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OXFORD BROOKES UNIVERSITY

New Developments in Adult Social Care

Professor John Bolton

Further considerations for developing a Six Steps Approach to delivering effective outcomes and managing demand

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Forward

Following the publication of "Six Steps to Managing Demand in Adult Social Care - A performance management approach" in March 2017, Professor John Bolton and I were pleasantly surprised at the positive response we got to the many examples of effective practice and the message that the simple measurement of key performance areas is vitally important to maintain an organisations focus on doing what matters. In addition to the feedback, John, was being made aware of developments across England that built on the principles of the Six Steps approach and could add to the evidence of outcome-focused, demand management models.

So, it was to this end that during the second half of 2018, Professor Bolton visited a small number of local authorities - Coventry, Leeds, Manchester City, Somerset, Swindon and Thurrock, to explore their work and draw from them the models and approaches described in this paper along with the lessons learned from the emerging practice from other local authorities in England[1].

At the same time of his visits, the 2018 National Children's and Adults Social Care Conference there was a parallel event called "Social Care Futures", where thinkers and activists involved in adult social care (some of whom were users and carers) met to discuss the future of care. They explored a range of options that focused on a more personalised, community led way of supporting people who had care and support needs. There was a common theme that ran through the discussions – *that trying to get the models from the 1990's to work better was not the way forward!* It is fortuitous then, that Professor Bolton's on-going own exploration of how councils were meeting the dual challenges of financial austerity and an ageing population (including adults with disabilities living longer) coincides with the need to develop a clear narrative for national, regional and local organisations (including independent and voluntary sector providers) that builds and shares a real understanding of which "model" for prevention

[1]A further visit took place to hear about the impressive community development in Barnsley but their links to adult social care were not as strong as the other places so they were omitted from the case studies despite the excellent progress in Barnsley for community development.

and maximising independence is the right one for their local vision and context and for their populations.

The Institute of Public Care (IPC) are very pleased to host this paper which sits alongside several previous discussion papers to which Professor Bolton has contributed and published by IPC. These can be found on our website: https://ipc.brookes.ac.uk/publications.html. Finally, Professor Bolton and I would like to thank those councils for giving their time and their thoughts that have contributed significantly to this paper.

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Assistant Director
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January 2019

Introduction

Each local authority is unique and has developed in their own way, typically therefore, they have often found it hard to replicate best practice from one place to another. However, in putting together the illustrations in this paper, I continue to offer the examples and my advice in the same context of my previous papers – that these offer examples of what can be achieved given a specific set of local conditions and moments in time. Notwithstanding the potential uniqueness of these conditions, like many of the examples in my previous papers, there are replicable models and arrangements which I feel confident do transfer successfully across geographical boundaries.

Furthermore, in presenting this paper, I do so as a continuation of the model and principles established in our Six Steps[2] paper advocating the need for clearly articulated strategic objectives and a systematic performance focus in six areas (see table below) as being critical to the way in which demand is managed by social care. Many of the examples in the paper do align to the areas below:

1. **Managing demand through the front door of the Council** - How is the front-end of the service set up in relation to handling initial enquiries, and how many of these can be resolved by the staff who handle them?
2. **Managing demand from acute hospitals** - How is the response from the acute hospital managed and what are the outcomes for older people?
3. **Effective short-term interventions for people in the community** - How are the initial offers of help to people designed, and can they respond with short term help that may reduce or eliminate the need for longer term solutions e.g. access to re-ablement?
4. **Designing the care system for people with long term needs** - How does the way in which we assist people help them gain opportunities for greater independence in the longer term. How do we assist people to manage their long-term conditions?
5. **Developing a workforce to manage demand** - To what extent has the work force been commissioned/managed (trained) to deliver the best possible outcomes for citizens at all of these different levels?
6. **Governance and management arrangements to sustain improvements** - How are managers in the authority and commissioned providers held to account for the delivery of the desired outcomes from the care system?

Therefore, in this paper I have attempted to draw out transferable principles so that we can better understand what may need to develop and what may need to change to achieve similar outcomes to the organisations I describe here. Their attention and

[2] Six Steps to Managing Demand in Adult Social Care -A performance management approach; https://ipc.brookes.ac.uk/publications/Six_Steps_to_Managing_Demand_in_Adult_Social_Care_Full_Report.pdf

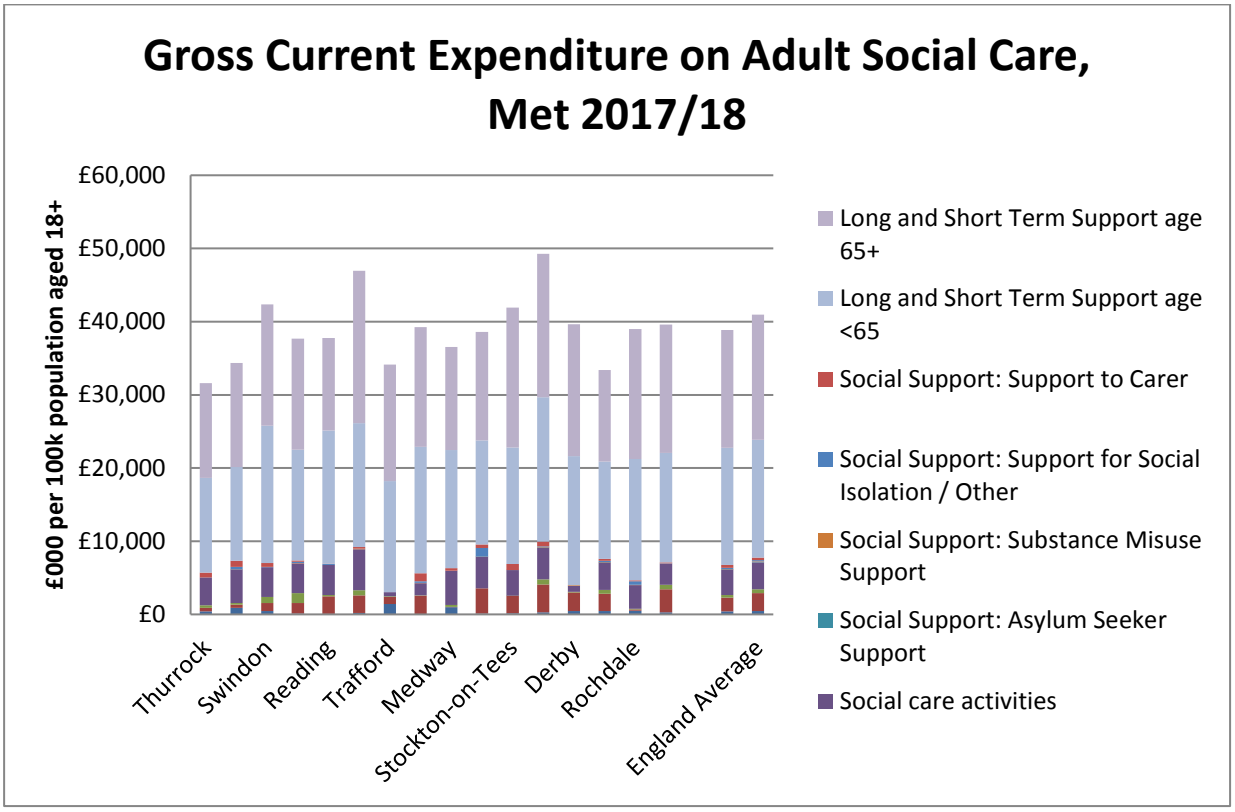
common practices I have observed in these organisations typically fall into the following categories:

Many places can demonstrate their direction of service development using at least two of the above descriptions, so I have offered examples and thoughts in each of these in the chapters below. I have also included a number of considerations/questions at the end of each section that are intended to help explore your current arrangements and potential direction of travel.

In addition to these developments, many of the authorities I spoke to describe the importance of organisational stability and continuity. There are historical reasons why services have taken a specific direction in one area rather than another, mostly related to local leadership. In Swindon and Manchester, the emphasis on outcome-based commissioning sitting alongside a strengths-based assessment model clearly has been led by the Directors. In Leeds the adult social care leadership has followed a direction over a number of years (at least a decade) and each leader has enhanced what the previous leader had already started with a strong focus on the community's contribution to the solution. Leeds has a long history of community development with close links with social care. Whilst, Thurrock has developed a personalised model for social care that builds on their commitment to Local Area Co-ordination with the same Senior Team that has been together for 12 years. Finally, Somerset and Coventry have some of these features but an absolute message of promoting independence for their customers.

Each place is impressive, but they have all achieved slightly different results. Both Coventry and Thurrock became of particular interest because their spend on adult social care is low and this has been sustained for the period of austerity (since 2010) and areas of deprivation within their boundaries. These are the places that appear to

be living within their budget and achieving positive outcomes for citizens in a sustainable way but even these two organisations have taken quite different pathways to achieve their ambitions for citizens and a balanced budget. [3]



One observation is that for progress to be identified it appears that there needs to be several years of commitment to an identified and clear approach to social care, The model in Coventry has evolved over a minimum of 5 years, whilst Thurrock described an eight year period of change. Though these councils have quite a different approach they both can demonstrate a strong value set. Both of these councils would say that they are on a journey which is still evolving. Leeds, Swindon, Somerset and Manchester are all at the start of their journey. There are however some really interesting lessons to learn from the way in which these councils have set out their store. A common approach starts with clarity about the role and purpose of adult social care and a clear direction for staff. This is at best accompanied by a freedom for staff to explore new ways of working within the context offered by senior management. Staff ownership of the approach is very important in each place – illustrated in the diagram below:

[3] This data and the table were provided courtesy of Rachel Ayling an independent consultant in adult social care

At the end of the paper there is an individual report based the council's visited highlighting their practice and the route they have taken.

Professor John Bolton
January 2019

Strengths/Asset Based Assessments

"Strength-based practice is a social work practice theory that emphasises people's self-determination and strengths. It is a philosophy and a way for viewing clients as resourceful and resilient in the face of adversity"[4].

My earlier papers[5] suggest that it is *not the assessment that is critical in getting the best for a person, but it is the way in which they are helped*. Sometimes an assessment can wrongly predict the longer-term prospects for the customer and can over state people's needs. For example, the evidence that the Newton Europe Studies[6] have shown in the over proscribing of care at the point of hospital discharge. Often an assessment sends a person along the wrong care pathway from which they never quite recover. Many assessments appear to only be undertaken in relation to the current availability of services and so are quite limiting in their outlook. Most assessments are rushed over a short period of time and the person who is being assessed is not really known or understood by the assessor. So, it was with interest that I set out to better understand whether strengths-based assessments provided part of the answer.

Many local authorities across the United Kingdom would report that they used a "strengths-based or asset-based"[7] approach to the assessments of people who come to them for help. This is a change to the traditional way in which people were assessed. The new approach means that the focus of the assessment considers all of the personal assets a person has (and their strengths) in order to contribute towards meeting their needs. This might include involving family members, neighbours and friends along with a clear understanding of what motivates the person and how helping them might be able to assist in them recapturing former benefits from life. This model has mostly developed in the UK since the Care Act 2014 (England). The guidance to the Care Act says that the assessor "should lead to an approach that looks at a person's life holistically considering their need in the context of their skills and ambitions and priorities".[8]

This approach is sometimes (but not always) linked to an approach which looks to find solutions to meeting needs from within local communities.

All the councils that I visited talked about their strengths-based assessments. Leeds and Thurrock linked their approach to the evolution of community development within their councils. Each place had a long history of both investing in and developing community capacity. The Leeds Neighbourhood Network had a range of people

[4] https://www.wikipedia
[5] Predicting and Managing Demand in Social Care – IPC https://ipc.brookes.ac.uk/publications/John%20Bolton%20Predicting%20and%20managing%20demand%20in%20social%20care%20IPC%20discussion%20paper%20April%202016.pdf
[6] Why Not Home – Why Not Today? Published by Local Government Association in 2017 https://www.local.gov.uk/sites/default/files/documents/NEW0164_DTOC_Brochure_Online_Spreads_1.0.pdf
[7] In this paper the term strength-based assessment is usually used but the terms appear to be used interchangeably.
[8] https://www.scie.org.uk/care

working alongside older people in the City as well as a community infrastructure with high investment; whilst Thurrock has a long-term commitment to Local Area Co-Ordination. Manchester's approach was strongly linked to their neighbourhood model where services were located within different localities across the City. Coventry had made an investment in community and voluntary sector organisations who had been specifically commissioned to assist people in finding their solutions from outside of formal council funded care services. Swindon whose focus was very much on outcomes, were still developing their model for assessment and care management and this was notably being developed alongside their prime domiciliary care provider. Somerset could build on their historic investment in village agents and their specific work to develop community enterprises across the county which was rooted in their communities.

The approach taken by councils can often find its roots in the emerging versions of how a conversation might be conducted based on the work of Sam Newman and the Three Conversation model[9].

Conversation 1: Initial contact

"How can I connect you to things that will help you get on with your life – based on your assets, strengths and those of your family and neighbourhood? What do you want to do? What can I connect you to?"

Conversation 2: When people are at risk

"What needs to change to make you safe and regain control? How can I help make that happen? What do I have at my disposal, including small amounts of money and using my knowledge of the community, to support you? How can I pull them together in an emergency plan and stay with you to make sure it works?"

Conversation 3: when long-term support is needed

"What is a fair personal budget and what are the sources of funding? What does a good life look like? How can I help you use your resources to support your chosen life? Who do you want to be involved in support planning?"

The strengths-based assessment focuses on the first of these questions. In Swindon their approach (which like Coventry links strengths-based assessments with promoting

[9] The 'three conversations' model: turning away from long-term care ... https://www.theguardian.com/.../the-three-conversations-model-turning-away-from-lo...
1 Nov 2016 - The chief architect of the *three conversations* model is *Sam Newman*, Director of consultants Partners for Change,

independence) has the following guidance for staff when starting the process in a conversation with an older person:

"What was life like when you were younger?"
"How did you live your life then?"
"What do you want to recapture now?"

The team in Swindon are working on the premise that people are happier when they can do more for themselves.

In Leeds where they have been developing a strengths-based approach for about 18 months they have taken a number of interesting developments. First, the issue is seen as clearly a matter for improving practice on the ground. Leeds starts with the staff in their "Contact Centre" who are very positive at advising people where they might find solutions for their problems within the community and the third sector.

In Leeds, the Contact Centre staff have moved away from a structured conversation which had to follow a set of predetermined questions to staff having a "conversation" with the enquirer which looks to explore the options open to find solutions to the person's presented problem(s). The focus is on helping the person state the outcomes they desire; getting the best possible picture of their life style and routines and options for signposting to places where people might get the help they require. Where a longer conversation was required (usually for more complex and urgent situations) there were two options - first there was a Rapid Response Team who could go out and see people and spend more time with them. They can also ensure people's safety in a crisis. The alternative was to arrange for a meeting in a community resource where a local social worker would see them to explore their concerns in more detail.

For those who require a social work assessment in Leeds the practice has been developed and built from front line staff.

There is an edict from the Director which states that *staff can be as innovative as they think sensible as long as they operate within the law and within the budget and do no harm to anyone!* Staff are encouraged to share best practice and they hold weekly case discussions in a peer challenge forum. Here they look at a range of cases using a simple approach which allows no more than ten minutes discussion – five minutes to explain the assessment and five minutes to receive feedback and suggestions.

The practice in Leeds is certainly being developed from the grass roots and is already showing some benefits. One of the immediate actions that staff recommended was to throw away the previous 21 page form and to introduce a one page information form and a second page to record the conversation held between the worker and the

potential customer. Again, a sustainable model of social care is being developed (given the levels of deprivation to be addressed).

The challenge for front line workers was whether they had sufficient knowledge and awareness of what was happening within local communities for them to enable people with needs to link to the right resources? There were examples where there were great opportunities for people to be appropriately redirected to community assets. This was often the case for older people where local schemes had evolved from the community development whether it was the village agents in Somerset or the Neighbourhood Centres in Leeds. Where these links were being made there are clearly benefits for people looking for help and support.

The approach in Coventry is slightly different.

Coventry have commissioned six voluntary sector organisations (covering all customer groups) that have a specific role to help and advise people who need help but outside of the formal council offer. There is no role for social workers in this service. Even when people are referred to the council for help they are most likely to be assessed by an Occupational Therapist and offered a recovery or rehabilitative based intervention (from provider organisations commissioned for that purpose). If it is found that people require on-going longer term social care assistance it is only at that point (or when a safeguarding matter is referred to the council) that the social workers undertake their strengths-based assessments.

This approach is not a common one (I have not come across it elsewhere). However, it is eminently sensible and follows a clear evidential pathway as to what are likely to be the best ways to assist people who need help. The approach helps to sustain a low cost model for the delivery of adult care with overall very good outcomes for citizens. This approach is the most developed in relation to “promoting independence” for their citizens and that philosophy is best delivered though the Coventry approaches.

Where the community development had a strong connection with adult social care one could see that this was positively helping the councils to meet the demands they were facing from the public. In both Coventry and Thurrock, it was adult social care that led the community development which impacted direct on the links between the organisations in the community and third sector and those with care needs. In Somerset though there was a corporate commitment to work with the communities it was adult social care that had taken the lead in the developments that might impact on people with care needs. In Leeds the impressive community development for older people was also led through adult care commissioners though the rest of the developments across the community were led from a different directorate. This was also the case in Barnsley, Swindon and Manchester.

There is a challenge where the development of community assets is being undertaken outside of adult care. That is not to say that community development doesn't add tremendous value to those communities who participate. The test I have used is to explore the extent to which people who might be socially excluded were engaged though the community development particularly those with a learning disability. In many cases it was disappointing to hear that the communities had not always reached out to this group of people who could benefit enormously from social inclusion with their neighbourhoods and local communities.

One common point that all of the councils who linked their strengths-based assessments with strong links with local communities made was about the benefits for people who may not always receive formal care. The most common example were the benefits they saw from those people who experienced low levels of mental ill health, isolated elders and others with more moderate needs. There were many examples shown that demonstrated how people who became active in their own communities could reduce their own anxieties and social isolation in a very beneficial way. Many of those who were encouraged to participate in community life themselves became volunteers to help others.

So how do strengths-based assessments reduce the criticism from my earlier work about the limitations of assessments?

There is still a tendency to rush through the assessments and to make longer term decisions based on the conversations held. However, the conversations do collect more information about the person and their life. Certainly, the conversations being held at the "front door" appear to be fuller and really trying to understand how the person's needs might be met. For example, the approach adopted by Leeds for their front of house staff seemed exemplary in facilitating the right conversation at the start of the process.

There is still a tendency for an assessment to be a moment in time and for the assessor to not really know the person. A service might get to know a person better once they see and meet with them on a regular basis. This might lead to the development of a "trusted assessor" model where providers can contribute significantly to any review. I suspect that the strengths-based model might lead to a development of a "Trusted Assessor" approach for some providers particularly to undertake reviews of people's needs using a strengths-based model. Of course, for those people where their problems are met outside of the formal care system this is much harder to achieve.

It is still the outcome of the assessment that matters and the menu of options that are open to the customer and the assessor from which to choose the best possible help. If the options are still limited then the assessment will be limited too. *This emphasises the point that those undertaking the assessment must have both a knowledge of the community services that might assist someone as well as the help that someone might need from a care agency that will support them in the short term with an aim to assisting*

in gaining or regaining degrees of independence. Where the worker has limited knowledge of the local community resources (or where these resources don't exist) it is much harder to see the full benefits of the approach. It is more likely that the assessment will focus on what the customer knows about their community or put a stronger focus on the person and the family (informal carers) to find their own solutions.

My conclusions are that strengths-based assessments can in themselves offer a much more positive way of assisting someone. They allow the "assessor" to work in partnership with the person to build a holistic picture. This is best achieved in a co-productive way. This has its own merits. Whether the role of the local community can play a part in contributing to the solution is impacted by other variables most particularly as to whether local community development has taken place and where it has how has adult social care played a part in it?

A weakness in the language for some of those councils who were working well with strengths-based practice was though they all offered some forms of short term help (mostly reablement for older people) it did not emerge as an important aspect as I might have expected within their approach (see later section on promoting independence). All of the Councils were keen to explain their direction of travel in relation to both empowering citizens and promoting their independence, however they did not all have the emphasis on the short-term interventions that might best achieve this. All of them were critical of previous approaches that had inadvertently created a dependency between the citizen and the council. They believed that empowered citizens through their communities would achieve their independence. Coventry (in particular), Swindon and Somerset (for older people) did recognise the importance of those short term approaches where there is some evidence of effectiveness: the recovery models in mental ill health; the reablement and reducing frailty approaches for older people and the progression model for adults with a learning disability (all covered in the earlier papers on managing demand in adult social care[10]). It would improve the outcomes for the citizens being assisted through strengths-based assessments if these short term offers of help featured more strongly in their model.

Finally, there is a challenge to the adult social care system that I did not find that the strengths based approach particularly addressed. *That is the way in which informal (family) carers can be better heard and supported.*

Despite legislation and guidance in recent years from all governments across the United Kingdom on the importance of carers and their assessments, it is widely acknowledged that the practice around carers' assessments has not improved. There is in fact a risk that strengths-based assessments could contribute in a negative way towards carers.

[10] ibid
Predicting and Managing demand in Adult Social Care - https://ipc.brookes.ac.uk/publications/John%20Bolton%20Predicting%20and%20managing%20demand%20in%20social%20care%20IPC%20discussion%20paper%20April%202016.pdf

For some people their family carers are their greatest asset (though not always). There is a risk that this could be taken for granted in the strengths–based model ignoring the carer as a person in their own right. It is still important that a conversation takes place with the carer as to how their needs might be addressed alongside those of the person being helped. This requires both sensitivity and patience on behalf of the assessor. It requires a clear understanding of why the carer may initially be reluctant to discuss their needs when they are often advocating for the person for whom they are caring. A carer needs to be given time and empathy to allow them to express their needs in a way that addresses both the emotional stresses of being a carer as well as some of the practical challenges. Strengths-based assessments should not be used to treat the carer solely as an asset and to therefore ignore their needs.

It is important though that councils look to ensure that their approach is having the desired impact on their finances and on their communities. This is often missing as Councils say it is difficult. If the strengths-based model assists in developing a sustainable care model one might expect to find that fewer people are assessed as needing longer term care and that particular groups of people will less frequently enter the formal care system. This needs to be measured and monitored. It is accepted that to gain these results will take time.

Questions and considerations for organisations

Strengths/Asset Based Assessments

The "Front-door"

1. How effective are the staff in your Contact Centres at advising people where they might find solutions for their problems within the community and the third sector? Do they for example, focus on helping the person state the outcomes they desire; getting the best possible picture of their life style and routines and options for signposting to places where people might get the help they require?

2. What arrangements do you have in place that encourages your staff to share their experience and best practice of innovative thinking and solutions to support people to find solutions for their problems?

Assessments

3. How would you rate the quality of your written assessments? Do they include statements or information that reflects that the conversation between the assessor and person has been strengths-based, person-centred and outcome focused?

4. What is the role of your Occupational Therapist in relation to their involvement in assessments? What % of all clients do OT's participate in their assessment?

5. What if any, role do your providers have in contributing to a persons' strength-based review (i.e. as trusted assessors?)

6. Are assessments only undertaken in relation to the current availability of services in your area? Are you clear on the menu of options that are available to your staff including community, short term and longer term services?

7. Do you consider your assessments to be innovative in the use of local community resources and services or are they limiting their solutions and in their outlook?

8. Do you know what the average time to complete an assessment is within your council? How do you assure that the person who is being assessed is not really known or understood by the assessor?

9. Do you ensure that the needs of informal carers are addressed within any assessment?

Development and knowledge of community resources

10. How have you specifically linked your strengths-based approach to finding solutions to meeting need from within local communities?

11. How specifically have you linked the approach to the evolution of community development within your local area to the health and social care needs of your community?

12. How do you rate your front-line workers knowledge and awareness of what was happening within local communities and their ability to enable people with needs to link to the right resources?

13. If adult social care does not take the lead role in the development of community resources, how closely are you involved in this activity with your corporate colleagues?

14. How effectively does your council engage people who might be socially excluded though the community development, particularly those with a learning disability?

Performance Management

15. Do you know the impact of your investment in community and voluntary sector organisations, particular where support has specifically been commissioned to assist people in finding their solutions from outside of formal council funded care services?

16. What performance management arrangements do you have in place that helps you to evidence that your strengths-based approach is having the desired impact on your finances and communities?

Promoting Independence

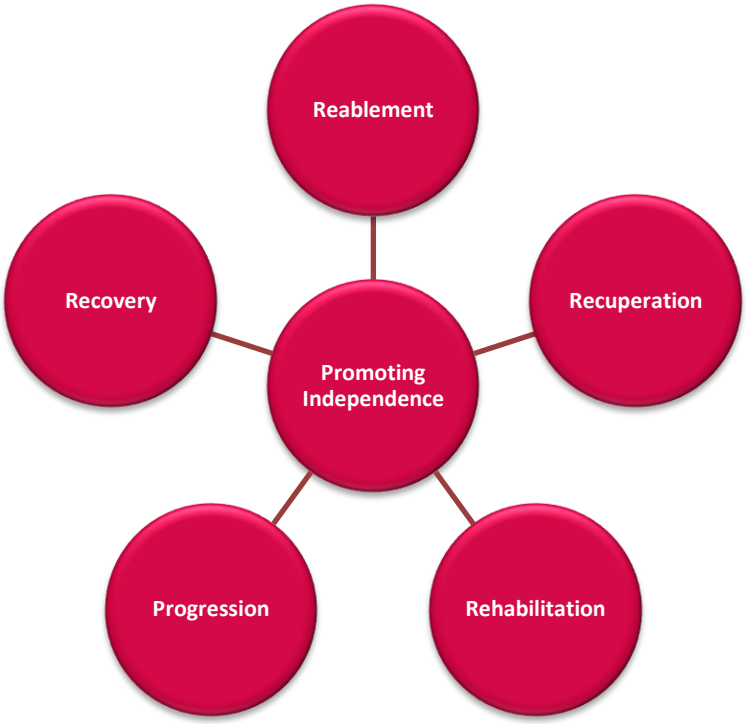
Most councils seem to recognise that the traditional approaches to social care of an assessment for eligibility - leading to a service had inadvertent risks associated with it in creating dependency from the potential customer and of creating an institutional response. Many councils use the language of "promoting independence" as an alternative to this. Councils have also tried to use the personalised approach to reduce these risks, focusing on empowering the customer thorough a personal budget.

In this study Coventry, Somerset and Swindon are all developing an approach where focusing on the opportunities for the person needing care and support to maximise their independence was the desired outcome. The features of these councils is that there is a significant importance given to the role of Occupational Therapists in the social care system, they all have providers who work with them to help promote independence, and they all look to develop their model in partnership with the NHS (which is often challenging).

Somerset were the fastest place for reducing delayed transfers of care for part of 2018 - they were proud of their progress from a very high start to a lower number of delays. However, when they looked at their performance data, they also found that too many of those who were being discharged quickly were ending up in a residential care bed. For some of these people they had not had an opportunity of recovery or recuperation post their acute episode in hospital. They changed their discharge arrangements (to introduce more intermediate care beds) experienced a small increase in delays but, a significant improvement in the outcomes for older people, with many fewer being admitted permanently to residential or nursing care.

Coventry has probably developed the most advanced model for promoting independence (described earlier in the paper). The case study (attached) highlights their approach with two really interesting aspects – the role that Occupational Therapists play within their social care approach and the role that providers play in a good partnership with the council in assisting people to regain or gain the appropriate levels of independence.

One of the keys to the promoting independence model is to ensure there is a good "menu" of short term help available for people when they need help but also for those with longer term conditions. The approach relies on a range of key interventions:



Reablement

This is the process which is usually led by Occupational Therapist (and Physiotherapists) where the short-term care that a person is offered focuses on assisting the person regain confidence and strength following an event (usually medical).

The evidence[11] supports the likely success in reducing care needs for a good proportion of older people who require this type of support. The help should focus on exercise, diet and life style as well as building personal resilience and addressing areas where a person has lost confidence. The aim is to assist people so that they can do more for themselves. For some people (particularly those who have had elective surgery) the help may be required for a relatively short period – just so they can "get back on their feet".

Though "reablement" is mostly referred to as a short-term service (usually domiciliary care) there are those who argue that *all delivery of social care should be reablement based, looking to work with the customer to consistently be re-assessing the person's ability to regain or gain new skills for independence*. In recent time the development of residential intermediate care services that can assist people in the short-term being discharged from hospital to support their recovery has added a new dimension to this approach.

[11] Maximising the potential of reablement – References https://www.scie.org.uk/publications/guides/guide49/research.asp

Recuperation

This is similar to the above help, but realises that sometimes a person just needs a bit of time to recover from a personal crisis (a loss) or a medical intervention. An example of this is where a person might require a bit of help after an episode in hospital but does not need formal care e.g. help with shopping. Again, a short term offer of help can enable a person to recover quite quickly. The key issue for both of these interventions is to help a person in such a way that they quickly start to do more for themselves. If a person stops doing things for themselves they are likely to deteriorate.

Rehabilitation

When a person has had a serious loss usually after an accident or an onset of a condition there needs to be psychological/emotional and practical help with how they are going to adjust their life to cope with their new condition. Many people can be helped but it takes time and it requires the right equipment and the right programmes of help. This might be assisting a person come to terms with limb, sight or hearing loss or other more complex conditions. How a person is helped with this can determine the degree to which they can maintain their independence.

Progression

The progression model operates for everyone with a long-term condition including a learning disability. It should start in a personalised way by considering current identified needs, challenges and experiences of the customer and then should designs a range of help that will enable the service user to live a more independent life. The person is offered a plan through which they might progress from one level of dependence to a level of greater independence. A person with lower levels of needs might be assisted in a way that they require much less formal support from the care system – undertaking work in the community; paid employment and living with a greater degree of independence. This approach very much lends itself to people who are living in the community but have become dependent on formal care.

This is not about solely closing day centres but enabling and empowering people to move into different settings. For people with more complex or challenging needs the care plan might focus on the help the person might receive to better manage their own behaviour to reduce outbursts and to reduce the risks to themselves. Each person should have a plan which focuses on the progression they might make over the coming period (usually between 6 months and a year).

Recovery

The recovery model in mental health services has demonstrated that people with a mental health problem can be assisted to self-manage their condition with support from peers. The approach starts with professionals helping a person who has mental health

issues to begin to better understands the triggers that might lead to a relapse. When a person gets to know their own signs of risk they develop a coping strategy to help them to find ways of reducing the risks from escalating. This is often done through finding a network of support of people that are willing to help the person to avert a crisis. This is usually developed through a circle of peers, through family members or through professionals. The key to the model is to help a person to become aware of their own risks and to seek to find ways of averting them.

Which "promoting independence" model?

For the promoting independence model to work there needs to be a range of services offering all of the potential interventions noted above. Of the councils visited only Coventry could offer a full range but they recognised they had more progress to make to ensure that the approach reached out to every one of their customers e.g. the need to have this approach operating consistently for residents of extra care housing.

There is a challenge to describe the best models of practice in adult social care. The traditional model suggests that a quick assessment and a readily available caring and supportive set of services are enough. The personalisation model wants the services to be controlled and designed by the customer in a co-productive way. *The promoting independence model is both challenging the customer to do more for themselves and pushing them to gain new skills.* Each approach is quite different and there is not agreement as to which direction the future of social care might take. It is clear that the promoting independence model is likely to deliver the lowest cost model but it has not seriously been developed fully in many councils.

Questions and considerations for organisations

Promoting Independence

1. Has your model for promoting independence been fully developed in partnership with NHS colleagues?

2. Hospital discharge arrangements which include the use of intermediate care beds have significantly improved outcomes for older people and reduced the number of people permanently admitted to residential or nursing care

3. The role and importance of using Occupational Therapists within a promoting independence model within the social care system is fully understood and acted upon.

4. You have a clearly defined and articulated strategy which describes how you will develop and maintain an effective working partnership and relationship with

your provider to focus on assisting people to regain or gain the appropriate levels of independence.

5. All the delivery of social care in your area is be reablement based, looking to work with the customer to consistently be re-assessing the person's ability to regain or gain new skills for independence?

Outcome-based commissioning

*Outcomes are defined as the **consequence or result** of a single action or set of actions. These are distinguished from the term input(s) which defines the action (or set of actions) which create a product or output.*

The third aspect of this piece of work is the emerging focus on "outcomes-based practice" – particularly outcomes-based commissioning in the world of adult social care.

My first observation is that the language is generally more commonly used by commissioners but their thinking about this has not always kept in line with the development in social work practice. Unless commissioners and practitioners are working to a common purpose it is unlikely that any of the changes that some may wish to see will develop successfully.

The second observation is that the language of "outcomes" and what was meant was used slightly differently in each of the authorities I spoke to. Most councils might say that they look to develop their care models to deliver the best possible outcomes for their citizens and yet what this shows in the form of performance varies between councils quite significantly. This piece of work suggests that one of the reasons for this is the very different emphasis on "outcomes" that councils have. I identified four main uses of the phrase – "outcomes for customers". These are characterised by:

1. Those outcomes that are demonstrated by the overall satisfaction of the customer.

These are mostly measures of happiness and contentment with a service received. This might be defined through the sentence: *"I am happy with the quality of my care and support and I know that the person giving me care and support will treat me with dignity and respect."* The weakness identified in this approach is often based on the assumption that some people can be grateful for the services they receive – even when the services are poor and therefore rate services better than they really might be. Despite the critique this is probably the most common approach and is widely used including by most regulators in the United Kingdom. The well cited "mum's test" used by the Care Quality Commission in England is an example of this.

2. Outcomes that are defined by the Department of Health (England) in their Adult Social Care Outcomes Framework (ASCOF)

The following phrases are used in this framework:

I am happy with the quality of my care and support and I know that the person giving me care and support will treat me with dignity and respect.

I am supported to maintain my independence for as long as possible. I understand how care and support works, and what my entitlements are.

I am in control of my care and support - I feel safe and secure.

I have as much social contact as I want with people I like.

Some of these statements would not be described as outcomes as they focus on the process and the outputs, but this is the way in which councils are currently measured by Government in England. The prime measures cover the following areas which clearly are not outcomes:

% of people receiving a personal budget
% of people delayed in hospital
% of people receiving information about services
% of people receiving community-based services
% of people living at home/residential care

These measures from the framework may be closer to outcome measures:

% of people at home 91 days after discharge from hospital
% of people who report that they feel safe
% of carers who report a good quality of life
% of those in paid employment

This is the measure that is understood by most people in corporate parts of councils in England, including many councillors. It is the most commonly shared information by adult social care on their progress or not. This is the data that is most likely to be analysed by Scrutiny Panels in Councils.

3. Outcomes are defined by the way in which users have expressed their goals and aspirations at the various stages of the help they get (or may get) and how much they indicate that they have been helped to make progress towards the stated goals.

These are often called “user defined outcomes”. These are the outcomes that might be described as being at the heart of “personalisation” – linked to the much-used phrase “nothing about me without me!” This is the definition of outcomes to which many front line practitioners refer and think that they are working towards. However, it is often hard to find these outcomes stated in the documentation by front line workers whose main currency still appears to be working in the number of hours of care a person might receive or the setting in which they should receive their care. The challenge for this approach is to find a way of measuring these outcomes to determine if they are being delivered without resorting to a very time consuming and bureaucratic administration. If every outcome agreed with a person receiving services was recorded and then reviewed and monitored this is difficult to capture.

4. Outcomes that are defined by the way in which a person has been helped to gain or regain their independence.

This is the model promoted by my papers and is the basis of the measures that support the approach to promoting independence. This is characterised by the sentence: "*How might I be helped in a way that assists me to fully or partly regain my independence?"* This is usually linked to the progression models of care – which use a range of different short-term interventions to assist people. These are referred to by the following words: *recovery, rehabilitation, recuperation and reablement.*

Each different approach depends on the customer and their current predicaments, but it is expected that a person will make some progress (from the state in which they are originally "assessed") with the probability that over time they will need less formal care and support. The approach may be seen as the opposite of some of those above as it may include a degree of challenge by a professional to a person in order that the person is enabled to do more for themselves. There is also evidence that the approach may be counter intuitive for many care workers because it is not always about caring for people but helping people in a way that leads to them doing more for themselves.

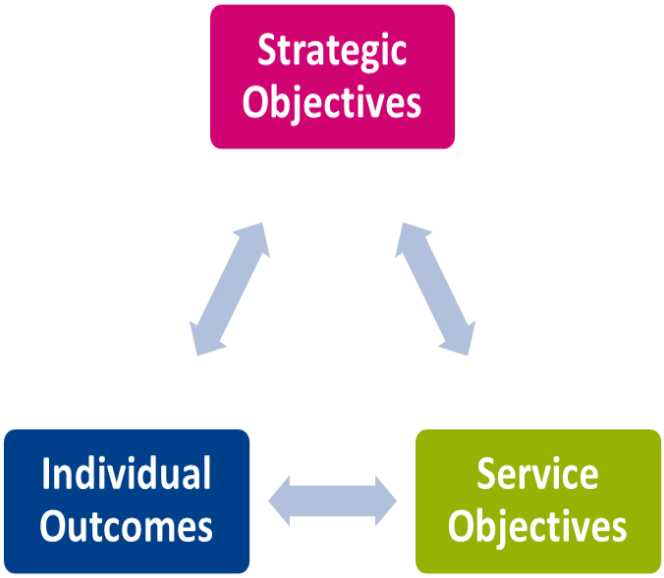
Why do the definitions of outcomes matter?

It is noticeable that the different emphasis on "outcomes" leads to very different practice results. For example, a residential care home for adults with learning disability may be well run, offer good day to day care, be clear on the risks regarding safeguarding of their residents, have highly satisfied residents' and as a consequence receive a high rating from the Care Quality Commission. But it may be the wrong service for these individuals. The service may not assist the people living there to gain greater skills towards independence and the residents may remain there happy for the rest of their lives but never challenged to achieve more.

This is a common scenario for social care. There are those who consider the happiness and good "quality" care to be sufficient. There are others who suggest this is the absolute opposite of "quality" in the sense that it may be institutionalizing the residents and holding them back (inadvertently) from making progress. The world of social care is divided as to which is really best practice! This in turn is then a challenge for commissioners.

If a council is describing their actions as "a move to outcome-based commissioning" it is important that the commissioners are clear as to the outcomes they might expect. It is important that commissioners are clear from the outset which type of outcome they are expecting from the services they commission. The diagram below attempts to clarify

this principle – note the use of the term "objective[12]" rather than "outcome" to describe the priority and focus for the council and provider.



Strategic Objectives – what the Council wants to achieve

Service Objectives – what services need to deliver to contribute to the strategic objectives

Individual Outcomes – the impact on their well-being and independence

Failure to do this can often lead to conflicting expectations between providers and commissioners. It is also important that assessment staff understand the types of objectives and outcomes that the commissioners are seeking from their providers. All three parties need to be in tune to get this right.

An example of this principle is shown below (adapted from a current specification for providing support to adults in extra care[13])

[12] Google Dictionary Definition: "a thing aimed at or sought; a goal. "the system has achieved its objective" synonyms: aim, intention, purpose, target, goal, intent, object, end, end in view, grail, holy grail"
[13] Borough of Poole

As a service, the Provider has been asked to contribute to the following "strategic objectives"

From the service specification – Service Objectives

- *To develop or sustain Service Users capacity to live independently within the community.*
- *To reduce the number of people entering into residential/nursing home care.*
- *To reduce the number of emergency admissions to hospital.*
- *To increase the number of people able to remain in the community.*
- *To provide support to Service Users' Carers.*
- *To increase the number of people enabled to move from a Care Home setting to Extra Care Housing*

The Provider has been asked to support to individuals to…

From the service specification:

1.9 - The Service to be provided in the Extra Care Housing Schemes is intended to support independence, achieved by enabling people to do things for themselves rather than doing things for them. In delivering the Service every opportunity should be taken, through enabling to maximise the Service Users capacity to carry out tasks themselves

As a service, the Provider has been asked to contribute to the following

From the service specification – Service objectives

1 - Support the ongoing care and wellbeing needs of the Service Users to reduce the likelihood of admission to long term care or hospital.

2 - Keeping healthy / improved health & well-being

3 - Introduction to and maintenance of social contact and company to enhance quality of life

4 - Ensure personal safety and security

Currently Philip Provenzano, Institute of Public Care and I are working with the commissioners, front-line practioners and home care providers on the Isle of Wight to explore the possibility of moving to a more outcome-focused set of care services. To assist this process the following statement was agreed by all parties:

"An outcome focused domiciliary care service on the Isle of Wight will build on the strengths and resilience of the person being supported whilst having a proper respect for their wishes and aspirations. The service is personalised and will enable and empower the person to take their responsibility to be "as good as they can be".

In Manchester they were looking to find improved outcomes for a population of older people across the city through a series of questions:

Do we understand the longer-term conditions that are prevalent in our different neighbourhoods?

How might a combined health and care system – including providers assist in helping people live more independent lives reducing hospital admissions and reducing demands on adult social care?

Their hypothesis was that if they could build stronger partnerships between Primary Care (GPs), Public Health (parallel to Thurrock approach), Community Services, social workers, providers of care with voluntary and community organisations they could deliver the improved outcomes identified: lower unplanned hospital admissions and lower demand for social care for elderly people.

For Swindon they wanted to make a stronger link between the help people needed to remain at home and recognising that this cannot be achieved alone by good domiciliary care.

The role of family, neighbours, telecare, equipment and communities can play alongside formal care is seen by them as an important part of a strong social care system. In order to progress with this approach they built stronger links between the domiciliary care providers and their assessment and care management teams so that together they could find the best way of helping people - some formal care and some informal care sitting side by side. The principle of all services being delivered was that they would be based on good reablement maximising older people's opportunity for independence.

The outcomes that were expected were similar to those in Manchester – lower unplanned admissions and readmissions to hospital and lower demand on social care.

Coventry has a slightly different approach. The focus is similar, but they apply their approach to all customers and potential customers of the adult social care services.

From the outset nearly everyone who needs some care and support will start with an assessment by an Occupational Therapist (not a social worker) who works alongside the potential customer to look at how they might be assisted in the short term to gain or regain skills that may enable them to live more independently. The outcome they are seeking is to have people living more independently making less longer term demands on the formal care system. A range of short term services are offered to these new people approaching the council for help. These services are mostly commissioned from local providers whose main purpose is to work alongside the Occupational Therapists to get the help they might need.

Consistently two thirds of the people who needed some form of help and support were able to improve sufficiently over a six-week period to reduce or eliminate their formal care needs.

In this small study the managers from Leeds and Thurrock had a focus on "user-defined" outcomes. Their approach and language was very much based on co-production and that workers role in assisting customers to articulate the outcomes they might expect from the help they received. However, neither of them had introduced any measures to demonstrate whether these were successful or not (mainly as I suggested above because it is very hard to do this and can become quite bureaucratic if not managed well). This does not mean that this is not a good approach it is limited in the evidence of its impact by the failure to capture success or otherwise and to help practice progress and develop.

In Swindon and Coventry, they were looking to measure outcomes that show they are assisting people in gaining greater independence. Both of these councils were working closely with their providers to ensure that they were helped in the best possible way to achieve the common outcome goals they set for sections of the population e.g. for those referred post hospital discharge there was an expectation that 66% require no further support within six weeks. In Manchester they were also looking for population outcomes with a focus not only on reducing longer term care packages but also in reducing the need for an unplanned acute hospital admission for older people from their domiciliary care contract. Somerset too is developing their approach based on the principles of promoting independence. In Swindon, Manchester and Somerset they were making great progress with this for older people but less so for other groups of service users.

IPC and I have worked on a number of projects where councils wish to move towards outcome-based commissioning for domiciliary care. We have also observed developments in some places which have not delivered the expected gains[14]. From this experience we offer our basic guiding principles for councils that wish to pursue this approach:

Only undertake the changes where there is a stable care market with reliable providers who already offer a good service. *Don't try and change the supply of care providers and move to outcome-based commissioning at the same time!*

Build the approach to outcome-based commissioning with your existing care market providers. It may take a while for them to come around to understand what the issues might be, but once they understand the approach there is generally broad agreement on its benefits.

Be clear (as outlined above) as to *what are the outcomes to which you might aspire.*

[14] See IPC paper – Messages on the Future of Domiciliary Care https://ipc.brookes.ac.uk/publications/pdf/The%20Future%20of%20Domiciliary%20Care%20%286%20April%29%20-%20Final%20version%2020180410.pdf

Ensure that the social work and assessment (and review) processes are also outcome focused and ensure they are part of the discussions to bring about the change.

It is likely to take 6 months or longer to negotiate the type of agreement that suits all partners. *This should not be rushed or imposed*.

Don't start with any complex payment mechanism. It can make the introduction so much harder.

Focus on simple measures that suit the population that is being helped (there is an example of the current measures being developed for the Isle of Wight in the text below).

These are measures of how a system is delivering better outcomes for older people – it is important all parts of the system participate in the discussions. *This is particularly pertinent to NHS colleagues*. The best outcomes for older people can't be obtained without their full support.

Don't hold providers to account entirely for the outcomes. Always allow for a discussion of all stakeholders so there can be an exploration as to why certain targets are met and others are not.

Change is only likely to be achieved when there is a high level of trust between all the parties. We have found that not to be the case in many cases. The trust is built through partnership working and discussions.

When trust is achieved, it will be possible to move to a trusted assessor model where providers can help with reviews and in particular when people are ready to end or reduce their services. This is a model that the Wirral Council report they are operating successfully.

Where providers have traditionally been excluded from discussions about the shape and type of service it may be helpful to have a neutral party to either chair or help to oversee the development of the approach.

These pointers have been developed whilst observing the move to outcome-based commission in domiciliary care, however I feel that it could be equally possible to relate them to any service. *The clarity has to start with the main purpose of the service and an agreement about what it is looking to achieve for its customers. This might be expressed in the language of outcomes.*

Overall, it is important to ensure that the simplest possible measures are developed to ensure that outcome-based commissioning doesn't lead to a complex, costly and bureaucratic model. We have observed a number of simple ways in which different councils have approached this. These are covered in earlier papers[15] [16] [17]. The following approaches were highlighted.

The model adopted in Coventry in 2013

Set clear outcome-based performance standards for each contract against which they can be measured. This sets targets for performance that a provider aspires to reach. There are no penalties for not reaching the target, but discussions take place as to why the target was not reached and what might need to change.

The model adopted by Wiltshire in 2013

(But abandoned in 2018) A clear set of outcomes for each customer against which providers could be measured and paid. Each customer had a service delivery plan for which the provider received a payment against an agreed set of personally agreed outcomes. This was probably too complex and bureaucratic to administer.

A model used by Nottinghamshire in 2013

Used for community support across the county for those with a learning disability. Here a budget was agreed with providers for the first year and then the amount subsequently reduced over the next five years as the providers helped more people to gain independence and reduce their needs for care.

Commission a lead provider to deliver services

Services to a subset of the population where the cost can be calculated based on an optimum performance where the provider will deliver improved outcomes which will mean that a percentage of people will require less or no care over a period of time. Torbay explored this approach in 2014 for their "prime provider". This was never implemented.

It is interesting to note that the approach adopted by parts of Government[18] including the Government Outcomes Laboratory at Blavatnik College, Oxford University for Social

[15] Messages on the future of Domiciliary Care Services: https://ipc.brookes.ac.uk/publications/pdf/The%20Future%20of%20Domiciliary%20Care%20%286%20April%29%20-%20Final%20version%2020180410.pdf

[16] Two discussion papers on domiciliary care commissioning and procurement August 2016 ipc@brookes.ac.uk 1 SSIA / National Commissioning Board for Wales. https://ipc.brookes.ac.uk/publications/IPC%20Two%20discussion%20papers%20on%20domiciliary%20care%20in%20Wales%20-%20August%202016_Final.pdf

[17] Emerging Practice in Outcomes-based Commissioning for Adult Social Care: IPC 2015 https://ipc.brookes.ac.uk/publications/John_Bolton_Outcome_Based_Commissioning_Paper_April_2015.pdf

[18] Introduction and guidance to developing Social Impact Bonds, information about sources of funding and available support. Published 16 November 2012 Last updated 26 September 2017 — see all updates From: Cabinet Office, Department for Digital, Culture, Media & Sport, and Office for Civil Society

Impact Bonds (SIB) has never really had traction in adult social care. The approach usually has a Social Investor who is prepared to fund a new service (or the additional costs of the service) where it is probable that by delivering the service in a different way (with a focus on outcomes) it is likely to lead to a reduced cost to the commissioner of the service.

The social investor gets a return for their investment from the savings then made. In addition, the social investor usually brings an "expertise" from the private sector on how to measure outcomes and they assist both the commissioners and the providers in how to achieve this. So, the investor helps with advice about the service, the outcomes to be achieved and the measures and how the data will be collected.

The Policy Innovation Research Unit undertook a study[19] of nine projects that had applied to use SIBs across Health and Social Care in the United Kingdom. They found little progress in moving towards agreed funding for new projects. At its simplest this was because in some of the areas it was too complex, and the benefits were not easy to identify.

For my part I think that it is perfectly possible to move to an outcomes-based approach without the necessity of new investment. Most models require changes in practice for commissioners, assessors and providers rather than new or different funding (though I am sure some funding for double running costs at the outset may be beneficial). Those local authorities that have considered SIBs have reported to me the following reasons why they have not pursued the opportunity:

First, the feeling that there is a heavy bureaucracy involved in counting the outcomes.

Second, the fact that strapped for cash local authorities can't afford to be sharing their "savings" with social investors.

Third, the social investors lack of knowledge of the outcomes possible from adult social care (unlike the clearer outcomes from the criminal justice system; homelessness and even children's social care).

Fourth, local authorities can move to outcomes-based commissioning with their providers and probably doesn't need a third party to assist with that.

The main challenge has always been how to measure the impact of the benefits from particular approaches and the fact that there are many interdependencies operating for services across health and care. The work being undertaken on the Isle of Wight which I referred earlier, shows that for a provider to improve the outcomes of older people receiving domiciliary care there needs to be better community health care support for older people, better access to equipment; better availability of therapists, as well as a

[19] https://piru.lshtm.ac.uk/projects/current-projects/social-impact-bonds-for-health-and-social-care.html#t3

better trained and funded workforce. For the Isle of Wight, the discussions have progressed to a set of measures that will *hold the system to account* for delivering improved outcomes for older people which will include measures as described below:

Measure for new Customers

% of people who receive help within 48 hours of being referred to the agency

90% of people should receive help within 48 hours.

% of people who require no further help within two weeks

33% of those discharged from hospital should require no further help within 2 weeks.

% of people who require no further help after 6 weeks

66% of the original people referred for help should require no further help after 6 weeks.

Measures for On-Going Customers

% of people entering residential care following support from domiciliary care.

No more than 5% (This figure may be higher (10%) for those diagnosed with a dementia).

% of customers who have reduced their care package

10% of customers should have had a reduced package.

% of Customers receiving support with their health care needs who reporting that their needs are being met

95% of Customers should report that their health needs are being met.

% of customers who have increased their care package in the last year

No more than 10% should have an increase in their care package each year.

% of people who have palliative care needs who experienced dignity at the time of their dying

95% of relatives should report that they person died with dignity.

% of carers who feel supported by the agency providing care for the person they have caring responsibilities for

95% of carers should report that they have felt supported through the care being given to the person for whom they have caring responsibilities.

The expectation is that a quarterly meeting will review the data and discuss whether the performance standard that has been set (which is based on best practice from a range of different authorities) has been met. If the standard has not been met – what needs to change in order to meet the target in the next quarter? The changes could be required from any of the stakeholders e.g. the district nurses may need to better support people with long term conditions and to advise home care workers; occupational therapists may need to better support front line care workers in getting people back on their feet; GPs may need to review medication; there may need to be more action from the Falls Service etc.

It is fair to say that much of the discussion on outcomes-based commissioning is still theoretical. The case studies referred to in this paper are mostly still at the planning stage – though Coventry have had an approach in place for over 4 years and Swindon have awarded a contract to a prime provider who will be using agreed measures for their service in the future.

In conclusion outcome-based commissioning offers a new way of constructing services that breaks some of the traditional rather tired approaches that are often criticized for not working e.g. the emphasis on “time and task” for domiciliary care. In both Coventry and Swindon this has also contributed to a more cost-effective model of care. But we have indicated that there is no guarantee that this will be achieved – it depends on the outcome focus that is adopted. Some may feel that just changing the focus is sufficient though it is clear that the real benefits are focusing on outcomes that a system can improve rather than sole agencies. All parties have to be committed to achieving this.

Questions and considerations for organisations

Outcome-based Commissioning

1. Be clear as to *what are the outcomes to which you might aspire.*

2. Ensure that the social work and assessment (and review) processes are also outcome focused and ensure they are part of the discussions to bring about the change.

3. *Don't start with any complex payment mechanism*. It can make the introduction so much harder.

4. Focus on simple measures that suit the population that is being helped (there is an example of the current measures being developed for the Isle of Wight in the text below).

5. *Don't hold providers to account entirely for the outcomes.* Always allow for a discussion of all stakeholders so there can be an exploration as to why certain targets are met and others are not.

6. Change is only likely to be achieved when there is a high level of trust between all the parties. We have found that not to be the case in many cases. The trust is built through partnership working and discussions.

7. Consider the move to a trusted assessor model where providers can help with reviews and in particular when people are ready to end or reduce their services.

8. Where providers have traditionally been excluded from discussions about the shape and type of service it may be helpful to have a neutral party to either chair or help to oversee the development of the approach.

Conclusion

So, it does appear that councils are working hard to find approaches to social care that offer them a more sustainable long-term solution. This is important as there does not appear to be any national government leadership or even appetite for this (at the time of writing this paper we are still awaiting a Green Paper from the Government on the sustainability of Adult Social Care).

This paper suggests that the three areas in the diagram are key practice and organisational considerations in the pursuit of delivering outcomes effectively and managing demand.

Strength-Based Assessments offer a more positive and constructive relationship with customers to share possible solutions. However important these assessments are, *the really significant way in which people's lives are transformed is through the help they receive.*

The models based on strengths-based assessments *does depend on a parallel approach in relation to community development* which focuses on the inclusion of people who may have care needs. This is particularly important if those who have learning disabilities are to gain from the approach. The evidence from Thurrock is strong that a sustainable care model can be developed on the back of Local Area Coordination. It is important though that councils look to *ensure that their approach is having the desired impact on their finances and on their communities.* This is often missing as Councils say it is difficult.

If considering which model for prevention is right for your council, it is clear that in designing a "promoting independence model" that is right for your locality is probably is

worth exploring, however you would want to ensure that the investment of such a model is likely to deliver positive outcomes and a financial return.

The focus on outcomes can be positive but, don't limit your ambitions to levels of satisfied customers – look at interventions that make a difference to people and their lives – promoting independence. Don't make the outcomes so complicated that you can't measure them. Don't dive into payment by results as it is both complicated and likely to be bureaucratic (costly) to administer. Get the right cultural focuses first working in partnership between commissioners, providers and assessors. Only explore further options when the approach is stabilised and working.

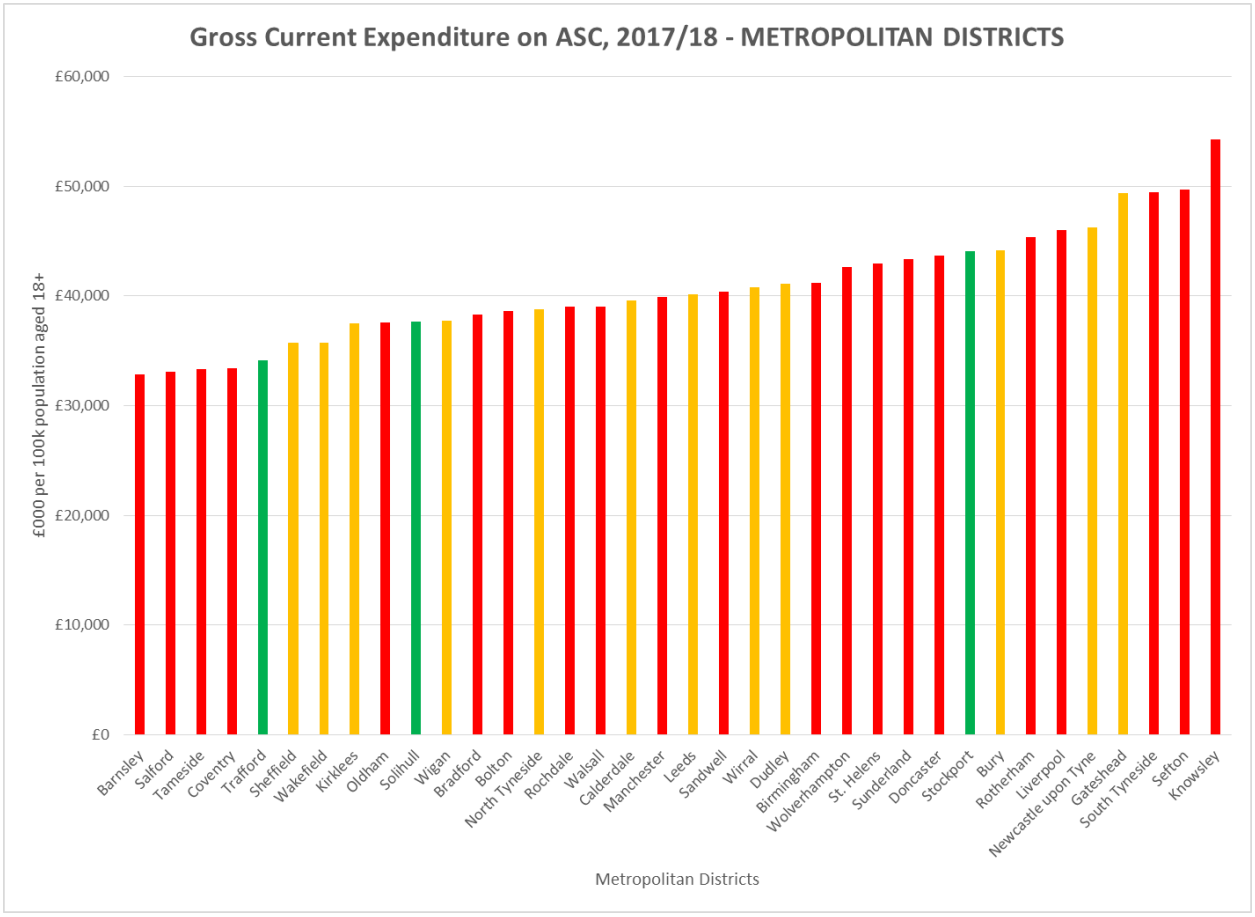
Finally, don't underestimate the importance of articulating a clear vision and purpose for the any of the suggestions described in this paper. Staff need to be empowered, motivated and supported to not only adopt new ways of working, but to embrace the values and principles of a strengths-based, outcome-focused approach which has at its heart, the promotion of promoting and maximising independence for the people with whom they work.

Professor John Bolton
January 2019

Appendices – Local Authority Case Studies

Coventry City Council Adult Care

Coventry City Council serves a population of 360,000 people one third of who are from the black and ethnic minority population. There are approximately 52,500 older people (14.6%) in the population, which is below the all England average. The spend per head on adult social care in Coventry has remained in the lowest quartile for metropolitan districts for over a decade.



Data provided by Rachel Ayling.

The premise of the whole adult care service in Coventry is to help people to gain or regain their independence. There is a simple and direct vision for adult social care in Coventry that is demonstrated by the graphic reprinted below. This is the clear direction for all staff who work in the council in relation to adult care. The strap line highlights the importance of enabling people in most need to live independent and fulfilled lives with stronger networks and personalized support is the dominant culture within the Department. One could almost call Coventry's adult care **a therapist led** approach to social care! Therapists working with front line workers to help new customers and with existing customers (including working with providers of care) to continue to assist people to live independent lives is at the heart of the way the council approaches adult

care. It is certainly fairly unique (for the United Kingdom) in the way in which the approach has been adopted.

The Council uses the language of strengths based assessments though probably in a slightly different way than some other councils. The emphasis is strongly on user agreed outcomes (with some challenge to the user) to help them to see the best prospects for them to regain or find the right level of independence. The approach goes across all work in adult social care for younger age adults and for older people where it is right for them.

The features of Coventry are that they receive comparatively low levels of referrals with evidence supporting that many people are well supported in their families, their communities and by third sector organisations. The Council has a preventative strategy which has offered 5 year funding to a group of voluntary and third sector providers to offer care and support to people in the City. 12 locally-based organisations deliver a range of different support models that enable people to maintain their independence in the community. There is constant dialogue with these providers to ensure that innovation is encouraged and supported. They help people with a range of needs including former mental health users, adults with physical and learning difficulties as well as older people (tackling social isolation).

Alongside the support available through the voluntary and community sectors the council has developed a self-assessment tool where people can identify for themselves

the resources that are available to support their needs. This system also includes the option to make a referral to speak with a social worker or an Occupational Therapist.

Many people who are referred for help are offered short term interventions appropriate to their needs and for a good percentage this is sufficient to help them regain levels of independence. This means that there are comparatively low numbers of people in receipt of longer term support, which demonstrates to their satisfaction the effectiveness of their promoting independence model. Of those who are supported longer term for most this is in their own homes. They tend to support fewer people but with higher costs for those who do require care and support from professional staff.

The essence of the model means that for those who approach the council for help (whatever their age), where it appears they are likely to have care and support needs as a result of a physical impairment or old age frailty the process will start for them with an assessment with an Occupational Therapist (OT) where together they identify the goals they might be able to achieve to gain greater independence as well as the support needs that are required at that time. The focus is very much on how the person might recover skills, confidence and regain abilities to tackle the tasks they wish to undertake. After the goals are set (irrespective of age) the person is referred to the domiciliary care providers (in the independent sector) who look to assist the person in meeting the agreed goals. During the process there are weekly meetings with either an OT or a named social worker and where appropriate either these people or an OT aide will undertake direct work to assist or support staff to meet the pre-agreed goals. The outcomes achieved are recorded for each person but also for all of these new referrals which might include older people discharged from hospital, younger adults with a learning disability, an older person with a new diagnosis of dementia, a person looking to recover from mental ill health or a person with a new diagnosis of a physical impairment. Approximately two thirds of all people who are assisted in this way do not go one to need a longer term service. They are now looking to extend the service to include all those people who are currently receiving a service but there is a request to increase the service. They believe this increase should not be agreed before an OT assessment has been completed and new goals set.

The providers of the short-term service are measured on the outcomes that they deliver for those referred to them. They have operated for almost five years within a performance framework. All three providers consistently achieve a two thirds success in assisting people in a way that they do not require longer term support. In part this figure is achieved because of the support that the council will offer particularly the opportunity for OTs or OT Aides to work with the providers and their customers to ensure that the agree goals are met. This service was built over 6 years ago through the cooperation of local care providers (all of whom had a good history of working in the city) who were willing to work with the council in partnership to deliver these excellent outcomes.

The model has been developed for younger adult most notably for adults with a learning disability developing their model from the approach demonstrated by Kent County Council (shown in the Local Government Association Efficiency Programme). They are looking to assist people in gaining the right life skills. They run a highly successful travel training programme along with other support to help people live a more independent life. The programme is also supported by OTs and an "access to work" team as well as the same care providers of the reablement domiciliary care support. In addition they have recently extended the model to assist older people with a new diagnosis of dementia where short term help is given on an intensive basis to assist older people to remain at home, using a combination of personal support and assistive technology. There is a strong partnership with the local Carers Centre and the Extra Care Charitable Trust (who also provide housing options) to support this work. This particular service operates 24 hours a day seven days a week.

Assistive technology is beginning to play a bigger part in the way that the council delivers adult care. New developments include using a mobile app device called "brain in hand" and extending the use of the just checking programme. The "brain in hand" has been particularly designed to assist people who may be anxious in particular settings. It is seen to be helpful for a whole range of social care users especially those living with autism, a mental health condition or a learning disability. It assists the person to make decisions and in so doing helps to control emotions and manage behaviour. "Just Checking" is a tool which helps to assess and monitor those with a learning disability or dementia to inform discussions on where unnecessary support may be provided.

The Adult Social Care Services in Coventry are proud of their workforce strategy. They generally have found that recruitment and retention to posts in the council has been good (with the exception of the Approved Mental Health Professionals – AMHPs which is a challenge for most councils). They use practice development forums and feedback from staff to refine and further improve their approach.

Coventry have demonstrated for a range of different needs how the approach can help people either to gain complete independence (with some managed risks) or to limit the care and support needs they actually have.

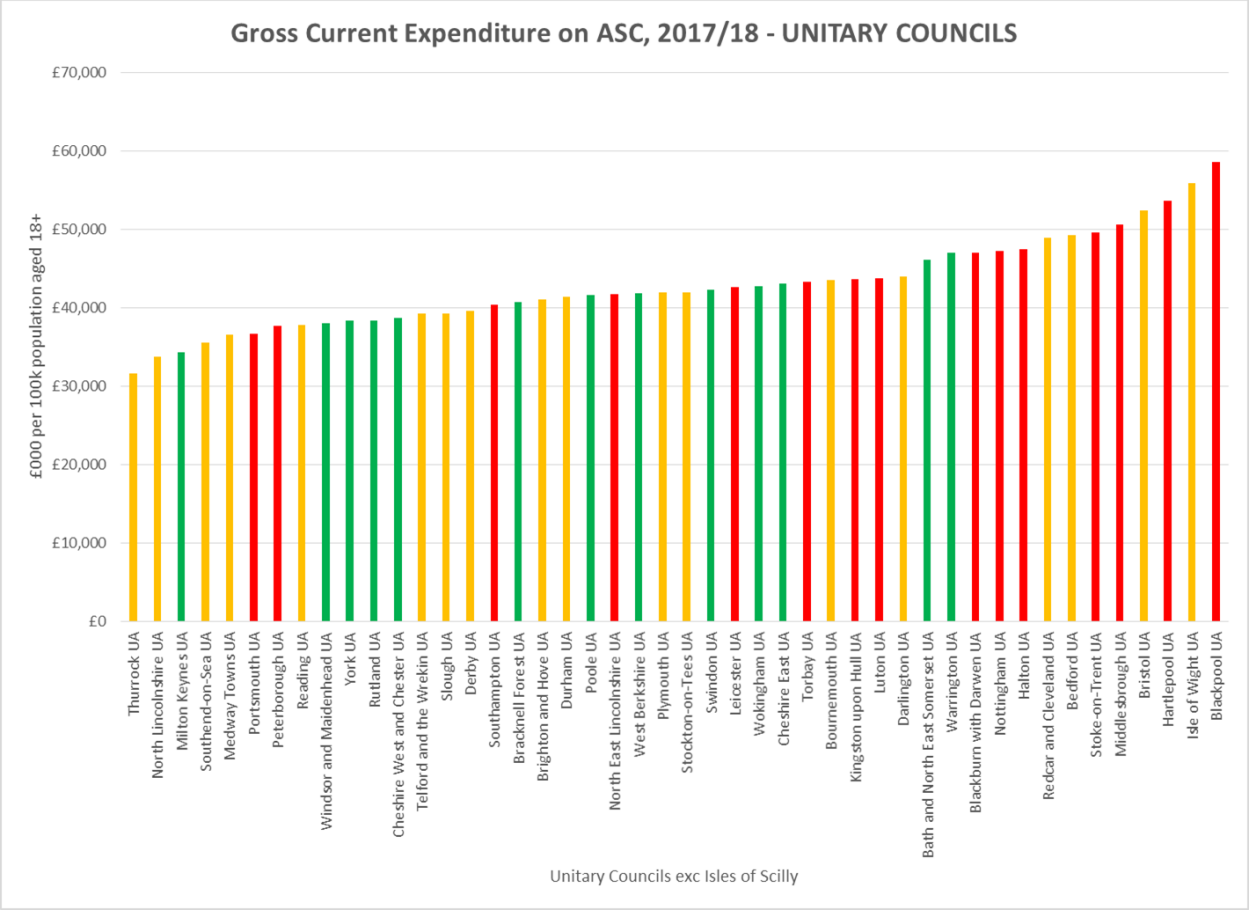
In order to continue to maximise people's opportunities to live an independent life the City Council has developed a very strong relationship across key providers in the City. There are three main providers offering between 585 and 665 hours of care and support each week to enable people to gain independence through short term support. This is the same service that supports hospital discharge. Last year 1,400 people were assisted by the service. There are just under 1000 people with care needs being supported to live at home in the City at any one time (about 1,300 people in total last year). They are supported by the delivery of 12,500 care hours per week (an average of 12.5 hours per person per week).

Coventry has by far the largest set of supported housing schemes for all ages in any part of the UK per 1000 in the population (including extra care housing for older people). There are 35 housing schemes run across the city. For older people 940 units where care and support are available are in 18 different housing schemes. The Council has nomination rights to 56% of these places. To be eligible for a council nomination in Coventry the person must need or be at high risk of needing residential care. Approximately 5,500 hours of care are delivered in these schemes. There is a current challenge as the occupancy levels have slightly fallen in recent time including those run by private providers in the city.

Coventry Adult care says that they have a sole objective for the future which is to continue to refine the approach, building stronger relationships with their providers and continuing to develop a workforce that can deliver their ambitions.

Thurrock Adult Care

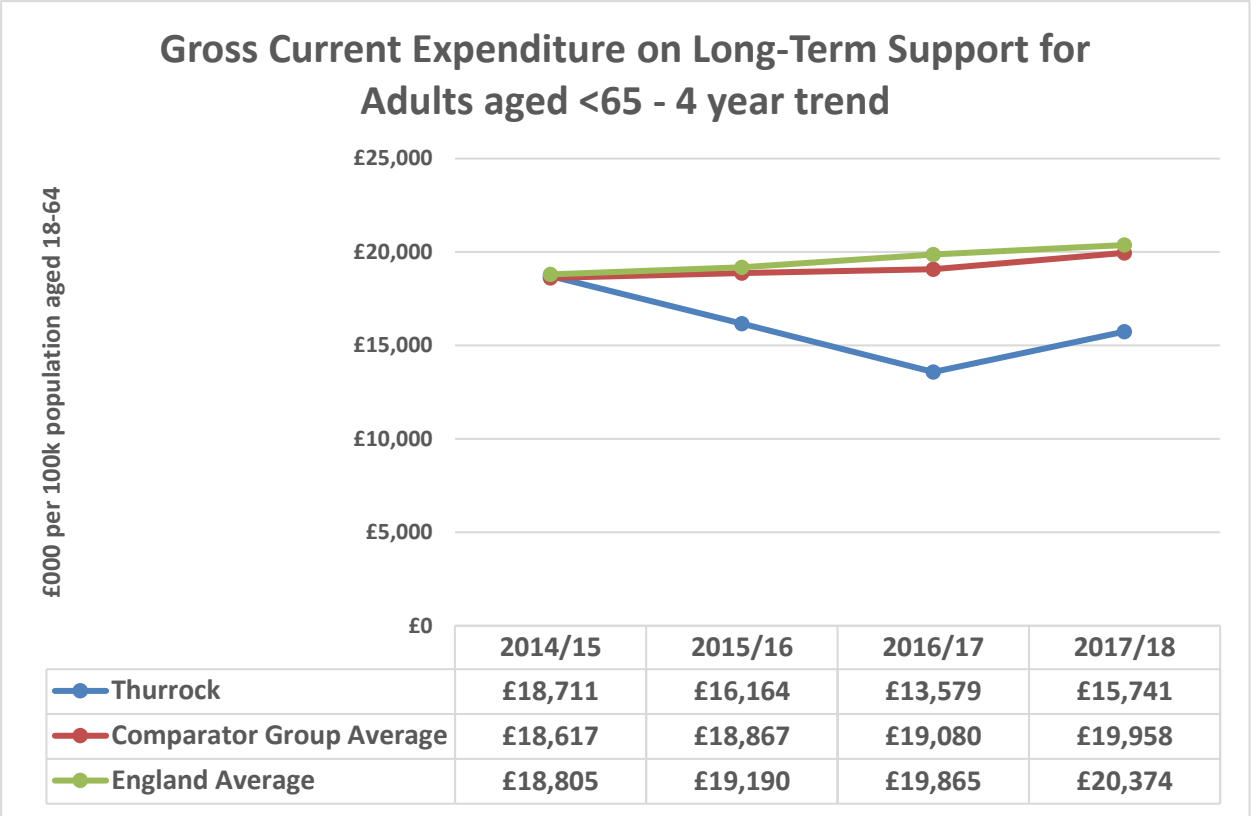
Thurrock is a small authority situated between the outskirts of London and the County of Essex. It has a population of about 170,000 of whom only 22,000 (13%) are aged 65 or older. The Adult Social Care Directorate is proud that the same management team has worked together in Thurrock for over 12 years. This has provided a consistency of approach with a desire to recognise innovation where it will improve outcomes for local residents. The Senior Team is proud that over the period they have worked together they have saved money for the council but always ensured that their budget is balanced. They are one of the lowest spending authorities on adult social care (spend per head of the population) despite serving an area with some high levels of deprivation. The graph below shows Thurrock as the lowest spend per head on adult social care amongst unitary authorities.



Data provided by Rachel Ayling

In 2010/11 Thurrock (alongside neighbours in South Essex and Southend Councils) had undertaken a "Commission of Inquiry" into the future of adult care. The recommendations of that inquiry formed the basis of the vision for adult care that is still being developed in Thurrock today. The recommendations focused on "the built

environment"; integration with NHS and Building Community Resilience. A vision for social care in Thurrock was developed from this which they called "Building Positive Futures. In relation to these developments they have made good progress in building community resilience and are now starting to make progress in both integration with the NHS and in creating a better built environment for their customers.



	2014/15	2015/16	2016/17	2017/18
Thurrock	£18,711	£16,164	£13,579	£15,741
Comparator Group Average	£18,617	£18,867	£19,080	£19,958
England Average	£18,805	£19,190	£19,865	£20,374

One of the significant features of the adult care is the long term commitment to the Local Area Co-Ordination model to help local citizens. Thurrock was one of the early pioneers in adopting the approach in the United Kingdom. The approach looks to employ front line workers who get to know and understand a set of community groups and organisation in a neighbourhood in order to help build community resilience and to enabled disadvantaged or disaffected individuals' to better use the assets that are in those communities.

For adult social care this has meant developing a team of 14 people who are the local area coordinators for their area/neighbourhood. Their role is to support people in a way that reduces the risks of them becoming dependent on the local state services by assisting them to find their solutions either wholly or in part through their local communities, whilst at the same time building the capacity that is available in the community to support local people. The work includes helping a range of people including those recovering from mental ill health, isolated older people and others who have become disengaged to assist them to rebuild local networks and for many of these people to enable them to become active citizens either as volunteers or as leaders of community activities. For Thurrock this commitment to Local Area Co-ordination has

been enhanced through a really strong partnership that has developed with the Voluntary Sector in the Borough. This programme is run under the banner headline of "Stronger Together". The Council of Voluntary Service (CVS) works alongside both the Local Authority Services and the Local Area Co-ordination to ensure that reliable data is available for citizens to inform them as to what may be happening in their area of the Borough. The CVS runs time banking schemes; volunteering programmes and supports community action to work alongside the local authority in sustaining the community work in the Borough.

Diagram 1 - <u>The principles of Local Area Co-ordination</u>

The principle	What it means in practice
Citizenship	All people in our communities have the same rights, responsibilities and opportunities to participate in and contribute to the life of the community, respecting and supporting their identity, beliefs, values and practices.
Relationships	Families, friends and personal networks are the foundations of a rich and valued life in the community.
Natural Authority	People and their families are experts in their own lives, have knowledge about themselves and their communities and are best placed to make their own decisions.
Lifelong learning	All people have a life-long capacity for learning, development and contribution.
Information	Access to accurate, timely and relevant information supports informed decision-making, choice and control.
Choice and Control	Individuals, often with support of their families and personal networks, are best placed to lead in making their own decisions and plan, choose and control supports, services and resources.
Community	Communities are further enriched by the inclusion and participation of all people and these communities are the most important way of building friendship, support and a meaningful life.
Contribution	We value and encourage the strengths, knowledge, skills and contribution that all individuals, families and communities bring.
Working together	Effective partnerships with individuals/families, communities and services are vital in strengthening the rights and opportunities for people and their families to achieve their vision for a good life, inclusion and contribution.
Complementary Nature of Services	Services should support and complement the role of individuals, families and communities in supporting people to achieve their aspirations for a good life

thurrock.gov.uk

This approach has been built into social work practice through the adoption of a "strengths-based" assessment model which also looks to have conversations with people which includes the option of finding help for them in their local communities. The social workers make introductions for people into community activities (not referrals) and there is opportunity for follow up to ensure that these introductions have worked.

In addition to the Community Development through Local Area Coordination, Thurrock has developed two locality based "well-being teams" who also work with people who approach social care to assist them in looking at aspects of their life style that will enable them to continue to live more independent lives. These teams will work alongside the new networks of health professionals which are being piloted in Thurrock.

Like many other councils Thurrock operates a single point of access – Thurrock First, a contact centre that aims to assist people with information and advice as well as to help make introductions to organisations and people who may be able to assist them (including the local area co-ordination workers).

Thurrock state that people come to them for formal care services at a later stage as they will have been helped outside of these arrangements prior to their needs becoming

high. This does mean that those receiving help from the council require more intensive help from them but this is for a lower number of people.

In the next stage the social workers are now being moved to be located with the neighbourhoods so that they can continue to build stronger links with the communities they serve. They operate with a number of key principles which include: avoid creating dependency; help people to find their own solutions; work with people to define their own outcomes and ensure people have choice where formal services are offered.

One positive bi-product from the work with communities has been the growth of an increasing number of micro-enterprises across Thurrock that are in part established to meet people's care needs either for self funders (though there aren't many of these in Thurrock) or through those people who are eligible for a personal budget. Over the last 18 months there are over 50 micro-enterprises that are helping over 300 local citizens with their care and support needs. This has both added to the choices available for those with eligible needs and also helped to ensure the care market is less fragile. This work with the community enterprises is particularly important as they look to reshape their domiciliary care market. They have experienced three provider failures over the last few years and they don't want to become over dependent on a single approach to domiciliary care. They will develop the micro-enterprises alongside an in-house care service as well as working with local providers to develop a more sustainable care market. As part of this they are clear that customers who use domiciliary care will have a choice of service provider as well as a choice of the payment mechanism used to pay that provider which will include the option for a Direct Payment; the use of an "Individual Service Fund" as well as traditionally procured services contracted by the local authority. They have found that their use of domiciliary care has significantly increased over recent years (Up from 5000 hours per week to 7000).

The work from the Local Authority with the NHS in Thurrock has involved a partnership for all the different Trusts with Public Health and Adult Social Care and the Voluntary Sector. The Director of Public Health has undertaken an analysis of the needs of the population and this has led to an integrated model of care being developed (as a pilot in Tilbury and Chadwell) bringing together GPs, other Primary Care and Community Care Services alongside Community Mental Health. The focus of the new team will be to work together to help people to better manage their longer term admissions and to seek to reduce their admissions to hospital. At this stage adult social care are not part of these new health teams but they will work closely alongside them within the community. The essence of the health model is also to assist where appropriate in ensuring that their patients are benefiting from the community resources and are using them to reduce the risks for their health and to promote their well-being.

The development of Housing in Thurrock has played a part in assisting adult social care. They have looked to support models of affordable housing as well as more specialist housing for those with care needs. The Local Plan requires good designs for housing as well as working with developers on getting the right balance of housing in

Thurrock. There are a range of specialist housing schemes that have been developed as part of this close partnership between Planners, Housing Officers and Adult Social care.

Work undertaken by Public Health in Thurrock demonstrated that adult social care were dealing with more people – but not to the extent that could have been predicted given population growth-but also that people entering the service had more complex needs and were therefore more expensive. This is a consequence of delaying service, although the preventative measures such as Local Area Co-ordination provide individual evidence of prevention. This seems somewhat contrary to the national evidence about the amount of people now not receiving a service compared to pre-austerity and therefore needs far more research but is worth consideration.

In the next phase of developments in Thurrock they will continue to meet the three challenges they set themselves in 2012. They will look to build closer links with the NHS linking their local services to the new model described above. They will continue to develop their work alongside the CVS with the voluntary and community sectors and they will look to develop new housing models for older people in the Borough which will include the development of a "21st Century Residential Care Home" which will have many of the features of Extra Care Housing but an ability to care for people with higher needs.

Thurrock senior managers state that though they retain their ambitious plans for the future they have sustained a low cost model for delivering adult care for over a decade. In discussions with senior managers we all acknowledged that because the past and future proposed changes are system wide it is difficult to evaluate, it is not self-contained re-engineering of a pathway or approach that can be more easily evaluated; they make no apology for that. However, much of what they have done and what they are about to do in the longer term is looking to change a system that has been 70 years in the making. This is why they are piloting small and then, hopefully scaling up, to do otherwise would be too risky. They strongly argue however, that a whole system re-design is the only way we can find the solution to how we provide a sustainable and successful well-being service in future; their challenge would be if not this then what?

Finally, they argue that the models they are trying to synthesise in to a whole system are not untried or without a strong evidence base of their own in terms of effectiveness and efficiency. They are building on Local Area Coordination, the Dutch model from Buurtzorg, Open Dialogue, shared lives, micro-development etc. most of these approaches have robust national and international evaluations that support them. All have great commonality in terms of core principles/predicates and seem to provide evidence that , whilst providing quality and meeting outcomes might not be cheaper, it is at least as cost effective as our current, failing, models.

Leeds Adult Care

Leeds is the second largest city in the United Kingdom with a population of just over 800,000 people of which 18% are from ethnic minority groups. The population of older people in the city is just over 150,000.

Leeds City Council has been introducing "strengths-based social work practice" over the last couple of years. It is making good progress with the pilot site showing really interesting findings already.

The DH guidance describes the approach as: "How local social workers can enable the people they work with to identify their personal assets and local systems of support and build on these to find sustainable solutions"[20]. This emerging approach to assessment has mostly developed in the UK since the Care Act 2014 (England). The guidance to the Care Act says that the assessor "should lead to an approach that looks at a person's life holistically considering their need in the context of their skills and ambitions and priorities".[21]

The introduction of this approach in Leeds has been built on several developments for adult social care. Leeds City Council engaged with the Community Led Support initiative, through commissioning the National Development Team for inclusion (NDTi) to work with them from February 2016. The NDTi supported Leeds to think differently about the way they were offering social work support and there has been a ''quiet revolution' in social work since then.

First there has been a new emphasis for the Contact Centre where staff are trained and supported to use the principles behind the model. They have moved away from a structured conversation which had to follow a set piece of questions to staff having a conversation with the enquirer which looks to explore the options open to find solutions to the person's presented problem(s). There is a single one side of A4 checklist that staff in the contact centre use to remind them of the basic approach (which replaced a six page check list that customer services staff were expected to follow). The new sheet focuses on helping the customer state the outcomes they desire; getting the best possible picture of their life style and routines and options for signposting to places where people might get the help they require.

The Contact Centre staff are supported by a team of social workers and well-being workers (Rapid Response Team) who can go out and see people and spend more time with them where the resolution of their concerns may be more complex and difficult. They can also ensure people's safety in a crisis. In particular they assist people in

[20] Strengths-based social work practice in adults – Department of Health 2017
[21] https://www.scie.org.uk/care

finding quick solutions to help contain more serious problems. Where people's concerns cannot be addressed either over the phone or with the rapid response workers (who might typically work with a new person over a couple of days) then usually an offer is made for the person to come and see a worker at one of the "Talking Point" assessment appointments which are located within community buildings around the city. Appointments for the "Talking Points" are usually made in the diary at the time of the initial call. These "Talking Points" have reduced the need for home visits and has speeded up the assessment process which in turn has significantly reduced waiting times.

Leeds Council used the Behavioural Insights Team[22], an independent consultancy who have used nudge theory to change the way in which staff work in the public sector to assist them in introducing the changes in the Contact Centre.

Leeds Adult Care managers have looked as to how to best change the culture in adult care from a traditional "deficit assessment" model to one that focuses on people's assets in a strengths-based model. With the support of the NDTi, they started with a pilot in one area of the city where those responsible for the care of elders and disabled people started to change the system to move towards the new approach. A group chaired by the Director of Adult Social Care (the DASS) and including front line staff from the team who were to pilot the approach spent time together. The Director was keen for the staff to build the new model from the ground. The Director across all service areas encouraged staff to consider innovative ways of helping people for whom she had three rules: "Don't blow the budget; don't break the law; and do no harm". They looked to find their own solutions to changing the way they worked. This included a new design for the referral and assessment forms; a new approach to peer support (where weekly meetings take place between workers and managers to discuss assessments that are being made and the practice reviewed in an open way) and the new assessment arrangements in the 13 Talking Points across the city.

The overall approach is led under the heading of "the Better Lives Strategy" which has as its strap lines: Better conversations; better living and better connections for people in the City. The data indicates that since the various aspects of the approach have been introduced there has been a significant fall in people requiring a full social work assessment. Prior to the introduction of the approach typically between 25-30% of enquiries to the authority resulted in a full assessment during the first year of the pilot this fell to 18% of new enquiries.

The data from Leeds shows that though demand for adult care is increasing through the numbers of new calls but these are now being handled in a more effective way.

[22] BIT – see www.gov.uk/organisations

Number of referrals	2016 – 36820 2017 – 48938 2018 – estimate 75000 based on 6250 referrals per month (1st Apr – 1st July)	This sets the context within which we are making changes; demand is clearly up year on year and continues to grow. Health Warning for 2018 figure which is an estimate based on average number of referrals per month to date in 2018.
Percentage total contact signposted	70% of all contact into the front door is signposted either by CSO (56%) or SW (14%)	If the figures are adjusted to remove all safeguarding referrals the signposting figures for CSO are 65% for 2017 and 2018.
Answer rate	2017 – 83.5% 2018 – 87.4%	Despite facing increasing demand the CSO answer rate is up which could be in part due to the new conversation at the front door which is more focused and saves time.
Number of Care Act assessments as a % of referrals	2016 – 20.3% 2017 – 17.6% 2018 – 15.2%	This shows a steady trend downwards in social worker assessments as a percentage of referrals.
Number Care Act assessments as a % referrals where there is no eligible need	2016 – 12.1% 2017 – 8.0% 2018 – 6.7%	When the above decrease is linked to eligibility it can be seen that it is positively associated with a decrease in social worker assessments where there is no eligible need.
Average time to be seen at a Talking Point	11 days	This factors in customer choice i.e. a customer may not want to be seen until 2 or 3 weeks when they are back from holiday etc.
% work done by Rapid Response that is classed as low level services e.g. Direct Access Provision, Non Care Plan Provision.	2016 – 23.5% 2017 – 25.4% 2018 – 27.1%	This demonstrates an increase in low level services work being carried out by the Rapid Response team.

The pilot team has established a “resource map” to build on the existing well regarded Leeds Local Directory but to look to provide more up to date information about the range of community and other activities operating within their area.

There is a strong focus in the work on the outcomes that a person is seeking as part of the help they will receive from the council. The conversation with the customer will always ask “what do you want and what are you expecting?” One strong feature of the Leeds model is not to rush to plan for a longer term service when someone is in a crisis. They have a focus on holding the person to make them safe and to give time to find possible solutions with the person. The social work team in Leeds is co-located with the community health services and so the conversation often links with the health staff so that together they can make a better assessment.

One of the very strong features for Leeds City Council is its high investment in community development and community activity. The City Council has continued to invest in a really strong set of infrastructures supporting different types of community workers some based in their Community Hubs; others based in the Neighbourhood Networks (serving older people across the city) and others based with local groups with specific needs e.g. migrant communities. This investment has allowed a whole range of community groups and activities to thrive locally. This gives a real opportunity to link people with care needs into a wide range of activities which might not be available in other places. The community development has been developed over a period of 40 years or more and has a real commitment therefore to the principles of Asset Based Community Development. This has given a really strong foundation in parts of the city.

For older people the Neighbourhood Networks operate in 37 different parts of the city potentially impacting on the lives of most elders who live in Leeds. Each Neighbourhood Network, which operate in a totally independent way (from each other or from the council), has a base from which a small teams of staff operate. They actively engage with people living in their neighbourhood looking to link people together, offer activities and build mutual support groups which are both formal and informal. Each Network has its own “Board” which might typically include older people and local ward councillors. The Neighbourhood Network which was visited as part of this case study described their work as:

- Offering people choice and control over the services they receive (in particular they highlighted a campaign to assist people maximise their benefits which for some people enabled them to pay for their own care e.g. through attendance allowance).
- Reducing social isolation for older people
- Empowering older people to take control over their lives in their neighbourhoods;
- Helping older people to improve their health and well-being.

The first neighbourhood network was established in 1985 with a growth in the current numbers to 37 over a 20 year period. The networks use staff but many unpaid

volunteers to help establish informal support for older people across the city. In recent years there has been a stronger focus on the workers providing less direct services themselves as they build strong leaders within their communities who can run and support very local networks (or services). There is a link social worker for each of the neighbourhood networks across the city. The Centre for Better Ageing is currently looking at how best the council can collect data that will give them further evidence of the impact that each of these neighbourhood networks has for older people. In the visit many anecdotes were shared which showed how the communities help people in a way that must reduce the demand on the formal care services. The strengths based social work approach is more likely to flourish in a place where there has been the history and strong infrastructure to build community resilience.

It is not just for older people that the council looks to use a strengths-based model for its social care- the ambition was to change every part of the service. For adults with a Learning Disability the approach is supported under the strap line – “Being Me”. The focus is to use the approach for all existing customers of the service and for those coming into the service through transitions. For the change to be driven across the service key partners were also introduced to the approach. This included a forum where providers met (tenfold), the carers groups (Carers Leeds) and advocacy groups (Through the Maze). There has been a focus on people living more independent lives in the community through better housing options, good transport training and building the esteem and confidence of citizens not least through the People’s Parliament.

The changes saw a reduced level of waiting times for new people coming into the service; better signposting (the numbers doubled from the previous year) and more people directly approaching “Through the Maze” to find out what might be their options. The approach has been used whatever the setting in which people live (including for those within residential care homes). However, for those in transitions there appears to be a positive trend where residential care options can be avoided and alternative provision can be made. In working with providers care managers are urging them to use community options and third sector resources to help people to meet their stated goals. There is a strong theme for people to become more independent and part of their community.

They describe the Mental Capacity Act as saying that people should be using “the least restrictive option”. This does mean that there needs to be a positive message about managing risks and indeed taking risks with people to secure their desired outcomes.

There is a similar approach to supporting people who have experience of poor mental health. As in the learning disability services there is a board that has been established to oversee the cultural changes that are expected to raise issues for workers in the service area. The board both oversees and promotes best practice but also oversees and holds responsibility for those people where actions are required to mitigate against risks. The social work team uses the “recovery model” as their basic approach and recognises that the strengths-based approach is very much a part of that approach.

Helping people to build local networks and to find support in their communities is a critical part of recovery for many people. Even those who have had long experiences in institutional care can benefit from being assisted to make stronger links and to participate in community activities.

For all people who are eligible for formal care services the council has developed a resource allocation model that converts the strengths-based assessment into a set of criteria which gives an indication of the resources that are available to meet formal needs.

There is a real opportunity in Leeds to develop their approach. Many of the right ingredients are in place. There are strong community basis across the city – particularly the neighbourhood networks for older people. The changes have in part been led by Practioners with strong encouragement from Senior Managers. The model of peer learning is a very positive approach for any council to consider when they are looking to bring transformational change into their services. If the progress continues at the current rate Leeds might expect fewer people to require full social work assessments; less reliant on formal care funded by the council and much greater inclusion for learning disabled or mental health users within the thriving communities.

Swindon Adult Care

Swindon is a relatively small unitary authority serving a population of just over 220,000 people; about 33,000 of these (15%) are over the age of 65. The older population of the borough is forecast by the council to double by 2035. Commissioners from the local authority reported that there were 15 active providers of domiciliary care from whom services were procured through public funds. These providers were delivering just over 10,000 care hours per week (including older people and younger adults with care and support needs). Swindon was spending about £14 million per annum on domiciliary care. In 2016 Swindon embarked on a new strategy to work alongside these fifteen providers in order to move towards a more outcome focussed model of domiciliary care.

Traditionally domiciliary care was procured by local authority staff (mostly from assessment and care management teams) on the basis of an agreed number of hours of care to be delivered each week to meet a person's eligible needs. This approach is often referred to as "time and task". There was a pre-determined job (or set of jobs) which were to be completed within an agreed time frame. Swindon Council Commissioners discussed with their providers if they would be prepared to test an approach which focused on the provider delivering better outcomes for their customers. (To read more see: "Messages on the future of domiciliary care" – published by Institute of Public Care 2018) [23]. As part of these discussions they also considered the option of having a single prime provider for each of the two parts of Swindon. This would mean that one provider would take most of the work in an area and be held to account for that work. The prime provider had the option of contracting out that work to the other providers in the borough. Swindon produced a tender document which included some outcome measures to be tested during the first phase.

Swindon went out to tender to find up to two organisations which were prepared to be the prime providers in the two areas of the borough. There had been much discussion with all the local providers prior to this tender process and four local providers bid for the position. One of these – First City Nursing and Care was eventually appointed as the lead Provider across the entire area. They were already in a good position. They had established a strong position in delivering good quality care for local people with a strong and relatively stable staff group. They also demonstrated a strong interest in being able to deliver a more outcome based model.

In parallel to these developments the assessment and care management staff moved towards a "strengths based" approach to social work assessments.

[23] https://ipc.brookes.ac.uk/publications/Messages-on-the-future-of-domiciliary-care-services.html

For Swindon they wanted to make a stronger link between the help people needed to remain at home and recognising that this cannot be achieved alone by good domiciliary care. The role of family, neighbours, telecare, equipment and communities can play alongside formal care is seen by them as an important part of a strong social care system. In order to progress with this approach they built stronger links between the domiciliary care providers and their assessment and care management teams so that together they could find the best way of helping people: - some formal care and some informal care sitting side by side. Swindon reported that they had learned from a visit to Leeds City Council where they saw social work practice that linked the strengths based approach to defining better and clearer outcomes for citizens. Swindon also said that their early evidence was that social workers were finding better solutions with people and were able to answer the simple questions: What was life like when you were younger? How did you live your life then? What do you want to recapture now? The team in Swindon are working on the premise that people are happier when they can do more for themselves. As part of their strengths based assessments there was also a renewed focus on using assistive technology for the assessors to help contribute to the outcomes for the people who needed help.

So the Swindon approach led to the development of three phases of work (of which they are still in Phase One):

- Continuing to work with providers on time and task but adding a dimension of a partnership for this with the customer, their family and their community (where relevant and appropriate) whilst developing and piloting an outcomes based approach.
- Move towards an outcomes based approach for customers who will be defined by a combination of the customer; the provider of care and the assessor.
- Move towards a capitalised budget where a provider will agree to meet the needs of older people in the population for an agreed budget. They will deliver a cost effective service because they will work to deliver improved lives for older people with the need for a formal service reducing for some customers as they regain independence.

As a part of Phase one the Commissioners, the Assessors (Occupational Therapists and Assessment and Care Management Staff); Age UK staff, Community Well-being Teams and the lead provider (First City) are being brought together to deliver improved outcomes for older people. A group of 70 older people who needed care and support have been considered by the combined skills of these organisations. This “pilot” approach is being locally evaluated and will help to define how the project develops and the speed at which they can move to Phase Two of the programme – defining outcomes for customers (rather than time and task) and trusting the provider to deliver on the outcome.

All pilots are testing the following;

- **Person centred planning**
- Locality based support planning, risk assessments and care and support delivery
- Salaried based staff
- A reabling approach that recognises that most people want to be as independent as possible
- Recognising that care and support staff often know the people they support better than others
- Replacing face to face care with input from family and friends/community activities, telecare and equipment
- **Outcome based support**
- **Induction and specialised training required for care and support workers**
- **Reviewing progress against outcomes daily/weekly/monthly**
- **Social and wellbeing outcomes in all support plans**

One feature of the current arrangement that might be noted is that the reablement based domiciliary care service where therapy input is required is still run by an in-house service. Their performance has recently improved (thanks to some help from external consultants – Newton (Europe). The service has been critical in reducing delayed discharges form hospital and improving independence. There is always a question to ask as to whether the lead provider should also be asked to deliver this service as part of an outcome based approach? The Council has decided that the responsiveness of the service and its ability to change and develop means the service remains in house. Given the success of the service, the local CCG invested an additional £220k in the service in 2018/19 plus an additional 3,800 hours capacity for winter 2018/19.

Swindon was also very mindful of the challenge that many places were experiencing in recruiting and retaining front line care and support workers. Part of their transformation was seeking to create posts for care and support workers that were both challenging but also rewarding both financially and emotionally for the staff. They hoped that the focus on outcomes would lead to greater job satisfaction for the workers involved.

So far Swindon has made the following progress:

- Working groups with partners to incentive and support them coming on the journey as partners
- Multi disciplinary meetings focused on individuals and joint reviews
- Workshops approach to gain common understanding – mirrored with sub contractors and partners
- Pilots have started and are capturing the journey including packages costs and hours from baseline from bridging (pre contract)

- Demand is largely being met for hospital and community – improvements in performance have been maintained (May 17 – 450 days/14 beds since February 2018 32 to 64days 1 to 2 beds. Our target is no more than 4.4 days/130 days.
- Looking at delegation of reviews to FCN in first instance and reviewing process change (testing in the pilots)
- Tolerances agreed to meet increase/reduce packages in pre and post assessment pilot

Reablement and Pre assessment domiciliary care from hospital provided by First City are working closely together. This has contributed to Swindon ensuring that delays for social care and health are now amongst the lowest in the South West (In quarter 1 2018/19 Swindon performed best in delayed transfers across health and social care)

Swindon has outlined the challenges ahead for them:

- Time and capacity to co produce – whole system change in relation to domiciliary care
- Change management with all stakeholders, including social care and sub-contractors
- A shift in the care and support workforce; a possibility of the contract being a catalyst for change
- A medium company moving to a large organisation – pace of change to adapt, particularly the leadership (transformational)
- Meeting the continuing demand as capacity is gradually released whilst changing the way the work is delivered
- Partnership approach to increase overall demand and make a difference to people's lives
- Capacity and skills in lead Provider to be a pseudo commissioner – brokerage, manage contracts etc.
- Engaging and involving sub-contractors to be part of the journey

See appendix for measures proposed for outcome based contract.

Outcomes and related performance indicators

Care Cohort	Service Outcomes
Short term recovery	■ The proportion of older people who enter residential care after receiving domiciliary care - <20% ■ Percentage of people who completed short-term reablement who were assessed as still requiring a service after 8 weeks – less than 33% ■ Percentage of people who are admitted to hospital within 2 years of receiving the service – less than 15%
Longer term recovery	■ The proportion of people receiving longer term care whose care needs have decreased – >15% ■ The proportion of older people receiving longer term care whose needs have increased – <25% ■ The proportion of older people who enter residential care after receiving domiciliary care - <20%
Helping a person to live/manage with a long term conditions	■ The proportion of people with a long-term conditions who are supported to remain at home and who do not enter residential or nursing care - >75% ■ Percentage of people whose needs are reduced within first year of receiving the service – over 20% ■ Percentage of people whose needs either remain the same or reduce over time 70% (do not increase)
Helping a person to live with/manage memory dementia	■ The proportion of older people with a diagnosis of dementia who are supported to remain at home and who do not enter residential care - >75%
Helping a person receive end of life care	■ Percentage of people who died in the place of their choice – over 75%
Supporting a carer who is helping any of the above	■ Percentage of people who have to visit GP? Less than 20%

Manchester City Adult Care and Health

Manchester City Council is part of the wider Greater Manchester City Region (population 2.8 million) that has signed a devolution agreement with Central Government to run their own devolved health and care system. The population of Manchester City is 543,000 of which just over 100,000 are over 65 (25,000 over 75). Manchester Health and Social Care Commissioning provide a single commissioning organisation for the city and is a partnership between NHS Manchester CCG and Manchester City Council. Their combined budget for community and primary care services is over £1 billion (this does not include spend on Acute Hospitals). The Borough has been divided into twelve neighbourhoods and Integrated Neighbourhood Teams of health and social care staff are in the process of being established in each neighbourhood. The Commissioning Unit will oversee the activity and the performance of these 12 neighbourhood teams in the Local Care Organisation.

As with the other councils in this study Manchester's Adult Social Care will be adapting their assessment process in order to use a strengths-based approach with a focus on improved outcomes for citizens. The theme of the care and support assessments will be "What would work best for you?" The assessors will look to draw on family members (where appropriate) and local community resources alongside the use of assistive technology and formal care services to ensure people can get the best possible help. The voluntary services and community groups are all seen as vital parts of the neighbourhoods that they served.

As part of the future commissioning of home care the Joint Commissioning Unit has undertaken two important exercises. First, it has undertaken an extensive consultation with people living in the 12 neighbourhoods with a focus on understanding the past experience and the future aspirations for people who need care and support. In the consultation exercise there was engagement with GPs, Carers, Local Voluntary and Community Sectors as well as people who had experience of using the services. This is seen as part of a ten year strategy in Greater Manchester region to ensure that conversations with the public create the services for tomorrow and bring the community together. The consultation has led to a very strong support towards a move to outcome-based commissioning.

Second, it has undertaken a comprehensive needs analysis of the population of each neighbourhood in order to understand their health characteristics drawing from data which is available from GPs, Community Care, Acute Hospitals and Social Care Records. This analysis also includes a detailed understanding as to which parts of the population are using the acute hospital for non-emergency admissions. They have been able to match the data for 1,700 people receiving homecare services through the council with 1,400 NHS records to give a picture of what happens to homecare users in the wider health and care system. They had found high levels of COPD (chronic

obstructive pulmonary disease – chronic bronchitis or emphysema) in one neighbourhood whilst in another they found higher levels of UTI (urinary tract infections). They found that the diverse health conditions that might lead to an admission are prevalent in different neighbourhoods. The hypothesis on which they are working is to ensure that both the Local Care Organisation staff and the providers of care in a particular neighbourhood know the conditions that are more prevalent in their neighbourhoods and gear up their activity and resources to target the way in which people are helped. The expectation is that this will have a significant impact in reducing unnecessary admissions to acute hospital as people will get the help and support they need (to best manage their conditions) in their own homes. This in turn might reduce their needs for longer term care. The commissioners have found that in discussions with all stakeholders about the future services having a detailed analysis of each neighbourhood's needs has really helped to gain a strong interest in the future and in planning the right services. The strong evidence that has been collected has assisted with gaining the ownership from clinicians, community members and providers.

Manchester Commissioners accept that the domiciliary care services in the past that they had commissioned were traditional, slightly risk averse and based on time and task as assessed by care managers. They had in recent times ensured that all care providers were paying the Manchester Living Wage. They started a conversation with the eight main local providers to look to change the way in which services are provided in the future. They wanted providers to deliver improved outcomes for older people which, would be demonstrated by: reducing non-elective admissions to hospital; increasing the independence of their customers; and reducing admissions to residential care. They wanted to move towards a "trusted assessor" model where the provider would work alongside the person with their local community to find the best solutions that would support them and enable them to remain in their own homes. They intend to let contracts for each of the twelve neighbourhoods. The providers who win the contracts will have to be able to demonstrate that they understand both the needs of people living in that neighbourhood and the potential resources available to assist in meeting those needs. These contracts should be let by the end of 2018. The contracts would include providing domiciliary care and support services to people in their own homes and to sheltered and extra-care housing within the neighbourhood districts. They would adopt a "prime provider" or "lead provider" model where one company would be awarded the contract for a neighbourhood and would be held to account for the work in that neighbourhood. The provider awarded "lead provider" status could sub contract (a minority of) the work to other local providers.

There was an expectation that the new approach would help to sustain the local care market for their providers. They are building a local training alliance to ensure that all staff had good opportunities for personal development. They were also considering a career pathway for paid carers which might enable them to specialise in the way in which they supported people including the creation of an ancillary care worker who could carry out simple nursing tasks in the community.

The outcome framework they are considering for the new contracts are looking at three different levels of outcome:

- The benefits as defined by the customer
- The benefits for the service
- The benefits for the wider health and care system

They will collect a basic minimum data set from providers who would ensure that this was available on a monthly basis for commissioners. There will be both a survey of customer views about the services but also a staff survey for each provider to ensure that their views were contributing to the success of the services.

The fundamental basis of the new domiciliary care contract will be that there is a recognition that if people are going to be helped in their communities and that unnecessary admissions to hospital were to be avoided then those factors that determined ill health in the community needed to be challenged and people assisted to improve. The Deputy Head of Commissioning said what might keep people out of formal health services is to tackle the wider determinants of ill health including reducing social isolation." The approach was not set up to directly save money for either the NHS or Social Care but if the programme is successful and it contributes to reducing admissions to acute care; residential care and reduces demand on formal community services then money may be saved.

As with other similar approaches from councils the out of hospital reablement based home care will continue to be provided in-house" as part of the work of the Local Care Organisation. The provider will still be held to account for the outcomes they delivered.

If a person is eligible for continuing health care funding (because they required a level of nursing care and support) then this should be aligned with the new domiciliary care contract.

Alongside the conversations with providers of domiciliary care the commissioners have also started some conversations with the regulator – the Care Quality Commission to ensure that when the outcomes-based model is adopted that the providers will not fall foul of any requirements placed on them which are based on the "traditional" approaches. These conversations are reported as being quite positive.

Manchester City Council and Health Partners recognise they may be entering "some uncharted waters" in relation to how domiciliary care is procured and commissioned. However, they know that this will be a learning experience for all which will change and progress as learning takes place. They are confident that it they retain their conversations with customers, providers, clinicians and other key stakeholders that they have every chance of success.

Somerset County Council Adult Care

Somerset County Council covers a region in the southwest with small towns and in parts a very rural population. It has a population of 550,000 people of whom over 125,000 are over the age of 65. Parts of the County have a very high density of older people living within it.

Somerset Adult Social Care has put a number of key ingredients in place as part of their transformation programme over the last three years. In 2015/16 the County was overspending on adult social care by a reported £8 million. This level of overspend continued to rise during 2016/17 as the Senior Management Team put a range of new actions in place. By the end of 2017 there were signs of the budget beginning to balance with finally a reported underspend of £1.5 million, which included delivering £4 million worth of savings. Somerset County have saved money whilst improving outcomes for customers particularly with their improved performance in reducing delays from hospital whilst improving outcomes for older people. The initial finances were unsustainable. At the time the Director of Adult Services said that the adult care services should be on “special measures” and being monitored by central government.

The transformation was based on the following important principles:

Building on a basic premise that the County would look to assist people to gain or regain as much independence as they could after critical events in their lives;

Looking to ensure that all arrangements had at the heart of their work the outcomes desired by customers or potential customers;

Building on the strengths in local communities to encourage people to help each other;

Working with the NHS to develop a Home First strategy to support hospital discharge;

Reducing admissions to residential care for older people particularly direct from hospital;

Developing the county contact centre to help more people over the phone and to seek to find solutions where that was possible – using strengths based approach;

Helping the locality social work teams to use strengths based approach supported by a philosophy of promoting independence;

Changing the staffing structure and almost ending the use of agency staff;

Putting in place a clear performance management structure to ensure that everyone understood where progress was being made and where it was not;

Having a quarterly meeting open to external scrutiny to ensure the managers were delivering on the agreed agenda;

Developing a Sourcing Care Team (brokerage) that were clear about the aims of the organisation and who understood the local market including the local community offer;

And

Using a panel to work towards consistent practice across the authority and to reduce admissions to residential care where there were better alternatives for people.

Some of these changes built on existing arrangements which had developed across the County. Somerset had always been committed to supporting local communities but the shock and terrible time that the floods brought to Somerset in 2013/14 had brought communities together in a stronger way. Adult Social care built on this community cohesion and the goodwill that it had generated. First, there was an emphasis placed on those working for the council to build strong relationships with their communities (many employees live in the County) and then key services were encouraged to use these links constructively. This was particularly so for the Contact Centre Staff who were supported to look to help people who phoned in to them to find solutions from within their local neighbourhoods prior to being passed on to the social work teams. These localities based professional teams also looked to find solutions within the community and the voluntary sector when people were passed to them (as well as having good discussions with the Contact Centre to review which people were passed to them and which may have had their problems resolved). Over the first year of the new service there was a significant reduction in people being passed on for a formal social work assessment. This has been sustained. (There was an increase from 40% to 60% of all contacts resolved by the Contact Centre Staff).

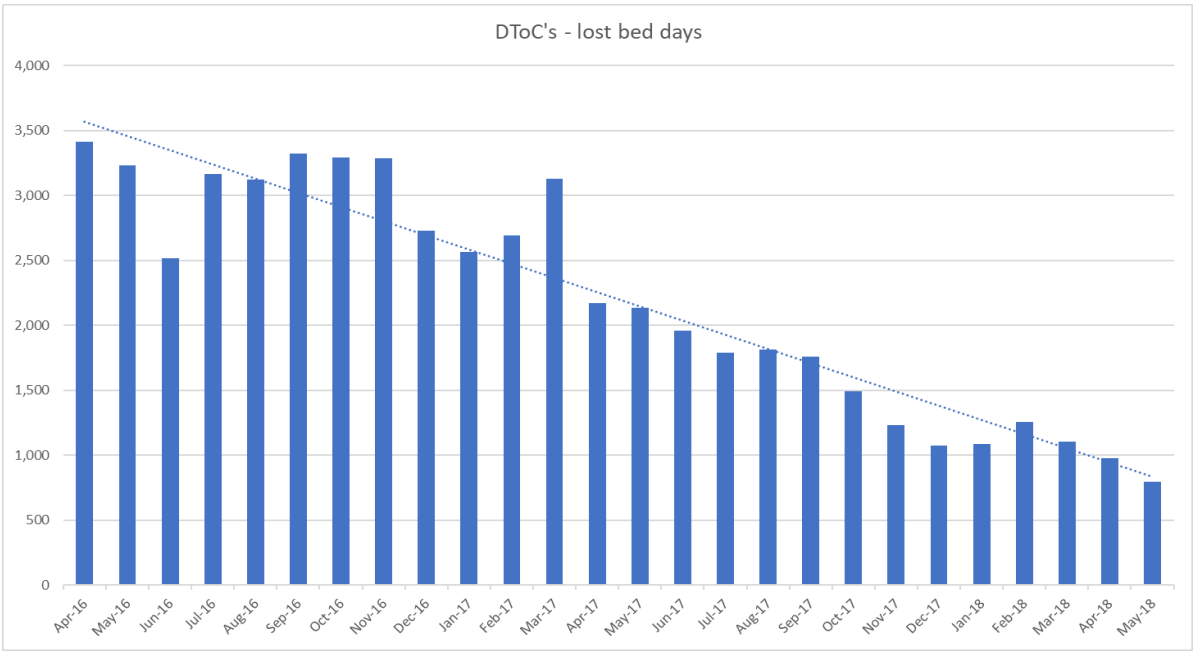
The community played its own part in recognising how it could contribute with a range of local initiatives including community café's (talking café's) and meeting points emerging across the county usually initiated by the Village Agents. People who arrived at the café's as recipients of service often became the volunteers. These meeting points were established in both towns and villages. In one town a local hotel gave over a room for the local meetings to take place. There was a very conscious effort for the council not to end up branding these places as part of their effort. Council buildings were not used for this purpose. The efforts were developed in the community for their community.

The work with the community has extended to support to the local hospital where Village Agents regularly sit in the discharge meetings to ensure people get the help they need at the point of discharge. This is an important part of the Home First strategy that the Local Authority led and put in place across the county to reduce delays from the

hospital. The work with the hospitals focused on reducing lengths of stay in hospital and reducing delays for those ready for discharge with a strong focus on improving the outcomes for older people. All partners signed up to a shared vision for what the services were looking to achieve. They developed Practice Development Forums to help those in the multi-disciplinary team discuss, challenge each other and develop a shared ownership of the discharge process. This did initially lead to some difficult conversations particularly when the judgements of senior clinicians were being challenged (something they weren't used to). Having members of the community present at times helped that conversation. Over time a shared vision and a more common practice emerged. A number of Joint Posts between the Local Authority and the Acute Trust were appointed and this also assisted the process of change. One project encouraged those who worked in the hospital to visit discharged patients in their own homes so that they could better understand how people coped in the place where they wanted to be. There was a common ownership of the discharge process and the data that accompanied it.

The diagram below (Diagram 1) shows the significant improvement in reducing delays for patients (a 75% reduction – reported by NHS Improvement as the fastest improving system in England). At the beginning this was in part achieved by more admissions to residential care but after a review from the social care workers they moved much more to a home first principle and this appeared to work very well leading to speedier discharges and fewer permanent admissions. The results were also achieved by good cooperation from local care providers. Intermediate care beds were commissioned and they helped people get back home. The care agencies responded with their own reablement based domiciliary care responding better and delivering improved outcomes for older people.

Diagram 1 - <u>Delayed Discharges in Somerset 16/18</u>



There was much work undertaken to look to improve the local care market. After an abortive attempt to bring in external provision for home care a much better working relationship developed with the local providers. For residential care an exercise was undertaken to come to a view on a fair price for care which resulted in most of the local authority 3% precept being spent on uplifting rates of care for 2018/19. The County Council has allocated its precept money entirely to support adult social care and alongside money from the Improved Better Care Fund (iBCF) and some tighter management controls this has helped to better balance the budget for the longer term.

The NHS has played an important part in contributing to the improved outcomes for older people e.g. a GP practice in Frome runs a strong preventive programme for older people promoting healthy life styles and there is evidence from this that fewer people are drawing on both NHS and social care resources.

Alongside this an organisation called Community Catalysts worked with commissioners at the council to help to develop a number of micro-enterprises building on those people in the community who were willing to help others. This enabled people with care needs to be matched with people who were willing to support them – either as a resource for people who funded their own care or for people who could pay with a Direct Payment. Currently about 75%of those who use these enterprises would have been categorised as “self-funders”. They are typically paying £18.00 an hour for care and support which is significantly less than the equivalent rate charged by the formally registered care agencies. This has raised some tension as those Care Agencies who have to be regulated to provide care are concerned about the risks that the community micro-enterprises that are unregistered might bring to the care market. However from the Council’s viewpoint this programme has delivered a range of benefits – both for local people in offering employment but also for those needing care as there was often a shortage of formal care agency support in the more rural areas. A final part of this jigsaw was the “Sourcing Team” who provides the brokerage function linking social workers and customers to local providers. They have built a good knowledge of the available resources, including community, formal agencies and voluntary sector organisations.

Finally, one of the keys to the transformational change was the strong emphasis on using the data to monitor progress against pre-set targets. Areas such as the number of assessments being undertaken by social workers that resulted in a service; the numbers being admitted to residential care; the nature and sizes of packages of care and the activity across all services has led to a monthly meeting where service managers meet with the Director and are held to account for progress in their area. A strong performance framework has been drawn up (based on the Six Steps to Performance Management model developed by the Institute of Public Care). Once a quarter an external professional chairs the performance meeting to bring some outside challenge and support for the process. The better use of data has certainly sharpened the minds of all those responsible for the transformation in Somerset.