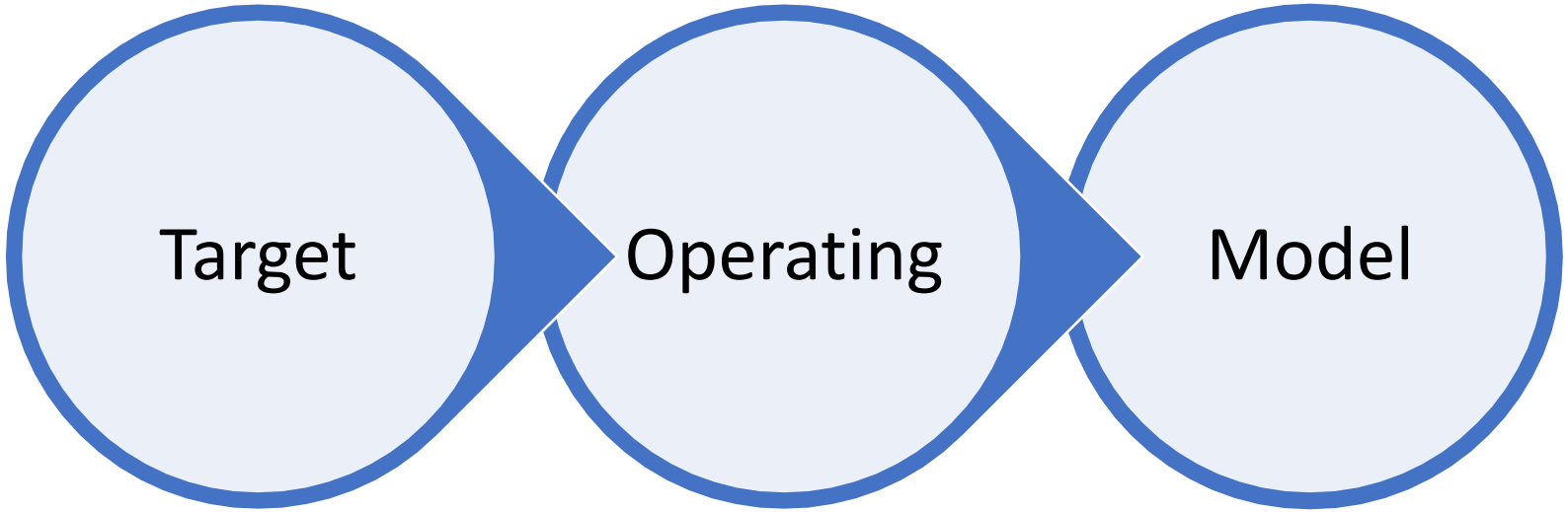
WIRRAL ADULT SOCIAL CARE
COMMUNITY REABLEMENT MODEL

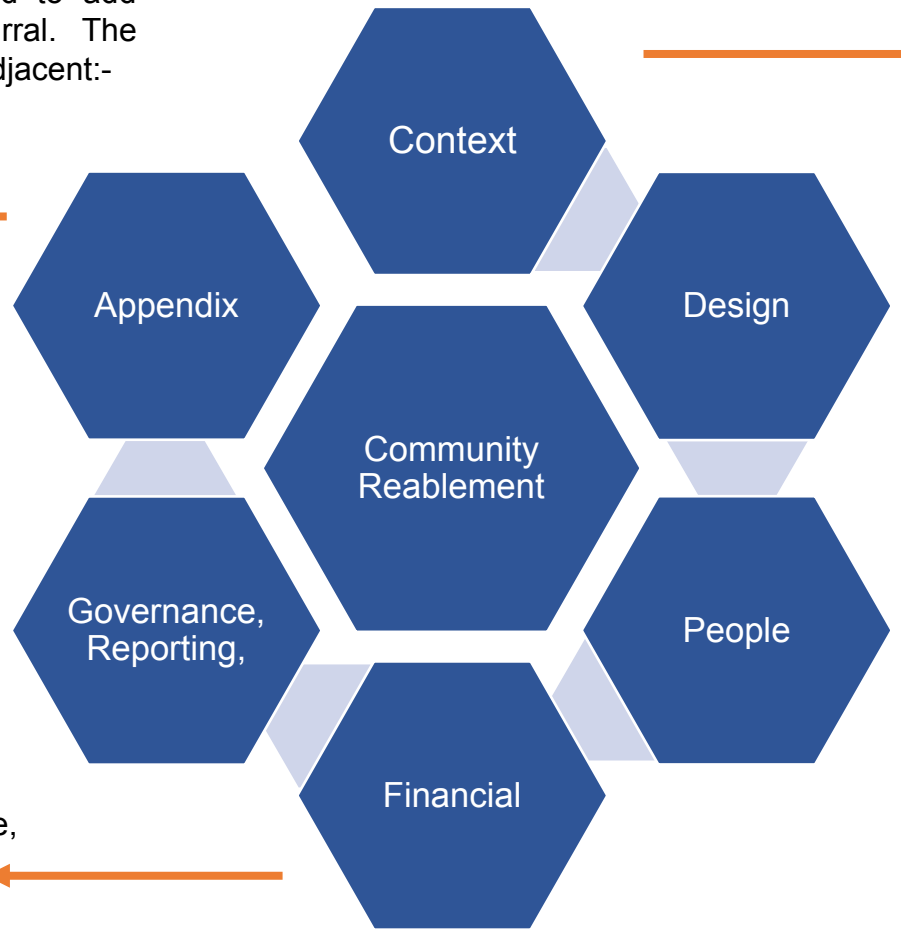


WIRRAL

Adults Care & Health Directorate
Produced May 2023 V3

ADULT SOCIAL CARE COMMUNITY REABLEMENT MODEL
TARGET OPERATING MODEL (TOM)

The purpose of a Target Operating Model (TOM) is to define the principles and operating model of a Adult Social Care Community Reablement Service designed to add value to Social Care & Health Market across Wirral. The document is split into six sections as illustrated adjacent:-



- ✓ Statutory duty, local context
- ✓ Scope
- ✓ Scale of the challenge / demands
- ✓ Strategic Framework
- ✓ Guiding Principles & definition

- ✓ Assumptions used
- ✓ Community Reablement defined and outcomes
- ✓ Community Reablement Journey
- ✓ Future System model & interdependencies
- ✓ Risks and mitigations

- ✓ Proposed structure
- ✓ Overview of roles

- ✓ Financial model of people,
- ✓ assets and projections

- ✓ Unscheduled Care Programme Board
- ✓ KPI's and outcome measures

- ✓ Best Practice
- ✓ Referral Process

Section 1

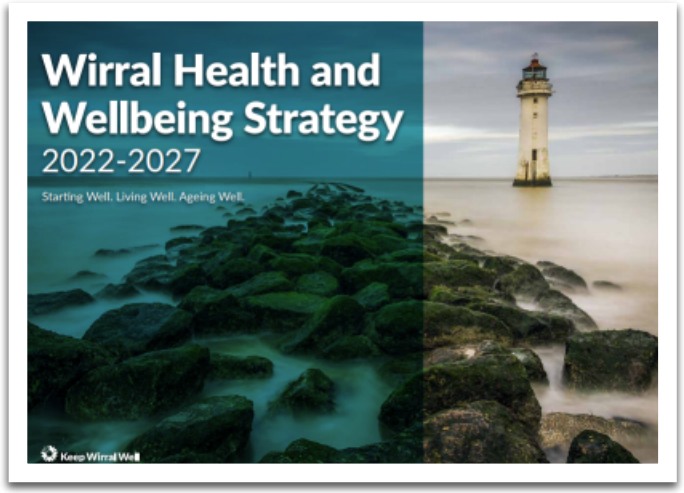
STATUTORY DUTY

- ✓ It is the statutory duty of a Director of Adult Services to provide Social Care Services for people assessed under the Care Act - this duty has been delegated through Wirral Council Commissioning Services Team who commission services that are regulated by Care Quality Commission (CQC)
- ✓ Care Act 2014 Reablement-Local authorities have a duty to prevent, reduce or delay needs for care and support (Care Act 2014 s2) for all adults including carers; this means early intervention to prevent deterioration and reduce dependency on support from others. Reablement is one of the ways they can fulfil this duty

LOCAL STRATEGIC CONTEXT

Section 2 of the Care Act 2014 identifies the local authorities duty to prevent, reduce or delay care needs, promote independence with a focus on its section 1 duties, the wellbeing principals. The general duty of a local authority in the case of an individual ,is to promote that individuals wellbeing.

The work of the **Adult Social Care Community Reablement Model** is also aligned and contributes to the '*Wirral Plan: Equity for People and Place 2021-2026*' with particular focus to the key theme of **'*Active and Healthy Lifestyle*'**, for people to live active and healthy lives with the right care, at the right time with the best possible outcomes for adults with care and support needs.. It also underpins Wirral Health and Well-being Strategy 2022-2027 for people to live and age well and Wirral Health Protection Strategy 2023 – 2027.



SCOPE

Background - On the 11th October 2022, the Adults Social Care & Public Health approved a resolution to design an Adult Social Care Community Reablement Model, working collaboratively with Wirral Community Health and Care (WCHC) NHS Foundation Trust and care system partners.

Outcomes

1. To enable greater alignment and joining up of services to improve outcomes for people accessing or in need for reablement to live well in their communities, and to aspire to more active, fulfilling, and independent lives as possible

2. To provide high quality reablement services that would enable greater opportunity to direct resources to those who would benefit the most

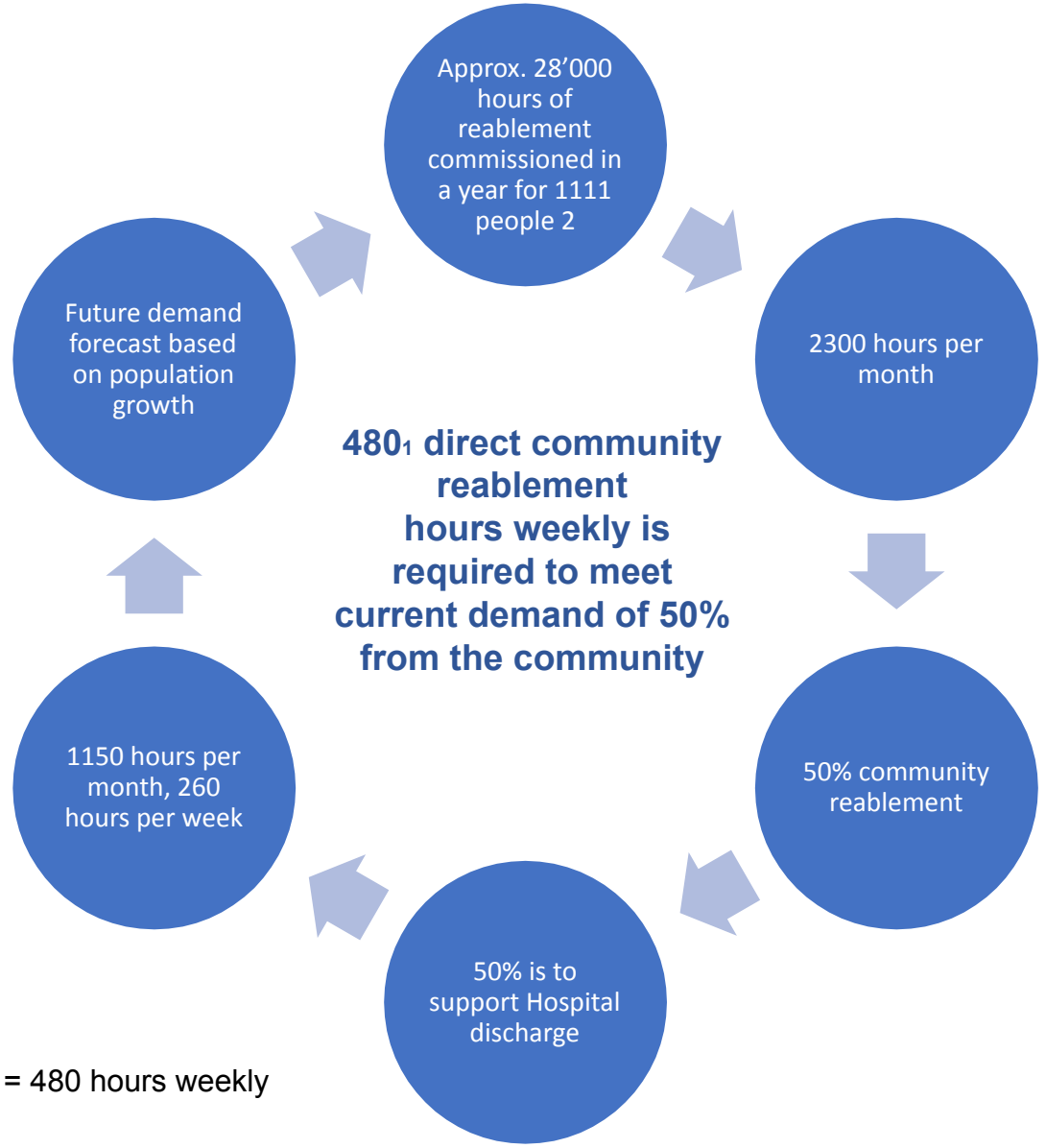
3. The approach to supporting people who require reablement services in Wirral will benefit from learning from other areas

4. To design an Adult Social Care Community Reablement Model, based on robust data analysis, financial modelling, assumptions, risks, constraints, and interdependencies that adds value to a person's experience

Guiding Principles

- ✓ Placing people at the heart of the service design model
- ✓ Embracing collaboration and coproduction with key stakeholders
- ✓ Maintaining and enhancing integrated services, benefits and positive outcomes for people who access the service
- ✓ Utilising data, insight, and intelligence, as well as best practice examples for robust modelling
- ✓ Enabling strength-based practices to improve personalised care and support
- ✓ Transparent scrutiny and challenge of the proposed model arrangements

SCALE OF THE CHALLENGE ACROSS WIRRAL



1. Total number of hours CRP (12 x 30hrs) + 50% of Senior CRP Hrs (8 x 15 hrs) = 480 hours weekly
2. 21-22 data approx. figures sourced from Wirral Council Business Intelligence

Adult Social Care Community Reablement Strategic Framew

Purpose
People will be cared for in the right place at the right time with the right support

Vision
Wirral people will live well in the place they want with the people they want

Mission
Working together to enable our people to have the right support at the right place and time

Values
Person-centred – 'People at the heart of the model'

Integrity – 'Doing the right things for the right reasons'

Inclusion – 'Embracing everyone'

Quality – Shared Vision, Decision Making and Outcomes

Collaborative – Integrated Services and Delivery

Contributory outcomes and benefits

Reduction in Harm, Prevention in deconditioning. Reduction in NCTR Bed days.

People are confident to be independent with support, Social isolation reduced

Workforce understand the system they work in. Increased morale

Better experience with choice to live well at home in their Community

GUIDING PRINCIPLES

Community Reablement is guided by the below set of principles:-

- ✓ Assume that a person is able to be independent until it is proved otherwise.
- ✓ Any needs identified initially will act as a trigger for a strengths based conversation in the persons home with a short and long term perspective.
- ✓ Risk is part of everyday life and can enhance opportunity. We can seek to reduce risk but not always eliminate.
- ✓ The community around the person and their strengths are best placed to support the person in the first instance.
- ✓ Goals should be meaningful to the person and not predetermined by professionals.
- ✓ Recognising that loneliness is a significant factor in peoples lives and effects the persons physical and mental health.
- ✓ None means tested. Working across four local neighbourhood teams
- ✓ Commissioned Domiciliary or residential care will be considered only when it is proven that other support does not meet needs.
- ✓ Maintaining and enhancing integrated services, benefits and positive outcomes for people who access care services
- ✓ Utilising data, insight, and intelligence, as well as best practices for continual improvement as part of a whole system approach

Section 2

ASSUMPTIONS USED FOR ADULT SOCIAL CARE COMMUNITY REABLEMENT MODEL

ASSUMPTIONS

- ✓ This is a future Community Reablement Model that will have a focus on preventative services that are mobilised when it is identified a person in the community is starting to struggle to manage and are at risk of a decline in health, well being and independence thus avoiding costs, system blockages and NCTR longer term
- ✓ Direct reablement care will be carried out by Council employees working within their local neighbourhoods as an multi disciplinary and integrated team
- ✓ Existing assessment teams within the current structures will be utilised, but will not provide direct care
- ✓ Community reablement workforce will be at a level where autonomy is expected to be able to identify and utilise the community around the person, their family and friends, and other organisations to create a- sustainable community support network that meets the persons needs
- ✓ Community support will be the first consideration for ongoing support not domiciliary or residential services
- ✓ The existing commissioned reablement budget will be used to fund additional staff/ resources outside of existing staff – Hospital Discharge Grant through Better Care Fund
- ✓ Outcomes and benefits aligned to Community Reablement Strategic Framework on page 8
- ✓ Will integrate with Home First expansion model who's initial focus is hospital discharge (step down) but with a focus on community (step up). However, It is not envisaged community reablement will accept referrals from Home First
- ✓ The existing commissioned contract which includes both reablement and domiciliary care will continue – this new service is additional
- ✓ The acuity of the person being supported will be less than those in the Home first service cohort
- ✓ 50% of community reablement is currently commissioned by community social work teams
- ✓ Less hands on personal care needed at peek times eg breakfast lunch bedtime calls- more even spread throughout the day
- ✓ Access the support of the community, voluntary and faith sector in collaboration with the expansion of Home First
- ✓ Appropriate monitoring and handoffs between services will be identified through the implementation plan stage

ADULT SOCIAL CARE COMMUNITY REABLEMENT MODEL DEFINITION, OUTCOMES & BENEFITS

DEFINED	OUTCOMES & BENEFITS
✓ Maximising a persons long term independence and quality of life ✓ Enabling people to recognise and access the support of people in their community to reduce social isolation ✓ Supporting people to stay healthy and happy in their own home for as long as possible ✓ When there is a decline in health, prevent hospital admissions by maximising treatment in the persons own home ✓ Ensuring that any provision of care is assessed on an ongoing basis so that a persons level of independence is not defined by a one off assessment but by skilled observations over a period of time in the home environment ✓ To appropriately minimise ongoing support required and thereby minimise the whole-life cost of care ✓ When it is identified that a person in the community is declining or struggling to manage their health and care needs and/or are isolated from their community a referral is made to Community reablement team. ✓ The community reablement team will case manage that person until such time that it is felt they have met their full reablement potential or 6 weeks has lapsed ✓ 8 till 8 service, 7 days a week	✓ Early strengths based conversation in the persons home triggered with person centred goals enabled ✓ Independence maximised, hospital admissions reduced and deconditioning from extended hospital stays avoided ✓ Persons social isolation reduced, moral and confidence increased ✓ End to end total case management achieved, greater choice and ‘hand offs’ reduced ✓ Social worker and care navigator capacity reduced ✓ Funded voluntary sector and community connector services better utilised ✓ Sustainable care is achieved as minimal commissioned services used. “The community is always there” ✓ Knowledgeable and skilled workforce able to motivate and empower people to reach their full potential in their community enhanced ✓ Preventive interventions, cost avoidance longer term within the care and health system ✓ Maintaining the community reablement offer separately to the Home First reablement, therapy, care and assessment offer would protect that resource when acute services are under increased pressure, maintaining the crucial reablement preventative service in the community

Adult Social Care Community Reablement Journey

STEP UP

Placing our residents strengths and independence at the centre of the services we provide

- Community team South Wirral
- Community Team Birkenhead
- Community team West Wirral
- Community team Wallasey

Community Referral

- Community Geriatrician
- Community health services
- Community Connectors
- Shared Lives / Day Services

Short term Care assessment & intervention

Community Reablement Team

Enablers

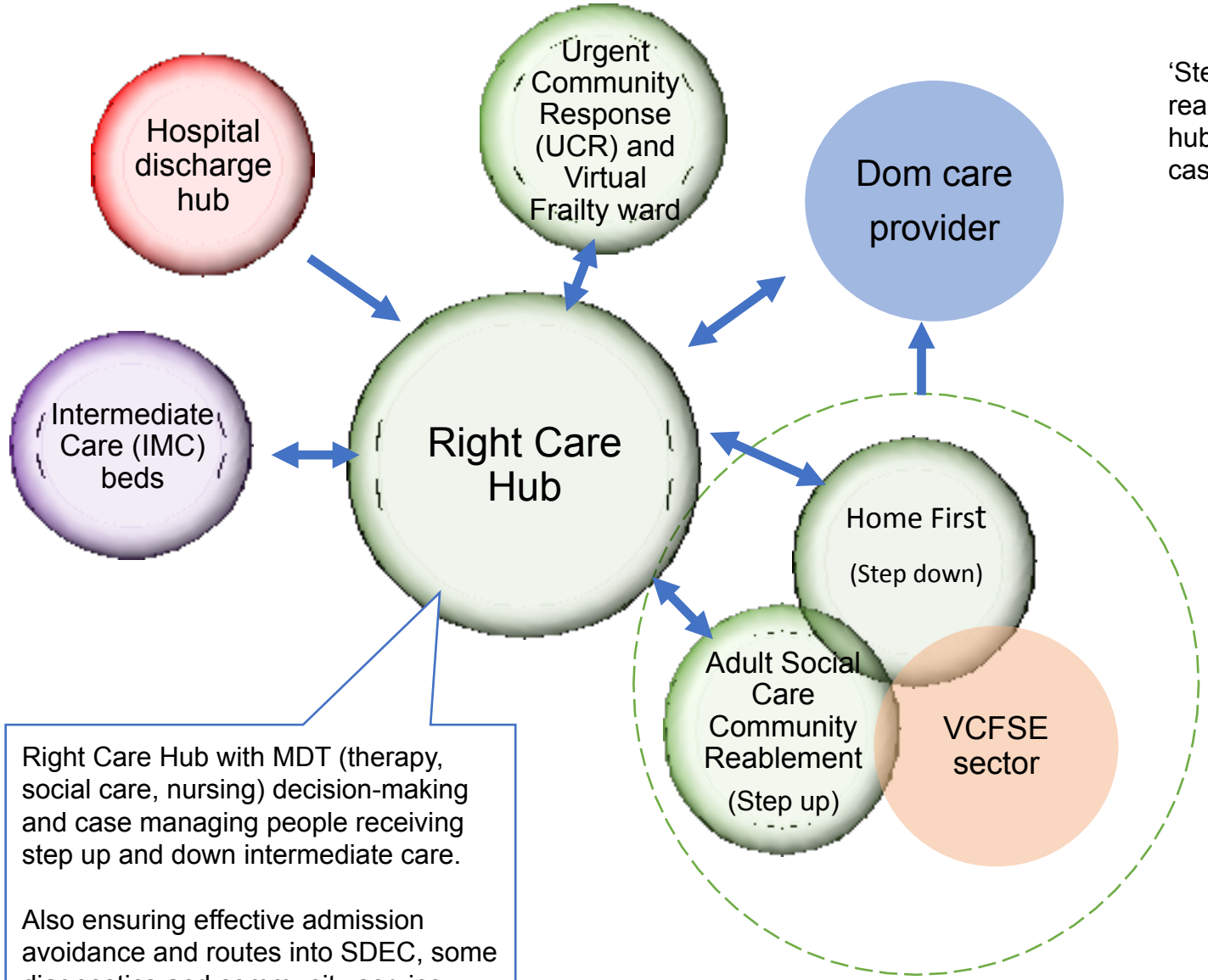
- Assistive Technology /equipment
- Family, Friends, Neighbours
- Voluntary, Community Faith, Sport sector
- Urgent Community Response
- Dom care

Outcomes & Benefits

- ✓ **ENABLE** people to self-care and retain autonomy
- ✓ **CONNECT** them to their communities
- ✓ **IMPROVE** their health & wellbeing
- ✓ **ACCESS** technology to increase independence
- ✓ Build on **STRENGTHS** to maximise independence
- ✓ **PREVENT** and minimise hospital stays
- ✓ **Cost avoidance** preservation of spends in care and health system overtime

Home First focus on Step Down – hospital discharges initially

PRPOSED FUTURE SYSTEM MODEL



'Step up and step down Home First reablement model with Right Care hub for IMC decision-making and case management'

Right Care Hub with MDT (therapy, social care, nursing) decision-making and case managing people receiving step up and down intermediate care.

Also ensuring effective admission avoidance and routes into SDEC, some diagnostics and community service bookings

RISKS AND MITIGATIONS
Adult Social Care Community Reablement Model

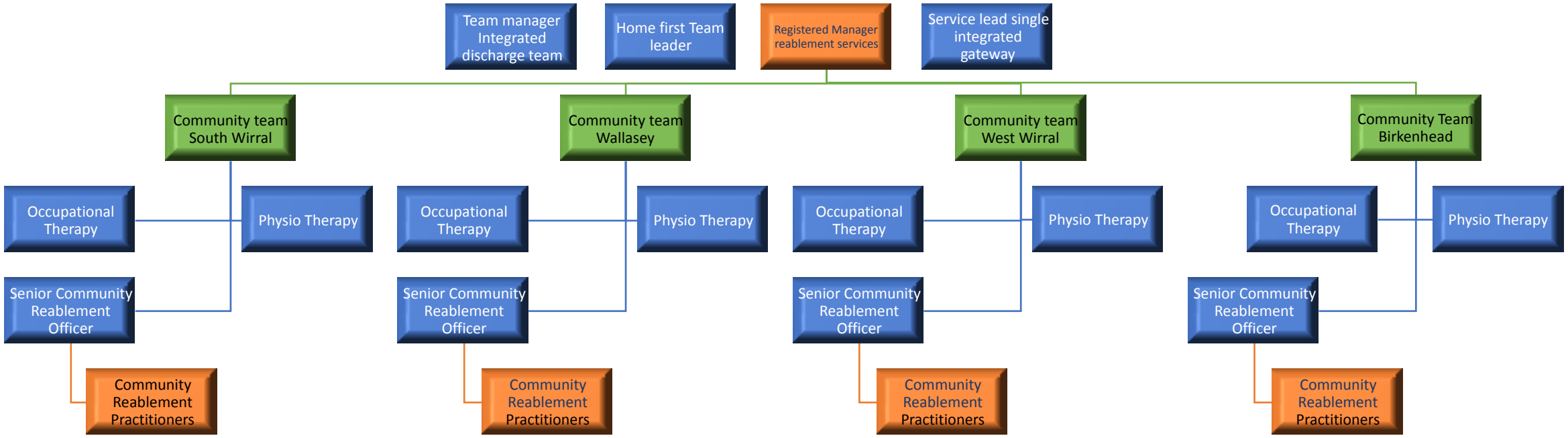
Risk	Description of Risk	Mitigating Actions
1	There are insufficient levels of reablement staff within Wirral to support staffing models for both a community reablement service and a Home First expansion	✓ Active recruitment campaigns ✓ Upskilling of existing workforce – career pathways
2	There may be duplication of roles due to the insourcing of staff into the council, linked to Home First and the new inhouse reablement model.	✓ Ensure joined up vision, outcomes and service delivery placing the customer at the heart of the journey ✓ Partnership agreement in place to ensure clarity of roles
3	There is a missed opportunity of not expanding the role out of Home First model to include community 'hands on' reablement.	✓ Continue to work in collaboration with WCHC and system providers to ensure services meet the demands of local people
4	There may be insufficient capacity within the Voluntary, Community, Faith and Sport sector to enable the right support at the right time or too much pull on those communities	✓ Clarify of the role and expectations of the VCFS sector ✓ Appropriate resources deployed ✓ Clear communications and partnership agreement in place
5	Community demand increase in line with population growth	✓ Dom care contracted providers to maintain reablement as part of the contract ✓ Regular monitoring of demands and supply's
6	There may not be enough resources to fund a new Community Reablement Team	✓ Redirect resources from hospital discharge funding (Wirral Council part)
7	Hospital capacity challenges may distort the home first reablement demands as people not signposted through the correct processes placing pressure on care homes and domiciliary care	✓ Continue to work in collaboration with WCHC and system providers to ensure services meet the demands of local people

Section 3

PEOPLE

Community Reablement Team

In order to achieve the outcomes and benefits defined in slide 12, and to meet the supply and demands illustrated in slide 7, it is proposed that the Adult Social Care Community Reablement Team would be integrated into a multi disciplinary teams within the four local neighbourhoods and would consist of**1 registered manager (new), 8 Senior community reablement officers (existing), 12 community reablement practitioners (New):-**



Those identified with an are new posts and will be allocated to local neighbourhoods based on supply and demands of the local area. The financial modelling is illustrated on slide 21. Those in are existing posts

OVERVIEW OF ROLES

- **Registered manager**– management of CQC registered services- supervision of senior Reablement Worker
- **Senior Reablement worker-** receive initial referral, complete initial assessment, allocate to team. Provide supervision to Community Reablement officers and provide care and support to the person in line with the principals of reablement to maximise independence for complex cases.
- **Community Reablement Practitioner -** provide care and support to the person in line with the principals of reablement to maximise independence. Review and amend support plans on a live basis.
- **Occupational Therapist** – Functional assessment including environment, regaining independence.
- **Physio Therapist**– Functional assessment including addressing muscle weakness. Complex case management

Community Reablement Practitioner

- ✓ Provide personal care and support with a reablement focus
- ✓ Assess the reablement needs and identify a support plan with input from other Reablement team members
- ✓ Implement the plan with a focus on using community support to reduce isolation and improve wellbeing as well as physical tasks
- ✓ Use innovative ways to maximise the persons quality of life, reduce social isolation and improve wellbeing
- ✓ Ability to effect change
- ✓ Monitor and review the support plan reducing Community reablement support and replacing with community support
- ✓ Live, constant review process
- ✓ Commissioning / enabling other services were appropriate
- ✓ Making referrals for other services to meet health and wellbeing needs where appropriate
- ✓ Managing the case until the point that it can be closed to Community reablement

Section 4

FINANCIAL

Adult Social Care Community Reablement Model

Post	Grade	No of Hrs	Headcount	Basic	NI @ 13.8%	Pension @ 18.7%	Enhancements @ 15%	New	Comments
Registered Manager	PO12	36	1.00	47,573	6,565	8,896	7,136	70,170	
Community Reablement Practitioners	Band H	360	12.00	416,676	57,501	77,918	62,501	614,597	
Estimated Travel costs								33,800	Note 2
Total Staffing								**718,567**	Note 1
Training & Development								**6,500**	Note 3
IT								**10,500**	Note 4
								735,567	

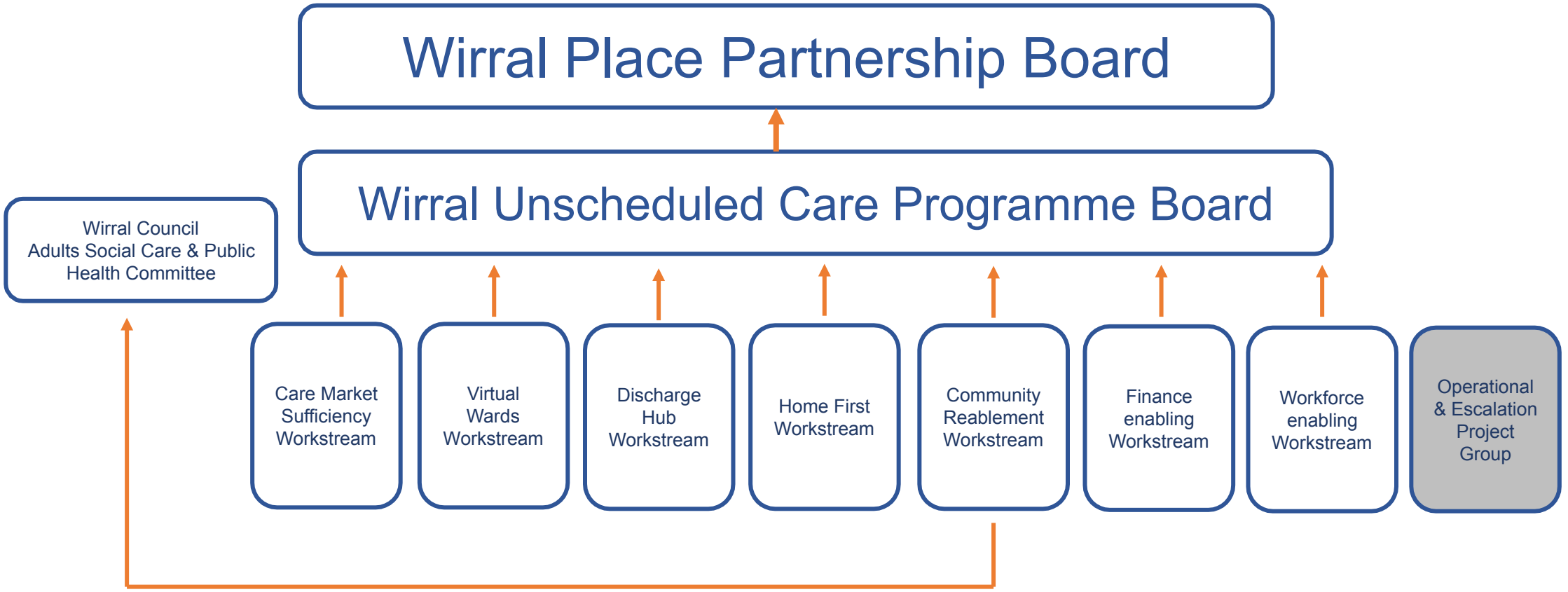
Other factors:	Unit cost	Units	Total Est	
DBS (New)	54.5	13	708.50	Note 5
Uniforms	58.98	13	766.74	Note 6
Mobile phones (handset / fees)	270	13	3,510.00	Note 7
CQC Fees (Capped at 1,700 SU's)	92,558		92,558.00	
Electronic Call & Monitoring Systems				Note 8
			97,543.24	

Notes

1 Costings based on 22-23 grades - will need to consider any 23-24 agreed uplifts
2 Based on £2,600 per fte
3 £500 per person
4 Laptops
5 DBS for new staff
6 Uniform for new staff
7 Handset £150 per person plus network charges = £270 annual cost per person
8 Included in Wirral Independence Service - Medi equip, assistive techology

Section 5

GOVENANCE & REPORTING



To be reviewed in June 2023

Section 6

APPENDIX – Best Practice

To insert Manchester proportionate modelling per activity /Sense check – data around outcomes for Manchester benefits

Adult Social Care Community Reablement Model
Referral flow chart

PLACING OUR RESIDENTS STRENGTH'S AND INDEPENDENCE AT THE CENTRE OF THE SERVICES WE PROVIDE