PROMOTING YOUR INDEPENDENCE

Adult Social Care in South Tyneside

2016-2020

South Tyneside Council

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FOREWORD BY THE LEAD MEMBER FOR INDEPENDENCE AND WELL-BEING

Local authorities are facing unprecedented pressure through reduced budgets and rising demand. Adult Social Care faces a considerable challenge, having experienced significant budget reductions at a time when people are living longer with higher levels of need for care and support. In South Tyneside, we remain committed to supporting our residents with the right support when they need it.

These challenging times require a fresh approach and new thinking. We want to encourage people to take responsibility for their own health and wellbeing, to make healthy choices, stay active and feel they are part of a community. We want to support families and carers to continue to help and support their loved ones or friends.

Adult social care will focus on preventing and delaying the need for care and support for as long as possible to maintain a person's independence. We will support people who need it, for as long as they need it, in the most effective and efficient ways.

We asked for the views of our residents, based on these new approaches, and we have used this feedback to inform this strategy. This sets out our commitment and approach so that we can meet the needs of South Tyneside residents within a very challenging climate.

COUNCILLOR TRACEY DIXON
Lead Member for Independence & Wellbeing

INTRODUCTION BY THE CORPORATE DIRECTOR, CHILDREN, ADULTS AND HEALTH

South Tyneside is a great place to live, invest and bring up families. It is a Borough facing real challenges about how it uses tax payer's money to support those people who need help and support to stay independent. South Tyneside Council, like all other Councils, has to look hard at how it delivers its statutory duties to people who need support and look for new approaches.

This means some difficult decisions and tough choices.

- Do we focus on people in most need or do we invest in prevention that can reduce or delay that need?
- Do we only pay for care that helps people in their personal daily tasks like getting up, washing themselves and ensuring they eat well and not on domestic tasks like laundry and cleaning?
- What are the key activities that keep a person independent?

South Tyneside spends most of its Adult Social Care budget on residential care places and, by comparison with other areas, places more people in residential care. By contrast short term recovery services can help a person regain their independence quickly with the right help. Support from family, friends and the community can be better than formal paid-for care.

People want their care and support coordinated around them, to tell their story only once and to expect health and social care professionals to work together for their benefit. We are committed to working in partnership with our health colleagues to support people in avoiding hospital admissions and aiding discharges following a hospital stay and have made good progress on this in a number of key areas.

We think that people are the best judge of what works for them and by working together we can make the best use of their abilities along with support from the Council to keep them as independent as possible.

JOHN PEARCE
Corporate Director - Children, Adults and Health

1. INTRODUCTION

The Council's Vision and plan for South Tyneside identifies ten key priorities:

- WORK WITH COMMUNITIES TO REDUCE POVERTY
- EARLY HELP FOR CHILDREN AND FAMILIES
- IMPROVE HEALTH AND WELLBEING
- FURTHER INTEGRATE HEALTH AND SOCIAL CARE
- IMPROVE EDUCATION AND SKILLS
- INWARD INVESTMENT, JOBS AND GROWTH
- FURTHER REGENERATE TOWN CENTRES AND NEIGHBOURHOODS
- HOUSING INTEGRATION AND GROWTH
- MAXIMISE VALUE FROM ASSETS
- IMPROVE TRANSPORT AND INFRASTRUCTURE

The work of adult social care is mainly focused on delivering the 'Improving Health and Wellbeing', and 'Integration of Health and Social Care'priorities.

Following on from this our vision for adult social care is:

> "To make the best use of available resources to keep people in South Tyneside independent".

What is the purpose of adult social care?

Adult social care is there to support people who need help with daily living so they can continue to be as independent as possible in the community. The care and support that adult social care commissions (arranges or provides) is based on the needs of adults (including carers and young people during transition to adulthood) who are supported using public money or pay for their own services. Keeping people safe is an important part of our legal obligations. The main responsibilities of adult social care are set out in three important pieces of legislation: The Care Act 2014, The Mental Health Act 1983 and The Mental Capacity Act 2005. The Care Act 2014 sets out the duties and powers of local authorities in relation to social care and extends existing responsibilities, including:

- Promoting well-being
- Protecting (safeguarding) adults at risk of abuse or neglect
- Preventing the need for care and support
- Integration of care and support with health services
- Information and advice for people to find what they need
- Ensuring a good quality and diverse market of support and services

However, adult social care is changing. Our focus will be to promote the well-being of the population and maintain and enhance people's independence so that they are healthier, stronger, more resilient and less reliant on formal social care services.

Our objectives for Adult Social Care:

- To help people to help themselves with more people living at home or in the community
- To reduce reliance on residential care or hospital stays through better support at home and evidence based alternatives
- Enable more people to have a good quality of life and more control through self-directed support and Direct Payments
- Ensure money is targeted at those who most need support, and that it is well spent on cost effective services
- Enable better outcomes for people and ensure people are better connected and supported in their communities
- Support staff in their role, with the right tools to do the job
- Focus on people's strengths and make best use of available resources and local assets, whilst meeting increasing demands for care and support
- Ensuring better joined up care through integration with health

"We have to remind ourselves that we don't know best. Sometimes it is best to forget previous assumptions".

2. OUR APPROACH TO ADULT SOCIAL CARE

We believe that we can continue to do more to promote people's ability to improve and maintain their health and well-being, to live independently, and cope well with deteriorating conditions. We will offer a timely and integrated approach to care and support. In short, this is based on the central idea of focusing on 'a whole life not a service'. We have decided to use this approach based on consistent feedback that current models of support seek to fit people into a narrow band of available services, whereas future support needs to be more personalised around the life and needs of the individual so people can live their life the way they want to.

We want to see the systems and culture in place across the whole health and care system whereby everyone we come into contact with is helped to be as independent as possible and this will be an ongoing process. The starting point will be to consider, with the person and their family and carers, what their specific goals are, what is important to them and what they would like to be doing that they cannot do at the moment. The above approach is supported by the Care Act which puts a person's well-being at the heart of the process. We will encourage people to make the best use of support from their own community, including family and friends and voluntary organisations. The way we approach and discuss these issues is critical and we wish to focus on getting to the heart of the presenting need in a straightforward way.

The 'three conversations model' provides a set of tools to enable our committed, principled and skilled workforce to have conversations based on what people want to tell us, not what we want to ask them. It makes us see them as people (not clients, service users or even customers) reminding us they are often part of a family neighbourhood and community. It is this kind of fresh approach that we are considering.

Three conversations

Some authorities have removed the traditional 'assessment for services' approach and created a new culture where practice is based on three conversations:

CONVERSATION 1

How can I connect you to things that will help you get on with your life – based on your assets and strengths,
and those of your family and neighbourhood?

What do you want to do? What can I connect you to?

CONVERSATION 2

Applicable to people who are at risk. What needs to change to make you safe? How do I help to make that happen? What offers do I have at my disposal – including small amounts of money and my knowledge of the community – to support you? How can I pull them together in an 'emergency plan' and stay with you to make sure it works?

CONVERSATION 3

What does a good life look like? How can I help you use your resources to support your chosen life? Who do you want to be involved in good support planning? What is a fair personal budget and where do the sources of funding come from?

3. OUR VISION EXPLAINED

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 people are supported to manage any risks appropriately in line with the principle of empowering individuals to be as independent as possible.

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 health services and other organisations to achieve more joined-up and cost-effective support

We have developed a model 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. We will support people to be safe; working with people to help them to manage the risk of abuse or neglect is central in everything we do.

Universal services, promoting wellbeing

Target 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 support by providing information and advice so that people can benefit from services, facilities or resources which improve their wellbeing. This might not be focused on a particular health or support need but is available for all residents of South Tyneside, for example, green spaces, libraries, adult learning, places of worship, community centres, leisure centres, and information and advice services. We will promote better health and wellbeing and work together with families and communities (including local voluntary and community groups).

PREVENT NEED

Mrs Simpson is becoming frail with age and is anxious about who will take care of her home and garden and pet dog. Previously the Council might have funded domestic support and even paid for her dog to be walked.

A care navigator works with Mrs Simpson and arranges volunteer support to manage her garden, family rota for meals, online shopping and a neighbour to walk her dog.

Mrs Simpson remains part of her community, retains her independence and is less anxious about her house deteriorating.

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 alongside our partners in the voluntary and community sector 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, making friends and a contribution to the community, 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.

REDUCING NEED

Ramesh is a 77 year old gentleman caring for his 73 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 a 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

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.

DELAYING NEED

Adam 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. Adam 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 Adam and his mum to set boundaries and to address his behaviour. The Transitions Team helped Adam 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 service offering activities matching Adam's interests was found for 3 days a week in school holidays. Adam enjoys this and knows he must attend school in order to go to the holiday service which also gives his mum a break from caring and she no longer needs extra respite.

Adam 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 Adam'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

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 through an assets based approach rather than focussing on what people cannot do. 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 support which is suitable to meet their outcomes. However, in all cases the Council will ensure that the cost of support 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.

MEETING NEED

William is a 50 year old man with a learning disability, who had lived in residential care for over 25 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 William focuses on maintaining his independence including budget management, daily activities and planning for the future. Transport and household tasks will become William's responsibility. 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.

4. THE BUILDING BLOCKS

In order to deliver this vision and approach it is important a number of key building blocks are in place:

- A NEW UNDERSTANDING BETWEEN THE COUNCIL AND THE CITIZENS OF SOUTH TYNESIDE
  It is important that residents understand what the Council will be responsible for in future and those things that the Council will no longer be able to provide. Good communication is important to understand the approach set out in this document, the responsibilities of South Tyneside residents for their own well-being, what can realistically be expected of the Council.
- CLEAR AND SIMPLE INFORMATION on how to find support and how to access services when these are needed.
- PROTECTION (SAFEGUARDING) from harm and neglect for those who may not be able to support themselves.
- A WORKFORCE that is skilled and caring; well supported with the right tools to do the job and with the ability to get to the heart of the issue and assist in finding the right solutions and enabling residents to do more for themselves. The workforce needs to be appropriately skilled and competent to meet local needs, be sustainable and flexible. Staff will need to put outcomes for people first, and their performance will be assessed against this rather than a task-based approach.
- EARLY HELP THAT GETS PEOPLE BACK THEIR INDEPENDENCE WHEREVER POSSIBLE. A number of services delivered with the right approach at the right time can get a person who has lost their independence back on their feet and functioning better. Reablement for older people that helps them to regain their daily living skills, recovery services for people following a mental health episode or training for people with a learning disability to be able to do more for themselves are all examples of this.

WHAT IS REABLEMENT?

A short term intensive support, usually delivered in the home by a trained care worker, which is offered to people with disabilities and those who are frail or recovering from an illness or injury.

Reablement helps people to relearn the skills required to keep them safe and independent at home. People using reablement experience greater improvements in physical functioning and improved quality of life compared with using standard home care and can get them back on their feet and independent again.

- A WHOLE SYSTEM APPROACH that makes the best use of the South Tyneside pound to ensure care and support are joined up across health and social care.
- Ensuring that the right support services and alternatives exist and are able to support those that need them in informal and formal ways using innovative and cost effective approaches. Traditional councils do this by paying for certain tasks at specified times to be carried out by a provider leaving less room for the specific needs of an individual to be taken into account. An outcome-based approach identifies what outcomes matter most, and payment to providers depends on achieving the outcomes and is not simply based on activities. Under this model, there is an incentive for different providers across health and social care to work together to achieve outcomes. Prevention activities are also given a clearer priority than is currently the case. More people will take up Direct Payments and have greater choice and flexibility about how their support needs are met. We want to involve people in the design of this approach.

- Integration and partnerships between agencies to ensure that resources are used to best effect and that where support is needed it is well coordinated around the needs of the individual where their choice and control is paramount. This involves approaching the health and care of the population as a whole system and breaking down barriers between sectors and organisations where they get in the way of better care and support. Our vision for adult social care is built on existing work with social care professionals, clinicians, carers, the public, and other partners in developing possible new models of support for the future. As a result, our vision is part of the broader process of joining up health and social care.

SHARED LIVES SCHEMES can provide a safe and secure long term home, a short break or emergency support to adults who have been assessed as needing them. Shared Lives has been used for people with learning disabilities but can equally support older people and others. Individual support is provided in an approved carers' home so that the person can live in a family surrounding.

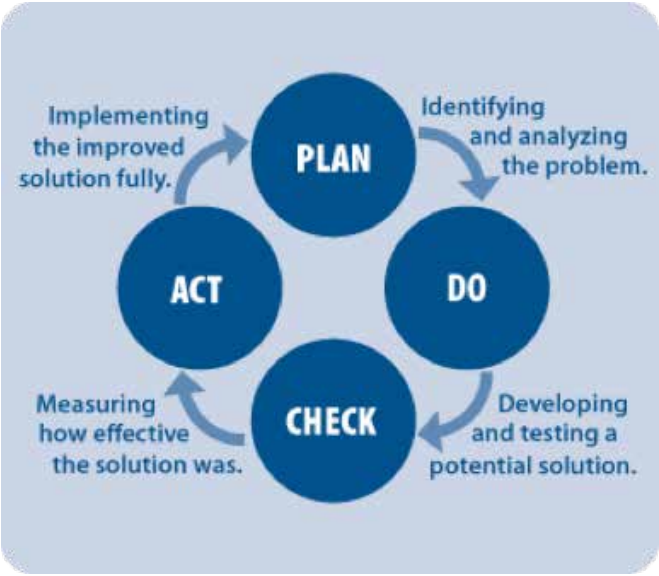
- Provide a safe and secure home that supports an individual's rights, independence, choice and inclusion
- Provide a comfortable homely environment
- Encourage the learning of skills to be more independent
- Support into leisure activities and new experiences
- Support and encourage 'get togethers' with family and friends
- Encourage involvement in the local community

5. HOW WE WILL KNOW HOW WE ARE DOING

We monitor our performance by looking at the benefits to the individual or family, something we call outcomes. This will include existing methods for monitoring performance plus the experience of people who use our services:

- Establishing clear programmes of work with robust accountability to deliver this vision and improve the way people in South Tyneside receive support
- Activity, finance and performance information reported and used by adult social care managers and comparisons with other authorities to keep track of progress
- Director's performance clinics
- Progress on our Improvement Programme reporting for the Adults Improvement Programme Board, senior management to account for progress against the priorities in our Improvement Plan
- An annual public report, called the Local Account, of how well adult social care is doing, produced with people who use our services and their carers, main partners and staff
- Corporate & Directorate performance management reporting
- Surveys and feedback from people who use services, and their carers, on their views and experience of services
- In depth examination of areas of service with the aim of improving outcomes
- Care Quality Commission (CQC) reports and service quality and other information put together by the CQC, the independent regulator of health and social care services
- Health and Well-being Board reporting of adult social care's contribution to the progress on outcomes in the Health and Well-being priorities and this strategy
- Peer reviews and other forms of external challenge comparing ourselves with others and using best practice to improve the way we do things
- Safeguarding Adults Board reports
- Scrutiny by Council members

6. HOW THE STRATEGY WILL BE IMPLEMENTED



We will take 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
- With those who use services and their carers, co-design our approach and with our partners and staff, 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 and clear and transparent funding arrangements for people's support where this is publicly funded
- Develop a detailed action plan, which will be regularly reviewed, updated and used to identify the next steps

For Adult Social Care enquiries, or more information about this Strategy contact:

www.southtyneside.gov.uk/care

0191 424 6000

If you know someone who needs this information in a different format, for example large print, Braille or a different language, please call Marketing and Communications on 0191 427 1717.