Review of In-House Enablement Service

1 Introduction

1.1 What is Enablement?

1.1.1 There is a growing population of older people with multiple co-morbidities for whom the evidence shows that shifting care from secondary care into the community will produce better outcomes. The enablement service is one of a number of community-based services which support this group of people with long-term conditions. It is provided to service users in their own home aimed at helping people to recover lost skills and building the confidence to support and enable people to live at home. These intermediate care services support people during the transition points in the system to maximise their level of independence and can reduce the need for ongoing long term and residential care after an episode of ill health.

1.1.2 The definition of enablement used in the National Audit of Intermediate Care which is carried out by NHS Benchmarking Network, the in-house benchmarking service of the NHS in which all Clinical Commissioning Groups and providers of intermediate care are able to participate is as follows:

" Enablement is a community-based service provided to service users in their own home aimed at helping people recover skills and confidence to live at home; maximising their level of independence so that their need for on-going homecare support can be appropriately minimised."

1.1.3 For the majority of service-users' interventions will last for up to six weeks but for many people the involvement will be for less than six weeks. During that time enablement workers will support people to recover independence and lost skills.

1.1.4 While the focus of "enablement" as a service currently tends to be on support for older people, and is often associated with regaining skills following time in hospital, the term is also used with wider meanings, as highlighted in the advice note provided by our independent LGA adviser (attached at Appendix 1) which describes the potential role of enablement in a range of services focussed around promoting independence and it is equally an important approach underpinning best practice across delivery of all adult social care services. It might be termed "recovery" in relation to promoting better mental health or "promoting independence" in relation to adults with a disability. The common theme is that if our purpose is to help people live the lives they want – and with independence, control and inclusion – then our focus needs to be on developing people's abilities and assets. The future role and function of the in-house 'enablement service' is actually just one part of this wider range and spectrum of meanings. In future considerations for the role of the service it would help to be clear what its focus is within this spectrum of meanings.

1.2 Background to Review

1.2.1 The review took place against a background of controversy regarding proposed changes to the BCC Enablement homecare service. Briefly:

- In July 2018 the Cabinet approved a business case for the reorganisation and improvement of the Enablement homecare service.
- Following an extensive dispute and protracted negotiations with trades unions a revised proposal for delivering the business case was recommended in January 2019.
- The decision to implement the revised proposal was subject to call-in by the Health & Social Care Overview & Scrutiny Committee in February 2019.
- Following the call-in, in a subsequent report which went to Cabinet on 22nd May 2019, the points made by the O&S Committee were accepted and the business case to redesign the BCC Enablement service was withdrawn.

1.2.2 That report contained a recommendation agreeing that a review of enablement provision in BCC should be commissioned, led by Overview & Scrutiny and/or an independent party.

1.3 Approach

1.2.3 The review was carried out in full committee and livestreamed for public viewing. The first evidence gathering took place on 13th August 2019 and the second, due to intervention of the General Election in December 2019, was deferred until 13th February 2020.

1.2.4 The intention was to produce a report to the Cabinet Member for Health & Social Care with a view to informing any decisions to be made by Cabinet about options for the future of the in-house Enablement service.

1.2.5 The O&S Committee were supported by an independent critical friend, Ian James, the Local Government Association Health and Care Improvement Lead for the West Midlands Region. Ian produced two Advice Notes for the Committee (See attached Appendices) highlighting recent research papers and which also looked in more detail at the experiences of Leeds, Coventry and Southwark and used this evidence to reflect on the implementation of the Birmingham Health and Care systems new delivery model.

1.4 Scope

1.2.6 At the outset it was made very clear that the intention of the review was never to re-open the Cabinet decision taken on 22nd May 2019.

1.2.7 The focus of the review was on providing an independent view on the current and prospective future in-house service within the context of the Cabinet report dated 22nd May 2019 which describes a future service that includes a focus on prevention. The emphasis for the work was on seeking viable options for the future of the in-house service model, following the Cabinet approval for the in-house service to undertake prevention work alongside the delivery of home care, and exploring key issues

which needed to be resolved in coming to a decision about those options for the service in the context of the move towards integrated care and early intervention and with more of a focus on prevention.

2 New Developments in adult social care

2.1 Current Challenges

2.1.1 Ian James, the LGA Care and Health Improvement Adviser, provided the committee with an Advice Note (See Appendix 1) which highlighted and summarised the main points from recent papers produced by the Institute for Public Care at Oxford Brookes University, co-authored by Professor John Bolton based on his work around the country working with a range of different councils.[1]

2.2 To summarise briefly, the report set out some of the challenges currently facing Adult Social Care – both from changing demography and changing expectations from local people – 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.

2.3 The report went on to say that 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 a discrete service. At the same time, it's helpful to understand how "promoting independence" best works for people in different situations and to have a typology of support to reflect this. This 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.

2.4 BCC together with its partners is already developing a service model that embraces these themes and the in-house Enablement service has great potential to support this approach utilising the skills and experience of staff. At the same time staff need to be supported to develop new approaches that support flexible and personalised approaches to individual situations.

2.2 Key Findings from Research

2.5 The paper looked at a coherent model for provision of Adult Social Care Services as a whole but built this around transferable principles centred on three areas of practice:

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

Six Steps to Managing Demand in Adult Social Care (March 2017) https://ipc.brookes.ac.uk/publications/Six_Steps_to_Managing_Demand_in_Adult_Social_Care_Exec_Summary.pdf

- Asset-based or Strengths-based Practice
- Promoting Independence
- Outcome-based Commissioning

2.6 The key points to emerge from the report were:

- There needs to be a long-term commitment to an identified and clear approach to social care.
- Best accompanied by a freedom for staff to explore new ways of working within the context offered by senior management.
- Strengths-based or asset-based approaches to assessment work best where there is a history and commitment to investment in community capacity.
- Even those councils delivering good asset-based approaches to assessment needed to focus more on short-term support to promote independence.
- It presents a typology for the range of services that are aimed at "Promoting Independence".
- Reablement, Recuperation and Rehabilitation cover support that most typically tend to be associated with hospital support.
- The "progression-model" operates for everyone with a long-term condition including a learning disability.
- The recovery model is focussed on people with a mental health problem and how they can be assisted to self-manage their condition with support from peers.
- The promoting independence model has not seriously been developed fully in many councils.
- The paper develops principles for a more outcomes-based approach to service delivery based around outcomes-based commissioning for contracted domiciliary care providers but recommends these are relatable to any service i.e. it's the outcome-focus that's important not who provides the service.
- In designing a "promoting independence model" that is right for your locality, you would want to ensure that the investment in such a model is likely to deliver positive outcomes and a financial return.

3 Examples of initiatives happening elsewhere

3.1 Other Local Authorities

3.2 Some examples of work happening/new initiatives were highlighted in the Independent Adviser's second paper, focussing on Leeds, Coventry, Southwark.

3.3 While no two places are alike, there are common themes linking current best practice, in particular:

- A focus on "strengths based" social work practice (e.g. 3 conversations).

- Strengths-based approaches running through the whole adult social care service, including contact centre/front door, and wider system working with NHS.
- Support for the voluntary and community sector, to provide community solutions for people.
- A focus on short-term support, with emphasis on outcomes rather than inputs and processes and reducing the number of people needing more formal and institutionalised care and support.

Alongside this service-focus, there are common themes relating to the achievement of effective transformation:

- A commitment to long-term change.
- A focus on the service user, carers and residents at all times and the positive difference the changes will make to them in practice.
- Co-designing with service users, carers and residents.
- Finding visible leaders across services who will model and promote new ways of working.
- Engaging, listening to and co-designing with front line staff.
- Having external support that acts as a "critical" friend.
- Taking a test and learn approach that involves practitioners.
- Acting "as if" you are already working in a new way and giving permission to do things differently.
- A focus on culture and behaviours rather than structures and processes.

3.4 The Independent Adviser noted that many of these "best practice" hallmarks are already integral to the Birmingham Older People's programme and the shift towards prevention and early intervention, commenting that 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.

3.5 The advice notes are included as Appendices.

4 Birmingham context

4.1 Social Work Practice Development

4.2 **The Three Conversations Framework** is based on the assumption that if you collaborate with and allow people to be co-designers of their support then their outcomes go up and their use of health and social care resources goes down. The Framework seeks to replace the 'contact, reablement, then assessment for services' culture with a new approach based on the assets, strengths and capabilities of people, families and communities.

4.3 The model is about being curious, believing that people have something to offer and by taking it back to basics, we can help people to remain as independent as possible for as long as possible.

4.4 Over the years social work nationally has developed complex systems and processes that social workers have to follow. The result was that social workers spent 80% of their time following these systems and processes with only 20% of their time in direct working with citizens, families and their communities. The challenge was to reverse this. The starting point was to use three conversations to focus on what is important to the person rather than completing the same full eligibility assessment with everyone.

4.5 Moving to a prevention and community first emphasis has required a significant change in focus at all levels. It is important that behaviours are changes rather than just replacing the current paperwork with new conversation records. Birmingham has implemented a culture change programme with a focus on owning and driving performance using the key principles of 3 conversations as the focus of any changes requires. This involves fundamentally changing how a social worker practises.

4.6 The key principles of the 3 Conversations framework which need to be maintained in order to ensure that cultural change is embedded are:

- Change of language – critical to transform thinking from the old processes to being person-centred.
- Focus on identifying and developing the strengths of citizens.
- Community focused.
- Not a linear approach – engagement focuses on the citizens individual situation and is proportional to the individual's needs.
- How the interactions of social care workers develop new light touch systems and processes is designed by the innovation teams in co-production with citizens and will evolve across the period of the city- wide implementation.
- Learning from each phase will support the design and implementation in the subsequent innovation phases.
- Birmingham feeds into and learns from the 3 Conversations National Network.

5 Wider Birmingham context

5.1 Birmingham Early Intervention Programme

5.1.1 The Birmingham Early Intervention Programme was the subject of a presentation and discussion at Committee on 21st January. It is a programme which is part of a wider vision and strategy based on a three-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.

5.2 The programme is an integrated model of care that provides urgent assessment, treatment and care to older people, as well as a range of integrated services that promote recovery and independence. The aim is to help people remain in their homes whenever possible. In most cases, this means older people are more comfortable and regain their independence more quickly if good quality therapeutic support is provided.

5.3 The Advice Note prepared for the Committee by the LGA Adviser in February 2020 referred to the fact that the LGA reviewed the Older People's Programme in 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 now feel confident it is now in a position to face and resolve the challenge ahead."*

5.4 They also acknowledged the:

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

5.5 The LGA review noted that there is some way to go for this to become whole-system and to develop the programme fully across the 3 themes of prevention, early intervention and personalised care and noted in particular 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.

5.6 The advice note was able to report that, six months on, there is tangible evidence of progress. In addition, feedback from those involved appears to be very positive. Staff involved seem to enjoy working in the new integrated way. Birmingham potentially has a win-win of improved outcomes for local people together with improved satisfaction for staff. This seemed to be borne out by the very

positive experience of the Chair and Deputy Chair of the Committee when they attended an event in November 2019 where they learned about the programme and met front-line members of staff from all the partners involved in the five areas testing the new model of care before it is rolled out more widely across the city.

5.7 Test Area 1 – Hospital Front Door

5.7.1 This test area is about helping older people as they enter the hospital to get the support they need, ideally back in their own home, thereby reducing the number of people that end up unnecessarily in a ward.

5.7.2 The test site chosen was the Older Person's Assessment & Liaison Service (OPAL) at the Queen Elizabeth Hospital. It comprises an enhanced and expanded Older Person's clinical team at the hospital front door, providing specialist care quickly, reducing hospital admissions and ensuring that we care for Older People in the most ideal setting for their recovery.

5.7.3 To support the case to invest in OPAL a study was conducted to evaluate how 'effective' OPAL is at stopping people being admitted into hospital. The results were clear – as an older person, if you see OPAL you have a 70% chance of going straight home. IF OPAL don't see you, you have a 52% chance of being admitted onto a ward.

5.8 Test Area 2 – Hospital Back Door

5.8.1 This work is about speeding up the time it takes to get older people out of the hospital. Also, when they get out, to get them to a place that is best suited to their situation because currently people are often provided with care in excess of their actual need thereby impacting on their ability to recover to their previous levels of independence.

5.8.2 The QE 'Complex Discharge Hub' was chosen as the test site. Before changes were put in place, the average time it would take to get a person out of hospital once they were declared medically fit was 12 days. As at November 2019 the average time was 8 days with 67% of patients returning home.

5.9 Test Area 3 – New Community Team – South Birmingham

5.9.1 This work was to bring the expertise currently found in services such as BCHC's Rapid Response alongside other services that, together, would provide the right care in people's homes that helps them regain their independence and stay at home for longer. A team of around 15 staff from the acute trust, the community trust and the Council came together to form a new 'community team'.

5.9.2 The South Community Team have consistently reduced the amount of care people receive and the decisions that staff are making about where to discharge people to have completely shifted. This has resulted in a significant reduction in people leaving the hospital with sometimes costly packages of care and significant proportions of people now go to the new community team who now help 70% of people they see to stay at home completely independent of any health or social care support.

5.9.3 There has also been a steady decline in the use of high intensity, costly nursing, residential and temporary beds.

5.10 Test Area 4 – Intermediate Beds – Norman Power

5.10.1 The test site chosen to participate in the trial was Norman Power and the team in Norman Power look after 32 intermediate care beds for older people. This work was to increase the number of discharges from the beds to settings more aligned with the needs of the person. And at the same time, decrease the length of time people stay in an intermediate bed.

5.10.2 Before any changes were tested the team were managing to get 25% of people home, whilst the average length of stay for a person was 44 days. After the pilot 55% of people were going home and the average length of stay was 30 days.

5.11 Test Area 5 – Acute Mental Health

5.11.1 The work here was to reduce the amount of time people were staying in the hospital as a result of unnecessary delays to getting them healthier or getting them home. To do this, the team were looking to increase the number of people discharged every day which, before the changes were introduced, averaged at 5.9 people per day and at the time evidence was provided, stood at 6.6.

5.11.2 The test team were based in the Juniper Centre, Moseley Hall Hospital.

6 Findings from the Review

6.1 The Review set out to consider options for the future of the in-house service, with regard particularly to its potential role supporting the wider Older Peoples Programme and the new Early Intervention Service, and to assess the key issues that would need to be resolved in deciding a way forward. We received evidence as follows:

6.2 Older Peoples Programme (OPP) and Early Intervention Service (EIS)

6.2.1 The OPP was subject of an LGA review in July 2019 and while this was focussed particularly on Delayed Transfers of Care, it drew some positive overall conclusions about the leadership and ambition of the programme (see Para 5.3)

6.2.2 Implementation of the Early Intervention Service is also showing positive results, with 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.

6.2.3 The Chair and Deputy Chair also attended an event showcasing the work and staff are clearly enthused by the new way of working. It is still early days, but our Independent Adviser has commented on potential prospects for a win-win of improved outcomes and improved staff satisfaction.

6.3 Evolution of the In-House Enablement Service

6.3.1 The in-house service has not stood still, with management looking to evolve its role in response to wider service developments and in recognition of the underlying challenges around costs and outcomes. We heard a joint presentation from management and Unison explaining how the service is now:

- Supporting the Out of Hours service to prevent escalation of acute needs, including as an alternative to contacting the Ambulance Service.
- Supporting timely hospital discharges by providing an escort service to enable husband/wife/partner to visit a person who has been deemed medically fit to leave hospital but needs a period of residential care before returning home.
- Providing 'wrap-around' support to people coming home from hospital and providing night-time support.
- Linking with the Early Intervention service to provide continuity when the EI service has completed its work.

6.3.2 We heard how Unison is working with management to support 'self-rostering' by teams, a process which is being rolled out city-wide and is improving service capability, increasing contact-time with service users and is part of a service shift to re-balance the service across the constituencies. There have also been voluntary transfers for some staff from day-time to night-time working.

6.4 Performance and Outcomes

6.4.1 There is evidence from performance reports that capacity within the in-house service has increased, with roughly twice as many people being supported compared to August 2019. However direct contact time with service users remains low at around 26% to 28%.

6.4.2 We were told by management and Unison that the roll-out of the changes described above is designed to increase contact time by a further 25% i.e. to 50%+.

6.5 Finance and Value for Money

6.5.1 Reliable comparative data for in-house enablement services is difficult to obtain as there is no national standard for how this should be calculated, and councils are naturally cautious about revealing their working out. However, we heard from the Interim Adults Business Partner, Finance, that his assessment of the evidence is that the benchmark cost is around £25 per hour for the cost of the service but in terms of actual contact time that is somewhere between £45-£50, with BCC costs at around £65-£70 per hour.

6.5.2 His assessment was that the service needed to get to 50% contact time to get within range of the benchmark hourly cost.

7 Some Outstanding Issues

7.1 From the evidence presented to the review we have a wider system and City Council programme (OPP and EIS) which is progressing well. As we heard, it still has further to go than it has come already and will require sustained leadership and focus, but it has delivered some early improvements in outcomes and has been generally well-received by staff.

7.2 At the same time, we have an in-house service that has sought to adapt to wider service changes and its own need to be responsive and part of that change. Before drawing conclusions, however, we summarise what we consider to be some outstanding issues below.

7.3 Performance and Outcomes

7.3.1 While capacity in the service is increasing (more people supported, contact time increasing) we were not able to assess what outcomes this is delivering nor the extent to which these are supporting our wider OPP and EIS ambitions.

7.3.2 Some measurement of performance and outcomes needs to be built-in to any further developments to support the ambition that capacity and contact time continues to increase; equally to be clear what added-value that capacity and contact time is delivering.

7.3.3 The value of this function should be formally demonstrated through current knowledge of the savings to the whole-system-cost of embedding and maintaining people at home and outside of institutional care. The use of a method such as a 'Social Return on Investment' model which measures extra social value not currently reflected or involved in conventional financial accounts – to show the outcome from the in-house team is a 'service that saves money' rather than just a cost of service - could be explored.

7.4 Value for Money

7.4.1 The descriptions of more flexible rostering and balancing work across day and night-time needs and across constituencies was very encouraging, as was the ambition to make this city-wide and to achieve a contact time percentage of 50%. We were also encouraged by the obvious commitment of service management and Unison to work together to these ends. Management and workforce have shown a commendable willingness to work together on co-developing the service re-design. This is a major achievement and ranks alongside the major transformational achievements of the EI programme. This achievement and the way it has been brought about against a difficult back-cloth should be recognised and commended. There was consensus across all stakeholders including Unison that the utilisation rate of the service needs to be closer to 50% and that the service will not be viable at the recent contact time percentage of 28%. Any future model relies on this condition being achieved, and all parties appear to share a commitment to achieving this.

7.4.2 At the same time this roll-out needs to be managed and needs to be assessed and tested to ensure the Council has confidence in its ability to deliver both improved outcomes and the value for money return. There is a need for some clear and transparent, verifiable metrics to demonstrate this, both

to the workforce themselves as a source of pride in achievement, and to show wider stakeholders that it is working.

7.5 Supporting Wider System Change

7.5.1 We heard some evidence of how the service changes are allied to wider prevention work (e.g. Out of hours) and to wider enablement through providing a continuation service post Early Intervention and providing wrap-around and other support to get people home from hospital.

7.5.2 What we did not hear about was the potential for the service to support wider service change related to e.g. Neighbourhood Networks, or the 3 Conversations programme or preventive work with the NHS e.g. social prescribing. It may well be that these are not appropriate, particularly given the other developments described above, and perhaps not now. However, the Cabinet Member may wish to explore this potential further.

7.6 One Programme

7.6.1 All the above points would be better addressed if the developments in train for the in-house service were set within the wider transformation programme. Presently they feel somewhat separate from the programme and, while supportive of it, they are not yet intrinsic to its delivery.

7.6.2 A long-term sustainable role for the in-house team needs to be more clearly and distinctively described within the broader system of the wider transformation programme.

8 Where do we go from here?

8.1 The Challenge

8.1.1 The City Council in-house enablement service has a group of skilled, dedicated and experienced staff who are providing a service which is valued both by citizens and staff and which was recently rated good in all areas by the CQC. These skills and experience seem to fit well with the work that is happening in the health and care system working with people in an enabling way to promote early intervention and prevention.

8.1.2 The Committee were provided with some positive performance information in relation to the in-house service which is providing services to an increasing number of citizens across the city. The Members were told about the ongoing constructive work being done in partnership with Unison on self-rostering which, it is anticipated, will continue to be refined and developed over the next 9-12 months with a view to potentially developing a consistent approach which can be rolled out city-wide. The expectation is that this should increase the percentage of contact hours and therefore utilization. This work appears to provide the potential to deliver significant improvements in the efficiency of the service.

8.1.3 The new Early Intervention Service is an example of excellent multi-agency integrated working. It is still at an early stage in implementation but the evidence to date seems to indicate that the new

service is delivering positive results and tangible benefits. These include reduced hospital admissions, reduced length of stay, more people being discharged home and staff who are enthusiastic about and committed to the new ways of working.

8.1.4 There does seem to be clear potential for the work being done by the in-house enablement service to be in some way 'more closely linked with' or 'brought together with' the work of the Early Intervention Programme. As was recognised in the evidence given by the Independent Adviser, the challenge for the Council is to bring the two together in a way that takes advantage of the opportunity to develop new ways of working for the City Council and which avoids the potential danger of the in-house service being left behind.

8.1.5 Equally there are other significant service changes in train including development of locality teams and neighbourhood networks and the City Council's ambition programme for sheltered and extra-care housing. These might equally use the skills and experience of some of our in-house Enablement staff. We set out these options in a little more detail below alongside a potentially viable role for the maintenance of a distinct in-house service working within this wide system. None of these options is mutually exclusive, and the key point is the need to confirm and clarify the role and standing of the in-house enablement team as an equal partner within the wider adult social care system.

8.1.6 There are numerous outstanding issues about the extent to which this can be achieved, and if so, how. This report is not intended to make these specific proposals. The intention is rather, to set out possible 'scenarios' or potential 'options' which might help to inform the thinking of the executive when they are considering future options for the in-house enablement service.

8.2 Possible Future Options for in-house enablement service

Option 1 - **Potential transition of some staff to a preventative role in the new Early Intervention Programme**.

8.2.1 There was evidence that there could potentially be opportunities for some in-house enablement staff who are willing to use their skills and experience to complement or enhance the new ways of working, for those who are willing to be integrated and make the transition to working within the new Early Intervention service model.

8.2.2 Members heard evidence about some new initiatives which are currently already being explored which link to wider prevention work, such as the new out of hours duty team which has been put in place. There are also initiatives linked to wider enablement by providing wrap-around and other support to get people home from hospital and links being made with the Early Intervention Community Team to work with service users to provide continuity of service and longer-term care packages in the community.

8.2.3 Given that some of these initiatives are already beginning to be established, the Cabinet Member may wish to examine these options further once the work has had time to develop further.

Option 2 – Role for staff within Locality Teams/Neighbourhood Networks

8.2.4 As noted previously in 7.5, whilst Members did hear some evidence about how some service changes are being allied to wider prevention and wider enablement work, Members did not hear about potential for the service to support wider service change related to work that is happening around Neighbourhood Networks, or the 3 Conversations programme or preventive work with the NHS such as social prescribing.

8.2.5 It may be that these are not appropriate, particularly given the other developments described above, and timing may be an issue. However, the Cabinet Member may wish to explore this potential further.

Option 3 – Role within Sheltered Housing Schemes/Extra Care Schemes

8.2.6 Sheltered and Extra Care Housing Schemes provide support to their residents to help them live independently for longer. They are aimed at people who can usually manage on their own but who feel safer knowing that support is on hand if needed and where the support can adjust flexibly as needs fluctuate

8.2.7 Birmingham City Council runs 130 sheltered housing schemes for older and more vulnerable people across the city and in addition there are around 25 Extra Care housing schemes aimed at people aged 55 years or over with support needs and some care needs which are run in partnership with the Extra Care Charitable Trust and housing associations.

8.2.8 Members heard that the in-house enablement service are the provider for 4 Extra Care Schemes, 3 housing schemes and a private provider but that that there are opportunities and plans to expand further in providing enablement support in these areas. The Cabinet Member may wish to take cognisance of developments in providing support within Sheltered and Extra Care Housing Schemes when considering options for the future of the service.

Option 4 – Role for staff remaining within an in-house enablement service

8.1 As an alternative to, or alongside, the options above there could potentially be a continued productive role for the in-house service. This very much depends on some of the provisos set out above – not least the completion of the service transformation and rostering and financial benchmark considerations – but more significantly this would rely on an assessment of how the service can be an equal and integral part of the wider model for service delivery. Some of this potential is evolving already, for instance around wrap around services and out-of-hours and to support hospital discharge. The feasibility of setting up a system of 'Bank Staff' which could supply staff to address service need across the city, is also currently being explored. Any such development, however, needs to be part of a planned and strategic approach and as part of the wider OP Programme.

8.2 The Cabinet Member may wish to further consider the latest data about the flow of referrals from the EI service to the in-house enablement services for enablement packages and the impact of that

together with the some of the other new initiatives being introduced, on utilization and efficiency of the service.

9 Conclusion

9.1 Extensive evidence was presented to the scrutiny committee about new developments nationally in adult social care, the new Early Intervention model being developed in Birmingham, and the collaborative work that is ongoing within the in-house enablement team between senior management and workforce. From this we have identified the potential to develop a long-term, sustainable role for the in-house enablement function, within a broader model for the provision of Adult Social Care Services and based around a range of help to enable service users to live a more independent life and progress from one level of dependence to a level of greater independence. The Cabinet Member is now invited to give careful consideration to these options.

9.2 Key considerations to guide this decision-making, as described above, will be:

9.2.1 Clarity on the role and focus of the in-house service and how it is brought together with other elements of the new integrated service model

9.2.2 Additionally (or alternatively) are there opportunities to transition some staff within the service into other evolving service changes (EI, Sheltered Housing, and Locality Teams etc)

9.2.3 These assessments to be made as part of the development of the wider programme

9.2.4 Confirming the increases in contact time and confidence that a reasonable financial benchmark can be achieved; equally an assessment of how the outcomes delivered represent a return on investment as part of the wider financial assumptions for the Older People's Programme.

9.2.5 Having a performance framework that allows ongoing assessment of service outcomes

9.2.6 Seeking to maintain the benefits of a shared and collaborative approach by management and staff.

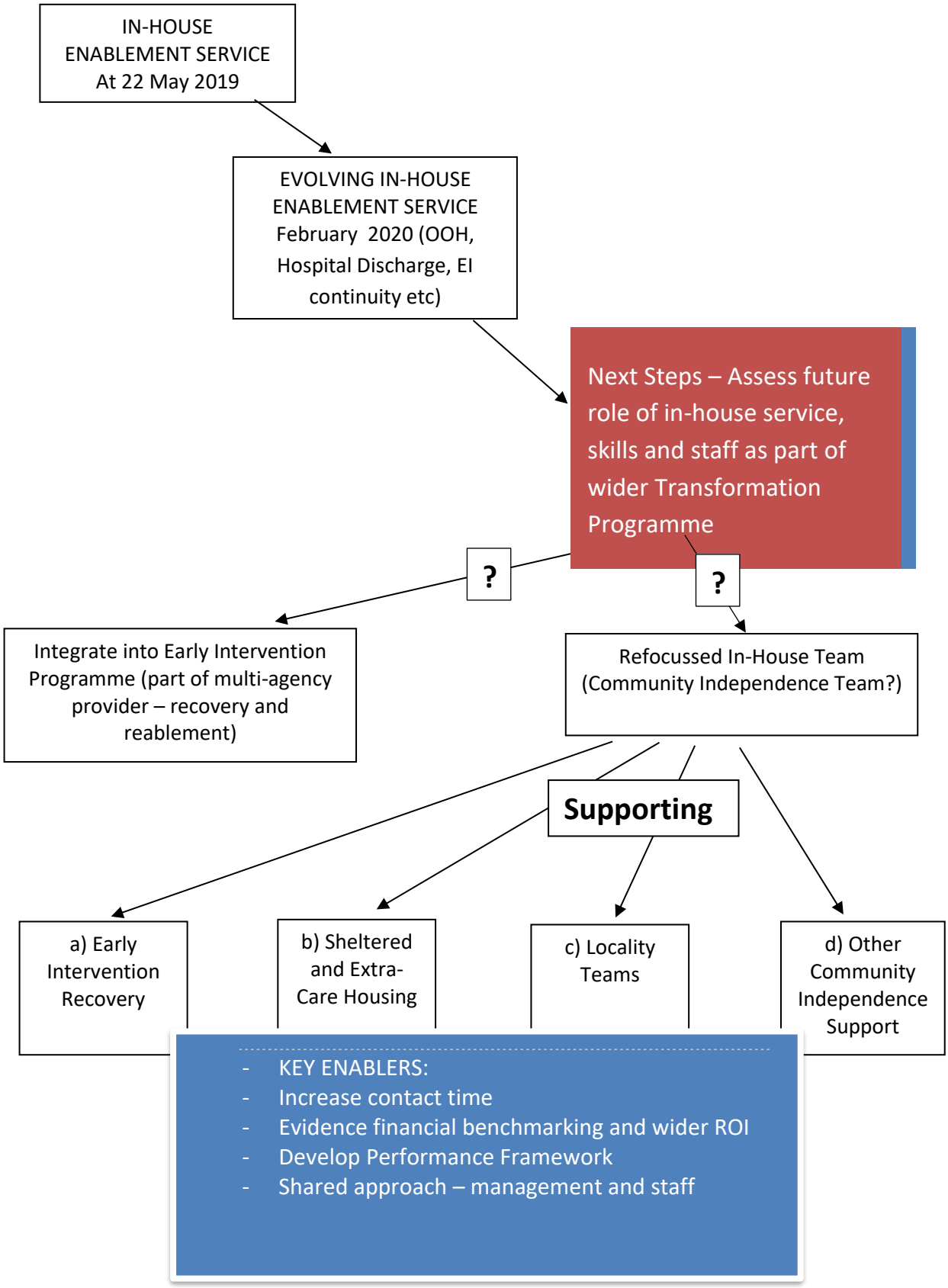
9.3 In addition, the evidence suggests that particular thought should be given to the key 'Critical Success Factors' emerging from recent research findings, as set out in the Advice Note provided, when looking at a developing a coherent local model for the provision of Adult Social Care Services. These factors include several years of commitment to an identified and clear approach to social care, freedom for staff to explore new ways of working (which is also a prominent feature of the EI programme), a focus on short-term support to promote independence and based on an outcomes-based approach to service delivery i.e., it's the outcome-focus that's important, not who provides the service. An integral part of any such exercise would seek to ensure that any model is likely to deliver positive outcomes and a financial return.

9.4 From the evidence heard by the members, the role of the in-house team within the broader system could be described as 'to enable community independence, progression, integration within the community and to support and enable people to develop the skills to self-manage outside of institutional care'. Bearing this in mind, this raises the question of whether there might be merit in

re-naming the in-house team to better reflect the function, such as 'community independence team' or 'progression and home care team'?

9.5 Without doubt there will come a future long-term commissioning end-point and, at that stage, the working model for the future in-house team, funded within the eventual funding model will need to be finally resolved. In the meantime, the diagram below represents an attempt at presenting some of the possible options emerging from this report in diagrammatic form, with a view to informing any future deliberations and decisions to be made about the future of the in-house enablement service.

POSSIBLE DEVELOPMENT ROUTE



APPENDICES

Health and Social Care Overview and Scrutiny Committee

Review of In-House Enablement Service

Advice Note on Recent Research Findings

Introduction

This advice note provides a summary of recent papers produced by the Institute for Public Care at Oxford Brookes University, co-authored by Professor John Bolton, well-respected researcher and authority on "enablement" services and, more broadly, the potential for Adult Social Care to reduce needs for long-term care by supporting people in a way which helps them maintain (and if needed regain) independence. It is based on his work around the country working with a range of different councils.

"*New Developments in Adult Social Care*" (January 2019)

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

This builds on a previous publication – *"Six Steps to Managing Demand in Adult Social Care"* (March 2017)

https://ipc.brookes.ac.uk/publications/Six_Steps_to_Managing_Demand_in_Adult_Social_Care_Exec_Summary.pdf

This paper summarises the main points from these reports and draws some implications for the current review.

Summary and Implications

The challenges facing Adult Social Care – both from changing demography and 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 a discrete service.

At the same time, it's helpful to understand how "promoting independence" best works for people in different situations and to have a typology of support to reflect this.

This 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.

At the same time staff will need to be supported to develop new approaches that support flexible and personalised approaches to individual situations.

The main points from the 3 papers are as follows:

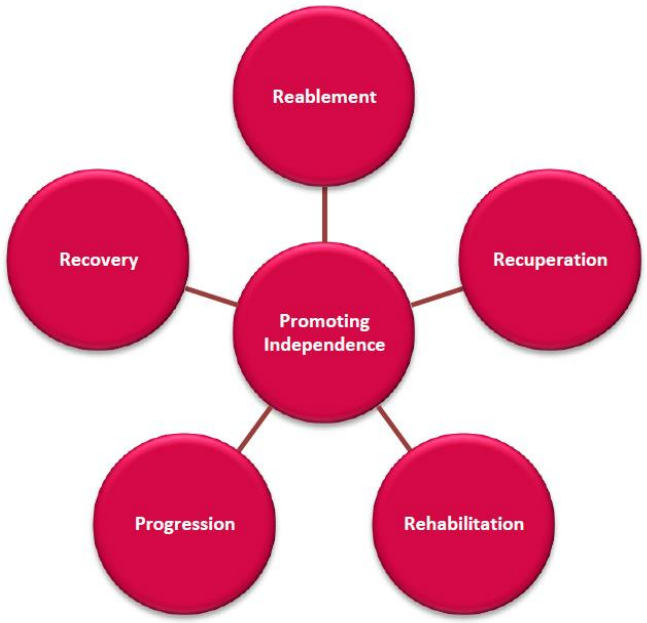
New Developments in Adult Social Care (2019)

This looks at a coherent model for provision of Adult Social Care Services as a whole but builds this around transferable principles that centre on 3 areas of practice:

- Asset-based or Strengths-based Practice
- Promoting Independence
- Outcome-based Commissioning

With Regard to the current review of the Enablement Service, the key points to emerge from the report are as follows:

1. There needs to be several years of commitment to an identified and clear approach to social care.
2. Best accompanied by a freedom for staff to explore new ways of working within the context offered by senior management.
3. Strengths-based or asset-based approaches to assessment work best where there is a history and commitment to investment in community capacity.
4. Even those councils delivering good asset-based approaches to assessment needed to focus more on short-term support to promote independence.
5. It presents a typology for the range of services that are aimed at "Promoting Independence"



6. Reablement, Recuperation and Rehabilitation cover support that most typically be associated with post-hospital support.
7. The “progression model” operates for everyone with a long-term condition including a learning disability. It should be based around a range of help that will enable the service user to live a more independent life and to progress from one level of dependence to a level of greater independence. A person with lower levels of needs might be assisted in a way that they require much less (or no) formal support from the care system. This approach very much lends itself to people who are living in the community but have become dependent on formal care.
8. The recovery model is very much focussed on people with a mental health problem and how they can be assisted to self-manage their condition with support from peers.
9. The Promoting Independence model has not seriously been developed fully in many councils'.
10. The paper develops principle for a more outcomes-based approach to service delivery based around outcomes-based commissioning for contracted domiciliary care providers but recommends these as relatable to any service i.e. it’s the outcome-focus that’s important not who provides the service.
11. In designing a “promoting independence model” that is right for your locality, you would want to ensure that the investment of such a model is likely to deliver positive outcomes and a financial return.

Six Steps to Managing Demand in Adult Social Care

Key points:

1. The demands from the acute sector can dominate the overall demands on social care if this is not well managed. It is important though that people who are referred through the community are given the same range of short-term support as those who may have been referred from the hospital.
2. There may be a better solution for about 50% of older people who are in receipt of lower levels of domiciliary care. For example, if an older person is socially isolated there are better ways of tackling the isolation through helping people link into their communities; resolve difference with their families or through volunteers / volunteering.
3. In essence, it is important that the principles of “promoting independence” or “the progression model” are used for the way in which all people within the care system are offered long-term assistance.
4. For those with challenging behaviours they may need psychological help to manage their behaviours.
5. For those who have become dependent on institutional care they may be assisted to move to independent living.
6. For those in independent living they may learn more skills to maximise their opportunities with the likely outcome that they will need less direct care and support.
7. Those with disabilities support to help gain skills of greater independence should always be the desired outcome.
8. Older people, where appropriate, should be encouraged to take exercise, manage their diet, including moderating their intake of alcohol, and look after their well-being.
9. For some they will need much more support e.g. those people living with dementia. This cohort can be assisted to live with their disease/condition.
10. For many (staff) this requires both a significant cultural change and a new skill set. Staff will need to learn how their care can lead people to greater dependency and how they can manage risk to assist people move towards greater independence. At the same time, they will need to understand each specific condition and the best way of assisting the person as an individual. One of the reasons why demand has not been as well managed in Councils as it should have been is because insufficient attention has been paid to the training and development of staff to deliver the agenda.

Ian James

Care and Health Improvement Adviser, West Midlands

Local Government Association

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.

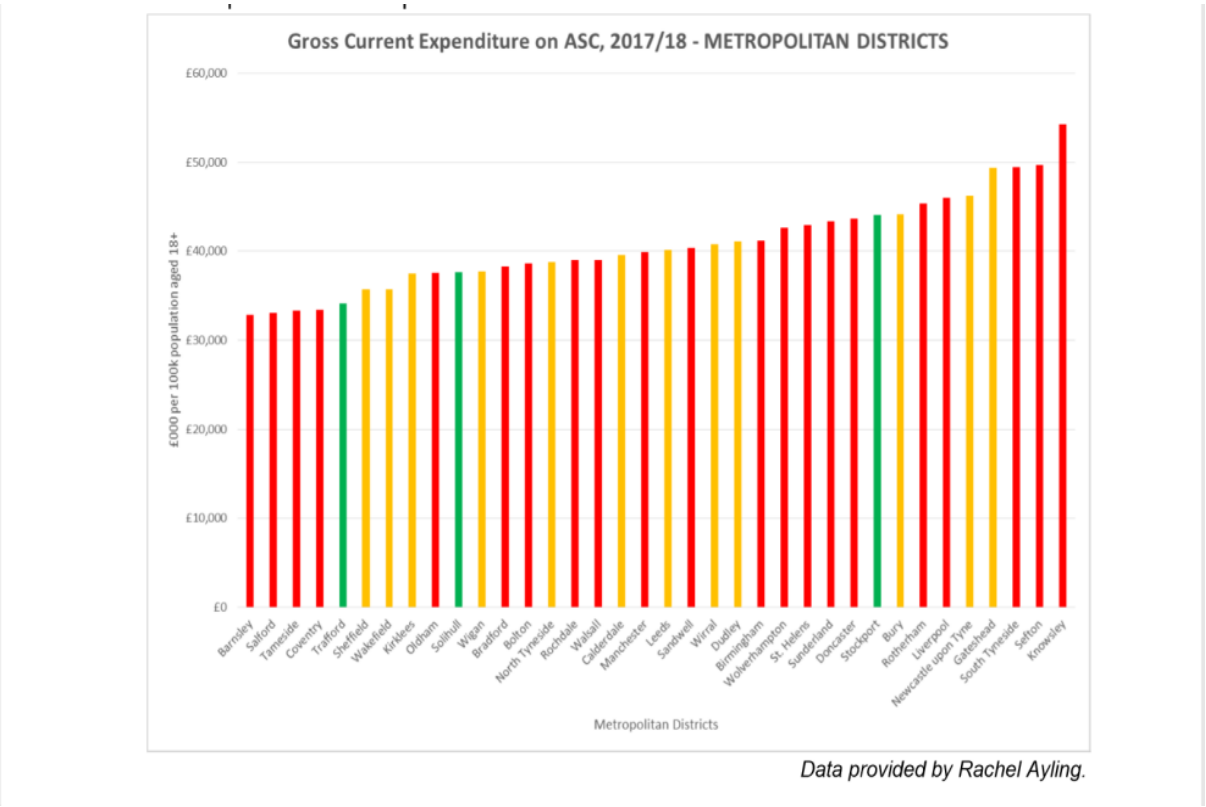
Finance

- 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.