# Item No: 16

**Meeting Date:** **Wednesday 12th December 2018**

# Glasgow City Integration Joint Board


**Report By:** **Susanne Millar, Chief Officer Strategy and Operations / Chief Social Work Officer**

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## TRANSFORMATIONAL CHANGE PROGRAMME: OVERNIGHT SUPPORTS - PROGRESS REPORT

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| **Purpose of Report:** | To update IJB members on progress made in relation to the transformational change programme to review overnight supports, in the context of seeking a safe and effective transition from sleepover support to suitable, alternative arrangements that maximise the opportunity for people to be supported to live independently in accordance with assessed need. |

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| **Background/Engagement:** | A comprehensive engagement event was held on 13th September 2018 for service users, carers and representative community groups. There was also an engagement event held on 10th September 2018 with service providers as well as separate staff briefings. As well as the topic of Overnight Supports, the events also covered the topic of Resource Allocation (https://glasgowcity.hscp.scot/publication/item-no-8-policy-development-resource-allocation-adults-eligible-social-care-support). All events were well attended. |

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| **Recommendations:** | The Integration Joint Board is asked to:<br><br>a) note the progress to date;<br>b) note the terms of reference and membership of the overnight support transformational steering group; and<br>c) note the proposed timescales for the change programme to report its initial findings and recommendations. |

**Relevance to Integration Joint Board Strategic Plan:**

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| The aims of the transformational change programme are consistent with the IJB's aspiration to deliver support at the right time, in the right place, and from the right person, and to provide health and social care services in local communities and in homely settings wherever possible. It aspires to maximise choice and control for service users and their legal proxies and to ensure resource is targeted on those with greatest need to mitigate risk. |

**Implications for Health and Social Care Partnership:**

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| **Reference to National Health & Wellbeing Outcome:** | While all 9 national health and wellbeing outcomes are relevant, outcomes 2 and 9 are directly related:<br><br>Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.<br>Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services. |

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| **Personnel:** | Social Work practitioners are supported to meet their responsibilities through a clear policy framework, underpinned with training and guidance material. |

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| **Carers:** | Carer support needs will continue to be identified through carer assessments and access to support in accordance with GCHSCP's commitment to meet the requirements of the Carers (Scotland) Act 2016. |

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| **Provider Organisations:** | Providers are key partners in the creation and delivery of services to meet assessed eligible need. The policy assumes this continued partnership. The implications for providers of a transition away from sleepover support arrangements will be considered as part of the process to introduce the 2019 framework agreement. |

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| **Equalities:** | An EQIA has been completed and published. This can be accessed at: https://glasgowcity.hscp.scot/publication/eqia-transitional-change-programme-review-overnight-supports-including-alternative. The action plan associated with the EQIA will be developed further, as necessary, by the overnight support steering group. |

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| **Financial:** | GCHSCP considers that the principle of a sleepover support arrangement no longer represents best value and that suitable, safe and effective alternative arrangements should be explored and adopted, where such alternative arrangements meet assessed need. In doing so, every effort will be made to |

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| | maximise the opportunity for people to be supported to live independently, in accordance with their assessed need. |

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| **Legal:** | Approved changes arising from the transitional change programme may be of relevance to any potential legal challenge to the outcome of assessed need. |

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| **Economic Impact:** | None |

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| **Sustainability:** | There are no environmental sustainability issues related to this paper. |

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| **Sustainable Procurement and Article 19:** | N/A |

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| **Risk Implications:** | An aim of the transitional change programme is to identify solutions and measures which support individuals to continue to live independently using a risk enabling approach. |

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| **Implications for Glasgow City Council:** | Approved changes arising from the transitional change programme will ensure Glasgow City Council continues to discharge its statutory duties to adults in need of community care support in a safe and sustainable way. |

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| **Implications for NHS Greater Glasgow & Clyde:** | None |

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| **Direction Required to Council, Health Board or Both** | Direction to: | |
| | 1. No Direction Required | ✓ |
| | 2. Glasgow City Council | |
| | 3. NHS Greater Glasgow & Clyde | |
| | 4. Glasgow City Council and NHS Greater Glasgow & Clyde | |

## 1. Purpose

1.1 To update IJB members on progress made in relation to the transformational change programme to review overnight supports.

## 2. Background

2.1 In June 2018, IJB members considered a paper that set out the context for the overnight support transformational change programme (https://glasgowcity.hscp.scot/publication/item-no-9-policy-development-transition-overnight-sleepover-support-alternative-support). This included the GCHSCP's view that the availability of a greater number and variety of technological solutions to assist people to be supported in the community, combined with the increasing cost of current overnight support services, presents an opportunity to review and refresh current service provision. In

particular, that the current pattern of service delivery is unlikely to be sustainable in future and a comprehensive review is necessary, and that continued wide scale use of sleepover supports is unlikely to represent Best Value due to the significant increase in the cost of delivering that service.

2.2 In recent years, advances in technology enabled care have allowed more people to be cared for safely within their home environment, maximizing the opportunity for independent living. It is acknowledged that this approach will not be suitable for all service users, however, there has been real progress in the use of technology to support people with more complex needs, using combinations of devices, lifestyle monitoring and bespoke responder arrangements. There is a growing number of examples of people with complex needs using technology enabled care as part of their support plan to achieve very positive outcomes. In particular, technology is being used to reduce support costs in some areas, such as overnight support, and allow service users the opportunity to direct more of their social care funding to achieving other outcomes which are important to them. There are also many examples where technology enabled care has substantially improved people's lives, for example, drastically reducing the number of times a person is admitted to hospital on an emergency basis.

2.3 In order to keep pace with the developments in assistive technology, Technology Enabled Care and Support (TECS) has been included as one of the six Categories of Support (Lots) in the 2019 Social Work Framework Tender for Selected Purchased Social Care Supports. The commencement of the Framework on 31.01.2019, this will support service users to access newer technology for the first time, and allow GCHSCP the opportunity to extend the use of technology enabled care and support as a way to help meet the assessed need of individuals. GCHSP considers that such approaches are progressive, will be of benefit to some service users and are likely to offer better value for money than current sleepover provision. This better use of resources will in turn have a positive impact on the overall availability of resources to meet people's needs.

Appendix 2 gives further details of some case examples provided by SOL Connect and Blackwood - two provider organisations with experience of implementing Technology Enabled Care in other local authority areas. These give a flavour of some of the outcomes service users are achieving and for some service users, the impact including Technology Enabled Care has had on their support costs.

## 3. Stakeholder Engagement

3.1 An engagement event covering both the policy work on Resource Allocation and on Overnight Supports was held with service users, carers and representative community groups on 13th September 2018. The event was well attended and participants engaged actively in the discussion. The majority of the discussion focused on the overnight support transformational change programme. However, a consistent theme was a concern by stakeholders that implementation of the areas of policy could increase the likelihood of a reduction in the levels of care people receive or an increase in the likelihood of people having to move out of their home to a more restrictive or residential care setting.

3.2 An engagement event was also held with provider organizations, again covering both topics, as well as staff briefings. At the engagement events, participants received presentations on some current technology enabled support solutions.

3.3 Key themes and messages from stakeholders at the engagement events are set out below:

3.3.1 Opportunities

- Provider presentation was well received and it was helpful to know the background and experience of the provider
- The most important thing is to help the person with support needs to be as independent as possible
- People want to continue to be supported in their own homes and assistive technology could do this
- Opportunities for a more collaborative approach between providers towards delivering services

3.3.2 Main Concerns

- Concern that this all about saving money – assistive technology cannot replace a person
- Concerns that introducing technology might in early stages 'free up' a degree of budget for people to spend in other ways (as per examples given) but that over time budgets will just be reduced to reflect the reduction in cost of this type of care
- Worries that assistive technology 'will be made to work' for everyone/every service user
- Fear 'core and cluster' models of care are a form of institutionalisation

3.3.3 Risk Management

- Concern about response in the case of a medical emergency – e.g. choking, fits etc. Are all care providers equipped to deal with that?
- There needs to be good risk assessment when looking at using assistive technology
- Providers offer very different services – how will they work together with people with very diverse and complex needs?
- Seems positive –but what about failures? Need to learn from what does not work
- What happens if technology fails or there is a power cut? How long does it take to rectify if the technology fails?

3.3.4 Assistive Technology

- Positive comments about the presentation from a provider of assisted technology – but this option is not possible for everyone
- There are good cases studies which demonstrate it can work for some people but not others

- HSCP should not under estimate value and reassurance of a carer or someone being in the house

3.3.5 Further Information Required

- More information and understanding on HSCP protocols, assessment and systems is needed for service users and their families
- Beneficial to know the provider's criteria for using assisted technology
- Easy to navigate and better public facing information would be welcomed, especially on the eligibility criteria

3.4 Continued Stakeholder feedback will provide an invaluable contribution to the transitional change programme and the steering group's remit will include the development of an ongoing communication and engagement plan. While there was constructive discussion in relation to the concerns expressed at the engagement events, it is recognized that much more requires to be done to gain the confidence of service users, carers and community groups. This will be best achieved by having an inclusive process that draws on the input of such stakeholders, which the steering group is committed to deliver upon.

## 4. Overnight Support Steering Group

4.1 The overall transformational change programme objectives are: to review the current services in place for people assessed as needing overnight support, and identify future overnight service provision which meets the objectives of supporting people to live safely, and as independently as possible at home, or in a homely setting, in a cost effective and risk enabling way. In doing so, it will seek to identify the arrangements for a safe and effective transition from sleepover support to suitable alternative arrangements, in accordance with assessed need.

4.2 A multi stakeholder steering group has been established to support the transformational change programme. The role of the group is to support and inform the development of the programme to meet its objectives and to ensure that the views of all main stakeholders are considered. The membership is drawn from HSCP officers, service user groups, people with lived experience, carer representatives, advocacy services, provider organizations and the Care Inspectorate. Meetings will commence in November 2018.

4.3 The Transformational Programme will be progressed by 4 operational work streams led by GCHSCP officers:

1. Development of the Overnight Support Review Process
2. Development of Technology Enabled Care and Support Services
3. Engagement, Communication and Information Sharing
4. Change Management

Each work stream will report back regularly to the Steering Group.

4.4 The change programme will aim to report its initial findings by March 2019. This will allow time for the full involvement of key stakeholders and to develop robust proposals around extending the use of technology enabled care and support.

4.5 Appendix 1 sets out the draft terms of reference for the steering group, which have been updated from the earlier draft submitted with the June 2018 IJB paper.

## 5. Recommendations

5.1 The Integration Joint Board is asked to:

a) note the progress to date;
b) note the terms of reference and membership of the overnight support transformational steering group; and
c) note the proposed timescales for the change programme to report its initial findings and recommendations.

**Appendix 1**

**Overnight Support Transformational Change Programme**
**Draft Terms of Reference**

## 1. Background

A policy development paper and associated documents were presented to the GCHSCP IJB in June 2018 to set out a clear and transparent policy direction for the transition from overnight sleepover support to alternative support arrangements that will inform service users, carers and service providers and guide the approach to be undertaken by social work practitioners. The IJB noted the content of this interim policy framework, which included the recommendation to establish a transformational change steering group to progress this work.

A further paper will be presented to the IJB in December 2018 covering issues raised by the IJB, a completed equalities impact assessment (EQIA) and feedback from stakeholder engagement. Further to the information set out in the IJB report, the proposed structure of the change programme is laid out below:

Programme Sponsors: Jackie Kerr, Assistant Chief Officer, Adult Services
Katrina Phillips, Head of Adult Services, North East

Programme Leads: Debbie Miller, Commissioning Manager
James Hogan, Service Manager

## 2. Transformational Change Steering Group

**Programme Objectives:**

To review the current services in place for people assessed as needing overnight support, and identify future overnight service provision which meets the objectives of supporting people to live safely, and as independently as possible, at home or in a homely setting, in a cost effective and risk enabling way. In doing so, it will seek to identify the arrangements for a safe and effective transition from sleepover support to suitable alternative arrangements, in accordance with assessed need.

The steering group will support and inform the development of the programme to meet the programme objectives and to ensure that views of all the main stakeholders are considered. Output from the steering group will also inform the development of a wider learning disability service strategic work plan.

| **Overnight Support Steering Group Membership** |
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| Head of Adult Services, North East & co-chair of Steering Group |
| Commissioning Manager (Personalisation) & co-chair of Steering Group |
| Service Manager & Deputy Chair of Steering Group |
| Service User representatives / People with lived experience (nominated by the Disabilities Strategic Planning Group) |

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| Provider Organizations (delivering Overnight Support – nominated by Commissioning Team) |
| Technology Enabled Care and Support (TECS) Providers (nominated by Commissioning Team) |
| Carers Representatives (nominated by Carers' Reference Group) |
| Advocacy Services |
| Service Manager – Central Review Team |
| Principle Officer: Disabilities Commissioning Team |
| Principle Officer: Commissioning (Assistive Technology Development) |
| Team Leader: Locality Overnight Support Review Teams |
| Finance Officer |
| Planning and Engagement Officers |
| Care Inspectorate Representative |

The steering group will also oversee the establishment of other engagement activities to ensure a wider group of stakeholders have the opportunity to be informed and contribute. The steering group will be established and have its initial meeting in November 2018. The group will then aim to meet every 6-8 weeks, with a view to reporting its initial findings and proposed implementation plan by March 2019.

## 3. Workstreams

There will be operational workstreams which will be responsible for developing particular aspects of the change programme. These will meet as required but at least once every 4 weeks to progress the work that they are focusing on. Workstream leads and members will be identified. Workstreams will report back to the wider steering group every 6- 8 weeks. The proposed workstreams are:

i. **Overnight Support Review Processes**
This workstream will focus on developing proposals for progressing service user case reviews including developing review criteria, processes, scope and phasing, as well as improving the access to assessment technology which is important to support the development of care plans for people looking to use TECS (technology-enabled support) going forward.

ii. **Development of Technology Enabled Care and Support**
This workstream will focus on proposals for the development of locality based technology enabled care and support services for people looking to use them as part of their assessed care plan

iii. **Engagement, Communication and Information Sharing**
This workstream will focus on the engagement and communication work required, as well as supporting the information sharing and knowledge base about the change programme, TECS and assistive technology.

iv. **Change Management**
This workstream will focus on identifying risks, opportunities and interdependencies in implementing the change programme and the development of an over-arching project plan. This will include consideration of

workforce and financial issues, as well as links with the work of the Central Review Team

## 4. Governance

The Programme Leads will report to the Project Sponsors via the Adult Services Core Leadership Group within Glasgow City HSCP (who will then report to GCHSCP Integration Transformation Board and the Integration Joint Board).
Links are also in place with the wider GCHSCP Assistive Technology Strategy Development.

**Appendix 2**

**Technology Enabled Care and Support Case Studies from SOL Connect:**

**Case Study: PB**

PB is a 36 year old gentleman who has lived in institutional care for most of his life. He attended a residential school and was then placed in a care home, aged 21. The care home was the only placement that could be found at the time to meet his complex needs. PB has cerebral palsy, epilepsy, uses a wheelchair and requires full support with all aspects of daily living. PB finally moved into his own home, aged 26, again with 24 hour support as he was deemed to be “high risk”. At this point in his life, PB had been labelled as “challenging” and “difficult to support”. Today, he is able to articulate that his behaviour was linked to how frustrated he was with the support he was receiving. At that time, however, the way he communicated his feelings resulted in him being labelled.

PB had been supported 24 hours a day 7 days a week for a long time and was beginning to feel trapped. PB is a very proud and independent young man who loves to be up to date with the latest trends. His hopes and dreams for his life were similar to those of many people:

- To be independent
- To have friendships and relationships out with paid support
- To do what other peers do, such as watch a game of football on TV without support being present
- To feel safe enough to spend time on his own

SOL worked hard with PB to support him to realise his dreams and helped him to look at what technology options could be used. PB decided on using the SOL Connect hub as a communication tool. He chose this as the Connect hub was so easy to use. It meant that PB could see who he was talking with and they could see him. It could also be integrated with other technology in his home to enable him to be as independent as possible and do things like turning his lights, TV and heating on and off.

PB Became so confident in using the technology that he developed the confidence to begin to spend time on his own. Nowadays, PB uses remote support for 15 hours a day (including overnight). This means that he is alone in his house but can contact his support staff whenever he wants to, and access direct support whenever he needs to.

He now enjoys the independence he always wanted. He receives 61.5 hours of direct support a week and a full SOL Connect support package at a cost of approximately £58,000 a year. Prior to this PB received 98 hours of support and 7 sleepovers a week, at a cost of approximately £119,000 per year.

The option SOL Connect gave PB to include technology enabled care as part of his support package has been instrumental in him achieving the lifestyle he wanted. PB is a firm believer in spreading the word about technology and has become an Ambassador for SOL Connect, often talking at events and conferences. He has also

worked with the SOL ‘tech team’ in the development of new equipment that enables him, and other people supported by SOL Connect, to make the most of the available technology. He is involved in training others in SOL and says he feels safe. He recently got engaged to his partner.

**Case Study: CJ**

CJ is an active 24 year old man. He has a diagnosis of autism and although he has strong verbal skills, he finds communication and social situations extremely difficult to interpret. CJ lived with his parents until March 2012, when his dad passed away. CJ found this very difficult to cope with and his mother, who had her own health issues, was no longer able to support CJ on her own. CJ moved to a shared support accommodation with other people who had a learning disability. CJ's anxiety and stress levels at times led to him posing a significant risk to others, and as a result was labelled as someone with challenging behaviour.

Support eventually broke down when the service experienced a high turnover of staff. CJ, already stressed from sharing his living arrangements, assaulted a fellow resident and support staff and damaged property. Following this incident CJ was admitted to hospital for assessment.

Assessment focussed on his strengths and capacities. We identified what was important to CJ to have a fulfilling life and what would be necessary for him to remain healthy, safe and included in his community. Support planning also considered potential risk factors and gathered information about what had previously worked or not worked for CJ.

Because family members were included in the assessment process, we discovered that when CJ lived at home with his parents they would often go out for a few hours and leave him in the house alone and he enjoyed this space to himself. At this stage we considered whether SOL Connect could be introduced as a way of enabling CJ to be as independent as possible whilst ensuring that his support needs were met. We carefully considered how CJ could be introduced to the technology, how we could support him to understand what it was for, how we could support him to learn that it could be used to request support. During this assessment, it was identified that CJ needed to have his own home, not sharing with others. He also had to have an amount of control over who came into his home and when.

Weekly planning meetings continued and agreement that a HUB and a Big Green Button would be installed in the living room along with door contacts and motion sensors in the hallway and doors. If the shared vision of CJ being more independent were to be realised, this technology would ensure that we would know if CJ became anxious. CJ would be able to signal for support if he needed it. This support would not always need a physical presence but could be carried out by a remote support team. If CJ did need someone to attend his home the SOL Connect Responder would attend. SOL Connect staff were all trained on how to engage with CJ via the HUB should he ever call through.

With staff fully trained and technology installed, CJ left hospital for his new home. From his first few days, CJ was telling his support staff, mum and his friend/welfare guardian how much he likes his new home and that he wants to be independent. CJ has become very house proud and within the first month was doing the housework, making his own breakfast, supper and ensuring that the house is safe and locked up

at night. CJ instigated the use of the technology, understanding that it is there to keep him safe and independent. CJ regularly calls the SOL Connect team to tell them what he has been doing and how he is feeling. There have been no instances of challenging behaviour since CJ moved home.

CJ very quickly pushed for staff not to be present overnight as he now felt independent. Therefore, with the trust in the technology and listening to CJ's wishes, overnight support was withdrawn and has not been there for over 4 years now.

CJ's support package on discharge from hospital was 120 hours support and 7 sleepovers costing approximately £131,000 per year. CJ's redesigned support package provides 56 hours of direct support and a SOL Connect package which costs approximately £78,000 per year.

We have continued to listen to CJ and have made further changes to his support. CJ is now independently administering his own medication with the assistance of SOL Connect technology. CJ is really enjoying every additional step he takes to becoming as self-sufficient as possible in his own life. He can regularly be heard saying. *'I'm an independent man now, you should be proud of me.'*

**Technology Enabled care and Support Case Studies from Blackwood**

**Case Study 1**

K is a middle aged man with learning difficulties. K receives support during the day and was also receiving a sleepover when he was referred to Blackwood's Night Support Service which uses our TEC enabled care system, CleverCogs™.
K is often anxious, especially at night, however, he was unhappy having a carer in his house overnight. The Night Support Service allows K to be supported remotely by a team of staff. The staff all know K and mainly support him using video conferencing and are also able to visit him if necessary.

The staff in the Night Support Service have built up a close relationship with K and using the CleverCogs™ TEC system can provide re-assurance and support at any time during the night. K phones most nights and depending on his level of anxiety he can call up to 10 times per night.

Before K received the TEC enabled Night Support Service he called NHS 24 and 999 several times a week and he was often upset when the sleepover staff came on duty. Since receiving the TEC enabled night support the number of calls to NHS 24 and 999 calls have reduced dramatically. Since receiving CleverCogs™, K is happier, less anxious and has learned new digital skills.

**Case Study 2**

W is an elderly man living in a housing association flat. After a spell in hospital it was agreed he required support overnight, however, as he lived in a one bedroom flat there was no room for someone to sleepover and there had been talk at that point of moving W into residential care.

Instead of moving W to residential care he was referred to Blackwood's TEC enabled Night Support Service. W was delighted to receive the CleverCogs system and used it to call the staff team most nights. He would also call during the night for support and re-assurance as he had difficulty sleeping and was often anxious when he woke up in the night. The night support team were able to talk to W using the video conferencing facility and he clearly enjoyed the social interaction with the staff. W told us that before he received the Night Support Service he would often call NHS 24 during the night as he had no-one else to call.

The night support service provided a service to W for about two years before he went into residential care. All the carers and social workers involved with W agree that he would have gone into residential care much earlier if he had not had the TEC enabled Night Support Service.