Additional Information Requested

Health Improvement Service, 14 September 2022

Expanding the Community Led Support Pathway into step-down support

There is not much detail provided as to the measurement and evaluation plan. Please could more specific detail be shared?

The following performance monitoring indicators will be used to evaluate the impact of the project:

- Reduce waiting times or overall waiting list for social care assessment accessed through the Centre of Contact – this data will be collated and reported by the ASCCT Manager
- Number of adults diverted from the Contact Centre as recorded through Liquid Logic
- Improved adult satisfaction self-reported and recorded on Liquid Logic
- Collecting adult's experiences will evidentially inform if adults are getting the right support and the right time by the right people in the right place.

Data will be collated and analysed by an Evaluation Officer over the entirety of the project, this will be both qualitative and quantitative in nature, measuring the impact of the initiative upon the efficiency of the service, and also the impact upon resident's experiences of social care. The evaluation will seek to understand and find examples of what makes a difference to people in helping them to stay independent and well. This will include undertaking an analysis of case study data, and well as a small number of follow up semi-structured interviews where consent has been given by the service user. The evaluation will be undertaken by an Evaluation Officer based within the City Council, alongside the NDTI (National Development Team for Inclusion) who are undertaking the evaluation and develop work for the Salford NCA Community Led Support programme.

Is this truly innovative? How does this differ from the previous roles it appears to be extending?

The idea of placing a Health Improvement staff member within a multidisciplinary team to provide wellbeing support and access to community led and VCSE assets is no longer, in itself, innovative as the service has worked within a variety of multidisciplinary teams and as part of numerous neighbourhood based pilots over the previous decade. However, during the Covid pandemic there were additional pressures within SRFT to speed up discharge and as such the organisation embedded and stepped up these support pathways. The Homefirst Rapid Discharge Hub formally acknowledge the importance and impact that community led support can have in helping people to stay independent and well by committing financial resources to this on long term basis.

Overall the support required within the model with the Homefirst Hub can be short term and practical in nature and based upon a secondary prevention model, however the work which will developed with the Adult Health and Social Care Contact Centre (outlined in this bid) is likely to require longer term support to help people to remain independent, as well as to be more deeply rooted in people's neighbourhood. This approach is based around a model of primary prevention in the sense that the focus is based around preventing people becoming unwell and requiring higher level, and more costly intervention. In this sense, the project we are requesting funding for is innovative as it has new features, it if further advancing the current model developed in the Homefirst Hub, and it will require creative new approaches towards integration based upon a primary rather than secondary model of prevention.