ADULT SOCIAL CARE –

TARGET OPERATING MODEL

November 2019

Leicestershire County Council

SUMMARY

The programme is on track to deliver the anticipated benefits in service user outcomes, staff ways of working and long term financial benefit

LCC ADULT SOCIAL CARE'S MISSION

"To make the best use of the available resources to keep people in Leicestershire independent."

Collaboration with partners to ensure holistic person centred care

Enablement foundations for long-lasting independence to **reduce need**

Reablement building independence and **delaying need**

Residential delivering the best settings of Care

Decision Making ensuring consistency & quality

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OPPORTUNITIES TO IMPROVE FOR OUR SERVICE USERS WHILST DELIVERING >£10.4M RECURRENT BENEFIT

14% of practitioner time is spent with service users. The remaining 86% is made up by the admin involved in that face-to-face time.

4/10 of our long-term service users did not receive a review last year

Some contact takers are resolving **7x** more cases than others with no further action, advice or universal services

34% of service users were not in the best setting for most independent outcome

¼ of the LD Working Age Adults in Supported Living could have been more independent within the same setting

30% of the Older Adults in Residential Care could be in a different setting to maximise their independence

800 people will receive better Reablement if we achieve the outcome in 25% less time

4 fold variation in ongoing care packages between providers, despite having the same incoming need

50% of the MH reablement team feel confident that their service would improve service users independence

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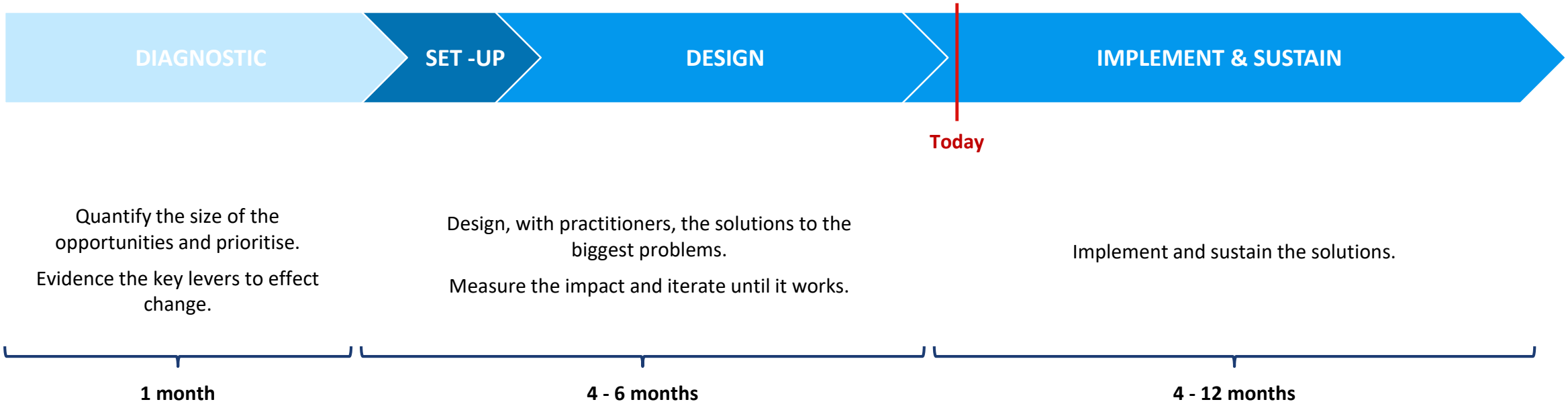
OVERVIEW OF THE PROGRAMME



Summary

The programme is on track to deliver the anticipated benefits in service user outcomes, staff ways of working and long term financial benefit

REABLEMENT CASE STUDY
ARTHUR FROM COALVILLE

Arthur and his partner moved to a care home after their bungalow flooded in March 2018. Sadly, a few weeks later, Arthur's partner passed away, and Arthur spent a further 18 months in the care home, waiting for repairs to be completed.

On 11th September 2019, the property was made ready and HART was asked to support Arthur 3 times per day with personal care, dressing/undressing, meal preparation and maintaining skin integrity, due to his bilateral leg ulcers and Atrial Fibrillation.

At the Welcome Visit, Arthur identified 3 goals for his assessment period:

1. To be independent with his personal care – strip wash/shower
2. To be independent with dressing/undressing
3. To be independent with meals and drinks

Arthur needed a shower chair, perching stool and leg covers to enable him to achieve two of his goals, so HART made a referral to NRS for the equipment and contacted the District Nurses for leg covers.

After 1 week of support, Arthur felt that he was now able to get himself undressed in the evening and get ready for bed. As a result, the PM call was withdrawn.

A shower assessment was completed once the chair and leg covers were in place, enabling Arthur to shower independently. The perching stool was set at the correct height to support him to sit at the kitchen worktop, enabling him to prepare his own meals and drinks.

On 24th September 2019, at the follow-up visit, Arthur demonstrated the ability to make himself something to eat and drink, to shower and get dressed/undressed independently. He asked for information about cleaning services and was given a Care Directory.

Arthur had achieved all of his goals in under 2 weeks, and the package closed with no further need.

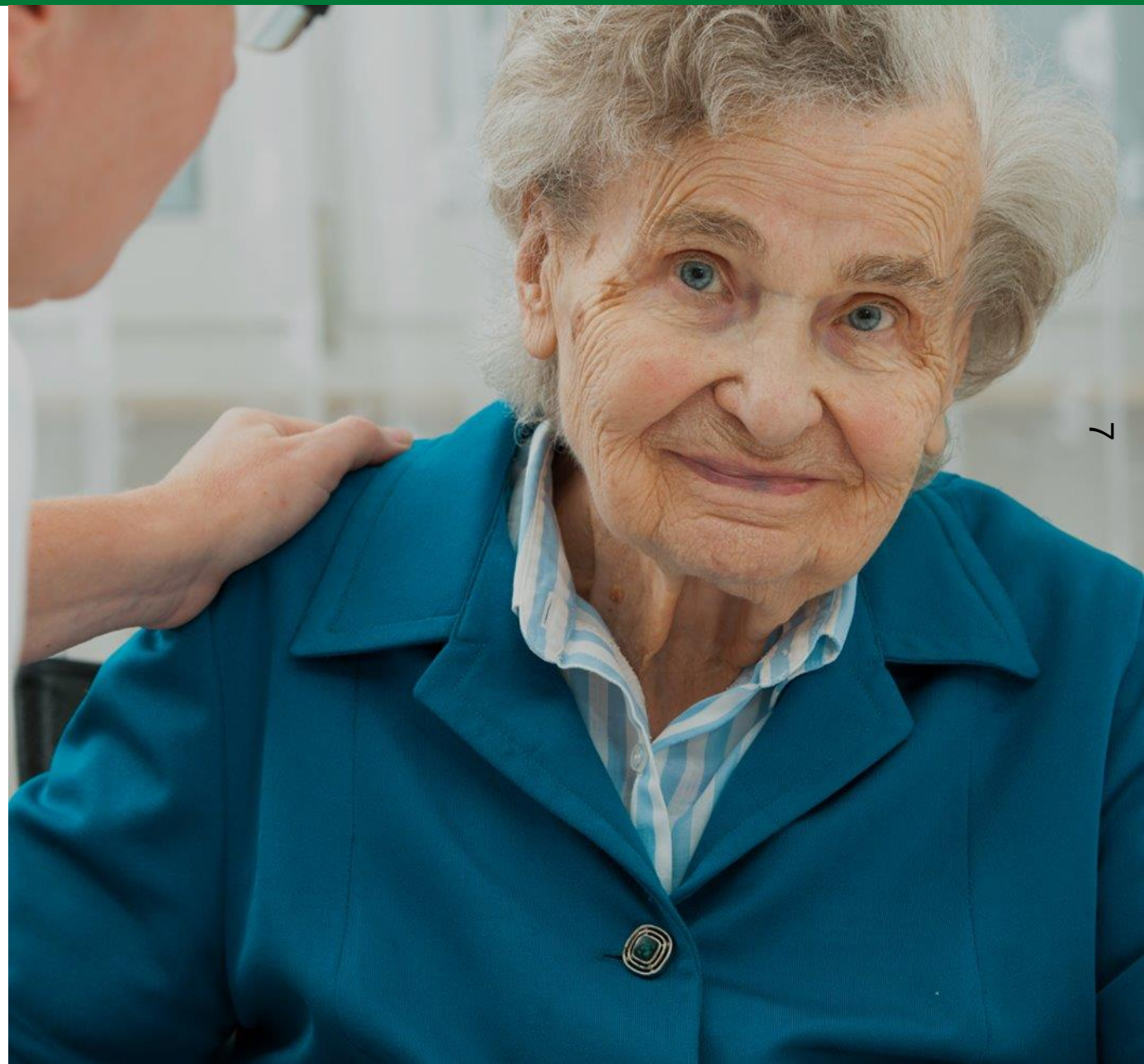
OLDER ADULTS CASE STUDY
JANE FROM LOUGHBOROUGH

Jane is a massive music fan. She has stacks and stacks of vinyls piled up in her front room that she's collected over the years and there is nothing she likes better than an afternoon enjoying her tunes on the record player.

Sadly over the last decade or so, Jane has been losing her sight. Her vision has now become so poor that she can't operate her record player and she's not been able to listen to her vinyls in 5 years.

But Lee, her Social Worker, refused to accept this and decided to get creative and shared this at the new TOM Group Supervision Meeting…

….Working with Jane's family, Lee got an Amazon Alexa delivered and set up. **"Hey Alexa!"**, Jane says excitedly, **"Play me some Ray Charles."** For the first time in half a decade, Hit the Road Jack blares from the speaker in Jane's front room. Let the tunes play!



WAA ACCOMMODATION CASE STUDY

SOPHIE FROM WIGSTON

Sophie is 27 and has a Learning Disability, and moved in residential care in 2013, when she was 21.

After a review in February 2018, she was identified as a potential candidate for moving to Supported Living, and was referred onto the waiting list for matching to an available property.

Over 14 months later, despite a vacancy list with over 50 vacancies, she was not matched with an appropriate vacancy and was still living in Residential Care. Sophie's mum got in touch with the worker to say they had, "not heard anything", and "felt a bit abandoned" as Sophie was so excited to move.

Within the first month of the TOM trial in May 2019, Sophie was matched to 4 potential vacancies from the existing list to go and visit, and is now due to move into her new property later this year.

Within 4 weeks of the TOM matching tool being introduced, **all 60 people in Residential Care on our waiting list for Supported Living were matched to an existing vacancy** that we are now exploring with them.

OPPORTUNITY MATRIX – DERIVED FROM BETTER OUTCOMES

	Workstream	Description	Estimated Annualised financial opportunity
Older Adults	OA1 Reablement	Ensure additional people who could benefit from reablement are systematically identified and referred into the care pathway Make further improvements to the reablement care pathway and outcomes to ensure consistency	£3,780,000
	OA2 Consistent and enhanced decision making	Prevent inappropriate admissions to residential care Improve the consistency of allocating domiciliary care and direct payment	£1,700,000
	OA3 Quality Improvements	Improvements to the quality and consistency of assessments and reviews (across both the Customer Service Centre and locality-based practitioners)	£1,420,000
Working Age Adults	WAA1 Enablement	Improve the independence of an identified cohort of service users in the community	£430,000
	WAA2 Change to setting of care	Move an identified cohort of people from residential care to supported living	£740,000
	WAA3 Consistent and enhanced decision making	Improve the consistency of allocating support packages to mental health and learning disability service users, and enable more independent living where appropriate	£1,140,000
	WAA4 Quality Improvements	Improvements to the quality and consistency of assessments and reviews (across both the Customer Service Centre and locality-based practitioners)	£1,240,000

	Estimated Annual Value
Estimated cashable/demand offset savings (OA1, OA2, WAA1, WAA2, WAA3 above)	£7,790,000
Less savings already identified within MTFS 2019	£1,250,000
Estimated total annual cashable savings	***£6,540,000***
Plus estimated total annual quality improvements (OA3, WAA4 above)	£2,660,000
Overall additional total annual savings and efficiency and quality improvements	£9,200,000

The 4 non-locality workstreams whose implementation started in August

- Customer Service Centre
- WAA Accommodation moves
- Acute
- Reablement

Adult Social Care TOM MOVING FORWARD

Checklist Key			
	In-progress	S	Silver – TOM in place, and sustainable
B	Bronze – TOM in place, but needs support	G	Gold – Continuous Improvement

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EXAMPLE "TOM CHECKLIST" SUMMARISING NEW WAYS OF WORKING – IN ADDITION TO PERFORMANCE KPI'S

Last updated: 10/10/19

TOM Checklist	Culture	Group Supervision	Develop & Refer	Matching	Support Planning	Supply Planning	Data & Dashboards	Governance
Accommodation	S	G	S	S	S	S	S	S

HoS	Forecast Silver Date	Comments and Actions If silver overdue, what is the issue and the plan to progress it?
TB	**13/09/19**	Silver Confirmed

TOM Checklist	Culture	Hub Model	Ownership Model	Knowledge Information	Data & Dashboards	Governance
CSC	S	S	S	S	S	B

HoS	Forecast Silver Date	Comments and Actions If silver overdue, what is the issue and the plan to progress it?
JW	**02/09/19**	HoS and SM recognise that TOM targets have been achieved, but that there is further room for continuous improvement. To be reviewed and plans consolidated 14th Oct.

TOM Checklist	Culture	Group Supervision	GSM Board	D2A Discussions	Data & Dashboards	Governance
Acute – APC	S	S	S	S	S	S
Acute - MW	S	S	S	S	S	S

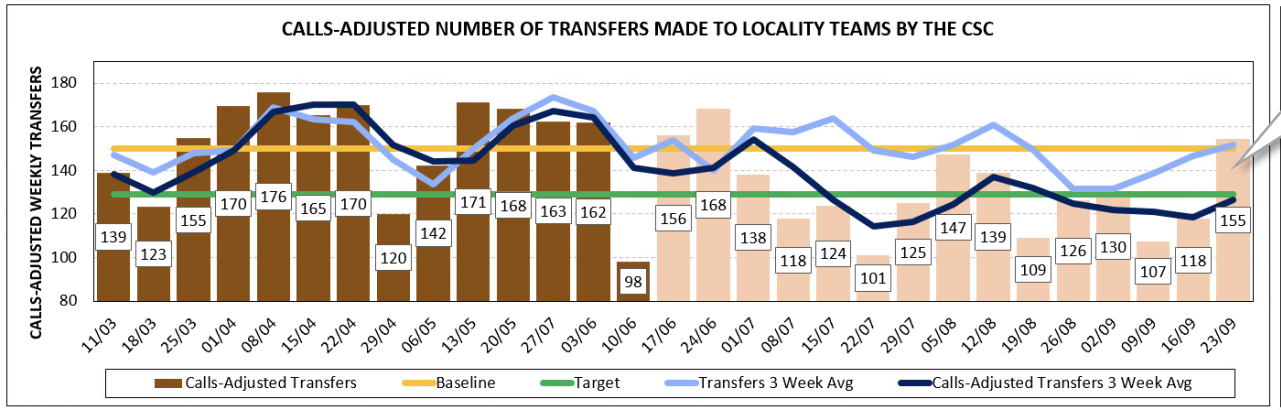
HoS	Forecast Silver Date	Comments and Actions If silver overdue, what is the issue and the plan to progress it?
JW	**02/09/19**	Silver achieved. Team have reviewed the use of the GSM board and have improved this by creating a daily email system used to track live cases and progress.
JW	**02/09/19**	

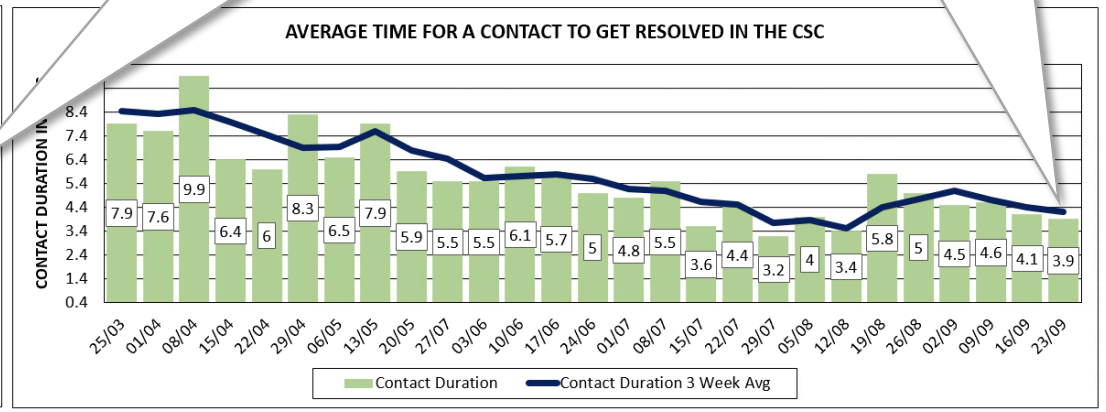
CSC PERFORMANCE

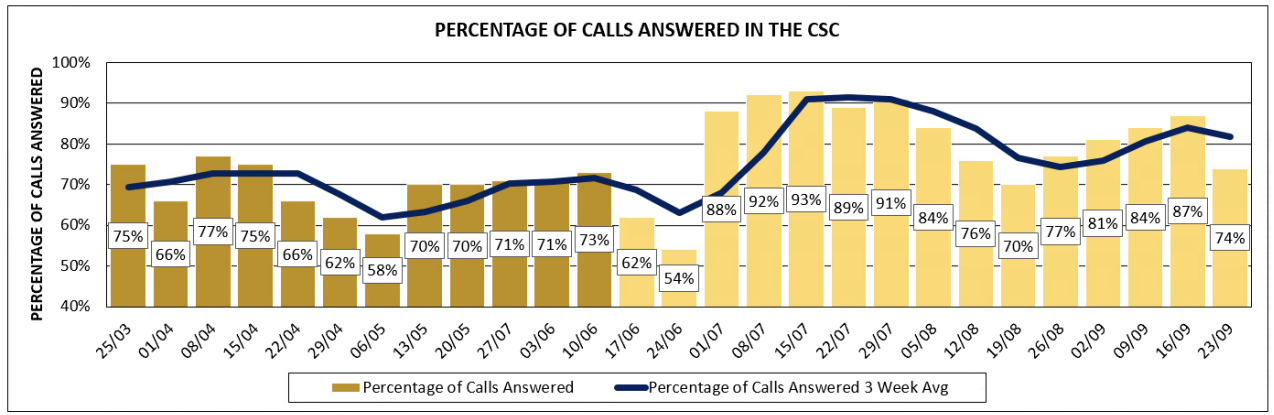
Avg. performance over last 12 weeks is 124.6 Transfers/week (target is >129)
About to enter a "Measurement period" which signifies team ownership of "Their TOM"

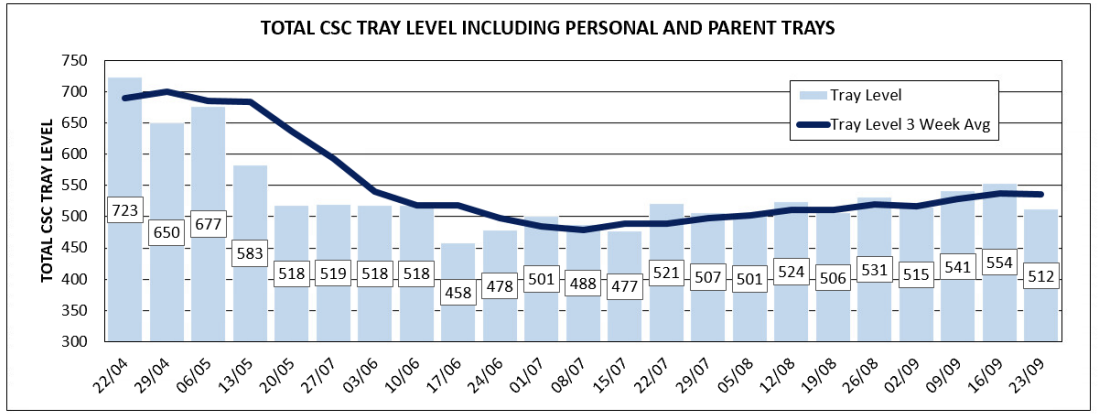
High number of transfers in w/c 30th Sept as BOW and NWL OA teams allocated Carer Assessments from CSC to meet allocation targets and make benefit of capacity in Locality teams released by TOM.

Case duration has reduced from 7.9 days to 3.9 days



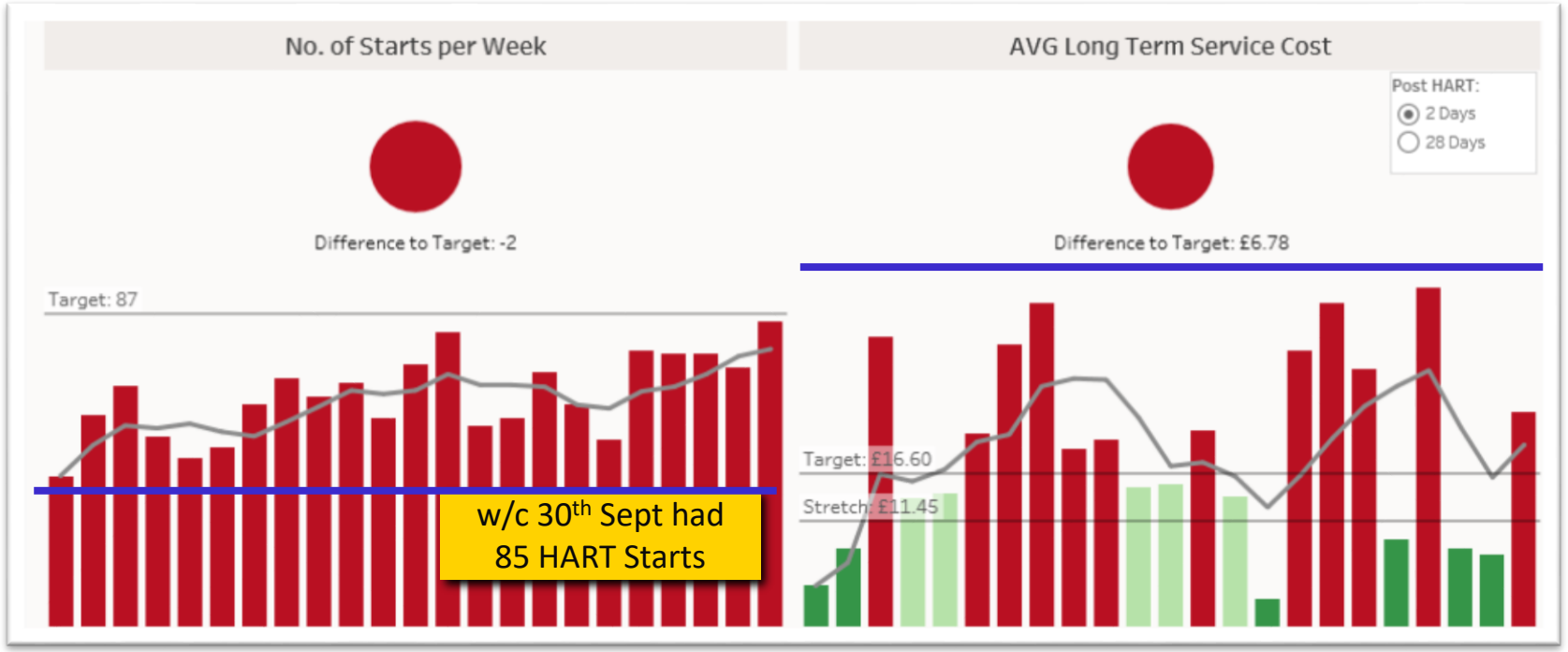






REABLEMENT

Baseline Volume
= 58 SUs/week



Baseline Outcomes
= £38.13/SU/week

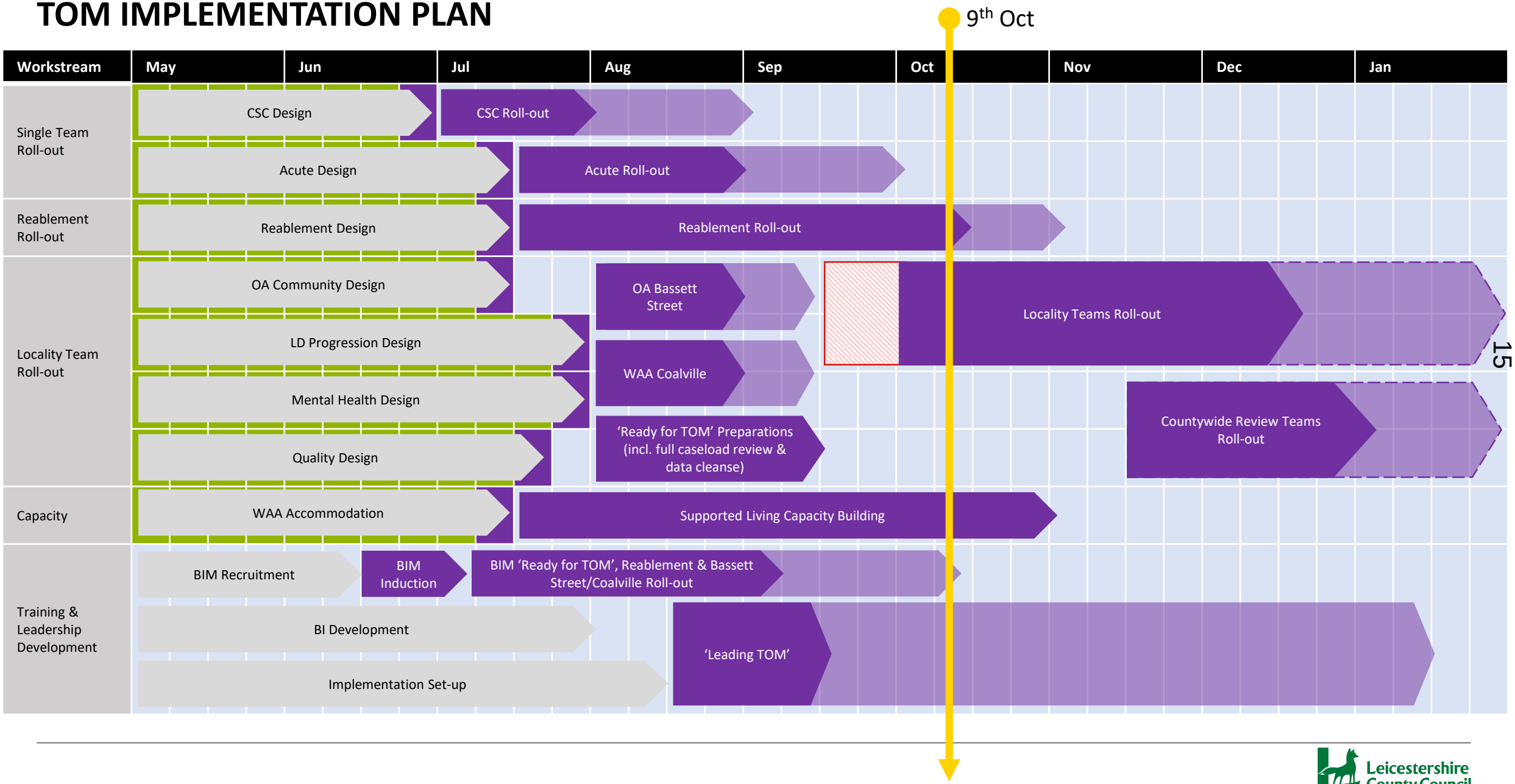
HART volume is at it's highest ever activity at 77.25 SUs/week (target 87).

HART Outcomes for 28 days post reablement are at £29.98 (against a baseline of £38.13).

The locality workstreams whose implementation started in October

- Older Adults
- Learning Disabilities
- Mental Health

TOM IMPLEMENTATION PLAN



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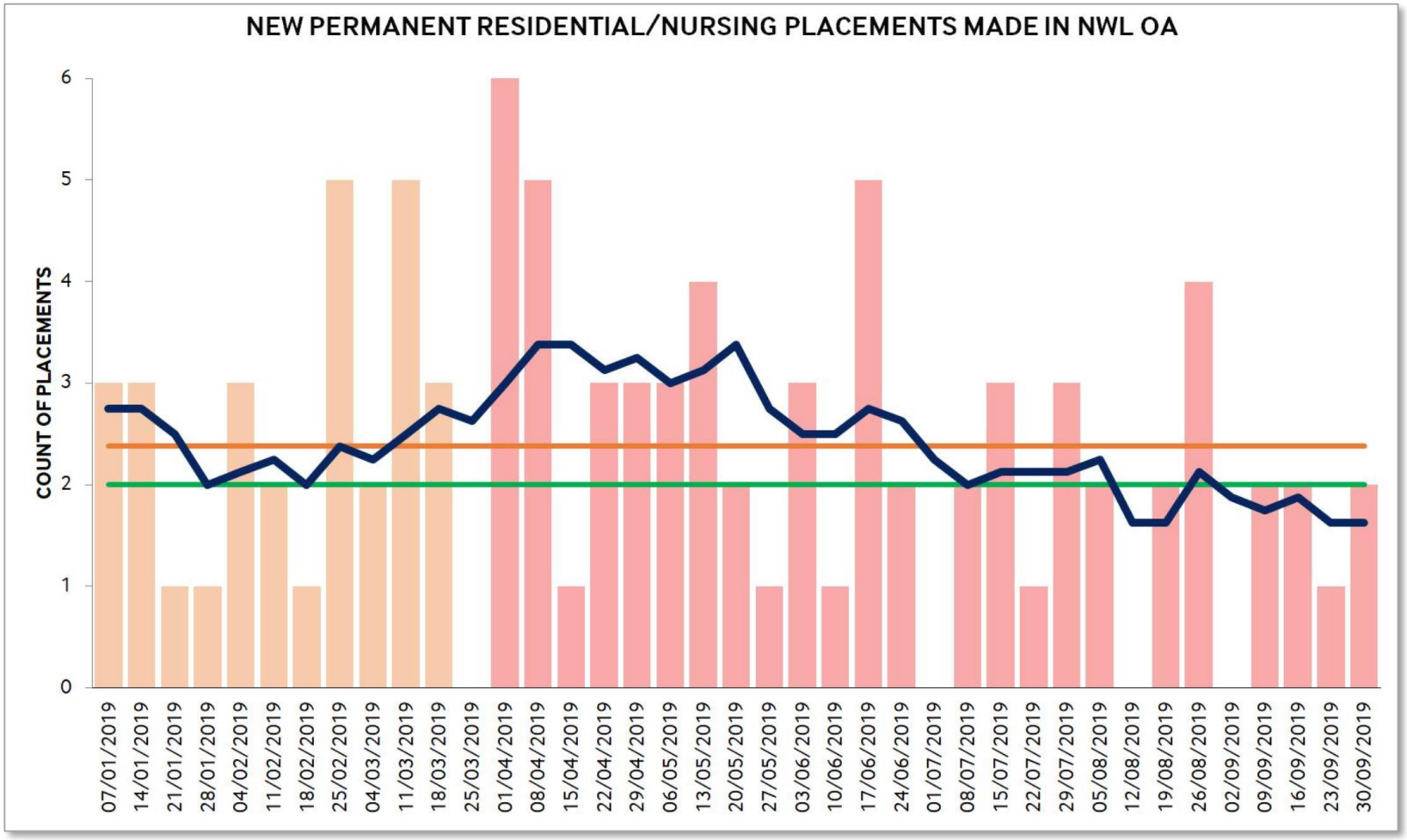
EXAMPLE SUMMARY OF CHANGE : WAA(D) LOCALITY TEAMS

ISSUE WITH OLD PROCESS	TOM SOLUTION	£ BENEFIT REALISATION
Workers sent **ineligible cases** and need to do **full Care Act assessments** to determine eligibility	Pre-Assessment checklist introduced to **quickly determine eligibility** and **signpost immediately** if ineligible	**Less time is spent on ineligible SUs** and care is given to fewer ineligible people
Service Users frequently given more care than needed: they **become dependent on care**	Weekly **group MDT** introduced to ensure everyone is given the most appropriate care to **promote independence**	Packages are challenged to **ensure all costs are necessary** for the SU
CERT Enablement not used to its full potential: **workers are not focussed on the original referral reasons** and **cases are open for many months**	CEW (CERT) cases allocated during group MDT. **Specific goals** set and delivered within a **12 week target**	SUs become more **independent,** so need **less commissioned care**

OLDER ADULTS – NWL DESIGN TEAM PERFORMANCE



In the NWL Design Team, we can see the impact the TOM has had on the packages of care placed by the Team.

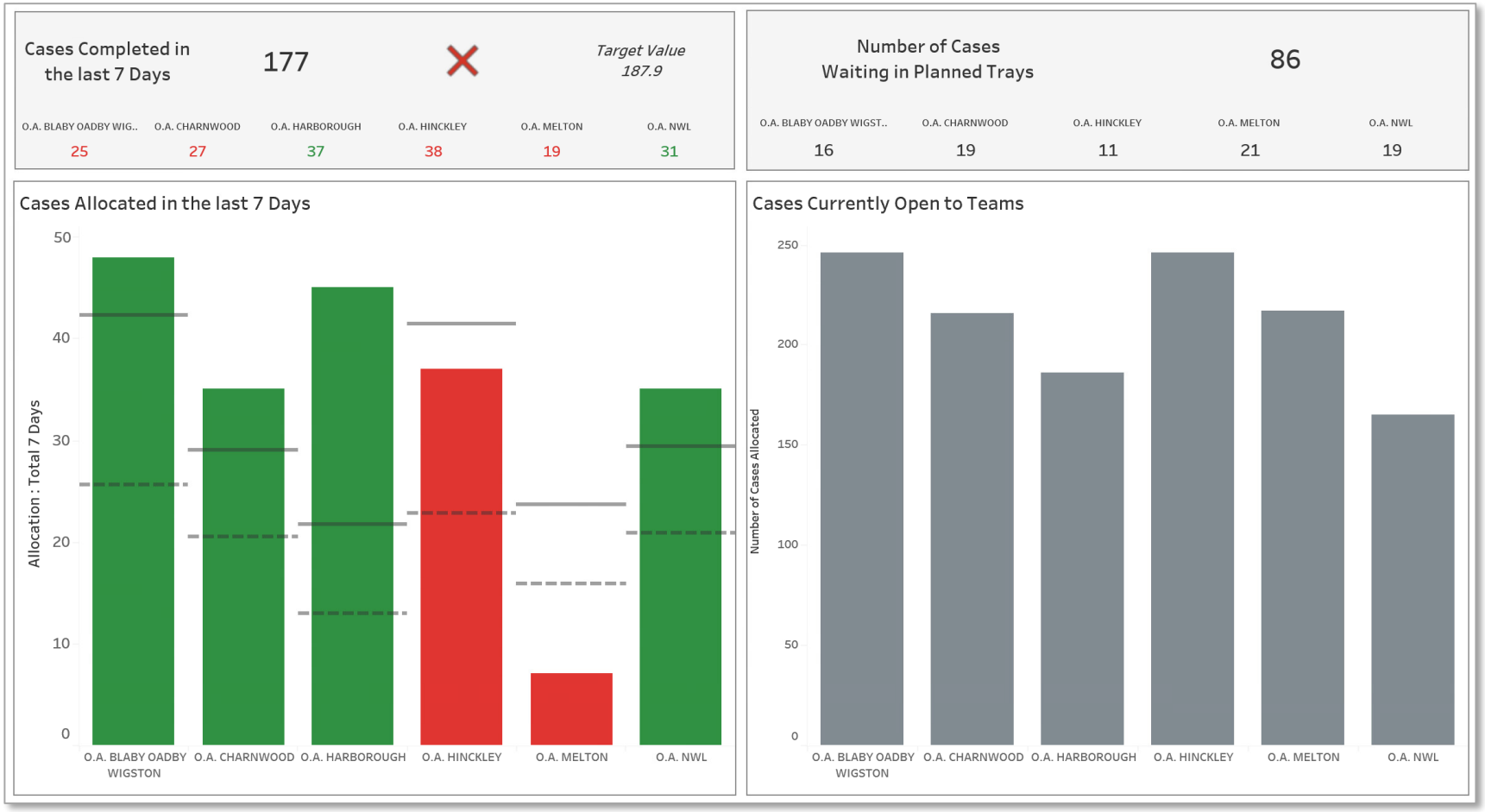
Residential placements are the largest source of cost in Older Adults service spend.

Baseline: Before the TOM, NWL made an average of 2.5 Permanent Residential placements each week.

Placements are now down by >15%, and have been sustained at Target level.

Example of new KPI dashboards and how that is supporting improvements in ways of working for staff, and reduction of waitlists for service users

CASE MANAGEMENT – ALLOCATIONS AND CASES COMPLETED



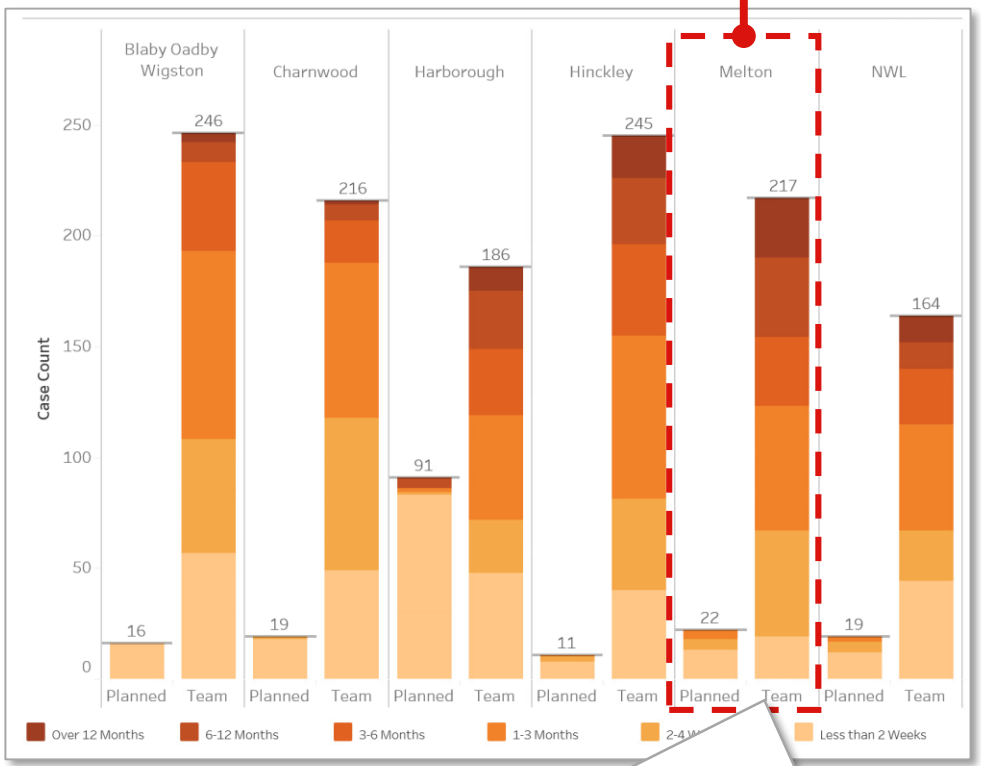
The Case Management Dashboard helps HoS to track SM weekly allocations, ensuring that each team maintains a healthy waiting list and is allocating a fair amount of work to their teams.

The graph on the right shows previous week allocations, with the baseline performance (dashed line) and the target (solid line) for each team. If teams are under allocation, then the HoS should be informed why.

The right shows the number of cases on the Planned List.

Allocations diagram shows last 7 days only, and needs context to be interpreted. For example, Melton have some of the best case management performance countywide, but as a snapshot have only allocated 7 cases in the last 7 days.

CASE MANAGEMENT – TIMELY CASE PROGRESSION



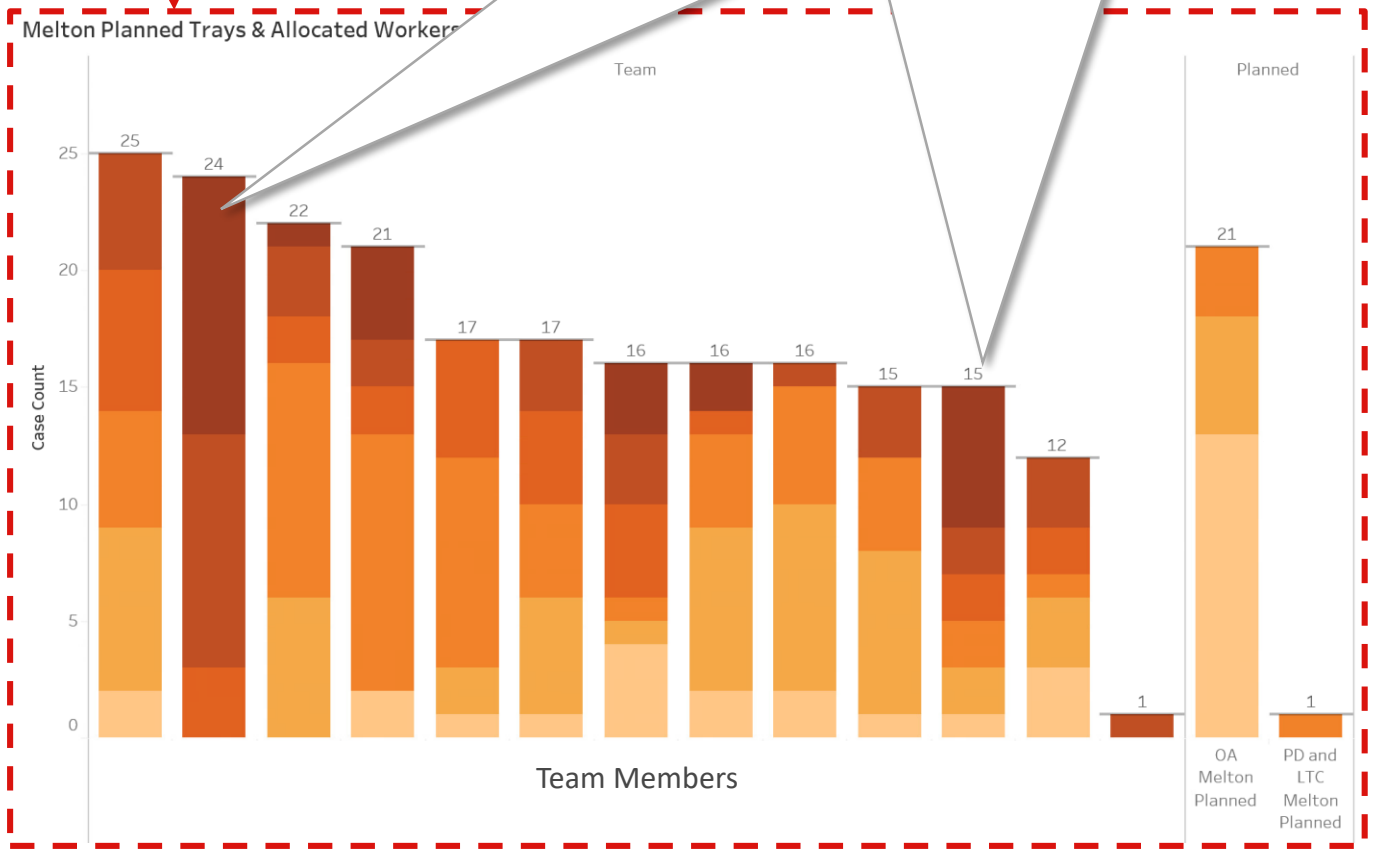
1

The Case Management dashboards help to show the volume and duration of cases currently open to teams. This helps SMs and HoS to focus on supporting teams to close cases.

In the above example, Melton has the oldest mix of cases, so the HoS or SM could investigate this by clicking on the team.

2

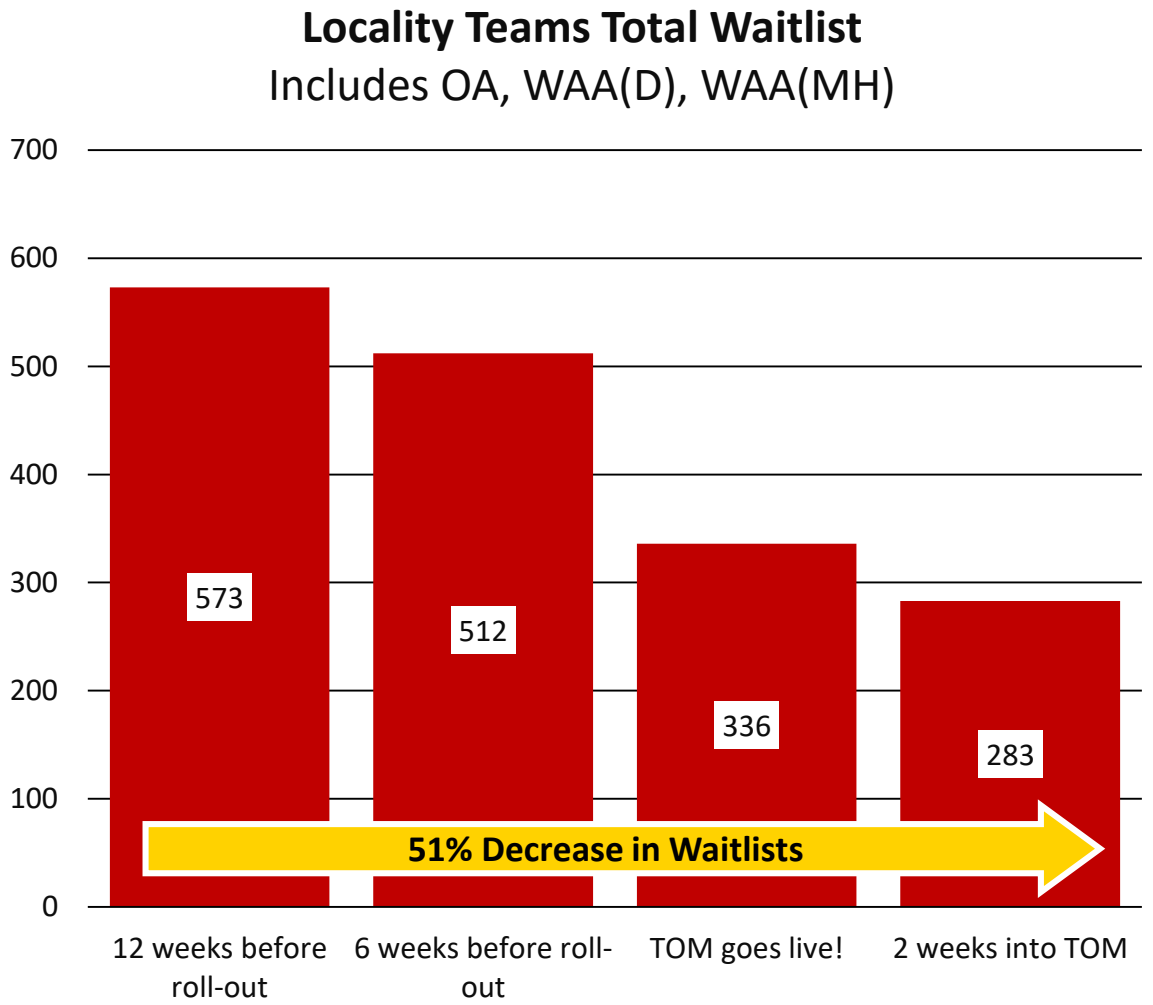
The next level down of the dashboard helps SMs to understand which team members have the oldest cases. This ensures that the SM can prioritise Case Progression Supervisions with their staff.



CASE MANAGEMENT
"SEE MORE PEOPLE"

- The new TOM case management process is all about
  1. Reducing waitlists
  2. Timely reviews
  3. Spending more time face-to-face with service users
  4. No one left behind

- We're off to a great start with allocations and case completions increasing across locality teams
- **Waitlists have halved** across locality teams
- This is enabling the teams to pick up additional appropriate work such as carers assessments and overdue reviews, which will further enhance independence and improve service quality



Data from TOM Case Management Dashboard on day after go-live date 30/09/2019

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ADULTS AND COMMUNITIES DEPARTMENT

OVERVIEW AND SCRUTINY COMMITTEE

TRANSITIONS SERVICE – POSITIVE FEEDBACK

Letter received from parents of Service User - 23rd October 2019

We wanted to give you some feedback on the support that you have provided in helping us to manage the needs of X.

X can be a real pleasure to be with, but the complexity of the issues that he has to cope with, including Downs Syndrome, Autism, AMID, transitions, limited communication and learning disability, can give rise to very challenging behaviours.

At the start of the year X's frustrations led to many severe incidents resulting in injuries to members of the family and damage to property in the home. During this very stressful time, interaction with Social Services appeared to us to be focussed on budget discussions and not addressing the needs of X and what was happening at home, which led to us seriously considering that we would need to place X in care because we were not coping.

When you were appointed in February of this year you very quickly familiarised yourself with X's situation. It was obvious to us that you had experience in complex cases such as X's and that you understood the challenges that we were dealing with and importantly X's needs.

You were able to effectively represent X's needs within the Social Services organisation and as a result the limited provision of 3 days of college and day services for 2 days which only started in December 2018, was increased to include day care for additional days to cover college holidays. In addition, you were able to support the allocation of a new respite for some evenings and weekends which had been badly needed, due to the previously limited respite provided by Z which was not suitable for X's needs.

Through your contacts and previous experience, you were able to recommend care providers that would be able to cater for X's needs. These providers have proved to be wonderful in understanding X and being able to give him a happy, stimulating and safe environment.

You are always contactable, and you have been proactive in calling Multi-Disciplinary Team meetings to review X's progress, ensuring input from care providers and ourselves. This has provided a good forum to ensure feedback from interested parties as well as from us as parents and has resulted in excellent relationships being built across the individual groups providing support to X.

The impact of your intervention has been huge. As parents we really appreciate what has been achieved through your efforts, we feel much more able to cope and are looking forward to a holiday next February, our first in quite a few years.

We cannot thank you enough for all that you have done and hope that in some small way that this letter provides the recognition that you rightly deserve. We are more than happy that you share the contents of this letter and would willingly provide more feedback in a different format, either verbally or written, as a measure of our appreciation for the positive impact that you have had on X and the household.

Letter received from Parents of Service User

Dear Social Worker

I just wanted to take this opportunity to say a massive Thank You for all of your support and hard work in helping to get X successfully living in his own place with support.

Naturally he still has challenges but he is settled very well in his flat. Z are fantastic and are providing a very flexible level of support that is tailored to X's needs. I understand that he is also working with the // to manage his finances.

We have seen a huge transformation with X successfully making decisions himself and building up the emotional resilience needed to manage the daily challenges that we all face.

I am very aware that none of this would have been possible without you continued long standing support fighting for X's Case and holding out for what's best for him.

I understand that there are many challenges you face within the system in order to achieve what is best for the young people that you support. We appreciate your honest approach and recognise all the hard work you put in behind the scenes to get a successful outcome for X.

Many thanks Social Worker. If you ever feel like you are fighting an uphill struggle and your work is a thankless task, I just want to tell you that it has not only transformed X's life, but the whole family. I now can build a relationship with X as his mum, as opposed to his carer. What you do has a really positive impact and I am very grateful to you.

Many thanks

Good Transition Example

X transitioned from school to College in September 2019, he attends College 3 days a week. X also attends CLC provision for 2 days a week.

- X has moved to College in September 2019 and he has settled in well and coped well with this change.

- Mum has stated that she has also seen notable progress at home and X is using new skills learnt from College at home, e.g. he is cleaning out his rabbit hutch without support from Dad. Mum has stated that X is happy at college and he is more confident

at home and in the community. X has developed a passion for woodwork and he loves looking after animals, both at school and at CLC provision.

- School have stated that X is using public transport, accessing the community, including shops, restaurants and cafes. X has developed confidence and he is telling staff what he needs and wants.

- Update from CLC provider is that X is participating, enjoying himself, learning new skills and developing in confidence. Mum was also pleased with how well X has transitioned with the project after he did not enjoy his previous CLC provision. Attendance at the provision also enables Mum to have time to do some of the things she would like to do as well as having the time to complete her household tasks etc (therefore there is a significant reduction in carer strain).

Nathan's Story – Outcome Scenario

Nathan has given approval for his story to be shared.

Nathan recently moved in September to our new Male Transition Service and he is on a pathway to more independent living, however we have supported him on outreach since August so we could get to know him better.

We are currently recruiting for this service and organised a Jobs Fair in Leicester to aid us with finding a good range of experienced candidates.

We invited Nathan to attend the jobs fair with our local recruitment lead. He and his staff took the bus to Leicester to be at this really important event.

We asked Nathan to speak to potential candidates about what he is looking for when selecting staff to support him, he said he wanted people to be fun, energetic, and respectful, which we agree are important attributes when looking for suitable staff.

In addition Nathan has recently agreed to take on paid employment with Aspirations as one of their regional Expert By Experience, he is attending a 3 day course in October / Nov to learn how to do this new role. Nathan is going to support X in her new role as Head of Quality Development to review and shape policies as well as other things such as recruitment events, talks about supported living, being a mentor to new people moving into Aspirations services, and doing Expert by experience audits and reports. The training is being run by the same company that delivered this to CQC! so he will be qualified to help you at LCC and also CQC if you choose to use his services.

I am looking forward to celebrating more of his achievements and outcomes in future months.

Peter Davis
Assistant Director
Care Pathway West
Adult and Communities Department

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