Nottinghamshire County Council
Adult Social care Overview

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Adult Social Care - who does what?

Initial Contact Services

- Adult Access Team
- Multi-Agency Safeguarding Hub
- OT Intake Team

Community Assessment Teams

- Older Adults
- Mental Health
- Learning Disability
- Physical Disability/Younger Adults
- Hospital Integrated Discharge Teams

Specialist Teams

- Transitions
- Adult Deaf and Visual Impairment Service (ADVIS)
- Deprivation of Liberty (DoLs)
- Approved Mental Health Professional (AMHP)
- Asperger's

Commissioning and Support

- Strategic Commissioning
- Quality and Market Management
- Adult Care Financial Services
- Mosaic Development Team

Direct Services

- Day Services
- Short Breaks
- Shared Lives
- I-Work
- Care and Support Centres
- Residential Unit (learning disability)
- Supported Employment Services
- Reablement (START) services

What are the key responsibilities of adult social care?

- **Based on a national eligibility criteria for social care support**, we have a responsibility to meet people's needs if a care and support assessment shows that:
  - **the needs come from, or are related to, a physical or mental impairment or illness**
  - **as a result of these needs, a person is unable to achieve two or more tasks specified in the guidance (e.g. managing personal hygiene, managing toilet needs, developing and maintaining family or other personal relationships)**
  - **as a consequence there is, or is likely to be, a significant impact on the person's wellbeing.**
- We have statutory duties in relation to:
  - **safeguarding adults**
  - **mental health assessments**
  - **mental capacity and deprivation of liberty**
- We also have a duty to assess and provide support to carers
- A Care and Support Plan, is developed with the person, based on how the identified needs can best be met
- Support may be offered through a Personal Budget or as a Direct Payment; care and support may be commissioned from an independent care provider or directly provided by the Council
- Reviews are undertaken to ensure that the support is appropriate and sufficient to meet the identified need
- We also have a responsibility to promote and ensure a sustainable social care market

Nottinghamshire's charter for the future of adult social care services

❖ We will promote individual health, well-being and independence
❖ We will share responsibility for maintaining the health and well-being of people in our communities with families, carer's, friends and other Organisations
❖ We will work to prevent or delay the development of needs for care and support by providing advice, information and services that support independence
❖ We will promote choice and control so people can receive support in ways that are meaningful to them, but will balance this against the effective and efficient use of our resources
❖ We will work to ensure people are protected from significant harm whilst allowing people to take risks
❖ We will always seek the most cost effective way to provide support, in order to ensure we can continue to meet the needs of all people who are eligible for care and support

What is the adult social care offer for people in Nottinghamshire?

- Information, advice and signposting from County Council website and Nottinghamshire Help Yourself
- Customer Service Centre (0300 500 80 80) or through an online enquiry form – 64% of enquiries were resolved at the front door (2015/16)
- People can be referred to adult social care by their GP, family member or another professional
- Adult Access Service – based at the Customer Service Centre – deals specifically with social care enquiries in order to resolve as quickly as possible (11% of enquiries passed on by CSC were resolved at this point – 2015/16)
- Referrals requiring a full Care and Support assessment are passed to teams in the relevant locality area
- Assessments can be undertaken by phone, in clinics or at home – online assessment is in development (and already available to carers)
- The Council sets itself a target of completing assessments within 28 days (wherever possible)

Current and Future Developments within ASCH

- Improving Lives Programme
  - Early Resolution – 3 Tier Approach
  - Better Support For hospital Discharge
- Integrated Accelerator Pilot
- Integrated Care Teams Project
- Interoperability Project

How do people or professionals contact us?

- Front door team – Customer Services - 0300 500 80 80 or via online forms http://www.nottinghamshire.gov.uk/contact-and-complaints/contact-us/contact-us
  http://www.nottinghamshire.gov.uk/care/adult-social-care/contact- us
- Customer Services handle calls on behalf of most of the Departments within NCC inc – Social Care, Children's, Highways - Note – we are exploring a dedicated line for professionals within the CSC Centre
- Customer Services have adopted a 3 Tier approach to conversations with people who contact us (Triage)
- Depending on the needs of the person contacting us CSC may pass the query on to specialist colleagues or a community team (all teams adopt a 3 Tier approach)

The 3 Tier model

- The 3 tier model uses a strengths based approach to help a person to help themselves and links to the Care Act 2014 guidance that encourages local authorities to look at all available options for support before considering commissioned services.
- This approach also supports an individual's independence, resilience, wellbeing and ability to make choices.
- When a person contacts Customer Services, we have a conversation with them that considers:

➢ Their immediate support network i.e. family and friends

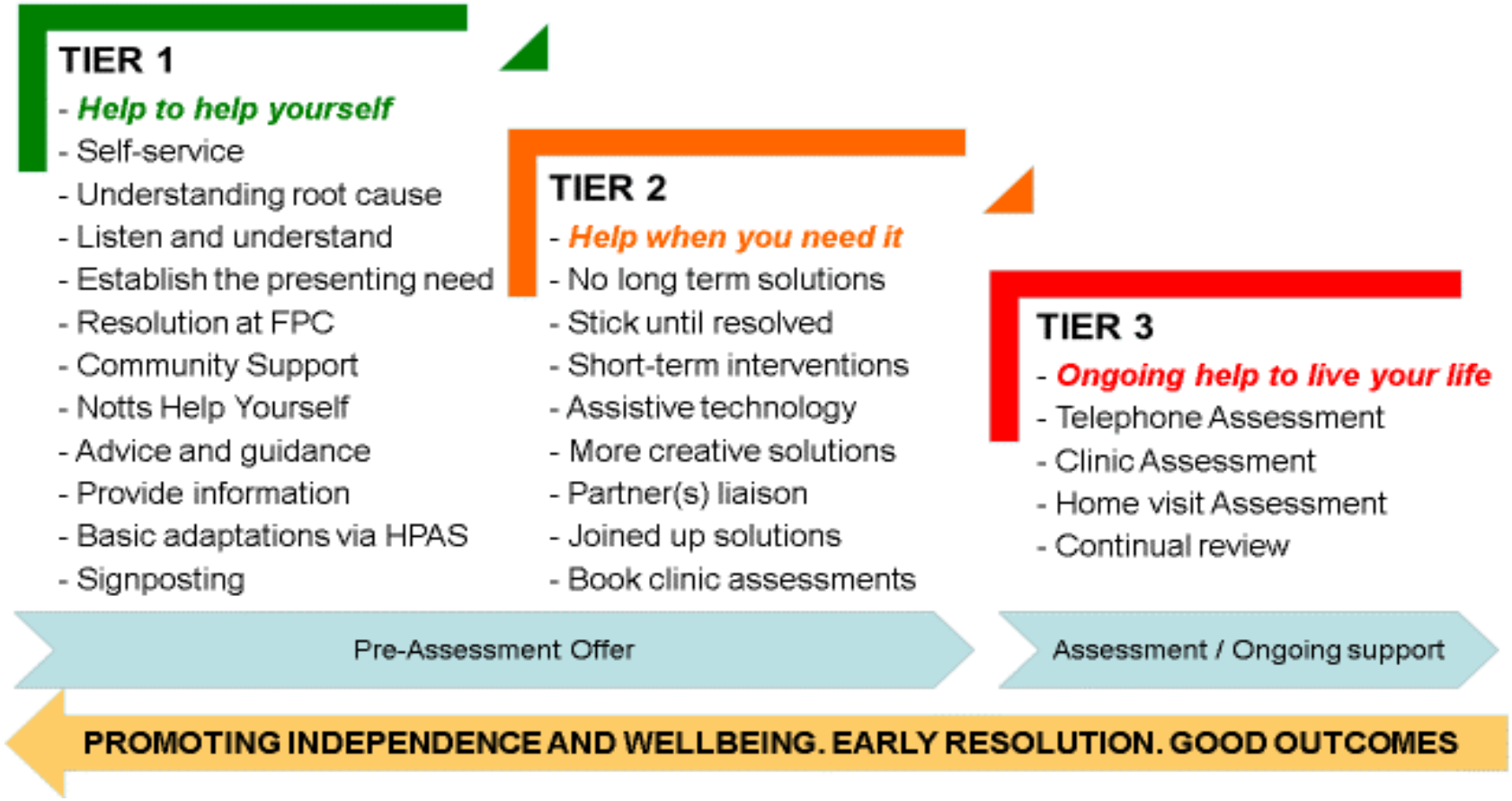
➢ Their local community

➢ Health based services

➢ Any other professional service

➢ Social Care services

3 tier the model



What has changed?

The way in which we have conversations with service users and their families when they contact us has changed

- **We removed many of the specific questions and assume a conversational, person centred approach from the outset**
- **We focus on resolution of problems and queries from the outset**
- **We encourage people to help themselves first (tier 1) using information and advice and signposting to appropriate community resources**
- **We support in the short term(tier2) before considering any longer term support (tier3)**

What are the benefits of 3T?

- Social care queries are resolved in a timely manner (adopting T1 & 2 strategies) without the need for a full social care assessment
- Quicker resolution through the provision of more focused short-term support to individuals that will aim to resolve presenting problems as quickly as possible
- A reduction in social care assessments completed in our District Teams allowing them to focus on more complex service users who need more support
- A reduction in the number of long term care packages commissioned through appropriate short term support put in place
- a reduction in community care budget spend through the increased use of community resources and a reduced need for ongoing long-term packages of care and support

Doncaster and Bassetlaw Hospitals NHS Foundation Trust

The Integrated Discharge Team meet every day at 9am to discuss all patients who have been referred to them from the wards. Representatives from each ward attend to update on their patients. They agree which worker is best to lead on assessment and discharge planning.

The worker visits the patient and carries out the assessment and support plan. If the social worker is leading on the work, s/he speaks with a health discharge coordinator to make sure that the health issues are covered.

The options available for discharge – Home/Family First is the preferred approach (via the Home First response service or START. There are intermediate care/assessment beds if people cannot go home straight away and a Rapid Response team can provide additional support to people in their home.

The aim is to discharge the patient on the “Predicted Date of Discharge”.

Have discharge processes got better or worse ?

How can we answer this question ?

- Ask patients and carers
- Look at information about the number of days that patients are delayed in hospitals

Someone is delayed when a patient is ready to depart from hospital care and is still occupying a bed. These conditions must apply :

a. A clinical decision has been made that patient is ready for transfer **AND**

b. A multi-disciplinary team decision has been made that patient is ready for transfer **AND**

c. The patient is safe to discharge/transfer.

What causes delays ?

- People have to wait for care homes to assess them before they can leave
- Waiting for assessment for 100% health funding of care
- Family take a while to find a care home or home care provider
- Person's partner does not want the patient home again
- The home is deemed unsafe for habitation
- Family want the patient to go into care but the worker assesses the person as being able to live at home with support
- These things aren't ready in time – medication, transport, equipment in the home
- The patient needs support in the home but it takes a long time to find a home care provider (especially for a large package e.g. 4 calls a day, 2 carers)