Adult Social Care Annual Report 2016/17 (Local Account)

Produced August 2017

Coventry City Council

www.coventry.gov.uk

Contents

Coventry City Council

What is the Local Account?

Every year Coventry City Council produces a report which tells people what its adult social care service is doing to help improve the lives of vulnerable people and how well as a service it's performing. This report is usually referred to as the 'Local Account' but is also referred to as the 'Annual Report' for Adult Social Care.

We hope you find this account of interest and that it provides you with an insight into adult social care in Coventry and the work that is being done to further improve.

Cllr Faye Abbott

Foreword

Cllr Faye Abbott – Cabinet Member for Adult Services

I am pleased to introduce this Annual Report for adult social care.

This report has been written so that local residents, people with care and support needs and carers can understand more about the support provided to adults and older people and their carers in Coventry.

The focus of Adult Social Care is to provide personal and practical support to help people live their lives by promoting their independence and wellbeing. In doing so we remain committed to providing support based around the individual at the earliest opportunity and supporting people in our communities who have the highest level of need.

During the period covered by this report, 2016/17, we have continued working to ensure we embed the principles of the Care Act (2014), which was introduced on 1 April 2015 into our everyday work. Perhaps unsurprisingly our focus remains similar between years, we are here to help the most vulnerable remain safe and healthy in their own homes and communities for as long as possible. The services we provide and how we do our work will continue to have this focus although how we deliver this will inevitably vary as we constantly seek to improve and work ever closer with our health colleagues.

Please do get in touch if you would like to provide feedback on the Annual Report by emailing abpd@coventry.gov.uk.

Introduction: About Adult Social Care

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

In 2016, a revised vision and simple strategy underpinned by values and principles in delivering Adult Social Care in Coventry City Council was established. This describes what we are trying to achieve, our purpose and our approach.

In a simple sense all of our work, at whatever level, should support the strategy of:

'Providing support, in the least intrusive manner possible, based on the assets, resources and abilities that are available to people.'

Adult Social Care Vision

To enable people in most need to live independent and fulfilled lives with stronger networks and personalised support.

Strategy: Provide support, in the least intrusive manner possible, based on the assets, resources and abilities that are available to people.

Adults and carers at the heart of everything we do:
People we work with are involved as equal partners in planning and decision-making.

High quality, person centred and effective support:
We deliver high quality, person centred effective care and support to service users, their carers and families. Empowering people with the right support, at the right time in the right way, using the resources that are available to them.

Reflective and responsive to change:
The support we provide reflects and responds to the changing needs of Coventry's diverse population of adults and older people.

Outcome driven and meaningful:
Support is outcome driven and we are clear about the impact we are having on the people we support.

Support around people and their families:
People are supported to live at home wherever possible. When people cannot live at home they will be supported to live in the most appropriate and least intrusive alternate setting.

Effective enablement and prevention and wellbeing:
We provide support to people in cost effective ways, to enable them to reach or regain their maximum potential so that they can do as much as possible for themselves.

Mature partnerships:
Our partnerships are mature, trusting and effective at both a strategic and operational level.
In all our work with partners, the focus remains on the people that need our support.

Committed workforce:
Our workforce is stable, skilled, motivated and committed to delivering excellent services. They feel supported to make decisions, assess and manage risk and work with people to achieve their outcomes.

Innovative:
We will develop new ways of supporting people and use innovation as a key way to deliver good outcomes for people and manage our resources.

High performing:
The outcomes we achieve for adults and older people compare favourably with similar local authorities.
We make an active contribution to the delivery of the Council Plan.

Adult Social Care supports people aged 18 and over who have care and support needs as a result of an illness or impairment. Support is also provided to carers who spend time providing necessary care to someone else.

On 1 April 2015 the Care Act (2014) came into force and the primary focus over the last two years has been on embedding the required changes to practice and policy set out by the Act. These included improvements when people first make contact with us, and in how we assess people and plan their support.

Our activity has been concentrated throughout this recent period of change 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

Supporting people with ongoing care and support needs

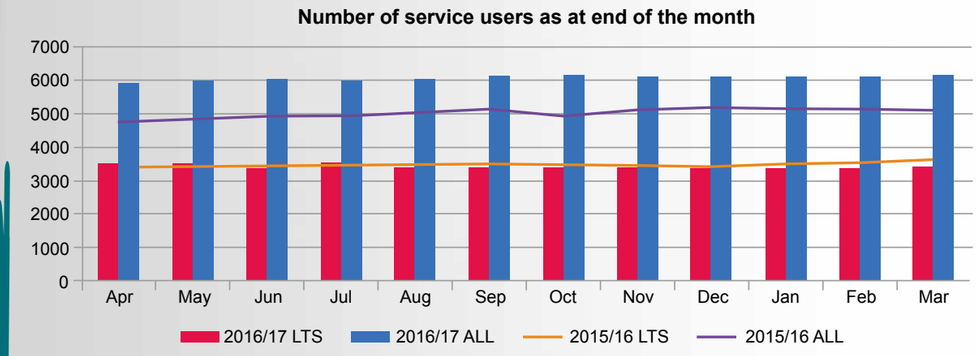
There has been an increase of 4% in new requests for adult social care support from 9,296 in 2015/16 to 9,691 in 2016/17. However there has been a reduction in numbers of people supported during the year (7% from 4,889 to 4,531).

This may be explained by a combination of factors including increased awareness of Adult Social Care and taking an approach that works with people to meet eligible needs in ways other than the provision of services.

Another reason behind this is that there has been an increase in new people who received Short Term Support to Maximise Independence (STSMI) in comparison to 2015/16, with the same proportion of people continuing to live at home following the end of this support (67%).

Over the same period the level of delays from hospital that are due to adult social care have also reduced.

Table 1: People in receipt of ongoing support



Based on CareDirector data only. LTS = people receiving long term support only.
ALL - includes low level support and excludes carer services

Despite the overall marginal reduction in overall numbers of people being supported they are being supported for longer periods of time. The number of people who have received social care support for over 12 months has increased by 18% in 2016/17 to 2646 people, which is 77% of those who received support as at 31st March 2017.

Comparison with statistically similar and neighbouring councils indicates that Coventry is supporting:

- fewer people in nursing care overall
- fewer people aged 18-64 in ongoing support
- a similar rate of people aged 65+ in ongoing support

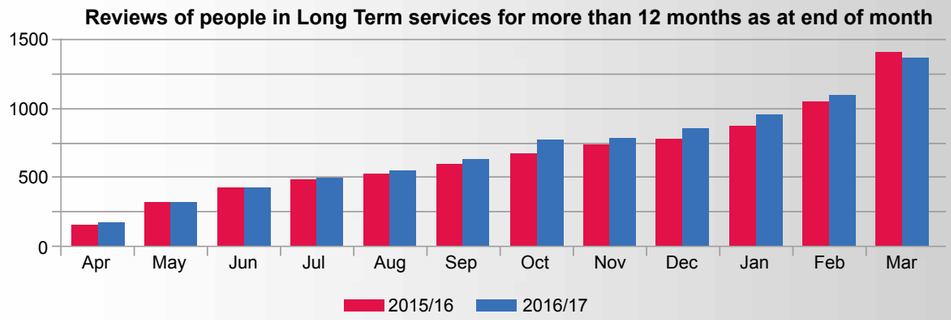
These performance highlights are attributed to a continuing focus on supporting more people to live in the community and ensuring that residential options are only used for those who cannot be effectively supported in their own homes.

The number of planned transitions from children's social care continued to increase with 55 young adults transitioning in 2016/17 compared to 48 in 2015/16.

Completion of reviews

The proportion of people in ongoing support for over 12 months who were reviewed reduced from 54% to 51% in 2016/17. This minor variation was mainly due to the prioritisation of resources on increased assessment activity as a result of more requests for Adult Social Care support. Table 2 identifies cumulative reviews which have been undertaken over the year.

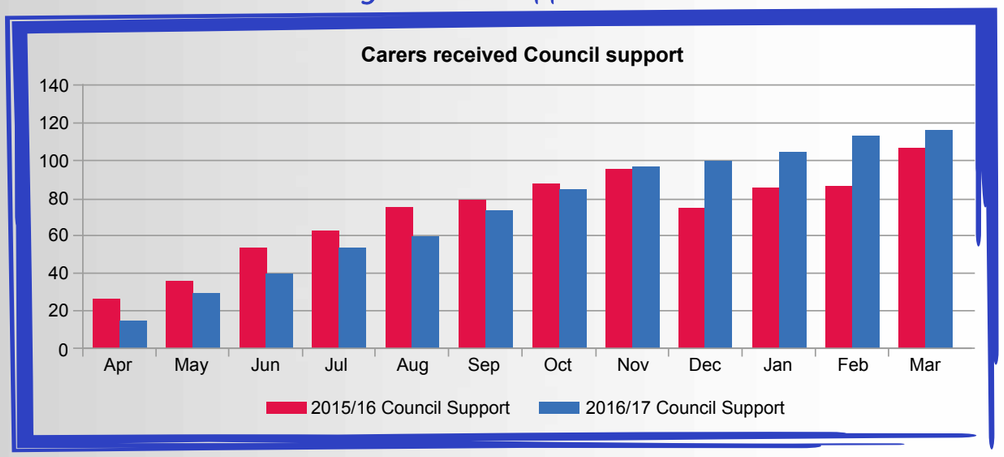
Table 2: Reviews of people in receipt of ongoing support



Supporting Carers

During 2016/17 we completed both the Adult Social Care Survey and Carers Survey with responses received from 422 service users and 305 carers. Responses to the survey indicated generally positive responses from people in receipt of ongoing support with results indicating that a higher proportion of people feel safe as a result of the support they receive from the Council and also show an improvement in the reported quality of life. However, and despite these positives, the overall number of carers' responses declined in comparison with 2014/15 when the survey was last completed, as did levels of satisfaction, which mirrors a reduction in carers' satisfaction nationally.

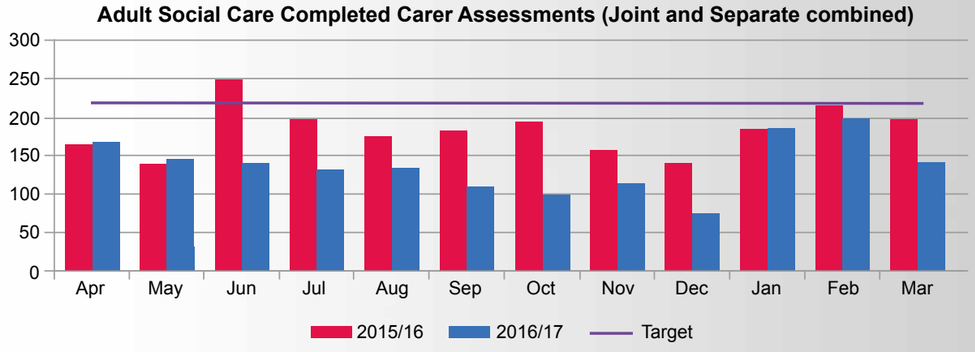
Table 3: Carers receiving Council Support



There has been a significant reduction in the number of separate carer assessments, direct payments, and support funded by adult social care compared with previous years. When this is considered alongside the decline in the performance of the satisfaction measures sourced from the Carers Survey this suggests that carers have experienced a change in how they have been supported.

Some of these factors can be explained by services that were previously considered carer support (short breaks and respite) now being considered support for the cared for, as receiver of the service, and the fact that Heart of England Carers Trust is completing some carers assessments and finding ways to support people without referring to Adult Social Care.

Table 4: Carer Assessments



Considering the vital role of carers in supporting both health and social care it is critical that we continue to provide support that is meaningful and beneficial to carers and this will be an area of increased focus going forward.

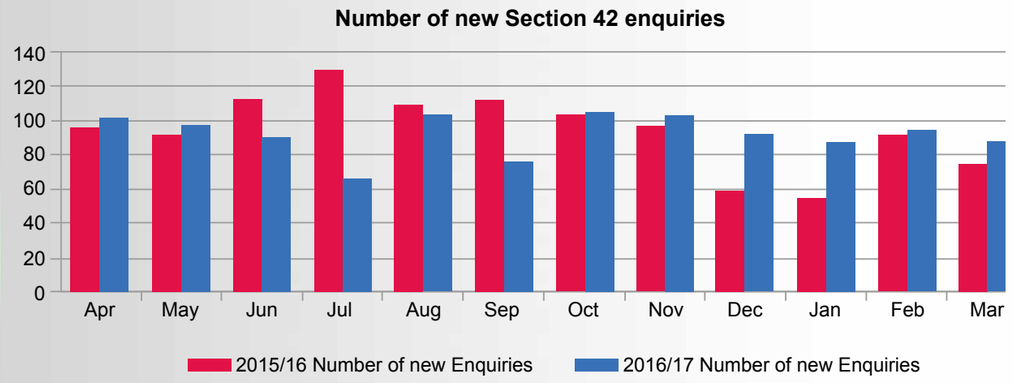
Early regional benchmarking indicates that there is a wide difference of approaches provided to carers, with Coventry being similar to Wolverhampton, Shropshire and Dudley in providing a lower rate of direct payments per population compared with others in the region.

Safeguarding

Improvements have been made in how we undertake safeguarding with more people having their identified outcomes fully or partially achieved than in 2015/16, more advocates being provided to those who lack capacity and more enquiries completed during the last 12 months than in 2015/16. This improvement will be partly due to the increased emphasis and activity in respect of 'Making Safeguarding Personal' undertaken in 2016/17.

The number of safeguarding contacts has increased by 55% in comparison to 2015/16 to 3,107. This is largely attributable to a change in how data is captured. 1,106 of these contacts went on to become a Safeguarding Enquiry which is consistent with 2015/16 and so remains at a higher rate per population than our comparators. This is to be seen as a positive indicator in terms of both people reporting suspected safeguarding and our efforts to ensure that concerns raised are properly considered.

Table 5: Safeguarding Enquiries



Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

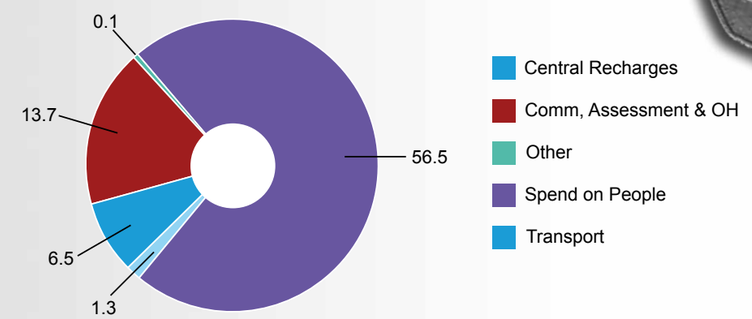
There has been significant improvement made in the timeliness of applications granted in comparison with 2015/16. The number of applications granted within 3 months of being received has significantly increased from 17% in 2015/16 to 52% in 2016/17. The number of applications received has significantly increased from 17% in 2015/16 to 52% in 2016/17, while those waiting over 6 months reduced to 6% from 42% in 2015/16.

There continues to be a year on year increase in new applications received, with a 19% rise in comparison with 2015/16 to 1382 in 2016/17. Of these 205 (12%) are in progress which is an improvement on 354 (23%) in 2015/16.

Money - Coventry City Council

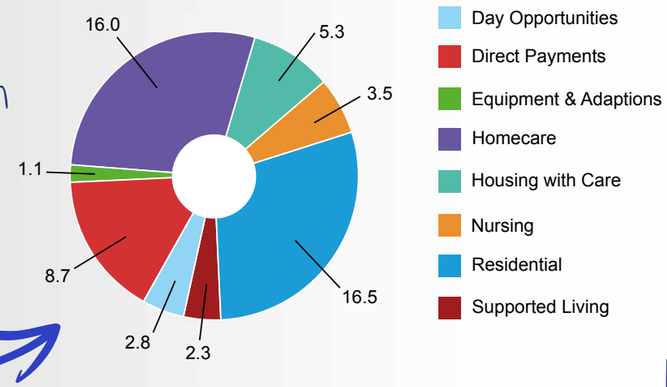
The Council is a large organisation spending a net £234.4m on revenue activity during 2016/17 with Adult Social Care being the biggest single area of City Council spend at £78.1m net. The breakdown of this spend for 2016/17 is shown below:

2016/17 Adult Social Care Spend (£78.1m)



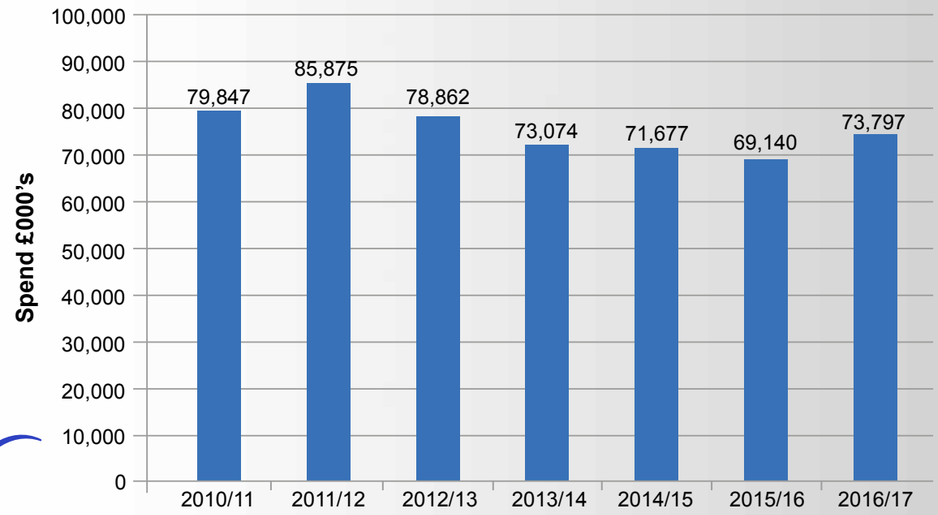
The 'Spend on People' referred to in the previous chart has increased from £53.5m in 2015/16. 'Spend on People' is money spent directly on the following support:

2016/17 Net Spend on Services (£56.5m)



Since 2010/11 the net spend by the City Council on Adult Social Care has changed by the amounts shown in the graph below:

Adult Social Care Spend
(Excluding Capital and Specific Grants)



This increase in spend between 2015/16 and 2016/17 was largely attributable to the cost of care as a result of factors including the introduction of the National Living Wage. The City Council made the decision to implement the Adult Social Care Council Tax Precept as a means to assist in meeting the increasing costs of providing Adult Social Care.

The Adult Social Care budget was overspent in 2016/17 by £3.4m – This overspend is included in the above graph. Although significant, this overspend has reduced from £5.2m in 2015/16 when Coventry also had the lowest % of overall spend on social care in the West Midlands region (29%).

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 number of factors including:

- An ageing population. We can expect a general increase in the age of the population, particularly those aged over 75, which is estimated to grow by 37% between 2015 and 2030
- As the population ages more people will be living with multiple health conditions that require support
- The numbers of people with severe physical or learning disabilities living into adulthood will continue to increase as long term survival rates improve
- More people are living alone, with a projected increase of 10% for those aged 75 years+ from 2015 to 2020. Those who are socially isolated are 2-5 times more likely to die prematurely than those with stronger social ties
- The levels of deprivation in the city, although improving, remain relatively high and those living with lower levels of wealth are more likely to develop poor health

With demand expected to increase we will continue to look for ways to manage this demand and deliver the aspirations of our strategy through developing initiatives including greater use of technology to enable people to identify what support they may be eligible for and increasing our deployment of promoting independence approaches in order to reduce requirements for ongoing care and support.

Workforce

(As at 31 August 2016)

The number of Adult Social care jobs in England was estimated at 1.58 million, an increase of 1.5% and 20,000 jobs since 2015. In the same period the number of people in the Council's internal Adult Social Care workforce has reduced by 7% from 1029 to 953, this reflects an 18.9% reduction when compared with the Full Time Equivalent (FTE) figure.

This is in line with the continued national shift away from local authority jobs. Since 2009 this has seen a reduction in Local Authorities of 37% (65,000 jobs) and towards independent sector jobs (+27% and 260,000 jobs).

Demographically the make-up of the Council's Adult Social Care workforce has stayed similar to 2015 with 82% being female, 46% aged over 50 and 3% disabled. In terms of ethnicity 77% are white, 20% from a black or minority ethnic (BME) background and 3% are not known. This compares with 26.9% of Coventry's 18-64 population being BME (2011 Census). Other information:

- The number of vacancies has increased by 47% from 38 in 2015 to 56 in 2016
- The number of leavers has decreased by 37% from 284 in 2015 to 178 in 2016
- The number of new starters has remained consistent with 146 in both 2015 and 2016

i. Adults and carers at the heart of everything we do

Adult Social Care Stakeholder Reference Group

We have developed a stakeholder reference group since our Peer Challenge in 2016. People and carers who currently receive support or have had previous experience of adult social care were invited to become participants in the group. The role of the group is to influence the future direction of service delivery and they have played a part in helping us shape the:

- Community-based Preventative Support Grant
- Adult Safeguarding Board priorities for 2017/18
- Adult Social Care Information Directory and online Self-Assessment

The group is still developing and two of the key activities going forward are to encourage new membership and input from a wider audience as well as developing the confidence of existing members in contributing to the agenda for how support is best delivered in the future.

Developing our approach to carers

Coventry has developed a Multi-Agency Carers Strategy with partner organisations which covers the period 2016-19 and relates to carers of all ages. The Strategy is accompanied by a comprehensive implementation plan which is overseen by the multi-agency Carers Strategy Steering Group. Key improvement priorities within the plan fall under four areas:

- Identification and Recognition
- Realising and Releasing Potential
- A Life Alongside Caring
- Supporting Carers to Stay Healthy

The plan is available on the Council website so that members of the public can view the current position.

http://www.coventry.gov.uk/downloads/76/carers_support

Additionally a new National Carers Strategy is expected in 2017 and our local strategy will need to be reviewed in this new context.

ii. High quality, person centred, and effective support

Making Safeguarding Personal

In 2016-17 a "Making Safeguarding Personal" (MSP) project was undertaken in adult social care with over 200 staff trained. In addition to the training the project included focussed groups of staff, managers and advocates and the collation of key data. A MSP Toolkit was developed for staff which is also available on the Council website. Key priority areas were: working with adults to achieve what was important to them, ensuring that adults are given the opportunity to feedback on their safeguarding experience, and ensuring adults who have substantial difficulty in participating in their safeguarding had a representative or advocate. An evaluation of the project was undertaken by Coventry University which will be available on the Council Website in 2017-18. This identified that there had been a positive impact on practice in relation to mental capacity and the use of advocates.

Adult Safeguarding awareness-raising Champions Seminars and Forums have been held during the year which were open to multi-agency partners, independent and voluntary sector staff. The expectation is that attendees cascade learning and information to their agencies. Topics included:

- Modern Slavery,
- Making referrals to the Police,
- Making Safeguarding Personal,
- Learning Lessons from Safeguarding Adult Reviews, and
- Female Genital Mutilation.

Developing our capacity to deliver more personalised support

An Individual Service Fund (ISF) is where people have choice and control over their personal budget from the Council by requesting that this budget is managed by a third party provider. This is usually the agency or organisation that is going to be providing some or most of their care and support to these people. The individual remains in control of what the money is spent on and agrees this with the provider, but does not have the responsibility of managing the budget themselves.

ISF's are already providing a small number of people in Coventry with choice and control over their personal budget and we are continuing to develop this approach.

One of the contracted providers that predominately supports people with learning disabilities is reviewing their processes, so that all of the people they support could potentially receive ISF's instead of directly arranged services. Any changes to the support will be co-produced with the people being supported ensuring that they have choice and control.

An example of an ISF is a person banking their support hours to enable more flexibility to participate in activities of their choice at a time that suits them. Another is purchasing support from a day centre of a person's choice to meet their eligible needs which cannot be supplied by the local authorities contracted providers.

An ISF steering group made up of internal and external stakeholders, including service providers, has been established to provide governance, evaluate the success of a pilot and to develop the new approach for the future roll out of ISF's. An event is planned during 2017 to raise awareness for all home support providers and we will be developing more consistent mechanisms for engagement with people with care and support needs and their carers so that more people are aware of how ISF's can be used to provide more person centred and effective support.

iii. Reflective and responsive to change

Voluntary and Third Sector Support

We are currently changing the way in which adult social care and health provide funding to our voluntary and third sector partners. Working with Coventry and Rugby Clinical Commissioning Group (CRCCG) and the sector themselves we have co-produced a new Community-based Preventative Support Grant.

This grant will be used to commission support from the voluntary and third sector and is intended to replace current funding arrangements.

This work has enabled us to refocus how funding is used to ensure that organisations support those people most in need to live well, stay independent and reduce or delay the need for formal support from the Council and/or the health services.

We have developed an outcomes framework which focuses on supporting people to develop their own strengths and resilience with the ability to access support from their community which is timely and responsive to their needs.

Re-tendering for home support

Coventry City Council in partnership with CRCCG has completed a re-commissioning exercise for long-term home support/home based continuing health care. The contract was developed using wellbeing and prevention principles of the Care Act (2014).

There are many positives for these new arrangements, including:

- Fewer providers contracted, resulting in improved sustainability and closer working relationships to improve quality and oversight
- Providers operating in line with guidelines including quicker referral turnaround times, and providers working to maximise independence, even within ongoing support packages
- Greater efficiency as each provider will be assigned to a geographical area of the city (aside from Learning Disabilities and Mental Health which are city-wide)
- Reduced handovers as the contracts also provide for CRCCG commissioned home support to meet continuing health care needs

iv. Outcome driven and meaningful

The initial contact with social care

The social care initial contact service has been further improved over the past twelve months. Social Work and Occupational Therapy staff are now co-located with customer service staff, enabling people to have a more timely and tailored response, along with effective signposting. The online offer has also been improved, along with the development of a services directory, and an online self-assessment and signposting tool. This means that people are instantaneously signposted to tailored support services according to their needs. Over the coming twelve months, work will be undertaken to develop an online carers' self-assessment, and an electronic calendar booking system so that people are given a date for their initial social care visit on first contact.

Safeguarding Performance

Following the Adult Social Care Peer Challenge in February 2016 we committed to making real and demonstrable progress on our implementation of Making Safeguarding Personal. This is a way of working that puts the individual at the centre of safeguarding and starts with what they want to achieve through the safeguarding process.

As safeguarding is everybody's business the Coventry Safeguarding Adults Board (CSAB) was engaged in this agenda with each member organisation making a pledge on what they would do to make safeguarding personal in their own organisation.

Progress on this can be seen through our safeguarding performance, where of the 423 concluded enquiries in which people had expressed an outcome they wished to achieve, 59% went on to fully achieve and 29% to partially achieve these outcomes. This is only one measure and therefore for the 2017/18 local account we will report on the findings of the Coventry University study of success in implementing Making Safeguarding Personal in Coventry.

Case Study 1: Mr G

Mr G has dementia and his wife is committed to continuing to support him to live at home despite this becoming more challenging due to Mr G arising several times in the night and going downstairs, impeding his wife's ability to rest and therefore her ability to support him longer term. Residential care was being considered.

Through the Community Locksmith service we were able to work with Mr G and understand what it was that was urging him to get up so often in the night. It transpired that he was getting up for work and was worried about being late – he used to work shifts which required non-standard working patterns.

A white board was installed at the top of the stairs with the simple message 'you are not at work today so can go back to bed'. On arising Mr G would read the message understand he didn't need to get up and would go back to bed. This apparently simple solution has a great impact on the lives of Mr G and his wife, who can now get proper rest that enables her to support him more effectively and no longer has to consider residential care.

v. Support around people and their families

Supporting families

There has been a review of a number of support packages funded jointly by Health and Social Care, together with higher cost single funded support by the City Council. This included a particular focus on assisting those placed out of the city to return to local provision closer to family and other support networks.

By September 2016 a number of reviews had been undertaken which resulted in individuals having support arrangements put in place that enabled them to have greater independence and access to community resources. This allowed them to access daily living activities that had previously been unavailable.

Case Study 2: Mr H

'H' has a diagnosis of a severe Learning Disability and Autism. He has limited verbal communication and uses sign to indicate his basic needs. He also has a diagnosis of epilepsy which is controlled by medication. Measures had been taken to protect H and protect the items that he owns, locks were placed on the cupboards and on the fridge and risk management plans were put in place so that H did not burn himself whilst cooking but this meant he did not participate in this activity either. Working with his family helped us to see what his skills could be and we involved them as his advocates to ensure that H remained at the centre of support with his wishes being considered from the start.

We worked with the family and service provider to find a house that could become a home for H, close to family and community connections. Finding a suitable property was not easy and took time. The whole family were involved in the recruitment of staff and this meant that they met the provider and any potential staff being recruited.

We planned week by week to enable H to participate in life. We continued to increase existing skills in activities of daily living that included cooking, washing and cleaning and developed new ways in which H can travel, using a step by step approach to develop skills, reduce anxiety and enable him to connect to his community.

'My son is not the same person as he was in his care home and moving has made a big difference for him, showing his true personality. This has proved that with the correct support and understanding of an individual a true account can be captured of an individual's personality' — H's Mum

Growing our Shared Lives scheme

The Council-run Shared Lives scheme has had a successful year recruiting and approving new Shared Lives Carers, with 46 now employed and 66 people being supported. This is a flexible personalised service which provides people with the level of support they need to live independently in the community.

The support is provided by the Shared Lives Carers using their family home which enables someone to live an ordinary life at the heart of their community. The Carers value the person and promote their independence and choice and provide them with support in day-to-day living, their own personal space, emotional as well as physical support and a sense of belonging. The placements are made by the City Council Shared Lives Scheme.

The scheme approves and trains the Shared Lives Carers, matches the needs of people seeking a service with Shared Lives Carers, and monitors their placements which can be for an extended stay or a short break.

Case Study 3: Mr I

The Shared Lives Scheme is particularly proud of their success in supporting Mr I to return back to Coventry after many years in a residential home in Devon.

The Scheme used innovative methods of communication to maintain links between the gentleman and professionals in Coventry and Devon, reducing the need for long distance meetings. Skype was used to make regular contact introducing the person and the Shared Lives Carer, making the first face to face contact more familiar and relaxed as he stated he felt he already knew everybody.

This has given Mr I the opportunity to return to his home town, re-establish old friendships and familiarise himself with his local community. The carer has invested time and support with Mr I by reintroducing some independent living skills that had been restricted in the residential home. This return also provided a more cost effective package of care than the expensive residential placement. The Shared Lives placement has not compromised the level of support he receives, but further enhanced his independence and lifestyle choices.

vi. Effective enablement, prevention and well-being

Discharge to Assess

People who are admitted to hospital may potentially need support when they are discharged, but it is possible to get an inaccurate view of their care needs in a hospital setting when they are often at a low point in terms of their health. This might mean that they leave hospital and move into a care setting that could be unsuitable for them, or they may be provided with services that they do not need.

Therefore we have worked with NHS colleagues to design new pathways out of hospital into short term services which better suit people's immediate care needs, and which presents an opportunity to assess whether they need any longer term help, and what this might be.

These "Discharge to Assess" pathways comprise services delivered to people in their own homes, in Housing with Care schemes, or in residential care homes. They provide the best opportunity to assess a person's needs so they can be provided with appropriate longer term support if required, and avoid unnecessary delays in an acute hospital setting.

Case Study 4: Mr S

Mr S has dementia and was admitted to hospital following a fall in which he suffered a fractured hip and consequently had a hip replacement. Prior to hospital admission Mr S lived with his wife and was fully independent. Due to his hip replacement Mr S's mobility had deteriorated during his stay in hospital and it was identified that he would require support when discharged. He was referred to the dementia reablement service and following the initial assessment it was agreed that he would receive 2 care calls each day, one in the morning to support him with personal care and medication and one in the evening to support him to get ready for bed.

Once Mr S was discharged from hospital an Occupational Therapist worked with him to practice his mobility, initially within his home and then out in his community and to identify suitable walking aids to support him to be able to go out for walks with his wife. He now has a 4 wheeled walker which he uses safely when outdoors.

The reablement service has proved to be a positive experience with good outcomes for Mr S. With this support, he has now settled back at home with the appropriate equipment and resources in place and is now independently accessing his local community and can complete most activities of daily living without support.

vii. Mature Partnerships

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

The integration of health and social care has been a long standing policy ambition of central government based on the premise that more joined up services will help improve the health and care of local populations and make more efficient use of available resources.

In this respect the Council has been working closely with partner organisations across the health and social care system in Coventry and across Warwickshire to develop plans and implement projects that facilitate the joining up of, and the efficient investment in, health and care services.

This has been taking place across two overlapping but complimentary change programmes. Firstly, the Better Health, Better Care, Better Value programme is focusing on the triple aims of the Sustainability and Transformation Plan (STP) for improving health, reducing the care and quality gap and addressing the financial sustainability of health and care across the wider geographical footprint of the Coventry and Warwickshire.

Secondly, the Better Care Fund (BCF) programme which was first implemented in April 2015 is a partnership agreement between the City Council and the CRCCG whereby the NHS and local authority contribute an agreed level of resource into a single pot, called a pooled budget, that is then used to drive integration and lead to the development, improvement and joining up of new and existing services.

Delivering our Better Care programme is an important step in the achievement of the local commitment to the integration of health and social care.

viii. Committed workforce

Workforce Development Board

We have established an Adult Services Workforce Development Board which enables an increased focus on the workforce development needs within adult services. This is much more than training and includes recruitment, retention, development, workforce planning and practice development.

A training needs analysis was completed and an internal 'learning and development' brochure has been produced which identifies a range of learning opportunities. The training on offer will fully support staff across adult services to meet all regulatory and personal requirements and support their professional development.

During 2016/17 a number of training events have been held regarding adult safeguarding, palliative, end of life and bereavement support and assessing capacity and 'best interests' decision making. This training activity is now complimented with a number of team based action learning sets to support staff to be up to date with legal frameworks and to support the adoption of more personalised approaches, thinking creatively with individuals and their families when planning their care and support.

Practice Quality Assurance

We have developed a Practice Quality Assurance Framework which aims to support a consistent approach to how we assure, evidence and improve our social work and social care service. The Care Act 2014 and The Mental Capacity Act 2005 set clear expectations for adult social care practice and enhancing the way we work with customers and carers is at the heart of the Care Act 2014.

The framework proposes the specific methods that we will use to provide assurance that social work and social care practice is of a satisfactory level of quality. The framework uses a combination of approaches and varying degrees of audit at both practitioner and organisational levels.

Following a series of briefings to team leaders and senior practitioners we formally commenced the use of the framework in early 2017.

Communicating and engaging with our staff

Communication is one of the most important aspects of being able to work effectively with immediate colleagues and as part of a wider team of people that work to deliver effective adult social care. We have started a regular monthly email newsletter to improve staff knowledge of what's going on in adult social care both in the Council and beyond.

This is just one of the things we have implemented to improve our communication and engagement. Other activities include regular 'Adult Service Roadshow' Events designed to raise awareness of the Adult Social Care agenda including key activities, developments, promote the involvement and engagement of all staff and celebrate success. We have also introduced a range of other approaches including; developing front line practice engagement forums, supporting mechanisms to value and celebrate the work of staff such as the City Council 'Phoenix Awards' and capturing examples of best practice via 'storyboards' and creating an evidence bank of best practice.

ix. Innovative

Information Directory and Self-Assessment

Members of the public have told us that they want to be able to easily access information at a time that suits them. This has been our driving intent behind the development of our information directory and self-assessment tools. The directory provides information about the variety of support available across Coventry including voluntary, third, private and public sector provision. The self-assessment tool allows individuals, or their carers, to complete a series of short questions. The system then advises whether they would benefit from a further assessment of need with a professional. Since the launch of the self-assessment over 500 have been completed, of which 75% have resulted in no further follow up, with people choosing to self-support using the information available in the directory.

Financial Assessment Advisory Tool

As part of the Council's drive for digital innovation we in adult social care are always looking at opportunities to provide the public with digital tools that enable them to self-support. The financial assessment advisory tool has been designed so anyone can complete a series of quick questions about their financial circumstances. Following this the system will advise whether they would be likely to have to contribute to the cost of care services. This information will help people make a decision about how they access support as and when they need it. Within the first two months of the tool being live it had been used by over 40 people.

x. High Performing

Adult Social Care Outcomes Framework (ASCOF)

Coventry's performance across the Adult Social Care Outcomes Framework (ASCOF), which reports annually across a range of national indicators, has improved in comparison with 2015/16. There has been improvement in 14 (54%) measures, 3 (11%) have remained the same and 9 (35%) measures have declined compared with 2015/16. Performance has improved in:

- higher proportion of people receiving a personal budget or direct payment,
- more people with a learning disability as their primary support reason are in employment and living in their own homes;
- reducing number of nursing/residential care admissions
- higher proportion of people aged 65+ still at home 91 days after receiving STSMI following discharge from hospital

There was positive improvement on several measures sourced from the Adult Social Care Survey including those under the headings of 'Enhancing quality of life for people with care and support needs' and 'Ensuring people are safe and protected from avoidable harm'. This demonstrates that the various actions undertaken within Adult Social Care in the past year are having a positive impact in improving the experience of people in receipt of services.

Improving our response

Work has progressed on reducing waiting lists and response times for assessments, and there has been a marked improvement in both the number of people waiting and the speed of completion. This has focused on social worker and team leader performance and through-put including setting out clear expectations, in terms of the professional contact they have with people they are working with.

Social care managers now have access to performance reports, enabling people to be allocated a social worker more quickly, and improving customer service. Additionally a public-facing document has also been produced, detailing what members of the public can expect from Adult Social Care:

http://www.coventry.gov.uk/info/78/care_and_support/980/assessments_eligibility_and_support_planning/7

In addition to this we are establishing a consistent adult social care approach and have developed common responses to contacts between the Older People Service and the All Age Disability Service for Younger Adults. Whilst our delivery may need to differ, the process that we all follow is now aligned and common expectations and operating procedures have been implemented. The results show a 20% reduction in cases that are waiting for a social worker to respond following an initial contact.

Awards

Awards

In the recent Coventry City Council Phoenix Awards the following Adult Social Care staff celebrated success.

Team of the year - Eric Williams House

The team of 77 provides a residential dementia care service, adapting to each person's unique needs and helping to keep many out of hospital.

The team works with others across healthcare and runs many fantastic services and is no stranger to awards, having earned many over the years for work in promoting each person's sense of control and self-worth.

Manager of the year - Sue York

Sue has been a manager within Learning Disability Day Opportunities for the past 10 years and regularly shows her outstanding leadership skills and flexible approach by managing three very different centres.

Sue has led by example and inspires confidence throughout the whole team.

Her team says she is open and honest and supports staff and volunteers with their own personal development, helping them to be the best they can be.

Sue has led all three services through times of change and has confidently and successfully managed difficult situations. She makes everyone feel their input is valued and respected and it's not just the team that benefits, but the communities who use the centres.

What's next - Key areas of development for Adult Social Care 2017/18

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. Making further progress on the delivery of our strategic intent is the focus for 2017/18 and beyond along with working ever closer with health colleagues on areas where there are clear benefits to be gained from integration.

The key areas we are developing in are:

- Increasing use of technology to make it easier for people to find out about Adult Social Care and how they can be supported
- Developing a community promoting independence approach which will support people to meet their outcomes at the earliest opportunity, through being preventative and proactive
- What we are doing and will do to provide effective and relevant support to people with learning and physical disabilities and their families and carers
- How people interact with social care and how we will work with them at each point this is often referred to as the 'customer journey'
- Focusing on the quality of practice and the workforce
- Our areas of joint working with health linked to both the Better Health, Better Care, Better Value programme and the Better Care Fund

Glossary

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

Short-term support to maximise independence	Page 7	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.
Ongoing Support	Page 8	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.
Direct payments	Page 9	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.
Safeguarding Enquiry	Page 11	A Safeguarding Enquiry is any action that is taken (or instigated) by a local authority, under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult.
Deprivation of Liberty Safeguards (DoLS)	Page 12	The Deprivation of Liberty Safeguards are an amendment to the Mental Capacity Act 2005. They apply in England and Wales only. The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests.
Joint Strategic Needs Assessment (JSNA)	Page 15	The Joint Strategic Needs Assessment (JSNA) looks at the current and future health and care needs of the local community. It is intended to inform and guide the planning and commissioning of health, wellbeing and social care services within a local area.
Making Safeguarding Personal	Page 18	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.
Individual Service Fund (ISF)	Page 19	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.

Glossary continued

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

Discharge to Assess	Page 27	Discharge to Assess aims to help those who might need support on leaving hospital earlier, by arranging a care package to support them at home.
Housing with Care	Page 27	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.
Sustainability and Transformation Plan (STP)	Page 29	STP's are five-year plans covering all aspects of NHS spending in England. Forty-four areas have been identified as the geographical 'footprints' on which the plans are based. In Coventry this is now referred to as the 'Better Care, Better Health, Better Value' programme.
Better Care Fund (BCF)	Page 29	The Better Care Fund is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.
Action Learning Sets	Page 30	Action learning sets are a simple way for individuals to learn from each other. Using the knowledge and skills of a small group of people, they involve stopping to reflect back on actions taken, drawing out learning from that reflection, and applying that learning to planned practice.
Financial assessment	Page 32	Once a local authority or trust has carried out a care needs assessment and worked out what care services people need, they'll carry out a financial assessment. This will work out if a person will need to contribute towards the cost of their care, and whether the local authority will pay for all or some of the care costs.
Adult Social Care Outcomes Framework (ASCOF)	Page 33	The ASCOF measures how well care and support services achieve the outcomes that matter most to people. The framework supports Councils to improve the quality of care and support services they provide and gives a national overview of adult social care outcomes.

POSTCARD

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