West Northamptonshire Council

People Overview and Scrutiny Committee

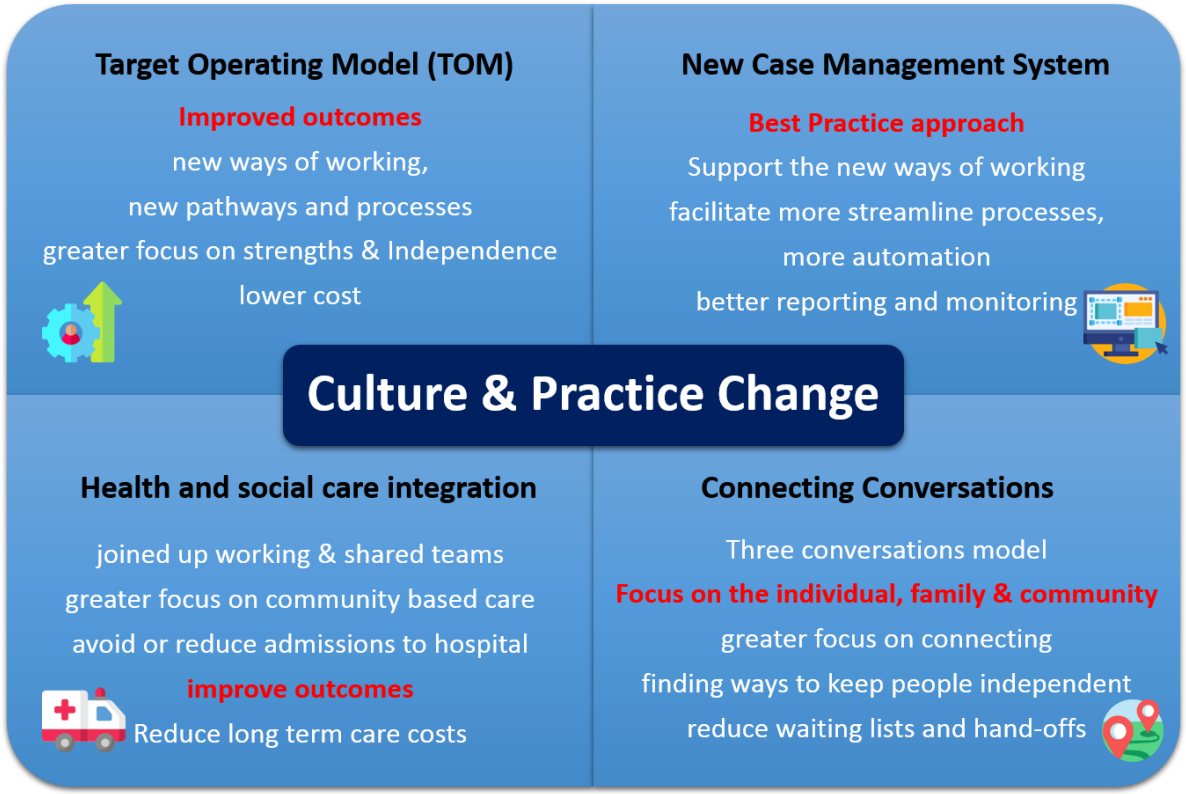
Adult Social Care – Target Operating Model

16th November 2021

TRANSFORMATION

OVERVIEW

- Adult social care commenced its transformation journey in 2019 and has been making significant changes.
- There were 4 key elements to the transformation programme, focusing on culture and practice change;
  - Working closely with our Health colleagues to reduce the reliance on bed base pathways in our system and to support people in the community instead
  - Redefine our social care practice model, focusing on the person and their independence, truly listening to them and working with them to achieve their ideal outcomes, supported by adopting the three conversations model
  - Developing and implementing a new case management system to support our new way of working
  - Building all of our changes into a new Operating Model that will ensure better outcomes for the people of Northamptonshire and create better working environments and practices for staff. This gives our service the autonomy that it needs to deliver a high quality service achieving fantastic outcomes for our people and releasing financial savings in the process
- Safe and legal – ensuring that adult social care in both unitary authorities can carry out all of it's statutory duties and operate safely from 1st April 2021



TRANSFORMATION

OUR JOURNEY TO EXCELLENCE

COUNCIL EXCELLENCE
2020-2021

- Redesign our TOM to maximise independence for people
- Focus on what we can directly control within the council decisions and influence
- Make our pathways simple and clear
- Move to a community based model
- Strengthen our links to the community and third sector

COMMUNITY EXCELLENCE
2021-2022

- Working as 2 unitaries
- Shape the market and work more strategically with Partners, third sector and the community
- Tailor services to our people's needs in each area
- Reach out and blur roles & responsibilities with partners to best support our people

SYSTEM EXCELLENCE
2022 ONWARDS

- Fully integrated across Health, Social Care, Partners, community services, and third sector
- Excellence achieved for all people across the system
- Further changes and improvements linked across the system

West Northamptonshire Council

Diagnostic

CURRENT OPERATING MODEL – SUMMER 2019

THE NEED FOR TRANSFORMATION

- The way the service was set up did not make sense to our customers and stakeholders and their feedback (via Healthwatch) was that we were taking too long to do some things, the service was confusing with many hand-offs and they wanted to have a dedicated social worker who knew them and stayed with them.

- Our processes and structure were also designed at every level to test, screen-out or process people based on a "computer says" model. Our social workers have been bound by an embedded practice or "bureaucracy" becoming the "border police" of eligibility criteria for one destination or the other – if you were Eligible you need formal social care and if you are not eligible then we took no further action. If a person had another crisis or something changed the process would be repeated

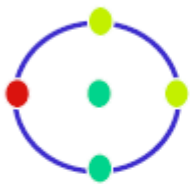
- The result of this was that people who contacted us were moved through the services by a series of referrals, hand-offs and allocations based on pre-determined view of the potential answers. The outcomes they got were also not consistent between social care staff. As they were passed between teams and lead workers and requests would also sit on waiting and pending lists at each stage.

- 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. We needed to work 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.

ASSESSMENT METHODOLOGY
RIGOROUS, EVIDENCE BASED, PRIORTISED

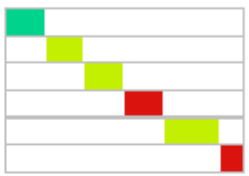
The rigor of the evidence and insight produced focuses on the level of potential improvement across outcomes, savings and staff engagement identified, as well as the understanding of the complexity which will need to be the basis of any implementation programme.

Pathway Workshops



- Front line practitioners actively participating in the collaborative review of live cases
- Focus on their existing setting, but also back through their pathway to this point.
- Explore potential for improved outcomes

Live Studies

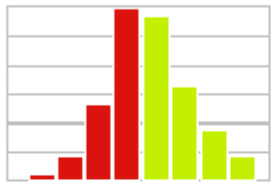


- Spending time directly at the front line with staff, shadowing activity and ways of working,
- Develop understanding of the issues constraining performance
- Supplemented with tick-sheets and surveys as appropriate

Discussions with Local Teams

- Leverage and augment the expertise that already exists within the organisation
- Testing our findings and hypotheses continuously with your team to make sure that we are all 100% aligned and bought-in to the output

Historical Data & Benchmarks



- Analysing data from core operational systems and wider sources, such as formal and informal excel spreadsheets
- Understanding baselines, trends, patterns and variance

Change Readiness

- Workshops, interviews and surveys to give a wider base of direct input
- From the leadership to the front line – as to the current culture and readiness for change across the service and wider organisation
- Vital insight in shaping implementation

Evidence: Prioritised Opportunities

- Multiple conversations with joint team to triangulate evidence
- All aspects of the assessment activity inform the understanding of the biggest areas of opportunity and critical 'levers' which can be tackled to effect improvement

WHAT ARE THE OPPORTUNITIES FOR OUR SERVICE USERS

OP WA

IDEAL OUTCOMES

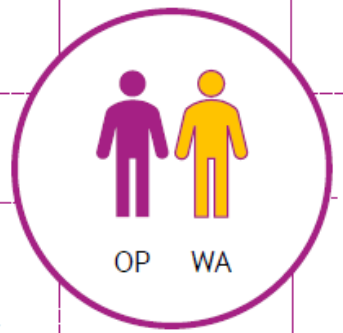
48% of customers could **receive support which is more ideal** to match their care needs

89% of our support plans **don't have SMART goals** or outcomes

MAXIMISING INDEPENDENCE

1600 customers per year **could be supported to maximise their independence**

38% of customers who finished reablement **could be more independent**



MARKET ENGAGEMENT

55 Days is the average waiting time for customers going onto a home care package

16% of our visits to service users is due to **resolving provider issues**

PATHWAYS & PROCESSES

3400 of service users are **overdue an annual review** across all our teams in the council

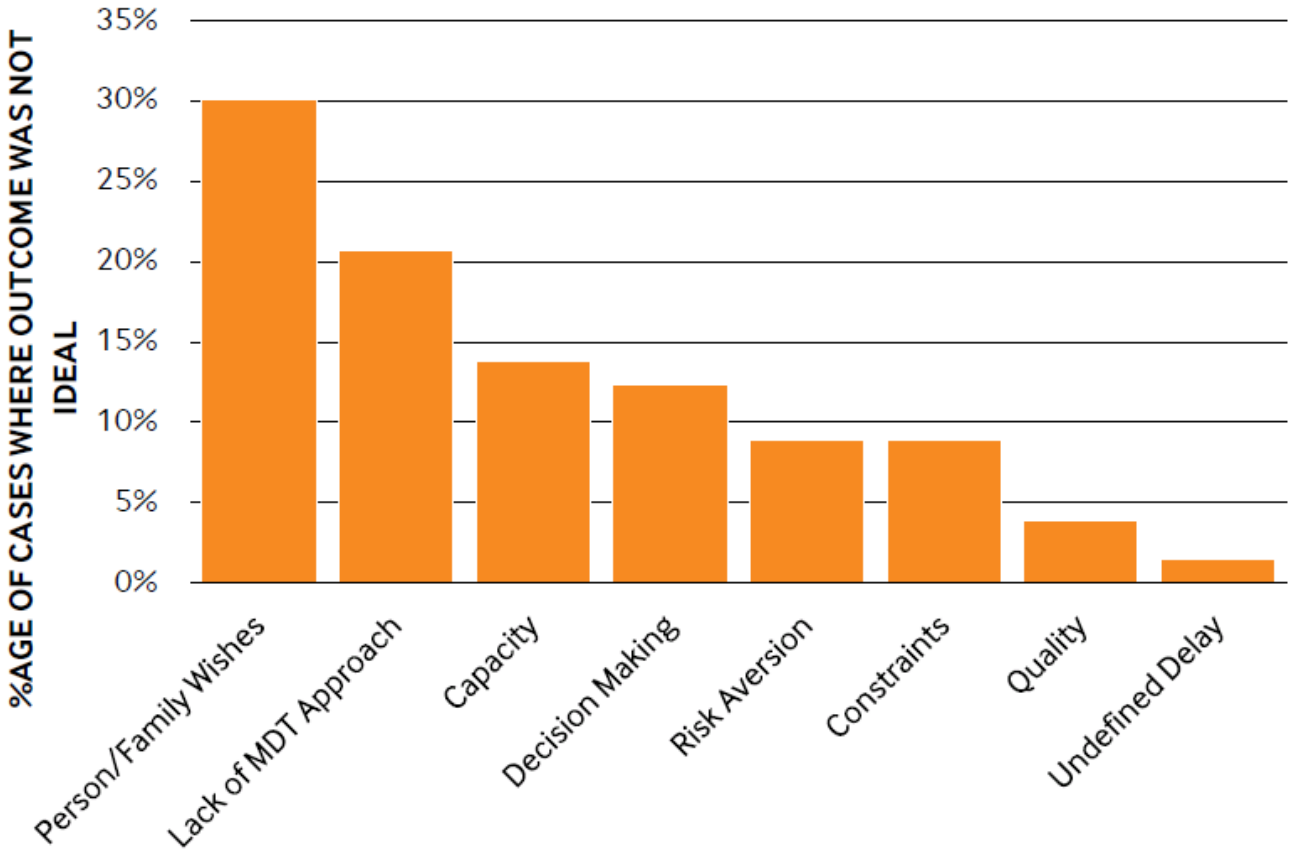
8% of our practitioner time is spent face to face with service users or their family

IDEAL OUTCOMES 1
MAXIMISING INDEPENDENCE 2
PATHWAYS & PROCESSES 3
MARKET ENGAGEMENT 4

COMMUNICATIONS & ENGAGEMENT A
CAPABILITY & TRAINING B
ORGANISATIONAL BALANCING & UNITARIES C
TECHNOLOGY & SYSTEMS D

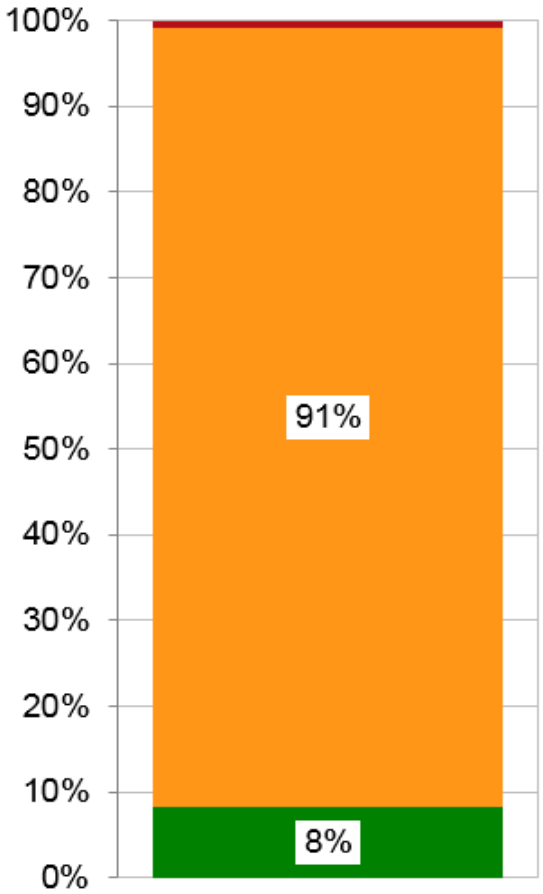
DECISION MAKING PROBLEMS

- The main reasons for non-ideal outcomes are:
  - Individual / family wishes
    - Not having agreement on "what is an ideal outcome"
    - Not having the confidence to challenge the individual / family wishes
  - Lack of MDT approach
    - No MDT approach across community
    - Current MDT approach in acute not working
  - Perceived lack of capacity
    - Specifically within reablement



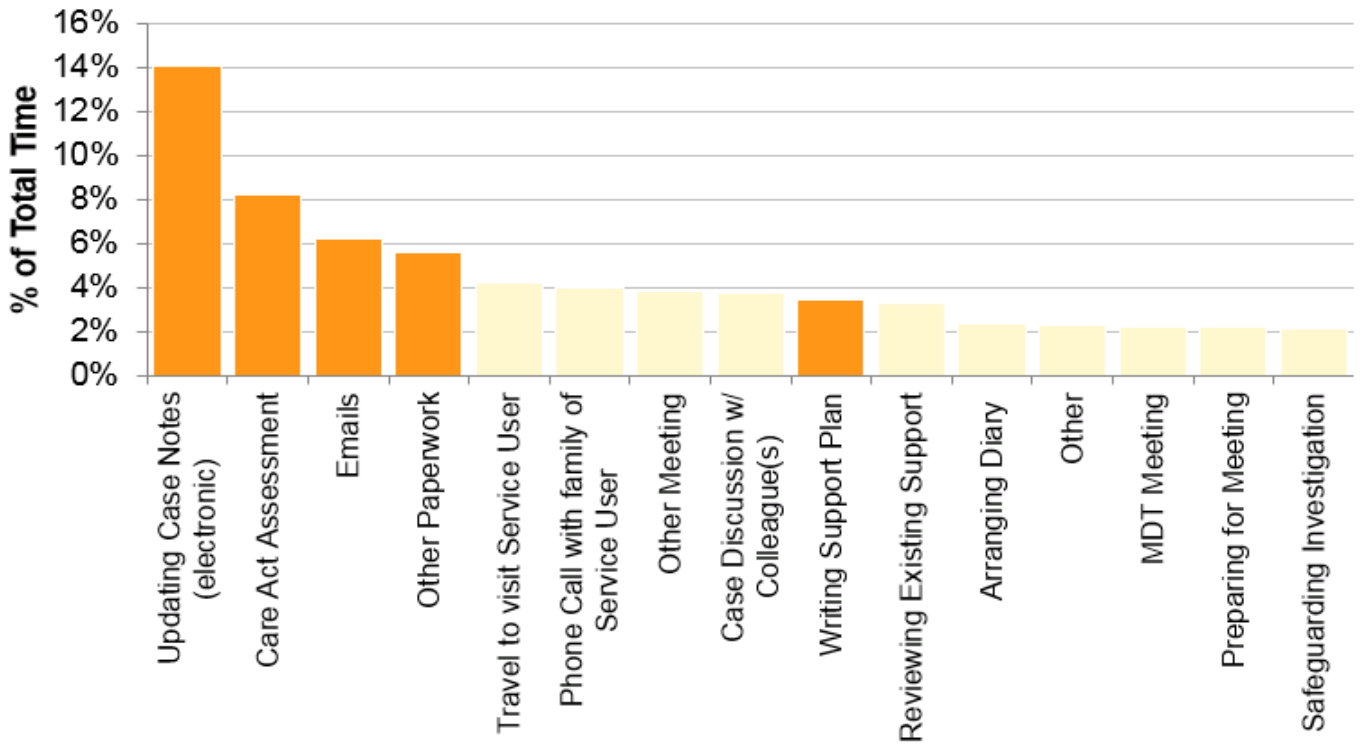
HOW DO WE AVOID OUR MOST COMMON TIME NOT SPENT WITH THE SERVICE USER? – OLDER PERSONS

Click to add subtitle



This is **over 5 times more** than the time we spend with SUs and their family

42% of our OP workers time is spent doing paper work or emails



Time spent with our service users/families

Essential time spent outside of contacts (eg writing case notes)

Non essential time spent outside of contacts (eg unsuccessful visit)

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Design

OUR VISION FOR EXCELLENCE

OUR MISSION IS TO MAKE THE BEST USE OF THE AVAILABLE RESOURCES TO KEEP PEOPLE IN NORTHAMPTONSHIRE SAFE AND INDEPENDENT

Our people want to live as independently as possible, but sometimes they hit a crisis and reach out to us for support. We will be **easy to get in touch with**, and always **have a conversation**.

We'll **think differently** about how we support them through their crisis, and increase their links into **communities, charities and family**. Where we **connect people to services** we'll 'stick like glue' to make sure everything works out.

People will **tell us their story once**, we'll **listen** to **their problems** to make sure we really **understand what they want and need**.

If people need ongoing help we'll **think creatively** to design the support they need, and once they're settled we'll check in to make sure it's **working for them**. We'll also get in touch annually to make sure the right options are in place.

SIMPLE, TIMELY PATHWAYS - LOCAL SUPPORT - MAXIMISING INDEPENDENCE

PROGRAMME OVERVIEW –

50% of our working age people aren't achieving the best outcomes for them at the moment

INCLUSION

Our working age people have different access to community services

INCLUSION

660 additional people could be supported to maximise their independence each year

REABLEMENT

FRONT DOOR — **AX / REVIEW** — **SHORT TERM SERVICE** — **CARE PACKAGE**

47% of our older people aren't achieving the best outcomes for them at the moment.

ACUTE AND COMMUNITY IDEAL OUTCOMES

3,400 people are overdue an annual review

PROCESSES AND PATHWAYS

It takes on average 55 days for our people to access a home care package

BROKERAGE

COMMISSIONING

(2) FRONT LINE LED DESIGN

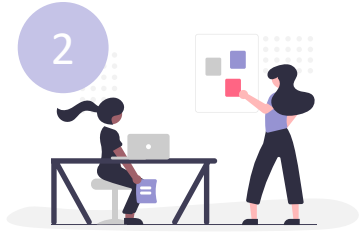
- New ways of working developed by practitioners
- Tested and evidenced to deliver the outcomes that we desired

designing the change

1

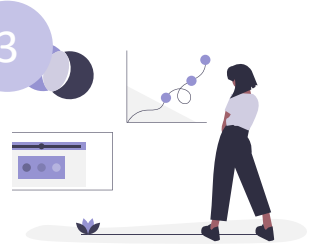
We started out by appointing **design leads** - talented, inspiring people from our front-line teams who we trusted would, with the right support, design changes that worked.

2



We ran **workshops** with front line staff to shape our initial design, then **trialled the changes** in small teams running regularly feedback sessions with staff.

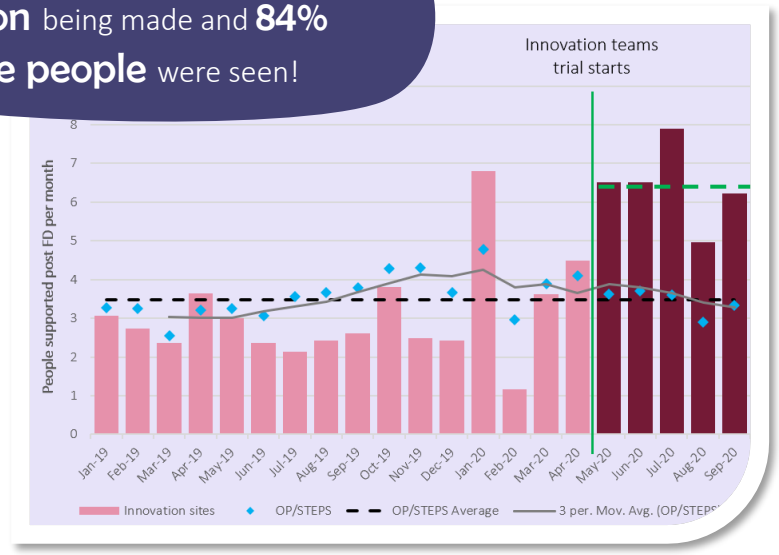
3



To ensure the changes had made difference, we captured data to help us measure **staff engagement** and **team performance.**

"It feels like we're finally being listened to." Care Manager
"This is refreshing and a change to the way changes have been introduced before" Social Worker
"Absolutely know we are going to transform the system" Service Manager
"We've had the social worker beaten out of us for too long and I think this is going to be a real opportunity to get back to that again" Social Worker

Through the community trial teams we saw **30% more independent decision** being made and **84% more people** were seen!



"It's thanks to the facts and figures that we're able to have these conversations" Team Manager

"Wow we have never had access to data like this, it's going to be so valuable" Team Manager

Some design results...

(3) ADOPT, EMBED AND SUSTAIN

- New ways of working completely embedded as BAU by everyone in the business

Training & documentation

100%

believe that the new way of working would support more timely outcomes

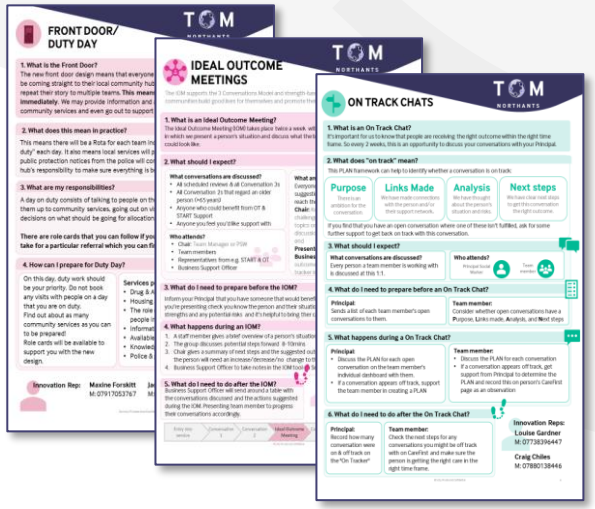
The changes proposed will help us achieve better outcomes for people of Northamptonshire?

95%

of people enjoyed the training sessions

... despite most of it being online

I am excited to start!



My Team is AMAZING. I feel listened to as a worker, there is organisation amongst the team and our team manager and now new service manager are very supportive and most importantly approachable.

I think the new way of working is going well in my team and everyone is very positive. We have a good team of staff who are positive and who are happy to learn together.

Engagement & support

WORKING WITH OUR PARTNERS

It is important for us to work with partners to achieve the highest quality service and best outcome for our residents. Our new ways of working are established on the principle that we break through organisational barriers and build professional relationships to make this easy, this includes;

- Getting to know our communities. We will be organised around our communities and actively build relationships with local providers and services such as volunteer groups, community groups and parish councils

- We will have direct links for partners such as GPs and the Police to our teams helping to build their understanding of our service and ours of theirs. Picking up the phone will be the default than a system referral form

- Relationships and service development with Health is a priority and will be further developed through active engagement with the system transformation programme "Integrated Care Across Northamptonshire"

- As we enter into our new unitary authorities we will focus on building the relationships across our departments, increasing the feeling of one team and one authority

"I just wanted to say a huge thank you to the Innovation team, you have been a god send and assisted me greatly in my role as a Housing Officer. You have made it easier to support my tenants and provided essential advice and assistance when I have had cause to make contact."

LOCALITY TEAMS

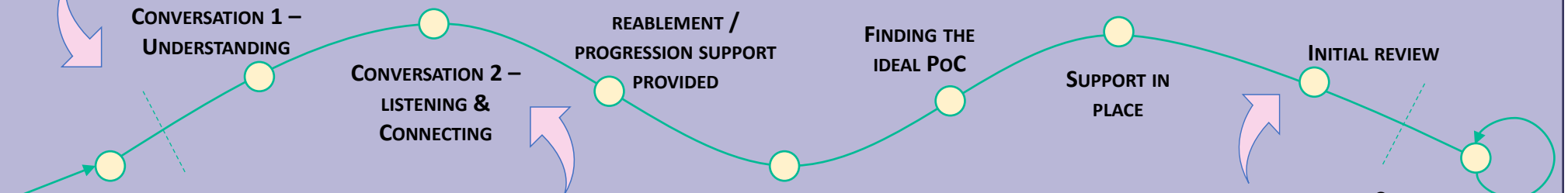
HOW WILL THIS FEEL FOR THE PEOPLE?
People will be connected to their communities, and supported to the most independent outcomes possible for them in a timely manner, through conversations that focus on their strengths

COMMUNITY

LOCALITY TEAMS

People don't have to wait to have a Conversation, and the person who has your Conversation 1 remains your point of contact throughout

Everyone who is able to benefit from reablement or progression in order to live a more independent life will do so



We will have strong links to the community which will support each individuals independence

Everyone will receive an initial review once they are in a package of care to ensure that it is right for them

The initial conversation with the council is more personal, and ensure that we don't turn anyone away who can benefit from our support

We aim to resolve people's crises, connect them to the community and find them their most independent outcome

People will regularly receive a review to ensure that they are still in the best package of care, and if there are any changes having the right conversations to understand how we meet these new needs

OUTCOME

HOW WILL THIS FEEL FOR OUR STAFF?

FRONT DOOR | AX / REVIEW | SHORT TERM SERVICE | CARE PACKAGE

Strengths-based mindset:
We know that the most effective way to make someone independent is not to care for them but to support them to reach their goals by themselves

Professionally curious:
We ask the right questions and challenge our assumptions to make sure we've got all the evidence we need to make the right decisions

Collaborative:
We work together with our people and their families, our teams, & our communities and partners to achieve the right outcomes

Challenging:
We are comfortable both giving and receiving challenge on our work

Creativity:
We are able to work differently and be creative in coming up with goals and plans

Positive Risk Taking:
We feel supported to take appropriate risks

Evidence Based:
We capture and review information to identify our key challenges and areas of progress within our services

Valued:
Our staff feel like their efforts and results are recognised and their successes are celebrated

PROGRAMME OPPORTUNITY

Area	Summary of Opportunity	Target	Stretch
OP Decision Making	• Supporting more people in a more independent setting and better matching support to need using a strength based approach focusing on independence. • ***Target reduced areas of spend: OP Residential and Home Care***	£3.2m	£5.2m
Older People Reablement	• Increasing the capacity and volume of service users who can benefit from Reablement services, increasing effectiveness in the process to ensure maximum independence. • ***Target reduced areas of spend: OP Home Care***	£4.2m	£5.3m
WAA Decision Making & Progression	• Better matching support to needs using a strength based approach focusing on independence and by reducing the need for formal support over time • ***Target reduced areas of spend: WAA Home Care, WAA Direct Payments, WAA Supported Living***	£3.3m	£5.8m
WAA Moving on	• Supporting more young adults in a more independent setting outside of Residential care by identifying and supporting people to move settings • ***Target reduced areas of spend: WAA Residential Care***	£1.6m	£1.7m
Pathways & Processes	• Changing the daily activities of staff to enable an improved new ways of working meaning backlogs can be cleared and the required demand serviced without hiring more people. • ***Target reduced areas of spend: Cost avoidance on Staff spend***	£2.8m	£7.1m
		£15.1m	£25.1m

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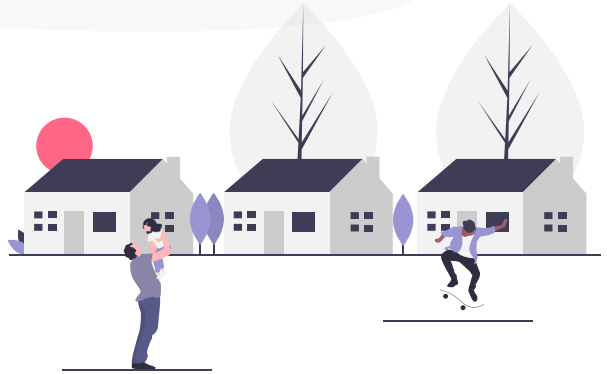
Implementation

PROGRAMME HIGHLIGHTS AS OF VESTING DAY

Over 600 NASS employees

have been directly involved in the TOM programme

50 Older people have avoided going to residential care in the 3 months since Christmas



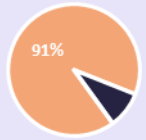
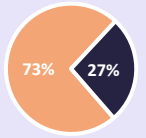
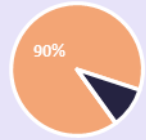
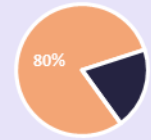
Over 4,500 people in Northamptonshire have already benefitted from the new ways of working

£2m cash has already been saved against the North & West combined MTFP target of £1.1m for the first year of the TOM

"What has been achieved during the last year given the national backdrop has been remarkable"

TOM SUMMARY OF OPERATIONAL PERFORMANCE

TOM NORTHANTS

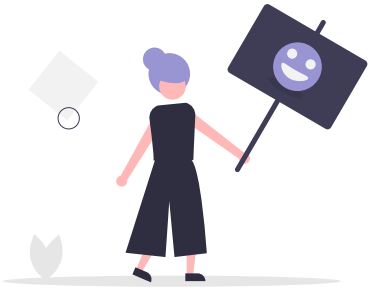
	Ideal Outcomes	Timely Outcomes	Adoption	Engagement
Older Adults Decision Making - Acute	% home from hosp: Target: 90% Current: 74% % home from D2A: Target: 25% Current: 58%	Hosp discharge time: Target: 2 days Current: 6 days D2A discharge time: Target: 21 days Current: 67 days	n/a	Do you believe the new ways of working will have a positive impact? 
Older Adults Decision Making - Community	Residential Target: 5.8 /wk Current: 2.7 /wk Homecare Target 243h Current: 239h	Target cases closed per active worker 2 /wk Current cases closed per active worker 1.4 /wk	Gold & Silver  Red & Bronze	Are you happy with the new ways of working? 
Reablement	Target effectiveness: 6.2 hrs/wk Current effectiveness: 5.4 hrs/wk	Target successful finishes: 46/wk Current successful finishes: 51.3/wk	Gold & Silver  Red & Bronze	Are you happy with the new ways of working? 
LD	Target increases: 4.5 Current increases: 5.2	Target cases closed per active worker 0.8 /wk Current cases closed per active worker 0.7 /wk	Gold & Silver  Red & Bronze	Are you happy with the new ways of working? 
Inclusion	Target increases: 4.9 Current increases: 4.8	Target cases closed per active worker 1.4 /wk Current cases closed per active worker 0.7 /wk	Gold & Silver  Red & Bronze	Are you happy with the new ways of working? 

REABLEMENT HIGHLIGHTS

Our assessment showed long waiting lists for reablement and fewer than 2 out of 3 people achieving their most independent outcome. Since then…

300+ more people are living fully independently

in Northamptonshire as a result of improved reablement support



500+ more people have benefited from reablement

in Northamptonshire as a result of improved progression through the Reablement service

People leaving reablement need 37% less formal support

As a result of more independent outcomes delivered through the new ways of working

"We have been given the tools to change the world"

- REABLEMENT TEAM MANAGER

"I would have ended up in hospital if it wasn't for your team"

- PERSON WHO RECEIVED SUPPORT FROM START

"All we've wanted to do is Reable people, but it's felt like we've never really had the opportunity…. Until now"

- START TEAM PRACTITIONER

COMMUNITY HIGHLIGHTS

Since adopting locality-based practice...

Over **50% more people** have been referred to reablement

In only 2 weeks after the rollout of the new CHC & CHRT teams, they have already supported **over 100 people**

On average, our workers are seeing **127 people for every 100** people they used to see

Safeguarding have successfully adopted new ways of working and processes with the community model

50% of people seen by the locality teams have **achieved a more independent outcome** than they would have previously – in line with our 2019 diagnostic

"I don't think I would be anywhere without the community team...they really supported me."

- PERSON WHO HAS BEEN SUPPORTED BY THE COMMUNITY TEAMS

"We're doing real social work! It feels like we can get out there and help people when they need our help. "

- TEAM MEMBER

"The new way of working 'works' and it is totally person centred and the best outcome is achieved."

- SOCIAL WORKER

"I like the huddles and IOM - It is quicker and more effective "

- CORBY TEAM MEMBER

West Northamptonshire Council

Post vesting day

PROGRAMME OVERVIEW

TOM NORTHANTS

28% of our working age people are having a more independent outcome

INCLUSION

Our working age people are **more closely linked** into their communities via their hub

INCLUSION

400 additional people are being supported to maximise their independence each year

REABLEMENT

FRONT DOOR → **AX / REVIEW** → **SHORT TERM SERVICE** → **CARE PACKAGE**

25% of our older people are having a more independent outcome

ACUTE AND COMMUNITY IDEAL OUTCOMES

900 more relationships are being close each year

PROCESSES AND PATHWAYS

FINANCIAL DELIVERY OVERVIEW

While the TOM is slightly overdelivering in the total annualised value of savings, the effectiveness and speed of delivery has meant that we are significantly ahead of our forecast delivery timelines as outlined in the MTFP.

Workstream	Savings to end of fy20/21	Savings this fy to P.5		Total	Status
Total TOM Programme	**£2m**	**£3.4m**		**£5.4m**	**– Ahead of target**
OP Resi	£55k	£164k		£219k	– Ahead of target
OP Homecare	£85k	£613k		£698k	– Ahead of target
Reablement	£967k	£999k		£1,966k	– Ahead of target
LD avoiding increases	£119k	£301k		£420k	– Ahead of target
PD avoiding increases	£483k	£692k		£1,175k	– Ahead of target
WAA decreases	£364k	£608k		£972k	– Ahead of target

TOM REVIEW EXECUTIVE SUMMARY

Successes

The new operating model is fully in place and the practitioners have really embraced strengths based working, 3 conversations and the community model

We are seeing significantly more independent outcomes for the people of West Northamptonshire

The new ways of working are meeting and in some cases exceeding initial forecasts

Challenges

Pockets of the LD teams have struggled to adopt the new ways of working due mainly to the inability to work with people face to face during COVID. This is a short-term barrier to better outcomes and some financial delivery

Productivity has been significantly improving over the last few months but is still slightly short of the nominated target

While volumes have greatly exceeded target, reablement effectiveness has only ever seen small improvements and should be a focus area now the teams have been successfully split and managers have accurate performance information for their services

Risks

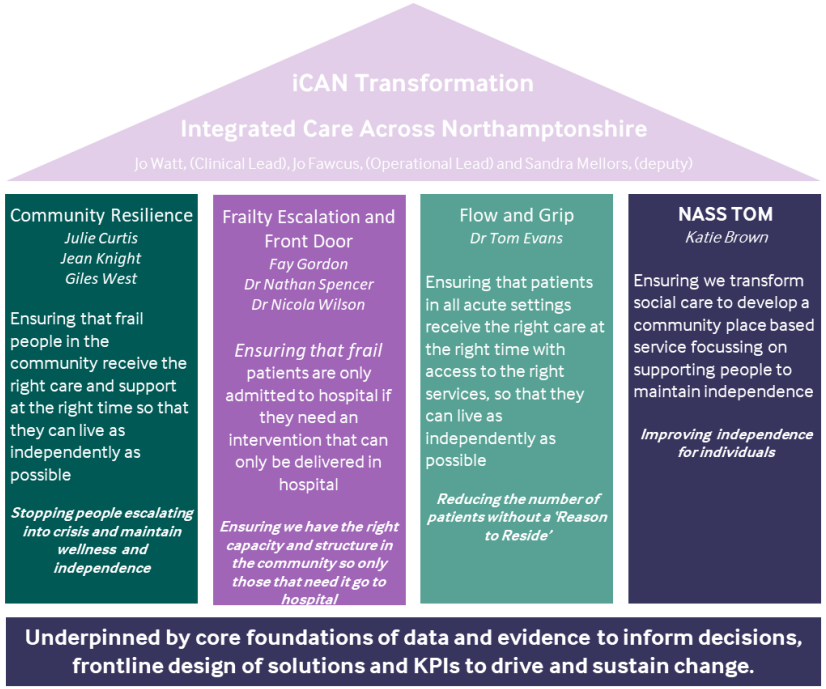
Volatility in the homecare market poses a long-term risk both in terms of flow and outcomes

The introduction of interim beds has resulted in an emergent budget pressure and preventing the need for these beds will be reliant on the successful delivery of ICAN

The full impact of covid and associated changes to demand will remain difficult to predict

LINKS TO ICAN

The ICAN programme presents West Northants with a great opportunity to build upon the successes of the TOM and further improve our performance as an authority



As the initial phase of TOM transformation has been completed, the key parts of ICAN which will link to WNC are Flow and Grip and Community Resilience

Community resilience links:

- Holistic care plans, welfare officers and frailty clinics supporting frail people in receipt of social care in the community
- Implementation or Care Home Directed Enhanced Service
- Remote monitoring in care homes
- Dementia hub model and falls pathway

Flow and Grip links:

- Modelling of how ICT best support pathway 1 discharges
- Discharge to assess and improved discharge decision making
- Discharge expectations

West Northants also has intrinsic links and can support the success of ICAN through the governance. Anna Earnshaw is the CEO sponsor for the programme, Stuart Lackenby is involved in regular update forums and Katie Brown and Amy Brock are the leads for those bricks led by the authority

NEXT STEPS FOR WEST NORTHANTS

To ensure the positive impact of the TOM is sustainable, it is important for the West to continue to develop and safeguard their offer for the future

Development of the TOM:

Building deep relationships and shaping our communities within WNC (housing) and the integrated care partnership, underpinned by the Health and Wellbeing Board strategy

Utilising governance and visibility of performance to always strive for improved outcomes

Working within ICAN to ensure excellence is delivered across the whole system