Appendix 3

Suggested Evaluation Criteria for the Re-structuring of Community Care Team Models

No.	Evaluation Criterion	Description	Model A
1	Ease of access	How geographically 'close to the customer' would the team be in terms of access to local offices/ services	Only the existing locality teams would be located close to service users (and thereby fitting with the sustainability agenda), the other 'specialist' teams would be more centralised. So, a Duty/Intake system would operate in <u>all</u> 11 teams in this model including within the 'specialist' teams such as the Integrated Learning Dis. Team; the Integrated Mental Health Teams and the Sensory Team. However, the 'specialist' teams deal only with their specialist client groups and these operate from fairly central locations and on a Falkirk wide basis so the referral system would be much more complicated within this model and would require clear pathways to assist stakeholders to identify which type of team to approach. Also, in mental health there are 3 teams, so there could potentially be 12 teams operating duty systems. In addition, the MHO rota would remain in place.
2	Speed of access	How fast and efficient can the response be	The complexity of the referral system suggest potential problems for stakeholders and that the response could vary a lot between the 11 or 12 different teams depending on demand, with different response times at different times of day and in different teams. More significantly, there could be inequalities in waiting times for assessment *following* duty referral depending on the demand in each of the 11/12 teams and the sizes of pending lists for assessment in these teams.
3	Responsiveness to service users and carers	How effective is the response to specific client groups as well as to all client groups	The *quality* of intake/ Duty could also vary a lot between the 11/12 teams with great potential for confusion for stakeholders about which team to approach or which team is dealing with a particular service user, especially since not all service users can be neatly categorised if they have multiple needs. However, after the Duty stage there would be greater clarity about which team was involved with a service and greater continuity for service users than Model B. Overall then, the Intake/Duty system seems to be much less streamlined and less able to deliver a faster response on assessment and service and lesser <u>quality</u> standards than Model B.

No.	**Evaluation Criterion**	**Description**	**Model A**
3			(Continued) Finally, budgets will be spread between locality teams and more centralised teams, but this could also result in *delays* for service users if the budget in a particular team is under pressure. This could also create *inequalities in impact* across the 11/12 teams, so that a service user might have to wait much longer for assessment and or service in one team compared to other teams.
4	Cost effectiveness	Is the model cost neutral, or cost saving	Overall, this model is broadly cost neutral since the model is similar to the existing pattern of service configuration. However, some staff would need to move to different teams, and this could require additional office accommodation for some of the specialist teams if their premises lack the additional capacity.
5	HR implications	Is the model cost neutral, or cost saving	The model is broadly cost neutral in overall terms, but the model does require some staff transfers from existing locality teams to the 'specialist' teams as the latter would be responsible for *all* clients in that client group specialism. Finally, the suggested small scale boundary changes may require some staff transfer involving four teams (2 teams losing staff and 2 gaining)
6	Meeting statutory requirements	How effectively does it address statutory responsibilities, e.g. MHO work; Adult Support & Protection etc	The standardisation and equalities agendas are less well-served by Model A simply because there are more teams with potentially different local practices (duty systems; case allocation/ pending lists; procedural compliance etc.). Basically, the more teams there are, the greater opportunity for variations from the standard. For the same reason this model may be less effective in responding quickly to adults at risk/adult protection issues than Model B.
7	Partnership approach	How well does it facilitate more streamlined work with partners, especially NHS Forth Valley	There are no obvious benefits with this model for existing stake-holders/partners, given the drawbacks noted above. However, the specialist teams which are multi-disciplinary would face additional pressures from either the transferred clients and/or the new direct referrals they would receive. The commensurate staffing resources would need to transfer to the specialist teams from locality teams.

No.	Evaluation Criterion	Description	Model A
7			(Continued) Additionally the proposal to move the geographic area of Whitecross to Bo'ness from Meadowbank would remove it from the currently coterminous GP catchment area.
8	Coherence to public and other stakeholders	The structure should not be too complex, so it is easier for the public and other stakeholders to understand	The operational model seems over-complex, based on a combination of geographical areas ***and*** more centralised specialist teams based on client groups. This could make it confusing for stakeholders to know which team to refer to even if clear pathways were developed, as people don't necessarily fit into one client group category but can have multiple types of need concurrently.
9	Comprehensiveness	Extent to which the model addresses majority of the key issues, without leaving others unresolved	The model seems over-complex organisationally and difficult for stakeholders to understand and refer to the appropriate teams for the reasons given above. Nor is it clear how this model would deliver an *improved* service to service users and other stakeholders in terms of the crucial improving outcomes, equalities and standardisation agendas. So the model does not seem to address the majority of the key issues.
10	Responsiveness to change	Is the model flexible enough to be amenable to change if required; e.g. future policy change	Model A could probably accommodate future policy changes, but the model already requires significant work on setting up and monitoring standardisation of work and protocols between 11/12 different teams. Yet such work would be essential to avoid the inequalities of access to assessment and service provision implied by the model. This model doesn't seem able to respond to the *existing* challenges relating to the national outcomes, never mind future policy changes.
11	Will support National Community Care Outcomes	How well does it support the improvement of outcomes for clients and carers	The development of the outcomes agenda is the latest policy development facing community care, but it is unclear how Model A could advance this policy, given the complexity of the monitoring arrangements required to establish and monitor the policy in so many teams. Constant monitoring would be required to achieve and sustain standardisation in all of the teams involved. Model A provides no evidence on how it would deliver improved outcomes on response times/time intervals for assessment and service provision as the duty system appears to be more complicated and less likely to improve response times than the current arrangements.

	Model A Summary		The model appears to have more disadvantages than the current arrangements, as the duty system proposed appears to be more complex and confusing for stakeholders. However, once a case has been through the duty system, it may offer more continuity of care for service users. However, it is not clear how this model could deliver on the key improvement agendas re standardisation; equalities; and improving outcomes for service users. This means it does not show potential to deliver improvements on most of the key issues and challenges facing community care.

No.	Evaluation Criterion	Description	Model B
1	Ease of access	How geographically 'close to the customer' would the team be in terms of access to local offices/services	Access to the local teams is more restricted than the status quo (from 7 locality teams in each locality to just 1 - or 3? - short term team(s), covering Central, East and West areas). However, most referrals are not made in person at local offices, but by telephone.
2	Speed of access	How fast and efficient can the response be	Since all referrals will go to either 1 (or 3) referral points instead of 7 local teams, Model B should be easier for stakeholders to make referrals and faster since the short term team will have more staff to take referrals than is available in the 11/12 teams in Model A. Model B should be able to provide a more streamlined and effective response using skilled intake workers. These will deal much faster with simpler, less urgent cases that might otherwise have to wait on team pending lists.
3	Responsiveness to service users and carers	How effective is the response to specific client groups as well as to all client groups	Model B requires clear pathways to be identified to avoid clients/stakeholders being passed between different teams. Model B should be more responsive than Model A as it is more streamlined, providing clearer assessment and prioritisation of referrals than is possible in Model A. Model B should also provide better *response times* (due to economies of scale) and *quality* because of the standardisation of response that is possible compared to the larger number of smaller teams operating within Model A. However, Model B provides less *continuity* of care for clients since cases will have to transfer from the Short term team to the Long term team after 12 weeks. This might affect some client groups more than others. Budget management is more centralised in Model B which means Model B should be fairer in responding to client needs across the larger area than Model A's smaller and more numerous locality and 'specialist' teams.

No.	**Evaluation Criterion**	**Description**	**Model B**
4	Cost effectiveness	Is the model cost neutral, or cost saving	This model suggests more savings on staffing than the current model. There appears to be scope for economies of scale given the more centralised Short term Duty team and fewer team managers (potentially reduced fro 7 to 4 (1 Short term and 3 Locality managers). Model B also seems to offer a more streamlined and efficient Duty/intake service than Model A, which might provide economies of scale in terms of staffing - particularly if only 1 short term team is created.
5	HR implications	Is the model cost neutral, or cost saving	The staffing levels are not specified within the model between the Short term and Long term teams, but fewer team managers are required to manage the smaller number of localities. However there is less potential for saving if 3 short term teams are created rather than one.
6	Meeting statutory requirements	How effectively does it address statutory responsibilities, e.g. MHO work; Adult Support & Protection etc	A more streamlined and effective intake assessment that identifies the appropriate level of intervention and priority of the case should deal more effectively with the increasing statutory work, especially adults at risk of harm.
7	Partnership approach	How well does it facilitate more streamlined work with partners, especially NHS Forth Valley	The Short term teams may be able to provide the more timely interventions required by NHS FV, while the Long term teams may be able to work in a more coordinated way with partner agencies such as NHS FV. Even with Short term and Long term teams, the operational model for Model B is simpler than Model A
8	Coherence to public and other stakeholders	The structure should not be too complex, so it is easier for the public and other stakeholders to understand	Having Short term and Long term teams will require clear pathways for stakeholders as it will not always be clear to referrers/other stakeholders whether a particular case is with the Short term or Long term team at any given time. However, Model B is still appears to offer a more coherent model to the public and stakeholders than the more complex Model A.

No.	Evaluation Criterion	Description	Model B
9	Comprehensiveness	Extent to which the model addresses majority of the key issues, without leaving others unresolved	Model B seems to be able to offer more comprehensive opportunities to address the improvement agenda issues, such as the national Community Care outcomes; impacts on equalities issues and the standardisation agendas. It also has potential to provide some cost savings because of the economies of scale that may result by having fewer locality teams. The main drawback is the need within this model to transfer cases from the Short term to the Long term teams, with the possibility of confusion for stakeholders unless clear pathways are defined. However, the social work Contact Centre may help to minimise problems for stakeholders as these staff can check SWIS to identify the correct team to pass the enquiry to.
10	Responsiveness to change	Is the model flexible enough to be amenable to change if required; e.g. future policy change	The smaller number of long term teams (3) would make it easier to monitor and manage compliance with procedures and the standardisation and equalities agendas. Future policy changes would also be easier to implement in 3 locality teams rather than in 11/12. Another advantage here is that Model B would also allow the possible extension of the short term team to include the Children & Families duty system in future, thereby potentially providing further economies of scale.
11	Will support National Comm. Care Outcomes	How well does it support the improvement of outcomes for clients and carers	Model B looks more likely to support the National Community Care Outcomes by improving the speed and prioritisation of response and the performance on time intervals for clients receiving assessment and for service provision.

	Model B Summary		This model offers potential rationalisation; streamlining of duty and some cost savings by reducing the number of locality teams. The creation of the Short term team looks likely to reduce waiting times for service users for assessment and service provision. This model looks more likely to improve outcomes for service users as well as the potential for easier standardisation; and fairer equalities impacts. The main disadvantage of this model is that it requires clear pathways to minimise stakeholder confusion about whether to contact the Short Term or Long Term team. However, this is also a problem for Model A, and as noted above, the SW Contact Centre may be able to minimise such problems.