ASC Transformation Delivery Plan

Contents

Executive summary

Adult Social Care services locally and nationally have faced significant challenges in recent years, and as a result the Council is holding significant risk in relation to the ability of the Council to deliver its statutory responsibilities to adults that require support within the available budget.

The nature of these challenges means that long term, sustainable change is needed to ensure that BCP Council Adult Social Care services are fit for the future and affordable.

The plans in this document follow a focussed period of scoping, called the 3-month sprint, that was undertaken during the months of February, March and April 2024.

The sprint built on and took learning from a range of pre-existing projects and areas of work and combined this learning with work to scope other opportunities for change.

These plans will enable the Adult Social Care Directorate, with support from wider Council colleagues and partners to deliver sustainable transformation and change to the way services are provided.

The plans set out proposal for investment of £2.9m in 4 key areas of Adult Social Care transformation that will lead to improved outcomes for adults that draw on support in BCP and support the Council to deliver this within the available financial envelope.

It is anticipated that the investment will lead to recurring savings of approximately just over £3.5m. This estimated savings opportunity is based on benchmarking data, which shows that the Council spends more per head of the population than comparator Councils.

Local and national drivers for change

A number of **significant pressures, challenges and risks, both nationally and locally** are driving the need for change

Local drivers

- The **creation of BCP Council** has resulted in a lot of focus and work on harmonising ways of working, systems, processes etc. This along with other change initiatives has drawn on Council resources and capacity and led to some reported change fatigue.
- The Council currently has **backlogs of assessments, reviews and people waiting for services**, which in turn creates failure demand. This needs to be addressed sustainably through new ways of working.
- The Council, in common with many other authorities, is managing **significant ongoing financial challenges,** with a large proportion of the Council's budget spent on Adult Social Care.
- Following recent Local Government elections in 2023, **a new Council administration** has been created.
- The creation of a **new strategic health authority** in July 2022 has and will continue to impact on the Council through new and developing partnership arrangements.
- The Council is accelerating plans to **transform the Council**, which the ASC Directorate must align with.

National drivers

- The impact of the **COVID-19 pandemic** is still being felt, with impacts on people's health and wellbeing, resulting in increased demand, and higher levels of need.
- **Societal inequalities** mean that people who require support achieve worse outcomes. Adult Social Care has a key role to play in ensuring social justice and fairness in our society.
- With **people living longer and an ageing population**, there is increased demand for support, and more complex needs.
- **Workforce shortages** across Adult Social Care, are putting pressure on the ability of local authorities to meet their statutory responsibilities to work with people and provide support.
- Local Government funding has failed to keep pace with the increased level of demand, resulting in **potentially unsustainable funding pressures**.
- The **Integration of Health and Social Care** is a key government priority, which is being delivered through the creation of Integrated Care Boards.
- The introduction of new arrangements for the **inspection of Local Authority arrangements to deliver Adult Social Care** by the Care Quality Commission will include the risk of government intervention.

Vision

Our vision for the transformation of Adult Social Care by BCP Council is:

To support people to live a fulfilled life based on the social care future vision

We all want to live in the place we call home with the people and things that we love, in communities where we look out for one another, doing things that matter to us.

That's the social care future we seek. #socialcarefuture

The Vision brought to life

The following examples describe how our transformation plans could support people to live fulfilled lives based on the social care future vision.

Initial contact

People can access advice, guidance and support through self-service options or through person-centred conversations. This approach connects people to things that help them to live a fulfilled life based on what is important to them.

Bob is a carer for his wife and feels isolated. He found information about local community support online and spoke to someone to get advice on how technology could help him and his wife to live independently and stay connected to others.

"I have been able to find out about a range of options that are of interest to me online and know who to speak to if I need further advice".

Relationship and strengths-based conversations

People can speak to someone who listens to what is important to them, building on what they can do and developing support with them.

Mary was recently discharged from hospital after a fall. She lives alone and is worried about whether she will be able to get back to doing the things she's always enjoyed. Mary was supported to access reablement support, and a named practitioner worked with Mary over time to plan for the future as she rebuilt her confidence.

"I really feel listened to. It's not easy to be able to do the things that are important to me, but I feel that the person I spoke was going to help me to find a way to make it work".

In control of my own support

People can access support in flexible and creative ways, that meet their needs and represent good value for money.

Tony's needs can change day to day, and he needs flexibility in how his support is provided. He draws on support from a Personal Assistant and has been supported to join a gardening club using an Individual Service Fund.

"I feel in control of my support, which is helping me to do the things that are important to me".

How we developed this plan

This plan was developed during a 3-month sprint from Feb-Apr 2024. The approach during the sprint drew on the following analysis:

- **The Adult Social Care Financial Review – undertaken by the Local Government Association**
- **The Adult Social Care Peer Review – led by the Local Government Association**
- **A review of available locally held activity data and nationally available benchmarking data**
- **A review of the status of existing projects and engagement with key stakeholders**

We also carried out detailed scoping work for the following 4 priority areas:

How we work	We have evaluated our learning from the 3 conversations approach and analysed the data to work out how we create the conditions for this approach to thrive.
Better short-term support	We want to improve community access to short-term support (reablement), so that we can prevent more people from needing long term care. The sprint has helped us to plan how best to do this.
Self-Directed Support	We want more people to be in control of their own support. We have planned how to develop more community-based options for people to access through a Direct Payment or Individual Service Fund.
Support at Home	We have reviewed the current Support at Home provision and developed plans for future commissioning, to ensure that we enable people to stay as independent as possible in their own home

Key insights and the opportunities for change

Analysis of the data has highlighted the following key opportunities for benefits realisation through a transformed approach:

Opportunity to reduce spend on long term support in comparison to other authorities

The Adult Social Care Financial Review (LGA) highlighted that BCP Council spends more on ASC support in comparison to other local authorities (6.3% more than the England average in 2022/23).

The review highlighted significant scope to reduce spending on older people in particular, where the spend on each long-term care package in 2021/22 was 24% more than the England average.

Missed opportunities to intervene earlier

50% of people who go on to receive a service contact the council via the ASC Contact Centre, before being passed to the Long-Term Condition Locality (LTC) teams.

On average the ASC Contact Centre pass 290 requests for care act assessments to the LTC locality teams each month. Of these only 102 receive a care act assessment. Of which only 27 receive a service.

This indicates that there are missed opportunities to intervene earlier.

Opportunity to make more use of short term reablement support

During 2023 only 12% of people who went on to receive long term services received reablement support, which seeks to maximise people's ability to remain independent without ongoing support.

BCP Council is ranked 129 out of all authorities nationally for the % people offered reablement following discharge from hospital and local data shows that very few people in the community are offered reablement.

There is a missed opportunity to support more residents with short term support before long term care is considered.

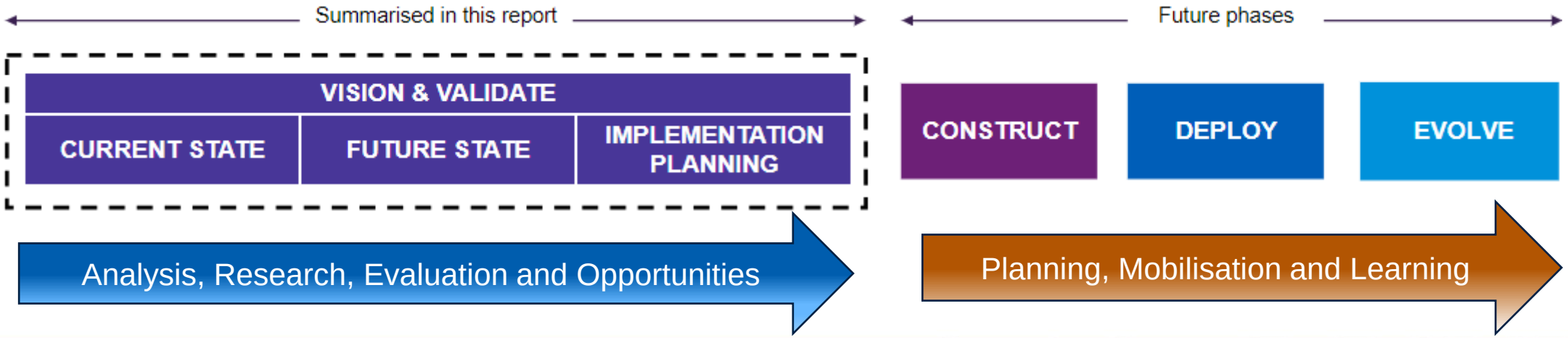
A more diverse market of support that can be self-directed

86.5% of total gross expenditure on ASC by BCP Council is spent on care costs, and 85% of that spend is on traditional services (care homes, domiciliary care and day care)

A more diverse market, which includes a greater focus on self-directed support will enable more needs to be met through more cost-effective means, such as micro-providers and personal assistants, with more expensive traditional services for those who need them.

Corporate Transformation Alignment

- The Corporate Transformation service design process commenced in September 2022.
- Much effort and consideration has been given to ensuring the methodology that was introduced from KPMG has been utilised and tailored to ensure effective engagement with the right approach for our organisation.
- Both through the 3-month sprint and the following transformation plan, there has been a focus on ensuring that this methodology continues to be utilised.
- The below, sets out the transformation methodology used across other directorates – it has been this approach that has been taken through the 3-month sprint and next phases.



Fulfilled Lives Programme

- Each key priority area of the 3-month sprint has gone through significant detailed diagnostic assessments of current state and future state, alongside potential opportunities.
- It is proposed that the 3-month sprint will now move into a formal transformation programme ‘Fulfilled Lives’ comprising of 4 individual projects.
- These individual projects and objectives have been set out within this slide to provide a high-level overview of what each project will look to achieve.

Fulfilled Lives Programme

Project Objectives

How We Work

1) Technology is used to support new ways of working and to reduce demand
2) The right people with the right skills intervening at the right time
3) Good quality data and intelligence is used to drive our approach
4) A stronger focus on preventative approaches
5) Reducing spend on long term support as a result

Self-Directed Support

1) Improved systems and processes for accessing self-directed support
2) There is a more diverse and available provider market
3) Improved culture and practice towards self-directed support
4) Residents are supported to embrace self-directed support

Support at Home

1) Develop a clear procurement timeline
2) Establish and define what support at home model we want in the future
3) Procure, establish and define new model of support at home

Short Term Support

1) Define, establish and embed new Reablement model
2) Establish key performance and quality data metrics for Reablement
3) Delivery service improvement plan

How we work – Assessment and Roadmap

Diagnostic assessment

Journey to date

- In February 2022 we started working with Partners for Change to introduce a new approach to our work using the “3 conversations”.
- From Feb 2022 to Summer 2023 five early pioneer Innovation sites helped us to test the approach.
- A second phase of innovation between November 2023 and February 2024 tested the approach in an innovation area across the ASC Contact Centre and Long-Term Condition teams.
- An evaluation of the approach and learning was undertaken during February/March 2024 with input from innovators.

What we’ve learned

- There is strong support for the principles of 3 conversations. We believe that this approach done right can be better for residents, better for staff and better for the budget.
- Innovation has been more successful in some teams than others and we are learning more about the conditions that support this approach to thrive.
- An over-reliance on process and inefficient systems drives ways of working that focus on getting tasks done and distances us from a person-centred approach.
- We need to ensure that all managers/leaders are on the same page and have the skills/capability to lead the change.
- We’re starting to build a clearer picture with data although the use of data is not embedded across the service . This tells us that most of our new work can be completed using a conversation 1 or 2 and most residents don’t require services as solutions.
- Making it Happen meetings have shown us the benefits and challenges of a more inclusive, open and transparent governance structure for change.

What will the future look like?

- The 3 conversations approach is rolled out across all teams and functions.
- Our operating environment (culture, ways of working and systems) supports person-centred rather than process driven practice.
- There is strong leadership, communication and engagement and an open and transparent culture where challenges and insights are shared, and we work together to problem solve and drive continuous improvement.
- The whole workforce is confident in their respective roles and responsibilities and know what good looks like.
- Teams, managers and leaders have access to good quality data and the skills to use it, and this is used to drive change and improved outcomes.
- We put the person at the centre, listen to what is important to them, and we work collaboratively across teams, functions and with partners to help them to achieve this.
- Technology is used to support new ways of working, reduce demand and provide better support to residents who need it

Roadmap

Short term
One – six months

Enhance first response function
- Deploy additional capacity in first response function
- Co-produce and deploy a front door data set and improve arrangements to capture required data
- Co-produce changes to ways of working in first response function (using 3Cs principles)
- Develop plan for introduction of self-serve/technology solutions
- Prioritise Mosaic changes that create efficiencies in first response (including conversation 1 and 2) and ensure staff are coached to use correctly
- Engage with specialist services to co-produce more efficient ways of working for professional contacts
- Define first response and business support roles, responsibilities and expectations including the development of practice guidance

Prepare for the future
- Maintain light touch support to existing Long Term Condition innovation teams and continue to develop understanding of current approach/practice/data
- Commence “3 Conversations” roll out across Mental Health and Learning Disability teams
- Scope and commission a training/coaching offer for managers
- Complete Mosaic health check and develop roadmap for future Mosaic development (see appendix)
- Development of Technology enabled care operating model
- Plan for introduction of Mosaic provider portal

Medium to Long term
Six to Forty-eight months

Develop new ways of working across all ASC functions
- Continuous approach to performance improvement further embedded within first response function
- Evaluate learning from 3 Conversations roll out across Mental Health and Learning Disability teams and use this to plan further service development work
- Roll out the 3 Conversations approach across all other ASC teams and functions, including: Long Term Condition teams, Hospital teams, Specialist Services and support functions and for all people who may need support including carers
- Deliver training/coaching to managers
- Deployment of Mosaic provider portal to improve invoicing and payment arrangements.

Development of preventative/early help approach
- Develop a prevention strategy including community & voluntary sector support to prevent, reduce and delay the need for long term care and support

Systems and performance management
- Deliver changes to Mosaic based on the health check and roadmap leading to more efficient ways of working
- Co-design performance and workload dashboards and embed their use within teams whilst rolling out the 3Cs approach.

Technology
- Deployment of online and telephony self-serve functionality
- Deployment of Tech enabled care operating model, including embedding changes to practice and an innovation roadmap to support a greater take up of technology.

Neighbourhood teams
- Engage with the Integrated Care Partnership in the development of Neighbourhood teams, ensuring alignment with other activity in “How we work”

Better Short-Term Support – Assessment and Roadmap

Diagnostic assessment

Journey to date

- Project commenced on 14th February 2024
- Scope – Bed and community based reablement services in the context of the wider hospital discharge, community referral and intermediate care system
- Understanding the current service delivery and performance – data and performance analysis, engagement with provider and wider stakeholders, case audits
- Review of referral process and effectiveness
- Review of delayed discharges from the service and barriers to timely discharge
- Explore potential service outcomes to evidence outcomes for people receiving reablement
- Co-production of a service improvement plan with Tricuro in line with national guidance and best practice.

What we've learned

- Community reablement was not providing a therapy led service with little or no Occupational Therapy involvement
- Service inefficiency due to productivity and geographical model within the service
- Long waits to commence service
- Service starting to implement more flexible recruitment processes to improve recruitment
- Some cultural challenges within workforce to resist change
- Coastal Lodge costs are in line with residential care costs
- Community reablement costs are high due to low productivity and high management costs
- Stakeholders are unclear about the referral routes into the service, purpose and model of reablement
- Low numbers of community referrals
- High numbers of people referred to community reablement did not receive the service
- High numbers of inappropriate referrals with no identified reablement needs or goals
- No meaningful performance data for Coastal Lodge due to MOSAIC recording processes
- Significant delays in discharge from the services due to ASC capacity and housing (extra care) processes
- Hospital discharge processes are over complicated and driven by PUSH model for P1 discharges and not based on individual needs of people, with referrals to multiple services to identify discharge capacity.

What will the future look like?

- Community reablement service will be therapy led, with OT/OTA assessment of all new referrals with clear reablement goals, timescales and early discharge planning designed with people and their families
- Service will be focused on the strengths of people, their families and creating community connections to maximise their independence and wellbeing
- Service will become more effective and efficient and deliver positive outcomes for people and evidence vfm
- Implementation of outcomes metrics including satisfaction questionnaires, impendence or reduced levels of care need, evidence-based outcomes tool measurements
- Access to service within 48 hours
- Service involvement in TOC and early assessment of people in hospital with potential reablement capacity
- Effective performance and quality data for Coastal Lodge
- Development of assistive technology as a core enabling tool for people
- Review opportunities for joint working with ASC to address process capacity issues including Trusted Assessor for service discharge
- Increased housing support and review of referral pathways for housing, in particular for extra care in the context of reablement pathways and timescales
- Potential to explore an extended reablement pathway for people referred to ASC to assess potential for reablement before decisions around LTC needs.

Roadmap

Short term
One – six months

Commissioning Activity and Capacity
- Recruit additional commissioning capacity 0.5 wte Snr Manager and 0.5 wte Commissioning Officer
- Review service specifications to include SOP and revised performance reporting
- Monthly contract monitoring meetings to include project information and updates
- Ensure reablement services are considered as part of review of assistive technology
- Discussions with Housing to review capacity and extra care timelines for people receiving bed based reablement

Service Improvement
- Ongoing review of Reablement service improvement plan
- Roll out of service information and presentations to include attending hospital and community teams to ensure future appropriate referrals and understanding of service purpose and model
- Agree and implement new referral requirements with referral agencies including timescale in line with system developments eg early MDT hospital discharge pathways.

Performance and Quality Data
- Establish MOSAIC recording of Coastal Lodge placements
- Embed weekly dashboard reporting

Future Preparation
- Understand emerging hospital discharge model and if includes case management of people through intermediate care and if not to further explore Trust Assessor Model for discharge from community reablement
- Ongoing consideration of reablement as an important element of intermediate care offer in the context of ongoing system discussions

Long term
Six to Forty-eight months

Quality and Improvement of Reablement Services
- On going monitoring of the quality, and performance of the service to include internal service issues and system issues and barriers to improvement
- Implementation of recommendations in terms of
    - Case management system or Trusted Assessor model for community reablement discharge
    - Review of housing support and extra care pathway for intermediate care services
    - Ongoing improvement of service focus on strength-based model including family and community connections to maximise opportunities to maintain independence and well being

Reablement Model Options
- Explore changes to reablement model. Current model is for people identified as having reablement capacity and goals. However, 88% of people accessing home care have not accessed reablement support first. This is backed up by feedback which suggests that the majority of people contacting the Council for support do not receive an assessment of their reablement potential. Need to explore if this assessment could be provided through ASC (SW/OT/OTA) or an expanded assessment pathway for reablement. This level of assessment would provide the opportunity to maximise independence for people, and potentially reduce demand and cost of LTC home care.

Long Term Strategic Partnership/Integration of Intermediate Care
- Involvement in the transformation of the Intermediate Care Model for BCP system in line with national guidance and best practice

Self-Directed Support – Assessment and Roadmap

Diagnostic assessment

Journey to date

Current data and insights
- Assessment of Direct Payment data and our insight work completed last year.
- Assessment of a range of literature on personal budgets and self-directed support.
- Assessment of the feedback from the Fulfilled Lives programme.

New data and insights
- Conversations with people who have Direct Payments (30).
- Conversations with practitioners across ASC (10 – 15).
- Conversations about Individual Service Funds (ISFs) with people who have experience of our services.
- Conversations about ISFs with care and support providers.

Insights from elsewhere
- Connections with other practitioners across the country through networks and direct connections.
- Participation in relevant webinars and presentations.

Co-production
- Understanding how we currently coproduce our work across ASC.

Personalisation Programme
- Continued the delivery of the wider Personalisation Programme activity using the insights gained through the sprint activity.

What we've learned

Culture and practice
- There is a tension between us wanting to be person-centred and having being risk averse in to maximise value and control costs.
- Self-directed support is a mindset not a set of processes.
- We have practice leadership that is inspiring and committed to person-centred approaches; the roll-out of Fulfilled Lives demonstrates this commitment.
- The Direct Payments Team has leadership that is committed to personalisation and self-directed support and the team works well with both practitioners and Direct Payment holders.
- The DP Team has dealt with its waiting list and taken on more activity in the DP process over the last year.
- We have practitioners across the directorate who want to support people to self-direct their support and want this to be easier to set up but we're not person-centred in everything we do across ASC.
- We're not consistently coproducing the way we do things with people who experience our services.

System and processes
- We often don't understand the Direct Payment process and we report that it is time consuming, complicated and doesn't create a different outcome.
- There is failure demand and delays in the Direct Payment process being completed – sometimes linked to the authorisation of care and support plans.
- Practitioners are looking forward to Individual Service Funds being available as this will grow our offer of self-directed support.

Provider market

We currently have a limited provider market and a lack of available Personal Assistants who can creatively support people with Direct Payments.

Feedback from people holding Direct Payments
- People are positive about the support they receive from the DP Support team and practitioners, but they would like to have more flexibility in how they use their budget.
- People report that any changes to their circumstances that impacts their finances results in a lot of work for everyone.

What will the future look like?

Culture and practice
- People who look to us for support are having the right conversation with the right person at the right time and in the right place.
- Person centred and strengths-based approaches are demonstrated in our practice across ASC and both staff, and the people we are supporting feel the benefits of this.
- Staff and the people they are supported feel they are listened to, and heard, in their conversations.
- We take every opportunity to enable people to self-direct their support and encourage them to create better outcomes for themselves.
- Our culture supports and encourages practitioners to work alongside people to turn conversations into personalised care and support plans that have solutions right for them.
- We have honest, open and timely conversations about costs, personal finances and contributions.

System and processes
- We have more options for personal budgets and self-directed support.
- Practitioners feel confident in offering these to people, are knowledgeable about putting them in place and know how to get support from the wider team if needed.

Provider market
- We have a diverse marketplace of creative and flexible providers who offer the care, support and activities that people want to purchase with their personal budget.
- The marketplace includes ISF accredited providers and community and micro-enterprises.
- Providers want to work with us to develop innovative models of support.

For people self-directing their support through a personal budget
- People have the best possible understanding of the personal budget arrangements and manage changes in circumstances.
- People have a choice in the personal budget options we offer.
- People have a choice in, and control over the support they purchase and that support enables them to thrive and live fulfilling lives.

Roadmap

Short term
One – six months

Continue the delivery of the Personalisation Programme
- Design and develop Individual Service Funds (ISFs) and the provider accreditation process.
- Deliver the Trusted Reviewers Programme with Community Action Network; working closely with day opportunities commissioning and providers and the Learning Disabilities SW team.
- Commission external support to deliver our community and micro-enterprises (CMEs) development programme.

Coproduction
- Ensure coproduction is embedded into the design and delivery of the programme.

Connect the Personalisation Programme to social work practice
- Use the opportunity of the Learning Disability, Mental Health, Autism and Preparing for Adulthood teams starting their 3 Conversations approach to connect the programme to their practice.

Involving people with lived experience of the support we provide
- Invite people with lived experience of personal budgets to join a co-produced Self Directed Support Forum that focuses on all aspects of our personal budget business.

Embedding personalisation and self-directed support into BCP Council strategy
- Coproduce a corporate policy that sets our approach to personalisation and self-directed support

Carers
- Support the redesign of the personal budget model for unpaid carers.

Training
- Develop a revised and comprehensive training package for personal budgets implementation

Medium to Long term
Six to forty-eight months

Continue the delivery of the Personalisation Programme
- Focus on embedding the programme into our social work and commissioning practice.

Evaluation of impact
- Understand impact so that some savings can be used as investment that enables the operations activity of the programme to continue after the first year and for further savings to be delivered.

Enhance the support for people wanting a personal budget
- Explore the options for enhancing our personal budget support offer through externally delivered information, advice and coaching for people wanting a personal budget. This could develop from the Trusted Reviewers Programme.

Develop the personalisation projects with further innovation in commissioning
- Explore models of Neighbourhood ISFs and models of neighbourhood care.
- Explore the development of the small provider market, e.g. Small Supports – could develop from the CME development.

Involve people with lived experience of the support we provide
- Explore the development of a peer review team of people with lived experience to assist us with quality standards and working with high quality providers– could develop from the CME development.

Voluntary and community sector (VCS)
- Explore options for continued investment in VCS-delivered activity that enables the Fulfilled Lives approach and contributes to our priorities around prevention, wellbeing and independence.

Coproduction
- Develop our coproduction strategy that sets out our aspirations for working alongside people with lived experience, partners and stakeholders to develop initiatives that are well informed by a diverse range of people.

Support at Home – Assessment and Roadmap

Roadmap

Short term
One – six months

Long term
Six – forty-eight months

Provider Market Analysis
- Further analysis of the market and potential impact of a new framework on the stability and sustainability of the market.

Specialist Needs
- Decision of how to address issue of people with moderate to advanced dementia, ABI, substance misuse etc and how these needs will be met either through incorporation into existing plans for MH/LD framework or additional lot as part of procurement.

Agree scope of home care provision
- Identify if this includes non-regulated activity such as shopping and domestic/laundry tasks

Further demand forecasting analysis

Explore utilisation of vol sector and community services to support people's non-care needs.
- Develop and embed plan as to how we engage and utilise the VCS for non-care needs

Audit of CAA for people accessing home care
- Seeking to ensure assessments are focused on delaying and reducing care needs and consistent approach to planning for home care provision

Consider reopening of the framework for a 3 year 2 +1 (ideally two years) year contract life
- Seeking to adhere to financial regulations and allow due diligence with market fairness

Develop a Home Care strategy to inform future model and provision
Model co-production through engagement with providers and wider stakeholders including NHS
- To include market view of how to address ongoing issues including capacity for small and large/complex packages, reaching difficult to source localities, workforce development, joint working
- Agree key principles and value base of model of care, strength based, person centred c
- Explore in detail trusted assessor model for the effective review of people's needs and adjustment to PoC

Pre-procurement Activity
- Market Testing to inform procurement decision eg preferred number of framework providers
- Specification development and performance and QA frameworks and processes
- Agree future commissioned capacity
- Agree final procurement process, likely to be framework procurement, potential for two lots, and limited number of providers

Procurement
- Develop and implement detailed procurement process, including award and appropriate governance processes and mobilisation plan to include risk register

Reducing Demand for Home Care
- Development of detailed practice and service plans to ensure principles of delaying and reducing demands for home care through CAA , assistive technology,

Performance Monitoring
- Regular monitoring of activity and costs for home care and impact of procurement

Development of Long-Term Strategic Model for Home Care
- Further review of emerging models of home care, this includes development of potential integrated health and social care teams addressing locality based population health

Development of Alternative Provisions to Home Care
- Further detailed work to be completed on triangulation of information from John Jackson, BCF metrics, service data activity, costs and forecasting for home care, ECH, care homes and DPs. Explore question of "home first" v's "right care, right time, right place" v's reducing/preventing harm v's financial sustainability?

Diagnostic assessment

Journey to date

- Project commenced on March 2024
- Understanding the current market and service delivery – data and performance analysis, engagement with provider and wider stakeholders, ASC questionnaire and case audits
- Review of referral and assessment process and effectiveness
- Understanding of needs for small packages of care and complex hard to source packages
- Explore potential to reduce demand on home care through review of assessment process, potential for reablement and maximising other services to reduce demand including assistive technology and vol sector
- Review of emerging models and best practice
- Understand reasons for current overspend and activity trends, including forecasting of future demand
- Explore potential procurement options to replace current framework

What we've learned

- Recent improvement in service with increased capacity, reduced waiting times and complaints over the last two years following additional on framework providers and recruitment drives
- Still some challenges in provision of small packages, carer sitting service and complex/specialist care needs in terms of sourcing
- Need for risk assessment for people waiting for packages with complex needs
- Workforce, ongoing review of recruitment and retention, upskill workforce especially around dementia and other complex needs
- Strong voice for the development of a specialist framework for advanced dementia with challenging behaviours, ABI, substance misuse that will not be covered by new MH/LD framework
- Need to review policy for provision of shopping and domestic work as part of care packages
- Current best practice models reflect high levels of health and social care integration and population health models which will require integrated strategy to be developed
- Three Conversations model should be reviewed against duty of reducing and delaying needs
- Key service developments required to reduce demand including: increasing community reablement access, use of extensive assistive technology model and increasing use of vol sector for support/unregulated needs
- Without change to current social care system we can anticipate growth in demand of between 1%-2.5%, based on demographic growth and current practice trends,

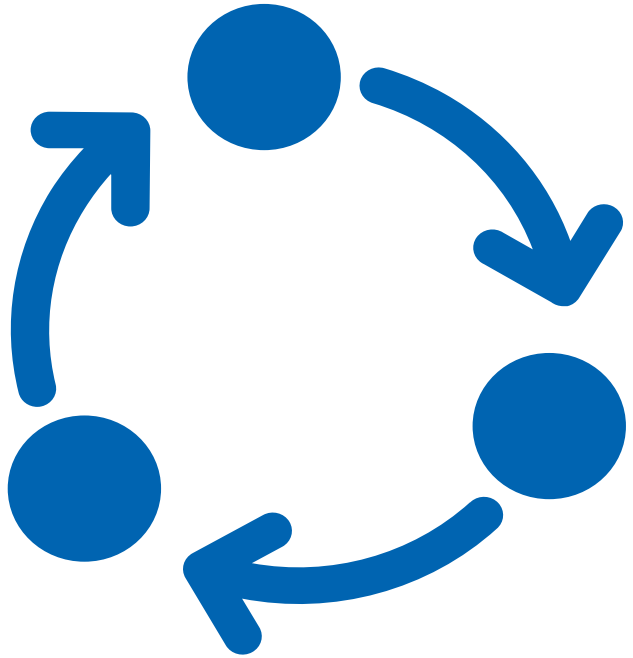
What will the future look like

- New home care framework will be procured and will be informed by current work to date, and further project work
- Further market analysis to understand implications of new framework on market stability and sustainability going forward
- Engagement with providers and other stakeholders to co-produce adjusted model to address ongoing issues such as workforce training and recruitment, managing complexity, and sourcing for challenging geographical patches and specialist needs
- Key best practice principles and values will be embedded into the new model
- Trusted assessor approaches will be considered to enable timely review and adjustments to PoC
- Risk assessment process to be implemented for those people awaiting care
- Consider mixed packages for support (vol sector) and care needs (home care)
- Ensure all framework providers use digital care records and management systems
- Audit of CAA's to ensure they are addressing need to reduce and delay needs, and practice relating to referral for home care is consistent across the borough
- Increase community access to reablement for people assessed as having reablement capacity through their CAA
- Roll out of new assistive technology model to maximise people who can be supported without or with reduced packages of home care support
- Increase use of vol sector and community services for support/non-regulated needs
- Ensure Extra Care services are utilised for people with more complex needs

Approach to Programme Delivery

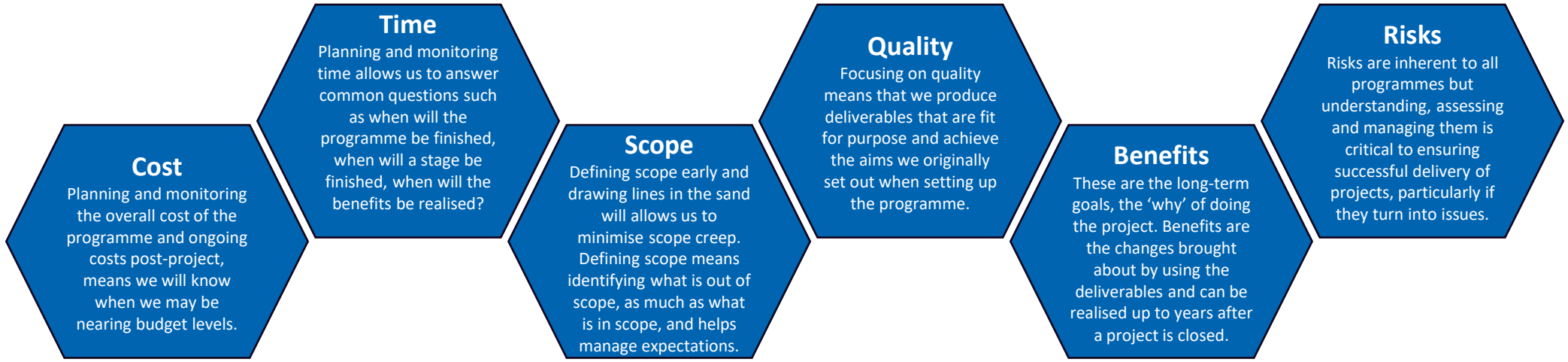
Programme Approach

- The proposed Fulfilled Lives transformation programme will adopt the BCP project framework methodology (See Appendices) .
- The programme will also utilise the newly established Project for the Web (PftW) software management tool, ensuring that all activity is appropriately managed and tracked throughout the programme.
- Each individual project attached to the Fulfilled Lives programme will be aligned to the project lifecycle and the activity that underpins it.
- It is acknowledged that the sprint approach has already delivered and supported some early project lifecycle stages i.e. scoping.

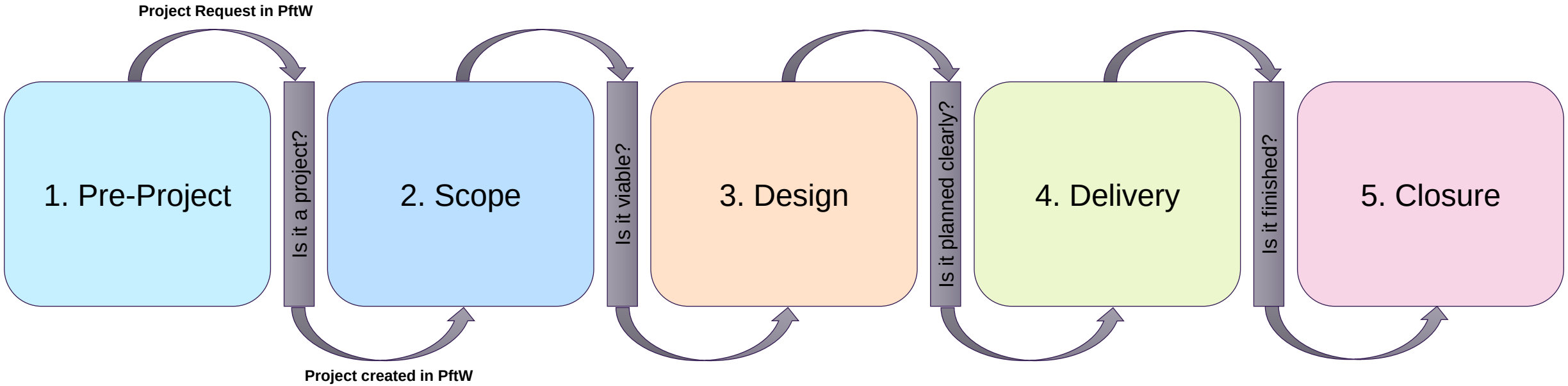


Core Programme Concepts

- The Fulfilled Lives programme approach will also provide ongoing focus of 6 key concepts, ensuring these are at the forefront and the programme structure and delivery. These are:



Fulfilled Lives – Individual Project Cycle



Initial investigation to see if there is a project worth pursuing

- Scale Assessment
- Priority Assessment

Initial planning & setting up project infrastructure

- Scoping Document
- Highlight Reports

Detailed planning for deliverables, resourcing & timeline

- Project Plan
- Business Case
- PID

Work to deliver against the plan

- Change Requests

Closing project functions & handing over to BAU

- Closure Report
- Lessons Learnt

RAID Log in Project for the Web

Fulfilled Lives Programme Governance

Corporate Transformation Board

Strategic Programme Governance

Fulfilled Lives Programme Board

Includes Corporate Director, Directors, SRO's, Programme Lead and Directorate Programme Manager

Meets monthly

Individual strategic oversight of the Fulfilled lives programme

Project Governance

Individual Project Board's

How we work

Meets monthly
Includes SRO, operational heads of service, workstream leads, PPM

Self-Directed Support

Meets monthly
Includes SRO, workstream leads, PPM

Support at Home

Meets monthly
Includes SRO, workstream leads, PPM

Short Term Support

Meets monthly
Includes SRO, workstream leads, PPM

Individual strategic oversight of project – responsibly for individual delivery of each project

Individual workstream huddles

Individual workstream huddles

- **Ways of working First Response**
- **Systems and Mosaic Dev**
- **Streamlining Professional Contact**
- **MH/LD 3 conversation**
- **Tech Enabled Care**
- **Homecare Procurement**
- **Individual Service Fund**
- **Trusted Reviewers**
- **Community and Micro Enterprises**
- **Reablement**

Individual focus on project activity

Fulfilled Lives – Board Roles and Responsibilities

Role	Description	Responsibilities
BCP Transformation Board	• To provide strategic leadership to all transformation activity in BCP. • To provide overall corporate governance and decision making for the council.	• Note and resolve escalations. • Approve additional programme budget expenditure (if needed).
Fulfilled Lives Board	• To provide strategic leadership to Adults Transformation. • To provide the overall governance and decision making for the Adult Fulfilled Lives Programme. • Brings together all workstream SROs and Programme management to manage and coordinate operational delivery of all transformation projects.	• Approve all PIDs. • Approve all programme budget expenditure. • Accountable for progress against the programme and benefits realisation plans. • Escalates issues/ risks to the Corporate Transformation Board as necessary.
Project Boards	• To provide an activity vehicle with the appropriate colleagues to deliver against approved business cases/ project initiation documents (PIDs). • To provide project governance and local decision making for approved activity related to business cases and project initiation documents • To provide a project structure which engages the appropriate internal and external colleagues/ partners • Allow for the creation and use of project plans, risk registers, action trackers and decision logs	• Accountable for progress against business cases and project initiation documents (PIDs). • Activity vehicles to achieve the programme and benefits realisation plans. • Escalates project issues/ risks to the Fulfilled Lives Board as necessary.
Workstream Huddles	• Provides opportunity to discuss smaller activities related to project • Informal approach • Greater flexibility and encourages creative thinking • Open discussion on activities	• To discuss openly progress of workstream activities. • Ensures colleague engagement and voices are heard, • share best practice and identify gaps in activities. • Discusses opportunities for workstream activity improvement.

Fulfilled Lives Programme - Leadership Roles

Name	Fulfilled Lives Role	Key Function
Jillian Kay, Corporate Director of Wellbeing	Fulfilled Lives Programme Senior Responsible Owner (SRO)	Overall strategic responsibility for the delivery of all aspects of the Fulfilled Lives programme
Unknown, Fulfilled Lives Programme Lead	Programme Lead	Responsible specifically for fulfilled lives programme delivery and oversight of projects that sit within the fulfilled lives programme
Betty Butlin, Director of Adult Social Care	Project SRO – How we Work	Responsible for ensuring the project meets its objectives and delivers projected benefits
To be identified and confirmed	Project SRO - Self-Directed Support	Responsible for ensuring the project meets its objectives and delivers projected benefits
To be identified and confirmed	Project SRO - Support at Home	Responsible for ensuring the project meets its objectives and delivers projected benefits
To be identified and confirmed	Project SRO - Short Term Support	Responsible for ensuring the project meets its objectives and delivers projected benefits

Name	Fulfilled Lives Role and Key Function
Corporate Directorate Programme Management: Harry Ovnik – Wellbeing Directorate Programme Manager	Overall directorate programme management leadership and coordination Link to all central enabling functions and mobilisation of project resource
Central Corporate Functions: Veronique Moorcroft (HR), Anna Fresolone (Finance), & Geoff Bridgman (IT) - Business Partners/ Managers, Comms, Procurement	Central leads to provide mobilisation, challenge and accountability
Project Managers (various)	Internal project support

Fulfilled Lives Programme Roadmap

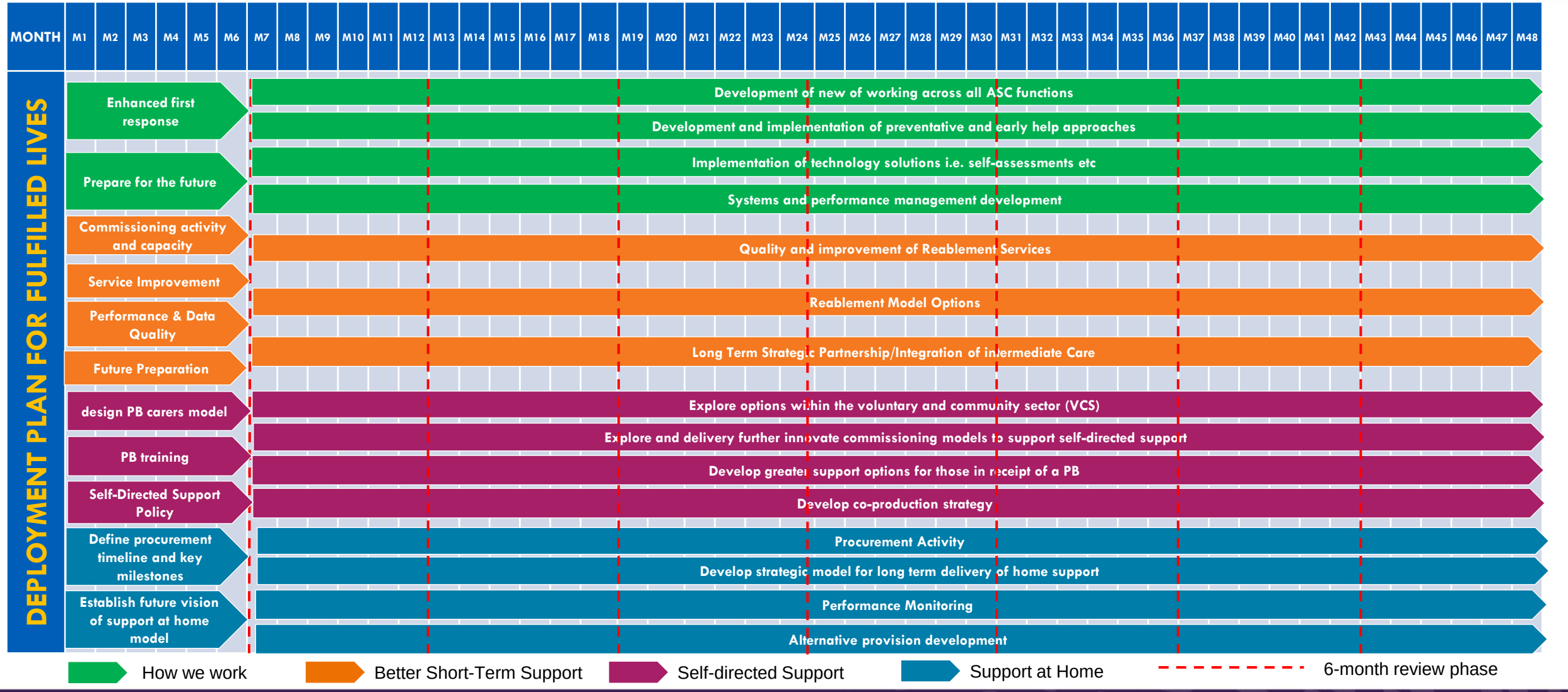
- The programme will be shaped against an agile approach, providing an iterative process environment, where the programme can learn and adapt as it progresses.

- The approach has been taken as a result of learning taken during the ‘3-month sprint’, and an acknowledgement that delivering transformation within ASC can be challenging – **doing everything at the same time can/will lead to failure.**

- The programme will be defined into 6-month stages, whereby at the end of each stage, we will assess, review, learn and reflect, before commencing and mobilising the appropriate next stage.

- In addition, at the start of each stage, defined plans etc will be drawn up, detailing the 6-month stage to come based on the long-term diagnostic assessment opportunities.

Fulfilled Lives Programme Roadmap



Fulfilled Lives – Change Management

- The Fulfilled Lives Programme will look to utilise additional and existing resource to support with change management. We are looking to ensure that the people affected by the change are supported to adopt and champion new ways of working.

- A transformation plan of this scale can lead to anxiety, confusion, and resistance from the people on the ground, who may not fully understand the need for the changes, or how to adopt and adapt to new processes.

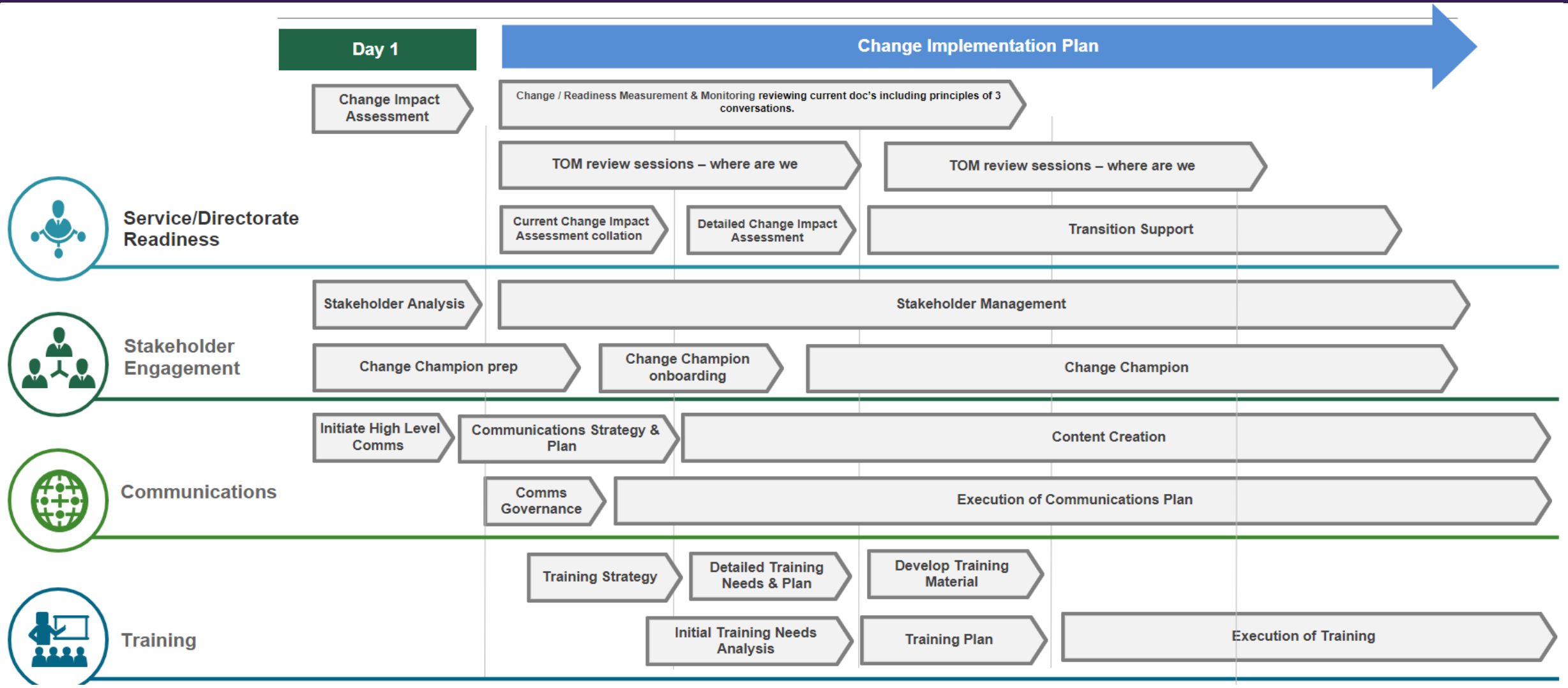
- Change management seeks to support and facilitate by:

  - Supporting the people affected by a project to transition smoothly through three process stages: ‘planning for change’, ‘managing change’ and ‘reinforcing change’.

  - Craft the messaging around the project and communicate the reason for the changes with employees and other stakeholders.

  - Determine how to move forward effectively and efficiently.

Fulfilled Lives – Change Management Approach



Programme Savings, Benefits and Investment

Savings – Context and Background

- The Use of Resources report in Autumn 2023 identified there were opportunities to reduce ASC spend and the importance of having a detailed plan/business case that set out resources and capacity needed to bring about long-term sustainable efficiencies over a 5-year period.
- There was a clear acknowledgement and appreciation that there would need to be investment to bring about the transformation.
- Based on this work and report, the ASC transformation business case has been developed. Below sets out the transformation investment required to bring about the change in 4 key areas as set out in previous slides.
- Since working with the LGA we have begun to implement areas of change where we are seeing green shoots develop; areas such as strengths based (3 conversations) working, improving Mosaic and culture.
- This has positively impacted on a number of areas that are showing a reduction in expenditure but require the investment below to deliver the roadmap and achieve sustainable savings and transformation.
- Without investment, the transformation will not be possible - and the long-term consequences for the Council's finances are challenging.

Benefits realisation - Savings

- As mentioned in the previous slide, this table summarises the investment and savings for a programme of transformation, with proposed estimated (some of costs and savings are currently estimates) expenditure of £2.9m and overall cumulative savings (over 5 years) of just over £3.5m.

Category	Element	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	Total
Transformation Investment	Programme Management	£31,000	£430,500	£448,500	£85,500	£0	£0	£995,500
Transformation Investment	Self Directed Support	£22,500	£138,000	£26,500	£0	£0	£0	£187,000
Transformation Investment	Short Term Support	£8,500	£67,000	£43,000	£0	£0	£0	£118,500
Transformation Investment	Support at Home	£14,500	£80,000	£62,000	£0	£0	£0	£156,500
Transformation Investment	How we work	£9,500	£810,856	£538,970	£122,830	£0	£0	£1,482,156
Total one off investment	**Total one off investment**	**£86,000**	**£1,526,356**	**£1,118,970**	**£208,330**	**£0**		**£2,939,656**
Income	Flexible use of capital receipts	-£86,000	-£1,526,356	-£1,118,970	-£208,330	£0		-£2,939,656
Total one off Income	**Total one off Income**		**-£1,526,356**	**-£1,118,970**	**-£208,330**	**£0**		**-£2,939,656**
Transformation saving	Change in LTC domiciliary care spend		-£250,000	-£327,740	-£409,265	-£488,172	-£160,934	-£1,636,111
Transformation saving	Change in LTC residential care spend		£0	-£450,507	-£446,002	-£441,542	£0	-£1,338,050
Transformation saving	Staff savings resulting from Mosaic provider portal		£0	-£105,000	£0	£0	£0	-£105,000
Transformation saving	Reduction in average cost of support for LD		£0	-£78,000	-£104,000	-£130,000	-£156,000	-£468,000
Total recurrent annual saving	**Total recurrent annual saving**		**-£250,000**	**-£961,247**	**-£959,267**	**-£1,059,713**	**-£316,934**	**-£3,547,161**
Cumulative annual saving	**Cumulative annual saving**		**-£250,000**	**-£1,211,247**	**-£2,170,514**	**-£3,230,227**	**-£3,547,161**	

Benefits realisation – Assumed changes

- The following table summarises the assumed changes in the numbers of domiciliary care packages and residential care placements in each year. These changes will need to be netted off increases already built into the MTFP for demographic growth. For example, if demographic growth, assumes growth of 25 domiciliary care packages in 2025/26, then the net position will be an increase of 3 (25 – 22).

Placement/package type		2024/25	2025/26	2026/27	2027/28	2028/29	Total
Change in 65+ domiciliary care (number of packages)		-18	-22	-28	-33	-11	-101
Change in 65+ residential care		0	-10	-10	-10	0	-30

The changes are based on average weekly cost per package/placement for 2024/25 as follows:

- 65+ Domiciliary care: £352.35
- 65+ Residential care: £1,070

Benefits realisation – Performance

The following table sets out a suggest set of key performance indicators that should be monitored by the Delivery Board to assess the impact of the programme and each workstream. These are informed by Six Steps to Managing Demand in Adult Social Care: a… | IPC Brookes

Workstream	Key performance indicator	Baseline BCP performance	England average (where known)	What does good look like
Programme	Gross current expenditure on adult social care per adult aged 18 and over	557.18	523.95	BCP Council spends more on ASC support in comparison to other local authorities (6.3% more than the England average in 2022/23).
	Spend on long term care per person, aged 18-64	269.21	264.46	Current spend is slightly higher than England average, aim should be to bring at least in line with England average
	Spend on long term care per person, aged 65+	1039.39	872.83	Current spend is significantly higher than England average, aim should be to bring at least in line with England average
How we work	Average number of people per month referred to LTC locality teams for care act assessment	290 of which 35% (102) receive an assessment and 9% (27) receive a service	Not available	Aim for reduced number of referrals for assessment and 90% of those referred receiving an assessment (any of C1,C2 and C3)
	Average number of people per month receiving a service from LTC teams	27 per month	Not available	Aim to reduce the number of people prescribed a service by Long Term Conditions teams (which accounts for 50% of all services prescribed)
	% people offered technology enabled care as an alternative to other types of long term support	Not currently measured	Not available	Aim to increase the % of people offered technology enabled care as part of C1 or C2 who don't go on to need other services.
Better Short-term support	% people still at home 91 days after discharge from hospital into reablement	71.60%	82.30%	Data from 2022/23 ASCOF returns show BCP performance as 139th nationally. Aim to bring in line with England average
	% people offered reablement support following discharge from hospital	1.30%	2.90%	Aim to bring in line with England average, but also monitor access to reablement from community teams
	% of people receiving a long term service who received reablement support first	12%	Not available	Local data shows very low use of reablement before long term support is provided. Six steps to managing demand analysis suggests this figure should preferably be more than 70%
	Spend on short term care per person, aged 65+	1.42	69.43	Spend on short term care per older person is significantly lower than the England average
Self-Directed support	% of overall ASC expenditure spent on traditional services	85% of ASC spend on care costs spent on traditional services (care homes, dom care and day care)	Not available	% spend on non traditional services should be tracked as an indicator of the success of efforts to
Support at home	% of people who receive less than 10 hours of domiciliary care a week (as a proportion of all older people receiving dom care)	41%	Not available	Six steps to managing demand analysis suggests this figure should preferably be no more than 15%

Proposed resources for delivery

Category	Element	Unit cost	Grade	FTE	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	Total
Programme Leadership / management	Programme Lead	£104,000	N/A	1	£31,000	£117,000	£78,000				£226,000
	Project Manager (Change specialist)	£57,000	J/K	1		£57,000	£28,500				£85,500
	Senior Project Manager	£62,000	L	0.6							£0
	Project Manager	£57,000	J/K	6		£256,500	£342,000	£85,500			£684,000
Total Programme Management					**£31,000**	**£430,500**	**£448,500**	**£85,500**	**£0**		**£995,500**
Self Directed Support	Senior commissioner	£53,000	J	1	£22,500	£63,000	£26,500				£112,000
	CME development costs					£75,000					£75,000
Total Self Directed Support					**£22,500**	**£138,000**	**£26,500**	**£0**	**£0**		**£187,000**
Support at home	Strategic Commissioning Manager (Homecare/Intermediate Care)	£62,000	L	1	£14,500	£80,000	£62,000				£156,500
Total Support at home					**£14,500**	**£80,000**	**£62,000**	**£0**	**£0**	**£0**	**£156,500**
Short term support	Commissioning Officer (Homecare/intermediate Care)	£43,000	H	1	£8,500	£67,000	£43,000				£118,500
Total Short term support					**£8,500**	**£67,000**	**£43,000**	**£0**	**£0**	**£0**	**£118,500**
How we work	Mosaic developer	£45,000		1		£33,750	£33,750				£67,500
	Mosaic specialist	£132,080	N/A	0.6		£59,436					£59,436
	Business Analyst	£45,000	I	1	£9,500	£34,250	£22,500				£66,250
	Senior Commissioner (prevention)	£53,000	J	1		£39,750	£39,750				£79,500
	Innovation lead	£57,000	J	1		£57,000	£28,500				£85,500
	Mosaic provider portal	N/A	N/A	N/A		£162,000	£93,000				£255,000
	Financial assessment online tools						£104,830	£80,830			£185,660
	Self assessment online tools (TBC)						£84,250	£42,000			£126,250
	Up front investment in first response capacity	£439,560				£329,670	£109,890				£439,560
	Lead information management officer	£45,000	I	1		£45,000	£22,500				£67,500
	Leadership development	£50,000		1		£50,000	£0				£50,000
Total How we work					**£9,500**	**£810,856**	**£538,970**	**£122,830**	**£0**		**£1,482,156**
TOTAL					**£86,000**	**£1,526,356**	**£1,118,970**	**£208,330**	**£0**	**£0**	**£2,939,656**

APPENDICES

How we work – Principles of 3 Conversations

The 3 Conversations

1 Conversation 1 : Listen & Connect

Listen hard. Understand what really matters. Connect to resources and supports that help someone get on with their chosen life, independently.

2 Conversation 2 : Work intensively with people in crisis

What needs to change urgently to help someone regain control of their life? Put these into an emergency plan and, with colleagues, stick like glue to help make the most important things happen.

3 Conversation 3 : Build a good life

For some people, support in building a good life will be required.

What does 'a good life' look like? What resources, connections and support will enable the person to live that chosen life? How do these need to be organized?

Principles of 3 Conversations

- We are not the experts in people's lives – people and families are
- Stop assessing / reviewing people for services (wrong focus) and start listening even more carefully to what matters to them
- Always start with the assets and strengths of people, families and communities
- Know more about the neighbourhoods and communities that people are living in
- Always work collaboratively with other members of the community support system
- No hand-offs, no referrals, no triage or screening, no acceptance of waiting lists
- Stick to people like glue during **Conversation 2** – there is nothing more important than supporting someone to regain control of their life
- Never plan long term in a crisis (work at helping someone get through the crisis)
- Always exhaust Conversations 1 **and** 2 before having Conversation 3 **and test this out with colleagues in huddles**

PPM – Project Framework and PftW

About our framework

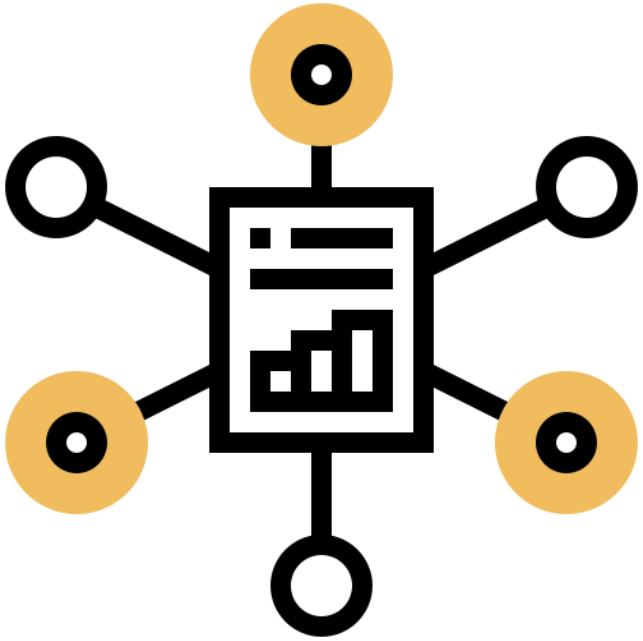
Designed to provide a consistent approach to project delivery across BCP. Our aim:

To drive exceptional project delivery through the shared understanding of expectations and the required standards to meet operational and strategic project activities.

We have designed our Framework to align with our project management software, Project for the Web (PftW), which is being implemented simultaneously. This enhances our role as a central function within BCP and helps us deliver better results for you.

Our Framework and software are not static - we will monitor, evaluate and refine them over time to ensure continuous improvement. We have established governance structures to support this process and ensure quality and accountability.

This document gives you a summary of our Framework, showing how our Officers use their skills and experience to support your projects, and what you need to do as our clients to make the projects successful. By working together, we can create and deliver outcomes that are sustainable and impactful beyond the project completion.



1. Pre-Project

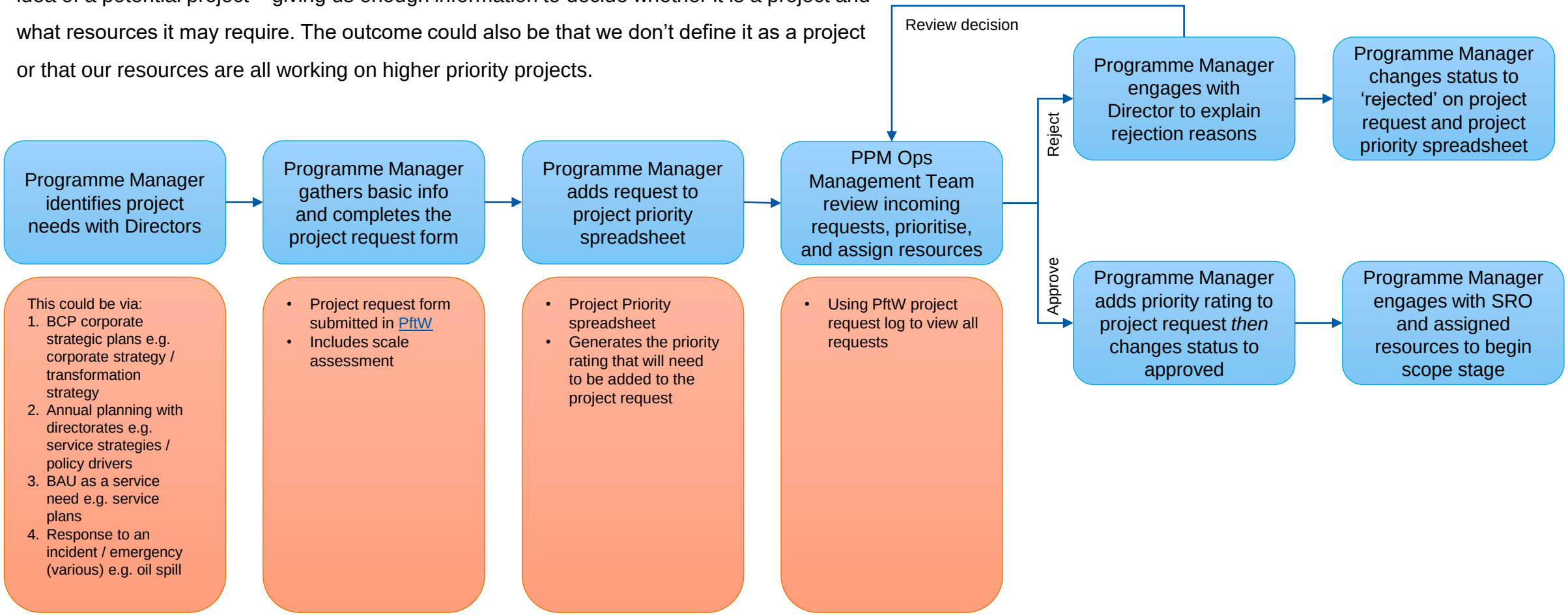
This stage is about identifying and understanding an incoming piece of work and assessing it to determine whether it is something the we will engage with.

This stage is primarily the purview of the Programme Managers, working with Heads and Directors, but may involve some PPM staff.

PPM Core Tasks & Responsibilities	Client Core Tasks & Responsibilities	Information Gathered	Stage Outcome
• Complete the Project Request Form in Project for the Web **Programme Managers** • Complete the Project Priority Record **Programme Managers** • Assign resources if a project is created **Programme Managers**	• Clearly articulate the issue trying to be resolved • Identify potential solutions • Provide high-level information on cost, duration, strategic alignment and impact/complexity of the project • Identify potential funding sources and amounts • Identify an appropriate Senior Responsible Officer (SRO) for the project	• General project details • Identified senior responsible officer (SRO) • High-level business case • Estimate of project scale & tier • A priority value • Indicative funding details • Estimated start & finish dates	The project request is assessed by the PPM Management Team and, if it is confirmed as a project, resources will be assigned, and a project will be created in Project for the Web.

Project Request Form

The project request form is housed within Project for the Web and is designed to capture the idea of a potential project – giving us enough information to decide whether it is a project and what resources it may require. The outcome could also be that we don't define it as a project or that our resources are all working on higher priority projects.



2. Scope

This stage begins to investigate the project in detail to allow an informed decision to be made on its viability (cost / resourcing / benefits) and lays the groundwork for the project in terms of governance and documentation. It is where the assigned Project Manager / Officer and the Senior Responsible Officer (SRO) start to work together.

PPM Core Tasks & Responsibilities	Client Core Tasks & Responsibilities	Information Gathered	Stage Outcome
• Set up Teams team **PPM Officer** • Establish initial project governance **PPM Officer & SRO** • Complete Scoping Document **PPM Officer & SRO** • Add initial Risk / Action / Assumption / Issue / Decision / Dependency (RAID) entries to PftW **PPM Officer** • Start producing project Highlight Reports via PftW **PPM Officer**	• Identify key initial stakeholders • Input into development of the scoping document • Approve scoping document via SRO and/or initial governance body • Highlight RAID entries and lessons learnt to PPM officer to record	• Project name • Project team composition • Project purpose • High level workstreams & deliverables • Key comms messaging • Initial risks, issues, dependencies and assumptions / constraints • Overarching scope • Out of scope items • High-level milestones	It is agreed that based on the high-level information and analysis to date that the project is viable and worth pursuing, so the project moves into the design stage where the low-level planning takes places.

3. Design

This stage plans the project in detail and captures that detail across key documentation so that it can be reviewed and approved appropriately. It is where all the necessary planning takes place to enable delivery to commence in the next stage.

PPM Core Tasks & Responsibilities	Client Core Tasks & Responsibilities	Information Gathered	Stage Outcome
• Develop the Business Case **PPM Officer / Project Team** • Develop the Project Initiation Documentation (PID) **PPM Officer / Project Team** • Develop the Project Plan **PPM Officer / Project Team** • Establish remaining governance bodies, manage RAID entries & produce Highlight Reports **PPM Officer** • Develop & agree stage gate criteria (Tier 1 projects) **PPM Officer & SRO**	• Input into development of the business case / PID / project plan • Identify resources to undertake project activity • Input into development of stage gate criteria (Tier 1) • Approve scoping document via SRO and/or initial governance body • Highlight RAID entries and lessons learnt to PPM officer to record	• Workstreams • Task / activities • Milestones • Required resources • Project options incl. financials • Management approach • Final governance structure • Stage gate criteria (Tier 1)	The business continues to agree that the work is viable and it is further agreed that the project has been planned in sufficient detail, with clear roles and responsibilities, and appropriate resources have been identified and allocated to allow the commencement of work on the deliverables.

4. Delivery

This stage is where all the planning goes into action and the team begin working on all the tasks that have been planned. It is generally the longest stage of our project cycle, requiring oversight and monitoring by the project managers / officers, alongside reporting and managing change. This stage ends with the completion of all deliverables and leads to project closure.

PPM Core Tasks & Responsibilities	Client Core Tasks & Responsibilities	Information Gathered	Stage Outcome
• Set project baseline **PPM Officer** • Manage project plan in PftW **PPM Officer** • Manage change requests **PPM Officer & SRO / Project Board** • Manage access requests for Teams & PftW **PPM Officer** • Add Lessons Learnt **PPM Officer** • Manage RAID entries & produce highlight reports **PPM Officer**	• Undertake project activity per agreed documentation • Submit change requests via PPM officer for consideration of project governance body • Highlight RAID entries and lessons learnt to PPM officer to record	• Change requests • Lessons learnt	All deliverables have been delivered to agreed specifications and all work has been completed. The deliverables are now ready to be handed over to the client to manage via BAU.

5. Closure

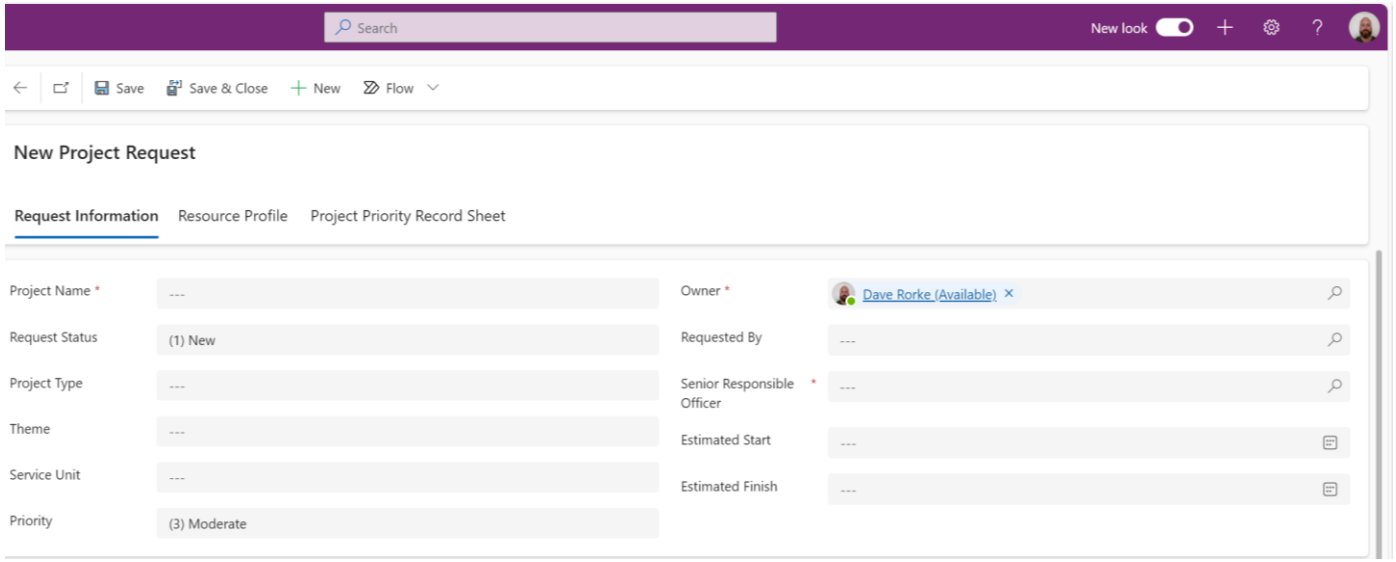
This stage draws together all of the work and documentation done to deliver against the planning done in earlier stages and officially closes a project. It is where we collect feedback from all our stakeholders and ensure that our customers have all the information to use the deliverables and oversee post-project benefits realisation once we've concluded our involvement in the project.

PPM Core Tasks & Responsibilities	Client Core Tasks & Responsibilities	Information Gathered	Stage Outcome
• Circulate project feedback form **PPM Officer** • Finalise lessons learnt in PftW **PPM Officer** • Complete closure report **PPM Officer & SRO** • Finalise documentation & archive project Team **PPM Officer**	• Complete project feedback form and encourage stakeholders to do the same • Contribute to development of closure report • Approve closure report via SRO and/or initial governance body • Highlight lessons learnt to PPM officer to record • Take ownership of project deliverables and ensure post-project benefits are realised	• Objectives review • Deviations from Business Case • Deliverables review • Stakeholder feedback • Lessons learnt • Benefits realisation • Post-closure actions	All lessons learnt and feedback has been collected from stakeholders and a closure report produced, which the presiding governance body and SRO have accepted.

Project for the Web (PftW)

We use Project for the Web, a Microsoft product that integrates with other Microsoft tools, to manage our projects in a cloud-based environment. This software helps our officers organise their work and report on their progress in a consistent and efficient way. You will receive regular highlight reports from us that show you the status, achievements, plans, and risks of your project.

Our Programme Managers will also use Project for the Web to submit a project request after exploring your project idea with you. This request will go through our review process and, if approved, will become a live project for our team to deliver via the system.



Mosaic Roadmap

Mosaic Roadmap – First 6 months

- The priorities shown on the following slide are recommended to be progressed within the first 6 months as part of the overall ASC Transformation Delivery Plan, within the 'How we work' workstream.
- The priorities will ensure alignment of Mosaic development work, with the ASC Transformation plan
- This includes the upgrade of Mosaic, which is an essential upgrade, and will take up a significant proportion of development time
- One day a week of specialist Mosaic contractor resources are already funded until end August (they will also be supporting the Mosaic upgrade for 2 days a week funded from wider Council funding source)
- Plans for the next priority areas of development should be developed through the first 6 months of delivery and agreed as part of the review of 'How we work' workstream at end of 6 months
- Fast track items will continue
- Communication of the current priorities via SMT is required once agreed.

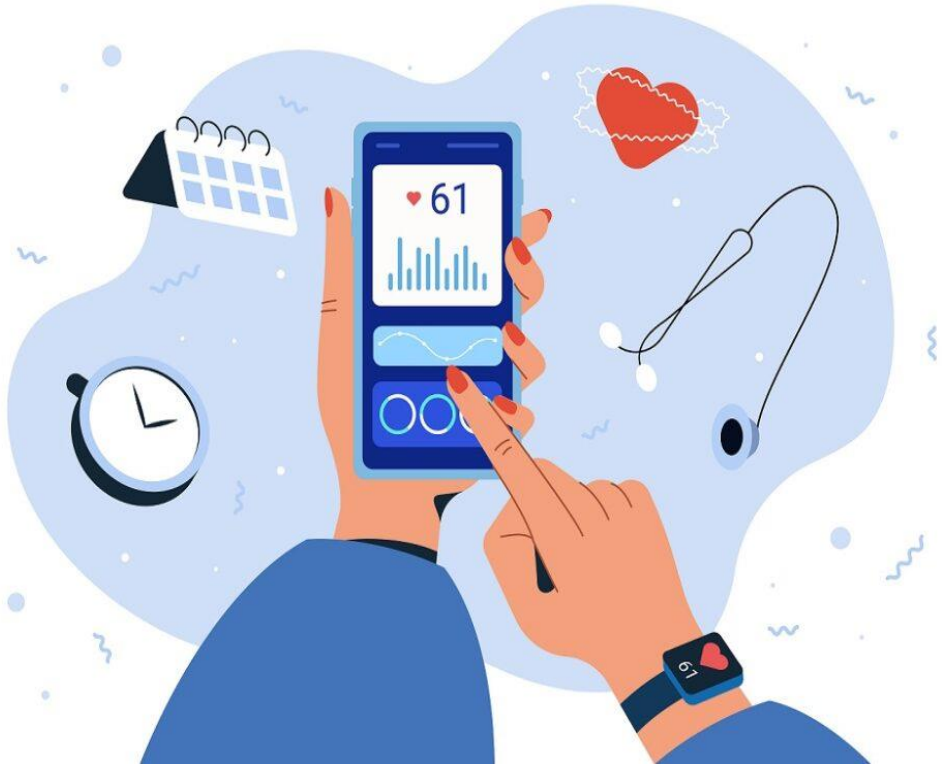
Mosaic roadmap – first 6 months

Priority	Area	Description - What needs to change
1	**Mosaic Upgrade**	Upgrade Mosaic to a newer version
2	**S117**	New pathway and templates
3	**Lifeline Team**	Change in the team on Mosaic. New staff to be added onto Mosaic. Current staff on Mosaic to be resent their login details.
4	**Care Technology**	Brand new workflow to be created on Mosaic
5	**Front door / First Response**	Consolidation of contact/ follow up templates
6	**C3**	New C3 forms and worksteps to replace Care Act Assessment, Care and Support Plan and Review processes
7	**C1**	Review how C1 is working and if anything needs to change (linkages from new First Response forms and streamlined info into C2/C3)
8	**C2**	Review how C2 is working and if anything needs to change (Action Planning)

Care Technology

Care Technology – Background

- Diagnostic review and options appraisal carried out by Hampshire County Council and PA Consulting in 2022.
- Recommendation of full-service transformation approved at Cabinet in October 2022.
- Aim to mainstream care technology across ASC.
- Enable more people to access Care Technology and delay, reduce or prevent the need for costly, long-term care and support.
- Savings of £3.3 million over 5 years



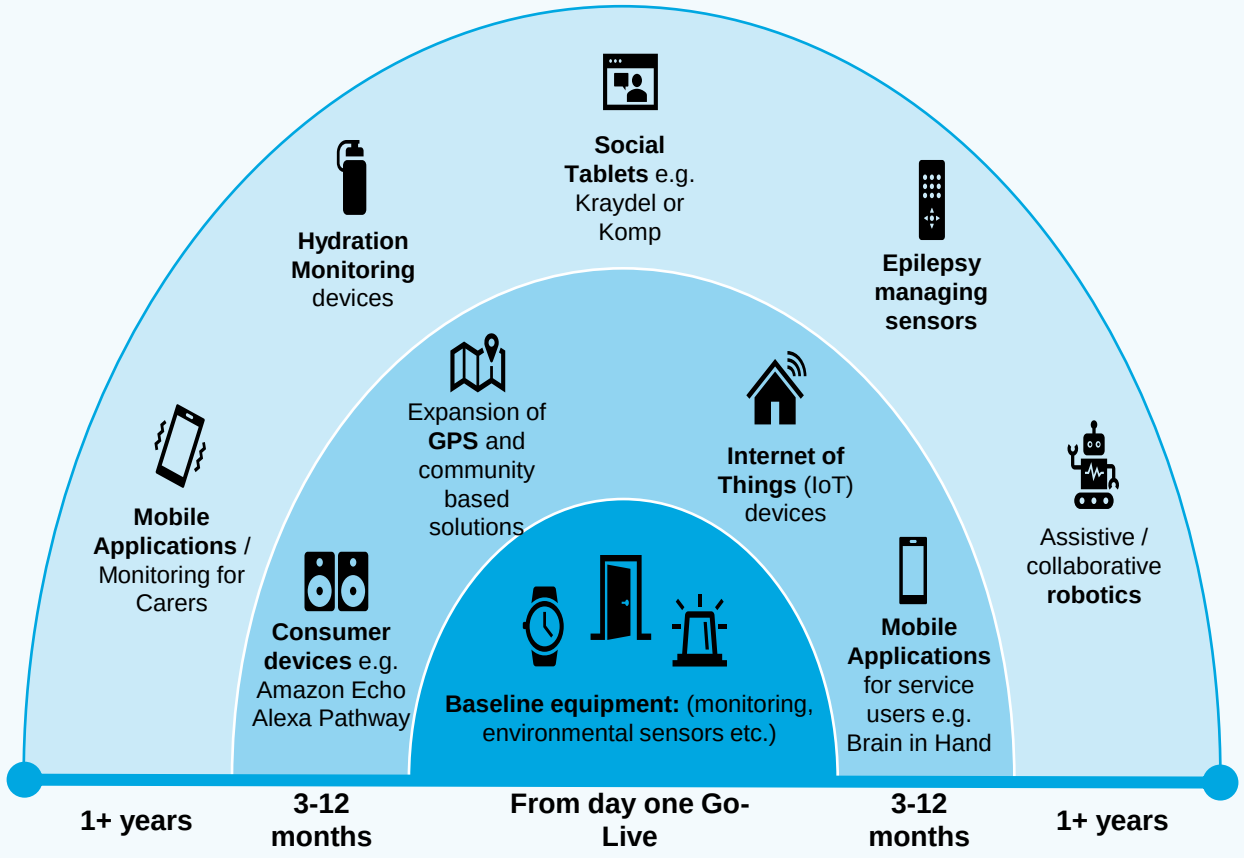
Care Technology – Current Position

- We are designing the Operating Model based on Trusted Assessor approach, where practitioners make outcomes-based referrals into a care technology team that carry out the assessment at the same time as installation.
- The care technology team would be based within our existing telecare service - Lifeline. This elicits maximal financial benefits and supports the sustainability of the Lifeline service. It must, however, be noted that this transition into lifeline is in addition to other MTFP pressures within the service.
- Preparation of job descriptions and team structure for imbedding the Trusted Assessor approach into Lifeline team is nearing completion.
- Redesign of the referral process has commenced, it will be followed by development, testing and training of the new automated referral form on Mosaic.
- Following the go-live of the referral form the training and engagement with relevant stakeholders as well as development of Power BI tools will commence.

Care Technology – Future Vision

- The project will look to develop and utilise not only traditional methods of technology but seek new and innovative models.
- The equipment development roadmap, sets out our ambition in terms of the potential use of technology, such as Alexa, mobile apps etc.
- The initial timeline for go—live was October 2023, however, due to the need to change proposed operating model, the project is expected to go live summer 2024.

Indicative Equipment Development Roadmap



Self-Directed Support Insights

Key insights from conversations

ASC Practitioners

‘The impact of a (pre LGR) Direct Payment audit and the direction that resulted from it- specifically related to carers - are still being felt’

‘Getting Direct Payments for carers agreed can feel like a battle each’.

‘Being creative feels like a battle- if you want to do anything different you expect it to be challenged.’

‘Direct Payments are meant to enable creative approaches but they can end up annoyingly rigid’.

‘If Direct Payments are going to be the first port of call, they need to change to be more usable.’

‘The time taken to complete a Direct Payments referral seems to be going up and up and up’.

Personalisation and our priorities

People’s lives and situations are messy and complicated. They often don’t fit neatly into the processes and policies designed to guide our work.

Social workers - as the advocates for these people, navigating them through our system – can feel their voice is lost.

It appears that we are spending a lot of time trying to get agreement for plans and budgets and dealing with failure demand arising from our processes and culture.

This is frustrating and there is a cost and lost opportunity of our time balanced against the savings we think we’re making.

Direct Payment Holders

‘My experience of setting up my Direct Payment was very good – I felt I had a voice in the process and the power balance was right.’

‘I had problems right at the beginning by needing to agree to things that weren’t applicable to me – I was told to just tick all the boxes and not worry about it. But it did worry me.’

“If BCP Finance Management can empower the DP team to make individual and sensible decisions instead of computer says no - will make our lives a lot easier”

“When no changes are made its great, but when changes happen it’s a nightmare to manage and follow”

Direct Payment Holders

‘Only seems to be issues when any changes happen – then seems to get complicated and not very clear for a layman to follow but would say an overall positive experience on the whole’.

“Does it all really have to be so complicated?”

‘Before Covid it was better and I understand Adult Social Care is under pressure but sometimes they are so cold with communication and approach’.

‘I use the BCP website to look for day opportunities but it would be good if they had an independent organisation reviewing as sometimes there are organisations out of date – perhaps some feedback or review system to help us have confidence who to choose if a change is needed’.

Early identified Programme Risks

Identified Programme Risks

Item	Risk Description	RAG	Mitigation
1.	**Leadership –** potential risk of lack of leadership capacity and coherence to support the programme.	12	Establish programme governance with Fulfilled Lives programme board being the senior responsible board for delivery of objectives. Board will have visibility and sight of any capacity challenges within the leadership team.
2.	**Benefits realisation –** potential risk that benefits may be overstated within the initial business case and as a result ability achieve savings/benefits will be challenged.	9	Benefits have been based on sound activity data and national benchmarking. Each individual project will be clear on the makeup of savings and any potential challenge will be captured and escalated early via the programme board.
3.	**Resourcing –** Risk that the ability to recruit to roles that support programme delivery may be challenged leading to delay and achieving programme deliverables.	12	Early engagement with HR to ensure recruitment is activity progressed at pace to avoid delay.
4.	**External factors –** Potential risk that CQC inspection takes place during key programme mobilisation OR alternative legislative changes impact programme delivery.	12	Consideration of temporary pausing some element of transformation to ensure appropriate focus on CQC.
5.	**Mosaic Re-procurement –** The current case management system for ASC (Mosaic) expires in December 2026. A re-procurement exercise leading to an alternative supplier would significantly impact programme delivery.	15	Re-procurement of case management system to be initiated and mobilised as early as possible to ensure adequate time to manage risks.

Impact score	Likelihood score	1 Very Unlikely	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
1	Negligible	1	2	3	4	5
2	Minor	2	4	6	8	10
3	Moderate	3	6	9	12	15
4	Major	4	8	12	16	20
5	Catastrophic	5	10	15	20	25

RAG status rating	Low	Moderate	High	Extreme
Aggregate score range	1 – 3	4 – 7	8 – 14	15 – 25