Next Steps for Personalisation

23rd November 2016
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Welcome

Thomas Maloney, NW ADASS Programme Director
Parking
Personalisation in Practice: A National and Regional Perspective

*Sally McIvor, Strategic Director of Health & Care, Pennine Lancashire and NW ADASS Lead for Integration*
Personalisation

In social care we have been talking about and working towards personalisation for at least a decade............

- Clear policy directive to the delivery of personalisation commenced with Putting People First (2007)
- 2010 Coalition Government set a target to make services more personalised, more preventative and focused on improving outcomes
- Think Local, Act Personal (2011) focused on arranging care and support around the individual, their individual, family and community strengths
- ‘Making it Real’ (2012) a sector wide commitment to moving forward with personalisation and community-based support
- The Care Act 2014 required local authorities to give all eligible users a personal budget from April 2015, embedding the personalisation of care services into the legal framework for adult social care
- The £3.8 billion Better Care Fund (2013) aim to accelerate integration in health and social care in order to create a system that is sustainable in the longer term
What are the benefits?

• DP and PBs allow people to access more personalised services
  ➢ Access social networks and promote independence
  ➢ Employ carers they feel comfortable with and who can meet their needs and lifestyle choices (Carr 2008)

• Personalisation can promote dignity among service users

• Increased choice and control can lead to better outcomes

• Personalised approaches to integrated health and adult social care and support can promote both primary and secondary prevention
What progress have we made?

Nationally

• At the end of March 2015 97,000 people in England were using a direct payment for some or all of their support, figures from the Health and Social Care Information Centre show. That’s 20% of those receiving long-term support for more than a year.

• 92,000 carers also received a direct payment during 2014-15, which is 67% of all carers who received ongoing support during that year.

• Due to funding cuts the number of people who received a social care service from English councils fell by 509,000 (29%) from 2008-9 to 2013-14. However the numbers receiving direct payments has continued to grow, increasing by 80% from 2009-14, show HSCIC figures.

Regionally

• For most of the indicators, the NW (and Y&H) are at levels below the National Average

• The NW is noticeably underperforming for 1C2A: Service Users receiving Direct Payments - it is the lowest ranked region nationally, and almost 75% of it’s CASSR’s are below the National Average

• Nationally and regionally a quarter of people who use services receive direct payments, while 85-90% use self-directed support.
Regional summary

- The highest ranking achieved between the two regions is Y&H – 3rd for % of Service Users receiving Self Directed Support

- 1C1B (Carers Self Directed Support): Both regions are ranked in the lower half nationally, but both have a high percentage of CASSR's outperforming the National Average – this indicates a small number of CASSR's are dragging the regional average down significantly
Regional summary

- This shows where our two regions are relative to the 9 regions
- The bottom three indicators are where we both perform less well
Mapping the Data

The % of People who use Services who have Control over their Daily Life

1b: The proportion of people who use services who have control over their daily life - source: ASCOF 2015/16
Mapping the Data: Self Directed Support

The % of Carers who Receive Self Directed Support

The % of People who use Services who receive Self Directed Support
Mapping the Data: Direct Payments

The % of Carers who receive Direct Payments

The % of People who use Services who receive Direct Payments
NW ADASS support for personalisation

• Our work focused on supporting networks for sharing good practice

• We worked with In Control to support a NW Personalisation Network during 2013-15. We commissioned a number of small research and consultation projects – appraising customer contact centres and council websites, and looking at transitions

• More recently we expanded our view of personalisation to focus on Community Resilience and asset based working

1. Community and personal resilience.
2. Self Care and Self Determination.
3. Citizens as co-producers of health and care.

• We realise we need to develop stronger evidence base for innovation that can be taken up at scale.
What are the challenges?

The working group helping to organise this event met and identified these challenges:

- We still lack a clear evidence base: The National Audit Office states it is impossible to draw any firm conclusions about the way PBs are working.
- To be effective there needs to be change in organisations cultures, business processes, administrative and management systems.
- We are under increasing pressure to do more with less:
  - Some groups of users need greater support to personalise their care: older adults, those in residential care, those with learning disabilities and those who lack mental capacity. Young adults with learning disabilities in particular often do not have access to a sufficient range of meaningful activities.
  - Increased demand at a time of reduced public spending makes it harder to provide emotional aspect of care (Lynch, 2007)
  - Funding cuts and wage pressures will make it hard to fulfil Care Act obligations.
- ASC commissioning is not yet creating the type of market development, diversification and community capacity building needed for PBs to be used productively and efficiently.
- Severe challenges for our providers - Local authorities face a substantial challenge supporting sustainable local care markets which offer the diverse range of provision needed for users to personalise their care, while care providers are struggling to recruit and retain appropriately qualified staff as financial pressures increase.
- SME providers are particularly vulnerable to adverse market conditions.
- Integration - there are significant barriers to implementing personal health budgets and integrated health and social care budgets. Many health staff are risk averse, to minimise clinical risks to users.
Where next for Personalisation?

• Embrace digital and raise our game here
• Explore strengths based approaches - Councils need greater understanding of the capacity within their communities and how to building community capacity
• Providing people with more choice and control can result in efficiencies, cost reductions, improved value for money and better outcomes but this required outcome based, user directed and flexible approaches to commissioning services
• Need a new approach to risk - personalising care means trying new, different and, therefore, potentially risky ways to meet users’ needs.
• Integrated working, early intervention and prevention services implemented as part of personalisation can result in cost savings.

• Will we see personalisation within BCF and STPs?
Personalisation – are we nearly there yet?

Martin Walker - TLAP
Ann Lloyd
A bit of background - what is Think Local Act Personal?

A national partnership of more than 50 organisations committed to transforming health and care through personalisation and community-based support.

The partnership spans:
- central and local government,
- the NHS,
- the provider sector,
- people with care and support needs, carers and family members with whom we engage via the National Co-production Advisory Group.
MAKING IT REAL
Marking progress towards personalised, community based support.
Personalisation and the Care Act

• Care Act embeds the policy of personalisation into law
• Mainstreams the Self-Directed Support process
• Also mainstreams wider concepts like information and advice provision, market facilitation and shaping
• Choice, control, co-production
• Wider context
  – System pressures
  – Integration
  – Money
Care Act stocktakes

• Six stocktakes
• Results from sixth and final stocktake not yet published
• Most Councils confident they have implemented the letter of the Act
• Many confident they are implementing the spirit of the Act
• Maybe we’re nearly there!
What do people say?

- Surveys
  - Carers UK
  - In Control on behalf of Independent Living Strategy Group
  - TLAP on behalf of Department of Health

- Challenges – Norfolk, Oxfordshire

- Maybe we’re a bit further away than we thought
Independent Living Survey

- 485 respondents, 51% of respondents 46-65, most having a physical or learning disability, broad spread from across the country, 45% having a direct payment, 25% previous recipients of ILF
- 48% report choice and control over support poor
- 33% reported level of choice and control over support had reduced
- 58% reported quality of life had reduced
- 86% reported LA listened to them when needs assessed
- 63% of those reviewed did not know how much money was available for their support
Independent Living Survey

• 37% struggle to find the information and advice they need
• 33% relied on friends and family, 22% user led organisations, 16% LA websites for information and advice
• 51% said information advice and support to manage direct payments was poor
Care Act Survey

• Not yet published
• Initial analysis – in line with Independent Living Survey
• 1181 respondents, including many carers
• Highlights many things we know
  – Frustrations with Home Care
  – People struggle to get good information
  – Good experience of process of SDS leads to good outcomes and vice versa
Is there anything that can help?

• Yes!
• TLAP work programme
• Parliamentary interest and scrutiny
  – National Audit Office / Public Accounts Committee
  – Gathering the evidence
  – What more needs to be done?
• Integrated Personal Commissioning pilots
• Individual Service Funds
Individual Service Funds

• A game changer?
• Under utilised, poorly understood
• Offer a solution of the conundrum of high degree of control meaning high degree of administrative burden for the person needing support
• Very few examples of good implementation
Individual Service Funds

• What are they?
• Option to take Personal Budget under Care Act
• PB held by a provider under contract with LA
• Budget used to arrange support flexibly
• Provider ensures transparency in use of budget to meet outcomes
• Different flavours nationally
  – Dom Care, Supported Living, Brokerage
Individual Service Funds

• Key shifts required
  – Building trust
  – Focus on outcomes
  – Flexibility
  – From purchasing at scale to market facilitation

• Integration
  – IPC sites exploring how to integrated PB’s and PHB’s and other funding streams
Individual Service Funds

• Support to regions to get an offer in place
• Y&H/West Midlands
• West Midlands – energy and action
  – Unpicked ‘sticky’ issues
  – Shared developing practice
  – Learned from elsewhere
  – Commissioners, providers and people who need support
    – co-producing progress
KEEP CALM 'CAUSE YOU ARE NOT ALONE
Commissioning & ISFs

- 3 Boroughs, London – strategic commissioning approach embedding ISFs in LD services
- Initially based on provider proposal
- Pilot helped build evidence and get people on board – remove some of the mystery
- Market engagement “give us flexibility”
- Procurement strategy inc housing needs
- At least £50m over 7 years with efficiencies
ISF “I Statements”
Matched people’s priorities
Doing things differently

- With providers - problem solving approach
- For commissioning & procurement & .... Letting go of some control?
- How to measure – outcomes, value for money
- Cross section approach – sometimes you trip over the little steps
- Keeping to the principles – flexibility, choice, community, accountability, outcomes
Are we there yet?

Keep checking the map....

And that it’s the right map.
Flexible Support/ISFs
Calderdale

Next steps.....

Angela Gardner
Commissioning Manager
20th September 2016
Background to where we are now

- Home care re-tender October 2014
- Moved to 3 zones with one preferred provider in each zone
- Developed ISFs to ensure capacity in the market and to offer people more choice and flexibility about how their care was delivered.
• We visited everyone who had home care to let them know what was happening with the re tender.

• Get their views on home care, the good the bad and the ugly......

• And how this may affect them and discussed options for them if they wanted to keep their current provider ie. Direct Payment or ISF or wait and see who got the new contract and transfer to them.
During the lead up to implementing ISFs a lot of work was also done with:

- Providers
- Social Care staff
- Developed information for staff and the public
• Initial indications suggested a 50/50 split in people wanting to stay with current provider using an ISF and people wanting the provider who secured the new contract.

• When it came to transferring people the numbers wanting an ISF rose substantially and some people also wanted to use their ISF to move to new providers who were waiting to move into the market.
The ISF market has remained stable since implementation.
There have been a few new providers come into the market
Market split
• Whole system has been reviewed

• Working with Simon and new guidance around Flexible Support/ISFs following the implementation of the Care Act

• Setting up a forum for people who use an ISF to help shape the future.

• We had monthly meetings with stake holders to understand issues from all perspectives
• **People using ISFs** (letters sent out asking for input into a user forum - 50 1:1 visits & survey results).

• **Providers** (ISF Forum & Monthly ISF meetings with 2 providers input)

• **Social Workers** (3 feedback sessions, & Monthly ISF meetings with SW manager input)
• ISF Support Team
• Contracts & Procurement
• Finance
• Audit
• Charging
• Legal Services
What are we doing now?

• Looking at good practice and building on it both within Calderdale and Nationally

• Taking an Asset Based Community Development approach working with communities, helping people link back to community and be active citizens

• Investing in preventative services
Recommendations

- Updates to the 3-Way Agreement
- Indicative budget up front for the individual and the provider to work with.
- Outcome based Support Plans – this will allow the individual and the provider more flexibility and not be tied to a time and task support plan.
- Outcome based reviews – POET
Recommendations

- Introducing some form of budget management system or pre payment card
  - Clear and transparent system
  - Individual/carer can access
  - Provider does not have to set up separate bank accounts and audit will be less time consuming
  - Council can answer individual queries quickly and in real time, audit more timely.
  - Review team can access information easily prior to reviews
Recommendations

- Pay 4 weeks in advance
- Exploring having the client contribution paid directly to the provider
Clear guidance on what Flexible Support/ISFs are in Calderdale and Key Principles as part of the registration

Clearer information and advice on Flexible Support/ISFs

Training/workshops – Joint
• This is not a quick fix

• It is a whole system shift and takes time

• You can implement new systems but if you haven't won the hearts and minds of the people implementing the systems nothing will change
The Current Opportunities & Barriers: Facilitated Group Discussions

Questions:

• Please comment on what you have heard so far...........what are the opportunities and barriers in truly embedding personalisation?

• Agree one key issue / discussion point you would like to feedback to the room
Break / Refreshments
ADASS NW Home Care

Lucy Woodbine
Principal Planning and Housing
3rd October 2016
Overview of project

• New models of home care for older people.
  • Stage 1: Literature review of best practice in home care for older people and residential care for older people.
  • Stage 2: Data collection scale and volume of home care services for older people in North West.
  • Stage 3: Customer journey mapping current model and new delivery model.
  • Stage 4: CBA up to three new home care models for the NW
Literature review

• Buurtzog
  • Based on nurses taking on caring responsibility in a generalist way
• Outcomes based models
  • Overall expectation is that if a provider can produce outcomes for customers that may reduce their need for longer term care they should be rewarded – examples in Wiltshire, Hertfordshire and Windsor and Maidenhead, Coventry and Kent
• Enhanced care worker
  • Mainly relates to residential care
Buurtzorg

- nurses are generalists and work in community groups;
- technology plays a big part;
- six key services provided: Holistic assessment (leading to a care plan); mapping networks of informal care; identify and co-ordinate any other formal carers; care delivery; support within social environment and promotion of self-care and independence;
- Challenging to lift the whole model to UK context but its successes especially around self-management has attracted considerable interest in the UK.
Outcomes based commissioning

• Outcome based commissioning means a provider could be rewarded for meeting someone’s need – especially if this included helping the person in a positive way so that they needed less long-term care;

• Many emerging outcome based models provide examples of objectives such as responding more quickly to older people’s needs, low delayed discharges from hospital and higher rates of reablement and low admissions to residential care;
Integrated care

- The provision of domiciliary care cannot be considered in isolation and by its very nature requires flexible, adaptable and tailored services to work together for the best outcome for all involved.
- Experts generally agree that long-term evaluation is necessary because the effects of integration may take a long time to become apparent but the lack of an agreed set of measures for assessing integration schemes across the UK makes comparison between schemes very difficult.
- There are a number of examples of this including the Greater Manchester Integrated Care Plan. GM recognise that new models of care need to be implemented in all their localities to address the system challenges. Part of this requires an open and transparent approach which supports innovation and the testing of new ideas.
Other issues

• With other models it is a matter of its desired outcome/focus such as reablement or reducing hospital admissions. How these are achieved could be through various means such as through home share, the use of technology or through the setting of a Local Authority Trading Company as in Oldham;

• Re-modelling of roles could include an enhanced care worker role, a “home help” role or support for self-help such as through informal family support or through private self funding.

• Personalisation/person centered delivery is key to achieving positive outcomes.
Skills and employment

• Care sector low pay area
• GM low pay work
• Understanding of skills and ability to upskill staff to new delivery model
• Focus on new delivery models potential
Skills and employment – low pay

Cost pressures have driven employers to implement extreme working patterns (for example, in the care sector scheduling rotas for three half hour appointments in each hour) that interviewees felt resulted in low quality services. ... Carers can receive as little as one week’s training before starting client-facing work. (p5)

The low paid tend to be young, female, part-time, temporary, from an ethnic minority, have held a job for less than a year and work in the private sector for a small firm. They are heavily concentrated in industries such as hospitality, retail, social care, cleaning, agency work and ‘people facing’ personal services (eg. hairdressing) and leisure (eg. fitness). (p12)
Carol – domiciliary care worker (page 17)

Carol works in the care sector visiting clients in their own homes for which she receives the National Minimum Wage and 7p a mile mileage. She has been doing it for three years, but says she is increasingly thinking of leaving because in her view the industry is getting worse. She says that the central frustration in her working life is not the pay, but that her employer schedules three half hour visits in each hour, meaning she is constantly late for each appointment and feels that she is short-changing the clients.

“You always feel you are letting everyone down. You are always late and always apologising. You never get to know people as well as you could do and they have to put up with constantly changing staff.”

“There are always one or two who would like to talk to you while they have their breakfast or whatever, but it’s not really encouraged.”

The work typically involves getting people up, getting them toileted and getting them to take their medicine. She says she has nearly left twice, but “likes being able to help people”. In one case she became friendly with an elderly lady and used to take extra time with her to do her paperwork while the client did her embroidery. “Everyone knows there are major problems in this industry and I know clients do not always get what they should, but it’s really not always the carer’s fault.”
### Table 6: Employment change in low paying industries, 2009-2014

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</thead>
<tbody>
<tr>
<td><strong>Increase in low pay employees</strong></td>
<td></td>
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<tr>
<td>Employment activities</td>
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<td>15,021</td>
<td>44.8%</td>
<td>6,528</td>
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<td>Residential care activities</td>
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<td>4,210</td>
<td>17.2%</td>
<td>2,720</td>
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<td>Security and investigation activities</td>
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<td>-5</td>
<td>0.0%</td>
<td>1,675</td>
<td>37.1%</td>
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<td>Food and beverage service activities</td>
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<td>1,875</td>
<td>3.2%</td>
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<td>3.2%</td>
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<td>Accommodation</td>
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<td>2,484</td>
<td>23.8%</td>
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<td>Social work activities without accommodation</td>
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<td>-1,642</td>
<td>-4.4%</td>
<td>408</td>
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<td>Gambling and betting activities</td>
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<td>307</td>
<td>6.9%</td>
<td>312</td>
<td>12.7%</td>
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<td><strong>Decrease in low pay employees</strong></td>
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<tr>
<td>Manufacture of textiles</td>
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<td>-118</td>
<td>-1.9%</td>
<td>-226</td>
<td>-10.3%</td>
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<td>Other personal service activities</td>
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<td>-2,749</td>
<td>-20.6%</td>
<td>-814</td>
<td>-13.6%</td>
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<td>Sports activities and amusement and recreation activities</td>
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<td>-4,631</td>
<td>-24.3%</td>
<td>-1276</td>
<td>-16.7%</td>
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<td>Retail trade, except of motor vehicles and motorcycles</td>
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<td>1,524</td>
<td>1.3%</td>
<td>-5202</td>
<td>-7.5%</td>
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<td>Services to buildings and landscape activities</td>
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<td>-8,312</td>
<td>-25.1%</td>
<td>-9371</td>
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<td>Travel agency, tour operator and other reservation service and related activities</td>
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<td>N/A</td>
<td>N/A</td>
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Customer journey mapping

- Assessment
- Care visit daily
- District nurse visit bi-weekly
- Hospital admission
- Home
- Care worker visit
- OT visit
- A&E visit
- District nurse visit
- Meals on wheels
- Residential care admission
- Home
- Care worker visit
- District nurse visit
- A&E visit
**Project: Home care service with enhanced worker**

**Contextual conditions:**
Home care delivered by a team of workers with significant input from other public services, poor client outcomes and difficulty joining up services.

**Key policy conditions:**
How to provide person centred, outcome focused and flexible care for an ageing population. Cost of care and care legislation.

**Programme Objectives:**
Deliver a new home care service for older people which improve individual outcomes and provide savings to the overall health and social care budget through an enhanced care worker.

**Rationale:**
Home care services at present do not deliver always the best client outcomes

**Inputs:**
Staff time from care service
Training
Additional agencies

**Activities:**
Enhanced care work with worker undertaking basic ‘medical tasks’ and flexibility

**Outputs:**
Fewer hospital admissions
Fewer residential care stays
More positive functioning

**Intended Outcomes:**
Savings to health budgets through fewer emergency and unplanned hospital admissions.
People able to remain independent at home for longer.
Increased confidence and well being

**Intended Impacts:**
Financial savings
Positive older people
Staff feel empowered and stable
Spend in ASC managed more effectively
What do we mean by costs and benefits?

Costs

- All additional costs needed to deliver project

Benefits

- Fiscal
- Economic
- Social
Running the CBA model

- Assumptions tested/updated via evaluation
- Optimism Bias (OB) correction applied to data
Family Intervention Project

- Local Authority
- NHS
- DWP (AME)
- Police
- Work Programme Primes
- RSLs
- CJS (excl Police)

Proactive Costs:
- £-
- £100,000
- £200,000
- £300,000
- £400,000
- £500,000
- £600,000
- £700,000
- £800,000
- £900,000
- £1,000,000

Reactive Cost Savings
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<tr>
<th>Ref.</th>
<th>Outcomes</th>
<th>Included outcome?</th>
<th>Benefits</th>
<th>Who does benefit accrue to?</th>
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<tr>
<td>B5</td>
<td>Mental health</td>
<td>Yes</td>
<td>Reduced health cost of interventions</td>
<td>NHS/Individuals</td>
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<tr>
<td>B6</td>
<td>A&amp;E attendance</td>
<td>Yes</td>
<td>Reduced cost of unnecessary attendance</td>
<td>NHS</td>
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<td>B17</td>
<td>Reduced hospital admissions</td>
<td>Yes</td>
<td>Reduced cost of an average admission to hospital (elective and non-elective)</td>
<td>NHS</td>
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<td>B18</td>
<td>Residential Care Admissions (weeks)</td>
<td>Yes</td>
<td>Cost savings through reduced use of residential care</td>
<td>Local Authority Adults services</td>
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</table>

![Pie chart](image)

- Local Authority: 16%
- NHS: 84%

**Net Present Value (NPV)**

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<th>Net Present Value (NPV)</th>
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<tr>
<td></td>
<td>£ 1,398,611.14</td>
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<td>£ 1,484,805.60</td>
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**Net Present Budget Impact**

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<th>Net Present Budget Impact</th>
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<td>£ -86,194.46</td>
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**Overall Financial Return on Investment**

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<th>Overall Financial Return on Investment</th>
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<td></td>
<td>1.06</td>
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**Payback period**

<table>
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<th>Payback period</th>
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<tbody>
<tr>
<td></td>
<td>1 years</td>
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</tbody>
</table>
Questions

Lucy.woodbine@neweconomymanchester.com

Pete.schofield@neweconomymanchester.com
Mapping Community Assets for Mutual Support
What’s the issue?

☐ A Growing Population
  ▪ city’s ageing population
  ▪ increase in the learning disabilities population

☐ Geographic inequalities
  ▪ growth of the private rented sector
  ▪ poor mental health and wellbeing linked with deprivation

☐ National austerity programme
The overall strategy

- maximise the potential of community assets and release the latent capacity for mutual support
- minimize the risk of a reduced state offer
- preventative and support approaches which maintain and promote well being
- better personalized health and well-being outcomes for individuals
- effective, whole-system outcome measurements
Community Resilience:

“Reflects the extent to which communities are able to come together to define, discuss and tackle common problems”

Technical Report – Survey of Leicester pilot project (Prof. Alexis Comber et al.)
Development

- ADASS Regional Personalisation Project
- Develop an approach to mapping community assets
  - relevant to preventative approaches
  - supporting people with care and support needs
  - involvement of Leeds Institute for Data Analytics
  - established investment model and strategy
  - more effective risk analysis and management
Review of existing academic and localised work has taken place in different areas of the UK:

- Resilience and Wellbeing: Community Sustainability (Prof. Alexis Comber et al 2013)
- The ‘Heat Project’ - Wellbeing and Resilience Measure: Taking the temperature of local communities (Nina Mguni and Nicola Bacon 2010)

Analysis using local and national datasets and applied a variant of existing models.
Methodology

- Data at Lower Super Output Area’s (LSOA) were utilised to create a score per theme;

- Themes were:
  - Household Income, Property, Disability, Overcrowding, Claimants, Medical, Deprivation, Education, Children’s Centres, Schools, Leisure Centres, Post Offices, Libraries, Health Facilities, Community Centres, Local Green Space.
<table>
<thead>
<tr>
<th>Type of Resilience</th>
<th>Source</th>
<th>Description</th>
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<tbody>
<tr>
<td>Household Income</td>
<td>Experian Mosaic Public Sector</td>
<td>Took the most dominant HH income for the LSOA defined by the number of postcodes with the HH income range</td>
</tr>
<tr>
<td>Property</td>
<td>Land Registry</td>
<td>House price data compared to household income and the difference between the two</td>
</tr>
<tr>
<td>Disability</td>
<td>SHBE</td>
<td>Postcode level data aggregated to LSOA using field 12 filtered for &quot;Employment and Support Allowance (IR)&quot;</td>
</tr>
<tr>
<td>Overcrowding</td>
<td>Census 2011</td>
<td>Based on the Occupancy rating (rooms) of -1 or less (indicating that there is 1 or more too few rooms for the household)</td>
</tr>
<tr>
<td>Claimant</td>
<td>NOMIS Website</td>
<td>Custom query based on &quot;claimant count by sex and age&quot; for Leeds LSOA 2011 (Apr '11 data)</td>
</tr>
<tr>
<td>Medical</td>
<td>Census 2011</td>
<td>Based on &quot;day-to-day activities limited a lot&quot; and &quot;Very bad health&quot; combined</td>
</tr>
<tr>
<td>Deprivation</td>
<td>Indices of Multiple Deprivation 2015</td>
<td>Simple copy of the 10 IMD deciles for LSOAs converted to quartiles</td>
</tr>
<tr>
<td>Education</td>
<td>Children’s Services</td>
<td>Combination of KS4, Outcomes: aged 19 Achieve Level 3, Secondary Home Persistent Absence (15%), Not in Education,</td>
</tr>
<tr>
<td>Children Centre</td>
<td>Leeds City Council (Leeds Data Mill)</td>
<td>(Low numbers - not used singularly*)</td>
</tr>
<tr>
<td>Schools</td>
<td>Children's Services</td>
<td>Took the number of schools and Early Years Centre for each LSOA. Higher number = better quartile</td>
</tr>
<tr>
<td>Leisure Centre</td>
<td>Leeds City Council</td>
<td>(Low numbers - not used singularly*)</td>
</tr>
<tr>
<td>Post Office</td>
<td>Royal Mail</td>
<td>(Low numbers - not used singularly*)</td>
</tr>
<tr>
<td>Library</td>
<td>Leeds City Council</td>
<td>(Low numbers - not used singularly*)</td>
</tr>
<tr>
<td>Health (PCT) facility</td>
<td>PH Intel Team</td>
<td>Basic list of GP Surgeries across Leeds (October 2015)</td>
</tr>
<tr>
<td>Community Centre</td>
<td>Leeds City Council (Leeds Data Mill)</td>
<td>(Low numbers - not used singularly*)</td>
</tr>
<tr>
<td>Local Green Space</td>
<td>Leeds City Council</td>
<td>Green Space as provided by City Development</td>
</tr>
<tr>
<td>Assets Combined*</td>
<td>Various</td>
<td>Mixture of Post Offices, Libraries, Community Centres, Leisure Centres, Children Centres</td>
</tr>
<tr>
<td>LSOA2011</td>
<td>INT</td>
<td>Ward</td>
</tr>
<tr>
<td>----------</td>
<td>--------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>E01011282</td>
<td>Armley Moor</td>
<td>Armley</td>
</tr>
<tr>
<td>E01011283</td>
<td>Armley Moor</td>
<td>Armley</td>
</tr>
<tr>
<td>E01011286</td>
<td>Armley Moor</td>
<td>Armley</td>
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<tr>
<td>E01011292</td>
<td>Armley Moor</td>
<td>Armley</td>
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<tr>
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<td>Armley</td>
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<td>E01032607</td>
<td>Armley Moor</td>
<td>Armley</td>
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<tr>
<td>E01032608</td>
<td>Armley Moor</td>
<td>Armley</td>
</tr>
<tr>
<td>E01011323</td>
<td>Armley Moor</td>
<td>Bramley and Stanningle</td>
</tr>
<tr>
<td>E01011324</td>
<td>Armley Moor</td>
<td>Bramley and Stanningle</td>
</tr>
<tr>
<td>E01011325</td>
<td>Armley Moor</td>
<td>Bramley and Stanningle</td>
</tr>
</tbody>
</table>
Example: Leeds Community Foundation funding

Number of successful bids
Example: ASC Domiciliary Care
Example: Assets and the CRI

CRI
- 4 (Poor)
- 3 (Below Average)
- 2 (Above Average)
- 1 (Good)
Updates to be implemented:

- Incorporate ‘distance from’ access to services as opposed to simple LSOA count;
- Revised housing affordability indicator;
- Revised disability indicator;
- Develop a ‘domain based’ CRI with specific indicators for each area of interest;

Further work:

- Physical site visits;
- Community engagement.
Thank you for your time

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- Malachi Rangecroft
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  - 07891 276 508
Following slides are footnote slides used in the main presentation
Example of a single domain: Adults/older people

Possible indicators:
- Social Isolation;
- Age;
- Ethnicity;
- Housing tenure;
- Access to services (libraries, council services etc);
- Community groups;
- Current council expenditure (direct payments, residential care, domiciliary payments).
Questions & Answer Panel
Next Steps for Personalisation

- What are your thoughts on the presentations about homecare? How can personalisation help transform homecare? Is it a precondition of a new model?

- What are your thoughts on mapping community resilience? How would this help your local authority?

- Local Authorities are facing unprecedented pressure but also need to engage in integration, particularly Better Care Fund and STPs, and many are looking to transform through devolution. How can personalisation make its contribution?

- What would progress look like over the next year? How can we best achieve that progress?

- Key messages back to TLAP and the regions – how can we help? What messages would influence national policy?
Conclusion & Next Steps
And Finally...

- Collate key discussion points
- Consult on suggested areas for action (Through appropriate networks)
- Referred to respective regional and TLAP networks.
- Strategic conversations with TLAP: Explore possibilities for joint working, shared learning and collaboration for 17/18
- Maintain engagement with colleagues / update on developments
- Get in touch!
Get in touch with us

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