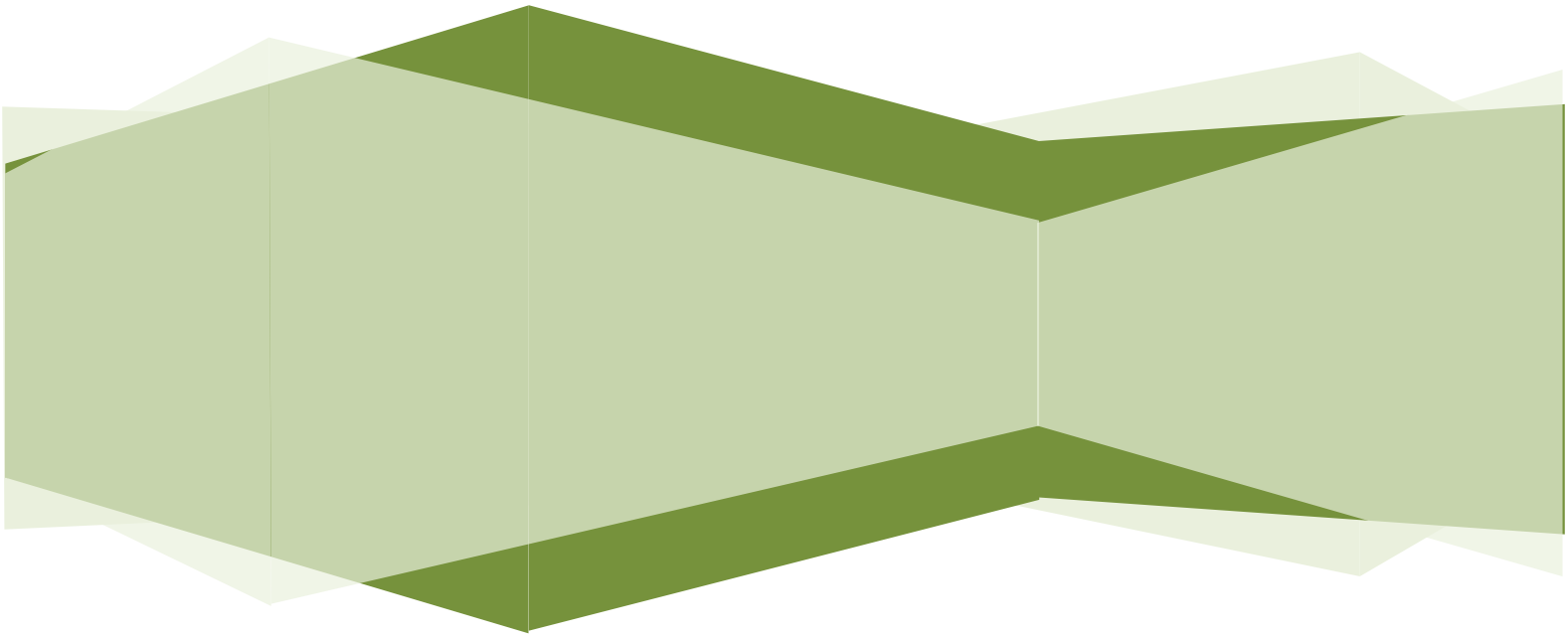
APPENDIX 1

Adult Social Care in Thurrock

Making a positive difference – how well are we delivering Adult Social Care support and services in Thurrock



Introduction

Welcome to our annual report on the performance of Adult Social Care. This report describes the progress we are making on our top 10 priorities that we set out in our last report.

In this report we will tell you about:

- How we spend our money
- Our main priorities
- How we are progressing on our priorities
- How you can give your views

In our previous reports we have talked about the financial challenges we faced combined with increased demand for our services - which will continue for a number of years. In addition, the Care Act 2014 has introduced new legal duties and requirements for Adult Social Care and support which has added further pressure. The new legal duties include increased rights for carers, developing more preventative services, integrated working with other colleagues such as health and housing, providing information and advice, and the implementation of a statutory Adult Safeguarding Board.

Our home care market remains exceedingly fragile. We have had a failure in two home care services over the past 18 months and another provider also gave notice on their contract for commercial reasons. This has resulted in waiting lists for care and people waiting longer to be discharged from hospital. Despite this our top priority remains keeping people safe and was one of the reasons for us bringing some of these services back in-house.

Looking forward we need to be radical in thinking about how we can change our approach to continue to support those in need but prevent people requiring services for as long as possible - and we can't do it on our own. We all need to take responsibility for the health and wellbeing of the people in our community, particularly the elderly and the vulnerable. We all need to work together - from the Council, our partner organisations and service providers, to the community charities and groups, and to the individual – to make our communities strong, resilient and full of resources that people can use to remain independent and active.

This report explains our vision for the future, what we have been doing to achieve it, how we have progressed with our key priorities, what we are going to do next, and most importantly how you can help us and get involved.

Councillor Sue Little
Portfolio Holder for Children's & Adult's Social Care

Roger Harris
Director for Adults, Housing & Health

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Our Vision

'An ambitious, aspiring and collaborative community, which is proud of its heritage and excited by its diverse opportunities and future'

The vision of Thurrock Council is 'An ambitious, aspiring and collaborative community, which is proud of its heritage and excited by its diverse opportunities and future'. In Adult Social Care we want people living in Thurrock to enjoy independent, rewarding and healthy lives in communities that are welcoming, inclusive, connected and safe. Unfortunately, we know that this is not the case for everyone, particularly for older adults and vulnerable people who require care and support.

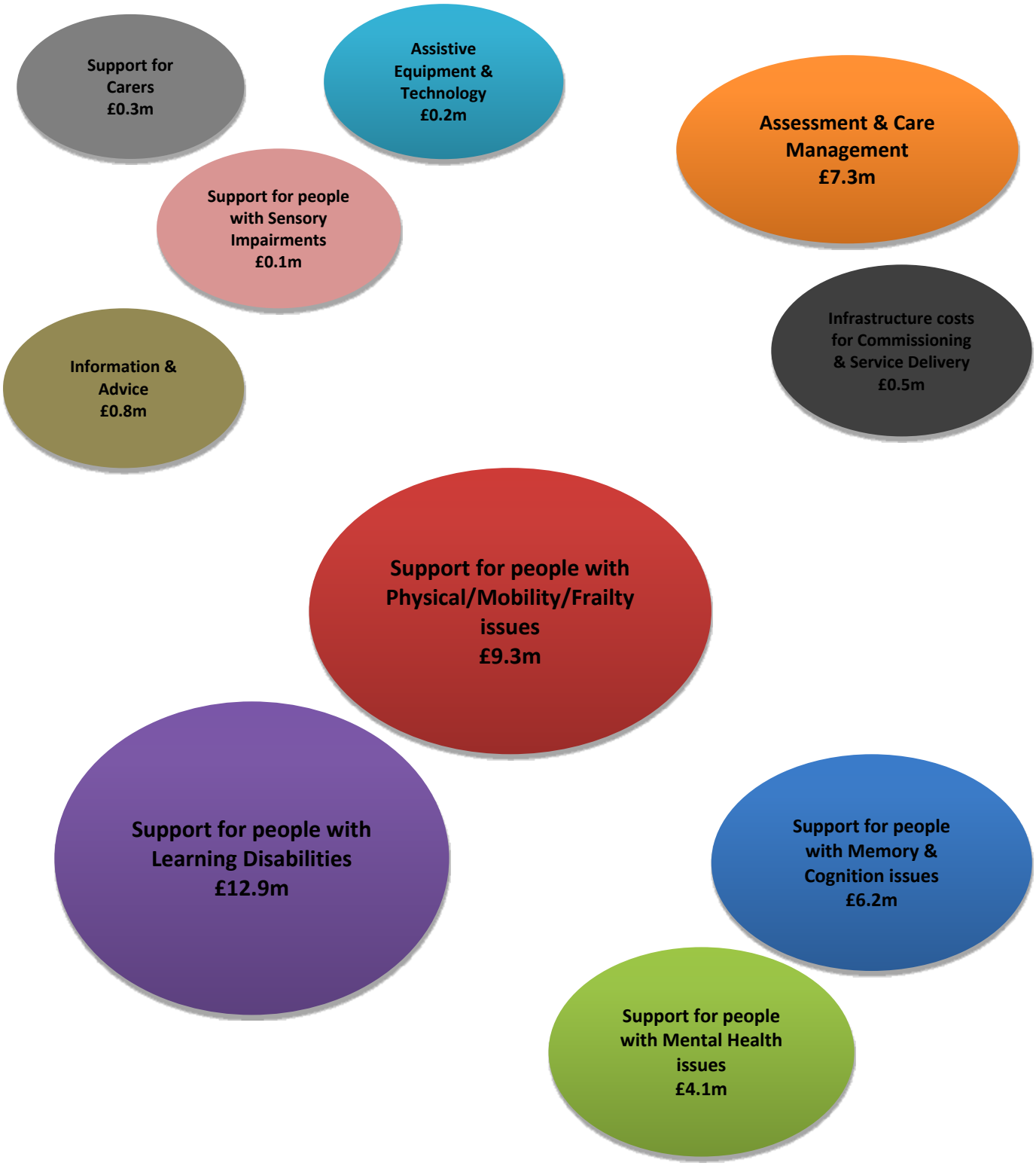
There will always be a need for health and social care services. The problem at the moment is that those services are often only available at the point of crisis. The rising numbers of older and vulnerable adults needing services, together with the increasing budget pressures the Council faces, means that the current way of working is not sustainable or desirable.

We recognise that there is no single solution and that what is needed is a 'whole-system' approach. This means working in partnership with communities, services, partner organisations and the private sector to shift resources towards preventative well-being services and community solutions. It also means supporting individuals and communities to become stronger and draw on community resources to enable people to find their own personal solutions to meet needs and supporting individuals to remain independent.

We call this a strength's-based approach and we have in place a programme to deliver these aims. Our programme is called Living Well in Thurrock.

Our Budget

We spent £41.7 million on Adult Social Care services in 2015/16. The chart below shows how our spending is split across key areas:



* Gross expenditure

Our Key Challenges

As with all other local authorities the funding of adult social care is a big challenge, we have also been embedding the Care Act (2014), the most significant legislative change to Adult Social Care for many years.

This positive legislative change has introduced new legal duties and requirements for Adult Social Care.

For example increased rights for carers, developing more preventative services, implementing a statutory Safeguarding Board, and more integrated working with other colleagues such as health and housing.

We continue to have a very fragile home care market and providers are struggling to recruit and retain staff . This year we have had failures with three home care providers resulting in the Council having to take back in-house most of the care packages from those providers whilst also having to provide additional resilience funding to our remaining external providers so that they can continue to provide care.

In 2015/16 we were above the national average in terms of permanent admissions to residential/nursing care (see **Appendix One** for details) and we know that we need to develop better and more local offers to people such as supported living and Shared Lives.

Our top priority remains keeping people safe and we are pleased that number of complaints remains relatively low and the satisfaction rates remain relatively high.

Review of Our Priorities for 2016

Join up health and social care services to support people better

Develop the services the Council provides to improve quality and reduce cost

Support small community based services in Thurrock to give people more choice

Investigate opportunities for buying services with other partners if this improves choice and cost

Make more use of Direct Payments to allow people to manage their own care

Allow more self service using the internet

Change our home care services to improve choice and quality

Change the support the Council provides to its front-line services to improve cost effectiveness

Change our services to reflect people's strengths and independence not just their needs; services should be more local and personal

Improve access to our information and advice so people have confidence in planning their own support

Priority 1 – Joint Health & Social Care Services

Join up health and social care services to support people better

In 2014 the Government introduced the Better Care Fund (BCF). The Fund consists of pooled money from local authorities (Adult Social Care) and the NHS (Clinical Commissioning Groups) to support the integration of social care and health, with an overriding aim of reducing the number of unplanned emergency admissions to hospital. The Fund is predominantly not new investment but brings together money already being used by Health and Social Care.

Our new plan for 16/17 was submitted on the 3rd May 2016 and continues to focus on reducing hospital and residential care admissions for older people aged 65 and over by ensuring that people have a good local community health and care offer. The full plan can be found here: Better Care Fund Plan.

We have appointed an Integrated Care Director for Thurrock which is a joint post between Thurrock Council and community health provider North East London Foundation Trust (NELFT). This post promotes joint working across the two organisations and works to integrate services where it makes sense to do so.

Over £27,000,000 allocated to a shared health and social care fund

The Plan has 4 main work streams:

Scheme No	Scheme Name
Scheme 1	Prevention & Early Intervention
Scheme 2	Out of Hospital Community Integration
Scheme 3	Intermediate Care
Scheme 4	Disabled Facilities Grant

Scheme 1 – Prevention & Early Intervention

The objective of this scheme is to provide a joined up response to individuals that uses existing and developing initiatives. The result will be a cohesive prevention and early intervention offer. The refresh of Thurrock's Health and Wellbeing Strategy has brought with it a stronger focus of preventing, reducing and delaying the need for health and care services. This is consistent with the introduction of the Care Act 2014.

Work carried out over the past year to contribute towards the delivery of the scheme includes:

- Continued development of Local Area Coordination (LAC) – with 10 LACs providing borough-wide coverage. The LAC service focusses on the 'what does a good life look like to you' question and aims to prevent crisis point and keep people connected within their own communities;
- The successful appointment of a provider to deliver an Integrated Data Set across Adult Social Care and Health – focusing on highlighting groups at greatest risk of ill-health at the earliest opportunity to allow effective intervention and prevent episodes of crisis and declining health;
- Delivery of a falls service as part of the Older Adults Health and Wellbeing Service; and
- Delivery of a diabetes prevention programme.

Scheme 2 – Out of Hospital Community Integration

This scheme aims to improve the care people get in their local communities by improving the coordination of community health and care services so that care delivered in the community is person centred regardless of the nature of the service required or who is providing the service required.

In order to achieve the aims underpinning this scheme, we have developed an integrated community older adults' health and wellbeing service. Through investment secured from the Better Care Fund, we have been able to develop a model that aims to close the gap between the hospital and community to prevent and anticipate crisis, avoid admissions to hospital and care homes, and provide integrated pathways that ensure people get the right care at the right place at the right time.

The model of care being taken forward brings together:

- The Community Geriatrician (specialists in health care for elderly people) provided by Basildon & Thurrock University Hospital (BTUH);
- Care Home support resource; and
- New resource for falls prevention including physiotherapy, occupational therapy, pharmacist and nurse.

The resource has been brought together and used to develop a service that provides services to people in a variety of settings. The service will work alongside health, social care and the voluntary sector to best deliver outcomes and meet needs.

Further work we are undertaking includes:

- Developing four local 'healthy living centres' which will provide a range of health and social care services, starting with Tilbury and Purfleet. Whilst these are being developed, we have put in place virtual Integrated Community Teams consisting of additional dementia nurses, community carers/support workers, additional Physiotherapists and Occupational Therapists. This will provide a 7 day service with links to our Local Area Coordinators and Community Hubs.
- Redesigning home care services – see **priority 7** for more detail.

Scheme 3 – Intermediate Care

We have a range of Intermediate Care services in place which can:

- Provide reablement and rehabilitation after illness or crisis to enable people to gain/re-gain the skills necessary to live independently
- Ensure people who have been admitted to hospital do not stay in hospital for longer than necessary
- Help people to return home with reduced need for ongoing care, preventing further hospital admissions
- Provide an alternative safe place for people in crisis to prevent hospital admission occurring in the first place.

90.8% of service users discharged from hospital into reablement services were still at home 91 days later (2015/16)

Services provided include:

- **Hospital Social Work Team -** based at Basildon Hospital. This is a team made up of social workers who work jointly with health to plan patients' discharges from hospital to ensure this is

both timely (i.e. they are not left in hospital for longer than necessary) and that appropriate services are in place prior to discharge to support patients rehabilitation.

- **Joint Reablement Team (JRT) -** a fully integrated service between health and social care to provide reablement/rehabilitation to individuals in their own home. In 2015/16 90.8% of service users discharged from hospital into reablement services were still at home 91 days later. This is 4.8% higher than the previous year and is 8.1% higher than the national average.
- **Interim Beds -** available at Collins House, our council-run residential care home in Corringham. This operates as both a step-down service from hospital whereby reablement/rehabilitation can be provided to help individuals to regain their independence as much as possible, and also a step-up service to people in crisis to prevent hospital admission. In many cases the beds are used as a safe place for a full assessment of an individuals' long term needs to be established outside of a hospital environment, thus not delaying discharges.

45% of service users staying in the interim beds in 15/16 were able to return to the community to either their own home or to extra care/sheltered housing

- **Health Funded Reablement Beds –** also based at Collins House, we have recently turned five beds into reablement beds funded by our health colleagues. The beds are open to those who have suffered a medical illness or injury, had an operation, had a fracture or have suffered a stroke and who require reablement/rehabilitation support to enable them to return to independence. These beds are proving successful and we hope to expand these in the future.

We have set up an Intermediate Care Working Group which has been running for a year and is made up of clinicians from health and social care. This working group has been reviewing the intermediate care services and as a result of this we are going to:

- Add Crisis Dementia Nurses to our Rapid Response Assessment Service (RRAS) to ensure people with dementia are supported in the community when they are in crisis.
- Develop Community Carers/Support Workers to support people through crisis. At present RRAS provide assessments but then need to refer individuals to other services to receive ongoing support. These workers will provide crisis support after RRAS has assessed them.
- Increase care staff for the Joint Reablement Team as demand for this service is growing, with additional Physiotherapist and Occupational Therapist.

Scheme 4 – Disabled Facilities Grant

The Disabled Facilities Grant (DFG) is funding provided to individuals, largely those who are disabled, to help pay for major adaptations to their homes. Eligibility for the grant is assessed by the Local Authority. In Thurrock, DFG's are delivered in partnership with a local home improvement agency, Papworth Trust.

The DFG is now included as part of the Better Care Fund and we plan to ensure DFGs form part of our wider goals to improve support to people living at home. The assessments for DFGs will be moving over to our community teams, including the Joint Reablement Team, so that the assessments and needs of the individual in terms of adaptations is looked as part of a larger, more holistic assessment of all their needs and requirements, rather than this being a stand-alone service.

Other – Social Prescribing Pilot

The relationship between patients and GPs is often over-reliant on physical health and clinical/medical interventions. GPs have 6 minutes for each consultation and do not have time to explore all factors impacting on a patient's health and wellbeing. Primary Care Teams are in an ideal position to tackle

health inequalities as they are accessed by 90% of their patient list per annum. However, they are often unaware of the range of community resources that are available locally and how to involve patients in community activities to improve wellbeing.

With this in mind, the CCG and partners aim to improve the relationship between GPs and the local community by commissioning a Social Prescription service to improve health and wellbeing outcomes and reduce inequalities. The objectives are:

- To build self-resilience amongst patients in order to assist them to better manage their holistic health
- To reduce demand on primary care services, particularly from high intensity users
- To empower GPs with a practical mechanism to assist patients who repeatedly present themselves with non-clinical issues.

The pilot will link with Community Hubs which will enable citizens to be more connected with their local community, and allowing more opportunities to be involved in activities or volunteering. The project is hosted by Thurrock CVS and will focus on four GP practices in Tilbury, East Tilbury, Aveley and Purfleet.

Priority 2 – Service Improvements

Develop the services the Council provides to improve quality and reduce cost

Due to the current financial climate and the continued need to make an unprecedented amount of savings Thurrock needs to, wherever possible, develop services to make improvements to the quality of services, but also to reduce costs. This is becoming more difficult since we have already had to make savings over the last few years, however this year we have made some significant savings by redesigning our day care and extra care services.

£400,000 savings made due to the redesign and improvement to our day care and extra care services.

Day Care Changes

Day care was provided to older people across five sites at significant cost both in terms of the properties used, and the separate staff teams employed to work at each of the sites. A review of this service showed that some of these sites were under-used by individuals, making the service less cost effective.

As a result of the review, we have completely remodelled the day care services and have reduced the number of locations to from five to three. Three of the original sites were closed and one new one has been created at a property already being used for other services. The staff have been redeployed to the new/remaining sites meaning that more staff are available in the three locations and more service users are attending each session. The service has been extended even though it is being provided in fewer locations.

The changes were done in full consultation with service users and staff and early indications are that there is a sense of renewed energy and excitement in the sessions, with greater interaction and participation in activities.

Extra Care Changes

Previously Extra Care was provided to older people across two sites in Thurrock. Extra care is similar to sheltered housing where individuals live in their own self-contained flats and have access to communal facilities on site. A member of staff is on duty at certain times to provide low level support to ensure residents are safe and well. Where extra care differs from sheltered housing is that residents receive more personal care support than they would in a sheltered housing complex. Extra care is aimed at older people who are becoming more frail and cannot do everything for themselves but still retain some independence so do not require residential care.

We have reviewed our extra care services and again have made significant changes and improvements to the service. We have closed one of the extra care services that was financially non-viable but extended the second to ensure no-one loses their service. We have also introduced an enhanced housing related support function, alongside a concierge service.

Once again, the changes have taken place with the full consultation and support of the staff and service users and feedback so far is that the service has improved.

Efficiencies Achieved

The redesign and remodelling of our day care and extra care services has delivered in excess of £400,000 of savings, making the services more cost effective, and the improvements to the quality of the services has improved value for money. This has been a significant achievement for Adult Social Care.

Future Changes to Council-Run Services

In future we are going to be looking at the possibilities and potential benefits of making some or all of our in-house Adult Social Care services external to the Council so that they are run by external organisations. There are lots of options to consider and we need to be careful of the risks and potential drawbacks of doing this as well as the potential benefits and cost savings.

Safeguarding Vulnerable People

In Thurrock we believe that safeguarding is everyone's business. Throughout all the work we do in Adult Social Care from giving advice and information to providing services, of utmost importance is that vulnerable people are kept safe.

Our Safeguarding Team is integral to ensuring services are good quality and keep people safe. Working in partnership with our Contract Compliance Team, the Safeguarding Team investigate any concerns arising in services, for example home care or residential care, and where concerns are substantiated, put in place action plans to make improvements. Action plans are then monitored closely by the team to ensure they are adhered to. Monitoring can include monthly visits, weekly visits and even visits during the night (e.g. to residential care).

In 2015/16 the Safeguarding Team received an average of **35** referrals per quarter and an average of **36** alerts per quarter.

Where required, the Safeguarding Team work in partnership with the Care Quality Commission, who regulate certain services such as residential care and home care, the Police, and our health partner the Clinical Commissioning Group (CCG).

Our Adult Safeguarding Board is now a statutory board under the new Care Act, which has an independent chair, and will commission independent reviews to investigate concerns where this is required.

We also have in place a Vulnerable People Protocol, jointly agreed with Adult Social Care, Housing, Thurrock Drug and Alcohol Action Team (DAAT), South Essex Partnership NHS Foundation Trust, and South West Essex Primary Care Trust. This protocol ensures a commitment to working in partnership to safeguard vulnerable people at risk in their homes or those who face re-housing or eviction.

87.7% of people who use services say that those services have made them feel safe and secure (2015/16 Survey). This is **2.3%** higher than the national average.

See **priority 9** for more information on safeguarding.

Priority 3 – Increasing Choice

Support small community based services in Thurrock to give people more choice

This year we have been continuing our key objective of supporting local communities to build the resources, assets and services they need to ensure people feel connected to their communities and have active and independent lives, with as little formal support from Adult Social Care as possible. Some examples of the types of support we have been providing to encourage more small community based services around Thurrock are set out in this section.

You can find out more about this work by visiting our Stronger Together website: http://www.strongertogether.org.uk/

Community Asset Transfer Policy

We have adopted the Community Asset Transfer (CAT) Policy which will enable local organisations or community groups to seek the use of land or property owned by the Council in order to set up community based services and local resources. If the activity the individual, group or organisation wants to carry out is within the agreed framework, they will be able to access the facilities they require at a subsidised rate.

Example of Community Asset Transfer (CAT) Policy in Action:

Friends of Hardie Park in Stanford-Le-Hope have been instrumental in making improvements to their local park, including preventing vandalism of equipment and anti-social behaviour and securing funding to install a brand new skate park. A pre-fabricated building has also been erected which will contain a café and space to deliver training sessions

Micro-Enterprise Project

Our Micro-Enterprise Project is being delivered in partnership with an organisation called Community Catalysts to provide free support, advice and information to people, groups and organisations who have an idea for a small local service (called a micro-enterprise) that will provide support to people in their local community.

The project will help with all aspects of the setting up of the business, including advice and support on training, insurance, funding, and how to get ongoing support.

Examples of what the Micro-Enterprise Project has helped with:

Support to set up a small team offering personal care and domestic support for people living with dementia.

Support to set up a small service for older and vulnerable people tailored to individual needs such as accompanied visits to GP's, drop-ins, and befriending.

Time Bank Thurrock

Time Bank Thurrock is a volunteer project that helps people to share their skills or spare time to help other people, and to choose help that they'd like in return. So for example, a Time bank member may help with clearing someone's garden, and in return, could get help with a DIY project from a different Time bank member. Each person decides what they can offer and everyone's time is equal.

Because Time banks are easy to use systems of exchange, they can be used in an endless variety of settings, for example shopping or doing simple errands, decorating and simple DIY home repairs, cooking and gardening.

Members can also bank their time credits to get support for other people such as neighbours or family members, or alternatively donate them into a community pot to help other vulnerable people.

Animate

We have been continuing with our three-year programme called 'Animate', which links younger and older people together to encourage an exchange of skills, experience and knowledge.

The aim is to target younger people who are jobless or are beginning work, and older people who have recently, or are about to, retire. The programme has the dual benefit of helping young people to gain the skills and knowledge required for them to enter the job market, whilst also allowing older people to remain active and independent, decreasing the chances of social isolation.

Animate is a European programme and we are working in partnership with e-learning studios, University of Geneva, Biomedical Research Institute for Health and HI-Iberia Ingenieriay Proyectos SL.

You can find out more by visiting the website here: Animate

Priority 4 – Buying Services with Other Partners

Investigate opportunities for buying services with other partners if this improves choice and cost

As well as being committed to exploring joint services with Health and Adult Social Care, this year we have also looked at what opportunities there are for buying services with other partners such as service providers. The information below gives a couple of examples of where we have done this.

Shared Lives Scheme

This year we have started the process of developing a Shared Lives scheme in Thurrock.

Shared Lives describes a situation where an individual or family are paid to include someone in need of support into a supportive family setting. This can be either short or long term and maximises the abilities, contribution and capacity of families in a local community and can offer more intensive emotional support than residential care.

We are developing this service in partnership with Social Finance, who are experts in setting up Shared Lives schemes across England. Social Finance will be working with the Council and commissioned provider to give expert advice and support to ensure the service is a success.

Shared Lives carers are recruited, trained and approved by a Shared Lives Scheme regulated by the Care Quality Commission (CQC).

Shared Lives offers a real alternative to other forms of support and accommodation and can be used as a long term home, a stepping stone towards independence or day support. Shared Lives carers and those they care for are matched for compatibility and then often develop excellent long term relationships with the carer acting as an extended family.

The tailored, highly personalised nature of Shared Lives fits in well with the personalisation agenda and builds upon our community development work. The Shared Lives scheme will contribute to Thurrock's aim of developing resilient and self-supporting communities which is seen as a key driver for finding solutions to loneliness and social isolation among the elderly and vulnerable population.

We have appointed our provider organisation – Ategi and they are currently recruiting staff.

Specialist Autism Services

The Council, in conjunction with Family Mosaic, a large housing association providing affordable homes and care and support services is developing 6 specialist homes in Grays for young people with autism and severe learning disabilities. The homes will be completed in summer 2018 and the Council is already working with representatives of Thurrock Autism Action Group to finalise the design, and with the potential tenants and their families to ensure a smooth transition from residential education to independent living.

Priority 5 – Direct Payments

Make more use of Direct Payments to allow people to manage their own care

Thurrock Council is committed to ensuring people requiring care and support have as much choice and control as possible over who provides their care and how it is delivered. We call this self-directed support.

83.7% of service users surveyed in 2015/16 felt that they had control over their daily life

When individuals are first assessed to find out what their needs are and whether they are eligible for support, we ensure that the individual and their carer/s views are heard and that they lead on what they think they need help with. Once eligibility has been established, we discuss the options for support and the person decides what would best suit their needs. This can be in the form of a service provided by the Council, or this could be a direct payment.

Direct payments are the purest form of self-directed support as they offer the individual complete control over their care. A direct payment is where the individual is given a cash payment by the Council and then the individual arranges their own care and uses the money given to pay for it.

In Thurrock the use of direct payments has been promoted over the last few years. We have been successful in providing carers with direct payments, but we have been less successful in increasing the numbers of service users receiving direct payments.

94.4% of carers receiving support in 2015/16 were receiving direct payments. This is **26.5%** higher than the national average.
28.6% of service users in 2015/16 were receiving direct payments. This is a **3%** reduction compared to the previous year; however it is in line with the national average (28.1%)

Purple (Formally Essex Coalition for Disabled People)

For those people who want a direct payment, we offer a service to help people manage their money and arrange their care. The service, run by Purple (formally Essex Coalition for Disabled People), also gives independent information and advice to help people decide whether they want a direct payment. The service can help service users to source individuals (called Personal Assistants) or organisations to provide their care, and also provides payroll services.

In 2015/16, Purple received 145 new referrals and supported an average of 294 individuals with their direct payments.

Future Plans

One of our plans for this year was to increase the numbers of people receiving direct payments and we have managed to do this for carers. However, we were disappointed that our percentage of service users receiving direct payments dropped in 15/16 compared to last year and we realise that we haven't done enough to promote this.

We have newly appointed a Commissioning Officer to spend the next year looking at how self-directed support, and direct payments in particular, can be expanded. One of our plans is to look at turning our day opportunities service for people with learning disabilities into direct payments.

Priority 6 – Online Self-Service

Allow more self-service using the internet

Assessments are carried out by qualified social workers and are used to:

- Determine whether an individual is eligible for support under our criteria
- Decide how best to support the individual (if eligible)

It is important that assessments are led by the individual to ensure they are personalised to their needs and aspirations. Once people have been assessed best practice is to provide them with an indicative Personal Budget that tells them approximately how much money they would have to spend on services. It is up to the individual to then decide how they want that money spent, e.g. through a direct payment (see **priority 5** for more details) or through a traditional council service.

In Thurrock we want to make the assessment process easier and more accessible for people by having an online self-assessment. This would allow prospective service users to complete the self-assessment in the comfort of their own home, receive their indicative Personal Budget, and then this would be received by Adult Social Care for processing and agreeing.

Resource Allocation System (RAS)

The Resource Allocation System (RAS) is a tool we developed in partnership with an organisation called Quickheart which is an online system that takes individuals through a self-assessment process. The individual can select what they need help with and explore the options of how this can be met. At the end of the assessment an indication is given as to whether they are eligible for care and support and if so an indicative personal budget is provided. A social worker would then check this assessment and estimated budget against our eligibility criteria and make any necessary adjustments. Once completed, the individual can decide how that budget is spent during the support planning.

We have been building this tool and using it internally for the past year and are committed to providing this service on-line in the near future.

Ordering Basic Equipment Online

Whilst we haven't been able to make public the Resource Allocation System as expected, we have developed a range of self-assessment forms for basic equipment which are available online for people to complete and send in to the Council. These self-assessments cover the following:

Getting on and off your chair
Getting on and off your bed
Getting to, on and off your toilet
Getting up and down the stairs
Getting in and out your bath or shower
Getting in and out your home
Making a snack, meal or drink

The self-assessments make it easier and quicker for individuals to get the basic equipment that they need as it often means that they do not need a visit and home assessment, which has a waiting list. A full self-assessment form is also available online for individuals to complete if they have more complex

needs. In this case a home visit may still be required. You can find the self-assessment forms here: **Home Adaptations and Equipment Self Assessment**

Priority 7 – Changing Home Care

Change our home care services to improve choice and quality

More people than ever require home care; however there have been considerable difficulties in recruiting and retaining staff in the home care industry. The way home care is provided hasn't changed in many years. Staff are required to travel all over the borough every day to provide support and this impacts on both the number of people we can support in any one day, and also the amount of time we can spend with each person.

We feel that this affects the quality of the service we can provide. With demand for the service increasing, staff in home care services are becoming more and more rushed to go from one person to the next and are only able to provide the basic care that people need.

Most individuals requiring home care are older people who, due to their frailty are often socially isolated from the community. In some cases, the carer from their home care service might be the only person they speak to that day. If the carer does not have the time to talk to the individual and is only concerned with getting the care completed as quickly as possible, this does not help the individual's health and wellbeing.

Living Well @ Home

In Thurrock, we want to redesign our home care services and move away from the traditional service. We want to develop a more flexible model with carers based in smaller local areas that they know, where they can help individuals to 'live well' by meeting their care needs, but also their nutritional, cultural, social and emotional needs through accessing local community resources and groups.

Examples of this could include:

- Helping an individual to get home cooked meals from a local café rather than accessing our traditional meals on wheels service.
- Helping an individual to attend a local community group or club rather than attending Day Care.

This new service is called Living Well @ Home and our intention was to pilot the new service this year.

The pilot will test the new ideas and models out in one or two local communities. This will then be evaluated with lessons learned and if successful will be rolled out as the new home care model.

Current Issues in Home Care

Unfortunately, we have not been able to pilot the new model yet as was our intention as we have had a number of issues arising in our home care services this year. One of our externally funded home care services was rated as 'Poor' by the Care Quality Commission (who regulates the services) and we had to terminate the contract with the supplier. In addition, another provider gave notice on their contract at around the same time. Both of these contracts ending would have potentially left a lot of vulnerable people without any care or support. To address the gap, we set up an in-house home care service, which took on all of the home care packages from the two providers.

Our Joint Reablement Service, which is already run in-house, also took on some of the care packages to help with the huge influx of care we needed to provide to ensure no-one had an interruption to their service. We were inspected by the Care Quality Commission and as a result of the strain on this service, received a 'Requires Improvement' rating which we are currently working on improving

Priority 8 – Support to Front-Line Services

Change the support the Council provides to its front-line services to improve cost effectiveness

This year we have taken a number of actions to change the way our back office functions operate to ensure we are providing the most cost effective and efficient support to our front-line services. Below are a few examples of the things we have done this year.

Bringing SERCO Staff In-House

For the last few years, many of our back-office staff in Adult Social Care were provided by a partner organisation called SERCO. This includes office functions such as Customer Finance, Administration, Community Solutions Team (our first point of contact in Adult Social Care), and our Call Centre at Harty Close.

In 2015 we have dissolved our contract with SERCO and brought all of these staff back in-house. The benefits of this have included significant cost savings, as well as creating a more efficient workforce as it has allowed staff to work closer together with more joined up approaches.

Re-Organisation of Administration Team

We have also reorganised the Administration Teams within Adult Social Care so that instead of having one large 'hub' of staff, we now have administrative staff members sitting within front line services to ensure front line staff have dedicated people to support them in their roles. This has again brought more effective working.

Integrated Data Set

To support our closer working relationship between Adult Social Care and Health and all of our work to provide joint care and health services to enable a more holistic service to the individual (see **priority 1** for more details), we have successfully appointed an organisation to provide an 'Integrated Data Set'. This is where we are bringing together vital information across health and social care services about individuals so that we have all the information necessary to support people. This will enable us to provide people with one service that meets all of their health and social care needs.

The Integrated Data Set will also allow us to undertake analysis of trends in Thurrock which will help us to predict what services and support we will need in the future, as well as demand for services, which will enable us to better plan for the future. It will also allow us to identify people at greatest risk of ill-health to allow effective intervention.

Priority 9 – Strength's Based Services

Change our services to reflect people's strengths and independence not just their needs; services should be more local and personal

Fundamental to the changes we have been making to services over the past couple of years has been changing the culture of the way we do things from being needs-led, i.e. what people can't do, to being strength's-led, i.e. what people can do and how can we help them to do more.

We are also moving away from traditional, Thurrock-wide services, and want services to be more personalised, tailored to individuals' needs, and rooted in local communities.

This section details some of the things we have been doing to achieve this key ambition.

Local Area Coordination

As discussed briefly in **priority 1**, Local Area Coordination (LAC) started in July 2013 with three Local Area Coordinators (LACs). We now have 10 LACs each working in their own specific local community where they have in-depth knowledge of what the community has to offer. We now have LACs across the whole of Thurrock.

LACs work as a 'critical friend' asking the question of what a good life looks like to the individual, and then helping them to find ways of meeting those goals, using community resources where possible.

Our Local Area Coordination service received high praise at both the LGC Awards 2016 (Team of the Year) and the Municipal Journal Awards 2016 (Excellence in Community Engagement)

Support provided is varied and can include:

- Helping people overcome social isolation by helping people to access local community groups and clubs
- Linking individuals together for mutual benefit
- Helping individuals to find volunteering opportunities where they can give back to their community
- Supporting people to access benefits and deal with housing issues including preventing eviction
- Supporting individuals to lead more active and healthy lifestyles, including reducing smoking and/or alcohol intake, joining exercise groups etc.

For every **£1** invested in Local Area Coordination there is a **£4** return on investment (Social Return on Investment analysis)

Micro-Enterprise Project

As discussed in **priority 3**, we have implemented a project to provide free advice and support to help local people and groups set up small local businesses and services to help the local community.

This is supported by the adoption of the Community Asset Transfer (CAT) Policy which helps individuals wanting to set up local community groups and services to access the facilities they need to do so by using land or property owned by the Council at a subsidised rate. See **priority 3** for more details.

Changes to Home Care Provision

As detailed in **priority 7**, we are changing the way our home care is provided to move away from traditional services towards services that empower individuals to become more independent by using local community resources to meet their needs rather than using formal services that have traditionally been a 'one size fits all' approach.

We will be piloting a new model, called Living Well @ Home over the next few months. Carers will be focussed in smaller local areas that they have knowledge of and will be spending more time with individuals finding out what would make their life better and then helping them to achieve their outcomes, using community resources. For example, the service might help an individual to attend a local group or club that is in-keeping with their own interests, rather than arranging for them to attend Day Care sessions.

If successful, the new model will be rolled out for all home care services.

Making Safeguarding Personal

Traditionally, Safeguarding processes were driven by the professional. Concerns raised would be investigated and if found to be true, actions would be taken to safeguard the individual to ensure it cannot happen again. For example, this could be increased monitoring or even a prosecution.

Whilst this approach ensures the individual is safeguarded, it doesn't consider how the individual being safeguarded felt about the investigation or action taken, or what they wanted to happen. Often, we only ask individuals how satisfied they were with the process and outcome after the safeguarding process has been completed.

Making Safeguarding Personal is a programme to shift the culture and practice in safeguarding teams to ensure individuals are at the heart of any safeguarding process. It is about having conversations with individuals upfront and asking them what they want to happen and what outcomes they want to achieve. For some this may be a prosecution, for others it may be to repair and retain the relationship they had with an individual prior to the issue.

In Thurrock we are signed up to Making Safeguarding Personal. Our practice is to put individuals in full control of the safeguarding process, involving them every step of the way in terms of how the issue is investigated, and what action is taken as a result. Going through a safeguarding process can be very traumatic for some people and our aim is to put the power back into individuals' hands through a fully personalised service.

Not only does this ensure that we achieve the outcome/s that the individual wants, but also allows people to have a positive experience of a process that respects their views and wishes, supports their wellbeing, promotes their independence, and ultimately makes a positive impact on their life.

Priority 10 – Information & Advice

Improve access to our information and advice so people have confidence in planning their own support

Thurrock is rich with community groups, resources, assets and services that people can join and tap into so that they feel part of their community and can lead socially engaging and rewarding lives with a network of friends, peers and colleagues.

It is very important to us that individuals wanting to join community groups that meet their interests or those needing help can easily find information and advice about what is available to them. Therefore the information and advice we offer needs to be clear, informative, and above all, easy to find.

85.8% of service users surveyed in 2015/16 felt that it was easy to find information and advice. This is **10.3%** higher than it was the previous year, and is **12.3%** higher than the national average.

We provide information and advice in a number of ways in order to reach as many people as possible.

Community Asset Map

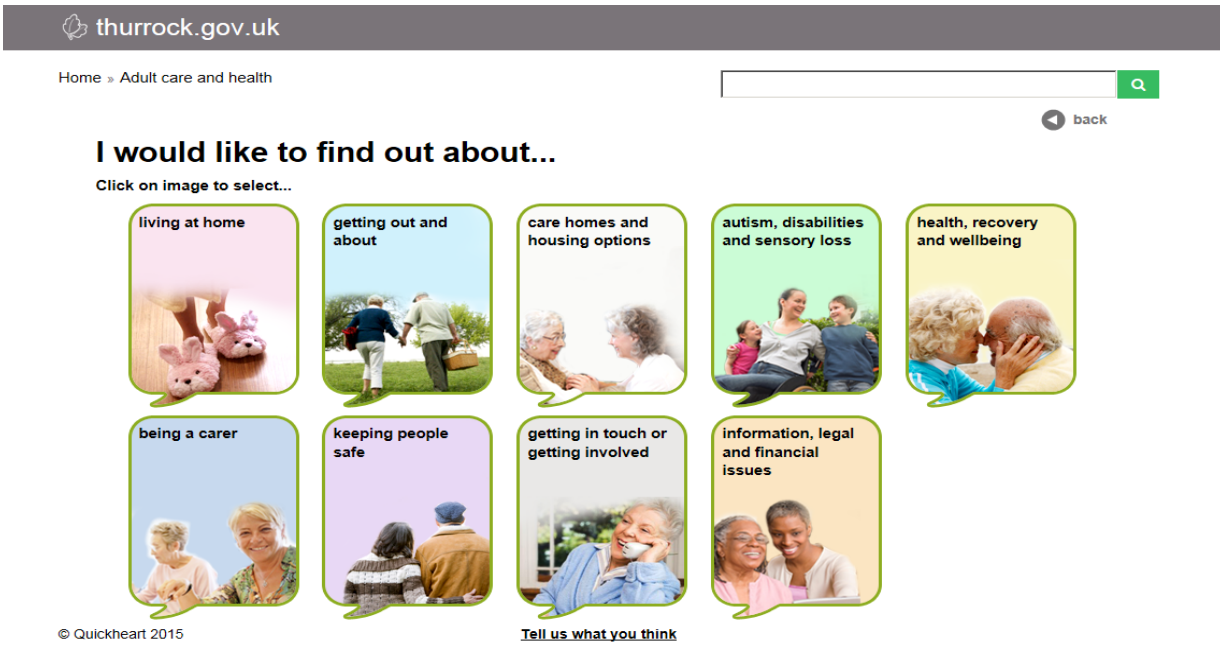
Working in partnership with Thurrock CVS (Council for Voluntary Service) a google map has been created which shows information about groups, organisations and services that are of community benefit. The purpose of this map is that it can be used to find 'non-traditional' services for people, for example a local lunch club offering dementia support.

All items on the map are for things that you wouldn't necessarily be able to find by looking elsewhere. Items are grouped into category and can be filtered or you can search for a postcode or keyword, or simply zoom in to the map. The map will be available via www.strongertogether.org.uk and is currently in testing phase. It will be made more widely available in early 2017.

Website

In 2014 we launched a new information and advice website which includes information on services and resources available locally in the community as well as services that the Council provides. You can see this website here: https://mycare.thurrock.gov.uk/

The website is very user-friendly and provides over 300 pages of information and advice on different options and services available for people requiring support. This year we have undertaken a further review of all the content on the website to improve health related topics and increase signposting to other useful sources of information, such as NHS Choices. We are also working to link into the new coming Stronger Together Community Asset Map (see above). As part of this review, we arranged a further testing session in partnership with our User-Led Organisation run by Thurrock Coalition, whereby a group of service users tested the website and provided feedback on what works and what doesn't. We will be launching the updated content in early 2017.



As part of the main council website, we also have 'My Account', an online system whereby members of the public can register for an account and deal with their finances online such as managing their council tax and housing benefits.

Community Hubs

Community Hubs are run by the local community in partnership with a range of organisations including Thurrock Council. The great attraction of Community Hubs is that local communities can play a significant role in deciding on local priorities for action.

There are currently 5 Community Hubs – in South Ockendon, Chadwell St Mary and Stifford Clays/Blackshots, Tilbury and Purfleet with a new hub planned for Aveley in 2017. Opening times and information about what is on at each hub can be accessed via http://www.strongertogether.org.uk/

Local people are responsible for what happens at their Community Hub. They respond to the ideas of their local communities about the activities and events that are run from the hub. Community hubs play a key role in supporting improved health and wellbeing in an area. As well as signposting to local information and services, hubs are used by Local Area Coordinators, Housing to provide surgeries, and a wide range of community associations to promote support networks to local residents.

Examples of activities managed by hubs include:

- Arranging events so that local residents can learn about local groups and organisations that offer activities, and how they can support their own community
- The recruitment of many local volunteers, some of whom have used their volunteering experience at the Hub to help them get permanent paid employment
- Working with local GPs so that residents with non-medical conditions can be referred to the Hub where they can join community groups, develop friendships and become more confident and able to enjoy their lives
- Support is given to a wide range of local people with form filling, support with on-line services and validation of documentation. This results in fewer trips into Grays – which is expensive for people with limited resources
- Helping citizens to resolve queries with the support of their peers.

Volunteers are being recruited to support the development of hubs across Thurrock. There are various volunteering roles available in community hubs such as meeters and greeters, booking coordinators, website/social media, providing online assistance on Thurrock Choice Homes/Universal Credit and much more.

Carers Advice and Information Service (Cariads)

We also have a Carers Advice and Information Service (Cariads) which is provided by three voluntary sector organisations, Thurrock Mind, Thurrock Lifestyle Solutions and Thurrock Centre for Independent Living. This is a service specific to people who care for a family member to ensure they get all the advice, information and support to allow them to live fulfilling lives whilst still continuing in their caring role.

The current contract for this service is due to come to an end and we have started the process of advertising the service for all prospective service providers to bid for the service. The new service will have an emphasis on being proactive in seeking out and identifying carers in order to offer support and working across the communities in Thurrock.

Our 10 Key Priorities for 2017

Continue to join up health and social care services through the Better Care Fund, to support people better

Continue to strengthen communities and build commuity resilience by supporting small community based services

Increase the use of Direct Payments to allow people to manage their own care

Implement online self-assessments

Complete the re-modelling of home care services to improve choice and quality

Roll out the delivery of Shared Lives in Thurrock

Put in place an independent system to ensure that our processes to financially assess individuals are fit for purpose

Re-tender the Healthwatch service to improve scope, ensuring quality of services

Develop a specialist autism service

Keep vulnerable people safe

Feedback – Tell Us What You Think

This is the end of our report. We hope you have found it interesting and informative.

We are very interested in your views about whether you have found this report helpful and your suggestions about how to improve it in the future. In addition, if you have any comments or suggestions about the activity being discussed in the report we would love to hear from you.

If you would like to give feedback on this report, you can do so through the following methods:

Email: ascfeedback@thurrock.gov.uk

Postal Address:
Contract Compliance Intelligence Officer
Performance, Quality & Business Support
FREEPOST ANG1611
Thurrock Council
Civic Offices
New Road
Grays
Essex
RM17 6SL

Telephone Number: 01375 652643

Appendix One – Adult Social Care National Key Performance Indicators 2015/16

	Thurrock 2011/12	Thurrock 2012/13	Thurrock 2013/14	Thurrock 2014/15	Thurrock 2015/16	Direction of Travel	England 2015/16	Thurrock Compared to England
1A - Social care-related quality of life	18.4	18.7	18.5	19.6	**19.6**	↔	19.1	In Line
1B - % of people who use services who have control over their daily life	74.0	76.5	72.7	74.2	**83.7**	↑	76.6	Better
1C(1a) - % of people using social care who receive self-directed support	41.1	58.8	70.7	70.3	**74.2**	↑	86.9	Worse
1C(1b) - % of carers who receive self-directed support	-	-	-	8.9	**94.4**	↑	77.7	Better
1C(2a) - % of people using social care who receive direct payments	10.5	19.2	26.6	31.6	**28.6**	↓	28.1	In Line
1C(2b) - % of carers who receive direct payments	-	-	-	8.9	**94.4**	↑	67.9	Better
1D – Carer-reported quality of life score	-	8.7	-	7.9	**-**		-	
1E - % of adults with learning disabilities in paid employment	3.6	5.8	6.1	7.3	**7.4**	↑	5.8	Better
1F - % of adults in contact with secondary mental health services in paid employment	7.3	9.0	8.5	8.9	**9.9**	↑	6.7	Better
1G - % of adults with learning disabilities who live in their own home or with their family	49.0	63.3	71.2	83.1	**85.2**	↑	75.4	Better
1H - % of adults in contact with secondary mental health services who live independently, with or without support	51.5	72.2	72.2	75.4	**72.2**	↓	58.6	Better
1I(1) - % of people who use services who reported that they had as much social contact as they would like	-	-	42.3	49.2	**47.9**	↓	45.4	Better
1I(2) - % of carers who reported that they had as much social contact as they like	-	-	-	45.1	**-**		-	
2A(1) - Permanent admissions of younger adults (aged 18 to 64) to residential and nursing care homes, per 100,000 population	51.2	8.0	12.0	16.9	**11.8**	↓	13.3	Better
2A(2) - Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	558.3	858.2	623.4	438.5	**674.1**	↑	628.2	Worse

2B(1) - % of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (effectiveness of the service)	92.0	89.3	89.9	86.0	**90.8**	↑	82.7	Better
2B(2) - % of older people (65 and over) who were offered reablement services following discharge from hospital	3.2	3.0	5.0	5.7	**4.2**	↓	2.9	Better
2C(1) - Delayed transfers of care from hospital per 100,000 population	5.4	5.9	7.3	7.4	**5.0**	↓	12.1	Better
2C(2) - Delayed transfers of care from hospital which are attributable to adult social care per 100,000 population	1.0	0.9	1.8	1.3	**1.2**	↓	4.7	Better
2D - % of new clients who received a short-term service during the year where the sequel to service was either no ongoing support or support of a lower level	-	-	-	49.4	**86.9**	↑	75.8	Better
3A - Overall satisfaction of people who use services with their care and support	60.9	59.6	62.4	64.5	**69.2**	↑	64.4	Better
3B – Overall satisfaction of carers with social services	-	45.4	-	42.9	**-**		-	
3C - % of carers who report that they have been included or consulted in discussion about the person they care for	-	79.9	-	71.6	**-**		-	
3D(1) - % of people who use services who find it easy to find information about support	76.3	73.8	77.5	75.5	**85.8**	↑	73.5	Better
3D(2) - % of carers who find it easy to find information about support	-	-	-	68.2	**-**		-	
4A - % of people who use services who feel safe	60.3	58.2	64.2	71.7	**72.8**	↑	69.2	Better
4B - % of people who use services who say that those services have made them feel safe and secure	82.5	64.2	66.5	91.5	**87.7**	↓	85.4	Better