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Adult Social Services Review Panel Agenda

To: Councillor Louisa Woodley (Chair)

Councillors Margaret Bird, Pat Clouder, Yvette Hopley and Callton Young

A meeting of the **Adult Social Services Review Panel** which you are hereby summoned to attend, will be held on **Wednesday, 1 November 2017** at **5.00 pm** in **F10, Town Hall, Katherine Street, Croydon CR0 1NX**

JACQUELINE HARRIS-BAKER
Director of Law and Monitoring Officer
London Borough of Croydon
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Tuesday, 24 October 2017

Members of the public are welcome to attend this meeting.
If you require any assistance, please contact the person detailed above, on the righthand side.

N.B This meeting will be paperless. The agenda can be accessed online at www.croydon.gov.uk/meetings

AGENDA – PART A

1. Apologies for Absence

To receive any apologies for absence from any members of the Committee.

2. Minutes of the Previous Meeting (Pages 5 - 8)

To approve the minutes of the meeting held on 28 June 2017 as an accurate record.

3. Disclosure of Interests

In accordance with the Council's Code of Conduct and the statutory provisions of the Localism Act, Members and co-opted Members of the Council are reminded that it is a requirement to register disclosable pecuniary interests (DPIs) and gifts and hospitality to the value of which exceeds £50 or multiple gifts and/or instances of hospitality with a cumulative value of £50 or more when received from a single donor within a rolling twelve month period. In addition, Members and co-opted Members are reminded that unless their disclosable pecuniary interest is registered on the register of interests or is the subject of a pending notification to the Monitoring Officer, they are required to disclose those disclosable pecuniary interests at the meeting. This should be done by completing the Disclosure of Interest form and handing it to the Democratic Services representative at the start of the meeting. The Chair will then invite Members to make their disclosure orally at the commencement of Agenda item 3. Completed disclosure forms will be provided to the Monitoring Officer for inclusion on the Register of Members' Interests.

4. Urgent Business (if any)

To receive notice of any business not on the agenda which in the opinion of the Chair, by reason of special circumstances, be considered as a matter of urgency.

5. Learning Disabilities Mortality Review Report (Pages 9 - 12)

To acknowledge the progression of the Learning Disabilities Mortality Review Programme.

6. One Croydon Alliance (Pages 13 - 26)

Presentation of One Croydon Alliance Vision

7. ADAPT Programme Update Report (Pages 27 - 54)

An update on the development of the all Age Disability and Adults Programme of Transformation.

8. The Social Work Health Check (Pages 55 - 66)

Presentation on the Health and Care Professional Council Standards on the Social Work Health Check

9. Exclusion of the Press and Public

The following motion is to be moved and seconded where it is proposed to exclude the press and public from the remainder of a meeting:

"That, under Section 100A(4) of the Local Government Act, 1972, the press and public be excluded from the meeting for the following items of business on the grounds that it involves the likely disclosure of exempt information falling within those paragraphs indicated in Part 1 of Schedule 12A of the Local Government Act 1972, as amended."

PART B

10. Minutes of the Previous Meeting (Pages 67 - 68)

To approve the minutes of the meeting held on 28 June 2017 as an accurate record.

11. Adult Safeguarding in Croydon (Pages 69 - 74)

To update the Adult Social Services Review Panel on the key developments in Croydon relating to Adult Safeguarding.

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Adult Social Services Review Panel

Meeting held on Wednesday 13 July 2017 at 5 p.m. in Room F10, the Town Hall, Katharine Street, Croydon CR0 1NX

MINUTES – PART A

Present	Councillors Louisa Woodley (Chair) Councillors Margaret Bird, Pat Clouder, Yvette Hopley and Callton Young
Also present	Pratima Solanki, Director of ASC and Disabilities James Burgess, Head of Disability Commissioning and Brokerage Paul Richards, Principal Social Worker & Head of Mental Health Social Care, Croydon Integrated Adult Mental Health Services

MINUTES – PART A

A18/17 Minutes of the meeting held on Wednesday 26 April 2017

The Panel RESOLVED that the minutes of the meeting held on 26 April 2017 be signed as an accurate record of the meeting.

A19/17 Disclosures of Interest

No disclosures of interest were made during the meeting.

A20/17 Urgent Business

There was no urgent business.

A21/17 Adult Social Care and All Age Disability Care Update regarding Mental Health Services and the 3rd Sector

Officers introduced the agenda item. They explained that in February 2017, the CCG governing body took the decision to serve six months' notice on a number of initiatives (marked in yellow in the report), advising them that their services would be decommissioned. They also served six months' notice on a number of other services (marked in blue in the report), which were to be reviewed by the CCG before a re-commissioning decision was made. Officers added that an urgent meeting was subsequently held between council and CCG officers, and that it was agreed that meetings would be held with the affected providers to try and ascertain the impact of the CCG's funding reductions.

The Council have proposed to produce a scoping paper on proposed measures to limit the impact of the cuts. Members were advised that the Council's Gateway service would be involved in mitigation work to reduce the impact of these cuts on affected service users.

Officers highlighted the services which the CCG governing body have decided to continue funding in 2017-18, which are set out in paragraph 4.5 of the report. They also listed the services which the CCG have now decided to decommission:
- Imagine Drop-In service
- Rethink Carer Support Service

The Cruse initiative is also being decommissioned by the CCG but the Council have agreed to accept responsibility for the CCG's element of the funding.

Members were advised that the CCG governing body had now accepted the Council's recommendations. They expressed disappointment at the cuts brought about by the CCG, after expectation had been raised following increases in funding from central government.

It was observed that some of the services which have been cut had not been reviewed for a number of years, and that there had been no analysis of outcomes from these initiatives, or of potential service duplication. This was a particular issue with joint contracts. Members stressed the need to do this systematically in future and expressed the need for a clear strategic plan for mental health service provision, with its various elements fitting in with objectives in a logical fashion. They expressed concerns regarding the adhoc nature of proposals for efficiencies, and feared that ill-thought through cuts could end up bringing about higher service costs.

Officers remarked that the Outcome Based Commissioning initiative should bring about greater clarity in terms of outcomes and effective use of funding.

Members expressed concerns regarding the decommissioning of the MIND welfare benefits advice service. They highlighted the fact that the Woodley review had acknowledged the fact that financial problems could cause or exacerbate mental breakdowns. They were advised that the Gateway initiative could cover some elements of this service but could not replace it in its entirety, and that officers were exploring the possibility of identifying sources of council funding which could cover this service.

Members also discussed service reviews initiated by the South London and Maudsley NHS Foundation Trust, including that of services for dementia sufferers. They expressed the wish to find out the outcome of the consultation process on this specific review.

The Panel RESOLVED to note the contents of the report.

A22/17 **Shared Lives Update**

Officers described this scheme, whereby an adult in need of support and accommodation moves in with a registered Shared Lives carer and shares in the carer's home and community life. The scheme is funded from housing benefit.

Members were advised that in the summer of 2016, NHS England had made available a sum of money for CCGs and partner authorities to bid for match funding to expand Shared Lives into other innovative areas. Croydon had put forward a case for using Shared Lives with mental health sufferers during periods of crisis with support from SLaM to prevent hospital stays. Unfortunately, the bid was unsuccessful. However, Croydon CCG and the council recognised the fact that the business case was strong and that a reviewed proposal should be considered for funding through the Better Care Fund. This new bid has been successful.

Members were advised that a steering group was to be set up to implement the scheme, which lines up well with the outcomes of the Woodley Review.

Officers informed Members that housing staff in the council had good networks for publicising the scheme and recruiting Shared Lives carers into the scheme, and that the Shared Lives coordinator gave high level support to carers and service users. They added that it was in all partners' interest to make the service work well, including during periods of crisis, in order to reduce demand for psychiatric beds.

Members welcomed these positive news and asked to be provided with a small number of case studies to illustrate the effectiveness of this scheme. They also suggested that summaries of these might be published in the council's magazine.

It was suggested that an update on this scheme be presented at a future meeting of the review panel.

The Panel RESOLVED to note the contents of the report.

A23/17 **Adult social care & all-age disability in 2017-18: finance update**

The Director of Adult Social Care and All-Age Disability introduced this report.

She highlighted the vigilance of the division in identifying what social care budgets should fund and what the CCG should cover, particularly in relation to costs incurred when a patient is discharged from hospital.

Members were reminded that the divisional budget for 2017-18 was £108.150m, which includes growth of £4.9m to address the additional costs from 2016-17 and emerging new pressures. This has been funded largely through the 2017-18 Adult Social Care Precept of 3%.

The Director outlined the various elements of the Better Care Funding allocated to the council for 2016-17 and 2017-18. Members heard that new IBCF funding would be paid out in two tranches per year.

The objectives of the second tranche will be to:

- Meet adult social care needs
- Support hospital discharge, including the Out of Hospital Programme (OoH)
- Stabilise the social care provider market

Members were advised that £1.232m would be allocated in 2017-18 to the Out of Hospital business case, including the enablement service, thus helping patient to stabilise more swiftly on their return home. The following year, the sum of £2m (50% of the IBCF funding) is due to be allocated to this service, and another £2m in 2019-20 (100% of the IBCF funding for that year). However, challenges remain on identifying ways of supporting carers after hospital discharge.

Members discussed work to stabilise the social care provider market. Officers explained that they were working with the CCG and other healthcare agencies to set fair prices and observed that the care market was no longer financially profitable for some companies. Members heard that the London Borough of Sutton was working with the CCG, pharmacies and care support teams and visiting care homes to provide support at a sustainable cost, and that part of shaping the market would involve exploring new models of care and the possibility of offering a range of provision for different needs. Officers stated that this stabilisation work would be implemented through Outcome Based Commissioning, and that work would also be carried out with service users to help them make the right choices with their personalised budgets. All this work would be carried out as part of the Transforming Adult Social Care (TRASC) strategy.

The Panel RESOLVED to note the contents of the report.

Part A of this meeting ended at 6.20 pm

REPORT TO:	**ADULT SOCIAL SERVICES REVIEW PANEL** **November 2017**
SUBJECT:	**The Learning Disabilities Mortality Review (LeDeR) Programme in Croydon**
LEAD OFFICER:	**Caroline Baxter, Assistant Director, Adult Social Care & All Age Disability**
CORPORATE PRIORITY/POLICY CONTEXT/AMBITIOUS FOR CROYDON: This report is for information only	

1. RECOMMENDATIONS

1.1 The Adult Social Services Review Panel (ASSRP) is asked to note the contents of the report

2. EXECUTIVE SUMMARY

2.1. The Learning Disabilities Mortality Review (LeDeR) Programme is delivered by the University of Bristol. It is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. Work on the LeDeR programme commenced in June 2015 for an initial three-year period.

2.2. The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. It aims to guide improvements in the quality of health and social care service delivery for people over 18 with learning disabilities and to help reduce premature mortality and health inequalities faced by people with learning disabilities.

3. DETAIL

3.1. A key part of the LeDeR Programme is to support local areas to review the deaths of people with learning disabilities. The programme is developing and rolling out a review process for the deaths of people with learning disabilities, helping to promote and implement the new review process, and providing support to local areas to take forward the lessons learned in the reviews in order to make improvements to service provision.

3.2. The purpose of the LeDeR reviews is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and

professional regulation. It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them.

3.3. In order to do this in a timely manner and to avoid duplication, reviewers need to be clear where and how the LeDeR process links with other reviews or investigation processes.

3.4. Other investigations or reviews may include, for example: Serious Case Reviews (SCRs), Safeguarding Adult Reviews (SARs), Safeguarding Adults Enquiries (Section 42 Care Act) Domestic Homicide Reviews (DHRs), Serious Incident Reviews, Coroners' investigations and Child Death Reviews.

3.5. The LeDeR Programme will also collate and share the anonymised information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements.

3.6. A further part of the LeDeR programme is to conduct a series of additional projects. These are:

- Finding out more about the age and cause of death of people with learning disabilities in England by linking different data sets
- Finding out more about the provision of 'reasonable adjustments' for people with learning disabilities
- Providing better guidance so that the cause of death written on death certificates of people with learning disabilities is recorded in a consistent manner
- Establishing a collection of reports about people with learning disabilities from which we can learn more about commonly occurring problems.

3.7. The LeDeR programme in the London Borough of Croydon is being led and chaired by the Clinical Commissioning Group (CCG) in partnership with the Local Authority and other partners.
A Steering Group has been set up and will be chaired by Rachel Blaney from the CCG. Caroline Baxter, Assistant Director of All Age Disability is the Senior Responsible Officer in the Council. Once the Group has finalised its terms of reference there will be invitations to join offered to members of the local voluntary sector and the Learning Disability Partnership and parent carers.
Information has already been shared with the Voluntary Sector and Learning Disability

3.8. Partnership to ensure they are fully briefed as to progress and the scope of the programme. A presentation was delivered on the 9th of October.
Staff from the CCG, the Local Authority and Health Partners have attended training to become reviewers of any cases that should occur in Croydon.
Managers have also received training so that they can support reviewers.
As yet no deaths have been reported by Croydon but there is currently a review of deaths since April of this year to identify any cases that reach the criteria for the programme.

3.9. Data analysis of the Croydon population suggest that we can expect to review approximately 15 deaths per year.
Once a case has been reviewed the report will be sent to the University of Bristol to add to the data being collated nationally.
Locally the LeDeR Steering Group will review reports on cases and make recommendations, if appropriate on any themes identified.
Those involved in an LeDeR investigation process should not be involved in the direct care of those individuals affected and if possible not work directly with those involved in the delivery of that care.

3.10. When acting as a reviewer officers should act with impartiality – challenging the 'status quo' to identify system weaknesses and opportunities for learning while making decisions based on objective criteria.

3.11. The Reviewing Officer will inform the LeDeR Steering Group about each report that significantly impacts on or is affected by another investigation or review, sharing the agreed plan for data collection and providing the Steering Group with reports on progress and completion of the review.

3.12. The needs of the family and carers will be paramount and should receive careful consideration to avoid duplication of questioning and unnecessary upset.
The Croydon LeDeR Steering Group will report to Senior Officers locally and the Health and Well Being Board findings, themes and recommendations. Information will also be shared with other Boards or Committees that require updates.

3.13. There is a statutory requirement in the Children Act 2004 to review all deaths of children. More recently, the Department for Education document, 'Working Together to Safeguard Children' (2015) sets out the review process for the deaths of children, and requires Safeguarding Children's Boards to review the deaths of children who are normally resident in their area. Hence the LeDeR programme will only review cases of adults over the age of 18. There will though be the opportunity to share information around child deaths to track any themes that relate to adult deaths too.

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One Croydon Alliance

Presentation to Adult Social Service Review Panel
Rachel Soni – Alliance Programme Director

16 October 2017

Rachel.soni@croydon.gov.uk

OBC Alliance Vision

'Working together to help you live the life you want'

The Alliance ambition is to shift health activity from an acute setting which is reactive in nature to proactive and preventative health and care in the community.

Our Ambition is articulated in 3 main ways:

- **Personal Outcome Improvements**
- **Improved financial sustainability**
- **Activity Shift – right place, right time**

Health and care partners are committed to an ambitious programme of innovation and change to transform the way we support the people in Croydon to be independent and healthy for longer and be able to access high quality care when necessary.

We will work holistically to use our resources wisely supported by developments in digital technology, training and development of our workforce and improved communication and engagement to communities to empowering individuals to manage their physical, psychological and social care.

Our Ambition

Personal Outcomes Improvement

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Your Health and Care partnership

Personal Outcomes

The 5 outcome domain "I-Statements" set with us by residents of Croydon provide the centre of our shared ambition

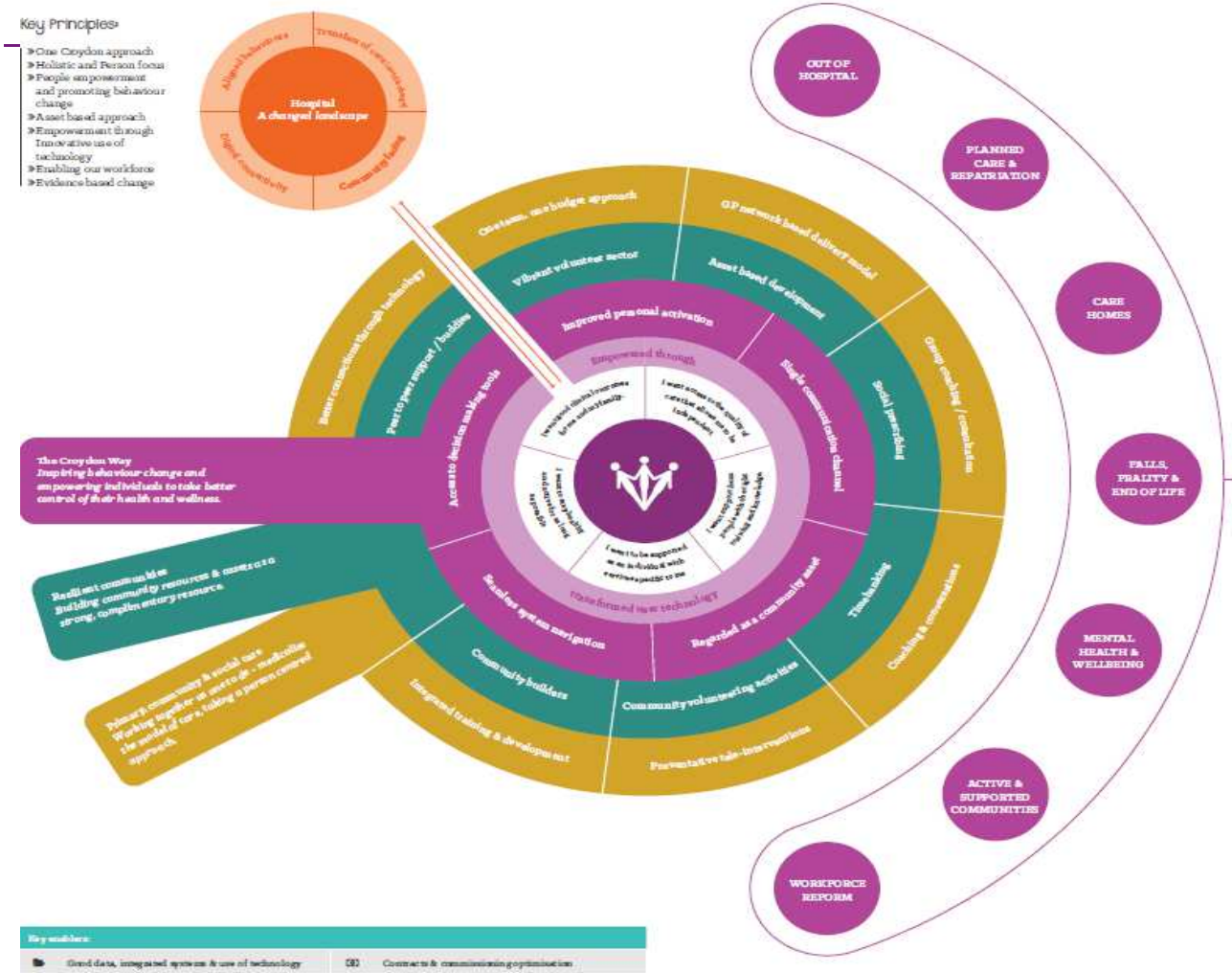
We aim to achieve the top quartile/decile status on the key outcomes as identified in the OBC outcomes framework during the term. We expect to achieve the outcomes that allows our people to achieve the best out of life.

1. I want to stay healthy and active for as long as possible	a) Injuries due to falls in people aged 65 and over b) Social care-related quality of life in people in the target population
2. I want access to the best quality care available in order to live as I choose and as independent a life as possible	a) Proportion of people who use services who have control over their daily life b) Proportion of people who use services who say that those services have made them feel safe and secure c) Emergency readmissions within 30 days of discharge from hospital for those aged 65 and over. d) - Proportion of people aged 65 and over who were still at home 91 days after discharge from hospital into re-ablement/ rehabilitation services.
3. I want to be helped by a team/person that has had the training and has the specialist knowledge to understand how my health and social care needs affect me	a) Proportion of patients and carers who report that they felt those involved in treating and caring for them worked well together to give them the best possible care and support b) Proportion of patients and carers who report that they have a named health or social care professional who co-ordinates their care and support c) Proportion of people who feel that the person acting as their first point of contact understands them and their condition d) Placeholder: Health equity audit is undertaken and published on at least an annual basis, with subsequent outcome aims identified and used as target indicators
4. I want to be supported as an individual with services specific to me	a) Proportion of people who said they were involved as much as they wanted to be in decisions about their care and support b) The proportion of carers who report that they have been included or consulted in discussion about the person they care for
5. I want good clinical outcomes	a) Rate of unplanned hospitalisations per 100,000 population aged 65 and over for chronic ambulatory care sensitive conditions b) Health-related Quality of life for people aged 65 and over c) Emergency admissions of people aged 65 and over for acute conditions that should not usually require hospital admission

Year 2-10 Transformation Plan

Key Principles:

- One Croydon approach
- Holistic and Person focus
- People empowerment and promoting behaviour change
- Asset based approach
- Empowerment through Innovative use of technology
- Enabling our workforce
- Evidence based change



Key enablers:

Good data, integrated systems & use of technology	Contracts & commissioning optimisation
Estates rationalisation	Primary care development
Stakeholder engagement & comms	Living conditions / housing
Workforce reform & organisational development	

Transformation scope & summary of key whole system changes:

Out of Hospital

Joined up proactive care in community where a person's wellbeing is managed holistically, caring for them physically, psychologically and socially.

- Development of Integrated Community Networks (ICN)
- Personal Independence Coordinators (PIC)
- Development of person centred 'My Life Plan'
- Community based points of access
- Integrated teams: Living independently for everyone (LIFE)

Planned Care & Repatriation

Delivering a holistic model of care, empowering people and promoting behaviour change.

- One website, one app
- Awareness and social marketing for both people & health/care workers
- Health coaching and lifestyle management
- Group consultation and group coaching
- Digital connectivity
- Enhanced primary care

Care Homes

A clear strategic approach to delivering holistic care to people in care homes.

- Commissioning and Pricing Strategy
- Contract Management Alignment
- Coordination of Support Services
- GP Alignment
- Technology
- Communications Strategy
- End of Life
- Shared Care Planning – Summary Care Plan
- Coordinated Workforce Development
- Pharmacy and Drug Strategy

Falls, Frailty & End of life

Promoting healthy living in over 65s: promotion, prevention and early intervention.

- Early Identification of Falls Patients
- Promoting Healthy Living in Over 65s
- Centralised and comprehensive Falls service and community bone health.
- Proactive case management and Osteoporosis Advice and Management in the Community.
- Medication Reviews
- Other Service Scope (e.g. Caseline, Telehealth, LAS, Counselling, Link with Care homes).

Mental Health & Wellbeing

Focus on improving quality of life, ambition and hope, not on illness and deficiency.

- Improving mental health urgent and crisis care
- Integrated delivery of care, frontline training and development
- Digital connectivity
- Transformed dementia diagnosis and holistic management
- Other areas: care homes and specialist care

Active & Supported Communities

Changing the way people consume, not just changing supply.

- Communication, engagement, information & advice
- Education & Workforce Development or Cultural Change
- Technologies
- Social Investment

Workforce Reform & OD

Enabling transformation and development of the local workforce to achieve the ambition of transformed delivery of health and care in Croydon.

- Training and development
- Role development
- Recruitment and retention
- Organisational culture and values
- Communication and engagement
- Croydon as a place to work

Out of Hospital

The beginning: *The New Model of Care*

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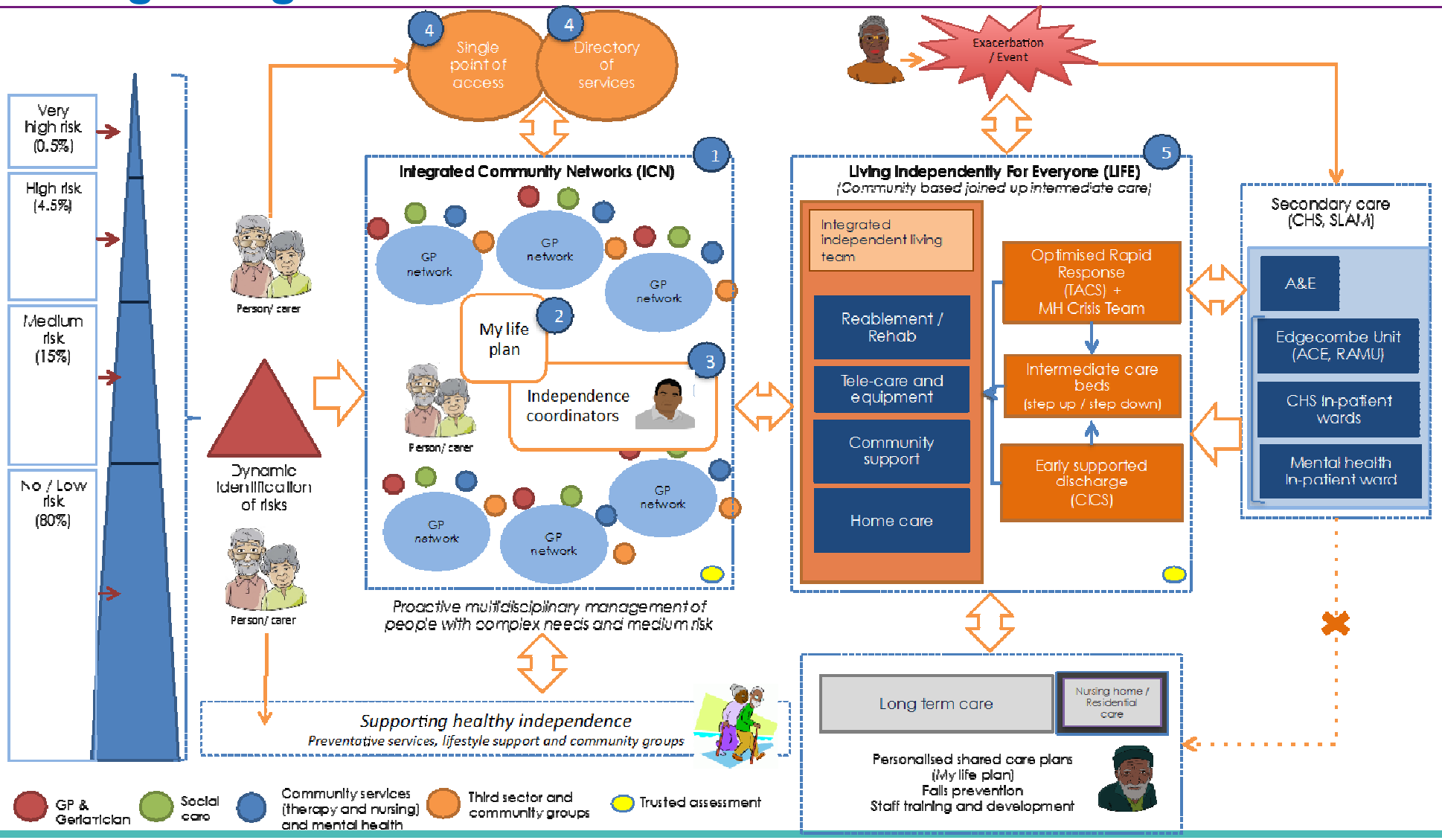

CROYDON www.croydon.gov.uk
NHS South London and Maudsley NHS Foundation Trust
Croydon GP Collaborative
NHS Croydon Clinical Commissioning Group
Croydon ageUK
Croydon Health Services NHS NHS Trust

Out of Hospital

Integrated Community Network Overview

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Integrated Community Network

1

Multi-Agency Working (MAW) and Huddles

1. Huddles held weekly for 30 minutes
2. Consist of Core ICN Team – GP, PIC, SCW, Community Nurse, pharmacist, VCS, & Network Facilitator.
3. Discusses, and case manages top 3 tiers of people in the Kaiser Triangle; v. complex, complex and medium risks

2

Complex Care Support Team (CCST)

1. Provides advice (9 – 5) and Case Management (one a month) of very complex people
2. Two CCST Hubs in the Croydon Network
3. Includes psychiatric nurse, frailty GP, geriatrician, community nurses.

3

Personal Independence Coordinators (PICs)

1. A member of the core ICN team, bringing together the voluntary sector and health and care organisations to support people over 55.
2. Independent of social services and the NHS, and not part of the person's family.
3. Works intensively with people with long term conditions,

Key Dependencies

Points Of Access and Information (POA&I) – prior to the start of each Huddle, a virtual or physical POA&I solution should be made both available and accessible to the Huddle and the Core ICN Team therein. Communications on the POA&I's scope and how to access should be made readily available.

My Life Plan MLP (MLP) – prior to the start of each Huddle, a MLP solution should be made both available and accessible to the Huddle and the Core ICN Team therein. Communications and training on how to access, create and update MLPs should be made readily available.

Galvanising Community Networks (GCN) – strengthening the formal and informal social networks, by encouraging the voluntary and community organisations who are commissioned to provide preventative services to Croydon residents to work together to find new ways of developing services and/or activities that meet the growing and changing needs of a diverse population within each of the ICNs

6. Transition Workstream Update

6.2.1 Y1 Transformation Delivery - ICNs

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WORKSTREAM STATUS SUMMARY	Executive Lead: John Chan	Workstream Lead: Rachel Soni

a) Progress Against Plan

RAG:

The overall ICN programme is Green. The Re-sequenced & Accelerated Multi-Agency Working (MAW) & Huddle Delivery Plan was created and agreed in August 2017. Delivery of this plan within the timelines will realise financial savings as indicated in the agreed Business Case. 8 Huddles have now implemented with another 4 scheduled week commencing 16th October, and each subsequent week thereafter. Pilot evaluation completed. Carrying out activities to reaffirm Organisational Development (OD) and operational best practice with the Core ICN Teams and the ICN PMO, via GP Network, Practice and workforce meetings. POA and Complex support work is progressing well but slightly behind schedule.

Deliverable/Milestone Status & Progress Summary

MILESTONE	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
MAW & Huddles: GP Comms, Facilities, & Tech Audit	4th						
MAW & Huddles – Implementation **START**		2nd					
MAW & Huddles – Implementation **ENDS**							5th
Complex Care Support Team (CCST) – Model Requirements	13th						
Complex Care Support Team – Detailed Design						28th	
My Life Plan (MLP) – Implementation	11th						
PICs – Recruitment Ends					15th		
Points of Access & Information					22nd		
POA&I – Mayday and Thornton Heath Implementation		30th					
Active & Supportive Communities – Detailed design	4th						

1. Re-sequenced and Accelerated implementation plan agreed - savings and investment tracking plan developed
2. ICN & Huddle roll-out proof-of-concept evaluation & readiness assessment complete and reported with ongoing work on patient feedback with Healthwatch. Included IT and facilities audit – completed.
3. IT and facilities Requirements and Business Case Completed, 25/08 and 26/09 respectively. Sent to CSU for CSU Project Support and costing 27/09
4. PIC's Recruitment – 1 PIC Service Manager engaged, ex front line PIC. 6 PIC' (Inc. 1 backfill PIC) & 1 support worker recruited. AgeUK Croydon's continuing recruitment advert for the remaining 6 PICs for January 2018.
5. Network Facilitators Recruitment – 3 recruited (now totalling 4). Continuing recruitment advert for the remaining 2 Network Facilitators for January 2018
6. CN pharmacists – 3 people recruited starting late Nov '17. Additional 3 to start Jan '18
7. Community Nurses recruitment - successfully completed
8. CCSS - modelling & referral process re-work meetings taking place with specialist teams
9. Active and Supportive Communities engagement with voluntary and community sector ongoing

b) Decisions, Interdependencies, Risks & Issues

1. Decision/ Discussion/Noting required by Programme Delivery Board (PDB)

None required.

2. Workstream interdependencies:

a) IT and Facilities requirements in place in time to support delivery of huddles

b) All core huddle staff member recruited and in place in time for huddle rollout

3. Risks to the critical path of this Workstream:

a) **Technology & Facilities - There is a risk that the Practice meeting rooms may not meet the minimum requirements to facilitate face-to-face and remote Huddles . | Mitigation: the project team has completed an audit of the practices. Business case to be prepared for additional equipment. Workaround : Core ICN Team to continue to have face-to-face meeting and working from hard copy worksheets.**

b) **There is a risk that the Huddles may not be fully resourced by the ICN Core Team. | Mitigation: Network Facilitators to be supported in the interim by OBC PMO. Medical Optimisation Team to support face-to-face in Mayday ICN & support by Best Endeavours until fully resourced in November 2017.**

4. Issues impacting critical path of this Workstream:

a. **There is a Issue that that the reviewed and agreed IG documents between the GP Collaborative, practices & the Alliance will not be in place before the launch of the huddle rollout. | Mitigation: CSU IG specialist has advised that the explicit patient consent on who data is being shared with is appropriate as a work around if all info & legal documents are not in place. IG Documents currently in review by Legal Department for compliance, prior to distribution to practices for sign off.**

b. **There is an issue that the Point of Access and Information hub for Mayday and Thornton Heath Networks and the** Active & Supportive Communities detailed design solution **will not be in place until March. | Mitigation: Meeting held on 28/09. Discussed proposed process and model re: six Locally Trusted Organisations (LTOs) aligned to each of the networks. The design will include how the physical points of access will support LTOs. Develop the LTOs to a certain standard. Define the development role, agree standards and costs. This is a key enabler workstream for ICNs, so new plan timescales need to be met.**

Out of Hospital

Living Independently for Everyone - LIFE Overview

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'As Is':

- Limited referral pathways;
- High hospital admissions (non-elective);
- High use of bed days;
- Delayed discharge;
- Multiple assessment and referral points (case studies suggest up to 20)
- Large domiciliary care packages which are not always reviewed (overall cost of £13m approx.)

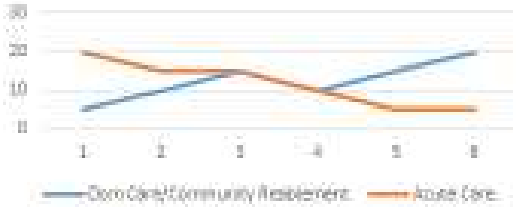
- **'One Name, One Budget, One Team':** A team providing intermediate care and reablement services plus other reintegration support to the over 65s of Croydon;
- **One core eligibility criteria:** to 'unblock' pathways and minimise assessments and referrals;
- **All services working to the same key outcomes;**
- **Making sure the correct services are being used most efficiently**
- **Creating more opportunities for client outreach**

Multiple points of entry (examples below)

'To Be':

- Decrease in non-elective hospital admissions;
- Decrease in bed days;
- Increase in smaller domiciliary care packages; (increase in larger) and community reablement
- Increase in wider community interventions;
- A cultural change around the need for domiciliary care;
- A sustainable single system;
- Increased range of entry pathways;
- Unblocking of community and environmental barriers

Changing the Profile of Acute and Community Care



Best case saving of 15.00 bed days (approx.) and 44 beds by year 10*

*Figures from MoC overarching document

6. Transition Workstream Update

6.2.2 Y1 Transformation Delivery - LIFE

One Croydon
Your Health and Care partnership

WORKSTREAM STATUS SUMMARY	Executive Lead: John Chan	Workstream Lead: Rachel Soni

a) Progress Against Plan

RAG:	Workstream Green 60% completed. Discharge to assess started on 3 wards on 25/09/17. 21 referrals have successfully been supported within 2 hours of discharge Roll out plan being developed

Deliverable/Milestone Status & Progress Summary

MILESTONE	AUG	SEPT	OCT	NOV	DEC
Community Reablement	1st				
Reablement Procurement North		25th			
Service/Process Mapping		5th			
LIFE Team recruitment				16th	
Single Assessment Form		5th			
Single Accommodation for LIFE team			1st	1st	
Telehealth, Telecare and equipment Business Case		30th			
OT Review		1st			
Staff consultation			13th		
Performance and Savings Tracker	14th				
D2A pilot three wards		25th			
D2A full rollout (April)					

1. Part B assessment completed 100%
2. Reablement Procurement North – 100% (monitoring dashboard still to be developed)
3. OT review to start October
4. Telehealth, Telecare review competed
5. Agreed banding for the joint LIFE manager, advert out 16th October
6. 5 health and wellbeing post advertised, 1 admin 16th October

b) Decisions, Interdependencies, Risks & Issues

1. Decision/ Discussion/Noting required by Programme Delivery Board (PDB)

a) PDB are asked to note the updated LIFE Implementation Plan [see slide 7]
b) Lack of project support, due to recruitment of a Change Manager

2. Workstream interdependencies:

a) IT and Facilities - Lennard Road has been identified as the LIFE office however staff needed to be moved to make space for LIFE Team. Develop Mobilisation plan. Planned move 1st November
b) Staff consultation requires sign off from the Transforming Out of Hospital delivery group
c) Service baseline to be agreed

3. Risks to the critical path of this Workstream:

a) Technology and facilities - the service will have to use both AIS and EMIS double entry) recruiting an admin person to upload the health assessments on AIS.
b) Allocations and understanding demand
c) Roles of the staff still to be defined
d) Delay with the staff consultation, due to agreement over staff weekend working
e) Health & Well being Assessors recruitment
f) That the Community Reablement Service, when located with the LIFE service, will lose it's preventative focus and instead be used to take on more people upon discharge from hospital
g) Social workers accessing equipment

4. Issues impacting critical path of this Workstream:

a) IT – accessibility to WIFI and internet at Lennard Road, may delay staff co-location specifically for Croydon Council staff

Out of Hospital

Discharge to Assess (D2A) Pathways *LIFE Services are playing a key role the delivery of D2A*

One Croydon
Your Health and Care partnership

D2A Model

Hospital Discharge (Pathways)

1

People who require no further input. Further needs can be met at individuals home setting

Advice and Information needed

Equipment telecare / telehealth needed

2

People will return home with Reablement / Intermediate care

Intermediate care beds or step down beds

Up to 6 weeks

Reablement/ LIFE team

Up to 6 weeks

3

People with complex care needs which may need continuing care, Step down beds
Residential nursing Care, including specialist placements

Complex situations / CHC Long term

Escalation

People with complex needs difficult to place within funding allocation
Could include; Clients with no access to funding, Homeless, Out of area

Escalation for Bespoke solution or leverage

Funding Sources

Self Fund / Self Care at home

LA Funded home care

LA Funded or Health

LA Funded & Health

CHC Funded Care or LA Funded care/ assessment for self funding or combination

Can be unclear/ undefined

SAFER Bundle

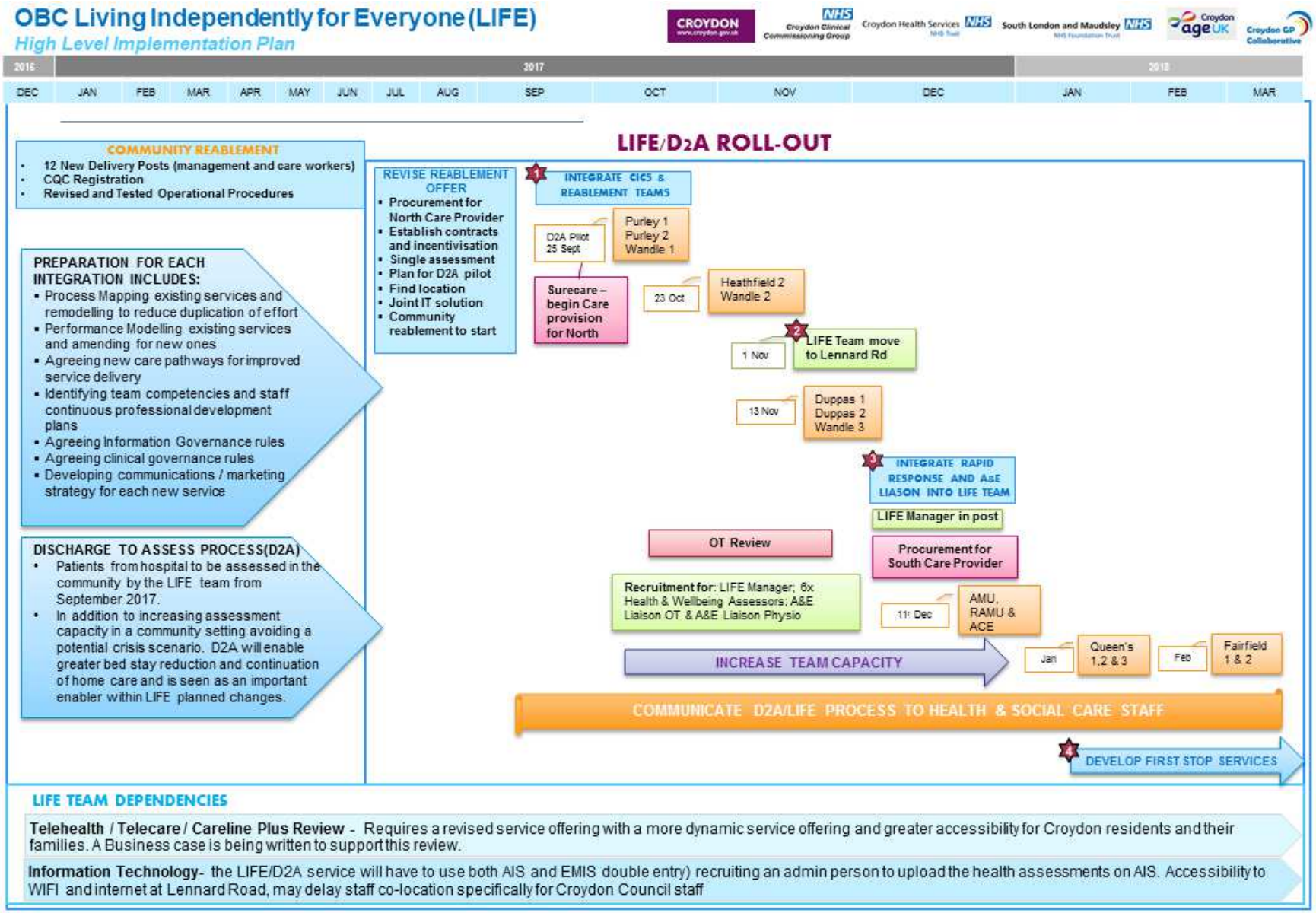
Scope of LIFE Services
£1.2m for reduced LoS

Pathway 3 in development

6. Transition Workstream Update

6.2.2a Y1 Transformation Delivery – LIFE: Update Implementation Plan

One Croydon
Your Health and Care partnership

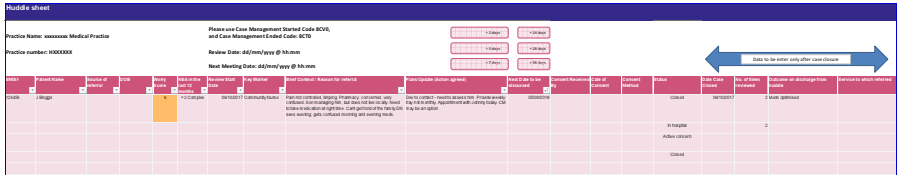


Snapshots of the trackers being rolled out for performance and activity tracking

Your Health and Care partnership

Huddles activities and outcomes trackers

		ICN Core Team Attendance (if more than 1 member of a discipline attends, only enter the number 1)												
Wk	Huddle Date enter dd/mm/yyyy	Total Cases	GP:	Community Nurse:	Social Worker:	PIC:	Pharmacist:	Network Facilitator:	Total	Percentage Attendance	Admission Avoided	New Cases	F/U Cases	Cases Closed	Cases Open
1	06/10/2017	1	1	1	1	1	1	1	6	100%		1	0	1	0
2	13/10/2017	0	1	1	1	1	1	0	6	100%		0	0	0	0
3	20/10/2017	0							0	0%		0	0	0	0
4	28/11/2017	0							0	0%		0	0	0	0
5	05/12/2017	0							0	0%		0	0	0	0



LIFE activities and outcomes trackers

Client - identification & channel							Activities			Savings drivers - Reduced Activities			
							LIFE	Rapid Response	A& E Liaison				
Service User ID	AIS number	NHS Number	Age	Source of referral Community/ CICS/Rapid/A&E+Q1:Y 1	GP Practise	Discharge to Assess	Episode Start Date	Diagnosis 1	Date of referral	Package reduction (No. of Hours/week)	Admissions avoided	Prevention going to Res /Nursing	Early Discharge
	2244954			Community									

Huddles Performance monitoring tracker

		Activities			Outcomes -Monthly guidances			
Practise	Network	Huddles per month (1 Huddle -30 minutes)	Cases monthly	Persons supported monthly	No cases reviewed monthly	No. of admissions avoided	No. of new cases	Huddles person who appear for NE Admissions
Brigstock and South Norwood Partnership	Mayday	4	32.8	10.8		7	26	
Eversley Medical Centre	Mayday	4	32.8	10.8		5	16	
London Road Medical Practice	Mayday	4	32.8	10.8		2	9	

Person journey tracker – cuts across LIFE & ICN

Client identification													Sources of referral		Gateways of Care	Pathways /Services		
Identifiers						Age & Demographics			Health			Social Care						
Service User ID	AIS number	ICD /Reed code	Network	GP Practise	NHS Number	Age	Gender	Network Location	Long Term condition	Risk Level	No. of hospital admissions /year	SALT codes	Level 1	Level 2		Team	Level 1	Level 2

Comments, Suggestions and Questions

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REPORT TO:	**Adult Social Service Review Panel** **1 November 2017**
SUBJECT:	**Adapt Programme update**
LEAD OFFICER:	**Pratima Solanki**
CABINET MEMBER:	*Councillor Louisa Woodley* *Councillor Alisa Flemming*
WARDS:	**All**

CORPORATE PRIORITY/POLICY CONTEXT/AMBITIOUS FOR CROYDON:

The all age disability and adults programme of transformation (ADAPT), builds on the transformation of adult social care (TRASC) programme (Cabinet report – January 2016); and now incorporates the all age disability service.

The community strategy priorities this programme links with are:

Outcome 2 a place of opportunity for everyone

- **Priority 2**: support individuals and families with complex needs

Outcome 3 a place with a vibrant and connected community and voluntary sector

- **Priority 2**: build cohesive and strong communities, connecting our residents, local groups and community organisations
- **Priority 3**: strengthen and mobilise our voluntary, community and social enterprise sector

FINANCIAL IMPACT

The savings and growth identified with the ADAPT programme impact on the People Department budget setting for 2018/19, and for 2019/20.

FORWARD PLAN KEY DECISION REFERENCE NO.:

N/A

1. **RECOMMENDATIONS**

1.1. Members of the Adult Social Service Review Panel are asked to note the developing themes of the ADAPT programme; and identify the date for a future update report.

2. EXECUTIVE SUMMARY

2.1. The purpose of this report is to provide an update on the development of the all age disability and adults programme of transformation (ADAPT).

2.2. The ADAPT programme (transformation phase two) follows the closure of the Transforming Adult Social Care (TRASC) programme (transformation phase one).

2.3. The core focuses of the ADAPT programme will be:

- A service that integrates with health where it makes sense to the end user
- A shift in resources into prevention and away from institutional care and around wider well being
- A greater emphasis on 'Whole family' and solution focused approach with wider colleagues such as Gateway and Housing

2.4. The two year ADAPT programme will be delivered through a divisional programme management office, focussed on transforming and integration of pathways alongside the identification of 2018/19 and 2019/20 savings.

3. MOVING TO PHASE TWO OF TRANSFORMATION

Transforming Adult Social Care (TRASC)

3.1. The Phase One (TRASC) programme was put into place to enable development of the following:

- **'A life not a care plan'** – Projects to enable better communication, engagement, culture and enabling our workforce
- **A new model of adult social care** - Getting the basics right, designing and implementing an operating model to deliver a personalised approach, AAP, AAD, enabling the new model with Gateway, data and ICT infrastructure.
- **A financially sustainable model of adult social care** – managing supply and demand, financial control, value for money and efficiency savings.
- **Commissioning for personalisation** – market facilitation for direct payments, care home market management, supported living accommodation and much wider market growth.

3.2. The focus during the period 2016/17 was managing demand through a set of projects as signed off and agreed. Getting the basics in place relating to workforce/practice/process and people.

3.3. Alignment of some of the business processes and wider projects which are on-going will be required to be rolled into the ADAPT programme as below –

- Resource Allocation System – Initial implementation in place (electronic Pathway implementation to roll into 2017/18 programme of work)
- Self-assessment on-line (underway – not yet implemented)
- How can the Council help you (underway – not yet implemented)
- Reablement (underway – part of Community Reablement).
- Communication and Engagement – underway.

All Age Disability and Adults Programme of Transformation (ADAPT)

The Rationale

3.4. The ADAPT programme (phase two) is about ensuring a sustainable future for services in Croydon. It will continue with the delivery of TRASC projects, whilst ensuring all projects underway and / or emerging, should where relevant progress against the objectives of the Croydon Alliance. This will contribute to the successful development of an integrated service of the future and include:

- Alignment to the integrated health and social care programme
- Activity will be based on multidisciplinary and integrated teams of support
- The creation of integrated services that will bring systems and processes together to maximise skills / budget / support services to the public
- Working closely with and managing relationship with the voluntary sector / providers / mental health services / acute and primary care
- To create an adults and all age disability (A&AAD) service that will focus the resources and energy across the whole population in the here and now; and also the projection of the population requiring health and social care services in the future
- Development of a shared care record across health and social care and full utilisation of electronic pathways and digital service provision wherever possible
- To establish a full population profile of the people within the A&AAD function to identify cohorts for planning around complex health or care needs in the future
- To continue to be aligned to discussions relating to joint budgets and integrated commissioning arrangements where A&AAD functions are needed
- To ensure the workforce are agile, trained, flexible, passionate and committed to new ways of working to take forward the changes required

3.5. Important to note, is that demand management within an operational statutory function is business as usual, that can be managed on a day to day basis through

the middle management structure and overseen through the strategic direction of the Senior Management Team.

3.6. The ADAPT programme will look to further develop opportunities that are presenting within the customer journey pathway and view the opportunities through the emerging Croydon Alliance work streams, to ensure the adult and all age disability function is in a strong position in terms of its infrastructure.

3.7. There are clear areas where work has already been completed under the (TRASC) phase one 2016/17 project development. During the remainder of 2017/18 ADAPT will strengthen, realign and integrate these projects in view with the wider integration agenda and realise the savings attached to them.

3.8. The ADAPT programme will need to map out all of the flows from first point of contact to end of life pathway across A&AAD; to alleviate any inconsistencies within the process. This is also the baseline for integration (each partner knowing every inch or their current pathways).

3.9. It will enable the production of very clear roles and responsibilities to the workforce and to ensure that people living in the London Borough of Croydon understand what is the core offer available relating to statutory services.

3.10. Through the delivery of robust information and advice provision, which is a key area of development, services will be required to concentrate key messaging to the public around choice, control, personalisation and maximising independence to reduce dependence on statutory services.

3.11. There will be a continued whole systems approach, and be prepared for the longer term integration work with partners.

3.12. Crucial in how the ADAPT programme develops transformation into business as usual, will be to develop and provide the workforce with appropriate tools to do their job. There is a lot to do and resources will continue to be scoped to move projects forward with a tenacious approach and strong communications.

Implementing the ADAPT programme in 2017/18 and beyond

3.13. Implementing the ADAPT programme is the first priority for the A&AAD function in the next 6 months. This includes:

- Delivery of the savings agreed during 2017/18 and moving over a number of projects from the original TRASC programme which have not been completed over into phase two programme for implementation, and realisation of benefits.
- Developing and delivering the 2018/19 and 19/20 transformation proposals

through rigorous project initiation documents, and where relevant validated through partners in finance, HR and legal; and moving these into full Initiation and delivery phase.

- Implementation of a monitoring and governance system that is transparent and inclusive and communicates fully with the workforce each stage of the way.

3.14. A programme office will be staffed appropriately with a blend of staff calling on system expertise externally only when necessary.

3.15. Implementation will be owned through designated senior responsible officers (SROs) at head of service level.

3.16. Implementation of projects will be monitored by a programme Board; and report by exception risks / issues / success and financial measures.

3.17. The programme will clearly communicate to the workforce and stakeholders in a timely way; and be clear on roles and responsibilities.

3.18. The programme will accelerate implementation and identify any quick wins that could potentially be delivered within 2017/18.

3.19. Proposed Time Line

Scoping - April to July 2017

- Scope of the original TRASC programme; savings achieved, review of work streams and outcomes
- Scope of the programme for 2017/18 outlined
- Build of governance and structure to agree and support projects
- Senior Management Team to consider 2018/19 proposal development
- Implementation of 207/18 saving proposals

Proposals development - July 2017 to December 2017

- Development of savings proposals and plans for 2018/19; 2019/20
- Agreement of governance for project working groups to move forward with working up draft proposals
- Clear understanding of programme reporting / milestones

Decision making - October 2017 to December 2017

- Decision making process mapped and in place – dates / requirements / proposals / consultation period / budget / people mobilised
- Meetings progressed and relevant documentation produced / consultations
- Governance and decision making structure progressed for agreement

Implementation – April 2018 onwards

- Projects begin and allow full year savings to be made
- Appropriate governance followed

4. 2018/19 & 2019/20 – KEY AREAS OF FOCUS

4.1. The ADAPT programme is currently working on transformation and savings proposals within the following areas. Growth and savings analysis is due for executive review at the end of October. Following approvals, worked up project initiation documents will be presented for sign off to next ADAPT programme Board.

Transformational areas

- 25-65 disabilities operations transformation
- A new offer on how people spend their time - Day services
- Over 65s – The Alliance and outcomes based commissioning

Efficiency

- Staffing transformation – reducing silos and management
- Mental health
- Commissioning and contracting

Managing within our means

- SEND – creating a strategy to reduce the overspend

5. CONSULTATION, CO-PRODUCTION AND CO-DESIGN

5.1. In line with statutory requirements and corporate guidance, the ADAPT programme Board will sign off a communications and engagement plan. This will ensure equality impact analysis, communications, engagement and consultation is understood across the 'full view' of the adults and all age disability services.

CONTACT OFFICER: Pratima Solanki, Director of Adult Social Care and All-Age Disability. Ext 64062.

APPENDIX: ADAPT Programme Presentation Slides

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Adults and All Age Disabilities

Presentation to Adult Social Service Review Panel

Adapt Programme

November 2017

Pratima Solanki & Richard Eyre

CROYDON
www.croydon.gov.uk

Objectives and Purpose

- The purpose of this presentation is to update ASSRP on the ideas being analysed to secure a sustainable future for adults and all age disabilities services.

- It follows a review of our current expenditure and how through transformation we can create better outcomes for people and sustain care and support for our most vulnerable population.

- This model builds on the Transformation of Adult Social Care (TRASC) Programme (Cabinet report – January 2016) and now incorporates the All Age Disability Service.

National Context

A nationwide crisis in Adult and All Age Disability

- Market
- Workforce
- Funding
- Health economy

CQC – State of Care 2017 report

www.cqc.org.uk/publications/major-report/state-care

Service Context

The Adult and All Age Disability service undertakes the Council's statutory functions with regard to:

- Children and young people and their families with regard to special educational needs and disabilities
- Adults including their carers between the ages of 25 and 65
- Older people 65+ and their families
- Adults with Mental Health and their families
- Safeguarding adults who are at risk from harm

This is done through legislation such as The Children and Families Act, Children with Disabilities Act and The Care Act.

A New Direction

- A significant shift we need to make going forward is one that shifts from the council of last resort to first resort
- A service that integrates with health where it makes sense to the end user (2020 Challenge)
- A shift in resources into prevention and away from institutional care and around wider well being
- A greater emphasis on ‘Whole family’ and solution focused approach with wider colleagues such as Gateway and Housing

Links to the Community Strategy

Outcome 2 - a place of opportunity for everyone

Priority 2: support individuals and families with complex needs

Outcome 3 – a place with a vibrant and connected community and voluntary sector

Priority 2: build cohesive and strong communities, connecting our residents, local groups and community organisations

Priority 3: strengthen and mobilise our voluntary, community and social enterprise sector

Key Strategic Objectives

GROWTH	INDEPENDENCE	LIVEABILITY	ENABLING
To create a place where people and businesses want to be	To help families be healthy and resilient and able to maximise their life chances and independence	To create a place that communities are proud of and want to look after as their neighbourhood	To be innovative and enterprising in using available resources to chage lives for the better
To enable more local people to access a wider range of jobs	To help people from all communities live longer, healthier lives through positive lifestyle choices	To make parks and open spaces a cultural resource	To have the right people with the right skills in the right jobs
To grow a thriving and lively cultural offer which engages communities and supports regeneration	To protect children and vunerable adults from harm and exploitation	To create a place where people feel safe and are safe	To drive fairness for all communities, people and places
To enable people of all ages to reach their potential through access to quality schools and learning	To help families and individuals be more financially resilient and live affordable lives	To build a place that is easy and safe for all to get to and move around in	To be digital by design in meeting the needs of local people
To provide a decent, safe, and affordable home for every local resident who needs one	To prevent Domestic Abuse and Sexual Violence where possible, support victims and hold perpetrators to account	To improve wellbeing across all communities through sport and physical activity	To be open and transparent and put communities at the heart of decision making

Key Principles of Creating a Sustainable Future

- Embrace personalisation
- Focusing on individual outcomes with people living as independently as possible leads to better outcomes for them, safer options and better value for money - ‘a Life, not a Care Plan’
- Corporate working is crucial
- Need for a strong and capable commissioning function which understands and works with adult social care
- Must have well led, professional and strong operational function which focuses on performance, money and safeguarding
- Finance business partners who will challenge DASS as well as provide high quality and timely financial advice
- Deliverable savings and good implementation arrangements
- If we get this right the following proposals are achievable

2018/19 & 19/20 - Key Areas of Focus

Transformational areas

- 25-65 disabilities operations transformation
- A new offer on how people spend their time - Day services
- Over 65s – The Alliance and outcomes based commissioning

Efficiency

- Staffing transformation – reducing silos and management
- Mental health
- Commissioning and contracting

Managing within our means

- SEND – creating a stategy to reduce the overspend

In Addition Tackling Other Financial Well Being

Income

- Better systems that ensure we maximise income at all levels

Debt

- Ensuring we tackle debt earlier on

Charging

- A revised Charging Policy ensuring compliance with short, medium and longer term recommendations

Self Funders

- Improving our information and advice offer to self funders to ensure appropriate care and support used

Staffing Transformation

Purpose: Review agency staffing, divisional structure, and senior management structure. Identify efficiencies and new ways of working.

Key Objectives

- Reduction in agency staffing
  Enablers: recruiting permanent staff

- New senior management structure
  Enablers: bring together functions to reduce and alleviate the number of hand off points

- New divisional structure
  Enablers: enhance the configuration of the teams and strengthen the consistency required in approach to service delivery

25 - 65 Disabilities Operations Transformation

Purpose: To ensuring quality services, timely and appropriate access, an effective customer journey and most efficient use of resources.

Key Objectives

- Prevent, reduce, delay access to social care provision
  Enablers: community assets; improved "front door"

- Increase independence, choice and control
  Enablers: direct payments, accommodation, employment

- Improve outcomes for customers
  Enablers: commissioning and contracting, market development, culture and OD, practice development

- Specific spending reviews completed including non statutory spend

Over 65s

Purpose: review the current reablement and rehabilitation referral pathways. Savings through robust contract management and improved contract performance.

Key Objectives

- Reduce long term care packages through targeted reablement activity
- Dynamic purchasing system for care homes, regularising control and spend
- Service redesign of extra care
- Mitigate income loss through improved timings of financial assessment

The key enabler will be the agreement of risk share mechanism in the OBC business case and contractualisation within the 2-10 Alliance agreement. It will establish an Alliance approach to whole system savings, enabling success in a way that does not destabilise partners.

Mental Health

Purpose: Strategic collaboration regarding joint funding with health partners; enabling best use of budgets for mental health services users.

Key Objectives

- Agreed strategic approach to funding arrangements across LA and CCG
  Enablers: joint commissioning intentions, S117 funding policy & protocols

- Increase the number of people with mental problems in employment
  Enablers: spend delivery arrangements between statutory and VCS

- Increase uptake of direct payments
  Enablers: needs based flexible approaches, market facilitation

- Reduce over provision and improve approaches to step-down services
  Enablers: options and cost benefits of specialist staff, with clinical input

Day Services

Purpose: Enabling alternative, creative ways of providing interesting, stimulating day / evening opportunities for people with a disability/ASD. Also to increase the uptake of direct payments for disabled people.

Key Objectives

- Establish the current state of the day service market in Croydon
  Enablers: attendance and care plan data, unit costs and direct payments

- Market analysis of day services
  Enablers: Co-design of support plans and services; transport costs

- Options appraisal
  Enablers: 2 FTE social workers co-produce with providers and users

- Review of support packages
  Enablers: Independent advocacy, alternatives to day centre activities

Commissioning and Contracting

Purpose: primarily to support and contribute to the delivery of £4million of efficiencies from the 25-65 purchase budget.

Key objectives

- Review support to frontline staff pre-complex care panel; & review panel
  Enablers: Staff feedback

- Build on High Needs Team success; embed practice in wider commissioning
  Enablers: engaging the market

- Improved contractual governance and targeted contract monitoring
  Enablers: Improved placement support and pre-panel support from operational commissioners

- Re-structure of commissioning teams
  Enablers: 0-65 contract and commissioning pilot, staffing transformation

SEND

- Three key pieces of work are underway:
  - Internal Audit on current spend and control systems
  - PPL 5 Year Forecasting programme using DfE Grant
  - EY analysis of the DSG Spend and recommendations
- All three will be delivered by end of November 2017 and need to form a strategy to reduce expenditure in 2018 onwards.

Protected Areas

In making these proposals the following areas have been protected:

- Safeguarding
- SEND
- Transformation & clienting

Next Steps: October 2017 – March 2018

- Programme Management Office established
- Adapt Programme Board launches 23 October
- 2 Year programme plan in development

- 17/18 savings plans being worked into new PIDs
- 18/19 &19/20 PIDs to be validated by finance
- Partnership development with key VCS
- Programme co-production offer being designed
- Staff and service users communications and engagement plan

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The Social Work Health Check

SMT Briefing 5th October 2017

Paul Richards

Principal Social Worker

CROYDON
www.croydon.gov.uk

WHAT is the Social Work Health Check?

The HCPC Standards for Employers of social workers states: ‘all employers should complete, review and publish an annual health check or audit to assess whether the practice conditions and working environment of the social work workforce are safe, effective, caring, responsive and well-led.’

WHY do the Social Work Health Check?

The health check and development tool is an important barometer of workflow and barriers to effective practice. Doing it annually allows employers to track progress as they work on implementing the Standards and good practice. It also means that problems can be picked up and addressed in a timely fashion rather than becoming entrenched and creating a negative culture.

The tool can be used as part of an employer's retention and recruitment strategy because it means social workers feel that they are listened to and that the employer is pro-active in tackling the issues that affect them at the front-line.

It is also a way of enabling employers to provide a well led professional environment as well as enabling social work professionals to maintain their professionalism and to practice more effectively.

The health check also supports openness and accountability by providing a regular snapshot to the organisation's leaders about workflow and organisational issues.

HOW do we do the Social Work Health Check?

The Social Work Task Force originally devised the Health Check as a series of 39 Steps now grouped into the 8 HCPC Standards for Employers

1 **Clear Social Work Accountability Framework**
Employers should have in place a clear social work accountability framework informed by knowledge of good social work practice and the experience and expertise of service users, carers and practitioners.

2 **Effective Workforce Planning**
Employers should use effective workforce planning systems to make sure that the right number of social workers, with the right level of skills and experience, are available to meet current and future service demands.

3 **Safe Workloads and Case Allocation**
Employers should ensure social workers have safe and manageable workloads.

4 **Managing Risks and Resources**
Employers should ensure that social workers can do their jobs safely and have the practical tools and resources they need to practice effectively. Assess risks and take action to minimise and prevent them.

5 **Effective and Appropriate Supervision**
Employers should ensure that social workers have regular and appropriate social work supervision.

6 **Continuing Professional Development**
Employers should provide opportunities for effective continuing professional development, as well as access to research and-relevant knowledge.

7 **Professional Registration**
Employers should ensure social workers can maintain their professional registration.

8 **Effective Partnerships**
Employers should establish effective partnerships with higher education institutions and other organisations to support the delivery of social work education and continuing professional development.

The 39 Steps – Section 1

Effective workload management	
1	How many unfilled posts are there in the team?
2	How many posts are being covered by agency/temporary staff?
3	How many posts are there where the post-holder is on long-term absence eg sick leave, maternity leave?
4	What is the level of staff turnover?
5	How many cases does each FTE hold?
6	How many hours are staff working on average a week?
7	What levels of TOIL and annual leave are still to be taken?
8	How often is supervision taking place – is this in line with organisational policy?
9	Have staff been able to attend the CPD opportunities planned in their appraisals or development reviews – how often is training cancelled or re-arranged?
10	What additional responsibilities are team members undertaking, for example supervising a student on placement, mentoring another team member, doing research?

Management reports or workforce data	Practitioner reporting	Combination of both

The 39 Steps – Section 2

Proactive workflow management	
11	How many cases are currently unallocated?
12	How many cases are being re-referred?
13	Are there changes throughout the year in workflow (peaks and troughs)?
14	How are unallocated cases risk assessed?
15	What is the escalation process for unallocated cases and alerts to senior managers?
16	How many cases are currently allocated to a) team members b) the team manager c) the duty team?
17	Are there delays in the transfer of cases between teams?
18	How often are workers required to cancel meetings with people who use services and other professionals in an average week due to re-prioritisation of work?
19	What specific blocks to workflow need to be considered eg efficiency of commissioned services, relationships with other agencies, transfer between teams and services?
20	Is the most efficient use of skills being made within the team and wider service - are social workers undertaking tasks for which their skills are primarily required or could they be done more effectively by someone with different skills eg an administrator, paraprofessional or other professional group?

The 39 Steps – Section 3 + 5

Having the right tools to do the job	
21	Do staff have access to the right equipment – for example, mobile working and IT access?
22	Do staff have access to the right professional services to support case work– translators, legal advice etc?
23	Do staff have access to the right resources, for example research or library facilities?
24	Do staff have appropriate office space, for example, desk, office chair, access to quiet space?
Effective service delivery	
35	Findings from compliments / comments and complaints
36	Feedback from service users
37	Feedback from stakeholders / other professionals
38	Staff survey results
39	Exit interview analysis

The 39 Steps – Section 4

A healthy workplace	
25	Is there a system in place to monitor frequency and quality of supervision in order to ensure effective practice is supported?
26	Is there a 360° appraisal in place?
27	Is there an employee welfare system in place and are staff aware of how they access it?
28	How often do team meetings take place?
29	Are staff able to contribute to the agenda?
30	Are senior managers accessible/ visible in the service?
31	How are stress levels monitored on an individual and service basis?
32	Is there a whistle-blowing process and are staff aware of what this is?
33	Are there processes in place to ensure staff welfare eg risk assessments of roles and activities, and call-back/monitoring processes to ensure safety whilst working away from the office base including out of hours?
34	What are the sickness levels in the team/service and what is the pattern over time?

AFTER the Social Work Health Check

It is recommended that Directors and Assistant Directors of social work and social care, use the health check in one-to-ones with Principal Social Workers to promote a well-led and effective service.

The health check process itself is usually a positive one for staff, giving them the chance to air issues and be listened to.

However, following up on what comes out of the health check is even more important.

A clear agreed action plan –regularly monitored and reported back to staff – is crucial.

"It's important to look at the things you can do almost instantly, like an audit of printers and IT; stuff that can make people's lives much easier very quickly. You must not underestimate how important these things can be to people."

NEXT STEPS

Steering Group?

Target Date?

Survey Monkey?

LGA Deadline is in November

Preparing for the Social Work Health Check

1. Agree a joint steering group to oversee the health check process across all social work teams, which could include partners, principal social workers, practitioners and trade union representatives.

2. Agree how the results will be published – to include social work staff and elected members/trustees/board members.

3. Develop a communications strategy for explaining and reassuring social workers about what the health check is for and how it will be used. Given assurances that anything said in discussions will not be used in any way against individuals but only to inform what extra support is needed.

4. Identify and scope the sources of information needed to complete the work – this will include:
    - NMDS data
    - Performance data e.g. service response times, workflow, complaints
    - Qualitative data e.g. quality of supervision, stress, caseloads, TOIL

5. Identify resources in terms of HR, systems and IT support needed to collect the required data. Technical guidelines will be needed covering areas such as:
    - A common date or period for data capture
    - A common definition of a case, for example where families or siblings are involved
    - How the result will be analysed on an aggregated basis

6. Decide the scope: in view of close working relationships and work organisation, many organisations have extended the health check to non-social work qualified practitioners who may be contributing to casework.

7. All team members will need to be given advanced notice and time to prepare for team discussions, focus groups etc.

8. Consider whether peer or independent facilitation of sessions with social workers could be helpful

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