Tony Kershaw
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14 January 2019

Dear Member,

Health and Adult Social Care Select Committee - Wednesday, 16 January 2019

Please find enclosed the following documents for consideration at the meeting of the Health and Adult Social Care Select Committee on Wednesday, 16 January 2019 which was unavailable when the agenda was published.

Agenda Item No 4b

4. Responses to Recommendations (Pages 3 - 36)

Enclosures for item 4b were omitted in error.

Yours sincerely

Tony Kershaw
Director of Law and Assurance

To all members of the Health and Adult Social Care Select Committee

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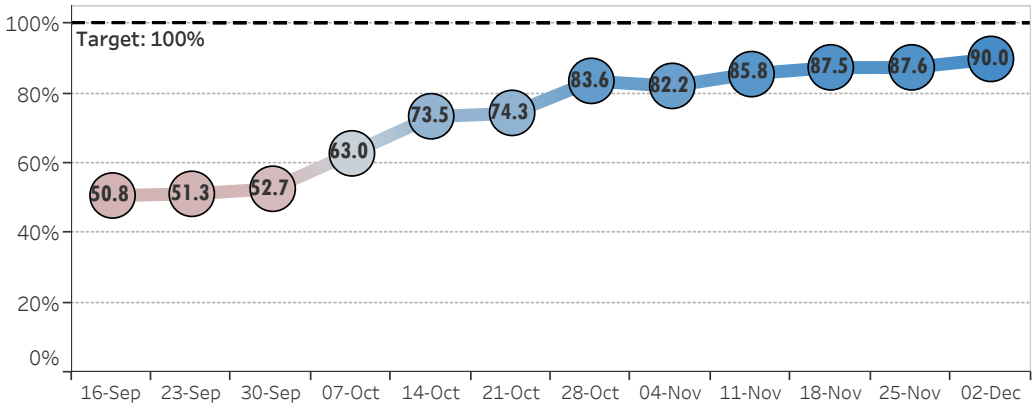
Adult Social Care Safe Indicators **10-Dec-2018**

1. New Safeguarding concerns with Assurance Decision in 5 working days

AMBER | **Target: 100% Aim High**

Current: **90.0%**

219 Safeguarding concerns received in the week ending 2-December, of which 197 (90.0%) had an assurance decision within 5 working days.

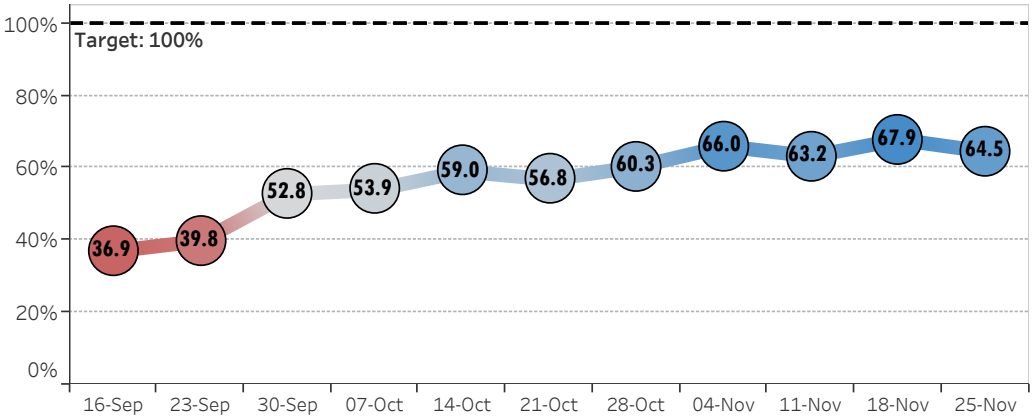


2. New Assessments started in 7 working days

RED | **Target: 100% Aim High**

Current: **64.5%**

383 new Initial Assessments, Assessments and Conversations in the week ending 25-November, of which 247 (64.5%) were started in 7 working days.

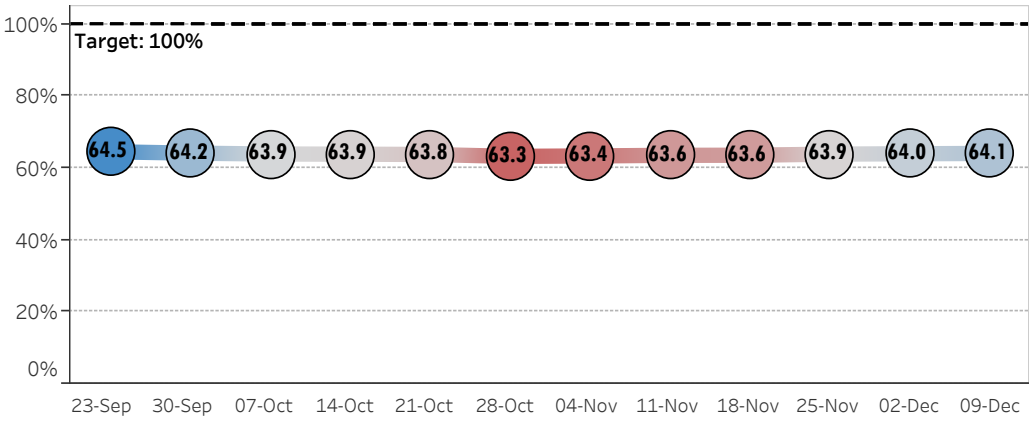


3. Long-Term customer Reviews completed in year

RED | **Target: 100% Aim High**

Current: **64.1%**

6598 customers in long-term services continuously for at least 12 months as of 9-December, of which 4228 (64.1%) had received a review in the last 12 months.



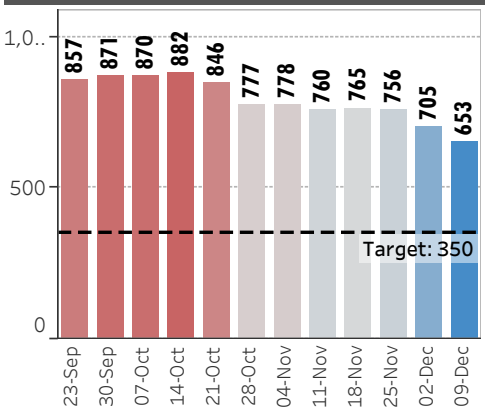
4. Open priority DoLS Assessments - Volume and Duration

RED | **Target: 350 (42 days)**

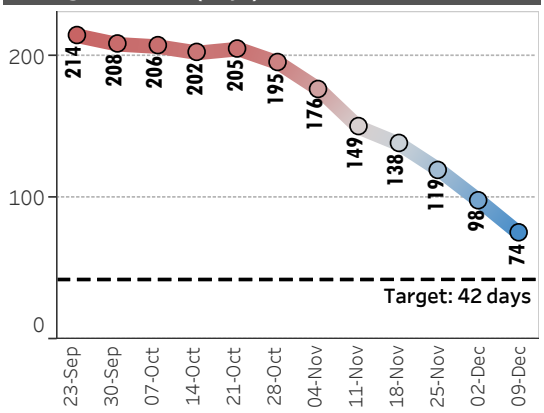
Current: **653** **(74.5 days)**

653 open DoLS Assessments as of 9-December that came in as Priority 1, Priority 2, Short stay hospital or had no priority given following triage. The average length of time that these 653 DoLS Assessments were open was 74.5 days.

Volume:



Average Duration (Days):



Safe Indicator Definitions

1. New Safeguarding concerns with Assurance Decision in 5 working days

Definition: The proportion of new Safeguarding concerns received in each week with an Assurance Decision made within 5 working days. Number of days calculated from the date the concern is received (or if this is not provided, the date it is input to Mosaic) to the date the Assurance Decision is taken and the concern stage is completed.

Why is this a safe KPI? WSCC has a principle of "no delay" so that the safeguarding response is made in a timely fashion with due consideration to the level of presenting risk, with significant risk cases contacted within 24 hours. This gives assurance that the concern has been looked at and an appropriate decision has been made in a timely manner.

How is the target calculated? WSCC aim is that 100% of Safeguarding concerns should have an Assurance Decision made in 5 working days.

2. New Assessments started in 7 working days

Definition: The proportion of assessments requested in each week that were started within 7 working days. Excludes known customers in receipt of long-term services or transitioning from Children's Social Care. Includes all Initial Assessment, Assessment and Conversation steps. Days are calculated from the trigger date of the initial assessment to the date the step is started.

Why is this a safe KPI? WSCC has a principle of initiating new customer assessments in a timely manner.

How is the target calculated? WSCC aim is that 100% of Assessments should be started in 7 working days.

3. Long-term customer Reviews completed in year

Definition: The proportion of long-term customers who had a planned or unplanned Review/Reassessment completed in the last year. Cohort includes only those customers who have been continuously in long-term services for at least 12 months as at the reported date. This can include short breaks (e.g. hospital admissions) of under a month. Mental Health customers are only included where they have a purchased service.

Why is this a safe KPI? Reviews should take place a minimum of once per year and this gives reassurance that it is happening.

How is the target calculated? WSCC aim is that 100% of long-term customers should receive a review at least once per year. The 2nd September 2018 base line was 64.7% therefore a proposal of short-term targets is 73% by Mar 2019, 81% by Sep 2019, 90% by Mar 2020 and 100% by Sep 2020.

4. Open priority DoLS Assessments - Volume and Duration

Definition: The volume and average days open for all open DoLS Assessments that were originally triaged as Priority 1, Priority 2 and Short Stay Respite Hospital, as well as any cases which were not triaged (no priority given). Priority 3, 4 and 5 assessments are excluded as the risk has been assessed as low. Days are calculated from the date the assessment is first incoming, which follows immediately after triaging of the DoLS Request.

Why is this a safe KPI? To ensure that priority work for DoLS Assessments is under control.

How is the target calculated? 6 week target for the DoLS Assessment does not include triaging of requests. It includes 1 week to allocate, 1 week for the Section 12 doctor's report, 3 weeks for the BIA report and 1 week to be signed off. The volume target is the number of assessments expected to be received in 6 weeks (based on average received in the last 12 months).

Evaluation of the New Adult Social Care Operating Model

FINDINGS AND RECOMMENDATIONS

Report by the
West Sussex Public Health and Social Research Unit,
West Sussex County Council
1st Floor, the Grange,
Tower Street, Chichester PO19 1QT.

Authors
Jacqueline Clay, Rachel Jevons, Matthew Dorey, Ryan Walkley, Tim Martin
Date: August 2017

Thank you to all the residents, innovation staff, project, evaluation sub group and performance staff across West Sussex for providing their time, energy and thoughts. And a special thanks to Jennie Barrett who spent many hours validating data, and providing advice and guidance to the evaluation team.

INTRODUCTION

This is a summary evaluation report of innovation undertaken by West Sussex County Council to change the approach used to meet the social care needs of adults. Data and evidence collected and analysed for the evaluation are detailed in a separate document.

A new way of working was tested as the existing way is viewed as a system centred on assessment and eligibility for services; a system which fosters waiting lists, where people are often signposted away and which has become focussed on process, not outcomes, for people and their families. There is also a concern that the current system only moves to action at the point of crisis, such as carer breakdown, rather than working with people at an earlier point, and that long term decisions were made when people were in crisis.

West Sussex managers examined models, adopted in other local authorities, that have variously been described as "strengths-based[1]" or "community-based" social care, the broad aims of which are similar:-

- to reach out to more people, earlier, to help support their independence and quality of life;
- to have "different conversations" with people based on assets, strengths and community resources;
- to, where possible, support people closer to home and in communities;
- to act fast in a crisis, with a focus on recovery, reablement and rehabilitation;
- and where there is no presumption that the offer of services is the goal.

In West Sussex it is also intended that a new model should:-

- Reduce forms and processes so that staff have time for conversations with more people at an earlier stage; and reduce queues and waits. The model proposed has been explained and summarised to staff as the Three Conversations Model developed by Partners 4 Change[2]. (Figure 1).

The basic premise of the model is that these conversations, and resultant action from them, are used to ensure people's needs are met; exploring in the first instance how people may use their own, their families' and/or community strengths and assets to meet their needs. It is hoped that increased, and

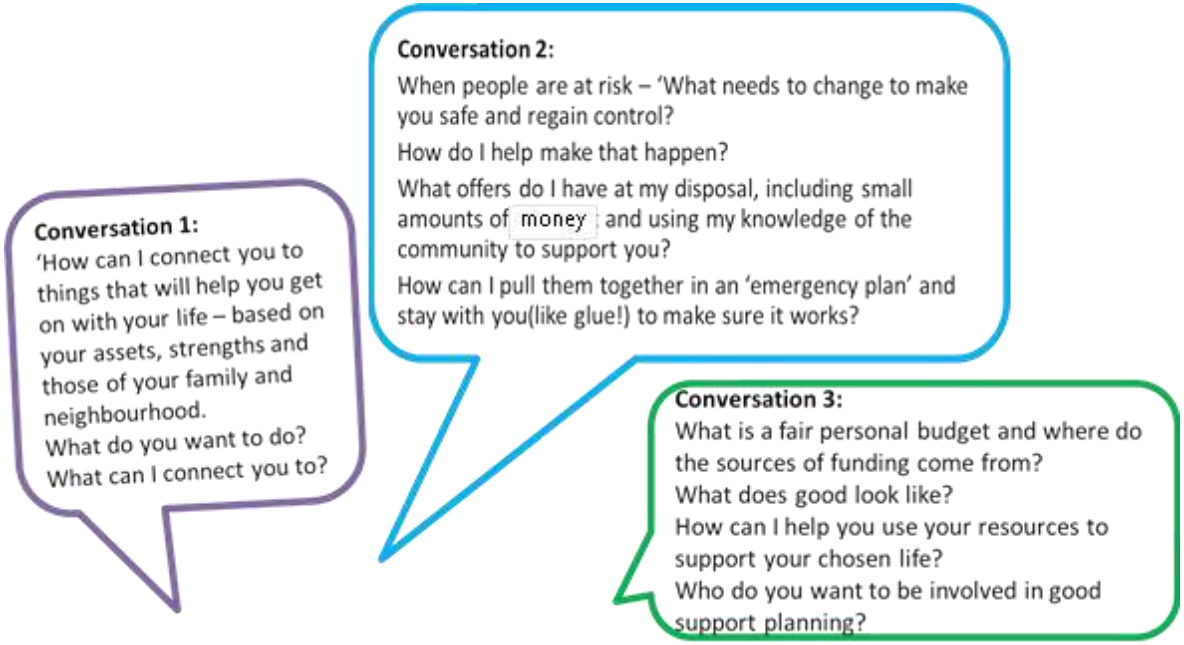
[1] Social Care Institute for Excellence describe strength–based practice as *"a collaborative process between the person supported by services and those supporting them, allowing them to work together to determine an outcome that draws on the person's strengths and assets. As such, it concerns itself principally with the quality of the relationship that develops between those providing support and those being supported, as well as the elements that the person seeking support brings to the process. Working in a collaborative way promotes the opportunity for individuals to be co-producers of services and support rather than solely consumers of those services"* (SCIE, 2014).

[2] Partners 4 Change is a consultancy of experienced social care professionals who developed the model and have worked extensively with local authorities.

effective, use of local family and community provision to meet needs, will act to reduce the use of funded social care services and other forms of statutory intervention.

The overarching aim of the new model is:-
"To support people to be well and happy, wherever possible to stay at home, feel connected to their communities and live fulfilling lives for as long as possible."

Figure 1 Summary of Conversations (Three Conversations Model)



Core elements of the model in West Sussex:-

- People are connected straight to the innovation site.
- Three conversations are used and recorded.
- People, including at Conversation 1, are followed up, to see how they are getting on.
- People are offered face-to-face conversations where requested.
- Staff "stick" with people (centred on Conversation 2).
- The model operates with no waiting lists.
- Getting Conversation 1 and 2 right should reduce the need for Conversation 3.

The model does not affect any eligibility for services. The approach tackles some of the concerns expressed by the Care Quality Commission (CQC[3]) *'For far too long people's needs assessments have been driven by the service on offer or that can be provided in a particular area… such an approach fails to recognise the richness and complexity of people's lives and fails to support or promote truly person-centred care.'*

[3] https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-act-factsheets#factsheet-2-who-is-entitled-to-public-care-and-support

Summary of Sites and Innovation Period in West Sussex

The Three Conversations Model was used in different ways in a number of settings in West Sussex:-

- **There were four geographic sites**, based in Adur, Crawley, rural Chichester and East Grinstead. In these sites the model was tested on "new customers", people previously unknown to the council or people who were not "open" to other teams. Excluded from the innovation in geographic sites were people in hospital and work relating to organisational safeguarding issues.
- **Themed sites** were based around learning disability, where people previously unknown, and those already known, to services were worked with. The model was also tested in two hospital teams based in St Richards' Hospital (Chichester) and Worthing Hospital, and a small group of workers tested the model on the Worthing review and reassessment of existing customers.

The model was tested for 12 weeks in each site. Start dates were staggered from mid-January to April. All sites had completed 12 weeks by the end of June. Sites were staffed by teams with mixed skills, professions and experiences. Geographic site teams had a mix including social workers (SWs), support brokers, occupational therapists (OTs) and occupational therapy assistants (OTAs), community connectors and assistant care managers (ACMs). There were some staff changes over the period, and not all skills/groups were available at all times. In total approximately 65 members of staff worked, both part time and full time, in the innovation sites and they were supported by site-based admin staff and project staff working across the county.

People and Conversations

Over 1,000 residents were seen/worked with in the innovation sites:

- 937 people in community sites.
- 50 people in review and reassessment site.
- 53 people in the learning disability sites.
- 53 in hospital sites (28 St Richards, 25 Worthing).

In the community sites there were:-

- 1,201 Conversation 1s.
- 72 Conversation 2s.
- 38 Conversation 3s.

SUMMARY FINDINGS

This summary has been divided into three sections:-

1) **Findings** – grouped into;
    - Overall findings;
    - Findings relating to inputs (staffing, training and preparation and venues);
    - Finding relating to processes and practice;
    - Findings relating to outputs and outcomes.

2) **A summary checklist** of what worked well, what didn't and issues for roll out.

3) **A table of recommendations**.

OVERALL HIGH-LEVEL FINDINGS

- Over 1,100 residents experienced the new way or working. 937 were seen in the geographically-based sites, the remainder in the themed sites.

- Of 937 people in the geographic sites, 38 went onto the have a long term package of social care; this was similar to the number of people who had a long term package in 2016, using equivalent time periods. Although there was no change in the number of packages, this is against a background of increasing demands and an increase in long term support packages overall. It is also recognised that the impact of this model needs to be considered over a much longer time period, to assess whether a quicker, more preventative, response can act to reduce, or delay, demand in the future. There may also be efficiencies in staff time relating to processes used, although more work is needed to understand workloads and administrative efficiency.

- Overall, staff liked the approach adopted during the innovation period. They liked being based in area teams and having a team with a range of disciplines and skills. They liked the increased emphasis on an asset/strength-based approach. They "loved" the slimmed down paperwork. This approach was perceived, by the vast majority of those who used it, to be better for staff and people experiencing social care, compared with the existing model of working.

- Residents who experienced the model stated a high degree of satisfaction. Of those who replied to a survey, when asked to rate their experience out of 10, the average rating was 8, and there were many favourable comments. Residents reported satisfaction with the speed of the response, helpfulness of the staff and some stated they liked having someone follow-up to see how things were going. For many residents this was their first experience of social care, so they were not able to contrast their experience with previous dealings with the council, but staff overwhelmingly said this model provided a better experience for residents.

- In terms of model fidelity, some aspects of the Three Conversations Model were not adhered to. There was also some variation in how Conversations were used and recorded across sites.

- At present, and accepting that the innovation period was used to try out and refine a new way of working, the experience was viewed, by frontline staff, more as an "approach" than a finalised model of working.

OVERALL HIGH-LEVEL FINDINGS *continued*

- In planning for the innovation, estimates were made relating to the number of people with lower level needs likely to be transferred into the geographic sites, notably from the contact centre (i.e. how many "calls" would become "customers"). The level of demand was considerably overestimated. Overestimation posed problems during the innovation period and it raises questions about how well the Council understands the volume of people with lower level needs and their entry routes for help.

- Staff said that in introducing the model, there was not sufficient acknowledgement of the extent of preventative work already going on in West Sussex, including the work of the Prevention and Assessment Teams (PATs). This meant that some of the work undertaken in the innovation areas in 2017 is likely to have been undertaken by other staff in previous years.

- In relation to the geographic sites, two versions of working were tested. The "thin front door" where all calls/contacts received were transferred to the site team, and the "deep front door". East Grinstead tested the latter, with four members of staff (two experienced CP2 workers and two CP1 advisors) comprising "EG1" and the locally based team being"EG2". EG1 were able to deal with many issues/cases and acted to triage cases into EG2. Although only one site tested the "deep front door" this is the preferred version of all site leads, with a preference that all workers should be co-located with the community team. It is important to note that EG1 staff were not co-located during innovation in East Grinstead.
-
- The demand for OT in this model was high, and during the innovation period the demand had reached a point where waiting lists were beginning to form.

- The issues of duty and safeguarding work would need to be tackled if the model is scaled up. The issue of duty was raised by a number of staff, but notably by OTs, who have voiced strong concerns that duty would act to reduce OT retention and recruitment.

- In relation to the themed sites:-
  - Questions were raised on how this model works in a hospital setting, with staff having to work within another organisational setting and a multitude of staff and processes. One hospital team is keen to see how this would work within A&E rather than wards.
  - In relation to the learning disabilities (LD) site, a number of staff expressed a preference for LD staff to be based in community-based geographic teams. Staff also expressed concerns that, for some people community solutions may be harder to find.
  - The approach was well received by staff in the review and reassessment site, with a view that some cost avoidance may be achieved, although relatively few people were subject to the model and further work is needed. Of the 50 people, 4 had reduced packages of care, 12 increased, 20 stayed the same, 14 remained uncompleted.

OVERALL MODEL - QUOTES

"Services provided very quickly and efficiently. Charming people." (Resident)

"I am a strong advocate for early intervention and no waiting lists. Having seen crisis after crisis occur with people we work with and due to delays in response, I strongly believe this is one of the best aspects of the new approach." (Staff)

"Goals are much more achievable for clients due to them being seen much faster - a very positive experience for clients and work force - much more job satisfaction."

"I am not entirely sure that this approach 'fits' a hospital setting. Whilst I understand and see the value of this approach I believe that it requires 'tweaking' to make it work."

"From an Occupational Therapy perspective, being creative and using core OT skills such as grading, adapting and activity analysis in innovative ways has been very beneficial. Being based within the community demonstrated to the public that we have a presence and care for those living in the community. Working with Proactive Care, Nurses and GPs is a way forward to working alongside health. This has already begun to reduce duplication of services and share knowledge with GPs."

"The person I spoke to was very competent, knowledgeable and thought through problems laterally".

"Timely intervention. Better for clients and staff morale. Reviews are a very positive experience. More scope to be innovative in my approach. Less prescriptive. Much better paperwork. Far easier MDT (*multi-disciplinary teams*) working. Enhanced learning opportunities across professions."

"…look at the overall picture of the of the client and their ability, not to always assume they are just trying to get something for nothing". (Resident)

"What is best about the approach? People are not made to wait at CP2. People get a quick response."

"Customers see people faster and see both professions as necessary. Process feels more proactive and positive for customers. We are learning more as professionals which is also improving our efficiency and this directly links to us helping customers with their goals. The reduced paperwork makes an infinite improvement as I feel I can focus on customers without the dread of the energy required to complete the associated paperwork - it makes more sense and feels quite liberating."

"In LD services innovation might work well but only if each customer has a full assessment first. From that point on innovation could work to a certain extent; my main concern would be trying to encourage customers and families to find solutions for themselves within the community when this will not be adequate. LD customers need services that can provide specialist support - not community based support. Otherwise, innovation could work well (in that it might help speed up processes and cut waiting time)."

INPUTS (STAFFING, TRAINING, VENUES)

- Over 65 people (headcount) staffed the innovation sites. The range of skills and experience was considerable and this proved very popular with staff. There was a high demand for OTs in this model, this meant that workloads for some staff were high, with limited cover when another worker was on leave or sick. The high level of part time staff increased issues with cover – especially where expected to 'stick like glue'.

- Staff had a range of training sessions for the innovation. These sessions had a mixed reception. The motivational interview training was extremely well received, approved assessor training was also viewed favourably but other sessions less so, with staff saying that, following training, they were not always sure what they were then expected to be able to do. Staff reported that some sessions felt more like "briefing sessions". Staff joining part way through the innovation period had less training and stated, at times, they struggled.

- Staff said there was a lack of clarity around roles and responsibilities. Upskilling and generic working became causes of concern *"We need clear roles and we need to establish what the 'cut off point' is for upskilling".* Staff also voiced concerns about financial viability of having highly skilled staff working on low level cases and job satisfaction.

- Leadership is crucial and in any scale up, there needs to be considerable investment in the support, training and development of the site lead role.

- There were issues raised on the nature of work and respective grades of staff; for example that Conversation 3 is not necessarily the remit of all workers and that a more realistic approach is required on the nature of roles prior to any full roll out. The role of the Support Broker (SB) was discussed on a number of occasions, discussions centred around the need to retain expertise and skills and how this role would work in a MDT setting, whether skills could be sustained. The Community Connector role was also identified as needing further work.

- Of the locations, Glen Vue (East Grinstead) worked well. Other areas had problems, notably rural Chichester where space within a health setting, although enabling closer working with health colleagues, was cramped with limited parking. This meant that being able to use the site for residents to come to was limited. Large rural areas pose challenges of where to locate, with consideration of the availability of suitable venues and accessibility via public transport.

- Finally, it is important to remember that staff who volunteered to take part, in their very propensity to volunteer, may be different from staff who did not. They may have a greater appetite for change, or may be more disillusioned with the existing way of working than colleagues. The knowledge and experience of these staff is central to any scale up, not just in the refinement, and robustness of guidance and processes, but in their wider role as ambassadors for change.

INPUTS - QUOTES

"The new approach is great, however, our team has constant uncertainty as to where we will be based… Our office space is small, hot and excessively noisy which, in my opinion, has reflected in my productivity."

"How far will upskilling go? Constantly working outside our professional sphere and comfort zone is stressful."

"Hierarchy in the teams needs to be acknowledged and is potentially problematic particularly if roles & responsibilities at different grades are not explicit. E.g. band 6 /7 ACM or PAT ACM/Community Team ACM, OTA."

Mixed skills…
"Mix of skill base and knowledge in the team is really positive and has been a key factor in enabling the success of the approach.
I think this element is brilliant and has really enabled us to be innovative, use each other's skills, provide a seamless and rounded service to our customers."

On Glen Vue – "This site feels like a nice site to bring people to. It is known because of the other users and location. As soon as you say 'Railway Approach' – everyone knows where that is."

"Surprised at how willing people are fine to come to Glen Vue...happy to come in – having things in a neutral place quite easy."

"MDT working makes the customer experience better as we don't have to refer across to other teams."

"Space matters to ensure that a team gels."

"Staff that want to develop must be given the opportunity to so, even if this sits outside the current requirements of their role, or these staff could become demotivated."

"Some staff may find themselves the 'go to' person and may need some support to put boundaries in place in order to positively assist colleagues but not become swamped by ad-hoc enquiries."

"The skills mix has been good but in BAU I don't think there will be the time for SWs or OTs to shadow each other to upskill, it will probably be the most suitable/qualified worker that picks up a person's referral."

"I am in agreement that we should mix skills and up-skill. I am not concerned about role blurring or generic working, but I do think that we should acknowledge that it takes time to develop expertise and cannot be mimicked by anyone quickly."

"A lot more training is needed".

PROCESSES AND PRACTICE

- Some staff, e.g. in hospital teams, continued 'business as usual' (BAU) work alongside innovation, but in the main staff only used the new approach. However most staff, at some point, encountered BAU processes and problems, such as welfare and benefits advice (WBA) waiting lists, which they felt had a negative impact on the timely pace of working. Some processes were outside of the council remit, such as the Disabled Facilities Grant. This raises the need to ensure that these processes are also reviewed to maximise the potential of a speedier response.

- There were some elements of the model that were not fully adhered to:-
  - *Sticking like glue*, there was confusion whether this related to all, or to Conversation 2. All sites, eventually, adopted a "team around the person" approach, matching the more appropriate worker to the person.
  - *The nature and boundary of Conversations 1 and 2* needs greater clarity. Practice varied across sites.
  - *There were waiting lists*, or waiting lists starting to form, notably around OT where demand was high. Although there is a question on what constitutes a "true waiting list"; some residents had been spoken to and were offered and waiting for appointments. Staff had, perhaps, set themselves too high an expectation of response times, sometimes quicker than residents themselves wanted!
  - *Follow-ups*. Not everyone was followed-up, for example SCARFs. There is evidence that some residents did not want to be followed up. For those who were followed up, greater clarity is needed on suitable timescales and at what point cases are closed.

- Some staff noted that they had Conversations 1s with people who had already spoken to voluntary and community organisations and so felt they were repeating conversations. It was noted that some of these organisations were funded by the council and suggested that their work could be incorporated into the work flow.

- The paperwork supporting the model was universally well received. It was broadly felt that IT systems were flexible when changes were suggested and staff appreciated the quick turnaround of suggestions they made.

- There were challenges in establishing Talk Local sessions. There was a feeling that teams were told to 'do Talk Local' but without guidance and clear sense of purpose. In relation to Talk Local, but also across all practice, there needs to be a greater discussion of what are 'standard elements', or 'givens', and what can be varied locally.

- While there was innovation in sites, staff said some of that innovation itself needs continued evaluation, for example one suggestion was to evaluate resolution rates of sited-based equipment clinics compared with home visits.

PROCESSES AND PRACTICE - QUOTES

"Assuming eligibility, rather than screening out. Having the Conversation first; Helping, rather than fobbing off. No rush to services, thinking outside the box."

"Having an experienced social care practitioner as team lead has been essential as her guidance and expertise has made our work less stressful knowing the answer to any query is just a desk away.... This is particularly relevant to the Non -Social care staff."

"Paperwork is much more time efficient. Joint working is a huge bonus, being co-located helps hugely with the joint working."

"Having a conversation with a person is refreshing, rather than scripted, it is good to be able to see an end result for the person and be able to go the extra mile for them and they have in general been very appreciative. (Although I am not sure how realistic in this will be in BAU)."

"I feel that the conversation approach opposed to an assessment has benefitted both the individual and the workers in building a rapport initially… I also feel that having no delay in time and no waiting list has reduced individual's situation becoming a risk."

"The approach particularly at Conversation 1 is very similar to the approach used in the PAT's across county. The majority of PAT work in my view meets customers goals & prevents customers needing to be referred to community teams for services. The more straight-forward paperwork is far better than what PAT currently has in place …therefore much more customer friendly when sending out documentation."

"Using a strength based approach is not a 'new' way of working for Occupational Therapy staff, the ethos of Occupational Therapy is based on a person's strengths and needs and putting the person at the centre. … The changes to the forms on FWI 'the conversations' just allow us to complete the above much quicker, in a holistic and appropriate way."

"Still feels like we have to do too many handoffs. Need to continue to improve further joint working between health, including mental health & community & hospital teams."

"Bypassing Adult Care Point 1 and 2 improves the customer journey through social services, reducing the amount of times they have to repeat their reason for contacting adult services. The person gets to speak to a trained and knowledgeable member of staff as opposed to a generic worker following a script. This also enables continuity from the staff members' perspective as well as the customer, enabling them to have confidence and trust in the service they are being provided."

OUTPUTS AND OUTCOMES

- At an early stage in each of the geographic sites it was noted that the volume of customers was far lower than expected. This required rapid expansion of areas covered and had implications for the innovation:-
  - Sites were overstaffed for their initial catchment areas. Staff were concerned that there would be too few people to test the approach on.
  - Given lower workloads, staff were concerned as to how they were being perceived by BAU colleagues.
  - The lower numbers also led staff to believe that the innovation was establishing a level and speed of response, and opportunities of joint/shadow working that would not be sustainable in the longer term.

- No outcome measurement tool was used during innovation at Conversation 1 or 2. Staff did not agree with use of EQ-5D or COPM and in hindsight use of these tools should not even have been proposed, given the breadth and types of intervention and needs. The sample size for the ASCOF survey was too small during the innovation period to provide meaningful comparison but should be adopted for on-going tracking.

- Expansion of sites was achieved relatively quickly. Overall over 1,100 residents experienced the innovation across all geographic and themed sites:- 937 people in geographic sites; 50 people in the review and reassessment site; 53 people in learning disability and 53 in hospital sites (28 St Richard's, 25 Worthing). There were over 1,200 Conversation 1s (some people have more than one Conversation 1), 72 Conversation 2s and 38 Conversation 3s (long term funded packages).

- Of those who responded to a satisfaction survey (29% response rate) residents most frequently mentioned the speed of response and helpfulness of the staff. Some people also appreciated the use of a follow-up call to see how they were getting on.

- Staff frequently mentioned their increased job satisfaction, ensuring that residents were quickly responded to and that innovative solutions could sometimes be found when working with the person and/or their carer.

- Staff did raise some concerns about the outcomes for specific groups, for example working age adults with mental health needs and people with learning disabilities. These concerns related to:-
  - whether staff were simply filling a gap of other services, including mental health services, and people will remain "stuck like glue" with little wider support available.
  - For people with higher level needs, for example with a moderate learning disability, staff would be encouraging residents and families to find community solutions which may be simply not there or adequate.

OUTPUTS AND OUTCOMES - QUOTES

"We always tend to achieve the goals in BAU but we are able to do this in a more timely way in the innovation site. We have a greater awareness of the services in the area so are able to advise more appropriately."

"There have been a very small proportion of people who need funded services. In general, I think people's satisfaction that they have got what they need from us is high but I think more work needs to be done to ensure we as social care staff hold on to the ethos of person led goals, whilst holding on to our professional judgement and duties."

"There is a danger of slipping back into needs led types of interventions as we continue to be aware of having to balance a person's goals and our limitations as a Local Authority. I think that some unqualified staff struggle with this at times due to less knowledge and understanding."

"Many of the people I have spoken to have commented on how quick the service has been. The speed we are able to respond has in itself allowed people to move forward with their aims or goals and have information on more choice or making better decisions."

"The way in which the customers engage in the conversations feels better and that they have voice in the process."

- "We found that we were listened to and treated with respect."
- "I'd like to say thank you for the help that has been giving me and how quick."
- "Understanding & helpful assistance on the telephone & with the follow up."

(Residents)

"We have found it very interesting to watch people's expectations change when we point out the strengths they already have in place and make suggestions they can fund themselves. It is much more satisfying to work in a positive, innovative environment where you are appreciated and allowed and encouraged to be creative about your work."

"I feel that having people able to come in and talk to people face to face at the office helps and being able to bring the cared for with them. Time frames have been really good and people are surprised at how quickly they can be contacted."

"Customers have been very happy with our quick response and how we have managed their cases with follow-ups etc. Some customers have had adaptations fitted very quickly by the local councils due to our quick response."

SUMMARY CHECKLIST

What worked well

- Speedier response for residents
- Satisfaction (staff and customers)
- Emphasis on a strength based approach (but this is not considered something new)
- Finding innovative solutions in the community
- Motivational interview training
- Area based mixed disciplinary teams (MDT) - greater understanding of roles, joint working, some good experience with other organisations (e.g. health)
- Increased links with the local community, being based in the community
- Co-production and ability to innovate – could be frustrating at times but there was increased communication. Testing new ideas like mobile equipment sessions
- Slimmed down processes and paperwork
- Venues (of note Glen Vue) and residents being happy to come to appointments
- Use of iPads (notwithstanding issues on iCloud and 3G!) show great potential
- *"Less bogged down with eligibility processes, able to have a conversation!"*

What did not work well

- Overestimation of referral levels
- Model fidelity around:
  - stick like glue - become the team not individual
  - Parts of the model less clear – (follow up, C1/C2)
- There were waiting lists forming, issue met with a dogmatic response
- Some of the training and preparation less well received
- Bumping into BAU – delays in existing processes – WBA, DFG
- Communication – who governs what, who owned the model
- Sometimes felt "instructed" rather than being able to innovate
- Dual line management – not always easy
- Talk Local needs more work
- Demand for OT high, unequal workloads
- Aligning with health around GP practices, issues around geographies and routes in for lower level needs,
- Outside of rural Chichester there was less opportunity for cross organisational working
- Innovation and reflection fatigue

Issues that need tackling for roll out

- Staff roles and profiles – including non-OT and non-SW – career progression and the "boundaries of upskilling"
- How duty is dealt with (big issues for some staff including OTs), and safeguarding for some staff
- Locations and venues matter – challenge in rural areas (how "local" can local be?)
- More consideration on how this works in hospital sites
- Continued innovation and evaluation – some things tried in innovation still very new
- BAU processes need to be tackled to maximise potential of model to have a speedier response
- Existing backlogs – could stifle new model
- Deep front door raises specific issues on location of CP2 staff
- Guidance and processes need finalising and reviewing
- Data and management information requirements from this model need to be thought through at a local, area and strategic level and need to meet statutory requirements.

RECOMMENDATIONS

REF	FINDINGS	RECOMMENDATIONS
1	**Overall** The approach adopted was viewed very favourably by staff. Staff liked being area-based, having a team of mixed disciplines and skills, the greater emphasis on a strengths-based approach and slimmed down processes. There were a wide range of interventions at Conversations 1 and 2, therefore the use of a single outcome measurement tool (such as the EQ-5D) was not considered suitable. During the innovation people who would be eligible for the ASCOF survey were identified, but there were too few during the innovation period to provide a meaningful sample. **"Deep door v thin front door"** The preferred version of the model, clearly stated by all innovation site leads, is the "deep front door", and with a preference for co-located assessment officers. It is important to note that co-location was not tested during innovation, there may be implications of decentralising a specialist team in terms of consistency and efficiency. During the innovation Customer Experience monitored abandoned call rates and EG1 had a higher rate than the rest of West Sussex. EG1 only had two workers so cover during any leave/sickness will have had an impact.	a) The approach is adopted. The overwhelming majority of staff who have experienced this approach prefer it and state it is better for residents who experienced it. b) The ASCOF survey should be used to compare outcomes. All people who have experienced the innovation approach and eligible for the survey, across all geographic and themed sites, should be separately sampled during the next statutory survey period in March 2018. c) To note the staff preference of the model, and that further testing be undertaken to review how this operates in practice. d) Targets on abandoned call rates would need to be adopted and monitored. e) The role of CP1 in this model, including who and when data are recorded, needs to be reviewed, to maximise use of existing resources.

REF	FINDINGS	RECOMMENDATIONS
2	**Processes and practices** Parts of the model that need greater clarification:- • Conversations 1 and 2 were used inconsistently. • The use of follow-ups needs greater clarity, this should include some expected timeframes when follow-ups would be expected to have occurred (accepting that rigid guidelines are unsuitable) and how follow-up as a task is monitored as a task (i.e. in understanding individual or team workloads). • There was some concern expressed that data recording was not consistent with statutory reporting requirements. • Case audits were undertaken as part of the evaluation. Two specific areas for improvement were identified for improvement.	a) Working with innovation staff, guidance and paperwork should be reviewed and finalised. Key issues identified relating to Conversations 1 and 2 and follow ups need resolution. b) Revision of Conversation 3 paperwork needs to be completed. c) Performance staff to ensure that any future changes, to data recording of processes remain consistent with statutory reporting requirements. d) There is a continued use of case audits to review quality and consistency of Conversation model in practice. Note the specific audit recommendations:- • Improvement required in the accurate recording of the consent to share information. • Sending out information to the public, specifically copies of a completed Care Act assessment, needs attention.

REF	FINDINGS	RECOMMENDATIONS
2	**Processes and practices** *continued* Although there are many systems to refer people into for support, many were unable to work at the pace of the innovation sites and the experience was that akin to a BAU case. Delays in support often meant that there were missed opportunities, especially given the strengths-based and motivational approaches. Of particular note: • Welfare and Benefits Advice (WBA) – this service had an existing backlog and therefore where people required this kind of support they were added to a waiting list. All sites reported this. • Direct Payments system - existing 12 week backlog highlighted by the Worthing Review Team. • The LD team highlighted that Work-Aid was currently working at capacity. • Work relating to Disabled Facilities Grant (DFG).	e) Discussion with and action by providers is needed to ensure that systems are aligned with expectations, including minimal service levels, with clear lines of accountability and these are understood by all staff. f) To maximise potential from this approach, there are a range of services and processes that need to be reviewed. We understand that some of this work is already underway (e.g. around DFGs). Managers need support (change and workforce management support) to ensure that changes/reviews are aligned with any wider roll out of a new operating model.

REF	FINDINGS	RECOMMENDATIONS
3	**Staffing, roles and responsibilities** There was an overall welcoming of joint working, but with certain caveats implied: • Staff feel passionately that multi-disciplinary team (MDT) working is necessary for providing the best possible service – joint visits not sustainable for all, but joint working is. • Understanding the difference between joint working and cross working. • Account needs to be taken of the skill level as well as the skill mix – i.e. newly qualified vs experienced staff numbers. • Protecting and enhancing professional identities whilst remaining flexible and adaptable. • Upskilling welcomed, but limits to this need to be set. • Safeguarding aspect of the role and expectations of what each role should be responsible for taking into account skill level, experience and profession. • Development of Community Connector role in line with exemplar role emerging. • Recruitment issues anticipated where roles within the innovation site appear to be unclear, with a fear there is a move toward generic working. • No clear career progression for those who are not registered practitioners. • Lack of parity in terms and conditions within and across the sites became a source of concern.	a) Ensure MDT is a key part of the new approach. b) Model should reflect a sustainable element – joint working is promoted but joint visits cannot be the 'norm' but permitted where time is saved and efficiency is enhanced. c) Ensure that sites contain a balance of professions but also skill levels within those professions (newly qualified staff and experience staff to work together). d) Providing staff with Job Descriptions which give clear boundaries on the following: i. Support for continuing their professional development as registered practitioner; ii. Limits of upskilling in terms of 'cross-working'; iii. Clear expectation of safeguarding responsibilities based on grade, experience and skill level. iv. If there is a 'generic role' that this is clear what this is, who would be expected to carry out that role and what the responsibilities are; v. Clear terms and parity within and across sites for staff doing the same job. e) Ensure that as an organisation there is a clear career progression pathway, including those not wanting to become registered professionals. f) Specific consideration should be made to the support, training and development of the site lead role in this model.

REF	FINDINGS	RECOMMENDATIONS
4	**Wider working, alignment with health, working with the community** **<u>Health</u>** The innovation site most aligned with health found a number of advantages in their approach. The main contributing factors were: • The MDT team in the innovation site included a registered nurse, from a Prevention and Assessment Team. • Co-location with GPs (although accommodation was unsatisfactory) and other primary care staff. • Proactive Care Team relationships were improved, with referrals made direct and staff reported an improvement in the quality of referrals. There were challenges on the ground in rural Chichester, including how in the absence of joint data systems, people were allocated to the site when the CCG Local Care Network (LCN) boundaries did not align with those for WSCC. This has wider and strategic level implications, such as whether place-based working is centred around GP patient populations or resident ("footprint") populations, or both. *Note: LCN boundaries refer to sub CCG areas in the NHS Coastal West Sussex area, in Crawley and Mid Sussex and Horsham sub CCGs areas are called Communities of Practice (CoP).*	a) When designing the skill mix and structure of the site staff for a wider roll out, a role for nurses should be included. b) Where new venues are being sought, co-location or regular outreach presence in a healthcare setting should be the preferred choice of location. c) Ensure that Local Care Networks (LCNs) and Communities of Practice (CoP) are aware of any difference in geographic boundaries and that provision is included in service planning. d) There should be joint workforce planning between health and social care.

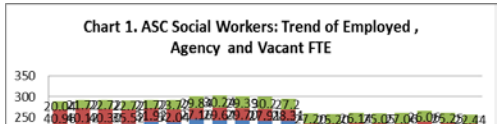
REF	FINDINGS	RECOMMENDATIONS
4	**Wider working, alignment with health, working with the community** *ctd* **Communities** Community connector (CC) roles were developed with varying degrees of success. There were a number of factors which contributed to this success: • Part time/job share impacted on the ability of CCs to spend sufficient time developing relationships. • Feedback mechanisms with the Communities Team at WSCC were good where the role was most successful. • Rural communities were more challenging to engage with, due to their long established formal and informal presence and success in meeting the needs of their local residents. **Role of voluntary sector and community organisations** Limited feedback from the community sector received so far suggests there is a lack of clarity and duplication of work – especially around Conversation 1. There is confusion over how the new model fits with other work being done, (including a social prescribing programme) and there is scant information and direction in terms of the Talk Local aspect of the model. **Local businesses/social care market** In relation to people seeking their own solution, people often turned to the council to seek trusted advice, including advice on local providers and traders. Some areas have poorly developed markets. Staff were also unclear on what type of information was available and suitable to provide to residents.	e) Community Connector roles should be a full time position where possible, to enable strong links to be forged and maintained, using the exemplar role emerging from Crawley. f) There should be an established process of feedback and support co-designed with staff and the Communities Team at WSCC. g) There should be co-designed ongoing communications plans which include representation from organisations, including rural community organisations. (h) Further work is needed in engaging the VCS, including VCS, commissioners in how these systems can work in a more joined-up way. (i) Consideration needs to be given as to what tasks within this model are already being done within the VCS and how this affects commissioning of services. j) Links to local businesses, trading standards and economic development staff, at a county and district level, should be developed to support frontline social care staff and people in seeking their own solutions. i. Local business organisations/communities should have clear signals about gaps in the market. ii. Review staff and customer access to local business and trader information.

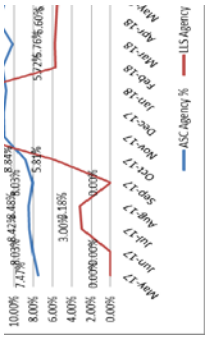
REF	FINDINGS	RECOMMENDATIONS
5	**Effective use of data and on-going monitoring** A considerable amount of data are collected, but challenges remain in relation to collection, collation and interpretation of those data. Some of the issues identified during the evaluation are not just confined to the innovation sites or pilot period. For example, issues around data quality (missing data, out of range information, time lags), which can lead to a lack of trust and confidence in information provided. Data are needed to provide intelligence (both management information and performance information) at different levels; at an individual worker level identifying tasks and workloads; at a team level to provide management oversight; at a strategic level to understand pathways and systems; and for statutory reporting. Information provided is dominated by transactions and processes. It is difficult to track people through social care systems. Performance staff have the skills and knowledge to progress this, but capacity is stretched. The overestimation of new referrals to community sites, raised questions about how well we can understand potential volumes in this new model. A better understanding is needed of the contacts into CP1 relating to Adults' Services.	a) More support is required to improve, and enforce, data quality so that there is improved standardisation of data collected. *(This is separate issue of the standardisation of practice).* b) Standardised reporting, at all levels, should be agreed with staff and articulated in a performance and information framework:- i. Site leads are key staff to review the quality of information and knowledge gained from initial aggregation of data. ii. Clear remit to be provided by senior managers on their regular reporting requirements from this model. iii. Further work at a strategic level is needed to ensure there is on-going information which details how the social care "system" is working. c) Work is needed, with Performance Staff, to consider how <u>people</u> can be tracked through the social care systems. d) The innovation cohort should be tracked over a 2 year period. e) Greater importance should be placed on how variation, between sites and over time, is monitored and interpreted. *Basically improve data quality, be clear on what and why you are collecting information and how you will know if things are working, or not.*

REF	FINDINGS	RECOMMENDATIONS
6	**The customer experience** Key findings from the survey completed by residents who experienced the new approach can be summarised as follows: • On the whole, residents' welcomed the new service with an overall satisfaction rating of 8/10. • Residents on the whole felt they were listened to and understood, with staff praised for their professionalism, courtesy and compassion. • Knowing who to contact and assurance that staff are available for support is important to people using the service, as well as how to get back in touch should other services be needed. • More work is needed to understand how people find information when they need support – half of those using the service did not find it easy to locate the information they needed. (*note Healthwatch are doing small piece of work on this in Crawley*) • Most residents would recommend this service and found it to be quick with satisfactory levels of contact maintained. Maintaining speed of response may not be sustainable over the longer term, but managing expectation and ensuring that levels of contact are maintained in line with expectation will support resident satisfaction.	From the findings, the following recommendations can be made: a) Ensure that the communications plan to support a wider roll out takes into account the findings of this survey and the work done by Healthwatch. This sought to find out how and where residents look for and find information when they are in need. b) Co-designed communications plans should involve at least the innovation site Community Connectors, Healthwatch researchers (in relation to Crawley), the WSCC Communities Team, Customer Experience and Community Engagement Teams.

Adult Services Social Worker Statistics

Organisation Details			Leavers FTE	Starters FTE	Turnover Rate	12 Month Turnover Rate	Budgeted FTE	Employed FTE	Employed Headcount	Vacant FTE
Business Unit	Group	Team								
Adult Services	Coastal Area Operations	Southern Area Operations	0.00	0.00	0.00%	8.57%	42.04	38.08	42.00	3.96
Adult Services	Coastal Area Operations	Western Area Operations	0.00	0.00	0.00%	2.68%	33.46	33.66	36.00	-0.20
Adult Services	Independent Living Service Countywide		0.00	0.00	0.00%	0.00%	3.33	2.50	3.00	0.83
Adult Services	Adult Social Care Improvement and Quality	Mental Health	1.00	0.00	1.75%	19.81%	58.68	47.74	57.00	10.94
Adult Services	Northern Area Operations		1.00	0.00	1.92%	13.35%	63.28	49.07	52.00	14.21
Adult Services	Life Long Services		0.00	0.00	0.00%	7.58%	48.05	38.77	43.00	9.28
Adult Services (Excluding LLS)			2	0	0.92%	10.66%	233.52	197.32	218.00	36.20




ASC Agency %
LLS Agency

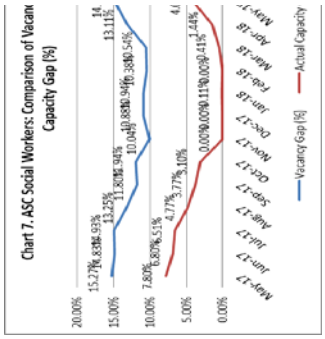
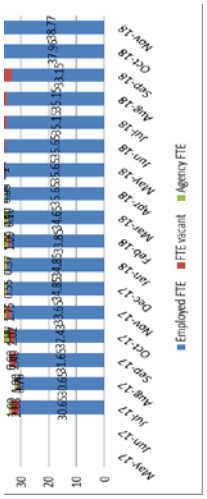


Chart 7. ASC Social Workers: Comparison of Vacanc
Capacity Gap (%)
Vacancy Gap (%)
Actual Capacity


Employed FTE
FTE vacant
Agency FTE

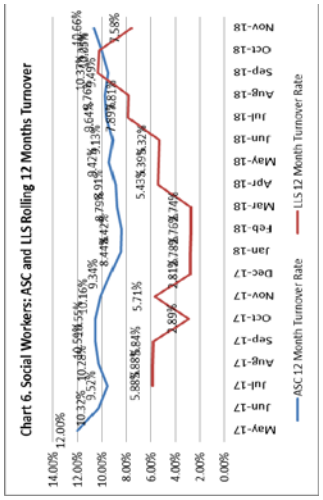
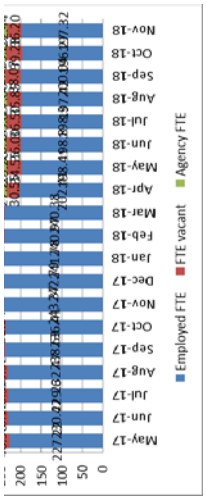


Chart 6. Social Workers: ASC and LLS Rolling 12 Months Turnover
ASC 12 Month Turnover Rate
LLS 12 Month Turnover Rate


Employed FTE
FTE vacant
Agency FTE

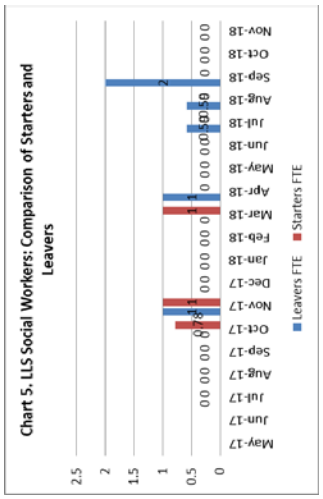
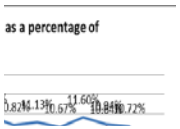


Chart 5. LLS Social Workers: Comparison of Starters and Leavers
Leavers FTE
Starters FTE

November 2018

Vacancy Gap (%)	Agency FTE	Agency %	Actual Capacity Gap FTE	Actual Capacity Gap (%) (including Agency)	Lost Time Rate
9.41%	0.00	0.00%	3.96	9.42%	2.10%
-0.60%	0.00	0.00%	-0.20	-0.60%	3.75%
24.81%	3.00	90.09%	-2.17	-65.17%	7.50%
18.65%	3.20	5.45%	7.74	13.19%	3.17%
22.46%	16.24	25.66%	-2.03	-3.21%	3.91%
19.31%	4.00	8.32%	5.28	10.99%	6.62%
15.50%	22.44	9.61%	13.76	5.89%	3.35%



Number o
Month
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Leavers FTE
Starters FTE

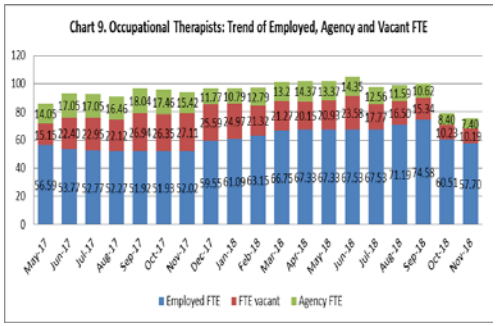
cy Gap and Actual
Gap (%)

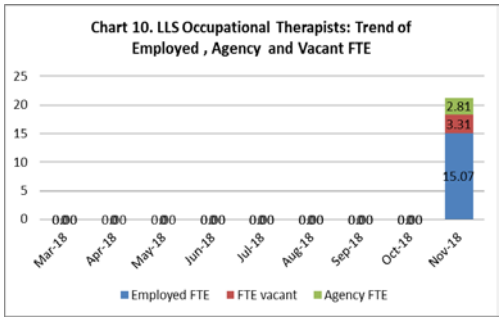
Chart 8. LLS Social Workers: Comparison of Vacancy Gap and Actual Capacity Gap (%)
30.00%
20.00%
10.00%
0.00%
-10.00%
-20.00%
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Vacancy Gap (%)
Actual Capacity Gap (%)

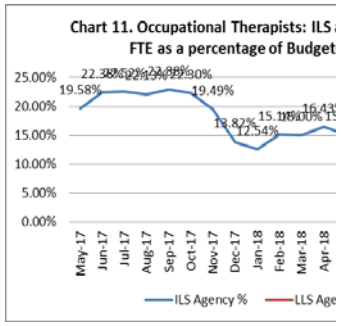
Adult Services Occupational Therapist Statistics

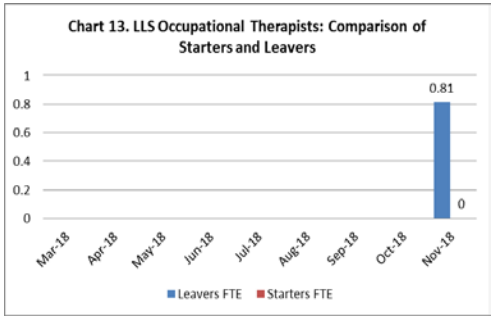
Business Unit	Group	Sub Team	Leavers FTE	Starters FTE	Turnover Rate	12 Month Turnover Rate	Budgeted FTE	Employed FTE	Employed Headcount	Vacant FTE
Adult Services	Independent Living Service Countywide	Independent Living Adur	0.00	0.00	0.00%	0.00%	5.28	5.56	8.00	-0.28
Adult Services	Independent Living Service Countywide	Independent Living Chichester	0.00	0.00	0.00%	0.00%	10.28	9.76	13.00	0.52
Adult Services	Independent Living Service Countywide	Independent Living Crawley	0.00	0.00	0.00%	0.00%	5.08	5.35	7.00	-0.27
Adult Services	Independent Living Service Countywide	Independent Living Horsham and Mis Sussex	0.00	0.00	0.00%	0.00%	8.81	7.46	10.00	1.35
Adult Services	Independent Living Service Countywide	Independent Living Littlehampton and Worthing	0.00	0.00	0.00%	0.00%	12.33	11.57	14.00	0.76
Adult Services	Independent Living Service Countywide	ACP2	0.00	0.00	0.00%	200.00%	3.91	0.66	1.00	3.25
Adult Services	Independent Living Service Countywide	Blue Badge	0.00	0.00	0.00%	0.00%	2.85	2.97	4.00	-0.12
Adult Services	Independent Living Service Countywide	RIS	0.00	0.00	0.00%	7.14%	18.39	13.37	16.00	5.02

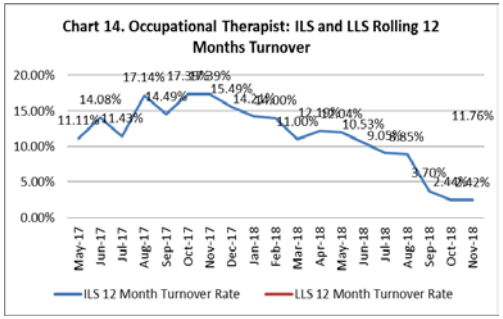
Adult Services	Life Long Services		0.81	0.00	5.88%	11.76%	18.38	15.07	17.00	3.31
Adult Services	Independent Living Service Countywide (Excluding LLS)		0.00	0.00	0.00%	2.42%	67.89	57.70	74.00	10.19

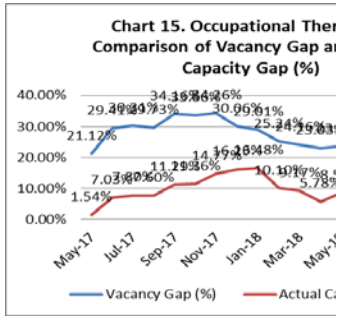












November 2018

Vacancy Gap (%)	Agency FTE	Agency %	Actual Capacity Gap FTE	Actual Capacity Gap (%) (including Agency)	Lost Time Rate
-5.26%	0.00	0.00%	-0.28	-5.30%	0.36%
5.05%	1.00	9.73%	-0.48	-4.67%	2.42%
-5.26%	1.00	19.69%	-1.27	-25.00%	0.61%
15.29%	0.97	11.01%	0.38	4.31%	2.06%
6.17%	0.00	0.00%	0.76	6.16%	1.84%
83.14%	3.78	96.68%	-0.53	-13.55%	0.65%
-4.21%	0.00	0.00%	-0.12	-4.21%	1.86%
27.31%	0.65	3.53%	4.37	23.76%	2.24%

18.02%	2.81	15.29%	0.50	2.72%	0.00%
15.01%	7.40	10.90%	2.79	4.11%	1.78%