HALTON BOROUGH COUNCIL

Health Policy & Performance Board

Scrutiny Review of Care at Home

Report
March 2015

1.0 PURPOSE OF THE REPORT

1.1 The purpose of the report is to present the findings of the scrutiny review, which:

Focused on the quality of Services provided to those who are supported to live at home within Halton. It examined the services that are already in place with a view to evaluating their effectiveness in meeting the needs of the local population. In addition the topic group examined access to other services e.g. Health Services that individuals supported to live at home have.

1.2 The full topic brief can be found at *Appendix 1.*

2.0 POLICY AND PERFORMANCE BOARD (PPB)

2.1 This review was commissioned by the Health PPB in June 2014. This report will be presented to Health PPB in March 2015. The report will also be presented to Communities Directorate Senior Management Team, Executive Board and boards or committees of stakeholders, as appropriate.

3.0 MEMBERSHIP OF THE TOPIC GROUP

3.1

Councillor Ellen Cargill (Chair)	Marie Lynch Divisional Manager, Care Management
Councillor Sandra Baker	Emma Bragger Policy Officer, Communities
Councillor Joan Lowe	
Councillor Pamela Wallace	
Councillor Chris Loftus	
Councillor Martha Lloyd-Jones	
Councillor Pauline Sinnott	
Mr Tom Baker (HealthWatch)	
Mrs Mary Baker (carer)	

4.0 METHODOLOGY

4.1 This scrutiny review was conducted through the following means:

- Information pack provided to Topic Group Members outlining national and local picture of care at home, summary of the key care at home services delivered in Halton, quality monitoring of care at home provisions, emerging issues facing care at home services and future delivery in Halton.
- Monthly meetings of the scrutiny review topic group;
- Presentations by various key members of staff ;
- Site visits, at which there was opportunity for service-user contribution.
- The final draft of this report was circulated to participating staff to check for accuracy.

4.2 The above methods enabled Member's to:

- Have an understanding of some of the elements of existing Care at Home provision in

Halton.

- Have an understanding of the role that partner agencies play in the provision of care provided to those living at home.
- Have an understanding of the different elements of service monitoring that take place in respect of this area of provision.

4.3 Which enabled Member's to consider, in making recommendations,

- National best and evidence based practice, and how it can be applied in Halton.
- Ways to continue to make improvements to services to ensure they continue to be effective in meeting the needs of the population of Halton.

4.4 The Chair and Members of the Topic Group would like to extend their thanks for the cooperation and contributions made by all those who have taken part in the review.

5.0 INTRODUCTION

5.1 As people get older, they are increasingly likely to need care at home.

5.2 In 2010/11, nationally an estimated 543,000 service users received home care of which 81 percent were aged 65 and over, and as our population ages, more people will inevitably need care at home in the future.

5.3 In terms of increases in the number and proportion of older people in the UK population, the percentage of persons aged 65 and over increased from 15 per cent in 1985 to 17 per cent in 2010, an increase of 1.7 million people. By 2035 it is projected that those aged 65 and over will account for 23 per cent of the total population.

5.4 Within Halton, the older people age group (65+) are projected to grow by 33% from 17,300 in 2010 to 25,700 in 2025.

5.5 Nationally, Councils with Adult Social Services responsibilities purchased or provided 200 million contact hours of home care during 2010-11, an increase of 13 per cent on 2005-06 and the percentage of contact hours provided by the independent sector (private and voluntary sectors) has been steadily increasing over the past few years, with 72% of hours being provided back in 2005-06 to 87% being provided in 2010-11.

5.6 Studies show that older people would prefer to stay at home until it is impossible for them to do so rather than move into residential care and that the benefits of home care are enormous, both to individuals and to the state. Home care provision also costs less than a place in residential or nursing care. In 2008-09 the national average weekly cost to local authorities for an older person in residential and nursing care was £497. In contrast, the average weekly cost of home care was £145[i].

6.0 EVIDENCE CONSIDERED BY THE SCRUTINY TOPIC GROUP

1) Overview by the Divisional Manager for Independent Living

6.1 The Divisional Manager presented an overview of the universal and targeted community services for people with low level needs, vulnerable people and those with complex needs.

6.2 Examples were given to illustrate how services are used to mobilise people in and around the community, support people to remain well at home, reducing social isolation and supporting people with complex needs within the community. Information about reablement services, assistive technologies and intermediate care facilities was also provided.

6.3 The Divisional Manager answered a number of questions about the effectiveness of these services, the impact on the individuals accessing the services and emerging issues and pilot work that is currently underway to further enhance care at home services.

Conclusion

6.4 As a result of the overview given the group were able to identify particular areas on which to focus their review. These areas were: The role of technology, extra care housing, reablement services, prevention and social inclusion, community nursing and quality assurance.

6.5 It was acknowledged by the group that despite the tough financial climate, and savings that have had to be made locally by the local authority and health partners, during 2013/2014 Halton has maintained a broad range of services to support people with a health and/or social care need to live well within the community.

2) Using technology to live well and independently

6.6 The Telecare Lead Development Officer and the Community Warden Service Officer provided information to the group about the service available in Halton. Telecare has been defined by the Department of Health as a service that uses 'a combination of alarms, sensors and other equipment to help people live independently. This is done by monitoring activity changes over time and will raise a call for help in emergency situations, such as a fall, fire or a flood ' (Department of Health 2009)

6.7 Halton Borough Council provides an accredited Telecare service delivered by a dedicated Telecare team and a Community Warden team, both supported by the Halton Borough Council Contact Centre. Halton has used Telecare since 1989. The service is audited by external organisation Telecare Service Association (TSA), and uses the Telecare Services key performance indicators. The service is currently accredited TSA Platinum and European Standard.

6.8 The teams provide 3 levels of service 24 hours a day, 365 days a year, supporting people with the use of Telecare sensors in their own homes. The service is able to provide remote and standalone monitoring technology.

1. **Service Level 1**
   Community Alarm Emergency Response Service
2. **Service Level 2**

Telecare Service Environmental Monitoring

3. **Service Level 3**
   Telecare Service Lifestyle / Environmental Monitoring

6.9 The types of conditions and situations that Telecare is currently supporting include; Reducing risk of, or notifying risk of falls, seizures, wandering, hyperthermia, health issues, reminder prompts, fire, floods and security (this is not an exhaustive list).

6.10 The benefits that Telecare service achieves includes:

- Promotes Independence and Choice
- Personalisation Agenda
- Manage Identified Risks
- Enables speedy discharges from hospitals
- Prevent Hospital Admissions
- Prevent / Delay Residential Placement
- Early Intervention and Prevention
- Enables people to remain in their own homes longer

6.11 During 2013/14 the Telecare Team saw a total of 1063 referrals with 188 connections to Telecare levels 2 and 3. There were 89,610 control centre /dwelling calls (to the contact centre), resulting in 8359 Community Warden call outs.

6.12 The service has been able to demonstrate a cost benefit to the NHS locally. During Quarter 1 2014, Community Wardens attended 183 falls at which they were able to assist the persons without any further involvement from the health service. Had the Telecare service not been installed then an ambulance would have been called to assist. Average cost of an ambulance call £247 X 183 cost saving of £45201 to NHS. (Source of Ambulance call cost Oxford Mail story 25/02/2013 Ambulance cost. NW Ambulance call out cost not available at this time).

6.13 A sample of 409 (20%) 'Service User Annual Review Questionnaires' and 'Post Installation Reviews: 2-6 weeks' were analysed for comments about the quality of the service provided[ii].

- **100%** of individuals reviewed considered that the Community Alarm Service met their needs, were satisfied with the service they were receiving and were given enough support using the equipment.
- **100%** reported that they would recommend the service to family and friends
- **99%** were pleased with the speed of the response they received from staff
- **99%** of those needing assistance found the staff friendly and helpful
- **100%** indicated it was Value for money service.
- Overall opinion of the service was:
  71% Excellent
  28% Good
  1% Adequate
  0% Poor

6.14 There is currently no issue with capacity of the service. Any significant increase in demand for lifeline services would have an impact on the lifeline infrastructure

(number of phone lines needed on the lifeline system), and operationally in delivering assessments and interventions to meet demand.

6.15 The cost of the Lifeline service is currently: level 1@ £5.64 , level 2 @ £6.75, level 3@ £9.00 per week.

Conclusion

6.16 Emerging issues for the team include investigating technologies to monitor daily living activities in the home and use this information as an early assessment tool, and investigating the use of mobile technologies to help support vulnerable people away from the home.

6.17 Service user feedback and involvement in the development of the Telecare service could be improved. It was noted that for one service user event, although 1000 flyers were circulated, only 3 service users attended. There needs to be some thought given to how customer views are gained, and where there is a use of marketing techniques, these should be suitable for the needs of the people who are in receipt of the service. One way of further promoting the service, and gaining user feedback, would be to engage at a greater level with community and support groups who may have members or carers who would benefit from understanding how technology can help maintain independence etc.

3) Planning for the use of technology to support health and wellbeing outcomes

6.18 Halton Borough Council and Halton NHS Clinical Commissioning Group Director of Transformation attended the September Scrutiny Review meeting to provide an update on the development of the Integrated Health and Social Care Technology Strategy.

6.19 A priority of the strategy is to enable health and social care IT systems to 'talk' to each other (intropability). By sharing patient information between agencies it is anticipated that this will support more efficient interactions. The strategy will also incorporate Tele health and Telecare.

6.20 The strategy will look at wider systems that could influence the provision of technology, including how financial investment can lead to increase usage.

6.21 The group were informed that the draft strategy will go to Health PPB and members will have opportunity to comment.

Conclusion

6.22 The group agreed that there is a need for greater emphasis on technology, including assistive technology, in the delivery of health and social care services to be able to meet the changing and complex demands of our local population. This may involve an 'invest to save' approach, and business cases will need to be robust to demonstrate cost /benefits of any investment in technology.

6.23 The benefits of having 'joined up' IT systems between health and social care partners in being able to provide seamless interventions is clear. However, some degree of caution will need to be exercised about the potential implications of data sharing. There will be wider reaching implications of 'intropability', which may mean modifying procedural ways of working. True integration of IT systems is likely to be some time away, but health and social care partners should approach negations with an open mind, with the joint vision of providing safe and quality services to health care patients and social care service users in Halton.

6.24 The use of assistive technology supports the personalisation of health and social care, and when used as part of an early intervention approach can be effective in reducing long-term demands on social care and increasing service capacity.

6.25 The group are clear that there are many potential benefits of the use of technology in supporting people to live independently and well within the community, but emphasise the need to put in place measures to ensure that technological advances in Tele health and Tele care do not come at the cost of human contact with patients and service users, where this would make the greatest difference to them. This could lead to the person being more socially isolated, which can affect emotional health. Recognising that difficult decisions relating to budgetary constraints will need to be made, the cost/benefit of human contact will require particular attention when faced with the situation where use of technology may be more cost effective than human resource.

4) Promoting active aging, independence and participation within community life.

6.26 The Principal Manager of the Sure Start to Later Life(SSLL) service gave the group an overview of the key activities of the service and how they are helping people remain independent, improve quality of life and in some cases, delay the need for more intense care and support. The service was initiated in 2006 as a government programme, but Halton are one of the few remaining authorities that still have a SSLL service.

6.27 The service provides information and support to people to reduce social isolation and improve quality of life for older people. Referrals come from a number of different routes. The aim of SSLL is to support relationships for service users, if that is what they wish, not replace social and emotional relationships or create dependant relationships with professionals. Being part of the Health Improvement Team, SSLL have access to a number of health prevention activities and services, along with wellbeing activities that SSLL signpost to.

The service offers:

Information Officers

6.28 Information officers undertake information needs assessments with people who are referred. They inform and sign post about the wide variety of local activities available to them. These officers visit people in their own homes.

Volunteer Befriending Service

6.29 The service has 6-13 volunteers at any one time. SSLL received referrals from Silverline – which is a telephone friending service for older people

Day Trippers

6.30 Around 36 trips out per year are offered to older people by the Day Trippers group. The group, of which there are approximately 300 on the register, decide where the trips are. There is door to door pick up/off. The trips are made affordable by working in collaboration with Halton Community Transport.

Care Home Activities

6.31 SSLL work closely with care homes by visiting residents to provide information and signposting and identifying with care homes what activities residents may wish to access. SSLL also work with the homes and residents to encourage take up of activities outside of the home. There is also a care home/school twinning project that SSLL supports.

Collaborative working with other teams and agencies to reduce social isolation

6.32 SSLL work with HBC Community Development and Health Improvement Team to look at how short term groups can have greater sustainability and bring positive outcomes to those who use them. SSLL is part of the Partnership for Prevention group, which brings together a number of key agencies who work on the prevention and early intervention agenda. SSLL are working with Community Development in the wards to speak to residents to see what they would make a difference to them in growing older in their area. Recent outcomes include the provision of benches in Windmill Hill.

Loneliness and Isolation screening and support

6.33 SSLL do screening for loneliness and social isolation, and have recently participated in the Living Well Pilot, which does memory screening, working closely with GPS who make referrals into the SSLL service.

Visbuzz

6.34 A 12 month pilot that uses easy use video calling for older people who are at risk, or experiencing, loneliness and/or social isolation. The aim of the pilot is not to replace human contact, but to make contact with loved ones, carers, professionals easier for people who may be vulnerable to social isolation/loneliness.

Measuring outcomes

6.35 There is an outcomes framework in place to capture qualitative information and case studies, to be able to show the impact of the services on outcomes for people. It is acknowledged that it is difficult to quantify the impact of preventative work, but the Principal Manager gave examples of recent outcomes for service users who have benefited from information provision and access to groups in improving their independence and quality of life. Case studies illustrating outcomes for SSLL users can be found in Appendix 2

Conclusion

6.36 Part of SSLL's success comes from having a single referral gateway to wide ranging services in the community, where potential problems are identified quickly and prevented from becoming worse.

6.37 Halton has an ongoing commitment in investment, strategy and activity to support the prevention and early intervention agenda. Local demographics and projected needs of our aging population suggest that the kinds of activities provided by the SSLL team will remain an important part of helping people live well in the community.

6.38 Increasing the number of volunteers and providing them with appropriate training would increase the capacity of the service to provide befriending services, but also other aspects of the service. Recruiting volunteers from the SSLL target demographic may enable the service to have an increased understanding of the needs and demands of the target profile, but also offer opportunities to the target demographic to take an active role in the community.

5) Enabling people to remain living in the community after a decline in health and End of Life Services

6.39 The Principal Manager for Enablement gave the group a verbal presentation on the reablement service. Reablement is a short and intensive service, usually delivered in the home, which is offered to people with disabilities and those who are frail or recovering from an illness or injury. The purpose of reablement is to help people who have experienced deterioration in their health and/or have increased support needs to relearn the skills required to keep them safe and independent at home.

6.40 The staffing structure is made up of a Registered Manager, Assistant Manager, Coordinators, Care and support staff. All staff are contracted with Halton Borough Council and undertake a comprehensive training programme.

6.41 Staffing levels to manage the 24 hour services were reported by the Principal Manager as being good. There is a bank of casual staff and regular agency staff (agency staff are used as infrequently as possible) which can be called on to cover periods of holiday and sickness cover.

6.42 As the 24 hour services are now managed by one management team, staffing resources can be shifted to cover high demand/emergencies. All casual/frequent agency staff have the same checks and training as permanent staff.

6.43 The 24 hour reablement services are made possible by the close working with Social Care and the CCG to be able to provide a holistic health and social care service to people within their own home.

6.44 The service is regulated for personal care and is subject to inspection by the Care Quality Commission (CQC).

6.45 The service receives referral from hospitals and community based professionals. Between April 2013- April 2014 the Reablement Service had 486 referrals, with 69% being for people aged 75+. 39% of referrals had their needs classified as 'high'. The average length of service was 31 days.

Early Supported Discharge

6.46 Early Supported Discharge is where carers provide care and support, as part of a multi disciplinary team, providing outreach specialists such as stroke rehabilitation in the patients home. This is a service for people who can be discharged from hospital with intensive support at home. Occupational Therapists and physiotherapists are among a range of professionals who support this service. Between April 2013-2014 the Early Supported Discharge Service had 32 referrals to the service, resulting in no readmissions to acute services, 248 acute bed days saved 25% discharged as independent and 50% discharged with reduced support from when originally referred.

Night Service

6.47 Night Service provides social care and health care checks for people .This service is for people who are assessed as needing support during the night, i.e. catheter care, continence needs. Providing this care at home can prevent the need for care home admission in many cases. Between April 2013 and 2014 the Night Service had 14 people on the caseload, with a length of stay on the service in excess of 12 months. 2 of the 14 have 2 visits per night.

End of Life Care

6.48 End of life care provides sensitive social care and comfort at home. It aims to enhance dignity and choice for those people who are at the end of their life. The CCG commissioned Community Nursing service delivers the health elements of end of life care. Between April 2013 and 2014 the End of Life Service had 122 referrals, with an average length of service being 36 days and 72% deceased at home (preferred place of care).

Conclusion

6.49 Preferred place of care and advanced care planning are priorities for the service.

5) Housing Providers , health and social care supporting people to remain living within the community.

6.50 A number of the Scrutiny Topic Group, made a planned visit to Dorset Gardens extra care housing scheme in Runcorn and Naughton Fields in Widnes. The visits were facilitated by the Registered Manager. The group had a tour of the buildings, spoke with the Senior Care and Support Workers on duty and people who have tenancies at the two schemes. A report from the visits can be found in Appendix 3

6.51 As a broad definition, extra care housing is a model that combines purpose-built and ergonomically-designed housing for older people with onsite flexible care that adapts to residents' changing needs and allows them to retain their independence. A 'home from home' feel is also a key aspect, which is achieved through the self-contained design of the housing units, as well as resident participation on management committees.

The main findings can be summarised as:

6.52 ***Care and Support*** –Care and support is delivered by different models in the two schemes. Dorset Gardens care and support is delivered by local authority staff based on site between core hours, with community warden and lifeline services available outside of these hours. In contrast, Naughton Fields care and support is delivered by a number of spot purchase providers. There is no care provider on site to deliver general care to tenants as and when required. The model at Naughton Fields was adopted based on the needs of residents when the scheme opened. There is a Housing Support Officer who provides support to tenants on housing related issues (whose role does not include the delivery of direct care).

6.53 Having the local authority carers on site at Dorset Gardens enables quick response to any needs that occur with little or no warning, and a consistency and knowledge of the dynamics between tenants to be able to identify when people's needs are changing.

6.54 The care given by providers at Naughton Fields is purchased on an individual basis, which is reflective of how domiciliary care is provided within the wider community. Those who are on the Life Line service have access to a quick response.

6.55 Within Dorset Gardens independence is promoted within the schemes and the 30%/40%/30% ratio of low, medium and high need tenants enables those with more complex requirements to live alongside those with no, or low needs, fostering pockets of peer support within the schemes. Naughton Fields is working towards a similar approach.

6.56 ***Integration with the wider community*** - The group were informed about the use of the facilities within both of the schemes by the wider community, which has been personally witnessed by members of the group. Enabling tenants to be integrated with the community was promoted by having a public access café and holistic therapy rooms. It was noted by the group the importance of providing opportunities for tenants of the schemes to engage in the wider community, and likewise, the importance of the scheme offering opportunities for the wider community to engage with tenants. Whilst this might largely be through planned activities and the scheme facilities (such as the cafes), it will contribute towards the wider community understanding the purpose of extra care housing and breaking down perceptions about how extra care housing operates, and the opportunities for people to remain living within the community with appropriate support. Members of the group felt that the housing schemes provided an opportunity to foster greater intergenerational integration through offering opportunities to link up with schools in the area, being encouraged to get involved in the activities taking place within the schemes, and supporting relationships with residents.

6.57 ***Quality of the physical environment*** - The group commented on the overall high standard of cleanliness, quality of the décor in communal areas and the lay out of the residential units throughout both of the schemes. Where applicable, housing adaptations have been undertaken to ensure that individuals homes can meet their needs. Members of the group commented that Riverside and Halton Housing Trust, as

the landlords, and Halton's Social Services should take pride in their achievements with these schemes. Tenants can influence the quality of environment through Tenants Committees, fund raising etc. This is encouraged and was viewed by the group as being an important part of the tenants' independence to have influence over the communal living areas, as well as within their own homes.

Conclusion

6.58 Overall the group felt that the environments support available and facilities were of a high standard, and that there were systems and processes in place to meet preventative and reactive support needs.

6.59 Whilst there were established quality and safeguarding processes in place within the extra care schemes, there is a risk that some cohorts of tenants, such as those with restricted mobility, cognitive impairment or learning disabilities, may be at similar risk of social isolation and safeguarding concerns, as those resident in the wider community in receipt of care and support.

7) Care provided within the home (Domiciliary care)

6.60 The Chair of the Health PPB and a Monitoring Officer from HBC Quality Assurance Team made a visit to clients who receive services from Just Care, a HBC commissioned domiciliary care provider, to gain an insight into the type of support available from domiciliary care providers.

6.61 The first client that was visited had a diagnosis of dementia and lived alone, with four visits from Just Care and support from family. The client's daughter was present during the visit and both she and the client, expressed satisfaction with the Carers who attend to the client's support needs.

6.62 Through discussion, the Monitoring Officer identified that the client was not fully aware of the communication process if she were to become dissatisfied at any point in the future. Client's knowledge of the comments and complaints procedure is an important part of the quality process, and whilst the client and daughter did known the phone number of Just Care they did not have HBC contact details. These details were in place but they were at the back of the client's Care Plan Folder. The Monitoring Officer arranged with the Just Care Office for this to be in a more prominent position in the Care Package Folder, as it is an important part of ensuring that clients are aware of the complaints process and how to notify HBC.

6.63 A second set of clients were visited (husband and wife). They were an elderly couple who were both receiving care in their own home. The wife had been diagnosed with dementia, although her husband had not got a dementia diagnosis, he had been diagnosed with memory problems. The couple were supported by their son and granddaughter, as well as having Care visits four times a day. They both expressed that they were happy with care they received. They praised the Just Care Staff, especially in the area of communication.

6.64 After some discussion it was apparent that the husband had been experiencing some falls, and although the Carer had been present at one of the fall's, there did not

appear to be any action plan in place. As a meeting with the Just Care Manager had been arranged for the following day, this was taken up with them at that time.

6.65 At the meeting with the Manager and Assistant Manager at the office of Just Care , it was discussed that the provider did not adopt any zero hours contracts. The majority of the care staff they employed were mothers who wished to work in the region of 16 hours per week, which would enable them to receive the benefits they were entitled to and was also convenient for the carer's with children in school.

6.66 The visits that were commissioned seemed to be adequate as carer's were recording that they were able to do medication visits in the time allotted. It was explained 'no user of the service would be left wanting' and that carers gave sufficient time with clients to ensure that they were happy and settled before they left.

6.67 They received all the required training, which is done in house and in conjunction with Halton Haven.

Conclusion

6.68 The role of carers inevitably means that a number of their clients may be nearing end of life. From discussions with the 3 clients on the visits undertaken, it was clear that for them, having the same carer each day made a big difference in building relationship and trust. This relationship should, wherever possible, be maintained during end of life care. This will require carers to have a suitable level of training and skill to enable them to deliver appropriate support at end of life. Awareness raising and training opportunities in other areas should continue to be promoted to providers through the Provider Forums. This can include promotion of services such as the Falls Prevention Service.

8) Health care nearer to home

6.69 The Clinical Manager of Halton Community Nursing and the Service Manager for Adult Community Nursing gave a presentation outlining the Community Nursing services that is delivered in Halton. The service is delivered by Bridgewater Community Health Care NHS Foundation Trust (Bridgewater).

6.70 The CCG are currently reviewing Community Nursing within Bridgewater. A revised specification is due in March 2015 to deliver a more integrated model of care that reflects the changes within primary care. Historically, commissioning of Community Nursing across the country has not always been activity based. This is now changing and the new specification will reflect the levels of activity undertaken by the Community Nursing teams in Halton.

6.71 Main services offered include: home visits to patients that are unable to leave their home and treatment room/clinics within the local community. Types of interventions include: assessment of needs, wound management, administration of medication (if an individual cannot self-administer) and end of life care. The service is not intended

to be a rapid or acute response service, and works with other partners to deliver services within the home (including intermediate care). Urgent response times during out of hours are within 4 hours.

6.72 The main finding are summarised below, further information about the service and activity levels can be found in the Community Nursing presentation in Appendix 4

6.73 ***Staffing*** - The Community Nursing Team consists of District Nurses, Community Matrons, Staff Nurses and Health Care Assistants. Teams are aligned to 17 GP practices in Halton. The teams operate out of treatment rooms within the community (ie GP practices and the Healthcare Resource Centre) and provide services within people's homes where people are housebound.

6.74 During times of high demand, holidays, sickness etc staffing levels are supported by offering part time staff within the service additional hours or reconfiguring resources from the other 4 boroughs services by Bridgewater. Where the staffing levels cannot be met this way, regular bank staff may be used.

6.75 Whilst there is capacity within the wider service to gain extra cover from existing part time staff or staff from the other boroughs services by Bridgewater, the current staffing levels in treatment room and out of hours service (due to sickness levels) mean that aspects of these services are not resilient (smaller staffing numbers). There is currently scoping taking place for demand against capacity within out of hours service. All current vacancies are being recruited to, to ensure that staffing levels are maintained.

6.76 ***Referrals*** **-** On average, the District Nursing Teams get 600 referrals per month. There is a high volume of work generated from a referral as the majority of patients are 'complex', including regular interventions, reviews, liaison with other health and social care professionals etc. Further details regarding referrals and activity can be found in the Bridgwater Presentation in Appendix 4

6.77 ***Quality and Safety*** **–** There is a robust competency based training and review schedule for all staff, including regular bank staff. There are systems in place to identify 'near misses' or incidents and staff report in 'real time'. There are systems in place to respond within the same day an incident occurs. It was reported that there is a culture of support, continuous development and learning from complaints, incidents and near misses when these occur. Managers work with staff to eliminate/reduce further risks through additional training and supervision, but there are formal competency procedures in place to manage staff who continue to pose a risk to safety or quality. There are weekly incident reports analysed by managers to identify any trends. There are quarterly reviews against The Care Quality Commission's 21 elements of the compliance declaration. There is no national published safer staffing levels for community nursing however Bridgewater Community Nursing have implemented an adapted version of the 'safer staffing' tool, (intended for hospitals and bed-based facilities).

6.78 ***Patient Feedback*** - Of 565 patient surveys there was a 60% return rate for Halton patients, which was noted as an excellent return rate, and higher than the return rates for the other boroughs serviced by Bridgewater. Ninety three percent (93%) of

respondents were satisfied when contacting the service, 97% were satisfied with the waiting times and 100% were satisfied with the remaining indicators. Overall satisfaction was reported at 99%. Bridgewater are the only community trust who are reporting against 'Open and Honest Care'. Their website publicises harm data on the 'open and honest' section of their website. http://www.bridgewater.nhs.uk/aboutus/openandhonestcare/

Conclusion

6.79 Members of the Health Policy and Performance Board would like to be kept informed on the progress of the specification development and investment in this service.

6.80 Any changes to the Bridgewater specification has the potential to have implications on social care services within Halton, and this must be carefully monitored to ensure services are able to manage existing and future demands.

6) Ensuring quality of care in the community

6.81 Quality Assurance Manager gave an overview of the role of the HBC Quality Assurance Team and how domiciliary care providers are supported and monitored in the delivery of care within the community.

6.82 The new domiciliary care contract was awarded in July 2014. Seventeen providers were awarded, 12 are currently delivering. There are 5 providers not currently delivering due to there not being sufficient care hours for them at this time.

6.83 Care packages are put in place through an assessment by HBC Care Management Team who then liaise with the HBC Care Brokers within the Quality Assurance Team to broker care packages within 3 or 4 days of referral. Individuals are prioritised and where there is a need for a care package to be in place sooner than the average of 3 or 4 days, this will be the case.

6.84 Providers operate within zones. Widnes and Runcorn are both split into two zones, to enable the most effective use of staff in travelling distances from call to call etc. There are 2 key providers and a spot purchase provider in each zone.

6.85 It is predicted that there will be a continued emphasis on providing care at home. The Market Position Statement has identified that commissioners will need to discuss opportunities to develop local services with providers that can meet highly complex needs.

6.86 All the HBC providers are registered with, and regulated by, CQC. CQC monitor the minimum care standards, with the HBC service specification detailing what the provider is commissioned to deliver and specific quality measures they must adhere to. Providers are subject to regular monitoring visits undertaken by the Quality Assurance Team where performance and quality measures are scrutinised.

6.87 In addition to monitoring visits, Electronic Care Monitoring (ECM) has been used for the last 18 months, and provides a retrospective picture (a month in arrears) of what care had been delivered and reports of any near misses or incidents. This information

is analysed for trends and quality/safety issues. In addition to providers having to input ECM data, providers must also report, in real time, any incidents or near misses (ie missed calls, variation's to care plans) to Quality Assurance Team, social worker, care management health partners etc.

6.88 As part of the contract monitoring process, providers must be able to evidence that they are using the ECM data themselves, as part of internal quality assurance processes, and take actions where necessary.

6.89 There is a 'care concerns' model in place in Halton, in the same way that there is in residential care. This is used to encourage and support **all** professionals engaged with individuals to raise concerns. Providers use this as part of their quality assurance processes. Interagency collaboration is essential in monitoring quality and performance. There is a schedule of enhanced monitoring activity that takes place, which also includes service user input and visits to service users.

6.90 Service users are informed, at the initial stages of care being initiated, about who to contact in the event of a complaint. This is also provided in written form in the front of their care folder that they keep within their home.

Conclusion

6.91 The Quality Assurance Team already have mechanisms in place to provide market oversight, however, with the Care Act, the Quality Assurance Team will have an increased role in managing the provider market, providing market oversight and preventing disruption to services (through market/provider failure).

6.92 There is lots of work going on locally to work with providers to make care more personal and person centred outcome driven. An invite has been extended to Member's of the Topic Group to attend the December 2014 provider forums to speak directly with providers to see how this is achieved locally.

7.0 RECOMMENDATIONS TO HEALTH PPB

1) **Research the evidenced base for *predictive and assistive* technology tools that could be used as part of the prevention and early intervention agenda, and the cost/benefits to potential investment. Health PPB to receive an update in Autumn 2015.**

Scoping of available, or developing, predictive and assistive technologies to :

- Utilise assistive technology to address loneliness
- Identify where these existing assistive technologies can be utilised within Halton and work with partners to achieve this.
- Support the Dementia Technology Charter by providing user friendly resources/information for people trying to access assistive technology

Outcomes that could be achieved through investment technology must be clear and evidence based. Outcomes should be as much about quality of life and added value, than just 'cost efficiency'. Investment in predictive and/or assistive technology must

be underpinned with investment in well trained quick responders and staff who are customer focused and appropriately skilled.

2) **Adult Social Care to be consulted on/contribute to any developments in the provision of tele*health* to help people maintain independence.**

Adult Social Care Telecare/assistive technology services should be consulted with in the development of *telehealth* technology in Halton, in light of the Integrated Technology Strategy, and the desire to have truly integrated systems. Any potential for integrated telecare/health systems should consider the funding implications and cost to the user in light of personal/health budgets.

3) **The Sure Start to Later Life Service (SSLL) should continue to have an important role in delivering personalised wellbeing outcomes.**

There continues to be a need to provide a range of preventative interventions later in life , ensuring that older people are targeted with active ageing opportunities. This should include the use of technology and maintaining links between health and social care to develop innovative ways to engage older people.

Members should be kept informed of progress against the actions contained in the Halton Loneliness Strategy.

4) **Attended care and support provision within extra care housing schemes**

Expectations about the role of staff in supporting tenants may vary between providers of extra care and so their role needs to be made explicit in the contract between the provider and the prospective tenant. This is especially relevant in schemes where there is currently no 'on site' provider during core hours.

As Naughton Fields continue to move towards the 30/40/30 ratio of care needs the model for care provision at that site should be monitored to ensure that the spot purchase approach continues to meet the needs of residents.

5) **Community Nursing Services**

In reviewing the service specification, Halton HHS CCG should consider the current and anticipated levels of activity and increasing demands to ensure that the appropriate level of funding is invested. Liaison with other professionals as part of the review may help identify gaps in the service and opportunities to promote integration between health and social care to further improve outcomes of people accessing the service.

6) **Quality Assurance**

The Council's Quality Assurance Team will have an increased role in market oversight, supporting quality improvements and preventing provider failure as a result of the Care Act.

There is, and should be, a continuous cycle of work with providers to improve quality and deliver person centred outcomes.

Health PPB should be updated on the implications of the Care Act on the Quality Assurance Team (market oversight) in Autumn 2015

Appendix 1 - TOPIC BRIEF

TOPIC BRIEF

Topic Title:	Care at Home Provision in Halton
Officer Lead:	Marie Lynch
Planned Start Date:	July 2014
Target PPB Meeting:	March 2015

Topic Description and Scope:

This topic will focus on the quality of Services provided to those who are supported to live at home within Halton. It will examine the services that are already in place with a view to evaluating their effectiveness in meeting the needs of the local population. In addition the topic group will examine the access to other services e.g. Health Services that individuals supported to live at home have.

Why this topic was chosen:

As people get older, they are increasingly likely to need care at home.

In 2010/11, nationally an estimated 543,000 service users received home care of which 81 percent were aged 65 and over,[1] and as our population ages, more people will inevitably need care at home in the future.

In terms of increases in the number and proportion of older people in the UK population, the percentage of persons aged 65 and over increased from 15 per cent in 1985 to 17 per cent in 2010, an increase of 1.7 million people. By 2035 it is projected that those aged 65 and over will account for 23 per cent of the total population.[2]

Within Halton, the older people age group (65+) are projected to grow by 33% from 17,300 in 2010 to 25,700 in 2025.[3]

Nationally, Councils with Adult Social Services responsibilities purchased or provided 200 million contact hours of home care during 2010-11, an increase of 13 per cent on 2005-06 and the percentage of contact hours provided by the independent sector (private and voluntary sectors) has been steadily increasing over the past few years, with 72% of hours being provided back in 2005-06 to 87% being provided in 2010-11.[4]

Studies show that older people would prefer to stay at home until it is impossible for them to do so rather than move into residential care and that the benefits of home care are

[1] Health and Social Care Information Centre - Community Care Statistics 2010-11: Social Services Activity Report, England (2012)
[2] Office of National Statistics (ONS) - Population Ageing in the United Kingdom, its Constituent Countries and the European Union (2012)
[3] ONS - Population Projections 2010
[4] Health and Social Care Information Centre - Community Care Statistics 2010-11: Social Services Activity Report, England (2012)

enormous, both to individuals and to the state. Home care provision also costs less than a place in residential or nursing care. In 2008-09 the average weekly cost to local authorities for an older person in residential and nursing care was £497. In contrast, the average weekly cost of home care was £145.[5]

Key outputs and outcomes sought:

- An understanding of existing Care at Home provision in Halton.
- An understanding of the role that partner agencies play in the provision of care provided to those living at home.
- Ensure services provided take into consideration national best and evidence based practice.
- Consider ways to continue to make improvements to services to ensure they continue to be effective in meeting the needs of the population of Halton.
- An understanding of the different elements of service monitoring that take place in respect of this area of provision.

Which of Halton's 5 strategic this topic addresses and the key objectives and improvement targets it will be help to achieve:

A Healthy Halton

- To understand fully the causes of ill health in Halton and act together to improve the overall health and well-being of local people.
- To respond to the needs of an ageing population improving their quality of life and thus enabling them to lead longer, active and more fulfilled lives.
- To remove barriers that disabled people face and contribute to poor health by working across partnerships to address the wider determinants of health such as unemployment, education and skills, housing, crime and environment.
- To improve access to health services, including primary care.

Nature of expected/ desired PPB input:

Member led scrutiny review of Care at Home provision.

Preferred mode of operation:

- Meetings with/presentations from relevant officers from within the Council/Health Services, partner agencies and contracted providers to examine current provision.
- Desk top research in relation to national best and evidence based practice.

[5] Equality and Human Rights Commission - Close to Home : An inquiry into older people and human rights in home care (2011)

Agreed and signed by:

PPB chair ……. Officer ……..

Date …… Date …….

Appendix 2 – Sure Start to Later Life Case Studies

ASSESSMENT/ACTION (intervention by SS2LL)	**OUTCOME EVIDENCE (Effect on client/family/carer)**
• Due to relationship issues with husband an assessment away from the home as per client's request. • Husband has terminal cancer. • Not documenting case notes as usual, as information disclosed was very personal concerning clients home situation. • Discussed wanting to get out more to make herself feel better, and she said she would like to volunteer. • Explained how our service works and she said she would like to give it a go. Agreed to pass her details on to Volunteer coordinator to contact for interview for volunteering	• Client is now ready to be matched with a client to support via volunteering, • In receipt of IT tuition from another volunteer. Client has continued to develop her independence and confidence. • She feels she is preparing herself for the time when she will be on her own. • The volunteering, building relationship and learning new skills will aid in this transition when the time comes. In the meantime she is able to cope with her situation better
• Clients only family is a nephew, who lives nearby. • Does not get out much since losing his car. • Client finds it difficult to go out as needs to go the toilet often, which is one of the reasons he stopped going out • Client did not want to go to groups as he felt he was not very social, discussed the volunteer service. • Discussed other transport options but	• After liaising with HCT managed to arrange a regular booking to the shops for client, which he enjoyed. • A volunteer was matched with client to visit him and take him out in her car. • Client attending a group Christmas meal – volunteer supported. • Volunteer takes client to hospital appts. Shopping and trips. • Volunteer identified and issue with keysafe, which was dealt with.

still appeared apprehensive. However, agreed for us to liaise with the local community transport. • Client has cancer	• Client joined the DayTrippers group • Client has been welcomed into volunteer's life as she has no parents, he has no children, and they have become good friends. • The volunteer has acquired a position within HBC, but continues to support the client. • This client returns to the team as and when he needs support
• Client says she gets sad and lonely, husband passed away 30 years ago and partner 4 years ago. • The client's only family lives in London and has 1 friend in locality. • Client does not go out except to do shopping once a week. We discussed the clients desire to go out more but says she finds it difficult to go out on her own, so the Volunteer service was suggested and though reluctant at first, the client agreed for referral. • Client is diabetic but does not get her feet checked - explained the podiatry service. – referral made for podiatry service with transport, • We discussed with the client a problem she was having with her answerphone and her lifeline service. • Client interested in Whist groups and	• After some reluctance, the client initially agreed to receive phone calls from a volunteer which progressed onto visits and now a volunteer takes the client out. • Issue with answerphone and lifeline resolved. • Had problems with Freeview box - referral to Age UK helping hands – problem resolved. • Client is now attending Whist drive. • During reviews identified on-going problems i.e. needed new carpet, problem with heating etc – all resolved. • Client enjoying visit from volunteer, client attends Christmas meals, Volunteer makes phone calls to client over Christmas period so the client did not feel lonely. Volunteer assisted by taking client to family graves. • Client has had feet checked at podiatry clinic.

participation groups or Community Centre activities. • Also needs info on Transport – Dial a Ride. • Client also has an issue with answer machine and Lifeline. – liaised regarding both issues. • Problem with Freeview box – referred for Age UK for Helping hands service. • During reviews additional issues identified – needed new carpet , problem with heating, volunteer identified progressive memory loss issue – team liaised with Social worker and GP for dementia assessment. Financial issue identified by volunteer as client had been given a credit card and did not understand the implications of using one.	• Credit card issue - Client had been provided with a Credit Card thinking she did not have to pay any money back, this was raised to the team by the volunteer, and the volunteer accompanied the client to the bank to return the card. There where further issues around finance where the client was vulnerable and where resolved with support from the team and the volunteer. • Due to client's memory loss, a dementia assessment was carried out and package of care was agreed. • The Client had many issues over the period she has been with us as a client, but the issues have been identified upon reviews and resolved effectively. The client enjoys volunteer visits, as does the volunteer. The volunteer input has been paramount in supporting the client effectively, providing preventative support and referring back to the team when the client appears to have an issue. For example, this support and referral system was shown when there where issues with the vulnerability of a financial nature along with the client's memory loss. The client was diagnosed as having dementia and a package of care was set up.

Appendix 3 – Site visits to Dorset Gardens and Naughton Fields

Health Policy and Performance Board Scrutiny Topic Group – 'Care at Home'

Visit to Dorset Gardens Extra Care Housing Scheme

25th September 2014

Attendees	
Councillor Ellen Cargill	
Councillor Pamela Wallace	
Councillor Chris Loftus	
Emma Bragger	Policy Officer, Communities Directorate
Jane English	Principal Manager, Communities Directorate
Yvonne O'Reilly	Registered Manager, Halton Borough Council (HBC)
Lynne Moss	Assistant Manager, Halton Borough Council (HBC)
Apologies	
Councillor Pauline Sinnott	
Councillor Martha Lloyd -Jones	

A number of the Scrutiny Topic Group, focusing on care at home, made a planned visit to Dorset Gardens extra care housing scheme with a view to get an insight into how the scheme operates, what support is in place to enable residents with various levels of need to maintain their tenancies and remain within the community. The scheme has been open since 2007.

The visit was facilitated by the Registered Manager and Principal Manager of HBC the service. The group had a tour of the building, spoke with the Senior Care and Support Worker on duty and meet two people who have tenancies at Dorset Gardens.

The visit was 2 hours in duration.

The report below summarises the key findings of the group and some of feedback from the staff and residents spoken to on the day.

Tenancies

Tenancies are available for people aged 55+ with no, low, medium or high care and support needs.

There are 40 apartments within the scheme which are on a tenancy basis. Two apartments are 2 bedrooms, with the remaining being single bedroomed and disabled access.

At the time of the visit there were 2 vacant apartments which were going through the allocation process. There is a waiting list of potential tenants for Dorset Gardens.

Where possible, Riverside (who are the building owners) and Halton Borough Council (who deliver the care and support services within the scheme) operate a 30:40:30 principal. That is, 30% of residents have high level needs, 40% have medium level needs and 30% have no/low level needs. It is acknowledged by the management that people's care and support needs fluctuate, and do change. Currently 4 tenants have a diagnosis of dementia.

Facilities

The group were shown around the communal areas, including lounge area, café, landings and viewed the garden areas from inside. All doorways are a suitable width for wheelchairs or other mobility equipment.

There is a well-equipped lounge area with large television, comfortable seating combinations (including high backed chairs), piano, pictures, bookcase.

There is hairdressing room and holistic therapy room for use by the residents on a bookable/payable basis.

The café is not only for use by residents, but also the wider community. It was reported by staff that members of the community do visit the café.

Each apartment has its own front door. Staff reported that whilst many residents do use the communal areas and services (hairdressing, therapies, café), some choose not to and remain private, as is their preference.

There is a guest room, which can be booked out by tenant's friends and relatives for short visits.

There are mature gardens surrounding the building, which can be viewed from almost every aspect through large 'scenery windows' on every level, as well as direct access to the outdoors is available from the ground and verandas of the apartments on the front of the building.

The faculties appeared to be well maintained.

Apartments

The group were invited to look around two apartments; Resident 1's apartment which was a disabled access apartments, and Resident 2's which was a single bedroom standard apartment.

Resident 1's apartment had low level kitchen units enabling ease of use for wheelchair users. All apartment bathrooms are wet rooms, but with a fully equipped bathroom, with bath, on each landing.

Tenants bring their own furniture and belongings and are able to personalise their own space, including the space immediately outside their front door.

Care and Support

Care and support is provided by HBC staff based within the building between the hours of 7.30am-11.30pm. Outside of these times there is a Community Warden service that is based off site. Some of the tenants have telecare. The scheme manager, a Riverside employee, is in the building during Monday-Friday afternoons.

Care and support is provided to approximately 60% of the tenants (low, medium and high level needs). The remaining 40% do not have any assessed needs at this time, but *may* have a health condition that is progressive and/or expected to deteriorate, and anticipate that they may need care and support at a later date. By taking up a tenancy prior to having any care needs, they are in a suitable environment to access care and support that may be required in the future, to remain independent for as long as possible.

Care and support is provided by a Coordinator and 5 care and support staff, plus an additional 2 staff that come on in the afternoon.

Tenant's extra care needs are assessed on a 6 monthly basis, unless there is cause to do so at a different time.

There is a support rota for those tenants who do not require care, or do not have carers, but may benefit from some very low level assistance. Support may be a short social visit to the tenant, help with shopping etc.

Activities

A number of activities take place on a regular basis including reminiscence activity, bingo and access to the mobile library.

There is a Tenant's Committee which is active in arranging activities and developing the environment ie they purchased a television for the lounge, are looking at getting a greenhouse and attend the Area Forum meetings which are held at Dorset Gardens.

Feeback from Resident 1 and 2

Members on the visit would have liked to talk to residents who were not hand picked, but that was not possible, and it is recognised as being area of the scrutiny that is very difficult to achieve.

Resident 1 had been a resident at Dorset Gardens for over 6 years. Resident 1's care and support needs have changed since they first moved to Dorset Gardens, and they receive support from HBC care and support staff within their apartment. Resident 1 reported that they have had some additional health problems recently but has had access to their GP over the phone (Castlefields Practice), which they said has been very good. Resident 1's experience of Dorset Gardens has been very positive and they had praise for the staff. Resident 1 feels that, on the whole, they understand their needs. Resident 1 likes to "have a laugh and joke" with them, and they feel that they gets this from the interaction they have with the care and support staff .

Resident 2 has only been a resident at Dorset Gardens for a month. They reported that they were "slowly adapting" to their new home. Resident 2 was quite happy with their apartment, although did note that , as a wheel chair user, it was quite difficult to open their front door from the inside due to it opening inwards and the weight of it. Resident 2 was happy with the level of care and support they had received so far.

The staff advised that Resident 2's move into Dorset Gardens had been facilitated by Occupational Therapy who had done an assessment of their needs. An application had been put in for an adaptations grant to modify their kitchen to take account of the wheelchair.

Members thanked Residents 1 and 2 for letting them view their apartments. Members thought it was useful to see the two apartments, Resident 2's was a before the changes for their needs were in place (but they would happen and were in hand.) Resident 1's apartment was after the changes for their needs had been done and was a wonderful example of home from home.

Overall Findings

Privacy and independence of tenants was helped by them having their own front door and access to the building.

Enabling tenants to be integrated with the community was promoted by having a public access café and holistic therapy room, which do get used by non-tenants.

It was reported by the staff attending the visits that the relationship between Riverside and the Council is good .

The staff were attentive and appeared to accommodate each resident's needs.

The group were impressed by the standard of cleanliness throughout the building. Members of the group commented that Riverside, as the landlord, and Halton's Social Services should take pride in their achievements at this facility.

Riverside we were told, plan to update the décor. The Cafe could showed some signs of 'wear and tear', but it is so well used that this is only to be expected.

The group were informed about the use of the facility by the wider community, which has been personally witnessed by members of the group

Members of the group commented that it would be nice to see greater integration being achieved with the schools in the area, being encouraged to get involved in the activities taking place within Dorset Gardens, and supporting relationships with residents.

After speaking to residents, care staff and representatives of the landlord , overall the group left with the impression that providers and carers were going that extra mile to make the residents feel secure, involved with all aspects of their care and at home.

Appendix 3 cont. – Site visits to extra care housing schemes

Health Policy and Performance Board Scrutiny Topic Group – 'Care at Home'

Visit to Naughton Fields Extra Care Housing Scheme

1st October 2014

Attendees	
Councillor Pamela Wallace	
Councillor Joan Lowe	
Emma Bragger	Policy Officer, Communities Directorate
Angela Deakin	Scheme Manager, Halton Housing Trust
Yvonne O'Reilly	Registered Manager, Halton Borough Council (HBC)
Maggie Aspinall	Housing Support Officer, Halton Borough Council (HBC)
Michelle McDonough	Local Solutions
Representative (Dan)	PWD Consultants

Three members of the Scrutiny Topic Group, focusing on care at home, made a planned visit to Naughton Fields extra care housing scheme with a view to get an insight into how the scheme operates, what support is in place to enable residents with various levels of need to maintain their tenancies and remain within the community. The scheme has been open since 2012.

Aims & Objectives of Naughton Fields Extra Care Housing

Extra Care housing provides a secure environment in which older people wishing to retain control over their own lives have access to a combination of tailored care and support services, enabling them to live independently in their own homes.

Whilst Extra Care housing can provide a home for life for many people, when a change in circumstances requires an ongoing need for residential/nursing care it is no longer appropriate. Residents requiring this level of care and support will be supported in a move to a more appropriate setting.

The required outcomes of the service are to:

- Enhance the quality of life for people with care and support needs
- Delay and reduce the need for care and support and residential placement
- Ensure that people have a positive experience of care and support
- Safeguard adults whose circumstances make them vulnerable, and protect them from avoidable harm

For residents this means:

- Residents will be enabled to lead as independent a life as possible.
- Residents are able to exercise choice and opportunities to achieve personal fulfilment will be maximised.
- The right of the resident to make their own decisions, exercise choice and incur calculated risks will be respected and supported.
- Linked Care and Support Plans will be developed in full discussion and with the full

  agreement of the resident

The visit was facilitated by the Scheme Manager and Registered Manager. The group had a tour of the building and spoke with a representative from Local Solutions, one of the main care providers delivering at that site and the Housing Support Officer . Members also met meet three people who have tenancies/ownership at Naughton Fields.

The visit was 2.5 hours in duration.

The report below summarises the key findings of the group and some of feedback from the staff and residents spoken to on the day.

Tenancies /ownership

Tenancies or shared ownerships are available for people aged 55+ with no, low, medium or high care and support needs.

There are 47 two bedroom apartments within the scheme. .

Where possible, Halton Housing Trust (HHT) (who are the building owners) and the Property Pool Plus Partnership try to operate a 30:40:30 principal. That is, 30% of residents have high level needs, 40% have medium level needs and 30% have no/low level needs. It is acknowledged by the management that people's care and support needs fluctuate, and do change.

Allocation criteria

For Naughton Fields the intention was to prioritise Halton residents given the significant capital investment being made by the Council, but in reality it was a struggle to identify sufficient numbers of local people with support/care needs. A small number of people from out of borough were accommodated but they were ones who fulfilled the 'local connection' criteria contained in the Property Pool Plus allocations scheme e.g. they had previously been residents of Halton, and/or needed to move to receive support from family/friends in Halton, and they demonstrated a need for a supported environment.

Facilities

The group were shown around the communal areas, including lounge area, bistro, landings and viewed the garden areas from outside. All doorways are a suitable width for wheelchairs or other mobility equipment.

There is a well-equipped lounge area with large television, fireplace, comfortable seating combinations pictures, bookcase.

There is hairdressing salon and spa therapy room , both operated as a commercial interest by external companies. They are open to residents and non residents.

The bistro is not only for use by residents, but also the wider community. It was reported by staff that members of the community do visit the bistro.

There is a guest room, which can be booked out by tenant's friends and relatives for short visits.

There are gardens surrounding the rear of the building, which can be viewed from through large 'scenery windows' on every level, as well as direct access to the outdoors is available from the ground and verandas of the apartments on the upper floors.

The faculties appeared to be well maintained.

Apartments

The group were invited to look around two apartments.

Apartments were spacious with open planned kitchen and living areas and natural light in the main living space through large windows.

Residents are permitted to smoke within their own homes, but not in communal areas.

Care and Support

There are three types of organisations on site at Naughton Fields:

Halton Housing Trust – Scheme Manager on site, manages the housing facility

Halton Borough Council – Housing Support Worker – providing support to residents, signposting, providing information, assisting with transport arrangements etc. The Housing Support Worker is on site Monday – Friday 9am-5pm, who also responds to life line calls during this time. Outside of these hours the lifeline service is transferred to community wardens.

Care Providers – Local Solutions is the main provider, but there are a number of other providers who provide domiciliary, personal care etc to residents. Care providers have access to the building 24 hours to meet the needs of their clients. Initially the scheme was to offer care on site from 7am-11pm, but the hours of required care where not identified prior to the opening and there had been issues with Local Solutions (the main provider) and HBC immediately prior to the opening, and it was evident that on site care could not be provided. Care is provided by Local Solutions, and others , on a 'spot basis'. There is currently no general on site care provision, however, HHT and Property Pool Plus are working o re balance the care needs levels to warrant on site care.

Approximately 12 residents have signed up to the Visbuzz pilot to aid them in reducing their social isolation through the use of the simple video calling.

Activities

A number of activities take place on a regular basis including singing for the brain, bingo, residents committee, visits from Age UK, Halton Borough Council Bridge Builders.

There is a Tenant's Committee which is active in arranging activities and funds to improve their environment such as equipment for the garden.

Feeback from Resident 3&4 and Resident 5

Members on the visit would have liked to talk to residents who were not 'hand picked', but that was not possible, and it is recognised as being area of the scrutiny that is very difficult to achieve.

Resident 3& 4 had been residents at Naughton Fields since it opened in 2012 and shared a two bedroom apartment. Both Resident 3 & 4 said that they were very happy with the facilities and environment that Naughton Fields provided. They had praise for the extensive support that was provided to them by the Housing Support Worker with form filling, appointment arranging etc.

Resident 3 & 4 did state that they felt there had been some difficulties in the delivery of their care packages since they took up residence at Naughton Fields. These concerns were reported though the appropriate channels for further investigation, where it was evident that Residents 3 & 4 were receiving care appropriate to their care package and identified needs, and number of professionals were engaged with them to ensure their needs were met.

Resident 5 had been resident in Naughton Fields for almost 2 years. She moved in with her husband who has mixed dementia. Another family member also lives in Naughton Fields. As her families care and support needs were changing she felt that Naughton Fields offered them the safe environment that could accommodate the changing needs. Currently Resident 5 provides care to her husband, but she is awaiting a social care assessment of her husband's care needs. She praised the support she has had from the Housing Support Worker, who has provided practical and emotional support to her during a hard transition period with her husband's declining health. Support provided by the Housing Support Worker included respite (where the Housing Support Worker took her husband and other family member to the on site Bistro for a drink, while Resident 5 was able to go out to the shops or bingo), signposting, emotional support.

Resident 5 was clearly very satisfied with the facility, but was experiencing trouble with disruptive neighbours, which was being dealt with by Halton Housing Trust.

Resident 5 also mentioned her disappointment with the Bistro now being closed at a weekend. The Bistro is a commercial operation, ran by an external company who have stated that it is not cost effective for them to run the café at a weekend. Resident 5 observed that for many of the residents this has had a negative impact and has resulted in isolation, particularly for her family member, and others who are unable or not wishing to leave Naughton Fields. There was some discussion as to the role of the residents committee to generate interest in the weekend service to make it viable to open at a weekend.

Members felt that the apartments, and communal areas of Naughton fields, were high quality and promoted a sense of independence, but provided reassurance through the access to the life line service.

Overall Findings

Privacy and independence of tenants was helped by them having their own front door and access to the building.

Enabling tenants to be integrated with the community was promoted by having a public access Bistro and Spa therapy room, which do get used by non-tenants.

It was reported by the staff attending the visits that the relationship between Halton Housing Trust and the Council is good .

The support provided by the Housing Support Officer, which was validated by the residents which the group spoke to, seemed to be key to those residents. The Housing Support Officer was attentive to the residents needs and provided a quality service to those who the group spoke to. The lack of on site, daily care is being addressed through the allocation process (to generate more care hours), but in the interim 'spot contracts' are in place for those who require care.

The group were impressed by the standard of cleanliness throughout the building. Members of the group commented that Halton Housing Trust, as the landlord, should take pride in their achievements at this facility.

After speaking to residents, care staff and representatives of the landlord, overall the group left with the impression that whilst there had been some 'teething' problems with residents settling into the scheme – due partly to advertising the scheme as having access to on site care during the day time, which is not in place, many of the residents moving into communal living for the first time, and a new residents committee being formed – a corner was being turned.

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[i] Equality and Human Rights Commission - Close to Home : An inquiry into older people and human rights in home care (2011)
[ii] Halton Community Alarm Service Annual Report 2014

Appendix 4 – Community Nursing Presentation