

1. Reasons for Recommendation – Detailed Description

- 1.1. Adult Social Care and Independent Living commissioned the Chief Operating Officers' Service to put in place technical solutions that empower Cheshire East residents to exercise choice and control over their wellbeing, care and support. These solutions also need to work for the care and support workforce and those who provide services and community activities. This paper details what is required to deliver these solutions in response to the brief below. It builds on the Care Act Phase 1 2014-15 work previously undertaken in Adults Social Care.
- 1.2. The aim was to identify and provide solutions to deliver the Care Act in the most collaborative way to meet the needs of both Adults and Children's Services. Incumbent systems and contract end dates have been dovetailed into the implementation plan, to minimise disruption and unnecessary further costs to service areas.
- 1.3. Consideration has been given to a co-ordinated customer experience with respect to Public Health; and, although it is not yet known whether the solution identified can meet all Public Health requirements to deliver a Lifestyle Wellness portal and improved information to the public – this is work in progress and will be explored in more detail.
- 1.4. Opportunities for sharing and future economies of scale could be achieved through common solutions, shared platforms and processes with other local authorities. It is the intention to, wherever possible; include CWaC as a named beneficiary in Adults, Children's and Public Health technical contracts so that they can also call-off the solutions, if appropriate.
- 1.5. This paper also takes into consideration other strategic initiatives; Cheshire Care Record, the North West ADASS Informatics Network (AIN) sub-regional collaborative Care Act solutions group, the Cheshire East Digital by Design or Digital Customer Services major change Programme and the emerging needs of the Complex Dependencies sub-regional agenda with CWaC, Halton and Warrington.
- 1.6. Adults Social Care 2015 have the following key strategic outcomes to:
 - Enable people to live well and for longer – (Council Outcome 5)
 - Enable people to live at home and as independently as possible – this is what people say they want
 - Enable people to fully contribute to and be supported in strong and supportive communities – (Council Outcome 1)
 - Enable people to access information, advice, early help and prevention so that they can help themselves and take responsibility for their well-being
 - Enable carers of people to live well and be supported to fulfil their caring roles
 - Ensuring vulnerable adults are safeguarded

1.7. The solutions recommended directly support access to information, advice, early help and prevention so that people can help themselves and take responsibility for their well-being. The solutions also indirectly support the following specific commissioning intentions:

1.7.1. For all adults:

- Provide support that informs, advises and encourages self-help and self-management to maintain healthy independence.
- Stimulate and enable a range of early help and prevention activity and informal support that prevents the need for more specialist social care support and improves outcomes.
- Greatly increase the choices of support available for social care need so that it can be tailored to particular needs and individual's preferences – personalising support.
- Adults should access the same opportunities to enjoy social/recreational activities in the community as others; strong and supportive communities enable this. Social isolation and loneliness blights lives and must be addressed urgently.
- Further develop support that helps people to gain or regain the capacity to live well independently.
- Enable access to support which affords adults protection from harm and safeguards them appropriately
- Redesign assessment and care management processes and systems to ensure customers receive a timely, effective, outcome-focused service.

1.7.2. Frail Older People

- Develop further the range and scale of community based wrap-around support to keep people living well at home and avoid the risk of needing long-term residential or nursing home care.

1.7.3. Older People Living with Dementia

- Develop the range and coherence of the health, social care and community support for people with dementia and their carers.
- Support the need for early diagnosis and specialist interventions/treatment. For example: Dementia reablement and the use of assistive technology.

1.7.4. Learning Disabilities

- Develop a more effective joint health and social care approach to support adults with complex needs, including challenging behaviour. The complexity of needs is growing in the group of young adults who from children's services to adult social care and health support (often referred to as transition).
- Community inclusion to be developed further to ensure that day time and social opportunities encourage and enable access for adults with learning disabilities, including voluntary work and employment.

1.7.5. Mental Health

- Develop the preventative support to people at risk of and experiencing poor mental health by working with Public Health and Health partners.
- Ensure that informal support is developed and encouraged to provide better community and social inclusion for those recovering from serious mental illness.

1.7.6. Physical and Sensory Disabilities

- Expand awareness of and access to assistive technology to ensure those with disabilities can maximise their personal independence.

1.7.7. Carers

- Increase the range of respite care choices available to ensure that carers can have periodic respite from their caring roles that meets their particular needs and preferences.
- Increase the range of early advice, information and support to people new to the caring role.
- Enable carers to develop skills and expertise to assist them in their caring role.

1.8. Children's Services 2015 have the following key strategic purpose:

To ensure that the needs of children, young people and their carers are effectively identified, early enough, so targeted prevention and protective services can promote their well-being and protect them from further harm. This paper directly supports the following objectives for targeted prevention and support for vulnerable groups:

- Working with a range of partners to close the gap in attainment for vulnerable children
- Targeting youth support to deliver an increase in vulnerable groups in education, employment and training
- Prevent, reduce, re/offending and young people placed in custody.
- Demand Management, re-commission targeted programmes, e.g. Multisystem Therapy, Troubled Families, Parenting support, Short breaks, Family Group Conferences,
- Implement with partner agencies and adult services effective pathways for children with complex needs so there is robust preparation for adulthood.
- Ensure policies and procedures and commissioned services meet the needs of children with disabilities and carers across the levels of need

1.9. The solutions recommended particularly support target youth and transition by providing information and advice, working with partners to provide

professional information on complex dependencies and to support troubled families.

- 1.10. This paper also tries to address the technical solutions required to support the Complex Dependencies programme. The Cheshire and Warrington Complex Dependency Programme has been set up from 2015 following a successful bid for Government funding through the national Transformation Challenge Award scheme. The Programme will build on what is already in place across the Pan-Cheshire Sub Region to establish a new, integrated, joined up model across agencies and services that tackle the causes of crisis for children, families and individuals across a range of related and complex issues. It will also ensure that there is more support available for families and individuals that are already in a state of crisis. In summary, the programme looks at both preventative work to help children, families and vulnerable adults to avoid reaching crisis, and providing crisis management for those that have.
- 1.11. Partners within the sub-region have recognised that there are a number of overlapping issues that lead to crisis and an increased dependency on the state for support. These issues that the Programme will focus on are:
 - Working with each locality on Stage 2 of the Troubled Families Programme.
 - Adults and children involved in crime or anti-social behaviour
 - Children who have problems at school
 - Children who need help
 - Children at the edge of care and edge of custody.
 - Adults out of work or families at risk of financial exclusion
 - Individuals and families affected by domestic violence and abuse
 - Abusers of drugs and alcohol.
 - Individuals with a range of (non-age related) health problems
 - Young people affected by homelessness/rough sleeping
 - Although the Complex Dependency Programme will work closely with the Troubled Families Co-ordinators in each locality, the list of issues outlined above shows that the Programme will tackle much more than Troubled Families across the Pan-Cheshire Sub Region. Across the Pan-Cheshire sub-region there are 10,000 individuals affected by these complex dependencies.
- 1.12. The partner organisations that have signed up to the programme are:
 - Cheshire East Council
 - Cheshire West and Chester Council
 - Halton Borough Council
 - Warrington Borough Council
 - Cheshire Police
 - Cheshire Police and Crime Commissioner
 - Cheshire Fire and Rescue Service
 - NHS England
 - National Probation Trust

- Cheshire and Greater Manchester Community Rehabilitation Company

1.13. What will success look like?

- Better outcomes for children, individuals and families affected by these complex dependencies.
- The model being an exemplar that can be adopted in other areas across the country.
- Reduced costs for agencies and services.

1.14. The Complex Dependency Programme will again rely on integration of information from case management solutions. A possible solution proposed is the LiquidLogic Single View and Atom solution, so this paper ensures that the existing components (LCS and Single View) are re-procured to support Troubled families, safeguarding and associated integration with LAS, and that Atom will be included within the LASA Framework for potential call off should this be the selected solution going forward. ICT Strategy continues to work with Children's Services on the needs for Complex Dependencies.

1.15. The Cheshire Care Record (CCR) is a professional portal for sharing health and social care information across the Cheshire footprint. Collaboration between all GP, hospital, community, mental health and social care services.

1.16. The Cheshire Care Record will help improve decision making about resident care (adults and children) by speeding up access to vital information which provides a fuller understanding of the care needs rapidly, without having to ask the individual time and time again for the same information or telephone colleagues in other areas of health and social care. This aids efficiency and outcomes.

Examples of benefit areas include:

- Reduced phone calls between the GP, hospital consultants, social workers and community teams.
- Reduced duplicate tests through access to all recent test results, regardless of which organisation requested/processed them
- Reduced admissions to A&E as better able to diagnose and treat patients as they will have access to existing conditions, medication, treatments and test results information
- Earlier discharge from hospital if professionals have access details about the social and community care packages that the resident has in place at home
- Improved safeties by ensuring that any new prescriptions are given are safe to take alongside existing medication and by being aware of known allergies.
- A better experience for residents as they don't have to repeat your story; full medical details, time and time again when seeing different staff groups

- Better coordination of care across multiple teams and organisations, which improves resident experience and improves efficiency.
- 1.17. Cheshire Councils and Community service providers are working together to develop integrated health and social care teams. These teams will combine community, social and primary care staff to plan total care packages and work more closely with residents to do this. However each service provider collects their own information about the individual and records this within their own systems. The Cheshire Care Record provides a means of bringing the summary data from multiple systems into one place so that there is one single view that can then be used in planning meetings about care for individuals.
 - 1.18. The introduction of the Cheshire Care Record has the potential to change the nature of and components within a patient's social care package. Better access to see which other services are seeing which resident and their care package, perhaps in terms of the number of home visits required but also in terms of when these visits are required. Care can be better coordinated across all services so that the resident gets visits when they want them, perhaps on different days by different services, thus providing a better and safer service to the patient and ensuring that someone is calling in to see them regularly. Many elderly, frail patients are visited for safeguarding purposes to ensure that they are managing to look after themselves. A more comprehensive service is provided if the delivery of care is managed across a week holistically between agencies to ensure that the residents are being checked routinely throughout the week.
 - 1.19. The Cheshire Care Record can also enable the social and community care teams to find if a resident has been admitted to hospital, perhaps if they turn up for their daily visit and they are not there and to also better plan for their discharge so that they know when to resume home care services.
 - 1.20. Some key benefits identified by GPs include:
 - Radiology results can be seen on the West Cheshire Care Record as soon as the results are available, rather than waiting for the letter notification from the Trust.
 - GPs can track progress on their patients when they are in hospital, this is particularly useful for long stay, complex patients, whom they would not hear progress about until the discharge letter follows, which can sometimes get delayed.
 - Cancer episodes, which may be long term, can be tracked.
 - A patient's lead social worker can easily be identified, including telephone numbers, for example if a GP needs to request an increase in a patient's social care package
 - A summary of the number and frequency of social care visits and their purpose is useful.
 - The mental health summary and cancer summary are both very informative
 - It is quicker to view letters as don't have to separately login to Medisec

- 1.21. The Cheshire Care Record (CCR) is dependent on the information held within the technical solutions recommended and continued integration of these systems.
- 1.22. The CCR Information Governance (IG) Group has representation from Cheshire East ICT Strategy IG, security and compliance teams which are working with Adults Social Care leads to ensure appropriate consent to share and view records is achieved, alongside documented and robust internal policies, processes and procedures.
- 1.23. Public Health will launch a new integrated health and wellbeing service, offering lifestyle advice and support to residents in an integrated way for the first time. This will include new services to create more support for residents who want to be more active and for those who want help to lose weight together with existing services offering support for people who want to stop smoking or need to access sexual health services urgently. We will bring all of these services together with a re-invigorated NHS health checks programme to ensure we can support residents to stay healthy for longer. This will deliver a number of core services which it is mandated to commission which include:
- Appropriate access to sexual health services,
 - Deliver the NHS Health Check Programme
- 1.24. The Integrated health and wellbeing service will also include additional investment to prevention premature mortality and reduce disability. The service will also deliver a full range of support for residents to change and adopt a healthier lifestyles including help to
- Stop smoking,
 - Reduce obesity and
 - Increase physical activity
- 1.25. Between 2015 and 2018, the Public Health agenda will focus more on the risk factors and behaviours that lead to early death and poor health. They are proposing to develop:
- An integrated wellness hub to support healthy behaviours.
 - A school project to improve the emotional health of children and young people.
 - Closer working between health visitors and children's centres.
 - A 'community navigator' service to help people find ways to do the things that will improve their wellbeing: connect, be active, keep learning, and take notice and 'give'.
- 1.26. It is proposed that this paper will enable Public Health to address two of the focus areas listed above, an integrated wellness hub and community navigator. ICT Strategy continue to work with Public Health to determine business requirements and clarify whether the proposed information and advice portal and eMarketplace (with back office integration with LiquidLogic and OCC components) will meet their requirements before

another portal (and associated financial management solutions) are procured.

- 1.27. Public Health have had a Business Case approved to invest in technologies in these areas, and while it is envisaged that this proposal will deliver a proportion of what they need, it is not anticipated that it will deliver the complete solution. It is understood that £200k has been allocated to the Public Health needs, and possibly up to £130k of that amount could be used to fund this business case, if the solution provided the required functionality.
- 1.28. There are two key components to the information technology solutions and information sharing needs of Cheshire East Council:
 - Public facing information and systems for residents, communities about communities, as well as the local care and support systems contained within the Citizens portals and
 - Professional information and systems for health and social care partners delivering some or all elements of planning and support i.e. Cheshire Care Record (CCR) and Complex Dependencies Programme.
- 1.29. This paper focuses directly on the technical solutions for the public facing information solutions but ensures indirect/interfaces with the professional solutions identified. Both approaches require secure identity management and adopt the NHS number as the unique identifier or all aspects related to health and social care.
- 1.30. While considering the public facing (Internet) solutions required for effective implementation of the Care Act requirements, the work being undertaken for the Digital Customer Services programme will be considered in order to avoid duplication and provide a consistent delivery of service.
- 1.31. It is proposed that a system to support the provision of information and advice will be procured (replacing existing third party Care Choices solution) which will:
 - Guide the citizen to relevant information in an attractive manner
 - Enable the citizen to bookmark and otherwise interact with the portal
 - Present audio visual material
 - Enable users to interact with the content through social media
 - Provide Chat rooms and discussion forums
 - Offer alternative solutions to the search for support e.g. housing solutions
 - Allow for self-assessment templates to be referred directly to the appropriate local authority department
- 1.32. In addition there will be the provision of a Resource Directory (eMarketplace) combining Adults and Children's existing systems (and potentially the Lifestyle Wellness) to include:

- A directory of approved providers, with 'self-service' for those organisations to update their records
 - A directory of services (both free and paid for), with 'self-service' for service providers and community input to update their records
 - Integration with the Citizens Portal Care Accounts (linked to back office financial and case management solutions) to enable direct and auditable purchases particularly for both self-funders (capturing expenditure) and those with costed care plans (local authority expenditure).
 - High quality search/browse/mapping of the directory data of a quality that the citizen experiences on other websites such as Amazon.
 - Council administration and moderation tools
- 1.33. Care Accounts will be need to be created by 2020, which integrate with both case management and financial back office systems including:
- Tools to enable citizens and carers to source, budget and pay for, and manage services
 - Access to Care and support plans with a view to co-production of a support plan (or interim documents) with experts in a joint process
 - Summary records
 - Transferrable records between Councils
- 1.34. It is proposed that the systems are procured through call-offs contracts under the LASA Framework (for Cheshire East) that includes all new components above and existing disparate Adults and Children's LiquidLogic and Oxford Computing Centre (OCC) systems (at end of contract date) to ensure parallel contracts with consistent end dates.
- 1.35. The following existing components will be procured through the two new call-off contracts under the LASA Framework with LiquidLogic and OCC:
- ContrOCC Adults
 - ContrOCC Children's
 - Market Place for Children's
 - Supporting People System
 - Children Case Management
 - Adult Case Management
 - LAS Data Warehouse and Business Objects Universe for Statutory Returns
 - LAS Equipment Workspace
 - LLPG integration
 - LDAP integration
 - LCS / LAS Integration
 - Customer Forms Designer and Repository for LCS, LAS & EHM
 - Hosting services
 - LCS Data Warehouse and Business Objects Universe for Statutory Returns
 - ContrOCC Children's Integration

- EHM (Early Help Module)
- EHM Hosting
- EHCP SEN module
- Troubled Families Generic Workspace

- 1.36. The suppliers of both LiquidLogic and ContrOCC have indicated that Cheshire West and Chester (CWaC) could adopt the same approach with two separate call-off contracts under the LASA Framework, but do not advise combined contracts. Economies of scale may be achieved whether technical solutions are implemented in collaboration, such as the eMarketplace and Complex Dependencies Programme. Further analysis will be required to support the Service Reviews and detailed business case.
- 1.37. Council administration and moderation tools may be procured in the short term through Crown Commercial Service RM1557vii Framework (GCloud 7) to enable the services to deliver a sub-regional eMarketplace solution prior to April 2016. It has been assumed that if this third party were not required, and that CoSocius could deliver these elements, similar costs would be incurred.