From:	Paul Carter CBE, Leader and Cabinet Member for Traded Services and Health Reform Graham Gibbens, Cabinet Member for Adult Social Care Anu Singh, Corporate Director of Adult Social Care and Health
To:	Health Reform and Public Health Cabinet Committee – 13 March 2018
Subject:	**ADULT SOCIAL CARE AND HEALTH LOCAL CARE IMPLEMENTATION PLAN**
Classification:	Unrestricted
Past Pathway of Paper:	None
Future Pathway of Paper:	Corporate Board – 12 March 2018

Summary: This paper describes the Adult Social Care and Health Local Care implementation plan. The implementation plan delivers the new asset based operating model for Adult Social Care and Health. The operating model provides the basis for how adult social care will work in local Multidisciplinary Teams or hubs, as part of Local Care, which is a central pillar of the integration of health and social care under the Sustainability and Transformation Partnership.

A Sustainability and Transformation Partnership Local Care workshop will be held on 20 March 2018. This will present an opportunity for individual organisations to set out their commitments for taking Local Care forward at scale and pace, through three flagship Local Care pilots.

Recommendation(s): The Health Reform and Public Health Cabinet Committee is asked to **CONSIDER** and **COMMENT** on the Adult Social Care and Health Local Care Implementation Plan.

1. Introduction

1.1 The Health Reform and Public Health Cabinet Committee received an update from Cabinet Members on the Sustainability and Transformation Partnership (STP) at its meeting on 24 January 2018 and it was agreed that the Corporate Director of Adult Social Care and Health and the Cabinet Member for Adult Social Care, should prepare a detailed report setting out an ideal model of integrated social care, health and public health, to be considered at the Committee's March meeting.

1.2 This report presents the ongoing development of the Adult Social Care and Health (ASCH) Local Care Implementation Plan. The implementation plan sets out how the new ASCH asset based operating model will be delivered. This model builds on a person's strengths and their networks and connects them to the right professionals or universal offer. The model will be used as the basis for joining up health and social care locally with the aim of improving outcomes for residents and to help the Council and the NHS to achieve their respective financial and service objectives. These changes will enable health and social care to support more people to live independent and fulfilling lives, in their own homes and communities and to do so with the same resources or less.

1.3 This report provides the Cabinet Committee with the opportunity to consider details of the ASCH Local Care Implementation Plan and to be updated on how the asset based operating model will be rolled out in practice as part of Local Care. The report also offers the Cabinet Committee the opportunity to discuss the key issues that the Council may wish to raise at the Local Care Workshop on 20 March 2018, in relation to informing the Local Care pilots.

2. Policy context

2.1 Integration of health and social care is a high priority for the Government as stated in key policy documents such as the NHS Mandate and the Five Year Forward View. The integration agenda is also important for the Council as expressed in the its Strategic Statement. ASCH is continuing to play a leading and active role in driving this agenda.

2.2 Summary of the New Operating Model

2.2.1 We are in stage 1 of a managed migration into the new operating model for ASCH. Appendix 1 provides further details of the change activity and the internal change work in place to migrate to the new model.

2.2.2 This model will achieve the following changes:

- **Safeguarding change:** this will improve execution of safeguarding through clearer targeting this skill and specialism

- **Practice change**: this will enable staff to deliver asset or 'strengths' based social care and support

- **Structural change:** this will create locality working in multidisciplinary teams to drive population health

- **Infrastructure change**: this will create new tools and systems for financial and practice management

- **Commissioning change:** this will create a shift into a blended landscape of outcomes focused provision across the Voluntary Community and Social Enterprise (VCSE), Health and commercial sectors

- **Workforce change:** this will create an improvement in the blend and supply of roles needed for future integrated working.

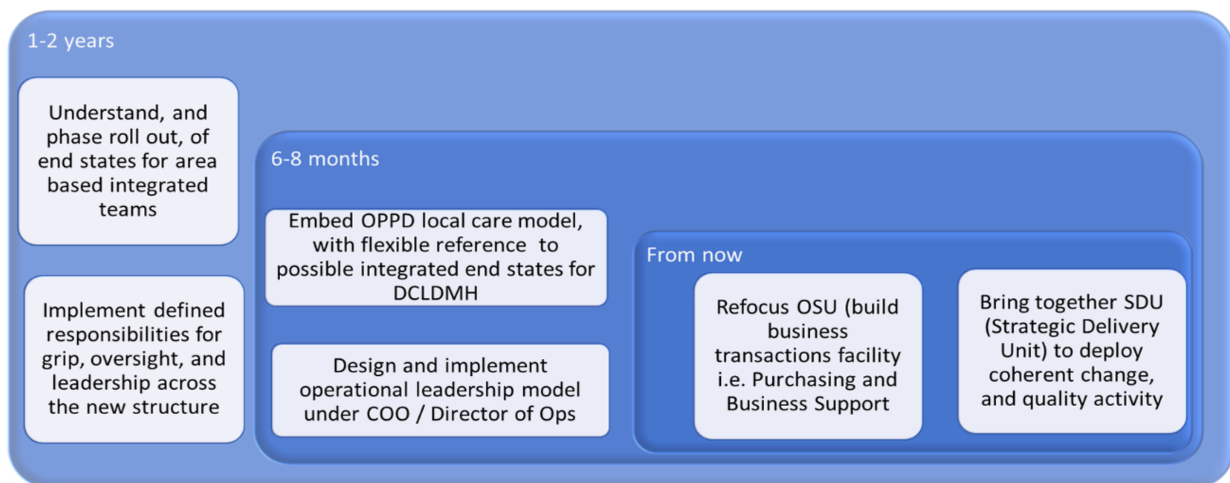
2.3 Implementation Timeline

2.3.1 The following key factors have shaped our implementation timeline:

1. Readiness of staff to absorb and deliver service changes (varying layers of transformation are already in place)
2. Delivery of the £18m savings detailed in the Medium Term Financial Plan (MTFP)
3. Fast track early implementation of two full blown Local Care Pilots in Kent;
4. Roll out of a Multidisciplinary Team (MDT) working Local Care model for 2019/20
5. Implementation of the Adult Social Care new client database (SWIFT) replacement ICT system in April 2019. The new system is known as Mosaic.
6.

2.3.2 These factors have meant that we are twin tracking (a) final design of new operating model with (b) phased early implementation of the new operating model for Older People/People with a Physical Disability (OPPD).

Fig 1
Phasing the change

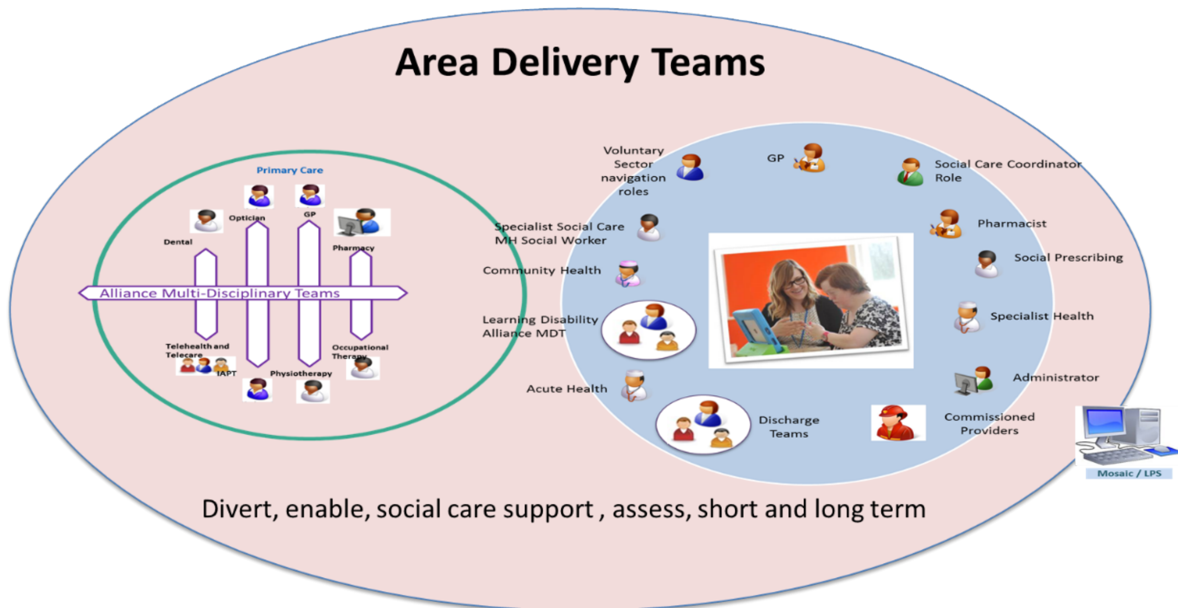


3. Current Transition and End State Operational Models

3.1 Asset based care and support is an approach that builds on what individuals, families and communities can do with the right support. It relies on different approaches such as social prescribing or time banking, and builds on a combination of support networks and community capital. By building on an individuals' strengths and capability, rather than focusing exclusively on their ***needs*** or ***problems***, asset based approaches make a meaningful difference. Under the Care Act the Council has a duty to prevent, delay, or reduce care needs. This approach promotes an individuals' wellbeing; supporting them to live independent and fulfilling lives in their own homes and communities.

3.2 We have been working with NHS colleagues to design the new operating model, along a 6-tier approach that delivers STP Local Care. The cornerstone of the approach is integrated MDTs, as illustrated in fig 2 below. Further detail of the STP Local Care models are attached to this report as Appendix 2.

Fig 2
MDT as developed through our work at Encompass Vanguard



3.3 It is anticipated that the new operating model for ASCH will be in place from August this year for OPPD and April 2019 for Disabled Children, Adult Learning Disability and Mental Health (DCLDMH). For transition purposes we are building a flexible local model, which can be easily locked and unlocked into MDTs as they come on stream, starting with two pilot Local Care sites. Each team will work with clients to focus on promoting independence goals, or work with providers on supporting independence goals and outcomes. Each team will be able to access specialist intervention from Social Work, Safeguarding, Quality Improvement, Mental Health, Sensory and Autism practitioners so the client has access to support required when required. This is a very different model from our current deployment of client specific teams.

3.4 We have completed the design of the ASCH end state structure. It is envisaged that each team will become part of the emerging Local Care teams when they are set up. Currently we have this operating in shadow form, with named individual workers that attend a range of hub/cluster/multidisciplinary teams - some are based in GP practices and some based in local offices. The image below shows how one segment of this integrated working is unfolding. We are currently testing an Integrated Triage and Integrated Assessment model with Kent Community Health Foundation Trust (KCHFT) in Coxheath in West Kent focusing on Maidstone Central and Malling referrals and rolling this out to the rest of West Kent in the next month.

Fig 3
Integrated Triage and Integrated Assessment model process

3.5 The design we are implementing will work across a minimum of nine locality teams across the county. We will deploy social care staff into MDTs to focus on promoting independence, and provide short-term targeted support that aims to make the most of what people can do for themselves. This will reduce or delay their need for care, and provide the best long-term outcomes for people.

3.6 The ultimate aim is to bring all Adult Social Care teams together to work locally into an overall East and West geographical area – which maps across the emergent health management structures. These will work seamlessly within our new **community assets** work. Below is an example of what this might look like in one local area such as Canterbury.

Fig 4
Canterbury MDT

4. Financial Implications

4.1 ASCH has planned savings targets of £18m in 2018-19 towards the County Council's savings target of £48m in 2018- 19. This level of savings commitment depends on successful implementation of the service changes described in this report.

4.2 The new operating model is profiled to save £9.8m with an investment needed of £4m. The table below outlines where the net £5.8m fits into our total savings plan. We currently have plans for £15m, and plan to draw down £3.1 from reserves.

4.3 Ultimately, achieving integrated working through Local Care will save the Kent system £218m. We do not yet know what the future costs and savings may be for the Council. This is a piece of work that will be completed in three months. The key issues are that

(i) Local Care modelling has been based on the frail elderly population. Costs for ASCH fund other populations such as Mental Health and Learning Disability, and this modelling work is still to be initiated; and

(ii) the original financial modelling for Local Care did not segment out Social Care. Whilst we cover some similar populations, health needs and social care needs are set at different levels. It is possible that maintaining a population below health needs level, will mean more costs for social care. This modelling is critical work, as the Council will need to make an investment case to the STP.

4.4 The high-level savings identified in the Local Care Investment Case are as follows:

- Once in steady state, the gross annual savings are estimated at £218m
- Annual reinvestment costs are estimated at £75m (~35% of gross annual savings). As outlined above, these costs may be greater as social care costs have not yet been costed appropriately.
- Leaving estimated net annual savings of £143m
- Non-recurring investment is required of £39m revenue (for double-running costs etc) and £164m - £190m of up-front capital costs to fund the provision of local hubs (estates) and digital capabilities.

4.5 The gross savings are derived from a reduction in A&E activity, non-elective activity, outpatient activity and bed days. Social care savings or costs have not been modelled. The annual reinvestment costs are largely related to the workforce (annual costs estimated at £52m). This includes the costs of care navigators and care managers across Health and Social Care and approximately 415 generic health and social care workers. Therefore, whilst a proportion of social care costs have been reflected in the Local Care Investment Case, further work is now required to ascertain the full financial implications for Social Care (including income). This work is being progressed through detailed modelling in West Kent and an integrated implementation plan for Local Care has been developed.

4.6 Work is now underway within Health, with input from Social Care, to design, cost and implement individual Local Care models at a locality level i.e. covering populations levels of between 30,000 and 50,000. Working initially with West Kent Clinical Commissioning Group (CCG) the full costs/implications for Social Care are now being identified as part of the West Kent model and will include, but not be limited to changes in workforce costs, supplier costs, estates and digital costs.

5. Legal Implications

5.1 The ASCH Local Care Implementation Plan and the operational arrangements will be taken forward in a way which is consistent with the Council's legal obligations as a council with adult social care responsibilities and these will be discharged accordingly.

5.2 Furthermore, Member decisions about the ASCH Local Care implementation will be informed by the principles outlined in the County Council report titled 'KCC engagement with the Kent and Medway NHS Sustainability and Transformation Plan, 7 December 2017'. Depending on the issue at hand, The General Counsel's legal advice would be sought on necessary matters.

6. Equalities Implications

6.1 All the significant changes will be approached in a manner that respect and adhere to the Council's equalities responsibilities. All appropriate advice will be sought from the Strategy, Policy, Relationships and Corporate Assurance Division. Indeed, the Division has already been engaged for their advice on the initial Equality Impact Assessment

7. Other Corporate Implications

7.1 We can only deliver this ambitious plan with the support of key corporate functions, such as Human Resources, Finance, and Strategic Commissioning.

7.2 The appropriate management oversight and programme board arrangements have been established. These ensure that both ASCH and corporate services can identify issues which impact on respective services to be addressed in the most effective way.

7.3 The assessment of the impact on KCC businesses is an ongoing activity which is kept under regular review.

8. Governance

8.1 The model has been shared with the Council's Corporate Management Team (CMT) and Extended CMT. CMT's endorsement and full engagement with the ASCH Local Care Implementation Plan will continue to be crucial as we move into the phased implementation of the changes.

8.2 We will continue to report to the relevant formal and informal Member meetings regarding decisions about all key changes flowing from the ASCH Local Care Implementation Plan. All such matters will be considered within the framework as set out in the County Council paper of 7 December 2017, included as a background document to this report.

9. Conclusions

9.1 The ASCH Local Care Implementation Plan is a significant change programme providing the Council with a firm foundation for joining up health and social care, in response to the integration agenda.

9.2 There is a strong desire to fast track early of two full blown Local Care pilots. It is expected that the Local Care workshop to take place on 20 March 2018, will give the Council the ideal opportunity to move the system towards a firm decision.

10. Recommendation

10.1 Recommendation: The Health Reform and Public Health Cabinet Committee is asked to **CONSIDER** and **COMMENT** on the Adult Social Care and Health Local Care Implementation Plan.

11. Background Documents

https://democracy.kent.gov.uk/documents/s81453/STP%20Governance%20Report%20-%20Final.pdf

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