Minutes

SOCIAL SERVICES, HOUSING AND PUBLIC HEALTH POLICY OVERVIEW COMMITTEE

5 September 2017

Meeting held at Committee Room 6 - Civic Centre, High Street, Uxbridge UB8 1UW

	MEMBERS PRESENT: Councillors: Wayne Bridges (Chairman) Jane Palmer (Vice-Chairman) Teji Barnes Peter Davis Becky Haggar Shehryar Ahmad-Wallana Tony Eginton Peter Money June Nelson Mary O'Connor (Co-opted Member)
	OFFICERS PRESENT: Ian Anderson - Business Manager, Complaints and Enquiries Gary Collier - Health & Social Care Integration Manager Nina Durnford - Assistant Director, Older People and Physical Disabilities Kevin Byrne - Head of Health Integration and Voluntary Sector Partnerships Neil Fraser - Democratic Services Officer
	EXTERNAL ATTENDEES Julian Lloyd - CEO Age UK Hillingdon Steve Curry - Hillingdon 4 All Dr Anil Raj - General Practitioner.
13.	**APOLOGIES FOR ABSENCE AND TO REPORT THE PRESENCE OF ANY SUBSTITUTE MEMBERS** *(Agenda Item 1)* There were no apologies for absence.
14.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)* None.
15.	**TO RECEIVE THE MINUTES OF THE MEETING HELD ON 20 JULY 2017** *(Agenda Item 3)* **RESOLVED: That the minutes of the meeting held on 20 July 2017 be approved as a correct record.**

16.	**TO CONFIRM THAT THE ITEMS OF BUSINESS MARKED IN PART I WILL BE CONSIDERED IN PUBLIC AND THAT THE ITEMS MARKED PART II WILL BE CONSIDERED IN PRIVATE** *(Agenda Item 4)* It was confirmed that there were no Part II items, and that all business would therefore be conducted in public.
17.	**ANNUAL COMPLAINT REPORT FOR HOUSING SERVICES AND ADULT SOCIAL CARE - 1 APRIL 2016 TO 31 MARCH 2017** *(Agenda Item 5)* Ian Anderson - Business Manager, Complaints and Enquiries, introduced the annual complaint report for Housing Services and Adult Social Care, which spanned the period 1 April 2016 to 31 March 2017. The Committee was advised that the statistics were broadly similar to the previous year. Key points highlighted were: <u>Housing Services</u> Within Housing Services, informal complaints had been seen to reduce, with 201 fewer complaints recorded, totalling 455, in comparison to the 656 complaints recorded in 2015/16. It was suggested that the reason for this reduction was the recent mild winter, during which residents likely had less need for repairs. Stage 1 complaints had increased by 7, to a total of 125, of which 22 were upheld, 14 partially upheld, and 82 not upheld. 7 complaints were either cancelled or withdrawn. The average time taken to conclude a Stage 1 complaint was 8.26 working days, against a target of 10 working days. Stage 2 complaints had been seen to have fallen, from 25 in 2015/16 to 12 in 2016/17. Of these, 3 complaints were upheld, and 9 were not upheld. The average time to conclude a Stage 2 complaint was 11.16 working days, against a target of 10 working days. There were no Stage 3 complaints. 22 complaints were concluded by the Ombudsman, with 1 complaint upheld, 2 partially upheld, 12 not upheld, and 7 not investigated. Compliments had reduced, from 23 in 2015/16 to 19 in 2016/17. It was recognised that compliments were less likely to be submitted than complaints. Overall, a greater number of complaints were now progressing directly from Stage 1 and or 2 to the Ombudsman, for example complaints received from residents who were ineligible for housing, but continued to challenge the homelessness policy. <u>Adult Social Care</u> Within Adult Social Care, informal complaints had reduced from 131 in 2015/16 to 105 in 2016/17. Stage 1 complaints had reduced from 39 in 2015/16 to 35 in 2016/17. Of these, 4 complaints were upheld, 9 were partially upheld, and 22 were not upheld. The average time taken to conclude a stage 1 complaint was 10.47

working days.

8 complaints were concluded by the Ombudsman during this period, with 3 upheld, 4 not upheld, and 1 discontinued.

Compliments had been seen to have increased by 61%, to a total of 79 in 2016/17, from 49 for 2016/16.

When comparing Hillingdon's statistics to those of other Authorities, it was apparent that the number of formal complaints received from adults in this Authority was substantially lower than that of Councils such as Ealing or Buckinghamshire. This was due to the proactive work carried out by Hillingdon officers to resolve issues at the informal stage and Stage 1 of the complaints process.

Home Care Providers received 96 informal complaints during the period 2016/17. Of these, 40 complaints were upheld, 25 were partially upheld, and 31 were not upheld. The most common complaints were related to poor time keeping (62 instances), missed calls (49 instances) and poor quality of care (42 instances). It was highlighted that an individual could cite multiple reasons for complaining, per complaint instance. It was felt that often these issues were basic errors that should not be repeated, and the Council was now actively working with providers to address these issues.

The Complaints department had seen a 7% increase in enquires from Elected Members, when compared to the previous year. The number of enquiries received totalled 9,185. Of these, Housing Service accounted for 11% (984) and Adult Social Care accounted for 3% (237) of all Member enquires recorded. Approximately 38% of enquiries related to waste or antisocial behaviour (ASBIT) issues.

Members expressed the view that, while the complaints received by the Home Care Providers may seem basic, such issues could be deemed as neglect or abuse, and it was important to ensure that vulnerable residents were receiving the expected level of care. Members sought further information on what was being done to address such issues.

Members were informed that the Contract Management team held a monthly, in-depth review, at which each individual complaint incident was discussed with the relevant Home Care Provider. A traffic light system was in place to monitor performance. This process was instigated approximately 12-18 months ago, and so was still in early stages, but the importance of improving had been recognised. If any issues recorded related to safeguarding, these were referred to the Safeguarding team, and dealt with via a separate process.

The Committee suggested that the comparatively low number of complaints received may be due to a perceived difficulty in submitting a complaint, or a fear that the complaint would prejudice a resident's care.

The officer explained that the process to submit a complaint was designed to be easy to carry out, with complaint forms submitted by social workers on residents' behalf. It was recognized that some residents may be fearful of retribution following the submission of a complaint, but that was would not be manifested by the care provider. It was accepted that some residents

may not be aware of how to submit a complaint, but that such residents were difficult to identify. In addition, it was felt that it was important to provide the Home Care Provider with the opportunity to resolve the issue, but that if the resident was not satisfied with the outcome, they could complain directly to the Council. Most complaints were upheld, but if issues were seen to have repeated, than the Home Care Provider could be changed. On occasion, complaints were not upheld, due to residents having unreasonable expectations of their Care Provider.

Members sought clarity on how the complainant was notified of the outcome of their complaint, and how the matters were reported on the Care Quality Commission (CQC) website.

It was confirmed that the CQC website held reports and recommendations, but that the process, with the relevant services, only came together within the Ombudsman's office. The outcome of the complaint was communicated by way of telephone call, email or letter, depending on the stage of the complaint. In cases where maladministration had resulted in a financial loss, compensation was offered. In some cases, a complaint is forwarded to the Council's insurer, who would deal with the complainant directly.

Members sought clarity on how unsatisfactory housing repairs were dealt with.

The officer confirmed that a senior manager would investigate such issues, and speak with the contractor in question, which could lead to a review of the contract itself. It was highlighted that most complaints received were about Council workers rather than contractors, and were dealt as part of the usual staff appraisal process. One of the more common complaints was in relation to mould and condensation, which was deemed to be a lifestyle issue, and for which the Council provided prevention literature.

The Committee requested that a breakdown of Member Enquiries, by Ward, be forwarded to all Members. In addition, it was suggested that the incident breakdown included in the report be amended in future reports to include what had been learned and what actions had been taken, rather than just a summary of the incident. It was also suggested that the wording relating to the time taken to respond to a complaint be amended to ensure clarity that this was a response, not a final conclusion of the issue.

RESOLVED:

1. **That the report be noted;**
2. **That a breakdown of Member Enquires, by ward, be forwarded to all Committee Members;**
3. **That the officer incorporate the Committee's suggestions, as set out above, when drafting next year's report.**

18. **MAJOR REVIEW WITNESS SESSION - LONELINESS AND SOCIAL ISOLATION: LOCAL PARTNERSHIP EFFORTS TO MITIGATE SOCIAL ISOLATION AMONGST OLDER RESIDENTS AND PEOPLE WITH MENTAL HEALTH ISSUES** *(Agenda Item 6)*

Gary Collier - Health & Social Care Integration Manager, provided a witness report as part of the Committee's review into Loneliness and Isolation amongst older residents. Mr Collier was supported by Nina Durnford - Assistant Director, Older People & Physical Disabilities , Kevin Byrne - Head of Health Integration and Voluntary Sector Partnerships, Julian Lloyd - CEO Age UK Hillingdon, Steve Curry - Hillingdon 4 All (H4All), and Dr Anil Raj - General Practitioner.

The Committee was advised of the strategic context of the review, which included the Health and Wellbeing Strategy and the Better Care Fund (BCF). The Chairman confirmed that the BCF plan would come to the Committee's November meeting as an information item.

The Health and Wellbeing Strategy 2018/21 was also to be brought to the Health and Wellbeing Board in September, and once approved, would be put into effect. The Strategy will implement the Hillingdon aspect of the North West London Sustainability and Transformation Plan and has three key aims:

1. Improving health & wellbeing;
2. Improving care & quality; and
3. Improving productivity & closing the financial gap.

Reducing social isolation was listed as one of the priorities within the Strategy. Hillingdon's Better Care Fund Plan (BCF), which is a government scheme intended to deliver better health and care outcomes for residents through integration between health and social care, includes actions that will contribute to meeting this priority. The 2017/19 BCF plan includes six schemes but scheme 1, entitled 'Early intervention and prevention', includes actions that are relevant to the Committee's review and these include:

- Improving access to information and advice to enable residents to help themselves;
- Risk stratification to identify people at risk of escalated needs earlier;
- Developing the third sector preventative role; and
- Keeping older people physically active, therefore supporting both physical and mental wellbeing

Early intervention was felt to be key to reducing instances or mitigating the effects of social isolation, and work was ongoing about how best to ensure residents were able to find the services available to them. It was likely that partnership working with the voluntary sector would be important. More specific details around services, particularly physical activities, were due to be heard at the Committee meeting scheduled for 2 October.

The role of adult social care in identifying social isolation, and the process for residents to access care and support, was outlined. The Committee was informed that social care assessments included a review of the resident's needs, their family circumstances, what pastimes they enjoyed, and activities that interested them. Care plans for people with eligible social care needs could include referrals to partners such as Age UK or other community based organisations and support to access locally run activities. Personal budgets for people with eligible social care needs can be used

creatively to support with external trips, such as fishing or the cinema, depending on their needs and preferences There is also the opportunity to refer older residents to services provided by Age UK Hillingdon, such their befriending services, and also to other locally run activities.

In order to support the safety of older residents, the Committee was also informed that the Council provided free access to the Telecareline for residents aged 80+. This service is also available to people aged under 80 for a weekly charge.

The Committee was informed about the Leader's Initiative. This has been established by the Leader of the Council in his capacity as Hillingdon's Older People's Champion. It is intended to address practical issues identified by older residents that will help to improve their quality of life.

Projects run through the Leader's Initiative had included free installation of burglar alarms for older residents, as well as various group activities. This year, activities had included the Barnhill Community summer trip and the Bell Farm Christian Centre coach trip. Additionally, smaller activities such as fish and chip suppers were run to help residents come together and socialise. The cost of such activities was less than £1,000per activity.

Dr Anil Raj of St Martin's Medical Centre advised the Committee from the perspective of a General Practitioner. Dr Raj confirmed that he had been a General Practitioner for approximately 5 years, and in those 5 years he had seen significant change within GP practices. Previously, GPs worked predominantly in isolation to other support services, and were often only made aware of a patient's circumstances when that patient was admitted to hospital. However, this was changing in Hillingdon due to the new development of integrated care which allowed GP's to proactively share information and foster closer ties with community care programmes and activities. A patient who was now considered to be socially isolated and/or lonely could be referred directly to nearby community programmes or services.

Care Connection Teams have been formed and piloted in the north of the Borough and are being extended to the rest of the borough. There will be a total of 15 teams once fully operational. The teams include a community matron who sees patients with chronic illnesses such as asthma, diabetes and dementia, and who are being trained to be able to proactively prescribe medication and care solutions, under consultation with the GP. In addition, the teams include a care coordinator who is involved in care planning and administration.

The teams meet weekly and patients deemed to be at risk highlighted through practice intelligence from GP surgeries, together with dashboard tools and a risk identification system which incorporated data such as hospital admissions and medication, together with a frailty index tool. From these meetings patients deemed to be risk are offered proactive care management in order to prevent escalated needs. Prevention can include a referral to the H4All Wellbeing Service.

The caseload for a single Care Connection team was approximately 50 patients, across several practices, and 15 teams, covering 44 practices, had signed up to the Care Connection scheme. New matrons and care

coordinators had been recruited, and the teams would now be a key point of call for GPs. Although this initiative remained a work in progress, testimony from GP's showed that they were enthused at helping to better support patients suffering from poor health or depression due to loneliness and isolation.

Julian Lloyd, CEO Age UK - Hillingdon, and Steve Curry, Hillingdon 4 All (H4All), addressed the Committee on the work of H4All, a collaboration between 5 third sector charities: Age UK, DASH, Hillingdon Carers, Hillingdon Mind, and Harlington Hospice, funded by Hillingdon's Clinical Commissioning Group (CCG).

The Committee was informed that H4All was delivering an enhanced provision of the former Primary Care Navigator Service (PCN) that was previously provided by Age UK Hillingdon. This included a free service working with local GP surgeries to support Hillingdon patients aged 65 and over with long term health conditions, including supporting people experiencing social isolation and/or loneliness.

The Committee was provided with some key statistics relating to social isolation and loneliness taken from several reports commissioned by groups such as Age UK and DWP:

<u>Isolation</u>

- 3.5 million people aged 65+ live alone
- Over 2 million, or nearly half (49%), of all people aged 75 and over live alone.
- 9% of older people feel trapped in their own home.
- 6% of older people (nearly 600,000) leave their house once a week or less.
- 30% say they would like to go out more often.
- According to research for DWP, nearly a quarter (24%) of pensioners do not go out socially at least once a month.
- Nearly 200,000 older people in the UK do not receive the help they need to get out of their house

<u>Loneliness</u>

- A 2015 study has indicated that loneliness can increase your risk of premature death by up to a quarter.
- Loneliness can be as harmful for our health as smoking 15 cigarettes a day.
- People with a high degree of loneliness are twice as likely to develop Alzheimer’s than people with a low degree of loneliness.
- 1.7% or 200,000 older people (65 and over) have not had a conversation with friends or family for a month.
- 3.1% or 360,000 older people (65 and over) have not had a conversation with friends or family for over a week.
- 12.04% or 1.2 million older people (65 and over in England) are persistently/chronically lonely.

Academic research had determined that the impact of loneliness on health was the equivalent of smoking 15 cigarettes per day. Preventing and

alleviating loneliness was therefore vital to enabling older people to remain as independent as possible, and therefore reduce the need, and cost, for health and social care services.

Referral routes open to partners included:

- Self referral
- Relative or friend
- Statutory provider
- Neighbour
- Voluntary sector provider
- GP

The number of referrals was seen to be lowest through self referrals, and somewhat higher through relatives or friends or well recognised brands such as Age UK. New referral pathways through the Care Connections team and GPs, as outlined above, would help to bring new people into the system and enable better identification, assessment, and triage. This was helped by H4All having a shared record system to enable easy, efficient sharing of information.

For those older residents referred, sector interventions included:

- Information, Advice & Support
- Practical support e.g. welfare benefits, falls prevention, counselling, home help, transport
- Befriending, Just to Talk, Good Neighbours
- Wide range of support, activity and social groups
- Individual Motivational Interviewing, Goal Setting and ongoing support to manage long term conditions
- Transport to Clubs & Groups (limited)
- Access to wider Voluntary & Statutory Services

The aim was to refer residents to 'doorstop' services to preclude the need for personal transport and enable greater attendance. Libraries were often used as a meeting point for activities due to their location and ease of access for a majority of residents. The impact of these services was being measured in a variety of ways, including motivational interviewing and goal setting, an Outcomes Framework, and the Campaign to End Loneliness Outcomes Measurement Tool.

Looking forward, H4All was reviewing how other groups were run, to identify and implement new models of working. For example, more traditional befriending services, while valuable, were often on a one to one basis and designed to support the achievement of a particular goal. As such, these were difficult to scale within existing models. Previous questionnaires issued by the Wellbeing service had found that traditional models were often focussed on people already engaged with services, and so new thinking was being employed to find and work with people who had a lower level of activation. Work was also being undertaken to identify new, more cost effect and self-sustaining working models.

Case studies were briefly referred to, and it was agreed that these be circulated, alongside all presentation slides, to the Committee following the

meeting.

The Committee thanked those present for their presentations, and sought further information on a number of points.

To Dr Raj, the Committee sought clarity on why GP's were previously only aware of a patient's circumstances upon that patient being admitted to hospital, and why GPs were not aware of what voluntary or community services were available to their patients.

Dr Raj confirmed that while new GPs underwent lengthy training to prepare themselves for the role, they would only be made aware of patient circumstances and the services available to patients if they were proactive in engaging with the local community. Work was now being undertaken to develop GPs who had a specialist interest or a willingness to engage further. It was also recognised that the prevalence of locum GP's, who were only present at practices for a short time, did not allow for the continuity of care that a more long term GP could provide. However, GP's were more likely to stay for longer, if provided more detailed training. In addition, the fact that all 44 surgeries had signed up to the Care Connection, reporting to H4All as a single point of access, would result in a more efficient use of GP time and a better level of information sharing that would ultimately benefit patients.

The issue of engaging with those residents for whom English was not their first language was raised, and Members suggested that any literature available was produced in a wide variety of languages.

In response, the Committee was informed that further outreach was needed, to ensure people were made aware of the benefits of the services. For those without English, faith groups were often useful in helping this message to be spread. However it was recognised that languages were an issue and attempts had therefore been made to recruit multilingual staff. On the suggestion that literature be provided to religious locations such as mosques, for in-house translation, it was agreed that literature could be made available upon request. It was agreed that Mr Kevin Byrne would forward a selection of booklets, detailing all available services, to Councillor Ahmad-Wallana for dissemination.

The Committee raised the question of counselling, and whether elderly residents who had experiences a significant event, such as the bereavement of a spouse, were spoken to, to assure them that it was 'ok to be frightened'. Members were informed that several counselling services existed, such as through Hillingdon Mind. In addition, volunteers at service groups were often elderly, and it was recognised that their participation was not only beneficial for themselves, but their presence and word of mouth could help to draw in other attendees.

Members requested that training on the topic of H4All be added to the schedule of Member Development.

The Committee highlighted concerns over how residents were informed of the services available, and suggested that the feasibility of amending correspondence sent by the Elections team be explored, to include notices of services available to elderly residents.

	Members requested that more data be provided on exactly what percentage of Hillingdon's elderly residents were known to be isolated and engaging with services. Members suggested amending the title of the review to make it clearer that the focus of the review was on the elderly residents of Hillingdon. The Chairman raised the prospect of a Member visit to Bell Farm Chistian Centre, to review the work the Centre was doing for elderly residents. It was agreed that Members be informed of the date of the visit, once finalised by the Chairman and the clerk. **RESOLVED:** **1. That the witness testimony be noted;** **2. That available literature detailing services be forwarded to Councillor Ahmad-Wallana;** **3. That a request for a training session on H4All be made to the Member Development team;** **4. That the feasibility of adding literature on available services to Electoral correspondence be explored;** **5. That further detail on isolation and engagement statistics be made available to the Committee;** **6. That the title of the review be amended to confirm that the focus was on elderly residents; and** 7. **That the Committee be notified of a date for a visit to the Bell Farm Christian Centre, once finalised between the Chairman and the clerk.**
19.	**DRAFT FINAL REPORT - THE IMPACT OF CHANGES TO HOUSING BENEFITS ON RESIDENTS AND THE COUNCIL** *(Agenda Item 7)* Members considered the draft final report on the Committee's review into the impact of changes to Housing Benefits on residents and the Council. Councillor Eginton suggested amendments to the report, including additional data such as a comparison of the reduction in benefits since the introduction of the benefits cap, details of delays in payment of benefits, and how the payment of benefits to residents who missed appointments were affected. In addition, Councillor Eginton highlighted that the most recent Corporate Risk Register did not include details on HRA arrears, and requested that this be checked. Councillor Eginton went on to request that the Welfare Reform and Mitigation Plan be forwarded to all Members. It was agreed that Councillor Eginton would forward a list of all suggested amendments to the clerk, for review by the Chairman. Members were supportive of the draft report, and agreed that it be put forward to Cabinet following consideration of Councillor Eginton's suggestions by the Chairman. **RESOLVED:** **1. That the report be endorsed for submission to Cabinet, following**

	consideration of Councillor Eginton's requested amendments by the Chairman; **2. That the Corporate Risk Register be checked for the inclusion of HRA arrears details; and** **3. That a copy of the Welfare Reform and Mitigation Plan be forwarded to all Members.**
20.	**CABINET FORWARD PLAN** *(Agenda Item 8)* **RESOLVED: That the Cabinet Forward Plan be noted.**
21.	**WORK PROGRAMME 2017/18** *(Agenda Item 9)* It was noted that the Chairman had commissioned a report to update the Committee on the use of Assistive Technology, including the Telecare Line, following the previous review conducted in 2011. The update report was expected to be brought to the meeting on 6 November 2017. It was requested that a date be reserved for a meeting of the Committee in December, should a further meeting be required. It was agreed that the clerk would discuss potential dates with the Chairman. **RESOLVED:** **1. That the Work Programme be noted; and** **2. That a date for a further Committee meeting be reserved in December 2017.**
	The meeting, which commenced at 7.00 pm, closed at 8.45 pm.

These are the minutes of the above meeting. For more information on any of the resolutions please contact Neil Fraser - Democratic Services Officer on 01895 250692. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.