

Adult Social Care in Rotherham

A Vision and Strategy

Introduction

Nationally, the provision of social care for adults has undergone enormous change over the past generation. While the direction of travel has been reasonably consistent, the pace of change has accelerated over the past few years as the demand for more personalised services continues to grow, traditional models of care are seen to be outdated and not delivering independence, choice and control and pressure on the system grows from more demand and less resources.

It is well-recognised that the state – national and local – has often created and maintained dependency rather than supporting independence. There is a recognition of the importance of building resilience at an individual, family and community level as this is better for people and offers a more sustainable model for the future.

Linked to this, the approach in Adult Social Care is increasingly based on an assets model – identifying with the person what they can do, what they do have, who they know and which community groups they are linked into, what their family and friends can do as carers and what the wider communities can offer.

Further, the focus in ASC is on outcomes – both for individuals and their carers and families but also for the wider community and residents. Improving the help and support for individuals who need it at any specific time benefits the whole community as they are likely to be family and friends of people requiring support or who may come to need it.

These changes have now been reinforced with the introduction of the Care Act – assessing on the basis of outcomes – health and wellbeing, quality of life, engagement in the community and so on. Equal rights for carers and the cared for which builds on years of legislation and enshrines the rights of carers.

For many years, care was based on an institutional model and as this began to change with the recognition of the scale of abuse that was taking place, more care began to be provided in the community. However, the replacement of large institutions outside of town with smaller ones based in towns was never a sustainable model as users and carers increasingly demanded “a life” not “a service”.

Therefore, there has been an increasing development of care based on a personalised model with people enabled to live in their own homes and to access services, facilities and buildings as part of the wider community. Consequently, the role of ASC has changed – rather than being focused on delivering a range of services, it has had to develop a strong partnership and influencing role. Within the

Council, it has led on the development of the recognition about making all services accessible to all sections of the local population. Further, it has led on developing the recognition that all members of the community, no matter how disabled or elderly all should be valued members of the community.

Beyond the Council, ASC has become a key partner with health services and this partnership has been enshrined in different ways – eg through the Health and Wellbeing Boards and the Better Care Fund. Increasingly, integrated services are seen as the way forward in delivering more personalised and holistic care.

In considering what integrated services look like, it is essential to ensure that mental health services are seen as a key element of the integrated care and health services. It is essential to put in practice the slogan “no health without mental health”. The evidence is very clear that physical health and mental health are inextricably linked and that it is essential to treat them equally in addressing people’s care and health needs. Many studies have demonstrated the benefits in terms of improved outcomes for users through the integration of services. Integration should include the commissioning and delivery of care services and physical and mental health services.

Further, as there has been a move to maintaining people in the community there has come the recognition that there needs to be a wide range of accessible community services, facilities, buildings, activities and community engagement. ASC has been central to the development of these community assets to which older people and people with disabilities should have access. Consequently, ASC has developed strong partnerships with third sector organisations, community groups, faith groups and individuals who are delivering a wide range of activities and services in local communities.

Over time, the nature of the needs that ASC must address has changed. Improvements in health and care services have meant that people with disabilities are living longer which has brought new challenges eg caring for people with learning disabilities who have dementia. The growth in the number of very elderly people has meant that there are more older people with more complex needs. While this has meant that these people require higher levels of service, there is also a recognition that more can be done to avoid them requiring intensive services and consequently, the aim is to divert people from the formal care system and to develop preventive services and rehabilitation services to enable people to regain and maintain levels of independence.

The importance of prevention and early intervention is well-recognised and this cuts across social care, physical and mental health. Further, the principle should be employed in whatever situation people live. It is essential that the person is seen in the whole – that their health and wellbeing are addressed – and that this is done in at every stage of people’s journey through life – whether they are outside of the formal

care system or whether they are receiving high levels of formal care and health services. It is essential that the opportunity is taken at all times to maximise people's independence and ability to make choices and take control of their lives.

Another major change over the recent past is the development of safeguarding for adults. While initially focused on protection and reacting to instances of abuse, the approach to safeguarding has developed to recognise that it is an integral part of the personalisation agenda helping to ensure personalisation is possible and deliverable. The recognition that safeguarding adults is everybody's business is well-established and the growing intolerance of hate crimes helps to ensure that older people and adults with disabilities can access wider community assets.

Another significant change is the funding available for ASC. This has grown significantly over many years but has been clawed back dramatically in the face of the economic recession. The national picture is that social care for adults is underfunded and resources have been transferred from NHS budgets to underpin adult social care budgets. Demographic pressures, rising standards and expectations have added to the challenge facing adult social care budgets and there has been enormous pressure to ensure that the available resources are used effectively and deliver best value. Consequently, new ways of delivering care have emerged – personal assistants, micro-enterprises, CICs etc.

Given these changes at a national policy level and given the groundswell of demand for change from users and carers it is essential that the vision and strategy for Adult Social Care take these changes on board and reflect them.

Vision for Adult Social Care in Rotherham

The ambition in Rotherham is that adults with disabilities and older people and their carers are supported to be independent and resilient. The outcomes that are desired for these groups are that they should live good quality lives and their health and wellbeing is maximised.

For most people, this will entail remaining in the community with friends and family. However, for some to achieve these goals, alternatives such as Shared Lives, Supported Living, Extracare Schemes etc will be necessary and for a small minority a residential placement may be necessary. The focus should be on maintaining people in the community and this requires long term support eg homecare as well as a wide range of prevention and rehabilitation services and a wide network of resources, services, groups and activities in the community.

It is essential to recognise that during the course of people's lives, there may be times when they need support and care and health services need to be prepared to intervene on those occasions. However, the aim should be to intervene appropriately with the aim of providing minimal support to enable people to maintain their

independence. There is always a risk that by providing too much support people will have their independence eroded.

In order to achieve this vision, it is fundamental that a network of support is created which includes Council services, health services, private and third sector services and voluntary, community and faith groups – as well as friends, family and neighbours. Further, it needs to be recognised that as people grow older or live with a disability, it is ever more important that local facilities and services are well-developed as these are the ones they will look to first and foremost. Therefore, what is required is a partnership across Rotherham.

The strategy to deliver this vision

The development of a wide range of community resources in Rotherham's communities underpins the strategy. This network of community assets provides the support for people to live fulfilling lives engaged with their family, friends and community. This prevents their physical and mental health deteriorating and is the basic building block for the strategy and without it the pressure on the formal care and health system will overwhelm it.

Therefore, the strategy must recognise that this network of community resources needs to be developed and invested in and that it is best delivered through a partnership with the third sector. The Council and the health services, along with other partners such as the police, must work in partnership with each other and with the third sector to build the community assets which ensure people thrive and not just survive in the community.

At any point, people may feel they need advice or support for themselves or for a family member or friend. Therefore, the strategy needs to ensure that there is a front door which listens to what people are asking for and addresses these requests in a way which supports them to take control of the situation for themselves and this could mean the provision of information or advice or it could include requesting simple equipment or undertaking a self-assessment. In this way, people are supported through simple, one-off interventions which allows them to maintain in control and to maintain their independence. The aim is that a minimum of 75% of these requests are dealt with successfully at the front door.

However, for some people it may be that their needs are greater or the initial response hasn't resolved the position. In these situations people will need to be assessed. However, again the aim is to assess for the desired outcomes and to support the person to develop a solution which maximises them taking control and minimises interventions from the formal care sector. This is where preventive services such as telecare and services such as rehabilitation and enablement become critical. But even here, it may be that the intervention that is required is support to re-engage with the local community which might be achieved through a volunteer offering support. The strategy focuses on building prevention, rehabilitation

and enablement throughout the system as well as one-off interventions such as telecare which give people back control and independence.

Even when people have begun to engage with the formal care sector, it is still essential to ensure that they are engaged with the community assets. Being supported to dress and look after oneself is a means to an end of social engagement and it is essential that this is seen as important as meeting the needs of daily living.

Particularly for people with physical and mental disabilities and mental ill-health, it is essential that the focus is on enabling people to live normal lives – employment, volunteering, education, leisure activities, social activities etc etc. Part of this is taking risks and being supported to make good choices that enhance people's lives. The strategy needs to focus on developing opportunities to participate in normal activities in the community – not separated off into separate activities.

For some people as a result of disability, it will be necessary to provide more support but the aim of the strategy is to develop alternatives to traditional services. So, the strategy promotes services such as Shared Lives, supported living, extracare schemes, homes suitable for older people, key ring schemes etc. The strategy seeks to minimise the use of residential and nursing care while recognising that there is a place for it in a care and health economy. Similarly, the strategy promotes personalised services as alternatives to day services and for some this will include employment while for others this will not be possible but people can lead fulfilling lives outside of day centres.

As well as working in partnership with the third sector, care and health services need to work in partnership with each other. The strategy promotes the development of integrated commissioning and integrated delivery of services such as intermediate care. It is inconceivable that care services can be delivered outside of an effective partnership which promotes integration at every opportunity.

It is essential to recognise that in Rotherham, the CCG, the mental health trust and the hospital trust are committed to developing their services in a similar way. There is a commitment to locality working and to utilising community assets effectively. Indeed, the CCG has developed a nationally recognised scheme on social prescription. Further, the emphasis on integrated services, prevention and early intervention are all key themes in the transformation programmes the Trusts are developing.

The underpinning thrust of the strategy is the personalisation of services and this carries over into safeguarding. There is a need for a shift in culture not just in the way social workers assess for outcomes rather than services but also in regard to safeguarding. Establishing desired outcomes, putting people at the heart of safeguarding rather than processes, allowing people to take risks with support if necessary and appropriate are essential elements of the strategy.

Delivering the strategy

In order to deliver the strategy a series of interrelated commissioning strategies need to be developed. These strategies will involve Council services – especially adults, children, housing but also community development and community safety - and health services and other organisations where appropriate such as the police.

The strategy should be owned by the Health and Wellbeing Board and the Adult Safeguarding Board and it will be delivered through a range of Boards and groups. Ultimately, the DASS as the Statutory Office has responsibility for developing the strategy and ensuring it is being delivered.

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