Delivering better services

Living Better Lives in Lancashire

Lancashire County Council

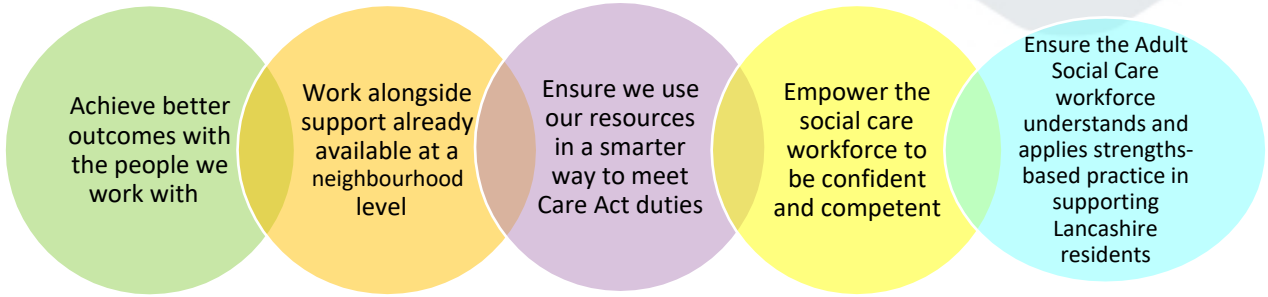
Living Better Lives in Lancashire

Living Better Lives in Lancashire (LBLiL) is a vision for Adult Social Care, offering support to Lancashire residents to live as independently as possible.

We are committed to delivering strength-based support which:

- Offers advice, information and signposting to support, which is close to where people live, to prevent, reduce or delay the need for formal social care support
- Offers short-term support (up to 6 weeks) to enable people to regain skills, confidence and independence so that they can live at home safely where it is possible for them to do so
- Ensures that when adult social care does assess people against Care Act (2014) eligibility that we do so in a timely way and offer support which enables them to live their best lives

Practice led Transformation will:



LBLiL Values

Listening to people with lived experience and treating them as equal partners in shaping future support

Creativity & innovation

Listening to our communities

Embracing collaboration with staff, providers and partners

Making use of information and data to inform our decision making

What does this mean for the people we support:

- "I matter"
- "I will be listened to"
- "I will have care and support that is coordinated, and everyone works well together and with me"
- "I will have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths, and goals"
- "I will be supported close to where I live"
- "I will be asked about my experiences and my suggestions for improvement"

What does this mean for social care professionals:

- We will ensure practitioners have access to strengths-based training to facilitate a culture change process to deliver our new vision for our people and our communities
- We will build upon the core values of social care practice within our new approach
- We will enable creative, effective and collaborative working
- We will experience a richer working environment with high satisfaction rates for staff and the people we serve
- We will significantly reduce bureaucracy, ensuring it is at the minimum that it needs to be
- We will ensure that our systems are improved and support best practice

And our partners and care providers:

- We will develop connections with our VCFSE sector, and as equal partners develop agreements on how we work with some groups
- We will become data led to support our new ways of working, to improve lives and to support people to live a good life
- We will change what we do through adopting a strengths focused, community first commissioning strategy.
- We will adapt out culture, basing it on trust, empowerment, and shared values across all our teams

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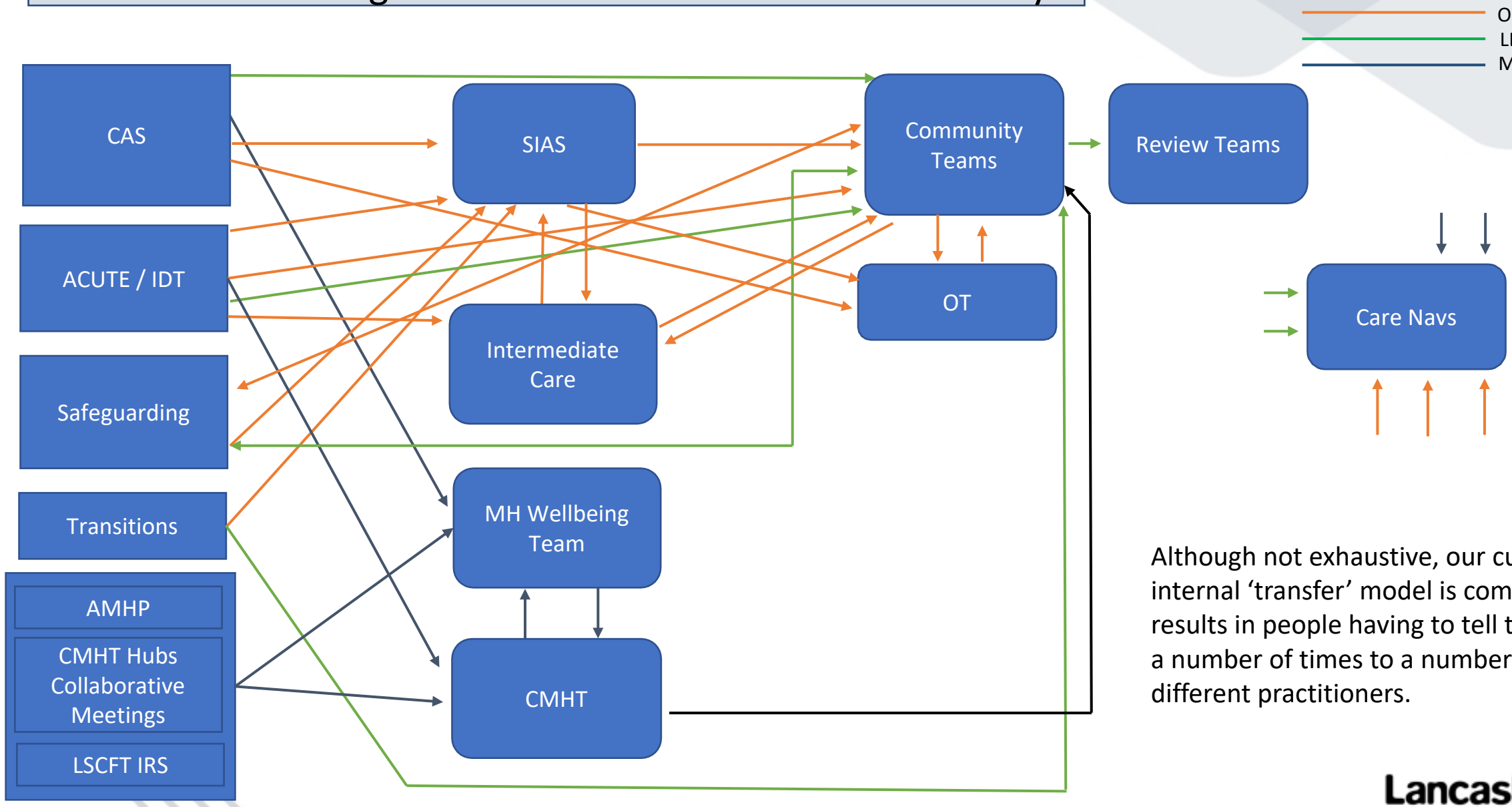
Adult Social Care Vision (April 2023)

Rationale for Change – Current Internal Transfers Pathways

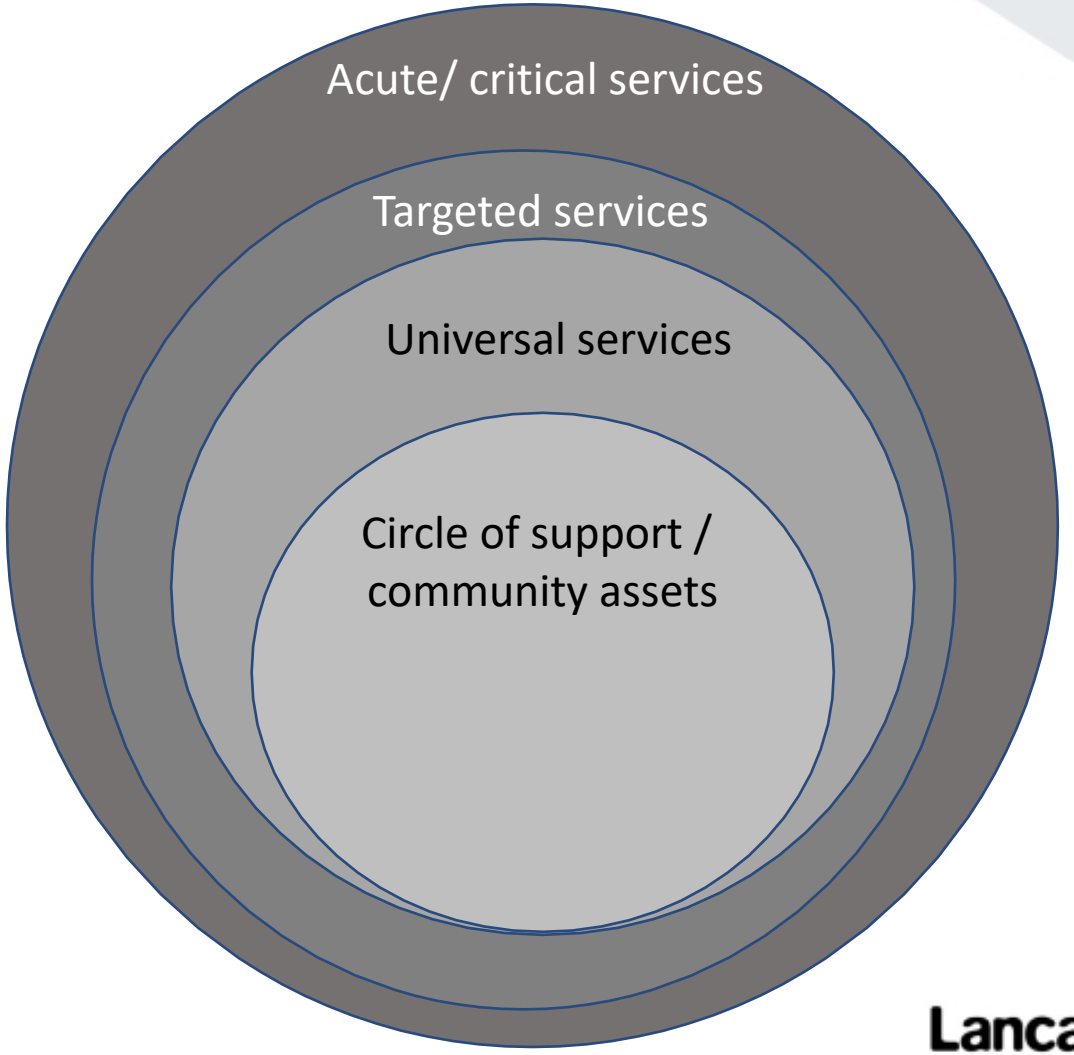


Although not exhaustive, our current internal 'transfer' model is complex, and results in people having to tell their story a number of times to a number of different practitioners.

Adopting a Strengths-Based Approach

Key elements of strengths-based approach

Strengths-based social care



Strengths Based Practice Framework and Practice Handbook (DoH, 2019)

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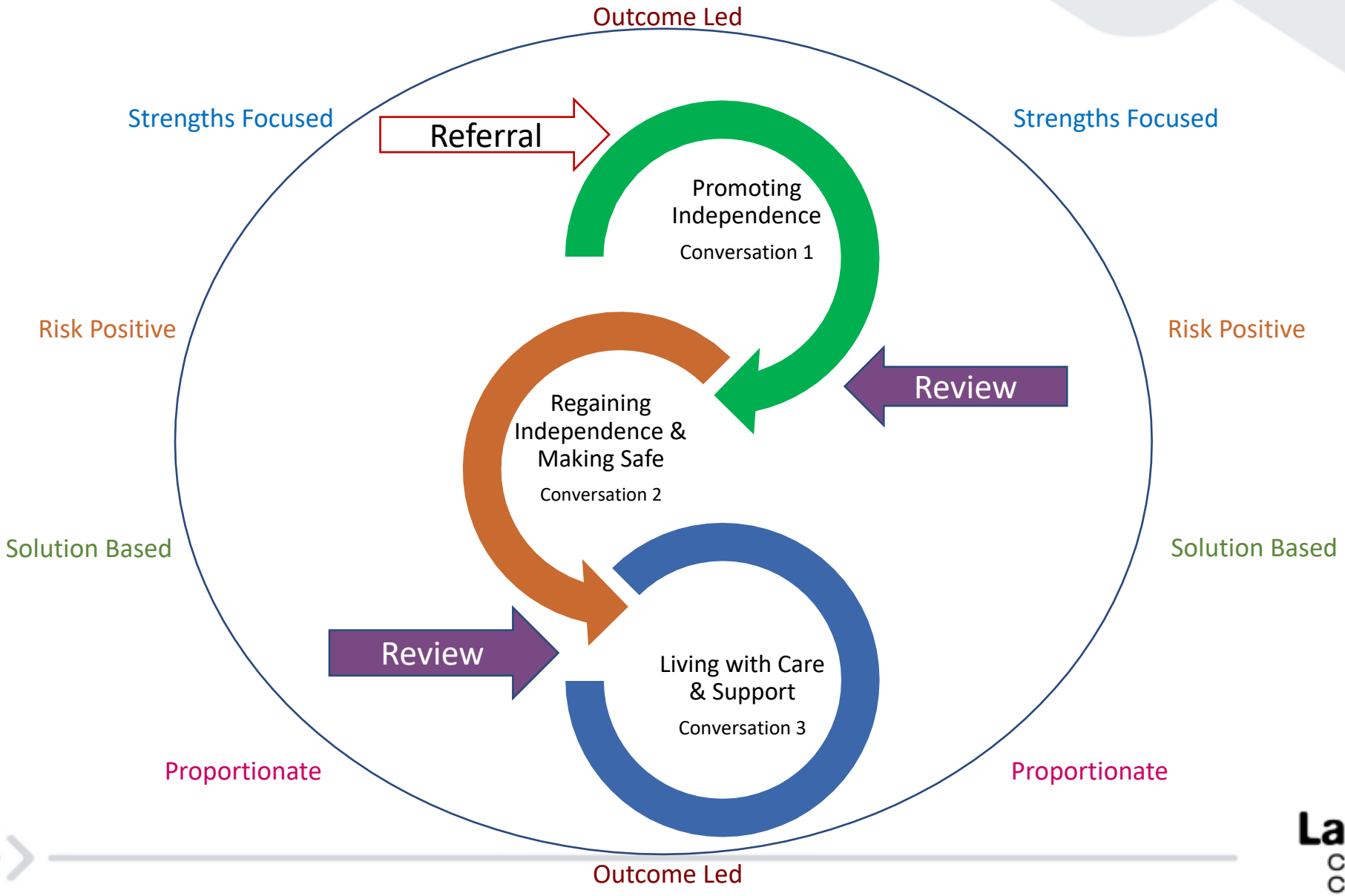
Living Better Lives in Lancashire Practice Model



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Living Better Lives in Lancashire Practice Model

Promoting Independence

Living Better Lives 1

This is our first conversation with people who access Adult Social Care. This is not a tick-box exercise or an assessment for formal care services. It is a strengths-based, solution-focused conversation to find out what the person wants to achieve.

- We will not exclude people who we may initially think are not eligible for support - this is to reduce/delay or prevent long term support
- We will listen to the person and their relevant parties, including those that they have asked us to talk to
- We will listen to and understand why the person has approached us - this is our focus
- We must understand and document their wishes and feelings
- Our work with people in this stage will capture and document what they can do for themselves, what their family and carers can do to support them, and how their community can support them
- We will collaboratively plan how to utilise these strengths to meet initial need(s)
- We will work with the person to ensure they are safe
- There are no resources committed at this stage of the assessment. If we need to look at more focused support that may require care or professional intervention you should move on to the second conversation.

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Living Better Lives in Lancashire Practice Model

Regaining Independence & Making Safe

Living Better Lives 2

In step 1 we looked at what the person wants to achieve, gathering information about their own strengths and abilities, personal networks, and local area which could help them. Sometimes, having explored these options, it is not possible to achieve all of their outcomes without some additional, short-term support or equipment.

Additionally, sometimes people contact us when they are in situations whereby something needs to happen quickly as they may not be safe, or those who help them to remain independent are not available. An urgent short-term plan, for up to 6 weeks, can be part of step 2.

- We will not spend time assessing for Care Act 2014 eligibility; however, we need to be sure that we are meeting social care needs, and that the time-limited intervention will help to reduce and delay Care Act 2014 eligible needs.
- We will listen to the person and their relevant parties
- We will understand from the people, and those who are important to them, what needs to change quickly to help people regain resilience and stability
- We will ask and document what needs to change to make them safe and regain control. Who is involved in their life? What does their community offer?
- We will enable people to gain the confidence to learn new skills, promoting their independence
- We will support people to regain skills, and delay and reduce needs where possible.
- We will check back with the person after 1 week, 3 weeks and 5 weeks whilst they regain stability and/or independence
- If the person continues to require intervention after approximately 6 weeks, we will move to a Living with Care and Support assessment to consider Care Act 2014 eligibility

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Living Better Lives in Lancashire Practice Model

Living with Care and Support

Living Better Lives 3

Our emphasis is to listen to people, connect people to their own and community assets. Some people will require long-term support linked to Care Act 2014 eligibility. Meeting someone's Care Act 2014 eligible needs does not always require commissioned services, the long-term support plan should include support from a range of services.

- Care Act 2014 eligibility is considered at this stage
- We will always revisit whether advice and guidance or community support services / the voluntary sector / faith groups / social enterprises can meet eligible needs
- We will already have a lot of the information we need from steps 1 and 2
- We will work with the person and their representatives to collaboratively undertake the support planning
- We will work with the person to ensure that they, their family and their carers are safe
- We will work the person to develop their support plan which will be focused on their strengths

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Lancashire County Council Adult Social Care

The Living Better Lives in Lancashire Model

LCC Early Engagement

Our role in prevent, delay & reduce

Community

LCC Libraries, Public Health, Community, Voluntary and Faith Groups

Early Enablement

LCC ASC Place-Based Investment – Community Services – e.g. carer services, social isolation prevention, community transport

LCC ASC Digital Front Door, including accessible resource directory, information and advice, self-assessments and support planning

Adult Social Care Wellbeing & Early Support

CAS

Wellbeing & Early Support

Long Term Care and Support

Initial reviews undertaken by Community Long-Term Teams (6 weeks)

Community Long-Term Teams

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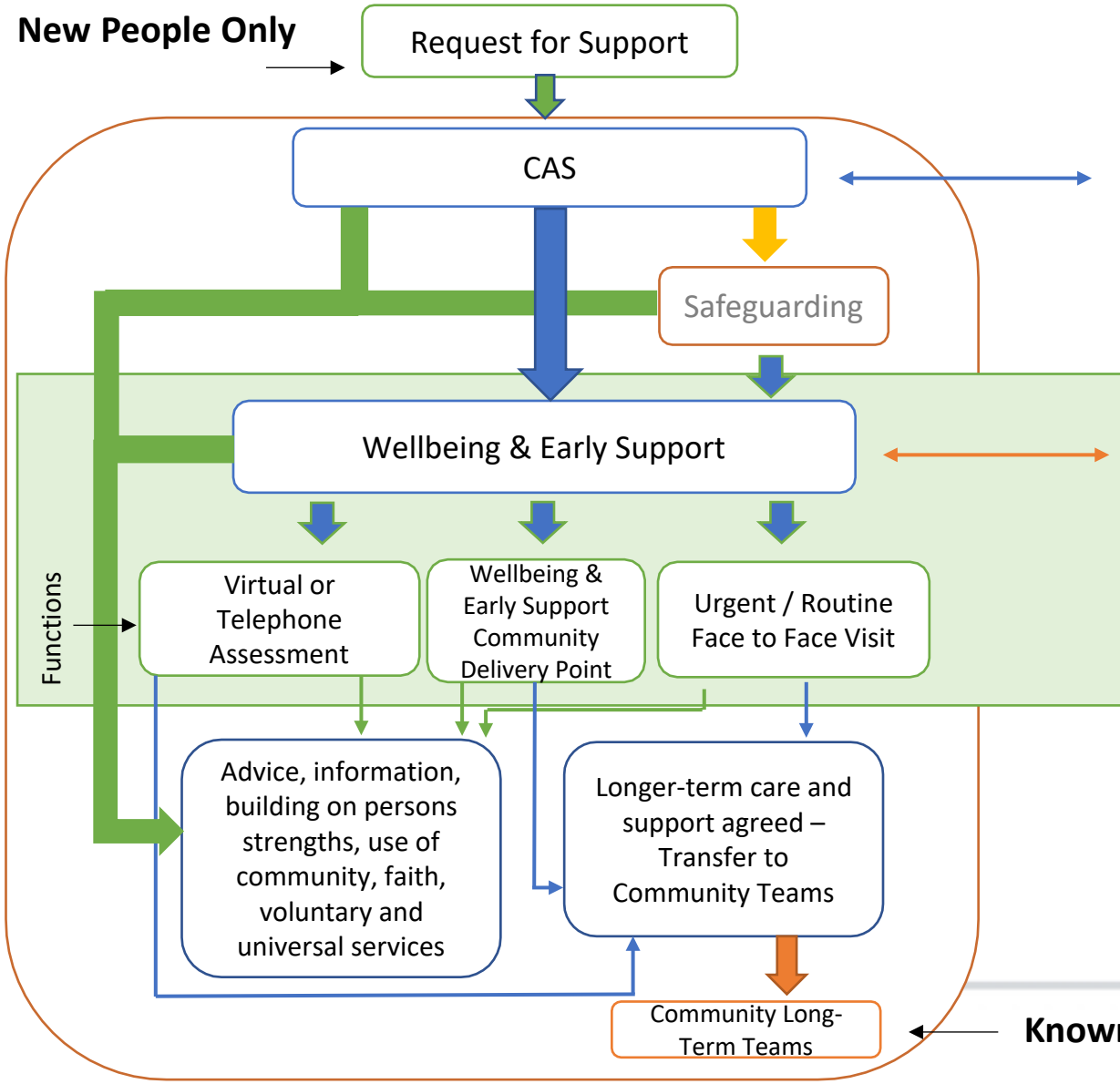
Adult Social Care – Wellbeing and Early Support

New People Only



One unified operating system across ASC, which will provide greater continuity for residents and prevent the need for them to recount their story multiple times.

Quick and efficient response to requests by trained CAS operatives who can take initial calls, collect demographic and appropriate information, and continue to support people to self-serve and or/or provide people with advice and guidance
CAS will continue to connect people to safeguarding as per protocol.

Where CAS are not able to provide appropriate advice, guidance, and support to self-serve, the call will be transferred to Wellbeing & Early Support. Duty will gather further information and ensure the person is routed effectively, taking into consideration immediate needs, strengths, response and risk.

A county-wide co-ordinating function providing a seamless ASC front door & supporting system, with networked place-based working.

Each function within Wellbeing and Early Support will undertake all elements of the practice model (our practice model and care and support planning, when appropriate)

Our community teams will introduce themselves to people whilst undertaking the initial review. A well as the initial reviews, community teams will complete annual reviews, provide a duty function for people known to ASC, and undertake unscheduled reviews and requests for reassessments.

Known People Only

People known to our services remain with our community long-term teams.

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Adult Social Care Wellbeing and Early Support

Principles of how it will operate

- This will be the initial involvement and access to our Adult Social Care Community Teams.
- We will have a number of skilled professionals within this function who will offer social care advice across Older Adults & People with Physical Disabilities; Learning Disabilities & Autism; Mental Health; Rovi, Substance Misuse; Occupational Therapy. Work is on-going to structure the Wellbeing and Early Support function.
- The ethos will be about reducing handoffs and people not having to tell their story more than twice.
- The Wellbeing and Early Support function will understand what community support is available to our residents, so they are able to connect people to relevant services and give information or advice to enable support to be provided close to where people live.
- Wellbeing and Early Support will link closely with other colleagues around hospital admission avoidance.
- Wellbeing and Early Support will work closely with partners within the VCFSE sector and where possible involve them in the function to respond to residents in a timely way.
- Wellbeing and Early Support will be close to, or within, people's homes and communities wherever possible.
- Wellbeing and Early Support will carry out their work within the three specific functions, offering greater choice to the people we work with from the start of our involvement.
- Wellbeing and Early Support will undertake all elements of the practice model.
- Wellbeing and Early Support will collaboratively undertake the care and support planning with the people they are working with and will then introduce them to the appropriate community team.

Adult Social Care Community Long-Term Teams

Principles for delivery

- The community long-term teams will introduce themselves during the initial review.
- After the initial review we will provide proactive way of undertaking regular reviews, even for people who have stable packages, to reduce demand linked to crisis/ unplanned reassessments - e.g. contact being made every three months.
- This will require a transition to a more proactive case management model incorporating strength based practice, rather than driven by the completion of assessments.
- We will embrace robust case management for people with complex care and support needs, self neglect etc.
- People will have access directly into the community teams via a duty telephone number and email address - so they do not have to come back via Wellbeing and Early Support.
- We will scope new ways of working to streamline processes, such as the potential to introduce an automated telephony system for people to keep in touch and complete light touch reviews; or online options for people to complete their own reviews.

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How will we know if we are successful?

Outcomes for people will improve.

We will measure improved outcomes via feedback from those we work with, their families and advocates. We will demonstrate an overall reduction in statutory interventions and an improvement in building on peoples strengths and communities and use of universal services.

Practice changes

Practice changes will be evidenced through more people having their needs met within Living Better Lives 1 or Living Better Lives 2. There will be a reduction of care commissioned for 10 or less hours, as the persons own strengths, use of the VCFSE, and use of universal services will support people to remain as independent as possible. People will remain in their own homes for longer will a variety of support discussed and agreed. We will complete annual reviews proactively and reduce the amount of re-referrals within 3 months of an intervention. We will reduce the amount of double up care being provided and make use of appropriate equipment and technology.

Staff satisfaction

Practitioners will have access to strengths-based training to support their development and confidence, whilst being able to build upon their core values of social care practice. Bureaucracy will be reduced and our systems improved. We will evidence this via staff feedback, focusing on how practitioners are being supported to be creative, effective and collaborative. A reduction in staff work-related stress absence and a more steady workforce will further evidence staff satisfaction.

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How will we know if we are successful?

Monitor Data.

A suite of KPI's will be developed, along with the introduction of targets for services and teams, to monitor our success and highlight our areas for further work. Using data and KPI's will enable continuous improvement by measuring our progress, highlight where adjustments need to be made, enable us to solve problems and embrace opportunities, provide the ability to analyse patterns over time.

CQC.

Implementation of our practice model is the **cornerstone** of our CQC improvement plan.
The practice model is our new Adult Social Care vision, and our number one priority for 2023/2024.

Savings.

The Local Authority has a range of savings targets to be achieved over the next few years. Adult Social Care is not exempt from enabling the Local Authority to reach it's savings targets. Adjusting our practice, and reducing the amount of commissioned services when the person's own assets, the services available in communities and the VCFSE, alongside universal services can meet assessed needs, will support Adult Social Care in achieving its agreed savings.

Thank You

Questions?

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