PAPER B

ISLE of WIGHT COUNCIL

1. CARE CLOSE TO HOME: AN UPDATE ON THE TRANSFORMATION PROGRAMME ACROSS ADULT SOCIAL CARE

1.2 This report provides an update on the implementation of Care Close to Home, the new strategy for adult social care introduced in February 2017.

1.3 **19 OCTOBER 2017**

1.4 **DR CAROL TOZER**
DIRECTOR OF ADULT SOCIAL CARE

2. Summary

2.1 Adult social care matters. It exists to transform the lives of vulnerable adults at risk of harm, in crisis and/or with long term conditions and needs. Excellent adult social care has a number of predisposing characteristics including: person centred professional practice delivered through competent and caring professionals; outcome based commissioning that works hand in hand with the people who need support, their families as well as experts based in the voluntary and community and independent sectors; and integrated delivery systems that are organised around the interests of users and based on good governance across care and health. The introduction of the Care Close to Home strategy in February 2017 was designed to deliver best outcomes for adults with social care needs within available resources. This report provides an update on the progress secured to date as well as the areas for ongoing development and/or concern.

2.2 Care Close to Home comprises seven pillars: three core delivery areas (promoting wellbeing, improving wellbeing and protecting wellbeing); and four enabling programmes (competent, confident, critical thinking staff; commissioning for value and impact; personalised practice and support; and partnerships and integration). Expressed succinctly, the aim of Care Close to Home is to manage demand (by providing assured support to people with low level needs, develop community based alternatives to residential and nursing home care and promote the use of direct payments) and to contain costs as set out in the Council's Medium term Financial strategy (securing £3.4millions of savings in 2017/18; £4M of savings in 2018/19; and £3.2M of savings in 2019/20).

2.3 Good progress has been made across all seven areas of Care Close to Home – although there is still much to do and it should be stressed that the full implementation of the strategy will take three years to secure.

2.4 **Some areas of progress include:**

- 74.5% of assessments were completed in 28 days (August 2017) – compared with 55.4% in January 2017.
- It took 5.6 working days to complete someone's financial assessment in August 2017 as opposed to 14.6 days in January 2017
- Whereas in January 2017 388 people had an outstanding review that was more than 3 months overdue, this had reduced to 93 people in August 2017
- 10.2% of all referrals received in January 2017 resulted in a permanent admission to residential or nursing home care in January 2017 as opposed to 1.4% in August 2017
- The number of elderly people in receipt of home care increased from 456 in January 2017 to 496 in August 3017

2.5 Our work with the CCG, as evidenced by the Better Care Fund submission and Improved Better Care Fund submission, has strengthened considerably this year. Unlike last year, we have signed off a s75 agreement with the CCG – and aspects of our submission has been disseminated by NHSE and ADASS as a regional model of good practice. Additionally, we exceeded our national September 2017 target for delayed transfers of care (DTOC) by 63% - while our combined DTOC target with health was also met. Almost 50% of all local care system (ie adult social care and the local NHS) did not achieve their local DTOC targets and so we have also been asked to host a national best practice "hospital to home" review in late October/November in order to explain how we have made the improvements.

2.6 Our financial performance to date this year has been strong. At the end of August 2017, our forecast overspend had reduced to £7k – despite very significant financial pressures. We have strengthened our internal panel arrangements whereby packages of care are approved and established a dedicated review team for all high costs packages. We have established dedicated project officers for every savings areas and progress is monitored and reported to the Department's Service Board. It must be stressed that the receipt of the Improved Better Care Fund monies (£3.2M in 2017/18) has been vital to securing investment in Care Close to Home as well as delivering robust financial performance. We have used these (three year limited) funds in agreement with health to provide vital investment in: new technology(£500k); home based reablement (£521k); early help delivered via the voluntary and community sector (£660k); raising standards across all registered providers of adult social care (£340k); investing in commissioning (£230k); and internal changes and additional support for adult social care packages of support and project management (£600k).

2.7 Staff engagement in all of the Care Close to Home changes we have put into place has been positive – and it is important to pay tribute here to my colleagues' considerable hard work in these initial days of our implementation journey. We now undertake quarterly (anonymous) staff surveys to test their morale and engagement with the changes being put into place. One of the questions is "morale is good where I work" (and respondents are asked to either: strongly agree; agree; neither agree nor disagree; disagree; or strongly disagree). From April to July 2017, the proportion of colleagues reporting positive morale increased from 27.58% in April 2017 to 40.39% in July 2017 (I await the September 2017 survey results at the time of writing this report).

2.8 **Ongoing areas for improvement/concern**

Despite the progress as identified above, the full implementation of Care Close to home will take up to three years to complete and we face a significant ongoing journey of improvement. There are four key areas of ongoing improvement: meeting financial pressures; delivering new forms of community based support as alternatives to residential and nursing care; integration with health; and person centred professional practice and support (especially, although not exclusively, for people with mental health problems).

2.9 In 2018/19, adult social care must secure a further £4.03 millions of savings - over 55% of all of the savings to be secured across the Council. The approach we have adopted towards identifying our 18/19 savings is twofold: the better management of demand; and the containment of costs (including raising revenue where we reasonably can). It is highly unlikely that we can secure the full level of savings required without reducing support to some people – although very obviously, our proposals will be going through detailed political scrutiny and decision making. As set out in para 2.6 above, we have deliberately used iBCF funds to support our implementation of Care Close to Home – i.e., for transformative purposes. These funds diminish to £2.1M in 2018/19 (and to £1m in 2019/20). And, because we have secured the DTOC targets we were set by NHSE in July 2017, we will receive the full amount of these monies in 2018/19. The intention is to maintain investment in early help, new technology and home based reablement in 2018/19 – as these are all vital in managing demand and containing costs and delivering improved outcomes. The funding pressures in adult social care are well known and accepted, with national developments such as the creation of the Improved Better Care Fund and Council Tax precept arrangements proof positive in this regard (and over 95% of all local authorities deployed the full 2% Council Tax precept in 2017/18, including the Isle of Wight). Adult social care needs a sustainable funding basis so that the most vulnerable members of our community and their carers can live a fulfilling life with safety and dignity and the Government is currently preparing a(nother) Green Paper on the future funding of social care. At the time of writing, it is unknown as to when this Green Paper might be published.

2.9 We are at the beginning of our efforts to establish community based alternatives to residential and nursing care. Of course, residential and nursing care homes provide vital support to the most frail elders and disabled adults. But because over the years we have neither commissioned nor invested in proven alternative community based models of care and support, we have ended up with a considerable overreliance on care and nursing homes as providers of care. For instance, if you are a disabled adult living on the Isle of Wight, you are four times more likely to live in a care home than elsewhere in England. New services such as Shared Lives, Extra Care and Supported Living will take time to establish. Progress is being made, but it will not be instantaneous. For instance, we have a detailed programme plan and our new Shared Lives service is due to start in February 2018. Equally, we will have 32 new units of supported living for people with learning disabilities by April 2018. Our progress in delivering Extra Care is very much a corporate priority – as it depends as much upon development grants from regeneration funds, and detailed planning permission as it does support from Adult Social Care for the care and support to be delivered. Without ongoing investment in commissioning capacity and capability, we

are likely to make only limited inroads into reducing our current overreliance on residential and nursing care.

2.10 Third, we need to maintain pace in terms of integration with health – and not only because this is a requirement of the 2014 Care Act. Health and social care are two sides of the same coin and the vision of the Local care Board (comprising senior membership from the Council, the CCG and the Trust) is that people's health and care needs are provided as much in the community as possible. The Local Care Board has agreed eight priorities: acute service redesign; integrated access; integrated locality services; frailty; hospital to home; rehabilitation, reablement and recovery; transforming learning disabilities services; and transforming mental health services. There are detailed charters for each of these programmes of work and transformation – and adult social care is a full member of all (with the exception of acute service redesign). Arguably, not enough progress has been made in realising the vision of the Integrated Locality Services. Whilst certain people are now benefit from more integrated responses to their circumstances, we need to establish a single multi-disciplinary team in each of the localities, all working to the same operating procedures, accountable to a single manager who holds responsibility for an integrated budget.

2.11 Finally, we are not yet implementing person centred professional practice at scale and in a consistent fashion – despite some excellent work done by frontline social workers, social care officers and provider staff based in our own residential care homes and home care teams. This issue was first highlighted by the Peer Review of Learning Disabilities that was undertaken in January 2017 – but it is fair to say that the findings in that review are mirrored by our own case file assessments. We have recently taken receipt of an independent review of our adult safeguarding processes and practices – and are in the throes of implementing a wide ranging action plan in order to ensure that we have properly implemented "Making Safeguarding Personal". Equally, we have commissioned an independent review of our mental health services – due to report in late October/early November – as we have high use of s117 aftercare services with people not being discharged as one would expect in any model that focusses on recovery.

3. Decisions, recommendations and any options

3.1 The Board is asked to do what:

To discuss and note this report, providing any recommendations to the Cabinet Member and Director.

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