Adult Social Care Services in Havering – Local Account 2016/17

Introduction and Foreword

Welcome to the fourth Local Account for Adult Social Care (ASC) services in Havering. The Local Account is an important part of the Government's plan and commitment to let people know about their local care and support services for adults in the borough, as well as how well these services are performing. It also gives us the opportunity to be open about how we spend money on adult social care services, as well as to highlight our successes, and to make more information available to residents on our challenges and priorities for the upcoming year.

The Council is committed to providing high quality adult social care services to those who need support, and to help individuals remain well and healthy for as long as possible in their own homes. Prevention is the underlying principle that we adopt; we aim to prevent the need for complex care packages wherever possible, thus ensuring that people can live full and active lives in the community for as long as they are able. We do this by working closely with our partners such as health services, care providers and the voluntary sector, as well as by listening to our residents and tailoring our services accordingly. We also safeguard those who are deemed to be at high risk to jointly manage situations as they arise, aiming for the best possible personal outcomes.

We have an obligation to manage our finite budgets as carefully as possible, while still providing quality services. This does mean that we have to carefully target our limited resources to ensure the best value for our residents, and to make sure that those in need are properly supported. Budget pressures have remained during 2016/17 so we have put in place plans to continue to manage our budgets well in future years, so that services are as resilient as possible. This includes working closely with those who provide care on our behalf, so that we jointly plan for the future.

We also provide information and advice to all borough residents, and to signpost to services, whether people have a care need or not. As such we have an information and advice website, CarePoint, a local information and advice service, and are planning to redesign our front door so that the right conversations happen at the right time, thus speeding up the time taken to assess need or signpost people in the best way that we can. Our services are inclusive and any commissioning initiatives are consulted on and an Equality Impact Assessment (EIA) is produced wherever necessary.

In summary, Adult Social Care is about providing personal and practical support to help people live their lives, to support them to maintain independence, dignity and control, with individual wellbeing at the heart of every decision.

The Local Account tells people:

1. How much money we spent on ASC
2. What we spent the money on
3. Our achievements over the last year
4. Our future plans

Local picture

Demand for adult social care services is increasing. In the UK people are living longer lives and this is resulting in a rise in the number of older people in the population. Havering is the third largest London borough, covering some 43 square miles. It is located on the northeast boundary of Greater London and has the oldest population in London with a median age of 40 years, as recorded in the 2011 census.

Havering Adult Social Care focuses on individual's wellbeing, to support people to do as much as they can for themselves, by utilising all their support networks to help them meet their personal outcomes.

Adult Social Care in Havering helps and supports residents with the highest social care needs. Our service users have a range of needs, including needs arising because of older age, physical disabilities, learning disabilities, mental health needs and memory and cognition needs.

Havering in numbers –

In Infographics…

According to the 2016 mid-year Estimates of population (published by the Office of National Statistics on 22nd June 2017), the population of Havering is **252,783.**

- Of these 192,471 are over the age of 20 (101,559 females and 90,912 males)
- Of these 46,241 are over the age of 65 (26,423 female and 19,818 Males).
- Of these 7,255 are over the age of 85 (4,832 Female and 2,423 Males)

The life expectancy for people living in Havering is 80.2 years (for males) and 84.1 years (for females) from birth. Life expectancy in Havering has been mostly higher than the England average and has been on the increase over the last decade.

The life expectancy at age 65 for males in Havering is 18.9 years.

- This is similar to the life expectancy for males in London (19.1 years) and England (18.7 years).
- Over a twelve-year period (of 3-year rolling periods – from 2001-03 to 2013-15), the life expectancy at age 65 for males in Havering has increased significantly from 16.3 years to 18.9 years – a 16% increase.

The life expectancy at age 65 for females in Havering is 21.6 years, 2.7 years longer than for males.

- This is similar to the life expectancy for London (21.7 years) but statistically significantly higher than England female average (21.1 years).
- Over a twelve-year period (of 3 year rolling periods – from 2001-03 to 2013-15), the life expectancy, at age 65, for females in havering has increased significantly from 19.0 years to 21.7 years – a 14% increase.

Nearly 43% of Havering's 85+ population use the boroughs Social Care Services.

The estimated number of people in Havering aged 18-64 living with moderate disabilities was 11,870 in 2017 (a rate of 7,865 per 100,000 population aged 18-65 years) and 3,506 adults aged 18-64 were estimated to be living with serious physical disabilities (a rate of 2,323 per 100,000 population aged 18-65). These rates are one of the highest amongst London local authorities, but it is statistically similar to England's rate (7,818 moderate and 2,298 Serious).

Due to having the oldest population in London and the high life expectancy, Havering has seen an increase in residents needing assistance from 2015/16 to 2016/17. Table 1 and Table 2 below, identifies how demand has increased.

Table 1 shows some comparable data to show rising demand:

In 2015/16	In 2016/17
272 older people (65+) were admitted to nursing or care homes, with an average age of 85 years. The admission rate was 609.9 per 100,000 populations.	321 older people were admitted to nursing or care homes, with an average age of 85 years. The admission rate was 700.0 per 100,000 population
2,131 service users received Homecare.	2,143 service users received Homecare.
Almost 85% (187 service users) of older people using our reablement service (who were discharged from hospital during the months of October – December) were able to remain living in their own home after leaving hospital. During 2015-16, 1,121 service users used reablement service.	Almost 88% (193 service users) of older people using our reablement service (who were discharged from hospital during the months of October – December) were able to remain living in their own home after leaving hospital. During 2016-17, 1,143 service users used reablement services.
We helped over 500 carers of older people with services like respite or a temporary care home stay for the person they care for.	We helped 577 carers of older people with services like respite or a temporary care home stay for the person they care for
At 31st March 2016 1,528 people chose to meet their agreed health and social care needs by receiving Self Directed Support.	At 31st March 2017 1,735 people chose to meet their agreed health and social care needs by receiving Self Directed Support.

Table 2 shows services provided in numbers over the last two years

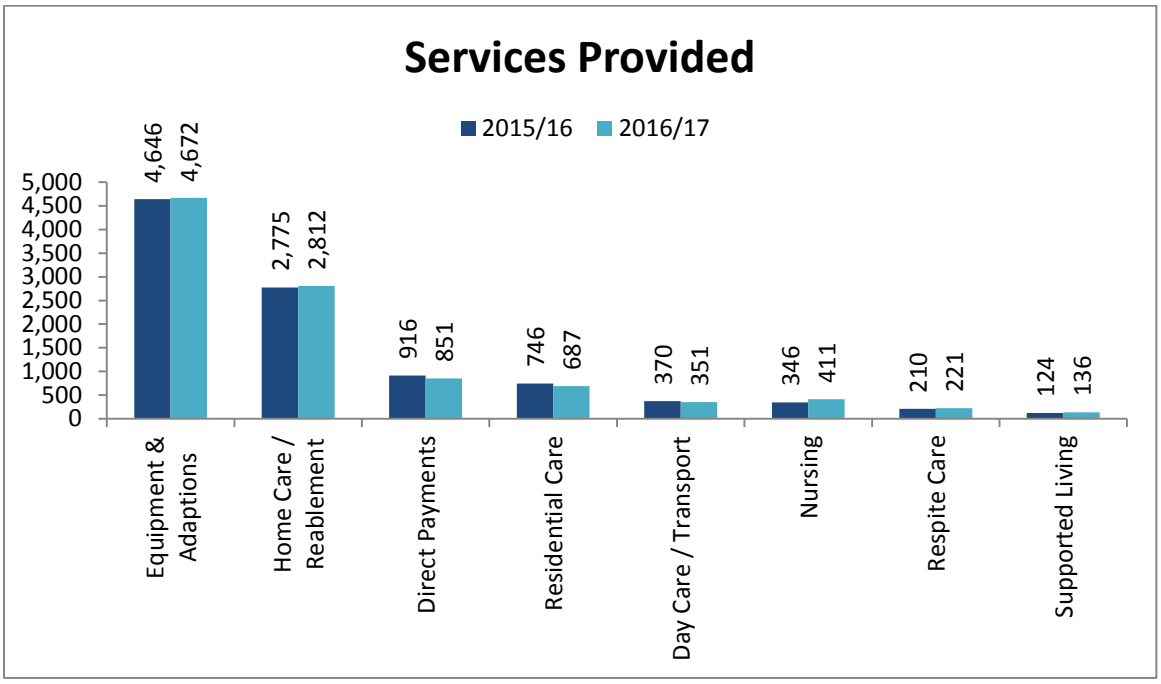
What adult Social Care services did from April 2015 to March 2017	2015/16	2016/17
People receiving long-term adult social care support	3,887	3,965
Carers received an assessment of their needs	867	1,091
Older people receiving long-term support in the community	2,371	2,398
At the 31 March the number of Older people living in residential / nursing accommodation	552	557
People with learning disabilities living in residential or nursing accommodation	155	147
Long term service Support Plans reviewed with service users	2,601	2,547
Enquiries for Adult Safeguarding	668	818
Deprivation of Liberty Safeguards	552	1083

Generally we are seeing increases in demand. This demand can be in the form of increases to hours of care provided in the community, or in terms of the complexity of packages that people need, rather than more people being given a care package. We are seeing that we are providing care and support in different ways; as our population changes our services are continually redesigned to keep pace with the changing needs.

Services we provide are outlined in the following graph, showing the number of people who services or equipment were provided for during 2015/16 and 2016/17:

Our 2016/17 Year

Services we provide



Although services provided generally are increasing, the number of those in receipt of a direct payment (a payment to an individual to pay for their care) had fallen, indicating that more people are opting to have services provided directly by the Council. This is something which we are reviewing as we would like to see more people in receipt of direct payments, as this introduces more flexibility around how their care and support is provided.

We have seen a rise of 9% in terms of Supported Living in the borough, meaning that more people are living in accommodation where assistance is available on site. Each area has increased in terms of numbers receiving services apart from residential care, showing the shift towards care and support at home and the aim to prevent the need for residential care for as long as possible. There are also less people in receipt of day care and transport provided by the council, which reflects changes to people's choice in how their care is provided.

Our Teams

A description of each team is provided below. Each area provides services to anyone aged 18 years or over, who has care and support needs, to provide a wide range of support plus information guidance and advice.

Integrated Locality Teams

Havering has integrated health and social care teams based in four health centres across the borough. These teams are comprised of our social workers and care staff with health colleagues. Social Care work closely with community health services which means that there is a more holistic, joined up approach ensuring better care, helping to minimise risk and improving the experience of individuals who use our services. A more joined up service appears more seamless and helps provide the right care at the right time, and communications are working arrangements are collectively improved.

Community Learning Disability Team (CLDT)

The Community Learning Disabilities Team supports people who need services to live their lives to their fullest potential. The team is integrated with health, so are able to bring in the right clinical support when it is needed, and supports when people have additional needs such as physical and/or sensory disabilities, speech and language difficulties, challenging behaviour or epilepsy.

The strong partnership working between Havering Adult Social Care and North East London NHS Foundation Trust (NELFT) means that there are clear priorities enabling high quality health and social care for adults with learning disabilities within the integrated multidisciplinary team.

Joint Assessment & Discharge Service (JAD)

The JAD team is based in the local acute hospitals (Queens and King Georges, part of Barking Havering and Redbridge University Hospitals NHS Trust), and is our multidisciplinary, multiagency Joint Assessment & Discharge Team. The team has staff from Havering, the London Borough of Barking & Dagenham, Havering's community health provider (North East London Foundation NHS Trust) and the Hospital Trust itself. The social workers and nurses that sit within the team work with residents across Havering and Barking & Dagenham who need support to return from hospital.

Sensory Service

The Sensory Team supports individuals to find solutions to challenges being faced when living in the community if people struggle with basic tasks, and offers tailored information, advice and guidance. They can support with: specialist training, such as mobility and orienteering training or hearing aid management training; assistive equipment, to help individuals make the most of residual sight or hearing such as a TV listener or specialist lighting; minor adaptations around the home, such as tactile markings on the cooker or use of contrasting colours around light switches.

The Sensory Team prides itself on really listening to individuals about their strengths and aspirations as well as areas they might need support with as the service wants people to be as independent as they possibly can.

Better Care Fund

The Better Care Fund (BCF) was established in 2015/16, creating a shared budget between the NHS and adult social care departments, to support working in a more integrated way, including commissioning of services to support vulnerable adults. It is important to note that the BCF was not new money for services; existing budgets were 'top-sliced' to create the fund. In Havering the BCF is used to provide or commission a number of services, including preventative services (from the voluntary sector), intermediate care, Telecare, Mental Health and carers support.

What this means for Havering

The Havering BCF plan stated that by 2019 we would have "a locality based integrated health and social care workforce comprising multi-disciplinary workforce across six GP cluster-based localities." There are currently four teams in place, Cranham, Harold Hill, Romford and Rainham/Elm Park.

In 2017/18 we are looking to utilise our BCF differently as we take the next steps with integration, making sure that we deploy the funding to protect social care services whilst ensuring we continue to support the safe and timely discharge from hospital and put the right community solutions in place. We plan to complete this effectively through working with our neighbouring boroughs and health colleagues. One major scheme is the creation of an Intermediate Care Tier, which builds on the already successful co-location of our community social care and health teams, to look at the hospital discharge pathway. Intermediate Care is the term for services that are wrapped round people as they return home form an acute care setting. It is important that we get this transition right and properly support people after a stay in hospital, enabling them to be able to be as independent as possible, with the right support in place.

Self-Directed Support (SDS)

There are two different kinds of SDS, **Direct Payments** and **Personal Budgets**.

Direct payments are payments made to individuals who have care and support needs, or to carers who are eligible for support. The money received can be spent on things that help meet the needs, as agreed in their support plan. The way direct payment works will vary depending on if this is being received as a direct payment because you are a carer, or because you have care and support needs.

A personal budget is the amount of money the local authority allocates for a residents care, based on its assessment of their needs. The resident and social worker or care manager will work together to create a care and support plan. This plan details the care and support needs, and will be used to work out the value of their "personal budget".

SDS covers personal budgets and direct payments, as well as individual service funds, whereby a provider administers funds on an individual's behalf to provide care, and council managed accounts, whereby the council carries out the administration. Anyone who is assessed as needing care services has the right to request a direct payment instead of having services provided by the council.

In the last Local Account we identified that we would be looking to:

- Increase the proportion of service users who receive some form of self-directed support.
  It has been recognised that the right support and availability of personal assistants needs to be in place to sustainably increase the numbers of people using self-directed support to arrange their care and support services. In 2017/18 we have started to properly develop a market of personal assistants (PAs) and completely overhauled our approach and build a list of PAs. We are also re-designing the processes by which direct payments are accessed and this will also lead to much easier flow from identification of need to delivery of service. We anticipate actual numbers of residents in receipt of direct payments will begin to increase significantly by 2018.
- Introduce a Havering Direct Payments Pre-Paid account and card to make managing direct payment a lot easier.
  We have implemented this and a more efficient card payment system is in place.
- Work with our voluntary sector including reviewing the services they provide and to continue to commission services that help people remain independent.
  The voluntary sector review has resulted in new contracts that are aligned with helping people remain or become independent. The new services are planned to start in February 2018.

Health and Wellbeing

Havering's Health and Wellbeing Board is a committee of Havering Council, and includes membership from Barking Havering and Redbridge Clinical Commissioning Group. The Board is designed to gather senior health and social care professionals together to work towards ensuring people in Havering have services of the highest quality which promote their health and wellbeing and to narrow inequalities and improve outcomes for local residents.

In March 2016, the Board reviewed its terms of reference, recognising the massive changes in the local health and social care economy since it was first established three years previously. Additional members were added to the membership, including the acute hospital (Barking, Havering and Redbridge University Trust), and the North East London Foundation Trust which provides many community health services.

The main responsibilities of the Board are to:

1. Agree the health and wellbeing priorities for Havering and oversee the development and implementation of a joint health and wellbeing strategy
2. Oversee the development of the Joint Strategic Needs Assessment and the Pharmaceutical Needs

3. Provide a framework within which joint commissioning plans for the NHS, social care and public health can be developed and to promote joint commissioning.
4. Consider how to best use the totality of resources available for health and wellbeing e.g. consider pooled budgets. Also oversee the quality of commissioned health and social care services.
5. Provide a key forum for public accountability of NHS, public health, social care and other health and wellbeing services, ensuring local democratic input to the commissioning of these services.
6. Monitor the outcomes of the public health, NHS and social care outcomes framework.
7. Consider the wider health determinants such as housing, education, regeneration, employment.

At the same time as reviewing the terms of reference it was also decided to review the Health and Wellbeing Strategy to take into account developments in health and social care, as well as the budget pressures and demands facing all member agencies of the Board. In January 2017 the Havering Health and Wellbeing Board agreed a refreshed version of strategy, which now focuses on four overarching themes, each with underpinning priorities for action:

- *Theme 1* - Primary prevention to promote and protect the health of the community and reduce health inequalities. Healthy life expectancy can be increased by tackling the common socio-economic and behavioural risk factors for poor health
- *Theme 2* - Working together to identify those at risk and intervene early to improve outcomes and reduce demand on more expensive services later on.
- *Theme 3* - Provide the right health and social care/advice in the right place at the right time
- *Theme 4* - Quality of services and user experience

Safeguarding

We understand the impact we have on people's lives, delivering and commissioning services that help people achieve their outcomes. So we are continuing to strengthen our safeguarding arrangements internally and externally to ensure we are doing as much as we can to protect people from abuse, both in terms of prevention, but also dealing with issues as they arise in a timely manner.

Havering Safeguarding Adults Board (HSAB)

The HSAB is the lead partnership with responsibilities for ensuring that all adults at risk in the borough are able to lead safe, fulfilling lives and not subject to abuse or neglect by others.

The statutory requirement set out in Care Act 2014, states that all Safeguarding Adults Boards (SAB) must publish an annual report on the effectiveness of safeguarding in their local area. The HSAB annual report is published every year and outlines how the board has been compliant with the Care Act through the introduction of policy and procedures, formulation of processes to identify serious adult reviews (SAR) and systems to monitor how individual agencies will ensure that they are compliant with the Act. The 2016/17 annual report was signed off in the autumn of 2017 and has been made publicly available on the Councils website.

Making Safeguarding Personal (MSP)

All staff within Adult Social Care are aware of the need to ensure practice demonstrates MSP and that their outcomes should be adult led. We have taken steps to improve our safeguarding response, which has been no small feat in the context of considerable increase in volume of Deprivation of Liberty referrals and renewals; however we know there is more to do in achieving our ambitions in terms of Making Safeguarding Personal.

Throughout the safeguarding process, adults are continuously asked about their views and their consent is checked at first point of concern and recorded on an alert form for all Safeguarding concerns.

Following case closure a 'satisfaction survey' is sent to all service recipients seeking their views on the service received, the process and whether the actions taken meet their assessed eligible needs.

Deprivation of Liberty Safeguards (DoLS)

The DoLS aims to make sure that people in care homes, hospitals and supported living are looked after in a way that doesn't inappropriately restrict their freedom or support living arrangements only deprives someone of their liberty in a safe way that is in their best interest.

You can see from the chart below that since 2013/14 and the Supreme Court Judgment in March 2014 (when the Supreme Court issued a judgment on deprivation of liberty, which clarified what may constitute a situation whereby someone can legally have their liberty taken away) the number of new DoLS requested has increased dramatically.

	New DoLS requested
2013-14	27
2014-15	351
2015-16	552
2016-17	1083

We recognise the risk of increased numbers of referrals and the impact this has on our resources, we will continue to ensure that decisions are always in an individual's best interest so our advocacy service is currently being recommissioned.

Multi Agency Safeguarding Hub (MASH)

We have a specialist Front Door service that works with residents the first time they come in to contact with adult social care; we call this the Multi Agency Safeguarding Hub (MASH). The purpose of the MASH is to improve the quality of information sharing and decision making at the point of referral, which is achieved through the facilitation of sharing of intelligence across agencies.

In 2016/17 the MASH has been able to successfully recruit more permanent staff which means there is more consistency within the team and more chance to build on good practice.

In 2016/17 the wider MASH service, including Children's Social Care, Police, Mental Health and other partners, reviewed thresholds and how the service worked. This has resulted in closer working and relationship building across all agencies which have led to being able to work collectively together with an emphasis on working on supporting young people turning 18 years of age to transition to adulthood, and accessing adult and mental health services where necessary.

Performance in 2016/17

	2015/16	2016/17
Self Directed Support (SDS)	1678	1735
Direct Payments (DP)	717	680
Rate of permanent admissions to residential and nursing care homes per 100,000 population (Aged 65+)	15 New Admissions	13 New Admissions
Rate of permanent admissions to residential and nursing care homes per 100,000 population (Under 65)	271 New Admissions	321 New Admissions
All Hospital delays	Average of 8 delays per month	Average of 14.8 delays per month
Social Care delays	Average of 1.4 delays per month	Average of 2.5 delays per month
Reablement	1142	1162

The number of service users who receive their care via self-directed support has risen slightly from 1678 users in 2015/16 to 1735 users in 2016/17 however the number who receive their care via a direct payment has reduced

from 717 in 2015/16 to 680 in 2016/17. Direct Payments continues to be an area which requires further improvement from Adult Social Care.

There was an improvement in the number of new admissions for service users aged 18-64 from 15 in 2015/16 to only 13 in 2016/17; however the challenge remains for Havering for new admissions for service users over the age of 65, where the number of new admissions rose from 271 in 2015/16 to 321 in 2016/17.

Delayed Transfers of Care (DTOC) looks at patients who are fit for discharge from hospital but are still occupying a hospital bed on one of 12 snapshot nights per year (this is the last Thursday of every month), the outturn is taken as an average of these 12 monthly snapshots. Delays for this indicator can be the responsibility of Health, Social Care or both parties. Part 1 of this indicator looks at all delays irrelevant of the responsible agency. Part 2 of the indicator looks at delays where either Social Care is responsible or both Social Care and Health are responsible. Please note that the definition for DTOC changed between 2015/16 to 2016/17. In 2015/16 delays waiting for Continuing Health Care funding were not included, however these were included as part of the 16/17 indicator, which impacted on the outturn of the indicator.

There has been a slight increase in the number of service users who have used reablement services; this has increased from 1142 in 2015/16 to 1162 in 2016/17.

Outcomes against the 2016/17 Objectives

Within the Local Account 2015/16 we set out eight priorities that Havering ASC would be working towards during 2016/17 year. Underneath each priority area, please see commentary as to our progress/completion.

1. Focus on prevention and early intervention through working more effectively across the Council to reduce the need for intervention and services in the first place, and support residents to be self-care as much as possible.
   Work with providers and stakeholders, to design a set of outcomes for our preventative offer, has been aligned across a range of conditions. An ongoing Social Reablement Project has been progressing to support people to remain living independently in their own homes.

2. Be more ambitious integrating services with our health partners to provide seamless care and support to residents. We need to provide more services that are joined up with health, provided by the NHS, and social care, provided by the council.
   An Integrated Care Partnership (ICP) has been established across Barking Havering and Redbridge (BHR) Social Care and Health system. The priority focus for partners in the ICP is to move towards an 'Accountable Care System', as well as well as our ongoing Havering work on Localities. The localities work is looking at developing new models of working across three locality areas within the borough. Our planning is well underway and we expect that this will improve both the relationship residents have with health and social care services, and the service offer to residents, including a focus on preventative approaches.

3. Provide more choice and increase take-up of personal budgets and direct payments. This is key to helping people manage their own care. We will also help shape Havering's care market to ensure real choice and control for everyone whether through a local authority managed budget, a direct payment, individual service fund or for those who self-fund their own care.
   A project, to implement individual service funds, is underway. The Project is based around the care budget being held by the care provider so they work with the individual to develop a personalised care and support package to meet the needs of the individual.
   The Joint Commissioning Unit (JCU) has recruited a PA co-ordinator. This has resulted in a number of new PAs accredited and on Havering's register and a new process to speed up DBS checks piloted. This is supporting the development of the personal care market in Havering by improving the choice for residents.

4. Be more strategic in how we commission and contract services not just across the Council but with our Health partners and with residents shaping the decisions we make.
   A Carers Strategy and Joint Commissioning Strategy were developed in partnership with the NHS and with people who are carers themselves. It was adopted by the Council on 18/01/2017. We also started work on an Autism Strategy for Havering, producing this with participation and involvement from people with lived experience of services. This was signed off by the Health and wellbeing Board on 15/11/2017. We have also continued work on a Joint Commissioning Strategy – that looks at establishing the right approaches to manage our local market of social care providers whilst looking to save money and at the same time protecting or enhancing the services to be sustainable and of high quality. The Joint Commissioning Strategy was signed off by Cabinet on the 13/12/2017.

5. Embrace our new responsibilities under the Care Act fully modernising our services including how we assess people's needs, put together a support plan, provide choice and control, improve well-being and maximise independence. In Havering, care and support is changing for the better as a result.
   The Care Act has become business as usual and is always at the forefront of every decision made in Adult Social Care. This doesn't mean we are sitting still, with priorities for 2017/18 now being taken forward.

6. Continue to strengthen our safeguarding arrangements to make sure we are doing as much as we can to protect people from abuse – preventing it happening in the first place and in dealing with issues quickly.
   All our Safeguarding Policies and Procedures have been refreshed to fall in line with the Pan London Policies and Procedures and have been agreed and signed off by the Safeguarding Adults Board.
   We are ensuring the right safeguards, risk assessments and support plans are in where someone's Liberty is being deprived and are working to the principle of least restrictive practice.
   All our assessment processes and safeguarding investigation processes are robust and completed in a timely manner.
   The first Safeguarding Week took place in 2016 and combined not only Adult Safeguarding but Children Safeguarding too. Not only was there the very well attended Havering Safeguarding Adults Board conference but there was also many short seminars across being run across many areas impacting on safeguarding. The week demonstrated the commitment of safeguarding and raised awareness with the involvement of the local media.

7. Ensure our workforce has the right tools to do the job and feels confident in meeting the challenges ahead. Our new principal social worker will help us focus on outcomes for people rather than our processes, our senior management restructure will help us integrate services with our health partners, and our Assistant Chief Executive will ensure that all adults health and wellbeing is a priority.
   We are better understanding the social care provider market and workforce arrangements to encourage greater stability in our workforce in Havering. A strategic plan, for engaging with the provider workforce, is being implemented and will include how we plan to address the workforce and capacity issues.
   As part of implementing the new homecare framework from February 2017, called the active homecare framework, we have set up forums as a means for engaging with providers and their staff on a regular basis to discuss and resolve workforce issues.
   A senior level restructure took place following the appointment of the new Chief Executive in May 2016. A Director of Adult Social Care role was established and appointed to. The Directors role is part of the senior leadership team of the council, and therefore ensures that adults who are vulnerable and/or have care and support needs, remains a priority area for the council in terms of service provision and safeguarding.
   The Interim Director of Public Health is the lead officer for the multi-agency Health and Wellbeing Board which brings together the key health and social care partners. The Public Health Service works with the locality design group to steer the Joint Strategic Needs Assessment (JSNA) programme, and provide information and intelligence which is informing the design of health and social care services at locality level. This includes piloting new ways of supporting vulnerable families in the north locality. The Public Health Service collaborates with a range of health and social care partners to protect the health of the local population, including through winter planning and seasonal flu immunisation. The Service is also supporting the Council's Human Resources service to refresh its workplace health offer with the aim of improving the health and wellbeing of staff and so improve the overall services provided to residents.

8. We need to ensure we effectively manage the Council's largest budget in light of significant demographic pressures and increased demands.
   Budget management is robust with improved monitoring and control techniques, backed up by detailed reconciliations, due to the strong and supportive relationship with corporate finance colleagues. There is a w*ell-developed medium term financial strategy which looks at possible scenarios for Havering and adult social care.*
   Councils have been given the added flexibility to raise additional income from Council tax (levy) (up to 6% over three years) from 2016/17 to fund ASC. Following an online Council Tax consultation in January 2017 it was agreed to increase the Council Tax in Havering of which £2m is to be ring-fenced for Adult social care.

Our Future Plans

2017/18 Service Objectives

We will continue to work with partners to provide the most vulnerable people in our communities with the most efficient and effective social care services.

We will offer adults in care the choice and control they need to work towards more independent and stable lives.

The following eight priorities have been identified as part of the 2017/18 service plan for Adult Social care:

1. **Target our limited resources on those who need the most support –** by actively engaging with service users and using customer insight effectively to shape services and inform commissioning decisions and by increasing our focus on outcomes for service users and carers. We will proactively manage demand through targeting our resources to prevent care need arising and actively supporting people to remain well and independent. An example of this is through better use of reablement and rehabilitation services. We will have a new reablement contract in place which we envisage will help people maintain independence after a stay in hospital. This will take an integrated approach to planning and providing an intensive reablement service to better support people to maintain life skills. Our Joint Commissioning Unit is looking to move to an outcome based commissioning model, where possible.
2. **Work in partnership with Health and other key partners to deliver improved services and improve VFM through integration –** by getting the best out of our resources and supporting staff to access the right training and development in the right way in order that we improve recruitment and retention. Preparing and equipping our workforce change; encouraging staff to innovate in response to our challenges, and ensuring that our teams understand and appreciate one another's pressures and priorities. . We already have our social work teams co-located in community settings with health colleagues. We will review this and develop a new localities model based on demographic footprint, so that services can be targeted to where they are needed most. We will develop a discharge to assess model, which means people will be discharged from hospital to receive an assessment in their home, rather than waiting for this to happen in an acute setting. This will shorten the time of hospital stay and it is seen that assessments can be more person focussed in the individuals own environment.
3. **Where needed we will intervene early to prevent further escalation of needs –** by identifying emerging issues and intervening early where necessary to prevent further escalation. A good example of how we will do this is through review of our multi-disciplinary teams, who already work well in community settings. We are looking to develop our future plans based on what has been successful to date. Multi-disciplinary teams are integrated teams comprised of staff with a range of health and care specialisms, who work collaboratively to wrap care services around the individual, to enable timely decisions and to reduce the number of times a person has to tell their story.
4. **People and communities will look after themselves and each other where possible –** by supporting people and communities consider their 'community assets' and see the Council as a last resort wherever possible. We will do this by adopting a "three conversations" model. This means that conversations happen in a staged manner, with a person's support frameworks being looked at initially. The first conversation is designed to explore people's needs and connect them to personal, family and community sources of support that may be available. The second conversation seeks to assess levels of risk and how to address these. The third and final conversation focuses on long-term outcomes and planning, built around what good looks like to the user, and how best to mobilise the personal and community assets available. This involves really deep listening, to get to the heart of what the situation is and how this can be collectively managed. This model is known as 'Better Together' in Havering and is being rolled out as the underlying principle behind the way we assess care and support needs. This model is designed to deliver better outcomes for individuals as well as being a more targeted way to manage resources.

5. **We will ensure universal services will effectively signpost people to the appropriate services –** by making sure we understand the service offer across the borough, both internal and external to the council, so that people can make the right decisions about how they can meet their outcomes. Our Joint Commissioning Unit administer our CarePoint website and commission the information and advice service that is available to all residents, regardless of whether there is a care need or not.
6. **Wherever possible we will seek to manage demand by prioritising the most cost effective provision –** by effectively shaping the market (in both the voluntary and private sectors) to respond to customer demand, we will downstream services to the most cost effective provision and allow the Council's limited and depleting resources to be focused on those who need the most support. Our Market Position Statement (MPS) outlines how we will do this, and we will be refreshing this and looking to move to a joint MPS with our neighbouring boroughs (Redbridge and Barking and Dagenham) in line with our Better Care Fund plan.
7. **We will seek to revitalise the voluntary sector to be best placed to deliver services in the most cost effective ways –** by working effectively in partnership with other agencies to deliver improved, more integrated services that offer better value for money to the public purse as well as facilitating better customer experiences and outcomes. Our Joint Commissioning Unit work closely with the voluntary sector to enable this.
8. **Maximise income for the service through reviewing financial assessment and ensuring billing is as efficient as possible.** Over the last year we have redesigned our Financial Assessment and Benefits Team to streamline the financial assessment process. We will be refreshing our charging policies by 2020. Our income collection rates during 2016/17 remain good with 95.1% of income billed collected for residential and nursing care and 95.7% of income billed collected for non-residential care services.

Key Challenges and Risks

The key challenges include a growing population, a rapid increase in demand for services is predicted and we are seeing that increased complexity of care is being required, against a backdrop of scarce resources.

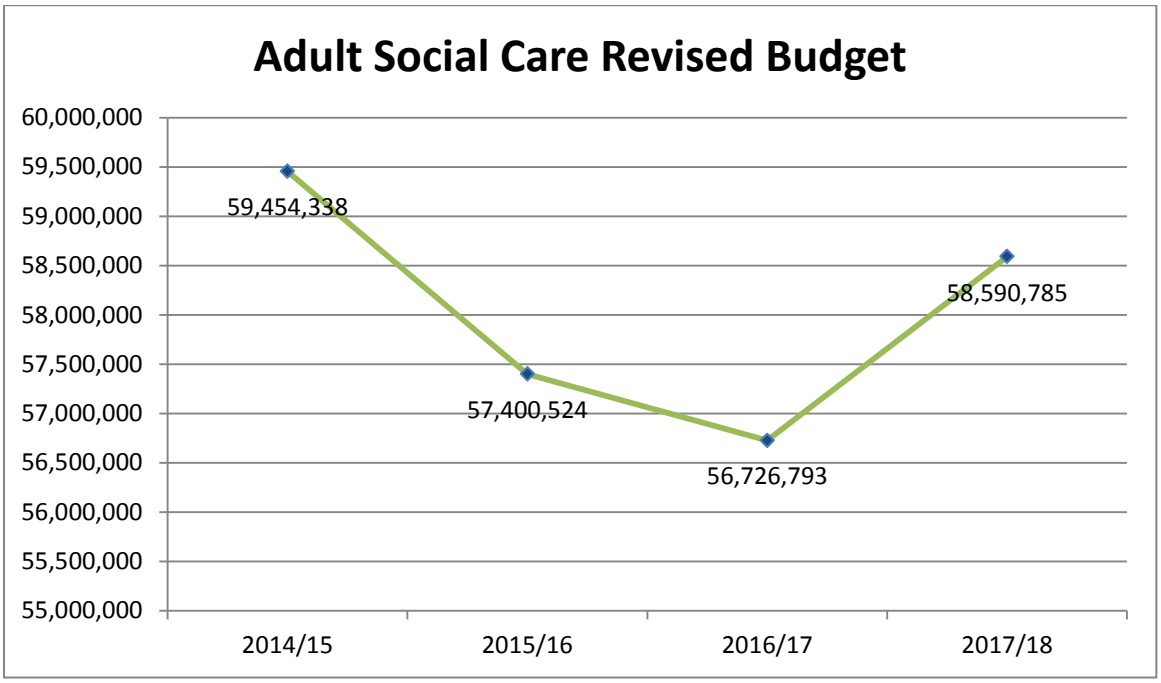
The Financial Challenge

Havering, like all councils, is facing a major financial challenge. We need to reduce our overall budget, in response to Government funding cuts, inflationary costs and a growing, ageing population.

The Council has made a strong commitment to deliver all statutory services like adult social care and improve services. It remains committed to protecting the services that matter most to the residents of Havering and keeping local people safe.

The 2016/17 settlement announced the option for local authority's to commit to a four year settlement. This presented Havering with a reduction in Revenue Support Grant (RSG) from £20.9m in 2016-2017 to £1.3m by 2019/20. The current funding gap currently stands at £13.567m over the three years leading to 2019/20 and further saving options will need to be developed. This figure is largely dependent on the achievement of savings already agreed so any shortfalls will increase the budget gap. Further information can be provided in the Council's budget reports as presented to Cabinet and full Council in February each year.

The Adults budget position is reflected below:



The budget has continued to fall since 2014/15, however due to the additional iBCF Funding received this year (2017/18) we have seen an increase in the budget allocated to ASC.

What this means for Adult Social Care

Adult Social Care has had a challenging past year in terms of budget, performance and safeguarding, although we are managing ongoing pressures. Delivering the Medium Term Financial Strategy (MTFS) savings was one challenge, although savings are broadly achieved there are more savings to come over the coming years, due to the reduction in the council's government grant settlement as outlined above, there will be the need to make decisions about how we continue to robustly manage our budgets whilst providing the services that are required.

Government has recognised at a national level that there are both demand and budgetary pressures facing Local Government, and have therefore enabled, local authorities to levy an additional council tax precept of 2% for Adult Social Care. As part of Havering's financial strategy, the additional 2% precept has been included as part of the budget strategy in 2016/17 and 2017/18. The Council will be finalising its 2018/19 budget in February 2018, with the final decision taken at this time about whether the precept will be utilised moving forward.

Havering Council has made a strong commitment to deliver all statutory services and improve the services being offered across the borough. We remain committed to protecting the services that matter most to the residents of Havering, whilst safeguarding those who are most vulnerable.

Budget Position – 2016/17 Outturn

The table below outlines our reported closing 2016/17 position. Although there was an overall overspend, steps are being taken to bring spend in line with budget in the future. This is focussed on better targeting resources and prevention rather than direct cuts to services.

Some areas within the overall Adult Social Care budget underspent so that we could partly mitigate the pressures arising in the community budgets, which fund the care and support to our older people. We have redesigned our Community Teams to ensure the right support is in place when people leave hospital, which has meant that our delayed discharges from hospital have been minimised and our performance in this important area has been good. Local authorities work closely with health colleagues to minimise delays in helping people return home after a stay in an acute setting. Havering were the 6th best for overall delayed days in London for 2016/17, with an outturn of 6.7 delays per 100,000, which is a low percentile.

During the year we experienced budget pressure against our Learning Disability budgets. This was largely due to the complexity of some packages of care.

A summary of the final 2016/17 budget position is outlined in the table below:

Adult Services 2016/17 Final Outturn Position

SERVICE AREA	BUDGET £	ACTUALS £	VARIANCE £ (under)/over
Adult Services Total	**56,379,654**	**57,624,992**	**1,245,338**
Adult Services Business Management	1,388,571	1,321,289	(67,282)
Strategy and Commissioning	3,736,353	3,758,993	22,640
Adult Community Team	24,715,062	25,894,343	1,179,281
Adult Safeguarding	903,729	761,300	(142,429)
Prevention	1,587,396	1,463,632	(123,764)
Learning Disabilities	19,037,483	19,871,061	833,578
Health & Social Care Other	932,640	558,173	(374,467)
Mental Health	4,078,420	3,996,201	(82,219)

Peer Review

Havering has signed up to be reviewed by other authorities through a peer review process. These reviews are used to identify any areas for improvement to our processes which could then be rectified, and also to find out what our peers feel is working well. Havering took part in a review in late October 2017, where the focus was on Commissioning and Use of Resources. There were many positives to come from the Peer Review, and this will be reported on in the 2017/18 Local Account.

Feedback from our residents

Adult Services aims to ensure that all residents have a say in how we plan and deliver services, how we can improve and to be able to comment on key decisions concerning changes to services. Complaints, compliments, customer surveys, regular forums and feedback at meetings are all used to understand what is important to local residents and how we can further improve the services we provide. Major decisions are consulted upon and decisions are published in line with our constitution.

Complaints

Adult Social Care drafts an annual complaints report each year, and is published on the Council Website. But in summary, the total number of complaints received by the council regarding ASC during 2016/17 was **121**. This is a 30% increase from 2015/16. Adult Social Care has seen a steady increase in the number of complaints received but a slight reduction in the number of enquiries received by the Ombudsman (10 in 2015/16 down to 8 in 2016/17).

Financial Year	2014/15	2015/16	2016/17
Number of Complaints	92	93	121

Compliments

As always the service received many compliments about their staff and services provided over the last year. Some of them have been provided to showcase some of our successes over the last year.

- Her visit and input had a reassuring effect and I would like you to pass on my thanks for a job well done. – Adult Community Team North
- Just a note of huge thanks for all your hard work and efforts in making Nan's life a bit more comfortable, having extra care at home every day now. Also for sorting out her respite home. – Adult Community Team South
- Many thanks for the professionalism showed by you as a council and to XX who clearly demonstrated that on your behalf. Many Thanks. – ASC Customer Services
- It is people like yourself and XX, who show understanding and compassion, who make ordeals bearable, and for the kindness you showed me I would like to Thank you very much. – Joint Assessment and Discharge Team
- I'll never forget all that you have done for me in the past. It was so much appreciated. A big thank you. – Learning Disabilities

Keep Informed

To keep up-to-date with the latest developments in adult social care in Havering, visit www.havering.gov.uk and subscribe to our email updates, including Health and Well-being, Carers, Care Connect and Active Living. Alternatively visit www.haveringcarepoint.org.uk.

Summary/conclusion

There is a strong focus nationally on integrating health and social care services. We need to ensure that our residents are at the heart of planning our services and that we make the best use of the resources across the NHS and social care in delivering this. Our Integrated Care Partnership Board, which has membership across the Barking and Dagenham, Redbridge and Havering, is leading the strategic direction of the borough as we move towards health and social care integration. We will continue to build on the Better Care Fund Plan, to strengthen the plan and deepen the ways in which it draws our neighbouring boroughs together and how it increasingly connects the NHS services commissioned by the CCG with ours. The Barking Havering Redbridge Accountable Care System development will build upon this start; it will need to connect to emerging commissioning arrangements across the

wider East London Health Care Partnership (aka the North East London Strategic Transformation Partnership) and provide clarity about how local services are increasingly connected across organisational boundaries, with joint budgets and management. The future for health and social care services is one where there will be fewer gaps between services, where people can be supported in the right place, at the right time and by the most appropriate means; the organisation structures are likely to change, but the underlying drive for the greatest efficiency and most effective services in place to support Havering residents will remain.

Although this year has seen a rise in demand, generally we have managed well in terms of deployment of resources. Our budget position at year end did show an overspend of £1.2m. This is being actively managed moving forward so that we can look to bring service delivery back inside the funding envelope. Nationally it is recognised that Adult Services are underfunded and Government will be issuing a Green Paper on Adult Social Care funding over the coming year. It is hoped that Better Care Fund resources will help to mitigate some of the pressure in future years, and help us transform services to meet demands and continue to support our communities in the best was possible.

The Peer review will help shape our thinking going forward as we continue to shape our services in order to meet both current and future demands. Our Joint Commissioning Unit is managing the market to help us ensure that we are resilient to future challenges.

In summary 2016/17 was a challenging year but also a productive one, with many firm foundations laid for the future, as we build integrated services and continue to work with our partners and community to provide care and support services.

Glossary of terms

Integration - is about placing patients at the centre of the design and delivery of care, to overcome organisational, professional, legal and regulatory boundaries within the health and social care sectors, with the aim of improving patient outcomes and satisfaction ensuring that patients receive the most cost-effective care, when and where they need it.

Making Safeguarding personal (MSP) – Making Safeguarding personal is a shift in culture and practice in response to what we now know about making safeguarding more of less effective from the perspective of the person being safeguarded.

Intermediate Care Tier – Intermediate Care Tier is the suite of services from across NHS and local authority which seeks to provide up to six weeks of care and support to help people get back on their feet and to live independently following a hospital stay or a change in their physical ability through, perhaps through a fall or bout of illness. In Havering, this includes services such as Reablement, Rehabilitation – both beds and home-based, Community Treatment Team and some voluntary sector services such as the Help Not Hospital service provided by the British Red Cross.

Multi-Agency Safeguarding Hub (MASH) - gathers and shares information from a variety of partner organisations aimed at achieving accurate data to inform our decisions, which ensures safeguarding interventions are timely, proportionate and necessary.

Case Study 1

Mr A living in private let accommodation with a diagnosis of dementia, facing eviction under section 21 notification (where landlord can ask for property back at any stage). Mr A was supported by his social worker to make a sheltered housing application, and to collate relevant evidence required for this. The social worker worked closely to arrange temporary accommodation in an appropriate setting whilst a permanent sheltered housing property was identified. Joint work was undertaken between the social worker, a local charitable organisation and the family to arrange for the permanent move to take place once a property was identified, and the social worker also supported Mr A to shop for carpets, and to set up standing orders for his bills at the new property.

This joint working approach enabled Mr A to access appropriate housing to meet his current and anticipated future needs for some time to come. It also ensured that there were systems and support in place for Mr A, to minimise the disruption and change to Mr A's routines throughout what was a very stressful and worrying period for him.

Case Study 2

Mr C was living in supported living accommodation. He was being supported with a daily care package however he required further support in-between call times. Mr C was also being supported by the scheme manager who was not able to continue providing such a high level of support.

Mr C was supported to make a sheltered housing application as it was felt he required a higher level of support daily. During this time safety concerns were raised following a fire in the property. Mr C was not able to make safe use of his home and consented to a temporary move to a residential setting whilst accommodation in an appropriate setting was sourced.

Joint work was undertaken between care assessor, social worker and care home staff to ensure Mr C had information needed to make a decision about his accommodation needs. Mental Capacity Assessment was completed by social worker. Care assessor ensured Mr C had access to high quality appropriate services to meet his needs by completing a review and ensuring care is person centred.

Case Study 3

MJ has severe arthritis in her back and legs and also pain in his gall bladder, her son is not local and he has refused carers and offers of supported services in the past. MJ struggles to get out of her chair and to stand for long periods of time and also states that she has difficulty managing the stairs.

Following a visit to A&E after a fall in her kitchen**,** MJ was a little hesitant about accepting help because she sees herself as independent and does not want to be a burden to anyone. However the British Red Cross (BRC) managed to build a rapport with her, and was able to identify some areas that the BRC could support with and she was willing for them to support her.

Initially MJ would only accept support from BRC with things like shopping and light housework. However by the end of the intervention she had started to accept one care visit at lunch time each day to support her with her meal preparation etc, a cordless phone was provided so that she could charge each night but have by her chair during the day and with her agreement the BRC were able to co-ordinate for a key safe to be fitted and telecare pendant alarm to give her some reassurance and her son peace of mind should there be any future falls.

Case Study 4

Following a fall where he fractured his left humorous EG fell ill with pneumonia and remained in hospital. EG was initially referred to BRC to support with household domestic tasks and the second referral was to support to settle at home after hospital discharge.

EG was not keen on the service BRC was offering initially but after a few attempts to help, and following being given choices of supportive service that would be available for EG to pay for, EG agreed to register on the Sainsbury's shopping service. As EG has not got internet Sainsbury's would have his bank card saved on their system and he would only have to called when he need shopping, he was supported to register for the service and his detail was saved and he was given a reference number that he needs to provide when shopping.

As regards to the laundrette, we look at Mobile laundrette in the area was also looked for with EG and BRC liaised with them with EG's permission and was give the prices for their service which was to pick up the washing and then return it to SU's house by the end of the day. He takes a taxi to the bank every couple of weeks to get the money to pay for the service.