APPENDIX 2

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COMMUNITY AND WELL BEING DIRECTORATE

OUTLINE DESCRIPTION OF A PROPOSED OPERATING MODEL LEADING TO A REVISED RESTRUCTURING OF ADULT SERVICES

1. INTRODUCTION

1.1. This papers sets out a summary of the proposed operational model for Assessment, Care Management and Reablement to older people, people with any form of disability and HIV services through current occupational therapy and social work services in the Community and Adult Social Care division.

1.2. This paper summarises each component of the model, from the "front end" (front portal, and the Hub), reablement and long term support.

1.3. The development of this model has drawn upon a range of sources including, mapping and analysis of existing processes, statutory returns, metrics from other local authorities and extensive formative discussion through workshops and away-days involving management and other staff from the division and My Council since January 2010.

1.4. This proposed operating model is being developed within the existing cash limit (budget) for Assessment, Care Management, Internal Homecare and Intermediate Care. Resulting financial savings are due to reconfiguring and re-organising staff and existing teams into structures and functions that better enable them to deliver improved outcomes to customers and alleviating duplication and hand-offs that are in the current structure.

1.5. The new model will have increased capacity in frontline staff and a reduction in management and administrative posts. There maybe displacement of some staff, who have to move to positions on a lower grade (but on protected salaries) or through potential redundancies (numbers to be confirmed once staff consultation is complete).

2. Drivers for the proposed operating model and key benefits

2.1 The key drivers for the redesign and reconfiguration of the current operating model are:

- Overall increased efficiency in service delivery
- Increased choice and control for customers
- Early intervention and preventative support at the earliest opportunity
- Enabling people to live independently
- Enhancing citizenship and access to community based services
- Improving responses to customers
- Providing targeted preventative support and support for carers
- Ensuring personal safety and high quality service provision
- "One Council" approach in being responsive to people's needs in Slough

2.2 The proposed model addresses:

- Delays and difficulties in contacting Slough Borough Council Adult Services;

- The requirement to deliver Personal Budgets
- The need for new functions and activities to deliver Personalisation
- The need for systems and processes that are “fit for purpose” in the future

2.3 The key benefits that the proposed operating model will deliver include:

- Improvements in timely customer responses at the first point of contact
- Improved access to consistent and high quality information
- A reablement service to promote recovery and minimise the need for long-term care

2.4 As a consequence of these improvements, Slough Borough Council will:

- Support more people to live at home for longer
- Reduce the costs of long term care
- Deliver efficiencies through changes to working systems, structures and patterns of service delivery

3. Principles and good practice standards

3.1 A set of principles and good practice standards were adopted as part of the development process of the model, and will form the standards against which success can be measured

- To have a single point of access for all new referrals, building on the “One Council” approach and enhancing the customer first contact experience
- To enable efficiency in terms of achieving better and increased outputs from the redesign of the adult social care service as well as cashable savings
- The whole process should be streamlined from initial contact to intervention in place.
- To limit/minimise the number of “hand offs” a person experiences so processes are simpler and quicker.
- Not to make longer-term decisions and/or commitments about someone’s care (wherever possible) while the person is unwell or in crisis.
- Financial assessments should take place at the earliest point in the process, and issues of finance and charging should be raised with users at the earliest opportunity.
- To focus on early intervention / prevention to promote independence and reduce reliance on long term care.
- Service users should be assessed only once; a principle of “tell it once” so people do not have to tell their story many times over.
- A plan that is person centred and owned by the user.

- Not to constrain thinking to traditional ‘care management’ and ‘social care’ models.
- That it must deliver self directed support & personalisation (in a timely manner for everyone).
- That safeguarding is a theme throughout the redesign process and future model.
- Assessment and care management staff are currently spread across a range of functions; the aim is to focus activity on specific pieces of work following the ‘customer journey’: referral → assessment→ reablement →support planning →support arranging→ review.

In addition the construct of the operational model needed to take account of two other issues.

- Identify the difference between administrative and professional processes.
- Right person, right skill set to the right level of task

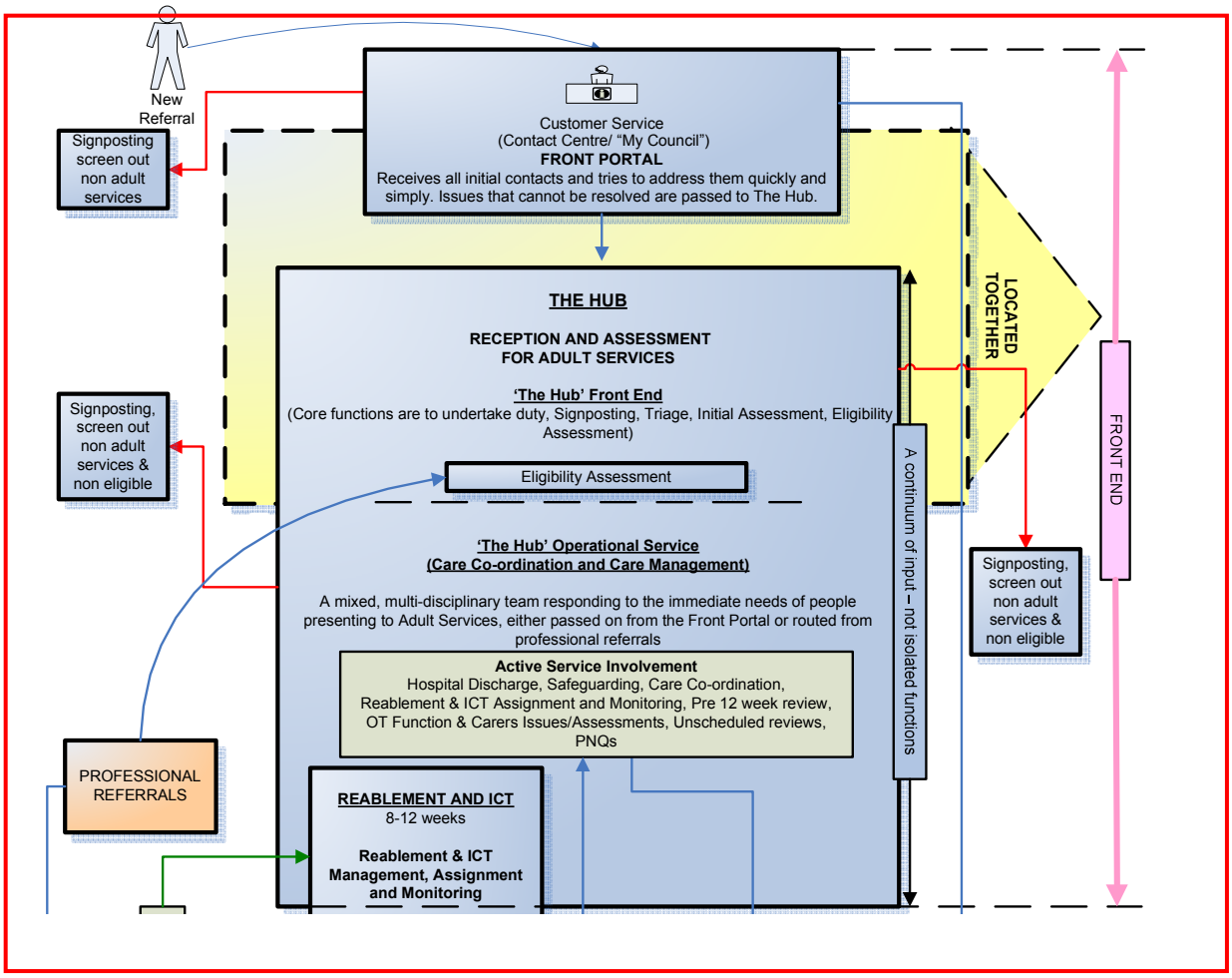
4. Summary of proposed operating model

4.1 The following represents a broad summary of the model to support the generic functions within adult services (including hospital discharge, learning disability, older people, physical & sensory disability, HIV and Aids).

4.1.1 The model has four key components:

- Customer Contact Centre (MyCouncil)
- The Hub
  - Reception access and initial assessment
  - Care Coordination function
- Reablement and Intermediate Care service
- Long Term Support and Intervention

4.2 My Council (Customer Contact Centre)



4.2.1 The initial contact is at My Council. Within My Council are a defined group of named Customer Service Advisors (CSA) who have been provided with specialist training to respond to enquiries that could potentially lead to Adult Services intervention or support. Advisors will have scripts, information, questions and a range of resources to identify if an Adult Services intervention is necessary. The objective will be to deal with the issue at this point of the process.

4.2.2 Upon receipt of a contact the CSA works with the customer to identify what support they are seeking from Slough Borough Council. The objective is to work towards identifying the correct resolution to the presenting issue, where possible signposting the person to places where they appropriately respond to the request.

4.2.3 CSAs are based at My Council, but are supported by Adult Services staff from the Hub who be located at My Council. Adult Services' staff they do not take first contact calls but work with the CSA to assist their resolution to the customer as an "offline" support to the CSA. The process will ensure that the handover is owned, smooth, supported, the person feels as though their issues are resolved and there is no need to repeat information.

4.3 Outcomes and criteria against which this element of the service needs to be measured

- Robust, accurate, timely response combined with an excellent telephone manner will reduce the need for people re-entering the system because what they have been given is inadequate to meet their request
- A time limit in which a call needs to be resolved before passing to Adult Services

5. The Hub

5.1 Reception, access and initial assessment

- The Hub will deal with issues presented from My Council that will require an Adult Services intervention. The Hub will provide the Adult Service primary contact, but for the customer this should be a seamless transition from My Council CSA to the person who will be able to help further.
- The Hub is a continuum of support to people who are referred to them. Eligibility Assessment will be undertaken (akin to triage) that includes and determines any eligibility for Adult Services intervention and if one-off Adult Services solutions could help (e.g. a bath aid). If a goal setting assessment or Personal Needs Questionnaire (PNQ) is required the Assistant Service Manager will allocate an appropriately skilled Care Co-ordinator to support the customer for a maximum of 12 weeks.
- For hospital discharge customers, the Care Co-ordinators based in the hospital, will undertake the eligibility assessment and the goal setting assessment / PNQ.

5.2 Care Co-ordination

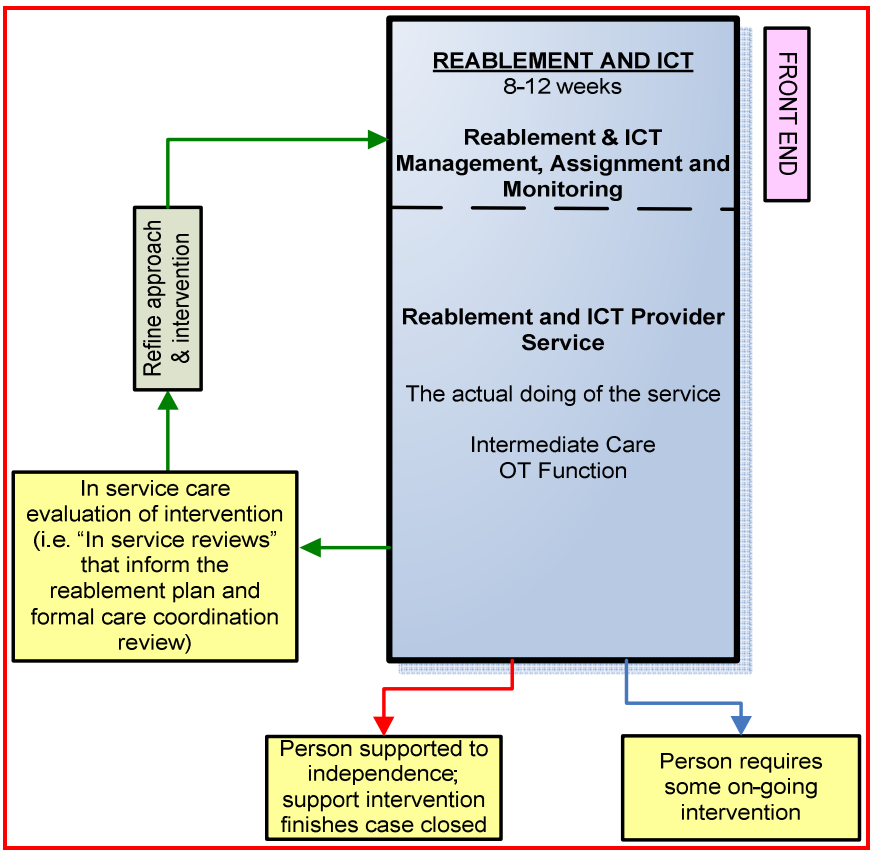
- The care co-ordination function of the Hub is where a range of unqualified and qualified[1] staff are located. This is where much of the detailed work with individual customers will be hosted. A named person is allocated to the customer to undertake assessments and person centred planning.
- The Care Co-ordinator may be required to provide an immediate service response to respond to any immediate “crisis” whilst the Personal Needs Questionnaire is being completed.
- The Care Co-ordinator will be the most appropriate professional to the customer and will be assigned to co-ordinate the whole intervention (not any single professional discipline) bringing other disciplines or workers in as necessary.
- The first intervention that will always be considered will be reablement, so as to maximise the customer’s independence.

[1] Unqualified means personnel who are experienced and knowledgeable in key areas of work and suitable experienced and able to attend to key tasks assigned to them;
Qualified means people who hold a professional qualification in a key area and who are a defined professional or discharge a given professional function

- At some future point either the customer will be in a position that they no longer need support (case closure) are at optimum levels of independence, or have regained the level of independence prior to reablement, or at steady state. If it is the latter, this is the point where a Personal Needs Questionnaire (Self Directed Assessment) is undertaken by the Hub Care Co-ordinator closely involving the customer and carer to identify their needs and the outcomes, they wish to achieve.

6. REABLEMENT AND INTERMEDIATE CARE SERVICE

6.1 This part of the model describes the Customer Journey in terms of the Reablement and Intermediate Care Service.



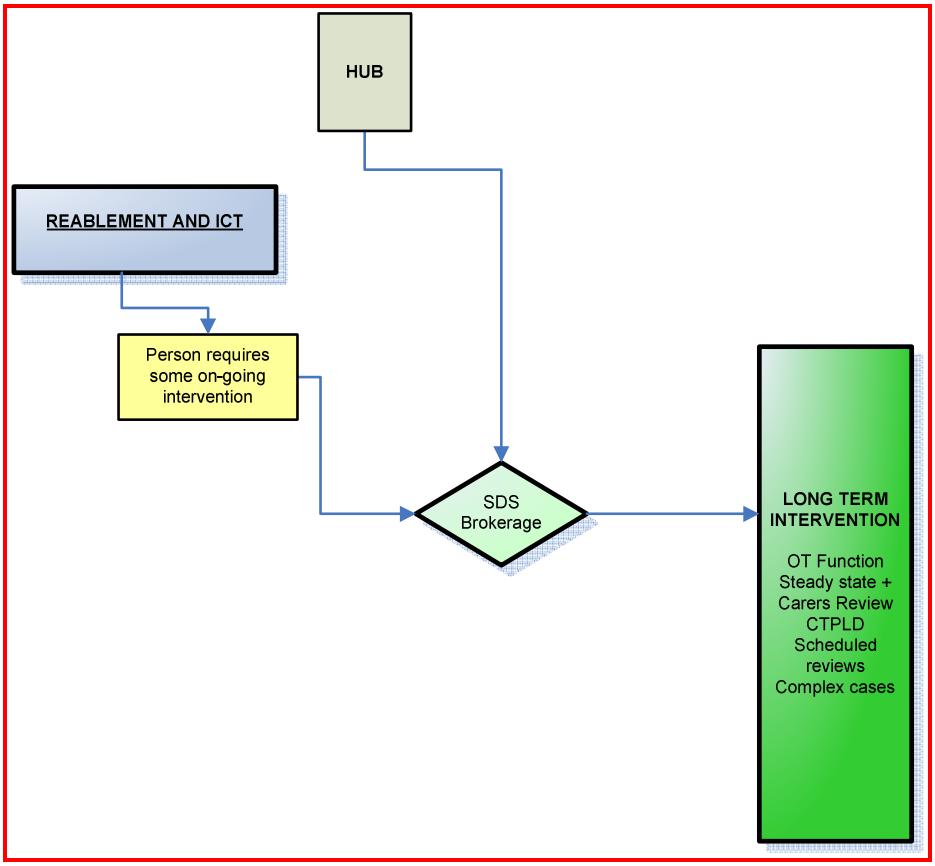
6.2 The Reablement and Intermediate Care Service (ICS) provides short term intensive support to people who have just come out of hospital, or have been ill at home, or people that have been referred from the Hub. This will also include people who have an episode that requires reablement support. The support is provided in the customer's own home, or in a rehabilitative setting. This will enable them to learn or relearn skills necessary for daily living and aid a person's recovery. This will be through the use of short term intensive programmes that:

- Maximise independence in people's own homes, choice and quality of life
- Minimise ongoing support and prevent the provision of unnecessary care
- Provide access to rehabilitative service

6.3 The Reablement and ICS service works collaboratively to ensure that a customer's health and social care outcomes are addressed. Focusing on the Reablement Programme and goals to be achieved, the Reablement Officers and Assistants undertake individual tasks with the customer enabling them to, as far as possible to achieve their maximum independence potential.

6.4 The Hub Care Co-ordinator will review customer progress at 5 weeks and then at 10 weeks. The 10 weeks review will ascertain whether the customer can be sign posted out of the system or if they need to be sign posted to the LTIS service, allowing move-on by week 12**.**

7. LONG TERM SUPPORT – LONG TERM INTERVENTION AND SUPPORT TEAM (LTIS)



7.1 Long Term Intervention and Support Team (LTIS) provides on-going Care Co-ordination of complex cases and cases where on-going support is required beyond 12 weeks. LTIS also undertakes annual reviews, provides transition of young people to adult services who require an ongoing adult services intervention, brokerage and external provider coordination. The service will work to support the principles of Personalisation and ensure that self directed support is the primary option in any service intervention.

7.2 There are two clear points of access into the LTIS service.

- The service can be accessed after the customer has undergone a maximum of 12 weeks reablement and it is agreed with the Care Co-ordinator, that long term support is required.
- The customer who has been assessed as having enduring care needs, in The Hub, and is judged by the Service Manager (First Contact and Assessment) to require referral directly into the LTIS team.

7.3 The Service Manager (Brokerage and Review) will receive and allocate the customer to a broker to develop their support plan (based upon their Personal Needs Questionnaire) and will identify appropriate services required to deliver their plan. The Broker will have detailed knowledge of the range of services and support options available locally and will be imaginative and creative in their approach to support planning to enable customers to make best use of the resources available to them.

7.4 The Broker will receive the PNQ that has been completed by the Hub Care Co-ordinator in conjunction with customer. The Broker then engages with the customer to identify how they would like to deploy resources to meet the needs and outcomes as identified in their PNQ. The Broker then develops a support plan in partnership with the customer.

7.5 The support plan requires approval from Slough Borough Council to ensure that it meets the outcomes as identified in the PNQ and is within the indicative budget allocation.

7.6 The final personal budget will only be agreed once there is a completed support plan that meets eligible social care needs. Indicative and final budgets allocation may differ because:

- The Council has a duty to meet eligible assessed needs
- The person may be able to meet their needs through universally available services, or through unpaid support
- Social care services are “means tested” and people may need to contribute some or all the costs of support from their own finances.

7.7 The customer will be given options of how they would like to have their Personal Budget:

- As a direct payment
- Part direct payment
- As a managed service
- Managed by a third party

7.8 The Broker will put the services and support in place and then review the support plan after two weeks to check that the support is responding to identified needs and outcomes, with a final review undertaken by the broker after six weeks. The customer will receive an annual outcomes based review of their support plan, but will be supported at anytime by either The Broker or Care Coordinator from the LTIS Team.

7.9 The reviewing function sits within LTIS team and will undertake statutory scheduled annual reviews for all service users over the age of 18 receiving any service/support.

7.10 LTIS team will include professionals who will support service users with complex needs and long term conditions.

8. ADMINISTRATIVE FUNCTION

8.1 Admin support to services and teams will be managed through a dedicated Business Support/Administration function. Admin staff of an appropriate level (grade) and in appropriate numbers will be provided to support the Operating Model in all admin functions including administration of all safeguarding processes.

8.2 The post of Business Support/Administration Manager will have line management responsibility for all administrative staff and provide responsive business support to each of the services in the proposed model.

9. HEAD OF SERVICE MANAGEMENT

9.1 It is recommended that, in addition to the Head of Mental Health Services (a joint post with Berkshire NHS Foundation Trust) there are two other Head of Service roles:

- Head of Access & Long Term Intervention
- Head of Reablement and Directly Provided Services

9.2 The capacity that these posts bring to the structure allows for direct senior management of key service delivery, but has capacity to take strategic leadership of key functions within the wider Adult Service

10. HUMAN RESOURCE AND COST IMPLICATIONS

10.1 It is not possible to accurately detail any redundancies at this stage; this will be determined following staff consultation and finalisation of the new structure.

10.2 There will be a reduction in management positions, with the proposals to remove the Team Manager (Level 9) and Assistant Team Manager posts (Level 8). Instead of teams the model will have discrete and overlapping areas of service, lead by a Service Manager (either level 9 or 10, subject to job evaluation) and supported by Assistant Service Managers (Level 8).

10.3 The exact costs of any redundancies and protected salary implications (for people moving to lower graded jobs) will be identified fully following the staff consultation. Efficiencies will be released over time (as protected salary costs are limited to two years, and redundancy costs are one-off). As the model is consolidated and the full operational effect is re-evaluated in year 2 and year 3, some further cashable efficiency maybe released in future years.