Adult Social Care Committee

Item No……

Report title:	**Promoting Independence progress and actions for 2017/18**
Date of meeting:	**10 July 2017**
Responsible Chief Officer:	**James Bullion, Executive Director for Adult Social Services**

Strategic impact

Promoting Independence is the department's strategy for accelerating the delivery of improved outcomes for people who require adult social care as well as meeting the financial imperatives agreed by the Council for the next three years.

The activities proposed in this report will implement the key changes required to deliver the planned strategic and financial outcomes for 2017/18 and lay the foundations for further changes in subsequent years.

Executive summary

This report summarises the overall purpose and case for change for Promoting Independence, highlighting the impact to date and the key activities which need to be delivered during 2017/18.

It reports a refresh and updating of the Cost and Demand Model (CDM) which has been developed with external support. The CDM is a vital tool for assessing and assuring the impact of different interventions on reducing overall demand and cost to achieve the required £47m of recurrent savings during the period 2017-2020 whilst sustaining support and services to build resilience and independence for users.

The programme of work for change is organised under a series of workstreams, and the milestones for each of those workstreams is set out for Members. The key activities for the year are:

a) High quality information at our 'front door'
b) A new 'offer' for people with learning disabilities which is based on enablement and promotes independence
c) Embedding strengths-based social work
d) Commissioning new forms of care and support which promote independence and reduce dependency
e) Robust management of contracts

The report explains the rationale for six high level measures and describes work using the CDM to further model and refine these and a wider set of targets. It recommends that the Corporate Strategy and Delivery Unit provides expertise and assurance in developing robust targets, profiled to align with the impact of key activities and in line with budget savings required.

Recommendations:

Adult Social Care Committee is asked to:

1) **Agree the priority activities for 2017/18 in section 6 & the milestones in Appendix 1**
2) **Agree the process for developing a full robust performance framework in section 7**

1 Background

1.1 Promoting Independence is the strategy for change for Adult Social Services. It is shaped by the Care Act with its call to action across public services to prevent, reduce and delay the demand for social care.

1.2 The strategy has these main elements:

1.3 **Prevention and early help** – Empowering and enabling people to live independently for as long as possible through giving people good quality information and advice which supports their wellbeing and stops people becoming isolated and lonely. It will help people stay connected with others in their communities, tapping into help and support already around them – from friends, families, local voluntary and community groups. For our younger adults with disabilities, we want them to have access to work, housing and social activities which contribute to a good quality of life and wellbeing.

1.4 **Staying independent for longer** – For people who are most likely to develop particular needs, we will aim to intervene earlier. Our social care teams will look at what extra input could help people's quality of life and independence – this might be some smart technology, some adaptations to their homes to prevent falls, or access via telephone or on-line to specialist tailored advice. When people do need a service from us, we want those services to help people gain or re-gain skills so they can live their lives as independently as possible.

1.5 **Living with complex needs** – For some people, there will be a need for longer term support. This might mean the security of knowing help is on tap for people with conditions like dementia, and that carers can have support. We will look at how we can minimise the effect of disability so people can retain independence and control after say a stroke or period of mental illness.

2. The Case for change

2.1 Promoting Independence was first agreed as a direction of travel for Adult Social Services in 2015. The drivers for change can be summarised as:

a) The need to implement fully the Care Act with its principles of reducing, preventing and delaying the need for formal care

b) The wellbeing principle at the heart of the Care Act which requires a shift away from the culture of assessing and providing care packages, to a new approach which promotes independence and sees fewer people needing ongoing social care support

c) Data and evidence which showed that Norfolk Adult Social Services was an outlier on some key indicators of enablement and independence and also pointed to higher spending on more intensive, formal care services:

   i. Higher numbers of young adults (18-65) in permanent residential care
   ii. High numbers of older people (65+) in permanent residential or nursing care
   iii. Spending patterns which saw a higher proportion of adults' budget spent on a relatively smaller number of people

d) Demographic and demand projections which – without major change – modelled a scenario whereby local authority funding regimes failed adequately to keep pace with the increasing volumes

e) Changes in funding for councils, including reductions in RSG. For Adult Social Services, this translated into a need to save £47m over three years. Without a fundamental change, the council faced a retreat to statutory minimum which was unsustainable and at odds with what people wanted

f) Continued expectation for integration between health and social care as part of the national strategy to deliver a sustainable health and care system

2.2 Promoting Independence aims to change the adult social services 'offer' so that interventions actively promote independence and reduce reliance on statutory support.

2.3 This approach is both in line with what people want, is in line with the Care Act and is a positive response to managing demand, and avoiding a retreat to statutory minimum.

3. Key outcomes for Promoting Independence

3.1

a) An effective Council '**front door'** which helps people to find solutions for their support needs. This will include the effectiveness of information, advice and guidance, short term help and the approach to prevention

b) Effective arrangements for referrals from health which are managed consistently with the front door and that **reablement and intermediate care** work to optimum effect

c) Improved methods of meeting the needs of people requiring **low level support** including greater and better use of assistive technology and equipment which support opportunities to maximise independence

d) Strengths-based **assessment and care management** which looks at the **assets** of the person being assessed and the involvement of family and community in a person's solutions

e) An **enablement** approach which helps people with long term conditions progress towards greater independence, and supports people with long term conditions, such as dementia

f) Availability and nature of **supported housing solutions** including supported living and extra care housing

g) Effective partnerships with **carers** and carers' organisations

4 Delivering savings and managing demand

4.1 The Adult Social Services Department have planning assumptions that require the delivery of £47m of recurrent savings during the period 2017-2020. These savings were agreed, and where necessary consulted on, as part of the budget setting process in February 2017.

4.2 The savings are balanced across demand management initiatives, implementing changed practice, commissioning and redesign of services and changes to charging.

4.3 To stay on track with the delivery of savings, each locality has been issued with a clear framework which takes account of current actual service demand, average costs, anticipated additional costs from demographic growth – including transition from children's to adults – increases in provider fees, and savings expectations. Currently, as reported elsewhere on this agenda, we are keeping within this budget.

4.4 Understanding the drivers of increased demand and being able to model and predict future scenarios is central to achieving a sustainable model of adult social care for the future in Norfolk.

4.5 Adult Social Services has worked with external consultants Impower to develop a 'modelling tool' which takes activity, spend and demographic data to give insights into the spread and pattern of activity and spend across the adult system – from the front door when people telephone with an inquiry, right through the various types of service to

when someone is in full time residential or nursing care.

4.6 The “Cost and Demand Model” (CDM) works by looking at the whole Adult Social Care pathway – from the first call to our Customer Service Centre through to formal services – and calculating how changes in one part of the pathway (for example a reduction in the number of people contacting the council that go on to an assessment) are likely to change volumes and costs in subsequent pathway steps. To this it applies projected increases in eligible population and costs to forecast the cost of delivering care in Adult Social Services over the next five years. The CDM enables us to add in interventions, planned as part of the Promoting Independence workstreams, and view what their potential impact will be on this spend. Using these scenarios we can set targets for key markers on the customer journey which, if met, should result in achieving the required level of spend.

4.7 The CDM provides us with a tool to more effectively and efficiently model important questions about our approach to change. For example, it might help us to consider questions such as:

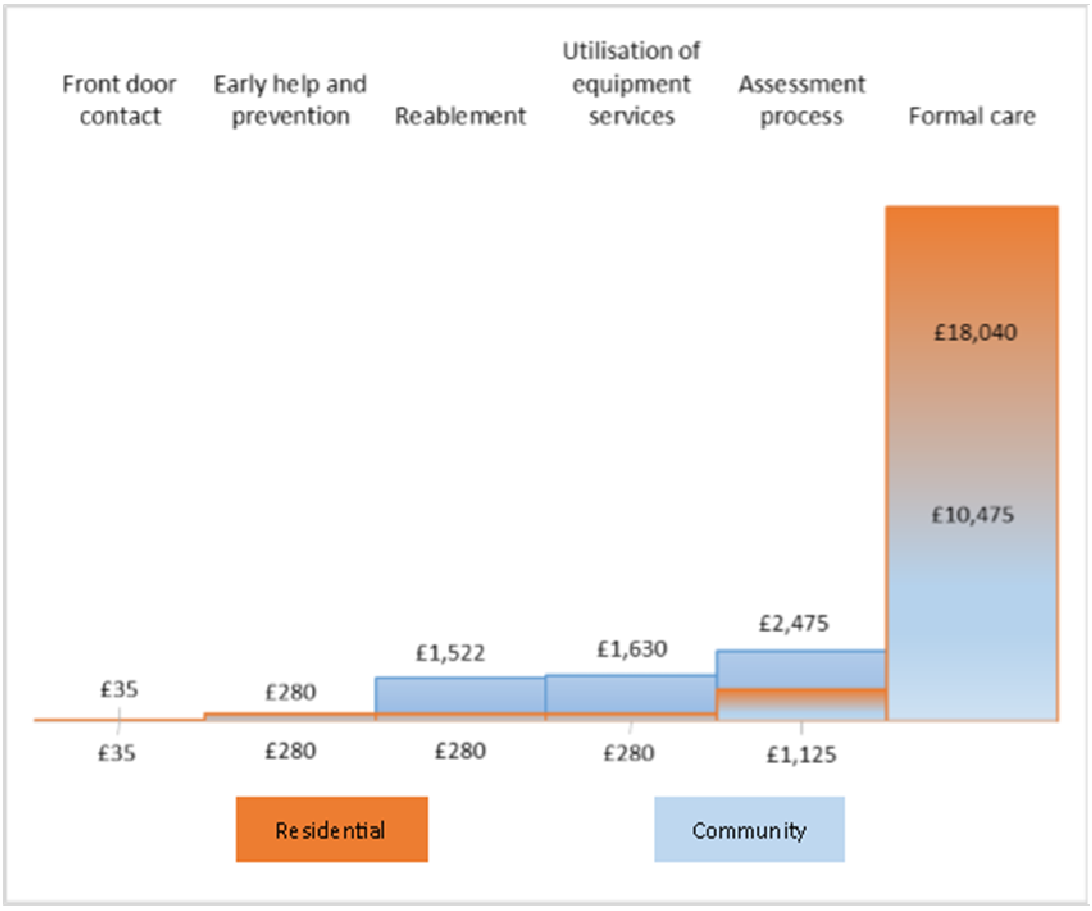
a) How quickly will improvements in Early Help reduce formal care packages?

b) What impact might a reduction in people requiring assessments have on the number of people in day support?

c) If our targets for reduced placements in residential care become unrealistic, where else can we make further reductions to make up the difference?

d) If we wanted to replicate the performance of certain high performing local authorities, what would the impact on volume and cost be?

4.8 A key component in achieving the level of savings required over the four years, is the need to change the balance of the care we purchase for people – shifting our spend away from more costly formal care towards more community-based help and support. Chart 1 below illustrates the relative costs of different elements of adult interventions, highlighting that a “left shift” in preventing, reducing or delaying demand represents cost effective usage of the Council’s resources.



4.9 In considering our critical impact points and segmentation of the care pathway, we have, therefore, grouped our programme management arrangements around four key workstreams, which are:

- Early help and prevention
- Entry points
- Younger adults
- Older adults

4.10 And two supporting workstreams of:

- Organisational development and cultural change
- Commissioning

4.11 A summary of the key deliverables and the milestones for 2017/18 for these workstreams is attached at Appendix 1.

4.12 We have aligned the savings against these workstreams as follows. The projects within the Entry Points workstream will not provide direct savings but will deliver enablers which will lead to savings in the other workstreams.

Gross Savings Requirement	2017/18	2018/19	2019/20
Reported gross savings - agreed by County Council	-14.213	-18.716	-10.000
Add: Removal of one-off grant		-4.197	
Target service savings	**-14.213**	**-22.913**	**-10.000**

Summary

Savings Programme	Workstream	2017/18	2018/19	2019/20
Promoting Independence	Early Help and Prevention	**-1.500**	**-3.500**	**-0.800**
	Entry Points	**0.000**	**0.000**	**0.000**
	Younger Adults	**-2.581**	**-6.794**	**-5.307**
	Older Adults	**-2.364**	**-2.665**	**-3.393**
	Commissioning	**-3.658**	**-9.724**	**-0.500**
Business as Usual	Other	**-4.110**	**-0.230**	**0.000**
Total		**-14.213**	**-22.913**	**-10.000**

4.13 Appendix C of the Finance Monitoring Report on the agenda for this committee meeting provides further details as to how the budget savings agreed by full council in February have been allocated to these activities.

5 Performance impact to date

5.1 Changes in operational and performance metrics evidence the impact to date of the strategy. These include:

a) Reducing the total number of recipients of long term services aged 65+. Better preventative and reablement services and improved social care practice has seen the total number of long term service users aged 65+ reduce over time from around 3,600 per 100,000 population in April 2015 to around 3,400 at the same time in 2017. Over a whole year this translates to a rate of around 5,500 long term service users per 100,000 population – a rate which means Norfolk is just below the average for its family group of similar councils

b) Reducing the number of permanent admissions to residential and nursing care for people of all ages. In particular the rate for people aged 18-64 has reduced significantly in recent years, although there is still much more to do

c) Reablement – Norfolk's rate of people that remain at home 91 days after discharge from hospital into reablement is consistently above 90% - one of the highest rates in the region

5.2 However, challenges remain, and these highlight some of the priority areas of improvement within the Promoting Independence programme. For example:

a) The rate of people aged 18-64 in Long Term Services is high in Norfolk – with Norfolk having the second highest rate in its family group, and with rates

increasing (albeit only slightly) in the last two years

b) Some recent increases in admissions to residential and nursing care for people aged 65+. Whilst the long term trend is downwards, Norfolk's rates of admission increased between September 2016 and March 2017 in response to pressures within acute hospitals and the home care market

c) Variable support for informal carers – with fluctuating levels of support over time

5.3 These trends have been covered in more detail in regular performance reports to the committee. Overall they show that specific improvement initiatives have delivered Promoting Independence objectives, but that tighter and more consistent implementation and governance is required to ensure that objectives are met consistently across all outcomes and service user groups, and to make sure arrangements are resilient to, and address together with partners, broader system-wide challenges.

6. Priority activities for change for 2017/18

6.1 Since the Committee's last update in November we have reviewed and refreshed the Promoting Independence Change programme. Attached at Appendix 1 is a summary of the workstreams, the key deliverables we want to achieve, and milestones for this year.

6.2 In summary, the priority activities we need to accelerate if we are to change outcomes for people and make our savings, are:

6.3 **High quality information at our 'front door'**

6.3.1 Analysis shows that having a good initial contact with the council – either through telephone or through our website – can mean that over 75% of people can find support and help without further involvement from adult social care. The key activities for 2017/18 are:

a) A refreshed and user-tested website that identifies emerging needs and helps people make good decisions about their and their families' futures, connecting them with other sources of formal and informal support in the community and which is fully Care Act compliant

b) A vibrant, updated Norfolk Directory of services which helps individuals and staff pinpoint activities, support and services in their area

c) All customer services staff and SCCE trained in tools and techniques and equipped with scripts which support the promotion of independence

6.4 **A new 'offer' for people with learning disabilities which is based on enablement and promotes independence.**

6.4.1 The current annual spend on services for people with a learning disability is £119m, and at any one time this is used to support around 2,600 service users. Current support draws heavily on traditional formal adult care services, and the intention is to modernise our offer to be more ambitious for service users, enhance independence and improve overall wellbeing.

6.4.2 Elsewhere on this agenda is a more detailed report about learning disability services; the main actions this year will be:

a) Commissioning new types of accommodation and support for individuals that have the promotion of independence and community engagement at their core. These will include supported living and residential accommodation and these

settings will be commissioned based on the care that they can provide, specifically that providers will work with individuals to maximise their independence and develop new living skills

b) Developing opportunities for individuals to stay with families under a shared lives scheme

c) Transforming day services so that they are focussed on supporting people to engage in their local communities, develop skills, find work and increase confidence; less about buildings that people go to and more about getting support that really meets their needs

d) Strengthening social care management to reduce the number of outstanding reviews

e) Travel training for all those who have been identified as having the capacity to increase their independence and life skills

f) Working in partnership with colleagues in Children's Services to develop a new, dedicated 14-25 Transitions Service that will ensure that children with disabilities receive a robust and integrated service as they transition into adulthood

g) Review existing services and contracts to better support people with learning disabilities into employment

6.5 **Embedding strengths-based social work**

6.5.1 Strengths-based social work relies on social care workers having conversations which support people to live as independently as possible, enabling them to overcome crises, and reducing the need for dependence on formal services.

6.5.2 This type of social work represents a shift away from the 'deficit approach' characteristic of the Care Management model introduced by the NHS and Community Care Act, 1990, towards a model that focuses on an individual's strengths and how they can be used to build resilience, well-being and independence.

6.5.3 It takes time and pays dividends in the long run – both for the person at the centre who stays in control of their life and as independent as possible, and for the council because of less reliance on more intensive costly services. The key activities for 2017/18 are:

a) Systematic roll-out of a new operating model, with input from an external partner with a strong track record of delivering changed social work practice

b) Investment to increase social work capacity in the light of detailed analysis of current workloads, practices, challenges and barriers to implementing a strengths-based approach

c) Targeted activity to address what is currently a significant backlog of reviews and assessments – both of which potentially undermine a critical strand of Promoting Independence. Evidence of sampling shows that 80% of cases reviewed recently could have had different outcomes; reviews will be prioritised and targeted where the greatest benefits can be derived for the individual and the impact on the ongoing cost of care

6.6 **A strengthened offer to help older people stay independent for longer**

6.6.1 Critical to helping people to stay independent for longer, or to recover after a stay in hospital are services which aim to recover as much confidence and independence and possible and avoid long-term decisions in a crisis. The key activities for 2017/18 are:

a) Putting in place consistent and clear support for people with dementia (a clearer 'pathway') which helps prevent breakdowns of care and avoid a crisis admission to hospital

b) Implementing a 'menu' of intermediate care options which our integrated social and health care teams can access, including accommodation-based reablement

c) Implementing new arrangements for end-of-life care

d) Recruit additional capacity in locality teams to embed strengths-based approaches and address the backlog of assessments and reviews

6.7 **Commissioning new forms of care and support which promote independence and reduce dependency**

6.7.1 Our evaluation to date (through audit) suggests that we are not yet routinely carrying through the strengths-based approaches explained above into Care and Support Planning.

6.7.2 The activities described above will in part address this, but there is also a need to develop new forms of care and support so that front line social care staff and individuals have real options that genuinely promote and support their independence. The key activities for 2017/18 are:

a) Reablement – sustain current reablement service which helps people get back on their feet after a crisis. Performance in key reablement services and short term services is good – exceeding targets and key benchmarks, with the proportion of people aged 65+ at home 91 days after discharge into reablement services continuing to be over 90%

b) Accommodation-based reablement – this builds on the existing reablement offer, but would take place in a residential setting (i.e. not the person's home.) It is aimed at people medically fit to go home from hospital, but who still need to re-gain skills to enable them to return home. It also benefits people who might be at risk of being admitted to hospital. A full business case will be developed.

c) Home care – a move away from contracting with over 100 different providers across Norfolk, to strategic partnership agreements. The business case, built up through a locality-level analysis of volumes, showing gaps, and duplication, will provide a more stable, resilient market for home care, present opportunities for providers to develop and enhance their service offer and build in expectations around improved independence outcomes for customers. Partnership agreements have been awarded in North Norfolk, Norwich and South Norfolk. Further arrangements will be completed by end of 2017/18

d) Carers - Norfolk's 94,000 informal carers (source: 2011 census) provide more support to Norfolk's vulnerable people than formal care services, and without them demand for health and social care would be significantly higher. Re-commissioning of a service for carers will be complete by September and, in partnership with support from front line social care staff, will ensure that all carers are supported *to "care confidently for my family member/friend and to keep myself informed, safe and well"*

e) Development of independent and supported living options for older people and younger adults including revising our housing with care offer. The changing aspirations and needs of people requires a range of accommodation and support offers in order that people can maintain their independence and quality of life. We will be working with districts, stakeholders, providers and people using services to refine and enhance accommodation options for older people

in Norfolk

6.8 **Robust management of contracts** The key activities for 2017/18 are:

a) Maximising the use of partnership agreements for the provision of home care; building capacity, local partnerships and expertise in the market. Our target is to provide 75% of NCC commissioned homecare through these agreements and engage providers in building local support and resilience networks and services

b) Maximising the use of block contracts for residential care, housing with care and day services. These contracts provide security of supply and support NCC in meeting its duties under the Care Act. Work in the next year will see the flexing of these arrangements to ensure the market is balanced and providing good value for money

7. Performance monitoring and measuring impact

7.1 Adult social services has a well-established framework for monitoring performance – outcomes, activity and quality, and monitoring spend against budget. Members receive regular performance and finance reports.

7.2 Each locality is working to a disaggregated budget which makes assumptions about reduced volumes of activity, and commensurate reductions in spend. Currently teams are within budget, as reported elsewhere on this agenda.

7.3 The challenge for the change programme is to develop alongside this, measures which track the impact of specific interventions, linking activity and cost.

7.4 There are six key measures identified which align with the key intervention points and where we expect and need to see changes. These are:

7.5 **Requests for support, and those requests which then translate into an assessment.**

7.5.1 We would expect to see the 'conversion' of requests to assessment to reduce, if we are effectively connecting people with good quality information and support.

7.6 **Proportion of assessment where no additional social care intervention is required**

7.6.1 We would expect this to remain steady or reduce, if we are effective in a strengths-based approach to social work, and if our 'front door' is effective. However, we would need to take account of the fact that if more cases are being resolved prior to a full Care Act assessment, then those which do go on to assessment may be more complex and harder to resolve without formal social care intervention.

7.7 **Reablement cases where the person does not require additional social care**

7.7.1 Reablement is a key intervention to maintain and restore independence and to divert further demand into formal care system. It is a measure which has a strong relationship with hospital discharges, and if the volume of reablement increases, there may need to be additional capacity to maintain impact.

7.8 **Reviews leading to a reduction or ending of services**

7.8.1 There is currently a backlog of cases awaiting review, and the service needs to increase the rate at which these are carried out. At the same time as increasing the rate of reviews completed, the strengths-based approach should result in fewer formal

packages of care.

7.9 **Permanent admissions for people aged 18-64 to residential and nursing care**

7.9.1 Significant reductions in the number of younger adults being admitted to permanent residential and nursing care has reduced since March 2015, however this was from a high base. Strength-based approaches and changing learning disability services should impact on this figure which is a measure of whether increasing numbers of younger adults are able to live independently.

7.10 **Permanent admissions for people aged 65 and over to residential and nursing care**

7.10.1 As set out elsewhere in this paper, Norfolk is no longer such an outlier against this measure, but still has a challenge to be in line with other similar councils. This is a measure which should be influenced by effective strengths-based social work, and new services, such as accommodation-based reablement. It is also a measure which will be influenced by the impact of NHS pressure to avoid delayed discharges.

7.11 **Developing the performance framework**

7.11.1 Adults will work with the Managing Director's Strategy and Delivery Unit and the Intelligence and Analytics service to develop robust metrics for the workstreams, using the delivery unit methodology and skills.

7.11.2 An initial Promoting Independence (PI) dashboard which focuses on key markers on the pathway to identify the overall cumulative effectiveness of the PI workstreams has been developed.

7.11.3 Committee will be asked to sign off Adults overall suite of performance measures at its meeting in September. This will include targets for the key PI measures above, and then these will be regularly tracked and reported.

7.12 **Programme Management**

7.12.1 The department is adopting a programme management approach to the planning, resourcing and assurance of the implementation of the Promoting Independence strategy. This approach will ensure that finite resource and investment is targeted on those prioritised initiatives and activities that can demonstrate the most impact on the agreed strategic outcomes.

7.12.2 Outline business cases have been developed for projects within the programme to set out the costs and benefits in terms of performance improvements and savings. These will be refined into full business cases where appropriate and the benefits will be aligned to the target trajectories developed using the cost and demand model.

7.12.3 Business cases will include project plans and milestones and each project will be tracked against these plans to ensure that projects deliver on time and therefore achieve the planned benefits on time. The programme of projects will also be monitored and regularly reviewed to ensure that delivery of the totality of savings and performance improvements across the programme is on track and timely and corrective actions are taken if required.

8. Financial Implications

8.1 The Promoting Independence programme has been scoped to deliver the financial targets set out in the existing medium term financial plan as described in section 4 of

this report.

8.2 The investment costs associated with delivering the Promoting Independence strategy fall within the parameters of the Annual Budget agreed by the Council.

9. Issues, risks and innovation

9.1 The risks in the adults' risk register are all pertinent to the delivery of Promoting Independence, given that it requires wholescale transformation. A full risk register for the programme of change is being developed, however, particular to the change activities outlined in this paper are the risks of not delivering at the pace required, and the challenge of embedding a major cultural change in time to meet savings requirements which are front-loaded. The pace at which outstanding reviews are able to be addressed is a further risk.

9.2 An emerging issue is the impact of developments and changes arising from new models of care being developed as part of the Sustainability and Transformation Plan. There is potential for CCG-led models for intermediate care to duplicate, overlap or even work against the PI driver to reduce the need for formal adult social care. There is also a challenge for adult social services in working with CCG-led locality solutions which may vary slightly from area to area. This can undermine a consistent whole-county approach with the benefits of scale and consistency.

10 Background Papers

10.1 Promoting Independence – next stage delivery plan report to Adult Social Care Committee November 7th 2016 page 37

Officer Contact

If you have any questions about matters contained or want to see copies of any assessments, eg equality impact assessment, please get in touch with:

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