NORTHAMPTON BOROUGH COUNCIL

Scrutiny Panel 4 – Adult Social Care

Your attendance is requested at a meeting to be held at The Jeffrey Room, The Guildhall, St. Giles Square, Northampton, NN1 1DE on 6 December 2018 at 6pm

George Candler
Chief Executive

If you need any advice or information regarding this agenda please phone Tracy Tiff, ext 7408 who will be able to assist with your enquiry. For further information regarding **Scrutiny Panel 4 - Adult Social Care Facilities** please visit the website www.northampton.gov.uk/scrutiny

Members of the Panel

Chair	Councillor Zoe Smith
Panel Members	Councillor Sally Beardsworth Councillor Julie Davenport Councillor Janice Duffy Councillor Anamul Haque (Enam) Councillor Jamie Lane Councillor Arthur McCutcheon Councillor Brian Oldham Councillor Cathrine Russell

Calendar of meetings

Date	**Room**
17 January 2019 6:00 pm 11 February 1 April	All meetings to be held in the Jeffery Room at the Guildhall unless otherwise stated

Northampton Borough Scrutiny Panel 4 - Adult Social Care Facilities

Agenda

Item No and Time	Title	Pages	Action required
1. 6:00pm	**Apologies**		The Chair to note any apologies for absence.
2.	**Declarations of Interest (including Whipping)**		Members to state any interests.
3.	**Deputations and Public Addresses**		The Chair to note public address requests. The public can speak on any agenda item for a maximum of three minutes per speaker per item. You are not required to register your intention to speak in advance but should arrive at the meeting a few minutes early, complete a Public Address Protocol and notify the Scrutiny Officer of your intention to speak.
4.	**Minutes**	**1 - 5**	The Scrutiny Panel to approve the minutes of the meeting held on 8 November 2018.
5.	**Witness Evidence**		The Scrutiny Panel to receive responses to its core questions from key expert advisors.
5 (a) 6:05pm	**Detective Chief Inspector, within Public Protection, Northants Police**		
5 (b) 6:20pm	**Director of Public Health, Northamptonshire County Council**		
5 (c) 6:45pm	**Director, Healthwatch Northamptonshire**		
5 (d) 7:05pm	**Director, Northampton Health Trust**	**6 - 13**	
5 (e) 7:20pm	**Local GP**		
6. 7:45pm	**Site Visits**	**14 - 18**	The Scrutiny Panel to consider the report detailing the findings from its site visits.

NORTHAMPTON BOROUGH COUNCIL

MINUTES OF SCRUTINY PANEL 4 - ADULT SOCIAL CARE FACILITIES

Tuesday, 6 November 2018

COUNCILLORS PRESENT:	Councillor Zoe Smith (Chair) , Councillor Sally Beardsworth (Deputy Chair), Councillors Enam Haque, Jamie Lane, Arthur McCutcheon, Brian Oldham and Cathrine Russell
Witnesses	Anna Earnshaw, Director, Adult Social Care, NCC Ken Fairbain, Deputy Director, Adult Social Care, NCC Councillor Stephen Hibbert, Cabinet Member for Housing and Wellbeing Phil Harris, Head of Housing and Wellbeing
Officer	Tracy Tiff, Scrutiny Officer
Members of the Public	Adore Morcea Walker

1. APOLOGIES

Apologies for absence were received from Councillors Davenport and Duffy.

2. DECLARATIONS OF INTEREST (INCLUDING WHIPPING)

There were none.

3. DEPUTATIONS AND PUBLIC ADDRESSES

Adore addressed the Scrutiny Panel on agenda item 6 (b).

4. MINUTES

The minutes of the meeting held on 8 October 2018 were signed by the Chair as a true and accurate record.

5. CO OPTEE TO THE SCRUTINY PANEL

The Scrutiny Panel reiterated its disappointment that no Councillors from NCC had come forward to be co opted to the Review.

6. WITNESS EVIDENCE

(A) CABINET LEAD: ADULT SOCIAL CARE, NORTHAMPTONSHIRE COUNTY COUNCIL

The Cabinet Lead: Adult Social Care, Northamptonshire County Council had submitted her apologies for the meeting.

(B) EXECUTIVE DIRECTOR ADULTS, COMMUNITIES & WELLBEING, NORTHAMPTONSHIRE COUNTY COUNCIL

Adore, individual addressed the Scrutiny Panel. She informed the Scrutiny Panel of how she had personally experienced budget cuts to services. She also highlighted that she was very impressed by the good work undertaken by the Executive Director, Adults, Communities & Wellbeing, Northamptonshire County Council. Adore referred to a complaint that she had submitted to NCC through its relevant complaints process. She was upset that she was not assigned a Social Worker currently. She commented on the need for Social Workers to be assigned to those individuals that need them and went on to refer to housing conditions. In response to a question Adore confirmed that she had used the services since 2014 and gave an example of how benefits had affected her care plan. She advised the Panel that she had been able to have a shower for over a year.

Adore was thanked for addressing the Scrutiny Panel.

Anna Earnshaw, Executive Director Adults, Communities & Wellbeing, Northamptonshire County Council, and Ken Fairbairn, Deputy Director Adults, Communities & Wellbeing, Northamptonshire County Council submitted the following papers to the Scrutiny Panel:

- Adult Social Care Briefing
- Understanding the Need for Specialist Housing in Northamptonshire

The general packs provided the Scrutiny Panel with background information.

In addition, Anna Earnshaw and Ken Fairbairn provided comprehensive responses to the core questions of the Scrutiny Panel:

- The budget for adult social care is £245.875 per year, of which around £190 million is directly spent on care.
- Discussions are currently underway regarding Unitary. It is envisaged that high level issues such as safeguarding, assessments and commissioning will be undertaken at a county level but discussions are still underway.
- Ken Fairbain is the lead commissioner with an active role in the Voluntary Sector. Joint delivery is key.
- The Voluntary Sector is involved through various groups such as the Health Forum.
- Adult Social Care meet regularly with the Care Association; as they do with the Voluntary Sector.
- A relationship has been forged with the Voluntary Driver Scheme and Age Uk.

- A lot of people do not want to be known to adult social care.
- There is a need to put preventative services in place so that the correct support and assistance can be provided to those that require it.
- Central Government provides grant funding.
- The care package and spend “goes with the person”.
- The Shaw PFI contract is challenged and has been in place since 2013. Discussions are underway regarding individuals with more complex needs, new contract management, long term use of the contract and work is underway with the Department of Health and Treasury about possible solutions. Shaw is being supportive. Their staff will be trained and NCC is working with Shaw.
- In answer to a query why individuals are going home from care homes, Anna Earnshaw advised that best practice has changed and people decompensate when they go into care homes. Best practice is for people to remain at home. The average age of an individual going into a care home is 89 and they live there on average for around 18 months.
- In response to a query about buying out of the Shaw PFI contract, the Scrutiny Panel heard that the contract was actively looked at together with the Department of Health and Treasury but this was not felt to be good value for money. Meetings have been held with Shaw. The type of care that is now required is complex nursing and dementia care.
- The point in which individuals pay for their own care is prescribed by Legislation. If they have less than £23,000 it will be paid for them; however, if they go into a care home, the value of their home is taken into consideration. If they are cared for at home, the value of the house is not taken into consideration.
- Costs vary depending upon specialisms. High end nursing care costs £900 per week
- There are 1,000 staff working in Adult Social Care. There are 450 providers across the county, of which 250 are care homes. There is a shortage in nursing care. There is a need to further develop dementia care. More needs to be don regarding supportive living.
- People living with dementia need to be located in the right place, there are lots of issues to be considered. For example, when a hospital goes on black alert, the cost of a bed rises. Northampton has the highest waiting list of individuals needed a bed in a care home.
- In answer to a query regarding the turnover of care worker staff, Anna Earnshaw commented that they often leave to work in a different profession. There is around 30% turnover of staff.
- Monitoring meetings and risk assessments take place. The profession is regulated by the CQC. Monitoring meetings are held regularly.
- Regarding safeguarding referrals, around 6000 are received annually. 91% are concluded as “no further action.” All referrals are screened then rated in terms of need.
- In response to a query regarding deprivation of liberty; the Scrutiny Panel heard that there are a number of claims in this respect. All of which have to be reviewed. Best Interest Assessors undertake the review.
- There is a high level of demand for care in the home and also a demand for dementia care.

Anna Earnshaw and Ken Fairbairn were thanked for their informative addresses.

(C) CABINET MEMBER FOR HOUSING AND WELLBEING, NBC

Councillor Stephen Hibbert, Cabinet Member for Housing and Wellbeing, NBC, and Phil Harris, Head of Housing and Wellbeing provided a written response to the relevant core questions of the Scrutiny Panel and elaborated upon them. A handout detailing best practice elsewhere was provided to the Scrutiny Panel.

Phil Harris gave background information regarding discussions he had had with the previous Director of Adult Social Care, NCC, and confirmed that now the current Director of Adult Social Care, NCC, is working with the boroughs and districts.

The Scrutiny Panel made comment, asked questions and heard:

- There is a huge demand for adult social care – there is a need to balance cost with pressures.
- Housing impacts on physical and mental wellbeing and also health inequalities. Housing options have evolved to meet new and emerging demand.
- Technology is being used to help people, such as telecare.
- The Scrutiny Panel was pleased the Eleanor House had been modernised and back in use.
- The need for more social housing, especially for older people, was highlighted.
- The need for more Extra Care facilities was emphasised.
- The Scrutiny Panel acknowledged that Parsons Mead is a flagship complex and "ticks all the boxes", being close to required amenities for older people. However, the need for repairs, such as the replacement of bulbs, should be undertaken by the Borough Council. This information would be passed to NPH.
- The Hospital Discharge Scheme has helped 350 people since 2015. Housing and Wellbeing have excellent engagement with Health Services

Councillor Stephen Hibbert and Phil Harris were thanked for their informative address.

(D) HEAD OF HOUSING AND WELLBEING, NBC

This agenda item was taken at 6 (c).

7. CFPS CONFERENCE: NATIONAL HEALTH SCRUTINY AND ASSURANCE CONFERENCE

Councillor Russell presented her briefing note on the CfPS Conference: National health scrutiny and assurance conference that she had recently attended. She highlighted, in particular, the key points from the workshop:

Feedback from the workshop: Transforming relationships with communities, led by Rosie Ayub, NHS England

The two workshops provided lots of thoughts about engaging with people and communities. Some of the developing principles which came out of the group included:

- Meet the community where they are – one size doesn't fit all • Needs to be solution focussed
- Genuine options for consultation – engage people in options appraisals
- Plan engagement at an early stage and be clear about what you are asking
- Listen – two-way dialogue
- Be open minded
- Be prepared to build relationships
- Make it understandable – no jargon, easy/simple information
- Focus on what you are trying to achieve, then find out from community about how they think it can be achieved
- The information was noted and would inform the evidence base of this review.

The information was noted and would inform the evidence base of this review.

8. BACKGROUND INFORMATION

The Scrutiny Panel received a paper around relevant Legislation.

The information was noted and would inform the evidence base of this review.

The Scrutiny Panel watched a short video on "last 100 days" but would be sent the link.

The meeting concluded at 20:00 hours

Northamptonshire County Council

Ms Tracy Tiff
Scrutiny Officer
Northampton Borough Council
Guildhall
St. Giles Square
Northampton
NN1 1DE

5th December 2018

Dear Tracy

Re: Scrutiny Panel – Adult Social Care Facilities

Thank you for the opportunity to contribute to your review of adult social care facilities and planning for the future needs of older people. Anna Earnshaw, my Director of Adult Social Care colleague has, I understand, previously provided information as have our colleagues in NHFT. I will therefore focus on the core questions posed as relevant to a public health response.

1 It is important to appreciate the totality of the need problem and its cost. How will this be apportioned between two Unitary Authorities?

Public health will be supporting our partners in Northamptonshire Adult Social Services (NASS) and across NCC, the Northamptonshire Health and Care Partnership (NHCP) and wider organisations with data to inform service planning, provision and commissioning regarding need and demand. This is an intelligence role we currently deliver.

2 How will better working/partnership be fostered with NHS and outside providers, i.e., Charities and private sector care homes?

As NHCP stakeholders, public health are working with our provider organisation partners to support an integrated approach to health and social care. We know integration is essential to meet the needs of older people who often have co-morbidities that require joint health and social care management. There is considerable evidence that this joined up approach is not only the best model of care for the service user, but is cost effective and improves outcomes.

Public health is supporting this work, for example, through the development of a new frailty service, on-going falls prevention investment, the commissioning of services to support people with complex substance misuse needs and leading the implementation of social prescription across the county.

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I understand that Angela Hillary from NHFT and Anna Earnshaw have both responded with other examples.

3 How will funding be apportioned?

I refer to the answer to question 1 and reiterate the fact that funding needs to be apportioned according to need. I understand Anna Earnshaw has provided other information on this to you already.

4 How will you sort the Shaw PFI contract?

Public health, as a directorate of NCC, is supporting the work that is being undertaken to address the Shaw Healthcare contract position. Anna Earnshaw will have advised you of the actions that are being taken.

5 How will Safeguarding principles be better applied?

Through our partnership with NHCP organisations, public health are committed to ensuring that we all strive for continuous improvement through shared information and integration as a place-based system that works effectively together to safeguard our vulnerable adults and young people.
Through our role as commissioners, public health includes the requirement that safeguarding referral and staff to be appropriately trained are standard in contracts and monitoring arrangements.

6 Please provide details of the relationship with private sector providers, i.e., care/nursing homes?

Public health has contractual relationships as commissioners for services that support vulnerable people, for example those people in drug and alcohol recovery, homelessness support and is a commissioner of services provided at Oasis House. In addition we have commissioned training for carers of people in long term care; for example mobility, falls prevention and dental health.

7 Please provide details of opportunities to combine care and housing provision in innovative ways?

There are a number of examples across the country that focus on specific groups of people dependent on their level of care need and any associated risk/ health needs.

8 Do you think there are any specific groups that are not accessing Adult Social Care Facilities, please provide details

There are vulnerable marginalised groups that are not accessing adult social care in the broadest remit – for example people with mental health needs, especially younger adults, including ex-armed force personnel, sex workers, and those with substance misuse social care needs. The reasons for this are not fully understood.

9 In your opinion, how can better management support be applied for both social workers and carers?

Integrated roles of health and social care workers that reduce duplication and ensure professionals are trained to look at the wider need of service users, rather than focus on a silo of health or social care will help. Caseload size and access to training and supervision are enablers of higher quality care, and assured responsiveness to escalation of concerns. Workplace health is also a priority for

public health and we are currently part of a county-wide group that looks at workplace health issues and provides strategic direction relating to intervention and improvement.

10 Please provide details of the statutory responsibilities in respect of the duty of care obligations and their financial consequences

This is not applicable to Public Health.

11 Are there any examples of new, innovative ways of working that we can learn from?

Examples already in place are Age Well Wellingborough, identifying what is being achieved through that project and delivering it at scale across the county would improve wellbeing.
Greater access to technology to support safe independent living, such as telemedicine, wearable devices that allow people to remain in their own home. Improved transition planning for those service users with life-long complex needs that focuses on independent living through an asset based assessment. The new social prescribing programme is also reviewing the evidence to identify programme of work we may wish to adopt in Northamptonshire to improve population health outcomes.

12 What models centred on the prevention agenda are being delivered? Are there plans to further expand this way of working?

Prevention starts from childhood and evidence shows that the risk of poor health and need for long term health and social care is linked to birth and childhood conditions and experiences, such as the income of your parents and level of deprivation, education opportunities and attainment, access to healthy food and physical activity and stability in your immediate environment and exposure to adverse events.

Evidence states that health and wellbeing is impacted more greatly by the wider determinants of health compared to access to health services, and if we get meaningful understanding and action on prevention, this is a considerable spend to save investment for the quality of an individual's life and finite statutory service resources.

Therefore greater focus on these wider determinants needs to be in place; family income, stable housing, good quality schooling, a safe and stable environment al allow an individual to maximise life opportunities, increase social mobility chances and subsequently have a greater quality of independent life.

Prevention and early intervention is key and needs to be the means underlying the long term sustainability of services. This approach is known to reduce the risk of avoidable poor health and wellbeing, and even for those people who require health and social care, recognition that early identification of a deterioration in health is key. Furthermore, access to effective primary and community care, home safety, good diet, access to exercise, community engagement and inclusion, and medical interventions such as health screening and immunisation all contribute to a healthier life.

13 How is the wider place making system (planning, highways, public transport) being engaged to create communities of the future that ensure older people stay healthy for longer

Healthy communities require good transport links across the geographical patch, whether that is access to concessionary travel, easy access routes to shopping, health care settings, or to parks and outdoor walks, (and organised walks to encourage socialising) and cycle paths that lead to places people want to access. This allows healthy behaviour to be established early, so that independent travel, especially walking and cycling are the norm, rather than reliance on cars and provided transport. For those who do require cars though due to disability, accessible parking that encourages people to leave their homes is important. This is an area where there needs to be more awareness of the impact on positive public health and more effective town and community planning that appreciates health and wellbeing outcomes. Public health are currently developing a programme of work with the Place directorate within NCC to join up thinking on these issues.

14 Do you have any other information, concerns or suggestions you wish to raise in relation to adult social care facilities?

Our view is that promoting independence from an early age, supported by a societal infrastructure which is safe and life enhancing, is the best approach. Healthy area planning is central to reducing avoidable poor health and wellbeing – prevention is better and has greater value, than cure across the lifecourse. This is the only sustainable model of care from a financial perspective too. When care is required, we need to recognise those people who do not access traditional health and social care and understand the reason why they don't and make help more accessible.

I hope this information is useful. If you require any additional information please contact me directly.

Yours sincerely

Lucy Wightman
Director of Public Health

Healthwatch Northamptonshire

Ms Tracy Tiff
Scrutiny Officer
Northampton Borough Council
Guildhall
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5 December 2018

Re. Scrutiny Panel 4 – Adult Social Care Facilities

Dear Cllr Smith,

Thank you for inviting us to contribute to your review of adult social care facilities and demand to inform Unitary Council plans. Apologies for the late response, the invitation to respond was not sent to us until after the initial deadline had passed.

Healthwatch Northamptonshire (HWN) is the county's independent, statutory, consumer champion for health and social care. Our central role is to be a voice for local people to influence better health and wellbeing and improve the quality of services to meet people's needs. To do this we engage with the public to gather feedback on services and issues and signpost them as necessary. This involves us visiting local services and talking to people about their views and experiences. We share our reports and findings with the local NHS and social care providers and commissions, and the Care Quality Commission (CQC), with recommendations for improvement, where required. We also sit on the Health and Wellbeing Board and are part for the Collaborative Stakeholder Forum that feeds into the Northamptonshire Health and Care Partnership (NHCP) Board.

We have the following rights and responsibilities:

- We have the power to monitor (known as "Enter and View") health and social care services (with one or two exceptions). Our primary purpose is to find out what patients, service users, carers and the wider public think of health and social care services.
- We report our findings of local views and experiences to health and social care decision makers and make the case for improved services where we find there is a need for improvement.
- We strive to be a strong and powerful voice for local people, to influence how services are planned, organised and delivered.
- We aim to be an effective voice rooted in the community. To be that voice, we find out what local people think about health and social care. We research patient, user and carer opinions using lots of different ways of

finding out views and experiences. We do this to give local people a voice. We provide information and advice about health and social care services.

- Where we do not feel the views and voices of Healthwatch Northamptonshire and the people who we strive to speak on behalf of, are being heard, we have the option to escalate our concerns and report our evidence to national organisations including Healthwatch England, NHS England and the Care Quality Commission.

Most of the core questions for this review do not apply to us but we have responded where possible below:

1. It is important to appreciate the totality of the need problem and its cost. How will this be apportioned between two Unitary Authorities?

This is not applicable to HWN but we believe it is important that adult social care needs and arrangements and children's services are considered at a county-wide level given that strategic planning of health, police and some other services provided by wellbeing partners (such as the Police, Fire and Rescue, and Ambulance services) is done at county level.

2. How will better working/partnership be fostered with NHS and outside providers, i.e., Charities and private sector care homes?

We believe it is important that partnership working takes place between 'Health' (NHS providers and commissioners) and 'Care' (social care providers and commissioners) across the whole county and extends to partnership working with wider health and wellbeing partners (such as the Police, Fire and Rescue, and Ambulance services) and the voluntary sector. This should include joint commissioning between health and care and support for the voluntary sector. The Northamptonshire Health and Care Partnership (NHCP) has shown vision and a desire to work in this way and we will continue to support and encourage integrated working through the NHCP Collaborative Stakeholder Forum. The voluntary sector provides valuable and innovate services and support to individuals, not always supported by statutory health and care services. The voluntary sector in Northamptonshire has been subject to funding cuts in recent years; it is important that the sector is properly resourced to provide support as part of an integrated health and wellbeing sector.

The CQC Local System Review highlighted the need for better partnership and integrated working across the county, particularly when it comes to ensuring timely and appropriate discharge of patients from hospital. We support the action plan devised as a result of this review, particularly engagement with people about what they want from health and social care partners when they are admitted to hospital and how they want to be involved in their care and discharge planning.

3. How will funding be apportioned?

This is not applicable to HWN.

4. How will you sort the Shaw PFI contract?

This is not applicable to HWN but we are aware that NCC have been working to make best use of the beds provided as part of the Shaw contract.

5. How will Safeguarding principles be better applied?

All HWN staff and volunteers receive safeguarding training so we can refer issues to the council's safeguarding team as issues arise.

6. Please provide details of the relationship with private sector providers, i.e., care/nursing homes?

We carry out Enter and View visits to care/nursing homes as part of our statutory role. All these homes are in receipt of public funding as well as private funding, visiting purely privately-funded homes is beyond our remit. We share our findings with the care homes, commissioners and CQC and publish our reports at: http://www.healthwatchnorthamptonshire.co.uk/enter-and-view
We attend care home information sharing meetings with NCC, CCG and CQC quality monitors and inspectors to ensure information is shared and that we are aware of the monitoring of care/nursing homes taking place.

7. Please provide details of opportunities to combine care and housing provision in innovative ways?

We are aware of the joint housing officer between Kettering Borough Council and Kettering General Hospital and believe this is beneficial to ensuring people are discharged with the right support to prevent future re-admissions.

There is a clear need for more effective partnership working between health and care services and local housing authorities and providers to meet the needs of the ageing population and the increasing number of younger adults with disabilities.

8. Do you think there are any specific groups that are not accessing Adult Social Care Facilities, please provide details.

Whilst we do not have specific evidence of groups not accessing Adult Social Care Facilities, we are aware of incidences where hospital patients or their relatives have felt pressurised to find a care home bed quickly so as not to delay discharge further. They do not always feel well supported in this and sometimes there are delays due to funding disagreements between 'care' (NCC) 'health' (CCG) or the family. In some cases the families do not feel they have sufficient choice of care homes and can themselves delay discharge by having expectations (such as a home near to where they live) that cannot be met. More support and integrated teams so that the family only has to deal with one person/organisation could help. We also heard earlier in 2018 of a large backlog of outstanding social care assessments (especially community assessments, but also hospital assessments). We were told by NCC that system work was in place to improve this.

We are similarly aware that there can be a fluctuating amount of domiciliary care available across the county and that providers can struggle to meet their contracts, resulting in carers not turning up or shortened visits. Obviously this could have a worse impact on those living on their own or isolated without the support of family, etc.

HWN is also concerned about the impact of support services and support workers being cut, particularly on vulnerable people and carers (non-professional), such as those with physical or learning disabilities. For examples, the proposed cuts to support services for Deaf/hearing impaired and Blind/visually impaired people would lessen the support they can give to help these people access health and care services.

9. In your opinion, how can better management support be applied for both social workers and carers?

Integrated working, particularly between social services, health, GP practices and Police/Fire and Rescue, and co-ordinated, person-centred care. Joined up teams could share training and resources so they are more aware of what each other does and which referral routes are open to them.

10. Please provide details of the statutory responsibilities in respect of the duty of care obligations and their financial consequences

This is not applicable to HWN

11. Are there any examples of new, innovative ways of working that we can learn from?

There are many examples of partnership working that are a step in the right direction. For example, the Adult Risk Management protocol can be referred to by a number of county agencies to join up support and interventions for adults at risk to themselves but deemed to have decision-making capacity. This was highlighted at the recent Northamptonshire Adult Safeguarding Board Conference and I suggest you ask them to contribute to this review.

The plans for countywide social prescribing as part for the NHCP have the potential to improve the support for a wide range of patients and make good use of the voluntary sector, if it is well implemented.

The joined up Intermediate Care teams between NHFT and NCC is a positive partnership focusing on frail elderly people and seeking to avoid admissions to hospital by investing more in services delivered in the community.

Age UK's Personalised Integrated Care service in Northampton is an innovative way of supporting over 65s with long term conditions and/or are isolated to achieve their desired outcomes, link in with other services, and reduce hospital attendance. GPs can refer patients to this scheme.

You may want to ask Voluntary Impact Northamptonshire to contribute to this review about innovative ways of working from the voluntary sector.

The comments above have been limited to developments with Northamptonshire. It is equally important for managers and planners to look beyond the county borders to learn from good practice elsewhere. We hope to contribute to this through an event in late spring of 2019 which is being jointly planned with key partners.

12. What models centred on the prevention agenda are being delivered? Are there plans to further expand this way of working?

All the examples highlighted above are focussed on prevention, particularly preventing hospital admissions and re-admissions. We feel it is important that such cross-county collaborations continue.

13. How is the wider place making system (planning, highways, public transport) being engaged to create communities of the future that ensure older people stay healthy for longer

This is not applicable to HWN but we support the integrated working this will involve.

14. Do you have any other information, concerns or suggestions you wish to raise in relation to adult social care facilities?

The following HWN reports and responses to NCC consultations may be of interest to you:

Discharge from hospital and follow up support, December 2017
Summary:
Discharge delays can create problems for hospitals, such as a lack of beds for incoming patients, and cause issues for older patients in particular. Conversely, discharging people too early or without the correct support in place can lead to them being readmitted to hospital. Healthwatch Northamptonshire sought to find out the experiences of patients being discharged from the two general hospitals in Northamptonshire - Kettering General Hospital (KGH) and Northampton General Hospital (NGH). We heard directly from patients about their experiences and views of the discharge process.

Over a three week period in November/December 2016 we spoke with 89 people in hospital on the day they were being discharged. Some were waiting to be discharged from the discharge lounge and others directly from one of the hospital wards. Nearly half of the patients we spoke to were aged 75 or older. We were able to speak to nine of these patients again to find out more about their post-hospital experiences. All the people who talked to us about their post-discharge period were generally happy with the support and advice they had received, however, some did not know what to expect, lacked information or felt under-supported.

In general, the patients we spoke with were very aware of how busy the local hospitals were and appreciative of the care and support received. However, the experiences of patients did highlight some areas for improvement or review. Read the report to find out our suggestions and recommendations and read responses from the hospitals:
http://www.healthwatchnorthamptonshire.co.uk/sites/default/files/discharge_report_final_dec_2017.pdf

Domiciliary Care Lay Monitoring Project Phase 2: November 2014 – March 2015
Summary:
Healthwatch Northamptonshire (HWN) found out what people who use domiciliary care and their families thought about the quality of this essential service. Domiciliary care (home care) is received by approximately 4,500 people across Northamptonshire from paid care workers who provide assistance with washing and dressing, meals and help with taking medicines. Of this total number, 2,614 people accessed their support via Northamptonshire County Council Adult Social Care and an estimated 1,886 people purchased a service independently.
Summary report -
http://www.healthwatchnorthamptonshire.co.uk/sites/default/files/dom_care_summary_phase_2_2015rn_19_june_2015.pdf
Full report -
http://www.healthwatchnorthamptonshire.co.uk/sites/default/files/dom_care_report_phase_2_aug_2015.pdf

Domiciliary Care Lay Monitoring Pilot Project (Phase 1), September 2014
Summary:
A growing number of older people, people with disabilities and long term conditions are supported to live at home and receive help with personal care and day to day living tasks. This kind of support is usually called domiciliary care or home care. Numbers are set to continue increasing as the numbers of older people rise and national and local policy has set out a clear vision that people should be supported to live as independently as possible in their own homes for as long as possible, with a reduction in admissions to hospital and to care homes. Healthwatch Northamptonshire has been working in partnership with Northamptonshire County Council on a pilot project to monitor the quality of home (domiciliary) care services. Phase 1 of the pilot involved Healthwatch Volunteers hearing from users and informal carers/family members, who use two local care agencies to find out their views of the services they received. We have called for major improvements to the way services are planned and delivered to ensure that home care services genuinely meet the needs of people who use services.
Summary report -
http://www.healthwatchnorthamptonshire.co.uk/sites/default/files/dom_care_summary_.pdf
Full report -
http://www.healthwatchnorthamptonshire.co.uk/sites/default/files/dom_care_mon_pilot_report_final_24_09_14.pdf

Response to NCC Utilising Block Residential Care Contracts consultation, January 2017 - see attached.

Utilising Block Res
Care Contracts res tc

Response to NCC Paying for Care and Support in Your Own Home consultation, January 2017 - see attached.

Paying for Care
Support in Your Own

Response to NCC New Delivery Vehicle for Services to Vulnerable and Eligible Adults and their Carers consultation, February 2017 - see attached.

HWN Resp to NCC
New Del Vehicle for S

Yours sincerely,

Dr David N Jones
Chair
Healthwatch Northamptonshire

30 January 2017

Engagement, Participation & Involvement Team,
Northamptonshire County Council,
Room 129, County Hall,
PO Box 177,
Northampton,
NN1 1AY

Dear Sir or Madam,

Response to Consultation on: Paying for Care and Support in Your Own Home

In response to the above mentioned consultation Healthwatch Northamptonshire submits the following response.

How understandable is the language used in the document?
Whilst the language used is relatively clear and understandable, there is a lot of information to digest and potentially, quite a number of questions and queries people may have. We feel it would be been appropriate and beneficial to have organized some locality based consultation sessions open to both current users and carers, as well as general members of the public.

Is there anything missing from the document
There is no reference to the Department of Health's Care Act Statutory Guidance document (updated 2016), which gives the basis on which local authorities can make decisions to make administration charges. Therefore, people are not aware that Section 8 - Care and Support, states the following:

8.60 Local authorities must not charge people for a financial assessment, a needs assessment or the preparation of a care and support plan.
8.61 It may be appropriate for local authorities to charge a flat fee for arranging care. This can help ensure people have clarity about the costs they will face if they ask the local authority to arrange their care. However, such flat rate costs must be set at a level where they do not exceed the costs the local authority actually incurs.

As a result, Healthwatch Northamptonshire would like to challenge the consultation process on two grounds:

a. Lack of accurate information prevents people from being able to make an informed decision.
b. Charging for assessments is not legal, as shown in the above extract from the Statutory Guidance document.

cont'd / …

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… / cont'd

Any other comments
In general, the vast majority of people have little knowledge or understanding of social care and how it works until there is a need. Often there is confusion after an initial post-hospital period of free reablement/enablement support, when people needing ongoing domicilary care support are advised social care support is needs assessed and means tested, so they will be required to partly or fully fund their support services.

Healthwatch Northamptonshire feels it is important, particularly if the decision is taken to introduce an administration fee for arranging care, for there to be clear information about accessing and paying for social care support, as well as the assessment and review processes, advocacy support and ensuring people are signposted to specialist agencies such as Northants Carers, Alzheimers Society, Age UK, etc.

Finally, we feel it is crucial to involve users, carers and others in the community in the planning and development of such information, and would welcome the opportunity of working with the County Council to promote the process and encourage involvement from the diverse communities across the county.

Yours sincerely,

William Pope
Chair
Chair Healthwatch Northamptonshire

Teresa Dobson
(Interim Chair from 1st April 2017)

Chief Executive's Office
St Mary's Hospital
77 London Road
KETTERING
NN15 7PW

Tel: 01536 452045
Web: www.nhft.nhs.uk

Ref: Scrutiny Panel on Adult Social Care Facilities (v0.3) 20181119
Date: 19 November 2018
Email: Chief.Executive@nhft.nhs.uk

Ms Tracy Tiff
Scrutiny Officer
Northampton Borough Council
Guildhall
St. Giles Square
NORTHAMPTON
NN1 1DE

Dear Tracy

Scrutiny Panel – Adult Social Care Facilities

Thank you for the opportunity to contribute to your review of adult social care facilities and the future plans for older people. I understand from Anna Earnshaw that she has already provided you with some information regarding how adult social care are working with Health partners in developing the Primary, community and social care workstream (PCS) within the STP in Northamptonshire. As a county-wide provider of community and mental health services locally we have considered the fourteen questions posed by the panel as part of this review and I have set out Northamptonshire Healthcare NHS Foundation Trust's (NHFT's) response in the paragraphs below.

1 **It is important to appreciate the totality of the need problem and its cost. How will this be apportioned between two Unitary Authorities?**
This is not applicable to NHFT.

2 **How will better working/partnership be fostered with NHS and outside providers, i.e., Charities and private sector care homes?**
We believe an integrated approach to health and social care is essential for older people, as they often have multi-faceted needs requiring joint support from social care, the NHS and other agencies. 'Personalised coordinated care' is both what people want and what evidence shows is effective.

Our work together on intermediate care through the Northamptonshire Health and Care Partnership (NHCP) is a good example of better working/partnership between adult social care, the NHS and the Voluntary, Community and Social Enterprise (VCSE) sector.

We have agreed a shared ambition to improve outcomes for people at times of crisis/escalation and to improve the management of our urgent care pathways. Building resilience to enable people to remain in their homes as long as possible will help us achieve our ambition. Social care and health providers are in the middle of implementing improvements to intermediate care services following collective agreement of the intermediate care business case by the NHCP Partnership Board.

Another example is the development of our Northamptonshire Winter Plan for 2017/2018 through multi-agency working. The core of the plan was increased provision of health and social care intermediate care – both 'home-based', and step down 'bed-based', packages. We saw a reduction in unplanned hospital admissions for those over 65 years of age and an improvement in our Delayed Transfer of Care (DToC) performance. Northamptonshire Adult Social Service , NHFT and partners have since built on this winter plan to identify further opportunities to improve shared care and support for people on discharge from acute hospital settings.

Teams from across social care and health care have come together to identify ways to improve discharge processes and the timely allocation of care packages. Solutions have been identified and implemented. Our integrated pathways are now delivering performance improvement, we have successfully reduced our DToC levels from 10% to 4% in the last twelve months, continued to support more people to be cared for at home when they have become unwell and reduced by one third the number of people who, when admitted to acute hospital, stay longer than three weeks.

We believe there is much more we could do to improve outcomes for our population, including:

- Delivery of health and social care in new innovative settings and approaches e.g. Community Asset Clinics
- Shared assessment tools e.g. Edmonton Frailty Scoring adopted by First For Wellbeing
- Strengthened planned and unplanned support for those living in residential and nursing care homes recognising that social isolation is a significant issue for many. We want everyone to have the opportunity to be an active member of their communities.
- Development of generic support worker roles able to work across health and social care boundaries both in communities and 24 hour care settings
- Social prescribing to improve local resilience and decrease demand for unplanned support
- Mental health support as an integral part of any place based provision
- Creating an agreed set of joint goals and expected outcomes, set through the Integrated Better Care Fund, will enable health, social care and voluntary sector partners to better plan and deploy collective resource.

Better working/partnerships between health and social care are, of course, not limited to physical healthcare services. Integrated approaches to mental health and adult social care are equally important. NHFT, as the county's provider of acute mental health services, experiences similar challenges in achieving safe and timely discharge of patients from acute mental health wards in Northampton and in Kettering. Like our acute physical healthcare provider counterparts, we need

integrated health and social care services to avoid unnecessary admissions and to facilitate discharge home following a spell on a psychiatric unit. In addition, we need close and effective working relationships with specialist social workers (Approved Mental Health Professionals or AMPHs) to enable us to assess people experiencing a crisis in a timely manner and to comply with the relevant legislation (e.g. the Mental Health Act). AMHP responses within 24 hours for assessment are currently challenged. 24 hours is a long time to be held in an assessment suite if you are in crisis waiting for people to decide what support you need.

Dementia and delirium are key factors that influence the time taken for recovery of older people when in hospital. We are working with acute physical healthcare partners to look at improved responses to people with dementia and or delirium. Improvements are likely to include exploring shared care wards with direct admissions to avoid patients having to navigate A&E and experiencing multiple in-hospital moves, which can increase confusion and heighten agitation. Solutions will require multi-agency approaches, bringing together acute clinicians with intermediate care professionals, mental health staff and the specialist adult social care dementia team.

For the future, we need to develop the brokerage capacity to support timely start of placements or packages of care.

We recognise the demand for, and capacity of, home-based domiciliary care continues to be a major pressure for Northamptonshire. Demand could be better managed though improved integrated health and care community working with earlier access to support in our local neighbourhoods. We believe this would reduce the intensive packages often needed after a prolonged hospital admission.

We are committed to working with adult social care and partners to coproduce a vision that breaks the cycle of just 'doing more of the same' year on year and makes better use of available community resources.

Within the NHCP Primary, Community, Social Care workstream (led by an NHFT Director) we are committed to delivering joined up services based around 'place'. We believe patient care should be as close to the patient's home as possible, whilst recognising the more specialist care becomes the further the distance will be from the patient's home. Building resilient communities is a primary goal and involves statutory and voluntary sector organisations working alongside the citizens themselves.

Whilst we believe, overall, there is 'good joint-working', we would like this county to have 'outstanding joint-working', as we believe this would make a significant difference to the health and well-being of the population.

3 How will funding be apportioned?

This is not applicable to NHFT.

4 How will you sort the Shaw PFI contract?

NHFT is supportive of the work NCC is currently undertaking to resolve the Shaw Healthcare contract position. Ensuring we make best use of our bed-based resources is very important to the entire health and care system.

5 How will Safeguarding principles be better applied?

We are committed to ensuring the whole system works together to safeguard our vulnerable adults and young people. Close integration between teams is essential. We are the health organisation representative in the Multi-Agency Safeguarding Hub (MASH). As our staff, and those of children's social care, are often the key presence in people's homes, we need to ensure we share information appropriately.

6 Please provide details of the relationship with private sector providers, i.e., care/nursing homes?

While we are not subject matter experts on how social care interacts with care homes, we appreciate it is really important to support care home providers, because they can be high users of A&E services.

The local health economy has invested in additional support to care and nursing homes to build confidence and skills. This has included formal and informal training along with access to remote specialist advice and support to avoid residents being unnecessarily conveyed to hospital in a crisis.

We provide both formal and informal training to private sector providers, such as care/nursing homes and care agencies. Informal training is typically on an ad-hoc basis through our day-to-day working relationships with care staff, for example, educating care staff about pressure area care and turning regimes, swallowing difficulties and dysphagia. We also provide formal training for all carers in areas such as insulin administration, catheter management training for carers of patients with complex needs, clinical observation skills training and Tissue Viability training programmes. We have developed and instigated Trauma Box training for care homes in the county to provide carers with skills and knowledge around managing low level skin trauma and we are in active discussions with NASS to provide a Clinical Observation Training package to its staff and have provided a range of clinical and non-clinical training to voluntary sector and private sector organisations.

Through our partnership with GPs in north Northants (3Sixty Care Partnership), we are testing a market leading telemedicine service provided by Airedale NHS Foundation Trust, called 'Immedicare'. This service provides care homes in the area with access to remote advice and support from clinicians at Airedale General Hospital via videophone/telephone 24/7. It enables 90% of residents to remain in the care home and reduces demand for GP and District Nurse interventions.

It is really important to ensure adult social care supports people in their place of residence for as long as it is safe and appropriate to do so.

7 Please provide details of opportunities to combine care and housing provision in innovative ways?

We have been part of a health and housing partnership with Kettering Borough Council and Kettering General Hospital through which we have delivered substantial reductions in DToC from mental and physical healthcare wards in our hospitals and have developed plans for future work together on prevention.

In our work on DToC, we have piloted a new approach where a housing options advisor from KBC became part of our ward teams, providing advice/support on systems and processes, making proactive intervention to resolve housing issues delaying a patient's discharge, and identifying broader improvement opportunities (such as changes to housing supply, establishing links with other agencies, etc.). Over a nine-month period, our work together released 638 mental health bed days we were able to use for other patients.

We have worked closely with NBC on the 'Hospital 2 Home' approach, which we estimate has seen a reduction in length of stay at Berrywood Hospital of 1-2 weeks on average for those patients with whom we have worked.

In Kettering, we are now expanding our work to develop solutions for people affected with hoarding disorder and those with more complex needs. We are also working together on solutions for the homeless and to meet our collective/several duties under the Homelessness Reduction Act.

We see the potential for broader links with planning authorities in designing healthy homes and neighbourhoods in conjunction with public health colleagues.

8 Do you think there are any specific groups that are not accessing Adult Social Care Facilities, please provide details

Whilst we do not have evidence of specific groups not accessing adult social care facilities, we are aware self-funders could be better supported through the assessment phase into selection/procurement of suitable support. Similarly, we are aware of the variation in supply across the patch, particularly when it comes to specialist facilities (e.g. those capable of caring for/nursing people with severe dementia, services for people with a learning disability, etc.) and domiciliary care (in the areas in which it is more expensive to live, or where someone needs multiple, double-up calls). Although some efforts have been made to address these inequities, we feel the system would benefit from further focussed work on these areas.

Overall, it is clearly really important we all support our vulnerable population, including those with a learning disability or mental illness.

9 In your opinion, how can better management support be applied for both social workers and carers?

The more effectively we integrate our approaches, the better we share information, the more connected a service the citizen will receive and the less we will duplicate.
It is clear to us joining up health and social care support for carers could be a good thing.

10 Please provide details of the statutory responsibilities in respect of the duty of care obligations and their financial consequences

This is not applicable to NHFT.

11 Are there any examples of new, innovative ways of working that we can learn from?

We are continually exploring new and innovative ways of working on our own and with our partners. Here are some of the examples we believe are most relevant to the review.

<u>Age Well Wellingborough</u>

Earlier this year, organisations came together in Wellingborough to develop an improved collective offer for over 65 year olds. The approach was built on the principle of taking interventions back to local communities. It involved professionals such as nutritionists, wellbeing workers, nurses and care managers attending local community asset clinics / lunch and event clubs.

Innovative approaches such as the 'Wellingborough 12 @ 12' conference call, were used to 'flag' the needs of up to 12 key people who need additional support and to agree how best to respond on basis of who has capacity and skills (not who has a contract).

All members of the team have honorary contracts and are co-located, enabling them to work effectively as a team using the same record – the SystmOne GP care plan.

<u>Integrated Contact Centre Vision</u>

For many residents of Northamptonshire, their needs do not rest solely within health or social care so ensuring key information is shared and care is co-ordinated across health, social care, private sector and the VCSE is paramount to maintaining their independence and quality of life. An integrated contact centre with a single entry point for all community health and social care needs would enable effective and efficient deployment of resources to meet residents' needs. We see an integrated contact centre being much more than a telephone call centre. We see it as central to the co-ordination of services our county's population need, offering multiple access methods, such as intelligent Instant Messaging and response, video calling, artificial intelligence chat-bots to help solve routine issues and interactive voice response. From multi-disciplinary needs assessment and planning, promoting and facilitating access to health and wellbeing improvement schemes, such as green gyms, to responding urgent care needs and preventing the need for a transfer to hospital, an integrated

health and care contact centre would facilitate the efficient use of resources across the system, provide an opportunity to share information across the system and provide a holistic response to an individual citizen or community's needs.

Technology and Wearables

We believe that there are significant opportunities to maximise current and future technology in order to enable citizens to live as healthy a life as possible, with an emphasis on maintaining independence in one's own home and providing clinical/social care as early as possible in the event of declining or deteriorating health. NHFT is actively exploring technology that could be deployed across health and social care within the county to support people to remain in their own homes, for example, the use of video 'consultation and conference' that enables people, those important in their lives, clinicians and social workers to jointly plan, review and agree care plans, linking citizens into on-line support groups to reduce social isolation, group or individual participation in health and wellbeing promotion activities, such as armchair exercise programmes.

Maximising the use of technology such as video consultation would transform the response time and engagement in supporting people at home, reducing lead-times in determining social care package configurations, improving the multi-disciplinary decision making in the care package process and enabling geographically disparate people to communicate in real-time in an accessible and engaging manner. Through the use of commonly held devices such as smartphones, tablets and laptops, citizens who are housebound or frail could be active leaders of their care planning, involving carers and family as they wish. The technology is readily accessible and is in line with the aspirations of the NHCP.

Efficient and effective deployment of health and social care resources can be supported through personal wearable devices that monitor health and wellbeing. We are trialling one such device – the HeartFelt monitor – that flags up any exacerbation in people with heart failure who cannot or will not engage with mainstream self-monitoring. We are considering the potential benefits of other devices including Dosette box sensors to identify if medication has been taken, falls sensors and wearable geo-location systems that alert a central point or nominated person if a person with dementia appears to have wandered off or is in need of help.

12 What models centred on the prevention agenda are being delivered? Are there plans to further expand this way of working?

Prevention is embedded in everything we do ranging from primary actions (e.g. immunisations), through secondary actions (e.g. chlamydia screening programmes) to tertiary prevention (e.g. our recovery college and work on intermediate care/rehabilitation). We believe our work on prevention could certainly be expanded, especially through greater integration with the local authority and VCSE.

We believe the most effective prevention services/preventive intervention are those delivered in an integrated way, in partnership across traditional service, organisational and sector boundaries.

13 **How is the wider place making system (planning, highways, public transport) being engaged to create communities of the future that ensure older people stay healthy for longer**
This is early days for the NHS, but something we are leading and are very committed to.

14 **Do you have any other information, concerns or suggestions you wish to raise in relation to adult social care facilities?**
We believe we need to use the opportunity of change in social care to integrate care between health and social care more effectively, we have a blank sheet of paper and with that comes a great opportunity to not replicate what has been done to date, but really consider how we could set new values and behaviours and work in new ways that would delivered joined up care.

I hope our response to the review is helpful. Please contact me if you have any queries.

Yours sincerely

Angela Hillery
Chief Executive
Northamptonshire Healthcare NHS Foundation Trust

c.c.
David Williams Director of Business Development NHFT
Anna Earnshaw, MD NASS

NORTHAMPTON BOROUGH COUNCIL

NORTHAMPTON BOROUGH COUNCIL

SCRUTINY PANEL 4 – ADULT SOCIAL CARE FACILITIES

6 DECEMBER 2018

BRIEFING NOTE: SITE VISITS

1 INTRODUCTION

1.1 At its inaugural scoping meeting, the Scrutiny Panel agreed that it would attend various site visits to inform its evidence base.

2 SITE VISITS

Discharge Team, Northampton General Hospital

2.1 On Tuesday, 30 October 2018, Councillor Zoe Smith (Chair), Councillor Sally Beardsworth (Deputy Chair), Councillors Janice Duffy and Arthur McCutcheon together with Tracy Tiff, Scrutiny Officer, met with the Lead Officers of the Discharge Team and the Health Assessment Team based at Northampton General Hospital (NGH).

2.2 Key information gathered from the site visit:

- A new discharge process was introduced on 29 October 2018 with the key aim of joined up working between both teams which will improve the patient experience, journey and patient flow. An Integrated Discharge Team (IDT) has been established comprising of staff from the health Discharge Team and Social Care. Social care workers together with staff from the Discharge team go out to work with the wards and meet with patients directly regarding their discharge. Whilst on the ward, The Integrated Discharge Team, which comprises, Ward staff, Therapies, Discharge, social and of course the patient, makes the decision as to the best discharge pathway for the patient. Previously, referrals for discharge planning were sent to the Single Point Access (SPA) Team who made the decision regarding the patient's discharge. This at times caused delays resulting in some discharges being deferred. In the longer term it is expected that the introduction of the Integrated Discharge Team will be of benefit to all. Newton was commissioned to undertake a case review.

The Newton Review provided valuable input into the introduction of the new discharge process. Newton also identified "*various delays and that patients stayed in hospital at NGH 128,000 days in one year more than was needed, the equivalent of 351 people spending an entire year in hospital at a cost of around £24.3 million".*

For the IDT to continue to work effectively further Social Workers are required to support every Ward, the ideal model of 1 Social Worker and 1 Discharge Coordinator on every Ward.

- There are Market Capacity constants in relation to services available for patients that require additional services and support upon discharge from acute services. The Discharge Team is an advocate in supporting a Trusted Assessor Discharge to Assess Model, as approved by NHS England, this is where patients are transferred to interim placements to continue further assessments in a non-acute environment. It is recognised that this would improve the patient's experience, patient flow and bed availability within the hospital as an acute hospital is not an appropriate setting for assessing patients once they are medically fit or optimised.

- Homelessness can be a problem for acute Hospitals it is recognised that that rough sleeping can sometimes be a lifestyle choice and in such instances individuals are discharged from hospital back to their desired destination. With the patients consent they are referred to support such as housing, money and advice etc. Some individuals need support regarding drug and alcohol abuse. Acute hospital beds is not the correct place for such support to be provided. Further interim facilities are also required to meet the needs of this cohort of patients, together with specialist support being available.

- Patients are assessed prior to discharge and if deemed appropriate a mental capacity assessment is complete to support the patients discharge. Patients are encouraged to make their own decisions regarding discharge.

- The Crisis Response Team works very well. Timed assessments are normally undertaken

within twenty four/48 hours; if further assessment is needed they are referred to Social Services. The Social Services assessment process must follow the Care Act; complex patients will take longer to assess, for example they may not have relatives, access to funds and mental capacity. In these specific situations, assessments may take considerably longer as an Independent Mental Capacity Advocate will have to be engaged before the patient can be assessed, if further interim placements were available in the Community these assessments could be conducted outside of the hospital.

- Patients over the age of 80 who spends 10 days in a hospital bed will lose 10% of muscle mass. This could be the difference between going home and going to a home. As of the 29th October 2018 there were 368 patients in Northampton General Hospital with a stay of over 7 days, 187 having been there for over 21days.

- NGH has an escalation process to support highly complex cases if required these are also escalated to the CCG and Social Services.

- Community Social Care Workers have to deal with high risk cases in the community, this has an added impact on patients waiting in hospital for a Community Social Worker. Community Social Care Workers caseloads are incredibly pressured with high volumes of community customers pending allocation.

- The CQC oversees the quality in care homes etc. Should there be safeguarding concerns such as financial, physical or emotional abuse they would be referred to the appropriate agency, Sometimes peoples' lives are chaotic and are not a safeguarding concern as to them it is "their norm."

- Avery Beds are provided by NGH, which is in close proximity to the hospital, this is a very expensive unit for the hospital to fund, these beds are used by the hospital to transfer patients while awaiting other services.

- Work with Social Services at Northamptonshire County Council is currently very good and joined up. There is a need for more joined up working with others such as Housing.

- The service and support provided by Northamptonshire Carers is excellent. An Officer from Northamptonshire Carers is based within the Discharge Team at NGH. Further resources in this area would be of great benefit to our patients in supporting discharges particularly for those that live alone,

St Andrews Hospital, Northampton

2.3 On Tuesday, 30 October 2018, Councillor Zoe Smith (Chair), Councillor Sally Beardsworth (Deputy Chair), Councillors Julie Davenport and Arthur McCutcheon together with Tracy Tiff, Scrutiny Officer, met with five Lead Social Workers and one trainee Social Worker based at St Andrews Hospital.

2.4 Key information gathered from the site visit:

- St Andrews is a charity organisation who treat patients from all over the UK. Patients are normally individuals that other providers have not been able to assist. Some patients have committed offences. There are around 600 patients on the Billing Road site and 800 across all sites. There is a very small percentage of private patients, the majority are funded by the NHS.

- Following the discharge route, patients may begin in a medium secure ward, then move to low secure before moving to locked and then discharge. Patients require support after leaving St Andrews until they move to their own home. Most are discharged from St Andrews into supported accommodation but there is often limited availability. A some patients may relapse due to the time it can take for appropriate accommodation and support to be found for them. Most patients discharged from SAH are not discharged to Northampton but will return to their home area.

- Any barriers in the discharge process are fed back via CPA reviews; an example of a barrier could be a patient does not need to remain in hospital but their care package is bespoke and expensive.

- It is aimed that patients return to the county that they came from but there are occasions where it is better for them to remain in Northampton. A referral meeting is held and a number of Agencies are involved. The laws in relation to ordinary resident status apply; an individual has to reside in a town for six months to be classed as an ordinary resident. Some

patients can't return to their home county due to issues such as exclusions, previous violence etc.

- There is a psychiatric intensive care unit at St Andrews. Patients come from all over the UK. It is usually a short term stay in the unit, 28-32 days. Once stabilised they move to a lower level unit within their own home town. There is a quick turnaround of patients in the unit. Most patients have one of the following:

  - Psychiatric breakdown
  - Drug induced psychosis
  - Bi polar

- Patients arrive by secure ambulance.

- A number of patients live with dementia. The patients are those who display challenging behaviour. They are funded by the CCG or by NHS England, depending on the level of security required.

- The young people's unit is for young people up to the age of 18. When the patient is 18 they move to adult services and less support is provided which can create problems.

- There are a number of private providers in Northampton which are mirrored in other areas. There is a need for a more joined up approach within care organisations in the community.

- There are lots of successes from the discharges from St Andrews, individuals leave feeling better about life.

- Patient from SAH would be extremely unlikely to move into local council accommodation

3 RECOMMENDATION

3.1 That the information provided informs the evidence base of this Review.