High level Summary of internal change work in place to migrate to the new model

As described in section 2.2 of the main report we can summarise all the change activity into the following six headlines:

- **Safeguarding change:** this will improve execution of safeguarding through clearer targeting this skill and specialism;
- **Practice change**: this will enable staff to deliver strengths based social care and support;
- **Structural change:** this will create locality working in multidisciplinary teams to drive population health;
- **Infrastructure change**: this will create new tools and systems for financial and practice management;
- **Commissioning change:** this will create a shift into a blended landscape of outcomes focused provision across the VCSE, Health and commercial sectors;
- **Workforce change:** this will create an improvement in the blend and supply of roles needed for future integrated working.

We describe below the internal activities in place that are building transition into the new model.

High level summary of change activity

Safeguarding	A dedicated safeguarding team will be established to lead the frontline operational practice to prevent and protect adults at risk of abuse and neglect. The team will be responsible for the delivery of the statutory functions of safeguarding and work alongside other teams such as the social work and quality improvement teams in ASCH. The new team will focus exclusively on managing all aspects of active safeguarding enquiries, investigations, and post safeguarding support planning. The operational processes and the management of work flow will be such that the resultant increase in productivity should mean that case management, including safe and timely closure of case will be the norm and avoid drift as it has been common under current practice. The safeguarding team will be led by a single manager countywide; however, the practice will take place at the local level working in partnership with other agencies. The team will spearhead putting Making Safeguarding Personal into practice. The testing of the new safeguarding team commenced 26 February 2018 and it will end on 8 August 2018. The evaluation of the new way of working is planned to take place by 15 August 2018 The team will be expected to carry out the following functions:

	1. Act as a source of advice on safeguarding matters for other professionals and organisations at the local level, placing greater emphasis on prevention. 2. Work with the NHS and Kent Police as statutory bodies with their responsibilities for safeguarding to secure the most effective response in protecting adults at risk of abuse or neglect. 3. Participate in appropriate Local Care multidisciplinary discussions when it concerns a person that the MDT is working to help to keep them safe. 4. Act as the point of contact and advice for care homes, working in concert with the Quality Improvement team.
Practice	Will change the current case management approach to a 'strengths-based' approach that uses the skills and talents of people in their own communities. The culture change required will be led by practice leads to ensure a culture of openness, feedback and challenge that enables progression towards independence. Social care workers need the training, time and mandate to be able to utilise the whole of an individual's resources, and their family's or community's resources, rather than feeling restricted to a narrow range of service responses, this could result in changes to the way cases are managed and impact on future workforce requirements to deliver the new operating model. To support practice change Outcome Focused Practice will also develop new tools; a care and support plans that will recorded individual's current and potential activities, capabilities, support and goals. Providers will be required to provide progress against goal delivery and be performance managed against the contract. Commissioning reports will be in place to inform where goals cannot be set due to provision gaps, allowing the market to be continuously shaped to meet the demand for services. Purchasing reports in place to ensure that commissioned services are being delivered by providers to ensure value for money.
Structural	Adult social care will operate in a minimum of 9 locality teams across the county. It is envisaged that each locality team will be part of the Local Care MDTs as they come on stream. We will start with two pilot sites in East and West / North Kent. The local operational delivery units which will form part of the MDTs is modelled to comprise of:

	• East Kent-13 • West Kent-7 • North Kent-7
Infrastructure	The operational delivery of the new asset based approach relies the right systems and tools to be available. The implementation of the new Mosaic IT system is the critical component. It will enable staff to work more flexibly and efficiently with improved processes and workflow. The management of admission to and discharge from hospital will also benefit. Secondly, other digital developments are currently in design or early implementation phase. These are listed below. Working as part of the MDT and operating from multiple locations will demand a number of things: 1. Single point of access 2. Mobile devices 3. Electronic shared care records/integrated care 4. Self-Care and Asset focused apps 5. Summary care records 6. Virtual MDTs Thirdly, we are completely rebuilding our financial management systems. Bringing together new functions such as Purchasing, along with improvements to the Placements function, and a new dedicated authorisations function. These will be supplemented by a shift towards a single business management oversight of operations; along with new tools to better model and grip spend.
Blended Provision	In order to realise efficiencies and outcome improvements in the new operating model, we will need to see a new blend of provision. This starts with new pathways and provision around a 'universal core offer', including Public Health contribution. This covers both commissioned services such as the new wellbeing and resilience VCSE offer and also, crucially creating pathways into universal services, into arts, parks, libraries and community clubs through **social prescribing** and **care navigation**. This continues with integrating first points of contact – bringing referral paths together and locking in the VCSE early into integrated triage and diversion into universal services. Building on the pilot work already delivered bringing together ICT (Intermediate Care Teams) and KeaH (KCC Enablement service) - we will bring together a blend approaches and provision for short term recovery interventions. KCC, the NHS Community Providers, and Mental Health Provider all provide short term

	recovery. Through better blends of local provision, we will bring costs down and better target support. Moving towards better blends of NHS generic worker, Homecare and Supporting Independence packages (focused on outcomes and recovery) will be a key driver in how we manage the re-let of Homecare / SIS contracts. Accommodation is about to be completely refreshed – with a very different blend of innovative solutions around extra care and partnering – especially with the community hospital bed base. The following eight actions have been agreed to drive this change: Strategic Commissioning Board agreed to the following recommendations in relation to the Older Persons Care Home Market Analysis presented on 14 December: 1. Further spend and unit cost level analytics to identify the financial impact of enabling people to remain within their own home. Measured in terms of the increase in Domiciliary Care and the corresponding reduction in residential placements. 2. Further research to consider the implications of an increase in former self funders (wealth depleters) using the demography data to determine potential pressure areas. 3. Release £1.5m from the new monies budget allocation, for the next two years, into the operational budget to support the increase of placement costs as needs increase. CPT to monitor and track changes in need and impact on placement costs changes. 4. Further work with the market to consider risks and issues; and to determine how KCC's aligned outcomes can be achieved in order to increase local authority capacity and postcode linked surety of supply. 5. Exploration of the opportunities of Extra Care Housing to meet the needs identified including identification of land and potential new entrant provider meetings. 6. Development of Strategic relationship with the Competition and Markets Authority (CMA) to work in partnership with their consumer agenda. 7. Development of a revised Market Position Statement (MSP) and production of a Commissioning Plan for April 2018 to launch the recommissioning of these services for 2020. The MPS will include our short, medium and long

	term approach to the commissioning of these services. 8. Work with the NHS to develop plan for Community Hospitals and workforce integration.
Workforce	The new operational model calls for the retention, recruitment and development of staff with the right skills and capable of working across organisational boundaries and practice from multiple and multiagency locations. It is essential that we develop and promote career progression pathways opportunities across adult social care, health and the wider sector workforce. We will develop a multi-professional workforce, with staff equipped with right mind-set and skills to work with service users and patients. Appropriate support will be provided to staff during the transition to the new organisational arrangements brought about by the new operating model and the refreshed vision and strategy. Also, we are developing and introducing a career pathway and capability development framework for unregistered workers who work directly with service users. Developing the workforce will not be limited to KCC staff alone. Providers delivering home care will sit as part of Local Care cluster/hubs within or supporting the multi-disciplinary team with supporting independence team workers either managing or supporting the providers. As part of the changes we will require the sector to take on evolving role in line with the phased introduction: 1. 1st phase- KCC to hold responsibility to assess, set and review outcomes, monitor progress and co-ordinate required activity. Provider to deliver outcomes-focused care 2. 2nd Phase- KCC to hold responsibility to assess, set and review outcomes and co-ordinate required activity. Provider to deliver and monitor outcomes-focused care 3. 3rd Phase- KCC to hold responsibility to assess, set and review outcomes. Provider to deliver, to monitor and to co-ordinates outcomes-focused care Importantly, this will be underpinned by providing the right support to the care sector workforce (including voluntary sector staff) through introducing a learning and development hub.