Report No. ACS10055	**London Borough of Bromley**	Agenda Item No.

PART 1 - PUBLIC

Decision Maker:	**Adult and Community Policy Development & Scrutiny**
Date:	**21st September 2010**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**SUPPORTING INDEPENDENCE IN BROMLEY PROGRAMME - CHANGES TO CARE MANAGEMENT ARRANGEMENTS**
Contact Officer:	Jean Penney , Programme Manager, Supporting Independence in Bromley Tel: 020 84617994Tel No E-mail: jean.penney@bromley.gov.uk
Chief Officer:	Terry Rich, Director, Adult & Community Services
Ward:	Borough Wide

1. Reason for report

This report outlines the future changes to the care management arrangements arising from the revised business operating model for the delivery of adult social care assessment and care management services in the light of the Supporting Independence Programme.

It also reviews the outcomes being achieved to date through the Re-ablement service.

2. RECOMMENDATION(S)

The PDS Committee

To note and comment on the revised arrangements for care management.

Portfolio Holder

To endorse the revised care management arrangements arising from the revised business operating model.

Corporate Policy

1. Policy Status: Existing policy.

2. BBB Priority: Supporting Independence.

Financial

1. Cost of proposal: Estimated cost 2.1 m set up grant over the 3 years of the programme which ends in March 2011.

2. Ongoing costs: Non-recurring cost. Any recurring costs must be funded from mainstream budgets after March 2011

3. Budget head/performance centre: Transforming Social Care - Programme Manager - Jean Penney

4. Total current budget for this head: £2.1 m over two years

5. Source of funding: Social Care Reform Grant

Staff

1. Number of staff (current and additional): 9 posts funded on short term basis

2. If from existing staff resources, number of staff hours:

Legal

1. Legal Requirement: Non-statutory - Government guidance. Government guidance. Grant conditions required to secure Social Care Reform Grant as above. Transformig Adult Social Care, LAC (DH) (2009) 15th March, 2009. Putting People First 10th December, 2007

2. Call-in: Call-in is applicable

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): The transformation agenda will impact upon all who require publicly funded adult social care as well as shaping the wider social care market for those who self-fund. Currently 10,000 adults per annum receive support and social care services in Bromley.

Ward Councillor Views

1. Have Ward Councillors been asked for comments? No.

2. Summary of Ward Councillors comments:

3. COMMENTARY

3.1 The Putting People First concordat (December, 2007) articulated:

- a new direction for care services;
- a shift from crisis intervention towards re-ablement and early intervention to promote independence,
- the need for support and services to be built around the specific needs and aspirations of individuals; to fit into their lives.

3.2 The Supporting Independence in Bromley programme has been established to deliver a change agenda which will:

- Maintain our focus on funding people deemed to have critical and substantial needs and safeguarding adults.
- Focus our specialist advice and support on those that need and want it and allowing those that prefer to do more for themselves to do so.
- Focus our internal resources on reducing need and building independence, through targeted short-term prevention, re-ablement and independence training.

3.3 The Programme will develop two "offers" i.e. two ways that services can be provided to residents of Bromley.

3.3.1 **The 'universal offer'** – this can be described as a signposting to a range of services that can be accessed without a care assessment, and therefore not subject to the meeting of the Council's eligibility criteria for supported care services.

This will include services provided through other parts of the Council – recreation and leisure facilities, supported or sheltered housing, assistance with transport or public health programmes. It may also include services provided through voluntary sector organisations, often where those services are provided with some Council support or funding.

3.3.2 **The 'targeted offer'** – this represents those services provided or funded by the Council following an assessment of needs for individuals who meet the Council's eligibility criteria for social care services – i.e. those having "critical or substantial" levels of need.

This will include access to residential or nursing home care, as well as the full range of services aimed at supporting peoples' continued independence within their own homes. Those services will, with the exception of residential and nursing care, be provided via a personal budget and increasingly through Direct Payments through which people will be able to arrange their own care.

3.3.3 The council and its local strategic partners have an important role to play in delivering the 'universal offer' whilst ACS is crucial to the delivery of the 'targeted offer'.

3.4 **Changes to Care Management Arrangements**.

3.4.1 There will need to be changes to the way in which the Council deploys its care management resource to meet the requirement of the supporting independence programme and a revised Business Operating Model has been developed and is described in the following paragraphs.

3.4.2 The current system locates the majority of the Care Management resource in two area based teams – one in Orpington and the other in Penge – these teams manage all demands for assessments and care planning for all older people. There are also separate teams for people with Physical Disabilities and Sensory Impairment and a team based within the Princess Royal University Hospital managing all referrals from patients within the South London Hospitals Trust. Another team manages reviews of existing care plans.

3.4.3 In the revised arrangements it is proposed to move away from this structure and to develop a team structure which supports the revised customer journey whereby all new referrals will be offered re-ablement with a smaller number of service users requiring long term care plans and support.

3.4.4 A team structure is being finalised which will see four main elements:

- A contact and assessment service – based around an expanded BSSD model
- Short term interventions team – incorporating the hospital service together with intermediate care and reablement,
- Case Management – aimed at a smaller number of cases requiring more concerted and continuing care management intervention – this will include cases with active adult protection issues.
- Co-ordination and review

3.4.5 Detailed proposals around team sizes and the implications for existing staff are currently being finalised and formal consultation with affected staff will commence shortly. Informal consultation with staff has taken place over July and August and comments and suggestions from staff have been taken into account when designing the revised business operating model and the staffing structure to support delivery.

3.5 BUSINESS OPERATING MODEL DESIGN

3.5.1 The proposed business model is based on the agreed customer journey for Self-Directed

Support and reflects the aspirations of Putting People First to meet need earlier and have a sound preventative model of care so that the numbers of people requiring specialist support are reduced over time.

3.5.2 The Re-ablement service, introduced in February 2010 has achieved very positive outcomes and has influenced the revised business operating model.

3.5.3 The Assessment and Re-ablement service aims to help people to regain their independence and improve their quality of life, perhaps after an illness or accident or something that has made them loose confidence. The service helps people make choices and take control of their life again.

3.5.4 The re-ablement service is being established through a ring-fenced recruitment from within the Council's in-house home care service therefore ensuring that the service benefits from the experience and skills of those staff.

Re-ablement Facilitators work with the service user to implement a personal re-ablement programme, in the persons own home enabling skills development and independent living this includes both Personal Care (getting in and out of bed, personal hygiene, assistance with use of a toilet or commode, preparing food, general mobility) and Practical and Social Support (improving confidence and daily abilities to regain optimum independence and control,

household administration, paying bills, shopping, filling in forms, getting medication/prescriptions, domestic tasks including cleaning, and laundry)

3.5.6 The Assessment and Re-ablement service has been introduced initially at a time of hospital discharge. The table below demonstrates the benefits of the programme over a 4 months period and how people are being supported to live independently and not need ongoing packages of care.

April – July 2010	Count	Percentage
Outcome 1: No ongoing care package	49	65%
Outcome 2: Reduced care package	9	12%
Outcome 3: Maintained care package	1	1%
Outcome 4: Increased care package	3	4%
Outcome 5: Did not complete re-ablement	10	13%
Outcome 6: Deceased	3	4%
Total	**75**	**100%**

3.5.7 Below are a few of the comments collated from the quality assurance questionnaire:

"Especially good service for those on their own or in difficult circumstances. The carers becoming real friends their service itself is very generous in the giving of equipment."

"Very satisfied with the service received the facilitators were all willing to help nothing was too much trouble for them. Always encouraged me to reach my goals that have been discussed. Very sorry it's coming to an end."

"Re-ablement has made me feel more confident and get back on my feet in my own home".

3.5.8 There are now 12 staff working as Re-ablement Facilitators and report that their job satisfaction level has increased as they are now empowering people to take control of their own lives. They feel that supporting people to achieve their goals and witnessing their achievements is very rewarding.

3.6 BUSINESS OPERATING MODEL

3.6.1 Contact and Assessment

For those people who are eligible for support from the local authority the Contact and Assessment Service will provide an integrated approach and meet need at this point of contact giving an improved user experience.

Example of the services that will be provided at this point are:

Information, Advice, Guidance signpost and supported decision making

- Sending out forms, packs etc.
- Contact Assessment, FACs criteria
- Making referrals to agencies e.g. bathing service, handyman service
- Fast track OT equipment – ordering urgent requests ordering of one-off pieces of simple equipment e.g. transfers on off bed, toilet chair and perching stool.
- Switching on low level service
- Changes to existing care packages, increase and decrease of care
- Referral for manual handling risk assessment

- Reviews for one off interventions provided by the Contact &Assessment service
- Day care or respite referrals

3.6.2 Short Term Interventions

There will continue to be a need for staff to be based in the hospital to undertake complex work and have a presence on the hospital wards.

Intermediate Care, as a jointly funded service, will continue to meet the needs of people who require therapy input and inform assessment for those people requiring long term care.

Assessment and Re-ablement will be a default service for those people meeting the Council's eligibility criteria for social care.

Re-ablement Assessors work with people to:

- assess the daily activities they need to do to remain independent
- find out if there are any risks to their safety and well-being
- draw up a plan to achieve what they want to do
- agree a programme that enable them to make changes and adjustments in their life
- help access the right services and resources that will enable them to regain and maintain independence, e.g. finding a shop and purchasing bathing equipment
- give advice and support that puts people in control of their life including advising on the use of Direct Payments.
- Supporting Re-ablement Facilitators in delivering the agreed reablement plan.

Re-ablement Facilitors: Facilitators work with the service user to implement the re-ablement plan in the persons own home enabling skills development and independent living this includes:

Personal Care

- getting in and out of bed
- assisting with personal hygiene
- using a toilet or commode
- preparing and serving food or drink
- general mobility as appropriate
- promoting and supporting independence

Practical and Social Support

- improving confidence and daily abilities to regain optimum independence and control
- support with household administration, paying bills, shopping, filling in forms
- getting medication /prescriptions

- Domestic tasks
- Essential hygiene cleaning
- Laundry

3.6.3 Case Management

A staff group who have specialist knowledge and skills will maintain a focus on supporting people who have complex needs and high level risks/unstable conditions. This will include people who require safeguarding interventions.

The intention is to develop an integrated approach with community health services so that people can experience a seamless service provided by health and social care professionals.

3.6.4 Review and Co-ordination

The Review and Co-ordination Service will:

- Produce Support Plans within estimated budget and support implementation
- Co-ordinate service/support for individuals who do not want to employ their own staff.
- Organise long term placements
- Complete proportionate reviews
- Undertake proportionate financial monitoring of Direct Payments
- Hold case responsibility for cases where risks are managed and the case is stable
- Undertake re-ablement assessments where identified as appropriate at review

Assessments, support planning and reviews will be proportionate to peoples presenting needs. The assessment will be used to indicate the level of financial resources required to meet the Fair Access to Care domains which are identified as critical or substantial.

A Co-ordinator will work to meet those identified eligible needs within the financial envelope and identify how other needs, which are not critical and substantial, can be meet within the persons own resources or within the local community network.

This work prevents the needs in other domains reaching the critical and substantial level.

A skilled support planner will also be able to reduce the level of funding required to meet eligible needs by including existing support networks and having a local knowledge of voluntary, charitable and informal organisations that can support individuals to live independent lifestyles.

4. POLICY IMPLICATIONS

4.1 The Supporting Independence in Bromley programme is a key driver of the Building a Better Bromley key aim of Supporting Independence and is a major priority of the Adult and Community Portfolio Plan.

4.2 The programme is in line with national developments to transform social care and supported by specific 3 year funding through the “social care reform grant”. This funding supports the vision as laid down in “Our Health, Our Care our Say” and the “Putting People First” Dec. 2007

5. LEGAL IMPLICATIONS

5.1 The Council has a duty to provide an assessment service and to meet the assessed needs of people with social care needs who are eligible under its Eligibility Criteria. The Eligibility Criteria must be consistent with the Fair Access to Care Services guidance.

5.2 The Council also has a duty to make Direct Payments available in appropriate circumstances to enable people to arrange their own care.

6. PERSONNEL IMPLICATIONS

6.1 Changes in staffing requirements, including the types and levels of staff required and the appropriate competences to deliver personalised social care will be subject to the Council's Management of Change procedures.

7. FINANCIAL IMPLICATIONS

7.1 Whilst there are no financial implications directly arising from this report, it should be noted that changes to the staffing arrangement will need to be within current staffing budgets and should take account of the need for financial efficiencies given likely reductions on public finances in the years ahead.

7.2 Re-ablement is designed to reduce the need for longer term domiciliary care support and savings associated with the service will be evaluated and will form part of future budget savings plans.

Non-Applicable Sections:	[List non-applicable sections here]
Background Documents: (Access via Contact Officer)	[Title of document and date]