Northamptonshire County Council

Performance Report

2019-20

Reporting Period: Quarter 3

Appendix: Supporting Narrative

Produced by: Business Intelligence, Corporate Services, February 2020

Corporate Performance Report - Summary of Supporting Initiatives/ Projects

This appendix to the councils main performance report provides a small sample of the many areas of work that are underway to transform local services in Northamptonshire, these areas are not necessarily directly supporting the indicators within the corporate scorecard but providing a wider performance narrative. Detail from the Future Northants programme hasn't been included here as updates for that programme of work are provided on a regular basis to leaders and members of all authorities.

1. **Directorate:** NASS **Initiative/ Project:** The Rapid Response Team

The rapid response team is a collaborative partnership approach to reducing avoidable admissions. Emergency calls to the ambulance service for people over 65 year old with non-life threatening issues are attended by a joint health and social care team. The crew assess the person's needs and put suitable interventions in place to avoid admissions including essential enablement equipment available for immediate use. Where appropriate health and social care packages area also put in place immediately and any other onward referrals made to support short term recovery. Although we currently only operate one crew that can't always be available, of the 141 calls the joint teams attended an admission was avoided in 57% of cases. We want to expand this service in the coming months. Customers have also giving really positive feedback, some examples of which are shown below

We also launched major winter scheme "**Home for Christmas**" in mid-December 2019. This has been led by social care to try and ease the pressure by helping discharge 170 of the longest staying patients in the two Acutes. Every one of these patients had stayed over 150 days and together represented 10,000 excess bed days in hospitals. Given an average cost of £430 a day for acute care the financial impact of this is also significant.

2. **Directorate:** NASS **Initiative/ Project:** Connecting Conversations

February has seen the launch of a new way of working in Adult Social Care. This new approach is called Connecting Conversations. Unlike traditional ways of assessing people for adult social care support, this approach focuses much more on the person's strengths and supporting them to connect to services in their local communities. Initially two

innovations sites are trialling the new way of working and are based with other partner organisations in the local area. They are covering the post code areas NN2, NN5, NN17 and NN18.

This will enable them to work more closely with partners and be based in local communities. The approach will mean staff can react quickly to support people as soon as they need it, working with them more intensively from the start to promote their independence and reducing the need for long term support. In the week since the sites have started we have already seen a number of positive outcomes achieved. The staff in the innovations sites will be integral in developing the approach and monitoring its effectiveness. The next phase will be to roll it out to other areas across the county.

3. **Directorate:** Public Health **Initiative/ Project:** improving health of rough sleepers

Evidence indicated that four local authorities in Northamptonshire had significantly higher numbers of homeless households in comparison to the England and East Midland average. Many of these people were engaging in unhealthy behaviours, including drug use, to survive the homeless conditions they found themselves in. However, homeless people frequently experience numerous barriers to accessing healthcare, including organisational barriers, attitudinal barriers and social stigma. It was clear that unless something was done to improve their health and resilience, they were at a high risk of serious illness and premature mortality.

Historically, there was limited data about the actual extent of the homeless population and little cross county working to build on; initiatives were typically local to each district and borough and often delivered via small voluntary sector organisations. There was little dedicated resource available and no strategically coordinated work taking place with a health protection focus to address the health needs of this population. Fundamental to designing a strategic and innovative response was ensuring that a nuanced and empowering approach was taken to enable the individuals to overcome the burden of stigmatisation and the destruction of their self-respect, confidence and self-efficacy. Development of a clear ethos that empowered and boosted homeless resident's ability to take control of their lives needed to be central to a project designed to prevent ill health, provide treatment of existing conditions, and support people towards achieving their goals and aspirations.

Review and development of a comprehensive health protection programme was being undertaken and the opportunity arose to capitalise on the interest of voluntary sector colleagues in providing health screening to homeless people. From an initial focus on TB screening, we expanded the local vision to develop a strategic programme to address health protection priorities identified in the annual DPH report and PHE Health protection profile, where Hepatitis C had been identified as one of the major issues identified in high risk population alongside increasing HIV prevalence and increased hospital admissions due to Hepatitis B related liver disease. Seasonal Flu vaccination uptake in this vulnerable group was also our challenge. Subsequently a care pathway was designed incorporating provision of a general health and wellbeing check, followed by screening for TB, Hepatitis A, B and C, and HIV; immunisation for

Hepatitis A and B, and vaccinations for flu. In addition to which, an opportunity for people identified as being at high risk were offered a liver scan and provided with advice and support to register with a GP.
The model was based on partnership working, with specialist health services coming out into community settings and community services in-reaching, with a "resource pooling" approach involving 24 key NHS and non-NHS partners.

The overall approach was based on a model which included prevention, treatment and rehabilitation elements, and was grounded in the "recovery model" to align with the overall ethos of the programme.

We engaged and re-engaged people who tested positive for TB with the local TB service, those with Hepatitis C /B and HIV to HIV, and liver services and also those with liver fibrosis to liver treatment centres. Relevant onward referrals were also made to primary or secondary care services for people with high blood pressure and mental health issues, and to smoking cessation services, weight management services and substance misuse treatment as required. 11 people with latent TB infection started treatment and 6 of them completed, 2 active cases of Hepatitis C were treated and are in care pathway now. Cases of moderate and severe liver fibrosis have been engaged with a specialist liver treatment service. Out of the 127 people who received lifestyle screening; 27 were overweight and 20 with high blood pressure were engaged with their GPs for further assessment and management. 10% of the rough sleepers screened who were not on a health care record and registered with a GP were helped to register with a local GP. The majority of those who attended, found the clinics a positive experience which gave them confidence in the local system and motivated them to take control of their health.

During the clinical sessions the team collected feedback from the people attending the sessions and from the formal debriefings from all our partners. A few of the statements from the homeless and rough sleepers and our partners are quoted below:

A rough sleeper who attended one of the clinics held at 'Bridge Northamptonshire' and was tested positive with Hepatitis C, fed back to the Centre Manager at the Bridge. Attendee stated that:

> "*This clinical session has been very much helpful, as it helped me to get my diagnosis and treated. Without this I would have missed the health condition as I was tested for the BBV before and was negative". He also said: "I liked the drop-in rather than appointments and wait. So many tests at one place was so helpful. I would like these clinics more frequently with more NHS one stop. It is such a quick process at a friendly place where we regularly visit"*

Another homeless person who was tested positive of Tuberculosis and was accommodated by the housing team said:

> *"I am so pleased that with the help of TB nurse, public health and the housing teams of two Local authorities, I have been accommodate on apriority basis so that I can continue my TB treatment and do not miss any medicine*".

The Community safety officer said that

> *"Partnership working was incredible and it was a great clinical team. It was impressive to watch a great coordination by public health which brought all of it together in a very short time frame" She also said: "The venues worked well, and going out to the places that the rough sleeping population access made a huge difference to getting people engaged."*

The first round of the yearly programme after the pilot has been successfully delivered in October 2019 with 125 people were screened in eight clinical sessions across the county; and next six clinics are across the county are planned for March 2020.

4. **Directorate:** Public Health **Initiative/ Project:** Healthy Towns Project

The Public Health team have made funding available to the County's seven district local Health and Wellbeing Forums for initiatives and projects that contribute to health and wellbeing and help deliver on locally identified health priorities. 21 projects have been submitted to draw on the £750k budget. This initiative recognises the important role of the boroughs and districts taking an active role in improving the health and wellbeing of our residents.

5. **Directorate:** Public Health **Initiative/ Project:** Social Prescribing SIB

Northamptonshire County Council's Public Health team, local NHS organisations and the voluntary and community sector have been working together through Northamptonshire Health and Care Partnership (NHCP) to develop a social prescribing programme serving the whole county. Social prescribing is a way of helping people to manage their own physical and mental health and wellbeing and achieve sustained lifestyle change. They work closely with a specialist 'link worker', who can refer them to relevant non-medical services in their local communities, such as leisure activities, social groups and healthy lifestyle advice.

Social prescribing is one of the national priorities outlined in the NHS Long Term Plan, and although it is already in practice around the country, Northamptonshire is believed to be the first area in England to establish an integrated social prescribing service at a county-wide level. At the heart of the service are social prescribing 'link workers', who are responsible for working with individuals to understand their needs, plan what steps they could take to improve their health and wellbeing and help them to access appropriate services. People can be referred to a link worker by their GP, nurse or other health or social care professional. A number of social prescribing link workers are already employed by GP practices across Northamptonshire, and the new county-wide service will recruit more while ensuring that all have access to the same training, development and support to succeed in their roles. Crucially, NHCP will also work closely with Northamptonshire's voluntary and community sector to plan, fund and deliver the necessary infrastructure to ensure local services have the capacity to meet the needs of people who need to access them.

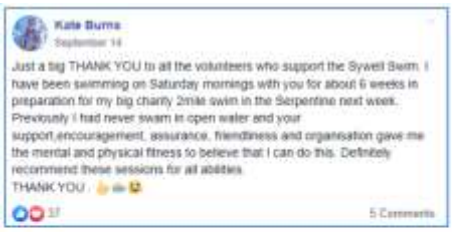
A formal procurement process has been under way to appoint local delivery partners with responsibility for planning, organising, providing and rolling out the service throughout Northamptonshire. These delivery partners have now been identified and are set to manage the delivery of social prescribing in the following localities, covering the entire county between them:

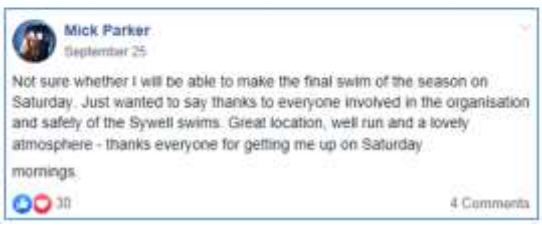
- Age UK Northamptonshire – Daventry and South Northamptonshire; Kettering and Corby
- General Practice Alliance – Northampton
- Northamptonshire Carers – Wellingborough
- Mayday Trust – East Northamptonshire

Working on behalf of the Northamptonshire health and care system and regularly reporting back to NHCP, each of the organisations will be responsible for ensuring local people in their respective areas have access to social prescribing. They will focus on supporting four particular groups who can benefit most from the service: people with mental health problems, carers, people with more than one long-term health conditions, and those who are socially isolated. Their work will include recruiting more social prescribing link workers, starting in the spring, to enable people to access the service, and then later supporting smaller voluntary and community organisations in their areas to provide socially prescribed services.

6. **Directorate:** Corporate Services **Initiative/ Project:** Open Water Swimming - Sywell

2019's inaugural season of Northamptonshire's first ever venue for organised open water swimming saw over 550 people take part during the course of the summer. Until this year anyone in the county wanting to swim in the open water had to travel down to Bedford or up to Leicestershire. However, thanks to a partnership effort led by Northamptonshire Sport and including Country Parks, Northampton Triathlon Club and the Royal Lifesaving Society, the redundant reservoir at Sywell Country Park was open every Saturday morning (8-10am) for novice and experienced swimmers to come down and enjoy the water.





The sessions were all run by volunteers and had safety as a priority with trained lifeguards, safety kayakers and a rescue boat always in attendance. Most pleasingly over 43% of those swimming were women and £3,247 additional car parking income was generated for the Country Parks service.

7. **Directorate:** Corporate Services **Initiative/ Project:** Parkruns

Parkruns are free of charge, volunteer led, mass participation 5km runs taking place all over the country at the same time (9am) every Saturday morning.

Oldest Runner – Racecourse (92yr old)! Roger Sawtell

Thanks to the support of partners Northamptonshire Sport was successful in the last months of 2019 in supporting the creation of two more Parkruns, both within the NCC Country Parks (Brixworth and Irchester) taking the total for the county to 8 (Corby, Daventry, Kettering, Brixworth, Upton, Racecourse, Irchester and Salcey Forest) plus 2 Junior Parkruns (Desborough, Daventry).

Over 34,000 people are now registered across the Northamptonshire Parkruns. In the lead up to Christmas an average of 1,908 were taking part every week across the 8 events. However, following the post Christmas / New Year boost, January saw over 2,578 taking part across the 8 events every week, a 35% increase.

8. **Directorate:** CFN **Initiative/ Project:** Ofsted Monitoring Visit & Performance Overview

Since December 2019, the service has ensured that all children have an allocated social worker within 48 hours and this is being maintained and carefully monitored.

The first Ofsted monitoring to the Front Door: the Multi- Agency Safeguarding Hub (MASH) and the Duty and assessment Teams (DAAT) took place in January. The inspection findings indicate we know ourselves well and know what needs to happen to improve; they could see green shoots of improved practice; increased workforce capacity and increased staff morale; social workers who spoke positively about working in Northamptonshire and feeling supported; conditions improving to enable good Social Work practice to flourish; all children having allocated Social Workers whilst caseloads remain challenging for some; decisions being made did not leave children at risk of harm. The areas we need to undertake further work on are already included in the improvement plans: consistency in quality of our work, timeliness of the initial visit, quality assurance and auditing to improve practice and outcomes, and continue to improve workforce capacity.

The numbers of children in need have continued to rise since the previous year, although are still lower than the statistical neighbour average. The number of children with a Child Protection plan has increased to the statistical neighbour average. Our numbers of children in care has seen a slight decrease over the last four months although we remain slightly higher than our statistical neighbours' average and just above the national average in terms of

rate per 10,000. The Northamptonshire Safeguarding Children Partnership is developing our Early Help Strategy, to ensure that children who need additional support are identified early and receive the right support to prevent issues from escalating. Our social care teams are also focusing on helping children who are in care to return to their families where it is safe and in their best interests to do so.