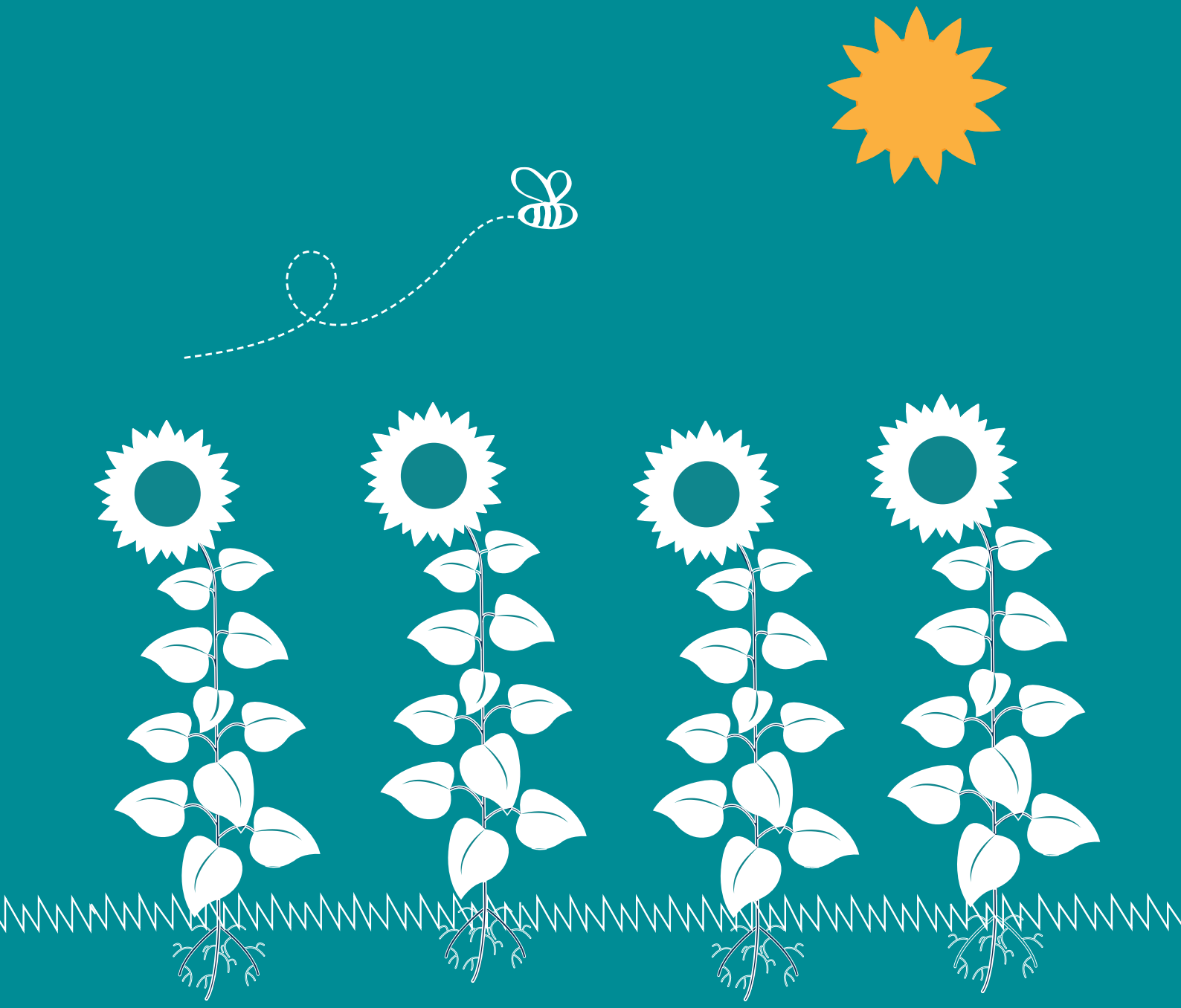
City of
Stoke-on-Trent

# Place To Be

## ADULT SERVICES STRATEGY – 2023-26



# Our Vision

Our vision is for every person in Stoke-on-Trent to live in the place they call home with the people and things that they love, in communities where they care and are cared for, doing and achieving the things that matter to them.

We believe passionately in every individual's right to pursue possibilities, dreams and aspirations.  To enable the achievement of everyone's full potential we will use our financial resources, the skills of our workforce and partnership with our local communities to help people make connections and build relationships in a way that improves wellbeing and fosters independence. We want everyone to be able to enjoy and contribute to community life.

We will make sure we are accessible to people and that they know their rights and what help is available to them. We will promote autonomy, choice and self-determination. If and when they need it, we want people to have access to a choice of good quality care and support that enables them to live the life they choose and do the things that matter to them, as independently as possible.

The result will be better experiences and better lives for those who receive support, and improved morale and satisfaction for Stoke-on Trent's social care and health workforce. It will also mean better use of public money because we will be achieving improved outcomes.

# Foreword

Living in a place where people feel cared for and have opportunities to achieve their dreams is central to the City Council's Stronger Together vision, and as the kindest city in the UK, Stoke-on-Trent is the place to be. Over the last 3 years we have shown this and through the unprecedented challenge of the Covid pandemic and now through one of the toughest winters known the city has shown how we come together and care for our most vulnerable in times of adversity.

As a city we are strong with our strength rooted in our communities, and this strategy reflects the assets in our local neighbourhoods, the strength of our voluntary, community, charity, social enterprise and faith groups that glue these communities together, and the role of the council as an enabler, supporting people to get the support they need. We have started on this journey through our Communities Together work, bringing a wide range of agencies together where people are, in Community Lounges, to resolve issues quickly and ensure people are linked into accessing the tools they need to fix problems quickly.

We have a number of challenges as a city, with people living longer and people struggling with mental health and living a healthy long life, as it stands this means escalating demand on a stretched workforce and a very real crisis for the social care market who provide care and support for our most vulnerable residents. This leads to poorer outcomes for our residents, and the current system is unsustainable, so we need to change what we are doing now. The traditional model of reliance on council and acute health services is no longer viable, and the way that health and social care services are set up is too fragmented leaving to our most vulnerable residents to join services up which makes a difficult situation even more of a mountain to climb.

This strategy is a call for change, towards a partnership approach, connecting people with communities, and communities with services to enable people to live independent lives. A partnership between health and social care that promotes integration and improves the experience of the city's residents. Behind this strategy is a well developed improvement plan which over the next 3 years will change the way that health and social care is delivered. This is a strategic vision that has communities at its heart, closer working with the voluntary sector and promotes an integrated model of '**place**'

I really look forward to seeing outcomes and people's experience of fulfilling their aspirations improve as the plan is delivered

## Councillor Ally Simcock

Cabinet Member for Adult Social Care, Health Integration and Wellbeing

# Our People of Stoke-on-Trent

Stoke-on-Trent is a fabulous place to live, visit and work, and the people of Stoke-on-Trent are the kindest in the UK[1], and the city is the happiest place to live in Britain[2]. Its greatest asset is its people, and the positive experiences, including living life in older age[3] come from living in vibrant, supportive, inclusive communities where the quality of life stems more from human interaction, suitable amenities and maximum independence. There are challenges too - local life expectancy is 2-4% shorter than the UK average, but healthy life expectancy is 11-14% shorter than nationally (the average number of years that an individual is expected to live in a state of self-assessed good or very good health, based on current mortality rates and prevalence of good or very good health). By 2030, the over-65 population of the city is projected to increase from 17.0% to 19.9%, an increase of 7,000 people. Over-65s whose day-to-day activities are limited a lot by long-term illness are predicted to increase from 14,876 to 17,324 between 2020 and 2030, a rise of 16.4%[4]. The prevalence of eight of the ten Long Term Conditions was higher in Stoke-on-Trent compared with England, including Hypertension (16.2% vs 13.9%) and Depression (17.4% vs 12.3%) and fuel poverty ranks second highest in the country, with 22.1% of households affected (England 13.2%).

Among our working age population, we have too many people with learning disabilities and mental health conditions living in residential care, some of them far from the city. Of those who are living in our community we have too few who are living independently, in employment and controlling their own finances.

1 | Circuit's Messages of Joy Campaign 2020
2 | Goodrays, August 2022
3 | Live in Care, February 2022
4 | JSNA, 2021-22

# Where we start

The challenges of responding to growing needs with less resources over time demands a different approach from Adult Social Care, one which relies on partnership and integration with our health colleagues and a different relationship with our local communities.

We have made a start, through programme such as Communities Together and new service offers like our Community Lounges, with the Council enabling a range of partners to work with people offering a range of services in communities in the places that people are most comfortable with.

We are determined to improve the experiences of the residents we serve. Often this will mean the council does not need to be the direct provider of services. Rather, we can develop the existing strong  voluntary, community and faith sector that already engages positively with many of our residents. It also means growing the capacity and capability of private care providers. This will enable us to provide excellent services to those who need it most.

With our health partners and public health professionals we are developing we are developing a real identity of Stoke on Trent as a 'place', bringing health and social care together through an unwavering focus on health inequalities and population health management.

We have a long way to go on this journey - the response of health and social care, indeed all public service organisations is too fragmented, expecting vulnerable people and their carers to join up services rather than doing it ourselves. We have not properly harnessed the power and reach of the business, voluntary, community and faith sectors. We have too often believed that the State has the solutions when far better solutions lie with communities themselves.

## We are determined to do better. This strategy sets out how.

# The bigger picture

The Council has developed a bigger vision for the City which we call Stronger Together. It contains the following priorities:

- **Support vulnerable people** in our communities to live well
- Enable our residents to **fulfil their potential**
- Help businesses to **thrive** and make our city more prosperous
- Work with our communities to make them **healthier, safer** and **more sustainable**

Other partners articulate similar priorities through their own plans. For example, our Police and Crime Commissioner's strategy includes a priority of early intervention, providing early help to individuals, families and communities before problems become entrenched, complex and costly to resolve. The City's Health and Wellbeing Strategy articulates a vision for Stoke-on-Trent to be a vibrant, healthy and caring city which supports its citizens to live more fulfilling, independent and healthy lives.

We have drawn on these and other statements of intent to ensure that this is a strategy that can be owned by the whole local partnership.

# Key Outcomes

**Safe** - people are protected from abuse, neglect or harm and are equipped with the skills and knowledge they need to keep themselves safe

**Healthy** – people have access to good health services and are equipped to self-manage their health and well being in communities that are healthy and promote well being

**Fulfilled** – people can aspire to life goals and feel purposeful and valued; they can live in a home that they choose that meets their needs and promotes independence where possible

**Included** – people have equity of access to good quality social and leisure opportunities in their community and can build relationships and connect with their neighbours and support systems

**Heard** – we will use the insight of people with lived experiences to motivate change and improve services.

**Cared for** – People have choice and control over the support they receive which is personalised to their needs and of a high quality.

# Strategic Impact Measures

## Safe;

- People who use services report positively on the outcomes of the safeguarding enquiry being fully achieved
- Timeliness of safeguarding enquiries
- People feel safe
- Number of safeguarding referrals made and % that meet s42 threshold
- % of individuals lacking capacity who were supported by advocate, family or friend
- Profile of CQC scores in Safe and Effective Staffing Quality Statement for adult social care registered providers
- Dementia diagnosis rate
- % of people with dementia diagnosis with a care plan

## Healthy;

- Average daily rate of delayed transfers of care per 100,000 population aged 18+ (attributable to adult social care/NHS)
- Emergency admissions ALL FALLS for persons 65 and over (Rate per 100,000)
- % of hospital readmissions in 30 days
- % of people identified as moderately to severely frail with an active health management plan
- % of people with learning disability receiving annual health check
- Average healthy life expectancy from birth (Years), broken down by key characteristics, e.g. with learning disability, long-term mental health condition etc.
- Suicide rate

## Fulfilled;

- Reablement - % of people who did not need ongoing support
- % of people with Learning Disability or mental health issue who live in their own home or with their family
- Proportion of people who use services who have control of their daily life
- Proportion of people who use services and receive direct payments
- Proportion of people with learning disabilities or mental health issues who are in paid employment
- Residential care – rate of older people per 100,000 population who have a permanent admission to residential/nursing care
- % of people 65+ who received reablement/rehabilitation services after discharge from hospital

## Included;

- People who use services and their carers who report that they have as much social contact as they would like
- Use of non-eligible care/support/equipment/lounges
- % of people whose preferred communication options are known
- Analysis of the outcomes data by equality factors such as protected characteristics

## Heard;

- People find they can access information about services
- Provision of Accessible Info and Advice measured by count of use and take up take up
- Carers – number of carers who received an assessment
- Carers feel included in the assessment of the person they care for
- Choice and control;
    - % of carers who receive direct payments/self directed support
    - % of people who receive direct payments/individual service funds/self directed support

## Cared for

- Quality of life: self reported quality of life through review
- Proportion of older people (65+) still at home 91 days after discharge from hospital
- Overall satisfaction with Adult Social Care services
- Number and Theme of Complaints received by ASC
- CQC ratings profile of adult social care regulated services by service type
- Percentage of long term support clients reviewed (planned and unplanned)
- Number of regulated adult social care service providers exiting the market.
- Percentage of providers completing capacity tracker
- Variation of the Skills for Care data re: qualification levels in the care and support workforce.
- Staff turnover/absence/feedback

# Priorities for Action

To achieve these ambitions requires a deep cultural change on the part of the Partnership that serves the City's residents. It represents a fundamental shift from a reactive, fragmented deficit-based model of engagement with people who use services to one that is enabling, strengths-based and deeply relational. At the heart of this shift is a collective commitment to a community led approach to professional practice that always puts the person at the centre.

**To secure these outcomes and create a positive shift towards these measures, we will focus collectively on the following priorities;**

1. We will connect people with their local communities, helping people make the most of existing networks and enabling communities to support people
2. We will ensure people are provided with good quality advice and information at the first point of contact
3. When people approach us for support, we will initially consider whether their needs can be met with some low level support such as equipment of assistive technology, that would enable them to remain independent.
4. When people approach us in a time of crisis or when they are desperate, we will respond quickly to prevent the situation becoming worse.
5. We will work with the social care market to ensure a diverse range of flexible care and support is available, giving choice and control to the individual and ensuring services are operating and delivering to the highest possible quality standard, ensuring value for money and best use of resource.
6. We believe people should live as close to home as possible and will seek to consolidate fragmented markets aiming to reduce out of area placements.
7. We recognise our joint responsibility in supporting the vital role undertaken by informal Carers and will support carers in this critical role
8. We will work closely with the voluntary, community and faith sector as a vital partner in supporting people
9. We will continue to keep people safe from abuse, neglect and harm by carrying out effective safeguarding partnerships across boundaries.
10. We will work with all agencies involved in the acute pathways to reduce admissions and delays, increase discharges back home and reduce risk of readmission

**We have created a set of principles that will guide the way we work under the mnemonic, Place To Be;**

**P**eople's voice at the centre of everything we do, listening and understanding people's needs and ambitions.

**L**istening when residents say they feel unsafe or they believe someone else is unsafe.

**A**ssessment of need in a timely way, using a strengths-based approach and always looking for solutions that keep people at home or close to home.

**C**o-production of  services with the people who will use them so that they make sense.

**E**nsuring technology supports people to maximise their independence and wellbeing, not as a substitute for personal care.

**T**argeting most support on those with the greatest need.

**O**ne team approach , the workforce and voluntary sector combining skills and resources.

**B**eing publicly accountable for our performance

**E**mpowering people to have maximum control over their lives.

# Developing a Programme Plan

During 2022 we have been reviewing everything about how our adult services currently work, assessing what needs to evolve/change by way of continuous improvement. We now have one transformation programme shaped around **5 key themes**, each if which has an older person's and working age element:

- Prevention and Early Intervention
- Assessment and Decision Making
- Emergency Response and Discharge
- Safeguarding
- Market Development and Management

**To deliver change there are 5 enabling workstreams;**

- Data
- Digital
- Quality Assurance
- Workforce
- Comms and Engagement

This Strategy and the programme plan fit together. They are ambitious. If we are to achieve our state objectives we need to be very well organised. We will therefore run the delivery of the strategy as a programme with its own programme office that will serve the whole partnership.

The development of the programme has prioritised certain activities and workstreams that will have the biggest impact on creating the momentum for change and delivering our vision. There are a number of conditions of success to be in place including;

- Ensuring the frontline staff and managers are engaged in the process of change and have the right permissions and space to engage.
- Ensuring the programme has the right capacity, skills and capability to drive the change agenda.
- Senior leaders are committed to the change and role model the behaviours, enthusiasm and empathy with staff to support buy in to change.

Also, all the workstreams will require collaboration not just between partners in the city but also with local communities.

Each of the projects will have a designated Senior Responsible Officer and will be pursued on a partnership basis with appropriate governance. Each will have its own project plan with clear milestones, contributing to an overall programme plan that will be owned by the Adults Improvement Board.

There will be some cross-cutting themes that traverse and infuse several different programmes. Examples would be the development of older people's care and support and the emergency response and discharge workstreams.

The programme office will also maintain a clear benefit plan to ensure that our actions are having the intended impact and a risk register so that we are identifying obstacles and blockages and removing or mitigating them as quickly as possible. Finally, the office will also maintain a resource plan to ensure that each project has an appropriate allocation of resources to ensure it can achieve its objectives and milestones.

# The Voice of People with Lived Experience

The development and delivery of our plans must be reflective of people's lived experience and their ambitions. We therefore have to hear and reflect their voice. We will ensure that under this strategy there is a wide programme of engagement with people with lived experience so that they have had a genuine chance to participate in the design and delivery of plans and programmes. This will include working closely with expert citizens and the insight academy, developing the Learning Disability Partnership Forum, Carers Partnership Board and creating a Mental Health Partnership Forum.

# Performance and Evaluation Framework

The strategic measures we have chosen are outcomes that are most important for the wellbeing of our residents. We need to know we are making progress towards them.

We will therefore develop a suite of supporting indicators and measures that will help us track that progress.

We shouldn't only be marking our own homework. We will invest in independent evaluation of our progress against this strategy.

# Governance

Each of the workstreams shaped around the key themes are led by a Strategic Manager supported by the Programme Management Office (PMO) who will operate an 'Air Traffic Control' room constantly staffed so that programme issues, check-ins on progress, clarifying focus and priorities is a live and iterative process.

There will be weekly panel meetings, which will review progress of workstreams, chaired by the PMO manager. At the weekly Operational Business Meeting, chaired by the Director for Adult Social Care, the strategy and improvement plan will be a standing item, and every 6 weeks the meeting will be dedicated to this topic to review progress.

At the 6 weekly Strategic Transformation Board, chaired by the City Director a summary highlight report will be prepared by the Director, and alongside the dashboards will highlight progress, any key issues by workstream, any overall risks materialising, any decisions required.

Progress will be reported through to the Corporate Transformation Board, chaired by the Leader of the Council.


City of
**Stoke-on-Trent**