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Havering
LONDON BOROUGH

# INDIVIDUALS OVERVIEW & SCRUTINY COMMITTEE AGENDA

| 7.30 pm | Thursday 10 July 2014 | Town Hall, Main Road, Romford |
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Members 7: Quorum 3

**COUNCILLORS:**

June Alexander (Chairman)
Philip Hyde (Vice-Chair)
Darren Wise
Ray Best
Viddy Persaud
Keith Roberts
Roger Westwood

**For information about the meeting please contact:**
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## What is Overview & Scrutiny?

Each local authority is required by law to establish an overview and scrutiny function to support and scrutinise the Council's executive arrangements. Each overview and scrutiny committee has its own remit as set out in the terms of reference but they each meet to consider issues of local importance.

They have a number of key roles:

1. Providing a critical friend challenge to policy and decision makers.

2. Driving improvement in public services.

3. Holding key local partners to account.

4. Enabling the voice and concerns of the public.

The committees consider issues by receiving information from, and questioning, Cabinet Members, officers and external partners to develop an understanding of proposals, policy and practices. They can then develop recommendations that they believe will improve performance, or as a response to public consultations.

Committees will often establish Topic Groups to examine specific areas in much greater detail. These groups consist of a number of Members and the review period can last for anything from a few weeks to a year or more to allow the Members to comprehensively examine an issue through interviewing expert witnesses, conducting research and site visits. Once the topic group has finished its work it will send a report to the Committee that created it and it will often suggest recommendations to the executive.

## Terms of Reference

The areas scrutinised by the Committee are:

- Personalised services agenda
- Adult Social Care
- Diversity
- Social inclusion

## 1 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

(if any) – received.

## 2 DISCLOSURE OF PECUNIARY INTERESTS

Members are invited to disclose any pecuniary interest in any items on the agenda at this point in the meeting.

*Members may still disclose any pecuniary interest in an item at any time prior to the consideration of the matter.*

## 3 CHAIRMAN'S ANNOUNCEMENTS

The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

## 4 MINUTES (Pages 1 - 6)

To approve as a correct record the Minutes of the meeting of the Committee held on 27 March 2014 and authorise the Chairman to sign them.

## 5 MEMBERSHIP OF THE COMMITTEE

The Committee are asked to note the membership of the Committee.

## 6 INTRODUCTION TO OVERVIEW AND SCRUTINY

The Committee will receive a presentation on the role of Overview and Scrutiny in Havering.

## 7 OVERVIEW OF ADULT SOCIAL CARE

The Committee will receive a presentation from the Head of Adult Social Care, explaining the remit of the Committee.

## 8 REVIEW OF SERVICES IN HAVERING FOR PEOPLE WITH DEMENTIA OR A LEARNING DISABILITY (Pages 7 - 30)

The Committee will receive a report and presentation from Healthwatch Havering on the findings of services for people who have dementia or a learning disability within Havering.

## 9 IMPACT OF SERVICES ON THE ELDERLY TOPIC GROUP REPORT (Pages 31 - 38)

The Committee will receive a report of the Impact of Services on the Elderly Topic Group.

The Committee are asked to agree and refer the report to Cabinet.

## 10 COMMITTEE'S WORK PROGRAMME REPORT

The Committee will receive a report setting out details of the work programme for the next municipal year.

The Committee are asked to agree the work programme report.

## 11 FUTURE AGENDAS

Committee Members are invited to indicate to the Chairman, items within this Committee's terms of reference they would like to see discussed at a future meeting. Note: it is not considered appropriate for issues relating to individuals to be discussed under this provision.

## 12 URGENT BUSINESS

To consider any other items in respect of which the Chairman is of the opinion, by reason of special circumstances which shall be specified in the minutes, that the item should be considered at the meeting as a matter of urgency.

**Andrew Beesley**
**Committee Administration Manager**

**MINUTES OF A MEETING OF THE**
**INDIVIDUALS OVERVIEW & SCRUTINY COMMITTEE**
**Town Hall, Main Road, Romford**
**27 March 2014 (7.00 - 8.40 pm)**

**Present:**

Councillors Wendy Brice-Thompson (Chairman), June Alexander (Vice-Chair), Jeffrey Brace, Pam Light, Linda Van den Hende, Pat Murray (In place of Denis O'Flynn) and Melvin Wallace (In place of Keith Wells)

Apologies for absence were received from Councillor Keith Wells and Councillor Denis O'Flynn

29 **MINUTES**

The minutes of the meeting of the Committee held on 19 February 2014 was agreed and signed by the Chairman.

30 **ACTIVE LIVING UPDATE**

The Committee received a presentation on Active Living in Havering from the Corporate Policy and Community Manager.

The Committee was informed that following research that was carried out on issues that affected older people in the over 65s bracket, Activate Havering was formed to provide an avenue for older people in the borough, to meet social needs, with funding provided by Havering Strategic Partnership. In March 2013, the group was rebranded Active Living.

The Committee noted that the goal of Active Living was to help older people stay healthier for longer by enabling local people to meet their social needs in the community.

The Corporate Policy and Community Manager detailed the following aims of Active Living:

- Reducing isolation and social exclusion through social networks
- Supporting people to remain active and independent
- Enabling people to make a contribution to their community

The Committee was informed that Active Living would work with, and build on, the vibrant voluntary sector and community activity that already existed in Havering. This involved joining the faith sector in building resilience group

and piloting new services with voluntary sector, such as social membership clubs.

It was stated that Active Living had the following four main strands:

1. Social – supporting Havering Circle to fill the gap since the closure of London Circle. Havering Circle would look to develop activities that suited local people.
2. Active - encouraging older people to take healthy walk around the borough. Taking advantage of the free swimming offered by SLM.
3. Giving back – encouraging older people to consider volunteering. Older people had in the past supported the Local Havering clean up initiative.
4. Supported - be-friending scheme organised by MIND and other initiatives such as cold weather befriend who helped with fuel bills during winter.

The Committee noted Active Living was looking ahead in the following directions:

- Another phase of the over 65s consultation project
- CAB; Benefits take up campaign
- Review befriending services
- Evaluating the four strands
- New community led solutions

The Committee noted the presentation.

## 31 FINANCIAL DEBTS

The Committee received an update on how outstanding Adult Social Care debts were dealt with from the Head of Adult Social Care & Commissioning.

The report informed the Committee that the data covered debt recovery activity for the period 1 April 2012 to 31 December 2013.

The Committee were reassured of the following key points:

- That debt recovery procedures were now more robust and efficient
- That the total number of debtors and invoices outstanding continued to decrease
- That the amount of repayment plans and income from repayment plans in increasing every quarter
- The amount of older debt is falling every quarter

The Head of Adult Social Care & Commissioning informed the Committee that Adult Social Care was responsible for the assessment adults and older people over the age of 18 who had disabilities or become frail and who had

social care needs. The current procedure determined that once it had been agreed that an individual was eligible for care and support from the Council, the Council undertook an assessment to see how much the individual had to pay for their care.

The following was detailed in the report:

- That between 45 and 60 new financial assessments were carried out per week as well as a further 30 to 50 financial reassessments to reflect changes in an individual's financial circumstances while care is on-going.

- That in April 2009 total debt in this area was in excess of £6.5m with a bad debt provision over £2m and less than £500,000 of the outstanding debt was secured. The debt recovery procedures at that time were very much reactive with only system generated reminder letters issued when the debt reached £5,000.

- That Adult Social Care recognised that this process of recovery action was flawed, with an unacceptable high level of debt, in particular unsecured debt.

- Therefore, since 2010/11 a much more pro-active approach to debt recovery was implemented through ensuring potential arrears situations are identified as early as possible in order for direct action at that stage.

- The current procedure entailed that the service started debt recovery action once an individual had two outstanding invoices. If no reasonable explanation or contact was received from the debtor within a 50 day period from the arrears being identified, the debt was referred for Legal action.

The Committee noted that an individual may have legitimate reasons for non-payment of their first two invoices (e.g. waiting for a Court of Protection application to be finalised, ill health, etc.), the initial debt recovery letter was regarded as an intervention approach rather than a straight up demand for payment.

The service would also offer assistance in financial advice as well as signposting to organisations that may be able to assist individuals who were having difficulties.

The report informed the Committee that changes in approach to debt recovery had resulted in total debt falling and the number of debtors decreasing as well as an increase in the number of repayment plans. As a result, a reduction in the amount of long term debtors and individuals with large unsecured debts was also recorded

The Committee noted that the introduction of a new Placement contract in early 2012 passed the responsibility for the collection of client contributions to care homes. The only circumstances under which a gross contract would be used are where individuals own property and therefore needed to enter into Deferred Payment Agreements or a situation where the customer does not have capacity to manage their finances and these were managed by a third party. This had resulted in a larger amount of fees that were deferred, and therefore cannot be collected while care was on-going, and also more short term debtors pending Court of Protection action.

The report detailed that Deferred Payment cases had increased in the last 20 months but they were considered to be secured debt.

Any individual who had property at the point of moving into a care home, must enter the Council's Deferred Payment scheme, which enabled the Council to secure any debt through placing a charge on the individual's property. The Care Bill that was anticipated to become law shortly stated that all LA's should implement an obligatory approach to Deferred Payments by 2015 – however the Committee was aware that this was already in place in Havering.

The Committee was reassured that bad debt had remained consistent because of the more pro-active approach to debt recovery not allowing so many long term or larger debts to accrue. This was attributed to the changes in procedure that had lowered bad debt despite the increase in total debt.

The Committee was informed that the Corporate Debt Management Board target around in-year collection rates, based on sums either collected or secured within the financial year, had been met for the last three financial years and Adult Social Care was on target to meet this year's target of 92%.

During general debate, members of the Committee made the following comments:

- They were disappointed at the level of debt in general
- Noted that intervention was triggered at two outstanding invoices but wanted officers to review current procedures and shortening of the process
- Noted the uptake of direct debit payment but suggested further encouragement of this method of payment
- Noted that improvement was being made steadily.

That Committee noted the report and the continued work in recovering debt owed to the Council.

## 32 PERSONAL BUDGETS

Following the meeting of 10 December 2013, the Committee received a further presentation on Personal Budgets from the Head of Adult Social Care & Commissioning.

The Committee was informed that the Personalisation agenda set out that there would be choice and control of the support received in all care setting.

The Head of Service explained that Self-Directed Support was available across all services and was embedded in the assessment of needs process. It was detailed that personal budgets could be used for different types of support, dependent on the individuals need. These included:

- Help with personal care
- Domestic help
- Social Inclusion
- Employment opportunities
- Equipment
- Short-term residential care (respite care)

The Committee was informed how personal budgets operated. An assessment would be carried out from which a support plan was developed and agreed. The allocation of resources would be agreed depending on the level of support needed and the personal budget deployed. There were three options for personal budget, these were:

- Direct Payment – cash payment made to eligible persons so they can purchase their own care and support
- Individual Service Fund – a virtual account that enables the eligible person to receive a service without a cash payment. A care agency provides a personalised service, as defined and agreed by the person needing support. The provider invoices the council and gets paid.
- Virtual Managed Account – a service without a cash payment but utilised to support social inclusion.

The Committee was taken through various slides that detailed the trends in personal budget allocation. The presentation detailed a 15.20% up take on direct payment in comparison to 2012 which was at 10.70%

The Committee was informed that the service had a target to increase direct payment.

The Committee was informed that the definition of denominator included certain items which were not available as a personal budget – such as small items of equipment and assistive technology. This has meant it had been difficult for the Service to achieve high performance for personal budgets

and direct payments. The Committee was informed that this was changing next year to exclude these one-off items.

The Committee noted the low uptake of direct payment since its inception. Members suggested that the service should make more of an effort to encourage service users consider using the direct payment method of payment.

The Chairman stated that the report was encouraging but more needed to be done to get people on to direct payment.

33 **FUTURE AGENDAS**

The Committee decided that an update on Dial A Ride be included on its work programme for a future meeting.

**Chairman**

*Have your say with* healthwatch Havering

# Services for people who have dementia or a learning disability

## A review of services in Havering

*A report of a series of workshops held by Healthwatch Havering*
*February and March 2014*

## What is Healthwatch Havering?

Healthwatch Havering is the consumer local champion for both health and social care. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and are able to employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary. There is also a full-time Manager, who co-ordinates all Healthwatch Havering activity.

**Why is this important to you and your family and friends?**

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforces the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution will be vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups and the Local Authority to make sure their services really are designed to meet citizens' needs.

***'You make a living by what you get,***
***but you make a life by what you give.'***
***Winston Churchill***

## Introduction

In late February and early March, Healthwatch Havering held a series of workshops at five locations in Havering. The purpose was to find out what services were available in Havering for people who have dementia or a learning disability and what needed to be done to secure improvements.

The participants included people who use services and carers, volunteers from local third-sector organisations working with people who have dementia or a learning disability and social and health care professionals from Havering Council and local NHS organisations.

We chose Learning Disability and Dementia because these two groups are among the most vulnerable within our community.

## Acknowledgements

Healthwatch Havering would like to thank all the participants for the open and frank contributions to the discussions at the workshops. The range of participants' experiences, knowledge and hopes, and their collective desire to secure the best possible outcomes for people who use services and carers made the exercise particularly valuable. Everyone who attended will be provided with a copy of the report

As a direct result of people coming together at the sessions, who would not ordinarily have come into contact, several initiatives have developed that might not otherwise have done so. We would like to thank the professional staff who took up these initiatives so quickly.

**The conclusions and recommendations reached are entirely those of Healthwatch Havering.**

## How the sessions were organised

Five sessions were held between 25 February and 4 March at venues across the borough: in Central Romford, Collier Row, Cranham, Harold Hill and Hornchurch.

Attendees included service users and carers, a number of representatives from the voluntary sector, NHS organisations and local authority departments, everyone made significant contributions to the discussions.

The framework for each meeting and both topics was:

"What is missing?"

"What would make a difference?" and

"What have you experienced that is good?"

Attendees worked in individual groups sharing their knowledge and experience on both dementia and learning disabilities. Each group was chaired by a member of Healthwatch Havering. At the end of each session there was an open forum and each group fed back and shared the experience of their group.

## *Conclusions and recommendations*

### *Our conclusions are:*

- Overall services for people who have a learning disability or dementia appear adequate and there have been some good, innovative developments.
- Service planning over the years has taken account of the needs of people who have dementia; but much remains to be done, especially in early diagnosis
- Services for people who have a learning disability appear to be less advanced. The challenges are across all the age groups, but many parents felt very strongly about the support and access to basics such as aids and equipment.
- A more contemporary and intuitive care model for learning disability and dementia, which addresses the inequity of service and access across the Borough, is needed.
- The feedback indicates that people who use services and carers need better means of communicating their views and a better understanding of how to seek the support and help that they need.
- That is not necessarily a criticism of the services – there was no suggestion that staff do not listen, or seek views, or try to tailor services to individual need. However, the statutory provisions under which services are provided tend to be aimed at common needs rather than individual circumstances.
- Personalised budgets will undoubtedly help people choose what they want rather than what is on offer. However, it may take time both to give people the confidence to make their own choices and for "the market" to develop service packages that are tailored to

individual choice. **A clear message from the five events is that people will need help and support in taking on this responsibility.**

- Service users and carers appeared to be confused regarding the services on offer, the role of various voluntary sector organisations and who to contact and when.
- Service delivery problems are not confined to one sector: and there is evidence of joint planning and working across the agencies. However, from the comments given by users and carers, there is no doubting professional staff commitment and passion to achieve the best possible care standards for the residents in the Borough.

## *Our recommendations are:*

### *Health checks*

- To review the arrangements for providing and monitoring annual health checks
- To consider developing a dedicated, centralised service for health checks, creating a cadre of clinical staff with special expertise in learning disability and dementia
- To publicise the access and entitlement of health checks

### *General Practice awareness*

- To ensure that all General Practitioners have the right level of training and expertise in dementia and learning disability
- To use those providers which are recognised as exemplars in good practice to mentor and support other general practice
- To determine where under-diagnosis of dementia is occurring within the Borough and establish a programme to address this
- To ensure that patients who need primary care services such as optometry and dentistry are promptly referred as appropriate
- To eradicate the delays between diagnosis and treatment
- To ensure that everyone has the opportunity, either by themselves or with the help of others, to discuss their health and social needs with practitioners

### *Communication and Awareness*

- To develop a Borough information pack for learning disability and dementia which all organisations contribute to – simplicity is the key, and information overload must be avoided
- To consider something similar to the Butterfly scheme for learning disability
- To support the work of the Dementia Alliance
- To encourage closer collaboration between the statutory and voluntary organisations
- To establish befriending schemes

### *Staffing*

North East London Foundation Health Trust to clarify the position in respect of Admiral nurses and their future role in the borough

### *One stop shop*

- For residents to have their community services delivered in one location, consideration should be given to providing a 'one stop shop'. This would benefit service users and carers, improving the opportunity for information sharing, faster referrals and access to services.
- To design IT systems that work between all the different organisations, ensuring that information is up to date and relevant

### *Joint Strategic Needs Assessment*

- To improve the level of local detail about learning disabilities and dementia, thus facilitating a better opportunity to plan and design care for the longer term.

### *Reachability*

- To introduce 'Reachability' as the new criteria for measuring access to services, because unless services are 'reachable' they will not be used to their best advantage for the most vulnerable in our community

## Specific points made during the five sessions

On the following pages is a summary of the contributions, discussions and comments made at the five events. The comments are set out using the question format of the sessions and under each question some key themes that emerged for both learning disability and dementia.

## Learning disability

There are approximately 700 people recorded with a learning disability in the borough. Population statistics suggested that there should be a higher number something of the order of 2,500. Problems seem to arise with the recording and categorisation of learning disability. Autism was not labelled as learning disability as it is a condition in its own right.

Our understanding is that there are:

- 27 homes for adults with Learning Disabilities, the largest has 34 beds and the smallest 3 beds (average 7 places).
- 15 supported living units
- 7 day providers

A more comprehensive data base, perhaps within the JSNA, and a more detailed study of the residents of Havering with learning disabilities would help to provide more comprehensive and accurate information which could support the design of the wider range of provision and care that is needed.

## What is missing?

### Annual Health Checks

- Concern was expressed that Annual Health checks of people who have a learning disability are simply not being carried out. Annual health checks are the responsibility of the person's GP but the GP cannot be forced to do them. Health checks can take 30 minutes, and GPs are paid to do them, some GPs seem reluctant to spend that time.
- Competing priorities, such as ordinary consultations take much less time and several consultations could be done in the time taken to do a health check

- There appeared to be a need to raise awareness of the issue, it was not clear whether this was a matter which the CCG or Healthwatch England had responsibility.
- An idea suggested was to have one designated GP to do all health checks for learning disabilities in the borough. This would not only provide a recognised focal point for this care, but would develop a clinical team with a much more detailed knowledge of working with learning disabilities.
- This was felt to be particularly relevant when looking at diagnosing dementia within this group. People who have a learning disability, particularly those with Down's syndrome, often develop dementia far sooner than the general population; it can be hard to spot and, when it develops, does so more aggressively.
- It can be difficult to get a diagnosis of learning disability or dementia, with the result that support is in turn delayed.
- There was a suggestion that many people of the Asian community are unaware of dementia and learning disability issues for cultural reasons and a dedicated Health check service would help to support this group

### *Communication with professionals*

- Any communications from health care providers, including hospital appointments – should be written in easy-to-read styles, so that people with a learning disability that included difficulty with reading could nevertheless read them for themselves.
- GPs, dentists and optometrists and other healthcare professionals are rarely trained to deal with learning disability.
- Although, understandably busy and therefore having little time to spare, staff at all levels in A&E need to be aware of how to deal with people who have such a disability – with particular awareness of the difficulty that some face in explaining their symptoms and feelings.
- Good practice is developing on learning disability within the Barking, Havering & Redbridge University Hospitals Trust (BHRUT) but the sharing of information between hospital staff and social care staff can be delayed and the social care team can sometimes not be made aware of an admission until a late stage.

- When admitted to hospital, people with learning disabilities still need support from carers particularly in communicating their needs and understanding what is happening to them. More input is needed from staff with a working knowledge of learning disabilities.
- Carers may need to stay in the hospital but this is not always possible. A short term budget increase may be needed to cover any extra costs and people need to know who to go to for advice
- Help is also needed for young people with learning disability in presenting their needs to the GP or other health care professionals.
- There was a feeling that there was a lack of support for people on the autistic spectrum. Quite often, a GP had to be convinced to refer them on to a specialist.

### *Helping people to be more independent*

- The development of facilities to enable people with a learning disability to access as much as they could for themselves without others' interventions was an urgent need.
- Living in a supported environment rather than with relatives enables a person to be more independent; carers can be over protective. But it is important to avoid isolation – a buddy system can be invaluable.
- There is no befriending scheme, and people do not understand the needs of those who have a learning disability, and especially those developing dementia.
- It is important that individuals be encouraged to help themselves more. For example, with public transport, carers can help a person gain the confidence to use it appropriately.
- There is need to know how to access funding and what is available – for example if a person wants to attend college, currently there is a lack of assistance in understanding what is in the care package.

### *Finding out what is available*

- People with a learning disability, especially those whose carers are themselves elderly, find it hard to access mainstream services. They often do not know how to, and thus cannot, communicate their needs to others.

- There was a call for more information generally, for example why not advertise more, or have slogans and adverts on buses. Letting people know where to go for advice: for example, how is the right to an annual health check communicated to the public?
- People who have a learning disability, and have never been in the system do not always get an inheritance from deceased parents or other relatives and so they become the responsibility of Adult Social Care.
- Carers of people who have a learning disability need to be aware of how to cope with dementia; the period following diagnosis can be a particularly traumatic time.
- If a carer has a problem, where do they go first? There is a lack of information, carers often not knowing where to start seeking support.

### *About how the services work*

- Services for children with a learning disability are generally good and, if a user is known to Adult Social Care, for example, on transferring from Children's Services at 18, then they are more likely to continue to receive appropriate care
- Parents of children with a learning disability need to know the key person who is there to support them.
- Those who do not receive intensive support – perhaps because all care is arranged within the family - seem to slip through the gaps.
- As parents get older, natural family support can be lost and those who live at home with family as carers generally do not become known to Adult Care Services until an elderly carer dies, at which stage continuity of care becomes a crisis rather than a managed transition.
- The various strands of learning disability need to be looked at to ensure that people are getting the correct support.
- Although awareness is improving, there is a tendency to categorise rather than address the very many different types of need.

# What would make a difference?

## Help with managing health care issues

- To raise awareness, there was a need for better training of health and social care professionals, voluntary sector helpers and carers.
- A welcome improvement is the forthcoming reinstatement of the providers' forum.
- Better sharing of information across service providers and quicker notification to social services when a person was admitted to hospital was essential.
- BHRUT should improve their communication with other organisations as this was vital to assisting the patient and the dedicated community support
- Information should be kept up to date, between BHRUT, the GPs and the social care teams.
- A central office/conduit could be set up to encourage the co-operation between such services.

## Families

- Families needed to be aware that people with Downs Syndrome were more likely to develop dementia earlier, and that the effects of the syndrome can mask the onset of dementia, making it harder to detect.

## Residential homes

- The signs of dementia in learning disability needed also to be understood by staff of residential homes accommodating people with learning disabilities.
- This should form part of the 'routine' training because of the high turnover of staff in those homes.
- Once dementia has been detected, it was necessary to forget the learning disability and deal with the dementia, and staff and carers needed to be aware of this.
- When a service user goes from a care home to hospital, they should be accompanied by a carer from the home, who knows all there is to know about the person.

## GP care

- GP services needed to be more aware of, and ready to respond to, the problems of people who have a learning disability.
- It was suggested that a scheme similar to the Butterfly scheme used by BHRT for dementia patients could be developed for the GP notes of people with learning disability this would alert reception and clinical staff to be alert and prepared.
- There would be an improvement in GPs monitoring of patients with learning disabilities if they could follow a learning disability health action plan.

### *Queen's Hospital (BHRT)*

- Improved education and training for staff to enable them to identify the needs of a learning disability service use when being admitted to hospital
- Could a scheme similar to the Butterfly scheme be developed for learning disability patients
- Clinicians need to be aware about the additional needs of their patients who have learning disabilities, particularly communication needs
- There is a new learning disability nurse in place at BHRUT, which should improve matters and was seen as a very positive approach
- This new post should be communicated/ published more widely, so learning disability service users know who to contact.
- There is a communication book from BHRUT and this should be made more available public

### *Carers*

- Families who are without other relatives support should be offered more respite care hours. They tend to use the hours up quickly when compared to families who have family support.
- There was a lack of understanding that carers and families had other responsibilities: their jobs, their homes, raising their children. They should not be made to feel guilty because they could not provide a home and full-time care for their relative
- There was concern that the Government was now expecting carers who were in receipt of welfare benefits to seek employment and report to the Job Centre, even though they were caring full-time.
- Carers also need to be aware of their entitlements to benefits.

- Service users and carers will need help and support in making sense of personal budgets
- Improved access to advice on financial matters from organisations that do not have a business interest in providing the information

### *Community learning disability passport*

- The learning disability passport gives information but is missing practical advice.
- Community passports need to be updated to show what date they are admitted into hospital
- Person-specific information such as by what name a person likes to be called, what they like and dislike and what upsets them. This applies to dementia as well as learning disability.

### *Practical support*

- It would be useful if there were more clubs and cafés for people with learning disabilities
- If clubs, cafés and other facilities for the general public were more welcoming of people with learning disabilities, perhaps develop a learning disabilities friendly logo
- A befriending scheme would help.
- Recognition of people with learning disabilities needs in using public facilities such as public toilets.

It was recognised work has started on many of the issues raised above and that good progress was being made. This is identified in the section below.

## *What have you experienced that is good?*

### *Support*

- Havering Adult Care Services were praised and appreciation was expressed of support from St Francis Hospice. The work of the new learning disability nurse at Queen's and residential homes staff were also praised.

### *Awareness*

- The overall view was that it was good.

- The professionals from the different teams were working together.
- Meetings such as this series of events were seen as a real opportunity for non-confrontational, open and frank discussion between the professionals, service users and carers.

### *Care services*

- There is good multi-disciplinary working, which should ensure that communication is used in the right way
- Mystery shopping takes place, and has worked well in identifying good practice and practice that needs change or developing
- There is a good partnership board that addresses employment issues.
- Supported living schemes help individuals to make better lives for themselves.
- In residential care settings, annual health checks are done.

### *Health services*

- There is a lot more awareness in hospitals, with recent training in BHRUT and consultants are attending these training sessions. Nursing staff receive learning disability training in their inductions
- There has been good feedback about A&E and end of life care from learning disability service users and carers.
- The handling of cases with complex discharge issues from BHRUT has been vastly improved.
- There is demonstrable good practice in dealing with learning disability
- The learning disability team at the Hermitage centre has created a learning disability pathway.

## Dementia

Havering has the highest proportion of older people in London and has experienced a 44% increase in the very elderly age groups 84 – 89 years; almost double that of London and England overall.

It is estimated that around 3,275 people in Havering (aged 65+) have dementia. This is predicted to rise to 3,794 by 2020.

There are 42 registered care homes for dementia but, of course, that figure will rise as residents living at home develop dementia.

## What is missing?

### Carers

- The view was expressed that there is little or no support for carers and the person with dementia, leaving people feeling isolated and unable to find help in the community but reluctant to involve Social Services initially.
- Once registered with Adult Social Care it is easier for people to gain access to the "front door".
- Carers have a right for their own needs to be assessed but need encouragement to come forward.
- Carers need greater awareness of the clinical issues affecting people with dementia
- There is no use giving people money in personal budgets if they do not know how or where to use it.
- An inability to find help in the community and leaving carers unable to get respite. There is very little respite, which is stressful for families.
- There is confusion over who is offering services. Age Concern no longer offers an advocacy service and there is no support for carers.
- Some patients refuse to visit the memory service – carers of people with dementia are told that the carer must compel the patient to attend the memory clinic, if not this would be a violation of the patients human right - but what about the carer's human rights?
- A crisis line to call for carers when a person becomes violent would be a significant help.

### *Access to information*

- Information points are needed; there is a lack of information in hospitals, libraries and other public areas.
- More is needed for the growing BME population – a multi-cultural approach, making services acceptable.
- People with dementia may not know much English or even revert to speaking their native language, which not only exacerbates the already difficult nature of communication with dementia patients but leads to isolation
- Because of language barriers, people may not be aware of the services available to support them.
- A unit that can offer translation services within the community would help address this.
- The voluntary sector lacks communication with health professionals.
- There was a suggestion that people are unaware of the resources, voluntary organisations and professional health and social care resources available in the borough.
- A more co-ordinated approach between professional to ensure that accurate information is shared about service users prior to visiting peoples home.
- There is a lack of communication between Adult Social Care and voluntary organisations, and referrals are not always treated appropriately.

### *GP Care*

- There is a lower than average diagnosis rate in Havering, possibly because of coding in GP practices if the incorrect code is used it sometimes is not picked up
- Demographics suggest there should be around 3,000 people with a formal diagnosis of dementia but only about 1,000 have been so diagnosed; the "missing" 2,000 should be identified quickly.
- Individuals and families did not know who to turn to when a diagnosis of dementia was made
- It seems that NELFHT and the CCG/GPs do not use the same coding systems.
- GPs need encouragement to diagnose under 50's.

- People can become lost between diagnosis and follow up and there are some very unacceptable delays
- It can be difficult to get GPs to make home visits
- When service users are discharged from clinics there is no continuity or follow-up service and carers and users seem to be left to fend for themselves.

### *General comments*

There is a hidden population – people in care homes who not are not necessarily known to Adult Social Care or voluntary organisations, never go to memory clinic sessions and receive care from their GP only if their behaviour worsens.

Health passports are not being used enough, nor up-dated.

It would appear that they are only mentioned when someone is admitted into hospital.

It would help if facilities could be shared: with say NELFT, Physiotherapy and voluntary organisations together on one site, in a "one stop shop".

## *What would make a difference?*

### *GP Care*

- GPs are the first port of call.
- When people go to see their GP about dementia the GP often holds back; how can this be overcome?
- GPs need better awareness and understanding of, and training about, dementia.
- When a diagnosis is made it would be really useful to have someone on hand for a chat about relevant information and telephone numbers.
- An information pack is being prepared, but care is needed to avoid information overload, could organisations work together to provide one concise pack.
- The waiting time from Memory Clinic to receiving a prescription is too long; it can take weeks. GPs blame the system but medication should be available immediately.

- Better liaison is needed between GPs and NELFHT; it is improving but more need to be done. Consultants now give out mobile numbers.
- Isolation exacerbates dementia – not just age – people with mental illness need more help from GPs.
- GPs lack empathy – some GPs say what you would expect from a person who is aged 80.
- Clinicians and receptionists need to listen more – even though they are busy, they should take time for the small things that matter, like getting names right.
- There used to be regular talks given by the PCT in particular at St George's Hospital; this should be reintroduced as the talk was usually given by clinicians and it was very useful.
- Patients often have other health needs, for example, diabetes and it is often very difficult to get medication changes and follow up care organised as the GP does not always fulfil the role of the link clinician

### *General comments*

- There is also concern about the lack of Admiral Nurses – and when one retires later this year, is understood that NELFHT will not be replacing her. That decision needs to be reversed.
- Age Concern raised their concern that they were no longer invited to attend multidisciplinary meetings and felt their input could make a positive difference.
- Wider membership of multi-disciplinary team would be helpful to share information before crisis point is reached
- The public need educating about dementia in order to overcome the possibility of stigmatising people.
- There are new national schemes working with children which have proven to have very positive outcomes
- Better information needs to be available on websites, or when calling centres.
- Advice on legal and financial help should be readily available.
- Carers need better training and overall support, it is a heavy burden 24 x 7
- A "buddy" scheme and a link so that carers and service users do not feel abandoned would help

- Carers need to know how to follow up problems before service users reach crisis point.
- Relatives should be given more information about their kin in care homes. What activities are being employed and how their time is structured.
- More awareness and information should be available. For example, people have commented that their friend is showing signs of dementia, who do they go to for advice about their friend?

## *What have you experienced that is good?*

### *Health services*

- There is good support from some GPs and the Admiral Nurses.
- The Council is investing in more liaison with carers. Carers forums are held and there is a single point of access at the Council
- Co-operation between the CCG and BHRUT is improving; information is being shared between them which they plan to send to The Memory Clinic and it is envisaged that a pattern will emerge. This should help identify the "missing" 2000 who have yet to be diagnosed with dementia
- Good community care can avoid the need for admission to hospital.
- The CTT and the CCG are proposing to provide facilities at night.

### *Social Care*

- Good support from Adult Care Services
- Occupational Therapists are supportive and give advice as to what is needed in the home, such as alarms.
- Havering is passionate about dementia services in the borough and there is now a Dementia Programme Manager.

### *The voluntary sector*

- There is good support from Age Concern, St Francis Hospice
- There are support groups for carers, lunch clubs and Alzheimer's cafés: these are well run, but people who are not in the "loop" find it difficult to access them.
- The Alzheimer's Society has issued a leaflet called "This is me" about the need of a dementia patient when they are receiving

treatment – it was originally for those going into hospital, but has been updated for all dementia patients undergoing treatment either in hospital, GP or in the home.

- The Alzheimer's Society has dementia champions, with training not only for their own staff and volunteers but for others.

## *Other*

### *Joint Strategic Needs Assessment*

- The JSNA is the document which helps to form the basis of informed decision making for commissioning services.
- It is robust in having well-documented national statistics, but it appears to be weaker in local data.
- Aspects of the JSNA such as statistics on learning disability and dementia should be provided in a simpler and shortened format for organisations working within this sector. The current format is a bit indigestible for people outside of the professional public health arena.

### *Library Services*

- This service is well respected by all the agencies.
- Libraries are really committed to helping support groups, and support anyone wishing to hold an event.
- A Dementia Action Alliance is being formed in Havering. It would be helpful if local shopkeepers could put a sign up saying that they are a "dementia-friendly" shop. This would make those with dementia and the carers feel more comfortable as they can feel alienated when visiting shops.

## *Making a difference – actions already taken*

In the course of the discussions, several issues were mentioned and it was agreed people felt should be taken forward as quickly as possible

. The following is a brief summary of some of the action taken:

- Following a suggestion that GPs lacked training in dealing with dementia, BHRUT agreed to investigate the position
- In respect of training for carers' groups, Adult Social Care is working with the CCG to find suitable premises as a matter of urgency
- NELFT and Age Concern are to discuss what happens when a person who has dementia refuses to see a GP or the memory service –
- Enquiries are being made about overcoming the obstacles to Age Concern and potentially any other relevant voluntary organisation resuming attendance as part of multi-disciplinary meetings
- The CCG is to discuss with NELFT the concern about the lack of Admiral Nurses – in particular, the suggestion that when one retires Note CCG have picked up on this and written to NELFT.
- A lead GP agreed to take forward the concerns on providing Health Checks to people with learning disability

Individual cases that came to light in the course of the events have been taken up with the relevant providers.

## Participation in Healthwatch Havering

We need local people, who have time to spare, to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering. To achieve this we have designed 3 levels of participation which should allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

**We are looking for:**

### Lead Members

To provide stewardship, leadership, governance and innovation at Board level. A Lead Member will also have a dedicated role, managing a team of members and supporters to support their work.

### Active members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

### Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

## Interested? Want to know more?

Call our Manager, Joan Smith, on **01708 303 300**;
or email **enquiries@healthwatchhavering.co.uk**

*Healthwatch Havering is the operating name of*
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# INDIVIDUALS OVERVIEW & SCRUTINY COMMITTEE

# REPORT

**10 July 2014**

| | |
|---|---|
| **Subject Heading:** | Impact of Services on the Elderly Topic Group |
| **CMT Lead:** | Andrew Blake-Herbert<br>Group Director Resources |
| **Report Author and contact details:** | Wendy Gough<br>Committee Administration<br>01708 432441 |
| **Policy context:** | Findings of the Impact of Services on the Elderly Topic Group |


**SUMMARY**

This report contains the findings and recommendations that have emerged after the Topic Group scrutinised the subject selected by the Individuals Overview and Scrutiny Committees in October 2012.

The financial, legal and HR implications are addressed within the topic group's report.


**RECOMMENDATIONS**

That Members:

1. Note the report of the Impact of Services on the Elderly Topic Group (attached);

2. Agree to refer the report to the next meeting of Cabinet.

**REPORT OF THE INDIVIDUALS OVERVIEW AND SCRUTINY COMMITTEE IMPACT OF SERVICES ON THE ELDERLY TOPIC GROUP**

## 1.0 BACKGROUND

1.1 At its meeting on 9 October 2012, the Individuals Overview and Scrutiny Committee agreed to establish a topic group to scrutinise the impact of services on the Elderly

1.2 The following Members formed the topic group at its outset: Councillors Wendy Brice-Thompson (Chairman), June Alexander, Pam Light and Linda Van den Hende.

1.3 The topic group met on four occasions including two visits. One for the group to look at the housing schemes for the elderly in Havering, and one to look at the schemes available in the neighbouring borough of Barking and Dagenham.

## 2.0 SCOPE OF THE REVIEW

2.1 Following an Ageing Well Event organised for Members, the Committee wished to understand the impact that housing services had on older people generally, older people with disabilities and vulnerable residents in Havering, together with finding out about services available for these groups and how easily the services can be accessed.

## 3.0 INITIAL PRESENTATIONS

Brief details of the various presentations are shown below:

3.1 <u>Havering Housing Services</u>

There were a number of housing types categorised for older people ranging from ordinary housing with adaptations suitable for the elderly to sheltered and extra care housing as well as residential homes. In Havering there were 19 sheltered housing schemes comprising 894 units. There were two extra care schemes in Havering Painesbrook Court and St Ethelburga's Court. A third scheme was being developed called Dreywood Court. This scheme subsequently was completed and opened in July 2013.

Homes and Housing had a capital budget for aids and adaptations for Council tenants. This covered works such as the installation of stair-lifts, walk-in showers and wheelchair ramps. For similar works for those who were not council tenants, there was a Disabled Facilities Grant. This was mandatory where there was a disabled household member. The Council had agreed a policy that a discretionary grant above the £30,000 cap could be sought although this was extremely rarely required.

The Telecare and Careline service was provided by Homes and Housing. The majority of referrals were now from Adult Social Care. The Careline service consisted of a call button worn on a pendant by service users and/or a pull cord(s) within clients' homes. The Telecare service provided a variety of sensors, for example fall detectors and flood detectors which automatically alerted the call centre when activated. When either the Careline or Telecare equipment was activated, the call centre answered. If a call-out was required a relative was contacted or staff from

Havering's Telecare Centre attended, this was based upon the clients' previously expressed preferences. The majority of people paid for Careline or Telecare themselves. Subject to Adult Social Care's Fair Access to Charging arrangements, Adult Social Care may pay for users' services directly.

3.2 Age Concern Havering Services

Age Concern was an independent charity that focussed on improving life for older people. Their work was funded by a range of sources – the Council, grants and trust funds. There were in excess of 250 volunteers at Age Concern Havering, many of whom were older people themselves but found the voluntary work rewarding.

A key role of Age Concern was health and health promotion. Support, information and advice were given following a stroke. Age Concern also ran a cancer awareness campaign to raise awareness of lung, bowel and breast cancer, together with a charity shop, day trips and holidays. Work was carried out across the borough; however the group had discovered that the Rainham area was difficult to cover fully **(See recommendation 6.2).**

There were two day centres that were core funded by the Council and run by Age Concern. HOPWA House in Hornchurch allowed active older people to take part in activities as they wished, and Painesbrook Court offered a day service for the frail elderly six days a week. Community and preventative services included a pub club and the Council funded "perky pensioners" service which provided reasonably priced meals and outings etc. A befriending service was available for older people who were housebound or people living alone. There was also a home support service which supplied volunteer handypersons to work in people's homes as well as a list of vetted tradespeople. The Pomelo Care service was committed to improving the quality of life of its clients. It included paid services to carry out domestic care, gardening, personal care and home visits.

## 4.0 VISITS TO HOUSING SCHEMES

Brief details on the visits undertaken by the group are shown below:

Housing Schemes in Havering

4.1 Cole Court

The group visited Cole Court, which was a modern sheltered housing unit, with 35 one bed flats. The criterion for the units was anyone aged 55 years and over. However for those aged 55 to 60, the client would have to be registered disabled. For the over 60s a proven social isolation need was necessary.

Residents of Cole Court were of differing needs (high, medium and low). The high needs residents were contacted everyday by the roving warden, whereas those on a medium or low need were not contacted as frequently. All units in the complex had the Careline box installed; this had replaced the old link-line system.

The group was informed that the average rental for a unit was £90-£100 a week, this included all service charges.

4.2 Painesbrook Court

The group visited Painesbrook Court, which was a high dependency care home run by Housing 21; however East Living were responsible for the care packages. There were 64 one bed units and the majority of residents suffered from mental health or learning disabilities. The age range of residents was between 59 and 98; however the criterion was a minimum age of 55 but with a high dependency need.

Age Concern ran a very successful day centre at Painesbrook Court, which members were able to observe. Residents were able to participate in the day centre for £2 a session. There were two sessions, one from 10am-3pm and the other from 11am – 4pm.

The group were informed that the rental was standardised and was approximately £219 a week, and this included all their utilities.

4.3 Royal Jubilee Court (RJC)

The group visited Royal Jubilee Court, which was made up of four large houses, Philip, Charles, Elizabeth and Anne. Within Philip House the group visited the bedsits that were being converted so that new shower units and kitchens were being installed to alleviate any shared facilities. There was also new double glazing and radiators being installed throughout the whole scheme.

Royal Jubilee Court was made up of three services; Reablement, Sheltered Housing and the Out of Hours Service. The sheltered housing was located within Anne House, including Hubb1. Hubb 2 was at Holsworthy House in Harold Hill and Hubb 3 was in Garrick House in Hornchurch. Each Hubb included one team leader, three mobile support workers and one activity worker. Each Hubb covered between 6-7 schemes, totalling 19 across the whole borough.

4.4 Telecare Centre (RJC)

The group visited the Telecare Centre and was informed that the service was a 24 hour, 7 day a week service. There was a mixture of different alarms and monitors that could be used, and any response came from the telecare centre. The service was looking to move away from the old pendant style alarm and move towards a wristwatch function. The user could wear the watch, which was fully functioning, however there was an additional button they could press and have a 2-way conversation with the control centre.

Adult Social Care promoted the service as part of the care packages. The service maintained the independence of individuals, so for example if a medicare machine was installed as part of the service, this would administer the medication rather than waiting for a carer to arrive. If however the medication was not taken, an alert would be sent to the telecare centre. Staff at the telecare centre would contact and prompt the user to take their medication.

The group was shown the Telehealth equipment, which were in line with the chronic obstructive pulmonary disease (COPD) requirements. This equipment could check vital signs including blood pressure, oxygen and weight if necessary. The equipment

would be linked to a clinician to assess the condition so that intervention can be made at day one. There had been a very successful pilot carried out.

The service also worked with the Police in respect of bogus callers, the Fire Service in respect of hoarders, as well as Age Concern, the Alzheimer's Society and Adult Social Care. There were 3500 clients on the system and approximately 19,000 calls were taken a year.

4.5 Dreywood Court

The group visited Dreywood Court in December 2012 whilst it was still being developed. The scheme was an extra care scheme with 24 hour personalised care, with waking night staff. Residents may start with a very low need, but may need to progress into end of life care in the future, without the need to move from their home.

The scheme comprised 98 one and two bed flats, with 20 for shared ownership. The shared ownership meant that a resident could buy up to 75% of the property, but 25% would remain with East Thames, and therefore there would be no outlay on the 25%. It was clarified that if a next of kin was to inherit the property and they did not qualify for the scheme because of the various eligibility criteria, such as age or need for social care, then they could not move into the property. A clause of the shared ownership lease would require resale to be offered exclusively by East Thames marketing team for the initial 4-6 weeks. After that initial restricted period, the next of kin would be at liberty to sell the property via an estate agent but subject to the eligibility criteria for residence.

Sanctuary Homecare Co. Ltd, won the tender for the 24 hour extra care support and began assessing applicants from April 2013. They established their office at the scheme in advance of the first residents moving in and have had an on-site presence since July 2013. East Thames Housing Group was the Registered Social Landlord responsible for developing the scheme in partnership with the Council. East Thames Group retained landlord responsibilities, issued tenancy agreements and provided on-going housing management. It worked closely with the care and support provider, Sanctuary Home Care Ltd, to ensure the scheme remained a vibrant and inclusive community.

To ensure the moving experience was not a barrier to the most vulnerable and elderly, Age Concern Havering were commissioned to support people to move. The level of support required had been tailored to people's circumstances. In addition a protocol had been developed with the Benefits Service. Each time an applicant moved into the scheme, the volunteers completed the housing benefit forms and verification documents which were collected on a daily basis. This ensured a smooth transition and reduced the burden of unnecessary delays or rent arrears.

4.6 Housing Schemes in Barking and Dagenham

The group visited the neighbouring borough of Barking and Dagenham to see how housing services in other boroughs were run, and to compare them with the schemes in Havering.

4.7 Fred Tibble Court

This was an extra care scheme, and had residents with early onset dementia. The scheme comprised 31 units (6x2 beds and 25x1 beds). Since the scheme was not a secure unit, they were unable to accommodate people with high level dementia need and could not accommodate people who wandered. The scheme was to support independent living. There were two support people who were on the site every day to provide activities for the residents.

The scheme had communal facilities which included a 15-seater cinema, activity room, library and laundry. There was a communal dining area with a chef who provided one cooked meal each day, 365 days a year. This was included in the rental paid by the residents. The rental varied, for a resident on benefits the rental was £120 a month. For self-funders the rental could be between £1200-£1300. The only bills that the residents had to pay were electricity and telephone.

4.8 Thames View Lodge

This scheme was developed and owned by London and Quadrant Housing. It was a category two sheltered scheme and contained 48 units within it. The scheme was centred on independent living All properties had pull cords and pendants. The residents were contacted each day to ensure they were ok, otherwise they were independent.

Reassessments of residents were carried out every six months to ensure that the care met their needs. With the consent of the resident and/or their family, arrangements could be made to move the resident into an extra care unit if their needs increased.

Members asked about the number of voids and how they were dealt with. Nominations came direct from the borough, however there was a waiting list for properties at Thames View Lodge and therefore there was a swift turnaround of properties. The minimum turnaround time for voids was 4 weeks.

The rental was £30 a month if the resident was on full benefits. The only expense would be their telephone bill, however in the bungalows there would be an additional cost for electricity. Communal facilities included a laundrette, a guest room with 2 single beds, a games room, hairdressers and a lounge.

It was explained that due to the heritage of the area, the residents referred to the area they lived as Thames View, and not Barking and Dagenham

4.9 Catherine Godfrey House

This was a category two sheltered accommodation unit. The scheme was owned and managed by the Council. There was involvement of social workers in delivering the care packages at the unit. Outside carers came in where needed and these were funded by personalised budgets. The scheme was person centred and there were some residents with early onset dementia. All residents who lived at the scheme were on the alarm system.

The group visited the communal facilities including the library, where the council library came once a month to deliver a new selection of books and videos; which residents could borrow. There was also a service run by Age UK who assisted with cleaning and domestic needs.

## 5.0 FINDINGS

5.1 The group felt that they had a full picture of the Council services available to the elderly and vulnerable residents of Havering and how these compared with provision in a neighbouring borough.

5.2 Research was undertaken by the Corporate Policy and Diversity team on the number of vulnerable and elderly persons that were in the borough through the Mosaic database. This was carried out to identify as accurate a number as possible of older people who may live alone, are not 'known' to the Council already through claiming benefits or being in receipt of social care services – in other words who might be socially isolated. This amounted to 805 households.

5.3 It was agreed that contact needed to be made with these individuals, to find out if they were aware of the social activities and voluntary sector led local services in their area. The Chairman of the Topic Group met with the Corporate Policy and Community Manager, who explained that a second round of the highly successful "Over 65s Consultation" Community Engagement project was soon to be rolled out as part of the Active Living programme. This initiative involved the recruitment of a cohort of volunteers who were provided with training from a range of agencies, and carried out face-to-face outreach consultation with older people in their homes. It was agreed that the 805 addresses would be incorporated into the next phase of the programme, due to start in June 2014, and those residents would be contacted by the council to see if they would like a visit from one of the volunteers, who could then signpost them to support that was available locally if needed.
**(see recommendation 6.1)**

## 6.0 RECOMMENDATIONS

6.1 That the individuals identified as potentially being socially isolated are visited by volunteers as part of the next phase of the Council's 'Over 65s Consultation project', which will be carried out in the summer in partnership with Citizens Advice Bureau, as part of the Council's Active Living programme. (see paragraph 5.3)

6.2 The council to seek to work in partnership with Age Concern Havering to find accommodation where services are currently not provided (Rainham)(see paragraph 3.2).

## 7.0 ACKNOWLEDGEMENTS

During the course of its review, the topic group met and held discussions with the following people:

Rama Krishnan – Age Concern Havering
Sue Witherspoon – Head of Homes, Housing and Public Protection
Claire Thompson – Corporate Policy and Community Manager
Daphne Edwards – Adult Social Care
Claire Carter – Careline and Telecare Manager
Ola Odupe – Mobile Support and Sheltered Housing Manager
Ken Jones – Divisional Director of Housing Strategy,
London Borough of Barking & Dagenham
Councillor Phil Waker – Cabinet Member for Housing,
(London Borough of Barking & Dagenham)
Councillor Linda Reason – Cabinet Member for Adult Services and HR
(London Borough of Barking and Dagenham)
Christopher Boyo – London Borough of Barking and Dagenham
Ben Ramsey – London Borough of Barking and Dagenham

Background papers list

Notes of the Impact of Services on the Elderly Topic Group Meetings:

1 November 2012
12 December 2012
5 February 2013
10 July 2013

## 8.0 The following comments are submitted by members of staff:

### FINANCIAL IMPLICATIONS AND RISK:

The Council run housing schemes are funded from within existing service budgets. Other Council services referred to within this report are also funded from within existing budgets. There are no direct financial implications arising from this report, which is for information purposes. The cost of distributing the letter will be met from existing resources.

### LEGAL IMPLICATIONS AND RISK:

The Head of Adult Social Care will need to consider whether or not the recommendations should be implemented. Legal advice may be required in respect of any data protection and procurement issues arising.

### HUMAN RESOURCES IMPLICATIONS AND RISK:

There are no immediate Human Resources implications as the Council run housing schemes and other services are already fully staffed and funded by the Council.