Adult Social Care Front Doors: Early Intervention Success Stories Webinar

Friday 15 March 2024 – 10.00 – 12.00PM

Partners in Care and Health

The **Local Government Association** and **Association of Directors of Adult Social Services** are **Partners in Care and Health** (PCH) working with well-respected organisations.

PCH helps councils to improve the way they deliver adult
social care and public health services and helps Government understand the challenges faced by the sector.

The programme is a trusted network for developing and sharing best practice, developing tools and techniques, providing support and building connections.

It is funded by Government and offered to councils without charge.

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Nyoka Fothergill
Head of Service Community Social Work
Leeds City Council

Background to Redesign of the Front Door

- Savings proposal approved by Exec Board in Nov 2021
- Business case for Strategic Review of Social Care at “the front door” to maximise capacity to meet growing demand for information and advice and demand for a social care assessment of needs, embedding an “Early Intervention” approach.
- Proposal to invest **£394,991.23** to deliver the Early Intervention Pilot (6 x OT and 2 WWB)
- Investment estimated to generate £1,552m over 3 year period 2022 – 2025 (£776,000 cost avoidance savings during 2022-23).
- Impacts of the above proposals to inform a longer-term model of area social work for the city.

Early Intervention Pilot (South NT)

Aims

- Utilise the skills and knowledge for both the Occupational Therapist and Social Worker professions
- Work with people in a strengths-based way, using a self-management approach to help people do the things that they want and need to do
- Focus on early intervention and prevention - utilising reablement, equipment and telecare to enable a person to become independent
- Create savings by finding alternative solutions to a person's needs by relying less on formal services/packages of care
- Create capacity by reducing the pressures on Social Work and DST Teams by reducing their volume of referrals and assessments

Early Intervention Pilot - Criteria

✓	✗
Be struggling with their needs at home	Urgent referrals (must go to Rapid Response) potential for these to go back into the EIT once made safe
Have direct access / basic equipment needs	Learning Disability
Have care & support AND equipment needs	Mental Health
Have had a YAS referral	Domestic Violence
Called to request Home Care	Food Parcels
Carer needs	Medically unwell
Risk of falls	Suicidal tendencies
	Safeguarding concerns – would still go to Duty & Advice and then if Safeguarding is eliminated Duty SW can redirect to EIT
	Living in a Care Home
	Welfare checks

Evaluation and Next Steps

Outcome: Avg 46 referrals per week to EIT by the end of the pilot phase

Avg home care avoidance per case during the pilot where OT(/OTA) intervention was made was a reduction of 7 hours.

201 ended with OT intervention, which would be expected to result in homecare hours being avoided.

Savings: Estimated cost avoidance savings YTD Financial year 2023-24: **£815,150**

Identified Risks : Role out of EIT Pathway requires exit to reablement service

Phase 2 – City wide implementation of EIT Pathway

- Currently scoping requirements for Phase 2
- Front Doors in scope
    - Contact Centre
    - Neighbourhood Teams
    - Hospital discharge
    - Recovery Beds

Redesigning the Front Door

Definition: The term 'front door' refers to all the ways that people contact us or find the information they need. It includes websites, in writing, email, neighbourhood networks, phone and visits to our buildings.

Key problems:

- Information that would prevent care needs developing or escalating hard to access.
- Limited opportunities to self- serve creating more pressure on the contact centre and less choice for people.
- High level of inappropriate referrals coming to the contact centre.
- High level of demand that could be managed differently to reduce costs, pressure on SW and OTs and waiting times for support.
- Potential of reablement, equipment and telecare to delay the need for care packages not fully utilised.
- Lower level of enquiries and referrals from some diverse communities.

Key design principles:

- Pro-active focus on prevention, specifically harnessing community solutions and the potential of TEC
- Multi channel offer that maximises opportunities to channel shift
- Approach that builds on 'strengths-based' working
- Timely and proportionate responses
- Using our resources wisely.

Identifying benefits

1. Reduction in number of referrals to Social Work teams
2. Reduction in waiting times
3. Reduction in the number of Home Care packages
4. Increased take up of telecare and TEC
5. Increase in the number of people going into reablement and exiting as independent
6. Reduction in calls to the Contact Centre chasing information and updates
7. Improving the experience for people accessing information and support.
8. Data collection that enables us to measure 'impact' and collect feedback

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Leigh Keeble
Head of Service Transformation
Hartlepool Borough Council

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Hartlepool Support Hub
Community Front Door for Adult Social Care

Leigh Keeble – Head of Service Transformation
Jade McLaren – Support Hub Manager
March 2024

SUPPORT @THE HUB

HARTLEPOOL BOROUGH COUNCIL

Hartlepool in Context

- Population of 92,334
  - 0-15 19%
  - 16-24 10%
  - 25-64 51%
  - 65+ 20%
- 10th most deprived local authority area in the country.
- Of the 58 neighbourhoods in Hartlepool, 32 were among the 20% most income-deprived in England.
- Hartlepool has one of the highest rates of child poverty in England.
- Hartlepool's unemployment rate is 5.0 % (2023) which is 1.3% higher than the rate for England (3.7%) and 0.5% higher than rest of the Tees Valley (4.5%)

Health Inequalities

- Population health is poor and below the national average on many indicators, e.g.:
    - Children starting school are more likely to be overweight or obese than anywhere else in the North East and England.
    - People are more likely to die from heart disease, drug or alcohol use than anywhere else in England.
    - Preventable early (under 75 years) death from heart disease and stroke are higher and rising compared with the North East and England.
    - People in Hartlepool live shorter lives than people in the North East and England. A women can expect to live to around 81 years old (compared to 83 in England) and a man can expect to live around 77 years old (compared to 79 in England).

Background to CLS

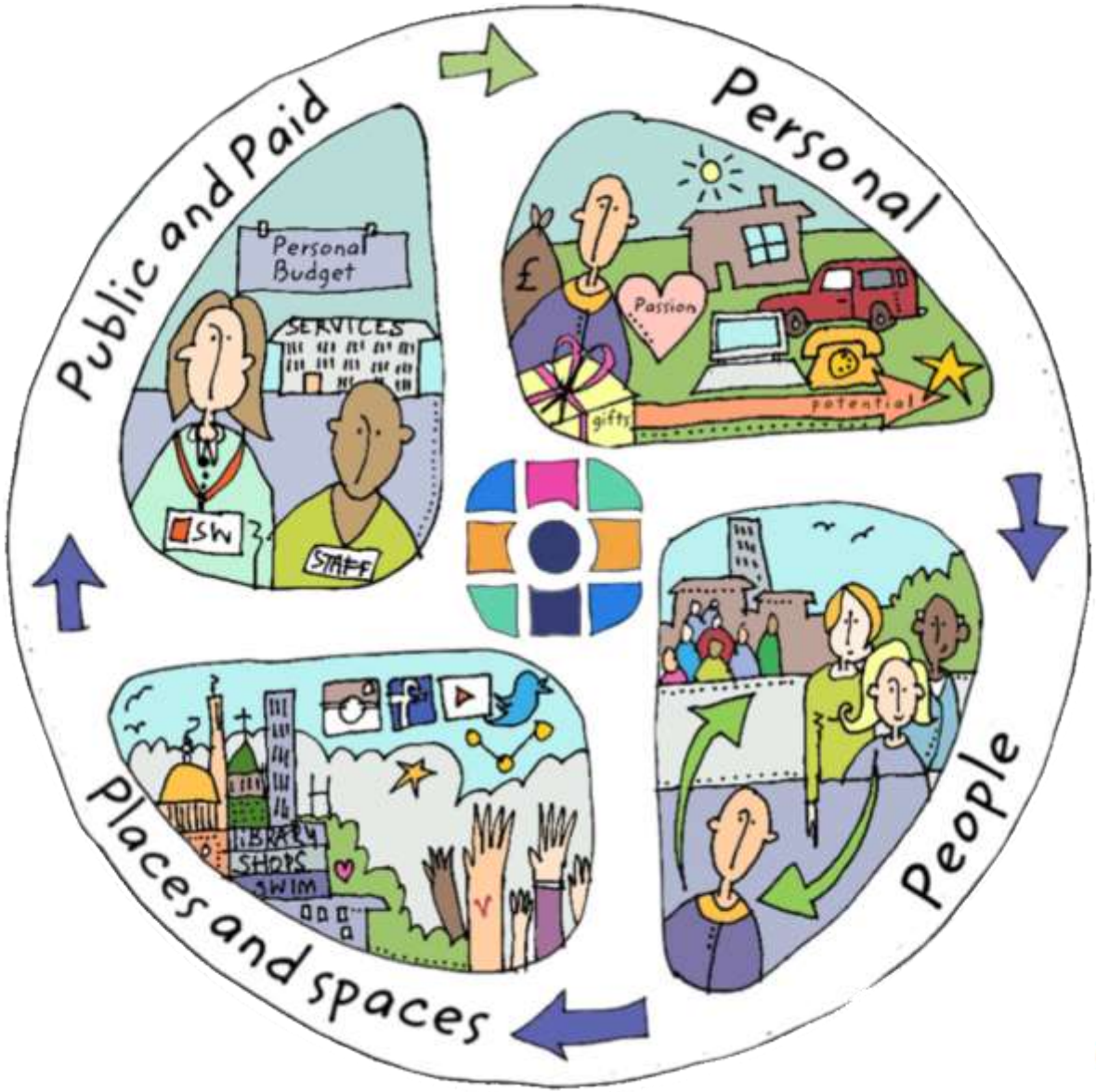
- Director signed up to Community Led Support (CLS) with the National Development Team for Inclusion (NDTI) in January 2019
- Readiness check took place in April 2019

Community Led Support principles

- Coproduction brings people and organisations together around a shared vision
- There is a focus on ‘place’, on community and on the ‘whole’ person
- People can get support and advice easily, when they need it so that crises are avoided
- The culture is based on trust, empowerment and shared values within and across teams and organisations
- Support is strengths based, building independence, control and community connections
- Bureaucracy is the absolute minimum it has to be
- The system is responsive, proportionate and focused on outcomes

Community Led Support
an NDTi Programme

Using the Resource Wheel to achieve outcomes



Community Led Support
an NDTi Programme

NDTi

Community Led Support is a conversation that helps people see their own strengths. It promotes independence by building on existing support networks, accessing early help and community resources so that people can be in control of their own lives.

Background continued…

- CLS innovation site launched in November 2019
- Second site launched in March 2020
- Lockdown

Responding to the Pandemic - developing the Support Hub

- Established in March 2020 in 3 days to support vulnerable people who needed to Shield/Clinically Extremely Vulnerable (CEV)
- Supported self-isolators
- Information leaflet to every home in the town
- 40 staff redeployed
- Used system that we had in place for CLS sessions
- Modelled on CLS approach – focused on good conversation and strength based approaches to supporting people

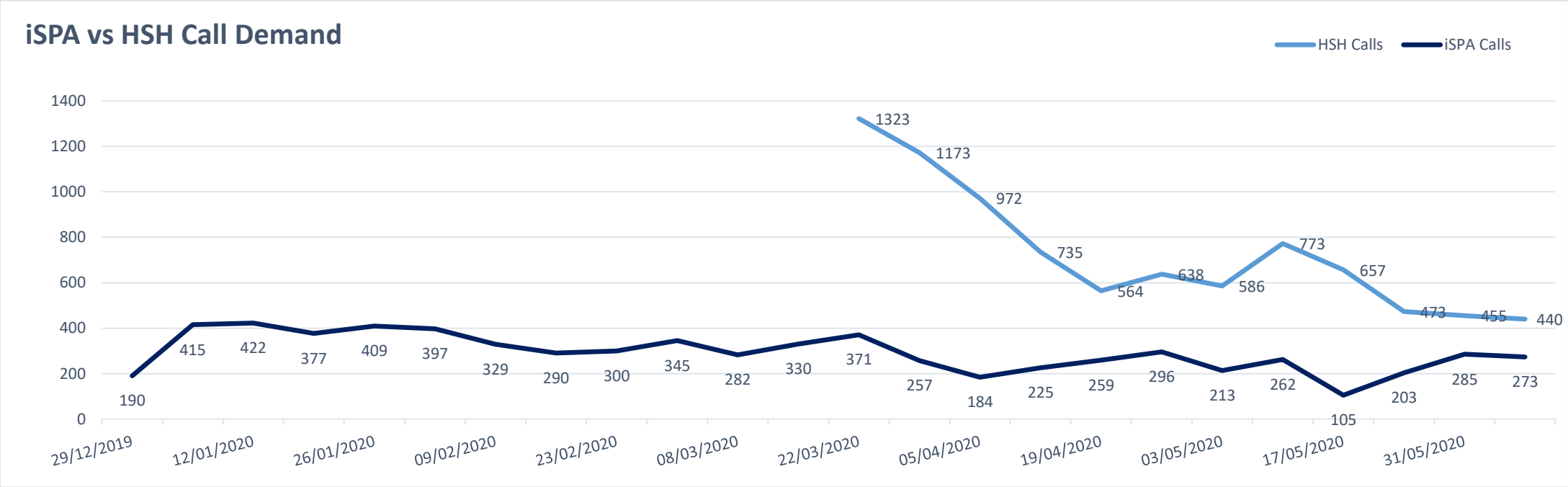
Who we were supporting

- 4,735 people on the Governments Shielded People's List (SPL)
- 912 of those identified as not having access to essential supplies – all contacted
- Support provided to 2,325 (shielded and non-shielded) people who were identified as isolated and potentially vulnerable
- 65% of people requiring support were aged over 60
- 50% were lonely, isolated and living alone
- 35% had a long term condition

19th April 2020 - 5th July 2020

- Received 11,131 calls
- Kept in touch with people by making 26,160 calls

Snapshot of data



The Support Hub now

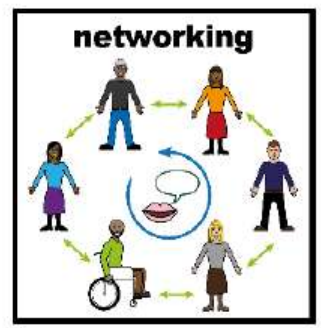
- First point of contact for Adult Social Care (community)
- Starts with a ‘good conversation’
- Focus on strengths, what’s working?
- Focus on reengaging with community (whatever that looks like)
- Focus on person centred approach – one size does not fit all
- We don’t have to solve everything – working in partnership


Community Navigator
Occupational Therapy Assistant
Lets Connect Support Worker
Hartlepool Carers IAG Worker
Reablement Worker
Link Worker
TEWV Access Worker
ASC First Contact Officer
Support Hub
Impact on Teesside
Substance Misuse Team Support Worker

Meet the Community Navigators

Our Community Navigators can help you:

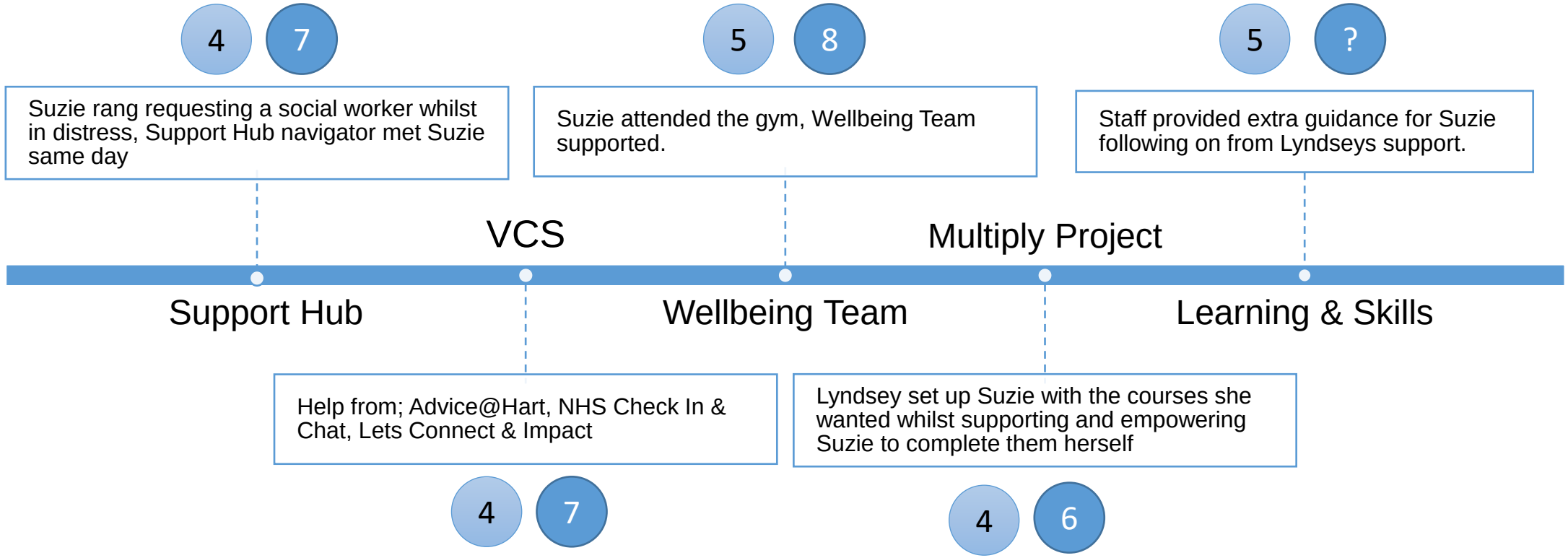
- Meet new people
- Try new things
- Find out what is going on near you.
- Be fit and healthy



A Community Navigator will:

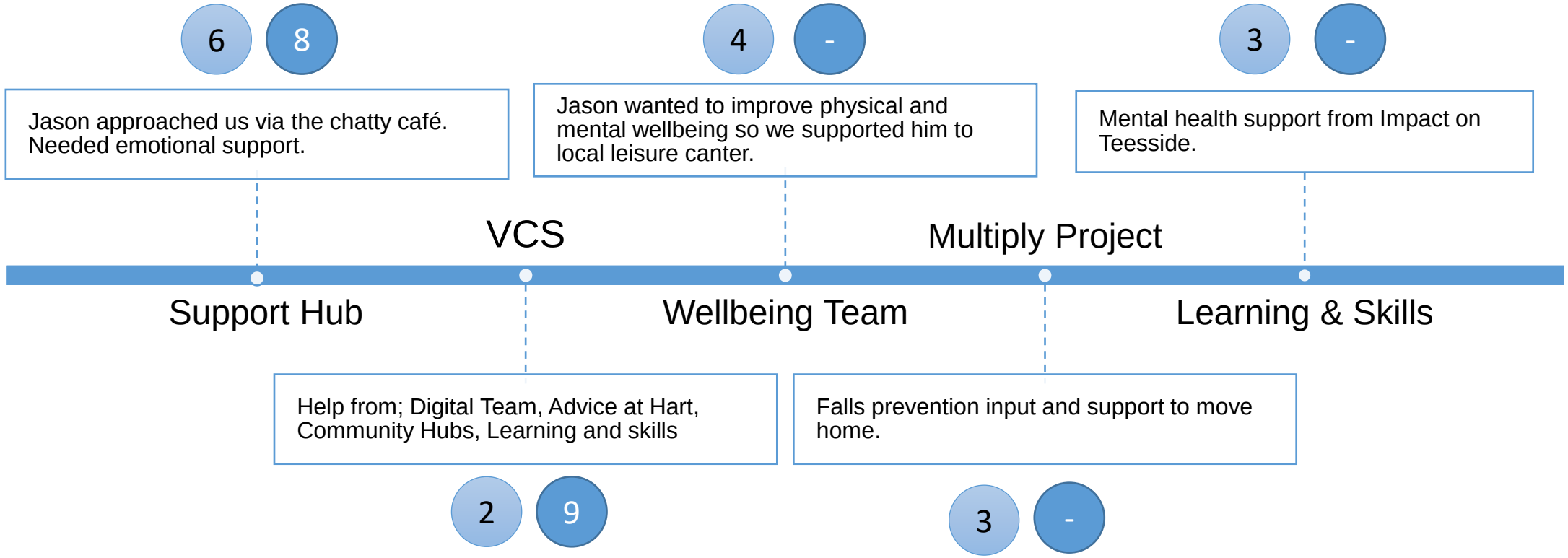
- Spend some time getting to know you
- Help you make a plan
- Help you do what you want to do
- Introduce you to new people and new things to do

Case Studies



- **Summary:** Ongoing Support, friendly faces, no need for a Social Worker, preventative support, life skills, more Independent, empowered

Case Studies



- **Summary:** Ongoing Support, no need for a Social Worker or OT, preventative support, Mental health support, more Independent, empowered

Successes, measurable impact and quantifiable benefits

Key learning points

- Community Led Support works – people are living a better life and are reconnected to their communities.
- Good partnerships are vital – Hartlepool Carers, TEWV, Impact, Let's Connect, START.
- Staff are empowered to work however they think is appropriate with people for the best outcomes.
- We are changing the narrative – we do not talk about service users, clients, patients, assessments, referrals etc.

Next steps

- Further embedding CLS across social care system.
- Continuing to work with partners including VCS to widen opportunities
- Developing our understanding of data to better inform our decision-making and understanding capacity.

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CLS Video - https://youtu.be/iclGkFyfXt8

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Thank You