ADULT SERVICES COMMITTEE

AGENDA

Thursday 23 November 2017

at 10.00am

in Committee Room B,
Civic Centre, Hartlepool

MEMBERS: ADULT SERVICES COMMITTEE

Councillors Beck, Hamilton, Hind, Loynes, McLaughlin, Richardson, and Thomas.

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS**

3. **MINUTES**

   3.1 To receive the Minutes and Decision Record in respect of the meeting held on 5 October 2017 *(previously published and circulated)*

4. **BUDGET AND POLICY FRAMEWORK ITEMS**

   No items.

5. **KEY DECISIONS**

   No items.

6. **OTHER ITEMS REQUIRING DECISION**

   No items

7. **ITEMS FOR INFORMATION**

7.1 Transforming Care – North East and Cumbria – *Director of Adult and Community Services*

7.2 Independent Living Fund Update - *Director of Adult and Community Services*

7.3 Tackling Social Isolation - *Director of Adult and Community Services*

8. **ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT**

FOR INFORMATION

Date of next meeting – Thursday 14 December 2017 at 10.00am in the Civic Centre, Hartlepool

ADULT SERVICES COMMITTEE

23 November 2017

Report of: Director of Adult & Community Services

Subject: TRANSFORMING CARE – NORTH EAST AND CUMBRIA

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1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 For information only.

2. PURPOSE OF REPORT

2.1 To provide the Adult Services Committee with an update on progress of the North East and Cumbria - Transforming Care Programme.

3. BACKGROUND

3.1 Following the Winterbourne View scandal a national programme was launched aimed at reducing reliance on long stay learning disability hospitals. In 2015 NHS England announced that the North East and Cumbria would be one of five national Fast Track areas for Transforming Care for people with a learning disability.

3.2 Since 2015 work has been undertaken to understand the current picture in relation to learning disabilities in the North East and Cumbria and a significant amount of work has been done to map out the system and stakeholders.

3.3 The focus for the North East and Cumbria has been on reducing reliance on in-patient beds, and increasing community based capabilities, the aims being:

- Less reliance on in-patient admissions
- Developing community alternatives
- Prevention and support to avoid crisis
- Better management of crisis when it happens
- Better, more fulfilled lives

3.4 A transformation plan was developed across the North East and Cumbria which identified that by improving community infrastructure, supporting the workforce and avoiding crisis by focusing on earlier intervention and

prevention, the area would be able to support people in the community more effectively thus avoiding the need for hospital admission.

3.5 The plan focuses on a systematic reduction and closure of learning disability assessment and treatment beds over the 5 years to March 2019.

3.6 The Transforming Care Programme highlights the importance of local partnership working between commissioners from local government and the NHS with an emphasis on the oversight and support of Health and Wellbeing Boards and Health Scrutiny functions.

4. PROGRESS

4.1 Following the launch of the national plan (Building the Right Support) and subsequent roll out in 2016/17, the North East and Cumbria received an additional £1.2m of national transformation funding to support local delivery of its plan. North East and Cumbria progress however has been less pronounced during this period, although there are a number of key developments and achievement which should be acknowledged. These include:

- Workforce; the production of the Workforce Strategy; establishment of the Positive Behavioural Support (PBS) hub and Leadership Training Programme(s), accompanied by a comprehensive work plan.
- A Community Model /Framework published, with 9 Local Implementation Groups (LIGs) confirming their existing local operating model and future vision.
- The Secure Outreach Team (SOTT) specification was agreed and the commissioning of this service initiated by NHS England specialised commissioning.
- Dynamic Support Register in place with system wide commitment to maintaining at risk of admission registers for both children and adults evidenced via its audit approach.
- Rethinking advocacy project has concluded with learning and outcomes utilised to inform the next steps of reshaping advocacy at local level.

4.2 The Transforming Care Board has agreed a work programme which identified priority areas and established associated work streams: namely:

- Co-production - partnership approaches
- Trajectories for inpatient services - including bed closures
- Service models - new models of care
- Finance - capital and revenue release.

4.3 During 2015/16 the programme has demonstrated positive progress against delivery of its local plan through achievement of planned trajectories and bed closures. It is however acknowledged that there remains a lot of work to do which will require a more collaborative approach. On this basis a South of the Region Implementation Group has been established covering Durham, Darlington and Teesside.

4.4 The Tees area has effectively reduced its commissioned inpatient assessment and treatment bed capacity significantly. Within Hartlepool the community infrastructure has seen investment through the delivery of an enhanced community support service (provided by Tees Esk & Wear Valley NHS FT), shifting investment from bed based provision to the community and providing a greater degree of resilience to those people being resettled from long stay inpatient care who required a high degree of intensive support.

4.6 In January 2016 a 12 month pilot was trialed in relation to 7 day working within the adult learning disability social work team. The pilot was focused on providing named social workers to people at risk of admission with a view to preventing placement breakdown in the community. A review of inpatient activity for Hartlepool identified a significant decrease in the number of admissions to hospital to that of the previous year (2014/15). The review was not able to determine if the pilot had a direct correlation to this however it was accepted that it was as a result of investment in several areas including staff training, enhanced community support, the implementation of blue light care and Treatment Reviews and alternative community approaches.

4.7 The Tees locality plan has identified three key areas for development, to build upon the progress already achieved locally:

- Crisis Care and Early Intervention
- Workforce Development
- Community Infrastructure

4.8 The Tees plan was presented to Adult Services Committee in March 2017 and remains unchanged.

4.9 It is proposed that through the delivery of these specific areas of the Tees Locality Plan there will be a more effective response to people who may require high levels of care and support.

5. ACTIVITY

5.1 CCGs provide weekly activity updates to NHS England. A summary of the achieved and planned discharges is set out below. As at October 2017 there are 7 people within CCG commissioned inpatient beds, 3 of whom are from Hartlepool, 15 within Specialist Secure inpatient settings and 1 young person in a CAMHS provision.

Total inpatients and planned discharges

CCG	Total inpatients as at 09/10/17		Discharges							
			Achieved				Planned			
			Q1		Q2		Q3		Q4	
	CCG	SC	CCG	SC	CCG	SC	CCG	SC	CCG	SC
HaST CCG	7	15+1	0	0	1	0+1	3	1	0	3

6. RISK IMPLICATIONS

6.1 There are risks associated with the need to ensure that the community is sufficiently resourced to prevent avoidable admission to inpatient settings. The reduction in inpatient beds can only be achieved safely with the development of alternative resources.

6.2 Following the success of the early 'fast track' implementation the rest of the country is now working on similar plans to reduce capacity with pressure falling on commissioners to find suitable placements in the community. This has caused some significant challenges in the care market with providers being asked to support a growing number of complex individuals often 'cross boundary'.

6.3 'Cross boundary' placements often have implications for the local health and social care infrastructure such as increased safeguarding activity, requirements for increased support from specialist community health teams and the impact for others in homes of multiple occupancy or shared living schemes.

7. FINANCIAL CONSIDERATIONS

7.1 An initial allocation of £1.4m was awarded to the North East and Cumbria Transformation Board from NHS England and further funding of £623k has since been made available to local CCGs to further support transitional costs. These resources are intended to assist with the double running / transition costs where required to ensure safe transition of service from inpatient care to community based provision and to maintain patient safety. However there remains a risk to both Local Authorities and CCGs in ensuring that the community infrastructure is robustly developed to prevent avoidable admissions whilst investment is released from the de commissioning of inpatient beds.

7.2 How much each CCG locality will release from bed closures, for packages of care and new community services, will vary from CCG to CCG. Detailed work is being completed to set out a full financial plan. A key pressure is the development of new community services for people whose needs are complex and often challenging to existing models of care and support.

7.2 Additional revenue and capital is being made available to CCGs in 2017/18 however it should be noted that the existing funding is not adequate in relation to covering the cost of the overarching plan and additional locality plans. Each local area is developing plans to target resources into priority areas.

7.3 A regional Transforming Care Finance Task and Finish Group has been established with representation from Local Authorities and CCGs to establish a fair and equitable approach to support the transfer of funding, linked to dowries.

7.4 Joint guidance was produced recommending a dowry payment in some cases. The dowry will be paid by the NHS to the Local Authority for those patients who had an inpatient spell of 5 years or more on 1 April 2016. The dowry will be linked to the individual and will terminate on their death and is intended to be a contribution towards the social care costs of a package.

7.5 An interim dowry proposal has been developed by the Regional Task and Finish Group for agreement at a locality level. The proposal has used proxy information gathered by considering the resources released recurrently from decommissioning hospital beds, based on those planned and already closed by NHS providers and an estimate for inpatients discharged from other sectors; and using planning assumptions developed around the proportion of resources released from inpatient beds that CCGs would reinvest in community services, alongside the investment in the Secure Outreach Transition Team by Specialised Commissioning from 2017/18.

8. HARTLEPOOL STEPPED CARE REFERRAL PATHWAY

8.1 **Appendix 1** describes the Transforming Care stepped care referral pathway. The model provides examples of the level of functioning, expected interventions and complexity of support required across a stepped care pathway for adults with a learning disability or autism.

9. LEGAL CONSIDERATIONS

9.1 The process to support a hospital discharge is often complex and practitioners have to consider duties associated within the Mental Health Act 1983, the Mental Capacity Act 2005 and consideration of ongoing restrictions by the Ministry of Justice.

10. CHILD AND FAMILY POVERTY

10.1 No child and family poverty considerations have been identified.

11. EQUALITY AND DIVERSITY CONSIDERATIONS

11.1 The Transforming Care agenda aims to improve equity for adults with learning disabilities and complex needs by enabling people to be supported in the community or close to home.

12. STAFF CONSIDERATIONS

12.1 There are no staffing considerations associated with the issue.

13. ASSET MANAGEMENT CONSIDERATIONS

13.1 There are no asset management considerations associated with this issue.

14. RECOMMENDATIONS

14.1 It is recommended that the Adult Services Committee notes the update and the progress to date against the regional plan.

15. REASONS FOR RECOMMENDATIONS

15.1 The successful implementation of the transformation of learning disability services and reduction in excess inpatient beds is dependent on a robust and sustainable community infrastructure. Implementation is being led through a South of the Region collaboration group comprising of the 6 Local Authorities and 5 CCGs across Durham, Darlington and Teesside.

16. CONTACT OFFICER

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Transforming Care stepped care referral pathway (Revisited 2017)

Appendix 1

Tees - Draft model

5

FOCUS - (unable to remain at home due to MH impact on safety/ behaviour) Urgent care Severe Mental Health Crisis, Acute Mental Health need. Risk to life/others, severe self-neglect, trauma, Acute MH need, social functioning significantly impaired**,** Behaviour

INTERVENTIONS AND RESOURCES (Specialised)
Inpatient care, combined treatments, etc.
Home intensive treatment
Crisis intervention to discharge home
MHA detention/MCA/DoLS / COP /After Care (s117MHA)

CARE PROVIDER(s)
SOTT - home treatment. CTLD Rehabilitation Service.
MHA /AMHP
Responsible Clinician /Nurse Led **(Risk Share) (NHS E / Clinician)**

4

FOCUS - Provisions (functioning severely impacted in several areas) Complex, severe or treatment resistant problems with significant risks, e.g. severe self-neglect, suicidal/DSH, specialist MH need e.g., eating disorder, Autism, PD, Psychosis, Trauma, Dual diagnosis (MH/Subs Misuse)

INTERVENTIONS &RESOURCES(Specialist) Psychiatric assessment, case management (including Social Care/), longer term monitoring i.e. risk, non-concordant, CTO; complex psychological interventions, MH & Safeguarding Adult/ Children/NICE Guidance Treatment/ identified need

CARE PROVIDER and referral route (Step 3+)
Access, **(Via GP)**
Crisis/home treatment **(inc self refer)**
CAS **(inc self presentation)**
AMHP (see guidance) **(Multi Agency)**

3

FOCUS – Learning Disability or Autism impacts on functioning in several areas
Primary Care - moderate mental health needs, assessment of mental health needs – disruptive/traumatic life events, relationship issues, chronic physical health issues; Moderate depression, anxiety disorders, i.e. GAD, health anxiety, PTSD, OCD, mild bulimia, substance misuse; Community & 'natural' social support

INTERVENTIONS & RESOURCES (targeted) CBT/Counselling/solution focussed/problem solving/Drug & alcohol/Social Support / PBS / DBT. Employment/financial/social isolation/relationship/family support, via community resources/signposting

CARE PROVIDER(s) (Step 2+)
Counselling inc Talking therapies. Specialist Learning Disability and Autism Framework providers (joint packages) **Social worker.**

2

FOCUS-Learning Disability or Autism need has some impact on functioning
Mild to moderate Learning Disability, mild anxiety disorders, /panic, sleep problems, phobias, Parenting

INTERVENTIONS AND RESOURCES (Maintenance) - Wellbeing
Medication via GP **(NICE Guidance)** Guided self-help, signposting, screening, brief psychological interventions (IAPT) Signpost to local resources - Hartlepool Now/Beautiful Minds/HPool Carers etc / Health action plan / Annual Health Check / Dom Care / Telecare

CARE PROVIDER(s)
GP/Primary Care
NHS Choices (self help)
MindSkills Consider Eligibility under Care Act. Resource Allocation / DP. (**Social Care Officer**)

1

FOCUS-Learning Disability or Autism, Little or no impact on functioning Recognition of symptoms; low mood, anxiety, hormonal, stress, anger, isolation, community support/peer support, chronic ill health

INTERVENTIONS AND RESOURCES (Universal Provision) - IAG
Prevention, non specialist assessment, 'community' resources, social prescribing & review (GP) NICE Guidance
Signpost to local resources – Hartlepool Now, welfare

CARE PROVIDER(s)
G.P./ Practice nurse, Community provisions e.g. local support groups practical support / Adult Ed / HWS Help e-learning / Ricochet. **(Navigator)**

Step 1 (Universal)
A low level strategy to meet the needs of the local population ensuring services are available and accessible (Equality of access to services for all) Information, advice and guidance in a range of formats to ensure people are supported to function at their optimum in society. Natural support, benefits maximised. www.hartlepoolnow.co.uk

- Voluntary Sector organisations, Charities, Social clubs and self help groups, Adult Education, Employment support, Welfare advice, Housing advice. Translation and Interpretation services.

Step 2 (Maintenance)
Eligible for services under the care act 2014, but do not require a ' disability' specific service, reasonable adjustments to community services and care and support through a DP or non client specific provider. (eg Telecare / Domiciliary care). Assigned a Social Care Officer / Reablement Worker

- As step 1 including support re Access to signposted services, short term intermediate support (about 6 weeks) - rehabilitation and reablement use of assistive technology, Domiciliary services

Step 3 (Targeted)
Requires care , support and /or accommodation, requires the skills and competence of a client specific provider (eg Autism frameowork). May require access to a crisis plan out of hours but needs could be managed in emergency respite care (Greenfields Building based provision - Place of Safety) Named Social Worker

- As step 1 & 2 Care coordination and (at least Quarterly contact by a social worker) Condition specific provider from approved framework, will have a Resource allocation and deploy to meet assessed needs, Provider with a focus on reducing demand and promoting independence.

Step 4 (Specialist)
Requires condition specific support linked to Learning Disability or Autism. Will have a joint assessment and contingency plan to prevent deterioration and escalation of needs, proactive care provision (cases managed by CLDT or HBC) . Joint funded packages of care. Social Worker (named) and Specialist Health team (TEWV) Multi Agency care coordination.

- AS step 1,2 & 3. Joint managed with TEWV, crisis plan in place, contingency plan agreed (which may include access to crisis funds) Access to emergency respite care (as identified in crisis plan) Plan shared with EDT / Out of Hours services, provider on call systems.

Tees Specialist Provider Framework- Providers who have been accredited to support people with complex presentations, Key competencies, skills and knowledge over and above Learning Disability registered providers (will be able to evidence psycho / social interventions and approaches to preventing placement breakdown) - PBS / DBT / CBT (Talk Therapies)

Step 5 (Specialised)

Urgent access to specialised services. History of offending or recent Police intervention pending prosecution. MAPPA / MARAC, Team Around the Individual, Vulnerable Victim Group, Vulnerable Exploited, missing persons, trafficked. May require access to urgent Mental Health Assessment (AMHP)

- As step 3 Case managed through a team around approach, Lead Agency Identification, restrictions, orders and specific conditions to support either step down from inpatient setting or prevent escalation. Requires intensive home support services to remain in community setting. Court of protection application as requires constant care support and accommodation, not free to leave. (Cheshire West) Likely to be FFCHC or Risk share (? Dowry eligible) S117

Secure outreach transitions Team / Adult Mental Health Professionals / Best interest Assessors / Advanced Social Workers - regular case tracking at CTM- community team meetings, North of Tees Partnership Meeting and CTRs. Crisis plan may require specialised intervention linked to recommendations from Responsible clinician / restrictions or

ADULT SERVICES COMMITTEE

23 November 2017

Report of: Director of Adult & Community Based Services

Subject: INDEPENDENT LIVING FUND UPDATE

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1. TYPE OF DECISION / APPLICABLE CATEGORY

1.1 No decision required; for information.

2. PURPOSE OF REPORT

2.1 The purpose of this report is to provide the Adult Services Committee with an update regarding the transfer of funding and responsibilities relating to the former Independent Living Fund (ILF).

3. BACKGROUND

3.1 The Independent Living Fund (ILF) was originally established in 1988 and provided financial support to disabled people so they could choose to live in their communities rather than in residential care. It was a directly funded government scheme that provided discretionary cash payments directly to disabled people allowing them to purchase care from an agency or pay the wages of a privately employed personal assistant.

3.2 To qualify for ILF an individual had to:

- receive social services support worth at least £340 a week or £17,680 a year. This could include direct payments or services from the local council, like going to a day centre;
- be living in the UK for at least 26 weeks a year;
- have less than £23,250 in savings or capital. This included any money their partner had, if they had a partner; and
- receive or be entitled to the highest rate care component of Disability Living Allowance.

An additional eligibility criteria was introduced from May 2010 restricting applications to those in work.

3.3 ILF funding was used by people with a wide range of physical and / or learning disabilities, some of whom had very complex needs and required significant levels of support to live in the community. Support funded by the ILF included help with personal care tasks that enabled a person to remain independent and support to access the local community. Most people who received ILF support also used it to access, or remain in, education or employment or to undertake voluntary work.

3.4 In December 2010, the Minister for Disabled People announced that the ILF was permanently closed to new applications.

3.5 In March 2014 the Minister for Disabled People announced that the ILF would close on 30 June 2015 and from 1 July 2015, the funding and responsibility of ILF care and support needs transferred to local authorities in England.

3.6 There was extensive consultation with the 43 people in Hartlepool who received support from the ILF at the point of transfer, from both ILF staff and Adult Services staff. All received a review where ILF closure and future plans were discussed and an ILF support plan was provided.

3.7 All relevant social workers were informed about the changes and were supported to update assessments and support plans.

4. MANAGEMENT OF THE GRANT

4.1 An approach was agreed in Hartlepool that resulted in no impact on existing ILF users in 2015/16, through maintaining the status quo in terms of both expenditure and contributions.

4.2 ILF users were required to pay a minimum of 50% of the care component of their Disability Living Allowance (DLA) plus, if they lived on their own, 100% of the Severe Disablement Premium Allowance. Individuals were then means-tested for any contribution in addition to this.

4.3 By definition, ILF users also received services from the Council, for which they are means-tested and any contributions towards ILF are not taken into account.

4.4 Following the transfer on 1 July 2015, former ILF users have received the same level of funding and contributed the same amount towards their ILF package as they did before the transfer of responsibility to the Council.

4.5 This approach has been consistently applied since 1 July 2015. In this time, the number of users in receipt of former ILF payments has reduced from 43 to 35 through attrition.

4.6 Having reviewed packages for individuals it has been decided that continuing with the status quo is no longer feasible. Former ILF funding will therefore be mainstreamed and considered alongside adult services funding within a single funding allocation. This will sit within the department's wider Personal Budget framework which looks at an overall basket of needs and allocates resources

accordingly. The current position does not allow care managers to review packages with individuals in a holistic manner due to the artificial separation between former ILF funding and adult services funding which can potentially to lead to ineffective use of resources. Mainstreaming ILF will address this issue and improve consistency without having any adverse impact for people who formerly received ILF.

4.7 In previous reports the risk linked to the rate of reduction in funding was highlighted and there was also a risk that personal contributions made by individuals would reduce.

4.8 A review of the financial impact of the reduction in those accessing this funding stream has indicated that the funding mechanism can be mainstreamed and the parallel contribution policy abandoned.

4.9 The grant allocation for the current financial year is £620,335. This reduces to £600,744 for 2018/19 and £582,493 in 2019/20. Current expenditure for ILF is approximately £519,000 with personal contributions in the region of £77,000. This means that currently there is a surplus of grant of approximately £100,000.

4.10 To change the policy and integrate packages into mainstream funding would incur loss of contributions of approximately £77,000 which will be absorbed by utilising the excess grant.

4.11 This will mean that individuals have one contribution to pay, in line with other users in the overall personal budget system, and that packages can be reviewed holistically to ensure effective, equitable and transparent use of resources.

5. RISK IMPLICATIONS

5.1 There is a risk that over time the rate of reduction in funding from estimated attrition levels is greater than the actual reduction through attrition. This could result in insufficient grant funding being received to cover the cost of former ILF packages. Given the pattern of attrition so far this risk is limited.

5.2 There is also a risk that grant funding will be significantly reduced in 2020/21 and beyond.

6. FINANCIAL CONSIDERATIONS

6.1 As previously reported, from 1 July 2015 all local authorities received a Section 31 non-ringfenced grant (pro-rata for 9 months of the financial year) which was paid as one lump-sum by the Department for Communities and Local Government (DCLG).

6.2 The amount transferred was calculated by the DCLG based on the number of ILF users at 30 June 2015 and the amount of ILF funding they received as at that date. 43 people in Hartlepool were in receipt of ILF at the point of transfer,

receiving annual funding of £670,000. The amount transferred by DCLG in 2015/16 (pro-rata for 9 months) was £507,000.

6.3 As the ILF was no longer open to new users this number cannot increase and it was anticipated that numbers would reduce over time owing to mortality, people requiring residential care or needs changing so that people become eligible for fully funded NHS Continuing Health Care. This was the basis for the proposal that the allocation would be subject to a reduction of 5% due to 'attrition'.

6.4 No additional funding was allocated for administration costs or to cover any overspends and there will be no claw back of unspent funds.

6.5 Funding allocations are shown below:

Table 1: Proposed 'Former ILF Recipient Grant'

	2015/16 *	2016/17	2017/18	2018/19	2019/20
	£'000	£'000	£'000	£'000	£'000
Grant	670	641	620	601	582
% reduction	n/a	(4.3)	(3.3)	(3.1)	(3.2)

* - actual annual allocation; only 9 months received

6.7 The current position in Hartlepool is that, since 1 July 2015, eight people who previously received ILF no longer require this support. A number of individuals have become fully health funded as their needs have changed and some are now supported in alternative settings such as extra care or residential care. These individuals have not been disadvantaged in any way as they continue to have their assessed needs met in an appropriate environment, and will no longer have to make contributions towards their ILF.

7. LEGAL CONSIDERATIONS

7.1 There are no legal considerations identified.

8. CHILD AND FAMILY POVERTY CONSIDERATIONS

8.1 There are no child and family poverty considerations identified. ILF funding aimed to support people with disabilities (including those who were parents) to remain living in the community, and also to access or remain in education or employment or to undertake voluntary work.

9. EQUALITY AND DIVERSITY CONSIDERATIONS

9.1 There are no equality and diversity considerations identified. The aim of ILF was to improve equity for people with disabilities by supporting them to live

active, independent lives in the community. The proposed change in approach will ensure that all users of adult services are treated equitably.

10. STAFF CONSIDERATIONS

10.1 There are no staff considerations in relation to this issue.

11. ASSET MANAGEMENT CONSIDERATIONS

11.1 There are no asset management considerations in relation to this issue.

12. RECOMMENDATIONS

12.1 It is recommended that Members:-

- Note the change in approach for ILF users which incorporates former ILF funding in to mainstream Personal Budgets and operates a single contribution policy for the 35 individuals concerned.
- Receive a further update should grant conditions or funding allocations be significantly altered.

13. REASONS FOR RECOMMENDATIONS

13.1 To ensure continuity of service provision for former ILF recipients.

14. CONTACT OFFICERS

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ADULT SERVICES COMMITTEE

23 November 2017

Report of: Director of Adult & Community Based Services

Subject: TACKLING SOCIAL ISOLATION

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1. TYPE OF DECISION/APPLICABLE CATEGORY

No decision required; for information.

2. PURPOSE OF REPORT

2.1 The purpose of this report is to provide the Adult Services Committee with an update on work that is underway to tackle social isolation.

3. BACKGROUND

3.1 As reported to Adult Services previously research by Age UK shows that:

- the effect of loneliness and isolation can be as harmful to health as smoking 15 cigarettes a day, and is more damaging than obesity;
- lonely individuals are at higher risk of the onset of disability;
- loneliness contributes to health problems including psychological stress, higher blood pressure and sleep problems; and
- loneliness puts individuals at greater risk of cognitive decline – one study concluded that lonely people have a 64% increased chance of developing clinical dementia.

3.2 A research briefing by the Social Care Institute of Excellence (SCIE) included the following key messages:

- Older people are particularly vulnerable to social isolation or loneliness owing to loss of friends and family, mobility or income.
- Social isolation and loneliness impact upon individuals' quality of life and wellbeing, adversely affecting health and increasing their use of health and social care services.
- The interventions to tackle social isolation or loneliness include befriending and mentoring.

- People who use befriending services reported that they were less lonely and socially isolated following the intervention. The outcomes from mentoring services are less clear; one study reported improvements in mental and physical health, another that no difference was found.
- Users report high satisfaction with services, benefiting from such interventions by increasing their social interaction and community involvement, taking up or going back to hobbies and participating in wider community activities.
- Users argued for flexibility and adaptation of services. One-to-one services could be more flexible, while enjoyment of group activities would be greater if these could be tailored to users' preferences.
- When planning services to reduce social isolation or loneliness, strong partnership arrangements need to be in place between organisations to ensure developed services can be sustained.

4. CURRENT SITUATION IN HARTLEPOOL

4.1 The Hartlepool BCF Plan includes a commitment to 'help identify and combat social isolation, as a major influence on overall health and wellbeing'.

4.2 It is estimated that 35% of older people in Hartlepool live alone. The recent national survey of users of adult services asked whether people had as much social contact as they would like. The results for Hartlepool were as follows:

Year	The proportion of people who use services who reported that they had as much social contact as they would like
2014/15	39.9%
2015/16	54.4%
2016/17	49.5%

4.3 There are a number of services already in place in Hartlepool that aim to help tackle the issue of social isolation but some of these services primarily support people who already have some identified social care needs, meaning that there will be some people who are not known to services who may be experiencing social isolation.

4.4 One of the ways that has been used to tackle social isolation is through low level support services that focus on maintaining independence. Low level services for older people provide a range of social inclusion services through one provider, encompassing information and advice, low level support, lunch clubs (and lunch club plus) and social inclusion opportunities within a building based setting. The service is called Hartlepool Getting Out and About.

The information and advice element of this service is incorporated in this service to enhance the overall provision for individuals who access the service. This enables individuals to build relationships with the provider and not have the need to be signposted to other services, providing a holistic approach in supporting them.

There are other complementary information and advice services commissioned that support different client groups, including the Dementia Advisory Service and the Handy Person Service.

The service model helps people to overcome barriers to accessing activities and resources for the first time; provides continued support until people feel able to continue to access independently and promotes continued engagement and attendance.

4.5 Other work undertaken to try and address this issue includes:

- Development of Hartlepool Now as a website, app and source of printed information, to provide people with information on what's going on in their local community. This includes information on one off events such as Dementia Awareness Week as well as regular activities including friendship clubs, exercise groups, arts and crafts groups and support groups for a range of long term conditions.
- Development of The Bridge as a town centre information hub for people with dementia and their carers.
- Support for Hartlepool Carers as the focal point for people who have a caring role that may result in social isolation and limited opportunities for interaction.
- The 'Men's Shed' model aims to reduce isolation through helping mend to make friends and improve their health and wellbeing. Hartlepool Men's Shed is aimed at all males living in the Borough and features a workshop environment where men can `make and mend` things of their choosing, for themselves or the wider community.

5. UPDATE ON DEVELOPMENTS

5.1 As previously reported to Committee on 9 June 2016 developments were underway with Cleveland Fire Brigade and the establishment of a Befriending Network.

5.2 <u>Work with Cleveland Fire Brigade</u>
Work is ongoing with Cleveland Fire Brigade to maximise their contacts with older people by utilising the contact made during their rolling programme of Fire Safety Checks for older people.

Close working relationships between the Fire Brigade and Adult Services have developed over a number of years with well established systems in place for the Fire Brigade to raise safeguarding alerts and tackle issues of fuel poverty and winter warmth, and it was identified that there were further opportunities for joint working. Fire Safety Checks provide a real opportunity for information to be gathered and shared with other statutory services that will support older people to stay safe, well and independent in their own homes as well as being a way of reaching out to older people to provide them with advice and information.

A range of issues had been identified which have been built in to a low level assessment / checklist that the Fire Brigade completes with an individual. This includes:

- Identifying older people who are socially isolated or lonely, who can then be signposted to services such as social activities, befriending or luncheon clubs.
- Basic screening questions in relation to meal preparation, shopping and weight loss that could identify is a person is at risk of nutritional decline.
- Basic screening questions in relation to financial worries which could lead to signposting to maximise benefits.
- Identifying environmental issues that could lead to falls risks, such as poor lighting and loose carpets which can be addressed by the Handyperson Service.
- Highlighting housing issues that may include an inability to maintain the property or hoarding issues which could result in the person being supported to better understand the range of housing options available.

In addition to gathering information, Fire Brigade staff are able to signpost people to support available in their community through use of the Hartlepool Now app, which has been loaded on their tablet devices. Social care staff have provided training for the Fire Brigade on how to use the app and how to support people to navigate through the various options. When a person is identified as having needs that cannot be met by low level services or existing community resources, the Fire Brigade is able to make a referral to the Early Intervention Service for further support, initially through reablement and potentially through a full social care assessment if required.

These checks went live in November 2016 following development of screening tools and appropriate training for Fire Officers. Data collected indicates that the Fire Brigade has completed approximately 470 screening tools for Hartlepool residents since November, 330 who are perceived to be the most vulnerable using GP data. From this they have referred approximately 40 people into the Falls Prevention service for further screening, advice and guidance. Of those referrals only 6 individuals declined further assessment.

There are regular meetings with the Fire Brigade and the reablement lead for adult services to ensure that training is appropriate and up to date, and that regular feedback occurs.

5.3 <u>Establishment of a Befriending Network</u>

There was an identified gap in services in Hartlepool in relation to befriending for people who may be socially isolated and at risk of developing health and social care needs, or who are not currently in contact with services. Befriending services had been piloted in neighbouring authorities and had demonstrated positive outcomes within a short space of time.

Befriending services are a way of supporting older people to remain living in their own homes for longer due to increased social contact and additional support with simple tasks around their home. Befriending also helps to reduce loneliness and isolation, which can lead to deterioration in mental well-being.

A Befriending Network was commissioned in Hartlepool in July 2016 with Age UK as a 12 month pilot with the option to extend subject to satisfactory performance and evidence of need.

During the first year of the service there were 56 referrals received and 13 befrienders recruited. The service has been actively promoted throughout Hartlepool using a variety of different methods including visits to residents groups, social care team meetings, GP Practices, websites including Hartlepool Now, and via the production of promotional leaflets and fliers.

The service has advised that recruiting volunteers can be difficult, but once volunteers are recruited into the service, the outcomes for volunteers are positive. Outcomes for individuals using the service have also been very positive with a high level of satisfaction.

Case studies and quotes from individuals are provided below:

Case Study 1
Mary is aged 88 and was referred by Hartlepool and East Durham Mind. She was identified as having anxiety issues and panic attacks and subject to low moods. She also has limited mobility and suffers from arthritis. Mary was feeling very lonely and isolated and had little contact from friends.

In November 2016 Mary was matched with a volunteer befriender Sylvia, and has benefited from regular visits and companionship from her volunteer since this date. Sylvia has also accompanied Mary on regular shopping trips, helping her get out into the community again.

Mary commented on how her confidence has improved since being matched with Sylvia and how she looked forward to the weekly visits and shopping trips and the difference the company and friendship had made to her.

Case Study 2
Ivy is aged 86 and was referred by a Care Coordinator from Hartlepool and Stockton Health. Ivy has a curvature of the spine, slipped disc and arthritis and has limited mobility. She still has contact with her family but she only sees them once a week on a weekend and most days during the week she is on her own and said she felt lonely.

Ivy was matched with a befriender, Adele in January 2017 and has been receiving weekly visits since this date. Ivy commented on how she looks forward to the visits from Adele and said that it was the best thing that had happened to her in a long time. She said that she feels like part of the community again, and when the weather picks up looks forward to going on some short walks with Adele.

As a volunteer Adele said that she felt privileged to be part of such a worthy scheme which gave her the opportunity put something back into the community and stated that being a volunteer has been beneficial both to herself and the elderly people that she visits.

Feedback from People Using the Service
'It has made a big difference to my life. I feel that my befriender has time for me'

'I look forward to her visits each week and the befriending service has made a real difference to me…she cheers me up'

'It (Befriending) came into my life at the right time. I was feeling low and now I look forward each week to visits from my befriender'

'It is good to have someone to talk to and I enjoy her company'

'I really appreciate the chance to get out and about again and so some shopping and socialising'

5.4 Project 65

Since the last report to Committee the department has acknowledged the huge advances in digital technology and the impact that has had within the older population. Project 65 has been funded by the Council's IT partner Northgate and aims to enable older people from a wide variety of backgrounds, including people with long and short term health conditions, to go on enjoying activities and interests as they get older including

- Providing opportunities for people to develop new skills and interests, retain and make new friends and if they choose do something different and interesting;
- Connecting people to their local communities ;
- Enabling people to be in control of their activities and choices;
- Helping people to develop their self-confidence and sense of well-being;
- Helping people stay healthier and well for longer.

The service loans electronic tablets to individuals for a period of between one week and six months. People are shown how to access social media sites and Skype and are introduced to websites such as Hartlepool Borough Council, Direct Gov and Hartlepool Now. Links to local organisations that deliver services to reduce the impact of social isolation are also provided together with additional apps for health related information, advice and guidance, leisure and community involvement. This enables people to access local information independently, or with support. The service provides drop in sessions at the Centre for Independent Living and has a held a number of specific workshops covering topics such as social media, online shopping and general navigation skills.

The project commenced in November 2016 with the target to complete 100 referrals into the service. As of 31 July 2017 there had been 107 referrals for information leading to 77 individuals loaning tablet devices. Of those 77 people approximately 80% have purchased their own device following the loan. The average age of users is 80 years with the oldest individual being 96.

The service has been very well received and has a steady stream of referrals. The drop in sessions are attended by individuals even when they have returned their loaned tablet demonstrating the wider benefits and the impact on social isolation.

Case Study 1
JN (90) – As J doesn't have internet access at home, he received a 'Hotspot' from 02. Supported by his daughter, he now regularly Skypes his family in Ireland. He also uses Google Maps and Google Earth to revisit places in Ireland where he grew up. He also enjoys watching old comedy shows and listening to music on YouTube. His family is considering buying him a tablet and having the internet installed.
(Referred by Hartlepool Carers)

Case Study 2
ML (80) – Found places to go in the town on the Hartlepool Now website after moving to the area. As a result of visiting the site, M now attends lunch clubs, exercise classes, social events, 'sing-a-longs' and bingo. M told us 'I never knew there was so much going on. I'm never in now and take my neighbour with me to the events.
(Referred by Care Co-ordinator)

Case Study 3
PW (69) – 'You'll never get me using one of these things!' said Pon his first visit! He then went on to buy his own tablet, after returning his loaned tablet a month early! P told us 'he is never off it' and went on to become the first Project Champion.
(Self-referral)

Case Study 4
JK (71) – J suffered a stroke in January this year and supported by his wife, is using the tablet to source Apps and organisations that support him with his rehabilitation. They are both regular attendees at the popular 'drop-in' sessions in the Bistro at the new Centre for Independent Living.
(Referred by Care Co-ordinator)

5.5 Home Library Service

The Home Library service delivers library resources on a monthly basis to those who are at risk of social isolation through lack of transport, ill-health or infirmity as well as their carers. The clients of the service are largely elderly people whose health or strength prevents them from selecting and carrying home their own books from a static library.

The Home Library service offers reading material in a variety of formats including Large Print and Spoken Word as well as normal print. The free loan of equipment and the ability to provide a supported download service has recently been extended prolonging client's ability to access and enjoy the spoken word. The service is also able to distribute advice and guidance leaflets to clients, keeping them in touch with what is happening in their community and providing information on what services are available to them.

The Home Library Service currently has 409 users, 75% of those are female and 25% are male. 80% of users are over 70 with 14% aged 90 or over and over half of the users have some level of visual impairment. 57% of the people using the service live alone.

Satisfaction with the service is very high with 98% of users rating the service as very good, and users commenting that the service *'changed my life, absolutely*

brilliant' and that they are *'Very, very, very, satisfied, would be lost without the service'.*

Adult services will be working with the Home Library Service over the next 6-12 months to maximise the benefits of the service and to ensure that links are made to other initiatives that promote independence.

6. RISK IMPLICATIONS

6.1 There is a risk that tackling social isolation identifies unmet need within the community that increases pressure on adult services. It is anticipated that this risk will be mitigated through identifying people earlier and signposting to low level interventions that reduce reliance on statutory services or delay the need for more intensive and costly interventions.

7. FINANCIAL CONSIDERATIONS

7.1 Most of the existing services that aim to tackle social isolation are funded from the Better Care Fund Pooled Budget.

7.2 The work with Cleveland Fire Brigade has no associated cost.

7.3 The Befriending Network is funded until March 2019 from reserves.

7.4 Due to the success of the scheme to date, additional funding has been secured from the Northgate Community Fund to extend Project 65 for a further year.

8. LEGAL CONSIDERATIONS

8.1 There are no legal considerations identified.

9. CHILD AND FAMILY POVERTY CONSIDERATIONS

9.1 There are no specific child and family poverty considerations identified although some services that aim to tackle social isolation, such as Hartlepool Now, could be used by parents to find out about local activities and also 'Money matters' including claiming benefits, managing debt and Local Welfare Support.

10. EQUALITY AND DIVERSITY CONSIDERATIONS

10.1 The aim of services to tackle social isolation is to ensure that people have equal opportunities to access a range of services within their local community regardless of their age, needs or disability.

11. STAFF CONSIDERATIONS

11.1 There are no staff considerations in relation to this issue.

12. ASSET MANAGEMENT CONSIDERATIONS

12.1 There are no asset management considerations in relation to this issue.

13. RECOMMENDATIONS

13.1 It is recommended that Members note the current provision to tackle social isolation and the implementation of previously planned developments.

14. REASONS FOR RECOMMENDATIONS

14.1 The Adult Services Committee has previously expressed interest in what is being done within Hartlepool to tackle social isolation, due to the potential impact this can have on vulnerable adults.

15. CONTACT OFFICER

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