Healthier Communities Select Committee			
REPORT	Adult Social Care Cuts Proposals – Summary Of Strengths & Asset Based Approaches		
KEY DECISION	No	**Item No:**	4
WARD	All		
CONTRIBUTORS	Director of Operations, Adult Social Care		
CLASS	Part 1	**Date:**	3rd September 2019

1. Purpose

1.1. The purpose of this report is to provide a summary of strengths and asset based approaches to managing demand and resources across Adult Social Care, which underpins the delivery of cuts proposals COM1a and COM2a (totalling £1.5m).

2. Recommendations

2.1. The Healthier Communities Select Committee is recommended:

- To note the content of this report (in the context of the main Adult Social Care cuts proposal proforma)

3. Policy Context

3.1. The content of this report is consistent with the Council's corporate priorities (as set out in the new Corporate Strategy 2018-22), particularly:

- *Delivering and defending: health, social care and support* – ensuring everyone receives the health, mental health, social care and support services they need

3.2. It is also consistent with the Lewisham Health & Care Partnership's vision to achieve a viable and sustainable 'one Lewisham health and care system' by 2020/21, which will:

- Enable our local population to maintain and improve their physical and mental wellbeing
- Keep people living independent and fulfilled lives
- Reduce inequalities and provide services which meet the needs of our diverse community
- Provide access to person-centred, evidence-informed, high quality, proactive and cost-effective care when it is needed

3.3. As part of this work, Adult Social Care have identified three priority areas:

- *Prevention and self-management* – supporting people to remain independent by utilising the widest amount of support and resources available to each individual
- *Assessing, planning and arranging care* – embedding an asset based approach across social care practice and commissioning that leads to improvements in assessments, outcomes and utilisation of resources, ensuring that care and support plans are jointly developed and personalised, taking into account the person's health, wellbeing, care and support needs
- *Quality Assurance & Safeguarding* – ensuring that there are a wide range of sustainable, high-quality services delivered from a vibrant, high-quality care and support market, working in partnership with key stakeholders to ensure that safeguarding vulnerable people from harm is everyone's priority

4. Defining Strengths & Asset Based Approaches

4.1. As in this report, the terms 'strengths based approach' and 'asset based approach' are often used interchangeably or jointly in reference to social work practice which places individuals, families and communities at the heart of care and wellbeing. Adopting a strengths and asset based approach to any intervention (and particularly to initial contact and assessment) is one of the critical principles underpinning the Care Act 2014, together with co-production, personalisation and the need to work preventatively. The Act requires local authorities to 'consider the person's own strengths and capabilities, and what support might be available from their wider support network or within the community to help' in considering 'what else other than the provision of care and support might assist the person in meeting the outcomes they want to achieve'.

4.2. Strengths and asset based approaches are not a new concept, but they represent a change to the established care management model, where individuals are assessed in order to identify deficits (i.e. needs) and then offered a traditional service (such as home care) to address these – an approach regarded by many professionals as creating a dependency on social care services. Instead, local authorities should work collaboratively with individuals to identify their strengths – including personal attitudes and motivations, social networks and community resources – and maximise those strengths to enable them to achieve their desired outcomes, thereby meeting their needs and improving or maintaining their wellbeing. The objective of the strengths-based approach is to protect the individual's independence, resilience, ability to make choices and wellbeing. Supporting the person's strengths can help address needs (whether or not they are eligible) for support in a way that allows the person to lead, and be in control of, an ordinary and independent day-to-day life as much as possible. It may also help delay the development of further needs.

4.3. There are a number of different methodologies that sit under the umbrella of the strengths and asset based approach (including 'three conversations', peer support, local area coordination, care navigators and social prescribing), but these are not prescriptive and there is no 'one size fits all' model

(interpretations vary and are shaped according to local circumstances and needs) – as a result, they may not lend themselves to being easily replicated.

4.4. A cultural shift is also required at all levels – there needs to be commitment from senior managers to changing the role of Adult Social Care and a clear direction for staff, accompanied by a freedom to innovate and 'own' the approach. This shift also extends to residents as strengths and asset based approaches may not always meet their initial expectations about social care services. Of course achieving cultural shift is not straightforward or easily mandated, but the benefits of working in this personalised and strengths based approach far outweigh the investment in delivering this change.

4.5. In addition, strengths and asset based approaches are dependent on there being a wide-ranging 'menu of support' that individuals can access, both from Council-run or commissioned universal services and the voluntary & community sector. Alongside this, social workers need to develop and maintain an in-depth knowledge of all local community resources, so that they are able to link individuals with the right support.

4.6. We have benchmarked with good practice from a number of other local authorities, as described in Appendix 1, and are implementing strengths and asset based approaches in order to promote and support self-management and independence wherever possible.

5. Managing Demand & Ensuring Financial Sustainability

5.1. Preventing, reducing or delaying the need for care, where feasible, is a key element of the 2014 Care Act, which states that 'effective interventions at the right time can stop needs from escalating, and help people maintain their independence for longer'.

5.2. According to the Kings Fund[1], two complementary trends in ageing are likely to drive a significant amount of future extra demand for Adult Social Care services:

- The demographic 'bulge' of people – the baby boomer generation – born in the twenty or so years after the second world war, who are now reaching retirement in the first decades of the 21st century
- The increased longevity of that population, with life expectancy in Lewisham at birth now 79 years for men and 83.7 years for women (Office for National Statistics (ONS). Despite the recent slowdown in improvements in mortality rates, the ONS predicts that life expectancy will continue to rise, though at a slower rate than previously. The average 'healthy life' for men in Lewisham is 61.9 years and for women is 64.3 years. As people progress beyond these 'healthy years', there is a marked increase in demand on both health and social care services

[1] https://www.kingsfund.org.uk/sites/default/files/2018-12/Key-challenges-facing-the-adult-social-care-sector-in-England.pdf

5.3. By 2066, the ONS estimates that there will be a further 8.6 million UK residents aged 65 years and over, taking the total to 20.4 million and making up over a quarter of the total population. The fastest increase is forecast in the 85 years and over age group. As a consequence, as the population ages, it has been predicted that by 2030 there will be 45% more people living with diabetes, 50% more people living with arthritis, coronary heart disease or stroke and 80% more people (nearly 2 million in total) living with dementia (Select Committee on Public Service and Demographic Change 2013).

5.4. Significant numbers of local authorities now say they are adopting strengths and asset based approaches as way of managing demand and resources across Adult Social Care. In 2018, the Association of Directors of Adults' Social Services (ADASS) annual budget survey found that 82% of directors saw developing asset-based and self-help approaches to reduce the numbers of people needing long-term care as 'very important', with 33% of planned savings for the 2018-19 financial year expected to come from this route.

6. Implementation Of Strengths & Asset Based Approaches In Lewisham

6.1. Ensuring individuals have access to appropriate preventative services such as social prescribing can reduce their need to contact Adult Social Care. This approach is well established in GP practices within the primary care networks, who work in partnership with a range of organisations (including SAIL, Community Connections and Sydenham Garden).

First Point Of Contact (SCAIT)

6.2. All initial contacts to Adult Social Care (which can come from a range of sources, such as members of the public, family members and health partners e.g. GPs and local hospitals) are received by the Social Care Advice & Information Team (SCAIT) – the skills mix of this team includes Information & Advice Officers, Social Workers, Occupational Therapists and Support Planners. Following an end-to-end review of the Adult Social Care pathway, we are increasing staff resources and the skill mix at the first point of contact and have redesigned business processes around prevention and the 'three conversations' model.[2] Equipment surgeries have also been established to support individuals to remain independent at this early stage of contact.

6.3. The 'three conversations' model involves a radical change in approach by putting empowerment and independence at the heart of interactions with individuals. It requires practitioners to:

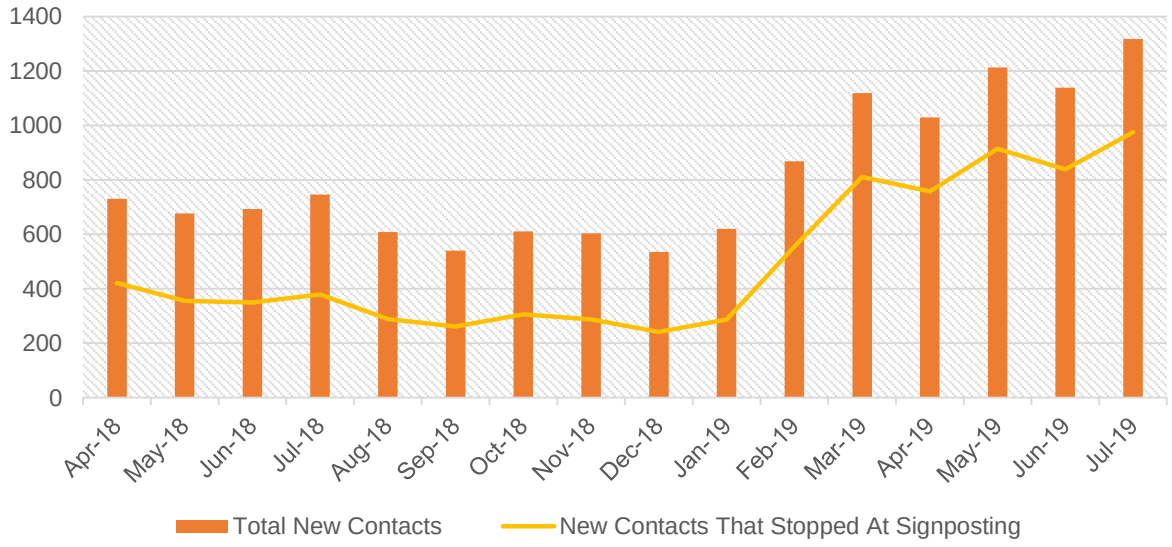
- Work with individuals, not do things to them
- Never plan long-term care when an individual is in crisis
- Listen hard to understand the crisis and help to resolve it
- Focus on what is important to the person, explored in conversations 1 and 2, before considering conversation 3 (longer-term planning)
- Stay involved to provide consistent support and avoid handovers

[2] More information about the 'three conversations' model can be found here: http://partners4change.co.uk/the-three-conversations/.

- Work closely with community partners and maximise individuals' links to community resources

6.4. As a result, staff within SCAIT are moving away from a structured 'interview' which is dominated by pre-determined questions to having conversations and making connections with individuals seeking support. This has necessitated a significant cultural shift in practice for staff who deal with contacts and assessments, which is being supported by a learning and development programme led by the Principal Social Worker (PSW).

6.5. Since we have started to use this approach, there has been a significant increase in the number of contacts that have been resolved by SCAIT, thus avoiding 'pulling people' into a prolonged and at times bureaucratic process while at the same time resolving their issues at the earliest opportunity. Essentially, the more focused the information and solutions provided at this early stage, the less likely it is that an ongoing referral to adult social care is required. As the service moves forward with this approach, so the hope is that the ongoing referral rate will reduce further. This in turn enables social care teams to focus on working with people with more complex needs.



6.6. The Community Connections service (run by a consortium of voluntary sector organisations) is established in each of the four neighbourhoods. Each neighbourhood has a community development worker, who works proactively with the local network and groups to help develop opportunities and capacity in response to the presenting enquiry. Access to universal services is promoted and supported, particularly in relation to promoting well-being for both service users and family carers. Family carers are an important contribution to the strength based approach. Taking account of the emotional stresses and practical needs of family carers is therefore an important element to this approach.

6.7. The approach is also of particular relevance to those people who may not always receive or require formal care. An example of this can be seen with those people who experience low-level mental ill health, active older people

who are isolated and people with a low or moderate learning disability. In these circumstances, participation in community life, access to volunteering or employment opportunities where there is support in place for the individual and it is cost effective for the employer, is often a positive experience that supports individuals with independence and their wellbeing. There is an opportunity here for the Council and its 'Lewisham Deal' partners (as large employers in the borough) to look at how we can together identify posts that can be job-carved and tailored so that they can be offered to individuals with disabilities or mental health needs.

6.8. Our approach to developing the provider market, making use of universal services and opportunities provided by the voluntary sector ensures that the strength and asset based approach is an operational reality and makes a meaningful contribution to supporting people to remain at home as independently as possible. We are undertaking a mapping exercise to ensure that the availability and diversity of support available reflects the needs identified from the conversations and assessment we undertake in partnership with individuals who make contact with Adult Social Care.

Digital Solutions

6.9. The development and delivery of successful, coordinated digital solutions across the local health and care spectrum is essential to help manage future demand. Digital platforms allow for the best possible use of resources as they can reach the greatest number. There are challenges in this and not all residents, particularly the most elderly, have digital devices and capabilities. However, evidence suggests this is changing and digital access is becoming more widespread. Despite this, non-digital solutions must continue for the near future.

6.10. There are a number of local examples that highlight the success of utilising digital technology:

Digital Technology	What Does It Do?	Who Is It For & How Do They Benefit?	What Equipment Is Needed?
Sign Live App	A communication app that allows British Sign Language users to contact the Council and other services remotely for advice and information via a face-to-face interpreter	Residents who communicate with British Sign Language users can contact the Council from home	Smart phone, tablet, laptop
Telecare	A number of home-installed gadgets that are connected to a remote monitoring system which promotes independence	Enables those who are disabled or have dementia to live securely at home	Sensors, phone line, access to the Council Link Line monitoring system
Health Apps	Takes a preventative approach to health and well-being	All residents of the borough can get immediate relevant advice	Smart phone, tablet, PC, laptop

		and information to do with their problem	
Online Health & Care Directory	One place on the Council website for Lewisham-based advice and information about to support, groups and classes in the borough (in development)	Anyone looking for information about a particular aspect of care, health and wellbeing	Smart phone, tablet, PC, laptop
Online Wellbeing Forms	Anyone in the borough interested in finding out more about help with care, health and wellbeing. Also able to submit a request for help to the Council (in development)	Any adult resident needing help with care, health and wellbeing	Smart phone, tablet, PC, laptop
Online Carer Forms	Any carer in the borough who wants to get more information about being a carer. Also able to submit more detailed information to the Council about their situation (in development)	Any adult resident needing help as a carer	Smart phone, tablet, PC, laptop
Connect Care	This is a local care record that shows what health and care information is available for individuals and allows both health and care to work together in partnership to deliver better care	All staff working across health, mental health and adult social care, enabling closer working between professionals	Smart phone, tablet, PC, laptop

6.11. To support the application of digital usage in the community, there is a 'Go On' project which positively encourages older people and other vulnerable groups to improve their use of technology. An example of this has been the invitations to 'Techy Tea Parties', which were held in conjunction with Age UK and the 'Go On' team. The online form for carers give some idea of how a carer may be able to get more support if they require it. Within the law, there is much emphasis upon the impact that caring has upon wellbeing and some suggestions are offered in the search results on this form.

Short-Term Interventions

6.12. The offer of effective short-term intervention is a key element of strengths and asset based approaches as it promotes independence and can reduce or eliminate the need for longer term solutions. Lewisham has an in-house enablement service led by Occupational Therapists and Physiotherapists who work with Enablement Officers to support individuals to establish and achieve personalised goals following illness, injury or a period in hospital. There is also a bed-based rehabilitation unit available within a care home that is largely

funded by the CCG. In partnership with health colleagues, a 'discharge to assess' (D2A) model has been introduced to facilitate early discharge from an acute hospital, with an emphasis on supporting people to return home. This approach has been successful in reducing the length of stay in hospital whilst contributing positively to the Council's performance in relation to delayed transfers of care (DTOC). It should be noted that it is clinically better for frail older people to return home as quickly as possible in that they are less likely to become more dependent. However, they need appropriate health and social care support at home to both reduce risk of readmission and achieve optimal levels of independence.

6.13. However, evidence from activity and finance data highlights the cost pressure to the Council that comes from the reduced length of stay in hospital as individuals are often provided with comprehensive levels of support following an acute admission and shorter length of stay in hospital. It is therefore essential that this short-term intervention considers an individual's strengths and assets and supports them to achieve their optimum level of independence. Performance data identifies that, at the end of this support, approximately 22% of recipients go on to receive long-term support (in comparison to the national average of 19%). Work is underway to improve this performance and it also underlines the importance of this approach and the Council's plans to ensure there is access to enablement, rehabilitation, recuperation and recovery for those individuals living within the community who have experienced a deterioration that may not need a hospital admission, but can be supported by this short-term intervention and ongoing multi-disciplinary work.

A PRACTICE EXAMPLE OF ENABLEMENT:

An older woman had a fall and broke her right leg. Following repair to the break, she could not wash and dress herself – she lived on one floor so getting up and down stairs was not a problem. After hospital discharge, the enablement service helped her to get up and ready for the day and returned later on to help her change for bed. After two weeks, she was able to do this herself and their support was no longer required.

<u>Assessment & Support Planning Within The Neighbourhoods</u>

6.14. The strength and asset based approach is embedded within the assessment process (for those individuals who require a full assessment and longer-term support plan) as well as at the first point of contact. In addition, there are continued reassessments of support plans using the strengths and asset based approach, with all care packages based on medium-term goals that assist individuals to move to greater independence where possible.

6.15. The strengths and asset based approach is further complimented by the Council's plans for integration and the 'Care at Home' delivery model. The neighbourhood teams of health and social care staff are multi-disciplinary and

work closely with the primary care networks and the lead domiciliary care providers. It is recognised that there needs to be a well-established systems in place to support the domiciliary care workforce, who are often the main provider of care to an individual who requires assistance to live at home. Work is in place with community nursing colleagues to pilot a 'trusted assessor' approach. This allows nurses to adjust a care package for their patients rather than waiting for Adult Social Care to undertake an assessment, thereby reducing duplication. The neighbourhood approach is used as a platform to strengthen the interface with mental health services who form part of the multi-disciplinary team within the neighbourhoods.

PRACTICE EXAMPLES OF PARTNERSHIP WORKING

An older woman with mobility difficulties, bladder problems and mild confusion was identified as being at high risk of a bladder infection and kidney damage. The nurses decided that a catheter would help and (with patient consent) this was fitted. They knew that she already had carers visiting once a day whilst her family were at work. Home Carers from the local provider were asked to stay an additional 15 minutes on the visits to help change the catheter. Adult Social Care were informed and the system was updated, with appropriate changes made to update the record.

An older woman was found by police walking around her neighbourhood after dark and returned home. Adult Social Care and her family were alerted. The family, who lived elsewhere, already had concerns and had contacted SCAIT for advice. The woman agreed to assessments with her family present and the mental capacity assessment showed she lacked capacity for decision-making about safety during her night time journeys, so a best interest meeting was held to think about how to manage her safety. Joint working with the mental health team followed and a care and support plan in her own home was suggested – as a result, she received a dementia diagnosis and telecare home safety equipment was installed as well.

<u>Promoting Independence & Self-Determination For Young People Who Transition To Adulthood</u>

6.16. The establishment of the Transitions Team has provided an opportunity to work with young people at an earlier stage to support them into adulthood. The strengths and asset based approach is used to co-produce support plans with young people that consider their education, health, care and support needs as well as their aspirations and what they would like to achieve. In summary, they are tailored to reflect both abilities as well as the management of any care and support needs. For some individuals with complex needs, the support plan is used to identify small but significant outcomes that demonstrate achievement and maintain health and wellbeing. For individuals who have less complex needs but require long support, there is a focus on setting goals regarding tasks that promote independence and provide access to meaningful activity, learning and employment wherever possible. We recognise that we need to work with our partners to improve the local

educational, employment and broader opportunities for young disabled adults in order to create better life opportunities closer to home. To further this way of working, there co-production meetings with providers, further education, health services and the local parent carer forum to identify how we can better support young people as they transition into adulthood.

6.17. Much work is taking place around the whole system model of care and encouraging all providers in the alliance to work consistently to this objective. As an example, we are encouraging housing providers in the borough to ensure that they are also focused upon strengths based working and that they use the resources of their housing and welfare officers to help residents help themselves. We are working to build up extra care housing to support those with dementia. In terms of prevention, we know that the sooner that someone who appears to be struggling at home in a non-sustainable way is moved to this type of alternative community housing, the more likely they will be able to settle into a new independent routine.

6.18. One other strand of this work is to look at how the provider care market is able to develop its own charter. This approach should support this fragile market place and allow some consistency of practice. In order to fill gaps in community provision and better support this new way of working, Adult Social Care staff work alongside the Community Development Forum. On an assembly basis, the intention is that different neighbourhoods will promote local themes to solve local issues and gaps in care.

7. Legal & Equalities Implications

7.1. All legal and equalities implications are outlined in the main Adult Social Care cuts proposal proforma.

8. Financial Implications

8.1. All financial implications are outlined in the main Adult Social Care cuts proposal proforma.

9. Crime & Disorder Implications

9.1. There are no specific crime & disorder implications arising from either this report or the main Adult Social Care cuts proposal proforma.

10. Environmental Implications

10.1. There are no specific environmental implications arising from either this report or the main Adult Social Care cuts proposal proforma.

If there are any queries about this report, please contact Joan Hutton (Director of Operations, Adult Social Care) on x48364.

APPENDIX 1 – Implementation Of Strengths & Asset Based Approaches In Other Authorities[3]

- The 'Wigan Deal' is a major transformation programme that has taken place over the last six years. The Deal has been an attempt both to manage demand for services and to transform how public servants and local people understand their roles in creating successful, healthy communities. The transformation in Wigan included four main components – asset-based working, permission to innovate, investing in communities and place-based working. The implementation of asset based working was driven by a desire to work with local people in a different way, recognising and nurturing the strengths of individuals, families and communities and to build independence and self-reliance. This started with social care workers being trained to have more open-ended, exploratory conversations with their clients and has now become a new way of working for the Council as a whole and, increasingly, for other organisations across Wigan.

- Cambridgeshire County Council's Community Navigator (CN) project began in 2012 as a key response to the views expressed by Cambridgeshire residents and stakeholders through the Ageing Well programme. From these events, it was clear that there was a wealth of community and voluntary activity that supported older and vulnerable adults in the county, but what was missing was a countywide infrastructure which linked and supported people to access these activities at a local level. In 2013, there were 2,451 navigations, but by 2015 this had risen to 4,000. These navigations have been achieved with a 95% client satisfaction rate. Client feedback shows that the main areas where the scheme has made a difference related to clients' wellbeing and feelings of being supported. In 2015, over 90% of clients felt that CNs support had made a difference to them, with nearly half of clients (46%) stating that it had made a significant difference.

- Blackburn with Darwen Borough Council's Assistive Technology Programme (Safe & Well) aims to improve the outcomes for citizens by supporting them to live independently at home whilst also reducing social care costs. It has consisted of three pilot projects to date: working with adults with learning and physical disabilities, nursing and residential homes and early intervention with adults not yet eligible for funded social care. As a result of this programme, Blackburn has moved from supporting 60 people to over 1900 people with assistive technologies.

- In 2014, Cambridgeshire County Council started its Transforming Lives programme to meet new requirements arising from the Care Act and, as part of this programme, the East Cambridgeshire Learning Disability Partnership Team began to pilot the 'three conversation' model in October of that year. The Learning Disability Partnership Team report that the model has enabled them to respond more quickly and provide support that is needs rather than systems-led, thus empowering service users to take greater control over their lives.

[3] See the Social Care Institute for Excellence (SCIE)'s research and practice library and the Kings Fund for more information on the examples provided in this report.

- Derby City Council's Local Area Coordinators (LAC) provide support and assistance to people who may be vulnerable due to age, disability, mental health needs or sensory impairments, but who may not meet the eligibility criteria for specialist services or are not yet at crisis point. They provide two levels of support – information, advice, advocacy and low-level support (1) and a longer-term relationship where they help vulnerable people describe and then pursue their vision of 'a good life', making best use of the individual and community resources around them (2). The service was first implemented in two wards in Derby from 2012 to 2014, each supporting 100 individuals (of whom, 22 received the more intense Level 2 support). There are now seven Local Area Coordinators in seven wards with plans to expand the service to ten wards pending funding agreement.

- Neighbourhood Network Schemes (NNS) are community based, locally led organisations that enable older people over 60 across Leeds to live independently and to take an active role within their own communities. Most are small, independent organisations run largely by and for older people and many have a significant amount of input from volunteers drawn from the local community. NNS aim to reduce social isolation, encourage contribution to (and involvement in) the community, promote health and wellbeing and help improve the quality of life for their members. They do this by providing social activities, a 'gateway' to information, advice and support and volunteering opportunities that respond to local needs and demands, so that each NNS will be different. Leeds City Council estimates that the work of NNS has prevented 1,450 older people from going into hospital and figures collected show that 617 have been supported after being discharged from hospital (working in conjunction with Age UK and British Red Cross).

- Ways to Wellbeing York is a social prescribing service which aims to improve the health and wellbeing of people referred by GPs by working with them to understand their needs and identify local services offering non-medical interventions which may be able to help. The service is hosted by York CVS and funded by the City Council and currently offers access to social prescription referrals through four surgeries in York, which are based in areas of greater deprivation. The main reasons for referral are issues relating to emotional wellbeing, loneliness and social isolation – initially, the majority of referrals were older women but the gender gap is now narrowing.

- The Community Team Plus service involves multi-disciplinary health and care teams who use a strength and asset based approach to support people across six Stoke on Trent localities. The service operates across three general practices who have shown a commitment to integrated working and has a three-level offer – information, advice, network building and equipment (level 1), reablement (level 2) and long-term formal support (level 3). At the first level, the multi-disciplinary health and care teams often facilitate groups at community centres in order to support people to establish networks and build their resilience.