directors of adass
adult social services

SOUTH WEST
REGIONAL IMPROVEMENT
& EFFICIENCY PARTNERSHIP

Delivering Putting People First in the South West

February 2011

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Foreword

'Putting People First – a shared vision and commitment to the transformation of adult social care' was published in 2007.

> 'The shared ambition is to put people first, through 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.'

The breadth and scale of the change required to deliver the Putting People First vision presented a formidable challenge to local authorities who were given the leadership for this transformation. Resources to deliver the change were allocated to LAs in the form of the three year Social Care Reform Grant. In the South West, the regional Joint Improvement Partnership has worked with local authorities and their partners, the regional Department of Health team and other regional networks to develop and implement plans for transformation. The regional Putting People First Steering Group, consisting of transformation leads from local authorities across the region, has led the work on the personalisation programme supported by a regional co-ordinator.

There has been considerable progress in many areas, with local authorities working with users and carers, providers and health partners to deliver greater choice and control, more diverse and personalised services, greater access to information and advice, more re-ablement and telecare care services, and more robust user-led organisations. We have seen innovation, creativity, genuine co-production, greater transparency, and more efficient joined-up approaches.

This document is a celebration of some of the good practice and learning that has taken place across the South West in last three years. I hope it will ensure that knowledge and experience is communicated and shared beyond the life of the Putting People First programme.

The journey has not ended; more needs to be done to embed the culture change and new ways of working, to grow the confidence to empower users and let go, to change and shape markets, to convince partners and make things work together in more efficient and cost effective ways. The new government Vision for Adult Social Care and the partnership agreement 'Think Local, Act Personal' outlines how the themes of Putting People First will be extended. But I wanted at this point to say a big thank you to all those individuals across the South West who have worked so hard and with such commitment to bring us this far along the road.

Kim Carey
Corporate Director for Adult Care and Support, Cornwall Council
Regional Joint Improvement Partnership Lead for Personalisation

Introduction

Transforming Adult Social Care in the South West

This document is designed to illustrate some of the good practice demonstrated by South West local authorities and their partners in implementing Putting People First. It has not been possible to include everything we would have liked to due to constraints of space. There are also many projects and initiatives still evolving which we have not included here.

The projects described are based around four key themes of Putting People First, but some of the activity could readily be included under several headings:

a) Developing Choice and Control

This section includes examples of projects and activity which have delivered greater choice and control by:

- providing accessible information and advice;
- supporting users and carers to exercise choice and control;
- managing risk positively;
- developing the market to provide greater choice and diversity.

b) Engagement and Co-Production

This section covers aspects of partnership working, user engagement and co-production and includes examples of:

- effective user led organisations working to deliver the PPF programme;
- user led organisations delivering services;
- co-production and joint planning initiatives.

c) Early Intervention and Prevention

This section focuses on projects which support and assist people at an early stage to stay independent for as long as possible or to regain independence after a period of illness. It includes examples of:

- community based activities to promote inclusion and participation;
- re-ablement schemes;
- telecare;

d) Efficiencies and Sustainability

This section gives examples of activities and projects which ensure systems are efficient and support the transformation process. It includes examples of:

- integrated services;
- collaborative working;
- financial systems to support Personal Budgets;
- efficient ways of working.

For more national and regional information on Putting People First, visit: www.puttingpeoplefirst.org.uk.
There is also information on mental health and personalisation on the South West Development Centre website
http://www.swdc.org.uk/SWDC/en/mental-health/mental-health/personalisation--mental-health/

Pam Richards (SW Region Personalisation Co-ordinator) Nick Harris (Consultant)

Editors

Theme 1: Developing Choice and Control

Host Carer Scheme

Bournemouth Borough Council and the Borough of Poole

Our approach:

This project is being developed to offer carers of older people an alternative short break in the day. Based on an existing model in Torbay, it is being developed specifically to be available to people on personal budgets and self funders. The locality has a higher than average number of older people and the current change agenda in health and social care is likely to increase the availability of potential hosts. The scheme aims to be self funding, and able to employ a care planner, within two years.

The scheme will recruit 'host' carers, paid at least the minimum wage, to collect up to four older people and bring them to the host's home for the day. The group will engage in personalised activities, have a cooked lunch, and be returned to their homes by the host. The project, through a group of hosts, needs to provide 56 days of service per week in order to become a self sustaining entity. The vision is that this will become a social enterprise with carers involved with the organisation's board.

Initiated as a partnership project between the Local Authorities and the third sector, a relatively small amount of pump priming money is being used. This will cover the costs of recruiting a project worker, who will support the recruitment of hosts and take referrals. The skills/interests of the hosts and the interests of the clients and other members of the group that day will be used to 'match' groups.

The clients will pay to attend, and this income will pay the hosts and the project worker/care planner. The ability to generate income from an early stage keeps the level of pump priming low.

Outcomes:

- Carers enabled to have a short break during the day with the provision of a personalised service;
- The cared for person has interest and stimulation during the day which can contribute to their quality of life, and that of their carer/s;
- The service is likely to be more appealing to cared-for people who resist going to a day centre, but whose carer is at risk of breakdown due to their responsibilities;
- The scheme is not dependent on grant funding from the Local Authority;
- Carers will be included in the organisation of the scheme in the longer term through the formation of a social enterprise.

Further information:

Debbie Hyde, Carers Commissioning Manager,
Deborah.hyde@bournemouth.gov.uk
01202 458714
Irene Roig, Commissioning Officer,
Irene.Roig@Bournemouth.gov.uk
01202 458132

Experts by Experience Group for Personalisation & Safeguarding

Torbay Care Trust

Our approach:

An 'Experts by Experience' group comprising people from across Torbay with different personal experiences of care and safeguarding was established, facilitated by a social worker personalisation champion & chaired by a Non-Executive Board Member. Safeguarding and domestic abuse training was made available to the group members.
The work the group has undertaken includes:

- Ensuring the safeguarding and personalisation processes are person centred and based on outcomes for individuals not processes;
- Checking literature and service information (e.g. direct payment leaflets) and providing feedback;
- Completing and submitting a report on the outcomes for citizens in regard to safeguarding;
- Providing two members to sit on the Safeguarding Board. The group feels empowered to raise questions through its members to the board;
- Assessing the Family Group Conferencing method of working and giving feedback from the citizen's perspective.

Outcomes:

- Service users planning and developing the group's programme. The group members bring their own experiences of using services and this is included in all aspects of the work;
- Service users planning and developing services; for example, following on from the 'outcomes' piece of work(see above), the group has felt empowered to ask for a further leaflet to be produced to assist citizens in their understanding of the safeguarding process;
- Service users within the group currently have access to training. It is hoped staff will also benefit from this training with participation alongside and including members of the Experts by Experience group ;
- Service users acting as ambassadors and liaising with other groups within Torbay.

Further information:

Jo Jackson, Social Worker & Experts by Experience Facilitator
Joannejackson2@nhs.net
01803 210617

Personalising Block Contracts for Extra Care Housing

Plymouth City Council

Our approach:

A block contract for the care provision at an extra care housing scheme for 16 residents, all FACS eligible, was due for renewal. There had been a number of complaints from residents about the lack of flexibility in the care provision offered to them. The provider was frustrated and constrained by the original contract terms and it was agreed to work together with the residents, supported by the Councils Putting People First Champions Team, to see how a personalised approach through the use of personal budgets could improve the situation.

The project aimed to recalculate the existing block to split out core costs required to deliver the 24/7 cover required and, through the use of a generic resource allocation system, allocate personal budgets to the residents so that they could develop more personalised support arrangements.

Each resident was assessed using the Plymouth RAS (resource allocation system) and support plans were developed with the provider with support from the Care Manager. Over a period of about 3 months each resident completed the process with some needing more support than others. The provider introduced an innovative electronic diary so that each week the residents sat down with the manager and their support plan and agreed the support they needed that week to meet needs and achieve their outcomes. Residents are now able to have much more flexible support and the service provider makes much more use of community resources to bring support in to the residents and to support them to go out in the community.

The contract is still managed as “block” but each resident has an identified personal budget that they are able to direct themselves.

Outcomes:

- Improved satisfaction levels and improved social care outcomes for residents;
- Flexible services delivered through informal personal budgets;
- Improved partnership relationship with the care provider;
- Cashable saving of £90,000 and better value for money for the council;
- Application of process and learning to a new 50 home scheme coming on line in March 2011.

Further information:

Jo Yelland, Lead for Transformation and Integration
jo.yelland@plymouth.gov.uk
01752 307554

AskSARA

Bath & North East Somerset Council (B&NES)

Our approach:

AskSARA, produced by the Disabled Living Foundation, is a free-to-use website, specifically (though not exclusively) aimed at enabling older and disabled people and their families or carers to obtain on-line advice about equipment and other practical actions which can help them in their daily lives.

B&NES has paid for a customised version of AskSARA: anyone using the site is requested to state which of the subscribing authorities they live in. This is so that they will receive information which is tailored to that particular area.

AskSARA covers areas such as health, home and daily living, and works on a self-assessment basis: after answering a series of questions (usually either 'yes' or 'no') on a particular topic (e.g. medication management, bathroom, help in emergencies), a report is produced which can either be read online or printed. It gives practical advice about the topic concerned, and suggests related products which may be of use. The information is impartial, and regularly updated.

AskSARA is also able to direct people to request a Community Care Assessment if their self directed assessment indicates that this might be needed.

Outcomes:

The intended outcome of commissioning AskSARA is to provide a universally accessible signposting service for people living in B&NES who may:

- Be eligible for a social care service but may not know who to contact to access support;
- Not be eligible for a social care but may contact social services unnecessarily when advice and signposting is available elsewhere.

The website shows us that since 2010, 25,905 have answered 355,179 questions and received 187,562 reports containing advice and guidance in relation to help with daily living.

http://asksara.org.uk/index.php?auth=bathnes&forceintro=true

Further information:

Sarah Shatwell, Associate Director, Non-Acute & Social Care
sarah_shatwell@bathnes.gov.uk
01225 477162

Personal Budgets with Supporting People Funding

Cornwall

Our approach

Cornwall Supporting People Team had funding to commission long term services for people with learning difficulties using a personal budget approach. An objective of the project was to enable sustainability via peer support and building social capital. We used some funding to work with people still living with elderly parents to give them skills to live independently (traditionally excluded from SP schemes).
The Supporting People team developed a basic RAS – roughly equivalent of £16 per hour and used the adult social care overview assessment form and focused on housing related support. An amount of £224 per week is awarded for a new tenancy for 3 months = 14 hours of support.
The assessment includes family, carers and circles of support.
The support plan is developed to enable the recipient to purchase services and products that are legal and meet identified outcomes but otherwise can be spent very flexibly; it is reviewed after 3 months.
Cash payments – most users use the In Control website for advice and set up; SP pays for a CRB check.

Outcomes

- Service users have expressed greater satisfaction with their support and have in many instances achieved their outcomes faster;
- There has been good buy in and support from adult social care;.
- Work will be undertaken to support the market to meet the needs of recipients;
- It is very cost effective and is reducing costs for Cornwall Council - have used a CAP Gemini tool to demonstrate how SP investment has saved money for other agencies and promoted inclusion and prevention;
- It is expanding into other areas – the learning from the work with people with learning difficulties is being evaluated, with a view to adopting the approach for all sectors where people have long term housing related support needs.

For further information

Liz Nicholls, Personalisation Development Manager, Supporting People, Cornwall Council
linichols@cornwall.gov.uk

Safeguarding and Personalisation Framework

Department of Health South West Region

Our Approach:

A regional working group was set up which included safeguarding leads, personal budget /self directed support leads, service users' representatives and representatives from organisations providing direct payment employment support, police representatives, and a representative from an NHS mental health trust. The working group was supported by an independent researcher and consultant. The purpose was to:

- Identify guidance and good practice which both empowers and protects service users within the self directed support process;
- Ensure that safeguarding is built into personalised approaches and is not a separate process;
- Make the discussion about and ownership of risk explicit;
- Support joint and supported decision making;
- Identify points in the self directed support process where risk assessment and management are particularly significant;
- Include a user perspective which identifies ways to support and empower service users to make informed choices and to better protect themselves.

A framework was produced and launched in May 2010. This contains a high level business process with links to examples of good practice and guidance. The framework contains an action plan to implement good practice and joint working.

Outcomes:

A survey in the summer of 2010 found that:

- All Local Authorities were aware of the framework;
- Two thirds of Local Authorities had reviewed their policies and procedures. Of these, several had developed an action plan to deal with gaps and areas of weakness;
- The framework had provided examples that informed training and the development of guidance and good practice;
- The development of robust Positive Risk Taking strategies is underway in most local authorities;
- There is clearly more work to be done but there is active engagement with all key partners including Safeguarding Boards;
- Further action was needed to support service users to manage risk and to ensure that there is more community based support.

http://www.puttingpeoplefirst.org.uk/Regions/SouthWest/

Further information:

Kate Spreadbury, Project Officer, South West Safeguarding Adults
Kate.spreadbury@n-somerset.gov.uk
07990 745055

Person Centred Planning Tools for Self Directed Support

Dorset County Council

Our approach:

Dorset recognised the need to support individuals plan their life and choose how, when and where they receive support, as well as helping them to identify what they can do for themselves and show how they can manage risks safely.

The Person Centred Planning Lead worked with the transformation team to compile and adapt a suite of person centred planning tools and devise a training programme to embed this in practice. A booklet containing the tools with a guide showing when and how to use them has been produced. Training has included locality teams, residential settings, day centres and the re-ablement team. It will be rolled out to other agencies. Below are some of the tools contained in the booklet:

Communication
What is Working/not
Important to/for
Good Day/Bad day
Circle of Support
Relationship Circle
Matching
Histories or My Life Story
Stay Well Plan
Decision making agreement
Wishing/Dreams
Learning Log
Appreciations – unique qualities
Staff

Outcomes:

It is early days, but evidence is emerging that the language and approaches used is changing and support plans are becoming more outcome focused and person centred.

http://www.dorsetforyou.com/transformingsocialcare select 'Personal Budgets – the Next Steps' (left hand column)

Further information:

Debbie Catanzaro
d.m.catanzaro@dorsetcc.gov.uk
01202 221000

Use of Targeted Reviews to Promote Outcome-Based Support Plans

North Somerset Council:

Our Approach:

We used temporary Personalisation Reviewing Officers in order to:

- increase awareness of the personalisation agenda, both amongst people in receipt of long-term support, and with providers;
- review individual and carer needs & embed use of outcome focused support plans, ensuring cost efficiency and service effectiveness;
- increase the number of personal budgets in line with PPF targets.

Two reviewing officers were commissioned from Supporting People providers to work alongside two members of council staff. Existing paperwork was modified to include the individual's own outcomes. This outcome focussed approach was adopted across all areas of services in the roll-out of personalisation and supported by an 'outcome based' training programme to engage both statutory and independent sectors.

A pilot was set up where people, whose primary need appeared to be for domiciliary re-enablement, were triaged at SPA (Single Point of Access) and passed directly to START (Short Term Assessment and Re-enablement Team) with a set of broad-brush outcomes and a delivery time parameter. START workers then visited the individual; enabled person/ carer to write an outcome based support plan and set up services with view to a 4/6 week visit by a reviewing officer to discuss a personal budget in more detail.

Outcomes:

- Using staff from Supporting People providers enabled staff to benefit from the outcome focussed ethos of those services and also helped to disseminate the personalisation message back into this sector;
- Research indicated that our target 'audience' preferred communication at face to face level, underlining the positive role of the reviewing officers;
- Work with START resulted in a speedier, more proportionate and targeted service which released capacity within locality teams. The review visit also afforded opportunity to address any unmet needs, cease services which were no longer needed, or make alternative arrangements (e.g. telecare);
- Created extra reviewing capacity into the system with the focus being on disseminating awareness of personalisation and personal budget opportunities.

Further information:

Christine Jupp, Planning and Development Manager
christine.jupp@n-somerset.gov.uk
01275 884289

Educating and Supporting People with Mental Health Problems in Understanding and Accessing Direct Payments

MIND PHEW Centre, Exeter

Our approach:

We wanted to spearhead development of Direct Payments as a means of personalisation, through:

- Supporting people in making an application for direct payments if eligible;
- Working alongside people who support the applicant and services related to the application or who will sustain the activity;
- Acting as an advocate for the person applying and providing peer support in the early advice and financial assessment stages;
- Assisting with the review and maintenance of the direct payment.

We held regular coffee mornings at the PHEW (Promoting Health & Well-Being – a social enterprise set up to provide MIND services) centre where people could meet with a peer support or a direct payment mentor to find out about direct payments. We supported staff in mental health teams to help people in exploring the opportunities that might be realised through direct payments, produced a high quality easy read booklet, together with a short film celebrating the personal outcomes of individuals through direct payments.

We supported a local initiative 'Wild Things in the Community' to develop pathfinder clusters of people who wish to pursue activities, and we hold six monthly celebration events to support people with direct payments in publicising their personal outcomes.

Outcomes:

- Positive results in people's health and well-being through being able to design and benefit from programmes funded through direct payments;
- Enabled people who have substantial mental health needs but no contact with statutory services to access direct payments;
- 30 people assessed in the past year for whom applications for direct payments have or are being made;
- Enabled direct payment assessments to be made by people other than mental health professionals.

http://www.mindex.org.uk/
(Wild Things Project: www.wildthings-community.org.uk)

Further information:

Patrick Corbett, Support, Time and Recovery (STR) Lead at PHEW
virtualbridgebuilder@googlemail.com
01392 204492

Market Shaping with the Voluntary Sector

Gloucestershire County Council

Our approach:

Gloucestershire Association for Voluntary and Community Action (GAVCA) working on behalf of the voluntary sector were contracted through the PPF programme to help prepare the sector for change arising from personalisation. They contacted all the voluntary and community organisations in our area to explain how the personalisation of social care might give them opportunities to increase their range of services, diversify their income, or possibly manage individual service funds on behalf of their users.

Organisations were invited to complete a PPF Organisational Healthcheck questionnaire about their organisation and their readiness to market their services. Those who completed the questionnaire were then offered free training to help them:

- Build up a clear picture of the organisation's position in the market;
- Get to grips with attracting new users to their services;
- Think about meeting the 'next need' of their existing users;
- Evaluate the risks of developing new services for a different set of people;
- Start the process of building a market strategy.

Outcomes:

The potential benefits of this work included:

- The local market shaped by the use of market analysis and user preference;
- Local providers increasingly innovating and diversifying to meet needs as they emerge;
- Under-used services decommissioned;
- Greater use of small-scale commissioning and non-traditional services.

http://www.gloshub.org.uk/our-work/ppf/ppf-healthchecks

Further information:

Louise Flaherty, Commissioning and Service Development Manager
louise.flaherty@gloucestershire.gov.uk
01452 426728
Jess Mace Gloucestershire VCS Assembly Team Manager
jessm@glosassembly.org.uk
01452 522600

Market Position Statement

Devon County Council

Our approach:

As part of further developing the way we commission social care and build upon our partnership with providers, we wanted to improve how we shared our market intelligence, enhance how we communicated our future strategic direction and learn from providers' own experience. Working jointly with the Institute of Personal Care we published an Interim Market Position Statement (MPS), a succinct document which laid out the future strategic direction for Social Care.

The statement was launched to approximately 200 provider organisations at our annual Provider Engagement Network Conference in September 2010. We are working on a revised version to be published this spring and linking it to our commissioning cycle. We expect to publish a revised statement annually, each autumn.

The MPS included the following topics:

- The Future Operating Model – Helping People to Help Themselves;
- The commissioning environment;
- The Role of Voluntary and Community Sector Organisations;
- Representation;
- Contracting arrangements;
- Financial Context;
- Characteristics of the provider of the future;
- Major shifts in approaches to service delivery.

The outcomes:

- A stronger relationship with the voluntary and independent sector providers;
- Served as a platform for establishing purposeful dialogue with an increasing number of providers;
- Facilitated an increasing dialogue between the Voluntary sector and independent providers;
- It has led to work on service user and carer involvement in service monitoring and development of a single specification for involvement;
- The focus on procurement within the MPS has facilitated mutual collaboration on the introduction of Framework Agreements.

www.devon.gov.uk/market-position-statement

Further information:

Giles Colton – Putting People First Programme Manager
giles.colton@devon.gov.uk
01392 384387

Pro Disability Personal Assistant Register

Borough of Poole:

Our approach:

Using a modest amount of pump-priming funding from the Social Care Reform Grant, the Borough of Poole funded a one year pilot scheme to enable Pro Disability, a local user-led organisation, to develop and maintain a Personal Assistant Register.

This funded a post for one year to market, recruit and manage the register. It was also the intention to register the scheme with the Care Quality Commission (CQC). After a long process, it emerged that there was no longer a requirement to register with the CQC; nevertheless the Register will be managed on the principles and processes agreed with the CQC, and the Council can now signpost people to a register that functions to CQC standards.

All Personal Assistants on the register need to be CRB checked before they go on the register. This process was also funded initially while the register was built up, but Pro Disability are now working out a pricing model which will set out how they will market and charge for this service, so that it becomes self-sustaining.

Outcomes:

- There are savings for both the service user and the council:
- Less time taken in finding a personal assistant who has been vetted and has a CRB check in place;
- An increased pool of personal assistants enabling people to be matched more easily;
- Reduced costs for advertising and recruitment;
- Greater flexibility for clients with a reserve of assistants to cover in case of emergency, holidays etc.
- There are currently 28 personal assistants on the register (as at January 2011) with up to 10 more awaiting registration.

Further information:

Jo O'Connell – Principal Officer, Joint Commissioning (LD)
jonathan.oconnell@poole.gov.uk
01202 261144

Asset Based Community Development

Gloucestershire County Council

Our approach:

The asset based approach recognises that all individuals and communities have skills, knowledge, experience and connections to share. This is in contrast with the more familiar 'deficit' approach that focuses on problems, needs and deficiencies, and which results in communities and individuals being disempowered and dependent, passive recipients of services.

Asset Based Community Development (ABCD) is about looking for the positive things/strengths in a community and making the most of them. The ABCD approach was pioneered in the United States but is becoming increasingly recognised in the UK. There is a growing body of evidence that a focus on what individuals and communities have (their assets) as opposed to what they don't have (their needs) increases a community's efficacy in addressing its own needs.

One of the challenges is identifying how individuals and local communities can become empowered to act in this way. The ABCD approach provides one innovative way for councils and their partners to respond to this challenge.

In Gloucestershire we organised a workshop which aimed to build on existing successes and explore the application of asset based community development and other strength based approaches to empower communities and build active citizenship, thereby helping communities to help themselves.

Outcomes:

- Leaders from the County Council, the voluntary and community sector and other key partners were able to share their experiences and hear from those who have succeeded in using different approaches to empower communities;
- Attendees identified how they might take forward ABCD as an initiative/approach and debated what they would stop doing, start doing and do more of;
- One of our VCS partner organisations agreed to arrange an inaugural meeting to co-ordinate the rollout of the ABCD across Gloucestershire by having these learning conversations within local communities. They have secured resources to be able to match fund ideas for community development;
- Gloucestershire County Council have launched the 'Supporting Active Communities' initiative which provides funding to help communities to help themselves.

Further information:

Julie Goodenough, Workstream Manager
julie.goodenough@gloucestershire.gov.uk
01452 426741

Theme 2: Engagement and Co-Production

Celebrating Age Festival

Bristol City Council:

Our approach:

The Celebrating Age Festival is an annual event which includes a week of activities and culminates in a day-long high profile event. Older people are supported by the Council to plan and deliver the Festival. 3,500 people attended our final day of celebration this year. 200 older people attended the launch of the Festival's week of events for the premiere of a film by actor Dudley Sutton on challenging age discrimination.

This year, the week of events ranged from walks, T'ai Chi to seminars and computer classes. Headlines were the world premiere of Dudley Sutton's film, performances by Acker Bilk and his Paramount Jazz Band, an inter-generational gospel choir, fashion show, speaker's debate and arts competition. The DVD is highly acclaimed by older people and was developed with Bristol communities - including performances by the Malcolm X Elders and LinkAge and ACTA older peoples groups.

The Festival is one of the big five ideas identified in the Quality of Life Strategy and governed by Bristol's Older Peoples Partnership Board.

Outcomes:

- Promoted positive images of older people;
- Celebrated the contribution of older people to Bristol;
- Challenged negative stereotypes of older people and tackle age discrimination;
- Provided an opportunity for older and younger people to get together.

These are achieved through a varied programme of small events over the course of one week, spread out in local communities of Bristol, culminating in the final celebration day.

Further information:

Sarah Salter, Project Manager, Putting People First in Bristol
Sarah.salter@bristol.gov.uk
0117 903 7899

Virtual Independent Living Centre

Access Dorset

Our approach:

Access Dorset is an umbrella organisation of local user-led organisations, with a total membership of approximately 4,000 people, which have come together to establish a virtual Independent Living Centre. The organisation, registered with Companies House as a company limited by guarantee, is in the process of registering as a charity.

The project was led by DOTS Disability, a user-led organisation with funding from the Department of Health, Dorset County Council, Bournemouth Borough Council and the Borough of Poole.

A key feature of Access Dorset is an easily accessible website which will bring together information on the activities and services provided through the Centre for Independent Living, complementing the information service currently being developed by Dorset County Council. The website will have a number of interactive features and will be a key tool for stimulating the market to provide new and innovative services.

The size of the charity will put it in a strong position to bid for tenders to provide other services, and funding opportunities will be used wherever possible to develop areas of work that will benefit people across the membership of Access Dorset.

Outcomes:

It is anticipated that:

- through the provision of information and advice, peer support, advocacy and training, the Independent Living Centre will support people to live independently and improve their life chances;
- The capacity and skills of disabled people, carers, older people and other users of support in Dorset, Bournemouth and Poole will be developed in such a way that they are better able to identify, and help meet, their needs and to participate more fully in society.

www.accessdorset.org.uk

Further information:

Dave Thompson, Development Manager, Access Dorset
dave@accessdorset.org.uk
01202 771336

Transforming Lives Congress

South Gloucestershire Council

Our approach:

We wanted to bring people together in a different and new way to make sure that the voice of all interested parties was influencing our Transforming Lives programme. We recognised that the engagement and inclusion of organisations and residents of South Gloucestershire was fundamental to the success of this work and wanted to find a way to do this which would make a difference and which would work alongside the existing fora that already existed.
We did this by bringing together citizens, service users, carers, providers, members of the council, PCT board, LINks, Patient Advice and Liaison Services and other representatives as a Congress. This met twice a year to review what has been achieved since the last meeting, to bring and debate proposals and suggestions for change, and to plan next steps.

Outcomes:

- We sought suggestions in advance from different groups and this helped to shape events around what people wanted to hear about;
- We offered interesting stories, viewpoints and presentations from several service users with personal budgets, a provider running a personalised service, a Social Worker, a Senior Citizen, the Care Forum and Professors Jon Glasby and George Giarchi. This helped to increase awareness of what personalisation means and how personal budgets offer greater choice and control;
- We ran small workshops at each event on various topics that would benefit from input and from each determined actions that we would take forward before the next event. We then reported progress at the subsequent event. This held us to account and helped people to see that they were making a difference;
- We had a Q&A session at the end to debate any burning questions and to give people the opportunity to air any views;
- As a result of these events, we have (amongst other things) changed our language in our public information material to reflect the language of service users, introduced more flexible search parameters in our service directory, developed more support for providers, and have given a higher priority to providing information;
- With the need to operate ever more efficiently, we are now reviewing how we engage with all groups across wider topics to see whether a similar and more comprehensive approach would be beneficial.

Further information:

Rebecca Harrold, Project Manager for Transforming Lives
Rebecca.Harrold@southglos.gov.uk
01454 868228

First Contact

South Gloucestershire Council

Our approach:

The First Contact Scheme was piloted between 1 September 2009 and 28 February 2010 and is now to be rolled out across South Gloucestershire. The scheme, run by the council and its partners, is helping to identify and support older people to access services which can help maintain their independence.

Various organisations that come into contact with older people complete a simple checklist during their visit to see if they can benefit from a range of services provided by partner organisations. Examples of the types of services available include access to community transport, healthy activities, fire safety advice, benefits advice, neighbourhood policing issues and practical support in the home.

Once assessed, the individual is then referred to the relevant agency to contact the older person directly to arrange for the services to be put in place. For example the Pensions Service visited someone who had recently had hip replacement surgery, and having completed the checklist, referred her on to the Active Lifestyles service who enrolled her in swimming lessons.

Outcomes:

- Between September 2009 and December 2010, 374 checklists were completed which have led onto 1170 referrals to partner organisations;
- It has enabled older people to have access to a wide range of services;
- The scheme has shown that there is the will from partner organisations to make the scheme work;
- Partnership working is bringing benefits in terms of mutual understanding of other services;
- Engagement has been patchy and sporadic in some organisations; some organisations have adapted to the scheme very quickly and efficiently, other organisations are taking longer to grasp the concept.

http://www.southglos.gov.uk/HealthandSocialCare/ then select ‘Older or disabled people’/ ’First Contact Scheme’

Further information:

Sue Jaques, Community Engagement Officer
sue.jaques@southglos.gov.uk
01454 868267

Appreciative Inquiry Process

Plymouth City Council

Our approach:

The aim is to involve service users, carers and staff in the design and priorities for new ways of working to support personalisation. Appreciative Inquiry is a strengths-based, creative process that brings people who provide and use services together on an equal footing to share personal stories of what it feels like when people have good experiences either using or working within the system. The process then helps people to identify the component parts of "good" and then to focus on how more of the good things could happen more often. This then forms the basis of the action plan for transformation. The Appreciative Inquiry process enables organisations to:

- Look for their successes and create images of the future based upon those positive experiences of the past;
- Plan their evaluation and change processes as a powerful intervention into the system with the power to alter and shape the future of that system;
- Benefit from and build on the continuity of the best of the past when innovating, creating, and delivering the change that is needed.

Outcomes:

There are now four published reports on the Inquiries we have held and each of them has influenced the direction of travel for the transformation of adult social care. The biggest impact of the process has been its role in changing the culture within the organisation helping workers to see their role as less "expert" and more enabling.

Actions that have come about from the process are:

- Increased investment in information and advice services including a web based "shopping site";
- Decision to introduce a pre-loaded payment card as mainstream for all direct payments;
- A streamlined assessment process for adult social care to be rolled out in 2011;
- Clearer understanding of what support planning could mean to people and the help they might need to complete aspirational support plans;
- A move away from "forms" to allow people to choose the format of their support plans which could be a picture, a letter, a DVD, tape recording or presentation;
- A series of visual images of what personalisation means to people which have been used in staff training.

Further information:

Jo Yelland, Lead for Transformation and Integration
jo.yelland@plymouth.gov.uk
01752 307554

Peer Support Sessions

Bournemouth Borough Council and the Borough of Poole

Our approach:

Following feedback from carers, a series of day and evening activities were commissioned during 2009/10. Day activities were arranged through local authority carers support staff and a local social activity provider for older people was commissioned to arrange monthly evening activities.

Day activities often involved going to a local place of interest; evening activities were varied, often lively, and sometimes included a meal. Some activities were limited to 20/30 attendees, others could accommodate 50.

It became clear during the year that there were some types of activity that limited the peer support that could be developed. It was also important to have an opportunity for the carers support workers to address everyone in the group so that carers, and the workers, were aware of their role during the activity. Carers tended to go to one type of activity, either day or evening. Some of the evening activities had limited numbers as they had to be booked in advance. Limited numbers meant that there was overbooking for some activities and carers were disappointed. Carers have also wanted to bring the person they cared for to events particularly if the carer was unable to leave the person they cared for.

Commissioners have involved carers in identifying future activities, explaining some of the learning that had taken place. Some, but not all, of the activities include the cared-for person, and a financial contribution has been introduced through carers suggestion in order to reduce the costs. Carers have started to fundraise through a raffle and are forming a group to organise this.

Outcomes:

- Carers have got to know each other during an activity and sustained contact afterwards.
- Engagement in an activity, and the arising social interaction, was beneficial to the carers' well-being.
- Carers report feeling 'uplifted' and the activities 'enjoyable' and 'appreciated'.
- Carers share concerns with peers or specialist workers in an informal setting.
- Carers learn from others with similar experiences, and hear about other support that has been useful.
- The activities give carers a short break away from their caring routines.
- Services are planned and developed with providers and carers.

Further Information:

Debbie Hyde, Carers Commissioning Manager
deborah.hyde@bournemouth.gov.uk
01202 458714.

Your Circle

Gloucestershire County Council

Our approach:

Following consultation with the public and stakeholders, 'Your Circle' was developed to improve access to information and advice for everyone.

'Your Circle' is based on 3 principles:

- instead of fitting people around traditional council services, they would be in control of the support and services they need;
- we would put people at the centre of everything we do;
- working together, we would help people identify trusted people, places and services – their support network, which will enable them to live their life their way.

The project set out to explain the concept of building circles of support and the changes to social care in a multiple of formats, including audio, large print, DVD and Easy Read. Material was developed to raise awareness of the Your Circle concept, explaining how people can identify and enhance their own circle of trusted people, places and services. Case studies were used to promote the benefits of personal budgets and Self Directed Support.

A one-stop-shop website was developed drawing together existing sources of information and advice. Research showed that most of the information and advice needed was already available, but not easily accessible, as it is held in many different forms and locations. We also worked with our partners - the voluntary and community sector, libraries, district and parish councils, housing associations, etc. so that everyone knew where to access information and advice – 'no door is the wrong door'.

Outcomes:

- Improved access to information and advice, by making it easier for everyone, whether or not they need council support, to identify the support they might need in order to maintain independence and live their life their way;
- Increased awareness across communities of how they can support older and more vulnerable adults;
- Wider understanding of the changes to social care;
- Tools for partners from the voluntary, community and commercial sectors to enable them to develop and publicise their own services;
- In the future we expect more people to develop and use their circle of support to enable them to live independently at home for as long as possible, and that there will be less reliance on long-term adult social care support.

www.yourcircle.org.uk

Further information:

Rachel Topps, Corporate Campaign Manager
rachel.topps@gloucestershire.gov.uk
01452 426406

Public Information Strategy

Devon County Council

Our approach:

We had a good range of public information in Devon already and benefited from having our 'Care Direct' team embedded within our Customer Services Centre. However we wanted to improve our offer and so developed and implemented a strategy to improve access to the channels we use and the range of information we provide. We reviewed our public information and advice provision in three ways:

- We set up three focus groups: with one group of older people, one of people of working age and one of service users and carers;
- We also conducted an internal audit of our publishing and information channels;
- We held a workshop with Care Direct and Care Direct Plus staff.

The recommendations were:

- Enable Care Direct to act as a single point of contact for all social care calls, adjust its branding accordingly and market the service with our basic public information;
- Revise our printed public information and our web site information to reflect focus group findings;
- Start using libraries as outlets for social care information;
- Ensure the third sector can act as effective providers of social care information;
- Complete development of the public-facing Community Directory;
- Develop Care Direct's capacity to offer non-FACS-eligible services.

Outcomes:

- We have redesigned the social care part of the council website;
- We are improving our web-based local information system;
- We started a tender process for a new web-based Community Directory;
- We have updated many of our factsheets to reflect 'Putting People First';
- A new leaflet 'Social Care for Adults' is available with added information on personal budgets and other changes;
- Care Direct has been rebranded and is now taking all adult calls;
- Libraries now act as public information points for social care as well as providing venues for some community based services.

www.devon.gov.uk/public_information_strategy_for_web.pdf

Further information:

Giles Colton, Putting People First Programme Manager
giles.colton@devon.gov.uk
01392 384387

Development of User Led Organisations (ULOs)

Department of Health South West Region

Our approach:

To build the capacity of User Led Organisations in the South West, to ensure a minimum of one ULO in each local authority area responsible for delivering adult social care, and to enhance collaboration within localities and across the region.

Outcomes:

A regional support network (South West Disability Equality Network) has gained strength, and functions in a focussed way to build capacity individually and collectively. The network is facilitated by Equality South West Ltd. This is likely to form itself into a separate legal entity within the next year.

A strong spirit of co-production has developed to build ULO capacity, both regionally with the Department of Health, and in particular localities.

There are some emerging beacons of excellence for ULO development in the South West. These include Access Dorset, which is a newly formed network charity of smaller ULOs in Bournemouth, Poole and Dorset, and Living Options in Devon. These ULOs have benefitted from a strong ethos of co-production with their local authority partners, and it is showing clear results.

The Fusion consortium in Devon (drawing from the wider SW experience) has produced a toolkit for ULOs wishing to adopt a consortium approach.

Gloucestershire Lifestyles is the only ULO in the South West actively offering support planning on a self funded basis. This is a clear area for future development as Local Authorities change their operating model. This service would support ULOs become more financially sustainable and it would serve to underline provision of choice to people who need to use social care services. This approach also has the potential to release efficiency savings for Local Authorities.

There has been an improved understanding by Local Authorities of different approaches to commissioning with small social purpose sector organisations.

Equality South West Ltd website – range of good practice resources on ULOs which have been developed through the capacity building project, and a tool to identify location of ULOs in your locality.

Link under User Led Organisations on South West webpage

http://www.puttingpeoplefirst.org.uk/Regions/SouthWest/

Further information:

Warminster Community Voices

Wiltshire County Council

Our approach:

Wiltshire County Council has a number of Area Boards which bring together elected members, parishes, partners and local people to tackle local issues. There has been a strong focus on improving public participation, community engagement and social inclusion.

The Warminster Area Board recognised a need to increase community involvement at Board meetings and wanted to ensure that local people who were unable to attend had an opportunity to have their views heard. The Area Board initiated the idea of recording the voices of local people to be played back at the meetings.

Area Board panel commissioned and funded Warminster Community Radio, which runs an all year service to the community including local hospitals and care homes, to carry out a pilot project capturing and recording local people's views. Drop-in sessions were organised so that local people could give their views on agenda items prior to Area Board meetings or raise their own topics or concerns for discussion. Warminster Community Radio volunteers also went out and recorded at locations such as the local shopping centre or at planned events. The combined recording sessions were edited and played back at the next Area Board meeting.

Outcomes:

- The pilot project has helped to raise awareness of topics and issues that affect local people in Warminster;
- The different voices and perspective now brought to the Area Board meetings through the recordings have made the Chair and people attending ask different questions and listen to different solutions;
- The benefit of recording people's opinions, as well as collecting statistical information, is the impact of hearing people's comments in their own words. It gives a context and can add weight to the statistics, which are otherwise depersonalised.

Further information:

Steve Milton, Head of Community Governance
steve.milton@wiltshire.gov.uk
01722 434255

Theme 3: Early Intervention and Prevention

Improving Services to People who Fund Their Own Care and Support

Dorset County Council

Our approach:

The demography of Dorset is heavily weighted towards older people and this is predicted to increase substantially. This will lead to an increased number of people likely to benefit from care and support who cannot be supported by the Council due to both Fair Access to Care Services eligibility criteria and financial criteria.

The broad aims of the project are to ensure that that people who fund their own care and support services have access to information, advice and advocacy at the points in their lives where they are planning services to maintain independence. This requires:

- identifying more accurately those people who are funding their own care and support needs and what support would be of most benefit to them;
- putting in place ways of reliably capturing data relating to activity undertaken to support people who fund their own care and support;
- promoting a person centred approach to support people who fund their own care and support, including ensuring that people from Black and Minority ethnic communities who fund their own care and support have equal access to assistance.

Outcomes:

The provision of a range of services designed to support this group to make informed choices will result in more cost effective choices that are of benefit to both individuals and the council. This includes:

- reducing the likelihood of people making choices that undermine their independence rather than promoting it, in turn reducing the risk of further calls on public funding in the future;
- improving the development of early intervention and prevention services using feedback from service users;
- improved understanding of the needs of the wider community contributing to the development of the social care market through the early identification of trends in developing needs, with the potential to stimulate the market for user led services, micro commissioning and self help services.

Further information:

Philippa Scott, Strategic Commissioning Manager
p.scott@dorsetcc.gov.uk
01305 221000

Active Directory 60+

South Gloucestershire Council

Our approach:

The Active Directory 60+ is a preventative service which enables older people in South Gloucestershire to make informed choices based on relevant information and therefore improve their health and well being.

It began in 2005 as a four page document of local opportunities to take part in physical activity. The 2011 edition is sixty (A5) pages including: exercise classes in the community, walking groups, swimming sessions, library services and information about healthy eating, and transport and services provided by the Community Care and Housing department. 15,000 copies are printed, of which approximately half are posted to 'Active' members who are aged 60+. The remaining copies are available at libraries, leisure centres, health centres, events etc. The 'First Contact' referral scheme gives isolated older people the opportunity to receive a copy. There is also a regularly updated online version.

Outcomes:

During the autumn of 2010 a comprehensive survey was conducted to ensure that the directory was meeting the needs of the older population. Responses from a hundred and seventy-five older people (including non-users) were received. Almost every respondent rated all aspects of the directory (overall design, range of activities, text size, information pages) as 'very good' or 'good'. 68% of respondents reported that they had attended up to five different activities listed in the directory. Respondents were asked to rate the various items in the directory from 'not important' to 'very important'. Consequently the content of the 2011 edition has been adjusted; for example, further emphasis has been placed on walking, healthy eating, exercise classes and library services but sports clubs have not been included this year.

The Active Directory 60+ is a result of effective partnership working across a range of services including leisure, culture, health and social care. It increases opportunities for older people in South Gloucestershire to lead an active, healthy lifestyle and has been proven to meet local needs.

http://www.southglos.gov.uk/Communities/CommunitySport/ActiveForLife/ and select 'Active Directory 60 Plus'

Further information:

Brian Gardner, Active Lifestyles Manager
brian.gardner@southglos.gov.uk
01454 862296

Wiltshire Dementia Telecare Service

Wiltshire County Council

Our approach:

This project promotes the use of technology to maintain the independence of people with dementia or memory loss and prevents or delays unplanned hospital or care home admissions.

For many people the equipment provided is less disruptive and intrusive that a team of care workers and is able to respond 24 hours a day. Furthermore it is more cost effective than the introduction of additional carers or other professionals. The unique element of this service is that if an individual triggers an alert this is responded to by a local call centre that is jointly commissioned by the NHS and Local Authority. The Centre has a range of possible responses that include: calling an ambulance, contacting a nearby relative or sending out a doctor, healthcare or social care worker.

The pilot was set up in close consultation with community mental health teams, care agencies and voluntary groups such as Alzheimer's Support. An interagency working group proposed a set of key performance indicators at the outset of the project to monitor processes and outcomes.

A telecare co-ordinator was recruited and trained both in the use of telecare equipment and in the needs of people with dementia. The role of the co-ordinator is to conduct assessments, identify the most appropriate equipment and to oversee installations, equipment management, removal of equipment (where required) and promote the service. Partnerships were formed with Care Connect as the call monitoring service, and Wiltshire Medical Services who provided the response service.

Outcomes:

- Hospital and care admissions were reduced/avoided/delayed;
- An independent evaluation found that carers felt supported and reassured as they felt the customer was safe with the technology in place;
- Service users are happier with a telecare installation compared to additional care staff as the equipment is less intrusive to their lives;
- Service users are able to stay at home for longer;
- Medication can be better managed;
- The risks to the customer from fire, flood, temperature extremes, wandering, bogus callers and other factors was significantly reduced;
- The average cost per installation is £300. When this is compared to 10 weeks of residential care for dementia at around £750 per week, approximate savings are £7,200 over the same period for one installation.

Further information:

Nicola Gregson, Head of Commissioning
nicola.gregson@wiltshire.gov.uk
01225 771673

LinkAge

Bristol City Council

Our approach:

LinkAge is a community based initiative between the council, voluntary sector (The Anchor Society, St Monica Trust, and Guinness Care & Support) and Public Health. It supports older people to develop and deliver local opportunities for themselves. Older people directly influence the shape of LinkAge through Local Advisory Groups. The guiding philosophy is to ensure 'older people are in the driving seat'.

The successes include:

- Creative drama workshops;
- Affordable foot care, including domiciliary visits;
- Woodwork workshops – 30 men attend;
- Local activities guides, and a 'toilets and benches map' put together by older people;
- Gentle Activities – a joint healthy ageing and falls prevention project which trains older volunteers to deliver exercise classes to other older people;
- A community safety project which has links with the Police Senior Citizen Advice Line (DVD available);
- Encouraging older people to become volunteers.

Outcomes:

- Older people wrote and acted a play about growing up in Bedminster, Bristol and performed this to 300+ children from the area which has promoted understanding across the generations;
- Footcare and the Gentle Activities group decreased the potential for falls and is helping older people to get out and about;
- The woodwork group has provided an opportunity for socialising for men, who, whilst enjoying the practical element, have had the chance to socialize, reminisce, join other initiatives and talk about bereavement.

http://www.bristol.gov.uk/ccm/navigation/health-and-social-care/services-for-older-people/ and select 'Link Age' (from bullet point list in centre of page)

Further information:

Kay Russell, Service Manager –Social Care Transformation
kay.russell@bristol.gov.uk
0117 903 7369

Oriental Pearl

Bristol City Council

Our approach:

The project is being funded by Bristol City Council and NHS Bristol to run a series of creative art workshops to engage isolated Chinese elders who have a diagnosis of or are at risk of developing dementia. The project also worked with carers.

These creative residencies will use visual, oral, text-based and cross-over art forms to engage participants and their families in an expressive forum, encourage inter-personal, inter-generational and inter-cultural communication to help them to develop and build strong support networks.

We will be working with artists who have experience of working with older people with dementia to deliver the project.

Each session begins with gentle physical exercise i.e. stretching and movement to help people warm up and focus their minds. This also helps to create a happy, relaxed and informal atmosphere that will bring the participants closer together.

The main part of the session will involve the making of different pieces of art that will give people the opportunity to share their experiences, memories, feelings and impressions about their past.

Outcomes:

- Raised awareness of dementia within the Chinese community and helped eliminate stigma;
- Provided opportunities for carers to share their experiences and break down the barriers which surrounds the condition;
- Improved quality of life, self-esteem, confidence, sense of self and belonging and skills amongst the participants;
- Increase ability of the carers to manage their emotions;
- Promote inter-personal and inter-generational communication;
- Provide further evidence for using creative arts as a tool to engage hard to reach communities;
- Through remembering past experiences, a person with dementia will access long and/or short term memories.

Further information:

Rosa Hui MBE DL, Director
rosa.bacwg@btconnect.com or admin.bacwg@btconnect.com
0117 9351462 / 0117 9540476

Social Prescribing

Bath & North East Somerset Council

Our approach:

The New Routes social prescribing project is a two-year pilot based in Keynsham. It assists socially isolated people to access opportunities within their local communities, via their GP. The project aims to improve participants' health and wellbeing, to develop a knowledge base of the range of local resources, and to gather feedback from service users and service providers about their experiences of social prescribing. The project also aims to build upon the personalisation agenda, facilitate cross-sector working and identify any gaps that may exist in current service provision.

New Routes began in April 2009 and started to take referrals in October of that year. It had 48 referrals as at the end of June 2010. The first three months of the project focused on setting up care pathways, designing assessment forms and evaluation tools, producing a database to capture information, undertaking a comprehensive audit of local services, and networking across Voluntary, Community and Social Enterprise Sector (VCSES) organisations and primary care teams.

Outcomes:

The University of Bath is evaluating the outcomes of this by measuring a person's sense of wellbeing, looking at the impact of services on individuals, and exploring the effect on and relationships with VCSES organisations.

Early anecdotal evidence suggests that, prior to contact with New Routes, individuals did not feel informed or empowered to make use of local services and opportunities. Most feel they have benefitted from a first assessment with one of the New Routes Coordinators, with some stating that this first assessment was enough for them to look at their life in a different way. Many people have stated they feel they did not have time to discuss their non-medical needs with the GP and that the opportunity to do so with New Routes Coordinators has been invaluable.

http://www.thecareforum.org/voluntary_sector/Social_Prescribing_Project.php

Further information:

Debbie Howitt or Anna Sansom, New Routes Co-ordinators
debbiehowitt@thecareforum.org.uk or annasansom@thecareforum.org.uk
Telephone: 0117 958 9303

Re-Ablement

Bath & North East Somerset Council

Our approach:

In order to focus re-ablement activity where it is most needed, we have appointed an experienced occupational therapist to work alongside our acute hospital's Discharge and Therapy Evaluation service in the medical assessment unit and the emergency department, in particular the observation unit. The aim of this project is to identify current gaps in the provision of both health and social care services to prevent re-admissions, unnecessary admissions and support early planned discharge from hospital. The project involves data collection as well as the recording of case studies which will be used to help shape our commissioning intentions.

We have initiated discussions with our major community housing provider to look at innovative ways of offering furnished units of accommodation to use as 'step down/re-ablement' facilities, particularly for service users who wish to remain independent in their own home. We have identified that there are particular pressure areas in relation to identifying appropriate re-ablement settings for non-weight bearing service users, older people awaiting placements or packages of care and those who need support with medicines management.

Our provider arm, Community Health & Social Care Services, is in the process of developing an integrated health and social care re-ablement service which will work across all localities in Bath & North East Somerset.

Outcomes:

Our ultimate aim is to achieve an integrated health and social care re-ablement service which supports older and vulnerable people across all age groups, all service user groups (older people, mental health, learning difficulties, physical and sensory impairment) and in all localities across Bath & North East Somerset.

Early outcomes include a reduction in the escalation of individual service user needs evidenced by the high percentage of people require no further package of intervention, a reduction in the incidence of episodes of unplanned care e.g. non-elective admissions to hospital, and a significant reduction in delayed transfers of care to permanent residential placements.

Further information:

Corinne Edwards, Associate Director, Urgent Care & Older People
corinne.edwards@banes-pct.nhs.uk
01225 831868

Folks @ Home Project

Torbay Council

Our Approach:

The remit of this Supporting People project is to deliver short term support (6 – 12 weeks) to individuals in order that they gain the ability to live independently and regain control over their lives. It is for people who are leaving hospital/finishing rehab/wanting to leave residential care. The focus is on re-establishing daily living skills, managing household tasks and managing money, and building confidence to participate in the local community.

The project has supported people at risk of losing a tenancy or losing their independence and entering residential care. People supported by the project have had a range of problems including alcohol misuse, mental health issues as well as physical ill health. The support staff focus on outcomes and establishing independence; the ultimate aim is to reduce a person's dependency on ongoing services. Referrals come from a range of sources including health and social care professionals, and housing providers.

The project has been extended and a thorough evaluation is expected by April. The evaluation has included cost modelling to capture potential cost benefits.

Outcomes:

- 24 clients have used the scheme so far.
- Clients have reported high levels of satisfaction with the service.
- It has built confidence, reduced isolation, improved independence, reduced the threat of eviction, and dealt with debts
- The early findings from the financial modelling indicate that the short term interventions have reduced the need for more costly long term care and support.

Further information:

Fran Mason, Supporting People Manager
frances.mason@torbay.gov.uk
01803 208424

Theme 4: Efficiencies and Sustainability

‘Equip for Living’

Bournemouth Borough Council, Borough of Poole and NHS Bournemouth and Poole

Our approach:

The aim of the service is to retain and build on the advantages of an Integrated Community Equipment Service whilst helping the community have personal choice in relation to its community equipment needs. Demographically the over 65 population across Bournemouth and Poole is projected to rise between 5 and 11% which will require the provision of more community equipment. To address this ‘Equip for Living’ was designed to:

- Deliver an equipment loan service via an efficient online ordering system and achieve very challenging service response times whilst minimising negative environmental impact;
- Provide driver technician and on-site assessor technician services that can provide basic equipment assessments to reduce waiting times for people in urgent need of simple equipment;
- Provide an equipment demonstration area where service users can be assessed for their equipment needs and trial equipment before it is installed in their homes;
- Allow choice on a catalogue selection of retail alternative equipment which is supplied minus a sum equivalent to the amount that would be paid for the supply and delivery of our standard loan equipment;
- Provide access to an online self assessment system as well as providing a comprehensively stocked retail area and information on local aids to independence retailers;
- Provide an equipment hire and maintenance solution for residential homes to allow them to be flexible in response to residents needs.

Outcomes:

- Access, including wheelchair access has been improved by the central location of the service. Service users can be assessed within the demonstration area thus avoiding the need to transport bulky equipment;
- When visiting the service, individuals have been able to get advice on their equipment needs and also purchase appropriate simple aids to daily living;
- An online ‘personalisation catalogue’ has been implemented which lists equipment where a retail alternatives can be chosen;
- Equip for Living is providing a highly cost effective provision of community equipment loan services whilst supporting individuals in their decision making in respect to aids to daily living.

Further information:

Steve Albin, ICES Contract Manager
steve.albin@bp-pct.nhs.uk
01202 541457

Good Neighbour Handbook and Network

South Gloucestershire Council (to be launched February 2011)

Our approach:

In communities across the country groups of volunteers have come together to create a Good Neighbour Network for local residents. This helps foster a feeling of wellbeing for the residents who benefit from the help they receive, but also gives the volunteers a sense of purpose and a way of giving something back to the community. A Good Neighbour Network recruits volunteers to help neighbours by doing small tasks. A core management team marry up requests for help with available volunteers offering those tasks. One scheme is already running and publicity to encourage other groups to start up is about to be launched via the Good Neighbour Handbook.

The Good Neighbour Handbook draws upon good practice to explain the advantages of a Good Neighbour Network, how they work and how motivated people in communities can come together to make it a reality. It gives useful information and sample documents to help demystify getting a network off the ground. Specialist advice is available from the council to help groups set up their network and to apply for start up funding.
Being part of a Good Neighbour Network enables local people to be involved and empowered in their own communities. As the networks develop, they will be offered the opportunities to come together to share best practice and what they have learnt from their experience.

Outcomes:

Anticipated outcomes are:

- Increased social capital and community cohesion, as new support and social networks are formed in local communities;
- Communities identifying areas of need and how they can make the local area a better place to live;
- The network has the potential to be a cost effective way of identifying older or disabled people who are struggling to cope at home, and could be an effective way of reducing isolation;
- Costs to the Council are low – in producing the handbook and in offering support to interested communities;
- It promotes the benefits that can be gained through volunteering.

Further information:

Denise Swain, Planning & Partnerships Officer
denise.swain@southglos.gov.uk
Sue Jaques, Community Engagement Officer
sue.jaques@southglos.gov.uk
01454 864323

Well Aware

Bristol, Bath & North East Somerset & South Gloucestershire Councils/PCTs: Care Forum

Our approach:

The Care Forum, three local authorities and three PCTs came together in 2009-10 to develop an open access database of health, wellbeing and community resources in Bristol, South Gloucestershire and Bath & North East Somerset. The Care Forum delivers the service, moderates all records and maintains the database. Additional start-up funding was provided by the South West Improvement and Efficiency Partnership.

Launched in May 2010, Well Aware is a free information service with over 4,000 records, searchable by anyone via its user-friendly website. Records cover voluntary, community, statutory and private providers, and the full range of health and wellbeing topics, including providers of personal care, lunch clubs and social groups, sources of advice on benefits and legal help, and all other forms of support.

Well Aware is free to use and be listed on. For anyone unable to access the internet, there is a freephone helpline (0808 808 5252) providing access instead. The site's online information library includes a Learning Difficulties section in Easy English, plus a dedicated portal for anyone needing information on mental ill health and employment. A Low Vision Resource is nearing completion, and special sections for older people and Limited English Speakers are also in development.

As well as a funders group, a stakeholder reference group provides formal oversight on the development of the project. This group comprises volunteers (both service users and service providers) from groups with particular accessibility needs around information.

Outcomes:

- Usage rates have exceeded the uppermost expectations for the site;
- Provision across a wide geographical area enables people to identify the full range of potential interventions, including ones in neighbouring authorities;
- A highly accessible service to give even isolated people the information necessary to initiate preventative action around their health and wellbeing – without having to go through statutory services first.

http://www.wellaware.org.uk/

Further information:

Leon Quinn, Information and Research Services Team Manager, The Care Forum
leonquinn@thecareforum.org.uk
0117 958 9307

Operating Model for Self Directed Support

Plymouth City Council

Our approach:

Our most important resource is our staff; we will only transform and develop our service through their actions. We wanted to involve staff in developing ideas, and in defining improvements.
A framework was developed as a basis for improving the internal operating system, based on 5 design principles:

- deliver agreed efficiency savings;
- improve the effectiveness & efficiency of the initial citizen contact point;
- simplify & streamline the assessment procedure;
- ensure staff use the full potential of their skills and experience;
- integrate the delivery of Health & Social Care Services where possible.

A staff reference group of 40 people was established to undertake an analysis to identify which aspects added value to the "customer". The front end process was mapped and an accountability and responsibility analysis completed. This was all put together in a report describing the "as is" system.
The group concluded that there was much that could be done to improve the way we work and make better use of people's skills and experience. Too much time was spent on paperwork which could be freed up to provide more direct contact with service users, as well as achieve considerable savings. The group has then worked together to define the "to be "system using the following design principles:

- Choice and Control: self directed support as mainstream;
- universal early intervention, prevention /re-ablement offer;
- safeguarding as an overriding principle;
- 'right first time' to eliminate duplication;
- unique client record for each service user;
- one initial point of contact and a single team delivering Adult Social Care;
- cashable efficiencies realized;
- transformation of Adult Social care cross-checked for alignment with corporate goals.

Outcomes:

- unanimous agreement on a new lean operating system that is owned and understood by our staff;
- identification of two key roles that could deliver the end to end process
- significant culture change;
- identifiable cashable saving;
- full support to roll out new system through a Proof of Concept team.

Further information:

Jo Yelland, Lead for Transformation and Integration
jo.yelland@plymouth.gov.uk
01752 307554

Reduction of Double Handling Project

Somerset County Council

Our approach:

This project looked at the potential for reducing the need for two carers to assist older people and those with physical disabilities by providing equipment instead. In a number of cases two carers were needed to help the service user manage tasks such as getting out of bed, being washed and dressed and finally returning to bed at the end of the day. However the introduction of new innovative equipment such as slide sheets or hoists could both reduce the need for additional carers, and afford the service user greater dignity.

As a result of interviewing key stakeholders, examining service user data, and carrying out desk top assessments of service users by OTs to evaluate the potential for utilising equipment, it was established that an invest-to-save existed where up to 40% of service users with two carers could benefit from the use of equipment.

Implementation required the establishment of a communications strategy to engage and bring on board private sector providers, OTs, service users and carers in the aims and objectives of the project. Joint training for private domiciliary care staff and OTs was established, together with new moving and handling documentation and the development of equipment management processes. Key throughout was the maintenance of a person-centred approach to ensure that a strict emphasis was kept on assisting older people in their own homes.

Outcomes:

- Service users felt more empowered in their home environment, particularly if the equipment used is controlled by the service user themselves;
- Care workers have developed a better rapport with the service user when on their own;
- Joint training has enabled care workers to increase their skill levels and improve their work satisfaction;
- Improved moving and handling documentation has increased consistency across the County's OT service;
- Significant cost efficiencies have been achieved. After the initial investment in equipment, together with the associated reduction in care providers' hours, payback can be achieved in up to 16 weeks.

Further information:

Clare Steel, Service Director, Adult Social Care
csteel@somerset.gov.uk
01823 355100

Charging Policy

Bath & North East Somerset Council

Our approach:

The roll out of Personal Budgets to all non-residential social care service users has raised significant challenges in relation to charging for social care services and the collection of financial contributions in Bath & North East Somerset. Previous charging arrangements were set out in several different charging policies; processes were confusing and lacking in transparency for service users, carers and internal administrative staff. Along with the need to respond to new Department of Health guidance, the advent of Personal Budgets prompted review and revision of social care charging policies in Bath & North East Somerset and the development of a new single contributions policy to be applied consistently across all service user groups.

Traditionally, charging policies for social care have been based on the 'units of service' a person receives and the unit cost of these services. In practice this meant that a person might be finically assessed in several different ways if they received several different services and the potential for incorrect charging was heightened. Under the new policy the total cost of all the services received by an individual is considered in relation to their ability to contribute, based on a personalised and detailed financial assessment. Disability related expenditure is also considered on an individual basis and the contribution a person is required to make is a single contribution, based on their ability to pay rather than on the size of their care and support package.

Outcomes:

The new policy was approved in early 2010 and its implementation has allowed good progress towards achieving better levels of fairness and equality within the social care system.

Previously some services were not chargeable and some service users were also excluded from being required to make a contribution. The overall effect was a charging framework which lacked clarity and transparency for users, and required some to contribute more than they could afford and some to contribute less than they were able. This was also difficult to administer for officers who were responsible for financial assessment and processing.

The new system is clear and transparent for service users, carers and those responsible for its administration. All social care users are assessed under the same policy regardless of the type of social care service they access and in this way we are aiming to eliminate inequality.

Further information:

Sarah Shatwell, Associate Director, Non-Acute & Social Care
sarah_shatwell@bathnes.gov.uk
01225 477162

Capacity Building to Plan for Future Workforce Needs

Department of Health South West Region:

Our approach:

The Department of Health has developed the skills of the Care Partnerships in the region to deliver support to care providers on workforce planning, to ensure that their workforce is able to deliver their future business priorities. A series of projects have been funded to cascade this support direct to care providers, in partnership with Local Authorities.

Outcomes:

A key focus has been on facilitating care providers understand the need to diversify what they offer, and the workforce implications of so doing. There is anecdotal evidence that this has been achieved.

This work has identified the need to offer further support, particularly to better understand re-ablement services, the potential of assistive technology, and how to improve efficiency and productivity. Support is being delivered, including a regional project to raise care provider understanding of LEAN efficiency methods, all of which are embedded in a focus on personalisation of services, which is attracting significant interest.

A short guide to workforce planning was developed by the Department of Health (South West), in consultation with the National Care Forum, to complement the longer guide published by Skills for Care. This is available on the South West Putting People First website. There is also a helpful presentation on workforce planning for providers and a hints and tips sheet.

http://www.puttingpeoplefirst.org.uk/Regions/SouthWest/Resources/Resource/

Further information:

SW Region Joint Improvement Partnership

Our approach:

The South West Region Joint Improvement Partnership (JIP) delivered a programme of bespoke support to authorities in relation to Resource Allocations Systems using Symmetric consultancy. During the delivery of this support, authorities requested practical guidance on four common topics affecting their organisations:

- Financial assessment and charging
- Monitoring personal budgets
- RAS and managing resources
- Personalisation and the Law

A series of papers were co-produced following workshops with input from South West authorities with experience of the topic within a personalised system. The papers utilise their knowledge with support from Symmetric, Sam Newman (consultant) and Pam Richards, South West Personalisation Co-ordinator.

Each paper defines the topic and why it is important. It details the key issues and offers practical solutions and a way forward. Each paper should be seen as practical guidance and advice; they do not compete with any policy, but try to interpret existing policy and make practical implementation suggestions for South West authorities. The solutions offered are intended to work now, therefore, each paper is framed to have a shelf life of 6-12 months.

Outcomes:

Workshops and the resulting products:

- Helped to clarify issues;
- Set out the operating model required to deliver Self-Directed Support and personal budgets;
- Set out clear guidance and on legal and financial issues;
- Offered suggestions and solutions to key problems.

The four documents are on the South West Personalisation webpage under Resources (link on left hand side of the page)

http://www.puttingpeoplefirst.org.uk/Regions/SouthWest/Resources/

Further information:

Mapping Health & Social Care Pathways

Torbay Care Trust

Our approach:

Working closely with MedeAnalytics we have developed a bespoke IT system capable of tracking cross-organisation activity and costs at client level. With it, we can understand the overlap of care being delivered by secondary care, social care and our community based teams. By using NHS numbers as the unique patient identifier, data extracts from multiple sources are transformed into a reporting and analytics tool that arm the Trust with actionable business intelligence to drive efficiencies across the health and social care (H & SC) system. The information can be reported at patient level or aggregated in various ways, e.g. by chronic condition, age range, GP practice, gender, type of care or staff profession involved, etc.

Torbay has a higher than average elderly population many of whom require significant on-going support and involvement in their daily lives. Whilst each organisation providing a person's care can appreciate their own resources used, the total quantum of costs incurred by both health and social care remained an enigma. The Mede system rectifies this and by analysing information in such a detailed way means we can begin to look at how costs can be moved around the H & SC system in order to release financial savings, whilst improving the responsiveness and quality of patient care.

Outcomes:

- Optimising the effectiveness of preventative services by targeting service redesign work in areas traditionally requiring both large H & SC inputs e.g. falls and stroke clients;
- Helping identify appropriate client cohorts for various pilots such as telecare, intermediate care and re-ablement, and evidencing their success;
- Tracking the complexity of needs associated with end of life patients;
- Appreciating the role nursing homes have in maintaining the flow of patients in and out of acute and community hospitals;
- Generating baseline data for use within our Personal Health Budget pilot;
- Ability to relatively easily evidence benefit realisation of specific initiatives over time;
- Tracking the resources used by people with multiple long term conditions;
- Fully appreciating how demands for social care services escalate with age and consequently modelling the financial impact of an increasing elderly population during the next 10 -15 years.

Further information:

Trudy Corsellis, Head of Business Planning & Performance
trudy.corsellis@nhs.net
01803 210500

Support for Cultural Change

Department of Health South West Region

Our approach:

This was a regional project, connected to Strategic Workforce Planning. It aimed to equip workforce, transformation leads and senior managers with a variety of tools and approaches to support cultural change. It built on learning from one of the Peer Learning Groups on the Revitalising Leadership Programme which focussed on overcoming the challenges of cultural change.

The work identified barriers to change, how to develop a clear a vision of where the organisation needs to get to. It also explored a variety of tools for analysing strengths and weakness in an organisation, planning for change and techniques for working with staff to introduce and embed change.

Outcomes:

- The work was showcased at an event in 2010 and the materials and products shared with key managers across the region;
- A variety of tools, developed by Local Government Improvement and Development (LGID) to support cultural change, have been used to good effect by some local authorities;
- A report containing the tools and approaches by the Dept of Health workforce lead Virginia McCririck is on the South West Putting People First webpage.

http://www.puttingpeoplefirst.org.uk/Regions/SouthWest/

Further information:

Implementing Locality Working

Dorset County Council

Our approach:

This project will align colleagues in social care fieldwork teams with Health colleagues working in local communities, with a focus on GP surgeries from March 2011.

This is part of the Connecting Health and Social Care programme in Dorset. The latter was approved by the Joint Commissioning Board as a programme to characterise and quantify current demand for Adult Health and Social Care in two Dorset localities (Weymouth & Portland and Christchurch) and then to pilot innovative, re-designed connected service delivery.

The pilots achieved their goal to demonstrate that Social Care and Health services working together at the frontline would not only improve services and reduce waste but promote further opportunities for streamlining operational processes, removing communication barriers and constraints between organisations and maximising the use of estates.

In June 2010 the Joint Commissioning Board supported moving towards an integrated locality model within a multi-disciplinary context.

Outcomes:

- People needing support will be put in touch with the staff who are best able to help them in a more timely way thus increasing opportunities for early intervention;
- There is the potential for more imaginative working as colleagues share knowledge and skills;
- There are more opportunities for social care and health colleagues to work from the same buildings and/or communicate more effectively;
- Efficiencies will be gained from the shared use of resources and integrated posts in the long term.

Further information:

Jacky Walters, Service Manager, Service Development
j.i.walters@dorsetcc.gov.uk
01305 224697

Putting people at the centre – changing the experience for people using health and adult care services

Swindon

Our approach

Swindon has joint posts for health and adult social care and is seeking to join up all processes and assessments across the two areas. Swindon is also a NHS pathfinder site for establishing a social enterprise for health and social care services. The aim of the project is for the customer to experience a seamless journey with interventions as person centred as possible. As a first crucial step, staff worked together to agree an operating model which linked the aspirations of the Putting People First and Transforming Community Services agendas. Workshops aimed to demonstrate how different professionals may use different language but health and social care staff have shared values which run through everything we are trying to transform and join together. One key task was to agree a different and direct terminology which the public could readily understand.

Outcomes

- A simple diagram of the integrated health and social care customer journey was agreed;
- Areas of joint working and areas where unique expertise was required were identified on the journey;
- Darzi headings (health) were translated into more accessible terms for the patient/ service user;
- The diagram was used in early sessions with staff when we were trying to get an understanding of how we would form a joint organisation;
- The diagram has informed the discussion about how we could improve the customer journey and outcomes for the individual;
- As the understanding grows, more detailed work on the stages of the journey has been undertaken e.g. a joint overview assessment which incorporates the RAS assessment has been agreed.

Further information

Angela King, Assistant Director Strategic Development and Personalisation
AKing@swindon.gov.uk

Terms and Abbreviations

Personalisation – the process by which state provided/funded services can be adapted to suit the individual. In social care this means everyone having choice and control over the shape of their support they receive.

Self directed support – a change to the way the social care system operates to give you choice and control and power over the support you receive.

Personal budget – an upfront sum of social care funding based on a resource allocation assessment.

Direct payment – a cash payment made directly to you so you can acquire your own support (one of a range of options for people getting a PB).

Transformation – the total changes outlined in the Putting People First concordat including development of early intervention and prevention, choice and control, universal services and community and social capital. This also embraces the system, infrastructural and cultural changes required.

Co-production - emphasises that the people who use services have assets which can help to improve those services, rather than simply needs which must be met. These assets are not usually financial, but rather are the skills, expertise

LAs – Local Authorities
ADASS – Association of Directors of Adult Social Services
RIEP – Regional Improvement and Efficiency Partnership
PPF – Putting People First
SCRG – Social Care Reform Grant
PBs – Personal budgets
DPs – Direct payments
SDS – Self directed support
RAS – Resource allocation system
SP – Supporting people
PCP- Person centred planning
ULO – User led organisation
PCT - Primary care Trust
DOH – Dept of Health

Useful websites

Putting People First – national site with link to SW region webpage
http://www.puttingpeoplefirst.org.uk/

SW Development Centre – regional mental health resources
http://www.swdc.org.uk/SWDC/en/mental-health/mental-health/personalisation--mental-health/

Equality South West – user led organisations
http://www.equalitysouthwest.org.uk/about-us/promoting-equality-for/our-projects/ulo-capacity-building-project.html

Assoc. of Directors of Adult Social Services ADASS – Social care transformation
http://www.adass.org.uk/

Skills for Care – see also SW page
http://www.skillsforcare.org.uk/home/home.aspx

SW Forum – regional voice of the voluntary and community sector
http://www.southwestforum.org.uk/

Local Government Improvement and Development -
Community Development – Adult Social Care
http://www.idea.gov.uk/idk/core/page.do?pageId=11215972

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