Short Term Intervention

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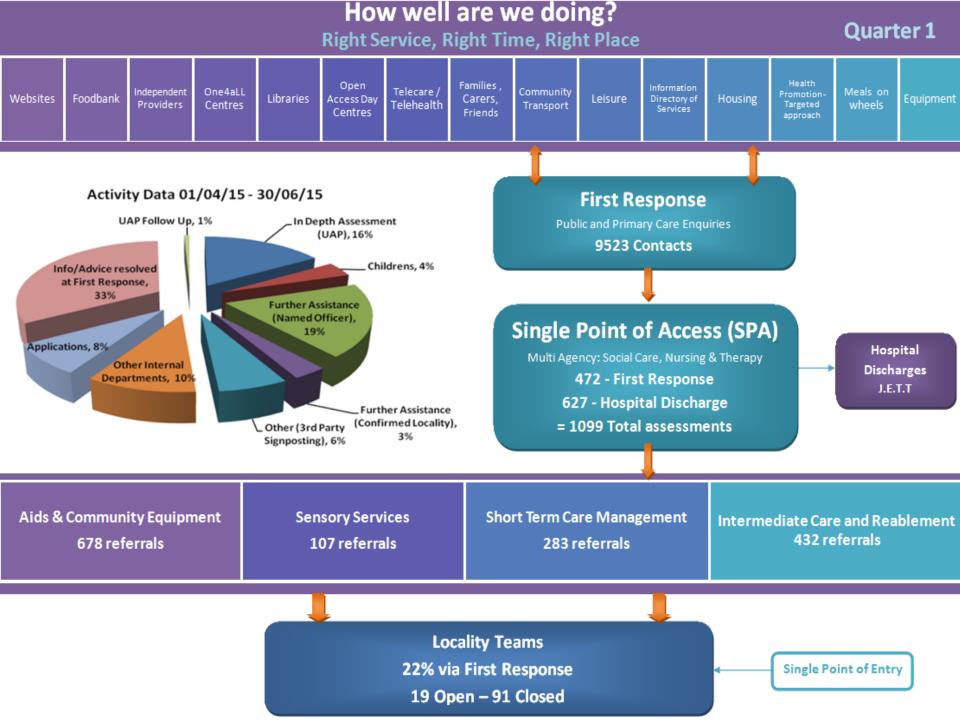
Short Term Intervention Service

- In partnership with Customer Care provide Information, Advice and Assistance to support people to help themselves
- Undertake a proportionate response
- Provide early intervention via preventative services to support independence and minimise the need for ongoing services
- Only those people whose needs cannot be met in any other way are managed by long term social care service.

Outcomes

- Reduce number of adults referred to a statutory service for assessment
- Reduce number of long term services





Short Term Intervention Performance

- Adaptations and Community Equipment (ACE)
- •80 % assessments completed on time current performance 88% All referrals allocated in under 56 days

Year	Ave. No. of people on waiting list	Ave. days taken to allocate
2013	706	78
2014	140	33
2015	172	23
2 nd 1/4	408	43

- Sensory
- •80% of assessments completed on time current performance 86% All referrals allocated in under 56 days

Year	Ave. No. of people on waiting	Ave. days taken
	list	to allocate
2013	174	80
2014	114	53
2015	111	47
2 nd 1/4	51	26



Short Term Intervention Performance cont.

Single Point of Access (SPA)

- Triage all referrals within 24 hours
 - 100% achieved over the past 2 years

Short Term Care Management

- No waiting lists in place over 2 year period the service received approx 2,300
 assessment requests, a waiting list has been operational on two separate occasions
 for 1 week on each occasion. In total only 35 people waited over 1 week for allocation
 of a worker for assessment
- Target of 80% of assessments completed on time over the past year 94% completed on time

IC & R

- 3 year WG outcome target set 1278 people access a Reablement Service
 - 2013/14 1424 people
 - 2014/15 1582 people
 - 2015/16 Quarter 1 405 people
 - 90% of people felt they achieved their goals



Short Term Intervention Performance cont.

IC & R continued

65% independent of services at the end of service

- Since April 14 between 75 81% independence levels achieved
- Of those who left services independent any return to social care is tracked
 - 3 mths later 68% remain independent of services
 - 6 mths later 58% remain independent of services
 - 12 mths later 50% remain independent of services

What does this mean for the person and the Council?

- Independent of service provision is able to continue as previously without reliance on formal service
- Cost avoidance previously services would have been commissioned
- Less reviews in the system



How do we know?

Escalation process

- To minimise risk an escalation process in place to ensure all referrals triaged and responded to in a timely manner
- Use of team resources rotate staff to other areas of service under pressure or reassign work throughout the team (therapists to risk assessor/ care manager to risk assessor/rotation with ACE/ seniors and managers work at SPA)

Issues logs

• Team maintain an issues logs where all members of the teams are encouraged to add any problems, issues or concerns to the issues logs. These are then reviewed 2 weekly at the managers meetings and actions taken recorded. Any trends or unresolved issues are reported to the Head of Service.

Databases

• Any issues which appear to have trends a separate database is established to monitor until the effect of the trend can be established then appropriate actions taken to address.



How do we know?

- Performance information
- Electronic performance books at team and individual level
- Trend data over a 1 year period for IC & R
- Service user satisfaction surveys
- Quality assurance audits of assessments, observations of practice
- CSSIW reports for direct services no regulatory requirements over the past 3 years
- RCT IC & R service in partnership with SSIA produced a resource document to support other areas to establish a Dementia Reablement Service



How can we improve things further?

- Understand and evaluate the impact of the new Social Services and Wellbeing Act
- Continue to work on changing the culture with our staff and residents of RCT
- Continue to monitor performance and refine service provision
- Evaluate the effectiveness of equipment provision over a 1 year period
- Build on current model of service provision
- Establish a formal partnership agreement with CTUHB for an integrated @home service



Proposal for an integrated @home

