OLDER PEOPLE'S PARTNERSHIP BOARD

14th June 2021

Zoom meeting.

1) Welcome, present and apologies.

Present

DD	Debbie Drew	Healthwatch – notetaker
GL	Graham Lewis	Healthwatch
BW	Brian Walker	Independent member – Chair
SE	Susan Edmunds	Independent member
KC	Ken Chung	Independent member
MM	Margaret Moffat	Independent member
JM	Joan Monk	Independent member
JB	Janet Boston	Independent member
SB	Sarah Bye	Commissioner
SW	Susie Willis	CEO, Care Network
KL	Kelly Law	Adult Safeguarding and information team PCC
MJ	Mike Jenkins	CEO, Camsight
LD	Lucy Davies	Head of Prevention and Early intervention
EG	Emily Gutteridge	Day Opportunities CCC
SS	Sunny Singh	Development manager-Community Navigators

Apologies
Marion Shaer, Paul McCloskey, Laura Adcock, Belinda Child, Joan Monk, Jackie Galway

Introductions were made and Graham explained the meeting would be recorded for the purpose of minutes.

2.Feedback from Independent Members
A premeeting was held the week before. Members expressed concerns about the discharge to support process. A presentation was shown at the Cambridge forum which left questions.

Members feel that people are being discharged with nothing in place with assessments not happening in hospital, so people end up being at home with no or little initial support.

Those being discharged from A/E or AAU are not getting assessments and families are left to try and organise.

Members are hearing that people are still struggling to get face to face appointments- or sometimes any appointment at all with the GP. Many people do not know they can insist on face to face but even then, they still must go through triage on the phone. The experience is different from one GP to another.

Any direct experiences of difficulties in getting the appointments can be fed into Healthwatch as it helps build a picture of the problem.

3.Feedback from Other Meetings and Adult Social Care Forum.
The ASCF looked at issues that have been raised by the boards and have decided to focus on three areas. Digital exclusion/ inclusion, Transitions, Co-Production

4. Update Older people's Services- Lucy Davies
We now have teams back in the hospital, working mostly on mental capacity assessments and safeguarding and, and for some only light touch assessments were needed.
The rest of the team is still working in the community and doing what we call "discharge to assess" assessments so when people get home there then visit in the home to do the assessments, or if appropriate doing the assessments over the phone.
I also manage the technology enabled care service, which was a major part of discharge to assess in Cambridgeshire.
We also have a service called enhanced response service which you may or may not be aware of which is a smaller team, which is available 24 hours a day for what we call urgent social care issues including somebody who may have had a non-injury fall. They are available 24 hours a day, across the county. Most of the people press their care line to access that service.
We also have a team of occupational therapist that work alongside the team setting goals, etc. and delivering equipment, making sure people are getting equipment to keep them in their own homes.
We also have a small social work team that's doing the assessments at the end of the reablement if people have not regained their independence.
KC Do people get tested for the covid before they leave the hospitals?
LD Yes everybody is now tested before they leave.
DD What is being done for people who are discharged from A/E often late at night and families are given no information?
LD We have 2 new posts so when people contact the contact centre, we can do an initial assessment over the phone, but this is only available during office hours 9-5. We have started looking at people who need to be discharged from A/E as to what sort of social care they can get. The reablement team get calls direct from A/E sometimes this service is available 7am-10pm. This service can be accessed by calling the Emergency Duty team at Adult Social Care contact centre.
KC There seems to be an issue that hospitals are discharging vulnerable unwell people late at night. This needs to be sorted.

5.Community Navigators- tender process- Sunny Singh

Our current contract ends on this September 2021, and we're looking to go out with a new contract which would be for the service to be delivered for 4 years to give it some proper stability. The current contract is around 325,000 pounds per year.

This new contract will sit as part of the early intervention and prevention framework which is bringing a lot of services that deliver these services under one framework.

The community navigators are in essence the navigators or what we call the signposting service, so they provide information and advice to local people about community activities and local solutions, but also, they provide a lot of information about how to get it how the pathway into statutory support.

The service is open to all Adult Social Care client groups and people with a disability, whether that be a learning disability, physical disability, sensory impairment or mental health problems, and older people and their carers.

Really importantly Community Navigators help remove barriers to help people access activities and services. Community Navigators are good at the guided conversations finding out what the person wants and what is stopping them.

In 2019 there were over 9000 navigations, so you can see that the community navigators. are really supporting a huge amount of people with information and advice queries and 43% of those referrals came into the service by friends and family and 23% of those referrals come in from our adult social care teams and the long-term teams.

We ask for feedback in our quarterly contract returns from the current provider and people really respond well to this service as you can see all the percentages are high.

After people have gone through the navigator service 87% of them feel that their well-being has improved. 74% of clients feel that they're more supported 81% feel more positive about their situation.74% would not have known where to go for information had it not been for the navigators.

Sunny gave a case study example of how someone was helped.

Another part of the Navigator service is support around mental health. There has been a real increase throughout the service history of see more people with issues around anxiety and depression. Because sometimes this is low level moderate anxiety and depression, there isn't really a route for support. What the navigators does is once they've had that a conversation with a client, they work with them and look at plans that could support them to overcome their anxiety and depression.

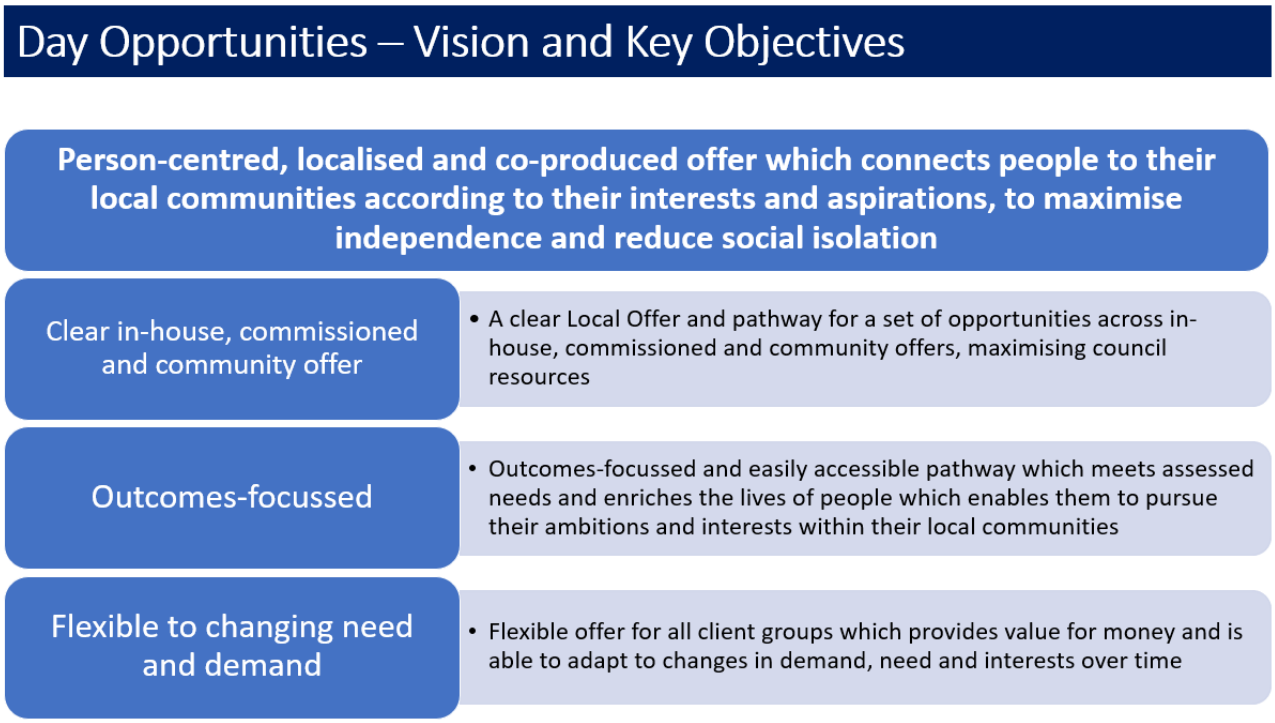
There is also a close working relationship with our other early help team as you can imagine, and a lot of the sort of complex cases and lots of different referral routes that might be needed also come through the navigators.

A new team that's been developed around Community Development called the thing communities team which is very much based on place-based working. The Navigators absolutely support this with alongside social prescriber which has been a big push from our health colleagues. The navigators work very closely with social prescribers to ensure that we don't duplicate services and people are supported at the right place at the right time.

So, in terms of engagement. What we tried to do is look at flipping what the navigator service was on its head. And we had a small working group of people, which can be in from different partnership boards to discuss what was important from an information and advice service and looking at the priorities for the new service.

BW The service probably needs more promotion as people do not know it exists.
SS There will be comms involved with the relaunch.
DD Are the navigators able to say do a bus journey with someone?
SS With our next specification we will be looking at wellbeing volunteers and some "hand holding" will be part of this.

6. Update on Day Opportunities- Sarah Bye (presentation)



We have 4 phases of work:
Discovery and Engagement-June-Sept 21
Design and Co-Production Oct 21-Jan 22
Governance Dec 21- March 22
Procurement March 22- Jan 23

We shared a survey previously with our providers and we had 11 responses from Older People and those with Physical disability and 24 responders with Learning Disability. We found out that OP/PD – providers support between 8-71 people.LD – providers support between 2-250 people.

As the project develops how can we continue to engage with the Partnership Boards to help develop the vision and future commissioning intentions for Day Services?

- How can we best reach service users and carers to help refine our thinking, co-produce the vision and ensure services are meeting their needs?
- What are your thoughts on Day Services and how these meet the needs of individuals? Any key areas we should explore further?

KC How are services monitored?
SB Many of the services are on a grant at the moment. Our LD provision is already on a contractual basis and the others will move to one which will make monitoring easier.
EG Moving forward we hope to see some improvements and will be looking at the impacts.
GL The LD Partnership are looking at their vision and this includes employment and volunteering opportunities.
SB We are linking up with these other strands of work.

7. Priorities Update
Digital inclusion - We will be doing something on this for our AGM on the 21st July.
Transport- Further to our transport task and finish groups last August the report has been published and has been received well. GL was asked to talk on BBC radio Cambridgeshire. The new mayor was positive about the report.

8.Minutes
These were approved from previous meeting.
Following up from those minutes Lynn O'Brien said she would come and talk about care suites. GL said that this is on the September agenda, however, the commissioner looking at the Housing Needs Assessment of Older People has asked if the Partnership Board would like a meeting be held earlier than this to explore the issue in greater detail.

ACTION: A T&F to be set up for the Housing Needs Assessment of Older People – this will include Care Suites.

9. To take to ASCF
The continued concern about discharge from hospital process and the gaps for people/ families being able to get support or know where to get support especially when the change in circumstance is sudden.

10.AOB
DD said this was her last OP board meeting. BW thanked her for her support.

AGM 21st July

Next Meeting

20th Sept- possibly in Huntingdon Library or a blended meeting TBC