**Overview & Scrutiny** Committee

SCRUTINY PANEL **2**

# Independent Living Strategy

**March 2012**

NORTHAMPTON
BOROUGH COUNCIL

# Index



APPENDICES

## Foreword

The objective of this Scrutiny Panel was to evaluate the draft Independent Living Strategy and make recommendations for development of this Strategy.

It was realised that the numbers of older people are increasing at a time when resources are reducing. Key documents were consulted such as "A Good Place to Grow Older" (CfPS) and "Breaking The Mould" (NHF). Evidence was gathered from a variety of sources, including the Housing Directorate, Age UK (Northamptonshire), CIH Consulting, Northampton NHS Foundation Trust, Adult Social Care (NCC), Northampton Pensioners Forum and the GP Consortium, Nene Commissioning. Therefore, in a time of change there is a need for a strategy to guide all Partners through this substantial change.

Members of the Panel also attended two CfPS Workshops and received information regarding the Local Government Ageing Well programme as well as the Centre for Independent Living.

The Scrutiny Panel was made up from members of the Overview and Scrutiny Committee Councillors Michael Ford, Elizabeth Gowen, Beverley-Anne Mennell and myself, together with a non-Executive Councillor Sally Beardsworth. County Councillor Judy Shephard, Chair, Health and Adult Social Care Scrutiny Committee, Northamptonshire County Council was co – opted onto the Scrutiny Panel.

The Review took place between July 2011 and March 2012.

I would like to thank everyone who took part in this piece of work.

**Councillor Lee Mason**
Chair, Scrutiny Panel 2 – Independent Living Strategy

**Acknowledgements to all those who took part in the Review: -**

- Councillors Sally Beardsworth, Michael Ford, Elizabeth Gowen, Beverley Anne Mennell and County Councillor Judy Shephard who sat with me on this Review
- Councillor Christopher Malpas, Portfolio Holder (Housing) for providing a response to the Scrutiny Panel's core questions
- Fran Rodgers, Head of Strategic Housing for her support to this Review
- Lindsey Ambrose, Community Engagement and Equalities Officer, for arranging for myself to attend a meeting of the representatives of the Northampton Pensioners' Forum
- Gary Parsons, Strategy and Performance Manager, Northampton Borough Council for consulting with the Scrutiny Panel on the draft Affordable Warmth Strategy
- Liam Condron, Chief Executive, Northants AgeUK, Councillor Robin Brown, Portfolio Holder, Adult Social Care and Chair, Shadow Health and Wellbeing Board, Northamptonshire County Council, Dr Darin Seiger, Chair, GP Consortium, Angela Hillery, Acting Director for Community Services, Northants Health, Andrew Jepps, Assistant Director, Adult and Children's' Services and Janet Doran, Assistant Director, Community Services, Northamptonshire County Council, Richard Medley of CIH Consulting, for providing information to inform the Review
- Ashley Poulton, Manager, Centre of Independent Living (CIL), Northampton, for spending time with members of the Panel when they visited the CIL
- Brenda Cook Consultant Coach Facilitator, Centre for Public Scrutiny (CfPS), for her advice to this Review.

## EXECUTIVE SUMMARY

The purpose of the Review was to evaluate the draft Independent Living Strategy for older people and make recommendations for development of this Strategy.

The Overview and Scrutiny Committee for 2010/2011 agreed at its work programming event in March 2010 to include a Review of Independent Living Strategy to its work programme for 2010/2011.

It was not timely for the Review to commence in July 2010. In January 2011, when there was space on the Work programme for further Scrutiny Reviews to commence, it was agreed that the allocated timescale of just two months was not adequate. Therefore, the Overview and Scrutiny Committee agreed to postpone the Review and to recommend to the Overview and Scrutiny Work Programming event 2011 that a Review of Independent Living Strategy be included within its work programme 2011/2012.

The Overview and Scrutiny Committee, at its inaugural meeting on 30th June 2011, agreed that a Scrutiny Review of Independent Living Strategy should commence in July 2011.

A Scrutiny Panel was established comprising Councillor Lee Mason (Chair); Councillors Sally Beardsworth, Michael Ford, Elizabeth Gowen, Beverley Anne Mennell and County Councillor Judy Shephard (co-optee).

The Review commenced in July 2011 and the Scrutiny Panel concluded its work March 2012.

This Review links to the Council's corporate priorities - Corporate priority CP2 Ensuring Homes are available for Local People – Support vulnerable people to live independently.

## CONCLUSIONS AND KEY FINDINGS

A significant amount of evidence was heard, details of which are contained in the report. After gathering evidence the Scrutiny Panel established that: -

The Panel recognised that the Review of Sheltered Housing undertaken by CIH Consulting was a key piece of work in developing the Council's future housing strategy. The findings were not a surprise and would form the basis of further consultation as the future of the sheltered accommodation was considered.

### Emerging Key Themes

### Actions to plan for the future demands of Older People

Demographic changes will result in people living longer, but not necessarily healthily, therefore demands on health and social services will be acute. It is clear that all Councils will need to have very robust Strategies and Plans in place to help

older people remain independent for as long as possible and to deliver the appropriate support.

**Definition of Independent Living for Older People**

After receiving a variety of example of other organisation's and Agencies' definitions of independent living for older people, the Scrutiny Panel felt that its definition should be short, concise and easy to read:

> "Independent Living is about enabling older people to have a voice, choice and control over any support they need in order to maintain an active, healthy and quality lifestyle that is suitable for their needs and which promotes positive ageing and wellbeing."

**A Joined up approach with Agencies/partnership working to achieve the right service at the right time**

Evidence gathered showed that there is a need for all partners to work together to achieve effectiveness and efficiency savings.

There is duplication and waste in terms of the way services for older people are currently provided via a range of different organisations. Northampton Borough Council and key partners do not currently provide joined up and accessible information for people to plan for older life.

**Charging for Services**

Very few services are now provided free of charge and a range of fees are applied. There is a need for older people to understand what is being provided for the fees charged and to ensure that the quality of those services is regularly monitored.

The Scrutiny Panel recognised the potential for individuals to access services via their personal budget arrangements.

**Education**

Generally older people perceive hospitals as the best and correct place to receive health care and often they are not aware of the number of available, more appropriate levels of assistance. There is a need to educate people and promote the right level of care and support depending upon the health need.

Preventative action and health education are key issues to include in the Independent Living Strategy for Older People, such as informing people of the potential harmful effects of drinking alcohol and smoking.

The Scrutiny Panel understood the importance of particular organisations and groups, such as the Northampton Older People's Forum to provide support within the community on health initiatives.

**Low Level Support Initiatives**

The evidence received from a variety of key expert witnesses highlighted the need to prevent higher cost services being required until much later in life, or not at all.

The Scrutiny Panel acknowledged that prevention is more than merely promoting initiatives and is about the range of support services tailored to individual needs.

**Choice**

Generally older people do not receive comprehensive information about the services that are available to them and/or are confused by the different services and way in which individuals are assessed as being eligible for services.

There is limited choice that can currently be exercised by older people in respect of the services that are available.

**Getting Users Involved**

The general perception of older people is that they do not feel listened to and that they do not have sufficient choices about the services that affect them. In order that involvement and consultation are effective, they must be meaningful and recognisable to older people. It often appears that people can suffer `consultation fatigue' by being consulted by various different Agencies, in a variety of ways, on similar topics. There is a need for the Agencies to be smarter around how they consult on similar issues.

The Scrutiny Panel realise that older people have not been as involved in the development of the Strategy so far, despite a number if invitations to representative organisations to take part and felt that their involvement and input was required.

**Tackling Age Discrimination and Inequality**

Evidence has highlighted that more needs to be done to tackle age discrimination in services for older people. The value of an Older People's Champion was recognised.

The evidence further emphasised that that not all partners have policies tackling age discrimination.

**Social Isolation**

A significant percentage of older people in the population are socially isolated and do not receive support or contact with friends, relatives or the wider community.

The evidence gathered emphasised the important role of for the community and volunteers in helping older people, for example providing assistance with shopping and gardening.

There is a clear link with the quality of home and neighbourhoods when looking at the total package of support for an older person.

**Sheltered Housing**

Northampton Borough Council is currently undertaking a review of its sheltered housing services for a number of reasons including the suitability of the accommodation and the uncertainty around the future funding.

The panel felt that the Review should take account of the recommendations of this Strategy Review when deciding on the stated of Sheltered Housing.

The needs of older people should be taken into account when new housing is being designed and developed.

From a district perspective, adult and social care requirements cannot be met without looking at housing needs and the provision and requirement of leisure activities. The Scrutiny Panel acknowledged that the Head of Strategic Housing has a clear remit to work with Adult and Social Care to ensure there is synergy between housing needs and those of Adult and Social Care. The Panel highlighted the need for this to be strengthened.

**Equality Impact Assessment**

The Scrutiny Panel felt that older people should be involved in the monitoring the Equality Impact Assessment for the Independent Living Strategy for Older People, for example the Northampton Pensioners' Forum or a specifically convened Group of older people.

**Scrutiny Review – Reflection**

Upon reflection, the Scrutiny Panel felt this Review had made some very important conclusions, key themes and recommendations. It was realised at the scoping stage that independent living was a vast topic and therefore narrowed it down to independent living for older people over the age of 65. This provided a clear focus for the Panel to work from.

The Panel devised its definition of independent living which again provided focus to the Review.

The Review was focussed on plans for the future.

The Panel received evidence from a wide range of external and internal witnesses and used the Centre for Public Scrutiny (CfPS)'s Guide for Scrutiny Committees; *A Good Place to Grow Older?* ¸as a basis for its questions. In assessing the questions asked and the evidence received, the Panel realised that there was a need to modify the questions and connect with the evidence. A further question was therefore asked of key witnesses, regarding their top three priorities for an Independent Living Strategy.

The Panel shared details of its draft conclusions, emerging themes and recommendations with partners who had provided expert evidence to inform the Review and asked for their feedback on these findings prior to the Panel agreeing its final report.

In looking how the Review process could have been improved, the Panel felt that older people groups could have been involved. It was acknowledged that contact had been made with the local Pensioners' Voice Group and there is a need to ascertain whether Pensioners' Voice would like to be involved in the development of an Independent Living Strategy.

This Review demonstrates the importance of an Independent Living Strategy for the Council.

## RECOMMENDATIONS

The purpose of the Scrutiny Panel was to evaluate the draft Independent Living Strategy for older people and make recommendations for development of this Strategy and its scope.

Scrutiny Panel 2, Independent Living Strategy, therefore recommends to Cabinet:

That the Strategy should contain a principle setting out the need for this to take place. There is a further need for the Council and its partners to have a common strategic framework regarding independent living for older people.

The Scrutiny Panel agreed that this should be a key part of the Strategy and that the role of Northampton Borough Council could be to enable this to happen as part of the wider county work.

**Independent Living Strategy**

6.1.1 That Northampton Borough Council's Independent Living Strategy is fit for purpose, containing a comprehensive Action Plan for the future delivery of services to older people.

6.1.2 That Northampton Borough Council's Independent Living Strategy reflects the emerging themes from this comprehensive Overview and Scrutiny Review as detailed in section 5 of the report.

6.1.3 That the title of the Independent Living Strategy should be *"Northampton is a good place to grow old'".*

6.1.4 That the Scrutiny Panel's definition of independent living be included within the Strategy:

> "Independent Living is about enabling older people to have a voice, choice and control over any support they need in order to maintain an active, healthy and quality lifestyle that is suitable for their needs which promotes positive ageing and wellbeing."

**Partnership working**

6.1.5 That all relevant organisations in Northampton seek ways to work together to support older people to live independently, this would include opportunities to establish integrated assessments and locality based teams.

6.1.6 That key Agencies in Northampton work towards a common approach to gathering and sharing data, including establishing a shared approach to involvement and engagement.

6.1.7 That funding is identified and maximised by the Council, from a range of organisations, to support Low Level Support Initiatives that can demonstrate their effectiveness in preventing more costly services being required.

**Working with Older People**

6.1.8 That clear and comprehensive information is made available to older people in ways in which they can easily access it and is test driven by older people before being implemented.

6.1.9 That older people be asked how they would like to be involved and consulted with (or engaged with), through Groups such as the Northampton Pensioners' Forum, so that Northampton Borough Council respond appropriately.

6.1.10 That Northampton Borough Council has a robust Policy in place, promoting positive messages that tackle age discrimination and inequality amongst older people.

6.1.11 That Northampton Borough Council appoints a Councillor as its Older People's Champion and local older people representatives from each of the four areas of the town.

6.1.12 That Northampton Borough Council provides opportunities for older residents and their representatives in the community to receive and/or give support to others by promoting self help and community support and reducing social isolation.

**Service Delivery**

6.1.13 That services are designed around the needs of the customer.

6.1.14 That there is a need to manage expectations of services with a greater emphasis on clear signposting to the most appropriate service to meet particular needs.

6.1.15 That the Housing Strategy makes adequate provision within its new build programme for older people's accommodation, and that older people are involved in identifying what this might look like.

6.1.16 That it be formally acknowledged that the Head of Strategic Housing, Northampton Borough Council, has a clear remit to work with Adult and Social Care, Northamptonshire County Council, to ensure there is synergy between housing needs and that of Adult and Social Care.

**Sheltered Housing**

6.1.17 That by recognising the role of sheltered housing in enabling older people to live independently that sheltered accommodation for older people is of an agreed standard and fully accessible and that it meets the needs of older people and recognises the needs of older people to live independently.

6.1.18 That some schemes should be solely for individuals over the age of 65 as a life style choice.

6.1.19 That individuals should receive support to live independently regardless of the accommodation that they are living in and according to their need.

**Funding Opportunities**

6.1.20 That Northampton Borough Council maximises the funding opportunities available to support initiatives for older people, such as Healthy Homes for Older People.

6.1.21 That where charges for services for older people are applied, clear information is provided to assist people in understanding what they are paying for.

**Monitoring**

6.1.22 That a comprehensive Action Plan comprising key timescales and milestones is produced to address all recommendations contained within this Overview and Scrutiny report.

6.1.23 That older people are involved in monitoring the Equality Impact Assessment for the Independent Living Strategy for Older People.

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

**Northampton Borough Council**

**Overview and Scrutiny**

**Report of Scrutiny Panel 2 – Independent Living Strategy**

## 1 Purpose

1.1 The purpose of the Scrutiny Panel was to evaluate the draft Independent Living Strategy for older people and make recommendations for development of this Strategy.

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

## 2 Context and Background

2.1 The Overview and Scrutiny Committee for 2010/2011 agreed at its work programming event in March 2010 to include a Review of Independent Living Strategy to its work programme for 2010/2011.

2.2 It was not timely for the Review to commence in July 2010. In January 2011, when there was space on the Work programme for further Scrutiny Reviews to commence, it was agreed that the allocated timescale of just two months was not adequate. Therefore, the Overview and Scrutiny Committee agreed to postpone the Review and to recommend to the Overview and Scrutiny Work Programming event 2011 that a Review of Independent Living Strategy be included within its work programme 2011/2012.

2.3 The Overview and Scrutiny Committee, at its inaugural meeting on 30th June 2011, agreed that a Scrutiny Review of Independent Living Strategy should commence in July 2011.

2.4 A Scrutiny Panel was established comprising Councillor Lee Mason (Chair); Councillors Sally Beardsworth, Michael Ford, Elizabeth Gowen, Beverley Anne Mennell and County Councillor Judy Shephard (co-optee).

2.5 The Review commenced in July 2011 and the Scrutiny Panel concluded its work February 2012.

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

- Context:
- Local statistics
- Demographics – national and local
- Housing profile
- National position
- Financial statistics/Funding decisions – decommissioning, reconfiguration of Health and Social Care

- Synopses of various research documents and other published documents
- Data from other (best practice) Local Authorities
- Published Guidance
- Evidence from internal Officers
- Evidence from appropriate external witnesses
- Evidence from partners
- Site visits and desktop research

2.7 The Scrutiny Panel recognised that a key part of an Independent Living Strategy is around the extent that Northampton Borough Council and its partners provide low level enablement support to help older people maintain independence.

2.8 There is a need for an Independent Living Strategy due to:

- Increasing demand for care and support
- An ageing population
- Increasing demand for housing related support, such as accommodation, assistance and advice with payment management
- Real budget pressures, for example reduced budget for Adult Care, supporting people funding and health

2.9 Independent Living Strategies are key to the Prevention Agenda, for example, if investment is made in housing related support; savings are made elsewhere, such as the reduction in hospital admissions and a reduction into long-term care.

2.10 Independent Living Strategies assist in supporting people to be able to live independently for longer, and link the Council's Corporate Plan (You section refers – Supporting you when you need it, ensuring homes are available for local people and encouraging healthy, active, green living).

## 3. Evidence Collection

3.1 Evidence was gathered from a variety of sources:

### 3.2 Background data

- Statistics indicate that over the coming decades the numbers of people over 50 years of age will rise considerably. They will have a different set of needs and expectations than those of previous generations
- People may be living longer but not necessarily in good health and more people will be living on their own
- There will be a greater demand on services, during budget cuts and reforms to Social Welfare and Housing
- It is expected that there will be a rise in the number of people who require support to remain in their own homes. The required support may comprise personal care; help with maintaining a property, adaptations for the disabled or assistance in claiming benefits
- Older people do not necessarily want to "down size".
- Expectations of older people need to be managed
- Modern technology may mean that there is more ability to do things remotely, but this may increase social isolation

- It is vital that partners invest in preventative measures to reduce the longer term costs. There should be more support and low level interventions
- Housing is a key service, as providing suitable housing can be the major component in maintaining independence. Owner occupiers may also have difficulty in maintaining their properties either because they are physically no longer able to do work themselves or because they do not have the available finance. They may also need assistance in finding honest and reliable companies to carry out these tasks
- There may be a need for more flexible Policies and to respond to older people according to their needs.
- **Localism Act** – Move towards decentralisation, diversifying the supply of public services
- **Social Housing Reform** – Changes to Allocations Policies, no inspections of Housing Services, self regulation. All new build affordable rents set at 80% of market rent. This general move to bring public and private rents closer together will make it even harder for people who are renting privately to be able to afford to save for deposits
- **Welfare Reform** – Universal Credit - One payment to the customer which they are responsible for managing. Under occupation penalties which could mean that those in receipt of benefit would be under pressure to move if they are in accommodation that is considered to be too large for their needs
- **Health and Social Care** – Abolition of Strategic Health Authorities and PCT'S. Move to GP commissioning of services.

## 3.3 Executive Summaries

3.3.1 Executive Summaries of various key documents:-

- Select Committee report on dementia
- Centre for Public Scrutiny (CfPS): A good place to grow older?
- National Housing Federation: Breaking the mould
- Pride of Place
- Independent Ageing

## 3.4 Centre for Public Scrutiny (CfPS) Workshop- A Good Place to Grow Older?

3.4.1 Representatives of the Scrutiny Panel attended the workshop – A Good Place to Grow Older. Presentations were given from:

**Local Government Group regarding its Ageing Well Programme.**

3.4.2 Suggested key facts from the presentations:

- The average older person will experience nine years limiting long term illness compared to six in 1981
- 1 in 5 pensioners in Britain live below the poverty line
- 1.7million additional people will require care in 20 years

- In 2008, there were more older people over 65 than younger people (under the age of 25)
- 1 in 4 people born today will live to 100

3.4.3 Alternative facts:

- By 2030 the positive net contribution of over 65s will grow to £77 billion
- 85% of older people do not come into contact with Social Services
- The estimated cost to the economy per year due to drop in work rates of over 50s and ageism in the workplace is between £16 billion and £31 billion
- Every year, each older volunteer spends an average of over 100 hours informally volunteering and more than 55 hours in formal volunteering roles. This is worth £10 billion to the UK economy

**3.5 Sandwell Age Forum**

3.5.1 The Vision for Agewell:-

- *To represent the older people of Sandwell via Agewell Members and to act on their behalf*
- *To be a direct voice for older people in Sandwell*
- *To promote a higher and more positive profile of older people enabling them to participate in the decisions that affect their lives*
- *The purpose of this is to promote greater recognition of the contribution older people make as citizens within their communities*
- *We will work with our communities and partners to develop and deliver high quality services, and forums, which are flexible and responsive to the needs and views of older people.*

**3.6 Centre for Public Scrutiny (CfPS) Workshop – Building Social Capital during a time of austerity: A strategic approach to engaging local communities in supporting older people**

3.6.1 The Chair of the Scrutiny Panel attended the workshop and presentations were received from:

**Sandwell Age Forum**

The organisation has 1,000 members and has the aim of being the `voice of older people"

**Stamford Forum**

- New paradigm for public service leadership
- Community development is key
- Volunteers are essential

**Making the Connections**

- Asset approach – vital in tough times
- Aim is to improve outcomes such as better health, cleaner

environment and saving money by using volunteers (the assets)

### 3.6.2 Looking at Best Practice and other Local Authorities

3.6.2.1 Desktop research was carried out regarding organisations, Local Authorities or Strategies in respect of independent living noted for best practice external to Northampton. The salient points are detailed below.

### 3.6.3 The Joseph Rowntree Foundation

3.6.3.1 The Joseph Rowntree Foundation commissioned its report `*Innovation and better lives for older people with high support needs: International good practice' as part of it's `A Better Life'* Programme. The Paper gives details of what it perceives to be good practice:

### 3.6.4 Advice Services

3.6.4.1 The paper advises that FirstStop Initiative is an example of good practice in advice services. The Initiative received funding from the Big Lottery Fund and Communities and Local Government. FirstStop comprises advisors from the Elderly Accommodation Council, Counsel and Care, Age UK and NHFA which is part of the HSBC bank that offers advice on financing long term care. The advice line provides assistance on care and housing support, rights and services available. FirstStop has a comprehensive website and a wide ranging library of information. Advice is provided by telephone, in writing or by case management for those with complicated queries.

3.6.4.2 Some Councils have introduced such an advice line, including City of Westminster and Hampshire County Council.

3.6.4.3 Kent County Council is reported to have adopted automated self assessment process, a gateway to direct and individual budgets by sharing information for example with reablement teams and hospital discharge teams. Cumbria County Council, Rochdale Metropolitan Borough Council and the London Borough of Lewisham have used the software Liquidlogic which facilitates communication between Agencies.

### 3.6.5 Black, Minority and Ethnic (BME) Group Support

3.6.5.1 The paper recognises good examples of innovation regarding black, minority and ethnic group support. It refers to the Leicester Age Concern BME Elders Group that brings together over forty groups representing the BME community.

### 3.6.6 Shaping Transport

3.6.6.1 The paper refers to the AUNT SUE Group (Accessibility and User Needs in Transport for Sustainable Urban Environments) commenting that this has worked very well in London and Hertfordshire looking at issues such as journey planners for people with high support needs and the adaptation of public transport to maximise age and disability friendliness.

### 3.6.6.2 The Beth Johnson Foundation

3.6.6.2.1 The Beth Johnson Foundation undertook a Project that investigated the Participation and Engagement of Older People in Stoke-On-Trent. The paper details examples of best practice relating to the development of participation and engagement of older people. Some are Local Authorities who have implemented Strategies; others are where there has been a wealth of initiatives on ageing and older people and Local Authorities that have demonstrated areas of practical development:

### 3.6.6.3 Birmingham

3.6.6.3.1 The Birmingham Older People's Partnership Board is made up of leaders of statutory organisations with social care, health and housing responsibilities for older people, the voluntary and private sectors and citizens. The Board meet three times a year with the Citizens Council of Older People – BACOP (Birmingham's Advisory Council of Older People). It is reported that the aims of the meetings are to increase accountability between Statutory Services and older people. The Board links into the Birmingham Health Partnership Board.

### 3.6.6.4 Bolton

3.6.6.4.1 An Older People's Charter has been developed by Bolton Metropolitan Borough Council, Health Trusts, Pensions Service, Voluntary Organisations and older people's groups. The stated aim of these bodies is reported *"to improve the quality of life of older people by working with them and other partners to develop strategies and services which respond to their changing aspirations and circumstances and to meet their changing needs".* All of the bodies have agreed to incorporate the eight principles of the Older People's Charter into the work of the organisation in order to achieve the stated aim.

### 3.6.6.5 Bury

3.6.6.5.1 As part of a Better Government for Older People Project, older people in the Local Older People's Forum became engaged in widening participation and breaking down social exclusion. One particular initiative was a peer research exercise carried out by older people on the needs and aspirations of other older people in the town. This involved a door to door survey undertaken by an ethnic pairing of white and Asian older people within a particular ward that was seen to have become cut off from the wider community due to a range of factors, including culture and the built environment. The survey provided a better understanding of the needs and aspirations of a range of older people, and it led to an increase in numbers and ethnic diversity in the membership of the Older People's Forum as well as greater participation in civic life.

### 3.6.6.6 Shropshire

3.6.6.6.1 Shropshire County Council has been awarded beacon status for services to older people, support for older people's forums and development of an overarching strategy for older people. The forums have been consulted on the Council budget, helped the Council to design the citizens' panel, tested out ways to engage hard to reach older people and assisted in the development of the overarching strategy for older people.

### 3.6.6.7 Local Government Group - Resource '*Positive engagement of older people to support and promote greater independence and well-being in later life*' theme

3.6.6.7.1 In accordance with the '*Positive engagement of older people to support and promote greater independence and well-being in later life*' theme, the following Local Authorities were awarded Beacon status. The theme covers two specific components of service provision:

- Positive engagement of older people
- Greater independence and well-being in later life

3.6.6.7.2 The theme relates specifically to the engagement and empowerment of older people (aged 50 years and over) as citizens.

### 3.6.6.7 Bradford Metropolitan District Council

3.6.6.7.1 The Local Government Group (LGG) reports that Bradford has developed a culture of sharing and delivering, with older people and partners working together. In Bradford older people are leaders in their own right and inform and influence both the strategic direction and service delivery.

3.6.6.7.2 Bradford has a wide range of engagement and involvement of older people which addresses the diversity of the area. Older people from 97 groups are members of the Bradford Older People's Alliance.

### 3.6.6.8 Lancashire County Council

3.6.6.8.1 The LGG reports that in Lancashire older people are engaged from the development of the strategy through its review process to the design of services and the enhancement of what matters most to older people. This has been achieved despite the size of the county and the need to take into account the needs of the 12 districts.

3.6.6.8.2 Lancashire has a strategy going beyond health and social care to include active participation in later life. Lancashire has appointed an elected member as the Older People's Champion to ensure that older people's issues are high on the agenda.

### 3.6.6.9 London Borough of Camden

3.6.6.9.1 The London Borough of Camden has a 12 year history of developing services for citizens and not organisations, and is continually responding to new challenges

from its diverse older population. Camden is responsive to the needs of the 50+ population with a view to promoting greater independence and well-being in later life. Older people are engaged in the on-going review of the LAA to ensure its effective implementation.

**3.6.6.10** **London Borough of Tower Hamlets**

3.6.6.10.1 Older people in the borough of Tower Hamlets represent 20 per cent of the total population and are involved at all levels. Older people themselves were involved in the Best Value review in 2006, which identified key cross-cutting themes addressing all aspects of independent living – that is, what matters most to older people. An older people's champion supported by champions in directorates ensures that older people are treated as a priority.

**3.7** **Core Questions**

3.7.1 The Scrutiny Panel produced a set of core questions that it put to key witnesses over a series of meetings. Copy at Appendix B

3.7.2 Key witnesses provided a response to these core questions at the meetings of the Scrutiny Panel held on 19th October 2011, 7th December and 11 January 2012.

3.7.3 Key points of evidence: -

**3.8** **Portfolio Holder (Housing)**

- There are a wide range of strategies in place, which relate to older people.
- There are a number of potential influences such as legislative changes, which along with financial challenges, will mean that these strategies may need to change.
- The current review of Sheltered Housing provision, which is almost complete, could have a significant impact on services and facilities provided to elderly and vulnerable customers.
- The Council will continue to talk to Social Landlords regarding making homes more appropriate for older people, allowing them to stay independent longer. However they are only able to encourage changes.
- Staff are very skilled and very flexible in their approach.
- The review of Sheltered Housing is reviewing all residents support plans. These will also be affected by the withdrawal of the Supporting People programme. Support Plans will be adapted based on the customers' own view of their needs.
- Direct charges are only made for the Call Care lifeline services, although all residents pay towards services through council tax revenue.
- There may well be additional charges that could affect all housing tenants should changes to housing funding become law.
- Consultation is often direct with the users of a particular service.
- There are also Pensioner/ Disabled people's forums and a Tenants Panel that the Council can consult with

- The number of responses to consultations is often low
- The housing options service has a range of accreditations.
- There is a wide range of information options available.
- There are very few complaints (or compliments) about the information provided.
- The Gateway Service has been introduced to provide low-level support to enable people to continue to live independently.
- Every opportunity for partnership working will be taken.
- There is concern over the financial challenges that are being faced, both now and in the future. Services will have to change and there will be the impact of welfare reform and the ending of the Supporting People programme to overcome.

**3.9** **Chief Executive, Age UK Northamptonshire**

- Age UK Northamptonshire is in the final year of a five-year strategy. There are 3 overall aims for the strategy: -
    - ·Maintain and develop a range of care services for older people.
    - Secure the future of the organisation so that it is able to continue to deliver services.
    - Ensure that the organisation is a good organisation, which is respected.
- The Strategy takes into account the anticipated decline in public sector funding. It is founded on “Big Society” principles and the aim is to provide services as requested to up to 100% of older people.
- There is also a role for campaigning to ensure that as the next generation of people ages they do not suffer the same deprivations.
- The organisation needs to be sustainable in order to continue developing and delivering services for future clients.
- The organisation undertook market research in 2011 in the 70/85 age group asking what services that people needed to maintain a good quality of life.
- People tend to approach Age UK Northants as a first port of call, often before the public sector. They have a good perception of the organisation.
- There is a mixture of paid staff and volunteers: approx 300 employed and 700 volunteers.
- Many of the staff have already had lengthy careers in another sector, often at a high level and bring a range of experience to their work.
- There will be a challenge in moving towards a social enterprise approach and marketing services directly to individuals. Where staff were traditionally committed to giving service regardless of economics, the future will see them providing a good service based on need and value for money.
- There is a huge range of services available. The organisation has developed several models of service based on a holistic approach to the needs of the customer.
- Typical services include: -
    - Provision of information
    - Day care/Lunch club facilities

    - Maintaining the home- including Domestic Care and a handyperson service
    - Shopping service
    - Care for people coming out of hospital
    - Support and assistance for carers
    - End of Life Care
- There is no means testing for the provision of services.
- Charges vary depending on the service, for example Handy persons service is based on £10 per hour for health and safety work £20 for other. Day care is charged at £15 a day, the actual cost is £28 with the County Council contributing around £5 and the rest made up from fund raising etc. Domestic care service is £10 p/h. Courses are between £1.75 and £5 per lesson.
- There is a benefits advisory service, which has identified around £2 million of benefits annually for clients.
- The organisation is also considering the development of a hardship fund as a way of developing more sustainable charging whilst still ensuring that some of the poorest are able to access services.
- Due to decreasing funding Age UK Northamptonshire is increasingly depending on other income sources to run services.
- Staff/ Volunteers and Trustees are all involved in planning services. Trustees are regularly involved with service users.
- There is a complaints system.
- There is one to one consultation whenever there are major changes. The charges for day care doubled this April and each of the 700 users had the changes explained. Of those only 15 withdrew form using the service.
- The organisation is pro active in tackling age discrimination and has always been involved in campaigning around age discrimination at a national and a local level.
- The organisation aims to provide quality information on a wide range of subjects. There is access to an advocacy service although this is no longer funded. There are approximately 7,000 queries a year. There is also a benefit from the association with the national Age UK.
- Originally the aim of the organisation was about meeting the needs of the frail older people. However in the last ten years that had widened to helping people make the most of their life as they age. It now includes providing people with opportunities to learn, congregate and contribute to society.
- Preventative work such as falls prevention can be very effective in saving resources. An investment of £35,000in falls prevention has saved approximately £830,000 to the NHS locally.
- One preventative initiative that the organisation is involved in is a Cooking for one and nutritional advice service.
- They also run Lifetime centres, which aim to provide carers with a break and provide socialisation for the older people.
- There is a new service, which is engaging volunteers in GP's surgeries, checking whether people who have been in hospital are coping with any changes in their circumstances.
- There has been a long history of partnership working with a wide range of different organisations, including Councils, Fire and Police service,

Crossroads care, NHS, private sector heath care provider, faith groups and ethnic minority groups. Traditionally voluntary sector provision has developed to cover the gaps in provision. In the future it may be more to do with capturing market share.

- Originally they were very much geared to the physical needs of the elderly person. Now there is more demand for services such as financial services and benefits checking. There is more work done on prevention such as falls prevention and hospital discharges. There is also a growing problem around dementia, and obesity issues may mean that health issues become a factor in quality of life at an earlier age. People are also frailer when they make their first contact, and services are working at capacity.
- The testing and replacement of electric blankets was also mentioned, as funding had previously been available from Age UK. This is no longer available and efforts were being made to include that element in a bid for funding from the "warm homes healthy people" initiative.
- There has been a massive increase in workload, individuals and carers want to keep people in their own homes as long as possible and are more likely to involve the voluntary sector for help in achieving this.
- Age UK Northamptonshire top three priorities:
    - Information Advice and Support
    - Access to Services
    - Social Inclusion

**3.10 CIH Consulting**

3.10.1 CIH Consulting was engaged by Northampton Borough Council to conduct a strategic review into the supported housing provision in the Borough.

3.10.2 Summary of the key findings.

- The review had been undertaken for a number of reasons including:
    - Whether the accommodation was fit for purpose in terms of quality.
    - The level of affordability for housing related support.
    - Changes in Housing Revenue Account (HRA) funding will happen from 2012, which may provide opportunities to release funds for investments.
    - The Council owns 75% of sheltered housing in the Borough. 80% of which is designated for occupation by older people.
- Most of the occupants receive housing related support, 90% currently receive Supporting People funding which has been cut nationally.
- There are a number of strengths and weaknesses identified:
    - **Strengths included:** - low number of bed sit style accommodation, high percentage of 2 bed sizes, some properties are very well located with good access to amenities.
    - **Negatives included**: - some properties are very poorly located, a substantial number of properties did not provide level access, several external and communal areas needed renovating and few properties have been specifically adapted with the needs of elderly and frail in mind for example wet rooms or low level

shower trays.

- Approximately half of the properties could be considered reasonable, one-third only part suitable and a fifth is unsuitable in current state.
- Consultation was conducted both with current and potential residents. Current residents respected and valued the service that they received but would like to see improvements in the quality of things such as kitchens and bathrooms. Steps into properties were also a problem.
- Potential residents would prefer more choice and would rather live in independent housing, not sheltered accommodation.
- Considerable investment is likely to be needed to make the properties fit for purpose. Some will be very difficult to improve. Options may include changing the amount of accommodation available, concentrate on a smaller amount of higher quality stock. Personal support could be split and determined based on individual needs across tenures.
- The use of community rooms could also be developed, involving use by a wider community.
- Any development strategy should be made in consultation with residents and stakeholders.

**3.11** **Acting Director for Community Services, Northants NHS Foundation Trust.**

- On 1 July 2011, services previously delivered by NHS Northamptonshire Provider Services were transferred to the Trust, making it the largest provider of NHS services in the county. This transfer takes the local NHS a step closer to fully integrated community physical and mental health services, better geared to meeting all of a patient's needs closer to where they live.
- Community Services is a general description that is used to cover a wide range of mental and physical health and wellbeing services provided to many, often vulnerable, people, families and communities. These services range from health promotion to end of life care, including falls prevention, health visiting, district nursing and community mental health services.
- The major opportunity arising from this change is to improve integration of services.
- A key priority of the Service is prevention, and the workforce needs to be made aware that that should be at the heart of everything that they do.
- Service delivery has to tailored to the needs of the client, different profiles apply to different areas of the county.
- Care models need to be developed on based on the whole needs of the client.
- As the service is provided by the NHS it is free at the point of delivery.
- Data analysis is being used more to target investment. Improvements in technology mean that it may more treatments can be delivered at home, or patients self manage their conditions.
- There has been a 57% increase in activity over the last couple of years. More clients have long term health issues. Crisis intervention is still at the heart of care provision, but the more people that are dealing with long term health issues the more important individual holistic health care

plans will be.

- Consultation happens at many different levels. Commissioners must supply a quality service, there are regular patient surveys and these are routinely used to develop services.
- Feedback received in the past has shown that fragmentation of services was seen as an issue. Case management is pivotal to maintaining effective levels of service.
- There is no discrimination, targets are often based on the over 75's but that relates to hospital admission levels and models used for that service provision is rolled out to other user groups.
- There needs to be more education that health care does not to be given in a hospital environment. More people need to understand that there are alternatives and choices to be made regarding their treatment. There is a perception that older people see hospital cars as traditional.
- There is a commitment to ensuring that whatever the targets, the care needs of the patient must be met. This may require more than just basic intervention, for example for someone with concerns about their nutritional state it could mean not just checking that they are eating but what food is in the house and whether it is safe.
- Partnership working is essential; it is the only way to build community capacity.
- Most referrals are made via GP's. There were 5,000 contacts in the last quarter and only 2 complaints. There are proactive care meetings as part of the care planning systems and every effort is made to prevent duplication and maximise the use of resources.

**3.12** **Chair, GP, Consortium, Nene Commissioning**

3.12.1 Key points of evidence are detailed at Appendix C. The three key priorities of Nene Commissioning are:

- Development of an integrated long term condition (LTC) model
- Further development of the Community Elderly Care Service
- Roll out of Personal Health Budgets (PHB) across Continuing Health Care (CHC)

**3.13** **Chair, shadow Health and Wellbeing Board and Portfolio Holder for Adult Social Care, Northamptonshire County Council (NCC)**

- The Intermediate Care Strategy, which is implemented in partnership with health services, is there to ensure successful outcomes for older people who are eligible for council support. This strategy is being implemented in partnership with health services.
- In 2005 NCC still operated a number of care homes, since that time they have moved away from direct provision and towards an enabling role. From April 2012 there will be an arms length company, which will be able to provide services to clients who are currently self funding care.
- More people are accessing services and more money is being spent

then ever before. Budget reductions may well mean that there hasn't been such a wide range of choice within services.

- A fairer charging policy has been introduced, which should allow for an improvement in services. Providers of services are being asked to demonstrate achievable outcomes.
- Contracts must be seen to be delivering good value for money no matter who the supplier was. A service delivered by the Young Men's Christian Association (YMCA), a million pound contract, had only delivered £700,000 of services. This contract has now been re issued. Voluntary sector organisations should not continue to hold contracts if they are not delivering value for money.
- There are also developments of new services for older people such as Crisis Response Service, Specialist Dementia Services and development of specialist residential service for older people with a learning disability.
- Bureaucracy must be reduced in order to ensure that the most vulnerable get the most services. If possible this can be improved by efficient use of local communities.
- NCC works in partnership with Care Choices Directory, which produces an annual directory of services.
- The Health and Well being Board is working on integrating services. This is working better in some areas of the county than others, and there are still issues to be sorted regarding discharging patients from Northampton Accident and Emergency.
- Investment in dementia care is very important; currently there are very few providers in that field. There needs to be a growth in that field and expansion of some of the Extra care facilities that promote independent living but do not accept dementia patients.
- NCC operates a banded charging policy, which enables older people to have an "indicative" charge prior to agreeing to a care support package.
- There are a wide range of methods used to consult on issues that may impact on Older People in Northamptonshire, including the Northants 50+ Network, which has more than 2200 members and 1700 group/organisation members.
- The Council undertakes Equality Impact Assessments and will take into account the impacts and possible mitigation to minimise or remove the impact for older people.
- The care services directory, carers' information booklets and leaflets on Living Independently are all available, numbers of additional leaflets have been reduced following the introduction of these three documents following customer feedback.
- Prevention/ early intervention, although important, needs to be examined carefully as there has to be a proper assessment as to where the benefit was being seen.
- NCC invested £1 million in 2009 on prevention pilots, from those has been the evidence and outcomes to continue funding some services for example SERVE rapid response service has been fully funded by Nene Commissioning as the benefits realised were to health.
- There are a higher percentage of people in residential care in Northamptonshire than anywhere else in the country. This is obviously the most expensive form of care and alternatives need to be considered.

- Funding will remain an issue; currently many of the people in residential care are self funding and using their assets to pay for care. Day care costs are based on a person's income.
- In March 2012 there will be an introduction of new social care proposals designed to encourage more people to remain in their own homes.

**3.14 Northampton Pensioners' Forum**

- The Pensioners' Forum was not aware of the details of the various Strategies, adding that there appeared to have been numerous changes, which made it difficult to keep up with the information.
- Help and assistance did not appear to be available.
- The Pensioners' Forum did not feel that older customers had a choice in terms of the services they currently receive. Services are not joined up.
- Often individuals will manage up to a point when they are desperate for assistance.
- The services that individuals receive are often dependent upon the recommendations of the individual's GP and can vary considerably.
- The Pensioners' Forum confirmed as not aware of the organisations that charge for their Services, advising that they would only be aware of this should they have the need to require such services.
- It would be useful for a leaflet to be available that detailed the services available together with the charging and criteria details.
- The Pensioners' Forum is consulted regularly by organisations and Agencies such as:
    - CAB
    - Bus Services
    - Refuge Services – NBC
    - NCC
    - NHS
- In the main the Pensioners' Forum felt that organisations did not provide good quality information to older people, but commended the Centre for Independent Living (CIL) advising that it produced an excellent directory detailing the services that it provides.
- The Pensioners' Forum felt that the following skills were required:
    - Patience
    - Life experience
    - Communication skills
    - Listening to older people
    - Involving older people in decisions
    - It is important for there to be regular activities and communication available for older people to help keep their minds active.
- Older people want to stay in their own homes.
- There needs to be communication between Agencies and Authorities.
- The Independent Living Strategy needs to be easy to read, in plain English.
- The document – "Wise Guide" produced by Independent Age, is an excellent document that provided details of a wide range of problems and was easy to read examples. It also provided contact details for the

various services and details of the different benefits available to older people.

**3.15 Flavell House, Northampton**

- Some people are aware there is something but have not read it-others were not aware at all
- It was felt that older people did not have much of a choice-more prescriptive and did not always meet their needs
- Northampton door to door, meals on wheels were mentioned-criteria not known
- The residents of Flavell House had not been consulted by Agencies
- On the whole it was felt that information was too lengthy/wordy and written in terms they couldn't always understand-pockets of good info but no-one could name
- Skills required by the workforce to meet future demands are:
- Listening
- To be non-patronising
- Treated as equals
- Communication skills
- Easy to read and understand info required
- Better communication between Agencies

**3.16 Case Studies**

3.16.1 The Scrutiny Panel visited various older people living in Northampton to ascertain details of their experiences of independent living. Details attached at Appendix D.

**3.17 Age UK Northamptonshire – Little Helpers' Project**

3.17.1 Case studies of individuals receiving assistance through the Little Helpers' Project was provided. Details contained at Appendix E.

**3.18 Northampton Borough Council's draft Affordable Warmth Strategy**

3.18.1 The Scrutiny Panel was consulted upon Northampton Borough Council's draft Affordable Warm Strategy and provided input during the consultation period:

- The Scrutiny Panel agreed with the proposed priorities with the draft document.
- The Strategy will help to tackle fuel poverty in Northampton. Anything that gives residents access to more information can only be helpful.
- It is not the responsibility of Northampton Borough Council alone to provide these services; it needs to be done with a series of partners. Overall there is a responsibility to help people to overcome fuel poverty but not necessarily provide it. Government grants are being reduced; more private financing could be investigated.
- All elderly and vulnerable people should be given priority regarding assistance with lowering their fuel bill and improving energy efficiency in

their homes regardless of tenure

- Consideration could be given to Northampton Borough Council allocating grants if finance could be found from other sources. Work is already done in partnership with credit unions.

**3.19 Site Visit – Centre for Independent Living (CIL), Northampton**

3.19.1 Main points of evidence:

- The CIL is a free Service and it promotes that it is open to everyone. There is no formal referral process.
- Drop in days are held during the hours of 10am to 3pm on Tuesdays at Northampton and Thursdays at Corby. However, anyone can make an appointment with a time to suit them.
- The Services offered by CIL includes:
    - Disability information
    - Equipment Display area
    - Welfare Benefits
    - Carers Information
    - Disability Rights
    - User Engagement
    - Citizen Leaders
    - Personalised support
    - Personalisation payroll
    - Training and consultancy
- There is a real need to engage with carers to ensure that CIL provides the right support in a sensitive way. Financial support is available for carers. Individuals are also signposted to organisations for further assistance.
- CIL does not sell the equipment but will refer individuals to suppliers. Suppliers will demonstrate how the equipment works and provide good aftercare support.
- A wheelchair hire Scheme will be in place by the end of 2011 at Northampton and Corby and is expected to bring in approximately £5,000 per year.
- There is a need for CIL to promote its work through various forms of medium. It does however work with schools so that they are aware of its work and the responsibilities of carers, in particular young carers. A poster will be produced and disseminated to GP surgeries providing details of the services offered by the CIL.

**4 Equality Impact Assessment**

4.1 The Scrutiny Panel was mindful of the eight protected characteristics when undertaking 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 Review progressed and evidence gathered.

4.2 The development of an Independent Living Strategy could have adverse and positive impact on the eight protected characteristics. However, as no Equality

Impact Assessment can be completed yet for the development of such a Strategy, its impact on these groups has not been subject to a detailed level of scrutiny.

4.3 The Scrutiny Panel acknowledges the need for a full EIA to be produced for the Independent Living Strategy.

## 5 Conclusions, Key Findings and Emerging Themes

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

5.1.1 The Panel recognised that the Review of Sheltered Housing undertaken by CIH Consulting was a key piece of work in developing the Council's future housing strategy. The findings were not a surprise and would form the basis of further consultation as the future of the sheltered accommodation was considered.

### Emerging Key Themes

**Actions to plan for the future demands of Older People**

5.1.2 Demographic changes will result in people living longer, but not necessarily healthily, therefore demands on health and social services will be acute. It is clear that all Councils will need to have very robust Strategies and Plans in place to help older people remain independent for as long as possible and to deliver the appropriate support.

**Definition of Independent Living for Older People**

5.1.3 After receiving a variety of example of other organisation's and Agencies' definitions of independent living for older people, the Scrutiny Panel felt that its definition should be short, concise and easy to read:

> "Independent Living is about enabling older people to have a voice, choice and control over any support they need in order to maintain an active, healthy and quality lifestyle that is suitable for their needs and which promotes positive ageing and wellbeing."

**A Joined up approach with Agencies/partnership working to achieve the right service at the right time**

5.1.4 Evidence gathered showed that there is a need for all partners to work together to achieve effectiveness and efficiency savings.

5.1.5 There is duplication and waste in terms of the way services for older people are currently provided via a range of different organisations. Northampton Borough Council and key partners do not currently provide joined up and accessible information for people to plan for older life.

**Charging for Services**

5.1.6 Very few services are now provided free of charge and a range of fees are applied. There is a need for older people to understand what is being provided for the fees charged and to ensure that the quality of those services is regularly monitored.

5.1.7 The Scrutiny Panel recognised the potential for individuals to access services via their personal budget arrangements.

**Education**

5.1.8 Generally older people perceive hospitals as the best and correct place to receive health care and often they are not aware of the number of available, more appropriate levels of assistance. There is a need to educate people and promote the right level of care and support depending upon the health need.

5.1.9 Preventative action and health education are key issues to include in the Independent Living Strategy for Older People, such as informing people of the potential harmful effects of drinking alcohol and smoking.

5.1.10 The Scrutiny Panel understood the importance of particular organisations and groups, such as the Northampton Older People's Forum to provide support within the community on health initiatives.

**Low Level Support Initiatives**

5.1.11 The evidence received from a variety of key expert witnesses highlighted the need to prevent higher cost services being required until much later in life, or not at all.

5.1.12 The Scrutiny Panel acknowledged that prevention is more than merely promoting initiatives and is about the range of support services tailored to individual needs.

**Choice**

5.1.13 Generally older people do not receive comprehensive information about the services that are available to them and/or are confused by the different services and way in which individuals are assessed as being eligible for services.

5.1.14 There is limited choice that can currently be exercised by older people in respect of the services that are available.

**Getting Users Involved**

5.1.15 The general perception of older people is that they do not feel listened to and that they do not have sufficient choices about the services that affect them. In order that involvement and consultation are effective, they must be meaningful and recognisable to older people. It often appears that people can suffer `consultation fatigue' by being consulted by various different Agencies, in a variety of ways, on similar topics. There is a need for the Agencies to be smarter around how they consult on similar issues.

5.1.16 The Scrutiny Panel realise that older people have not been as involved in the development of the Strategy so far, despite a number if invitations to representative organisations to take part and felt that their involvement and input was required.

**Tackling Age Discrimination and Inequality**

5.1.17 Evidence has highlighted that more needs to be done to tackle age discrimination in services for older people. The value of an Older People's Champion was recognised.

5.1.18 The evidence further emphasised that that not all partners have policies tackling age discrimination.

**Social Isolation**

5.1.19 A significant percentage of older people in the population are socially isolated and do not receive support or contact with friends, relatives or the wider community.

5.1.20 The evidence gathered emphasised the important role of for the community and volunteers in helping older people, for example providing assistance with shopping and gardening.

5..1.21 There is a clear link with the quality of home and neighbourhoods when looking at the total package of support for an older person.

**Sheltered Housing**

5.1.22 Northampton Borough Council is currently undertaking a review of its sheltered housing services for a number of reasons including the suitability of the accommodation and the uncertainty around the future funding.

5.1.23 The panel felt that the Review should take account of the recommendations of this Strategy Review when deciding on the stated of Sheltered Housing.

5.1.24 The needs of older people should be taken into account when new housing is being designed and developed.

5.1.25 From a district perspective, adult and social care requirements cannot be met without looking at housing needs and the provision and requirement of leisure activities. The Scrutiny Panel acknowledged that the Head of Strategic Housing has a clear remit to work with Adult and Social Care to ensure there is synergy between housing needs and those of Adult and Social Care. The Panel highlighted the need for this to be strengthened.

**Equality Impact Assessment**

5.1.26 The Scrutiny Panel felt that older people should be involved in the monitoring the Equality Impact Assessment for the Independent Living Strategy for Older People, for example the Northampton Pensioners' Forum or a specifically convened Group of older people.

**Scrutiny Review – Reflection**

5.1.27 Upon reflection, the Scrutiny Panel felt this Review had made some very important conclusions, key themes and recommendations. It was realised at the scoping stage that independent living was a vast topic and therefore narrowed it down to independent living for older people over the age of 65. This provided a clear focus for the Panel to work from.

5.1.28 The Panel devised its definition of independent living which again provided focus to the Review.

5.1.29 The Review was focussed on plans for the future.

5.1.30 The Panel received evidence from a wide range of external and internal witnesses and used the Centre for Public Scrutiny (CfPS)'s Guide for Scrutiny Committees; *A Good Place to Grow Older?* ¸as a basis for its questions. In assessing the questions asked and the evidence received, the Panel realised that there was a need to modify the questions and connect with the evidence. A further question was therefore asked of key witnesses, regarding their top three priorities for an Independent Living Strategy.

5.1.31 The Panel shared details of its draft conclusions, emerging themes and recommendations with partners who had provided expert evidence to inform the Review and asked for their feedback on these findings prior to the Panel agreeing its final report.

5.1.32 In looking how the Review process could have been improved, the Panel felt that older people groups could have been involved. It was acknowledged that contact had been made with the local Pensioners' Voice Group and there is a need to ascertain whether Pensioners' Voice would like to be involved in the development of an Independent Living Strategy.

5.1.33 This Review demonstrates the importance of an Independent Living Strategy for the Council.

## 6 Recommendations

6.1 The purpose of the Scrutiny Panel was to evaluate the draft Independent Living Strategy for older people and make recommendations for development of this Strategy and its scope.

Scrutiny Panel 2, Independent Living Strategy, therefore recommends to Cabinet:

That the Strategy should contain a principle setting out the need for this to take place. There is a further need for the Council and its partners to have a common strategic framework regarding independent living for older people.

The Scrutiny Panel agreed that this should be a key part of the Strategy and that the role of Northampton Borough Council could be to enable this to happen as part of the wider county work.

**Independent Living Strategy**

6.1.1 That Northampton Borough Council's Independent Living Strategy is fit for purpose, containing a comprehensive Action Plan for the future delivery of services to older people.

6.1.2 That Northampton Borough Council's Independent Living Strategy reflects the emerging themes from this comprehensive Overview and Scrutiny Review as detailed in section 5 of the report.

6.1.3 That the title of the Independent Living Strategy should be *"Northampton is a good place to grow old'".*

6.1.4 That the Scrutiny Panel's definition of independent living be included within the Strategy:

> "Independent Living is about enabling older people to have a voice, choice and control over any support they need in order to maintain an active, healthy and quality lifestyle that is suitable for their needs which promotes positive ageing and wellbeing."

**Partnership working**

6.1.5 That all relevant organisations in Northampton seek ways to work together to support older people to live independently, this would include opportunities to establish integrated assessments and locality based teams.

6.1.6 That key Agencies in Northampton work towards a common approach to gathering and sharing data, including establishing a shared approach to involvement and engagement.

6.1.7 That funding is identified and maximised by the Council, from a range of organisations, to support Low Level Support Initiatives that can demonstrate their effectiveness in preventing more costly services being required.

**Working with Older People**

6.1.8 That clear and comprehensive information is made available to older people in ways in which they can easily access it and is test driven by older people before being implemented.

6.1.9 That older people be asked how they would like to be involved and consulted with (or engaged with), through Groups such as the Northampton Pensioners' Forum, so that Northampton Borough Council respond appropriately.

6.1.10 That Northampton Borough Council has a robust Policy in place, promoting positive messages that tackle age discrimination and inequality amongst older people.

6.1.11 That Northampton Borough Council appoints a Councillor as its Older People's Champion and local older people representatives from each of the four areas of the town.

6.1.12 That Northampton Borough Council provides opportunities for older residents and their representatives in the community to receive and/or give support to others by promoting self help and community support and reducing social isolation.

**Service Delivery**

6.1.13 That services are designed around the needs of the customer.

6.1.14 That there is a need to manage expectations of services with a greater emphasis on clear signposting to the most appropriate service to meet particular needs.

6.1.15 That the Housing Strategy makes adequate provision within its new build programme for older people's accommodation, and that older people are involved in identifying what this might look like.

6.1.16 That it be formally acknowledged that the Head of Strategic Housing, Northampton Borough Council, has a clear remit to work with Adult and Social Care, Northamptonshire County Council, to ensure there is synergy between housing needs and that of Adult and Social Care.

**Sheltered Housing**

6.1.17 That by recognising the role of sheltered housing in enabling older people to live independently that sheltered accommodation for older people is of an agreed standard and fully accessible and that it meets the needs of older people and recognises the needs of older people to live independently.

6.1.18 That some schemes should be solely for individuals over the age of 65 as a life style choice.

6.1.19 That individuals should receive support to live independently regardless of the accommodation that they are living in and according to their need.

**Funding Opportunities**

6.1.20 That Northampton Borough Council maximises the funding opportunities available to support initiatives for older people, such as Healthy Homes for Older People.

6.1.21 That where charges for services for older people are applied, clear information is provided to assist people in understanding what they are paying for.

**Monitoring**

6.1.22 That a comprehensive Action Plan comprising key timescales and milestones is produced to address all recommendations contained within this Overview and Scrutiny report.

6.1.23 That older people are involved in monitoring the Equality Impact Assessment for the Independent Living Strategy for Older People.

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

# Appendices

NORTHAMPTON
BOROUGH COUNCIL

**Appendix A**

# OVERVIEW AND SCRUTINY

## SCRUTINY PANEL 2 – INDEPENDENT LIVING STRATEGY

## 1. Purpose/Objectives of the Review

To evaluate the draft Independent Living Strategy for older people and make recommendations for development of this Strategy.

## 2. Outcomes Required

- A fit for purpose Strategy to address the needs of the ageing population to live independently in Northampton
- The development of a joint Independent Living Strategy with key Partners in Northamptonshire
- A clear definition of Independent Living

## 3. Information Required

- Context:
  - Local statistics –
  - Demographics – national and local
- Housing profile
- National position
- Financial statistics/Funding decisions – decommissioning, reconfiguration of Health and Social Care
- Synopses of various research documents and other published documents
- Data from other (best practice) Local Authorities
- Published Guidance
- Evidence from internal Officers
- Evidence from appropriate external witnesses
- Evidence from partners
- Site visits and desktop research

## 4. Format of Information

- Officer reports/presentations
- Baseline data such as:

    - Total Place
    - Big Society
    - Low level intervention and prevention
    - Social Housing Reform Agenda
    - Localism Bill

- Published reports such as:

    - Select Committee Report on dementia
    - Centre for Public Scrutiny Reports: A good place to grow older?
    - National Housing Federation: Breaking the mould
    - Affordable Warmth Strategy

- NBC - Portfolio Holder (Housing) evidence
- NCC - Portfolio Holder ( Health and Adult and Social Services) evidence
- Evidence from various representatives of Northants Health including GPs
- Evidence from Age UK
- Evidence from Pensioners' Voice
- Evidence from Adult and Social Care, Northamptonshire County Council
- Evidence from the Health and Wellbeing Board, Northamptonshire County Council
- Evidence from CIH Consulting
- Expert advice
- Best practice evidence external to Northampton
- Witness interviews/evidence

## 5. Methods Used to Gather Information

- Minutes of meetings
- Desktop research
- Site Visits (if applicable)
- Centre for Public Scrutiny Workshop – *"A good place to grow older?*"
- Officer reports
- Presentations
- Examples of best practice external to Northampton
- Witness Evidence:-

    - Key Partners
    - Key Officers

- Portfolio Holder (Housing) – Northampton Borough Council
- Portfolio Holder (Health and Adult Social Services) – Northamptonshire County Council

## 6. Co-Options to the Review

Suggested Co-Option:

- Chair of Northamptonshire County Council's Health and Social Care Scrutiny Committee

### 7 Equality Impact Screening Assessment

- An Equality Impact Screening Assessment to be undertaken on the scope of the Review

## 8 Evidence gathering Timetable

July 2011 to February 2012

- 13 July 2011- Scoping Meeting
- 15 September – Evidence gathering
- 19 October - Evidence gathering
- 7 December – Evidence gathering
- 11 January 2012 – Evidence gathering (if required)
- 15 February – Approval of final report

Various site visits will be programmed during this period if required.

Meetings to commence at 6.00 pm

## 7. Responsible Officers

Lead Officer Fran Rodgers, Head of Strategic Housing

Co-ordinator Tracy Tiff, Scrutiny Officer

## 8. Resources and Budgets

Fran Rodgers, Head of Strategic Housing, to provide internal advice.

## 10 Final report presented by:

Completed by 15 February 2012. Presented by the Chair of the Panel to the Overview and Scrutiny Committee and then to Cabinet.

## 11 Monitoring procedure:

Review the impact of the report after six months (September/October 2012)

**Appendix B**

**NORTHAMPTON BOROUGH COUNCIL**

**OVERVIEW AND SCRUTINY**

**SCRUTINY PANEL 2: INDEPENDENT LIVING STRATEGY**

**Core questions**

1 Please can you describe your organisation's strategy or strategies in relation to older people?

2 What actions is your organisation taking to plan for the future demands of older people?

3 What skills are going to be required by your workforce in order to meet these demands?

4 How much choice do your customers have in terms of the services you provide for them?

5 Do you charge for your services, if so, what criteria do you apply?

6 How do you consult with older people in your organisation?

7 Are you proactive in tackling age discrimination and inequality? Please give examples?

8 Does your organisation provide good quality information to older people? Please give examples?

9 Does your organisation embrace the principle of low level support and prevention initiatives to delay the need for more costly services for longer? Please describe any initiatives that you are involved in.

10 Are there opportunities to work in partnership with others to achieve efficiency savings? If so who?

11 Any additional comments?

Dated: 22nd September 2011

**Appendix C**

**NORTHAMPTON BOROUGH COUNCIL**

**OVERVIEW AND SCRUTINY**

**SCRUTINY PANEL 2: INDEPENDENT LIVING STRATEGY**

## Core questions

### 1 Please can you describe your organisation's strategy or strategies in relation to older people?

Nene Commissioning via the Northamptonshire Integrated Care Partnership has developed, commissioned and implemented the community elderly care service (CECS) as a quality driven, systematic approach to delivering care for the elderly. CECS is designed to address acute service pressure particularly in the area of emergency admissions, and manages and redirects care where appropriate to the community for patients aged 75+. The service delivers a responsive appropriate alternative to hospital admission through the use of an extended Integrated Care Team and works flexibly with consultant geriatricians and psycho-geriatricians to enable the delivery of care at home and in the community.

CECS commissioned 18 Specialist Care Centre (SCC) beds with enhanced medical and nursing support to offer an appropriate alternative to hospital admission for elderly patients with "sub-acute" medical needs. NCC has reinvested funding to provide additional Care Managers and a dedicated START team in each SCC, enhancing the service received by patients and focusing on implementing earlier discharge, and ensuring patients receive the care they require in a timely manner whilst in a setting that is appropriate to their needs.

CECS has used an evidence base to support the development of its care model and capacity and demand planning. For example data from the Office for National Statistics (ONS) predicts that the total number of patients aged over 75 years will rise by 15% by 2015. The most significant change in the age profile in Northamptonshire is the increase in the numbers of older people. It is predicted that this is so large that it will require that the types and number of services, and the way they are delivered, will have to change if needs are to be met effectively and efficiently. It means that any level of over-reliance on institutional services (such as residential and nursing care) to reduce and prevent emergency admissions will be unsustainable, and requires an acceleration in the development of services that improve the quality of life for older people and improve their health and wellbeing.

During March 2010 an audit was undertaken 8625 individual emergency admission spells of patients aged 75+. The audit suggested that a total of 1613 patients presented with conditions that potentially did not necessitate an in-patient hospital stay. This evidence was used to plan the future demands on health and social care for patients and develop the CECS model to deliver the most appropriate level of care, in the most appropriate setting to meet the needs of patients/service users.

### 2 What actions is your organisation taking to plan for the future demands of older people?

CECS is an integral element of the health economy's demand management strategy, which is addressing acute service pressure particularly in the area of emergency admissions, and managing and redirecting care where appropriate to the community.

CECS combines a range of projects which are interdependent and required the simultaneous, on-going development of all projects to optimise success:

1. Deployment and integration into ICT of specialist Consultant Geriatricians and Psycho-geriatricians
2. Expansion of Intermediate Care Teams (ICT)
3. Reclassification of SCC Beds including the development of 4 outreach teams attached to each SCC funded through reinvestment of released resources
4. Links to Dementia Strategy
5. Development of Chronic Disease Management (CDM) model for diabetes and COPD
6. Investigation into the development of a community based assessment unit for frail, elderly patients
7. Assignment of community bed stock through Transforming Community Services (TCS)
8. Countywide Falls review and resultant service change
9. Redesign of rehabilitation / re-enablement services and resultant service change

## 3 What skills are going to be required by your workforce in order to meet these demands?

Education and training of staff groups is considered to be imperative to the delivery of quality services for older people. The organisations involved in delivering the CECS model have a range of staff grades/bands that currently have differing competencies and training opportunities. The CECS team is establishing agreed standards in staff competencies and joint ongoing training so that care is delivered in the most appropriate manner by the most appropriate staff grade.

Examples of this are:

Shaw Healthcare (who deliver the “CECS” SCC beds) have received the following training from NGH to support delivery of care into the “CECS” beds:

- Early Warning Scores/AVPU/Patient assessment
- Acute and chronic renal failure an overview
- Tissue viability & basic wound care
- Venepuncture
- Cannulation
- ACS/ assessment of Chest pain & Basic ECG recognition
- Stroke pathway and basic stroke care
- EWS/AVPU/Patient Assessment
- Diabetes overview
- The breathless patient an assessment/Overview of COPD
- Continence Assessment

In addition to this training delivery both NGH and KGH have supported Shaw Healthcare staff attending phlebotomy clinics to accelerate the sign off of competency to practice phlebotomy.

There is ongoing work as part of CECS to review competency frameworks for all service providers to ensure comprehensive, outcome focused training needs analyses can be generated and actioned to ensure staff have the relevant training to enable them to deliver patient centred care for patients as part of CECS.

## 4 How much choice do your customers have in terms of the services you provide for them?

CECS has enhanced choice available to elderly patients in Northamptonshire by offering real alternatives to hospital admission where appropriate for patients. Examples of this are the 18 SCC CECS beds which are available for patients in the community to be “stepped up” into in situations where they require more support than available at home, and where previously an admission to an acute medical ward or medical rehab ward would have been one of the only other available options. Likewise patients in hospital can be “stepped down” into these beds from A&E or medical admissions wards as an alternative to a hospital admission.

There are systems and processes in place at the SCCs to support patient choice in regards to information management and record sharing.

The significant increase in the ICT workforce has also meant that more elderly patients are being cared for in their own home, an example of this is:

Week commencing 14/2/11 ICT had a caseload of 242 patients compared to 140 patients for the same week in 2010, this represents a 73% increase in caseload of patients being cared for in the community.

## 5 Do you charge for your services, if so, what criteria do you apply?

CECS is an NHS service and therefore is free at the point of access to all patients

## 6 How do you consult with older people in your organisation?

Consultation document produced for Nene Commissioning's associate members summarising proposals and asking for three specific inputs:

- Views on existing services for frail elderly
- Views on CECS proposal
- Views on any additional change needed to make the proposals work

Briefing circulated to Nene Commissioning's 50+ Associate Members (individuals and groups with an expressed interest in the development of local primary care based health services)
Overall Feedback– poor experience of current services due to fragmentation, poor communication and slow responses. High level of support for CECS proposals with emphasis on easy access, support closer to home, engagement of carers and genuine integration.

Key messages from responses on current care:

- Current services not "joined up"
- Cross-communication between services poor – particularly on discharge
- Access to social care, physiotherapy and necessary equipment "slow and poor"
- Insufficient support and care available at home and lack of assessment in own home
- Lack of engagement of carers in care planning
- Services "sometimes, but not always, fragmented, inconsistent, unavailable, untimely, expensive, and out of date"

Key messages on CECS proposal:

- "Should resolve most if not all" of the existing problems
- "I am really pleased that improvements are underway"
- "The service you describe sounds like a big step in the right direction"
- "I am pleased to see that a care plan developed around the specific needs of the carer and patient will be undertaken"

Key messages to guide/influence proposals:

- "lack of a comprehensive county-wide falls and fracture liaison service"
- "better link between GPs and social services as the home-help situation is sadly lacking"

- "I hope the role of family carers will be part of the overall picture of the care plan for frail elderly people"
- Needs a mobile team to respond, recognising the difficult frail and elderly people have of accessing services
- Need more staff and more community beds
- Must ensure genuine integration e.g. staff recruited with the correct motivations and skills, given the necessary resources, given clear roles and responsibilities and who are trusting of each other

In addition to this key developments in the CECS project has been discussed and reviewed at Nene Commissioning's patient public council to ensure that the public and key stakeholders have had an opportunity to influence the development of the service model.

## 7 Are you proactive in tackling age discrimination and inequality? Please give examples?

CECS has improved patient experience and seen an increase in the quality of service patients receive by reducing the risk of complications associated with extended hospital inpatient stays, such as hospital acquired infections, reduced mobility and independence echoing NHS Commissioning standards "to add life to years and years to life".

CECS used analysis of hospital admission data across the county and nationally to inform its model. When analysing the socio- economic influences on emergency admissions in Northamptonshire those patients under the age of five and those above the age of sixty-five experience high admission rates. In this older group the rate of emergency admissions rises markedly with age. Admission rates in the oldest age group (85+) are more than five times greater than the PCT average, and more than ten times greater than the rate amongst the 5 – 14 age-group.

In Northamptonshire there are over 47,000 people over the age of 75 years and over 26% of these experienced a hospital admission last year. The national picture concords with this finding as there are increasing numbers of elderly admissions with long lengths of stay, with 52% of frail elderly and 30% of >70s readmitted within 3 months. The local audit of >75 elderly frail patients showed that 22% of patients locally had been admitted to hospital in the previous 8 weeks. >50% of elderly, frail patients experiencing an emergency admission also suffered with Diabetes, COPD and / or Heart Failure.

In 2008/09 there were 53,009 emergency admissions across both Northampton General and Kettering General Hospitals, of these 24% (12,656) were aged >75 years and over. Of the total number of A&E attendances it is more likely that the attendance will result in an admission to hospital for elderly patients than those who are younger.

Historically intermediate care services were commissioned differently across the county. The south of the county has never received the investment in ICT at the same level as the north and therefore start at a much lower base. The service in the south had a greater focus on rehabilitation and therefore average length of stay in the service is much longer than the north team average.

CECS has addressed the in-balance across the county by redesigning and refocusing the current model to deliver rapid responsive crisis management services 13 hours per day, 7 days a week responding to referrals within 3 hours. In summary by ensuring that elderly patients have access to senior clinicians in the most appropriate setting who are able to develop comprehensive, holistic care plans, and that there is an Multi disciplinary ICT team in the community to deliver these plans CECS is tackling inequality around elderly patients pathways and access to appropriate medical services.

## 8 Does your organisation provide good quality information to older people? Please give examples?

The Provider's involved in delivering the CECS Model (Kettering General Hospital, Northampton General Hospital, Northamptonshire Healthcare Trust, Northamptonshire County Council and Shaw Healthcare) each have patient information leaflets for their part of the CECS pathway pertinent to the service user.

As patients may access different parts of the "CECS" pathway discreetly there is no specific overarching patient information leaflet. This could be developed in the future.

An example of how Nene as a commissioner has commissioned services to ensure good quality information is the section from the SCC CECS beds service specification below:

*Patients and their carers should be provided with the ICS patient information leaflet (if they have not already received it), have any concerns or questions addressed, and be aware both that their records from ICT and their GP will be shared with the SCC and that their SCC records (at least Individual Care Plan and Discharge Letter will be sent to other service units. They should also be provided with relevant information leaflets and personal explanations about their ongoing care, medications, and exercise regimes to help them manage their condition.*

The passage below is from the ICT service specification we have commissioned for CECS:

*Following assessment a goal/treatment plan is developed with the client/patient, their carers/family and the team, this details their needs, goals and treatments/interventions, this plan is continually reviewed to meeting the needs of the client. Visits are arranged between the clients and the appropriate Intermediate Care Team staff to undertake the plan and reviews, the length, duration and frequency is dependant on the clients presenting needs.*

## 9 Does your organisation embrace the principle of low level support and prevention initiatives to delay the need for more costly services for longer? Please describe any initiatives that you are involved in.

SCC capacity has been reconfigured into step down and if required step up beds for patients with health needs. Furthermore and in order to enable patient flow, NCC have reinvested funding to provide a dedicated Care Manager and a Short Term and Rehabilitation Team (START) to each of the 4 SCCs. The START will support patients in their own homes by providing help with personal care and daily living tasks. This care package will enhance the current service available to patients, will focus on implementing earlier assessment and hence enable discharge, and deliver timely and appropriate care that meets the need in the right setting. The service will operate between 0700-2300 hrs, 365 days a year.

During their stay service users, where it is safe for them to do so, will be encouraged to undertake as many activities of daily living as is appropriate to their medical and physical conditions which may include self management of medications. Service users undergoing active rehabilitation will be involved in regular goal setting meetings at which they will agree a plan of activities that they can either do by themselves or assisted by staff. Service users may be given exercises by therapy staff appropriate to their needs. The therapy staff will include Physiotherapists, Occupational Therapists or Speech and Language Therapists. Rehabilitation assistants will also encourage or help service users with exercises or activities as prescribed by the therapists.

Each service user will have an Individual Care Plan which will be assessed regularly and agreed with the patient wherever possible. Once an individual is soon to, or has reached an optimum level of independence. By providing this alternative to hospital admission CECS has demonstrated the principle of delivering "low level" support in the community, with access to medical resource where appropriate, is an effective alternative to more costly services.

## 10 Are there opportunities to work in partnership with others to achieve efficiency savings? If so who?

There are definitive opportunities to develop the integrated working model established in CECS to deliver high quality, appropriate, cost effective care to patients/service users.

Examples of where this is currently under implementation are the development of CECS multi-disciplinary team meetings with acute, community and social care to support care planning and delivery for patients with long term conditions in the community.

Work is also underway to assess the viability of offering specific CECS/ICT support to 3 residential and nursing homes in Northamptonshire as a pilot to reduce the reliance on emergency ambulances and secondary care.

Staff involved in delivering CECS have also been involved in the implementation of the "section 256" schemes aimed at delivering social care projects which have both a social and health care benefit, for example the crisis response team which involves ICT.

Ongoing work streams could include integrated falls and falls prevention models, dementia care, specialist care centres, care homes, community nursing/care management, psychiatric liaison services, personal health budgets, difficult to reach groups, palliative care, community intravenous therapy models, expansion of community geriatrics as well as general medical community rehabilitation, for example neurological, cardiac etc.

## 11 Any additional comments?

Winning the National Association of Primary Care Award for best outcome focused redesign, and being shortlisted for the Health and Social Care category of the LGC Awards represents national recognition of the hard work and strategic vision of all those involved in designing, developing, implementing and delivering the CECS model. By focusing the care model on patients and recruiting staff who have the skills and knowledge to assess and implement personalised care plans CECS has been able to improve outcomes for patients, and also efficiency for the health and social care economy.

By commissioning integrated care pathways, care can be truly patient focused, and improve efficiencies by enabling providers to concentrate on delivering health and social outcomes together for individuals as opposed to "silo working".

Dated: 2nd December 2011

**Appendix D**

## Case Studies

Councillors have provided the following case studies. Names of individuals have been changed.

**Ron** is 81 years old retired builder and lives with his 79 year old wife in a bungalow. He suffers form Altzeimers Disease and has severe Parkinsons. He has a bed hoist, specially adapted chair and bed and a commode all supplied by Daventry Physiotherapists following assessments.

Ron has two carers who attend twice a day seven days a week throughout the year including all Bank Holidays. His wife cannot praise them enough. They get him up in the morning and shower and dress him and put him in his specially adapted chair. Two carers at night come to toilet him and put him into his pyjamas and into bed. His wife does all the cooking, medication, feeding (he has to have all his food liquidised as he has difficulty in swallowing) and laundry and all other household duties and any other requirements.

Once a week on a Monday he goes to Eleanor House in Booth Lane which is a dementia care specialist unit. He travels via specially adapted community transport. This is the only day that Ron's wife has as respite. These days are very precious to her as it is the only time she can leave the house to shop for food and attend any appointments for herself.
She says he is "the perfect husband and it is only fair that she looks after him!"

**Katie** is 98 years old and a former school PE Instructor. She lives with her son and daughter-in-law in a specially adapted granny annexe attached to the main house. She has dementia, urine incontinence and is very unsteady on her feet. She walks with a Zimmer but if she goes out she walks with a stick as pride takes over! She can only walk very short distances.

She has been assessed by Daventry and has a Medic Alert cord around her neck (as she is prone to falling), a riser chair and an especially adapted raised seat toilet and hand rails. Inco pads are delivered free on a 'demand' basis from Daventry.

Katie attends Chapel House Day Centre in Moulton once a week on a Thursday (£12.00 a session) and collected by taxi arranged by NCC. A chiropodist calls once every 6 weeks (£15) and a mobile hairdresser once a week (£10).

A private carer calls twice a day during the weekdays. In the morning to get her up, bathe, give her breakfast and change her inco pad, and at lunchtime to give her some food and a drink and to change her pad (her son and daughter in law both work in the week but look after Katie at the weekends).

Katie is on medication but is incapable of taking it herself or of making any meals or drinks for herself although she can put herself to bed! It is doubtful if she understands what the emergency cord is for that is around her neck although she can remember the past as clear as a bell!

**Pop** is 97 years old and is a retired farmer. He is an exceptional case! He is independent and lives alone. He has a lady who cleans his flat once a week and his son and daughter-in-law keep an eye on him. He walks to the shops every day using a wheeled shopping basket which he sits on if he gets tired.

Pop is a man of routine and he goes out for a coffee and then out for lunch and has tea out too! He has a firm belief that he must keep moving and must keep active. He has no ailments and only takes a ¼ of an aspirin daily. He has a medic-alert but he refuses to wear it. Pop had a quadruple bypass 13 years ago when he conveniently collapsed in a hospital car park and has never looked back since! He continued combine harvesting way into his seventies.
His daughter-in-law calls him ”a survivor”!

The interviewee lives in the Kingsthorpe area. She is a widow in her 80’s who lives in her own house. She has diabetes.

She was asked which things enable her to live independently. She thought that the most important things are:-

1. Good information. Knowing where to go if she needs help.

2 Good medical care. She is very satisfied with her local G.P. who monitors her diabetes and makes any necessary appointments with the hospital.

3 Security. Knowing where to go if there are any problems.

4 Good neighbours. Local people help each other.

**Appendix E**

## Age Uk – Little Helpers' Scheme

# Case Studies

## Case Study 1

Client suffers with renal problems, multiple sclerosis and severe depression. She lived on jam tarts, coca cola and some days never got up, refusing help from M.S. nurses, Age UK staff and the council, sometimes not letting them in.

Little Help gradually befriended client and it materialised that the client was embarrassed to let people in because her house was in a mess. Little Help did a one off blitz clean and put in a regular domestic carer. The cleaner has become a good friend and looks out for the client informing us immediately of any problems. Little Help also used the Handypersons Services to put up a rail, paint, decorate, put a washing line up and install a cat flap for the clients 4 cats.

Although all of this had a positive affect we discovered the clients deep depression was exacerbated because she was not taking her medication. Little Help telephoned twice daily to remind her and to get the client into a routine of taking her tablets. Little Help also accompanied her to have steroid injections for her m.s. and also at the client's request sat in to take notes when obtaining test results from her specialist in case she does not remember all that is said. Little Help liaised continually with health professionals throughout.

The client has family problems and would like to find her missing son. Little Help contacted the Salvation Army on her behalf and helped register her son's details.

Regarding the client's unhealthy diet, she agreed for Little Help to refer her to Meals on Wheels and the client began to gain weight. She felt she would like to go out occasionally, especially on her birthday so Little Helper arranged for a volunteer to take the client to a coffee shop and short shopping trips.

The client was interested in computers and Little Help arranged for SCOPE to install a computer enabling the client to access the internet. The client is now compliant enough to be able to shop on the internet and this in turn helped with her depression and gave her something to think about when she felt low.

In time the client's confidence returned and a milestone was achieved when she went out on her own in a taxi to meet a friend. The client has now registered herself with the Volunteer Car Service but we still accompany her on important medical appointments if she needs reassurance.

Unfortunately the client's health will never improve and after many relapses is now at the stage of needing daily personal care. The client struggled with paying for personal care so Little Help did a benefit check to ensure she was getting all of her entitlement and liaised with Social Services for a full assessment. Little Help successfully assisted the client in gaining

her full entitlement to Self Directed Support payments. The client now has complete control over her care and stated that she has had the best Christmas ever.

The easing of her financial pressures lowered her stress levels which in turn helped her depression and m.s. thus breaking the circle of events.

## Case Study 2

Mr P was referred by Advanced Nurse Practioner as client had many small strokes and was prone to falls and completely lost confidence to go outside. After a meeting with the Falls clinic and the ANP it was decided for a Little Help homecare assistant to visit, befriend and accompany client on short walks. A full OT Assessment was done before any further action and the client began to take short walks outside his home when he felt well and able. Little Help continually liaised with health professional if there were any problems.

The client was receiving a large amount of scam mail where he was duped into parting with a large amount of money. Little Help helped client to change his telephone number and client agreed for Little Help to write to the senders of the scam mail to take his details off their mailing lists, many of which were from overseas. A filing system was made and the homecare support worker helped to sort the mail. The client was paying a high amount for his electricity supply and after investigations Little Help managed to get client on a better tariff with lower monthly payments.

The scam mail eventually stopped but Little Helper continually supports the client if he requires letters written on his behalf.

The client now has daily personal care and Little Help arranged for a key safe and hand rails to be fitted. Our Handypersons also fitted a telephone extension lead at a later date. There was an occasion when the client was ill and Little Help sat with the client until the GP arrived. On another occasion Little Help managed to obtain on behalf of the client two upright chairs and rearranged his furniture for safety.

The client's health is poor and he is now in the process of moving into sheltered housing. Little Help arranged help with packing and obtained at the client's request smaller items of furniture more suitable for his new accommodation from the Age Concern Shop and a removal van for the day of moving. This will ease the stress as much as possible which could trigger any further illness. Little Help will continue to support the client and see him settled in his new home.

## Case Study 3

JC aged 59 suffers from diabetes, chronic kidney disease, hypertension and asthma. She has been in and out of hospital and now has dialysis 3 times a week.

JS has a very turbulent and troubled past, which has left her mentally scarred. She is lonely and depressed and does not mix well. She is very skeptical of people, quoting her own words 'no one has ever cared for me before'. We built up a good relationship with the client over a

period of time and gained her confidence as well as befriending this client. We have supported her with finances, shopping, collection of prescriptions and cleaning.

JC has a volatile relationship with her only daughter. This has a detrimental effect on the client's physical and mental wellbeing.

Leicester Hospital referred her to MIND but this was not followed up in the community. We liaised with MIND and arranged for the client to attend the local MIND Centre. She was accompanied until she felt able to attend on her own. Although she has attended mental health establishments in the past, she feels that there has been no ongoing support in the community.

JC currently lives in a three bedroom house. The house is not suitable for her needs and is extremely cluttered and was at risk of falls. She had no hoover, we purchased a hoover on her behalf and carried out a one off clean. When finished the client had more space to maneuver about.

JC recently went through a particularly bad spell, refusing to open the door to anyone even the doctors, nurses and carers. She was refusing to dialyse, hence having a serious effect on her health. She was refusing any help and became abusive. She threatened to take her own life. The GP and community mental health team both assessed the client as having the mental capacity to make informed choices. Therefore not sectionable, without dialysis the client was becoming seriously ill.

We continued to support her and were in constant contact with her (including evenings and weekends), at this time the relationship with her daughter was very acrimonious and they were not on speaking terms. One evening the client contacted us saying that she wanted to go back to dialysis as she was scared of dying. After liaising with the Dialysis Unit an ambulance was arranged for the same evening. We sat with her until the ambulance arrived. She was admitted into hospital straight after dialysis as she was so ill.

JC is still in hospital on the Renal Unit. She is recovering from a heart attack. We have continued to support JC in hospital. We have visited on a regular basis and have purchased clothes, personal items and magazines etc, to ensure her stay in hospital is made as comfortable as possible.

After numerous telephone calls, meetings, visits, we have achieved a good outcome for the client. The client has been offered sheltered accommodation in a nice location. She now has a community long term social worker who has agreed to get the client help regarding her mental health issues. Her care package has been increased to meet her needs, we will continue to support the client in her new bungalow.

When JC went to view the bungalow she was overwhelmed with emotion. It was at that point seeing the different professionals come together and the sheer delight on the clients face that all the hard work and effort had finally paid off. This client has gone from the brink of death to wanting to live life again.

This has been a complex case. Only with sheer perseverance and determination we have managed to bring together many professionals to ensure the best outcome for our client. Professionals include District Nurses, GP's, Community Mental Health, MIND, short and long term Community Social Services, Hospital Social Services, Doctors, Nurses, Consultants,

Occupational Therapists, Physiotherapists, Renal Specialist Units, Housing Manager and Care Agencies.

## Case Study 4

Client A moved into the area from London with very little support. He was advised to move on medical recommendations to a cleaner air environment. He has acute health problems including a heart condition, (several heart attacks in the past) COPD, diabetes and chronic asthma. His mobility is very poor as a result of ill health and he uses a spray to help with his breathing difficulties. Medication is in place to include warfarin and as client is allergic to steroids so effective treatment is limited.

Client was referred to Little Help after two weeks of his move and an assessment visit arranged. Client is very independent and was reluctant to accept any help. He was very distressed having been placed in the wrong flat (according to his pre-arranged request) and unable to communicate with the Resident Housing Manager.

Some of his furniture and personal items had been badly damaged by the removers and his cooker and fridge freezer did not fit in the kitchen. He was very agitated and admitted to having suffered chest pains and anxiety attacks during the weekend.

He only had the use of a microwave oven to cook his food as his cooker did not fit so was not connected, this proved difficult when following a diet convivial to his medical conditions. The fridge freezer also did not fit so was left unplugged in the centre of a very small kitchen making it very hazardous for client with his poor mobility.

Social Services were initially involved in obtaining a grant from SSAFA for furniture items for the client and arranging a visit for a benefit/advocacy check with a local agency.

The first half hour of our visit was spent allowing the client to talk about his frustrations and problems until he gradually agreed to accept some support from us. Addressing our clients immediate needs involved food shopping and completing and delivering a registration form with a local doctor's surgery. After several calls to the housing agency we completed a moving form on client's behalf, as he was too distressed to write.

Client was unable to go into his lounge as it was stacked high with boxes. He spent most of his time sitting on the bed in his bedroom watching TV surrounded by more boxes and paperwork. His wardrobe had been transported in pieces and his clothes remained in cases and boxes between all the rooms. He had no curtains at the windows as they could not be found in the muddle.

We arranged with Handypersons to erect his wardrobe and make good (several missing parts) and our Support Worker visited to help client unpack his clothes and put away. He was given a local telephone directory to make his own choice to call taxi firms to take him to a cash machine and continue to make use of our support for shopping essentials.

Two washing loads have been done by the Support Worker (on site) and she will be showing him how to use the facility in order to do it himself. Handypersons have been booked in again to re-point his curtain track and fit his curtains up. White goods have been purchased via SSAFA and client is now able to cook correct meals and keep his food stored safely. SSAFA

also arranged for a new single bed to be delivered but the company were not authorised to put it together so client slept on the mattress on the floor for three nights. When we were alerted to this we arranged for staff to visit and put it together for him.

Client's mobility appears to have improved, he is less stressed (but more demanding and very chatty) and has been very grateful for our help and support. Now that he has decided not to move to his original flat choice, there are issues that we will take up with OT to enable him to safely access the shower which he cannot use at present.

We hope to increase the client's confidence with our continued support and guidance during the following weeks in order that he can gain his independence to enable him to live in a healthier and safer environment.

## Case Study 5

Mr E from Wellingborough referred to the service by a Community Matron. The Matron's role is to help prevent clients in the community who are highlighted as having above average admissions to Hospital.

Mr. E has been in the habit of telephoning an ambulance on Friday afternoons. The Matron had to discover what the causes were and by putting strategies in place to help prevent this reoccurring. Little Help carried out a home assessment and highlighted the practical problems in his flat.

In the past Mr E had refused social and care management input. Little Help contacted the Rocket Team who are no longer providing home care as Mr E was never in for appointments. Mr E also has learning difficulties and is unable to read or write.

**Outcome:**

Bed – ACN contacted Sofawise Furniture Scheme for replacement single bed as Mr E's bed was broken. They donated a single bed and a new mattress, delivered this to his property and placed the old bed outside the property for the council to collect.

Linen – provided two sets of linen and a backrest for the new bed.

Cleaning – ACN staff and a volunteer carried out a blitz clean to the whole flat and provided Mr E with a clean and safe environment.

Laundry – As Mr E had a number of bin bags containing laundry that had been in the flat sometime Little Help decided to clear the bags and take them to a local launderette. However the launderette refused to wash the clothing as items in the top of the bags were badly soiled and un-washable. Little Help took the washing home as it was felt that this practical task was very necessary.

Little Help contacted the council and arranged for the broken bed to be removed, replace the broken toilet seat and repair the leaking toilet (the repairs to the toilet were carried out within three working days).

Finances/Debts – the Service Advice Team assisted Mr. E with his debts, bills and benefits.

The Community Matron is more than happy with the service and input provided by Little Help. The team was able to access the local information, contacts and resources available to enable Mr. E to take responsibility and pleasure in his home. Hopefully this will help him feel more settled.

## Case Study 6

B has multiple sclerosis and receives twice daily visits from carers. He is struggling with the housework. During the day, B goes to town or the resource centre on his scooter. He finds evenings difficult to cope with since his wife left and has been hospitalised following suicide attempts.

B's case manager referred him to the A Little Help Service. At the initial visit with the co-coordinator B agreed that he needed a change of activity in the evening. He enjoys watching sport but his television was broken and he is unable to do crosswords as his hands shake uncontrollably. The co-coordinator suggested learning how to use a computer to play games, to do crosswords and download songs. They drew up an action plan with goals and how to achieve them.

The team obtained a second hand television and B now watches sport on Sky TV. He attended a local free IT course and now has a computer, obtained at a minimal costs with a key guard fitted to enable him to only press the required key.

The team arranged for B to attend a Living Well course and set up weekly domestic care to help with the housework. He was given assistance with financial issues following a benefits check.

Over Christmas and the New Year the team visited and called regularly to support him through his first Christmas without his wife.

B no longer worries about his housework and is happy to invite friends to visit. He watches sport and plays games and does crosswords on his computer. He has made new social contacts through the Living Well and the computer courses. He is more content and has a new outlook on life and has not needed to go to hospital for several months.

Bill said about the Little Help team 'Brilliant people, A1 gold star. I would be lost without them'.

## Case Study 7

P has COPD, is on oxygen, and has diabetes and learning difficulties. He lives alone in warden controlled premises. He was admitted to hospital fortnightly in the months preceding referral to the service. He was referred by the case manager as a trial referral to see how the service would help his situation.

There were various initial problems to be addressed. The coordinator was unable to contact him as his phone had been cut off, and he couldn't read the letters sent to him. He was never at home when staff visited.

Once contacted, it was found that P had been sleeping in a chair as his bed was broken. The washing machine was also broken and the dirty washing was in black bags around the flat. The toilet leaked. His day care place had been stopped. He was unable to manage finances adequately and was in debt.

The staff dealt with immediate essentials before starting action plan. They accessed a new bed at no charge and provided bed linen. They arranged for the toilet to be repaired (the flat is council property), took away all the washing and returned it cleaned, and gave an initial clean to the house in order that P could continue to manage it.

An Age Concern Advisor then carried out a benefits check and helped to sort out P's finances to avoid debt problems and the utilities being interrupted. Once this had been done he could see that he had enough money to buy a new washing machine.

P wanted to be able to return to day care so that he could have a bath as he wasn't able to manage the bath at home. He also wanted to meet his friend at the working men's club in the next village.

The team arranged a day centre place where P could have a bath, and accessed bus tokens so that he could travel free of charge to meet his friends. A trolley to enable him to carry shopping and his oxygen cylinder easily at the same time was accessed at no cost. Arrangements have now been made for a shower to be installed in the flat and half funding accessed for a washing machine which has now been installed.

P still requires a lot of input and still does have attend hospital but not at the previous level. His flat is a little cleaner and he is keeping up with his washing. A simple financial file has been put together so that he can manage to keep his household bills and letters in order. He attends the day centre and goes on the bus to the working men's club. He also attended one day of the well being course. He receives regular phone calls and visits from the team.