ADULTS AND HOUSING SCRUTINY
17 JANUARY 2017

ITEM NO. .....

ADULT SOCIAL CARE TRANSFORMATION PROGRAMME

SUMMARY REPORT

Purpose of the Report

1. The purpose of this paper is to set out the vision, objectives and overall approach to the Adult Social Care Transformation Programme and to highlight the interdependencies between this programme and the projects being delivered as part of the Better Care Fund.

Summary

2. The Care Act provides the context to review and implement a new, clear operating model for adult social care services, which can be owned and understood by staff, service users and carers, and which can deliver good quality services at a sustainable cost.

3. This Transformation Programme will enable this sustainable operating model to be delivered in Darlington and will also deliver efficiencies which will support the delivery of the Medium Term Financial Plan (MTFP).

Recommendation

4. It is recommended that :-

   (a) Scrutiny Committee note the plans to transform Adult Social Care and request updates to be brought to a future meeting of this committee.

   (b) Scrutiny Committee participates as a key stakeholder group as and when Member input is required during the transformation programme

   (c) Members ask any questions and request further information.

Suzanne Joyner, Director of Children and Adults

Background Papers

MTFP

Patricia Simpson: Extension 6082

S17 Crime and Disorder	n/a
Health and Well Being	Adult Social Care is central to health and

	wellbeing
Carbon Impact	None
Diversity	If significant changes are proposed an EIA will be undertaken
Wards Affected	All
Groups Affected	People in receipt of, or potentially in receipt of Adult Social Care
Budget and Policy Framework	MTFP
Key Decision	No
Urgent Decision	No
One Darlington: Perfectly Placed	Aligned
Efficiency	New ways of delivering care have the capacity to generate efficiency

MAIN REPORT

Information and Analysis

The need for Transformation

5. The challenges arising from change in local demographics have been subject to much debate in recent years, particularly in relation to social care and health services. As life expectancy improves, and life prolonging health interventions continue to be developed, there has been a significant impact on the number of people that require social care support. The Care Act established new statutory requirements on Councils to promote individual wellbeing and prevent the need for care and support. This approach will also assist councils in managing the current and increased future demand for care and support services.

6. The financial challenges are also significant, with increasing pressure on Adult Social Care budgets as a result of reducing resources and increasing demand for services.

7. These challenges require a thorough transformation of service delivery through a new operating model which will enable the Local Authority to respond to external changes and challenges in a managed and measured way.

The vision for the transformed service

8. Engagement with staff and managers within the service will result in a vision for ASC, aligned with the Council's overarching strategic vision expressed in "One Darlington, Perfectly Placed" for the service to be created through this programme.

Project objectives

9. The vision will be delivered through a systematic and controlled delivery of projects and task and finish activities that will result in:
   - A robust preventative approach delivered through signposting, self-screening assistive technology
   - Delayed and reduced need for care and support through targeted and effective reablement support
   - Specialist service provision being delivered through personal budgets and direct payment
   - Deliver the MTFP budget reductions for Adult Social Care, resulting in a sustainably reduced base budget

The new Adult Social Care Operating Model

Developing a robust Preventative approach

10. People in Darlington will be supported to stay healthy, well and safe from harm through accessible universal and targeted prevention and early help support. This will enable independence and will divert those at risk of becoming vulnerable due to health and care needs away from dependence on formal care systems. Individuals

will be able to access information and advice to help them manage their care needs. They will know what support networks are available to them locally, what they are entitled to, and who to contact when they need help.

11. This will be achieved through:

- Enabling individuals to access high quality information and advice, without necessarily contacting the Council, through an online community directory. This will identify a wide range of voluntary sector, community groups, volunteering, befriending schemes and other locality based networks. This will result in a reduction in contacts into the department, as more people will understand what is available to meet needs that do not meet the eligibility threshold for care and support

- An online self-screening tool will also be developed, which will allow an individual to check if they may be eligible for care and support services. Where they are screened as not meeting the criteria for support, they will be diverted to appropriate sources of information and advice, mostly via the website. Where they may need more detailed advice, or where the self-assessment suggests that they could have initial eligible needs, they will be diverted to the department

- Where contact is made with the department, this will be through a Front Door Service, staffed by a multi-professional resource (Social Worker, OT, Reablement) that will provide immediate, effective and efficient triage. The individual will then be directed to the most appropriate place to meet their immediate needs. This will predominantly be through signposting and guiding them on to support networks in local communities, and/or providing information as to how they can access more specialist support and advice relating to specific conditions, such as Alzheimer's, Stroke support etc.

- Use of assistive technology, which is built around the Home Alarm Service, and includes mobile response, will be offered not only as a universal offer to anyone needing this type of assurance, but also as the immediate 'default' offer to meet any eligible needs identified at the triage point

- Maximising the economic growth in the town, by encouraging people to access employment opportunities and apprenticeships, particularly working age adults who may have disabilities or mental health issues

Delaying and reducing the need for care and support

12. Individuals will be supported to take control of their lives, through access to a range of health and care information, community and voluntary sector networks and groups, in a timely, cost effective and outcomes focused way.

13. The reduction in reliance on formal care settings is paramount to a sustainable future care model. This will be realised through a stronger emphasis on prevention and wellbeing, defined periods of reablement interventions and at the right point in an individual's circumstances, care in an individual's own home.

Targeted Reablement Support

14. Following initial triage via the multi-disciplinary team, if an individual may have some initial care and support needs, they will be referred on to the reablement service. Earlier diagnosis, intervention and access to effective reablement support is known to be successful in improving an individual's daily living skills, and independence, thus reducing their reliance on long term services, and in many cases, this can positively result in no ongoing support needs.

15. Dedicated specialist services are available for individuals to maximise independence and to minimise decline, thus reducing dependency on formal care services. Through this targeted approach to delivering social care and health support, individuals will be diverted away from the formal care system, and thus reduce the risk of further dependency on long term support.

16. Where an individual is thought to have some potential eligible care need, they will receive a period of reablement and/or intermediate care assessment and support, which is flexible in terms of time, depending on individual needs, but will generally last no longer than 6 weeks (standard intermediate care timescales).

17. During this period of reablement, assessment of improved daily living skills will be ongoing and integral to the service, to monitor progress, and prepare the individual to transition back to full independent living. This ensures that an individual is assessed for their potential capacity to be independent when they are at their optimum point, using an asset based approach. This is particularly important following a period in hospital, as it gives an individual time to regain the skills that were potentially lost either due to the illness, or to prolonged hospitalisation.

18. For those fully enabled back to their best/previous level of independence, and have no further ongoing care needs, they will be discharged from the reablement service. They will be given the same information relating to community support groups and networks in the area that is provided via the online directory, which enables them to access wider support systems should they require or wish.

19. Following screening and/or reablement, where an individual is felt to have ongoing care needs, a Care Act assessment will be completed to fully determine the level of need, using the principles of self-directed support. This will be done at the point whereby that individual is deemed to be close to the optimum level of independence. This will ensure that their needs are assessed and identified in a way that continues to build on their achievements, and doesn't result in them becoming more dependent on the care they receive.

Eligible Needs

20. If an individual has ongoing care needs services will be provided following a full Care Act Assessment using National Eligibility Criteria to ascertain the level of need.

21. Individuals will have the choice to purchase and arrange their own care, through a direct payment, or have the council arrange their care for them, through the traditional service delivery route. They will be encouraged and supported to utilise direct payments wherever possible, to enable them to have more control over how their needs are met.

22. An individual's needs will be met by diverse service provision, with a market of high quality service providers, ensuring that people have a positive experience of care and support.

23. Carers will be supported in their caring roles and helped to maintain their quality of life, through carer assessments, information, advice and services were eligible.

Safeguarding people whose circumstances make them vulnerable and protecting from avoidable harm

24. Risk is no longer an excuse to limit people's freedom; however, there are sensible safeguards against the risk of abuse or neglect. This work is overseen by the statutory Safeguarding Adults Partnership Board, which is multi agency and includes representatives from statutory and voluntary sector organisations.

25. Where there are concerns regarding an individual's safety and wellbeing, whether emotional, physical, neglect or financial, mechanisms will be in place to screen the level of risk, and to take appropriate action. Safeguarding investigations will be completed with the individual at the centre of it, in a transparent way that takes account of their wishes, and ability to make decisions. Where an individual is unable to make those decisions, an advocate will be available if required.

Project governance and control

26. Six Transformation workstreams have now been initiated each comprising of a number of projects some of which are quick task and finish pieces of work and others that require more extensive work.

27. Whilst any change process can bring with it increased risk, this can be controlled and managed by using a clear, tried-and-tested approach to project delivery, ensuring new ways of working and new tools are properly worked through before being embedded in the service, and that the benefits they are to bring about are specified and able to be realised.

28. An overview of the Programme Structure and Governance are attached at **Appendix 1.**

Transformation Programme Structure