Health&Social Care
North Lanarkshire

REPORT

Item No: 9

SUBJECT:	New Model of Home Support
TO:	**Integration Joint Board**
Lead Officer for Report:	Chief Accountable Officer
Author(s) of Report	Head of Planning, Performance and Quality Assurance Head of Adult Social Work Services
DATE:	8 March 2018

1. PURPOSE OF REPORT

This paper is coming to the IJB

For approval	☒	For endorsement	☐	To note	☐

2. ROUTE TO THE BOARD

This paper has been:

Prepared	☒	Reviewed	☒	Endorsed	☐

The paper was prepared by the Heads of Planning, Performance and Quality Assurance and Adult Social Work Services and reviewed by key members of the Senior Leadership Team.

3. RECOMMENDATIONS

3.1 The IJB is asked to:

1. Approve the new Home Support model that includes the viable outputs of the Cross Party Working Group noted in Appendix 1 (section 3)
2. Request an implementation plan with timelines, is co-produced, with staff and trade unions, by the end of April 2018
3. Approve that all Home Support staff who choose to pursue their SVQ2 qualification are supported to do so by October 2020
4. Agree to monitor funding of the new Home Support model through the PFA Sub Committee and build in the financial projections outlined in appendix 1 (section 3.5) into the IJB's long-term financial plan
5. Agree to monitor the performance of the new Home Support model for 2 years through the PFA Sub Committee
6. Request ongoing engagement with service users through the implementation process and review stages of the new Home Support model

4. BACKGROUND/SUMMARY OF KEY ISSUES

4.1 In September 2016, a paper was presented to the IJB outlining the challenges facing the Home Support service in terms of increasing demand and the requirement to meet Scottish Government statutory directives around Self Directed Support (SDS), in respect of Older People.

4.2 The IJB agreed to the commissioning of a new framework for third and independent sector providers to be in place by April 2017 and tasked officers with developing options for a future Care at Home service, focusing on more responsive and flexible supports to prevent admission to and support discharge from hospital.

4.3 At the June 2017 meeting of North Lanarkshire Council's Policy and Resources Committee, it was agreed that a Cross Party Working Group on the Ageing Population Demographics be established. The group reported its recommendations to the Policy and Resources Committee on 30th November 2017, which were noted and remitted to the IJB for objective consideration.

4.4 Officers have also researched Home Support services across Scotland and wider, in conjunction with the developments around the Integrated Service Review Board work on the wider Health and Social Work configuration of services. Visits were also made to Sheffield to review their Discharge to Assess model, in line with the outputs of the Cross Party Working Group aspirations.

4.5 After consideration of the outputs of the Cross Party Working Group and advice from officers, a proposed new model has been developed (see appendix 1), which focuses on five major elements:

- **Integrated Model** (Discharge to Assess in Localities)
- **Same Day Response/Reablement/First Support** (Intensive and time limited)
- **Specialist Teams** (e.g. supporting people with frequently changing needs and end of life / Palliative Care)
- **Ongoing Paid Support** (allocation of an individual budget to deliver individual outcomes as part of SDS)
- **Quality Assurance** (improving standards of care)

4.6 Due to increasing demand from demographic growth and an aspiration to assist people to be supported at home wherever feasible, the new model still presents a financial challenge to the IJB, however, it represents a significant 'cost avoidance' over the traditional model of a cumulative £25.6m over five years.

4.7 Crucially, the proposed new model forms an integral component of the Integrated Service Review Board aspirations, approved by the IJB in November 2017.

5. CONCLUSIONS

5.1 Home Support plays a crucial role in supporting individuals to remain at home, connected to their friends, family and local community for as long as possible. The new model of Home Support is a key element of the future integrated model in North Lanarkshire.

5.2 Implementation of the new model will improve the outcomes that the service is able to deliver to people, improve system performance (particularly around unscheduled care and delayed discharge), meet requirements as they relate to relevant acts, policies and guidance and reduce projected increases in cost.

6. IMPLICATIONS

6.1 NATIONAL OUTCOMES
Home Support services are a crucial element of supporting people to remain at home in the community, impacting particularly on outcomes 2, 3 and 4.

6.2 ASSOCIATED MEASURE(S)
Home Support services impact on a range of the national outcome indicators, but particularly on 2, 3, 4, 7, 12, 13, 15, 19, 21 and 22.

6.3 FINANCIAL

This paper has been reviewed by Finance:

Yes	☒	No	☐	N/A	☐

6.4 PEOPLE
The development and roll out of the new model will require collaborative working with service users, carers, staff and Trade Unions, with a commitment to annual focus groups to review service delivery.

6.5 INEQUALITIES

EQIA Completed:

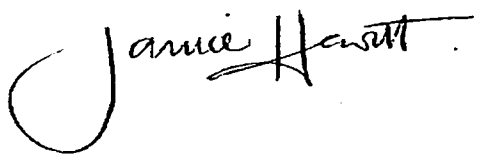
Yes	☐	No	☒	N/A	☐

An associated EQIA is currently under development.

7. BACKGROUND PAPERS

8. APPENDICES

Appendix 1: Remodelling Home Support in North Lanarkshire, March 2018



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CHIEF ACCOUNTABLE OFFICER (or Depute)

Members seeking further information about any aspect of this report, please contact Janice Hewitt on telephone number 01698 858 320.

Health&Social Care
North Lanarkshire

Appendix 1: Remodelling home support in North Lanarkshire

March 2018

1. Background

1.1 In a paper to the IJB in September 2016, officers set out the wide range of demand and operational challenges, including new legislative requirements, faced by the current Home Support service and the need for transformation to ensure the continued provision of a high quality service.

1.2 In 2016/17, the Home Support service delivered just less than two million hours of paid support in North Lanarkshire at a cost of £52m. The in-house service, delivered by just over 1000FTE Home Support Workers, provided 73% of this care with the remaining hours by third and independent sector providers.

1.3 Most care is provided in 30min slots, focusing on supporting people with personal care, food and eating, taking prescribed medications and managing risk in daily living.

1.4 The key drivers for change in Home Support are as follows:

- **Demographic growth** – the rising number of older people, and the rising complexity of cases supported in the community (which often require more than one worker attending each visit) will continue to increase demand for Home Support services, equating to an additional 1,500 hours per week per annum
- **Self-Directed Support (SDS)** – there is a legislative requirement to offer people choice and control over the types of support they receive, when they get the support and who provides it. In North Lanarkshire, we currently support around 80% of younger adults who require a service in this way, but only around 13% of older adults
- **Integration** – the model needs to fit in with the outputs of the Integrated Service Review Board Report, which was approved by the IJB on 23/11/17, moving towards locality-based multidisciplinary teams, which will provide a more seamless service to the residents of North Lanarkshire
- **Finance** – The demand cost of Home Support services has been rising at a rate of around £2m per year over the last financial years and over and above this, the re-grading of Home Support Workers has added a further annual financial impact of £6.2m and an additional £0.7m per year for the next three years as staff work up through the pay increments.
- **Whole-system performance** – the Scottish Government has set a requirement for all IJBs to deliver against the 'big 6' measures from the Health and Social Care Delivery Plan. Delivery on a number of these targets is contingent on having an effective model of Home Support, which includes a move towards a Discharge to Assess approach and same day response.

2. Developing the New Model

2.1 Cross-Party Working Group

2.1.1 At its meeting of 21 June 2017, North Lanarkshire Council's Policy and Resources Committee agreed to the establishment of a Cross Party Working Group on the Ageing Population demographics.

2.1.2 The working group was established to:

- Explore the future challenges and opportunities for the council arising from the demographic changes within the older population in North Lanarkshire
- Understand the current service delivery model(s), associated resources and legislative requirements, that are used to respond to the needs of older people within North

Lanarkshire including a) wider community supports b) council supports and services c) commissioned services

- Explore future aspiration, supports and service delivery options that will meet the predicted future needs, promote quality and improve independent living within growing population
- Make recommendations to the North Lanarkshire Integrated Joint Board for their consideration within their legal responsibilities to plan for the issues that relate to an ageing population.

2.1.3 Following a number of meetings which included evidence from the Chief Executive of the Improvement Service and a range of key officers from the Health and Social Care Partnership, a final report was presented to the Policy and Resources Committee on 30th November 2017. The report was noted and remitted to the IJB for objective consideration.

2.1.4 The Working Group proposals were as follows:

- Development of the Reablement approach, supporting better outcomes for service users and also driving down the demand for long term care
- Roll out of a model of Discharge to Assess as profiled in the Sheffield Model
- Reject the policy of freezing recruitment and backfilling with the independent sector
- Change practice and reinstate the policy of re-hiring in-house staff

2.1.5 A key aspiration of the Working Group proposals was to retain high quality council delivered services. The aspirations have been discussed with key support officers i.e. legal, finance, HR and trade union colleagues to ensure that, where legal and practicable, the proposals are factored into the new model of Home Support for the future. (See Section 3)

2.2 Learning from other areas

2.2.1 Officers researched Home Support services across Scotland and wider, in conjunction with the wider literature searches undertaken as part of the Integrated Service Review Board process.

2.2.2 Through this process, some key service requirements were identified:

- In line with legislative requirements, switching from a 'service led' support to one that gives people more choice and control as to how their needs are met
- Integrating services within Localities, as detailed in the Integrated Service Review Board
- Increasing provision of Reablement and First Response
- Increasing provision of Specialist Teams for intensive support and end of life care

2.2.3 Following the discussions at the Cross-Party Working Group, officers visited Sheffield to further learn about their Discharge to Assess model, which is widely regarded as the most advanced in the UK. Collaboration with Sheffield has supported the development of North Lanarkshire's Discharge to Assess proposals, outlined in the Integrated Service Review Board report.

3. Proposed new Model of Home Support in North Lanarkshire

3.0.1 After consideration of the outputs of the Cross-Party Working Group, the advice from support officers and wider officer research, the proposed new model focuses on five major elements:

- **Integrated Model** (Discharge to Assess in Localities)
- **Same Day Response/Reablement/First Support** (Intensive and time limited)

- **Specialist Teams** (e.g. supporting people with frequently changing needs and end of life / Palliative Care)
- **Ongoing Paid Support** (allocation of an individual budget to deliver individual outcomes as part of SDS)
- **Quality Assurance** (improving standards of care)

3.1 Integrated Model

3.1.1 The development of a Discharge to Assess approach, such as the Sheffield Model, and integrated locality teams, as outlined in the Integrated Service Review report, are critical elements of a new model of Home Support. A single point of access for services will include Home Support for both those still at home and for coordination of discharges from hospital.

3.1.2 Home Support will form an integral component of the Long Term Conditions and Frailty teams in each Locality, supporting closer working with colleagues in District Nursing, Physiotherapy and Occupational Therapy to create a more coordinated and streamlined service for individuals.

3.2 Same Day Response/Reablement/First Support

3.2.1 The Reablement/First Response teams will work with all new service users or service users who have had a change of circumstances, particularly where there is increasing dependence or a proposed change in level of support arrangements on discharge from hospital. The integrated teams will do the initial assessment, including planning discharge to assess from hospital, setting goals with the person and their family as to what matters to them and how to help them regain optimum independence building on their personal, family, friends and community resources.

3.2.2 The reablement approach will provide an intensive period of care over a period up to twelve weeks, with the aim of supporting the service user to maximise their independence. Around week six, a decision will be taken to decide if the person can be supported to the point where they no longer need formal paid support, or whether ongoing support will be needed. If individuals no longer need a service from this point, we will work with the voluntary sector in linking to other community activities where loneliness or isolation may be an issue for the person. However, if paid ongoing support is needed the person will be assisted to develop a support plan to achieve agreed outcomes which can be met via an allocated individual budget.

3.2.3 Learning in North Lanarkshire suggests around 50% of individuals require no ongoing support following a period of reablement, maximising independence. The new offering will make this service universal for all new requests and through extending the maximum period of support, will enable a more holistic approach.

3.2.4 The Reablement/First Response teams will be developed with capacity to support a same day response for both community (unscheduled care) and hospital discharge. This responsive approach forms a vital element for the development of Discharge to Assess, whilst also offering a significant support within Localities to reduce the need for hospital admissions.

3.2.5 The Discharge to Assess approach requires a reactive wrap-around service to ensure individuals are able to be safely supported at home while further assessment is undertaken, which will be provided by the Reablement/First Response teams. Complex assessments can have life-changing consequences and the Discharge to Assess approach has been shown to maximise the chance of supporting individuals to remain at home, connected with their own family, friends and wider community.

3.3 Specialist Teams

3.3.1 As the number of individuals in the community with complex care needs continues to rise in North Lanarkshire, the requirement for more specialist provision becomes more apparent. The Intensive Support Team, working alongside the reablement teams and colleagues in health, will offer support and care for those with complex and frequently changing needs, palliative or end of life care, overnight support needs, sheltered and very sheltered housing and children's services teams.

3.3.2 The Intensive Support Teams can also augment existing support packages, (for up to two weeks), for people who require more intensive support for a short period of time. Overnight teams form an important element, being Locality-based and able to provide specific interventions during the night, such as turning a person in bed, or checking on someone with dementia who may be prone to being unsettled during the night.

3.3.3 Similarly to reablement, the focus on specialist intervention improves both service user and staff experiences, being more responsive and better able to address individual needs. The direction of travel agreed with the Hospices around Palliative Care, which will see a gradual move towards more 'Hospice at Home' activity, will require a similar shift in requirements for appropriately skilled supports in the community, highlighting the need for more specialist provision.

3.3.4 The highly skilled elements of Reablement/First Response and Specialist Home Support teams will be provided by North Lanarkshire Council staff, who will be supported to achieve SVQ2 training levels by 2020.

3.4 Ongoing Support

3.4.1 Self-directed support (SDS) aims to improve people's lives if they need social care by empowering them to be equal partners in agreeing their care and support. The four legal principles employed to do this are – participation and dignity, involvement, informed choice and collaboration.

3.4.2 The ten-year SDS strategy was introduced jointly by the Scottish Government and COSLA in 2010. The Social Care (Self – directed Support) (Scotland) Act 2013 is the main driver for the changes envisaged and it came into effect in April 2014. The Act sets a clear duty on authorities to give people more choice and control over arranging their social care needs by identifying how much money is available to support them and then helping them to choose from one of four options outlined in the legislation:

- Option 1 – A person or their legal appointee can choose to take a direct payment
- Option 2 – A person can ask the local authority to arrange their support from an organisation of their choice.
- Option 3 – A person can ask the local authority to arrange their support service on their behalf.
- Option 4 – A person can seek a combination of any of the three options noted above.

3.4.3 The guidance for the Act notes that the "authority should view its commissioning role as being a facilitator of choice. This involves providing information about choices and commissioning and procurement processes that allow people to have a real choice of provider and type of support."

3.4.4 In North Lanarkshire, significant progress has been made in developing the SDS approach for children affected by disability and younger adults, but less so for older adults, as identified in

the recent Joint Inspection of Adult Services by Healthcare Improvement Scotland and the Care Inspectorate, published in February 2018. An identified area for improvement was that the "partnership should produce a plan to develop a mixed economy of care...offering choice, control and equity of access across all localities..."

3.4.5 Set within this context, in the event of a person needing longer term paid support, an individual budget will be agreed and the person helped to choose one of the four Self Directed Support options. This approach means that individuals will have choice and control over how their needs are met, which may not require any formal ongoing paid social care service. People's personal and social capital needs to be factored into achieving outcomes first and foremost.

3.4.6 It is anticipated that a significant number of service users will choose to use their individual budget in different ways, including the use of Personal Assistants, use of technology or freeing duties done by family members to allow them to take on personal care tasks. This is evidenced within the Audit Scotland report on SDS, which notes the increasing number of people in receipt of direct payments and the decreasing number of Homecare clients, reflecting the alternative and often innovative solutions found to meet individual needs.

3.4.7 Where paid support is required, the authority is obliged to act as a facilitator of choice, providing unbiased information and support around choices and commissioning and procurement processes to enable individuals to have a real choice of provider and type of service.

3.4.8 There are currently fourteen independent sector providers on the NLC commissioning framework.

3.4.9 There is a strong commitment within the service to work with Trade Unions and staff to make the in-house service as efficient, flexible and attractive as possible to ensure the retention of high quality council delivered services. However, the future mix and volume of service provision will be shaped by service user demand.

3.4.10 Annual focus groups with service users, carers, staff and Trade Unions and will take place to review service delivery.

3.5 Quality Assurance

3.5.1 There is a strong desire to shift the management focus of the Home Support service from one of direct staff management to quality assurance. This will be increasingly important in moving to a model of SDS, with additional quality assurance and management required of individual budgets and arrangements that people put in place or are helped to do so.

3.5.2 Experience from younger adults identifies the need for the service to provide regular six-monthly reviews for all people with an individual budget, to ensure the quality of service provided is in line with expectations. In addition, all external providers are subject to Care Inspectorate inspections at least annually.

3.5.3 There are currently over 1200 people supported with an individual budget in North Lanarkshire, with systems and processes developed over a number of years to ensure the safety and quality assurance of the arrangements put in place.

3.5.4 There is a bespoke framework agreed and endorsed by the Council for all providers, which was established following the supported living developments in North Lanarkshire. This

includes minimum staffing levels, qualifications, a complaints procedure, value and practice base and training e.g. adult protection, moving and handling etc.

3.5.5 North Lanarkshire Council's Quality Assurance section monitors the framework providers and meets with each regularly. In addition, there is a quarterly development session for Social Work managers and Supported Living and Support at Home providers to share learning, agree development and build on best practice. This latter process has been shown to be very beneficial in terms of genuine partnership working with a focus on personal outcomes for service users.

3.5.6 The Care Inspectorate has a significant role, in that each individual organisation must be registered and meet their set standards. Some of these areas overlap with those of the Social Work contract and their inspection regime stands alone. There is close liaison between the Care Inspectorate and the Quality Assurance section and whilst there are areas of overlap, the respective inspection regimes stand alone.

3.5.7 These approaches support improvement and the early identification of concerns. If concerns arise, in each Locality a nominated Senior Home Support Manager is identified to provide liaison, support and monitoring of performance of the organisations working within the locality area.

3.5.8 Finally, assessment and planning staff have a responsibility to indicate any issues or concerns which arise both to their line manager and the QA section. Where concerns are raised, providers are placed on enhanced monitoring by the Quality Assurance section which liaises with the Care Inspectorate and local Home Support Managers and Care Managers to formulate and monitor an improvement plan. Where improvements are not forthcoming or if serious concerns are raised, an embargo on new work is imposed alongside a review of all existing service users to ensure their safety.

3.6 Costs

3.6.1 One of the key elements explored within the Cross-Party Working Group was the ageing population and the anticipated increase in demand for Home Support services.

3.6.2 While the development of the reablement approach should minimise the impact, the proposed transformational service model still projects an increase in funding required over a five year period. However, the proposed model projects significant 'cost avoidance' in comparison to the traditional delivery model.

Cost Profile	Baseline Year	Year 1	Year 2	Year 3	Year 4	Year 5
	£	£	£	£	£	£
Traditional Delivery Model	51,340,175	53,945,463	56,562,015	59,190,017	61,229,654	63,281,116
Proposed Model	51,340,175	52,541,110	53,559,823	54,360,739	54,426,604	55,133,593
Difference	0	1,404,353	3,002,192	4,829,278	6,803,050	8,147,523

3.6.3 The proposed model would include anticipated cost increases of £3.8m by Year 5. These relate to inflationary cost pressures and an anticipated increase in demand. On a year by year basis, these will be addressed as part of the annual financial processes undertaken across all Health and Social Work services to manage inflationary and demand pressures.

3.6 Outcomes

The proposed model will:

- Assist people and their families to retain and/or regain abilities to be as independent as possible
- Keep as many people as possible supported at home with quality support and care arrangements if they need this
- Support individuals in crisis to remain at home through rapid and intensive supports, reducing unnecessary hospital admissions
- Have more effective working relationships with hospitals
- Support the development of a Discharge to Assess model to ensure nobody remains in hospital longer than needed, reducing the risk of unnecessary deterioration and maximising independence
- Enhance the development of specialist teams within North Lanarkshire Council:
    - Reablement and First Response
    - Intensive Support
    - End of Life Care
- Support all NLC staff to achieve SVQ2 by October 2020
- Provide choice and control to individuals who require ongoing paid support, with fair and unbiased information and advice to make the best choices
- Make the NLC service as competitive as possible, financially and operationally, providing a flexible, value for money option for those requiring ongoing support
- Respect staff skills and competencies, providing additional training opportunities and support for those wishing to develop a career in Health and Social Care. While the future form and volume of the in-house service will be shaped by service user demand, there will be no compulsory redundancies.

4. Conclusions

4.1 Home Support plays a crucial role in supporting individuals to remain at home, connected to their friends, family and local community for as long as possible. The new model of Home Support is a key element of the future integrated model in North Lanarkshire. Implementation of the new model will improve the outcomes that the service is able to deliver to people, improve system performance, meet requirements as they relate to relevant acts, policies and guidance and reduce projected increases in cost.

4.2 The new model focuses on the further development of in-house specialist services to maximise people's independence and support those with more complex conditions, including end of life care, within their own home.

4.3 The development of the specialist teams will help the service to future proof against the projected rising demand, whilst supporting the challenge of living within budget and achieving best value for the public purse.

4.4 The roll out of the SDS approach for those requiring ongoing paid support will create a more person centred approach in North Lanarkshire, where younger adults and families of children with a significant disability are already supported with an individual budget. As the uptake of older adult SDS increases the balance of support and care that will be provided through the in-house or other providers, will determine the level of recruitment of staff required in either sector.

5. Recommendations

5.1 Officers recommend that the IJB:

- Approves that the new model of care across the 5 areas of transformation:
    - **Integrated Model** (Discharge to Assess in Localities)
    - **Same Day Response/Reablement/First Support** (Intensive and time limited)
    - **Specialist Teams** (e.g. supporting people with frequently changing needs and end of life / Palliative Care)
    - **Ongoing Paid Support** (allocation of an individual budget to deliver individual outcomes as part of SDS)
    - **Quality Assurance** (improving standards of care)

- Requests an implementation plan is co-produced with staff and trade unions by April 2018
- Approves that all Home Support staff who choose to pursue their SVQ2 qualification are supported to do so by October 2020
- Agrees to monitor funding of the new Home Support model through the PFA Sub Committee and build in the financial projections outlined in appendix 1 (section 3.5) into the IJB's long-term financial plan
- Agrees to monitor the performance of the new Home Support model for 2 years through the PFA Sub Committee
- Requests ongoing engagement with service users through the implementation process and review stages of the new Home Support model