Adult Social Care

Annual Report for 2011/12 (Local Account)

Produced November 2012

Coventry City Council

www.coventry.gov.uk

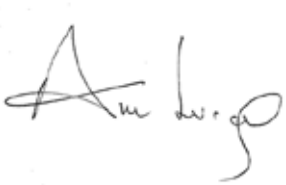
Foreword

Councillor Ann Lucas
Cabinet Member for Health and Community Services

I welcome this Annual Report as an important part of the Council's commitment to be transparent with local people about what we do and what we have achieved for the people in the City who use our services and carers.

Since our last Annual Report, we have seen the publication of the Care and Support White Paper – Caring for our Future. Whilst the issue of funding social care in the future was not fully addressed, the White Paper provides a sound platform for reforming the social care system, and builds on areas we are already committed to in Coventry, including developing preventative practice and early intervention.

In Coventry, we are committed to ensuring good quality, safe, efficient and creative services so that we can face the challenges of the future with confidence. I hope you find the report useful and use it to help us to continue to improve our services in spite of a challenging financial environment.



Brian Walsh
Director of Community Services

I am pleased to present our second Annual Report on the performance of Adult Social Care. The process for how councils are assessed on their delivery of adult social care services has changed. Rather than reporting on performance to Central Government, all councils responsible for delivering adult social care will now report directly to local residents. This will be achieved through the publication of the Annual Report.

It is important that people using Adult Social Care services, carers and also the wider community understand the challenges we face, and how we are responding to these in a positive way. We are all tasked with managing ongoing budget pressures whilst addressing increasing demand for care and support services. This report reviews our successes and challenges over the year, and describes the progress we have made against the priorities we set in last year's report.

The Annual Report is intended to be easy to read and is aimed at both people who use social care services and the wider community. You can help us improve future reports by giving us feedback on this document and telling us the type of performance information which is of most interest to you.

Our contact details are provided at the end of the report, and we very much welcome any comments you may have.

Contents

What it means to receive Adult Social Care support in Coventry

Adult Social Care is part of the Community Services Directorate of the Council. We work with internal departments and partners across the City to support adults over the age of 18 and older people who may need information, advice or support to remain independent. This Annual Report is a way of communicating to the people of Coventry about how the Council and its partners are meeting the needs of people who require social care and support.

If you live in Coventry and receive social care support, you are more likely to be living independently and safely in your own home, supported by equipment or adaptations, than if you lived in many other cities across England.

The latest available data compares the Council with similar councils across England. It shows that:

- Coventry is spending a higher percentage of money on supporting people to live in the community rather than in residential or nursing care.
- Coventry is spending less money on residential and nursing care overall.
- 46% of people receive equipment or adaptations to support them to live in their own homes; this is higher than the England average.

Throughout this report we are able to show that we are delivering the priorities highlighted within the **Council Plan 2011/12 – 2013/14.** This plan sets out the vision for the City for the next three years. The priorities have been identified by Elected Members based on what people have reported as being most important to them. For Adult Social Care this means **protecting the City's most vulnerable residents, supporting older people and disabled adults to live independently and safely,** and for people to have **more choice and control over their health and social care.**

Facts and figures 2011/12

Between 1st April 2011 and 31st March 2012

8,998
people received support from Adult Social Care during the year, a decrease of 344 (3.7%) from 2010/11.

5,314
people received a review of their support during the year - 59% of all people who use services.

3,791
Blue Badges were issued during the year. There are 12,501 Blue Badges in use in the City.

53%
of people aged 18-64 who were assessed were female; this figure rose to 65% for those aged over 65 years.

9,366
people were referred to Adult Social Care and 4,628 people received an assessment, an increase of 944 from 2010/11. 2,040 (44%) went on to receive further support.

1,344
carers received an assessment or review and were provided with information, advice or a service.

70%
of people with learning disabilities aged 18 to 64 who receive support from Adult Social Care live in their own home or with their family.

30,461
items of equipment were delivered.

17%
of people aged 18-64 who receive support from Adult Social Care are from black or other minority ethnic groups. This figure is 9% for those people aged over 65. This is broadly representative of Coventry's diverse population.

95%
of people who responded to our Adult Social Care survey told us they feel safe.

Our Staff

As at 30 September 2011 there were 1,114 people employed within Adult Social Care, 62% in part time posts. 84% of the workforce is female and the workforce is broadly ethnically representative of the local community.

We know that it can be difficult for young people to get started in a career in care and support. We are planning to have 14 apprenticeships in Adult Social Care by the end of 2012/13, supporting the Council to achieve its target of employing 120 apprentices across the organisation by 2014.

An apprentice currently working at a Housing with Care scheme describes her experience…..

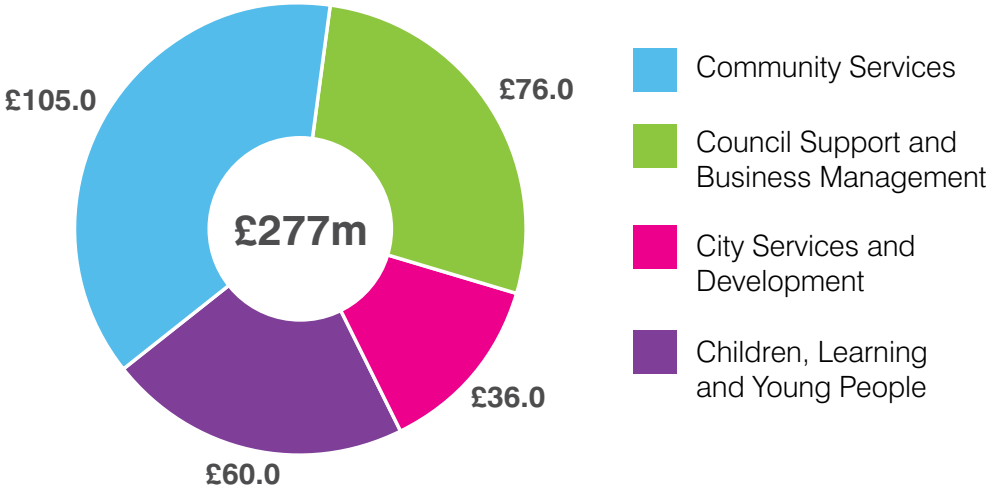
"...Since taking up the apprenticeship, I feel I have developed a lot more knowledge about working in Housing with Care and a lot more of an understanding with what to do and how to go about things with the tenants. Before I started the apprenticeship, I was out of work and wanted to be able to go into work with older people, but as for my age, no one really wanted to give me a job and because I had no experience no one would. Since starting my apprenticeship I have so much more experience.

I also know I will be gaining a lot more useful information before I leave and it will help me go a lot further with my career."

Money

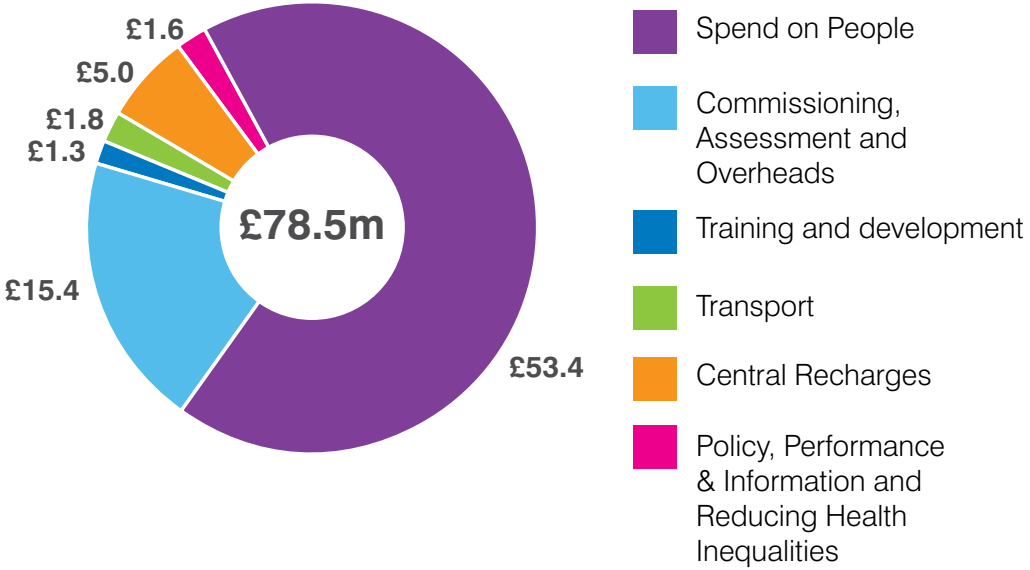
The City Council is a large organisation spending a net £277m on revenue activity during 2011/12. Each year the Council reviews its spending in light of existing and new legislation, the demographics of the City and the Council's own priorities and objectives in order to set a budget. The chart opposite identifies the areas of spend across the Council during 2011/12.

2011/12 Revenue Spending Position (£m)



Of the £105m spend for Community Services, £78.5m was spent on Adult Social Care. The chart opposite shows how this was spent.

2011/12 Adult Social Care Net Spend (£m)



Our Annual Report

This Annual Report describes Adult Social Care's performance for 2011/12. By acknowledging what we have done well and where we need to improve, we are being transparent and accountable to the people who live in the City.

It is important that we understand whether the advice, information and support we offer to people with care and support needs is making a difference. To do this, we focus on the four areas of performance that we report to Government.

These are:

- Delaying and reducing the need for care and support
- Enhancing quality of life for people with care and support needs
- Ensuring that people have a positive experience of care and support
- Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm.

A performance summary at the end of each section highlights some areas where we are performing well and where we need to take steps to improve.

To illustrate the work that we do, case studies have been used to demonstrate the impact Adult Social Care, and its partner agencies, have on individuals and their families. The case studies are examples of the range of ways people can be supported to achieve independence and do not describe the detail of how the person has been assessed as eligible for support from Adult Social Care. During an assessment, we look at specific outcomes in relation to **health and wellbeing, choice and control, economic and educational participation,** and **social and community participation;** the case studies show a variety of ways these outcomes can be met. Adult Social Care may not have funded all of the support described in the case studies; services that any person in the City can access will have been used, for example, transport, leisure and advice services, as well as an individual's own resources and any support they may receive from other sources.

The report concludes by setting out our priority areas for 2012/13.

Understanding your views and experiences

We want the people who use our services and carers to be at the centre of the decisions we make about Adult Social Care. To do this we need to understand people's experiences of care and support, involve them when we need to make changes and take on board their views when decisions are made. We do this in a variety of ways and are always looking for new and creative ways to engage with people about the things that matter to them. For example, in 2012/13 we are surveying people who use our services about their experiences and comparing ourselves with other authorities in the West Midlands. These results will be reported in next year's annual report.

The Learning Disability and Older People's Partnership Boards and the Physical and Sensory Impairment Combined Reference Group are well established fora where representatives of the people we support can set the agenda based on what is important to them. The way the Boards operate mean we get the chance to understand new or long-standing issues directly from the people they affect, and can support ways to address them.

Coventry Local Involvement Network (LINk) is an independent network of local people and voluntary and community groups working together to make NHS and social care services better. Coventry LINk held six focus groups to enable people who use services to have their say about how choice and control is developed in Adult Social Care. LINk's findings and recommendations led to the development of better information for people who use services and an ongoing commitment by LINk and Adult Social Care to work together.

Consultation

When we consult about changes to services, we want to reach as many people as possible and engage with them in a way that is understood and accessible. During the year, we held three formal consultations on changes to direct payments, home meals and Blue Badges. 5,191 people responded to our consultation on Blue Badges (43% of those contacted). This is a very good response and we think it shows that how we consult enables people to share their views and influence decisions that are being considered.

When we consult on changes to services we will do some or all of the following:

- Write to, telephone, or visit all individuals potentially affected by the proposal to explain the change and ask for their views.
- Produce leaflets to explain the proposed changes and make them available in relevant venues.
- Devise questionnaires or surveys for people to complete.
- Hold public meetings where anyone can attend to ask questions and give their views.
- Provide information to voluntary and partner organisations and encourage them to give us their views.
- Place information on the Council's website, including using online questionnaires and downloadable versions of the consultation materials.
- Provide case studies so that people can understand more clearly how proposed changes might affect them.
- Present proposals at partnership boards or other relevant meetings, for example, the Disability Equality Advisory Panel, Older Peoples' and Learning Disability Partnership Boards.
- Support groups to formally respond to national government consultations.

Here is an example of how we have consulted on changes to Direct Payment services and taken your views in to account:

We proposed – changes to the policy for direct payments

You said - the changes do not promote independence and restrict choice, impacting on people's ability to lead full and active lives in the community.

We did – developed revised proposals. A further consultation on the revised proposals ran until 8 October 2012.

Delaying and reducing the need for care and support

We can show that: There are more opportunities for people to have the best health and wellbeing throughout their life, and to access support and information to help them manage their care needs

The **Keeping Coventry Warm** campaign aims to improve the quality of life of the City's older population and other vulnerable groups through the winter months. 30 GP practices across the City support the campaign by referring vulnerable individuals for free energy efficiency assessments, fuel debt advice and emergency support. As a result of the campaign, 30 additional heaters were distributed to older people during cold weather to ensure they remained warm, whilst longer term interventions were implemented. This case study outlines how the campaign supported one person to remain safe, warm and well.

Case Study

Background:

Mrs A is 77 years old, living on her own in a rented property. Her central heating system had broken down and she had no alternative source of heating. Her housing association had agreed to repair the system but couldn't come out straight away. Worried about spending a night without heating in freezing weather, Mrs A called Age UK Coventry's Contact & Connect service to ask for their help.

Action:

Through funding available from the Keeping Coventry Warm campaign, Contact & Connect were able to arrange for Mrs A the immediate loan of two electric heaters and covered the cost of a home assistant from the Helping Hand service to deliver and set up the heaters.

Impact:

The repair of Mrs A's heating system turned out to be a bigger job than expected. As a result of the heaters, Mrs A was kept safe, warm and well during two cold nights while the work was carried out.

At **Eric Williams House**, a Council run residential care home for adults with dementia, residents can find it difficult to describe their health symptoms because of their condition. Although support staff recognise when residents are unwell, they can lack the confidence to judge levels of risk, so calling the emergency services may seem the best option.

With co-operation from the local GP medical practice, a computerised clinical decision support system, designed for use by support workers and nurses working in nursing and residential care homes, was piloted. The system supports the assessment and treatment of any condition presented by a resident by providing support staff with easy to follow health care advice.

Whilst initially staff needed a lot of support with the new technology, they have embraced the new system and found that it enhances residents' care and reduces the need to seek support from emergency services. There has also been an improvement in the referral process to GPs, with some residents being started on appropriate medication within the hour.

The use of the technology within Eric Williams House has been so successful that staff are continuing to use the application now the pilot has ended.

We can show that: Earlier diagnosis, intervention and reablement mean that people and their carers are less dependent on intensive services

During the year we have developed our **promoting independence pathway** for adults who require social care support. A team of occupational therapists and social workers work with people when they first need support from Adult Social Care. They focus on ensuring that people are able to continue living independently in their own home. This may involve practicing tasks such as preparing a meal or drink, or increasing a person's confidence to walk up and down their stairs safely. The support is short term and focused on the goals that the individual wants to achieve. This type of early, intensive support means that some people will not need to rely on longer term support from social care.

The following case study describes how this approach delivers positive outcomes for the individual and cost effective outcomes for the Council.

Case Study

Background:

Mr B is 86 years of age and lives with his wife in their own home. Prior to his referral to Adult Social Care, Mr B had experienced a stroke that had left him with left-sided weakness, particularly in his hand and no vision in his left eye. The stroke also initiated some behavioural changes, with Mr B becoming aggressive and antagonistic towards his wife. Mrs B was struggling to cope with the situation and a tenancy within Housing with Care looked like a suitable option for Mr B.

Action:

A **promoting independence** assessment was undertaken and showed that Mr B lacked the motivation to meet his own needs, even where he was able to, and that he had an impaired ability to assess risks, for example, road-safety. A promoting independence package was implemented with a male support worker making four morning calls per week to support with his personal hygiene. By the third week, Mr B was washing and dressing himself before the support worker arrived and no longer needed his assistance. In addition, Mrs B underwent a Carer's assessment, and was signposted to agencies who could offer her the support she needed.

Impact:

Mr B met and exceeded the goals of the promoting independence package and no longer requires support from Adult Social Care. Mr B was also provided with equipment to help him remain safe and an 'Exit Sensor' (Telecare) so that Mrs B is aware when he is leaving the house.

Enablement and Therapy Services work with children and adults who face challenges in their daily lives due to their difficulties in carrying out every day tasks. The service focuses on how people can become more independent by providing equipment, such as mobility or bathing equipment, or making adaptations to their homes. The following case studies demonstrate how Enablement and Therapy Services, and the use of equipment, can make changes that improve the quality of people's lives.

Case Study

Background:

Ms C is 36 years old and lives with her parents. Nine years ago, she was hospitalised for 11 months and never regained full function of her limbs. Her parents have since cared for her with no involvement from social care services. Ms C would sleep in the alcove of the rear lounge of her parents' home, with curtains creating privacy from the living area. She used a downstairs toilet and her parents would carry her to the upstairs bathroom to bathe twice a week. Ms C's mother's health is poor and Ms C was beginning to realise how dependent she was on her parents . Ms C contacted Adult Social Care for advice and was referred to the Opal Assessment and Demonstration Centre for an assessment.

Action:

Following an assessment, Ms C set out the things she wanted to achieve, including, wanting to sleep in a private area and to meet her own personal hygiene needs. A Disabled Facilities Grant was provided and a through-floor lift was installed in the home, allowing Ms C to access the upstairs bathroom and a private bedroom. A ceiling track hoist was installed in the bedroom and bathroom and equipment provided to allow Ms C to bathe independently.

Impact:

Ms C wrote to staff to express how the equipment had changed her quality of life.

"……I wanted to write to you to say thank you so much for everything you have done for me, I am so very grateful!!! All of the equipment is just making our lives so much easier; I just cannot describe to you how much you have helped me and mum!!"

Home environments can create barriers to maintaining an individual's independence and roles within their family life. **Disabled Facilities Grants** enable adaptations to a person's home, aimed at providing easier access in and out of the property and to essential facilities such as bathing, toileting and family rooms. In the last year, the Council provided 350 disabled facilities grants.

Case Study

Background:

Mr D is 90 years of age and had been living at home independently. Following a fall, he was discharged from hospital to a high dependency residential placement where he stayed for three months. All of his tasks were undertaken by staff at the placement and it was anticipated that it may not be safe for Mr D to return home.

Action:

On reviewing the case, Mr D's social worker saw that he had potential to be more independent and undertook a joint assessment with an Occupational Therapist. It was possible that with some minor equipment and adaptations Mr D's safety and independence would be good enough for him to think about returning home. Additional stair rails, grab rails, and a commode for use on the ground floor were supplied. Mr D was advised to sleep on the ground floor until he was fully confident to use the stairs again. Mr D returned to his home and a six week promoting independence package was implemented to support him with his medication, meal and drink preparation, shopping and outdoor mobility, personal care and mobility practice. A response alarm was fitted so that Mr D can call for assistance if he has an emergency at home (such as a fall), giving him more confidence.

Impact:

Mr D achieved all of his goals and is now able to undertake all of his tasks safely and independently. He regained his ability to use the stairs, and is now sleeping in his first floor bedroom again. Mr D no longer requires any support from Adult Social Care and is fully independent.

During the year, 30,461 items of equipment were provided to people by our **Integrated Community Equipment Service.** Our colleagues in the NHS and City Services and Development Directorate support us in the delivery of this service.

We have worked in partnership with NHS Coventry and Coventry and Warwickshire Partnership NHS Trust to design and implement a **Falls Prevention** service. Since June 2011, 230 older people have completed a six week rehabilitation programme, to improve strength and balance in order to reduce the risk of a fall and the need for intervention from health and social care services.

Older Adults Mental Health services use assistive technologies in a way that mean people can remain in their own homes for longer. Door sensors and pressure mats are examples of simple items that can be installed into a person's home and can alert that assistance may be needed. For people experiencing mental ill health and for people with a diagnosis of dementia, remaining within the familiar home environment can be beneficial, if risks are managed appropriately. The sensitive use of tracking technology (GPS) can enable people to remain within their familiar surroundings, while assuring family members and social care services that the person is safe.

We can show that: When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence

With our partners in health, we provide a range of **reablement** options for people when they are discharged from hospital. Long term decisions about a person's care should not be made when they are in hospital and the opportunity for short term reablement services should be available wherever possible. We work with our health partners to support people to be safely discharged from hospital and to prevent people from being admitted to hospital in the first place. We offer home support short term services, short term tenancies in Housing with Care, and short term residential placements. During the year, a total of 1,382 people accessed a short term reablement service. 43% of people needed no ongoing support when the reablement period ended; they had regained the skills they had lost and could maintain their independence.

The **Home Support Short Term Service** (HSSTS) is a reablement service helping people to go home from hospital or to avoid hospital admissions. This case study demonstrates how HSSTS support people in their own home to regain skills and abilities so that they can be as independent as possible.

Case Study

Background:

Mrs E is in her 70s and has lived alone since her husband passed away a couple of years ago. After a fall in which she broke her wrist, Mrs E was fearful of falling again and struggling to maintain her independence. Mrs E had never received social care support previously and was reluctant to accept help.

Action:

HSSTS worked with Mrs E to establish her routines and what support she felt she needed to speed up her recovery. Three visits a day were soon reduced to two, as Mrs E built her confidence and wanted to start getting out and about at lunchtimes. Once the plaster cast was removed, HSSTS continued to support Mrs E for a couple of days to ensure she had built strength in her wrist and was able to manage daily living tasks safely.

Impact:

Through the time limited support from HSSTS, Mrs E remains at home and feels safe and confident. She has the full and active life she had prior to her fall and does not require a long term package of care.

Short term tenancies within **Housing with Care** schemes can be accessed by people who need some extra support following a stay in hospital. When we compare people's outcomes with those who enter residential care, short term tenancies support people to achieve higher levels of independence. During the year, 50% of people who took on a short term tenancy stayed on within the same or a different Housing with Care scheme. 23% returned to their own homes, confident that they could continue to be safe and independent at home. Only 6% moved into residential or nursing care homes. This case study describes how short term tenancies enable people to make longer term decisions about their support needs.

Case Study

Background:

Mrs F is 86 years of age and moved into a short term tenancy in Housing with Care, following a stay in hospital. Mrs F had little mobility, requiring assistance with all aspects of personal care, and was unable to make herself drinks and snacks.

Action:

With support from staff, Mrs F's mobility started to improve as she began to walk around the flat with the assistance of a rollator frame. Mrs F was supported to increase her levels of independence further and started to wash and dress herself.

Impact:

When the short term tenancy was due to end, Mrs F decided that she would like to take on a longer term Housing with Care tenancy. A flat was available and Mrs F moved in straight away. Mrs F has continued to make good progress; she enjoys the company of other tenants and needs minimal assistance from staff.

Our performance

- Overall, Coventry continues to have lower numbers of permanent admissions into Nursing and Residential Care for people aged 65+ than the England average.
- 70% of people were still living at home 91 days after their discharge from hospital to a short term reablement/ rehabilitation service to promote their independence; this is lower than the England average. We will continue to work with our health colleagues to improve our performance in 2012/13.
- The rate of delayed transfers of care from hospital to community settings is above the national average, although delays attributable to social care are low.
- Coventry & Rugby Clinical Commissioning Group has established a forum to continue to improve performance across a number of organisations.

Enhancing quality of life for people with care and support needs

We can show that: An increasing number of people manage their own support, so that they are in control of what, how and when support is delivered to match their needs

We wanted to find out how the Council's **Personalisation Programme**, and in particular the use of **personal budgets** and **direct payments,** is impacting on people and the quality of their lives. We asked Coventry University to undertake a piece of research to find out if people who are given personal budgets as direct payments (where money to pay for care and support goes straight to an individual) have better outcomes in terms of their wellbeing, independence and autonomy, than those who don't. We also wanted to find out if people who receive a direct payment have more choice and control over the services and support they can purchase.

The research found that, overall, the provision of a direct payment seems to be associated with small improvements in choice and level of control over services and support for most, but not all, direct payment recipients. The research report suggests that we need to:

- Improve the quality and quantity of information we provide about direct payments, and about the various services and support that recipients can spend their direct payment on.
- Focus on ways of reducing the delays experienced by people who have decided to try a direct payment.
- Pay particular attention to the needs of older direct payment users whose experiences and sense of control seemed less positive.
- Work with local care providers to offer a greater range of choice of care and support.

The Council's **home meals** service, where meals are provided to people in their own homes, had been in operation for a number of years, but use of the service had been declining and costs increasing. A new service is now delivered by an independent organisation, providing home meals that offer people more choice and variety, and more options to meet dietary and cultural needs, while keeping the cost to people the same and reducing cost to the Council. Home meals can now be accessed by anyone in the City, not just those eligible for social care support.

Providing the right kind of facilities in city centres and other public places is important so that people with a disability or specific health need can access the same social and leisure opportunities as everyone else. The Council has worked with Coventry Mencap to provide the City Centre's first **Changing Places** toilet, located in the Central Library. A Changing Places toilet is different from a normal accessible toilet as it provides equipment such as changing benches and hoists, and enough space to accommodate more than one person. It means that disabled people and their carers can access the City Centre more easily as there is a safe, well equipped facility for them to use. There are also two other Changing Places facilities in the City, at Wilfred Spencer Centre on Whitaker Road and Gosford Hub on Ribble Road.

We can show that: Carers can balance their caring roles and maintain their desired quality of life

Caring responsibilities can often limit the amount of time carers have to themselves to pursue leisure activities they enjoy, or to simply have a break. Through the provision of **short breaks**, carers are supported to get a break when they need it. A short break can mean that a carer can participate in hobbies and activities of their choice or can pursue education or career opportunities.

Group breaks provide carers with the opportunity to talk to other carers and build supportive networks, helping to reduce feelings of isolation, and supporting them to maintain their caring role.

Case Study

Background:

Mr and Mrs G have been caring for their daughter, who has a learning disability, all her life. They have never requested a break as they felt their daughter would be too upset and distressed to be away from home, but were finding it increasingly difficult to cope.

Action:

The family was referred to the Short Break Service at **Maurice Edelman House**, a specialist residential care home for people with Learning Disabilities run by the Council. Mr and Mrs G made an initial appointment to talk about their anxiety about leaving their daughter in unfamiliar surroundings with people not known to her. After meeting staff, Mr and Mrs G were reassured by the experienced staff team and the person-centred approach at Maurice Edelman House.

Impact:

Mr and Mrs G booked their first holiday abroad and booked their daughter's first stay at Maurice Edelman House. On returning, it was agreed that the break had a positive impact on the whole family. The family went on to book regular short breaks and Mr and Mrs G saw how their daughter's stays at Maurice Edelman House were building her confidence and she was developing new skills. This culminated in the decision by Mr and Mrs G to support their daughter to fulfil her wish to move away from home.

Telecare is the term we use to describe a range of assistive technologies and devices that help with everyday living and support people to regain and maintain their independence. Telecare can provide carers with peace of mind that the person they care for can raise an alert and get help if they are not around, while also promoting the independence of the person they care for.

Telecare bed sensors alert the carer when the cared for person hasn't returned to bed ten minutes after getting up. Carers have reported that this technology allows them to have a better night's sleep, knowing they will be alerted if the person they care for does not return to their bed.

Training for carers on a range of subjects, from coping strategies, to stress relief and assertiveness, is delivered in partnership with Crossroads Coventry & Warwickshire. 95% of people who attended a course felt that the training would have a positive effect on their health and wellbeing and on their role as a carer. One attendee stated:

"Your training was very helpful and supportive … The training will help me in my future caring role, realising that most difficulties can be surmounted or worked round and that there are often a number of options or choices of equipment. I feel less isolated and more confident to deal with situations. Thank you."

We can show that: People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation

The **Shared Lives** Scheme offers the opportunity for people, who may otherwise need residential care, to live in a family environment whilst being supported to regain and maintain their independence.

During the last year, the scheme has implemented a change meaning people who use the service are able to maximise their income, have greater disposable income, and more opportunities for choice and control over how they spend their time. This case study demonstrates how the change has benefitted people who use the service.

Case Study

Background:

Mr H lives with a Shared Lives carer. The carer received payment as though Mr H was living in a residential placement. Because of this funding arrangement Mr H's only disposable income was his weekly personal allowance of £22.60. With this money, Mr H would buy all of his personal items and any social activities. It was a challenge for Mr H to lead a fulfilling life with such limited resources.

Action:

The scheme was changed to enable people to maximise their income.

Impact:

Mr H now has a formal agreement to live at the property and his weekly disposable income is now £98 per week. Mr H can now socialise more often and can choose to take part in more social activities.

This case study describes how small changes to how support is delivered can have big impacts on a person's **social and community life**.

Case Study

Background:

Mrs J had been receiving social care support for some time before being admitted to hospital. When preparing to return home, it was found that Mrs J's package of support was still suitable for her needs. However, Mrs J explained that she was feeling very isolated and had no family in the area. She had stopped doing her usual social activities when she became reliant on using a wheelchair to get about.

Action:

Outcomes Brokers explored further with Mrs J the activities she used to do before she became reliant on using a wheelchair. Mrs J had regularly attended her local church and many social functions relating to it. Because Mrs J requires the support of two carers to transfer to and from her wheelchair, she is not able to take herself to church. Mrs J's support was re-arranged so that her carers attend 30 minutes later on a Sunday morning so that she could be transferred into her chair and be taken to church.

Impact:

Mrs J has re-engaged with her social circle at church, friends now visit Mrs J in the week, reducing her feelings of isolation. Attendance at a local, community church achieved Mrs J's desired social outcomes with no need for traditional day care services to become part of Mrs J's support package.

As part of our commitment to support adults to have equal opportunity to a fulfilling and rewarding life, we have focused on supporting people to gain **work experience** and to access and retain **paid employment.** In the last year, we supported 12 people with autism to achieve paid employment.

Support into employment has been provided through a programme delivered on behalf of **Jobcentre Plus**, through **The Employment Support Service** (TESS), within City Services and Development Directorate. People are supported to develop their work skills and employers are supported to offer employment opportunities to people with autism.

The **Independent Travel Team** works with young people moving from children's services into adult services and with adults with learning disabilities. The team assess the potential of people who use services to travel independently, balancing the risks involved with the benefits. An individual training package is created and the team support the individual through their training, evaluating their progress and assessing them when they are able to complete their journey safely. 60 young people and adults have been trained during the year to travel independently. This case study presents an example of a young person completing their Independent Travel Training and becoming an independent traveller.

Case Study

Background:

Mr K was referred to the Independent Travel Team by his school, who recognised his potential for travel training. Mr K has a diagnosis of autism and has difficulties with communication and memory. Mr K's family were anxious about him learning to travel independently.

Action:

Mr K started his training package and was supported to overcome his initial reticence about learning to travel alone. His family met with the travel trainer who allayed their anxieties. Mr K worked with his travel trainer regularly, practising a specific journey. Mr K's skills and confidence improved to the point that it was felt he was able to lead another travel trainer on his bus journey, demonstrating his learning and being assessed as safe to independently complete a one-way journey.

Impact:

Mr K now travels home from school independently and carries a contact card with his home and school details, in case of emergency. With the support of the travel trainer, Mr K's achievements have surpassed what was expected of him.

His father said, *"I haven't caught a bus in years...he showed me how and where to go!"* His mother noted, *"I have seen a real change in his confidence…thank you!"*

Our performance

- 40% of people supported to live in the community receive a personal budget. 13% receive a direct payment. This is an improvement on the previous year.
- When surveyed, 61% of people who receive social care support feel they have a good quality of life, whilst 28% feel their quality of life is okay.
- When surveyed, 79% of people who receive social care support said they have control over their daily life.

Ensuring that people have a positive experience of care and support

We can show that: People who use social care and their carers are satisfied with their experience of care and support services

The Pod is a Council resource for people striving to improve their mental health. **Journeys to Recovery** shows how the Pod has supported people in their recovery.

Community Services' Health Development Service work with the Pod to offer a Men's Martial Arts and Health Programme. An independent evaluation of this approach concluded that the programme was viewed very positively, with all of the men who took part reporting changes in their health-related behaviour and perceived improvements in their health. This case study shows an example of how the Pod's creative and innovative approaches have supported one man's recovery.

Case Study

Although he did not realise it at the time, not so long ago Mr L's life was spiralling out of control.

"My life pretty much was in and out of different institutions. It is scary to think of the place that was but the turnaround over the last year or so has been amazing. I'd accessed so many services in the past but as soon as I was referred to the Pod everything started to change.

The difference coming to the Pod is that you are not told what you have to do, you are listened to and they help you achieve your aims. It sounds an obvious thing to say but that is not the way it always is.

I joined a number of different groups the Pod offer and one of them was the martial arts course. It was great and I really enjoyed it. The discipline it teaches really helped but every one of us in the group got something out of it.

It made such a difference that I started going to the 'dojo' outside of the classes and I haven't looked back. In the first six months I made such progress that has changed my life so much I can now look back and see how low I actually was. That is a major achievement in itself. The opportunity of an apprenticeship with the instructor came up and I was lucky enough to get it.

I know I still have a long way to go in my journey but the progress I have made is great and for the first time in years, I am actually looking to the future with confidence."

We can show that: Carers feel that they are respected as equal partners throughout the care process

Moving Forward is a toolkit designed to support older carers and their families to plan for the future. Working jointly with Coventry Carers' Centre, Coventry Mencap and a group of family carers, the toolkit has been developed to allow older families to access support to plan for emergencies. It aims to ensure that families have the confidence to make their own decisions and to know that the person they care for will be well supported when older family carers are no longer able to care for them.

The Moving Forward toolkit allows carers to express their wishes, prior to a crisis, about the future support their relative will need and allow for choice about where they live and who will support them, giving carers peace of mind. This case study shows how one carer was supported to use the toolkit.

Case Study

Background:

Mrs M is an older person who was struggling to cope with her caring role. As a family, it was decided that the time was right for the cared for person to move out of the family home. Mrs M and the person she cares for needed support to make the next steps and choose the right accommodation.

Action:

A Carers Assessment Worker completed the Moving Forward Toolkit and person centred plan with Mrs M and the person she cares for. The process took about four months to complete.

Impact:

The person cared for has moved into a supported tenancy and Mrs M visits weekly for Sunday lunch. Mrs M says, 'I feel happy as they have a lovely new home and I have peace of mind.' Mrs M now mentors other carers to complete person centred plans.

We can show that: People know what choices are available to them locally, what they are entitled to, and who to contact when they need help

Contact & Connect provides information and signposts people to a wide range of local services with the aim of maintaining the independence and improving the quality of life of people aged over 60 in the City. In 2011/12 Contact & Connect provided information to 2,169 people, and 3,295 signposting connections to other support services were made.

The **Opal Assessment and Demonstration Centre** provides a central venue for people to visit to access information and assessment for equipment and adaptations to support their health and independence. The centre welcomed a total of 7,876 people through its doors during the year. 3,195 people received information and advice relating to their disability, 3,500 people used the space for conferences, workshops and training events, while 1,181 people received assessments, for example, for Blue Badges and for equipment to support their independence.

Our performance

- 93% of people surveyed stated that they were satisfied with the care and support they received (of whom 63% were very satisfied).
- 75% of people who attempted to access information and advice about support, services and benefits found it easy to obtain.

Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm

The Council takes a lead role across the City to ensure, with partners, that:

- People enjoy physical safety and feel secure
- People are free from physical and emotional abuse, harassment, neglect and self harm
- People are protected, as far as possible, from avoidable harm, disease and injury
- People are supported to plan ahead and have the freedom to manage risks in the way that they wish.

We can show that: People's lives are improved as a result of safeguarding

Safeguarding alerts are concerns, raised by anybody, that abuse may have taken place. A **safeguarding referral** is where a concern is raised (an alert) and an adult safeguarding investigation is started. During the year, we received 813 safeguarding alerts, which is comparable to other similar authorities.

All safeguarding investigations in Coventry conclude by analysing the improvements made to people's lives. The analysis of this information for 2011/12 shows an improvement in a person's circumstances in 81.5% of cases completed.

From 2012/13, an adult at risk is asked at the beginning of a safeguarding investigation about their desired outcomes, and again at the end, to find out if these been achieved. This will be a more robust and substantial indicator of the improvement (or otherwise) made through our intervention.

Case Study

Background:

Mrs N is 60 years old and was referred to the Community Mental Health Team by her GP after her family became concerned about her memory loss and difficulties managing her behaviour. Mrs N had moved in with family members following the death of her husband as they felt that she was no longer safe to live alone. Her family said she was forgetful, would leave cigarettes burning and needed a high level of supervision to keep her safe. The Community Mental Health Team arranged for Mrs N to be admitted to hospital for assessment of her mental health and to determine the extent of her confusion. Whilst in the hospital, it was discovered that Mrs N was often taken out by family members to make large withdrawals from her bank accounts. A neighbour also raised concerns. It was decided that a safeguarding investigation should be undertaken.

Action:

It was established through an examination of Mrs N's financial affairs that her pensions and benefits were being misused by her family. Following a mental capacity assessment it was determined that Mrs N was not capable of managing her own finances and an application was made to the Court of Protection to appoint someone to manage her finances.

Impact:

Mrs N has returned to live in her own home with support from a live-in carer, and her quality of life has improved. The Court of Protection has appointed a solicitor to manage Mrs N's financial affairs and she has supervised contact with her relatives. Work has been undertaken with family members to help them better understand her condition and how they can continue to be positively involved in her life.

We can show that there is independent scrutiny of safeguarding and dignity.

The annual report of the **Coventry Safeguarding Adults Board** is subject to formal scrutiny by the Health, Social Care and Welfare Reform Scrutiny Board (Scrutiny Board 5). Comments from Scrutiny Board 5 are incorporated into future planning processes. In addition, a nominated Elected Member from Scrutiny Board 5 attends the Coventry Safeguarding Adults Board in an observer role, reporting back to the Board when necessary.

There have been no formal inspections or external reviews of our safeguarding arrangements in 2011/12. However, a number of improvements have been built into the formal Safeguarding Board Business Plan for 2012/13. We have also implemented the revised West Midlands Adult Safeguarding Policy and Procedures from October 2012.

A Serious Case Review (Mrs C) was undertaken during the year and reported to Coventry Safeguarding Adults Board and Scrutiny Board 5 in the summer and autumn of 2012.

We can show the effectiveness of the Coventry Safeguarding Adults Board

Coventry Safeguarding Adults Board is a formal partnership Board with senior representation from a wide range of organisations across the Coventry social care and health sector. These include:

- Coventry City Council
- NHS Arden Cluster (NHS Coventry and Warwickshire)
- University Hospitals Coventry and Warwickshire NHS Trust
- Coventry & Warwickshire Partnership NHS Trust
- West Midlands Police
- West Midlands Fire Service
- Staffordshire and West Midlands Probation Trust (Coventry District)
- West Midlands Ambulance Service NHS Trust
- Care Quality Commission
- Crown Prosecution Service
- Coventry Consortium of Social Landlords
- Coventry Older People's Partnership Board

Coventry Safeguarding Adults Board is supported by a set of committees, responsible for carrying out detailed developmental work. These committees were reviewed during the year and now cover:

- Serious Case Reviews
- Policy and Procedures
- Partnership and Practice Development
- Quality and Audit
- Workforce Development

The Coventry Safeguarding Adults Board produces an annual report, which describes the achievements and challenges of the year. The annual report for 2011/12 will be available on the Council's web pages from November 2012.

In addition, Coventry Safeguarding Adults Board holds an annual development day to review its performance for the previous year and determine priorities for the year to come. The development of a revised workforce development strategy is a key priority for 2012/13.

Our performance

- When surveyed, 95% of people who use services said they felt safe.
- 70% of people who use services say that those services have made them feel safe and secure.

Priorities for 2012/13:

- Continue to offer short-term, goal-focused support, which gives people the opportunity to regain lost skills, confidence, and independence, prior to establishing any ongoing support.
- Continue to increase the choice and control people have over their support by ensuring that all people who receive ongoing support receive a personal budget.
- Improve people's experience of transferring from a hospital to community setting by working with our partners to support a reduction in the number of people who have a delayed transfer of care from hospital.
- Continue to ensure that carers receive the timely advice, information and support they need, and increase the number of carers who receive assessments.
- Continue to support people to achieve their identified outcomes from safeguarding processes.

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http://www.coventry.gov.uk/speakup

More information can be found **here**