Adult Services

Samantha Fitzgerald – Assistant Director

North Northamptonshire Council

Meet the Team

Boby Paul – Service Manger Community Hubs, Care home review Team and CHC

Sharon Dartnell - Service Manager Hospitals and Reablement

Karen Burrows Service - Manger Inclusion, Learning Disability and Moving into Adulthood

Sarah Morris – Chief Principal Social Worker

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Service Objectives

- Undertake statutory assessments of need in line with the Care Act 2014.
- To continue to embed the practice and quality improvements focussing on strengths-based practice associated with the “Three Conversations model”
- To deliver the 'Moving forward with place' transformation programme ensuring that ASC frontline teams are mobilised into place based formation, enabling economies of scale, resilience and a seamless Journey for the people engaging with ASC. These improvements will enable Adults to reduce waiting times and mitigate rising demand.
- To continue to consider and deliver the benefits associated with integrated working with health, including best use of funding such as the BCF to deliver good outcomes for the people of North Northants.
- Promote and enable people to regain independence or become more independent
- Assess and support the needs of informal carers in their caring roles
- Continue to develop the performance management approach to provide assurance to the council of the efficiency of the services’ approach to supporting people that have, or may have, social care support needs

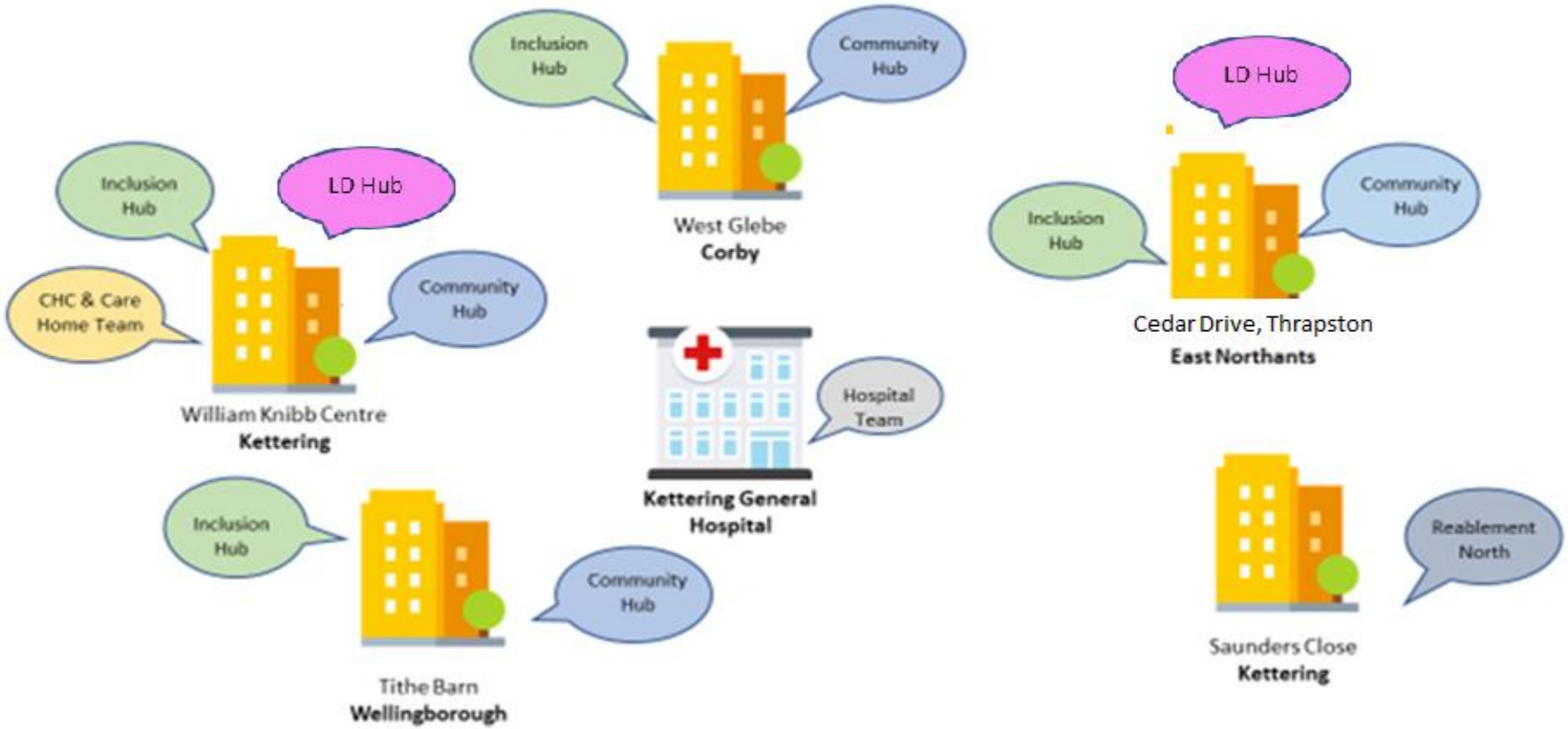
Introduction

Adult Social Care support people through a ‘Three Conversation Model’ so that we can offer a person centred and outcome focused service. We work in partnership with those requiring our support, using a strengths-based approach and the 3 conversations model, to help them live more independently and achieve the right outcomes for them. This can be through their own resources, their family and friends, community networks, or formal support.

- Community Hubs x4
- Inclusion Hubs x4
- Learning Disability Hubs x2
- Dedicated Adult Social Care Hospital team x1
- Continuing Health Care Team x1
- Care Home Review Team x1
- Reablement North

Within all our teams and services, we work alongside partner agencies, putting the people we support at the centre of all we do, to produce consistently better outcomes for people.

Introduction



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Strengths Based

- Operates a strengths based approach
- Works with adults ages 18+
- Supports adults with mental health, physical health, vulnerabilities, aged related issues, and learning disability

From →	To
Doing things **for** people	Doing things **with** people
Risk assessment as prevention	Risk assessment as an enabler
Focus on what is important for people	Focus on what is important for people + what is important to people + why it is important to them
People have **weaknesses**	People have **strengths**
See the **problem**	See the **person**
Service-led	**Needs/outcome-led**

3 Conversation Model

The 3 Conversations approach

Conversation 1
Listen and Connect

Conversation 2
Work intensively with people in crisis

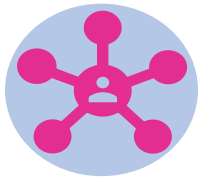
Conversation 3
Build a good life

Supported by our new ways of working together as a team

FRONT DOOR

ON TRACK CHATS

HUDDLES



IDEAL OUTCOME MEETINGS

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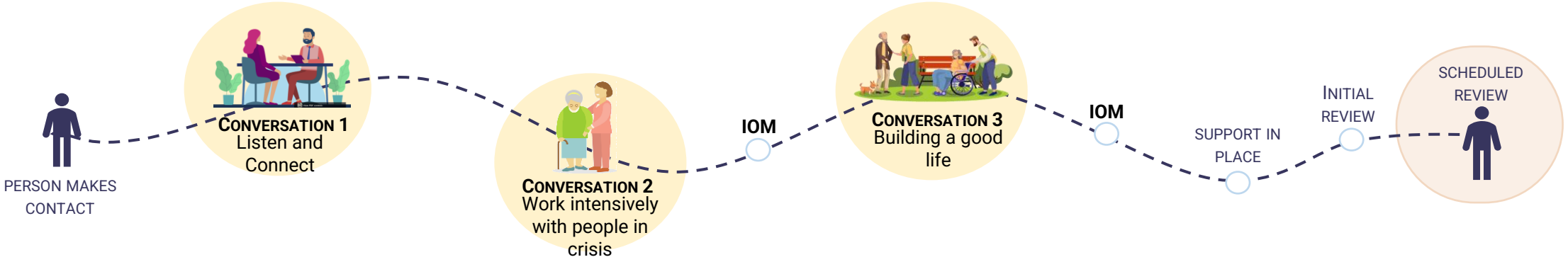
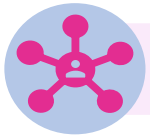
The Journey through Adult Services



Front door – Acting quickly



Ideal outcomes meeting – Group discussion

Huddles – Receive & provide peer support.

On track chats – Receive support from Principal.

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Community Hubs

Community Teams manage all new referrals coming through Adult Social Care, except those with a learning disability.

Referrals are progressed through the ‘three conversation’ model focusing on early intervention and outcome focused services.

Community teams also provide long-term social care support to people over 65 years, including re-assessment and reviews

At the front door, community teams work closely with all key partners to ensure we are offering an integrated support system to people approaching Adult Social Care.

In each locality, the team work very closely with the local Integrated Care System (ICS), Northamptonshire Healthcare Foundation Trust, and other relevant stakeholders.

Inclusion Teams

Currently we have 2 Inclusion Teams working with people aged 18-65 based in North Northants,
one covering Kettering/Corby, and one covering Wellingborough/East Northants.

The teams also work with children who are transitioning into adulthood from the age of 16 onwards.

The workers within these teams complete assessments using the 3 conversations model; they take a strengths-based approach to help maximise people's independence and reduce their reliance on formal support.

Progression workers support people who have a formal package of care to help progress them out of service and be more independent.

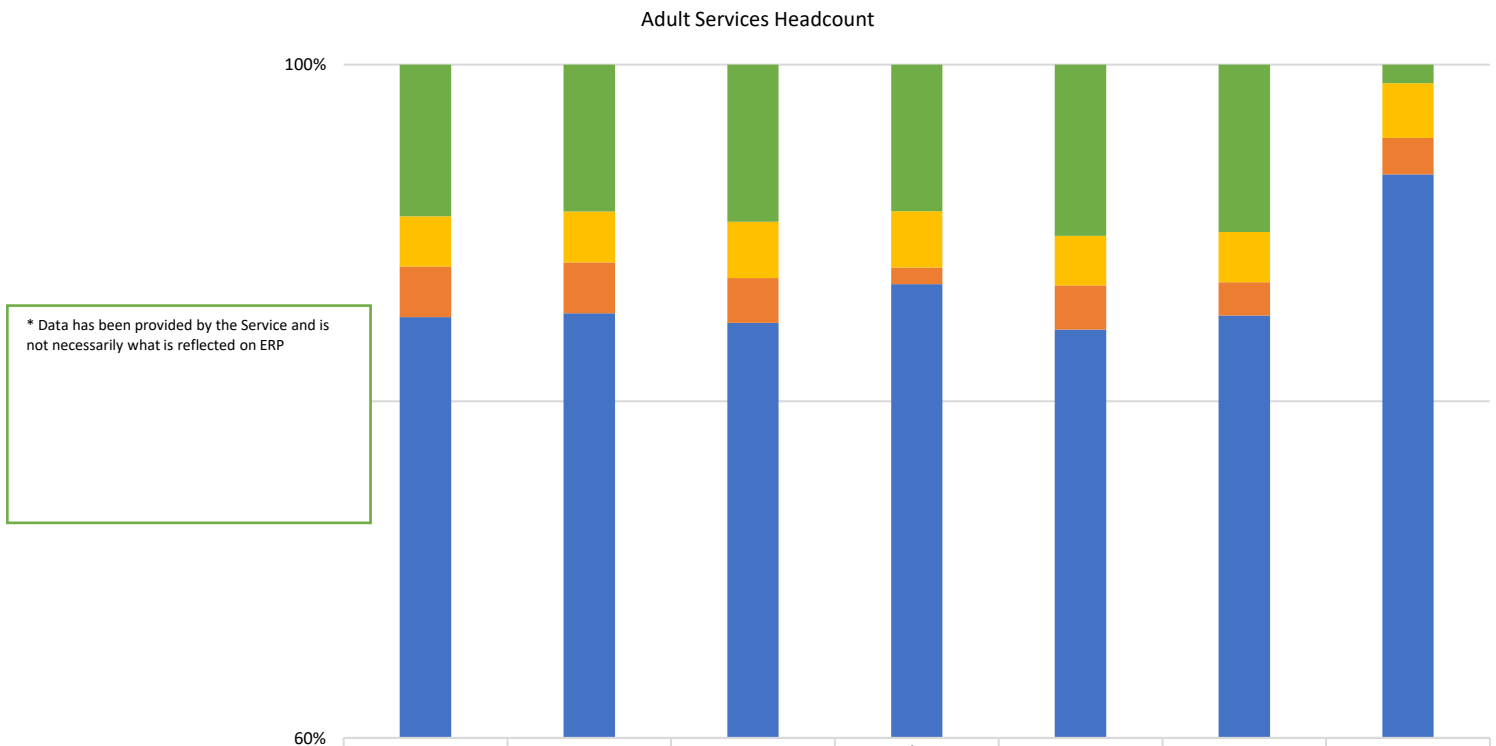
LD Teams

People living in North Northants, who have a diagnosed Learning Disability, are supported by our Learning Disability Teams. Their geographic footprint is the same as the Inclusion Teams.

There is no upper age limit for this service, and they will work with people transitioning from Children's services (aged 16+) to end of life.

The ways of working are the same as the Inclusion service and the focus is about maximising someone's potential and improving people’s quality of life.

Recourses



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Vacancies on e-recruitment	27	26	28	26	31	30	3
Relief (casual/zero Hrs) - Headcount	9	9	10	10	9	9	9
Agency covering vacant posts*	9	9	8	3	8	6	6
Employees - Headcount	255	254	254	260	257	257	258

Net Adults Budget of £99,229,416

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Adult Services

Sam Fitzgerald

Key Performance

Currently Adult Services is actively supporting **4598** people, of these **1736** are aged 18-64 and **2862** are aged 65+.

Service Type	18-64	65+	Total
Day Care	385	109	494
Direct Payments	570	201	771
Home Care	448	1,260	1708
Nursing	31	378	409
Rehab + Respite	48	200	248
Residential	215	787	1002
Residential (Pre ERP Gold)	1	205	206
Specialist Equipment for Service Provision	42	57	99
Supported Living	513	97	610
Grand Total	**1,736**	**2,862**	**4598**

Team	18 - 64	65+	Total
CARE HOME REVIEW TEAM NORTH	2	1143	1145
CHC NORTH	18	106	124
COMMUNITY CORBY HUB	8	672	680
COMMUNITY EAST NORTHANTS HUB	21	823	844
COMMUNITY KETTERING HUB	28	874	902
COMMUNITY WELLINGBOROUGH HUB	20	787	807
HOSPITAL ASC TEAM NORTH	28	444	472
INCLUSION CORBY / KETTERING TEAM	964	51	1015
INCLUSION WELL / EAST NORTHANTS TEAM	880	57	937
KETTERING GENERAL HOSPITAL OP/PD TEAM		1	1
LD CORBY / KETTERING HUB	932	96	1028
LD WELLINGBOROUGH / EAST NORTHANTS HUB	882	170	1052
Grand Total	**3783**	**5224**	**9007**

Risks and Challenges

•Increase in demand of ASC older people has increased by 25% for Older persons and 15% in younger adults (523 People)

•Availability of external social care provision namely residential and Nursing care for Older persons continues to impact on the ability of adult services teams to support people in a timely way.

•Key roles such as Social workers remain difficult to recruit to, although the MFS has had a positive impact on the recruitment and retention of these roles.

•Hospital Pressures continue to be a key challenge with volumes of those requiring ASC support upon discharge increasing and no additional winter funding announced.

•Impact of significant volumes of provider failure on Social Care teams both in terms of capacity and financial impact.

•Waiting lists for assessment and Reviews remain a concern and although they are risk rated and prioritisation tools applied the points above further compound the challenge.

Hospital Flow

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Hospital Team

Support all adults 18+, who have been identified by hospital staff as in need of reablement, and/or long-term care and support needs, to facilitate their discharge from Hospital.

We support discharges primarily from our local Acute and Community hospitals in Northamptonshire, however, we will support the discharge, and ongoing assessment, of any North Northants resident from any Acute / Community Hospital, or Private Hospital in the country.

Adult Services

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Hospital Team – Key Performances

4 - Week Avg Proportion of People Going Home
(Across the whole pathway)

88.8 %

Hospital Beds

81%
4 - Week Avg. Proportion of People Discharged Home

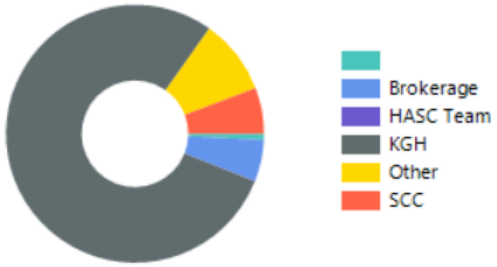
7
4-Week Average Days to Discharge with NASS

28
Number of People on HASC Team Caseload
Click to see active caseload list

10
4-Week Average Number of Non-HASC Outcomes

Outcome	N		Brokerage	HASC Team	KGH	Other	SCC
D2A Home	1	2.1					
	2						3.1
	4				2.7		
	10					14.6	
	11		4.5				
D2A Residential Care Bed	1		10.0		197.2		8.8
	2					3.9	
SCC	1			0.1	18.1		
	5					7.7	4.1

Breakdown of Average Days to Discharge with NASS



Number of Residential Outcomes Last Week
(Across the whole pathway)

7

Community Settings

38 %
4 - Week Average Proportion of People Going Home

49
4-Week Average Days to Discharge from D2A

157
Number of People on Caseload- D2A/SCC Tracker
Click to see active caseload list

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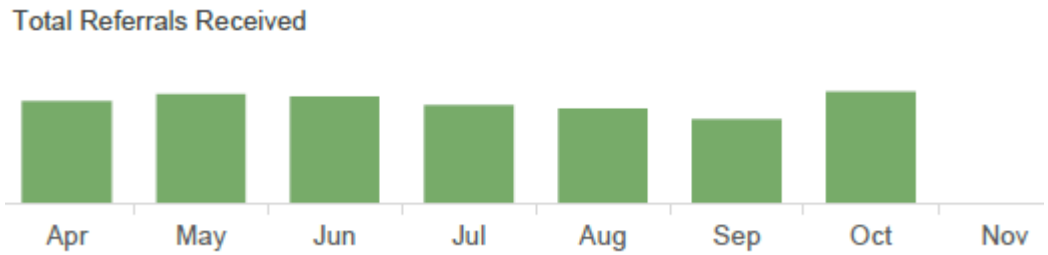
Reablement North

Accept referrals for reablement, adopting the discharge to assess model from Acute Hospitals and community Hospitals both in and out of county.

There is also an Admission Avoidance function within Reablement linking closely with the SDEC and Frailty units in ED, but also the community health provider and GPs looking to offer Reablement alongside clinical interventions to enable people to remain at home.

Reablement North also accepts referrals from people already in the community; particularly targeting reablement support to develop independence skills and reduced reliance on formal care and support.

Reablement North – Performance Report October 2023



Forecast for service is up from forecast in June of at 1,314 to a forecast now of 1,763 compared to a on Last year total of 1,298 starts in service in 22/23.

Episodes Commencing by Pathway

- Number commencing by episode start month

	Path %	Oct	YTD	Avg. P/M	Oct v Sep	Avg. Gwth	YE Fcst
Discharge to Recovery	74.6	79	624	89	2	-5.3	1,043
Community Reablement	1.0	1	8	2	-2	0.0	18
Hospital Admission Avoidance	23.9	34	200	29	7	1.3	350
Care Management Complex Discharges	0.2	0	2	1	0	-0.2	6
Cont. Reablement Following Res Stay	0.2	0	2	1	0	-0.2	6
Total		114	836	119	7	-4.3	1,411

Episodes Commencing by Location

- Number commencing by episode start month

	Loc %	Oct	YTD	Avg. P/M	Oct v Sep	Avg. Gwth	YE Fcst
Hospital	75	79	626	89	2	-5.5	1,046
A & E	12	20	103	15	12	0.3	178
Community	13	15	107	15	-7	0.8	188
Total		114	836	119	7	-4.3	1,411

Referral Timescales

- referral received to closed days by closed month

	Oct	YTD
Average days on referral caseload	2.9	4.1
Hospital Discharges (DTR)	3.0	3.7
Admission Avoidance	1.6	1.6
Community Referrals	3.5	9.0
Avg. days to discharge (DTR)	3.2	3.8
Avg. days to failed discharge (DTR)	2.6	3.3

Thackley Green October performance

Service Demand

	Oct	YTD	Avg. P/M	Oct v Sep	Avg. Gwth	YE Fcst
Total Referrals Received	32	179	26	-4	2.5	319
Open Referrals (at month end)	3	-	3	0	0.0	-

Referral Outcomes
- by referral closed month

	Out %	Oct	YTD
Admitted	91.2	28	156
Cancelled	8.2	0	14
Rejected	0.6	0	1
Total Closed		28	171

Referral Sources
- by referral received month

	Src %	Oct	YTD
Kettering General Hospital	91.1	32	163
Northampton General Hospital	2.8	0	5
Out of County Hospital	4.5	0	8
Community Reablement	0.6	0	1
Community Respite	0.6	0	1
Not Captured	0.6	0	1

Referral Timescales
- referral received to closed days by closed month

	Oct	YTD	Oct v Sep
Average days on referral caseload	4.1	2.5	1.5

Length of Episode
- Avg. Length of Episode Days

	% Band	Oct	YTD
Average Days		32.3	30.3

Length of Episode Banding:

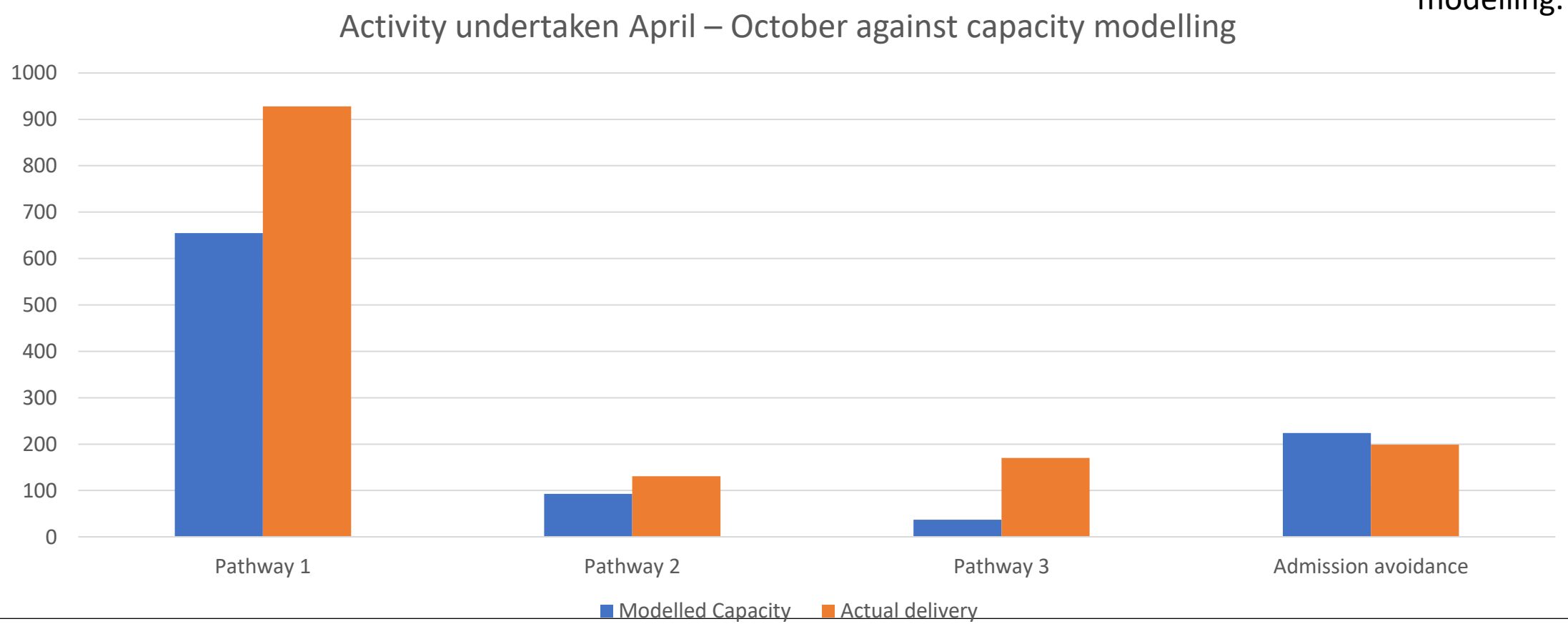
24 hours	3.2	0	5
48 hours	1.9	0	3
72 hours	0.6	0	1
4 - 7 days	7.1	2	11
1 - 2 weeks	14.3	4	22
2 - 4 weeks	29.9	6	46
4 - 6 weeks	24.0	8	37
> 6 weeks	18.8	5	29

Episode Outcomes
- Number ending by episode complete month

	Out %	Oct	YTD
No Further Action	40.3	9	62
Hospital Admission - Service Ended	34.4	13	53
Existing Care & Support Plan	1.9	1	3
Trans to Community LA Led	6.5	1	10
Trans to Community Self-funding	1.3	0	2
Trans to Residential LA Led	3.2	0	5
Trans to Residential Self-funding	1.3	0	2
Trans to Reablement North	3.9	1	6
Deceased	0.6	0	1
Respite Ended	0.6	0	1
Not Admitted	5.8	0	9
Total		25	154

Adult Social Care Discharge by Pathway

Discharge activity 56% above modelling.



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Areas of Focus for the next 12 Months

- Moving Forward with Place (Front door / Demand management, link with VCSE and communities).
- MHLDA (Explore opportunities for closer working with mental health & Learning Disability services).
- LD progression model (Review of high-cost packages / commissioning frameworks).
- Health system transformation (Pathway 1, Pathway 2 [Thackley Green], Delirium Pathway, SPOA, System Dashboards).
- Recruitment and Retention of Social Care Workforce, including career pathways.