Bath & North East Somerset Council

Review of Social Care Transformation Strategy 2009-2011

March 2011

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CONTENTS

1 EXECUTIVE SUMMARY

This document looks at the ways in which Bath & North East Somerset (B&NES) Council has implemented the process of Personalisation, which gives adults in receipt of social care services much more choice and control over the services they receive.

It looks at the context in which Personalisation was introduced, and examines the original draft document produced by the Council in 2009 which described the way that Personalisation would be implemented in B&NES.

The report then reviews the ways in which B&NES has reacted to some of the challenges brought about by Personalisation.

It then looks at the way that Personalisation has been implemented, under each of the 4 elements of Personalisation, i.e. Social Capital, Choice and Control, Prevention and Early Intervention and Universal Access to Services, as well as Local Commissioning.

The report will conclude with a look at the next steps in the implementation of Personalisation in B&NES, and some concluding observations.

It is followed by 3 appendices: the first details B&NES Supported Living and Communities' spend in 2010-11 and 2011-12; the second lists local authorities' adult social care duties and statutory responsibilities; and the third is a checklist for developing Personalisation in the future.

Finally, there is a bibliography citing all the sources consulted in the course of writing this report.

2 INTRODUCTION

The purpose of this document is to provide an update on the progress that B&NES Council has made in the implementation of the Putting People First (PPF) agenda (see 2.1) and to identify those areas where progress is still to be made. The basis of this review is the draft document *Commissioning Strategy 2009-2011: Social Care Transformation*, which was produced by B&NES Council's Adult Social Care and Housing department in February 2009. This laid out the basis for adult social care transformation, the challenges, implications and priorities for the Council's commissioning in this area.

In addition, the Council's implementation of PPF will be reviewed in the light of latest policy statements from the government (e.g. *A Vision for Adult Social Care: Capable Communities and Active Citizens*[1]) and documents from other organisations (e.g. *Think Local, Act Personal: Next Steps for Transforming Adult Social Care*).

This report is structured around the milestones produced by the Association of Directors of Adult Social Services (ADASS) for each of the areas of Personalisation[2]. The milestones are stated at the start of each section.

2.1 The context - *Putting People First*

The *Putting People First* protocol was issued by the government in December 2007, following on from the *Our health, our care, our say* white paper of 2006. The purpose was to reform adult social care services, giving recipients of those services, and those caring for them, greater choice and control over the services they receive, thereby enabling them to retain or increase personal independence, dignity and choice. It is summarised in the phrase 'no decisions about me without me.'[3]

2.2 Current national and local policy

2.2.1 In July 2010 the government published its NHS white paper, *Equity and Excellence: Liberating the NHS*, and followed this up in November of that year with a vision document which emphasised the need for whole-system reform that should aim both to ensure good outcomes for people who need social care and to make best use of resources. It highlights the importance of:

- helping people to stay independent for as long as possible;
- developing crisis or rapid response services;
- providing care and support to meet people's goals;

[1] Details of documents referred to in this report can be found in the Bibliography following Appendix 1
[2] The milestones were published on the Putting People First web site – see Bibliography
[3] See http://www.nrcpicker.com/Newsletter/2010-08/Pages/No%20Decisions%20about%20Me%20without%20Me.aspx This phrase is repeated in the government's press release announcing *Equity and Excellence: Liberating the NHS*: http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_117360

- reducing spending on long-term residential care for reinvestment in other services;
- maximising spend on front-line services;
- ensuring high quality assessment and care management services;
- developing a strategic approach to quality and outcomes.

The vision document also calls for faster progress in offering people choice and control over their services and confirms that Personal Budgets (preferably in the form of Direct Payments) should be provided for everyone eligible for ongoing social care by April 2013.

There are three elements of the July 2010 white paper that impact on the Council's commissioning:

- the Council will become responsible for the public health services currently within the PCT (Primary Care Trust). It will also be required to establish a new Partnership Board to take over the statutory function of the Health O&S Committee and to work with partners to shape the local NHS and influence strategic planning.
- PCTs will cease to exist from April 2013. Commissioning is currently integrated across health, social care and housing. The Council will need to decide how best to engage with the new GP Commissioning Consortium, which replaces PCTs, and to determine whether or not to retain the current integrated commissioning arrangements.
- PCTs are required to divest themselves of directly provided community health services by 2011 or to have made substantial progress towards this in the case of a transfer to a new organisation.

The current delivery of service is fully integrated across health and social care. If the Council wish to maintain this integration, it will need to work together with the PCT on a revised structure to meet the requirements of the Coalition Government.

It should also be noted that that there is an agreement in place between the Council and the PCT that covers existing partnership arrangements. Under that agreement it would normally be appropriate for any material change in the arrangements (or any notice of termination) to be given by 12 months notice on 1 April of the relevant year. However, the Council and the PCT are making every effort to progress revised arrangements in accordance with government requirements and without invoking the terms of the agreement. It is important, however, to recognise that there is a formal agreement currently in place to protect all parties.

3 REVIEW OF CHALLENGES IDENTIFIED IN RELATION TO PUTTING PEOPLE FIRST

3.1 Draft Commissioning Strategy 2009-2011

In February 2009 a draft commissioning strategy for adult social care was produced for the period 2009-2011 on behalf of the B&NES Health &

Wellbeing Partnership to take into account the changes brought about by the Personalisation agenda.
The strategic vision was premised on the four elements of Personalisation, i.e.

- universal access to services, with no 'entry requirements';
- social capital (aka people) being a valued and promoted resource;
- preventative services and early intervention;
- choice and control for service users in the services they receive to promote their wellbeing.

This strategy document outlined the challenges that Personalisation presented, and ways in which they could be met in B&NES. The remainder of this document describes the ways in which these challenges have been faced, and the actions which have been taken to ensure that the elements of Personalisation have been incorporated into the strategies and working practices in adult social care.

3.2 Cultural change

In 2004 the strategic direction for BANES PCT was established, which was to develop more integrated services that were able to support health rather than responding to illness, and that offered more options to support people at home. The development of integrated health and social care community services was directed further by two key strategies in 2005 and 2006.

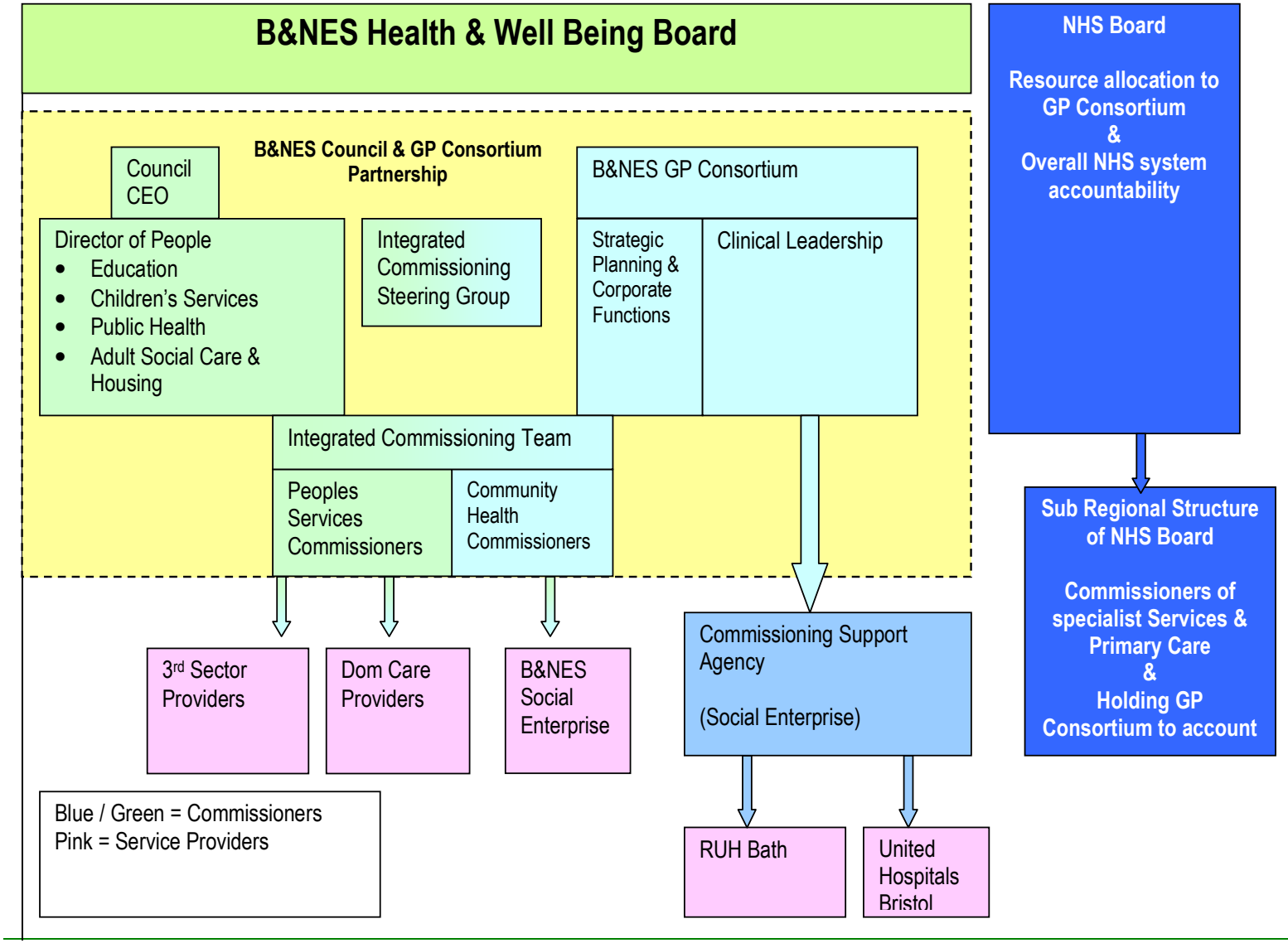
This model of care for community services in B&NES is based on a joint approach to provide and commission both health and social care adult services. The partnership between the council and the PCT which resulted from this is known as the Health and Wellbeing Partnership. This joins up Health, Social Care and Housing into a single body. Working together helps the Partnership to achieve:

- more effective planning and decision-making
- the seamless delivery of care services to local people
- improved efficiency and value for money.

The Partnership comprises two 'arms': Commissioning and Provider. The Provider arm may bid for services which the Commissioners have decided to buy.

The work of the partnership is overseen by the Partnership Board for Health and Wellbeing where representatives of the PCT and the Council come together. Committees and teams within the organisation run the commissioning and providing functions under a single senior management team. The team is led by the Chief Executive who also has the role of Director of Adult Social Services.

The new organisational structure of the partnership is shown below:


B&NES Health & Well Being Board
B&NES Council & GP Consortium Partnership
Council CEO
Director of People
Education
Children's Services
Public Health
Adult Social Care & Housing
Integrated Commissioning Steering Group
B&NES GP Consortium
Strategic Planning & Corporate Functions
Clinical Leadership
Integrated Commissioning Team
Peoples Services Commissioners
Community Health Commissioners
3rd Sector Providers
Dom Care Providers
B&NES Social Enterprise
Commissioning Support Agency
(Social Enterprise)
RUH Bath
United Hospitals Bristol
Blue / Green = Commissioners
Pink = Service Providers
NHS Board
Resource allocation to GP Consortium
&
Overall NHS system accountability
Sub Regional Structure of NHS Board
Commissioners of specialist Services & Primary Care
&
Holding GP Consortium to account

There has been, and continues to be, the challenge of ensuring that the Council and PCT teams work efficiently and effectively together. Moving the Council's Adult Social Care department to the PCT's premises at St Martin's hospital in October 2010 was intended to make communication and joint working easier. This has broadly succeeded, though, with the PCT now due to be disbanded by April 2013, and the concurrent formation of a social enterprise from the provider arm, there will need to be continuing flexibility from the Council to manage the changing situation and ensure continuation of a high level of provision to service users.

3.3 Workforce development

Workforce development concentrates on the skills, knowledge and behaviours that are needed by the workforce to deliver services both now and in the future and how these will be resourced. Learning and development opportunities are detailed in workforce development plans which meet identified needs for new or different skills, trainee opportunities, talent management schemes, professional development, career pathways, etc.

The CQC report on Bath & North East Somerset Adult Social Care states: 'For the last two years the partnership has had an area for improvement relating to the fact that the partnership's workforce was not representative of the local community. Much work has been undertaken and, as stated elsewhere in this report, the position has improved although there remains a number of staff taking the positive step not to record their ethnic origin. Bath and North East Somerset is a largely white middle class area with an increasing Polish community and the workforce is becoming more representative of this.'

The B&NES *Service Action Plan 2011-2012* states that the following strategy will be followed to achieve the aspirations in the current (2011) financial environment:

- We will develop a workforce which is, at all levels, more highly skilled, more knowledgeable and more self-confident in its practice. Specifically, we will need to develop clinical skills which have historically been aligned with hospital based care.
- To develop staff with strong clinical and leadership skills.
- We will offer opportunities for staff currently working in the acute sectors to be redeployed to community practice as the acute workforce reduces in line with the QIPP vision.
- We will develop a workforce which goes beyond providing care and treatment but also sees its role as educating, enabling and empowering individuals and families to take charge of their own health and well-being – they will address health opportunities as well as health needs.
- We will develop a workforce in which practitioners feel confident in working with service users and carers with complex needs which cross over traditional boundaries between mental health and physical health and between health needs and social needs.
- To ensure staff have the relevant skills and expertise to safeguard children and vulnerable adults.

- We will develop a workforce which has a strong customer service ethic – each of our patients, carers or other service users must feel like a valued customer.
- We will find ways of working smarter not harder so that we are able to demonstrate improvements in productivity and value for money.
- We will encourage, support and enable staff to work flexibly across existing and new service areas.
- We will work with our commissioners to develop ways of commissioning services based on the outcomes we deliver and the quality standards we meet as well as on the quantity of inputs we provide.
- We will become a sophisticated and professional business capable of competing successfully against global healthcare organisations.
- We will develop a stable but dynamic workforce to which we attract the brightest and best and in which we retain people who expect to pursue long and varied careers in health and social care.

The fundamental changes being brought about by the demise of the PCT adds an extra dimension to these plans and maintaining or improving service quality will be a particular challenge during this unsettled period.

3.4 Market stimulation

In recognition of the changing landscape for both providers and commissioners, a programme of market development has been undertaken by the Adult Social Care Commissioners. This has taken place through a range of events directed at current and potential providers.

The CQC assessment of this work in its November 2010 report was:

'…the partnership has worked hard to embed the Personalisation culture ensuring there is real personal choice and has targeted providers in the area and facilitated workshops.'

3.4.1 Workshops

The main shift has been from service users accepting the services allocated to them, both by service providers and the local authority, to having a much greater degree of choice and control over the services they receive. Also, rather than working to a set of outputs, providers are now required to concentrate on achieving measurable outcomes for their services: an outcome is defined as 'the [positive] impact/result of services on a person or population'[4].

To communicate this to service providers, three workshops were delivered from October 2009 to January 2010, to which all 180 voluntary and community organisations in B&NES were invited.

[4] http://www.dartington.org/research-in-practice-for-adults

The first workshop introduced the concept of Personalisation, including the 4 elements of universal access to services, prevention and early intervention, social capital and choice and control. It also covered brokerage, Individual Budgets (as Personal Budgets were then called), Direct Payments, Social Prescribing and safeguarding.

The second workshop looked at how third sector organisations could market their services more effectively, and concentrated on outcomes and the self-accreditation scheme.

The third workshop was held in January 2010, and looked in more detail at outcomes and the self-accreditation scheme (see 3.4.2).

Other workshops and events, with a similar purpose, were held in 2009 and 2010 for different audiences:

- An overview of Personalisation was presented to a meeting of the B&NES LINk (Local Involvement Network) LINk members have been invited to all the workshops which we have held.
- A presentation about Personalisation was made at Care Learning's PPF Provider workshop.
- A presentation about PPF was given at a workshop for members of third sector organisations hosted by The Care Forum.
- A presentation on B&NES' progress on implementing PPF was given at The Care Forum's workshop on collaboration between third sector organisations.
- A workshop concerning Support Planning, in the context of PPF, was held, in conjunction with Bath People First.
- A workshop for providers of Supporting People & Communities services was held to set out commissioning plans for 2011 onwards. The context of the discussion included the new coalition government, the challenging economic climate and how this was likely to play out in the Third Sector. As well as the challenges and opportunities these elements presented, the workshop also dealt with market development, self-accreditation, self-directed support and Personal Budgets.
- An introduction to Personalisation for senior managers of the B&NES PCT. This was followed by questions and a discussion of the implications of the Transformation agenda.
- Four joint workshops were held with Policy and Partnerships in order to promote consistent messages regarding outcomes. These workshops were:
    - Working in Partnership This aimed to encourage providers to consider working in collaboration with other organisations in future bids, as a way of being more effective and meeting budgetary requirements.
    - Lottery Funding This was a presentation by The Big Lottery Fund about the best way for organisations to make a strong application for Lottery funding.
    - Forming a Social Enterprise . Delivered by Elaine Flint from Social Enterprise Works, a detailed description was given of the methods,

advantages and disadvantages of forming a social enterprise, together with an overview of some of the alternatives.
- Managing in Tough Times Again delivered by Social Enterprise Works, this dealt with ways of assessing risks and how a third sector organisation can manage and adjust to change.

Changes in the attitudes and expectations of service providers were noted over this period. At the first workshop, held in October 2009, some of the service providers' delegates were under the impression (wrongly) that all their funding would stop on 31st March 2010, and that their income would be entirely dependent on the spending decisions of those service users with Personal Budgets. This impression was swiftly dispelled on the day.

However, by the time of the workshop in January 2010, it was evident that providers had started to realise that they needed to make changes in the way they offered services. Subsequently some requested that a workshop on collaborative working be held. One such workshop was arranged by The Care Forum, and B&NES held one for Supporting People providers in June 2010, with a further one held in September of that year in collaboration with Policy & Partnerships, who had wanted to organise a similar event for their commissioned service providers.

The workshops and events described above gave service providers the opportunity to prepare for the financial and performance management environment in which commissioned services currently operate.

3.4.2 Self-accreditation

The self-accreditation scheme was developed in order to give those in receipt of a Personal Budget, and self-funders, as wide and informed a choice of service provider as possible. It is a 'light-touch' process based on the providers' own assessment and does not aim to provide a directory of approved services. The scheme encourages providers of adult social care who are not commissioned or contracted by B&NES to provide detailed information about their organisation and working practices which, if verified by a B&NES officer, entitled the name of the organisation to be added to a list of such organisations on the council's public web site.

The idea of a Care with Confidence scheme was broached by the Council's Trading Standards department. This would be similar to the existing national Buy with Confidence scheme,[5] but would apply to organisations offering adult social care services. Naturally there would have to be a great number of safeguards and checks in place before such a scheme could become operational. This scheme has been piloted by Oxfordshire council. At the time of writing (February 2011), B&NES' Trading Standards department is aiming to meet with their counterparts in Oxfordshire to discuss the viability of launching a similar scheme in B&NES.

[5] www.buywithconfidence.gov.uk

3.5 Shift from care management to Personalisation

National Indicator 130 is defined as : 'The number of adults, older people and carers receiving self-directed support in the year to 31st March as a percentage of clients receiving community based services and carers receiving carers' specific services aged 18 or over.' Local authorities are required to achieve a target of 30% by April 2011.

Local performance against this NI is encouraging. In 2009/10, 17.8% of clients receiving community based services in B&NES were in receipt of Personal Budgets, compared with a national average of 13.8% (see 3.8 below).

Comment: Can we get the latest figure on this?

Comment: There wasn't a set percentage before the 30% by April 2011 – it was just whether it was over or under the national average.

Deleted: the period 1st April 2009 – 31st March 2010

3.6 Commissioning arrangements

A decision was taken in 2010 to merge the Supporting People and the Community Funding (the B&NES terms for voluntary and third sector organisations) commissioning functions: this was later reinforced by the appointment of an Associate Director, Non-Acute and Social Care, to oversee all adult social care commissioning functions. The purpose of this was to streamline and rationalise the commissioning process within one team, as a result of which it now contains the following functions:

- Housing related support
- Residential and nursing care
- Domiciliary care,
- Extra Care
- Carers
- Supported Living
- Community health and social care
- Unplanned care and social care transformation
- Strategic planning.

The team is currently looking at a range of fundamental issues including governance, shared policies and procedures and alignment of payment processes, contracts and other key documents.

3.6.1 Domiciliary Care

To meet the anticipated changes brought about by the Transformation agenda, the Domiciliary Care Partnership was set up in 2008 to develop closer working links with fewer providers. Following a commissioning process, five providers now work across the area to provide Domiciliary Care. This new approach aims to develop a range of services to meet both traditional domiciliary care requests and new services that were expected to be demanded as an increasing number of people took up Personal Budgets. It also guarantees a level of stability in demand for providers, enabling them to recruit and train staff to deliver high quality services.

The commission takes an innovative approach to the management of Personal Budgets in that it allows service users to carry forward hours of care. This means that they could have the service at times which suited them, rather than the provider, as long as the overall Care Plan was met. This is new in a domiciliary care contract – previously, time slots were rigidly prescribed by the commissioner and the same pattern was adhered to each week.

80-85% of commissioned work is currently with these providers but a list of accredited providers with a framework contract has been retained for spot purchase. This widens the choice available to Personal Budget users, while control over quality is maintained through B&NES' monitoring mechanisms. As expected, some of these have received very little commissioned work from B&NES, but those who have adapted to new demands and developed innovative ways of working have retained a base of private and Direct Payment service users which ensures there is a vibrant and competitive marketplace in B&NES.

3.7 Single Panel Process

The Integrated Single Panel was set up in 2010 to provide guidance and support during the funding process and to monitor and control budgets. The Panel assesses new applications for funding and makes decisions on reviews of packages for funding as appropriate. It includes representatives from health and finance and a locality manager and is jointly chaired by the Associate Director Non-Acute and Social Care, and the Associate Director, Safeguarding and Personalisation. All service users from each client group are represented.

The Panel offers advice, recommendations and where necessary alternative options to be considered, in addition to identifying and disseminating good practice.

3.8 Measuring success and measuring impact

The ultimate measures of success of the transformation agenda, as set out in *Putting People First*, are that everyone will be able to:

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

'… the partnership has worked hard to embed the Personalisation culture ensuring there is real personal choice and has targeted providers in the area and facilitated workshops…

'One of the themes that the partnership focused on from the Putting People First agenda was prevention and early intervention work which led to market testing for an independent living service for older people. The partnership has procured a self assessment tool which will act as a first enquiry point for people needing help with independent living and for those that need onward referral to the health and social care access team.' (CQC report, November 2010).

3.8.1 National Indicators

The Local Area Agreement (LAA) specifies a number of national and local performance indicators (NIs) which demonstrate the degree of the Council's success in achieving some of its stated outcomes[6]. The most recent set of Indicators and performance against these are for Q3 2010 and are as follows:

National Indicator	B&NES Performance	National Average
NI125 – Achieving independence for older people through rehabilitation/intermediate care. The proportion of older people discharged from hospital to their own home or to a residential or nursing care home or extra care housing bed for rehabilitation, with a clear intention that they will move on/back to their own home…who are at home…three months after the date of their discharge from hospital.	93.0%	81.7%
NI130 – Social care clients receiving self directed support (Direct Payments and individual budgets[7]) Number of adults, older people and carers receiving social care through a Direct Payment (and/or an Individual Budget)in the year to 31st March	30.0%	13.9%
NI132 – Timeliness of social care assessment. Acceptable waiting times for assessments: For new clients (aged 18+), the percentage from where the time from first contact to completion of assessment is less than or equal to four weeks.	73.5%	82.5%
NI133 – Timeliness of social care packages. Acceptable waiting times for delivery of care packages following assessment: For new clients (For 2008/09: Adults aged 65+, from 2009/10 Adults all ages 18+) the percentage for whom the time from completion of assessment to provision of all services in the care package is less than or equal to 4 weeks.	88.5%	92.5%
NI135 – Carers receiving needs assessment or a	22.6%	26.3%

[6] 'We are… dismantling the National Indicator set' – Secretary of State for Communities and Local Government in a letter to all English local authorities, 20-10-2010. See also *Transparency in outcomes*: *a framework for adult social care*, chapter 3.
[7] Now known as Personal Budgets

review and specific carer's service, advice or information) The number of carers whose needs were assessed or reviewed by the council in a year who received a specific carer's service, or advice and information in the same year, as a percentage of people receiving a community based service in the year.		
NI136 – People supported to live independently through social services The number of adults per 100,000 population that are assisted directly through social services assessed/care planned, funded support to live independently, plus those supported through organisations that receive social services grant funded services.	1890.0	3301.4
NI145 – Adults with learning disabilities in settled accommodation The percentage of adults with learning difficulties known to the Council in settled accommodation at the time of their last review.	37.0%	56.1%
NI146 – Adults with learning difficulties in employment The percentage of adults with learning difficulties known to the Council in paid employment at the time of their last review.	7.0%	6.6%
NI149 – Adults in contact with secondary mental health services in settled accommodation The percentage of adults receiving secondary mental health services in settled accommodation at the time of their most recent review.	77.3%	61.3%
NI150 – Adults in contact with secondary mental health services in employment The percentage of adults receiving secondary mental health services in paid employment at the time of their most recent review.	14.7%	10.5%

B&NES has therefore exceeded the national average in 5 out of the 10 measurements. The most important of these is arguably NI130, as it is the indicator which has a target attached to it. It is noteworthy that B&NES had reached this target in November 2010, 4 months ahead of the government deadline.

3.9 Service user involvement and engagement

In 2009, the public's views were sought as part of a drive to ensure health and social care services across Bath and North East Somerset were improved in line with the policy framework, local priorities and the views of local people. NHS B&NES consulted on the development of the 5 year strategic plan which detailed the priorities for health and care investment and delivery. Four events were staged across the area with 3 events in different neighbourhood locations open to the public, patients and interested parties; attendees were

able to learn about plans to improve health and social care services and to debate and discuss the priorities.

Over 100 people attended the public events which were welcomed and generated good debate. This approach of public engagement continued into 2010/11.

A fourth event was held specifically for providers of services, and was well attended by some 80 participants.

The strategic plan incorporating the results of the consultation was published and made available through the NHS B&NES website.

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3.9.1 Our Healthy Conversations

Ensuring the views of local people are embedded into Trust plans is a principle aim of the NHS B&NES and Bath and North East Somerset Council partnership. Since 2010, a series of meetings under the title Our Healthy Conversation have been held in Bath, Keynsham and Radstock. The purpose is to provide families, carers, voluntary groups and the general public with the opportunity to shape the future direction of health and social care services in Bath and North East Somerset.

3.9.2 Health and Wellbeing Network Workshops

An extension of the Our Healthy Conversation programme is the twice yearly workshop events held for our Health and Wellbeing Network. The Network is a virtual grouping of some 200 individuals representing patients, carers, members of the public, advocacy groups and providers who come together to debate and discuss key healthcare issues and developing ideas.

The network met in February and November 2009 and was attended by 40-50 people on each occasion. Presentations and information were provided at the beginning of the meetings. Strategic direction, long term plans, urgent care, communications, public health and living healthier lifestyles were some of the topics covered. Officers present at the meetings engaged in the workshop sessions and took away the key points and perspectives of people to build into the developing plans.

A full report of the conclusions of the events with a summary of points raised was made available to all participants and is available on application from The Care Forum.

3.9.3 Strategic Planning for Engagement and Involvement

The Non-Acute & Social Care Team is currently developing a strategic approach to the long term engagement of user, carer and hard to reach groups. A document setting out proposals will be developed and promoted during 2011/12. .

4 SOCIAL CAPITAL

Putting People First Milestone 1: Effective partnerships with people using services, carers and other local citizens

Successful delivery of Putting People First will depend on citizens, people accessing care and support and carers working in a co-productive relationship with Local Authorities and their partners at all levels in the design, planning and delivery of new personalised systems and services.

Formal and informal structures should be in place to allow citizens and the full spectrum of user and carer representatives to contribute to the local design and delivery of social care transformation. This should go well beyond traditional 'consultation'.

User-led organisations can provide expertise (such as service user experience) that is not always available within local authorities and this expertise should be harnessed to co-produce the transformation of social care.

4.1 Social prescribing

Social prescribing is a term used to describe the formal and informal referral of patients to services outside of health in voluntary and community settings.

The New Routes (NR) 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. The University of Bath is evaluating the outcomes of this by measuring individual distance travelled in respect of a personal sense of wellbeing; looking at the impact of services on individuals; and exploring the effect on and relationships with Voluntary, Community and Social Enterprise Sector (VCSES) organisations.

New Routes was established 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 the VCSES and primary care teams.

Early anecdotal evidence suggests that, prior to contact with NR, individuals did not feel informed or empowered to make use of local services and opportunities. Most feel they have benefited from a first assessment with one of the NR 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 NR Coordinators has been invaluable.

It is also clear that lack of confidence to start new social or vocational endeavours is endemic. Gaps in service provision can make motivating oneself even more of a challenge. Significantly, as referrals of clients with complex or more acute needs has been the norm, the large majority of support has been offered from the NR Coordinators over a longer time frame than was initially envisaged.

4.2 Give Us A Break

In 2009 B&NES Council was awarded £600,000 to act as one of 12 demonstrator sites for a new scheme called Give Us A Break (GUAB). The project runs from November 2009 to the end of June 2011. The scheme has developed new ways of giving short breaks to carers, defined as adults, or young people in transition from the Young Carer's service to adult services, who give regular unpaid care for someone else (e.g. a family member, friend or neighbour), even if the person being cared for does not receive support from Social Services, or pays for their care themselves.

At the outset of the project the Department of Health said that they would evaluate the scheme and, if it was deemed to have been successful, to roll it out across the country. However, at the time of writing, it is anticipated that the scheme will cease in June 2011 unless additional funds are allocated by central government.

A survey showed that 72% of members rated the organised activities as very good, with 28% rating them as good: none rated them as adequate or poor.

The scheme was run in partnership with a wide range of agencies in B&NES, including:

- Off the Record
- Soundwell Music Therapy
- Communities Arts Therapies
- Creativity Works (formerly known as nesa (North East Somerset Arts))
- Norton Radstock College
- City of Bath College
- Crossroads Care
- Active Leisure
- Heritage Service
- Genesis Woodworks
- Community Learning Service
- SWAN Volunteer Transport
- B&NES Carers Centre
- The Alzheimer's Society
- B&NES Library service

At the end of March 2011 membership was 423 and so had exceeded its target of 400 members[8]. 70% of members had no previous contact with statutory or carer services.

One of the main benefits of the project is shown in the way that carers assessed their own health and wellbeing before and after attending a GUAB activity:

Carers' overall health and well-being	Before activity	After activity
Very good	10.4%	16.8%
Good	36.0 %	70.4%
Adequate	43.2%	11.2%
Poor	10.4%	1.6%

Carers have also benefited from meeting with other carers to share experiences and offer support to each other. In addition, as a direct consequence of their involvement with the scheme, some carers have come up with their own solutions and have established social support structures to enable them to take break opportunities.

4.3 Centre for Independent Living (CIL)

'The partnership has made progress against the majority of the Putting People First milestones however they are unlikely to meet the target of having a user led organisation [ULO] in place by the end of 2010[9]. They do have concerns that further progress against the milestones could be affected by capacity and financial issues.' (CQC report, November 2010).

A Centre for Independent Living is defined as: '… a local organisation, run and controlled by disabled people. The focus… is on disabled people, carers and other people who use support and their organisations, in England.

'[They] have an aim to promote independent living and demonstrate this commitment through their activities… the expectation is that organisations might provide:

- information and advice
- advocacy and peer support
- support in using Direct Payments and/or individual budgets
- support to recruit and employ personal assistants
- assistance with self-assessment
- disability equality training; and
- support the implementation of the Disability Equality Duty by public sector organisations in the locality (including consumer audits).'

[8] According to the 2001 census there were 16,255 carers in B&NES, of whom 2,055 had high level caring needs.

[9] Reading their remarks in context, it is clear the CQC report should have referred to a CIL. See below for the distinction between a ULO and a CIL.

(DoH, 2009)

As was clear to the CQC at the time of their inspection, B&NES did not achieve their target of having a CIL in place by the end of 2010. In the light of the current financial restraints, the Partnership has revised its strategy for the formation of a CIL. The intention is to work towards the formation of a CIL by remodelling existing contracts, and by using some of the principles of the government's Big Society, i.e. empowering individuals and communities; encouraging social responsibility; and creating an enabling and accountable state.

In fact, there have been developments in broadening an existing ULO, Bath People First, into a CIL, as they are becoming involved in equalities (through Equality BANES[10]), safeguarding and Personal Budgets. Additionally, Bath People First want to broaden their scope so that they can provide advice and information about the recruitment of Personal Assistants, support planning and self-assessment. To do this they will need to include a wider circle of disabled people, so that they can become more empowered themselves, and in turn empower other disabled people. One practical way of doing this will be to offer (free) support plan writing, as it is felt that some disabled people may not have the confidence or the knowledge to write their own support plans, or may be persuaded by professionals, family or carers to take an easier or more traditional route which would not be as effective in meeting their needs as something more innovative. They may be more willing to discuss their needs and ideas with those of their peers who are more familiar with the possibilities that are available.

5 CHOICE AND CONTROL

Milestone 2: Self-directed support and Personal Budgets

Systems are in place to allow citizens who require social care support to easily find and choose quality support, and control when are where services are provided, and by whom.

For those citizens eligible for council funding, the amount available to those individuals should be known prior to starting person centred support planning.

People should have the ability to spend part or all of their money in a way that they choose; including being able to mix directly purchased and council provided services.

Extra help should be available to any citizen that needs help with information and advice or to negotiate their support.

[10] www.equalitybanes.org.uk

5.1 Self-directed support

B&NES Council has invested in two pieces of software which are available to anyone with access to the internet, whether or not they are in receipt of a Personal Budget. They are both intended to provide a wide range of information to will enable people to make decisions about their own health and wellbeing needs without going through any of the statutory services.

5.1.1 Well Aware

Well Aware (www.wellaware.org.uk) is a free-to-use internet database, hosted by The Care Forum in Bristol and jointly funded by B&NES, Bristol and South Gloucestershire councils and the corresponding PCTs. A member of B&NES' Adult Social Care Commissioning team was closely involved in the design and development stages. Well Aware is signposted from 8 different pages within B&NES' public web site.

The site contains a wide range of wellbeing resources available from public, private and third sector organisations which are offered in B&NES, Bristol and South Gloucestershire.

Other key features of the site include:

- A Learning Difficulty specific section in Easy English
- A Mental Health specific section on employment

The Well Aware site went live in May 2010. At the end of February 2011 there had been 44,681 visits from 33,342 unique users, and the 50,000th visit occurred on 16th March 2011.

As at the end of February 2011, the most popular search terms, in descending order of frequency, were:

- Counselling
- Bereavement
- Women
- Support groups
- Gardening
- Mental health
- Transport
- Befriending services
- Mental health support
- Befriending

- Counselling
- Bereavement
- Mental health + Mental health services
- Befriending services + Befriending
- Women
- Support groups
- Gardening
- Transport

5.1.2 AskSARA

AskSARA[11] (www.asksara.org.uk), produced by the Disabled Living Foundation, is also a free-to-use web site, 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 improvements which can help them in their daily lives. AskSARA covers health, home and daily living, and works on a self-assessment basis: after answering a series of questions on a particular topic (e.g. medication management, bathroom, help in emergencies), a report is produced. Practical advice is given and information on related products which may be of use. The information is impartial, and regularly updated. All information is tailored according to the area the person using the site lives in.

B&NES Council has purchased a customised version of AskSARA, which gives information specifically about services and suppliers in B&NES.

AskSARA is also signposted from B&NES Council's public web site.

5.2 Personal Budgets

5.2.1 Background, National Context and Examples of Implementation

Personal Budgets (previously known as Individual Budgets) deliver the Personalisation of care services by allocating a budget that people can control themselves. They can then decide how to spend this to meet their assessed eligible care needs and agreed outcomes, in line with a personalised support plan. The allocated budget may be taken as cash or as a service managed on their behalf where they have choice and control over how the funding for their care is spent, and can be used to design and purchase support from the public, private and third sectors, increasing people's autonomy over their care and support.

A Personal Budget (PB) can be used in one of 3 ways:

- As a Direct Payment. This is a cash payment given to service users in lieu of the community care services they have been assessed as needing and can be spent by the service user in a way which they believe will best meet their care needs. However, this is subject to the service user's support plan, showing how the PB is to be spent, being signed off by an authorised officer of the local authority. There are checks in place to ensure that the money is spent on what was agreed in the service plan, and regular reviews with social services to see whether the PB is being spent effectively, and whether there are any changes in the service user's care needs.
- To obtain care commissioned by the local authority; in other words, the service user asks the local authority to produce a care package for them;
- A mixture of the above.

[11] SARA stands for Self Assessment, Rapid Access

Contrary to the understanding of some service users[12], and an article on the Community Care web site[13], the monetary value of service users' PBs are not dictated by the services(s) they have chosen: rather, it is the reverse. However, a service user receiving a Direct Payment may choose to add their own money to the PB if they want to commission a more expensive service.

A Personal Budget must be spent on services specified in the support plan, although there is an ongoing debate amongst professionals and service users about expanding the range of eligible activities.

In November 2009 Personal Budgets were extended to people who lack the capacity to consent, and to people with mental health problems who are subject to mental health and certain criminal justice legislation.

As part of the Putting People First agenda, every English council has been required to have transferred a minimum of 30% of social care service users to a Personal Budget by April 2011, and 100% by 2013[14]. Unlike many other areas, the 30% target was reached by B&NES by the end of November 2010, which is a cause for congratulations to the staff tasked with making this happen.

How the increasing take-up of Direct Payments and Personal Budgets impacts on 'traditional' services is a concern for commissioners. This was anticipated and was covered during the various events held regarding transformation. It is likely that the future will see much more co-operation and collaboration between service providers, and a move towards the sharing of premises and back office staff to reduce costs. Providers may well have to diversify, and react to a changing market by offering services other than those they have traditionally provided.

A study of one council's progress with Personalisation has indicated that there have been cases where social workers have imposed Direct Payments on users as opposed to council-managed Personal Budgets[15]. As this goes directly against the principle of client choice and control, it is recommended that an audit of B&NES' Direct Payments be undertaken to ensure that this is not being practised in B&NES; and if it is, that steps are taken to ensure its immediate cessation. As with Direct Payments, Personal Budget holders tend to be among client groups with disabilities or learning disabilities, though there are attempts to expand take-up among mental health service users and

[12] In June 2010 the report's author attended a meeting of parents of young adults with autism. The members of the group had been told that their children's Personal Budgets could be extended to meet their care requirements. They expressed shock and anger when they were informed this was not the case. It could not be determined with any certainty where this information had come from…

[13] See third paragraph of Community Care article on Personal Budgets, http://www.communitycare.co.uk/Articles/2010/12/09/102669/direct-payments-personal-budgets-and-individual-budgets.htm

[14] http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_121690

[15] See http://www.communitycare.co.uk/Articles/2010/08/02/115034/social-workers-imposed-direct-payments-on-users.htm

homeless clients. There is also a pilot programme in West Sussex to test the extension of the concept to people with substance misuse problems.[16].

It has been stated that the growing use of Direct Payments and Personal Budgets are also contributing to a rise in user charges across England[17]. Warwickshire County Council, for instance, says its user charges are below average and in July 2010 they launched a three-month consultation on plans to remove or reduce subsidies for services including home, day and respite care, Direct Payments and transport. The authority said it could no longer afford to subsidise services at current levels, particularly given government plans to cut council budgets and freeze council tax levels in 2011. It added that it needed new charging policies, as it introduced Personal Budgets for all adult social care clients, with a full roll-out due by 2012. In addition, it would find a way of giving carers better access to Direct Payments.

A study of over 500 Personal Budget (PB) users by the charitable organisation In Control[18] in 2009 concluded that PBs have improved the lives of most users but fewer clients have true control over their care and support than official estimates indicate.
The report said that 68% of users reported their lives had improved since they started using a Personal Budget and 58% said they were spending more time with people they wanted to.

Finally, the concept of Personal Budgets is being extended into health through personal health budgets, though pilot sites have already run into resource problems (see Jones *et al*).

5.2.2 B&NES' implementation of Personal Budgets

At the end of 2005 B&NES was one of 13 local authorities selected to pilot Individual Budgets (now known as Personal Budgets) for adult social care[19]. The Department of Health (DH) provided some financial support, but authorities were expected to finance the project out of their existing social care budget. Analysis of the pilot can be found at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_089508.pdf **,** but in summary, the results from all 13 pilot sites were:

- IBs were typically used to purchase personal care, assistance with domestic chores, and social, leisure and educational activities;
- people receiving an IB were more likely to feel in control of their daily lives, compared with those receiving conventional social care support; satisfaction was highest among mental health service users and physically disabled people and lowest among older people;

[16] see http://www.communitycare.co.uk/Articles/2010/11/24/115872/substance-misusers-should-have-personal-budgets.htm
[17] See http://www.communitycare.co.uk/Articles/2010/12/09/102669/direct-payments-personal-budgets-and-individual-budgets.htm
[18] A national charity with the aim of creating a fairer society for all – see http://www.in-control.org.uk/
[19] For the full background to the project see Caroline Glendinning *et al*.

- little difference was found between the average cost of an IB and the costs of conventional social care support, although there were variations between user groups;
- IBs appear cost-effective in relation to social care outcomes, but with respect to psychological well-being, there were differences in outcomes between user groups.
- staff involved in piloting IBs encountered many challenges, including devising processes for determining levels of individual IBs and establishing legitimate boundaries for how IBs are used; there were particular concerns about safeguarding vulnerable adults;
- despite the intention that IBs should include resources from different funding streams, staff experienced numerous legal and accountability barriers to integrating funding streams; at the same time there was frustration that NHS resources were not included in IBs;
- IBs raise important issues for debate, including the appropriate principles underpinning the allocation of resources to individuals and the legitimate use of social care resources.

In addition, people receiving an IB were significantly more likely to report feeling in control of their daily lives, welcoming the support obtained and how it was delivered, compared to those receiving conventional social care services. However, there were differences between groups:

- mental health service users reported significantly higher quality of life;
- physically disabled adults reported receiving higher quality care and were more satisfied with the help they received;
- people with learning disabilities were more likely to feel they had control over their daily lives;
- older people reported lower psychological well-being with IBs, perhaps because they felt the processes of planning and managing their own support were burdens.

An internal report concerning B&NES' participation in the pilot project noted that a great deal had been achieved, including:

- the development of a single assessment/resource allocation system that can be used for any service user group e.g. learning difficulties, older people
- more than 180 people are now in receipt of an IB including many who choose to manage their own allocation
- we have developed a support planning and support brokerage service to assist service users to achieve maximum choice and control
- a cultural shift in the way we work – a move away from 'command and control' and a move towards 'choice and control'
- leading the way in terms of the social care transformation – early intervention & Personalisation agenda

The report highlighted the following issues which needed to be addressed in order for mainstreaming to continue within budget and within the original vision of choice, control and flexibility:

- the assessment and resource allocation needed to be further simplified to ensure that it is user friendly for both service users and staff;
- the assessment and resource allocation needed to be aligned with the requirements of the Single Assessment Process (SAP), a shared assessment between social care and health, as there was a move to a more integrated service;
- there needed to be a continuing communication of the message of user choice and control, continue with the cultural shift, and the continued support of creative thinking in relation to achieving desired outcomes for service users.

B&NES' policy is to give all new clients PBs, and to put all existing service users on to a PB when their case is reviewed. Eligibility for a PB is determined by FACS (Fair Access to Care Services) criteria: currently those in B&NES who are in either the Substantial or Critical category are eligible for assessment. In common with other local authorities, B&NES uses a Resource Allocation System (RAS) to produce an indicative sum for eligible service users, based on their personal circumstances and care needs. Someone who has savings, exclusive of the value of their house, of £23,250[20] will not be eligible for a PB.

A B&NES draft internal audit report on Adult Care[21] Personalised[22] Budgets was produced in February 2011. The review looked at the scheme from the financial point of view, and assessed that 'the administration and management of the system of internal controls was adequate. However, there are a number of areas detailed in the Assurance Summary which require improvement.' It may be noted that of a population of 220 records, the sample size was 10.

5.2.3 Support Planning

In March 2011 an audit of Support Plans for people on Direct Payments was undertaken, to assess whether the principles of choice and control were being included in support planning. The conclusion of the audit, which looked at 20% of the Support Plans, was that it appeared that choice and control was only evident in about 50% of the sample, and it was recommended that urgent steps be taken to ensure that choice and control issues were addressed. See also footnote 19 above.

5.3 Brokerage

The Individual Budgets Evaluation Network (IBSEN) pilot study of Individual Budgets (2008) (see 5.2.2 above) touched on the notion of support brokerage being provided by independent brokers. The purpose of a Brokerage service is to ensure that the purchasing of services for clients within Adult Services are appropriate, effective, timely and cost efficient. B&NES is one of four Brokerage pilots operating in the South West and employs 3 full-time members of staff.

[20] Correct as at January 2011
[21] The title page refers to 'Adult Care', but pages 2 and 3 of the report refer to 'Adult Health'.
[22] Terminology varies between 'Personalised Budgets' and 'Personal Budgets' throughout the report.

The team finds packages of domiciliary care, residential and nursing home vacancies and day care for all Social Services and Continuing Health Care (CHC) clients and self-funding service users. The latter are free to choose whichever service(s) they consider are most appropriate to their needs and budget. CHC referrals comprise a minimum of 50% of total referrals, with a small number from self-funders and the Intermediate Care Team. The remainder are from the various social work teams across the authority. The team arranges approximately 60 care packages each week.

The team keep records of all calls and care packages, and this information is used by senior management in discussions with the 5 domiciliary care strategic providers who cover the area on a rota basis (spot providers are occasionally used when none of the 5 strategic partners is able to provide the required service).

6 PREVENTION AND EARLY INTERVENTION

Milestone 3: Prevention and cost effective services

This milestone looks at a whole system approach to prevention, intervention and cost effective services.
This includes the support available that will help any citizen requiring help to stay independent for as long as possible. A key part of this is ensuring council-wide and partnership approaches to universal services e.g. leisure, adult education, transport, employment, healthy living and health improvement (backed by targeted intervention), along with housing and supported living options.
Examples of intervention include reablement type services that help people regain independence to live in their own home. It also helps people to avoid becoming dependent on council provided services with national studies demonstrating many people finish reablement services with either a reduced need for care, or no ongoing requirement at all.
It is important that the council and the NHS are jointly investing in early intervention and prevention and monitoring the effectiveness of services together e.g. Joint interventions at best include telecare, case finding/case co-ordination and joint teams for complex and end of life care.
Being able to evidence these types of savings is crucial, and reablement type services should form an intrinsic part of any Putting People First operating model.

6.1 Older People's Independent Living Service (OPILS)

'One of the themes that the partnership focused on from the Putting People First agenda was prevention and early intervention work which led to market testing for an independent living service for older people. The partnership has procured a self assessment tool which will act as a first enquiry point for people needing help with independent living and for those that need onward referral to the health and social care access team.' (CQC report 2010).

Research undertaken by the Council in 2009 showed that due to the diverse demographics of B&NES there was the potential to introduce a tenancy-neutral independent living service for older people and other vulnerable people. Additionally, the research indicated that having a service which was more flexible than the existing accommodation-based one would meet the unknown and/or unmet needs of those not living in social rented accommodation.
The client group for this service comprises older and vulnerable people who have support needs, are unlikely to sustain their independence without support and have one or more of the following vulnerabilities:

- vulnerability due to age
- physical and/or sensory disability
- chronic and progressive long term condition e.g. dementia
- long term limiting illness
- learning disability
- mental health illness

A two-year pilot service was commissioned from Somer Housing in November 2010 and began operation in January 2011. Early feedback is very positive and is being used to develop the service.

6.2 Floating support service for socially excluded service users

A number of housing related floating support services had been contracted under the Supporting People framework to work with people who fell into the following categories:

- Homeless families
- Homeless single people
- Rough sleepers
- Offenders
- Vulnerable young people
- Low-level mental health problems
- Low-level learning difficulties

As with all SP services, key aims fell under the prevention and early intervention banner. During the term of the contracts, it had been noted that there were areas of duplication across providers and conversely that geographical areas of B&NES were not well served. With the imminent expiry of all SP contracts the team took the opportunity to reduce this duplication and commissioned a new, combined service to operate across the area, working with a cohort of users broadly defined as ‘socially excluded’. Innovative, collaborative approaches were particularly encouraged. In January 2011, a consortium of providers, branding themselves as Reach, was commissioned to provide the new service from May 2011. The prevention and early intervention agenda will continue to be central to the new service.

6.3 Floating support service for service users with learning difficulties and physical/sensory impairments

As with the Socially Excluded Floating Support Service, an opportunity to reduce duplication and encourage innovation presented itself with the expiry of SP contracts. A combined LD and PSI floating housing related support service was commissioned from Freeways in February 2011 to start in May 2011.

6.4 Accommodation based support service for teenage parents

In order to better meet targets around avoidance of unplanned second pregnancies in young parents aged between 16 and 21 and to ensure the authority can include young fathers in support provision, a new accommodation based housing related support service was commissioned in February 2011. Specifically, the commission will provide 6 units of supported accommodation for young parents and their children, and will include at least one unit for a two-parent family.

6.5 Redesign of B&NES mental health support services

As a result of a number of combining factors, the opportunity was taken in late 2010 - early 2011 to make some strategic changes to the Mental Health Support Pathway in B&NES.

In line with the Mental Health Strategy 2008-2012 and associated strategies and plans (see Bibliography) the aim of the redesign was to focus on better facilitating:

- the development of personalised services;
- the expansion of peer led and localised support activities;
- the centralisation of local information accessible to all;
- access to the intensive support needed for people to remain in their own homes;
- engagement with creative and practical activities that develop confidence and skills;
- individual's access to mainstream community education, training, leisure and employment opportunities;
- developing mainstream community facilities and networks, including developing social enterprises.

In order to realise these aims a care pathway that enables a clear range of support options is being commissioned.

The purpose is to develop:

6.5.1 Re-enablement services

The re-enablement service will work with residents who are experiencing mental health problems and who are eligible for health and social care services under CPA and the terms of the local authority's eligibility criteria FACS. The service, which is free to all users, will work with people for 6-8 weeks. It will enable people to avoid admission into hospital as well as leave hospital appropriately, safely and as promptly as possible. The overall objectives are:

- to help people to remain living at home;
- to achieve maximum independence;
- to prevent hospital admissions or re-admissions;
- following risk assessment, to reduce the level of care needed;
- to enable people to manage their mental health problems.

There will be a new re-ablement team specifically for mental health needs, which will be part of the Joint Community Teams. The service will be accessed by :

- the specialist mental health service's Crisis Resolution and Home Treatment team (CRHT) (who manage admission to beds, facilitate early discharge and provide home treatment in a crisis for a period, on average, of 2 weeks);
- the Community Mental Health Teams (CMHT);
- the general community through referral from GPs into the single point of access;
- IAPT[23] counselling.

6.5.2 Community Floating Support Service

The Community Floating Support service will be available for clients following re-enablement or directly through referral from CMHTs, and will be an alternative to Supported Living accommodation. The aim is that floating support would provide 'whole life' recovery focused support that reflects in practice the Recovery Star approach[24] and involve an element of social prescribing (see 4.1). This service would operate closely with the CMHTs, so that there is a seamless, integrated service with the workers linking directly with the care coordinators and their caseload.

The first and main remit of the service would be to enable people to remain in their own homes and communities and near to their social networks. Secondly, the service would be aimed at supporting people to return to their own accommodation and to live independently, after they have been within Supported Living provision. It will also focus on engaging people in meaningful local day activities available in B&NES.

It is anticipated that the community Floating Support services should be the first option presented to clients, while people are still in their own accommodation.
A key component of the floating support is that it will also focus on engaging people in meaningful local day activities available in B&NES. In this respect, all Floating Support services will be contracted to integrate service users into local communities and help people to establish lives and routines that add value to their health and wellbeing.

For 2011-12 commissioners are planning to commission a Community Floating Support service within the Community Health and Social Care

[23] Improving Access to Psychological Therapies
[24] See, for example, http://www.mhpf.org.uk/recoveryStar.asp

services. This enables retention of the skills and expertise of the existing social support and community options teams.

The Home Link, Home Support and Community Options teams will be re-formed into Re-ablement and Floating Support teams.

It is recognised that the full impact of implementing PBs and the Fairer Contributions policy is not yet understood, so it is suggested that the service is reviewed after 6 months in order to help reshape all Floating Support services for 2012-13.

The review would specifically look at:

- the impact of the Fairer Contributions policy on the numbers of clients and the services they view as having value;
- the impact of PBs and the scope and range of services seen as having value.

It is intended that the service will be commissioned by open tender, with a set of preferred providers to give choice to PB holders.

This reshaping and open tender will include Floating Support provided through Supported Living services where the aim will be to disentangle support services from housing provision, thereby protecting clients from destabilisation following house moves. This new arrangement will see support decrease and eventually cease, rather than clients move on from housing as support needs decrease.

6.5.3 Live Along scheme

This proposal from Options for Living[25] in Bristol originated from a consultation they conducted with tenants, who said that they wanted to remain in their own accommodation during and after assisting them deal with their mental health issues. The purpose of the scheme is to develop cost effective schemes that provide value for money, whilst at the same time continuing to promote the independence of service users, reducing their dependency on support, but without placing unrealistic expectations on them to 'move on' at all costs.

It is intended to develop a shared housing scheme where tenants can reside independently, with a small allocation of floating support bolted on. Tenants at similar stages of their recovery will be identified, who, whilst independent in many ways, still require the reassurance of a supportive presence throughout each week.

The level of funding would provide:

- Manager responsible for overseeing the service.
- Senior management on call service 24 hours a day
- Liaison with CPA professionals and external agencies
- Support to facilitate and attend meetings/appointments

[25] See http://www.optionsforliving.co.uk/

- All tenancy related support.
- Facilitation of regular house meetings.
- Negotiation and management of any issues of conflict that arise including anti social behaviour towards other service users and/or neighbours & communities.
- Ad hoc crisis management.
- Maintenance issues that arise, which will include monitoring and support to maintain health and safety of the individual and the environment.
- Direct 1:1 needs led support.

Service users would also have access to existing groups and activities provided within Options for Living.

6.5.4 Building Bridges to Wellbeing

This service will be commissioned for a period of 3 years from June 2011. The commission is to work alongside, and in conjunction with, services which provide one-to-one support to individuals to take up opportunities in the community as part of their agreed care plan.

The purpose of the service is to:

- help to improve the experience of people with mental health problems when they access community facilities,
- develop and help to reform mental health day service provision;
- facilitate mental health organisations in tailoring services to the values and norms of the communities they are serving;
- provide a person-centred planning approach for clients, to support someone's transition from using mental health services to joining in with community-based activities;
- encourage / enable service users to become more involved in life domains such as employment, education, art, volunteering, faith communities and sports / leisure groups;
- increase people's independence and integration into the local community;
- help people who have a mental health issue to feel more involved and to participate in their local community.

The role of the service will be to:

- be independent of any particular service or professional model;
- provide a resource and a supportive link between communities and mental health services;
- play an effective role as a change agent, service developer, access facilitator and capacity builder;
- utilise the resources communities themselves have in bringing about change.

The service will:

- reduce and minimise dependence on specialist mental health services and to maximise engagement or re-engagement with the wider community;
- help people to support each other in their chosen activities;
- provide support to reconfigure existing day service provision to meet the needs of a wide range of people with mental health problems living in the community;
- provide support to individuals to grow and maintain their friendship and peer support networks and thereby access activities and facilities of their choice;
- provide support to people with mental health problems to make informed choices about their own community participation;
- provide encouragement, support and signposting for individuals or groups to access funding from Quartet;
- provide high quality and culturally sensitive community development support;
- provide support to existing local community groups / organisations so they can be partners in developing services;
- provide capacity building support within mainstream services to ensure that they are accessible for the people supported;
- work in partnership with the local Not for Profit sector to develop means of targeting local needs and hard to reach groups in the community;
- provide support to people with mental health problems in developing relevant skills, knowledge and confidence to become involved in creating individual solutions for themselves;
- to research, maintain and ensure the availability of an up to date information resource (i.e. WellAware) of local mainstream community activities and opportunities related to the life domains in the statutory, voluntary and commercial sectors;
- ensure other identified barriers to community participation (for example housing, debt, etc) are identified and addressed through links with appropriate mainstream services;
- build partnerships with other agencies so as to foster understanding, access resources and create a wide spectrum of opportunities for people with mental health problems;
- work closely with statutory bodies to develop mental health services for and in the community, and have input into the service redesign process.

6.5.5 Service user involvement before community facilitation service start

There is a need to carry out a survey of current day service users, to see what they feel they have got out of day provision, such as drop ins, coffee mornings etc, whether they wish them to continue and in what form, and what they feel would be useful alternatives. There will be 3 service user events in April, and one with Creativity Works for follow-up consultation.

6.5.6 Economic Development Service (EDS)

The aim is that this service will incorporate the Mental Health Work Development Team thereby increasing capacity and including mental health within the spectrum of socially excluded adults. This service will be dynamic and proactive: whereas access to it is currently by referral, in future CMHTs will work with service users to encourage them to access the service themselves.

Comment: I'm not sure I understand this bit. Why will this happen?

Comment: I'll ask Bas if I get a chance – this is his description!

The aim of the EDS is to increase the proportion of socially excluded adults in employment, education or training, with particular focus on:

- care leavers aged 19 or over;
- adults in contact with secondary mental health services;
- adults with moderate to severe learning difficulties;
- adults with physical disabilities and/or sensory impairments.

The objectives of the EDS in relation to mental health service users are broadly similar to the existing work development team:

- create sustainable opportunities for paid employment;
- to develop and lead on a multi-agency Employment Strategy for socially excluded adults that includes job coaching, vocational training, and employment options including training, social enterprises, and supported employment;
- to train staff about the effectiveness of employment in improving the life experience of service users;
- increase employer understanding and acceptance of needs of people with mental health conditions in order they comply with the law;
- increase employment of people with learning difficulties, mental health conditions or physical disabilities within the existing organisation.

The EDS, as well as supporting people with mental health problems to take up employment, could also include supporting people to develop their skills and expertise around making social enterprise a real sustainable option. Potentially, this could include case studies and pitfalls, business planning and the local economy, researching and looking at gaps in the market, help in assessing viability (or the level at which it could operate), pricing up work, legal models, such as joint venture companies and working with other community organisations etc, developing business cases for seed funding from Quartet, and using peer support networks to develop ideas. It would also involve safeguarding individuals so that they didn't take on too much and affect their mental health, and workers would attend CMHT meetings regularly so that again there is an integrated approach, and all learning and weaknesses are shared. This could link in with, and work alongside, employment training services.

6.5.7 Checking/monitoring services

It is also proposed to commission a low level checking/monitoring service that people can choose to engage with for low level support and act as an early warning system if people need to access services again for a short while. This proposal will be part of the Floating Support service.

6.5.8 Advocacy services

Advocacy services are a key component of mental health service provision and to date it have been funded on a rolling basis and delivered by Bath MIND. A decision has been made to re-commission all advocacy services for 2012-13 so that they can be clearly articulated, contracted and performance managed.

6.5.9 Community services that will interact with all of the above

It is important that there are a range of options available across B&NES for people to access that will further support their recovery. To this end it is envisaged that the following provision will be available:

- **Well Aware database** (see also 5.1.1 above)
- **Quartet**
  Quartet is a charitable foundation, which holds funds and disburses them in the form of grants to charities, social enterprises and individuals against criteria agreed with the donors. The intention is that funding will be donated annually to Quartet to set up an endowment to provide seed funding for social enterprises, service user led groups and activities to provide the impetus and means to start or develop a service or group. This would provide an opportunity for peer groups to become established when they might otherwise have been denied the opportunity due to lack of capital or resources, as many service users are reliant on benefits.
- **Back office function**
  At the time of writing (February 2011) there is currently wide consultation concerning further opportunities for service users to become involved in developing computer and work orientated skills. Longer term this could expand so that these 'back office' skills were available to provide business facilities (accounting, constitutions, money management, etc.) and support for social enterprises developed by clients who have mental health problems.
- **Environmental projects**
  Commissioners are keen to further develop locality based options for involvement in horticulture e.g. working on allotments. Again, the aim is to stimulate opportunities for service users to be given longer term opportunities to develop social enterprises that provide meaningful and valued occupation (as opposed to 'placement' or 'package' models currently in operation) and enable people to earn a small income as well as develop skills through training.

6.5.10 Mental Health Creative Support Service

This service will be commissioned from April 2011 for a period of 3 years. The service will provide a person-centred planning approach for clients, and will work alongside, and in conjunction with, services which provide one-to-one support to people with mental health needs to take up opportunities in the community. It will support their transition from using mental health services to

community-based activities, based around the life domains of arts and culture, employment, education, training and vocational activities.

In particular, the service will provide:

- tasters and engagement courses which improve their health and wellbeing through engagement with socially inclusive creative activity;
- provide support to people with mental health problems to make informed choices about their own community participation;
- Maintain and ensure the availability of an up to date information resource of local community activities and opportunities using the WellAware database;
- work alongside the new Community Facilitator service to link service users to creative, leisure and training activities or work skills development;
- enable people with common interests to set up self support groups, activities, networks or social enterprises, and offer appropriate training, mentoring and advice;
- develop and implement procedures for individualised progression routes;
- model a social prescribing approach to the projects that addresses early intervention and includes support for severe & enduring mental health;
- develop links with GP, health visitors, primary care teams and people who are FACS eligible for inclusion in courses and progression support.

The purpose of the service is to:

- help to improve the experiences of people with mental health problems, enabling them to live more meaningful lives;
- encourage and support them to feel more involved in and part of their local community;
- support prevention and early intervention;
- integrate creative informal learning, progressions and re-integration with the community into jointly developed projects, with participants and the community both playing key roles;
- provide a resource and supportive link between communities and mental health services.

6.5.11 Current Situation (March 2011)

- Discussions have taken place with the Community Health, Social Care and Housing services and Social Care Support services regarding the potential reorganisation of the Home Link/Home Support and Community Options services in the re-enablement and Floating Support model. This will include the long term savings that could result from merging the 3 services into 2.

- Existing community service providers have been informed about the new model in order that they can understand the recommissioning implications for 2011-12.
- It is intended to share the proposals with the responsible Council cabinet member.
- The proposals with other local stakeholders at events in April 2011.
- A plan for the implementation of agreed changes is being developed.

6.6 Re-ablement

Re-ablement is defined as 'the restoration of optimal levels of physical, psychological and social ability within the needs and desires of the individual and his/her family. It requires the expertise of a number of disciplines within a comprehensive and integrated service which must span agency boundaries.'[26] B&NES policy is to use the widest possible definition of re-ablement across both the statutory and voluntary sectors.

In October 2010, the government made £70m available for re-ablement activities, with another £162m made available in January 2011 to help with winter pressures. It is planned that allocations will rise to £150m in 2011-12 and £300m in 2012-13. Of this, B&NES received a total of £707,000 in 2010-11, and will receive £475,000 and £591,000 in 2011-12 and 2012-13 respectively. The sums will be made available by changes in the tariff arrangements for acute hospitals (such as the Royal United Hospital (RUH) in Bath). The purpose is to enable smoother and quicker transitions from hospital to free up resources for community re-ablement activities. The government's focus is on hospital discharge and the prevention of re-admissions within 30 days. To achieve this the B&NES Wellbeing Partnership has integrated the re-ablement teams and functions into a single in-house, multi-professional team, with the aim of enabling people to take preventative measures to avoid them entering the social care system, and stemming demand for long term social care packages.

There has been progress in this area with:

- a partnership approach with the RUH, Somer, Age Concern, Care & Repair, CH&SC and others to develop an integrated model of re-ablement;
- a mapping and gapping analysis by the DATE (Discharge and Therapeutic Evaluation) team;
- the distribution of funds to local providers to enhance/develop re-ablement capacity;
- the development of new settings for care and support;
- working with the Strategic Health Authority as an early implementer site;
- making sure that tariff arrangements are fully in place;
- the development of a single, good practice model/team for re-ablement co-ordination;
- a partnership with Wiltshire Council to maximise learning.

[26] http://www.csed.dh.gov.uk/_oldCSEDAssets/esppt.ppt#2

6.7 Home Improvement Agency (HIA)

HIAs work in partnership with local authorities to advise and assist vulnerable and older people with housing repairs, improvements and adaptations to enable them to retain their independence. Owner-occupiers, or tenants with a repairing obligation, who are over 60 or disabled and need small repairs or minor maintenance work about the house may get help from the B&NES HIA, referred to as the Care & Repair Handyperson service. Generally a job that can be done by one person in a maximum of two hours will come under this service. Referrals to the service come through social workers, occupational therapists and community alarm schemes, as well as through self-referral.

Outcomes for the service are:

- to improve the living conditions and quality of life of the clients, so they can remain independent in their own homes;
- to increase the safety and security of clients by fitting smoke alarms and grab rails;
- to increase knowledge of Care and Repair services, including hard to reach and socially excluded groups;
- to assist the Home Improvement Team to target resources to vulnerable clients and achieve a budget spend.
- Links with other initiatives such as Warm Front

The current HIA provider also project manages larger household works, such as converting a downstairs room into a bathroom.

The provider is working towards the following indicative targets:

- deal with 2,000 enquiries a year;
- complete 1,500 Handyperson jobs per year;
- complete 100 jobs a year to a value of £200,000. A job is defined here as a repair or adaptation to a client's property with the provider assisting the client to get the repair and/or adaptation complete.

7 UNIVERSAL ACCESS TO SERVICES

Milestone 4: Information and Advice.

All citizens should be able to easily find locally relevant quality information and advice about their care and support needs in order to enable control and inform choice. Information should be available in a range of formats and through channels to make it accessible to all groups. Provision of information, advice and guidance should move from being largely developed from separate initiatives to a single coherent service strategy.

7.1 Communication

The council has used a variety of media and methods to communicate information to everyone in Bath & North East Somerset about available wellbeing services. Whilst much is available via the council's website, B&NES

is aware that not everyone has access to the internet, and therefore the following information has also been made available in print form:

- New information concerning safeguarding vulnerable adults in the form of a leaflet (also available in easy-read and Polish), bookmark, poster and new credit-card sized card.
- New Personal Budgets flyer and accompanying bookmark, which are also available on line[27].
- The Directory of Services for Older People is available in 2 print formats: standard size and large print.
- Give Us A Break marketing materials – poster, flyer, pens, coasters.
- Articles about Give Us A Break, Personal Budgets and Safeguarding adults have been written for various publications, including Council Connect, RUH Insight magazine, PCT news, In Touch newsletter, Inside Out, RUH volunteers' magazine.
- In October 2010 a range of were sent to over 580 addresses in B&NES (ranging from Parish Councils to Hospitals);

Web-based information and other digital communication:

- Pages on the Council's public web site which have been viewed either infrequently or not at all have been removed to ensure only important and useful information is on the public site: feedback has indicated that there has been too much information, which has caused some confusion;
- Five adverts (safeguarding vulnerable adults, Personal Budgets, Well Aware, AskSARA and Give Us A Break) of twenty seconds' duration have been shown on Connect TV. Connect TV is the Council's digital signage TV system which shows, in a one-hour loop, a mix of short videos, news, adverts and information from the Council and partnership initiatives. Screens are situated in: Council Connect, Bath; Bath, Keynsham and South Wansdyke Leisure Centres; Bath Central Library; and Keynsham Library;
- In early-2011, short informative articles about Give Us A Break, safeguarding adults, Personal Budgets, Well Aware and AskSARA were sent to a wide variety of voluntary organisations and places such as parish councils, with a request that these articles are included in their newsletters or websites, to continue raising awareness;
- throughout the period under review the Information Officer attended many events and took along publications for people to take away. Information about various council services was also given informally at these events.

7.2 Library outreach

[27] see http://www.bathnes.gov.uk/SiteCollectionDocuments/Health%20and%20Social%20Care/Information%20Sheets/PB%20flyer%20-%20final%20version%20Aug%202010%20.pdf and http://www.bathnes.gov.uk/SiteCollectionDocuments/Health%20and%20Social%20Care/Safeguarding%20Adults/Stop%20Abuse%20Bookmarks.pdf

B&NES' library service has made contact with a number of people, mostly living in villages in B&NES, who have hitherto not been reached by other agencies, such as social services. Most of these people are isolated, housebound and living alone. This presents an invaluable opportunity to improve access to early intervention and prevention services to a new cohort of people. In January 2011 the Information Officer attended a meeting of the library service's 150-200 volunteers to disseminate information on services available. The reception was very positive, and it is hoped to repeat the meeting in future, with the approach being built into the early intervention and prevention strategy:

Mendip Care & Repair have proposed a bibliotherapy scheme, aimed at those in the community with mental health issues. The scheme would involve members reading out loud in the group, and would have the intended outcomes of increasing members' self-esteem and self-confidence, and reducing social isolation. The intention is to have one of their project managers trained in bibliotherapy, and to offer this service both separately and in conjunction with their existing gardening scheme in Radstock.

8 LOCAL COMMISSIONING

Milestone 5: Local commissioning

Councils need to ensure the development of a diverse and high quality market in care and support services to offer real choice and control to service users and their carers.

Commissioning strategies based on the local JSNA, and in partnership with other local commissioners, providers and consumers of services should incentivise development of diverse and high quality services, and balance investment in prevention, early intervention/reablement with provision of care and support for those with high-level complex needs.

User-led initiatives and a much wider range and scale of services to address local need should emerge, in a market that is increasingly populated by individual purchasers.

Because of local authorities' reduction in funding from central government from April 2011 onwards, the amount of money available for adult social care services, along with all other services provided by the council, was also reduced. Decisions about the funding of adult social care services therefore had to be made in the light of the new restrictive financial climate, and the effect on the Supporting People and Communities budgets and services is summarised in Appendix 1. The aim was to continue to provide effective services for service users whilst meeting budgetary requirements.

8.1 Joint commissioning

A draft paper published in January 2011 by the PCT's Associate Director - Learning Difficulties/PSI outlined the route map for commissioning health and social care in B&NES. The paper proposed the following:

- The council would be host agency for a formal commissioning partnership between the Council and the GP Consortium similar to that currently in place between B&NES PCT and the Council, but with NHS staff, employed by the GP Consortium, seconded into the Council commissioning team.
- The Partnership would establish a single team commissioning community based health, social care, public health and housing services for adults and children.
- A Partnership Steering Group (or similar) should be established between the Council and the GP Consortium for joint agreement of strategy and priorities and outcomes framework to which the integrated commissioning team will be held accountable
- Although initially budgets are likely as now to be aligned, over time the expectation would be for an increasing proportion of funds to be pooled and jointly managed by the team.
- This model also lends itself to the Council working collaboratively with neighbouring Local Authorities to create greater commissioning leverage.
- The clinically led GP commissioning consortium will drive service and financial strategy that secures improved health outcomes for local people, design of locally sensitive pathways of care in line with best practice guidance and oversight of the clinical quality of care commissioned;
- A small in-house commissioning / planning team who support the development of service and financial strategy and secure through contracts with commissioning support agencies (CSA);
- A Commissioning Support agency, formed initially from commissioning staff within PCTs, and with a view to becoming Social Enterprise, will service the needs of NHS and LA commissioners.
- The PCT Cluster, to be in place by June 2011 and led by a single Executive Team, will ensure appropriate governance, decision making and accountability through PCT Boards until April 2013.
- The PCT Cluster will develop the initial structure for commissioning that transfers to NHS Board (Primary care & Specialist services). Footprint likely to be bigger than NHS B&NES & Wiltshire

9. NEXT STEPS

9.1 Lean Review

In 2010 the consultancy firm Vanguard was engaged to instruct and support B&NES staff in developing their method of analysing the way in which adult social care is delivered by the B&NES NHS partnership, with the aim of looking at the current system and making it more efficient, cost-effective and a better experience for service users.

Engagement with carers produced examples of areas for improvement. One such was a group of parents of young people with autism living in supported living accommodation. They had contacted at least six people from both sides of the health and social care partnership to try to get their children's finances sorted out, without success. The parents said they would have found it much more beneficial to have a single point of contact.

The first phase of the Vanguard process was to look at the way the organisation is currently operating ('Check' phase). Amongst the findings were:

- 67% of all incoming calls to the Access team were defined as Failure Demand, i.e. the client's call had no value to them. For example, they may have called to find out where they are on a waiting list; or they may call on a subject which the Access Team cannot help with (e.g. housing benefit);
- measures are imposed from management level (e.g. targets, KPIs, monitoring), which do not relate to the service user's experience, and do not improve the way the service is delivered;
- clients' experience is that service delivery is confusing and fragmented, and there are many duplications and delays;
- a lot of the work is carried out because it is demanded by the system, not because it adds value to the client lists;
- Case Managers have to spend a lot of time inputting performance data, which is required for the targets and not the clients;
- assumptions made about the system (e.g. 'we need to control work' and 'setting targets will improve performance') are often groundless and slows down the way people work.

It was found that all these factors had a detrimental effect on service users and staff.

The second phase of the Lean Review is to redesign the system so that:

- all the work done is of value to the client;
- wasteful and expensive processes are abandoned;
- front line staff are empowered and trusted;
- senior managers create structures and processes which support the purpose of the organisation.

The third phase, which runs from January 2011, is to test, measure and improve the system. Improvements identified by practitioners and service users will be continually embedded into new practices.

The following changes to the system will be tested:

- integrating Care and Financial Assessment (done in parallel with Finance Officer in team);
- brokerage functions in teams;
- assessment/re-enablement integral to flow/process;
- discretion over need for 6 weeks unscheduled reviews – no personal or team targets for activity;

- retain existing spot purchasing providers to give more choice to those receiving services from a block contract provider move to self-funding;
- single authorisation of spend;
- Performance Indicators will be developed by people doing the work;
- direct discussion with strategic partners (no Quality Monitoring form);
- collect essential Equalities data only once;
- case ownership and management.

The aim is to bring about culture change to:

- obtain a strong commitment from senior management to embed the cycle of test-learn-improve in everyday practice;
- gradually bring in more case workers to work with this method, and to test the proposed flow with their particular caseload: everyone is involved;
- question non-value work;
- embed system thinking into policy and practice guidance development.

At the time of writing (February 2011) the partnership's Safeguarding and Personalisation group team have found that while B&NES has implemented robust policies regarding PBs, the quality of the practical implementation of those policies across the social work teams is not consistent. This is partly because of the priority being given by the PCT to their future after their abolition in 2013. In the current financial climate, no budget has been identified which will provide the Direct Payment support needed to improve practice and develop knowledge. There is a need to instigate a 'feedback loop', i.e. a mechanism for practitioners to feedback to policy makers the effects of new policies and procedures to determine whether or not they are effective. This would fill the existing gap between commissioners and providers. Without this ,the Council could be subject to legal challenge in cases where implementation has not been correct, due to a lack of understanding or knowledge of DP guidance and employment legislation.

9.2 *A Vision for Adult Social Care*

In November 2010 the Department of Health published *A Vision for Adult Social Care*. The document states that the government is committed to 'reforming the system of social care in England to provide much more control to individuals and their carers' (p6). The seven principles appear very similar to those in *Putting People First*.
The document indicates that Councils should make care services available to more than those who are classed as having Critical needs by the FACS criteria.

9.3 *The Social Care Reform Bill*

This bill is scheduled to be published in the Spring of 2012. It is anticipated that it will cover:

- Regulation
- Assessment

- Carers
- Eligibility
- ordinary residence
- Amendment of the National Assistance Act and the Chronically Sick and Disabled Act

9.4 *Practical approaches to improving productivity through Personalisation in adult social care*

This report, published in December 2010[28], looks at the ways that adult social care transformation has developed since the coalition government came to power in May 2010. It identifies the following key aims and areas for development:

- The cost-effectiveness of Personal Budgets;
- Understanding costs at individual and strategic level;
- Building community capacity;
- Achieving better value for money for people who require ongoing support;
- Shaping markets to offer personalised services at a fair price;
- Personalisation: the key driver of strategic change

9.5 *No Health Without Mental Health*

In February 2011 the government announced its new Mental Health Strategy to transform health and wellbeing, *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*. This superseded the *New Horizons: a shared vision for mental health* strategy published at the end of 2009.

The purpose of the new strategy is to give mental health the same importance as physical health. The government pledged to:

- launch the Health Visitors Implementation plan, which involves an additional 4,200 health visitors;
- through the Early Intervention Grant bring together funding for early intervention and preventative services for children, young people and families, which can also be used for Targeted Mental Health in Schools (TaMHS). Local authorities will have greater freedom and flexibility to put in place programmes that can reduce conduct disorder, improve family relationships and reduce costs to social care, youth justice, education and health systems;
- provide extra investment to ensure the best treatment possible for veterans with mental health problems;
- ensure that by 2014 people in contact with the criminal justice system will have improved access to mental health services;
- work in partnership with the Time to Change programme to challenge stigma and discrimination;

[28] Ayling and Cattermole – see Bibliography

- establish community budgets in 16 local areas for families with complex needs (including mental health problems) as part of a national campaign to turn around the lives of families with multiple problems;
- ensure that all psychological therapy sites have an employment co-ordinator who will work with Jobcentre Plus offices, employers and occupational health schemes to help people get back into work;
- launch a consultation to extend to all employees the right to request flexible working, which will help carers of people with mental health problems to manage their caring role alongside work; and
- publish a new cross-Government suicide prevention strategy.

Central to the emphasis on prevention and early intervention, the government announced that there would be an additional investment to extend access to psychological therapies, such as Cognitive Behavioural Therapy, Counselling for Depression and Interpersonal Psychotherapy to 'all those with mental health problems'.

9.6 The future of social care transformation in B&NES

In February 2011 the Personalisation Coordinator for the South West Region produced a checklist for mainstreaming and developing Personalisation. The document is reproduced in full in Appendix 3, but three questions are relevant here:

1. *Does your council have an emerging new whole system approach to delivering adult social care underpinned by the principles of Personalisation?*

We have good evidence that this is the case in Bath & North East Somerset . There has been a genuine and wholehearted effort to implement the values and practices of Personalisation in all parts of B&NES' adult social care delivery. All the items listed are either in place or are being implemented. In addition, the requirements for successfully developing the market as summarised in *Practical approaches to market and provider development* (see 9.4) are in place: the paper identifies the council's 'ability to play a leadership role in this activity through supporting people with Personal Budgets and direct payments to drive change in the market. It will also involve developing better knowledge about local markets, building more collaborative relationships with providers, developing a range of flexible arrangements for securing services and establishing more effective mechanisms for local engagement.'

2. *Does your council have a resilient plan for mainstreaming this work into the future*
Good progress has been made but there are still areas for development. The work that has already been done has ensured that the principles of Personalisation have been integrated into the mainstream of adult social care.

3. *Is your council refreshing and re-invigorating your transformation programme to ensure it is fit for future challenges?*

While there are resource issues (for example, there will be no staff member specifically responsible for social care transformation after 31st March 2011), some of the items listed in the sub-questions have been effectively addressed, while others have yet to be implemented. Of the 30 elements of this question, 18 have been or are being implemented, while work on the remaining 12 is either yet to begin or has yet to be completed. See Appendix 3 for the detailed list.

Implemented	Yet to be fully implemented
Develop a flexible Self-Directed Support (SDS) system which allows users reasonable discretion	Review and refine SD process to maximise efficiencies
Ensure carers' assessments are included	Use outcomes focussed approach throughout SDS process; evaluate user outcomes and feed into quality and commissioning plans
Put in place measures to monitor progress of PB rollout	Implement positive risk taking strategy with training for staff and support for service users
Identify further opportunities to streamline back office processes	Review and amend IT system
Further progress on integration of health and social care commissioning	Adopt a budget model to measure changing pattern of costs, and reflect user preferences and changing patters of provision
Joined up approach to avoid hospital admissions	Detailed operating model adopted as the mainstream and old systems switched off/deleted
Link more closely with private and social housing providers	Link with key partners to ensure information on support and services is widely available in the community
Work with partners to support community networks	Embed co-production in developing new services
Continue to develop communication with providers	Prepare systems and support to meet the increasing use of Direct Payments
Ensure providers offer more flexible and personalised services	Mobilise people's own resources and those of communities more effectively
Use market intelligence to shape the market	Use third parties to assist with support planning
Embed outcomes based approach in provider contracts	Deliver an approach which supports whole families and ensures carers are not pushed to breaking point
Embed SDS approach in transition for children	
Link with Mental Health Trusts	
Develop workforce strategies for the leaner operating model	
Focus resources on legally required areas	

Support the development of new types of workers, e.g. Personal Assistants	
Support providers to work in a way which provides flexible and personalised support	

10. CONCLUSION

There is no doubt that Personalisation has been genuinely and comprehensively embraced in B&NES, with radical changes to the way services are commissioned and to the way that the Council department responsible for delivering adult social cares services is structured, and major efforts made to inform services users, providers, practitioners, other council staff and the people living in the authority of all the changes and opportunities which Personalisation brings. However, it is also clear that the effective and meaningful implementation of Personalisation remains a great challenge to all local authorities, including Bath &North East Somerset.

The Social Care Institute for Excellence report on the potential for Personalisation states that 'Personalised approaches to integrated health and adult social care and support can promote both primary and secondary prevention'. In this respect the establishment of the Health and Wellbeing Partnership puts B&NES at an advantage, although the demise of the PCT by April 2013 once again proves that 'constant change is here to stay'.

However, the report adds that 'evidence that investment in prevention can generate savings is probably clearer than that presently associated with Personal Budgets and self-directed support'. This would appear to imply that the money spent on Personal Budgets has been at best ineffective. Nevertheless, the report acknowledges that 'It is too early, and there is not enough robust data available, to make conclusive evidence-based decisions on whether or how Personalisation (specifically self-directed support, Personal Budgets and direct payments) has delivered efficiency savings, reduced costs and improved productivity in adult social care'.

B&NES' approach to adult social care has been to shift the emphasis from crisis intervention to prevention and early intervention. Although this will undoubtedly yield benefits for residents, the full impact is not likely to be seen for a number of years. In the meantime, sufficient resources (human and financial) and increased flexibility for commissioners and providers of services are key to the success of the drive towards Personalisation.

Appendix 1 – B&NES Council Supported Living and Communities spend: 2010/11 and 2011/12

Sector	Spend 2010/11	Services 2010/11	Savings	Spend 2011/12	Services 2011/12
Advice, Information & Advocacy	£597,332	Universal and specialist advice and information; vol sector network; Well Aware; statutory and other advice services; complaints advocacy	16%	£500,000	Universal and specialist advice and information; vol sector network; Well Aware; a NEW single advocacy service combining statutory and non-statutory services; complaints advocacy
Carers	£481,041	Replacement care; sitting; information and support; Involvement and Consultation Body; carers' breaks; provider forum	15%	£410,000	A NEW carer's centre; remodelled sitting services; provider forum; other supporting services
Older	£1,837,881	Sheltered	12%	£1,700,000	Sheltered

People		housing; extra care housing; handy person service; community equipment; community alarm; advice and information; day services; lunch clubs; community transport.			housing; OPILS (see 6.1 above); more Extra Care; care and repair; handy person; community equipment; community alarm; advice and information; day services; lunch clubs; community transport.
People with disabilities	£2,212,074	Floating support; supported housing; HIV/AIDS; support for people on Direct Payments; equipment support; day services; art therapy; peer support network.	15%	£1,878,037	Supported housing for people with higher needs; HIV/AIDS; support for people on Direct Payments; equipment support; day services; art therapy; extended peer support network; NEW floating support; supported housing
People with housing and support needs	£1,958,942	Safe house/refuge; floating support and outreach; resettlement; direct access hostel; supported housing; temporary accommodation; dry houses; deposit bond scheme; private rented access schemes; 'meaningful	16%	£1,600,000	Safe house/refuge; NEW housing related floating support and outreach to enable independent living; direct access hostel; supported housing; temporary accommodation; Dry house and NEW community

		occupation'.			treatment project; deposit bond scheme; private rented access schemes; 'meaningful occupation'.
Young People	£505,994	Supported housing; floating support; outreach; mediation; supported lodgings; foyer; supported accommodation for young parents.	6%	£476,000	Supported housing; NEW housing related floating support; mediation; supported lodgings, including emergency provision; foyer; NEW supported accommodation for young parents.

Appendix 2 - Adult Community Care Duties and Statutory Responsibilities (as at September 2010)

Act	Section	Duties/Responsibilities
National Assistance Act 1948	21	Provision of residential accommodation for persons aged 18 and over who because of age, illness, disability or any other circumstance are in need of care and attention which is not otherwise available to them; and for expectant and nursing mothers in the same circumstances.
	22	Charges for accommodation
	24	Provision for those who are homeless or who don't normally live in the LA [Local Authority]
	29	Promotion of welfare for disabled people
	48	Protection for property of those admitted to hospital etc under S47
Health Services and Public Health Act 1968	45	LA promotion of the welfare of 'old people' and commissioning of voluntary agencies
Chronically Sick and Disabled Persons Act 1970	1	LA must know how many people there are in the LA to whom S29 of the NAA 1948 applies.
	2	LA must meet the needs of those in S1 through provision of: practical home

		assistance; educational and recreational facilities; travelling to services; home adaptations; meals at home; a telephone and equipment to use it.
Local Authority Social Services Act 1970	2 & 3 6	LA must have a social services committee A director of Social Services can operate across LAs, and there must be adequate staff to assist him in his functions.
National Health Service Act 1977	21 & Sched 8	Social services are responsible for care of expectant and nursing mothers; prevention, care and after-care; home help and laundry facilities [i.e. dom care] for vulnerable people .
Health & Social Services & Social Security Adjudications Act 1983	17 Sched 9 Pt II	The amount charged by a LA for its services must be reasonable The provision of meals and recreational activities for old people can be devolved to a voluntary organisation
Mental Health Act 1983 (as amended MHA 2007)	117	A strong joint duty on health and social services to provide after-care services to certain former mental health patients.
Housing Act 1985	9 11	LA may provide housing by building or acquiring accommodation LA may provide welfare services in connection with this housing
Act	**Section**	**Duties/Responsibilities**
Disabled Persons (Services, Consultation and Representation) Act 1986	3 4 8	LA have to assess the needs of disabled persons When requested to do so by a disabled person, his authorised representative, or any person who provides care for him a local authority shall decide whether the needs of the disabled person call for the provision by the authority of any services. LA must take into account the abilities of carers.
Children's Act 1989	20	LA must provide accommodation for any 'child in need' over 16 whose welfare will be seriously prejudiced if they don't make the provision.
National Health Service and Community Care Act 1990	46 & 47	Duty for LA to assess people for social care and support. LA resources can be taken into account, but if it is deemed that services are required, they must be provided, and cannot be withdrawn later if resources become limited. People giving the care must adhere to the care value base. Enabled people with long-term care needs to live in their own homes if feasible.

		(The Act also set up the 'internal market').
Carers (Recognition and Services) Act 1995	1	Local authorities have a duty to carry out a carer's assessment where the cared-for person is being assessed under the NHSCCA 1990 (or the Children's Act 1989).
Community Care (Direct Payments) Act 1996		*Repealed by Health and Social Care Act 2001*
Housing Act 1996 Part VII (as amended)	175 – 178, 191 213 & 213A	Definitions of: homelessness; occupiable accommodation; reasonable occupation; who may occupy LA accommodation; intentional homelessness LAs must co-operate with each other to accommodate those who qualify for LA accommodation
Care Standards Act 2000	3 23 80 121	Definition of care homes National minimum standards apply to LA establishments Definition of care worker and vulnerable adult Definition of disability
Carers and Disabled Children Act 2000	1 – 6	Carers have a right of assessment; the LA must consider whether they have needs in relation to the care they provide; includes those with responsibility for disabled children
Act	**Section**	**Duties/Responsibilities**
Children (Leaving Care) Act 2000		LA retains responsibility for the welfare of children and young people leaving their care, even if they move out of the LA area, unless there is agreement between the LAs to transfer responsibility and funding.
Housing Act 2000 - amendments		LA required to develop housing strategies for: homeless people; care leavers; single women fleeing domestic abuse; those in 'institutions'.
Health and Social Care Act 2001	49 50	Nursing care excluded from community care services Responsibility for provision of accommodation for qualifying people transferred to LAs
Homelessness Act 2002	1 3	LA homelessness strategy must be published within 5 years of their previous one Definition of a homelessness strategy
Carers (Equal Opportunities) Act 2004	1 & 2	LA has a duty to: to tell carers about their right to an assessment; consider whether the carer works or wishes to work, wishes to study or have some leisure activities, when they are carrying out a carer's assessment. It also gives the LA strong powers to enlist the help of health, housing and education authorities in providing support for carers.

	3	LAs must co-operate in providing information. (Amends the C(RS)A 1995 and CDCS 2000).
Housing Act 2004	3	New system for assessing housing conditions and enforcing standards. LA must keep housing conditions under review
The Mental Capacity Act 2005 (as amended by the Mental Health Act 2007)		Deprivation Of Liberty Safeguards (DOLS). Briefly: • if a hospital or care home 'managing authority' [MA] identifies that a person who lacks capacity is being deprived of liberty or risks being deprived of liberty they must apply to the 'supervisory body' (PCT or LA depending on whether it is a hospital or care home) for authorisation of the deprivation of liberty; • The MA informs the person's family, friends and/or carers they have applied for a deprivation of liberty authorisation; • When the LA (or PCT) gets an application, they must carry out: a mental health assessment; a mental capacity assessment; an eligibility assessment; a best interest assessment; a 'no refusals' assessment. Only if all the above are satisfactory is authorisation given.
National Health Service Act 2006	254 and Schedule 20	LA must provide Dom Care for vulnerable adults 'adequate to the needs of the area.' *(However, the LA is not obliged to provide employment facilities for those who are long-term unemployed due to a disability).*
Health and Social Care Act 2008		*(Although the Act refers several times to Social Care, its function is to legislate for the setting-up of the CQC. References to social care and social care workers are in headings only!)*

Remarks

'A simple search of "Statutory Duty" on the Department for Communities and Local Government (DCLG) site yields 1,000 individual results… we can draw three basic conclusions from this fact. Firstly, there appear to be many statutory duties. Secondly, we are unsure how many. Thirdly that DCLG, the department responsible for managing local authority's compliance does not appear to include a list of local authorities' statutory duties on their website. This appears to be a conspicuous and regrettable omission.' (Glyn Gaskarth, *http://conservativehome.blogs.com/localgovernment/2010/03/statutory-duties-*

-councils-are-legally-obliged-to-fulfil-their-statutory-dutieshowever-few-know-the-number-of-statutory-dut.html, accessed 12th August 2010)

A definition of social care services is contained in section 156 of the Health and Social Care Act 2008:
'"social care services" means services which an English local authority must or may provide or arrange to be provided under any of the following provisions—
(a) Part 3 of the National Assistance Act 1948 (c. 29),
(b) section 45 of the Health Services and Public Health Act 1968 (c. 46),
(c) section 117 of the Mental Health Act 1983 (c. 20), and
(d) section 254 of, and Schedule 20 to, the National Health Service Act 2006 (c. 41),
or services which are similar to such services.'

Section 9(3) of the same Act states that '"Social care" includes all forms of personal care and other practical assistance provided for individuals who by reason of age, illness, disability, pregnancy, childbirth, dependence on alcohol or drugs, or any other similar circumstances, are in need of such care or other assistance.'

Appendix 3 – Checklist for mainstreaming and developing Personalisation (February 2011)

1. Building blocks in place by March 2011

'Does your council have an emerging new whole system approach to delivering adult social care underpinned by the principles of Personalisation?'

- Embedded vision for delivering transformed and personalised approaches - at the heart of all strategies and plans
- Commitment at all levels of the organisation to the ongoing transformation of services which lead to greater choice and control and better outcomes for users and carers.
- Agreed high level operating model for self directed support
- Robust partnerships with user and carer organisations which can deliver ongoing co-production, quality assurance and innovative services
- Constructive partnerships with providers which are shaping and developing the market
- A re-ablement service either in place or being rolled out
- A method for delivering an upfront allocation of resources e.g. RAS
- Staff and partners trained in self directed approaches to assessment, support planning and review
- SDS policies and processes reviewed jointly with safeguarding leads – positive risk taking policy in place
- A universal information service which can offer advice and signposting to the wider public and assist people to find their own solutions
- Good partnerships with health and other sections of the council that streamline responses to the public and provide opportunities to maximise independence, choice and control

2. Next steps – up until March 2011

'Does your council have a resilient plan for mainstreaming this work into the future?'

- Review and evaluate transformation work streams
- Sign off completed streams and allocate ongoing accountability for mainstreamed work
- Identify areas for further work and either integrate into ongoing transformation plan or carry forward project where capacity and resources are allocated
- Health check on culture change – are we doing things differently, are users empowered and in control, is it making a difference to people's lives
- Celebrate and publicise success !

3. Medium Term Plan for Ongoing Transformation from March 2011

'Is your council refreshing and re-invigorating your transformation programme to ensure it is fit for future challenges?'

Think Local, Act Personal -

' The principles of Personalisation remain at the centre of change, underpinning a leaner, more outcome focused and outward facing role for the public sector. The overall aim is to secure a shift to a position where as many people as possible are enabled to stay healthy and actively involved in their communities for longer and delaying and avoiding the need for targeted services. Those who do need help, however, should have maximum control over this, with the information means and confidence to make it a reality.'

Operating systems

- Review and refine SDS process to maximise efficiencies
  - implement information and advice strategies to help people to help themselves wherever possible
  - maximise capability to advise and signpost the public at the front door
  - integrate front door customer services and re-ablement in the end to end operating model
  - focus social work time on key statutory functions and complex cases
  - develop external support planning and brokerage services
  - reduce handoffs and transactions
  - simplify and reduce processes and paperwork
- Develop a flexible SDS system which allows users reasonable discretion at all stages on the journey
- Ensure that carers assessments etc are included as part of the operating model

- Use outcomes focused approaches throughout the SDS process and ensure that there is a system in place for evaluating user outcomes and feeding these into quality assurance and commissioning plans
- Risk management – implement positive risk taking strategy with relevant training for staff and support for service users.
- IT – review and amend the business process of your client IT system and use opportunities to commission systems which can service your operating model
- Put in place simple measures for monitoring the progress of the rollout of Personal Budgets
- Adopt a budget model which measures changing pattern of costs e.g. impact of re-ablement, at different points of the operating model. It should also reflect user preferences and changing patterns of provision.
- Identify further opportunities to streamline all back office processes e.g. pre payment cards, simplified charging policies
- Detailed operating model adopted as the mainstream and old systems switched off/deleted

Universal approaches

- Progress further the integration of health and social care commissioning and processes to reduce duplication, intervene earlier and improve user outcomes
- Join up preventative approaches to avoid hospital admissions
- Link more closely with private and social housing providers to improve options for increasing independence
- Work with partners to support community networks and improve public access to community resources
- Link with key partners to ensure that information on support and services is widely available in the community

Market place

- Continue to develop open and ongoing communication with providers to bring greater diversity and quality to the market including introduction of small scale and micro providers
- Work to ensure a changing offer from providers which is more flexible and personalised including residential care
- Gather and utilise market intelligence to develop market position statements which can be used to shape and develop the market
- Embed co-production in all approaches to developing new services to ensure commissioned services meet people's identified needs and aspirations
- Embed outcome based approaches in contracts with providers

Targeted support for particular groups

- Prepare systems and support to meet the increasing use of direct payments by those eligible for a Personal Budget.

- Mobilise people's own resources and those of their communities more effectively
- Use third parties to assist with support planning (families, ULOs Third sector etc)
- Embed an SDS approach and use indicative budgets in the transition for children
- Link more effectively with Mental Health Trusts to ensure that users of mental health services access Personal Budgets and more personalised services
- Deliver a whole family approach which supports families in an integrated and flexible way to ensure that carers are not pushed to breaking point

Workforce

- Develop workforce strategies which service the requirements of the new leaner operating model
- Focus council resources on areas that legally require local authority involvement
- Support the development of new types of worker including personal assistants
- Support all providers to work in a way that provides flexible and personalised support

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