Health and Social Care Overview and Scrutiny Committee

Review of In-House Enablement Service

Advice Note from LGA Care and Health Improvement Adviser

Introduction

This paper builds on the advice note prepared for O&S Committee in August which highlighted the recent papers produced by Institute for Public Care at Oxford Brookes University, in particular

"*New Developments in Adult Social Care*" (January 2019)
https://ipc.brookes.ac.uk/publications/new-developments-adult-social-care.html

In summary, in August report said:

> *The challenges facing Adult Social Care – from changing demography, from changing expectations from local people and as a Care Act requirement - increasingly require responses that avoid the need for people to come into the formal care "system" by building on their own and their family assets and providing community connections that support them to lead the lives they want.*
>
> *Even for those eligible for more formal care and support the aim should be to promote people's independence to enable them to lead the life they want.*
>
> *Hence "promoting independence" needs to be an underlying philosophy to all services rather than, or as well as, a discrete service.*
>
> *At the same time, it's helpful to understand how "promoting independence" best works for people in different situations (e.g. people leaving hospital, people with long term conditions, people with mental ill-health) and to have a typology of support to reflect this.*
>
> *This approach helps to reduce demand and make best use of resources but should primarily be seen as a way of delivering better lives for local people.*
>
> *Birmingham City Council (with its partners) is already developing a service model that embraces these themes.*
>
> *The in-house Enablement Service has great potential to support this approach utilising the skills and experience of staff.*

This further paper:

> Part 1 - Looks in more detail at the experiences of Leeds, Coventry and Southwark (Summaries below; more detail in appendices).
>
> Part 2 - Uses this evidence to reflect on the implementation of the Birmingham Health and Care systems new delivery model.
>
> Part 3 - Suggests that these developments should be used as an opportunity to review how the skills and experience of staff in the in-house Enablement Service might be part of these exciting and innovative new approaches.

Part 1 – Case Study 1 - Leeds

https://ipc.brookes.ac.uk/publications/new-developments-adult-social-care.html

Like Birmingham, Leeds City Council has been introducing "strengths based" social work practice. This has been combined with a number of other service changes, in particular:

1. A new Contact Centre with a focus on staff having a conversation with the enquirer which looks to explore the options open to find solutions to the person's presented problem, getting the best possible picture of their life style and routines and options for signposting to places where people might get the help they require.

2. Contact Centre staff supported by a team of social workers and well-being workers (Rapid Response Team) who can go out and see people and spend more time with them where needed and "Talking Point" locations which are within community buildings around the city for face to face conversations.

3. Staff have built the new model from the "ground up" looking to find their own solutions to changing the way they worked.

4. Harnessing this to an overall strategic approach – the Leeds **"Better Lives Strategy"** adopting common principles at individual practice level, service level, community level and whole systems level.

5. Working with people with care and support needs, carers, partners and staff to build a picture of what the constituent parts of a "good life" and using this to measure success.

6. The data indicates that since the various aspects of the approach have been introduced there has been a significant fall in people requiring a full social work assessment.

7. Investment in asset-based community development and community activity.

8. Adapting this approach so it is relevant to older people, adults with a learning disability and to supporting people who have experience of poor mental health.

9. Helping people to build local networks and to find support in their communities is a critical part of recovery for many people.

10. The Leeds approach is under-pinned by a performance management framework based around 5 domains:

    Better Conversations ……. Better Connections ……. Better Living ……. Safeguarding ……. Finance

Part 1 – Case Study 2 - Coventry

https://ipc.brookes.ac.uk/publications/new-developments-adult-social-care.html

Coventry City Council has developed an approach to supporting people live independent lives over a number of years and the hallmarks of the service are as follows:

11. There is strong involvement of OT's and OT Aides. Coventry's model has been called a "therapist-led" approach to social care. Therapists work with front line workers and providers of care.

12. "Strengths-based" assessments with an emphasis strongly on user agreed outcomes (with some challenge to the user) to help them to see the best prospects for them to regain or find the right level of independence. The approach runs through all work in adult social care.

13. A strong preventative strategy, including 5-year funding to a group of 12 voluntary and third sector providers to offer care and support to people in the City. They help people with a range of needs including those with poor mental health, adults with physical and learning difficulties as well as older people. As a result, Coventry receives comparatively low levels of referrals.

14. Use of a self-assessment tool so people can identify for themselves the resources that are available to support their needs with the option to make a referral to speak with a social worker or an Occupational Therapist.

15. Focus on short-term support with a good percentage (two thirds) helped to maintain or regain levels of independence. This means Coventry has comparatively low numbers of people in receipt of longer-term support. Of those who are supported longer term for most this is in their own homes.

16. Providers of the short-term service working within an outcomes-based performance framework.

17. A strategy for developing supported housing, including extra care housing for older people, as an alternative to use of residential care.

18. The spend per head on adult social care in Coventry has remained in the lowest quartile for metropolitan districts for over a decade.

Part 1 – Case Study 3 - Southwark

https://ipc.brookes.ac.uk/publications/intermediate-care-southwark.html

19. In May 2015, the Director of Adult Social Care, Southwark Council and the Director Operations & Strategic Development, Guy's and St Thomas' NHS

Foundation Trust formed a provider coalition and commenced work with front line staff, managers and other key stakeholders to consider what more could be done to further develop and improve integrated working across the out of hospital pathways.

20. There followed an intensive 18-month period of staff engagement, service user engagement and very concentrated leadership project meetings to re-imagine and redesign what the 'new' service should look like and how it would operate.

21. In April 2018, this work culminated in the creation of the integrated service – "Intermediate Care Southwark". This brought together under shared management arrangements four separate services: Southwark Enhanced Rapid Response Service, Southwark Supported Discharge Team, Reablement Service (for older people and people with physical disabilities) and the social work urgent response function.

22. It is included here, not so much for the service model, but for a subsequent exercise to understand the lessons learnt, all of which have a resonance wider than Southwark and are applicable in Birmingham. In summary these are:

    - Be in it for the long term.
    - Remain focused on the service user / patient at all times and the positive difference the changes will make to them in practice.
    - Find visible leaders who will model and promote integrated working.
    - Take action, agree an achievable starting point and make a start – be pragmatic.
    - Engage, listen to and co-design with front line staff, service users/patients.
    - Build trust, long lasting relationships and a working culture that will embed and sustain integrated working in practice.
    - Create capacity and have external support that acts as a "critical" friend and works with you as part of a team to build what you want.
    - Expect that there will be problems – draw them out and work together to find practical solutions.
    - Take a test and learn approach that involves practitioners.
    - Use the development of a business case as a tool to gain consensus and approval across organisations.
    - Act "as if" you are already working in an integrated way – give permission to do things differently.
    - If possible and appropriate, locate services in one place with one shared Head of Service.

Part 2 – Birmingham Early Intervention Programme Implementation

23. The Birmingham Early Intervention Programme was subject of a presentation and discussion at the Committee on 21 January. It's a programme which is part of a wider vision and strategy based on a 3-pronged service model aimed at:
    - Universal prevention services aimed at supporting people to manage their own health and wellbeing.
    - Early intervention to promote fast recovery for those that need it.
    - Ongoing personalised support to help older people remain in their own homes and communities.

24. This approach dates back 2 years to the diagnostic carried out on behalf of system partners and the subsequent agreement by system leaders and the Health and Wellbeing Board of a Joint Health and Social Care Framework. This also the Older People's Partnership Group to oversee the transformation programme.

25. The LGA has separately reviewed the programme (July 2019) on behalf of the Better Care Fund and reflected positively on the programme:

    "The review team is in no doubt that senior leaders in Birmingham have jointly grasped the nettle and are working together on a broad range of programmes intended to take a new and bold approach to improve outcomes for older people. At a senior level the analysis of the challenges is jointly owned by the senior leaders we met."

    "……continuing with these change plans has the potential to make real and lasting improvements that positively impact people's lives."

    "Birmingham should feel confident it is now in a position to face and resolve the challenges ahead".

26. They also acknowledged:

    - The long-term commitment.
    - The focus on doing the right thing for Birmingham people.
    - The visible senior leadership across the health and care system.
    - The involvement of front-line staff in shaping change.
    - The "test-bed" approach.
    - The need to reflect on and respond to challenges as they arise.

27. As this Committee heard in January there are now tangible benefits accruing from the Programme including reducing hospital admissions, reducing length of stay, reducing costs of ongoing care and more people being discharged home.

28. There is some way to go for this to become whole-system and to develop fully the programme across the 3 themes of prevention, early intervention and personalised care. The LGA review in particular noted the need to sustain the programme, to get the right balance between pace and dealing effectively with the complexity of change and the need for appropriate investment to manage the change process. They also flagged the potential to learn from other systems engaged in similar change programmes.

29. Six months on there is tangible evidence of progress. In addition, feedback from those involved appears to very positive. Staff involved seem to enjoy working in the new integrated way. Birmingham prospectively has a win-win of improved outcomes for local people alongside improved satisfaction for staff.

30. Rightly, much of the work to date has focussed on care in and outside hospital. There is still a lot to do in this regard as well as embedding new ways of working across the 3 prevention, early intervention and personalisation themes.

Part 3 – Implications for the in-house Enablement Service

31. This section focusses in particular on the skills and experience of staff in the in-house service and on the potential for those skills to complement or enhance the new ways of working.

32. This reflects the scope of the O&S review and the need to seek options for the service in the context of the move towards integrated care and early intervention and with more of a focus on prevention.

33. The in-house service itself seems to have continued to operate largely in isolation from the new service developments, though it may well be picking up some referrals from the new teams.

34. Overall there is good evidence that the in-house team has increased capacity and the number of new people being supported has roughly doubled since the end of August. However, the council needs better understanding of where the referrals are coming from, whether they are long or short term and the extent to which they are re-abling citizens and supporting prevention of the need for inappropriate higher levels of service provision.

35. Given the generally positive wider service developments referred to above, however, the Council (and wider system) may wish to consider whether there is potential for this group of staff, to be involved in prevention and early intervention in the new service delivery arrangements.

36. There has been significant pace of change since last Summer when the scope for the O&S review was drawn up. Perhaps the key point is that there is a risk of the in-house service being “left behind” with the opportunities not being grasped that could benefit citizens, services and staff.

37. However, any such consideration needs to be undertaken in the context of staff and TU’s avowed intention to retain existing Terms and Conditions and working arrangements.

Conclusions

The work in Birmingham is pioneering and reflects well on the sustained efforts at all levels and across a hugely complicated system to deliver better for the people of the City.

The work of the Older People’s Partnership Programme is also in line with best Adult Social Care, and Care and Health, practice elsewhere, as evidenced in this report.

There are opportunities to learn from elsewhere and the City should seek these out, not only to learn from others but because the City has a lot that others can learn from.

The pace of change has been significant over recent months and, while the programme has further to go than it has already come, the council should assess how the skills and experience of in-house staff might complement and enhance the new model of service provision. It should at least be planning how and when that consideration needs to be made within the wider programme planning, even if over the medium term.

Ian James
Care and Health Improvement Adviser
Local Government Association

Appendix 1

Leeds City Council

Like Birmingham, Leeds City Council has been introducing “strengths based social work practice. This has been combined with a number of other service changes, in particular:

38. A new Contact Centre where staff are trained and supported to use the principles behind the model. They have moved away from a structured conversation which had to follow a set piece of questions to staff having a conversation with the enquirer which looks to explore the options open to find solutions to the person’s presented problem. There is a single one side of A4 checklist that staff in the contact centre use to remind them of the basic approach. The new sheet focuses on helping the customer state the outcomes they desire; getting the best possible picture of their life style and routines and options for signposting to places where people might get the help they require.

39. The Contact Centre staff are supported by a team of social workers and well-being workers (Rapid Response Team) who can go out and see people and spend more time with them where the resolution of their concerns may be more complex and difficult. They can also ensure people’s safety in a crisis. In particular they assist people in finding quick solutions to help contain more serious problems. Where people’s concerns cannot be addressed either over the phone or with the rapid response workers (who might typically work with a new person over a couple of days) then usually an offer is made for the person to come and see a worker at one of the “Talking Point” locations which are within community buildings around the city.

40. Leeds Council used the Behavioural Insights Team22, an independent consultancy who have used nudge theory to change the way in which staff work in the public sector to assist them in introducing the changes in the Contact Centre.

41. The Director was keen for the staff to build the new model from the ground. The Director across all service areas encouraged staff to consider innovative ways of helping people for whom she had three rules: “Don’t blow the budget; don’t break the law; and do no harm”. They looked to find their own solutions to changing the way they worked.

42. The overall approach is led under the heading of “Better Lives Strategy” and operates at four levels:
    - **At individual practice level**: working in a different way to help individuals and their families find solutions that build on their strengths and assets.

- **At the service level**: building flexible, empowering and responsive services that are delivered in new and innovative ways.
- **At the community level**: building and harnessing the strength of resilient individuals, families and communities.
- **At whole systems level**: collaborative working with our colleagues in the wider public, third and private sectors to engineer a win-win solution across health and social care to manage demand pressures and to keep people safe and well.

What does success look like: what is a good life?

43. The City Council has worked with people with care and support needs, carers, partners and staff to build a picture of what the constituent parts of a good life are and this is what people have said:
    - Having somewhere decent to live.
    - Having friends and people who love you in your life.
    - Having enough money to make choices.
    - Exercising control over your life.
    - Living as independently as possible.
    - Feeling safe.
    - Participating in society as a contributing citizen.
    - Enjoying the best quality of life irrespective of frailty and/ or disability.
    - Having aspirations and hope.
    - Having fun!

44. The data indicates that since the various aspects of the approach have been introduced there has been a significant fall in people requiring a full social work assessment. Prior to the introduction of the approach typically between 25-30% of enquiries to the authority resulted in a full assessment during the first year of the pilot this fell to 18% of new enquiries.

45. One strong feature of the Leeds model is not to rush to plan for a longer-term service when someone is in a crisis. They have a focus on holding the person to make them safe and to give time to find possible solutions with the person. The social work team in Leeds is co-located with the community health services and so the conversation often links with the health staff so that together they can make a better assessment.

46. One of the very strong features for Leeds City Council is its high investment in community development and community activity. The City Council has continued to invest in a really strong set of infrastructures supporting different types of community workers some based in their Community Hubs; others based in the Neighbourhood Networks (serving older people across the city) and others based with local groups with specific needs e.g. migrant communities. The community development has a real commitment therefore to the principles of Asset Based Community Development.

47. It is not just for older people that the council looks to use a strengths-based model for its social care- the ambition was to change every part of the service. For adults with a Learning Disability the approach is supported under the strap line – “Being Me”. The focus is to use the approach for all existing customers of the service and for those coming into the service through transitions.

48. There is a similar approach to supporting people who have experience of poor mental health. As in the learning disability services there is a board that has been established to oversee the cultural changes that are expected to raise issues for workers in the service area. The social work team uses the “recovery model” as their basic approach and recognises that the strengths-based approach is very much a part of that approach.

49. Helping people to build local networks and to find support in their communities is a critical part of recovery for many people. Even those who have had long experiences in institutional care can benefit from being assisted to make stronger links and to participate in community activities.

50. The changes have in part been led by Practitioners with strong encouragement from Senior Managers. The model of peer learning is a very positive approach for any council to consider when they are looking to bring transformational change into their services. If the progress continues at the current rate Leeds might expect fewer people to require full social work assessments; less reliant on formal care funded by the council and much greater inclusion for learning disabled or mental health users within the thriving communities.

51. The Leeds approach is under-pinned by a performance management framework as follows:

Better Conversations

- % of new referrals for social care which were resolved at initial point of contact or through accessing universal services.
- % of adult social care assessments completed in the month within 28 days (all assessments).
- Numbers / % of carers using social care who receive self-directed support as a direct payment.

Better Connections

- The ratio of people who receive community-based support vs people who are supported in care homes.
- The number of people completing a re-ablement service.
- Delayed discharges from hospital due to social care (per 100,000 population).

Better Living

- The % of CQC registered care services in Leeds rated as “good” or outstanding”.
- % of people who use social care who receive self-directed support as a direct payment (including mixed budgets).
- Number of permanent admissions to residential and nursing care homes for people aged 18-64 including 12-week disregards.
- Number of permanent admissions to residential and nursing homes people aged 65+ including 12-week disregards.
- Number of new units of extra care housing.

Safeguarding

- The percentage of people with a concluded safeguarding enquiry for whom their outcomes were fully or partially met.

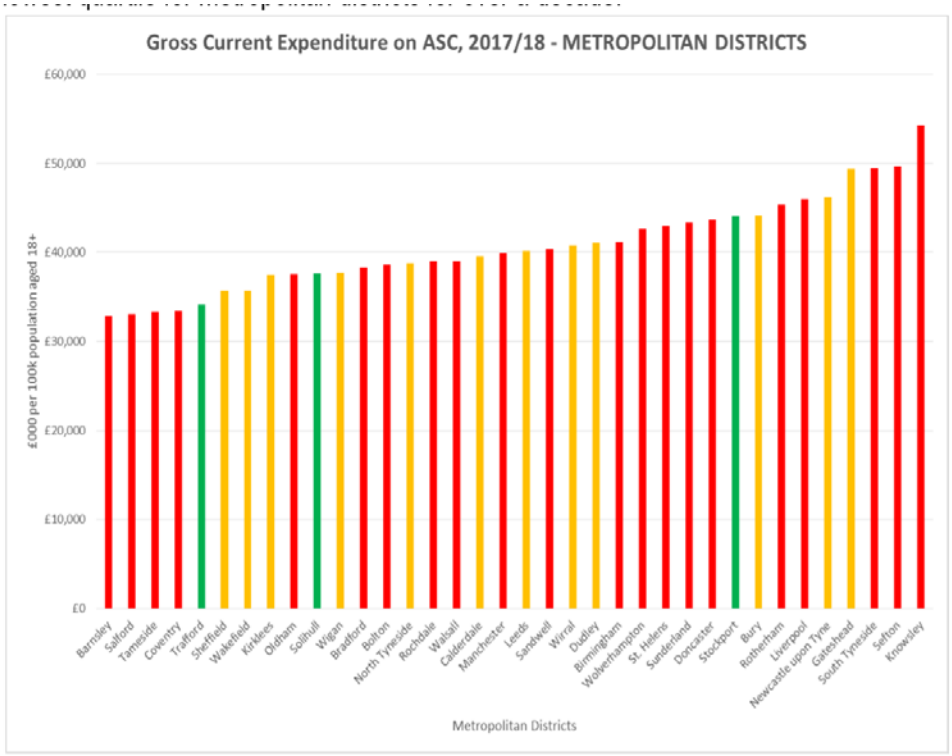
Finance

- Forecast expenditure of Directorate.

Appendix 2

COVENTRY

52. Coventry City Council has developed an approach to supporting people live independent lives over a number of years and the spend per head on adult social care in Coventry has remained in the lowest quartile for metropolitan districts for over a decade.



Data provided by Rachel Ayling.

53. The premise of the whole adult care service in Coventry is to help people to gain or regain their independence. One could almost call Coventry's adult care a therapist-led approach to social care! Therapists working with front line workers to help new and existing customers (including working with providers of care) to assist people to live independent lives is at the heart of the way the council approaches adult care. It is certainly fairly unique (for the United Kingdom) in the way in which the approach has been adopted.

54. The Council uses the language of "strengths-based" assessments though probably in a slightly different way from some other councils. The emphasis is strongly on user agreed outcomes (with some challenge to the user) to help them to see the best prospects for them to regain or find the right level of independence. The approach goes across all work in adult social care for younger age adults and for older people where it is right for them.

55. The features of Coventry are that they receive comparatively low levels of referrals with evidence supporting that many people are well supported in

their families, their communities and by third sector organisations. The Council has a preventative strategy which has offered 5-year funding to a group of voluntary and third sector providers to offer care and support to people in the City. 12 locally-based organisations deliver a range of different support models that enable people to maintain their independence in the community. There is constant dialogue with these providers to ensure that innovation is encouraged and supported. They help people with a range of needs including former mental health users, adults with physical and learning difficulties as well as older people (tackling social isolation).

56. Alongside the support available through the voluntary and community sectors the council has developed a self-assessment tool where people can identify for themselves the resources that are available to support their needs. This system also includes the option to make a referral to speak with a social worker or an Occupational Therapist.

57. Many people who are referred for help are offered short term interventions appropriate to their needs and for a good percentage this is sufficient to help them regain levels of independence. This means that there are comparatively low numbers of people in receipt of longer-term support, which demonstrates to their satisfaction the effectiveness of their promoting independence model. Of those who are supported longer term for most this is in their own homes. They tend to support fewer people but with higher costs for those who do require care and support from professional staff.

58. Approximately two thirds of all people who are assisted in this way do not go on to need a longer-term service. They are now looking to extend the service to include all those people who are currently receiving a service but there is a request to increase the service. They believe this increase should not be agreed before an OT assessment has been completed and new goals set.

59. The providers of the short-term service are measured on the outcomes that they deliver for those referred to them. They have operated for almost five years within a performance framework. All three providers consistently achieve a two thirds success in assisting people in a way that they do not require longer term support. In part this figure is achieved because of the support that the council will offer particularly the opportunity for OTs or OT Aides to work with the providers and their customers to ensure that the agree goals are met. This service was built over 6 years ago through the cooperation of local care providers (all of whom had a good history of working in the city) who were willing to work with the council in partnership to deliver these excellent outcomes.

60. Coventry has by far the largest set of supported housing schemes for all ages in any part of the UK per 1000 in the population (including extra care housing for older people). There are 35 housing schemes run across the city. For

older people 940 units where care and support are available are in 18 different housing schemes. The Council has nomination rights to 56% of these places. To be eligible for a council nomination in Coventry the person must need or be at high risk of needing residential care. Approximately 5,500 hours of care are delivered in these schemes.