WOKINGHAM
BOROUGH COUNCIL

Local Account

Annual Report for
Adult
Social Care

2016/17

Local Account 2016-17

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 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.

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Our vision for adult social care

- co-produced by staff and customers as well as voluntary and statutory partners

We want our customers to lead fulfilling and healthy lives and, should they require care and support, to access services directly and arrange and manage their own care if they are willing and able to do so.

We will support carers to stay well and healthy and we will assist them with carrying out their caring responsibilities.

We are integrating social care services with health to ensure that it is easier to access support, our customers and carers do not need to give the same information to different organisations and we are able to draw on a wide range of resources to offer responsive and flexible services.

To ensure sustainability, value for money and offer better services, we also work on developing flexible and personalised services in partnership with all our customers, carers, voluntary, private and statutory sector organisation.

We will not only focus on meeting our customers' care and support needs, but also help to fulfil their aspirations. We will do this by connecting our customers with local communities and facilitating access to a wide range of education, employment and leisure opportunities.

We will ensure that appropriate and well-balanced safety measures are in place to protect our customers from harm whilst maximising choice and control of care and support.
Our workforce will be well supported and trained to offer the highest quality advice and support.

Progress on last year's priorities

A. SERVICES PROVIDED UNDER THE BETTER CARE FUND
The Better Care Fund (BCF) is the pooling of resources and integration of health and social care services to deliver better outcomes to our communities. We are delivering our BCF plan in partnership with Royal Berkshire NHS Foundation Trust (RBFT), Berkshire Healthcare Foundation Trust (BHFT), South Central Ambulance Service (SCAS) and Optalis.
There were four main developments that took place under the Better Care Fund during 2016-17:

1. Integrated Front Door
The Health and Social Care Hub, managed by Berkshire Health Foundation Trust (BHFT), provides a single point of contact for all health and social care contacts and referrals. The staff offer advice and information to residents about how they might meet their needs in the community, providing small items of equipment, as well as carrying out assessments for rehabilitation and social care needs. The Hub dealt with 3,103 contacts during 2016/17.

2. Wokingham Integrated Social Care and Health (WISH) Team
WBC's and BHFT's health and social care teams have joined forces to create a more flexible service where people no longer have to repeat their details again and again. Service users are offered an assessment and then referred for short term support to increase their mobility and independence and/ or longer term support to support them in their own homes. This integrated service has reduced the number of people needing to be admitted to hospital or to residential or nursing care and has avoided more people being delayed in hospital when they are fit to return home. Its success has led Wokingham Borough Council to become one of the high performing local authorities for managing to reduce Delayed Transfers of Care (older people who are delayed in hospital once they are medically fit to leave) and to reduce emergency admissions into acute hospital by managing patients in their own home.

3. Community Health and Social Care (CHASC)
CHASC – Community Health and Social Care (Previously called Neighbourhood Clusters, Primary Prevention and Self-Care)

This is a partnership project between WBC, Wokingham CCG, BHFT and Wokingham GP Alliance. The overall aim is, to keep the residents of Wokingham fit,

well and living as independently as they can be in their own homes for as long as possible by working as a single health and social care system that supports people, promotes self-care and prevention and ultimately makes the most effective use of all resources in the system. CHASC will deliver the following:

- A single long-term Health & Social Care Team focused on early interventions and prevention
- Remove organisational boundaries
- Users only tell their story once
- A single key worker
- Development around 3 localities
- Target top 10% of health & social care users
- Work with the 3rd Sector – Community Navigators (social prescribing)

The aim is to go live testing the integrated service in one locality in November 2017. The main deliverables will be a reduction in A&E Attendances of 499, a reduction in NELs of 331, a reduction in GP appointments 99 per year, full year effect.

Community Navigators
A new service that has recently started as part of the above initiative is the Community Navigators Scheme. This service aims to provide up-to-date information about local community resources to service users and their families to help support them self-care and maximise their wellbeing. The service is live in five GP practices and will be fully rolled out by December 2017. In 2016-17 the service received 126 referrals with 90% reporting an improvement in health and wellbeing.

4. Connected Care
This is an integrated IT system, covering NHS and social care services in Berkshire, which was launched in February 2017. Currently information is supplied to the system by most GP surgeries and two local authorities, one being Wokingham. When fully implemented later this year it will allow GPs, ambulance staff, hospital staff, community health workers and social care teams to share some of the key items of information needed to deliver improved care to patients and service users. For more information about how your information is used in Connected Care, please see https://www.shareyourcareberkshire.org/

B. SUPPORT TO CARE HOMES – RAPID RESPONSE AND TREATMENT SERVICE (RRAT)
The Rapid Response and Treatment Service is a medically led multidisciplinary service whose aim is to assist people to remain in their care home with the right support to meet their needs, and avoid hospital admission.

The RRAT service has reduced Non-Elective Admissions from Wokingham Care Homes into acute hospitals by about 15% in 2016-17 with approximately 80 less admissions into hospital than expected.

C. THE STEP UP/STEP DOWN SCHEME

Step Up
This project, due to commence in December 2017, and provided in partnership with Wokingham Community Hospital will provide 6 hospital beds for intensive rehabilitation to those people at risk of an acute hospital admission or premature admission to long term care with the aim of prompting their recovery and maintaining their independence in the community.

Step Down
Three flats are available locally enabling families to stay in touch and visit. The flats have been used in a variety of ways for both single occupancy and couples, where one person is the main carer and there has been anxiety about returning directly home from hospital. The flexibility these flats provide enables timely hospital discharges where either, further intense reablement is required which cannot be undertaken at home, or where there are reasons which prevent an immediate return home and a short stay is required. This benefits the person, as all the time they are in hospital waiting to leave they are at risk of acquiring a hospital infection and

ensures that hospital as the beds are not being used inappropriately for people no longer requiring medical interventions.

CASE STUDY

Mr B was admitted to hospital with an infection. He was living in unsuitable accommodation with no sanitation or heating. On discharge he could not return to this accommodation and was admitted to the Step Up / Step Down accommodation at Alexandra Place (Extra Care Housing).

A package of care was organised to support Mr B and assess his abilities with regard to personal care and meal preparation. He was given help to apply for sheltered accommodation from Wokingham Housing Department, information on benefit entitlements and local services and a property was offered locally in a sheltered housing unit. Mr B moved into the property and he is now living independently.

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 4,988 people in 2016-17 (based on local unpublished figures).

WHAT HAPPENED FOLLOWING REQUESTS FOR SUPPORT?

Short Term Support

In 2016-17 275 new clients went on to receive **Short Term Support to Maximise Independence** (down from 320 in 2015-16). 27 of these were aged 18-64 (10%) and 248 were aged 65+ (Of these 110 went on to receive a long term service, 56 ended early, 47 had no identified needs after the service ended, 31 went on to receive ongoing low-level support, 6 were signposted to other services, 24 still had identified needs after the service ceased but became self-funders, 1 declined further support.

Long Term Support
In total, 1,776 people accessed **Long Term Support** during 2016-17 (which is similar to the figure for 2015-16 of 1,785). Of these, 720 clients were aged 18-64 (41%) and 1,056 were aged 65+ (59%). As of 31st March 2017, 657 people aged 18-64 and 739 aged 65+ were still receiving services, making a total of 1,396.

Residential and Nursing Care
Of those clients receiving Long Term Support in 2016-17, 326 people accessed residential care of which 220 were 65+ and 106 were aged 18-64. 207 people accessed nursing care of which 194 were 65+ and 13 were aged 18-64.

Autism and Asperger's Syndrome
As of 31st March 2017, there were 73 clients with Autism (down from 75 the previous year) and 48 with Asperger's Syndrome (down from 50) in receipt of long term support.

CASE STUDY

Jordan is a young man with Autism and a learning disability who would at times become overwhelmed when faced with busy and noisy places. He found it hard to understand information people were giving him and could not communicate how he was feeling and what he wanted. When faced with these situations he would become very distressed.

Jordan attended an Optalis learning disability day service where the staff team worked hard to understand and support him with his anxiety. He was helped to

develop an understanding of how he expressed himself and learnt relaxation techniques to use when anxious. This helped him to feel in control of his environment and reduce his anxiety.

Carers

In 2016-17, the combined figure for carers requesting services or already receiving services was 620. Of these, 452 resulted in support provided directly to the carer (73%). Of the remainder, 110 requests resulted in respite or other forms of support being given to the person they care for (18%) and 58 resulted in no direct support (9%). The number of carers receiving help has decreased from 2015-16 when 625 had support provided directly to them and 195 were helped by respite or other forms of support being given to the person they care for.

CASE STUDY

Mrs B, aged 69, is the main carer for her husband who has Parkinson's and depression, and her father who is in the early stage of dementia. Her husband has very limited mobility, however, her father is fairly mobile. Mrs B receives domiciliary care for her husband but not for her father who requires supervision to maintain his independence. Although her husband has once a week day care, caring for two people has had a detrimental effect on her well-being, especially her emotional health. She feels stressed, isolated, depressed and trapped. Following a carers assessment Mrs B was referred to our **Carer's Flexible Sitting Service, provided by Crossroads,** which provides breaks twice a week to support the whole family, and with an overnight stay when required. Mrs B now has 2 breaks a week which she uses to meet up with friends to reduce her stress and isolation. She also uses the time to go for a walk which has improved her depression and physical heath. Above all, she feels that she can have a 'normal' conversation with the regular care worker who understands her worry and frustration.

Outcomes for people

Care and support is something which affects us all. We all know someone, a family member or friend, who needs some extra support to lead a full and active life. The Adult Social Care Outcomes Framework (ASCOF) measures how well that support achieves the things we would expect for ourselves and for our friends and relatives. It measures the outcomes which matter the most to people who use social care services.

Anyone can use this information to see how well their council is performing, making local
authorities answerable to their communities for the quality of care. Councils themselves use the measures to help them drive up standards, and give people choice and control over the services they use. To see all of the ASCOF measures please see the following link:
www.gov.uk/government/uploads/system/uploads/attachment_data/file/263783/adult_
social_care_framework.pdf

The following section sets out how well Wokingham has performed against these measures during 2016/17.

ENHANCING THE QUALITY OF LIFE FOR PEOPLE WITH CARE AND SUPPORT NEEDS

In 2016-17, Wokingham scored 19.3 out of a maximum possible score of 24 (up from 19.0 in 2015-16) for the overall measure for enhancing the quality of life.

CASE STUDY

Clive has autism and a learning disability. He needs a high level of care and support as his needs are complex. Clive's parents are preparing for a time when they will no longer be able to care for him in the family home. They want Clive to grow in confidence away from his home environment and develop his independence.

Clive was already attending the Optalis Learning Disability Day Service when he joined the Out and About service also run by Optalis. Initially he took part in day sessions and outings, which worked well. Building on this success, the Out and

About team started to prepare for Clive's first overnight stay. He thoroughly enjoyed his time away and then went on to enjoy two nights away.

His mother says Clive has blossomed in the last two years. She largely attributes the Out & About service for this positive change. She believes the exposure to new places has made him willing to accept different situations. She feels attending Out & About has also had a knock on effect in other areas of his life. He is able to communicate better and will more readily engage in activities. The service has enabled him to pursue new interests and try new things and he has a new found independence and sense of self-esteem.

Another outcome we measure looks at whether people using services feel in control of their daily life i.e. has their wellbeing and what is important to them and their family been taken into account? 79% of people using services in 2016-17 felt they had control over their daily life. This has reduced from 81% in 2016-17. This may have reduced in part due to the number of people in receipt of a personal budget or direct payment having reduced in 2016-17. However, the proportion of carers in receipt of a personal budget and receiving a direct payment remained at 100%.

During 2017-18 we aim 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 to give people more flexibility, choice and control about the type of service and provider they want.

People with a learning disability

The number of people with a learning disability in paid employment has increased during 2016-17 to 14.4%, up from 11.8% in the previous year. This compares very favourably with the figure of 6.2% for South East England.

The proportion of adults with a learning disability who live in their own home or with their family has also increased from 74.7% in 2015-16 to 78% in 2016-17. Again this compares favourably with 70.2 % for South East England.

CASE STUDY

A young 19-year-old woman with a learning disability living in the community was referred for a Safeguarding Enquiry following concerns regarding sexual exploitation. The situation was complicated as she also had a history of non-engagement with services and professionals. A social worker met with the young woman and worked hard to gain her trust and to ensure that she was safe from exploitation. She is now fully engaged with services and is taking part in a life skills development programme, education and training as well as engaging with a support worker.

Mental Health

The proportion of adults in contact with secondary mental health services in paid employment has risen from 15.8% in 2015-16 to 26.7% in 2016-17. The proportion of adults in contact with secondary mental health services living independently, with or without support, has also increased from 84.4% in 2015-16 to 93.5% in 2016-17.

CASE STUDY

A 40-year-old man was diagnosed with treatment-resistant schizophrenia. This major mental health problem started when he was at university. He lives with his parents and they provide support.

During his recovery he received various psychiatric and psychological support and his family also received support as carers. During the final stages of his recovery a support worker helped him build his confidence and manage his voices to enable him to go out into the community.

He started voluntary work in a charity job at the beginning of this year and has now been discharged from Community Psychiatric Nurse support. He still hears voices and can get paranoid but, the support he has received has made a really positive change to his self-esteem.

DELAYING AND REDUCING THE NEED FOR CARE AND SUPPORT

The council has a range of reablement programmes provided in partnership with health colleagues to support people to relearn lost skills to promote their independence and enable 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 2016-17 was 72.7%. This has reduced from 76.8% in 2015-16 and is lower than the South East England figure of 81.1%. We are exploring why this figure has reduced and believe it may be due to a recording issue.

However, the Council's policy of enabling people to stay living independently in their own homes has seen the number of older people admitted to residential and nursing care homes in Wokingham reduce to 444.48 per 100,000 people 65+ in 2016-17 from 646 the previous year.

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 46.4% in 2016-17 (down from 82.7% in 2015-16). We are currently looking into why this figure has reduced so drastically.

CASE STUDY

John has a diagnosis of Ataxia, which effects his coordination, balance and speech. Following discharge from hospital after a fall, John spent three weeks recuperating at Alexandra Place step up/step down service and then returned home with support from the START service. In the first week of his 5 week rehabilitation the START reablement workers spent time with John to assess his abilities and agree achievable goals. They would regularly assess and record progress and plan their ongoing support. John's motivation to regain his independence was a strong contributing factor to his success; combined with the skills and experience of the reablement workers who understood when and how to give him the time, encouragement and space to do things for himself.

Since START's involvement John has greater control over his daily life as he is much less reliant on paid support services and his care has reduced from 4 calls to 1 call per day.

John said of START, "strangely I wasn't very well when I came out of hospital. I couldn't have coped without help from START. I found it very good. They helped me to help myself".

HOW SAFE DO OUR SERVICES MAKE YOU FEEL?

The proportion of people using services who say that those services make them feel safe and secure has increased from 78.8% in 2015-16 to 90% in 2016-17.

Safeguarding referrals

During 2016-17 we investigated 510 concerns about people to ensure that they were safe.

CASE STUDY

"I am writing on behalf of my wife and myself to express my appreciation and gratitude for your efforts in helping us to recognise and come to terms with the 'Adult Abuse' we have experienced in our daily lives as we grew older - I am 78 and my wife is 77.Your involvement was a bit like having someone shine a light in a dark corner where you know something is wrong but you don't know what it is or what to do about it. It was a life-changing moment for me and I am grateful to you and your organisation for that."

What you think about our services

ADULT SOCIAL CARE SURVEY
Overall, 66% of users reported that they were extremely or very satisfied with the care and support services they received in 2016-17. This is down from 67.3% in 2015-16 but higher than the South East Region average of 65.7%.

CARERS SURVEY
Overall 37.5% of carers reported that they were extremely or very satisfied with the support services they received in 2016-17. This is down from 39.7% in 2015-16 and lower that the South East region average of 41.2%.

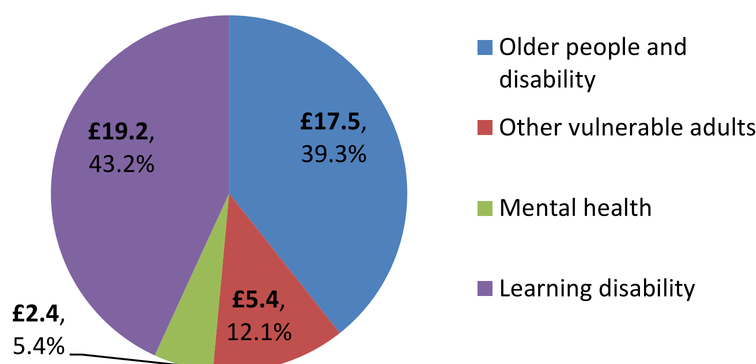
COMPLAINTS
In 2016-17 Adult Social Care teams received five formal complaints (the same as in 2015-16).
The reasons for the complaints were:

- Attitude/Conduct of Staff: 1
- Accuracy of File/Report: 1
- Contact with Relative/Carer: 1
- Financial Assessment: 2

Of these five complaints, four were resolved at Stage 1 of the complaints process and the other at Stage 2.

How we spend your money

EXPENDITURE ON ADULTS OVER 18 2016-2017 IN £MILLIONS



Priorities for 2017-18

Delivery of adult social care is one of the biggest challenges the country faces with the sector under severe pressure nationally. In the next 20 years the number of older people aged 65 years and over will increase, placing a greater demand on the health and social care system in the Borough as there is a higher likelihood of people living with Long Term Conditions, dementia or frailty. This highlights the importance of prevention, to ensure people age well and avoid dependency and self-manage their health effectively.

- WBC is working in partnership with health and the voluntary sector to ensure we have integrated services that provide responsive, cost effective and efficient services.
- We want to stimulate a diverse range of care and support services in Wokingham to ensure that people and their carers have choice over how their needs are met and that they are able to achieve the things that are important to them.
- We will be developing a 0-25 service which will ensure that the transition from Children's to Adult's services is efficient and seamless.
- We will be opening two new extra care units
- Our Carers' Strategy will be reviewed and brought up to date in line with government policy
- We want to ensure that we use assistive technology to support prevention and maintain the independence of older and vulnerable adults.