

Devon
County Council



***Modernising our Care
Management System
Programme***

**Assessment and Review Team
Evaluation Report**

1 Executive Summary

In July 2007 SMG agreed to implement two distinct and separate pilots of the Assessment and Review (ART) teams, one based in Exmouth and covering the Exeter and East Devon locality the other in Barnstaple that would cover the North Devon area.

ART function is to resolve all contacts and will only transfer work where there is a long term condition, complex need or equipment, adaptation, moving or handling need. Acting as a filtration system for all non-telephony contacts coming into ACS, telephone calls come into ART either via the Customer Service Centre (CSC) or the professional lines.

ART deals with:

- Transfers from the CSC;
- Calls to the professional lines across the county;
- Post;
- Faxes;
- Emails; and
- CareFirst 6 assessments from CSC and re-assigned cases from the locality.

Each pilot site was asked to collate all their activities in line with the evaluation criteria framework agreed and signed off SMG in September 2007 so that this data could be used to analyse the disparate ART processes and identify timings. This was achieved by staff completing daily activity spreadsheets, as with any manual collection of information there is always a margin of error to be considered.

Where possible comparison data has been provided, however the Exeter and East Devon pilot captured additional data outside of the framework that has been used in this report to highlight pertinent points. Such data is prefixed with "Exeter and East Devon pilot".

1.2 ART Models

The ART pilots in Barnstaple and Exmouth trialled two distinct operational models to deal with all the requirements of Older People and Physical Disabilities service users over the telephone that did not have long term conditions or complex needs. The requirements ranged from general enquires related to all aspects of the care management system including completing care plans, switch on services and reviews.

For the pilots it was expected that Exeter and East Devon would be staffed by 13 Full Time Equivalents (FTE) and Barnstaple would be staffed by 8 FTE. The difference in staffing levels reflected that Exeter and East Devon would be taking approximately 40% more calls than Barnstaple as it served both East Devon and Exeter catchment areas.

1.2.1 North Devon

The North Devon ART model retained existing Directorate roles and responsibilities such as Referral Co-ordinator, Reviewing Officers and Community Care Worker (CCW).

The majority of contacts that came into North Devon ART pilot were "cold" meaning that the Referral Co-ordinator would need to make outbound calls to gather as much information as possible. Once enough information has been gathered the Referral Co-ordinator passed the information over to a Practice Manager to make a formal decision on who would undertake the assessment. If the Practice Manager thought that the referral was for:

- A complex need or long term condition then the assessment would be passed to the field based locality team for a face to face assessment;
- An equipment, adaptation or moving and handling need then the assessment would be passed on to an OT to make an initial diagnosis over the phone;
- A need that could be resolved with domiciliary care, day care, meals on wheels etc then the assessment would be passed to the ART CCW to undertake over the telephone.

This is shown in the diagram below:



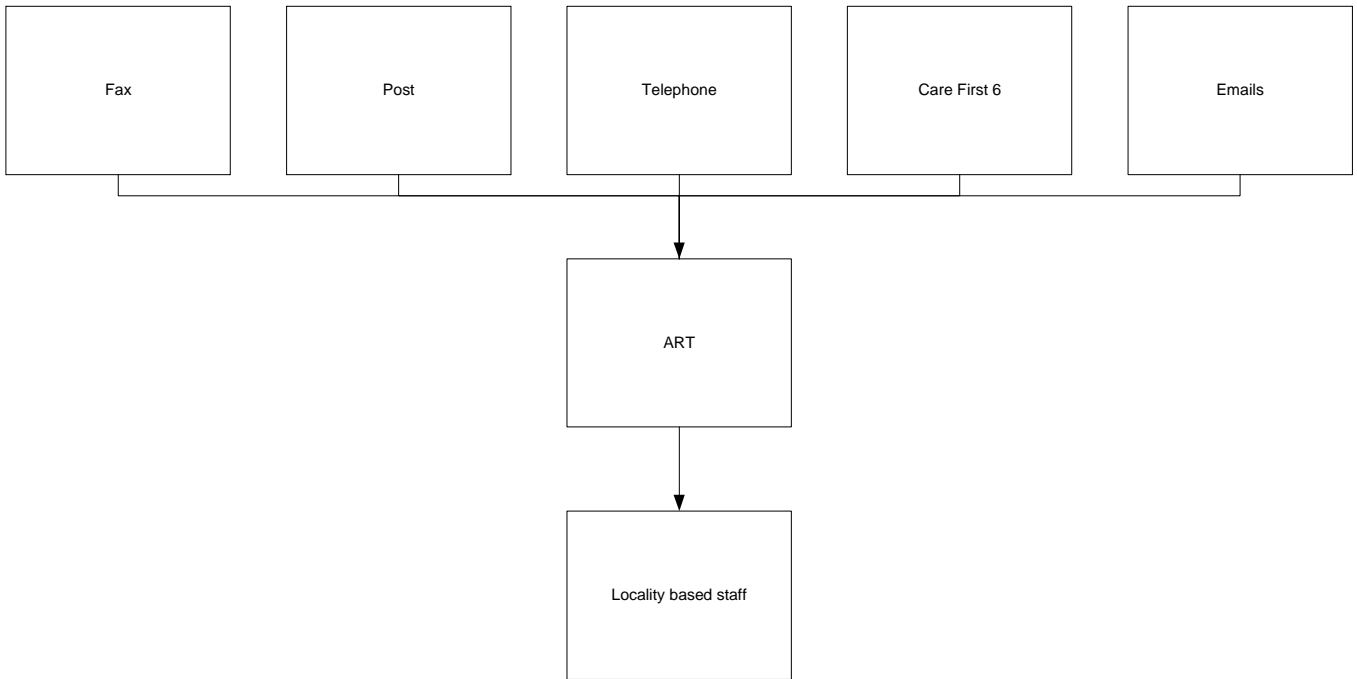
The CCWs in the North Devon pilot were on an ART rota, meaning that for two weeks out of every sixteen they would undertake ART assessments over the telephone. Although they could sit within the ART room within St George's Road most CCWs chose to sit in their existing locations or in some instances work from home.

Later within the pilot ART CCWs were given additional responsibilities and undertook duty calls i.e. urgent assessments that require a same day response.

1.2.2 Exeter and East Devon

The Exeter and East Devon pilot was staffed against a new "ART Worker" job description whose main responsibilities were to undertake holistic assessments; maintain and manage a dynamic case load; provide information, advice and signposting to the public about services that are available across Adult and Community Services (ACS).

This is shown in the diagram on the next page:



1.3 Evaluation of Pilots

Each ART pilot documented the amount of work they undertook and completed within September. This included the “method of contact” i.e. the channel that the contact was made. A brief description of each method of contact is shown below:

- In the table below CF6 stands for Care First 6 and is the information system utilised by ACS. When a call comes into the Customer Service Centre (CSC) from a potentially new service user or a person known to ACS but are **currently not in receipt** of services, the CSC will open a contact assessment to gather the pertinent information before assigning to this assessment to the existing help desks or the ART pilots.
- Emails are messages about existing service users who **are currently in receipt** of services from ACS.
- For the Exeter & East Devon pilot, when the CSC opened a contact assessment for a potentially new service user or a known person they would attempt to complete a “warm” hand over of the call to ART and this call would then appear in the telephony statistics as a call. If the CSC could not get through to an ART worker they would assign the contact assessment to the Exeter & East Devon ART pilot and this would then appear as a CF6 referral.
- Faxes received by the ART pilots were predominantly from Health professionals or other similar organisations with information on either new, existing or known people for ACS to follow.
- Post received by the ART team is similar to faxes.
- Telephone calls into the North Devon pilot would originate on the “professional” line i.e. calls from local GPs, District Nurses etc, telephone calls into the Exmouth pilot would come via the professional line but also the CSC as outlined above.
- Both ART pilots were situated in ACS premises that had open access for the public, and where pertinent a person who came into the premises was seen by a member of the ART team.
- “Other” is a catch all statement where the method of contact does not fit naturally in to any other category.

The comparison of contacts completed i.e. moved on to assessment or closed with no further action (NFA) for September in each pilot area is shown in Table 1 on the next page:

Table 1:

Number of contacts dealt with September 2007		
Method of Contact	N. Devon	Ex & E. Devon
Email	184	620
Fax	43	48
CF6	120	480
Post	21	104
Tele	45	1273
In person	3	5
Other	0	24
Total	416	2554

Table 2 shows the total number of hours worked by staff within each pilot. This shows that on average the Exeter and East Devon pilot had .95 Full Time Equivalent (FTE) a week more staff than the North Devon pilot, rather than the additional 5FTE planned to manage the higher catchment. This means Exeter & East Devon was operating, on average, at 58% of planned capacity through the pilot period.

Table 2:

Total Hours Worked				
Week Commencing	North Devon	Exeter & East Devon	Difference	FTE
03 September 2007	202.5	287.2	84.7	2.29
10 September 2007	261.7	269.8	8.1	0.22
17 September 2007	261.7	252.8	-8.9	-0.24
24 September 2007	247.5	304.9	57.4	1.55

Table 3 demonstrates the average time taken to complete an ART assessment. It takes on average 67 minutes longer to complete an assessment in the North Devon model than it does in the Exeter and East Devon model:

Table 3:

Average time taken to complete an assessment			
Date	North Devon (mins)	Exeter & East Devon (mins)	Difference
03/09/2007	97	36	61
10/09/2007	110	43	67
17/09/2007	106	31	75
24/09/2007	116	51	65
Average difference			67

Table 4 demonstrates that the average time taken to complete an assessment in each model. This shows that unless deemed as urgent it takes 2 days to for a contact to get from the North Devon Help Desk to ART CCW. In Exeter & East the majority are completed in the same day the enquiry is received.

Table 4:

Average time taken to resolve incoming contact				
	Same Day	1-2 days	3 - 5 days	5+ days
Exeter & East Devon	69%	8%	5%	18%
North Devon	1%	50%	35%	14%

There are various routes that a contact can come into ART but once received there are four outcomes, these are:

- Services switched on – where “simple” services like meals on wheels, domiciliary care etc were provided for service users over the telephone.
- No Further Action (NFA) or Signposting – this could be where a service user does not have a need identified or they are not eligible to services due to FACS. In this case and for other queries general information is given to help the person resolve their query.
- Face to face assessment – if the person contacting ART need is deemed complex or long term they are assigned to a practice manager to allocate these visits to Care Managers.
- Other calls – these calls do not lead to any of the other three outcomes and are generally feedback on existing services being provided i.e. Meals on Wheels not being delivered, general information about the service user’s family or a worker requesting a file from Exmouth to be sent to them.

Table 5 shows the number of assessments completed by ART that resulted in either being completed (services switched on/cancelled, or NFA) or passed on to field based staff in September by both pilots:

Table 5:

Number of assessments completed in September				
Outcome	N. Devon		Ex & E. Devon	
Services Switched On	66	47%	72	12%
NFA/Info Provided	39	28%	312	53%
Face to Face Assessment	33	24%	192	33%
Service Cancelled	1	1%	12	2%
Total	139		588	

Further information is available for each of these categories, this is now described.

1.3.1 Services Switched On/NFA/Information Provided

The original prediction presented to SMG in July was that ART would switch on 7,697 services, extrapolating data from brokerage shows that in fact ART would switch on approximately 5,616 services per annum a difference of 2,081 that is a 27% reduction.

It is widely acknowledged within the Directorate that there is some confusion on when is an assessment actually a review and there is anecdotal evidence that assessments has been carried out when in fact a review should have taken place. This is evidenced by analysing the number of services switched on for new service users by Exeter and East ART and those switched on for existing service users in Table 6.

Table 6

Average number of care plans completed by ART per week		
	Number	Percentage
New	9	25%
Existing	27	75%

One of the fundamental principles behind ART is it will facilitate and support a uniform process across the county. The ART processes will ensure that reviews that at present are being recorded as assessments will in the future be recorded as reviews and picked up as part of the review function of ART; this is the reason for the reduction in the number of assessments being carried out by ART.

One of the major challenges to the department is completing statutory reviews for each service user, the last RAP return had a figure of approximately 64% of reviews being completed. The figures above clearly shows that 75% of ART care plans were for existing users, this statistic highlights two challenges faced by the Directorate:

- Providing care to older people is dynamic, as people get older their needs will change resulting in a great dependence on ACS.
- Improved performance in completing reviews to proactively capture changes in circumstances will reduce the need for existing clients to have to contact ACS to increase their care packages and improve satisfaction with the departments’ customer service.

1.3.2 Face to Face Assessments

In the Exeter & East pilot when a worker detects a potential complex case or a service user with long term conditions they will complete the contact assessment and then reassign to the field based teams in the localities.

In the North Devon pilot, as depicted in 1.2, the Practice Manager has to review all contact assessments and then decides if further assessment is required by ART or the field based staff.

In the Exeter and East Devon pilot before the contact assessment is transferred to the locality it is “screened” by the ART Manager and from the 16th August 2007 through to the 19th October 2007 all assessments transferred were logged before being reassigned.

Analysis of this log showed that 321 assessments were transferred from ART to the locality teams and a further breakdown is shown below as this identifies that the majority of need for a personal visit relates to equipment, adaptations, moving or handling.

Table 7:

Number of assessments transferred to the localities from Exmouth ART (16/08/07 - 19/10/07)		
Type of Assessment	Number	Percentage
Equipment, Adaptations, Moving and Handling	225	70%
Social Care Assessments	96	30%
Total	321	

Further information available is the breakdown of the total number of Equipment, Adaptations, Moving and Handling assessments into individual categories. This is described in the chart below

Chart 1:

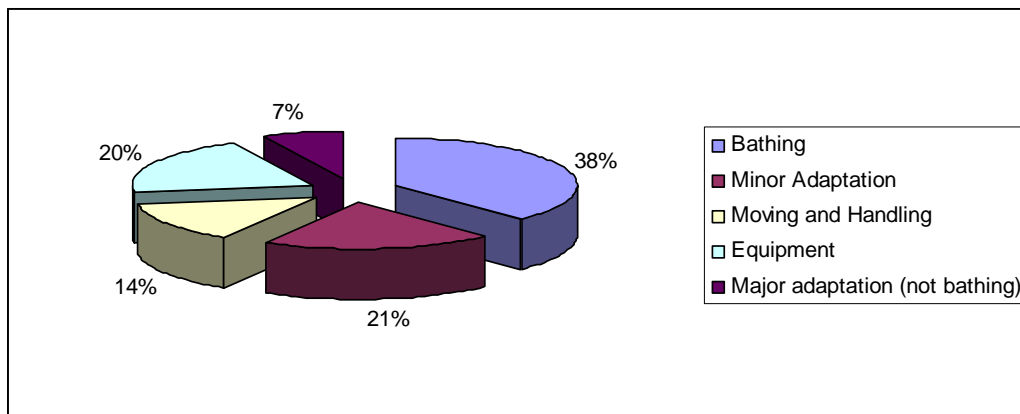


Table 7 on the previous page identified the total number and type of assessments being passed by the Exeter & East ART to locality teams; this has then been averaged to give a daily total in the table below:

Table 8:

Breakdown of daily assessments transferred to the localities from ART (16/08/07 - 19/10/07)	
Type of Assessment	Number per day
Equipment, Adaptations, Moving and Handling assessments	5
Social Care Assessments	2
Total	7

Another view of activity, using CareFirst 6 data for a one week period provides a view of types of clients being passed to locality teams. New or, existing (i.e. receiving services) or ‘previously known’ but closed (i.e. on Care

First but not receiving services at present) and then the purpose, social care assessments or Equipment, Adaptations, Moving and Handling assessments. This is shown in table 9 below:

Table 9

Breakdown of number of face to face assessments from ART to the locality (15/10/07 - 19/10/07) by type				
Type of Assessment	New	Existing	Previous known but closed	Total
Equipment, Adaptations, Moving and Handling	10	5	17	32
Social Care Assessments	1	2	1	4
Total	11	7	18	36

Analysing the detailed data provided by the Exeter and East Devon pilot it is possible to summarise, as percentages, the following information:

- 50% of all ART to locality transfers were from previously known but closed cases;
- 31% of all face to face assessments were for potentially new service users;
- 19% were existing service users
- 94% of the previously known but closed cases were for Equipment, Adaptations, Moving and Handling related work;
- 81% of potential new service users requested Equipment, Adaptations, Moving and Handling assessments; and
- 9% of potential new service users were referred to the localities for actual social care assessments.

As mentioned earlier, North Devon were not asked to collect this level of information as part of the Evaluation Criteria and so there is only Exeter and East Devon's data for analysis.

1.3.3 Other work

Utilising data taken from the telephony system and analysis of the telephony outcomes from the pilots it is possible to project and breakdown the number of inbound calls that will be received across the County.

Table 10a

Projection of inbound calls and outcomes		
Incoming	Numbers	Time (mins)
Other calls	8,442	538,178
Services switched on	4,996	257,300
NFA/Signposting	23,732	545,826
Pass to CCT	12,490	371,422

As can be seen data analysis from the two pilots above, it is identified that of all the inbound telephone calls 42% do not actually result in an outcome and are labelled "other" Utilising data gathered by the Exeter and East Devon pilot team allows further breakdown of "other" activity. This is shown in table 11:

Table 10b

Services Provided - Others	Amount
OT related	28%
Dealing with Queries from other Organisations	19%
Dealing with other admin, faxes, email, post, etc	10%
Closed/Services Cancelled	9%
Dealing with Messages from/for other workers	9%
Chasing Assesment/Referrals	7%
General Queries	5%
Working on existing case	5%
Meals	5%
Follow up on previous case	3%

1.3.4 Reviews

It was planned that the scope of both pilots was to include completion of telephone based reviews.

The Exeter and East Devon pilot however operated at 58% capacity (see 1.3 table 2) and therefore has not been able to complete review activity. However the North Devon ART pilot has two Review Officers who have conducted reviews over the telephone, this identified it takes an average call length of 117 minutes to complete a review. It is this figure that has been used in the FTE calculations in this report.

It is noteworthy that the majority of care plans completed in the Exeter and East Devon ART pilot (Table 6) were for existing service users. Simply put, at present ACS are reactive not proactive with the very real danger that a simple need could escalate resulting in a long term condition or a more complex need.

This fact has a detrimental effect on the ART function as on average it takes 1 inbound call and 4 outbound calls to update care plans for existing clients, reducing the number of outbound calls that can be conducted to complete reviews.

Older peoples needs do often change more rapidly than an annual review can respond to, however improved performance on reviews would see in the order of a 30% reduction in activity completed during the pilot to manage changes to existing cases.

1.4 Conclusions

The two models piloted had approximately the same staff capacity, Exeter and East Devon catchment area was 40% larger than North Devon's yet analysis of results shows that the Exeter and East Devon Pilot completed six times more work than their North Devon counterparts.

The three step process of the North Devon pilot created inefficiencies as work had to be handed off twice before the assessment began which would be at least two days after the initial contact meaning that the process was almost one hour longer in North Devon than Exeter and East Devon and clients has a delayed response.

In Exeter and East Devon 69% of all contacts were resolved in the same day, North Devon the only contacts resolved in the same day were urgent referrals that went through to the Duty Team.

Over 40% of all telephone calls taken by the Exeter and East Devon ART pilot did not result in an outcome with approximately 50% of all "other" calls being either related to OT waiting lists or dealing with queries from other organisations such as health . It is anticipated that by undertaking further business process re-engineering there will be a reduction in these "other" calls/ tasks coming into ART , being managed more appropriately by CSC, Complex Care teams or other functions.

1.4.1 Timings

Until the ART pilots it was difficult to ascertain the volumes that came through all the referral sources and difficult to quantify time taken to get to a completed an outcome. The early estimated headcount figures for an ART function were calculated primarily from telephony information, a comparison with what we have now learned is shown below:

Table 11a

Comparison of timings used to calculate assessments			
Outcome	Original Timings (mins)	Revised Timings from pilot (mins)	Difference
Switch On Services	63	52	12
No Further Action and Signpost	40	23	17
Forward to CCT	43	30	13

The timings used in the re-calculation of FTE requirements, against source and outcomes are shown below:

Table 11b

Source	Services switched on			NFA/info provided			Face to face assmt		
	Shortest	Longest	Average	Shortest	Longest	Average	Shortest	Longest	Average
Email	30	60	50	5	30	16	5	40	22
Fax	0	0	0	5	5	5	15	30	25
CareFirst 6	45	180	105	10	90	28	20	90	37
Post	90	90	90	0	0	0	20	30	24
Telephone	20	90	52	5	135	23	5	60	30
In person	0	0	0	5	10	8	0	0	0
Other	0	0	0	20	145	64	0	0	0

1.4.2 Headcount

A projected headcount figure for ART was presented to SMG when requesting approval to progress the ART pilots. This was based on mathematical calculations applied to historic systems data, staff feedback and some assumptions

Table 12:

Staff profile (FTE)	ART
Social workers	0
Community Care Workers	54
Occupational Therapists	0
Practice Manager	5.4
Specialist Teams	0
Total	59.4

One of the key objectives of the pilot was to test these assumptions and mathematical calculations for accuracy and also to identify additional work undertaken within the ART function that could not be quantified from CareFirst 6 data.

Using timings sourced from ART staff against each individual source of referral and then breaking that down into the three outcomes and then identifying and calculating "other work" the following FTE figures for an ART function, based on the Exeter and East model have been produced:

Table 13

Breakdown by source of the FTE needed to complete volumes of work			
Function	Number	Time (mins)	FTE
Email	9,804	334,101	5.11
Fax	1,872	41,984	0.53
CF6	6,991	300,349	3.76
Post	4,475	139,569	1.75
Telephony	264,507	2,238,703	22.69
Review	32,523	3,805,156	38.49
Total			72.31

Table 14 shows the difference from the original figure presented to senior management and headcount figures now based on the pilot's findings.

Table 14:

Difference between headcount calculation			
	Original	Revised	Difference
	Headcount (FTE)	Headcount (FTE)	
ART Workers	54	72.31	18.31
Practice Managers	5.4	6.03	0.63
Total	59.40	78.34	18.94

The 18.31 FTE difference can in part be attributed to “other work” and the number of outbound calls that was not clearly identifiable in the earlier work with staff and systems data. The impact of so many existing case contacts, again involving significant outbound calls to manage these effectively was not expected, as stated earlier this is believed to be a direct impact on reduced performance in achieving case reviews.

1.5 Next Steps

1. This report will be reviewed and discussed with Members over the next few weeks so they are fully informed of progress and learning from the pilots;
2. Staff and TU consultation feedback will then be considered; and
3. The preferred model will then be recommended following completion of the consultation.

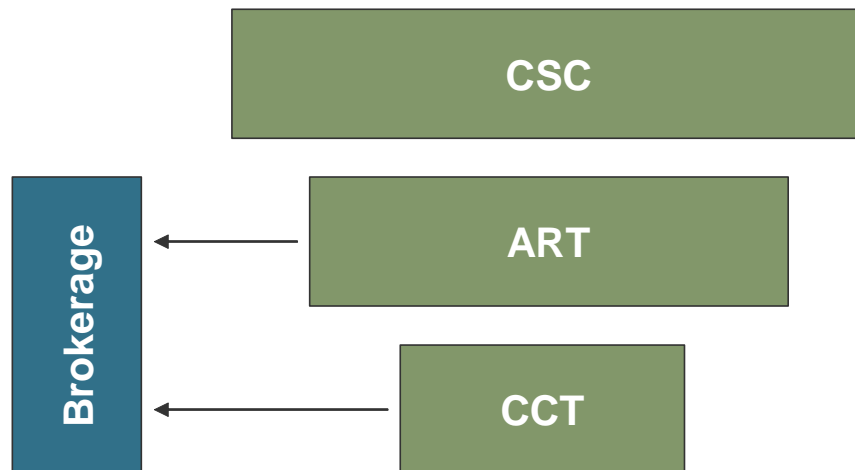
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2 Introduction

The concept of an ART team is part of the wider initiative “Modernising our care management system” programme which proposed a revised model consisting of 3 tiers and is consequently part of the present formal consultation with staff and unions



This model described the function as

“The **Assessment & Review Team**” (ART) will complete an assessment over the phone and if the services required are not related to long term conditions or complex needs, a care plan will be completed which will then be forwarded to Brokerage to fulfil. The ART function will also undertake the majority of Directorate reviews again over the phone.

In July 2007 SMG agreed to implement pilots of two models of delivery mechanisms for the ART function, one based in Exmouth and covering the Exeter and East Devon locality, the other in Barnstaple that would cover the North Devon area. Both pilots undertook a different process to complete their work; the only similarity is that they would undertake all their work over the phone.

To aid in the consultation and allow management to make informed decisions on the viability of the ART concept a set of evaluation criteria was defined for these pilots and agreed by SMG. These measures enable, as far as possible, a “like for like” comparison between the two process models, recognising constraints such as configuration of teams, technology and some manual recording. This evaluation also enables good practice to be identified.

The ART evaluation report aims to inform staff, management, trades unions and Members of the outcome of the pilot models and of benefits that can be achieved for service users by employing such a function.

2.2 Data collection mechanism

The tables contained within this report were sourced from a myriad of spreadsheets collected by both pilots and from telephony data supplied by ICT.

Each pilot site was asked to collate all their activities so that this data could be used to analyse the disparate ART processes and identify timings. This was achieved by staff completing daily activity spreadsheets which were shared with the project team on a regular basis. With any data capture system that relies on staff manually completing an activity log there will always be a margin of error and these needs to be taken into account.

2.3 Context

Authority to proceed with the ART pilots received from SMG in July 2007 was based on a report defining the purpose, scope, objectives and potential benefits and impacts of the function, Findings are reported in Section 3.

2.3.1 Scope

The ART pilots in Barnstaple and Exmouth will trial two operational models to deal with all the requirements of Older People and Physical Disabilities service users over the telephone that do not have long term conditions or complex needs. These requirements will range from general enquires all the way through the care pathway to completing care plans to switch on services and reviews.

2.3.2 Pilot objectives

- Trial the Exmouth and Barnstaple operational models to ascertain a good practice operational model for a future roll out of ART.
- Test the relationship between ART and Brokerage.
- Understand the impact of the ART pilot on other teams within the locality
- Test the transfer processes into and out of ART from the field based teams.
- Test the capacity of ART.
- Analyse the ART job description against the role to identify additional skill competencies and ensure that it accurately reflects the role they have undertaken.
- Test the first contact business processes for the CSC and ART.
- Test the proposed governance structures for ART.
- Create the training material to support ART.
- Define, implement and monitor the key operational performance indicators and quality assurance factors for the ART team.
- Test where possible and pertinent the project assumptions collated in this document.

2.3.3 Approach to pilot

The purpose of ART is:

- To switch on services over the phone using a contact assessment for low risk service users;
- Identify the need for a face to face assessment; or
- Complete the review of an existing service user.

The ART function was piloted from August 2007 with the CSC and two ART sites located in Barnstaple and Exmouth.

2.3.4 ART Models

Exeter & East and North Devon pilots are of separate operational models. For the pilots it was expected that Exeter & East would be staffed by 13 Full Time Equivalents (FTE) and North Devon will be staffed by 8 FTE. The difference in staffing levels reflected that Exeter & East would be taking approximately 40% more calls as North Devon as it encompasses both East Devon and Exeter catchment.

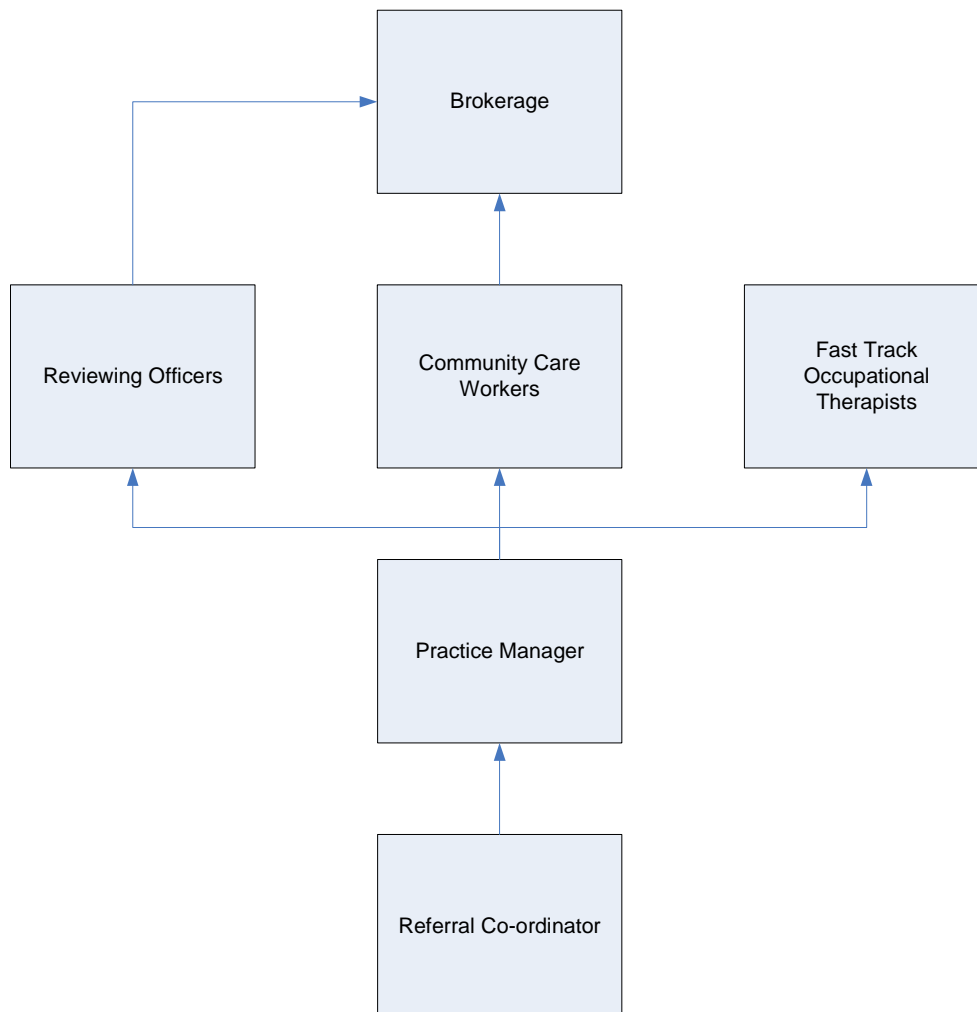
2.3.4.1 North Devon

The North Devon model was a continuation of the work that had been undertaken by the North Devon initiative (NDI) and saw a continuation of the existing roles such as Community Care Worker (CCW) but utilising the telephone for filtered assessments instead of a face to face visit.

The North Devon pilot continued to use Referral Co-ordinators as a filtration system to decide on what could be dealt with over the phone and what need to be completed face to face with the allocation of the referral decided by a Practice Manager.

ART staff are located in and around St. George's Road in Barnstaple, although some continued to work in their permanent location whilst one worked from home.

The North Devon model is highlighted below:



For the North Devon pilot the Community Care Workers (CCW) were rotated into the ART centre for two weeks over a sixteen week period.

2.3.4.2 Exeter and East Devon

The Exeter and East Devon pilot was located in Exmouth Town Hall and was an amalgamation of the existing help desks in Exeter, Honiton and Exmouth. The Exeter and Honiton help desk telephone numbers were "forwarded" to the Exeter and East Devon ART number so that existing service users and professional referrals would go through to ART.

The telephony infrastructure within Exeter and East Devon pilot site facilitated a hunt group approach meaning that all the telephones on ART team members' desks will be linked together and when a call came through to ART it was directed through to a team member based on availability and a time algorithm.

The Exeter and East Devon pilot was staffed against a new "ART Worker" job description whose main responsibilities was to undertake holistic assessments; maintain and manage a dynamic case load; provide information, advice and signposting to the public about services that are available across Adult and Community Services (ACS).

2.3.5 Working assumptions

An ART workers utilisation rate is:

Metrics			Time (mins)
ART worker works:	37	hours	2220
Utilisation rate:	85%		1887
Works:	45	weeks	84915

- Number of Assessments p.a. dealt with by ART is 22,261 of which 9,235 will go to CCT.
- The number of assessments resulting in service switch on is 7,697.
- The number of assessments that result in no further action are signposted are 5,328.
- Number of review events p.a. dealt with by ART is 32,523.
- Number of review events that resulting in service switch on are 18,630
- The above multiplied by estimated activity time of:
 - Switch On Services = 63 minutes
 - No Further Action/Signpost = 40 minutes
 - Forward to CCT = 43 minutes
 - Review Event = 108 minutes
- Total demand p.a = 76,794 hours.
- Indicative staffing resource requirement of ART function = 54 FTE
- 1 Team Leader per 10 staff = 5.4 FTE
- Total indicative resources for an ART function for Devon = **59.4 FTE**

3 Findings

3.2 Overview

The ethos behind ART is that will act as a filtration system for all non-telephony contacts coming into ACS, telephone calls come into ART either via the Customer Service Centre or via the professional lines. ART will attempt to resolve all contacts and will only hand over cases where there is a long term condition, complex need or equipment, adaptation, moving or handling need. ART will deal with:

- Transfers from the CSC;
- Calls to the professional lines across the county;
- Post;
- Faxes;
- Emails; and
- CareFirst 6 assessments from CSC and re-assigned cases from the locality.

As outlined in 1.2 there are two ART models that have been piloted in Devon, one in North Devon and the other in Exeter and East Devon. The North Devon pilot was based on the present operational business model within the directorate and current job roles and responsibilities were maintained. This model is a 3 tier model where all contacts were taken by the help desk who would then filter the contacts and pass on referrals to a Practice Manager to review and then distribute either to field based staff to complete a face to face assessment or to a CCW within the ART function who would call the referrer back and if appropriate switch on a services where deemed “safe and pertinent”.

The Exeter and East Devon pilot created a new team who dealt with all the contacts that came in and where deemed “safe and pertinent” would switch on simple services. If not they would pass the contact assessment to one of the locality teams.

Utilising population data sourced from the ACS Management Information team in October showed that the North Devon pilot was supporting 40% less people than the Exeter and East pilot.

Table 17

North Devon Population		Exeter and East Devon Population	
Barnstaple	36980	Axminster	11149
Bideford/Northam	29266	Exeter	111599
Braunton	9265	Exmouth	38883
Great Torrington	9718	Honiton	13822
Holsworthy	11319	Ottery St Mary	12340
Ilfracombe	15331	Sidmouth	15012
South Molton	10534	Total	202805
Total	122413		

Each ART pilot documented the amount of work they undertook and completed within September and further broke this down into the “method of contact” i.e. the channel that the contact was made. A brief description of each method of contact is shown below:

- In the table below CF6 stands for Care First 6 and is the information system utilised by ACS. When a call comes into the Customer Service Centre (CSC) from a potentially new service user or a person know to ACS but are currently **not in receipt of services**, the CSC will open a contact assessment to gather the pertinent information before assigning to this assessment to the existing help desks or the ART pilots.
- Emails are messages about existing service users who **are currently in receipt** of services from ACS.
- For the Exeter 7 East pilot, when the CSC opened a contact assessment for a potentially new service user or a know person they would attempt to complete a “warm” hand over of the call to ART and this call would then appear in the telephony statistics as a call. If the CSC could not get through to an ART worker they would assign the contact assessment to the Exeter & East ART pilot and this would then appear as a CF6 referral.

- Faxes received by the ART pilots were predominantly from Health professionals or other similar organisations with information on either new, existing or know people for ACS to follow.
- Post received by the ART team is similar to faxes.
- Telephone calls into the North Devon pilot would originate on the “professional” line i.e. calls from local GPs, District Nurses etc, telephone calls into the Exmouth pilot would come via the professional line but also the CSC as outlined above.
- Both ART pilots were situated in ACS premises that had open access to the public, and where pertinent a person who came into the premises was seen by a member of the ART team.
- Other is a catch all statement where the method of contact does not fit naturally in to any other category.

The comparison of contacts completed i.e. moved on to assessment or closed with no further action (NFA) required for September in each pilot site is shown in Table 18 below:

Table 18:

Number of contacts dealt with September 2007		
Method of Contact	N. Devon	Ex & E. Devon
Email	184	620
Fax	43	48
CF6	120	480
Post	21	104
Tele	45	1273
In person	3	5
Other	0	24
Total	416	2554

3.2.1 Capacity

Although the staffing ratios between the two pilots were similar due to a staffing issue within Exeter and East Devon covered in Section 3.5, the ART process in North Devon naturally restricts the throughput of contacts as only the Referral Co-ordinators actually deal with the contacts coming into ART.

Breaking down the headcount figures of North Devon showed that on average just 46% of ART workers dealt with contacts model against 100% of ART workers in Exeter and East Devon. The North Devon process model creates a natural bottleneck as there is a disproportionate amount of staff dealing with the higher number of contacts and if this headcount is reduced due to sickness or holidays the impact on the number of referrals going through the process is dramatically reduced.

3.2.2 Assessment time

Analysing the time it takes to complete an assessment with the two Art processes shows that on average it takes 67 minutes longer to complete in North Devon than it does in Exeter and East Devon, this is a result of the two handovers in the North Devon process between the Help Desk and the Practice Manager and then the Practice Manager to the ART CCW. This is shown in the table below:

Table 19:

Average time taken to complete an assessment			
Date	North Devon (mins)	Exeter & East Devon (mins)	Difference
03/09/2007	97	36	61
10/09/2007	110	43	67
17/09/2007	106	31	75
24/09/2007	116	51	65
Average difference			67

Average time to resolution as broken down into actual days shows that unless deemed as urgent it takes on average 2 days to get from Help Desk to ART CCW in the North Devon process model, this again can be attributed to the handover of work, whereas in the Exeter and East Devon model 69% of all contacts were resolved within the same day.

Table 20

	Average time taken to resolve incoming contact			
	Same Day	1-2 days	3 - 5 days	5+ days
Exeter & East Devon	69%	8%	5%	18%
North Devon	1%	50%	35%	14%

There will naturally be cases that cannot be resolved in the same day due to the need to speak to other people or the proposed service user themselves, but for all the assessments undertaken by the Exeter and East Devon ART team that were either to switch on services or resulted in NFA then 99.7% of all assessments had been completed within the statutory 28 days.

It was decided by senior management within North Devon that the ART CCWs would also undertake the duty function. With only 2 CCWs at any one time in the ART function it was common that as an urgent cases came through the system that there were times when no CCWs were available to undertake ART assessments which created a single point of failure in the process.

Universally agreed as a good idea the rota system, moving staff in and out of the ART function, adopted within North Devon had an impact on the number of assessments that could be completed within the ART function as CCWs coming in also had their own case load to actively manage whilst part of ART. Another point to note is that a number of these CCWs only work part-time; this impact was not factored in when setting the ART headcount.

3.3 Assessment Process

3.3.1 Overview

As outlined in the 3.2 there are various routes into ART for a contact, but once received there are four outcomes, these are:

- Services switched on – where “simple” services like meals on wheels, domiciliary care etc were provided for service users over the telephone.
- No Further Action (NFA) or Signposting – this could be where a service user does not have a need identified or they are not eligible to services due to FACS. In this case and for other queries general information is given to help the person resolve their query.
- Face to face assessment – if the person who has contact ART need is deemed complex or long term they are assigned to a practice manager to allocate to care managers in the field.
- Other calls – these calls do not lead to any of the other three outcomes and are generally feedback on existing services being provided i.e. Meals on Wheels not being delivered, general information about the service user’s family or a worker requesting a file from Exmouth to be sent to them.

The table below shows the number of ART completed assessment outcomes that resulted in either being completed (services switched on/cancelled, or NFA) or passed on to field based staff in September by both pilots:

During September, from a service user perspective, this shows that North Devon ART completed 76% of their assessments (services switched on, NFA or services cancelled) where as 67% were completed in Exeter and East Devon ART.

Table 21:

Outcome	Number of assessments completed in September			
	N. Devon		Ex & E. Devon	
Services Switched On	66	47%	72	12%
NFA/Info Provided	39	28%	312	53%
Face to Face Assessment	33	24%	192	33%
Service Cancelled	1	1%	12	2%
Total	139		588	

Table 22- utilises data captured from Exeter and East Devon during the week commencing 15th October 2007 as a useful snapshot, the outcomes achieved can be broken down by source. Unfortunately North Devon did not capture this level of detail for a comparator,

Of note also is that emails usually originate in CSC from calls received that have not been able to be transferred to ART, the number of these resulting in no further action is high and may not have been accepted for handling by ART. A further impact of the number of emails received is that one or possibly a series of outbound calls would be required to address these:

Table 22

Breakdown of Exmouth outcomes by incoming source type, week commencing 15th October					
	Services switched on	NFA/info provided	Face to face assmt	Total	Percentage of total
Email	11	33	13	57	24%
Fax	1	4	7	12	5%
CF6	4	16	30	50	21%
Post	1	4	4	9	4%
Tele	12	57	30	99	42%
In person	0	1	0	1	0%
Other	0	6	0	6	3%
Total	29	121	84	234	
Percentage	12%	52%	36%		

Please note that although one service was switched on due to the receipt of a fax the ART would have had to make a number of outbound calls to interested parties before the service was switched on.

3.3.2 Services switched on / NFA

From the September outcome table in the section above (table 21) the filtration system used between the Helpdesk and ART in North Devon is clearly evidenced i.e. the number of services that are switched on within the North Devon pilot are substantially larger (47%) than Exeter and East pilot (12%).

This can be attributed to the fact that all referrals are reviewed by the Practice Manager before they are assigned to an ART CCW or field based member of staff. Once the Practice Manager has reviewed the referrals only the ones that have a clear need are assigned to have an assessment the others will be sign posted or no further action and closed. This point is further evidenced that North Devon only 28% of all outcomes resulted in NFA whereas in Exeter and East Devon where they deal with all their contacts the NFA rate was 53%.

3.3.2.1 Performance

A table extracted from the report to SMG requesting approval to pilot the ART function is provided below. As can be seen it was envisaged that ART would resolve approximately 59% of all assessments undertaken, and would switch on "simple services" such as domiciliary care, meals on wheels, day care and some respite services.

Table 23

	Assessment and Review Team	
	Assessment	Services
Older adults	8175	3978
Older People Mental Health	0	0
Physical disability/Younger adults	826.5	500.5
Sensory impairment	0	0
Learning disability	0	0
Vulnerable People / Substance Misuse	0	0
Carers	4024	3219
Mental health	0	0
Total	13026	7697

As can be seen in section 3.3.1 (table 22) Exeter & East Devon ART completed 234 outcomes in a week, 52% of which result in NFA or the contact being signposted. This means that 48% lead to either a face to face

assessment or a service switched on. Extrapolating this figure across a potential of 3 ART centres across the county this equates to approximately 17,289 assessments per year an increase of 4,263 against the perceived figure.

It is widely acknowledged within the Directorate that there is some confusion on when is an assessment actually a review and there is anecdotal evidence that assessments has been carried out when in fact a review should have taken place. This is evidenced by analysing the number of services switched on for new service users by Exeter and East ART and those switched on for existing service users in Table 6.

Table 6

Average number of care plans completed by ART per week		
	Number	Percentage
New	9	25%
Existing	27	75%

One of the fundamental principles behind ART is it will facilitate and support a uniform process across the county. The ART processes will ensure that reviews that at present are being recorded as assessments will in the future be recorded as reviews and picked up as part of the review function of ART. It is anticipated that this is the reason behind the reduction in the number of assessments being carried out by ART.

One of the major challenges to the department is completing statutory reviews for each service user, the last RAP return had a figure of approximately 64% of reviews being completed. The figures above clearly shows that 75% of ART care plans were for existing users, this statistic highlights two challenges faced by the Directorate:

- Providing care to older people is dynamic, as people get older their needs will change resulting in a great dependence on ACS.
- Improved performance in completing reviews to proactively capture changes in circumstances will reduce the need for existing clients to have to contact ACS to increase their care packages and improve satisfaction with the departments' customer service.

The North Devon ART pilot in September switched on services for less than 5 service users a week, so the sample data is too small to compare.

Analysis of services switched on within the ART shows that Domiciliary Care was the largest single service switched on as shown below:

Table 25

Service outcomes by type (September 2007)		
Outcome	N. Devon	Ex & E. Devon
Daycare	13	21
Dom/Pers Care	45	72
Meals	24	13
Respite Care	20	31
Waiting list	0	12
Urgent in-tray	0	6
Other	35	96
None	6	42
Total	143	293

3.3.3 Face to face Assessments

In the Exeter & East pilot when a worker detects a potential complex case or a service user with long term conditions they will complete the contact assessment and then reassign to the field based teams in the localities.

In the North Devon pilot, as depicted in 1.2, the Practice Manager has to review all contact assessments and then decides if further assessment is required by ART or the field based staff.

In the Exeter and East Devon pilot before the contact assessment is transferred to the locality it is "screened" by the ART Manager and from the 16th August 2007 through to the 19th October 2007 all assessments transferred were logged before being reassigned.

Analysis of this log showed that 321 assessments were transferred from ART to the locality teams and a further breakdown is shown below as this identifies the majority of need for a personal visit relates to equipment, adaptations, moving or handling.

Table 26

Number of assessments transferred to the localities from Exmouth ART (16/08/07 - 19/10/07)		
Type of Assessment	Number	Percentage
Equipment, Adaptations, Moving and Handling	225	70%
Social Care Assessments	96	30%
Total	321	

Further information available is the breakdown of the total number of Equipment, Adaptations, Moving and Handling assessments into individual categories. This is described in the chart below

Chart 1:

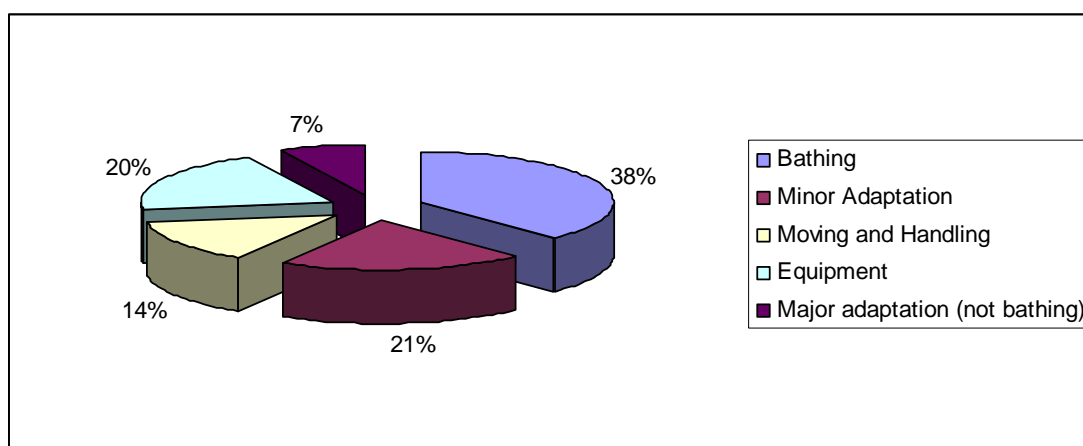


Table 26 above identified the total number and type of assessments being passed by the Exeter & East ART to locality teams; this has then been averaged to give a daily total in the table below

Table 27:

Breakdown of daily assessments transferred to the localities from ART (16/08/07 - 19/10/07)	
Type of Assessment	Number per day
Equipment, Adaptations, Moving and Handling assessments	5
Social Care Assessments	2
Total	7

Another view of activity, using CareFirst 6 data for a one week period of the pilot provides a view of client type passed to the locality teams i.e. new or, existing (i.e. receiving services) or 'previously known' but closed (i.e. on Care First but not receiving services at present) and then the purpose of the assessment be it social care or Equipment, Adaptations, Moving or Handling. This is shown in table 28 below:

Table 28

Breakdown of number of face to face assessments from ART to the locality (15/10/07 - 19/10/07) by type				
Type of Assessment	New	Existing	Previous known but closed	Total
Equipment, Adaptations, Moving and Handling	10	5	17	32
Social Care Assessments	1	2	1	4
Total	11	7	18	36

Analysing the detailed data provided by the Exeter and East Devon pilot it is possible to summarise, as percentages, the following information:

- 50% of all ART to locality transfers were from previously known but closed cases;
- 31% of all face to face assessments were for potentially new service users;
- 19% were existing service users
- 94% of the previously known but closed cases were for Equipment, Adaptations, Moving and Handling related work;
- 81% of potential new service users requested Equipment, Adaptations, Moving and Handling assessments; and
- 9% of potential new service users were referred to the localities for actual social care assessments.

The evaluation criteria framework was signed off SMG in September 2007 and both pilot sites gathered the data required. However the Exeter and East Devon pilot captured additional data that has been used in this report to highlight pertinent points.

Analysis of the Exeter cluster co-ordinator’s log collated from the beginning of September shows that ART was the second highest referrer of contacts into the clusters, although as a total percentage they only make 28% of all the contacts the rest is made up of health referrals as shown in the table below:

Table 29

Source of Exeter CCT referrals	Number
RD&E	58
District Nurse	36
ART	62
Other Health	68
Total	224

Of the 224 contacts collated by the cluster co-ordinator 166 had distribution information allowing analysis of whom ultimately received that contact within the clusters.

The full information set is provided below:

Table 30

Distribution of incoming contacts into the Exeter clusters (06/10/07 - 15/10/07)								
Rapid Response	Community Matron	District Nursing	Domiciliary Pharmacist	ART	Social Services	OT Related	Reablement	Continuing Care
27	3	55	8	7	30	31	2	3
16%	2%	33%	5%	4%	18%	19%	1%	2%

3.3.3.1 Health referrals

Analysing the destination of the contacts within the cluster it shows that 43% of all 224 contacts were social care related but only 4% of these contacts were deemed such that ART could resolve them meaning that Health are passing 11% of all social care referrals directly to Social Care staff within the cluster bypassing the ART function, which is understandable as it is easier to speak to some one face to face or leave a piece of paper on a desk than call ART. Although by sending health referrals through to ART may seem to put an extra step in the process from a service user and Directorate perspective it makes sense.

For the service user, any referral from Health into ART will be actioned in most cases within the same day and if the service user needs can be satisfied within ART they will be switched on. If ART deem the referral is complex or a long term need then the referral will be transferred to a cluster practice manager to allocate to a worker with capacity to fulfil the referral.

For the Directorate, Health referrals in the first instance going through to ART will provide accurate management information through the capture and logging of the referral into CareFirst 6 and subject to the usual statutory guidelines i.e. resolved within 28 days.

3.3.4 Other

Utilising data taken from the telephony system and analysis of the telephony outcomes from the pilots it is possible to project and breakdown the number of inbound calls that will be received across the County.

Table 31

Projection of inbound calls and outcomes		
Incoming	Numbers	Time (mins)
Other calls	8,442	538,178
Services switched on	4,996	257,300
NFA/Signposting	23,732	545,826
Pass to CCT	12,490	371,422

As can be seen data analysis from the two pilots above identified that of all the inbound telephone calls 42% do not actually result in an outcome and are labelled "other". Utilising data gathered by the Exeter and East Devon pilot team allows further breakdown of "other" activity. This is shown in table 11

Table 32

Services Provided - Others	Amount
OT related	28%
Dealing with Queries from other Organisations	19%
Dealing with other admin, faxes, email, post, etc	10%
Closed/Services Cancelled	9%
Dealing with Messages from/for other workers	9%
Chasing Assesment/Referrals	7%
General Queries	5%
Working on existing case	5%
Meals	5%
Follow up on previous case	3%

As mentioned in the Executive Summary, North Devon were not asked to collect this level of information as part of the Evaluation Criteria and so only have Exeter and East Devon's data for analysis.

3.3.5 Telephony Data

One of the key data sets required for this report was the system generated telephony statistics for the Exeter and East Devon pilot. Even though clear guidance was given in June to ICT on the requirements of the reports it took 11 weeks from the inception of the pilot to receive accurate and complete call reports on a daily basis.

For the purpose of this report ICT were asked to give a frank explanation of why it took so long to generate these reports and gave the following six points as to why this situation occurred:

- Initial configuration of telephony did not allow for reports to be created to satisfy evaluation criteria requiring a reconfiguration exercise;
- Change in personnel between initial and revised telephony configuration;

- Revised reports highlighted further errors in the telephony configuration including a hardware fault within the call logging facility at Exmouth Town Hall;
- Third configuration of telephony required to correct highlighted errors requiring engagement with a 3rd IT party;
- Three full system tests required in total; and
- Complexity of the interpretation of available reports resulting in confusion as to what was being reported and the errors contained within it.

Recently an “intermittent” fault with the telephony system has been identified where by ART workers are waiting for calls but people who ring get the engaged tone, this has been raised with the IT Help Desk. This fault is highlighted in the table below where there is a large spike in the number of unanswered calls on the 26th and 30th October 2007.

Table 33

Date	Number of unanswered calls
22-Oct	5
23-Oct	15
24-Oct	3
25-Oct	4
26-Oct	39
29-Oct	18
30-Oct	31
31-Oct	3

Analysing the Exeter and East Devon ART telephony data showed that, on average, they were taking 71 calls a day with the average inbound call time of just under 4 minutes.

However what can be clearly seen from the data below (table 34) is that the amount of outbound work undertaken by the ART team to resolve a contact results in three times the number of outbound calls than inbound, having said this the length of outbound call is shorter with an average of just over 2 minutes, nevertheless it impacted on the capacity to respond to inbound calls.

Table 34:

Date	Calls			
	Inbound		Outbound	
	Number	Time (secs)	Number	Time (secs)
22-Oct	71	318	276	125
23-Oct	104	215	358	146
24-Oct	64	239	253	159
25-Oct	70	171	352	141
26-Oct	60	196	266	112
29-Oct	70	213	225	193
30-Oct	65	203	225	193
31-Oct	69	275	292	127

3.3.6 Repeat Contacts

The ART model is a fundamental shift from the traditional Social Care model that would see all potential service users given a face to face assessment in their own home. It has been raised by staff and unions that by not seeing people in their own homes it will be difficult to give a holistic assessment and things may be missed resulting in repeat assessments.

Analysis on the number of repeat assessments (table 35) between the two pilots shows that there were four times the number of repeat assessments in Exeter and East Devon than there was in North Devon. Analysis showed that the number of repeat assessments within Exeter and East Devon were reducing throughout September and into October which suggests that as this new process embeds itself this figure will continue to reduce.

However it will probably not reach a similar figure as North Devon as only 25% of all their assessments went through to ART, 75% were carried out face to face.

Table 35:

Number of repeat contacts into the ART pilots (06/08/07 - 19/10/07)			
	Number of assessments	Number of repeat assessments	Percentage
North Devon Pilot	272	9	3%
Exeter and East Devon	916	110	12%

3.4 Reviews

It was planned that the scope of both pilots was to include completion of telephone based reviews.

The Exeter and East Devon pilot however operated at 58% capacity (see 1.3 table 2) and therefore has not been able to complete review activity. However the North Devon ART pilot has two Review Officers who have conducted reviews over the telephone, this identified it takes an average call length of 117 minutes to complete a review.

It is noteworthy that the majority of care plans completed in ART (Table 6) were for existing service users. Simply put, at present ACS are reactive not proactive with the very real danger that a simple need could result in a long term condition or a more complex need.

This fact has a detrimental effect on the ART function as on average it takes 1 inbound call and 4 outbound calls to update care plans for existing clients, reducing the number of outbound calls that can be conducted to complete reviews.

Older peoples needs do often change more rapidly than an annual review can respond to, however improved performance on reviews would see in the order of a 30% reduction in activity completed during the pilot to manage changes to existing cases

3.5 Resources

3.5.1 Staff

Of the two pilot sites, staffing in Exeter and East Devon was an issue from the beginning. Unlike the North Devon pilot that used existing job roles, the Exeter and East Devon pilot seconded staff against an ART worker job description. As mentioned in section 2.3.4 the pilot in ART was to be staffed by 13 Full Time Equivalent (FTE) staff.

The Exeter and East Devon pilot never achieved this, and with ART going live during the peak holiday season when people had already had their leave agreed at one stage Exeter and East Devon was running at just 45% capacity. Below is a full breakdown of staffing within Exeter and East Devon from the 6th August 2007 until 19th October 2007:

Table 36

Total number of hours worked in Exeter and Devon				
Week Commencing	Total Hours Worked	Shortfall (hrs)	Shortfall (FTE)	Percentage under resourced
06 August 2007	347.6	133.4	4	28%
13 August 2007	263.7	217.3	6	45%
20 August 2007	221.16	259.84	7	54%
27 August 2007	218.2	262.8	7	55%
03 September 2007	287.2	193.8	5	40%
10 September 2007	269.8	211.2	6	44%
17 September 2007	252.8	228.2	6	47%
24 September 2007	304.9	176.1	5	37%
01 October 2007	289.6	191.4	5	40%
08 October 2007	378.3	102.7	3	21%
15 October 2007	252.8	228.2	6	47%

The table below shows the total hours a week worked within the ART function within North Devon.
Table 37:

Total number of hours worked in North Devon	
Week Commencing	Total Hours worked
06 August 2007	258
13 August 2007	258
20 August 2007	239.5
27 August 2007	217.5
03 September 2007	202.5
10 September 2007	261.7
17 September 2007	261.7
24 September 2007	247.5
01 October 2007	232.7
08 October 2007	246.9
15 October 2007	261.7

Retention was not an issue within North Devon as again people were working against their original roles except CCWs who rotated in and out of ART. However in Exeter and East Devon one ART worker decided to leave ART and the council altogether.

There was no PD35 Stress Assessment completed by staff for either pilot.

In section 3.2 it was evidenced that Exeter and East Devon completed six times the number of contacts than North Devon. Analysis of the total hours worked within both pilots shows that on average the Exeter and East Devon pilot had .95 FTE a week more than the North Devon pilot.

Table 38:

Week Commencing	Total Hours Worked			FTE
	North Devon	Exeter & East Devon	Difference	
03 September 2007	202.5	287.2	84.7	2.29
10 September 2007	261.7	269.8	8.1	0.22
17 September 2007	261.7	252.8	-8.9	-0.24
24 September 2007	247.5	304.9	57.4	1.55

3.6 Service User / Staff Satisfaction

3.6.1 Service User satisfaction

The Directorate commissioned Age Concern to undertake a survey with ART users to ascertain their views on the service they had just received. Due to technical difficulties Age Concern Devon have managed to complete approximately 30% of the total number of contacts requested at the time of writing this report.

3.6.2 Staff

In both pilot areas staff were invited to ART evaluation workshops to discuss their views on the relevant ART processes. As agreed with the trade unions all staff comments have been reported verbatim, no analysis was carried out.

3.7 Complaints, Complements and Comments

Analysis of complaints, complements and comments across North Devon and Exeter and East Devon showed that there was just one compliment on ART (tracking number 1296) the person was paying for 2 x 15 mins care a day, but not receiving that much. Carer helped to make sure she got the full amount paid for and she was impressed with the speed with which it was implemented and very satisfied with the result.

4 Conclusions and Recommendations

4.1 Overview

This report has been drafted so that it can be distributed to staff during the consultation period and to inform SMG's consideration of next steps on receipt of consultation feedback.

4.2 Process

The two models piloted had approximately the same number of staff and that Exeter and East Devon catchment area was 40% larger than North Devon's, but when analysing the results the Exeter and East Devon Pilot completed six times more work than their North Devon counterparts.

The three step process of the North Devon pilot created inefficiencies as work had to be handed off twice before the assessment began which would be at least two days after the initial contact meaning that the process was almost one hour longer in North Devon than Exeter and East Devon.

In Exeter and East Devon 69% of all contacts were resolved in the same day, North Devon the only contacts resolved in the same day were urgent referrals that went through to the Duty Team.

To discuss: SMG to consider strengths and weaknesses of the 2 ART pilot models.

To discuss: SMG to consider extending ART pilots to enable processes to be further tested for other service groups and provide further opportunity for learning in:

- Older Peoples Mental Health;
- Learning Disabilities reviews; and
- Supporting People.

To discuss: If an ART style function is to be taken forward following consultation feedback then business process re-engineering is required to address the level of "Other" contacts including work with CSC, Finance and to inform thinking for Complex Care team processes..

Technology

Within the original paper delivered to SMG in January it was recommended that should an ART function be deployed in the future that it would be done so as a 'virtual' model. This means that as a call is passed to ART the next ART worker available will pick up the call. This means a call to North Devon could be taken by an ART worker sitting in Exeter & East. The main issue staff raised at consultation meetings and some senior managers about this approach is that to be able to carry out this function local knowledge is needed. However the Exeter and East Devon pilot saw staff from Exeter switching on services for service users in East Devon and vice versa, localities they did not have local knowledge on. This was achieved by updating relevant and pertinent information on services available in each area and making it easily accessible to staff. Over the lifetime of the pilot staff have become familiar with this information and now have no qualms in switching on services across the Exeter and East Devon locality.

Discussing the virtual method against the localised method with SMG members created almost a 50/50 split in thinking between the virtualised model and another option which is the individual ART centres act as an overflow for each other when all the lines are busy in one ART centre. The overflow option is a viable option but staff would effectively still be working in a "virtualised" model to deliver this 'overflow' option.

To discuss: Should an ART style function be taken forward which model of call handling is preferred, this will impact on technologies employed and an indication will enable further investigation in this regard.

4.2.1 Proposed Model

The present consultation regarding the proposed 3 centre model will provide further staff and TU input to the preferred model. There are other options being raised by managers and staff during the consultation process, this is discussed further in the following information. Up to four models have been identified as options to implement an

ART type function. The views of SMG members have been collated to inform this debate and are recounted in the following commentary.

4.2.1.1 Centralised ART centre

This model would see a single, centralised ART centre where all ART staff and management would be located.

From a cost perspective potential this is the most cost effective model as only one building would need to be outfitted, however if SMG agree that ART and Brokerage are co-located and Health adopt ART there is potentially no suitable building within the Joint Estates portfolio. This would mean a new build or lease so potentially could be as expensive as the other models.

It was the general consensus of SMG that adopting a centralised model would lead to a disconnect between ART and field based staff and that ART would become remote from the day to day operation of the Directorate and it was clear from all SMG members that this was a link that should not be broken.

It was also agreed by SMG members that the recruitment and retention of staff would be an issue with the single ART centre model as would localised knowledge as discussed in 4.5.

4.2.1.2 Two ART centres

This model would see two ART centres created along geographical lines i.e. North/South or East/West.

From an accommodation perspective this option is easier to facilitate than the single ART centre model, however it was felt by SMG members that if the recommendation was for the two centres model then the single option may as well be chosen as all the same issues around locality, recruitment and retention would be still there.

In effect it minimises the weaknesses of the 1 and 3 centres respectively, a 'half way house', that consequently does not maximise on the strengths of either.

4.2.1.3 Three ART centres

This the preferred option of all SMG members and aligns itself to the corporate strategy of 1-3-28.

One of the major issues to consider around any implementation of the three centres model is whether the model aligns to new CCT boundaries i.e. North Devon on its own or is the traditional North and Mid Devon model adopted. This potentially has an impact on Governance that will be covered in section 4.5.2.

Another reason the three centre model was preferred was that it would allow ART to maintain good working links with the locality and would allow the team to maintain a "local" feel.

If ART was located within major towns within each of the three localities it was felt that the recruitment and retention of staff would not be as big an issue as one or two ART centres. Various SMG members as well as senior operational staff made the point that, depending on where the three sites were located; there is the potential that those staff currently involved may not travel elsewhere in the locality and important learning and experience may be lost.

4.2.1.4 One ART centre per CCT cluster

This model was raised by staff working within the clusters within Exeter. An ART function in each CCT cluster is the most costly and inefficient option as each team would effectively become a "mini helpdesk" and potentially suffer the inherent bottlenecks experienced in the past. The telephony system required to support this model of the ART function makes this the most costly option. A summary of the findings are shown below in table 39:

Table 39:

Options appraisal for ART implementation

The options for implementation have been reviewed against the areas for consideration and identified simply as the strongest or weakest model, and that which sits between these. On early discussion with the majority of SMG members the dispersed model has been discounted, it was not presented as part of the business case and does not meet the most basic need in each of the areas under consideration.

	Option 1 1 central	Option 2 2 centres	Option 3 3 centres	Option 4 dispersed	Summary Comments
Cost effectiveness	Green	Orange	Orange	Red	The option with a single management structure is more cost effective, than repeating I however many instances
Efficiency	Green	Green	Green	Red	Economies of scale re staff always better on single site, but should be possible on 3 sites due to number of staff group.
Performance- statutory	Orange	Orange	Orange	Orange	Performance management should be robust in any structure. The ability to liaise with Brokers has been of benefit to ART workers in the pilot, speeding resolution of services
Performance- operational	Green	Orange	Orange	Red	
Environmental	Red	Orange	Green	Green	It is viewed that staff will come from closer if located in 3 geographic areas, should be less travel and so 'greener'.
Consistency	Green	Orange	Red	Red	Diverse location can contribute to 'local ways', could mitigate with 1 bridging role of ART Manager that the ART centre managers work to (develop, performance manage processes, practice & policy)
Proportionality of staff	Green	Orange	Orange	Red	Economies a scale, ability to better apportion tasks to skill level, not expensive resource doing simple tasks because there isn't anyone else.
Infrastructure costs- property	Green	Orange	Orange	Red	It seems fair to assume 1 property is more cost effective than 3. The 3 could be mitigated by approach.
Infrastructure costs- technologies	Green	Orange	Red	Red	
Staff recruitment	Red	Orange	Green	Green	3 localities are more likely to support reasonable recruitment. Over time, staff profile changes may make it appropriate for a single centre.
Staff retention	Red	Orange	Green	Green	3 localities are more likely to support retention. Over time, staff profile will change, may make it appropriate for a single centre.

Key: Fit to maximising those benefits under consideration

Strongest	Green
Median	Orange
Weakest	Red

Definition

Cost effectiveness	Overall cost of revised workforce model
Efficiency	Overall head count of revised workforce model
Performance- statutory	Improvements in statutory performance indicators
Performance- operational	Improved efficiency of the workforce and outcomes for services users
Environmental	Contributes to "green" objectives
Consistency	Ability to consistently apply policy, process and best practice
Proportionality of staff	Appropriateness of staff to the level of skills required by tasks
Infrastructure costs- property	Self explanatory, need to look for interim solution to enable implementation and long term goal
Infrastructure costs- technologies	Networking, cabling and provision of IT required
Staff recruitment	Self explanatory, need to look for interim solution to enable implementation and long term goal i.e. re-deployment of existing workforce
Staff retention	and development over time regarding staff turnover

The population of the options appraisal has been drafted for SMG discussion based on:

- learning from the pilots
- fit to objectives drawn from the benefits ascribed in the BPR business case agreed by SMG in January 2007
- and informed by meetings with as many Assistant Directors as could be achieved in the past 2 weeks

The strengths in the 3 centre approach remain around staff recruitment staff retention and ease of access.

To discuss: Is there a view from SMG regarding any viable option that can improve on the 3 centre approach, this view will then be further informed by the consultation outcomes

4.2.2 Governance

With the integration agenda blurring the demarcation line between Health and Social Care, the governance structure of an ART style function and where it sits within the agenda needs to be considered. The options outlined below have been informed through discussions with SMG members.

4.2.2.1 ART reporting to Cluster manager

It was felt that an ART style function reporting into a cluster manager was not appropriate given all the other day to day responsibilities that this person would have including managing community hospitals. It was also felt amongst SMG members that ART may not be a priority when competing with health aspects of this role, yet performance in assessments and reviews is a cornerstone to ACS success in meeting the needs of Devon's population.

4.2.2.2 ART reports to three Integrated Assistant Directors

This model would facilitate the "local feel" and joint working that SMG members wish to foster.

The weakness of this model is there is no structure in place to ensure a uniform process across an ART function. This is a key point as one of the fundamental objectives of the ART function was to put in place a good practice model that was replicated across the county, if this governance structure was implemented there is a very real danger that each centre start to do things differently.

Again there is a concern regarding the priority this could be given the scope and scale of the integrated Assistant Directors roles

It has been identified that an ART Performance and Development Manager role that spanned the ART centres (assumed to be 3) could ensure consistency in practice, process and application of policy as well as future development of the function and of course learning and development of staff. This post could be matrix managed by the Integrated Assistant Directors and bring value by supporting maximum performance in the area of .assessments and reviews.

4.2.2.3 ART reports to a single Integrated Assistant Director

All three ART centres reporting into a single integrated Assistant Director would raise the profile of the function and become an important part of that person's role. Again though a very real fear is that of competing with other priorities e.g. health aspects and remit of the role.

4.2.2.4 ART reports to a single ACS Assistant Director

A further option is to move this function under an ACS only Assistant Director, however this role also needs to be an operational role, these roles within ACS will in future be integrated posts therefore this option although relevant is not practical.

To discuss: Preferred governance should an ART style function be implemented following consultation. This is relevant as it can inform the consultation on further integration with health of senior management.

4.3 Timings

Until the ART pilots it was difficult to ascertain the volumes that came through all the referral sources and difficult to quantify time taken to get to a completed an outcome. The early estimated headcount figures for an ART function were calculated primarily from telephony information and a comparison with what we have now learned is shown in table 40 below:

Table 40:

Comparison of timings used to calculate assessments			
Outcome	Original Timings (mins)	Revised Timings from pilot (mins)	Difference
Switch On Services	63	52	12
No Further Action and Signpost	40	23	17
Forward to CCT	43	30	13

The timings used in the re-calculation of FTE requirements, against source and outcomes are shown below:

Table 41:

Source	Services switched on			NFA/info provided			Face to face assmt		
	Shortest	Longest	Average	Shortest	Longest	Average	Shortest	Longest	Average
Email	30	60	50	5	30	16	5	40	22
Fax	0	0	0	5	5	5	15	30	25
CareFirst 6	45	180	105	10	90	28	20	90	37
Post	90	90	90	0	0	0	20	30	24
Telephone	20	90	52	5	135	23	5	60	30
In person	0	0	0	5	10	8	0	0	0
Other	0	0	0	20	145	64	0	0	0

4.4 Workforce Implications

A projected headcount figure for ART was presented to SMG when requesting approval to progress the ART pilots. This was based on mathematical calculations applied to historic systems data, staff feedback and some assumptions

Table 42:

Staff profile (FTE)	ART
Social workers	0
Community Care workers	54
Occupational Therapists	0
Practice Managers	5.4
Total	59.4

One of the key objectives of the pilot was to test these assumptions and mathematical calculations for accuracy and also to identify additional work undertaken within the ART function that could not be quantified from CareFirst 6 data.

Using timings sourced from ART staff against each individual source of referral and then breaking that down into the three outcomes and then identifying and calculating "other work" the following FTE figures for an ART function, based on the Exeter and East model have been produced:

Table 43:

Breakdown by source of the FTE needed to complete volumes of work			
Function	Number	Time (mins)	FTE
Email	9,804	334,101	5.11
Fax	1,872	41,984	0.53
CF6	6,991	300,349	3.76
Post	4,475	139,569	1.75
Telephony	264,507	2,238,703	22.69
Review	32,523	3,805,156	38.49
Total			72.31

Table 44 shows the difference from the original figure presented to senior management and headcount figures now based on the pilot's findings.

Table 44:

Difference between headcount calculation			
	Original Headcount (FTE)	Revised Headcount (FTE)	Difference
ART Workers	54	72.31	18.31
Practice Managers	5.4	6.03	0.63
Total	59.40	78.34	18.94

The 18.31 FTE difference can in part be attributed to “other work” and the number of outbound calls involved in this activity, this was not able to be clearly identified in the earlier work with staff and systems data. The impact of so many existing case contacts, again involving significant outbound calls to manage these effectively was not expected, as stated earlier this is believed to be a direct impact of reduced performance in achieving case reviews.

The 18.31 FTE increase in headcount against the original estimate in July equates to an additional cost of approximately £450,000, however this figure is calculated in isolation to the other dependant projects and outcomes from the Equipment and Minor Adaptation project and the implementation of Complex Care Teams that potentially will affect this figure.

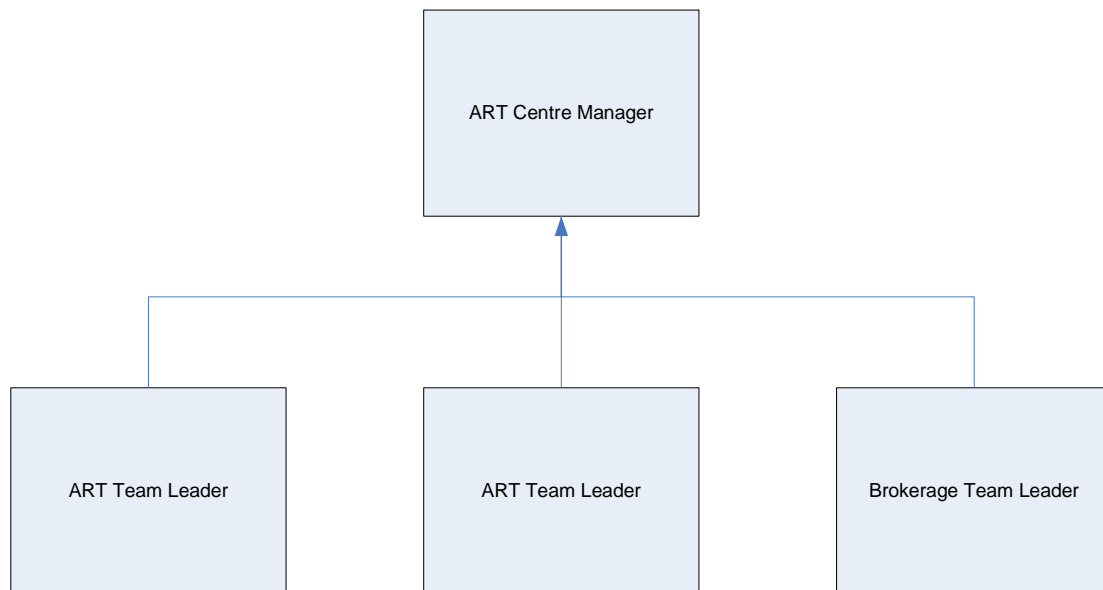
4.4.1 Managerial Structure

When calculating the number of team leaders required for an ART function should an industry good practice value of 1 team leader to 12 staff be used it would produce the following managerial headcount:

Table 45:

Management team	Number
Practice Manager (team leader)	6.03
ART Centre manager	3
Total	9.03

It is also assumed that each ART centre will have an overall manager who will manage not only the ART team leaders but also the Brokerage Team Leader as well.



4.4.2 Efficiency

The two ART process models in reality was testing the existing operational model (North Devon); albeit it using the telephone for the assessment, against a new operational model with new roles and responsibilities (Exeter and East Devon).

The data shows that even when taking into account the client base difference the Exeter and East Devon process was able to complete substantially more (6x) work than their North Devon counterparts in far less time (on average 53 minutes less).

From a service user perspective the Exeter and East model within one week of contacting ART the service user had there new services being delivered to them substantially reducing the waiting time for service delivery.

From a statutory perspective the Exeter and East Devon ART model completed 99.7% of all their assessments within the 28 day statutory period against a Directorate average of just over 60%.

4.4.3 Capacity

As can be seen in section 3.3.3 that approximately 33% of work from ART is transferred to the locality based field workers, this equates to approximately 9 referrals a day of which only approximately 2 a day are social care referrals. When the Trusted Assessor pilot begins it is assumed that this figure will be reduced by 50% as the Equipment, Minor Adaptation and Bathing assessments will be undertaken within the new process.

Factoring in urgent response this means approximately six new referrals a day to be dealt with per locality (excluding Health referrals which at present are bypassing the ART process) allowing the majority of field based staff to spend more time with their clients and in the longer term releases capacity in the localities to service increasing volumes as per an aging population.

To discuss: If an ART style function is taken forward, the benefit of Health utilising the ART process and not go directly to Social Care colleagues within the clusters.

4.4.4 Technology

Assuming that SMG agree to adopt the Exeter and East Devon process model then from a technology perspective an upgrade of the telephony system will make ART more efficient.

To expedite the roll out of ART in Exeter and East Devon, the existing telephony system used provided the basic functionality to allow calls to be distributed to the ART workers. However the system did not give real time information to the ART manager on how many people were able to take calls at any one time, and with ART being spread over four different rooms difficult to gauge who is available to take calls.

Regardless of if SMG agree to use each ART centre as an overflow outlet or virtualised, the technology is the same and the only way this can be achieved is by upgrading the telephony switch.

To upgrade the telephony "Pro-centre switch" and licenses will cost approximately £85,000 for 80 users across the county.

To discuss: If an ART style function is taken forward, the telephony system utilised by ART can be upgraded to facilitate and support real time management of ART and to enable the overflow/virtualisation model.

Every contact into ART is important, however a telephone call needs to be answered straight away otherwise not only will it result in another call back later but will also cause frustration and annoyance with the person who called where as for an email or piece of post needs to be dealt with but not quite in the same timescales. To allow this distribution of labour to be successful and efficient call modelling software can be used that uses historical data to predict the peaks and troughs of calls coming into ART which will allow the managers to release the right number of staff to complete for example emails whilst knowing they have the optimum number of staff to deal with incoming calls.

It is assumed that the Directorate will be able to make use of the County's relationship with the existing provider of call modelling software within the CSC and is assumed to cost approximately £75,000 for 80 users across the county.

To discuss: That call modelling software be purchased if an ART style function is taken forward