TO: EMPLOYMENT COMMITTEE
1 JULY 2015

RESTRUCTURING IN ADULT SOCIAL CARE, HEALTH & HOUSING
(Director of Adult Social Care, Health & Housing)

1 PURPOSE OF REPORT

1.1 The purpose of this report is to inform the Employment Committee of the restructuring of the Older People and Long Term Conditions (OPLTC), Community Response & Reablement (CR&R) and The Bridgewell Intermediate Care Unit Teams and seek approval for any redundancies which arise from it to be dealt with by the Chairman and Director. The OPLTC and CR&R teams were consulted on a revised structure and supported person's journey and work is now proceeding on the processes required for the restructure. The implementation date for the new structure is 1 October 2015. Staff at Bridgewell are being consulted on new rotas which will be implemented in September.

2 RECOMMENDATION

That the Employment Committee:

2.1 Note the proposed changes to the ways of working for ASCH&H staff outlined in the report.

2.2 Agree to delegate any redundancies (and their funding from the Structural Changes Reserve) which arise as a result of those changes to the Director in consultation with the Borough Treasurer and the Chairman of the Committee and have those reported back to the next meeting of the Committee.

3 REASONS FOR RECOMMENDATIONS

3.1 A review of the journey by an individual supported by the Council was undertaken in order to remove the need for "hand-offs" from one professional person or group to another so that the individuals experience of Adult Social Care was as smooth as possible. Before the review a person could potentially be passed from one team to another for different social care reasons. This raised the possibility of a service breakdown between teams and any consequent adverse effects on the individual receiving support.

3.2 In addition to this, the process needed addressing to conform to the requirements of the Care Act 2014. The Care Act promotes people's wellbeing, puts individuals in the centre and supports integrated and co-ordinated care

4 ALTERNATIVES OPTIONS CONSIDERED

4.1 Not to introduce the new approaches outlined in the report. However these changes need to happen to conform to the Social Care Act 2014.

5 SUPPORTING INFORMATION

5.1 The restructure into teams, North and South of the Borough, combines the Short Term (CR&R) and the Long Term (OPLTC) teams so that there is a seamless transition between the two. There would also be a Support Co-Ordinator for each person to see them through their journey within Adult Social Care.

5.2 The consultation document which was issued to all staff in OPLTC and CR&R is attached at Appendix 1. This explains in detail the reasons for the reviews and the intended outcomes.

5.3 The restructure is also being made with a view to trying to create some spare capacity to mitigate against the increased costs of the anticipated growth in demand for Adult Social Care assessments that the Care Act reforms due 2016 will bring about.

5.4 There are no redundancies planned for this restructure as there are sufficient posts for the current staff. There will be a need for some team members to upskill and additional training may be required for them. However redeployment or redundancy may arise if any of the roles change to the point where they are not regarded as suitable alternative employment or the individual's skills do not reach the required standard. It is not believed that this would affect any more than one or two people.

5.5 Through annual appraisal, and talent talks, all staff will be encouraged to identify any training/knowledge gaps they have to ensure a planned approach to development in readiness for new roles.

5.6 The consultation at The Bridgewell Centre is as a result of changes to the rotas for day staff and the changes in some roles for supervisors or team leaders. Again, no redundancies or redeployment are envisaged but upskilling of staff is needed and the changes to staff rotas may mean that if some staff cannot work to the new rotas they will be liable to be considered for redeployment or redundancy. The consultation document for the Bridgewell is attached at Appendix 2.

5.7 The need to introduce change is to enable the service to respond to the Joint Commissioning Strategy for Intermediate Care 2015 -2018 and deliver outcomes of the Bridgewell centre review undertaken through 2014.

5.8 As the Employment Committee is not due to meet again until mid October and the implementation dates for these restructurings pre date that meeting, it is requested that if there are any staff losses, these are dealt with by the Chairman and Director.

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 The relevant legal provisions are contained within the main body of the report.

Borough Treasurer

6.2 Whilst no redundancies are planned at this stage of the process the report identifies a risk that redundancies may be required following the review of role changes and skills audit. Any redundancy costs will be met for the Council's Restructuring Fund that is set-up to accommodate such costs.

Equalities Impact Assessment

6.3 As per initial Business Case

Strategic Risk Management Issues

6.4 None identified.

Borough Human Resource Manager

6.5 The matter is being dealt with in accordance with the Council's Protocol on Organisational Change.

7 CONSULTATION

Principal Groups Consulted

7.1 A process of consultation with all the teams affected was undertaken in line with the Organisational Change Protocol, Unison and GMB unions have also been consulted and following their concerns, the initial period of consultation was extended. Berkshire Health Foundation Trust are a partnership organisation who have also been consulted for matters concerning NHS employees.

Contact for Further Information

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Appendix 1

Staff Consultation

Introduction

All Adult Social Care and Health staff will be aware of the RIE (Rapid Improvement Event) week that took place in March. As a reminder, the focus of this was to identify issues that were having an adverse impact on staff being able to provide people with as smooth and problem free experience of Adult Social Care as possible. The arrangements we were looking at were – in the main – those for older people, and people with long term conditions, so the main teams affected were

- CR&R (assessment and planning functions, so excluding Bridgewell and the Community ICS service),
- OPLTC
- CHMT-OA.

Some of the issues that were identified during the week could be addressed quickly whilst others required further in-depth analysis and consideration. There are also significant changes required in response to the Care Act, and this has been an opportunity to incorporate all developments in one major project.

What was found

One of the main common themes was the number of "hand-offs" experienced by people when they are referred to the Department. Many people are passed from one team or practitioner to another, numerous times, with the potential for delays, misunderstandings, poor communication, repeated information gathering and assessment, with nobody being responsible for coordinating the "journey" through assessment, support planning and implementation of those plans. There were many examples given of how people have had poor experiences as a result, some of which resulted in safeguarding concerns. Practitioners were not able to be person-centred in their approaches and solutions, and it was clear that not all staff felt they were able to do as good a job as they would like to do. It was clear that the organisational arrangements, the wide range of roles, and business processes that have developed over a number of years are no longer "fit for purpose" and need to change in order to enable practitioners to support people to achieve their required outcomes.

What was agreed

It was agreed that every person needing support (including carers), whether the support was needed in the short term or long term would be allocated a practitioner who would be responsible for coordinating assessments, plans and implementation, and wherever possible, would remain the named contact person for as long as required. This includes the coordination of hospital discharge and intermediate care provision.

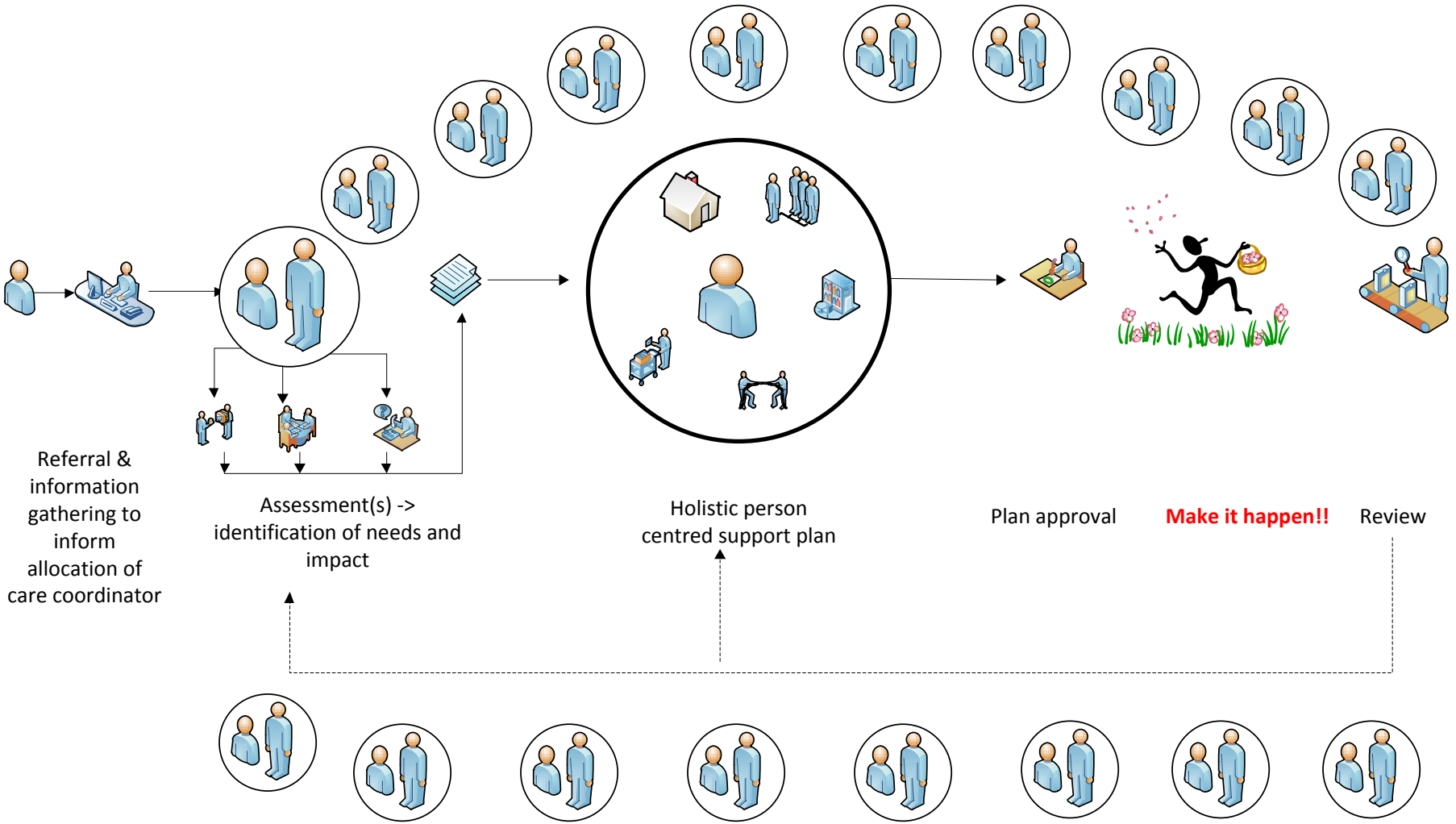
There were a number of workstreams arising from the RIE work, looking at documentation, business processes, LAS configuration, training needs etc., and staff have been kept involved and/or informed as appropriate throughout.

Outcomes

One major work stream has focussed on what staffing resources are required and how those resources need to be organised to ensure that staff are able to offer the best service possible. This consultation presents those proposals, which have been developed following

- the principles outlined above, which are in line with the person-centred, outcome focussed requirements of the Care Act
- analysis of current demand, based on whether people have needed
    - short term support only, including basis equipment
    - long term support, including basic equipment
    - long term support responding to complex needs and/or circumstances
    - specialist therapy assessment and associated provision.

Customer “journey”



Proposed Staff Organisation

Principle:-

- Every person should have one practitioner coordinating all stages of their "journey", unless a change is dictated by a change in needs or circumstances, or staff turnover.

Implications:-

- Staff need to be organised in such a way as to ensure that each team has the appropriate resource levels and expertise to facilitate that journey without unnecessary hand-overs to other teams. Teams within OPLTC will therefore be organised on a geographical basis, rather than on the basis of a specific function or sub-function.
- CMHT-OA will have an appropriate level of resource and training to enable them to coordinate hospital discharge and the use of Intermediate Care provision.
- The range of practitioner roles will be reduced, and each role/JD will reflect the principles above. Allocation of practitioner to a person requiring assessment will be according to the anticipated complexity of the person's needs and circumstances.
- The practitioner allocated to a person will remain the named contact for the time that support is required, and will carry out all reviews and respond to contacts between reviews.
- Intermediate Care is a **function** not a specific team/service, and the responsibilities associated with this will be devolved to each team as appropriate.
- Provider services (Bridgewell, Heathlands and Community ICS team) will not be managed by a Community Services Manager (CSM). Registered managers are peers of the CSMs. Any team will be able to refer to those services.
- The management "location" (i.e. North or South teams) of the sensory needs service, falls service and Blue Badge assessments is not finalised.
- The role of senior practitioner is a job within a structure, and as such must be applied for when a vacancy arises, as with any other role. It is not a status to be awarded on achievement of competencies.

Other Points

- The Duty/triage function will be carried out by staff on a rota basis.
- Training has been arranged in relation to Care Act responsibilities, including the requirement for personalised approaches. All staff should have been booked on. "Person-centred in all we do"
- Business processes must change in the light of Care Act requirements, and workshops to enable staff to understand those business processes are being arranged to run in conjunction with "Person-centred in all we do"

Frequently asked questions

Q. What happens if the allocated practitioner is not able to respond to an urgent contact?

A. It is recognised that there will inevitably be times when an allocated practitioner will not able to respond to a contact in relation to someone to whom they are allocated but is "dormant", and a response may be needed by another practitioner. However, the original person should take over as soon as possible unless it is clear that it is more appropriate that another practitioner or team should be allocated in response to changing needs.

Q How many people would a practitioner be the coordinator for?

A The figures below are obviously approximate, and relate to 1 x FTE staff.

	Active coordination required	"Dormant"
Support coordinators (Straightforward/short term only support)	16	33
Support Coordinators- Complex Social Care	16	33
Support Coordinators - Complex Therapy	8*	16
Senior Support Coordinators	5**	5

*reflects the fact that therapists will be carrying out assessments for people for whom they are not coordinator

** and a supervisory ratio of c1:5

Q Why are the OPLTC teams "North" and "South"?

A The numbers of people involved mean that one team would be too big to manage. Because of the fundamental principle that one practitioner coordinates the work for a person throughout their "journey", it would be inappropriate to split the teams according to function. More and more work is being done in partnership with NHS colleagues, and therefore the teams are "groups" in alignment with the GP clusters. Adding the people from the Ascot practices to the people from the "North" cluster means that the teams will have roughly equal demand. However, as this analysis of demand was over a short time period, it will need to be reviewed regularly to ensure that resources are organised appropriately.

Q What about other Community teams?

A All other Community teams already work according to the principles outlined above: one allocated coordinator. There will need to be some further examination of some roles to ensure consistency. However, given that CMHT-OA have assumed responsibility for a large number of people from OPLTC, and that they will have

greater responsibility in coordinating hospital discharges for people they are supporting, there will need to be a transfer of resource and addition of therapy to reflect this. This could be vacancy or somebody who wishes to be considered for this opportunity. They are included in this consultation

Q What about Heathlands, Bridgewell and the Intermediate Care Community Team?

A There will be no changes to the functions of these services as a result of this workforce strategy. Each could be managed by either of the Heads of Service, and the location of the provider of the GP contract for Bridgewell may influence the final decision. Any team can make referrals to any of the services using the current referral processes. The Sensory needs service, falls service and blue badge assessments will also be separate

Q How will Hospital discharge work?

A There are a number of operational details that will be worked through, but the principle of one coordinator should still apply. There will need to be somebody responsible for maintaining information on who is in hospital, and their likely discharge date, but the arrangement of support on leaving hospital should be with an existing coordinator of the person is known to the Council.

Q How will referrals for a specialist assessment be made?

A There are a number of operational issues that will need to be determined, and staff will have the opportunity to contribute to developing appropriate procedures. However, these should be consistent for all teams where appropriate.

Q How will Safeguarding alerts be dealt with?

A Each team will have DSMs, and will respond to Safeguarding alerts for the area that they cover, following the same process as they do now.

Q If a person's needs change, and they would be better supported by another team, how will they be transferred?

Staff Consultation **Appendix 2**

Introduction

In December 2014 the Joint Commissioning Strategy for Intermediate Care 2015 – 2018 was agreed by Council Executive and Bracknell & Ascot Clinical Commissioning Group (BACCG).

This strategy builds on the successful approach to the provision of Intermediate Care currently provided by the Council in partnership with Berkshire Healthcare NHS Trust (BHFT), and which is jointly commissioned between the Council and BACCG. Specifically this strategy sets the strategic direction for people who require Intermediate Care and their carers continues to reflect:-

- The needs of people concerned
- National strategic direction
- Recognised best practice

The strategy alongside the review of Bridgewell Centre through 2014 informed the newly developed service specification for Bridgewell Centre whilst also establishing the need for a revision of care governance arrangements for the onward delivery of the service.

Some of the issues that were identified during the review could be addressed quickly whilst others required further consideration in light of the new service specification for Bridgewell.

What was found:-

Through the review and thus development of the new service specification the following has been identified:

- The present working rota pattern does not meet new working time regulations.

- The need for introducing a Care Dependency Tool based on best practice benchmarking across rehabilitation wards around the country that have similar dependency of 'individuals' to Bridgewell Centre. This has meant that staffing ratios in response to 'dependency' and need has had to evolve to effectively meet people's needs. **(Already implemented)**

- The current staff skill mix is not balanced which can result in an imbalance in skills and competency on shift compromising the Centre's ability to consistently provide high quality support. For example, on some days a Duty officer, two Senior Support Workers and a couple of Support Workers could be on duty and other times there might be a Senior Support Worker and 4 or 5 Support Workers. Senior Support staff currently act as both duty officers and support staff which does not optimise their competency set.

- Change in staff work locations. Bridgewell Centre building is not fit for purpose; the facilities do not effectively facilitate and support people with their reablement goals.

Outcomes & Proposals:-

As you might imagine there has been a great deal of focus on what staffing resources are required and how those resources need to be organised to ensure that staff are able to offer the best service possible and help with meeting the new service specification. This consultation presents those proposals:-

- A new working rota pattern that meets requirements of the working time regulations.
- Maintaining and sustaining the use of the Care Dependency Tool.
- A change in staffing establishment and structure. The permanent introduction of a revised staffing structure, job roles and skill mix in to Bridgewell Centre will meet the requirements of the newly commissioned specification and further complement and improve the quality, coordination and operational efficiency of the service.
- The Bridgewell 'service' is relocated to a more appropriate building fit for purpose within Bracknell Forest. The change in work 'locations' includes Support Worker staff becoming Reablement Support Workers so they can be asked to work as part of the registered intermediate community service.

Proposed Staff Organisation

Staff will need to be organised in such a way as to provide ongoing management oversight whilst also ensuring that each 'shift' has the appropriate resource levels and expertise to facilitate effective, person centred intermediate care.

Implications:-

a) The present Assistant Unit Manager post will be assimilated in to the Duty Senior Co-ordinator role. The reason for this is that:-

b) The Duty Senior Co-ordinator posts will have increased recognised responsibilities. The current role holds the responsibility for the day to day running of the shift but this is not reflected in the job description that is currently in place. The new job description will provide management with a tool to support staff to reach their potential through clearly defined responsibilities and meet the management oversight needs of the service.

c) The revised Duty Senior Co-ordinator role / job description and capacity will enable and ensure there is a responsible person on each shift providing robust management oversight.

d) The Senior Support Workers (all NHS Trust staff) will and are having their care competencies re-evaluated and where necessary training will be provided to ensure the service is getting the best value out of the position and the staff themselves, have the opportunity to utilise and practise their full skill set.

e) Support Workers job description will change with more of a focus on reablement and assimilated with community ICS service Reablement Support Workers. This will not only provide the overall intermediate care service with a greater pool of skilled and competent staff, it will also provide the foundation for truly person centred reablement

for people using the service including aspects of daily living, meal preparation, and therapy programs.

f) **Admin staff, Domestic and laundry Assistant as well as Night staff are not affected by the proposed new working pattern rota.**