Derby City Council

COUNCIL CABINET
30 April 2014

Appendix 2

Report of the Cabinet Member for Adults and Health

Your Life, Your Choice – building sustainable care and support in Derby

SUMMARY

1.1 Adult social care is at cross-roads: with rising need and shrinking local government budgets we could, if we are not careful, resort to an ever-tighter interpretation of eligibility criteria and intervention only in a crisis.

1.2 This report asks for permission to consult the people of Derby upon a proposed "Your Life Your Choice" strategy for adult social care that is built on "Big Conversation" principles. The strategy sets out the significant challenges currently facing adult social care, and promotes the need to think differently so that the Council can continue to serve people well while working within the resources that are available. The report sets out a proposed alternative strategy that would "break out" adult social care from its current path towards being an emergency service and re-positions it as closer to, and working with, individuals, families and communities in collaboration with our partners.

RECOMMENDATIONS

1.1 To commence formal consultation with Derby residents, social care customers, carers and key stakeholders on the Council's proposed "Your Life Your Choice" strategy.

1.2 Following consultation and consideration of responses, to bring back a final version of the "Your Life Your Choice strategy" for formal approval with an action plan for its implementation.

REASONS FOR RECOMMENDATIONS

3.2 Derby City Council needs to set out a strategy for managing the demands and pressures of providing an adult social care service that is sustainable and in line with the Labour administration's key values.

3.3 Some of the potential benefits for social care customers from the proposed "Your Life, Your Choice" strategy are illustrated via the pen pictures in **Appendix 2.** The proposed strategy is not only about better use of Council resources. It is also intended to enable adults with social care needs to feel more in control, and more connected, in the way they choose to live their lives.

Derby City Council

COUNCIL CABINET

Report of the Strategic Director for Adults, Health and Housing

SUPPORTING INFORMATION

4. Introduction

4.1 Adult social care is at cross-roads. With rising need and shrinking local government budgets we could, if we are not careful, resort to an ever-tighter interpretation of eligibility criteria and intervention only in a crisis. This strategy is not sustainable and would deny support to people who need it to live their lives in dignity and without fear. If we continue to operate the same service model we will fail people. This report sets out an alternative strategy that would "break out" adult social care from its current path towards being an emergency service and re-positions it as closer to, and working with, individuals, families and communities in collaboration with our partners.

4.2 Adult social care is affected by social, political and demographic changes. What we do is framed by complex legislation that has its roots in the Poor Law. However, people's expectations and aspiration for their lives are changing and this affects how we meet people's care and support needs. It is increasingly clear that our future is intertwined with other strategic partners as we seek to promote people's independence and safeguard people in Derby.

4.3 The proposed strategy seeks to focus our energy on what matters to people and acting swiftly to achieve it. We seek to build the systems, relationships and resources to support people to live lives that are meaningful and uphold their dignity. We want to ensure that support is provided as close to home and family as possible.

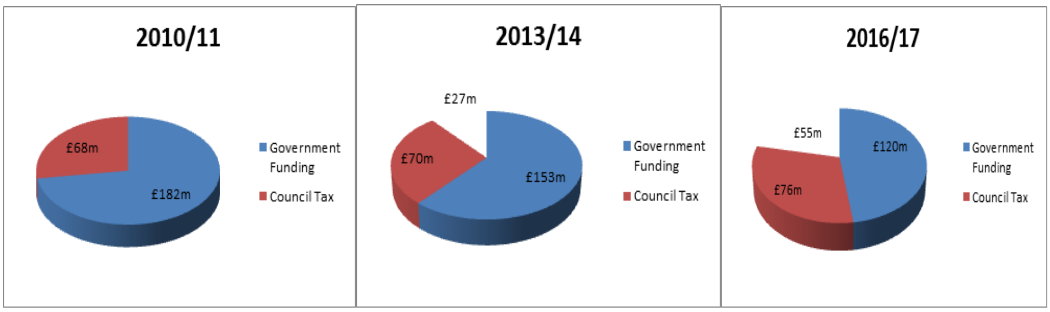
4.4 Local Government has a place-shaping role and we must use this mandate to have new and different conversations with our citizens, our communities and our partners to ensure that Derby can continue to survive and thrive in these unprecedented times. Collaborative leadership will be key in achieving our shared vision for our city.

4.5 This report sets out our challenges and describes our direction and actions for the years ahead.

The challenge

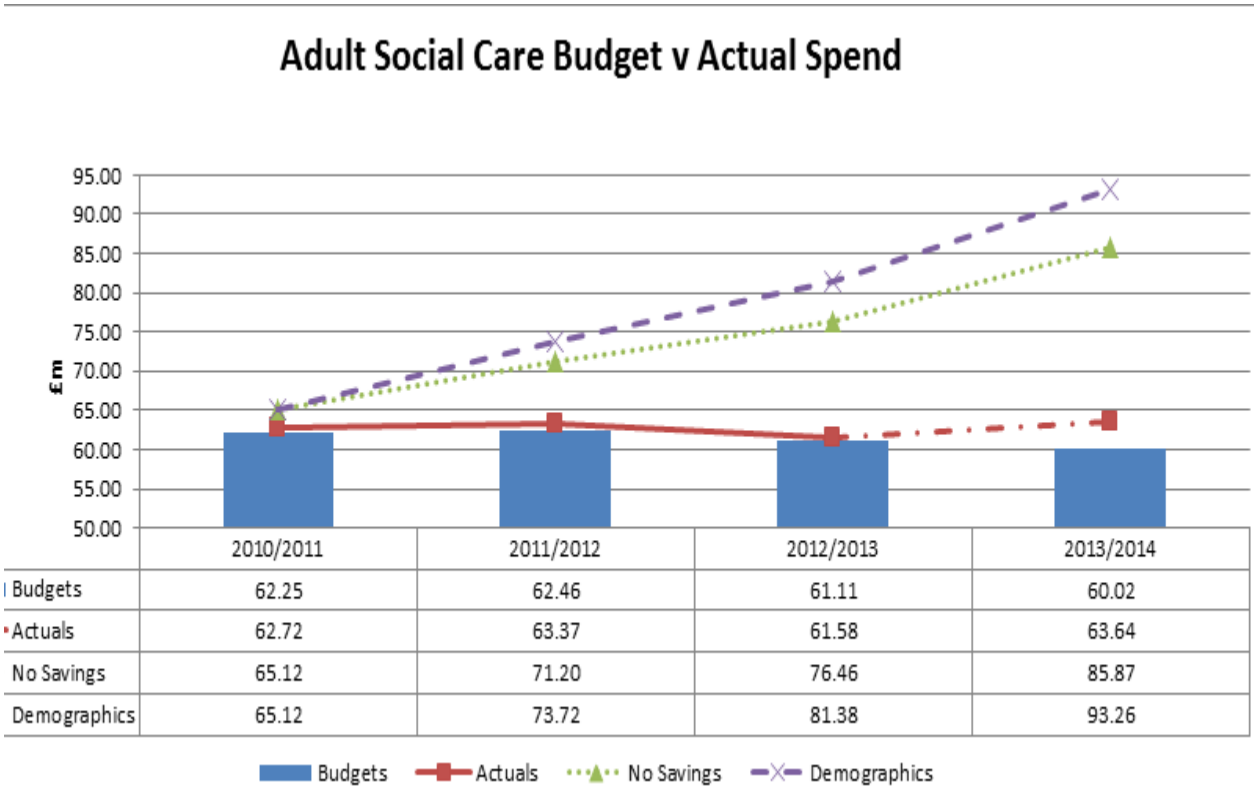
4.6 The estimated savings required to balance the Council's budget, reported in the Council's budget strategy in September 2013, was approximately £77m over the next three years. The latest forecast requires savings of £79m to balance the budget. This includes £28m in 2014/15, £30m in 2015/16 and £21m in 2016/17.

4.7 Set out below is an illustration of how much money the council has lost over the preceding years and where we will end up in 2016/17:



4.8 After the schools budget, adult social care is the next biggest single area of controllable spend in the council's budget. Demographic changes (chiefly the increase in numbers of people aged 85+ with their attendant social care needs as well as the increasing numbers of people living longer with very complex disabilities) mean an approximate additional £2m annual budget needs to be addressed. The Council needs to therefore continue to innovate in how it meets people's statutory social care needs while remaining within existing resources.

The graph below sets out what the trajectory of the expenditure for adult social care would have been and what is has been with the difference representing the level of savings that have been delivered so far.



	2010/2011	2011/2012	2012/2013	2013/2014
Budgets	62.25	62.46	61.11	60.02
Actuals	62.72	63.37	61.58	63.64
No Savings	65.12	71.20	76.46	85.87
Demographics	65.12	73.72	81.38	93.26

4.9 An analysis of the unit costs for adult social care suggests that the council is achieving good value for money. However, bench-marking shows that Derby spends a relatively higher than average percentage of its budget on residential and nursing care with expenditure for community-based services lower than average for our comparator group. Our balance of care is not right. We need to do more to support people to remain living in the community. Our joint investment with the NHS through the Better Care Fund will help us with this ambition. Supply side strategies need to

continue to address the balance of care with a greater number of people supported in the community and a step change (reduction) in the number of people supported by the local authority in residential and especially nursing care.

4.10 However, moving resources from residential and nursing care into community support will not by itself create a sustainable social care offer. Above all, the Council needs to shift its focus to addressing demand: how it can support and empower people to find their own solutions or, if they need help, how we can find the most cost effective solutions to help people gain or retain their independence.

Our journey: what we are trying to achieve

4.11 Since 2010/11 the Council has been delivering essential public services within an ever-diminishing budget. It is critical that we are clear about what we are trying to achieve for local people and where we are heading. As part of our "Think Local, Act Personal" work we have been talking to people to better understand what their experience of our service is like and whether we are focusing on the right things.

4.12 People told us that:

- It is sometimes difficult to get good advice and information in order to make informed decisions
- When we make changes we do not always explain it very clearly
- People can find it difficult to speak promptly to the person who can help them with their issue and waiting times at the "front door" are growing
- They can sometimes feel passed around and have to tell their story again
- The assessment process tends to focus on the things people can't do and misses out the things that people can do for themselves or they can do with help from family or friends
- Our processes are over-bureaucratic and fetter the time staff can spend focusing on solutions
- We are sometimes too quick to offer the usual menu of services rather than think through more creative but simpler solutions
- We often get involved too late in a situation which makes it so much harder to find a good solution

4.13 Having reflected on this feedback we have identified what we need to do to change how we operate. This can be summarised as:

- Our starting point is focusing on people's strengths and assets – as individuals, within their families and as part of their community
- Having different conversations with individuals around "what does a good life look like to you" and "how can we work together to find solutions"?
- Redesigning our "front end" so people can speak to someone who can assist them straightaway
- Thinking about how we can intervene earlier on who is the best person or partner to do this
- Making the focus of social work assessment and review
- Building much stronger partnerships with primary and community health

services
- Maximising every part of our system to support people's independence, recovery and rehabilitation
- Working with partners to ensure no one goes unnecessarily to hospital or into long term care
- Building a culture that supports creativity and innovation - removing the barriers that hold citizens and our staff back
- Finding new ways to engage with individuals, families and communities to deliver services differently

4.14 The failure to find new solutions is potentially a high one. We need to engineer a new paradigm to deliver sustainable care and support to vulnerable people. This report goes on to set out our purpose, principles and three year strategy.

Our purpose, principles and approach

4.15 **Our purpose:** at September 2011 Cabinet we set out our Values and Principles as part of out "Putting People First" transformation programme. We believe our vision at that time is as relevant now as it was then.

Our vision for people in Derby is that they have the right support so they can live happy, fulfilling and independent lives

4.16 This is under-pinned by the following **principles:**

1. Self determination – each person should be in control of their own life and, if they need help with decisions, those decisions are kept as close as possible to them.
2. Direction – each person should have their own path and sense of purpose to help give their life meaning and significance.
3. Money – each person should have enough money to live an independent life and are not unduly dependent upon others.
4. Home – each person should have a home that is their own, living with people that they really want to live with.
5. Support – each person should get support that helps them to live their own life and which is under their control.
6. Community Life – each person should be able to fully participate in and We will maximise the opportunities for you to learn or re-gain the skills to be as independent as possible
7. Contribute to family and community life.
8. Rights – each person should have their legal and civil rights respected and be able to take action if they are not.
9. Responsibilities – each person should exercise responsibility in their own lives and be able to make a contribution to their community.
10. Assurance – people can have confidence in the quality of the services the Council commissions or provides directly itself.

4.17 We need to build on the approach we embarked on in 2011. Set out below are what we believe should be our **key commitments** to citizens for a reformed social care system :

- We will listen carefully to understand what makes a good life for you
- We will communicate clearly and in a way that works best for you

- We will listen to, and value, what you, your family, your friends and your community say
- The focus of our intervention will be to facilitate solutions
- We will work with you at a pace that is right for you
- We will actively engage with our local communities, support networks and partners to develop alternative solutions for people
- You will only have to tell your story once and we will make sure our systems and procedures support that
- We will ask your permission upfront to share information to help keep you safe and well
- We will empower our front-line staff to design different solutions with you
- Only by exception will you go into long term care from an acute hospital bed
- Keeping you safe is paramount: and we will work collaboratively with you and other agencies to manage risk appropriately
- We will work equitably within our resources
- We will actively work with our partners to remove barriers to delivering our purpose

4.18 Our **approach** needs to operate at four levels:

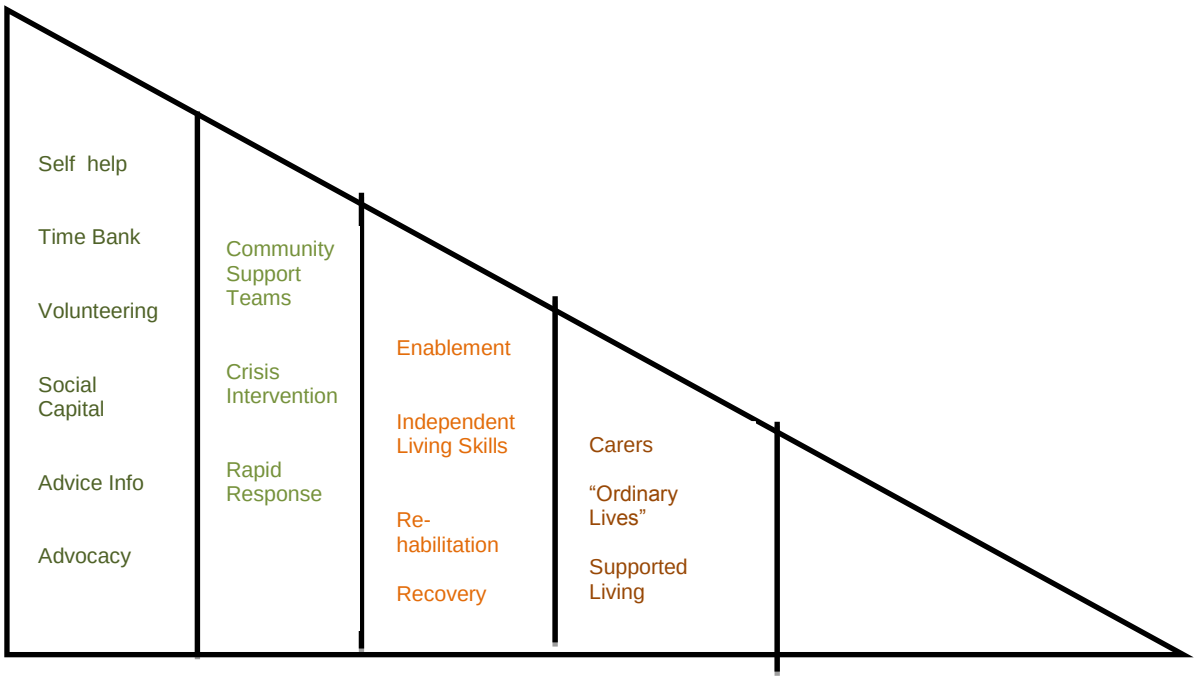
(i) At the **community** level: building resilient individuals, families and communities

(ii) At **individual practice** level: working in a different way to help individuals and their families find solutions that build on their strengths and assets

(iii) At the **service** level: building flexible, empowering and responsive services that are delivered in new and innovative ways

(iv) At **whole systems** level: recognising that part of the solution to our challenge rests in collaborative working with our colleagues in the wider public and private sectors. We need to engineer a win-win solution across health and social care to manage demand pressures and to keep people safe and well.

4.19 The Council has worked with local partners to set this out in picture form, represented by the “Care and Support wedge”.



Residential &
Nursing Care

Direction of Travel

4.20 Our aspiration is that, as much as possible, people find the support they need to the left hand side of the “wedge” and that resources are shifted from the right to the left side of the system. However, there is much to do in order to achieve this.

OTHER OPTIONS CONSIDERED

5.0 Doing nothing is not an option as we need to take action both to improve our balance of care and take positive steps to address the demand for care and support.

This report has been approved by the following officers:

Legal officer	Olu Idowu – Head of Legal Services
Financial officer	Toni Nash
Human Resources officer	Liz Moore
Service Director(s)	Phil Holmes, Brian Frisby, Perveez Sadiq
Other(s)	

For more information contact:	Cath Roff, 01332 643550 e-mail cath.roff@derby.gov.uk
Background papers:	None
List of appendices:	Appendix 1 – Implications

Appendix 1

IMPLICATIONS

Financial and Value for Money

1.1 The council spends approximately £59m on adult social care. It faces a recurrent pressure on this budget due to demographic pressures of £2m a year.

1.2 Bench-marking has shown that the council is achieving value for money in most areas against the services it commissions.

Legal

2.1 The council has a duty under the National Health Service and Community Care Act 1990 to assess those people it thinks is in need of adult social care services. There are a range of legal duties and powers that require the council to meet people's eligible needs.

Personnel

3.1 There are no specific implications.

Equalities Impact

4.1 There are no specific implications.

Health and Safety

5.1 There are no specific implications

Environmental Sustainability

6.1 There are no specific implications

Asset Management

7.1 There are no specific implications

Risk Management

8.1 As adult social care is the largest single area of spend after the dedicated schools budget, it is important that the adult social care expenditure stays within the planned amounts in order to support the Council's Medium Term Financial Plan.

8.2 The Council also has to consider the risks to vulnerable individuals in how it formulates its adult social care strategy in order to sure risk is appropriately and adequately balanced with the financial risk an over-spending adult social care budget might pose.

Corporate objectives and priorities for change

9.1 This draft adult social care strategy supports the Council's overall objective to promote the health and well-being of its citizens.

Appendix 2: Pen pictures

Local Area Co-ordination: Connecting people to their community

Mrs Shardlow is a 72 year old widow. Following the death of her husband two years ago there were numerous referrals and requests made to Adult Social Care for Mrs Shardlow, resulting in assessments and equipment provision.

Whilst on a visit, one agency worker raised concern about Mrs Shardlow's lifestyle and proceeded to refer her to a number of different services. This experience had a significant impact on Mrs Shardlow's confidence and resulted in her becoming increasingly dependent on the original worker, more withdrawn from her natural community networks, and less confident about making decisions for herself often deferring to the worker for support.

The Local Area Co-ordinator (LAC) was one of the services Mrs Shardlow was referred to. The LAC met Mrs Shardlow and again spent time getting to know her and started to talk about the things she wanted from life, they talked about the things that worried Mrs Shardlow, but the majority of the conversations focused on her gifts, skills and interests. Mrs Shardlow talked about the fact that she felt very lonely and so together they drew up a plan of action to address this.

This asset based approach meant that alongside the LAC, Mrs Shardlow was able to *connect in to local activities and develop relationships with neighbours, therefore reducing her reliance on workers to meet her social contact needs.*

Mrs Shardlow now attends a 'knit and natter' session in the local library and has been introduced to a neighbour who shares her passion for antiques. Mrs Shardlow then worked with the LAC to think about her house and together they planned out what she wanted to do to make her home more secure and comfortable, Mrs Shardlow was able to call on her friends and neighbours to make some of this happen. The LAC still calls in on Mrs Shardlow every month for a cup of tea and a chat and Mrs Shardlow is happy to know that the LAC is still around. She also reports feeling more able to cope, knowing that the LAC is on hand should she need support.

Community Support Teams and assistive technology

Mrs Khan has Chronic Obstructive Pulmonary Disease (COPD) and Emphysema which leaves her short of breath and prone to lots of chest infections. She was going to the doctor or A and E 4-5 days a week for oxygen or a nebuliser. She lives on her own.

The district nurse in the Community Support Team suggested she tried a POD. The POD is a gadget that measures Mrs Khan's oxygen levels and asks her a few simple questions every morning. The results are transmitted straight to the district nurse who phones her within minutes if they see anything that concerns them. They help her get an appointment at the GPs or if she needs a prescription they pick it up and drop the medicine to her.

At the weekly multi-disciplinary team meeting the district nurse mentioned that Mrs Khan was lonely. The social worker suggested Mrs Khan be buddied by Mrs Hussain, also a COPD sufferer and POD user who was keen to help other people manage their condition as she had.

Mrs Khan rarely goes to the GP or A & E anymore. She no longer panics if she is short of breath and her incidence of chest infections has dropped. She feels in control of her COPD, is reassured by the nurse being on the end of a phone and has made a new friend in Mrs Hussain.

"Home First" services help people to remain at home:
Mr Walker is 85 and has dementia. He is cared for by his wife Iris who is 81. Iris is getting very tired because Mr Walker's dementia means he is up a lot in the night.

Mrs Walker wakes up one morning with a high temperature and feels fluey. She calls the GP but is more worried about who will look after Mr Walker as she feels too ill to get out of bed.

The GP talks to the social worker who he knows well as she is part of the Community Support team aligned to his practice. She gets on the phone to the Council's integrated recovery service "Home First". They are able to schedule carers to go in that evening and the following five days to provide support to Mr and Mrs Walker until she recovers. This is better for Mr Walker as he is being cared for in his own home – in the past he probably would have gone into respite care, an unfamiliar environment, while his wife recovered.

They also suggest Mr Walker has a bed sensor fitted so Mrs Walker can go to sleep reassured the sensor will wake her up on the occasions her husband wanders in the night. They put her in touch with a local dementia support group where Mr and Mrs Walker can meet up with people in similar circumstances to make friends and gain support.