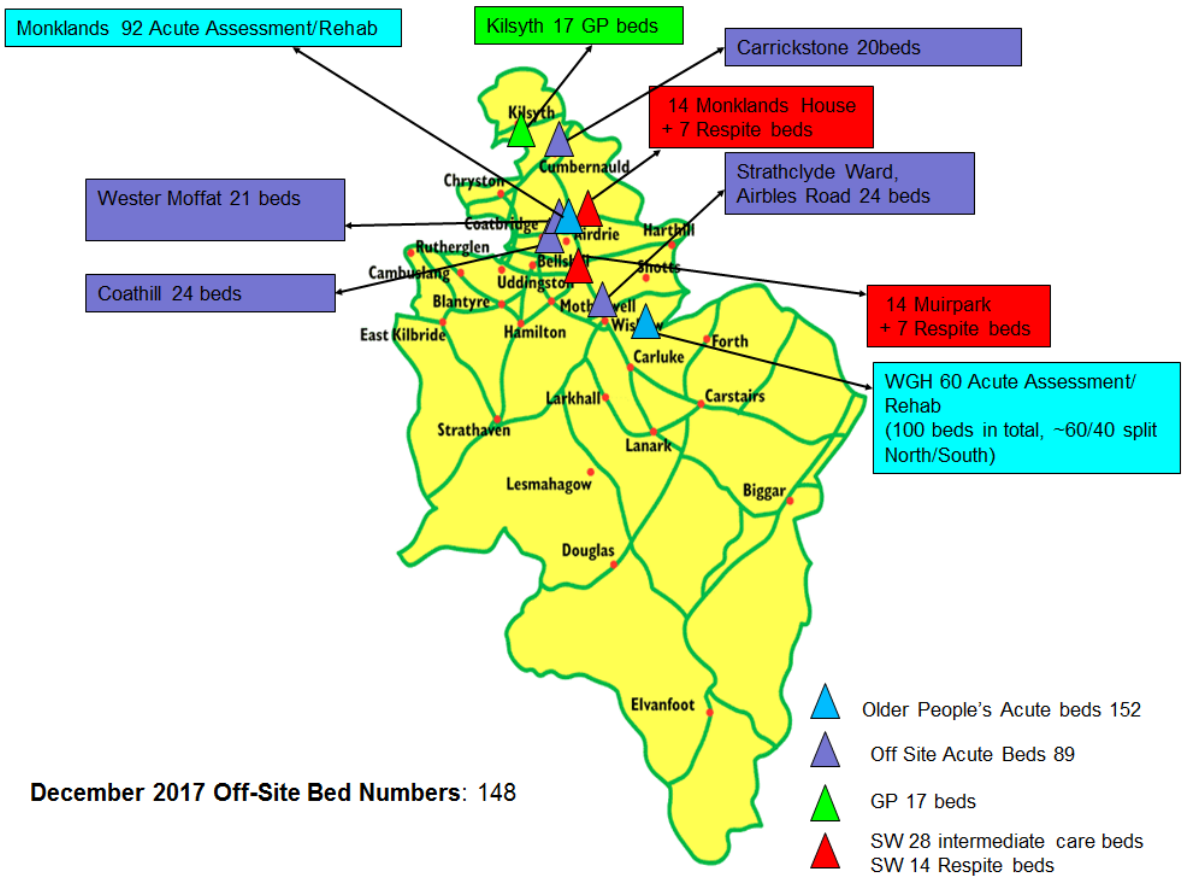
2.4 A well developed, integrated model of intermediate care can:

- Prevent unnecessary acute hospital admission or premature admission to long-term care

- Support safe, timely and person centred discharge from hospital
- Promote faster recovery from illness
- Support anticipatory care planning and the self-management of long term conditions

3. **Current Position**

3.1 At present in North Lanarkshire, there are 148 community-based beds covering off-site acute, Social Work Intermediate Care and the Cottage Hospital:



December 2017 Off-Site Bed Numbers: 148

3.2 In general terms, the University Hospital Monklands catchment area is better served with 103 beds, than University Hospital Wishaw with only 45.

3.3 There is a lack of consistency of model across the current sites, which is highlighted by the table below. It should be noted that patient complexity will have a significant impact on both length of stay and the percentage discharged home, making direct comparisons difficult.

Facility	Beds	Nurse wte	AHP wte	Snr Medical	Cost per bed	Av LoS (days)	% Dx home
KVCH	17	18.07	0.1	GP	£60.5k	49	57
Monklands House*	21	0	CARS	GP	£61.7k	44.5	79
Wester Moffat	21	23.07	MK	MK	£45.7k	58	37
Coathill	24	23.09	MK	MK	£54.5k	54.5	29
Carrickstone**	20	n/a	CARS	MK	£40.6k	39.5	38
Muirpark*	21	0	CARS	GP	£61.7k	44.5	79
Parksprings**	26	27.37	CARS	WG	£53.1k	32	34

*Monklands House/Muirpark data is composite data for both sites

**Carrickstone Nursing component provided by Four Seasons Healthcare as per contract

***Parksprings transferred to Strathclyde Ward, Airbles Rd in July 17, but new figures not yet available

3.4 At present, Kilsyth Victoria, Monklands House and Muirpark are managed within the partnership and Coathill, Carrickstone, Strathclyde Ward and Wester Moffat are managed via Acute.

3.5 In November 2017, the North IJB approved the Integrated Service Review Board report and subsequently the associated implementation plan in February 2018. This will see a range of community supports further developed over 2018/19, including:

- An integrated single point of access for community services
- Integrated Locality teams, including rehabilitation supporting community based assessment and therapy
- Multi-disciplinary rapid community response
- Hospital at Home
- Discharge to assess, via development of integrated Long Term Conditions and Frailty teams in each Locality
- Development of the integrated equipment store to ensure rapid access to equipment to facilitate early discharge
- New model of Home Support offering:
    - Rapid access
    - Reablement
    - Intensive Home Support
- Dementia support
- Wide range of community and third sector supports

3.6 Set within this context, it was agreed that the planned Social Work Intermediate care facility at Greenlea Road in Chryston, could be put to better use. Within North Lanarkshire Council's Local Housing Strategy, the need for additional amenity housing suitable for older people was identified, particularly within the Moodiesburn/ Chryston area. Following approval at the IJB and at North Lanarkshire Council's Social Work Committee and Policy and Resources Committee, the facility has been transferred to Enterprise and Housing Resources for the purposes of amenity housing.

4. Developing the New Model

4.1 In December 2017, a Short Life Working Group (SLWG) was established to undertake a review of inpatient Intermediate Care services, with a view to establishing a single proactive, preventative and anticipatory model for North Lanarkshire.

4.2 The SLWG reports to the Unscheduled Care/Delayed Discharge Improvement Board, then onwards to the respective Corporate Management Teams, Social Work Committee, PPPRC and ultimately the IJB for final approval.

4.3 The membership of the SLWG was as follows:

Ross McGuffie	Head of Planning, Performance and Quality Assurance
Alastair Cook	Medical Director
Gautam Reddy	GP
Ben Adler	Consultant, Older People's Services
Ana Talbot	Lead Clinician and Consultant, Older People's Services
Gillian Buckner	Consultant, Older People's Services
Trudi Marshall	Associate Nurse Director
Dennis McLafferty	Manager Adult Services (Frailty & Long Term Conditions)
Bobby Miller	Head of Adult Social Work Services
Owen Watters	Head of Health
Jim Duffy	Service Manager, Older People's Services
Murdoch Wilson	Service Improvement Manager
Jennifer Allan	Service Improvement Support Manager

Maggs Thomson	Health and Social Work Manager
John O'Brien	Senior Officer Adults Services
Alistair McVean	Consultant, Older People's Services

4.4 The review commenced with the broad aim of agreeing a single model of intermediate care across all sites that:

- Creates a genuine focus on prevention, rehabilitation, reablement and recovery
- Strongly links to the community, with in-reach rehabilitation and reablement services, ensuring continuity on discharge
- Focuses on maximising independence, confidence and personal outcomes
- Is based on holistic assessment to maximise independence, confidence and personal outcomes sought by the individual
- Supports a multi-disciplinary workforce including Geriatric Consultant, Nurses, Social Workers, Physiotherapy, Occupational Therapy, Carers and Support Workers, GP Practices, Locality teams and family members/carers

5. Proposed New Model of Intermediate Care in North Lanarkshire

5.1 Discharge to Assess

5.1.1 The future model of inpatient intermediate care needs to be set within the framework of a Discharge to Assess approach. Within North Lanarkshire, there is commitment to develop an approach that ensures where people are medically fit for discharge, they are supported to be discharged to their own home where possible, or another community setting, to ensure that the assessment for longer-term care and support needs is undertake in the most appropriate setting and at the right time for the person.

5.1.2 The default pathway will be to enable people to go straight home with rapid and appropriate access to services, creating the primary focus for intermediate care within the community. However, where this cannot be safely supported, the alternative pathway will be to an off-site facility.

5.1.3 It is envisaged that in the majority of assessment and rehabilitation cases supported in the off-site facilities will be time limited to around four weeks with the aim of providing a rapid assessment, in conjunction with individuals and their families, to get the best possible outcome.

5.1.4 While total bed requirements may change over time, it was the view of the group that the current number of NHS beds should be maintained in the short term until demand from the new model is more fully understood.

5.2 Changing Ward Culture

5.2.1 Studies have shown that for every 10 days of bed-rest in hospital, the equivalent of 10 years of muscle ageing occurs in people over 80-years old and building this muscle strength up takes at least twice as long as it does to deteriorate. One week of bed-rest equates to a 10% loss in strength and for a frail or older person who is at threshold strength for climbing the stairs at home, getting out of bed or even standing up from the toilet, this could be the difference between dependence and independence. Irrespective of age or frailty, all patients will lose muscle strength during their stay, albeit at different rates, along with loss of confidence and connection to their community supports.

5.2.2 It is therefore vital that the new model of care is based on a genuine culture shift towards active rehabilitation and reablement within these facilities, with a focus on a time-limited stay that maximises the chance of independent living. This will require changed working practices, but also education for relatives and carers to become involved in supporting this approach.

5.2.3 This approach will have significant benefits for individuals, but will also improve flow through the off-site facilities, creating greater capacity for step down from acute sites and improving performance around both unscheduled bed days and delayed discharges.

5.3 Core Functions

5.3.1 To ensure a consistent model of care, four key functions were identified, which will be delivered within all off-site facilities:

- Active Rehabilitation
- Complex Assessment
- Hospital Based Clinical Complex Care
- End of Life Care

5.3.2 To support this development, workforce changes will be required, to ensure appropriate Consultant, Nursing, Social Work, Reablement and Allied Health Professionals (AHP) input to each site.

5.3.3 Following discussions with the Scottish Government and Information Services Division, it was recognised that off-site facilities are often multi-functional, with few able to be termed Intermediate Care facilities in their own right. It is vital that the new Trakcare-based system for the management of delayed discharges is able to code individual patients appropriately to ensure accurate reporting of their care journeys.

5.4 Integrated Model

5.4.1 With the development of integrated Long Term Conditions and Frailty teams in each of the six localities in North Lanarkshire, which include Rehabilitation and Reablement staff, the new model will see off-site facilities supported by their host Locality, for example, Muirpark supported by Bellshill Locality.

5.4.2 The Locality will provide in-reach support for reablement, rehabilitation, assessment and discharge, providing a seamless and more efficient model in supporting an individual's recovery and transition home.

5.4.3 The model aspires to integrated working between staff in the off-site facilities and the Locality teams, creating a capable workforce that has the collective skills to support people to realise their full potential for health, independence and wellbeing.

5.4.4 The in-reach model will be tested with the Motherwell Locality Integrated Rehabilitation Team and the Strathclyde Ward at Airbles Road in early 2018 with the aim of developing the service model before wider roll out across North Lanarkshire in 2018/19. A key component of the test of change will be the use of a workforce tool to monitor the workforce implications of the new model.

5.4.5 The change in approach will require training and support for staff in the wards and Locality teams, to ensure they have the appropriate skills and competencies for the new model. A Training Needs Analysis will also be undertaken during the testing phase of the development.

5.4.6 A subgroup of the Integrated Workforce Steering Group will be formed to support the development of the new model.

5.5 Social Work Intermediate Care & Respite

5.5.1 The Social Work Intermediate Care Facilities in Monklands House and Muirpark will see the greatest impact from the move towards Discharge to Assess. As these facilities currently have no ongoing nursing input, they support individuals with the lowest acuity who, with the

newly approved Home Support model will most likely go straight home with appropriate support and therefore have better outcomes. This is exemplified by the fact that around 80% of current cases return home, demonstrating the lower level of acuity of patients.

5.5.2 Learning from visits to Sheffield highlighted the impact that a Discharge to Assess model will bring, with the average bed days for older adults dropping from 6.9 days to 1.2 days following roll out. The Sheffield data also highlights that through earlier supported discharge, deterioration of patients is minimised, with only around one third of patients requiring ongoing support following the initial intensive input on discharge.

5.5.3 The biggest consideration for reducing Social Work Intermediate Care bed numbers is around the geographical coverage. There are currently 103 off-site beds supporting University Hospital Monklands, while there are only 45 beds supporting University Hospital Wishaw.

5.5.4 It is therefore proposed that Monklands House be closed, which will still leave 82 off-site beds supporting the University Hospital Monklands catchment area and maintain the 45 around University Hospital Wishaw in North Lanarkshire.

Hospital	**Off site beds available in the localities surrounding DGH's**
University Hospital Wishaw	45 (proposed 45 beds with new model of care)
University Hospital Monklands	103 (proposed 82 beds with new model of care)
Difference	Capacity of 21 beds (patients/service users supported at home)

5.5.5 During 2018/19, it is proposed that a review be undertaken to explore the potential of converting the Muirpark facility to provide the same model of care as the NHS off-site beds. This would see enhanced clinical cover with named Consultant and full Nursing compliment and would expand the admission criteria of the facility. Doing so would provide a significant increase in the off-site capacity for the Wishaw site thus improving flow and the discharges and outcomes for patients who would otherwise have remained in hospital for longer.

5.5.6 Monklands House currently provided seven respite beds, used for both respite and Adult Support and Protections cases, with around 60% usage. Therefore, an extra four respite beds will be created within the Muirpark facility to ensure no loss in capacity in the immediate term, while work commences on identifying local externally commissioned Care Home places for future use within individual Localities, linked into the partnership's Market Facilitation Plan.

5.5.7 There are currently three longer term residents in Monklands House, who will require to be supported into a new care environment. Officers within the service are well experienced in managing such transitions and individual plans will be developed in conjunction with the service users and their families.

5.6 Management

5.6.1 A number of partnerships across Scotland have taken a different approach with intermediate care, which transfers management of the sites to the Health and Social Care Partnerships, with the aim of more fully integrating practice with Locality teams.

5.6.2 To aid continuity during the change process, it is proposed that the management of the sites does not transfer to Health and Social Care Partnerships in the short-term, however, it was acknowledged that the current arrangements are not optimal.

5.6.3 At present, all off-site NHS facilities are managed from the Wishaw site, but an interim move would be to split the management responsibility between the two acute sites, with one

Service Manager covering the University Hospital Monklands catchment area (both on-site and off-site) and one for the Wishaw catchment.

5.6.4 Health and Social Care Partnership management arrangements will be developed and trialled in Kilsyth Victoria and Muirpark with the longer term aim of transferring management responsibility for the other sites in future during 2019/20.

6. Impact and Outcomes

The proposed inpatient intermediate care model will:

- Form an integral component of a Locality-based Intermediate Care model, which includes:
  - Integrated Locality teams supporting a multi-disciplinary rapid response
  - Rapid access to equipment
  - A new model of Homes Support providing rapid access, reablement and intensive support
  - Hospital @ Home
  - In-reach assessment, rehabilitation and discharge support
- Enable more people to live independent lives, with meaning and purpose, within their own community
- Support a model of Discharge to Assess, providing an alternative pathway from acute hospitals for those unable to go directly home
- Provide a consistent model across all sites, covering four key functions:
  - Active Rehabilitation
  - Complex Assessment
  - Hospital Based Clinical Complex Care
  - End of Life Care
- Shorten stay in hospital and support people home earlier, reducing the risk of deterioration and maximising the chance of independent living
- Create a culture change towards a much greater focus on reablement and rehabilitation
- Support a significant reduction in both unscheduled care bed days and delayed discharge bed days

7. Conclusion

7.1 Currently in North Lanarkshire, there is considerable variance in practice and service models between the seven off-site facilities, resulting in divergent performance and patient outcomes.

7.2 Following the Integrated Service Review Board report, the Health and Social Care Partnership has set a direction of travel that significantly alters the service landscape, creating integrated Locality teams that will in-reach to Hospital sites, offer rapid community response, support the Hospital at Home model and create a model of discharge to assess. These developments will fundamentally change both the interface with and demands placed on the off-site facilities in future.

7.3 Arguably the greatest impact will be on Social Work Intermediate Care, as those with lower acuity will either be supported at home with no requirement for step up through rapid response, or where admitted to an acute site, discharged directly home for a period of assessment and reablement. It is anticipated that the future demands on Social Work Intermediate Care will therefore significantly diminish, though the Partnership will require to find alternative approaches for respite and suitable safe placements for those undergoing the adult support and protection process.

7.4 Central to the new model is a change in ward culture to create a much stronger emphasis on reablement and rehabilitation, tackling 'pj paralysis' and focusing on time-limited stays that maximise the chance of independent living.

7.5 Each site will be developed to provide four core functions, ensuring a consistent approach across North Lanarkshire, supported by Locality in-reach for assessment, rehabilitation and discharge planning. Each site will have a 'host' Locality, which will have sufficient capacity built into its integrated Long Term Conditions and Frailty team.

7.6 Planned changes will require sign off via the Support, Care and Clinical Governance committee and the Healthcare Quality Assurance and Improvement Committee, the Area Partnership Forum and Social Work Committee.

7.7 It is anticipated that implementation of this model will support a significant reduction in both unscheduled care and delayed discharge bed days, whilst supporting more people to live independently within their own community.

8. Recommendations

8.1 It is recommended that:

- The proposed new model is implemented across the 5 NHS sites with immediate effect, covering the four key functions:
    - Active Rehabilitation
    - Complex Assessment
    - Hospital Based Clinical Complex Care
    - End of Life Care
- The Social Work Intermediate Care facility at Monklands House is deemed surplus to requirements
- A review of Muirpark Social Work Intermediate Care Home be undertaken in 2018/19 to ascertain the potential for expanding its service model in line with the NHS facilities
- An implementation plan is agreed via the Social Work Committee, covering the support to existing residents and staff, future respite provision and other operational issues
- Approval for the approach be sought from the Support, Care and Clinical Governance Committee and the Healthcare Quality Assurance and Improvement Committee, Joint HR Committee, Area Partnership Forum and Social Work Committee
- The Long Term Conditions and Frailty teams in Localities be sized in line with the additional requirements for providing in-reach for assessment, rehabilitation and discharge planning to sites within their boundaries
- A workforce plan be created to identify the future requirements for Consultant, Nursing, Social Work and AHP input
- A programme of training and development be created for ward staff on active reablement and rehabilitation to support a change in culture
- Alternative local provision of respite and adult support and protection placements is developed in 2018/19 and outlined within the partnership's upcoming Market Facilitation Plan