Healthier Communities Select Committee		
Title	Overview of the Adult Social Care service	
Contributor	Executive Director for Community Services	Item 7
Class	Part 1 (open)	September 2018

1. Summary

1.1. This report and appended information aims to provide:

- an introduction to the principles and priorities guiding the Adult Social Care service
- an overview of the customer journey through Adult Social Care from contact to provision of appropriate care and support,
- an overview of the current performance of the service
- measures being taken to improve the operation of the service

2. Recommendation

2.1. The Committee is recommended to:

- Note the information provided within this report

3. Policy Context

3.1. In allocating resources to adult social care services, the Council seeks to ensure that those with the most needs receive the community care services they need to maximise their independence and to enable them to live in their own homes in their local communities wherever possible.

3.2. This supports the Sustainable Community Strategy priority of Healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and well-being.

3.3. It also supports the Council's corporate priorities of: caring for adults and older people, working with health services to support older people and adults in need of care and; Inspiring efficiency, effectiveness and equity : ensuring efficiency and equity in the delivery of excellent services to meet the needs of the community

4. Adult Social Care Priorities

4.1. The enduring focus and responsibility of the Adult Social Care division is to ensure the timely provision of appropriate information, support, assessment and care to those who need it, fulfilling our statutory responsibilities under the Care Act whilst

working in partnership to achieve the aspirations of an Integrated Care and Support system in Lewisham and South East London.

4.2. The three priority areas of strategic focus which underpin and shape all of our day to day work, and our approach to improving our services going forward, are:

Prevention and self-management
Supporting people to remain independent by identifying and utilising the widest amount of support and resources available to each individual

Assessing, planning and arranging care
To embed an asset based approach across social care practice and commissioning, that leads to improvements in assessments, outcomes and utilisation of resources. To make sure that care and support plans are jointly developed and personalised, ensuring consideration of the person's health, wellbeing and care and support needs.

Quality Assurance and Safeguarding
To ensure there are a wide range of high quality services delivered from a vibrant care and support market. To work in partnership with key stakeholders to ensure that safeguarding vulnerable people from harm is everyone's priority

5. From Contact to care and support

5.1. The flowchart at Appendix A gives an overview of the customer journey through the ASC service. The four elements of our service (contact, assessment, care and support plan and reassessment) are each described in more detail below.

Contact

5.2. We currently receive all initial contacts to our service via our Social Care Advice and Information Team (SCAIT). We receive contacts from members of the public, family members but also from our health partners such as GPs and local hospitals. As a result of the contact there are a number of different things we may be required to do to support someone including:

- Provide or sign post people to appropriate information & advice,
- Arrange a short term intervention/adaptation or "enablement" by referral to the appropriate team or service
- Refer the person to the appropriate neighbourhood team or the Learning Disability team for an assessment of need to be carried out.

5.3. In line with our aim to support people to remain independent wherever possible for as long as possible, we offer a wide range of short term interventions and adaptations to enable people to remain at home, or return home from hospital, wherever possible. Our enablement team provide up to 6 weeks of free intensive support to enable people to return home and regain their independence after a period of time in hospital or to prevent a hospital admission if appropriate.

Assessments

5.4. If necessary, as required by the Care Act, an assessment of care and support needs will be carried out by a social worker within 28 days from the date of contact.

If the contact relates to hospital discharge our hospital based multi-disciplinary team carry out the assessment in a much shorter timeframe to support timely discharge from hospital. All assessments are strength/asset based taking into account what a person can do for themselves.

5.5. In addition to a Care Act assessment, there are a range of other assessments we and/or partner agencies may also be required to carry out. The Deprivation of Liberty Safeguards (DoLS) assessment is part of a procedure to ensure an individual's rights are protected if there is a need for them to be detained in a hospital or care home in England or Wales and they lack mental capacity to understand and retain information and to make a decision based on that information. (The timeline for the Council as a Supervisory Body to carry out a DoLS assessment is 21 days for a standard request and 7 days for an urgent request.)

5.6. If a Safeguarding concern contact is received, the concern should be considered within one working day, and where appropriate a Section 42 safeguarding Enquiry should be concluded within 30 days

Care and Support

5.7. If eligible care and support needs are identified within the Care Act assessment, an appropriate "Personal Budget" will be allocated and an appropriate care and support plan to meet the identified needs will be drafted. The care and support plan should be in place within 10 days of the assessment being completed. A support planner from the neighbourhood team will then broker/arrange the required services, supported by our commissioning team, as outlined in the care and support plan.

Reassessment

5.8. All care and support plans should be reviewed within 12 months, or sooner where there is an identified change in need or circumstances. A reassessment should take account of changed needs and revise the care and support plan and resultant package of care as appropriate.

6. Current demand and performance

Contact

6.1. The number of contacts continues to decrease slightly month on month and in relation to last year. We measure those contacts completed within 5 days and YTD performance is currently 92.7%. Email remains the channel with the highest volume of contact and is used primarily by professionals.

6.2. We plan to improve routine performance reporting around the various short term interventions provided to better measure the impact of the interventions in terms of outcomes (i.e. in terms of prevention of escalation of need by reporting enablement cases still at home after 91 days etc).

Assessments

6.3. The total number of assessments carried out each month is over 500, but this includes DoLS assessments and other assessments such as safeguarding. The number of Care Act assessments each month is closer to 300, and of these 300 over 80% are completed within 28 days. There are no formal requirements around timescales for completions of Care Act assessments, however 28 days is a self-set target based on previous national requirements. 80-85% is felt to be good

performance given the challenges faced in coordinating all of the necessary partner/family input in challenging and complex cases. Operational managers review those assessments that missed the 28 day target to identify any themes or recurrent issues to improve performance.

6.4. 500 assessments will not necessarily be 500 clients as a number of people will have had more than one type of assessment, i.e. DoLS, Safeguarding and a Care Act assessment. The overall number of assessments continues to grow with DoLS assessments doubling in 17/18.

Care & Support Plan

6.5. Over 400 plans were created each month so far this year, with a YTD of 79% completed within 10 days. The quality of plans, and appropriateness of provision requires qualitative/managerial analysis on a case by case basis as part of a quality assurance approach we are building through the creation of a Quality Assurance team.

Re-assessments

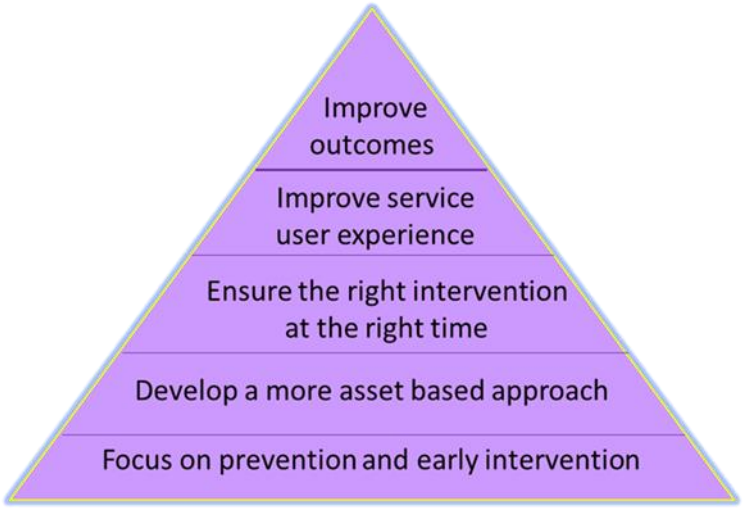
6.6. Current performance against a target of re-assessments being completed early or within 10 days of when they are due requires improvement. Investigating this performance has highlighted that support plans are often "updated" rather than recorded as reviewed and re-assessed when a change of circumstances is identified. We are currently addressing this issue by changing recording practice and monitoring arrangements.

6.7. We are looking to improve our recording of contacts, assessments and care and support planning in the round to better reflect, and monitor the impact of, our approach to prevention of escalation of need and an asset based approach.

6.8. Work is planned to improve recording compliance and our ability to monitor performance, impact of intervention and quality of practice.

7. Plans to improve

7.1. We are always looking to ensure our services are as effective as possible and we are currently redesigning the way we work in a number of areas to:



7.2. We have identified a number of ways we could simplify and improve the pathway through our service for people, building on some of our partnership work we have been developing through pilots with the CCG and provider trusts in the Neighbourhoods. The system, structure and process changes we are in the process of making in Lewisham will enable us to make improvements throughout the service and also make better use of our resources.

7.3. We are shifting more resources to the initial point of contact to improve response at that stage. Initial contact will be better managed, with a clearer focus on prevention and enabling independence, with quicker routes for appropriate referral, assessment of need and provision of appropriate support. This manages demand more effectively, improves user experience and makes better use of resources throughout the service.

7.4. We will further embed a strategic partnership approach to hospital discharge and arranging care through closer integration with NHS pathways and restructured staffing resources to ensure a more robust and consistent approach to arranging and commissioning appropriate care. The same partnership approach will also be strengthened through the redesign of our neighbourhood and transition arrangements.

7.5. We will embed a greater focus on prevention and an asset based approach to assessment and care planning too which will be better reflected in our performance management reporting and approach.

8. Financial context

8.1. The total budgeted gross spend on Adult Social care is currently £108.05m. The net budget (net of grants, recharges to health and service user charges) is £71.27m.

9. Financial implications

9.1. There are no financial implications arising out of this report.

10. Legal implications

10.1. There are no legal implications arising out of this report.

If you have any queries about this report, please contact Joan Hutton, Head of Adult Social Care, extension 48634