

## **TRANSFORMING SOCIAL CARE**

Report by the Director of Community Services (Interim)  
Executive Member for Health and Adult Community Services

### **Purpose**

To agree the Council approach to the implementation of the Transforming Social Care programme.

### **Action proposed by the Executive Member for Health and Adult Community Services:**

The Executive is requested to:

1. note the progress made so far on delivering Transforming Social Care;
2. agree the key components of the new model of Care; and
3. agree the consultation and engagement process on this new model.

### **Reason for action proposed**

To meet the requirement to implement the national Transforming Social Care programme and to reflect the shaping principles of One Council and Destination Kingston and aim to transform the way Adult Social Care is delivered locally.

## **BACKGROUND**

1. The Transforming Social Care programme is the biggest change to the way Adult Social care is delivered since the Community Care changes in the early 1990's. The aim of the Transformation process is to improve the model of care and support, putting people at the centre of the system and giving them greater choice and control.
2. This major policy change builds on the progressive changes which have seen the move to give individuals greater control over the organisation of their care through the mechanism of Direct Payments. Kingston was one of the early implementers of the Direct Payment scheme in the mid 1990's. A wide range of words and phrases are used when discussing these changes. A glossary, which defines the terms most in use, is at **Annex 1**.
3. The current policy shift was heralded by **Putting People First**. This is a concordat between national and local government and the third and private sectors and was published by the Dept of Health on the 10<sup>th</sup> December 2007. It sets out a clear intent to transform adult social care and support services. It outlines key requirements and milestones for all local authorities to respond more flexibly and creatively to individuals and their families and carers.

*“ Across government, the shared ambition is to put people first through a radical reform of public services, enabling people to live their lives as they wish, confident that services are of high quality, are safe and promote their own individual needs for independence, well being and dignity”*

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4. This was followed by a series of Local Government circulars and further guidance, which set out the deliverables, as outlined by the Department of Health. The four main deliverables are that by April 2011 we:
- provide a more ‘universal response’ to all citizens (including self funders), not just those who would appear eligible for Social Care.
  - provide maximum opportunities for individuals to recover or maintain their independence for as long as possible (reablement) and remain in their own homes for as long as possible. This will involve short term focussed interventions as well as provision of appropriate equipment and assistive technology
  - offer those with long term needs more choice and control about how they are supported to achieve positive outcomes in their life. By April 2011, the provision of ‘Personal Budgets’ is expected to become the norm for people who are eligible for Social Care. This will be measured by a National Indicator (NI130) and every local authority is expected to achieve the following targets:
    - By April 2010 15% of people receiving community based services will be doing so via the Self Directed Support process and a Personal Budget.
    - By April 2011 this target will increase to 30%. This will mean that assessment will be led by the individual and that it focuses on the outcomes that they want to achieve. The person will know the amount of money that is likely to be available to achieve these outcomes. This will be calculated by use of a Resource Allocation System (RAS). People will then have a choice whether they take this amount as a Direct (cash) Payment or that the Council arranges support to that value on their behalf. We need to ensure there is advice and support available to individuals to help them plan their care (Brokerage) and that statutory help is available to those who cannot manage a budget themselves or where things have gone wrong.
  - Develop ‘Social Capital’ – authorities are expected to develop a more flexible Social Care market so that people have real choice about how they wish to spend their allocated budget to meet the outcomes they have identified. It also means ensuring that people have equal access to mainstream services and can engage in their communities as equal and active citizens.
5. The Department of Health has issued a three year grant to local authorities to support this process. The table below outlines the grant given to Kingston.

| 2008/09  | 2009/10  | 2010/11  |
|----------|----------|----------|
| £188,000 | £439,000 | £540,000 |

6. There has been further ongoing guidance from Dept of Health and they have also set key milestones, which local authorities should be hitting. Kingston has plans in place to deliver on all of the milestones within the expected timescales (see **Annex 2** for Dept of Health milestones report)
7. Over the last 18 months there has been concentrated work on developing the building blocks to help us make the change. This builds on longstanding work in

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Kingston, which has emphasised personalisation and choice; particularly through direct payments. The values underpinning this approach are directly related to shaping principles of the One Council approach:

- Prevention
- Personalisation choice and control
- Local Settings
- Working with Partners
- Customer First

8. We have worked with other local authorities to share learning and there has been support from Dept of Health and other national organisations, such as the Social Care institute for Excellence and the Association of Directors of Adult Social Services, to develop best practice and share learning. We have also run a six month Personalisation Pilot within Community Care Services. The aim of the Pilot was to test out the changes and new processes involved. A summary of initial findings are detailed below

#### **PERSONALISATION PILOT: HEADLINE EVALUATION FINDINGS, NOVEMBER 2009**

9. In general, people found that the self directed support process was easy and relevant to their needs. They found that support planning was particularly valuable as they were able to decide on the best way to meet their needs. The people interviewed were all excited about getting their new support in place and seeing what difference it makes to their lives.
10. Care Managers have found that the real value of personalisation lies in being able to work with people in an individualised way. They found this way of working particularly rewarding and are able to see that the potential benefits to people are significant.
11. The pilot team have been able to test the new procedures and resources and have made adjustments to create a practical and meaningful process. Assessment has been streamlined and accurately captures individual needs and the Resource Allocation System has produced consistently appropriate allocations for people to begin planning their support. Support planning, whilst difficult at first, has been particularly valuable in enabling tailored and creative packages of support that have the potential to add real value to people's lives.
12. The pilot team have also worked hard to share learning across the department by joint-working on cases, holding sharing the learning sessions and uploading information to the intranet. They have also just set up a support group to continue this work after the life of the pilot.
13. The pilot has enabled the team to identify actions for further improvement to the process and to ensure that other staff are readily equip to begin working in the new way.
14. A full evaluation of the pilot will be published in February 2010. People who have been through the process will be interviewed in March 2010 to evaluate the impact of self directed support on their lives. The report on outcomes for people will be available in May 2010.

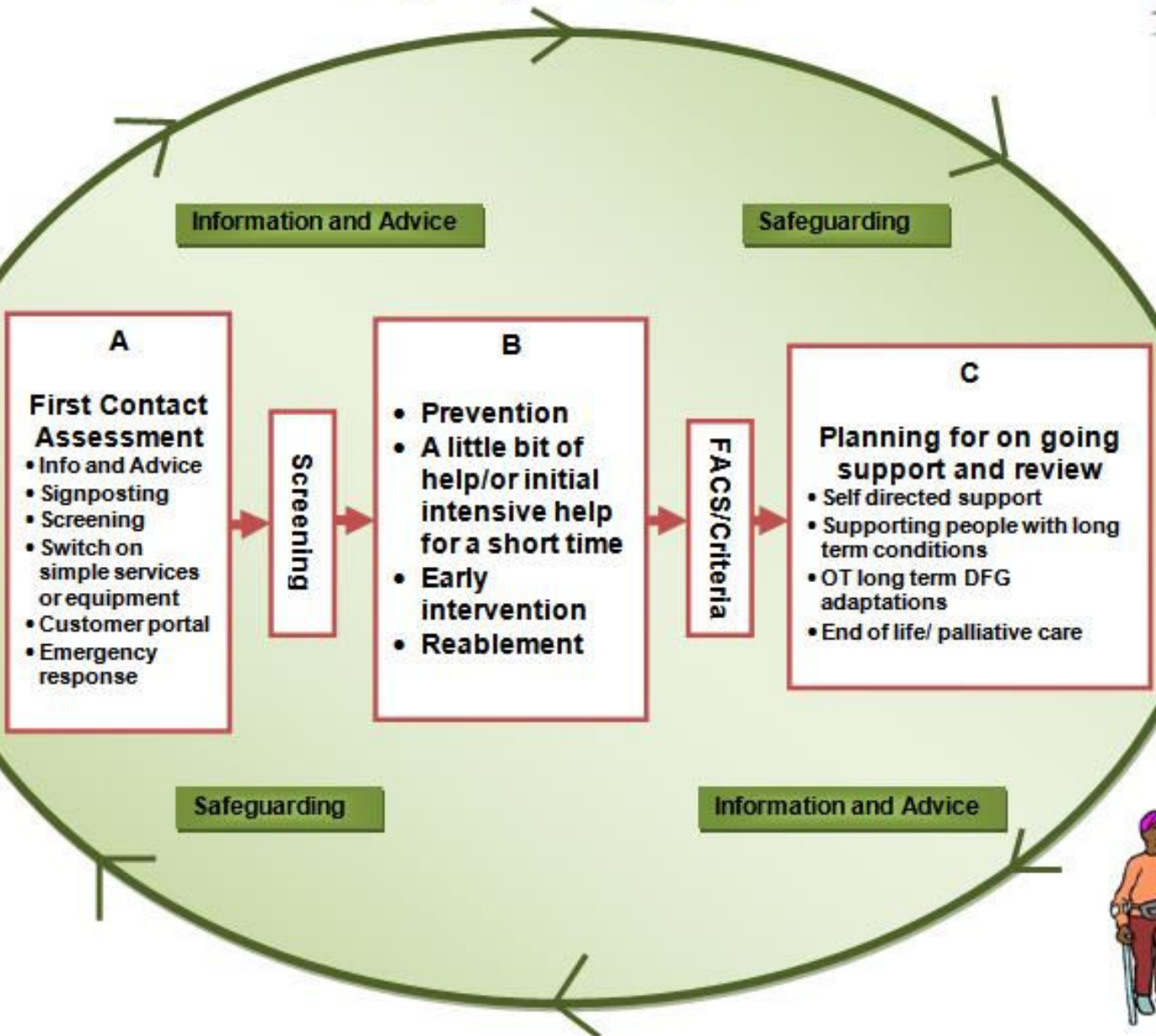
**PROPOSAL**

15. The aim of the change is not only to deliver the personalised model of support, but also to redesign the Community Care structure and pathway to effectively deliver the requirements of Putting People First

*“A system is likely to be most efficient when it is getting the right people at the right time into the right part of the system and produces the best outcomes for people from “Use of Resources in Adult Social Care. Putting people first – a guide for Local Authorities.*

16. Set out in the diagram below is the proposed new model of service, which is Kingston’s local formulation of national policy.

**Target Operating Model**



## **EXPLANATION OF THE DIAGRAM**

17. People would contact and navigate the Social Care system from left to right. It is anticipated that if people are given good information and advice at the front end of the service and that they are given an early opportunity to recover and maintain their independence with the right intervention then there will be a reduced need for longer term support. The skills and structures of future teams will reflect this customer journey.

## **PROPOSED MODEL FOR NEW SERVICES**

18. This section summarises the key features of the three elements. More detail is set out in **Annex 3**

### **A. Information and Access Service**

19. It is proposed that we develop a Single Point of entry for all Adult Social Care (excluding people who are in hospital or people who use Mental Health and Drugs and Alcohol services). This service will be delivered in line with the One Council Customer First Strategy and would form one of the 8 Customer Access Points identified in the Strategy. The Service would involve the transfer of all information, advice and duty functions which are currently based in locality and specialist teams to a team of trained and dedicated Information and Access officers who would have the support and line management of professionally trained staff.

#### **Outcome**

20. Citizens would have equal access to Information and Advice that is timely, proportionate and appropriate to their needs and that those needing further support from Community Care Services would be informed and assisted appropriately. That this would be done in a consistent and efficient manner and that customers would have the majority of their queries resolved at the point of contact (80% resolved within 24 hours)

#### **Principles**

21. The principles are:
  - Advice, information and assessment are proportionate to the level of emerging need.
  - That the right information is given at the right time – ‘get it right first time’ approach
  - Staff have the appropriate skills and knowledge to deliver the right information, advice and support
  - Any intervention is timely and proportionate to need and urgency
  - People are supported to help themselves with the right level of intervention and information

## **B. Reablement Service**

### **Components of the service**

22. The Reablement at Home Service will be the gateway to long term support in Kingston. The aim of the Reablement Service is to work with service users' strengths, abilities and aspirations, intensely and for a short period of time, to enable them to live more independently in their own homes. This would maximise their potential and reduce the need for long term support. The service will provide assistance with personal care and ensure people have access to equipment, telecare and any other support which may increase their level of independence. The service will be delivered by occupational therapists, physiotherapists, and rehabilitation assistants who will work alongside people and support them to manage their conditions. If people have ongoing needs at the end of the period, a rehabilitation / outcome based support plan will be devised with the person and a resource allocation identified to meet the person's ongoing needs.

### **Outcomes of service**

23. The expected outcomes of the service are as follows:
- To maximise an individual's independence in their own home and community environment and increase their ability to manage their own care. Achieve a year on year increase in the number of people supported at home after 91 days after the ceasing of the service.
24. The measurement of success of the service will be based on:
- Reduced dependency for: ongoing support at home, admission to residential and nursing home, admission to hospital.
  - Individual remaining at home 91 days after the service has ceased
  - Improved quality of life. This will be measured through an evidence based quality of life questionnaire which will be provided at the beginning and end of the service.
  - Increased ability to carry out activities of daily living
  - Working with partners. One of the main aims of the new model is to develop reablement in partnership with the NHS, in order to improve outcomes, efficiencies and help people maximise their capabilities. There have already been and are continuing discussion with NHS Kingston on both a commissioning and provider level to ensure we work together to deliver an integrated model.

## **C. Support Service for Older and Disabled People with long term needs (assessment, self directed support and brokerage)**

25. Once people have been through a reablement programme it is anticipated that only people with long term needs would require support from this Service. For example people with dementia or people who are living with the long terms effects of a stroke or other chronic condition.
26. The key features of a personalised service will be:
- Self directed assessment

- Personal Budgets (calculated using a RAS)
- Support Planning and Brokerage
- Safeguarding
- Review

The definitions of these terms are in **Annex 1**.

## **FUNCTION OF THE SUPPORT SERVICE**

27. To facilitate:

### **Self directed assessment**

28. The service will encourage people to lead their own assessments and identify what support they think they need. National guidance suggests this could be done by use of a Supported Self Assessment Questionnaire which is then validated by a professional.

### **Personal Budgets and the Resource Allocation System (RAS).**

29. One of the requirements from the DH is that we develop a clear and fair process to allocate resources. Under the new system all users who are entitled to support; meeting the Council's criteria, will be allocated a real or notional cash amount to fund their support. Kingston has worked along with 20 other Councils with an organisation called FACE to develop a RAS. This is based on common data collected across the country that allocates points, which in turn determine entitlements. We have participated in local and national analysis of social care activity which has measured the correlation between the needs of the population and the cost of care and support. We will continue to develop and refine it in partnership with the FACE and the other participating authorities. We will also carry out an Equalities Impact Assessment of the model. The DH has issued further guidance in the development of the RAS, but there is no national system.

### **Support Planning and Brokerage (assisting people to arrange their support packages).**

30. We are currently exploring the option of some Brokerage functions being delivered by non Community Care Services. We are working with Kingston Centre for Independent Living and a consortium of interested voluntary organisations to develop a Brokerage model that promotes choice for individuals and innovation within the Third Sector. We aim to offer individuals a plurality of choice about how they are supported in arranging their services.

### **Risk and Safeguarding.**

31. In our consultation so far, there have been some concerns expressed that people may be at risk of exploitation if they are given cash budgets instead of traditional care. There are also concerns that people may not spend their money on the support they need to stay safe, independent and well. We have already introduced a Risk Enablement framework where a panel can meet with the individual and their representative to discuss any concerns or risks that have been identified in relation to the use of a Personal Budget. We will work with the Safeguarding Adults Board to ensure that our Safeguarding Adults policy is embedded across all practices. We will also review people carefully and regularly to ensure that their needs and outcomes are being met safely and appropriately. It is also important to note that people will have a choice about whether or not to receive their Personal Budgets as

cash payments. If they chose not to or it is felt that there is an unacceptable element of risk involved, then the Council can arrange services on the individual's behalf.

**Review**

32. Reviews will be person centred and will focus on how people are managing under the new system of Personal Budgets. They will be carried out at least once a year or more frequently if there are concerns about risk.

**STRATEGIC IMPLICATIONS FOR DELIVERY**

33. For successful Transformation to take place other key elements will include:
- A commissioning strategy and framework that supports Transformation, particularly in relation to market shaping and developing communities as well as responding to the specialist needs of specific groups.
  - A robust safeguarding process that supports people who are vulnerable to abuse
  - A Risk enablement framework that allows people maximum choice and control without putting themselves or others at undue risk.
  - An effective transition between children's and adult's services
  - A Carers strategy that promotes and supports carers needs within a Transformed system
  - A review of our current Fairer Charging policy to ensure it complements a new and affordable Transformed system

34. Four key strategic issues for consideration identified thus far are:

**Resources.**

35. The process of Transformation is intended to make the system more efficient and less bureaucratic. The DH anticipates the wholesale change will yield a 3% overall efficiency. We will also aim for further efficiencies through the Business Process Re-Engineering (BPRE) process and potentially through the Resource Allocation system. These efficiencies will be built into future Budget setting processes.

36. The recently announced changes to Adult Social Care, which are contained in the Personal Care at Home Bill, which is currently working their way through Parliament will have an estimated cost of £670 million, of which £250 million is to be sourced from efficiencies in Adult social Care. Work will be undertaken to scope the possible impact of these changes on budgets within the Council.

**Staff.**

37. This proposed model will mean significant changes for staff in Community Care. The response from staff has been excellent, with staff at all levels showing a willingness to embrace change and try new ways of working. In order to deliver the new model, detailed work on staffing numbers, roles and skills needs to be done and will be completed through the BPRE work with Agilysis. This work will be subject to a separate consultation process for staff.

**Working With Partners.**

38. Transforming Social Care is not just about reorganisation of Adult Social Care but involves strategic planning and partnership working across all Council departments and key partner organisations. This is already happening through the work of One Council, the implementation of the Independence and Well Being and Shaping Places plans.

## CONSULTATION

39. The proposed changes are significant and will do as they intended to, transform the model of care. The work so far has sought to be inclusive, with involvement of a wide range of stakeholders and staff. Without their contributions we would not have made the progress we have. However, such a major change requires a full consultation, so that as many people as possible can give their views and the proposed model has as much public scrutiny as possible. The proposed model and the issues associated with will be subject to consultation. A summary is set out at **Annex 4** containing the consultation questions, which are focused on whether the characteristics of the proposed model are the right ones and what concerns there might be about implementation. Set out also is a plan of how the consultation would operate. The aim is to engage with people both through existing mechanisms and to try to reach out beyond the usual constituencies.
40. The Consultation period will also allow time for the detailed work on BPRE to take place, which will focus on how the new system fits with other Council processes and how we can make the pathway as smooth as possible. The consultation will run from Monday 19<sup>th</sup> January until 18<sup>th</sup> April 2010. A further report detailing the response to the consultation and setting out a detailed implementation plan will come back to the Executive in June 2010. If people have any questions, views or wish to become involved in the Programme they can contact:

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## ACTIONS FROM JANUARY TO JUNE 2010.

41. Whilst it is important that the model has the fullest possible exposure and comment, the work to transform Adult Social Care needs to continue to make progress against the Dept of Health Milestones. Therefore the following actions are proposed:
- Publish an evaluation report of the Personalisation Pilot Team ( Jan 10)
  - Consult with citizens, stakeholders and staff on the proposed changes
  - Roll out Self Directed Support and Use of Personal Budgets to all older and disabled adults from February 1<sup>st</sup> 2010 ( N1130 targets and DH milestones )
  - Conduct a Personalisation Pilot within Mental Health Services ( January to April 2010)
  - Ongoing Development of Brokerage Consortium in partnership with Kingston Centre for Independent Living ( January to April 2010)
  - Review and refine the Resource Allocation System in partnership with FACE.
  - Launch the Information and Advice website ( May 2010)
  - Continue the engagement with Health Partners in the development of a joint reablement model

## NEXT STEPS

42. A further report outlining the final model (post consultation) and a detailed implementation structure and plan will be submitted to the Executive in June 2010.

## EQUALITIES IMPLICATIONS.

43. The changes to the proposed model will potentially have an impact across the whole of Kingston. One of the key aims of the new system will be to facilitate access to all citizens and to ensure that the new ways of working do not disadvantage any groups. Consequently Equalities impact assessments will be undertaken in during the consultation period. These will cover:

- The resource allocation system
- The information and advice proposals
- The reablement proposals
- The long term conditions proposals

## ENVIRONMENTAL IMPLICATIONS

16. None

**Background papers:** held by Simon Pearce, Head of Community Care and Avril Mayhew Project Manager Transforming Social Care (authors of report)], 020 8547 4659; e-mail: [simon.pearce@rbk.kingston.gov.uk](mailto:simon.pearce@rbk.kingston.gov.uk) & [avril.mayhew@rbk.kingston.gov.uk](mailto:avril.mayhew@rbk.kingston.gov.uk)

Putting People first DH December 2007

Local Authority Circular LAC DH 2008(1) January 2008

LAC(DH)(2009)1: Transforming adult social care March 2009

DH Personalisation toolkit <http://www.dhcarenetworks.org.uk/Personalisation/Topics/>

## Transforming Social Care – glossary of terms

### What is Personalisation?

Starting with the individual as a person with their own strengths and preferences. It reinforces the idea that the individual is best placed to know what they need and how those needs can be best met.

It means people can be responsible for themselves and can make their own decisions, but that they also should have information and support to enable them to do so.

Services should respond to the individual instead of the person having to fit in with the service.

Personalisation is more than just giving people the option to have a Personal Budget; it is about giving people much more choice and control in their lives.

It is about early intervention and prevention so that people are supported early on and in a way that's right for them.

It is not just about people who live in their homes but should be applied across all care settings.

### What is Self Directed Support?

The concept of Self Directed Support involves finding out what is important to people with social care needs and their families and helping them to plan how to use their personal budget to achieve these aims.

### What is a Personal Budget?

A personal budget is the term used to describe the amount of Social Care money that will fund a person's care and support costs. It is calculated by assessing the person's needs. It is spent in line with a support plan that has been agreed by both the person and the Council. The individual may choose to pay for additional support on top of the budget. The Personal Budget can be taken in the form of:

- a. A **Direct (cash) Payment**, held directly by the person or by a suitable other where they lack capacity.
- b. or the Council arranges the support on the individual's behalf.

### What is Support Planning and Brokerage?

**Support Planning** is the process by which the Individual sets out the outcomes they wish to achieve and how the Individual Budget will be spent to meet those outcomes.

**Brokerage** is the support given to the individual to arrange these services. This could be carried out by the individual themselves or a family member or a Support Broker.

### What is reablement?

This can be described as an approach or 'philosophy' within Social Care which aims to help people 'do things for themselves' rather than 'having things done for them'. Support is offered for a short but intensive period which enables people to develop the confidence and practical skills to carry out the activities themselves.

Department of Health Milestones

# Putting People First

## Transforming Adult Social Care

### PROGRESS MEASURES FOR THE DELIVERY OF TRANSFORMING ADULT SOCIAL CARE SERVICES

1. In December 2007, the Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA) joined with a range of other agencies and six Government Ministers to sign the vision for adult social care laid out in Putting People First. Over the last 18 months, we have been working closely with these partners to support the delivery of this vision.
2. In April 2009, the Adult Social Care Reform Grant was allocated to Councils to enable us to start to deliver the vision. LAC (DH) (2009) 1 laid out the changes that were expected to be delivered using the Grant. It lays out in Paragraph 15 a number of aspects of the transformation:
  - Integrated working with the NHS
  - Commissioning Strategies, which maximise choice and control whilst balancing investment in prevention and early intervention.
  - Universal information and advice services for all citizens
  - Proportionate social care assessments processes
  - Person centred planning and self-directed support to become mainstream activities with personal budgets which maximise choice and control
  - Mechanisms to involve family members and other carers
  - A framework which ensures people can exercise choice and control with advocacy and brokerage linked to the building of user-led organisations
  - Appropriate safeguarding arrangements
  - Effective quality assurance and benchmarking arrangements

These need to be supported with local market development, a workforce strategy and an approach, which demonstrates effective use of resources, including the delivery of 3% efficiencies year-on-year.

3. In March of this year, ADASS and LGA undertook a survey of members to examine how progress was being made to deliver these key objectives. The findings overall were very encouraging but they did show a discrepancy between those councils who were making substantial progress and others who were just starting on the change processes.
4. In order to support the process of change ADASS and LGA have worked in partnership with DH and other key stakeholders (including the Care Quality Commission - CQC) to establish a set of milestones against which we can judge progress. All the key stakeholders involved in the delivery of the Transformation of Adult Social Care have accepted these. We hope that every council will also be able

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to adopt these areas as their key priorities for the period up to 2010 and by April 2011 (the end of the grant). We expect that setting these milestones will serve as a strong foundation upon which a longer-term framework for progress can be developed.

5. The DH have agreed with ADASS and the LGA that there are 5 key priorities during this first phase of transformation (by April 2011):
  - That the transformation of adult social care has been developed in partnership with existing service users (both public and private), their carers and other citizens who are interested in these services.
  - That a process is in place to ensure that all those eligible for council funded adult social care support will receive a personal budget via a suitable assessment process.
  - That partners are investing in cost effective preventative interventions, which reduce the demand for social care and health services.
  - That citizens have access to information and advice regarding how to identify and access options available in their communities to meet their care and support needs.
  - That service users are experiencing a broadening of choice and improvement in quality of care and support service supply, built upon involvement of key stakeholders (Councils, Primary Care Trusts, service users, providers, 3rd sector organisations etc), that can meet the aspirations of all local people (whether council or self-funded) wanting to procure social care services.
  
6. In order to measure progress at key stages we have identified the following milestones:

|   | <b>April 2010</b>  | <b>October 2010</b>   | <b>April 2011</b>  |
|---|--|---|--|
| <b>Effective partnerships with People using services, carers and other local citizens</b> | <p>That a communication has been made to the public including all current service users and to all local stakeholders about the transformation agenda and its benefits for them.</p> <p>That the move to personal budgets is well understood and that local service users are contributing to the development of local practice. <b>[By Dec 2009]</b></p> <p>That users and carers are involved with and regularly consulted about the councils plans for transformation of adult social care.</p> | <p>That local service users understand the changes to personal budgets and that many are contributing to the development of local practice.</p> | <p>That every council area has at least one user-led organisation who are directly contributing to the transformation to personal budgets. <b>(By December 2010)</b></p> |

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|  |   |  |  |
|--|---|--|--|
| <p><b>Self-directed support and personal budgets</b></p> | <p>That every council has introduced personal budgets, which are being used by existing or new service users/ carers. *</p>   | <p>That all <b>new</b> service users / carers (with assessed need for ongoing support) are offered a personal budget.</p> <p>That all service users whose care plans are subject to review are offered a personal budget. **</p>   | <p>That at least 30% of eligible service users/carers have a personal budget.</p>  |
| <p><b>Prevention and cost effective services</b></p>     | <p>That every council has a clear strategy, jointly with health, for how it will shift some investment from reactive provision towards preventative and enabling/ rehabilitative interventions for 2010/11. Agreements should be in place with health to share the risks and benefits to the 'whole system'.</p>  | <p>That processes are in place to monitor across the whole system the impact of this shift in investment towards preventative and enabling services. This will enable efficiency gains to be captured and factored into joint investment planning, especially with health.</p>   | <p>That there is evidence that cashable savings have been released as a result of the preventative strategies and that overall social care has delivered a minimum of 3% cashable savings.</p> <p>There should also be evidence that joint planning has been able to apportion costs and benefits across the 'whole system'.</p> |
| <p><b>Information and advice</b></p>                     | <p>That every council has a strategy in place to create universal information and advice services.</p>  | <p>That the council has put in place arrangements for universal access to information and advice.</p>  | <p>That the public are informed about where they can go to get the best information and advice about their care and support needs.</p>   |
| <p><b>Local commissioning</b></p>                        | <p>That councils and PCTs have commissioning strategies that address the future needs of their local population and have been subject to development with all stakeholders especially service users and carers; providers and third sector organisations in their areas.</p> <p>These commissioning strategies take account of the priorities identified through their JSNAs.</p> | <p>That providers and third sector organisations are clear on how they can respond to the needs of people using personal budgets.</p> <p>An increase in the range of service choice is evident.</p> <p>That councils have clear plans regarding the required balance of investment to deliver the transformation agenda.</p> | <p>That stakeholders are clear on the impact that purchasing by individuals, both publicly (personal budgets) and privately funded, will have on the procurement of councils and PCTs in such a way that will guarantee the right kind of supply of services to meet local care and support needs.</p>                           |

\* *The ADASS/LGA survey showed 8% was already the national average in March 09 (although it also suggested that the majority of authorities were below this*

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*average). It is believed that Councils should have reached a 10% minimum target by March 2010, if they are going to guarantee the 30% target for 2011; the survey itself indicated that only around 20 authorities were not expecting to have reached a 10% level by March 2010.*

*\*\* Given the expectation that service users receive reviews at least annually, this milestone may in itself drive an allocation of PBs in excess of the 30% target for April 2011.*

7. The following current key performance indicators may afford a wider context in which to judge progress. The data from these indicators will not be available until after the end of each year.

- NI 125 – achieving independence through rehab/intermediate care
- NI 130 – the proportion of eligible service users with a direct payment and/or a personal budget
- NI 134 – number of emergency bed days
- NI 139 – people over 65 who say that receive information, assistance and support to live independently at home.
- NI 145 – settled accommodation for adults with learning disabilities
- NI 146 – employment for adults with learning disabilities
- NI 149 – settled accommodation for adults with mental health problems
- NI150 – employment for adults with mental health problems

8. It is recognised that the Transformation of Adult Social Care cannot take place without the full engagement:

- of all service users.
- of all staff working to support the delivery of care, which includes people working in the provider services and third sector organisations.
- of Primary Care Trusts and the wider health community.
- And leadership of local politicians
- of all parts of local councils and of other key strategic partners.
- And the support of regional and national programmes.

9. In order to achieve the transformation the following issues will need to have been addressed:

- A system is in place, which manages the risks associated with the transformation that includes both the risks for individuals and financial and other risks.
- Clarity of the business models that will need to be adapted to support the transformation.
- Financial systems, which support the delivery of personal budgets.
- A local project plan for the delivery of the transformation with clear projections and targets to reach locally identified milestones.
- Business cases, which track the new investments, and disinvestments that will be required to support the change.
- A workforce strategy that supports the transformation.

10. We intend that local councils will use these milestones to help self-assess on their progress, inform their business planning and inform investment decisions. These milestones will also enable all stakeholders to judge progress on the delivery of PPF transformation.

The Department of Health (through the National TASC Programme and the Deputy Regional Directors) intend to use these milestones to support progress on delivery and to assist ensuring that national/regional resources are invested to offer the best support to local areas.

The Care Quality Commission will consider (subject to their usual consultation process) use of and further development of these milestones for the 2010/11 and 2011/12 years to assist them in making consistent judgements in order to contribute to the Comprehensive Area Assessment. Both CQC and the DH will consult with stakeholders on how future progress will be measured and what may be required from councils.



**Jenny Owen**  
President  
ADASS



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## Detailed model

### A. Information and Access (Customer First) Service

#### 1. Introduction

As part of RBK's plans to transform Adult Social Care and implement the requirements of both Putting People First and the Customer First Strategy (RBK One Council Project), the Head of Community Care Services and Departmental Management Team wish to develop a universal Information and Access team/service as the single point of access and 'front door' to Community Care Services.

#### a) Information and Advice Project

The Information and Advice Project has been set up by CCS in partnership with local organisations to support both the Independence and Wellbeing and the Transforming Social Care agendas. The aim of the project is to help people to help themselves through relevant and timely information and advice. The service will benefit people with lower level support needs who do not meet eligibility criteria, self-funders and will also support any person receiving social care to help themselves.

The Information and Advice Service will be delivered by a network of existing information and advice providers including the new Information and Access Service and a wide range of voluntary organisations and statutory agencies. The project aims to support these providers by:

- Offering a single online resource for accessing coordinated, reliable and timely information and advice
- Agreeing quality standards for the content and delivery of information and advice
- Developing existing networks to enable a more coordinated approach to provision and referral
- Developing new service delivery options where needed
- The information and advice website will be designed so that it is accessible to people who wish to access information and advice directly online.
- The project will be delivered in two phases:
  1. By May 2010 – a basic service will be launched: including a web-based resource holding information and advice that is relevant to the majority of beneficiaries; agreed quality standards and an operational network.
  2. Beyond May 2010 – service development based on evaluation of basic service, developing service delivery options and including specialist information and advice.

The Information and Advice Service website will be a central resource for CSS when offering people information and advice. By coordinating existing provision from across the Borough, all information and advice will be timely and up-to-date. Furthermore, the project will establish better coordinated working arrangements with other providers of information and advice so that accurate and appropriate signposting/referrals will be able to be made. The proposed Information and Access Team will be central to the success of this model as a core provider of information and advice and referring/referred to agency.



**b) One Council Customer First**

In developing a new Access Service we would ensure that we are working within the ethos and principles of One Council, particularly the Customer First Strategy.

**2. Current model in Community Care Services**

At present there are numerous access routes to Community Care Services:

- Hollyfield Road – head office for Community Care Services
- South Locality Older People’s Team
- Kingston Locality Older People’s Team
- New Malden locality Older People’s Team
- Kingston hospital Social Work Team
- Community Learning Disability Team
- Occupational Therapy Teams
- Sensory Impairment Team
- Health and Disability Team
- RBK council switchboard number

The 8 teams listed all run a Duty System whereby enquiries and referrals to the Department are processed. Normal duty systems involve a Duty worker participating on a rota basis and supported by an Admin officer, back up Duty role and Duty Manager. This means that on any given working day in Community Care Services there are potentially 24 staff members working on Duty (not including back up arrangements). This also does not include the time given by staff in other office areas (Guildhall and HFR, provider services) that may also be responding to and fielding enquiries.

The current arrangements offer a locally based response to enquiries and contacts and a degree of ‘specialism’ depending on the team that is contacted. However there are also risks that this approach is costly in terms of the time commitment and skill base of the people operating the Duty Systems.

**3. Proposal**

It is therefore proposed that we provide a Single Point of entry for Adult Social Care (excluding people who are in hospital and Mental Health and Drugs and Alcohol services). This would be one of the 8 Customer Access points that is outlined in the Customer First Strategy. It would involve the transfer of all Duty activity from mainly professional staff based in locality and specialist teams to a team of trained and dedicated Information and

Access officers who would have the support and line management of professionally trained staff.

#### **4. Outcome**

Citizens would have equal access to Information and Advice that is timely, proportionate and appropriate to their needs and that those needing further support from CCS would be informed and assisted appropriately. That this would be done in a consistent and efficient manner and that customers would have the majority of their queries resolved at the point of contact (80% resolved within 24 hours)

#### **5. Principles**

- Advice, information and assessment are proportionate to the level of emerging need.
- That the right information is given at the right time – ‘get it right first time’ approach
- Staff have the appropriate skills and knowledge to deliver the right information, advice and support
- Any intervention is timely and proportionate to need and urgency
- People are supported to help themselves with the right level of intervention

#### **6. Function and Scope of the Team**

- Information, advice and signposting to all (including self funders)
- Undertake contact assessments for all adults potentially eligible for Community Care Services ( excluding people whose predominant need is for mental health services)
- Processing initial safeguarding alerts and investigations
- Establish eligibility
- Switch on low level services
- Screen for reablement services and refer to Reablement Team
- Facilitate self assessments
- Facilitate financial assessments/ benefit information and income maximisation
- Respond to emergencies
- Administration of blue badge, taxi card and freedom pass applications
- Provide outreach and offer booking in systems to other preventative services
- Provide a call back service to customers to follow up whether the information and advice given was appropriate.

#### **7. Potential Benefits:**

- Maximise resolution at point of Contact
- Economies of scale and cost efficiencies
- Higher productivity
- Reduced risk of duplicate activities and customers being passed around
- Continuity for customers
- Requests for simple services dealt with at point of contact
- Skill base and level of intervention at front end is proportionate to need
- Promotion of ‘self service’. CRM solution / self assessment/ customer portal
- Consistency of Information and Advice given

## 8. Key Skills Required

- Ability to quickly and accurately determine type and nature of contact.
- Good call handling and customer care skills
- Be able to recognise presenting issues, including potential safeguarding alerts
- Be able to answer and resolve queries/ signpost appropriately
- Carry out Contact Assessment and determine whether a more detailed assessment required
- Ability to switch on simple services
- Clear route to decision making and determining when professional advice and emergency intervention is required
- Ability to make minor adjustments to care packages e.g. cancellations/change times/small increases
- Self assessment – help navigate people through this pathway

## 9. Cost benefit analysis

- To establish if a Single point of access is feasible and cost effective we have begun to:
- Map current process to establish numbers of contacts to the department and where and how they are dealt with
- Establish the numbers, salaries and skill base of staff dealing with these contacts
- Establish the total cost of managing contacts
- Project and compare costs of operating a Single Information and Access Service.

## 10. Proposed Structure of Team and skill mix

- Team Manager (OT or SW )
- Deputy Manager (OT or SW)
- Small team of professionally qualified staff ( OT and SW)
- Information and Advice Officers ( OTA's and unqualified Care Managers)
- Admin officers

## B. Kingston Reablement at Home Service

### 1. Introduction

This section describes the proposed Reablement at Home Service for people living in Kingston Borough. This paper serves as a service specification for the Reablement at home service and outlines a blue print for a consistent and equitable service across Kingston and sets out:

- the national context
- components of the service
- outcomes from the services to be provided
- performance framework

The report then goes on to describe the next steps to design and deliver a joint intermediate care/reablement strategy and service specification with health partners.

## 2. National Context

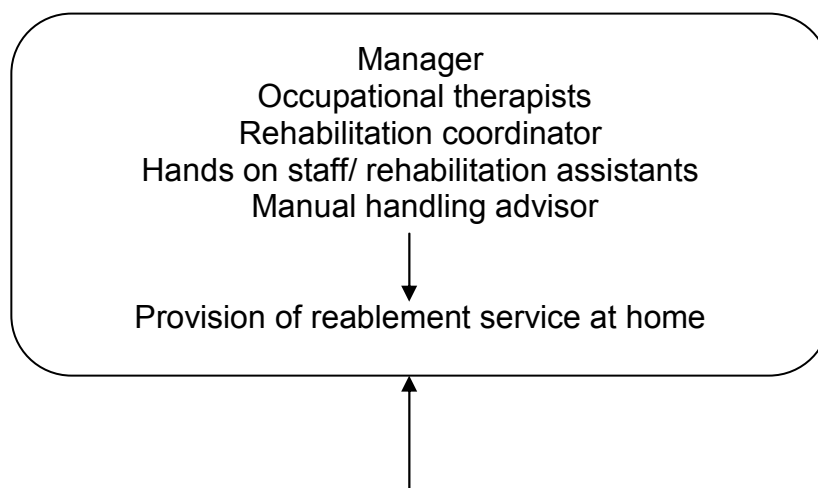
Putting People First and ADASS guidelines for transformation have identified the vision for enabling / rehabilitative interventions in partnership with health, which are expected to be in place by April 2010. DH guidance making a strategic shift to prevention and early intervention stated “There is a need to have in place an enabling or rehabilitative response which does all it can to maximise people’s functioning. Re-engineering homecare and / or the development of intermediate care are key features. The DH paper “Benefits of Homecare Reablement for People at Different Levels of Need” identified that different cases have a range of outcomes, although it is clear that significant benefits arose for the people that had undergone a phase of Reablement when compared to traditional homecare packages. It is clear there is a significant net reduction for all three FAC’s groups. It is clear that the national expectation is that we should redesign current services to achieve this model of service delivery.

## 3. Components of the service

The Reablement at Home Service will be the gateway to long term support in Kingston. The aim of the Reablement Service is to work with service users’ strengths, abilities and aspirations, intensely and for a short period of time, to enable them to live more independently in their own homes and maximise their potential. The service will provide assistance with personal care and ensure people have access to equipment, telecare and any other support which may increase their level of independence. The service will be delivered by occupational therapists, physiotherapists, and rehabilitation assistants who will work alongside people and support them to manage their conditions. The care managers or intermediate care nurses will conduct an initial contact assessment and determine if the service user requires personal care support at home and is able to engage in Reablement. The Reablement service will respond to the referral within 24 hours 7 days a week and identify Reablement outcomes and devise a care plan within the first three days and predict a discharge date.

Throughout the period the service is delivered, regular reviews will be undertaken (at least weekly). If people have ongoing needs at the end of the period, a rehabilitation / outcome based support plan will be devised with the person and a resource allocation identified to meet the person’s ongoing personal needs.

See annex A for further explanation regarding how the service could operate. The composition of the new service will be modelled on an analysis of current activity. Based on this figure the service would comprise of the following groups of staff.



Input from multi disciplinary team to assess/care plan.

OT's, physios, nurses, social workers, sensory impairment and telecare expertise.

#### **4. Outcomes of service**

The expected outcomes of the service are as follows:

- To maximise an individual's independence in their own home and community environment and increase their ability to manage their own care. Achieve a year on year increase in the number of people supported at home after 91 days after the ceasing of the service.
- The measurement of success of the service will be based on:
- Reduced dependency for: ongoing support at home, admission to residential and nursing home, admission to hospital.
- Individual remaining at home 91 days after the service has ceased
- Improved quality of life. This will be measured through an evidence based quality of life questionnaire which will be provided at the beginning and end of the service.
- Increased ability to carry out activities of daily living

#### **5. Performance Indicators**

The key national indicator for measuring rehabilitation / reablement is NI125. This indicator measures the benefit to individuals from intermediate care and rehabilitation following a hospital episode within a service which has the following ingredients:

- provides a service to people aged 65 and over discharged from hospital
- provides a planned outcome of maximising independence and enabling people to resume living at home
- provides a multi disciplinary assessment resulting in an individual support plan
- offers a service for no longer than 6 weeks
- provides a joint health and social care assessment / care planning process

Performance is measured through the percentage of people who were at home 91 days later after discharge from the service.

#### **6. Principles of service**

The current service will shift towards an individualised and tailored approach which is preventative and outcome focussed and will include the following principles:

- Individuals to be empowered to maximise their ability and potential through an individualised approach which focuses on people's strengths and abilities.
- Provision of a universal Reablement service open to all regardless of diagnosis or clinical rehabilitation potential

## **C23**

- All individuals to have the opportunity to receive a period of intensive assessment and rehabilitation at home.
- Fair access to the service no matter where accessed.
- Service is inclusive of all communities.
- Service offers assessments and care planning that is holistic and proportionate.
- Everyone should have an opportunity to rehabilitate.
- People in the community and in hospital should not be placed into residential and nursing care without the opportunity to access a holistic assessment and rehabilitation.
- Existing users of the current services will have access to the service if they would benefit from a short period of rehabilitation due to their changing needs.
- Work in partnership with individuals and carers to maximise independence.
- Individuals to be empowered to link with other support services and activities to promote choice and wellbeing.

### **7. Scope of service**

The service will be available:

- To all adults who are resident in the Royal Borough of Kingston upon Thames and are able to engage in reablement. People who have dementia, a learning disability, a mental health disability or palliative care needs should not automatically be excluded from the service.
- People who have advanced dementia and may not be able to follow instruction and those people receiving end of life care may not be suitable because of their particular care needs.
- for a period no longer than 6 weeks

The service capacity will be managed through receiving referrals in the following order;

- People discharged from hospital
- All new service users living in the community
- Current service users who are receiving long term support who require an increase in the level of assistance. Particular priority will be given where consideration is being given to admission to a care home.

### **8. Charging policy for service**

The following charging policy will apply to the Reablement service:

- Assessment and care planning progress reports or therapy input will be free whether delivered through health or social care.
- The community care services charging policy would apply to the number of direct hours provided to work with people towards the agreed objectives and outcomes.
- There is no evidence that the introduction of a charging policy influences the outcomes for service users.

## C24

- As part of the wider charging policy review attention will be given to a charging policy for low level pieces of equipment and care line, plus telecare devises will be undertaken.

### Next Steps to achieve redesign of reablement service

1. Service model to be agreed with Community Care Services DMT 22/10 /09 and agree role of in-house domiciliary care services.
2. Full business case and service specification to be devised including cost / benefit analysis of proposed service provision, mapping of care pathway, staffing structure, functions roles and job descriptions
3. Arrange a health and social care stakeholder event with NHS Kingston to:
  - Share vision/national context
  - Share proposed joint model
  - Agree criteria for joint service
  - Agree resources for assessment/care planning
  - Agree resources for personal care at home service / equipment
  - Review current funding agreements to reflect service redesign and review section 75 agreement

Timescale January 2010

4. Redesign of domiciliary care services to deliver reablement services at home by March 2010
5. Devise joint overarching intermediate care/reablement service specification / strategy by June 2010. Recommission services and review section 75 agreements with NHS Kingston. This overarching service specification would provide the following functions:
  - Daily living assessments
  - Aids and telecare adaptations
  - Physiotherapy
  - Falls prevention
  - Sensory impairment aids and support
  - Communication aids and support

See annex B for ideal model for reablement

6. The service specification / strategy and model for reablement at home service need to address the following areas;
  - Establish joint criteria for reablement at home for people discharged from hospital.
  - Consider whether FAC's criteria would not apply to those leaving hospital but would apply to people who are living at home.
  - Consider whether the changes to who accesses the service should be incremental or across the whole service.

7. Propose domiciliary care contracts are reviewed to ensure that the private domiciliary care agencies can meet the needs of people with

- End of life care needs
- Advanced dementia
- Brain injury

### **C. Supporting People with long term needs**

#### **1. National Context**

“A move from a model of care where the individual receives the care determined by a professional to one that has person centred planning at its heart, with the individual firmly at the centre in identifying what is important to deliver his or her outcomes”. “in the future all individuals eligible for publicly funded adult social care will have a personal budget; a clear up front allocation of funding to enable them to make informed choices about how to best meet their needs, including their broader health and well being. Having an understanding of what is available will enable people to use their resources flexibly and innovatively, no longer simply choosing from an existing menu, but shaping their own menu of support.”

(Department of Health LAC (DH) (2008) 1)

#### **2. Outcomes of service**

- To maximise an individual’s independence in their own home and community environment and promote maximum choice and control in the way they are supported in the long term.
- Person centred assessment, support planning and review which is outcomes focussed becoming mainstream
- Individuals having choice and flexibility in the way they are supported
- Professional support and intervention is focussed on people whose needs are most complex and who need the most support in engaging with the process

#### **3. Scope of service**

The service would be available to all eligible adults over aged 18 who have long term conditions or disabilities and are living in the borough. Eligibility will be determined by Fair Access to Care criteria. It is assumed that the majority of people coming through to this service will have had a period of reablement and that they have been then assessed as needing further long term support. There will be some exceptions to this i.e. people who due to their condition or disability lack the cognitive ability to follow a reablement plan or people who need end of life care.

#### **4. Principles of service**

- Continued joint working with health professionals in locality based teams
- Assessment and support planning processes that are person centred and outcomes focussed
- People who need ongoing support will have real choice and the ability to design support around their own needs

## C26

- A resource allocation system that is equitable and transparent but also affordable
- Plurality of support planning and brokerage offered to those who need it
- Sound safeguarding policies and practices
- A risk enablement framework that promotes individuals rights to autonomy, choice and control
- Carers needs are recognised and supported through person centred assessments and services
- Commissioning practices that shape the market, promote choice, quality and flexibility as well as best value for the customer
- The level of professional support and intervention is proportionate to the needs of the individual.

### 5. Maximising efficiencies and streamlining assessment and Care Management systems:

- Focus on supported self assessment and streamlined processes and paperwork
- Assumption that less people will need long term support if they have had appropriate reablement and rehabilitation
- Locating Duty functions within one service

### 6. Performance Indicators

The key **national** indicator for measuring self directed support is **NI130**. This indicator measures the benefit to individuals from directing their own support via a Personal Budget and or Direct Payment. In order for Local Authorities to meet this indicator a percentage of people (30% by April 2011) receiving services must be:

- Be getting a direct payment: or
- Have in place another form of personal budget which meets the following criteria:
- The person or their representative knows how much money can be spent
- There is an agreed Support Plan making clear what outcomes are to be achieved with the money
- The person (or their representative) can use their money in ways and at times of their choosing. “

The key **local** target is the LAA Target for Long Term Conditions: a year on year improvement in the numbers of people with a long term condition that are satisfied with the support they are given and feel that they are independent and in control of their condition

### 7. Functions and Activities of long term support teams:

- Assessment with an emphasis on supported self assessment
- Application of a resource allocation
- Support/care planning \*
- Authorise support plan
- Arrange support \*
- Review

## C27

- Care co-ordination ( depending on level of complexity and specialist needs)
- Joint working with health professionals
- Safeguarding investigations and planning
- Reviews

\* Functions which could also be carried out by the individual themselves or with support from family members or external brokers

### 8. Proposed Structure:

- Three locality based health and social care teams for people with long term conditions or disabilities ( excluding people with mental health problems and people with learning disabilities, including people who have HIV/ Aids)
- One community health and social care team for people with learning disabilities
- One safeguarding team
- Mental Health services will not be affected directly by CCS changes

### 9. Brokerage options

We are currently exploring the option of some Brokerage functions being delivered by non Community Care Services.

We aim to provide individuals with choice about how they are supported in arranging their services:

- a) they could do it themselves with appropriate information provided
- b) they could receive assistance from family members or friends with appropriate information
- c) they could choose to have Support Planning and Brokerage from an independent source
- d) they could choose to have Support Planning and Brokerage from a voluntary organisation
- e) they could choose to have Support Planning and Brokerage from the council (CCS)

An interim CCS model pending the development of Support Planning and Brokerage services in the Third Sector would be that

people who did not wish to arrange support themselves could receive Support Planning and Brokerage services from the long term Support teams.

## Consultation

### Summary of Consultation plans:

A main emphasis of Putting People First is on 'co-production' i.e. citizens being involved in the design and delivery of the Transformation Programme. To this end we have sought to involve service users, staff and stakeholders in all elements of the programme.

Our plan is to consult on the detailed model outlined in Annex three.

We will:

- Produce an easy read version of the model
- Publish the model in various formats and explain the purpose of the consultation
- Engage with all our existing partnership boards and user led groups
- Host a consultation event for all stakeholders, including members of the public
- Convene a 'Transforming Social Care' engagement group for service users and carers. This group will continue to operate post consultation to participate in the delivery of the new model

### Proposed Consultation questions:

1. Do you understand the new model that has been proposed?
2. Will it directly affect you? As a service user/staff member/member of a voluntary org/ independent provider/ member of the public?
3. What benefits and improvements do you think this new model will bring?
4. What risks or challenges do you think this new model will bring?
5. What improvements would you suggest to this new model?
6. Would you like to be involved in implementing these changes?
7. How would you like to be kept informed about developments?

We welcome all contributions, so if people have any questions, views or wish to become involved in the Transforming Social Care Programme they can contact:

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