



Local Account

Report for Adult Social Care

2014/15

Local Account 2014-15 – pdf version

Our local account of services

Each year we produce a local account to tell people what their adult social care services are doing. The report explains:

- What we have been doing to make people's lives better
- How much we spend
- What we spend money on
- What our plans are for the future

To find out more about adult social care services see the WBC web page Care and support for adults.
We have split the local account into seven chapters:

Contents

Our priorities

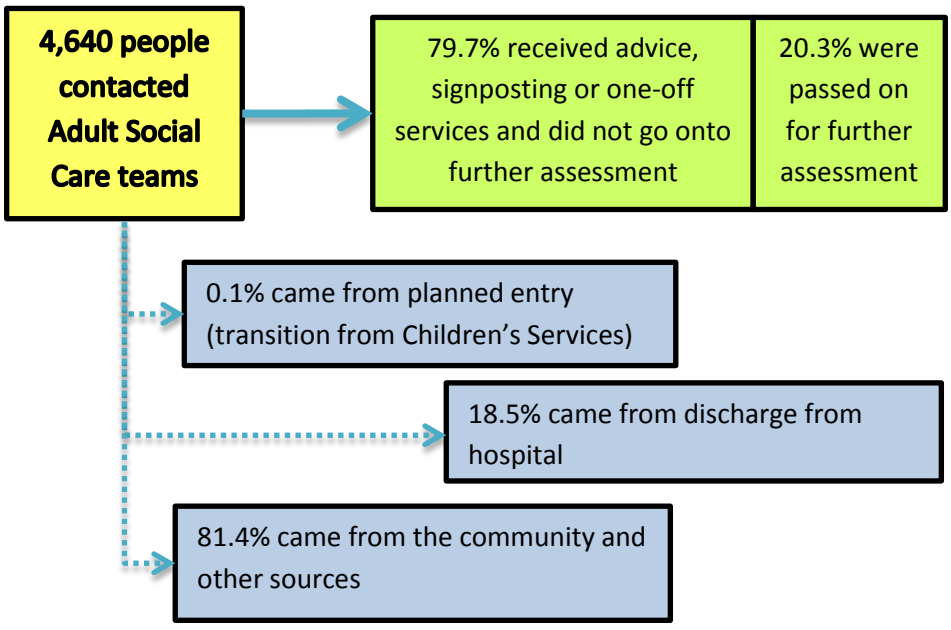
Our **Vision for Adult Social Care** has been co-produced by our staff and customers as well as voluntary and statutory sector partners. It outlines our priorities for adult social care, how we support our customers and how we work with our stakeholders. It is for our customers, carers, Council staff and for the voluntary, private and statutory sector organisations we work with. Ensuring the well-being of our customers, both mental and physical, is at the core of our services. For further details see Adult Social Care Vision.

What we do for you

We provide Adult Social Care services to thousands of people each year. Our statutory services support vulnerable adults with a wide variety of specific needs. In addition, there are a range of more general prevention services available to help improve the health and wellbeing of all adults in the Borough.

Who contacted us?

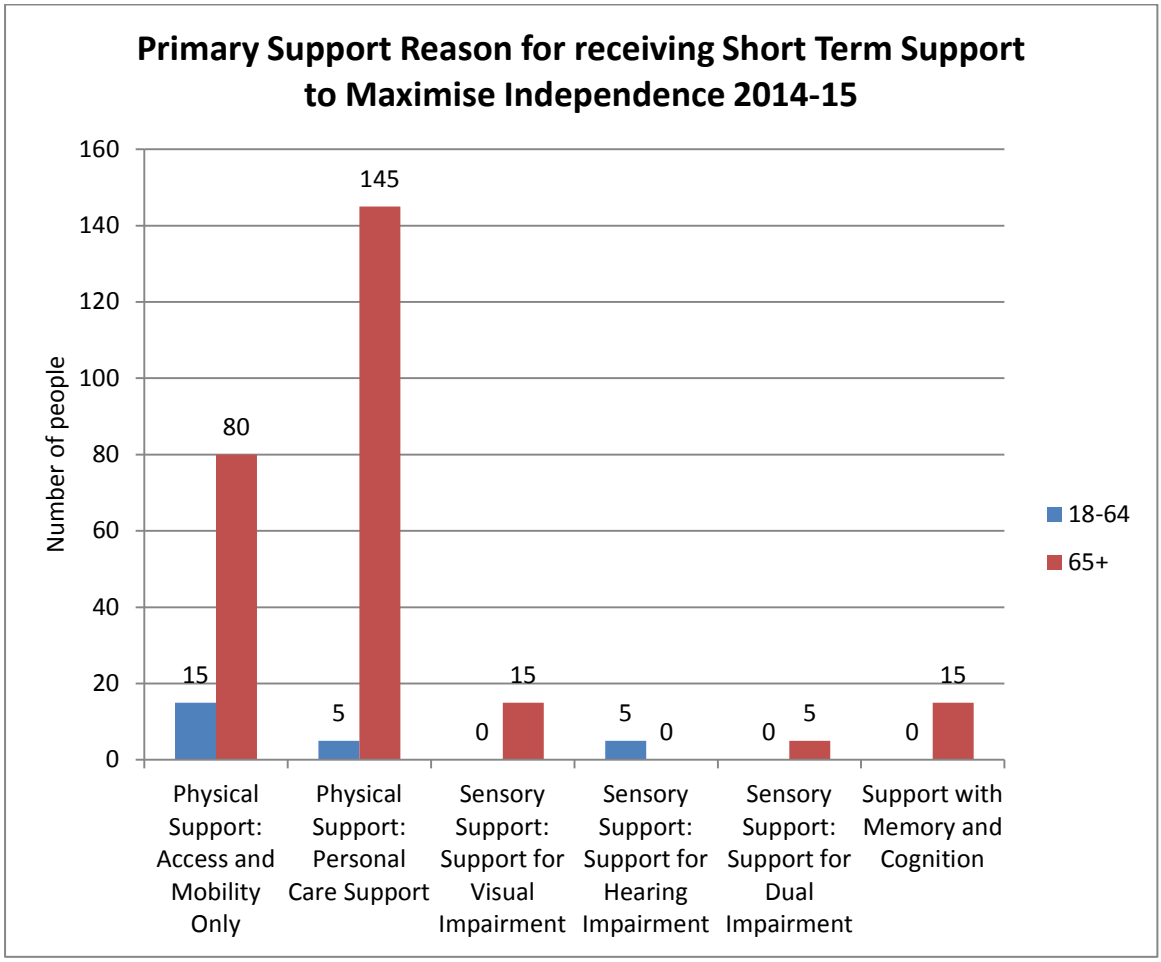
Our Adult Social Care teams were contacted by 4,640 people in 2014-15.

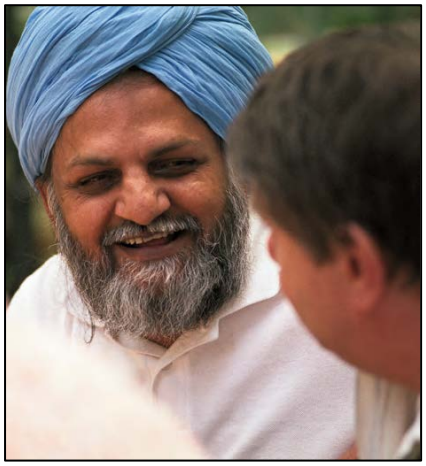


What happened following requests for support?

Short Term Support

In total, 285 new clients went on to receive **Short Term Support to Maximise Independence**. 25 of these were aged 18-64 (8.8%) and 260 were aged 65+ (91.2%). The most common reason for receiving this support was 'Physical Support: Personal Care Support' (52.6%) followed by 'Physical Support: Access and Mobility Only' (33.3%).



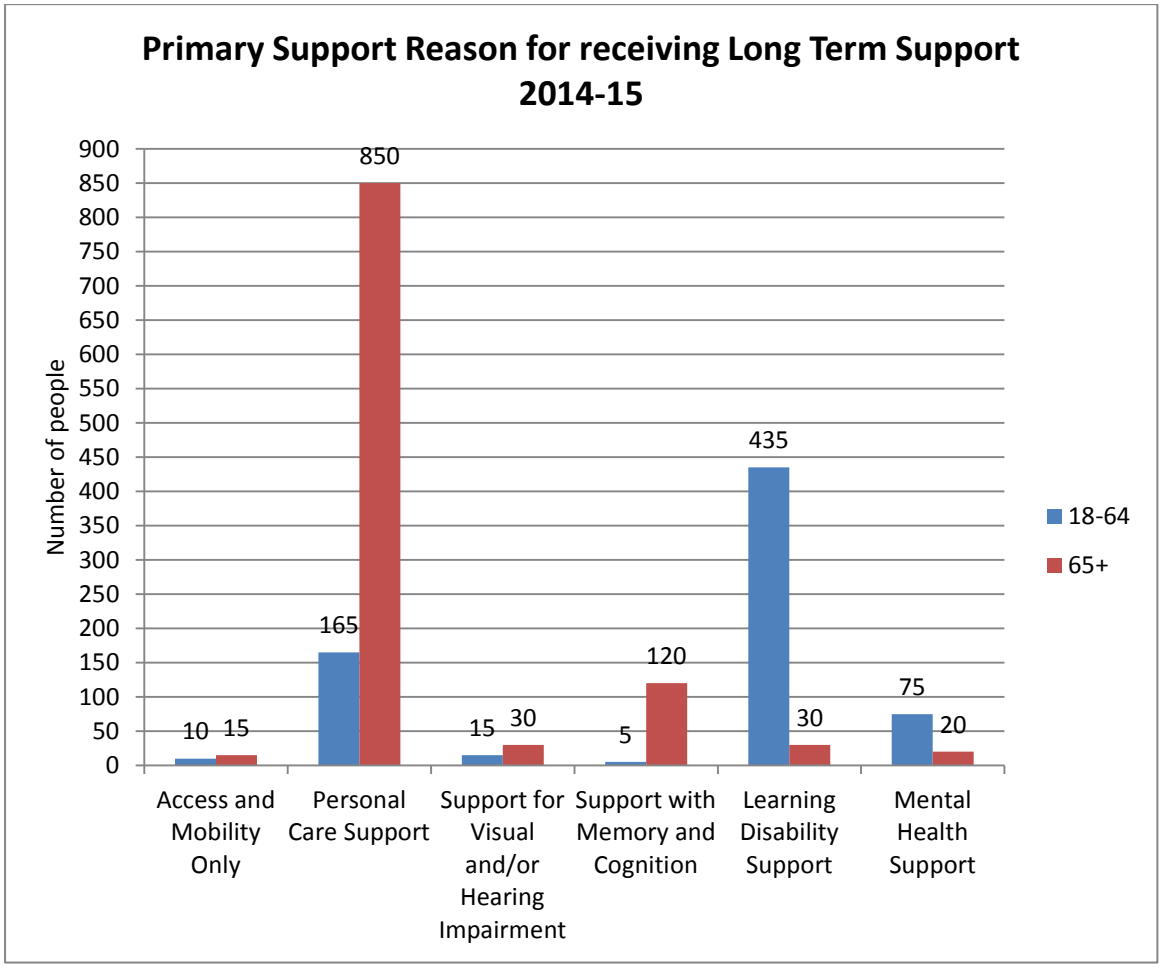


Of these 285 new clients who received **Short Term Support to Maximise Independence**, 50 went onto long term support, 15 ended early, 5 went onto ongoing low level support, 5 had identified needs but were self-funding, 5 declined the support offered, 5 were signposted or went onto universal services, 190 had no services offered because they had no identified needs and 10 went onto other short term support.

Long Term Support

In total, 1770 clients accessed **Long Term Support** during 2014-15. Of these, 705 clients were aged 18-64 (39.8%) and 1065 were aged 65+ (60.2%). As of 31st March 2015, 650 people aged 18-64 and 720 aged 65+ were still receiving services, making a total of 1370.

The most common reason for receiving this support for clients aged 65+ was 'Physical Support: Personal Care Support'. For those aged 18-64 the most common reason was 'Learning Disability Support'.



Residential and Nursing Care

Of those clients receiving Long Term Support in 2014-15, 330 people accessed residential care of which 210 were 65+ and 120 were aged 18-64. 260 people accessed nursing care of which 250 were 65+ and 10 were aged 18-64.

The rest of the people receiving long term support were supported in the community.

Autism and Asperger's Syndrome

In this first SALT (Short and Long Term) data collection, it was mandatory to report on those clients with Autism and Asperger's Syndrome who received Long Term Support at year end. As of 31st March 2015, there were 55 clients with Autism and 45 with Asperger's Syndrome in receipt of long term support. These clients were all aged 18-64. Combined, they accounted for 7.3% of all clients receiving Long Term Support at year end.

Carers

Carers have a right to receive an assessment of their own needs and may be eligible for services to support them in their caring role. In 2014-15, there were 950 requests for carer support. Of these, 545 had support provided directly to them (57.4%) of which 20 instances (2.1%) related to carers aged under 18. Of the remainder, 225 were helped by respite or other forms of support being given to the person they care for (23.7%) and 180 received no direct support (18.9%). Nationally, 24% of requests for carer support received no direct support.

What difference have we made?

We provide services to people in a wide range of circumstances. The main aim of these services is to promote and maintain the health and wellbeing of vulnerable adults in the Borough by enabling them to live safely in their own homes. Some people will only need information and advice to do this, others may require short-term support to get them back on their feet and a smaller number will need more intensive, long-term services. Below are some examples of the support we provide.

Your stories

Case Study A: personal budget and becoming an adult

A is a very vulnerable young man who attends a special school and lives at home with his mother. When he reached the age of 17, he was supported by a social worker during his transition from Children's Services to Adult Social Care. The adult assessment highlighted that his mother was responsible for supporting A in all aspects of his life. A Personal Budget was arranged that would allow A to meet new people and develop a sense of independence while giving regular short breaks to his mother allowing her to make plans for herself. A Support Plan was drawn up which detailed how A wanted to spend his budget and how he would be supported safely. He was able to choose his support worker himself and has been able to plan more and more what he would like to do and when he would like to do it. A, with the help of his support worker, fulfilled a long-held dream by travelling to a rock concert to see his favourite band. He made a video of the whole day which he presented to the Learning Disability Partnership Board. This has made a huge difference to his confidence and he is now thinking about going to college next year.

Case Study B: how a personal budget allowed a lady to stay in her own home

Mrs B suffers from a number of serious medical conditions. She has been paying privately for full-time, live-in care without which she would have to go into a care home. When her funds depleted, she approached us. After assessment, a Personal Budget was set up to fund her care needs. This is paid in the form of a Direct Payment which is managed by a member of her family. This has enabled Mrs B to have choice and control over her care. All her needs are met by carers with whom she has a close relationship. Mrs B is happy that she can carry on living in her own home with all its fond memories. Her family are happy as they can see that Mrs B is well cared for and safe.

Case Study C: how a personal budget helped a resident fulfil their choices

Mr C has a rare degenerative illness and, after an active life, was forced to retire as the illness took its toll upon his physical abilities. He feared being moved out of his beloved home. We first became involved by altering aspects of Mr C's home to allow wheelchair access and to make adaptations designed to help him make the most of his home. For the tasks that Mr C couldn't manage, a Personal Budget was agreed which would pay for support-carers to visit and he made the most of his abilities to remain independent. To do the heavier domestic tasks Mr C had come to rely upon a person he had known for many years. After a period of time, we became involved again when it was suspected that this person had been taking advantage of the relationship for their own financial gain. Our Adult Protection Team worked with Mr C to ensure his safety, and looked again at his Personal Budget. His needs had changed because he could no longer trust this person in his home. Mr C's Personal Budget was therefore increased to pay for his support-carers to undertake all of those domestic tasks that he could not manage, freeing Mr C of his dependency on volunteers/friends and furthering his opportunities to live in his own home safely and to continue to enjoy making his own choices in life.

Case Study D: how support allowed a carer to continue in her caring role

D was referred to the assessment team for a Carers Assessment. D is the main carer for her son who has extremely high care needs and is unable to meet any of these needs independently. D provides full support. D's assessment recognised that there are aspects of her day to day living which have been exacerbated due to caring for her son such as the expense of shopping and the amount of laundry she has to do for him. D has said she is happy to continue to support her son despite the impact. However, the washing machine was 'on its last legs' and it would be very difficult for her to take the washing to the launderette. This was causing her stress. A one-off personal budget payment allowed D to buy a new washing machine which meant she could continue her caring role.

The Step-Up /Step-Down Scheme

The step-up/step-down service is a comprehensive reablement and social care package to prevent people being admitted to hospital unnecessarily, or to enable them to be discharged earlier than would otherwise be possible. Following assessment, trained reablement workers will work with the individual, slowly reducing the level of support they need to carry out the tasks of daily living as they become more independent.

The step-up option will be available for people who are experiencing a sudden and severe change in need, and who need a period of intensive support and rehabilitation so that they may return home safely.

The step-down option will provide a reablement environment for people who are ready to be discharged from hospital but are not ready to return to their former home or level of independence. They may require a period of intensive short term care and therapy before returning home to a reduced package of care than would otherwise be achieved.

Where is the service based, and how many beds are available?

Initially there are two flats at Alexandra Place (extra care housing scheme) in Woodley. This number may be increased after the impact of the service has been assessed. The bedroom and bathroom in the flats have been adapted and have a range of equipment. There is a kitchen where meals can be prepared or people can use the cafeteria. The step up/step down service includes placements where a couple can work through reablement needs together.

What happens afterwards?

Anyone who is assessed as having on-going support needs on leaving the service will have a care and support plan plus a risk management plan. The care and support plan will identify any wider social care or health needs, and will identify any assistive technology which will be used to support the person to live independently in their own home.

What are we hoping to achieve?

The scheme will encourage individuals to manage their own long-term condition in their own home and will also reduce the amount of ongoing home care a customer will need. It will reduce unplanned admissions to hospital and to care/nursing homes and will contribute to the reduction in the number of delayed discharges.

End results for people

The **Adult Social Care Outcomes Framework (ASCOF)** is a way of looking at outcomes (or end results) for people who use social care. You can look at any authority in the country and see how outcomes for the key measures compare with other areas.

The Adult Social Care Outcomes Framework (ASCOF) measures are split into four domains:

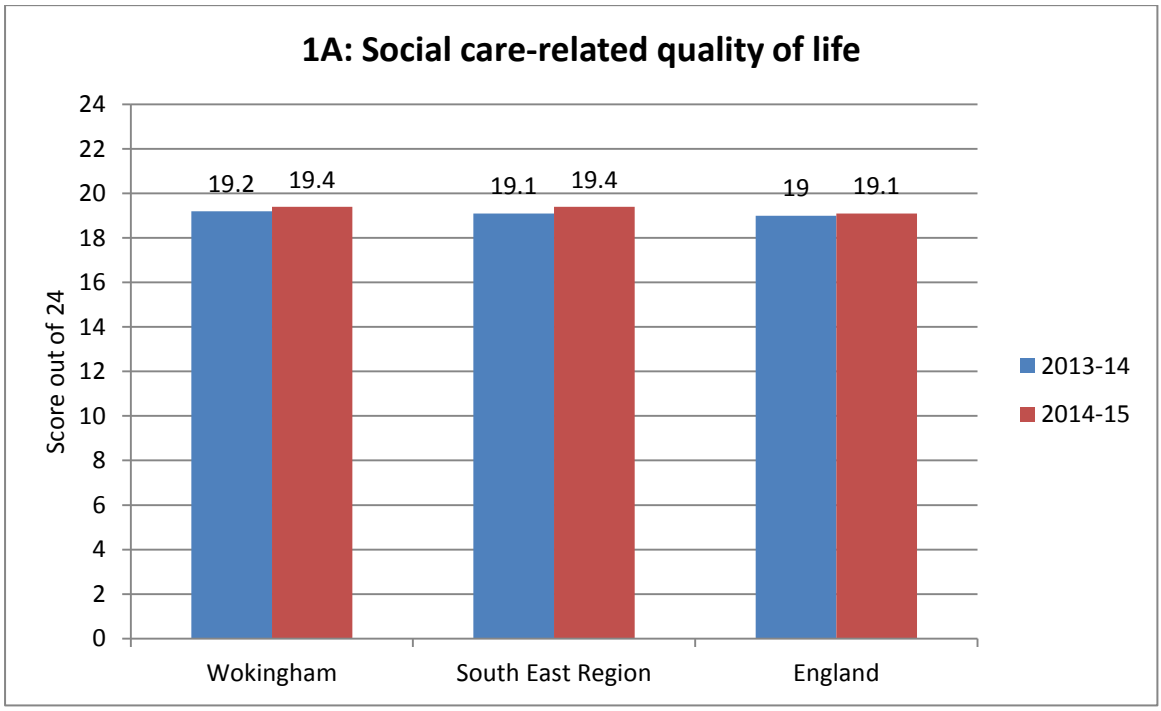
- Domain 1 – Enhancing quality of life for people with care and support needs
- Domain 2 – Delaying and reducing the need for care and support
- Domain 3 – Ensuring that people have a positive experience of care and support
- Domain 4 – Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

For further information about the indicators that make up the ASCOF see the GOV.UK web page Adult social care outcomes framework (ASCOF) 2015 to 2016

Domain 1 – Enhancing quality of life for people with care and support needs

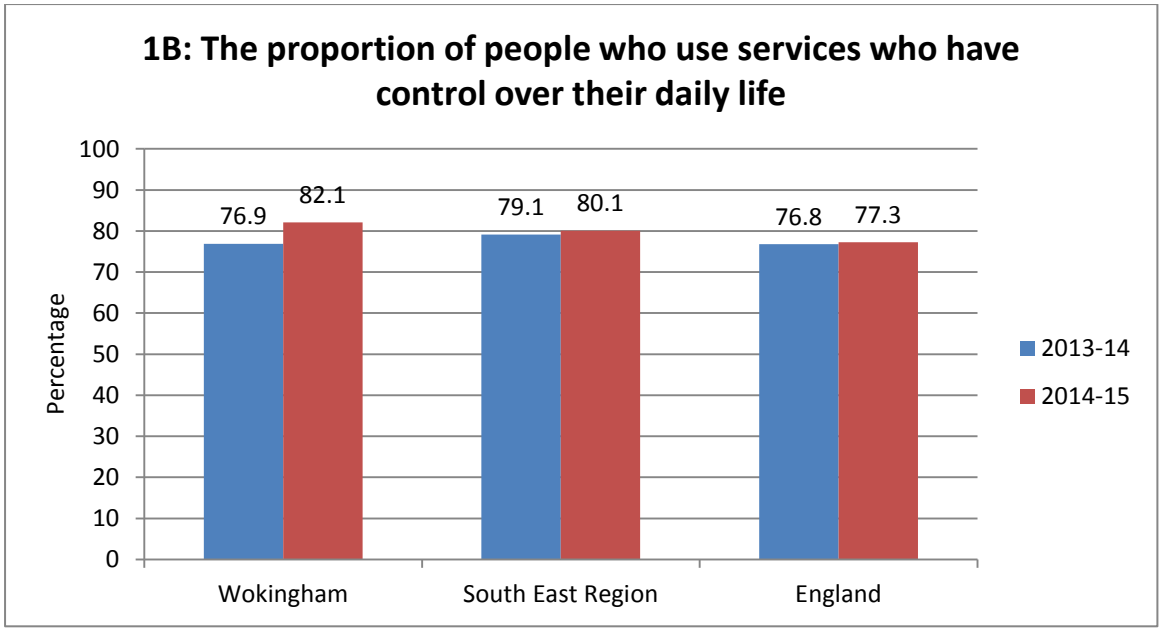
1A: The **social care-related quality of life** measure within the ASCOF gives an overarching view of the quality of life of **users of care and support**. In 2014-15, social care-related quality of life for Wokingham was 19.4 out of a maximum possible score of 24. This is:

- up from 19.2 in 2013-14 ↑
- the same as the average for the South East region ↔
- higher than the average for England as a whole (19.1) ↑

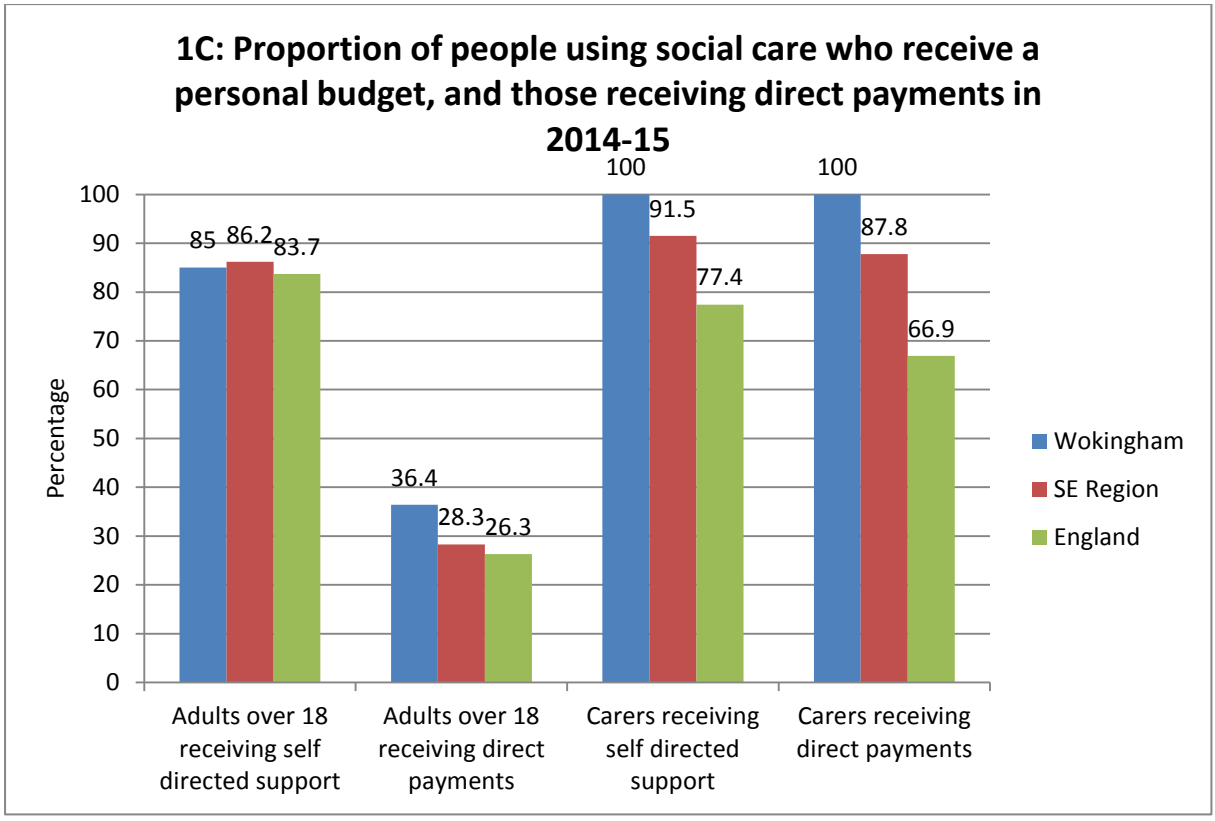


Any decisions about a person's care and support will consider their wellbeing and what is important to them and their family. One measure of this is the proportion of people who use services who have control over their daily life. For Wokingham this was 82.1% in 2014-15 which is:

- up from 76.9% in 2013-14 ↑
- higher than the average for the South East region (80.1%) ↑
- higher than the average for England as a whole (77.3%) ↑



To give people more flexibility and choice about the type of service and provider they want, we have continued to increase the number of people with a personal budget as well as the number receiving all or part of their personal budget through a direct payment.

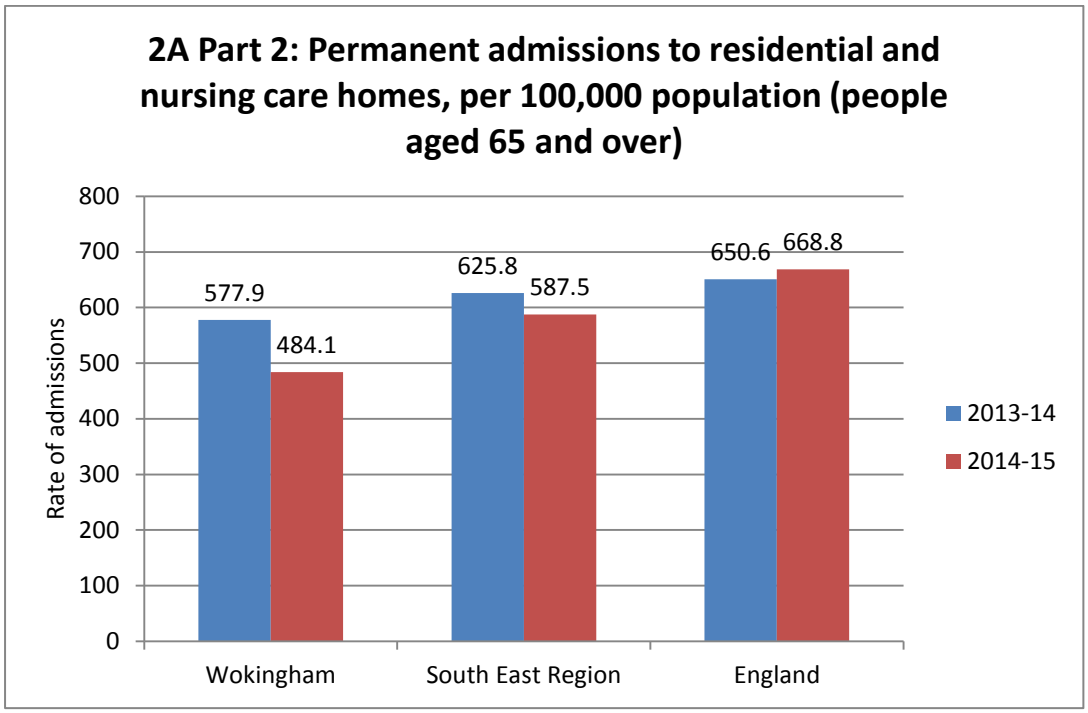


In 2014-15, **carers** reported an average **quality of life** score of 7.8 out of a maximum of 12. This is much the same as the scores for the South East Region (7.7) and for England as a whole (7.9).

Domain 2: Delaying and reducing the need for care and support

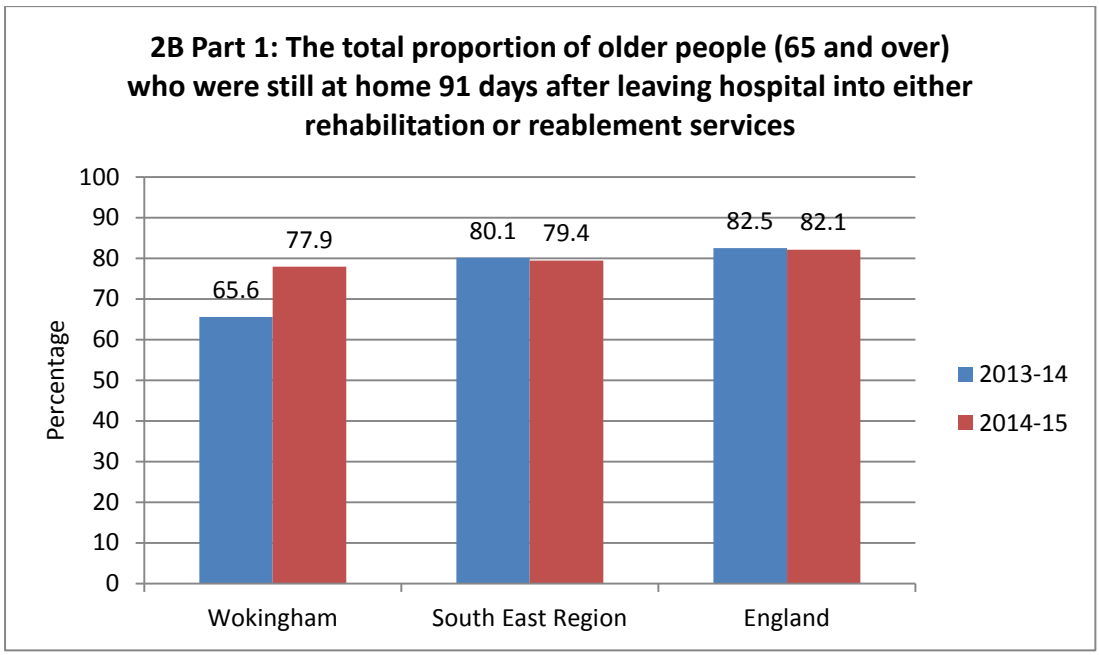
The number of older people admitted to residential and nursing care homes in Wokingham has continued to reduce in line with the Council's policy of enabling people to stay living independently in their own homes. The rate of admissions for 2014-15 was:

- lower than the rate in 2013-14 ⬇
- lower than the average rate for the South East region ⬇
- lower than the average rate for England as a whole ⬇



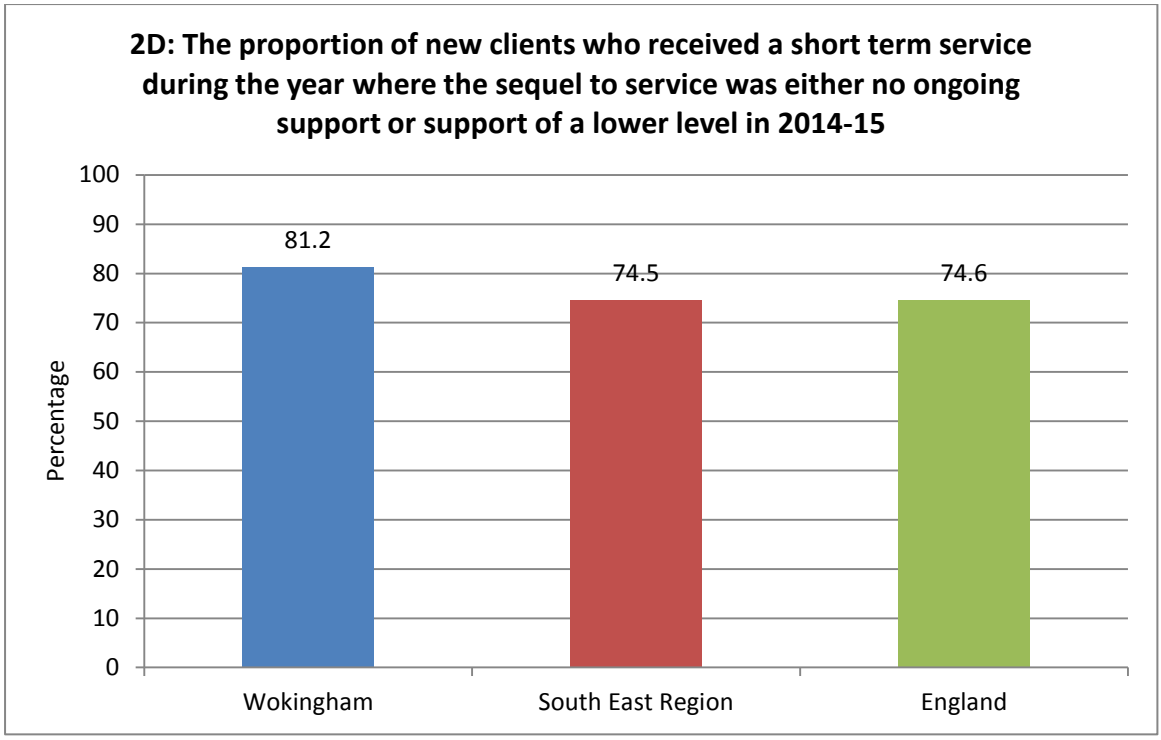
The reablement service aims to support people to relearn lost skills. It promotes independence and enables them to continue with their life. One measure of the effectiveness of this support is to see how many people who have been given reablement services when they leave hospital are still at home 91 days later. For Wokingham, the figure for 2014-15 was 77.9%. This is:

- up from 65.6% in 2013-14 ↑
- lower than the average for the South East region (79.4%) ↓
- lower than the average for Eng land as a whole (82.1%) ↓



Some people who contact the Council for help will only need short-term support to get them back on their feet. We can see how effective this is by measuring what percentage of the people required no further support (or only support of a lower level) after they received short-term support. For Wokingham this was 81.2% in 2014-15. This is:

- higher than the average for the South East region (74.5%) ↑
- higher than the average for England as a whole (74.6%) ↑



Domain 3: Ensuring people have a positive experience of care and support

See chapter on **What you are telling us**

Domain 4: Safeguarding

See chapter on **Keeping people safe** below

For a full list of the results see the National Adult Social Care Intelligence Service (NASCIS) ASCOF Comparator Report for Wokingham (pdf).

Keeping people safe

Everyone has the right to live in safety, free from abuse and neglect. See the WBC web pages about Personal Safety.

The Safeguarding Adults Board
The Safeguarding Adults Board is made up of local organisations which work together to protect adults at risk of abuse or neglect and keep them safe.

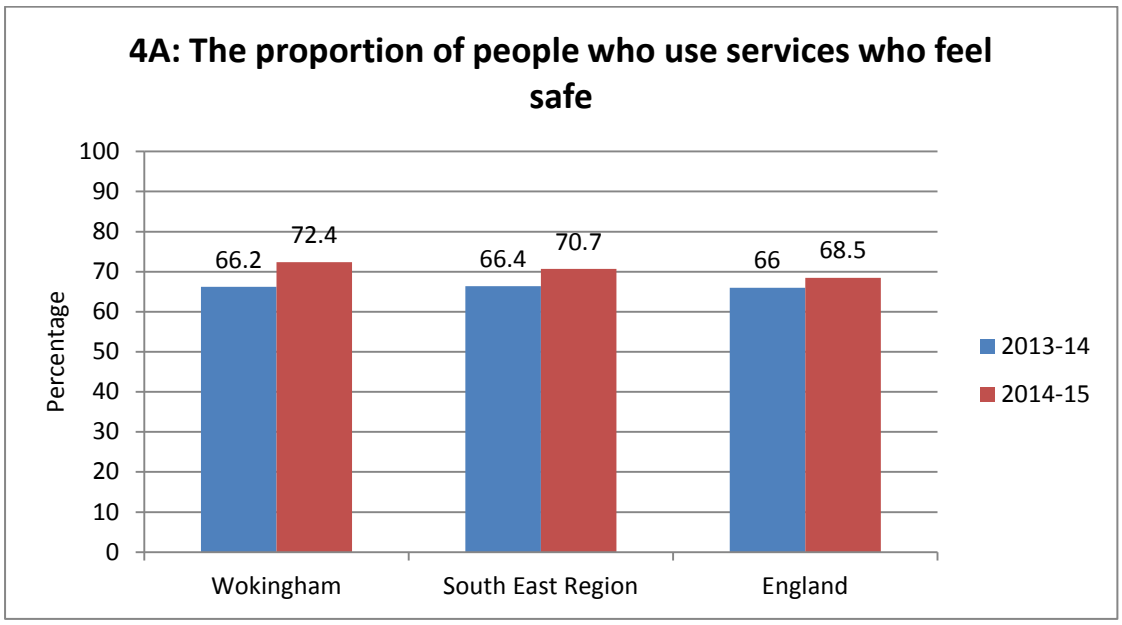
West of Berkshire Safeguarding Adults Board
Reading, West Berkshire & Wokingham

You can find out more on the West of Berkshire Safeguarding Adults Board website.

How safe do you feel?

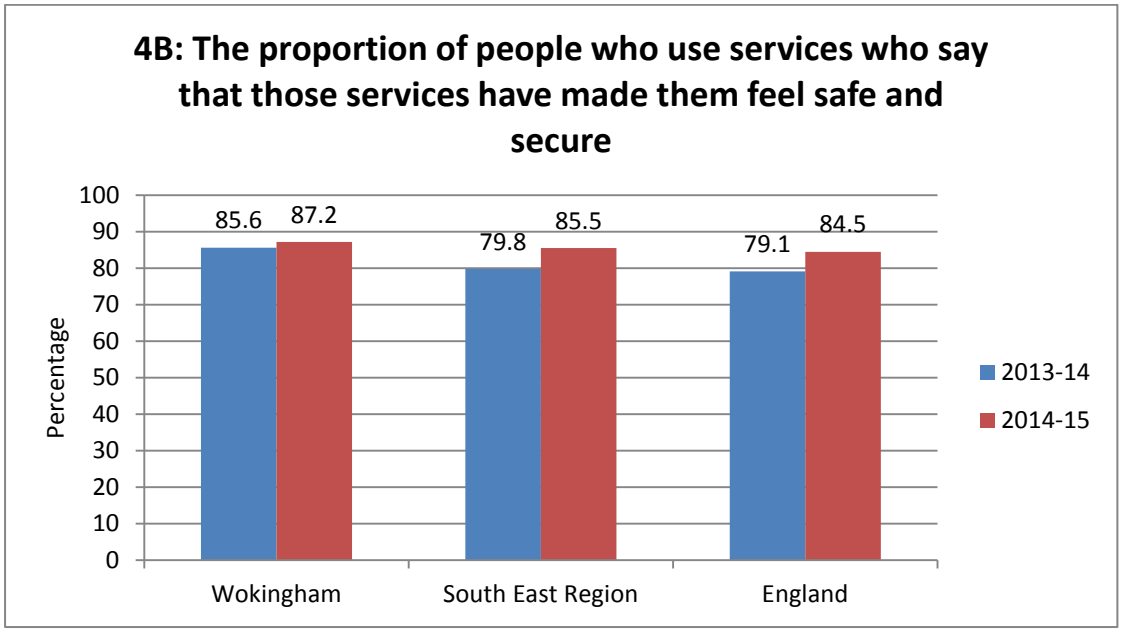
People who use services The **proportion of people who use services who feel safe** measure within the Adult Social Care Outcomes Framework shows that, in 2014-15, 72.4% of clients in Wokingham felt safe. This is:

- up from 66.2% in 2013-14 ↑
- higher than the average for the South East region (70.7%) ↑
- higher than the average for England as a whole (68.5%) ↑

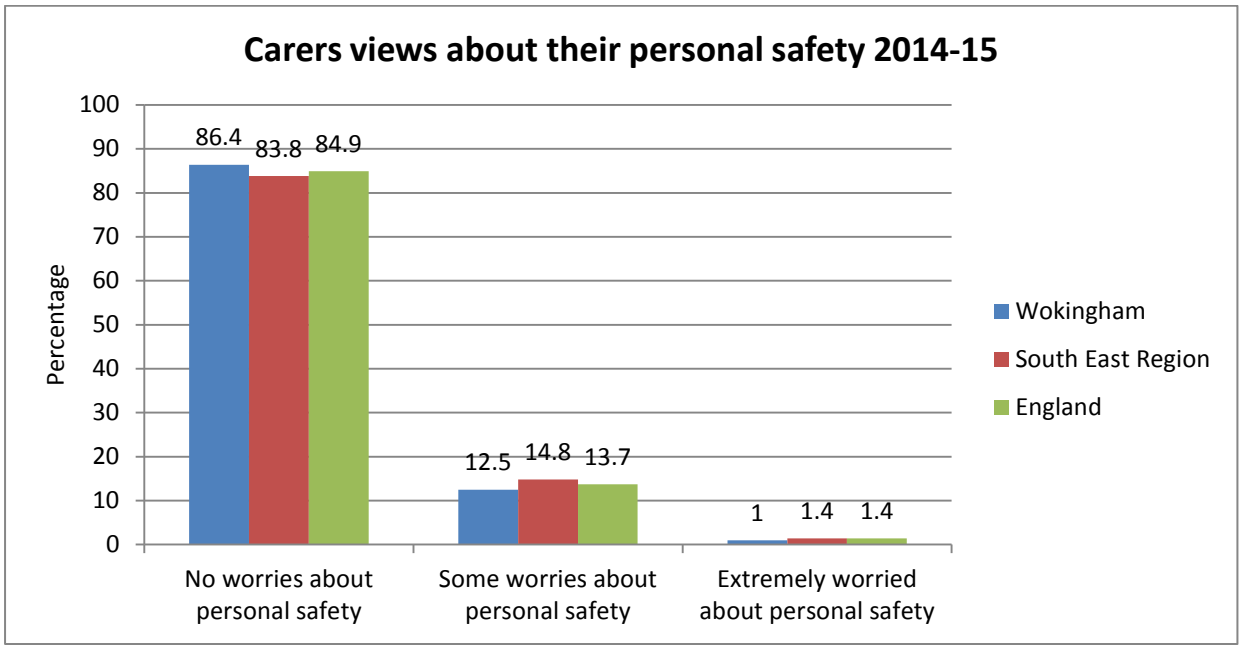


For Wokingham, of the people who use services, 87.2% said that those services have made them feel safe and secure. This is:

- up from 85.6% in 2013-14 ↑
- higher than the average for the South East region (85.5%) ↑
- higher than the average for England as a whole (84.5%) ↑



Carers The results from the **Carers survey** show that 86.4% of carers in the Wokingham Borough had no worries about personal safety, 12.5% had some worries about personal safety and 1% were extremely worried. The local results are a very close reflection of the National and Regional figures at 84.9%, 13.7% and 1.4% respectively (SE Region: 83.8%, 14.8%, 1.4%).



Safeguarding

There were 400 referrals to the safeguarding team during 2014-5, with only 68% of these referrals being for people already known to Wokingham's Adult Social Care service; 60% of these referrals were for females believed to be at risk. The age breakdown of the people referred to the safeguarding service was:

Age	%
18 – 64	28%
65 - 74	10%
75 - 84	23%
85+	39%
Total	**100%**

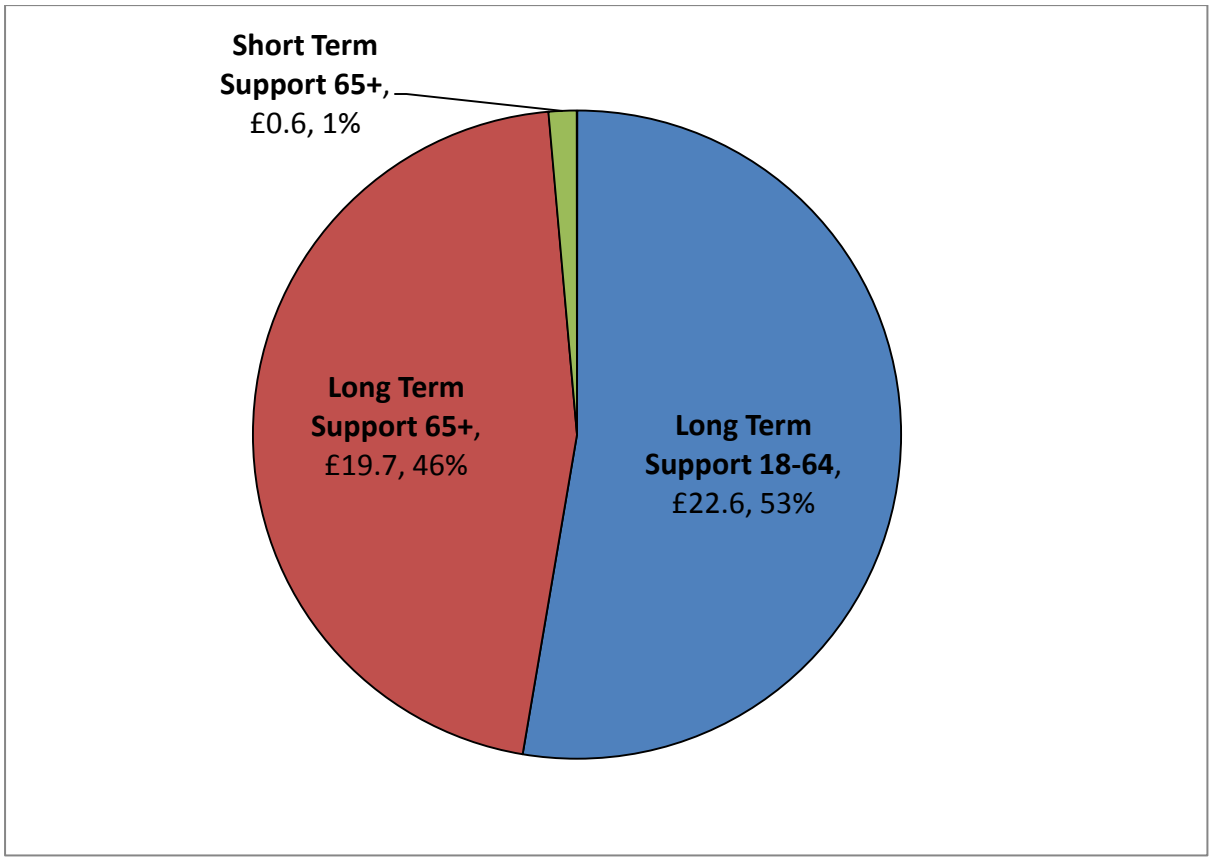
None of these referrals resulted in a serious case review.

How we spend your money

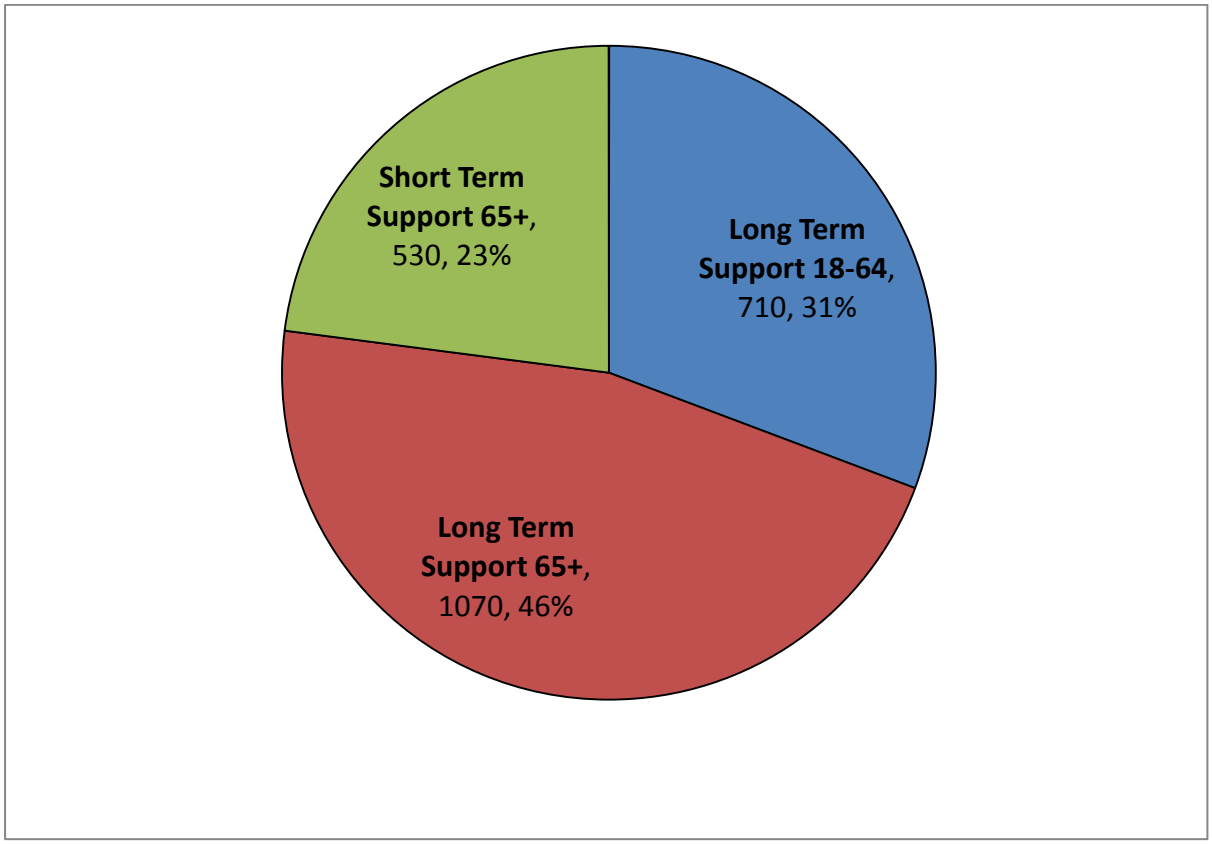
In Wokingham Borough in 2014-15 £42.9 million of gross current expenditure was spent on long and short term support combined; of which

- 47.3 per cent (£20.3 million) was spent on people aged 65 and over
- 52.7 per cent (£22.6 million) on people aged 18 to 64.

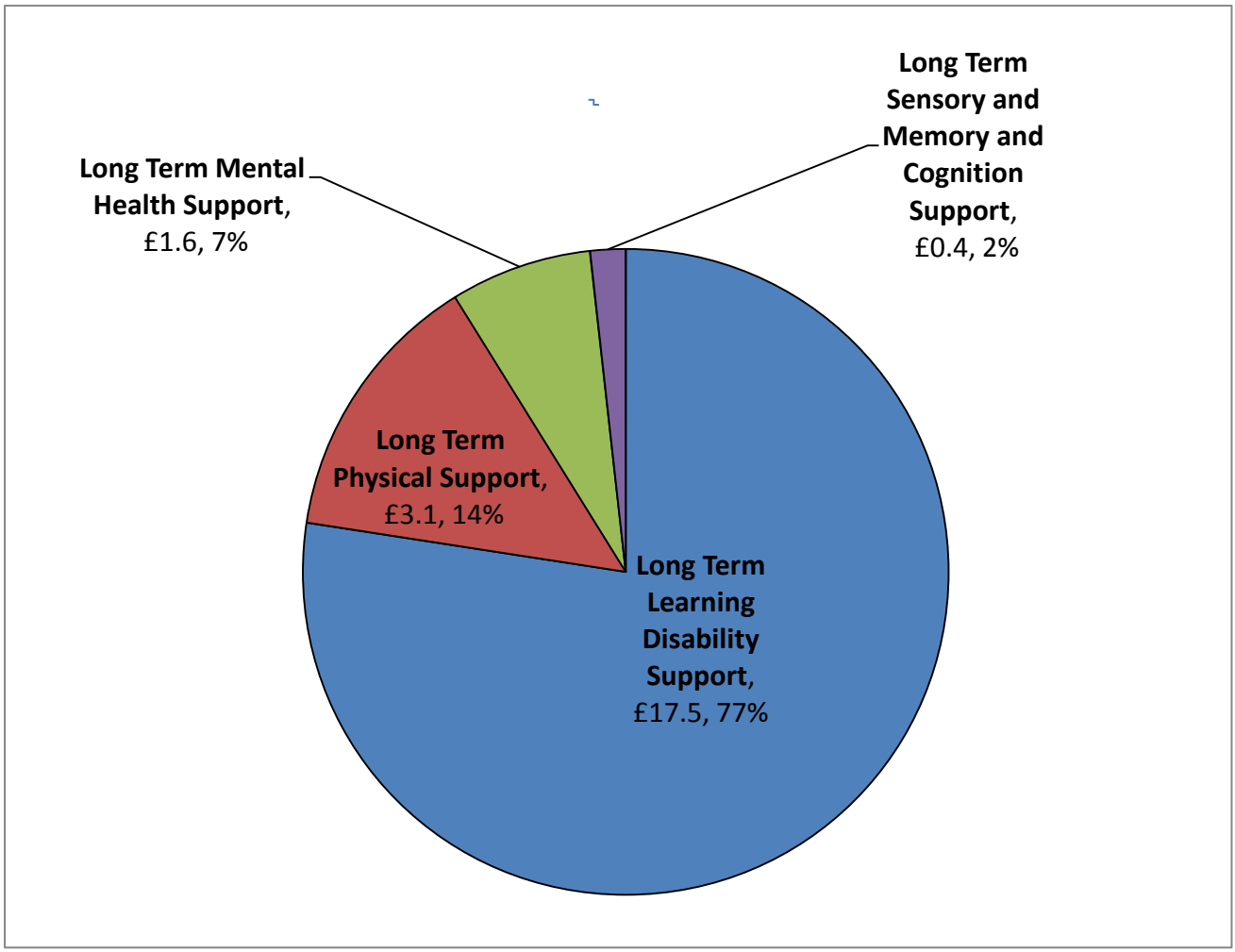
Total Expenditure in 2014-15 in millions



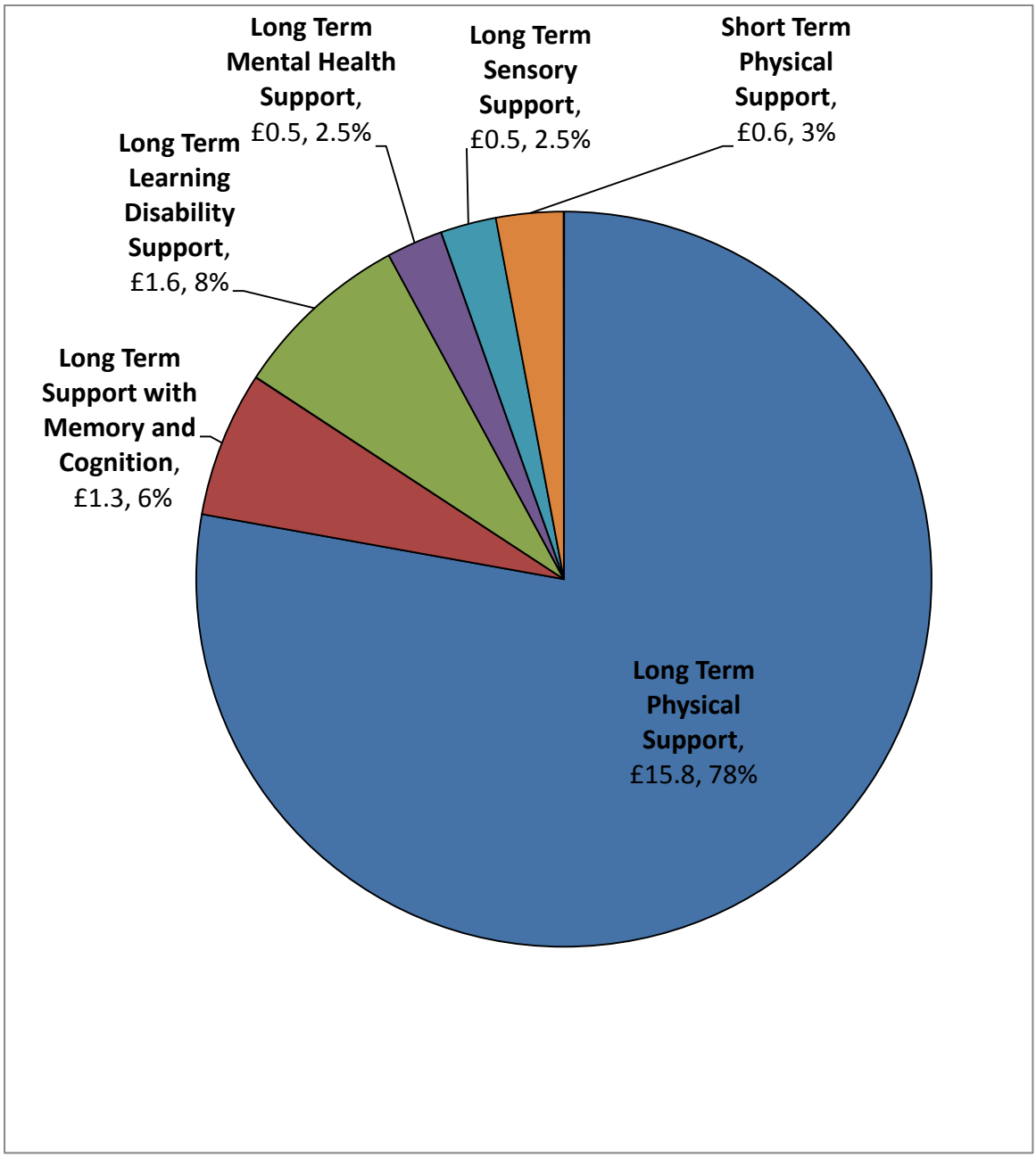
Total number of people supported in 2014-15



Expenditure on people aged 18-64 in 2014-15 in millions



Expenditure on people aged 65+ 2014-15 in millions



Facts and figures

Expenditure on long term support

In 2014-15 43.5% (£22.6 million) of gross current expenditure was spent on long term support for people aged **18 to 64**; of which £17.5 million was spent on learning disability support, £3.1 million on physical support, £1.6 million on mental health support, with the remaining £0.4 million split between sensory support and support with memory and cognition.

Of the £22.6 million spent on long term support for adults 18 to 64 year olds, expenditure on residential care amounted to £8.1 million, whilst expenditure for direct payments amounted to £3.8 million and supported living £6.3 million.

For people aged **65 and over**, expenditure on long term support accounted for 38% (£19.7 million) of gross current expenditure; of which £15.8 million was spent on physical support, £1.3 million on support with memory and cognition, £1.6 million on learning disability support, £0.5 million on mental health support and £0.5 million on sensory support.

Of the £19.7 million spent on long term support for adults aged 65 and over, expenditure on residential care amounted to £6.3 million, whilst expenditure on nursing care amounted to £6.4 million and home care amounted to £5.3 million.

Expenditure on short term support

For people aged **65 and over**, expenditure on short term support accounted for 1.2% (£0.6 million) of gross current expenditure; of which £0.6 million was spent on physical support.

Other Social Services Expenditure

In 2014-15 17.3% (£9 million) of gross current expenditure was spent on other social care activities including commissioning and service delivery.

For information on key priorities and headline budgets see Wokingham's Medium Term Financial Plan.

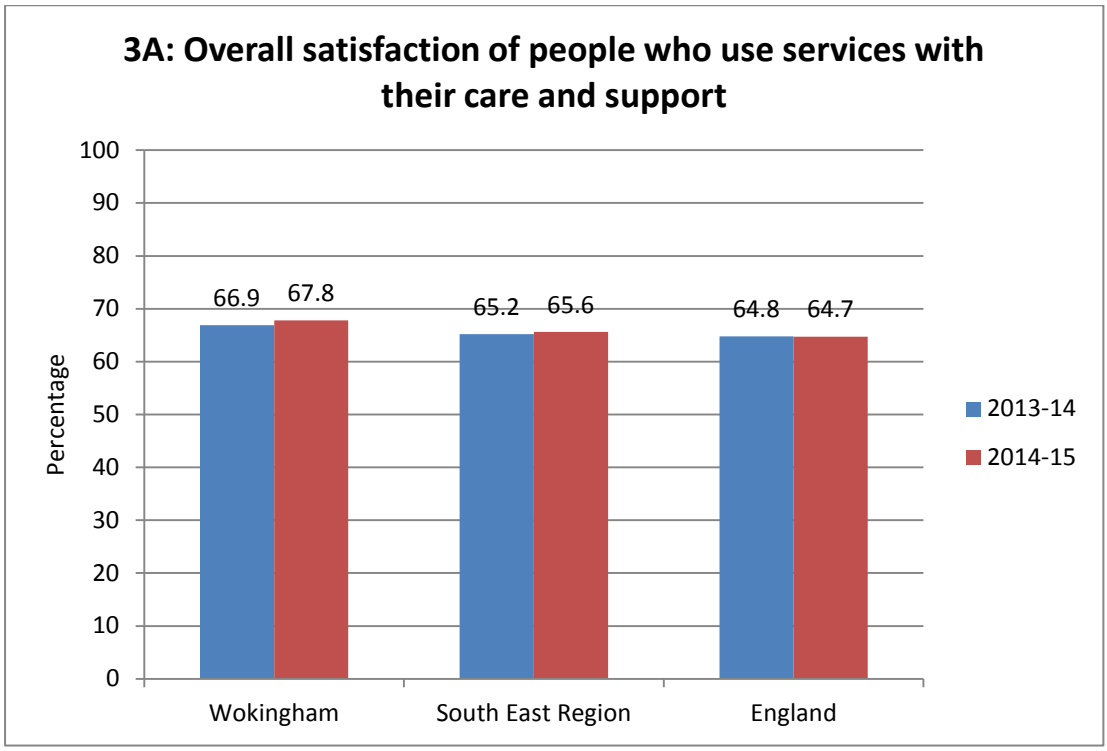
What you are telling us

Adult Social Care Survey

Each February, as part of a national survey, we send out a questionnaire to **people over 18 who use social care** to find out what they think about their services. In 2015, 775 surveys were sent out and 303 people responded (39.1%).

Overall, 67.8% of users reported that they were extremely or very satisfied with the care and support services they received in 2014-15. This is:

- up from 66.9% in 2013-14 ↑
- higher than the average for the South East region (64.6%) ↑
- higher than the average for England as a whole (64.7%) ↑



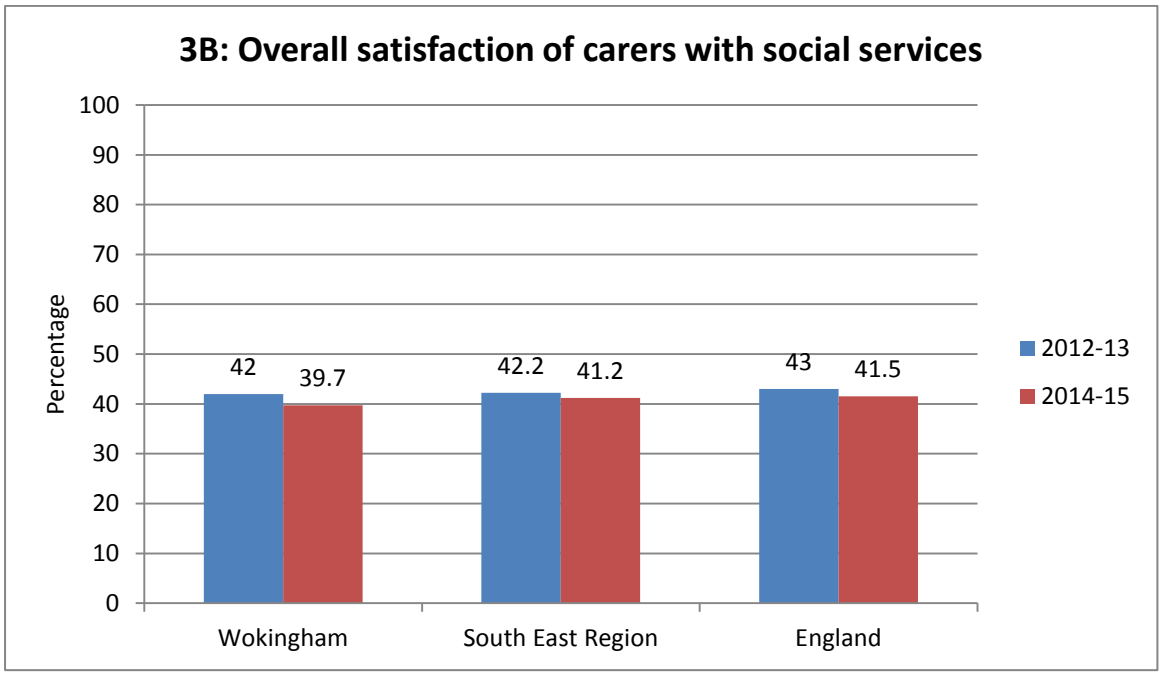
For further information see Personal Social Services Adult Social Care Survey 2014-15 Report (pdf).

Carers Survey

In addition, every two years a survey is sent out to **carers**. In 2015, 520 surveys were sent out and 277 people responded (53.3%).

Overall, 39.7% of carers reported that they were extremely or very satisfied with the support services they received in 2014-15. This is:

- down from 42% in 2012-13
- lower than the average for the South East region (41.2%)
- lower than the average for England as a whole (41.2%)



For further information see Personal Social Services Survey of Adult Carers 2014-15 Report (pdf).

Complaints

If you are unhappy about something, it is important to let someone know. Most issues are dealt with straight away by Adult Social Care staff but if the complainant remains unhappy, the complaint will be passed to the Council's Complaints Team. If everything has been done to resolve the complaint and a person is still not satisfied, they can ask the Local Government Ombudsman to review the matter. See web page How do I complain?

In 2014-15 Adult Social Care teams received 13 formal complaints. The reasons for the complaints were:

- Appropriateness of Service 1
- Quality of Food 1
- Delay in Arranging Service 4
- Financial Assessment 2
- Quality of Service 1
- Other 4

12 of the complaints were dealt with at Stage 1 and the other is still with Local Government Ombudsman.

Learning from complaints

The Assessment Team were made aware of a client who had been moved into residential care funded by us but who had not subsequently had an Annual Review of her care. Unfortunately, the placement wasn't suitable in the longer term but we hadn't made contact with the family to check all was well. As a result of this complaint, which was upheld, we made an unreserved apology to the client and her family and have ensured she is now in suitable accommodation where she is happy and settled and being well cared for. To ensure this will not happen again, changes have been made to our recording processes to electronically transfer this information to our Reviewing Team, and we have also put in place some additional reporting tools so that this can be checked for accuracy on a regular basis.

Priorities for the next year

Pre-Paid Cards for Direct Payments

Some people feel that the administration involved in receiving a Direct Payment is not worth the benefit as you need to open a special bank account and send in regular bank statements and receipts.

Work is going on to introduce Pre-paid Cards for Adult Social Care direct payments. The cards are, in effect, a simple electronic bank account that we can monitor online. They will be used in any location or transaction process where a typical credit or debit card can currently be used. This includes shops, banks, ATMs (if allowed), over a telephone or via the internet. You will be able to set up direct debits or standing orders. If you are required to contribute to the costs of your care, you will be able to add your contribution to the card account, keeping all funding in a single place.

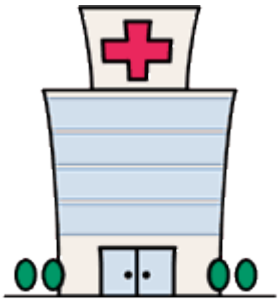
We expect to have a contract in place in the final quarter of this financial year. We will then carry out a trial with a small number of current Direct Payment recipients before introducing them to all new and existing customers sometime during the first half of 2016-17.

For more information on direct payments see Paying for my support with a direct payment

The Integrated Hub

We have listened to our residents and customers and, in conjunction with Berkshire Health Foundation Trust during the course of 2016 we plan to have an integrated health and social care hub or Single Point of Access for new referrals for adult social care and NHS services. This will change the current model of two points of contact for WBC and NHS services respectively into a single integrated service. As we develop this towards April 2016 more information will be made available to service users, carers and professionals.

Joint working across the wider health community – the Frail Elderly Project



A report published by The King's Fund has set out a plan to reduce hospital admission rates, release resources for patients to be cared for at home and stem the growing demand for hospital beds. The plan is based on community services working much more closely with groups of general practices and building multidisciplinary teams to care for people with complex needs.

Across the West of Berkshire the hospitals, GPs, Clinical Commissioning Groups and Local Authorities are working together to deliver on these recommendations. The "Frail Elderly Project" is designed to provide better, more joined-up services to people living in the community as their needs increase with age. Our aim is to develop a health care pathway that responds to the needs of individuals rather than one shaped by the organisational structures, whilst using our combined resources more efficiently to improve the experiences of older people and their families. To take this project forward we are currently:

- mapping services across organisational structures,
- looking at the costs of services provided and desired,
- sharing details on the types of people we currently support.

We are expecting that this analysis will have been finished by spring 2016, so we can make progress towards implementation of the changes during the coming year.

The King's Fund Report

Radical changes to community services are needed to move more care out of hospital and closer to people's homes, according to a report published by The King's Fund. The report argues that previous policy has failed to achieve this longstanding ambition. It sets out seven interrelated steps:

- reduce any unnecessary complexity in community service provision
- forge much closer relationships with groups of general practices
- build multidisciplinary teams for people with complex needs, including social care, mental health and other services
- support these teams with specialist medical input – particularly for older people and those with chronic conditions
- create services that offer an alternative to a hospital stay
- build the information infrastructure, workforce, and ways of working and commissioning that are required to support this change
- reach out into the wider community to improve prevention, provide support for isolated people, and create healthy communities.

To see how this might work for an individual, please see Sam's Story at *http://www.kingsfund.org.uk/audio-video/joined-care-sams-story*

Service Developments

Dementia services

- Ensuring we have a range of providers with a skilled workforce which can deliver care with compassion and maintain customers dignity
- Ensuring there is appropriate support for younger people with dementia

Supported Living options for working age adults

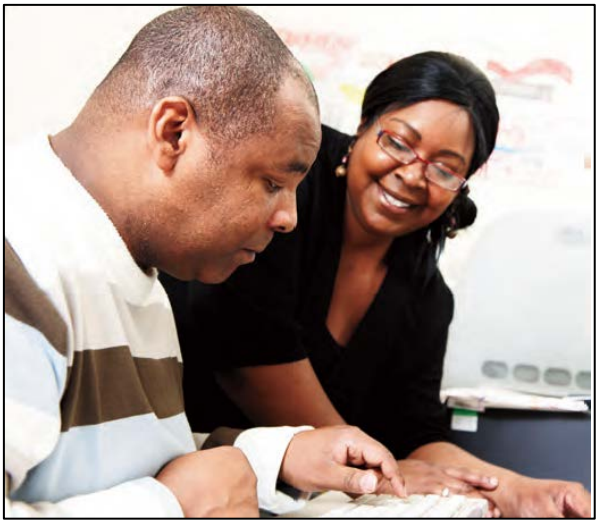
- Continuing our aim to provide care for people in the local community rather than in regulated care homes and outside of the borough
- Working with health partners to meet the needs of those with challenging behaviour

Older People's Housing – Extra Care (See WBC Housing Strategy 2015-18)

- Making sure we have the right mix of housing and sufficient provision for older people

The redevelopment of the former Fosters Care Home in Woodley as an extra care housing scheme will allow older people to live independently in their own home, with additional facilities and care staff if they need it. There will be 34 self-contained flats, all with a private balcony or ground floor terrace, as well as communal facilities including a lounge and dining room, and a specialist dementia facility.

Carers (See Support for Carers)



- Ensuring there is a range of services available to
  - support carers in their caring role
  - support carers to have a life outside caring
  - support carers to maintain their health and wellbeing

  This will include services to provide/offer
  - information and advice
  - emergency support specialist support

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