Appendix B

Practice Challenge Group – Health Select Commission 2/3/2017

Background

The Practice Challenge Group (PCG) was introduced to further develop and support social work practice and support a strengths based approach to social work and to reinforce and support practice as defined by the Care Act 2014. This in turn will ensure a holistic approach with customers and carers. Furthermore prevention and wellbeing will be the cornerstone of practice within RMBC

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The group provides an opportunity to discuss cases, support the development of practice and decision making to ensure an asset, individualised solution is provided. The process ensures those with eligible adult care needs presented to the group are provided with proportionate support and services to promote and maximise independence in a person centred, strengths based approach.

The PCG meetings provide an opportunity to support practitioners to fully explore community based assets, to provide an opportunity to be creative in meeting needs and doing something different alongside gaining intelligence to help understand and support the business.

The development of the group supported data being produced and a tracker was developed to understand activity support to the workforce including training and development. Rather than taking minutes, data is recorded on to the tracker (a spreadsheet) and outcomes of the meetings are captured on the Adult Care system to enable timely sharing with the allocated worker for action.

Data on the tracker is analysed on a monthly basis and fed in to the Housing and Adult Care Directorate Leadership Team. Part of the process affords opportunities to promote good practice and use good examples to support developing a learning environment, sharing best practice throughout the service.

The information recorded captures key intelligence of the business and builds a weekly picture of activity in relation to;

- To support embedding the Care Act principles
- Personalised and creative options
- To support community solutions and appropriate use of residential care if needed
- Number of cases at each PCG meeting
- Number of new cases
- Number of existing cases and what services/support a person is currently receiving and the cost of current care package
- What services are being proposed and the cost of this care package
- Whether the case is agreed, deferred or rejected
- If a case is agreed, what the actual package of care is and the actual cost and the date the package of care becomes effective.

The key benefits of tracking this information and having all the information in one place ensures the directorate is able to –

1. Identify areas of good practice and learning points which are fed back to managers to pick up on celebrating good practice, highlight themes and trends and ascertain any training and development opportunities and see a reduction in the number of re-submissions to the PCG
2. Identify whether the Indicative Budget is in line with the actual cost of the package of care
3. Quantify the amount the budget will fluctuate per individual and overall
4. Explain movement in the budget; what is the story behind why spend increases or decreases and map which cohort fluctuations are attached to
5. Track the customer journey in relation to the difference in what a customer is receiving currently, what is being proposed and what is agreed relating to both type of service and cost
6. Capture demand and identify any gaps in provision or capacity issues of providers to deliver support and services; this information will be fed to commissioning to inform and shape the market
7. Over time, identify a movement away from traditional packages of care towards alternative, community based solutions.

Example Analysis: **PCG meeting 18th January 2017**

Number of cases: 14 (4 new, 10 existing)

Re-submissions: 2/14

Outcome: 8 agreed, 6 deferred, 0 rejected

Of the 8 agreed: 4 were increases to the existing package of care which met identified need and 4 were new cases and therefore increases.

Total increase: £1,034.29 p/w

On all occasions the 'proposed' package of care was agreed / became actuals.

Of the 6 deferred: all were existing cases with no identified urgent need

3 were proposing an increase, 1 no change (extend residential care), 1 no costs available, 1 proposing a decrease (clarification required on eligibility).

Reasons for cases being deferred:

- Client views should be articulated in the assessment
- Further information required and clarity on the options in the package of care; more descriptive text needed to explain these options
- Resource Allocation System (RAS) incorrect, Social Prescribing could be considered, input from Dual Sensory Team could be considered

- Unclear pathway; querying Social Worker involvement as case is open to Mental Health Services
- Clarification required on Care Act Eligibility
- Timeliness of the Decision Support Tool for Continuing Health Care, this should have been carried out sooner.