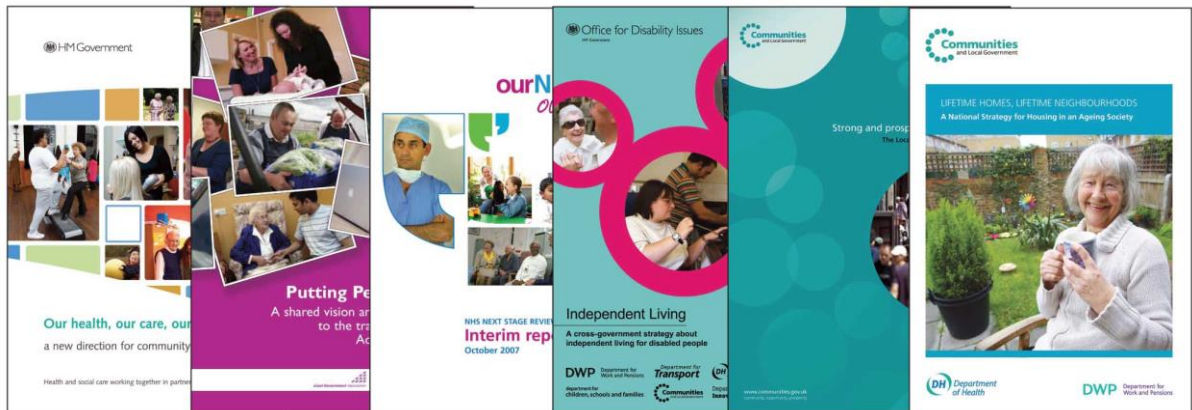




Cambridgeshire
County Council



Shaping *our* Future – A Framework for Action

Transforming Adult Social Care in Cambridgeshire
through Personalisation



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Executive Summary

1.1

Introduction

The past ten years have seen a national drive for change, centred on empowering citizens to shape their own lives and the services they receive. Consequently, public policy reform has focused on moving service provision from a 'one size fits all' model to one in which support is designed around the needs of the individual or community – 'Transformation through Personalisation'.

For health and adult social care these changes have culminated in Putting People First¹ which set out a shared agreement on the direction of travel, a commitment to transform (fundamentally change) adult social care and to achieve that significant change by March 2011. It outlined four, linked, areas which councils and their partners should focus on to achieve the right results and outcomes for all people.

Figure 1. The Four Areas of Focus



This vision requires that the focus of attention is not only on people with acute complex needs, but also on promoting the wellbeing of all and the development of universal services to support this.

Cambridgeshire Adult Social Care is at the vanguard of the movement towards personalisation through engagement in high profile, national pilot projects and the strength of its partnership working, integrated teams and community engagement experiences. Together, we are striving to:

- build services that respond to the needs of citizens, rather than services that reflect organisational structures; and
- develop new capabilities to ensure citizens are empowered to make choices about services with relevant and timely information.

¹ **Putting People First:** A shared vision and commitment to the transformation of adult social care, HM Government December 2007

Adult Social Care in Cambridgeshire

Historically, Cambridgeshire County Council directly provided all adult social care, with limited use of the independent sector. Over the last ten years, the direct provision of social care has increasingly been delivered through contracts with service providers in the independent sector and, more recently, integrated working arrangements with health services have been put in place. Adult Support Services works to implement the Council's vision of 'creating communities where people want to live and work now and in the future', supported by the objectives of:

- enabling people to thrive, achieve their potential and improve their quality of life;
- supporting and protecting vulnerable people, by promoting choice and control over the delivery of adult social care to support the health and wellbeing of each individual, aiming for the best possible quality of life, irrespective of personal circumstances.

In so doing, Adult Support Services describes its overall purpose as being:

"... committed to develop communities in which older people and adults affected by disability (learning disabilities, physical disabilities, sensory impairments, mental health problems and HIV/AIDs) are truly engaged, and exercise choice and control over their lives."

In order to address the four areas of focus within Putting People First, the Council's vision, and Adult Support Services purpose we need to:

- **understand future needs** by predicting, planning, acquiring, managing and sharing relevant data from internal and external sources;
- **shape the place** by working together with citizens and providers to support individuals to translate their aspirations into timely and quality services which meet their needs, enable choice and control, are cost effective, and support the whole community (CSIP 2008);
- **support the citizen** by ensuring individual outcomes are achieved.

How will we start to make the changes?

1. Gain the support of Cabinet to consult on this draft strategy for a 12 week period.
2. Gain Cabinet approval of the final version of the strategy, informed by the consultation.
3. Work with our principal partners and stakeholders to develop an implementation plan for the final version of the strategy, setting SMART objectives that will deliver 'significant progressing and cultural change'² by the target date of March 2011.
4. Raise awareness of the personalisation agenda across the whole system.
5. Scope and map current services.
6. Extend active engagement and partnership working.

² Transforming Adult Social Care LAC (DH) (2008) 1

What difference will the changes make to Cambridgeshire citizens?

Cambridgeshire citizens should ultimately be aware of changes in terms of:

- easier access to information and services made easier through a greater variety of access points in the community;
- proportionate assessment for people with less complex needs through (supported) self-assessment;
- much more choice and control over their services;
- plans that are person-centred and outcomes-focused;
- more people using Personal Budgets and Direct Payments;
- need being met earlier through a clear focus on prevention;
- an increase in enablement services;
- an improved ability to support people with complex needs;
- more people in paid work or volunteering;
- more people spending time doing things they choose during the day;
- more people supported to remain in their own home or become home owners/tenants in supported living – rather than residential care;
- an increase in user-led organisations and advocacy services;
- family carers receiving more support and assistance enabling them to have their own life and be healthy.

Increasing our chance for success

Both nationally and locally it is not known whether suggestions contained in this strategy will deliver the desired outcomes. The potential for success increases however if:

- we challenge our own internal practices, think creatively and balance risk and choice;
- commissioners move away from:
 - focusing on commissioning by individual client groups and from traditional service models;
 - focusing on particular resources and funding streams;
- commissioners move towards a culture of commissioning that focuses on individuals and their personal aspirations, needs and risks – defining and agreeing outcomes;
- suppliers shift to business models that focus on citizen need and not ‘bricks and mortar’;
- citizens assume more responsibility and can move away from an expectation that the state and statutory agencies have and can provide all the solutions;
- we are all prepared to work on a ‘let’s try it’ based version of partnership – and a ‘can do’ approach.

Introduction

This is a 'work in progress' document encompassing all vulnerable adults. It is intended to provide an overarching framework that outlines a vision, direction, priorities and long-term plan of action (strategy) for transforming adult social care services in line with public policy. It is set within the context of [personalisation](#) linked to the individual, the neighbourhood and the wider community. Rightly, Adult Support Services has developed this initial Transformation Strategy as required by government. However, early ownership and on going development with representatives across the County Council, our statutory sector partners (Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), NHS Cambridgeshire, Cambridgeshire Community Services), City and District Councils, and our key stakeholders is essential if the desired outcomes are to be achieved.

2.1 Why have a strategy?

A strategy is a long-term plan of action designed to achieve a particular goal. By being aware of national and local policies, programmes such as Supporting People, good practice, and involving users, carers and other key stakeholders, we can plan for what we want to achieve, what we all need to do in order to make it happen, and measure how much progress we make towards our vision.

2.2 The aims of the strategy

This strategy aims to:

- identify what is driving the transformation agenda;
- summarise the public policy reforms that are underpinning the transformation agenda;
- describe a potential view of services in 2020;
- outline Cambridgeshire's current and proposed response to the Transformation of Adult Social Care Agenda; and
- detail the next steps.

2.3 What is social care?

Social care is the wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and work with complex relationships. In Cambridgeshire, adult social care is delivered through the County Council's Adult Support Service, Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), Cambridgeshire Community Services, and many third and independent sector organisations. Advances in public health, healthcare and changes in society mean that people are living longer and with more complex needs. As communities become more diverse, the challenges of supporting the increasing demand and diversity becomes more apparent.

2.4 What do people want in terms of social care?

People have higher expectations of what they need to meet their own particular circumstances, wanting greater control over their lives and the risks they take. They want dignity and respect to be at the heart of any interaction. They want to access high-quality services, support to be closer to home and available at the right time – enabling them and their supporters to maintain or improve their wellbeing and independence rather than relying on intervention at the point of crisis. Social care cannot meet these challenges without ‘radical change in how services are delivered’.³

2.5 Background to the Transformation Strategy

The transformation of social care is set within the Government’s approach to personalisation, which can be summarised as ‘the way in which services are tailored to the needs and preferences of citizens. The overall vision is that the state should empower citizens to shape their own lives and the services they receive’.⁴

So, if personalisation is a cornerstone of the modernisation of public services, what does it mean for social care?

‘What it means is that everyone who receives social care support, regardless of their level of need, in any setting, whether from statutory services, the third and community or private sector or by funding it themselves, will have choice and control over how that support is delivered. It will mean that people are able to live their own lives as they wish, confident that services are of high quality, are safe and promote their own individual requirements for independence, wellbeing and dignity.’ LAC (DH) 2008 1 Transforming Adult Social Care.

Ultimately the ideal for social care is a model that has a

‘...single community-based support system focused on the health and wellbeing of the local population. Binding together local Government, primary care, community-based health provision, public health, social care and the wider issues of housing, employment, benefits advice and education and training’.⁵ Putting People First, 2007

2.6 Support for delivering the reform

Backing for the reform comes from:

- Social Care Reform Grant, [LAC (DH) (2008) 1];
- Department of Health (DoH) working with consortium of LGA, ADASS and IDeA to develop regional support;
- new skills academy to support world class commissioning and leadership in social care;
- cross-government ministerial engagement;
- explicit link to NHS Operating Framework.

³ Transforming Adult Social Care LAC (DH) (2009) 1

⁴ Building on progress: Public Services, HM Government Policy Review, DoH 2006

⁵ Putting People First: A shared vision and commitment to the transformation of adult social care, HM Government December 2007

Please refer to [Appendix 1.1 Brief Overview of Legislation and Social Policies](#) for brief details of each area. More comprehensive background to each can be found in [Appendix 1.0](#).

By March 2011 'significant progress is expected'⁶ with engagement and consultation fundamental throughout the process, from design stage onwards. Achieving the level of reform envisaged will require 'a huge cultural, transformational and transactional change in all parts of the system, not just in social care, but also for services across the whole of local government and the wider public sector'.⁷ Cambridgeshire is already well placed and acknowledged to be at the vanguard of the move towards personalisation through its participation with the 'in Control' organisation.⁸

⁶ Putting People First: A shared vision and commitment to the transformation of adult social care, HM Government December 2007

⁷ Transforming Adult Social Care LAC (DH) (2008) 1

⁸ 'in Control' is highly influential nationally and has driven much of the philosophy behind the publications of Putting People First and Transforming Social Care

Adult Social Care in Cambridgeshire

Historically, Cambridgeshire County Council directly provided all adult social care, with limited use of the independent sector. Over the last ten years, the direct provision of social care has increasingly been delivered through contracts with service providers in the independent sector and, more recently, integrated working arrangements with health services have been put in place.

Personalisation means this way of working is set to extend rapidly across individual, community, voluntary and independent sectors.

Adult social care works to implement the Council's vision of 'creating communities where people want to live and work now and in the future'. In so doing, it describes its overall purpose as being:

"... committed to develop communities in which older people and adults affected by disability (learning disabilities, physical disabilities, sensory impairments, mental health problems and HIV/AIDs) are truly engaged, and exercise choice and control over their lives."

In order to achieve our purpose we need to:

1. **understand future needs** by predicting, planning, acquiring, managing and sharing relevant data from internal and external sources. We are doing this through the Joint Strategic Needs Assessment (JSNA), which identifies the health and wellbeing needs of the local population. This will lead to more effective service provision by informing the Sustainable Community Strategy, Local Area Agreement, and other relevant commissioning strategies. Together these strategies will drive improvements in the health and wellbeing of local areas and lead to a reduction in health inequalities;
2. **shape the place** by working together with citizens and providers to support individuals to translate their aspirations into timely and quality services which meet their needs, enable choice and control, are cost effective, and support the whole community (CSIP 2008);
3. **support the citizen** by ensuring individual outcomes are achieved. In supporting the citizen's journey, the Council's actions will be underpinned by principles of Self-Directed Support and the promotion of independence.

By reforming the **whole system** including **universal services** and partnership working, we believe we will be able to:

- become commissioners of a service focused on supporting people with the most complex needs, who require specialised or tailored support services to enable them to access mainstream services wherever possible;
- work as a key partner in contributing to universal, mainstream services and the wellbeing agenda through investment in low level, open access and early intervention services to support people with emerging or low level social care needs;
- develop world class personalised services to meet future challenges;
- develop new forms of support and encouragement for people to improve their own health, wellbeing and skills;
- achieve value for money and productivity through greater efficiency and better targeting of resources; and

- understand the impact and outcomes for service users and citizens and use this information to review and further develop partnership working and commissioning.

What is driving the transformation agenda?

There are significant drivers both nationally and locally that are encouraging the Council to 'transform' its operations. These include:

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.

Demographics: People are living longer and communities are becoming more diverse. In the next 20 years, the number of people over 85 in England will double,⁹ and across the entire adult population, over 1.7 million more people will need care and support.¹⁰

Cambridgeshire County Council Research Group mid 2007 population estimates indicated similar patterns, for example:

Of the 586,800 people, living in Cambridgeshire approximately 83,000 are aged 65+. By 2021 forecasts suggest this figure will increase by a further 52,000. Current figures indicate 13,900 older people in Cambridgeshire are physically or mentally frail, or both. By 2011 predications suggest an increase to 15,700; by 2016 to 18,600; and by 2021 to 21,500. In association with this increase, the number of people with dementia is set to rise from approximately 6,580 in 2006 to 10,240 in 2021. Population ageing is likely to have the greatest impact in the rural districts.

An estimated 10,000, people with learning disabilities aged 15 and above live in Cambridgeshire. The Learning Disability Partnership teams provide health or social care support to around 2,230 individuals with a learning disability, of who around 1,700 receive social care support. Forecasts indicate the numbers of people with a learning disability aged 65+ will more than double by 2021. Of these, it is expected that between 300 and 450 will require support.

As with national predictions, the dependency ratio in Cambridgeshire is forecast to change, with relatively fewer people of working age to provide support for an older population. The number of people aged 15-64 per person aged over 65 is forecast to drop by 31.6% by 2021. This later figure is based mainly on falling birth rates. Current and ongoing economic difficulties may well result in more people leaving Cambridgeshire daily or permanently for work and therefore not available to undertake caring roles, which may place additional demand on services. This further reinforces the need to actively pursue the wellbeing and prevention agendas, so that demand for high level, costly support is minimised.

⁹ Government Actuary Department projections, 2007

¹⁰ Personal Social Services Research Unit (PSSRU) projections. This estimate is for personal social services only – not the entire care and support system.

Legislation and public policy reform: A common set of outcomes binds the following government documents: Our health, our care, our say,¹¹ Putting People First,¹² Transforming Social Care,¹³ Strong and prosperous communities,¹⁴ High Quality Care for All,¹⁵ Lifetime Homes, Lifetime Neighbourhoods,¹⁶ The case for change,¹⁷ and the Comprehensive Spending Reviews of 2007¹⁸ and 2008. See [Appendix 1.1](#) for brief details of these.



4.1 Strategic objectives and common themes of the public policy reforms

Identifying the strategic objectives associated to the public policy reforms revealed an overall set of common themes, which focused upon delivering outcomes that support:

- prevention, early intervention and enablement as the norm;
- personalisation, choice and control, and **empowerment** for citizens and communities;
- citizens co-producing, co-developing and co-evaluating opportunities that promote independent living;
- joint **place shaping**, strategy planning and delivery with public, private and voluntary sector partners;
- devolved decision making and neighbourhood working;
- a greater focus on **commissioning**;
- a continual drive for efficiency and value for money;
- an emphasis on sustainability;
- increased scrutiny of partnerships; and
- improved collaboration across local authority boundaries.

11 White Paper Our health, our care, our say: A new direction for community services, DoH 2006

12 Putting People First: A shared vision and commitment to the transformation of adult social care, HM Government December 2007

13 Transforming Adult Social Care LAC (DH) (2008) 1

14 Strong and prosperous communities – The Local Government White Paper, October 2006

15 Our NHS – Our Future: NHS Next Stage Review, DoH June 2008

16 Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society, DoH and DWP February 2008

17 The case for change – Why England needs a new care and support system, HM Government 12th May 2008

18 October 2007 Budget Reform and Comprehensive Spending Review, Meeting the aspiration of the British People

Please refer to [Appendix 2](#) for more detailed information regarding the strategic objectives and common themes.

To deliver these outcomes will mean 'working across the boundaries of social care such as housing, benefits, leisure, transport and health. It will mean working across the sector with partners from independent, voluntary and community organisations to ensure a strategic balance of investment in local services.' LAC (DH) (2008) 1

4.2

So what does this all mean for the citizens of Cambridgeshire?

If all stakeholders work together to support the common themes identified in paragraph 4.1, the citizens of Cambridgeshire should ultimately be aware of the changes in terms of:

- easier access to information and services made easier through a greater variety of entry points in the community;
- proportionate assessment for people with less complex needs through (supported) self-assessment;
- much more choice and control over their services;
- plans that are person-centred and outcomes-focused;
- more people using Personal Budgets and Direct Payments;
- need being met earlier through a clear focus on prevention;
- an increase in enablement services;
- an improved ability to support people with complex needs;
- more people in paid work or volunteering;
- more people spending time doing things they choose during the day;
- more people supported to remain in their own home or become home owners/tenants in supported living – rather than residential care;
- an increase in user-led organisations and advocacy services;
- family carers receiving more support and assistance enabling them to have their own life and be healthy.

In real, simple terms, at an individual level it means:

Patrick from the Fenlands is 78 years old. For 30 years, he has been a member of the local pub darts team three miles away from his home. A stroke has made Patrick vulnerable and wheelchair bound leaving him unable to get the bus or drive. A weekly visit to a nearby day centre is suggested so he can meet people with similar disabilities. Adopting a personalised approach however would enable Patrick to use some of his Personal Budget on taxis with disabled access to take him to and from the pub to be with his friends, if this is what he wants.

4.3

The overall message from public policy reforms

In summary, the overall message is simple:

- philosophy of personalisation is clear – major shift in approach and **transfer of control**;
- **whole system reform** – looking beyond personal budgets to universal services and partnership working;

- driven by new **Local Performance Framework** and integral to local government agenda;
- **housing** has a vital role to play;
- Putting People First makes it clear it is not about if transformation happens, but **when and how**;
- Green Paper debate on longer-term arrangements, still centred on **high quality, personalised services** shaped to the needs of the user.

Establishing the vision and changing the direction

The future vision requires that the balance shift from focusing only on people with acute complex needs to focusing on promoting the wellbeing of all. This needs to be underpinned by clear wellbeing outcomes and indicators to monitor progress in achieving them. It requires a broadening of the approach to prevention and the development of universal services to support this.

- There should be a set of local outcomes for people linked to the vision and strategy and the needs of the local community.
- Agreement of national and local key performance indicators to be used across agencies to monitor the effectiveness of interventions upon outcomes for people. In agreeing these indicators, every opportunity should be explored to amalgamate various outcome frameworks; this will strengthen consistency of approach and reduce duplicate data collection.
- Performance indicators should be few but important, easy to collect, and easy to benchmark. Local performance indicators should be owned, understood and easily recognised by the local community.
- Information systems across agencies need to be aligned so that outcome measures and performance indicators from different agencies and other sources can be collated and analysed.
- The importance of local authorities taking a whole systems approach to promoting the needs of people within communities should be reinforced, with full commitment from across the Council to delivering this agenda, including areas such as transport, economic development and growth.
- Resources need to be made available at a local level, to develop a dedicated team of people to implement, monitor and review the strategy, ensure that resources are spent according to the principles of best value, and facilitate partnership working.

5.1

Changing the way services are commissioned

There is a need to develop a community-based whole systems framework for commissioning universal and specialist services involving community members and a range of organisations – for example social care, health, housing, leisure, education, the independent sector and voluntary agencies. This will ensure locally based commissioning is built around communities.

5.2

Changing the way services are governed

It is important that there is a coherent framework for decision-making and accountability, at a national and local level.

- Community and Adult Services will lead, from within the County Council, on the delivery of this significant change, recognising the importance of engaging other parts of the County Council and other partners.
- The Care, Health and Wellbeing Partnership Board, reporting to Cambridgeshire Together, will need to ensure that there is clear accountability and responsibility for delivering the strategic developments and co-ordination of resources, making appropriate links with other Thematic Partnership Boards, as appropriate.

5.3 **Changing the way services are delivered**

Services in future need to be user driven, delivered in partnership with others, integrated, community-based, flexible and easily accessible. There must be different kinds of services to meet people's needs. This would include a continuation of the reduction in use of residential and nursing home care, and further expansion of community services, including different forms of extra care housing based on the concept of normalised dwellings adjusted to individual need.

- Universal services need to be reviewed, ensuring they meet people's needs and that new services are developed.
- Local councils should examine how people can better access lifelong learning including basic skills.
- A clear framework needs to be developed to allow agencies, communities and individuals to complement each other's efforts rather than compete with them. Services need to be delivered based on community needs.

5.4 **Changing the workforce**

If we are to develop a more integrated approach to tackling priorities and providing a catalyst for joint strategies, we must build partnerships and networks across a range of agencies. The workforce needs to be multi-skilled and multi-disciplinary, and there needs to be a greater understanding and appreciation of each other's roles and responsibilities. This has major implications for induction, training and workforce planning.

- A workforce strategy for adult services has been developed, to create a multi-skilled workforce, taking account of the implications of Self-Directed Support on the workforce.
- All frontline staff working in adult services should have a core set of knowledge and skills to give appropriate advice and information. This will involve whole systems induction programmes and shared professional training.
- The development of new skills should be encouraged, with the removal of barriers to learning and improved access to learning opportunities.
- Funding for leadership programmes, based around communities, should be made available bringing together managers across agencies to enhance partnership working, develop joined up strategies, and pool skills and experience. Such opportunities should be open to service users, carers and the public.

5.5 **Potential service models**

To be effective, services need to be user driven, based around communities and have real accountability. Thematic Partnership Boards will be the mechanism for pulling together all local services so that accountability for outcomes is clear. Whether services are universal or targeted, generic or specialist, through the Thematic Partnership Boards they should form a coherent whole.

Access to the 'active community' will be direct to users and their informal carers. It is important that an easily accessible information service is located in the locality, to help people know what is available within the 'active community' and how to access the universal services.

A clear pathway as to how a person moves from universal services to specialist services is essential. Access to the 'specialist community' should be through a multi-disciplinary team of local professionals who will carry out the initial single assessments, and then commission or deliver specialist services, when a person requires them through the Self-Directed Support system.

Key features of this new service model are that they will be:

- **person-centred** – active involvement of the service user and their carer in designing flexible services to meet their needs;
- **easily accessible** – 24 hour, 7 day a week services;
- **delivered in partnership** – the partnership will include health, housing, leisure and social care services, community members, the independent and the voluntary sector;
- **community-based** – locally determined and locally delivered, but within a national framework.

A potential picture

Paragraphs 6.1 – 6.11 use the previous information to create a potential picture of how adult social care may look in 2020. To get the most out of this section we suggest you take yourself forward in your imagination to 2020 – just over ten years from now. This is a ‘make over’ in reverse! To help you move forward in time consider the following.

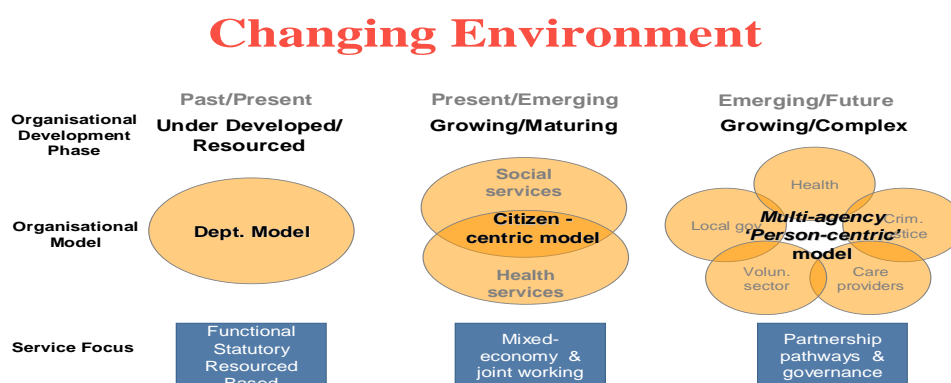
- How old will you be in 2020?
- Will you have started a family, be approaching mid life or retired?
- Will you be in the same house, living in the same area or country?
- Will you be in the same type of work, a completely different area of employment or engaged in further education?
- How old will your friends and family be, what will they be doing and what will you be doing with them?
- If you are affected by mental health, disability, domestic violence etc. – what will your expectations and requirements be?
- What will your ambitions and dreams be in 2020?

Cambridgeshire in 2020

For sometime, we successfully engaged in supporting services that had at their centre the needs of the person and were able to adapt to the changing needs of the individual. Despite the marketplace supporting a mixed economy, it had limited diversity and lacked transparent partnership working.

Since 2015, we have been moving towards a multi-agency model. We now feel confident that the aspirations and principles first articulated in Valuing People¹⁹ some 16 years ago, and built upon by subsequent policy reform are now embedded within Cambridgeshire. We have remained in the vanguard of development, and acknowledged as one of the few areas to have a single community-based support system focused on the health and wellbeing of the local population.

Figure 2. Cambridgeshire 2000–2020



¹⁹ Valuing People: A new Strategy for Learning Disability for the 21st Century, March 2001

What's Cambridgeshire's business as a commissioning authority?

In 2020, in partnership with NHS Cambridgeshire (the local Primary Care Trust) and other stakeholders, the authority now has a clear view of the needs of the whole adult population, based on the Joint Strategic Needs Assessments including service user group and community profiles, which were completed in 2007, 2009, 2011 and 2013. However, the partners are now focusing on achieving outcomes for the whole community not just those eligible for social care.

The authority has moved beyond a social justice model (emphasis on user led services and key roles for brokers and navigators) and prevention model (emphasis on role of upstream, universal, low level, community-based services). These are embedded in our work and we now use a social inclusion model with its emphasis on:

- helping people stay away from social care and health;
- enablement role and avoiding dependency;
- more competent mainstream services and
- more supportive communities.

Partnerships with health and others are delivering the health and wellbeing agenda and the actions from all the Directorates across the authority support this. We are helping people transform their own lives, through having:

- much more control over their lives;
- more choice about services; and
- more capacity to do things everyone else takes for granted.

Our task is to ensure that the majority of people's needs are met through ordinary, everyday services accessible to all. The local authority's leadership role means we are championing not only the needs of vulnerable citizens, but also their access to and inclusion in universal services.

Two key components of our business

First as commissioners of a service focused on supporting people with the most complex needs who require specialised or tailored support services to enable them to access mainstream services wherever possible.

Second as a key partner and commissioner in contributing to universal, mainstream services and the wellbeing agenda through investment in low level, open access, and early intervention services to support people with emerging or low level social care needs.

Both these components are delivered within a social model of care, which ensures that the person's support networks (social capital) are woven together with publicly funded services. This model encourages earlier interventions that can support individual and family coping strategies.

6.4

Who are we supporting?

- People with long-term social care/support needs whose independence requires some form of care or support on a long-term basis.
- People with long-term social care/support needs whose independence can be improved over time with enablement/rehabilitation/learning new skills types of support, thus reducing their reliance or dependence on care or support.
- People with shorter term social care/support needs, who with the right type of enablement, rehabilitation and/or learning new skills/types of support will require little or no care or support in the future.
- People with minimum social care/support needs whose independence can be improved or maintained by signposting to and support from universal community-based services.
- Communities and neighbourhoods in their work to become more self-sufficient and supportive of vulnerable adults.

6.5

What does it look like for the citizens of Cambridgeshire in 2020?

6.5.1

Getting the right information

Having started with a single 'case finding' approach in 2008 led by NHS Cambridgeshire, we now have a range of predictive tools to identify people at risk of social and or health related issues which if left unattended would require more intrusive and costly interventions. For those people preferring a DIY approach, information on health, housing and social care is available through a wide variety of outlets including:

- libraries, supermarkets, faith buildings and community information hubs;
- Community Support Teams (including neighbourhood wardens);
- health centres, integrated multi-agency Health and Social Care Teams (Care Navigators), acute health services;
- online from the Internet or from specialist consumer-focused websites;
- customer contact centres or one-stop shops;
- Disability Rights Groups, Partnership Boards;
- community centres, resource centres;
- gateways for low level support services and information.

Getting the right information out to citizens is a shared responsibility across services and accessing the information is available through guided support.

6.6

How do people access services in 2020?

At a very basic level, a home support simple screening and referral tool is in place across social care, health, housing, Fire, Police and Ambulance services so that home visits for whatever reason can trigger an early referral for help across several agencies. The authority has already visited all over 80 year olds (in partnership with others) to run a simple screening tool to identify possible problems. Case finding is via these referral and home visiting schemes.

At the next level, there is a more detailed screening tool, which helps identify those people needing to access specialist services through an assessment. This operates through the information outlets on a guided basis or an online DIY basis using a self-assessment tool.

People with long-term conditions are able to complete their own full assessment in relation to a range of specific services, e.g. community equipment, or can access a specialist online assessment /diagnostic service.

Anyone living in Cambridgeshire and seeking support knows that they can get access to information from the directory of low level services – a spin off from the accreditation process for providers and the associated catalogue of support providers started in late 2008. A recent upgrade of the directory reflects the work of the local [Gateway Direct Access Services](#) – Care and Support Networks, which include universal services.

The [Fair Access to Care Services \(FACS\)](#) threshold remains at ‘substantial and critical’ and people who meet these thresholds either for a short-term intervention, via [reablement](#) or rehabilitation or for long-term support have their needs assessed via the [Common Assessment Framework \(CAF\)](#) either through a self-assessment process or via a facilitated support process.

The CAF includes specialist components to assess people’s mental health needs or the social consequences of their disability. People are encouraged to complete as much of the assessment as they can by themselves and to contribute information from their person-centred plans.

Our task, at this stage is to help people conduct their own self-assessment and purchase and manage their own package of care through a Personal Budget. Following the CAF, an [indicative resource allocation](#) is quickly agreed, including any contribution the individual has to make. Then the individual and their support group pull together a [Support Plan](#), which draws on the [Personal Budget](#).

Personalised Services, using Personal Budgets, with [Direct Payments](#), and social credit cards to pay directly for services, when required, are the norm for most people. People unable, unwilling or too frail to take control of their own social care budget have a service purchased by Adult Support Services from a [preferred provider scheme](#).

People intending to pay for their own care are offered information and advice about community-based alternative services and their charges. Older people receiving residential care are able to rent their property to produce an income as an alternative to selling up.

Those people who do not meet the FACS threshold are signposted to the Gateway Service Direct Access Services (Care and Support Network) in each area. These provide information, guidance and access to practical support from the Voluntary, Community and Faith Sector (VCFS) and from accredited small traders. They offer a range of assistance for example supporting people back into work (potentially through volunteering); enabling people to access the benefits they are entitled to; reducing hospital admissions through such schemes as home maintenance, health and wellbeing initiatives, leisure and pleasure; all of which are enabling people to live independently and remain healthy for longer.

Many agencies and organisations are able to signpost people on to the local Gateway Service, which is delivered from a range of different host premises, including libraries, resource centres, and supermarkets.

A network of small voluntary organisations co-ordinate consultation and co-production processes throughout the County.

Improving people's health and wellbeing in 2020

A planned and managed reduction in acute hospital beds in the PCT area has generated a major investment in community-based health services including preventative and early intervention services designed to help people take more control of their own health and wellbeing.

Wellbeing is accepted and promoted by all partners as a shared responsibility covering the full range of the seven outcomes.²⁰ At mid-life, NHS 'Life Checks' now offer a self-assessment followed by personalised advice and support. This also provides an additional point of entry to services through built-in triggers for a more detailed assessment.

There is improved access to talking therapies and computerised cognitive behavioural therapy. There are more Occupational Therapists (OTs) within the integrated community teams providing clear practical assistance to support reablement, and short-term intervention services.

Self-referral to physiotherapy is in place. People are supported to manage their own long-term conditions through:

- information on prescription which gives them information both about their condition and available self care support services;
- integrated health and social care plans;
- improved access to the [Expert Patients Programme](#);
- a much wider range of home treatment services; and
- Personal Health Budgets.

New models of support have developed through investment from [practice-based commissioners](#) into prevention (who are required to work jointly with the authority's commissioning team) and early intervention services designed to avoid unnecessary stays in hospital. There is a multiplicity of health care providers and some contracted-out PCT services (e.g. OTs, Health Promotion services) are provided by the authority and some through joint health and social care '[social enterprises](#)'.

GPs are purchasing some social care. [Assistive technology](#) is helping people stay in their own home longer. Integrated, co-located and community based teams are in place across all adult health and social care services to provide an integrated model of care.

What is it like from the informal carer's perspective in 2020?

Unpaid family carers and circles of friends take a full and active part in designing Support Plans and commissioning support packages from a range of sources. Their contribution is considered critically important in helping people become more independent.

As part of the 'New Deal for Carers' an information service and helpline, sponsored by the government is in place and accessible to carers. Carer self-assessments are well publicised and are routinely offered and taken up. [Care pathways](#) are published so that families know what sort of support is available. In each locality, there is an emergency short break service, including overnight stays, to help with continuity of support.

²⁰ White Paper Our health, our care, our say: A new direction for community services, DoH 2006

Unpaid carers, families, supporters and advocates are able to influence and shape the sort of services that are now provided in the community, and have a much greater say over where, how and by whom the support is provided. They also have more ways to influence the shape of services generally, e.g. through upgraded Partnership Boards linking directly to Local Strategic Partnership (LSP) 'health and wellbeing' groups, and through the [Local Involvement Networks \(LINKs\)](#), which enable people and communities to engage with statutory and non statutory services.

Community capacity building programmes delivered through the voluntary sector are explicitly embracing the protection, development and support of families and other sources of informal care and volunteering.

6.9 **What is it like from a community perspective in 2020?**

There are now many more opportunities for different neighbourhoods and groups to influence and shape the wellbeing of their communities, through:

- involvement in their local Sustainable Community Strategy;
- the Local Strategic Partnerships (LSPs);
- Local Involvement Networks (LINKs);
- Partnership Boards and Forums;
- [Community Calls for Action](#) and the monitoring of Neighbourhood Charters; and
- participative budgets that support [neighbourhood management](#).

People are more engaged in their communities, but this has taken investment and time. LSPs are accountable to local communities and provide them with annual performance reports based on agreed targets.

The [Joint Strategic Needs Assessments](#) have helped to identify those areas and processes where the community's voice was weakest.

Investment in capacity building means that communities are much more involved in delivering health and wellbeing. The Council's duty to ensure the participation of local citizens and local voluntary/community groups is actively pursued and we are judged on how well we engage with these groups as part of our annual performance rating.

Citizens and communities have better access to local health services through the growth in community-based services. Adult social care has commissioned new community 'involvement' staff to provide a direct link between people, their communities and the statutory services ensuring they are key participants in the community and regeneration agendas.

New partnerships between health, social care, probation, district and parish councils, police, and the third sector are delivering Gateway Direct Access Services in each community offering support to vulnerable adults who are at a moderate or low-level risk of losing their independence. Through these co-ordinated care networks a wide range of simple practical support schemes are open to everyone and there are clear links with more specialist (but still universal) low/medium level support, for example:

- [social prescribing](#) in mental health services;
- information and leisure prescribing through GPs;

- low level housing support for vulnerable people;
- low level home improvements from accredited providers.

Health and wellbeing telephone follow-up support is available to identified vulnerable people. Good neighbour schemes and village support groups are in place. Housing and neighbourhood wardens, youth workers, and community organisations support dedicated neighbourhood policing teams.

Libraries and community services are making a key contribution to social inclusion and community cohesion. They are offering information and advice, signposting, learning opportunities, engagement and involvement opportunities. These services are linked to the community information hubs, resource centres, village halls and to Gateway Direct Access Services and considered a community asset.

People with diverse backgrounds and needs are living in the same community. There is a movement towards acknowledging and respecting people for their abilities rather than their disabilities and no longer a requirement for people to move home to be supported, it comes to them. Therefore, social isolation and labelling linked to people's 'conditions' is significantly reduced.

6.10 What does it look like from the Adult Support Service perspective in 2020?

The Service has restructured to take on the [social inclusion model](#) and now provides two key services.

Firstly, a service focused on supporting people with the most complex needs who require specialised or tailored support services to enable them to access mainstream services wherever possible. This is delivered by integrated and co-located health and social care teams and in a manner, that maximises people's own contribution to the transaction. The service includes cross agency work with vulnerable adults. Self-Directed Support is the norm and support is available from navigators who work closely with the authority's brokerage service.

The service focuses on the health and social care aspects of disability, irrespective of age, and includes short-term intervention designed to help people gain, regain or maintain their independence.

Secondly, a partnership and wellbeing service whose task is to achieve outcomes for the whole community not just those eligible for social care support. Delivery is through a series of partnership agreements with statutory, commercial, third and community sector partners to shape the health and wellbeing of local communities in Cambridgeshire. Its main tasks are to:

- invest in low-level, open-access prevention and early intervention services to support people with emerging or low level/moderate social care needs, primarily through the Gateway Direct Access Services, telecare, supported housing and an enhanced role for the voluntary sector;
- mobilise universal, mainstream services to ensure that they are open to all citizens, (including adult learning, leisure, sports, libraries and cultural services, training and employment, housing and counselling) and that they provide a wider range of occupational, daily living, health and wellbeing activities, which were previously thought of as exclusively the work of social services;
- commission capacity building in local communities, specifically around the health and wellbeing agenda.

The authority's key role is as a commissioner of services to support the health and wellbeing of the local community. It has drawn on the Joint Strategic Needs Assessments to develop a comprehensive Commissioning Framework taking a ten-year view of both the community development implications for the service and the changes in the social care market. It also identifies how other Council services and organisations are contributing to the support of community wellbeing. This has led to a diverse market that is appropriately dynamic as it responds to the changing needs of individuals. The authority has devised Strategic Workforce Plans together with providers and these have helped identify new roles such as Neighbourhood Wardens, [Care Navigators](#) and Support Brokers.

7 Moving forward with the transformation agenda

7.1 How are we going to achieve this transformation?

Sections 5 and 6 outlined a vision with a clear direction and a potential picture of life in Cambridgeshire from a health and social care perspective. Working towards realising the Cambridgeshire of 2020, we need to develop a strategy which:

1. has common ownership;
2. has a set of shared values and outcomes, part of which is a mainstream system focused on prevention, early intervention and enablement;
3. ensures empowerment of citizens both at individual and community/macro levels. The latter evidenced by a breadth and depth of personalisation, choice, control and influence over the support services individuals receive and the extent to which groups of people can shape their neighbourhoods and communities;
4. builds on Joint Strategic Needs Assessments (JSNA) that have been produced and therefore owned by the Local Strategic Partnership (LSP) and are heavily populated with evidential information that has breadth and depth at a local level and referenced at a national level;
5. utilises the JSNA to directly inform the health and wellbeing outcomes of the Local Area Agreements and Community Strategies;
6. creates opportunities to promote a whole systems view by making connections between different services; and
7. has a clear and constant drive towards efficiency savings.

7.2 Key themes underpinning the Transformation Strategy

Using the referenced framework of strategic objectives, the recurring subjects were grouped together under three key themes enabling this strategy to provide the foundations of common ownership:

7.3 Key theme 1 - Personalisation

This key theme is founded on the principals of independence, choice and control, empowerment, and addressing inequalities. It recognises and builds upon the capacity of people and their social networks (social capital) to co-produce (owned and managed by users) good outcomes for themselves and others. From a social care perspective, it also incorporates Self-Directed Support (SDS) and Personal Budgets. This ensures the person is in control of their assessment, their support, the quality they will demand and the price they are willing to pay.

7.3.1 Examples of what we have done as part of the transformation journey

- The County Council and NHS partners joined the 'in Control' project as a direct result of a successful earlier project involving 12 people with learning disabilities and their families, who were willing to take on board the principals of SDS and trial Personal Budgets.
- Cambridgeshire was one of only ten authorities originally involved in this project, led by 'in Control', a highly influential organisation that works closely with the Department of Health and Ministers. It has driven much of the philosophy underpinning Putting People First and the transformation agenda.

- Created an 'in Control Total' Project which is accountable to the Quality for Adults Programme Board. There is a Service User Reference Group and established work streams – financial sustainability, market management, people and culture, processes and systems and policy development.

Through the 'in Control Total' Project the number of people using Personal Budgets has increased to 56 and is being rolled out to new and existing customers from April 2009. In addition the proportion of funds spent on residential and nursing care is smaller than the national average and balanced by a larger than average spend on supported living.

The experiential learning generated through the 'in Control Total' Project has informed Cambridgeshire's Self-Directed Support Policy²¹ and will continue to influence the roll out of SDS²² across all vulnerable adult groups who are eligible to receive social care support as of April 2009. We believe that as people become familiar with SDS and stories of innovative approaches to meeting individual's needs are shared, confidence will increase and more people will begin to move away from the current traditional models of service delivery.

The overall aim of the changes underpinning the SDS policy is to:

'...further enhance the empowerment of the citizens of Cambridgeshire, so that they might remain or become active participants in their local communities; and that those communities will be more responsive to the needs of all their members. Individual social capital will be enhanced via a contribution from the Council (the Personal Budget) so that life goals can still be pursued as social care needs are met.'²³

This policy marks a key stage in the Council's implementation of the Local Authority Circular Transforming Adult Social Care in which SDS and Personal Budgets become mainstream.

- Supporting People Programme is a partnership between the County Council, the District Councils, health, probation and the majority of providers from the third sector. Established in 2003, it is rooted in personalisation in that:
 - personal support plans are produced in partnership with the individual, detailing their own focused packages of support;
 - a quality assessment framework enables providers to improve service quality and policies such as safeguarding; and
 - a local, inclusive forum engages with providers so that they can influence how the programme is implemented locally.

7.3.2 Moving forward

As part of moving forward with the transformation agenda the following key elements of work are in place, or progressing on target:

- An SDS process is being rolled out in a phased way for new referrals and existing service users between April 2009 and March 2011.

²¹ Cambridgeshire Self-Directed Support Policy December 2008

²² Control is transferred from social services to the individual who decides what form their support will take, when it will take place and who will provide that support.

²³ Self-Directed Support Report to Cabinet Agenda Item 4 16th December 2008

- A Support Questionnaire – a user friendly, streamlined approach to asking key questions about circumstances and social care support.
- A process for early calculation of Personal Budget enabling support planning to be undertaken with a genuine knowledge of the available social care resources, using a [Resource Allocation System \(RAS\)](#) that links level of need to a financial allocation. The design is transparent, objective and provides a consistent resource response to eligible need. This enables it to be both personal and equitable, two of the main issues the transformation agenda is striving to address. Work has also started on the RAS for Mental Health (MH) including developing the scoring for the Support Questionnaire and bandings in conjunction with MH staff.
- Guidance document for light-touch monitoring has been developed with input from Internal Audit.
- A training and developmental programme for staff and providers to support them to implement SDS across Cambridgeshire.
- Becoming one of only five ‘trailblazer’ sites nationally working in a development partnership to assess the feasibility of a web-based system called ‘Shop 4 Support’²⁴. The system is designed to support individuals to manage their Personal Budget; provide access to market information and enable direct invoicing in a cost effective manner between providers and individuals. It will also provide the Council with information about how budgets are spent and identify existing or emerging gaps to be considered in the ongoing shaping of the market.
- Engagement with providers to develop a buoyant and choice orientated marketplace. The work includes the formation in November 2008 of a Champion Provider Steering Group. It is ‘a cross-sector provider’s network – to promote and develop the implementation of Self-Directed Support across Cambridgeshire’.²⁵ Members represent all service areas from the independent sector and in-house provider services. Information from the monthly meetings informs the new SDS Provider Briefing which commenced in December 2008. The briefing document has a circulation list of over 500 providers across the County. Increased access to the document and a set of frequently asked questions for SDS is available via the County Council’s website. The Steering Group links to the Shop 4 Support programme and The Opportunities Trust.²⁶ In addition, a countywide Adult Mental Health Provider Forum has been established, which is meeting quarterly.

²⁴ Shop 4 Support is now a social enterprise based online marketplace that is majority owned by inControl. See <http://www.in-control.org.uk/site/INCO/Templates/General.aspx?pageid=989&cc=GB> for progress report and link to website.

²⁵ Champion Providers Steering Group Terms of Reference

²⁶ The Opportunities Trust is a group of organisations working together to provide a rich menu of activities and support for people with disabilities and impairments across Cambridgeshire.

- Undertaken countywide workshops with disability service providers (October 2008) and older people's service providers (February 2009) i.e. in-house, independent, voluntary and service user reference groups. These workshops provided opportunities for people to: a) gain an understanding of the fundamentals of SDS; b) participate in the ongoing development of SDS; c) appreciate how over time, Personal Budgets present the service user with individual possibilities and choices and; d) engage in the new contracting arrangements which are being introduced on a rolling programme from April 1st 2009.

7.3.3 Next steps

We will use the experiential learning gained from local and national experience through the 'in Control Total' Project to move forward with all current developments. Specifically over the next two years, we will focus on:

1. developing Self-Directed Support web pages and downloads;
2. developing a bank of case studies and service user/family carer presentations around Personal Budgets;
3. rolling-out a promotional film produced about Self-Directed Support;
4. designing and delivering awareness-raising sessions for wider staff groups. As part of the strategic long-term approach for learning and development for SDS, a number of further initiatives are either in early development or are currently being considered. These include:
 - a) an [e-learning package](#);
 - b) coaching and Action Learning Sets for Managers; and
 - c) mini training sessions for Care Managers e.g. Support Planning and RAS;
5. continuing to work on the development of a RAS for Sensory Impairment and Occupational Therapy;
6. extending the process of Personal Budgets for everyone eligible for publicly funded social care support then incorporating people with long-term conditions accessing NHS resources through Personal Health Budgets;
7. ensuring person-centred planning and Self-Directed Support encompasses social capital;
8. refining the Resource Allocation System;
9. developing and expanding self-assessment opportunities for those with low to medium needs within an outcomes-based Personal Budget Assessment Framework;
10. working with Health colleagues to integrated care pathways, starting with long-term conditions;

11. working with GP partners to increase social care and social intervention commissioning, prescribing through [Practice-based Commissioning](#)²⁷ and ensuring information and leisure prescribing becomes mainstream; and
12. building on the Outcome Framework in order to provide evidence of effective support and intervention.

7.4 **Key theme 2 – Prevention and early intervention**

This key theme addresses the need to make a strategic shift towards delivering services that focus on prevention, promote health, wellbeing, enable or re-enable people as part of maintaining and retaining their independence. This not only maintains and improves people's quality of life but also prevents or delays the need for more costly interventions from statutory services such as health, housing, social care and probation.

7.4.1 **Examples of what we have done as part of the transformation journey**

- Using six years of prevention and early intervention experience gained through the Cambridgeshire Supporting People Programme and the national programme to inform our thinking. For example, 'Research into the financial benefits of the Supporting People programme' CLG January 2008, demonstrated nationally that for every £1 of Supporting People money invested, there is a net gain of £1.78.
- Piloting 'case finding' within the Older People's Service. This is the first predictive tool to be trialled. Research is underway to identify other tools that combine health and social care indicators.
- Established a reablement project that has defined and gained agreement for a definition of reablement and evaluation criteria. In addition the project is investigating reablement models across the country.
- Negotiated a new contract for the provision of community equipment services funded by a pooled budget between the County Council (CCC) and NHS Cambridgeshire and delivered by an independent sector provider. It provides an equitable, accessible service across the County. Self-assessment facilities are available through the Independent Living Service. A detailed leaflet identifying all providers across the County is extensively available through the Contact Centre, Cambridgeshire's website, GP surgeries etc.

²⁷ Practice-based Commissioning (PBC) Clinical Commissioning: our vision for practice-based commissioning. DH 4th March 2009
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_095692

- The PCT and CCC joint fund the countywide Assistive Technology and Telecare (ATT) Service. It works in partnership with the District Councils, the independent call centres and ten main registered social landlords. In 2007–08 people accessing this service included 152 with memory problems and mental health, 99 with physical disabilities and frailty, 22 with learning disabilities and 16 with sensory impairments. An evaluation in 2008 of 398 cases issued with ATT equipment in 2006–07 found 220 were still using their equipment, enabling them to maintain their independence, with 25 supported at home until they died. The evaluation demonstrated over £1.1 million of savings related to care packages, avoided admissions to hospital, and residential and respite care. With the support of the Preventative Technology Grant²⁸ more people are able to be supported and new technologies to be considered.

Maggie is 56 she is in the early stages of dementia and requires regular medication throughout the day. An automated dossett box (pill dispenser) allows her to access the correct medication and, maintain her independence. From Maggie's perspective her independence, dignity, choice and control are maintained. From a service perspective there is a saving of four care calls per day equating to an annual saving of £6,000+.

One day training to become an assessor for telecare equipment has been provided to 500+ frontline professionals in health, housing, social care, the voluntary and independent sectors. This is extending access through mainstream services with plans in progress for an e-learning version of the training programme thereby further increasing access.

Cambridgeshire County Council is working in partnership with Luminus (RSL) who provide the premises for a very successful demonstration smart home flat and training venue. Work is on going with community matrons and their very high intensity service users to expand Wristcare an automatic personal alarm system.

7.4.2 **Next steps related to prevention and early intervention**

We will continue to move forward with all current projects. Specifically over the next two years, we will focus on:

1. designing a universal information and advice service through co-production between the DoH and other partners including the Pensions Agency and voluntary sector;
2. identifying and building the linkages between SDS and the equipment service;
3. identifying how advanced assistive technologies such as telehealth and telecare can further support integrated working, integrated systems, extra care and self care with particular regards to people with long-term conditions or those who are predicted to require intensive health or social care support in the future;

²⁸ The Preventative Technologies Grant (LAC (2006) 5, March 2006)

4. building upon and integrating the work of the Supporting People Programme. Cambridgeshire has recently volunteered through CLG to be a pilot site in developing a model to determine the benefits at a local level of the Supporting People Programme which if selected will provide a rich source of learning and knowledge in progressing transformation through personalisation;
5. developing a 'reablement' evaluation framework;
6. evaluating current Intermediate Care Services;
7. reviewing Day Services in line with SDS principles;
8. demonstrating the improvement in outcomes, especially the benefits of early intervention and prevention;
9. building on universal services – recognise the diversity of people's needs and actively remove barriers to their accessibility. In this context, 'universal services' refer equally to commercial services (e.g. shops, banks and cafés) as to community services (e.g. leisure centres, libraries and transport). Leisure services, education, housing and primary care are moving away from being designed to serve the 'average citizen' to being personalised around a wide range of differing needs. The more this process is advanced the less need there may be for some types of specialist services or the extra help required for disabled or older people to access universal services;
10. linking with libraries, community development and community learning to maximise social interventions across the County;
11. working with Care Response 24, Police, Fire, Ambulance and other out of hour's services to deliver alternative care pathways to divert people from high-end services;
12. applying case finding to other vulnerable groups across the County and piloting alternative predictive tools identified through our research;
13. working towards a locally agreed approach in which prevention, early intervention and enablement become the norm and inform the Sustainable Community Strategy;
14. investigating the value of extending to other groups of vulnerable adults, the 'Life Style Advisor' role. This role currently focuses on people with a physical and or sensory disability. Advisors support people in accessing universal services, engage in meaningful activities including volunteering, slithers of time employment, part- and full-time employment;

15. becoming an active participant in discussions related to the design and location of 'Lifetime Homes and Passive Houses'.²⁹ Link these discussions to Cambridgeshire's Disability Housing Strategy,³⁰ to ensure planning and developments take into account the views and needs of disabled people;
16. develop a model identifying the whole system costs of providing Lifetime Homes v failure to provide. The model will include build costs of a lifetime home compared to the build costs of a 'standard' home plus adaptation, admission to hospital, delayed discharge and discharge to residential care costs;
17. Working with key stakeholders to develop a Volunteering Strategy. The strategy should:
 - integrate the White Paper New Opportunities Fair Chances for the Future³¹ that sets plans for investment in communities, families and citizens that will give all people the best possible chance of fulfilling their potential in order to build a more prosperous economy and a stronger, fairer society;
 - link up with 'involved volunteer programme' introduced in April 2008 by the Office of the Third Sector³² (OTS). This programme is funding 152 third sector organisations to create new volunteering opportunities for young people that tap into their passions and interests. Some of these projects will also be working with target groups to ensure that the involved programme widens access and increases participation in volunteering activity;
 - link to independence wellbeing and engagement in meaningful activities. Provide compelling stories that challenge the approach of identifying people by their disabilities rather than their abilities.

By using these drivers and approaches the volunteering strategy will have the potential to be dynamic, integrated and stimulate significant change at individual, organisational and community levels.

7.5 **Key theme 3 – Whole systems requirements to underpin the delivery of key themes 1 and 2.**

Adopting a cross cutting approach to the following ensures the approach to transformation is adopted by the whole system rather than a set of disconnected projects within social care.

²⁹ Passive Homes – This refers to an integrated design process and refers to a construction standard that aims to reduce the heating needs in housing to a point where conventional heating systems are no longer necessary, and carbon emissions are reduced to zero.

³⁰ Cambridgeshire Disability Housing Strategy 2008–2011 Draft, 12th February 2008, for consultation and comment

³¹ New Opportunities: Fair Chances for the Future, HM Government January 2009

³² As part of the Cabinet Office, the Office of the Third Sector (OTS) leads work across government to support the environment for a thriving third sector (voluntary and community groups, social enterprises, charities, co-operatives and mutuals), enabling the sector to campaign for change, deliver public services, promote social enterprise and strengthen communities.

Examples of what we have done as part of the transformation journey

- Engaged in creating a shared vision and governance arrangement through the overarching partnership board – Cambridgeshire Together. The Board has five strategic objectives and is the overarching mechanism or vehicle to ensure the management and delivery of the transformation agenda involves the whole system and is supported and steered by partnership arrangements. The Cambridgeshire Together vision is the basis of the Local Area Agreement that informs and agrees partnership strategies e.g. Sustainable Community Strategy and action plans.
- We have contributed to the Joint Strategic Needs Assessment³³ (JSNA) with Public Health colleagues. In essence this is a structured way of creating a ‘community picture’ and is a fundamental building block in understanding the needs of our communities so that we can target resources where they will have the greatest impact. The JSNA process currently encompasses six separate JSNA’s which are focused on different groups within the community: a) older people; b) people of working age; c) adults with learning disabilities; d) adults with mental health problems; e) adults with physical disability and sensory impairment, and long term conditions; and f) children and young people. By contributing to the ongoing development of the JSNA we have used information from the JSNA workstreams to inform our strategies for example:
 - adults of ‘working age’ – specific work underway to better understand preventative needs from the perspective of the population and service providers. A new countywide Health and Wellbeing Partnership will oversee this work;
 - older people – data from the JSNA on Older People underpins the PCT Long Term Conditions Strategy and has informed the multi-agency Older People’s Strategy which focuses on the broader determinants of health. It is also informing the Joint Commissioning Strategy for Older People;
 - Commissioning Strategy for Learning Disabilities 2008–2011;
 - Commissioning Strategy for Physical Disability and Sensory Impairment November 2008;
 - Commissioning Strategy for Mental Health 2008;
 - Supporting People Commissioning Strategy 2008–2010;
 - Supporting People Needs Analysis 2009
- Cambridgeshire Supporting People Programme commissioned a needs analysis as outlined in the document ‘Needs Analysis, Commissioning and Procurement for Housing-Related Support’.³⁴ The initial work has established housing related support needs for the County across 20 different client groups on behalf of all partners (County Council, District Councils, health and probation, voluntary sector providers and citizens). The data collected is currently being analysed and incorporated into the new Supporting People Strategy.

³³ JSNA introduced in the Government’s ‘Commissioning framework for health and wellbeing’ published in March 2007. JSNAs form the basis of a new duty to co-operate for PCTs and local authorities.

³⁴ Needs Analysis, Commissioning and Procurement for Housing-Related Support: A resource for housing-related support, social care and health commissioners, CLG July 2008

- contributed to the Cambridgeshire County Council's emerging Community Engagement Strategy;
- linked all strategic documents to local and national policies and priorities and underpinned them with examples of best practice;
- developed a Workforce Development Strategy that supports the roles, responsibilities, skills and behaviours required to deliver the personalisation agenda;
- extended and enhanced users, carer and other key stakeholders engagement mechanisms so that activities are co-designed and that plans and strategies are genuinely co-produced. Examples include;
 - the Partnership Boards linked to learning disabilities, older people, physical disabilities and sensory impairment, and carers;
 - the 'in Control Total' Service User Reference Group;
 - Cambridgeshire Carer's Strategy 2008–2011.

We have also contributed to the Shaping Places Shaping Services document.³⁵

- Developed a Performance Management Framework (PMF) that is rooted in delivering the best possible outcomes for users and their carers. Because we attach such strong importance to involving and engaging with stakeholders, they are identified as an integral circle within the Performance Management Framework.
- Started to develop an Outcomes Focused Framework with key stakeholders in order to demonstrate the effectiveness and impact of our involvement with people. As John Waters of 'in Control' has stated: 'Change will not stick or be valued unless the positive outcomes it achieves are measured and understood. The effort to change must be constantly balanced with the effort to understand how that change has impacted on people's real lives.'
- Extending and enhancing our partnership working through for example, Supporting People, a national programme providing support services for a range of vulnerable people across Cambridgeshire (20 client groups). The partners include users and carers, the County Council, District Councils, Health, Probation, voluntary groups, charities and independent organisations. The programme strategically plans, commissions, monitors, improves housing related support services, for some of the most vulnerable, and socially excluded members of our society.

³⁵ Shaping Places Shaping Services: Cambridgeshire's approach to community engagement, 30th January 2009

Next steps in relation to whole systems requirements to underpin the delivery of key themes 1 and 2.

1. Contributing to phase 3 of the JSNA, which is focused on current services and commissioning arrangements; and phase 4 which will concentrate on further improving the level of engagement with and between the Districts.
2. Stimulating and managing a dynamic market by:
 - engaging the community, including The Opportunities Trust and providers of social care and housing related support, in discussions on market development;
 - developing the capacity of the community – linked to social capital and the voluntary sector.
3. Identifying and starting to address the implications for information and communications technology (ICT) in supporting the delivery of Putting People First. In the LAC (DH) (2009) 1, it refers to the development of a work programme for 'improving social care information' through co-production between the DH and partners. It states that the 'strategic programme aims to respond to the specific needs of different parties in the system, whether those of service users planning their own support or councils sharing benchmarking information. It will combine technical and policy solutions to change the way information is collected, held and used by councils. Amongst other things, this will incorporate work to provide public-facing information resources on social care, and to develop whole-systems approaches to information sharing between local councils and with the NHS and DH. The development and use of data standards, starting with the roll-out of the NHS Number in adult social care, will be an important factor in enhancing the way information is used'.

This raises numerous questions for Cambridgeshire County Council and our partners that are yet to be answered.

- To what extent will the business processes underpinning the transformed service represent an increasing reliance on IT?
- What impact will the transformation strategy have on other areas of Cambridgeshire County Council's IT environment?
- What are the dependencies and are there any special infrastructure requirements, i.e. anything that will need to change in order to facilitate the implementation of the new strategy?
- What changes are needed to the current adult social care related IT environment in order to deliver this strategy?
- What differences will there be in the way we use IT?
- Will the strategy require new systems and or applications to be commissioned and implemented and if so, does this mean some existing systems will no longer be needed?
- To what extent does the strategy require a shift in current IT policy and strategy in relation to innovation, risk and leading edge developments or will we only use "tried and tested" IT solutions?
- Will we need greater investment in IT in order to achieve the outcomes of the strategy, if so how will this be funded?

- Is there an expectation that the workforce, citizens and or their representatives will need to have increased IT skills in order to access services? If so how will they be supported in gaining these new skills?
 - To what extent will greater use of IT leverage back office savings?
 - To what extent will greater use of IT link to improved customer satisfaction and meeting the personalisation agenda?
4. Extending the remit of the workforce development strategy to address the needs of the social care workforce across the whole County regardless of the employing agency. This will be co-produced, co-developed and co-evaluated with our principle partners, the community, voluntary and independent sectors.
5. Continuing the work of the group focusing on evidencing outcomes, and develop an implementation plan. The plan will:
- state an aspiration in developing an outcomes approach in Adult Support Services;
 - state the current position of services in relation to outcomes;
 - establish targets for further development across services; and
 - allow flexibility to respond to any national policy developments.

Mapping of outcomes-based activity (assessments, care plans, reviews, complaints, contracts etc) within services has been carried out, and shows activity that is in place or is being planned. This information will be used to cascade outcomes activity into other services, and establish an expectation of further development of outcomes for service or team planning.

Information and training in understanding outcomes is required and is in part being delivered through training for staff in the introduction of Self-Directed Support. The training will be supported by written information and case studies available on the intranet.

Creating systems for compiling accessible evidence of outcomes. This will include an 'Evidence Bank' for case studies, good practice and the development of current information systems in services.

As part of the outcomes-focused agenda, we will be identifying how we are going to evidence financial activities and deliver efficiencies. Alongside the transformation of social care, councils have key targets to deliver 3% efficiency savings per annum (on average across the country) to meet demographic challenges and to balance the budget. These efficiencies are being delivered in a number of ways, many of which are compatible with the objectives of social care reform and personalisation, for example:

- simplifying assessment processes, including self-assessment, developing reablement and other preventative services that promote independence and reduce the requirement for longer term interventions;
- developing housing support solutions and assistive technologies that allow people to live in their homes longer rather than in residential care;
- collating information on outcomes and purchasing patterns so that better decisions are made regarding the type of services people want.
- pooling resources to achieve maximum efficiency, effectiveness and therefore value for money (VFM).

6. To consider as part of our strategic financial plans how, as a transforming service with a changing pattern of expenditure, we forecast the spending profile to develop over a period of years, and put in place arrangements to monitor these changes as they take place.

7.6 **Success criteria**

Beyond the new Performance Management Framework there are three areas we want to track and evidence our progress against: 1) partners and organisational stakeholders; 2) citizens; and 3) the service. One approach is to pose a series of questions for example:

7.6.1 **Partners and organisational stakeholders**

Do we feel confident that there is evidence of or progress towards:

1. 'Authentic partnerships' with Corporate Directorates, local NHS, other statutory agencies, third and private sector providers, users and carers and the wider local community;
2. agreed and shared outcomes ensuring citizens, irrespective of potential funding stream, need, illness or disability, are supported;
3. development and ownership with local partners of the Joint Strategic Needs Assessment (JSNA);
4. developing an understanding of the future needs by predicting, planning, acquiring, managing and sharing relevant data from internal and external sources, to create an understanding of future needs in a timely and appropriate way. This will include Joint Strategic Needs Assessment which should lead to more effective service provision by informing the Sustainable Community Strategy, Local Area Agreement, and other relevant commissioning strategies, driving improvements in the health and wellbeing of a local area and leading to a reduction in health inequalities;
5. shaping the market to meet the personalised agenda whilst balancing investment in prevention, early intervention/reablement and providing intensive care and support for those with high-level complex needs;
6. a locally agreed approach, which informs the Sustainable Community Strategy, is utilising all relevant community resources especially the voluntary sector so that prevention, early intervention and enablement become the norm.

7.6.2 **For citizens**

Do we feel confident that there is evidence of or progress towards:

1. supporting citizens to remain in their own homes for as long as possible with the alleviation of loneliness and isolation as much as possible;
2. commissioning universal information, advice and advocacy service for people needing support and their carers irrespective of their eligibility for public funding;
3. implementation of a commissioning framework to drive commissioning based around customer needs, wants and experience;
4. person-centred planning and self-directed care being mainstreamed and the principles underlying Putting People First underpin all commissioning activity.

7.6.3 For the service

Do we feel confident that there is evidence of or progress towards:

1. Ensuring Personal Budgets for everyone eligible for publicly funded adult social care support other than in circumstances where people require emergency access to provision;
2. Developing an effective and established mechanism to enable citizens to make supported decisions built on appropriate safeguarding arrangements; and
3. Market development and a stimulation strategy, which outlines actions identified to deliver the necessary changes.

7.7 Current partners to support, drive and deliver on the transformation agenda

The following is not an exhaustive list, but it does demonstrate the wide range of partners who are or will be involved in the transformation process.

- Cambridgeshire County Council
- East Cambridgeshire District Council
- Cambridge City Council
- South Cambridgeshire District Council
- Huntingdonshire District Council
- Fenland District Council
- NHS Cambridgeshire
- Cambridgeshire and Peterborough NHS Foundation Trust
- Cambridgeshire Community Services for Older People
- Cambridgeshire Police Authority
- Cambridgeshire Constabulary
- Cambridgeshire Fire and Rescue Authority
- Cambridgeshire ACRE (Actions for Communities in Rural England)
- Cambridgeshire Infrastructure Voluntary Sector Consortium (CVSIC)
- Cambridgeshire and Peterborough Learning and Skills Council
- The National Probation Service
- Job Centre Plus
- Sport England (through Cambridgeshire Living Sport)
- Business Link
- Age Concern
- Cambridgeshire and Peterborough Association of Local Councils (CPALC)
- Greater Cambridge Partnership
- Cambridgeshire Horizons
- 'in Control'
- 'Valueworks'

Partnership mechanisms to deliver on the transformation agenda

There are a number of partnership mechanisms that have the potential to offer significant support and provide a driving force in moving the transformation agenda forward these include:

1. **Cambridgeshire Together** – with particular focus on three of the five goals identified to deliver the vision: 1) Growth; 2) Equality and inclusion; and 3) Strong communities initiatives.
2. **Thematic Partnerships** – in particular Care, Health and Wellbeing Partnership Board, and the Supporting Officer Groups.
3. **Client-focused Partnership Boards**

8 Overall next steps

Whilst we may be some time and distance from our 2020 scenario and achieving the goal envisioned in Putting People First, i.e.

‘Ultimately, we ‘seek to have a single community-based support system focused on the health and wellbeing of the local population. Binding together local Government, primary care, community-based health provision, public health, social care and the wider issues of housing, employment, benefits advice and education and training.’

....we certainly have a good foundation from which to move forward. Our next steps are therefore to:

1. gain the support of Cabinet to consult on this draft strategy for a 12 week period;
2. gain approval of Cabinet to a final version of the strategy, informed by the consultation;
3. work with our principal partners and stakeholders to develop an implementation plan for the final version of the strategy with SMART objectives set to deliver ‘significant progressing and cultural change’³⁶ by the target date of March 2011;
4. raise awareness of the personalisation agenda across the whole system;
5. scope and map current services; and
6. extend active engagement and partnership working.

8.1 Will the draft Transformation Strategy work?

It will if:

- we challenge our own internal practices, think creatively and balances risk and choice;
- commissioners move away from:
 - focusing on commissioning by individual client groups and from traditional service models;
 - focusing on particular resources and funding streams;
- commissioners move towards a culture of commissioning that focuses on individuals and their personal aspirations, needs and risks – defining and agreeing outcomes;
- suppliers shift to business models that focus on citizen need and not ‘bricks and mortar’;
- citizens assume more responsibility and can move away from an expectation that the state and statutory agencies have and can provide all the solutions;
- we are all prepared to work on a ‘let’s try it’ based version of partnership – and a ‘can do’ approach.

³⁶ Transforming Adult Social Care LAC (DH) (2008) 1

If you would like a copy of the Executive Summary of this document in large print, Braille, audio tape or another language, please contact Amanda Davies on 01223 699650 or at in.controltotal@cambridgeshire.gov.uk

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