DIAGNOSTIC ASSESSMENT

EXECUTIVE SUMMARY

January 2020

west sussex county council

NEWTON

DIAGNOSTIC ASSESSMENT

SCOPE / APPROACH

- Engagement of a Strategic Partner to support the delivery of The Adult Social Care Improvement Programme (ASCIP)
  - A three-year Adults service improvement plan to enable the realisation of the vision and strategy for 2019-21
  - The aims of the strategy are to increase people's independence, reduce the reliance on formal social care provision and develop new ways of managing demand
  - A similar approach in Lifelong Services, the Council's service focussing on children, young people and adults with lifelong disabilities and autism and their families

Understand and communicate to inform the scope of the programme.

Ensure this is informed by strategic aims and existing transformation activity.

Quantify the size of the opportunities and prioritise. Build an evidence base around the key drivers that will effect change.

Design, with practitioners, and trial the solution to the biggest problems. Measure the impact and iterate until it works.

Iterate and roll out solutions developed during design until embedded and sustainable countywide, with the desired outcomes achieved.

We are coming to the end of this phase now, with the output complete and findings being shared

DIAGNOSTIC ASSESSMENT

APPROACH

QUESTIONS

Decision Making
Are we effectively tackling variation in decision making, and consistently making the best decisions to maximise independence?

Outcomes
Are the services effective? Are we referring people to the right place, and is that delivering the desired outcome?

Use of Resource
Are we set up in a way that makes best use of our limited resource? What is the financial impact on staff numbers and commissioned spend if we deliver this improvement?

Culture
How well does the culture and leadership support people to effect change and perform at their best?

APPROACH

Pathway Workshops	Workshops, interviews and surveys as to the current culture and readiness for change
Live Studies	Analysing data to understanding baselines, trends, patterns and variance
Discussions with Local Teams	Leverage and augment the expertise that already exists within the organisation
Historical Data & Benchmarks	Front line practitioners actively participating in the collaborative review of live cases, exploring potential for improved outcomes
Change Readiness	Time at the front line, shadowing activity and ways of working to develop an understanding of the issues constraining performance

EVIDENCE

Opportunity Matrix
Identified priority opportunities with a projected impact on both outcomes and financial savings.

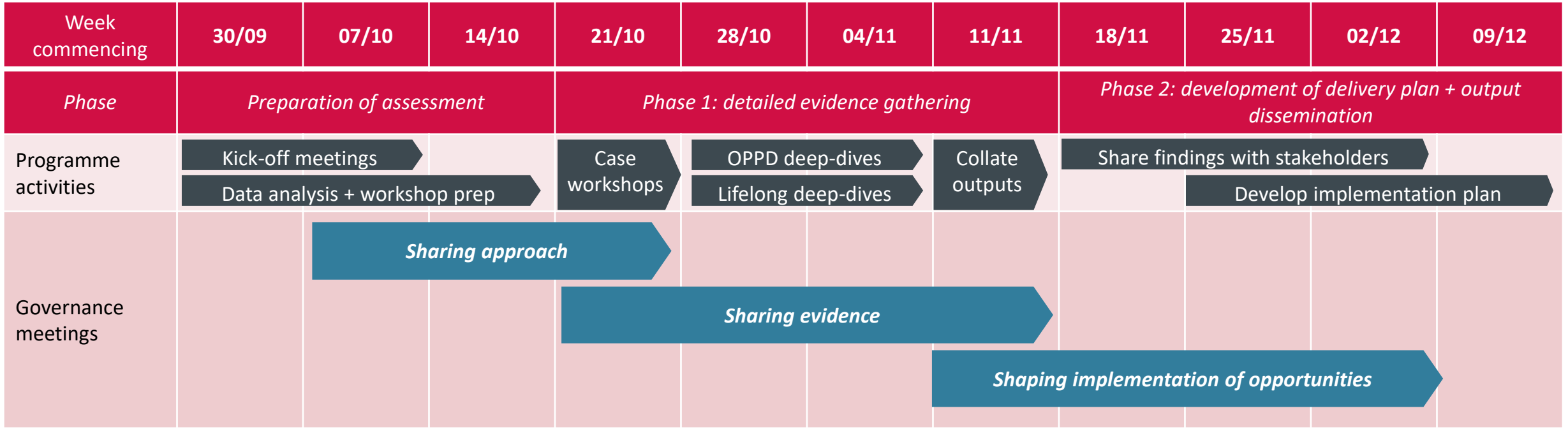
Complexity of opportunities
An understanding through evidence of the deep complexity to be tackled in achieving the identified opportunities.

Immediate pressures
Understanding the immediate pressures, which need to be considered in designing the shape and pace of activity.

Readiness for change
Reflecting the 'readiness' of the organisation to deliver the necessary activity to sustainability achieve the identified opportunities, while leaving a positive legacy for WSCC.

DIAGNOSTIC ASSESSMENT

HIGH-LEVEL TIMELINE



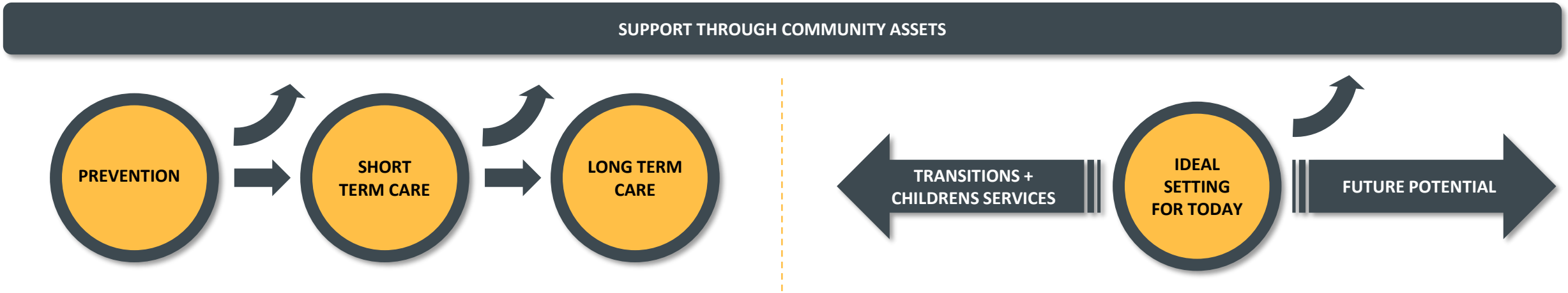
We've now finished the phase where we worked to gather all of the information and evidence needed to inform a view of the priority areas for change and the root causes of current difficulties in those areas

We're now in the process of sharing the findings and working to shape a proposal for the design and implementation work required to deliver the outcome improvements we'll show you today

WEST SUSSEX COUNTY COUNCIL

ADULT SERVICES

LIFELONG SERVICES

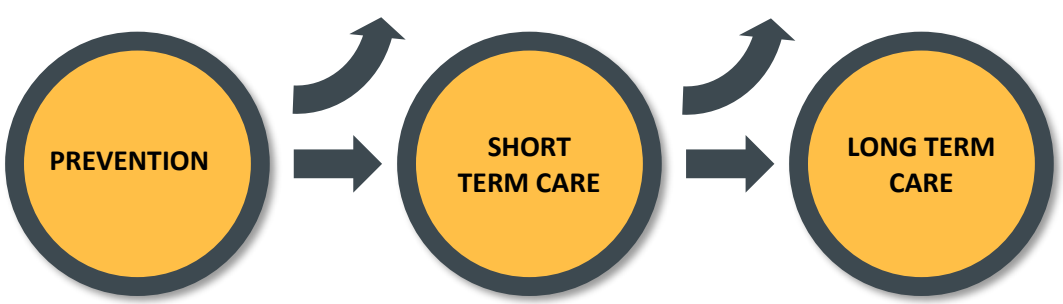


WEST SUSSEX COUNTY COUNCIL

ADULT SERVICES

LIFELONG SERVICES

SUPPORT THROUGH COMMUNITY ASSETS



COMMISSIONING

WORKLOAD + STAFF CAPACITY

ORGANISATIONAL AND SERVICE CULTURES

READINESS FOR CHANGE + EXISTING CHANGE INITIATIVES

UNDERSTANDING OUTCOMES
CASE-REVIEW WORKSHOPS

27
PRACTITIONERS

5
DISCIPLINES

101
OUTCOMES REVIEWED

Over the course of two sessions, pathway workshops were conducted to understand whether or not the ideal outcomes had been achieved for individuals in receipt of long term packages.

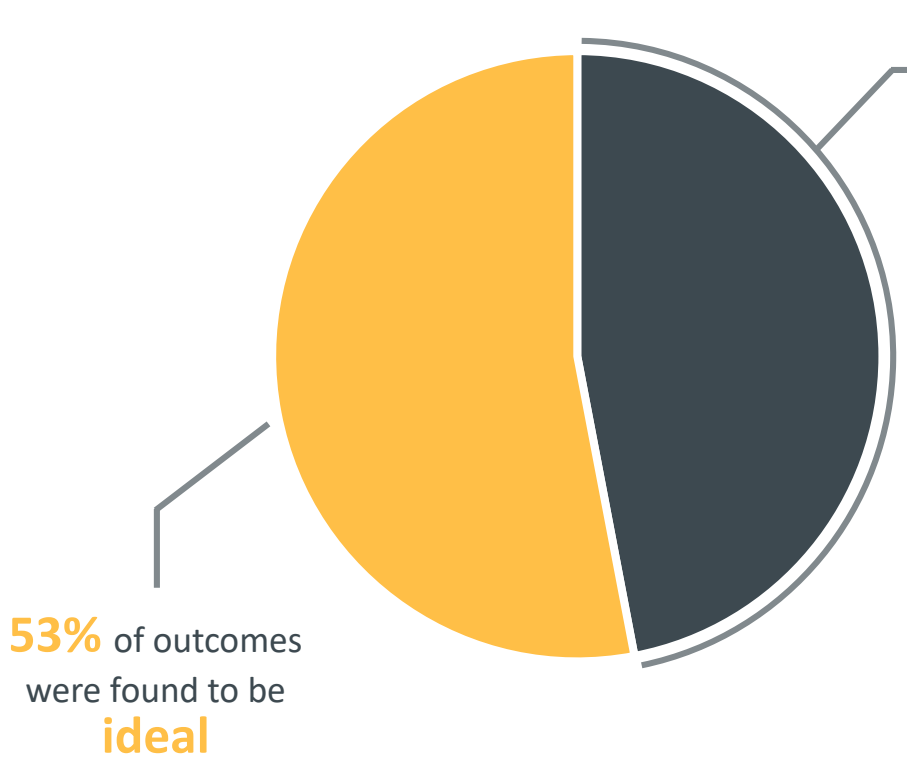
This was done for individuals whose cases had passed through a combination of hospital and community teams.

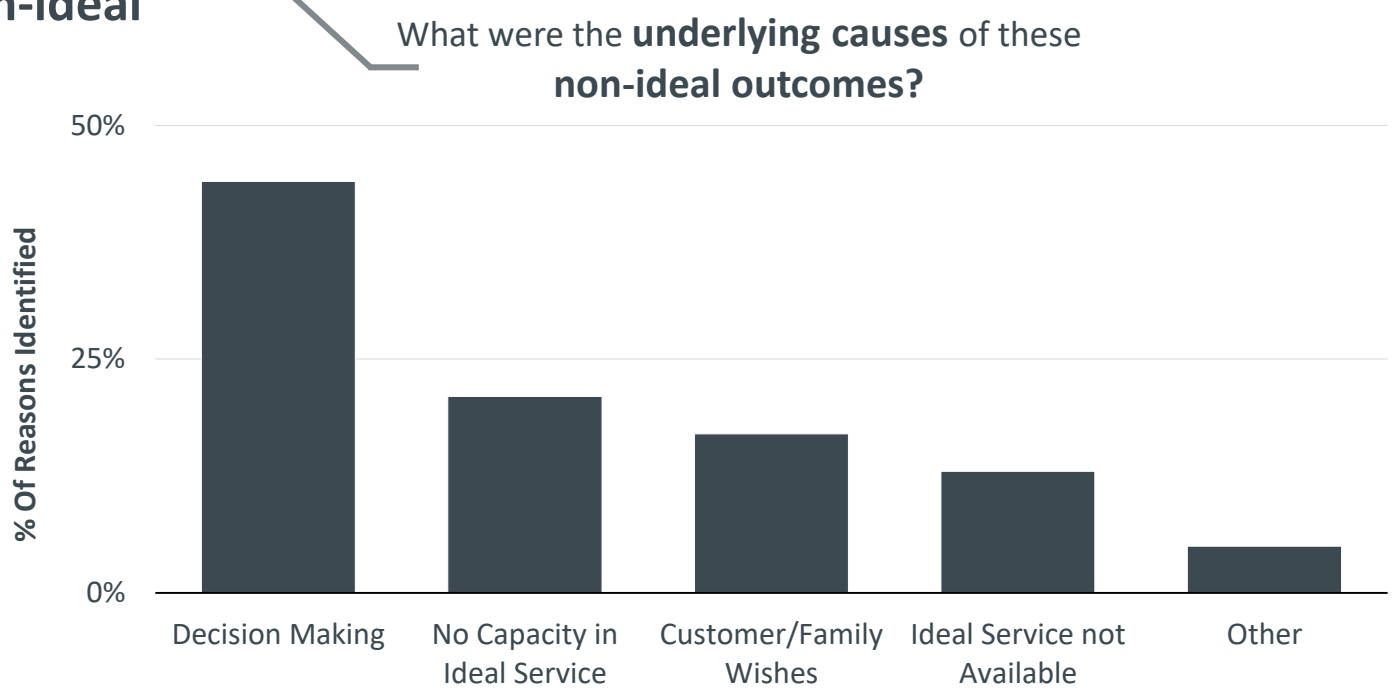
For each case reviewed, groups were asked to answer the following questions:

- What was the ideal outcome for this individual?
- What were the underlying reasons for any differences to the actual outcome?

UNDERSTANDING OUTCOMES
CASE-REVIEW WORKSHOPS

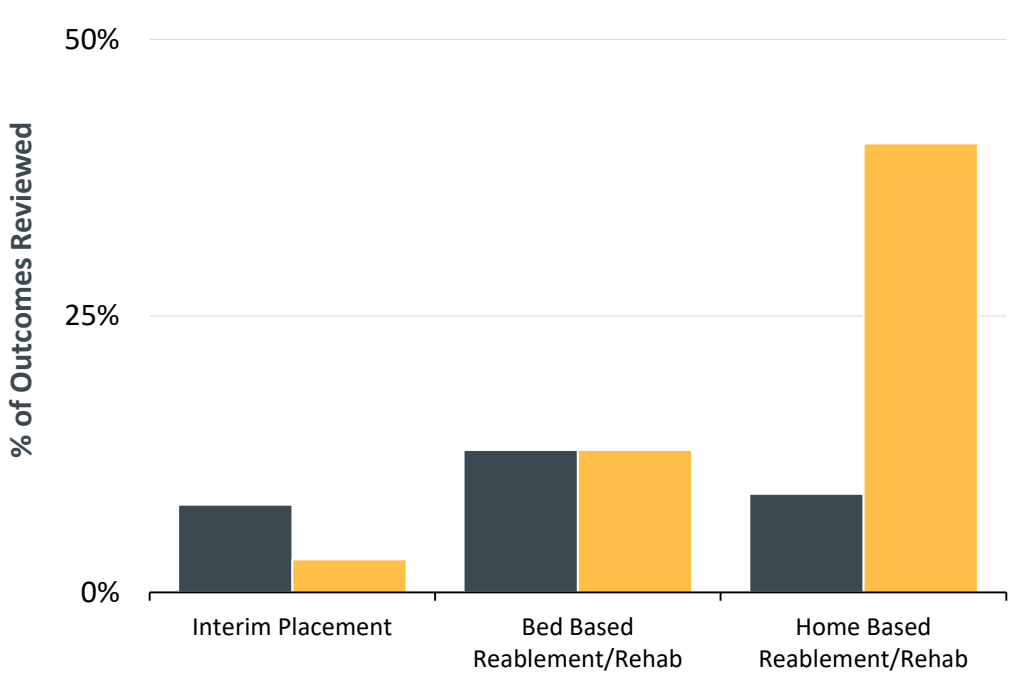
Case review workshops were held across West Sussex, with **27 practitioners** from a range of professions reviewing **101 cases** to understand what the **ideal outcome** would have been for each older person based on their need, and to identify the **underlying reasons** for any differences between these ideal outcomes and the actual outcomes achieved.



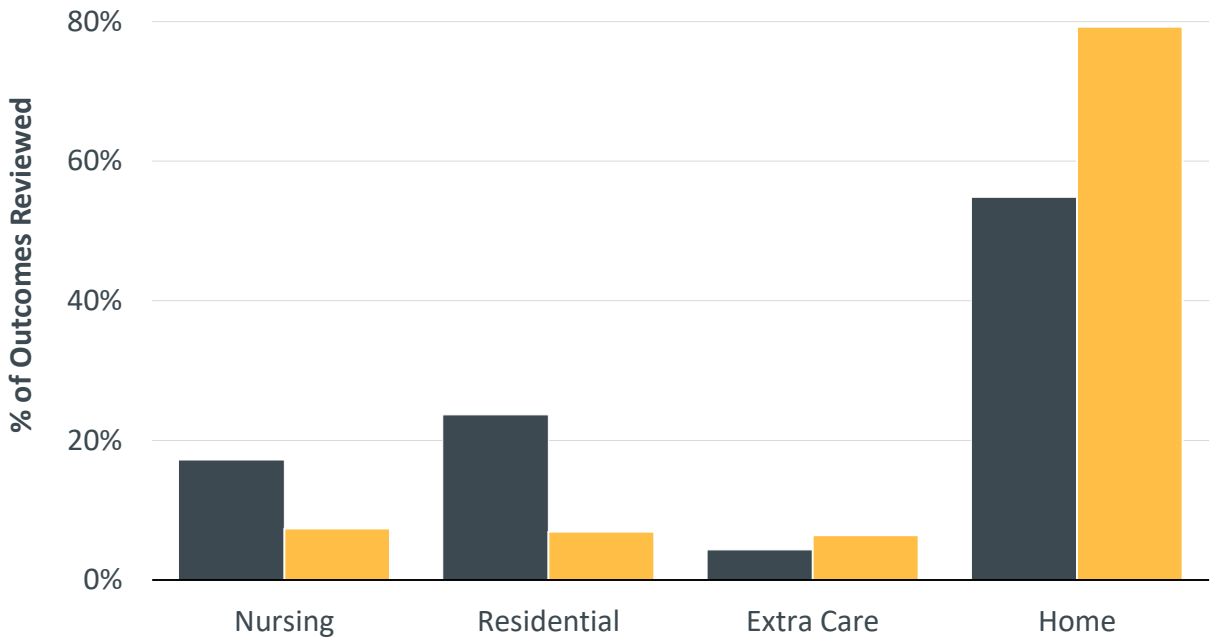


UNDERSTANDING OUTCOMES
CASE-REVIEW WORKSHOPS

What **short term services** were required to achieve ideal outcomes for these individuals?

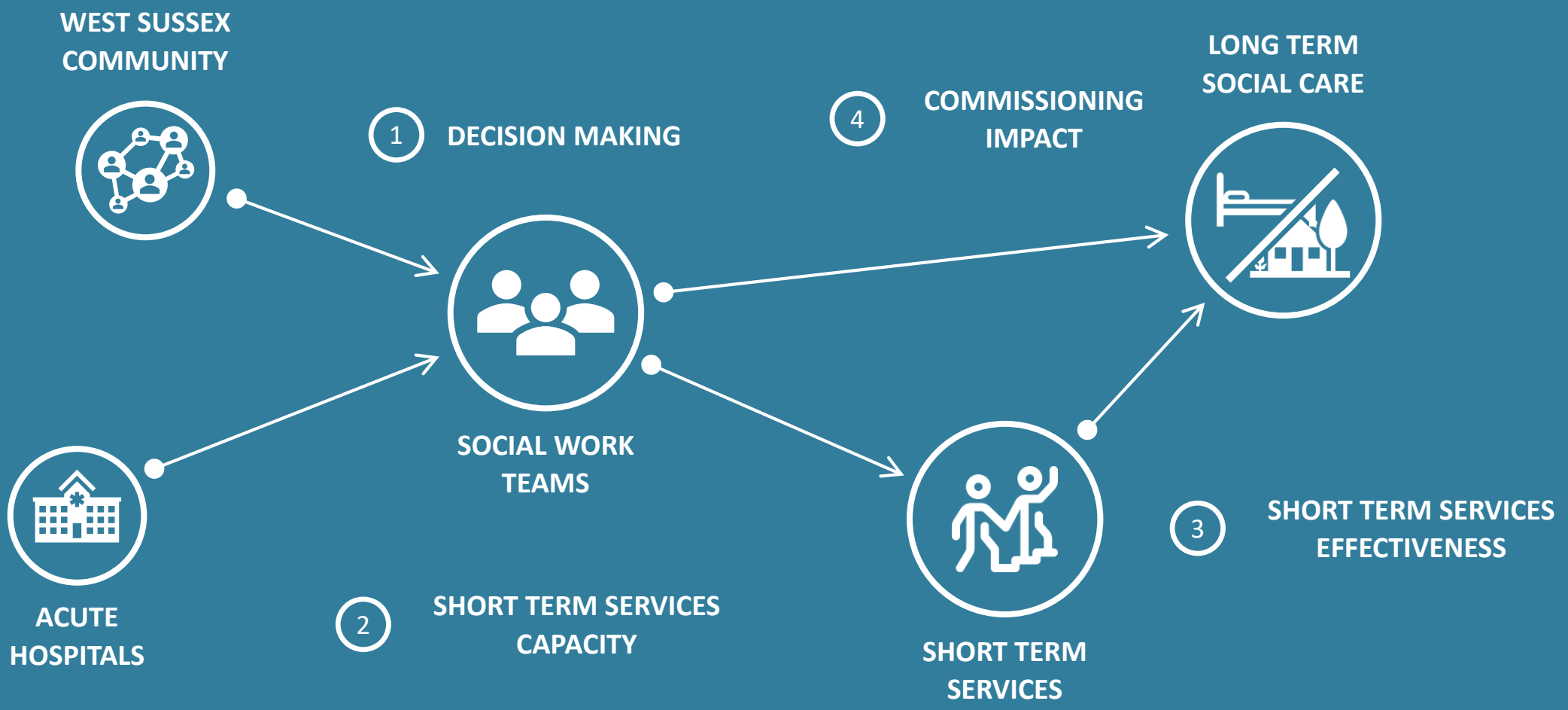


How do the actual and ideal **long term outcomes** compare for these individuals?



- Actual Outcomes - Ideal Outcomes

UNDERSTANDING OUTCOMES
ASSESSMENT OVERVIEW



DECISION MAKING
UNDERSTANDING INFLUENCING FACTORS

As decision making was found to be one of the biggest drivers for non-ideal outcomes, we wanted to understand what the **biggest challenges** are that decision makers face on a daily basis. The following are results are from the survey responses of **50 social care decision makers**. The survey asked staff to score how likely each of the following factors to influence them to make a **risk averse decision**:

DECISION MAKING
UNDERSTANDING INFLUENCING FACTORS

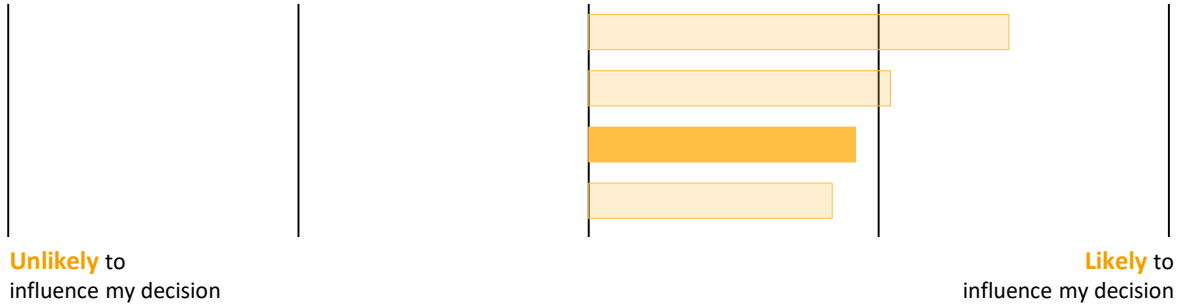
As decision making was found to be one of the biggest drivers for non-ideal outcomes, we wanted to understand what the **biggest challenges** are that decision makers face on a daily basis. The following are results are from the survey responses of **50 social care decision makers**. The survey asked staff to score how likely each of the following factors to influence them to make a **risk averse decision**:

I would feel **accountable** if something went wrong

I feel **pressured** by how **quickly** I need to make the decision

I don't trust the timeliness and availability of the community services

I feel **pressured** and **influenced** by the wishes of the **customer** or **family**

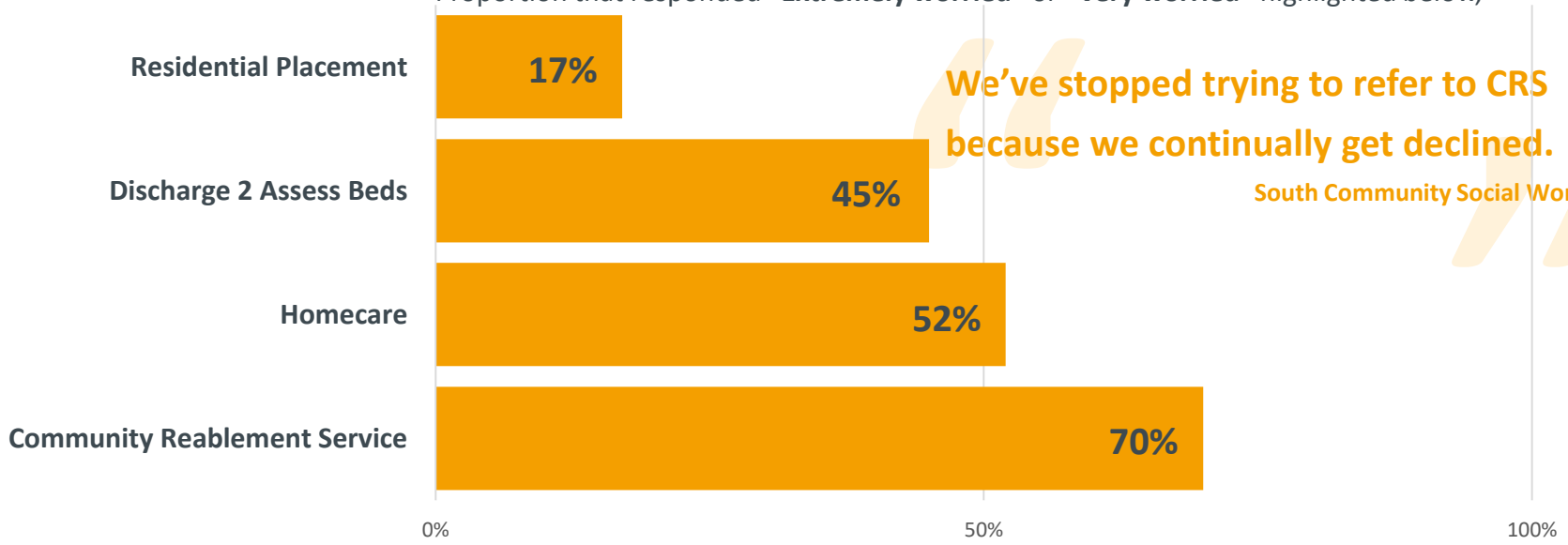


As practitioners had identified timeliness and availability of services as a key contributing factor in making less independent decisions, we asked 50 practitioners the following question,

How worried would you be about sending someone into the following services based on timeliness and availability?

Staff in community teams are most worried about finding capacity in precisely those services that offer more independent outcomes for people.

Proportion that responded **"Extremely worried"** or **"Very worried"** highlighted below,

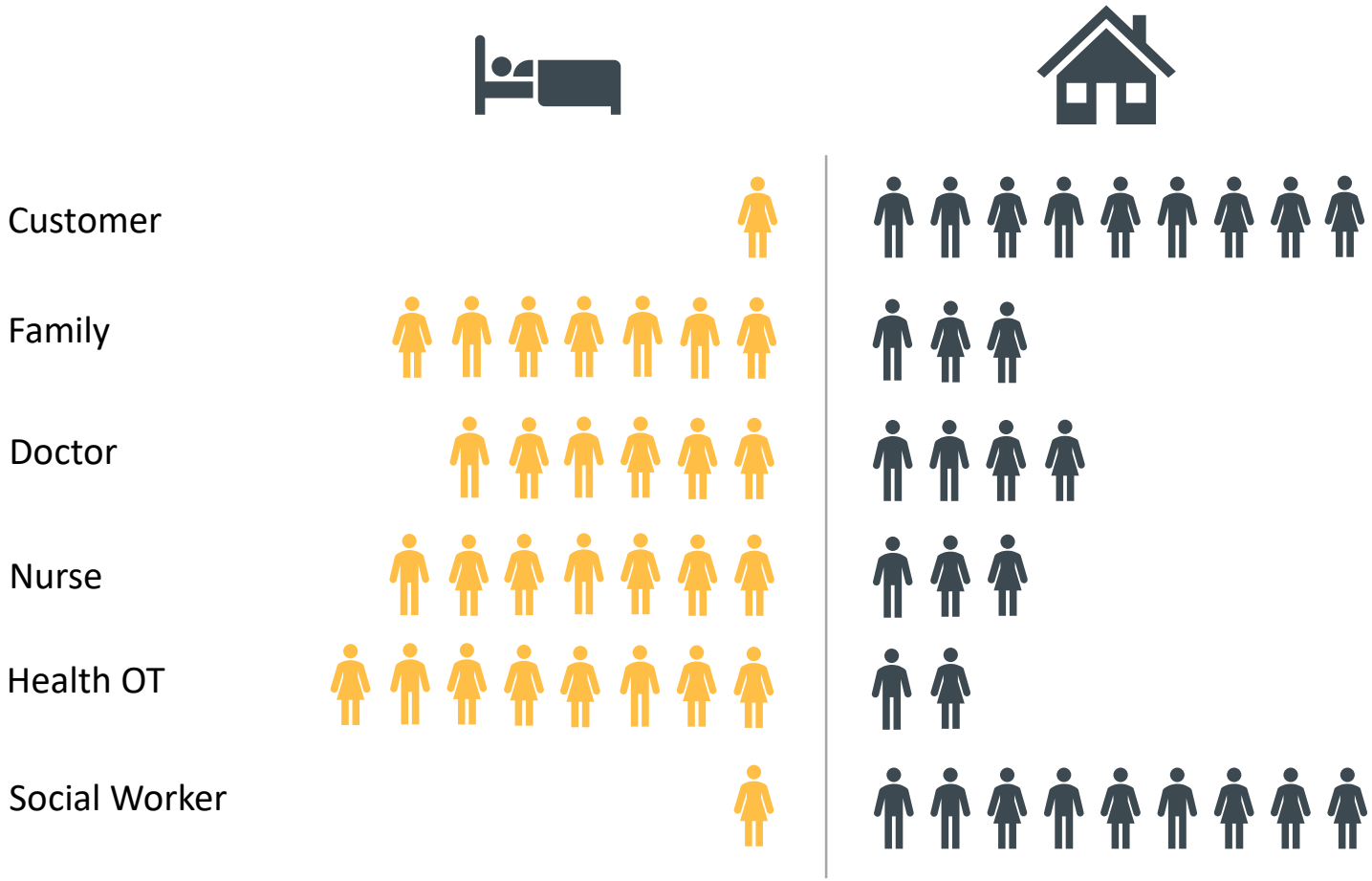


> **We've stopped trying to refer to CRS because we continually get declined.**
>
> South Community Social Worker

DECISION MAKING
UNDERSTANDING INFLUENCING FACTORS

We studied 10 individuals across 2 hospitals

"What would be your preference on where you are discharged to?"



It feels like a lonely place, everyone is against us.

West Hospital Social Worker

The Hospital OT wanted it formally documented that they "didn't agree" with my decision to send her home

West Hospital Social Worker

Our staff know what good outcomes look like but it can feel like an uphill struggle to achieve these with some health partners, who are incentivised to focus on discharge timescales rather than outcomes.

Joan, 101, previously lived at home with a single call a day to support her with washing and dressing in the morning. She otherwise lived independent of formal care and was fortunate to have a number of supportive neighbours.

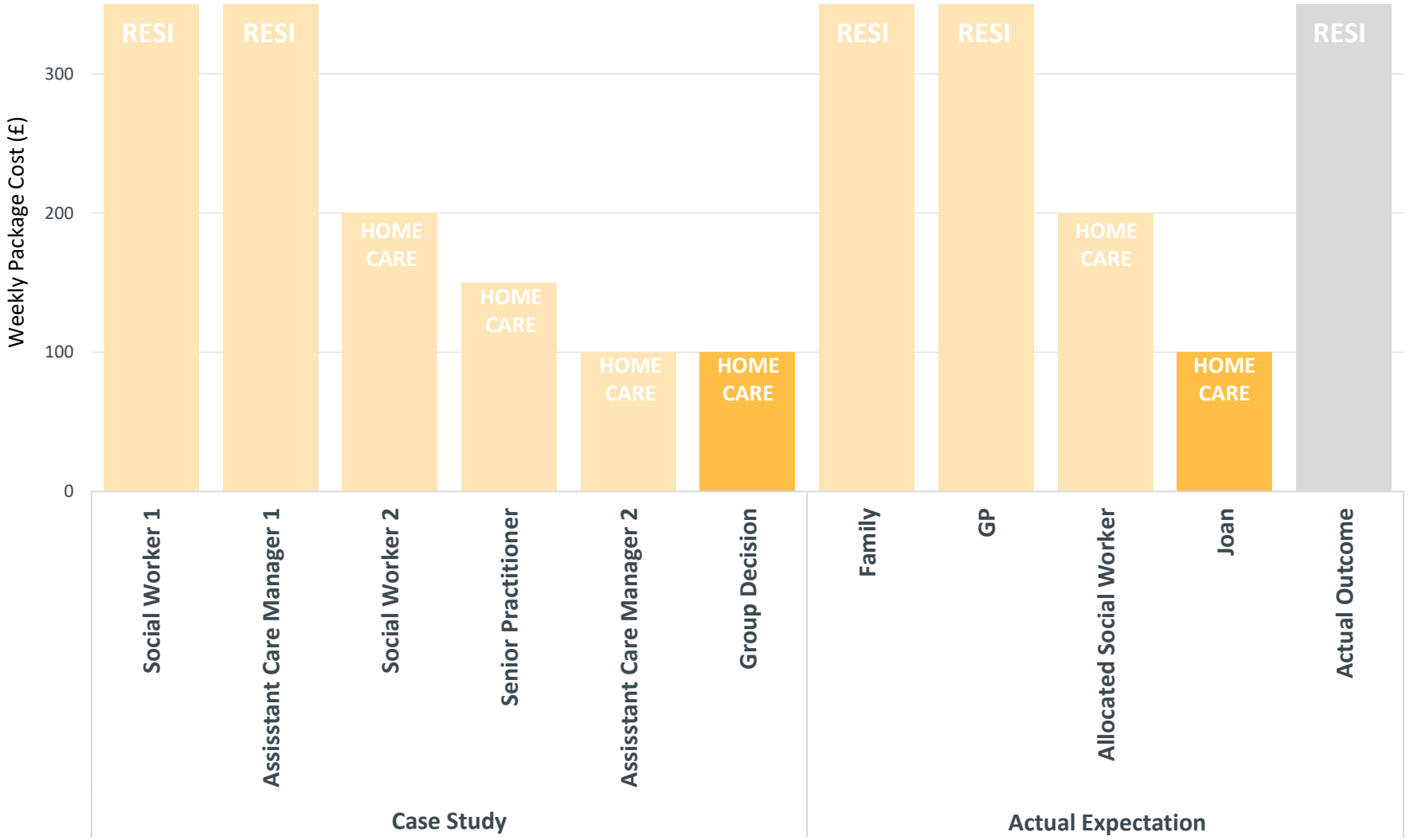
In April 2019, Joan's daughter contacted Adults Services requesting an assessment for her mother. She stated that she had found a suitable residential placement for her mother to move into and voiced concern that this placement would become unavailable if an assessment was not completed soon.

Despite being fully independent with her toileting, mobility and transfers, and not having any diagnosed medical conditions, it was decided that Joan was to move into a residential home in May 2019, where she currently resides.

Joan expressed a desire to remain in her own home but understood that this is not what her family wanted.

DECISION MAKING
JOAN'S CASE

When we ask different people to say what the best outcome for people is, we find that decisions made in a structured group environment lead to the most independent options.



Case Study Exercise

Individual — Individual practitioners reviewed Joan's case and determined an ideal outcome.

MDT — Joan's case was discussed in an MDT and the group decided on an ideal outcome.

Joan's Actual Case

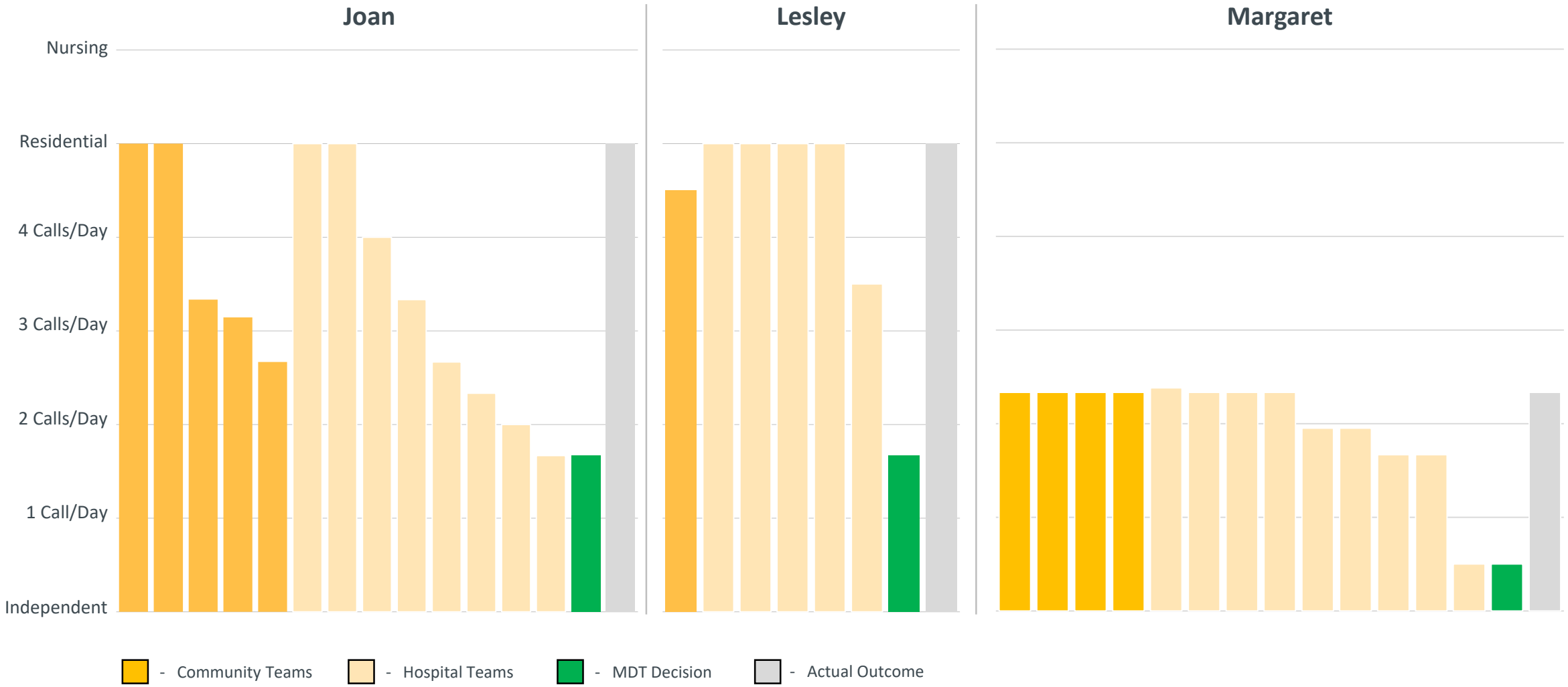
Prof. opinion at the time — Joan's case notes were reviewed to determine the recommendations from the professionals at the time.

Joan — Joan's case notes were reviewed to determine the recommendations from the professionals at the time.

Actual Outcome — The actual outcome for Joan.

DECISION MAKING
EXAMPLE CUSTOMERS

…and it wasn't just in Joan's case. We repeated the exercise and found that structured group decisions were consistently developing more independent outcomes



ADULTS SUMMARY

Short Term Services

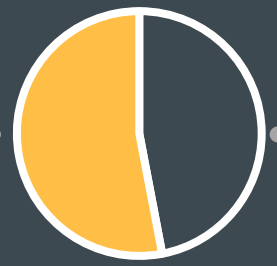
1,920 additional individuals could access reablement each year

40% increase in effectiveness of home based reablement

Outcomes

53% NON - IDEAL SETTING

47% IDEAL SETTING



1,883 individuals could be supported in a more independent setting

Long Term Support

673 individuals could be supported at home instead of in a placement

371 individuals could be independent of ongoing support

WEST SUSSEX COUNTY COUNCIL

ADULT SERVICES

LIFELONG SERVICES

SUPPORT THROUGH COMMUNITY ASSETS

COMMISSIONING

WORKLOAD + STAFF CAPACITY

ORGANISATIONAL AND SERVICE CULTURES

READINESS FOR CHANGE + EXISTING CHANGE INITIATIVES

LIFE LONG SERVICE

SCOPE

Would a different series of interventions, services or approach to meeting the individuals needs have achieved a more ideal outcome today?

TRANSITIONS + CHILDRENS SERVICES

IDEAL SETTING FOR TODAY

FUTURE POTENTIAL

is there any potential for the SU need to change to become more independent? What services and future support plan would be required to achieve this?

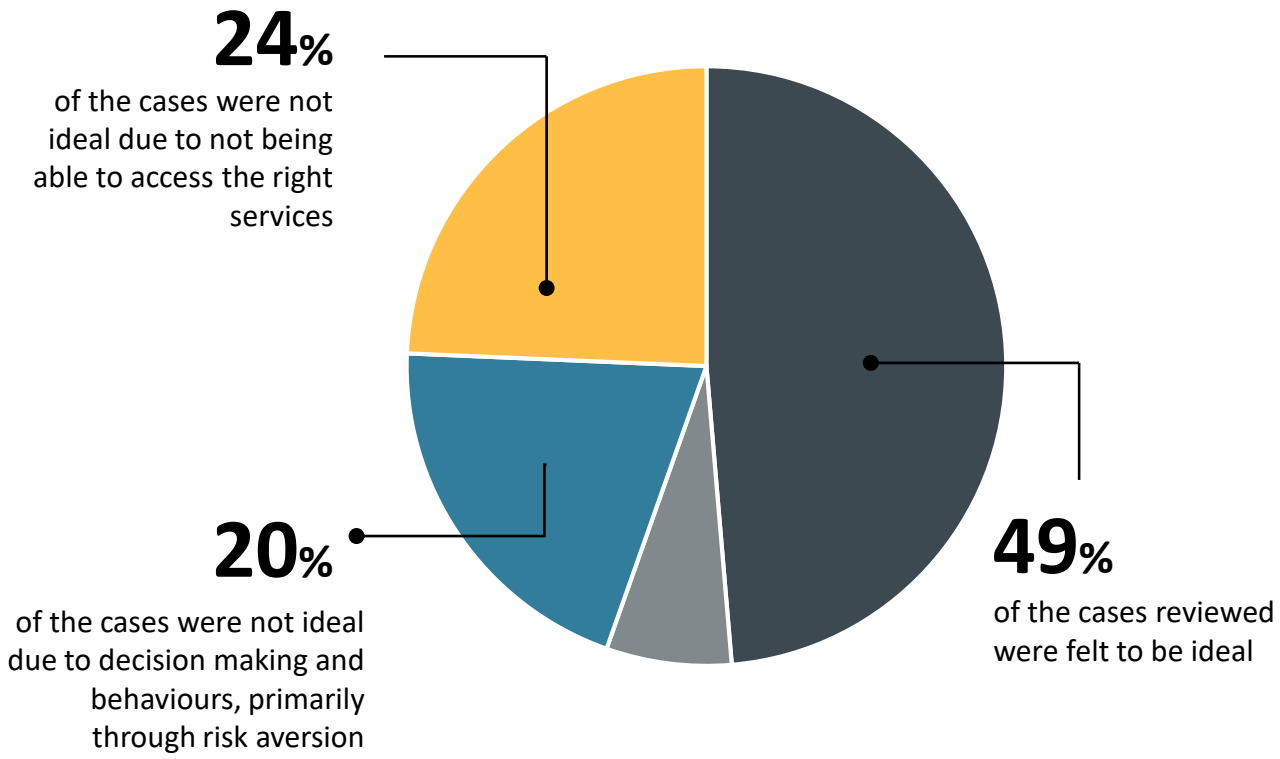
Is the setting and support plan for a service user the most ideal for the individual?

ACHIEVING THE RIGHT OUTCOMES

LLS ACTUAL VS IDEAL OUTCOME

With **31 practitioners and managers** from **11 teams**, we conducted pathway workshops of individuals who were in receipt of a long-term care package.

The workshop group were first askes **"Are we supporting this person to reach achieve their ideal outcome?"**



When we asked those same practitioners, **what would have been the ideal moves**, they told us…

1) Residential to Supported Living

2) Residential to Shared Lives

3) Supported Living to Shared Lives

ACHIEVING THE RIGHT OUTCOMES – DECISION MAKING

We wanted to really understand what the main reasons were for this across both **Supported Living** & **Shared Lives**, so we asked the following questions….

1 Is there a **genuine capacity problem** across our services?

Based on current demand:

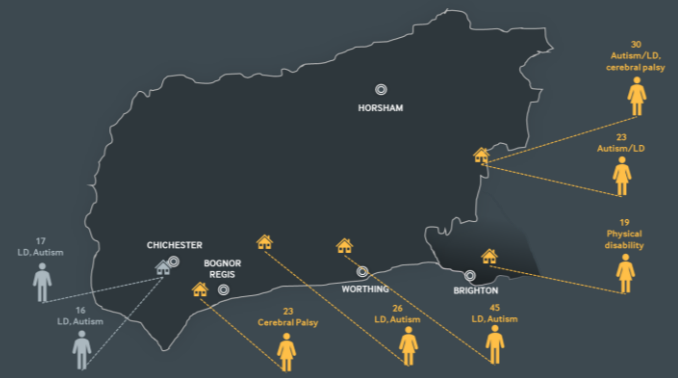
10% *Additional capacity in* ***Residential Homes***	**4%** *Additional capacity within* ***Supported Living***	**1%** *Additional capacity in* ***Shared Lives Placements***

Based on future demand:
(Workshop output plus predicted trend in SUs)

45% *Additional capacity in* ***Residential Homes***	**8%** *Under capacity within* ***Supported Living***	**49%** *Under capacity within* ***Shared Lives Placements***

2 Is there **a mismatch** between needs & placements available?

There is a large variation between what practitioners prioritise when looking for a placement.

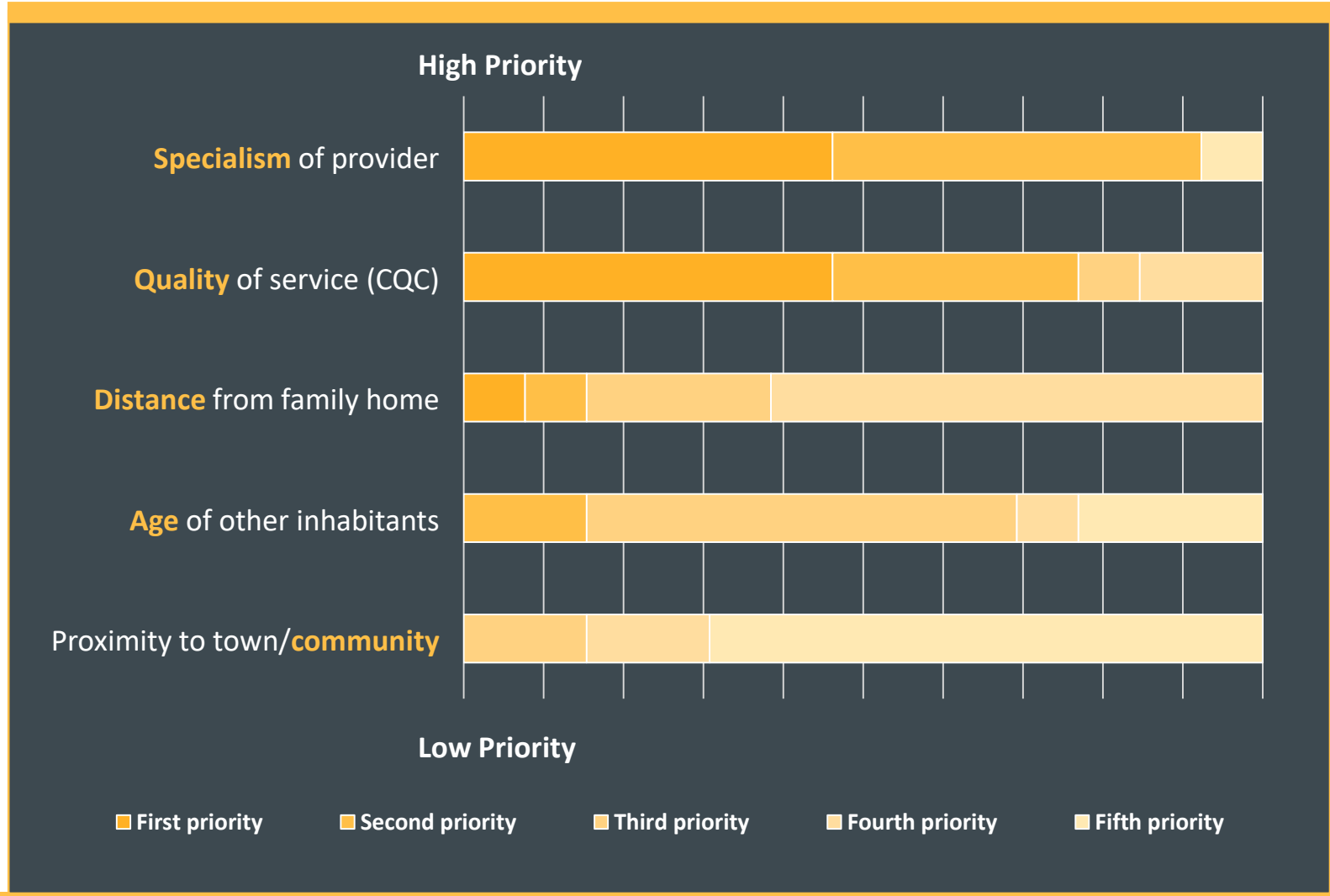


Using practitioner consensus to define parameters, we found suitable placements for **75%** of the cases from the workshops that ended up in Residential care due to the lack of suitable placement.

WHAT ARE THE CRITERIA FOR A SUITABLE PLACEMENT?

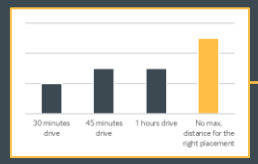
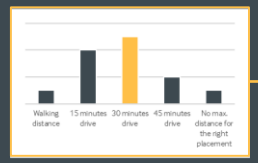
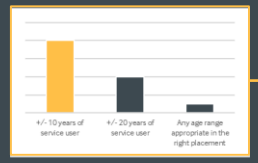
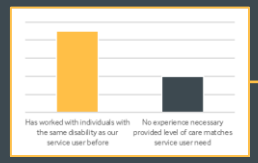
We wanted to understand what practitioners **saw as priority** when looking for a placement for a Service User, to understand what could **potentially cause a mismatch** between placement & individual.

We asked social workers a series of questions around five placement factors. To the right is the way the social workers ranked factors by order of priority, with specialism and quality of the service coming out on top.



WHAT ARE THE CRITERIA FOR A SUITABLE PLACEMENT?

We then asked social workers to help define these parameters. We took the consensus views below to form the parameters for our study.

DISTANCE FROM FAMILY HOME		No max distance for the right placement
DISTANCE FROM TOWN/COMMUNITY		30 minutes drive
AGE RANGE		+/- 10 years
MINIMUM QUALITY RATING		Good CQC Rating
NECESSARY SPECIALISM		Has worked with service users with the same disability before

HOW DOES THIS CRITERIA MAP AGAINST OUR VACANCIES?

We then used the vacancy list and spoke to providers to identify placements for service users identified in the workshops as incorrectly placed due to lack of capacity. **We identified places that matched our criteria in 75% of cases.**

DISTANCE FROM FAMILY HOME

No max distance for the right placement

DISTANCE FROM TOWN/COMMUNITY

30 minutes drive

AGE RANGE

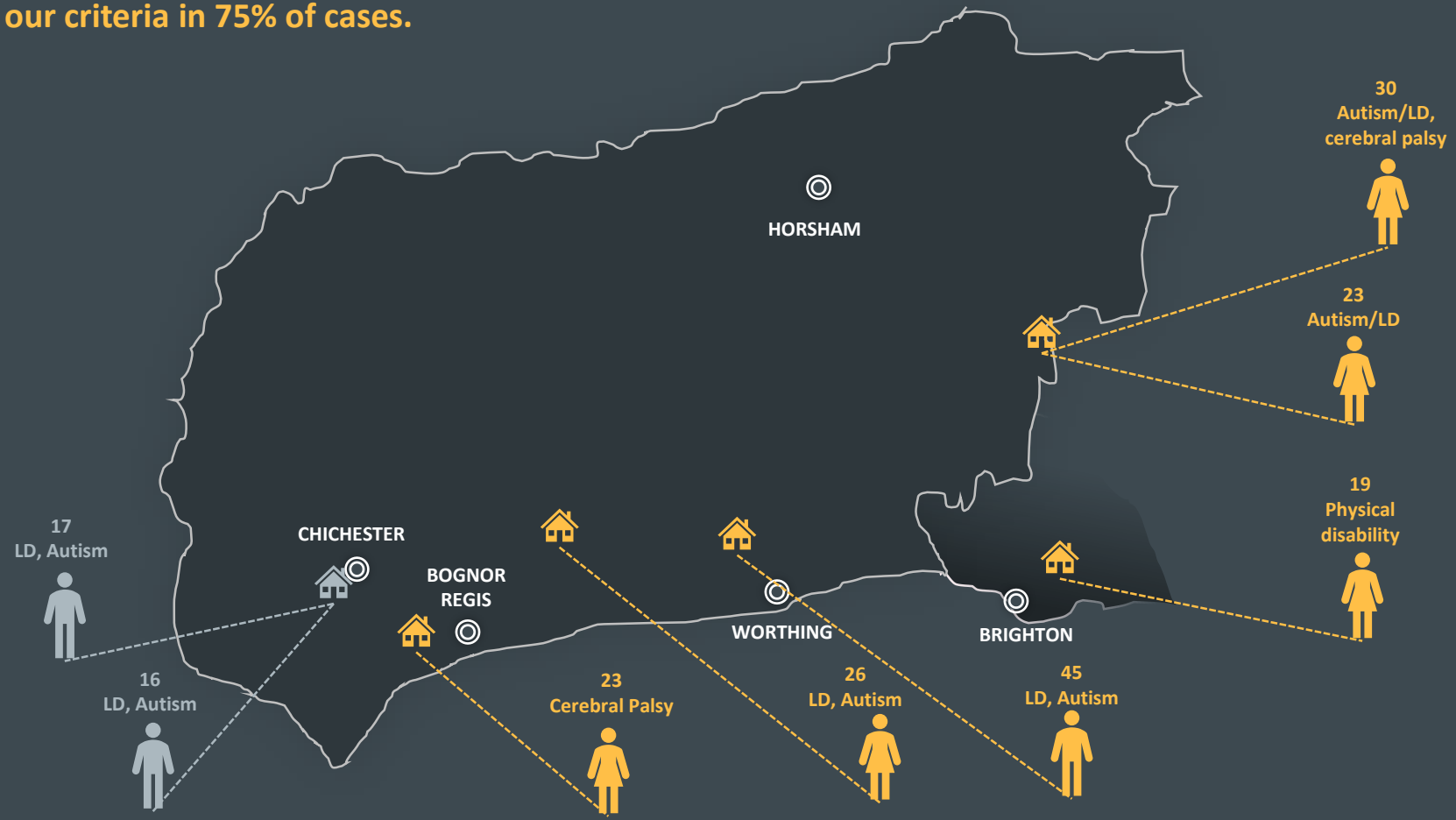
+/- 10 years

MINIMUM QUALITY RATING

Good CQC Rating

NECESSARY SPECIALISM

Has worked with service users with the same disability before



LIFE LONG SERVICE

SCOPE

Would a different series of interventions, services or approach to meeting the individuals needs have achieved a more ideal outcome today?

TRANSITIONS + CHILDRENS SERVICES

IDEAL SETTING FOR TODAY

FUTURE POTENTIAL

is there any potential for the SU need to change to become more independent? What services and future support plan would be required to achieve this?

Is the setting and support plan for a service user the most ideal for the individual?

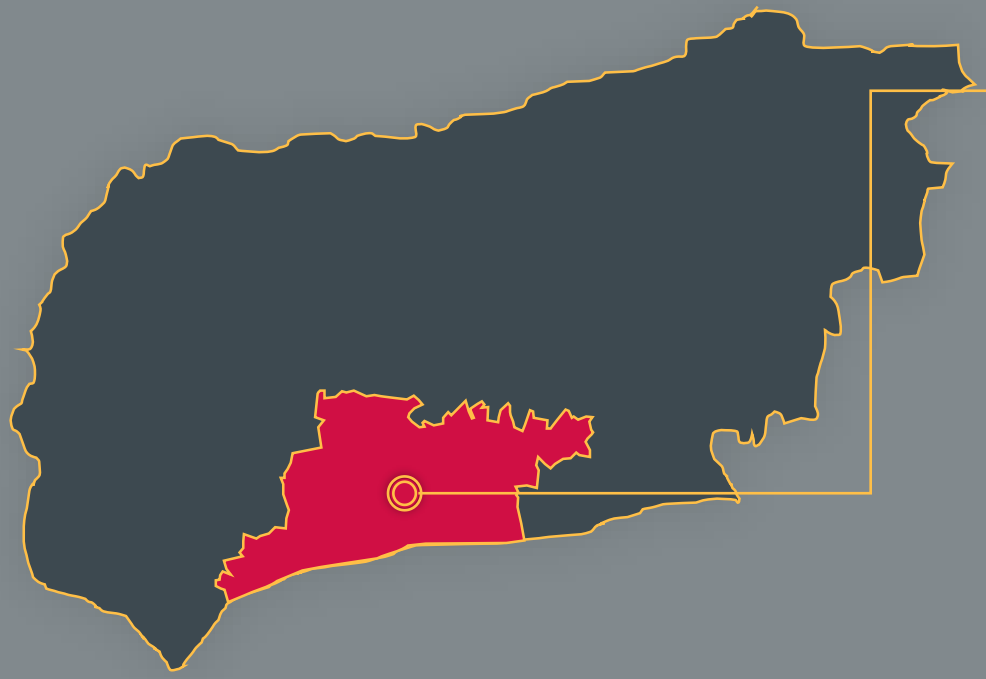
MAXIMISING THE PROGRESSION OF OUR SERVICE USERS

SUPPORTING NUTRITIONAL MANAGEMENT (EXAMPLE)

42% Service users reviewed could become more independent in managing their nutrition

"Just because he hasn't cooked before, doesn't mean that he can't"

Adults Social Worker



In Arun district, we run free weekly cookery courses to teach quick, healthy and cheap meals to individuals at varying needs levels.

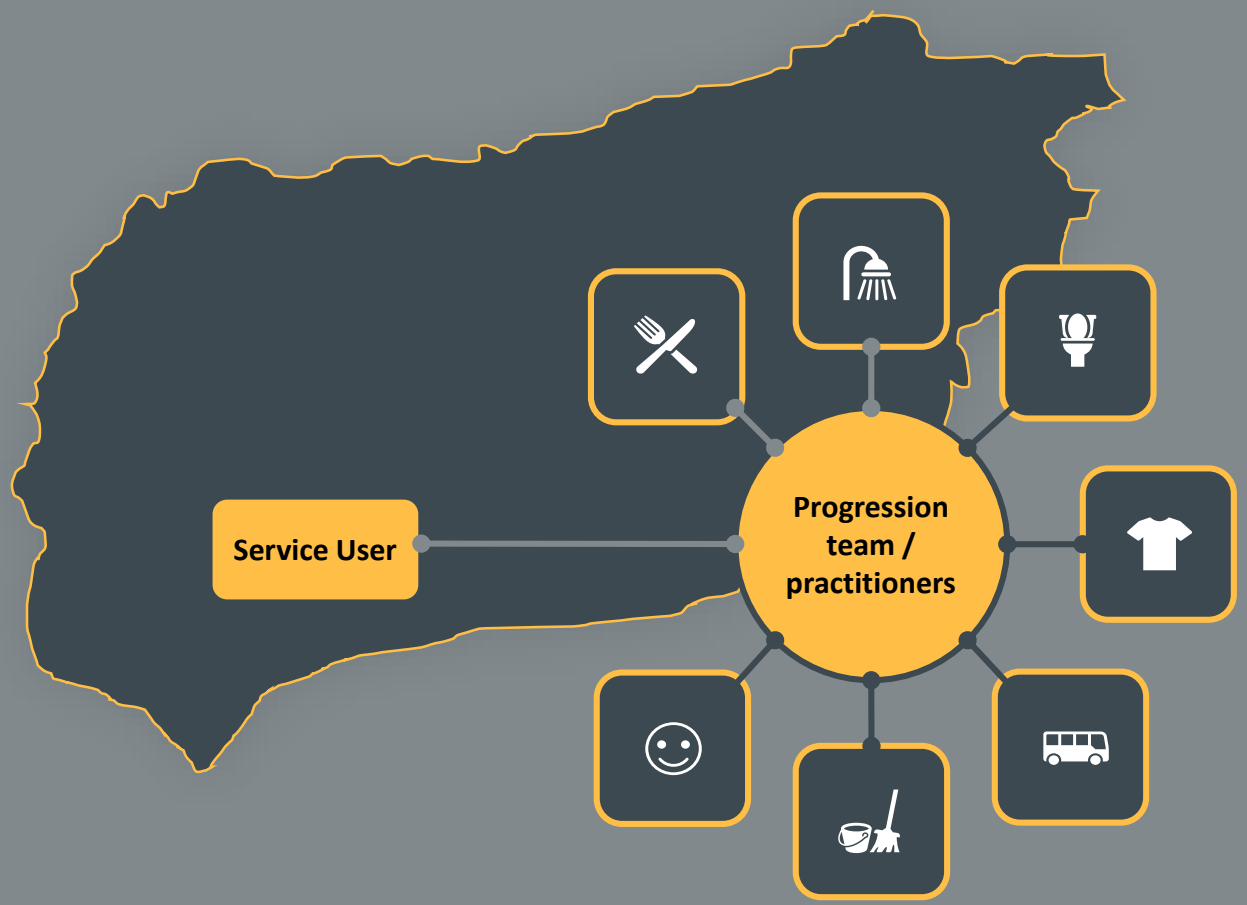
This is the **only course** in the county known to social workers to progress Service Users nutritional management

The cookery course had capacity for **50 attendees** per year, supporting a range of customers from LD and MH, but is being **decommissioned**.

Needs profiling highlighted that **825** customers could **progress** with supporting **nutritional management** across the whole county.

PROGRESSION TEAM

Having individual services to aid progression will not result in **as large an impact** or **across as many people** in the county as having a specialist team. It is important that this team supports the following:

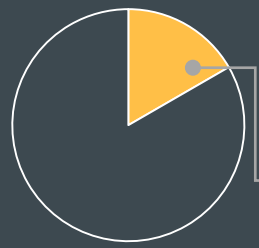


- **County wide** offer
- **Suite of services** across all regions
- Understanding where the **largest need** for progression is
- Working with individuals for **3-12 months**:
  - Co-ordinating **courses**
  - Following up with **1:1 support**
- Being able to **track the success** of the progression

LLS SUMMARY

TRANSITIONS + CHILDRENS SERVICES

For over **300** young adults, we thought that **engagement** with better **progression** could further decrease need

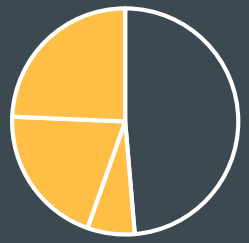


We believe that **79%** of the progression of a child is the responsibility of the family, but only **16%** of families feel supported to do this

IDEAL SETTING FOR TODAY

51% NON - IDEAL SETTING

49% IDEAL SETTING

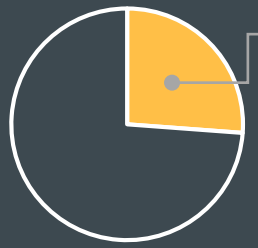


170 individuals could end up in a more ideal setting with the right access to that setting

140 individuals could end up in a more ideal setting with less risk averse decision making

FUTURE POTENTIAL

550 individuals could reduce their need score through progression



For those with progression potential, their required support could decrease by an average of **26%**