ADULT SOCIAL CARE AND SERVICES SCRUTINY PANEL

A meeting of the Adult Social Care and Services Scrutiny Panel was held on 11 February 2019.

PRESENT: Councillors McGee (Chair), Coupe, Davison, Uddin, J Walker and Walters.

ALSO IN ATTENDANCE: J Bracknall – Chief Executive, Carers Together.
J Cain – Press.
M Davis – Chief Executive, Middlesbrough Voluntary Development Agency (MVDA).
M Dawson – Programme Manager, Ageing Better Middlesbrough (ABM).
L O'Brien – Strategic Development Manager, Carers Together.
L Spaven – Head of Community and Service Development, MVDA.

OFFICERS: C Breheny, C Lunn, E Scollay and C Walker.

APOLOGIES FOR ABSENCE: Councillors Dryden and McGloin.

DECLARATIONS OF INTERESTS

There were no Declarations of Interest.

MINUTES - ADULT SOCIAL CARE AND SERVICES SCRUTINY PANEL - 7 JANUARY 2019

The minutes of the Adult Social Care and Services Scrutiny Panel meeting held on 7 January 2019 were submitted and approved as a correct record, subject to the addition of C Walker to the officer attendance details.

MATTERS ARISING

There were no matters arising.

NOTED

INTEGRATION OF HEALTH AND SOCIAL CARE - VERBAL UPDATE

The Director of Adult Social Care and Health Integration provided the Panel with an update regarding the integration of Health and Social Care.

Members were informed that proposals regarding the advancement of integration work had been presented to the Joint Health and Well-being Board in recent weeks.

The NHS' ten-year plan had recently been published, which contained reference to 'Primary Care Networks'. This referred to the notion of services operating around a cluster of GP practices within communities. Reference was made to an initiative entitled 'Primary Care Homes', which related to 'Primary Care Networks'. This referred to groups of GP practices operating together as a consortium, which would have greater control over how resources were utilised in their particular area.

Locally, at present, the Clinical Commissioning Groups (CCGs) were working with GPs to determine potential alliances of GP practices. In terms of the Local Authority, consideration was being given to the alignment of local areas with GP practices; the NHS' perspective was that this would reflect population blocks of 30,000-50,000. Consideration was being given as to how this would work in Middlesbrough, particularly as there was no clear correlation between the GP practice that people attended and the area in which they lived. Consideration was also being given towards the relationship between Social Care and GP practices in terms of area base working, and the benefits that this could offer to the broader health and well-being of Middlesbrough's residents.

Reference was made to prevention and case conferencing work in relation to complex individuals and how area base working could work. The importance of meeting the needs of the individual area concerned was highlighted. Work was currently ongoing to look at this; progress would be reported to the Health and Well-being Board accordingly.

Reference was made to a pilot project currently being undertaken with care homes in Darlington. The CCG had invested in some additional GP time, with those GPs working in selected care homes. The GPs did not act as replacements for the residents' existing GPs, but instead provided a routine whereby if a person's health was deteriorating, that person would be reviewed. Over the course of the ongoing pilot, it had been found that residents/patients were being taken off medication and hospital admissions had been significantly reduced.

It was indicated that there were three parts to integration - integrated commissioning, integrated data and integrated working. It was felt that if virtual pool budgets were realised for each area, these could be balanced against the demographics in order to allow for equity across the area to be dealt with more efficiently.

Outline details were provided in respect of the Health and Well-being Board's joint working arrangements, and the role of GPs and the CCGs in terms of accountability for future work activities.

A Member commented that residents may be registered at GP practices across Middlesbrough, and potentially neighbouring Boroughs. In response, the Panel was provided with the example of North Ormesby, where circa. 80% of residents did not go to GPs around that area. It was a big issue, but had been identified and further consideration would be given accordingly.

The Panel considered the alignment of GPs in particular localities. Members were informed of the work currently being undertaken by the CCGs in relation to this. It was explained that a different delivery model could be experienced in Middlesbrough than in Redcar; brief consideration was given towards the different delivery models around this.

In response to an enquiry, it was explained that although the Darlington care homes pilot project had been in operation for less than twelve months, evidence already demonstrated reduced hospital admissions and a number of people being taken off medication. It was felt that lessons could be learnt from this approach, with potential for this pilot exercise to be replicated in Middlesbrough (with the possibility of Better Care Fund money being utilised). In terms of a methodology to replicate this, a selection of care homes from both Middlesbrough and Redcar and Cleveland would need to be chosen, and a GP commissioned to provide support.

The representative of ABM referred to a recent report in relation to Integrated Care Models, which indicated that such models potentially required increased financial resource from the health service. Although these findings were based on a short period of time (2-3 years), the article presented a caveat that the more work that was undertaken and the more services offered, the more resource was required. It was agreed that a link to this article would be forwarded to the Democratic Services Officer for circulation to the Panel Members. The view of supporting more people at home to avoid them having to enter care homes was supported by Adult Social Care, but it was acknowledged that this was often more expensive. Regarding integration, instructions to integrate had been received, and services ought to have ensured that the best benefit, with the resources available, was being attained. It was hoped that additional expenditure in the short term would potentially lead to increased savings in the long term, but this could never be guaranteed.

A Member queried the timeframe in respect of the alignment of GP surgeries. In response, it was explained that a Chief Officers Group had started to meet and work was progressing to gain the first sense of which communities would be looked at. A date for implementation had not been identified as of yet, but a plan as to how it would be developed had been proposed and, in essence, held by the Health and Well-being Board. It was anticipated that an update report would be taken to the next meeting of the Health and Well-being Board.

From the perspective of the voluntary sector, the Chief Executive of MVDA raised the notion of the number of people that visited their GP for non-acute medical issues, and the NHS' long-term plans and commitment to the Primary Care Network and support staff. It was indicated that nationally, for example, there were plans for 1000 social prescribing Link Workers to work within Primary Care Networks (e.g. the employment of paramedics and physiotherapists), to enable GPs to spend more time with patients. In terms of the NHS' long-term plan, plans for some of this was to be published by 30 June 2019. MVDA was keen to put arrangements in place for colleagues across the sector in Middlesbrough, and possibly across the South Tees, to assist with this.

The Panel gave brief consideration to the Council's social regeneration agenda and how this work could potentially complement that, together with how place-based responsibility would meet broader health and well-being requirements.

The Chair thanked the Director of Adult Social Care and Health Integration for the update.

AGREED that:

1. **ABM's Programme Manager would forward a link to the Integrated Care Model article, as detailed in the preamble, to the Democratic Services Officer.**
2. **The information, as presented, be noted.**

SOCIAL CARE SUPPORT FOR OLDER CARERS - FURTHER INFORMATION

Representatives of ABM and MVDA had been invited to the meeting to provide information in respect of the 'Social Care Support for Older Carers' investigation.

ABM's Programme Manager tabled a briefing note, which covered the following topical areas:

- Learning about working with carers;
- Caring being part of the bigger picture relating to complexity;
- 'Hidden carers' and the language of caring;
- Identity and relationships;
- Evening and weekend loneliness; and
- Post caring.

It was explained that ABM was now in its fourth year of six. The programme had engaged carers in many different ways. Of the programme's circa. 3600 network members, a number had identified themselves, voluntarily, as carers. Older people were engaged in the Assertive Outreach and Psychological Therapies elements of the programme, and also in community development activities and taster sessions out in the community.

In terms of statistics, 89% of people referred onto the programme's Assertive Outreach project (which worked with the loneliest and most socially isolated people in Middlesbrough) who identified themselves as carers, also identified themselves as having a long-term physical or mental health issue. It was highlighted that, when talking about carers, the term itself implied that this was a group of people that separated out from everybody else that ABM worked with in terms of loneliness, which was not the case. Caring was part of a bigger picture that related to complexity. For example: older people who were lonely and isolated may have also been experiencing wider issues around domestic violence, their own physical health issues, debt, substance misuse, poor housing, etc., whilst also caring for a relative or friend. This made it difficult to separate out the learning in relation to caring in particular.

In relation to 'hidden carers', some older people did not always resonate with the term 'carer', as they would see themselves as being a husband/mother/son, etc., but not a carer. This made it difficult when undertaking formal learning around carers, as only those that associated themselves with having a caring role would come forward, which was an issue. Interestingly, there was also a question around the point at which carers became 'unhidden', e.g. they received a carer's assessment and accessed services, but were then 'hidden' again.

As part of the 'Age Friendly Middlesbrough' project, ABM's advisory group had spoken to people about caring. One of the findings was that carers were most concerned with the day-to-day stresses around caring for someone, for example: being ill themselves, or facing other unplanned / crisis scenarios.

A key issue arising from ABM's Psychological Therapies and Assertive Outreach programmes revolved around identity and relationships. For example: the psychological impact upon individuals in long-term relationships suddenly presented with a change in circumstances, such as physical health difficulty or conditions such as dementia.

Regarding the issue of transport and caring roles, the Panel was advised that services, activities and transport were mainly provided during weekdays, within working hours. It was explained that feelings of isolation and loneliness could intensify after 17:00. Transport issues arose across all of ABM's learning for carers and for people who were lonely and/or isolated, with additional layers of complexity also presenting.

In terms of post caring, i.e. when the person being cared for passed away, this linked with the issue of 'identity'; people could struggle to understand their purpose or value and lack the confidence and skills to re-connect with others. Some issues could only be addressed through one-to-one personal support.

Members heard that a further element related to ageism, and why sometimes older carers were missed. It was explained that, as people aged, there was an expectation that caring was part of the cycle, and therefore people did not recognise or validate the loss, impact or significance of caring on that person. In terms of assisting with this, offering validation, listening and providing ongoing support and access to appropriate community support and activities all helped.

The Chief Executive of Carers Together highlighted that the trends identified were consistent with those raised at the last Panel meeting, particularly in terms of the issues around people being 'hidden' at different times and caring being an additional role. In terms of identity and what it meant to be a carer, it was felt that legislation recognised carers, even if they did not recognise it themselves, and set out that Social Care had responsibilities towards carers. It was felt that the integration of Health and Social Care could offer assistance by providing a heightened level of consideration towards the duties and rights of carers, which would facilitate earlier engagement before crisis ensued.

A discussion took place regarding the current partnership working between the Local Authority, health colleagues and the voluntary sector. Reference was made to a joint commissioning group, which included MVDA, the Council and CCG colleagues, and focused upon the needs of carers across Middlesbrough. It was hoped that work would be extended with Redcar and Cleveland next year, in order to look at the South Tees approach to supporting carers across the board. This would include both 'hidden' and older carers. Consideration was given to the varying remits of different voluntary sector organisations; the difficulties in ensuring that all sectors could be represented at all meetings; and the role of both human interaction and technology in supporting future work.

The Panel discussed changing technology and the impact upon older carers. The Chief Executive of Carers Together advised that the organisation had been delivering work around digital inclusion for carers, for example: online shopping and booking medical appointments. It was felt to be a 'digital world', and one that could be lonely and isolating for older people who did not use technology or the internet. A Member commented that all organisations had a responsibility to assist older people as times and communities changed. ABM's Programme Manager highlighted that 65% of its members currently required hard copies of documentation, and issues such as 'pop ups' when using computers did stall progress. It was commented that, due to the ever-evolving nature of technology, this was not a one-off process, and therefore ongoing support was necessary. Reference was made to digital inclusion work being undertaken with partners including: Barclays, Debenhams, Digital Eagles, M&S and Santander.

The Chief Executive of MVDA highlighted that various work initiatives were currently taking place through the Carers Partnership, including the implementation of a 'We Care You Care' campaign, which was concerned with raising the profile of carers locally.

The proposed Aim and Terms of Reference for this Scrutiny investigation had been circulated for Members' consideration. These were as follows:

Proposed Aim:

To examine, and raise awareness of, the issues surrounding older carers (aged 50+)

Proposed Terms of Reference:

1. *To ascertain the support available to older carers by examining the work that the Council, its partners and voluntary sector organisations are currently undertaking.*
2. *To identify new ways of working by exploring the provision available for key support activities, including guidance and advocacy work, and to consider how this could be advanced further.*
3. *To understand the key issues around, and potential changes to, financial resources and the impact that these may have on service provision.*

During discussion, Members considered the reference to older carers at age 50+, and whether this age range ought to have been adjusted. Reference was made to ABM's 50+ remit, and younger people were also discussed. In conclusion, it was agreed that this would remain at 50+, although it would be borne in mind that other service areas, such as Children's Services, may also be supporting carers within this age range. For example: a 50-year-old parent caring for a 10-year-old child with a learning disability, may be receiving such support.

The Panel approved the proposed Aim and Terms of Reference without the need for amendments.

The Chair thanked the representatives for the information provided.

AGREED:

1. **That the proposed Aim and Terms of Reference for the Scrutiny investigation, as detailed in the preamble, be approved.**
2. **That the information, as presented, be noted.**

MVDA - COMMUNITY CONNECT SERVICE - UPDATE

The Chief Executive of MVDA delivered a presentation to update the Panel about the Community Connect Service. The presentation covered the following topics:

- Community Connect Service - Aim and Principle;
- Background;
- Who the service was for;
- The challenges;
- Learning;
- Clients;
- Complexity;
- Befriending;
- What had been done;
- Feedback from clients and referrers; and
- Future work.

The statistics provided during the presentation were based on an in-depth review of 48 clients, but was in the context of the wider service.

Copies of three client case studies were tabled for Members' perusal.

The Panel heard that the Community Connect Service aimed to encourage people to be more independent and take control of their well-being by supporting them to access community-based services and activities. It was person-centred and worked on the principle of early intervention to prevent, postpone and delay the need for formal care. Members were reminded of the processes around the establishment of the service, funding streams, and provided with details regarding staffing arrangements (i.e. 4 FTE currently in post).

The service was for all Middlesbrough residents aged 18+ who were experiencing practical and/or emotional barriers preventing them from accessing their communities. The primary referral route was through Adult Social Care, although organisations such as the Citizen's Advice Bureau (CAB) had also made referrals.

The current challenges being experienced by the service were outlined to the Panel. These included:

- A lower rate of referrals from Adult Social Care;
- The complexity of the referrals being significantly higher than anticipated at the beginning;
- Gaps in local service provision, such as in the area of befriending;
- Transport barriers; and
- Evidencing prevention.

Members discussed the issue of transport, which had been raised during the Panel's previous review around 'Reducing Loneliness and/or Social Isolation in Later Life'. Work was currently taking place around this transport issue. ABM's Programme Manager referred to a recent study undertaken by Teesside University, which related to this.

Regarding learning, Members were informed that:

- The level and complexity of need was significantly higher than anticipated;
- There were more people meeting the threshold for Adult Social Care today than when Community Connect first started, which was having an impact on the service;
- Ongoing work and sessions with partners were taking place on the learning achieved around the gaps in service provision, e.g. in respect of befriending and transport, and availability of provision on an evening; and
- Exploration of a variety of ways to encapsulate the full picture of the services' impact was needed, although work was ongoing towards this. Reference was made to a current project, which would look at the social return in terms of investment from the Community Connect Service.

In terms of clients, Members were advised that the age profile of clients had not changed dramatically since the last update was provided. The referrals predominantly came from the Council's Access Team, but other Social Care teams also referred in. 60% of clients were female; 94% were white British, which coincided with the Access contact data; and 46% resided in the top 1% most deprived wards in Middlesbrough.

In response to an enquiry, it was explained that discussions were taking place with different community group networks in order to increase the number of clients from BAME communities. Circa. 30% of MVDA's support was provided to groups and organisations in the BAME community, consequently discussions were focused on accessing the communities already identified. However, the restrictions on referrals coming through Adult Social Care was to be borne in mind. A Member made reference to a BBC documentary that was discussed during the last Panel meeting. It was felt that increased promotion and education around the service would assist in reaching out to different communities.

With regards to the 46% of clients residing in the top 1% most deprived wards in Middlesbrough, ABM's Programme Manager provided comparable statistics for ABM's services. It was indicated that for ABM's Assertive Outreach project, the figure of 46% raised to circa. 78%, but for the community development element, the figure dropped to circa. 15%. Possible reasons for this included an unwillingness, or feeling unable, to engage with community activity, or individuals meeting the threshold for Social Care, which would negate

the need for referral to the Community Connect Service.

Regarding complexity, it was explained to the Panel that when the service was first designed, it was envisaged that clients would be at the lower-end level of prevention, but in reality were at the higher. Reference was made to the Care Act definition of prevention and the terms 'Primary', 'Secondary' and 'Tertiary'; more people accessing the service were at the 'Secondary' and 'Tertiary' stages. Work was currently taking place around defining complexity. The following statistics were provided to Members:

- 46% of clients were referred for three-plus referral reasons;
- Only 16% were referred for a single issue;
- 90% of clients had at least one health condition;
- 59% of clients had two or more health conditions;
- 33% of clients had a mental health condition;
- 76% of clients had at least one physical disability; and
- 81% of clients had engaged with the service for six-months plus.

In terms of befriending, Members heard that 42% of clients had requested befriending support, ranging in age from 31 to 90 years. There were two organisations currently providing a local befriending offer (Age UK Teesside and Independent Age), though it was indicated that there were still gaps in provision. It was hoped that provision could be increased over the next six months.

With regards to accomplishments and what the service had achieved to date, 214 people had been introduced to 94 local services. It was indicated that the large number of introductions had been unexpected, but was very positive in terms of reflection of the service and meeting clients' needs. Of those, 57 introductions were to services addressing social isolation, including ABM. 92% of clients had been prevented from re-entering Adult Social Care, which was an excellent result and higher than anticipated. It was hoped that this outcome would be maintained. In relation to gaps in local provision, challenges around provision in Coulby Newham had been observed. In response to this, work was currently taking place with a range of stakeholders in terms of what provision was available and how people could access it.

It was outlined to Members that gaps in service provision for young people had also been identified. The Panel discussed the rise in young people being diagnosed with autism and how this trend could affect services in the future. Reference was made to Children's Services seeing an increase in complexity in the recent past, which had become a national issue. This matter of complexity was being observed in Adult Social Care at the moment, whereby a smaller number of people were receiving support from Social Workers, but there was clear pressure for additional staff resource due to increasing complexity and more overlapping issues.

It was highlighted to the Panel that, in terms of the capacity of the other services that clients were being introduced to, aside from the gaps mentioned around befriending and transport, capacity issues had not been encountered, which was especially positive.

The Panel heard that the top three reasons for referral were for: Information and advice; Emotional support; and Practical support. Reference was made to the development of an Outcome Star Model, which had been outlined to the Panel previously. The top three Outcome Star improvement areas were: Social Networks; Feeling Informed and Supported; and Emotional and Mental Health. All ten Outcome Star areas had seen an overall improvement for the service's clients. It was explained that an Outcome Star baseline assessment was completed at the beginning of an individual's journey with the Community Connect Service, which was repeated at various intervals, up until the end point.

Prior to an example being presented to the Panel, it was explained that case studies were produced to demonstrate the work being undertaken and the progress of referrals.

Members heard that, in December 2018, an exercise to obtain feedback from clients accessing the service was undertaken, with a 15% response rate being achieved. 88% of

respondents stated that, of the options 'good', 'average' and 'poor', the service had been 'good'; no respondents rated the service 'poor'. In terms of the people that referred to the service, a 22% response rate had been attained. 100% of respondents stated that they would refer to the service again, and there was only one suggestion for improvement, which related to extending the service for longer support. This would be explored further in due course.

In terms of next steps, these were outlined as follows:

- Befriending Hub - exploring opportunities to develop;
- Transport workshop - the Panel was advised that feedback in respect of this could be provided in due course;
- Social prescribing pilot - discussions were currently taking place with GPs in respect of this;
- Exploring the opportunity to deliver a social prescribing pilot in Linthorpe Surgery using the Community Connect Delivery Model;
- Continuing to learn and develop;
- Social return on investment was a priority for the service at present in terms of savings, etc.; and
- Bringing together community well-being services and programmes, e.g. mapping out the work that services were doing. The Panel was informed that an internationally-renowned professional on complexity theory would be undertaking some work in Middlesbrough, which would be applied in the context of Community Connect.

In response to an enquiry regarding the Outcome Stars, Members were informed that a three-month review was undertaken with all service users. The project was two years old; a further piece of work would be carried-out in the near future to revisit the cases from year one.

The Chief Executive of MVDA advised that statistics may be available regarding the number of older carers accessing the Community Connect Service. This would be looked into and the figures forwarded to the Democratic Services Officer, if applicable.

The Chair thanked the representative for his attendance and update.

AGREED:

1. **That the Chief Executive of MVDA would forward any available statistics regarding the number of older carers accessing the Community Connect Service, to the Democratic Services Officer, if applicable.**
2. **That the information, as presented, be noted.**

OVERVIEW AND SCRUTINY BOARD UPDATE

The Chair provided a verbal update on the matters that were considered at the Overview and Scrutiny Board meetings held on 8 January 2019 and 15 January 2019.

It was highlighted that the Panel's report regarding 'The LGB&T Community and Elderly Care' would be submitted to the Executive meeting on 12 March 2019 for consideration.

NOTED

DATE OF NEXT MEETING - 11 MARCH 2019.

The next meeting of the Adult Social Care and Services Scrutiny Panel had been scheduled for Monday, 11 March 2019.

NOTED