social care
institute for excellence

Transforming care

Transforming care and support

Future of care link 1 **No 8 – November 2018**

Foreword

The Government's October 2018 announcement of £650 million additional money for adult social care in 2019/20 is welcome news although – as independent experts have argued – the sums involved are unlikely to be sufficient. The challenges faced by the sector are well documented and daunting: rising demand; escalating shortages of workers; a fragile care provider market; and severely constrained local authority budgets.

No matter the sums of money, it is essential that any new money is invested with evidence of what works in mind. Evidence-informed co-production could be better harnessed to drive commissioning decisions on how new money, as well as existing core budgets, are spent. There are a growing number of innovative and effective models of care that should be mainstreamed. Investment should be targeted on evidence-based ways of working which prevent or reduce the need for care in the first place, or improve outcomes when they are needed.

As this report demonstrates, there is already enough good evidence to make the change to a more proactive, preventative way of working which delivers more of what people want: a life.

The Care Act 2014, with its focus on wellbeing, prevention, personalisation and co-production, offers a strong foundation on which to build a better way of doing care and support, but the rate of change on the ground has often fallen short of the Act's ambition. Government should use the opportunity of the forthcoming Green Papers on adult social care and prevention to accelerate the pace of change: to

present a vision for how care and support goes beyond the traditional boundaries of social care to foster people's wellbeing, social connections and independence.

As SCIE argued in **Growing innovative models of health, care and support** link 2 (SCIE 2018), which we developed with Nesta, PPL and Shared Lives Plus, there are many promising models of innovative care, but they remain stuck in endless pilots and small-scale trials. We need to invest in these to bring them to scale.

Moreover, as we demonstrate in our paper **Total transformation of care and support** link 3 (SCIE 2017), produced with Birmingham City Council and Shared Lives Plus, we can save money and improve outcomes if we pursue a whole-systems approach to fostering innovation.

This paper draws together the emerging evidence and insights from much of SCIE's recent work. We hope that it will provoke a discussion with both national and local policy-makers about how to transform care and support services to ensure they are genuinely effective. We are not arguing for transformation for transformation's sake, but we do know that more of the same is not good enough.

Paul Burstow, Chair, SCIE

Key messages

National policy-makers should:

- Use the Green Papers on social care, and on prevention, to present a consistent vision for how care and support moves beyond traditional models of social care
- Invest in scaling innovative evidence-based models that promote individual wellbeing and build on people's and community strengths
- Coordinate policies across government departments so that they support people's long-term wellbeing, such as the new planned Prevention Green Paper, Industrial Strategy and NHS Ten Year Plan
- Create the right system incentives to promote and sustain the adoption of new models including changing public accounting rules to make spending on prevention and early action visible
- Review and reset the data that is collected to support the shift to asset-based working
- Put budgets in people's hands and make co-production business as usual for public services
- Support the ongoing development of the evidence base for what works to effectively transform care and support

- Support the development of system leaders

Local policy-makers should:

- Develop an integrated, asset-based approach to planning and delivery
- Co-produce solutions with local citizens – including commissioning plans
- Invest in innovative models and bring them to scale – including use of technology, intermediate care, and preventative services
- Use data to predict and prevent escalation in need and support independent living
- Build the capacity of local community and voluntary sector infrastructure
- Devolve budgets to neighbourhoods, families and individuals
- Evaluate services based on their impact on people's lives including their wellbeing and connections to others

Core features of transformed care and support

Investment and reform can create the conditions for a transformed care and support system. Evidence and our work in and across the sector suggests that a truly transformed and effective system should have the following features:

- People's health, care and support are shaped through strengths- and asset-based conversations that seek to address a whole person's life, rather just assessing a narrow set of needs.
- Services and the wider systems are co-produced with the people whose lives they touch. This means that everyone involved identifies priorities, co-designs services and systems and works together to co-deliver the work that takes place
- A flourishing range of community groups, organisations and resources are supported, available and focused on building the knowledge, skills and confidence of people to manage their own care and wellbeing.
- Neighbourhood-based multidisciplinary and integrated teams work with communities and volunteers and focus on what is important to each person. This can be done through personalised planning which aims to include all aspects of family and community life.
- Budgets are devolved as far as possible down to neighbourhoods, families and individuals (where this is their preference), maximising choice and control over how money is spent on people's care.
- Community buildings, including care homes and primary care centres, are reassigned as multi-use community resources.

- All care and support services, including small community-based providers, are funded and measured on the basis that they make positive changes in people's lives, in terms of prevention, wellbeing, resilience, independence, connections to others and the ability to self-care.
- A thriving voluntary, community and social enterprise sector, working alongside people, families, communities and the health and care system.

> *"Individuals, their families and day-to-day supporters have valuable knowledge to share with health and social care staff that can meaningfully impact upon their recovery and their successful and timely discharge from hospital. And yet, this expertise is often ignored, even though access to information and full participation in all aspects of decision-making is essential to ensure the emotional and physical wellbeing of our population."*
>
> Kath Sutherland, SCIE Co-production Network

Priorities for improvement

Developing an asset-based framework for change

Every area has the potential to achieve more through the effective use of all the skills, knowledge and assets available within communities and individuals – as well as the public, private and voluntary sectors.

> *"We recognise that in order to offer more personalised care through people having more choice and control, the system must harness the existing expertise, capacity and potential of local people, families and communities. Building this local community capacity is one of the universal approaches to supporting people to stay well and build community resilience by enabling people to make informed choices in their time of need."*
>
> James Sanderson, Director of Personalised Care, NHS England in **Unlocking community assets for better health and wellbeing** link 4 (SCIE 2018)

This is known as an asset-based approach, where the emphasis is on people's and communities' assets, as well as their needs.

An asset-based approach can:

- enhance health, wellbeing and resilience
- reduce long-term pressures on higher-cost health, care and support services
- enable people to participate in and benefit from community resources and activities.

These outcomes will not be achieved through a single initiative or a bolt-on to existing services. The development of an asset-based approach requires a strong overarching vision and a different approach to commissioning to bring about significant change.

In Somerset this has meant actively encouraging the entrance into the local market of small-scale, community-orientated providers. Somerset Community Connect is a framework for connecting people who need care and support to local community-based providers, community agents who can help people find the support they need, and a vast range of community and voluntary sector services.

There is no one-size-fits-all method of designing and implementing an asset-based approach. At its core, it starts with the individual person and place, seeking to identify and build on existing strengths, rather than impose an external framework or preconceptions of what is required to facilitate change.

Five key enablers or building blocks along with examples of specific associated examples of initiatives or activities – as outlined below – can support local areas in implementing the approach.

1. Reframing towards assets

Developing a new narrative:

- People as assets
- Shifting power to communities through co-production and partnership with VCSE sector
- Public services as catalyst and facilitators.

2. Recognising assets

- Community asset mapping
- Personal strengths-based assessments
- Conversations

3. Connecting to assets

- Community navigation
- Peer support
- Social prescribing and community link workers
- Community circles

4. Mobilising and growing assets

- System and infrastructures that support partnership, co-production, VCSE representation in strategic leadership and governance.
- Funding, grants and social investment
- Inclusive commissioning

5. Monitoring impact and learning

- Co-producing a simplified outcomes framework
- Developing a comprehensive set of indicators
- Learning by doing
- New evaluation models
- Funding research

> *"This model is about community asset-led services, and it is grounded in co-production and personalisation principles that seek to promote self-care / management and, most importantly, link people to 'place'. It is a model that will support individuals in their communities with a key emphasis on prevention, early intervention and good quality advice and information to support people to make informed decisions."*
>
> Martin Farran, recently Director of Adult Social Care York, now Director Adult Social Care Liverpool.

Backing innovation

There are a growing number of innovative models of care. These span early intervention, supporting people at home, improving accommodation and support, and helping people home. **Realising the value** link 5 (Nesta 2016), **Six innovations in social care** link 6 (Think Local Act Personal 2018), and **Total**

transformation of care and support link 7 (SCIE 2017) have highlighted a number of the innovative care models within the sector which are transforming outcomes in a cost-effective way. These innovations remain, in most cases, small scale: we need to invest in bringing these to scale.

> *"Investing £10 million in an innovative community investment fund – and asking groups for their ideas to support people – has unleashed the most amazing array of fabulous work in grassroots organisations and we can see the effect it is having on our public services."*
>
> Donna Hall, Chief Executive, Wigan Council in **Asset-based place: Just do it** link 8 (SCIE 2018)

In many cases, better ways of supporting people emerge from thinking very differently about the interplay between design, technology and the built environment. In **The 100 year life** link 9 (SCIE 2018), a paper we wrote with the Design Council and Centre for Ageing Better, we discuss the enormous scope for social care to transform outcomes through better design, and by thinking about the built environment.

> *"As we live longer we are presented with new challenges but also opportunities. To realise these a shift in thinking is required. By galvanising our collective insight and bringing together a diversity of experience and skills, we can generate new approaches, insights and solutions that are people centred. Engaging with people in later life we can co-create solutions that respond to their daily needs, designing products, services, homes and neighbourhoods that support their health and wellbeing and ultimately us all."*
>
> Sarah Weir OBE, Chief Executive, Design Council

In **Growing innovative models of health, care and support** link 10 (SCIE 2018), we argue that the keys to success are:

- a shared ambition to 'embed person- and community-centred ways of working across the system, using the best available tools and evidence'
- co-production: planning with the people who have the greatest stake in our services from the beginning

- a new model of leadership which is collaborative and convening
- investment and commissioning approaches which transfer resources from low quality, low outcomes into approaches which work effectively
- effective outcomes monitoring and use of data to drive change
- a willingness to learn from experience.

High-quality intermediate care

Intermediate care services provide support for a short time to help you recover and increase your independence, and the evidence base is growing about its positive impact. Yet as Richard Humphries, a SCIE associate, argues in **Intermediate care** link 11 (SCIE 2017), 'Investment in intermediate care is not keeping pace with rising need'.

The paper highlights the following features of effective intermediate care:

- A single point of access for all types of local intermediate care services, including a referral process that is widely understood across the whole system and a single assessment process.
- Shared access to health and social care records – ideally single patient records.
- A single management structure for the service as a whole and individual elements within it.
- An agreed multidisciplinary team composition in which staff are able to work flexibly across services and undertake transdisciplinary roles.
- Joint training and induction programme for health and social care staff.
- Weekly multidisciplinary team meetings attended by health and social care staff.
- A single performance management framework.

Promoting independence through intermediate care link 12 (SCIE/NICE 2018) provides practical advice to staff within these types of services. The focus is on how they can promote independence through, for example, good communication, positive risk-taking and building resilience.

For further information see our resources on **intermediate care and prevention** link 13.

Creating safe communities

Taking an asset-based approach clearly requires the involvement of an increasingly wide range of organisations to support people to live independently. That also

requires those organisations to keep people safe from the risk of abuse or neglect.

Developing high-performing Safeguarding Adults Boards, supporting providers to develop good policies and procedures, and training staff to ensure they recognise and manage safeguarding risks and incidences must be a priority. But it goes further than that. Individual organisations – from community and voluntary sector agencies and faith groups – need to understand and fulfil their responsibilities, and how they fit in to the wider system.

SCIE's experience of working with providers, councils and other agencies shows the added-value of taking a systems-approach to safeguarding. SCIE's **Learning Together** link 14 model provides a method for getting to the bottom of professional practice and exploring why actions or decisions that later turned out to be mistaken, or to have led to an unwanted outcome, seemed to those involved, to be the sensible thing to do at the time. The answers can generate new ideas about how to improve practice and so help keep people safe.

Enabling system change

The evidence base is growing about what works in transforming the system and enabling better experiences and outcomes for people.

Systems leadership

The demands on social care and the need to deliver change, requires a different approach to leadership – systems leadership. In research we conducted for the NHS Leadership Academy on systems leadership in integrated care systems, we identified leaders as needing to be good at:

- identifying and scaling innovation (e.g. from pilots)
- having a strong focus on outcomes and population health
- building strong relationships with other leaders, and often working with them informally to develop joint priorities and plans
- establishing governance structures which drive faster change, often going where the commitment and energy is strongest
- setting the overall outcomes and expectations on behaviours, but handing day-to-day decision-making to others
- supporting the development of multidisciplinary teams (MDTs)
- designing and facilitating whole-systems events and workshops to build consensus and deliver change
- understanding and leading cultural change
- building system-wide learning and evaluation frameworks

- fostering a learning culture across the whole system.

Co-production with citizens

In **Growing innovative models of health, care and support** link 15, we describe how important co-production is to scaling good models of care. Co-production is a 'relationship where professionals and citizens share power to plan and deliver support together, recognising that both have vital contributions to make in order to improve quality of life for people and communities'. It can enhance quality of care, help create more personalised services and help reduce waste.

Oxfordshire County Council has recruited Co-Production Champions – a group created as part of a ground-breaking partnership between SCIE and the Council.

The Champions will promote and support co-production. The group is made up of people who use services, carers, council staff, professionals from health and social care, and voluntary sector organisations who are learning and working together to make change happen. They aim to promote co-production by holding events, providing training and helping to set up or support co-production projects by advising on what good co-production looks like.

Find out more about **co-production** link 16.

Technology and data

Technology is a key enabler across social care, health and housing and is increasingly more accepted by individuals, carers and family as they use technology in everyday life.

> **93 per cent of directors of adult social care considered the use of 'assistive and communications technology' to be quite or very important in making financial savings (ranked third out of all options).**
> **ADASS budget survey 2018** link 17 .

Across the UK, local authorities are increasingly looking at the provision of technology-enabled care, identifying opportunities to use technology to deliver care and support more effectively. Similarly, the intelligent use of big data can help to predict where support is likely to be needed in order to prevent a deterioration in people's wellbeing and an increase in their needs.

The additional social care funding provides an opportunity to move the use of technology and data into the mainstream. This will require a sustainable shift in how technology is considered and implemented. For example, it should involve the

use of a wider range of technology solutions and applications and creating a more proactive, prevention approach. It is important to not only review the potential for technological solutions, but also to identify partner agencies to collaborate to deliver responses and proactive support.

> *"Technology is an everyday norm, it should be an intrinsic element of an asset-based offer, enhancing wellbeing and providing opportunities for new models of behaviour."*
>
> Sharon Houlden, ADASS Digital Communications & Technology lead, and DASS Southend-on-Sea Borough Council

Key areas where technological developments can help transform care include:

Falls prevention

Wearable technology and activity sensors can help to identify those at risk of a fall by, for example, remotely monitoring their activity and gait – and enable mitigating action to take place. In care homes, falls sensors can be linked to staff pagers to alert them to the fact that someone has left their bed, or had a fall.

Remote video triage

In many instances, out-of-hours GPs have to recommend calling an ambulance because they cannot see the patient or have any vital signs information. Remote video consultation and basic vital signs monitoring within care homes is supporting staff to know when an ambulance is required or not.

Remote video triage examples can be found in **Airedale NHS Trust in partnership with Immedicare** link 18 . **NHS Calderdale CCG** link 19 has also been successful in the use of both telehealth and telecare within care homes.

Using data to predict and prevent escalation of needs

The effective use of 'big data' can help to identify local areas, and in some cases individuals, who would benefit from preventative support or public health services.

For example, data can be used to create a map of areas where people are already receiving a range of wellbeing and preventative services and, through this, to identify pockets of current low take-up for targeted awareness raising of the services on offer.

To enhance this, it is recommended that partners are trained as trusted assessors for basic telecare, alongside identification of needs and onward referrals to a range of services.

In Dudley Metropolitan Borough Council, **Living Well, Feeling Safe** link 20 involves a rolling programme of door-to-door visits and community events to encourage the take-up of preventative services.

In Shropshire, the Council is using existing data to identify and target people likely to require support. Using combined data sets such as the temperature of a home from thermal imaging, ONS data and social care information, there is the ability to identify those in a cold home, over 75, living alone and not known to social care. Linking this, supported by Information Governance, with elements of health data, Fire & Rescue Service information, would further expand the opportunities.

Utilising data held within Telecare monitoring centres and social care records systems, a cohort of people could be identified for proactive contact in relation to, for example: flu jab reminders, keeping hydrated, preparing for winter, reminder of exercise routines post-reablement, and the ability to link into local services for follow-up. The success of this approach has been well-documented in Spain, but adoption has be limited in the UK. See **Birmingham Telecare Service** link 21 .

Activity monitoring to reduce risk of UTI/dehydration

Technology can also monitor people's trends and habits over time in order to predict the risk of dehydration and urinary tract infections. For example, technology can monitor lack of movement and changes in activity such as bathroom visits, boiling the kettle, use of a microwave.

Such solutions, incorporating robust data analytics, could enable informed decision-making by TEC services and social care practitioners. They could also notify staff to provide prompts to move about the property, make a drink etc, potentially via the TEC monitoring centre or involving community services.

The data held by GPs and admission avoidance or rapid response teams could be used to identify those at greatest risk of UTIs and/or hospital admissions – and therefore to identify those who would benefit most from such activity monitoring technology.

Monitoring technology could also help reablement teams to identify progress in areas of daily living activities and inform when to step up or step down services.

In some areas of the UK – such as Northamptonshire's **Canary Care** link 22 service – activity monitoring is being used with people with lower care needs, to successfully delay or prevent their need for a formal care package.

Personalised care

Evidence tells us that processes and activities that focus on care coordination and continuity out of hospital (community settings, at home, involving primary care and preventative services) are critical to improving people's experience of care.

The forthcoming NHS 10 Year Plan is likely to demand that personalised care and support planning become the norm. Local areas can act now to progress this approach by:

- mapping the assets based within the local community, and using that knowledge to shape the future care and support market
- co-producing the redesign of systems and processes with local citizens
- investing in staff skills in personalised care planning and delivery
- changing contracts with providers so that they are incentivised to deliver personalised outcomes and evaluating against those outcomes
- implementing the **Making it Real framework** link 23 (developed by Think Local Act Personal) to support personalised care.

Progress is being made in several areas towards delivering this vision of personalised care. In Nottinghamshire, as part of the **Integration Accelerator Pilots** link 24, which SCIE is evaluating, the Council is implementing joined-up assessments and personalised care planning at scale. Building on its integrated personal commissioning pilot, it is providing people with a single strengths-based assessment, which leads into ongoing support to the person through a multidisciplinary team.

In Halton, the council and clinical commissioning group have introduced Named Social Workers to explore how to provide wrap-around, personalised advocacy and support to young people making the transition into adulthood. Part of a DHSC funded pilot, Halton has managed to reduce episodes of young people entering periods of crisis, improve wellbeing and satisfaction with services and reduce reliance on expensive packages of support.

For more information

See resources including evaluation and case studies from the **Named Social Worker pilot** link 25.

Multidisciplinary teams (MDTs)

Multidisciplinary teams (MDTs) have been shown to be an effective tool to facilitate collaboration between professionals and hence improve care outcomes. But you

need to invest in their development.

In **Delivering integrated care: the role of the multidisciplinary team** link 26 (SCIE 2018), Robin Miller, of the University of Birmingham, identifies the following features of effective MDTs:

- An identified manager and/or practice leader who oversees and facilitates the work of the whole team.
- A single process to access the workers in the team, with joint meetings to share ideas, insights and concerns.
- Electronic records of all contacts, assessments and interventions of team members with an individual and their family.
- A 'key worker' system through which care for those with complex support packages is coordinated by a named team member.

Conclusions

The Budget's additional funding for adult social care and recent Green Paper on prevention, plus the forthcoming Green Papers on social care, present real opportunities to transform care and support into a more effective and sustainable system.

In order to maximise these opportunities, central and local policy-makers should invest in evidence-based, innovative models which are:

- focused on improving people's whole lives
- co-produced with local citizens
- aimed at building the capacity and strengths of local communities
- integrated with related services such as housing, public health, education and employment.

This represents a substantial shift from the current system, though some areas are making progress. SCIE will continue to support central and local policy-makers by identifying effective models of transformation and system-wide change.

Further reading

- **Growing innovative models of health, care and support** link 27 (SCIE 2018)
- **Intermediate care** link 28 (SCIE 2017)
- **Total transformation of care and support** link 29 (SCIE 2017)
- **Unlocking community assets for better health and wellbeing** link 30 (SCIE 2018)

- The 100 year life: the role of housing, planning and design link 31 (SCIE 2018)
- Promoting independence through intermediate care link 32 (SCIE/NICE 2018)
- Asset-based place: Just do it link 33 (SCIE 2018)
- Delivering integrated care: the role of the multidisciplinary team link 34 (SCIE 2018)
- Realising the value: Ten actions to put people and communities at the heart of health and wellbeing link 35 (Nesta 2016)
- Six innovations in social care link 36 (Think Local Act Personal 2018)

SCIE support

SCIE acts as an improvement partner to local areas and systems across both children's and adults' services.

We provide a combination of capacity, expertise, knowledge, support and challenge as local areas reconfigure their care services and systems.

We work with the whole system including local authorities, clinical commissioning groups, care and health providers, user-led organisations, local citizens, voluntary, community and social enterprises – to develop and deliver improvement plans.

View: Consultancy support on transforming local care and support systems link 37.
Contact: Contact SCIE to find out more link 38

link 1 | https://www.scie.org.uk/future-of-care
link 2 | https://www.scie.org.uk/future-of-care/adults
link 3 | https://www.scie.org.uk/future-of-care/total-transformation/
link 4 | https://www.scie.org.uk/news/opinions/unlocking-community-assets
link 5 | https://www.nesta.org.uk/project/realising-value/
link 6 | https://www.thinklocalactpersonal.org.uk/Latest/Six-innovations-in-social-care-/
link 7 | https://www.scie.org.uk/future-of-care/total-transformation
link 8 | https://www.scie.org.uk/news/opinions/asset-based-just-do-it
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link 13 | https://www.scie.org.uk/prevention/independence/intermediate-care

link 14 | https://www.scie.org.uk/children/learningtogether/

link 15 | https://www.scie.org.uk/future-of-care/adults

link 16 | https://www.scie.org.uk/co-production

link 17 | https://www.adass.org.uk/adass-budget-survey-2018

link 18 | http://www.airedale-trust.nhs.uk/services/telemedicine/immedicare/

link 19 | http://www.tunstall.com/media/1142/calderdale-quest-for-quality-in-care-homes.pdf

link 20 | http://www.dudleyci.co.uk/kb5/dudley/asch/service.page?id=NgsvMu9iXVQ

link 21 | https://www.tsa-voice.org.uk/news/telecare-with-proactive-calling-%E2%80%93-new-report-from-birmingham

link 22 | https://www.canarycare.co.uk/

link 23 | https://www.thinklocalactpersonal.org.uk/makingitreal/

link 24 | https://www.scie.org.uk/consultancy/integration/index.asp#nhsenglandaccelerator

link 25 | https://www.scie.org.uk/social-work/named-social-worker

link 26 | https://www.scie.org.uk/integrated-health-social-care/measuring-progress/role-multidisciplinary-team

link 27 | https://www.scie.org.uk/future-of-care/adults

link 28 | https://www.scie.org.uk/prevention/independence/intermediate-care/highlights

link 29 | https://www.scie.org.uk/future-of-care/total-transformation

link 30 | https://www.scie.org.uk/news/opinions/unlocking-community-assets

link 31 | https://www.scie.org.uk/future-of-care/100-year-life

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link 33 | https://www.scie.org.uk/news/opinions/asset-based-just-do-it

link 34 | https://www.scie.org.uk/integrated-health-social-care/measuring-progress/role-multidisciplinary-team

link 35 | https://www.nesta.org.uk/report/realising-the-value-ten-actions-to-put-people-and-communities-at-the-heart-of-health-and-wellbeing/

link 36 | https://www.thinklocalactpersonal.org.uk/Latest/Six-innovations-in-social-care-/

link 37 | https://www.scie.org.uk/consultancy/transforming-care

link 38 | https://www.scie.org.uk/contact/training-and-consultancy-enquiry