Whole System Approach to the Personalisation of Health and Social Care

Health, Social Care and Housing Committee
19 June 2012

1 Purpose of report

1.1 To inform members of:

- the adoption of a whole system approach to the ongoing modernisation and transformation of health and social care services in order to embrace changes in legislation, policy and best practice; and
- the production of a document as a means of engaging with key partners and stakeholders, including people who use services and carers regarding the proposed approach (the document is attached at Appendix 1).

2 Main report

Background

2.1 In recent years, there has been a significant shift in national policy in relation to both public service as a whole and health and social care, which seeks to change:

- the relationship between the individual and the state, from passive recipient of services to active partner
- the ethos underpinning the provision of support from a focus on those things people are unable to do for themselves to an asset based approach, which seeks to prevent the need for intensive support and maximise the independence of the individual
- the way in which services are organised and delivered so that those individuals in need of support and their carers have as much choice and control as they wish and is appropriate over how that support is provided; and
- the way in which services are evaluated and assessed by focusing on outcomes rather than outputs.
2.2 These changes have been reflected in a number of national policies, for example, Reshaping Care for Older People, Reducing Delayed Hospital Discharge, Shifting the Balance of Care, Delivering for Mental Health, The Road to Recovery, Self Directed Support Strategy and draft Bill, and most recently the Integration of Health and Social Care.

2.3 Much good work has been and continues to be done in Edinburgh to modernise and personalise services in line with national policy and strategy, from the closure of Gogaburn Hospital to the development of a successful reablement service, and creative, flexible alternatives to residential respite provision for people with learning disabilities. Other examples include:

- the Community Connecting initiative funded through the Change Fund for older people works in partnership with communities to improve the health and wellbeing of people who may otherwise access mainstream social care support
- the Local Area Coordination Team works with people with moderate learning disabilities who have used the residential respite care facility at Glenallen to provide alternative short breaks based on individual needs and aspirations
- in mental health services, peer support initiatives have been developed as part of recovery approaches
- the Neighbourhood Network established in Craigmillar through the Thistle Foundation brings together a group of people living within a small geographic area who are seeking to build up their social networks to a point where they become self sustaining
- the direct payment support service operated by Lothian Centre for Independent Living provides a range of support for managing direct payments
- Recovery Hubs which provide same day access to a range of services to meet the immediate needs of people with drug and alcohol problems.

The diagram at Appendix 1 illustrates the transition is taking place in terms of service delivery.

**Whole system approach to change**

2.4 The changes required involved complex, inter-dependent systems, which all need to be addressed in a coordinated way to ensure the best outcomes. A whole system approach to the personalisation agenda will allow for this coordination and will provide a framework for addressing cross-cutting themes, whilst recognising the differences between the various service user groups, services and organisations.

2.5 The key elements of this approach are:

- the availability of a range of high quality, accessible information to allow people to make informed choices and decisions about the way they live their life
• recognition of the importance of preventative services available to all in order to promote health and well-being and reduce or delay the need for intensive long-term support

• the provision of support, which is progressive and proportionate in relation to individual circumstances and level of need, and flexible in response to changes in these

• a focus on maximising independence and supporting people to exercise as much choice and control as they wish and is appropriate over the way in which their care and support needs are met

• the use of outcomes as a means of measuring performance

Delivering the change

2.6 The Council cannot deliver this change alone, but needs to work with key partners, including people who use social care services and their carers, to agree a set of desired outcomes for the people of Edinburgh, which will be delivered through a number of work streams and a clearly defined work programme, with explicit deliverables and timescales. Membership of the work streams will include Council officers, representatives of partner organisations from the public, independent and third sectors, and people who use services and their carers.

2.7 The following high level objectives, which have been identified for the programme will be developed further through engagement with partners:

2.7.1 Develop a ‘Customer Journey’, setting out the customer experience we are seeking to deliver.

2.7.2 Ensure a range of high quality, easily accessible information and advice is available to assist people to make informed choices.

2.7.3 Increase access to universal services for vulnerable people.

2.7.4 Reduce the demand for ongoing care and support through investment in preventative services, which promote good health and wellbeing.

2.7.5 Embed a focus on outcomes throughout the customer journey, from first point of contact through assessment, planning, service delivery and review.

2.7.6 Embed a focus on ‘maximising independence’, wherever possible, throughout the customer journey, using approaches such as reablement, intermediate care, rehabilitation and recovery.

2.7.7 Ensure that people are appropriately assisted to direct their own support.

2.7.8 Ensure that the range of care and support services available is sufficient to provide people with real choice.

2.7.9 Ensure that services are outcome focused and personalised, regardless of whether they are provided within people’s own home or in an institutional setting.
2.7.10 Ensure that self directed support is a reality for all, including people with complex needs.

2.7.11 Ensure the Council’s financial frameworks support the principles of personalisation and self directed support.

2.7.12 Ensure that the Council’s commissioning and procurement frameworks support the delivery of personalisation and self directed support.

2.7.13 Maximise the opportunities for working with communities.

2.7.14 Ensure alignment with the proposals for the integration of health and social care.

2.8 Progress against the programme plan will be monitored by both a Checkpoint Group and Health and Social Care. Reports will also be submitted to the Council’s Corporate Management Team and the relevant committee(s) of the Council, as required.

2.9 The success of the programme will be measured by the achievement of the objectives set out above and the outcomes agreed with all partners and stakeholders. The mechanism for determining success in respect of these outcomes will be agreed with stakeholders once the outcomes themselves have been agreed.

**Engaging with partners and stakeholders**

2.10 A document setting out the Council’s proposed approach to transforming the way in which vulnerable citizens are supported is attached at Appendix 2. This will form the basis for consultation and engagement with people who use social care services, their carers and other key partners.

**3 Financial Implications**

3.1 The Scottish Government has made some provision for the implementation of the Self Directed Support legislation. Edinburgh’s allocation from these funds is:

<table>
<thead>
<tr>
<th>Year</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
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<tbody>
<tr>
<td>Allocation</td>
<td>£452,000</td>
<td>£909,000</td>
<td>£452,000</td>
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</table>

3.2 In addition, the Council has agreed a non-recurring sum of £190,000 for 2012/13 to support the changes required.

3.3 The full costs of long-term transformation and those of the associated alternative service delivery models are not quantifiable at this stage, however, as changes are made and services developed, detailed reports will be provided to members and provision sought in the annual budget-setting process.

**4 Equalities Impact**
4.1 A scoring for relevance to equalities undertaken in respect of personalisation indicates that a full equalities impact assessment is required. This will be undertaken as part of the work to develop the detail of the programme, linked to appropriate milestones and in advance of any recommended changes. The assessment will build on the work already done in respect of equalities in respect of the Commissioning Plan for Care and Support and personalisation and outcomes. An equalities officer is part of the proposed project team.

5 Environmental Impact

5.1 There are no environmental issues arising from this report.

6 Recommendations

It is recommended that the Health, Social Care and Housing Committee notes:

a) the adoption of the whole system approach to the personalisation of health and social care in order to embrace changes in legislation, policy and best practice

b) the use of the document attached at Appendix 2 as a means of engaging with key partners and stakeholders, including people who use services and carers regarding the proposed approach

c) that further reports will be submitted to the Committee as the personalisation programme progresses.

Peter Gabbitas
Director of Health and Social Care

Appendices

1. A Whole System Approach to Personalisation of Health and Social Care in Edinburgh

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Wards affected
All

Single Outcome Agreement
Outcome 6: We live longer, healthier lives
Outcome 7: We have tackled the significant inequalities in Scottish society

Background Papers
Population ‘needs’

General population

Low to moderate needs

Substantial needs

Complex needs

Old model

Gogarburn
NHS continuing care beds
Care homes

Home care
Learning disabilities day centres and workshops

Universal packages of care

Inclusion

New models of care

Timely discharge from hospital/care home
Intensive care at home

Day care
Reablement
Visiting support

Local area coordination
Co-production
Community Connecting

Community Development
Information, advice, signposting, lifestyle
A Whole System Approach to Personalisation of Health and Social Care in Edinburgh

May 2012
Version 0.8
Introduction

In recent years, there has been growing recognition of the need to change the way in which support is provided to people who have social care needs, in order to deliver better outcomes for both the individuals themselves and the communities of which they are a part.

This document sets out the City of Edinburgh Council’s proposed approach to the ongoing transformation of the way in which vulnerable citizens are supported, primarily through Health and Social Care, but also the wider Council and its partners.

The document covers 3 key issues:
- why things need to change
- how things need to change
- how the Council plans to deliver the change

Why things need to change

The Report of the Christie Commission on the Future Delivery of Public Services published in 2011 states clearly that:

“Scotland’s public services are in need of urgent and sustained reform to meet unprecedented challenges.”

In terms of social care, one of the main findings of the ‘Report of the 21st Century Social Work Review - Changing Lives’, published by the Scottish Executive in 2006 was that:

“Doing more of the same won’t work. Increasing demand, greater complexity and rising expectations mean that the current situation is not sustainable.”

For public service as a whole and social care in particular, there are 3 key challenges, which need to be addressed:

- Demographic pressures brought about by the fact that people, including those with long-term conditions and complex needs are living longer and are therefore more likely to need to access social care support. In particular, the fact that more people are living longer has also led to an increase in the number of people living with dementia.

  The number of people aged over 65 in Edinburgh (72,273 in 2012), is predicted to have increased by 54% to 111,319 by 2032. The total number of older people with dementia (currently estimated to be 7,142)
is set to rise by an average of 160 per year over the next ten years. After that, the average annual rise will almost double to 295 per year.

- Current ways of providing social care support will become unsustainable as a result of:
  - increased demand and the current financial climate, both of which place pressure on public sector budgets; and
  - the increase in the proportion of the population aged over 65, which means that relatively fewer people are available to deliver social care services and meet the cost through the tax system.

- People's expectations about the way in which their care and support needs are met are changing. No longer content to be passive recipients of a limited range of traditional services, they want to be treated as customers playing an active part in deciding how, when and by whom they are supported to live their life in ways that suit them. This change is reflected in the increase in the number of people in Edinburgh who receive direct payments to purchase and manage their own support, which has increased from 67 in 2000/2001 to 679 in 2010/11. The Council’s expenditure on direct payments in 2010/11 was £10.17 million.

In recent years, there has also been a shift in public policy in relation to both public service and social care, which seeks to change:

- the relationship between the individual and the state, from passive recipient of services to active partner
- the ethos underpinning the provision of support from a focus on those things people are unable to do for themselves to an asset based approach, which seeks to prevent the need for intensive support and maximise the independence of the individual
- the way in which services are organised and delivered so that those individuals in need of support and their carers have as much choice and control as they wish and is appropriate over how that support is provided; and
- the way in which services are evaluated and assessed by focusing on outcomes rather than outputs.

**How things need to change**

**Overarching Policy Drivers**

There is significant agreement between the findings of the Christie Commission and the Report of the 21st Century Social Work Review in terms of the changes required in public services in general, and social work in
particular. In both cases, people and communities are placed firmly at the heart of good public services and key priorities were identified as being:

The **Personalisation** of services, increasing the independence of those using public services by giving them more choice and control over how, when and by whom their needs are met.

The active **Participation** of citizens and communities in the planning and delivery of services, making best use of individual and community assets and ensuring that the services delivered are those that people value and want.

**Partnership** working between public, voluntary and private sector organisations to ensure value for money through joined up approaches and best use of collective resources.

Investment in **Prevention** and preventative services as a means of helping communities and individuals to maintain their independence and quality of life and reduce the demand for more intensive and costly intervention.

**Productivity** measured in terms of outcomes rather than outputs.
Policy Drivers in Social Care

Over the last 10 years, there have been a number of national policies in relation to health and social care, all of which have addressed the need to improve some aspect of the way in which adults with social care needs are supported:

- Better Health, Better Care
- Caring Together
- Integration of Health and Social Care
- Public Protection
- Reshaping Care for Older People
- National Strategy for the Management of Offenders
- Reducing Delayed Hospital Discharge
- Road to Recovery
- Same As You?
- Scotland’s Relationship With Alcohol
- Self Directed Support Strategy and draft Bill
- Shifting the Balance of Care
- Draft Mental Health Strategy for Scotland

Cross-cutting themes run through these policies, which, when taken together, provide the key elements of a whole systems approach to transformation:

- The development of personalised approaches which provide choice and control for those in need of support.
- A focus on maximising independence through the use of reablement, rehabilitation and recovery approaches.
- Co-production between the public sector, people who use services, their carers and communities in the planning, design and delivery of services.
- Joined up working and resources across agencies.
- Utilising and supporting the assets available within communities to support their more vulnerable members and themselves.
- Prevention as a means of maintaining independence and reducing demand for intensive services.
- Carers recognised and treated as equal partners.
- A focus on delivering outcomes.
- Accessible mainstream/universal services, such as leisure facilities, transport and shops.
- Accessible, good quality information and advice to enable people to make informed decisions.
- Promotion of and support for an ethos of self-care and self-management.
- The development of clear and well understood care pathways.

The diagram below summarises the strategic shifts required to deliver this cross-cutting agenda.
A Whole Systems Approach

Change of this scale is transformational and cannot be delivered successfully in a piecemeal way, which focuses on specific areas such as prevention or self-directed support in isolation. A whole systems approach is required, which provides a framework for addressing the common agendas across services, whilst recognising the differences between the various service user groups, services and organisations.

The diagram on the following page describes a model of delivery, which incorporates the strategic shifts outlined in the previous section.
The Changing Landscape of Adult Social Care
Whole System Approach to Delivering the Strategic Shift

- People can receive support at more than one level at the same time.
- The intention is to meet people’s needs at the earliest possible level in order to keep them out of the tip of the funnel.
- People will move up and down the funnel as their circumstances change and needs reduce or increase.
- There is a focus on public protection and a positive approach to risk enablement throughout.

At all levels support is progressive, proportionate and focused on maximising independence choice and control and delivering outcomes.

These services can be accessed directly without the need to come through Health and Social Care. However, they may also form part of a package of support facilitated through Health and Social Care.

Services may be accessed directly or put in place following an assessment.

Reablement should be seen as part of the assessment process and time limited. Rehabilitation and recovery may be a desired outcome rather than a specific service and would not necessarily be seen as time limited. The focus is on maximising independence throughout.

Focus is on maximising independence, choice and control as far as possible and appropriate in terms of how outcomes are met.

Focus is on personalised approaches, maintaining independence and enabling people to exercise choice and control as far as possible and appropriate through to end of life. Dependent upon circumstances the emphasis may be on supporting people to return to the community.
Achieving the Change

We are not starting with a blank sheet of paper in Edinburgh, as much good work has been and continues to be done to modernise and personalise services, including the following examples:

- The Community Connecting initiative funded through the Change Fund for Older people is an excellent example of working in partnership with communities to improve the health and wellbeing of people who may otherwise access mainstream social care support.
- The Local Area Coordination Team works with people with moderate learning disabilities who have used the residential respite care facility at Glenallen to provide alternative short breaks based on individual needs and aspirations.
- In mental health services, peer support initiatives have been developed as part of recovery approaches.
- The Neighbourhood Network established in Craigmillar through the Thistle Foundation brings together a group of people living within a small geographic area who are seeking to build up their social networks to a point where they become self-sustaining.
- The direct payment support service operated by Lothian Centre for Inclusive Living provides a range of support for managing direct payments.

By and large, these initiatives have been developed within individual service areas and focused on specific service user groups. The Council believes that if whole system change is to be delivered in Edinburgh, the experience, skills and innovative thinking already demonstrated need to be harnessed in a more co-ordinated way. We therefore want to adopt a programme approach in order to provide a framework within which to drive forward the transformation of support for vulnerable adults.

We want to work with our partners, including people who use social care services and carers, to agree a vision and a set of desired outcomes for the people of Edinburgh, which will be delivered through a number of workstreams and a clearly defined work programme, with explicit deliverables and timescales.

Our own analysis of the current position in Edinburgh and our understanding of the transformation, which needs to be delivered have led us to identify 14 key objectives that the Personalisation Programme needs to achieve.

Programme Objectives

1. Develop a ‘Customer Journey’ setting out the customer experience we are seeking to deliver.

2. Ensure a range of high quality, easily accessible information and advice is available to assist people to make informed choices.
3. Increase access to universal services for vulnerable people.

4. Reduce the demand for ongoing care and support through investment in preventative services, which promote good health and wellbeing.

5. Embed a focus on outcomes throughout the customer journey, from first point of contact through assessment, planning, service delivery and review.

6. Embed a focus on ‘maximising independence’, wherever possible, throughout the customer journey, using approaches such as reablement, intermediate care, rehabilitation and recovery.

7. Ensure that people are appropriately assisted to direct their own support.

8. Ensure that the range of care and support services available is sufficient to provide people with real choice.

9. Ensure that services are outcome focused and personalised, regardless of whether they are provided within people’s own home or within an institutional setting.

10. Ensure that self directed support is a reality for all, including people with complex needs and those from groups which have not traditionally made use of social care support.

11. Ensure the Council’s financial frameworks support the principles of personalisation and self directed support.

12. Ensure that the Council’s commissioning and procurement frameworks support the delivery of personalisation and self directed support.

13. Maximise the opportunities for working with communities.

14. Ensure alignment with the proposals for the integration of health and social care.

**Delivering the Programme**

The objectives listed above are deliberately high level, as we want to work with our partners, including people who use social care services and their carers to decide how they are achieved. With regard to objective 7, for example, we want to work with others to identify what forms the assistance available to people to direct their own support should take.
Programme Organisation

The following tables set out the proposed governance arrangements for the Personalisation Programme, which is underpinned by 3 key principles:

- People who use services, carers and communities are active partners in delivering the Personalisation Programme.
- Opportunities for partnership working will be maximised.
- Linkages will be made with the governance arrangements for the health and social care integration programme.

<table>
<thead>
<tr>
<th>Programme Governance</th>
<th>Programme Delivery</th>
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<tbody>
<tr>
<td>Executive Sponsors</td>
<td>Financial Framework</td>
</tr>
<tr>
<td>Monica Boyle and Michelle Miller</td>
<td>Engagement Network</td>
</tr>
<tr>
<td>Senior Management Leads</td>
<td>Communication and Engagement</td>
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<tr>
<td>Nikki Conway - Operational</td>
<td>Programme Team</td>
</tr>
<tr>
<td>Wendy Dale - Strategic</td>
<td>Wendy Dale and Nikki Conway - Chair</td>
</tr>
<tr>
<td>Gordon Dunbar – Programme Manager</td>
<td>Work stream leads</td>
</tr>
<tr>
<td>Sarah Holiday – Executive Support</td>
<td>Market Shaping</td>
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<tr>
<td>Departmental Management Team</td>
<td>Workforce and Organisational Development</td>
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<td>Checkpoint Group</td>
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Roles

<table>
<thead>
<tr>
<th>Roles</th>
<th>Responsibilities</th>
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<tbody>
<tr>
<td>Executive Sponsor</td>
<td>To provide overall leadership for the programme and act as champions at Corporate Management Team.</td>
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<tr>
<td>Strategic Lead</td>
<td>To take responsibility for the strategic direction of the programme and ensure coherence with both corporate policies and strategies and national legislation and guidance.</td>
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<tr>
<td>Operational Lead</td>
<td>To ensure that:</td>
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<tr>
<td>Roles</td>
<td>Responsibilities</td>
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<td></td>
<td>- The strategic approach takes full account of the operational realities of delivering social care services in Edinburgh; and&lt;br&gt;  - The strategic direction drives changes in culture and practice</td>
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<tr>
<td>Programme Manager</td>
<td>To:&lt;br&gt;  - Take responsibility for day-to-day delivery of the programme plan ensuring that milestones are achieved on time and within budget.&lt;br&gt;  - Maintain risk registers and issue logs&lt;br&gt;  - Regularly report on risks, issues and progress against the plan to senior management leads&lt;br&gt;  - To champion the culture change required to achieve the transformation across the organisation</td>
</tr>
<tr>
<td>Executive Support</td>
<td>To provide support to the programme and Executive Sponsors.</td>
</tr>
<tr>
<td>Programme Administrator</td>
<td>To provide administrative support to the Programme Team and in particular maintain project documentation such as project plans, risk registers, issues logs and progress reports.</td>
</tr>
<tr>
<td>Checkpoint Group</td>
<td>To contribute to the oversight and quality control of the Personalisation Programme through constructive, critical appraisal and support and in particular ensure that engagement and consultation activities are appropriate and reaching the right audiences.</td>
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</table>

**Workstreams**

The programme will be delivered through 8 workstreams, each of which will have a clear remit and a set of milestones and deliverables. The membership of each workstream will include representation from the Council, the NHS, service users, carers and voluntary and private sector organisations.

All work stream leads will be members of the Programme Team, which will be responsible for co-ordinating activity across the workstreams in line with the programme plan. The Programme Manager will be a member of all
workstreams to ensure they have an overview of activity across the whole programme.

The table below gives details of the workstreams and their remits.

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Remit</th>
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<tbody>
<tr>
<td>Communication and Engagement</td>
<td>To develop overarching engagement and communications strategies and plans in respect of the Health and Social Care Personalisation Programme and oversee the related communication and engagement activity.</td>
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<tr>
<td>Engagement Network</td>
<td>To contribute to the development and implementation of the Personalisation Programme across Edinburgh through constructive, open discussion and the creative formulation of ideas.</td>
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<tr>
<td>Financial Framework</td>
<td>To ensure that the Council’s financial frameworks support the principles of personalisation and self directed support</td>
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<tr>
<td>Market Shaping</td>
<td>Ensure that the Council’s procurement frameworks and market shaping strategy support the delivery of personalisation and self directed support.</td>
</tr>
<tr>
<td>New Models of Delivery</td>
<td>Develop and redesign core social care services to enable people to maximise their independence and exercise as much choice and control as they wish over the way in which their care needs are met, in order to achieve the outcomes that are important to them.</td>
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<tr>
<td>Prevention</td>
<td>To develop and implement a strategy in respect of universal and preventative services which reduces the need for social care support through early intervention and the promotion of wellbeing.</td>
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<tr>
<td>Support Infrastructure</td>
<td>To support the delivery of the Personalisation Programme and the strategic shifts that underpin it by exploring the implications for performance management, quality assurance and IT systems and developing appropriate responses.</td>
</tr>
<tr>
<td>Workforce and Organisational</td>
<td>To support the ongoing Health and Social Care Personalisation Programme by facilitating and leading change in the following key areas:</td>
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<tr>
<td>Development</td>
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<tr>
<td>Workstream</td>
<td>Remit</td>
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<td></td>
<td>business processes</td>
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<td></td>
<td>working methods and practices</td>
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<tr>
<td></td>
<td>organisational culture</td>
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**Monitoring the Programme and Measuring Success**

An overarching programme plan will be produced setting out clear deliverables, milestones and timescales. Progress against this plan will be reported to both the Checkpoint Group and to Health and Social Care. Reports will also be submitted to the Council's Corporate Management Team and the relevant committee(s) of the Council, as required.

The success of the programme will be measured by the achievement of the programme objectives set out above and the outcomes agreed with all partners and stakeholders. The mechanism for determining success in respect of these outcomes will be agreed with stakeholders once the outcomes themselves have been agreed.