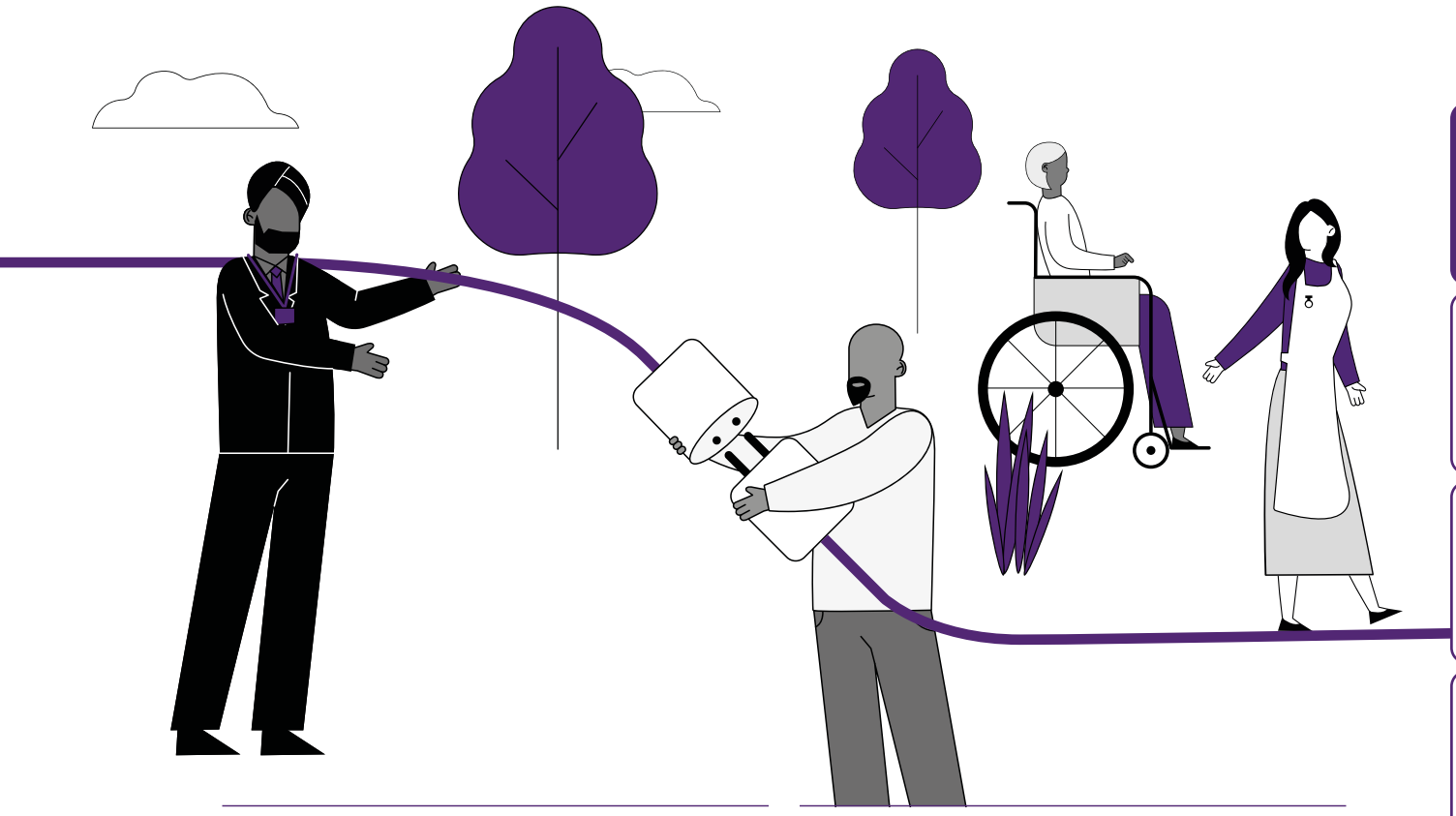
The Future of Adult Social Care

www.futureasc.com

Optimised Local Delivery

Contents



The County Councils Network

Founded in 1997, the County Councils Network is the voice of England's counties. A cross-party organisation, CCN develops policy, commissions research, and presents evidence-based solutions nationally on behalf of the largest grouping of local authorities in England. In total, the 25 county councils and 11 unitary councils that make up the CCN represent 26 million residents, account for 39% of England's GVA, and deliver high-quality services that matter the most to local communities.

Find out more by visiting
www.countycouncilsnetwork.org.uk

The Association of County Chief Executives

The Association of County Chief Executives (ACCE) brings together the Chief Executives of 34 large English upper tier and unitary authorities. Members of ACCE work to identify common challenges, commission research and share solutions, and discuss key issues with senior Whitehall Civil Servants.

Find out more by visiting **www.acce.org.uk**

Newton

Newton specialise in designing and delivering large-scale, complex, operational transformation programmes. They have worked with over 100 public sector organisations across adult social care, children's services, health providers and with whole health and social care systems. They take an evidence led approach to reimagine and redesign ways of working, and deliver services which are better for people, better for staff and deliver significant, sustainable and guaranteed financial benefit.

Find out more by visiting
www.newtoneurope.com

As part of this programme of work, deep dives will continue beyond the publication of the initial report, ensuring the conversation continues and themes are developed into increasing levels of detail.

Updates will be published via the microsite **www.futureasc.com**

Introduction

Even before the global COVID-19 pandemic emerged, the Government was under pressure to set out its long-awaited plans for adult social care reform. The issue had been identified by commentators across the political spectrum as *the* principal policy question which the UK would need to answer in the coming decade as the 2020s dawned.

The impact of COVID-19 has raised the public profile of adult social care, as weaknesses in the system have been exposed. It has acted to give renewed emphasis on the need to reform care services in England, with Government stating that its proposals for reform are now set to be shared in 2021.

Somewhat inevitably, the national discourse on reform is dominated by the uncertainty on how the Government will tackle the long-term funding solution for adult social care – both in terms of the quantum of funding required as well as potential revenue raising mechanisms.

This issue – and in particular addressing how to manage the risk of catastrophic care costs for individuals – has been at the root of both the imperative for reform, and the inherent difficulties in achieving change.

As it currently stands, government funding accounts for 45% of the total estimated costs of providing adult social care services in England,[1] with the majority of state funded care resourced through locally raised taxation. This statistic alone shows that the decision on how, and from whom, we fund care can only follow once a decision is taken on how best to deliver adult social care going forward, and the roles that need to be played by both local and central government. This requires establishing a common set of values and beliefs to underpin a reformed system and optimising the delivery of adult social care, ensuring the service delivers good outcomes for people cost effectively.

[1] CCN Spending Review Submission, p. 38 www.countycouncilsnetwork.org.uk/download/3248

This report presents an evidence base for how adult social care can be delivered effectively and how local councils and health partners are best equipped to support this in a reformed system.

As we near the publication of the government's reform proposals, and as the country works to cope with the ongoing impact of the pandemic, now is the time to have this important discussion. To date, at the most basic level, much of the national conversation has sought to explore the idea of a 'nationalised' care system compared with modernising and improving current localised delivery.

To help shape and influence an evidence-based discussion on the reform of care services in England, the County Councils Network (CCN), Association of County Chief Executives (ACCE) and Newton have collaborated on an extensive programme of work that seeks to form a perspective on the future of adult social care and, in particular, what it takes to optimise the delivery of this vital public service in a reformed system. The scope of this work has been deliberately specific and, as such, while it has considered the necessity of funding reform, this is not the primary aim of the programme. The aim has been to support the inevitable decisions that will need to be made around funding by assessing and demonstrating the features of an optimised model of adult social care.

This programme has been informed by extensive engagement with national and local adult social care stakeholders, 'deep dives' with county authorities, Newton's evidence from change programmes over recent years, case studies from other authorities and analysis of national data sets. Some 24 county authorities have engaged directly in this work through one or more of these means, and this report represents the outcome of conversations with over 150 individuals.

The evidence and insight which support the key points draws on Newton's 20 years' experience of delivering major change programmes within the sector.

Counties deliver care across large, complex, and diverse geographies – usually incorporating urban, rural, and coastal communities, and often work across multiple or overlapping boundaries with health agencies. Whilst these challenges are a key focus, this report has deliberately drawn on evidence from a range of authorities, including non-county authorities, in order to develop an optimised model of delivery and a set of conclusions that should be relevant and consistent to the whole adult social care and health sector. This report presents an evidence base for how adult social care can be delivered effectively and how local councils and health partners are best equipped to support this in a reformed system. Whilst this report demonstrates that we need to recognise and build on the exceptional practice that already exists across the sector, it also shows that achieving an optimised local delivery model requires improvements to current ways of working. In doing so, the aspiration is for readers from within the sector, in central government, in partner organisations and in private businesses to learn from the exceptional practice and understand their role in delivering an optimised model.

As well as questions for policy makers, this will lead to ideas for service leaders to consider within their own systems, alongside a range of potential steps that can be taken today to further optimise delivery now and in the future.

Methodology

This programme of work has been a collaborative process across CCN and ACCE's member authorities (and beyond), supported by Newton. Developing this work has involved extensive engagement with over 150 Chief Executives, Treasurers and Directors of Adult Social Services from CCN's member authorities, as well as providers of care, individuals with lived experience, health leaders, representatives from the LGA and digital experts in the sector.

This report, an output of the programme of work, is a product of those conversations and is designed to try and honestly reflect the breadth and depth of the views, opinions and stories that have been shared. This is overlaid with insight and analysis from a number of sources, including Newton's evidence from change programmes over recent years, case studies from other authorities and analysis of national data sets. It also references the published work of Professor John Bolton, most notably his study "Six Steps to Managing Demand in Adult Social Care" (published by the Institute of Public Care 2018).[2] A number of county authorities have also participated in 'deep dives', exploring a specific theme or idea through analysis, workshops and interviews. This has typically led to a case study, which underpins a key point within the report. These deep dives will continue beyond the publication of the initial report, ensuring the conversation continues and themes are developed into increasing levels of detail.

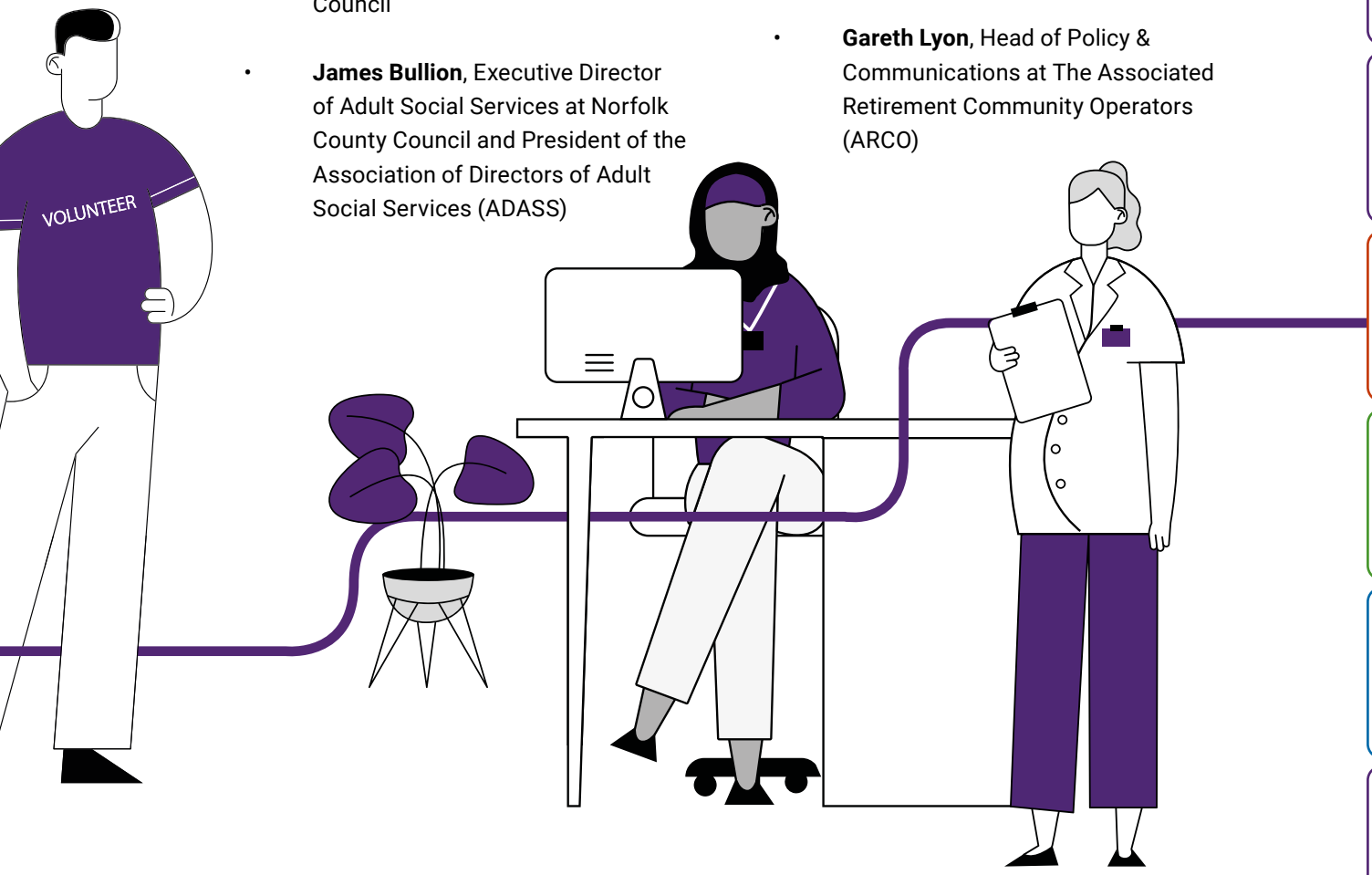
CCN, ACCE and Newton would like to extend their thanks to all those involved in this programme of work for being so generous with their time, expertise and support. All three organisations hope that this report will not be the end point of this programme, but the beginning of a conversation both locally and centrally as the nation looks to the future of its adult social care system across the decade to come.

[2] John Bolton and Philip Provenzano; 'Six Steps to Managing Demand in Adult Social Care - A performance management approach'; IPC Report

The programme of work has been driven by a cross-sector core advisory group who have been instrumental in providing insight, challenge and thinking.

They include:

- **Cllr David Fothergill**, Leader of the Council at Somerset County Council and Health & Social Care Spokesman for the County Councils Network (CCN)
- **Rachael Shimmin OBE**, Chief Executive of Buckinghamshire Council and Social Care Lead for the Association of County Chief Executives (ACCE)
- **Louise Taylor**, Executive Director of Adult Services and Health and Wellbeing at Lancashire County Council
- **James Bullion**, Executive Director of Adult Social Services at Norfolk County Council and President of the Association of Directors of Adult Social Services (ADASS)
- **Chris Tambini**, Director of Corporate Resources at Leicestershire County Council and Vice President of the Society for County Treasurers
- **Adam Littlefield**, Forums Manager at Engaging Kent CiC
- **Simon Williams**, Director of Adult Social Care at the Local Government Association (LGA)
- **Oliver Spence**, Commissioning and Brokerage Manager at First City Nursing & Care
- **Gareth Lyon**, Head of Policy & Communications at The Associated Retirement Community Operators (ARCO)



Section A

What is Adult Social Care

It has only been in recent decades that the policy debate around adult social care has been viewed as a nationally significant issue. Whilst seismic changes in the immediate post-war period have resulted in a national insurance and national health system that is cherished at home and envied abroad, the related issue of providing for social care has arguably remained unresolved.

However, in more recent times it has become more visible as a growing problem. Much is now known about the scale of the mounting pressures in adult social care and the frailties of the current system from the many national reviews and reports published on the subject.

In order to consider the features of an optimised model for adult social care, it is critical that the scale of the challenge is recognised. But equally important is a common understanding of what adult social care actually is. Today, the range of people who receive social care support and the nature of the services provided is not widely understood, by the public, or by those in decision-making positions.

The below statements summarise a shorthand definition of adult social care:

- Adult social care is the support provided to help adults of all ages with physical or learning disabilities and autism, frailty, mental illnesses, or substance misuse. The goal of this support is to ensure people can live a fulfilling life, where they are able to realise their potential to contribute to their local community.

- Adult social care is responsible for the assessment of people's care needs and meeting those needs. Help can be provided formally by councils and provider organisations, or informally by carers, relatives, and the voluntary and community sector (VCS), through traditional face-to-face channels, or by leveraging technology and digital platforms. The duties for adult social care are laid down by parliament in legislation, specifically the Care Act (2014).

- Adult social care is responsible for ensuring that the services people receive are co-ordinated, effective and appropriate to meet their needs. Those who experience these services need to be assured that they are getting the best help for their needs, and that they have some choice in the way in which their needs are met. Adult social care needs to ensure that the right provision is available in their area to meet the needs of their local population, including personal assistants (people who are employed directly by an individual managing and paying for their own care through a social care direct payment or personal budget).

1.9m

During the financial year 2019/20 there were **1.9 million requests for adult social care support** from 1.4 million new clients, equivalent to 5,289 requests for support received per day, an extra 239 requests per day compared to two years ago.[3]

838,530

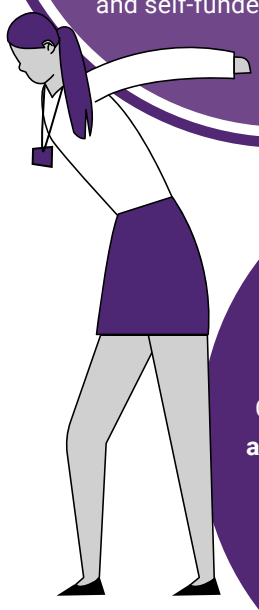
In 2019/20, **838,530 adults received publicly funded long-term adult social care,** primarily in residential care homes, nursing homes, or in their own homes. In addition, there were 261,605 episodes of short-term care provided to maximise independence.

£103bn

In 2018, the NAO estimated that **informal and voluntary sector care accounted for most of the value of adult social care** (£103 billion), followed by care provided through local authorities (£19 billion), and self-funded care (£11 billion).

33%

In 2020/21, adult social care is projected to represent **33% of authorities' total service costs**. For CCN member councils, this figure is 39% due to the different responsibilities that county councils have.[4]



1.65m

In their 2019/20 report, Skills for Care estimate there to be **1.65 million adult social care jobs in England**. Local authorities employ 7% of staff, the independent sector employs 79% of staff, and direct payment recipients employ 8% of staff. The rest are employed by the NHS.[5]

[3] ASCFR 2019-20 (www.digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2019-20)
[4] www.countycouncilsnetwork.org.uk/download/2262
[5] www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2020.pdf

Explaining social care

Why might someone need adult social care?

Adult social care needs are often caused by a long-term health condition or a life-changing event that impacts the individual's health.

These are the common needs that adults have when they approach social care for help:

- A long-term condition of ill-health (physical or mental) that means they are unable to carry out the normal tasks of daily living without some help. For older people, this could relate to a specific illness, or more broadly to the process of ageing.
- A brain injury, a learning disability, or a level of dementia that requires someone to prompt or to directly help the person in carrying out the tasks of daily living.
- A set of behaviours that might be experienced by the person or by others as challenging, that need monitoring and modifying where feasible.
- A recent spell in an acute hospital where they have required medical, surgical, or acute mental health treatment and they need help whilst they recover.

"There are 6.5 million people in the United Kingdom who are supporting a loved one who is older, disabled or seriously ill."

What support does adult social care commission and provide?

Support can include assisting an individual with the tasks of daily living such as dressing, washing, keeping clean and in good hygiene.

It might mean help with managing their household, their finances, or their decision-making. It may also encompass help with going out (including to work); with communication with others; with reading; or with personal safety. The help people need will be a mixture of practical help, physical and emotional assistance.

All of those in the situations described above may also, in addition to support with the tasks of daily living, need support with their health needs; their housing; their leisure activities; their participation in their community; and to live with their families or on their own.

These may all be examples of social care assisting in meeting the person's goals that they have, where they can, expressed.

As noted above, in addition to practical support, many people who look to social care for help will also need support for the emotional traumas that they are going through. This might be related to living with their disability, having a new disability, or being the carer of a person who needs support to overcome new challenges. Social care systems need to focus as much on services which meet people's emotional needs as people's practical needs. So, care can be offered to people in a number of circumstances to meet different needs in a range of ways.

It is important to state that whatever role adult social care can and does play in helping people with care and support needs, this is only a small part of the way in which our caring society offers support to people. Carers (UK) report that "*there are 6.5 million people in the United Kingdom who are supporting a loved one who is older, disabled or seriously ill*".[6] As such, a person approaching social care may also be a family-carer in the community who is finding that they are feeling isolated, stressed or overwhelmed by the tasks they carry out. They too could require some care or support.

[6] www.carersuk.org/about-us/why-we-re-here

Below is a set of examples of how social care might support adults with different needs.

Arnav, 35 years old

Arnav has bipolar disorder and schizophrenia. He reached a crisis point with his mental health and was admitted to an acute mental health hospital. He stayed there for two weeks before being discharged into a residential setting. At the time of discharge, he was assessed, and it was agreed that he required 24hr support to help him manage his mental health. After six months in the placement, Arnav expressed the desire to live more independently and move into the community. His support needs had reduced since his stay in hospital and practitioners felt that he would be able to live safely and more independently in a supported living scheme.

Afsaneh, 26 years old

Afsaneh has grown up with significant care needs as a result of autism and ADHD. Afsaneh has been in care since she was four years old. She attended a specialist school and was supported by the disabled children's service. This support allowed her to create independence focussed goals and plan for adulthood throughout her teenage years. At 17, she moved from a foster care setting to a semi-independent setting and the transitions team were involved in planning her transition to adulthood. Afsaneh is now thriving in a supported living scheme. Her progress leads practitioners to believe that it would be appropriate for her to live more independently in the future and they are working with her to achieve this.

George, 55 years old

George has an acquired disability, and is a wheelchair user. He uses his personal budget from his local authority to pay for a personal assistant (PA). His PA supports him to enjoy an active social life, as well as with day to day needs such as personal care and tasks around the house.

Mary, 83 years old

Mary lives alone in her own home without any formal support. However, after falling and hurting her hip, she was admitted to hospital for a hip operation. She did not have any further acute health needs after her operation, but she would have struggled to support herself at home. She was discharged to a community hospital for rehabilitation. After three days, the team felt she was well enough to return home with regular input from the community reablement team to support her to continue her rehabilitation. After ten days, Mary was looking after herself fully independently and was discharged from the reablement team. The reablement team were able to link Mary to a voluntary organisation in her local area that could help look out for her and ensure she was staying well. Two years later, Mary suffered a stroke and was admitted to hospital again. Her family thought she would need to move to a residential home, but Mary wanted to return home. With support from the reablement team again, Mary was able to return home. After assisting with her rehabilitation, she was discharged with domiciliary carers calling on her twice a day to support with washing, dressing, and meal preparation.

How does adult social care work?

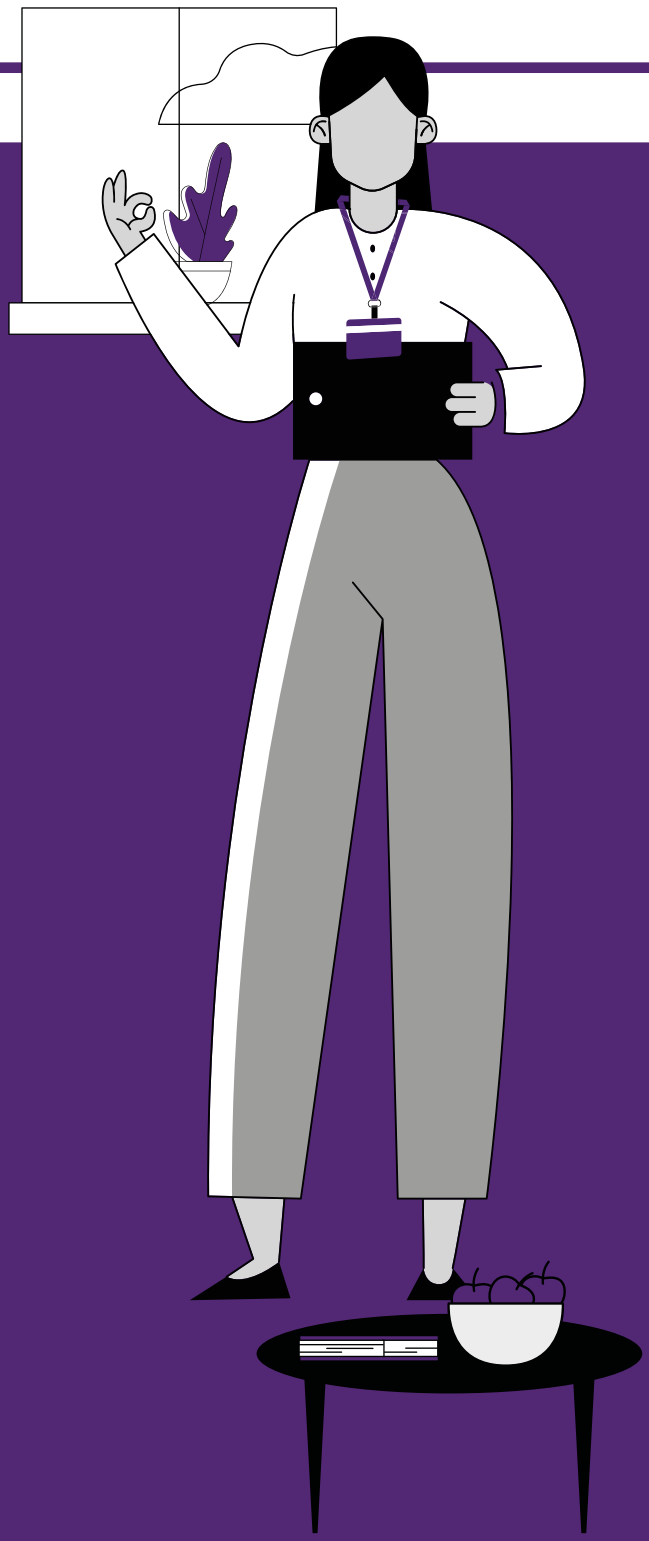
When people (or their representatives) approach a council for help, their needs are assessed and an agreed way of meeting those needs is established. Councils vary slightly in their approach to this.

Some places focus on how they can help the person to regain lost skills or find new skills through rehabilitation or recovery-based help, which is often led by therapists employed in the care system. In other places, there is a strong focus on how the family, or the voluntary and community sector can meet the person's needs.

If either or both of these offers of help do not meet a person's needs, they will be assessed for more formal services such as domiciliary care or for a budget where they can employ a person of their choice (a personal assistant).

There are places where all three of these approaches might be used to see how best a person will respond.

For some people, their needs are so high that they require more intense care and support and the assessment will identify that their needs can only be properly met by 24-hour staff on duty (be that in a residential setting or in their own home).

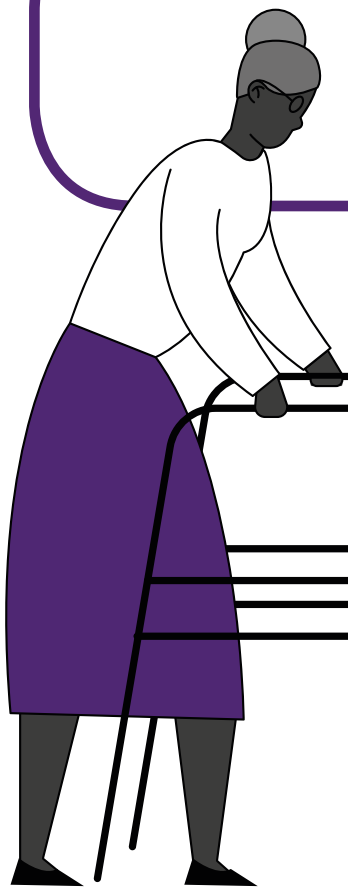


What role does an adult social care service play in the context of both the local authority and its community?

Adult social care is an important part of a local council. It has to provide leadership and structure to a number of key aspects of community life for those who experience disability, frailty, mental ill health, or other social problems. The local democratic system of a local authority holds adult social care leaders to account in their leadership and the delivery of adult social care. Locally elected councillors oversee, challenge, and help to set priorities for adult social care which, in turn, ensures these priorities are informed by the needs, wishes, and priorities of the local population.

The leadership role is co-developed in partnership with those living in local communities and mostly with those who have day to day experience of requiring some sort of support. This shared leadership may be demonstrated in many different ways through responsibility for:

- The wellbeing of everyone in their area. This includes supporting the role of public health, sport, culture and leisure services to ensure that all individuals are mindful of their physical and mental health in their day to day living.
- Ensuring that people in their local area are helped in a way that reduces their risk of requiring longer-term care and support. People should be helped in a way that prevents or delays them receiving formal care.
- Safeguarding vulnerable adults in their communities by ensuring they are protected from harm and helped when they are being exploited; sexually, physically, or emotionally harmed; or put at risk by their formal or informal (family) carers.
- Being connected to their local neighbourhoods and communities so that they can assist people in making the best use of the voluntary and community sector resources that are available.



Finally, adult social care encourages the wider council to ensure that the breadth of services offered are inclusive and sensitive to people's needs. For example, that the place where people live and work is accessible (especially for those in wheelchairs); that sporting venues, libraries, transport, adult education, and other community resources are inclusive and welcoming to people who have support needs so they can participate in all the activities on offer; that shops and cafés/restaurants are aware of the needs of those with disabilities or dementia and that all community activity is open and inclusive to anyone whatever their personal circumstances. The council ensures that there is the right range of appropriate housing, sport, recreation, leisure, and community resources available for all its population. One area that was raised throughout this programme of work was housing, and the associated relationship between a county authority and district and borough councils where there is two-tier local government. This is discussed further in *Section D*.

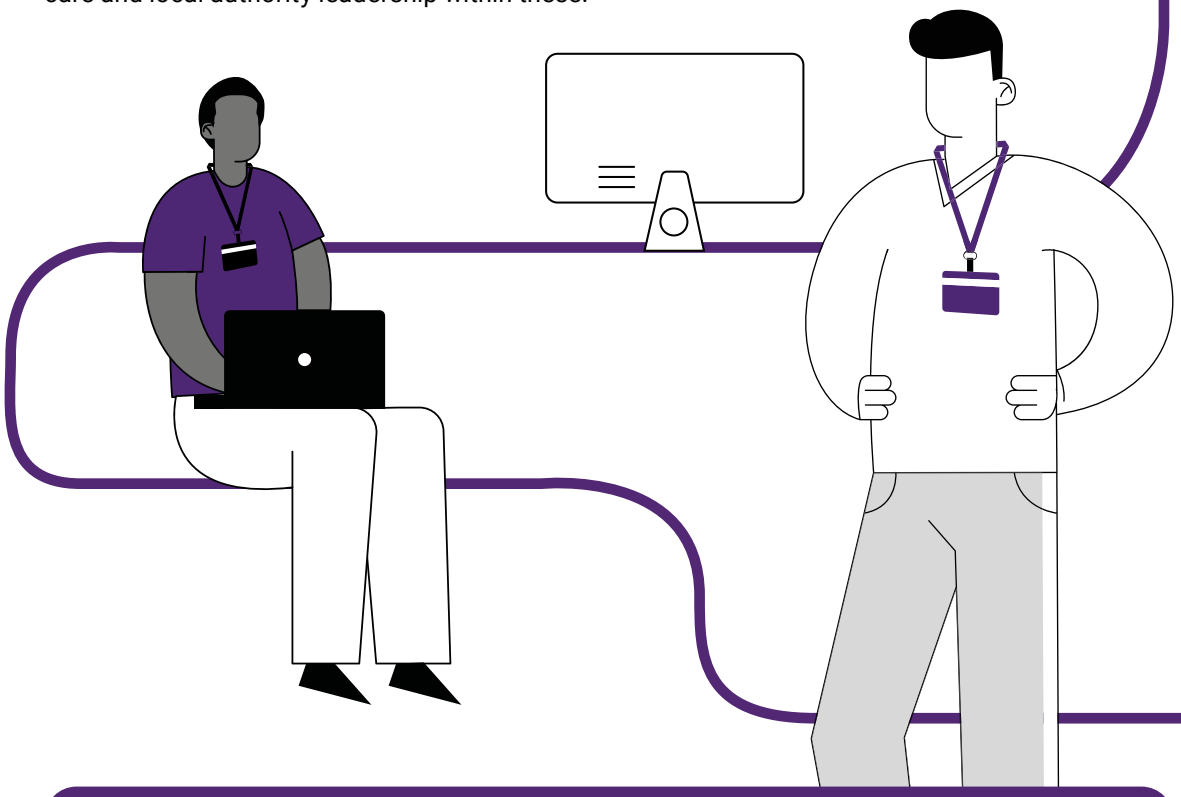
The leadership of adult social care plays a very important role in ensuring that all people, whatever their circumstances, are able to access places, are not discriminated against and have the same rights to community services.

Section B

The Foundations of Reform

The national and local foundations necessary for the optimised model.

To achieve an optimised model, there are a set of foundations that need to be in place at a national and local level. These foundations include a shared vision and trusting relationship between central and local government, underpinned by the right national funding arrangements; structures; reporting; governance; and communication – all of which are essential to empowering local systems to optimise adult social care. It is also important to reflect on the national direction of health and social care towards Integrated Care Systems and Primary Care Networks, and the role of social care and local authority leadership within these.



A fair and collaborative partnership between central and local government is essential to enabling effective delivery of adult social care. In the context of the current challenges facing adult social care and the wider debate on the future direction of reform, this section outlines the key foundations that need to be in place in order to deliver the optimised model of delivery described in this report.

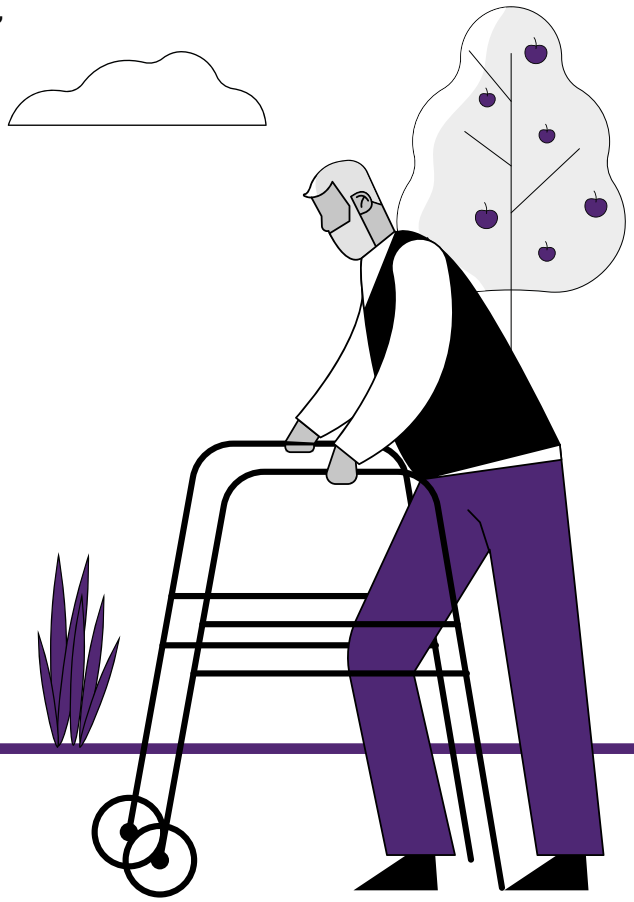
Foundation 1

A positive profile for adult social care that is fully understood and valued by decision makers, both in central and local government, and importantly by the public.

The consequence of the lack of understanding of adult social care.

The COVID-19 pandemic has increased the visibility of adult social care, but there remains a general **lack of understanding of what adult social care is and how it is delivered**. For a fleeting moment, there was nearly parity of esteem with the NHS as the nation clapped for carers, all carers, and recognised the challenges faced by the social care workforce in keeping vulnerable people safe and maintaining their quality of life. However, it remains that the full scope and role of social care – described in *Section A* – is not always commonly understood, or indeed fully appreciated, either by the general public, or by those in positions of power.

Although well intentioned, decisions that are taken about adult social care without a detailed, local understanding of service delivery, can have unintended consequences. For example, there can be frustration at the ability of local authorities to directly influence care provision. However, the provision of care is a complex issue with a range of variables that influence what happens locally, combining individual decisions by entrepreneurs to establish care businesses with local authority decisions to procure or commission other local services. This is made even more complex if these services are providing support to self-funders (individuals who privately fund their care).



Visibility and stigma of social care

There can be a **negative societal perception of social care**, where individuals seek to avoid engaging with the sector. This can result in their situation escalating to the point of needing a more intensive (and expensive) intervention, and the opportunity to prevent or delay this need being missed.

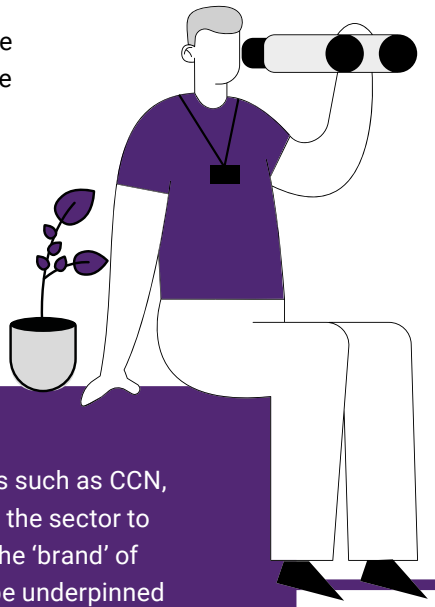
While the COVID-19 pandemic has increased the visibility of adult social care, a number of people who were engaged as part of this programme of work (including those working in local authorities as well as individuals with lived experience) cited a stigma attached to needing social care. They felt that the sector needs to look at how to 'rebrand' social care, in part to give social care workers more respect in society. This means changing the culture, so that social workers and other care workers are accorded a status and value more akin to that afforded to GPs or dentists, who are approached by the general population to help them make the right decisions over their health and welfare.

As explored in *Theme 7*, **the social care workforce is nationally undervalued**. It is difficult to describe an aspirational career, or even provide appropriate remuneration for the effort and sacrifice of staff. In part, doing so will mean improving the status of social care to be more in line with the NHS, where there is a stark discrepancy.

Raising the profile of adult social care

The **profile of adult social care** therefore needs to be raised so that people feel there is no stigma attached to approaching these services, and for the whole workforce to feel proud to work in the sector, and see a clear route to career development and progression.

In this regard, the NHS serves as a useful case study, especially in the way that its perception has developed through the COVID-19 pandemic.



The work of regional and national representative organisations such as CCN, the LGA, ADASS and ACCE, as well as others working across the sector to represent the voice of adult social care, is vital in ensuring the 'brand' of social care is clear and positive. However, this profile should be underpinned by a shared vision for adult social care, deeply understood both locally and nationally, that supports and enables individuals to live as independently as possible. These values and beliefs are explored further in *Section C*.

Foundation 2

Local delivery supported by national oversight.

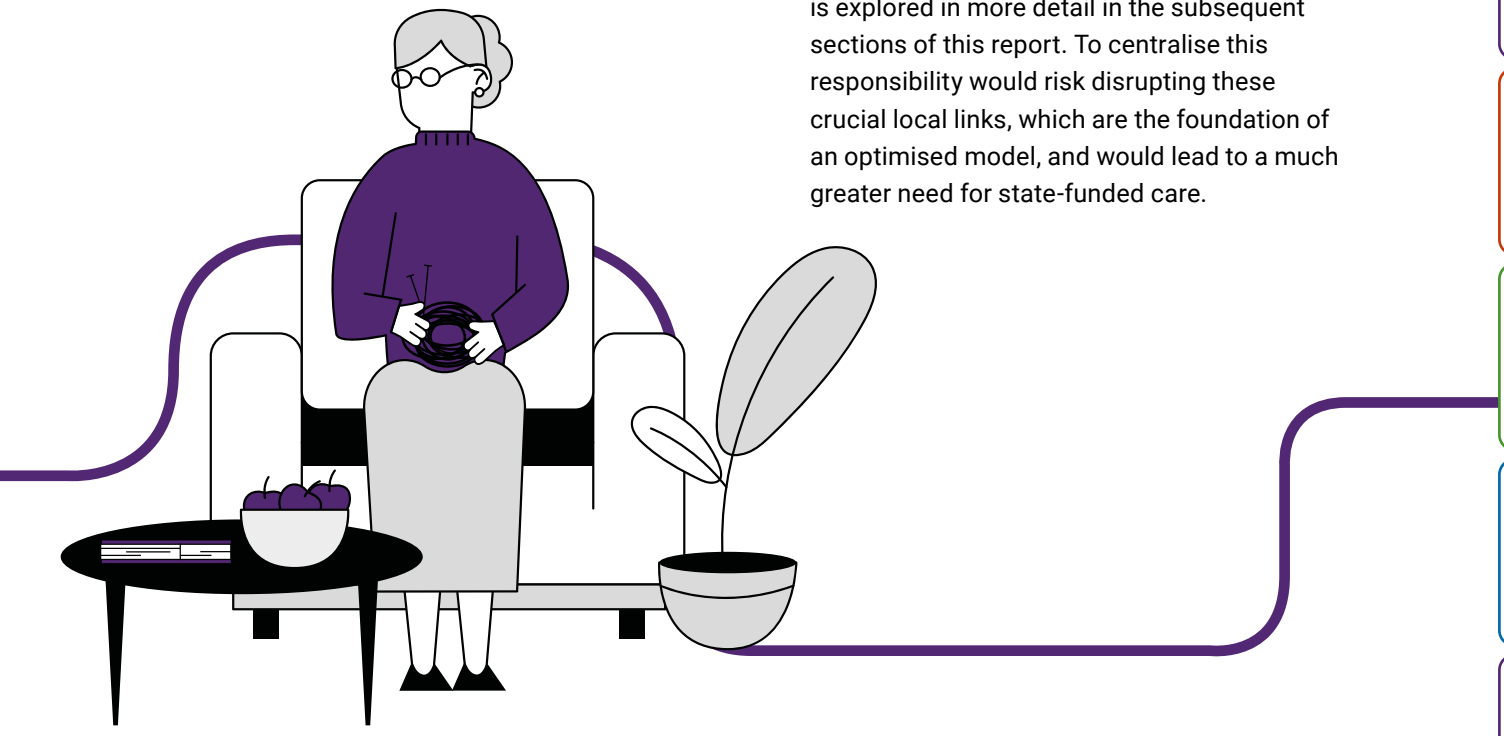
Some commentary in the immediate wake of the pandemic has suggested that the solution to the present adult social care crisis would be to create a National Care Service, or to transfer responsibility partly or fully to the NHS. In contrast, and based on the evidence set out in this report, the optimised model is predicated on the understanding that social care is fundamentally locally centred and embedded in communities.

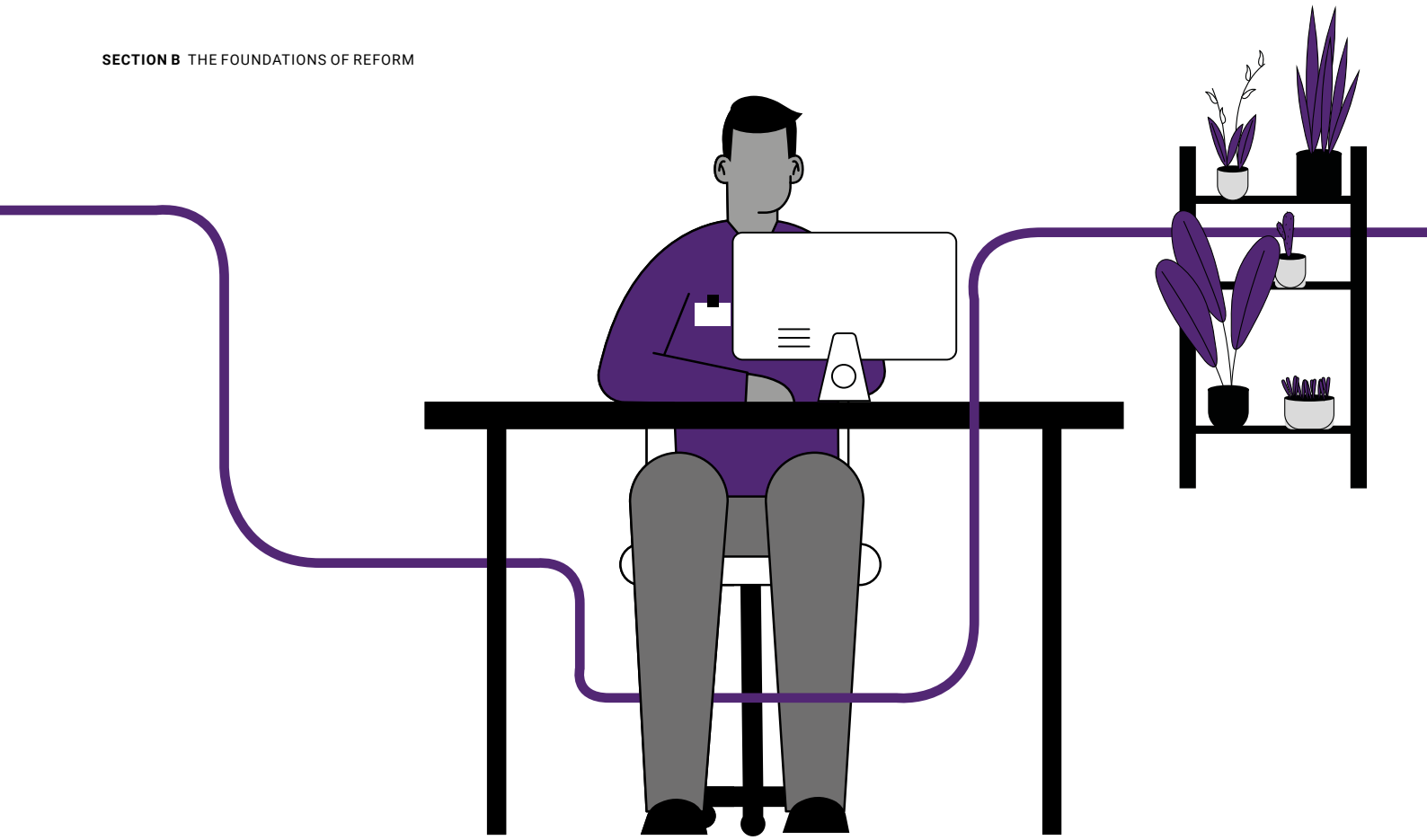
A centralised or health-originated model would risk under-estimating the breadth of support which adult social care incorporates (as described in *Section B*) – it is far more than simply those issues most visible during the present pandemic such as care homes or transfers of care from hospital, important as they are.

So much of social care is about prevention and enhancing long-term wellbeing. This is in contrast to the NHS, where much of the focus is on responsive acute services.

Health services more easily lend themselves to a national system of delivery. The vast majority of healthcare is provided via formal services by professionals, whereas for social care, only a small proportion of the overall care and support is delivered in this way. The majority is provided informally through families, informal carers and voluntary and community groups and assets.

Local government is uniquely placed to effectively coordinate and manage this overall ecosystem, with deep roots in informal care networks that exist in a community. This role is explored in more detail in the subsequent sections of this report. To centralise this responsibility would risk disrupting these crucial local links, which are the foundation of an optimised model, and would lead to a much greater need for state-funded care.





Therefore, local and central government both have critical roles to play in achieving an optimised model for adult social care. They have separate responsibilities, but a shared goal – to deliver the best possible outcomes for individuals and society in the most cost-effective way:

- **Local government's role** is to have a deep understanding of its local population's unique needs; the assets in its local community; and the resources available in the local care market. Local authorities then use these assets and resources efficiently, effectively, and sustainably to meet the population's needs.
- **Central government's role** is to provide funding, information, support, and legislative frameworks that empower local systems to deliver successfully, whilst knowing when and how to intervene.

This report seeks to develop an optimised model of delivery by exploring the present experience of local authorities as the lead agency for social care, in collaboration with local partners. The wealth of expertise, practice, and data provides a clear outline of how a reformed system can achieve improved outcomes for people, at a sustainable cost, thus making it fit for the future. This model has local delivery at its heart.

Developing the right governance and assurance mechanism

Historically, national data and reporting have not helped local systems understand their relative performance, nor provided central government with adequate clarity on those local areas in need of additional attention. While a performance framework currently exists, it does not provide the necessary level of assurance on outcomes achieved or value for money. In addition, the framework does not promote the right behaviours, for example by overly focussing on system capacity rather than the quality of outcomes achieved.

A shared understanding of both local and national performance could begin to create the conditions for parity and help each party to understand how they best play their role in improvement and innovation. An outcomes-based performance framework would serve to highlight local areas of innovation or best practice that could be shared, tailored, or adopted as appropriate.

Democratising this information is a critical enabler of building trust in the relationship. Data and performance information needs to flow both ways, rather than being seen to be held and used centrally, without local consultation. While not outcomes-focused, and predominantly targeted at residential care settings, the ability of local systems to access their own reported data via the Capacity Tracker provides a glimmer of hope that there is an opportunity for local empowerment through democratisation of data. However, this ought to be the beginning of the journey.

Moving to an outcomes-based performance framework, aligned to the values and beliefs of promoting independence, could offer a positive way to unify both parties around a common objective. This report provides an articulation of what optimised adult social care looks like, providing a basis for future measurement and reporting models.

Why is demand for adult social care changing?

Life expectancy has soared from 68 years to 81 years between 1950 and 2020.[7] Between 2009 and 2019, the number of over 65s increased by 23% across England and by 26% in CCN member authorities.[8] The number of over 85s increased by similar proportions; 20% and 23% respectively. There were 1.16m more individuals aged over 65 in CCN member councils, 61% of the total national increase. Even though older people are healthier than ever in older age, as a whole population a larger number of people are now more likely to need at least some social care during retirement. Similarly, miraculous advances in healthcare have enabled people with chronic health conditions to live lives well beyond what could have been expected seventy – or even ten or twenty – years ago. For instance, there are now more working age adults with disabilities living longer, and with more complex needs, and a cohort of people with mental health needs who require support in their community. This is a particular challenge, since supporting adults with a learning disability has the highest unit costs.[9] In CCN member councils, 34% of all service costs were on learning disability support for adults 18 or over.[10]

Over the last decade there has also been a number of new challenges that those involved with adult social care have had to face, with both new responsibilities and new pressures. These include growing numbers of 'safeguarding' cases; new responsibilities under Deprivation of Liberty Safeguards (DOLS); and a recognition of people who have not had their care needs met under the previous arrangements, such as younger adults who are assessed as being on the autistic spectrum.

To meet these challenges, authorities have responded, and practice has developed over the years. For example, the growth of reablement services to maximise independence and the introduction of strengths-based practices have helped people achieve more independent outcomes, and therefore offset some of this demand growth.

It must also be recognised a high percentage of older people have to pay for the costs of their own care (following a means test) which has unique implications for the reform of care services. The proportion of self-funders in county areas is significantly higher on average, with previous research suggesting an average of 53%, with some areas as high as 80%.[11]

Some older people therefore do not approach councils for advice before they make a decision about the care they may need. This means that an older person may establish themselves in a care home prematurely, but paying for their care. Some of these people will then run out of money and therefore need support from adult social care. This is a particular challenge in those councils where there is a good supply of care homes and a number of wealthier older people.

Some county authorities have experienced pressure on their budget as a result of the need to fund these places. Moreover, providers are at risk due to the continuation of a funding model which is so heavily reliant on cross-subsidisation of private fee payers to compensate local authority fees, which are on average 40% lower. The disparity in fees has led to an estimated £670 million 'fee gap' in county areas alone.[12]

[7] www.macrotrends.net/countries/GBR/united-kingdom/life-expectancy

Foundation 3

Developing the right funding model.

Adult social care has experienced more austerity measures than most parts of the economy (2010-2020). The Association for Directors of Adult Social Services (ADASS) reported that services have made a total of £7.7 billion of savings from their budgets since 2010.[13]

At the same time, independent analysis for CCN conducted prior to this programme of work shows the costs of providing care at the same standard as in 2015/16 could increase by £6.1 billion nationally by 2024/25. It is estimated that CCN member councils account for 48% (£2.9 billion)[14] of this total increase in costs and that in 2020/21, government funding was meeting 45% of the estimated cost of providing services, and only 33% in county areas.[15]

In 2020 a new challenge has had to be met by social care – COVID-19. People with long-term health conditions are particularly vulnerable to the virus, and there has been a higher death rate amongst older people, including those residing in care homes.

The financial implications of COVID-19 have exacerbated these pre-existing cost pressures for local authorities and providers. As of November 2020, councils in England were reporting additional adult social care costs of £2.9 billion in 2020/21.[16] While the majority of these short-term costs have been funded, research has suggested that there will be medium-term 'legacy costs' from the pandemic which could become embedded, including uplifts in provider fees.[17]

Moreover, under-occupancy in residential care could create further instability in the residential market, impacting the viability of providers and driving up unit costs. While the pandemic has put short-term pressure on demand for care in people's own homes (domiciliary care), going forward it will be important that the provider market continues to rebalance, reinforcing the continued increase in the use of domiciliary care over residential settings. Whilst the implications of the pandemic have been devastating for many, rebalancing could be a positive step in reducing the number of individuals being placed in high dependency settings prematurely.

There is no doubt that any reformed system should be based on **stable finances and a funding model that promotes the right behaviours** by those who commission care services.

8 Analysis on ONS data www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland
9 Unit costs from "Adult Social Care Activity and Finance Report, England - 2018-19" – NHS Digital www.digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2018-19
10 Independent review of local government spending need and funding May 2019 Summary Report: http://www.countycouncilsnetwork.org.uk/download/2258/ and Technical Report: http://www.countycouncilsnetwork.org.uk/download/2262/
11 LaingBuisson (2016), County Care Markets www.countycouncilsnetwork.org.uk/download/122/, p.21
12 LaingBuisson (2017), County Care Markets update www.countycouncilsnetwork.org.uk/download/1179/
13 www.adass.org.uk/media/7295/adass-budget-survey-report-2019_final.pdf
14 Independent review of local government spending need and funding May 2019 Summary Report: www.countycouncilsnetwork.org.uk/download/2258/ and Technical Report: http://www.countycouncilsnetwork.org.uk/download/2262/
15 CCN Spending Review Submission, p. 38 www.countycouncilsnetwork.org.uk/download/3248
16 www.gov.uk/government/publications/local-authority-covid-19-financial-impact-monitoring-information
17 Grant Thornton: Analysing The Impact of Covid-19 on County Authority Finances www.countycouncilsnetwork.org.uk/download/3052/

Adult social care is delivered locally, and while most of the funding for care services is raised through local taxation, central government funding is, and will remain, critical. Decisions made centrally have a significant impact on both the quantum of funding local authorities have access to, as well as, to a certain extent, what they need and are able to spend it on. This creates a tension that makes **adult social care both a local responsibility and a national responsibility.**

The way in which adult social care funding is allocated to local authorities (normally on an annual basis) makes it **difficult to plan strategically**, especially when set in the ever-changing context of wider local government funding and income. While adult social care has always received temporary grants, in recent years there has been an increase in piecemeal funding initiatives. Temporary grants currently make up 59% of all adult social care funding from central government.[18] This makes it extremely difficult for adult social care to plan with certainty and leads to more short-term thinking and planning. **The effects of this can be felt beyond the adult social care directorate, with the local authority having to work across the breadth of their budget to make up any shortfall, which can result in further cuts to 'non-essential' services.** This is in marked contrast to the NHS, which receives a long-term settlement.

Local authorities are also required to **submit a balanced budget every year**. Whilst this drives clear financial accountability, it can also limit local government's ability or appetite to invest in longer-term initiatives that will sustainably reduce costs over a period of time. This is in contrast to the NHS, which is able to run deficits over a number of years. This means that **change efforts become focussed on achieving short-term, immediate savings**, rather than longer-term sustainable transformation.

This leads to a proliferation of 'pilots', funded through specific grants, which do not have the right long-term backing to be fully developed, understood, and subsequently rolled out if successful. There is also a degree of inefficiency associated with this funding model. In order to access a particular funding pot, there is an **associated bureaucracy** around evidencing particular outcomes or conditions which detracts from the ability to deliver the service.

This also means that adult social care cannot **engage with providers and markets to give them any certainty of income**, which makes it more difficult to build long-term market development plans or negotiate longer-term contracts with providers as well as negatively impacting on workforce recruitment and retention. Authorities are also tempted to add more to their reserves, rather than invest in service delivery, to provide security against future uncertainty.

A funding model which gives longer-term certainty would promote local accountability and support local leaders to make decisions in the best interests of the local population. This will enable local authorities to tailor services to their unique demographic, delivering good outcomes at a sustainable cost through the optimised delivery model described in this report.

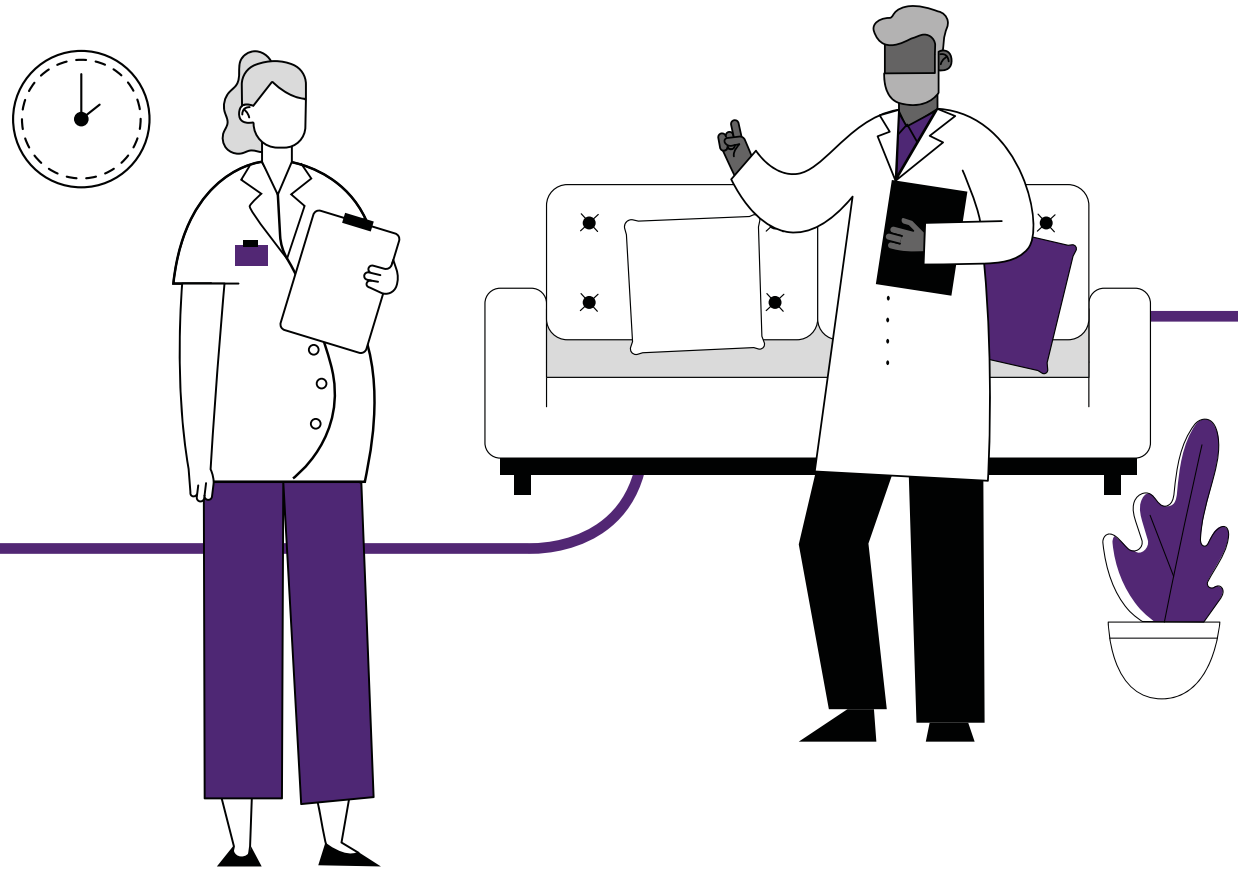
[18] www.countycouncilsnetwork.org.uk/wp-content/uploads/dlm_uploads/CCN-Submission-CSR-2020.pdf

Foundation 4

A whole system approach and partnerships with Integrated Care Systems.

Over the last decade, through the formation of Sustainability and Transformation Partnerships (STPs) and now Integrated Care Systems (ICSs) and Primary Care Networks (PCNs), there has been a push towards integrated health and social care systems. The view is that fragmentation leads to poorer outcomes at a greater cost for the population. This is a significant challenge, as even before wider integration is considered, local authorities and the NHS themselves have to face the challenge of fragmentation within their own organisations.

There have been efforts over the past decade to begin to address the disparities between health and social care. Most visibly, this is represented by the creation of the Department for Health *and Social Care* recognising the importance the Government has placed on social care. 'Integration for integration's sake' will not provide an answer. For the system to become truly effective, appropriate integration with other local services may provide a way forward. To achieve the best outcomes at a sustainable cost, any integrated service should be built with a focus on people and their outcomes. This is not only for health and social care integration, but includes ways of working with housing; children's services; even business and economy.



The principles of Integrated Care Systems and Primary Care Networks, and the role of adult social care in that context

The NHS long-term plan sets out the vision for ICSs, built off the foundational building blocks of PCNs. The plan to implement ICSs relies on **governance changes and improved wider system relationships**. It is not (currently) strengthened with strict legislation, policy or more profound changes to organisational form or function. The recent ICS consultation paper (December 2020) does lay out a potential strengthening of structure and legislation for NHS bodies but does not bring any new 'harder' positions on local authorities' responsibilities or budgets.

Many of the health and social care leaders who were engaged as part of this programme of work shared the view that without these more fundamental changes to legislation, policy, or organisational form, delivering the opportunities that ICSs present will be **highly dependent on the strength of local relationships, shared values of leadership and equity of voice**.

Equity was discussed in depth with leaders from both social care and health, who agreed that **parity of esteem, parity of funding models and parity of brand** will be essential for organisations to truly work in partnership within the ICS model. This will help ensure neither side becomes a poor relation in this ongoing relationship, which brings with it the inevitability of degraded services and outcomes. This is achieved when authorities see it as their role to **work as part of the ICS system leadership**. However, they also cited that one of the challenges to achieving this alignment will be the different geographical building blocks.

Through engagement and discussion with leaders, many viewed **PCNs as a real opportunity** for social care to make a long-term impact on outcomes. However, they reiterated the need for more than just basic structures and multi-disciplinary team (MDT) working.

" Putting a social worker in an MDT meeting once a week will deliver nothing. However, creating a clear purpose for an MDT, with a clear mandate, a clear role description, and clear measurables could see genuine impact, preventing escalation of need and even admissions ".

What do we mean by Integrated Care Systems and Primary Care Networks?

There are currently 18 Integrated Care Systems (ICSs) in England, with the rest of the country covered by Sustainability and Transformation Partnerships (STPs). The ambition is for all areas of England to be covered by an ICS by April 2021.

The objective of ICSs is to bring together providers and commissioners of NHS services, local authorities, and other partners in a geographic area to work collaboratively and integrate care to meet the needs of the local population.

Primary Care Networks are set out to be the building blocks of an ICS, enabling placed-based population health and care management centred around populations of 50,000.

"Primary Care Networks build on the core of current primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care. Clinicians describe this as a change from reactively providing appointments to proactively care for the people and communities they serve. They are small enough to provide the personal care valued by both patients and GPs, but large enough to have impact and economies of scale through better collaboration between practices and others in the local health and social care system".[19]

Social care leadership in PCNs and as an ICS requires building **strong local relationships with health partners**; investing the time and effort into ensuring there is a **common purpose, mandate and accountability** for joint teams; and building, **coordinating and navigating community assets** to fundamentally reduce the presenting need of the future population.

Structures such as PCNs, ICSs, and STPs are strategically aligning health and social care at regional and local levels more closely than ever. The ongoing NHS consultation looking at the next steps for ICSs offers a great opportunity to further develop the infrastructure around a social care system and get it right. This opportunity will only be realised in terms of better outcomes for the population if the structures, processes and governance are underpinned by a strong vision and common mandate, which is led by all partners, national bodies, and most importantly, understood and welcomed by the public itself. The optimised local delivery model presented in this paper is designed to support and enable better collaboration at a local level, and is consistent with this wider direction of travel.

[19] www.england.nhs.uk/primary-care/primary-care-networks/

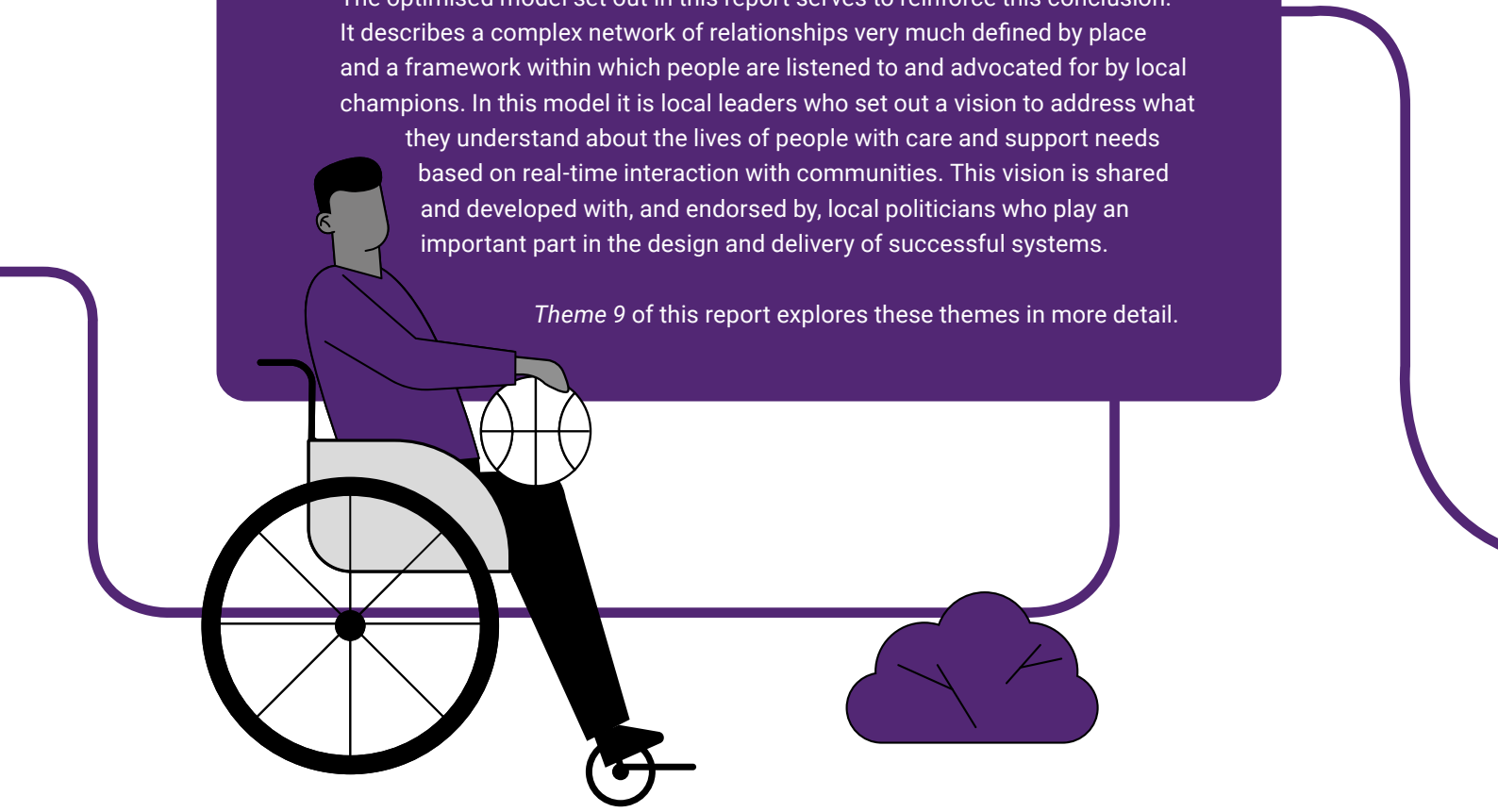
A whole-council approach

Delivering adult social care is not only the responsibility of the adult social care directorate within a local authority. The far-reaching nature of the system and its intersection with a host of other services – most notably health, but also housing, benefits, children's services, the voluntary and community sector and many others – makes partnership working across different agencies not just desirable, but completely essential. Collaborating across the whole local authority to use the wider service remit of the council, with partners across the health and care system – and, crucially, with individuals – enables a holistic, effective, and efficient approach to delivering care.

Given that good adult social care systems require such co-production and cross-agency buy-in, it is important that the leadership of the system is situated in a way which can best provide local leadership as well as the necessary connections to the local community. Local authorities are well placed to draw together a wide range of stakeholders from across the local area. Historically, Health and Wellbeing Boards have been established as a key conduit within local authorities to attempt to lead this system coordination, seeking to bring a focus on tackling the wider determinants of poor health that lead to more complex needs in later life.

The optimised model set out in this report serves to reinforce this conclusion. It describes a complex network of relationships very much defined by place and a framework within which people are listened to and advocated for by local champions. In this model it is local leaders who set out a vision to address what they understand about the lives of people with care and support needs based on real-time interaction with communities. This vision is shared and developed with, and endorsed by, local politicians who play an important part in the design and delivery of successful systems.

Theme 9 of this report explores these themes in more detail.



Section C
Values and Beliefs

People who use social care services say,

"Don't we all want to live in the place we call home with the people and things that we love, in communities where we look out for one another, doing things that matter to us?"

- Social Care Future[20]

This report seeks to present an optimised model for adult social care reform. But optimised for who? In what way? To achieve what outcomes? As with any debate, there will be differing views which underpin people's perspectives. It is important to state upfront the **values and beliefs** which form the basis for this programme of work, and therefore how an optimised model of adult social care has been explored.

These values and beliefs are focussed on promoting people's independence. This approach states that the best outcome that can be achieved for an individual is one which enables them to live as independently as possible, whilst remaining safe from harm. Within this context, it is very important that a proper balance is always achieved between safeguarding the interests of the individual and maximising their potential for change to improve their situation.

This is achieved by taking a **strengths-based, or asset-based approach**. This approach focuses on what an individual can do without formal social care support, by using the assets they have themselves (their own, personal strengths), in their informal network (such as their family or friends) and their local community. It is only once this has been considered that formal care and support is used to support an individual with what they cannot do.

Promoting wellbeing, promoting independence, and supporting independence is not only best for individuals – it is also a cost-effective way of meeting the needs of the population, as more independent individuals typically require less care.

These values and beliefs recognise the importance of personalisation and choice. The best way to deliver them is by working alongside those who need care and support to help them achieve the goals that they define for themselves. These might be long-term goals such as to gain employment or housing, or shorter-term goals such as to cook for themselves, or to become more active. The assessment of someone's assets, strengths and goals ensures that the support plan is personalised in line with those elements, as defined by each person.

However, for some people, their life experience means that they have low expectations of themselves or of the way in which they might be helped. Sometimes it can be relatives and those who love the person who have less ambition for them, albeit for the 'right reasons' in a very caring and protective way. It is right that we listen to these concerns, but also where it is appropriate, professionals can play a role in helping individuals – and their families – to lift their eyes beyond their current horizons and to assist them to aspire for more than they think they might achieve.

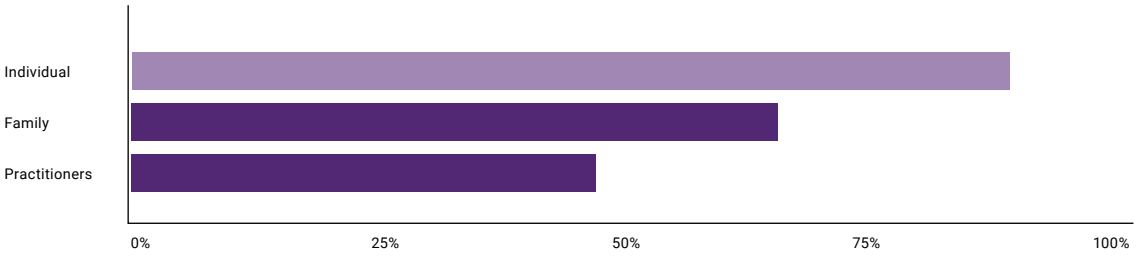
[20] www.socialcarefuture.blog

Insight

An individual's most preferred outcome is often the most independent.

Promoting independence is an important aspect of putting people first and this report will explore how this is being achieved in innovative ways and at scale. The diagram below is taken from a study of acute and community hospital discharges in one county authority.

72 individuals were asked: "When you get discharged from this hospital stay, where would you like to be discharged to?". For the same individuals, expectations were collected from their **families** and several **practitioners** across the health and social care teams who were involved in their discharge planning.



Proportion of cases where the preferred option was 'home'

This study demonstrates that the majority of individuals wanted to return to their own home. It also shows that their families and the health and social care practitioners involved in their discharge did not always agree with the individuals' expectations. This exemplifies the opportunity for more creative, risk-aware approaches to support planning, drawing on all possible community assets to help an individual achieve their wishes by maximising their independence.

Listening to the individual was an important theme that came through during engagement with individuals and their networks as part of this programme of work. Firstly, they noted that the level of independence which someone aspires to, or can be achieved, will mean very different things to different people. For one person, it may mean living independently in their own home. For another, they will be safer in residential care, but independence of mind is important, so they value being able to choose their own meals. For others it may mean gaining independence from a challenging family environment, finding a way to manage their mental illness so they can return to work, or to live independently following a transition from children's services to adult social care. Ultimately, they reiterated the importance of placing the individual at the centre and used the phrase "*no decision about me, without me*".

Section D

An Optimised Model of Delivery

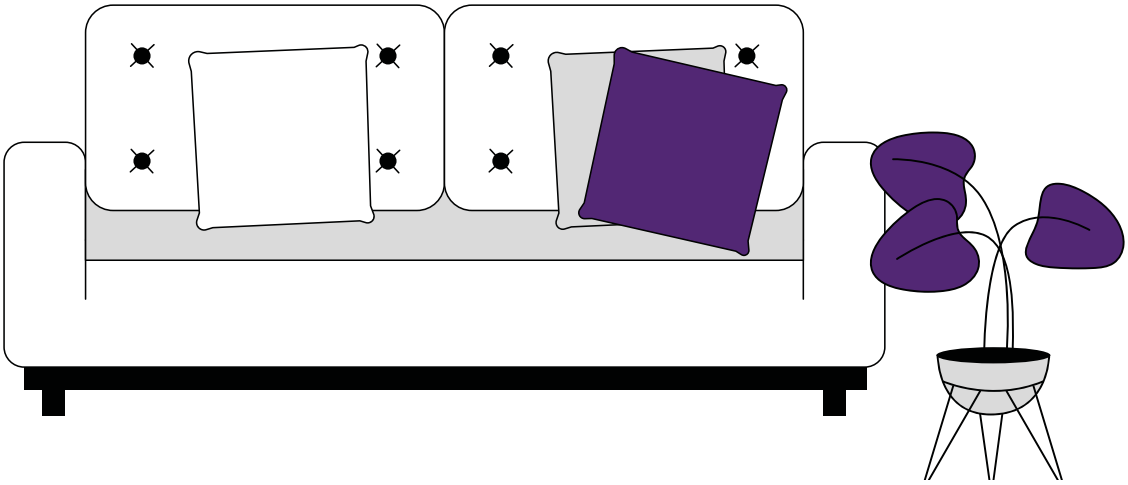
To achieve these values and beliefs consistently, across the wide and varied populations, geographies and demographics of individual county authorities, requires a carefully optimised and resilient model of delivery.

This programme of work has collated the real experiences and practice of county authorities to create a blueprint for the foundations of such a model upon which overarching reform of the adult social care system can be built on.

This optimised model is based on a delicate balance of achieving good independent outcomes for individuals while keeping them appropriately safe. It requires the ability to innovate, whilst holding onto those principles that are so vital to ensure that all adults, no matter their care or support needs, are able to live fulfilling lives in their community.

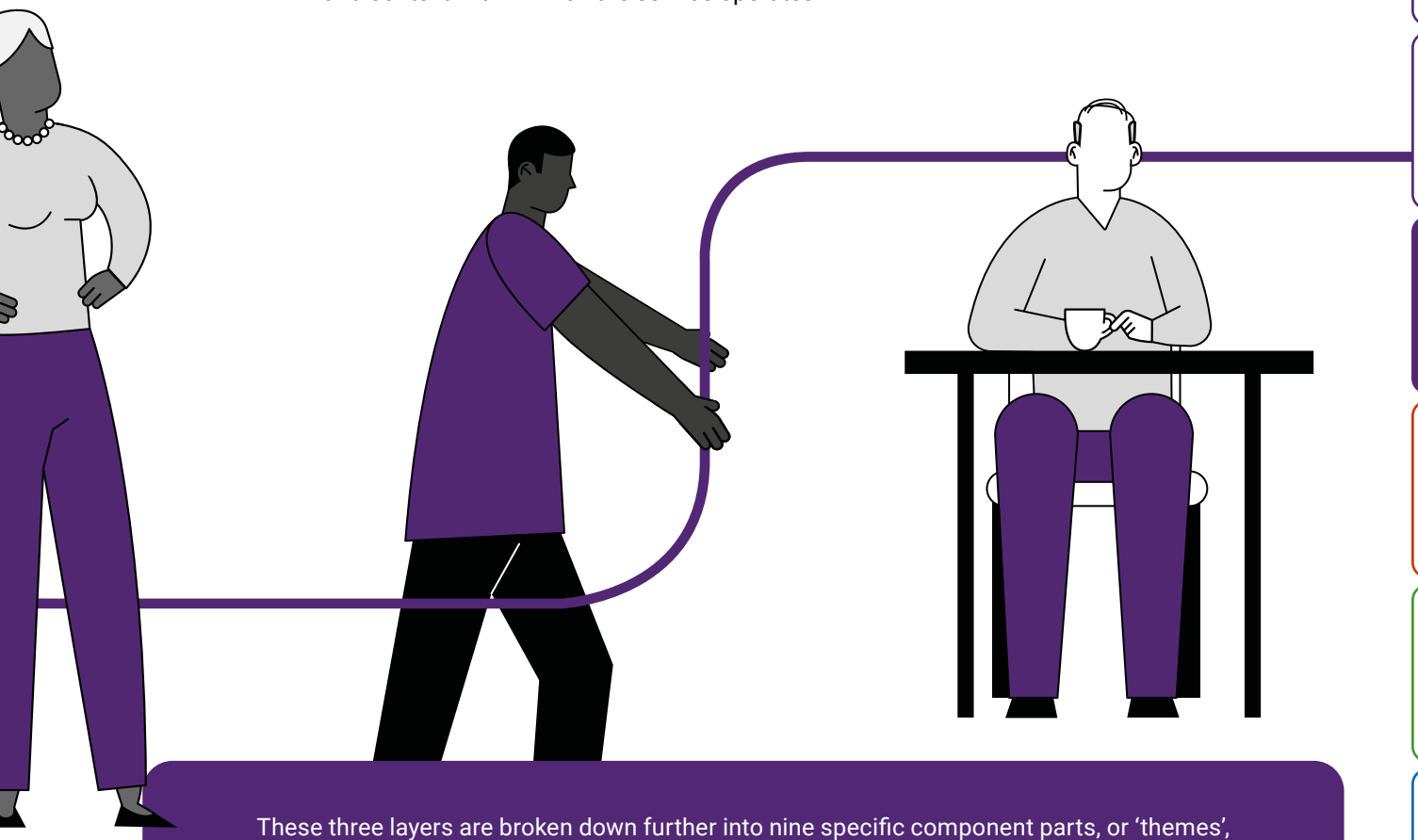
The basic idea that underpins this model is that designing and delivering adult social care needs to start from the fundamental principle of achieving the best and most independent outcomes for individuals. From this core, service 'layers' can then be built out, with each layer supporting, enabling, and reinforcing the values and beliefs.

These layers are essential, because coordinating thousands of staff across a dispersed geographic area – the reality for large county authorities – requires structures and processes which enable the easiest route to take to be the one that achieves the best outcome. This approach ensures that 'form follows function' and the system is set up in the best way to achieve the values and beliefs.



There are three major layers which will be considered:

- **Service delivery enablers:** the factors associated with the direct delivery of services, be those the practitioners or partner organisations involved in providing services, the model of practice they employ or the way that pathways are constructed.
- **Organisational enablers:** the factors which wrap around and support service delivery, including the use of digital and technology, workforce, culture, leadership and strategic commissioning.
- **Organisational and structural form:** the fundamental structures and context within which the service operates.



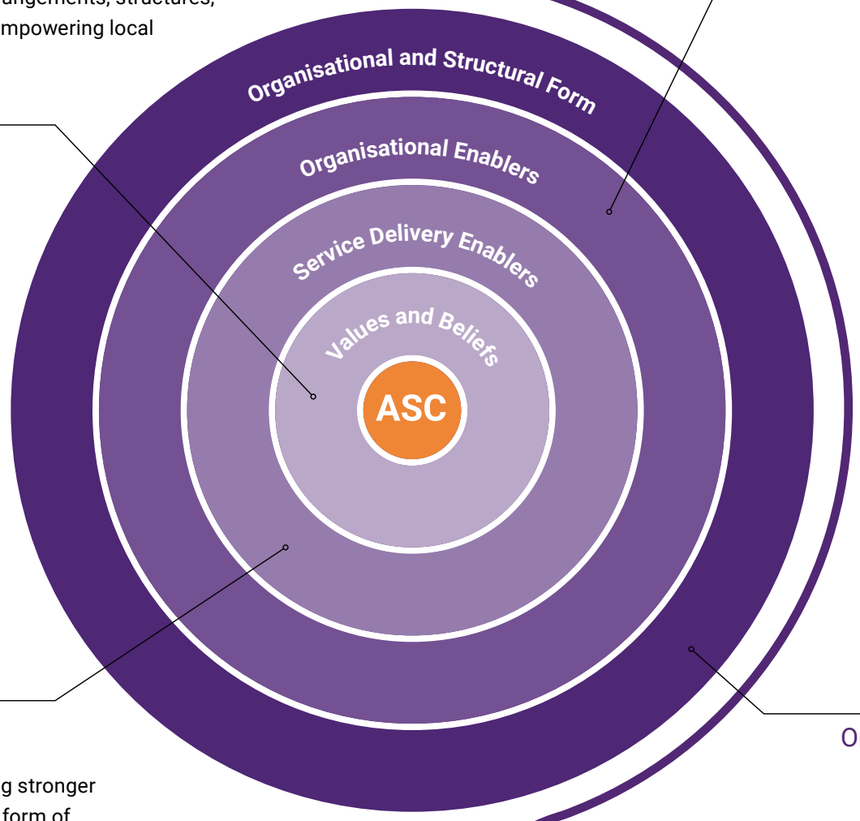
These three layers are broken down further into nine specific component parts, or 'themes', comprising the optimised local delivery model. The main body of the report systematically details the importance of each of these component parts, which together create a detailed description of how an optimised local delivery model can operate in practice.

Foundations of an optimised model

In order to achieve the optimised delivery model, there are a set of **foundations that need to be in place at a national and local level**. These include a shared vision and trusting relationship between central and local government, underpinned by the right national funding arrangements; structures; reporting; governance; and communication – all of which are essential to empowering local systems to optimise adult social care.

Values and Beliefs

The values and beliefs which underpin this programme focus on **promoting wellbeing, promoting independence and supporting independence**. These values and beliefs recognise the importance of personalisation and choice. The best way to deliver them is by working alongside those who need care and support to help them achieve the goals that they define for themselves. However, for some people, their life experience means that they have low expectations of themselves or of the way in which they might be helped. It is right that professionals listen to these concerns, but also where it is appropriate, they can play a role in helping people to aspire for more than they think they might achieve. This results in a service that is delivered with a shared vision to help individuals to set their own goals, build on their strengths, make a positive contribution to their local community, and live as independently as possible.



Service Delivery Enablers (p43-85)

1. The right **provision of services** promote independence by building stronger and more resilient communities, helping an individual with some form of recovery, rehabilitation or reablement or by effectively supporting those individuals who have longer-term care needs.

2. The right **pathways** – which are designed from the perspective of the individual rather than the service.

3. The full buy-in and support from **local partners and providers** is essential to achieving the values and beliefs.

4. Strengths-based practice can only be delivered consistently in a working environment which is fundamentally designed with this approach in mind, and by ensuring **practitioners feel supported, empowered and challenged**.

Organisational Enablers (p86-119)

5. Exceptional **leadership and a consistent culture** are the key enablers to embed the right values and beliefs throughout the organisation.

6. Embracing **emerging digital opportunities**, whether through the use of technology, systems, data or analytics, presents a compelling opportunity for services to improve outcomes for people at a sustainable cost. This requires an environment which promotes **digital innovation**, alongside a clear understanding of the desired impact of any investment on the end user (whether staff or person).

7. While the COVID-19 pandemic has raised the profile of the adult social care sector, there remains a significant challenge locally and nationally to ensure the **right workforce** is recruited and retained by making working in adult social care (whether as a professional or frontline carer) a desired and rewarding career.

8. To meet the needs of the population, authorities are best equipped to work with the provider market, achieve the best outcomes for individuals, and do so in the most cost-effective way, when they have an effective **strategic commissioning function**.

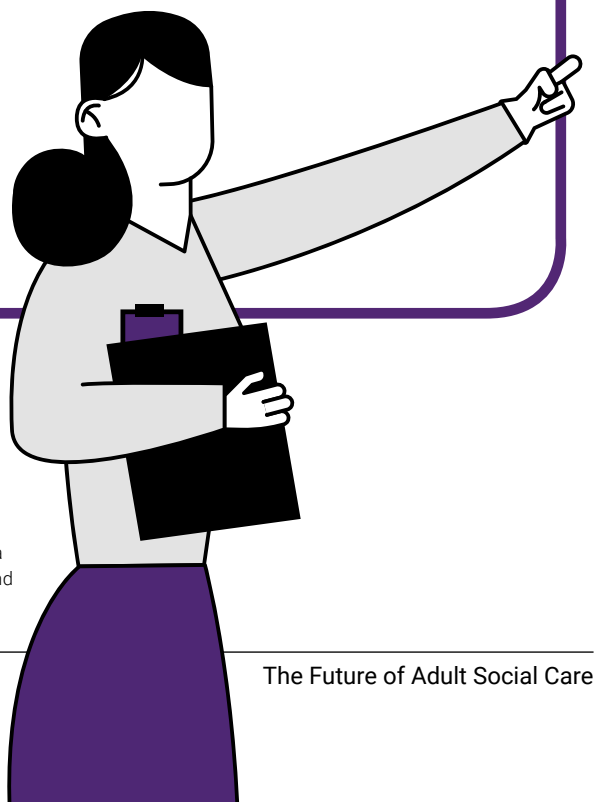
Organisational & Structural Form (p120-127)

9. Delivering adult social care is not only the responsibility of the Adult Social Care directorate; collaborating across **the whole local authority**, and with partners across the wider health and care system enables a holistic, effective and efficient approach to delivering care.

Importantly, based on extensive engagement and assessment of council practices to date, the analysis shows that there are potentially significant benefits that could be achieved if this model of local delivery was fully adopted and implemented, including across this range of **six key service outcomes**.

- **Supporting older adults to maximise their independence through short-term services**
- **Enabling working age adults with learning disabilities living in the community to be more independent**
- **Supporting older adults to live in the most independent setting**
- **Better connecting older and working age adults to their local communities when, or before, their needs escalate**
- **Supporting adults with learning disabilities to live in the most independent setting**
- **Helping older adults with long-term home care to live more independently**

Delivering the optimised model for adult social care across all local authorities in England can significantly improve outcomes, and in aggregate, reduce the demand for increased spending by an estimated £1.6bn per year.[21]



[21] These figures are net of income and the proportion of this financial benefit will vary by authority based on their current performance. In some authorities, this will result in a proportion of this benefit being realised as a reduction in spend, and in other authorities as a slowing of increased spend - or a combination of the two.

After exploring the evidence underpinning the optimised local delivery model and the benefits that could be achieved, this report will then conclude by posing a set of recommendations for policy makers aimed at exploring how such an optimised local approach can be achieved and maintained consistently, and what changes need to be considered across the sector to enable this to happen.

It is important to recognise the full benefits of the optimised model can only be delivered if the foundations of reform were put in place, including a resolution to the long-term funding of adult social care. Therefore, the full benefits should not be considered as savings that could be achieved by councils within the current model of provision and associated funding constraints, but rather opportunity benefits that would result from a reformed adult social care system.

What we could achieve if an optimised model was adopted across all of England through reform

Based on extensive engagement and assessment of council practices to date, the following examples evidence some of the benefits that the different components could achieve if the model of local delivery was fully adopted and implemented.

90,000

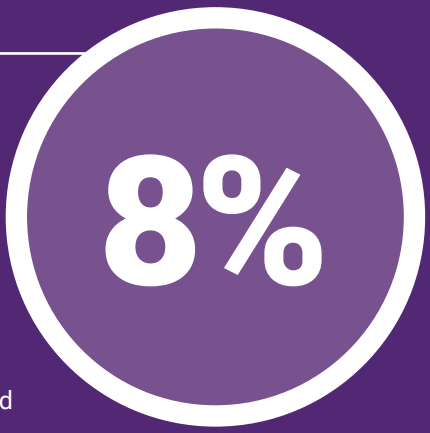
At least 90,000 more older people could benefit from improved short-term services to maximise their independence.

Effective short-term services can **reduce or prevent** an individual's need for long-term care. At least **90,000** more older people could benefit from short-term services each year, equivalent to a **40%** increase. If everyone who would benefit from a short-term service were able to access one, and if all services were as effective as the upper quartile, this could offset spending requirements on long-term care by an estimated **£867 million per year**.[22]

This could be achieved through commissioning the right coherent suite of effective short-term services and creating the right capacity to support all individuals who would benefit (*Theme 8*). The best services set clear and ambitious goals for individuals and create an environment for practitioners to be challenging, creative, and adopt a performance culture (*Theme 1.2*).

[22] Current and potential values for volumes and effectiveness are taken from case reviews and delivered Newton programmes from 13 local authorities, with the double count from care homes opportunity removed.

8% average reduction in formal support hours, by enabling working age adults with learning disabilities living in the community to be more independent.



There are over **104,000** people with learning disabilities (aged 18-64) living in the community with some form of local authority-funded formal support.

The number of hours of formal support they receive could be reduced by **8%** through strengths-based practice (*Theme 4*), stronger links to voluntary and community sector (VCS) services (*Theme 1.1*) and effective use of short-term services, such as enablement (*Theme 1.2*). This would offset spending requirements by an estimated **£261 million per year**.[23]

18% increase in older adults living in a more independent setting of care.

60,000 older adults move into a publicly funded care home each year for long-term care, with 1 in 3 coming from a discharge from hospital, the rest from the community. At least **18%** of these people could be supported in a more independent setting, for example in their own home. This change of setting would offset spending requirements on long-term care by an estimated **£178 million per year**.[24]

This could be achieved through improved strengths-based practice and creating the right environment to support practitioners (*Theme 4*), pathways that are built around the individual (*Theme 2*), and effective strategic commissioning (*Theme 8*).

[23] Delivered Newton programmes and case reviews demonstrated an average reduction of 8% in care hours, which has been applied to total net spend on non-residential long-term care for working age adults with learning disabilities.

[24] Data from Newton transformation programmes and case reviews with 11 local authorities, extrapolated to national level. In some authorities this figure is as high as 50%. Financial benefit per person calculated from difference between average care home weekly cost and upper quartile domiciliary care package weekly cost.

4-6% reduction in total commissioned home care hours by better connecting older and working age adults to their local communities when, or before, their needs escalate.

1,400,000 new requests for council-funded support are received each year through the community front door. There is scarce data available on effective use of community and VCS services, but it has been demonstrated by a sample of councils that they could make better use of these services to help reduce the total number of hours of commissioned home care by **4-6%**, which could offset spending requirements by an estimated **£95 million per year**.[25]

This could be achieved through local delivery of adult social care (*Section B*), strong relationships with voluntary and community organisations (*Theme 1.1*), and effective pathways at the community front door (*Theme 2.3*).

Over 11,000 more adults with learning disabilities living in non-residential settings.

27,000 adults with learning disabilities are living in residential homes. Up to **43%** of these people could be living in a more independent setting, such as supported living or with a Shared Lives carer. If these people were to move to these settings, this could offset spending requirements by an estimated **£74 million per year**.[26]

To help move people currently in residential care, sometimes they would need support in gaining new skills, confidence, and specific support to move to more independent settings (*Theme 1.3*). To help prevent people inappropriately moving to residential homes in the first place, effective transitions pathways (*Theme 2.2*) are needed from children's social services, with 'promoting independence' plans being developed in childhood. In both cases, the right provision would need to be available in those independent settings, through effective strategic commissioning (*Theme 8*).

[25] Combination of delivered programme benefit and Newton reviews with local authorities demonstrated a 4.7% average (range 4-6%) reduction in domiciliary care hours. This has been applied to net spend on domiciliary care for all adults, with the double count from the provider-collaboration opportunity removed.

[26] Data from delivered Newton transformation programmes and case reviews with 11 authorities. Financial benefit per person calculated from average of difference in packages for the same individual between residential and more independent settings.

5% average reduction in formal care through collaborating with trusted providers to enable older adults to live more independently at home.

5%

Up to **225,000** older adults use publicly funded long-term domiciliary care services or direct payments each year to fund support in their own home, the majority of which is delivered by the private provider market. Providers are the people who spend the most direct time with individuals who use these services, so are able to have frequent conversations with them about their goals and support. When providers are trusted to adjust care packages based on these conversations, they are able to better tailor their support to the person's needs. **5%** of formal care can be avoided, on average, when providers are trusted to make these adjustments, resulting in more independent outcomes for those individuals. This may involve making the most of wider assets available in the community, such as voluntary and community sector services. This could offset spending requirements on home care by an estimated **£75 million per year**.[27]

This could be achieved through forming collaborative relationships between providers and authorities (*Theme 3*), with both parties incentivised to achieving the best outcomes for individuals through outcomes-based commissioning (*Theme 8*).

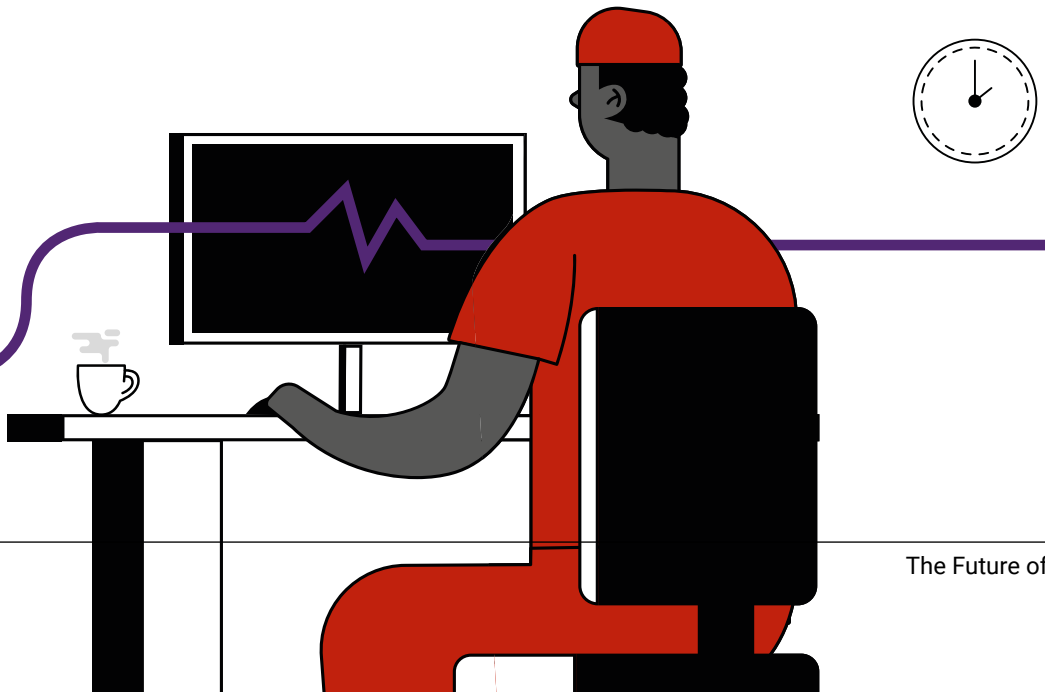
[27] Delivered programmes and trials with local authorities demonstrated a reduction in care hours by 5% on average. This reduction is applied to annual net spend on older adults domiciliary care across England.

Navigating this section

D1. Service Delivery Enablers

D2. Organisational Enablers

D3. Organisational and Structural Form



Service Delivery Enablers

Theme 1 - Provision of services

The right provision of voluntary, community, and formal services promotes independence by building stronger and more resilient communities; helping an individual with some form of recovery, rehabilitation or reablement; or by effectively supporting those individuals who have longer-term care needs.

Adult social care needs to offer a provision of local services that **empowers individuals** to live their best life. Individuals need to have a say in what they receive; how they receive it; when they receive it; when service levels will be reviewed; and why they receive what they get – whilst practitioners should appropriately challenge and support the individual to be ambitious about how independently they can live their life.

Engagement with individuals and their families during this programme of work highlighted the importance of this. Sometimes the feedback was that individuals were fitted into available services, rather than their support being tailored to what they specifically want and need. Those spoken to as part of this programme of work described how an optimised approach to service provision requires getting to know the individual as a person, as well as asking questions and challenging assumptions about the support that an individual may have around them.

There needs to be **clarity on how to access informal and formal services**, whether the individual is being referred by someone else, or seeking to refer themselves.

There also needs to be a **wide range of services** available that meet individuals' needs in the following ways:

- Voluntary and community sector services that help people to be involved in society and lead more fulfilling lives. These services both prevent individuals going into crisis and reduce their need for formal support.
- Short-term services that help an individual with some form of recovery, rehabilitation or reablement and are highly effective at reducing or eliminating their need for long-term care.
- Long-term services, including domiciliary and forms of bedded care, which continue to maximise independence and prevent people's needs from escalating.

When the care system provides a **range of services** in each of the categories above, while maintaining a clear **focus on setting tailored and bespoke goals** with individuals, it is able to make the best use of resources and achieve better outcomes for people.

1.1

Effective and accessible voluntary and community sector services (including those not directly commissioned by the council) help individuals to be involved in society and lead more fulfilling lives. They play a crucial role in both preventing individuals going into crisis and reducing their need for formal support.

Introduction

Voluntary and community sector (VCS) services help promote the wellbeing and social inclusion of the person by bringing together people with common interests, to undertake activity, education, and to reduce social isolation. Connecting people with their local community can be appropriate to anyone that may be seeking support from adult social care.

These services play a part in preventing some people needing social care (by staying active and healthy), adding value to the lives of those who require long-term care (by building circles of friendship and support in their communities), and proactively increasing the independence of individuals. These services also play a valuable role in supporting informal carers.

There isn't much data available when it comes to understanding the existence, use or effectiveness of these services. However, what data there is appears to demonstrate value. For example, in one council it was found that increasing the use of VCS services for individuals receiving small packages of care would result in a cost saving of £1,082 per individual.[28]

It was also found that 40% of people receiving a care package with fewer than 28 hours per week could have some of their package replaced by input from the voluntary sector. This would equate to a saving of 6% of the council's spend on domiciliary care for adults.

[28] Case reviews involving seven people (£28.40 average reduction in weekly package cost multiplied by the expected duration of benefit to last 38.1 weeks before care needs increase.)

What do we mean by voluntary and community sector services?

These services are found in the community, culture, leisure and sport activities in a local area, or they can be specialist services that support people with pre-existing conditions, such as dementia cafés or support groups for people recovering from mental ill health. These services are often run by voluntary groups, or commissioned by external organisations or parts of the local authority other than adult social care. These services are often described as enhancing the quality of life for those who participate.

In recent years there has been a resurrection of thinking about adult social care that was very common in the 1970s[29], where the development of community capacity to assist with the role of adult social care is seen as crucial. There have been a number of initiatives ranging from the Australian model (Local Area Co-Ordination), to the more local developments associated with organisations such as Community Catalysts and the National Development Team for Social Inclusion (NDTi). These initiatives look to develop capacity in communities, make links with local organisations, and develop a range of groups and individuals which can play a part in helping with the inclusion of people within their communities who are experiencing difficulties. Much of the capacity that is created through these initiatives builds on VCS effort. Some of the initiatives also assist with the recruitment of people who are willing to take on paid tasks to support those in need; usually linked to people who are using Direct Payments.

VCS services can also support those people who offer care to a loved one 'informally', which represents the majority of people as a proportion of all those receiving care. In 2016, 2.2 million people were estimated to be receiving support from informal or voluntary services.[30] The value of this care is £103 billion, which would cost local authorities an additional £62 billion if they were to provide it themselves.[31] It is therefore important that every council ensures that the needs of informal carers are being met.

29 'The Seebohm Report' – published by HM Government in 1969

30 Office for National Statistics – Household satellite account, UK: 2015 and 2016 (www.ons.gov.uk/economy/nationalaccounts/satelliteaccounts/articles/householdsatelliteaccounts/2015and2016estimates#focus-on-adult-care)

31 National Audit Office – Adult Social Care at a Glance. Net and gross costs of informal and voluntary care. (www.nao.org.uk/wp-content/uploads/2018/07/Adult-social-care-at-a-glance.pdf)

The principles of effective voluntary and community sector services

Fundamental to supporting people to live their best lives, those authorities that deliver an **asset-based strategy** achieve the beliefs and values by strengthening and developing local services in the community that already have an understanding of the local population.

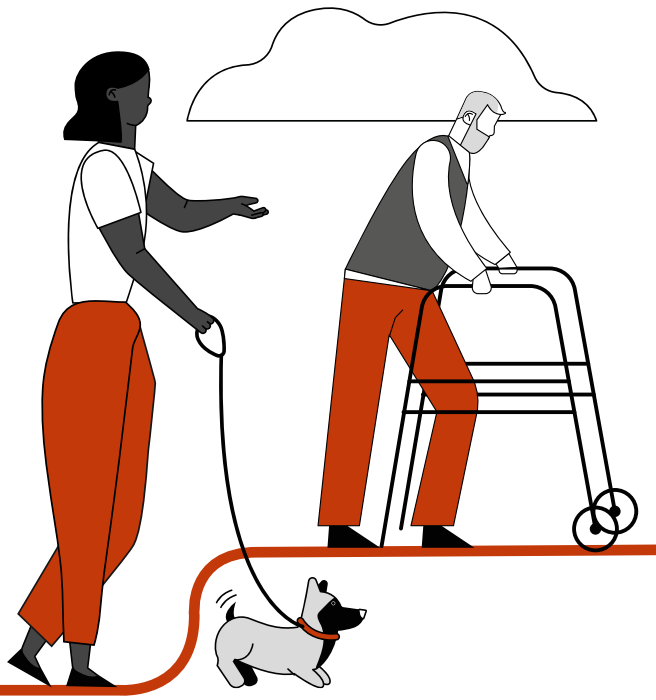
In order to support these services, in an optimised model, authorities have a detailed understanding of the **nature, capacity and geographic spread** of the VCS services. This understanding is matched with a deep **knowledge of the local population's needs** and opportunities. This crucial mapping enables these authorities to facilitate **consistent service delivery** across the county whilst also raising the base level of community assets.

These county authorities know the effectiveness of these services, as measured by their ability to improve people's lives and delay or prevent their need for formal care, which is shared with the VCS services. This process informs the authority's long-term **commissioning strategy** and is a basis for supporting partners to continually improve. This evidence-based approach allows the development of a clear case for these organisations to receive a form of **targeted funding support**, without undermining their autonomy.

Engagement with Directors of Adult Social Services through this programme of work highlighted both the **complexity and importance** of this approach in order for them to decide which VCS assets to fund and grow. One example cited was how a 'lunch club' could be a brilliant way of reducing social isolation for people but may also inadvertently lead to the individual becoming dependent on the service and unable to cook their own food.

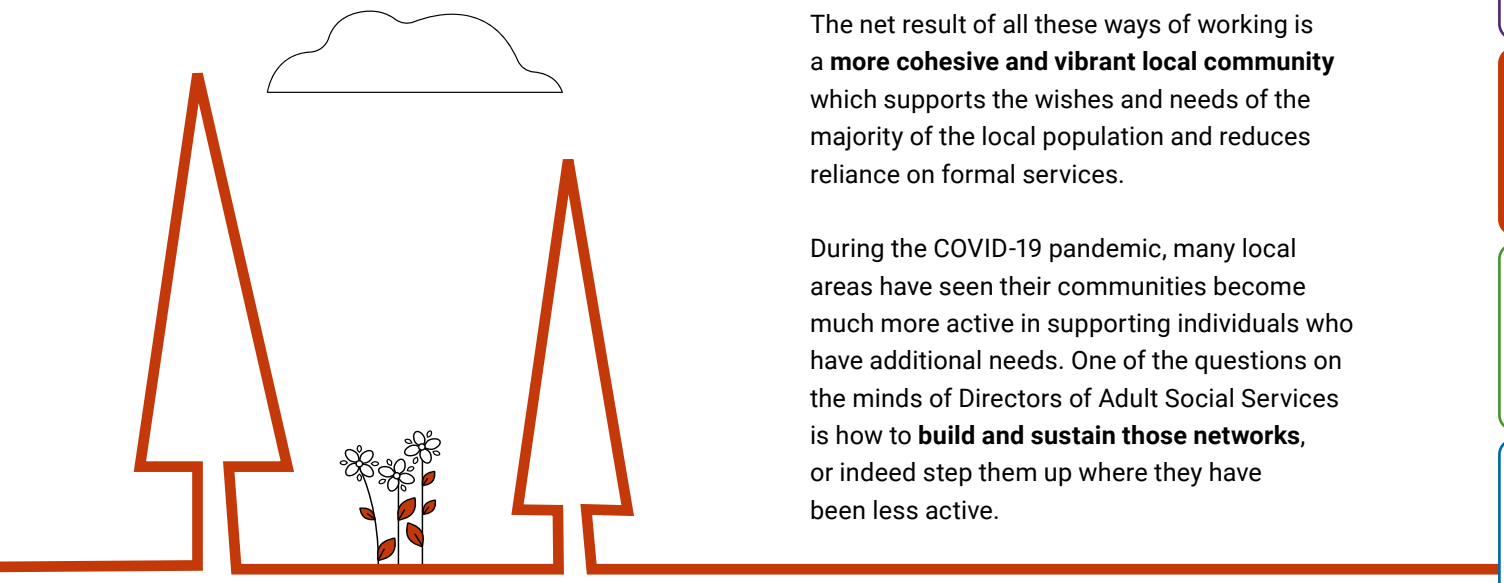
This is a clear example of how a set of core values and beliefs need to underpin any effectiveness measure.

To achieve such values, the local authority workforce needs a strengths- and asset-based belief system which means they **creatively seek to engage** VCS organisations for individuals and their network, irrespective of their matching to eligibility criteria. To achieve this, there is a detailed and **needs-ranked service repository**, with the ability for professionals and individuals to rapidly engage these services. Local authorities who use **digital tools and innovation** can make more significant strides in this area (*see Theme 6*).



In an optimised model, authorities confidently and **structurally build** services provided by VCS organisations **into their care pathways**, including when an individual or their network first makes contact and in multi-disciplinary forums where short- and long-term support plans are being designed.

It is well understood that **informal carers, principally family and friends,** provide the majority of care and support in England.[32] Optimised systems actively understand and address the needs of these carers, consider how carer input can be supported with community assets, and support these individuals with community assets and wider services for their **own wellbeing**.



One of the ways this is done most effectively is through the support of a 'Carers Centre', run by carers, for carers, with paid staff available to offer advice and support to people who contact them. These centres can also reach out into the local community to identify people who might have needs as carers but may not come forward to get help.

An optimised system also needs to be sensitive to the risks of **family-carer breakdown**, which can trigger significant (and often worse) changes to the outcome of the person that they care for. The authority will have preventive measures in place to reduce the pressure on carers, such as offering respite breaks which may be for a day or weekend; linking them to a support network; or offering emotional and practical help when requested.

The net result of all these ways of working is a **more cohesive and vibrant local community** which supports the wishes and needs of the majority of the local population and reduces reliance on formal services.

During the COVID-19 pandemic, many local areas have seen their communities become much more active in supporting individuals who have additional needs. One of the questions on the minds of Directors of Adult Social Services is how to **build and sustain those networks**, or indeed step them up where they have been less active.

[32] Formal Care packages from "Adult Social Care Activity and Finance Report, England - 2018-19" – NHS Digital (www.digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2018-19) and informal care estimates from Facts and Figures - Carers UK (https://www.carersuk.org/news-and-campaigns/press-releases/facts-and-figures)

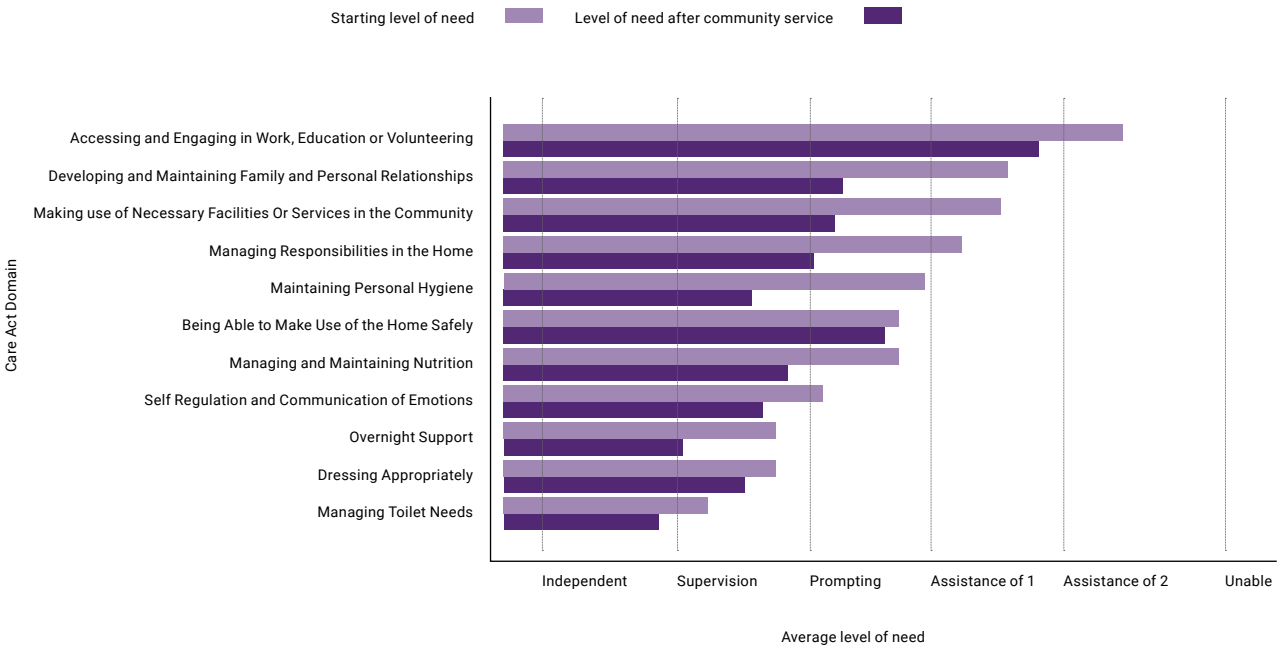
Insight The value of VCS services

In one county authority, a survey was conducted with all 36 community team managers, representing 622 members of staff, to understand how often their teams were able to support individuals by using VCS services. **Two in three teams** said the main reason people could not access VCS services was because it was either too difficult for practitioners to know about the existence and appropriateness of the range of services, or that the referral process was too complicated.

However, evidence demonstrates that practitioners believe VCS services are incredibly important in helping individuals lead more fulfilling and independent lives. In a different service, a multi-disciplinary team reviewed the cases of 57 working age adults with learning disabilities. They found that 60% of those individuals could become more independent with access to specific opportunities in the community that would provide them with social support, home skills, employment support or travel training.

From the sample of 57, seven individuals were chosen who they thought would benefit from VCS services, to understand the impact they would have on their independence. Their current level of need for support in each of the 11 Care Act domains was compared with what they could achieve if they were accessing a service in the community.

The following chart shows the aggregated increase in independence of all the cases reviewed.



Case Study

Developing a community social enterprise model with Community Catalysts

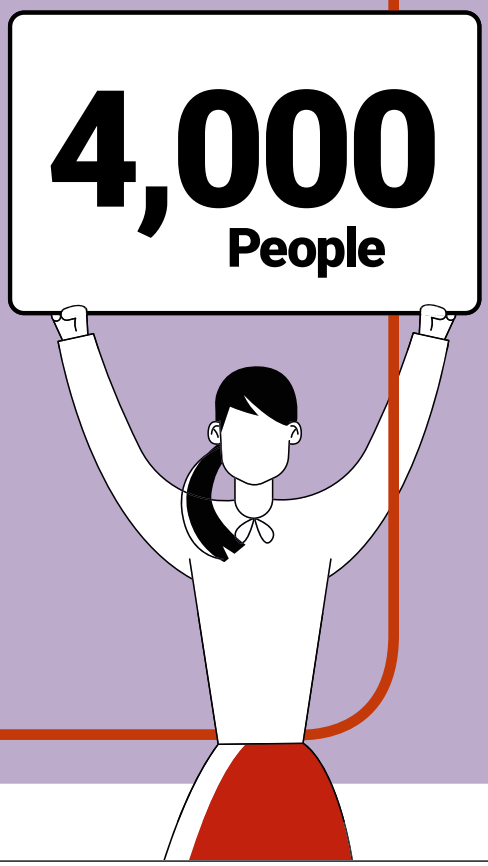
The increasing complexity that authorities are now seeing can only be managed by having an effective and different response for those whose care is less complex and whose needs can be met locally in line with their wishes and desired outcomes.

Somerset County Council has focussed on developing its Community Social Enterprise model with the help of Community Catalysts.

The critical success factors of this model were:

- A new vision was shared and developed with all partners.
- A strong focus on support for informal carers.
- A focus on local support, shaped locally and linked closely to the community and voluntary sector offer.
- A different relationship with key community partners to develop a greater sense of working together across the county, particularly with the voluntary sector and with local providers of care and support.

As a result, over **4,000** people now use micro enterprises (community services) for some, or all, of their support. This includes self-funders (69%) and people who are receiving formal support from the council through direct payments (31%). Over 18 months, they have seen a 3.5% reduction in the number of people receiving paid for support, and a reduction in the number of hours of paid support by blending formal support with community solutions.



Case Study

Trialling voluntary sector staff within the discharge hub to better access voluntary and community services

One authority wanted to increase the number of people benefitting from VCS services on discharge from the acute hospital. The aim was to reduce the number of people needing formal packages of domiciliary care. To achieve this, the hospital discharge team trialled having a representative from a local VCS service co-located within the team.

The representative is equipped with a **breadth of knowledge of what local VCS support is available** so they can both **make referrals** and come up with more **creative solutions** to better support people being discharged.

In one example, a patient wanted to go home but they needed their bed on the ground floor. However, they had no family who could help them move it from the first floor, and as such, the individual couldn't leave hospital. The volunteer picked up this case and knew of a service which could help. They subsequently arranged for the patient's bed to be moved.

Having this perspective and knowledge allows for creative solutions and better access to community services. This can reduce the demand for smaller packages of formal support and improve the independence of people leaving hospital.

" They will actively pick up on conversations we are having about difficult patients and say, 'I can help with that' and that has been really, really beneficial ".

– Discharge Team Manager

1.2

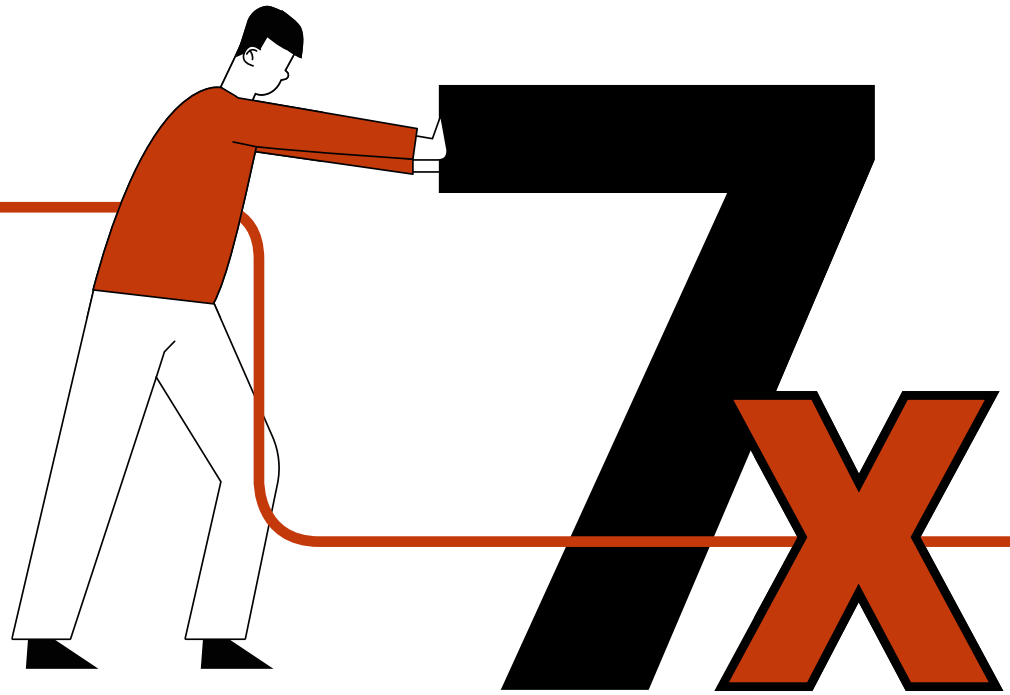
Short-term services that help an individual with some form of recovery, rehabilitation or reablement are highly effective at reducing or preventing their need for long-term care.

Introduction

Short-term services help a person achieve their goals and to develop approaches that may **reduce or prevent** their need for long-term care. This may involve regaining or improving aspects of their personal confidence or independence, their strength, or their health.

Short-term services can be delivered in a person's home, a residential bed or a hospital bed. They are delivered by a team of practitioners with a range of skillsets, including therapists.

Short-term services are extremely effective at promoting and supporting an individual's independence. They also offer a high return on investment. For example, analysis across 11 different authorities shows the average amount of long-term care and support required after one such short-term service, reablement, is £8700 cheaper than if the individual had not received reablement. This is a return on investment of seven times the cost of the short-term intervention.[33]



[33] Newton Analysis: calculated from difference in starting need and ongoing need from 11 different services Newton has worked with. Assuming average duration of long-term package of 72 weeks at £17.48 per hour all-up cost of domiciliary care.

What do we mean by short-term services?

Although referred to as 'short-term', these services may involve a two-week intervention, or a longer process which supports the person's journey to meeting their goals and objectives and striving towards a greater level of personal independence. Adults of all ages can benefit from a range of short-term services depending on their needs:

Reablement is an approach used to support (usually) older people **retain or regain their skills or confidence after a period of illness**. It is usually delivered in someone's own home and is described as a 'doing with' model, as opposed to traditional homecare which is a 'doing to' model. Older people normally require reablement for a period of 2-6 weeks, following a hospital stay or via a community referral. **Enablement** is a term sometimes used interchangeably with reablement but can also refer to support given to those with disabilities to help them gain new skills. Disabled individuals with personal lived experience of social care who were engaged in this programme of work highlighted the importance of creative enablement which takes into account the **physical and environmental limitations** alongside the emotional well-being of a person. This report considers both traditional reablement services for older people, as well as exploring how the reablement mindset can support younger people and those with mental ill health. Furthermore, some councils are considering a form of reablement for carers to help avoid carer breakdown.

People recovering from mental-ill health may benefit from short-term **recovery** services to empower them to be resilient and take control over life's challenges. It is based on the principle that people need to first understand the triggers that are likely to set off a mental health episode and to develop coping mechanisms that can reduce the risks. In addition, people need supportive relationships around them and people to whom they can turn when they are feeling at risk. Those who use the recovery model look to offer both personal support but to also build a circle of support that will enable a person to better cope with their illness.

The concept of **rehabilitation** is widely used to describe the support that is offered to people who have had recent experience of a disability. Rehabilitation services generally, although not necessarily, take place over a longer period. This applies, for instance, to service personnel who lose limbs whilst serving their country abroad, as well as people in road accidents or others who by some misfortune have experienced a loss of some kind such as the onset of a visual or hearing impairment. Each person who has a new level of disability should, in the first place, be offered a period of rehabilitation to assist them both physically and emotionally to deal with their loss. People may require specialist equipment, practical help, redesign of their property or other support to help them to adapt to their new situation. Many people with disabilities can live quite independent lives if they are given the right support.

The principles of effective short-term services

When VCS services can no longer fully support an individual to regain or maintain their independence, then **every individual** should have the opportunity to maximise their potential through a short-term service, prior to the receipt of a long-term service.

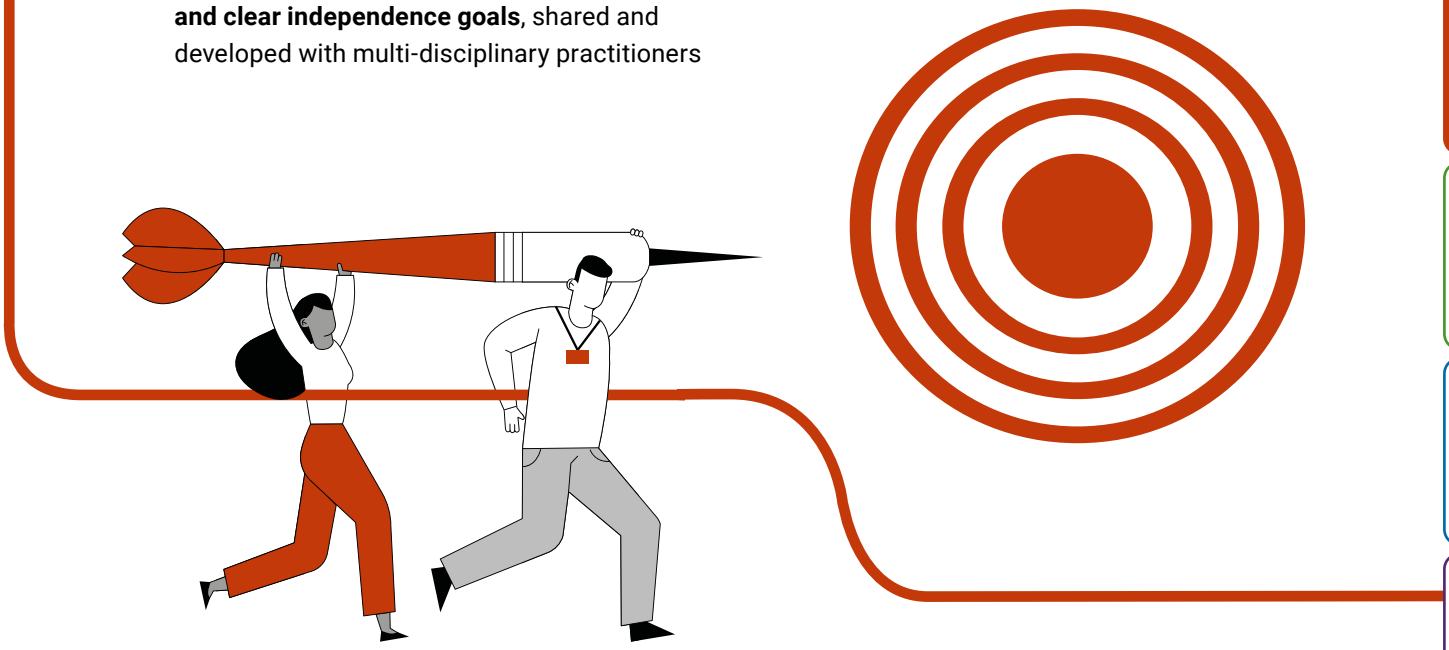
Those authorities achieving the beliefs and values through the optimised model place short-term services at the heart of achieving independent outcomes and managing demand.

These authorities achieve the most independent outcomes by commissioning short-term services **coherently with local system partners**, avoiding duplication, overlap and market strain. **Adequate capacity** exists to deal not only with fluctuations in demand, but also the full potential cohort of individuals who would benefit. This empowers practitioners across the system to **confidently, quickly and easily refer** into these services and helps maximise the quality of life of individuals by reducing the need for inappropriate referrals into long-term services.

To achieve the best outcomes, all individuals in receipt of a short-term service will have been at the centre of developing their own **specific and clear independence goals**, shared and developed with multi-disciplinary practitioners and other stakeholders. These goals are **regularly tracked**, and the intervention adjusted dynamically to achieve the goals.

These teams are made up of the right practitioners. These practitioners are **motivating, creative, challenging, and ambitious** to help individuals be the best they can be. They rigorously **judge and improve the effectiveness** of their service delivery based upon the long-term outcomes achieved.

Digital technology is a fundamental enabler of the optimised delivery of short-term services. It enables practitioners to have live and up to the minute information about the person they are working with, their outcomes, and their progress so far. It also drives valuable analysis of the systematic strengths and weaknesses of the service, based on individuals' achievement of goals, to promote continuous improvement (*see Theme 6*).



Case Study

Improving availability and effectiveness of reablement for older adults

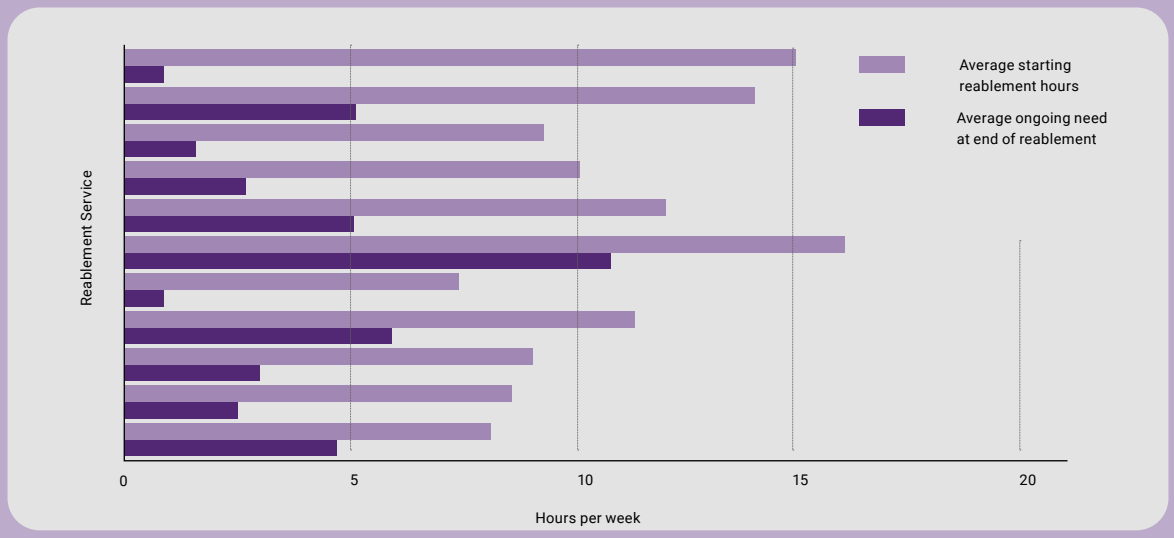
Multi-disciplinary reviews of 1000 cases across 11 local authorities[34] showed that almost twice as many people could benefit from reablement. Those individuals usually end up receiving larger than ideal packages of ongoing care, diminishing their independence. The multi-disciplinary teams agreed the main reasons for individuals not receiving reablement were practitioner decision-making (33%), service capacity (16%), and the family or individual's preference (16%).

Equally as important as **the right people** having access to reablement, is ensuring the service is **delivering excellent outcomes**. This is measured by comparing the 'end need' (the amount of long-term care and support required after a short-term intervention) to the 'start need' (the estimated amount of long-term care and support required without the short-term intervention). A study of a sample of 11 reablement services across the country demonstrates that the most effective service, according to this measure, adds **five times the value** of the least effective service (see below).

Furthermore, there is a divide between authorities who have in-house reablement services and those with outsourced services. No answer is right or wrong – it is about the adherence to the principles above underpinned by system-wide ways of working and leadership.

Lancashire County Council achieved dramatic improvements to their reablement service, with a **64% increase** in appropriate volume (47 people per week) and a 17% improvement in outcomes (£9 per person per week).

This was achieved over the course of two years (2016-18) through fundamental changes to the culture and ways of working – including, for example, a focus on increasing in-house capacity to ensure the best outcomes were being achieved consistently, effective resource allocation, challenging thresholds, a service-wide approach to performance, and monitoring and better ways of working with the brokerage team. Therapists were a fundamental part of the team and helped to improve practice and therefore service effectiveness.



[34] Newton case reviews with MDTs across 11 local authorities to determine what the ideal outcome would have been in each case.

Joe's story

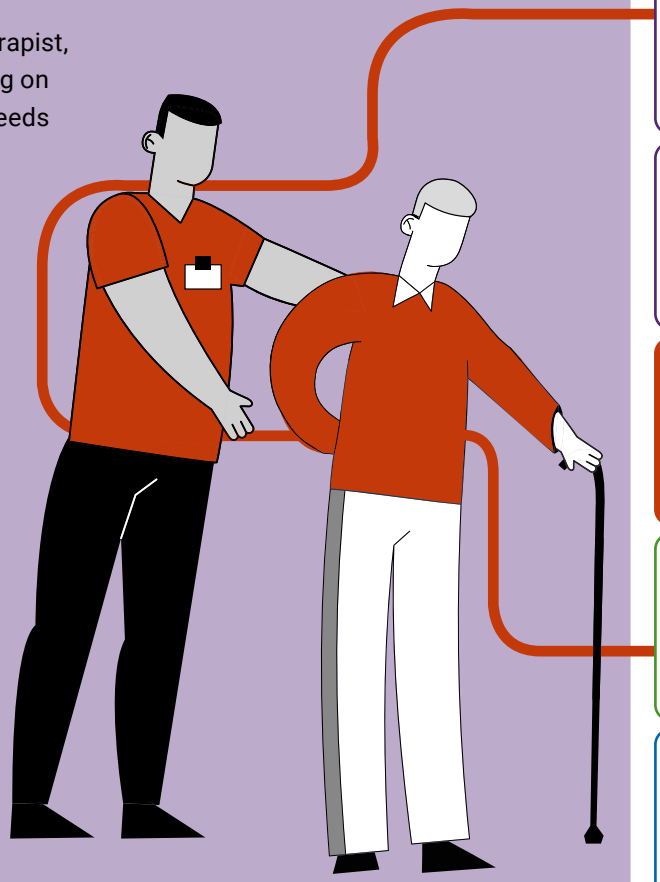
Joe, 94, was referred to reablement following a hospital stay. He was discharged with a package of care consisting of four calls a day with two workers at each call – a total of 31.5 hours of support a week. Due to Joe's high support needs identified, the reablement service was initially unsure of Joe's reablement potential. The day Joe was discharged from hospital he was visited by a senior reablement worker and occupational therapist.

Joe identified a number of goals he wanted to achieve:

- Develop his confidence with transfers and use a rotunda.
- Improve his mobility and be able to walk.
- Complete his personal care independently and prepare his own meals.
- Access the upstairs of his property using his stairlift.

The council's occupational therapist, health physiotherapist, and reablement staff worked with Joe, initially focusing on his mobility and personal care, reducing his support needs from two workers to one. As his confidence with mobility grew, reablement staff began to work on meal and drink preparation, but Joe still required occasional assistance with aspects of his personal care. A multi-disciplinary team meeting agreed a further week of reablement to progress this, as it was felt that Joe had the potential to undertake all tasks independently.

The team reflected that the specific, measurable and regularly reviewed goals; timely support and intervention by the occupational therapist and physiotherapist; and adoption of an MDT approach to facilitate communication and action setting, were the aspects that had enabled them to support Joe so effectively.



Most importantly, Joe is now **living independently** in his own home, and does not need a long-term package of care.

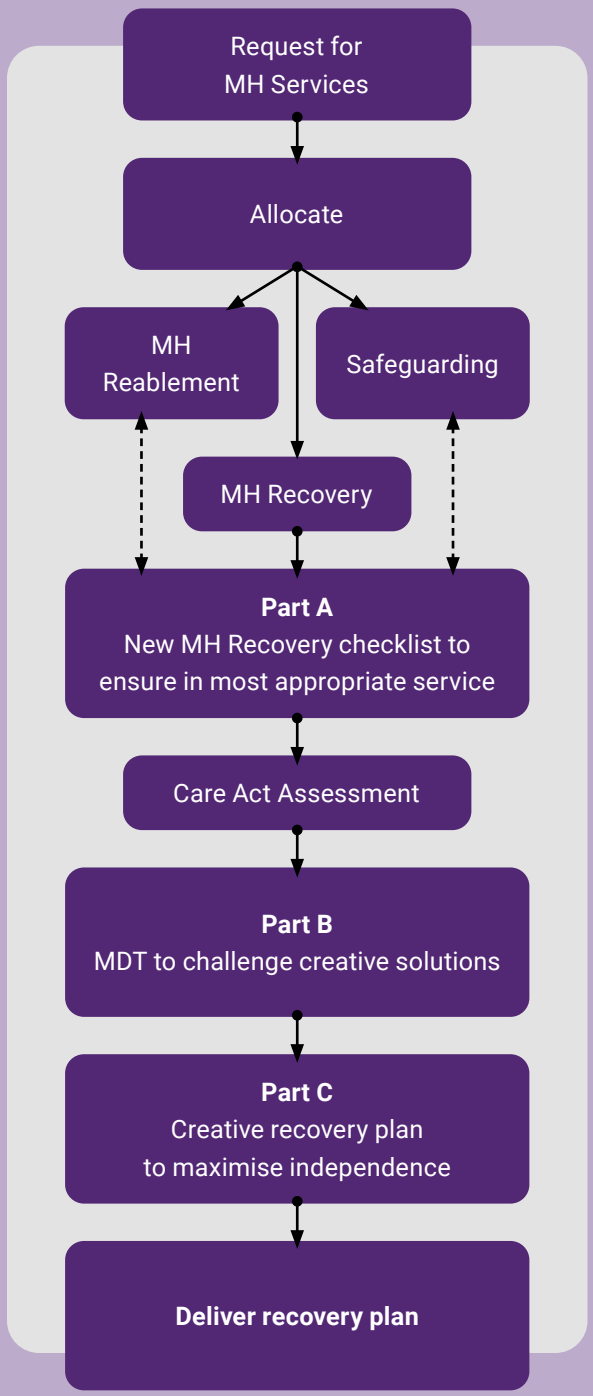
Case Study

An effective recovery service from mental ill health

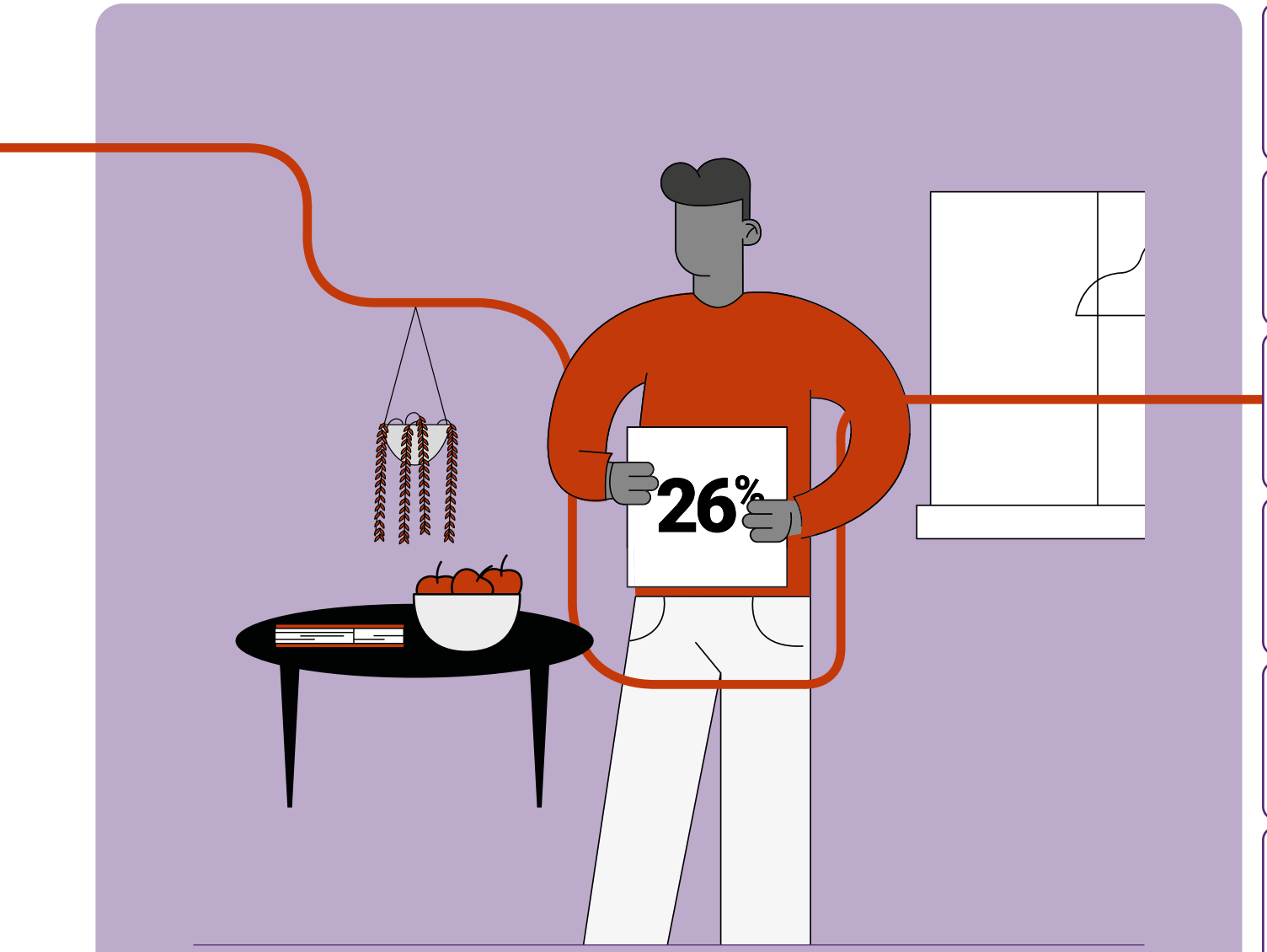
Given the complexities around mental health recovery, it can be challenging to achieve the most ideal outcome for individuals. Services which take a strengths-based approach to recovery can ensure individuals have the best opportunity to achieve their recovery outcomes.

Leicestershire County Council undertook a process of re-design to ensure every resident was on the ideal recovery pathway. This focussed on ensuring the best use of recovery planning and reablement, and ensuring the service was only working with eligible cases. Alongside the mental health community team, the service fundamentally redesigned the pathway for individuals with mental ill health. This is based on the principle that every individual has the potential for recovery or progression to improve their independence. This means always first asking what mental health reablement can do to support an individual achieve their goals.

Some of the ways in which they have achieved delivering this new pathway include a better way of ensuring the service is only working with the right individuals; group discussion to focus on creative solutions that reduce the reliance of individuals on commissioned services; and strengths-based recovery planning for every individual. At the end of the short-term intervention, the social worker reviews the individual's progress towards independence overall and makes a commissioning decision before closing the case.



Now, **64%** more individuals are on the path to achieving their ideal outcome.



John's story

John is a 26-year-old gentleman with schizophrenia, and a history of drug misuse. John has been in residential care for four years, but there was no plan to increase his independence, or work towards recovery.

The social worker responsible for John's case brought it to a group discussion. By working together, they identified significant potential to increase his independence in a community-based setting. The mental health team came up with a six-week plan of goals to build his independence through developing his skills around personal hygiene, managing nutrition, and maintaining a habitable home, before looking to move him to a more independent setting.

John is **living more independently** – for example he now keeps his room clean and makes his bed on his own. The commissioned provider is supporting John with prompts when required. John is due to move out of his residential setting and into a Supported Living placement.

1.3

Long-term services, including domiciliary and forms of bedded care, continue to maximise the independence and prevent the escalation of needs of individuals.

Introduction

Once individuals have been through a short-term intervention, and made the most of VCS assets, there needs be a wide range of local services for those who have longer-term care needs. These services should continue to promote and support them to achieve the best quality of life and level of independence.

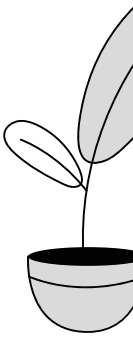
This includes helping people to progress in their lives, to rehabilitate those who will benefit in the longer-term and to achieve goals set by the person. The person receiving the service may choose to use services procured by the council, or use their personal budget to manage their own choices. A minority of these services might be delivered by the council, but the same principles apply.

Adult social care spend on long-term services accounts for £15.4 billion (78%) of the £19.7 billion total adult social care gross current expenditure.[35] Although there are far more older adults in receipt of long-term care than adults of working age, there is an even split between spend on those cohorts, due to the higher unit costs of supporting adults of working age.

What do we mean by long-term services?

Long-term services support individuals who have needs that cannot be met solely by VCS services or a short-term intervention. These services may be required by younger adults with physical or learning disabilities, individuals with mental ill health, or older adults who can no longer live completely independently.

Long-term services range from high-intensity services such as nursing care to lower-intensity support such as domiciliary care. For some people, their accommodation is an important part of receiving care and the choice of extra-care housing, supported living, shared lives and other housing schemes are as important as residential or nursing care. For others, their services may be rooted in their local community, within their families, or in more specialist commissioned services.



[35] "Adult Social Care Activity and Finance Report, England - 2019-20" – NHS Digital (www.digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2019-20)

The principles of effective long-term services

In an optimised model, authorities shape their long-term service provision **ahead of evolving trends** in specialist population need, such as mental health conditions. They create an environment where **provider partners feel safe, confident and incentivised** to innovate their service offerings. This confidence is created through surety of business volume and a shared vision of their future partnership.

Long-term service providers have a **unique relationship** with the individuals they support and understand their aspirations and needs. Providers working to an optimised model are motivated by a set of beliefs to improve the quality of life of individuals. Local authorities partnering with these providers seek to capitalise on this culture, embracing the principle of **trusted assessors** and working to grow these providers. These authorities benefit not just from their first-hand care knowledge, but also the creation of additional assessment capacity (*see Theme 3*).

The potential of **community assets and short-term interventions** to further enhance the potential of individuals is continually considered alongside long-term services.

The provider market is of a manageable scale and shape that means services can **build proper relationships** with each provider, where all partners benefit. The relationship is framed around **performance**, underpinned with visibility and clarity of the outcomes being achieved across aggregate cohorts of individuals.

Once again, **digital technology** is woven into the fabric of service provision. However, decisions made on any new technology are based on the evidence that it will demonstrably improve outcomes which match the individual's aspirations (*see Theme 6*).

Authorities recognise that social care has been, and always will be, on a **journey to improve**. Some councils face a legacy of service provision which is not aligned with their strategic objectives. An example of this is the over-provision of residential care for individuals with a learning disability. Some authorities are enabling these people to move into their own more independent and enriching settings of care and, alongside this, **future-proofing provision** by taking providers on the journey to more suitable forms of support.

Insight

Changes to long-term packages are partially driven by the supplier of care

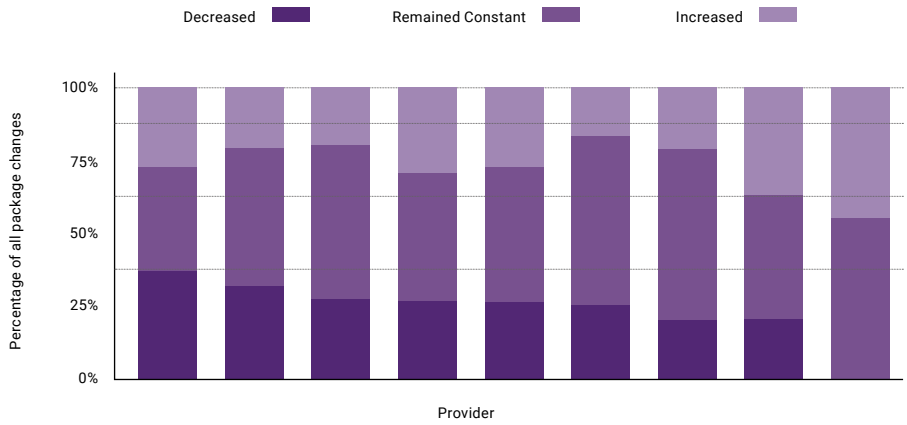
For people in receipt of long-term packages of care (residential or domiciliary), the extent to which they will have their independence sustained is influenced by the supplier of that care.

All packages of care across nine domiciliary care providers were analysed to understand whether the packages changed after a review by a social worker and whether the amount of support increased or decreased. The results demonstrated that some providers were better at promoting independence than others. For example, in one provider, over a third of reviews resulted in more independent packages of care, whereas in another, almost half resulted in an increase in package size.

Since providers often spend most time with an individual on an ongoing basis, it is likely they will be the first to realise when there is the opportunity to adjust a package of care. To facilitate this, councils and providers work closely together to challenge whether packages could better promote independence, by making sure the right trusting relationships, conversations, processes and incentives are in place (*see Theme 3*).

Directors of Adult Social Services engaged as part of this programme of work cited that they see significant variation between providers in terms of quality of care which has a dramatic impact on quality of life. This is further exacerbated by the postcode lottery and ability to pay for care.

The following chart shows the variation in package changes between domiciliary care providers on review



Case Study

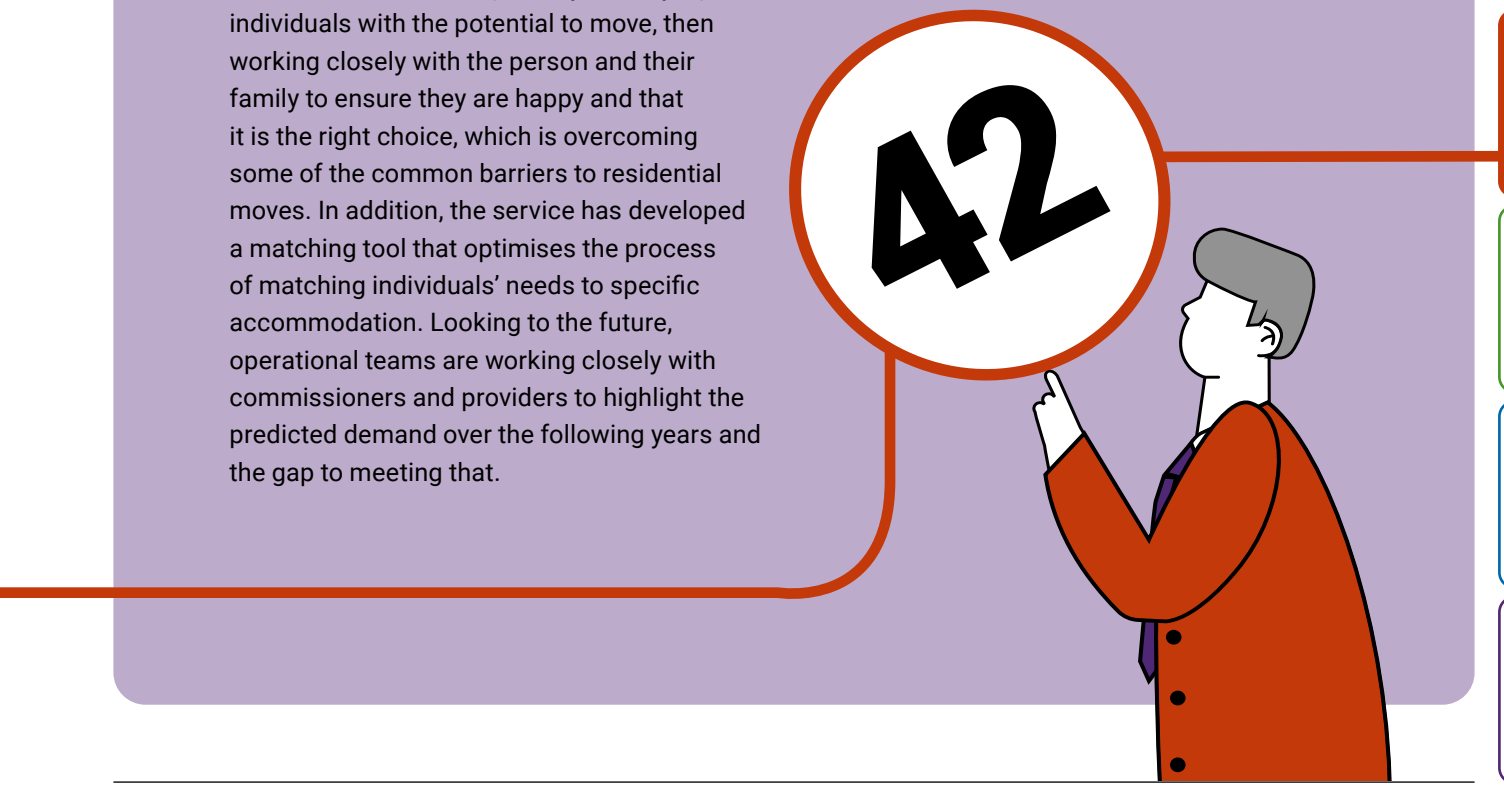
An example of a successful programme to promote the independence of individuals with learning disabilities

Being able to live as independently as possible is incredibly important to individuals with learning disabilities – in terms of having a place in the community, as well as choice and control over how they live their lives. While services such as extra-care housing; supported living; Shared Lives; and other housing schemes are not commissioned by all authorities, they have been shown to support individuals to achieve the goals they aspire to.

Leicestershire County Council conducted a review which demonstrated that 47% of individuals in residential settings could have been placed in supported living. However, only 4% of reviews resulted in a move there. Generally, these people would require some level of enablement to learn new skills in order to help them move to a more independent setting.

In the first year of the programme, the service has moved **42 individuals** with learning disabilities from residential homes to supported living with a further 158 identified as future candidates.

The service is achieving this by identifying individuals with the potential to move, then working closely with the person and their family to ensure they are happy and that it is the right choice, which is overcoming some of the common barriers to residential moves. In addition, the service has developed a matching tool that optimises the process of matching individuals' needs to specific accommodation. Looking to the future, operational teams are working closely with commissioners and providers to highlight the predicted demand over the following years and the gap to meeting that.



Service Delivery Enablers

Theme 2 - Pathways

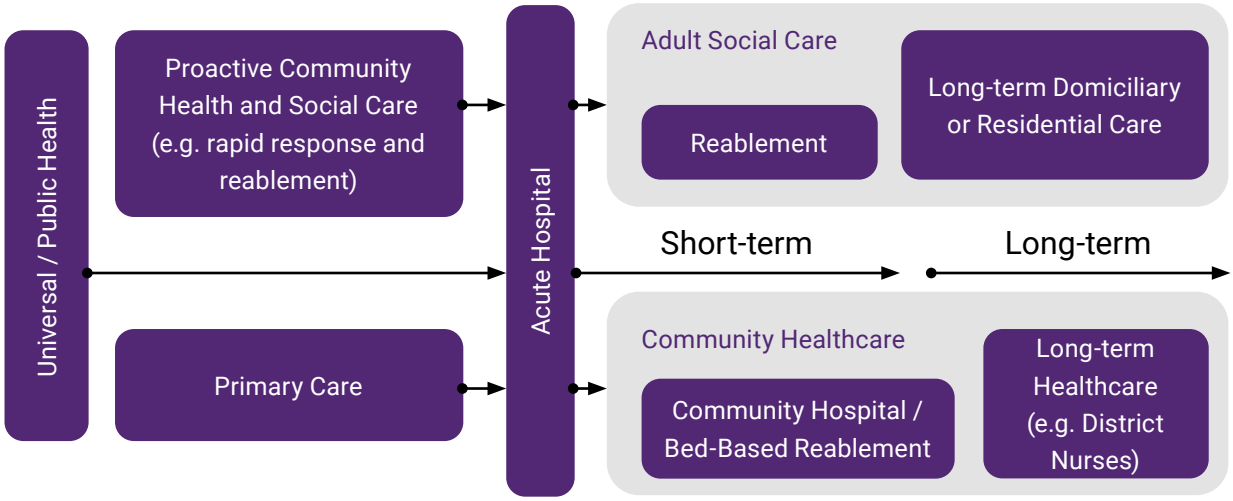
The right pathways – which are designed from the perspective of the individual rather than the service.

Individuals do not fit into neat areas of service provision. Their needs can be complex, both emotional and physical, evolve over time, and require input from a number of different professionals. Optimised adult social care services ensure that the person is truly at the heart of everything they do, by designing pathways and provision that wrap around the individual in a holistic, consistent and joined-up way.

Where teams, services, and organisations work together in a coordinated and integrated way, the result is a system which works for the individual and their network. There are as few handoffs as possible, and the minimum number of individual practitioners and professionals are involved in the delivery of support. This means activity is not duplicated, and no one 'falls through the gaps'.

This theme explores three focus areas:

- Where health and social care work together in the delivery of care and support.
- Where different local authority directorates work together in the delivery of care and support (children's services and adult social care for young people transitioning to adulthood).
- How the 'channels' into social care can be designed from the perspective of the individual.



2.1

Optimised health and social care systems break down organisational barriers and focus on the outcome for the individual.

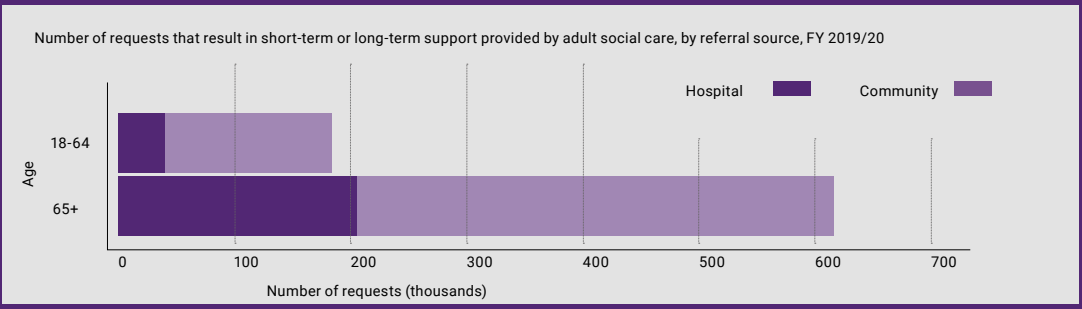
Introduction

Individuals with social care needs also have healthcare needs; health and social care systems need to work together closely to ensure individuals receive joined up and efficient care. However, with significant differences between health and social care, for example in their values, culture and funding models (explored further in *Theme 3*), this can be challenging. To deliver the best outcomes for individuals, optimised systems ensure that the best health and social care pathway for an individual is the 'default' pathway.

What do we mean by health and social care pathways?

The graph below shows that referrals from hospitals represent 35% of all requests for social care for older adults.[36] This includes requests from acute and community hospitals, but not other health referrers such as GPs or District Nurses; these are included in community requests.

A health and social care pathway refers to when an individual is receiving some form of care from both health partners and social care. Of interest are those interfaces between the two, separate, organisations, and particularly how these interfaces can impact on an individual's journey, experience and outcomes. It is important to note that such pathways can be very complicated in the number of organisations and services involved. A generic example of a health and social care pathway is shown to the left.



[36] "Adult Social Care Activity and Finance Report, England - 2019-20" – NHS Digital (www.digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2019-20)

The principles of effective health and social care pathways

In an optimised system, authorities **create seamless health and social care pathways** based around the individual, which enable the right professional to make the right intervention at the right time. The pathway which maximises the independence of individuals is always the path of least resistance.

There is **clarity of the professional skillset** needed to develop the plan for each individual. These professionals are involved from the beginning and fully understand the pathways available and how to access them. To achieve the best outcomes, practitioners work in **multi-disciplinary teams across organisations**. They set clear and consistent expectations with individuals and their network in terms of their level of ongoing support, and they work towards **ambitious goals** which maximise independence.

This is enabled by having **clear roles** and responsibilities, both operationally and clinically, supported by a **culture** of achieving the most independent outcomes for people, which is backed by **leadership** across the whole system. **Digital tools and technology aid the process**, distilling myriad options into precise decision support. This enables practitioners to make the best decision for the individual, regardless of organisational boundaries and individual knowledge and experience.

The whole system has a **clear and unified focus** on **rehabilitation and recovery**, and long-term decisions are never made in a crisis. This transcends all system partners, including acute hospitals, community health providers, primary care, social care and the VCS. When being discharged from hospital, a single assessment for all ongoing care and support is always **carried out in the community, never in an acute setting**. The right capacity and breadth of health and social care support is commissioned to enable this, including the appropriate short-term services (*see Theme 1.2*).

These pathways use **resources efficiently** and there is **no duplicated effort** between health and social care. Data and information are shared freely and securely, which means every practitioner can access an individual's full story, so the individual never has to tell it twice. This insight also means leaders across the system can maintain **absolute clarity on demand and system capacity** and the key issues driving this.

There is a fundamental alignment of priorities at an organisational level, including between flow out of hospital to maintain capacity and the right long-term outcome for the individual. A model of 'Discharge to Assess' is used as a critical enabler in striking this balance. This relationship is explored further in *Theme 3*.

Insight

The impact of delayed discharges on outcomes for individuals

One of the interfaces between health and social care is for those people who need social care following a stay in a hospital. This applies to both older and younger people, whether in an acute, community, or mental health hospital.

A study in 2018 showed that 27% of all general acute beds were occupied by someone who had been declared medically fit for discharge.[37] Some of the patients were waiting for decisions about their ongoing care, usually following an assessment, whilst others were waiting for ongoing services to become available, such as a package of care or a bed.

The study also showed that, on average, 44% of individuals experiencing delayed discharges were subsequently placed in settings of care that were not the best possible for that person. In 92% of these delayed cases, the setting was providing a more intense level of care than would have maximised the individual's independence. In such instances, there is an opportunity for health and social care to work together in a different way.

A delayed discharge from hospital negatively impacts outcomes for individuals and introduces significant cost into the system. There are ever growing waiting lists for elective care, and a hospital bed for delayed patients can cost over £2,000 per week.[38]

In addition, a subsequent placement into a higher acuity setting will very quickly reduce someone's independence, while also costing the system in the long-term. For older people, a bed in a care home can cost over £650 per week and people can live in care homes for several years, especially if they are admitted prematurely.[39]

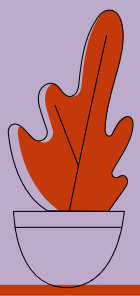
[37] Based on Newton 'point of prevalence' studies across 10,400 patients in 14 acute trusts (April-July 2018) - www.reducingdtoc.com

[38] AgeUK (www.ageuk.org.uk/latest-press/articles/2017/october/four-million-hospital-bed-days-lost-since-2011-due-to-problems-securing-social-care/); NHS analysis of costs of excess bed-days (www.improvement.nhs.uk/documents/1972/1_-_Reference_costs_201718.pdf)

[39] "Adult Social Care Activity and Finance Report, England - 2018-19" – NHS Digital (www.digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2018-19)

Case Study

Ensuring the optimum pathway becomes the default and no long-term decisions are made in a crisis



During the COVID-19 pandemic, Cornwall accelerated their integrated care ambitions through the rapid creation and roll-out of a new model of care coordination and a single point of contact referral process.

Before the pandemic, the system was already committed to changing how they worked together to deliver better care for older people more effectively. They had identified that they faced significant delays in older and frail people being discharged from acute and community hospitals and nearly half of people being discharged were not achieving their ideal outcome. In most of those cases the care was at a greater acuity than that person required.

The COVID-19 national modelling for the area suggested demand for community services would exceed four times the capacity of frontline teams. At peak, there would be 350 people in the community who would not be offered support, over 50 of whom would have acute medical needs.

In this system, previously each service that was available on discharge from hospital (for example, the community hospital, domiciliary care, residential care, reablement) had its own access point. This made the decision-making process extremely complex, with the acute hospital discharge teams, community hospital discharge teams, and community health services needing to approach each service separately to determine whether they had capacity, after they had assessed the person's needs.

Given the environment, the system moved to a new model of care coordination made up of three Community Coordination Centres (or CCCs). CCCs are multi-disciplinary teams made up of staff from all partners who have excellent knowledge and links into short-term and ongoing services.

All professionals referring individuals now have one point of contact via a single electronic referral form. This is quickly triaged and balanced by the CCCs which place it into the correct service. This removes the need for hundreds of referrers having to know all the services in their area and understand how to contact them. It also gives the system the ability to balance pressures as different services have experienced different issues throughout the pandemic.

One of the benefits of the new CCCs is that it means no long-term decisions are made in a crisis. Instead, the decision made by the referrer is purely around the correct pathway, which is then dealt with by the right team who can identify the best option. All referrals for individuals going home are sent to the CCC, which is able to access the right support services, always considering a short-term service such as reablement first. All referrals requiring a short- or long-term bed are sent to

a centralised bed bureau, which manages beds across the community hospitals or works with the council's brokerage team to source a residential bed. This single point of contact is also used by non-acute referrals, e.g. step-ups from community.

This new approach has been supported by the implementation of a new digital system which is giving better visibility of all system referrals, system capacity and demand, and accurate performance metrics. The visibility this provides is supporting the system to make critical decisions.

By aligning the right behaviours and metrics, in seven months this new service has enabled the system to:

- manage the outcomes of **27,250 people** from 7966 referrers
- support **1651 people** through the multiple community teams in partnership
- avoid **841 people** being admitted due to a community intervention
- support an **extra 531 people** in the community, despite initial requests for beds.

2.2

Young people transitioning to adulthood require a specific focus and a lifelong approach to managing disability and mental ill health.

Introduction

Transitioning to adulthood can represent a period of significant change for a young person with a care needs, particularly across their wider support network, including their education (they will stop attending school), their relationship with their family, and possibly their accommodation (they may be moving out of the family home). At the same time, this is typically the point where the management of the individual's care and support 'transitions' from children's services into adult social care.

By the time a young person reaches their teenage years, it is often possible to predict whether they are likely to have long-term care needs, as well as what support they will need to continue to prepare them for their adult life, to maximise their chance of living as independently as possible in their community. These young people may need help with the basic skills of day-to-day living or they may require more complex help such as with managing challenging behaviour or emotional support.

It is essential that children's services and adult social care are communicating throughout the young person's teenage years to ensure that they are achieving the best possible outcomes.

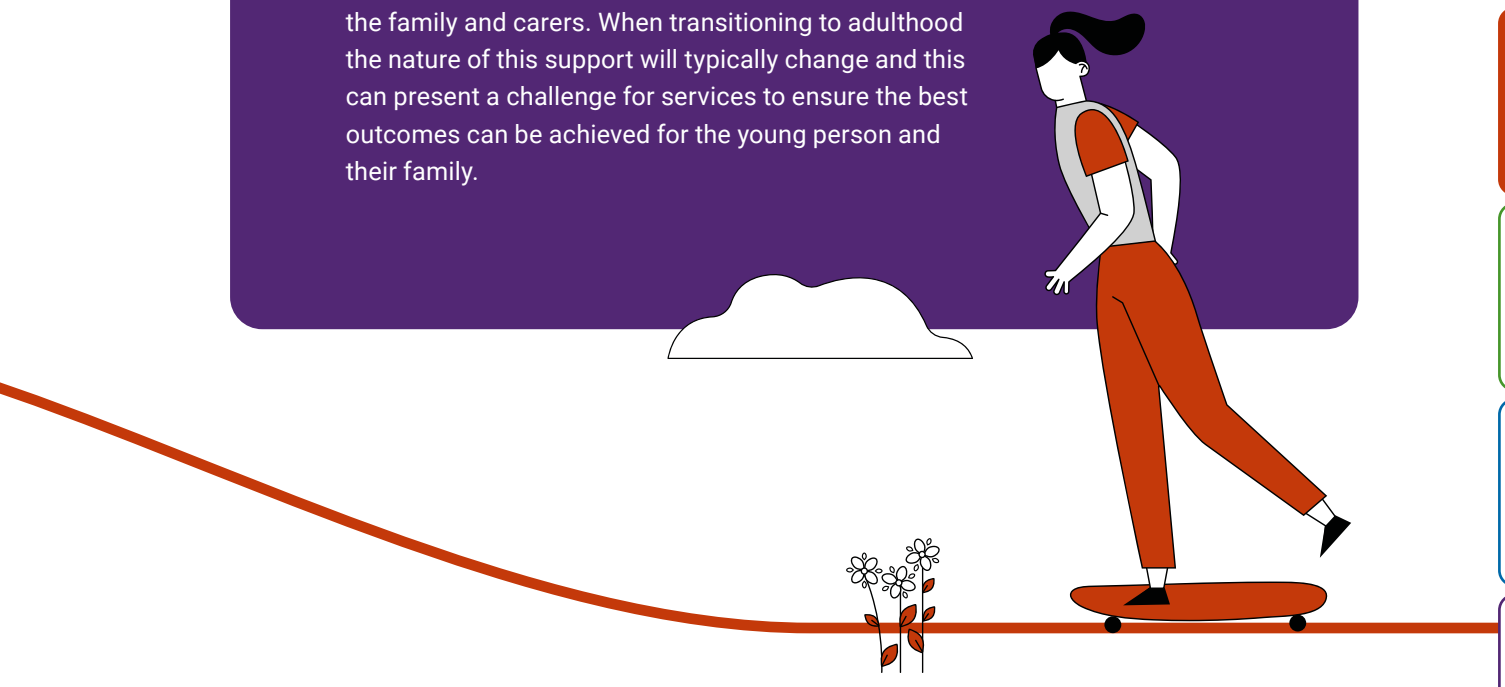
As a result of these challenges, this is a common area where authorities feel there is opportunity for improvement. Practitioners in one county authority reviewed the cases of 28 individuals who had been through a transition and identified that in more than half of cases, a more independent outcome could have been realised for the young person.

What do we mean by transitioning to adulthood?

Young people with care and support needs, including physical and learning disabilities and mental ill health, are typically supported by children's services until the age of 18 under the Children and Families Act. At this point, if they have ongoing care and support needs, they will 'transition' to be supported by adult social care teams. These teams will typically support adults from the age of 18 until the end of their life under the Care Act. There may also be a further 'transition' point later in life from a 'working age' service into an 'older age' service, usually when an individual reaches 65.

'Transitions' often refers to planning for and managing this process. Some services set up dedicated teams and structures to work with young people through this period of their lives. For example, some county authorities have a dedicated transitions team, often supporting children between the age of 16-25, which may sit as part of their children's or adult's service. Others have also constructed whole-life disability directorates – where disabled children and adult teams sit within the same organisational leadership.

Often, young people with physical and learning disabilities and mental ill health, and their families, receive significant care and support. This might include specialist educational support, such as a placement in a specialist residential school; 1:1 (or higher) ratios of care and support at home or in the community; and significant respite support for the family and carers. When transitioning to adulthood the nature of this support will typically change and this can present a challenge for services to ensure the best outcomes can be achieved for the young person and their family.



The principles of effective transitions to adulthood

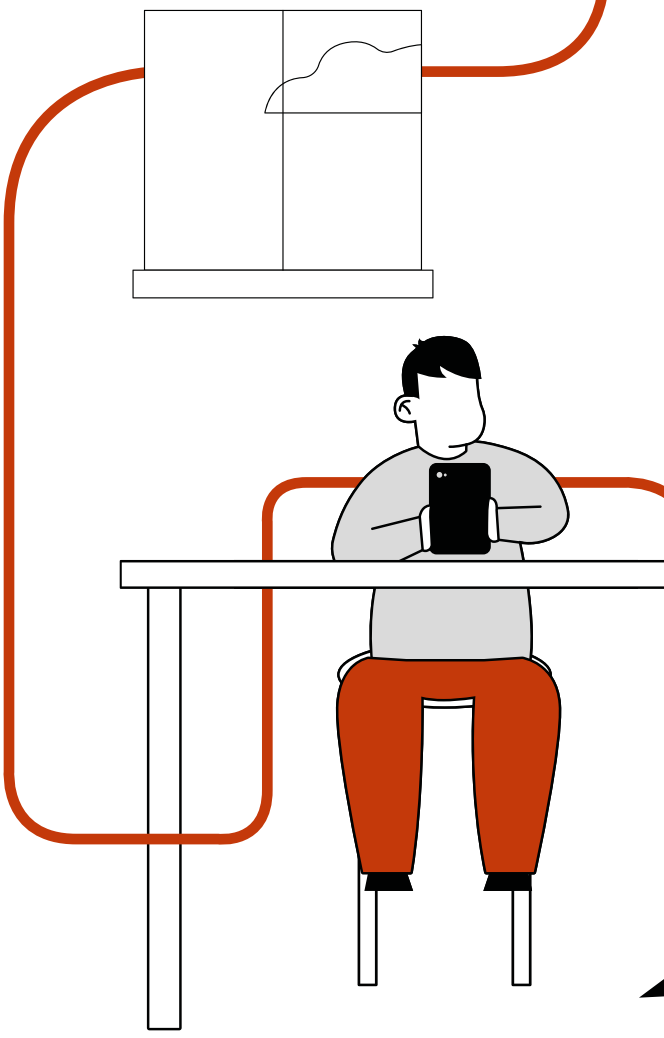
Optimised adult and children's services challenge the notion of transitions to adulthood altogether, by creating a **unified, lifelong disability pathway**. This doesn't necessarily mean any particular organisational structure, but rather relies on having practitioners collaboratively and carefully planning for the full range of care and support needs of a young person and their family.

These services begin to rigorously **plan for transition very early on**. This is often as early as when the young person enters their teenage years, and an initial understanding of likely aspirations and potential, and subsequent ongoing care and support needs, can be understood. 'Promoting independence plans' are developed from this early stage, with **clear goals**. To achieve this, there is **close collaboration** between the child, their family and support network, children's services and adult social care practitioners, and ideally other interacting organisations (education, health etc.). These plans are **regularly reviewed and challenged** throughout.

There is a **single, joined up commissioning strategy**, which ensures the right placements and provision are available at the right time. This means there are **no delays** when a placement, such as a specialist residential school, comes to an end for a young person. This is particularly important when ensuring **consistency** for the child, even when different legislative and regulatory challenges apply to children's and adults' support providers.

Commissioning is based on a **detailed understanding of the actual strengths and needs** of the current cohort of young people at both an individual and population level. Services make excellent use of the **data, insight and understanding** they have about their young people, who are already known to the local authority, and use this to proactively plan and ensure the best provision is in place.

The **family and carers are never overlooked** - services recognise that transitioning to adulthood is a challenging time for those caring for and supporting a young person. Appropriate support plans and provision are put in place to recognise this, including use of respite and carer support when required.

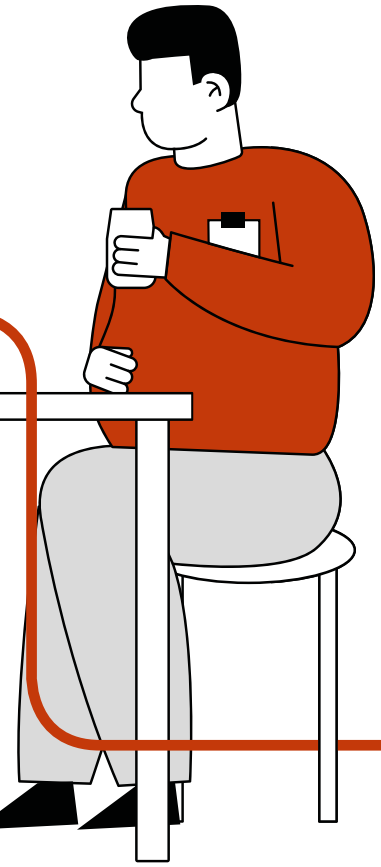


Case Study

Early planning for transitions through collaborative working across teams

In one county authority, culture surveys conducted across children's services and adult social care demonstrated a difference in their view of an ideal outcome for disabled individuals. Children's services staff believed the best outcome was around an individual's safety and the family unit being supported. Adult social care staff felt independence was most important, whilst managing expectations and positive risk taking. There was a need to recognise the importance of all of these outcomes, while supporting the individual and their family in a way that didn't result in a significant inconsistency when an individual transitioned between the teams.

"Both general managers and frontline staff want the same things for the individual but are looking at it from different directions".



Practitioners felt that a number of individuals could be better supported at the point of transition – both in terms of the planning and outcome achieved – if the service were better able to start planning when the individual was an early teenager.

One of the challenges identified was that children's Education Health and Care Plans (EHCP) and Care and Support Plans did not align in terms of identifying what the child is able to do, and their plan for the future.

The service is now looking to use data to create visibility of every child's transition date. This will look to allow each individual to be reviewed at the right time by a joint team including a children's services social worker, an adults practitioner and a SEND officer. Working together they can get a joint understanding of the child's current needs against the Care Act domains and engage with the child and their family around future potential and aspirations. Each case will look to receive input from a broader team of other disabled children's social workers through group peer discussion. The aim is that a detailed Children's Care and Support plan is created and the EHCP is able to mirror similar goals.

This work is still ongoing, but early desktop exercises indicate that children are expecting to see an average reduction in the level of support required of **20%**, and more importantly be better set up for a greater level of independence in their future adult life.

2.3

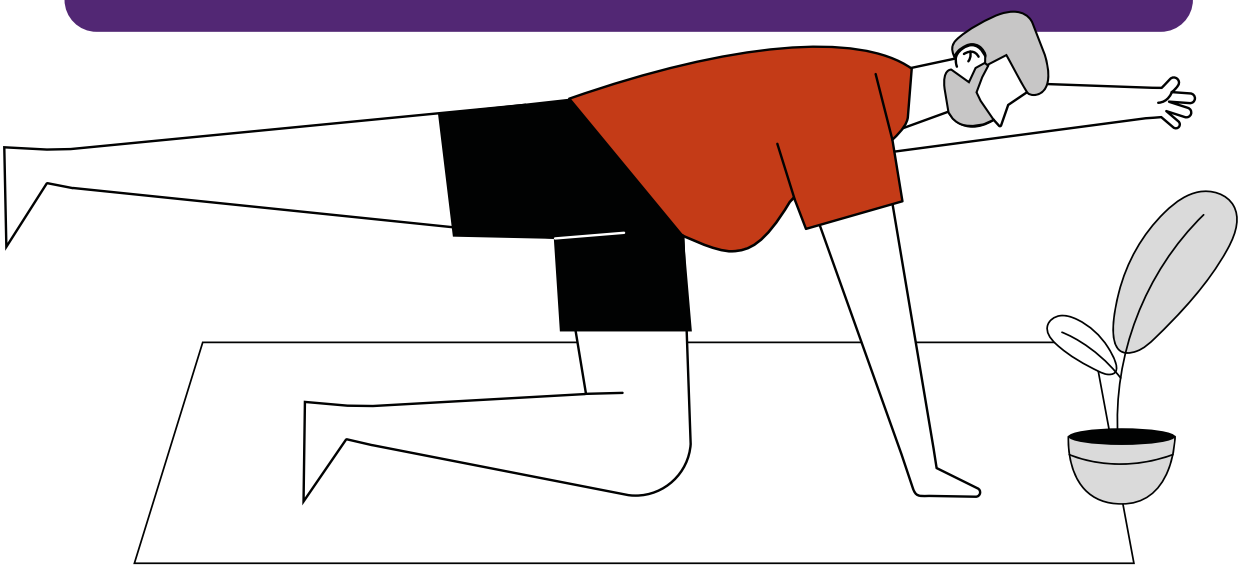
The primary purpose of an effective front door into social care is to connect individuals to support available from their informal networks and local communities.

Introduction

For those people who contact the council, the majority can be assisted with advice and guidance. This can either immediately resolve their concern or direct them to alternative services in the VCS. For those individuals that contact the service via the phone or in person, typically 67% of enquiries can be successfully resolved without the need for further formal intervention.

What do we mean by front door?

There are normally a variety of methods through which individuals or their network access the local authority's front door – in person, online or over the phone. Each method has different benefits in terms of ease of access, effectiveness at handling queries and efficiency of delivery. Referrals from health partners, including on discharge from hospital, are typically managed separately.



The principles of an effective front door

Optimised adult social care services **tailor their front door** dependent on the population they are serving; the health and social care system they operate within; and their local network of community services.

The front door is informed by what is happening **in the community** and sees its primary function as connecting people to what is available **locally and informally**, wherever appropriate.

An effective front door is managed efficiently, without impacting on quality of delivery, and **automated wherever possible**. Digital plays an increasing role, both in terms of decision-making support for practitioners and by creating online platforms for people to 'self-assess' their own strengths and needs, without the need for any intervention from social care.

Optimised services ensure there is **the right balance of resources and professionals**. Professionals, such as occupational therapists, are on hand to support 'one-stop' decision-making, and those who work within the front door have an intimate knowledge of available local support. Some services choose to have a **community organisation manage this function** in its entirety, to guarantee this local knowledge and focus.

Practitioners help individuals to understand **what really matters to them** and, where possible, individuals are supported to 'self-serve', by finding and accessing resources in their own informal networks and communities.

County authorities recognise, together with key partners including healthcare providers; primary care providers; and (in two-tier areas) district and borough councils, that individuals and their network do not need to understand the complexity of the system and work to **simplify pathways and referral routes**. Collaboration **across the system** ensures that, regardless of the individual professional or route through which contact is made, the individual will get a consistently high-quality experience and the most independent outcome.

The **right balance** is found between good customer service, handling enquiries quickly, efficiently, and to a complete resolution at the initial point of contact, and achieving the most independent outcomes for the individual.

This is enabled by using the **right metrics**, which provide clarity and visibility over both aspects of performance.

Case Study

A call centre that connects people to support in their local communities

Somerset County Council's contact service handles 6,700 phone calls for adult social care per month. On average 62% of these calls are resolved with no requirement for a full adult social care assessment.

This has been achieved by providing support and training to staff to enable them to focus the conversation on what matters to the person and what they might be able to achieve by helping themselves or accessing their local community. Staff have been empowered to make changes to ways of working and to focus on resolving calls, so that people are provided with solutions that meet their needs, without onward referral for paid for services. Key to achieving this has been support from social work staff in key areas such as training in safeguarding and mental health to ensure appropriate triage, as well as regular customer satisfaction checks.

Before, around 30% of calls were resolved without the need for formal care. Now, over 60% of callers find solutions without onward referral to social care.

Those that are referred receive a call back on the same day from the local social work triage team. Sometimes, the social worker or occupational therapist is able to help the person consider community solutions, particularly if they have already had some involvement from social care. This results in a further 15% of people being offered community solutions without formal assessment.

This has not only helped people to find a quick resolution for their problems, it has enabled social workers to ensure that their assessments are undertaken only for those who really need their help and enabled the teams to manage demand effectively.

When social workers do undertake an assessment, they find a high percentage of these people are eligible for a service, confirming to the council that the right people are being passed through to the adult social care locality-based teams.

During the COVID-19 pandemic, the council established a specific pandemic response line. Staff have been supported with a revamped induction programme, peer supervision, and a focus on good training. They are now integrating webchat and social media exchanges into the work of the service.

Key to the success of the programme has been the investment in and development of community connectors (Village Agents who work in their community and help develop community resources and link people to local activities and groups). In addition, a 'micro-enterprise programme' has led to the establishment of over 600 micro-providers (social enterprises) who can assist people with a range of care needs providing an alternative to commissioned care and support.

Case Study

A locality-based front door model that helps people achieve their most independent outcomes by connecting them to the right local services

Northamptonshire County Council has moved to a locality-based front door model. Before the change, feedback from individuals and their network suggested the process to access social care support was confusing, lengthy, and involved multiple hand-offs. Practitioners agreed that they felt bound to embedded practice and constrained by binary options.

The new model represents a shift towards much stronger links with the community. All routes into the council through the community now come through a locality team. The vision for the locality teams is to:

"Aim to resolve people's crises, connect them to their local community, and find them their most independent outcome."

This means the individual is supported by a team based within that person's local community. They have a breadth of knowledge of all the services that can support an individual to maximise their independence.

The locality teams work with partners to achieve the highest quality service and best outcomes for people. The ways of working are established on the principle that they break through organisational barriers and build professional relationships to make this easy, this includes:

- They are organised around communities and actively build relationships with local providers and services such as volunteer groups, community groups, and parish councils.
- They have direct links with partners such as GPs and the Police - helping to build their understanding of the service and vice versa.
- Relationships and service development with health is a priority and will be further developed through active engagement with the whole system transformation programme.
- Building relationships across departments, increasing the feeling of one team and one authority.

This all means the person's initial conversation with the council is more personal, with the intention that the range of services they are referred to are more closely aligned to their needs.

Early trials of this new model, as part of a wider adult social care transformation programme, show that **84%** more people are now seen in a timely manner, and decisions are achieving **30%** more independent outcomes for individuals.

Service Delivery Enablers

Theme 3 - Partner and provider relationships

The full buy-in and support from local partners and providers is essential to achieving the values and beliefs.

Introduction

The local authority is uniquely positioned in a place to forge relationships between all partners and providers involved in the delivery of adult social care. To achieve this, authorities will see one of their roles as the **key coordinator of local relationships at a place level**. This is a core part of adult social care leadership (*see Theme 5*).

The importance of these partnerships has been brought into sharp focus during the response to the COVID-19 pandemic. Demand for care has fluctuated significantly, and all partners have had to rapidly adapt to new processes and ways of working. This strain has placed even more importance on these critical relationships.

What do we mean by partners and providers?

The term 'partners and providers' refers to those services or organisations that have a key interface with adult social care. These include district and borough councils, acute trusts, community health providers, primary care, CCGs, public health, mental health trusts, private organisations who deliver care and support, the voluntary sector, police, and local and regional representative organisations (LGA, ADASS, ACCE, SOLACE and more).

Since the late 1980s, most of the services that have been established to help people are either run by not-for-profit voluntary organisations (including charities; co-operatives; or housing associations) or by independent profit-making providers of care, rather than being 'in house'. In recent years, some county authorities have encouraged the development of social enterprises or other co-operative schemes, whilst others have focused on individuals in their communities who are willing and able to act as personal assistants (PAs) to help local people with care or support needs. In broad terms, the needs of older people are mostly met through private providers, whilst younger disabled adults prefer to have some control by employing their own PAs, however, there are always exceptions in both cases.

The principles of effective partner and provider relationships

In an optimised system authorities recognise that they can't deliver their ambition for promoting independence on their own, and so seek the **full support and buy-in** from their local providers and partners.

Perhaps one of the most fundamental conditions that helps bring organisations together is **sharing a common goal**. During the local response to COVID-19, the safety of individuals (people receiving care, the general population and staff) has become the primary objective of every organisation – whether a partner, a provider or a commissioner. This has provided a **very clear and shared goal**, which in some cases has improved the quality of partnerships, with everyone pulling in a unified direction to meet the challenge together. However, some systems have experienced a worsening of relationships under this significant strain, which demonstrates the need for other conditions to underpin brilliant partnerships.

A common constraint is the **ability to share data and information freely** between partners. In an optimised model authorities will have the **right legal relationships** (Data Sharing Agreements) between partners across the system and invest in digital systems with a high degree of interoperability (explored further in *Theme 6*). During the pandemic, rules around information governance have been relaxed by DHSC, who gave the instruction to **share what information is necessary** to keep people safe. There have been some excellent examples of partners working together in new ways. One example would be District Nursing sharing information with reablement workers, allowing them to work out who is best placed to see someone, while limiting their potential exposure. With absolute respect to personal data and the important laws around it, health and social care systems, and all partners involved, are now reflecting on what was enabled by increased data sharing and looking at how to move forward if, or when, regulations change.

Financial constraints also represent a significant challenge to building local partnerships and productive relationships. Where individual organisations within the system have significant pressure to meet their budgets, this can lead to decision-making which protects the financial position of individual organisations as opposed to the whole system. Collaborating with partners to **remove financial constraints and share risk**, allows authorities to optimise the outcome, both financially and in terms of outcomes for individuals, across the whole system.

This requires an **alignment of organisational incentives and imperatives**. Some authorities achieve this through **good strategic commissioning**, where partners are incentivised to deliver outcomes that promote independence and share the financial benefit of doing so.

Others establish this alignment by developing a **'system-first' mindset**, where the outcomes and financial benefits are always put before those of individual organisations. This is difficult to achieve, and relies on strong system leadership, collaboration, and clarity on shared performance measures and targets, which transcend organisational boundaries. Authorities with a system-first mindset have **frequent, open, and two-way communication** with partners and providers. Good communication is key to trusting relationships and helps to avoid action that protects an individual organisation at the cost of the whole system outcomes. To achieve this, they have the **right governance forums** in place to bring together system leaders, with the right common objective, the right environment to promote open discussion and the right data and insight to ensure decision-making is evidence-based.

Care providers

Historically private sector organisations who deliver care and support have been seen as 'providers'. However, increasingly optimised systems are treating these relationships as **mutually beneficial partnerships**, rather than traditional 'commissioner – provider' relationships.

When working with **care providers**, these authorities find alternatives to commissioning care on a 'time and task' basis (which incentivises organisations to maintain unnecessarily high levels of care and support when the resident doesn't require it). Instead, these authorities **commission with a focus on outcomes**, such that there is a fundamental alignment of organisational objectives, and care providers are incentivised to achieve the most independent outcomes for individuals through a commissioning mechanism that rewards them for doing so. *Theme 8* explores the role of strategic commissioning further.

This approach requires the **authority to trust care providers** and allow them to flexibly adjust care and support as required to achieve an individual's goals. These authorities recognise that care providers are **well placed to make these decisions**, since they are often the people who spend the most time directly working with a resident. However, they also realise that care providers will need support and development to build their capability to be able to play this role effectively, and these authorities invest significant time and funding in **developing their local market**. To support the relationship, authorities are increasingly moving away from formal, quarterly or monthly 'provider reviews' and towards **frequent informal discussions**.

To drive greater transparency, authorities are also moving towards '**open book accounting**' with their care providers - this is two-way, where the authority shares the funding they have available to meet an outcome, and the care providers share their financial models, what their costs are and what profit they stand to make. Built on a foundation of trust, this allows partners to work together to **optimise the use of the available funding**. Providers engaged as part of this programme of work echoed the strength of this model – citing it can result in them being able to better respond to what is needed in a way that still ensures they can meet their costs.

Health

When working with **health partners as part of an optimised system**, authorities are adept at managing the tension between effective 'flow' out of hospital (people being discharged from hospital quickly to create and maintain bed capacity) and achieving the best long-term outcome for the individual (ensuring they are discharged into the most appropriate setting of care). However, relationships with health go beyond just discharging a patient from hospital – and extend to other partners such as primary and community care. Optimised systems recognise that the two disciplines of medicine and social work take a **different approach** and create appropriate space for the two to work in harmony.

Social care leaders who were engaged as part of this programme of work cited the fundamentally **different belief systems** as one of the challenges to building productive relationships. An example of this in practice would be when comparing the social model of disability and the medical model of disability. The medical model says people are disabled by their impairments or differences whereas the social model says that people are disabled by barriers in society.[40]

In optimised systems, **these two disciplines work closely together** but also recognise their differences and respect each other's roles in the system, acknowledging both sets of skills are important to improve the lives of individuals.

Housing

One area that was raised throughout this programme of work was housing, and the associated relationship between a county authority and district and borough councils where there is two-tier local government. Poor quality or inadequate housing can significantly increase a person's need for care and so ensuring **appropriate housing is available** is an important part of adult social care. This can operate at a strategic level or at a very personal level.

In some single-tier councils, the role of Director of Social Services is combined with the role of Director of Housing, which means the strategic direction of both services can be aligned. This is much harder to achieve in upper-tier county authorities, where the housing responsibilities sit with the district council, and so adult social care **need to influence their district partners**. Where plans for local government reorganisation are being explored this may go some way to solving this and maximising the benefits of housing policy strategy.

[40] Social Care Model of Disability (www.scope.org.uk/about-us/social-model-of-disability/)

Case Study

Targeted support for care homes providers and their residents during the COVID-19 pandemic

During the COVID-19 pandemic, care homes came under huge stress in terms of managing demand and infection control.

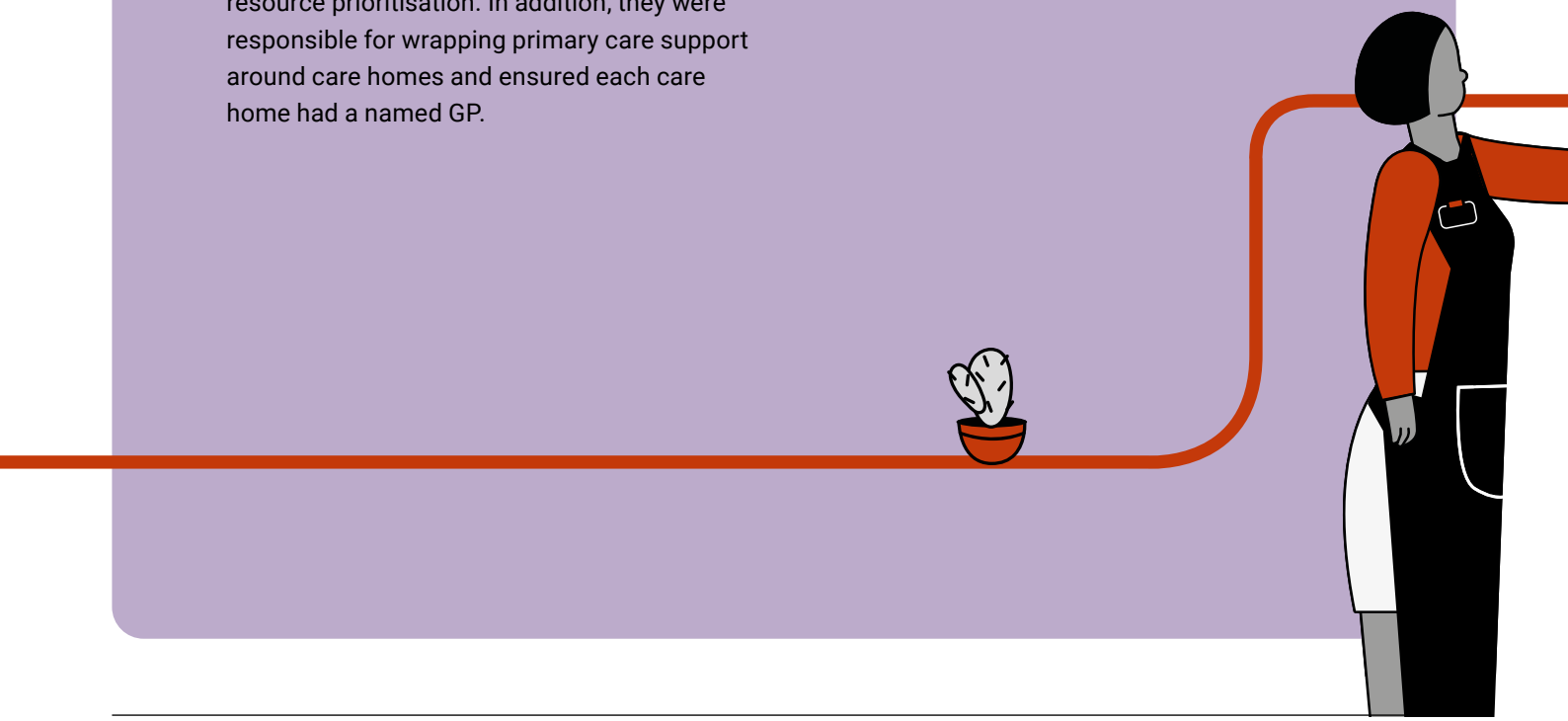
Cornwall created a new care home support group, chaired by a GP but with involvement from the local authority and CCG to provide dedicated support to care homes.

This team met daily to identify, prioritise, and provide wrap-around support to care homes that were experiencing outbreaks of the virus or were at risk of an outbreak.

The group was responsible for managing risk in the community. For example, they monitored and improved the state of care homes; ensured infection control practice was upheld and that there was adequate PPE supply; oversaw the implementation of national policy and guidelines; and linked up national PHE data with local intelligence to give an accurate picture of outbreaks or potential outbreaks which allowed resource prioritisation. In addition, they were responsible for wrapping primary care support around care homes and ensured each care home had a named GP.

Together, they were able to reduce A&E admissions as well as bring down and maintain a low number of cases in care homes. This team allowed the system to respond quickly to any emerging outbreaks and give targeted support where it was most needed to keep people healthy.

This support ensured those individuals living in care homes were able to remain as safe as possible and maintain their levels of independence. In addition, the number of care homes feeling positively supported increased.



Case Study

Empowering domiciliary care providers through provider-led reviews

Cornwall has empowered their provider market to identify changes to need, and in doing so, better support people's independence. Following a successful first phase, they are now entering a second phase.

Results from the trial have demonstrated that:

Providers are capable of making effective judgements about a person's needs.

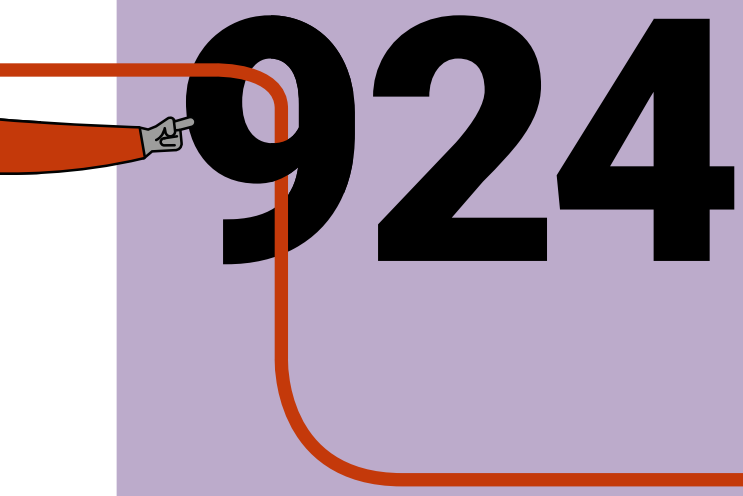
During the trial, selected practitioners were able to propose package changes for people in their care. This was then checked by an assessor. In 91% of cases, it was approved. This is a significant improvement on a previous manual process which could take up to a year to result in a decision.

Providers are well placed to identify changes to a person's needs – especially where care has been over prescribed.

This trial ran for under two months and the changes proposed by providers reduced the average package size by four hours for the cases submitted. This freed up 924 hours per week of capacity in the home care market.

Empowering providers to lead reviews benefits the individual, the provider, and the commissioner.

For the individual, this way of working reduces over proscription of care, which can lead to greater dependency. Equally, responding quickly to increased needs improves safety. For the provider, greater autonomy improves staff engagement and allows for a more efficient use of staff time. For the commissioner, there is a decrease in the workload for the assessment team, which reduces overdue reviews and reduces cost.



Service Delivery Enablers

Theme 4 - Practice

Strengths-based practice can only be delivered consistently in a working environment which is fundamentally designed with this approach in mind, and by ensuring practitioners feel supported, empowered and challenged.

Introduction

In any social care team, there needs to be a range of people with the skills and awareness to work with individuals in the way that best suits their needs. The person whose needs are being met, and their aspirations and requirements, should be put at the heart of the service being delivered. Some people need emotional support to help them address their challenges; some need help with recovery and rehabilitation; others need to feel they are in control of the care they are getting; whilst other people will need a circle of friends and to feel included in their communities.

Individuals should be supported to co-develop their own care and support plan. However, this does not always mean that the individual will know best. Some people, because of their previous experiences and expectations, may limit their ambitions, while others may be over-institutionalised and need the security of the place they have always known. The skill of any professional is to be able to listen to what an individual wants for their care but also, where appropriate, help them to aspire to achieve more than they may have previously felt able to do.

What do we mean by practice?

'Practice' describes the process, skills, and behaviour of having these conversations and developing these goals for individuals. Different approaches, frameworks, and theoretical bases can be used to guide this way of working.

Over the years, there have been a number of strong theoretical bases on which local social care is based: psychotherapy in the 1960s; community social work in the 1970s; task centred practices and family therapy in the 1980s; recovery models in the 1990s; personalisation in the 2000s; and more recently outcomes-based practices (including trusted assessors) and asset-based or strengths-based social care.

The principles of consistent practice

Optimised services which consistently deliver good quality, strengths-based practice, do so by carefully **designing every aspect of the environment that practitioners work within**. These services recognise that systems; ways of working; processes; paperwork; management structures; and leadership influence practitioners' day-to-day activity as much as their own professional training and capability.

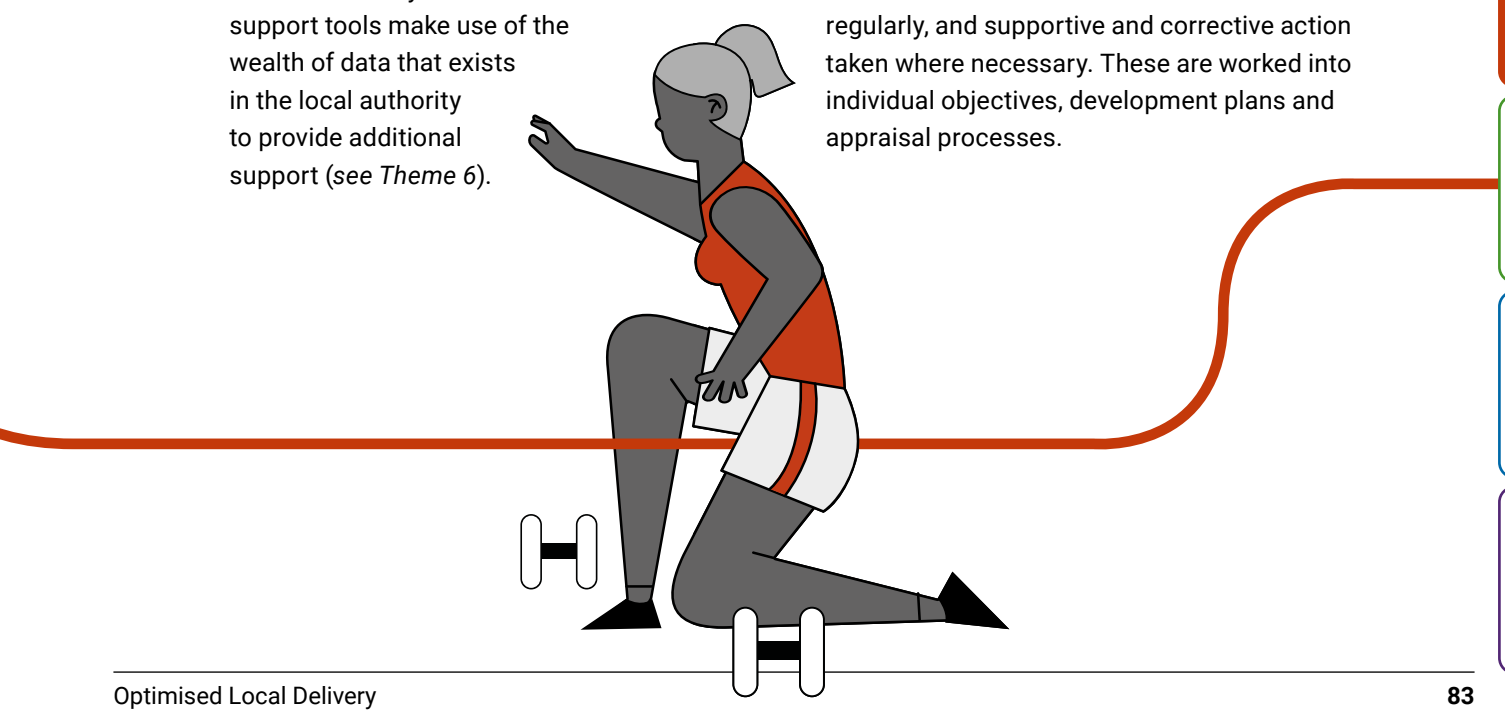
Practitioners working within optimised services share a common set of **beliefs and values**. These are role modelled and communicated by passionate leaders, and are easy to relate to practical, day to day actions and activities.

There is **strong practice leadership**, with time and support built into the working week for continued professional development including training, support and reflective supervision. Regular audit processes provide the insight to enable **continuous practice improvement**, by highlighting both individual strengths and weaknesses, and systematic challenges that require a service-level intervention.

Consistent practice is **digitally enabled**. The right information and data are made available to practitioners in the right format, at the right time, to ensure practitioners have a full picture of the individual, their strengths and needs, and their local community network. Decision support tools make use of the wealth of data that exists in the local authority to provide additional support (*see Theme 6*).

Consistent ways of working - including daily, weekly, and monthly rhythm and routine - have a clear focus on achieving independent outcomes. Ample time is given to 1:1s and group supervision, where practitioners can collaboratively develop strengths-based support plans. The support of colleagues and managers promotes positive risk-taking, avoiding practitioners feeling isolated in decision-making. Individuals with lived experience engaged as part of this programme of work noted how important it was for support planning to **be personal and outcome focussed** based on the how the person wants / needs to meet their outcome. They also highlighted the need for people to be supported to **set their own goals** and outcomes.

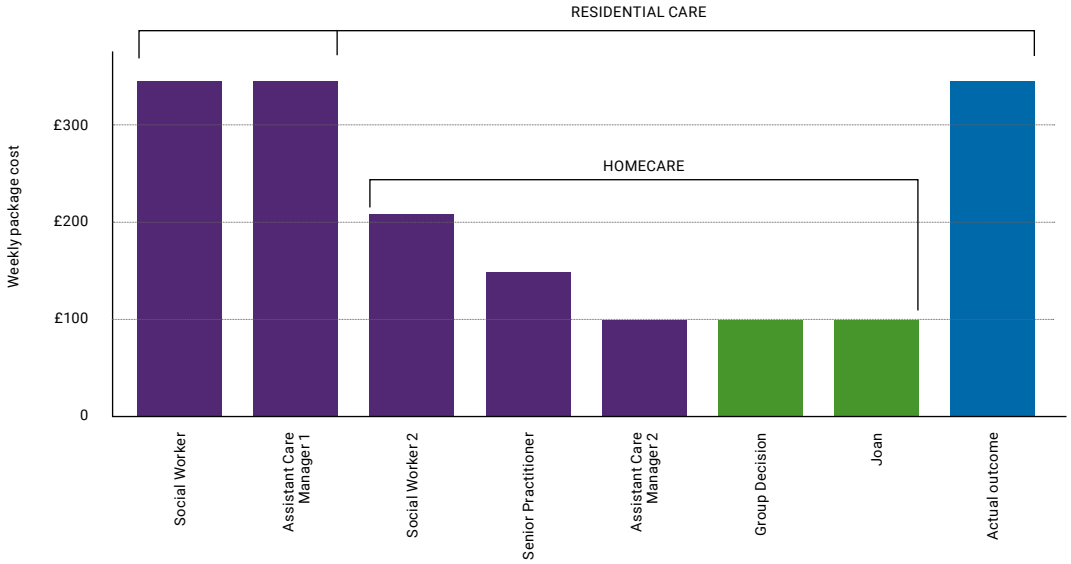
Performance is measured using carefully designed KPIs, which balance both the timeliness of interventions and the quality of the outcome. These go beyond purely focussing on reducing hours of care. These measures are reviewed regularly, and supportive and corrective action taken where necessary. These are worked into individual objectives, development plans and appraisal processes.



Insight Impact of peer group discussions

Peer group discussions are shown to have a significant impact on the outcomes that are achieved for individuals. When practitioners feel supported in their decision-making, and are able to draw on the expertise of colleagues, they are likely to explore more creative routes and embrace positive risk taking.

The figure below shows this in practice. Five different practitioners (as shown in the purple bars) were asked to review Joan's case, with each one offering a different answer for her. The practitioners were then brought together to examine the case as a group. Together, they chose the most independent outcome, which was also aligned to Joan's preferences (as shown in the green bars).



In over 1000 case reviews across 11 different authorities, multi-disciplinary teams were asked what they believed the ideal outcome would be for each individual. In **99.6%** of cases, the group chose an outcome which was the same or more independent than that of the individual practitioner.

Case Study

The impact of consistent ways of working

Northamptonshire County Council has established new ways of working in their community teams to improve the consistency of their practice. These include:

- In order to ensure people get the support they need, Principal Social Workers support their teams through **'on-track chats'** every two weeks. These involve providing guidance and support to all open cases, understanding where any cases are off track and ensuring that all individuals are achieving the best outcomes in the right amount of time.
- **Huddles** ensure the team are supported by providing an opportunity to feedback, share positive stories and receive support.
- **Scheduled reviews** ensure the team check in with the people they support regularly to help them live the best life possible. These cases are then taken to an Ideal Outcomes Meeting to receive additional knowledge and expertise.
- **Ideal Outcomes Meetings** ensure the best decisions possible are being made for individuals by allowing practitioners to access wider knowledge and expertise. These are held twice a week, with experts from other services. These sessions are designed to be co-productive, challenging, creative and non-judgemental.

Early trials of the Ideal Outcomes Meetings demonstrate that the team are now making decisions which result in **30%** more independence for individuals.

Organisational Enablers

Theme 5 - Culture and leadership

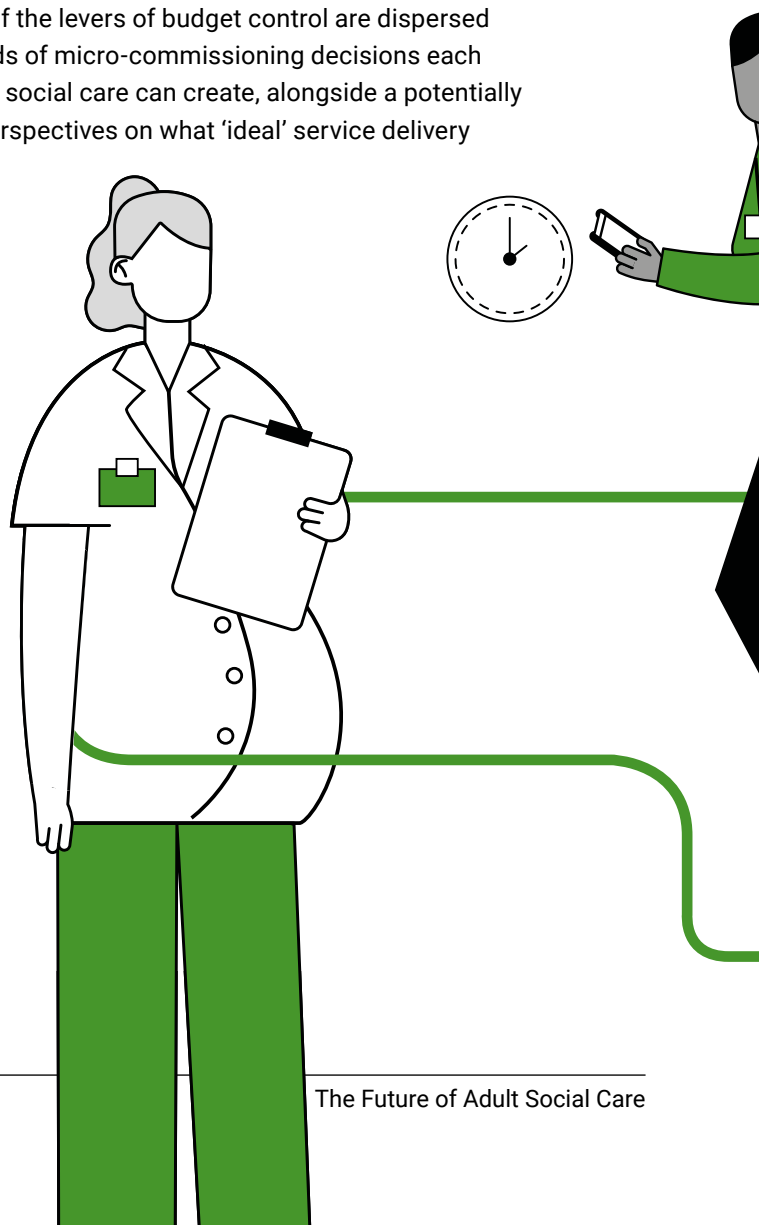
Exceptional leadership and a consistent culture are the key enablers for embedding the right values and beliefs throughout the organisation.

Introduction

The need to exhibit system leadership capabilities in adult social care is critically important. The breadth of responsibilities ranges from statutory accountability for the safeguarding of an individual, to creating and delivering strategic multi-million-pound partnerships with providers which have a profound long-term impact on the wellbeing of the local population. Stakeholder engagement spans the breadth of people and their families; individual business owners; councillors and MPs; health executives; national representatives; and most importantly a large and diverse workforce.

Budgetary pressures are unprecedented, and many of the levers of budget control are dispersed through the workforce, which can be making hundreds of micro-commissioning decisions each week. Furthermore, the highly personalised nature of social care can create, alongside a potentially fluid provider and community landscape, differing perspectives on what 'ideal' service delivery is at an individual and service level.

There is a further leadership requirement of optimising the population outcomes across a wider health and social care system, whose leaders would recognise many of their own organisational pressures reflected in those faced within adult social care. Sometimes, the optimum solution for an individual partner may not lead to an optimum system-wide solution, nor the best outcome for individuals with care and support needs. Effective joint leadership teams look at maximising the long-term outcome for the individual first, mobilising all their stakeholders behind this and as such moving risk, resource, and reward within and across organisational boundaries.



Clarity of an organisational belief system

Excellent leaders clearly and confidently **convey and embody a set of beliefs and values** rooted in maximising long-term independence and quality of life. They understand that this frame of reference needs to permeate all interactions their organisation has with people, partners and providers. This allows clarity and expectations to be communicated through the service as to how people should be supported, and enables leaders to lead.

These leaders recognise that adult social care is within the context of a larger place-shaping organisation and that all services are on an **evolving journey**. They encourage and support cross-organisational working and positive team-based risk taking, and critically analyse the success of these endeavours.

Recognising the strengths and development opportunities within the workforce

Studies have identified the predisposition of an adult social care culture to operate within **the 'clan mindset'**.[41] This is characterised by the desire to work collaboratively, invest in the wellbeing of all stakeholders and being willing to apply discretionary effort to achieve the right outcome for local people. Unsurprisingly, this mindset offers significant potential for helping support people achieve great outcomes by deliberately **designing better ways of working**.

For instance, when multi-disciplinary groups of practitioners work together collaboratively to challenge how best to support an individual they are able to tap into a wealth of experience of potential alternative forms of support. This results in them taking **positive and balanced risks** before consensually agreeing on a course of action. The same studies have consistently shown that these decisions result in **significantly more independent outcomes being achieved**, at lower cost and with greater satisfaction for individuals and staff, when compared to isolated decision-making (*see Theme 4*).

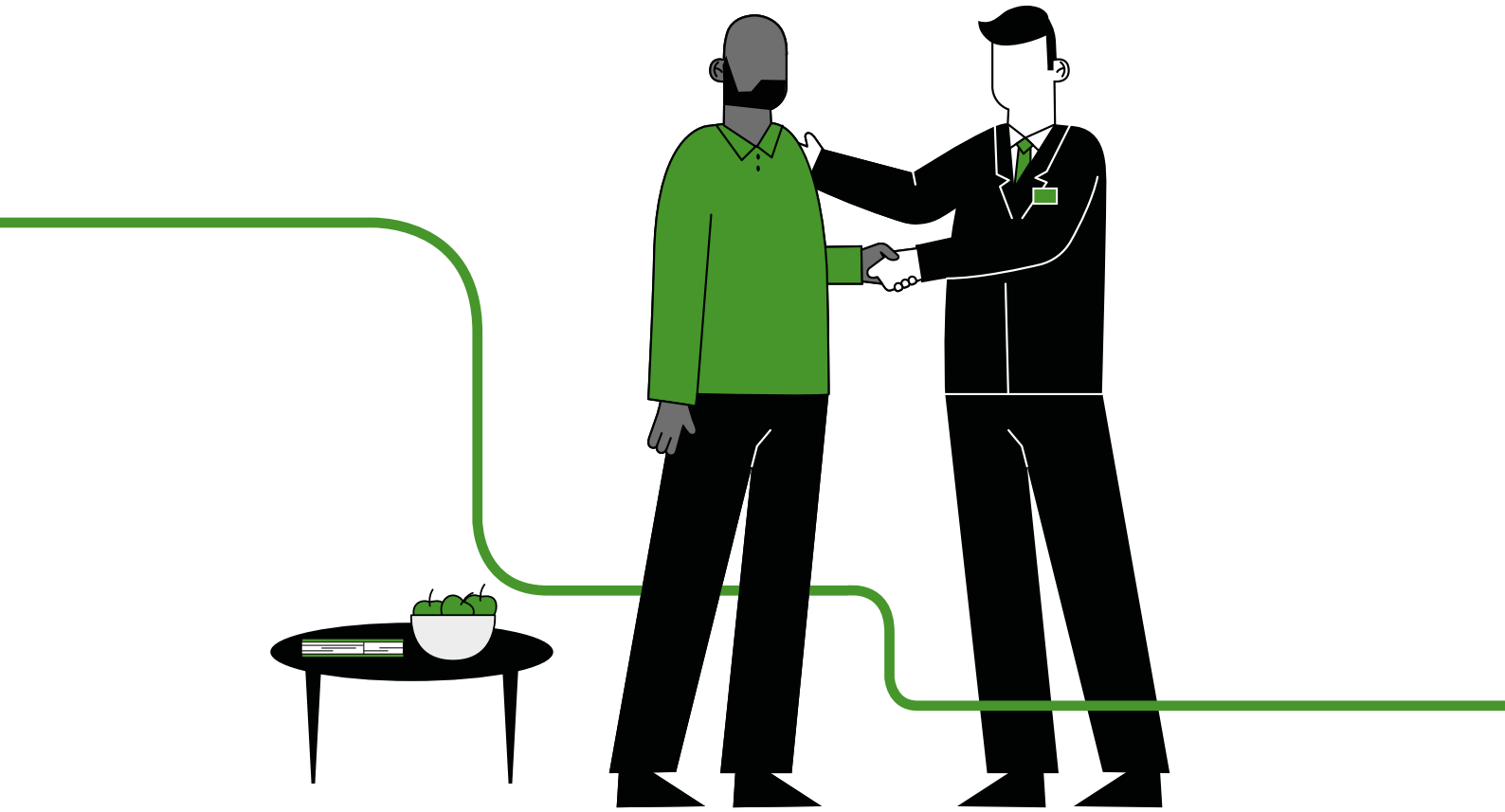
Great social care leaders also recognise the opportunities to **develop their workforce** to be the fully rounded managers and leaders required to optimise such complicated systems. Developing a curiosity for and an understanding of **data**, and its power to improve decision-making in an organisation, is not always routinely developed in the social care workforce. Once this **curiosity and confidence around data is embedded**, the benefits are profound, touching every part of the service – from better support planning for individuals based on an understanding of a service's effectiveness; supporting a team manager's development based on an objective view of their team's performance; determining solutions to persistent and systematic challenges; and creating new services to achieve improved outcomes.

[41] Newton 'Environment for Change' surveys carried out across 5 authorities with 174 members of staff.

Development of future leaders is central to the success of an organisation's future. Great social care leadership teams **embrace diversity** and welcome individuals from varied backgrounds, including those who may not previously have pursued a career in social care, and create a management team who are representative of the population they serve. These individuals are skilled in managing performance in a positive way, through the objective analysis of practice-based data, and this is key to their progression and future leadership standing. Directors of Adult Social Services who were engaged as part of this programme of work cited the importance of both diversity in social care leadership as well as the importance of data-driven performance management as a critical leadership skill in social care, which they believe isn't currently valued highly enough.

Mobilising the broader organisation

The successful delivery of adult social care relies on effective working with wider functions and bodies. **Building productive partnerships** is a core capability within the leadership of social care and local authorities recognise their unique role within a place as a catalyst and facilitator in bringing together partners from different parts of the system and uniting them around a common set of beliefs and values. This requires skills in relationship building, facilitation, communication, and change management.



Case Study

Clarity of an organisational belief system underpinned by data-driven decision-making

In Leicestershire County Council, the vision for the adult social care service is to ensure that it achieves the best outcomes for people by making sure they receive the right support, at the right level, and at the right time. The belief system is one in which maximising the independence of every resident should always be the desired outcome.

However, insight demonstrated that many individuals were not receiving reviews annually. Half of the older adults in residential care could have been in more independent settings and younger people with learning disabilities and mental ill health could have been working towards more independent outcomes.

To achieve their vision consistently across the service, the leadership knew that it had to adopt more of an 'independence first' culture. However, they also knew that it can be difficult for staff, as individuals, to make these decisions due to the complexities and risks associated with older adults, mental ill health, and adults with long-term disabilities.

> ***" The leadership wanted to ensure that every member of staff feels that they have the responsibility, and the power, to achieve the vision and make a truly positive impact on the people's lives".***

In the first instance, the leadership team collaborated with staff from across the service to co-create the vision, before communicating it across the service through a combination of channels including roadshows, newsletters, and 1-1 meetings.

To achieve the vision, a change programme was designed and delivered, with a diverse team made up of colleagues from across the council including Business Intelligence; Finance; the Transformation Unit; Communications; Learning & Development; and Design Leads directly out of the service. Through the programme, the service brought in new structures and processes in every team to support the independence first culture.

Developing a curiosity for and an understanding of data

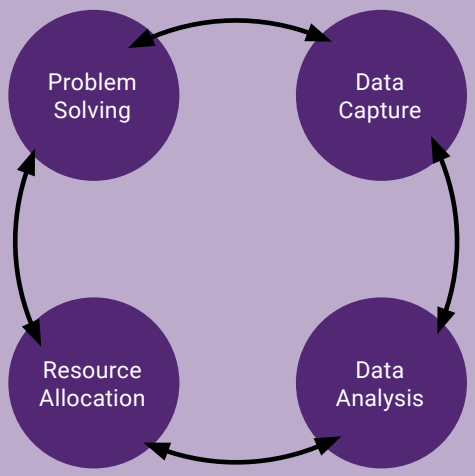
One of the ways that a step change in performance has been achieved is by improving the understanding and use of data across the workforce, underpinned by a department-wide 'improvement cycle'.

A culture of continuous improvement and feedback

Skills present within the organisation to manage change and improvement initiatives

Clear communication and resolution of issues sustainably

Skills and training to do the job



Accurate, timely, complete data capture about the most important processes

Effort is expended on understanding data, not collating it

An effective meeting structure that promotes quick allocation of people, with robust mechanisms to track and follow up on quantifiable actions

A clear cascade of messages down and problems up the food chain

Ownership and accountability

Management information enables rapid decision-making, based on facts, not gut feelings

Clear and complete reports produced from robust systems in a timely manner

Improvement cycle meetings have been implemented at all levels of the organisation to review the key measures, identify challenges, and then agree an owner to take each action forward. The 'cycle' aspect of the improvement cycle ensures they can monitor performance on an ongoing basis.

This structure not only provides clear accountability of performance, from an individual team to an entire service, but also provides an escalation route for those working on the frontline to the senior leadership team. This reinforces the belief that everyone's input is valued, and everyone can have an impact on the wider service. Within this structure, managers and team leads are empowered to create a culture of continuous improvement by encouraging all staff to share and escalate service improvements or issues.

Impact

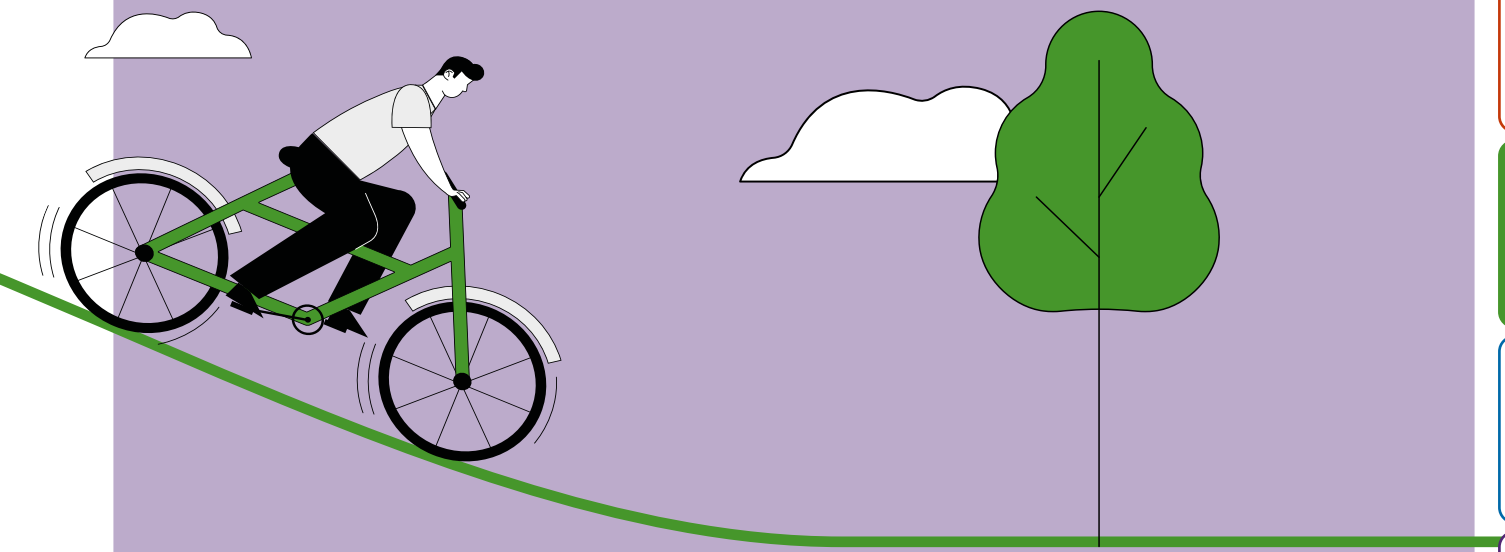
As a result of these changes, independence levels have increased across all teams and staff are working together in much more positive environments.

In particular:

- 150 fewer people are leaving their own homes to go to residential homes each year.
- 50% more people with learning disabilities are now on track to achieving more independent outcomes.
- 64% more people with mental ill health are now on track to achieving more independent outcomes.

" I have seen and heard about people going the extra mile, embracing change, transforming lives, or showing resilience during uncertainty".

- Director of Adult Social Services



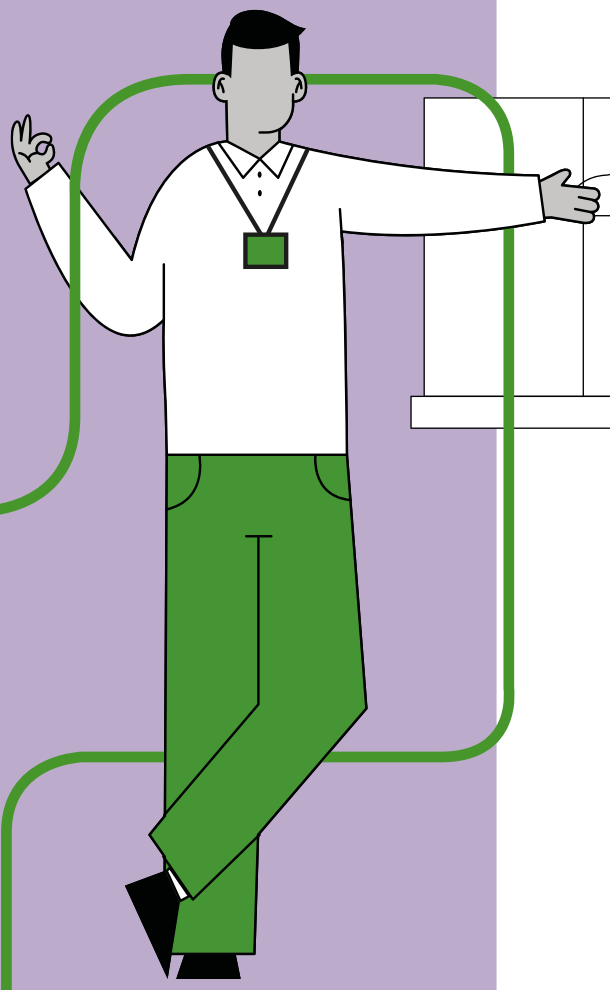
Case Study

A 'checklist' for Assistant Directors and Heads of Service

In the same council, Assistant Directors and Heads of Service were fundamental to ensuring the success of the programme. A 'checklist' of competencies was defined with them to help them adopt the new ways of working which better promoted people's independence. These competencies are not exhaustive and were used in addition to the requirements of their specific roles.

Behaviours – striving to develop and foster a service where every individual achieves their best outcome. Ensuring all behaviours within our teams are consistent with this vision.

- Assistant Directors and Heads of Service can clearly articulate, and have faith in, the aims and impacts of the programme.
- Heads of Service seek to ensure Service Managers can articulate and have faith in the new ways of working and reinforce their importance with their teams.
- Heads of Service foster a culture of supportive challenge in support planning with their Service Managers and teams, while also being able to have difficult conversations when required.



- Heads of Service foster a culture where Service Managers utilise peer support, openly ask for support and help with the change programme and KPIs while ensuring there is also focus on inward problem-solving and ownership.
- Assistant Directors and Heads of Service work together to remove blockers and communicate these efforts to Service Managers and their teams.
- Assistant Directors and Heads of Service can articulate how to link operational performance to financial benefits.

Governance – ensuring accountability for service performance by ensuring good performance is recognised, issues are explained, and solutions identified and implemented for improvements needed.

- Assistant Directors and Heads of Service prioritise the weekly Heads of Service meeting to escalate risks and issues and review key service performance measures, with Heads of Service prepared to provide a performance update.
- Assistant Directors and Heads of Service prioritise escalations in an effective manner by focussing on the largest problems.
- Heads of Service hold a weekly Improvement Cycle meeting with all Service Managers, ensuring attendance and prep-work is a priority.
- Heads of Service and Improvement Cycle meetings are focussed and structured with detail provided by exception.
- Heads of Service hold Service Managers accountable to team KPIs by asking for evidence of clear next steps to address the issues raised/performance gaps and have mitigation agreed and in progress.
- Clear actions discussed at Heads of Service and Improvement Cycle meetings are followed up to ensure they are completed.

Performance Culture – ensuring data is correct and up to date, performance is understood, and decisions are evidenced.

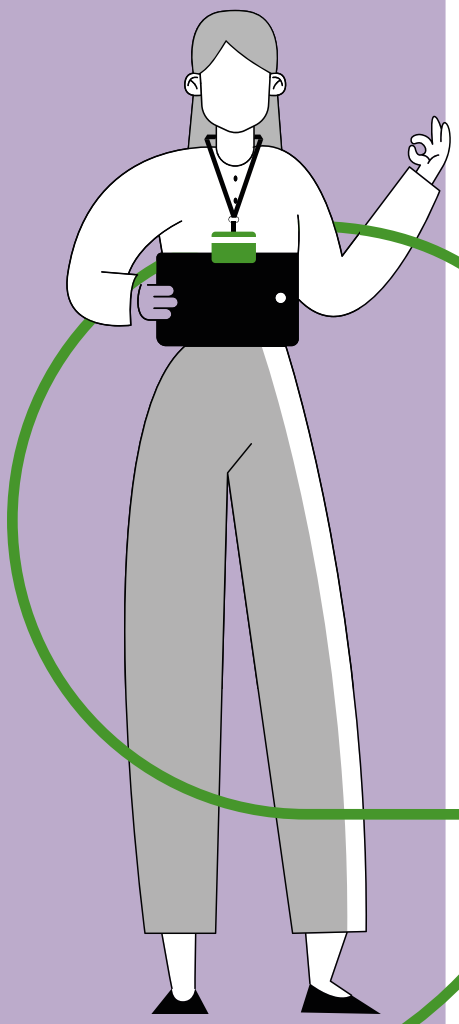
- Assistant Directors and Heads of Service understand the dashboards and how they can be used to understand problems, they know how to use them and review them regularly.
- Dashboards are used to prioritise discussion at Heads of Service meetings.
- Assistant Directors and Heads of Service use dashboards to celebrate successes.
- Assistant Directors and Heads of Service apply a structured approach to understand the data and investigate why performance is not on track.
- Assistant Directors and Heads of Service challenge underperforming teams by getting into the detail and asking for assurance and evidence that the new ways of working are being robustly used and team checklists are revisited.

Case Study

Association of Directors of Adult Social Services (ADASS) 'Accelerate' Programme

One of ADASS's objectives is to support the development of adult social care leaders. They believe that the sustained pressure on adult social care means Directors of Adult Social Services, aspiring directors, and senior managers need to have great leadership skills and the ability to successfully transform complex services for the better.

They also recognise that the pace and type of change social care leaders are being asked to deliver has become noticeably different over time. With many leaders in adult social care having worked their way up through the service over many years, this can mean that leaders have amazing service and organisational knowledge and people skills but may not have been exposed to the leadership capabilities required to deliver very complex transformational change in the context of the current pressures on services.



ADASS believed there were significant gaps in the development support available for senior leaders in adult social care. This led them to create the *Accelerate* programme. *Accelerate* supports senior leaders to develop the leadership capabilities required to oversee or manage teams to deliver complex change. This is approached from a range of perspectives; strategic, operational, behavioural and political, while addressing the role of transformation in building efficient and effective services.

Accelerate is about to recruit for its fourth cohort, and has been recognised by ADASS, its members, and the participants so far as a valuable tool to develop essential leadership capabilities, demonstrating the critical role ongoing development plays at all levels.

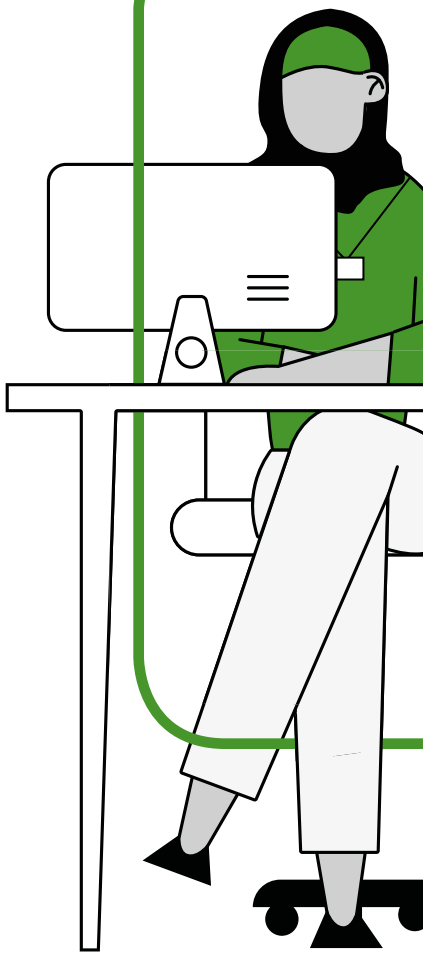
Organisational Enablers

Theme 6 - Digital

Embracing emerging digital opportunities – whether through the use of technology, systems, data or analytics – presents a compelling opportunity for services to improve outcomes for people at a sustainable cost. This requires an environment which promotes digital innovation, alongside a clear understanding of the desired impact of any investment on the end user (whether staff or person).

Introduction

Much has been written about the potential power of machine learning, artificial intelligence (AI), and predictive analytics. These advancements clearly promise an exciting future for adult social care, and the public and private sectors more widely. There is a huge range of possible applications: notably to make service delivery more efficient and to fundamentally shift the emphasis of adult social care towards prevention by identifying emerging need before an individual reaches a point of crisis. The number of tools that have been developed is vast, with some demonstrating more success at improving outcomes than others.



Leading services realise the benefits of this technology to deliver a real and measurable impact on the authority, the service, the workforce, and people's lives and independence. Each local area will have a different and bespoke set of challenges and opportunities, and will need to invest in different digital solutions.

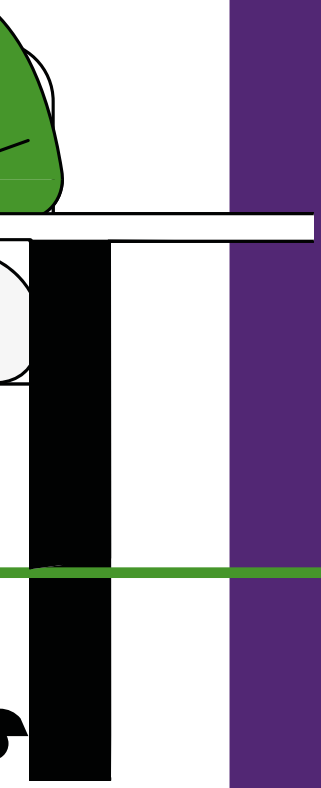
In order to truly leverage the power of digital, services recognise the historic context of lower levels of investment in systems and technology across the sector and concentrate on creating a new environment which fosters digital innovation. This requires the right infrastructure, structures, and culture along with a relentless focus on the desired outcome for the end user.

What do we mean by digital?

The term 'digital' can refer to a wide range of different applications. This report aims to cover some fundamental principles which underpin making the best use of digital applications.

These include:

- **Technology** – such as sensors, smart speakers and other devices which can be either used directly in individuals' homes or can be used by social care practitioners to assist in directly supporting a resident or gathering more information to aid their care and support.
- **Hardware** – such as smart phones and laptops, which can be used to support the care workforce to work effectively and efficiently.
- **Systems** – such as case management systems and financial management systems that store, analyse and present information, usually within the organisation to support the workforce.
- **Digital tools** – such as decision support tools, which can make use of the data available to provide practitioners and leaders with advice, guidance and support to make decisions about individuals or the service delivery as a whole.
- **External interfaces** – such as websites, through which people can directly interact with adult social care services or get further information.
- **Analysis and business intelligence** – where analytical techniques can be applied to large quantities of data to provide insight which helps to drive service design.
- **Management information** – turning the data that exists within the service into meaningful information and KPIs that support managers in making day-to-day decisions about how the service is run.
- **Infrastructure** – the underpinning technology and processes that ensure data can be stored securely, readily accessed, and connected between different systems where necessary.



6.1

Creating an environment that fosters digital innovation.

Introduction

Adult social care (as well as local authorities more broadly) are data rich environments. However, against a historic context of lower levels of investment in systems and technology, it can be hard to extract insight and meaning from the wealth of data that exists.

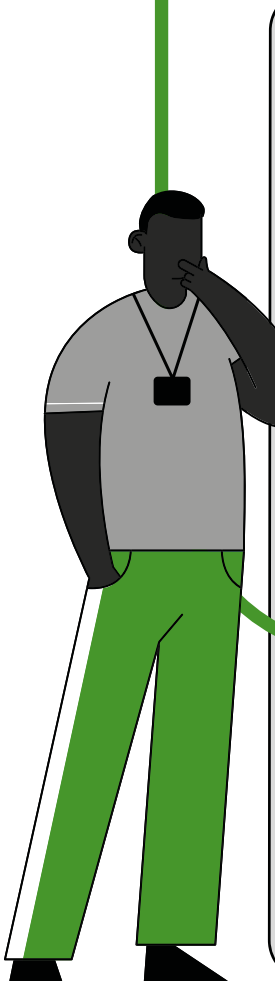
The consequence of this is a comparatively longstanding lack of digital innovation within the sector, which in itself presents a huge opportunity. Authorities are now taking action to correct and embrace this, creating an environment where digital innovation can flourish, reducing the 'friction' and allowing the undoubted benefits of technology, systems and data to be realised, and ultimately deliver improved outcomes cost effectively.

The principles of creating an environment for digital innovation

Authorities that create an environment in which the benefits of digital innovation are realised do so through **strong leadership and a clear vision**. This is built around the outcomes the service is aiming to achieve, but positions digital innovation and data-driven decision-making as a core enabler.

Those services that have created a **single source of truth**, by bringing together accurate data from multiple systems into a single platform to build a clear picture of their population, have found this to be a hugely valuable asset. This type of platform serves as the basis for more ambitious digital applications. Optimised services recognise that they have a wealth of data already, and the challenge is in bringing it together to drive value.

Once brought together this **data and information can be democratised**, putting the data in the hands of users wherever they are in the organisation to allow people to use this directly for their own purposes. Because the information becomes self-serve, this moves away from having performance teams producing reports and allows the focus of analysts to be on developing genuine insight and intelligence that drives the service forward.



To do this, local authorities put in place **the right infrastructure and analytics to be able to securely collect, store, analyse and structure the information**, and then the right leadership, culture, capability and capacity to take action. This is rarely a simple task. The data needed to drive insight and appropriate action can come from multiple organisations (e.g. health partners), directorates (e.g. Leisure, Finance) and digital systems.

Optimised adult social care services are moving away from **expensive proprietary technology** and to open source systems and software, which can be shared widely and modified locally. This promotes collaboration between different authorities, and the pooling of scare and valuable resources. This is enabled by having experts in **digital procurement**, who are well educated in the latest advancements in the marketplace.

These services ensure that there is **collaboration and partnership** across the local authority, so that digital experts work alongside practitioners to design and implement new solutions which will have the greatest impact. Collaboration also extends to partners, including providers and other authorities. Taking a major step forward with digital can be difficult for a single authority with their buying power and in-house expertise. Digital leaders from across the public sector engaged with as part of this programme of work agreed that central government has a role to play in supporting the sector as a whole move forward.

In these authorities, digital innovation is as much a focus of **HR and people processes**, including learning and development; and recognition and reward. Digital is a competitive environment for employers, and it can be challenging to attract the best talent into the public sector. In order to attract the best people, authorities consider how they can develop compelling career paths, development opportunities and competitive compensation.

6.2

Digital solutions are designed with a clear outcome in mind.

Introduction

Technology and digital solutions offer an exciting and innovative opportunity to support people to achieve independent outcomes cost effectively. These solutions can be designed to support a user - be they social care staff, a social care manager, or a leader - by gathering data, providing insight, supporting a decision or allowing action to be taken efficiently. Technology can also support individuals themselves, either in guiding their behaviour, or monitoring and keeping them safe.

The key to unlocking the clear potential of these solutions is to begin with an absolute focus on the outcome, usually a behavioural change, which needs to be achieved.

The principles of digital solutions

Optimised adult social care services consider **digital solutions a means to an end, not an end in themselves**. They are implemented as part of a holistic programme which seeks to change behaviours and ways of working. Without this they become (expensive) white elephants. The user experience is recognised as the most important factor in a successful solution, rather than the underlying capability of the technology, and so **the end user is always put at the heart of the design process**. Digital experts from across health and social care engaged as part of this programme of work echoed this sentiment, agreeing that solutions should be used to foster human connection which helps to improve the human outcomes.

They start solutions small and simply, with a '**minimum viable product**' which can be quickly put into the hands of the user. A 'test and learn' process ensures that user feedback is acted on and the design is iterated rapidly, which relies on digital specialists working closely with end users. This builds momentum, with the ability to demonstrate the impact of a solution from a very early stage, before any significant investment is required. This enables those services to **demonstrate the business case** of a technology investment with real evidence of impact.

This process also builds trust, avoiding any concept of a 'black box' which users would rightly feel wary of.

These services consider the impact of **digital inequality**, both in terms of their own workforce and the individuals they serve. Where technology enables a resident pathway, alternatives are designed to ensure that individuals can have the same experience, regardless of their access or capability to work with a digital solution. Services focus on building the skills of their entire workforce, to equip them to make the best use of technology. Above all, these services recognise that digital solutions will **never replace the professional judgement and skillsets of practitioners**, but also that they should not aspire to. Rather, in optimised delivery models, technology enhances, enables and influences professional decision-making with digital solutions, to create an optimised and holistic solution.

Case Study

An agile and iterative approach to building the right digital infrastructure for a health and care system to progress their integrated care ambitions

During the COVID-19 pandemic, Cornwall accelerated their integrated care ambitions through the rapid creation and roll-out of a new model of care coordination and a single point of contact referral process.

When the system moved to the new model of care (*as discussed in Theme 2.1*), it was evident early on that a new digital tool would be a key enabler of the changes.

Before, the multiple access routes to the different community services available after discharge from hospital (for example, the community hospital; domiciliary care; residential care; or reablement) meant decision-making was incredibly complicated. Each service was managed by a separate team with its own case management and referral system.

A new Single Electronic Referral System (SERS) has been designed which means anyone needing to refer a patient to a community service can now fill in one form, which is then triaged by the new teams into the right service. Crucially, this means SERS gives cross-system visibility of a patient's record to any practitioner who needs it.

The system identified a number of core objectives that SERS needed to achieve. It needed to make the right information available so practitioners could manage individuals through the referral process and get them access to the right support. At a system level, it needed to provide a complete view of community referrals, so that if capacity became outstripped by demand, clinical decision-makers could use this information to appropriately prioritise cases. To achieve that, it needed to be able to track live performance. The tool also needed to be easy to use for thousands of staff – in GP surgeries, hospitals, and the community – irrespective of the technology available; their technical ability; or the organisation they worked for. Given the time pressure from the pandemic, it also needed to be quick to design and implement as well as flexible.

The SERS tool has fundamentally changed how the system is able to work together in a coordinated way to best deal with the pandemic.

The key factors that have led to its success include:

- **The system leadership shared a clear vision** about what needed to be done and therefore what the requirements of the tool needed to be. They weren't constrained by existing products or trying to force existing solutions to answer the problem. System leaders were committed to this vision before starting the work.
- There was the **right digital infrastructure** through Office 365. This meant everyone had access, it could be easily managed through organisations, and was simple to trial and iterate.
- Designing and implementing SERS relied on **good information governance** between organisations, which meant it was possible to share sensitive data securely.
- The team took an **agile approach to development and iteration** that allowed them, during a crisis, to deploy the first version within two weeks and continue to add more features in a prioritised way, maximising the effectiveness of the tool.
- The key people with the **right expertise** worked in partnership, across organisational boundaries, including the Chief Information Officer and Business Intelligence teams. This allowed quick decision-making and clear routes to escalate problems.
- The operational frontline teams were heavily involved in co-designing SERS to ensure it was **fit for purpose and quickly adopted**. This meant that problems were quickly fixed and ensured a sustainable solution was built from the outset, rather than having separate build and handover phases.

Results of SERS include:

- Rapid and successful rollout. The tool was **built in two weeks** and launched two weeks later.
- Additional improvements were effectively prioritised and implemented, meaning the tool became increasingly valuable after it was rolled out.
- It has supported the system to manage the outcomes for **27,250 people** in its first seven months (discussed in detail in *Theme 2.1*).

Case Study

Designing a tool with practitioners to increase the use of community services

A council was working to implement a more asset-based approach to practice. As part of this, they identified an opportunity to make better use of the wealth of services that existed in the community in order to support people with their independence, rather than relying purely on more formal services. However, due to the sheer number of services available (over 700), practitioners were finding it difficult to know about all of them, and therefore ensure that people were being recommended local services that would enhance their lives.

The council decided to build a digital tool that would combine both data about a resident with all local services, which would allow practitioners to recommend services based on a resident's strengths and requirements.

To ensure this was going to be a valuable investment, the council trialled an early version of the tool. A cohort of staff were identified who were already experts in local services in the community, and a front door 'test team' was also created. Any new referrals were passed to the test team via the expert panel, who would make a few suggestions for appropriate services. At the same time, a simple tool was built which would allow members of the test team to search for their resident, then see these suggestions.

The test phase saw staff discovering new services in the community that would be relevant to the individual and reporting back positively on the tool. This showed that the tool would be valuable to both staff and individuals.

Having identified that the key metric for the success of the tool was the number of community service referrals, the council was able to prioritise development and iterate the tool to best deliver against this measure.

The tool started off by recommending services nearby to the resident, based on the resident's address. This suggestion was sometimes suitable, but often provided unhelpful results. The team started to pull in other information about the resident, such as their age, sex, strengths and needs, which could each be used to make measurably better recommendations, leading to measurably more referrals.

To create a sustainable solution, the tool now incorporates a 'learning' algorithm. Practitioners are asked to 'rate' the recommendations they receive based on their relevance to the individual being considered. This allows the tool to promote services which have been rated as more relevant for particular groups of individuals, increasing the usefulness.

Use of the tool so far has led to practitioners discovering over 330 relevant local services that they were previously unaware of. Going forwards, the team will be building a plan to ensure the tool can work with a new case management system, will be starting to make use of cloud services, and will be improving data collection and data structures across the council.

Case Study

Creating simple solutions with a clear and measurable outcome – building a reablement app

Derbyshire County Council was seeking to help their reablement service see more people each month and best support those individuals to be as independent as possible.

However, a review of cases showed that individuals were spending too long in the service and could be achieving their goals twice as quickly. Addressing this would not only benefit the individual but would free up additional capacity to accept more individuals onto the service. In addition, upon finishing their reablement package it was found that individuals could be achieving a greater level of independence. Discussions demonstrated that to achieve this, the service needed clear goals for individuals and a plan to get there; to frequently review progress against those goals; and better communication between the reablement teams and on-going care teams about when the goals have been met.

To achieve this, the team created an app for the reablement worker. After each visit, the worker uses the app to feedback on how a resident is doing on the service, and how they are progressing against their goals.

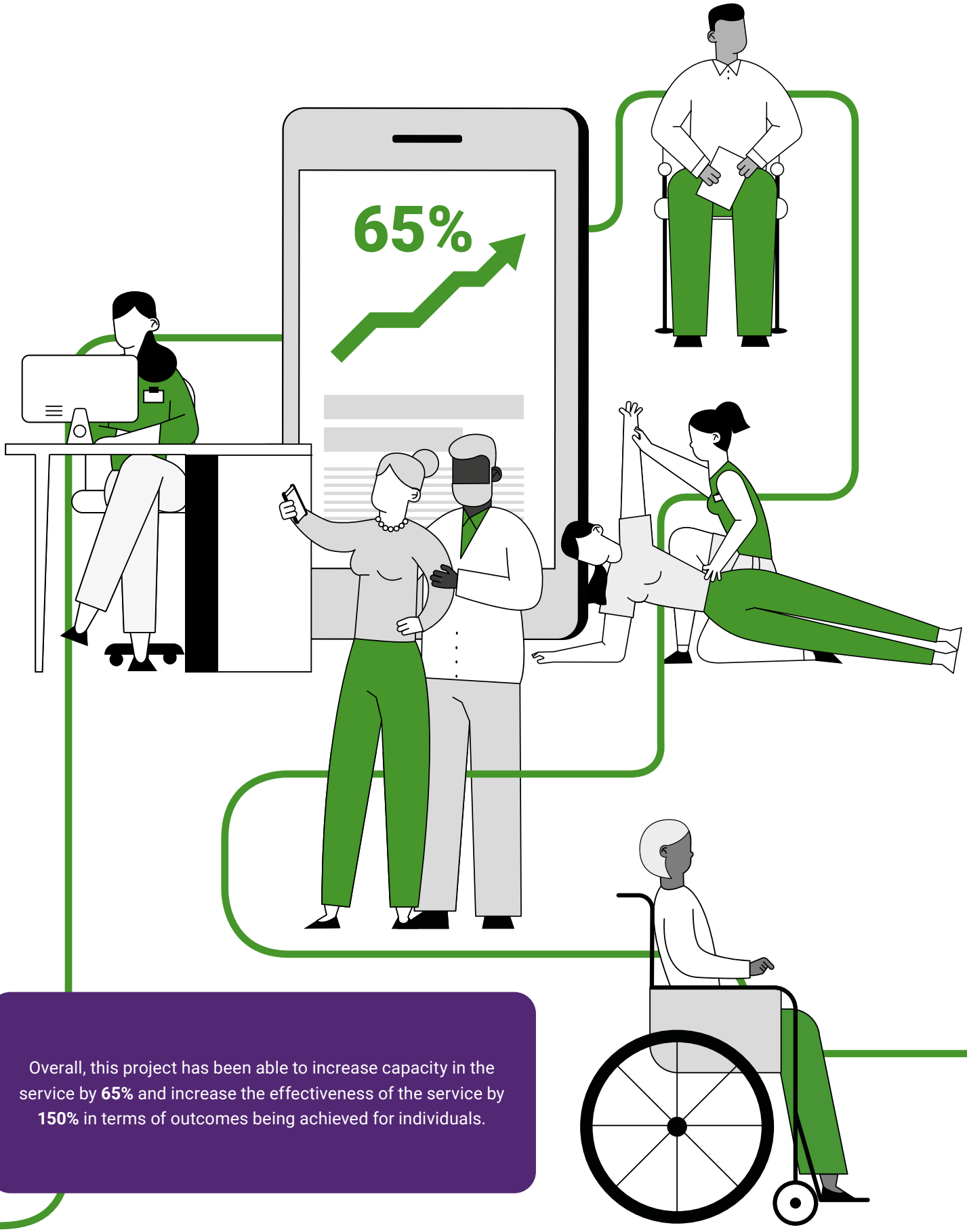
This instant and direct feedback from the frontline has strengthened the service in three ways.

1. It means the team can appropriately reduce the length of stay within the service by flagging when a resident has achieved their goals. This is providing additional capacity on the service for other people to benefit from reablement.

2. The detailed resident information, which can be quickly gathered, builds a better understanding of the individual's strengths and needs, which allows for any ongoing support to be more personalised.

3. The data being gathered is providing clarity on where there might be gaps in service provision, or where the team could be focussing to support an individual to become more independent more quickly.

This app was made possible by the infrastructure, capability, and culture at the council, and was developed in only two days by the team as a result. The environment was ready, and the team was able to start using it immediately.



Overall, this project has been able to increase capacity in the service by **65%** and increase the effectiveness of the service by **150%** in terms of outcomes being achieved for individuals.

Organisational Enablers

Theme 7 - Workforce

While the COVID-19 pandemic has raised the profile of the adult social care sector, there remains a significant challenge locally and nationally to ensure the right workforce is recruited and retained by making working in adult social care (whether as a professional or frontline carer) a desired and rewarding career.

Introduction

Through engagement with social care leaders as part of this programme of work, workforce was frequently discussed as one of the **most significant risks** to the social care system.

While local authorities can face issues **competing for and retaining regulated professionals** who are often in short supply, overall they have a turnover rate for all staff working in adult social care of around 13%[42], which is broadly comparable to other public sector roles such as teachers.

The most pressing workforce issue facing the sector is the **retention of direct care workers employed by the independent sector**, where the turnover rate is around 30%.[43] Broadly speaking, those who work for the private and voluntary organisations involved in the direct delivery of care may not have the same benefits as a local authority employee (such as pay, pension contributions, or certainty of contract). Addressing the reasons behind the high turnover of care workers in the independent sector (and increasing retention) is a **key requirement of creating a sustainable care sector**. Furthermore, the British press are now regularly reporting stress in the homecare industry, the part of the sector with the largest workforce. A study by business analysts for Radio 4's You and Yours programme found 715 of the 2,731 home care operators in the UK are in danger of closure.[44] The risks of a **shrinking domiciliary care workforce** are already being felt by a growing number of local authorities and health systems.

What do we mean by workforce?

In their 2019/20 report, Skills for Care estimate there to be 1.65 million adult social care jobs in England.[45] Local authorities employ 7% of staff; the independent sector employs 79% of staff; and direct payment recipients employ 8% of staff. The rest are employed by the NHS.

As described earlier in this report, this does not account for the 6.5 million 'informal carers' supporting a loved one who is older, disabled or seriously ill.

[42] Analysis performed by Newton with source data from Local Authority Comparisons - Skills for Care (www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/local-information/Local-authority-comparison.aspx)

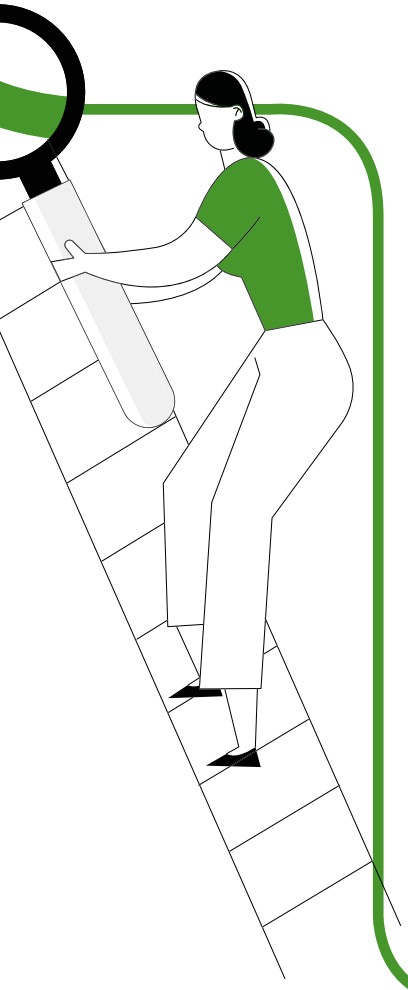
[43] Ibid

Care provider workforce

In an optimised system, authorities **work with private care providers to ensure their values and beliefs** (promoting independence) become embedded in these organisations' vision and purpose and that this carries through into the practice of their staff.

Providers with a stable workforce will be able to offer better continuity of care and, presumably, better quality of care. A recent CQC report states:

> ***"Our staff have said that when providers valued and cared for their staff team, it can create the conditions for both high-quality care and an engaged and loyal workforce."***[46]



In optimised systems, local authorities help support the provider market to **deliver an attractive career structure**. They work with providers to put in place the right practice, processes and professional supervision to create a safe and stimulating environment for staff, whilst wrapping around pastoral care to help with the emotional demands of working in care.

These authorities realise the **strength of the local government brand**, and the leverage and positivity that this can bring to the funnel of the future workforce. The authority will not assume it to be the sole job of the providers, big or small, local or national, to attract the right workforce. The authority actively reaches in, constantly, to help recruit and develop the right quantity and quality workforce of tomorrow, fully understanding its role in the leadership to achieve this objective.

The main reason cited for high turnover of carers in the private sector is low pay. Authorities use their leverage with partners to promote **fair renumeration across the market** and may go as far as to require it of providers. For staff providing care, the terms and conditions are tough and the emotional pressures high. While they tend to be deeply committed to caring for people, and take pride in their work, pay has to remain a consideration.

44 "Quarter of UK care home operators face going bust" – BBC (www.bbc.co.uk/news/amp/health-54987407)

45 "The state of the adult social care sector and workforce in England" - Skills for Care (www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx)

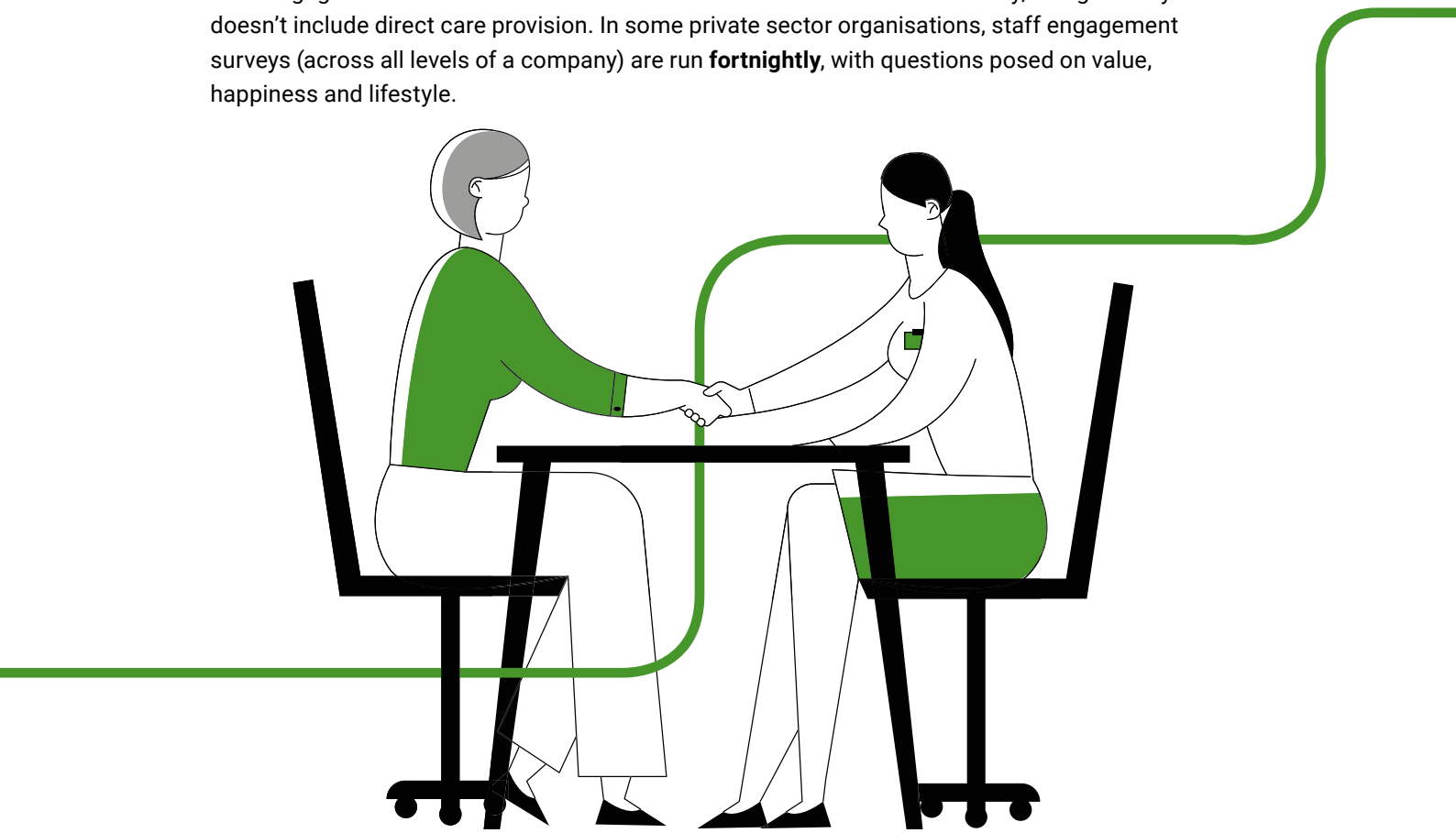
46 "The state of health care and adult social care in England 2018/19" (p41) – CQC www.cqc.org.uk/sites/default/files/20191015b_stateofcare1819_fullreport.pdf

Local authority workforce

Turnover rates in local authorities are significantly lower than the sector as a whole (13%)[47] which brings them in line with other similar professions. However, they are not without their workforce challenges and council staff still face the high emotional demands of working in social care. Moreover, councils may be forced to compete for a regional scarcity of a particular professional group. Neighbouring councils and NHS trusts will both require professionals such as occupational therapists, and generally the terms and conditions for NHS employees will be more favourable. Good councils **will demonstrate that the work is rewarding**, and focus on purpose, motivation and longer-term development opportunities in order to recruit and retain staff.

As part of a wider system, authorities seek to work in partnership with health, the voluntary sector and local education establishments to **maximise the availability of the right skills**, whilst **minimising instances of creating unhelpful swings in staff base between organisations** due to pay and conditions, as well as status or 'brand'.

Staff engagement is a key performance indicator and requires regular measurement. Traditionally, staff engagement measures have been limited to the annual workforce survey, and generally this doesn't include direct care provision. In some private sector organisations, staff engagement surveys (across all levels of a company) are run **fortnightly**, with questions posed on value, happiness and lifestyle.

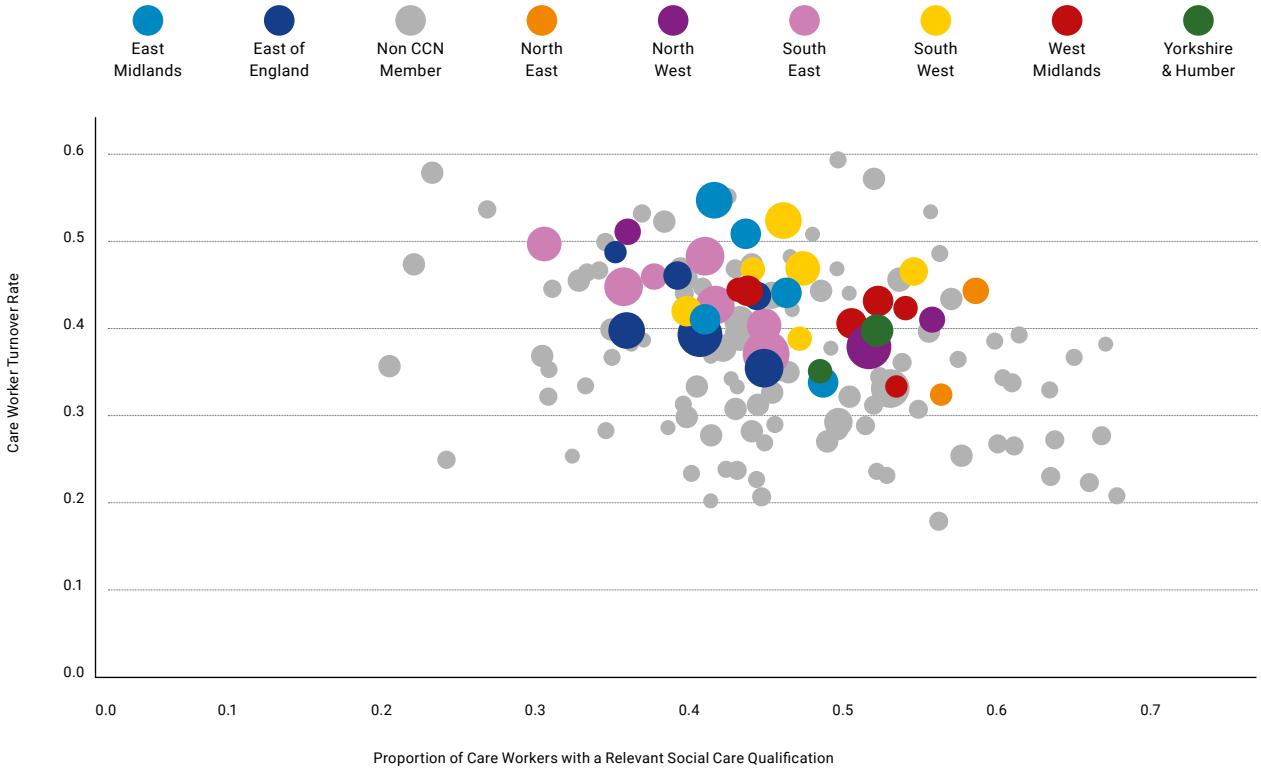


[47] Ibid

Insight

The relationship between qualifications of care staff and turnover

The chart below demonstrates that there is a **correlation between the proportion of frontline care workers in the independent sector with a relevant social care qualification and the turnover rate**.[48] Regions where a greater proportion of care staff in the independent sector have a relevant social care qualification experience a lower turnover of those same staff.



The sector also struggles to retain younger workers, with turnover rates in care provider organisations amongst under-20s at 46.9%, compared to 22.4% for those 60 and above.[49] Traineeship schemes or apprenticeships are a great way of encouraging people to work in care as they offer the opportunity to learn more about the sector while pursuing a recognised qualification. Those organisations which encourage staff to pursue development opportunities and create a future career in care see this reflected in the longevity of a workforce.

Providers who were involved in this programme of work echoed the importance of qualifications and training. One suggestion made was around the potential for more local authorities to support training sessions across the care workforce. Not only would this support quality of care and retention, this would also reduce overheads for the providers.

[48] Analysis performed by Newton with source data from "Local Authority Comparisons" - Skills for Care (www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/local-information/Local-authority-comparison.aspx)

[49] "The state of the adult social care sector and workforce in England" - Skills for Care (www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx)

Insight Fair remuneration for care workers

Most care workers are paid close to the National Living Wage, with the majority actually earning less than the real National Living Wage due to, for example, not getting paid for travel time.[50] Ultimately, this situation has been exacerbated by care providers needing to deliver care at the lowest possible cost, as local authorities have sought to make savings cuts in line with austerity measures.

While care worker pay has increased, it's still amongst the lowest of the economy in general. Historically, care worker median hourly pay was higher than other job roles such as in hospitality or retail. However, that gap has been narrowing. Now, sales and retail assistants are paid more per hour on average than care workers.[51] Alongside low pay comes a high degree of uncertainty for the workforce. Frontline care workers are often on zero-hour contracts, and there is a higher degree of turnover for those on zero-hour contracts.[52]

Engagement with care providers through this study has highlighted potential benefits to authorities and providers by working together in an open, two way, and transparent manner. They suggest that when the provider is given clarity on how much can be paid by the authority for the care and, in turn, the provider is open with the service about how much they stand to gain from the contract, this can support the right arrangements, which in turn helps ensure that workers are being fairly remunerated. However, given the scale of the challenge, there clearly also needs to be a regulatory role for central government to ensure there is more fairness and certainty for the workforce when it comes to remuneration.

While the challenges of pay are not unique to England, evidence suggests that those countries which have committed to paying carers more fairly experience lower turnover rates. For example, it is possible to conclude from stability index data that turnover in Scotland is less than 22.9%. At the same time, the Scottish Government's commitment to ensure all social care staff are paid the Living Wage, while not wholly solving the issue, does mean that more carers in Scotland are paid the real Living Wage than in England.[53]

50 "What happens after the clapping finishes? The pay, terms and conditions we choose for our care workers" – Resolution Foundation www.resolutionfoundation.org/publications/what-happens-after-the-clapping-finishes

51 "Average pay for care workers: is it a supermarket sweep?" – King's Fund (kingsfund.org.uk/blog/2019/08/average-pay-for-care-workers))

52 "The state of the adult social care sector and workforce in England" - Skills for Care (www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx)

53 Ibid

Case Study

Measuring engagement in a local authority

There are examples of authorities regularly measuring engagement during transformation programmes in order to ensure changes are sustainable. Some have gone so far as to automate the process. These provide a live indicator of how staff are feeling through change, whether they trust the direction, and if they see it as a positive. Engagement is considered to be the best leading indicator of sustainable change.

Below shows the results of an early engagement survey during a significant transformation programme at Lancashire County Council (2016-18). This powerful information enabled leadership to instantly spot the areas to focus resource (and their own time) on.

80% Felt there was **lots of room for improvement** in their area.

71% Believed that with the right support the **changes are achievable**.

96% Said the reasons behind **why we are changing are clear** to them.

99% Felt comfortable they could **speak to their manager** about the changes if needed.

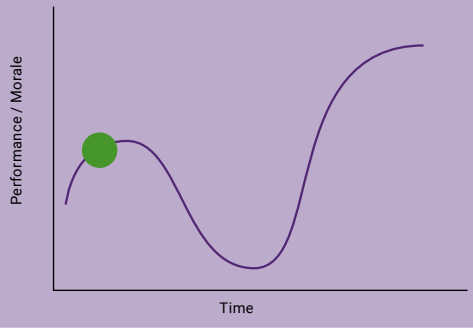
94% Said they were **keen to change** things for the better.

39% Understood how the changes will **impact them**.

84% Agreed that the changes will help us **deliver better outcomes for service users**.

57% Are clear, and if asked, could **describe the details of what is actually going to be different**.

Where are our colleagues on the change journey?



Comments.

1. Excellent initial results
2. Majority at start of journey
3. Lower score on 'clarity of changes' and 'impact' to be expected this early.
4. Trust in management very high (key change driver)

Case Study

Engaging new care staff with a clear purpose and empowering them to achieve the best outcomes improves retention rates

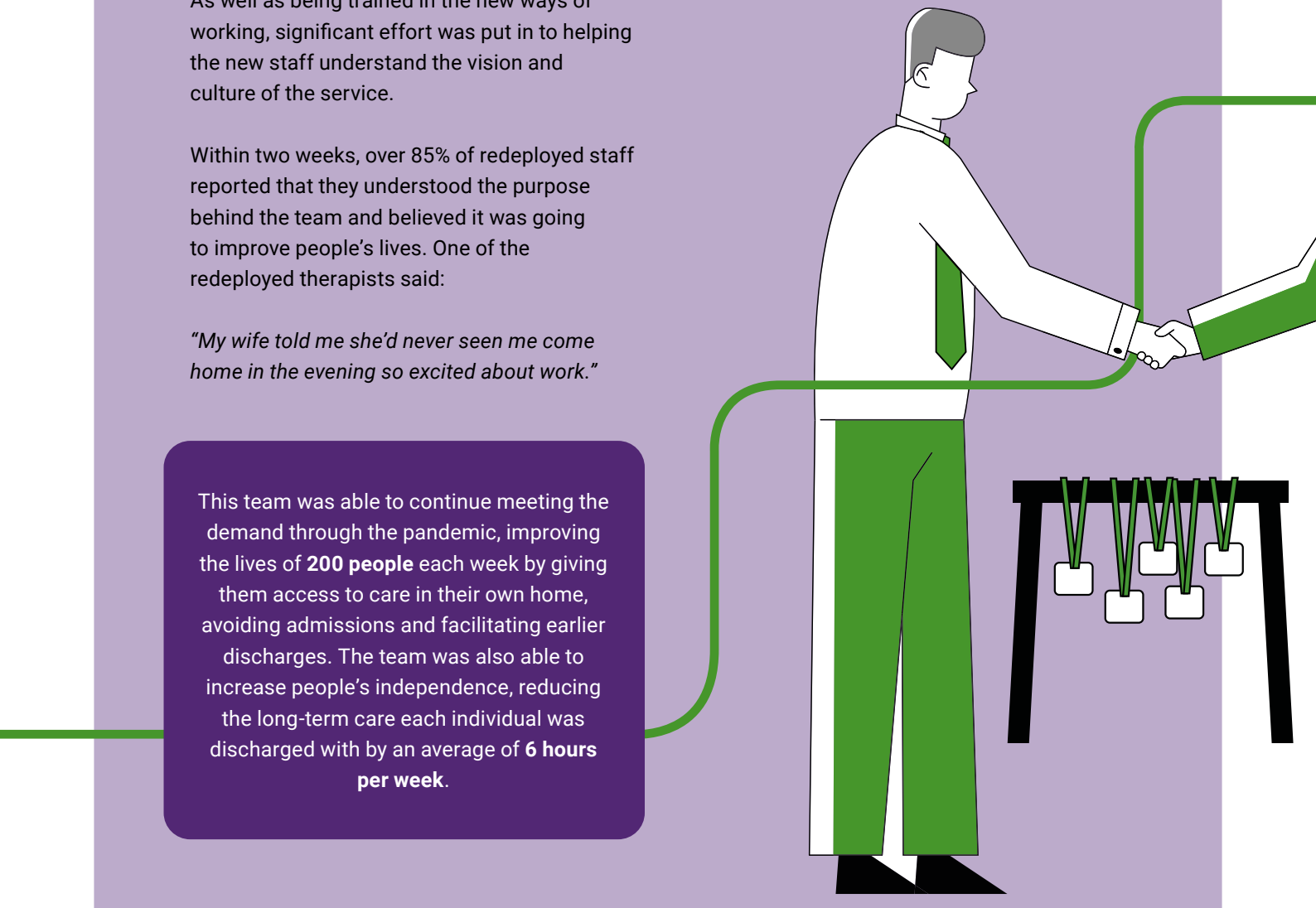
In early 2020, one council created an integrated health and social care Intermediate Care Team. This team has a clear purpose around promoting independence, a culture of collaboration and shared goals to support practitioners to achieve better outcomes for individuals in their care.

During the first wave of the COVID-19 pandemic the team had an additional 150 staff redeployed into their workforce. Other services had been stood down during the outbreak and more capacity was needed to meet the COVID-19 demand. This included therapists, nurses, and administrators from the same organisation and various other organisations that were able to release staff.

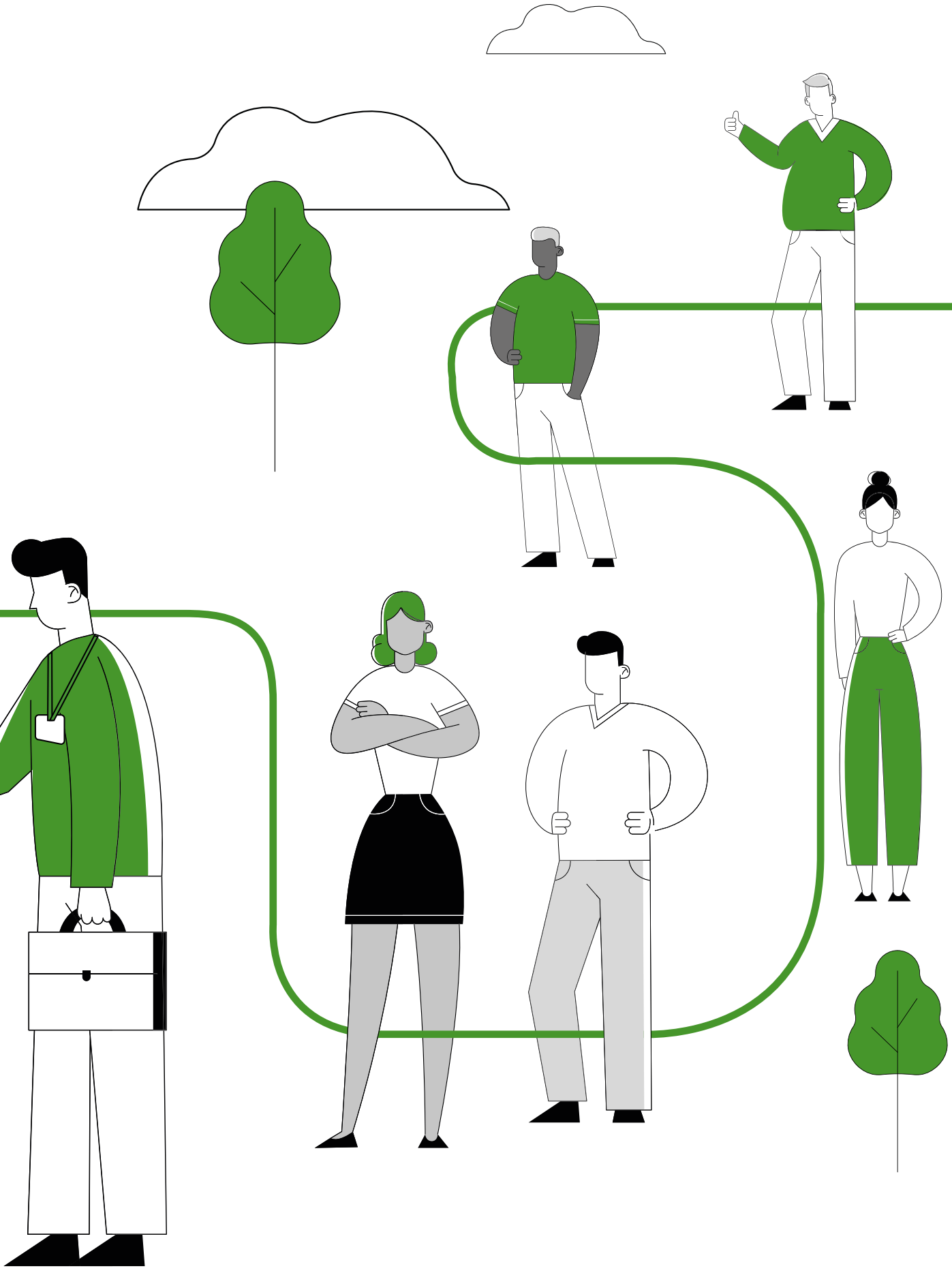
The redeployed staff were onboarded rapidly. As well as being trained in the new ways of working, significant effort was put in to helping the new staff understand the vision and culture of the service.

Within two weeks, over 85% of redeployed staff reported that they understood the purpose behind the team and believed it was going to improve people's lives. One of the redeployed therapists said:

"My wife told me she'd never seen me come home in the evening so excited about work."



This team was able to continue meeting the demand through the pandemic, improving the lives of **200 people** each week by giving them access to care in their own home, avoiding admissions and facilitating earlier discharges. The team was also able to increase people's independence, reducing the long-term care each individual was discharged with by an average of **6 hours per week**.



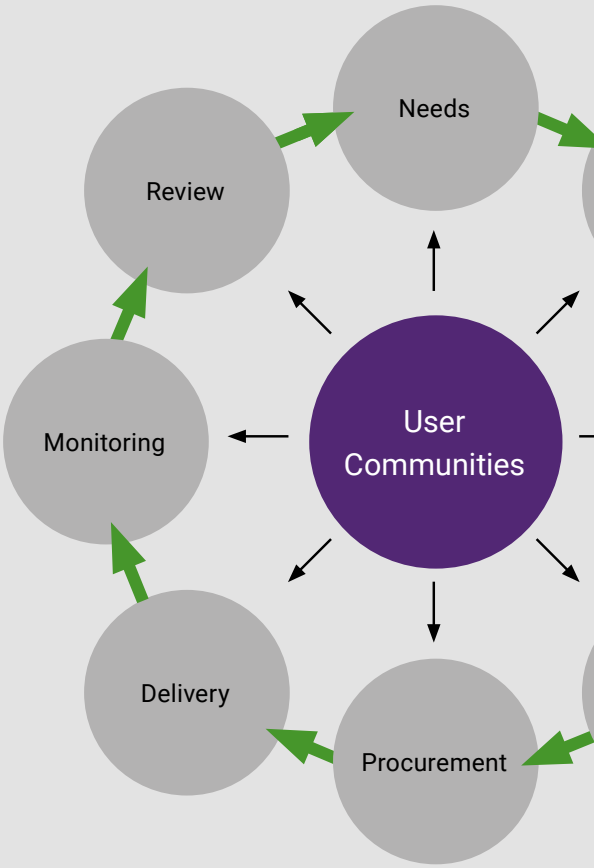
Organisational Enablers

Theme 8 - Strategic commissioning

To meet the needs of the population, local authorities are best equipped to work with the provider market, achieve the best outcomes for individuals, and do so in the most cost-effective way, when they have an effective strategic commissioning function.

Introduction

The strategic commissioning function of a local authority provides the foundation for meeting the needs of the population. Optimised functions work to a well-articulated strategy, with clear objectives, built on an understanding of the local and national context, regulation, existing policy, and political priorities.



What do we mean by strategic commissioning?

'Strategic commissioning' is the activity of identifying need, allocating resources and procuring a provider to best meet that need, within available means.

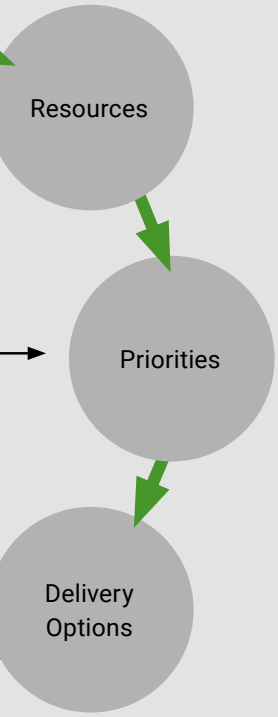
Commissioning combines effectiveness and efficiency (achieving the best possible outcomes within the resources available) and sees procurement as the means of achieving this.

The most frequent description of strategic commissioning is in the form of a continuous improvement cycle (analyse, plan, do, review).

The principles of effective strategic commissioning

At the heart of the strategic commissioning function is **analysis of the population's actual needs**. Optimised functions recognise that this goes well beyond analysis of what the market is currently able to supply. They build up a picture, based on a **detailed understanding of residents' individual strengths and needs** in an unconstrained environment, suspending the context of what services are currently provided. Strategic commissioners understand that the existing commissioned provision and current capacity influence how need can be assessed.

Optimised functions work **collaboratively with other local commissioning partners** such as CCGs. They understand the modern population often has **multiple needs**, spanning health, education, housing and more. They work hand in hand to maximise not just the value of every pound spent by the local authority, but the value of every pound of public money spent overall. This is best achieved when operating across a large enough population and strategic scale.



Strategic commissioners go beyond just consulting with current providers, people and practitioners to a **process of co-design**, where these stakeholders are actively involved and engaged in the process. Potential models are piloted, wherever possible and practical, with a period of iteration and modification to ensure the outcomes can be met. This approach takes into consideration the practice and decision-making of social care teams, as much as the providers and people. As part of this process, services may **make changes to ways of working** to ensure that the provision is being used in the most efficient and effective ways to meet the needs of individuals.

Strategic commissioners actively work to **maintain a healthy thriving market**. Alongside value for money, they also recognise the need for sustainable profits. This has resulted in some commissioners moving away from the procurement of an hour of care, to constructing contractual incentivisation which aligns the vision and objectives of the service and the outcomes an individual aspires to achieve with the reward or penalties of a contract. The natural consequence of a healthy, thriving market is that some private businesses should be allowed to fail. Clearly, this needs to be carefully managed, but is essential to allow the market to function efficiently.

Commissioners recognise their role in **actively developing the market** to be able to deliver the provision their population requires. This is often detailed work, operating alongside providers to support them to design and develop the processes; systems; ways of working; and capabilities they may need to deliver a new model of care. This process could take many months (or even years) and may require an up-front investment of funding to allow partners to transform. **Authorities ensure this work is properly resourced**, with the right balance of operational, strategic and change management capability.

Optimised functions have **live data and evidence** driving the commissioning continuous improvement cycle. They work in partnership with business intelligence services, providing the robust data for the commissioner to analyse on a constant basis.

Understanding the impact of 'self-funders'

Unlike in the NHS, where services are generally free at the point of delivery, social care is **means tested**. This adds an additional complexity for both councils and the public. Individuals may be required to either meet all of the costs of their care or make a contribution to their costs, depending on their personal wealth.

The number of older people self-funding services can make a significant difference to both the domiciliary and residential care market. This has a greater impact in the wealthier parts of England, where there tends to be a greater proportion of self-funders. Where the private market flourishes, **there are likely to be some providers who don't work with local authorities** and others who **subsidise local authorities paying lower fees by taking more money from self-funders**. This will also impact on the rate that the care home charge, with a higher number of self-funders generally leading to a higher unit cost. This can weaken the role of the local authority in their local care market. The Institute of Public Care[54] reported that 39.6% of people in residential care homes and 47.6% of people in nursing homes were self-funders.

Furthermore, there is also the issue of self-funders whose **funding 'runs out'**. Some people do not approach councils for advice before they make a decision about the care they may need. This might mean that they establish themselves in a care setting prematurely, whilst funding their own support. Some of these people will run out of money and then have to turn to the council for help. This in turn puts pressure on the council's resources and can make it harder for a council to judge the future demand for care. Authorities work closely with individuals; voluntary organisations; GPs; and health professionals to help to manage this risk, encouraging and **ensuring people make early contact with the local authority when considering options for care**, even when this will be privately funded.

There are a number of wider questions being posed as part of the discussion on reform, and much political debate, particularly around the principle of means-testing and how to take into account the value of an individual's home when assessing the ability for someone to fund their own care. While these questions are not considered as part of this report, which is concerned with the characteristics of an optimised system, they are acknowledged as important contributions to the overall discussion.

Authorities in an optimised system pay careful attention to the local private market and make this an important consideration when commissioning care. They thoroughly understand the impact this has on the care market more widely and have open and transparent conversations with providers to understand the full breadth of care and support they are providing locally. They recognise the need to ensure delivering 'public' provision is attractive for care providers alongside their private clients.

[54] Institute of Public Care: Understanding the self-funding market in social care, October 2015

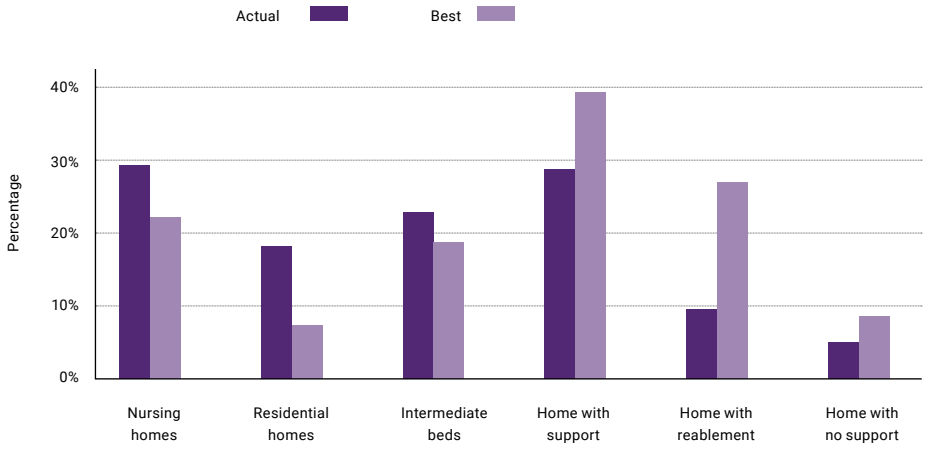
Insight Perceived demand vs actual demand

The following graph shows the difference between perceived demand and actual demand. This was taken from analysis of 10,400 patient journeys across 14 health and social care systems.[55]

The perceived demand (marked 'actual' on the graph) is based on the output of the assessment conducted at the point of discharge by either a local authority practitioner or a health clinician. This is heavily influenced by 'on the day' pressure for flow and the availability of services (so is influenced by previous strategic commissioning activity).

When the same cases were fully analysed by a multi-disciplinary team and without the 'on the day' pressure or the perceived (or real) capacity constraints, the 'should-be' demand (marked 'best' on the graph) is significantly different. For the local authorities in this study, this meant that, on average, they would need a greater provision of intermediate reabling services and a reduction in long-term bedded care.

Strategic commissioners facilitate this analysis with practitioners to inform the creation of the right capacity and services. This brings the future 'actual' in line with the 'best'.



Understanding the data:

1. Nursing & residential home placements could reduce by half
2. Going straight home with some support could increase by almost a third
3. Going home with reablement could increase almost threefold

[55] "Why not home? Why not today?" – Newton www.reducingdtoc.com

Case Study

The impact of COVID-19 on the need for reabling short-term discharge to assess beds

In March 2020, when the initial modelling of the COVID-19 impact was released, hospitals were instructed to decant and protect as many beds as possible. In a matter of days, many achieved near 50% bed occupancy. A typical local authority reaction was to use short-term beds from the residential market, a common response when significant pressure occurs in stressed acute or community hospitals.

In one local authority, a multi-disciplinary team analysed the needs of the people in these beds. 95% of the individuals could be living independently in their own home but had high levels of short-term need. Care in their own home would have been the best service but this was deemed impossible to service at short notice. The beds commissioned were spot purchased residential beds, which were no different in form to a long-term bed. This meant that no additional reabling services were wrapped around those beds due to supply constraints.

Analysis of the cohort three months later showed that 45% of those individuals would now require permanent bedded care.

Whilst COVID-19 shone a light on the gap between provision and need with regard to discharge to assess beds, this need is prevalent in the majority of services. Strategic commissioners in many local authorities now have the challenge of truly understanding the need for quality reabling functions in bedded settings.

Optimised services have worked with the national Discharge to Assess (D2A) policy and guidance, and understood the different nature of service required, both in practice and to deal with demand that goes through significant surges. Optimised health and social care systems have recognised the similarities and links between these services and community hospitals.

This is being addressed in one health and social care system through a coordinated, whole system bed strategy. The aim is to reduce the number of people inappropriately admitted to a non-acute bed when they could be in a more independent setting and improve the quality of outcome achieved in the least amount of time.

Before the work, there was a range of provision of non-acute bedded care across multiple sites and provided by different organisations.

Leaders from each of the system's organisations came together to form a 'bed strategy group' to set out a vision and strategy for a new care centre model. They wanted to create one type of bed which achieved ideal outcomes in a timely manner.

Through the work they looked at the ideal number and location of beds, demand, staffing, clinical model, leadership, referrals and finance.

A test site demonstrated the potential to decrease on-going care costs by **14%** through better bed-based reablement and reduce length of stay by **14%**.

Work is ongoing to scale the model across the system based on a locality-based bed centre model across multiple sites with consistent provision provided by the right referrals.

Case Study

Outcomes-based commissioning

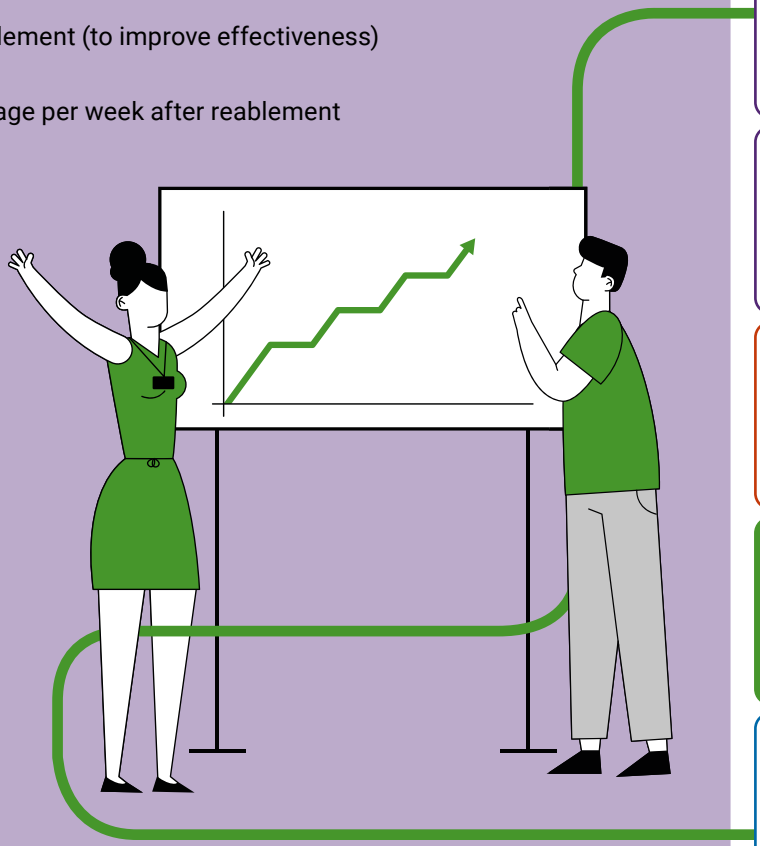
Lancashire County Council identified that the number of people accessing reablement was half that of other authorities of a similar size, and the size of ongoing care packages for people after a period of reablement was higher on average than in other councils.

Over a period of two years (2016-18), the council trialled and rolled-out new ways of working in the service, underpinned by a newly commissioned reablement service with an innovative outcomes-based contract. The new contract incentivises providers to support individuals to achieve their maximum level of independence and achieve their goals as soon as possible, so they spend less time on the service and more individuals can then benefit from reablement. This was achieved by establishing four key metrics:

- Number of individuals finishing reablement per week (to increase volume)
- Average time to reable (to increase volume)
- % of people independent after reablement (to improve effectiveness)
- Average cost of ongoing care package per week after reablement (to improve effectiveness)

The outcomes-based commissioning model was based on average performance on these metrics across a cohort of individuals (rather than on an individual basis).

The council collaborated with the provider market throughout the whole process. They hosted workshops with 60 providers to explain the progress on the programme to date, and how the service specification worked before the tender was released.

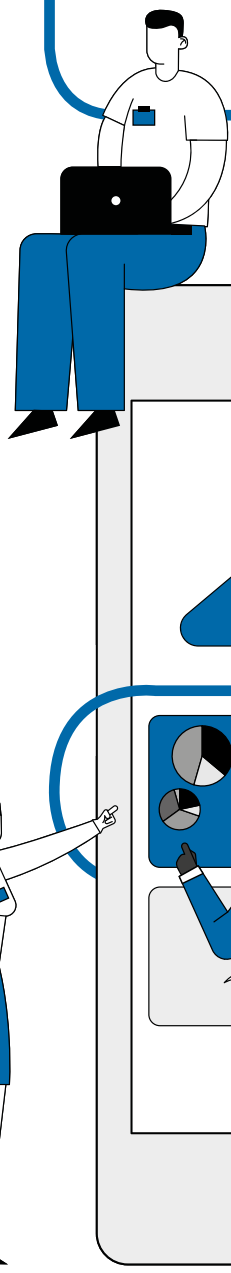


The new contracts were innovative and resulted in appropriate referrals into reablement increasing by **2,200 per year**. In addition, the service became **15% more effective** at achieving independence for individuals.

Organisational and Structural Form

Theme 9 - Adult social care in the context of the whole local authority and wider system

Delivering adult social care is not only the responsibility of the adult social care directorate; collaborating across the whole local authority, and with partners across the wider health and care system, enables a holistic, effective and efficient approach to delivering care.



Introduction

The successful delivery of adult social care relies on effective working with, and leadership from, wider functions and directorates within the local authority, as well as other organisations in the health and care system, including district councils in two-tier county areas.

What do we mean by corporate functions?

As well as the core business functions of finance, HR and legal, increasingly local authorities are further investing in enabling functions such as change management and communications; digital and business intelligence; and a programme delivery offer. These enabling functions are rapidly evolving in function and form in recognition of how the needs of social care are changing. To avoid cuts to services, and deliver financial improvement via better outcomes for people, the modern model of change in social care is rooted in people-centred change and engagement, driven by data and insight.

9.1

Services are built on effective partnerships with corporate functions (finance, business intelligence, HR, continuous improvement). This adds considerable value to service delivery by providing the right blend of capability, support and accountability, with minimal bureaucracy, to guide operational and strategic decision making.

The principles of effective relationships with corporate functions

In an optimised system, authorities have effective relationships with corporate functions, often through a business partnering approach. This approach results in service leaders being better supported with **key operational and strategic decisions**. Business partners are well informed, with detailed knowledge of how the local system (directorate) functions and have the time to invest in building **deep and trusting relationships** with service leaders.

Business finance and intelligence functions **collaborate with the service** to directly translate operational performance into financial outturn. This enables robust tracking and understanding of performance improvement initiatives, and budgets being set and managed in a meaningful way, with clear accountability for service leaders. Enabling leaders to see the impact of their actions on financial performance enables **better decision-making** and in turn, the finance function can provide important challenge and support to service colleagues as they transform and manage services.

These local authorities use **high quality business intelligence and insight** to underpin effective transformation and decision-making. Services take a data-driven approach to decision-making to leverage this insight to continually improve.

There is a **degree of data literacy** across the workforce (from frontline to management), and an effective partnership with performance / business intelligence teams which means that what is being developed is genuinely useful. Performance teams have a sufficiently **good understanding of the service** so that they can help to think about what will be most valuable. This results in basic data and insight being readily available, automated, and 'self-serve' (democratised). Furthermore, it means the critical capabilities of analysts can be used to develop valuable and bespoke insight to inform a strategic priority, as opposed to purely standard reporting.

In partnership with other enabling functions, authorities benefit from the role **continuous improvement teams** can play in improving the delivery of adult social care. This is delivered through a culture of collaboration and support, rather than one where continuous improvement are 'imposed' on a directorate. The team have a **robust model for change**, which works seamlessly alongside practitioners and service leads who are at the heart of the approach.

These authorities also benefit from the **expertise of change management, organisational development, and communications partners** and recognise they are the backbone of the continuous improvement journey. These teams seek to engage and develop a workforce of hundreds or thousands of staff so that they remain aligned to a service vision.

Effective partnerships are enabled by a **shared and collaborative culture** across the local authority; a shared vision for the organisation as a whole; a leadership team that focus on building productive relationships with partners; and robust, simple and transparent processes which minimise bureaucracy. COVID-19 has presented us with an example of this environment in practice, where the authority as a whole has a unifying 'burning platform' and non-essential processes and ways of working have been discarded.

Case Study

Engaging corporate functions and the wider organisation to continue delivering improvement in adult social care

As part of a major change programme, Leicestershire County Council needed to build on and maximise the cultural and behaviour change across the workforce to ensure significant results were sustained in the long-term. To do this, they worked effectively with individuals and teams from across the authority to achieve their vision for the service.

A collaborative team, made up of individuals with a diverse skillset, was pulled together to deliver the programme including:

- Eight Design Leads and an Assistant Director were freed up from their operational roles and backfilled. These eight experienced managers worked alongside the Director to design the new ways of working in line with the departmental vision of maximising independence.

- The transformation unit hired four Business Improvement Managers (BIMs) and embedded them full-time in the programme. They worked alongside the practice experts from adult social care and were fully accountable to the adult social care leadership for the programme duration. These BIMs were recruited and trained for their ability to bring a rounded skillset to transformation including strong analysis; modelling; facilitation; change management; and mentoring skills.

- Three members of the business intelligence function with expertise in creating user-friendly performance dashboards and turning raw data into KPIs worked hand-in-hand with Team Managers and Design Leads. Together, they produced the data and insight the service wanted and needed to be able to performance manage their business.

- Two finance professionals were assigned to the programme team, with a remit to engage all levels of the service. They mapped improving operational activity to financial performance, and critically modelled the impact of this on future budget outturn.

- A full-time communications and engagement specialist was seconded into the programme team. They designed and ran a change strategy covering the full programme lifecycle. This included regular dip checks of staff engagement and their understanding of programme objectives and success; regular open dialogue events where ideas, feedback, and challenge could inform potential improvements; and full use of communication channels to brief stakeholders and communicate the programme. Based on this, proactive activities were designed to address any emerging areas of concern.

All of the individuals above were as much a part of the adult social care team as the practitioner staff base whom they were supporting to live and breathe this change journey. This enabled this service to continue their strong legacy of delivering improvement by demonstrating improved outcomes for over **5000 individuals** per year, and an improved financial performance equating to **8% of net budget**. Part of this journey involved an **89% increase** in the practitioner usage of performance dashboards which was one indicator of the cultural shift towards a more evidence-based performance approach.

Case Study

Collaborating with finance to deliver a system-wide health and social care programme

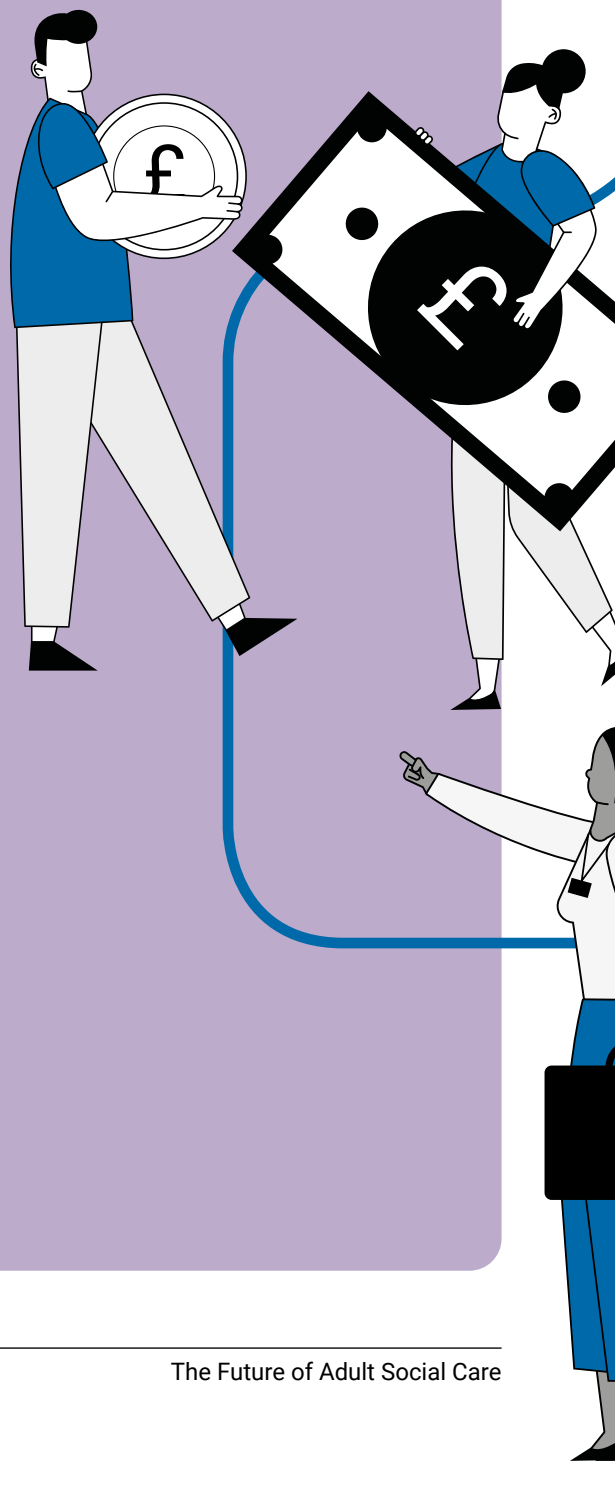
One health and social care system embarked on a programme to fundamentally redesign how its staff worked together to integrate health and care for older people. By doing so, the programme aimed to reduce acute hospital admissions and length of stay; reduce community bed days; and reduce residential and nursing home placements.

The system wanted to work together in a more integrated way to achieve these outcomes. While the financial benefits would impact each organisation differently, the system recognised that each of those areas of opportunity would require operational involvement from at least two organisations.

A named Finance Business Partner (at Deputy Director level) from the organisation who would benefit from the financial saving was paired with the Senior Responsible Officer for the operational delivery of the workstream, who wasn't necessarily from the same organisation. Together, they worked to understand both the operational and financial implications, challenges and benefits of the work.

One element of this meant working out the financial mapping to link the operational KPIs to a financial impact. This would allow the operational teams to focus on achieving the programme objectives above, while the financial teams would have confidence that this would translate to measurable financial benefit. They used the delivery plan to understand how the operational metric would change over time and were then able to use this mapping to forecast the financial impact and support budget setting.

This clarity meant that the system could have meaningful conversations on how benefits would be shared across organisations, and whether any additional funding was required to help the operational teams achieve the benefits.



9.2

Promoting independence is the role of the whole council and its partners as a system; this requires a shared vision across the authority and effective collaboration across directorates and with partners.

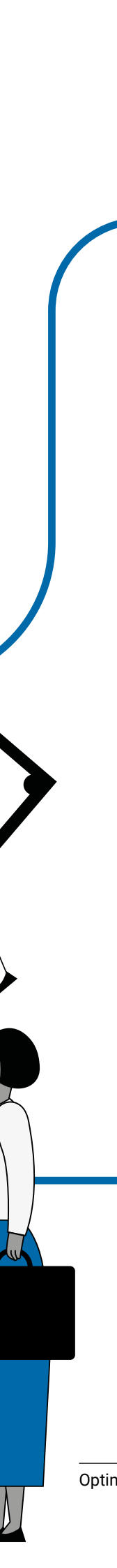
The principles of effective collaboration across directorates

In an optimised system, the Management Board and the Cabinet have a **shared vision for the whole council** and work collaboratively to ensure that this vision is delivered. The vision addresses the lives of people with care and support needs and is **shared and developed with local politicians** who play an important part in the design and delivery.

The council, with its range of responsibilities for the **experience and opportunity of local people** and the design of the place where people live, recognises that it has an **important role to play** in making the **biggest difference** to the quality of the lives of people with care and support needs.

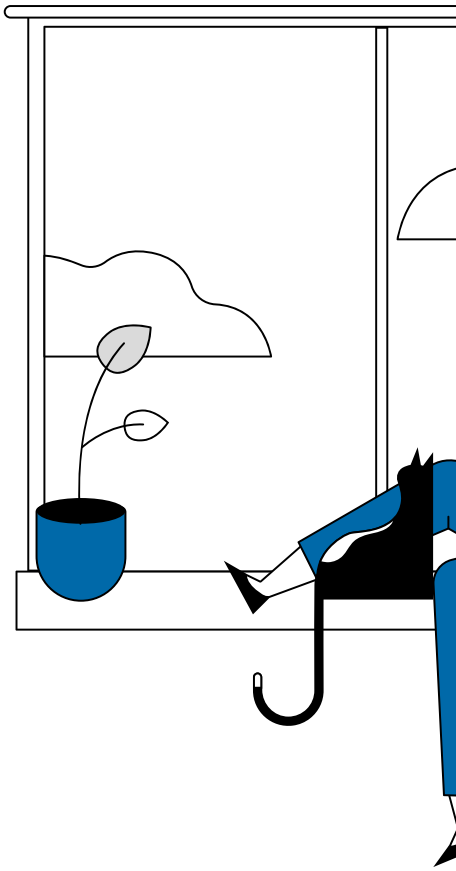
The values and beliefs are achieved when a local authority embraces its role as the **'glue' that holds a place together**, seeing the importance of the role of brokering relationships, and uniting partners around a common goal to serve local residents. The **leadership take a holistic approach**, one that promotes collaboration and cohesion, and requires staff to be **'outward looking' at every level**. The leadership of adult social care plays an important role in this, being the proxy voice for people with care and support needs.

Local authorities understand that the role of adult social care in any community is to ensure that the way the place is set up considers the needs of a range of individuals who might otherwise be excluded from the opportunities that are available. They also know that achieving this goes beyond just the responsibility of the adult social care directorate and **requires input from the whole council and its partners**.



This might include:

- Ensuring that pavements and access to premises (including shops) are wheelchair friendly.
- Ensuring that staff working in leisure, retail, and cultural places are sensitive and able to support people with disabilities, mental ill health or other conditions.
- Ensuring that the street scene and public service points are conscious of the needs of people with visual impairments.
- Supporting the existence of community cafés that assist people with dementia.
- Creating neighbourhood advice centres where people can drop in for support.



There are many ways in which how a place operates can either make it easier or more difficult for people who have care or support needs to fulfil their potential and play a full role in their local community.

Disabled individuals with experience of social care who were engaged in this programme of work suggested that there needs to be a shift in attitude, thinking and culture to ensure people understand physical barriers are often easily solved as opposed to **attitudinal and cultural barriers**. In addition, they said that there needs to be time and investment in supporting improved understanding of the Mental Capacity Act and Best Interests to support improved decision-making, ensuring professionals are confident and competent.

To achieve this, collaboration across the silos of departmental lines is required. **Adults' and children's services** work together on transitions for younger people with disabilities (*see Theme 2.2*); **cultural**, **leisure**, **and library** services will be sensitive to groups of people who may be challenged to access their services; and **community and neighbourhood** teams ensure that they are inclusive and involve a range of individuals whatever their support needs.

Case Study

A shared vision for the whole council which addresses the lives of people with care and support needs

As noted above, a whole council's vision should address the lives of people with care and support needs and fit seamlessly with the vision for the adult social care directorate.

Leicestershire County Council has set a vision for what type of organisation it strives to be over the next 20 years and what this will mean for people.

Their vision is "*Working together for the benefit of everyone.*" This breaks down into five strategic outcomes and unifies all directorates:

1. **A strong economy** to benefit everyone and support resilient, clean growth.
2. **Wellbeing and opportunity** to allow people to live in a healthy environment and to take control of their health and wellbeing.
3. **Keeping people safe** and protected from harm.
4. **Great communities** that are thriving and integrated places where people help and support each other and take pride in their local area.
5. **Affordable and quality homes**.

The council's vision, at a macro-level, clearly addresses its role in supporting people who have care and support needs. It also aligns to the adult social care directorate's vision which is "*promoting independence, supporting communities.*"

Section E

Conclusions and Recommendations

As part of social care reform, the conditions have to be created for local authorities to deliver an optimised service. Given the breadth of scope of the adult social care system, the complexity and nuance of the communities within which it is delivered, and the evolving national context, this is a complex task. However, this report seeks to provide a basis for an optimised service, and points to the key enablers that need to be prioritised in order to make this a reality.

It is the hope of the authors of this work that any reform will ensure these enablers can be taken forward systemically, leading to a consistent and sustainable solution for the future.

The central overarching conclusions for adult social care reform which have been drawn from the report are as follows:

i. Promoting Independence

A sustainable system should put the individual at the centre of their own support and be designed to promote independence.

This requires a move away from a paternalistic approach of 'providing care', and towards a system that promotes independence, whilst putting individuals and their networks at the heart of determining their own care solutions. To achieve the most independent outcomes, professionals need to work alongside the individuals they care for to focus on their strengths; to think about what this means they can achieve themselves and what their families and communities can support with; and then to offer tailored help and support to maximise their potential.

In addition to achieving good outcomes for the population, this report demonstrates that this approach can also result in a more cost-effective service. Whilst there is no doubt that long-term funding needs to be addressed, there is an opportunity for local authorities to make best use of their limited financial resources by achieving more independent outcomes for people.

ii. An explicit set of social care values and beliefs

The values and beliefs of adult social care, built around promoting independence, need to be explicit and pervasive across the partners involved in the delivery of services and the individuals accessing services.

In order to optimise the delivery of adult social care, these common values should be clearly articulated, and communicated, and should permeate across all partners and providers involved in delivering the service. This should include representative bodies, introducing a degree of consistency across the country. Crucially, the individuals who access services need to be involved in shaping what these values mean for the local community so they fully understand and believe in the values.

The challenge of achieving a shared vision for adult social care should not be under-estimated. This report explores the complexity involved with aligning every aspect of service delivery, the wider organisation and local and national relationships. These factors cannot be dealt with in isolation. This work has demonstrated how they all weave together to form an optimised model. One component cannot be optimised without having the others in place. This complexity underlines the need for a consistent value set, sitting at the heart of service design.

iii. An optimised delivery model for care has local government at its heart

An optimised model of adult social care requires a depth and breadth of local understanding and relationships.

While the model for optimised delivery may be consistent across the country, the way in which adult social care is then shaped and delivered by any service is down to the complex nuances of the local area. This report has explored the critical nature of this local bias, from understanding the population in order to strategically commission services, to the importance of collaborating with local community and voluntary services, partners, providers and the broader workforce, who often are not employed by the local authority.

iv. Investment in local and national adult social care leadership

Strong and visible leadership of adult social care is essential at the local, regional, and national level, and is enabled by continued investment in growing and developing the right people.

Strong and visible national leadership is also required to steer, represent and be the voice of the sector. Locally, recruiting high quality individuals who can become leaders in the future, is a vital pre-requisite to success and the right learning and development support needs to be in place to allow them to fulfil their potential and become effective in their role. This enables the local authority to fulfil its critical leadership role in aligning all service provision across a place.

v. Achieving parity of esteem between health and social care

Realising the positive outcomes of health and social care integration relies on strong, local relationships, where local government has an equal say. This is based on an understanding of each other's importance in the system and the needs met by the different organisations.

Arguably, one of the most crucial partnerships to be forged by local government is with the local health system. There continues to be much debate about governance and structures, including the direction of Integrated Care Systems and Primary Care Networks. However, on their own, these structural changes will not be the solution until there is a shared purpose, and adult social care is positioned as an equal partner. While parity of funding models with the NHS will be important, this issue transcends funding, workforce and national leadership, and achieving a degree of parity is a fundamental enabler of realising the benefits of integrated working. This can be enabled by strong local leadership, which fosters relationships between partners.

vi. Enabling a new funding settlement

The relationship between local government and central government is a critical success factor for optimising outcomes and maximising the impact of the public pound.

The current model of funding adult social care – which relies on a balanced budget at the start of each financial year and is dependent on supplementary grants – prevents the long-term thinking needed to deliver an optimised model. There is no doubt that long-term funding needs to be addressed - both for today and for the future - in the context of changing demographics, including people living longer lives with more complex conditions. This is also an important enabler of parity within a fully integrated health and care system.

Consistent implementation of the optimised model set out in this report will provide assurance that money is being spent effectively. This will require continued investment in high quality local leadership. Together, these factors will create the conditions for longer-term settlements, enabling continued and sustainable progress to be made.

vii. A new performance framework

A new, cross-departmental performance framework can provide a shared and data-driven understanding of local and national outcomes, providing the basis for an open and transparent relationship with central government.

The transparent, two-way flow of data and information between local and central government is an important enabler of a trusting relationship. Communities are varied, and so will require different service solutions. Therefore, re-thinking existing performance frameworks to shift the focus to outcomes (driven by shared values and beliefs) will align all stakeholders around a common goal.

There should be clear standards set, which promote consistency whilst allowing flexibility. Central government should have the right mechanism to intervene where needed, which will give further confidence for longer-term funding. It is crucial that the flow of information is two-way, and data that can be used to drive local service development is freely shared back with authorities.

If you would like to discuss the findings of this programme of work or have any questions please contact:

James Maker
Head of Policy & Communications
James.Maker2@local.gov.uk

Daniel Sperrin
Director
Daniel.Sperrin@newtoneurope.com

The Future of Adult Social Care

www.futureasc.com

NEWTON

CCN