PAPER D

Isle of Wight Clinical Commissioning Group

1. HEALTH AND WELLBEING BOARD

1.1 CARE CLOSE TO HOME: A NEW STRATEGY FOR ADULT SOCIAL CARE

1.2 This paper is for general publication.

1.3 **29 JUNE 2017**

1.4 Dr Carol Tozer, Director of Adult Social Care

2 **Summary**

2.1 This paper sets out a new strategy for Adult Social Care: Care Close to Home. The strategy aims to close three gaps between: the quality of care and support; users' and carers' outcomes and well-being; and organisational efficiency and finance. The success of Care Close to Home, therefore, will be measured by how much we successfully narrow these gaps over time. The implementation of Care Close to Home is being funded by use of £650K of the new funds (Improved Better Care Fund) awarded by Government in its spring budget.

2.2 The Strategy's three core delivery activities are: Promoting Wellbeing; Improving Wellbeing: and Protecting Wellbeing. The four enabling activities are: competent, confident, critical thinking colleagues; commissioning for value and impact; person centred care and professional practice; and integration and partnerships. Each of these activities is described in detail below. The implementation of Care Close to Home creates a major programme of root and branch reform across the whole of Adult Social Care. Care Close to Home has been positively evaluated and welcomed by staff across adult social care. The Director of Adult Social Care has also engaged with colleagues from the wider Council, Chief Executives from the voluntary and community sector and partners in health. They, too, have welcomed Care Close to Home and support its vision, priorities and different areas of work. Health partners, in particular, have satisfied themselves that care Close to home aligns with the vision, priorities and work programmes set out in My Life a Full life and the Southampton, Hampshire, Isle of Wight and Portsmouth Sustainability and transformation Plan.

2.3 Section eight of this report sets out the wider context within which adult social care currently operates. This is included because, nationally, adult social care is, to quote the Care Quality Commission's 2016 annual State of Care report "at a tipping point". More people are living longer and there are more disabled people who need care and support than ever before. But fewer and fewer

people are receiving publically funded adult social care and highly respected think tanks such as the King's Fund, as well as important organisations such as Age UK – point towards rising levels of unmet needs. We are far from immune from these pressures on the Isle of Wight and securing the 2017/18 £3.485M savings will not be easy or simple. The additional national funds made available to adult social care earlier this year are very welcome indeed – and we will use them to good effect in support of the implementation of Care Close to Home – but they are tapered over the course of three years and cannot simply be deployed in a way that will meet short term pressures by shoring up longer term problems. Nationally, there remains an urgent need to address the future funding and composition of adult social care. Care Close to Home has a more limited

2.4 Care Close to home will impact on all wards across the Island and will affect all partner agencies represented on the health and Wellbeing Board.

3. Decisions, recommendations and any options

3.1 The Board is asked:

- To endorse the vision, priorities and activities set out in Care Close to Home
- To recommend that progress reports, detailing milestones, resources and outcomes are brought to the Board in September and December 2017
- To recommend that the Health and Adult Social Care Overview and Scrutiny Programme reviews Care Close to Home as early as possible, making recommendations as to any changes to the Cabinet and Health and Wellbeing Board

4. Why do we need a new strategy for adult social care?

4.1 Adult social care supports, cares for and safeguards vulnerable adults and elders across the Island. The largest spending department of the Council (accounting for 39% of the net revenue budget), even more is spent on adult social care locally by those who self fund their own care. When adult social care is designed and delivered well, it transforms the lives of those who receive it and achieves value for money. When adult social care gets it wrong, people are condemned to live unfulfilling lives – and at the extreme, enduring repeated physical, emotional, sexual or financial abuse. So it is vital – for moral, societal, and financial reasons – that we get it right.

4.2 Our current model of adult social care is not working well enough. Too many of the people we serve are not securing the outcomes they wish for and we are not achieving best value for money. There are a variety of reasons why this is the case: our exceptionally high use of residential and nursing care; our lack of commissioning capacity and capability to ensure that services are modelled on peoples' needs and preferences; ineffective demand management strategies; and not enough success in delivering the skills, systems and processes that are needed to ensure that frontline staff and

managers systematically deliver person centred care and professional practice.

4.3 Our vision in ASC is to help people to improve or maintain their wellbeing and to live as independently as possible. We need to do this effectively within existing resources and by working in partnership with those we serve (users and carers) and other organisations in the public, private and voluntary and community sectors. Our partnership working with health is especially high profile because of the national mandate to achieve integration across health and social care by 2020. We need this action plan to have widespread ownership across ASC and beyond and recognise that there is complexity in what we are trying to achieve – as well as a multitude of actions needed in how we move from our current state to our future state. In order to try and keep things as simple as possible, therefore, we have decided to call this strategy "**Care Close to Home**" – because that is at the heart of what we need to achieve in all aspects of our work moving forwards.

5. The Seven Pillars of Care close to Home

5.1 Specifically, **Care Close to Home** has seven main pillars of activity: three core delivery areas and four cross cutting enabling programmes. This is set out diagrammatically at Appendix 1. We refer to the three core delivery areas as our "PIP":

Promote well-being - through encouraging and enabling people to look after their health and well-being and thereby avoid or delay the demand for adult social care

Improve well-being – through providing early help in order to avoid unnecessary escalation of needs as well as short term support so that people can regain their maximum level of independence possible after an illness, operation, accident or crisis

Protect well-being – through providing ongoing person centred adult social care that enables people to live their lives as they wish, safely and with dignity, in their own homes wherever possible.

5.2 Well-being is at the heart of our PIP and it is defined broadly in the 2014 Care Act as including personal dignity, physical, mental and emotional well-being, protection from abuse and neglect and control over daily life. The Care Act recognises that a person's care and support is a shared responsibility between the person (and their carers and families) and public services – and this means that we must work with the people who use ASC care and support services, and their carers, in the design of the care and support we commission and deliver.

5.3 It is important to emphasise that each of the three PIP core delivery areas pertains equally to carers – who, of course, provide the vast majority of care and support to those people who need adult social care and to whom ASC has a legal duty of regard and support. And each of the PIP delivery areas should be accorded equal prominence in our action plan because not only do we need to address current service and quality deficits but because we must

simultaneously shift our current operating model to one that proactively manages demand down and provides assured support to people with complex needs in their own homes. This is a different way of working and will involve a significant culture shift as well as wholesale change in activity across ASC – as to date the great majority of our focus and activity has been on the "Protect well-being" delivery area, within which we also currently have a wholly disproportionate reliance on residential and nursing care.

5.4 In addition to the PIP three core delivery areas, **Care Close to Home** has four cross cutting enabling programmes:

- **Person centred practice, care and support**
- **Competent, confident and critical thinking staff**
- **Commissioning to secure both value and impact**
- **Integration and Partnerships – with health, other Council departments and the voluntary and independent sectors**

5.5 Each of **Care Close to Home's** seven pillars align with the vision and priorities set out in the **My Life a Full Life (MLFL)** vanguard programme that adult social care is a major participant in and leader of. There is also a very high degree of synergy with the ten key programmes set out in the October 2016 Southampton, Hampshire, Isle of Wight and Portsmouth Sustainability and Transformation Plan. **Care Close to Home,** therefore, is not "reinventing the wheel" or attempting to subvert or divert any of the change programmes already underway. Moreover, its progress will be reported to the Local Care Board (recently established by the Council, CCG and IoW NHS Trust as the key way in which we will deliver our Local Care Plan as required by the Sustainability and Transformation Plan).

6. The Values Underpinning Care Close to Home

6.1 **Care Close to Home** is predicated on a simple set of **principles and values** that guide all of our work in ASC. These are:

Supporting people to be safe – we work with people to help them identify and manage any risk of harm, abuse or neglect, being clear about the outcomes they wish to achieve when doing so.
Prevention – we aim to prevent, delay or reduce people's need for care and support. And even when people have complex needs and ongoing requirements for care and support, we will still focus on how we can help them have maximum levels of control possible over how they live their lives.
Ambitious – we are ambitious for those we serve as well in terms of the outcomes they achieve. We are also ambitious for the department, its staff and the wider Council. We want to become a place of national best practice and innovation in adult social care.
Responsible use of resources – Adult social care is the largest spending area of the IoW Council over which there is local democratic control. We will make the most of the resources available to us, benchmark our performance against others and be evidence-based in how we make decisions.

Engaging – we will involve those we serve (users and carers) in the development and delivery of their individual care and support. We will also involve users, carers, frontline colleagues and partners in how we develop new ways of working and make key changes to our current operating model.

7. The Seven Pillars Explained

a. Promote well-being - through encouraging and enabling people to look after their health and well-being and thereby avoid or delay the demand for adult social care

7.1 Many elders and disabled adults can manage their own care and support needs and continue to live at home safely and with dignity. But to do so, they may need help and advice – including how to access community facilities, retain or get a job, apply for benefits, identify aids and adaptations for use at home and achieve or maintain a healthy lifestyle. The services and supports in this PIP area must be widely and easily available throughout our different communities. These services aim to prevent or delay people from entering the health and social care system and help prevent the circumstances that lead to people needing formal care and support in the first place, such as unhealthy lifestyles, loneliness and falls. Intrinsic to this area of the PIP, therefore, are the ways in which we seek to strengthen communities – maximising what sociologists term "social capital" - so that elderly and disabled people can be supported to participate in their local communities and benefit from all that is on offer. This means systematic investment in volunteering, befriending and good neighbour type schemes – whereby we enable local people and community groups to connect with, and enable the participation of, elderly or disabled people at risk of social isolation. Equally, advice and support provided in this area of the PIP must focus on the specific needs of carers – preventing their social isolation also.

7.2 In terms of information and advice, the Island benefits from a flourishing, diverse and expert voluntary and community sector – much of which already provides information and advice on subjects in which they are expert. Equally, the Council provides a "one stop shop" for all queries relating to Council services via its call centre at Westridge. GP surgeries and pharmacies also all display an array of good advice and information. Despite this, we know that people still find it difficult to know about all that is on offer locally and how they can access it. The ASC web site is a particular area of development moving forwards and it is especially important that we greatly improve the information available to people who fund their own care so that they are fully aware of the options available to them, how to access the advice and care that they need – with full information about the costs and quality of services that they will need to purchase. The effectiveness and future options for Islehelp are currently being evaluated – no matter what the conclusion regarding this particular provider, ASC needs to be instrumental in providing support (and funding) to ensure that our communities are cohesive in the support they offer to elders and disabled adults and all information is easily accessible.

7.3 Promoting well-being is also about encouraging people to live healthy lives and working with Public Health colleagues is a key component of this area of

the PIP. Public health provides evidence-based universal and targeted programmes of advice and intervention to help people achieve and maintain healthy lifestyles – and it is important that ASC promotes public health campaigns and programmes that support people to change their behaviour (such as to stop smoking, drink sensibly and take more exercise). It is also important that ASDC and public health join up more systematically in tackling the Island's inequalities in health. Positively, Public Health and ASC have recently embarked on a programme to improve how people with learning disabilities access mainstream health services and develop healthier lifestyles (as people with learning disabilities are known to suffer disproportionately from diabetes, COPD and poor dental health). This initiative is being focussed first on the eight residential care homes currently run by ASC and at the time of writing Local Area Coordinators and managers of the care homes are at the early stages of working together to assess the health related behaviours of residents, identify how the staff in the care homes might work differently in supporting healthy lifestyles and then identify individual residents who want to work with a Local Area Coordinator in order to gain control of their health related behaviours.

b: **Improve well-being – through providing early help in order to avoid unnecessary escalation of needs as well as short term support so that people can regain their maximum level of independence possible after an illness, operation, accident or crisis**

7.4 Assured access to early help is known to be vital in delaying and/or reducing the need for ongoing help and support from ASC. ASC operates national eligibility criteria – and our care management systems and processes are focussed on those people who meet those criteria. As referred to above, one of the main changes to care management processes in Care Close to Home involves developing a systematic offer to people not eligible for adult social care to advice and information and early help services – as our data currently reveals that over one third of all referrals coming into the department simply results in no further action, meaning that these people are at high risk of having unmet needs that could escalate quickly with no alternative offer of advice or support. The voluntary and community sector are the obvious source of this early help – and the aim would be that they would case manage people with low level needs in order to reduce any unmet needs and thereby avoid, or at least delay, the need for adult social care. This is the model that children's services already operates through its partnership with Barnados – and thus there is cross sector learning to be applied in any roll out of such an early help offer in ASC.

7.5 Getting the right aids, equipment and technology in someone's own home can make a considerable contribution in them maintaining/regaining their independence. And whilst our Wightcare telecare service installs and provides a 24/7 reactive community alarm, monitoring and equipment service, and the Integrated Community Equipment Store provides access to specialist equipment, we have not yet developed our approach to Trusted Assessors. These are people based in the community who are trained to assess whether a person might maintain/improve their independence from the provision of

simple household aids or pieces of equipment (for instance, that it does not take a qualified occupational therapist to have to identify). Rather, Trusted Assessors work alongside professionals – providing a more proactive role in demonstrating the benefits of simple aids and adaptations to people at the earliest stages of reduced mobility or difficulties. This frees up occupational therapists and other professionals to target their expertise on those who need more specialist assessment and support.

7.6 Rehabilitation and reablement services are at the heart of improving well-being and involve the provision of intensive support and use of adaptations (including telecare and telehealth) in restoring someone's previous levels of independence. They invariably involving occupational therapists, physiotherapists, speech and language therapists, dieticians and reablement home care or reablement residential care staff. It is important to stress that reablement services are not only about providing help with the physical restoration of skills and functions, they are also an effective way of working with people with mental health problems after acute episodes of ill health (where they focus on supporting the person to regain their confidence or ability to resume key relationships, activities or employment). Rehabilitation and reablement can be bed backed – or delivered in someone's own home. Our performance data in this area reveals that we already perform well: in 2016/16, 92.8% of elderly people who received reablement services post hospital were still at home 91 days post discharge. So there is much we can build on here. The three key issues we face in doing so pertain to scale, integration across health and social care and our ability to deliver reablement services to people in their own homes (as we need to adopt the stance that a person's own bed is the "best" bed). In terms of scale, and despite good performance, only 2% of elderly people leaving hospital in 2015/16 immediately entered reablement. Second, we do not have an integrated rehabilitation and reablement pathway across health and social care – with rehabilitation being seen primarily as "clinical" and reablement as "social". Third, the current domiciliary care market is underdeveloped in terms of reablement home care (which is fundamentally about doing "with" the person so that they regain their activities of daily living skills as opposed to doing "for" when, for instance, ensuring that a person is washed and dressed.

c. Protect well-being – through providing ongoing person centred adult social care that enables people to live their lives as they wish, safely and with dignity, in their own homes wherever possible.

7.7 This part of the PIP pertains to those people who need ongoing care and support – people with invariably high level, complex needs and a parallel requirement for assured care and support that enables them to lead their lives with dignity, safety and fulfilment.

7.8 The Care Act places a person's well-being at the heart of the care management process and after clarifying that someone is eligible for ASC, the assessment process should consider, engaging with the person (assuming capacity) and any carers, what their goals are, what is important to them and how they wish to live their life. All assessments – despite any obvious need

for ongoing care and support - should also start with a presumption that the core social work task is to support someone to be as independent as possible. And for that reason, even before considering what ongoing care is available, Care Close to Home will seek to ensure that the default starting point in assessments will always be what aids, apps and adaptations might help maintain/restore independence. Implementing this approach, however, is very different to ASC's current assessment processes and its implementation will require wholesale systems, procedural and practice change. It will also require more systematic investment in technology enhanced care. As part of thinking about how radically different our current care management processes should be, it has been important to expose frontline colleagues and managers to how other local authorities have implemented the Care Act – as our current levels of productivity are worrying low and frontline colleagues and managers are adamant that this is because of cumbersome and repetitive procedures that have resulted in the loss of proportionality in approach.

7.9 Our intent in this part of the PIP is also to develop more community based options for people with ongoing care and support needs. The main priorities here are the development of extra care housing, more supported living schemes, a new Shared Lives service and more options for respite care. Succinctly, the aim is for fewer people to live in residential or nursing homes because there is improved availability of other accommodation options.

7.10 Working with colleagues in housing, the Extra Care Housing Strategy will be discussed at the July 2017 meeting of the Cabinet. The Strategy is predicated on the delivery of Extra Care Housing being available for rent, shared ownership and ownership – as well as technology enhanced care and care and health related services provided within the extra care facility. It is especially important that the Extra Care facilities we seek to promote have specialist skills in supporting people with dementia – as currently the main option available for people with dementia is residential or nursing home care (or reliance upon a family carer). We have been in discussion with several potential providers of extra care housing over the past few months and need to pursue these options with due diligence (and alacrity) – ensuring that they fit with the Island's wider Regeneration Strategy.

7.11 Several registered social landlords and care providers already offer supported living on the Island – but there are not enough and they have been developed piecemeal, as opposed to in a joined up way. We need to jointly commission with housing so that we have sufficient supported living capacity – as well as commissioning clarity and confidence about the levels of care needs that supported living providers must meet.

7.12 Our Shared Lives service will be completely new to the Island and provides supported placements for adults with care and support needs in a family home. We have recently competed the development of our policies and procedures in this area and have identified a suitably qualified and experienced commissioner to implement the scheme (i.e., development of payment schemes, recruitment and approval of carers, matching carers with the person who might live with them, overseeing proper induction and

continuing professional training for carers). We aim to support at least 12 adults with ongoing care needs in Shared Lives scheme within 12 months of launch – and some of the people will currently be living in residential care. services.

7.13 In terms of introducing Shared Lives and growing Supported Living options, as recommended by the Learning Disability Peer Review, we need also to develop and implement a programme whereby we can move people with learning disabilities out of our internal residential care facilities where possible because their well-being would be enhanced by doing so. It is important to stress here that we do not anticipate any staff redundancies - rather we will redeploy our own residential staff into Shared Lives and the new supported living schemes. Accordingly, we will need to involve Trades Unions colleagues in how we move forward.

7.14 In terms of respite, we currently offer three bed backed respite services at the Adelaide and Gouldings (for elders) and Westminster House (for adults with learning disabilities). Previously agreed plans involved reducing the number of respite beds at Westminster House from 10 to 4. The full implementation of these Plans, however, has stalled – and the Assistant Director for Integrated Delivery is looking at these plans afresh. We need to look at how all three of these services is currently organised in order to: expand the reablement offer at Adelaide and the Gouldings, ensuring that not only do we facilitate prompt discharge from hospital but also offer assured therapy services that will get people "back on their feet" and returning home even more quickly than is currently the case; ensure that we allocate scarce respite care places more evenly across everyone in need of bed backed respite care; and develop more home based respite services.

7.15 Of course, the people with the most complex needs who require dedicated 24/7 care and support will be supported to enter residential or nursing care – and this is a vital part of the continuum of services that must be available to people. But our level of current use is wholly disproportionate when we benchmark ourselves with others. It is also very expensive – especially for people with learning disabilities. So even when people need to enter residential or nursing care, we need increasingly to be use residential care for convalescence or respite purposes - always seeking to move people back to their own homes if they are able and it is safe to do so. Consequently, a key component of this area of the PIP is about how we work independent providers in supporting them to provide more reablement and convalescent care to people – especially after an acute illness, a carer's temporary breakdown or an episode in hospital – so that someone's entry into residential care is not always permanent.

7.16 We also need to develop the Personal Assistant and domiciliary care market on the Island. In particular, we need to develop recruitment, employment and support services for those people who would like a Direct Payment but who are deterred because of the responsibilities of becoming an employer and/or are concerned about the assured continuity of care PA holidays, illness or other absences. We need more specialist domiciliary care staff and agencies

also across the island – most especially reablement home carers – as well as ensuring that we can cover those more remote areas of the island currently underserved by home care agencies.

7.17 Finally, but by no means least, Care Close to Home will pay dedicated attention to the needs of carers. The vast majority of help and care is provided by family and friends – and making sure that carers are supported properly is vital to the delivery of all three areas of the PIP. We recognise an urgent need to work with carers and their representative organisations in the development and delivery of a wider range of services and supports for carers on the island so that they can continue with their caring responsibilities and minimise any adverse impact on their own health and well-being. Equally, ASC care management staff must involve any carers in their work to support an individual, respecting their knowledge and skills – as we recognise that providing the right sort of support to someone in need of ASC also supports carers. Another component of our support for carers in Care Close to Home is the further development of personal budgets for carers – because this is how carers best have control and choice over how they are supported and enabled to continue in their caring responsibilities.

The cross cutting enabling themes

d. Person centred practice, care and support

7.18 Expressed simply, person centred practice, care and support is about focusing on the need of the person rather than the needs of the service. While there is no single definition of person centred practice (terms such as "personalised", "user centred" and "individualised" are often used interchangeably), making sure that people are involved fully in the development and delivery of their own care and support is synonymous with high quality health and social care Person centred practice, care and support is an approach that sees the person using ASC as an equal partner in determining how their care needs are met. Person centred practice also means that professionals need to use "asset based" approaches in how they work alongside someone in need of care and support: this focuses on a person can do, to identify the person's strengths and to use meaningful community networks (including friends and neighbours) to help them manage their situation.

7.19 It is important to acknowledge that sometimes a person will not wish, or be able, to tell a ASC professional what he or she thinks or wants. This pertains especially to people with severe dementia or mental health problems as well as some people with complex learning disabilities. Understanding our legal duties and responsibilities around mental capacity, therefore, is key to how we implement person centred practice, care and support. Using appropriate communications methods is vital in these sorts of circumstances – as is the use of independent advocates and invoking Best Interest Assessments when in the interests of the person needing support from ASC that we do so. Of course, the person's carer(s) often does know what a person is communicating – even if they do not/cannot verbalise. So unless there are

very good reasons for not doing so, engaging carers in these circumstances is key to successful person centre practice, care and support.

7.20 Person centred practice, care and support pertains equally to safeguarding adults at risk. In 2014, the LGA and ADASS published the Making Safeguarding Personal guide (following on from earlier iterations in 2010). Succinctly, Making Safeguarding Personal aims to shift the professional emphasis from undertaking a safeguarding process (and measuring things like timeliness and length of time to complete a safeguarding investigation) to working alongside the person at risk of neglect and/or abuse or harm and helping them to identify what changes they wish to see in terms of reducing /removing any safeguarding risks and the outcomes they wish to see secured through any safeguarding interventions. This means that professionals must manage safeguarding situations in a way that enhances the involvement, choice and control of the adult at risk – because a person's experience of safeguarding processes and interventions is as important to them as the outcomes achieved. Making Safeguarding Personal aims to ensure that safeguarding practice puts the person more in control and that they define, not the professional, what changes or outcomes matter in responding to the risk of neglect or abuse that they are facing. And, of course, it is key that action is taken, whenever possible, before a person is harmed.

7.21 Implementing person centred practice, care and support involves a major change programme across ASC involving: changes to policies and procedures; the activities, skills and recoding practice of care management staff; the skills and practice of colleagues working in our provider services (e.g., the residential care homes and day services); performance and commissioning systems; and managerial supervision and audits. Currently, our PARIS care management system has not been developed with the primary focus of desired outcomes in mind – and neither have we systematically developed or trained our care management staff and managers to deploy person centred practice – although we know from feedback at the Big Conversations that they want to do so. We have only very recently developed our action plan in relation to Making Safeguarding Personal – as our current practice and performance monitoring in this area was not compliant with its principles and outcome focus. Moreover, care management staff are consistently stymied in deploying person centred practice care and support because of the lack of community based options available to enable someone to remain at home. Despite their very best endeavours, residential or nursing care is the only option currently available.

e. Competent, confident and critical thinking colleagues

7.22 Without the right staff in place, Care Close to Home will be nothing more than worthy words. People working in ASC (whether in the department, the independent or voluntary and community sectors) must be appropriately competent and confident in their jobs. As set out immediately above, person centred practice, care and support involves culture as well as procedural and skills transformation across ASC. And it precisely because we need to secure this culture shift that we also need staff to be "critically thinking" because: we

need our colleagues to be part of defining the transformational changes required as well as responding to them; we need to engender a healthy culture of support and challenge throughout the department, based on good evidence as well as professional insight; and we must harness the good ideas and expert knowledge of our colleagues across the department in developing new ways of working.

7.23 We have revised our approach to learning and development in the Department and invested in new staff engagement and development activities such as Big Conversations and Lunch and Learn sessions. We have also developed a more proactive approach to leadership development and launch a joint leadership development programme with children's services later this year. We have been driving a high completion rate of PDRs this year – as this will create the basis of our Training Needs Analysis.

7.24 Whilst developing our internal TNA, we must not forget that ASC and health staff will increasingly work together in integrated teams – delivering new models of care. This might involve ASC staff undertaking tasks previously delivered by health staff – and we must ensure that they are adequately trained if we are not to place people at risk. Equally, we need to ensure that our digital platforms in ASC and health are compatible – with practitioners at least able to read across/access each other's records. To not do this risks us becoming more inefficient because frontline staff might And we need to make more of the training and development opportunities that we convene to be available to colleagues from the independent and voluntary and community sectors – underpinning a system wide approach to the skills of staff working in ASC, no matter what sector.

7.25 We also need to enable staff to work flexibly – especially harnessing the benefits of digital technology in doing so. Care management staff currently spend the bulk of their time in front of computer terminals in our open plan offices at Enterprise House. Digital technology could enable to spend more time with those we serve – and thereby help increase job satisfaction and morale in the process.

7.26 Finally here, we need to ensure that we are working with our health, independent and voluntary and community sector colleagues in the development of a system wide approach to workforce planning (as is recognised explicitly in MLFL) and delivery of training and development opportunities. The whole health and adult social care system is struggling to recruit and retain good staff – with particular issues recruiting and retaining social workers, nurses, home care workers, occupational therapists, and frontline managers. This results in the need to employ agency workers (who are expensive) and/or make excessive demands of existing staff (as the work still needs to be completed). Equally, the health and adult social care workforce is ageing – with one in five people working in ASC now aged 55 or older (2016 England average figure). Accordingly, we need to develop our approach to succession planning as a whole system and look at how we can work with the Island's schools, College for Further Education, and local Universities in: raising the profile of health and social care (and the career

prospects therein); influencing the curriculums delivered locally so that school and college leavers have the skills we need; widening access to apprenticeships and bursaries (including graduate level ones); and offering incentives to high calibre university students who have had placements with us and who are interested in joining us post successful completion of their courses.

f. Commissioning to secure both value and impact

7.27 Simply expressed, commissioning is all about deciding what kinds of services should be provided to local people, who should provide them and how they should be paid for. For commissioning to be most effective, these decisions must be based upon good analyses of local needs and preferences and proactively engage users, cares and providers in the development of commissioning intentions and plans. The Care Act 2014 provided local authorities with key duties and responsibilities to facilitate a diverse, sustainable high quality market for their whole population, including those who pay for their own care, and to promote the efficient and effective operation of the adult care market as a whole. And the Act set out that we should develop a Market Position Statement which explains how we will achieve this diverse and high quality market.

7.28 Recent government guidance (February 2017) sets out that responsive and sustainable markets can be developed and supported in three ways by local authorities: market shaping (i.e., activity to understand the local market of care providers and stimulation of a diverse range of care and support service to ensure that people and carers have choice); market oversight (i.e., to have good intelligence about what is happening in the market so that we can act to avoid difficulties); and contingency planning (i.e., preparing for a provider failure and ensuring that people continue to receive the care and support they need should their current provider cease to provide services for any financial or quality failings). The Care Act 2014 also stipulated that ASC must work with the NHS to deliver integrated commissioning and joined up services at the local level.

7.29 As a Department, ASC has underinvested in its commissioning skills and capacity – and this is evidenced most clearly by the fact that we have not developed the usual array of community based options that most other local authorities have had in place for some time. The new Assistant Director for Integrated Commissioning joins us on the 27 June. He is jointly funded by the CCG and under his leadership, we will bring together all of the CCG's community health and adult social care commissioning personnel over the next few months. Positivity aside, we need to resource, even if on a temporary basis, additional commissioning capacity in ASC so that we can deliver the extra care housing, supported living and early help offers set out above in the discussion of the PIP. Equally, we urgently need providers in the residential and nursing home sectors to adjust their existing business models so that they provide reablement, convalescence and community outreach – as well as permanent placements. This means supporting residential, nursing and domiciliary care providers to change with dedicated in-reach – in order to both

support their care of people being discharged from hospital and the accompanying development of their staff and managers in new ways of workings.

7.30 The ASC Single Point of Commissioning Team is a brokerage service providing the key interface between social workers seeking services and support for individual people who meet our eligibility criteria and providers offering care and support. It can provide the equivalent service for self funders for a fee, but take up to date has been low. The introduction of ADAM (an online dynamic purchasing system) allows self funders to procure residential, nursing and domiciliary care for themselves. We are also introducing ADAM LIFE – which will provide the same support to self funders looking for help in their own homes.

7.31 We have limited understanding of providers' costs. However, in developing our first Market Position Statement (which will be ready by the end of the summer), we have deliberately used the organisation commissioned to produce it to develop non disclosure agreements with individual providers so that, whilst not knowing their individual circumstances and financial circumstances, we will nevertheless receive a meta-analysis of the financial state of our local market. The imminent publication and launch of our first MPS marks a positive development in delivering greater clarity to providers about the sorts of services and supports we wish to commission for the population we serve, now and in the future.

7.32 At the time of writing, together with the CCG, we are developing our fees proposals for 2017/18. Expectations of fee uplifts are currently high from providers – perhaps exacerbated based on the 4.5% and 4.8% uplifts (domiciliary and residential/nursing care respectively) awarded last year. There is little provision for fee uplifts available in the 2017/18 budget and the additional new national funds awarded to adult social earlier this year are temporary. Accordingly, we have developed proposals to fund providers' learning and development needs – thereby reducing their cost basis.

7.33 Commissioning adult social care through personal budgets and direct payments is an important way of supporting users and carers to have more control and choice over how their care needs are met. But we are increasingly finding personalised commissioning a challenge as we seek to save money – and some of our direct payments are far in excess of the costs of traditionally commissioned services. It is perhaps relevant to note here that the Care Act 2014 guidance explicitly acknowledged that responding to users' needs in personalised ways and securing their desired outcomes can increase the cost of care.

7.34 We will apply equal commissioning rigour to our internally provided services as to those commissioned via the independent and voluntary and community sectors. It is still public funds that are being used and the Department should not be in the business of providing services directly if those services are neither effective nor efficient.

7.35 The final element of the Commissioning for Value and Impact theme pertains to our performance management and quality assurance systems and processes. We have worked hard over the past six months to further develop our performance management culture – so that commissioners and operational managers alike have access to, and routinely use, good data, information and intelligence about service quality (including care management), user and carer outcomes, and finance and efficiency. Our business intelligence unit, in particular, has done a lot of good work over the last few months in developing the weekly, monthly and quarterly performance reports – but we need now to start to integrate these with our finance reports so that the links between quality, outcomes and costs are better understood and drive our commissioning priorities (both internal and external).

g. Integration and Partnerships – with health, other Council departments and the voluntary and independent sectors

7.36 The Care Act 2014 sets out that health and social care should be integrated by 2020. The Act's basic premises for this objective are threefold: to improve population health; to improve the individual experience of care; and to control costs. Key lessons from the available evidence on effective integration across health and social care reveal the importance of: integrating for the right reasons (the most successful integration systems have grown organically with strong clinical and professional leadership rather than from an imposed top down approach); integrating frontline staff before any organisational integration; local quality and improvement priorities being used to drive integration; having the right incentives; recognising that economies of scale and improved outcomes might take some time to deliver; and Leutz's "sixth law" – that all integration hinges on strong local leadership identifying solutions to specific local problems.

7.37 The local development of plans and resources set out in the Better Care Fund provides a primary vehicle for integrated commissioning and delivery across health and social care. However, we have been unable to agree a section 75 agreement with the CCG for 2016/17 because the CCG had to reduce its contribution to the support of adult social care by £1.4M – resulting in an adult social care overspend. We have worked with Better Care Advisors in developing our BCF plans for 2017/18 which will necessarily be smaller in scale and focus primarily on those proposals which either deliver greater integration or prevent the escalation of need.

7.38 As one of 23 national vanguard sites, our MLFL programme sets out a compelling vision for the future organisation and delivery of integrated health and care services. Fundamentally, MLFL's multiple work streams coalesce in defining and responding to the health and care needs of the Island's population as a whole, single, system – where the focus is on breaking down barriers between different services and organisations as well as making "a shift to the left" (i.e., avoiding and reducing the use of expensive hospital, residential and nursing homes through the provision of more community based services and options). MLFL has already piloted several New Models of Care to good effect including technology enhanced care homes, local area co-

ordinators and care navigators – and as commissioners, we now need to mainstream these new models.

7.39 Integration across health and social care is at the heart of the MLFL programme – and the Transforming Community Programme has Integrated Locality Services and an Integrated Access Hub as two primary levers of change in delivering wholesale integration across health and social care. The first of three Integrated Locality Services was launched at the end of February 2017 covering the North and East of the Island. The second went live at the beginning of June and the final ILS will go live in August. Integrated Locality services bring together community health and social work staff in identifying and assertively case managing cases in the community where there is a risk of hospital or residential care home admission or carer breakdown.

7.40 The Integrated Access Hub is in its final stages of development – with implementation due by September. This will bring together: the 111 service, the patient transport service, Adult Social Care First Response duty service, Wightcare and the social work emergency duty service (including mental health). The intention is that people trying to access health and social care will have a single port of call. This idea is currently receiving top political priority locally.

8 Supporting documents and information

The Wider Context in which Adult Social Care Currently Operates

a. Funding for adult social care

8.1 Adult social care is experiencing a funding crisis – and it is impacting on the lives of frail elderly and disabled people and their families. These are not histrionic words. Instead, the funding crisis in adult social care is universally acknowledged and, at its simplest, has dual underpinnings: reduced state funding and increased needs. Around £24billion, of which the state contributes £14billion, is spent on adult social care in England: most of which is spent on older people receiving care either in their own homes or in a residential or nursing care home. Adult social care often comprises the largest single spending area for upper tier local authorities – meaning that it has been a primary area for savings since the 2010 election. Consequently, while local authority spending on social care increased by an average of 6% per annum in the 15 years leading up to 2009, Kings Fund research confirms that spending on social care in 2015 for all age groups was 10% less than it was in 2009 and that 26% fewer older people received state funded care (Kings Fund, 2016, “Home Truths”). This is despite the fact that there has been a 34% increase in the numbers of the over 85s since 2002 as well as significantly increased longevity amongst disabled adults with complex needs (the two groups most likely to need social care). Indeed, future projections estimate that there will be a 49% increase in the demand for publicly funded care home places between 2015 and 2035 (Care Quality Commission, The State of health care and adult social care in England 2015/16, p42). Yet while projected increases in demand pressures amount to 4% of total budget per

annum – it has been estimated that public funding for adult social care will rise by only 0.6% in real terms from 2015/6 to 2019/20 (Health Foundation 2016, "A Perfect Storm").

8.2 The most recent Budget Survey undertaken by the Association of Directors of Adult Social Services in 2016 draws six main conclusions:

- **Funding does not match increased needs for, and costs of, care for older and disabled people** (with the social care precept in 2016/17 raising less than two thirds of the calculated £330million costs of the introduction of the National Living Wage 2016/17 and local authorities having to secure savings of £941M in adult social care – 7% of the total net budget)
- **More people's lives are being affected by reductions in social care funding** (for instance:, 24% of the savings total will be effected by cutting services or reducing personal budgets; more providers report increasing quality pressures because of the prices paid)
- **Directors are increasingly unclear about where the funding needed will come from** (with the majority of adult social care departments overspent their budgets to the total of £168M in 2015/16)
- **The continuity of the care market is under threat** (with 80% of Directors reporting that providers in their areas are facing financial difficulties with an increased number now exiting the market)
- **Investment in prevention is being further squeezed** (prevention and integration are identified as two of the most important ways to make savings in the longer term but investment in these areas is compromised because of the immediate imperative to prioritise statutory provision – with councils spending 4% less on prevention in 2016/7 than the previous year)
- **The reduction in funding for adult social care has a wider impact** (the NHS has been placed under greater pressure and this has negatively affected both the performance and finances of individual Trusts and providers in the independent and voluntary sectors are facing tangible financial difficulties and quality challenges).

8.3 These warnings are echoed by the independent regulator of all health and adult social care in England, the Care Quality Commission in its most recent annual report:

"The fragility of the adult social care market and the pressure on primary care services are now beginning to impact both on the people who rely on these services and on the performance of secondary care. The evidence suggests we may be approaching a tipping point."

(Care Quality Commission, 2016, "The State of health care and adult social care in England 2015/16" p4).

b. Workforce

8.4 Based on returns from employers, Skills for Care estimated that 1.43 million people were working in adult social care in England in 2015 (1.11 million full time equivalents) - an 18% since 2009 (or 240,000 more jobs). Of these, 1.34 million people worked in statutory local authority or the independent sectors – with the remaining people being employed by direct payments recipients or the NHS. Looking forward, and assuming the adult social care workforce grows proportionately to the projected number of people aged 65 and over, Skills for Care estimates that the number of adult social care jobs will increase to 1.83 million by 2025. Of the 1.34 million people currently working in local authorities and the independent sector in 2015: 51% were full time; 37% were part time; and the remaining 11% had no fixed hours. Very notably, 24% of all employees were on zero hours contracts (with 49% of all domiciliary care workers being employed in this manner).

8.5 Turnover rates across adult social care are high and increasing: it was 27.3% in 2015/16 (representing a 4.7% increase from 2012/13). Notably, a high proportion of people leaving sector do so very soon after joining – with leavers being especially high among younger employees. High turnover is accompanied by rising rates of vacancies across adult social care – 6.8% in 2015/16 (up from 4.5% in 2012/13).
The great majority of adult social care workers are women (82%) and 20% is aged 55 years or older. The adult social care workforce has a greater reliance on non EU workers (11% of the total workforce) than EU workers (7%) – a reliance that could further compromise workforce supply.
(Skills for Care, Sept 2016, "The state of the adult social care sector and workforce in England", data above drawn from p4 to p21).

8.6 Low pay is widespread across the adult social care workforce – with obvious negative consequences for recruitment and retention and in direct contradiction to the national aim of professionalising the adult social care workforce (primarily through the Care Certificate) and the imperative to improve quality and outcomes for those people in receipt of social care. A review by the House of Commons Public accounts Committee in 2015 found that: care workers' median pay was £7.20 per hour (meaning that many people earned well below this amount); those working in community settings were frequently not paid for travelling time; and up to 220,000 care workers were paid below the statutory minimum wage. (House of Commons Public Accounts Committee 2015, "Adult social care in England" HC518). The April 2016 introduction of the national living wage, although by nowhere near fully funded, will be paid to all employees aged 25 and older. Starting at £7.20 per hour in 2016, it will rise to £9.15 per hour by 2020.

c. Independent providers in adult social care

8.7 Encouraged and enforced by legislation since the 1980s, local authorities are now predominantly commissioners, as opposed to providers, of adult social care. Indeed, almost three quarters (72%) of the adult social care workforce is employed in the independent sector – with a further 14% employed by people in receipt of personal budgets. The private care market is highly dichotomised in nature. In residential care, for instance, while just over 40% of care home

providers operate three or fewer homes, the ten largest care home providers account for 20% of the total UK care home market. These largest operators operate a business model commonly based upon homes containing 60 or more ensuite bedrooms and their successful growth strategy depends upon access to finance from capital markets (as opposed to traditional business loans from high street banks). (Centre for Health and the Public Interest, 2016, “The failure of privatised adult social care in England: what is to be done?” p8).

8.8 The funding crisis in adult social care has affected adult social care providers of all shapes and sizes with two thirds of all local authorities seeing contracts “handed back” by providers or providers leaving the market altogether. Indeed, over the past six years, the numbers of care homes in England has decreased by 1,500 to 16,600 (BBC news, 11 October 2016) – and there have been a number of high profile “market failures” (such as the 2011 Southern Cross failure which left more than 30,000 elderly people at risk of being forced out of their care homes) as well as “market exits” (such as the September 2016 announcement by not-for-profit Housing and Care 21 that it would be withdrawing from all of its council contracts because fee levels were not enough to maintain quality of care – amounting to 35,000 hours of domiciliary support a week across 150 different local authorities).
For several years, organisations such as CareEngland have highlighted the widespread emergence of a two tier adult social care system: there is differential access to those who are paying for their own care as opposed to those who are state funded and self funders are subsidising for the lower rates paid by local authorities via two tier fee structures.

d. Integration across health and social care – whole person, whole system, whole place

8.9 The national focus on the integration of health and social care, and its potential to deliver better, more cost effective services, has three main drivers: spending cuts and the need to deliver further savings; demographic changes with predicted rises in the need for health and social care due to an ageing population and rise in the numbers of people with a long term condition; and a recognition that too many people are not getting the care they need, delivered in the right setting. In addition, however, it is now accepted that reductions in local authority adult social care and related budgets such as housing has resulted in unmet need – needs which have negatively affected the performance and costs of the NHS (primarily in the form of avoidable hospital admissions, delayed transfers of care, cancelled elective activity and missed A&E/referral to treatment time targets). Furthermore, because the nature of the nation’s health care needs have changed – from acute illnesses to chronic diseases (that cannot be cured, but can be managed with people staying at home, thereby placing less reliance on hospital care), effective partnership working across health and social care is now regarded as a prerequisite for achieving good health and wellbeing outcomes. Indeed, recognition of these inter-dependencies of spend and performance, in addition to the aim that service users must have access to effective, efficient and co-ordinated care

services from a range of providers, means that integration across health and social care is the contemporary “holy grail” of public policy in these areas.

8.10 Integration is understood as essential to the delivery of improved outcomes and efficient spend because: it ensures that services “whole person” – they are joined up around the person rather than people having to navigate fragmented services; resource allocation decisions across different local organisations are based upon the impact on the “whole system”, leading to more efficient use of the local public pound; and local commissioners are encouraged to adopt a “whole place” approach in their planning and delivery systems so that there is clarity about care pathways spanning different professional skills required. The influential US Institute for Health Improvement talks about the “triple aim” that underpins integration across health and social care: to improve population health; to improve individual experience of care; and to control costs. Such a triple aim is reflected in the Care Act 2014, which mandates more formalised, integrated ways of working across the two sectors, giving local authorities a duty to promote integrated services and introducing the Better Care Fund, a pooled fund to underpin partnership working to support more people to be cared for in the community (although this is not “new”, additional money and has been described as “papering over the cracks of deteriorating NHS finances and social care budget cuts”. R Humphries and L Bennett, “Making best use of the care fund” Kings Fund 2014).

8.11 For care to be successfully integrated, organisations and professionals must bring together all aspects of the care that a person needs. Approaches vary from loose networks (where, for example, staff in different teams and locations share electronic patient data) to full structural amalgamation (where health and social care professionals are physically integrated in a single location under single line management and single work processes). A meta-analysis of the research evaluating critical success factors for integration across health and social care reveals:

Organisational structures and behaviours

- Good leadership is essential to successful integration – and should be distinguished from clinical or professional leadership
- The effective management of integrated teams is also essential – but this should be separated from clinical or professional management

Staff roles, recruitment and retention

- The creation of new roles working across professional boundaries supports integrated delivery
- A focus on the service user/patient helps in overcoming professional boundaries
- An understanding of different roles and responsibilities is important to successful integration within a team – and while different terms and conditions can be challenging, they are a barrier that can be overcome

Communication/ICT

- Information sharing can be improved by integration

Training and education

- Training is a key success factor for integrated working, particularly to reflect changing roles and responsibilities
- Co-location can support team working

(Institute of Public Care, "Evidence Review – integrated health and social care", published by Skills for Care, 2013 p5-7).

Contact Point: Dr Carol Tozer, Director of Adult Social Care ☎ *821000 e-mail* carol.tozer@iow.gov.uk

DR CAROL TOZER,
DIRECTOR OF ADULTSOCIAL CARE

CLLR CLARE MOSDELL
CABINET MEMBER FOR ADULT SOCIAL CARE AND PUBLIC HEALTH

APPENDIX 1

Diagram of Care Close to Home