APPENDIX 2

Social Care for Adults in Birmingham – A Fair Deal in Times of Austerity

Background

Local Councils are facing considerable challenges in terms of providing services with decreasing budgets and have to make some difficult decisions. We are facing cuts in government funding on a scale that has never been seen before. Prior to the current economic crisis there was already considerable debate nationally regarding the funding of social care. The important area within the debate was the recognition that "if we do nothing" the cost of social care would double within 20 years. Some of the reasons for this, confirmed by government research, are linked to the demographic changes within the population, rising social care needs and increased public expectations.

Here in Birmingham, the City Council will need to make big changes to balance the books in the years ahead. These changes will have an impact on everyone in the city, and we will need to be clearer on our priorities and ensure that we only spend money on things that support these priorities. We as a council are committed to working with all our partners such as the NHS, voluntary sector and local communities to develop new ways of working so that we can get maximum value from all the resources available to the citizens of Birmingham.

The Adult &Communities Directorate had already set out on a journey of transformation in 2009 and we now have in place the things the government advocates: preventing delaying or reducing people's needs for care and support through access to support services. We have consulted service users on detailed proposals before and they have told us what is important to them. We therefore re-iterate our commitment to:

- **Always meet assessed unmet eligible needs**
- **Increase or decrease as necessary individual budgets to ensure unmet eligible needs can be provided for and**
- **Meet needs as detailed in support plans until they are changed either by re assessment or review.**

The City Council has identified a number of key principles for the delivery of adult social care. These key principles are:

- We will always meet your assessed unmet eligible needs by carrying out an assessment to determine whether you have eligible needs. This means that we will work with everyone who appears to have a need for community care services to see how we can assist them to regain their confidence, or to re-learn essential skills so that they can do more for themselves again. People who already receive care may also be able to regain some of their independence and over time we would expect some packages of care to decrease as people are able to do more for themselves;

- We will provide sufficient funds to ensure that your unmet eligible needs can be purchased; and meet your assessed unmet eligible needs as detailed in your Support Plan, until it is changed either by re-assessment or review

- We will assess and review your care needs in line with statutory requirements.

- We will support an approach which stresses both the rights and responsibilities of individuals and includes a greater emphasis on assets instead of a deficit-based approach which focuses on what people cannot do for themselves and need money from the state to do;

- We will focus on integrated approaches to provide 'early help' across all agencies, third sector and private organisations;

- By linking with our Housing Support Colleagues we will reduce the escalation of need by enabling people to live independently within their communities through the delivery of appropriate housing support solutions.

- We will work to reduce 'future demand' at the highest levels of need, including 'troubled families', and to ensure that our most disadvantaged young people are able to maximise their potential from education and training.

- We will work with our providers to build a philosophy of care that focuses on outcomes, such as being able to live independently.

- We will always seek to achieve value for money in all services

Future Model – our proposal

Birmingham City Council is committed to delivering safe services to residents who have eligible unmet care or support needs. We are also committed to working with our partners (particularly the NHS, the voluntary sector, the local communities and local providers of care) to develop services for people that help them live as independently as possible with minimal interference.

We will develop a fair system of social care where the resources that are offered relate to the level of assessed unmet eligible needs a person might have, taking account of the assessed financial contribution they will make towards the costs of their care.

- We will work across the Council to promote health and wellbeing through the effective development of community based services accessible to all ensuring that we are able to offer 'something for everyone' through provision of clear information about facilities and activities in their local community;

- We will give priority to helping people recover, recuperate and rehabilitate so that they are able to live as independently as possible. We will ensure that all employees understand how to work with service users in ways that promote their independence, ensure their safety and support their recovery

- We will proactively work with partners to develop appropriate housing and care pathways to keep people living independently in their own communities wherever possible.

Our Approach

Universal Assessment

- Everyone who appears to have a need for community care services will be offered an initial Social Care Assessment. Assessments will be carried out over a reasonable period of time to ensure that we have not made long-term decisions about people before we have had a chance to work with them through a recovery or recuperative plan;

- This means that where possible we will have shared health and social care assessments and a single plan that will help people to retain independence in the community. For example, the interventions from occupational therapy, physiotherapy and social care input detailed in one support plan;

- If required a Continuing Health Care (CHC) assessment will be undertaken in partnership with Health to determine whether Continuing Health funding will be applied. If your needs change a reassessment may result in a change of provision. If you refuse a CHC assessment then this may affect your receipt of health services;

- If following an assessment it is determined that a lower cost package can meet your unmet eligible need, the presumption will be that we will move you from your existing care setting to the lower cost option. You will be encouraged to take a direct payment of an equivalent amount and make your own care arrangements (subject to them being signed off as meeting your unmet eligible need) as an alternative – **see scenarios 2, 4 and 6;**

- We will work jointly with young people and their families as early as possible to support a smooth transition into adult life;

- We will always ensure that the assessment is offering more than just a response to a current crisis and work with partners to offer support to ensure that each person is getting the right health, housing and other support alongside their social care – **see scenarios 1 and 4;**

- We anticipate that the solutions that many people have to meet their care needs can be found within their own families, their communities and within themselves. We will work with each person and their network to find these solutions. Where people have lost their support networks we will work together to rebuild them – **see scenario 3**;

- We will encourage our service users, our partners and our staff to help find innovative, creative solutions to meet the outcomes that they wish to achieve;

- We recognise that the right to self-determination can involve risk. However, we will ensure that we are balancing risk by empowering citizens as well as safeguarding our service users; and

- We take our responsibility seriously as the lead organisation within the locality to work to prevent abuse and will work with local organisations to ensure policies and procedures are in place to safeguard vulnerable adults

Independent living in your own community – see scenario 4

We will:

- Always work with you to ensure you are enabled to maximise your independence;

- Continue to develop easier ways to find advice and information in order to support service users to access information and services to meet their needs;

- Work with young people and their families as they move through to adult services to maximise their independence in adult life;

- Support user-led organisations, social enterprises and other groups who can meet our aspirations for social care

- No longer admit any person directly from a hospital to a permanent residential care home without enablement or a longer term assessment;

- Continue to develop a community based model of social work; and

- Support you to maximise your economic well-being including signposting to employment opportunities.

Manage your care through a direct payment - see scenario 2

We will

- fund the provision of services to meet your eligible unmet need and will offer you the opportunity to manage your own care through a direct payment;

- expect you as citizens to manage your own money, resources and care wherever you can; and

- only manage care on behalf of individuals where they or their families are unable to do so.

Valuing carers

- Some people who need help to live at home may be supported by their informal carers (e.g. family, friends, neighbours). Recognising there may be increased responsibilities for these carers, the council will offer a Carer's Assessment to ensure their caring duties can be appropriately maintained.

Working with our Partners

We will:

- continue to develop an integrated and outcome-focused approach to our work with all our partners to provide better outcomes for service users within the resources available;

- need to ensure that we and our partners share common goals in assisting people to remain independent in their own homes;

- with the consent of the service user, also share details of care packages and review of those packages with their GP so that the GP is clearly aware of the interventions in place to promote independence and maintain the wellbeing of their patient; and

- work with our health partners to ensure that people get the appropriate health prevention and early health interventions.

Value for money – see scenario 6

We will:

- always look for solutions which offer value for money; for example we will consider residential over community based services if they are deemed to be more cost effective;

- always look at all available options ; if there is a range of options at a similar cost, we will chose the option that best meets the outcome of helping you live independently, if at all possible;

- with the combination of growing demand and reduced resources available to the council, ensure that money is spent in a fair and equitable way. It is possible that some of our current service users and their carers may see a reduction in the amount of money that is available to them. We need to reduce some historical levels of service provided to service users which are greater than the associated levels of assessed need. Whilst ensuring fair and equitable services means we cannot delay this process unduly, we will take a sensitive and understanding approach;

- if the funding for a care package is reduced, involve the user and their carers in any changes. In particular we will manage reductions in a clear, transparent and negotiated way;

- ensure that there are services available for service users and their carers to meet their unmet eligible needs within the resources that will be made available to them through their Direct Payment;

- undertake a financial assessment in order to determine your contribution to your care costs; if this is refused you will be liable for the full costs of your care;

- when your capital falls below the threshold, provide you with an assessment and this may result in a change in provision - **see scenario 5;**

- always look for solutions that offer value for money (quality in delivering the agreed outcomes against the cost to the public purse);

- work with local and regional service providers and local communities to identify and develop services that meet citizens' needs;

- develop all commissioning activity jointly with our health partners and in consultation with our service users and carers and we will learn lessons from elsewhere; and

- ensure that citizens are aware of quality of social care provision in the market by publishing quality ratings where available.

Outcomes

- We will expect to see an increase in the number of people being helped to live independently within their communities safely. This will be achieved by supporting the development of community services and support systems on a locality basis. Therefore our primary focus will be to support you to **access services on your own** and only intervene where this is not possible

- We will use a universal approach to resource allocation to ensure equity across all service user groups, based on individual needs.

- We will reduce the number of people being **admitted to residential care** by promoting the use of direct payments so needs can be met in their local community.

- We expect to see **an increase in the number of people successfully completing recovery** and enablement and being supported to live in their own homes

Scenario 1

Mrs A, who lives in Quinton has a diagnosis of early stage dementia. Mrs A's daughter, who lives in Hall Green thinks her mother is lonely and depressed and is not eating properly since her father died recently. Mrs A's daughter talks to some of her friends about her concerns, but cannot decide what to do for the best. During one of her visits to her mother, she speaks to a neighbour who mentions that a local church holds a luncheon club.

She contacts the church and they confirm that they have space generally on a Thursday. Mrs A's daughter changes her hours at work and picks her mother up and takes her to the club each week for a meal and some friendship.

After a couple of weeks the staff at the club notice that Mrs A is confused and distressed at times when attending the club. The luncheon club co-ordinator suggests that Mrs A's daughter contacts social services and gives her the number for the Adults and Communities Access Point (ACAP)

Mrs A's daughter phones ACAP, who carry out a contact assessment. From this it appears that Mrs A would meet the eligibility criteria for social care. The ACAP member of staff referred Mrs A to the Enablement service - Enablement is short-term intensive service which aims to improve someone's ability to care for themselves.

In discussion with Mrs A and her daughter, the Enablement Team draw up a structured plan, which looks at the tasks that Mrs A can physically do but creates a repeat pattern for carrying them out. The team also refers Mrs A to the telecare service, who install some alarms, so that if Mrs A wanders and attempts to leave the property at night, the alarm sounds with her daughter's voice reminding her not to go out. Mrs A also has a pill dispenser which has a verbal prompt alarm to remind her to take her medication.

During the six week service the Enablement staff undertake an enhanced assessment which indicates that although Mrs A's levels of independence have increased she may well have on-going, presenting needs. The team chat these things through with Mrs A and her daughter. Mrs A is concerned about how she is going to cope, but her daughter feels confident that between herself and Mrs A's friends they can make sure that she retains the skills and patterns learned during enablement as well as building some new social links. The Enablement Team ask a social worker to call to undertake a carer's assessment and refer Mrs A to her GP for further assessments on dementia and access to NHS dementia services.

Mrs A's daughter did not require any services at this point and the case was closed.

Scenario 2

Mr B who lives in Ladywood has been having a number of falls at home and has hurt himself. His son lives in Newcastle and after a telephone conversation Mr B reluctantly agrees to go to his GP for a check-up. During the consultation the GP identifies that Mr B was struggling to care for himself and refers him to the Adults and Communities Access Point (ACAP).

Staff at ACAP undertake an initial and contact assessments and determines that Mr B has unmet eligible needs and refers him to the Enablement service - Enablement is a short-term intensive service which aims to improve someone's ability to care for themselves.

Mr B has a six week period of enablement which helps him with his daily living tasks, such as getting in and out of bed, washing, dressing and going to the toilet. During the six week service the Enablement staff undertake an enhanced assessment which indicates that although his levels of independence have increased, Mr B may well have on-going, unmet eligible needs. As a result the team passes Mr B's case to a social worker who makes contact with Mr B.

The social worker undertakes a Community Care Assessment and discusses Mr B's eligible unmet needs with him and a number of options for how they could be met. After the discussions, the social worker offers Mr B a Direct Payment so he can arrange services to meet his unmet eligible needs, for himself.

Mr B did not want to have to make the arrangements himself and asked if the social worker could arrange the services on his behalf. The social worker explains how a direct payment might benefit Mr B and details the support that was available to help him manage it, including some specialist third sector organisations. The social worker also refers Mr B to the marketplace on www.MyCareinBirmingham.org.uk. Mr B reminds the social worker that he is over 70 and doesn't know how to use a computer. In conversation, Mr B mentions however that his son is an accountant and they decide that Mr B will telephone him and ask him to go on-line.

Having talked to one of the third sector organisations and understood how they could help, Mr B accepts his Direct Payment and arranges his own support with help from his family.

Although the paperwork looks complicated, Mr B finds that the third sector organisation is very skilled and helpful and the carer he employs has some good ideas about ways in which Mr B can continue to regain his confidence.

Scenario 3

Mr C is a single young man with a diagnosis of schizophrenia, he is unemployed, not motivated to care for himself, in financial debt, socially isolated, and living in the community in private accommodation in Saltley. Mr C is supported by his local Multi-Disciplinary Team (MDT) which has already undertaken an assessment and has identified his needs.

At a MDT review meeting it is identified that although some of Mr C's unmet eligible needs are now being met, he still needs support with debt management, a social network and support with improving his confidence and self-esteem. The MDT therefore refers Mr C to an enablement service known as Support, Time and Recovery (STaR) service, to help him access community-based services.

After completing a short period of enablement, which focussed on making him more independent in undertaking his personal care, Mr C still needs community based support to reduce his isolation. The STaR services refers Mr C to a Supporting People provider for on-going support.

Mr C will continue have contact with the Community Psychiatric Nurses and benefits from the MDT approach.

Scenario 4

Mr D is a young adult with Learning Difficulties and challenging behaviour. He is currently living with his ageing parents who can no longer care for him due to their failing health. Mr D is attending a day centre, six miles from home, five days a week. Mr D's parents have telephoned staff at the day centre asking for advice as they are frightened about what would happen to him when they are too ill. The day centre staff suggest that Mr D's parents talk this through with a social worker at their son's annual review.

Having raised their concerns at the review, the social worker contacts Mr D's parents and arranges for a multi-disciplinary re-assessment to take place. As part of the re-assessment Mr D's parents are offered a carers' assessment. During the re-assessment it is decided that Mr D would benefit from a period of Enablement - Enablement is an intensive service which aims to improve someone's ability to care for themselves.

The suggested Enablement service is a bed-based one. Although this is a few miles away from his home, Mr D has his own room and soon settles into using the kitchen and communal room each day. The purpose of a bed-based service is to allow the Enablement Team to observe and help Mr D with his daily living skills, such as getting in and out of bed, washing, dressing, going to the toilet and keeping tidy.

At end of the enablement period Mr D's independence has increased and in discussion with him and his family it is suggested that Mr D would be able to live independently in a Shared Lives placement– Shared Lives involves moving into an established family setting and being supported by that family who are trained and paid for by the Council.

Mr D and his family agree to arrange for him to enter into a Shared Lives placement. Due to the Council's recruitment drive for Shared Lives carers, Mr D's family are happily surprised to find a placement within their local community. Mr D soon settles in and his family visit him regularly. The carers also make sure that Mr D has plenty of opportunities to meet his old friends from the day centre.

Mr D's parents also benefit from their carers assessment which helps them through the transition of their son leaving home.

Mr D has an annual review and the MDT provide support to the Shared Lives carers to ensure that they are meeting Mr D's needs in the best way.

Scenario 5

Mrs E is an older adult who has been in a residential home placement in Perry Barr for the past 5 years. Mrs E has lived in Perry Barr all of her life, but her only daughter now lives in the Selly Oak area. Mrs E is self-funding her care, but now her disposable income has dropped below the national capital threshold. Mrs E's family has approached the Adults and Communities Access Point (ACAP) as she is no longer able to pay for her own care. The cost of Mrs E's current placement is £800 per week and her family have no access to funds to support her care costs.

ACAP undertake an initial and contact assessment and Mrs E is referred to the social work team.

A social worker visits Mrs E and her family and carries out an assessment in the residential home. As part of the assessment the social worker explains that Birmingham City Council may not be able to fund Mrs E's current placement if it is in excess of the average cost of care in the market for someone with similar needs. As part of the assessment, the social worker talks to Mrs E and her family to develop a Support Plan, which identifies Mrs E's needs and how they might be met.

The social worker explains that the Support Plan will be passed to a colleague called a broker, who will be able to help them identify the most appropriate residential placement which can meet Mrs E's needs. This is done using a process called micro-tendering which allows residential care providers to describe how they will meet Mr E's identified needs. The broker will then assess the providers' descriptions against the quality of the service provided at that residential home, the cost of the service and the location of the home – Mrs E's family had requested that the home be within 5 miles of their address.

The provider with the highest score, combining both quality and price will be suggested to Mrs E and her family. The broker informs the social worker of which home best meets Mrs E's needs.

Although a particular home has been identified, Mrs E's family could chose an alternative at the same cost, or they could choose another home and use their own resources to pay any additional charges.

Mrs E has an annual review.

Scenario 6

Ms F is aged 30 with learning difficulties and challenging behaviour, she has been living in a residential care home outside of Birmingham for 12 years.

An annual review is undertaken by the multi-disciplinary team (MDT) to identify whether Ms F's needs have changed and if her existing care is still meeting her needs. The review identifies that Ms F's needs have changed. Therefore, the recommendation is that a reassessment is undertaken by the Social Work team.

After contacting Ms F's family for a suitable date, a multi-disciplinary team, including health professionals begins the re-assessment. It is recognised by Ms F's family that the placement is a distance from them and they are now finding the travelling more difficult.

As the re-assessment is completed it is suggested that Ms F could be supported in a community setting as this would both promote her independence and allow her to be nearer to her family. The social worker also raises the point that the cost of the placement is not providing value for money. Through Person Centre Planning and a referral to Housing Pathways suitable properties begin to be identified.

Ms F and her family are anxious and concerned about the suggested placement. Although they have been involved in the assessment and have received regular updates from the MDT Ms F's parents disagree with her being moved as she is settled in her current home and has a number of friends.

Ms F's family raise their concerns with their MP, who contacts the Strategic Director. In response to the concerns raised, a response is provided that outlines why the City Council supports an enabling approach to meeting care needs, the reduction in out-of-City placements as well as commissioning care of an appropriate quality and cost. The social worker is informed of the family's on-going concerns and visits to re-assure them.

The social worker explains that Ms F will undertake a period of bed-based enablement before moving into her placement. The purpose of a bed-based service is to allow the Enablement Team to observe and help Ms F with her daily living skills, such as getting in and out of bed, washing, dressing, going to the toilet and keeping tidy. Following a successful period of enablement, Ms F takes a tenancy in a Supported Living scheme – in Supported Living, Ms F will have her own home as a tenancy and will receive on-going support from a care package to maintain her independence. Supported Living is usually a small community of 4-6 people, supported by a single care provider. The social worker also explains that this is more cost effective and Ms F would return to Birmingham nearer to her family. A support plan is drawn up and a care broker uses this to micro procure and identify the most suitable support provider.

Ms F and her family are involved and kept informed about the assessment however, they disagree with her being moved as she is settled in her current placement. Her family has sought legal advice and contacted their local Member of Parliament to complain.

A multi-disciplinary case conference was arranged and the outcome was that Ms F's case was handled correctly, it followed Council policy and the recommended move went ahead. Ms F's new placement will be monitored and reviewed.