Care, Support and Wellbeing of Adults in Lancashire

Presentation for Health and Wellbeing Board

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What is the picture we are painting?

- Keeping people safe, well and connected
- Keeping people independent and living at home, or close to home
- Keeping response, plans and expenditure reasonable and proportionate

Context - High Level Budget Analysis

- The county council has to find £135m savings over the next 2 years to balance the books, general reserves will be depleted at that point;
- If we cannot balance our books, unlike health, government will not fund the deficit;
- LCC has already taken c£350m out of the base budget over the last 5 years;
- Central government is aiming to phase out general revenue support grant from 2020/21;
- Our income in the future will be from specific grants, locally collected business rates, and income from charges;
- Local authorities cannot generate 'profits' through charging;
- Local authorities can only increase council tax each year by a certain amount, currently 1.99%, without a local referendum;
- Local authorities have been able to increase council tax for adult social care by 2% pa over the last 3 years. In Lancashire this has generated an additional c£7m pa, this has nowhere near covered the ASC 'gap', which is c£90m pa.

Context - High Level Budget Analysis

- LCC Adult Social Care gross budget for 2018/19 is £555M, net budget £347M;
- Adult Social Care currently makes up 41% of LCCs gross revenue budget, 45% of LCCs net revenue budget;
- Adult Social Care has been targeted with between £49m and £61m additional savings. This is in addition to the £63m already taken out of the Adults budget between 2018/19-2021/22;
- The 2018/19 total County Council budget is supported by reserves totalling £42m. £19m of this reserves is supporting Adult Social Care services in 18/19;
- Public Health grant is reducing year on year, and is likely to be un-ringfenced within 2 years;
- Extra £5.5m for adult social care to fund additional winter pressures, and some additional funding in the Chancellor's budget;
- Will not address the inherent funding gap. Health withdrawing funding on the back of these announcements will compound the pressure.

Evidence shows

- Heavy reliance on Bed Based Services for all population groups;
- Comparatively high use of care homes in the NW and Lancashire (but much better than 5 years ago);
- There is growth in the use of residential care beds, but a reduction in nursing beds, the reverse of what we need;
- Large residential homes tend to score lower quality than smaller homes, and nursing homes tend to score lower quality than residential;
- Near average use of direct payments – England average is 28%, we're at 26%, but top local authority performers are nearer 45 to 50%;
- High % of adults going on to receive long term support;
- Low % referred to universal services – LCC at less than 10% whereas best authorities are at 70%;
- High % spend on LD&A unit costs on the current model of supported living;
- Very high % spend on MH residential care;
- High numbers of people with MH receiving a funded service from LCC;
- Lancashire's population is ageing;
- Population health in Lancashire is varied, and in some parts, amongst the worst in the UK, and declining;
- Many health related conditions are avoidable or reversible.

We know ….

- Our information and advice offer is poor;
- Community and neighbourhood working is relatively under developed;
- More Older People and those with Physical Disabilities receive long-term services;
- Mental Health customers are far more likely to receive a residential based service than other comparator councils;
- Culture of risk aversion/ over dependency not enabling e.g. high spend on night time support, single and small tenancies for LD&A;
- Many customers still receive homecare rather than an offer which will help them regain or support independence;
- Admissions to care homes are too high and quality is still too variable despite recent improvements;
- Our Extra Care remains small scale and patchy;
- We do not systematically identify or get agreement to joint funding from Health and subsequently can struggle to collect any agreed Health funding;
- We struggle to distinguish demand from need.

Why do we, as a system, need to change?

- As a system our current approach is putting undue pressure on all our staff, who are faced with increasing backlogs and increasing expectations from people wanting services;
- The county council is funding some services that arguably should be paid for by health, and vice versa, our respective staff teams are wasting time and energy in arguing over funding;
- As a system we are placing people into long term residential based accommodation, which would not be their first choice, but is often seen as the safest and most expedient option for hospital staff, who are themselves under pressure to make a speedy discharge;
- Our staff can demonstrate that reablement is a safe alternative to long term residential placement;
- We know that the packages/services we put in place are often inadvertently reducing and sometimes removing people's ability to look after themselves and/or recover from a period of ill health;
- As a system we can no longer afford to provide long term/high cost packages of care and support;
- As a system we need to focus far more on prevention and wellbeing;
- As a system we are not always listening enough to our skilled and knowledgeable providers, partners, developers, customers and staff;
- Others are changing, we need to keep pace.

What our staff are telling us

- Jointly provided services would make so much more sense to staff and the public;
- There are examples from other countries (Ireland, NZ), and other parts of the UK (Lincolnshire), where integrated systems work, so why can't we make it work;
- Members of the public do not care who provides care and support services, they do not want to be passed around our systems and repeat their story;
- If our staff could jointly use the same systems, or at least share information, it would save time and frustration, and improve the customer experience;
- Our staff spend a lot of time arguing with each other over funding. This is divisive, wastes time, and the person needing care is stuck in the middle;
- Health professionals often recommend a residential based solution as the 'safest' option, without upfront discussion with social care staff. This can then be difficult to row back from, is likely to cost more, and be dis-abling for the person;
- Some social care staff are afraid of being blamed if something 'goes wrong';
- Hospital referrals for Reablement are not always appropriate eg end of life;
- Co-location of teams and joint training would be greatly beneficial;
- We have lost some of our local presence and knowledge.

Building on what works

- Reablement
- Home First
- Telecare
- Night time support / falls lifting service
- Trusted Assessors
- Shared Lives
- Passport to Independence

What we will do differently

- Based on best available evidence and legitimate challenge from external colleagues eg John Jackson LGA, John Bolton's '6 Steps to Managing Demand';
- Nothing radical – has been done elsewhere, however not all at once and at such scale;
- Accelerate existing activities e.g. Remodelling, Direct Payments, Telecare;
- Shift emphasis from bed based to community;
- Engage purposely with the NHS regarding joint funding and joint working arrangements;
- Review in house provision – strategic purpose, cost / benefits and other ownership and operating models;
- New models of support in LD&A and Mental Health;
- Additional external support from NW ADASS for Market Position Statement, and LGA for Housing with Care, and a Peer Review of the 'Front Door'.

What we must do together?

- NHS England state that 30% of people in a hospital bed could receive more appropriate care in an alternative setting;
- If we continue with the current model of care we jointly know:
  - we can't afford it;
  - we can't staff it;
  - it's wrong anyway;
  - it doesn't always deliver the best outcomes.
- We need a profound system shift to:
  - improve prevention;
  - avoid referrals and admissions;
  - discharge earlier and more appropriately;
  - manage in primary and community care.
- ***The system is health and care, an equal partnership.***

Specific areas for collaboration?

- Market Position Statement
- BCF
- Fee uplifts
- Home response / falls lifting service
- Extra Care Housing
- Additional funding for winter pressures
- Intermediate Care
- Workforce / apprenticeships

3 key things to agree?

- **Can we work together as a system to agree our approach to:**

1) **market management** – what needs stimulation/development, what we might want to change /diversify eg housing with care and support to reduce reliance on residential admissions and keep people at home;

2) **funding issues** – what can we jointly fund, what can fund via pooled budgets, what should be health funded, what should be LA funded;

3) **prevention** – what can we do better together in our neighbourhoods, are we clear on the joint impact of disinvestment in preventative services, have we got the focus right, do we focus too much on acute pressure/discharge issues/providing services after the event, should we focus more on reducing and preventing admission/improving our community services.

Does this make sense?

Is any of this a surprise to you?

Have we got any of this wrong?

Thank You