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