Report to Healthier Communities and Adult Social Care Scrutiny & Policy Development Committee 20 March 2019

Report of: Phil Holmes
Director of Adult Services

Subject: Update on Adult Social Care Performance

Author of Report: Phil Holmes (Director of Adult Services)
(Liz Tooke - Performance and Risk Officer, Business Strategy)

Summary:

This agenda item provides a summary for scrutiny members of adult social care performance in Sheffield. The last time this topic was covered by Scrutiny was January 2018.

The report sets out:

- How adult social care is performing in Sheffield across a number of key measures
- Further updates on improvement activity since the last report
- What we will be doing over the next year to improve.

Type of item: The report author should tick the appropriate box

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	x
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	
Other	

The Scrutiny Committee is being asked to:

The Scrutiny Committee is asked to review the information provided in the presentation and appended documents and provide comments on it and identify any priorities for improvement.

Background Papers:

- Adult Social Care Outcomes Framework Benchmarking overview (2017/18)
- Making our Conversations Count: Sheffield's Local Account for 2018 *(draft)* - ***Note – the appended is draft and will be considered by Cabinet on 20 March.***

Category of Report: OPEN

Report of the Director of Adult Services
Update on Adult Social Care Performance

1. Introduction

1.1 This agenda item provides a summary for the Scrutiny Committee of Adult Social Care performance in Sheffield. The last time this topic was covered by Scrutiny was January 2018.

1.2 Adult Social Care supports people over the age of 18 to remain independent, safe and well and to get on with living the kind of life they want to live. This includes care and support for adults, older people, adults with a learning disability, adults with autism and adults with a mental health condition. We also provide support for carers and for families with a disabled young person (as part of their journey into adulthood).

1.3 Adult Social Care sits within the People Portfolio, which is an integrated service supporting adults, children, young people, families, carers and communities with three key areas of focus:

- Early intervention and **prevention**, enabling the people we work with to live successfully and safely. Our strategy has been and continues to be delivery of the right level of support by the right people at the right time.
- **High-quality**, diverse and robust support for people, building better lives for them and making more equitable use of our limited resources.
- Developing our **workforce**, making sure we have the right-sized staff groups with the right values and behaviours, enabled by effective systems and support to develop their skills**.**

1.4 Our ambition is for an 'All Age' approach to disability related support across the portfolio which supports people from childhood through to older age in a consistent and seamless way, and without barriers or difficult transition points. We are ambitious for all children, young people, adults of working age and older adults with disabilities and will work with them, their families/ carers and their communities to help them achieve their full potential.

1.5 Our vision for Adult Social Care is underpinned by our 'Conversations Count' approach. Conversations Count is about listening to people and understanding what matters to them, and what a good life looks like to them and their family. Instead of assessing needs, ticking boxes on forms and putting in 'one-size fits all' services, it's about seeing people as individuals and as experts in their own lives, acknowledging their strengths and what they want to achieve, and working with them and others to organise the support they need to live the best life possible.

1.6 At the heart of the approach are the three distinct conversations we use to understand what really matters to people and families, what needs to happen next for them, and how we can be most useful.

- We start all our conversations by listening hard to people and their families and working with them to make connections and build relationships to help them get on with their life independently
- If people need some urgent help, we stick with them to make sure change happens quickly and help them regain stability and control in their life. We don't plan any long-term support until the immediate crisis is over, when we can all think more clearly about what support, if any, they'll need
- Where people do need longer-term support, we work with them to understand what a good life looks like to them and their families, and help them to organise the support they need to achieve this

1.7 We're continuing to develop our Conversations Count approach, and we're already hearing some extremely positive stories about the difference the approach has made. We've included a selection of our stories as Appendix 3.

1.8 While we're making some great progress, we're also aware of the challenges we face. The scale of the financial challenge facing adult social care nationally and locally is significant. As well as continuing Government cuts in funding, we have faced significant increases in demand for support. In Sheffield, the Council's financial pressures can broadly be defined in two categories:

- Rising provider costs, predominantly the costs associated with the crucial investment in staff wages to meet the National Minimum Wage
- An increasing demand for care and support services resulting from increasing numbers of people requiring higher levels of support in the community for longer. A significant element of these demand pressures is associated with progress in supporting increasing numbers of people out of hospital faster.

1.9 The strategic intention of Adult Social Care in Sheffield is to support a shift into prevention and well-being. This means moving away from a crisis intervention model and instead increasing focus on access to universal services and early help and preventative support. This will improve outcomes for local people and promote better usage of adult social care resources. The Conversations Count approach supports this shift whilst reducing the time spent on processes and systems in order that staff are able to respond more quickly to more people.

1.10 In the context of the situation described above, this report sets out:

- How adult social care is performing in Sheffield across a number of key measures
- Further updates on improvement activity since the last report
- What we will be doing over the next year to improve.

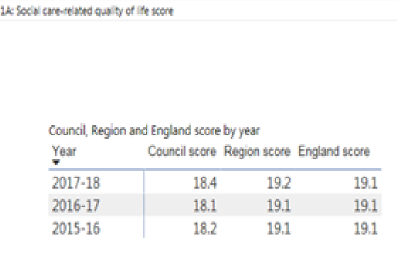
2 Adult Social Care Performance in Sheffield (key measures)

2.1 Headlines from our 2017/18 Adult Social Care Outcomes Framework (ASCOF) results are set out below. ASCOF measures how well care and support services achieve the outcomes that matter most to people. Some of the measures are based on a survey of people accessing adult

social care services in Sheffield. The measures are grouped into four domains which are typically reviewed in terms of movement over time. Data is provided at council, regional and national level. For some measures high scores signify good performance, and for others low scores signify good performance.

2.2 *Theme 1: ensuring quality of life for people with care and support needs* - **Social care quality of life score**

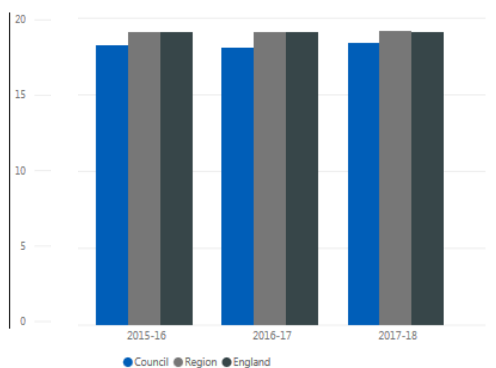
- This measure is an average quality of life score based on responses to the Adult Social Care Survey. It gives an overarching view of the quality of life of service users of social care. Scores are out of a maximum score of 24.



1A: Social care-related quality of life score

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	18.4	19.2	19.1
2016-17	18.1	19.1	19.1
2015-16	18.2	19.1	19.1

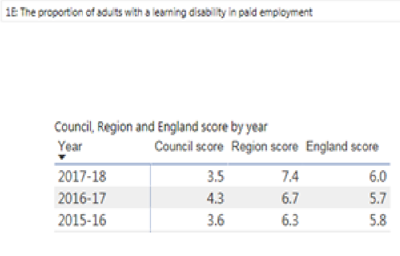


- There has been an increase in self-reported quality of life over 2017-18. This brings the Council closer to both the regional and national score but there is still more to be done.

- In 2017/18, the working age quality of life score in Sheffield (score: 18.6) was higher than the score for people aged 65+ (score: 18.1). This trend is reflected in other local authorities as well.

- We expect that the roll out of our “Conversations Count” approach across teams will form the basis for further improvement.

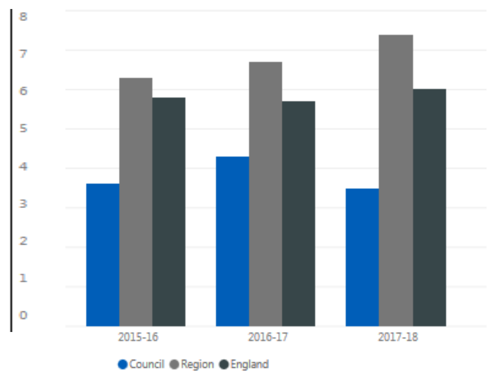
2.3 *Theme 1: ensuring quality of life for people with care and support needs* - **Proportion of adults with learning disabilities in paid employment**



1E: The proportion of adults with a learning disability in paid employment

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	3.5	7.4	6.0
2016-17	4.3	6.7	5.7
2015-16	3.6	6.3	5.8



- The percentage of adults with a learning disability in paid employment rose in 2016-17 but dropped back again in 2017-18. We have seen an improvement during 2018/19 and present performance is at 4.3%.

- Some caution needs to be exercised about regional and national comparison because Sheffield is one of the only places still to maintain a Case Register for people with a Learning Disability and supports a comparatively larger population than most other areas.

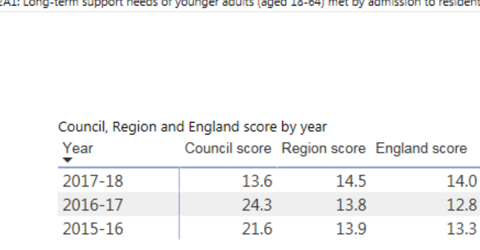
- Nevertheless there is much more that can be done to help people with a learning disability access employment. For example, in June 2018, we brought prevention work and occupational therapy together to provide time-limited support to help people to gain/regain confidence and skills, to build on strengths and to connect with community assets. One of the benefits of this project is that it will support people to actively contribute to their local community, through volunteering, paid employment, and sharing their skills and knowledge with others.

- We are also seeking to increase opportunities through work with Learning and Skills colleagues, in particular to develop opportunities for young people with disabilities preparing for adulthood.

2.4 *Theme 2: Delaying and reducing the need for care and support:* **Permanent admissions to residential and nursing care homes, per 100,000 population - younger adults (aged 18-64)**

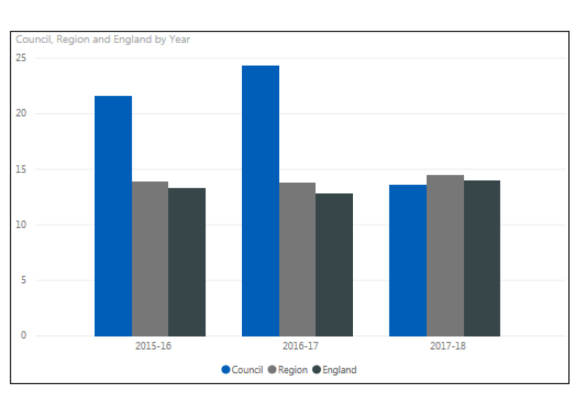
- 2017/18 showed a significant improvement from the previous two years.

2A1: Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 population | Sheffield



Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	13.6	14.5	14.0
2016-17	24.3	13.8	12.8
2015-16	21.6	13.9	13.3



- The main area of improvement between 2016/17 and 2017/18 for this age group was in Mental Health admissions - one of the reasons for the higher admission rate in 2016/17 was due to a cohort of people moving from long stay hospital to residential care during 2016/17. However, the downward trend for Mental Health has continued in 2018/19. In quarter 3 2018/19 Mental Health admissions make up about a quarter of all admissions. The ongoing reduction in admissions is due to more rigorous authorisation procedures and a strategic direction which is about offering more accessible alternatives to residential care that increase both inclusion and independence for adults aged 16-64.

2.5 **Theme 2: Delaying and reducing the need for care and support:** *Permanent admissions to residential and nursing care homes, per 100,000 population - older adults (aged 65+)*

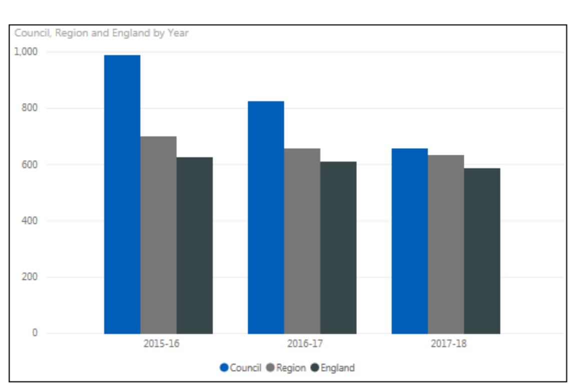
- Year end data shows a significant improvement from 2015/16 to 2017/18.

2A2: Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	657.4	632.6	585.6
2016-17	824.1	658.4	610.7
2015-16	987.9	699.5	628.2



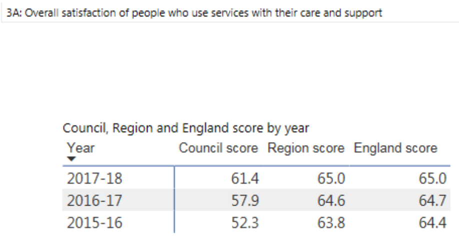
- A key factor in this improvement is that we now have less admission direct from hospital to care homes as we have improved access to community support. This enables a greater proportion of older people to return home from hospital in line with their wishes.

- Care home admissions for older people are currently lower than the same time last year. Comparison with regional neighbours suggests the potential for further improvement, and reducing care home admissions continues to be an area of focus for the service.

2.6 **Theme 3: ensuring that people have a positive experience of care and support**: *Overall satisfaction of people who use services with their care and support*

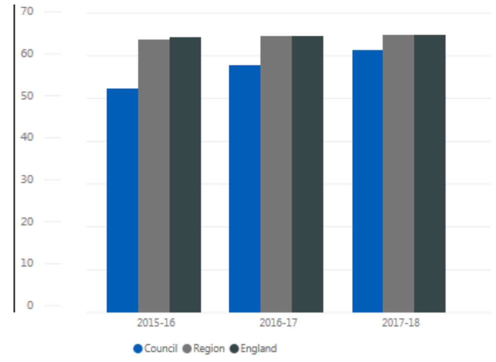
- Our scores have significantly improved since 2016 (the trend for 2017 regionally/all England was to stay the same). Therefore we are now closer to the regional and national average but have more work to do to achieve this.

3A: Overall satisfaction of people who use services with their care and support



Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	61.4	65.0	65.0
2016-17	57.9	64.6	64.7
2015-16	52.3	63.8	64.4

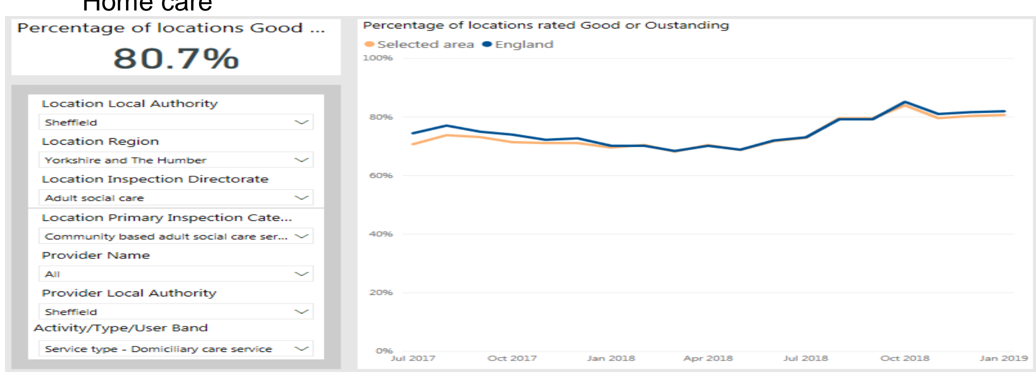


- Working age people in Sheffield (66.6% satisfied) are more likely to express satisfaction than people aged 65+ (57.2% satisfied). This trend is reflected in other local authorities as well.

- The Council has significantly invested in Home Care, Supported Living and Care Home provision over the last three years and this is likely to be the biggest factor in our improvement.

- The graphs below show the percentage of care locations which were rated ‘good’ or ‘outstanding’ by CQC in Sheffield compared to All England rates.

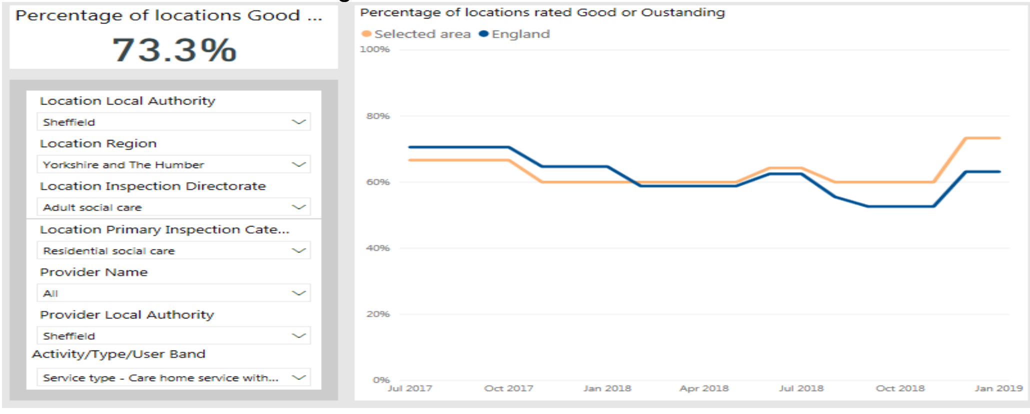
Home care



Care Homes - *Without nursing*

Percentage of locations Good ...
91.1%
Location Local Authority
Sheffield
Location Region
Yorkshire and The Humber
Location Inspection Directorate
Adult social care
Location Primary Inspection Cate...
Residential social care
Provider Name
All
Provider Local Authority
Sheffield
Activity/Type/User Band
Service type - Care home service witho...
Percentage of locations rated Good or Oustanding
Selected area
England
100%
80%
60%
40%
20%
0%
Jul 2017
Oct 2017
Jan 2018
Apr 2018
Jul 2018
Oct 2018
Jan 2019

Care Homes - *With nursing*



- Ratings for home care and care homes (without nursing) are now close to national averages. Ratings for care homes with nursing are above the national average.

- Council staff working on Contracting and Quality Assurance have focussed their efforts on improving the quality of commissioned home support in the city, including regular supportive monitoring visits, contract compliance, CQC focussed workshops, sharing best practice, etc. This work has delivered positive change, including in an improvement in ratings for commissioned support.

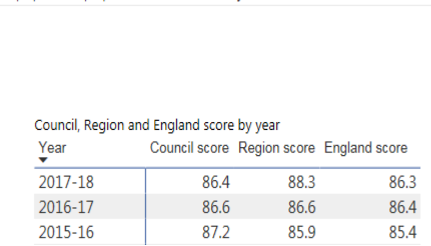
- Staff have also strengthened relationships since 2017 with residential and nursing care homes, through scheduling more frequent monitoring visits. This has resulted in Care Homes being more likely to respond

positively to the team's recommendations, and to contact the team if they are experiencing difficulties. Feedback from Care Home managers has shown that the Council's support has been valued and has helped CQC ratings (for example through early identification of issues, sharing good practice, and support to make improvements).

- Latest data on complaints (quarter 3 2018/19) shows a 15% reduction in the number of complaint investigations compared with numbers seen in the previous year.

2.7 *Theme 4: Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm* - **The proportion of people who use services who say that services have made them feel safe and secure**

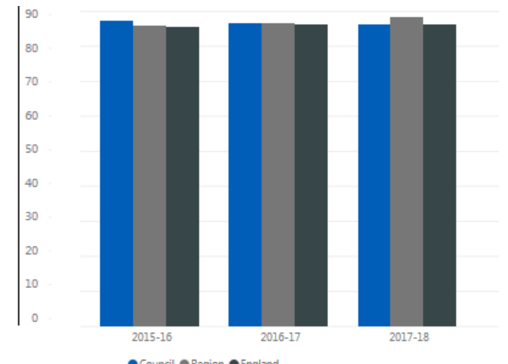
- We are slightly better than the average for England, but slightly below the regional average. Our score has remained similar over the last 3 years.



4B: The proportion of people who use services who say that those services have made them feel safe

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	86.4	88.3	86.3
2016-17	86.6	86.6	86.4
2015-16	87.2	85.9	85.4



2.8 Full details of how we scored against the Adult Social Care Outcomes Framework in 2017/18, and how we benchmark with others, are included in **appendix 2**.

3. Further updates on improvement actions since last report

3.1 We have arranged home care services for many more people. We know we provide home care for more people compared to most other councils in the area, helping people to stay in their own home so they don't have to move into a care home.

3.2 We have helped more people return home quickly after a stay in hospital. We work closely with hospitals to make sure people can return home as soon as they are well enough. 'Delayed Transfers of Care' (DTOC) performance has shown month-on-month improvement since October 2017 and in early February 2018 continues to show significant improvement in terms of delayed patient and delayed day volumes, maintaining improvement over the last 12 months. Slight increases have continued to be effectively managed to ensure lower numbers than the same period last year overall. However there is still more to be done to work with NHS colleagues and improve performance.

3.3 Our new Conversations Count approach has started to improve the time taken to understand the support people need and then plan and arrange the support. Our processes and the way our services worked needed to

change to allow us to have better conversations at an earlier point in time. On average it is now taking us:

- 14 days to understand what Adult Social Care support is required.
- 13 days to then put in place ongoing Adult Social Care support once it has been determined that the person needs it.

3.4 These changes are making a real difference, for our staff and the people we support. Staff have been telling us they feel free to listen to people, and to work together on building a good life. People we support say it makes such a difference to be able to talk to a social care worker about their life, rather than answering questions as staff fill-in each box on a form.

3.5 Over the last year we have improved our performance regarding the percentage *% of people who have had an annual Conversation reviewing their longer-term Adult Social Care support* (currently at 43%, from 37% this time last year). However there is still significant improvement required, as we move more towards timely and planned (as opposed to unplanned or reactive) reviews. We benchmark poorly for reviews compared to regional counterparts, but we are not alone in finding this challenging - our performance is very similar to Leeds, North Yorkshire, and Wakefield. Going forward, performance monitoring information on this measure will be available for teams at locality level, to help teams manage performance and any variation between teams.

3.6 Appended to the report is ***Making our Conversations Count: Sheffield's Local Account for 2018 (draft).*** Sheffield's 2018 Local Account is a public document which provides an overview on Adult Social Care performance. It provides background information on the service, highlights activity over the last year, and what we plan in the year ahead. ***Note – the appended version is draft and will be considered by Cabinet on 20 March.***

4 What we will be doing over the next year to improve

4.1 For the 2018-2020 improvement plan the focus of our work will be structured under five themes:

- Increasing the shift to prevention. The strategic intention of Adult Social Care in Sheffield is to support a shift into prevention and well-being. This means that we are increasingly moving our focus to early help and preventative support. This approach is improving outcomes for local people and promoting better usage of adult social care resources.
- Increasing the independence and inclusion of adults of working age including helping adults and young people as they transition to adulthood to access social and community activities, employment and universal services, providing better outcomes for individuals and for their communities.
- Developing a sustainable provider market. 2019/20 will see a renewed focus on the Council's relationship with external contractors as well as a strong emphasis upon helping our in-house services achieve their full potential.

- Increasing the proportion of adults who are able to live at home. Better preventative support means that people are able to live in their own homes and remain active in their communities for longer. We continue to improve our joint working with NHS colleagues to ensure people are able to able to return home from hospital in a timely way, and we continue to ensure best practice is in place to avoid care home admissions as a default option.
- Fairer charging. A range of initiatives aimed at supporting people to pay their contributions for care and avoid accruing debt to the Council will continue into 2019/20. In 2019/20 the Council will also introduce an in-house Deputyship Service which will be able to provide vulnerable people with quicker access to Deputies at a lower cost than is available currently.

5 What does this report mean for the people of Sheffield?

5.1 Social care affects the lives of many Sheffield citizens and their families. In the year 1 April 2017 to 31 March 2018:

- More than 11,000 adults received an adult social care service.
- We spent over £187 million on providing adult social care services.

5.2 Clearly, therefore, adult social care's performance is absolutely critical for a significant number of Sheffield people and their family, friends, carers and wider community.

5.3 In addition, adult social care is facing a significant increase in demand for support, anticipating a 10% rise between 2012 and 2020 in people aged over 65 with long-term limiting health needs. Viewed in the context of significant budgetary restraints, adult social care needs to be as effective and efficient as possible to ensure that those Sheffield people who need support receive it as appropriate and to a high quality.

6 Equality of Opportunities

6.1 The Council has a duty under section 149 of the Equality Act 2010 (the public sector equality duty) in the exercise of its functions to have regard to the need to:

a. eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
b. advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
c. foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

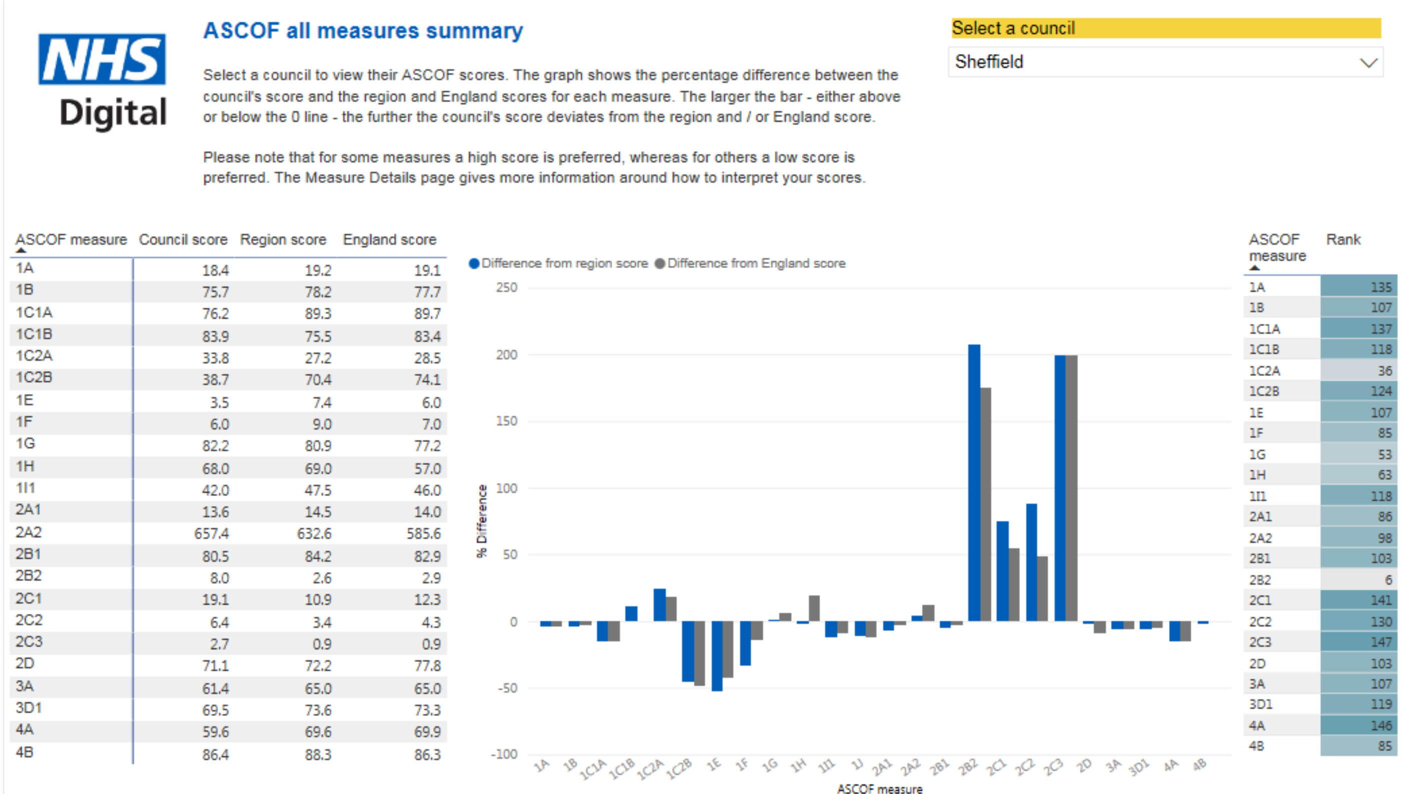
6.2 Although an Equality Impact Assessment (EIA) has not been undertaken for the production of the report, this duty has been taken into account during consideration of key change activities detailed in the report. Planned activity 2018/19 will also be subject to EIA.

7 Recommendation

7.1 The Scrutiny Committee is asked to review the information provided in the presentation and appended documents and provide comments on it and identify any priorities for improvement.

Appendix 1 - Adult Social Care Outcomes Framework Benchmarking overview (2017/18)

Full data set can be found online.



NHS Digital

ASCOF all measures summary

Select a council to view their ASCOF scores. The graph shows the percentage difference between the council's score and the region and England scores for each measure. The larger the bar - either above or below the 0 line - the further the council's score deviates from the region and / or England score.

Please note that for some measures a high score is preferred, whereas for others a low score is preferred. The Measure Details page gives more information around how to interpret your scores.

Select a council

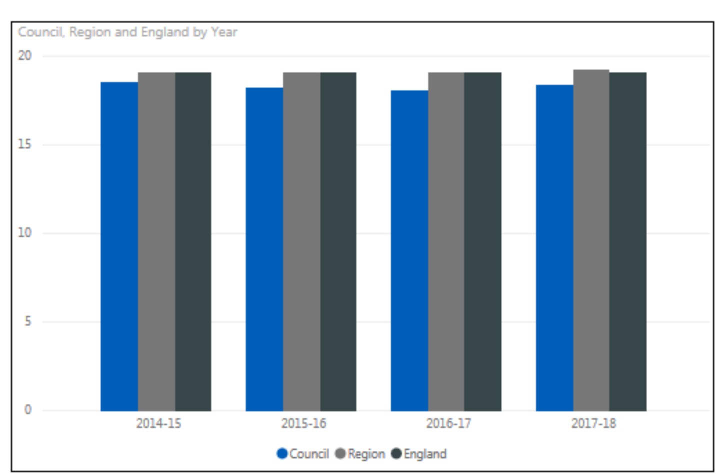
Sheffield

ASCOF measure	Council score	Region score	England score
1A	18.4	19.2	19.1
1B	75.7	78.2	77.7
1C1A	76.2	89.3	89.7
1C1B	83.9	75.5	83.4
1C2A	33.8	27.2	28.5
1C2B	38.7	70.4	74.1
1E	3.5	7.4	6.0
1F	6.0	9.0	7.0
1G	82.2	80.9	77.2
1H	68.0	69.0	57.0
1I1	42.0	47.5	46.0
2A1	13.6	14.5	14.0
2A2	657.4	632.6	585.6
2B1	80.5	84.2	82.9
2B2	8.0	2.6	2.9
2C1	19.1	10.9	12.3
2C2	6.4	3.4	4.3
2C3	2.7	0.9	0.9
2D	71.1	72.2	77.8
3A	61.4	65.0	65.0
3D1	69.5	73.6	73.3
4A	59.6	69.6	69.9
4B	86.4	88.3	86.3

ASCOF measure	Rank
1A	135
1B	107
1C1A	137
1C1B	118
1C2A	36
1C2B	124
1E	107
1F	85
1G	53
1H	63
1I1	118
2A1	86
2A2	98
2B1	103
2B2	6
2C1	141
2C2	130
2C3	147
2D	103
3A	107
3D1	119
4A	146
4B	85

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	18.4	19.2	19.1
2016-17	18.1	19.1	19.1
2015-16	18.2	19.1	19.1
2014-15	18.5	19.1	19.1



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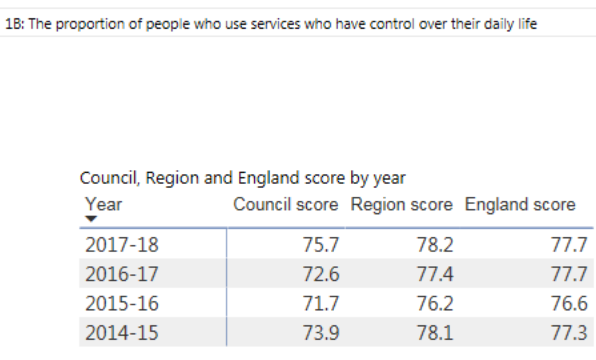
Appendix 1 - Adult Social Care Outcomes Framework Benchmarking overview (2017/18)

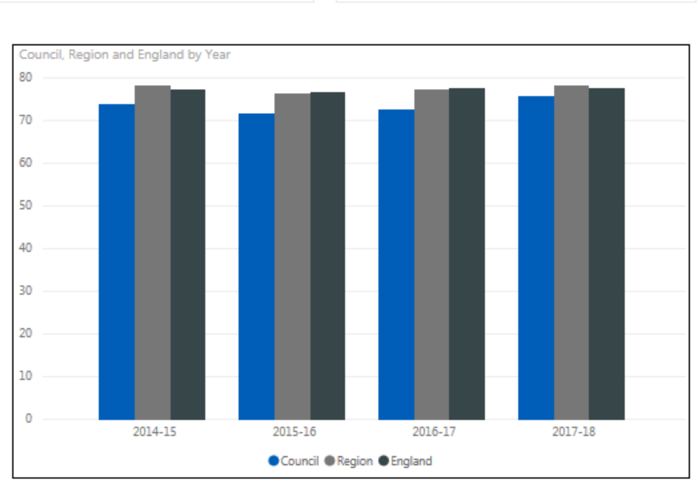
1B: The proportion of people who use services who have control over their daily life

Sheffield



Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	75.7	78.2	77.7
2016-17	72.6	77.4	77.7
2015-16	71.7	76.2	76.6
2014-15	73.9	78.1	77.3

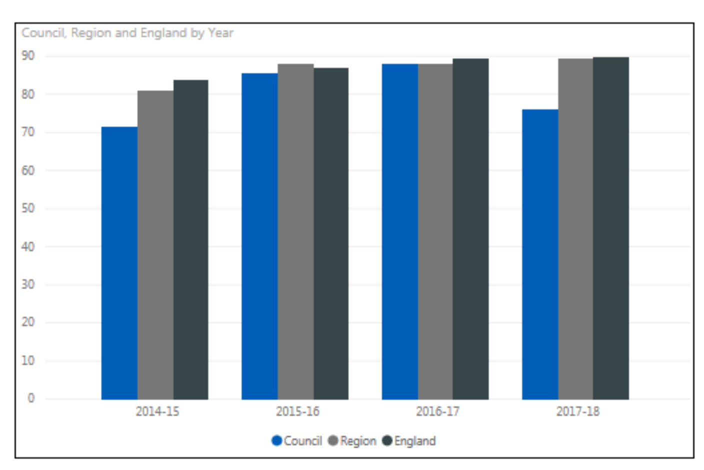


1C1A: The proportion of people who use services who receive self-directed support

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	76.2	89.3	89.7
2016-17	88.0	88.1	89.4
2015-16	85.4	87.9	86.9
2014-15	71.6	81.1	83.7

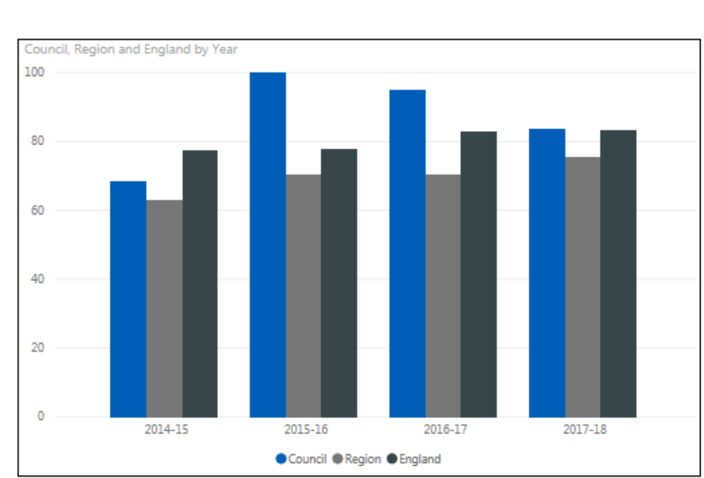


1C1B: The proportion of carers who receive self-directed support

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	83.9	75.5	83.4
2016-17	95.0	70.4	83.1
2015-16	100.0	70.3	77.7
2014-15	68.5	63.1	77.4



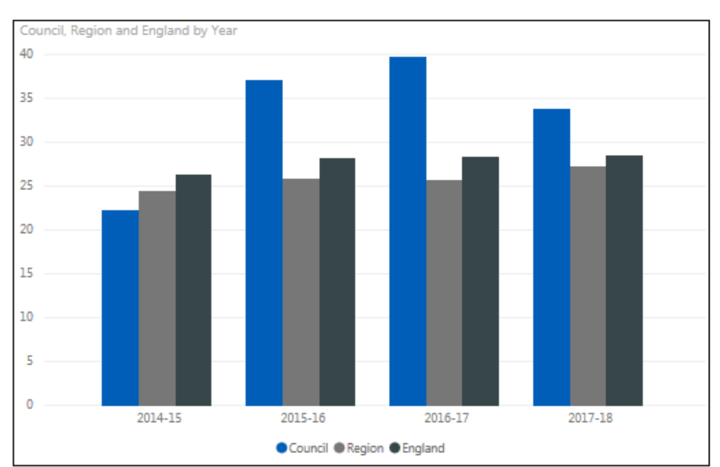
Appendix 1 - Adult Social Care Outcomes Framework Benchmarking overview (2017/18)

1C2A: The proportion of people who use services who receive direct payments

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	33.8	27.2	28.5
2016-17	39.8	25.7	28.3
2015-16	37.1	25.8	28.1
2014-15	22.3	24.4	26.3

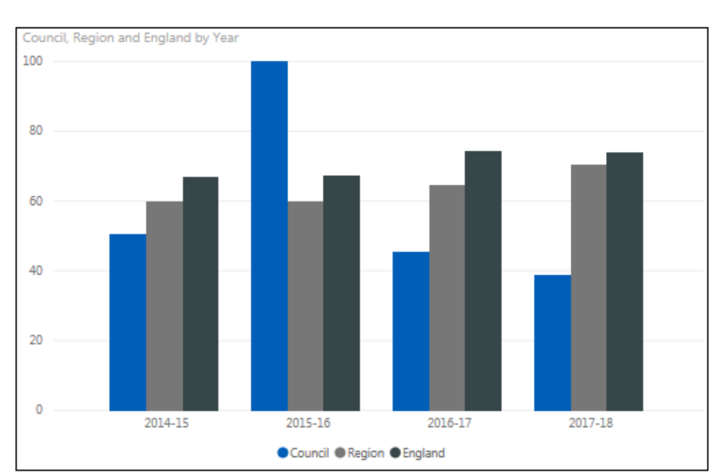


1C2B: The proportion of carers who receive direct payments

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	38.7	70.4	74.1
2016-17	45.6	64.5	74.3
2015-16	100.0	59.8	67.4
2014-15	50.5	59.9	66.9

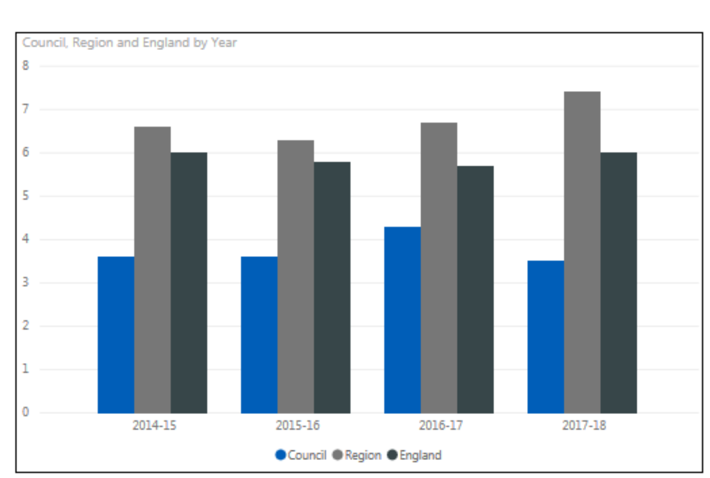


1E: The proportion of adults with a learning disability in paid employment

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	3.5	7.4	6.0
2016-17	4.3	6.7	5.7
2015-16	3.6	6.3	5.8
2014-15	3.6	6.6	6.0

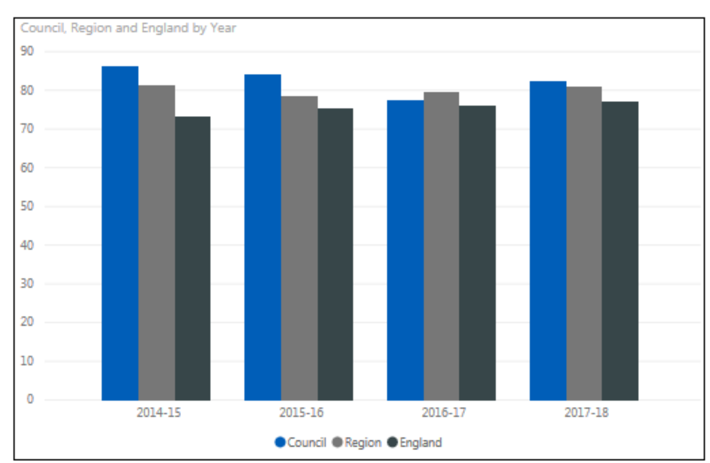


Appendix 1 - Adult Social Care Outcomes Framework Benchmarking overview (2017/18)

1G: The proportion of adults with a learning disability who live in their own home or with their family — Sheffield

Council, Region and England score by year

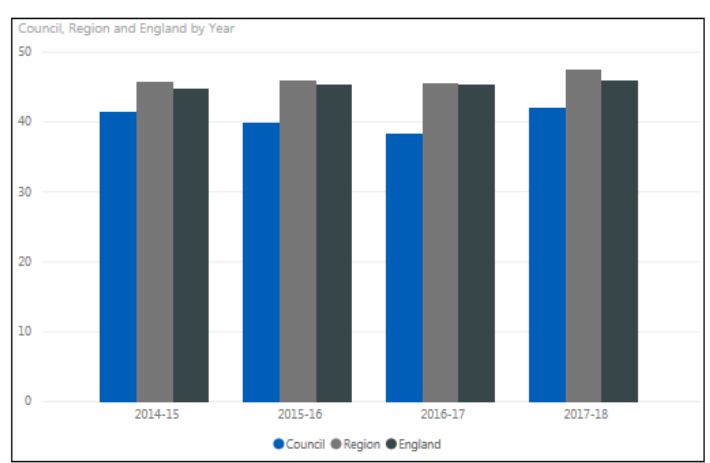
Year	Council score	Region score	England score
2017-18	82.2	80.9	77.2
2016-17	77.3	79.4	76.2
2015-16	84.1	78.6	75.4
2014-15	86.3	81.4	73.3



1I1: The proportion of people who use services who reported that they had as much social contact as they would like — Sheffield

Council, Region and England score by year

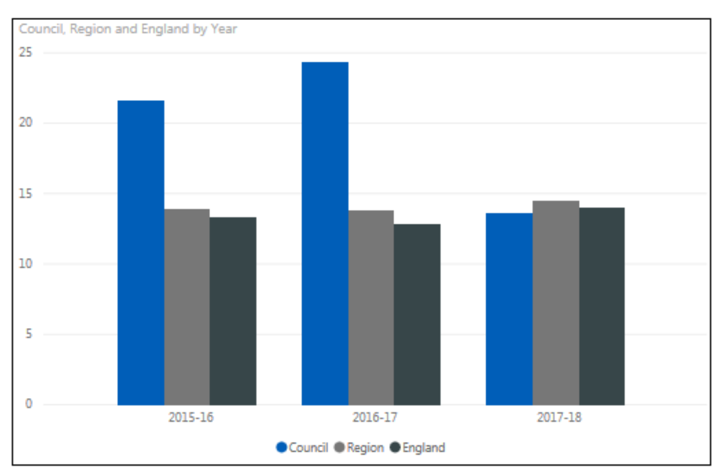
Year	Council score	Region score	England score
2017-18	42.0	47.5	46.0
2016-17	38.3	45.6	45.4
2015-16	40.0	46.0	45.4
2014-15	41.5	45.7	44.8



2A1: Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 population — Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	13.6	14.5	14.0
2016-17	24.3	13.8	12.8
2015-16	21.6	13.9	13.3



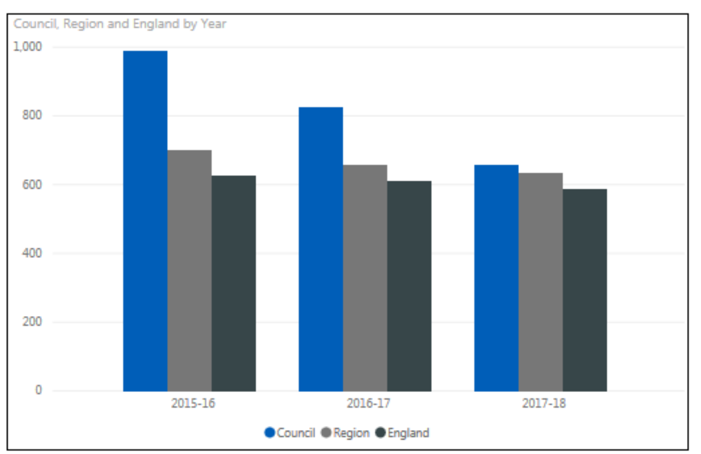
Appendix 1 - Adult Social Care Outcomes Framework Benchmarking overview (2017/18)

2A2: Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	657.4	632.6	585.6
2016-17	824.1	658.4	610.7
2015-16	987.9	699.5	628.2

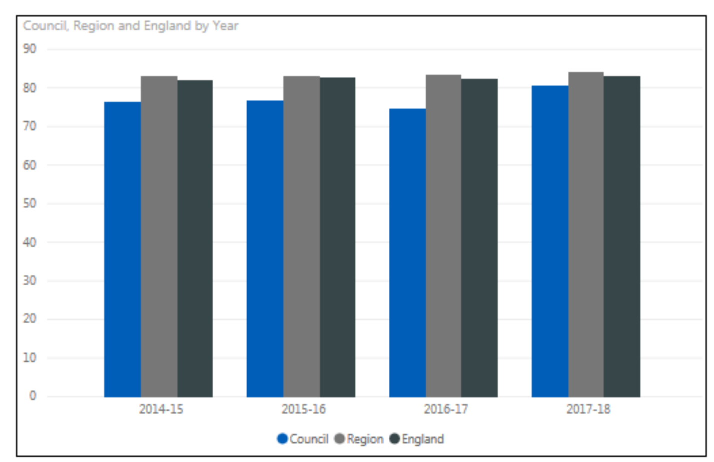


2B1: The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitati...

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	80.5	84.2	82.9
2016-17	74.7	83.4	82.5
2015-16	76.7	82.9	82.7
2014-15	76.5	83.2	82.1

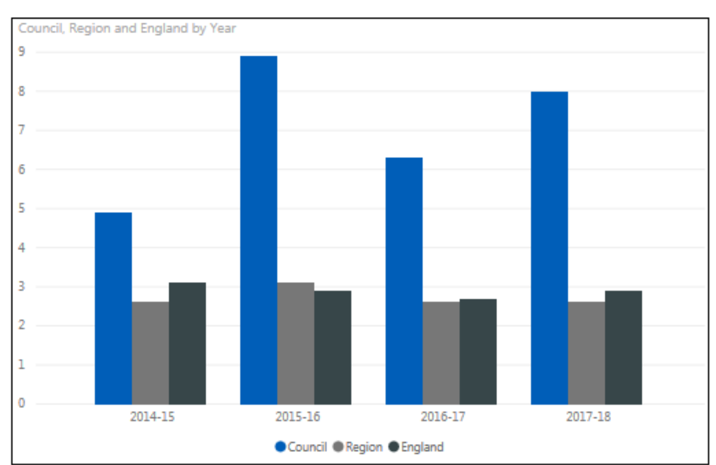


2B2: The proportion of older people (aged 65 and over) who received reablement/rehabilitation services after discharge from hospital

Sheffield

Council, Region and England score by year

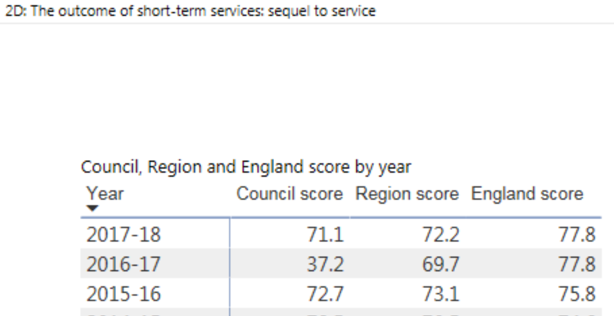
Year	Council score	Region score	England score
2017-18	8.0	2.6	2.9
2016-17	6.3	2.6	2.7
2015-16	8.9	3.1	2.9
2014-15	4.9	2.6	3.1



Appendix 1 - Adult Social Care Outcomes Framework Benchmarking overview (2017/18)

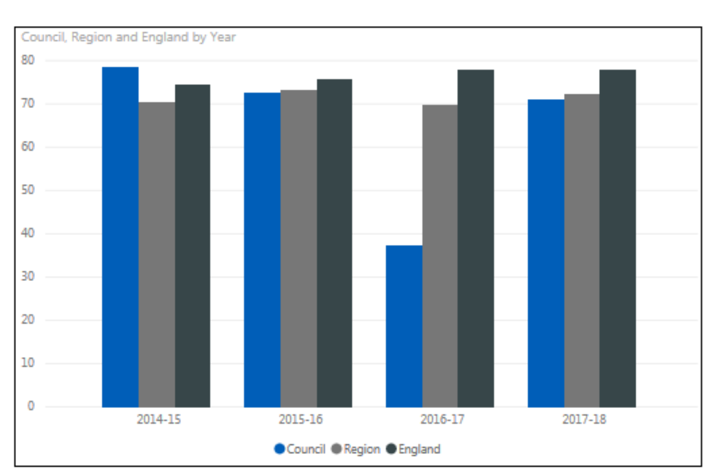
2D: The outcome of short-term services: sequel to service

Sheffield



Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	71.1	72.2	77.8
2016-17	37.2	69.7	77.8
2015-16	72.7	73.1	75.8
2014-15	78.5	70.5	74.6

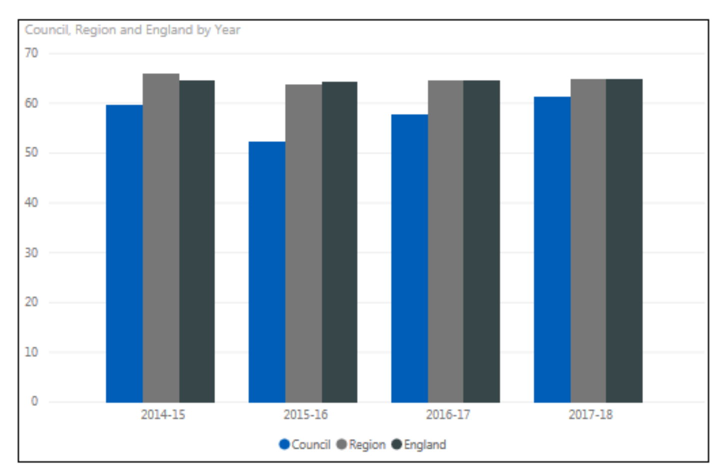


3A: Overall satisfaction of people who use services with their care and support

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	61.4	65.0	65.0
2016-17	57.9	64.6	64.7
2015-16	52.3	63.8	64.4
2014-15	59.8	65.9	64.7

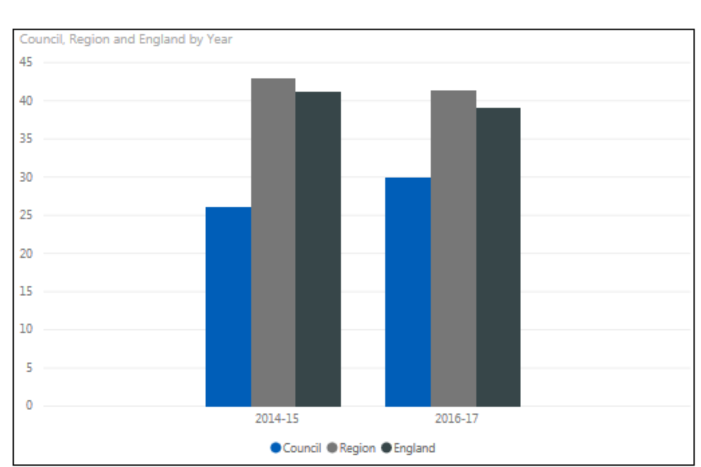


3B: Overall satisfaction of carers with social services

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2016-17	30.0	41.3	39.0
2014-15	26.0	43.0	41.2

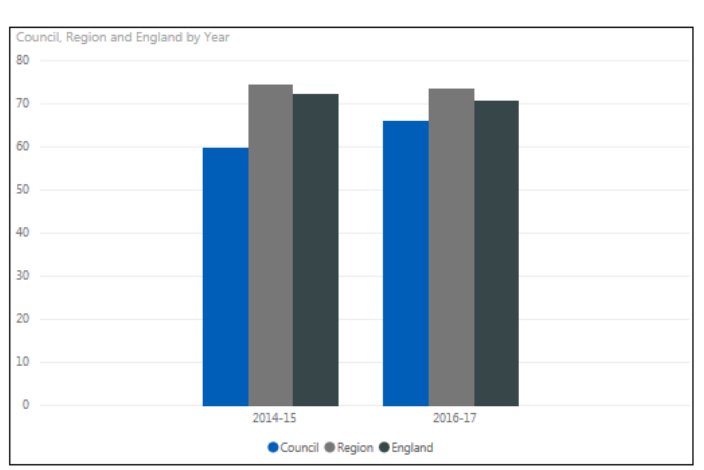


Appendix 1 - Adult Social Care Outcomes Framework Benchmarking overview (2017/18)

3C: The proportion of carers who report that they have been included or consulted in discussion about the person they care for — Sheffield

Council, Region and England score by year

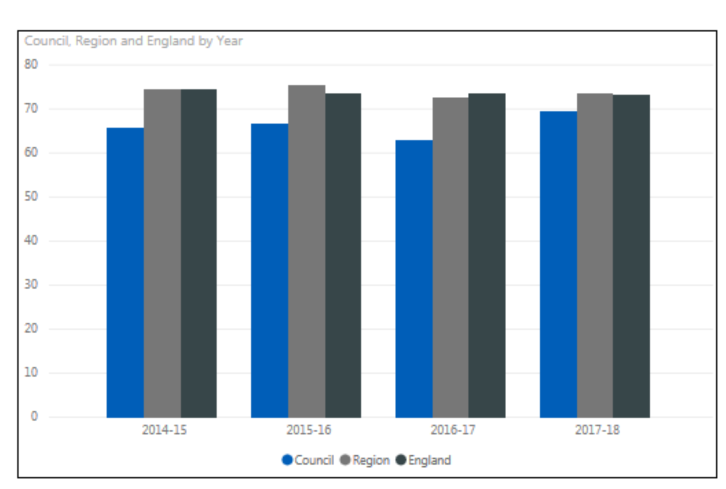
Year	Council score	Region score	England score
2016-17	66.0	73.6	70.6
2014-15	59.9	74.6	72.3



3D1: The proportion of people who use services who find it easy to find information about support — Sheffield

Council, Region and England score by year

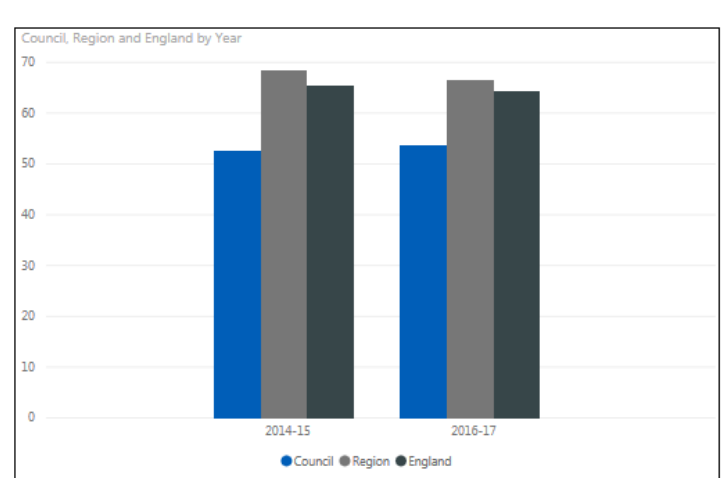
Year	Council score	Region score	England score
2017-18	69.5	73.6	73.3
2016-17	63.0	72.6	73.5
2015-16	66.7	75.3	73.5
2014-15	65.7	74.4	74.5



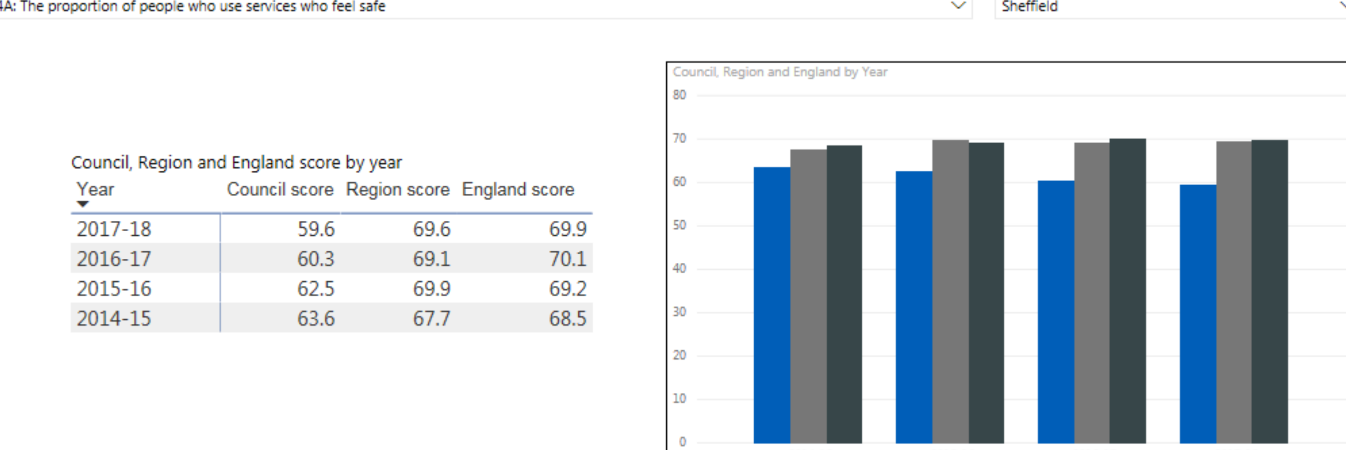
3D2: The proportion of carers who find it easy to find information about services — Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2016-17	53.8	66.4	64.2
2014-15	52.5	68.3	65.5



Appendix 1 - Adult Social Care Outcomes Framework Benchmarking overview (2017/18)



4A: The proportion of people who use services who feel safe

Sheffield

Council, Region and England score by year

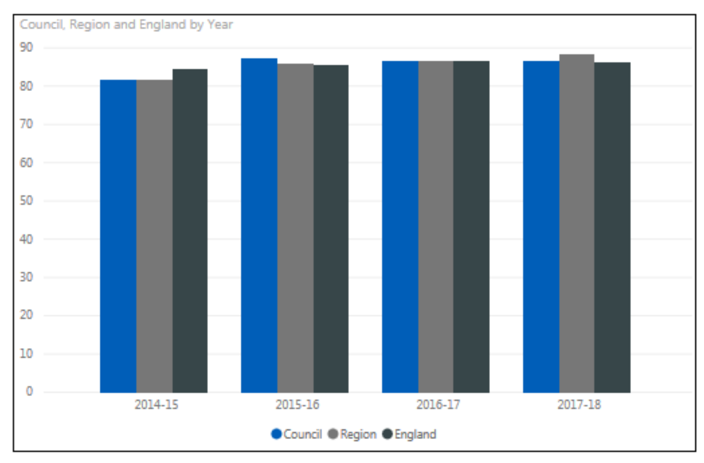
Year	Council score	Region score	England score
2017-18	59.6	69.6	69.9
2016-17	60.3	69.1	70.1
2015-16	62.5	69.9	69.2
2014-15	63.6	67.7	68.5

4B: The proportion of people who use services who say that those services have made them feel safe and secure

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	86.4	88.3	86.3
2016-17	86.6	86.6	86.4
2015-16	87.2	85.9	85.4
2014-15	81.5	81.8	84.5



Sheffield

Sheffield City Council

Making our Conversations Count

This report explains how we help people in Sheffield stay independent, safe and well. It explains our achievements, priorities and challenges in 2018, and our plans for the next year.

DRAFT

2018 Adult Social Care Local Account

Welcome

This has been another challenging year for the Council, and the city.

As well as continuing Government cuts in funding, we have faced significant increases in demand for health and social care support, for adults and for children and young people.

Sheffield is now recognised as a leading city for the way in which organisations are working together to face these challenges.

For example, the Local Government Association recently shared details of our work to reduce the number of people remaining in hospital when they didn't need to be there with other councils, to help them to learn how to tackle issues of disjointed systems, processes and decision-making. You can read more about our work in this area so far, and our next steps, later in the account.

We think we now need to bring together all the services that support children, young people and adults with a disability, to make sure all our citizens can access all areas of the city and all parts of city life. We want everyone to be independent and equal in society, and have choice and control over their own lives.

We know it's often the way services are organised that creates barriers for people, not a person's physical or mental impairment, illness or difficulty. And many times people face problems because of the way services are provided at key points in their lives, such as when they move from being a young person to an adult, and in later years as they become an older person.

So a key part of this work will be to make sure services are provided 'seamlessly', and help people as early as possible to grow and develop, and build a good life. As with all the different topics in this account you can get more information about this work from our Information Service (details on page 12).

Councillor Christine Peace,
Cabinet Member for Health and Social Care

Councillor Jackie Drayton, Cabinet Member for Children, Young People and Families Health and Social Care, and all age disability

What does ADULT SOCIAL CARE *do?*

Adult Social Care helps people over the age of 18 to get the care and support they need to remain independent, safe and well. This includes care and support for adults, older people, adults with a learning disability, adults with autism and adults with a mental health condition. We also provide support for carers and for families with a disabled young person (as part of their journey into adulthood).

'Care and support' is the help some people need to live as well as possible with any illness, disability or impairment they may have. It can include help with things like washing and dressing yourself, preparing and eating meals, getting out and about and keeping in touch with friends and family.

Social care affects the lives of many Sheffield citizens and their families. In the year 1 April 2017 to 31 March 2018:

- more than 11,000 adults received an adult social care service.
- we spent over £187 million pounds on providing adult social care services.

Adult Social Care works with many other organisations and services in the city, to:

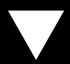
- improve the health and wellbeing of all our citizens.
- help patients in hospital return home as quickly as possible.
- protect people from harm (also called safeguarding).

There's more detail about this work later.

For the 2018-2020 improvement plan the focus of our work will be:

- increasing independence and inclusion.
- increasing the shift to prevention.
- increasing adults able to live at home.
- developing a sustainable provider market.
- ensuring fairer charging.

Find out more



For a copy of our improvement plan contact our Information Service (details on page 12).

So... how did we do?

Every year we collect information about how many people we help, what services we provide, and how people feel about the support they get. We compare our performance to 14 other councils in the Yorkshire and Humber area, like Barnsley, Doncaster, Leeds and Rotherham.

You can download all of the details from NHS Digital (see below). Comparing our scores over the year April 2017 to March 2018, we:

● **supported more people in their own home,** so they didn't have to go into a care home. We know people prefer to stay independent in their own home for as long as possible, so we continue to work to help even more people stay in their community. The number of people moving to a care home each year in Sheffield is similar to that of other councils in the area, but we're working to reduce this further.

● **arranged home care services for many more people.** We know we provide home care for more people compared to most other councils in the area, helping people to stay in their own home so they don't have to move into a care home.

● **helped more people with a learning disability find employment.** We know employment can make a huge difference to a person's health and well-being. While we have improved this year, we know there's a lot more we can do to help even more people into employment.

● **helped more people return home quickly after a stay in hospital.** We work closely with hospitals to make sure people can return home as soon as they are well enough.

This year the number of people who were well enough to return home, but remained in hospital, reduced from 24 each day, to 19 each day. While this is good progress we continue to focus on reducing this with our NHS partners.

You can read more about this work on page 10.

So... how did we do?

We continue to work to improve things where we compare poorly to other councils in the area, including:

● **the quality of home care services.** The Care Quality Commission inspects the quality of all the companies that provide home care services. While the quality of Sheffield services improved this year, we're committed to helping home care providers raise the quality of their services even further.

We're working closely with NHS Sheffield services to help home care companies improve their services. Similar work on improving the quality of local care homes has significantly increased the Care Quality Commission rating of care homes in Sheffield. We continue to work with local nursing homes to improve their services.

● **the time taken to assess people's needs, and arrange their support.** Our processes and the way our services worked needed to change to allow us to have better conversations at an earlier point in time.

As part of a major improvement programme we began last year, we've made significant changes in our working practices, and replaced our IT system.

We now have a specialist team that talks to new people asking for help for the first time, often providing advice and help immediately, without having to wait for an assessment.

We also have 7 teams that work in specific areas of the city. These new locality teams have detailed knowledge about community support in the local area, and can respond quickly to help people work out what matters to them about their life, what's working and what isn't. We call this new way of working 'Conversations Count'.

Find out more ▼

Read more about the impact of Conversations Count on page 8. To compare Sheffield's performance to other councils in the area visit NHS Digital: https://digital.nhs.uk.

Keeping people safe

Adult Safeguarding Partnership

Lots of different organisations in Sheffield help to keep people safe, from the Police, the Council and the Fire Service, to small organisations like home care providers. Many of these organisations work together as part of the Sheffield Adult Safeguarding Partnership.

The partnership makes sure these organisations work well together to prevent abuse and neglect (also called safeguarding), promote safety and wellbeing, and support people who have been abused. A Customer Forum makes sure local people (including those with a learning disability) are fully involved, including representation on the Executive Board.

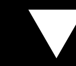
This year we received 3,156 safeguarding concerns, 35% fewer than last year. Of these 973 we resolved quickly, with 2,183 needing further investigation before being resolved.

The partnership reviews their work every year, identifying new ways to further reduce abuse and neglect, and opportunities to improve practice across the city.

The four current priorities are:

- Prevent abuse and neglect of people at risk taking place – people at risk suffer less abuse and feel safe.
- Make safeguarding personal – people experiencing harm are supported to achieve the outcomes they want.
- Make sure safeguarding works well.
- Protect adults who have care and support needs from abuse and neglect.

The partnership website has advice for carers, plus advice and support to make your home safe (like escape plans and fitting smoke alarms). There's also advice about support across the city when you're out and about. The Safe Places scheme provides temporary safe refuges where adults who find themselves in difficult situations can get assistance.

Find out more 

For more information about the partnership contact our Information Service (details on page 12), or visit the partnership website: www.sheffieldasp.org.uk.

Our plans and priorities

Better city-wide working together

There are many organisations in Sheffield all working to keep people healthy, independent, safe and well. How these organisations work together must improve if Sheffield is to meet the challenges and pressures on health and social care.

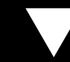
In March the Care Quality Commission looked at how Sheffield's NHS services and adult social care work together (or don't) to keep older people healthy and well. They found we hadn't got it right, but there was "a strong commitment to achieve the best outcomes for the people of Sheffield".

We have now begun to work in a radically new way with partners like the NHS Sheffield Clinical Commissioning Group, to find more ways we can support each other, and better deliver services that prevent people from becoming ill, needing hospital or needing support. We've agreed new rules that will make us work better together. We call this our Joint Commissioning Approach, and it's a significant commitment by all of us.

Through this approach we will make decisions together, agree joint aims, share our resources and funding, and share the risks and pressures on the city (like winter pressures, when many more people are admitted to hospital). A key focus of our work will make sure we can get support to people as early as possible, to prevent their illness, impairment or problems getting worse.

Through the approach we will make sure:

- people get health and social care support closer to home, without a stay in hospital.
- health and social care support is provided in a much more coordinated way, so people feel support is provided 'seamlessly'.
- we improve the lives of all our citizens. We know people living in some wards have poorer health and need greater support. We are committed to ending health inequality.

Find out more 

For more information about our Joint Commissioning Approach please contact our Information Service (details on page 12).

Our plans and priorities

Conversations Count

We've been changing the way we support people since 2017. Instead of a focus on forms and processes like assessments and reviews, we now:

● listen to people – what matters to them about their life, what's working and what isn't.

● recognise people's skills and strengths, and their experience in managing their support, their family and their whole life.

● focus on wellbeing, prevention and independence, to help the person build a good life.

● help people to get support from their community and neighbourhood. Often these are creative solutions that are far better than our traditional support services like home care and care homes.

● make sure support fixes the things that aren't working now, and helps people to plan for the future.

Many of our teams now work in this way, and we expect the whole service will have changed to this way of working in 2019.

As part of planning this change we've involved people and carers, to help us develop our approach and involve our local experts by experience. This includes regular briefings at Service Improvement Forums and the Learning Disability Partnership Board.

'Stories of difference'

These changes are making a real difference, for our staff and the people we support.

Staff tell us they feel free to listen to people, and to work together on building a good life.

People we support say it makes such a difference to be able to talk to a social care worker about their life, rather than answering questions as staff fill-in each box on a form.

Our plans and priorities

Feedback

"I've been able to work with Joy longer to get a better picture of her needs."

"The freedom to talk more and write less really worked for Justin and his aunt."

"I was able to focus on exploring activities for Violet instead of completing forms. I found many resources within the community, which I can offer to other people."

"Family was anxious at first but relaxed as the conversation flowed."

"I feel like I am important – my life is important. I didn't expect that."

Carers and families tell us they feel much more included, respected and listened to.

People say they feel more in control of their own lives, with a plan they helped to create (rather than having support 'done to them').

We're finding the support people need is often less than we would have provided previously, and more creative solutions often cost less for the person and the Council.

Conversations Count is making a difference to the lives of the people we support, for younger adults, people with a physical or learning disability and for older people. Here's a quote on the difference our new approach is making:

"I have had input from a wide range of professionals over the last few years, since my injury/illness, a few have been excellent in what they do, fewer still have really inspired my confidence and made me feel like I am in the presence of a caring friend (which is exactly what I need) and I count Jennifer amongst them."

Find out more

For more stories of difference, and websites and resources about this approach, please contact our Information Service (details on page 12).

Our plans and priorities

Why not home, why not today?

Adult Social Care works closely with Sheffield NHS services to make sure patients can return home from hospital as soon as possible.

This is much better for the patient, and makes sure our hospitals can help as many people as possible.

While work with Sheffield Teaching Hospitals and the Clinical Commissioning Group in 2016/17 lead to significant improvements, we knew there was more we could do.

So we worked with a company that helps services improve (called Newton Europe) to find new ways to work better together. They looked at financial and performance data, read hundreds of patient stories, and talked to about 100 staff. They found we had some outstanding best practice, and a high desire to improve.

From this work we developed a new plan to reduce the amount we spend on high intensity and emergency care, to less costly, earlier support, like services from your doctor and community services like district nursing. We also agreed changes so that NHS staff and Adult Social Care staff work together in new ‘multi-agency’ teams.

This has improved the way we support people to return home, and made sure care is arranged quickly to help the person recover at home.

A report on the changes we made in Sheffield was shared with other councils looking to improve (see links below).

Find out more ▼

For a copy of the report Why not home, why not today visit: https://reducedtoc.com, or visit the Fab Stuff website: https://fabnhsstuff.net, or read the Local Government Association report from their website: www.lga.gov.uk.

For more detail about the work we’re doing to reduce hospital discharge in Sheffield contact our Information Service (details on page 12).

What do local people tell us?

Complaints

We deal with every complaint carefully. Most of the time we identify ways to improve things for the person, and improvements we can make to the way we provide our services.

We received 152 complaints about adult social care services in the year April 2017 to March 2018. This is 7 fewer than the previous year, and compares well to other councils in the area.

We regularly check how long it takes us to respond to complaints. Often we can respond quickly to sort out a minor problem, but it can take longer when a complaint is complicated.

This year on average we took 85 days to respond fully to adult social care complaints, 5 days longer than last year.

We're changing the way complaints are managed and working to speed-up the time to respond to complaints, so we can improve the time it takes in future.

Service User and Carer Surveys

We regularly contact people who get support from us (also called service users and carers) to ask them for their views. We use government advice on what questions to ask, how to contact people and so on. Most councils in England also take part in these surveys.

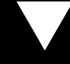
This year service users told us:

- 6 out 10 people are satisfied with the support they get. This is better than last year, but we know there's more we can do to increase this.

Similarly, we're looking at how we can improve people's views about:

- their quality of life
- how safe they feel
- how much control they have over their daily life.

Find out more



For a copy of our complaints report for this year, contact our Information Service (details on page 12), or visit the council website: www.sheffield.gov.uk/tellus.

Your questions, ideas and comments

For many of the sections in this account we have told you how you can get more information, either from our website or by contacting our information service:

- telephone: (0114) 273 4119.
- email: information@sheffield.gov.uk.
- in writing: Information Service.
Sheffield City Council People Portfolio.
Floor 9 East, Moorfoot building,
Cumberland Street, The Moor, Sheffield S1 4PL.

We've also produced an email that gives more information and sources of data for many of the topics in this account. To receive this email please email: information@sheffield.gov.uk.

If you have any questions or comments about this report please get in touch. You can also contact us with ideas on how we can improve the report, or what you would like to read about next year.

Sheffield City Council.
Adult Social Care Services.
2018 Local Account.

This document can be supplied in alternative formats. Please contact (0114) 273 4119.

Appendix 3 - Adult Social Care 'Stories of Difference' (March 2019)

Please find below several stories of difference (collated by the Practice Development team) which represent a great cross-section of the service and the support we've provided to a range of different people using the new approach.

The stories are from

- Focused Reablement (David)
- Localities (Joseph, locality 6, and Ella, locality 5)
- Preparation for Adulthood (Stephen and Oliver)
- HomeFirst (Nigel)
- Future Options (Mandy)

All names and other identifying details have been changed in all stories except David's as he is happy for his story to be shared.

Story of difference: David

Worker	Jennifer	Team	Focused Reablement	Date	September 2018

Reason for contact

David is 53 years old and lives independently in his own home. He has cerebral palsy that primarily affects his right side and is registered blind, with some vision remaining (40%). He is able to walk independently but struggles to fully extend his fingers and has reduced sensation in his fingers, and this impacts greatly on his fine motor skills. We contacted David as he was one of the group of people we'd identified to work with in the Focussed reablement team.

What would have happened (old world)

In the old world David would probably have waited a long time for a review by a worker in a Locality team. When they did visit him they would have reviewed at his care package and it would probably have continued with no change until his next review.

The conversation(s)

When I first visited David he was fairly hostile and reluctant to engage. He raised his voice several times and expressed clear views about his reluctance to attend activities associated with people with learning disabilities. As we talked I found out that his mum lives locally and visits often, and David and his dad go for a walk around Hillsborough Park every week and they also have season tickets for Sheffield Wednesday. Other than these outings, David rarely left the house.

David's family support him with shopping, washing and household/financial matters. A carer comes in for 40 mins each day at approximately 5pm to provide a hot meal and put out cereal and a sandwich for the following day. Any remaining time is used to support David with domestic tasks.

Through the conversation, it became apparent that David's care agency had changed hands a couple of times over the past two years, which had caused him considerably uncertainty and anxiety. He had also recently lost his two favourite carers to another agency and was very angry about how he perceived they had been treated. David's frustration and anger was causing tension between him and his mum, and was hindering him in his relationship with his new carers. David relaxed through the conversation. It became apparent that he relied quite heavily on his carer calls for social contact. We talked about ways of increasing social contact and activities he could try.

What happened next?

David was interested in finding out more about the Cycling 4 All group in Hillsborough Park, so I arranged to go there with David and we both had a go at cycling. David was keen to go again, he got to know a few people, 'got the bug' and is now attending twice a week, every week and has become a volunteer.

I helped David compose a letter of apology to one of the carers which helped him to accept the situation and move on, so he can engage with his current carers with an open mind. This is no longer causing tension between him and his mum.

I also went with David to the Zest Centre in Upperthorpe and he signed up for a gym induction.

The experience

I have loved working with David. He is now healthier and happier and is going out on a daily basis. His attitude to the Council is a lot less hostile and now, and instead of talking about his carers he talks about his friends. Although his care is unchanged, we have greatly influenced David's access to his community, his mental and physical wellbeing and his friendships.

Story of difference: Joseph

Worker	Samantha	Team	Locality 6	Date	February 2018

Reason for contact

Joseph is an alcoholic who had broken his hip and was in hospital for some time before being discharged to a 5Q bed. It was believed that he also had dementia but they could not tell how advanced this was due to his alcoholism. His wife who also had mental health issues was very worried that if he came back home she could not cope. He was referred to us through the 5Q hospital discharge process.

What would have happened (old world)

Joseph would have been placed in residential care.

The conversation(s)

I spoke at length with the family and asked that we take it day by day before they make a decision about him going into permanent care. I listened to Joseph's wife's fears of how she could not cope with how he was and I listened to his daughters and how they felt this impacted on their mother but they did fear for their father going into permanent care. I spent time meeting with the family at the care home and I spent time with Joseph. On my first visit he did not have capacity and he did not know where he was or why. On the second visit I noticed he was slightly more aware and able to have short conversations that made more sense. He had been detoxed in hospital and that had been some weeks prior but he was still asking for alcohol and he was still confused.

When we noticed that Joseph was gaining an understanding of where he was and was able to communicate better we discussed the possibility that he was improving and that the dementia was not as advanced and that he was still adjusting to living without alcohol. We moved onto talking about home support. I made it clear that I would be with the family throughout the process and I wouldn't hand them over to a new worker, as they feared they would be abandoned once Joseph came home. I made them a promise that I would see it through with them so that if he came home and it was going badly I would come out immediately and see them.

By my third visit Joseph was lucid and he knew where he was and what was happening and he was asking to go home. His daughters and wife were able to speak to him about their concerns about him demanding drink or hurting himself to get alcohol. He tried to assure them that he would behave. His eldest daughter was giving him drinks of Ribena at the home and telling him it was his alcohol and he seemed satisfied with this so the daughter kept doing it and assuring him it was his favourite alcoholic drink and that he was only allowed a little a couple of times a day. This actually worked and he went home with 4 calls a day.

What happened next?

Every couple of months the times and frequency of the care calls have been reduced. The eldest daughter would call and tell me how well he is doing and that he does not need the calls and reduce them down. We also put a key safe in so that carers could go in when the wife was out so it did not make her feel she needed to sit in all day waiting for care calls. Joseph is now only having 3 calls of 30 minutes in a week just to give him a wash and shave. He is learning to care for himself and the wife is coping well with the support that she does provide.

Joseph does not pester for alcohol or put himself at risk trying to get it as he believes the Ribena he drinks a couple of times a day is his alcohol and due to the dementia he can't remember what alcohol really is. I did discuss this with the daughter when she attempted this substitution; that it is well known that alcoholics when in recovery substitute alcohol for sugary drinks, hence why the daughter attempted it to see if it would work.

The experience

I was relieved that Joseph was able to go home and live with his wife as were his daughters. They were also pleased that I kept to my word of sticking with them and seeing it through so that they knew who to call and what was agreed before he went home. It made everyone feel safe that there was support that was constant and an agreed back up plan that could be utilised.

Most importantly it is about listening to the person and family members so that you get to know who they all are and understand them and their strengths and limitations and when they know that you have a thorough understanding and that you will commit to them not just the client, because it affects the family as a whole, in knowing their fears and limitations and taking that on board allows them to trust you, which allows them to try something that they would of said no to such as Joseph going home.

Story of difference: Ella

Worker	Andy	Team	L5	Date	March 2019

Reason for contact

Ella is an 85-year-old woman who has lived in Apple Tree retirement apartments for many years but recently the care provided by Apple Tree had broken down. Concerns had been raised about Ella's medication as her friends (one of whom is a retired GP) felt some of it was unnecessary. Ella's friend (who is also her Power of Attorney) contacted us as Ella had said she wished to move into a nursing home.

What would have happened (old world)

Under our old allocation system Ella would have had a lengthy wait as she would have been seen as a 'low priority'. This would have led to a significant depletion in Ella's savings and a distressing situation for her friends. Most of the questions in the old assessment questionnaire would not have been relevant to Ella, and would feel intrusive to an 85 year old. We wouldn't have been able to explore Ella's options in the same way, so there's a good chance she would have moved into a nursing home as she already had places in mind.

The conversation(s)

On meeting Ella, I found her to be very upbeat, friendly and chatty. We had an interesting and lengthy discussion about her life, how she'd travelled extensively, is still an active part of the church and how at the age of 85 still leads an independent and active life.

I met with two of Ella's friends, and the staff at the retirement apartments, who all felt that moving to a nursing home would limit Ella's independence, and that she didn't need that level of care. Her friends and I talked to Ella together to sensitively raise the subject of the move and discuss the pros and cons. Ella was open to this discussion, in which she decided to remain in her current home at least for the time being.

Ella is paying privately for her current care that had been sourced in haste by her friends after the breakdown in support from Apple Tree. Ella's friends said they had no knowledge of care companies or the cost of care. I calculated how much Ella is currently paying, and explained to her that if she changed care company the cost of her care would be reduced by almost £20,000 a year. Although she has a good relationship with her current carers, through our conversations she felt assured about being able to build an equally good relationship with new care staff, and appreciated that her savings would not last very much longer if she continued to pay the current rate.

I also talked to Ella's GP about her medication, which he said could be reduced with no detriment.

What happened next?

Ella's friends and I met with Apple View to discuss the possibility of reinstating their care if necessary. The manager assured us they would be happy to review the situation, and will continue to provide social and emotional support. Ella has also agreed to change to a less financially restrictive company. This will allow for extra care calls if required and still allow huge savings to be made. Ella's friends appreciated the information, advice and support I provided and feel this has taken a lot of burden from them.

The experience

For me as a worker, it has been a good and enjoyable piece of work to have been involved with. I have met and supported three people who previously had no knowledge of services or how the process works and therefore what pitfalls there can be especially in regard to finance. I have enjoyed acting a conduit into accessing appropriate and cost-effective services. Ella felt supported and listened to, and both she and her friends appreciate the rapid response and the positive outcome for Ella's physical and emotional self, and for her financial well-being. I have received verbal and written feedback as to how pleased everybody is with this outcome and Ella and her friends know they can call for further advice or information if required.

Story of difference: Stephen

Worker	Avi	Team	Preparation for Adulthood	Date	October 2018

Reason for contact

Stephen is a 19 year old young man who lives at home with his parents and brother. Stephen has been attending a specialist college for two years and has now progressed on to the supported internship course. The referral came to us as Stephen's carers expressed that college is moving to 3 days per week from 5 and that Stephen would be getting bored at home and would like to be carrying out further activities.

What would have happened (old world)

In the old world we would have assessed Stephen's needs and as the family had found day services already we would have gone forwards with a package of support that included day services for 2 days a week.

The conversation(s)

I got to know Stephen through speaking to him, his carers and his college tutor, and explored with him how he thinks his future could look like. We discussed his aspirations and found that he had a particular interest in metal work. Speaking to his college tutor and seeing examples of his work it was clear that he had both an interest and a talent for this. Stephen spoke about his ideal job within the metal work or jewellery industry.

I carried out some research and found a work based activity making glockenspiel which involved both metal work and wood work. We discussed the workload there and it was agreed that Stephen would attend two half days.

I did further research and found out about evening groups for adults that carried out activities that were of interest to Stephen.

What happened next?

Stephen will be able to further his training around wood and metal work, and gain transferable skills towards an employment area he would like to be working in the future, rather than a long term reliance on social care. He will be able to experience a workshop work style environment and engage in an activity independent from his carers. Stephen will attend two half days at a day service that costs £65 per day rather than two days that will cost £45-£55 per day.

The experience

Stephen expressed that he was happy to be able to progress his skills especially around metalwork. Stephen was happy he would be able to carry out an activity on the two days he was not in college. Stephen was happy he got to travel on public transport from his home to the workshop.

I felt that rather than an assessment questionnaire tick box exercise to document all Stephen's needs we were able to focus on the initial reason for the referral.

I was able to focus on a lot more practical support and set defined outcomes for support rather than involving someone in an open ended relationship with social care and day opportunities.

The conversation felt more natural rather than imposed and process driven.

Being able to practically support somebody to work towards a goal they would like to achieve was fulfilling.

Story of difference: Oliver

Worker	Manos	Team	Preparation for Adulthood	Date	February 2018

Reason for contact

We started working with Oliver (18) after his respite placement broke down when he assaulted staff and produced a knife. Oliver was drinking heavily, being abusive and regularly urinating in this room. His mum could not cope with his behaviour at home and was desperate for the respite to continue, but other respite providers would not accommodate Oliver due to his behaviour.

What would have happened (old world)

In the old world we would have referred Oliver to alcohol services and pursued other respite options.

The conversation(s)

I had a number of conversations with Oliver, his mum and his grandad. Speaking to Oliver's grandad proved very important. Oliver had previously lived with him so I asked about that happening again- thus providing the respite mum needed. Oliver was happy with that idea. Grandad was happy to do this but explained that his daughter had moved back in so there were not enough rooms. Grandad was willing to have the room partitioned so I spoke to Equipment and Adaptations and they are going to do this.

I was quickly able to build up a relationship with Oliver by speaking to him alone in his room, allowing him to be more comfortable with me. I don't believe that many people went into his room, certainly not professionals. I think this made a big difference to how he felt about me. I showed him a great deal of respect listening to his own views. This way I was able to really tackle his drinking personally. We talked about hangovers, his family, his behaviour and the physical concerns. He was able to think about the personal effect of his own drinking and was more motivated to change. I also spoke to his mum about how she could support this change and she was more positive working with him to do this.

Through speaking to Oliver I also learnt how he was enjoying the gardening group (day service) he attended.

What happened next?

Oliver is now hardly drinking any alcohol. I arranged a deep clean of his bedroom and since the clean Oliver has made more effort to clean up for himself. Oliver has increased the time he spends with his gardening group, which has increased his confidence and improved his well-being. The group leaders say Oliver has developed socially and is participating in all activities more. He is now eating openly with everyone and is clearly much happier.

The experience

Oliver is more positive and confident. His behaviour has improved in tandem with his wellbeing. He has much more positive relationships with all members of his family, and they are all happier too.

As a student social worker I was happy to see that my work contributed to a positive change to this family.

In the long run we have also saved money as the family are providing respite.

Story of difference: Nigel

Worker	Sean/Claire	Team	Home First	Date	February 2019

Reason for contact

Nigel was presented with a notice to quit his tenancy due to flammable substances being stored in his flat. He was not attending dialysis appointments and as a result of this his health had deteriorated so much that medical professionals were preparing to provide end of life care.

What would have happened (old world)

We would have requested that Nigel be taken to hospital where he could be looked after and made as comfortable as possible. We would have supported Nigel to apply to court for a stay hearing to prevent him from being evicted due to the current situation regarding health deterioration.

The conversation(s)

When we first met Nigel he had not been well for some time and had not been attending his dialysis appointments due to poor health. He was in bed and could not get up due to the deterioration of his mobility and his health. We thought it would benefit Nigel if he could be supported to get out of bed for a while, and with support he managed to get out of bed, get dressed and sit in a chair. We realised that he just needed a little prompting and support.

We met with the staff where he lived and explained the situation and they said if Nigel stopped storing fire lighters in the flat and kept to the standards required under the tenancy agreement they would consider removing the notice to quit. We cleaned and tidied the property to prevent any further issues with the landlord and to prevent Nigel becoming ill due to poor home hygiene.

Over the next couple of days Nigel began to improve in health and started to eat. We decided that we would go food shopping on the days he got paid to ensure that he had fresh food to eat. Nigel soon felt well enough to start his dialysis treatment and within a week was back to his normal self. The end of life plan is no longer relevant at this moment in time.

What happened next?

The Notice to quit has been put on hold without having to go to court and putting Nigel through unnecessary anxiety/stress. Nigel has an excellent relationship with us and agreed that we should look for a care provider to support him on a permanent basis. He was upset that we would be pulling out but understood that he needed more support. We liaised with a care company and social worker and introduced the care provider to Nigel. They really got on and it was agreed that Nigel would be provided with support.

The experience

Nigel is able to go out in the community and have the support he needs. This will enable him to do things he said he would never do again such as trips to Derbyshire and even a food shop in a supermarket rather than just the small shops which he used to use because they were the closest. Nigel will have support to attend dialysis and see his GP and other health professionals. He is happy and looking forward to the future and planning activities. Nigel's parents can relax more in the knowledge that he is being looked after.

This has been complex work and has taken a lot of hours, but to see Nigel now from where he was just a few weeks ago is truly heart-warming and rewarding. We really thought that Nigel would not be here today but with a bit of hard work, compassion and empathy, we managed to prevent him losing his life, and improve his outlook on his life. It makes us feel so proud.

Story of difference: Mandy

Worker	Julie	Team	Future Options	Date	September 2018

Reason for contact

Mandy is in her early 50s and had previously been discharged from hospital into a nursing home following two significant strokes, so was living with much older people who were mainly in their 80s and 90s. The Deprivation of Liberty (DoLS) team referred Mandy to us following a DoLS assessment.

What would have happened (old world)

In the old world Mandy's support in the nursing home would have been reviewed and the boxes ticked as the home appeared to be meeting her needs. This had actually happened not that long before I was asked to visit by the DoLS Team. The lady had funded nursing care and place as this was a Nursing Home. In the old world it would have been a standard review to check that FNC was still eligible (this had actually happened and the nurse assessor worked jointly with the care manager to agree this was still appropriate). Although this lady didn't have nursing needs any longer, she wasn't being hoisted in /out of bed any longer and didn't require any specialist support or nursing involvement.

The conversation(s)

By having several conversations with Mandy I was able to understand a lot more about her and her circumstances. Mandy didn't want to continue living in the nursing home so we talked about her moving into supported living. I engaged very closely with Mandy and her advocate, who was advocating for a move from the nursing home asap otherwise a S21a challenge to the Court of Protection was going to be made. It was only the relationship with the advocate and the promise that I would get this lady moved asap that held off the court application. Due to being involved with a supported living scheme, merely 100 yards up the road from the care home, which was used for our team's innovation site, I was able to identify a placement for Mandy. Obviously, other places were considered but these were across City and Mandy had lived in the nearby vicinity for many years, prior to moving into the nursing home, so it was felt appropriate to keep her in the area she was used to. Due to the nursing home not taking Mandy out, she had not been able to purchase shoes or essential items for herself and her money had significantly increased. By working closely with Mandy and her advocate, I was able to identify a private provider that would start to take Mandy out and about in the community. This commenced within a couple of weeks and Mandy was able to go out 3 times per week to wherever she wanted. She purchased new items of clothes, did her own shopping and had her hair done! She absolutely loved going out and still does. She has been able to buy all her own furniture and items that she needed for her new home. Mandy has built up a very good relationship with the private support worker, who also spends time with Mandy using her new communication Ipad, which the Specialist Speech and Language Nurse supplied her with.
Since moving into her new home, Mandy has come on immensely, she is so much more independent and

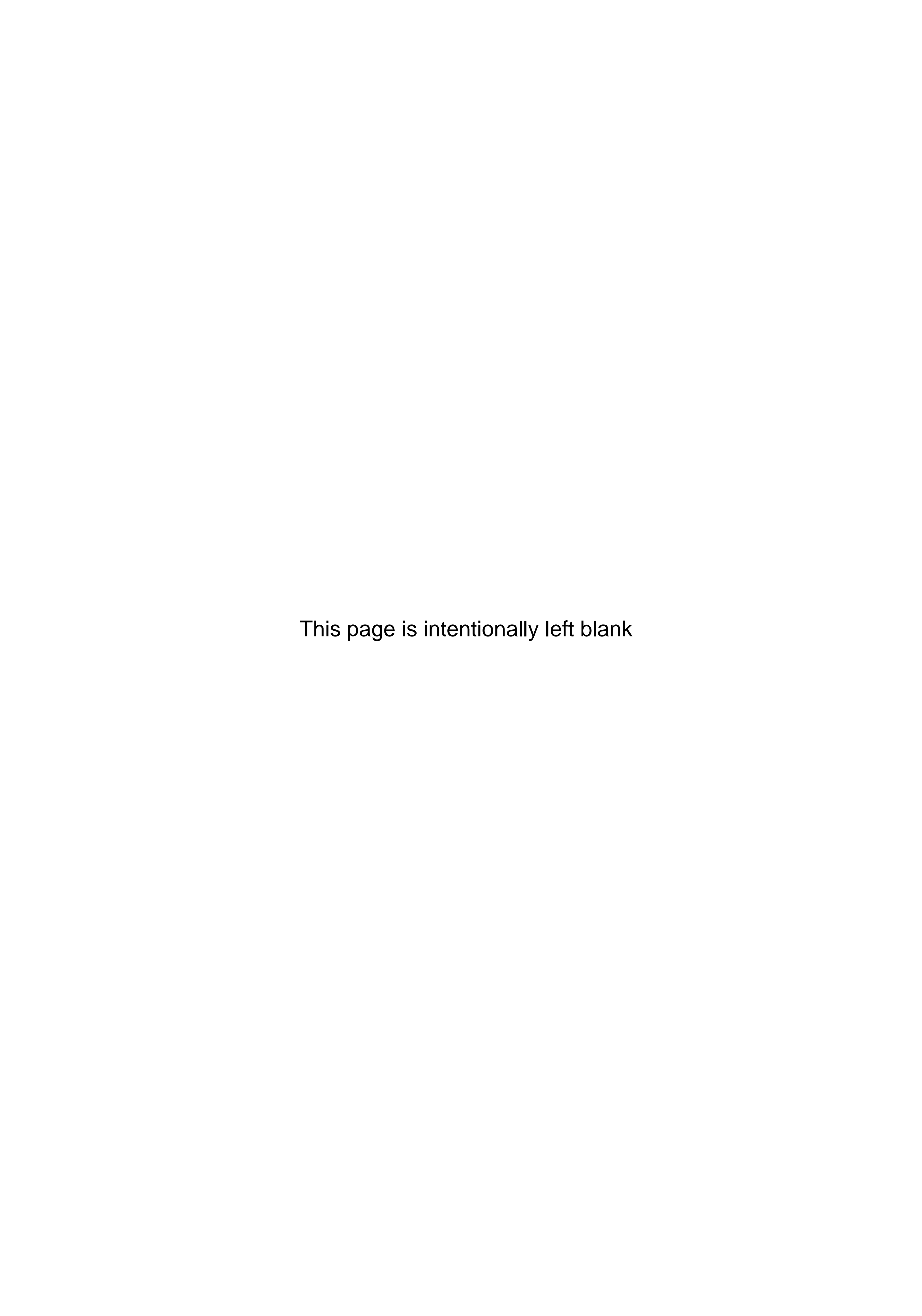
speaking more. She sings with her support workers, joins in with the baking session in the flat next door and she has been to Blackpool with others from the scheme. Another holiday is being planned for later this year! Prior to this, Mandy was living in a nursing home for 5 years and only went out for short periods of time approximately once per month. She now has more control of her life and making choices for herself.

What happened next?

Mandy has moved into supported living. She has been out to buy wallpaper and paint to decorate her new home, and has been on holiday to Blackpool with the other people she's living with. She has learnt to use an iPad, she goes shopping with staff so she can pick what she wants and she is being encouraged to become more independent and improve her speech. Her life is transformed. She actually made the hot drinks for us all at her last meeting!

The experience

Anyone wanting to know how this experience has transformed Mandy's life only needs to see huge smile on her face. She was sad and lonely in the nursing home, whereas now she is fully involved in all goings on at the scheme and has lots of new people to mix with and to go new places with. The plan is for her to go to the cinema and theatre with the lady in the next flat.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