Appendix 6

Lewisham Future Programme 2015/16 Revenue Budget Savings Report

Mayor and Cabinet 12 November 2014

Healthier Communities Select Committee Referral Responses – A1, A3, A4, A6 and A8.

These responses have previously been shared with the Healthier Communities Select Committee.

A1 - Cost Effective Care Packages

The majority (87%) of the Adult Social Care Net Budget (£79m) is spent on the provision of care to individuals, either in their own homes or in a residential or nursing setting. Before any decision is made on the care and support needs of an individual, and before a care and support plan is prepared, consideration is given to an individual's particular circumstances, and a full assessment or review of the individual's needs is carried out. When deciding how best to meet an individual's social care needs the Council is entitled to take into account its own resources as well as the client's preferences.

At 31/3/2014, Lewisham had provided services to 5,036 people during the year. At any one point in time during the year, adult social care supports approximately 3,400 adult service users and their carers. The difference in the two figures can be explained by the following:

- some people only receive enablement services for a short time after discharge from hospital;
- others are reviewed and no longer need their care because their situation has changed;
- people move out of the borough;
- sadly, others die.

Of the 3,400, around 650 are placed in either Residential Care or Nursing Care, the remaining 2,750 have services that support them in the community.

To achieve efficiencies and to ensure that support and care is provided in a consistent and equitable way for all client groups, we must:

- Encourage people, where appropriate, to take more responsibility for their own care and to use their existing resources, whether financial, social or otherwise, to achieve their stated outcomes. We must help people to help themselves by promoting access to universal services and by linking them to support available to them within their own families and communities.
- Refine an assessment model that takes greater account of personal assets and the contributions an individual can make to ensure their needs are met in ways which they prefer and choose for themselves.

- Develop the use of prevention and short term early intervention services which enable people to maintain and regain independence reducing people's need for and reliance on long term care and support;
- Establish different ways in which residents can select and pay for their care. This requires commissioning models of care that meet a wider array of the outcomes that residents are looking for. Historically people have had to mould their needs and stated outcomes into what was on offer – rather than the offer being flexible enough to meet very different needs.
- Ensure all assessment and support planning staff and providers work with service users in ways that reduces dependency and promotes independence, ensures safety, and supports recovery;

Assessments and reviews and possible changes to packages of care

Any decision as to whether an individual requires a package of care or a change to their existing level of care can only be made following a community care assessment or review that assesses both need and risk. These assessments or reviews are carried out by care management staff within Adult Social Care. Until an assessment or review has taken place, the number of packages of care that may be changed or reduced cannot be established. The proposed level of savings is therefore based on an estimated change in their care needs.

Annex A provides a number of examples on how costs can change following an assessment or review. Some care packages will of course increase in cost where there is significant increase in a person's needs and where meeting these needs has a cost implication.

Direct Payments

Direct payments allow a service user to purchase services which they have been assessed as needing.

For long term needs, direct payments can be offered so that the person can purchase the unmet needs identified in their Support Plan. Direct payments may be used to enable users to secure assistance with personal and domestic tasks, such as getting in and out of bed, dressing or preparing a meal. It can also be used for one off purchases, such as computers to address social isolation or washing machines to help with laundry.

Direct payments may be used to employ a personal assistant or a carer directly, or to use the services of an agency to provide services. Current advice from the Council's legal department is that direct payments cannot be used to purchase local authority services or paid to family living in the same home as the Service User.

Direct Payment Rates

The breakdown of the current Direct Payment (DP) rate of £11.58 p.h is shown below.

This is designed to allow the service user to employ a Personal Assistant (PA) at London Living Wage rates. Service users are free to choose a care agency as part of their personal

budget (PB) – see below. In these cases we would normally commission and pay the provider directly, not fund it through a DP. Some service users have, however, negotiated their own rates with providers which have allowed them to continue to pay the London Living Wage, in accordance with the direct payment contract with the Council.

As part of our retendering of domiciliary care we will introduce Individual Service Funds which give the user some of the control they have over a directly employed PA but with the resilience of an agency to support them.

Some service users have chosen to use their DPs to purchase care from agencies that are not on our framework. The contract that we have with our service users to take Direct Payments stipulates that they are obliged to ensure London Living Wage is paid for any care received.

Lewisham DP Rate Increases 2014-15

Lewisham 2014-2015 **DP Standard Rates**		
	COSTS	
Hourly Rate	**£8.80**	This is the new LLW rate for workers which we will pay from 6 April
Annual Leave	*£0.95*	This amount builds up to pay for 4 weeks annual leave each year
Employers NI	*£1.13*	This amount pays for the employers NI contributions
Public Holiday	*£0.19*	This amount builds up to pay for extra costs on public holidays x8 per year
Contingency	*£0.51*	This is for emergencies and insurance renewal that occur during the year
TOTAL DP	***£11.58***	This is the DP rate payable by Lewisham (minus any personal contributions)

Examples on how service users are using their Direct Payments is shown at Annex B.

Personal Budgets

Personal Budgets have grown directly as a result of effective lobbying from service user led organisations, and evolved from Direct Payments, which have been mandatory for Local Authorities to offer since the early 1990s.

The term 'Personal Budget' is really an umbrella term that covers

1. Direct Payments, where people get Council funding in cash, which they then spend on their care
2. Managed Accounts, where people agree their care arrangements with the Council, who supply the services through their contracted providers
3. Individual Service Funds, where the Council passes the care budget for a person to the provider of their choice, and the person and the provider agree the care arrangements.

As mentioned above, people using Direct Payments often employ qualified Personal Assistants, or buy support from established care agencies. However, some people use them more creatively to get support from people they know already, or do activities like – going to a pub, or a park.

Evidence shows that many people using Direct Payments get better outcomes and are more satisfied. There are many reasons for this, and not everyone benefits to the same extent. However, Councils will always have a vital role in helping people to plan and manage a Direct Payment safely and effectively.

'Managed Accounts' and 'Individual Service Funds' can sound technical, but their principle is simply to allow people to tailor their support without having to take a Direct Payment. Often, they allow people to make small changes – who comes into their house to help them wash next week; or to stipulate what time they go to bed on Sunday nights – that allow people more dignity and which councils cannot know and organise for everyone. The Domiciliary care providers are working with us to develop further this more flexible person centred model of support.

The Care Act rewrites the law on social care in England. It has been developed in close partnership between Local Authorities, Central Government, user/carer groups and the Voluntary Sector. The statutory guidance to Councils states: -

> "*Everyone whose needs are met by the local authority... must receive a personal budget as part of the care and support plan...*"
>
> "*At all times, the wishes of the person must be considered and respected. For example, the personal budget should not assume that people are forced to accept specific care options...*"

Councils still have extensive responsibilities to make sure that eligible care needs are met by quality services. However, in respecting the rights and dignity of disabled people, and those

unable to care for themselves we must by law allow them to take part in the decision making and purchasing of the care and support they use.

Provision of hot meals

The numbers of people choosing meals on wheels has vastly decreased over the last 3 years. We have seen the numbers of meals provided to Service Users in their own home reduce from 97,000 to 54,000 meals per year. This number continues to decrease; the reasons for this include:

- Improvements in ready meals available from supermarkets;
- Increased delivery options from Café's and Takeaway food outlets;
- An increase in those needing intensive care packages which means a carer is available at meal times to prepare food.

Other authorities have notified similar trends. The service users and their families have very much influenced the future shape of this market by responding to different options available. People are given information on how to directly purchase from specialist MoW providers such as Apetito or Wiltshire Farm Foods.

Currently 300 people receive a hot meal delivered to their own home or Day Centre. Of these, 263 (88%) are also in receipt of another service such as day care, personal care or a direct payment. Food preparation is a core task already provided by care agencies, and no additional training is therefore needed to take in this role if required.

There are 37 people who receive a hot meal only; of these, 15 are carers services where the full time carers have other commitments, the others are currently being reviewed. There are another 15 people who only get a meal when they attend day centres, these are also being reviewed to look at alternative ways of providing meals. To date, people have chosen to have support to have their meal in a café as an alternative to a delivered meal.

Hot Meals Summary

	Budget
Expenditure	314,700
Income	247,800
Cost to Council	66,900

Day Centre Meals Summary

	Budget
Day Centre 1- Expenditure	48,300
Day Centre 1 - Income	- 26,000
Day Centre 2 - Expenditure	34,300
Day Centre 2 - Income	- 17,900
Day Centre 3 - Expenditure	55,000
Day Centre 3 - Income	- 29,800
Cost to Council	63,900

The proposal is:

- Not to retender the current Mow contract, but to continue to provide information on how this service can be purchased by individuals.

- Increase the use of Direct payments/ Personal budgets and work with local cafés and restaurants to develop the market so that people have more choice regarding meal delivery options. This will include meals provided at Day Centres.

Laundry

This service was transferred from Health over 20 years ago at a time when incontinence care was not as effective as it is now and when there was more limited use at home of a washing machine. Currently 100 people are in receipt of the laundry service commissioned by the Council. Of these, 93% are also in receipt of domiciliary care or a direct payment. The Council spends approximately 89k per year on the laundry contract.

As most homes now have washing machines or access to local Laundry facilities.

The proposal is to:

- Not retender the current Laundry contract;
- Ensure Support plans incorporate laundry duties as a standard, so that washing machines in the home are the first choice or are linked to any shopping services, i.e. the laundry can be dropped off at a laundry on the way to collect milk, bread, etc;
- Make use of local laundry services who collect, wash, dry and return for an average of £10 per wash load and use a Direct payment to meet this cost if the needs are eligible;
- Provide one off Direct Payments where help is needed to purchase any washing machines.

Annex A – Examples of care packages which have reduced costs following review.

J

Adult with a learning disability, male age 24, high functioning, in care since a child, went into residential care placement on the South Coast as an adult, funded by Lewisham.

The 2011 review of care whilst in residential placement found that he was unhappy with his life in that environment.

After much work to remedy this situation by the team it was found J wanted to live a more independent life. Over a period of 18 months of working with the team J secured a home in the private rented sector on the South Coast, he used housing benefit and his other state benefits to contribute toward setting up a new home and he had a small care package of carer visits daily.

After a further review at 2 years he decided that he wanted to live permanently in that South Coast borough, which has happened.

Care Package and Changes:-
2011 Residential weekly cost- £1,200 per week
2013 Reduced to care package cost of 14 hours per week- £220
2014 Now nil cost as J is now a resident of this South Coast borough

Outcomes for J
Lives independently now with help from staff, alone in his own home, attends college, is volunteering in the Gaming shop his passion, and mixing on an everyday basis in his community.

JM

JM, female aged 76, lives north of borough, with son as main carer, has significant cognitive impairment. Her son called the duty desk 6 months ago to say JM was getting fed up and becoming tearful, and that he as the carer was struggling to cope as it was getting him down. The team assessed both the client, and the son as carer and identified that some sort of day activity, and memory service help would be beneficial to give her a change, assess her mental health and to give the son a break.

At assessment it emerged that she was resistant to outside help but was able to self care with prompting from her son, had friends locally who she had not seen for a long time, and that she knew the Deptford area well. However, she could not be left alone at all night or day as her dementia had deteriorated and her short term memory was poor. She was encouraged to consider going once a week to a free lunch club for 3 hours every week in the local community centre. To do this she needed help, both to get there, remain there and be safe, and to get back home. In consideration of this fact she was awarded a direct payment for 3 hours per week and would use her own resources to pay for lunch there. She was supported to identify a carer from the personal assistant bank and this is now working well.

Assistive technology was installed to keep her safe and monitor her movements if the carer popped out.

Care Package and Changes:-
2012 no services
2013 £35 per week for a personal assistant to support to attend lunch club locally - this was where her old friends were meeting too.
This care package avoids the need to attend a traditional day centre attendance, at a unit cost in the region of £100 per day.

Outcomes for JM:
Supported to remain in the community living with her son in a familiar environment and able to pick up on her old friendship networks.
Carer gets a regular weekly break.
JM becomes familiar with accepting outside help in case her care needs increase in the future.

AN

Female aged 40, living with partner and autistic son in a Lewisham Home's property. She had a road traffic accident about 3 years ago and was in hospital for a while. Although she could stand up and mobilise short distances, she needed help with all her activities of daily living because of significant nerve and muscle damage. She and her family had significant support from occupational therapy services with moving to an adapted property, where there was a good range of aids and adaptations made available. On leaving hospital she had a care package of 21 hours a week of personal care, with some domestic support of 1 hour per week to help keep the home tidy and was supported to apply for additional disability related benefits to help the household finances now she could not work. Her partner carried out all other tasks. During this time she had a number of other therapeutic interventions to help increase her independence.

Through the ongoing process of annual review the care package continued to be reduced to remain relevant and appropriate to meet her needs. Today she has difficulties with some of her activities of daily living but she has recovered some of her former strength and ability.

Care Package and Changes

3 years ago on discharge from hospital 21 hours of personal care plus 1 hour domestic help, at a cost of £350 pw
2 years ago- reduced to 14 hours plus 1 hour domestic help at a cost of £200 pw

Now – reduced to 6 hours with domestic help of 5 hour at a cost of £100 pw

Outcomes for AN
Tailored package of care to suit improving ability to self care, increased confidence due to improved independence, greater ability to participate in family and community life. Now volunteering as a way to get back into the workplace.

Mrs BW

Mrs BW, age 82 lives at home with her daughter, who is also her informal carer. Her daughter works full time and prepares/
cooks main meal in the evening. Daughter also carries out all day to day activities like housework.

Mrs BW was admitted to University Hospital Lewisham (UHL) 2 years ago following a major stroke, which resulted in cognitive impairment, confusion, reduced mobility, left sided weakness, left sided inattention, visual impairment, reduced self-help skills and double incontinence. Mrs BW had difficulty with swallowing and was at risk of choking so all her food needed to be soft.

Mrs BW was discharged home with a care package of 2 carers per visit – 4 calls a day 7 days a week. She was unable to weight bear or mobilise and needed assistance of two with all aspects of personal care and mobility.

Action Plan identified at review to assist Mrs BW regain some of her former abilities
Referral to LATT (Lewisham's physiotherapy team) for mobility programme. Encourage enablement self-help outcomes within the care package i.e. Mrs BW to wash and cream top half of her body herself, for her to help with moving on the bed and for her to mobilise with walking frame over short distances.

Care Package and Changes
Two years ago care package 4 visits daily and 2 carers each visit costing £500 per week
Today reduced to single person care visits at £250 per week

Outcomes for Mrs BW
Mrs BW completed a mobility programme with physiotherapist and her mobility has improved. She is able to transfer assisted by one person and is able to walk a few paces with her walking frame and with supervision. Mrs BW is independent to wash her face and hands now. Continues to live with her daughter in their home in the community.

DW& MM

During our review of a day centre provision, these 2 ladies came to our attention. Both had been attending the same day centre for 4 years, 1 day per week each. They both stated that they only came to the centre so that they could meet each other and have lunch together. They had been friends for many years and did this when they were independent. They stated that they did not use any of the other facilities of the day centre, but this was the only regular social contact they both had.

They both agreed that they would be happy to consider other options as long as it meant that they could meet up regularly. Our Support and Review officer worked with the ladies and both were given a DP of 2 hours per week each to meet their social isolation need. With help of a PA that they both share on their weekly outings, both ladies now visit

different café's & restaurants of their choice, the PA picks them both up, escorts them throughout the meal and ensures that they get back safely home and settled.

Care Package and Changes
Both ladies had 1 day at day care plus day centre meal – 2 x £100 per day = £200 per week, plus use of Borough Transport

They now each receive £23.16 direct payment per week = £46.32, they pay for their meal and no Borough Transport is used.

SM

SM is a 72 year old lady who lives in sheltered accommodation, when she originally took on the tenancy, there was a communal laundry room. The communal laundry room had not functioned for over 3 years. At an assessment 2 years ago, to support SM laundry needs, a service was set up to weekly collect her laundry, wash, dry and return the following week.

SM detailed in her recent assessment that she would be able to do her own laundry, but she has no access to a washing machine and is unable to take it to a local laundrette as her mobility was poor.

We agreed a one off direct payment that included installation of a washing machine in her home with a 3 year service warrantee.

SM now carries out her own laundry as is no longer in receipt of ongoing services.

Care Package and Changes
Previous, bag of laundry collected and returned 1 collection x 52 weeks = £840
One off direct payment £370, no ongoing service.

A3 - Changes to Sensory Service Provision

Lewisham provides sensory services to a range of people, these include:

- People who are blind/severely sight impaired or partially sighted /sight impaired (Visual impairment)
- People who are Deaf - those who (even with a hearing aid) have little or no useful hearing)
- People who are hearing impaired - those who (with or without a hearing aid) have some useful hearing and whose normal method of communication is by speech, listening and lip reading
- People who have a dual sensory impairment including those who are deaf/blind

Lewisham currently has 2,517 people registered as having a sensory disability. Of these 409 receive ongoing services (16%), and of these 266 are people over the age of 65 (65%). The majority of people in the under 65 age group will have been born with a sensory impairment, or will have developed impairment during childhood and early teens. For a small majority of younger adults their impairment will be caused through accidents or illnesses such as strokes.

The highest number of people affected by a sensory impairment are in the 65 plus age group, for most people sensory impairment is due to the ageing process and onset of illness/illnesses such as macular degeneration or diabetes.

Policy requirements

In considering any changes to sensory services officers have been mindful of the requirements of the Care Act which requires councils to ensure access to information and advice, provide prevention and early intervention services to facilitate other forms of self-help and self-identification of need and meet the vision for personalisation.

Current service

Lewisham has been at the forefront of providing specialist information and advice services in a range of communication methods including British Sign Language (BSL), which is provided by suitably qualified staff as part of the Council's Customer service provision (Access Point). A camera is also installed in customer services giving access to a remotely accessed sign language interpreter. This allows staff from all areas of the council to communicate to deaf people who use BSL as their first language.

In addition to the information and advice services provided within Customer Services, people with a sensory impairment are also supported by teams within adult social care. Two teams a) Visual Impairment (VI) and b) Deaf and Hard of Hearing (D&HoH) operate currently as stand-alone teams. The contacts and referrals for these teams come from across the adult social care system and include referrals from the Social care information and advice team (SCAIT), the hospital discharge service, intermediate care or Social Workers in other

teams. The two sensory teams are made up of 14 staff (10.5 FTE) that carry out a variety of functions including:

- Social Work
- Information and Advice/support work
- Equipment ordering, installing and training
- Rehabilitation and Mobility Training

Proposals for new service

The new model will ensure that where appropriate people with a sensory impairment have continued good access to information and advice, and that their needs are met at the earliest stage possible and in the most efficient manner. Rehabilitation services will continue to be provided to people who are newly diagnosed with a visual impairment and /or dual sensory loss. There will continue to be specialist social work practitioners to support young people who transition from CYP services.

The proposal plans to improve services by:

- Improving accessible information and advice;
- Giving swifter access to equipment and technology aids;
- Streamlining access to enablement/rehabilitation* services;
- Reducing the number of times service users need to give information;
- Giving more choice and control to the user on how their rehabilitation and training needs should be met;
- For users with high needs and young adults reaching adulthood, improving access to specialist qualified staff.

  * services which are provided for a limited period of time to people diagnosed with a visual impairment to help them regain or maximise their independence.

The proposal for the development of the new service model has four elements as described below:

Advice and Information

As mentioned above, the provision of information and advice is a key part of the Care Act. The BSL trained officer within Customer Services currently has contact with over 170 people with sensory impairments per month (2100 per year) asking for support on a wide range of issues, such as completing forms, letter writing, and providing information on local and council services. In addition, staff are trained within the Social Care Information and Advice team as well as within the Care Management teams.

As part of the integration project, a new website is being created bringing together information from the Council, Health, users and the community. There are plans to have the most relevant areas of the site interpreted in British Sign Language via video clip (BSL). In addition, there will also be information available in Braille.

All of the existing BSL information and advice support detailed above will be retained. Within the new model, the plan is to enhance this area by further developing information and tools to support self help and by ensuring good access to information. This will ensure people with sensory impairment receive high quality information and advice at an early stage of contact with the Council.

Enablement support/ rehabilitation/ provision of equipment

In the new model, BSL trained staff will be available to provide enablement to deaf people who are based on hospital wards and awaiting discharge. They will also be available during core hours to support deaf people who are at high risk of going into hospital (admission avoidance).

For people who require equipment, an assessment for specialist sensory equipment to support independence will be provided by trained Trusted Assessors within the Enablement service. This will ensure that the provision of equipment can be linked into the wider assessment of a person's needs.

Sight/Guidance

In the current structure, staff undertake rehabilitation work and communication /guide work for people who have a dual sensory impairment.

It is recognised that people should have more choice over the purchasing and delivery of rehabilitation and guide/communication support. In future, users will be supported to access a direct payment which will enable them to purchase specialist support through organisations such as Sense, RNIB and other local and national sensory providers.
We are in discussions with LB Greenwich and LB Bromley to look at how we can further increase this provision locally across the three boroughs.

Social Work (Transitions and support to people who require statutory social work support.

It is recognised that those people with a sensory impairment who require statutory social work support often have other support needs such as mental illness, a learning disability or are transitioning from children's services. There will continue to be specialist practitioners in the proposed model to provide this support to the care management teams.

Achievement of savings

The saving proposed will be achieved through a reorganisation of the existing staffing to better align resources to the model outlined above with a reduction in the overall staffing costs. Subject to the outcome of a formal consultation with staff this is likely to include:

- Some staff moving to the Enablement Service, where further training will be given
- Specialist Social Work staff moving into the Neighbourhood teams.
- A reduction in the overall number of staff within this service

A4 - Remodelling Building Based Day Services

At the time that the Hughesfield Centre closed there were 19 people attending for a total of 29 days per week. Following closure, 12 people attended the Council's in-house provision, mainly at Mulberry and Ladywell, for a total of 18 days per week.

Seven people used other providers of day services in the borough for a total of 11 days per week. For 5 of these their replacement service is delivered from other buildings but not day centres (e.g. the M'Eating Place café).

The replacement service for the remaining 2 people is delivered in community based locations, and one of these has opted to take their one day a week as a Direct Payment.

A6 and A8 - Public Health Programme Review

Access to advice services is one of four themes within the main grants programme and will continue to receive a significant proportion of the grants budget. The grants criteria provide scope for advice agencies to work with us to design the most effective and efficient use of our shared resources. It will be important to ensure that advice services are linked to the integrated health and social care neighbourhoods to ensure that the most vulnerable clients and those with co-morbidities are able to access services.

At present the provision is delivered through 12 GP surgeries and therefore leaves gaps in access to provision for residents who are not registered with these GP practices. GPs will be able to refer to the new neighbourhood bases.

For further information please contact either Joan Hutton, Head of Adult Social Care on 020 8314 6304 or joan.hutton@lewisham.gov.uk, or Dee Carlin, Head of Joint Commissioning on 020 8314 9863 or dee.carlin@nhs.net.