# ADULT SOCIAL CARE ANNUAL REPORT 2017/18

## (LOCAL ACCOUNT)

Coventry City Council

www.coventry.gov.uk

# CONTENTS



# 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 is 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.

# FOREWORD

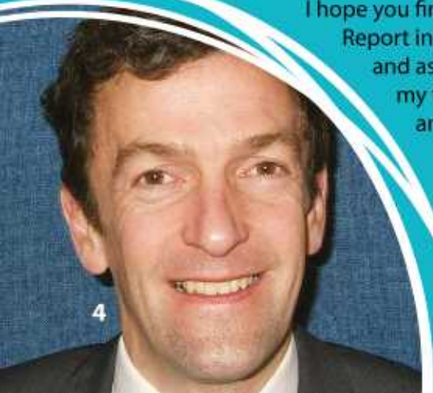
## PETE FAHY
DIRECTOR OF ADULT SERVICES

**The production of this Report remains an important landmark in the annual cycle of Adult Social Care. It provides an opportunity for honest reflection on the achievements and challenges we face in delivering Social Care within the City.**

In producing this annual report we have deliberately focussed on what we have done and are doing to improve – this is important and deliberate within an environment where much of the debate on Adult Social Care is dominated at a national level by debates on funding and financial sustainability or issues such as Delayed Transfers of Care (DTOC). Of course these are important issues but we should also highlight and reflect on the many examples of what is done to support people to live independently that will never reach the headlines.

As well as looking back over 2017/18 we also need to be cognisant of what lies ahead: in particular the impact of the expected Green Paper and the continued drive for closer working with our health partners, plus the future of the Better Care Fund which has provided an essential injection of resources for Adult Social Care nationwide. As always it is practically impossible to predict what the future holds but whatever is in store for the sector we will continue to work to provide the best possible support available to people within the resources we have available.

I hope you find this Annual Report informative and as always myself and my team are happy for any feedback.



## COUNCILLOR FAYE ABBOTT
CABINET MEMBER FOR ADULT SERVICES

**I am pleased to introduce this Annual Report for Adult Social Care. Social care is an important issue for everyone and Coventry City Council is committed to helping our most vulnerable people, their families and carers to get help as soon as they can.**

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.

In this report we take the opportunity to tell you about what we have done in the last year, how we have spent our budget, and what you have said about the services and advice we provide. We have set out our future plans for improvement and you will see that there is a lot of great work going on.

This report includes some incredibly positive stories, but we continue to face financial pressures and have seen an increasing complexity in people's needs. We continue to work hard to find new and innovative ways to enable people to get the right support that meets their needs. To meet the challenges we face we will need to focus more on prevention and well-being. Access to universal services and early help and preventative support will be an important part of this approach. This will improve outcomes for local people and promote better use of Adult Social Care resources.

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's vision is 'working in partnership to improve the life chances of all and protect the most vulnerable'.**

In 2016 we established a simple vision and strategy which underpins the principles of Adult Social Care, and we continue to work in support of this. 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 continue to support the strategy of: 'Providing support, in the least intrusive manner possible, based on the assets, resources and abilities that are available to people'.

A significant event for social care and its health partners in 2017/18 was the system review undertaken by the Care Quality Commission. There is more on this later in the report but one of the findings was that staff understood their role in supporting people to be independent at home – this is a real positive in confirming that our simple approach to strategy is understood and creates a meaningful purpose for those who work in Adult Social Care.

# ASC VISION

**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. We continue to work in accordance with our primary legislation the Care Act (2014) and the required changes to practice and policy set out by the Act. The Act required improvements when people first make contact with us, and how we assess people and plan their support.

The delivery of Adult Social Care in Coventry, as embodied in our vision is that we focus on approaches that promote well-being and independence to prevent, reduce or delay the need for long term support and to enable people to achieve their outcomes. In performance terms this means that we would expect to see a relatively smaller number of people in receipt of ongoing social care, and where ongoing social care is required that this is mainly provided in peoples own homes. We would also expect that the short term services we have in place to enable people to be independent are successful in reducing demand for ongoing Adult Social Care.

## 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.



# FACTS AND FIGURES

## SUPPORTING PEOPLE WITH ONGOING CARE AND SUPPORT NEEDS

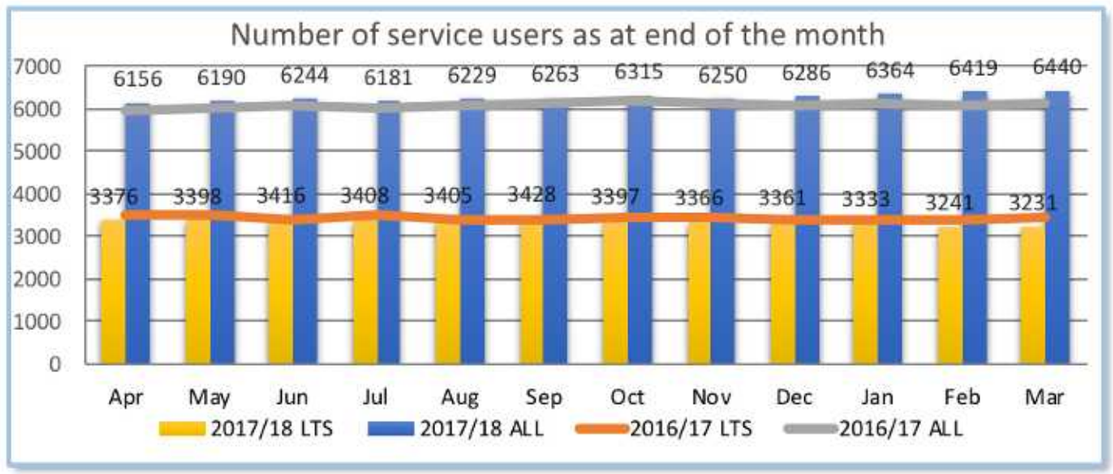
**There has been an increase of 6% in new requests for Adult Social Care support from 9,691 in 2016/17 to 10,330 in 2017/18. However there has been a reduction in numbers of people supported during the year (down 4% from 4,531 to 4,343) which continues the downward trend over the past three years.**

There is no single identified reason for this but it is likely to 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 a continued increase in people who received Short Term Support to Maximise Independence (STSMI) in comparison to 2016/17, with the same proportion of people continuing to live at home following the end of this support (75%).

Over the same period the level of delays from hospital that are due to Adult Social Care have also reduced. Our performance has remained below the national targets we are expected to work to.

**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

The number of people accessing any level of support has seen a 3% increase over the course of 2017/18. However there has been a decrease of 2% in the number of people accessing long term ongoing support, which over the past three years is a continued downward trend.

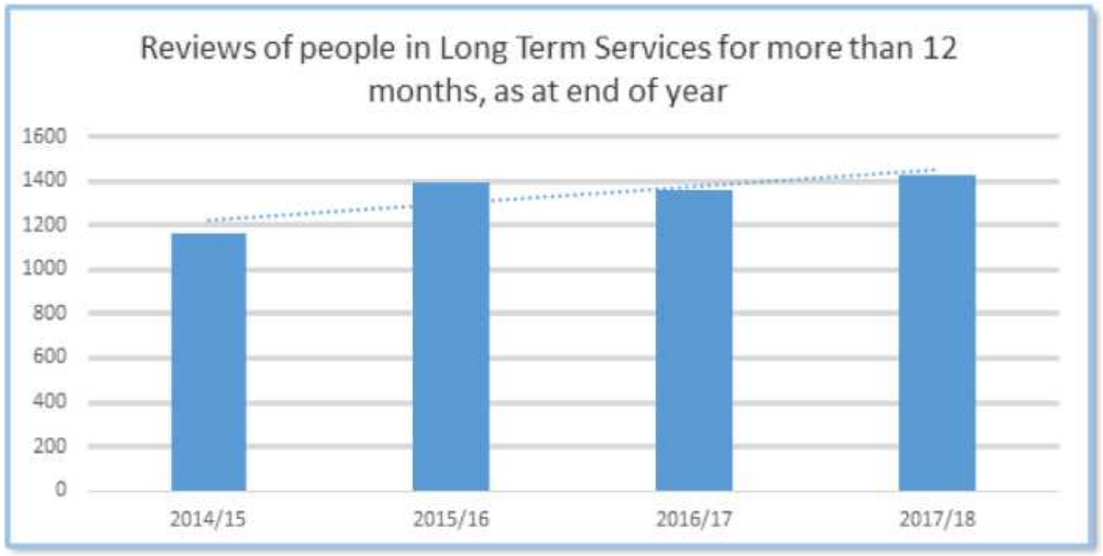
There were 3,230 people receiving ongoing long term adult social care support as at 31 March 2018, of which 75% (2431 people) had received support for over 12 months.

The number of planned transitions from Children's Social Care continued to increase over the past three years, with 59 young adults transitioning in 2017/18 compared to 55 in 2016/17.

## COMPLETION OF REVIEWS

The proportion of people in ongoing support for over 12 months who were reviewed increased from 51% to 59% in 2017/18. We have ensured we respond to reviews concerning any changes in circumstances, which are often more challenging than a review undertaken where nothing has changed.

**TABLE 2:** REVIEWS OF PEOPLE IN RECEIPT OF ONGOING SUPPORT



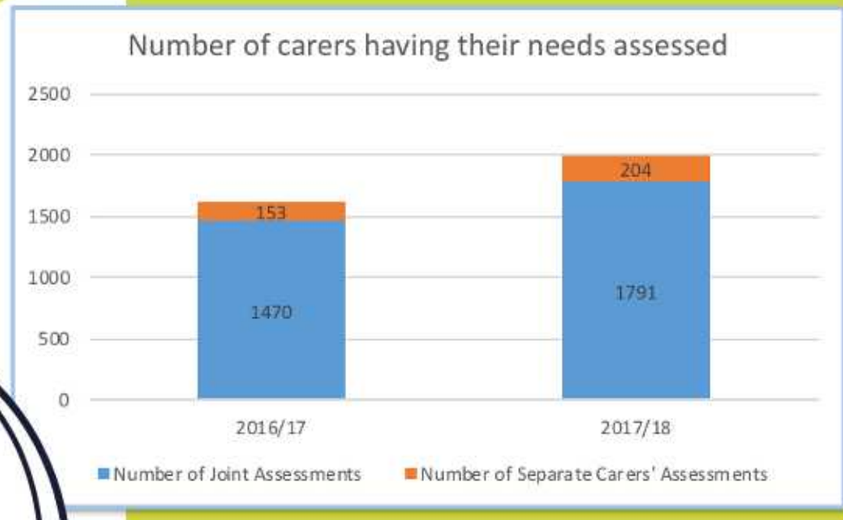

PEOPLE ACCESSING ANY LEVEL OF SUPPORT HAS SEEN A **3%** INCREASE OVER THE COURSE OF 2017/18.

## SUPPORTING CARERS

**Carers are one of the greatest assets of Coventry and supporting carers to get the support they need, when they need it, is integral to the delivery of effective Adult Social Care.**

This year there has been an increase in both the amount of Joint Assessments (where a carers' needs have been assessed alongside the needs of the person they care for) and a rise in separate Carers' Assessments, which is reflective of the overall increase in requests for initial support. The increase in separate carers' assessments is a positive reflection that carers' needs are being considered and planned for on an individual basis.

**TABLE 3:** NUMBER OF CARERS HAVING THEIR NEEDS ASSESSED




There continues to be a change in how carers' needs are met with a continued reduction in the provision of Carers' Direct Payments and evidence of many carers' needs being met with the provision of good quality and robust advice and information. Working closely with the Carers Trust Heart of England has been key to making sure this is delivered.

AN INCREASE OF

**8%**

IN SAFEGUARDING CONCERNS

## SAFEGUARDING

The number of safeguarding concerns continues to rise year on year to 3359 in 2017/18, an increase of 8% in comparison with last year. Coventry has a higher rate of safeguarding concerns per 100,000 population than comparators. The number of new safeguarding enquiries started in the year has reduced by 35% from 1106 in 2016/17 to 717 in 2017/18. As a result, the conversion rate from concern to enquiry, (where further investigation is required) has reduced from 36% in 2016/17 to 21% in 2017/18. The number of enquiries that has been completed during the year has decreased by 41% from 965 in 2016/17 to 570 in 2017/18, due to the reduced number of enquiries started in the year. This indicates that we are addressing more safeguarding issues at the point they are raised therefore not requiring further investigation.

There was an increase in the proportion of people asked about their desired safeguarding outcomes from 55% in 2016/17 to 78% in 2017/18, which is above the 2016/17 England rate of 67%. Coventry has increased the percentage of fully achieved/ partially achieved outcomes from 89% in 2016/17 to 97% in 2017/18 which is slightly above the 2016/17 England rate of 95%.

## 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 a 29% rise in the number of DoLS applications from 1736 in 2016/17 to 2248 in 2017/18. Of these, 314 (14%) are in due process compared to 205 (12%) in 2016/17. There is a significant increase in number of applications, but considering higher number of applications received, the percentage of not completed applications remained similar.

In total in 2017/18 1934 applications were completed which is a 26% increase on 1531 in 2016/17. Despite the demand for DoLS increasing and the subsequent resource challenges, we had relatively low rates of decisions outstanding and cases open at the end of the year.

As well as new DoLS applications there is also the requirement to review existing DoLS arrangements on an annual basis. The review requirement grows year on year as new applications grow. Resourcing this area of activity is of ongoing concern and will be subject to review to ensure we are meeting our legal duties in the most effective manner possible.

**TABLE 4:** SAFEGUARDING ENQUIRIES

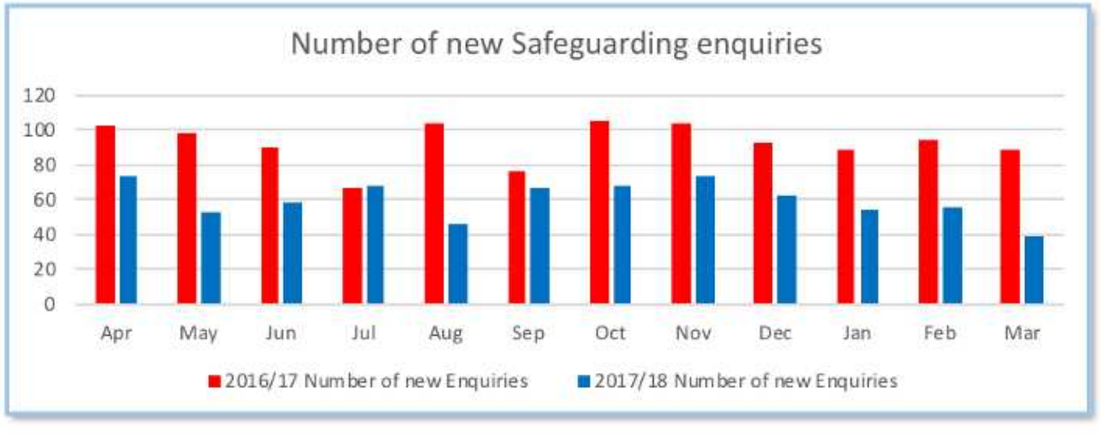
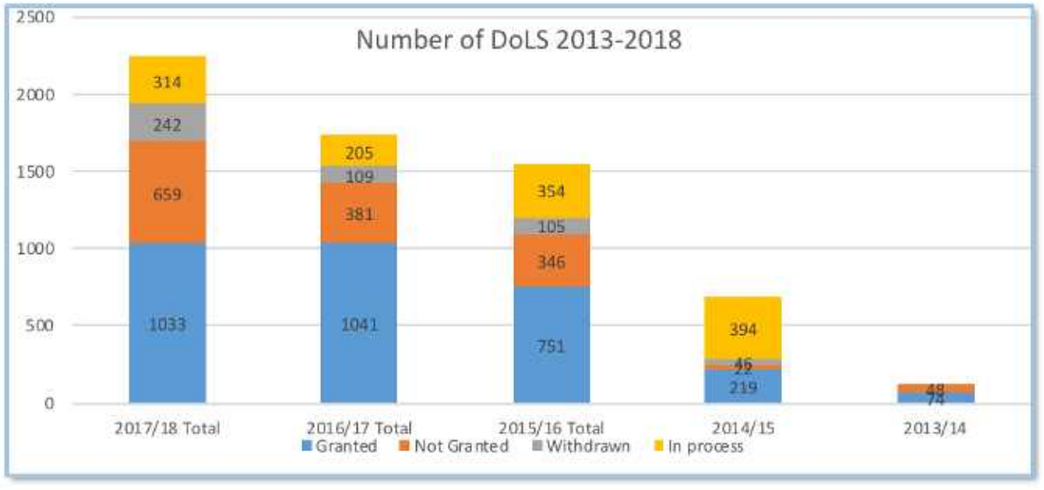



**TABLE 5:** DoLS TRENDS AND DIFFERENCES FROM 2013/14 – 2017/18

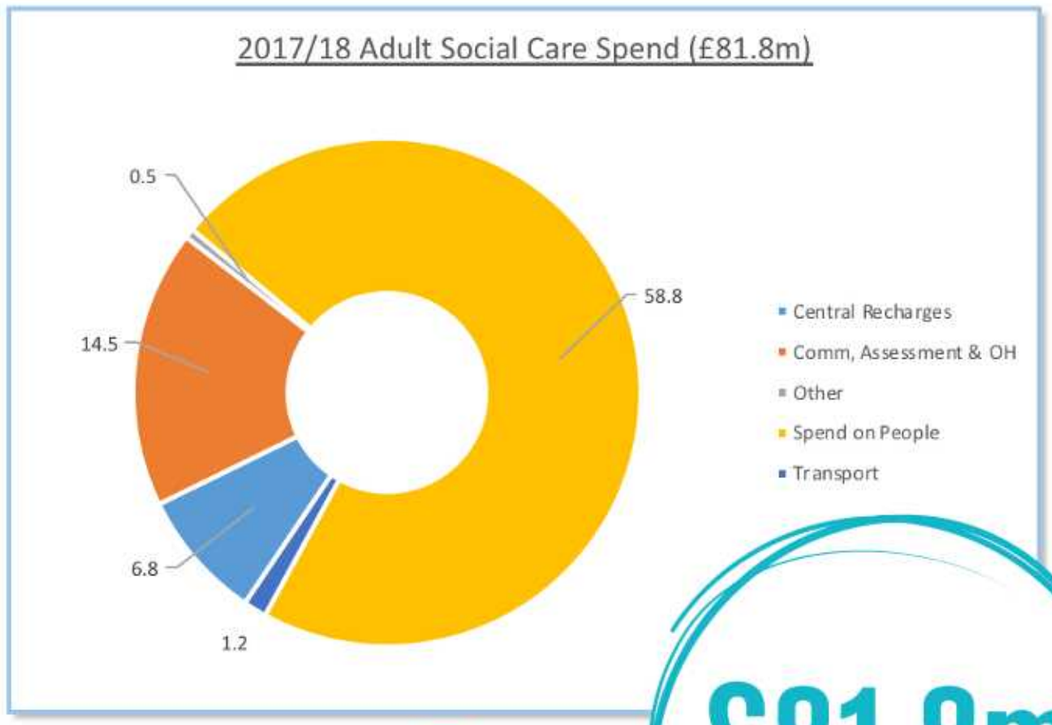


# MONEY -
# COVENTRY CITY COUNCIL

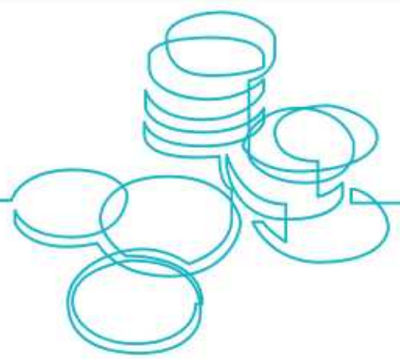
**The Council is a large organisation spending a net £230.9m on revenue activity during 2017/18.**

The Adult Social Care spend in 2017/18 net of service user contributions was £81.8m as shown below.

**TABLE 6:** 2017/18 ADULT SOCIAL CARE SPEND (£81.8M)




**£81.8m**
2017/18 NET ADULT SOCIAL CARE SPEND

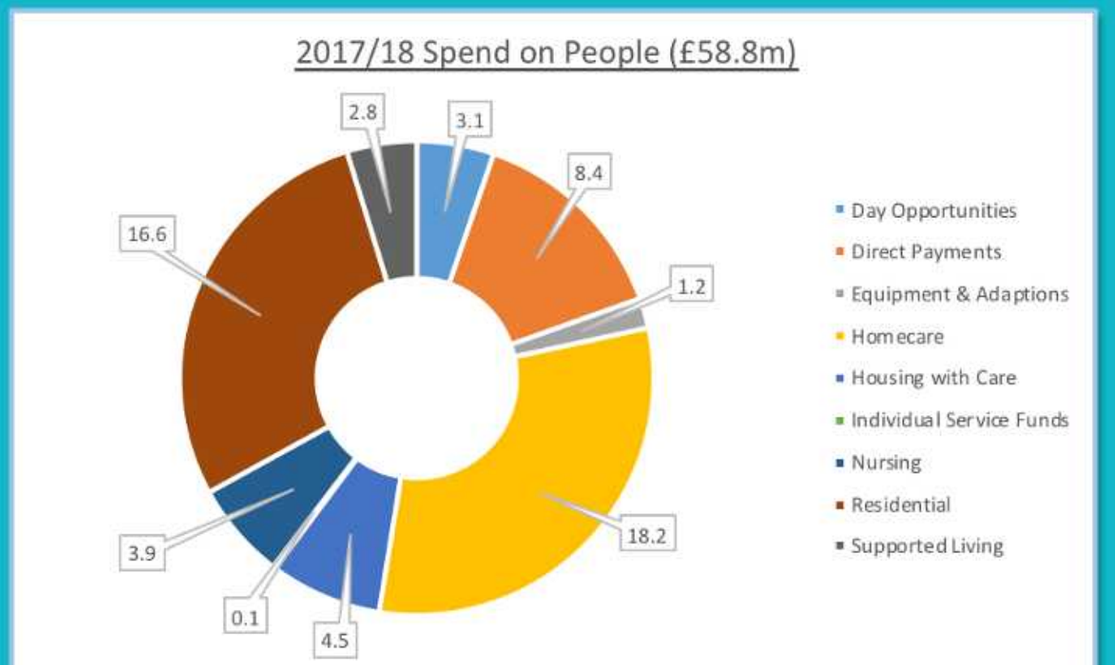




This compares to a spend of £78.1m in 2016/17. The increase was largely due to increases in care costs brought about by the National Living Wage.

The 'Spend on People' referred to in the above chart has increased from £56.5m in 2016/17. 'Spend on People' is money spent directly on the following services:

**TABLE 7:** 2017/18 SPEND ON PEOPLE (£58.8M)




This increase in spend was incurred despite the reduction in total numbers of people in receipt of ongoing care and support and is a result of increasing costs of care as a result of external factors including National Living Wage and the complexity of the care needs that people are experiencing.

In 2017/18 the Council underspent its Adult Social Care Budgets by £1.2m.

# 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:

- Coventry has a relatively young population but the number of older residents is increasing and the age of the population will start to increase. In particular, those aged over 85 and over is expected to grow by 22% in the next 10 years.
- The increasing number of older residents is related to increasing life expectancy amongst Coventry residents. However, on average Coventry residents are living a significant period at the end of their life in poor health.
- 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 life expectancy increases.
- The levels of deprivation in the city, although improving will remain relatively high and those living with lower levels of wealth are more likely to develop poor health.
- There is a projected 21% increase in the number of those aged 75 years and over between 2017 and 2025 who will be living alone. Those who are socially isolated are between two and five times more likely to die prematurely than those with stronger social ties.

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.

Approaches such as greater use of technology, focusing on people's strengths and what they can do for themselves, or be supported to do by families, friends and relatives along with the increasing the use of promoting independence models in order to reduce requirements for ongoing care and support.



PROJECTED

**21%**

INCREASE IN THE NUMBER OF THOSE AGED 75 YEARS AND OVER BETWEEN 2017 AND 2025 WHO WILL BE LIVING ALONE

# WORKFORCE

## AS AT 31 AUGUST 2017

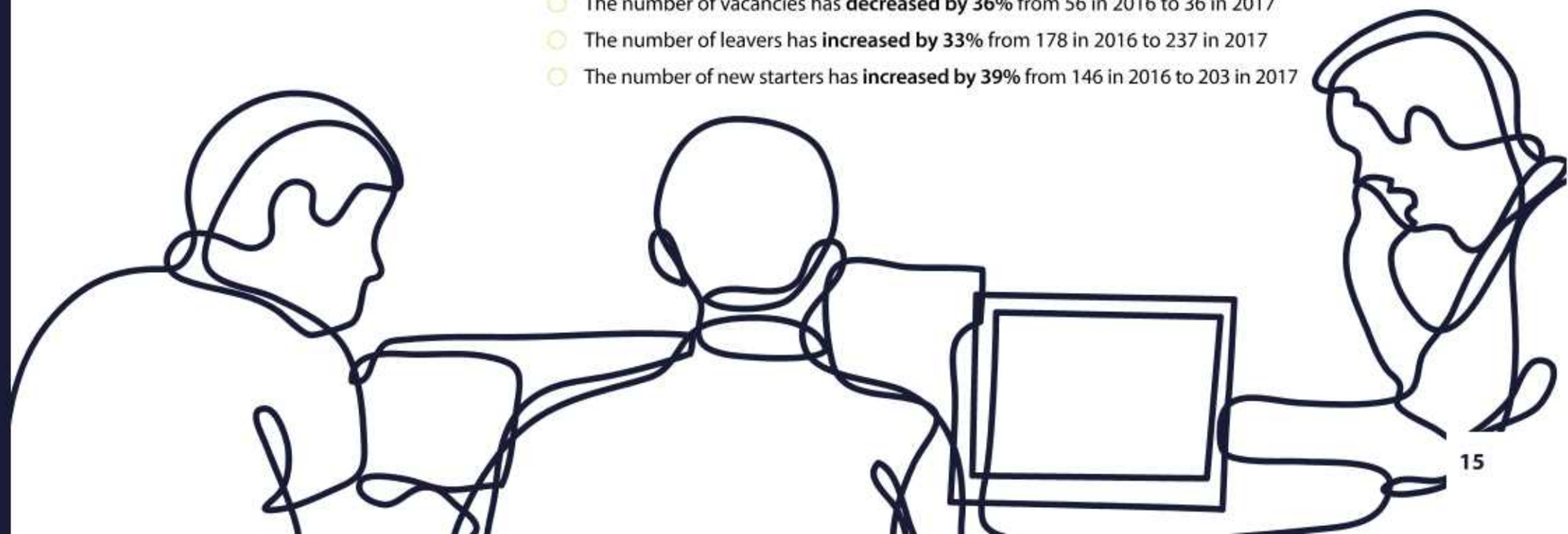
**The number of people in the Council's internal Adult Social Care workforce has reduced by 9.6% from 952 to 861 in 2017, this reflects an 8% reduction when compared with the Full Time Equivalent (FTE) figure. This reduction in workforce is consistent with the national profile where since 2009, local authority jobs have moved to the independent sector.**

Demographically the make-up of the Council's Adult Social Care workforce has stayed approximately the same as in 2016, with 82% being female, (the same percentage as the Personal Social Services: Staff of Social Services Departments, England national statistics.) and 3% disabled (no comparison national statistic available). There has been an increase in the workforce aged over 50 years of age from 46% in 2016 to 52% in 2017. However, overall the average age of the adult social care workforce is 48 years, similar to the average age of workers in adult social care departments within Local Authorities which was 47 years, and has not changed since 2011.

Ethnicity breakdown remains similar to 2016 with 77% of the workforce being white, 21% from a black or minority ethnic (BME) background and 2% are not known. This compares with 26.9% of Coventry's 18-64 population being BME (2011 Census). Ethnicity varies significantly between regions- from 50% of London local authority adult social care workforce to 2% in the North East- so comparison with the local population is more relevant than the national average of 85% white and 13% BME.

**Other information:**

- The number of vacancies has **decreased by 36%** from 56 in 2016 to 36 in 2017
- The number of leavers has **increased by 33%** from 178 in 2016 to 237 in 2017
- The number of new starters has **increased by 39%** from 146 in 2016 to 203 in 2017



# KEY ACHIEVEMENTS

## BASED ON THE ADULT SOCIAL CARE VISION AND OUR PRIORITIES FOR 2017/18

## 1. ADULTS AND CARERS AT THE HEART OF EVERYTHING WE DO

### ADULT SOCIAL CARE STAKEHOLDER REFERENCE GROUP

**Our Stakeholder Reference Group was created in 2016. The role of the group is to get involved in shaping future service delivery.**

During the last year, a key focus of the group has been to work with our strategic commissioning team to recommission support provided by voluntary sector agencies to help people live well and independently. The group has been involved in evaluating the applications received and providing vital feedback on proposals for future services. Where the group had questions about proposals these were put to the providers and the responses informed the decision-making process. The new voluntary sector support arrangements will last for five years and offer greater flexibility of support to meet people's needs.

A recent meeting of the Adult Social Care Stakeholder Reference Group

Looking forward to 2018/19 the group will be involved in improving service delivery through contributing to the implementation of the Care Quality Commission Local System Review action plan.

The group is keen to encourage more people to be involved. If you currently receive support from Adult Social Care or are a Carer and might be interested in joining the group please read our leaflet www.coventry.gov.uk/getinvolvedasc or contact us by email to getinvolvedasc@coventry.gov.uk

### DEVELOPING OUR APPROACH TO CARERS

In 2017/18 voluntary sector services were reviewed with the scope of offering support at the earliest possible opportunity to those most requiring it. Carers were integral to the recommissioning process and a key priority area. The Carers Trust continue to provide services for carers rebranding their service as the Coventry Carers Wellbeing Service, marking a reflection in their focus on wellbeing and their holistic approach to meeting carers' needs. They have increased their opening hours to further meet the needs of Coventry's carers who may struggle to access their services during working hours. The Alzheimer's Society now have additional capacity to facilitate the Carers Information and Support Programme, a very valued programme for carers of adults with dementia.



## 2. 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, which included developing a MSP Toolkit for staff. An evaluation of the project was undertaken by Coventry University. Both the toolkit and the evaluation are available on the Council website: **http://www.coventry.gov.uk/info/158/safeguarding_adults/2785/my_safeguarding_experience**

The evaluation identified that there had been a positive impact on practice in relation to mental capacity and the use of advocates. We received feedback though that we needed to ensure our forms were more supportive of person centred practice so in 2017 we introduced a new suite of safeguarding forms developed in conjunction with our practitioners. We also heard that we needed to promote more timely and appropriate referrals for advocacy. We therefore held a number of training sessions with Adult Social Care teams alongside one of our Advocacy Providers; Grapevine. In 2018/19 we intend to develop Risk Enablement Panels and Family Group Conferencing to support the Making Safeguarding Personal agenda.

As a local authority we are also a key statutory partner of the Coventry Safeguarding Adults Board. We work closely with other Board members and have supported the development of a Coventry wide Safeguarding Workforce Strategy.

The Board also organises conferences to raise the profile of Adult Safeguarding. On 9 November 2017 the Board held a conference entitled 'Safeguarding at the heart of everything we do'. This event provided a great opportunity to reflect on how all partners are working together to make safeguarding personal. **http://www.coventry.gov.uk/info/233/coventry_safeguarding_adults_board/3168/workforce_development/4**

### TRANSFORMING CARE

Adult Social Care has continued to work in partnership with other agencies to take forward the Transforming Care agenda supporting adults with learning disabilities. This has included signing up to Care and Treatment Reviews (CTRs). These form part of NHS England's commitment to transforming services for people with learning disabilities, autism or both.

The All Age Disability Service has assisted in both discharge and admission avoidance for adults with complex health and social care needs and continues to play a key role in the multi-agency process that exists in Coventry.

New processes and services have been introduced during the last 12 months to support individuals with a focus on professional staff working together to reduce the risk of hospitalisation and to ensure that discharge arrangements are robust and achieve the required outcomes.

Delivering the requirements of the Transforming Care Programme is a key challenge for social care and its health partners. Although 10 people have been discharged in 2017/18 there were 12 admitted. As a result of this, along with size of the original baseline, we are not meeting the trajectory required by NHS England. There are, however, recovery plans in place, the delivery of which is closely monitored through the programme board in place to oversee this work.

## THERAPY AND ENABLEMENT SERVICES

Our Occupational Therapy and Visual and Hearing Impairment (VHI) teams play a key role in helping people of all ages to overcome the effects of disability caused by illness, ageing or accident, so that they can carry out everyday tasks or activities important to them. Often before someone has a need for traditional forms of care and support our staff will provide practical solutions to support recovery and overcome any barriers that prevent them from doing the activities that matter to them. This may be achieved by simply helping to identify local support networks, by providing a period of rehabilitation, provision of equipment or adaptation of the home. Our goal is to support people to live as fulfilled lives as possible and not to just exist!

### CASE STUDY 1 – MRS H

Mrs H has acquired hearing loss and is unable to hear speech over the telephone. She uses lip reading and speech to communicate. Mrs H contacted the Visual and Hearing Impairment (VHI) team asking for provision of a minicom/text phone to enable her to contact her GP herself rather than asking her family to do so.

A member of the VHI team advised her of the Next Generation Text Service (NGTS). This allows users to make text calls through an application on tablets/mobile phones and they arranged to visit to explain how the service worked.

With support from the VHI Team to install the NGTS application on her mobile phone and to practice using the service Mrs H has been able to contact her GP surgery independently. Mrs H plans to use the NGTS application to contact other services like the bank and utility companies.

Support from the VHI team enabled Mrs H to utilise equipment she already owns to increase her independence. This is an example how technology is progressing rapidly and simple things like a smart phone can unlock a whole new breadth of support.



# 3. REFLECTIVE AND RESPONSIVE TO CHANGE

## VOLUNTARY AND THIRD SECTOR SUPPORT

During the year a major reshaping of preventative health and social care services provided by the voluntary sector was undertaken with the new arrangements commencing on 1 April 2018. The grant funded arrangements are more outcome focussed and based on longer term agreements giving more certainty to customers and providers. There are also opportunities for closer partnership working between the Council, Coventry and Rugby Clinical Commissioning Group and providers. The new arrangements also enabled the commissioning of a new service to improve the lives of people with compulsive hoarding behaviours.

## NEW HOME SUPPORT ARRANGEMENTS

In June 2017 new home support arrangements came into effect within Coventry. Nationally it is recognised that the home support industry faces significant challenges especially with recruitment and retention of their workforce. Coventry also face the same challenges locally. The New Home Support framework was recommissioned with the aim of improving quality and performance. This has led to a reduction in waiting times for services to start. The new services are based in local areas, meaning a greater understanding of the needs of local communities. Providers are required to use Electronic Call Monitoring Systems, which enables the provider and the local authority to monitor care workers visits, duration of visit and timeliness.

In order to ensure continued quality and improvement we are working closely with our providers. These arrangements include regular provider forums and contract meetings. In 2018/19 the aim is to embed accreditation approaches such as React to Red within home support.

# 4. OUTCOME DRIVEN AND MEANINGFUL

## INITIAL CONTACT WITH SOCIAL CARE

Building on the successes of last year, with the launch of the online self-assessment tool, an online Carers' self-assessment was launched in January 2018. Working closely with the Carers Trust Heart of England, processes have been developed to ensure carers are linked to the most appropriate support at the earliest opportunity. The online support is aligned to the pre-existing Adult Social Care information directory, ensuring the public have consistent access to information about services available in the city.

Internal improvements have seen the implementation of the social worker appointment booking system. When a member of the public requires a visit from a social worker they are given an appointment date and time. The benefit for the public is that people know when they can expect a visit, reducing any anxiety they may have when they are waiting for a social worker to make contact. The system has initially been implemented with the older people social work teams with plans for 2018/19 to include Occupational Therapy and the Adults Disability Team.

## THE POD

'The Pod' uses social brokerage as a means to support and transform the lives of people with severe mental illness whilst also benefitting the wider community with its cutting edge and ambitious programming. This year it relocated from its base at Lamb Street to a Grade 2 Listed medieval building in Far Gosford Street. This new location in Far Gosford Street is perfect for The Pod – it's a cultural corridor where creativity can underpin practical help for citizens and inspire social activism. The building and its location supports all aspects of the work that The Pod team do – facilitating mental health recovery, promoting cohesion, addressing food poverty and stimulating regeneration. It is street facing and the space alone creates a reason for people to feel optimistic and believe in themselves and the city.

In 2017 Think Local Act Personal (TLAP) and the National Development Team for Inclusion published a report detailing The Pod's evolution since 2009 and continued commitment to transformative practice: **https://www.thinklocalactpersonal.org.uk/Latest/Lamb-Street-to-the-Pod-The-Journey-from-Service-Users-to-Citizen/**

# 5. SUPPORT AROUND PEOPLE AND THEIR FAMILIES

## TRAVEL TRAINING

The Independent Travel Team has been established in Coventry since 2006. They are a small team with four Travel Trainers offering travel training to young people from 11 years old onwards with Education, Health and Care Plans, and people over 18 with identified care and support needs.

The Independent Travel Team offers a city-wide service, working in schools, colleges and in the community.

Starting in 2017/18 the Team now supports the Promoting Independence Service that has been introduced for Adults with a Learning Disability and has supported individuals to achieve independence within and outside of the city boundary. The service has successfully supported adults with learning disabilities to engage in employment, activities, volunteering and supported carers to return to work.

The service works with 48 people (12 Adults/36 young people) at any one time and in 2017/18 has supported approximately 30 people to travel independently. In many cases this has transformed people's lives.

## CARE CLOSER TO HOME

The Council's All Age Disability Team has continued to extend the principles of supporting individuals to consider care options nearer to home and families. This has built on the good practice outcomes from the long term care initiative funded though the Better Care Fund. We have worked across services to develop local options and now have in place a plan to assist users back into Coventry and into supported living. We have seen the benefits of this in terms of the impact on emotional wellbeing and more independent living.

## CASE STUDY 2 – MR B

Mr B is a 19-year-old man with learning disabilities and autism who attends a local college. He worked extensively with a Travel Trainer to learn the bus route from his home to college. The support included learning about the practicalities of independent travel, recognising the bus stop, using a bus pass and flagging down a bus. This also included supporting him around keeping himself safe, who are safe people to offer help if required and contingency planning for "what if" scenarios that might affect his journey.

The team supported Mr B for six months. His mother previously drove him daily to get to and from school and then college. Following the period of support from the travel training team Mr B was independent with the route to college and his mother was able to seek employment for the first time in 16 years.

The Travel Trainers worked again with Mr B as part of the Learning Disability Promoting Independence Service. Mr B is learning a new bus route from his home address to a local gym. This will support him to participate in activities outside of college, in his leisure time, improving his fitness and enabling him to make friends and make good use of community facilities.

The outcomes for Mr B and his mother have been hugely positive. Travel training with Mr B has reduced transport costs to college and will continue to promote his future independence as he develops his skills further.

IN 2017/18 THE SERVICE HAS SUPPORTED APPROXIMATELY

**30** PEOPLE

TO TRAVEL INDEPENDENTLY



# 6. EFFECTIVE ENABLEMENT, PREVENTION AND WELL-BEING

## PROMOTING INDEPENDENCE PATHWAYS

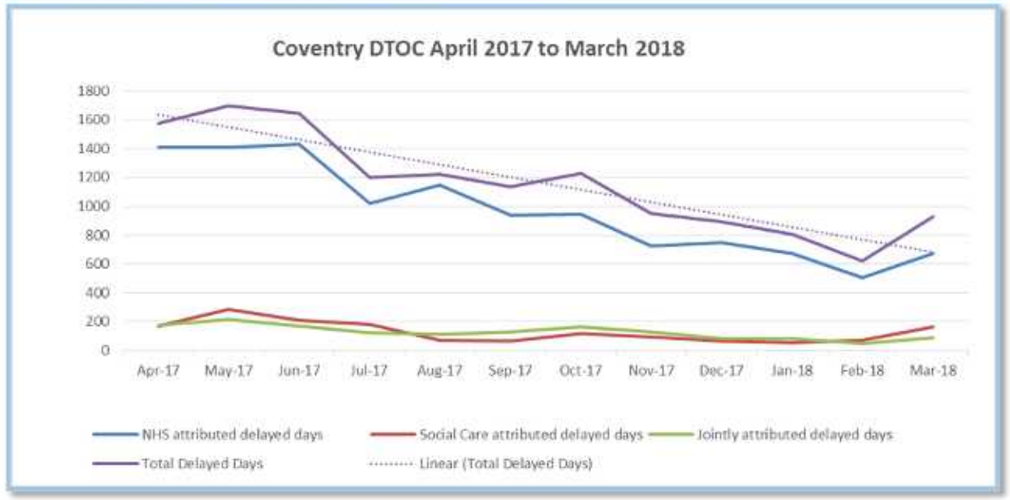
We have established a new service for older people and adults with a physical disability which provides short term support to help individuals regain their independence e.g. after a period of illness. We all want to carry on doing things for ourselves so a team of Occupational Therapists, Social Workers and home support workers help individuals to regain confidence in carrying out specific essential tasks of everyday daily living. After receiving support, we have found that many people don't need any further help, or only a little, so they can carry on living independently in their own homes. In the first six months since the service started there have been 108 people referred. A total of 66 people referred to the service did not go on to receive long term care. The service uses kitchen facilities at Gilbert Richards Centre that have recently been modified, to enable the Occupational Therapists to carry out kitchen assessments where appropriate and promote the person's independence.

We have established a new service for adults with a learning disability that supports the assessment of need and supports people to develop new skills. The principles we apply are very much the same as for all adults but the service is more specifically tailored to adults with learning disabilities. Delivering this is a 'whole service' approach across Occupational Therapy, Travel Training and internal provider services such as Jenner8 to support adults to try new things and to live as independently as possible. Since the pilot started in July 2017, in the first twelve months 88 people have been referred into the service and so far 12 people have successfully accessed support from the service.

## DELAYED TRANSFERS OF CARE (DTOC) AND ADMISSION PREVENTION

Once a person is admitted to hospital and they have finished their treatment, it is really important that they leave hospital in a timely manner before an individual risks losing essential skills. Working with partners we have improved our Delayed Transfers of Care performance and achieved national targets set for Coventry. Schemes including the Community Discharge Hub, Red2Green Campaign and new contracts with reablement providers helped us improve our performance. We have supported care homes with good primary care services and initiatives including "React to Red Skin". The aim of this campaign is to educate as many people as possible about the dangers of pressure ulcers and the simple steps that can be taken to avoid them and to ensure these are put in place to avoid unnecessary hospital admissions.

**TABLE 8:** COVENTRY DELAYED TRANSFERS OF CARE



# 7. MATURE PARTNERSHIPS

## WORKING WITH HEALTH PARTNERS TO DELIVER A SUSTAINABLE HEALTH AND SOCIAL CARE ECONOMY

We have continued our work to develop services and relationships with our key health partners and work in collaboration to develop joint solutions. Our work in relation to Delayed Transfers of Care has impacted positively on discharge activity so that people leave hospital as soon as they are able to the most appropriate setting for them.

We have well established discharge pathways from hospital and regular multi-disciplinary meetings to ensure that people get appropriate support when discharged, receiving the right short term services in order to reach their full potential in the longer term.

This, together with new preventative services, have supported people to avoid unnecessary admissions to hospital. This targeted use of the Integrated Better Care Fund has allowed us to develop, or extend, a number of initiatives to help people to remain safe and well in their own home and include transport services, home safety checks, services to improve nutrition, community support, and home heating services.

Targeted use of Integrated Better Care Funding has also supported sustainability of the local care market to ensure viable and good quality services.

We have also progressed discharges under the Transforming Care Programme which has benefitted adults with a learning disability. We have established processes that support our staff to work across organisational boundaries for adults with a disability. Two new posts have been developed specifically to work with those most at risk of hospital admission as part of a multi-disciplinary team.

## CARE QUALITY COMMISSION (CQC) LOCAL SYSTEM REVIEW

The Care Quality Commission (CQC) completed a review of the health and social care system between December 2017 and March 2018 within Coventry, to answer the question "How well do people move through the health and social care system, with a particular focus on the interface between the two, and what improvements could be made?"

The review concluded that Coventry is well situated to make further improvements given the already existing commitment from partners to work together. There was good evidence of effective leadership and commitment to improve services and support integration between Health and Social Care. The full report can be found on the CQC website at **Local system review: Coventry.** The Coventry Health and Wellbeing Board has led the development of an improvement plan to take on board the findings of the CQC review and ensure these are embedded as other system work progresses.



# 8. COMMITTED WORKFORCE

## SUPPORTING OUR WORKFORCE

During 2017/18 we have developing a Workforce Strategy for Adult Services to ensure 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 activities. **https://www.coventry.gov.uk/info/192/adult_social_care_strategies_policies_and_plans**

In support of practice development, we developed a new role of a Practice Development Social Worker. This role now co-ordinates and provides support to newly qualified social workers on the Assessed and Supported Year in Employment (ASYE). It also co-ordinates and supports social work student placements and the learning of those students within Adult Services.

Having specific capacity dedicated to practice development will help to strengthen the practice skills and knowledge of front line staff and managers, providing onsite learning and coaching. The role will also establish any existing gaps in knowledge and support for continued workforce development.

## PRACTICE QUALITY ASSURANCE AND ENGAGING WITH OUR STAFF

In early 2017 we commenced the implementation of our Practice Quality Assurance Framework. This is a Framework which focuses on self-assessment and quality assessment methods at practitioner and organisational levels. Our practitioners now receive annual observations of their practice and dedicated time to reflect on their practice with their manager.

The aim of this work is to achieve greater consistency and accountability in the quality of the service we provide and put the right support and challenge in place to improve practice.

Our Framework also included the requirement to undertake an annual 'Organisational Health Check'. This was undertaken using a survey and focus groups with staff in the summer of 2017. This is an important way of ensuring that staff are listened to and that as an employer we are pro-active in tackling the issues that affect them. The Health check was well received and identified a number of strengths with staff positive about their supervision and being able to raise issues and concerns with their managers. We did however receive feedback that we needed to look at our assessment forms as these were felt to be too long. We have planned to look at this next year in 2018/19.

## 9. INNOVATIVE

### NEW SERVICE FOR PEOPLE WITH DEMENTIA

The city has a new facility offering a purpose-built specialist Housing with Care Scheme (HWC) specifically for people either living with dementia or with a cognitive impairment. The scheme consists of 33 self-contained flats. Each flat consists of lounge, kitchen and a single bedroom with ensuite bathroom. The scheme also has communal living facilities to enable social interaction, one of the key principles of the Eden Alternative care model which underpins the scheme.

More information of the care model can be found here: **http://www.edenalt.org/about-the-eden-alternative/mission-vision-values/ https://www.thegreenhouseproject.org**

This innovative model moves away from the traditional HWC models of support and provides a more structured approach to enable people living with dementia to live independently in a safe environment. There are a very limited number of such schemes across England adopting this approach, putting Coventry in the forefront of innovative services for people living with dementia.

## CASE STUDY 3 – MRS C

Mrs C has Alzheimer's disease. She lived at home on her own with her dog and has a supportive son.

Mrs C often became very anxious resulting in her contacting her son up to 40-50 times every day, including during the night. This had a huge impact on his working life. Mrs C had stopped cooking and wasn't reliably taking medication. Telecare and homecare was unsuccessful. The main issue was the high levels of anxiety which impacted on Mrs C's level of confusion and her need for constant reassurance.

Her son felt the only option was residential care. The specialist Housing with Care (HWC) provision was suggested as an alternative as Mrs C wished to be more independent. Residential care would have also meant her no longer living with her dog which is very important to her.

Mrs C and her dog moved into the specialist HWC. Her son has stated the change has been "unbelievable" & "incredible". Since moving, Mrs C no longer rings her son as regularly. She states she is really happy and a lot less anxious. Living with her dog has been vital and the dog is much loved by other tenants, supporting Mrs C to make new friendships.

Mrs C has started cooking again and getting her own meals and is now taking her medication with the aid of a telecare medication dispenser. Mrs C and her son feel her mental health and memory have actually improved as she is a lot less anxious. She states she is reassured by the presence of staff and she knows they are there if she needs them. She is now far more independent, has regained skills and is a lot happier.



### INNOVATIVE USE OF TECHNOLOGY

The use and benefit of technology in the social care sector is increasing. With the introduction of smart technology that enables real time monitoring and assessment of an individual's condition there is a significant opportunity to expand the way we use digital innovations to support the people of Coventry. In early 2018 software known as "Brain in Hand" was identified as an alternative support mechanism to more traditional arrangements. The application enables people who have cognitive impairments to create prompts and coping strategies that they can use throughout the day. The aim is to improve resilience and reduce reliance on traditional models of care. Further use of the application will commence in the summer of 2018.

## CASE STUDY 4 – MR M

Mr M has a mild learning disability. He was referred to the Jenner8 Project, a promoting independence service. He was described as socially isolated during his days off from college. Mr M preferred to stay upstairs, researching his favourite hobbies on his tablet computer. He did not travel independently.

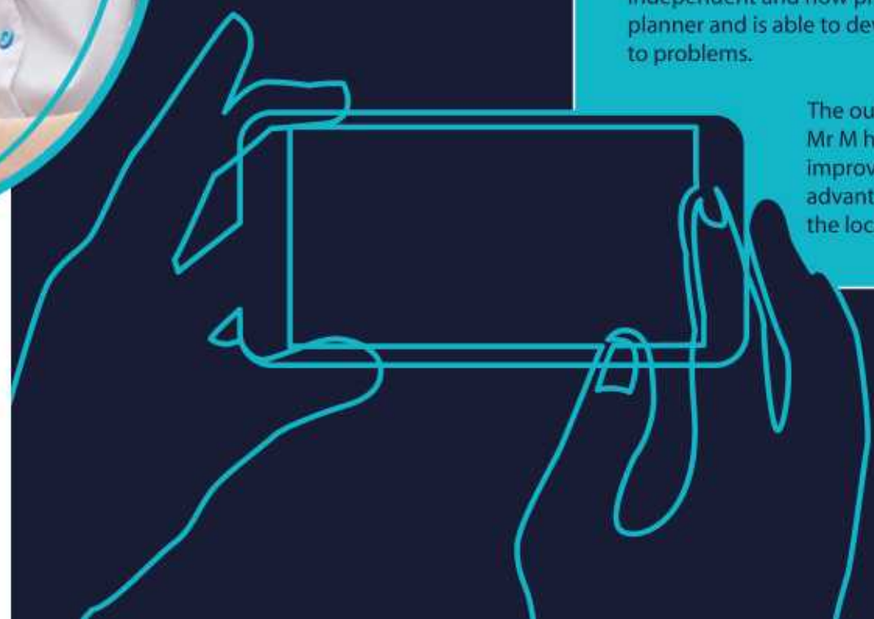
Jenner8 staff met with Mr M and his family, to explore what he wanted to achieve. He was restricted because he couldn't travel independently. He wanted to get involved in the performing arts.

Mr M commenced travel training with the Independent Travel Training Team alongside the support of Jenner8 so that he could attend a theatre performance group in Coventry, joining the stage scenery group.

Mr M settled in quickly and started to talk with other people in the group. Mr M met people with common interests and started to develop ideas for the next performances. Workers gradually withdrew as he gained confidence and independence.

Subsequently, Jenner8 invited him to take part in the pilot of the "Brain in Hand" application. He has good IT skills and is enthusiastic about sharing them with others. He attended a session about the application at the library. He identified that he wanted to be more independent and now programmes his own personal planner and is able to develop his own solutions to problems.

The outcome of the support is that Mr M has been able make choices to improve his independence and take advantage of opportunities within the local community.



# 10. HIGH PERFORMING

## ADULT SOCIAL CARE OUTCOMES FRAMEWORK (ASCOF)

Coventry's performance across the Adult Social Care Outcomes Framework (ASCOF), which reports across a range of national annual indicators, has been maintained. There has been improvement in four performance measures, 12 have remained at a similar rate to last year or had declined slightly in line with the target set for the year and four measures have declined and are below target.

**Performance has improved in four measures:**

- Reducing the number of admissions into nursing/residential care for people aged 65+
- Reducing the rate of delayed transfers of care from hospital per 100,000 population for all delays
- Reducing the rate of delayed transfers of care from hospital per 100,000 population for adult social care/joint delays;
- Increasing the proportion of people still living at home, following Short Term Services to Maximise Independence

These four key performance measures monitored through the Better Care Fund programme, evidences that our focus for 2017/18 has been successful in driving through improvement in these areas. Performance has improved as a result of our focused attention on effective enablement, prevention and well-being and continued effective working with health partners.

**Performance has declined and we have not met our target in the following four measures:**

- Proportion of people who use services who have control over their daily life
- Proportion of carers receiving self-directed support
- Proportion of carers receiving direct payments for support direct to carer
- Proportion of people who use services who find it easy to find information about services.

A key action identified for 2018/19 is to improve the customer experience at initial points of contact and to update all our public information which we hope will impact positively on the results of people who use our support satisfaction surveys.

## IMPROVED INTERNAL PROVISION AND RATINGS

The Council continued to receive "good" ratings from the Care Quality Commission across its internal directly provided care services. These services include two care homes (one for people with dementia and one for adults with learning disabilities), six housing with care schemes, a 'Promoting Independent Living Service' that supports people with learning disabilities in their own homes and an established Shared Lives Scheme that provides support for a number of adults and older people to reside within a family home environment.

Services have been inspected against the five key areas: i.e. Safe; Effective; Caring; Responsive and Well-Led. All of our internally proved services have achieved "good" ratings in all of these areas in recent inspections.

Whilst there are some challenges in improving and maintaining good quality in contracted provision, CQC care directory data shows that the quality of providers in Coventry compares well against the national picture and local authority comparator averages . The proportion of care providers in Coventry rated as 'Good' is 83.4% with the national (England) rate being 84.1%.

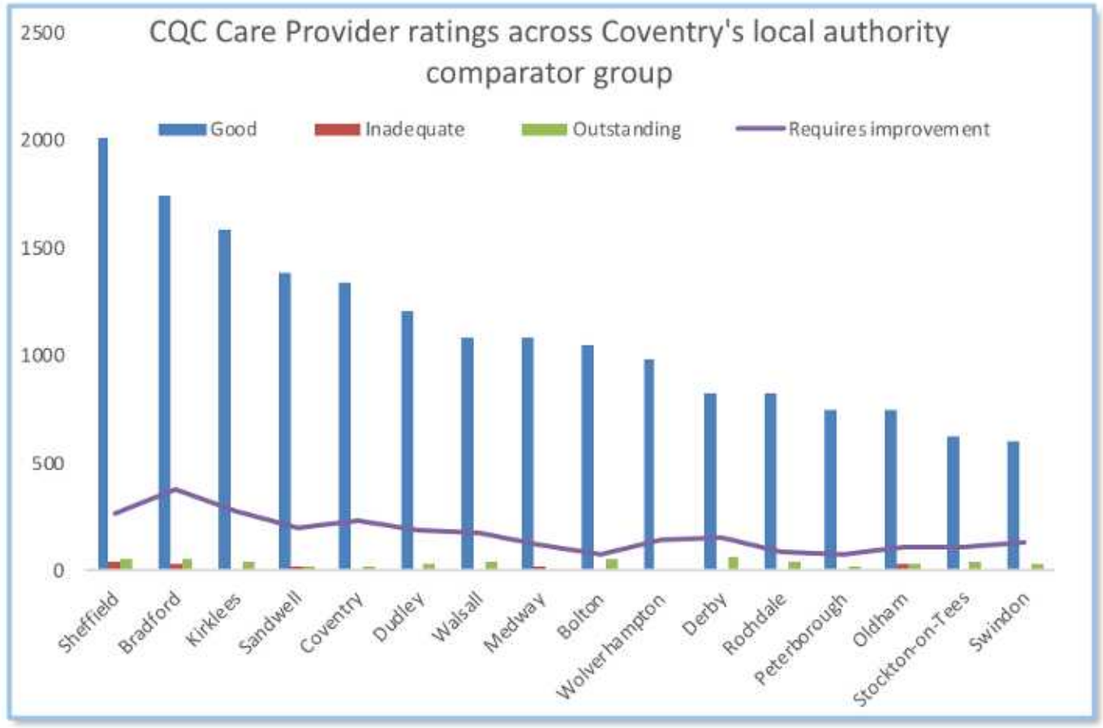
**Some comments from inspections that took place in 2017/18:**

"YES I FEEL VERY SAFE AND SECURE HERE."
(Housing with Care Scheme tenant)

"NONE AT ALL (CONCERNS) IT IS ABSOLUTELY EXCELLENT; THEY ARE MARVELLOUS."
(Care home resident's relative)



**TABLE 9:** CQC CARE PROVIDER RATINGS ACROSS COVENTRY'S LOCAL AUTHORITY COMPARATOR GROUP




[1]The local authority comparator group is drawn from the Chartered Institute of Public Finance and Accountancy's Nearest Neighbours model that identifies 15 local authority areas most similar to Coventry.

The data also shows that 0.6% of providers in Coventry are rated as 'inadequate.' This is lower than the national rate and local authority comparator group average of 1%. The focus for Coventry is around the group of providers that are rated as 'Requires Improvement.'

A key challenge is recruitment and retention of care staff. The Council is working with providers to think creatively about how to attract and retain good staff through a number of initiatives such as the care home provider forum which encourages sharing of ideas around best practice. However, according to the Skills For Care West Midlands Regional Report the staff turnover rate in Coventry is 27%, the sixth lowest of the 14 local authorities in the West Midlands.

The care home sector-led registered managers' forum has also been re-established and meets regularly facilitated by Skills for Care and supported by the Council. A number of care home improvement initiatives are in place in collaboration with our NHS partners including 'React to Red' skin pressure ulcer prevention and treatment accreditation and 'Say No to Infection', a programme which accredits homes for infection prevention and control.

React-to-Red' has 24 care homes accredited along with 'Say No to Infection' that has 9 care homes accredited. All accredited homes have been avoidable pressure ulcer free since accreditation.

# AWARDS AND GOOD NEWS

## SUPPORTING OUR NEWLY QUALIFIED SOCIAL WORKERS

**In Coventry we are fortunate to have a very good retention rate, with most of our social workers having worked in Coventry for a number of years.**

We do though recruit new social workers and some of these are newly qualified. A newly qualified social worker has an initial 'Assessed and Supported Year in Employment' and we are pleased that this year both Otis Hinds and Grace Boahene-Darfour completed this successfully.

## ON THE MOVE TO ONE FRIARGATE

In October 2017 Adult Social Care began moving into a new 11 storey building called "One Friargate". This building offers a modern working environment in an open plan layout. For the first time most of adult social care are now based within three floors of the building supporting collaborative working and greater integration with commissioning, Public Health and the rest of the Council. It's an exciting time for Adult Social Care introducing new ways of working.

## PHOENIX AWARDS

Adult Services continued to support the Council's annual award scheme. Shortlisted entries included Kelly Boyce, a Community Case Worker in the category of "Rising Star" and Carol Chapman, a Support Assistant at Brandon Wood Farm in the category of "Role Model."



# WHAT'S NEXT

## KEY AREAS OF DEVELOPMENT FOR ADULT SOCIAL CARE 2018/19

**Continuous improvement is key for Adult Social Care to enable us to provide support based around the individual and carers within the resources available.**

We will be further strengthening our links with health colleagues, joining up and collaborating wherever this will give better outcomes for those people we support during 2018/19.

**The key areas for development and improvement are:**

- Building on the success of our community promoting independence approach to enable more people to remain independent and wherever possible to continue to live in their own homes
- Exploring a range of Assistive Technology options to support people in new ways ensuring individual needs are met through a person centred approach
- Working with the provider market to ensure stable and varied living options are available to meet the future needs of the people we support within the resources available
- Improving the customer experience at initial points of contact used by the public to enhance the opportunities for people to manage their own care requirements
- A continued focus on the quality of practice and the workforce
- Working with health colleagues to ensure that Adult Social Care supports the effective delivery of the Out of Hospital model of support
- Continuing to contribute to the delivery of the improvement plan arising from the CQC system review

# GLOSSARY

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

| | | |
|---|---|---|
| **Delayed Transfers of Care (DTOC)** | Page 4 | A Delayed Transfer of Care refers to a situation when a patient is ready to leave hospital but is still occupying a bed. |
| **Better Care Fund (BCF)** | Page 4 | 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. |
| **Care Quality Commission (CQC)** | Page 5 | This is the independent regulator of all health and social care services in England. |
| **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 Concern** | Page 10 | A Safeguarding Concern is an alert regarding suspicions or allegations of abuse or neglect. |
| **Safeguarding Enquiry** | Page 10 | 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 11 | 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 2005 allows restraint and restrictions to be used – but only if they are in a person's best interests. |
| **Joint Strategic Needs Assessment (JSNA)** | Page 14 | 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 17 | 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. |
| **Safeguarding Adults Board** | Page 17 | A Board which represents the various organisations in a local authority area who are involved in adult safeguarding. |
| **Transforming Care** | Page 17 | A national programme aimed at supporting people with learning disabilities, autism and behaviours that challenge who are either in hospital or a risk of admission by developing community services and prevent unnecessary admissions to hospital settings. |
| **Care and Treatment Review (CTR)** | Page 17 | Care and Treatment Reviews are multi-disciplinary meetings for adults with learning disabilities, autism and mental health who are at risk of hospitalisation under the Mental Health Act due to escalated behaviours. |
| **Clinical Commissioning Groups** | Page 19 | Clinically Led statutory NHS Bodies responsible for the planning and commissioning of health care services in a local area. |
| **React to Red** | Page 19 | A campaign, raising awareness of pressure sores, how to prevent them and how to identify those most at risk of developing them by delivering training and support to those involved in care. |
| **Think Local Act Personal (TLAP)** | Page 19 | A national partnership transforming health and social care through personalisation and community based support |
| **Promoting Independence Service** | Page 20 | A service which works with people for a time-limited period to maximise their independence with everyday living skills. |
| **Assessed and Supported Year in Employment (ASYE)** | Page 23 | This is a 12 month employer-led programme of support and assessment for newly qualified social workers. |
| **Housing with Care** | Page 24 | A housing scheme which can provide the varying levels of care and support that people may need whilst living within their own tenancy. |
| **Adult Social Care Outcomes Framework (ASCOF)** | Page 26 | 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. |
| **Skills for Care** | Page 27 | An organisation which supports workforce development in Adult Social Care. |
| **Say No to Infection** | Page 27 | A campaign that aims to reduce and prevent infections within care home and domiciliary care settings by providing training and educational assistance for anyone involved in care. |

# CONTACT US

You can contact us about this report at: **getinvolved@coventry.gov.uk**

You can contact **Adult Social Care Direct** at:
Email: **ascdirect@coventry.gov.uk**
Telephone: **024 7683 3003**
More information about Adult Social Care can be found at:
**www.coventry.gov.uk/adultsocialcare**