Agenda Item No: 6

ADULT EARLY HELP DEEP DIVE

To:	**Adults Committee**
Meeting Date:	**11 January 2018**
From:	**Wendi Ogle-Welbourn, Executive Director: People and Communities**
Electoral division(s):	**All**
Forward Plan ref:	**N/A**
Key decision:	**No**
Purpose:	**To note this 'deep dive' report on the Adult Early Help Service which includes an update on performance as well as future plans to continue to provide a holistic and preventative offer.**
Recommendation:	**a) To consider the report and provide comments on progress so far and issues raised.** **b) To suggest Members visit the Adult Early Help team to learn more about the services it provides to Clients**

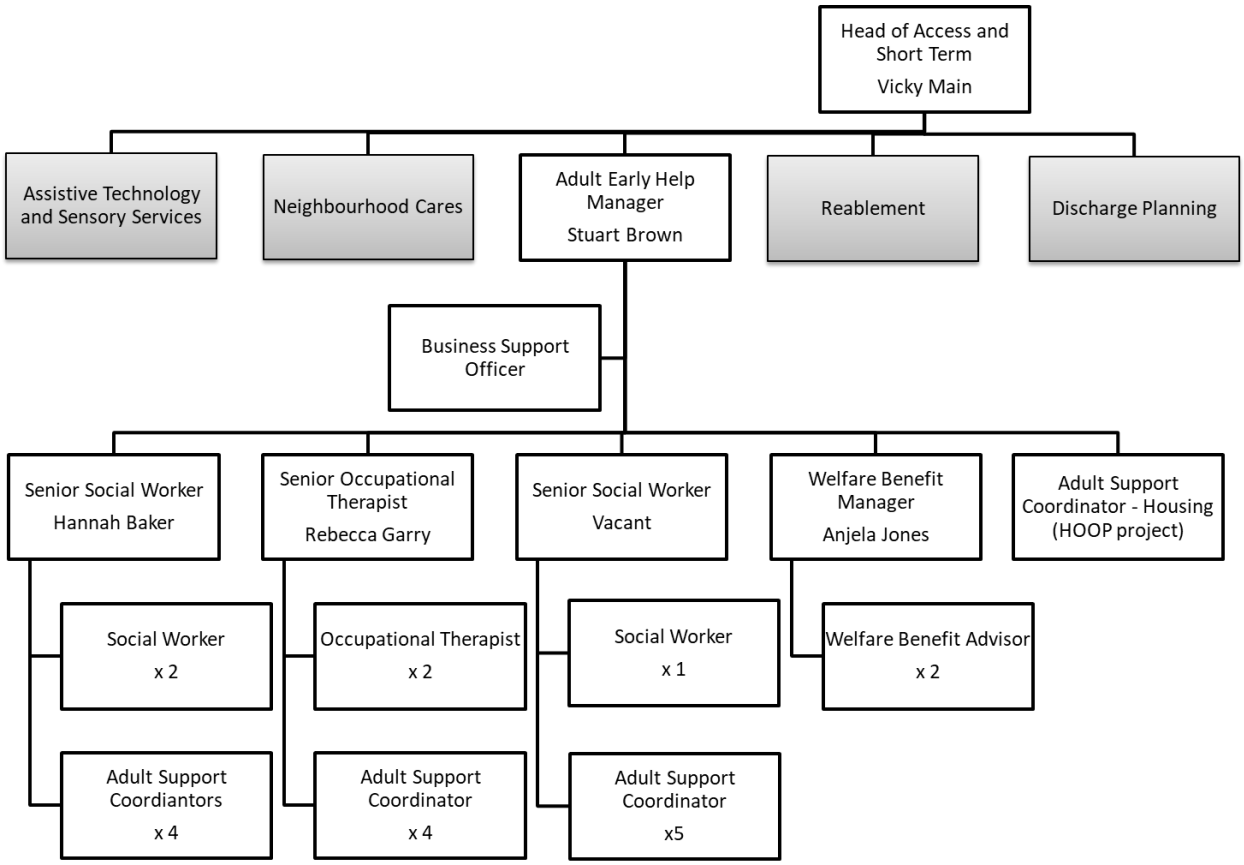
	Officer contact:		***Member contacts:***
Name:	**Vicky Main**	Names:	Cllr Bailey/Cllr Howell
Post:	Head of Access and Short Term	Post:	Chair/Vice-Chair
Email:	vicky.main@cambridgeshire.gov.uk	Email:	annabailey@hotmail.co.uk/ mark.howell@cambridgeshire.gov.uk
Tel:	01223 714766	Tel:	01223 706398

1.0 BACKGROUND

1.1 The role of the Adult Early Help Team

1.1.1 The Adult Early Help team, established in April 2016, provide advice and support to anyone over the age 18 who is seeking support or social care. We are a team made up of Social Workers, Occupational Therapists, Welfare Benefit Advisors and Adult Support Coordinators from a variety of backgrounds. This breadth of training, knowledge and experience allows us to provide a holistic approach that creates sustainable solutions for individuals. We offer support to individuals and also to families and carers accept referrals from any source. The team structure and links to the wider preventative teams are shown in this structure chart:

1.1.2



1.1.3 The Adult Early Help team were introduced to deliver the County Council's response to requirements in the Care Act to work in a more person centred and preventative way, following the principals set out in our Transforming Lives programme and the tiered approach to support and care:

1.1.4

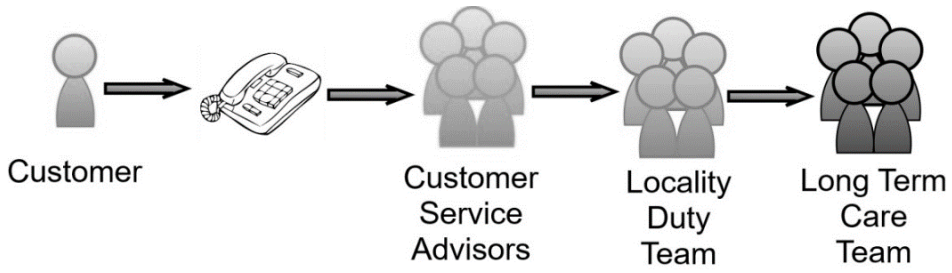
Help To Help Yourself
Accessible, friendly, quick, information, advice, advocacy, support to carers and families, universal services to the whole community, prevention, early identification and early intervention

Help When You Need It
Immediate short-term help, time limited, reablement, rehabilitation, intense support to help regain independence, minimal delays, no presumption about long term support, goal-focused, integrated support

On-going Support for Those Who Need It
Self-directed, personal budget based, choice and control, highly individualised, integrated support, strengths based

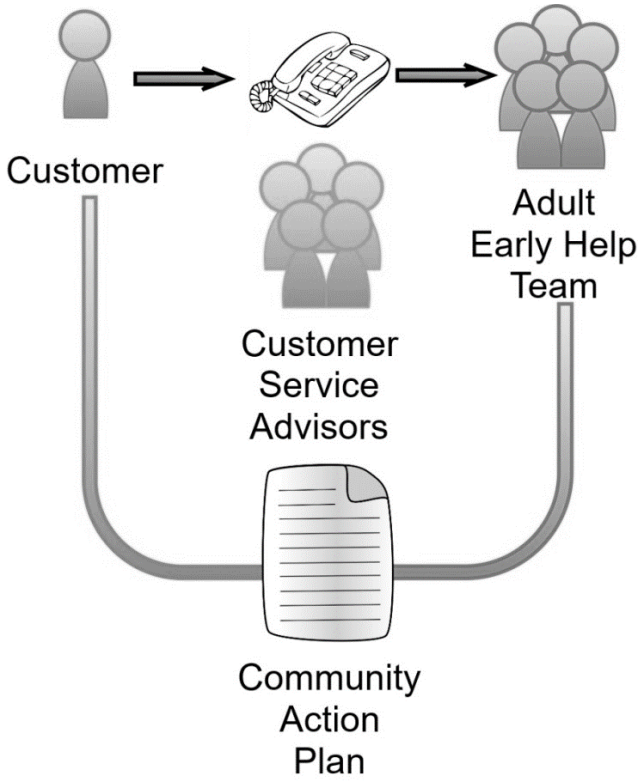
1.1.5 Prior to the establishment of Adult Early Help requests for support and help had been passed from our Contact Centre to our long term teams where the focus was on need, eligibility for support and commissioned social care as an outcome. The journey can be summarised in the following diagram:

1.1.6



1.1.7 Adult Early Help introduced a significant yet simple change to this process. By focusing on the individual, asking them what is important to them, talking to them about their strengths and allowing them to take decisions about their support we are able to work in a much more preventive way. Our focus is on building and maintaining the independence of customers. We do so by working alongside the Contact Centre, supporting them to build their knowledge around early support, information, advice and signposting and then taking calls as a live transfer where the individual needs further help. We support the customer to build a Community Action Plan, something they can own and keep as a record of their conversation and solutions and that can also be used to make ongoing referrals. This is shown in the following diagram:

1.1.8



1.1.9 The team are based in St Ives placing us central to the county. We are co-located with the Contact Centre, Assistive Technology and Sensory teams. These provide strong links and allow us to work together to best support customers. Through telephone calls, or home visits (in about 17% of cases) where appropriate, a strengths based approach is used to understand and appreciate an individual's interests, aspirations, concerns and goals. Existing networks of family, friends and wider community support are explored. The Community Action Plan developed focuses on what the individual can do for themselves, what natural support they have or can be developed, the provision of information and advice, equipment (Occupational Therapy and Assistive Technology), short term reablement, voluntary sector support etc.

1.1.10 Where long term social care is required our conversation forms the start of the assessment process. This ensures the long term teams have a clear indication of the outcomes that the individual is seeking.

1.1.11 Our Plan on a Page can be seen in Appendix 1. This summarises our team's mission statement, values, aims and priorities.

1.1.12 The Adult Early Help team will:

- Support people and their carers throughout Cambridgeshire to improve wellbeing, maintain independence and create sustainable long term solutions.
- Enable carers to continue to fulfil their caring role by focusing on their wellbeing and own support needs.
- Help people to access local universal and voluntary sector services as well as a range of preventative expertise and equipment.
- Develop a Community Action Plan (CAP) that will provide the customer with a record of

our conversations and agreed plan. With the agreement of the individual this is also used to refer to other support providers.
- Provide advice to professionals working with individuals to share knowledge and work together to provide coordinated support.
- Follow up after two to three weeks to establish whether the support has helped and outcomes have been met.

1.1.13 Through meeting these key objectives and working alongside Cambridgeshire's wider preventative services, we will contribute to the management of demand, allowing limited care resources to be used most appropriately and contributing to the overall business plan targets.

1.2 Team make up and funding arrangements

1.2.1 Currently there are 27 posts within the Adult Early Help team made up of:

- Team Manager
- Business Support Officer
- Senior Occupational Therapist
- 2 x Occupation Therapist (1.6FTE)
- 2 x Senior Social Worker (1 post vacant)
- 3 x Social Workers
- Welfare Benefit Manager
- 2 x Welfare Benefit Advisors (1.6FTE)
- 13 adult Support Coordinators (3 vacant posts – total 11.2FTE)
- Adult Support Coordinator Housing (0.2FTE fixed term to April 2018)

1.2.2 Funding for the initial team (Team Manager, Business Support, 1 each Senior Occupational Therapist and Social Worker, 2 Social Workers and 10 Adult Support Coordinators) was made up of a permanent allocation of £333,000 with remaining posts being established from the Adult Social Care Locality Teams. Our Occupational Therapists are employed by Cambridgeshire and Peterborough Foundation Team (CPFT) and funded through the section 75 arrangement.

1.2.3 During 2017/18, a further £109,000 was made available through the transformational fund to allow Adult Early Help to cope with increased contacts with the plan being to review and upstream further funding from the long term teams. This allowed us to bring in 3 additional Adult Support Coordinators and 1 social worker.

1.2.4 Our second Senior Social Worker position will be appointed from March 2018 and budget will be transferred from the Sensory Services budget. This will allow us to provide additional support around complex cases, Care Act knowledge, safeguarding and Mental Capacity support for the Adult Early Help team as well as across Assistive Technology and Sensory Services.

1.2.5 The Welfare Benefit Manager and Welfare Benefit advisors transferred to Adult Early Help this year along with funding for their permanent posts. The Adult Support Coordinator – Housing is a fixed term position until April 2018 to lead on our Housing Option project (see paragraph 4.11). Funding for this post has been agreed through the review of the Disabled

Facilities Grant. It is anticipated that this will become permanent funding for a full time post from April 2018 will come from the Disabled Facilities grant.

1.3 Data source and Outcome Focused Review

1.3.1 Over the next year, the Council has committed to reviewing its portfolio of services so that the organisation is clear about the outcomes it is aiming for, clear about every service's contribution to these outcomes and clear that they are delivering these outcomes in the most cost effective and commercially advantageous ways. An 'Outcome-Focused Review' will be carried out into the Adult Early Help service in the first quarter of 2018; the work completed for this Deep Dive will inform the review.

1.3.2 Throughout this report two sources of data will be used:

- AIS reporting – The strength of this data is that it is automatic and consistent. Recent comparison to local data has highlighted inaccuracies in reporting that we are working with the Business Intelligence team to resolve. Reporting from December onwards should resolve this.
- Local data – This provides more detail on the teams work however is reliant on individuals entering and updating, as well as ensuring accuracy of their data entry.

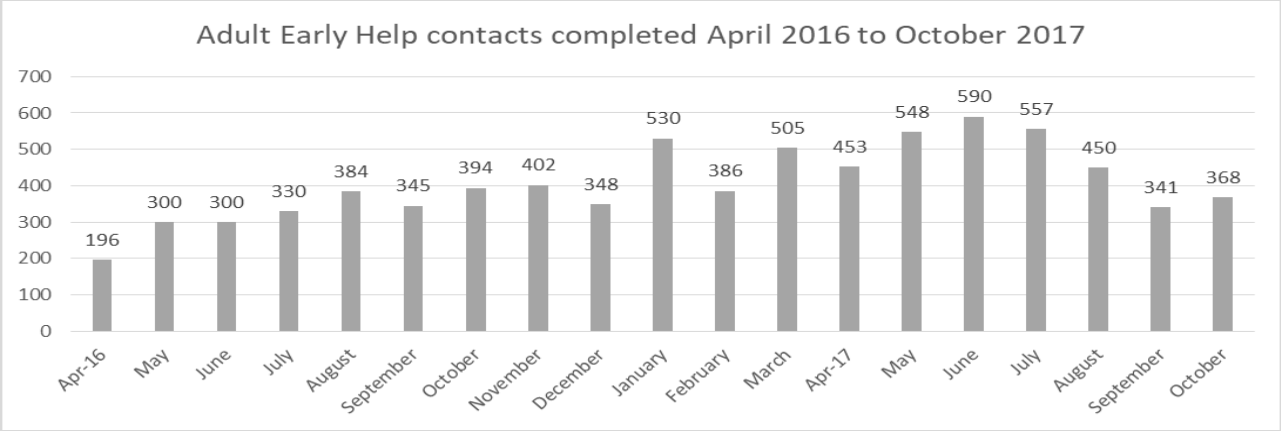
2.0 MAIN FINDINGS

2.1 The following graph shows the contacts that are completed each month. This shows the demand on the service as well as team throughput. There was a consistent rise in contacts resolved from April 2016 until August 2017 as the service became better known particularly amongst professionals but also as customers returned for further support. There are 2 points to note when reviewing this:

2.2
- Up to August 2017 the pathways for referrals for basic Occupational Therapy equipment requests made to Cambridgeshire's Customer Service team had been to send these to Adult Early Help. Since August and in agreement with CFPT these calls are being directly put through to the locality Occupational Therapy teams. This will allow the Adult Early Help Occupational Therapists to focus on joint requests for therapy and social care and upskilling the team (see 4.6). Subsequently there has been a fall of approximately 90 referrals a month to the team.

2.3
- The AIS reporting is not currently identifying contacts created by the Adult Early Help team themselves, occurring mainly when we receive a direct professional referral, conservatively there are around 30 per month. These numbers are increasing as professionals become aware of our contact details. We are working with business intelligence to adjust reporting to include these referrals and hope to be able to report on this way from December.

2.4

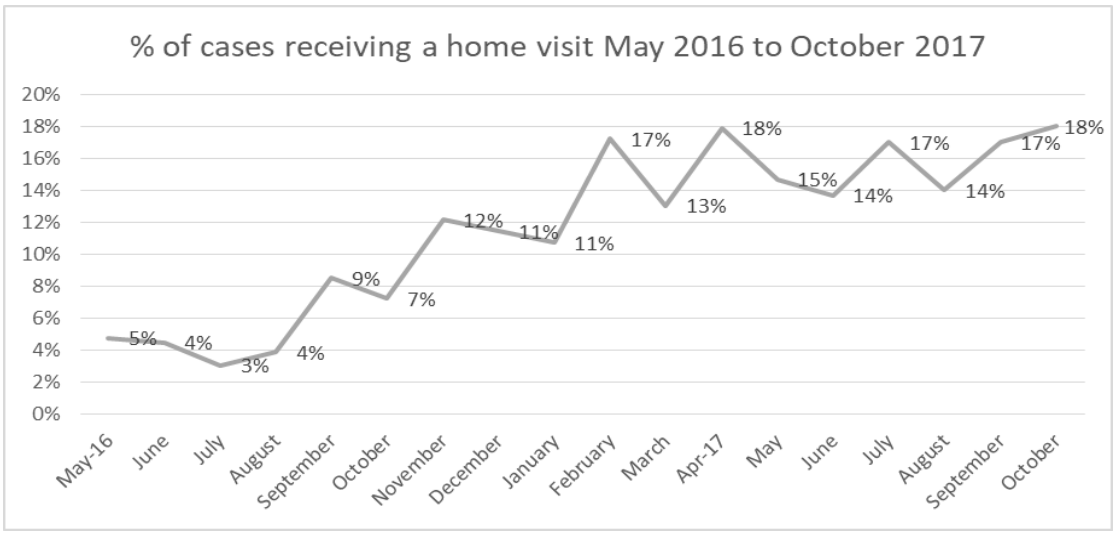


2.5 The Adult Early Help team is based in St Ives, placing us central to the county. Being co-located with the Assistive Technology and Sensory Services teams we are well placed to work together on cases and involve each other in our team's work. We carry out the majority of our work through telephone assessments. We also carry out home visits, as can be seen in our case studies Appendix 2, for a number of reasons including:

- Concerns over a customer's cognition or capacity.
- Difficulty in being heard over the phone.
- The need to take an objective look at the home environment.
- Providing peace of mind to be assessed in a natural setting.
- A number of people involved in the natural care and support of the individual so more effective to meet together.

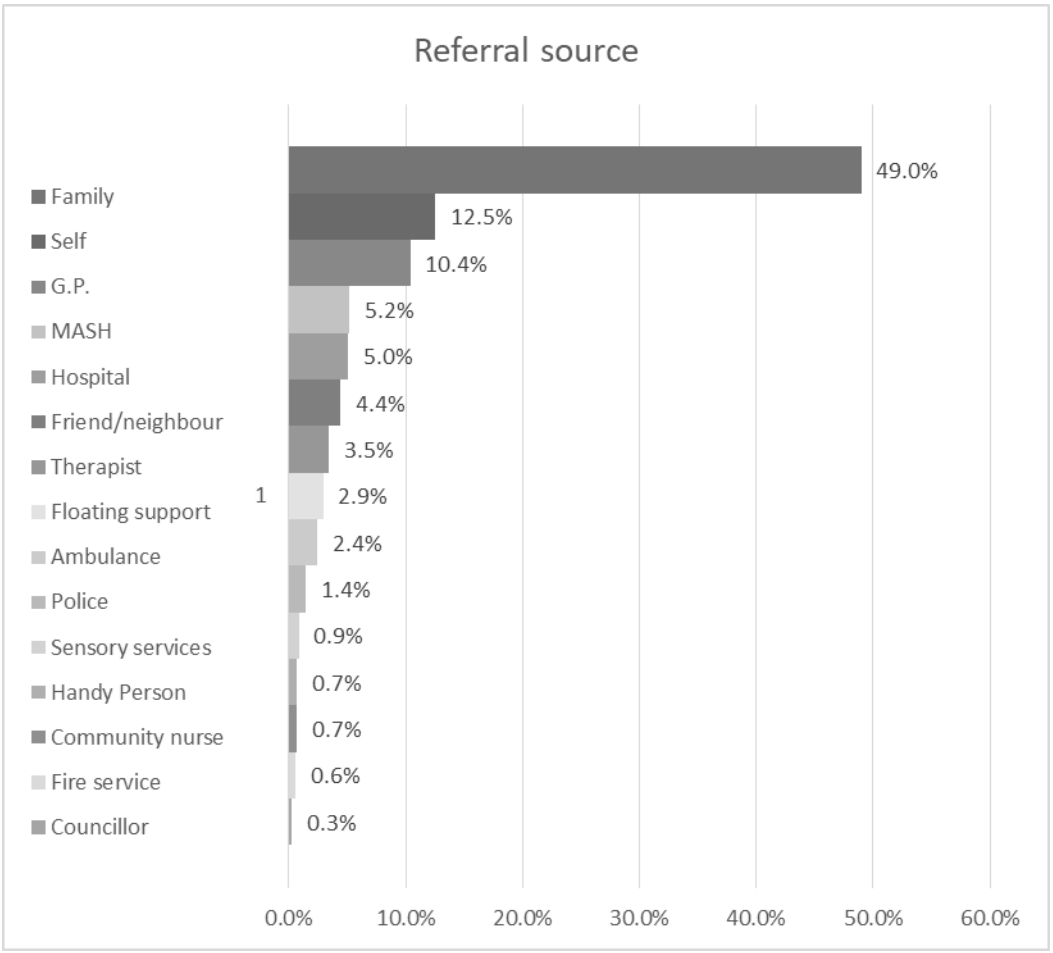
2.6 The percentage of cases receiving a home visit compared to telephone assessment has remained relatively constant at around 17% since February 2017:

2.7



2.8 Referrals to the Adult Early Help team are generally made through the Customer Service team either by telephone, email or online form. Professionals can contact the team directly by telephone or email. The following chart shows the source of referrals:

2.9



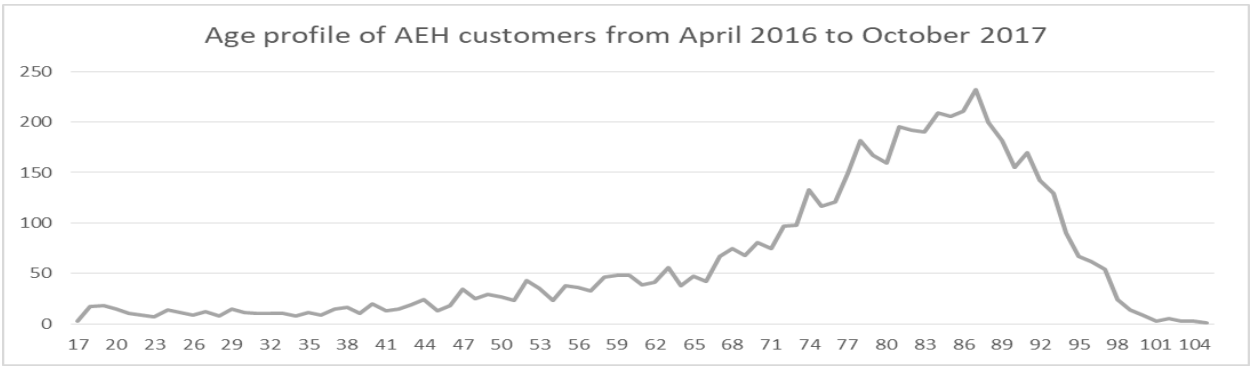
2.10 The majority of referrals are from family members. Professional referrals do demonstrate awareness of the team amongst key partners like GP's and floating support services.

2.11 Self-referrals are comparatively low which suggests a need to better target marketing of the service to individuals as well as continuing to foster strong partnership working with professionals who work with people and can identify increasing need and either contact us for support or make referrals to us. Similarly it suggests outreach work, such as in community hubs, may be required to reach people at an earlier stage.

2.12 We are also currently working with the Customer Service team to review cases that they are supporting through signposting and advice and not passing through to Adult Early Help to identify cases that may benefit from a more detailed and preventative conversation. Early signs indicate several scenarios where our approach could benefit the customer and provide a more thorough support package that will prevent or delay the return of the customer at a point of crisis and better support independence.

2.13 The following graph shows the age profile of the 5492 unique customers who have contacted Adult Early Help identified through our AIS reports (there is likely to be some under reporting due to the previously mentioned reporting limitations):

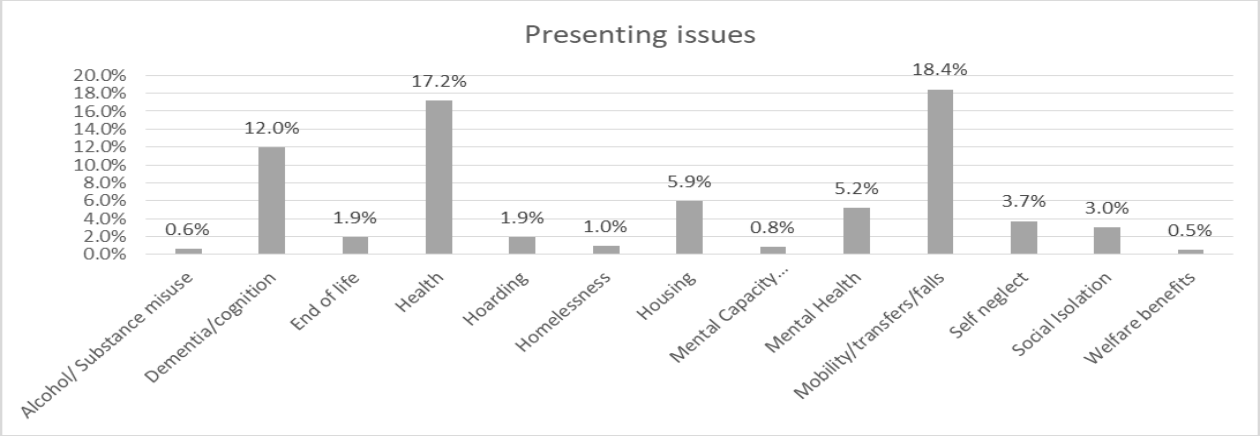
2.14



2.15 The average age of our customers is 76 with the most frequent age being 87 years old. By comparing first year to second year data (from April 2017) we can see that the number of people under the age of 65 contacting us has grown. In our first year they made up 18.32% of all of our contact but since April 2017 they have made up 20.37%.

2.16 We ask the team to record when they identify specific needs while working cases. This shows the wide variety of areas the team can and do offer support in and gives an indication of the complexity and variety of the team as well as the need for constant training and awareness raising of services. We have developed strong links with key partners and encourage the team to champion different areas to give strong links to partners and experts that the team can turn to. Additionally the data supports our drive to bring in key expertise in areas such as Housing Options, see paragraph 4.11 and Mental Health support, see paragraph 4.13:

2.17



2.18 We measure case outcomes in Adult Early Help by their concluding tier to give an indication of the sucsess of our interventions. These tiers correspond to the Transforming Lives model (see 1.1.2) where Tier 1 is information, advice, signposting and support to another professional on a case etc. Tier 2 are short term interventions such as reablement, referrals to visting support, community navigators, voluntary services, equipment provision etc. Tier 3 is a referral to a long term team for assessment.

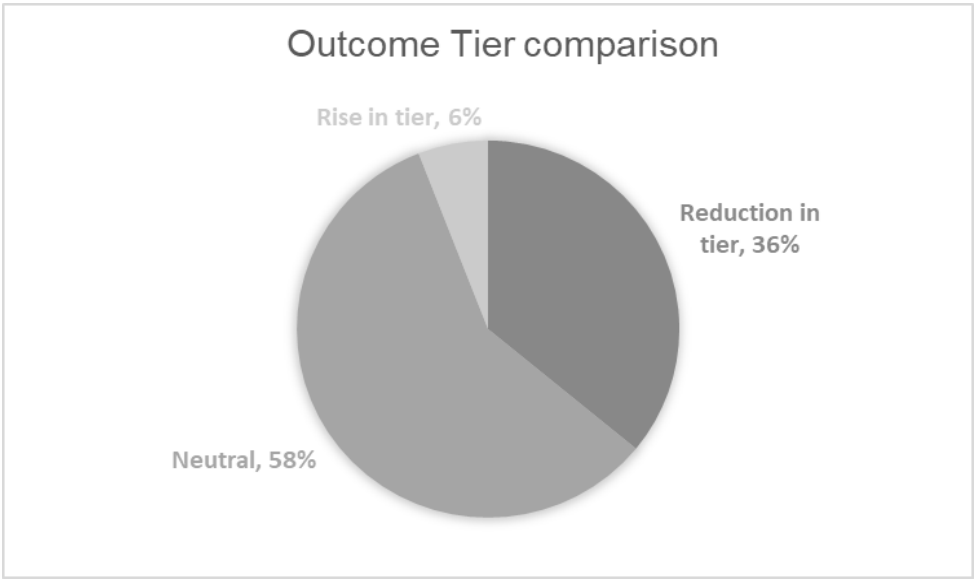
2.19 In the period from July 2017 to October 2017 our local data shows that 75% of cases concluded in a Tier 1 or 2 outcome or needed no further action. Only 25% of cases were passed to a long term team, either our older persons or physical disabilities teams or secondary mental health services.

2.20 Some of our Tier 1 and 2 outcomes over this period included cases where:

- Advice to professional was given 204 times.
- 800 examples where information and advice was given to individuals, family or friends.
- Use of Occupational Therapy outcomes on 378 occasions including equipment provision, housing assessments and referrals for physiotherapy, speech and language therapy, community therapy support etc. 2/3 of which were provided by our Adult Early Help Occupational Therapists.
- 120 referrals to the community navigator service and care network.
- 54 referrals for short and medium term support including visiting support services, homelessness trailblazers and to support workers from the National Autistic Society.
- 65 direct referrals to assistive technology (not including joint working).
- 246 individuals referred to our reablement teams.

2.21 By comparing the initial reason for referral with case outcome we can report on reductions in the level of support and provide an approximation of the success of our interventions. This shows that we are seeing a reduction in 36% of our cases (and where the initial request is for Tier 3 support around 50%). This may occur when someone requesting social care (Tier 3) is supported through reablement and Occupational Therapy equipment (Tier 2):

2.22



2.23 The benefit of this level of diversion from long term support meets 2 key objectives of the Adult Early Help team. We are supporting the ongoing indpendance of individuals, giving them choice over their support options to meet individual outcomes and aspirations. In doing so we are also containing the demand on long term teams, allowing them to focus support on people that most need it and ensuring on the whole that only approriate cases are passed through for assessment.

2.24 A further key aim of the Adult Early Help service is to contribute towards the saving targets of the Adult Social Care Business Plan and support the overall management of demand on the teams. The 2017/18 Business Plan included a savings target of £384k to be achieved from Adult Early Help activities. The business case assumed the dual effect that:

2.25
- Significant proportions of people at lower levels of need would be completely diverted and not require a care package. Currently around 75% of people contacting the team are being supported in this way to remain independent with short term support, equipment and onward referring/signposting.

2.26
- People at somewhat higher levels of need would not be diverted altogether but would require a smaller care package because of the work done in the Adult Early Help team. A clear example of this can be seen in the third case study in Appendix 2.

2.27 Savings achieved by the Adult Early Help Team are delivered through cost avoidance rather than being 'cashable' savings. This means that performance against the target is difficult to monitor, but in order to achieve the savings, an approximate diversion rate of 35% of full time equivalent (or new) Tier 3 packages is required. Data collected by the service has recorded 1,982 cases in the period July – November, and of these 1,009 have presented as Tier 3 cases. Approximately 20% of contacts are repeat callers, and so taking this into account a diversion rate of 40% has been achieved on Tier 3 cases. Therefore, it is reasonable to assume that Adult Early Help savings are on track to be delivered.

2.28 Customer satisfaction with the service is monitored through a postal satisfaction survey. The results of this show that:

- 92% would recommend us to friends and family.
- 99% feel that they were treated with dignity and respect.
- 92% that they were offered the right support.
- 95% felt involved in decisions about their support.
- 97% rated our overall service as okay or better.

2.29 As part of the upcoming Outcome Focused review (see 1.3.1) we will gather more detailed feedback from customers that will be used to further shape and develop the Adult Early Help service.

3.0 Key challenges

3.1 The key challenge to Adult Early Help has and will continue to be one of team resources. This is seen both in our ability to respond to peaks in demand and respond in a timely way, and also in terms of meeting the general demand on the service.

3.2 This has been met in 2017/18 with £109,000 fixed term funding from the transformational fund that has allowed us to bring in additional team members and increase the working hours within the existing team to provide essential flexibility.

3.3 It has been agreed that £130,000 fixed term funding will be vired from reablement budget on a fixed term basis for the 2018/19 financial year. Work will continue to review the resources within long term teams with a focus on upstreaming resources to the prevention teams.

3.4 It has not been possible to do this during the current financial year. Whilst the work of the Adult Early Help team has reduced the number of referrals to the long term team's challenges in the recruitment of qualified staff needed to complete assessments and reviews have led to a need to maintain existing resources. The Adult Early Help Manager will be running a workshop at the Social Worker Recruitment event being held on 20 January 2018, demonstrating the benefits of the Transforming Lives approach and how a focus on the individual during assessments can promote independence, delay the need for formal care and result in better outcomes for the person seeking help and support.

3.5 A further challenge can be seen in the resourcing within our reablement services. The service's Deep Dive report highlighted challenges in terms of Homecare Capacity (5.1) and Workforce Pressures (5.2) that limit their capacity and ability to respond to cases identified within Adult Early Help. The following extracts from the Reablement Deep Dive have direct relevance to the work of Adult Early Help and our links to the current strategies to reduce Delayed Transfers of Care:

3.6 **Early Intervention and Prevention:** Enabling more people to benefit from Reablement is crucial to Cambridgeshire County Council in providing preventative interventions to prevent and/or delay the need for ongoing support, and for the individual to remain in their own home. The Reablement Service needs to work towards realising capacity to support more preventative interventions, balancing demand between the community and hospital discharge. Currently, the South Team receive 93% of referrals from Addenbrookes, whilst North Team receive approximately 55-60% of their referrals from acute trusts.

3.7 **Investment from the Improved Better Care Fund:** Building on current work and plans to enable older people to stay living at home and in the community successfully through the provision of assistive technology, early help, community equipment and housing related support. Work will be undertaken to increase effectiveness of Reablement in collaboration with partners. As part of this, the service will receive additional funding in 2017/18 through the Improved Better Care Fund, with the specific aim of reducing Delayed Transfers of Care (DTOC) from hospital to 3.5%.

4.0 Key opportunities and developments

4.1 The current review of Adult Social Care being carried out by Capgemini and iMpower is producing key findings on how all services, including Adult Early Help, can be improved. Adult Early Help have been engaged throughout the process and will continue to do so. This will include sharing the strengths of our team's learning and development with other prevention and long term services. Some key learning to date includes:

4.2 - The current strength of our preventative offer has been recognised.

4.3 - There are concerns arising from case study reviews that signposting and Tier 1 information and advice can sometimes not be followed particularly by individuals. This raises a concern that people will represent later with more serious concerns or in crisis. In Adult Early Help we often receive very positive feedback on our Tier 1 outcomes but will review these to ensure we are using them effectively and also be asking the team to reflect, learn and share when supporting people who contact us a second time after Tier 1 outcome. We are also working with the Contact Centre team as set out in 2.11 to review their support particularly of self-referrers to ensure people are passed through

where appropriate to Adult Early Help rather than signposted away with information and advice.

4.4 • There is a need for all teams to maximise the use of assistive technologies and think beyond the more obvious solutions the Assistive Technology and Telehealthcare team can provide. We have been and will continue to focus on increasing the joint working between our 2 teams and raise the team's awareness of emerging solutions such as the use of Amazon's Alexa device as a support solution.

4.5 • The Adult Early Help team provides good help and support to carers however we want to strengthen our offer and ensure we are as focused on the wellbeing of carers as we are for the cared for. This will come both from the team's developing understanding of the various local support networks that are available for carers and also by focusing on how assistive technologies can support carers including the use of the Jointly app. This helps informal carers link together to easily plan support and help for the person they are caring for. We will also be exploring with The Carers Trust in January to see how we can make use of The Carers Support Needs Assessment Tool in Adult Early Help. This evidenced based assessment has been demonstrated to have great benefits in supporting carers to focus on their own wellbeing as they are often dedicated to the support of the person they are caring for to the detriment of their own needs.

4.6 **Adult Early Help Occupational Therapists -** The refocus of our Occupational Therapists mentioned in 2.1.1 will allow us to bring a greater focus on therapy as a support option. Our therapists will be jointly working more cases with the team as well as delivering bespoke training both of which will continue to develop the knowledge and awareness of the team to make better use of therapy outcomes. Examples of this can be seen in 2 of the case studies shown in Appendix 2. We are similarly reviewing the use of our Social Workers and looking to greater distinguish their role with a focus on areas such as Safeguarding and Mental Capacity.

4.7 **Reablement and discharge planning -** We are exploring opportunities for Adult Early Help to support the development and knowledge of the reablement team and will be building in work shadowing opportunities, case reflection and professional supervision from our seniors for their qualified staff. In turn it is anticipated that the reablement service will see benefits in term of throughput and successful sign off of individuals which will increase their overall capacity and ability, not only to respond to requests from our team, but also support the drive to reduce Delayed Transfers of Care from hospital. We are also beginning to explore what support our team can offer the Discharge Planning teams to better support this area.

4.8 **Neighbourhood Cares -** Adult Early Help have been supporting the launch of Neighbourhood Cares. This new pilot service has been established to explore the benefits of providing a localised response to requests for care and support. Two teams cover Soham and Saint Ives and are present in the heart of the community. They are already building strong networks and their aim is to help develop services that are person-centred, preventative and flexible.

4.9 Adult Early Help have been actively involved in the development and launch of the service including sharing our knowledge and experience and advice, helping set up contacts with partners and supporting the induction of the team. Moving forwards we will be identifying

and handing over appropriate cases, sharing knowledge and good practice examples, seeking joint opportunities to build up partnership and community links. As two distinct approaches, albeit with strong synergies, providing preventative help, support and advice we are committed to supporting each other's success and development.

4.10 As learning emerges from the Neighbourhood Cares pilot Adult Early Help will be flexible to developing ideas and ways of supporting our customers. Critical to this will be the long term integration of a county wide and very localised prevention offer.

4.11 **Learning Disabilities pathway review -** The Adult Early Help team have been supporting a growing number of adults with learning disabilities over recent months who would traditionally have been referred to the Learning Disability Partnership teams or Adult Autism team. This highlights the difficulties faced by the Contact Centre team sometimes in identifying diagnosed conditions and distinguishing the correct pathway for referrals. The person centred, Transforming Lives approach of the Adult Early Help team lends itself well to supporting any adult. A case study in Appendix 2 shows how we have recently supported a couple, one of who had autism, to avoid a breakdown of informal care and achieve an immediate improvement in quality of life and relationship through some simple person centred work.

4.12 We are working with the Learning Disability Partnership team to make the Adult Early Help team the first point of contact for adults with Learning Disabilities. This will bring equality to our initial prevention offer for individuals. We are working towards a potential start date of April 2018 for this.

4.13 **Further developments -** In order to maximise the preventative offer of the team we are actively seeking opportunities for strong partnership working and to explore new areas. Examples include:

4.14
- Extra care assessments being carried out within the team – successfully trialled in Huntingdonshire and currently rolling out to the City and South area. This allows us to improve the customer journey by reducing waiting time and focusing on strengths, exploring all relevant areas of support as well as housing options.

4.15
- Community Hubs – We have been supporting the Carers Trust by attending their hub sessions for carers. Early indications show this is a very beneficial way of allowing us to provide low level support and advice, and raise awareness of our service with carers who would not normally have contacted us unless in crisis. The challenge here will be balancing this type of work and the regular demand on the service.

4.16
- Housing Options for Older People (HOOP) trial – as part of the review of Disabled Facility Grants and the need to provide a more preventative approach to housing options advice amongst older people, we are trialling a partnership approach with South Cambridgeshire District Council and First Stop, part of Elderly Accommodation Council. The latter provide an online tool known as HOOP and a telephone advisory centre that supports people to consider their current housing, what options are available and then provide advice on local services as well as written guides and resources. We are working together to build their knowledge of local services, take direct referrals where they feel someone would benefit from a wider conversation about their support and wellbeing and also providing a home visit service. To this end we are bringing in a Housing Options officer who will also support the wider Adult Early Help team with cases involving housing issues. A key aim of the approach is that over time we will see

a realignment of advice that will increase moves to better suited accommodation and reduce the need for expensive home adaptations. We anticipate rolling this approach out across the county from April when we employ a full time Housing Options worker within Adult Early Help using funding from the Disabled Facility Grant. Future developments of the role could be in supporting other teams in cases where housing options advice needs to be explored alongside wider care, support and wellbeing needs.

4.17 • Developing links with the Primary Care Mental Health Service (PRISM) service – we are supporting both the induction and training of PRISM staff. These Community Mental Health Nurses will provide a primary support service linked to GP surgeries for people with low and moderate mental health needs. They will work in a similar way to Adult Early Help carrying out proportionate strength based assessments. This example of joint working is one area where we are developing strong ongoing links and clear pathways with mental health services. In turn this will greatly benefit our customers who have both joint mental health and social care needs by improving access to appropriate and timely support and advice and reducing needs escalating to a point of crisis where more costly and limited secondary mental health support is required.

4.18 • Alongside this we have worked with CPFT and Peterborough Adult Early Help colleagues to develop a business to bring mental health Social Workers into both Adult Early Help teams and the PRISM service through the section 75 arrangement. If approved we feel the current advantages that we see of embedding professionally qualified staff (Social Workers and Occupational Therapists) in the Adult Early Help team both in terms of direct support to our customers and also supporting the wider team will be replicated and effective prevention support can be provided as well as appropriate and timely referrals to secondary assessment and support.

5.0 ALIGNMENT WITH CORPORATE PRIORITIES

Report authors should evaluate the proposal(s) in light of their alignment with the following three Corporate Priorities.

5.1 Developing the local economy for the benefit of all

5.1.1 The following points set out details of implications identified by officers:

5.1.2 A key role for the Adult Early Help team is to contain demand on our long term teams social care budgets through preventative support and advice. We set out case examples in Appendix 2 that show how our interventions have helped people to maintain independence, improve quality of life and avoid the need for full Social Care Assessments and potential funded care.

5.1.3 The team are well placed to offer support and advice to people to access welfare benefits that they are entitled to. This not only benefits them in terms of being able to fund support and assistance but also supports the local economy.

5.1.4 The team work alongside partners such as The Richmond Fellowship in identifying people who wish to access employment and need support. This in turn helps people gain employment, contribute to their local economy and improve their own health and long-term wellbeing.

5.2 **Helping people live healthy and independent lives**

5.2.1 The report above sets out the implications for this priority throughout. It is the main focus of the team and of our strength based approach.

5.3 **Supporting and protecting vulnerable people**

5.3.1 The report above sets out the implications for this priority throughout. The Adult Early Help team are in place to support vulnerable people and meet their support needs. We work alongside the Multi Agency Safeguarding Hub (MASH) service to not only identify safeguarding concerns but also support customers referred to them who have wellbeing needs.

6.0 **SIGNIFICANT IMPLICATIONS**

6.1 **Resource Implications**

6.1.1 The report above sets out details of significant implications in section 3.1.

6.2 **Procurement/Contractual/Council Contract Procedure Rules Implications**

6.2.1 There are no significant implications within this category.

6.3 **Statutory, Legal and Risk Implications**

6.3.1 Adult Early Help provide part of the Council's preventive services which enable us to meet the requirements set out in the Care Act 2014.

6.4 **Equality and Diversity Implications**

6.4.1 There are no significant implications but the following are areas to highlight:

6.4.2
- The Adult Early Help team work with all adults and across traditional client group boundaries including mental health and physical disabilities.

6.4.3
- Our individual, person centred approach starting from a question of what the customer wants to achieve lends itself well to a wide and diverse range of needs, preferences and views.

6.4.4
- We are starting to explore the possibility of Adult Early Help taking referrals from people with learning disabilities not known to the Learning Disability teams. This would remove our only access criteria that we have in place and ensure equality of access to the service.

6.5 **Engagement and Communications Implications**

6.5.1 The report above sets out the implications for this priority in 2.11 – self referrals and 4.15 Community hubs.

6.6 **Localism and Local Member Involvement**

6.6.1 There are no significant implications within this category.

6.7 **Public Health Implications**

6.7.1 The following points set out details of implications identified by officers:

6.7.2 • Adult Early Help are well placed to deliver public health messages.

6.7.3 • The team manager is a member of the Ageing Well Strategy Board. Through this we are able to contribute to development of key documents and approaches such as the dementia strategy.

6.7.4 • Our Senior Occupational Therapist attends regular meetings with NHS colleagues and contributes to strategic developments. An example would be the role out the new falls prevention pathway by including a simple falls assessment in our conversations with customers.

6.7.5 • Our work with individuals can highlight emerging and unmet health needs. An example of this is lack of support with the application of surgical stockings. We have experienced a high volume of regular calls from community nurses on about this and will be exploring what opportunities there are to work with health colleagues to meet need.

If any Member wishes to learn more about Adult Early Help or visit the team they are more than welcome to contact the team manager Stuart Brown whose contact details are: stuart.brown@cambridgeshire.gov.uk, 01480 373251.

Source Documents	Location
None	

Appendix 1 Adult Early Help plan on a page.

Cambridgeshire County Council

Cambridgeshire and Peterborough NHS Foundation Trust

Adult Early Help

Supporting people throughout Cambridgeshire by agreeing a joint plan to improve wellbeing, maintain independence and create sustainable long term solutions that reduce the need for long term care.

One phone call and assessment

Joint plan
I will, you will…

- Information and advice
- Natural support
- Reablement
- Assistive technology
- Occupational therapy
- Voluntary organisations

Our values

Quick response,
Tell us once,
Proportional,
Speak to others involved in support,
Safeguarding.

Person centred,
Agreed goals,
Outcome focused,
Empowering,
Focus on strengths,
Creative solutions.

Our Priorities

Ensure our customers are at the centre of our work.

Deliver and champion the Transforming Lives approach,

Establish a skilled and effective multi-disciplinary team,

Establish good communication with other professionals and partners,

Reduce handoffs and improve the customer journey,

Reduce overall costs to the social care budget.

Reducing
Dependency
Long term care
Hospital admissions
Waiting times

Increasing
Independence
Choice
Control
Wellbeing

Adult Early Help Team 01480 373440

Appendix 2 Adult Early Help case studies.

Case study 1 - Taking a personalised approach to requests for social care

A daughter contacted our Adult Early Help team. She was caring for father and was beginning to struggle. Both are from Poland and speak very little English. Her father had a bellow knee amputation shortly after his wife died and moved in with his daughter. He is left alone during the day and gets lonely. He had applied for pension credit but after 2 years and various issues including language difficulties and not having a National Insurance number this remained unresolved. He was struggling with his personal care and they wanted to find social care to help with this and keep him company in the day. They did not have the money to afford this themselves.

Our Polish speaking Adult Support Coordinator spoke to the family and arranged a home visit with one of the Welfare Benefit Advisors on the team. On the visit they supported an application for Pension Credit and Attendance Allowance. Issues around mobility were identified including accessing the small bathroom and a poorly adjusted walking frame. The daughter explained that her father was unable to leave the property due to steps to the front door and also could not access any upstairs rooms due to steep stairs. They wanted support to apply for a social housing move. The father really enjoys gardening but he cannot access this in the current property.

A second visit was set up with our Adult Support Coordinator and an Occupational Therapist on the team. They supported to translate some benefit letters that had been received in response to the claim. They also took some information on local Polish community groups for the family to contact to help with social isolation. Our Occupational Therapist adjusted the walking frame and the father was able to use it better. They also carried out a bathing assessment for bathroom equipment and a home assessment to support their housing application.

The father now has attendance allowance and pension credit. He and his daughter have been in touch with a local Polish community group who will be sending a befriender to visit. Bathing equipment has now been delivered and the father is able to manage his own personal care with minimal support from his daughter. The family have been prioritised for ground floor housing and they hope to move to a more accessible property with a garden soon.

The benefits of the person centred approach taken by the Adult Early Help team for requests for social care support can be seen in this case. Rather than carrying out an assessment based on need our team took a holistic approach, looking at the wider situation and listening to the customer and daughter about what was important to them. We were able to break down the language barriers and ensure they received individualised help. Issues they had been struggling with on their own for 2 years were resolved and they now have an opportunity to move to much better suited accommodation that will further reduce the likelihood of their needs escalating, thus preventing the need for further interventions.

By providing information on local community groups the risk from social isolation can be avoided. We are not only linking communities through steps like this but also raising the quality of support the individual receives and giving them choice over their support options.

A direct cost saving can be seen in the use of bathing equipment instead of commissioning care and clearly demonstrates the advantage of the use of Occupational Therapists in supporting assessments where there is a request for social care.

Case Study 2 - Taking a personalised approach to potential carer breakdown

Our Adult Early Help team received a call from a GP concerned about carer breakdown for a patient who cares for her husband with autism. We called the wife and she explained how she was "At the end of her tether" coping with her husband's hoarding, refusal to engage with support and debts. She had been drinking heavily to cope and had a fall which was when she realised that she needed help.

We carried out a home visit and it became evident that the husband was collecting and storing magazines. He would regularly subscribe to part works and was building up considerable debts. He and his wife agreed they needed support and would like to free up some disposable income. They also explained that they could not afford their Direct Debit from their energy provider so were not heating their home or water. The wife was concerned about her husband's health, he was not engaging with community nurses who were trying to treat his ulcerated legs. She was also concerned about the fire risk from all of the collected magazines. These issues were all causing her distress and she wanted to feel more in control of her life with a more positive relationship with her husband.

We supported the couple to contact and cancel 12 magazine subscriptions saving over £100 a month. We then contacted their energy company who found a mistake on the account that had set the Direct Debit to high. This was reduced freeing up a further £175 a month and a £2000 rebate was agreed. We supported the couple to speak to their bank and they arranged for their account to need both to sign to set up any further payment agreements.

We made a referral to the fire service who visited and installed new smoke detectors and gave advice on clearing the house.

Through 4 follow on calls we encouraged both to communicate positively with each other. The husband accepted advice to take the support of his community nurse and he is now getting treatment for his ulcerated legs. They were using their energy rebate to hire a skip and were beginning to clear their property. They have also booked a holiday and the wife now feels as though she is in a much better place to carry on supporting her husband.

This case was very motivating for the member of staff involved and the team as a whole. By taking the approach we did and focusing on enabling the couple to continue to live independently without support from others we were able to deal with what was important to the couple rather than the immediate presenting needs.

For the couple it provided a timely intervention that enabled them to focus on each other rather than the chaotic lifestyle that they found themselves in. By freeing up income and putting some checks in place to avoid repetitions of the issue the couple are better placed to help themselves and take time to enjoy themselves and what is important to them.

Case study 3 - A proportionate and timely assessment with Occupational Therapy support

Our Adult Early Help team was contacted by the daughter of a gentleman, Mr P, who needed emergency care. Her mother and father live in annex to her property and over the past year his health has been deteriorating. She explained that her father was unable to talk due to vascular dementia and that he also has Parkinson's disease. She and her mother shared lasting power of attorney for her father's finances and wellbeing.

She explained that her father was very unstable on his feet, he falls regularly, at least once a month and that as her mother has been with him on her own she has found it very difficult to lift

him. Following the last fall they set up a door bell to call through to the main house if help was needed.

She went on to explain that her family have been supporting with her father's personal care with her mother leading on this. He was totally incontinent, and it often needed two people to change him and always needed two to shower him. Her mother would use the bell to call for help as she does not feel she can leave Mr P alone to come to the house to ask for help. When helping him to the toilet it took two people to stop him slipping into the bowl.

Both her father and mother enjoy spending time with her and her husband. Her husband will stay with her father so that she can take her mother out shopping and for a break. Her father is usually able to move around with a walking stick but recently he has had to borrow a wheelchair from a friend to get to the doctors.

Our senior Occupational Therapist and the Adult Support Coordinator who took the initial contact carried out a joint visit. At this time Mr P was unwell and had been diagnosed with a chest infection and high blood pressure. He was unable to get out of bed or sit up unaided. This was making personal care and managing continence very hard for the family.

They found that his dementia was causing difficulties communicating. He was able to communicate using single word answers and by pointing and through this agree to things his family were saying and support options offered.

They assessed the home environment and advised the family not to use their shower as it was not suited to two people supporting someone. It did not lend itself to equipment so they discussed strip washing using a perching stool as a safer alternative. They discussed a profiling bed that would be beneficial supporting with personal care particularly when Mr P was unwell.

From our assessment it was clear that a joint social care and carer's assessment was needed. The family were asking for care in the morning and also respite care so that they could take their mother on holiday. With their agreement we made a referral to our older person's team.

We suggested that we make a series of immediate referrals that were agreed and included:

- Our Occupational Therapist agreed to:
    - Make a referral for physiotherapy assessment to look at current lack of mobility and wider general mobility.
    - Order a combined toilet seat and frame to help with toileting.
    - Order a perching stool to help when strip washing.
    - Through the community therapy teams order a profiling bed.
- That we would speak to the GP and ask for:
    - A review to be arranged from the Parkinson's nurse.
    - A referral for Speech and Language therapy.
    - A referral to wheelchair services to source own wheelchair.
- We provided information on the services provided by Parkinson's UK including local support networks. The family agreed to make contact and seek further advice and support.
- Through our Assistive Technology team a bed sensor linked to a pager were put in place to allow the wife to spend time in the main house and return if Mr P got out of bed.

Based on detail of our initial assessment and the immediate referrals made for equipment our social care team were able to directly commission care. They will complete a full social care

assessment once care is in place and they are able to assess long term needs following recovery from current illness.

Key outcomes and benefits of our intervention include:

- It is likely that this initial assessment with a focus on support, advice and Occupational Therapy input will provide a long term benefit both in terms of quality of life and also allowing for an appropriately commissioned and focused care package to be set up.
- The support and reassurance provided to the wife and family will enable them to spend more quality time together and reduce the risk of carer breakdown and more costly interventions. Additionally the equipment provided will allow them to retain independence throughout the day and safely support Mr P.
- There was a communication barrier caused by the father's vascular dementia that initially provided difficulty in assessing over the phone. By using a home visit and taking the time to speak to and engage the father he was able to contribute to decisions about his support.
- This type of joint visit not only allows us to make full use of the knowledge and skills of our Occupational Therapists in requests for social care but also allows our wider team to build their understanding of therapy solutions that will benefit future cases.
- For the family they received a timely, wide ranging and holistic assessment and although a therapy assessment may have been requested if this had proceeded directly to the long term teams without our intervention this would likely have taken time to arrange potentially resulting in a less joined up approach.
- The benefit of the combined approach was clear in the ability of our social care teams to commission care directly from our assessment reducing handovers, delay and ultimately allowing us to get care put in place quickly to support the family and avoid a carer breakdown and crisis.