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Promoting Independence & Person-Centred Approaches in Adult Social Care

2018/19 Strategy

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Introduction

Adult Social Services in Somerset work to support, promote and enhance strong communities in order that people can live their lives as successfully, safely and independently as possible.

Maintaining independence makes people happier, healthier, and helps reduce the need for future services. We believe that people themselves are best placed to determine what help they need and what goals they wish to achieve.

This strategy sets out the 6 key areas of work we are concentrating our efforts on to achieve improved outcomes for those people we support, to better manage demand and to help us better understand the impact of our work and interventions:

1. Prevention and early intervention
2. Managing demand and capacity
3. Short term interventions
4. Long-term care and support
5. Workforce
6. Governance and management

Three core principles form the foundation of our strategy:

- ✓ Promoting independence and wellbeing
- ✓ Promoting choice and control
- ✓ Ensuring quality and value for money.

In practice, this strategy is about:

- Maximising independence to support people to remain in their homes and communities, without formal social care support wherever possible
- A changed relationship with the public where we manage expectations and are realistic about what we can do and what we expect from individuals, families and communities
- Working differently with partners to support people to get the right level and type of support at the right time
- Asking staff to think and practice in new and different ways, and to change the conversations we have with those requiring our assistance
- Ensuring we have the right enablers in place to achieve our ambitions.

1. Prevention and early intervention

Objective 1a: All community connect conversations are person-centred, asset-based, prevention-focused, maximise personal capability, promote independence, explore natural resources and community solutions before funded solutions, and promote Adult Social Care as an enabler

Objective 1b: People receive an excellent experience whenever they present and feedback demonstrates good quality outcomes and high levels of satisfaction

Objective 1c: Outcomes promote independence and are aspirational and, where appropriate, short-term, low-cost and community-focused

Objective 1d: Resources and skills are targeted according to need and enable early intervention and prevention

Objective 1e: People are able to make informed choices and know where to go for information and advice

Objective 1f: People have the support and tools required to develop their own network of support

Objective 1g: Partners support the Community Connect approach and work together to promote independence, empower communities and ensure people can be supported in their community wherever possible

Objective 1h: Staff are empowered to be creative, share good practice and take ownership of their own development and the continuous improvement of the service

We know that:

- Communities and local networks are assets that help people to help themselves
- Collaboration with the voluntary and community sector should be embraced as a key partner in the early help and prevention agenda
- Opportunities afforded by digital technology should be exploited
- Delivering a strategic shift to prevention and early intervention requires a 'whole system' approach, that is not just about health and social care

We will manage performance in this area via the following measures:

a)	Staff confidence in using the community connect approach *We would expect staff confidence to increase as they become more familiar with adopting a community-focused approach*
b)	Signposting to community solutions (IACs, drop-ins, assistive technology) *We would expect to see more contacts being resolved at the front door, fewer cases work flowed to locality teams and an increase in signposting to community solutions*
c)	Proportion of people accessing / using the Community Connect map *We would expect to see an increase in the number of people utilising the CC map*
d)	Customer satisfaction / complaint levels *We would expect to see an increase in customer satisfaction/compliments and a decrease in the number of complaints*

e)	Proportion of people returning to Adult Social Care after a Community Connect conversation and community solution outcome *We would expect to see a reduction in the number of people returning to Adult Social Care for support following a Community Connect intervention*
f)	Visits to drop-ins, IACs *We would expect to see increased visits to drop-ins and IACs*
g)	Calls to Somerset Direct *We would expect to see a reduction in the number of calls received by Somerset Direct*
h)	Referrals from professionals *We would expected to see a reduction in the number of referral calls from professionals, and more professional referrals submitted via the online form*

2. Customer Focus through the front door of the Council – Somerset Direct

Objective 2a: There is an effective council front door that helps people find solutions to their problems and can demonstrate its impact in terms of diversions from formal care and the delivery of good outcomes

We know that:

- Few people present directly to a Council for help; the majority of requests are made over the phone or via web-based systems
- Most contacts are made by third parties, not by the people seeking help for themselves
- The majority of the requests for help will not require an immediate social work assessment, or even a social care response, and could be sign-posted elsewhere for help
- Councils that are effective in helping people resolve their problems have contact centres with a strong focus on finding community-led solutions that provide an alternative to formal care
- Councils can inadvertently 'suck people into the care system' and create dependence when it is unnecessary because there are better ways of helping those who come in a crisis
- Time and resources can be 'wasted' on assessments when there are alternative and relatively straight-forward solutions available upon which frontline staff should be able to advise
- The focus should be to listen and talk with customers to identify local solutions and to have a follow-up conversation with the people they have helped to ensure a resolution was found to their problems

We will manage performance in this area via the following measures:

a)	The proportion of people referred from the community to Somerset Direct who have their needs resolved at the point of first contact *We would expect this figure to be around 75% of new enquiries from the community*
b)	The proportion of people who have approached Somerset County Council for help who go on to receive an assessment *We would expect this figure to be around 25% of new enquiries from the community*
c)	(Of those people who receive a social care assessment) the proportion of people who go on to receive a service/package of care *We would expect this figure to be around 90%, although the initial service may be help that is focused on supporting re-ablement, recovery, rehabilitation and recuperation*

d)	Volume of cases awaiting allocation (by locality)
e)	Proportion of contacts allocated for full assessment (by locality)
f)	Proportion of full assessments requiring funded care
g)	Management of funded care within allocated spend limits
h)	Time for point of contact to outcome

Customer Focus from Acute Hospitals

Objective 2b: There is a clear set of arrangements in place between the Council and NHS partners that enables for the speedy discharge of patients from hospital and achieves the best possible outcomes for those individuals

Objective 2c: Use of re-ablement is timely, targeted and effective. It is focused on enabling independence and self-management, and avoiding the over-prescription of care. Health professionals managing medical conditions and delivering therapeutic help work closely with those offering re-ablement or rehabilitation to deliver the person's outcomes

Objective 2d: Sufficient intermediate care services are available in the local community to support discharge from hospital and are held to account for the outcomes they deliver

We know that:

- Large numbers of older people referred from acute hospitals are likely to require a service or some form of help from social care, even if only for a short period of time
- If the focus on the care and health system is on the best possible outcomes for the patient through the discharge process, it is more likely the system will be able to manage the flows of people from discharges and reduce delays
- The services available at the point of discharge should, in most cases, offer short-term help focused on supporting recovery and recuperation. These must involve therapists, nurses and care workers who share the outcome-focused approach as this can only be achieved when health and care services work collaboratively
- Patterns of demand should be well-understood so there is a readily available range and supply of required services, including some residential intermediate care beds as well as community support
- Many important aspects of an assessment are better taking place in a setting outside hospital, preferably within the person's own home. The point of discharge is rarely the time for people to make longer-term assessments. An intermediate care solution is the more appropriate response.
- Speedy discharges from hospital may actually produce poor outcomes for older people
- Evidence suggests that 1 in 5 people leaving hospital are over-prescribed the level of care they require, and approximately one third of direct permanent admissions to residential care from acute hospital beds are avoidable
- If the overstatement of needs could be addressed, it would release much needed capacity and resources for the health and care sector, as well as improving outcomes for older people. If patients receive the minimum help they require, more capacity is made available. If their needs are overstated and they are assessed too soon or inappropriately, there will be more demand for

care. If the right help is not available at discharge, this can lead to higher demands in the longer-term

- Shortfalls in the support available to people in the community results in increased hospital admissions and reduced recovery post-discharge
- Recovery is best supported by community and intermediate care staff

We will manage performance in this area via the following measures:

a)	The proportion of people (including those aged 65 and over) discharged from hospital requiring further support from Adult Social Care (Notification 2s) *This figure should preferably be close to 30% but requires the Local Authority to be advised of the total number of people discharged from acute hospitals in Somerset*
b)	(Of the above) The proportion of people discharged into re-ablement services, either bed or domiciliary *This figure should be around 83%*
c)	Proportion of people discharged into re-ablement support that require ongoing (core) domiciliary support *This figure should equate to approximately 34% of discharges into re-ablement / 8.6% of total hospital discharges*
d)	Proportion of people discharged into re-ablement support that require long term residential/nursing placements *This figure should be less than 1% of total hospital discharges and approx. 3% if discharges into re-ablement*
e)	Number of discharges direct to long-term residential / nursing placements
f)	Number of discharges direct to core domiciliary care
e)	Number of acute and non-acute delayed transfers of care (DTOC)
g)	The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services (ASCOF)

3. Effective short-term interventions for people from the community

Objective 3a: There is timely, targeted and effective use of reablement and rehabilitation, including use of assistive technology which has a focus on enabling independence and self-management, and avoids the over-prescription of care

We know that:

- The way the care system responds to a person's set of needs in the first instance can make a significant difference to the longer-term outcome for the person and impact on future service demands
- The care system should not rush to find solutions for people within formal care where there may be other more appropriate community-led options or solutions
- Too many people are placed permanently in residential care before other options, including their recovery, have been explored
- The concept of reablement should not just be an approach for older adults; it should also be available as an approach to assisting anyone with social care needs
- Before anyone is assessed for their long-term needs, there should be a period in which they can be assisted in an appropriate way to help manage their long-term condition

We will manage performance in this area via the following measures:

a)	The proportion of older people receiving less than 10 hours of domiciliary care (as a proportion of all older people receiving domiciliary care) *This figure should preferably be no more than 15%*
b)	The proportion of older people assessed as having care needs who are offered a reablement-based service *This figure should preferably be more than 70%*
c)	The proportion of adults with a learning disability who should be offered a programme to assist them achieve a higher level of independence *This figure should preferably be more than 30% (100% of those with moderate-low needs)*
d)	The proportion of adults who have a newly acquired disability who should be offered an assessment to help them maximise their opportunities for independent living *This figure should preferably be more than 90%*
e)	The proportion of adults receiving from mental ill health who should have a programme to support their long-term recovery that includes helping to both self-manage their symptoms and includes peer support *This figure should preferably be over 70%*
f)	The proportion of people who are assessed as needing domiciliary care who receive their care within 72 hours of the assessment being completed *This figure should preferably be over 90%*

4. Designing the care system for people with long-term care and support needs

Objective 4 People with long-term conditions have care and support plans in place which focus on achieving the maximum possible independence as is possible for their individual circumstances. Plans are reviewed regularly based on outcomes achieved

We know that:

- People should be helped in a way that assists them in living with their long term condition(s) and best managing their conditions with a view to always seek ways to maximise their opportunities for independence
- Every person within the formal care system should have a care plan which seeks to maximise their opportunities for independence
- Discussions should fully involve the person themselves and be agreed with the informal carer (where they will play an active part in care delivery)
- Traditional approaches to assessment of needs have focused on what people *cannot* do for themselves (the deficit model) rather than on their abilities, their network and the potential they may have (the asset model)
- Assessments should focus on what people can do for themselves, how their families/neighbours/friends/wider community can assist them and how any formal care might support and build on existing circumstances
- People with challenging behaviours may need psychological help to manage their behaviours; those who have become dependent on institutional care may be assisted to move to independent living; those in independent living may learn more skills to maximise their opportunities with the likely outcome of needing less care and support
- Older people should be encouraged to take exercise, manage their diet, moderate their intake of alcohol and look after their well-being
- The emergence of assistive technology, the role of mind as well as physical exercise, the importance of diet and the support to carers can all help sustain older people within their own homes for a longer period than in the past
- Care plans should look at the help being offered to the person which will help them gain, regain or retain their levels of independence; the annual review should focus on whether the help being offered has assisted the person with those key objectives. Any new care plan agreed should focus on these as the key outcomes that should be expected from the provider of care

We will manage performance via the following measures:

a)	The proportion of older people receiving longer-term care whose care needs have decreased from their initial assessment / latest review *This figure should preferably be around 15% of the older people supported*
b)	The proportion of younger adults receiving longer-term care whose care needs have decreased from their last review *This figure should preferably be around 66% of all younger adults receiving care and support*
c)	The proportion of older people receiving longer-term care whose needs have increased since their initial assessment / latest review *This figures should preferably be no more than 25% of the total receiving care*
d)	The proportion of older people (without a diagnosis of dementia) who enter residential care after receiving domiciliary care *This figure should preferably be at a maximum of 20% of those receiving care*

e)	The proportion of older people with a requirement for palliative care who died at home *This figure should preferably be at least 75% of those who stated that they wanted to die at home*
f)	The proportion of younger adults receiving longer-term services who are living in registered residential care *This figure should preferably be less than 10% of those who need care and support*
g)	Total spent by a council on all adult residential care *This figure should preferably be no more than 30% of the gross adult social care budget*
h)	The proportion of older people living in extra-care housing who are receiving more than 14 hours of care *This figure should preferably be no more than 10% of those living in an extra-care facility at any one time*

5. Developing a workforce that promotes independence and community-led solutions

Objective 5 The workforce is fully trained and supported to work with people needing social care which fits with the ethos and principles of our organisation

We know that:

- The practices of frontline assessment and care management staff in determining and managing demand is often underestimated
- Staff who work closely with carers, other family members, community members, the voluntary sector and other parties to help people find solutions using local assets rather than formal care can make a significant impact on who gets care, how care is delivered, and the size and nature of care packages
- It is of critical importance to have the right workforce to assist in delivering the vision of this strategy, and to maintain good levels of recruitment and retention
- Sufficient attention should be paid to the training and development of staff, and have opportunities for career development
- Staff should be both empowered and supported to work more efficiently
- Staff need to be trained and rewarded for the outcomes they deliver, and should receive good quality, regular and reflective supervision and support
- Staff need to understand the options in the community and to where people can be sign-posted and be able to see the outcomes of their work
- Staff in hospitals and those working in communities in assessment and care management need to be able to assess for the most appropriate intervention that will assist a person to maximise their opportunities for independence post-discharge

- Staff working in post-hospital discharge services need to have the skills to assist people in achieving the things that matter to them
- Staff working in domiciliary care re-ablement services need to understand the ways in which they can help a person regain confidence and skills for daily living, and enable their personal goals and aspirations to be achieved
- Staff working in the community need to understand the various conditions that people might have and the best way to assist those people, to live with their long-term conditions, reduce their need for longer-term services, and achieve their personal goals and aspirations, where appropriate
- Staff in residential and nursing care need to understand the nature of the people's needs, personal goals and aspirations, and how these can be assisted and/or achieved assisted
- All staff must understand how to manage risk in order to get the right balance between assisting people to gain independence and protecting people from harm

We will manage performance via the following measures:

a)	End of month detailed establishment grid reporting (by team and roles): i. Vacancies (FTE) ii. SCC (FTE) iii. Locum (FTE) iv. Starters v. Leavers vi. Vacancy rate
b)	Starters and leavers by role and movers summary: • Starters and leavers in/out of SCC • Movers within ASC teams • Movers into/out of ASC teams
c)	Annual turnover rates (12 months to date): • 12 months of annual turnover rates plotted to identify trend line over time • turnover rates by role and team
d)	Capacity: long-term sickness / maternity leave by team: • FTE employees on maternity or LTS as at last day of month
e)	Working days lost per employee (culmulative for financial year to date for each service line by role) • Current year WDL • Comparator for previous year
f)	Development schemes and Learning & Development: • Average caseload per employee, per role • ASYE data (newly qualified SWs); SFYP (OTs) • Appraisal data by role • Number of qualifications held/completed/being worked towards (The Learning Centre) • Face-to-face course data held on The Learning Centre (no of attendees by area) • E-learning data held on The Learning Centre (no of attendees by area)
g)	Supervision rates
h)	Age profile (by team, by role)
i)	Years' service within cOUNCIL
j)	Annual Health Check survey data, staff surveys and workforce-related audit findings

6. Governance and management arrangements to sustain improvements

Objective 6 Performance data (activity, outcomes, finance) is collated and analysed, and supports an understanding of whether there has been an impact on the delivery of desired outcomes and the management of demand

We know that:

- The vision and direction for adults social care in Somerset must be clear, and have the support of elected members, senior leaders in the local authority, partners (including NHS partners, the voluntary sector, and the main local providers) and local citizens, including users of the services we provide
- Analysis of what is working and what areas require improvement helps determine were effort and energy is required from senior leaders
- Progress against targets should be reviewed on a regular basis, with managers held to account for the performance that is required. Governance structures – which include representation from other partner organisations - should be in place that agree/regularly review and monitor the delivery of a shared health and social care vision and strategic priorities with a focus on delivering better outcomes to manage demand
- Providers of care also need to be held to account for the outcomes they deliver for local people receiving care, with a focus on whether they are creating dependency on the services they provide or are supporting people to achieve greater independence (in part through effective contract management)
- There should be a clear alignment between strategic vision and priorities, and operational objectives, quality standards and plans
- Care pathways and processes should be analysed to understand which elements are effective / ineffective
- Good performance evaluation is a key tool in developing a cycle of continuous improvement within organisations. Qualitative and quantitative data should be collected and of a sufficient quality to inform operational and strategic planning and review
- Users and carers are actively involved in monitoring services, and peer review of services

We will manage performance via the following measures:

6a)	Managers in the authority and commissioned providers are held to account for the delivery of the desired outcomes from the care system (PIMS meetings; Peer Review)
6b)	ASC Budget v Actual

This strategy has been informed by 'Six Steps to Managing Demand in Adult Social Care – A Performance Management Approach', John Bolton and Philip Provenzano, March 2017