Agenda Item 6

Report to:	**Scrutiny Committee for Adult Social Care**
Date:	**27 November 2008**
By:	**Director of Adult Social Care**
Title of report:	**'Putting People First' Update report**
Purpose of report:	**To provide an updated briefing on a major change programme in ASC and to propose an indicative budget for the Social Care Reform Grant**

RECOMMENDATIONS:

ASC Scrutiny Committee is recommended to:

1. acknowledge and approve the 'Putting People First' [PPF] programme. PPF aims to give people more direct control over their own social care arrangements, and to shift the focus of Adult Social Care (ASC) from urgent interventions to prevention and promoting independence; and
2. note ASC plans for use of the Social Care Reform Grant (SCRG) to support PPF.

1. Financial Appraisal

1.1 PPF involves fundamental change in the relationship between adult social care and the public. The SCRG will be used to fund a range of projects, deliver new ways of working and to enable a major cultural shift that gives local people much more direct control over care plans and care resources. The scale of change will require significant changes to investment with movement from traditional provision as local people make their own choices about the services they require and prefer. This will affect all current service areas and will need to be managed within agreed cash limits.

1.2 Department of Health funds have been provided nationally to support the PPF change programme through a Social Care Reform Grant. The SCRG allocation to East Sussex is: £0.861m 2008/9; £2.021m 2009/10 and £2.502m 2010/11. An indicative budget is attached as Appendix 1.

2. Background and Supporting Information

2.1 Across Government the shared ambition is a radical reform of public services, enabling people to live their own 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. Those ambitions have been expressed in a range of helath, social care and housing policy published over the last two years, including:

- 'Our Health Our Care Our Say' [2006], White Paper [Department of Health]
- 'Our NHS, our Future' [2007] NHS Next Stage Review, [Department of Health]
- 'Independent Living Strategy' [2008] [Office for Disability Issues]
- 'Lifetime Homes, Lifetime neighbourhoods' [2008] [Communities and Local Government]

There is close resonance between this national agenda, Council Plan, and the ASC Three Year Plan. There is also some evidence, from comparative public surveys, that older people in East Sussex have been getting more involved and becoming better informed about social care and long term health conditions. See the POPP public survey attached as Appendix 2.

2.2 'Putting People First' [PPF] is a Department of Health initiative, set out in the Local Authority Circular [LAC 2008, 1] and the 'Putting People First Concordat' [attached as Appendix 3 and 4]. The concordat outlines a vision for a single community based support system focussed on the health and wellbeing of the local population, with the citizen at the centre.

The main changes required by 'Putting People First' are:

- ASC taking lead responsibility for helping local people plan and arrange social care services – irrespective of their eligibility for public funding, and including carers
- Self assessment and self directed social support becoming routine and mainstream
- People eligible for publicly funded services having direct control over the budget to purchase their services – 'Personal Budget'
- ASC making a significant shift from urgent and emergency interventions to prevention and promoting independence.

2.3 Locally early work scoping PPF began in April 2008 and in June 2008 the emergent 'Putting People First' programme [PPF] merged with the Assessment and Care Management change programme. That built on the reforming work of the ASC Business Transformation Programme, ASC Commissioning Strategies and the ASC Three Year Plan.

3. Current Position

3.1 A PPF programme team has been established, led by the Director of ASC, with work streams led by ASC Assistant Directors. It is anticipated that each work stream will include at least three and probably more projects involving pilot or prototyping activities:

Work stream	Sponsor	Manager
PPF Programme Manager	Keith Hinkley	David Liley
Access and self directed support ASDS	Mark Stainton	Kay Reeve
Choice, market development and engagement CMDE	Beverly Hone	Vicky Smith
Business systems, processes and infrastructure BSPI	Rita Stebbings	Alex Garnett
Workforce [still in early development]	Sam Williams	Vacant

A PPF Programme Board has been set up as a sub-committee of the ASC Departmental Management Team and a Programme Initiation Document [PID], milestone plan and risk log have been prepared. Details of the programme structure are included at Appendix 5. A summary timeline is attached as Appendix 6 and a sample PID from one of the projects within the programme is attached as Appendix 7. Members [September 2008] and ASC staff [June 2008] have been briefed and consulted, with further engagement events planned for November, December and January 2008.

4. Conclusion and Reason for Recommendation

4.1 It will be prudent for COMT, ASC Scrutiny Committee and Lead Member to receive routine reports on the progress of the PPF programme over its three year life and to be routinely advised of any significant corporate issues, risks or potentially controversial issues as they arise.

4.2 It will be important to closely align PPF with related corporate business to make best use of resources and to ensure delivery timetables are realistic. Scrutiny Committee may wish to consider including key projects within PPF into their forward plan.

4.3 Risk and issues will include: Personal Budgets; safeguarding vulnerable people from exploitation and safeguarding public resources from inappropriate use; establishing new information, payment and commissioning systems to support PPF; changes to the ASC and wider workforce; and the capacity of the local care market to satisfy emergent demands.

KEITH HINKLEY
Director of Adult Social Services

Contact officer(s): Name: David Liley Tel: 01273 336761

Local Member(s): All
Background Documents: None

Appendix 1 - PPF Indicative Budget Summary

Putting People First

		2008/09 £'000	2009/10 £'000	2010/11 £'000
Grant Allocation		861	2,021	2,502
Staffing Costs by Workstream:				
PPF Programme Workstream	KH	220	353	366
Access and SDS Workstream	MS	159	441	448
Choice and Market Development Workstream	BH	66	178	142
Business Process Workstream	RS	58	239	246
Workforce Development Workstream	KH	30	75	79
DMT Awayday 30 April 2008	KH	1		
Staff Stakeholder Engagement Events in May/June	BH	21		
Further items for agreement by PPF Board in November 2008				
Workforce Planning - Consultant 2 days per week - 20 wks		10	10	
Staff Engagement Events	BH	25	46	46
Stakeholder Engagement	BH	30	30	30
RAS Development - FACE	BH	20	20	
In Control Membership	BH	8	16	16
In Control Pilot - Mental Health	BH		25	25
Service User Engagement Officer (LW)**	BH		40	42
Senior Business Analyst (Contract)	RS		92	92
IT Project Manager CAF/ICES	RS		110	110
SAQ Web Based Developer	RS		92	92
Sequel Developer - ongoing development of BW*	RS			92
Project Manager - RTTM, BW, Service Planning, Funding *	RS			110
Project Manager - Atlas/Abacus/Bed blocking/ICES*	RS			70
Project Manager - Interfaces*	RS			25
Transport Policy development - consultant	RS	15	15	
Transport Strategy implementation	RS		40	40
Carefirst 6 Upgrade to support SAQ	RS	50		
SDS - Back fill for Practice Managers (included below)	MS			
SDS - IT, including laptops	MS			
Joint Information and Access Project (Phase 2)	BH	5		
ACM Programme Costs (TT, Andy, Susanna)	MS	125	95	
Total Budget Allocation		**843**	**1,917**	**2,070**
Balance on Grant Allocation to be carried forward		18	104	432

* - funded in 2008/09 from the ASC Risk Reserve
** - RPR bid in 2011/12

Services for older people have improved

East Sussex County Council works in partnership with healthcare, voluntary groups and families to improve services for older people.

In 2005, people with long term health conditions such as diabetes, stroke and asthma were selected at random, using census data, to give their views about health and social care. In 2008 the survey was repeated with people aged over 65 .

3968 older people with a long term condition completed the 2005 postal survey and 723 completed the 2008 survey. The response rates were about 60% in 2005 and about 10% in 2008. The age, gender and ethnic breakdowns were similar, and broadly matched the population.

In 2008, older people were more likely to:

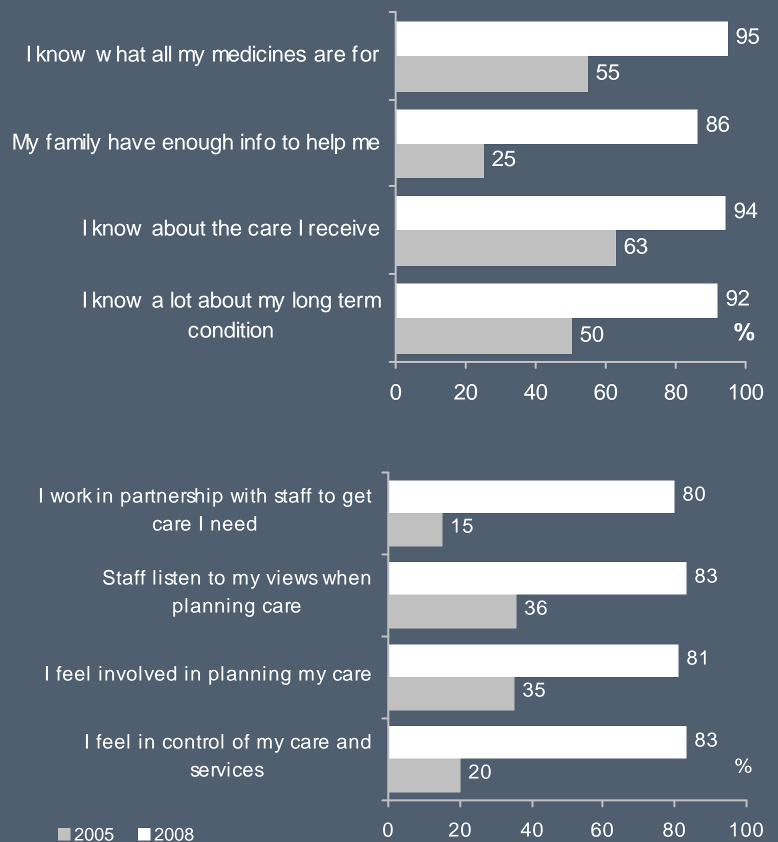
- say they **knew a lot** about their long term condition (92% in 2008 vs 50% in 2005)
- **feel in control** of the care and services they receive (83% vs 20%)
- believe they **work in partnership** with services to get the care they need (80% vs 15%)
- say that health and social services **work as a team** (73% vs 14%)
- **feel confident** they get good care (92% v 51%)
- say the **quality of healthcare** was very good (81% vs 60%)
- say the **quality of social care** was very good (65% vs 44%)

THE
Evidence
Centre

Information & involvement

- Nine out of ten older people say they know about all the care they receive
- Nine out of ten older people say their family have enough information to help them
- Nine out of ten say they know what all their medicines are for
- Eight out of ten say they feel involved and in control of their care
- Eight out of ten say health and social care teams listen to their views when planning care

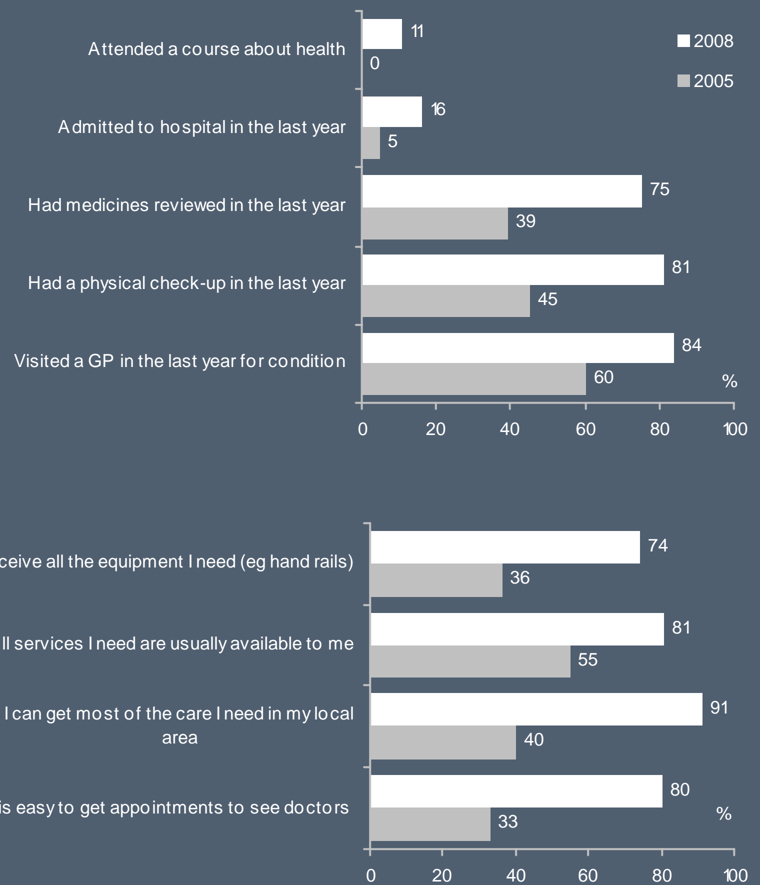
These are all significant improvements over the past three years



"Someone is always on hand. They really care."

Using services

- In 2008, older people were more likely to say they had attended a course to learn about their health, visited a GP, had a physical check up or had their medicines reviewed in the past year compared to 2005.
- But older people were also more likely to say they had visited a hospital A&E department or been admitted to hospital in 2008.
- Nine out of ten people thought that most health and social care services they need are available locally and seven out of ten thought it was easy to access services.

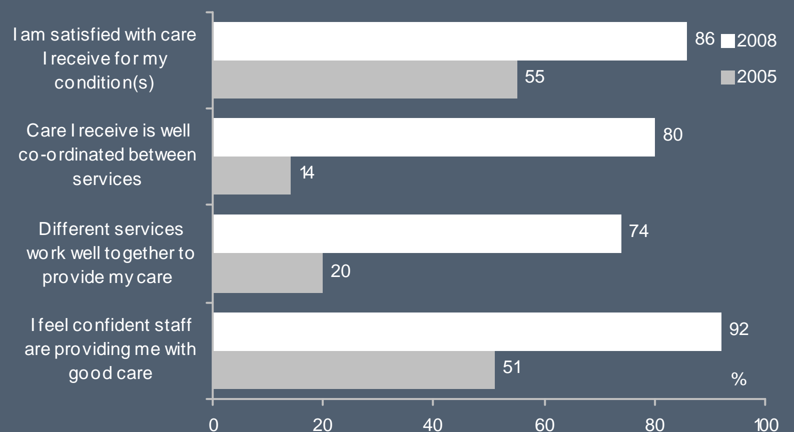


"Services and facilities are comprehensive and quickly available"

Partnership & satisfaction

- Eight out of ten older people say they are satisfied with the health and social care they receive to support them with their long term conditions
- Eight out of ten older people say care is well co-ordinated between services
- Seven out of ten think that different services work well together to provide their care
- Nine out of ten say they feel confident health and social care staff are providing them with good care

These are all significant improvements over the past three years



The surveys suggest that older people think there have been significant improvements in health and social services over the past three years. The main areas thought to need continued development were transport, after hours services and social activities.

"I consider myself very fortunate to live in this area where the elderly have such good services"

Department of Health

Local Authority Circular **LAC (DH) (2008) 1**

To: The Chief Executive
County Councils)
Metropolitan District Councils) England
Shire Unitary Councils)
London Borough Councils
Common Council of the City of London
Council of the Isles of Scilly
Director of Adult Social Services
Councils with Social Service Responsibilities in England

Copied to: Chief Executive – Strategic Health Authorities
Chief Executive – Primary Care Trust
Regional Directors of Public Health
Government Office Directors
Regional Directors, CSIP RDCs

Date: 17 January 2008

Gateway Reference: 9337

TRANSFORMING SOCIAL CARE

1. This Local Authority Circular sets out information to support the transformation of social care signalled in the Department of Health's social care Green Paper, *Independence, Well-being and Choice* (2005) and reinforced in the White Paper, *Our health, our care, our say: a new direction for community services* in 2006. The approach was confirmed in the landmark '*Putting People First'* Concordat[1] between six Government Departments, the Local Government Association, the Association of Directors of Adult Social Services, the NHS, representatives of independent sector providers, the Commission for Social Care Inspection and other partners, published in December 2007. There are four sections to this circular:

   - **Part 1:** (Pages 2-8) looks at what needs to be done, the vision for development of a personalised approach to the delivery of adult social care, the history and the context in which this policy is grounded.

   - **Part 2:** (Pages 9-15) sets out how the Department of Health (DH) and sector leaders propose to develop a sector led programme to support councils with social service responsibilities in delivering this modernisation agenda.

   - **Annex A:** (Pages 16-26) is a copy of the Social Care Reform Grant Determination. It sets out the details of the new ring-fenced grant to help councils to redesign and reshape their systems over the next 3 years.

   - **Annex B:** (Page 27) Is a list of useful websites.

[1] *Putting People First: a shared vision and commitment to the transformation of Adult Social Care,* HMG, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081118

PART 1: A PERSONALISED APPROACH

Introduction

2. Consultation responses to the White Paper[2] confirmed that people want access to support when they need it and they expect it to be available to them quickly, easily and fit into their lives. They also want adult social care services to make provision for a range of needs with a greater focus on using preventative approaches to promote people's independence and wellbeing. The emphasis should be on enablement and early intervention to promote independence rather than involvement at the point of crisis, within the framework of Fair Access to Care Services.

3. To make this happen the sector needs a shared vision. The direction is clear: to make personalisation, including a strategic shift towards early intervention and prevention, the cornerstone of public services. In social care, this means every person across the spectrum of need, having choice and control over the shape of his or her support, in the most appropriate setting. For some, exercising choice and control will require a significant level of assistance either through professionals or through independent advocates.

4. This is a challenging agenda, which cannot be delivered by social care alone. To achieve this sort of transformation will mean working across the boundaries of social care such as housing, benefits, leisure and transport and health. It will mean working across the sector with partners from independent, voluntary and community organisations to ensure a strategic balance of investment in local services. This will range from support for those with emerging needs, to enabling people to maintain their independence and to supporting those with high-level complex needs. When considering transformation partners should look at resources spent through mainstream services, the NHS, housing and other relevant statutory agencies, the voluntary and private sectors, and not just those resources spent via the adult social services department.

5. The new Local Performance Framework will be of fundamental importance in supporting this to happen. Primary Care Trusts and Local Authorities are working in the Local Strategic Partnerships (LSPs) to agree new Joint Strategic Needs Assessments. Joint Strategic Needs Assessments (JSNAs) will provide the foundation for health and wellbeing outcomes within each new Local Area Agreement (LAA). Our ambitions for modernising social care sit entirely within this Framework.

6. The importance of this holistic approach is recognised and underpinned by '*Putting People First: A shared vision and commitment to the transformation of Adult Social Care',* a concordat that establishes a collaborative approach between central and local Government, the sector's professional leadership, providers and the regulator. It sets out the shared aims and values, which will guide the transformation of adult social care.

7. Across Government, the shared ambition is to meet the aspiration to put people first through a radical reform of public services. It will mean that people are able to live their own lives as they wish, confident that services are of high quality, are safe and promote their own individual requirements for independence, well-being and dignity. Local priority setting will be focused on meeting local needs and playing a leading role in

[2] *Our health, our care, our say: a new direction for community services*, Department of Health (2006)

shaping strong and cohesive local communities[3]. This document sets out the contribution of social services, working in partnership across Local Strategic Partnerships, to support local leaders and their partners to make this happen.

Context: Why change is needed

8. Advances in public health, healthcare and changes in society mean that we are living longer, and as communities become more diverse, the challenges of supporting that diversity becomes more apparent. People have higher expectations of what they need to meet their own particular circumstances, wanting greater control over their lives and the risks they take. They want dignity and respect to be at the heart of any interaction, so that they can access high-quality services and support closer to home at the right time, enabling them and their supporters to maintain or improve their wellbeing and independence rather than relying on intervention at the point of crisis. Social care cannot meet these challenges without radical change in how services are delivered.

9. The change in the structure of our population is one of the most significant challenges we face in the 21st century. Life expectancy has increased considerably with a doubling of the number of older people since 1931[4]. Between 2006 and 2036, the number of people over 85 in England will rise from 1.055 to 2.959 million[5], an increase of approximately 180%. This trend will continue (eg the numbers of people with dementia in England, around 560,000[6] in 2007, is expected to double in the next 30 years) and with it, demand for support across the continuum of need will increase. In addition, the numbers of people aged 50 and over with learning disabilities are projected to rise by 53% between 2001 and 2021[7]. And, thanks to advances in medicine, more children with complex needs are surviving into adulthood. We need to recognise their aspirations and their desire to live life as fully as possible.

10. More people are being supported to live independently at home, but at the same time resouces are increasingly targeted at those with the greatest need[8][9][10]. This is despite emerging evidence from the Partnership for Older People Projects (POPPs) which indicates that earlier interventions before people reach high levels of need may be more cost-effective for the heath and social care system and provide better outcomes for individuals. This is also reflected in the Office for Disability Issues report '*Better outcomes, lower costs'* into housing adaptations[11].

11. Supported by the DH's efficiency programme, councils have increasing shown how developing homecare re-ablement services can support independent living and deliver value for money. Assistive technology such as telecare and minor adaptations, like fitting a handrail, can also enable people with support needs to continue to live in their own homes. The commitment to develop a National Dementia Strategy recognises the importance of people receiving an early diagnosis and being offered appropriate choices, rather than at a time of crisis.

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[3] *Strong and Prosperous Communities: The Local Government White Paper,* Department for Communities and Local Government (2006)
[4] Royal Commission on Long-term Care for the Elderly (1999)
[5] *2006-based principal population projections* , Office for National Statistics (October 2007)
[6] *Dementia UK: Report to the Alzheimer's Society,* Knapp et al, Kings College & London School of Economics & Political Science (2007)
[7] *Estimating future need/demand for support for adults with learning disabilities in England,* Emerson & Hatton (2004)
[8] *State of Social Care in England 2005-06,* Commission for Social Care Inspection (2006)
[9] *Time to care? An overview of home care services for older people in England,* Commission for Social Care Inspection (2006)
[10] Council Self Assessment Surveys, Commission for Social Care Inspection (July 2007)
[11] *Better outcomes, lower costs: implications for health and social care budgets of investment in housing adaptations, improvements and equipment: a review of the evidence,* Heywood and Turner, Office for Disability Issues (2007)

12. Demographic changes will also have an impact on the number of people able to care and support family members, which will in turn influence the wider provision of care. The role of carers was highlighted in *Our health, our care, our say*[12], and the issues it raised are now subject to a wide-ranging consultation with the Government committed to publish a new Prime Ministers Strategy for Carers in spring 2008.

13. All this indicates that, faced with long-term demographic change, the current system of social care delivery will need to fundamentally re-engineer and modernise to respond to the pressures on the system, the increased expectations placed upon it and tackle substantial culture change. It will also need to be set in the context of the recognition of the need to explore options for the long term funding of the care and support system. The Government has announced its intention to produce a Green Paper in 2008, to identify the major challenges, the key issues and setting out options for reform, to ensure any new system is fair, sustainable and unambiguous about the respective responsibilities of the state, family and individual.

14. However, many councils find it difficult to invest in approaches aimed at promoting independence such as prevention, early intervention or re-ablement programmes, which are necessary to promote well-being and meet the population challenges. Social care and wider local government services need to work with the NHS, the voluntary, community and independent sector to harness the capacity of the whole system. It needs to shift the focus of care and support, across the spectrum of need, away from intervention at the point of crisis to a more pro-active and preventative model centred on improved wellbeing, with greater choice and control for individuals.

The Vision – what reforming social care means

15. The wider government approach to personalisation can be summarised as "*the way in which services are tailored to the needs and preferences of citizens. The overall vision is that the state should empower citizens to shape their own lives and the services they receive*"[13]. It forms one element of wider cross-government strategy on independent living, to be published early next year.

16. If personalisation is a cornerstone of the modernisation of public services, what does it mean for social care? What it means is that everyone who receives social care support, regardless of their level of need, in any setting, whether from statutory services, the third and community or private sector or by funding it themselves, will have choice and control over how that support is delivered. It will mean that people are able to live their own lives as they wish, confident that services are of high quality, are safe and promote their own individual requirements for independence, well-being and dignity.

17. To do this will require a common assessment of individual social care needs, emphasising the importance of self-assessment. The role of social workers will be focused on advocacy and brokerage, rather than assessment and gate keeping. This move is from the model of care, where an 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 personally important to deliver his or her outcomes. With self-directed support, people are able to design the support or care arrangements that best suit their specific needs. It puts people in the centre of the planning process, and recognises that they are best placed to understand their own

[12] *Our health, our care, our say: a new direction for community services*, Department of Health, 2006
[13] *Building on Progress: Public Services*, HM government Policy Review, Prime Minister's Strategy Unit, London (2007)

needs and how to meet them. They will be able to control or direct the flexible use of resources (where they wish to), building on the support of technology (eg telecare), family, friends and the wider community to enable them to enjoy their position as citizens within their communities.

18. Direct payments and individual budgets (currently being evaluated) are an existing way to foster this transformation in the community. Individual budgets (IBs) build on what works with direct payments and, like direct payments, they give people more choice and control. IBs can bring a number of income streams together to give the individual a more joined-up package of support. Critically they allow the person to plan how to achieve outcomes, which meet their needs within a clear allocation of resources.

19. In the future, all individuals eligible for publicly-funded adult social care will have a personal budget (other than in circumstances where people require emergency access to provision); a clear, upfront allocation of funding to enable them to make informed choices about how best to meet their needs, including their broader health and well-being. Having an understanding of what is available will enable people to use resources flexibly and innovatively, no longer simply choosing from an existing menu, but shaping their own menu of support. A person will be able to take all or part of their personal budget as a direct payment, to pay for their own support either by employing individuals themselves or for purchasing support through an agency. Others may wish, once they have decided on their preferred care package, to have the council continue to pay for this directly. The approach, which may be a combination of both, will depend on what works best for them. The term personal budget will describe this transparent allocation of resources.

20. Importantly, the ability to make choices about how people live their lives should not be restricted to those who live in their own homes. It is about better support, more tailored to individual choices and preferences in all care settings.

Making personalisation a reality for the 21st century

21. Reforming social care to achieve personalisation for all will require a huge cultural, transformational and transactional change in all parts of the system, not just in social care, but also for services across the whole of local government and the wider public sector. The scale and purpose of this ambition should not be underestimated. The experience with direct payments makes this clear. For the past ten years, direct payments have successfully given some people the ability to design the services they want but their impact has been very limited. The latest figures show that about 54,000 people out of a potential million recipients receive support through a direct payment[14]. Evidence shows major variations in take up across the country, with success determined less by the characteristics of people who use services or the features of direct payments themselves, than by local leadership, professional culture and the availability of support.

22. The challenge will be to translate the vision into practical change on the ground to make a real difference to the way individuals engage with services and support and, in so doing, make a real difference to their lives. It will also mean changes in how professionals engage and work to support people's needs. Personalisation is about **whole system change**, not about change at the margins. It will require strong local leadership to convey the vision and the values, which underpin it and to reach beyond

[14] Council Self Assessment Surveys, Commission for Social Care Inspection (July 2007)

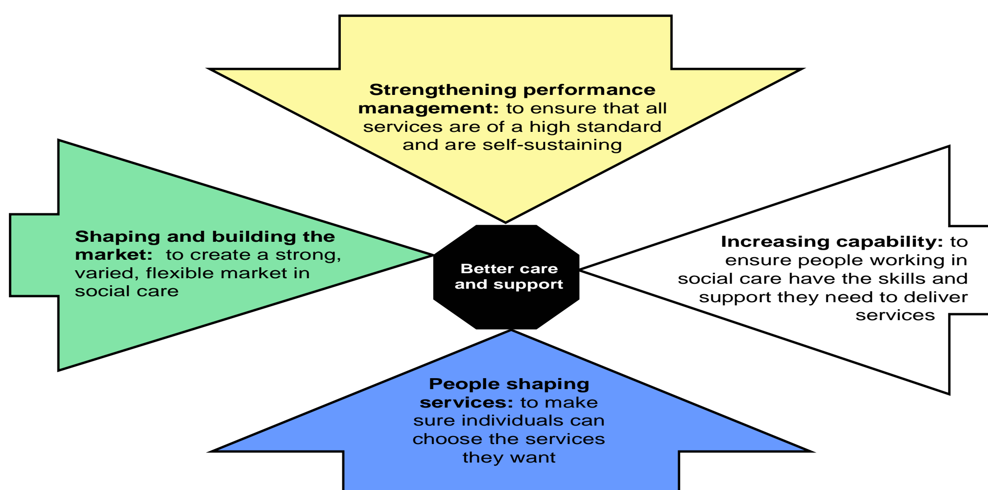
the confines of social care. It is essentially about a significant cultural shift and management of change for the wider social care and local government sectors. To achieve this, all stakeholders will need to work in partnership to construct a comprehensive delivery model, which works across social care and touches on the wider reforms within the NHS and in local government.

23. It will take time. There are significant cultural and organisational barriers to overcome and it cannot be driven from the top down. Ultimately, it will be for those at local level to deliver the change and the Government will need to work with its partners in the wider social care and local government world to support the right environment for this to happen.

24. With the increasing demand on resources, it is essential that councils work the with the NHS, other statutory agencies, the third and private sectors and their local communities to ensure a strategic balance of investment in prevention and approaches to promote independence and providing intensive care and support for those with high-level complex needs. Pooled budgets and integrated funding between health and social care can provide the flexibility for funds to be invested in early intervention and preventative approaches. Local commissioners working with local partners, in particular the NHS, should consider how resources may be released from across the whole system and redirected to enable investment in early intervention and prevention for all levels of need.

25. All participants across the sector will need to engage to bring about both the transformational culture change and the systems change needed to deliver personalisation. The reform model (below) identifies the four domains the Government and its partners must address in order to reform social care, not just in a sustainable manner, but also in a way that improves the quality of people's experience.

26. The purpose of this reform is to ensure people have choice and control over the support they need to live the lives they want. It is necessary to tackle all four together to deliver the Government's aims of better health and better care for people who need treatment and support, as well as better value for taxpayers.



[15]

[15] '**Better care and support**' at the centre of the diagram is a proxy for the seven outcomes for social care as set out in *Our health, our care, our say* (2006): improved health and emotional wellbeing; improved quality of life, making a positive contribution, choice and control, freedom from discrimination, economic wellbeing and personal dignity.

Achieving Personalisation: where are we now, and what will the new system look like?

27. In the future, the social care system will allow individuals to make real choices, and take control, with appropriate support whatever their level of need. Everyone, with support if necessary, will be able to design services around their own needs, within a clear personal financial allocation. For those funding their own support and care it will mean that there are clear information points, and support and brokerage services that enable them or their supporters to navigate the system, access qualified and appropriate advice and purchase quality services or support which meets their needs.

28. It will also mean a very different relationship between national and local government, one that follows a participative model of service transformation. DH will work with partners, including users and carers, local government, the NHS, and local third and independent sector organisations to develop the mechanisms and strategies to achieve personalisation at a local level.

29. Different councils are at different points in this process; transition cannot and will not happen overnight. Councils should consider setting clear benchmarks, timescales and designated delivery responsibilities to ensure tangible short-term progress, and by March 2011, significant moves towards fundamental system-wide change. Councils will also need to talk directly to disabled people and their organisations. What is clear is that doing nothing is not an option.

30. However, this transformation is not starting from zero; a number of building blocks are already in place. There has been significant investment in tools and technologies to support change and this will continue over the next three years with further dissemination of the learning and experience from the DH efficiency and personalisation programmes, the POPPs pilots, the Department for Work and Pensions LinkAge Plus pilots, Individual Budget pilots and the work of In Control. Councils should be working to develop and embed these into their systems and cultures over the next spending period in order to deliver the ambitions of personalisation.

Challenges

<u>Resources</u>

31. The aspirations for the modernisation of social care through personalisation, choice and control must be set in the context of the existing resources and be sustainable in the longer term. However, transformation is about looking at the full range of services commissioned and provided to ensure that they all pull together towards the same objective of improved outcomes for individuals.

32. Personalisation must be delivered in a cost effective way. It is important to recognise that personalisation, early intervention and efficiency are not contradictory but will need to be more strongly aligned in the future. If delivered effectively personalised support can be a route to efficient use of resources, offering people a way to identify their own priorities, and co-design and focus the support they need. There is already some evidence that this can be made a reality. Emerson et al[16] undertook a longitudinal evaluation of the impact and cost of person centred planning and concluded that the

[16] *The impact of person centred planning,* Emerson et al, Institute for Health Research, Lancaster University, 2005

introduction of more personalised support had a positive benefit on the life experiences of people with learning disabilities. Importantly this benefit had been achieved without additional service costs once initial training costs were taken into account.

33. In Control[17] work has begun to show that self-directed support does not have to cost more than traditional services when based on an effective resource allocation system. In the pilots, individual satisfaction levels increased very significantly. In addition, evidence emerging from the POPPs pilots indicates that a shift to early intervention and re-ablement allows money to be spent in a more cost effective way.

34. In the wider context, the Government will be developing a reform strategy for the long-term funding for people in need of care and support. The plan is to spend the next period in conversation with the public, private and third sectors. Early in 2008, DH will set out a process, which will involve extensive public engagement and will lead to a Green Paper, which will identify the scale of the challenge, key issues, and give options for reform.

Workforce

35. The vision for a personalised approach to adult social care has huge implications for the workforce of the future[18]. It is clear that, given population and workforce demographics as well as rising expectations of people who use services, the current and future workforce need to change radically to meet the challenges it will face.

36. Sustainable and meaningful change depends on the capacity to empower people who use services and to do this we need to win the hearts and minds of frontline staff, from all sectors. It is vital that local workforce development strategies are co-produced, co-developed, co-provided and co-evaluated with private and voluntary sector partners, as well as users and carers, with a focus on raising skill levels and providing career development opportunities.

37. In response to this, DH is working with its key delivery partners to develop an Adult Workforce Strategy. This will address and plan for the key workforce priorities in the short and longer term to underpin and enable delivery of the personalisation agenda. In particular, it will recognise that in developing a personalised approach, **it is essential that frontline staff, managers and other members of the workforce recognise the value of these changes, are actively engaged in designing and developing how it happens, and have the skills to deliver it.**

38. It is recognised that a key component of the reform of social care will be effective leadership, management and commissioning skills. Work is underway to develop a Social Care Skills Academy to develop these skills.

39. In addition, to help meet the costs of training staff in social care, DH has issued a number of grants in 2007/08. The majority of the funding is to develop National Vocational Qualifications to ensure a better-trained and qualified workforce to raise the quality of social care services in both the statutory and independent sectors. Money has also been provided to support councils in developing their human resource capacity and capabilities, which will begin to equip the workforce for the opportunities of personalisation.

[17] *A report on in Control's first phase 2003-2005*, Carl Poll et al, In Control, 2006
[18] *Independence, wellbeing and choice: Our vision for the future of social care for adults in England*, Department of Health, 2005

Part 2: Developing a Sector Support Programme for the Transformation of Adult Social Care

Overall aim of the Programme

40. The Department of Health (DH) and its partners want to achieve the transformation of social care to deliver support tailored to individuals and local populations irrespective of their circumstances or level of need. The Department will work collaboratively, with partners, including disabled people and their organisations, to develop, produce and evaluate the programme of implementation work ahead and support capacity building at a local level. This is a major programme of change to achieve and one which will require different approaches and ways of working from all those involved with social care.

41. Driving change on the ground in a top-down Whitehall-led model is not the answer. Therefore, the approach deliberately focuses on building the strengths and capacity of individual councils to make local decisions on priorities reflected though improvement targets in LAAs. The success of this whole-system change is predicated on engagement with communities and their ownership of the agenda at a local level. The new Public Service Agreements (PSAs), the Local Government National Indicator Set (NIS) and LAAs provide the incentives and framework to make local delivery a reality[19].

42. The Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS) and the Improvement and Development Agency (IDeA) are in a unique position in terms of raising awareness and engaging with local government leaders at all levels. The skills, knowledge and attitude of the leaders will be critical to delivery of the programme.

43. There is a clear role to provide both strategic leadership and also to develop and increase leadership capacity and capability across councils. Personalisation and early intervention are issues for the whole of local government, not just for directors of social services. The links to delivery of the corporate agenda must be explicit to gain local buy-in. Shared purpose is required if the political and managerial leaders in councils are to promote the investment in preventative services and the devolution of control and the integration of wider objectives are needed to make personalisation a reality.

44. The establishment over the past year of Joint Improvement Partnerships (JIPs) in each region provides a strong foundation to build on. The national programme will work to integrate the JIPs in each region into the work and governance structures of the Regional Improvement and Efficiency Partnerships (RIEPs). This will ensure a more coherent, joined-up approach, and will emphasise that system reform on this scale cannot be achieved by focusing solely on adult social care.

45. ADASS, LGA and IDeA will work together as a sector-led ‘consortium’ at national level to support the change agenda. At a regional level, the RIEPs will work with the JIPs, to facilitate regional implementation and local activity, and provide local leadership.

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[19] *The New Performance Framework for Local Authorities & Local Authority Partnerships: Single Set of National Indicators*, Department for Communities and Local Government, 2007

46. This will support the goals of our framework for the *National Improvement and Efficiency Strategy*[20] (NIES).

47. Councils will be supported to make substantial progress on transforming their services over the next three years, with performance across health and social care measured against relevant indicators in the National Indicator Set (and any relevant LAA improvement targets). This information will inform the joint performance assessment across health and social care undertaken by the new joint inspectorate, the Care Quality Commission, and the Comprehensive Area Assessment (CAA). The prize is huge, transforming the areas in which we live, the lives of our citizens and creating self-improving public services, which can provide personalised support to all.

48. For its part, DH, jointly with the national consortium, will work on facilitating a range of national tools to assist reform at a local level and on policy and statutory issues that require a cross-government approach. This will include, for example, the development of tools and technologies, guidance for professionals and leadership development.

What are we doing to help?

Core funding

49. Over the Comprehensive Spending Review 2007 (CSR07) period, provision for social care will benefit from the real terms increase in Revenue Support Grant (RSG) to local government. This includes support for PFI projects and represents an increase by an average of 1% a year in real terms over the next three years. This is worth £2.6 billion more by 2010/11. Direct DH funding for grants, including those for carers, mental health and the social care workforce, will also increase by an average 2.3% real per year, worth £190 million by 2010/11. In addition, resources spent by PCTs on social care for Adults with learning disabilities will be transferred to local authorities from 2009/10.

50. Alongside this additional investment, councils will be expected to spend some of their existing resources differently, utilising mainstream services to ensure the health and wellbeing of their communities and working in a genuinely collaborative way with third and private sector agencies.

Social Care Reform Grant

51. In addition to local partners using some existing resources across the health and well-being system differently, DH will be making over half a billion pounds available as a ring-fenced grant to local councils over the next 3 years. The new Social Care Reform Grant is worth £85 million in 2008/09, £195 million in 2009/10 and £240 million in 2010/11. This includes money from resources secured in CSR07 for the NHS and recognises the positive impact investing in social care can have on people's health and the demand for healthcare. The grant determination for 2008/09 is attached as an Annex A to this Circular (pages 17-27), in addition to details of allocations and conditions.

52. The objectives of the Social Care Reform Grant will directly inform each DH regional business plan to ensure our priorities are informed by local strategies. Each of DH's new Regional Deputy Directors for Social Care and Local Partnerships will be a key

[20] http://www.communities.gov.uk/localgovernment/performanceframeworkpartnerships/lpffaqs/efficiencystrategy/efficiencystrategy/

member of the regions JIPs. The RIEP and the JIP will need to work together to agree the priorities for regional facilitation. Every local transformation process will need to include clear benchmarks, timescales and designated delivery responsibilities.

53. To support this, the Department will provide some additional funding to support and facilitate local activity. This will ensure the best value for money through local collaboration to deliver the aims of the transformation programme in partnership with the RIEPs. This is described in more detail in paragraphs 58-60. DH's Efficiency Programme will also be working to align its support with the RIEPs to ensure an effective and joined-up approach to support transformational change.

Implementing change at a Local Level

54. Using the total resources provided through CSR07 (including the Social Care Reform Grant) and through ensuring improved value for money, we are confident that each council is in a position to make real and measurable progress to achieve the systems changes that will deliver the transformation of social care for their local populations over the next three years. For most councils, this will require investment in system change tailored to their needs and they will need to work either individually or collaboratively as part of a wider group with common areas for development.

55. Councils are in different places on this journey. There will be differences in terms of local priorities but the overall direction and strategic goals are clear. In order to do this effectively, councils will need to develop their own transition strategies. They will need to assess where they are, using a range of diagnostic tools to ensure that their plans are feasible and sustainable and that they focus resources on their own core priorities.

56. Some tools are already available (see Annex B for links); others will need to be developed. In particular, a means to capture how the wider contribution of local government services, such as housing, leisure, adult education, transport, and environmental services, can support personalisation. DH and the consortium will work together to commission and develop these tools to assist councils and their partners in identifying local priorities for improvement, drawing on information gathered through Joint Strategic Needs Assessments, and making decisions to feed into LAAs. This will also help ensure support and available resources, at both regional and national levels, are focused on the identified priorities.

57. Whilst there will be some local variation in the process of reform, there are core elements which councils will need to develop to ensure they have the capability and capacity to respond flexibly and responsively to the demands placed on them. These are listed in more detail in Annex A of this document (Appendix B).

At a Regional Level – Sector-led Support

58. Though the national consortium will not provide 'hands-on' change management support, it will develop a mechanism to facilitate the sharing of information across the regions, to maximise the learning from any local and regional investment.

59. To support this regional facilitation role, DH will expect its Regional Deputy Directors for Social Care and Local Partnerships to agree priorities for a £2million top-slice of the Social Care Reform Grant to be spent on regional improvement initiatives in

consultation with the RIEP and JIP. DH will look at how, from 2009/10 this resource might be transferred to the RIEPs, in line with the principles of the NIES.

60. This £2million top-sliced money will be in addition to existing resources in the system for implementation and improvement activity, to support a coherent regional strategy for transformation. It is anticipated that, taking account of local priorities, all councils in each region will be supported to ensure there is:

- Close working with DH's regional teams in each Government Office to align and join up policy delivery.

- Dissemination of tools and technologies to support excellence in delivery and transformational change, such as implementing the new operating system being developed by the IB pilot sites (learning from the evaluation), disseminating the early learning from the POPP pilots and the wider prevention agenda (including signposting of individuals who do not currently access statutory services) and DH efficiency and re-ablement work.

- Work to shape and develop local and regional markets with the capacity and the variety to offer the range of options the population demands. This will include a mixed economy of care providing a range of services delivered by organisations across all sectors and sustainable advocacy and brokerage organisations that are accessible to both those entitled to public support and self-funders.

- Support for local leadership, for example through IDeA programmes on peer review and mentoring, for both elected members and directors.

- Facilitation of information exchange and improvement work, bringing together "clusters" of councils and their partners where shared priorities have been identified.

- An agreed strategy for the commissioning of specific regional support and facilitation, such as building workforce capacity and capability to use the tools of personalisation (eg resource allocation systems) or managing change through project management, business case development and benefits realisation.

- A joined-up approach with the work of the DH efficiency programme which will also be working to align its support with the RIEPs.

- Support for councils in developing performance management systems to measure the outcome benefits for people and communities of personalisation and early intervention and collect other types of robust evidence, which can be used for performance assessment processes, to inform commissioning without requiring extra work.

- Proactive identification of under performers to engage them in developing strategies and key areas for investment (eg change management) either individually or at a regional level.

At a National Level

61. DH is committed to developing a real and meaningful partnership with the consortium and other key stakeholders to take the transformation agenda forward. This means the Department will work strategically with the consortium, In Control and other partners to jointly commission or undertake activities to facilitate reform where it is best placed to do so.

62. An additional £1m top-slice from the Social Care Reform Grant will be used to enable DH and the implementation board (paragraph 63) to:

    - Commission and develop key tools and technologies, which will be required by all councils, although dissemination will be facilitated at the regional level. This will include the development of key components of the new social care system, eg a Common Assessment Framework, charging guidance and workforce development. Identifying the need for new universal tools will be done in partnership with the consortium and will reflect their regional intelligence.

    - Facilitate a range of national mechanisms to support implementation, in particular the interface of policy and statutory issues and cross-government agenda. This will include working through the Innovation, Capacity, Efficiency Programme Board facilitated by the Department for Communities and Local Government.

    - Provide strategic advice, in particular on the four key areas identified to deliver public sector reform, people shaping services, increasing capability, shaping and building the market and strengthening performance management.

    - Establish jointly with the consortium, a national information network for facilitation at the regional level with an information loop back from all nine regions on good practice for national dissemination. This will include the learning coming out of key pilot programmes such as POPPs and IBs.

    - Work with the Social Care Institute for Excellence to establish a good and emerging practice library to support the role out of the transformation agenda

    - Work with the consortium to develop the capacity to commission support services from a range of suppliers including accredited independent consultancy companies (eg with a framework agreement to ensure rapid call-off of support).

    - Work with the regulators (the new Care Quality Commission and the General Social Care Council) to ensure their roles and functions support the transformation agenda.

63. Recognising that the principle of sector leadership of the programme applies equally at national as well as regional level, DH will work with the consortium to second a programme director from the sector to drive forward this challenging agenda. An implementation board will oversee the programme, which will include senior representatives of the consortium (ADASS, IDeA, and LGA) and DH, and representatives from the RIEPs and the Society of Local Authority Chief Executives.

Outcomes Expected

64. From April 2008, the new local performance framework for local government working alone or in partnership, will be introduced. The health and adult social care priorities for places will be drawn from the National Indicator Set[21], which cover those aspects of DH's Public Service Agreements (PSAs) and Departmental Strategic Objectives (DSOs) that are delivered in partnership.

65. DH has three DSOs (*Better health and well-being for all; Better care for all and Better Value for all*) from which our two PSAs (*to promote better health & well-being for all and to ensure better care for all*) naturally fall. These cover a range of health and social care priorities, which specifically include:

Better health and well-being through:

- Improving people's health and emotional wellbeing by enabling them to live as independently as suits them.
- Designing systems that build on the capacity of individuals and their communities to manage their own lives, confident that they have access to the right information and interventions at the right time should they need more support.
- Focusing on prevention, early intervention and enablement, rather than crisis management, to bring long-term benefits to individuals' health and wellbeing.

Better care through:

- Strategic working with NHS partners to enable people with long-term conditions to manage their health and wellbeing more effectively.
- Ensuring information is available and accessible for all to support decision-making and access to care services, irrespective of people's social circumstances and eligibility for statutory services.
- Supporting people to maintain or improve their wellbeing and independence within their own homes and local communities and through avoiding unnecessary admission to hospital.
- Enabling people to make choices and be in control of their care to deliver successful outcomes first time. Promoting shared decision making to encourage ownership.
- Providing quality care that promotes dignity, and is safe, effective and available when and where people need it.

66. DH's third Strategic Objective – **Better Value for All** - is also key in delivering the best outcomes for communities in the most cost effective way. Councils, working with local partners, will have their own ideas of how to deliver better value at a local level. One example of a way for councils to deliver this locally might be by harnessing resources from across the whole system to shift the focus of care and support away from intervention at the point of crisis to a more pro-active, early intervention model. This can deliver long-term benefits to individuals and the system in terms of improved outcomes and more cost-effective use of resources.

[21] *The New Performance Framework for Local Authorities & Local Authority Partnerships: Single Set of National Indicators*, Department for Communities and Local Government (2007)

67. These objectives support the shared outcomes set out in '*Putting People First*'[22]. These are that all signatories should ensure people, irrespective of illness or disability, are supported to:

- live independently
- stay healthy and recover quickly from illness
- exercise maximum control over their own life and, where appropriate the lives of their family members
- sustain a family unit which avoids children being required to take on inappropriate caring roles
- participate as active and equal citizens, both economically and socially
- have the best possible quality of life, irrespective of illness or disability and
- retain maximum dignity and respect.

Measuring Success

68. Independent annual assessment of performance has proved a good incentive for improvement across both health and social care. Commissioners will be assessed by the regulator on their performance against the outcome-focused metrics set out in the National Indicator Set. The new Care Quality Commission's performance assessment will contribute to the Comprehensive Area Assessment (CAA).

69. Councils will need to develop their own monitoring systems to understand how the change is experienced by the population. This diagnostic data will need to look at not only efficiency, but also take into account quality assurance and customer satisfaction. Councils will be able to use this information to develop coherent support plans for delivery of personalisation, as well as to identify additional needs and priorities. These should directly inform their Joint Strategic Needs Assessment and local commissioning strategies.

Cancellation of this circular

1. This circular should be cancelled on 1st April 2009.

Enquiries

2. Any queries about this document should be addressed to Helen Tomkys, Department of Health, Social Care Policy and Innovation Team, Wellington House, 133-155 Waterloo Road, London SE1 8UG. You can email: Helen.Tomkys@dh.gsi.gov.uk

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[22] *Putting People First: a shared vision and commitment to the transformation of Adult Social Care,* HMG, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081118

ANNEX A: DETERMINATION UNDER SECTION 31 OF THE LOCAL GOVERNMENT ACT 2003 OF THE SOCIAL CARE REFORM GRANT FOR 2008/2009

Introduction

1. This Determination is made by the Secretary of State for Health ("the Secretary of State") under section 31 of the Local Government Act 2003[23] ("the 2003 Act"). It specifies grants that the Secretary of State proposes to pay to certain local authorities in England.

2. Before making this Determination, the Secretary of State obtained the consent of the Treasury in accordance with section 31(6) of the 2003 Act.

Amounts payable to authorities

3. Pursuant to section 31(3) of the Act the Secretary of State hereby determines that the local authorities to which grants are to be paid, and the amount of each grant, are the local authorities listed in column 1 of Appendix A and the corresponding amounts set out in column 2 of that Appendix.

Purpose of the grant

4. (a) Pursuant to section 31 of the 2003 Act, the Secretary of State hereby determines that the grants shall be paid towards revenue or capital expenditure incurred or to be incurred by local authorities in the financial year 2008/2009 for the purpose of social care modernisation and reform as described in Appendix B;

   (b) "Capital expenditure" has the same meaning as specified in section 16(1) of the 2003 Act.

Payment

5. The grants shall be payable to local authorities in one instalment on or before 30th April 2008. Local authorities must be able to identify expenditure against the grant monies for the purposes set out in Appendix B, paragraphs 8-11 if required by the Secretary of State to do so.

Grant conditions

6. The Secretary of State may request the repayment of the whole or any part of the grant monies to the extent that they are not used for the purposes for which they are given as set out in Appendix B, paragraphs 8-11.

Janet R Walden

Signed by authority of the Secretary of State
17 January 2008

[23]. 2003 c.26

Appendix A

Local Authority	Social Care Reform Grant		
	2008-09	2009-10	2010-11
Principal Metropolitan Cities	6.611	15.367	18.823
Other Metropolitan Districts	13.985	32.670	40.218
Metropolitan Sub Total	20.596	48.037	59.041
Inner London	5.524	12.845	15.753
Outer London	7.253	16.864	20.680
London Sub total	12.777	29.709	36.433
Shire Counties	35.149	82.738	102.652
Shire Unitary Authorities	13.477	31.516	38.874
Shire sub total	48.627	114.254	141.526
England Total	82.000	192.000	237.000

Local Authority	Social Care Reform Grant		
	2008-09	2009-10	2010-11
Principal Metropolitan Cities			
Birmingham	1.973	4.584	5.609
Leeds	1.175	2.740	3.367
Liverpool	1.035	2.397	2.922
Manchester	0.942	2.194	2.691
Newcastle upon Tyne	0.516	1.193	1.455
Sheffield	0.970	2.260	2.778
Sub-Total	6.611	15.367	18.823
Other Metropolitan Districts			
Barnsley	0.437	1.027	1.272
Bolton	0.482	1.130	1.393
Bradford	0.808	1.890	2.329
Bury	0.288	0.674	0.832
Calderdale	0.320	0.751	0.928
Coventry	0.534	1.243	1.524
Doncaster	0.521	1.221	1.506
Dudley	0.540	1.265	1.559
Gateshead	0.384	0.891	1.093
Kirklees	0.638	1.498	1.853
Knowsley	0.343	0.799	0.979
North Tyneside	0.362	0.844	1.039
Oldham	0.398	0.929	1.143
Rochdale	0.378	0.885	1.092
Rotherham	0.470	1.102	1.366
Salford	0.464	1.077	1.317
Sandwell	0.629	1.463	1.791
Sefton	0.544	1.269	1.558
Solihull	0.280	0.658	0.813
South Tyneside	0.314	0.728	0.890
St Helens	0.339	0.793	0.977
Stockport	0.437	1.018	1.252
Sunderland	0.554	1.288	1.580
Tameside	0.407	0.952	1.174
Trafford	0.331	0.771	0.946
Wakefield	0.593	1.391	1.721
Walsall	0.491	1.145	1.406
Wigan	0.561	1.318	1.634
Wirral	0.651	1.520	1.870
Wolverhampton	0.486	1.131	1.383
Sub-Total	13.985	32.670	40.218
Metropolitan Sub-total	20.596	48.037	59.041

Local Authority	Social Care Reform Grant		
	2008-09	2009-10	2010-11
Inner London			
City of London	0.018	0.043	0.053
Camden	0.471	1.107	1.371
Greenwich	0.471	1.095	1.345
Hackney	0.490	1.133	1.381
Hammersmith and Fulham	0.333	0.773	0.946
Islington	0.430	0.996	1.217
Kensington and Chelsea	0.366	0.866	1.082
Lambeth	0.498	1.150	1.399
Lewisham	0.470	1.085	1.322
Southwark	0.524	1.211	1.478
Tower Hamlets	0.491	1.135	1.383
Wandsworth	0.455	1.051	1.281
Westminster	0.508	1.200	1.494
Sub-total	5.524	12.845	15.753
Outer London			
Barking and Dagenham	0.327	0.752	0.916
Barnet	0.505	1.179	1.452
Bexley	0.303	0.708	0.871
Brent	0.460	1.069	1.309
Bromley	0.400	0.932	1.145
Croydon	0.457	1.068	1.313
Ealing	0.478	1.107	1.353
Enfield	0.449	1.047	1.285
Haringey	0.374	0.867	1.060
Harrow	0.336	0.783	0.962
Havering	0.336	0.783	0.961
Hillingdon	0.350	0.815	1.001
Hounslow	0.316	0.733	0.897
Kingston upon Thames	0.188	0.439	0.540
Merton	0.259	0.602	0.737
Newham	0.485	1.121	1.368
Redbridge	0.381	0.887	1.090
Richmond upon Thames	0.220	0.515	0.635
Sutton	0.253	0.589	0.725
Waltham Forest	0.375	0.868	1.060
Sub-total	7.253	16.864	20.680
London Sub-total	12.777	29.709	36.433

Local Authority	Social Care Reform Grant		
	2008-09	2009-10	2010-11
Shire Counties			
Bedfordshire	0.503	1.189	1.480
Buckinghamshire	0.568	1.334	1.651
Cambridgeshire	0.788	1.863	2.323
Cheshire	0.985	2.317	2.872
Cornwall	0.961	2.271	2.829
Cumbria	0.882	2.072	2.563
Derbyshire	1.279	3.015	3.744
Devon	1.230	2.898	3.604
Dorset	0.642	1.509	1.874
Durham	0.966	2.259	2.789
East Sussex	0.861	2.021	2.502
Essex	2.000	4.710	5.845
Gloucestershire	0.847	1.989	2.461
Hampshire	1.537	3.618	4.490
Hertfordshire	1.414	3.309	4.085
Kent	1.980	4.655	5.770
Lancashire	1.908	4.481	5.547
Leicestershire	0.798	1.886	2.346
Lincolnshire	1.136	2.694	3.364
Norfolk	1.418	3.340	4.149
North Yorkshire	0.835	1.969	2.448
Northamptonshire	0.896	2.119	2.638
Northumberland	0.528	1.239	1.533
Nottinghamshire	1.195	2.813	3.489
Oxfordshire	0.788	1.853	2.295
Shropshire	0.468	1.106	1.376
Somerset	0.836	1.970	2.450
Staffordshire	1.211	2.857	3.549
Suffolk	1.093	2.576	3.201
Surrey	1.336	3.128	3.858
Warwickshire	0.759	1.792	2.228
West Sussex	1.092	2.558	3.162
Wiltshire	0.602	1.421	1.766
Worcestershire	0.808	1.907	2.369
Sub-total	35.149	82.738	102.652

Local Authority	Social Care Reform Grant		
	2008-09	2009-10	2010-11
Shire Unitary Authorities			
Bath & North East Somerset	0.252	0.589	0.727
Blackburn with Darwen	0.261	0.609	0.748
Blackpool	0.318	0.743	0.914
Bournemouth	0.294	0.682	0.836
Bracknell Forest	0.119	0.279	0.346
Brighton & Hove	0.414	0.956	1.167
Bristol	0.677	1.576	1.931
Darlington	0.168	0.392	0.484
Derby	0.401	0.939	1.159
East Riding of Yorkshire	0.504	1.193	1.488
Halton	0.220	0.514	0.633
Hartlepool	0.175	0.408	0.503
Herefordshire	0.301	0.712	0.886
Isle of Wight Council	0.269	0.635	0.790
Isles of Scilly	0.010	0.010	0.010
Kingston upon Hull	0.507	1.178	1.443
Leicester	0.523	1.213	1.483
Luton	0.264	0.617	0.760
Medway	0.310	0.730	0.905
Middlesbrough	0.258	0.597	0.728
Milton Keynes	0.285	0.677	0.847
North East Lincolnshire	0.273	0.638	0.786
North Lincolnshire	0.254	0.600	0.745
North Somerset	0.309	0.731	0.911
Nottingham	0.530	1.230	1.504
Peterborough	0.261	0.612	0.757

Local Authority	Social Care Reform Grant		
	2008-09	2009-10	2010-11
Shire Unitary Authorities			
Plymouth	0.430	1.007	1.243
Poole	0.211	0.493	0.607
Portsmouth	0.296	0.688	0.847
Reading	0.188	0.436	0.533
Redcar and Cleveland	0.250	0.584	0.720
Rutland	0.045	0.106	0.133
Slough	0.170	0.395	0.482
South Gloucestershire	0.308	0.728	0.907
Southampton	0.371	0.864	1.063
Southend-on-Sea	0.287	0.669	0.824
Stockton-on-Tees	0.289	0.677	0.838
Stoke-on-Trent	0.483	1.126	1.381
Swindon	0.241	0.565	0.698
Telford and The Wrekin	0.259	0.613	0.763
Thurrock	0.219	0.514	0.637
Torbay	0.300	0.706	0.877
Warrington	0.281	0.659	0.816
West Berkshire	0.166	0.390	0.484
Windsor and Maidenhead	0.154	0.360	0.443
Wokingham	0.130	0.307	0.382
York	0.245	0.573	0.709
Sub -total	13.477	31.516	38.874
Shires Sub-total	48.627	114.254	141.526

Appendix B

THE SOCIAL CARE REFORM GRANT 2008/09

Summary

5. The White Paper[24] set out the role adult social care services should play in increasing people's independence and promoting inclusion in communities through preventative approaches and the promotion of well-being, rather than intervention at the point of crisis.

6. To meet this goal, the system will need to undergo significant reform and redesign to ensure people have access to early interventions and to exercise choice and control over the services and support they need. It will also require investment in training and support for the workforce to enable them to meet the challenges of this new way of working.

7. This transformation will take place within the new local performance arrangements and in partnership with the full range of local statutory, voluntary and private sector organisations. Councils will need to work with health partners in their Local Strategic Partnerships to undertake Joint Strategic Needs Assessments (JSNAs), which will in turn be informed by, and support other needs assessments and plans (eg the Sustainable Community Strategy and local housing strategies). This reflects the shared responsibilities for health and wellbeing of citizens, families and communities as set out in the NHS Operating Framework[25].

8. Appendix A of this document sets out the resources available for the year 2008/09 for undertaking this redesign of systems, processes and transactions to transform delivery. The allocations are made on the basis of the Adult Social Care Relative Needs Formula. The Grant will continue over the three years of the CSR07 settlement and indicative allocations for 2009/10 and 2010/11 are included for planning purposes.

Purpose of the monies

9. The Department of Health (DH) is making available, through the Social Care Reform Grant, monies to support councils in this transformation. It is in addition to the monies provided through the Personal Social Services funding and is specifically for the range of process reengineering, capability and capacity building activities required to design the entire system including work to:

   (i) Change the social care system away from the traditional service provision with its emphasis on inputs and processes towards a more flexible, efficient approach, which delivers the outcomes people want and need and promotes their independence, well-being and dignity.

   (ii) Create a strategic shift in resources and culture from intervention at the point of crisis towards early intervention focused on promoting independence and improved wellbeing in line with the needs of the local population, reaching out to those at risk of poor outcomes.

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[24] *Our health, our care, our say: a new direction for community services*, Department of Health (2006)
[25] The Operating Framework for the NHS in England 2008/09, pp25
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094

(iii) Ensure that people are much more involved in the design, commissioning and evaluation of services and how their needs are met. This choice and control should extend to individuals in every setting and at every stage; ranging from advocacy and advice services, prevention and self-management to complex situations where solutions are developed in partnership with professionals.

(iv) Remodel systems and processes so they are not only efficient and equitable but also recognise the ability of individuals to identify cost effective, personalised solutions through wider community networks and innovation.

(v) Join up services to provide easy to recognise access points, which coordinate or facilitate partner organisations to meet the needs of individuals. Systems should be put in place to identify hard to reach people and strategies developed to meet their needs.

(vi) Raise the skills of the workforce to deliver the new system, through strengthening commissioning capability, promoting new ways of working and new types of worker and remodelling the social care workforce.

(vii) Develop leadership at all levels of local government and communities to enable this change to happen.

10. In practice, what this means is that by 2011 all 150 councils will be expected to have made significant steps towards redesign and reshaping their adult social care services (in the light of their JSNAs), having most of the core components outlined below in place:

- An integrated approach to working with the NHS and wider local government partners. Moving to harness resources from across the whole system, with a strategic shift in the focus of care and support away from intervention at the point of crisis to a more holistic, pro-active and preventative model centred on improved well-being. This might include focus on specific outcomes such as hospital discharge, intermediate care, transition to adulthood and co-location of services.

- A commissioning strategy which includes incentives to stimulate development of high quality services that treat people with dignity and maximise choice and control as well as balancing investment in prevention, early intervention/re-ablement and providing intensive care and support for those with high-level complex needs. This should have the capacity to support third/private sector innovation, including social enterprise and where appropriate undertaken jointly with the NHS and other statutory agencies such as the Learning and Skills Council.

- Universal, joined-up information and advice available for <u>all</u> individuals and carers, including those who self-assess and fund. Enabling people to access information from all strategic partners (eg third sector organisations, LinkAge Plus, Pensions Agency). Councils could do this using the ‘first stop shop’ model. Links to advocacy and support services will need to be considered where individuals do not have a carer or in circumstances where they require support to articulate their needs and/or utilise the personal budget.

- A framework for proportionate contact and social care needs assessment to deliver more effective, joined-up processes. Greater emphasis on self-assessment, enabling social workers to spend less time on assessment and more on support, brokerage and advocacy to ensure users experience a 'no wrong door' service.

- Person centred planning and self-directed support to become mainstream, with individuals having choice and control over how best to meet their needs, including through routine access to telecare.

- A simple, straightforward personal budget system, which will lead to maximum choice and control being in the hands of people who use services as well as support to increase the uptake of direct payments.

- Mechanisms to involve family members and other carers as care partners, with appropriate training to enable carers to develop their skills and confidence.

- An enabling framework to ensure people can exercise choice and control with accessible advocacy, peer support and brokerage systems with strong links to user led organisations. Where ULOs do not exist, a strategy to foster, stimulate and develop user led organisations locally.

- An effective and established mechanism to enable people to make supported decisions built on appropriate safeguarding arrangements, eg risk boards and corporate approaches to supporting individual choice. Supported by a network of "champions", including volunteers and professionals, promoting dignity in local care services.

- Active membership of the local/regional personalisation networks to ensure access to the latest information, advice and support. Effective local information systems to capture inputs/outputs and outcomes for individuals to support local quality assurance.

11. Councils will also be expected to have started, either locally or in their regions, to develop:

- A market development and stimulation strategy, either individually or on a wider regional basis with others, with actions identified to deliver the necessary changes. This may include a transformed community equipment service, consistent with the retail model.

- A workforce with the capacity and capability to deliver choice and support control, staff who are appropriately trained and empowered to be able to work with people to enable them to manage risks and resources.

12. In summary, in the longer term, all 150 councils with social services responsibilities should be transformed to deliver personalised services, which enable individuals or groups to develop solutions, which work for them. Key components should include:

- Everyone eligible for statutory support, should have a personal budget, a clear and transparent allocation of resources, with many more people having the opportunity to take all or part of this budget as a direct payment.

- A strategic balance of investment between enablement, early intervention and prevention, providing intensive care and support for those with high-level complex needs.

- A Common Assessment Framework in place across health and social care to deliver a more diverse range of local services and solutions.

- An established mechanism to ensure that views and experiences of users, carers and other stakeholders is central to every aspect of the reform programme.

Actions

13. Councils will be expected to:

    (i) work with regional consortia and improvement agencies to start to develop and identify local actions needed for service transformation.
    (ii) engage with other partners, including disabled people and their organisations to ensure this priority contributes to and is properly represented in discussions on Local Area Agreements.

14. DH will work with partners in Government and across the sector to develop and improve outcome-based indicators around prevention and early intervention informed by the evaluation of the POPPs pilots and provide tools, technologies and approaches flowing from the learning from the IB pilots and related initiatives.

ANNEX B - Useful web-links

Dementia Tool-kit - Strengthening the Involvement of People with Dementia
http://www.olderpeoplesmentalhealth.csip.org.uk/service-user-and-carer-engagement-tool/download-the-toolkit.html

Care Services Efficiency Delivery (CSED) Programme
http://www.csed.csip.org.uk/

Partnerships for Older People Projects
http://www.dh.gov.uk/en/Policyandguidance/SocialCare/Deliveringadultsocialcare/Olderpeople/PartnershipsforOlderPeopleProjects/DH_080122

Promoting Independence toolkit – The Long Marathon to achieving choice and control for older people
http://www.changeagentteam.org.uk/index.cfm?pid=597

Self-Directed Support Network
http://kc.csip.org.uk/about.php?grp=36

Individual Budgets
http://individualbudgets.csip.org.uk/index.jsp

Increasing the Uptake of Direct Payments - Solution Set
http://kc.csip.org.uk/solutionset.php?grp=601

CSIP Networks
http://www.integratedcarenetwork.gov.uk/index.cfm?pid=5

National Service Framework and System Reform for Older People
http://www.dh.gov.uk/en/Policyandguidance/SocialCare/Deliveringadultsocialcare/Olderpeople/DH_079331

Valuing People Support Team
http://valuingpeople.gov.uk/index.jsp

New Deal for Carers
http://www.dh.gov.uk/en/Policyandguidance/SocialCare/Deliveringadultsocialcare/Carers/NewDealforCarers/index.htm

Our Health, Our Care, Our Say: A New Direction for Community Services
http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Modernisation/Ourhealthourcareoursay/index.htm

Commissioning Framework for Health and Well-Being
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604

Local Government White Paper: Strong and Prosperous Communities
http://www.communities.gov.uk/localgovernment/currentagenda/strongprosperous/

LinkAge Plus evaluation
http//www.dwp.gov.uk/asd/asd5/WP42.pdf

Creating Strong, Safe and Prosperous Communities [draft statutory guidance on Local Area Agreements, the duty to co-operate and commissioning]
www.communities.gov.uk/publications/localgovernment/statutoryguidance

Putting People First

A shared vision and commitment to the transformation of Adult Social Care

Local Government Association

adass

NHS

Putting People First

A shared vision and commitment to the transformation of Adult Social Care

1 Introduction

The Our health, our care, our say White Paper and statements in the 2007 budget report and Comprehensive Spending Review announcement outlined the key elements of a reformed adult social care system in England; a system able to respond to the demographic challenges presented by an ageing society and the rising expectations of those who depend on social care for their quality of life and capacity to have full and purposeful lives.

Demography means an increasing number of people are living longer, but with more complex conditions such as dementia and chronic illnesses. By 2022, 20% of the English population will be over 65. By 2027, the number of over 85 year-olds will have increased by 60 %. People want, and have a right to expect, services with dignity and respect at their heart. Older people, disabled people and people with mental health problems demand equality of citizenship in every aspect of their lives, from housing to employment to leisure. The vast majority of people want to live in their own homes for as long as possible.

In the context of changing family structures, caring responsibilities will impact on an increasing number of citizens. Examples include an eighty-year-old woman having to cope with her husband's dementia, a young mum pursuing a career and bringing up a family while looking after her elderly parent, a business executive working overseas whose widowed mother is hospitalised overnight following a stroke and older parents seeking for the right support to ensure their adult son with a learning disability can live independently.

We agree that there is a need to explore options for the long term funding of the care and support system, to ensure that it is fair, sustainable and unambiguous about the respective responsibilities of the state, family and individual. As stated in the Comprehensive Spending Review (CSR) announcement 2007, the Government will produce a Green Paper following extensive public consultation setting out the key issues and options for reform. Notwithstanding the Green Paper on longer-term reform of the funding system and following the recent CSR settlement, there is now an urgent need to begin the development of a new adult care system. A personalised system which can meet the challenges described earlier and is on the side of the people needing services and their carers. While acknowledging the Community Care legislation of the 1990s was well intentioned, it has led to a system which can be over complex and too often fails to respond to people's needs and expectations.

This landmark protocol seeks to set out and support the Government's commitment to independent living for all adults. It also outlines the shared aims and values, which will guide the transformation of adult social care. It is unique in establishing a collaborative approach between central and local Government, the sector's professional leadership, providers and the regulator. It seeks to be the first public service reform programme which is co-produced, co-developed, co-evaluated and recognises that real change will only be achieved through the participation of users and carers at every stage. It recognises that sustainable and meaningful change depends significantly on our capacity to empower people who use services and to win the hearts and minds of all stakeholders', especially front line staff. Local government will need to spend some existing resources differently and the Government will provide specific funding to support system-wide transformation through the Social Care Reform Grant, in line with agreements on new burdens.

We do not seek to prescribe uniform systems and structures in every part of the country. However, access to high quality support should be universal and available in every community. Some of these reforms can be made within the parameters of the local adult social care policies. Others require adult social care to take a leadership role within local authorities, across public services and in local communities.

Ultimately, every locality should seek to have a single community based support system focussed on the health and wellbeing of the local population. Binding together local Government, primary care, community based health provision, public health, social care and the wider issues of housing, employment, benefits advice and education/training.

This will not require structural changes, but organisations coming together to re-design local systems around the needs of citizens. The new local performance framework, which covers the delivery of all services by local government working alone or in partnership, will help to create an improved approach to local partnership, enabling local authorities and partners to work together to lead their area and better meet the public's needs. The transformation of adult social care will be delivered through the new performance framework, and will draw on new mechanisms within the framework, such as the new statutory requirement on local authorities and PCTs to undertake a Joint Strategic Needs Assessment, to ensure that the transformation process really delivers on the challenges for each local area.

In future organisations will be expected to put citizens at the heart of a reformed system. Incentives will include the new focus of the local performance framework, guidance on commissioning for health and wellbeing, Human Rights legislation, and any international obligations such as the new UN Convention on the Rights of Persons with Disabilities.

2 Values

Ensuring older people, people with chronic conditions, disabled people and people with mental health problems have the best possible quality of life and the equality of independent living is fundamental to a socially just society.

For many, social care is the support which helps to make this a reality and may either be the only non-family intervention or one element of a wider support package.

The time has now come to build on best practice and replace paternalistic, reactive care of variable quality with a mainstream system focussed on prevention, early intervention, enablement, and high quality personally tailored services. In the future, we want people to have maximum choice, control and power over the support services they receive.

We will always fulfil our responsibility to provide care and protection for those who through their illness or disability are genuinely unable to express needs and wants or exercise control. However, the right to self-determination will be at the heart of a reformed system only constrained by the realities of finite resources and levels of protection, which should be responsible but not risk averse.

Over time, people who use social care services and their families will increasingly shape and commission their own services. Personal Budgets will ensure people receiving public funding use available resources to choose their own support services – a right previously available only to self-funders. The state and statutory agencies will have a different not lesser role – more active and enabling, less controlling.

3 A personalised Adult Social Care System

The key elements will be:

3.1 **Local authority leadership accompanied by authentic partnership working with the local NHS, other statutory agencies, third and private sector providers, users and carers and the wider local community to create a new, high quality care system which is fair, accessible and responsive to the individual needs of those who use services and their carers.**

The current Darzi review of the NHS has recognised the relationship between health, social care and wider community services will be integral to the creation of a truly personalised care system.

3.2 **Agreed and shared outcomes which should ensure people, irrespective of illness or disability, are supported to:**

- live independently;
- stay healthy and recover quickly from illness;
- exercise maximum control over their own life and where appropriate the lives of their family members;
- sustain a family unit which avoids children being required to take on inappropriate caring roles;
- participate as active and equal citizens, both economically and socially;

- have the best possible quality of life, irrespective of illness or disability;
- retain maximum dignity and respect.

3.3 System-wide transformation, developed and owned by local partners covering the following objectives:

- A joint strategic needs assessment undertaken by local authorities, relevant PCT and NHS providers. This should be undertaken in conjunction with other local needs assessments and plans (for example, local housing strategies). The joint strategic needs assessment and these other plans will inform the Sustainable Community Strategy. It will also be accompanied by an integrated approach with local NHS commissioners and providers to achieve specific outcomes on issues including:
  - relevant preventative public health policies, e.g. infection control and fall reduction strategies;
  - hospital discharge arrangements;
  - the provision of adequate intermediate care;
  - the management of long term conditions;
  - packages of support with a health and/or nursing care element;
  - co-located services, bringing together social care; primary care and other relevant professionals;
  - community equipment services;
  - universal information, advice and advocacy;
  - carer support and public/patient involvement;
  - complaints systems.

  The full range of relevant local statutory, voluntary and private sector organisations need to be fully engaged. Where appropriate, Local Area Agreements will be the vehicle to bring together national policy with local priorities, informed by the vision developed by local partners. This will mean organisations being willing to allocate funding to others, if this will have greater impact on shared outcomes. The NHS Operating Framework will reflect a new shared responsibility for the health and wellbeing of citizens, families and communities.
- Commissioning which incentivises and stimulates quality provision offering high standards of care, dignity and maximum choice and control for service users. Supports third/private sector innovation, including social enterprise and where appropriate is undertaken jointly with the NHS and other statutory agencies eg Learning and Skills Council, employment services, and Housing Authorities. This must be shaped by the Joint Strategic Needs Assessment.
- A locally agreed approach, which informs the Sustainable Community Strategy, utilising all relevant community resources especially the voluntary sector so that prevention, early intervention and enablement become the norm. Supporting people to remain in their own homes for as long as possible. The alleviation of loneliness and isolation to be a major priority. Citizens live independently but are not independent; they are interdependent on family members, work colleagues, friends and social networks.
- A universal information, advice and advocacy service for people needing services and their carers irrespective of their eligibility for public funding. A 'first shop stop', which could be accessed by phone, letter, e-mail, internet or at accessible community locations. Key strategic partners to be the Pensions Agency and relevant voluntary organisations. The LinkAge Plus pilots are providing strong evidence of the benefits for older people of this approach. Personal advocates to be available in the absence of a carer or in circumstances where people require support to articulate their needs and/or utilise the personal budget.
- A common assessment process of individual social care needs with a greater emphasis on self-assessment. Social workers spending less time on assessment and more on support, brokerage and advocacy.
- Person centred planning and self directed support to become mainstream and define individually tailored support packages. Telecare to be viewed as integral not marginal.
- Personal budgets for everyone eligible for publicly funded adult social care support other than in circumstances where people require emergency access to provision. Lord Darzi's recent NHS next stage review interim report suggested that in the future personal budgets for people with long-term conditions could include NHS resources.

- Direct payments utilised by increasing numbers of people, as defined by locally set targets in LAAs.
- Family members and carers to be treated as experts and care partners other than in circumstances where their views and aspirations are at odds with the person using the service or they are seeking to deny a family member the chance to experience maximum choice and control over their own life. Programmes to be supported which enable carers to develop their skills and confidence.
- A transformed community equipment service, consistent with the retail market model.
- Systems which support integrated working with children's services, including transition planning and parent carers, and identifying and addressing concerns about children's welfare.
- Support for at least one local user led organisation and mainstream mechanisms to develop networks which ensure people using services and their families have a collective voice, influencing policy and provision.
- Systems which act on and minimise the risk of abuse and neglect of vulnerable adults, supported by a network of "champions", including volunteers and professionals, promoting dignity in local care services.
- Local workforce development strategies focussed on raising skill levels and providing career development opportunities across all sectors. Strategies to be co-produced, co-developed and co-evaluated with the private and voluntary sectors.

Adult social care will also take responsibility for championing the rights and needs of older people, disabled people, people with mental health needs and carers within the local authority, across public services and in the wider community. Early priorities will be intergenerational programmes involving older people as active citizens, integrated policy development which supports independent living (housing, access to work, education/training and leisure) including transition planning for young disabled people and local action to tackle the stigma faced by people with mental health problems.

4 Support for Reform

The Department of Health will provide funding over the next three years to support system-wide transformation in every local authority. Local authorities and their partners will agree together how this funding will be spent to develop the personalised system described in Section 3.

A detailed prospectus consistent with our core principles will be published in December.

In line with the soon to be published National Improvement and Efficiency Strategy (NIES), Department of Health (DH), will refocus the relevant activities of Care Services Efficiency Delivery Programme (CSED) and Care Services Improvement Partnership (CSIP) and seek partnerships with Regional Improvement and Efficiency Partnerships, local consortia, In Control and other 'change agents' to ensure every local authority has access to high quality support for the necessary change programme.

DH, and where appropriate, other Government Departments, will ensure new capital investment supports a more integrated approach to health and wellbeing in every community.

DH will lead a new cross-ministerial group including the Treasury, Department for Communities and Local Government (CLG), Department for Work and Pensions (DWP), Department for Innovation, Universities and Skills (DIUS) and Department for Children, Schools and Families to ensure a joined-up approach to adult social care transformation and the review of long-term funding. The need for legislative and regulatory changes will be considered in consultation with local Government, providers and other stakeholders.

A new skills academy is being developed with partners to support world class commissioning and leadership in social care. Skills for Care and the General Social Care Council (GSCC) will provide leadership to ensure entry level training, continued professional development and workforce registration to reflect the new skills required in a personalised system. In taking this forward, we will ensure that opportunities for co-ordination and joint capacity building are exploited with the World Class Commissioning programme for PCTs and those programmes in Children's services and the rest of local government. DH will also work with CLG and the Local Government Association (LGA) to consider how best to take this forward in the context of the NIES.

Social Care Institute for Excellence (SCIE) will be expected to promote, identify, and disseminate best practice and innovation, acting as a catalyst for system-wide transformation. Commission for Social Care Inspection (CSCI) and their successor regulator will align their approach to inspection and regulation with the reform agenda, in the context of the Comprehensive Area Assessment (CAA).

5 Timescale

Every local transformation process will include clear benchmarks, timescales and designated delivery responsibilities.

By the end of the CSR period in March 2011, we expect people who use services and their carers as well as front line staff and providers to experience significant progress in all local authority areas. Incremental progress should be evident over a shorter period of time.

6 Engagement/ Consultation

If we are to win the hearts and minds of all stakeholders, especially frontline staff, it is essential that they are participants in the change programme from the design stage onwards.

It is hoped that every local authority will create forums, networks and task groups which involve staff across all sectors, people who use services and carers as active participants in the change process.

7 Conclusion

We recognise that organisations such as In Control, other voluntary organisations and some local authorities have been at the cutting edge of innovation in adult social care for some time. The Individual Budget, Partnerships for Older People and LinkAge Plus pilots have begun to demonstrate what works as well as identifying barriers to progress.

However, national and local leadership is now essential if we are to achieve system-wide transformation. This is necessary because of demographic realities, but driven by a shared commitment to social justice.

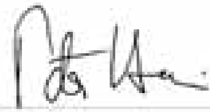
This protocol seeks to be a catalyst – not a straightjacket – for innovation and is the first stage in a unique attempt to co-produce, co-develop and co-evaluate a major public service reform.

We will judge our success through the views and experiences of those who use the social care system, progress in supporting adults to live independently, objective measures of performance, and the job satisfaction of those working at all levels of the system.

In the future, adult social care will touch the lives of an increasing number of families.

By signing this historic protocol, we accept our shared responsibility to create a high quality, personalised system which offers people the highest standards of professional expertise, care, dignity, maximum control and self determination.

Secretary of State for Health



Secretary of State for Work and Pensions

Secretary of State for Communities and Local Government

Secretary of State for Children, Schools and Families

Chief Secretary to the Treasury

Secretary of State for Innovation, Universities and Skills

Chair, Local Government Association

President, Association of Directors of Adult Social Services

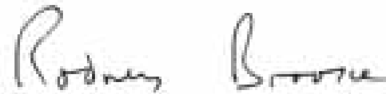
Chief Executive, NHS

Chief Executive, NHS Confederation

Chair, Society of Local Authority Chief Executives

Chair, Commission for Social Care Inspection

Chair, Social Care Institute for Excellence



Chair General Social Care Council

Chair Skills for Care

English Community Care Association

National Care Association

UK Home Care Association

Executive Director, National Care Forum

csci

English
Community Care
Association

General
Social Care
Council

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National Care Association

THE NHS CONFEDERATION

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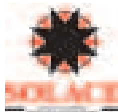
SOLACE

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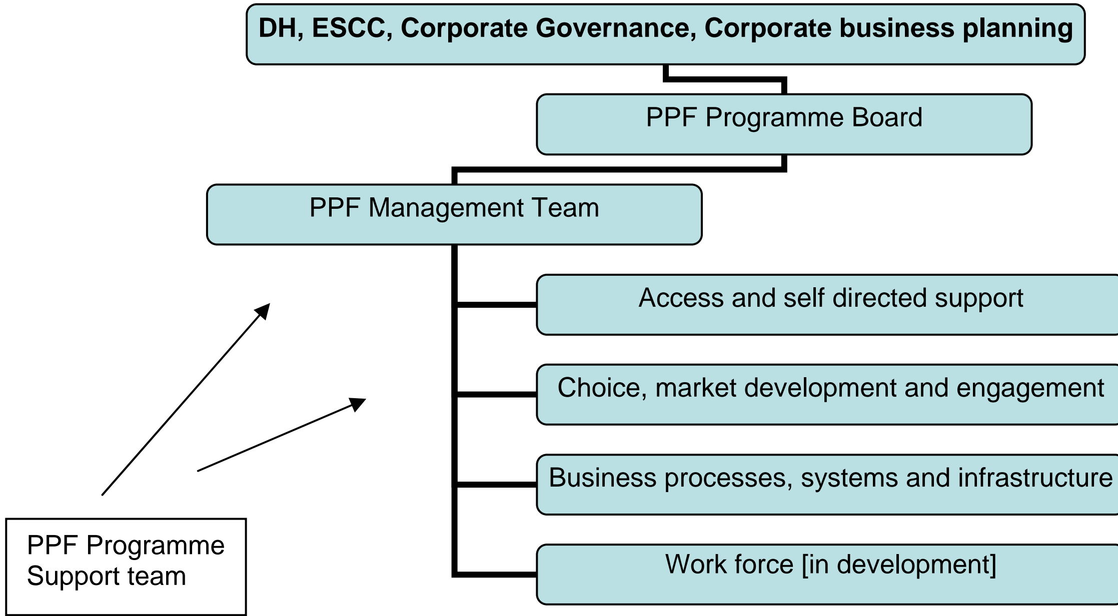
‘Putting People First’ Programme organisation chart



PPF Summary Timeline v4

	Oct - Mar 2008/2009	April - Sept 2009	Oct - Mar 2009/2010	April - Sept 2010	Oct - Mar 2010/2011
SDS Process & Activity					
SDS team in place	■				
12 Service users for 1st PB pilot identified	■				
Prototype policies/procedures completed (inc finance, audit, legal)	■				
Prototype fairer charging policy agreed	■				
1st Personal Budget pilot started	■				
1st PB pilot completed		■			
Advocacy & brokerage pilot started	■				
Advocacy & brokerage pilot completed		■			
Interim policies/procedures completed (inc finance, audit, legal)		■			
Interim fairer charging policy agreed		■			
50/100 Service Users for 2nd PB pilot identified		■			
2nd PB pilot completed			■		
Clear future role of advocacy in SDS process agreed			■		
Mainstream policies/procedures completed (inc finance, audit, legal)			■		
Mainstream fairer charging policy agreed			■		
SDS high level process approved	■				
SDS detailed process approved	■				
Aim all new referrals go through SDS process				■	
SDS Tools Development					
250 case data sent to FACE	■				
Interim RAS prototype agreed - electronic	■				
Mainstream RAS agreed		■			
Interim SAQ prototype agreed - document	■				
Interim SAQ prototype agreed - electronic (care assess)	■				
Mainstream SAQ agreed - document			■		
Mainstream SAQ agreed - electronic (care assess)			■		
Mainstream SAQ agreed - electronic (web based)			■		
PB Accounting System prorotype agreed	■				
CF6 training and upgrade rolled out to 700 users		■			
EDRM solution		■			
PB Accounting System interim agreed	■				
Support Plan prototype agreed - document		■			
Support Plan prototype agreed - electronic		■			
Support Plan processes and procedures agreed - prototype		■			
Support Plan training rolled out			■		
Support Plan processes and procedures agreed - mainstream			■		
Support Plan mainstream agreed - document			■		
Support Plan mainstream agreed - electronic			■		
PB Accounting System mainstream agreed			■		
Market Development					
Client group areas - agree with commissioning managers	■				
Client group PPF events - providers and users		■			
DPS reviews - Older People		■	■	■	
Tender process initiated for new Homecare contract		■			
New Homecare contract awarded			■		
New Homecare contract started				■	
Supporting People retendering		■	■	■	
Voluntary Sector contracts reviewed					■
Engagement					
Blueprint for future services consulted on			■		
Published strategic direction tested against blueprint/strategies			■		
Blueprint for future services finalised and published					■
Commissioning & Procurement Model					
Draft strategy of commissioning & procurement model to DMT		■			
Strategy of commissioning & procurement model completed			■		
Information and Access					
CRM full implementation		■			
Health & Social Care Website			■		
Phase 2 scoped and agreed	■				
DP developments					
Bank cards/light touch - policies and procedures		■			
Programme Management					
High level business case and plan completed	■				
Full Business Case developed, consulted on and published	■				
Full Business Plan developed	■				
Performance & Engagement Frameworks Developed	■				
Proposed EIA Action Plan Developed	■				
Key programme milestones identified	■				
PID signed off	■				
PPF Board established	■				
PPF Management Team established	■				
Programme Assurance review carried out		■			■
Equalities Impact Assessment (reviewed annually)		■			
Vision, Objectives & Deliverables agreed	■				
Benefits identified and mapped	■				
Benefits tracking, evluation & performance	■	■	■	■	■
Risks and issues tracking and corrective action	■	■	■	■	■
Workforce					
Workstream Scoped	■				
Care Management, brokerage and advocacy	■				
Directly Managed Services - workforce		■			
Private & voluntary sector		■	■		
Social enterprise			■		
Communications					
Communications Plan completed	■				
ESCC Corporate, ASC workforce	■	■			
Local opinion formers, partners, suppliers & other key stakeholders	■	■		■	
Formal consultation	■		■		
Organisational Development					
Programme management capacity building	■				

Project Initiation Document

Project Title:	CareFirst Upgrade (Version 6 & CareAssess)
Department:	Adult Social Care
Sponsor:	Mark Stainton (Assistant Director)
Customer Contact:	Alex Garnett (Head of Business Development)
Author:	Charity Thrussell (Business Manager, Business Development)
Date:	29 April 2008
Version:	Version 0.6 - DRAFT

Revision History

Revision Date	Version	Summary of Changes	Changed by
25 April 08	V0.2	Changes made post a review with the BA's involved in this project	Charity Thrussell
30 April 08	V0.4	Changes made post a review with Kate Griffiths	Charity Thrussell
07 May 08	V0.6	Changes made post a review with Alex Garnett	Charity Thrussell

Approvals

This document requires the following approvals. Signed approval forms are filed in the project files.

Version	Name	Title	Signature	Date of approval

Guidance
This PID template has been created using the East Sussex County Council Project Management Toolkit Template with small changes to reflect OGC best practise.
Projects initiated under the Assessment and Care Management Programme should use this PID template.
Guidance has been provided in italics – red text refers to guidance found on the ESCC Project Management Toolkit PID template, to ensure corporate requirements are fulfilled and corporate advice followed. Black text reflects best practise guidance and is provided to assist with content formulation.
Please delete Italic text as appropriate whilst working through the document.

Purpose of a PID
This document defines all major aspects of the project and forms the basis for its management and the assessment of overall success. There are two primary uses of the document:
To ensure that the project has a complete and sound basis before there is any major commitment to the project
To act as a base document against which the project can assess progress, change management issues, and ongoing viability questions. As a minimum the document should answer the following fundamental questions about the project:

- *What the project is aiming to achieve*
- *Why it is important to achieve it*
- *Who will be involved in managing the process and what are their responsibilities*
- *How and when the project will be undertaken*
- *The PID has to answer the above questions to a sufficient level of detail to maintain control of the project.*

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1. Purpose of document

The purpose of this document is to define all major aspects of the project, to inform the basis for its management and the assessment of overall success.

2. Background

East Sussex County Council has successfully implemented an Electronic Social Care Record (ESCR) by utilising CareFirst, CareStore and CareDoc to underpin its core business operations. This has allowed an alignment of managerial information requirements against the ability for end users to capture necessary data. End user acceptance of these systems has been achieved and they firmly support day-to-day activities within Adult Social Care and Children's Services. These systems are also seen as the building blocks that will support further improvement.

CareFirst 5 is the current version of software used within Adult Social Care and Children's Services to record information relating to client cases electronically.

OLM, the providers of CareFirst software have released an upgrade, CareFirst 6.x. Within this web enabled upgrade is included a module called CareAssess. This is a significant upgrade and new assessment module which has the potential to bring improvements and efficiencies to how information is recorded within CareFirst.

3. Objectives

- To deploy CareFirst 6 functionality to support the delivery of Adult Social Care via modern web-enabled business support tools.
- To improve on current operational/business process using new technology provided with CF6.
- To improve the users experience of the CareFirst system.
- To provide a practitioner led system that supports business needs.
- To build a technology platform that can be made accessible to joint/external parties such as Health.
- To provide a technology platform to help support government targets/programmes such as Putting People First and Individualised Budgets
- To meet current E-Government and ESCR standards

4. Scope and Exclusions

4.1 In Scope

Phase 1

- Technical implementation of ICT infrastructure and software for CareFirst 6.x
- Procurement of business operation software via a formal procurement method or by direct purchase
- The upgrade and deployment of CareFirst 6 Web Version across Adult Social Care based on current business processes (note: phase 1 will not include CareAssess)

Phase 2

- An audit and review of the current CareReports
- Delivery of CareReports alongside the deployment of CareFirst 6

Phase 3

- Analysis of the current processes supporting the individual business operational areas
- The implementation of CareAssess, deploying questionnaires and worlflows to support Adult Social Care business processes

All Phases

- Identification of potential changes to current processes including their impact on the business.
- Assistance with the implementation of changes to processes including working with managers and staff in the business operational areas to ensure that changes are a success.

4.1 Out of Scope

- An audit / review of reports produced in Business Objects or Infoview
- Delivery of any changes to other systems (or interfaces) other than CareFirst
- The review/design of forms and documentation tools supporting business processes (e.g. Single Assessment Questionnaire (SAQ) or Resource Allocation System (RAS))

5. Risks

This part of the PID has been prepared after an initial consideration of initial risks to the project and the provision of ongoing services. It aims to evaluate the possibility of risk occurring, the impact should risk occur and identify actions to either eliminate or mitigate a given risk.

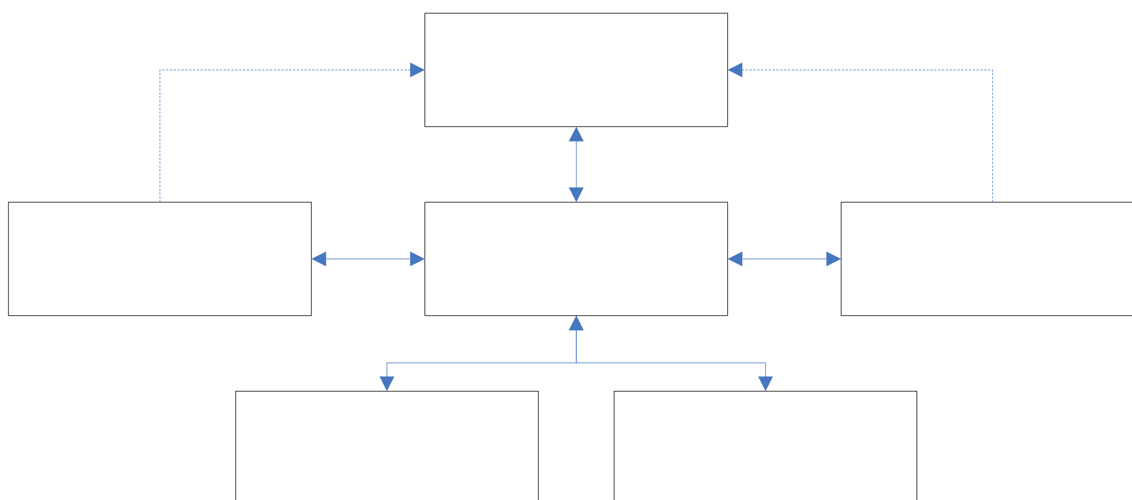
Please refer to **Appendix B** to see the Risk Log.

6. Responsibilities

The roles and responsibilities of the main Project Team are listed below:

Role	Responsibilities
Charity Thrussell (Project Manager)	• Compiling and collating progress information relating to the Project. • Planning and managing the detailed level of the Project Plan. • Responsibility for the quality control and assurance procedures. • Ensuring project outcomes are delivered on time. • Maintain sub-project documentation. • Manage the resources to attain the project outcomes. • Engage with stakeholders to facilitate change. • Identification and management of project risks.
Scott McLean Samuel Pritchard Lucy Johnson (Business Analysts)	• Assist the Project Manager in preparing and maintaining the project plan and associated documentation. • Support the Project Manager to co-ordinate and manage the project work. • Engage with stakeholders to facilitate change. • To carry out project tasks as allocated in the Project Plan • Assist in identifying and managing project risks and issues

7. Project Organisation



Listed below are the governance arrangements and responsibilities

7.1 Project Board

The CF6 project board will provide approval for the project and approval and acceptance of project phases/stages as outlined in the project plans.

Name	Role
Alex Garnett	Head of Business Development
Charity Thrussell	Business Manager / Project Manager CF6
Kate Griffiths	Business Manager
Mick Acott	Business Manager
Isobel Pennington / John Moore	Children's Services
Eric Hanslip	Corporate ICT / CF6 Technical Project Manager
TBC	Operational Representative

7.2 Project Technical Team

The Project Technical Team are responsible for the hardware and software implementations required for the CF6 upgrade project. They will report to the CF6 Implementation Team and the CF6 Project Board.

Name	Role
Alex Garnett	Head of Business Development
Charity Thrussell	Business Manager / Project Manager CF6
Eric Hanslip	Corporate ICT / CF6 Technical Project Manager
Isobel Pennington / John Moore	Children's Services
Mike Brett	Corporate ICT
Phil Russell	Oracle Developer (Contractor)
Sarah Western	Systems Administrator

7.3 Project Implementation Team

This is a key team, working closely to understand CF6 functionality. This team will build their knowledge of CF6 in order to support the project tasks they undertake. This group will report to both the CF6 project board and to the CF6 wider project team. This group will meet weekly.

Name	Role
Charity Thrussell	Business Manager / Project Manager CF6
Lucy Johnson	Business Analyst
Samuel Pritchard	Business Analyst
Scott McLean	Business Analyst
Michelle Parsons (once a month)	Business Analyst

The CF6 Wider Project Implementation Team will meet monthly to communicate, consult and feedback on the status of the CF6 project.

Name	Role
Charity Thrussell	Business Manager / Project Manager CF6
Lucy Johnson	Business Analyst
Sam Pritchard	Business Analyst
Scott McLean	Business Analyst
Michelle Parsons	Business Analyst
Sarah Turner	Business Analyst
Kate Griffiths	Business Manager
Isobel Pennington	Children's Services
Sarah Western	Systems Administrator
Mick Acott / Adam Norton	Business Information
Admin Co-ords TBC	Operational Reps

7.4 Project Testing Team

The Project Testing Team will be responsible for the technical testing of CF6 before it is tested with operational staff. Operational Staff will be invited to attend as and when it's appropriate to test the user functionality.

Name	Role
Scott McLean (Chair)	Business Analyst
Lucy Johnson	Business Analyst
Michelle Parsons	Business Analyst
Business Support Officers	Business Analyst
Admin Co-ordinators	Operation Reps
Operational Team Reps	Operational Reps (when required)

7.5 Project Reporting/Information Team

The Project Reporting Team will be responsible for ensuring the current CareFirst reports and/or CareReports can deliver the performance information needed. This group will report to the Implementation Teams andProject Board and keep the Performance Board informed also.

Name	Role
Charity Thrussell	Business Manager / Project Manager CF6
Mick Acott / Adam Norton	Business Information
Chris Searle	Business Analyst
Sam Pritchard	Business Analyst
Phil Russell	Oracle Developer (Contractor)
TBC	Operational Rep
TBC	Children's Rep

8. Communications Plan

Stakeholder:	Method(s):	Frequency:
Sponsor	Project Board Meetings Highlight Reports End of stage reports	Monthly Monthly End of Stages
Business Development Manager	Project Board Highlight Reports End of Stage Reports	Monthly Monthly End of Stages
Business Development (Business Analysts)	Via Implementation Team Meetings Via Highlight Reports	Monthly Monthly
Business Development (Business Support Officers)	Business Dev Team Meetings Demonstrations / Workshops Involvement in the CF6 Testing Team	Every 2 months TBD TBD
Business Information	Via Wider Implementation Team Meetings Involvement in the CF6 Reports/Info Team Via Highlight Reports	Monthly Monthly Monthly
ACM Managers	Via updates to ACM Wider Network Meetings (to be cascaded to Operational Teams)	Monthly
Operational Teams /Staff	Via representation in CF6 Wider Implementation Team Via representation/involvment in CF6 Testing Team Demonstrations in Team Meetings	Monthly Various TBD
Finance & Business Information Teams	Via representation in CF6 Wider Implementation Team Via representation/involvement in CF6 Testing Team Demonstrations in Team Meetings	Monthly TBD TBD
Children's Services	Via Implementation Team Meetings Via Highlight Reports	Monthly Monthly
Corporate ICT	Via CF6 Technical Team Meetings Via Wider Implementation Team Meetings	Monthly Monthly
Systems Admin	Via CF6 Technical Team Meetings Via Wider Implementation Team Meetings	Monthly Monthly
All	Brief Encounter Articles	Quarterly

Note: Please see appendix C for the stakeholder matrix.

9. Resource Requirements

Project Manager
This role will manage the project and ensure delivery of the project outcomes and milestones.

Corporate ICT
Phase 1a - Technical Installation will be managed by corporate ICT (Eric Hanslip).

Business Analysts x 3
These project assistants will be involved in organising and delivering many of the tasks in this project from testing to implementation.

Business Information Team
A number of project tasks require the skills and involvement of the Business Information Team. This team's involvement is particularly required for Phase 2 (CareReports) and with testing and monitoring the impact on performance indicators.

Note: It is acknowledged that additional resources and skills (SQL / Actuate) may be required (above that of the Business Information Team) to carry out Phase 2 (this is also detailed as an additional project cost).

Business Support Officers (BSOs)
The BSO's work closely with operational staff and carry out CareFirst training. Resource from this team will be required throughout the project and particularly during the user testing, deployment and implementation stages. Consideration must be given to the availability of this teams resource. The BSO team may well require temporary additional resource to complete CareFirst6 training.

Operational Staff
Involvement of operational staff throughout this project is essential. Along with the BSO's operational staff will be required during user testing, deployment and implementation stages. Operational managers will be consulted in relation to the level of operational staff involvement required

CareFirst System Administrators
The CareFirst System Administrators will be required to set up the security groups and user accounts etc…within CareFirst.

10. Project Approach

PRINCE2 methodology will be used to plan and manage the project.

A detailed breakdown of the steps and tasks required is included in the project plan. The high level approach for this project is split out into the different phases of the project.

10.1 PHASE 1 – CareFirst Upgrade to CF6 Web Version

Below outlines the project stages that will be undertaken during phase 1.
A review will be held at the end of each stage.

- **Phase 1a – Technical Installation**
  This stage covers the hardware and software installation of CareFirst 6

  Target Completion Date: August 2008

- **Phase 1b - Functionality Testing**
  This stage will ensure that CareFirst 6.x meets the functional requirements to support Adult Social Care processes currently handled in CareFirst 5.x. This stage will:

  - Compare and test the new front end of CareFirst 6 with that of CareFirst 5.
  - Test that the data entered is successfully stored in the CareFirst 6 database.
  - Test the data input requirements for PAF indicators
  - Evaluate and test the dependencies with CareStore, CareDoc and CareReports.
  - Test security/permissions

  Target Completion Date: Sept / Oct 2008

- **Phase 1c – User Testing**
  During this stage we will be carrying out user testing with operational staff across Adult Social Care. This will involve scenario based testing

  Target Completion Date: TBC (dependency on Phase 2c)

- **Phase 1d – Deployment**
  This stage will include:
  - Updates to guidance and procedures
  - User account setup (not activated)
  - Agreeing training strategy / plans
  - Deployment of CareFirst URLs

  Target Completion Date: Oct 2008

- **Phase 1e – Implementation**
  - Staff training
  - User accounts activated
  - Go Live with CF6
  - Post Implementation Review

  Target Completion Date: Jan 2008

Note: 1c, 1d and 1e will be phased, i.e. work will be undertaken on a team by team basis.

10.2 PHASE 2 – CareReports

CareReports is a module of CareFirst that handles the reports accessed via the CareFirst desktop client. As part of the CareFirst 6 upgrade, the reporting software used by CareReports will be changed from Oracle6i Reports to Actuate Reports (or other solution as determined by the CareReports working group).

This phase handles the tasks required to manage the imposed change to CareReports and will run in parallel to Phase 1

- **Phase 2a – CareReports Audit**
  This stage will identify the current status of CareReports used in CareFirst5.
  Target completion date: May 2008

- **Phase 2b –CareReports Evaluation**
  This stage is to identify how the CareReports are transitioned when we upgrade to CareFirst 6.
  Target completion date July 2008

- **Phase 2c – CareReports Implementation**
  This phase will be further defined as phases 2a and 2b are completed.

10.3 PHASE 3 – CareAssess

CareAssess will be evaluated as phases 1 and 2 progress.
This phase will be analysed, planned and implemented once phases 1 and 2 have been completed.

This phase will introduce the enhanced functionality provided by the CF6 upgrade (i.e questionnaire and workflows)

11. Costs & Funding

Please refer to the business case (Appendix A)

12. Benefits

Please refer to the business case (Appendix A)

13. Deliverables

13.1 Phase 0 - Project Initiation

- Project Initiation Document
- Project Plan
- Risk/Issue Log
- Stakeholder matrix

13.2 Phase 1

Phase 1a – Technical Installation

- Technical Transition Study (produced by OLM)
- Hardware in place for CareFirst 6 implementation / deployment
- CareFirst 6 software installed (front and back office)

Phase 1b – Functionality Testing

- Testing plans and scripts
- Functionality reports (documenting functionality changes in CareFirst6).
  Note: These reports will highlight changes that may require a business process changes due to the upgrade to CareFirst6.
- Updated Risk / Issues Log
- End of Stage Report

Phase 1c – User Testing

- User Testing plan (phased approach by team)
- Testing scripts (scenario based)
- Agreed and documented permission groups
- User guidance for CareFirst 6 (draft)
- System Admin Guidance (draft)
- Updated Risk / Issues Log
- End of Stage Report

Phase 1d – Deployment

- User guidance for CareFirst 6
- System Admin Guidance
- Communication Plan / Strategy
- Training Strategy / Plan
- User Account List (detailing accounts to be created)
- Updated Risk / Issues Log
- End of Stage Report

Phase 1e – Implementation

- Training Manual / Course Guidance
- User Accounts List (highlighting accounts to be activated)
- Post Implementation Report
- Updated Risk / Issues Log
- End of Stage Report

13.3 Phase 2

Phase 2a – CareReports Audit

- Audit Report for CareReports

Phase 2b – CareReports Evaluation

- CareReports implementation plan (to highlight how we will progress and transition the reports that are currently in CareReports CF5).
- End of stage report

Phase 2c – CareReports Implementation

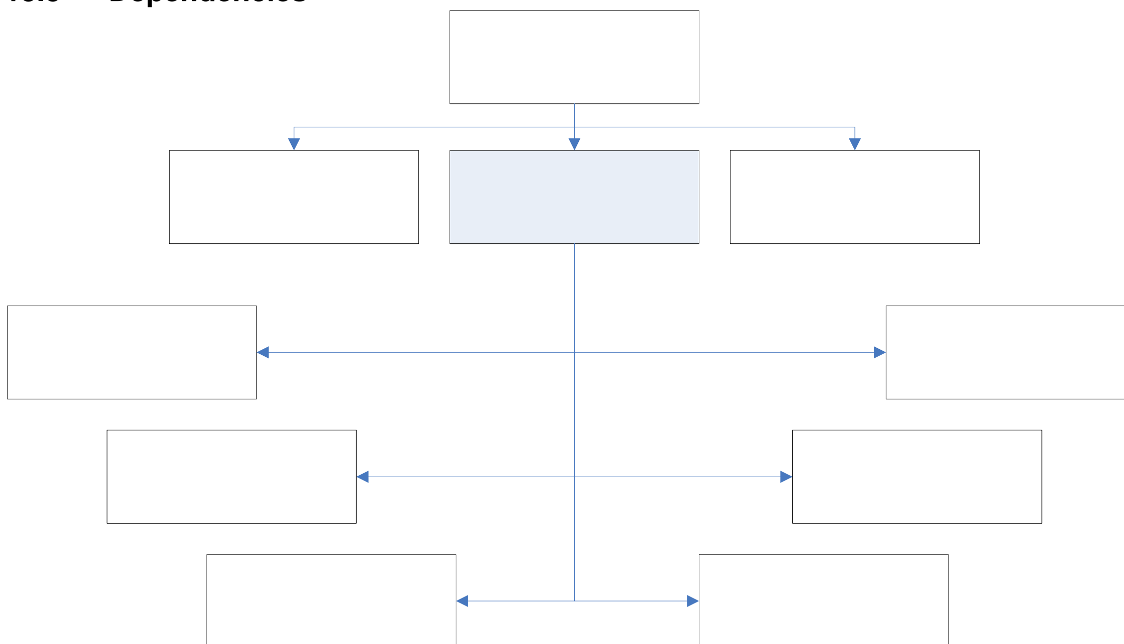
- TBC

13.4 Phase 3

CareAssess

- Deliverables and plans for this stage will be defined once the requirements of the ACM Programme are understood

13.5 Dependencies



13.6 Assumptions

- Availability and capacity of resources needed to support planned deliverables, including the training of end users, against other competing priorities.
- The implementation will be configured to current (as is) operational practices in Phases 1 & 2.
- That the Technical Transition Specification document (provided by OLM) has accurately scoped the technical requirements for this project.
- Network and hardware compatibility

14. Project Controls

The project will be run according to the PRINCE 2 project management standard.

The Project Board will first meet to authorise the project, then at the end of each project stage (stage boundaries will be defined in the project plan) before proceeding to the next stage. Additional meetings of the board will beheld if an exception has occurred, external events need to be considered, or there are resourcing issues.

15. Quality Plan

The quality of this project will be monitored via the CareFirst 6 Project Board.

Key deliverbales such as end of stage reports are to be reviewed and signed off by the CareFirst 6 Project Board.

Test plans will be written and agreed with key stakeholders working on the project. These test plans will be the basis for the user acceptance testing of CareFirst 6 and will confirm that functionality and business requirements have been meet.

Project documentation will be accessible on the network. Project documentation will be managed by the CareFirst Project Team.

Audit will have access to project documentation. The project manager will regulary meet (monthly) with audit to ensure that audit requirements are met.

16. Exception Process

The project manager will monitor timescales and costs at regular intervals. If she forecasts that tolerances for the cost will be exceeded, she will prepare an exception plan and present this to the Project Board. If necessary, the exception plan will be taken forward to the Assessment and Care Management Strategy Programme Board.

17. Change Control

Any requests to change the definition of the project as set down in this document must first be assessed by the Project Manager. She will give her assessment of the impact of the change to a subsequent meeting of the Project Board who will decide whether to accept the request.

18. Risk Management

The Project Manager will maintain a log of risks to the project. She will take risks into account in drawing up plans, and propose mitigations. The Risk Log will be reviewed by the Project Board.

19. Contingencies

This project is a system upgrade managed in a phased approach. As the backend database is unchanged, the contingency for this project would be to revert to using the CareFirst 5 client.

A disaster recovery test will also be added to the project plan and will be scheduled appropriately with corporate ICT.

20. Project Closure

Following the project completion, a formal Project Completion meeting will take place with all parties involved in the project. From this meeting the following documents will be written and presented to the Project Board. The project will be formally signed off by the Project Board via the Customer Acceptance form.

- Cost Summary – subject to subsequent reconciliation.
- Post Project Review – will identify the extent the project objectives have been met; if the project was completed to cost, time and quality constraints and if the benefits have been realised.
- Benefits Realisation Report – will highlight the benefits achieved by the project.
- Lessons Learnt Report – will highlight what was done badly or well, and identify any problems to address.

21. Customer Acceptance

The overall consideration in accepting the deliverables from the project is that the objectives set out in the business case have been met.

The key deliverables from the project are:

- Phase 1 – CF6 Web Upgrade
- Phase 2 – CareReports
- Phase 3 - CareAssess

Provided that the components making up each of these major deliverables have been signed off, the overall project should be regarded as fit for acceptance.

The criteria to assess acceptance with individual deliverables or classes of deliverables should be agreed as part of developing the detailed plans.

Appendix A – CareFirst 6 Business Case

Business Case

Title:	Business Case - CareFirst Upgrade (Version 6 & CareAssess)
Department:	Adult Social Care
Sponsor:	Mark Stainton (Assistant Director)
Customer Contact:	Alex Garnett (Head of Business Development)
Author:	Charity Thrussell (Business Manager, Business Development)
Date:	29 April 2008
Version:	Version 0.1 - DRAFT

Revision History

Revision Date	Version	Summary of Changes	Changed by
28 April 08	V0.1	First Draft	
08 May 2008	V0.2	Revisions made post review with A Garnett	Charity Thrussell

Approvals

This document requires the following approvals. Signed approval forms are filed in the project files.

Version	Name	Title	Signature	Date of approval

Contents

Subject		
1.	Purpose	
2.	Reasons	
3.	Benefits	
4.	Costs	
5.	Funding	

1. Purpose

The purpose of this document is to provide justification for undertaking a project to upgrade from CareFirst5.x to CareFirst6.x within Adult Social Care.

2. Reasons

The business case is based on an identified need to support operational Social Work practices and processes using modern web-enabled business tools. The deployment of such tools will also build on ESCC's investment in CareFirst as its record system for Social Care service clients and enhance the business benefits in:

- Providing front line staff with modern working tools
- Improving information access, availability and quality
- Achieving service improvement and efficiency targets
- Supporting corporate e-government objectives
- Enabling strategic business transformation changes

The availability of modern web-enabled technology is a pre-requisite for change. Such facilities provide the necessary capability for an information-led service on which much depends for achieving integration and the familiarity for staff of an 'at home' computing experience. From a technical perspective there are, in addition, imperatives for moving to a web-enabled operating environment as quickly as possible. First, there are time limits within which Oracle 'forms based' versions of the CareFirst application will no longer be supported thereby creating a business risk concomitant with application dependency for effective service management and delivery. Secondly, there are recognised cost of ownership efficiency savings from a moving to a web browser desktop strategy for application deployment and maintenance.

CareFirst 6/CareAssess has been designed in the context of the current policy drivers impacting Social Care services such as the Integrated Children's System (ICS) and Single Assessment Process (SAP) for adults. The expected outcomes from deploying a web-enabled system are therefore embodied in the service improvement objectives for these key modernization drivers.

Key product features of CareFirst 6/CareAssess that are expected to make a positive contribution in supporting new models of working with a modern web platform include:

- Enhanced end user experience of using CareFirst through;
- Improved look/feel
- Extended workflow capability,
- Online help facilities
- Structured e-forms tool (CareAssess) to support case recording for practitioners.
- Improved system security supporting single sign-on
- Role-based security supporting extended system access
- Enhanced embedded performance management tools (Actuate/CareReports) and document production facilities with integrated security facilities
- Mobile and remote working support capability

2.1 Investing for the Future

CareFirst 6.x is the next generation of OLM's social care application and is designed to ensure a seamless move to a native web environment. The upgrade to CareFirst 6.x has been designed by OLM to take advantage of new technology developments that protect their investments by providing a seamless upgrade path. CareFirst 6.x represents the next step in technology evolution that will ensure they can adopt a web deployment platform.

With web enabled platforms emerging as the de facto industry standard in local government and essential to effective information sharing, OLM committed to a major programme of product development in 2003. CareFirst6.x has been developed by OLM to ensure that it will be equipped with a heterogeneous web platform to meet the challenges they face in the future. CareFirst 6.x is to be considered part of a future technology strategy designed to meet the ever increasing demands being placed on social care services.

CareFirst 6.x has been engineered in a n-tier architecture to comply with current industry standards for all future application design. This approach effectively separates the presentation, business logic and data components to provide future flexibility, improve maintainability, and provide necessary security for utilising the internet.

A common database schema has been maintained to ensure compatibility and ease of transition from the existing version of CareFirst, and protecting the current data set. As with previous adoptions of new technology, CareFirst 6.x has been designed to enable users to operate mixed environments so that the new technology can be introduced at a pace that suits particular customer circumstances.

2.2 Progress by Design

Core to OLM's investment in CareFirst 6.x has been the goal of easing customers adoption of new technology while making available new features to improve the usability and maintainability of the CareFirst application. In the realisation of this goal a number of key strategic objectives were set for the development of CareFirst 6.x:

- Enhance end user experience in utilising CareFirst – improving look and feel, extending workflow capability, introduce on-line help and tips, integrating e-form capability and improve case recording

- Develop a flexible and standard security layer which conforms to industry standards, and which builds a platform to support single sign on e.g. LDAP, across the OLM product suite including the new reporting environment

- Integrate enhanced performance management tools – support standard report library including statutory returns, embed reporting capability into application presentation, provide enhanced visual capability such as graphs and improve output standards

- Enhance quality and standard of output – support existing CareDOC functionality and extend capability to incorporate PDF format for more secure document control

- Ensure compatibility with existing CareFirst – provide a common database schema to secure existing data investment, support co-deployment of web and oracle forms across user community, ensure existing customer reports continue to operate.

- Maintain and enhance accessibility standards defined by the RNIB and the OLM user group.

- The ablity to build on investments already made and ensure compliance with e.gif standards and new business requirements.

2.3 Key Features

Enriched User Experience
By the very nature of their design, browser based applications offer a significant advance in the user experience of enterprise-wide applications. CareFirst 6.x delivers enhanced screen layout with significant improvements to both usability and readability. OLM have employed the latest standards in Web design and layout to provide a user interface look and feel that will feel intuitive to users familiar with other internet or web applications.

Taking account of customer feedback, enhancement ideas and UI good practice, CareFirst 6.x has been designed to deliver an enhanced user experience for workers as they interact with the application.

Enhancements in CareFirst 6.x include:

- Enhanced MyCareFirst look and feel to ease navigation and system access
- Enhanced facilities within MyCareFirst based on customer feedback
- Enhanced use of icons for visual presentation and user prompts
- Enhanced navigational aids with the use of system “crumb trails”
- Enhanced use of hyperlinks to ease system navigation and access
- Enhanced query functions and features
- Enhanced use of toolbar for standard system functions e.g. screen print
- Enhanced menu display and toggle facilities to maximise screen display
- Enhanced on-line tool tips and help facilities
- Enhanced application audit facilities
- Enhanced diary management and presentation
- Enhanced use of filters for on screen presentation and navigation
- Enhanced caseload management facilities and client chronology

By applying the latest industry design standards, CareFirst 6.x offers a richer end user experience with consequent increase in user acceptance, buy-in and data quality. The enhanced design offers immediate benefits in terms of training, support and system lifecycle costs. With the advent of the Gershon Report and its focus on efficiency and effectiveness, CareFirst 6.x delivers new capabilities for customers to drive productivity and performance within the context of social care.

Leading in Accessibility Standards
OLM has partnered with the CF Access Consortia and RNIB specialists. These partnerships have informed each step in the design of CareFirst 6.x to ensure compliance with accessibility standards. By consulting and incorporating the requirements for accessibility from the outset CareFirst 6.x leads the market in accessibility for our users with Visual Impairment (VI) and other access needs. The screens themselves are more readable than in previous versions, employing the latest access standards and best practice. The RNIB through the consortia have been actively engaged in each stage of the design, development and testing to ensure compliance with the agreed standards.

Innovating in Performance Management
With increasing pressures from inspection and government policy to demonstrate effective performance management in social care, the need to move beyond the old models of reporting has never been greater. CareFirst 6.x comes with a fully embedded reporting environment designed to enable customers to integrate and develop performance management across the organisation.

OLM has recognised our customers demand for a more sophisticated and flexible analytical reporting capability. CareFirst 6.x is released with a powerful reporting capability, CareReports, which is embedded within the application. Through extensive research and evaluation OLM identified the most appropriate reporting tool. The Actuate reporting environment provides

customers with a best of breed reporting solution. By employing Actuate as its reporting engine CareFirst 6.x offers customers:

- A flexible and advanced reporting tool embedded into the desktop
- A integrated and robust security model integrated with the application
- A comprehensive analytics solution for decision support
- Automated production reporting for multiple output formats
- A integrated common look and feel for end users
- Simplified access to complex data sources
- A tool that reduces the cost of reporting significantly

The new reporting tool has been fully embedded into CareFirst 6.x to ensure a common security environment and look and feel. The resulting reporting engine ensures that customers can capture, validate, refresh and deliver key performance information through a common presentation layer.

CareReports

CareReports significantly enhances the reporting capability and presentation of key performance management delivered direct to the users desktop. CareReports appears as Web pages integrated seamlessly with CareFirst 6.x with the same look and feel. As a result CareReports is simple to deploy enabling users to access key performance data without having to undergo additional training or learn how to access another system. CareReports offers a more cost effective solution to satisfy the increasing demand for more analytical information.

- Object Oriented design reduces maintenance and development overheads
- Content rich development toolset to support complex data analysis
- Adopts a dataset approach to extracting data to support reporting
- Provides enhanced presentation and data analysis toolkit e.g. graphs, drill-down
- Results can be output to a wide variety of formats including PDF

3. Benefits

Adult Social Care operates in an increasingly complex and rapidly changing environment, both in terms of business and technology requirements. CareFirst 6.x offers key business and technological benefits while protecting existing investment in data.

3.1 Business Benefits

CareFirst 6.x has been designed in the context of the latest business drivers impacting social care including ICS, ISA and SAP enabling customers to realise immediate benefits from its adoption:

- Enhanced usability reduces training and user support overheads
- Structured e-forms tool to ease practitioner recording
- Complies with emerging business requirements for ICS & SAP
- Improved workflow to enhance data quality and productivity
- Integrated on-line help to support users
- Web interface offers intuitive look and feel familiar to end users
- Embedded secure reporting and performance management environment
- Reduced support overheads in the development and distribution of reports
- Role based security model to support extended access
- Enhanced output capability with integrated security
- Supports mobile and remote working

3.2 Technology Benefits

CareFirst 6.x delivers full compliance with current standards and ensures a move to an industry standard web based environment for this critical application. The adoption of a true thin-client environment offers immediate benefits for customers in maximising their current IT investment while providing the flexibility and scalability to develop new models of working across their user community.

- Conforms with e.Government interoperability standards
- Employs industry standard web browsers for access
- Significantly reduces system support and maintenance overheads
- Provides access anytime, anywhere through existing networks
- Supports application clustering to optimise infrastructure investment
- Is fully scaleable and robust to meet customers changing needs
- Eliminates costly desktop management and support

4. Costs

4.1 Technical Installation Costs (estimated)

Item	Cost
ICT Staff Costs	£28,000.00
VMware Training	£5,000.00
Dell VMWare Consultancy	£5,000.00
OLM Installation Support:	£12,000.00
CareFirst 6 software	£89,500.00
Oracle 10g Application Server	£4,000.00
Microsoft software	£4,500.00
VMware	£19,863.35
Annual Support (CareFirst 6)	£11,000.00
Annual Support (Oracle 10g Application Server)	£1,000.00
Annual Lease (PowerPath)	£210.00
Hardware	£19,135.77
ICT Infrastructure	£1,500.00
Contingency	£15,000.00
Total	**£215,709.12**

The allocation of costs is: Adult Social Care: 77%
Children's Services: 23%

4.2 OLM Consultancy Costs

OLM have offered support with the implementation of this project.
If any support from OLM is required, the following costs will need to be included.

Item	Cost
5 days @ £800 / day	£4,500

4.3 Actuate Consultancy / Training Costs

During Phase 2 (CareReports) of this project we will establish what work we will have requiring SQL / Business Objects / Actuate Reporting skills. Additional resource and skills for this work will most likely be required. The cost of providing this resource and skill are estimated to be:

Item	Cost
Actuate Training (5 days @ £500 pd / pp)	£2,500
Actuate Developer (6mth contract – 120 days @ £350 pd)	£42,000

4.4 Training Costs

CareFirst training is carried out by the Business Support Officers (BSOs). When the training strategy and plans are agreed, it is likely that additional but temporary resources will be required to carry out the training for CareFirst 6.

There is currently a temporary resource within the BSO team. The project would require an extension to this temporary resource.

Item	Cost
1 x fte Business Support Officer (scale5/6)	£18,907 - £22,845 per annum
Training Venues	TBD

5. Funding

Funding for this project will be provided from the Business Transformation Programme (AG to confirm this)

6. Cashable Benefits

Cashable benefits relating to this business case are still to be determined.

Appendix B – Risk Log

The table below provides an extract from the CareFirst 6 ‘Risks & Issues’ log. This file is located under:

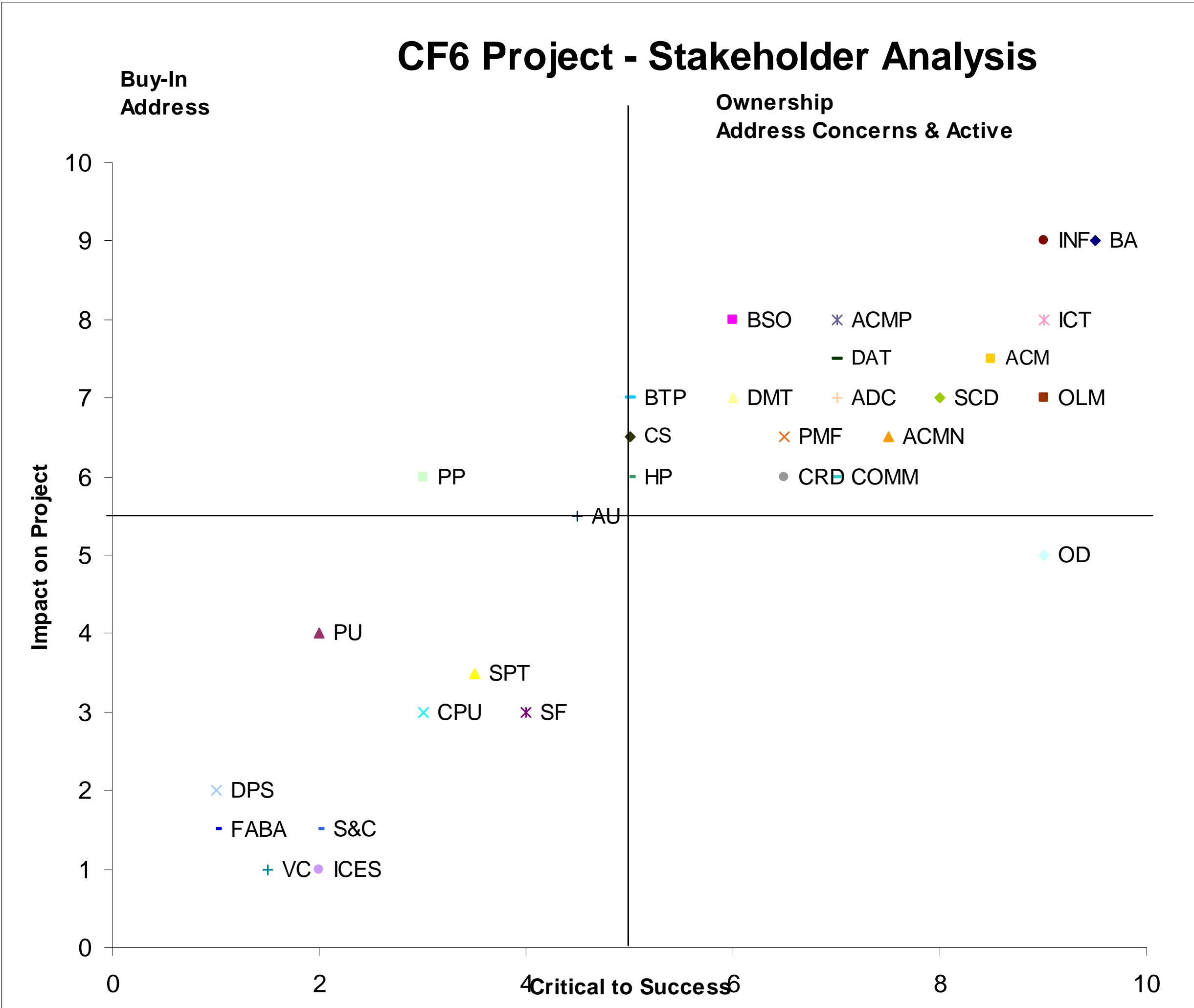
W:\E-Business Unit\Business Analysis Projects\BD 0008 - CF v6\4. Project Documentation\Risks and Issues Log

*(**Note:** Going forward, the template provided by the ACM Programme will be used)*

Risk ID	Category	Date Raised (dd/mm/yyyy)	Description	Owner	Probab-ility (1-5)	Impact (1-5)	Score	RAG	Status
CF6 - 001	External	22/04/2008	Due to the uncertainty around direction, content and timescales for the ACM Programme, together with the appreciation that this is a dependency for the CF6 Project, means there is a risk to the progress of CF6 until there is more detail on ACM to factor into our planning. (relates to Phase 3)	CT	4	3	12	A	Open
CF6 - 002	External	23/04/2008	Expectations re benefits realisation of CF6 implementation need to be managed. Awareness that CareAssess will not be implemented until Phase 3	CT	3	3	9	A	Open
CF6 - 003	External	28/04/2008	Blue Car Badge Team as a risk due to the fact that their manager is retiring soon meaning that the knowledge and skills of the role will be lost on some level. Wendy Shirvani is taking over this role.	CT	4	2	8	A	Open
CF6 - 004	Internal	28/04/2008	CareStore as a risk as we are yet to ascertain whether or not we are able to create a link to CareStore from CF6 with the relevant security permissions.	CT	4	3	12	A	Open

Appendix C – Stakeholder Matrix

BA	Business Development - BA's/BM's
BSO	Business Development - BSO's/Trainers
SPT	SPT(CPU)
CPU	CPU (excl SPT)
SF	Strategic Finance
INF	Info Team (FaBI)
VC	Visiting Co-ordinators (FaBI)
FABA	Finance & Benefits Assessment (FaBI)
BTP	Business Transformation Programme
OD	Oracle Developer (Phil Russell)
PP	Policy & Performance
DMT	DMT
DPS	DPS
ICT	ICT
ICES	ICES
ADC	Admin Co-ordinators
S&C	Strategy & Commissioning
COMM	Communications Team
SCD	Social Care Direct
ACM	Assessment & Care Management
ACMN	ACM Network
PMF	Practice Managers Forum
ACMP	ACM Programme team
CRD	CRD
AU	Audit
HP	Health Partners
DAT	DAT
CS	Childrens Services
OLM	OLM
PU	Personnel & Unions



Appendix B - Project Plan

Work In Progress……….

The Project Plan provides a statement of how and when a project's objectives are to be achieved, by showing the major products, milestones, activities and resources required on the project.
It is used as a baseline against which to monitor project progress and cost stage by stage.
It provides the business case with planned project costs and it identifies the management stages and other major control points.

The plan should contain the following:

- *Plan description, giving a brief description of what the plan covers*
- *Project prerequisites, containing any fundamental aspects that must be in place at the start of the project and any that must remain in place for the project to succeed*
- *External dependencies, identifying the products that must be provided to the project so that it can continue but which the Project Management Team has no authority over and so cannot ensure delivery fits the project requirements.*
- *Planning assumptions concerning availability of resources, skills/competency requirements etc*
- *Project plan, covering:*
- *Project level Gantt chart or bar chart with identified management stages, e.g. milestones and control points*
- *Project level product breakdown structure*
- *Product descriptions, defining what the project will deliver including the required quality level*
- *Project level activity network and product dependencies*
- *Project level table of resource requirement*
- *Requested/assigned specific resources*
- *Project change budget (if appropriate)*
- *Project level tolerance, for both time and budget as triggers for contingency plans and escalation processes*
- *Contingency plans, explaining how it is intended to deal with the consequences of any risks that materialise*