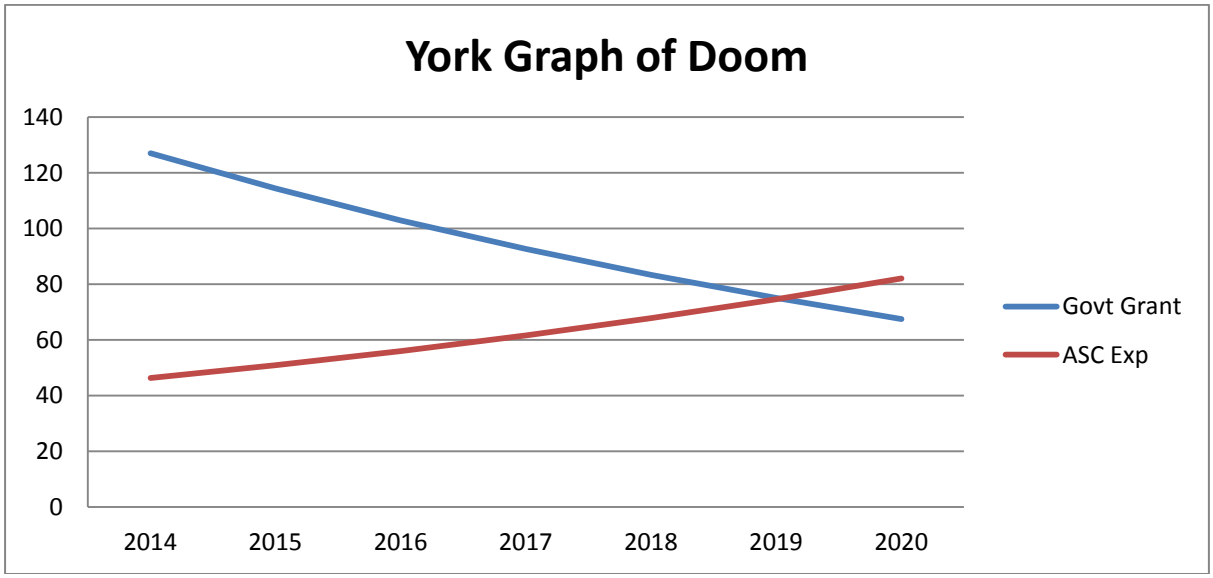
Annex 1. Adult Social Care Transformation

Why the future of adult services needs to be different from today

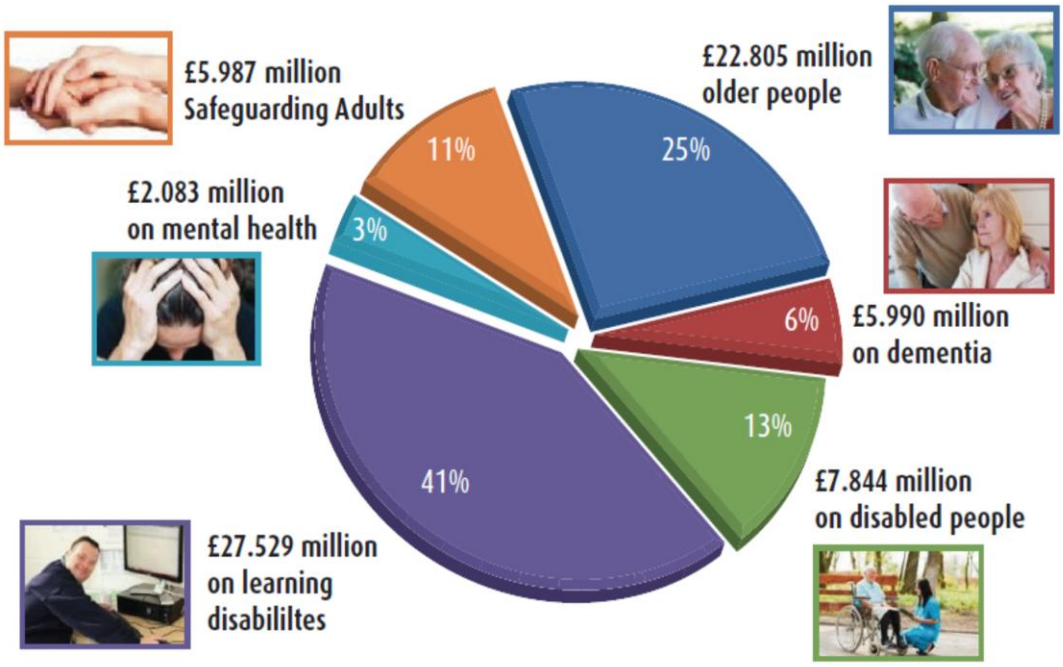
1. Across local government, the most significant service pressures are being faced by Adult Social Care. York is no different. The social care system is under pressure from escalating costs that provide no evidence of increased satisfaction for residents and service users. The current system is unclear for many and in the case of self funders has been slow to recognise the support that many of them need. Adult Social Care Services have not, nationally, demonstrated strong value for money and more needs to be done to ensure that the right outcomes are being purchased or provided for residents. It is widely recognised that the national system is unsustainable due to demographic change and more people living longer with disease and disability.

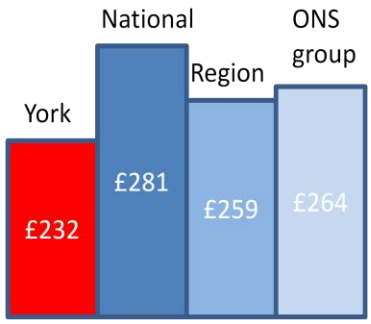
2. The context of Adult Social Care services in York



In line with other councils, York has its version of the Barnet 'graph of doom'. By 2019 the amount of money required for adult social care will outstrip the funding received from the Government.

In 2013/14 City of York Council spent £72.238 million on adult care, support and services from a total gross service expenditure of £347.609m.

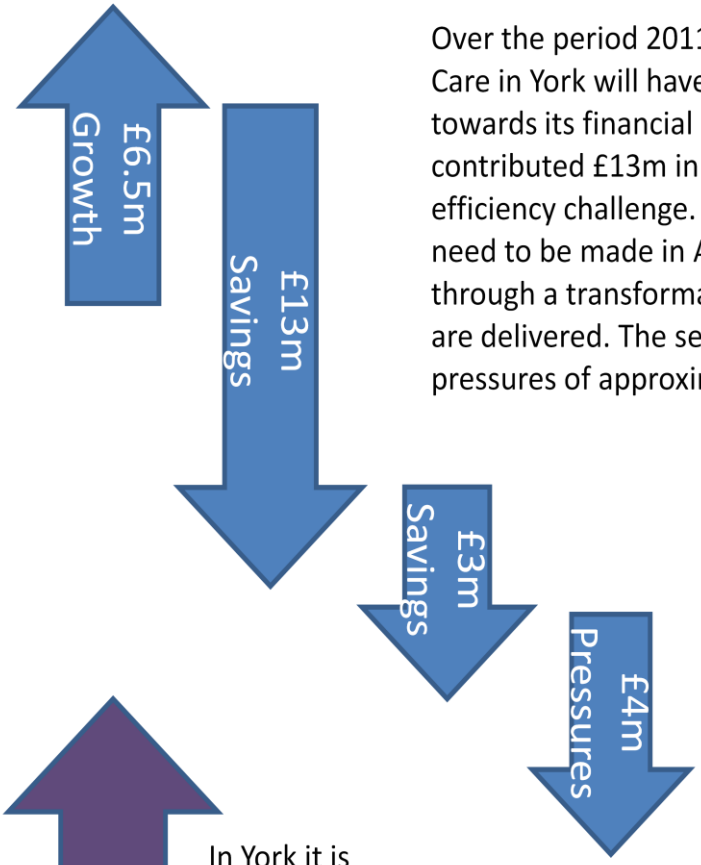




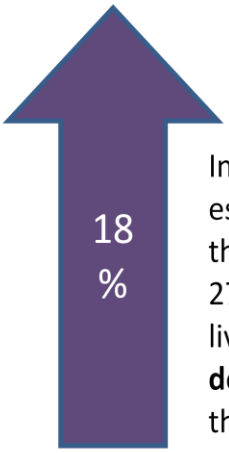
York is a relative low spender on Adult Social Care overall. Total spend per head is lower than the national and ONS cluster benchmarks.

£46.3m

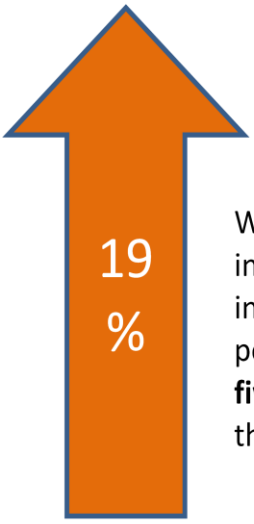
In total, approximately £46.3m is spent in York on services which are "commissioned" under some form of contractual arrangement from the voluntary, independent or private sector. This includes expenditure commissioned by Care Management to provide Residential care, Home Care and on Community Support in Learning Disabilities. It also includes specific commissioned services managed by the ASC Contracts team



Over the period 2011/12 to 2014/15 Adult Social Care in York will have received £6.5m in growth towards its financial pressures but will also have contributed £13m in savings towards the council's efficiency challenge. Additional savings of £3m need to be made in Adult Social Care by 2017/18 through a transformation in the way that services are delivered. The service also faces funding pressures of approximately £4m.



In York it is estimated that there are around 2725 people living with **dementia** and this is expected to rise to 3209 by 2020.



We expect to see an increase of 19 percent in the number of people **over eighty five** living in York over the next 10 years

28%

It is estimated that 28% of adults in York between the ages of 18 and 65 are living with poor **mental health**, similar to the English average. We have higher rates of hospital admissions for mental health conditions than the English average.

York's vision for the future of Health & Wellbeing Services

3. City of York Council wants people to live independent and fulfilling lives, based on choices that are important to them. We want care and support services to be more effective and focused on individuals so that they can be independent and get involved in their local communities. We want to see more integration with health services and a renewed focus on early intervention.

4. If we are to achieve good outcomes for residents and operate within the funding we have, there is a need to fundamentally shift the way in which services are delivered. The council is committed to developing a sustainable care system with our partners and communities that;
    - puts people in control of their own care and support;
    - makes sure that the most vulnerable people are supported; and
    - delivers value for money for local residents.

5. *It is important to recognise that reform must cover all aspects of the health and social care system. It requires a complete overhaul of the entire system*.

6. To try and achieve this, we need to create a very different set of expectations and radically change the way we do things. We need to minimise what we spend on administrative costs and find more innovative ways of helping our residents to support themselves with fewer formal council services. A key part of this is shifting the balance of care away from costly residential homes and towards more personalised services in community settings. This paper sets out how we propose to work towards this model in the coming years. We recognise that this is a very challenging task and we want to continue working with all groups locally to harness good ideas and maintain good quality services for people who access care and support.

Policy Reform

7. The financial challenges described earlier are accompanied by large scale reform of the Health and Social Care sector. The Care Act represents the most significant reform of care and support in more than 60 years, putting people and their carers in control of their care and support. Central to the Act is the concept of wellbeing. First and foremost councils will now have a duty to consider the physical, mental and emotional wellbeing of the individual needing care. They

will also have a new duty to provide preventative services to maintain people's health. Councils will have to offer information and advice to help everyone understand what support they'll need to help them better plan for the future. Further, every council will have to offer a deferred payment scheme, meaning no one should be forced to sell their home during their lifetime in order to pay for their residential care. People pay for their care costs now, and will continue to do so in the future subject to a cap, but the Care Act seeks to give people more choice and control over how they'll pay for it.

Emerging Consensus

8. Whilst there are slightly different political and policy making perspectives, there is an emerging consensus about the key features of a future health and social care system. In broad terms these are:

    - integrated Health and Social Care;
    - centred around the individual and focused on outcomes;
    - pooling budgets and commission;
    - focus on Prevention, co-production and personalisation;
    - properly funded baseline; and
    - localism not centralism.

Health & Social Care Integration

9. In order to meet the requirements of the Care Act and to achieve our vision of a health and social care system with residents at the heart of it, we wish to move as quickly as we can towards an integrated health and social care model in York. To support this approach, Government has created a joint health and social care budget called the Better Care Fund. The £3.8bn budget – a joint NHS and local government initiative will help support health and social care services to work more closely together at a local level. City of York council has over £5m invested in this programme subject to the progress we make in integrating our services.

10. In York we have been working hard to make sure that Adult Social Care services are tailored to individuals' needs and put people back in control of their own support. Health and social care teams in the

city are working on a more joined-up approach to local health and social care services by:

- developing local care hubs of health and social care staff who will rapidly assess and diagnose issues and needs to help people remain at home or return there at the earliest opportunity;
- creating Shared Care Records, so people only have to provide their details and case history once;
- creating a Single Point of Contact for customers– a single health or social care-lead who will take responsibility for the individual as they move between services.

11. However, we recognise that there is much to do.

12. Our key aspirations for integrated care in York are to deliver:
    - More care in people's homes and in their local neighbourhoods;
    - Person-centred care, organised in partnership with the resident and their carers;
    - Better experience of care for people and their carers;
    - Emphasis on pro-active and preventative work;
    - Improved range of support and care at home, with less reliance on care homes and hospital based care;
    - Less duplication and 'hand-offs' and a more efficient system overall;
    - Improvements to key outcomes for people's health and wellbeing;
    - Stronger, more resilient communities.

What will it look like?

13. We will know we have achieved our ambition for integrated health and care in York when we need to rely less on hospital-based care and care homes, because more care will be delivered in resident's homes and in their local neighbourhoods. Feedback from residents tells us that this is what they want. Also, they will be admitted to hospital quickly when they need to be, with access to the first class facilities and services. Hospitals will be able to discharge people quicker, because effective and pro-active services at home and in the community will help people get back on their feet and stay healthy and independent for longer.

The changes we want to achieve

14. We want to create a sustainable system that supports the most vulnerable and delivers value for money. To achieve this we need a significant cultural shift across the whole system. This means a different set of relationships between the NHS, the Council and the community, moving to a model where local residents are seen as people who can contribute and exercise control over their own lives, improving their own health and well-being.

15. We want to tackle health inequalities and develop a more effective approach to preventing poor health and supporting people to better manage their own conditions. We need better integrated early interventions so that people get the right help when they need it and we need to ensure that people who have more complex conditions receive an integrated and personalised service.

16. We recognise the vital role that carers play both in delivering care and in helping prevent further deterioration, so that people do not need more intensive packages of support over time. This means we need to ensure that carers can access the right support to maintain their own health and well-being and to continue in their caring role.

17. We recognise we need to invest in the development of social capital across the city, with a particular focus on enabling people to take control and giving them the tools to manage their conditions effectively. To help build community networks and a more personalised approach we will organise health and care services on a neighbourhood model around groups of primary care practices. This means that doctors, nurses, social workers, therapists, housing support workers and home carers will be able to build a strong set of relationships and work in a more integrated way, with common objectives to improve health outcomes for their local population and to offer a good experience that promotes better quality of life for local residents.

18. The role of the voluntary sector will be vital in driving forward the approach for building strong community engagement and the experience of the sector will be invaluable as we look to provide more preventative measures in place to support residents to stay healthy.

19. We will mobilise our communities and recognise their assets, strengths and abilities, not just their needs. We will build on the

assets in our community to support active self management by people, and support between peers, carers and families to take control of their own health and well being to address issues such as smoking, loneliness, exercise and eating.

20. Integrated care and support is about partnerships beyond the NHS and social care – involving individuals, communities, voluntary and private sectors and the Council's wider services, particularly employment, skills and housing.

What does it mean for how we will commission services?

21. The Council and Vale of York CCG are committed to using our joint resources to achieve our shared objectives. The way that services are currently commissioned and organised does not always achieve these aims. We will move towards the creation of a joint commissioning function to enable us to buy health and social care outcomes. This will mean realigning finances to commission more pro-active support that offers continuity of care and is joined up around people's needs. Our plans, if successful, will mean less reliance on care in hospital or care homes, and more care in people's home or delivered in community based settings. We will work with partners in CCG and the acute sector to enable this shift of resources to happen.

Key aspects of change

22. Some of the key aspects of change we intend to achieve in York are:
    - more care for older people and people with long term conditions will be delivered through locality based community multi-disciplinary teams with a lead professional responsible for co-ordinating the care of individuals. This will ensure an integrated and personalised approach to case management by all services working with each person – Social Care, GPs, Community Health, Housing, Mental Health workers and hospital services;
    - there will be less care needed in acute settings. A&E attendance and avoidable emergency admissions will reduce as community teams provide more targeted support to those at risk;
    - when people do need acute care they will stay in hospital for shorter periods, returning home safely with the help of enhanced discharge support;

- re-ablement and intermediate care will increasingly provide effective short term interventions that rehabilitate people, restoring health and independence;
- the balance of social care will shift away from care homes towards support in people's own homes and supported housing schemes including Extra Care;
- home care services will be funded with a view to radically improving quality and outcomes, with home carers linked in with other health and care professionals through the multi-disciplinary team approach;
- there will be a greater role for technology through the use of telecare to help people live safely at home;
- a more integrated and coherent approach to preventative services including the voluntary sector tackling issues such as social isolation;
- services will be responsive and accessible 7 days a week, including social care and admission avoidance community services as well as primary care;
- a new focus on developing dementia related services;
- a neighbourhood health champions model.

23. Achieving genuinely integrated care will have far reaching implications for the health and social care workforce and for the way that staff are trained and work together. Our workforce will need to be well-informed, appropriately skilled and clear about its common purpose in delivering person-centred care. We are committed to investing in the workforce so that they are appropriately skilled and trained for new ways of delivering care, and have a shared approach to coordinating care around people's needs. Staff will need to work increasingly flexibly in integrated teams, with more staff working in the community and in people's homes. We will ensure that we have the right range of staff to respond flexibly to people's needs and that all staff across our system feel valued for their contribution to keeping York's residents as healthy and independent as possible.

Getting Ourselves in Shape

24. We plan to make a series of changes over the next 12 months to ensure that we are moving our services towards a position where

they can be effectively integrated with others and provide better outcomes for residents. In line with the approach taken to date with the transformation programme, we intend to spend the time from December 2014 to March 2015 engaging with residents and staff on how we can make these changes in a way that is sustainable. We will bring proposals back to cabinet in March 2015.

Project 1 – New Operating Model for Adult Social Care

25. We will explore the development of a new operating model that would mean that all new customers (and some existing customers) will be channelled through a range of "preventive" services before they are assessed for longer term care and support. These services are designed to offer an immediate response to the person seeking help in a way that looks at options in which they can be assisted without necessarily assuming that they will need longer term help, if this first intervention can resolve their problems. The success of "preventive services" would then be demonstrated by fewer people needing long term help but people still getting their needs met in a timely and appropriate manner.

26. To do this we need to work with residents and staff to change the way in which advice and information is provided. We need to explore how we can develop a much more effective web portal and ensure that residents can access health and social care information in a way that is convenient to them. We will review our existing Advice and Information service and talk to residents about how it can be improved. We will talk to our partners such as the CCG and Hospital and also to internal partners such as Young Peoples Services, to establish how we could integrate our access points to enable residents to get better and joined up information and advice. In doing this, we will need to align our workforce more efficiently to the way in which residents want us to work. We know that residents do not like being handed from one team to another and we will consider how these customer 'pathways' can be serviced by specific individuals or teams. As part of a review of the operating model we will consider how we use 'assistive technology'. If we are to offer more preventative services then assistive technology and adaptations to homes need to be considered as part of the core service for residents.

Outcome Sought from Engagement

- Design for how advice and information should be provided

- Working Group to support website design
- Proposal on the use of assistive technology
- Proposal to realign the adult social care staffing around customer 'pathways'
- Proposal on how to integrate health and social care access points in York

Project 2 – Carers Service

27. Carers are incredibly important and without them it would not be possible to care for all those who require support in our city. However, we need to explore how we can develop a carers 'offer'. By that we mean a single access point in the city; both physical and virtual, where carers can get support to access services for those that they are caring for but also get information and advice on services or community groups that can help them. We recognise how important it is to recognise and support carers. We will work with the Carers Centre, Carers Groups and service users to redesign the way that we work with carers.

    Outcome Sought from Engagement

    - A comprehensive set of requirements for carers in the city
    - Proposal to develop a single hub (physical and virtual) for carers

Project 3 – Joint Commissioning with the CCG.

28. We will work with partners to establish a joint commissioning function across health and adult care under the governance of the Health and Well Being Board. We will work to define what our commission priorities are using the joint strategic needs assessment, completed for the Health & Well Being Strategy.

    Outcome Sought from Engagement

    - Establishment of a joint commissioning function

Project 4 – Elderly People's Homes (EPH)

29. A key aspect of the transformation of Adult Social Care will be the re-provision of care homes. A project has already commenced to

deliver this. The project will focus on meeting York's increased need for dementia care.

Project 5 – Key Workers

30. We recognise that there is a shortage of care workers already in York and the pressure for resources will continue to grow. In a city with virtually full employment, we need to develop a strategy for how we will create capacity to support residents. As part of this work we will need to work with partners to understand the staffing requirements across the whole health and social care network and determine how resource needs are addressed. As part of this, we will need to consider what can be learnt from other cities such as London in creating a sufficient supply of key workers.

    Outcome Sought from Engagement

    - Proposal for recruitment and retention of key workers in York and what the council could contribute/enable.
    - Proposal for how CYC's Workforce strategy could be amended to support the recruitment of key workers

Project 6 – Mental Health Services and Voluntary Sector Capacity

31. We are acutely aware of the crucial role that the voluntary sector can play in delivering services and supporting residents. We are keen to find practical ways that we can help the voluntary sector to do more. In particular we are keen to explore how we could increase the capacity of mental health charities to provide more services. Many of them tell us that funded work is available but they are constrained by a lack of suitable accomodation. We want to work with Mind and others in the sector to explore how we could use council assets in a way that might help increase the provision of key services and further strengthen the relationship between the council and voluntary services.

    Outcome Sought from Engagement

    - Business Case for increasing mental health service provision through the use of council assets.