READY, STEADY, GO!
Driving stability and innovation in the adult social care market
With the sustainability of the care market a key risk for adult social services, ADASS and EY organised a roundtable of adult social care leaders to debate the challenges and explore potential ways to put the market on a more stable footing.

"There is still a massive gap in the amount of home care we need to be commissioning and the availability of it."

KATE TERRONI, DIRECTOR OF ADULT SOCIAL SERVICES, OXFORDSHIRE COUNTY COUNCIL

INTRODUCTION
Ever since the Care Act took effect, councils have been grappling with their new duty to foster sustainable local markets for adult care services.

The duty arrived at a challenging time. Local authority finances are under unprecedented pressure, demand for services is rising and the risks of market failure have been made clear by the high-profile collapse of several care providers.

In February, with concerns about adult care provision continuing to make headlines, the Association of Directors of Adult Social Services (ADASS) brought together a group of adult social care leaders for an EY-sponsored roundtable debate about the issue of sustainability.

Sustainability of the social care market is a topic that comes up over and over again in the ADASS commissioning network’s discussions. Particularly significant issues include the financial constraints, the quality challenges and the expectations of what people want from social care and whether that can be delivered.

IS IT ALL ABOUT MONEY?
But is ensuring sustainability just about money? the roundtable were asked. Kate Terroni, director of adult social services for Oxfordshire County Council, thought it is not just about the money.

“Oxfordshire pays the highest hourly home care rates in the country, about £20.10,” she said, adding that the council has also given providers guaranteed cost and volume contracts. “Despite all that there is still a massive gap in the amount of home care we need to be commissioning and the availability of it. So, for me, this is absolutely not just about the money. Money is important, but for me it’s a big society thing. Do we value the people who deliver care and do we offer career pathways where people think at 18: ‘I’m going to go and become a care worker?’”

Trying to fill the gaps through spending carries risks too, replied Glen Garrod, the director of adult care and public health for Lincolnshire County Council. “Your neighbouring councils, who might not be in quite the same financial space will feel the effect of that,” he said. “In a way there’s a danger of everybody trying to rise to the top as much as there is a danger of everybody trying to diminish to the bottom.”

Helen Sunderland, the lead on social care practice at consultants EY, noted that the Local Government Association’s Adult Social Care Funding: 2016 State of the Nation Report highlighted that, whilst the people polled supported additional funding for social care, it was unclear whether people agreed this should be funded by council tax rises.

This, coupled with the analysis in the report suggesting the precept will not address the funding gap, puts at risk the likelihood of a purely financial solution to sustainability. “Is it a new relationship between the state, a family and the individual that needs to be thought through and, within this context, how the market can sustainably respond to that?” she asked.

THE IMPACT OF SELF-FUNDERS
“If a rethink of the state’s role in social care is where we’re heading there are two big issues,” said Margaret Willcox, the director of adult social services at Gloucestershire County Council. “One issue is that if that’s the way we’re going we need an honest conversation with the public that says this is not a nationally funded service anymore,”
she said. “The NHS is but local government won’t be because if social care is going to be determined on local finances then it isn’t national.”

The second problem, she continued, is that the councils best placed to raise extra money are often those that need it least. “There will have to be subsidy from somewhere and if you don’t sort that out as a funding formula nationally and leave it to local taxation then we’re back to the system we had pre-1948,” said Willcox.

Places where there are not many people who are paying for their own care can also make a big difference to commissioning and to the sustainability of the market.

High numbers of self-funders brings a different challenge said Iain MacBeath, the director of adult social services for Hertfordshire County Council, who noted that his authority struggles to buy care regardless of how much it pays because of competition for limited care capacity from self-funders and their families.

Higher pay for care workers will not necessarily fix the shortfall of care workers either, said Cathy Kerr, the director of adult social services for the London boroughs of Richmond and Wandsworth: “In one of the boroughs in which I work we’re paying a decent wage and we’ve got an outcomes-focused, seven-year contract for providers, but we still can’t recruit the staff and the staff can’t afford to live in the borough.”

**BETTER CAREER PATHS**

The roundtable agreed that making care work more attractive as a career is vital for sustainability and higher hourly rates are not the only way to attract people into the sector. “It isn’t all money,” said MacBeath. “A lot of it is about leadership and job satisfaction.”

MacBeath cited the example of a nineteen-year-old care worker he met at a supported living unit. She previously worked at a pound shop earning the same money as she does now but loves her new job. Now, having seen how happy she is, many of her former pound shop colleagues have also gone into care work.

“We do need to stop talking care work down though,” said Wilcox. “We’ve spent a lot of time telling the public that the home
care they get is second rate. “Now that’s possibly how it was in the ’70s but it’s not how it is now. Some of the organisations are truly inspirational, they’ve got tremendous staff but we haven’t changed the story.”

But poor career paths mean that even those who become care workers can drift away, said Kerr who gave an example of a worker in a nursing home who became frustrated by the lack of development opportunities. “It was going nowhere,” she said. “You have got to make care work attractive but also then have a scheme that gives people an opportunity to grow and develop.”

Garrod felt that the new associate nurse role could be used to make care work more attractive. “Associate nurses could provide the opportunity for an enriching experience as a care worker, doing things that otherwise might have been reserved for others,” he said. “So if you’re not going to get into a graduation position you can still have a good career within a vocational route. I don’t think that’s made enough of at the moment.”

**CAR-SHARING AND BUTLIN’S**

Care work apprenticeships, such as the one run by Milton Keynes Council, could help said Sue Wilson, the head of commissioning and quality in adult social care for Leicestershire County Council. “I met some of their apprentices at a recent East Midlands workforce event,” she said. “There were about a hundred and twenty who have gone through the system now and we were saying it’s something we ought to consider. But then there’s the challenge, particularly in the domiciliary care market, of how do they get about? In a rural area how do they afford a car and insure it?”

Sunderland suggested that car-share companies might provide a solution to the transport issues. “Corporate partnerships with organisations that provide car rental services in thirty or sixty minute slots can work particularly well in cities,” she said. “Proactive discussions with such organisations with regards to more rural areas could be productive if a readymade customer base using their services every day can be shown.”

Thinking differently about where to find potential care work recruits is also important, said Garrod. “On the east coast of Lincolnshire we have got a very large Butlin’s, which has a very significant
downtime during the winter when we reach peak demand and their redcoats have half the skill set at least of some of our best home care workers,” he said.

Warming to the theme, Willcox said military garrisons are another potential source of recruits that councils could help providers connect with.

“I recently did a peer review and we were in a garrison town,” she said. “There were thirty percent vacancies in their domiciliary care market and how many hundreds of people sitting in the garrison wishing they had a job but couldn’t make the journey because the husband who is the soldier has got the car? Sometimes we need to knit things together.”

NEW CARE MODELS

Beyond the workforce challenges to sustainability, the roundtable felt that new approaches to commissioning will be crucial to developing a healthy adult social care market.

MacBeath told the roundtable that through Hampshire’s new care model vanguard work, the Better Care Fund pays £70 per person per week premium to care homes for residents with higher needs. In addition care staff have been trained in clinical matters and a community pharmacist has helped to shave money off pharmacy bills, which in turn has cut the time spent administering medicine and saved the NHS money.

“That’s a win, but the biggest win is that the care home is not phoning the ambulance,” said MacBeath. “They feel able to cope. There has been a forty-five percent reduction in admissions from that - it’s enormous - and that pays the bill of £70.”

The big question is whether this model can successfully scale up from the eight homes currently involved to all of the county’s two hundred or so homes.

ASSISTIVE TECHNOLOGIES

Assistive technology also offers opportunities for innovation in care services, the roundtable agreed, but there are commissioning and cultural barriers to overcome.

“Having just seen this from the pathway redesign perspective, there are many missed opportunities for assistive technology to reach its full potential,” said Sunderland. “Part of this challenge is the way that telecare is commissioned. There is a real need for it to move towards a properly managed service that has a proactive care pathway redesign and then an active searching for cases rather than just waiting for it to come along.”

That, however, requires new ways of working said Karen Sugars, the acting divisional director for integrated commissioning at Tower Hamlets. “What our staff find quite difficult is articulating the risks and the on-going requirement to manage and respond to the assistive technology,” she said. “It’s ok to put a pull cord into someone’s home when you have a call centre but if you give someone a GPS tracker the worker has to work out what happens if someone goes outside of an agreed area; who responds? When you’ve got a social work team that are very busy and trying to get through their workload, doing this sort of work requires a different conversation, analysis and care planning.”

ADASS assistant director Hilary Paxton said fostering a culture of change among social workers is an additional challenge.

“It would show providers that we value them as professionals a bit more if we gave them more flexibility on the care plan,” said MacBeath. “We value them as professionals a bit more if we gave them more flexibility on the care plan.”

Iain MacBeath, Director of Adult Social Services, Hertfordshire County Council
There are many missed opportunities for assistive technology to reach its full potential

HELEN SUNDERLAND, DIRECTOR AND NATIONAL SOCIAL CARE LEAD, EY

older people because they don’t like computers. There are some who may not, but many do.” Contracts must change if we’re to make the most of technology, said Sunderland: “We don’t actually allow the home care provider to say, ‘You know what? I’m going to deliver this package differently because I’m going to use assistive technology for this, this and this outcome or analytics to manage this performance management that you want to hear back from me on.’” Bringing providers in at the design stage would help. “We’re not the experts here,” said Terroni. “Why wouldn’t we bring in the subject experts? But we need to have more conversations about this with our lawyers because they get twitchy when I say I want to bring in providers at the design stage.”

NON-LINEAR PRODUCTS
Garrod, however, worried that technological solutions could prove too binary and make it harder for services to meet the needs of individuals. “For example in one village we couldn’t get home care for love nor money and there were three or four people who needed a service,” he said. “They said give us the money you would have spent on us, allow us to use your systems and we will arrange what we need. That’s a non-linear product. It requires you to be very different because we are not used to allowing individual consumers to come together as a collective to purchase services using our technology. It upset everybody and it’s only because I have a certain job title that it happened.”

The roundtable felt that inflexible care plans are a problem for care provision too. “It doesn’t help that social workers still issue time- and task-driven care plans so care workers have no flexibility,” said MacBeath, recalling how he got an “ear bashing” from an elderly lady at a Flexicare unit after she was given a hot shower she did not want. “She had been washed to within an inch of her life and the care worker said if we don’t do it we haven’t done what is on the care plan. I’m always amazed at how expert care workers are in medication, moving and handling. They know exactly what to do but we don’t give them any flexibility. It would show them that we value them as professionals a bit more if we gave them more flexibility on the care plan. I am determined that is what we’re going to do.”

RETIREMENT VILLAGES
Kerr raised the question of whether retirement villages with on-site care services can play a role in sustainability. “There is a cohort of older people who still want to be owner-occupiers but who would live somewhere else as long as they could own their flat or whatever,” she said. MacBeath said one Hertfordshire provider built a village and set aside half of its forty-two flats for owner-occupiers. “We didn’t put a penny into that as a council, but the developer realised that if he collaborated with the council we’d always have a waiting list,” he said. “But do you just want to live with older people when you get old?” asked Wilcox. “I think that loneliness can mean that some people do want to live among other people,” replied Paxton.

The infrastructure side of such developments is also still new territory for adult social care. “We are developing an Ageing Well strategy and one of the challenges for the team is to think about the offer and whether it is possible to have a village-type approach,” said Sugars. “That’s some way off but up until a couple of years ago we probably wouldn’t have considered the opportunities to invest our Community Infrastructure Levy or S106 funding to develop these types of solutions.”

Wilson agreed: “That’s something we’ve always tried to work out with our community infrastructure levies and 106s. What’s the calculation for adult social care? Schools are easy, the communities and libraries side is easy, but we’ve got some huge developments that are going to put pressure on us but we can’t come up with the sums.”

INSOURCING
On the question of dealing with provider failures, MacBeath said Hertfordshire is planning to have to step in and start providing services itself if it happens again. “We’ve had two failures, but we’ve managed to find providers to absorb them,” he said. “But in domiciliary care we’ve now got two agencies that are so big they have got forty percent of the market between them, so it’s risky for us and them to ask them to do more. Should another agency fail, we’ll have to consider taking it in-house.”

The question Hertfordshire is grappling with is whether there is a way to turn another failure into an opportunity to raise the bar for care provision: “Is there a way the council
could run that business on the same money that we offer to the private sector but perhaps achieve better outcomes for people? Mediate the market by reabling people and reducing care packages so it becomes, ‘If we can do it, why can’t you all?’”

Sunderland said the roundtable’s discussion suggested that the relationship between care providers and local authorities has become more mature. “It’s not a ‘I pay you, you respond’ relationship,” she said. “It has become a much more advanced conversation about how can we innovate together for mutual benefit. How we move from that conversation to the pragmatics of procurement will be the trick.”

And doing that successfully will mean getting the inspectorate involved, she added: “There are a lot of exciting ideas in this room but when it comes to an inspection you don’t know how many of them are going to get marked down.”

**CONCLUSION**

While pressured finances, market failures and rising demand suggest a hostile climate for sustaining adult social care market, the roundtable discussion identified many ways in which new thinking can tackle these challenges.

Making care work a more attractive vocational career option and appealing to pools of potential recruits, such as unemployed partners living on military garrisons, offer a way to deal with the workforce challenges.

Working with housing and care providers more closely can help find new ways to deliver both the quality and quantity of accommodation and support adults need.

The use of technology and care plans that give providers more scope to use the expertise they have are also promising.

Finally, experiments such as Hampshire’s premium payments for higher need individuals are already delivering savings and better care. The challenge may be big but the adult social care sector is anything but short of creative ideas on how to deliver change for the better.
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CHOICE IS KEY
Where next for accommodation and support for people with learning disabilities?

New Dialogues is a series of think pieces supported by the partners of ADASS
ABOUT THIS REPORT

In adult social care it is essential to reflect on our thinking and that is why ADASS is pleased to bring you this provocative report on accommodation and support for people with learning disabilities or autism or both.

This report brings together a range of views – and not all of them are ones that ADASS members will all agree with.

Nor, for that matter, are they necessarily views shared by the learning disability provider Consensus, whose sponsorship made this report possible.

But as we all continue with our efforts to improve the lives of people with learning disabilities or autism or both, it is important to maintain an open debate.

Challenging our notions is helpful. We might not change our minds but it is always worth questioning our beliefs so that we do not fall into lazy oversimplification of complex problems.

Exchanging ideas is vital if we are to develop personalised services that enable people with learning disabilities to live more independent lives.

I hope you find this report as stimulating and useful as I did.

SEAN MCLAUGHLIN
ADASS LEARNING DISABILITY CO-LEAD
Imagine a ship on the open sea. Rain is lashing down and waves are pushing the ship off course. On board the crew are battling to ride out the storm but just over the horizon the storm clouds give way to brighter skies.

That ship, says Neil Revely, the co-chair of ADASS’s Housing Network, is where those tasked with transforming accommodation and support for people with learning disabilities currently are.

The destination is clear: a future where people with learning disabilities or autism or both – including those with challenging behaviour - have more choice and control over their lives. “The direction for many years now has been towards securing independent living options, so moving in that direction is a constant,” says Revely. “But sometimes you get a bit blown off course.”

What is different today is that health and social care are heading in that direction with more determination than ever before. “Health and social care have been talking about doing this for the past 20 years,” says Simon Leftley, Southend’s director of adult social services and co-lead of the ADASS Learning Disabilities Network. “What is different now is that there is a political will to do this.”

The organisations that provide accommodation and support to people with learning disabilities are also determined to make the difference, says James Allen, the managing director of learning disability provider Consensus.

“There should be no doubting the commitment from providers to play their part in bringing about the necessary change – they have after all been engaged in innovating and investing in new community based services for years, often at risk to themselves,” he says.

Yet, while the will is there, progress is patchy says Leftley. Big strides have been made when it comes to people with more predictable and manageable learning disabilities, he says, but there is still “a long way to go” for the so-called Winterbourne View cohort; the individuals with complex and challenging behaviours most likely to wind up in institutional care.

Steven Rose, chief executive of the learning disability charity Choice Support, feels little progress has been made. “When the Winterbourne View scandal broke in 2011 there were somewhere around 2,500 to 3,000 people in inappropriate private hospitals and NHS assessment and treatment units and my understanding is that the numbers remain much the same today,” he says.

**WIDENING CHOICE**

Central to delivering change is ensuring there are more ‘settled accommodation’ options that give people control over where they live and how they are supported.

NHS England, ADASS and the Local Government Association’s Building the Right Home guidance uses the Cabinet Office’s definition of settled accommodation; namely accommodation in the community where individuals have security of tenure in the medium to long term.

That definition includes multiple models: owner-occupier schemes where individuals own or part-own their home; supported living services where people’s needs are met by separate providers of housing and care; tenancies in accommodation owned by friends, family or providers of social housing.

What these models have in common is that the individual’s status as an owner-occupier or tenant allows them to access certain benefits and, if they wish, change their care provider without having to move home.

But what is explicitly excluded from the definition is the model that has long been the default support and accommodation option for people with learning disabilities or autism or both: residential care.

Residential care is not included in the definition of settled accommodation because the occupant does not own the accommodation or hold their own tenancy.

Despite this residential care still has a role to play says Amy Swan, the national housing lead for Transforming Care. “Residential care has a really important role to play as part of a housing pathway, as one of a number of different options available to people,” she says. “First and foremost
Peter Kinsey, chief executive of care and support provider CMG, says the effort to move on from residential care means issues with supported living services are being overlooked. “It’s like Emperor’s New Clothes. Everybody’s too frightened to say anything other than supported living is wonderful, but there can be two very important downsides to supported living that nobody ever mentions.”

The first problem, he says, is that supported living requires a separation of housing and support so that individuals can change their care provider without losing their home in the process.

“That separation is absolutely a good idea, but usually you get a housing association providing the accommodation and many housing associations are poor at maintenance,” says Kinsey. “In supported living the care provider has no control over the housing provider and so the environment can be damaged for a long time before things are repaired or replaced.”

Kinsey’s second issue with supported living schemes is that he feels the Care Quality Commission does not monitor them to the same degree as residential care.

Transforming Care is about choice and what is important right now is widening the accommodation and support options that are available.

“It does not feel like there is the choice of accommodation options available yet for people with learning disabilities. What we’re trying to do with Transforming Care is to work with the communities and providers to develop more options for settled accommodation.

“To do that we have to try and move away from developing new residential care, which we have a lot of, and ensure there are different options available.”

BESPOKE ENVIRONMENTS

Some providers of accommodation and support, however, feel that in the push to widen choice, good quality residential care is being dismissed as an option even when supported living schemes are inappropriate.

“Currently, the focus is all about the model and how people are perceiving registered and non-registered care and the perceived advantages and disadvantages of each,” says Allen of Consensus, which provides residential and supported living services for people with learning disabilities.

“We’ve been struck by some of the conversations we’ve had with commissioners about the very different perceptions of what modern residential care and supported living looks like. Some people do not recognise that many providers are investing in quality bespoke environments that in many cases don’t look much different to supported living.”

We need to recognise the importance of ensuring the workforce understands the difference between registered care and supported living.”
Supported living services are inspected in a similar way to domiciliary care. Usually a head office is registered and the CQC inspects that and a sample of the services that office runs.

Kinsey says that means many supported living services go uninspected: “People with learning disabilities, particularly those with complex and challenging behaviour, are the most at-risk group when it comes to abuse and poor care but they are being moved to services where they may never have an inspector walk through the door.”

Rose, however, says the regulation regime is up to the job: “Yes it is a sample the CQC looks at but, generally, if you’ve got a good care provider you’ll see that reflected in the sample and if you’ve got a poor care provider you will see that reflected in the sample.”

DEREGISTRATION

There are concerns that some residential care homes are rebranding as supported living but doing little more than deregistering from the CQC.

“We would encourage any residential care provider to see supported living as more than de-registering a service with the CQC and fixing locks onto bedroom doors,” says Kaysie Conroy, the principal strategic commissioning officer at Central Bedfordshire Council. “We need to recognise the importance of ensuring that the workforce understands the difference between registered care and supported living and provide the necessary training for staff to shift the culture and mindset.”

Mike Ranson, director of development and partnerships at Consensus, says labels can be misleading. “The perception of residential care is institutional care where individuals have no control over where they live, eat, what they share, etc. but some supported living environments are in fact like the old residential care models,” he says.

Rose says this is happening less following the mainstreaming of Supporting People funding. “When Supporting People funding came in there was a huge rush of this,” he says. “There was a huge financial incentive in claiming Supporting People funding and not being registered, and people did change the sign outside but the practices didn’t change. That incentive isn’t around so much now so the trend has slowed down, but it still happens.”

Ranson says: “Whilst Supporting People funding ceased to be a significant influencing factor in 2009, more recent commissioning strategies, since Winterbourne View, have seen some local authorities actively encourage ‘in-situ’ de-registration of residential care.”

Even when providers truly embrace the supported living model, delivering such a service for the more complex and challenging individuals can be difficult. “We did supported living for about 18 months and then we pulled away from it,” says Richard Smith, managing director of residential care provider Homes Caring for Autism.

There were multiple reasons why Homes Caring for Autism abandoned supported living but the primary issue was that the model made it hard to support a client base that requires at least one-to-one support at all times. “Each one required a sleep-in seven days a week and the staff were required to lone work with no immediate support available,” recalls Smith.

As an example of the challenges of doing supported living without clustering...
services together, Smith tells the story of a young man in one of their residential homes who ripped his toilet out ten times over a three-week period. “If that happens in one of our clustered services we can make sure that we’ve got staff support on hand to help de-escalate and divert,” he says. “You transport that person into his own home with no other staff support than the person who is working with him on that day and you have the same situation, where does the lone staff member get support?”

**HOUSING SLOWDOWN**

These challenges have led Homes Caring for Autism and some other providers to develop residential care services for people with complex and challenging behaviours that offer greater levels of choice and control and more individualised environments.

“Residential care homes these days look very different,” says Ranson. “It can be that some have shared living space, some can be individual flats in a registered service where you have your own front door, lounge, kitchen, bathroom and bedroom. It’s not about the label, it’s about the quality and values of the management, the approach and the capability of that environment to consider what the individual requires and to provide that outcome flexibly and sustainably.”

Some providers expressed uncertainty about future service developments. They are aware that the CQC has completed a consultation on guidance relating to registration of learning disability services (Registering the Right Support). This considered Building the Right Support, national Transforming Care policy and accepted good practice, which followed on from the scandal at Winterbourne View and supports the development of smaller-scale services. The outcome of the consultation, which closed in February, was due to be published in May and will now be published after the general election. Some providers have expressed fears that an application for registration of a new care home may be refused if the service is too large.

In the light of this, Homes Caring for Autism has scrapped plans to develop a registered care service in Somerset that would have given residents their own flats.
The development would have consisted of several apartment blocks, each with six flats. “It wasn’t the six person bit that was the problem, it was that we would have had more than one of those blocks on the site,” says Smith. “The CQC won’t look at your proposals in advance. Instead they say you do it and we’ll then come and decide. Well, that’s just financial nonsense so we pulled out.”

Conroy notes: “Whilst we fully support the notion of smaller and more bespoke service provision, we need to acknowledge that there are some excellent services that are provided in larger schemes.”

Ranson notes that the policy could also hamper efforts to modernise existing residential care services. “If a provider wants to change what they are currently providing to a more innovative or bespoke service by taking a 10-bed service down to an eight beds there’s a risk they won’t get registered,” he says.

Further uncertainty surrounds housing benefits. The government has delayed plans to cap the local housing allowance for supported housing until 2019/20 but what happens after that remains unclear. This, says Swan, has led to reports of “a bit of a slowdown on new developments”.

NEW THINKING NEEDED
In addition local services are still grappling with the financial pressures of austerity and rising demand for health and social care. Solving these kind of financial challenges may mean thinking differently about public money, suggests Leftley.

“If someone has been in a 52-week school and then a residential placement, by the time they reach 30 we’ve probably spent £2m to £2.5m,” he says. “With that life cost you would be better off working with the family to buy that person a house and provide them with support in a different way. It would be really interesting to challenge the government to create a small fund where you could bid in to do it and see if that made a difference.”

Another tough problem for the Transforming Care agenda is how to support those with challenging and complex learning disabilities to move into settled accommodation.

Nonetheless Rose of Choice Support, which provides services to this group, that while there are challenges in moving this group out of institutional care it can be done. “It’s a lot more complex to support people with that level of need or challenge but it is quite possible to do and to do very well if it’s approached properly,” he says.

“There remain a number of blockages. There is a huge financial incentive for the private providers not to support or encourage people to move on. Some local authorities still put them in their ‘too difficult’ pile or are risk adverse and don’t want to risk a scandal. “But all of the evidence is that when the work is done properly, as evidenced in the Association of Supported Living’s There is an Alternative report among others, it is often significantly less expensive than private hospitals and assessment and treatment units, and people have long-term, happy placements in the community.”

FORENSIC SUPPORT
Southend, Essex and Thurrock’s Transforming Care Partnership is hoping to achieve just that through the creation of a multi-disciplinary community forensic service that works across the three local authority areas. The goal is to help people whose behaviours and disabilities have led to them experiencing very extended stays in secure hospitals, move into community based accommodation.

“It is a peripatetic service that can be mobilised to a number of different locations,” says Simon Dickinson, the programme manager for the Essex Transforming Care Partnership. “Its purpose is to allow us to discharge people who have a risk or history of forensic behaviour and keep them in the community. Most usually this involves sexual behaviour, people who because they have a learning disability and/may be more at risk of behaving inappropriately. The function of the

“If someone has been in a 52-week school and then a residential placement, by the time they reach 30 we’ve probably spent £2m to £2.5m”
service is to provide that assurance to the responsible clinician and commissioners that there is an appropriate support role that the individual can access to help manage those behaviours and perceived risks.

“The role of the community forensic service in reality is twofold. It provides some short, sharp training up of the individuals who will provide the core community care; and second, they will provide an ongoing case management role meeting with and supporting the individual to make sure their behaviours are being monitored and maintained in a way that is appropriate.”

Coupled with additional support from social workers and other professionals at local authority level, the intention is that the service can respond should an individual’s behaviours start to escalate in ways that could start to endanger them or others in the community.

The service has a caseload of just 18 to 20 across the partnership. As such, the scale of the service is not really viable to be commissioned on an individual agency footprint, says Dickinson. Instead the service is currently being funded by the seven clinical commissioning groups (CCGs) in the three local authority areas on a “risk share basis”, with the costs shared between CCGs as a block service rather than based upon usage by each individual CCG.

**TACKLING ISOLATION**

Creating stable community placements is one thing, but ensuring people with learning disabilities or autism are happy there is quite another.

One of Leftley’s biggest concerns about the Transforming Care agenda is whether enough is being done to help people find employment and access mainstream services once they are in settled accommodation. “That could lead to what people see as a good thing - people living independently - becoming people trapped in their own homes without a lot of access to local community assets,” he says.

Conroy shares his concern: “We’ve had occasions where people wanted to move back to residential. We are pushing people towards having a home of their own but actually some people are not finding that this is a model they prefer.”

Often, she says, the problem boils down to the nature of communal space and the needs of the individuals housed there.

Conversely, big communal areas can create flash points for people with challenging, complex behaviours. “People

“Let’s not get hung up on models – let’s focus on outcomes”
with learning disabilities have such varied needs I don’t think one size fits all works,” she says. “We really need to be thinking about the design of the property because if you get that right it can really help in maximising people’s independence and minimising their deprivation of liberty.”

There is also a need to think about how accommodation is going to be used in the future, adds Sarah Cavill, a team manager with Central Bedfordshire’s adult learning disability team. “What we have to do with commissioning housing is ensure the accommodation is multi-purpose and multi-functional,” she says. “You don’t want to build a whole lot of things that your emerging population cannot access because the doors aren’t wide enough or the walls can’t be moved slightly or because the shower is not level access.

“It’s really positive that housing partners are working with services to provide good accommodation that is flexible to the needs of individuals now and in the future,” she adds. “We would want to avoid investing in developments that were unable to respond environmentally to changes in people’s needs by reason of age or disability.”

Gaining the input of people early in the design process can help with this, adds Allen. “It works really well when you can get people with learning disabilities and their families involved in the planning right from the beginning,” he says. “If commissioners can say this is the group of individuals we think this service will be for then providers such as us can get them involved at appropriate stages and truly provide control for the individual.”

Central Bedfordshire Council is developing a transition service that will support 16 to 25 year olds with a learning disability. Conroy says the service will focus on helping individuals develop their skills and confidence to help “maximise their level of independence”.

“Sometimes young people find it too much of a jump from being nurtured in children’s services to supported living and being in their own flat,” she says. “It’s a big step so interim support may bridge that gap.”

CHANGING THE CULTURE
Culture and mindset issues are also an ongoing challenge for efforts to re-engineer accommodation and support for people with learning disabilities or autism. “There is still a lack of ambition around social workers in terms of seeing where people can go and the potential people have got,” says Leftley. “As local authorities, we spend a lot of time making social workers follow forms and do assessments and all the rest of it. We need to get them back to where they want to be. In my experience social workers want to do it and so often it is our processes and risk-adverse policies that prevent them from doing it. Once you get people enthused about it, social workers will become the best advocates.”

But it is important not to view those who resist change negatively, adds Revely: “Some of the mindset issue is there for very good, genuine reasons. The people who struggle with the mindset are not bad people, they are not trying to do the wrong thing, but sometimes they are not aware of or open to the possibilities.”

Nor is that resistance limited to professionals. Often the resistance comes from the families. “For very good and proper reasons family members want to protect their loved ones,” Revely says. “They probably fought very hard to get whatever service they currently have and to move on from what
they see as safe and secure placements is a concern. They are not necessarily comfortable with their loved ones taking a few risks as we all do in life. We don’t want to be maverick about that but in a controlled way we can give people new leases of life.”

In order to overcome these mindset barriers, real-life examples of the benefits of independent living and more risk taking are necessary, he adds, recalling an example of a plan to move a young man out of a long-stay hospital when he was a director in Sunderland. “We were told he couldn’t have anything other than nurses looking after him literally 24-7, two people at a time,” he says. The man subsequently moved to home in a group of six bungalows to live independently with floating care, one-to-one care during the day and ‘on call’ overnight support. “I was told previously that no one could visit him unless you had been slowly introduced to him because of his behavioural difficulties but when I visited him he showed me his video diary of him going to the supermarket, etc. And the people who were most against the move became the advocates of doing this sort of thing.”

Swan says that more examples of success are needed to win people over: “We don’t have enough good practice to be able to share with commissioners and clinicians to show them that it is possible and to make them comfortable with some of those choices.”

More open dialogue between providers and commissioners is also important, says Allen: “Commissioners need to find the time to go out and engage in a conversation with providers about what they have delivered. That enables a relationship to be developed with some consistency and that gives confidence to providers to take some risks about funding and find new solutions.”

NO GAME STOPPERS
The challenges in delivering more choice and control for people with learning disabilities or autism or both are many. Funding, commissioning, culture, regulations and scale issues are all helping to whip up the storm that is threatening to blow the ship off course. But, says Revelly, what is important is to understand that none of these are insurmountable problems.

“We will emerge out the other side of this,” he says. “Necessity is the mother of invention and the necessity for us in the sector is to find ways to support people to live independently and therefore we will find a solution. I see some of the issues people see as game stoppers as just being almost a transition point to find our way through. It’s quite often about those important but not fundamental things like where do we find the money?”

Putting the outcomes for individuals first will be paramount to overcoming the challenges, says Allen. “The challenge for commissioners and providers really is as it has always been. We need to work together with individuals and their families to find the best outcomes whilst not being bound by ideology. Let’s not get hung up on models – let’s focus on outcomes.”

And there are developments on the horizon that could accelerate progress towards giving people more independence too, Revelly adds. “People talked about how you can’t get robots to do personal care tasks for disabled people. Well, the Japanese are doing that. It’s a practical issue we are solving internationally. That tech is potentially applicable to people with learning disabilities if they also have physical disabilities. What impact will driverless cars have? People might not have the cognitive ability to drive but what if the car drives itself?”

“There has been a stalling of people building the housing we need at the moment because people are unsure about the ongoing sustainability of what they build.”
CONTRIBUTORS

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This think piece report is designed to stimulate debate and discussion and as such it does not necessarily reflect the views of ADASS. The report is sponsored by Consensus but ADASS retained editorial control of the content.

Content was written by Tristan Donovan
Graphic Design by Forty6Design

ADASS would like to thank everyone who contributed to this report.
1. Name of Policy area: **End of Life Care**

2. Progress on key issues since the last Executive Council:
   - Continued to advocate for social care most recently at the National Roadshow for the EoLC Programme.
   - Continued to support the Ambitions Partnership which recently agreed a revised Memorandum of Understanding and a renewed #eolcommitment being established.
   - Continue to increase awareness of the Knowledge Hub to share learning, new products and resources. [http://endoflifecareambitions.org.uk/](http://endoflifecareambitions.org.uk/)
   - As noted in previous updates for some time Dr Bee Wee, NHSE National Clinical Director for EoLC, and ourselves have talked about setting up a forum for Regional NHS and Social Care leads to come together. Bee achieved that this month by inviting ASC leads to her Regional Network meeting in March and it was great to see the Social Care perspective represented in discussions and for links across the ADASS regions to be strengthened.
   - For more details about work undertaken see John Powell’s blog [https://www.adass.org.uk/end-of-life-care](https://www.adass.org.uk/end-of-life-care)

3. Key issues for the work programme over the next three months:
   - Understanding how the national programme ties directly into the National Programme Board work streams is invaluable and now that Bee has kindly invited us to join this group it is vital that each of the regions is represented. Therefore we would like to challenge each director to identify a lead contact for us and ask them to email with details to programme.support.officer@LondonADASS.org.uk

4. If there are any issues that you would like discussed at the next Executive Council meeting please indicate here and attach a short briefing paper if necessary.

Please return to team@adass.org.uk
1. Name of Policy area:  Safeguarding Adults

2. Progress on key issues since the last Executive Council:

   - Plan for the network for 17/18 being worked up based on three priority areas agreed by Executive; Quality; Making Safeguarding Personal; social isolation and prevention.

   - Completing ‘think piece’ on social isolation and prevention and presenting at “volunteering matters” conference (see item on today’s agenda).

   - Work with Royal College of General Practitioners on their training package on adult and child safeguarding for all GPs and their practice staff completed. New toolkit to be launched to all GPs April 2017.

   - Co-chair joined Joint Fraud Taskforce for Victims & Susceptibility to work on safeguarding adults from financial abuse and scams.

   - Work on RIPFA and SCIE national repository for SARS underway and proposal presented to network meeting

   - Co-chair joined and attended NPCC national ‘Violence and Public Protection Board’

   - Meeting with College of Policing representatives on their ‘vulnerability’ work programme

   - Feedback and conversations with Home Office and National Audit Office on modern slavery

   - Development of Making Safeguarding Personal resources for partners, SABs, and on service user engagement

   - ADASS conducted a short Survey of DASS on MSP in April (results to be presented at Spring Seminar)

   - Interview and support for researcher for File on Four programme on safeguarding and domiciliary care

3. Key issues for the work programme over the next three months:

   - ADASS Spring Seminar workshops on MSP and Prevention
   - Finalise MSP resources for June ADASS Executive meeting, to then launch and circulate
Policy report for the ADASS Executive Council

- Agree priorities for MSP work programme 2017/18 (funded by LGA and commissioned through ADASS)
- Starting the work on Quality and Safeguarding
- Developing networks made with national organisations further to “Volunteering Matters” conference and exploring opportunities for developing an evidence base.
- Identifying pilot sites for social isolation and prevention innovation.

4. If there are any issues that you would like discussed at the Executive Council meeting on Monday May 8th, please indicate here and attach a short briefing paper if necessary.

- Prevention and social isolation ‘think piece’ – for agreement
1. Name of Policy area: Standards and Performance

2. Progress on key issues since the last Executive Council:

The work stream is currently being led by Steve Peddie. Other co-chairs have withdrawn and there is an ongoing advertisement for a DASS co-chair

Quarterly S&P meetings have taken place. Through the Chair the group links to the ASC-DOB (Adult Social Care Data Outcomes Board), Data Co-ordination Board, and Data Transparency Board. These are all means of managing the work being progressed through DH, NHS-D, CQC and the LGA, the burden of collection, the development of new data streams, the method of collection and communication etc

The S&P group has working on Exec priorities
- Support for understanding impact of Budget savings
- Support for Data Quality Assurance around the new national returns
- Support for TEASC and Regional SLI/Performance
- Identifying our role in implementation of Health and Social Care Integration
- Ensuring effective lines of communication between the local, regional and national performance networks.

The workload in this area is growing, partly due to the ambition of the Department of Health to move to a single data outcomes framework, drawing on client-level data and, through CQC, to provide a single view of all provider level data. The former would, in future, obviate the need for grossly time-consuming manual manipulation of the data – for example to populate the SALT / ASCOF returns

The North West pilots are trialling client-level data

The LGA is creating ‘Local Government Inform’, which brings together data in one place. E.g. LG Inform Reports (links):
- Monthly delayed transfers of care
- ASCOF – single council in detail
- ASCOF – Regional comparison

The S&P group is sharing good practice across regions on the SLI agenda. NW Region shared work around:
- Action learning sets
- LGA peer review work
- Team to team peer challenge
- Buddying and shadowing
- Development of NW balanced scorecard using ASCOF, CQC and NHS data (e.g. DTOCs and non-elective care)
Policy report for the ADASS Executive Council

- Work streams had also been developed in: Market-shaping; Integrated and urgent care; Workforce and Safeguarding

The S&P Group has considered a estimating the burden of ASC local authority data collections. There was a wash-up session in autumn 2016 and then a workshop in early March 2017. There has been learning shared between ADASS members and NHS-Digital and some site visits.

3. Key issues for the work programme over the next three months:

(i) CQC have a strategic priority to move to a more intelligence-driven approach which will support commissioning and market-shaping. S&P has considered a report about promoting a single, shared view of quality and intelligence information. A prototype of ASC insight went live in November 2016. Consultation continues.

(ii) Options have been discussed for developing client-level data. 7 options (some of which are linked) are on the table. The NW client level data pilot will continue (informing option 1). The CQC provider data pilot (option 3) will continue. We need to get governance right so we can all learn from the pilot and move from pilot to mainstream. We need to work up what the other options look like.

(iii) The basket of indicators is being consulted on to monitor the impact of the government’s additional £2B investment in the Spring Budget and to measure the effectiveness of developing an integrated health and social care offer at a wider system level. ADASS will be actively involved in the development.

4. If there are any issues that you would like discussed at the next Executive Council meeting please indicate here and attach a short briefing paper if necessary.

Alongside (iii) above there is a slower track work stream in the department of health. Referred to as ‘the new models of care programme, as part of the NHS Five Year Forward View’ a team is working specifically on creating a performance system for accountable care system approaches, working with MCP and PACS vanguards to develop contracts and business models to enable implementation of these approaches. One aspect of the programme is the design of an integrated performance and incentive scheme.

A prototype performance dashboard of (existing) metrics has been referred on by me to the LGA for consideration / critique as the framework does not appear to offer any meaningful way of evaluating the genuine dividend to either service users or the system of true integration between social care and health organisations.

Some discussion of this arena would be useful, particularly since plans for ACOs/ACSs are proliferating and indeed are now the de facto means of ‘graduation’ from the BCF.

Steve Peddie, Deputy DASS, Warrington

Please return to team@adass.org.uk
8th May 2017

1. Name of Policy area: Housing

2. Progress on key issues since the last Executive Council:
   - Continue to be involved in the DCLG consultation on the funding for Supported Housing (and the link to LHA)
   - Work on the web based resource for Directors in relation to Technology Enabled Housing has progressed – on the Exec Agenda separately
   - Proposed Joint Conference with CIH – separate item on the agenda
   - Improving Health through the Home – National MOU; bi-annual monitoring meeting held (hosted by PHE) and looking for a ‘light touch’ refresh

3. Key issues for the work programme over the next three months:
   - Joint Conference with CIH
   - Refresh of MOU
   - Consultation and Green Paper on Funding for Supported Housing
   - Supporting Partner Organisations in relation to consultations and updates

4. If there are any issues that you would like discussed at the next Executive Council meeting please indicate here and attach a short briefing paper if necessary.

   - Separate items are on the agenda

Please return to team@adass.org.uk
1. Name of Policy area: Care and Justice

2. Progress on key issues since the last Executive Council:

We have been building stronger working relationships with both NOMS (now HMPPS) and colleagues on the NHS England Health & Justice Directorate. Through our Associate, Ian Anderson, we are well engaged in the Prison Reconfiguration work ensuring both that individual councils who may be affected by the change of role or closure of prison in their area or by the opening of a new prison are engaged early in the planning process and also that could social care practice is built into the design of new and refurbished prisons. To this end Ian and a colleague from London Borough of Greenwich have attended two workshops with NOMS and their architects to provide an input to the model design for the new “Resettlement” prisons.

We have also become more engaged in the roll out of national Liaison & Diversion services and will be leading a workshop on this at the Spring Seminar. In recognition of the value of our support, we have now been asked to join the national L&D Implementation Board.

NHS England and the Home Office have started work on developing a “Sexual Abuse Services Strategy” based on the NHS 5 Year Forward Plan. We were pleased to be invited to attend an initial roundtable discussion on the scope of this and have been asked to remain involved and to help NHS England engage with more specialist interests in ADASS, LGA and ADCS.

Operationally, there clearly remain inconsistencies in joint working with NHS England Health & Justice commissioners, prison health care providers and local authorities especially where there are prisoners with more profound health and social care needs. Mostly these disputes relate to the responsibility for the provision of specific items of equipment, issues which have generally long been sorted in the wider community.

Planning for the discharge of prisoners is still not firmly embedded and the Care & Justice Network has focussed attention on both how to work with Parole Boards and ensuring that when prisoners are released on compassionate grounds because of the severity of their health conditions that there is a prompt and effective response from the local authority to which they will be returning.

Safeguarding in prisons remains an issue and although progress is being made in many places due to the active support of both local authorities and Local Safeguarding Adults Boards there remain periodic concerns.

Finally, I am very pleased to report that the value of our input has been recognised to such an extent that I have been invited to join the national Health and Justice Partnership Board which brings together the most senior civil servants of the Department of Health, Ministry of Justice and DCLG.
3. Key issues for the work programme over the next three months:

The key issue facing the work programme going forward is how to resource the capacity to service all the requests we now have to engage at a national level. Over the past 3 years we have been very reliant on Ian Anderson, ADASS Associate and for the first two years of that ADASS received funding from DH to support him.

The Care & Justice Network has never received any financial support from either ADASS or the LGA and we are now in discussions with DH, NHS England and HMPPS to cost a programme of national support and to explore how it could be funded, perhaps by relatively small contributions from each key partner (approximately £5k across all of them)

4. If there are any issues that you would like discussed at the next Executive Council meeting please indicate here and attach a short briefing paper if necessary.

James Bullion, Director of Adult Social Services, Norfolk (Chair)

Please return to team@adass.org.uk
1. **Name of Policy area:**

   Older People Network

2. **Progress on key issues since the last Executive Council:**
   
   The care market work commissioned through the NWADASS Branch has been advertising and shortlisting has commenced. The network has contributed to the national trusted assessment guidance. The network has contributed to the “Engaging Citizens Online” briefings which will be shortly published.

3. **Key issues for the work programme over the next three months:**

   Supported the University of Birmingham with a research bid around the impact of care home closures.

4. **If there are any issues that you would like discussed at the next Executive Council meeting please indicate here and attach a short briefing paper if necessary.**

Please return to team@adass.org.uk
1. Name of Policy area:  Workforce Development Network

2. Progress on key issues since the last Executive Council:

   - Regional Network group established. The group speak every 6-8 weeks to discuss regional workforce issues and opportunities. These are then taken forward at a national level via the Workforce Development Network or cascaded through to regional groups.

   - The network are supporting the National Audit Office’s workforce study. The group will participate in developing dialogue for the audit team and provide insight into the workforce landscape.

   - The development of the commissioning workforce workstream continues with the support of Skills for Care. This will be a discussion item at the Spring Seminar.

3. Key issues for the work programme over the next three months:

   - Implications of the increased budget allocation for Adult Social Care still to be understood.

4. If there are any issues that you would like discussed at the next Executive Council meeting please indicate here and attach a short briefing paper if necessary.

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