**NORTHAMPTON BOROUGH COUNCIL**

**Overview and Scrutiny**

**Report of Scrutiny Panel 4 – Adult Social Care Facilities**

**Draft Version 1**

## 1 Purposes

1.1 The purpose of the Scrutiny Panel was to investigate Adult Social Care Facilities in the area to identify future demand patterns, in order that any new Unitary Council is able to better plan for the needs of older people.

### Key Lines of Enquiry

- To gain an understanding of the demand patterns for Adult Social Care in the area that is proposed for the new Unitary Council
- To assess the extent of the need for Adult Social Care in the area and assess the initiatives currently in place to provide Adult Social Care
- To gain an understanding of the causes and barriers to receiving Adult Social Care
- To gain an understanding of the current facilities for Adult Social Care and whether there are any gaps of provision
- To gain an understanding of partnership working for Adult Social Care and how this can be improved
- To gain an understanding of the structure of the Adult Integrated Care Programme
- To gain an understanding of the Governance Arrangements for the Social Care Integrated Programme
- Identify any specific groups that are not accessing Adult Social Care Facilities
- To gain an understanding of care in the community and how it is assessed and monitored
- To gain an understanding of the extent of adult care responsibilities that will fall upon the proposed new Unitary Authority and the degree of necessary preparation.
- To gain an appreciation of the statutory responsibilities in respect of the duty of care obligations and their financial consequences.

1.2 A copy of the scope of the Review is attached at Appendix A.

## 2 Context and Background

2.1 Following a motion to full Council on 9 July 2018:

"*Whatever the boundaries of the new Unitary Councils, for Northamptonshire, those councils will take on responsibility for the care of older people in our community, from 2020.*

*A recent study estimated that 35% of inpatients in local hospitals were there simply waiting for suitable after care to be available (so called Bed Blocking).*

*This Council asks scrutiny, working with NCC scrutiny and partners, particularly health service partners, to carry out investigation into Adult Social Care facilities in the area to identify future demand patterns, in order that the new Unitary Council is able to better plan for the needs of older people in the future".*

Overview and Scrutiny included this Scrutiny Review onto its Work Programme for 2019/2020.

2.2 A Scrutiny Panel was established comprising Councillor Zoe Smith (Chair), Councillor Sally Beardsworth (Deputy Chair); Councillors Julie Davenport, Janice Duffy, Penny Flavell, Anamul Haque, Jamie Lane, Brian Oldham and Cathrine Russell.

2.3 This review links to the Council's corporate priorities, particularly corporate priority – Improving our governance.

2.4 The Scrutiny Panel established that the following needed to be investigated and linked to the realisation of the Council's corporate priorities:

Background data, including:

Presentation to set the scene: Current Adult Social Care Facilities
Relevant national and local background research papers
Definitions in respect of Adult Social Care
Relevant Council Policies, Project Plans, Business Plans and Strategies:
Relevant Statistics

Relevant Legislation and Guidance, including:

ADASS Guidance 2009
The Health and Social Care Act 2012
CARE Act 2014
Human Rights Act 1998
Mental Health Act 1983

Relevant published papers on Adult Social Care

- Best practice external to Northampton
- Report back from the Centre for Public Scrutiny Conference – Health and Social Care

Internal expert advisors:

Cabinet Member for Housing, NBC
Head of Housing and Wellbeing, NBC

External expert advisors:

Head of Protecting Vulnerable Persons, Northamptonshire Police
Director of Public Health, Northamptonshire County Council
Director, Healthwatch Northamptonshire
Director, Northampton Health Trust
Ward Managers, Northampton General Hospital
Other various representatives of Northants Health including GPs
Chief Executive, Northants - Age UK
Chief Executive, Northants Carers' Associations
Manager, Independent Living organisation, Northampton
Cabinet Member for Adult Social Care, Northamptonshire County Council
Director for Adult Social Care, Northamptonshire County Council

- Case Studies from Ward Councillors
- Site visits, as applicable

## 3 Evidence Collection

3.1 Evidence was gathered from a variety of sources:

### 3.2 Background reports and information

### 3.3 Core Questions

3.3.1 The Scrutiny Panel devised a series of core questions that it put to its key witnesses over a cycle of meetings (Copy at Appendix B).

3.3.2 Key witnesses provided a response to these core questions at the meetings of the Scrutiny Panel held on 6 November 2018, 6 December, 17 January and 11 February 2019.

3.3.3 **Executive Director Adults, Communities & Wellbeing, Northamptonshire County Council (NCC)**

Presentation to set the scene

Understanding the Need for Specialist Housing in Northamptonshire

- The budget for adult social care is £245.875 million per year, of which around £190 million is directly spent on care.
- Joint delivery is key.
- The Voluntary Sector is involved through various groups such as the Health Forum.
- Adult Social Care meets 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. 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
- 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.
- 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 done regarding supportive living. There is around 30% turnover of staff.
- 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.
- Monitoring meetings and risk assessments take place. The profession is regulated by the CQC. Monitoring meetings are held regularly.
- Regarding safeguarding referrals, around 6,000 are received annually. 91% are concluded as "no further action." All referrals are screened then rated in terms of need.
- Best Interest Assessors undertake a review regarding deprivation of liberty.
- There is a high level of demand for care in the home and also a demand for dementia care.

**Cabinet Member for Housing and Wellbeing, and Head of Housing and Wellbeing, Northampton Borough Council**

Key points:

- The current Director of Adult Social Care, NCC, is working with the boroughs and districts.
- 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 need for more social housing, especially for older people, was highlighted.
- The need for more Extra Care facilities was emphasised.
- Parsons Mead is a flagship complex and "ticks all the boxes", being close to required amenities for older people.
- The Hospital Discharge Scheme has helped 350 people since 2015. Housing and Wellbeing have excellent engagement with Health Services.

**Detective Chief Inspector, within Public Protection, Northants Police**

Key points:

- Rough sleepers with suspected mental health problems are not always accessing the required services
- Prevention is key. The Police often come across individuals when they are at crisis point and they may then present differently to professionals when they are free from the effects of drugs or alcohol.
- Around half the calls Northants Police respond to do not involve a crime but are concerns for public welfare and safety. There are around 120 documented calls a week regarding mental health issues, although the impact of mental health is suspected to be far higher than this. It is not unusual for calls to be received from individuals in crisis themselves, carers or organisations such as the Samaritans. The Local Authority provides an approved Mental Health practitioner (AHMP) Worker, 24/7. However this individual has other responsibilities and out of hours calls can take several hours before being responded to. It is common for Police to stay and monitor persons they detain under the mental health act for many hours where there is no Social Worker or nurse to take ownership for the case. This has been recognised in a new national HMICFRS report on the impact of Police responding to Mental Health There are a number of effective multi-agency groups coordinating mental health and suicide Prevention – the latter being a new county wide group that is viewed as positive
- Early intervention at all levels prevents crisis – and is seen as positive by Police. It can negate persons becoming criminalised and reduces the harm (physical and emotional) associated with crisis intervention
- Partnership working is generally strong in the county. Northants Police have appointed a Superintendent to lead on work associated with the future provision of services and the proposed 2 new local authorities model, replacing the current district and borough approach.
- MARAC provides effective support for Domestic abuse victims, and has around 1,200 cases a year. Adult Social Services joined MARAC around 12 months ago which was welcome.
- The pressures that Adult Social Services are under are acknowledged by the Police.
- Police budgets have faced considerable pressure over the last 8 years. Nationally there are 20,000 less officers now than in 2010. Recorded violent crime is increasing for the first time in 10 years; Northants Police budgets and staffing reflect the national picture.
- Concerns remain over the future provision of funding to support services. An example is the Sunflower Centre (who support High risk victims of domestic abuse) who work closely with the Police. A third of their budget emanates from the County council. When NCC didn't pay the contribution for 2018/19 they lost 3 highly trained staff. Funding has been restored by Northamptonshire County Council (NCC) but uncertainty remains and the

service provided by the sunflower has had to reduce over the last 6 months – this negatively impacts on vulnerable, high risk victims and provides a further challenge for the Police.

**Director of Public Health, Northamptonshire County Council (NCC)**

Key points:

- 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 it currently delivers
- As NHCP stakeholders, public health are working with its provider organisation partners to support an integrated approach to health and social care. The Director of Public Health knows 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. Funding needs to be apportioned according to need.
- Through Public Health's partnership with NHCP organisations, public health is 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 its role as commissioners, public health includes the requirement that safeguarding referral and staff to be appropriately trained are standard in contracts and monitoring arrangements.
- 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.
- 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.
- 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.

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

- Public Health's 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 life course. 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.
- Positive actions are currently be taken in respect of the opportunities that the proposed Unitary Councils will provide.
- Capacity and resilience is increasing.
- During the 12 week period, an Advisor will look for signs of social isolation; not everyone wants to integrate back or have their own "social hub." Funding of £3.5 million from the Social Impact Fund will help to develop the additional workforce required.
- Partnership working is increasing; everyone is committed to taking on shared responsibility. Services will be aligned to make best use of expertise.

**Chair and Deputy Chair, HealthWatch Northamptonshire**

Key points:

- 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.

- 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. Health Watch supports 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.
- Health Watch (HWN) is aware that NCC have been working to make best use of the beds provided as part of the Shaw contract.

- All HWN staff and volunteers receive safeguarding training so Public He can refer issues to the council's safeguarding team as issues arise.
- Health Watch carries out Enter and View visits to care/nursing homes as part of its 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. It shares its findings with the care homes, commissioners and CQC and publishes its reports at: http://www.healthwatchnorthamptonshire.co.uk/enter-and-view
- Health Watch attends care home information sharing meetings with NCC, CCG and CQC quality monitors and inspectors to ensure information is shared and that it is aware of the monitoring of care/nursing homes taking place.
- Health Watch is 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.
- Whilst Health Watch does 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. It does 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). NCC confirmed that system work was in place to improve this.

- Health Watch is 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.
- Integrated working, particularly between social services, health, GP practices and Police/Fire and Rescue, and co-ordinated, person-centred care is needed. 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.
- 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.
- 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 65’s 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.
- All the examples highlighted above are focussed on prevention, particularly preventing hospital admissions and re-admissions. Health Watch feels it is important that such cross-county collaborations continue.
- This is not applicable to HWN but we support the integrated working this will involve.
- The following HWN reports and responses to NCC consultations may be of interest to you:
- 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). Health Watch heard directly from patients about their experiences and views of the discharge process.

- Over a three week period in November/December 2016 Health Watch 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. HWN was able to speak to nine of these patients again to find out more about their post-hospital experiences. All the people who talked to HWN 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 Health Watch 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.
- 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.
- 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.
- Data published by the CQC states that Norhamptonshire County Council (NCC) is close to national and regional figures regarding adult social care. The main outlier is delayed transfers of care (DToC) but the most recent data provided orally to HWN suggests that there has been a very significant

improvement in DToC. There are some challenges too such as high spend per capita on children's services.

- Dementia is a key issue for health services and social care.
- Healthwatch is consulted by NCC when it undertakes consultations. Healthwatch has a good relationship with Public Health and health service partners. Healthwatch is a statutory member of the Health and Wellbeing Board in each area.
- A joint appointment of a Housing Officer to improve awareness of health and wellbeing within housing services has been created by Kettering Borough Council, Northants Healthcare Foundation Trust and Kettering General Hospital which is a good, creative initiative.
- There is a need for trust to be built amongst all the partners and for there to be an honest understanding of the situations.
- The public needs to have a more informed understanding of the real costs of health and social care and why it is necessary to see an increase in taxation to pay for these services in order to sustain the current level of service let alone to improve the quality.

**Director, Northampton Health Trust**

Key points:

- Northampton Health Trust (NHT) believes 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.
- A shared ambition has been agreed to improve outcomes for people at times of crisis/escalation and to improve the management of its urgent care pathways. Building resilience to enable people to remain in their homes as long as possible will help NHT achieve its 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 NHT's 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.

- NHT's integrated pathways are now delivering performance improvement, it has successfully reduced its 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.
- NHT believes there is much more it could do to improve outcomes for its 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. NHT 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 NHT's acute physical healthcare provider counterparts, NHT needs 20 integrated health and social care services to avoid unnecessary admissions and to facilitate discharge home following a spell on a psychiatric unit.
- In addition, NHT needs 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. NHT 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. NHT believes this would reduce the intensive packages often needed after a prolonged hospital admission. NHT is 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 work stream (led by an NHFT Director) NHT 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 NHT believes, overall, there is 'good joint-working', NHT would like this county to have 'outstanding joint-working', as it believes this would make a significant difference to the health and well-being of the population.
- NHFT is supportive of the work NCC is currently undertaking to resolve the Shaw Healthcare contract position.
- NHT is committed to ensuring the whole system works together to safeguard our vulnerable adults and young people. Close integration between teams is essential. NHT is 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.

- NHT appreciates 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.
- NHT provides 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. NHT also provides 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.
- NHT has 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 its partnership with GPs in north Northants (3Sixty Care Partnership), NHT is 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.
- NHT has 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 its work on DToC, NHT has piloted a new approach where a housing options advisor from KBC became part of NHT's 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 NHT was able to use for other patients.
- NHT has 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 NHT has worked. In Kettering, NHT is now expanding its work to develop

solutions for people affected with hoarding disorder and those with more complex needs. NHT is also working together on solutions for the homeless and to meet our collective/several duties under the Homelessness Reduction Act. NHT sees the potential for broader links with planning authorities in designing healthy homes and neighbourhoods in conjunction with public health colleagues.

- NHT does 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, NHT is 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, NHT feels the system would benefit from further focussed work on these areas. Overall, it is clearly really important everyone supports the vulnerable population, including those with a learning disability or mental illness.
- 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.
- NHT's 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. Age Well Wellingborough 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. Integrated Contact Centre Vision 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. NHT sees it as central to the coordination 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 24 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.

- NHT believes 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 online 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.

- 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. NHT's recovery college and work on intermediate care/rehabilitation). NHT

believes it work on prevention could certainly be expanded, especially through greater integration with the local authority and VCSE.

- NHT believes the most effective prevention services/preventive intervention are those delivered in an integrated way, in partnership across traditional service, organisational and sector boundaries.
- NHT believes it needs to use the opportunity of change in social care to integrate care between health and social care more effectively, NHT has 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 NHT could set new values and behaviours and work in new ways that would delivered joined up care.
- The Trust has been rated outstanding by the CQC. It has also won Trust of the year which is an NHS award. It is all about staff and culture and partnership working.
- Lots of steps are being taken to improve crisis services.
- Crisis cafes are a great example of partnership working to support people.
- A lot has been achieved through partnership working in recent times.
- £1.8 million of support has been achieved through partnership working
- Hard work is underway collectively to ensure capacity is directed to the right places
- Primary and social care workstreams are very important and need to work together
- The pilot being run in Kettering whereby a Housing Officer is dedicated resource to Kettering General Hospital is working very well
- It is important that there is a holistic approach regarding integration and integrated services; integrated care is vital. It is important that there is one service working together to deliver the same outcomes
- Discharge from hospital has to be safe; support at home is a social care responsibility. Previously, teams have worked separately.
- Ways to increase community support are being investigated
- Future options need to include: preventative initiatives, community response, support at home, including appointments etc. A whole range of ideas will be explored
- Valuing and retaining the workforce is vital. CQC acknowledged that staff are valued and recognised for what they are doing

**Chief Executive, Northants Age Concern**

Key points:

- The need reflects the numbers of older people, their age and how they are concentrated, in particular, the levels of ill health, such as long term conditions, the levels of loneliness and mental health issues and the levels of deprivation and poverty (income and wealth). All older people need advice and support so a 'per head allocation' needs to be the basis of any budgeting system. This could be weighted to those who are over 85 years of age. Additional monies could be allocated in relation to addressing mental health, poverty and ill health (LT conditions). It is recommended that there is a representative sample survey of existing clients to ascertain the location and confirm the depth of these issues across the County.

- A key requirement for any charity is to be able to plan its services over the medium to longer term. An essential requirement for any intervention to be successful is that it is well co-ordinated with other interventions and support. Consultation, structured and over a period of time, with the charitable or voluntary sector is, therefore, essential. Once decided, then interventions need to be jointly planned and jointly implemented with robust systems for review, reflection and revision. Trialling is essential for success. This needs to be coupled with certainty of potential funding over the longer term and early decision making on change or continuation.

- Frontline staff need to be encouraged to build a relationship over the longer term to establish consistency of practise and improve decision making and information provision.

- Clarity of role for each of the key providers in the system needs to be established. Older people do not want to be passed from one organisation to another to find the answer to their query. It is, therefore, essential that their questions are answered first time and that any specific interventions are met as the first and immediate follow up to that first enquiry. This will require a capable and sophisticated system for 'navigating' the system; a 'one stop' approach is recommended which all partners, statutory and non- statutory will support.

- Specifically in relation to private sector care homes there is a need for statutory and voluntary bodies to 'join up' their offer and to reduce any perceived overlap otherwise their residents will be disadvantaged from accessing the support services available.

- Funding needs to provide for the strategic co-ordination of key partners, including consultation, commissioning and testing/trialling. Funding needs to provide for a capable 'navigation' service. Older people need to have access to expert support that will take ownership of their 'problem' and support them to a satisfactory conclusion. This could be provided by the voluntary sector (See the London Borough of Islington). Funding also needs to provide for specific and expert interventions by a range of partners, including the voluntary sector, in order to address specific local needs.

- It will be important that the capacity of the existing centres is maximised and that there is a flexible but reasonable proportion of places to be able to respond to the growing needs of, for example, dementia sufferers and those needing rehabilitation.

- The current system does not have sufficient capacity to handle the existing level of safeguarding issues highlighted through the electronic safeguarding form. Therefore, as time goes on, many cases will be unreported. It would also be difficult to prioritise the more acute cases in the current system, especially because there is only very limited dialogue with an advisor or consultant. A well-functioning safeguarding system would be able to respond to the acute or urgent cases and to broker or signpost support to the non-acute cases. This would also directly support the prevention agenda. Other partner resources, in particular from the voluntary sector, could be harnessed proactively to support all cases, especially those that are non-acute.

- There is the potential to be more proactive in terms of training and worker responsibility and understanding of safeguarding issues. Knowledge is broad but not deep. All workers involved (across partners) could be more involved in the follow up to issues (rather than simply the raising of the issue) so that learning and skills could be improved.

- There is substantial dialogue with private providers in relation to each Age UK Northamptonshire client's needs and we would underline the point about the need to make each intervention person centred rather than service centred.

- Age UK Northamptonshire have a range of support activities in relation to the prevention agenda. We provide a very wide range of activities that are focused on preventing people from becoming isolated and vulnerable. A range of classes include Keep Fit, chair based exercise and Aquafit, Nordic Walking, Tai Chi, Get Set Go, Art, Photography, Bridge and Whist, and Family History at various levels. Of particular note is the success of the exercise classes set up in rural areas where isolation can be a problem. Examples of current popular activities are Boccia & Kurling, Curry & Kurling,

OTAGO, falls prevention classes and Short Mat Bowls. Over the previous financial year, a total of just over 900 people regularly attended these activities.

- The team also work with Care Homes taking Boccia, Kurling, Bowls and OTAGO to residents who are unable to leave the residence. There is much more that could be done to utilise the facilities of residential homes and nursing homes most of which are underused currently.

- Age UK Northamptonshire would like to encourage more 'pop up' day centres within the communal areas of extra care, care homes and retirement properties. This encourages residents to interact but can also be extended to bring other people who live locally.

- Older people are reluctant to ask for help: because they don't think there is any help or they don't know who to ask or where to get the information. They lack confidence and they are nervous about starting down a 'slippery slope' into the care setting. Age UK Northamptonshire provides a very well used information and advice service. We are seeing more and more clients that are confused by the advice they have been received from other sources, in particular, in relation to financial benefits.

- Other groups in particular that are often overlooked in relation to financial support or for health and social care are:

    - Tenants in sheltered accommodation
    - Tenants in private rented accommodation
    - Carers who are just about managing
    - Anyone unable to use online resources or not physically able to get to a Library / One Stop Shop
    - Ethic groups, for example, the Chinese community are very private and isolated.

- Those with sensory impairments have very little dedicated support, for example, formats of letters not legible for those with a Visual Impairment, contact/referral routes lacking specialist support for those who use BSL/Deafblind or English without speech.

- It is important to maintain a good understanding of other services that social workers can refer to or that can be integrated into a care plan will ensure the package of care is more holistic and varied. A high turnover of staff or a high usage of Agency staff does not help build expertise and capability.

- There is a general lack of understanding of essential qualifying criteria for various benefits that older people can claim, both means and non-means tested. We know this from the information provided on referrals we receive.

- There is a growing older population which places a disproportionate pressure on health and social care services more generally. The population of those in the County of Northamptonshire over the age of 65 was 117,400 in 2014, 16.6% of a total estimated population of 706,600. Northamptonshire has the fastest growing population of over 65 year olds of any County area in the country rising 12.5% between 2013 and 2016 and many times higher than the overall growth in the population of the county of Northamptonshire (3.2%). The proportion of 65 year olds is projected to increase in the next 10 to 20 years driven by the post war spike increase in birth rates. The numbers of over 65 year olds are expected to grow to 155,800 by 2024 or 28.2% higher than in 2014.

- Life expectancy is also growing well and in the county in 2015 was 83.1 years for females and 79.4 years for males. This increase in life expectancy increases the need amongst an older population who will be becoming more frail, susceptible to diseases and incapacity. There are Increasing numbers of older people will need help in relation to frailty, poverty and loneliness

- The Care Act 2014 sets out a Duty to assess all clients and to support them with decision making (including self-funders around care in the home/nursing home placement). This is not something currently, or historically, that has been fully implemented. It is felt that there has been a very strong focus on financial eligibility for care to the detriment of the duty to provide an assessment to each client and their carer. Being able to access the correct information from the start could prevent many cases from getting into greater difficulties at a later stage.

- A key challenge is to build a system of prevention, support and response that is person centred rather than service centred. To do this effectively will require a proactive 'navigation' system. This needs to be based on a face to face conversation, often in the person's own home.

- There are a number of examples of good practice that should be highlighted, in particular, in relation to non-clinical support for clients. The Age UK Northamptonshire in house teams of: Personalised Integrated Care (Northampton): Collaborative Care team (Kettering, Wellingborough, East Northants) and Later Life (throughout the County) all provide examples of

good practice in relation to ‘hands on’ one to one client support, often seeing clients in their own homes. They illustrate the effectiveness of a model that supports excellent navigation, and substantially more effective than taking phone calls and signposting.

- Externally, the London Borough of Islington is an excellent model of good practice in relation to proactive navigation and support, including social proscribing. They support clients over 16 needing some support with a health or wellbeing challenge, including clients over the long term, with a person centred prevention service.

- Age UK Northamptonshire is working alongside Kettering General Hospital on the active support of patients to prevent unnecessary admission to Hospital and to facilitate early discharge. We would also highlight the Home from Hospital Service run by Age UK Milton Keynes.

- Locally, we are working with both Northampton Borough Council and Kettering Borough Council on their housing support options and would highlight the Kettering Housing Options pilot as a project outside the Borough but close at hand.

- Age UK Northamptonshire have a range of support activities to support the prevention agenda. We provide a very wide range of activities that are focused on preventing people from becoming isolated and vulnerable. A range of classes include Keep Fit, chair based exercise and Aquafit, Nordic Walking, Tai Chi, Get Set Go, Art, Photography, Bridge and Whist, Picturedrome Tea Dance and Family History at various levels.

- There is also befriending type support to encourage participation for those that need longer to build confidence. There is a real need for more of this support. This requires funding to ensure effective co-ordination and quality control.
- Maintaining the independence of older people will keep them healthier for longer. A key aspect for older people is accessing services and a main determinant of that is access to transport. We are working with other transport providers to help improved access to our own Day Care provision. Supporting more transport provision, especially volunteer will help ensure that access to services is achievable and not cost prohibitive.

- There is a need to encourage strongly GPs and their practice managers to think outside the normal preoccupations and to take forward actively social prescribing and other onward referrals.

- Social prescribing can have a very positive impact on local community groups and provide essential 'demand' in order to keep them going and viable. If all partners, including GPs were active in social prescribing then the network of provision would increase and improve.

- There is often a feeling that people who contact existing social services provision do not get the right support, support that will prevent them from deterioration so needing greater support later on. We feel that addressing difficulties earlier – such as investment in prevention and proactive social proscribing would be a more cost effective way of supporting those in need, especially when working for the longer term needs of the older people in Northampton and Northamptonshire.

**Deputy Chief Executive Northants Carers**

Key points:

- It would seem sensible at least in transitional periods to look at some joint commissioning functions between the two unitary councils and possibly to include NHS commissioning in this to maximise resources and promote integration. This would also risk manage in terms of ensuring statutory duties and responsibilities were met and ensure there is proper consideration given to services that may need to be Countywide albeit with a local focus.
- It would be sensible to build on partnerships that are already there such as the Health Care partnership or liaison. with any thematic partnerships such as Carers Partnership or Mental Health collaborative and to also utilise voluntary sector infrastructure work by Voluntary Impact Northampton

- There would be much better provision if these contracts could be changed especially if more resource could be directed at community based services or supporting people in their own homes

- It would seem sensible whilst having overarching systems to have some locality focus in any new models

- Although this does not directly affect us, anecdotally they are struggling with funding no meeting costs of service delivery.

- Northants Carers currently working with GPs, housing, social care and voluntary sector as part of the 'Aging Well' locality project in Wellingborough. Please see attached summary.

- Due to demand and capacity issues within social care, it could be argued that it has been difficult to proactively approach hidden or hard to reach groups such as those with dementia from BAME backgrounds

- Utilising what the Voluntary sector can offer and looking at partnership place based approaches such as aforementioned Aging Well project in Wellingborough or our award-winning Breathing Space COPD project which brings together medical professionals in a voluntary sector group setting.

- Northants Carers delivers NCC's Carers statutory duty (including carers assessments) under the 2014 Care Act. NCC oversight for the better care fund matrix and responsibilities around Carers

- Northants Carers aforementioned Aging Well and Breathing Space projects. Northants Carers also has very popular Carer Gym Memberships and Sitting Service. These could be rolled out into other areas as part of the social prescribing model.

- The vast majority of Northants Carers' services, including those within CCG & NCC Carers and Young Carers contracts all have preventative approaches. Please see the attached Twenty-Twenty overview of our wide range of services.

- Investment in Carers services is at a good level but there is significant demand pressures that will get worse. Carers strategy and implementation plan and partnership and set of services delivered against it are a strong model that shows how resources across health, social care and the voluntary sector can be best applied. Please see our attached Carers Support Model document.

**Case Studies – Ward Councillors**

Case studies to inform the Review were submitted by Ward Councillors:

**Individual A**

Miss A was a hoarder and had no downstairs cloakroom. She had been advised the only option was a commode. This was not suitable for her needs and Miss A was not coping well with the situation. The Ward Councillor obtained the trust of Miss A and helped to clear and tidy her house; she also made contact with the relevant Officers and a downstairs toilet was put in for Miss A.

**Individual B**

Miss B was a vulnerable adult that also had housing issues. There was no liaison between Adult Social Care and Housing Services. The ward Councillor made contact between the two Agencies and felt there is a need for more joined up thinking.

**Individual C**

Miss C was also a vulnerable adult that had mental health needs. The ward Councillor had contact details from a clearing company that she had used for Miss A and made contact. The ward Councillor gained the trust of Miss C. When she had first visited Miss C, her front door had been open. Miss C would buy a book every afternoon, read two chapters and then buy another book the next day. The ward Councillor suggested that the books were donated to Northants Age UK and Miss C agreed. Miss C had not been sleeping on a proper bed and a suitable bed was organised by the ward Councillor. A Sex Worker had been using Miss C's property; the ward Councillor arranged for an intercom system to be installed on the property to prevent this continuing.

**Centre for Public Scrutiny Conference – National Health Scrutiny and Assurance Conference**

A member of the Scrutiny Panel attended the Centre for Public Scrutiny Conference – National Health Scrutiny and Assurance Conference on 18 September 2018.

Key points from the Conference:

The programme of conference was wide ranging and a number of high profile speakers addressed the floor.
The programme included:

- Accountability for health and care
- Successful Strategies for health and care accountability
- Quality in health and care
- There were a number of workshops that delegates took part in:

    - STPs and ICSs - approaches to joint health scrutiny
    - Why NICE guidance matters
    - Hot topics in health and social care
    - A participatory workshop focusing on transforming relationships with communities

Key information 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

### 3.4 Site Visits

**Discharge Team, Northampton General Hospital**

3.4.1 On Tuesday, 30 October 2018, representatives of the Scrutiny Panel together with the Scrutiny officer met with the Lead Officers of the Discharge Team and the Health Assessment Team based at Northampton General Hospital (NGH).

3.4.2 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**

3.4.3 On Tuesday, 30 October 2018, representatives of the Scrutiny Panel together with the Scrutiny Officer, met with five Lead Social Workers and one trainee Social Worker based at St Andrews Hospital.

3.4.4 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. 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

**London Borough of Islington**

3.4.5 Representatives of the Scrutiny Panel together with the Scrutiny Officer, visited the London Borough of Islington on 17 April 2019. The site visit met with key Officers – Deputy Head of Provider Services, Head of Re-enablement Team, Head of Service (Community Services) and the Associate Director (Community Mental Health).

3.4.6 Key findings from the Site Visit:

- Adult Social Care at the London Borough of Islington has an excellent level of integration; with a close relationship with the CCG and health colleagues at both operational and commissioning level.

- Each social work team has a Senior Social Worker.
- In the Integrated Learning Disability Partnership all Officers are in the same building and comprise:

    - Social workers
    - Speech
    - Physio
    - Transition Team

- Learning Disability is an integrated partnership and also has a pooled budget for placements 87.3%/12.7% split with the CCG.

- There are lots people with dual diagnosis with cross-cutting issues.

- There is a total annual budget of £30 million.

- There is a dynamic purchasing system.

- Managing expectations is currently being investigated regarding the Transition Pathway.

- There is a high proportion of supporting living accommodation in the borough with a number of new builds planned.

- Shared experience and knowledge is key to the success of the integrated partnership. There is also very strong links with community colleagues in the community with very robust transforming care. There are 4 – 5 officers in the Assessment Unit.

- The Adults Safeguarding Board and the London Hub covers the whole of London.

**Community Locality Social Work teams (adults with physical disabilities or older people)**

- The Community Team has responsibility for individuals over the age of 18, the team focusses on individual's strengths, for example: Mr X can do this and is able to do that. Various assurance mechanisms have been set up. This approached has saved money and is more efficient.
- The Community offer capitalises on the voluntary and community offer - there is a real need to work with this Sector. For example, looking at issues such as fear of crime etc.
- There is an in-house Benefits Maximisation Team.
- A Rising Risk Panel has complicated cases referred to it. The Panel comprises representatives from Adult Social Care, Community Health, GPs, Housing Services and Mental Health. The Panel looks how it can resolve the issue together. The Panel does not leave the room until it has produced action plans for the case. Each case is personalised.
- Universal Credit has had an impact on the service users as a consequence there are a number of Food Banks in the borough.

- Nine Integrated care meetings take place each week at GP surgeries – these are multi-displinary team meetings, where difficult cases can be discussed to enable resolution.
- The London Borough of Islington is the largest social landlord in the country. Its population is around 250,000.
- Strong co-production and a strength based Policy is key to success.
- Some provision is provided in-house:

    - 5 day services
    - Specialist service for autism
    - Specialist service for older people and disabled individuals
    - Employment for people with disabilities

- Re-enablement is also an in-house service. It is mainly funded by the CCG but it is a Council run service. There is a joined up approach between Health and Social Care. Within the Service is a specialist Re-enablement Team. The Case Management Team undertakes reviews, and these are attended by a number of partners. Individuals are assessed at home as people can be assessed more accurately at home. A Medication Policy has recently been implemented that has been very successful and reduced the work of the District Nurses.

**Joint Commissioning**

- A quarterly meeting takes place – to oversee Joint Commissioning is chaired by directors of commissioning for Health and Social Care.
- The Governance arrangement also includes a Health and Wellbeing Board.
- The relevant Cabinet Member at the London Borough of Islington has a clear understanding of the roles, structures and systems and the importance of the relationship with the CCG.
- Regular meetings are held between Adult Social Care and the CCG regarding the strategic relationship and how this is delivered, there are S75 agreements and BCF in place where pooling of budgets and joint commissioning takes place.
- By integrating health and social care, people are discharged from hospital quicker.
- The integrated system was developed around 20 years ago; budgets are pooled and jointly managed. Learning disability has the biggest pooled budget.
- There is a need to work together with a joined up approach between Adults' and Children's Services and the Council has just established a People's Department to facilitate this. For transitional services, for example, 13-14 year olds to adulthood there is a need to plan in advance. There is a Preparation for Adulthood Board that looks at 16-25 year olds and its remit is looking at how they can be supported.
- Strong engagement with residents is important, to find out what they want; this helps to develop services' outcomes. Residents also then understand

funding restrictions and priorities. It is important that different types of media are used and Focus Groups and Target Groups held.

## 3.5 Key Legislation

### ADASS Guidance 2009

3.5.1 ADASS reports that the national framework comprises 11 sets of good practice standards and it believes that the implementation of each standard will lead to the development of high quality adult protection work across the country that is consistent.

3.5.2 The Guidance gives further details on each of the 11 standards and highlights that it puts together both best practice and aspirations to form the 11 good practice standards. The intended purpose of the Guidance is for it to be used as an audit tool and guide by all those whose role is to implement adult protection work.

3.5.3 The 11 Standards:

| | HEADLINE STANDARD |
|---|---|
| Standard 1 | Each local authority has established a multi-agency partnership to lead 'Safeguarding Adults' work. |
| Standard 2 | Accountability for and ownership of 'Safeguarding Adults' work is recognised by each partner organisation's executive body. |
| Standard 3 | The 'Safeguarding Adults' policy includes a clear statement of every person's right to live a life free from abuse and neglect, and this message is actively promoted to the public by the Local Strategic Partnership, the 'Safeguarding Adults' partnership, and its member organisations. |
| Standard 4 | Each partner agency has a clear, well-publicised policy of Zero-Tolerance of abuse within the organisation. |
| Standard 5 | The 'Safeguarding Adults' partnership oversees a multi-agency workforce development/training sub-group. The partnership has a workforce development/training strategy and ensures that it is appropriately resourced. |
| Standard 6 | All citizens can access information about how to gain safety from abuse and violence, including information about the local 'Safeguarding Adults' procedures. |
| Standard 7 | There is a local multi-agency 'Safeguarding Adults' policy and procedure describing the framework for responding to all adults "who is or may be eligible for community care services" **and** who may be at risk of abuse or neglect. |
| Standard 8 | Each partner agency has a set of internal guidelines, consistent with the local multi-agency 'Safeguarding Adults' policy and procedures, which set out the responsibilities of all workers to operate within it. |
| Standard 9 | The multi-agency 'Safeguarding Adults' procedures detail the following stages: Alert, Referral, Decision, Safeguarding assessment strategy, Safeguarding assessment, Safeguarding plan, Review, Recording and Monitoring. |
| Standard 10 | The safeguarding procedures are accessible to all adults covered by the policy. |
| Standard 11 | The partnership explicitly includes service users as key partners in all aspects of the work. This includes building service-user participation into its: membership; monitoring, development and implementation of its work; training strategy; and planning and implementation of their individual safeguarding assessment and plans. |

3.5.4 The Guide gives examples of good practice around the country, detailed below are examples of those provided:

## Example 1:

**GOOD PRACTICE**
'Safeguarding' Adults' – Partnership Membership and links
(as appropriate for the local area)

| Statutory organisations | Other potential members | Links to other partnerships |
|---|---|---|
| Local Authority<br>▪ Adult Social Services<br>▪ Housing<br>▪ Welfare Rights/Benefits<br>▪ Education/Community Education<br>▪ Legal Services<br>▪ Licensing<br>Police<br>Crown Prosecution Service<br>Probation<br>Primary Care Trusts<br>Other NHS Care Trusts<br>Hospital Trusts<br>Commission for Social Care Inspection<br>Health Care Commission<br>Strategic Health Authority<br>Housing Trusts<br>Supporting People Board<br>Department of Work and Pensions<br>**Definitive links to**<br>Coroner<br>Public Guardianship Office<br>Courts<br>Witness Service<br>Fire Service<br>Ambulance Service | Service users'/patients' organisations<br>Carers' organisations<br>Advocacy providers<br>Direct Payments 'Umbrella' organisation<br>Care Home and Domiciliary Care providers/associations Supporting People providers<br>Victim support services e.g. Victim Support, Rape Crisis, Women's Aid<br>Voluntary sector service providers e.g. Age Concern, Help the Aged, MIND, People First, MENCAP, SCOPE<br>Voluntary sector groups working against abuse of adults e.g. ACT, Action on Elder Abuse, PAVA, POPAN. | Local Strategic Partnership<br>▪ Regeneration<br>▪ Health<br>▪ Crime and Disorder Reduction Board<br>▪ Domestic Violence<br>▪ Drug and Alcohol<br>▪ Neighbourhood forums/ Communities of interest<br>MAPPA (Multi-Agency Public Protection Arrangements)<br>Strategic Safeguarding Boards (Children)<br>Joint planning and commissioning for people with:<br>Learning Disabilities<br>Mental Health issues<br>Long term and chronic illnesses<br>and<br>Disabled people<br>Older people<br>Carers |

## Example 2

**GOOD PRACTICE**
Role of 'Safeguarding Adults' Co-ordinator

**Many Local Authorities have appointed an 'Adult Protection ('Safeguarding Adults') Co-ordinator' to support the work of the partnership. This role should be clearly defined, and including responsibility to:**

1) Advise and support the partnership
2) Advise and support partnership members in the implementation of 'Safeguarding Adults' work within their organisation
3) Maintain an overview of the development of local 'Safeguarding Adults' work
4) Provide information about relevant national and regional developments
5) Collate monitoring and quality assurance information
6) Provide information and advice on the implementation of the 'Safeguarding Adults' procedures to all
7) Provide information and advice to the **Safeguarding Managers** *(see Standard 9)*

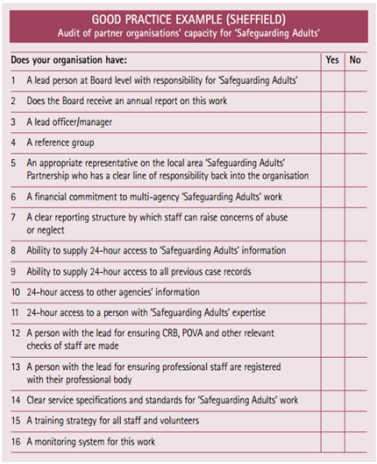
It may also include responsibility to:

8) Plan and commission work to be undertaken by the partnership
9) Manage work undertaken by the partnership. This often includes the partnerships joint training and information strategies. In some areas it includes the management of a 'Safeguarding Adults' Unit which includes dedicated **Safeguarding Managers.**

## Example 3

**GOOD PRACTICE EXAMPLE**
Relationships of Safeguarding Adults Partnership to key local partners and partnerships

**Example 4**



GOOD PRACTICE EXAMPLE (SHEFFIELD)
Audit of partner organisations' capacity for 'Safeguarding Adults'

| Does your organisation have: | | Yes | No |
|---|---|---|---|
| 1 | A lead person at Board level with responsibility for 'Safeguarding Adults' | | |
| 2 | Does the Board receive an annual report on this work | | |
| 3 | A lead officer/manager | | |
| 4 | A reference group | | |
| 5 | An appropriate representative on the local area 'Safeguarding Adults' Partnership who has a clear line of responsibility back into the organisation | | |
| 6 | A financial commitment to multi-agency 'Safeguarding Adults' work | | |
| 7 | A clear reporting structure by which staff can raise concerns of abuse or neglect | | |
| 8 | Ability to supply 24-hour access to 'Safeguarding Adults' information | | |
| 9 | Ability to supply 24-hour access to all previous case records | | |
| 10 | 24-hour access to other agencies' information | | |
| 11 | 24-hour access to a person with 'Safeguarding Adults' expertise | | |
| 12 | A person with the lead for ensuring CRB, POVA and other relevant checks of staff are made | | |
| 13 | A person with the lead for ensuring professional staff are registered with their professional body | | |
| 14 | Clear service specifications and standards for 'Safeguarding Adults' work | | |
| 15 | A training strategy for all staff and volunteers | | |
| 16 | A monitoring system for this work | | |

3.5.5 The full document can be accessed.

**The Health and Social Care Act 2012**

3.5.6 The legislation was enacted in April 2013.

3.5.7 The reported key areas of the Act:

- establishes an independent NHS Board to allocate resources and provide commissioning guidance
- increases GPs' powers to commission services on behalf of their patients
- strengthens the role of the Care Quality Commission
- develops Monitor, the body that currently regulates NHS foundation trusts, into an economic regulator to oversee aspects of access and competition in the NHS
- reduces the number of health bodies to help meet the Government's commitment to cut NHS administration costs by a third, including abolishing Primary Care Trusts and Strategic Health Authorities
- establishes Health and Wellbeing boards to each upper tier local authority.

3.5.8 The full Act can be accessed.

**CARE Act 2014**

3.5.9 The CARE Act 2014 received royal assent on 14 May 2014. The statutory guidance sets out how local authorities should meet the legal obligations laid on them by the Care Act and regulations. They must follow the Act and Guidance unless they can demonstrate legally sound reasons for not doing so.

3.5.10 The reported key provisions contained within the Act include:

**The principle of wellbeing - section 1**

The definition of wellbeing includes suitability of living accommodation. The principle must reinforce the functions of the local authority in addressing a person's care and support needs.

**Preventing, reducing and delaying care and support needs - section 2**

Local Authorities are required to understand and identify existing, unmet and future needs for care and support, and link this into Joint Strategic Needs Assessments and strategies to shape services. Local Authorities should have an understanding of the services in their local area, including services targeted at whole populations such as accessing good quality information or measures to promote healthy and active lifestyles. Local Authorities should consider how to align or integrate with other local services to develop approaches to prevention.

**Information and advice – section 3**

Section 3 refers to the duty placed on Local Authorities to establish and maintain a service that provides information and advice relating to care and support. The Local Authority is not required to directly provide all elements of the service but to understand, coordinate and make effective use of other service provision of information and advice, for example, One Stop Shop care and housing advice and its local partners or other housing options information.

**Safeguarding adults – section 14**

Section 14 ensures that safeguarding adult boards (SABs) are now placed on a statutory basis. Housing authorities and providers are not included as statutory partners, although locally they may and often are included.

**Integration, co-operation and partnerships – section 15**

Local Authorities are required to carry out care and support responsibilities with the aim of promoting greater integration with health and health-related services. Housing is clearly documented as a health related function. This is in relation to preventing needs; provision of information and advice; reducing/ delaying needs; improving the quality of services and outcomes achieved. It can be promoted through planning for services, commissioning, providing

information and advice; and connecting up services in the assessment and support planning process.

3.5.11 The full Act can be accessed.

**Human Rights Act 1998**

3.5.12 The Human Rights Act can be used by every resident in the UK, regardless of whether they are a British citizen or a foreign national, a child or an adult, a prisoner or a member of the public. Public authorities must follow the Human Rights Act.

3.5.13 The rights that the Human Rights Act protect are as follows.

- The right to life
- The prohibition of torture and inhuman treatment
- Protection against slavery and forced labour
- The right to liberty and freedom
- The right to a fair trial and no punishment without law
- Respect for privacy and family life and the right to marry
- Freedom of thought, religion and belief
- Free speech and peaceful protest
- No discrimination: everyone's rights are equal.
- Protection of property: protects against state interference with your possessions.
- The right to an education
- The right to free elections

3.5.14 The full Act can be accessed.

**Mental Health Act 1983**

3.5.15 The Mental Health Act 1983 details the rights of people who have mental health disorder:

- assessment and treatment in hospital
- treatment in the community
- pathways into hospital - civil or criminal

3.5.16 The Key sections of the Act are around:

- Rights when a person is detained in hospital against their wishes

- The family's rights when a person is detained
- Rights when a person is detained in hospital and also part of the criminal justice system
- Rights around consent to treatment when a person is detained
- Rights when a person leaves hospital, including how to have their section lifted and care planning
- Rights when a person being treated in the community, for example receiving section 117 aftercare

3.5.17 The Mental Health Act 1983 was amended in 2007. The changes that were brought about by the amendment:

- how mental disorder is defined
- the professionals who have specific roles within the Act
- additional rights for patients to displace their Nearest Relative how treatment is defined, and when it can be given
- the introduction of Supervised Community Treatment (SCT) and Community Treatment Orders (CTOs)
- a new right for patients to have an advocate
- some changes about how Mental Health Review Tribunals operate

3.5.18 The full Act can be accessed

## 4 Equality Impact Assessment

4.1 Overview and Scrutiny ensures that it adheres to the Council's statutory duty to provide the public with access to Scrutiny reports, briefing notes, agendas, minutes and other such documentation. Meetings of the Overview and Scrutiny Committee and its Scrutiny Panels are widely publicised, i.e. on the Council's website, copies issued to the local media and paper copies are made available in the Council's One Stop Shop and local libraries.

4.2 The Scrutiny Panel was mindful of the eight protected characteristics when undertaking this scrutiny activity so that any recommendations that it made could identify potential positive and negative impacts on any particular sector of the community. This was borne in mind as the Scrutiny Panel progressed with the review and evidence gathered.

4.3 So that the Scrutiny Panel obtains a wide range of views, a number of key witnesses provided evidence as detailed in section 3 of this report.

4.4 Details of the Equality Impact Assessment undertaken can be located on the Overview and Scrutiny webpage.

## 5 Conclusions and Key Findings

5.1 After all of the evidence was collated the following conclusions were drawn:

5.1.1 That there are key themes emerging:

- Assistance required for the BAME community
- Particular need for joined up communications
- Exploration of a centralised system - centralisation is very important

5.1.2 It was acknowledged that Adult Social Care Services is under resourced.

5.1.3 It is important that there is a holistic approach regarding integration and integrated services; integrated care is vital. It is important that there is one service working together to deliver the same outcomes. It was recognised that there is not a Multi-Agency Safeguarding Hub, in existence for adults as there is for children. The Site Visit noted that Adult Social Care at the London Borough of Islington has an excellent level of integration; with a close relationship with the CCG and health colleagues at both operational and commissioning level.

5.1.4 Partnership working is essential. The Scrutiny Panel acknowledged that there is a need to build on Partnerships. The voluntary sector can bring in funding.

5.1.5 Evidence received highlight the Project that is funded by NCC – "not enough money in the pot". Wellingborough had been chosen as a pilot for this Project, mainly due to the size of the Borough for the Ageing Well Project.

5.1.6 The good work undertaken by various organisations and groups was highlighted. For example some services run by Northants Carers carrying out statutory assessments. These are currently offered county wide and the Scrutiny Panel queried how these would continue to run without causing disruption post Unitary. It was highlighted that the contract is due to come to an end in October 2021. Northants Carers has a "sitting service" and carer's gym membership, which are very popular. It has won a national award for bringing together various professionals – Breathing Space Project. In Northamptonshire, investment in carers is relatively good. The Scrutiny Panel noted that the BAME Community is hard to reach. Northants Carers works with a number of partners and other groups. Recently, it put on events in Wellingborough. It runs an Asian Ladies Carers Group. Northants Carers works with the organisation "Dostiyo". It also works with faith groups and individuals.

5.1.7 The Pilot being run in Kettering whereby a Housing Officer is dedicated resource to Kettering General Hospital is working very well.

5.1.8 The Scrutiny Panel was pleased the Eleanor House had been modernised and back in use. Additionally, it was recognised that Parsons Mead is a flagship complex and "ticks all the boxes", being close to required amenities for older people.

5.1.9 It was felt that it would be useful for there to be a facility where individuals could go when they no longer needed hospital care but needed care at home, but such care was not available.

5.1.10 Currently, a number of GP practices proactively refer to organisations such as Age UK Northamptonshire so as to positively support their clients' needs. Literature from Age UK Northamptonshire is widely available in GP surgeries across the County, and in Northampton and the North in particular given the services supported by NHS funds.

5.1.11 Clients being supported through NHS funded services are referred from a mix of sources. Some are referred via word of mouth and many from other Age UK Northamptonshire services. Around two thirds of the referrals for Age UK Northamptonshire NHS funded services are from GPs.

5.1.12 The Scrutiny Panel emphasised that loneliness is, arguably, the most significant issue that needs to be dealt with. It can be very isolated for carers.

5.1.13 It was realised that some individuals don't claim for the benefits that they are entitled to.

5.1.14 The Scrutiny Panel felt that it would be good if best practice could be shared between the two Unitary Authorities.

## 6 Recommendations

6.1 The purpose of the Scrutiny Panel was to investigate Adult Social Care Facilities in the area to identify future demand patterns, in order that any new Unitary Council is able to better plan for the needs of older people.

**Key Lines of Enquiry**

- To gain an understanding of the demand patterns for Adult Social Care in the area that is proposed for the new Unitary Council
- To assess the extent of the need for Adult Social Care in the area and assess the initiatives currently in place to provide Adult Social Care
- To gain an understanding of the causes and barriers to receiving Adult Social Care
- To gain an understanding of the current facilities for Adult Social Care and whether there are any gaps of provision
- To gain an understanding of partnership working for Adult Social Care and how this can be improved
- To gain an understanding of the structure of the Adult Integrated Care Programme
- To gain an understanding of the Governance Arrangements for the Social Care Integrated Programme
- Identify any specific groups that are not accessing Adult Social Care Facilities
- To gain an understanding of care in the community and how it is assessed and monitored
- To gain an understanding of the extent of adult care responsibilities that will fall upon the proposed new Unitary Authority and the degree of necessary preparation.
- To gain an appreciation of the statutory responsibilities in respect of the duty of care obligations and their financial consequences.

6.1.1 Whilst acknowledging data protection constraints , an integrated system, hosted by Adult Social Care, that can be used by all relevant Agencies, is explored by the proposed West Northamptonshire Unitary Authority.

6.1.2 In researching a potential integrated system, the systems and processes adopted by Adult Social Care at the London Borough of Islington are referred to.

6.1.3 That a housing officer is linked to Northampton General Hospital, a similar arrangement to the Kettering Pilot.

6.1.4 That support is given for social prescribing in relation to day care.

**Overview and Scrutiny Committee**

6.1.5 The Overview and Scrutiny Committee, as part of its monitoring regime, reviews the impact of this report in six months' time.