APPENDIX 1

# Adult Social Care in Thurrock

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

2015

# Introduction

Welcome to our third 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 previous 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 talked about the unprecedented financial savings we need to make which are on a scale we have never seen before and will continue for a number of years. With increasing populations in the Borough of vulnerable people with complex needs, frail elderly and those with dementia, and children transitioning into adulthood with autism, we have an ever increasing demand on our services for care and support with less and less money with which to meet those needs.

In addition the Care Act 2014 has introduced new legal duties and requirements for Adult Social Care and support, for example increased rights for carers, developing more preventative services, integrated working with other colleagues such as health and housing, and providing information and advice.

In the past councils have provided the same traditional types of services such as residential care, and care has typically only been arranged for people once they have reached crisis point. This is no longer viable anymore. We need to be radical in thinking about how we can change our approach to support those in need but also to introduce new ways or delivering a person's outcomes that are more efficient and effective, and that keep people independent in the community for longer. This includes a range of non-service solutions that focus on strengths and move away from a focus solely on meeting need.

But 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 need to all 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 work has already started and we have seen a lot of good achievements and positive changes over the last couple of years. This report aims to update you on what we have been doing, how we have progressed with our priorities and vision, and most importantly, how you can help us and get involved.

**Councillor Barbara Rice**
**Portfolio Holder for Adult Social Care and Health**

**Roger Harris**
**Director for Adults, Health & Commissioning**

# Contents

# Our Vision

**‘Resourceful and resilient people**
**in resourceful and resilient communities’**

Our vision for health and well-being is ‘resourceful and resilient people in resourceful and resilient communities’. 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.

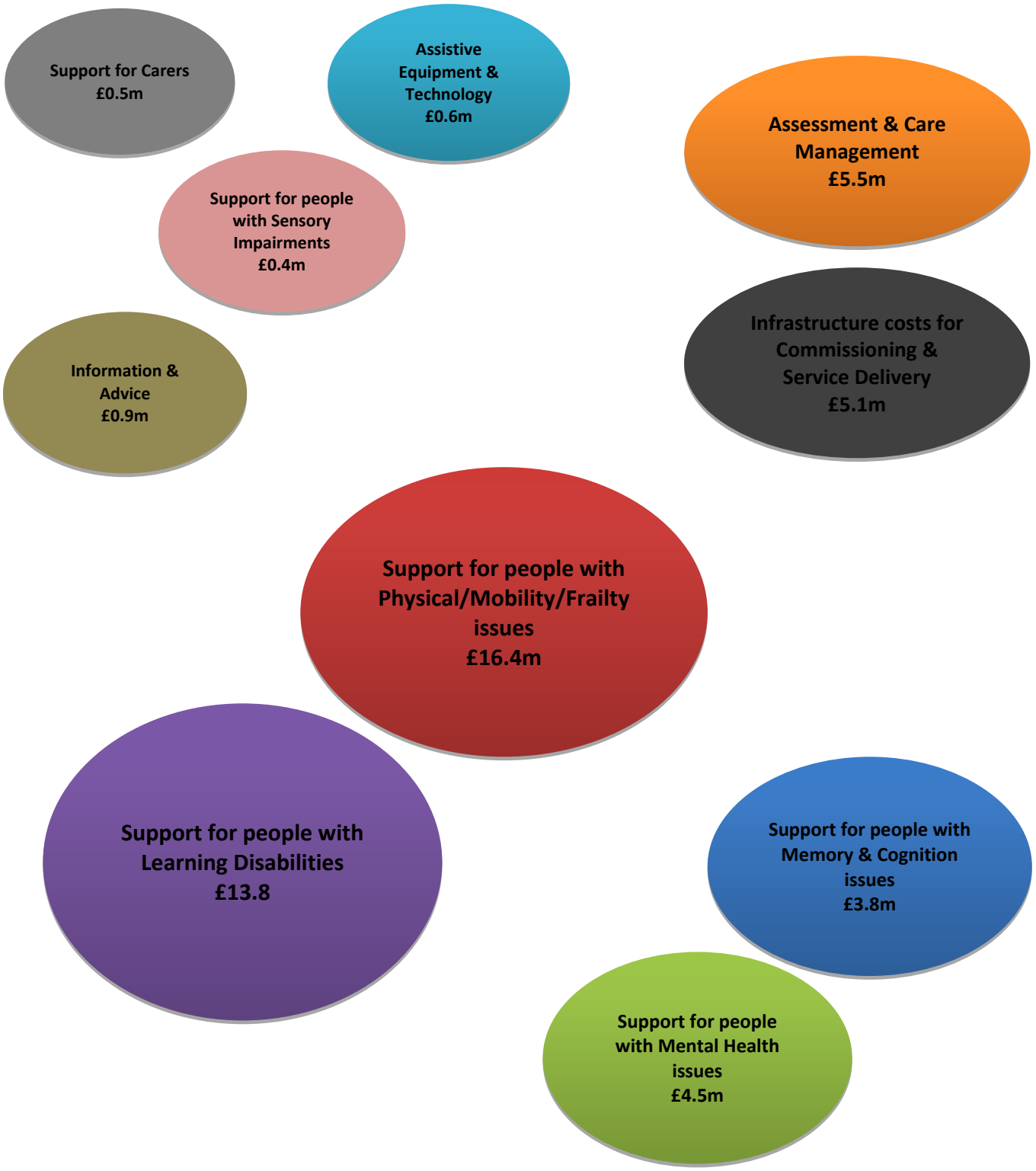
There will always be a need for health and social care services. The problem at the moment is that those services are often only available at the point of crisis. The rising numbers of older and vulnerable adults needing services, together with the increasing budget pressures the Council faces, means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

Because of the scale of the challenges ahead, 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.

Building Positive Futures is our programme to deliver these aims:

# Our Budget

We spent £51.6 million on adult social care services in 2014/15. The chart below shows how our spending is split across key areas:




* Gross expenditure

# Our Challenges

Thurrock Council faces cuts on a scale that has not been seen in the Borough before. The Council has to reduce its spending by around £32 million over the next three years, with further savings likely beyond that. This means a 25% cut in our total budget as a Council.

We have already had to make significant savings over the last few years. Until now we have managed to make most of these savings through cuts and increased efficiency in back office functions; however it is becoming increasingly difficult to find ways of making savings that don't impact on front line services.

In addition to the budget pressures, Thurrock's population of older people is growing and the complexities of people's needs are increasing. For example, data shows that:

- Our older person's population (65+) in Thurrock is predicted to increase by 49% by 2030, with a predicted 118% increase of people aged 90 or over
- The numbers of people aged 65 and over who have dementia is predicted to increase by 68% by 2030 with a 52% increase in those with a limiting long-term illness
- More older people will be carers; a predicted 44% increase by 2030;

We are also predicted to see an increase in the number of people aged 18-64 with a learning disability (6% increase by 2030), and physical disability (7% increase by 2030). 7% more people aged 18-64 will have an autistic spectrum disorder and 11% more people aged 30-64 will have early onset dementia.

Furthermore, there are 57 young people aged 14-17 who will be transitioning from children's social care services to adult social care over the next 4 years. This will put added pressure on the budget. 54% of these young people are also on the autism spectrum and as we have no specialised services for people with autism currently, we will need to look at how we can meet these needs in the future.
It is recognised nationally that there is a crisis in home care and there is no difference in Thurrock. Providers of home care services are struggling to recruit and retain staff within the current financial climate. This is something that we are constantly monitoring, however the situation continues to be a significant risk and stabilising the home care market is a key priority going forward.

Recruitment and retention of qualified staff and care staff continues to challenge both the Council and all our health partners. Social Work and Occupational Therapist recruitment has been difficult for us, however due to different ways of approaching this we have been successful in retaining and recruiting social workers for this year.

# Our 10 Key Priorities for 2015

- Implementing the new duties and requirements in the Care Act 2014
- Developing more joint health and care services designed to support people to stay strong, well and connected in their own communities, e.g. Personal Health Budgets
- Expanding and accelerating our Building Positive Futures programme and strengths-based approaches (such as Local Area Coordination, community building and time banking) to maximise independence and make services more local and personalised
- More joint working with schools, health and education to keep disabled young people transitioning into adult social care independent in their communities through volunteering and employment opportunities
- Launching a new and improved information and advice website so that people have easy access to information and advice and have confidence in planning their own support
- Making it easier for people to access social care by developing online self-assessments and the ordering of basic equipment online
- Making sure that where eligible, people receive support through a personal budget and wherever possible a cash payment that offers the most choice and control
- Developing a greater range of small-scale services to enhance choice and control, driven by our Market Position Statement e.g. micro-care enterprises
- Ensuring that we have the right plans and strategies in place to ensure the best possible support for conditions including autism
- Continuing to implement Thurrock's dementia-friendly communities initiative, helping to support people with dementia in their own communities

# Priority 1 – Care Act 2014

## Implementing the new duties and requirements in the Care Act 2014

The Care Act 2014 is the most significant piece of legislative change affecting adult social care since the introduction of the National Assistance Act in 1947. Part 1 of the Act became operational in April 2015 and introduced a number of new duties and requirements for councils and their partners including a general duty of wellbeing, a duty to prevent, reduce and delay the need for care and support, and the duty to provide information and advice. Part 2 of the Act was supposed to be introduced from April 2016 and would have introduced a cap on the cost of care and an extension to the means test. The Government recently announced that part 2 of the Act would be delayed until 2020.

### Duty to Provide or Arrange Services that Prevent, Delay or Reduce the Need for Care & Support

In Thurrock, we already have a huge emphasis on services that prevent, delay or reduce people's need for care and support services. This is the basis of our vision for adult social care – Building Positive Futures (BPF). Our BPF programme is focussed around strengths-based approaches such as Local Area Coordination to maximise the independence of the individual in the community. Please see **priority 3** on page 14 for further information about our progress with this programme.

In addition to the Building Positive Futures Programme, we also have a range of other preventative services such as the Rapid Response Assessment Service (RRAS), which aims to prevent unnecessary hospital admissions or admissions to long term care by responding to people in or at the point of crisis. Our Joint Reablement Team (JRT) also provides support to people to regain skills or mobility after a period of illness or hospital admission. Our Interim Beds run out of our Council-run residential care home can provide support to enable people to regain their independence after illness or hospital admission so that they are able to return home. We also provide a wide range of telecare equipment to enable people to remain safely in their homes without the need for intrusive, higher level support, and also have a range of supported housing services to establish or maintain people's independence in the community.

Our Community Solutions Team, which is the single point of access for adult social care signpost individuals to preventative services and these services are considered before more intensive services are put in place.

In addition, we are working closely with our partners to prevent, reduce and delay the need for care and support. This includes work with Housing colleagues to provide specialised housing for older people and also for people with Autism. We are also working with planning colleagues and the NHS to ensure that future developments in Thurrock have a positive impact on health and wellbeing and that health infrastructure can focus on prevention as well as ill-health.

### Duty to Promote Integrated Care and Support with Health Services

We continue to work with our health colleagues to provide integrated services where it makes sense to do so. In 2013 the Government announced the introduction of a Better Care Fund (BCF) across the NHS and Adult Social Care. The BCF consists of a pooled fund made up of NHS (Clinical Commissioning Group) and Adult Social Care funds to be used to promote integrated working with the aim of reducing the number of unplanned admissions to hospital. All local areas had to submit a plan detailing how the fund would be spent during 2015/16.

We already have some excellent examples of joint working with health which will continue to be funded through the Better Care Fund:

- Our Rapid Response Assessment Service (RRAS) and Joint Reablement Team (JRT) as described above are both services provided jointly by social care and health to ensure individuals have a holistic service that meets both their health and social care needs.
- We also have a social care team based at Basildon Hospital that works very closely with Basildon Hospital to plan timely discharges of patients, ensuring the right care is in place to appropriately support individuals as they leave.

We have also recently agreed a joint post with our health partners for an Integrated Care Director for Thurrock. This post will be focussing on how to integrate more health and social care services. One of the first things to be considered will be a joint single point of access for social care and health services.

For more information on these initiatives, please see **priority 2** on page 10.

## Duty to Provide Information and Advice

We have 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/

Our Local Area Coordinators (LAC's), who work in specific areas across Thurrock, are vastly knowledgeable on the local resources available in the community and one of their key functions is to provide advice on what is available that can meet individuals specific needs.

We also have a range of advice and information available in our Community Hubs, which brings local resources together in one place. We currently have Hubs in South Ockendon, Chadwell St Mary and Stifford Clays/Blackshots but we have plans in place for more.

Our Carers Advice and Information Service (Cariads) is provided by three voluntary sector organisations, Thurrock Mind, Thurrock Lifestyle Solutions and Thurrock Centre for Independent Living and has been running for over a year. In 2014/15, the service had contact with 506 new carers who had not received any support from Cariads in the past.

## Market Shaping

The Care Act gives the Council the duty services to ensure there is a diverse range of high quality services available.

Over this year we have developed a Market Position Statement which sets out how we will be developing the market over the next few years and helps existing and new providers of services identify what Thurrock's requirements are. Please see **priority 8** on page 24 for more information.

## Duty to Undertake Assessments for Care & Support

Assessments have shifted to be outcome and wellbeing focussed rather than needs based. This means that a far broader range of options should be considered when looking at how the individual can meet the outcomes they have identified as being most important to them.

Carers rights are far stronger under the Act, and they now have the same legal right to an assessment as those they are caring for regardless of the level of need the person they are caring for has.

The Act also introduced a new national minimum eligibility threshold that all council's must use to determine whether people are eligible to access council support. The new eligibility criteria is outcome-focussed and looks to what the individual can rather than cannot do, and focuses on the need for

councils to provide a range of options to meet outcomes, moving away from traditional service responses.

We have introduced a new assessment form that is compliant with and embodies the ethos of the Care Act and use this on all assessments we carry out.

## Entitlement to a Personal Budget

Individuals will have a legal entitlement to a Personal Budget, which is a statement on the costs of their care. We are already providing Personal Budgets to some services users but this will need to be expanded to all service users.

This year we have developed a Resource Allocation System (RAS); a web-based programme which provides an indicative personal budget based on an individual's needs. Currently this is being piloted by staff and is not yet 'live' for the public to use. This will continue to be developed.

Please see **priority 6 and 7** on pages 22 and 23 for more information.

## Duty to have an Adult Safeguarding Board

Thurrock Council has had an Adult Safeguarding Board in place for several years and we welcomed the opportunity for the Board to be put on a legal footing comparable with Children's Safeguarding arrangements. Our Adult Safeguarding Board has ensured that it is compliant with the Care Act.

## Funding Reforms

Part 2 of the Care Act introduced significant funding reforms including a cap on care costs so individuals will not have to pay towards their care costs once this cap is reached, and an extension to the means test, which means that more individuals will qualify for financial assistance.

Originally due to be introduced in April 2016, the Government announced during 2015 that the part 2 changes would be deferred until 2020.

# Priority 2 – Joint Health & Care Services

**Developing more joint health and care services designed to support people to stay strong, well and connected in their own communities e.g. Personal Health Budgets**

In 2013 the Government introduced the Better Care Fund (BCF). The Fund consists of pooled money shared between local authorities (Adult Social Care) and the NHS (Clinical Commissioning Groups) to support the integration of social care and health where appropriate, with an overriding aim of reducing the number of unplanned emergency admissions to hospital. The Fund is entirely made up of existing money funding streams. There is a mandated amount that councils and Clinical Commissioning Groups (CCG's) must add to the pooled fund, but there is local discretion to add more to the Fund.

Together with our health colleagues in the Thurrock NHS Clinical Commissioning Group, we produced a Better Care Fund Plan which focuses on reducing hospital and residential care admissions for older people aged 65 and over. Our Plan was approved nationally in February 2015 and can be found here: Better Care Fund Plan

Since this time we have established a group called the Integrated Commissioning Executive (ICE). Made up of senior colleagues from both health and social care, the ICE will be responsible for overseeing and monitoring the delivery of the BCF Plan. A full implementation plan was agreed in June 2015

The Plan has 4 main work streams:

| Scheme No | Scheme Name |
|---|---|
| **Scheme 1** | Local Service Integration |
| **Scheme 2** | Frailty Model |
| **Scheme 3** | Intermediate Care |
| **Scheme 4** | Prevention & Early Intervention |

## Scheme 1 – Local Service Integration

The aim of this scheme is to integrate services in Thurrock around four Community Hubs which will align with four GP clusters. This is so that we can offer services to the people of Thurrock based on an understanding of the needs of each local community. Services will include community health services, mental health services, housing, adult social care and primary health care. The services will target people with long term conditions who are most at risk of admission to hospital or a care home.

The new Integrated Director for Care will be ensuring a single point of access for people that provides information about health, social care and wellbeing.

## Scheme 2 – Frailty Model

This scheme aims to provide enhanced services to older people who have complex needs including frailty and dementia who are at the most risk of their health deteriorating. The model will provide support to individuals in the community to promote self-care and independence and to prevent crisis, deterioration, hospital admissions and residential care admissions.

There are already many services in place to support frail elderly people; however these often operate in isolation of one another. This scheme aims to bring them together into integrated services.

Our Rapid Response Assessment Service (RRAS), which is already an integrated service with social care and health, has already been very successful in supporting people in crisis. In 2014/15, the RRAS

had 3,404 referrals (an average of 284 per month). 87% of referrals were for people aged 65+. Of those who were visited and assessed, only 3.2% resulted in an immediate admission to hospital. This is a 1.5% reduction from 2013/14 and is well under our target of 7%. The Frailty Model will see a greater expansion of this service to a 24 hour service.

We already have good end of life care for those individuals in the final year of their life. We maintain a coordinated care register for individuals at end of life to ensure advanced care planning takes place that is in-keeping with the service users' wishes. Currently 100% of all patients on the coordinated care register have an advanced care plan within 3 months. The end of life care service will be further enhanced by being included in the single frailty pathway.

We have been using Telecare and Telehealth devices for some time to provide discreet solutions to support individuals with long term conditions to live safely in the community and maintain their independence. In 2014/15 there was a 99% service user satisfaction rate with the telecare services provided by a contracted organisation, Red Alert. The continued use of telecare and telehealth will form a part of the frailty model.

Our Older People Mental Health Team is already very well established and this will be further strengthened by introducing a single point of access for GP's which is currently not in place, particularly for people with dementia.

We have introduced Multi-Disciplinary Meetings (joint meetings incorporating social care and health colleagues) in our care homes through the Community Geriatrician which reviews all patients residing in the care homes and identifies those most at risk of hospital admission. Plans are then put in place to minimise the risks. We have also employed a dedicated Community Psychiatric Nurse to work with care homes to ensure mental health needs are identified. The Frailty Model will further integrate and develop this approach and will see the Community Geriatrician role integrated into the Frailty Model positioned at the initial point of access into services to ensure individuals with complex needs are identified at the point of referral to ensure they get the right care quicker.

We have also maintained our attendance at all GP Multi-Disciplinary Meetings which has resulted in improved joint working across health and social care.

We will also continue to work with the Ambulance Service to ensure they understand the different range of support available that may be better suited to meet needs rather than a hospital admission.

## Scheme 3 – Intermediate Care

We already have Intermediate Care services in place which are services providing reablement and rehabilitation after illness or crisis to enable people to gain/re-gain the skills necessary to live independently. These services are used to ensure people who have been admitted to hospital do not stay in hospital for longer than necessary and they can help people to return home with reduced need for ongoing care, preventing further hospital admissions. In addition, they can provide an alternative safe place for people in crisis to prevent hospital admission occurring in the first place.

This scheme aims to further extend the availability of intermediate care services available and develop an enhanced home care service that will enable people, where appropriate, to be discharged from hospital back to their own home where an assessment will be carried out focussing on how that person can best be supported to remain at home.

The Council has in place a 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.

We also have in place a Joint Reablement Team (JRT) which is a fully integrated service between health and social care to provide reablement/rehabilitation to individuals in their own home and is working very successfully. In 2014/15, 576 individuals completed a period of reablement, an 8.5% increase from 2013/14, and of these, 65% resulted in having a reduction in care package or no care package at all (2% increase from 2013/14). 94.1% of people using the service who completed a survey in 2014/15 reported that the quality of their day to day life had completely or mostly improved following support; and 87.5% stated that the service had helped them to be more independent to stay in their own home. 85% of older people (aged 65 and over) who were discharged from hospital in 2014/15 into a reablement or rehabilitation service were still living independently at home 91 days later.

We have a number of Interim Beds available at Collins House, our council-run residential care home in Corringham, which 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. Due to funding restrictions the beds have been reduced to 12. Demand now outweighs capacity and we are looking to increase these in the future.

In 2014/15 there were 83 referrals to the Interim Beds and of these, 66% were from the hospital team to facilitate timely discharge, assess long term needs and where appropriate, provide rehabilitation. In addition 29% of referrals were to avoid admission to hospital. There were 83 departures from the service in the year and the table below shows the destinations of these individuals:

| Destination | Number/% of Service Users |
|---|---|
| **Returned to the Community/Home** | 44.6% (37) |
| **Moved to Extra Care** | 4.8% (4) |
| **Moved to Residential Care** | 36.1% (30) |
| **Admitted to Hospital** | 12.0% (10) |
| **Deceased** | 2.4% (2) |

## Scheme 4 – Prevention & Early Intervention

Prevention and early intervention is a key element of the new Care Act, and is the main focus of our Building Positive Futures Programme. Prevention and early intervention is also the key focus of whole system transformation – ensuring that where possible, people avoid ill-health and can better manage poor health when it arises. The aim of the scheme is to further develop and embed our prevention solutions.

We already have many initiatives and services that aim to prevent the need for more intensive services and to avoid hospital admissions, but our main approach is Local Area Coordination (LAC), which is jointly funded by social care, public health and the fire service.

Local Area Coordination (LAC) was implemented in July 2013 beginning with three Local Area Coordinators (LAC's) working in specific local communities. The LAC's work with individuals focussing on their strengths rather than their needs and help them to find their own solutions within community resources to better their lives. The service aims to help people stay independent and active in their communities without the need for more intrusive services. Following the success of the initial pilot, a further three LAC's were recruited and as part of this scheme in the Better Care Fund Plan, another three LAC's have now been recruited, providing full coverage of all the local communities in Thurrock. Initial studies have demonstrated the importance of the scheme in helping people to avoid requiring a service or spiralling towards crisis point and more expensive health and care interventions.

The work of the LAC programme is discussed in more detail in **priority 3** on page 14.

We have also reviewed and developed our falls prevention programme that targets people most at risk of, or who are experiencing, falls and supports individuals to minimise these risks. A high proportion of older people entering hospital as an unplanned admission do so as the result of an avoidable fall. This part of the scheme is being funded by Public Health, who will also be leading on a review to identify individuals with high numbers of admissions to hospital with the aim of being able to use this knowledge to plan support that can prevent admissions.

As discussed in scheme 2 above, the Council already provides a range of telecare and equipment to improve people's independence. However, this can only be provided to individuals who meet our eligibility criteria. For people whose needs are not substantive enough to meet our criteria but who have low needs that could get worse with time, equipment can still be an effective way of preventing those individuals from deteriorating. As such, part of this scheme will also be to improve both the knowledge of the public, and their access to equipment that they can purchase privately.

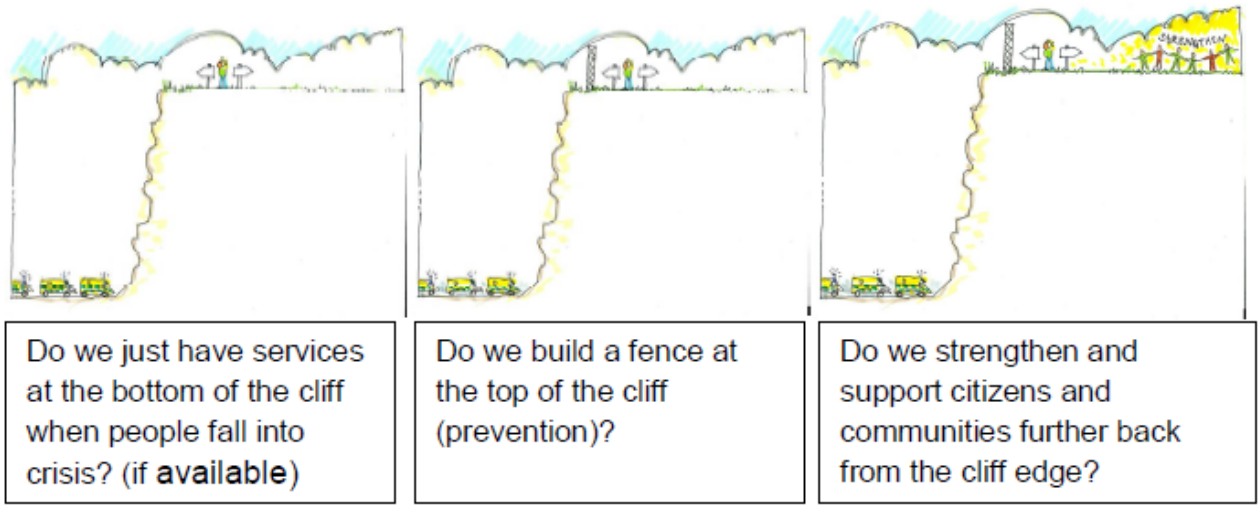
# Priority 3 – Building Positive Futures

**Expanding and accelerating our Building Positive Futures programme and strengths-based approaches (such as Local Area Coordination, community building and time banking) to maximise independence and make services more local and personalised**

As mentioned in the 'Our Vision' section at the beginning of this report, Building Positive Futures is the Council's main programme to deliver our vision of 'resourceful and resilient people in resourceful and resilient communities'. We want to move away from assessing people only in terms of what they need and what they can't do, and start finding out what people can do, what their strengths are and how these can be built on. This is called an asset-based approach.

The Building Positive Futures programme also looks at how the assets and resources of local communities can be built on, supported and strengthened to make them inclusive for all people, safe and full of community resources that individuals can draw on when they need help rather than having to turn to the Council for support.

Our vision is in keeping with the Care Act 2014 as it focusses on preventative services.




The next few sections give some examples of the work being carried out as part of this programme and you can find out more at the following website: www.strongertogether.org.uk

## Local Area Coordination (LAC)

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

LAC's 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.

The programme has seen great success in working in partnership with other organisations; for example one of the LAC's is part funded by the Fire & Rescue Service and has been able to help a number of individuals minimise the risk of fire in their homes, particularly hoarders. Three of the posts are funded

by Public Health who have recognised the value of the programme in helping people's health and wellbeing. The remaining posts are being funded through the Better Care Fund (see **priority 2**).

In November 2014 a 14-month evaluation of Local Area Coordination took place; at this time there had been over 300 people introduced to LAC. Support provided has been varied, examples include:

- helping people overcome social isolation by helping people to access local community groups and clubs;
- linking individuals together for mutual benefit such as gardening, laptop tuition and providing transport to appointments;
- 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, jointing exercise groups etc.

## Community Builders

Two Community Builders were appointed in July 2014 to work in the Stifford Clays/Blackshots and South Ockendon areas. Their aim was to build up the connections, goodwill and neighbourliness of the people in their communities, linking people together and identifying Local Connectors – people who have a passion for their neighbourhood and who are willing to give their time to help build more welcoming, friendly neighbourhoods that are inclusive. As part of their work Nurture Development has commissioned a report that showcases some of the great work, or stories, that they have been a part of. This report is viewable at: Nurture Development

Following the success of these two community building projects, the Stronger Together partnership are looking at approaches to extend asset based community development by identifying Local Connectors. In October 2015 we have identified 25 volunteers that are interested in becoming a part of this project, although their main role will be to connect people they will also begin creating an asset map for Thurrock.

## New Flats for Older People

In the last report we explained that we had secured funding to build 28 one-bedroom flats for older adults in South Ockendon. These flats are now in the process of being built and are designed to be 'care ready' so that occupants will be able to remain independent for as long as possible and will not be required to move if their care needs increase. They will include attractive balconies overlooking communal gardens, communal areas for socialising, well-proportioned rooms, and space for wheelchairs etc.

Further funding has also been secured for similar housing comprising 38 new flats to be built in Tilbury. This scheme is due to go on site shortly.

The Council, in partnership with Family Mosaic, has put in a bid to secure funding for 8 units of housing specially designed for people with autism.

## Small Sparks

We have set up a fund called 'Small Sparks' to provide one-off small amounts of money to community projects to enable communities to start building assets and resources. To date many people have applied for this funding and below are a few examples of what it has been spent on:

- Equipment to create a community garden comprising 3 planters and a safe area for children to play

- Lockable storage cabinet for storing park equipment to help keep a local park clean and litter free
- Multi-cultural street party which was free attendance and enabled members of the community to come together and build relationships
- New equipment for a picnic area in a local park for children
- Start-up costs for a new friendship club for elderly gentlemen
- Funding to enable a school to open on Christmas Day to provide a Christmas Dinner and social activities for people without families.
- Table Tennis Table for a club that has been running for over 8 years primarily for older adults providing fitness and social engagement
- Tools and supplies for a knitting club providing clothing for babies residing in a neonatal unit.

## Timebanking

Timebanking is a volunteer scheme where members of the scheme offer and receive services without any exchange of money. People offer their services which other members can receive and by doing so they build up hours, which they can then redeem by choosing to accept services that other members are offering.

Services offered can include anything and all time is equal so an hour spent giving a service to someone else equals an hour banked that you can use to get a service from someone else. An example of this is someone spending an hour doing gardening for a neighbour who is not able to, and in exchange receives tutoring in computers from another member.

Our Timebanking scheme was officially launched in February 2015 and now has 167 members who have exchanged around 6000 hours.

## Animate

Animate is a three year programme which links younger people with older people 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

## Shared Lives Scheme

Over the coming year a key area of focus within our Building Positive Futures programme is to develop 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.

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

Shared Lives can be used to support short breaks (respite care), day support, home from hospital care, emergency support, a stepping stone towards independence or a long term home for people. Shared Lives carers and those they care for are matched for compatibility and then often develop excellent relationships with the carer acting as extended family.

With the introduction of the Care Act, it is anticipated that an increasing number of carers will be identified, many of whom will benefit from ‘replacement care’ services, such as Shared Lives.

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.

The community work we have already focussed upon in Thurrock, including the development of the Community Hubs and the Local Area Co-ordinators, means that we are in a good position to be able to link closely with our local families.

# Priority 4 – Education & Employment for People with Disabilities

**More joint working with schools, health and education to keep disabled young people transitioning into adult social care independent in their communities through volunteering and employment opportunities**

For young people who have a Statement of Special Educational Needs (SEN) and/or a disability or complex long term health condition, support is provided through our Children's Social Care Department. However, when those young people reach adulthood they are transitioned into Adult Social Care.

This can be a very daunting process as Adult Social Care has different funding and thresholds for services compared to Children's Social Care and so some young people may find that they are not eligible for the same services they used to receive.

Therefore, it is important for Children's Social Care and Adult Social Care teams to work together with our young people to make this transition as smooth as possible. We must also work with our partners in schools, health and education. This process of transition takes place over a long period from when the young people are aged 14 up to them turning 25.

## Thurrock Transition Strategy

Our Transition Strategy was produced in 2013 and spans three years up to 2016. In this strategy, our vision is:

**'Our vision is to help young people take their journey into adulthood with confidence, enabling them to achieve and reach their full potential, living lives they want to lead'**

The strategy sets out an action plan to ensure young people have:

- Choice and control over their support and services when they transition into adulthood
- Control over the assessment process which is person-centred
- Confidence that our staff are skilled and trained to a high standard with an understanding of the barriers our young people may face as well as knowledge of the support available
- Confidence that information about young people is shared appropriately with the person's knowledge so that support can be seamless between children and adult services
- The correct advice and information on what support is available in the community and from health and social care

We have in place the Thurrock Transition Support Group (TTSG) to ensure we deliver the actions in the strategy. You can read the full strategy here: Transition Strategy

## Supported Internship Programme

Thurrock Council is working with partners Thurrock Lifestyle Solutions and Thurrock Adult Community College to deliver the Supported Internship Programme; a programme aimed at young people aged 16-24 who have a statement of special educational needs, a Learning Difficulty Assessment, or an EHC plan, who want to move into employment and need extra support to do so.

Participants gain accredited qualifications and work experience with the aim of this leading to paid employment. With the help of a job coach and support which is tailored to each individual's needs, participants will develop the skills that employer's value, enabling them to demonstrate their value in the workplace and develop confidence in their own abilities to perform successfully at work.

To date a small number of pilot programmes have supported 9 young people into paid employment, others into voluntary work or further education, and some continue to receive support securing further work experiences or paid employment. The Pilot programmes helped us develop a new year long programme and in July a further 15 students started work with their Job Coaches. They spent a few hours a week getting to know each other, enabling the Job Coaches to build a picture of interests and support needs, and in September the students started college where they develop and learn skills that they will need in the workplace. Work placements will soon commence and the feedback from students and job coaches is that they are already learning new skills and enjoying themselves too.

## Work with South Essex College

South Essex College has this year launched two new programmes; the Learner Pathways Programme and the Pathways to Independence Programme.

The Learner Pathways Programme is aimed at students who may not have had a good experience in school or who had difficulty engaging in school. This programme helps students decide the next steps to adulthood, students will gain accredited qualifications and experience in a number of different vocational areas with progression to a L1 vocational programme of their choice or apprenticeship/employment.

The Pathways to Independence Programme (Physical & Sensory Disability and Employability Programme) is designed for students who have a Learning Disabilities Assessment (LDA) or Education & Health Care Plan (ECHP). The Physical & Sensory Disability Programme covers a range of independence skills including working with others, money management & healthy living. Students will participate in work related workshops; take part in employer related community projects, work experience/voluntary placements with a view to progressing to the Employability Programme which further develops the skills needed in the workplace. Thurrock has over 40 students participating in these programmes and feedback is again very positive. We have a greater number of students who have complex needs and require High Needs Support attending college this year and the feedback from students and parents about the courses and the support provided is very positive.

In addition we have a number of learners with learning difficulties and or disabilities attending various mainstream programmes at Palmers, SEEVIC, Barking and Dagenham and Havering Colleges.

## World of Work Service

One of the main priorities of young people when they reach adulthood is to gain employment. Our World of Work service is provided by Thurrock Centre for Independent Living (TCIL) and is designed to support people with learning disabilities to prepare for, and obtain, employment. This will enable individuals to gain more independence in the community, increase their confidence and improve their social isolation.

Key activities of the service include:

- Skills development
- Preparation for work training
- Support to access training and education opportunities
- Support to access work experience placements
- Support to obtain paid or voluntary employment

In 2014/15 the service supported on average 64 individuals at any one time. Approximately 31% of service users were young people aged 16-25 years old and a further 26% were aged 26-35 years old.

Outcomes in 2014/15 were as follows:

- 93% of service users participated in skills development
- 86% in preparation for work activities
- 68% participated in training and education
- 48% participated in a work experience placement
- 13% obtained paid work
- 57% obtained voluntary work

There was a 91% average satisfaction rate of service users with the service.

## Day Opportunities Service

Another service we have in place is a Day Opportunities Service for adults with learning and/or physical disabilities. This is provided by Thurrock Lifestyle Solutions (TLS). This service provides a range of day services and activities, but one of their focus areas is on employment, education and training opportunities.

Key aims of the service are:

- To provide support and day activities for people with learning and physical disabilities that live independently
- To provide a transition service that prepares people to become independent

The philosophy of the service is to encourage and motivate service users to greater independence and towards supported employment.

In 2014/15 the service supported on average 167 service users at any one time. Approximately 26% of service users were aged 16-25 years old and a further 20% were aged 26-35 years old.

Outcomes in 2014/15 were as follows:

- 100% of service users reviewed in the year stated that their outcomes had been met
- 16% participated in paid work
- 15% participated in voluntary work
- 5% participated in training/education

# Priority 5 – Information & Advice Website

**Launching a new and improved information and advice website so that people have easy access to information and advice and have confidence in planning their own support**

One of the new legal responsibilities in the Care Act 2014 is having comprehensive and up to date information and advice available for service users and prospective service users to be able to understand what is available in the community, what they are eligible for, and how they can access services. This is so that individuals have the right information at the right time to help them plan for their care needs and can exercise real choice and control over their lives.

## Corporate Website Redesign

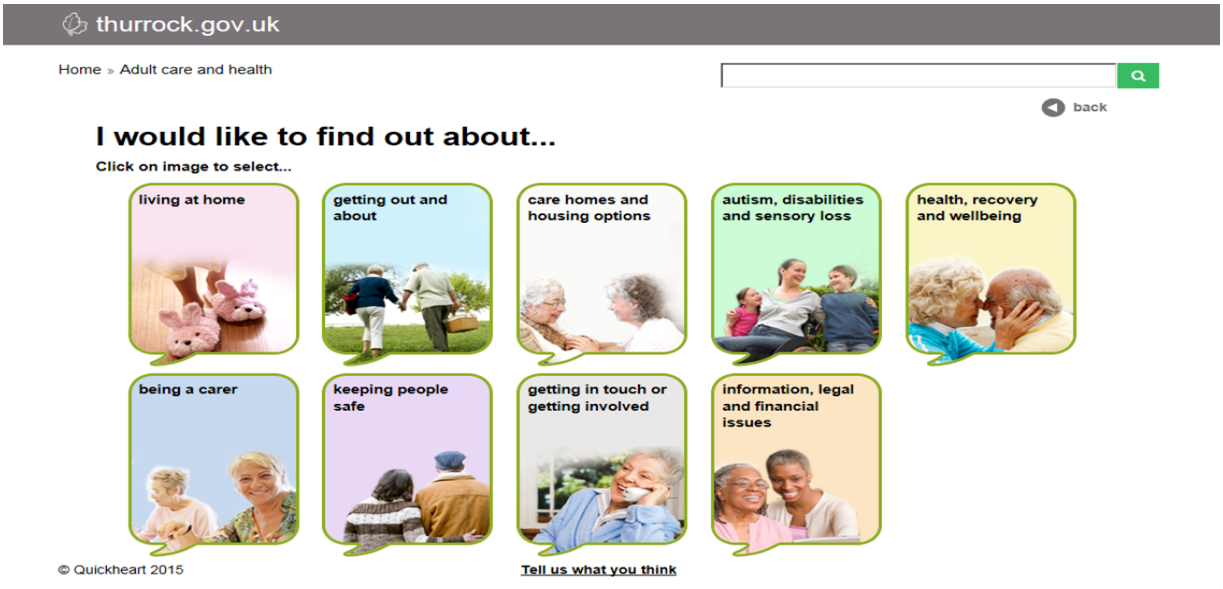
Our section of the Council website was completely redesigned and re-launched in 2014 which makes finding information and advice far easier and more straight-forward. Old information has been removed and the website is now up to date and more user-friendly.

As part of this work the Council also launched '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.

## Advice & Information

Alongside this we have also launched a new specific information and advice website at https://mycare.thurrock.gov.uk/ where the public can find information about services provided by the Council as well as local community groups, services and resources.

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. We will be keeping it under review to make sure it remains up to date with relevant information.



# Priority 6 – Online Self-Assessments

**Making it easier for people to access social care by developing online self-assessments and the ordering of basic equipment online**

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

- Determine whether an individual is eligible for support under our criteria
- Decide what services (if eligible) would best support the individual

It is important that assessments are undertaken in partnership with the individual to ensure they are personalised to their needs and aspirations. Having an online self-assessment tool would allow prospective service users to undertake this assessment themselves, ensuring easy access to adult social care, and guaranteeing that the assessment is personalised as the individual themselves are completing it rather than a social worker.

## Resource Allocation System (RAS)

The Resource Allocation System (RAS) is a tool we have 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. The personal budget is an estimate of how much money the individual may be entitled to based on their needs.

A social worker can 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, i.e. through a cash payment that they can then use to buy their own services, or the Council can put services in place on behalf of the individual and pay the service provider directly.

We are currently testing the RAS tool so it is not yet available online for the public to use; however it is hoped that this will be available soon.

## Ordering Basic Equipment Online

Unfortunately we have not been able to develop an online system for people to order basic equipment. However, 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 in and out your bath or shower
- Getting up and down the stairs
- Getting in and out your home
- Making a snack, meal or drink

The self-assessments make it much 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 can have a waiting list. A full self-assessment form is also 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: Basic Equipment Self-Assessment Forms

# Priority 7 – Personal Budgets & Direct Payments

**Making sure that where eligible, people receive support through a personal budget and wherever possible a cash payment that offers the most choice and control**

A few years ago the Government announced the introduction of Personal Budgets. This is a statement of what a person's care costs based on an assessment of their needs.

This is then taken a step further in that individuals can exercise more choice and control over their lives by deciding how they want that budget to be spent to meet their needs. This can still be through a service the Council provides, or the individual could choose to take a cash payment (called a direct payment) and arrange their care themselves in any way that they choose.

Under the new Care Act legislation, individuals will now have a legal entitlement to receive a personal budget and to choose to have a direct payment if they want it.

## Personal Budgets

We have been promoting the use of personal budgets for the past few years. For example, all people who were receiving a home care service were given a statement of their personal budget. They were then offered the choice of receiving this money through a direct payment (whereby they could arrange and pay for their care directly or the Council continuing to manage this on their behalf (therefore becoming a Council Managed Personal Budget).

We are currently testing a new online self-assessment process called the Resource Allocation System (RAS) which will immediately give individuals an indication of their personal budget based on the individual selecting what they require support with. This will provide a quick and on the spot idea of what people can expect to receive, although it is subject to change as we would need to check the assessment and ensure individuals are eligible for support.

The RAS is currently being tested by staff and will be available online to the public in the near future.

## Direct Payments

Direct payments have also been promoted in Thurrock over the last couple of years. In 2014/15 31% of the people who use adult social care chose to have a direct payment rather than the Council arranging their care on their behalf.

We also have a service in place to help people with their direct payments. The service is run by Essex Coalition for Disabled People (ECDP) and provides independent information and advice to help people decide whether they want to have a direct payment, and also gives ongoing support to those that do take up a direct payment.

The service can help service users to source individuals (called Personal Assistants) or organisations to provide their care, and also provide payroll services.

In 2014/15, ECDP received 87 new referrals and supported an average of 290 individuals with their direct payments.

Going forward we will be undertaking a project to look at how direct payments and personal budgets can be further rolled out and made available, and how we can shape the market of service providers to ensure they are able to directly contract with individuals using direct payments rather than the Council.

# Priority 8 – Market Development

**Developing a greater range of small scale services to enhance choice and control, driven by our Market Position Statement e.g. micro-care enterprises**

Over the last year we have undertaken extensive consultation events on what our Market Position Statement should look like, including holding events with current and prospective service providers and a Meet the Commissioner event.

Our Market Position Statement was completed and formally approved on the 16th July 2015 by our Health & Wellbeing Board.

The document sets out the current needs of the residents in Thurrock, potential future demand, and how we expect to change and develop the services in Thurrock over the next three years to meet those needs. You can find a full copy of the report here: Market Position Statement

## Key Priorities for Market Development

- Encourage providers to be geared up to directly contract with service users rather than the Local Authority as direct payments become mainstream.
- Support to voluntary and community groups with initiatives that strengthen the community
- Support the development of micro and social enterprises, including an increase in PA's available for people requiring support in their own home.
- Support the development of a Shared Lives Scheme as an alternative to residential care (see page 16 for more information)
- Possible development of a high quality small dementia/challenging behaviour nursing home or unit
- Development of a step up/step down service for people with mental ill-health
- Possible development of a small extra care service for older people and people with dementia in the west of the borough (as there is currently no provision there)
- Possible development of a small extra care service for people with learning disabilities
- Development of autism services
- Increased range of organisations providing day services for people with learning disabilities
- Stabilise the home care market and review the model of service provision.

We also aim to change the way we buy and contract services. As we will be promoting greater use of direct payments; more individuals will be organising their own services and will not need the Council to do this for them. However, we still want good quality services that we can recommend to individuals. As such, there will be some services where we aim to use Framework Agreements; this is an agreement that organisations sign up to where they agree to meet specific criteria such as quality standards. The service user can then choose to have their service from one of our recommended providers from the agreement using their direct payment.

As the Market Position Statement has only recently been developed, many of the key actions are currently being scoped and planned for further development. For example, day services for people with learning disabilities will be advertised in the near future for potential organisations wanting to deliver this type of service to apply for. A property is currently being looked at to potentially be used as a step up/step down service for people with mental ill-health. Options for the Shared Lives Scheme are currently being explored.

# Priority 9 – Strategies for Specific Conditions

**Ensuring that we have the right plans and strategies in place to ensure the best possible support for conditions including autism**

We have a number of strategies in place for specific client groups/conditions with actions plans in how we will develop support in the future:

## Autism Strategy

The exact number of people with an autism spectrum condition (ASC) in Thurrock is not known however nationally it is around 1% of the population. This would mean approximately 1,000 people in Thurrock. Approximately half of those individuals with autism will also have a learning disability. There will also be a number of adults who have not received a diagnosis.

In Thurrock, the population of people with autism is expected to rise considerably, with a predicted 11% increase by 2030. Furthermore, there is a specialist school in Thurrock that works with children with autism. This has meant that more families with autistic children are moving to the area to gain a place at the school. Figures from our Children's Social Care Department indicates that there are 57 children aged 14-17 years old who will be moving into Adult Social Care services over the next few years, 54% of which will have autism and will require support.

Support is provided through several different teams across Adult Social Care and Health, mainly through mental health or learning disability teams, neither of which can always fully meets these individuals' specific needs. Locally there are no specialised residential care homes or supported housing services for people with autism, often resulting in individuals having to move long distances away from the area.

The increasing numbers of people with autism and the lack of specialised services for this client group make this a priority for us and will be developed as part of the Market Position Statement.

Thurrock's Adult Autism Strategy 2014-2018 was formally approved by the Health & Wellbeing Board on the 16th July 2015 after an extensive consultation.

Our vision is based on the national core areas of activity:

- Increasing awareness and understanding of autism among frontline professionals
- Developing a clear, consistent pathway for diagnosis in every area, which is followed by the offer of a personalised needs assessment
- Improving access to the services and support which adults with autism need to live independently within the community
- Helping adults into work
- Enabling local partners to plan and develop appropriate services for adults with autism to meet identified needs and priorities

An action plan has been developed as part of the strategy which we will be working on over the next couple of years; some of the actions that we have already completed are:

- We have completed an autism self-assessment which looks at where we are at currently and this will be updated annually. The self-assessment is available on our website (see link below).

- The Council's Housing Strategy has been updated and includes the housing needs of people with autism. .
- Autism training is now available for all Council staff and social workers are more equipped with the right knowledge to ensure care planning reflects people with autism's needs.
- We have set up an Autism Action Group (AAG), which is a mandatory requirement. The AAG is made up of representatives from social care and adults with autism and their carers and oversees some of the actions from the strategy. Representatives from other areas are invited to discuss specific areas of work as appropriate, for example representatives from health, education, housing and the criminal justice system.

Some of the main actions outstanding include:

- Ensuring there are low level community preventative services available for people with autism who do not meet the adult social care eligibility criteria for support
- Health colleagues to lead on the development of a local diagnostic pathway for people with autism to ensure individuals get the right diagnosis and that this leads to a community care assessment
- Health colleagues to develop a programme in GP surgeries to give health checks to people with autism
- To become an Autism Friendly Council
- Explore options for apprenticeship schemes, internships, work experience and volunteering opportunities for people with autism

You can read the full strategy, action plan and self-assessment here: Adult Autism Strategy

## Mental Health Strategy

The South Essex Joint Mental Health Strategy has been in operation since 2013 and spans five years up to 2018. It was developed in partnership with Essex County Council, Southend Borough Council, and the corresponding Clinical Commissioning Groups (CCG's) who are our health partners.

The strategy has the vision that the services we have will support the following outcomes:

- People will have good mental health
- People with mental health problems will recover
- People with mental health problems will have good physical health and people with physical health problems will have good mental health
- People with mental health problems will have the best possible quality of life

The strategy is already being implemented and covers activities such as:

- Developing a new gateway into mental health services
- Developing a new IAPT Plus service (Improved Access to Psychological Therapies)
- Reviewing and developing specialist care for people who have complex needs and are at significant risk
- Redesigning the pathway of care for those in crisis

## Carers Strategy

Our Thurrock Carers Strategy was written in 2012 but spans five years up to 2017. Over 3 in 5 people in the UK will become carers at some point in their lives. This is around 1.4 million carers nationally and saves the Government up to £119 billion per year.

We realise that carers are a crucial partner in delivering social care and we strongly believe that we need to support carers in their caring roles and in their own health and well-being so they can continue to support us in caring for the vulnerable people in our communities.

In Thurrock, carers have always been entitled to and encouraged to have a carer's assessment to ensure the carers needs and aspirations are taken into account. The Care Act 2014 has now put carers on an equal legal footing as service users as they now have the right to an assessment.

Services typically provided to enable carers to take a break from their caring role include day care, respite services and outreach services which include sitting services for the people they are caring for. However going forward we are promoting direct payments for carers so they have more choice and control in how they are supported.

Our Carers Advice and Information Service (Cariads) has been operating for over a year which provides invaluable support, advice and information to carers and potential carers. In 2014/15, this service had contact with 506 new carers who had not received any support in the past. Support available includes counselling and support groups.

You can read the full strategy and action plan here: Thurrock Carers Strategy

# Priority 10 – Dementia Support

## Continuing to implement Thurrock's dementia-friendly communities' initiative, helping to support people with dementia in their own communities

Our vision of having 'resourceful and resilient people in resourceful and resilient communities' means that everyone, regardless of their age, vulnerability or disability, should be able to live full, active, independent lives in their communities. Neighbourhoods should be welcoming and inclusive, and no-one should feel left out or at a disadvantage.

For people living with dementia, this can be a difficult thing from them to achieve. That's why we are committed to Thurrock becoming a dementia-friendly place to live.

In 2013 there were an estimated 1,469 people in Thurrock with dementia; however many people can go a long time without having their dementia diagnosed. The diagnosis rate in Thurrock in 2013 was 41.9%.

### Dementia Friends Training

Our dementia-friendly communities' programme set up and delivered in partnership with the Alzheimer's Society has been ongoing for some time. All staff have been encouraged to become dementia friends, and even the Councillor's in the borough have received training. We also have a number of Dementia Friends Champions within the Council who can deliver training to others to become dementia friends.

We have carried out a significant number of events in local communities around the borough that the public attended to receive the training, and we have also carried out training with staff in other local businesses, for example the bus service.

We have visited our local residential and nursing care homes and given advice and assistance on how to make these homes more dementia-friendly.

### Other Services for People with Dementia

The Alzheimer's Society in Thurrock offer a range of service for people with dementia, for example a Memory Group, information and advice, awareness raising, one to one support and support groups.

We also contract with an organisation called POhWER to provide advocacy services for people in Thurrock, including those with dementia. POhWER also deliver Independent Mental Capacity Assessments (IMCA's). They hold regular drop in sessions around the Borough. In 2014/15 the advocacy service received 488 service users, 4% of which were people with dementia (20 individuals).

# Our 10 Key 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

# 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 Key Performance Indicators 2014/15

| | Thurrock 2011/12 | Thurrock 2012/13 | Thurrock 2013/14 | Thurrock 2014/15 | Direction of Travel | England 2014/15 | Thurrock Compared to England |
|---|---|---|---|---|---|---|---|
| 1A - Social care-related quality of life | 18.4 | 18.7 | 18.5 | 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 | ↑ | 77.3 | Worse |
| 1C(1a) - % of people using social care who receive self-directed support | 41.1 | 58.8 | 70.7 | 70.3 | ↔ | 83.7 | Worse |
| 1C(1b) - % of carers who receive self-directed support | - | - | - | 8.9 | - | 77.4 | Worse |
| 1C(2a) - % of people using social care who receive direct payments | 10.5 | 19.2 | 26.6 | 31.6 | ↑ | 26.3 | Better |
| 1C(2b) - % of carers who receive direct payments | - | - | - | 8.9 | - | 66.9 | Worse |
| 1D – Carer-reported quality of life score | - | 8.7 | - | 7.9 | ↓ | 7.9 | In Line |
| 1E - % of adults with learning disabilities in paid employment | 3.6 | 5.8 | 6.1 | 7.3 | ↑ | 6.0 | Better |
| 1F - % of adults in contact with secondary mental health services in paid employment | 7.3 | 9.0 | 8.5 | 8.9 | ↔ | 6.8 | 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 | ↑ | 73.3 | 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 | ↑ | 59.7 | 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 | ↑ | 44.8 | Better |
| 1I(2) - % of carers who reported that they had as much social contact as they like | - | - | - | 45.1 | - | 38.5 | Better |
| 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 | ↑ | 14.2 | 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 | ↓ | 668.8 | Better |
| 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 | ↓ | 82.1 | 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 | ↑ | 3.1 | Better |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 2C(1) - Delayed transfers of care from hospital per 100,000 population | 5.4 | 5.9 | 7.3 | 7.4 | ↔ | 11.1 | 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 | ↓ | 3.7 | 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 | - | 74.6 | Worse |
| 3A - Overall satisfaction of people who use services with their care and support | 60.9 | 59.6 | 62.4 | 64.5 | ↑ | 64.7 | In Line |
| 3B – Overall satisfaction of carers with social services | - | 45.4 | - | 42.9 | ↓ | 41.2 | Better |
| 3C - % of carers who report that they have been included or consulted in discussion about the person they care for | - | 79.9 | - | 71.6 | ↓ | 72.3 | Worse |
| 3D(1) - % of people who use services who find it easy to find information about support | 76.3 | 73.8 | 77.5 | 75.5 | ↓ | 74.5 | Better |
| 3D(2) - % of carers who find it easy to find information about support | - | - | - | 68.2 | - | 65.5 | Better |
| 4A - % of people who use services who feel safe | 60.3 | 58.2 | 64.2 | 71.7 | ↑ | 68.5 | 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 | ↑ | 84.5 | Better |