Full Business Case for the Adults and Communities Transformation Programme

Purpose
The purpose of this document is to present a benefit case for the business transformation of the Adults and Communities directorate and define the programme that will deliver the transformation in order to seek support in the form of funding for the first three years of the transformation of the Adults and Communities Directorate.
By signing this document the signatories below are confirming their acceptance of the detail contained within this document.

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1. Executive Summary

This Full Business Case builds upon the Outline Business Case, presented in September 2007, for the Transformation of the Adults and Communities Directorate. This continuation of that work within this document allows for the expansion and analysis of initial OBC concepts, the development of the required 'models' to articulate the 'transformed' service and the appraisal of the financial impact to the Council from the implementation of the programme.

The FBC has been structured to present the following story:

- Introduction and background to the programme;
- The **Drivers for Change** created by the demographic predictions and the financial and budgetary pressures and changing customer expectations;
- The transformation vision which sets out the **Future Operating Model (FOM)** which articulate the span of capabilities required for the entire Directorate , and the **Service Delivery Model (SDM)** which articulates the flow of citizen activities within the new access channels and team structures required to meet demand;
- The **Delivery Approach**, which outlines the Programme Scope and Plan for the delivery of the projects required for the transformation;
- The **Business Case** including the anticipated costs and benefits associated with the programme.

1.1 The Drivers for Change

There are significant pressures upon the Council to 'transform' its operations. These pressures are coming from three main areas:

Citizens: regardless of their eligibility for funding, want to experience independence, wellbeing and dignity through greater control over their care and support and getting the right services at the right time rather than relying on intervention at the point of crisis.

Workforce: *'Putting People First: A shared vision and commitment to the transformation of Adult Social Care',* and *'Local Authority Circular: Transforming Social Care'* released in 2007 and 2008 respectively, builds upon the White Paper by setting out the desired shared values, aims and objectives which the government proposes will be required to guide the transformation of adult social care.

Demographics (national and local): Projections of a 34% rise in over 85s in next 20 years. The ADSS 2004 review of Learning Disabilities predicted an increase in LD of 11% by 2011 and 17% by 2027.

Faced with these drivers for change, the directorate has a number of options:

1. Maintain current budget – Raise eligibility criteria and provide services to only critical service users and disregard self funders.
2. Fund the demographic projections – BCC projection suggests an additional £270m funding requirement over 10 years. This does not include projections for asylum seekers, "other adult services" and service strategy, which account for £34m of the current budget. Work by the LSE assumes a higher starting budget, includes these elements, and results in an additional 10 year funding requirement of £500m. A direct comparison with the BCC projections is not possible, but the LSE work does suggest additional funding will be required.
3. Transformation – Increase capability to meet growing demand by up to 50%, improving services to self funders and increasing community capacity. This will result in an estimated

saving of £230m against the BCC demographic projections. This will still require an increase in year on year funding to maintain current levels of services.

It is therefore clear that there is a compelling case for transforming the Directorate in order to ensure the predicted scenario of higher costs of care for a smaller number of higher need citizens does not materialise.

1.2 Transformation

The transformed vision for the Directorate is built upon 2 models:

- The Future Operating Model; and
- The Service Delivery Model.

The Future Operating Model was presented as part of the OBC and outlines the key components (strategic, managerial and operational) required from the Directorate in order to respond to the predicted challenges.

Incorporated within this model was a requirement to transform the way the Directorate delivers services to citizens and engages with them. This new approach is articulated by the Service Delivery Model.

The transformed Service Delivery Model introduces;

- The identification of citizen vulnerability and assistance through predictive modelling;
- The capability of self care through a web enabled access;
- Initial support through a telephony based service;
- A level of brokered support;
- A specialist team supporting those citizens with high needs and high risk; and
- The presumption is that self directed care is available at every level.

The model is predicated on an assertive approach to enablement and rehabilitation. The model therefore seeks to 'shift' citizens upwards into the self care channel through rehabilitation and enablement.

1.3 How we will deliver transformation

In order to deliver transformation we will:

- Use greater choice and personalisation of services to drive out the inefficiency that is inbuilt within some of our current models of care. For example, current day care carries high fixed costs for very inflexible services;
- Use self assessment and greater information about services to influence the way that the citizen spends their own money on social care. It is probable the market will gravitate to high cost/revenue provision like residential care. We will need to open other choices for self funders that in turn widen access to more services for all;
- Develop approaches to using information intelligently to make proactive offers to citizens. For example using customer insight we can identify citizens who are providing informal care for their relatives and ensure that they are aware of the range of support services available. We want to start to be proactive rather than a service that is reactive to people at points of crisis;
- Have to ensure that enablement approaches are used to reduce the costs that the individual or the city is paying for care, by maximising the ability of the citizen, such as making greater use of enablement in home care to improve functioning at home. Our use of intermediate care in the new care centres needs to show evidence of improved functioning for citizens and a reduced demand for high cost care; and

- Have to encourage a more proactive approach to assistive technology so that we can improve the support to people at home and provide the reassurance to their carer. For example, citizens using new technology at home can adapt these systems to increase the care support available them and to include vital monitoring data for health care needs.

These routes to transformational change are sometimes untested and the lack of a significant evidence base reflects that we have never lived in a society with more people of older than working age. The impact that this has on our economy as a city and on the need for greater capacity for communities and citizens to be involved in their own care is profound.

The scale and nature of this change has risk. The LSE's analysis shows the significant risk of a standstill position, where demand will soon rapidly outstrip the resources available. There are major risks to the council from the impact of choice and self directed care upon the "provider" services that it runs. The council also faces growing discontent from self funders about the financial burden imposed upon them combining with a lack of significant support services.

1.4 Outcomes from transformation

The transformation is designed to provide the following outcomes for the citizens and staff of the Council:

- Citizens have control of their care;
- Preventative activities ensure citizens remain independent for longer;
- Predictive activities ensure citizens and targeted communities remain independent for longer;
- Citizens are better able to manage their own care through advice and advocacy reducing numbers requiring specialist services;
- Citizens have access to quality information in order to make informed decisions about their care;
- Citizens can self assess in order to identify their needs as they perceive them;
- Increase in the choice of services and providers for citizen;
- Swifter access to services for citizens;
- Enhanced skills for care workers and associated staff;
- Increased joint operational synergies between Health and A&C;
- Increase in range of diverse workforce skills and competencies**;** and
- Care workers are able to focus on implementing individualised services.

1.5 The Delivery Approach

In order to deliver the transformed Directorate, an initial 3 year programme of work will be undertaken.

The programme of work has been divided into the themes below:

- Service Delivery Model – prediction, prevention, enabling support and self-directed care; and
- The remainder of the FOM – develop services, commissioning and internal capability.

These themes are further broken down into individual projects which can be classified as follows:

Foundations: are a precursor to the delivery of the Future Operating Model and lay down the environment in which the transformation projects will be built.

Development Transformation Projects: The projects covered by this grouping have been themed to indicate which area of the Future Operating Model they contribute to.

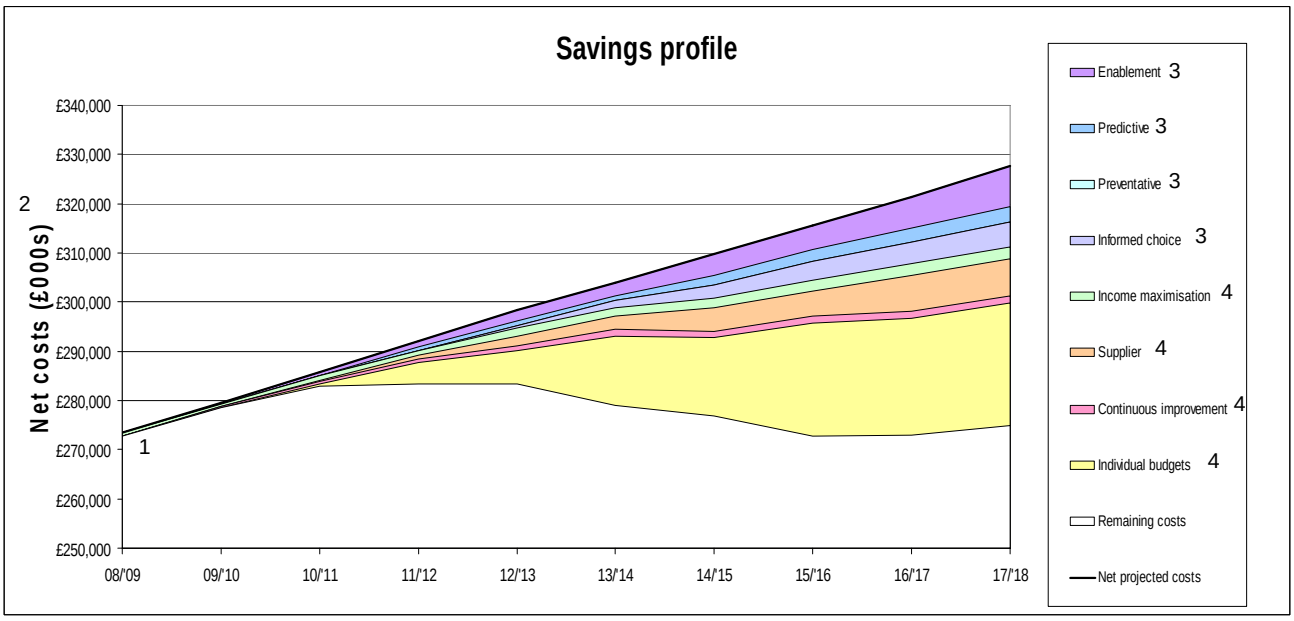
Defined Transformation Projects: are those which have already been identified for delivery or have proceeded to individual business case level.

Proof of Concept (PoC): is tool that can be used in either to confirm the level of benefit that can be delivered by a project or where roll-out of a solution has to be phased due to impact or complexity

1.6 The Business Case:

The programme includes initiatives to reduce the demand for services, decrease costs and exploit the additional sources of income and funding.

Because there is little empirical data to establish benefits, a set of models have been developed to project these benefits, which have been signed off by the management of the Directorate. The figure below shows the profile of these potential benefits over a period of 10 years against a top line projected cost relative to the demographic projection outlined earlier in the document.



Note 1: Budget for 2008/9 is £273.5m

Note 2: All costs are net after consideration of income

Note 3: Non-cashable benefit

Note 4: Cashable benefit

Note 5: Figures on 2006 / 07 basis, uplifted for inflation less an efficiency allowance

Figure 1: Savings profile

The 10 year programme affordability projection is shown below based upon the savings profile above and costs estimated for the 3 year programme and the ongoing maintenance.

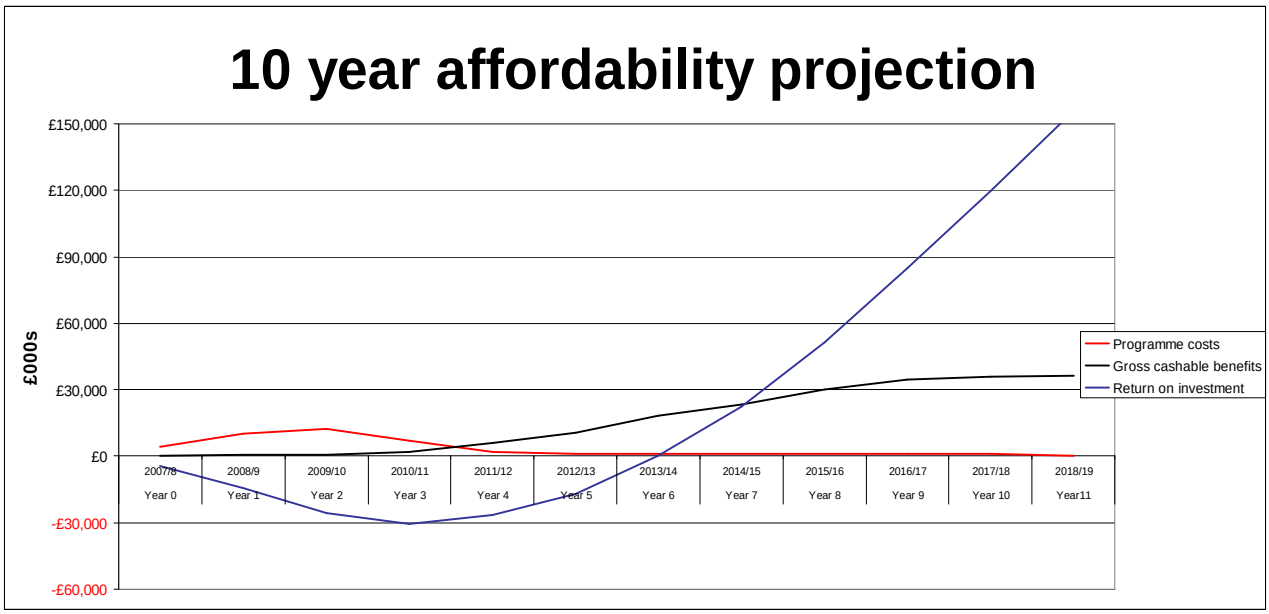


Figure 2: 10 year affordability projection

The transformation programme is based upon a strong business case showing a financial pay back during year six.

We are looking for approval of this Full Business Case, which will put Adults and Communities into a major transformation programme that will need to be aggressively pursued.

In delivering this programme the Council will be seen as implementing a cutting edge transformation programme putting Birmingham in a position to shape the CSR 2011/2012.

2. Introduction and Summary

2.1 Purpose of the document

The purpose of this document is to present the Full Business Case (FBC) (Phase Two of the Transformation programme), for transforming the Adults and Communities Directorate (the Directorate) over a ten year period, reaching maturity in 2018.

This document builds upon the Outline Business Case (OBC) from Phase One of the programme, and as such, should be read as a continuation of the principles established in that document.

This document will present:

- The background to the transformation programme (para 2.3);
- The need for change (para 3.2);
- The transformed directorate, including the Future Operating Model (FOM) and the Service Delivery Model (SDM)(section 4);
- The associated benefits to the Council (para 4.9);
- The approach to be taken in delivering the transformation programme (section 5); and
- The business case (section 6)

2.2 Summary of the Adults and Communities Transformation Programme

DMT developed the following vision for the Directorate during the OBC:

'We exist to assure the quality of life for the citizens of Birmingham today, tomorrow and always'

Reforming the Directorate to achieve personalisation for all citizens will require a huge cultural, transformational and transactional change in all parts of the local health and social care system. The challenge will be to translate the vision contained in the OBC into practical change on the ground to make a real difference to the way individuals engage with services and support and, in so doing, make a real difference to their lives. It will also mean changes in how professionals engage and work to support people's needs.

Transformation for the Directorate must deliver:

- 3% cashable efficiency savings assumed for 2008/9- 2010/11;
- A plan for greater individual control and choice – a different relationship between the council and its citizens;
- A resource analysis on getting the best outcomes from the spend of citizen and council; and
- A cutting edge transformation programme putting Birmingham in a position to shape the CSR 2011/2012.

The aim of the programme is to "maximise the quality of life outcomes for the minimum cost" (public or private £).

To achieve this aim the transformed Directorate must strive to provide a tailored service blending the following key ingredients:

- State funded care;
- Informal care;
- Self purchased care; and
- Community based capabilities.

2.3 Background

The transformation programme was established in April 2007 and completed Phase One in September 2007 with the sign off of the OBC.

The OBC sets out at a high level the scope for change, the FOM for the Directorate, a proposed programme delivery option and plan, associated costs and benefits, risks and dependencies.

The FBC has taken the principles and 'case for change' established by the OBC and built upon them in order to deliver a detailed case for the transformation of the Directorate.

Dependencies with existing and future transformation programmes have also been identified as part of the production of the FBC. Important communication links have been established with other programmes in order to promote meaningful dialogue on the ownership and responsibility agreements surrounding benefits linked to such dependencies.

During the FBC process, the Directorate Management Team (DMT) have been involved in the design and development of the Service Delivery Model and business case.

3. Imperative for Change

3.1 Introduction

The purpose of this section of the document is to set the scene as to the imperative for change which underpins the necessity and desire to transform Adults and Communities services in Birmingham.

This will involve presenting the:

- Customer requirements (para 3.2.1);
- Citizens imperative for change (para 3.2.2);
- Efficiency and demographic imperative for change (para 3.2.3); and
- Workforce imperative for change (para 3.2.4).

3.2 Need for Change

There are multiple internal and external factors which create the imperative for change within the Adults and Communities Directorate.

3.2.1 Customer requirements

Building upon the consultation undertaken as part of the OBC, further desk top research was carried out for the FBC identifying additional needs, wants and preference statements for a variety of customer groups, with the purpose of identifying their requirements from the transformed directorate.

A range of customer groups were identified as having a call upon the Directorate over the next 3, 5 or 10 year timeframe. Table 1 shows the customer groups who formed the priority group for the initial phase of transformation (“The 3 year customer groups”).

The 3 Year Customer Groups			
Citizens	**Regulators**	**Referrers**	**Decision Makers**
Carers for adults	**CSCI/ Care Quality Commission**	**Carers for adults as Referrers**	**Chief Executive's Directorate**
Citizens currently using services		**Citizens currently using services as Referrers**	**Resource and Support Directorate**
Citizens who will use funded services in the future		**Family and friends as Referrers**	**Department of Health**
Citizens who will self fund in the future		**Professional Referrers**	**Service Birmingham**
Hard to reach groups			

Table 1: Customer groups

Following the prioritisation of the customer groups, the customer requirements were derived from analysing relevant source documentation containing different customer group needs, wants and preference statements. This enabled information to be collated into themes which formed prioritised Customer Requirements (see product 4: Customer Requirements), for the purpose of ensuring that the Directorate customer requirements are woven into the planning and programme design process for the transformation programme going forward.

The customer requirements for the initial phase of transformation are as follows:

- Access to affordable, convenient and reliable transport;
- Being able to manage my own resources and affairs;
- Being able to mix, meet and be with other people;
- Being heard and having a voice;
- Being recognised as an individual;
- Being responsible for myself;
- Being supported to fulfil my caring role;
- Being treated with respect;
- Care and support which is tailored for me;
- Choice and control;

- Communication and information is responsive to my personal preference;
- Equitable provision for all;
- Feeling good about myself;
- Safeguarding;
- Feeling well;
- Having choice and access to good quality accommodation;
- Making best use of my resources and maximising my income;
- My needs are proactively and effectively understood and supported;
- Opportunities for personal development;
- Proactive and effective service responses; and
- Well coordinated care.

Table 2 below outlines the strategic partners which the Directorate will need to engage with to deliver the transformed services, as well as market shaping partners in order influence the whole social care market.

Strategic Partners			
Chief Executive's Directorate	**Resource and Support Directorate**	**Service Birmingham**	**Housing Directorate**
Department of Health	**Private Sector Providers**	**Public Sector Providers**	**Voluntary & 3rd Sector Providers**
PCT (commissioning)	**Joint Commissioning**	**Birmingham Strategic Partnership**	**Investors**
Market Shaping Partners			
Private Sector Providers	**Public Sector Providers**	**Voluntary & 3rd Sector Providers**	**Investors**

Table 2: Strategic partners

3.2.2 The Citizen imperative for change

People are living longer and communities are becoming more diverse and citizens have higher expectations of the services they receive. Citizens, regardless of their eligibility for funding, want to experience independence, wellbeing and dignity through greater control over their care and support and getting the right services at the right time rather than relying on intervention at the point of crisis.

The present customer experience, both at the national and local level, shows a picture whereby a significant number of those requiring some form of social care (and their families and carers) cannot navigate their way around the system or have been blocked at various points along the way from getting what they need or are entitled to. These challenges are compounded in the cases of citizens who fund their own care and those citizens who do not have financial resources but do not meet the criteria for support and are left to navigate the system without any professional input – often at a time of change and considerable personal upheaval.

3.2.3 The Efficiency and Demand imperative for change

There is an increasing pressure on the Directorate to deliver better outcomes with fewer resources. This need for greater efficiency is driven by a number of factors:

3.2.3.1 Financing

The Comprehensive Spending Review (CSR) has allocated the Council 1.5% of growth plus 3% efficiency gains p.a. for the next three years

This therefore requires the Council to deliver 3% cashable gains per annum.

3.2.3.2 Demographics

During 2007 the London School of Economics (LSE) undertook a 'Birmingham Strategic Resource Analysis' (see LSE report). This study established a context for this document, as it outlined the need for change. Although the modelling supporting this document is not the same as that carried out by the LSE, and as such direct comparisons cannot be made, the two approaches are broadly in line. The output of the LSE work is however more pessimistic than the current modelling and the extent to which this is real adds to the imperative for change. LSE anticipate the following significant pressures on the future affordability and costs of social care within Birmingham:

- The needs distribution in terms of 'Activities of Daily Living' (ADL) of citizens in Birmingham over the age of 65 was significantly higher in 2007 than the England average.

- Office of National Statistics projections of Birmingham population growth (baseline 2007) suggest numbers of older people will grow at a much slower rate than the England case. Projections of a 34% rise in over 85s in next 20 years (half the England total growth rate). This may be due to expected net migration of older people out of cities (most likely those who can afford to fund their own care).

- The Association of Directorate of Social Services (ADSS) 2004 review of Learning Disabilities (LD) predicted an increase in LD of 11% by 2011 and 17% by 2027

- LSE study included Mental Health (MH) and Physical Disabilities (PD) 20 – 64 age cohort, however it is acknowledged that LD, PD and MH categories are more difficult to predict as they are more susceptible to factors such as immigration and random accident rates than older people studies which are based upon more predictable inputs and outputs,

- Without limits, demographic demand pressures would increase expenditure by 2.7% p.a. in real terms to 2017 from the baseline £140m net public spend in 2007. Without transforming the Directorate, expenditure limits would need to be introduced and would be achieved through tightening of the eligibility criteria. The current thresholds of 100% of substantial and critical to would need to change to:
    - 70% of people in substantial band and all in critical (for a 2% expenditure limit)
    - 10% of substantial and all in critical (for a 1% expenditure limit)

As a consequence of changing the eligibility criteria. i.e. from substantial and critical to just critical, there would be a marked reduction in supported community-based care recipients (and hours of care) and an increase in unmet personal care need.

Therefore, if the Directorate does not transform, there would be a reduction in the number of citizens supported by the Council. For those that would remain eligible to receive funded care and support, it will remain to be focussed on intervention at the point of crisis as opposed to a more holistic, pro-active and preventative model centred on improved well-being. Whilst, for the increasing number of citizens who will have to fund their own care, advice and support in obtaining and managing their care provision and independent review of the services would be limited or non existent.

3.2.3.3 ***Projected change in expenditure***

As figure 3 overleaf shows, the base net public expenditure is £140m for 2007. However, spending is set to increase:

- In next 10 years (from 2007) by 30%
- in next 20 years by 63%, rising to nearly £229m.

The base year private expenditure is £129m, the bulk of which is in the care home sector. As with the public expenditure, private contributions are also set to increase substantially:

- Increase in 10 years: 26%
- Increase in 20 years: 78%.

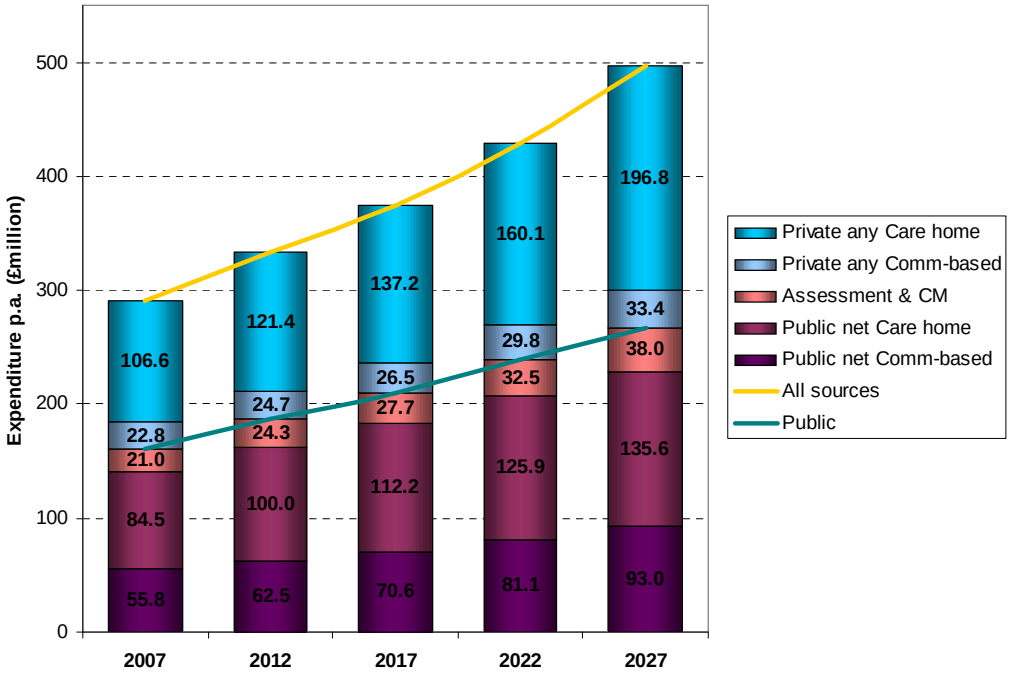


Figure 3: Changing need, wealth and unit cost assumptions – effects on projected net public expenditure in the future- real terms expenditure (2007 prices).

3.2.3.4 Total expenditure

With base case assumptions, the rate of growth of net public spend increases slowly through time with total expenditure showing an increasing rate of growth.

The proportion of total spend paid out-of-pocket increases from 48.0% to 50.2%. This includes

- Charges on Council supported care;
- Top-up payments on Council supported care; and
- Private purchase of care services.

This demographic pressure presents the Directorate and the Council with three choices:
1) Maintain current budget – Raise eligibility criteria and provide services to only critical service users and disregard self funders.
2) Fund the demographic projections – BCC projection suggests an additional £270m funding requirement over 10 years. This does not include projections for asylum seekers, “other adult services” and service strategy, which account for £34m of the current budget. Work by the LSE assumes a higher starting budget, includes these elements, and results in an additional 10 year funding requirement of £500m. A direct comparison with the BCC projections is not possible, but the LSE work does suggest additional funding will be required.
3) Transformation – Increase capability to meet growing demand by up to 50%, improving services to self funders and increasing community capacity. This will result in an estimated saving of £230m against the BCC demographic projections. This will still require an increase in year on year funding to maintain current levels of services.

3.2.4 The Workforce imperative for change

The move towards increased choice and control for citizens using adult social care service began more than ten years ago with the legislative introduction of Direct Payments in 1996. Since then, both policy and practice have moved towards choice and personalisation of services. The 2006 White Paper *'Our health, our care, our say'* set out the governments vision to reform and improve community services, through a genuine focus on prevention, independence, well being and choice. *'Putting People First: A shared vision and commitment to the transformation of Adult Social Care',* and *'Local Authority Circular: Transforming Social Care'* released in 2007 and 2008 respectively, builds upon the White Paper by setting out the desired shared values, aims and objectives which the government proposes will be required to guide the transformation of adult social care.

The transformation agenda will influence and guide the changes required of the workforce in order to meet the challenges of the transformation. New models of care, moving from containment to enablement, outcome based assessments rather than needs and risk assessments, placing services around the citizen rather than attaching services to the citizen, mean that established practices, regimes and cultural ways of working will need to be broken down to meet the demands of the community.

The Local Strategic Partnerships and new methods of working to support enablement and prevention work, means cross organisation and inter departmental working will be a critical and required change of working practice to deliver personalised and outcome based services. The role of the community will also play a major role in the working arrangements. Also, the imminent introduction of the Comprehensive Area Assessment (CAA) introduces new Key Lines of Enquiry (KLOE) under the Use of Resource element of the CAA for which the Council will be assessed against.

The 2007 *Local Government Workforce Strategy* outlines five strategic priorities:

1. Organisational development – effectively building workforce support for new structures and new ways of working to deliver citizen-focused and efficient services, in partnership.
2. Leadership and management development – building visionary and ambitious leadership which makes the best use of both the political and managerial role, operating in a partnership context.
3. Skill development – with partners, developing employees' skills and knowledge, in an innovative, high performance, multi-agency context.
4. Recruitment and retention – with partners, taking action to address key future occupational skill shortages; promote jobs and careers; identify, develop and motivate talent and address diversity issues.
5. Pay and rewards – modernising pay systems to reflect new structures, new priorities and new ways of working and to reinforce high performance, including encouraging a total rewards approach.

There is a clear expectation for a range of process reengineering, capability building activities required to design the entire system, including work to:

- Change the social care system away from the traditional service provision with its emphasis on inputs and processes towards a more flexible, efficient approach, which delivers the outcomes people want and need and promotes their independence, well-being and dignity;
- Create a strategic shift in resources and culture from intervention at the point of crisis towards early intervention focused on promoting independence and improved wellbeing in line with the needs of the local population, reaching out to those at risk of poor outcomes;

- Ensure that citizens are much more involved in the design, commissioning and evaluation of services and how their needs are met. This choice and control should extend to individuals in every setting and at every stage; ranging from advocacy and advice services, prevention and self-management to complex situations where solutions are developed in partnership with professionals;
- Remodel systems and processes so they are not only efficient and equitable but also recognise the ability of individuals to identify cost effective, personalised solutions through wider community networks and innovation;
- Join up services to provide easy to recognise access points and care pathways, which coordinate or facilitate partner organisations to meet the needs of individuals. Systems should be put in place to identify hard to reach people and strategies developed to meet their needs;
- Raise the skills of the workforce to deliver the new system, through strengthening commissioning capability, promoting new ways of working and new types of worker and remodelling the social care workforce; and
- Develop leadership at all levels of local government and communities to enable this change to happen.

3.3 Summary

The Directorate is faced with a range of internally driven and externally imposed challenges which require it to fundamentally change the way it engages and delivers services to its citizens. Based upon the consultation, research, evidence and forecasting carried out, the 'do nothing' option is not viable. In order to meet the Customer Requirements established in para 3.2.1, the citizen expectation of choice and personalised budgets, and avoid the demographic and budgetary pressures which would force the Directorate to concentrate solely upon critical need citizens in the near future, the Directorate must transform its entire operations and services.

Nationally it is recognised that transformation on this scale is challenging, requiring a strategic shift. Putting People First, the concordant published in December 2007, established a set of shared aims and values between those agencies involved in the regulation, provision and use Health and Social Care services. These aims and values form the foundation for transformation in the Directorate Vision and Strategy and, in turn, the FOM and the Programme Delivery Options developed during the FBC. The FBC therefore is not a case for change, challenging demographic factors, budgetary pressure and changing community needs have forced the case. The FBC articulates how the Directorate proposes to rise to the challenges over the next 3, 5 and 10 years.

The necessary transformational requirements are presented in the next chapter.

4. Transformation

4.1 Introduction

The purpose of this section of the document is to set out the transformational vision for the Directorate.

This will involve presenting the:

- Future Operating Model (FOM) for the Directorate (para 4.2);
- Future Service Delivery Model (SDM) including the purpose of the model, an overview of the model and narrative to support the principles (para 4.5); and
- Benefits to be delivered by the SDM.

4.2 10 Year Future Operating Model

The FOM presents a holistic view of all the functional and strategic elements required to meet the future needs of adult social care in Birmingham. It defines the model for the Directorate that will be in place by 2018. Inspired and driven by the DMT's vision for the Directorate, the FOM outlines the blueprint for the future success of the Directorate as it moves forward. The FOM is constructed around the development of key roles and capabilities that the Directorate needs to have in order to deliver the outcomes expected by the citizens of Birmingham. Moving to this new way of working will require clear communication of new roles and responsibilities within the new Directorate, often supported by investment in training and recruitment.

The FOM sets out the composition and operation of the entire Directorate that will deliver the desired outcomes and ultimately the vision.

Further detail to the Services and Customer Interaction elements of the FOM are provided through the SDM, para 4.5. It should be noted therefore that the FOM represents the functions of the entire Directorate, including the strategic functions, whilst the SDM focuses upon the services and customer elements as represented by figure 4.

4.2.1 Design Principles

The design principles for the FOM outlined below articulate the core requirement for the sustained delivery of the model over a number of years. In developing these principles due consideration has been given to factors both internal and external to the Directorate and central to the citizen.

- The FOM will enable the Directorate to adopt a market shaping role for the overall provision of adult social care across Birmingham;
- The Directorate will provide leadership and direction to the social care economy;
- The SDM will be based on giving choice, control and accountability to citizens;
- The Directorate will have in-built flexibility to enable it to respond to changing requirements from citizens and partners over the long term;
- The FOM will allow the Directorate to meet any statutory duties;

- The Directorates operations will contribute to citizens outcomes in partnership with other providers;
- Service provision will be individualised to meet the specific needs of a citizen;
- The Directorate will continuously improve services over time;
- Business Support functions must be aligned to support organisational delivery; and
- The organisation will be built around citizen needs, not internal structures

4.2.2 The Future Operating Model

The operating model shown below in figure 4 presents a holistic view of the future of adult social care in Birmingham.

The FOM is represented as an 'organisational system'; it comprises six key parts that are dependent and inter-dependent on each other and the whole. The Directorate model is presented below showing the holistic components of the organisation:

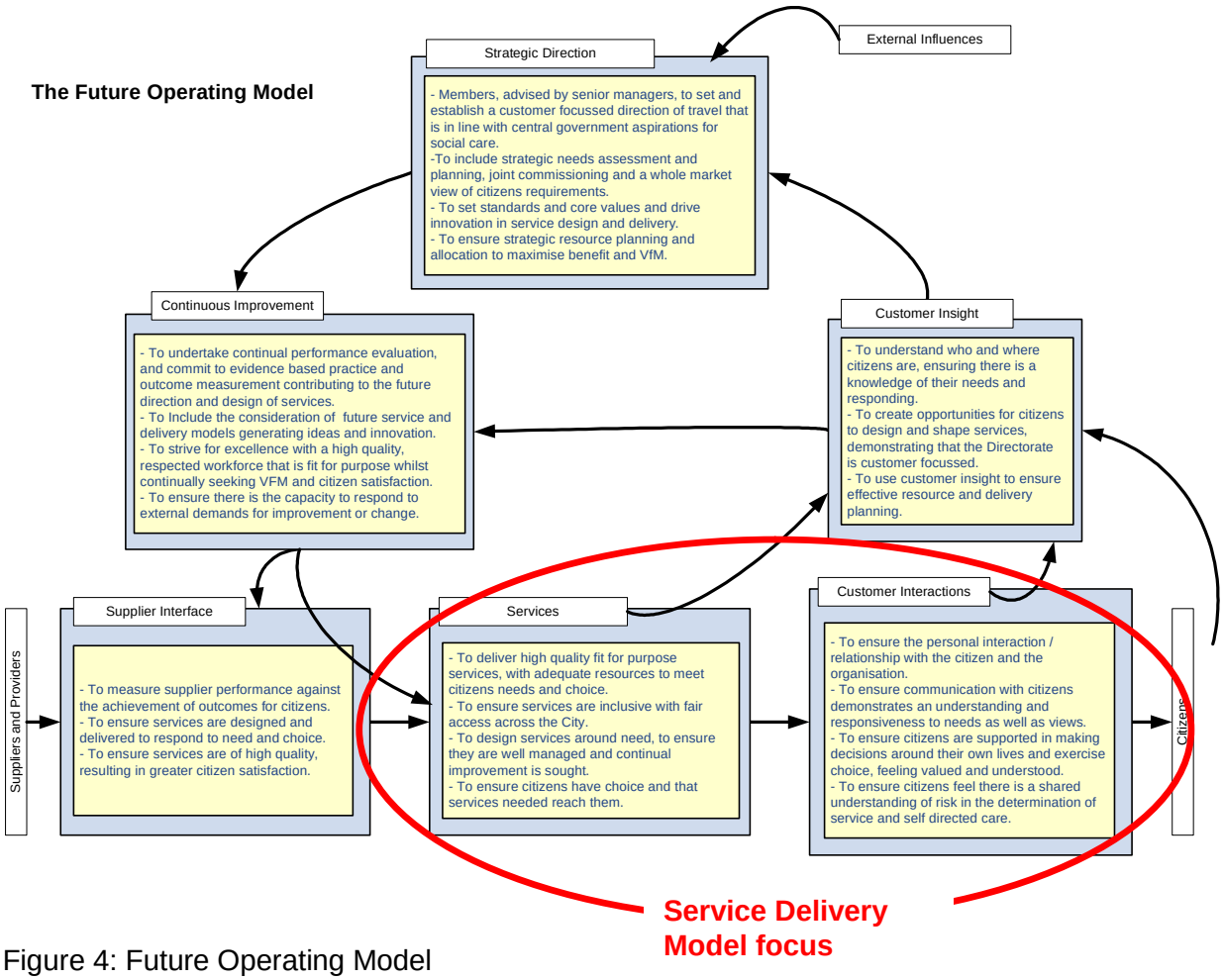


Figure 4: Future Operating Model

4.2.3 Organisation Roles

There are nine organisational roles that sit across the FOM. These roles are the core interdependent functions that make the system work. Figure 5 shows the Directorate as an organisation with key roles identified and mapped against the system as a whole. Although these roles are anchored in one area of the organisational system they will inevitably impact on the whole system. These represent the structured approach to designing the FOM and become the location of capabilities.

The roles are as follows:

- Shaping the place and the market;
- Providing leadership and direction to the social care economy;
- Managing continuous improvement;
- Assessing strategic need;
- Assuring the quality of services and delivery of outcomes;
- Attracting and managing resources effectively;
- Delivering services (internal and external);
- Safeguarding vulnerable citizens; and
- Empowering citizens to make informed choices.

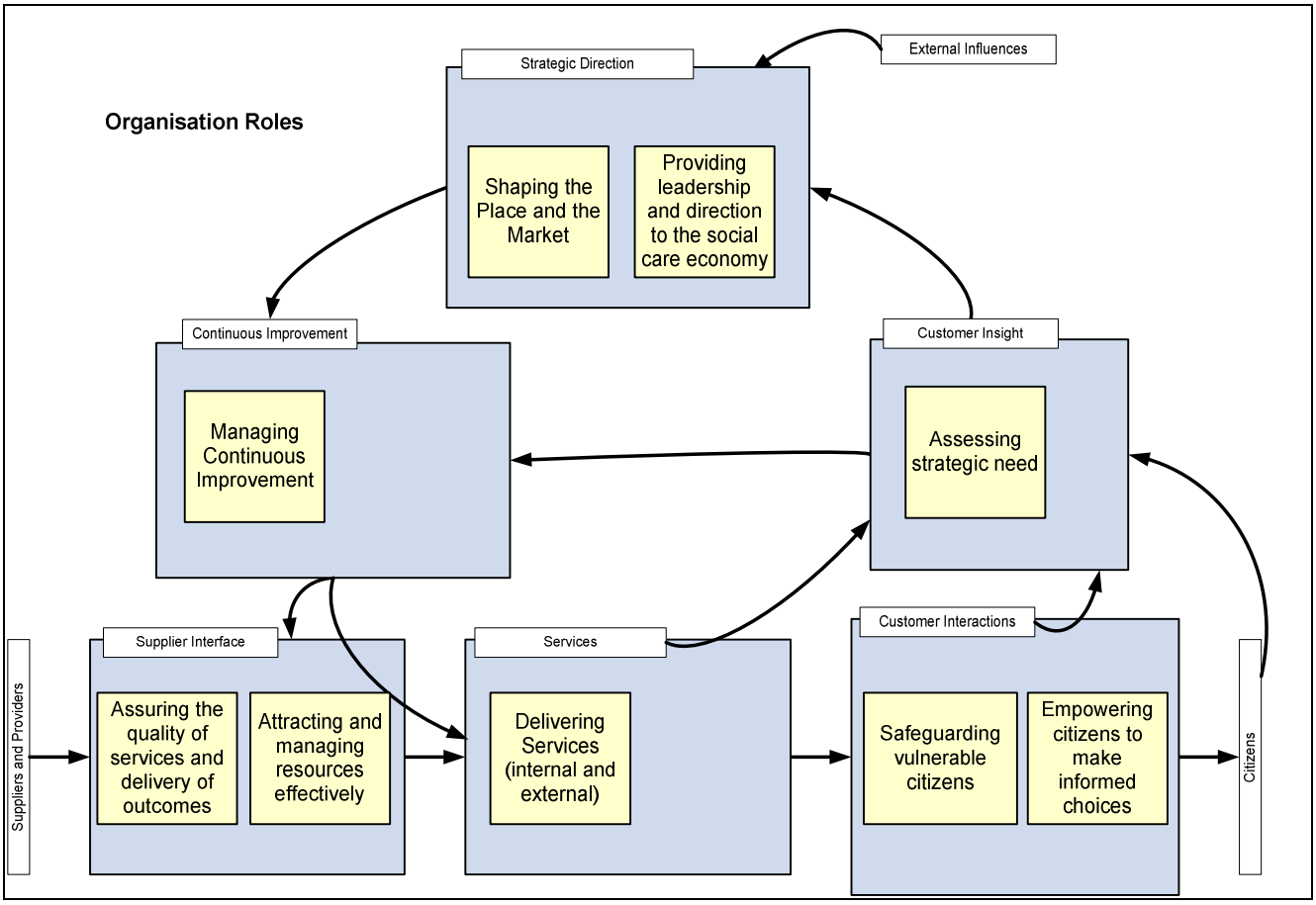


Figure 5: Roles within the FOM.

4.3 Outcomes

Turning the FOM into a reality will result in outcomes being delivered to citizens in terms of independence, well being and choice.

The Directorate has determined and detailed a series of outcomes which will be delivered by the FOM. The outcomes outlined below have been constructed at a level to ensure there is recognition and inclusion of all the necessary drivers, for example; the Department of Health's White Paper 'Our health, or care, our say' and the Councils five corporate strategic objectives.

- Citizens have control of their care;
- Preventative activities ensure citizens remain independent for longer;
- Predictive activities ensure citizens and targeted communities remain independent for longer;
- Citizens are better able to manage their own care through advice and advocacy reducing numbers requiring specialist services;
- Citizens have access to quality information in order to make informed decisions about their care;
- Citizens can self assess in order to identify their needs as they perceive them;
- Increase in choice of services and providers for citizen;
- Swifter access to services for citizens;
- Enhanced skills for care workers and associated staff;
- Increased joint operational synergies between Health and the Directorate;
- Increase in range of diverse workforce skills and competencies; and
- Care workers are able to focus on implementing individualised services.

4.4 Measures of Success

In order to ensure that the FOM delivers the desired outcomes, it will be necessary to measure success across a range of criteria. The full measures of success criteria are available in product 5: Measures of Success, and summarised below:

- Authentic partnerships with Corporate Directorates, local NHS, other statutory agencies, third and private sector providers, users and carers and the wider local community;
- Agreed and shared outcomes ensuring citizens, irrespective of potential funding stream, need, illness or disability, are supported;
- Development and ownership with local partners of a Joint Strategic Needs Assessment (JSNA);
- Shaping the market to meet the personalised agenda whilst balancing investment in prevention, early intervention/re-ablement and providing intensive care and support for those with high-level complex needs;
- Locally agreed approach, which informs the Sustainable Community Strategy, utilising all relevant community resources especially the voluntary sector so that prevention, early intervention and enablement become the norm;
- Supporting citizens to remain in their own homes for as long as possible with the alleviation of loneliness and isolation as much as possible;
- Establishing a universal information, advice and advocacy service for people needing services and their carers irrespective of their eligibility for public funding;
- Sufficient availability of personal advocates in the absence of a carer or in circumstances where citizens require support to articulate their needs and/or utilise the personal budget;
- Implementation of a framework for proportionate contact and social care needs assessment to deliver more effective, joined-up processes with increased emphasis on self-assessment;

- Person centred planning and self directed care will be mainstreamed and define individually tailored support packages;
- Ensure personal budgets for everyone eligible for publicly funded adult social care support other than in circumstances where people require emergency access to provision;
- Effective and established mechanism to enable citizens to make supported decisions built on appropriate safeguarding arrangements; and
- Market development and stimulation strategy, which outlines actions identified to deliver the necessary changes.

4.5 The Service Delivery Model

Building upon the FOM, the Service Delivery Model (SDM) expands into further detail the component parts of the FOM around Services and Customer Interactions. The full SDM is presented as a 'flow' of activities, events and functions held in Appendix 1. The narrative to support this flow is presented below in para 4.6.

4.5.1 Current Service Delivery Model

The current Service Delivery Model is shown below.

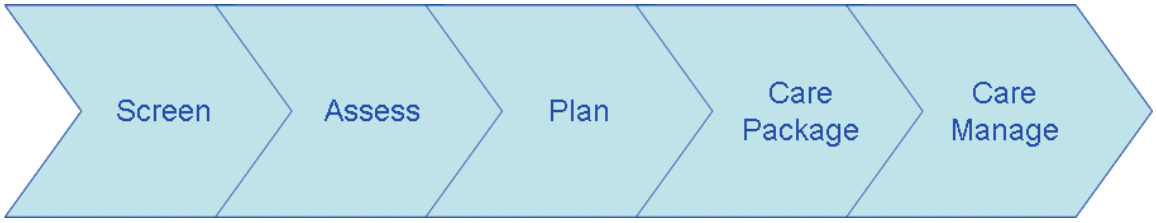


Figure 6: Current Service Delivery Model.

Citizens are screened for assessment then assessed for eligibility. Those who are eligible for care are provided with a care package based upon their presented need. This process is managed by a qualified social worker.

The Directorate is one of the four strategic directorates of the Council. The Directorate provides services to 30,000 citizens in Birmingham, it employs approximately 6500 staff and its budget in 2007/08 was £249m.

The Directorate is currently structured around four service areas:

- Older Adults;
- Vulnerable Adults;
- Policy Strategy and Commissioning; and
- Finance & Resources.

For the 2007 Annual Performance Assessment undertaken by CSCI, the Directorate were given an overall rating of 2 stars. The Directorate was judged as having a 'good' contribution to the delivery of outcomes to citizens, whilst being judged as having a promising capacity to improve. The initiation of the Business Transformation Programme was highlighted by CSCI as a key strength and as such has contributed towards CSCIs promising capacity to improve judgement.

The following work was completed as part of the As-Is review of the organisation, this information can be found in product 9: Adults & Communities organisation and services.

- Production of organisation charts detailing the current structure of the organisation and the numbers of staff in the current cohort (including headcount, numbers of full-time equivalents and numbers of vacancies);
- Summarisation of budget, actual expenditure, performance data and activity data for the financial years 2006/07 and 2007/08; and
- Compilation of services available to citizens including a brief description.

4.5.2 Reason for a new Service Delivery Model

The Directorate have set about a transformation programme to deliver change through reforming the provision of services, increasing the depth and extent of integration with both statutory and non statutory providers, reconfiguring access to services for users and carers through personalised care models.

The national agenda sets out a policy framework that encourages a vision for adult services to be outcome led and placing more emphasis on prevention and early intervention. As well as the user/ carer and partnerships, the policy and vision, by implication, demands the modernisation of the workforce. The challenge for the Directorate is to modernise, decentralising controls and reconfiguring services to support independence, choice and wellbeing, whilst remaining accountable for safeguarding those who are most vulnerable within society.

4.5.3 Self Directed Care

The SDM is based on a Self Directed Care approach that still provides appropriate levels of support throughout the customer journey as required by the citizen regardless of their funding mechanisms. Through information provision and advocacy, citizens and their carers will be able to exercise choice in the care to meet their needs, the provider of that care and how their care package is managed and by whom. The SDM will also ensure that citizens share the risk and responsibility for managing their own lives whilst ensuring that there is sufficient safeguarding in place to protect them and support them. Providing them with good information and advocacy will enable citizens to make informed decisions about their care needs and enablement will ensure they remain independent for longer. With citizens taking more responsibility for managing their own care this will free up the time of social care practitioners to focus on those citizens withmore complex or more demanding needs.

Self Directed Care and Individual Budgets will allow citizens to maintain control over their own life and the care they require in order to do that. The citizen's choice of service and service provider remains their own whilst at the same time the SDM allows citizens to make use of varying degrees of support as and when they require it.

The SDM will allow the same freedom of choice to all citizens and ensures that there is support available to citizens to enable those with higher degrees of need or more complex requirements the equal opportunity to manage their own care and make their own decisions. The safeguarding measures through the customer journey ensure that a citizen can lead as independent a life as possible with the security of knowing that their progress will be monitored and supported.

4.5.4 The New Service Delivery Model

The new SDM is constructed around 2 axis:

- The activities representing the care pathway; and
- The access channels and supporting capabilities available to the citizen.

4.5.4.1 The new care pathway

The new care pathway is made up of the following activities:

1. Pre-emptive (prevention and prediction): The SDM includes greater focus on prevention activities designed to deliver the wider well-being agenda and by making best use of information to run targeted early interventions. The intention for many citizens will be to prevent or defer the need for more costly intensive support and therefore promoting the quality of life of citizens and their engagement in their community.

2. Assess: Citizens will be able to complete their own assessment with support where required. As part of the self assessment process citizens will get an early indication of the level of resources for their need, which will assist with planning the support. The individual budget, however, will be verified at a later stage.

3. Plan: Planning will involve facilitating the citizen to plan their support to achieve the outcomes they want. It will build on the citizen's networks available in the community and considers the roles family / carers may play. Information on services will be available to assist in the decision making process as well as the ability to purchase services on-line. Different levels of help with planning, depending on personal circumstances and preferences, will be available from Council staff, independent support brokers, existing service providers, advocacy organisations, or peer support.

4. Implement: Individualised budgets will be available to all citizens who are eligible for funding and will be initially calculated through a resource allocation system as part of the self assessment process. Individual budgets will provide an upfront transparent allocation made up of multiple funding streams. including the citizens' own resources, different benefits, possibly NHS monies, and including other sources such as supporting people. By pulling all of these together the Directorate will be able to work with citizens to design a care plan that meets their needs. Crucially this will remove traditional rigid boundaries between services as the citizen will set out a holistic view of their requirements and the approach to meeting those needs.
5. Review: The review process will centre on how well the outcomes set out in the support plan have been achieved, and what has been learnt along the way. This will be a process undertaken as a partnership between the person and the reviewer. The review process will also become more targeted and proportionate to need, identifying those with greater risks to independence or wellbeing and undertaking more active monitoring and support. The monitoring of care packages will become more efficient with greater use of technologies with the ability to flag areas of concern where outcomes are not being met.

4.5.4.2 The new Access Channels and supporting capabilities

The delivery of the new pathway is through a range of access channels with supporting capabilities:

- Self care;
- Level 1 support;
- Level 2 support; and
- Specialist support.

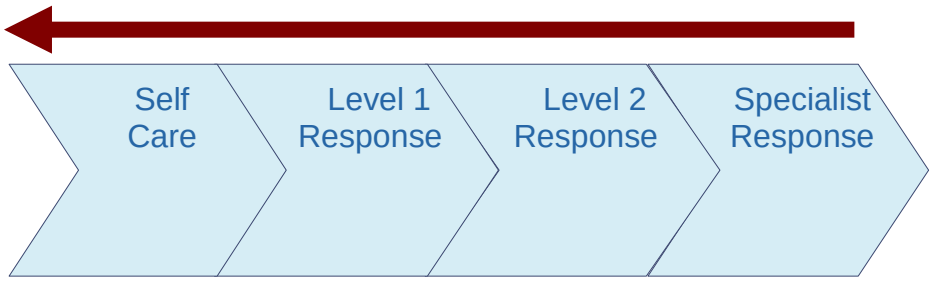


Figure 7: SDM capabilities

These access channels and supporting capabilities are described further below:

1. Self care: The SDM introduces the online capability (access channel) which allows citizens to manage and direct their own care services without recourse to social care practitioners.
2. Level 1 support: The SDM supports citizens through the online process through a contact centre support facility, where questions can be answered and support provided in completing forms or answering questions.
3. Level 2 support: The SDM provides the capability for an additional support layer to citizens, which can be provided through an external advocacy or brokerage role through a 3rd party or through the Directorate. This level of assistance can be either telephone based or face to face.
4. Specialist Support: The SDM continues to provide support for citizens with high needs and risk through fully qualified social worker input.

The model provides the capability, through 'channel shift' to allow a greater number of citizens to manage their own care with reduced 'Care Professional' input by operating as close to the self care channel as possible given their care needs and risks. This channel shift aims to create capacity within the Specialist Support care teams to support more citizens with 'specialist' needs and risks

A high level representation of the SDM is shown below in figure 8, representing the two axis and the intended direction of channel shift. The full detailed SDM is held in Appendix 1.

The significant feature of this new model of care is that it shifts the emphasis of care being provided to a few adults to a new model based on a universal approach. The Council will have to maximise its customer insight into all adult groups and ensure that its whole capacity is brought to bear on better information, earlier engagement and appropriate universal services aimed at a different population mix.

A key part of this universal approach will be to ensure that the Council is engaging with people much earlier about decisions they make using their resources which influence their future care. This then extends right through into shaping and influencing expensive self-financed care packages. However, without earlier engagement significant sums money identified by the LSE survey in Birmingham will largely enter a residential model of care which in itself poses significant financial risks to the City Council. Given the size and influence of the expenditure identified on private residential care it is easy to see how market shaping in the future may not be determined by Local Authority commissioning should it remain solely focused on those of highest need and lowest means.

This greater emphasis on a universal approach will have significant practical implications. The Council needs to identify in the design stage how it will use information and customer insight tools

and how it will ensure that it changes its approach to giving people information to be more linked to life stages than to the receipt of particular services.

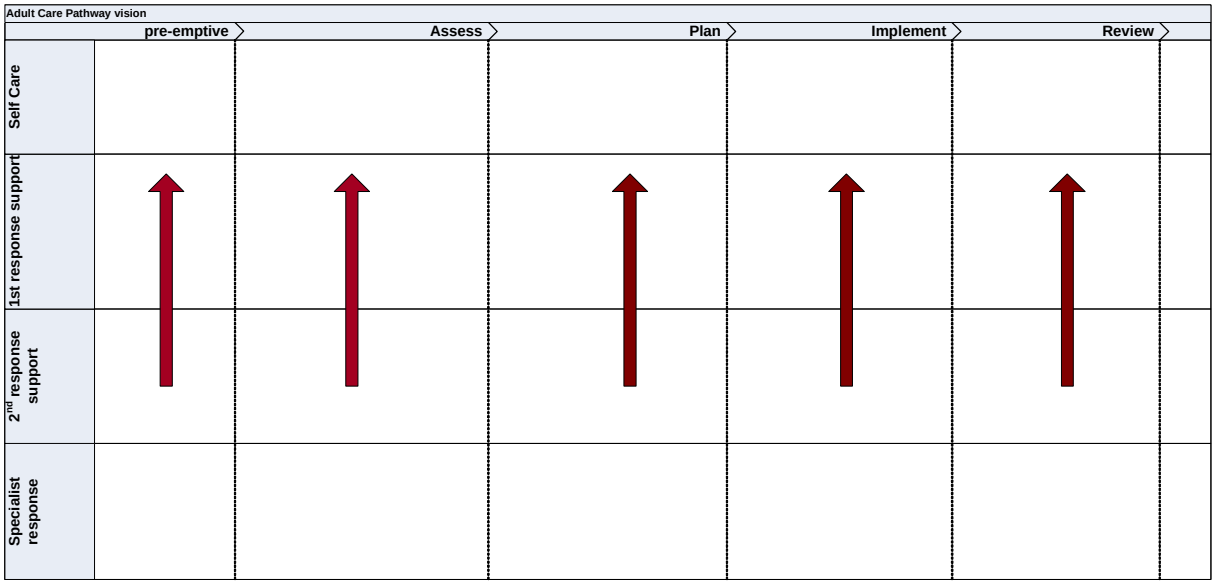


Figure 8: Service Delivery Model

4.5.5 Market Placing and Shaping

The FOM has determined that programme design options include activities to shape and build the provider market and the directory of services available. This will provide a wider choice of services and providers from which these services can be obtained. By driving the market and improving choice and competition it is anticipated that it will generate supplier savings.

In order to provide the choice of providers and services envisaged by the SDM there will need to be significant stimulation and shaping of the provider market. The programme has a number of activities defined within it to do this including working with PCT's and the 3rd Sector to develop partnerships and provider relationships.

Through the use of Individual Budgets and the policy governing them, the Directorate will maximise the contribution that a citizen makes to their own care. Additionally, by careful shaping of the market and the services provided, income can be generated from other sources (e.g. State benefits, DLA, Health benefits) to offset the cost of care. By encouraging competition and setting standards within the market place, the cost of care should fall whilst the standard and quality of care is controlled and improved.

With the implementation of Individual Budgets, market shaping and income maximisation the Directorate will be able to ensure and demonstrate value for money. The continuous improvement activity within the programme will seek to monitor performance and efficiency of the Directorate, service providers and the outcome of care plans to ensure that where necessary changes are made to improve the service provision and value for money for the citizens of Birmingham.

4.6 SDM narrative

4.6.1 What does the SDM represent?

The SDM held in Appendix 1 presents the high level process through which a citizen in the future would interact with contact points and professionals associated with delivery of personalised adult care services.

The model does not attempt to show how each domain within the present Directorate will operate, but rather represents a high level model which walks through the components of the new Adult Care environment. Detail design underpinning the model will be developed during the Common design stage of the programme.

4.6.2 Is this just a representation of how Birmingham City Council Adults and Communities will work?

The council will have to achieve a shift whereby it concentrates on all people who are requiring social care and how they can best meet their needs. This will require a focus upon community and individual capacity and capability.

This is an expansion of demand upon the service which has historically coped by working in a rationed and controlled environment. This approach will only be possible if the individual is enabled to play a greater role in directing the care that they require. This will in time allow citizens to define the way in which they use council, health and third sector services.

The model does not presuppose at any stage that the Council will be the sole agency engaged in delivery of personalised adult care services and self directed support.

4.6.3 How far in the future does the SDM represent?

The overarching principles and structures of the SDM will be in place within a three year period. It is then envisaged that this will grow to transform the entire service within a ten year period.

4.6.4 What are the principles of the model?

The model has been developed around the principles of:

- Effectively meet all statutory duties within an outcomes framework throughout the citizen journey;
- Maximising independence through proactive/preventative approaches including enablement and use of innovative technologies;
- Enablement for everyone to prolong citizen independence and minimise the cost to the state and individual;
- Self directed care with individualised provision
- Citizens will have greater choice, accountability and control;
- Citizens accessing services through channels which are suitable to their preferences and their lifestyles;
- An organisation built around citizen needs, not internal structures;

- The Directorate providing leadership in the health and social care economy, contributing to achievement of citizen outcomes delivered through partnerships; and
- The Directorate making a major contribution to sustainable communities.

4.6.5 What does 'effectively meets all the statutory duties within and outcomes framework' mean?

The SDM recognises that the Directorate has a number of duties around assessment and reviewing adult needs and are the lead agency with a statutory responsibility for the investigation of abuse and protection of vulnerable adults. The SDM recognises the role of safeguarding within preventative services and the need to ensure that the development of access points is based on an understanding of who and where vulnerable citizens are, and that systems, processes and staff development create and put in place measures to ensure safeguarding.

The SDM is designed to allow citizens to choose from a variety of channels how they interact with adult care services e.g. through web technology, phone contact and for people with a higher level of need through face to face support. Self directed care must both help individuals achieve the outcomes that they choose and allow the council to fulfil its statutory responsibilities. The interactions between these can be complex, given the right of adults with full mental capacity to make decisions .This will require sophisticated processes and staff skills that allow individuals to give full consideration to risk and how that can be reduced. The system needs to build the confidence of citizens to engage with the council in reaching these decisions.

The model introduces a new layer of proactive / preventative activities which take place before assessment and planning activities which will be designed to offer a new layer of safeguarding and opportunity to minimise risk of exposure to increasing future needs. Safeguarding is intrinsic within each stage of a citizen's journey through the process, and a repeated 'preventative' check which ensures that any factors or risks identified in any earlier activity are maintained and the citizen does not regress back into a higher risk category. Identification of safeguarding issues may trigger the citizen moving onto a greater level of support.

4.6.6 What does 'maximising independence through proactive/ preventative approach including enablement and use of innovative technological solutions' mean?

The SDM focuses upon prevention, early intervention and enablement. There will be a greater emphasis on working with citizens and enabling them maximise their independence and then determine their needs and how to meet these needs with maximum independence and choice.

Enablement will be both a design principle which underpins the SDM and a range of services available to support citizens to develop or rebuild skills and confidence necessary for every day living. Services will encourage citizens who have lost their skills for daily living, to re-learn them (or to acquire new skills), to build up their confidence and to enable them to be as independent as possible within their own homes. The overall objectives are to help citizens to remain living at home, to achieve maximum independence, to prevent hospital admissions (or re-admissions) and when appropriate, to reduce the level of care needed. Enablement will bring in best use of technologies to assist citizens in daily living, keep people safe in their own home and promote their independence.

Enablement has a hard edge – there is a continual requirement to ensure that the costs of care packages (regardless of how they are paid for) are minimised in order to get the best use out of scarce resources. Enablement will also help drive some of the market shaping – for example it should lead to self funders considering home based support rather than residential options.

Enablement/prevention checks throughout the SDM will ensure that there is ongoing monitoring and review of citizens and that their needs are being met, and in turn, outcomes being realised at all stages along the pathway. These checks may result in additional or alternative solutions being recommended to the citizen if their needs have changed or are not being met. Interventions required may be in the form of an intensive enablement support package, longer term preventative measures or some other change to the individual care plan.

4.6.7 How does 'Citizens will have greater choice, accountability and control' work?

The SDM is based on the principle that all citizens of Birmingham should have access to information and support to maintain their independence and wellbeing. Where a need for support is identified it will be planned against outcomes so that services are arranged in a way that gives the citizen ultimate choice and control rather than selection from a narrow group of traditional services. Dependent on a citizen's situation and capability they can choose to take on greater accountability to manage their own care package. For those with a low / medium level of need it is envisaged that citizens will be able to self navigate their way through IT based information systems; or be directed to access support through contact centre based signposting.

4.6.8 How does "citizens accessing services through channels which are suitable to them and their lifestyle' mean?

How citizens interface with the Directorate will transform with communication preferences taken into account for all adults. This will mean harnessing best use of technologies through all stages of the SDM, ranging from self navigation via the internet to intelligent tools that support specialist trained staff to engage with people with sensory impairments or learning disabilities. The SDM accommodates all relevant access channels including self service, phone, face to face and outbound SMS functionality (text messaging).

4.6.9 What does an 'organisation built around citizen need, not internal structures' look like?

The underlying principle of self-directed care is the move to a system where adults are facilitated to take greater control of their lives and are enabled to make decisions and manage their own risks. Citizens will be central to assessing their own needs, deciding how best those needs can be met, and tailoring support to meet these individual needs. Self directed care aims to offer people the optimum control and personalisation of their planning and support, whatever their willingness to take on the responsibility for its delivery. The processes within the model will ensure citizens are central to the design of their service, which they can then choose to manage in a variety of ways to suit their willingness and capacity to be supported by people / professionals and the use IT systems where applicable. Self directed care develops a culture and the tools to enable individual citizens and their supporters to be involved in their assessments and to allow them to make the decisions as to how this is provided, within available resources, to provide that care. The Directorate will be an enabler supporting the citizen to achieve this principle.

The model seeks to provide services to citizens in a way which is not directed by existing or planned internal structures and services, but according to respond to the needs of all citizens. It is a fundamental change that personalises how the Directorate interfaces with citizens through using the most effective channels with citizens regardless of their communication requirements, community grouping or needs. Throughout the self directed care process, citizens are enabled by the Directorate to lead in the building of their own plans and networks to remain as independent as possible and in control of their own care arrangements. The Directorate will develop new capabilities to ensure citizens are empowered to make choices about services with relevant and timely information. Citizens will be entitled to access intermediate care / enablement which will be

multiagency services where appropriate and will offer support to people to plan and organise their care regardless of their financial status.

4.6.10 What does 'the Directorate providing leadership in the health and social care economy contributing to the achievement of citizens outcomes delivered through partnerships' mean?

The Directorate must change to meet the new leadership challenges posed by the demographic change facing the city. It needs to take partners with it in new ways of working and the different values that the model is based upon.

The Directorate will require the active support of many partners if it is to offer citizens a comprehensive approach to meeting outcomes.

4.6.11 How does this model enable the Directorate to transform and respond to future demands?

There is a recognised challenge, both nationally and locally, to respond to changing legislation, demographics and budget pressures. The SDM therefore has to be flexible enough to respond to these pressures whilst allowing greater responsiveness to the citizen with existing resources.

In order to manage this likely scenario, the SDM is designed to support self directed care for all citizens, and in doing so empower citizens to have maximum control over their life.

The model is based on 'channel shifts' upwards, introducing processes of support which allows for a greater number of citizens to be managed through earlier resolution whilst balancing their needs and risks.

4.7 Services within the scope of the Service Delivery Model

Over the course of the programme all services currently provided by the Directorate will be reviewed to assess:

- The preferred sources for services i.e. insourced, open market, third sector;
- The current contractual arrangements in place for the provision of external services;
- The expected need for provision of services;
- The capability of the external market to provide services;
- The economic case for service provision; and
- A schedule for sourcing of services from the external market.

The transition of services under the programme is likely to be undertaken on the following basis:

- Years 1 to 3 – Transition of services of low complexity or where there is a readily available external market for service provision to enable effective use of individual budgets and comprehensive enablement services;
- Years 3 to 5 – Services where markets for provision have to be developed or where existing contractual arrangements for provision are such that it is economically and legally viable to exit existing arrangements and contract alternatively for supply. This will support roll-out of self-selection of services/self-directed care; and
- Years 5 to 10 - Services where existing contractual commitments require the contract to be run to its conclusion and an economic case cannot made for exiting the contract e.g. Residential Care.

In the cases of years 5 to 10, it should be noted that, whilst the existing supply contract should be honoured, preparations can still be undertaken to ensure readiness of the supply market when the existing contracts terminate.

4.8 Incorporating existing transformation activity (In Flight Projects)

Prior to the OBC and FBC, the Directorate had already embarked on a range of transformational activities. The FBC has aligned the existing transformation programmes and projects to the FOM.

In total, 12 projects were considered by DMT against the strategic model, the outcome being 5 projects classed as Business as Usual and the remaining 7 completing Project Charters to elicit costs, benefits and alignment to the strategic model.

The projects form part of the range of activities identified in years 1 to 3, and will be subject to common design, bringing further alignment to the FOM.

4.9 Benefits to be derived from the FOM (incl SDM)

The benefits anticipated to be derived from the FOM (including the SDM) are assessed across a 10 year horizon against the 3 year programme. There are eight 'Benefit Themes', four related to cost avoidance and four related to cashable savings. These are explained in further detail in para 6.2

The programme of work (explained further in para 5.5) has been divided into the themes below to show the mapping between projects, benefits and areas of the FOM

- Service Delivery Model – Prediction, Prevention, Enabling Support, Self-Directed Care; and
- The remainder of the FOM – Develop Services, Commissioning, Internal Capability.

The identified benefits arising from the introduction of the FOM and SDM are outlined below.

4.9.1 Customer Benefits

A number of qualitative benefits have been identified that specifically relate to the wellbeing of citizens. These benefits are delivered over time by various projects and support the outcomes originally identified in the OBC;

- Citizens have control of their care;
- Preventative activities ensure citizens remain independent for longer;
- Predictive activities ensure citizens and targeted communities remain independent for longer;
- Citizens are better able to manage their own care through advice and advocacy, thus reducing numbers falling though to high and critical care needs;
- Citizens have access to quality information in order to make informed decisions about their care;
- Citizens can self assess in order to identify their needs as they perceive them;
- Increase in choice of services and providers for service users; and
- Swifter access to services for core client group.

4.9.2 Workforce Benefits

There are also a number of qualitative benefits that have been identified that specifically relate to care workers. These benefits are delivered over time by various projects and support the outcomes originally identified in the OBC:

- Enhanced skills for care workers and associated staff;
- Increased joint operational synergies between Health and the Directorate;
- Increase in range of diverse workforce skills and competencies; and
- Care workers are able to focus more on their core role and handle more of the highest need cases.

4.10 Summary

The transformation for the Directorate will be based around two main constructs:

- The Future Operating Model, including a new
- Service Delivery Model.

The FOM represents the dynamics and relations between all the elements (strategic and operational) required for a transformed Directorate, and the SDM focuses upon the new care pathway bringing into effect the concept of self directed care for all citizens regardless of their eligibility for care.

The SDM introduces a stratified response to the care pathway through distinct access channels. By supporting citizens in the correct way and at the right time, it is anticipated that there will be a successful 'channel shift' upwards, in favour of more self directed care bringing with it associated cost benefits.

By introducing the revised FOM and SDM, the proposed benefits are:

- Citizens have control of their care;
- Preventative activities ensure citizens remain independent for longer;
- Predictive activities ensure citizens and targeted communities remain independent for longer;
- Citizens are better able to manage their own care through advice and advocacy, thus reducing numbers falling though to high and critical care needs;
- Citizens have access to quality information in order to make informed decisions about their care;
- Citizens can self assess in order to identify their needs as they perceive them;
- Increase in choice of services and providers for service users;
- Swifter access to services for core client group;
- Enhanced skills for care workers and associated staff;
- Increased joint operational synergies between Health and the Directorate;
- Increase in range of diverse workforce skills and competencies;
- Care workers are able to focus more on their core role and handle more of the highest need cases.

5. Delivery Approach

5.1 Introduction

The purpose of this section of the document is to outline the how the FOM and SDM introduced in the previous chapter will be delivered.

This will involve presenting the:

- Scope of the programme of activities to deliver the FOM (incl the SDM) (para 5.3);
- Interdependencies with other programmes (para 5.4);
- Programme Structure (para 5.5);
- Programme Governance and Board structure (para 5.7);
- Costs attached to the programme (para 5.10);
- Risks associated with the programme (para 5.12); and
- Business Case for the programme (chapter 6).

5.2 Objectives

The programme of work required to deliver the transformation has to be aligned with the outcomes set out in the table at para 4.3. Measurement of delivery of these outcomes is largely based on customer views of the services provided to them. This being the case, it is essential that the programme is structured around initial and ongoing customer insight and feedback. Such mechanisms are an intrinsic part of the design, pervading all elements of the FOM and SDM.

The programme delivery option detailed below and further expanded in Appendix 2 has been structured to enable initial customer insight to inform a common design phase for the programme, thereby ensuring alignment with citizens wishes, desires and expectations.

5.3 Programme Delivery Scope

The SDM defined to address the requirements of the Directorate presents a process by which the Self-Directed Care agenda can be delivered.

In addressing the transformational requirements of the Adults and Communities Transformation Programme it is necessary to address not only the process itself, but to identify and plan for change in organisational structures, policies and strategies that form the foundation upon which the programme will be built. If these areas are not addressed the programme becomes merely an implementation of a different way of doing the same job as at present and the opportunity to truly transform service delivery will be missed. The vision that “We assist to assure the quality of life of the citizens of Birmingham today, tomorrow and always” must be a mantra that runs through all decisions made during the course of the programme.

The programme of work required to deliver the processes identified by the FOM have been assessed, along with those elements that lay the foundations for true transformation in the areas of:

- Strategy;

- Performance;
- Process;
- Culture;
- Organisation;
- ICT; and
- Property

When considering the work packages required to deliver the SDM a number of options were taken into account. These options took into consideration the scope of the selected SDM and its context in the overall FOM. The options analysis also took into account projects that are currently under way or being defined within the Directorate as a whole.

Where applicable, or where project dependencies dictate, these projects have been included in the overall implementation scope of the Programme.

Within the confines of project dependencies, the programme has been structured to enable implementation of elements of the transformed process in order to enable benefits realisation as early as possible. Early projects have also been structured to deliver proof of concept results within a timescale that allows the project to be rolled out or excluded from the Programme. The impact of removing a project from the portfolio following an unsuccessful proof of concept will be managed by the Programme Management Office (PMO).

5.4 Associated Initiatives

Any programme that is the size and complexity of this programme will contain a number of interrelationships and interdependencies. Dependencies will determine, to some extent, the order in which projects must be undertaken to deliver the programme. Dependencies may also exist where common components are required to deliver a number of projects e.g. a rules engine will be used at all stages of the programme, from assessment, through service selection, review and, ultimately, prediction of care requirements. The portfolio of projects and the programme of work to deliver them has been influenced by these dependencies.

Table 3 overleaf summarises the dependencies within the programme and between the programme and other initiatives. It should be noted that dependencies may not relate to delivery of a project in its entirety but that a dependency may relate to specific delivery channel, certain groups of customers, etc.

The dependencies defined relate to the development transformation projects and their interrelationships with each other and current Council technology and other projects.

Dependency	Description
1	Customer First will hold data that will be required to enable the predictive analysis to function. There is therefore a dependency on the availability of that data to the prediction team. For prediction and prevention activities to operate successfully the Council will need access to services that enable prevention. There is therefore a dependency on the development of suppliers.
2	The movement of staff from reactive to proactive roles and full operation of the predictive analysis tools requires all of the elements of prediction and prevention to be in place.
3	Full, multi-channel operation of self-directed care is dependent upon the following: ▪ Customer First integration to provide multi-channel access and de-specialisation of first line support to customers ▪ Integration/interface with CareFirst to enable case histories to be maintained in a single database ▪ Availability of third sector relationships to enable brokerage and advocacy services to be created, thereby releasing professional social workers to manage customer care ▪ Self-directed care is dependent upon the supplier market being developed and services made available through all channels of access
4	Supplier and market development is one of the areas of the programme with the greatest impact on other projects. A developed and shaped market is critical to the deployment of the self-directed care agenda and efficient operation of individual budgets: ▪ The enablement process, whilst not wholly dependent upon a revised marketplace, will not reach full effectiveness until all of the potential enablement services are available ▪ The third sector must be included in the market shaping exercises to maximise the potential supplier base. Equally, for the third sector to operate as an effective advocate or broker for services, the developed marketplace must be available as an enabler ▪ Integration with SAP Finance systems will be necessary to manage financial recording, ordering of services from suppliers and payment of suppliers and individuals, in line with the policies defined during the foundation stage of the Programme

Dependency	Description
	▪ Integration with CareFirst will be required to enable maintenance and management of case management records ▪ Development of new care services will generate a requirement for provision by the market. The market development activity must take these new service requirements into account
5	Audit and review processes will require close integration of data gathered at assessment, service selection and customer feedback stages in the care pathway. Integration is therefore necessary between review facilities and CareFirst, Customer First and the data gathered at stages in the self-directed care journey. This will require consideration in the context of the outcomes based quality framework defined during the foundation phase of the programme.
6	Integration of SPA and Customer First is required to provide a seamless handoff of process where necessary. Timing of implementation of Customer First functionality is critical.

Table 3: Project inter-dependencies.

5.5 Programme Structure

As stated in para 5.3 above, the programme must be structured to deliver the self-directed care agenda for the Council. This must be undertaken in the context of the desired outcomes, and in the overall context of the FOM and with the aim of delivering cashable and non-cashable benefits as early as possible in the life-cycle of the programme.

5.5.1 Structuring the Programme for delivery

The following sections of this document define the outcome requirements of each component part of the FOM in both logical and physical terms

To apply structure to the types of projects involved in delivery of the programme the following groups of projects have been defined:

5.5.1.1 Foundations

In order to make the programme transformational and to align it with the vision for service delivery it will be necessary to define new ways of working aligned to the requirements of both the Council and the community of customers it serves.

Foundation projects lay down the environment in which the transformation projects will be built. By implementing foundation projects the Council can ensure that delivery of the selected SDM meets the objectives and outcomes of the FOM. These projects will address policy and information requirements upon which delivery of the SDM projects are dependent. In addition, projects that provide a capability across the programme have been included in this grouping e.g. implementation of rules-based processing to enable self-service and brokerage.

As the SDM is essentially a process solution to the implementation of Self-Directed Care, the transformational agenda of the Directorate must be inherent in all aspects of design and delivery of

the revised service. It will therefore be necessary to define the Council's strategy to align it to its objectives in a changing demographic and cost environment.

If the Council is to change its emphasis, from a reactive provider of prescribed services in response to citizens care requirements, to an organisation that focuses on the outcomes its citizens wish to achieve, allied to an ability to predict and prevent referrals for care it must understand the market to which it is providing service. The Council must also define its role in the supply chain of care between citizens and providers of care. A strong foundation is essential to the effective delivery of the programme and sets the rules upon which each subsequent service delivery function will be built e.g. without a clear policy on the Council's role in the process of contracting and supply of services to citizens, the market shaping and supplier recruitment process cannot be aligned to the requirements of the programme.

There are therefore a number of components that need to be addressed during the foundation stage of the Programme:

- Customer Insight

  If the Council is to align its future services, and therefore its supply chain, to the needs of citizens it will be necessary to listen to the views of citizens and potential citizens of the service. This is achieved through surveys of citizens views on both qualitative and quantitative perspectives.

  Customer insight should form the basis of the exercise to shape the market of care providers to the current and future requirements. Customer insight should also be taken into account when designing processes to deliver the transformation agenda. This focus on citizens expectation will contribute to delivery of transformation when the change and transition management surrounding changes of process are developed and delivered.

- Outcomes Based Service Delivery

  The service delivery function of the Council will change from one in which qualified social workers determine a package of care based upon assessed care need to one based upon a citizen's stated required outcomes from the service. The focus of the role of the care practitioner will therefore change i.e. less time will be spent working with and helping customers through the process of assessment and more will be spent ensuring that the services that are delivered are meeting the citizen's needs.

  By basing assessment of need on outcomes there will be a need to align care supply to achievement of those outcomes and to review the effectiveness of that care in achieving the outcomes.

  This requires the creation of a framework covering the operation of an outcomes based approach at all points in the continuum of care.

- Commissioning

  The implementation of individual budgets, an increase in the level of self-funded citizens, self-direction and outcomes based care provision and review will require a different approach to the interaction of the citizens with the care supply/services market.

The Council wishes to transform its role in the supply chain, from ordering of services to payment of suppliers, to provide the citizens with more autonomy. This can be achieved by a combination of self-direction by a citizens themselves or via a third party on a brokerage basis.

The Council also wishes to transform its role from one of a provider of care itself to one of an enabler for care provision to customers via an expanded care services market.

This change requires the definition of internal policies and strategies to enable this shift in emphasis. These policies will be defined in the context of internal and external priorities identified through customer insight surveys and internal discussion.

The outputs form this activity will be material to the design of processes and physical delivery mechanisms developed during the common design phase of the Programme.

- Baselining the Organisation

  Effective transformation of an organisation requires more than the imposition of new processes and methods of working. The people working in the organisation must be carried along with the transformation in an effective and planned way. To enable this transition it is necessary to know who is affected, at what time, and in what way by the implementation of the transformed organisation. A detailed study of the roles of individuals in the process of care delivery should be undertaken.

  The output from this activity enables the programme to determine who will be affected by changes in process aligned to the FOM and to identify individuals whose roles will change as a result of implementation. This enables more accurate identification of cashable and non-cashable benefits and feeds information to the HR transition element of the project e.g. training needs analysis, training plans, role redefinitions and redundancies.

  The project will be the first phase in embedding a continuous improvement ethos in the Service leading to a more streamlined Directorate, better aligned to the needs of its citizens, the Market and the Council.

5.5.1.2 Development Transformation Projects

In order to ensure that the delivery of the Programme is aligned with the outcomes desired by the Council, the planning of programme delivery has been aligned with the outcomes and also with the requirements of the FOM. In doing so, a number of “themes” were identified and the individual components for delivery have been aligned with them. These themes are:

- Prediction – implementing business intelligence capabilities that enable the Council to accurately predict the needs of citizens before they require care services. This is an area of concentration of health and private health insurers, used to reduce the numbers of citizens who require long term care by “catching them early” and introducing preventative care measures. Prediction will feed into the prevention processes with the aim of improving citizens’ long term health and wellbeing, thereby reducing, removing or delaying the need for care provision by the Council. Integration with health records will increase the predictive capability;
- Prevention – targeting of communities and citizens with services designed to meet a possible future need with the aim of preventing future long-term care. This theme covers one long term aim of the transformation to become a more proactive provider of services thereby reducing the requirement for expensive long-term care packages;
- Enabling support – again, this theme is aimed at reducing the need for long-term or residential care by citizens. Enablement provides a package of care for the first six weeks

from assessment of need. This package may include physiotherapy, occupational therapy, assistive technologies, etc. to help a customer to maintain independence e.g. after a hip replacement;

- Self-directed care – the cornerstone of the transformation agenda, self-directed care provides the citizen with greater control of the care they require to meet their needs. Choice of routes to identification of service requirements, selection of suppliers and services and methods of payment will be offered. As well as retaining the ability in-house to help customers to assess their needs and to select services to meet them, development of third party brokerage services will provide support to citizens who cannot serve themselves. This will reduce the workload on professional social workers at the assessment stage and will release them to meet the care needs of a growing demographic population;
- Develop services – creation of new services in line with the transformation agenda e.g. Telehealth, a service which provides support to citizens in their own homes, thereby reducing placements in residential homes;
- Commissioning (develop suppliers/market) – creating the supply infrastructure to support self-direction, changing needs and a larger population. The market of care services will be changed by the introduction of individual budgets, an increase in self-funding citizens and their ability to choose from a wider range of services under the self-direction agenda. The market must be shaped to ensure that those needs can be met. New processes for ordering of goods and services and payment for them will be required. The market must be aware of these changes and must be able to react to them. There is also a need to work more closely with delivery partners such as PCT's to deliver integrated services to address social care and medical need. In the longer term, third sector organisations will be encouraged to participate as brokers or advocates as well as service providers; and
- Internal capability – development of appropriate spans of control, management systems, including a culture of continuous improvement and review is required to support and maintain transformation. Reviews of funding sources, both directly to the Council, or via third party and third sector involvement, may deliver financial benefit to the Council. This work could lead to the development of a funding options framework to evaluate and maximise different funding options for categories of individual circumstance and requirements. The process of case review will also be transformed to enable variable periods between review of citizens cases. This review process will focus on achievement of outcomes set by citizens at assessment. This will encompass citizen and supplier feedback, thereby contributing to the quality of life and wellbeing aims of the transformation. The projects delivered under this theme are critical to the establishment of a framework for service delivery and for monitoring of outcomes, aligned to performance management regimes to be established in the Directorate.

It should be noted that, whilst the process described by the model appears linear it is, in fact, a continuum from prediction of requirement through assessment of requirement, design for delivery, delivery and review. Ongoing review will provide data to support more effective prediction of requirement, and so, through another cycle. Review will also form an integral part of the performance management regime to be encompassed on the programme development plan.

The transformation programme is required to deliver a changed organisation and operation over a period of ten years. The programme must, however, deliver the majority of the change required to implement the FOM in a shorter timescale. Figure 9 overleaf indicates those projects which should be carried out within a one to three, three to five and five to ten year timeline. This diagram identifies each project within each of the themes identified above to align them with the new operating model:

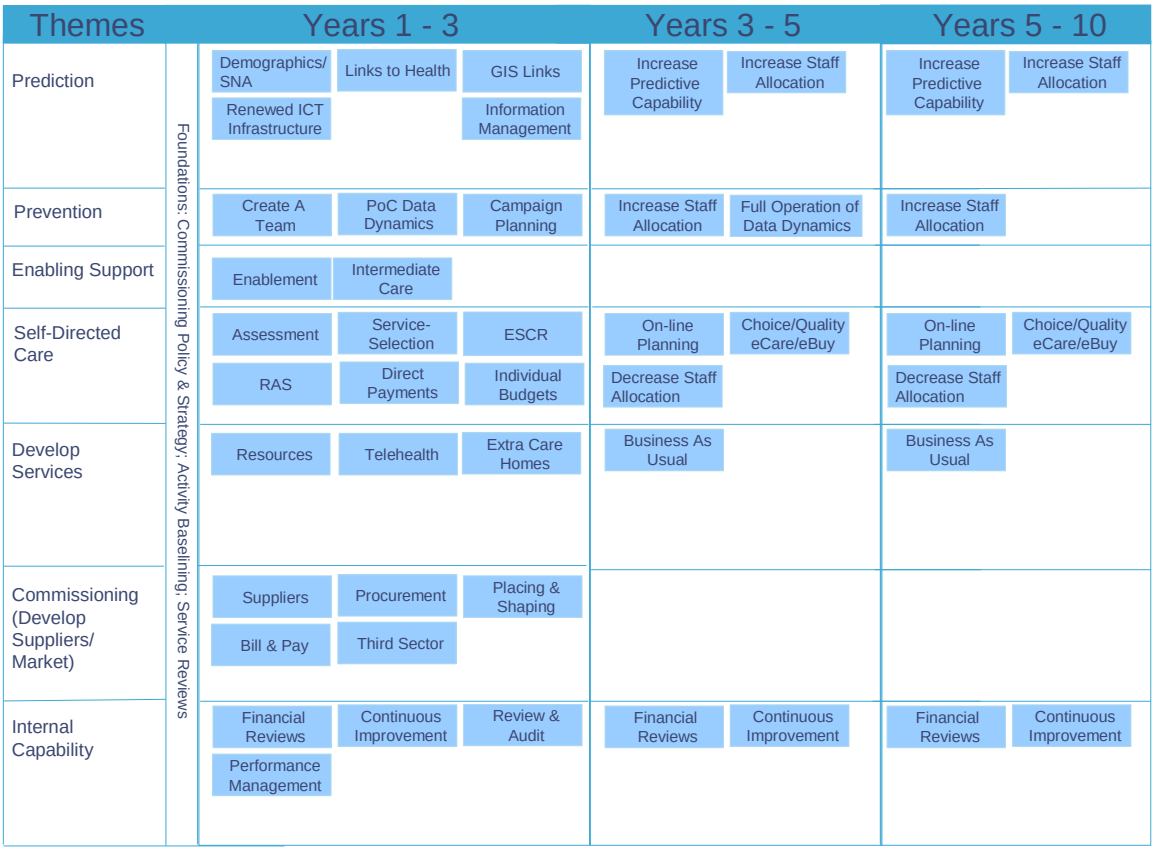


Figure 9: Scope of the programme.

Descriptions of each project are provided at Appendix 2.

5.5.1.3 Defined Transformation Projects

Defined transformation projects are those which have already been identified for delivery or have proceeded to individual business case level within the Transformation Programme i.e. it is known what is to happen to deliver these projects e.g. 2010.

Figure 10 outlines the projects that have been defined and project charters created for them:

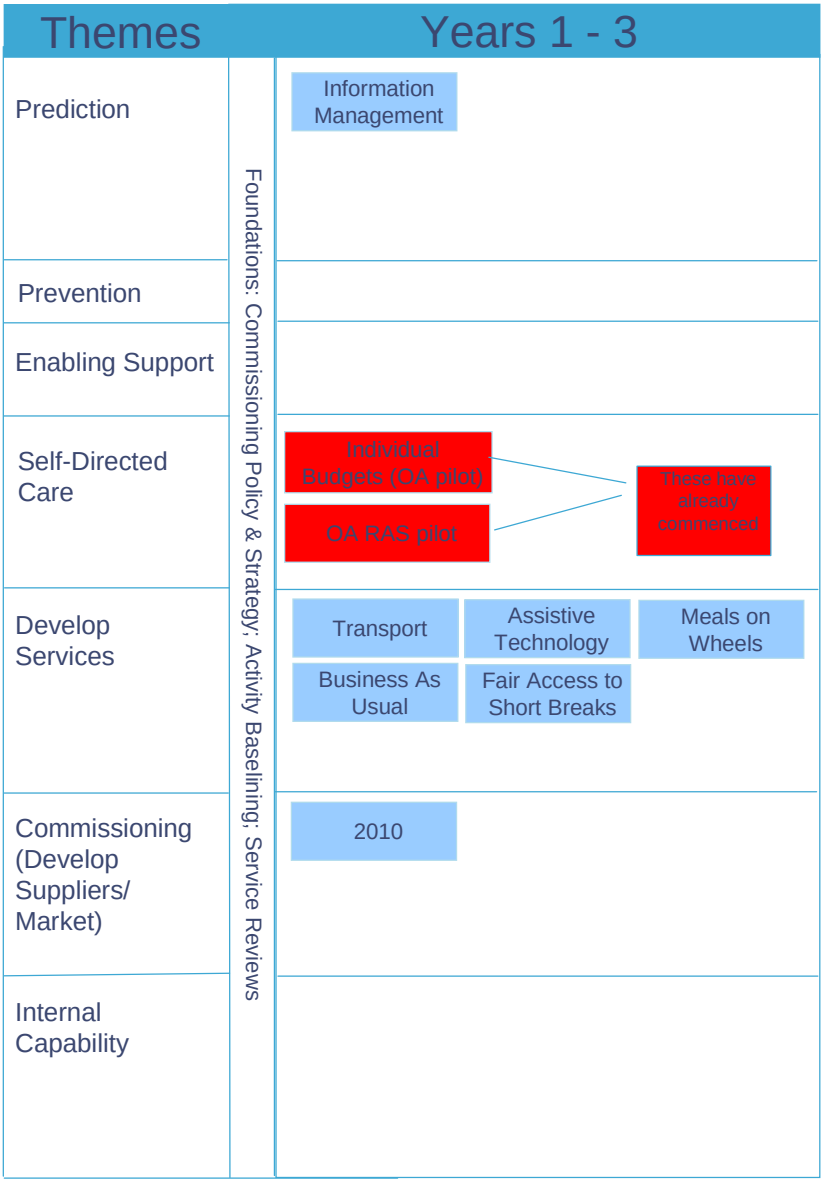


Figure 10: Defined transformation projects.

5.5.1.4 Proof of Concept

When defining the delivery timescales for each project, it may be decided to implement a proof of concept phase. Proof of concept is tool that can be used in either of two cases:

- Where the benefits to be delivered by implementation of a new process, technology system, policy, etc. is unclear e.g. there is a theoretical saving to be created but until the concept is tried out, the scale of benefit cannot be judged; or
- The benefits can be articulated but it is not practical to roll the project out across the Directorate in one tranche. It may therefore be decided to deliver in phases.

The need to carry out a proof of concept phase will be considered in each detailed project plan.

5.5.2 Alignment with Inspection Requirements

The Commission for Social Care Inspection has presented a report outlining a number of improvements it would like to see in the operation of the Directorate. Figure 11 below shows the alignment of these recommendations with the Programme.

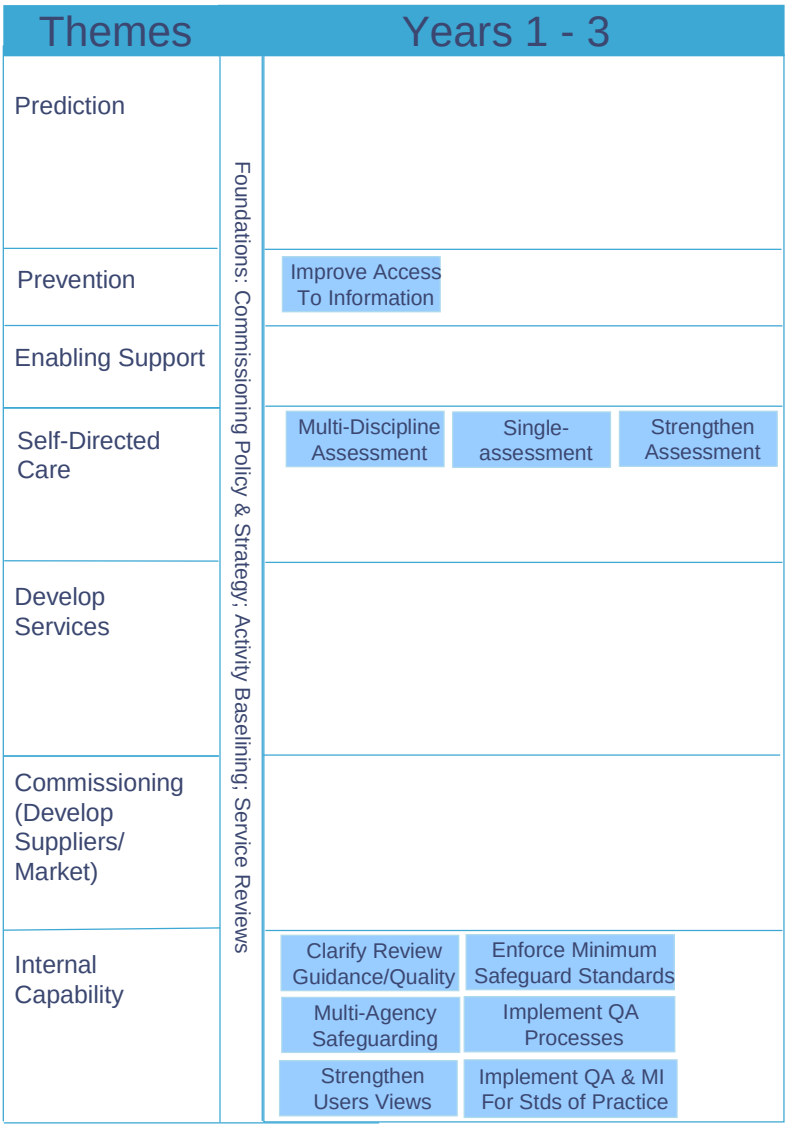


Figure 11: Alignment with inspection requirements.

5.6 Stakeholders and Communication

The transformation of the directorate will require significant change across all the stakeholder groups. Imperative to successful change is communications.

A list of key stakeholders and their needs are detailed in product 6: Stakeholder and Communications Plan.

The communications strategy (Product 25: Communications Strategy and Stakeholder Engagement) looks at the approach required to educate, embed and drive transformation amongst key stakeholders. It is presented in three parts;

- A vision plan to be printed double-sided and laminated for use with senior level personnel. This gives a top-level summary of the communications approach for the next three years and aims to show how communications objectives align with the vision and priorities of the Directorate
- A discussion document outlining key areas for consideration over the next three years – this provides supporting detail to work in conjunction with the vision plan and features a high-level plan showing phased activity over the longer term highlighting in particular where resources and attention need to be directed
- A **s**takeholder engagement plan for briefing and securing 'buy in' from stakeholders on the planned approach and solution in the run up to FBC submission

5.7 Governance

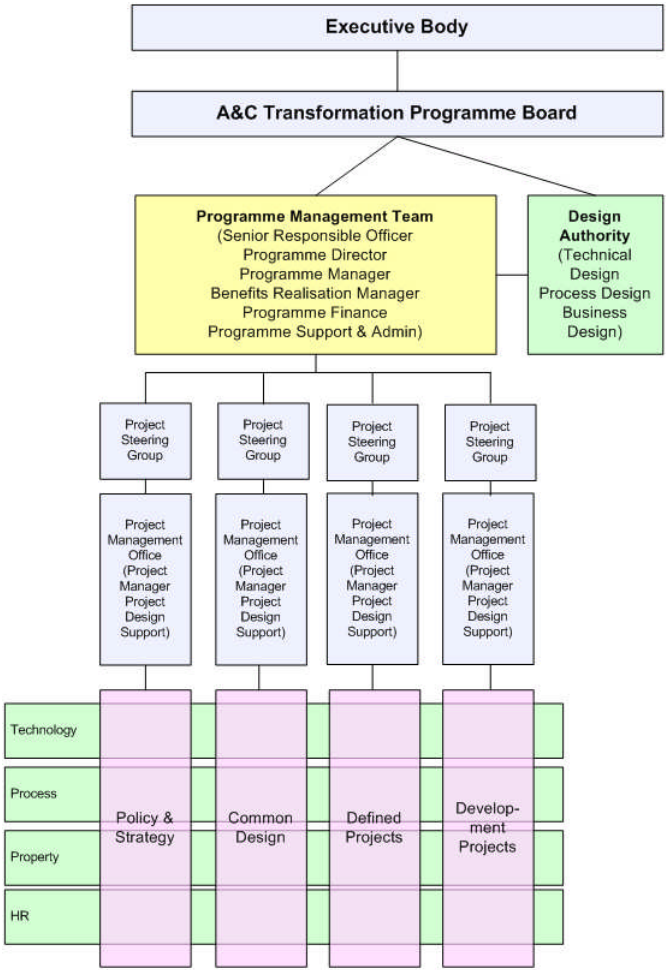


Figure 12: Governance structure

5.7.1 Programme Board Members

The Programme Board will consist of:-

- Cabinet Portfolio member;

- Adults and Communities DMT;
- Senior stakeholders;
    - Housing;
    - Corporate Transformation;
    - Children's and Young People;
    - Customer First;
    - Service Birmingham;
- Senior Overview and Scrutiny representatives; and
- Union representatives.

5.7.2 Programme Board responsibilities

The overall responsibility of the Business Transformation Programme Board is to:

- Determine the outcomes to be achieved by the programme;
- Ensure that all outcomes are measurable;
- Ensure that all outcomes are "transformational" and in line with corporate objectives;
- Determine and be responsible for the delivery of the programme;
- Commission specific projects to achieve the Programme;
- Work with other Programme Boards to ensure the most effective delivery of corporate objectives;
- Provide the Programme Mandate and investment decision (including cost benefit analysis);
- Provide visible leadership and commitment to the programme;
- Create an environment in which the programme can thrive;
- Approve the programme progress against the strategic objectives and through programme gateways;
- Endorse, advise and support the Programme Sponsor; and
- Ensure and confirm successful delivery and sign off at the closure of projects contained within the programme.

5.7.3 Governance Timings

The Executive body will be scheduled to meet at least bi-monthly, with the Programme Board also scheduled to meet bi monthly before the Executive body meets.

The project Steering Groups will be scheduled to meet on a monthly basis, with project team meetings happening weekly.

5.7.4 Governance Reporting

The Project Team will maintain the risk logs, workstream plans, Stage reports, technical docs etc.

Each Project Manager (PM) will provide the Project Steering Group with a PM report outlining progress of Project against plan, budget, risk log and future plans

The Programme Manager will produce the programme report to the Board outlining progress of Programme against plan, budget, risk log and future plans

5.8 Benefits Realisation

The FOM implies a number of changes, with associated benefits, to the Directorate and the services it offers. A portfolio plan has been drawn up which defines a benefit realisation plan. It should be noted that while the projects in the portfolio enable the benefits, realisation depends on the determination of the Directorate to achieve the benefits, supported by the Benefits Management Team.

Table 4 below summarises the relative timing of benefit realisation, together with the projects that will be enabling them:

Benefit area	Programme theme	Enabling projects and dependencies	Timing of benefit enablement and realisation
Enablement, rehabilitation and assistive technology demand reduction	Enabling Support	Assistive technology project Intermediate care and the PCTs	This process is already being piloted and so the impact on demand will be immediate, continued by an enablement project within the portfolio. There are dependencies on the assistive technology project, particularly in younger adults, and intermediate care and the PCTs. There is also a dependency on the other demand reducing initiatives; the predictive, preventative and SDC components.
Predictive demand reduction	Prediction	ESCR single assessment project Customer insight project	The benefit will be enabled from year 4 by the ESCR single assessment project, while the customer insight project will further impact the benefit realised later. There is also a dependency on the enablement, preventative and SDC initiatives.
Preventative demand reduction	Prevention	Proactive intervention team Interim preventative care project	Enabled by the proactive intervention team and the interim preventative care project, with a dependency on the enablement, predictive and SDC initiatives. What benefits could actually be realised are yet to be determined.
Informed citizen decision making and management of own care demand reduction	Self Directed Care	Self planning project Customer First	This benefit is enabled in year 4 by the self planning project. At the same time there is a dependency on the other initiatives of enablement, predictive and preventative.
Citizen contributions income maximisation	Self Directed Care	National funding sources including the DLA, state benefits and health benefits	This is a strategy/policy that is already being implemented and so benefits could be realised immediately.
Policy decision related to individual budgets	Self Directed Care	Older Adults pilot Individual budgets policy	This is enabled by the individual budgets policy and there is a live pilot in Older Adults.
Supplier savings	Commissioning	Self service project Market shaping project	Market shaping will not begin until year 3, when it will be enabled by the self service project.
Continuous improvement	Internal Capability	Electronic assessment project Self managed care project Customer First and EPM	Enabled by the implementation of the various elements of the self assessment component of the solution. The first of these elements will be put in place by the electronic assessment project in year 2.

Table 4: Benefits realisation.

5.9 Programme Plan

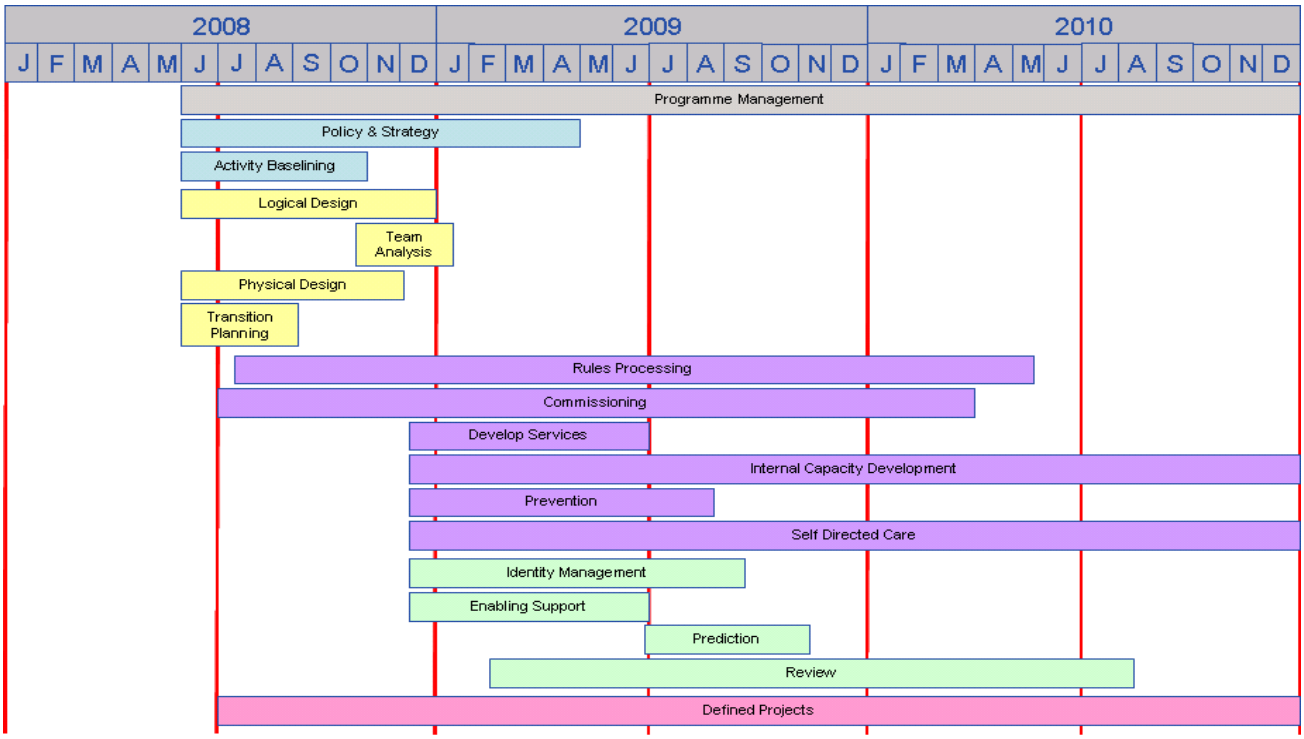


Figure 13: Programme plan

A further detailed programme plan is held in Appendix 2.

5.10 Lifecycle Cost

Costs by portfolio component

£000s	Year 0 2007/8	Year 1 2008/9	Year 2 2009/10	Year 3 2010/11	Year 4 2011/12	Year 5 2012/13	Year 6 2013/14	Year 7 2014/15	Year 8 2015/16	Year 9 2016/17	Year 10 2017/18	Year11 2018/19	TOTAL
OBC and FBC	£4,436	£466											**£4,902**
Programme Management		£1,734	£1,329	£1,304	£173	£0	£0	£0	£0	£0	£0	£0	**£4,540**
Policy and Strategy		£1,574	£120	£104	£0	£0	£0	£0	£0	£0	£0	£0	**£1,798**
Activity Baselining		£1,321	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£1,321**
Continuous improvement		£0	£0	£0	£814	£915	£915	£915	£915	£911	£915	£79	**£6,378**
Common Design		£1,733	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£1,733**
Rules Processing		£596	£734	£15	£0	£0	£0	£0	£0	£0	£0	£0	**£1,345**
Commissioning		£477	£916	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£1,393**
Develop Services		£2	£13	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£15**
Internal Capacity		£22	£127	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£150**
Performance Management		£67	£908	£1,106	£463	£0	£0	£0	£0	£0	£0	£0	**£2,544**
Prevention		£52	£349	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£401**
Self Directed Care		£257	£2,251	£149	£0	£0	£0	£0	£0	£0	£0	£0	**£2,656**
Service Selection		£155	£746	£473	£203	£0	£0	£0	£0	£0	£0	£0	**£1,577**
Proof of Concept		£106	£1,421	£338	£0	£0	£0	£0	£0	£0	£0	£0	**£1,865**
Defined Projects		£553	£222	£222	£222	£222	£222	£222	£222	£222	£222	£0	**£2,549**
Software / Hardware		£0	£2,000	£2,000	£0	£0	£0	£0	£0	£0	£0	£0	**£4,000**
Other		£1,100	£1,100	£1,100	£0	£0	£0	£0	£0	£0	£0	£0	**£3,300**
TOTAL	**£4,436**	**£10,215**	**£12,236**	**£6,812**	**£1,875**	**£1,136**	**£1,136**	**£1,136**	**£1,136**	**£1,133**	**£1,136**	**£79**	**£42,468**

Table 5: Programme lifecycle costs.

5.11 Resource Summary

Days by type

Days	Year 1 2008/9	Year 2 2009/10	Year 3 2010/11	Year 4 2011/12	Year 5 2012/13	Year 6 2013/14	Year 7 2014/15	Year 8 2015/16	Year 9 2016/17	Year 10 2017/18	Year11 2018/19	TOTAL
BCC	6,211	4,784	1,077	3,092	3,132	3,132	3,132	3,132	3,120	3,132	260	**34,204**
External	4,776	6,094	1,973	530	0	0	0	0	0	0	0	**13,373**
Insourced	543	685	390	0	0	0	0	0	0	0	0	**1,618**
Secondee	44	416	249	2	0	0	0	0	0	0	0	**710**
Secondee/Insourced	561	548	710	236	0	0	0	0	0	0	0	**2,055**
TOTAL	**12,135**	**12,526**	**4,398**	**3,860**	**3,132**	**3,132**	**3,132**	**3,132**	**3,120**	**3,132**	**260**	**51,960**

Table 6: Resource summary

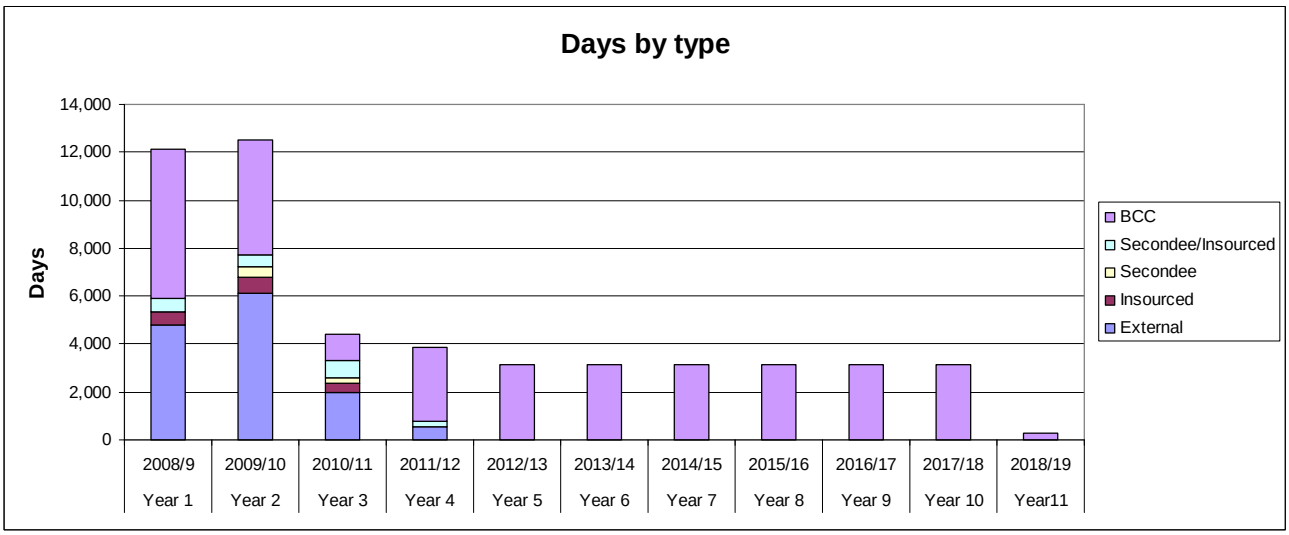


Figure 14: Resource days by type.

5.12 Risks

Within the programme portfolio each project will maintain its own risk register which will be integrated at the programme level by the Programme Management Office.

At this stage a number of programme level risks have been identified:

Risk	Probability	Management
Insufficient internal resources with the right skills will not be available to implement the programme	M	Work with the Business Support Unit to identify correct resources internally or to source resources from the market
Directorate projects will not deliver on time	M	Manage dependencies and reflect project delays in the programme plan, highlighting events to the Programme Board for decisions and resolution
Staff will not react well to	M	Continuous communication with

Risk	Probability	Management
changes		staff, seeking feedback. Management buy-in and championing of changes is essential
Benefits will not be realised	L	Proof of concept projects will be set up where necessary to determine and validate benefits profiles
The market will not react or be able to react to changes	L	Early market communications and supplier feedback sessions will be undertaken
Technology solutions will be too expensive to derive benefits	M	Alternative methods of delivery will be evaluated within the remit of each project
Delays in policy setting will delay the programme	H	Manage the foundation elements of the programme closely to deliver on time
HR consultation periods will impact on the delivery timescales of the projects	M	Early identification of roles in the new operating model and matching of current to future roles, early in the project
Changes of core operational systems will impact on delivery	L	Build flexibility into the build of individual components to minimise effect of change
Results of May election will change policy	L	Review delivery if policy changes
PCTs will not engage fully	M	Active management of relationships
Customer insight will change the requirements of the transformation	L	Manage policy development in line with customer insight results

Table 7: Risks

6. Business Case

6.1 Introduction

The purpose of this section of the document is to summarise the financial costs and benefits of the transformation programme.

This will involve presenting the:

- Initiatives on which the business case is built (para 6.2.1 and 6.2.2);
- Savings profile predicted for the directorate (para 6.2.1);
- Benefits ratio and Returns on Investment profile (para 6.2.3);
- Affordability projection (para 6.2.3).

The full cost benefits case is detailed in product 37: Cost Benefit case. This is summarised below.

6.2 Business Case

The net budget for the Directorate is £273.5m. Applying ONS demographic projections to this budget suggest that by 2018 this budget would need to be closer to £330m, and even then it is doubtful that the same level and quality of service could be offered.

A number of initiatives to address this problem have been modelled in the business case. The initiatives can be divided into two groups:

- Cost avoidance through prediction and prevention; and
- Income maximisation and individualised budgets.

6.2.1 Cost avoidance

One element of the business case sets out to avoid costs by reducing demand for services, particularly the higher cost services. These cost avoidance initiatives include the

- Setting up of enablement services;
- The establishment of predictive and preventative teams; and
- A new self service access channel, which will help citizens make informed decisions up front that prevent them falling through to the higher cost end of the care continuum.

The business case suggests that over 10 years a total of £31m of demand can be avoided through enablement services, £13m of demand can be avoided by the establishment of a predictive team, and a further £18m of demand can be avoided with the help of the new self service access channel.

The demand avoided by the establishment of a preventative team is difficult to estimate and so no saving has been assumed in the business case as yet. The total cost avoidance benefit is therefore £62m over the next 10 years.

6.2.2 Income maximisation and individualised budgets

The second element of the business case presents cashable benefits. £15m has been modelled for an income maximisation initiative. A further £113m has been modelled for the introduction of individual budgets in conjunction with policy decisions by the Directorate, supported by various elements of the SDM.

A fine balancing act will be required by the Directorate to ensure that their policy decisions are not undermined by an unfavourable economic imperative for citizens, taking into account the state of the market place at the time of policy making. Market shaping initiatives will therefore go hand in hand with the introduction of individual budgets and an additional cashable benefit of £30m has been modelled. Finally the self service access channel will allow social workers to focus more on their core job and reduce the demand for administrative activities and support. A cashable benefit of £9m has been modelled in this case. The total cashable benefit is therefore £168m over the next ten years.

6.2.3 Benefit Analysis

The programme includes initiatives to reduce the demand for services, decrease costs and exploit the additional sources of income and funding.

Table 8 below shows the benefits to be accrued through the programme split between those associated with cost avoidance and those with financial cashables.

Benefit area	Programme theme	Enabling projects and dependencies	Hypothesis	Assumptions	Benefit type	10 year gross benefit £000s
Enablement, rehabilitation and assistive technology demand reduction	Enabling Support	Assistive technology project Intermediate care and the PCTs	Demand will be reduced, particularly among those requiring high end care, by a small percentage as a result of the new enablement process, supported by assistive technology	Straight line projection of demand reduction to 5% (residential care) and 4% (community care) by year 10	**Cost avoidance**	£30,580
Predictive demand reduction	Prediction	ESCR single assessment project Customer insight project	Demand will be reduced by a small percentage as a result of predictive data analysis and identification of high risk groups	Straight line projection of demand reduction from year 4 to 2% (residential care) and 1% (community care) by year 10	**Cost avoidance**	£13,076
Preventative demand reduction	Prevention	Proactive intervention team Interim preventative care project	Any reduction in demand would be enabled by the proactive intervention team and the interim preventative care project	No evidence of any demand reduction	**Cost avoidance**	£0
Informed citizen decision making and management of own care demand reduction	Self Directed Care	Self planning project Customer First	Demand for residential and community based care will be reduced as a result of citizens being better informed of their choices by the new social care portal. As a result they will be able to take charge of their care needs and make decisions up front that avoid them falling through to the high cost end of Council provided care	Straight line projection of demand reduction from year 4 to 5%, moderated by a shift from residential care into community based care, where demand will consequently actually increase by 1%	**Cost avoidance**	£18,023

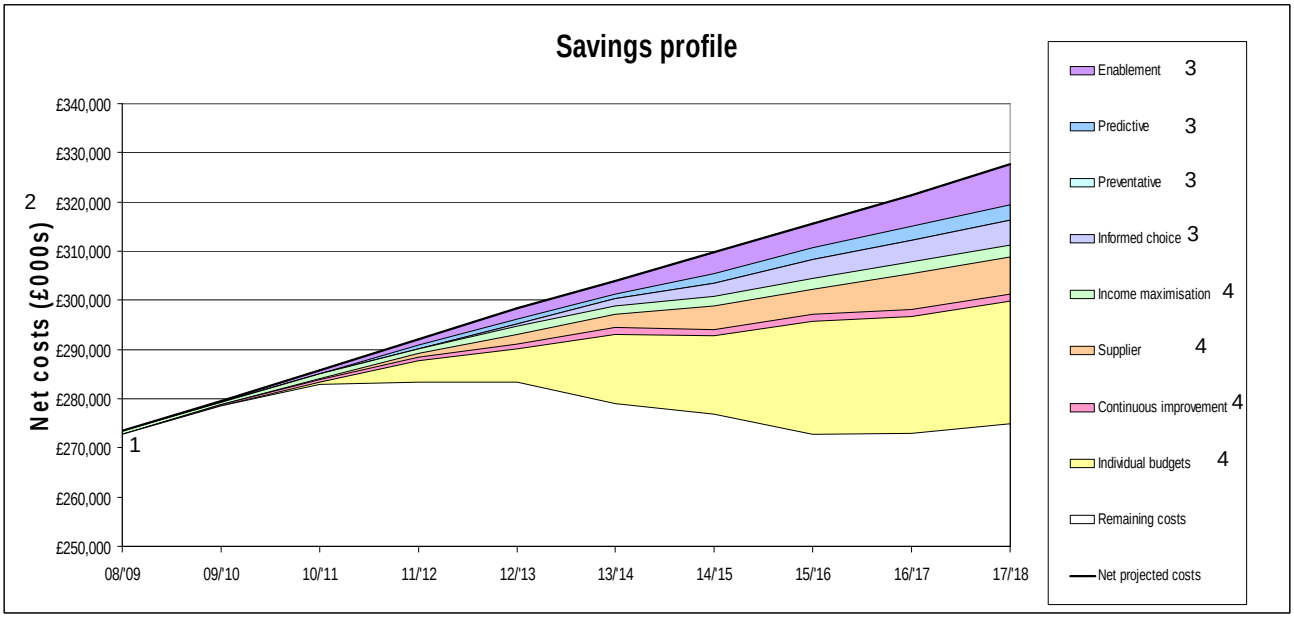
Citizen contributions income maximisation	Self Directed Care	National funding sources including the DLA, state benefits and health benefits	An effective increase in the contribution of citizens to their own care costs will be possible, either from an increase in their means tested contribution, charging for services mechanisms, or additional grant and funding sources	Straight line projection of additional contributions to 5% by year 10	**Financial cashable**	£15,143
Policy decision related to individual budgets	Self Directed Care	Older Adults pilot Individual budgets policy	A proportion of citizens will take up an individual budgets, driven by related policy decisions that set the level of funding that citizens then receive. These policy decisions must be balanced with a consideration of the quality of life and safe guarding responsibilities	Up take assumed to only reach 70%, levelling out as a result of potential policy driven reductions in the funding provided to those with their own budgets. Budgets will be set at a stretch target of 10 to 15% of the average cost of care	**Financial cashable**	£113,317
Supplier savings	Commission –ing	Self service project Market shaping project	Once users have taken up individual budgets they will go to the market place for care and that savings for the same level of care will be available there because of market intelligence and market shaping initiatives	Straight line projection of supplier savings from year 3 to 4% by year 10	**Financial cashable**	£30,305
Continuous improvement	Internal Capability	Electronic assessment project Self managed care project Customer First and EPM	A 30% saving (typical saving resulting from lean operation initiatives) is possible among Directorate admin and IT support staff as a result of the implementation of the various elements of front end of the solution	Ramp up to 30% saving between years 3 and 6	**Financial cashable**	£9,330

Table 8: Efficiency analysis.

6.2.4 Savings Profile

Because there is little empirical data to establish benefits, a set of models have been developed to project these benefits, which have been signed off by the management of the Directorate. The figure below shows the profile of these potential benefits over a period of 10 years against a top line projected cost relative to the demographic projection outlined earlier in the document.

The savings profile is shown diagrammatically overleaf in figure 15.



Note 1: Budget for 2008/9 is £273.5m

Note 2: All costs are net after consideration of income

Note 3: Non-cashable benefit

Note 4: Cashable benefit

Note 5: Figures on 2006 / 07 basis uplifted for inflation less an efficiency allowance

Figure 15: Savings profile

6.2.5 Net Financial Effect

If all these benefits can be fully realised the net budget for the Directorate will essentially remain neutral over the next 10 years. However, realising these benefits is expected to cost £42m. The business case models much of this cost (22m) to occur in the first two years of the programme. In the early stages of the programme various proof of concept projects (para 5.5.1.4) will establish with greater certainty the full extent of the benefits that may be realised. The programme then continues with delivery projects in the third year, costing £7m, giving way to continuous improvement in the remaining years of the programme (costing £1.1m a year). When the modelling of benefits and costs are compared the predicted return on investment is expected to fall in 2013, the sixth year of the programme.

£000s	Year 0 2007/8	Year 1 2008/9	Year 2 2009/10	Year 3 2010/11	Year 4 2011/12	Year 5 2012/13	Year 6 2013/14	Year 7 2014/15	Year 8 2015/16	Year 9 2016/17	Year 10 2017/18	Year11 2018/19	TOTAL
3 year programme plan	£4,436	£10,215	£12,236	£6,812	£1,875	£1,136	£1,136	£1,136	£1,136	£1,133	£1,136	£79	**£42,468**
Gross cashable benefits	*£0*	*£450*	*£737*	*£2,050*	*£5,932*	*£10,572*	*£18,349*	*£23,298*	*£30,272*	*£34,388*	*£36,011*	*£36,221*	***£198,280***
Benefit ratio	*0.00%*	*0.04%*	*0.06%*	*0.30%*	*3.16%*	*9.30%*	*16.15%*	*20.50%*	*26.64%*	*30.35%*	*31.69%*	*456.99%*	
Return on investment	-£4,436	-£14,201	-£25,701	-£30,462	-£26,405	-£16,969	£244	£22,405	£51,541	£84,796	£119,670	£155,811	

Table 9: Summary of programme costs and benefits

Note 1: The programme costs are supported by a MSP plan and Excel cost model

Note 2: The programme costs include no contingency as a time and materials charging mechanism has been assumed, and are based on Schedule 7 rates, with no further indexation

Note 3: The programme costs include £4m for IT integration and £3.3m for accommodation, based on half the CST estimates, as suggested by the TDU, and expenses of £1.4m

Note 4: The benefits are supported by an Excel model, the outputs of which are the benefit cards

Note 5: Beyond the costs and benefits presented here it may be necessary to invest in a new core IT system at the point where the existing technology no longer adequately supports the solution. Additional transformational costs may also be required to extend the benefits to fully close the demand gap created by the demographic pressures Birmingham Adults are facing over the next 10 years

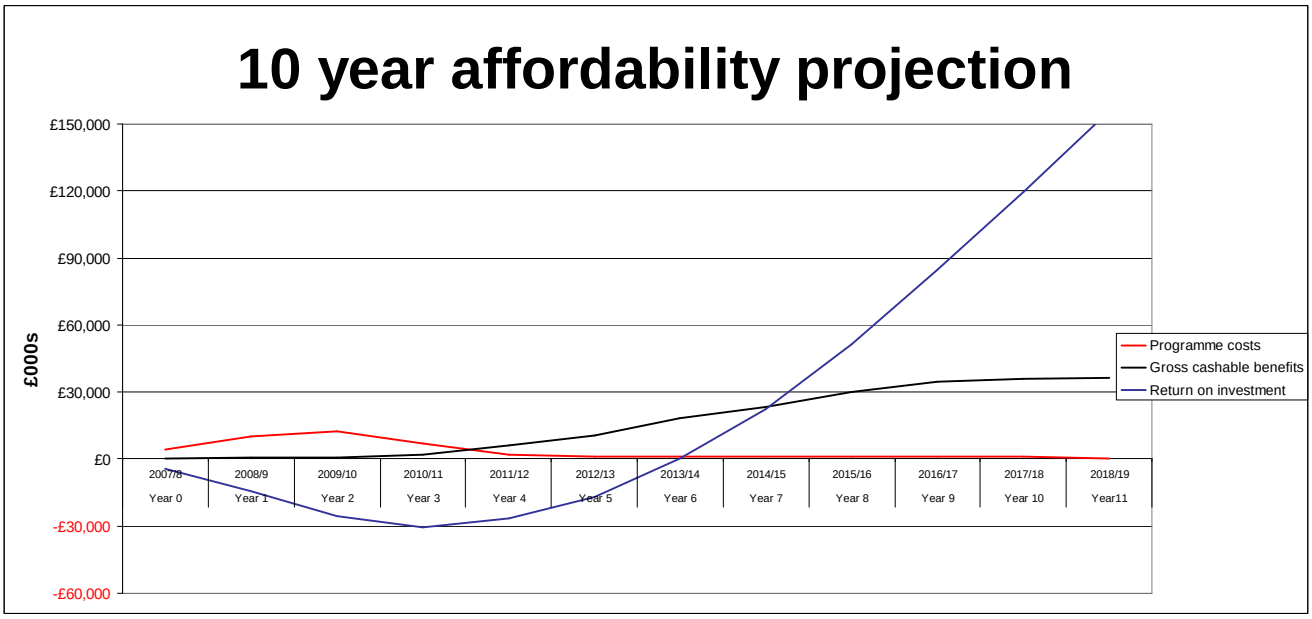


Figure 16: 10 year affordability projection

6.3 Summary

The research showed that the Directorate projected budget is going to be outstripped by the demographic demand indicated by ONS figures. This means that it is likely that the Directorate will soon only be able to offer critical care.

The FOM represents various initiatives to address this problem. This includes initiatives to reduce the demand for services, initiatives to decrease cost, and initiatives to exploit additional sources of income and funding.

In turn an attempt has been made to model the potential benefits associated with these initiatives. The basis of the modelling is to project current financial and volumetric data, based on the ONS figures, and compare this with the expected costs after implementation of the solution, thus defining the potential savings.

It should be noted that there is very little empirical data on which to base the modelling. Instead hypotheses have been postulated, based on assumed projections of the potential change.

To answer the questions of whether the hypotheses are legitimate and the assumed projections are likely proof of concept projects will be initiated in the first 3 to 6 months of the next phase of the programme.

As shown throughout the document the transformation programme is based upon a strong business case showing a financial pay back during year six.

We are looking for approval of this Full Business Case, which will put Adults and Communities into a major transformation programme that will need to be aggressively pursued.

In delivering this programme the Council will be seen as implementing a cutting edge transformation programme putting Birmingham in a position to shape the CSR 2011/2012.

Appendices

The table below lists all the appendices to the FBC. The key appendices are attached to this document.

Appendix	Title	Location
1	Selected Service Delivery Option	Attached
2	Selected Programme Delivery Option	Attached
3	Benefits Management Strategy	Attached

The documents below are referenced within the FBC and are available on request from the Sharepoint library.

Programme Scope & Objectives	Available on request
Customer Tree	Available on request
Operational Services & Functions	Available on request
Customer Requirements	Available on request
Measures of Success	Available on request
Potential Service Delivery Options	Available on request
A&C Organisation & Services	Available on request
A&C Process Maps & Data (3yr FOM)	Available on request
A&C Technology Review	Available on request
Programme Governance	Available on request
Planning Principals	Available on request
Project Integration Strategy	Available on request
Testing Strategy	Available on request
Risk Management Strategy	Available on request
Knowledge Transfer Strategy	Available on request
Training Strategy	Available on request
Benefits Inventory	Available on request
Benefit Cards	Available on request
Benefits Realisation Plan	Available on request
Cost Benefits Case	Available on request
A&C Outline Business Case	Available on request
Toolkits Glossary v0.2	Available on request
LSE Report	Available on request
Equalities Impact Assessment	Available on request
Stakeholder & Communications Plan	Available on request
Communications Strategy & Stakeholder Engagement	Available on request