Our Northamptonshire Adult Social Services Strategy 2019-22
Our Vision for adults Social Care in Northamptonshire

Adult social care in Northamptonshire is changing. Like all Adults social care services across the Country we need to do this as we cannot meet growing levels of demand within the budget we have and predicted demand over the next ten years shows this challenge will only grow. Unless we find more effective ways to keep people in their own homes or communities for as long as possible, to avoid hospital admissions, delay or reduce the escalation of need and find innovative ways to meet peoples need through what we buy or “commission” we will not have a safe or sustainable service.

We also recognise we are not organised in a way that makes sense to our customers and we are taking too long to do some things. We want to change this. We will be improving how we work and manage requests to make things easier for people and more efficient.

Until very recently our health and care organisations acted in isolation with each organisation accountable only for the part of care they provided to the patient or service user and not enough focus on the person. Unfortunately this has meant that someone who needs care for a variety of conditions could be receiving services from five or six different organisations with very little coordination between them.

This is confusing and a wasteful use of resources, and the reality is that this situation leaves no one taking overall responsibility for the coordination of this fragmented care. We are working on improving the quality of the services we provide and outcomes for our patients and service users by working better together in a more integrated way. Underlying all we do is the desire to help those we care for stay well and live well – so we know it is time to change.

Working increasingly with Public Health, District and Boroughs, and our wider public sector partners our focus will be to promote, maintain and enhance people’s independence so that they are healthier, stronger, more resilient and less reliant in future on formal social care services. Doing this is better for people in terms of their long term outcomes and better for the Council in helping make our money go further. It is also better for health partners as it will help reduce hospital admissions.

To do this we will move towards increased and integrated community-based support that helps people stay independent, healthy and safe in line with our Health and Care Partnership vision for the County and the NHS 10 year Plan:

Northamptonshire Health and Care Partnership

“A positive lifetime of health, wellbeing and care in our community”.

Working with partners to plan at a population level we will identify people who may be at risk of needing help in the future and for whom support in the short term may prevent longer
term needs developing and wherever possible people are enabled to manage their own care. Where people experience a crisis in their lives, rather than intervening to remove people from the crisis we will work with people and families to manage the crisis, become more resilient and develop skills to deal with issues in the future.

We will also need to engage earlier with Children and young people who are receiving help from Childrens Social Care and who may go on to need our help when they become an adult. Engaging earlier will help us provide advice and information families on the criteria for receiving adult care support (which is very different to those in Childrens services), their choices, to set expectations and to ensure we can meet their aspirations and outcomes. Most of all we need to ensure that there is no gap in support as they move between the two services, which means we need to have an all age focus.

Where people do need support we will make it as easy to access as possible. People will be able to get the help, advice and support they need online, by phone and in future through community wellbeing hubs or where required through pre-scheduled home visits. On first contact with people we will try to resolve their problems as quickly as possible and seek to utilise support from families and communities before resorting to formal social care services.

We will do this because we know that this helps people to be more resilient and have better social outcomes; it reduces isolation and is more cost-effective. Support identified in people’s local communities outside of local authorities makes life better for both the individual and the community.

Working together with partners, sharing information and using it intelligently, and joining up services will help us to avoid duplication wherever possible and also to understand people’s total health and care needs. We will continue to work in a more integrated way with health partners.

We aim to deliver services which will enable people to gain or regain skills to help them to live independently and recover from illness. We will do this in the most unobtrusive and least restrictive manner possible. This means that we will support people in the short term whilst expecting that wherever possible people will support themselves in the longer term.

For most people, long term support from the local authority will be the exception rather than the rule. We will provide ‘just enough’ support to assist people to build on their current strengths and develop their abilities to look after themselves without becoming overly dependent on council support.

We will work with partners to ensure that people have the right access to housing, health and community services so that they can have a good quality of life and make a positive contribution to their communities. Our aim is for people to have access to work, housing, and social networks which support them to be independent, improve their wellbeing and reduce isolation. Our move towards local Government Reform and two new Unitary Councils in the County will help support this aim bringing services together and organised around community and customer needs.
We will seek to use equipment and technology to provide less intrusive and more cost-effective care. Wherever possible we will keep people at home, with families and friends to enhance their social and personal experience.

Where people need ongoing support we will share this responsibility with the individual, their families and their communities and have conversations about how needs may be best met and to ensure that expectations are realistic. We will try to meet people’s needs in a personalised way which delivers the outcomes that people require.

However, in delivering and commissioning services we want to achieve the best value and most cost-effective means of delivering good quality care. This is important, not just because local authorities are receiving less funding from government to provide care, but also because everyone should expect that the services they are buying or receiving represent the best possible value.

Therefore whilst choice is an important factor in people being able to manage their own care, it cannot be unrestricted. Wherever possible we will work with individuals to deliver personalised social care and health services, but we will only do this in the context that the services people receive will maximise their independence and provide the very best value for money. Working with providers of care we will constantly review people’s care arrangements to ensure their outcomes are being met in a cost-effective way.

We recognise that for some people there is an enhanced risk to their personal safety because of their particular disabilities or frailties, or due to wider issues in society. However we also recognise that we all need to take and accept a level of risk in order that we grow and develop as individuals. We will therefore work with people to enable them to understand and manage risks appropriately, whilst also providing arrangements to safeguard people from significant harm. Our response to concerns about people’s safety will be proportionate, flexible and personal and will always be based upon the individual’s wishes and feelings alongside the best interests of the wider community.

The Governments Green Paper on Adult Social care is expected in 2019 and at that point we will need to reflect and consider its impacts and how we respond. This strategy is therefore a three year one with this in mind and will be refreshed based on that and the need to reflect the priorities on the new Unitary Councils.
Our Design Principles

To make this happen, we will work to a set of guiding principles which aim to put the person at the centre and to ensure that the support they receive can deliver the right outcomes and manage any risks appropriately. These principles are shown below:

- **The right person**: people who really need our support are identified and prioritised.
- **The right time**: we will intervene to prevent things getting worse, increase resilience and maximise independence.
- **The right place**: we will ensure people are cared for in the best setting whether at home, in the community or in a specialist setting – according to need and what is most cost-effective.
- **The right support**: we will provide just enough to keep people safe and prevent, reduce or delay the need for long term help, delivered by the right people with the right skills.
- **The right partner**: working more effectively with individuals, their friends and families and in partnership with other organisations – to achieve more joined-up and cost-effective support.
Our Strategic Approach

To meet our obligations under the Care Act 2014 we have developed a model which is ‘layered’. It is designed to ensure that people can get the right level and type of support, at the right time to help prevent, reduce or delay the need for ongoing support, and maximise people’s independence.

1. Prevent Need

We will work with our partners in health and across communities to prevent people needing our support. Closer ties with Public Health going forward mean we will do this at scale and working closely with their wellbeing advisors to act quickly where we identify risks of falls and frailty.

We will do this by providing information and advice so that people can benefit from services, facilities or resources which improve their wellbeing. This service might not be focused on particular health or support needs - but is available for the whole population – for example, green spaces, libraries, adult learning, places of worship, community centres, leisure centres, and information and advice services.

We will promote better health and wellbeing and work together with families and communities (including local voluntary and community groups).
2. Reduce need

Where we identify high risks groups or people most at risk of having escalating need or in crisis we will intervene early if possible to help them to stay well and prevent the further need for services. For example we might work with those who have just been diagnosed with dementia, or lost a loved-one, people at risk of isolation, low-level mental health problems, and carers. We know that acting early can significantly help improve people’s longer term outcomes.

Our work will be targeted at people most likely to develop a need and try to prevent problems from getting worse so that they do not become dependent on support. This might include: information, advice, minor adaptations to housing which can prevent a fall, support and assistance provided at a distance using information and communication technology via telephone or computer.

3. Delay need

This will focus on support for people who have experienced a crisis or who have an illness or disability, for example, after a fall or a stroke, following an accident or onset of illness. We will try to minimise the effect of disability or deterioration for people with ongoing health conditions, complex needs or caring responsibilities.

Our work will include interventions such as reablement, rehabilitation, and recovery from mental health difficulties. We will work together with the individual, their families and communities, health and housing colleagues to ensure people experience the best outcomes through the most cost effective support.

4. Meeting need

The need for local authority funded social care support will be determined once we have identified and explored what’s available to someone within their family and community.

People who need our help and have been assessed as eligible for funding, will be supported through a personal budget wherever possible. The personal budget may be taken as a payment directly to them or can be managed by the council.

Wherever possible we will work with people to provide a choice of help which is suitable to meet their outcomes. However, in all cases the council will ensure that the cost of services provides the best value for money. Whilst choice is important in delivering the outcomes that people want, maintaining people’s independence and achieving value for money is paramount.
How we plan to achieve our vision

2. Prevent need

How it works now:
- People don’t know how to find the information they want
- People don’t know who does what
- People don’t follow up when we signpost them to other services for advice or support
- People rely upon formal services for support in most cases

In three years’ time:
- Information and advice will be co-ordinated and easily accessible
- People will be better informed about maintaining their own and their family’s health and wellbeing, and identify what they can do for themselves and each other
- People will think about the future and plan ahead in case they need support

We will:
- Support initiatives in the community which help people to stay independent
- Promote and facilitate access to ‘universal services’ through wellbeing or community hubs – which are for everyone
- Further improve access to information and support people to plan ahead

Preventing need

Maggie is 55 and got in touch with the Advice Service because she has a progressive physical condition and wanted to make plans for her future finances and housing arrangements. An Advice Service Worker met with her. She has now put in place a Lasting Power of Attorney so her wishes can be enacted if she is unable to make decisions for herself later in life.

2. Reduce need

How it works now:
- We often have low expectations of what people can do for themselves
- We don’t actively identify people who are at risk of losing their independence and wait for them to come to us or have a crisis before we act
- We provide carers with assessments and support when asked

In three years’ time:
- We will identify more people who may be at risk

V0.9 May 2019
• We will have good information about current and predicted situations and use this information to plan more effectively, intervene earlier and provide early advice
• We will use more of the resources in the community and help develop more community support with partners and providers
• We will make Carers aware of support available, early in their caring role

We will:
• Adopt the three conversations model designed to connect people to the things that help them get on with their lives, maintain control and use their resources to support their chosen life.
• Support initiatives alongside our partners which identify those at risk early - through, for example, our work with GPs and health colleagues or through community hubs
• Work with our partners to further develop and deliver services that reduce the need for help - such as peer support groups, telephone care and targeted advice
• Support carers to remain mentally, emotionally and physically well
• We will have a more integrated transitions service.

Reducing need
Bhavesh is a 77 year old gentleman caring for his 76 year old wife who has had a stroke. He has no family living locally and is keen to continue to care for his wife but is struggling with lifting and supporting her properly. Following contact with the council-funded Carer Support Service he was supported to enrol on a specific carer training course to learn techniques and to access equipment to enable him to make his day to day caring role easier so that he can continue to provide the care he wants to for his wife. He was able to find community transport to the training course, and has continued to meet with fellow course members on a regular basis which is helping him reduce his sense of isolation following his wife’s stroke.

3. Delay need

How it works now:
• The focus is too often upon people’s disabilities or those things they find difficult
• Services are commissioned to maintain people at the same level of need
• We do not have good information about which interventions can reduce need
• We don’t always set expectations early enough for children entering the service
• We don’t manage care in a joined up way between partners

In three years’ time:
• We will focus upon what people can do for themselves and enable people to be as independent as possible
• The proportion of people needing long term support will be reduced
• People and communities will be supported to help themselves
• There will be effective recovery, rehabilitation and reablement services
• We will have good communication with staff - who understand what we are trying to do and work towards this
• There will be more joined up services across health and social care
• There will be a transparent and robust pathway in place for young people transitioning to Adulthood

We will:
• Work with Children and Family Services to ensure young people have their opportunities maximised to live independently
• We will talk about how we might solve problems before we go through detailed assessments with people
• Target help which helps people to get better and stay well in the future
• Join up with health partners to delay the need for our help.

Delaying need

Vic is in his 60’s and now lives alone. He had a stroke which affected his left side and has little function in his left arm (he cannot grip). His partner, who died a year ago, did all the cooking in the household – since then Vic has been reliant upon his daughter and domiciliary care services for his drinks and meals. The reablement service worked with him to help him learn to use a microwave and a kettle fitted onto a tipper so that he can make drinks and reheat ready meals for himself. He is happy to be more independent, his daughter has more time for herself and Vic is no longer having any domiciliary care.

Felix is a young man who has a diagnosis of a severe learning disability and Autistic Spectrum Disorder, who lives at home with his mum and brothers. Felix started to refuse go to his specialist school, or to wash and dress; he was staying up late watching football and didn’t want to think about or discuss what he would do when he left school. Learning disability nurses worked with Felix and his mum to set boundaries and to address his behaviour. The Transitions Team helped Felix and his mum to learn to use an iPad app to identify his interests and dislikes, and a support plan was developed. A local Community Life Choices service offering activities matching Felix’s interests was found for 3 days a week in school holidays. Felix enjoys this, and knows he must attend school in order to go to the holiday service – this also gives his mum a break from caring, and she no longer needs extra respite. Felix has now joined a local inclusive football team, learned to walk to the football ground safely on his own, and has chosen a college course. At Felix’s review meeting, it was agreed that he would not need a Personal Assistant at this time, as had previously been expected, because he was doing so well and gaining confidence daily.
4. Meeting need

How it works now:
• Community and individual resources that can support people are not fully explored
• People have expectations that care will be funded through the council
• Services are ongoing regardless of people getting better or worse
• In some cases services may create reliance rather than promote independence, and avoid rather than manage risk

In three years’ time:
• We will provide support to meet people’s needs where families and communities cannot
• Care will be focused on the person and be cost effective
  Support will be focussed on supporting people to achieve their identified outcomes and will support them to progress to greater independence
• People will be supported with less funding from the council
• We will effectively manage demand within budget

We will:
• Develop the skills our staff need so that they are innovative and creative when helping someone
• Regularly look at what we do so that we’re working as effectively as possible and making the most of public money

Work together with partners to manage risks and make sensible decisions which provide benefits which we can measure

Meeting need

Malcolm is a 42 year old man with a learning disability, who had lived in residential care for over 20 years. He moved to supported living, with 20 hours per week of support. Twelve months later, he has learned to cook simple meals, do his own washing and keep his home clean, how to be safe at home and what to do if he needs some help. His support package has now reduced to 7 hours per week, and work with Malcolm focuses on maintaining his independence including household tasks, budget management, daily activities and planning for the future. To support him to be both safe and independent, and reassure his family, the property where he lives has door sensors fitted so that if he goes outside at night an alarm is triggered. The property also has fire detection equipment such as smoke and heat detectors. The alarm calls go through to waking night staff located nearby.

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Key activities to deliver the model

We will need to take some action to underpin our approach and help us to deliver what we have set out.

We will:

- Develop our staff to ensure that people have the right skills and knowledge, the right tools available, and are deployed in the right places
- Develop new ways of working, new practices and new procedures
- Gather good information about what people need, what we are supplying, and what works, to help us manage performance
- Understand local priorities and work with communities to develop and improve services
- Coordinate with partners and stakeholders to plan how and where they can work with us to ensure the best outcomes and greater independence for people
- Develop internal processes that are simple, transparent, consistently used and easy to understand
- Manage robust financial systems – making it clear who is accountable
- Develop a detailed action plan, which will be regularly reviewed, updated, and used to identify the next steps

Monitoring our performance

Our progress will be monitored and reviewed regularly with the support of partners including Healthwatch and the Health and Wellbeing Board. Progress will be reported through our business plan and a quarterly performance updates.

We also report yearly to the Association of Directors of Social Services (ADASS) and must submit performance data against the measures set out in the Adult Social Care Outcomes Framework (ASCOF).