APPENDIX A

Leicestershire County Council

Promoting independence, supporting communities

Our vision and strategy for adult social care 2016 – 2020

Introduction

Mr Dave Houseman MBE, County Councillor
Cabinet member for adult social care

Adult social care supports people - including unpaid carers - who need practical or emotional support to lead an active life. Social care helps people do everyday things, participate in their community, and safeguards people from significant harm.

The number of people who might need adult social care services in the future is expected to rise significantly.

The number of people in Leicestershire over the age of 65 years will double by 2030

We know that the number of people in Leicestershire over the age of 65 years will double by 2030 and the number of people with complex disabilities will increase by 30%. This rise in demand for care comes at a time when funding is decreasing – because the government continues to reduce local authority budgets to meet the national budget deficit.

Nationally, social care budgets have been reduced by 26% in real terms over the last four years. Half of this has been through spending reductions and half through managing demand differently. To continue to do this means new ways of working.

In Leicestershire, the council has continued to prioritise social care and is investing additional resources to meet the demands on the service. Whilst there is a requirement to save £25.6m to balance the budget in the medium term, the council is working with NHS partners to protect social care services whilst making the necessary budget savings.

The Care Act 2014 brings new responsibilities for local authorities, with new eligibility for services, support for carers, new areas of work around information, advice, prevention, support for the care market and safeguarding. Social care services are changing and Leicestershire County Council needs to renew what it offers to people who need our help.

This is our plan for the next four years. It sets out how we will:

- put in place a new, more cost effective approach to delivering adult social care
- manage our finances
- work with partners to provide more joined up health and social care
- focus on preventive services which help to avoid problems from getting worse
- reduce demand and free up resources for those who most need them

Social care budgets have been reduced by 26%

Read more

- To find out more about the specific levels of need now and what's predicted in the future – please read the 'Joint Strategic Needs Assessment'
- More information about the current social care market in Leicestershire can be found in the council's market position statements

Our vision for adult social care in Leicestershire

Jon Wilson
Director, Adults and Communities

Adult social care in Leicestershire is changing. Our focus will be to promote, maintain and enhance people's independence so that they are healthier, stronger, more resilient and less reliant on formal social care services.

To do this we need to ensure that everyone has access to information and advice which supports their wellbeing. Increasingly this will be online information, and telephone advice supported by trained customer service staff and advocates. This means information can be more responsive, up to date and tailored to individual requirements. Information will be available to enable people to assess their own needs, their eligibility for services and to understand the financial consequences of the decisions they are making. This will allow people to think ahead and plan for their future.

> We need to ensure that everyone has access to information and advice which supports their wellbeing

We will ensure that there is a wide range of information on services which may support people outside of the statutory social care services. This will enable people and families to help themselves through a range of preventative local services which can help people to stay healthy and well.

We will work with local communities and other providers of health and care services to develop local, community-based support that helps people stay independent and safe.

Working with partners we will also be able to identify people who may be at risk of needing help in the future and for whom support in the short term may prevent longer term needs developing. This will include working with colleagues in health services to ensure people's needs are diagnosed early, their care needs identified, and wherever possible people are enabled to manage their own care. Where people experience a crisis in their lives, rather than intervening to remove people from the crisis we will work with people and families to manage the crisis, become more resilient and develop skills to deal with issues in the future.

Where people do need support we will make it as easy to access as possible. People will be able to get the help, advice and support they need online, by phone, through clinic appointments or where required through pre-scheduled home visits. On first contact with people we will try to resolve their problems as quickly as possible and seek to utilise support from families and communities before resorting to formal social care services. We will do this because we know that this helps people to be more resilient and have better social outcomes; it reduces isolation and is more cost-effective. Support identified in people's local communities outside of local authorities makes life better for both the individual and the community.

> We will work with local communities to develop local, community-based support that helps people stay independent and safe

Working together with partners, sharing information, and joining up services will help us to avoid duplication wherever possible and also to understand people's total health and care needs.

We aim to deliver services which will enable people to gain or regain skills to help them to live independently and recover from illness. We will do this in the most unobtrusive and least restrictive manner possible. This means that we will support people in the short term whilst expecting that wherever possible people will support themselves in the longer term. For most people, long term support from the local authority will be the exception rather than the rule. We will provide 'just enough' support to assist people to build on their current strengths and develop their abilities to look after themselves without becoming overly dependent on council support.

Where people need ongoing support we will share this responsibility with the individual and their families and communities

We will work with partners to ensure that people have the right access to housing, health and community services so that they can have a good quality of life and make a positive contribution to their communities. Our aim is for people to have access to work, housing, and social networks which support them to be independent, improve their wellbeing and reduce isolation.

We will seek to use equipment and technology to provide less intrusive and more cost-effective care. Wherever possible we will keep people at home, with families and friends to enhance their social and personal experience.

Of course for some people, social care services are required for longer to enable them to live fulfilling lives. Where people need ongoing support we will share this responsibility with the individual, their families and their communities. We will try to meet people's needs in a personalised way which delivers the outcomes that people require.

However, in delivering and commissioning services we want to achieve the best value and most cost-effective means of delivering high quality care. This is important, not just because local authorities are receiving less funding from government to provide care, but also because the vast majority of people using support services contribute to the cost, and many thousands of people in Leicestershire fund their own care entirely. Everyone should expect that the services they are buying or receiving represent the best possible value.

Everyone should expect that the services they are buying or receiving represent the best possible value

Therefore whilst choice is an important factor in people being able to manage their own care, it cannot be unrestricted. Wherever possible we will work with individuals to deliver personalised social care and health services, but we will only do this in the context that the services people receive will maximise their independence and provide the very best value for money. Working with providers of care we will constantly review people's care arrangements to ensure their outcomes are being met in a cost-effective way.

We recognise that for some people there is an enhanced risk to their personal safety because of their particular disabilities or frailties, or due to wider issues in society. However we also recognise that we all need to take and accept a level of risk in order that we grow and develop as individuals. We will therefore work with people to enable them to understand and manage risks appropriately, whilst also providing arrangements to safeguard people from significant harm. Our response to concerns about people's safety will be proportionate, flexible and personal and will always be based upon the individual's wishes and feelings alongside the best interests of the wider community.

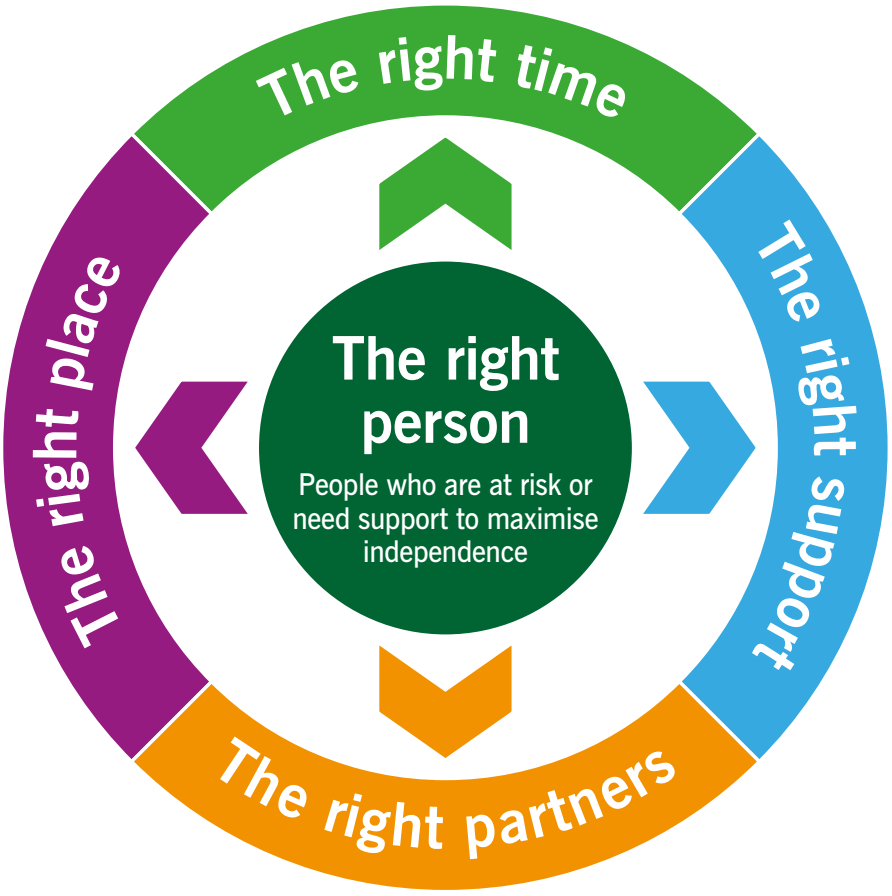
OUR MISSION

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

Key design principles

Our future model for social care will work to a set of principles which aim to put the person at the centre, and to ensure that the support they receive can deliver the right outcomes and manage any risks appropriately.

- **The right person:** people who need support are identified and prioritised
- **The right time:** to prevent things getting worse, increase resilience and maximise independence
- **The right place:** at home, in the community or in a specialist setting – according to need and what is most cost-effective
- **The right support:** just enough to keep people safe and prevent, reduce or delay the need for long term help, delivered by the right people with the right skills
- **The right partner:** working more effectively with individuals, their friends and families and in partnership with other organisations – to achieve more joined-up and cost-effective support.



Our strategic approach

To meet our obligations under the Care Act 2014 we have developed a model which is 'layered'. It is designed to ensure that people can get the right level and type of support, at the right time to help prevent, reduce or delay the need for ongoing support, and maximise people's independence.

Universal services, promoting wellbeing

Targeted interventions for those at risk

Reablement, rehabilitation, recovery

Progressive planning - using a broad set of social resources (family, community, personal budgets) to ensure affordability

1. Prevent need

We will work with our partners to prevent people needing our support. We will do this by providing information and advice so that people can benefit from services, facilities or resources which improve their wellbeing. This service might not be focused on particular health or support needs - but is available for the whole population – for example, green spaces, libraries, adult learning, places of worship, community centres, leisure centres, information and advice services. We will promote better health and wellbeing and work together with families and communities (including local voluntary and community groups).

2. Reduce need

We will identify those people most at risk of needing support in the future and intervene early if possible to help them to stay well and prevent further need for services. For example we might work with those who have just been diagnosed with dementia, or lost a loved-one, people at risk of isolation, low-level mental health problems, and carers. Our work will be targeted at people most likely to develop a need, and try to prevent problems from getting worse so that they do not become dependent on support. This might include: information, advice, minor adaptions to housing which can prevent a fall, support and assistance provided at a distance using information and communication technology via telephone or computer.

3. Delay need

This will focus on support for people who have experienced a crisis or who have an illness or disability, for example, after a fall or a stroke, following an accident or onset of illness. We will try to minimise the effect of disability or deterioration for people with ongoing health conditions, complex needs or caring responsibilities. Our work will include interventions such as reablement, rehabilitation, and recovery from mental health difficulties. We will work together with the individual, their families and communities, health and housing colleagues to ensure people experience the best outcomes through the most cost effective support.

4. Meeting need

The need for local authority funded social care support will be determined once we have identified and explored what's available to someone within their family and community. People who need our help and have been assessed as eligible for funding, will be supported through a personal budget. The personal budget may be taken as a payment directly to them or can be managed by the council. Wherever possible we will work with people to provide a choice of help which is suitable to meet their outcomes. However, in all cases the council will ensure that the cost of services provides the best value for money. Whilst choice is important in delivering the outcomes that people want, maintaining people's independence and achieving value for money is paramount.

How we plan to achieve our vision

1. Prevent need

How it works now:

- People don't know how to find the information they want
- People rely upon formal services for support

In four years' time:

- Information and advice will be co-ordinated and easily accessible
- People will be better informed about maintaining their own and their family's health and wellbeing, and identify what they can do for themselves and each other
- People will think about the future and plan ahead in case they need support

We will:

- Support initiatives in the community which help people to stay independent
- Promote and facilitate access to 'universal services' – which are for everyone
- Further improve access to information and support people to plan ahead

Preventing need

Maggie is 55 and got in touch with the Advice Service because she has a progressive physical condition, and wanted to make plans for her future finances and housing arrangements. An Advice Service Worker met with Maggie to discuss her needs and wishes and the options available to her. She has now put in place a Lasting Power of Attorney so her wishes can be enacted if she is unable to make decisions for herself later in life.

2. Reduce need

How it works now:

- We have low expectations of what people can do for themselves
- We don't actively identify people who are at risk of losing their independence

In four years' time:

- We will identify people who may be at risk
- We will have good information about current and predicted situation
- We will maximise what's in the community
- We will develop the support available in the community
- Carers will be aware of and will access support available, early in their caring role

We will:

- Support initiatives alongside our partners which identify those at risk early - through, for example, our Local Area Co-ordination work
- Work with our partners to further develop and deliver services that reduce the need for help - such as peer support groups, telephone care and targeted advice
- Support carers to remain mentally, emotionally and physically well

Reducing need

Bhavesh is a 77 year old gentleman caring for his 76 year old wife who has had a stroke. He has no family living locally and is keen to continue to care for his wife but is struggling with lifting and supporting her properly. Following contact with the council-funded Carer Support Service he was supported to enrol on a specific carer training course to learn techniques and to access equipment to enable him to make his day to day caring role easier so that he can continue to provide the care he wants to for his wife. He was able to find community transport to the training course, and has continued to meet with fellow course members on a regular basis which is helping him reduce his sense of isolation following his wife's stroke.

3. Delay need

How it works now:

- The focus is upon people's disabilities or those things they find difficult
- Services are commissioned to maintain people at the same level of need
- We do not have good information about which interventions can reduce need

In four years' time:

- We will focus upon what people can do for themselves, and enable people to be as independent as possible
- The proportion of people needing long term support will be reduced
- People and communities will be supported to help themselves
- There will be effective recovery, rehabilitation and reablement services
- We will have good communication with staff - who understand what we are trying to do and work towards this
- We will have an integrated transitions service
- There will be more joined up services across health and social care

We will:

- Work with Children and Family Services to ensure young people have their opportunities maximised to live independently.
- Focus on how we can solve problems before we go through detailed assessments with people
- Target help which helps people to get better and stay well in the future
- Join up with health partners to delay the need for our help

Delaying need

Vic is in his 60's and now lives alone. He had a stroke which affected his left side and has little function in his left arm (he cannot grip). His partner, who died a year ago, did all the cooking in the household – since then Vic has been reliant upon his daughter and domiciliary care services for his drinks and meals. The reablement service worked with him to help him learn to use a microwave and a kettle fitted onto a tipper so that he can make drinks and reheat ready meals for himself. He is happy to be more independent, his daughter has more time for herself and Vic is no longer having any domiciliary care.

Felix is a young man who has a diagnosis of a severe learning disability and Autistic Spectrum Disorder, who lives at home with his mum and brothers. Felix started to refuse go to his specialist school, or to wash and dress; he was staying up late watching football and didn't want to think about or discuss what he would do when he left school. Learning disability nurses worked with Felix and his mum to set boundaries and to address his behaviour. The Transitions Team helped Felix and his mum to learn to use an iPad app to identify his interests and dislikes, and a support plan was developed. A local Community Life Choices service offering activities matching Felix's interests was found for 3 days a week in school holidays. Felix enjoys this, and knows he must attend school in order to go to the holiday service – this also gives his mum a break from caring, and she no longer needs extra respite. Felix has now joined a local inclusive football team, learned to walk to the football ground safely on his own, and has chosen a college course. At Felix's review meeting, it was agreed that he would not need a Personal Assistant at this time, as had previously been expected, because he was doing so well and gaining confidence daily.

4. Meeting need

How it works now:

- Community and individual resources that can support people are not fully explored
- People have expectations that care will be funded through the council
- Services are ongoing regardless of people getting better or worse
- In some cases services may create reliance rather than promote independence, and avoid rather than manage risk

In four years' time:

- We will provide support to meet people's needs where families and communities cannot
- Care will be focused on the person and be cost effective
- People will be supported with less funding from the council
- We will effectively manage demand within budget

We will:

- Develop the skills our staff need so that they are innovative and creative when helping someone
- Regularly look at what we do so that we're working as effectively as possible and making the most of public money
- Work together with partners to manage risks and make sensible decisions which provide benefits which we can measure

Meeting need

Malcolm is a 42 year old man with a learning disability, who had lived in residential care for over 20 years. He moved to supported living, with 20 hours per week of support. Twelve months later, he has learned to cook simple meals, do his own washing and keep his home clean, how to be safe at home and what to do if he needs some help. His support package has now reduced to 7 hours per week, and work with Malcolm focuses on maintaining his independence including household tasks, budget management, daily activities and planning for the future. To support him to be both safe and independent, and reassure his family, the property where he lives has door sensors fitted so that if he goes outside at night an alarm is triggered. The property also has fire detection equipment such as smoke and heat detectors. The alarm calls go through to waking night staff located nearby.

Key activities to deliver the model

We will need to take some action to underpin our approach and help us to deliver what we have set out.

We will:

- Develop our staff to ensure that people have the right skills and knowledge, the right tools available, and are deployed in the right places
- Develop new ways of working, new practices and new procedures
- Gather good information about what people need, what we are supplying, and what works, to help us manage performance
- Understand local priorities and work with communities to develop and improve services
- Co-ordinate what we are doing with our partners
- Develop internal processes that are simple, transparent, consistently used and easy to understand
- Manage robust financial systems – making it clear who is accountable
- Develop a detailed action plan, which will be regularly reviewed, updated, and used to identify the next steps

Monitoring our performance

Our progress will be monitored and reviewed regularly with the support of partners including Healthwatch, and the Making it Real Focus Group. Progress will be reported through our business plan and local account each year.

We also report yearly to the Association of Directors of Social Services (ADASS), and must submit performance data against the measures set out in the Adult Social Care Outcomes Framework (ASCOF).

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