Adult Social Care Annual Report 2015/16 (Local Account)

Coventry City Council

www.coventry.gov.uk

Contents

Cllr Faye Abbott

Foreword

Cllr Faye Abbott – Cabinet Member for Adult Services

I am pleased to introduce our sixth Annual Report for Adult Social Care. The Annual Report has been written so that local residents, service users and carers can understand more about the support provided by Adult Social Care, the key areas of progress we are making, and the challenges we face.

I am also proud to be Cabinet Member for Adult Social Care, an area where it is possible to have a hugely positive impact through providing personal and practical support that helps people live their lives.

2015/16 has been a very significant year for Adult Social Care nationwide. The Care Act was introduced on 1 April 2015 which heralded the biggest statutory change in Adult Social Care for 60 years, this change has brought both new challenges and new opportunities to consider how we support people.

Of course our work is challenging, the resources available have reduced significantly in recent years yet the demands on us continue to grow. I am however committed to ensuring that we continue to support our most vulnerable people in a way that makes a positive difference to their lives and the lives of the people who support them.

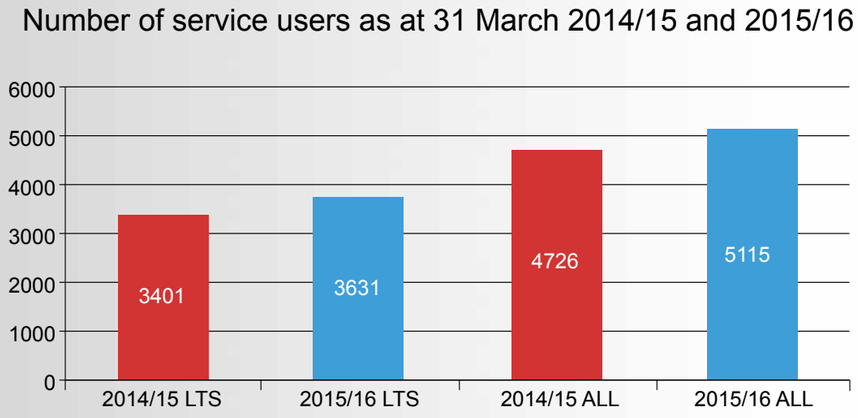
Introduction: About Adult Social Care

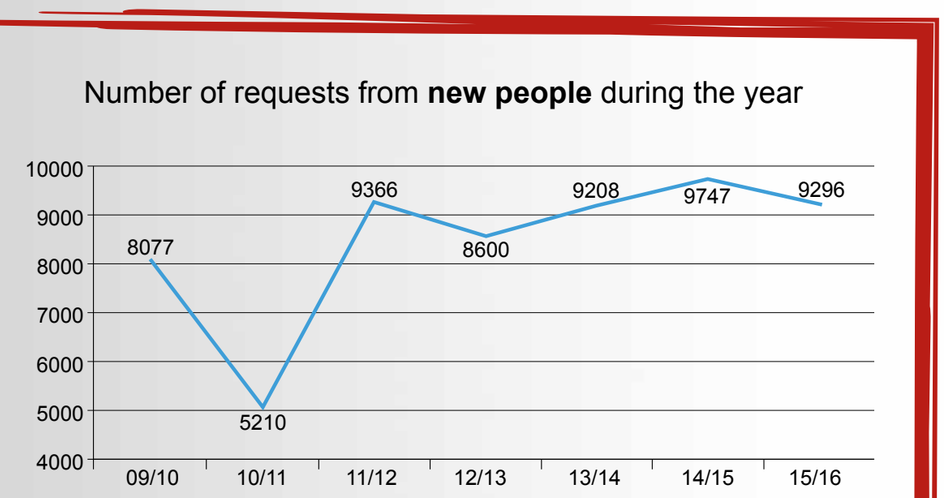
Adult Social Care is part of the People Directorate at Coventry City Council. The People Directorate vision is to 'work in partnership to improve the life chances of all and protect the most vulnerable'

Adult Social Care supports people aged 18+ who have a range of care and support needs because they are getting older or have an illness or disability. Support is also provided to people who are looking after someone else. Adult Social Care is about providing personal and practical support to help people live their lives.

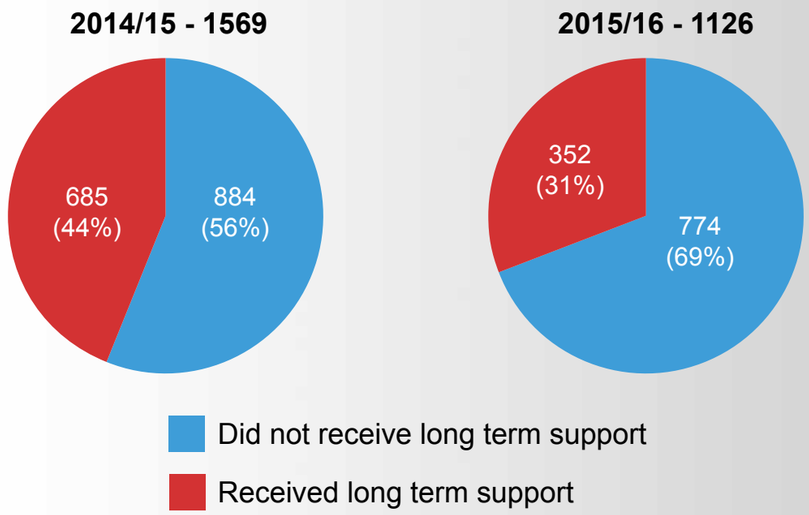
The Care Act 2014 came into force on 1 April 2015 and the primary focus in 2015/16 has been on embedding the changes to practice and policy required by the Act. These included improvements around when people first make contact with us, in how we assess people and plan their support. The focus throughout is on promoting wellbeing and independence; to prevent, reduce or delay the need for long term support and to enable people to achieve their agreed outcomes.

Facts and Figures





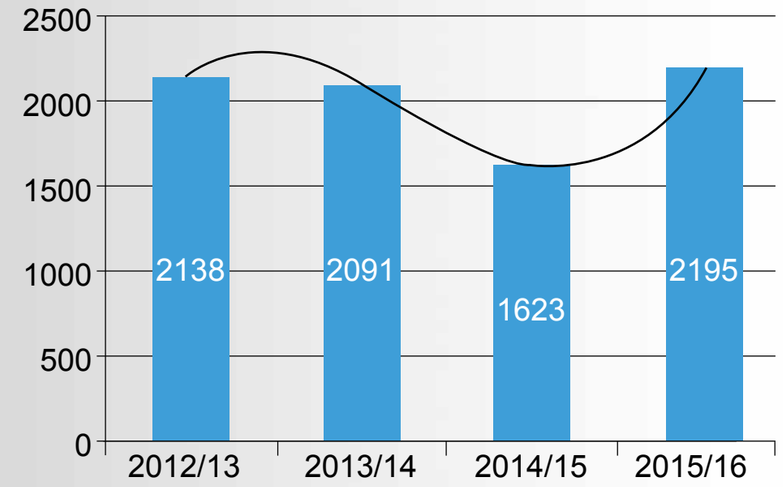
Number of **new people** whose request resulted in a period of **short-term support** (to maximise Independence)



The number of requests for support from new clients has remained relatively static over the last year although the number of people supported during the year has increased between 2014/15 and 2015/16. There has been an increase this year in the numbers of people receiving long term support (LTS). During the year, 1126 new clients received a period of short term support to maximise independence, following which 69% of people did not require long term support which is a higher percentage than the previous year. Despite this improvement in delaying or preventing the need for long term support, the overall numbers of people receiving Adult Social Care support is increasing.

The numbers of people receiving long term support from Black and Minority Ethnic (BME) communities has increased slightly from 12% as at 31 March 2015 to 13% as at March 2016.

Carers' Assessments completed during the year

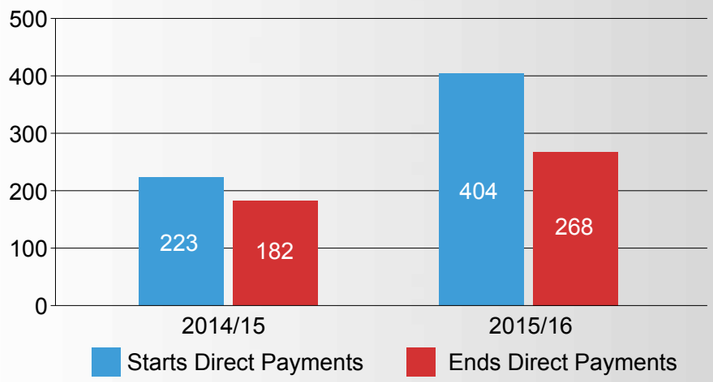


Supporting carers' to continue in their caring duties is an important role for adult social care. The above graph shows that overall the numbers of carers' assessments have remained relatively static over the last four years, with 2014/15 being an exception. Since the introduction of the Care Act in April 2015 we have commissioned the Carers Trust – Heart of England to undertake carers' contact assessments for newly identified carers. The support they provide is focussed on targeted prevention and early intervention which helps people find alternative means of support. Since the introduction of the Care Act there has also been an increase in the number of joint assessments completed by City Council staff.

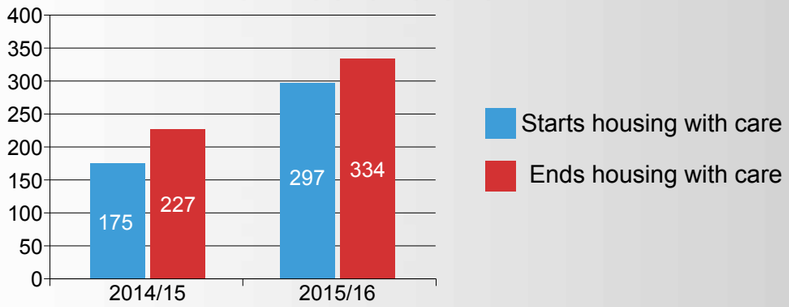
Adult Social Care Activity

The graphs below demonstrate activity levels across different types of support provided by Adult Social Care. In 2015/16 more people chose to take a Direct Payment and arrange their own care and support compared to 2014/15. This increase can largely be attributed to the cessation of the Independent Living Fund (ILF) where many people previously in receipt of ILF chose to receive a Direct Payment to meet their eligible care and support needs. The numbers of people receiving long term home support (home care) has remained static but fewer people ended their service during the year. Additionally people under 65 are receiving home support services for longer compared to 2014/15. More people are being supported in Housing with Care whereas the numbers of people being supported in residential and nursing care is decreasing compared to 2014/15. This indicates a positive direction of travel in supporting people in the setting that provides the most independence.

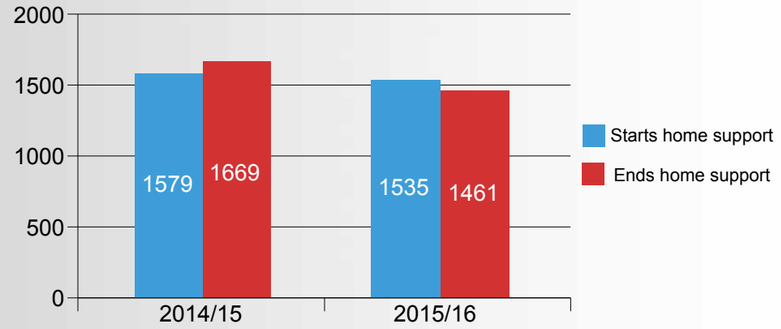
Direct Payments starting and ending during the year 2014/15 and 2015/16



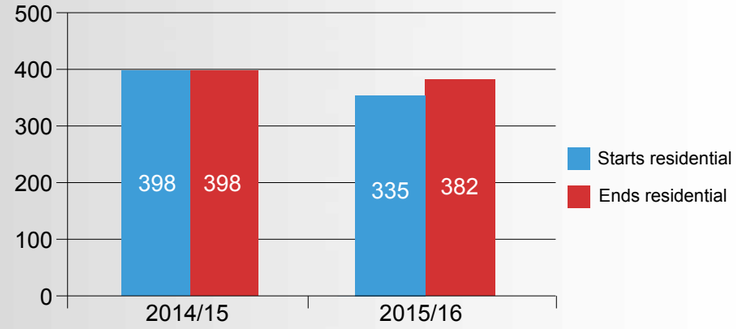
Housing with Care starting and ending during the year 2014/15 and 2015/16



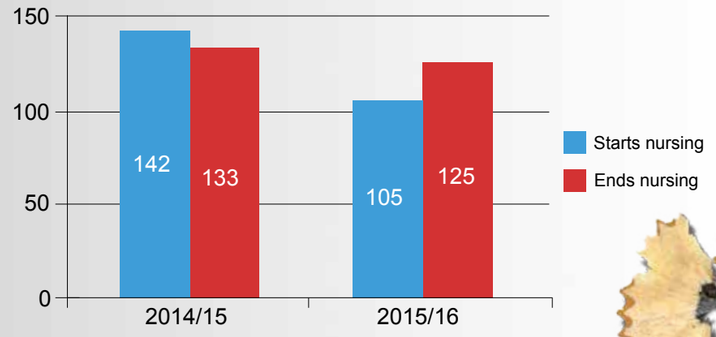
Long term home support starting and ending during the year 2014/15 and 2015/16



Residential care starting and ending during the year 2014/15 and 2015/16



Nursing care starting and ending during the year 2014/15 and 2015/16

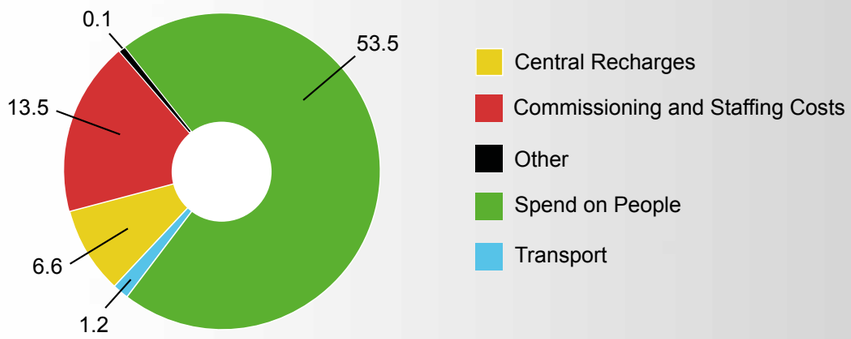


Money - Coventry City Council

The Council is a large organisation spending a net £239.7m on revenue activity during 2015/16 with Adult Social Care being the biggest single area of City Council spend at £74.9m net.

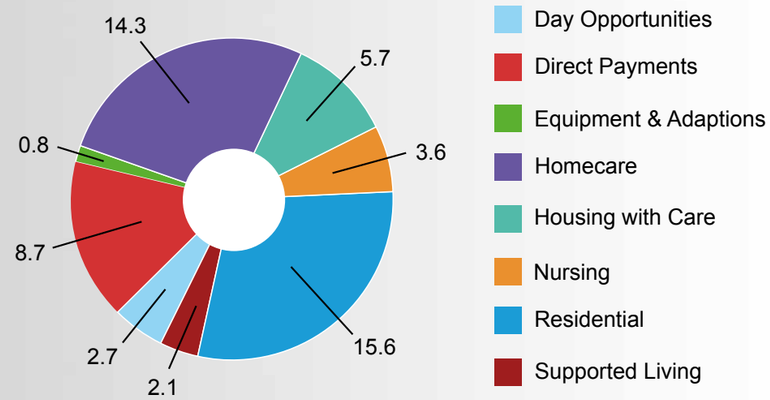
The breakdown of this spend for 2015/16 is shown below:

2015/16 Adult Social Care Net Spend (£74.9m)



The 'Spend on People' referred to in the previous chart has increased marginally from £52.7m in 2014/15. 'Spend on People is money spent directly on the following services:

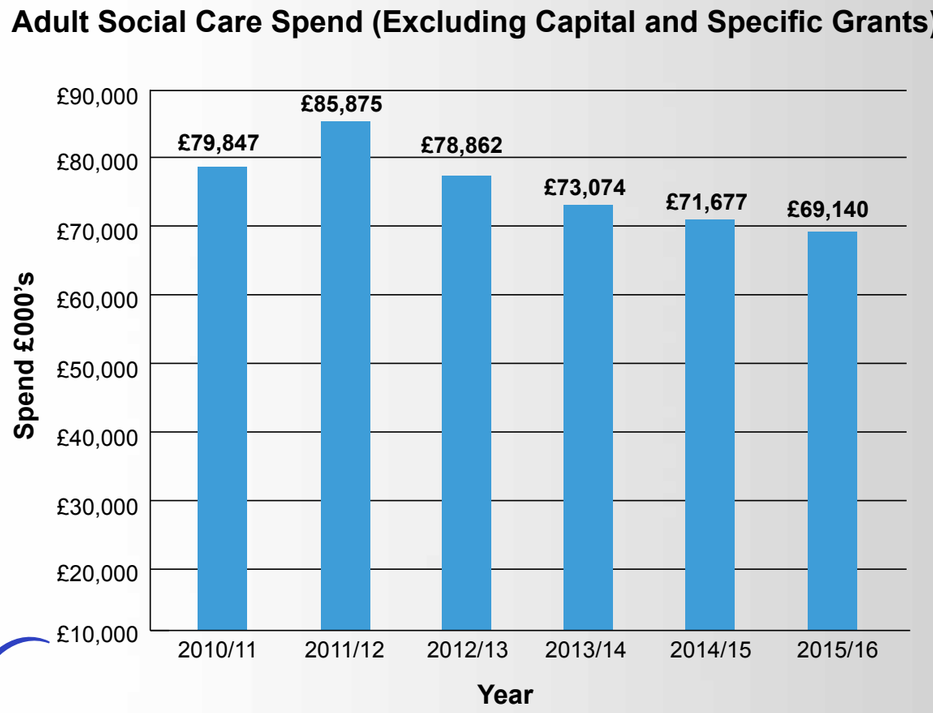
2015/16 Net Spend on Services (£53.5m)



Corresponding to changes in activity, the spend on residential care has reduced from £17.5m in 2014/15 to £15.6m in 2015/16, whereas the spend on homecare has increased over the last year from £13.5m in 2014/15 to £14.3m in 2015/16.

This is in line with the principle of supporting people to remain at home.

Since 2011/12 the total spent by the City Council on Adult Social Care has decreased each year as shown in the graph below:



Despite this decreasing spend the Adult Social Care budget was overspent in 2015/16 by £4.8m – This overspend is included in the above graph.

The fact that spend is decreasing whereas activity levels are increasing indicates that Adult Social Care is making good use of the limited resources available to meet the needs of people in the City.

Drivers of Demand

Understanding potential demand for Adult Social Care is important in understanding what is required to meet the changing needs of our population. Other key publications such as the Joint Strategic Needs Assessment (JSNA) helps identify future need, which is generally driven by a large number of factors, including an ageing population:

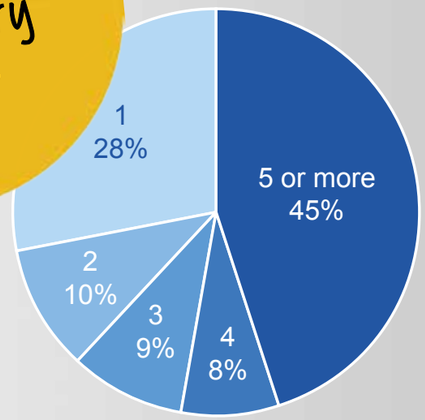
Population of Coventry

Age	2016	% of pop	2026	% of pop
Total population	341,000		381,000	
55-64	31,900	9.4%	38,200	10%
65-74	26,300	7.7%	27,800	7.3%
75-84	16,300	4.8%	20,400	5.3%
Over 85	7,400	2.2%	9,800	2.5%
Over 65	50,000	14.6%	58,000	15.2%

We can expect a general increase in the age of the population, particularly those aged over 75 (+9.8% by 2020)

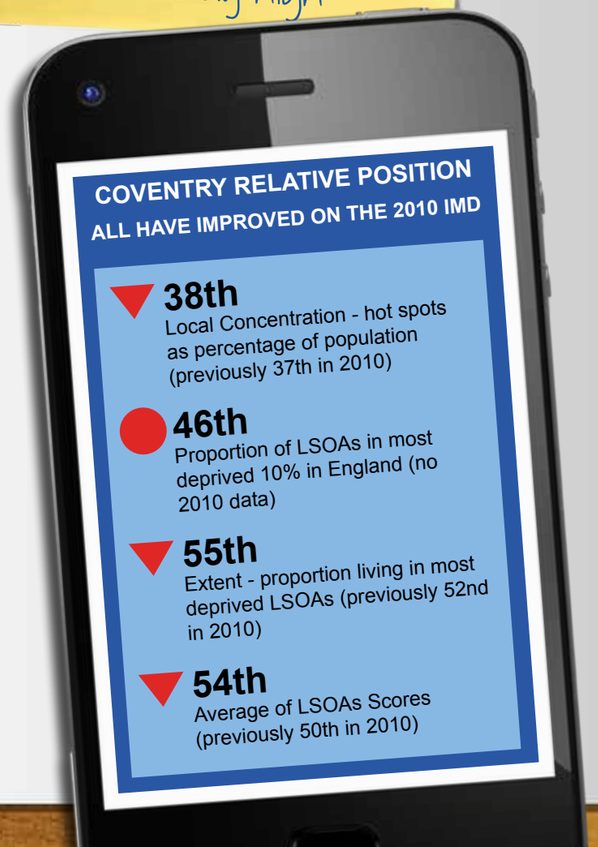
The numbers of people developing multiple health conditions and requiring support with 5 or more Activities of Daily Living (ADL's) is an indicator of who may require care in the future. ADLs are routine activities that people tend to do every day without needing assistance. There are six basic ADLs: eating, bathing, dressing, toileting, transferring (walking) and continence.

Number of ADL's in Coventry service users



Levels of deprivation in the city, although improving, remain relatively high

The Indices of Deprivation 2015 ranks all small areas in England according to different measures of deprivation and are the most widely used measure of deprivation. The small areas are called Lower Super Output Areas (LSOA's). The Index of Multiple Deprivation (IMD) combines all domains of deprivation; employment, income, health, education, crime, access to services and the living environment, to measure the level of multiple deprivation experienced by residents of neighbourhoods. Overall Coventry has improved marginally between the IMD 2010 and the IMD 2015.



Workforce

Between 2013 and 2015 the size of the City Council workforce in Adult Social Care has decreased. There were 1354 workers on 31 July 2013, 1222 on 31 July 2014 and as of 31 August 2015, there were a total of 1029 employees employed by the City Council in Adult Social Care. This workforce reduction has contributed to the continuing reduced spend as staffing is a major cost in the delivery of Adult Social Care.

It is recognised that many more people work in Adult Social Care outside of the City Council, employed in private, voluntary or third sector organisations. The national minimum data set (NMDS), the tool used to assess the overall size of the workforce estimates that 8,000 people are employed in the delivery of Adult Social Care in Coventry.

Key areas of progress since 2014/15

Since the 2014/15 annual account was produced we have made the following progress in key areas:

Implementing the Care Act 2014

Our objective was to:

To ensure that the Care Act principles of wellbeing, prevention and integration are embedded in everything we do.

Our progress includes:

The principles of wellbeing, prevention and integration are reflected throughout the information and advice we provide on the council website.

Further Care Act training has been run throughout 2015/16. To ensure that Care Act principles are reflected in day to day social work practice file audits are being carried out.

Adult Social Care staff now have access to a new online procedures manual which supports practitioner understanding and the application of Care Act principles.

It does need to be recognised that this work can never be considered 'done' as there is always more progress to make so we will continue to improve through 2016 and beyond.

Closer working with health organisations to improve outcomes

Our objective was to:

Work with our health partners to:

- extend the Integrated Neighbourhood Team (INT) pilot across the city (now known as Your Health at Home)
- ensure appropriate community based provision is available to enable people to remain independent in their own homes

Our progress includes:

During 2015/16 the Integrated Neighbourhood Team (INT) ('Your Health at Home') was implemented and is now providing a fully operational multi-disciplinary service operating across the city. The City Council is continuing to work with health partners to improve the support that INTs provide.

The 'Why not Home, Why not Today' initiative, a collaboration between Health and Social Care organisations, was launched to look at ways that frail, elderly patients can be assessed upon presentation at hospital to prevent unnecessary admission and enable appropriate care and support in the home environment.

Improve support for people with mental ill health and dementia

Our objective was to:

Improve the range of support provided in Coventry for people living with dementia and their carers

Our progress includes:

- development of Dementia Navigators service for Coventry
- implementation of an Admiral Nurses service for Coventry and Rugby
- books on Prescription for Dementia launched in libraries
- raising the standard of environment and care in some dementia care homes through training, advice and targeted work

Ensure that we using our resources effectively

Our objective was to:

Continue to work with people who use services, their families and carers, and partner organisations as we develop and implement plans that will enable us to continue to deliver Adult Social Care services within the resources available.

Our progress includes:

We have robust mechanisms for allocating resources demonstrated by the increased activity and the reducing budget for Adult Social Care outlined within the finance and activity sections of this report. We continue to work with people with care and support needs, their families and carers to plan support.

We have worked with The Carers Trust – Heart of England to support carers to access support at an earlier stage. The service is focussed on targeted preventative and early intervention support which are key principles under Care Act.

Key Achievements

This section of the Local Account provides evidence of positive work undertaken in Adult Social Care to evidence delivery against the six 'Think Local, Act Personal' (TLAP) 'Making it Real' statements.

TLAP 1) Information and Advice: having the information I need, when I need it

The standards that apply to this statement and progress made is as follows:

- **having the information and advice you need in order to remain as independent as possible**

We have:

Made our Care and Support Directory available on the Council website since April 2015. Between 1 April 2015 and 31 March 2016 there were 6445 visitors to the directory. http://www.coventry.gov.uk/careandsupportdirectory

Recognising that some people need more specific support, we have reviewed our advocacy services in 2014/15 to meet advocacy requirements under the Care Act. Age UK Coventry and Grapevine deliver this service for all adults aged 18 and upwards. All referrals for the service are made via Adult Social Care staff. During 2015/16 there were 249 referrals made to this service.

- **having access to easy to understand information about care and support which is consistent, accurate**

We have:

In 2015/16 the website content for Adult Social Care has been improved to support people to find all the information they may need about care and support.

Healthwatch Coventry considered the new website content a considerable improvement on the previous version.

Since September 2015 care and support for adults has been a 'top 10 task' and has contributed to increased usage of the webpages. This work was a key part of ensuring information and advice is available for the population of Coventry.

- **Knowing where to get information about what is going on in your community**

We have:

Made the Community Activities Directory available on the Council website since April 2015.

Between 1 April 2015 and 31 March 2016 there were 14,311 visitors to the directory.

In September 2015 there were over 700 groups and activities listed, since then it has grown and now has 1226 groups and activities listed. Many of the activities listed can support people to remain independent and enable them to maintain or improve their overall wellbeing.

Case Study 1 Having an Advocate Keith's Story

The difference that good information and advice can make:

Background

Keith lived in sheltered housing, but had a severe alcohol dependency which meant he needed support with daily living tasks. He also regularly displayed difficult behaviour towards both care staff and other residents.

Action

An Advocate was appointed when Keith was facing eviction from his home due to putting both himself and other residents at significant risk whilst cooking his meals. He was burning food and creating repeated fire incidents.

The Advocate was able to help Keith understand how critical the loss of both his tenancy and daily support services would be. The Advocate explained all the issues of concern and helped him to weigh up the impact of the options he was facing. The Advocate was able to listen to Keith's wishes and concerns and liaised closely between the client and his current support provider, successfully negotiating a withdrawal of their notice to quit for not complying with his current tenancy's health and safety regulations.

Outcome

Keith moved into a new, local, sheltered housing complex where he is supported with essential and daily tasks. He is extremely happy with his new home and, as a result, has formed a new and positive relationship with the staff. The former fire risks associated with his meal preparation were successfully addressed and Keith is now able to sustain both his tenancy and his independence for the long term.

Keith said, "I love it here! It's brilliant! Thanks for everything you've done."

TLAP 2) Active and supportive communities, keeping friends, family and place

The standards that apply to this statement and progress made is as follows:

- **having opportunities to train, study, work or engage in activities that match your interests, skills and abilities**

We have:

The Community Development Service has supported the development of a new group called Men Shed Project – 'a place to escape and relax'. This was initiated by a resident who had experienced mental health issues and wanted to help men in similar situations. The City Council helped him set up the group, recruit members, and organise activities such as art therapy, cooking and gardening classes. Many men are regularly using the project; six regular attendees from the group are now being mentored and supported to expand to other parts of the city. The project has also established a referral process with Recovery Partnership.

- **feeling welcomed and included in your local community**

We have:

The Community Development Service has worked with a local community activist in Willenhall to set up a craft club - Let's Get Crafty - which regularly has 12 older people attending.

- **having a network of people who support you – carers, family, friends, community and if needed paid support staff**

We have:

Been developing the new multi-agency Carers' Strategy for Coventry with partners in health and the voluntary sector which will be launched later in 2016 along with the first year's action plan. The focus of the strategy is to help us identify practical things that can be put in place to make a positive difference for carers of all ages.

The Carers Trust Heart of England continue to carry out some Carers' Assessments on our behalf, helping us to increase the numbers of assessments overall. This means that carers who may not have approached social care are now getting help at an earlier stage in keeping with the principles of the Care Act.

CASE STUDY 2 CARERS TRUST PHIL'S STORY

The difference that having a network of people to support you can make:

Background

Phil cares for his partner Steve who has limited mobility due to three previous hip replacements and is awaiting another. Steve is in remission for blood cancer and is always in agony due to extreme pain in his legs. Phil had a Carer's Assessment with Carers Trust Heart of England and discussed some of the problems he has been having. His main responsibility is to help/support his partner to be mobile.

Action

The Assessment Worker arranged for referrals to be made to Occupational Therapy and Wheelchair Services for equipment and a wheelchair to help them at home. Additionally the Carers Trust arranged for Phil to receive some training at home on moving and handling techniques and signed him up to the Carers Response Emergency Support Service (CRESS).

Outcome

Phil came in to tell us how his life was so much easier because he could take his partner out, whereas before this was impossible. Phil and Steve are more confident that Phil won't injure himself when supporting Steve following his training. Steve is now more independent and is able to wheel his own wheelchair which has allowed Phil to do other things. Phil feels more at ease going out and leaving Steve at home as he knows he can call for help if needed and the CRESS service back up gives him peace of mind should he have an emergency.

TLAP 3) Flexible integrated support: my support, my own way

This means:

- **having care and support that is directed by you and responsive to your needs**

We have:

Implemented the Dementia Discharge to Assess project which focuses on supporting people with a diagnosis of dementia who are discharged from hospital. The service, delivered in partnership with Carers Trust, works with individuals and their families to maximise a person's independence through a range of specialist interventions, including an Occupational Therapist and a Dementia Locksmith. The Dementia Locksmith uses their knowledge to unlock people's potential and unpick issues in their present experience of life.

Evidence from the Discharge to Assess Service indicates that people are able to be discharged from hospital and remain within their own homes following a short period of intensive support.

- **having support that is coordinated, co-operative and works well together and knowing who to contact to get things changed**

We have:

In January 2016, following a successful pilot, 'Your Health at Home Coventry' (previously known as Integrated Neighbourhood Teams) was launched across the city. The multi-agency service provides assessment and care planning support to older people with complex needs who require specialist levels of support in order to return them to their pre-event level of health and wellbeing and avoid unplanned admissions to hospital.

- **being in control of planning your care and support**

The Dementia Navigator Service commenced in October 2015 following a reconfiguration of services provided by the Alzheimer's Society. The Dementia Navigator Service provides access to a range of services to support people with their day-to day living, independence, wellbeing and to be part of the community for longer. This enables people to be in control of planning their support.

Case Study 3 Dementia Navigators Michael's Story

The difference being in control of planning your care and support can make:

Background

Michael was referred to the Dementia Navigator service from the memory clinic post diagnosis service at the hospital. Michael was experiencing great difficulty with disorientation during the night and was regularly trying to leave the house. Michael was attending a day centre which he did not enjoy as the people were older and frailer than him and were unable to interact with him.

His wife was finding it difficult to cope when her sleep was disrupted at night. She was becoming increasingly worried about leaving her husband alone in the house in order for her to take a break.

Action

The Dementia Navigator worked with them to arrange for an Admiral Nurse to support the family with specific difficulties coping with some of the symptoms of Michael's dementia. Michael was supported to explore different options of things to do in the daytime. He now attends an Alzheimer's Activity Group. Michael has been provided with a date/time clock which was mounted in his bedroom. This has assisted him in orientating himself at night, has led to less disrupted nights and minimised the occasions he has attempted to leave his home.

A carer's assessment has enabled Michael to access a short breaks service which allowed his wife to have a regular weekly break and continue her own hobbies.

Outcome

Michael is now enjoying taking part in daytime activities. Michael is continuing to attend groups and therefore be less isolated. Being able to manage his dementia better means he requires less support from social care and health services, and he will be less reliant on his wife who will therefore be more able to live her own life.

TLAP 4) Workforce (and awards): my support staff

This means:

- **having good information and advice on the range of options for choosing your support staff**

We have:

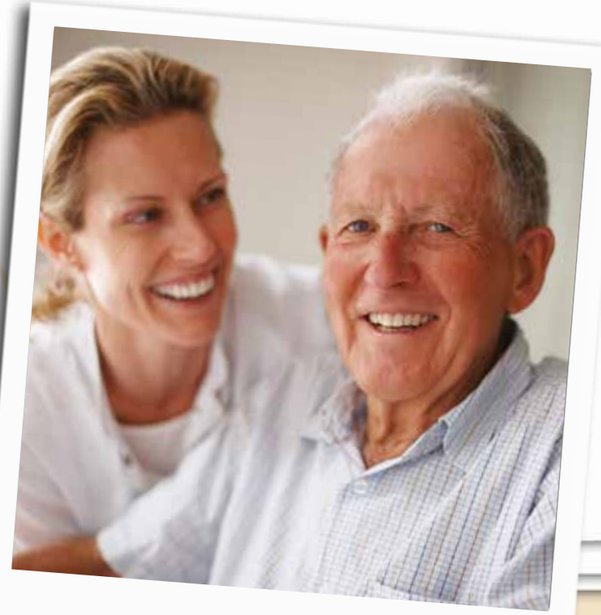
A Personalisation Champions group that provides a forum for sharing best practice, learning and the problem solving from individual cases. Additionally all assessment staff have received refresher training on Direct Payments that enable people to choose their own support staff.

Improved the website content for Adult Social Care to support people to find all the information they may need about care and support. This includes a Care and Support Directory which provides information about different care and support providers commissioned by the City Council.

- **being supported by people who help you to make links in your local community**

We are:

Developing a number of action learning sets to support staff to adopt personalised approaches, thinking creatively with individuals and their families when planning their support. These will also focus on maximising individual strengths and using networks of support and community resources to meet their care and support needs whilst improving their overall wellbeing.



Awards

The Pod, Food Union – Winner Community Cohesion Award (Public Sector Category) 2016

The ‘Food Union’, which is part of The Pod, supports people with their mental health recovery journey and their Food Union project (launched in 2014) has recently won a Community Cohesion Award. The awards celebrate projects which build upon the city’s heritage as a city of peace and reconciliation. In order to apply for an award your application needed to be endorsed by an independent person or group. The Food Union was endorsed by the Centre for Agroecology Water and Resilience at Coventry University.

Food Union was designed to create conversation, community and action around food with a focus on food growing from two sites in the city. The produce is shared out among participants and is used in community cooking events or regular ‘café takeovers’ where members can run the café at The Pod, devising and implementing a menu of their choice.

The Pod, Time Union – Finalist for national award

The ‘Time Union’, which is part of The Pod, was a finalist in the Municipal Journal Local Government Achievement Awards, and was shortlisted for the excellence in community engagement category. The Pod supports people with their mental health recovery journey and their Time Union project (launched in 2014) has inspired people in Coventry to exchange skills and develop interests and connections. The Time Union is a city wide time bank and is open to all adults in the city (18+). The idea is that people give an hour of their time in exchange for an hour back in return. The Time Union currently has over 80 members who regularly exchange their time and skills. Find out more at www.coventry.gov.uk/timeunion

“Time Union shows how local councils can back community time-banking without unduly imposing their outcomes or expectations on it. It feels a lot more like a piece of enabling social infrastructure, rather than a ‘public sector intervention’ into the lives of citizens and communities.” - Paul Slatter - Director, Time Bank Researcher, Chamberlain Forum

Finalist in the National Learning Disabilities & Autism Awards 2016

Sue York is a support co-ordinator who works within our learning disabilities day services, and she was a finalist in The National Learning Disabilities and Autism Awards in the category of “Frontline Leaders Award”.

TLAP 5) Positive risk enablement: feeling in control and safe

This means:

- **being able to plan ahead and keep control in a crisis**

We have:

Embedded crisis planning into our assessment and support planning process. The number of carers registered with the Carers' Response Emergency Support Service (CRESS) also increased. During 2015/16 170 more people registered for the service, an 18% increase on the previous year. During 2015/16 emergency call outs were slightly lower than in the previous two years; 41% of all call outs were to support someone caring for a relative living with dementia.

- **feeling safe, living the life you want and being supported to manage any risks**

We have:

Making safeguarding personal (MSP) is a shift in culture and practice in response to what makes safeguarding effective from the perspective of the person being safeguarded. It is about having conversations with people about how we might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life and wellbeing.

Work this year has focused on capturing the outcomes that people (or their nominated advocate or representative) want from their safeguarding experience. We will use data going forward to set targets for improvement both in ensuring outcomes are sought and achieved but also to ensure those without capacity have appropriate advocacy support.

- **Feeling that your community is a safe place to live and local people look out for you and each other**

The Care Act changed safeguarding terminology and safeguarding alerts are now called safeguarding concerns. In previous years Coventry has had a lower rate of reported alerts and referrals compared to other councils. However in 2015/16 the rate of individuals aged 18+ involved in safeguarding concerns, per 100,000 population, has increased to slightly above our comparators, as we received 2,009 safeguarding concerns for 1787 people in 2015/16.

The increase in concerns is not necessarily an indicator that more abuse is happening. However, it does indicate that awareness of adult safeguarding continues to increase across the local community and that people know how to raise an alert when they are worried about someone. The increase also indicates that we are appropriately capturing the activity we do.

The Coventry Adult Safeguarding Board produces an Annual Report and Business plan. Over the last year, the Board has published three serious case reviews. All of these reports are available on the Council website.
http://www.coventry.gov.uk/downloads/download/4367/annual_report_2015_-_16

TLAP 6) Personal Budgets and Self-Funding: my money

This means:

- **having the kind of support you need and knowing when, where and how to receive it**

We have:

Over the last year we have supported staff to undertake more creative support planning with individuals and their families which focuses on building on people's strengths and enabling people to connect and use community resources.

The overall aim is for individuals to have a person centred support plan which takes a holistic view of their life, supports improvement in their health and wellbeing and ensures identified care and support needs are appropriately met. Within the care and support plan people know, when, where and how they will receive their care and support.

A scheduled review also provides the opportunity to think differently about how care and support needs can be met. Recent examples have included:

- reviewing people in receipt of Independent Living Fund (ILF) and focusing on promoting their independence
- double-handed care reviews of packages of care where the individuals currently have two carers on each visit
- residents living in our Housing with Care schemes, that were due to cease providing care and support, were helped to move into alternative accommodation, which in some cases was within a less intensive care and support environment
- knowing the amount of money available to you for care and support needs and determining how this is used (whether it's your own money, direct payment, or a Council managed personal budget)

We have:

Direct payments are where people have money paid to them (or someone acting on their behalf) so that they can arrange their own care and support. During 2015/16, 404 people started a direct payment. This is an increase on the previous year. Some people tell us that they want more control of the money allocated to them to meet their identified care and support needs but not the responsibility of managing the money. We have been working on alternatives to respond to this feedback and in 2015/16 we have used Pooled Personal Budgets where a group of individuals pool some of their personal budget with others as part of how their support is delivered.

The difference a pooled Personal Budget can make:

Case Study 4 Pooled Personal Budgets - Nicola, Debbie and Sam's Story

Background

Nicola, Debbie and Sam are young people who have profound levels of learning disability with complex needs and challenging behaviour. Nicola, Debbie and Sam are friends from school. They were all due to attend College but their placements were not funded.

Action

Everyone involved in the assessment and support planning process recognised that Nicola, Debbie and Sam had good friendships with one another, had similar interests and support needs and lived locally to one another. They each required a robust package of support that would meet their complex needs (with some elements of 2:1 support) but it was also identified that some elements of their support could be shared and that they had previously been supported together.

The Brokerage Team were asked to find a provider who was able to provide support to Nicola, Debbie and Sam and be willing to include some hours of shared support for them to spend time together as a small group. A provider was found and currently provides 10 hours of shared support a week.

Outcome

The provider devised a varied and vibrant activity planner that reflected the individual needs of Nicola, Debbie and Sam and met their individual outcomes. The impact of pooling a personal budget has meant their friendship could continue after leaving school and that they are able to access community based activities.

What's next - Key areas of development for Adult Social Care 2016/17

The work of Adult Social Care is a process of continuous change and improvement as we strive towards delivering support based around the individual and their carers within the resources we have available.

The key areas we are developing in are:

Using technology to make it easier for people to find out about Adult Social Care

We know from our recent Adult Social Care Survey in March 2016 that some people are still struggling to find information to help them.

We are currently developing a new information portal called the 'Adult Social Care Information Directory' with the option for people to complete an online self-assessment. On completion of the self-assessment tailored information and advice is provided based on the answers that have been entered. It is hoped this will enable more people to find the information and support they need without requiring a formal social care assessment.

The new portal will combine both the Care and Support and the Community Activities Directories into a single directory. It is now possible to create a 'shortlist' of information that people can save or print for future use. The Directory will be available in Autumn 2016.

Supporting people to meet their outcomes at the earliest opportunity

Since the Introduction of the Care Act in April 2015 professional social work support has been introduced to our Customer Services Centre meaning more people contacting the City Council have their outcomes met at first contact. We want to improve how people arrange to see us so are intending to implement a calendar booking system for people to book appointments online.

Staff working in the Customer Services Centre and across Adult Social Care will be able to use the new information portal to enable people to plan their support and meet their outcomes.

Improving the market for key support services

Market sustainability and quality are key elements of effective social care and as social care is constantly evolving the market needs to change. Specific areas of focus for this year include working with relevant stakeholders to ensure that support provided in the voluntary and third sector makes a clear contribution to supporting people through alternatives to social care. We are working with our colleagues in the Coventry and Rugby Clinical Commissioning Group to ensure that both our home support and residential and nursing markets are delivering positive outcome for people that require this support. These priority areas will be aligned to strategic objectives and continue to ensure continued compliance with Care Act requirements.

Developing our approach to carers

A new Coventry Multi Agency Carer's Strategy has been developed by representatives from across Health and Social Care and the voluntary sector.

A number of local key improvement areas have been identified based on local carers' feedback:

- develop and implement a Carers' Charter
- clarify pathway for carers and simplify processes for registering and signposting carers
- increase information and access to support through GP surgeries
- develop support for young adult carers in relation to education, training and employment

Ensuring that support to carers is aligned to these priorities will be fundamental to ensuring these strategic intentions are delivered.

Developing our capacity to deliver more personalised support

We will be implementing an Individual Service Fund (ISF) pilot in order to determine our ISF offer going forward. An ISF is where people can use their personal budget from the Council to pay for support (such as home care) from a particular provider, the money can be held by that provider in an Individual Service Fund. People remain in control of what the money is spent on, but don't have the responsibility of managing the budget themselves.

We will be developing more consistent mechanisms for engagement with people with care and support needs and their carers. A stakeholder personalisation reference group will also be established to ensure we are listening to those that are ultimately impacted on by what we do.

Working with health partners to deliver a sustainable health and social care economy

Sustainability across health and social care is a key challenge. The Better Care Fund (BCF) plan is committed to investing more in community provision to reduce the reliance our patients have on acute hospital services, and empowering our population to look after themselves better and seek alternatives to hospital through improved signposting and awareness of more appropriate services to care for their needs. These steps help with sustainability but on their own will not be enough. Therefore engaging fully with health partners through the Sustainability and Transformation Programme (STP) is a key priority to help ensure that long term sustainability and improvement is delivered across Health and Social Care.

Glossary

This section provides an explanation of some definitions and terms that appear throughout this document.

Long-term support (page 4)	Any service or support which is provided with the intention of maintaining quality of life for an individual on an ongoing basis, and which has been allocated on the basis of national eligibility criteria and policies (i.e. an assessment of need has taken place) and is subject to annual review.
Wellbeing (page 4 and various pages throughout document)	Wellbeing is a broad concept, relating to many areas including: personal dignity, physical and mental health and emotional wellbeing and/or protection from abuse and neglect.
Short-Term Support to Maximise Independence (page 6)	Support that is intended to be time limited, with the aim of maximising the independence of the individual and reducing or eliminating their need for ongoing support by the Council. At the end of the time limited support package a review or assessment for ongoing future need will take place to determine what will follow.
Home Support (Home Care) (page 8 and various pages throughout)	Care provided in your own home by paid care workers to help with daily living tasks. It is also known as domiciliary care.
Housing with Care (page 8 and various pages throughout)	Housing designed for frailer adults and older people, with various levels of care and support available on site. People who live in Housing with Care have their own self-contained flats, their own front doors and a legal right to live in the property. Housing with Care is sometimes known as Extra Care Housing.
Direct Payment (page 8 and various pages throughout)	A direct payment is the sum of money that you (or someone acting on your behalf) receive on a regular basis from your council so you can arrange your own care and support, instead of the Council arranging it for you.
Dementia Navigator (page 22 and 23)	Providing early intervention and preventative post-diagnostic support through provision of information and advice following a diagnosis of dementia or to those going through the diagnosis journey. They signpost to support services available locally (e.g. dementia cafes or carers support groups) and provide practical and emotional support to people with dementia diagnosis and their carers.
Dementia Locksmith (page 22)	The role of a person who uses their knowledge to unlock people's potential and unpick issues in their present experience of life. The Locksmith must understand the problems caused by the condition to an individual but also focus on the person's strengths to enable them to 'live well with dementia.
Making Safeguarding Personal (MSP) (page 26)	Engaging the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

Glossary continued

This section provides an explanation of some definitions and terms that appear throughout this document.

Safeguarding concern (page 26)	Report of a suspicion or allegation of abuse or neglect of an adult.
Serious Case Review (page 26)	The Care Act 2014 requires that all Safeguarding Adults Boards must arrange a Serious Case Review when an adult in the local area dies or has experienced serious abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect them.
Individual Service Funds (page 30)	If you want to use your personal budget from the Council to pay for support (such as home care) from a particular provider, the money can be held by that provider in an Individual Service Fund. You remain in control of what the money is spent on, but you don't have the responsibility of managing the budget yourself.
System Transformation Programme (STP) (page 30)	The STP programme will oversee wider system development and transformation showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.

POSTCARD

Contact us

You can contact us about this report at:

abpd@coventry.gov.uk

You can contact Adult Social Care Direct at:

Email: ascdirect@coventry.gov.uk
Telephone: 024 7683 3003

Any comments, compliments or complaints can be made by contacting Coventry Direct on 0500 834 333, or in person at any of the Council's reception or enquiry areas, or by filling in an online form.

More information about Adult Social Care can be found at:

www.coventry.gov.uk/adultsocialcare

If you need this information in another format or language please contact us:

Telephone: 0500 834 333