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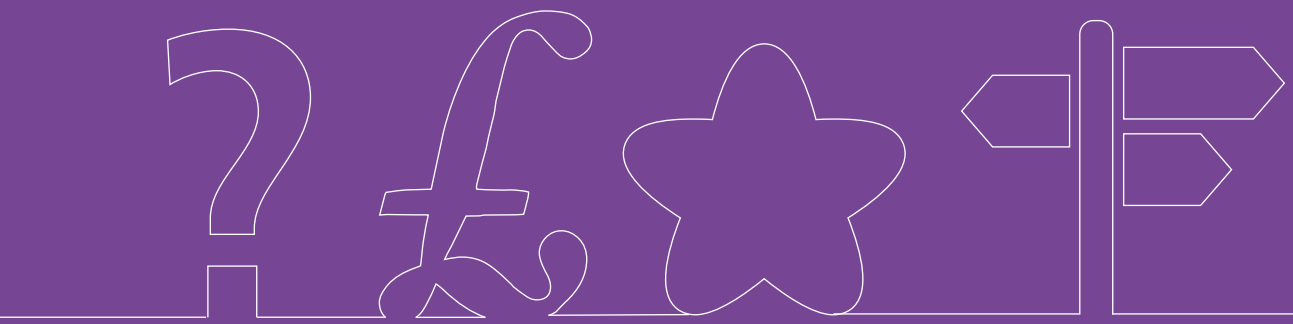
Your Local Account 2014/15



Integrated Adult Care in North East Lincolnshire 01472 256 256

NORTH EAST LINCOLNSHIRE COUNCIL
www.nelincs.gov.uk

NHS
North East Lincolnshire Clinical Commissioning Group

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Foreword

I am delighted to present this local account of adult social care services in North East Lincolnshire, which reflects our progress as a partnership over the past year. In common with last year, financial resources have become increasingly constrained and we have been working hard to ensure that the services we provide make the best use of all resources across the health and social care system by continuing to integrate access, care and support. As part of our drive towards improving our service offer we started work on site to deliver our first 60 bed unit of extra care housing. This will provide an alternative offer to traditional residential care homes and enable people to live independently, but within a supportive and caring community.

We welcome the Care Act reforms, particularly the strengthened duties around preventing the need for care and support which builds on the approaches we have been developing over the past few years. We were ready for the implementation of the new system of assessment from April 2015, and have strengthened our advice and information service provided at the single point of access. We also took the opportunity to revise our fairer charging policy in the light of government reforms. We hope that the changes we have made ensure equitable treatment of personal resources in coming to a view as to what individuals' should contribute to their care As funding cuts begin to have an impact, we need to ensure that our arrangements for ensuring the quality and safety of services are as robust as possible and it is my intention as Director of Adult Services to strengthen the assurances provided across the health and social care system through the strengthened statutory role of the Safeguarding adults board. In addition, we have strengthened our approach to deprivation of liberty safeguards, following recent case law and now have robust process in place to ensure that no one is unlawfully deprived of their liberty under the Mental Capacity Act.

We have also continued to pursue less traditional models of care and support by encouraging local voluntary groups and organisations to develop a range of alternatives to prevent older and vulnerable people from becoming socially isolated and to feel more a part of the communities in which they live.

Joanne Hewson

Director of adult social services
North East Lincolnshire Council

I am pleased to present this year's Adult Social Care Local Account which outlines the progress which has been made throughout the year 2014/15 where we have strived to further build upon the progress and successes made in the previous year. We aim to be a conscious organisation who really considers the effect any changes will have on individuals in the community and look to continually drive improvements through a collaborative approach; involving individuals from the public, colleagues across the entire health and social care system including our colleagues from North East Lincolnshire Council.

As I hope you will see from this Local Account, when planning services we give serious consideration to the individuals who will be and are receiving care to ensure that their views are addressed and realised in the design of services. Though the growing demand for services and the increasing financial pressures will continue to be key factors, I'm encouraged that quality of care and support has been sustained and further improved upon by providing services more efficiently.

It is credit to the staff throughout the health and social care system this has been possible; through working collaboratively, developing relationships with other organisations and professions, and through their consideration of implications to the wider system when working to develop different areas within health and social care.

The introduction of the Care Act 2014 has placed significant emphasis on the wellbeing of individuals and has prompted further integrated approaches with an aim to prevent, reduce and delay the need for formalised care services. Furthermore, we need to ensure individuals have the right information, advice and support to be able to live as independently as possible and make informed choices about their care. It is imperative we continue to work with our partners in the local authority and other organisations to ensure quality care and support services which meet the needs of the local population, and which are delivered effectively in a sustainable and integrated way. The Government's announcement that implementation of the Care Act's funding reforms has been delayed until 2020, will allow us more time to fully establish our new duties to date, and to ensure that we are ready to introduce the new funding system in future.

Dr Peter Melton

Peter Melton

Chief Clinical Officer
North East Lincolnshire Clinical Commissioning Group

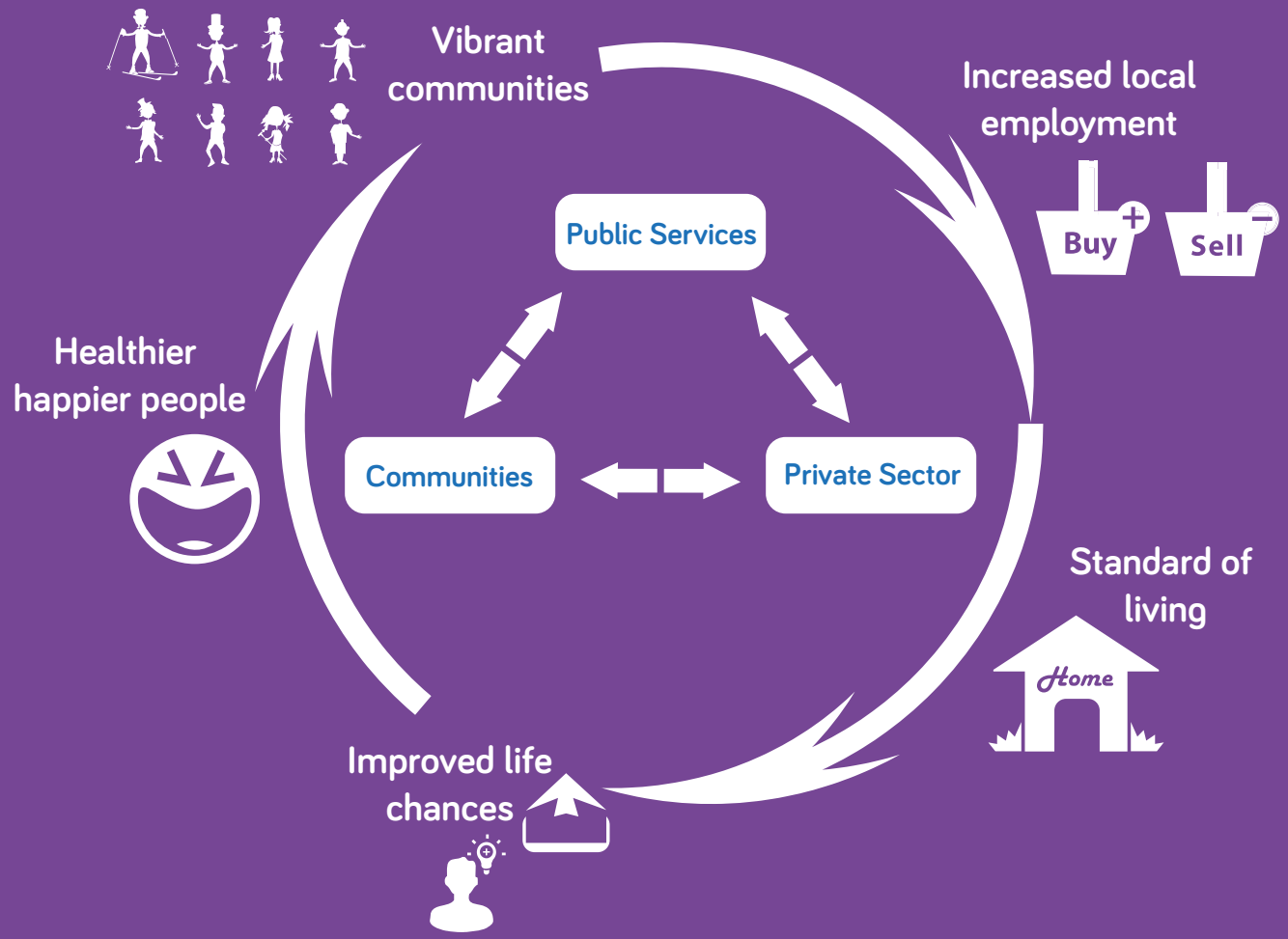
Your local integrated adult care arrangements

Since 2007, the council and NHS have been working together to ensure a more co-ordinated approach to health and social care. Your local Council and your local Clinical Commissioning Group (CCG) (who have responsibility for arranging health services) have joined together their funding for health and adult social care. The CCG takes the lead in commissioning local companies and organisations who in turn provide and deliver care to people either in their own homes or in other settings.

What is commissioning?

Commissioning is the process in which we describe, plan, secure, fund and monitor our local care services. The process is led by local GP's who have been appointed to ensure we are commissioning the right services for local people. You might be familiar with all or some of the organisations who provide care locally, whether they be community nursing providers, mental health care providers, home care providers or residential care providers. They may be in the public sector, the private sector or maybe social enterprises or voluntary organisations. All these organisations have been "commissioned" to provide the adult care services they offer by the local CCG.

For more information please see the 'Your local services' section.




THE PIER
THE PAVILION CLUB

What is a Local Account

What is a local account?

The local account was introduced by the Government and is a document about social care in North East Lincolnshire. It provides an opportunity for us to tell local people about how services are performing, what we have spent and how we are delivering value for money, and whether our future plans make sense to you.

We provide details of our priorities for the future, success and challenges that lie ahead. This is our fourth local account and ultimately it provides a means for the community to hold the council and CCG to account.

What people said (about previous local account) / what we did

Last year we received feedback on the local account and these are some of the things we were told:

- Format very strong
- Graphics good
- Useful involvement of health perspective
- Bright colourful pages with superb photographs of the area
- Liked seeing the photographs of the teams instead of faceless departments
- Good understanding of integration between health and social care
- Like the layout and how displayed on how the money was spent
- East to read and jargon free
- Appears balanced. Gives evidence how each department works and gives positive and negative stories
- No mention of the Care Act
- More thought on the voice of the citizen
- More information on the wider social care market
- An explanation of personalisation
- Certain sections could be more concise, which would make them stronger

We have listened to this feedback and have improved by:

- Introducing easy read information, graphic style and electronic interactive format
- Reducing further, and including pictures
- Reducing the length of text and more concise
- Reducing the number of sections to 6 with an electronic structure
- Introducing a new style and a themed approach to make it more eye catching
- Including a new section about our local providers & legislation changes
- Including more information about how we develop with citizens

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Cleethorpes
AIRSHOW

Your local services

How services are commissioned

How does the CCG commission services, how do they know what is needed?

The CCG works closely with colleagues in the health and social care system to understand what the care needs of the population are at present and what they are likely to be in the short, medium and long term. The CCG gathers as much information as possible from a wide range of sources in order to make the best decisions when it comes to allocating resources to ensure care services are available. The CCG have embedded members of the community into the decision making process through the membership organisation called ACCORD.

- www.nelccg-accord.co.uk

Within the CCG, a number of care specific "triangles" have been created to ensure that each commissioning decision is formulated with input from a GP and from a community member. This way the CCG can be assured that clinical and community considerations have been taken into account.

What kind of services are commissioned and planned in this way?

Your local GPs, supported by professional commissioners and community members have responsibility for formulating commissioning plans that cover the following areas;

- Residential & Nursing care homes
- Domiciliary care (Home Care)
- Extra Care Housing
- Supported Living Services
- Transport Services
- Mental health Services
- Intermediate care services
- Community health services
- Befriending Services
- Support and Advocacy
- Single point of access

In North East Lincolnshire we also commission social work from a relatively new organisation called focus – independent social work. We did this to ensure that our social workers had the freedom to organise themselves in ways that best meet the needs of the local population.

focus independent adult social work

focus community interest company (CIC) was the first independent adult social work practice in the country and provides all of the statutory social work functions across North East Lincolnshire, these include:

- Assessment and review
- Long-term case management
- Safeguarding and
- Mental Capacity Act & Deprivation of Liberty Safeguards

Working in partnership, with the CCG, GPs and health providers, focus operates an integrated approach to service delivery, including:

- A health and social care single point of access
- A continuing health care assessment and review service, and
- Making arrangements for care to be provided to individuals

focus operates within the local community, focus looks at what support the individual can access within the community and focuses on their abilities, rather than their disabilities, aiming to promote independence and wellbeing.

For more details about focus independent adult social work visit our website at **www.focusadultsocialwork.co.uk** or telephone **01472 256 256.**

Care Plus Group

Care Plus is a social business that provides community health and care services for adults of all ages and exists to support people to achieve their best quality of life.

Established as a Community Benefit Society in 2011, we are owned by our staff and run for the benefit of our community – any profit we make is reinvested back into the development and delivery of services ensuring we can constantly evolve and develop the services we offer to our communities. We employ approximately 800 members of staff.

Care Plus Group provides services right across the communities of North East Lincolnshire, covering Grimsby, Cleethorpes, Immingham and the surrounding villages. Our services are diverse and are entirely about care and supporting those who have health and care needs in our community.

Care4all, part of the Care Plus 'family' or organisations, is a local charity that provides a wide range of services for older people and people with disabilities living in North East Lincolnshire.

Our services include:

- Community Nursing
- Rapid Response
- GP Out of Hours call handling
- 24 hour triage service
- Discharge team
- Specialist Nursing
- Rehabilitation and Re-ablement/Nursing and residential care
- Palliative and End of Life Care Services
- Intermediate Care at Home and Crisis Response
- Community Learning Disability Services
- Intensive Support Team
- Community Occupational Therapists
- Substance Misuse Services in partnership
- Falls and Chronic Obstructive Pulmonary Disease (COPD)
- Health and Wellbeing Collaboratives
- Employability Services
- Training
- IT services
- Transport

During 2014-15, Care Plus Group received some excellent feedback from both our staff and the people who use our services. On the NHS Friends and Family test we have seen improvement in the number of staff who would recommend us as an employer from 62.69% to 79.76%. Equally, on the question of whether staff would recommend us as a provider of care to their friends and family, we saw an impressive positive response of 94.53%. We were successful in the revalidation of both our ISO 9001 and ISO 27001 last year with our End of Life Services (Macmillan and Haven Team) added to our portfolio of services with ISO 9001 accreditation.

For more details about Care Plus Group visit our website at **www.careplusgroup.org** or telephone **01472 266999.**

NAViGO

NAViGO Health and Social Care is an award winning social enterprise that provides mental health and associated services to the NHS and beyond. Our state of the art facilities offer support to those requiring acute in patient treatment right through to those requiring help and support from our more specialist services such as eating disorder, Improving Access to Psychological Therapies and forensic services.

NAViGO is an employee owned business with its membership at the heart of its operations. The organisation values the involvement of its members and service users and ensures that their unique perspective is fostered through inclusion in organisational and membership activities.

We are truly unique in that we have a voting membership giving service users/ carers equal rights to staff. We are 'owned' by our members (both staff/community) and unlike private healthcare providers', we do not make a profit. Any money that is saved through working more efficiently is reinvested back in to local services for local people: the money stays within the NHS.

Here at NAViGO our mission is to provide services that we would be happy for our own families to use and on that basis we strive to continually develop quality services and innovation through consultation with the people who know our services best, our service users, carers and employees.

For more details about NAViGO visit our website at **www.navigocare.co.uk** or telephone **01472 583000.**

Case Study

J.M is a 67 year old retired lady who has a diagnosis of Chronic Obstructive Pulmonary Disease, Cardiac problems and has recently experienced two Trans- Ischaemic Attacks. At assessment J was feeling low in mood and unmotivated, she was constantly anxious, worried and on edge and had the feeling that "Something awful will happen" her confidence was low and she was avoiding socialising. J had also avoided driving to new places. Her concentration was poor and she was not engaging in pleasurable activities within the home.

J found it difficult to relax and felt "Guilty" when resting, She had thoughts of "I should be doing something" as a result of these thoughts J developed various checking behaviours, she would constantly check her doors were locked, her bedrooms tidy, lights were off, the kitchen floor for crumbs and carpets for bits. She would also walk around the garden picking up leaves and checking that outer doors and gates were locked. J was constantly exhausted and due to not pacing herself was becoming more breathless.

At discharge J's checking behaviours have extensively reduced, she has joined a local community centre and is engaging in activities and made friends. J is less worried, resting more, she is also engaging in pleasurable activities within the home and more confident when driving.

Residential and Nursing Care

Residential care offers long-term care and respite in residential care settings. In North East Lincolnshire there are 36 residential care homes for older people, four residential care homes for people with mental health care needs and three residential care homes that specialise in care for people with a learning disability.

Unique integrated commissioning arrangements mean that residential care providers are seen as equal partners in the provision of health and social care to the community of North East Lincolnshire. Furthermore, the CCG, focus and Care Plus Group continually work with providers to improve knowledge and deliver best practice in care settings. This includes initiatives such as the Long-term Care Provider meetings which are provided to improve provider knowledge.

With the aim of continually driving improvements in the quality of care for older people, the Clinical Commissioning Group has developed a method of assessing and rating care homes; the Quality Framework. This allows us to pass on information to people in North East Lincolnshire about the relative quality of care on offer.

As a result of the Quality Framework Process across residential care for older people in 2014-15, four care homes achieved Gold standard, twelve care homes achieved Silver standard and twelve care homes achieved the Bronze standard. The care homes and their awards can be found on the Services4Me website.

Care at home (domiciliary care)

Care at Home providers deliver a range of personal and support care services to individuals in their own homes. As existing contracts were coming to an end the CCG took the opportunity to review the local "Care at Home" arrangements to ensure a responsive person-centred service could be sustained.

During 2015, we will be transitioning from the old "Care at Home" model to the new arrangements. Current arrangements are that providers operate in a geographical area based on the wards and neighbourhood areas of North East Lincolnshire. In contrast, the new arrangements mean that the geographical areas will be based on service user population and three 'Lead' providers will deliver care in more equally attributable areas going forward.

We are currently commissioning nearly 10,000 hours of care each week from our providers and the CCG and its partners are constantly monitoring the relative quality of care. We work with providers to ensure it is as flexible and person-centred as possible.

Extra Care Housing

Major strides were made during the year on the development of Extra Care Housing in NEL, in line with the CCG's ECH strategy. The most noticeable sign of progress was the construction work on Strand Court, the ECH scheme off Albion Street in East Marsh, which will offer 60 flats for frail elderly people needing care and support, when it opens in July 2015. The four storey building really started to take shape in 2014, following site and foundation works in 2013. It is being developed by Ashley House plc under a joint venture with the CCG and will be leased and run by Inclusion Housing CIC, who will act as landlord to the tenants. Progress was also made on the planning and design of further schemes, with planning applications being approved for similar schemes at Winchester Avenue (Nunsthorpe) and Pelham Road (Cleethorpes). These schemes are now designed and the sites are being acquired by Ashley House, ready for a start on site in the near future.

Providing these purpose-built schemes is an important part of the CCG's strategy for changing the care we can provide for our older people, but this will only really work if we have a process in place to ensure the most appropriate people take up places in the schemes and that they are properly prepared and supported in their moves into the new accommodation. In 2014, the CCG invited Focus to support the allocation process, through the employment of an ECH Coordinator post to lead work on the assessment of individual applicants and the allocation of places.

Sarah Moody was appointed to this post in February and has since been working closely with Inclusion Housing, LQCS (the CCG's contracted home care provider) and Focus case management colleagues to assess applicants in relation to the agreed criteria. Sarah and the team then submit cases for consideration by a panel led by the CCG, which agrees nominations to the housing provider (Inclusion Housing), based on agreed criteria. This process was in its early stages by the end of March, the start of an intensive piece of work leading up to the opening of Strand Court in July. We will say more about that next year, but the early indications were that there was plenty of demand for the places, with a high level of needs identified in the applications.

Healthwatch

Healthwatch North East Lincolnshire is a local organisation that works to give residents of North East Lincolnshire a say about the health and social care services they use. Healthwatch does this by collecting patient experiences and working with providers and commissioners to make sure that services are developed and improved based on community and patient needs.

Once a resident shares their experience with us it is immediately logged on our database where we look for themes and patterns to help us work with providers to spread best practice and to tackle common or severe problems. We do this through our unique statutory powers which dictate that NHS providers must respond to our requests for information and our recommendations.

As well as working with providers and commissioners, Healthwatch North East Lincolnshire also operates a Partner Programme in which we aim to engage with voluntary organisations and recognize their contribution to giving residents a voice on health and social care services.

Healthwatch North East Lincolnshire also acts as a signposting organisation, helping residents find the health or social care services they need when they need them.

As part of our role in shaping local health and social care, we have a place on the local Adult Safeguarding Board as well as a statutory place on the Health and Wellbeing Board, making Healthwatch well-placed to influence commissioners and providers based on the experiences patients share with us.

Healthwatch also includes the Independent Complaints Advocacy service, which helps patients through the process of formally complaining about a health and social care service. This partnership gives us a well-rounded picture of patient opinion of health and social care services in North East Lincolnshire.

We are part of Healthwatch England, an organisation which speaks for patients on a national level based on the findings of local Healthwatch. This gives us the ability to escalate issues to national bodies when appropriate.

If you would like more information, you can visit:

www.healthwatchnortheastlincolnshire.co.uk or call 01472 361 459.

Michael Bateson

Chair of Healthwatch North East Lincolnshire

One of the tools available to Healthwatch North East Lincolnshire is Enter and View, which allows our volunteers to visit services and collect the views of service users, carers, and relatives. These visits aim to provide an informed view of the quality and scope of services, and they inform evidence-based reports which often include recommendations for how the services can improve.

Over the past year our Enter and View programme has been shaped by our partnership with the North East Lincolnshire CCG, and we have agreed to focus on maintaining the dignity and respect of care home residents. During this time we have completed 12 Enter and View visits.

How your money was spent

Where the money is spent

'Within North East Lincolnshire there are three main independent social enterprises providing community health and social work services.

North East Lincolnshire Council (NELC) funds a wide range of local services as well as adult social care, including children and education, housing, highways and environmental, planning and cultural services.

It receives income from Council Tax, rates, Central Government support (including education) and other grants, totalling £130.6M in 2014/15.

Of this sum, £47.9M was allocated to adult social care to support the service objectives outlined within this Local Account.
During 2014-15 four thousand and five hundred people with a variety of needs received adult social care services in NEL. This includes services based in the community such as care at home, direct payments, supported living and day care, as well as residential care.

Key facts

£47.9M was allocated to adult social care to support the service objectives outlined within this Local Account.

During 2014-15 four thousand and five hundred people with a variety of needs received adult social care services in NEL.

The graphs below show how this spend is shared between people with different needs and what services it pays for:

Overall spend

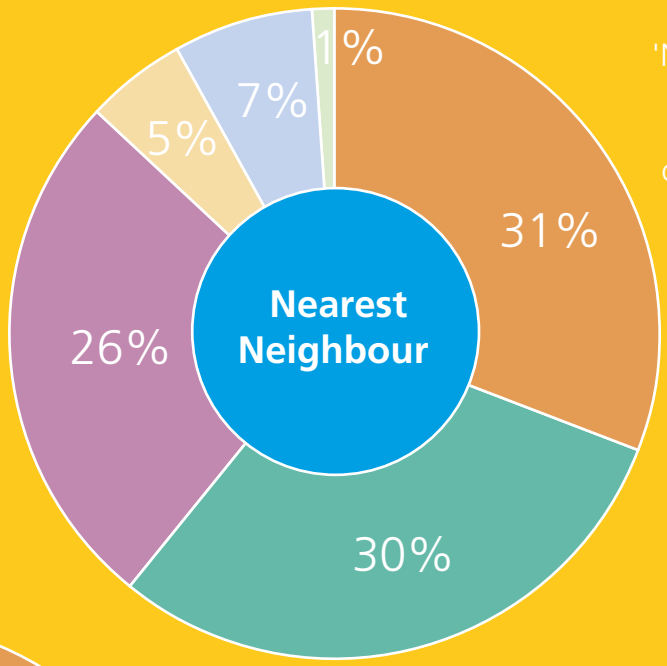
- Physical support **39%**
- Learning Disability & sensory support **28%**
- Service delivery & other Social Care support **13%**
- Mental Health needs **7%**
- Social care activities **7%**
- Information & early intervention **5%**
- Support with memory & cognition **1%**
- Support for carers **1%**

Breakdown of strategic spend

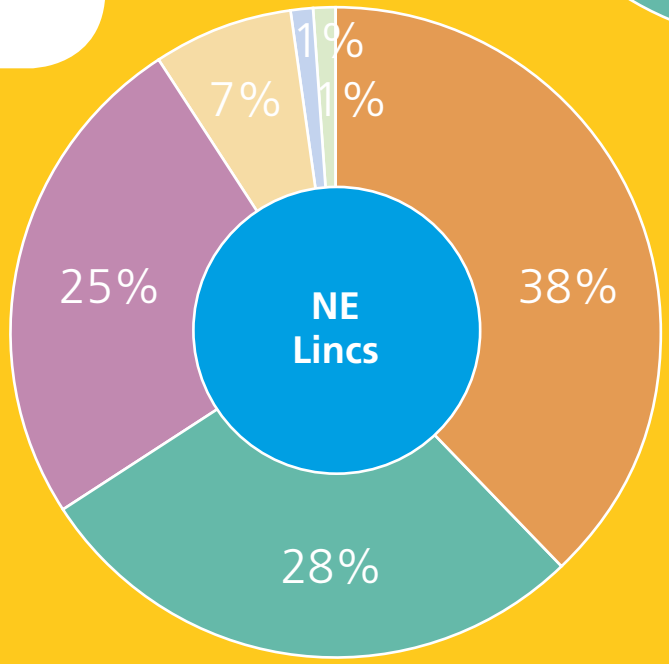
- Long and Short term Residential support **28%**
- Domiciliary and Day Care **13%**
- Direct Payments **7%**
- Supported living **15%**
- Other Community services **7%**
- Development & Service Delivery **15%**
- Social Work Activities **7%**
- Universal Services **8%**

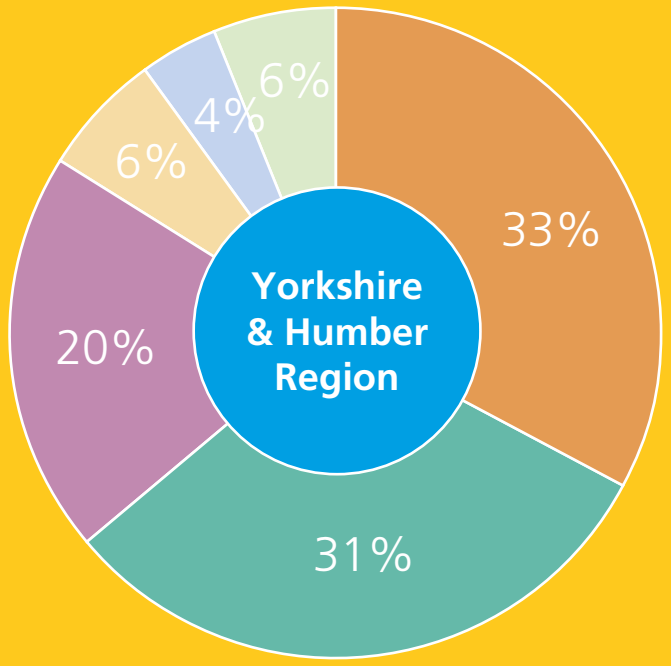
Spend patterns compared locally and nationally

- Physical Support
- Learning Disability Support
- Information, Carers and other Social Care support
- Mental Health Support
- Support with memory & Cognition
- Sensory & Support



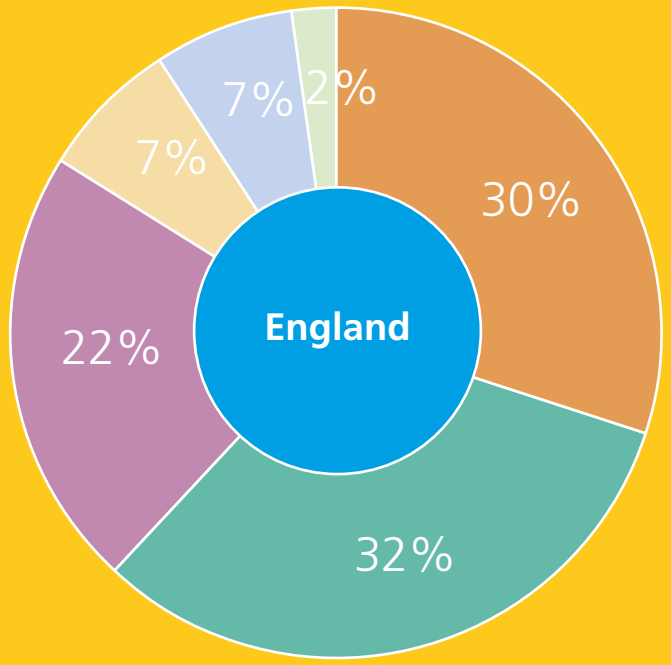
'Nearest Neighbour' - 'Is defined as a specific group of other organisations identified that is similar in terms of population and demographics etc. Not geographical.





The charts on this page show if the spread of spend in North East Lincolnshire is different or the same to that of other Local Authorities similar to us in terms of size and nature, regionally and nationally. Overall North East Lincolnshire shares a similar spread of spend to most other Local Authorities, although it is shown to spend less than others on Adults with learning disabilities and more on Adults with Physical needs.

These charts represent spread of spend, how well this money is used and is shown throughout the Local Account, which shows the performance for different aspects of care and how people feel about the services they receive; e.g. 92.3% positive response, proportion of people using services who say that those services have made them feel safe and secure.



Income from people who've been supported

For North East Lincolnshire Council to deliver the full range of planned services for all people in our area with eligible social care needs, it relies on service users contributing towards the cost of their care, where possible.

The aim of the Income policy in North East Lincolnshire is to be a consistent and fair framework for all service users that receive care and support services.

Charges will only be levied against those who are deemed able to afford it, following a financial assessment which takes into account individual financial circumstances. Levying charges against those who can afford it contributes to the continued funding of adult care and support services within our local area.

The graph on the next pages shows how the total income paid by service users with different needs supports the services they receive

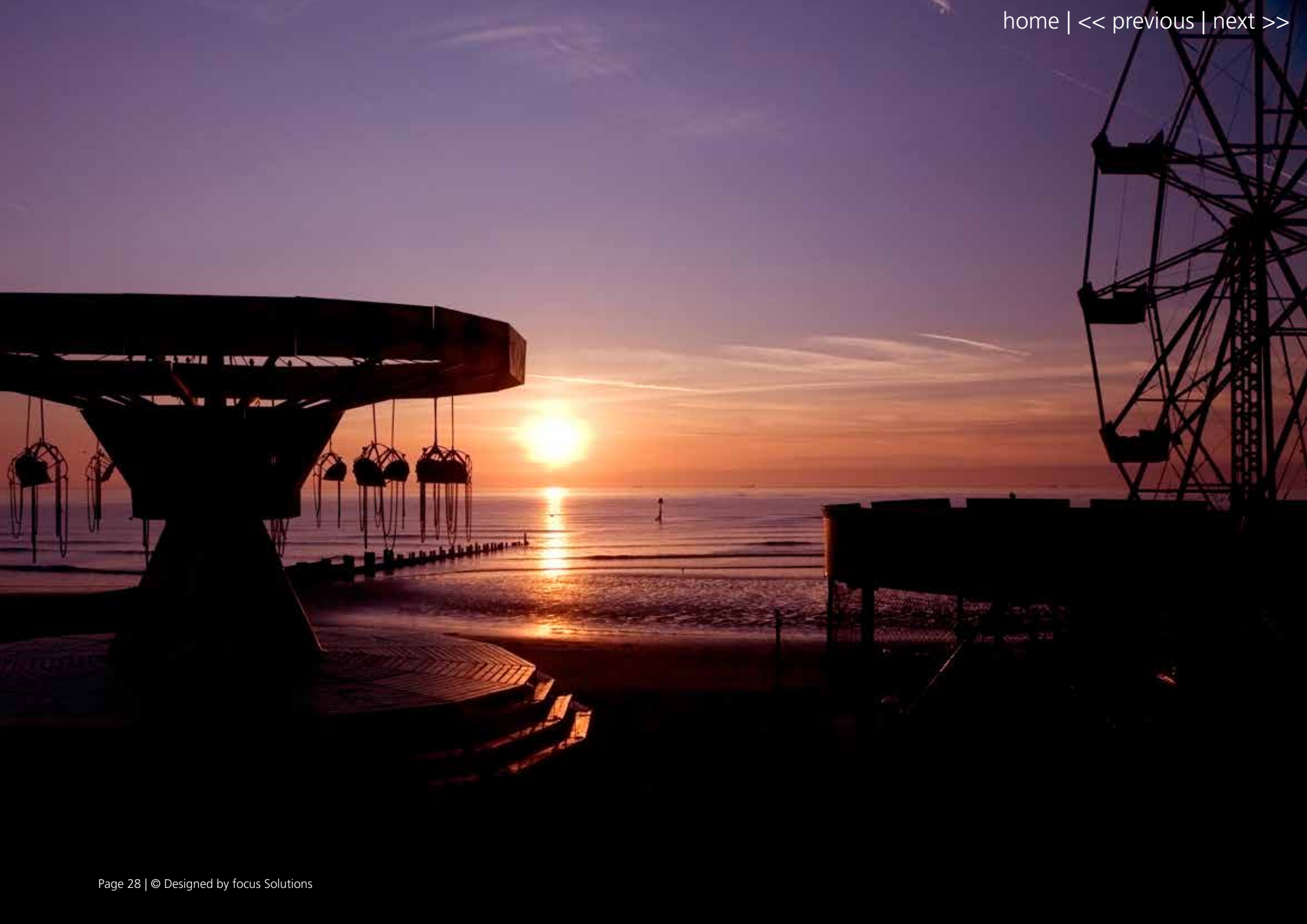
Key facts

£8m of income was due to be paid by service users to support services provided to them during 2014/15. Of that income nearly £900k remained unpaid at the end of the year.

Any Income which is not paid means there is less money to support people with their care and support needs, and the variety and amount of services available for people may be reduced. Therefore we do and will continue to take appropriate Legal steps to recover all money due.

Income due from service users:

- Physical support **85%**
- Learning Disability & sensory support **11%**
- Mental Health needs **3%**
- Support with memory & cognition **1%**



How are we working together to improve your Health & Wellbeing

Single Point of Access

In 2013 the Single Point of Access (SPA) commenced its expansion plans, co-locating the whole of the A3 team (responsible for demand management for Adult Social Care statutory support)

This enabled call handling, screening and multi disciplinary triage to be physically co-located within Kent St Resource Centre, alongside Care Plus Group unscheduled care teams. The whole process involved a huge amount of commitment and hard work for all of the teams now within the SPA, however the extra effort required from the A3 team, who were also required to move buildings needs to be acknowledged.

Benefits of co-location have been realised, particularly the development of relationships with the Intermediate Tier at Home Team and Short Term Case Management. Both teams have a shared responsibility for the same cohort of individuals requiring short term enablement. Individuals are receiving a better co-ordinated approach to their care and support.

The SPA team of Integrated Advice Officers and A3 Assessors provide the 24/7 telephone access team for Adult Social Care, they are a high achieving team, effectively managing at least 75% of all calls into Adult Social Care. Their resources have been expanded by the use of WebV an online bed management and monitoring system utilised by North Lincs and Goole Hospitals and Care Plus Group unscheduled care teams. Along with more easily accessible professional advice and the ability to smoothly transfer calls requiring a more complex response.

During early 2015, there are plans for Navigo to co-locate into the SPA for adults (under 65yrs old) within the health and social care SPA, initially for weekdays, with a view to extending. This will further enhance the skill set within the SPA.

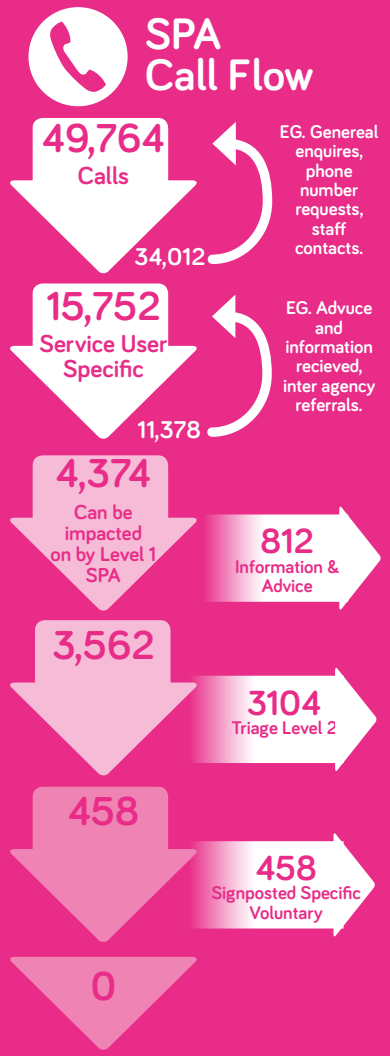
Future plans include the introduction of primary care in the form of a GP.

Case Study

During my night shift, I took a call from an elderly gentleman whose wife has recently gone into residential care. He rang to say he was experiencing a panic attack so I put him through to a GP Out of Hours Senior Nurse (GPOOH). After a while on the call, we realised he really just wanted reassuring. He explained his worse times was through the night as he wasn't sleeping. He said he felt lonely and missed his wife.

I remembered Sanctuary, so called them while he was still speaking to GPOOH. It was explained to me there is always 2 people on shift at the Sanctuary (open Door) from 8pm until 7am. When I explained who we had on the telephone they said they would gladly talk to him. I intervened with the call and asked him if he would like to ring the Sanctuary. The gentleman felt uncomfortable with this so I arranged with Sanctuary for them to call him back once our call had ended.

Later we called Sanctuary for feedback. They had arranged for a taxi to be sent and paid for to the gentleman's home to collect him and take him to open door. He had a cup of tea, by this time it was 2am, while having a right old laugh with them about the good old days with his wife and he felt so much better. Sanctuary have arranged with him to go on their list for a call every single night for as long as he wanted. He can go in to them for a face to face chat anytime he wants and is aware of this. Sanctuary have advised we can refer anybody of this nature to them anytime we feel it appropriate. They said this service is felxible when deemed appropriate.



Performance Summary

The Council (along with others nationally) is responsible for reporting on a national framework which is set out by central government. The framework is called ASCOF (Adult Social Care Outcomes Framework). All councils submit the same set of data each year which can then be compared on a national level.

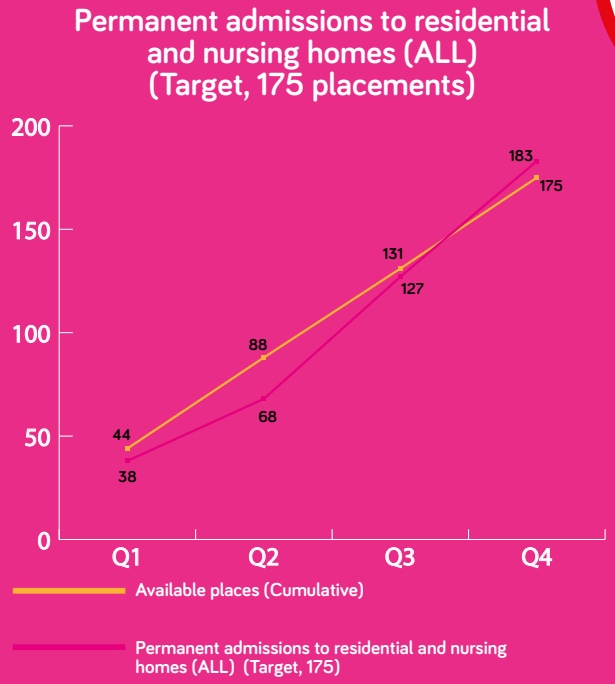
Throughout this document you will see graphical bubbles like the ones below where performance data relates to each section, displaying performance data relating to each section with the target also shown. You can also find out more, and view North East Lincolnshire's performance online using the link below, a copy can also be found within the appendices;

- http://ascof.hscic.gov.uk

In 2014-15 North East Lincolnshire, on a national comparison, has achieved 'Top Quartile' for some of these measures. This means on a national level we are performing above average overall and are amongst the top performing providers of statutory Adult Social Care. Some of these measures are displayed below;

For some measures we did not do so well, and work has been undertaken to explore the reasons behind this and to take action and plan work to increase performance for 2015-16. The two main areas to focus on relating to social care, is reducing permanent admission into residential care and ensuring everyone in receipt of a service recieves a review.

Please see the glossary for further guidance on the performance measures.



Meeting Public Demand and Community Development

The introduction of the Care Act 2014 has further driven the development of preventive and wellbeing services. These services are intended to support the development of communities, enabling them to be independent and meet the needs of its residents. Community development is a critical component of managing demand.

Work has continued to:

- Link in with key stakeholders in order to deliver better prevention activity
- Promote self-management, keeping people independent
- Care navigation, ensuring people know what is available in the community and how to access it
- Use of alternatives, for example community or voluntary services
- Provision of high quality advice and information 24/7
- Be accessible and easy to contact
- The application of the priorities framework at frequent intervals
- Control of access to resources via the single point of access
- Undertake specific projects in relation to data collection for the CCG
- Develop individual staff projects

Data obtained from these activities feeds into the decision making for Adult Social Care commissioning of community services, via two commissioning boards. This enables the better targeting of resources, along with improved community and individual outcomes. Examples of this would be the commissioning of The British Red Cross, supporting hundreds of individuals to recover from a crisis or period of ill health, collaborative working with charities such as the Lindsey Blind Association and enhancing the scope of support available at the new Assisted Living Centre.

Continuing Healthcare (CHC)

The Continuing Healthcare (CHC) team are a direct responsibility of North East Lincolnshires Clinical Commissioning Group and is hosted by focus. The team co-located with focus at Heritage House early 2015. Lines of management have been developed to facilitate a co-ordinated, integrated approach across both health and social care. The team has expanded to include 7 qualified Nurse professionals undertaking assessment and review function for all adults over 18 years old with a GP within North East Lincolnshire's with a primary health need.

Referrals into the team usually start with the receipt of a CHC checklist. Any adult with care and support needs which are beyond the scope of adult social care and/or of services able to be provided by community nursing teams and GP's are able to request a CHC checklist – individuals should ask their involved health or social care practitioner. CHC funding can be partial or full care cost and fixed contributions known as a funded nursing contribution.

Funding can either be commissioned directly from a range of providers or delivered in the form of a Personal Health Budget (PHB). A PHB enables individuals to be in control of who delivers their care. There is recognition that many people prefer to employ someone that they know to deliver their care, a PHB facilitates this. There are rules which apply to the use of a PHB

The team also undertake retrospective assessments for individuals who consider they have incurred financial cost to meet needs as described above since April 2013

All retrospective claims have been referred to a third party, the Yorkshire and Humber CSU for completion within the national government timescale by April 2017.

The team benefits from a wide range of experience and skill and since forming in late 2014 they have established themselves effectively and achieved excellent performance standards.

Plans for later in 2015 include transferring records and case management functions onto the shared health and social care data base – SystmOne.

Carers

Caring for our Carers – North East Lincolnshire (NEL)

We recognise that carers are the lynchpin to care in our communities. Without them we would not be able to meet the needs of our most vulnerable people. Our shared vision is to ensure that carers are recognised, valued and supported as individuals with a right to a life outside of caring. Any work to support local carers automatically involves carers, local communities, organisations and agencies and is coordinated via the NEL Carers' Strategy Group and annual action plan. Achievements in the last year include:

Integration of North East Lincolnshire's Carers' Support Services (CSS) into the Care Community

The NEL CSS promote, supports and improves the mental, physical and emotional well-being of all NEL carers so carers can continue in their caring role, look after their own health and wellbeing and have a life of their own (i.e. opportunities for work/ training/education/leisure/social interaction). The Service has registered 1,750 carers since opening on 1st April 2014. Services include specialist advice and information, benefits advice and checks, advocacy support, befriending, support groups, counselling, social activities, holistic therapies and carer training. Carers are actively involved in the operation of the Service via the Carers Forum and community consultations; the Carers' Forum Chair sits on all contract monitoring meetings.

Key facts

- 1164 people made contact with
- 1102 Outreach bus contacts
- 81 GP drop in clinics continued
- 37 LGBT (Pride)

Case Study

"Lisa kept me going through my darkest moments and stopped me from committing suicide – I used to go into the centre in tears and when I left I felt the sun was shining and I felt more hopeful…Throughout everything Lisa was fantastic and congruent".

Mrs A. Austin

"Counselling has really helped me to accept myself and look at things differently… talking to someone who would listen to me has meant I didn't have to go on antidepressants. I am coping better now and feel I have been given the tools to cope if that sounds right. I feel stronger in myself. Also, because I am not as stressed my blood pressure has gone down. SO all in all it must have worked and has been a great help."

Mrs I. Smith

Identifying Hidden Carers through Engagement with the Local Community

A carer animation DVD was produced, with NEL carer input, as part of the local commitment to reaching carers across diverse mediums. Carers helped write the script, design the animation and narrate the final work; the DVD has been regionally acclaimed.

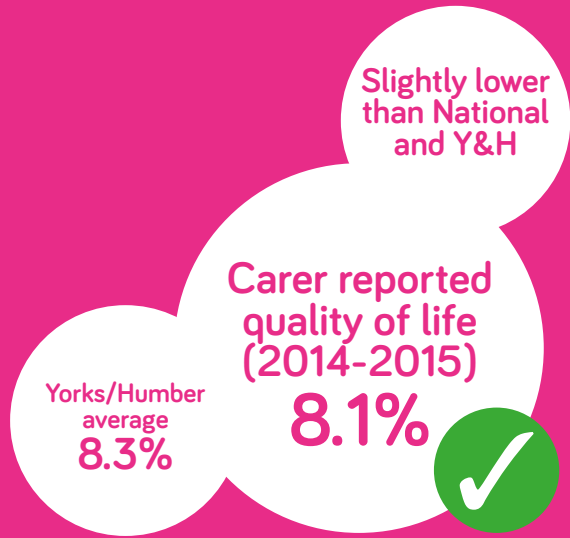
Focus, along with Carers' Strategy Group partners, ran a mobile bus community outreach campaign throughout 2014-15, in order to highlight the valuable input unpaid carers make to our communities and to promote awareness of the importance of maintaining carers' health/wellbeing. A range of professionals ensured that services locally were promoted and the various bus locations ensured easy access to advice and information. Carers' drop in advice and information sessions were also delivered throughout 2014/2015 within a number of GP surgeries across NEL.

Carers Health Checks

Carer health checks were trialled with participating GP surgeries (September 2014 to March 2015). These health checks pulled together social and wellbeing aspects specific to carers, as well as relevant medical questions from the standard health check. The trial explored the potential benefits of these checks to prevention/early diagnosis of medical issues or social/emotional pressures on carers. A review will take place to determine future plans for Carers Health Checks.

Identifying and assessing carers' needs

Significant work has been undertaken to ensure that carers, where appropriate, are involved in the care and support planning of the person they care for, are encouraged to have an assessment of their own needs and are included in the process as an expert care partner.



Social Work

Part of focus' core business is providing assessments to people in the community who may need help with their day to day health and social care need; in 2014-15 focus undertook 3532 full care assessments (33% increase from previous year) and 1356 financial assessments.

Care assessments were undertaken to determine the level of need and financial assessments to identify the contribution a person may be asked to make.

The change from Care to Case Management has continued for the long term case management teams and to assist this, the "Connect Programme" has been launched. This is based on solution focused practice and the emphasis is to have conversations with people rather than just filling in the forms. The programme is being run by a former social worker and a psychologist who have worked with a small group of practitioners to test the theories, carry out observations of practice and facilitate group discussions. The reason focus believes this is so important, is because of how effective it has been for the single point of access, and enabling staff who take the calls to work with individuals to empower them.

To date one group has undertaken this programme with some powerful results and all involved feel they are carrying out more traditional social work rather than being a slave to a process.

This bodes well with the forthcoming implementation of The Care Act 2014 which has social work values as its heart and firmly places the service user central to practice. A case study with an example of some results has been provided.

The Carers Team

North East Lincolnshire has a designated carers lead within the CCG. The carers lead, with assistance from the carers team (which is part of focus independent adult social work), is responsible for the overall implementation of the North East Lincolnshire carers' strategy and action plan. The team work closely with carers, carers' representatives and other professionals across statutory and voluntary organisations and agencies to support the effective development, implementation, delivery and monitoring of carers' support and services locally. As a priority for the coming year, focus has identified the need to increase the number of review assessments that are undertaken. This is to ensure the family's needs are identified and supported holistically. More information around carers can be found above in the carers section.

The Heritage House project was started in January 2014, when it was discovered that the lease on Olympia House was due for renewal in July 2014 and that the rent costs were much higher than on other similar properties in the area. This gave us the opportunity to find a more preferable and accessible location whilst saving money. We formally moved to the new building opposite the Fishing Heritage Centre in January 2015.

Key facts

- 3532 people received a full care assessment (33% increase from 2013-14)
- 1566 people received a review
- 1356 people received a financial assessment

Safeguarding

2014/15 has been an interesting year for Safeguarding Adults, and it has seen Safeguarding Adults embedded in legislation for the first time following the implementation of the Care Act 2014 on the 01 April 2015.

The Safeguarding Adults Board (SAB) has ensured that it is prepared for compliance to the Act by:

- Appointing an Independent Chair to the SAB, and gaining on-going commitment from the 3 statutory partners; Health, Council, and Police
- Developing a process for conducting Safeguarding Adults Reviews (SARs) [formerly known as Serious Case Reviews] – and the establishment of a SAR panel that meet to discuss any cases that have been referred for consideration
- Making sure that local safeguarding systems are in place to undertake statutory enquiries in line with Section 42 of the Care Act 2014

The SAB has also been working on delivering the outcomes in the 'Safeguarding Vision and Priorities Plan' which covers the focus of the SABs activities between 2014 – 2016. Some of the achievements that relate to the six key principles of all safeguarding work include:

'**Empowerment** - People being supported and encouraged to make their own decisions and informed consent'

North East Lincolnshire has continued to be involved in the national 'Making Safeguarding Programme' and is developing better ways of measuring to what extent people are achieving the outcomes that they wanted following a safeguarding action. The safeguarding team are also starting to measure how many people are using services such as advocacy to support them during safeguarding interventions.

'**Prevention** - It is better to take action before harm occurs'

The SAB have been making sure that agencies follow safer recruitment processes, and that they train their staff appropriately to deliver services safely and to a high standard.

'**Proportionality** - The least intrusive response appropriate to the risk presented'

The SAB has continued to use risk assessment tools as a guide for the level of responses needed in certain situations, giving a range of responses to safeguarding concerns. These span from advice only to full scale multi-agency investigation.

'**Protection** - Support and representation for those in greatest need'

The proportional approach (above) ensures that resources remain focused on those who may be most at risk. The SAB have made sure that raising a concern is easy, and during 2014/15 every household in NEL received information about how to report a safeguarding issue; this can be done 24 hours a day, 7 days per week.

'**Partnership** - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse'

The SAB recognises everyone's contribution to safeguarding adults, and is making sure that everyone throughout NEL knows how and when to share information and/or take action. It is a statutory duty on all local services as part of their on-going commitment to the SAB to share relevant information to safeguard the individuals that they work with, and for members of the public to alert agencies if they have concerns.

'**Accountability** - Accountability and transparency in safeguarding practice'

The SAB has amended their reporting processes to reflect the requirements of the Care Act and other statutory returns. The performance report also includes information from partner agencies to demonstrate their activity and contribution to the system. The SAB are now feeling more confident that the reports that are produced are helping to inform progress against the vision and priorities and better reflect activity of the whole system.

The SAB annual report is a public document and can be viewed by visiting http://goo.gl/YM2aot

Mental Capacity Act (MCA) and MCA Deprivation of Liberty Safeguards (MCADoLS)

2014/15 has been a challenging year for the Mental Capacity Act/Deprivation of Liberty Safeguards (2007) (MCA/DoLS) system on a national scale. In March 2014 the Supreme Court passed a judgement (often referred to as the 'Cheshire West Judgement') which meant that a lot more people became eligible for an assessment under the DoLS legislation. The DoLS legislation requires the Local Authority (the Supervisory Body) to undertake a number of assessments to ensure that when a person who lacks capacity is receiving care or treatment in a hospital or care home, and they are 'not free to leave' and are 'under constant supervision and control' by the care provider (Managing Authority); then this must be done only when it is in the person's best interests and where it has been properly authorised by the Supervisory Body.

The impact of the Cheshire West Judgement has been that the referral rate for DoLS Authorisations within North East Lincolnshire has jumped from about 30 applications per year – to 880 applications having been received between 01.04.14 – 31.03.15.

To respond to the increase in demand, North East Lincolnshire Safeguarding Adults Board has taken a number of steps:

- More Best Interest Assessors (BIAs) have been trained, and a number of 'independent' BIAs have been recruited.
- A Quality Panel has been established to make sure that all of the assessments completed are of a consistently high standard
- All of the applications for DoLS authorisations are triaged and prioritised to make sure that those of highest risk are dealt with first
- A dedicated business team has been recruited to process the applications and make sure that they are actioned appropriately

There is a national recognition that local authorities are not able to process all of the applications that they receive, and the government have announced that they will be revising the DoLS process before the end of 2016. However, until any change in process is implemented, North East Lincolnshire are responding to the applications that they receive in line with best practice and Association of Directors of Adults Social Services (ADASS) guidance. We are continuing to work hard to ensure that best practice guidelines are followed.

The MCA/DoLS team reports local activity to the Safeguarding Adults Board (SAB) and the SAB annual report contains can be viewed by visiting http://goo.gl/YM2aot

Key facts

- 598 Safeguarding allegations were referred to the team
- 151 of these had a full investigation
- 44 % of these were partially or fully substantiated
- 881 applications were received under the MCADoLS

Better than last year. Above regional average

Yorks/Humber average 81.6%

Proportion of people using services who say that those services have made them feel safe and secure

92.3%

Better than last year. Below regional average

Yorks/Humber average 67.9%

Proportion of people using services who feel safe

65.7%

Intermediate Care

What is Intermediate Care?

The Care Act 2014 identifies intermediate care and reablement support services as services that can delay or prevent the need for more intensive support services. It consists of a range of integrated services that can be offered on a short term basis to promote faster recovery from illness; prevent unnecessary acute hospital admission; prevent premature admission to long-term residential care; support timely discharge from hospital and maximise independent living.

Intermediate care, part of the Care Plus Group, aims to offer care and support services to citizens to enable them to maintain or regain the ability to live independently in their own home or avoid premature admission to residential care. It is a time limited intervention. The support provided should depend on individual needs and the outcomes the support seeks to achieve. Intermediate care should be seen as a stage in overall care, not simply an isolated service.

In 2014/2015 the integrated Rapid Response service (part of Care Plus Group's Intermediate Tier services) received over 7300 referrals, many of these calls were from citizens and their family/carers experiencing a crisis at home. The professionals within the Rapid Response team visited to deal with immediate needs and where required referred on to other services. Many of the Rapid visits prevented attendances to the A&E department and possible admission to hospital by providing the urgent response in the citizen's own home.

The Intermediate Care at Home team who provide personalised care in the citizen's own home and encourage independence received over 1100 requests for services. The Beacon, Care Plus Group's Residential rehabilitation service supported 175 citizens. The Beacon only operated from a bed base of 15 beds for a substantial part of the year but opened to full capacity of 27 beds in January 2015.

During the year some innovative new projects have been introduced to improve outcomes for people in receipt of Intermediate Tier services. Intermediate Care at Home staff have begun a project purchasing equipment that they can sell onto service users in order to enable them to get back to independence sooner. The staff had found that many service users were unaware of the different products that are on the market or they are unable to access the community to purchase them. The equipment will be sold at a small profit, enabling the purchase of larger equipment in the future if the scheme is successful.

The Beacon Community Connectors project began in February 2015 and aims to reduce social isolation of people staying at The Beacon who are returning home without any social support. The Health and Wellbeing Collaborative team members work with The Friends of the Beacon and Beacon staff to identify service users social needs, form friendships and buddy up with people who are at risk of being socially isolated. Team members then look at someone's needs and support them in gaining information and knowledge to attend an activity or club of their choice back in their own community and offer to escort them there for the first couple of visits.

As part of the project a 'Keep In Touch' card has been developed for people who have formed a friendship whilst at The Beacon to swop their details with each other, this enables patients to be in regular touch with each other by phone, once they have returned to their own home, reducing their social isolation.

Overall the North East Lincolnshire Clinical Commissioning Group remains a top quartile performer on the measure of how many people remain in their own home 3 months after discharge from hospital into a re-enablement/rehabilitation service – 92.86%.

Case Study

Mrs T is a service user who Intermediate Care at Home have been assisting with 4 calls daily. Mrs T has had a severe stroke, a life and death situation, she has also had complex health issues and had to follow a diet plan provided by a dietician because of swallowing problems. Mrs T had no intention to follow the plan so a risk assessment was completed. Intermediate Care at Home were there to assist Mrs T with personal care but she is now completing this task herself. Mrs T has now recovered with the help and support from Support workers within Intermediate Care at Home.

Mrs T lives with her Son who has learning disabilities. The son has always had support from his mother but roles have now reversed and the son has tried to support his mother. The reversed roles did not go well in the beginning and Safe guarding were informed but now the situation has calmed down both have come to terms with the change of roles. They have always done the shopping together and while out shopping they would have a snack, it was their quality time together. Being unable to go out shopping on their own was an issue for both of them. Intermediate Care at Home are now providing support for them to assist with shopping and snacks and medication. The support given has enabled them to stay in their own home.

Mrs T always did meals for both herself and her son. Mrs T's son is now completing the task with Microwave meals and sandwiches so Intermediate Care at Home have been able to reduce the calls to 3 calls daily. They were both involved in a darts team which they both attended every week on a Tuesday. They both enjoyed this evening out by Taxi and they are now planning to start going again.

Reduced on previous year. Still above regional average

Proportion of older people (65+) who were still at home 91 days after discharge per 1000 popn.

88.7%

Yorks/Humber average 88.1%

Same as last year. Below regional average

Proportion of older people (65+) who were still at home 91 days after discharge (offered the service) per 1000 popn.

1.2%

Yorks/Humber average 2.0%

Direct Payment

Reduced on previous year. Below regional average.

Propn. of people using social care who receive direct payments
25%

Yorks/Humber average
31.7%

Direct payments offer people the opportunity to receive money to buy the care they need to achieve the needs and outcomes within their support plan. They give people increased autonomy, inclusion, choice and flexibility to help them live in their own homes, be fully involved in family and community life, and take part in work, education and leisure. Many people recieving them experience the benefits of increased opportunities for independence, social inclusion and enhanced self-esteem.

Direct payments come with responsibilities on the part of the person receiving them, and the organisation managing the direct payment (focus). People are supported as appropriate to manage their direct payments appropriately. The organisation (focus) managing the payments will strike a balance between enabling choice and control for service users, whilst managing individual and corporate risks associated with having them. This also ensures that public funds are used appropriately. Where direct payments are not used responsibly appropriate actions will be taken.

Those recieving will be reviewed and monitored at regular intervals, and at least annually.

Case Study

A referral was received from Bill, stating that he and his wife were divorcing. He was profoundly deaf himself and advised that his wife, Pat (names changed to protect confidentiality) was profoundly deaf and blind. The domestic dynamics were strained; Bill had moved his new partner into the home but he was still supporting Pat with her daily activities.

A crisis developed which resulted in Pat threatening suicide to which a Mental Health professional responded. Upon discovering that they were unable to communicate with Pat, I was requested to attend in order to support. I commenced communication with Pat, interpreting for mental health. The situation de-escalated, and no further action was required from a mental health perspective, however, Pat needed both practical and emotional support.

Over the coming weeks, I continued to actively support Pat to be independent as her husband and his partner left the home.

Her domestic and marital circumstances required interpretation with multiple agencies and professionals. In addition to this, Pat had a number of health appointments to attend, I was able to facilitate primary care preventive and screening activities to be introduced.

Pat was enabled to have a personal budget; she interviewed and selected her personal assistant and utilises third party support to facilitate it, however, the successful candidate could not communicate directly with Pat. I continued to support Pat by teaching her PA the deaf blind manual, (hands- on communication) and her motivation to learn allowed this to happen relatively easily; soon Pat and her PA were able to develop a trusting relationship. Ultimately, Pat was able to live an active and independent life with improved health, due to preventive screening.

Personal Budgets

Personal budgets are an allocation of funding identified for people after an assessment of need.

People can either have this as a direct payment or ask the organisation (focus) to commission services, or they can have a combination of the two. Whichever, the person would still be involved in how their needs could be met.

Better than last year. Well above regional average.

Propn. of people using social care who receive self-directed support

91.4%

Yorks/Humber average

87.8%

Case Study

Michael and Emma have been living in their home for 5 years. Richard joined them in December 2015. The support was originally provided by a commissioned provider. It worked well at first but then they were so many staff changes, it became very distressing. Families approached the CCG to see what could be done to make this better for their family members and the service lead for the disability triangle talked about how the families could pool their budgets to provide a service fund which would give them more control of how their relatives were supported. Some of the families didn't want the responsibility of managing staff but did like the idea of pooling the budgets into a service fund. The CCG contacted CARE4ALL and looked at how we could achieve this. They helped the families recruit the right staff for their relatives and supported them in deciding the best way to support each other They each have comprehensive care plans which have been agreed with all involved to get the best outcomes for the tenants working in partnership with Speech and Language therapists, physiotherapists and the Intensive Support team are in place to ensure that their individual health and wellbeing needs are being met. Mike, Richard and Emma are involved as much as possible in decisions regarding their ongoing care and the running of the household which includes helping with washing, cleaning and meal preparation.

The three individuals, accompanied by staff regularly visit places in their local community either together or on their own. They enjoy going to the local pub, restaurants and shops and are well known to their neighbours who are invited around to the bungalow.

There are regular meetings with families who take the lead and are consulted about all aspects of care and the management of the bungalow.

Parents now make the decision of who is recruited to support their relatives and are involved in the introduction of potential staff members to the home. Staffing levels are higher which allows for more one to one community activities . Staff members are matched to the tenants and support is there when the individual wants it. The flexible rotas are designed around the needs and daily activity programmes of the three people.

Members of staff say that there is more of a sense of working for Mike, Richard and Emma and not a company. As a consequence, staff turnover is extremely low.

'It has been like a miracle. Richard is happy and has settled in well'

'Michael has been at the service at Parker Road since it opened. It gives us peace of mind knowing that he is well looked after by caring staff and we do not have to worry about his future. It is the best thing of it's type we have seen in a bungalow in a great part of town. It is a great family atmosphere at parker Road with friendly approachable staff who provide Mike with varied and interesting activities. Mike is happy and more independent and has a better social life than we could provide. A very happy Peter and Linda'

Learning Disability, Physical Disability & Mental Health

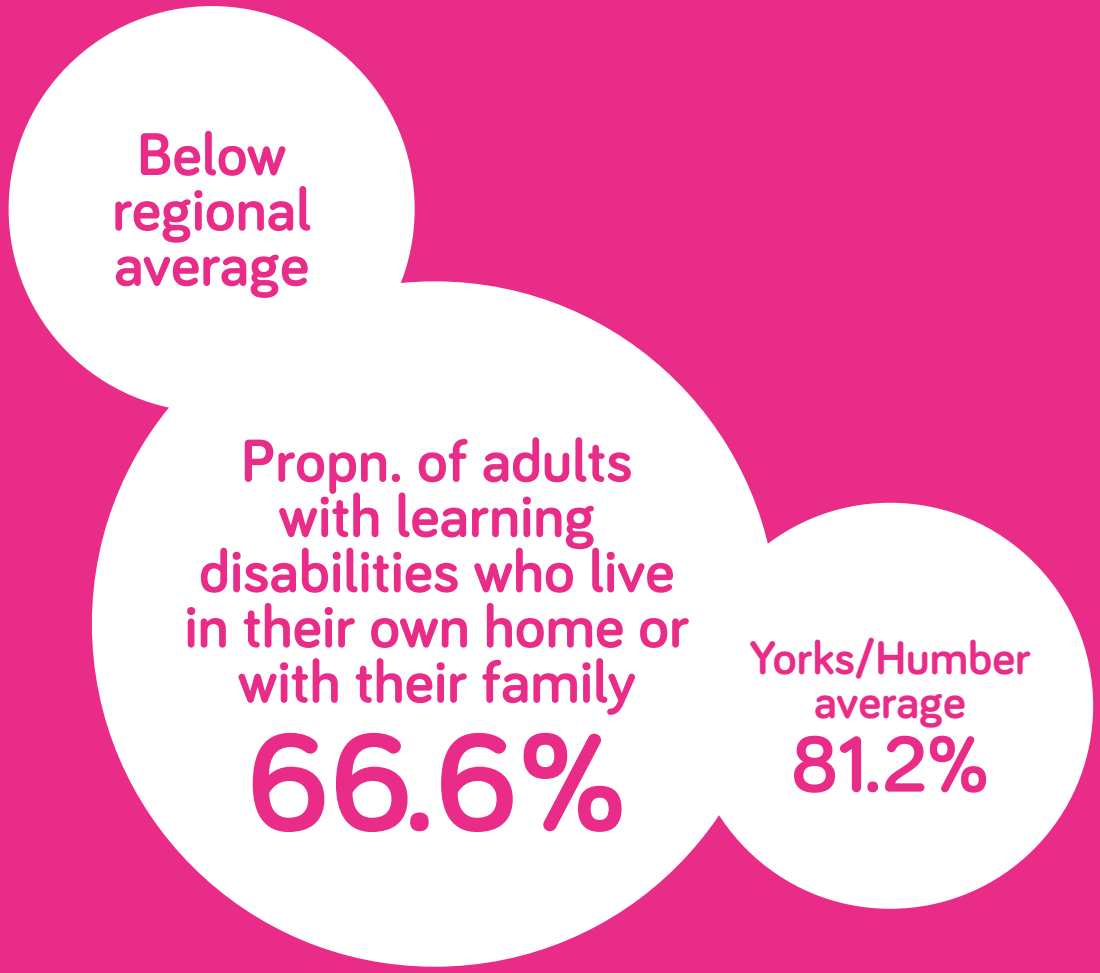
The aim of the disabilities and mental health triangle is to ensure high quality, safe, and sustainable services for people with disabilities and mental health issues in North East Lincolnshire through a combination of commissioning, market development, and partnerships across health and social care.

The Mental Health Crisis Care Concordat has been established – seeing all the agencies involved in the Crisis Care pathway working together to improve services.

People with long term conditions such as Chronic Obstructive Pulmonary Disease and Cardiac Failure are more likely to experience depression and anxiety. The depression and anxiety also makes Long Term Conditions feel worse for people. Our Improving Access to Psychological Therapies (IAPT) service, Open Minds, has worked alongside services that help people with Long Term Conditions and has evidenced that this joint approach has not only eased symptoms of depression and anxiety, but has reduced the symptoms associated with people's Long Term Conditions – enabling people to have a better quality of life for longer.

There is much evidence indicating that people with Severe and Enduring mental illness are much more likely to develop Long Term physical health conditions also. 2013-14 saw the development of the Wellbeing and Health Improvement Service (WhISE) programme through NAViGO– introducing a more thorough physical health check and easy access to health improving advice for people with Severe and Enduring mental illness. There has been widespread recognition for the approach which is seen as good practice.

Working with our Mental Health providers, NAViGO, we have successfully remodelled Hope Court to better support mental health rehabilitation to independence. As we move forward to next year we will see more people stepping down their support needs, and moving to their own accommodation with the right support for them.


Below regional average
Propn. of adults with learning disabilities who live in their own home or with their family
66.6%
Yorks/Humber average
81.2%


Below regional average
Propn. of adults with learning disabilities in paid employment
1.9%
Yorks/Humber average
6.5%

Care Act 2014

Most of the reforms within the Care Act 2014 took effect in April 2015. In preparation, our approach within North East Lincolnshire has been to divide the task of implementation into workstreams, and appoint an expert to lead each workstream. These experts are drawn from North East Lincolnshire Council, the CCG and focus. This team of experts identified and managed the key tasks of implementation, in partnership with wider organisations across the third and voluntary sector. For example, members of the team led on the revision of North East Lincolnshire's charging policy (following consultation) and the redesign of care and support assessment paperwork, to secure Care Act compliance. Alongside this, specifications for commissioned services such as advocacy and domiciliary care have been reviewed to ensure conformity with the Care Act's objectives, and re-tendered where it was felt improvements could be secured.

In addition to consideration of practical changes, the task of ensuring that all relevant parties are aware of their new duties under the Care Act has been considerable. With partners at Care Plus and NAViGO, the team delivered an extensive programme of briefings and awareness raising activities, involving health and social care colleagues across the public and voluntary sector. A highlight is the visit of eminent lawyer Luke Clements to deliver tailored training on the links between the Care Act and the Children and Families Act 2014, designed to ensure that children and their families in North East Lincolnshire receive coordinated help across both pieces of legislation.

The team's activities have been supported by the Care Act Partnership Group (CAPG): a focus group of around 12 volunteers drawn from ACCORD (the CCG's membership body) and Healthwatch. The CAPG received presentations on six key areas of the Care Act, following which they were able to pose queries and offer comments. The CAPG's input has been invaluable in providing a community perspective, offering a targeted two-way conversation between commissioners and residents of North East Lincolnshire. A number of CAPG members have gone on to be involved in wider areas of commissioning activity.

There are few new services as a direct result of the Care Act, but there are increased opportunities to work together differently. Drawing on the advantages of its integrated health and social care architecture, North East Lincolnshire's focus on partnership working will provide the best opportunities to embed the Care Act's reforms, and to continue working cooperatively to realise the Act's vision.

You can find out more online here:

- www.services4.me.uk/careact

Survey

Each year a national survey is conducted across a random selection of people in each of the Local Authorities across Great Britain. This is known as the Personal Social Services Adult Social Care Survey (PSSASCS) and the responses to this survey form some of the outcome statements that are used for performance to be monitored.

Reduced from last year. Below regional average.

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

64%

Yorks/Humber average

66.5%

Supporting people with Dementia

Identifying early signs of dementia

In NEL we recognise the importance of receiving an early dementia diagnosis - it allows access to support, information, medication and gives people the opportunity to understand and accept their diagnosis. Those with dementia and their carers can make informed choices, enabling them to plan for the future and for living well with dementia. Early diagnosis also increases the chance of preventing future problems and crises.

The dementia diagnosis rates in NEL have significantly increased during 2014-15. Locally we have achieved a diagnosis rate of 66.6%; this is higher than the national average. Despite this, further work is still required to identify the estimated 700 people who have not received a diagnosis; this is a priority for the coming year.

The Dementia Portal

This is an online resource, providing up to date local dementia service information. Access is via:

- www.services4.me.uk/mylife

The Alzheimer's Society (AS)

The NEL Clinical Commissioning Group (CCG) and the AS have been re-negotiating the local contract, utilising community consultation/ feedback. The service will ensure those with dementia and their carers are identified, recognised and supported through targeted advice, information and signposting (i.e. via the Dementia Advisor), one to one support (including befriending), memory cafés and peer support groups (i.e. Singing for the Brain), educational and social/ leisure activity groups and training (including Carer information courses). The AS will offer local residents meaningful activities which engage and encourage them to remain independent and part of the community.

Dementia Action Alliance (DAA)

The DAA is a national movement, aiming to create a society-wide response to dementia. The DAA encourages and supports practical actions that enable people to live well with dementia in their communities. The local DAA contains individuals, organisations and agencies, and is spearheaded by the AS. This year they built on their initial partnership working and their "Dementia Friends" campaign to continue to spread dementia awareness and encourage dementia friendly communities.

Prescribing Antipsychotics

Many people with dementia experience behavioural/psychological symptoms, i.e. agitation and aggression. Antipsychotic medicines may help reduce some of these symptoms. However, they can cause serious side effects and are sometimes inappropriately prescribed. There have been continued efforts to raise awareness around the risks of prescribing antipsychotic drugs for dementia patients, in response to universal concerns that overall they are harmful.

Locally, health professionals continue to explore alternative treatments for patients with dementia, and over the last few years the prescribing of antipsychotics has continued to reduce.

Case Study

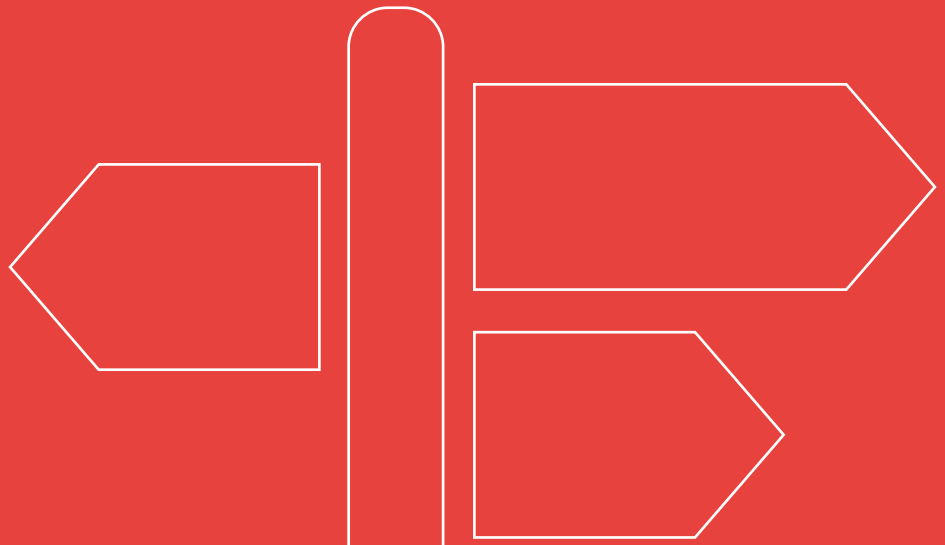
Julie is a carer for her dad Geoff, who has dementia. Julie herself has had depression, and had concerns with the house, money and employment. At the point of referral, Julie felt stressed, and had no respite in her full time caring role. She received Carers Allowance and Income Support.

The Carer Support Worker and Admiral Nurse worked to support Julie to access CAB for financial advice, and referred her for a Carers Assessment (for respite/sitting) and a CASS payment (for a holiday). A St Bernard tracker was organized with Care Link, to aid peace of mind with Geoff's wandering. When Geoff's condition worsened, the Carers Support Worker also helped with referrals to focus for the Carer Break Service and to the district nurse, with practical advice regarding nutrition, personal care and cutlery difficulties and information regarding 24 hour residential care.

CSW continues to support Julie with three monthly meetings, as well as being available for Julie to speak with when needed over the phone. As a result of the support received, Julie has returned to work, has been able to have a holiday and has a 4 hour break a week to see friends while her sister sits with their Dad.


NATIONAL FISHING
HERITAGE CENTRE

How to get support now and in the future



What is a Single Point of Access?

For access to community health and social care support or advice and information the single point of access is always open, and this includes overnight, weekends and Bank Holidays.

In addition the single point of access also provides access to social care crisis response, community health advice, mental health advice and access to mental health services, and can offer information and guidance through the Health and Social Care systems.

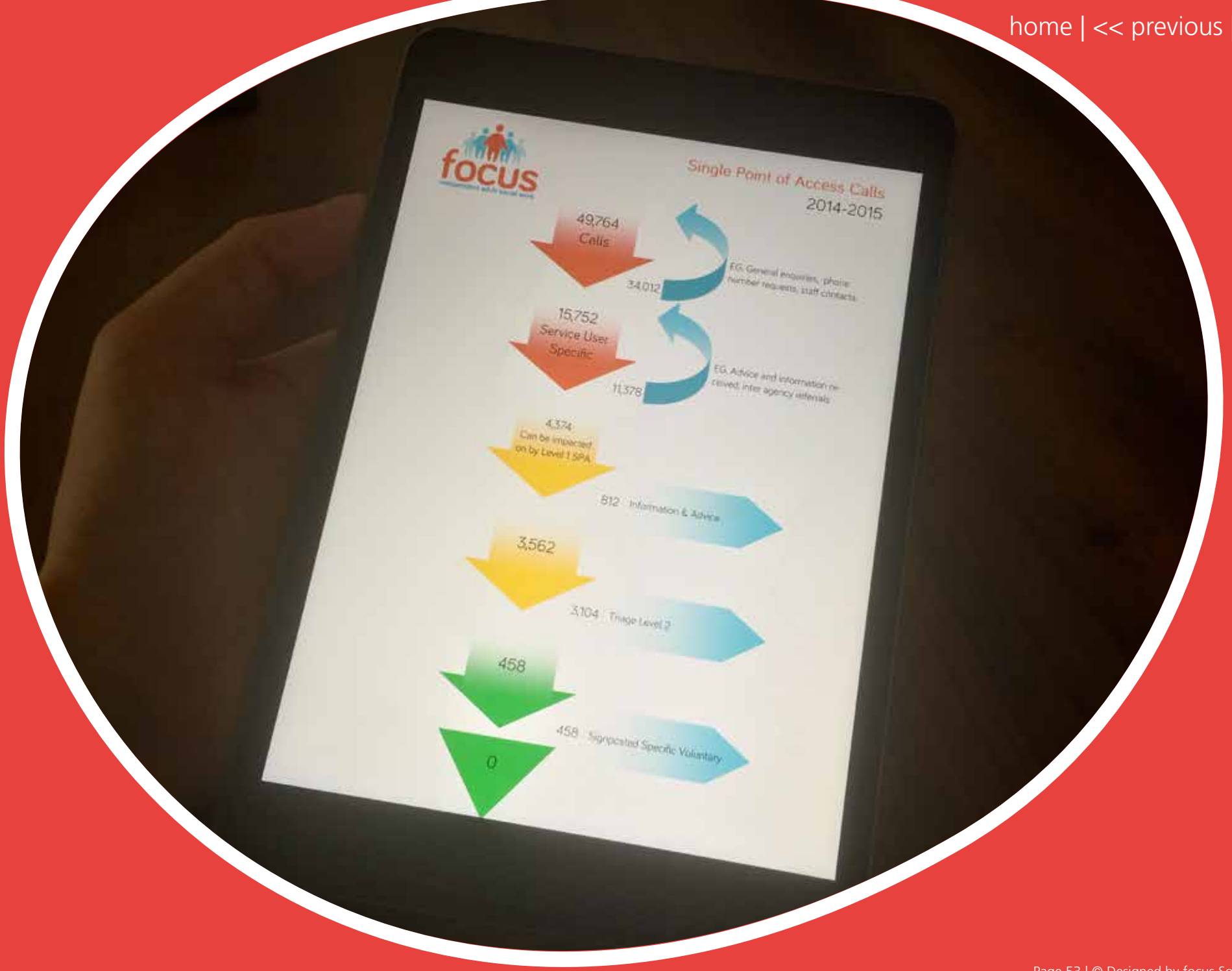
The single point of access is delivered through an alliance of organisations working together to offer a range of services for residents within North East Lincolnshire. This means that it is local, based in Grimsby, and calls are dealt with by the agencies that operate services in North East Lincolnshire. People who call can be confident that they are assisted to the most appropriate outcome for themselves, including:

- Advice, information and signposting
- voluntary and community services
- Rehabilitation and re-enablement
- Social complex case management

The SPA strives to find suitable and appropriate outcomes, whatever your enquiry. All the calls received by the single point of access will either:

- Resolve your issue
- Offer relevant advice and information including onward referrals for assessment
- Re-direct you to the most appropriate person or service who will be able to help

It is our plan over the next year to bring in more health and wellbeing services to make them more easily accessible through the SPA, and to increase the number of ways people can contact the SPA, so it becomes even more useful for people looking to access health and wellbeing services in North East Lincolnshire.


focus
Single Point of Access Calls
2014-2015
49,764
Calls
34,012
EG. General enquiries, phone number requests, staff contacts
15,752
Service User Specific
11,378
EG. Advice and information received, inter agency referrals
4,374
Can be impacted on by Level 1 SPA
812 Information & Advice
3,562
3,104 Triage Level 2
458
458 Signposted Specific Voluntary
0

What is Services4Me?

Services4me was launched in 2012 to respond to the growing need to bring together information, advice and support to help people understand and access adult social care and health services online. It is part of a drive to help achieve and maintain independence; ensuring that individuals have as much choice and control as possible when considering services to support their needs. It also provides an online 'self assessment' tool which allows individuals to be much more involved in the process of assessing, determining and positively managing their on-going 'needs'.

The website, 'Services4.me.uk', is managed and delivered by focus independent adult social work. It is a partnership initiative with all the key agencies in the area; CCG, the Council, the carers centre, Voluntary Action North East Lincolnshire (VANEL) and other voluntary and community organisations coming together to ensure that it provides the best and most effective advice and support.

Towards the end of 2014-15 the wesbite was redesigned to be fully mobile responsive and include new portals such as the Information, Advice & Guidance Portal.

It has been developed as an easy to use, interactive platform which offers an online, one-stop directory; providing information and signposting to services, events and activities for adult social care, health care, wellbeing, voluntary and community services right across North East Lincolnshire. Its design and approach were informed by working closely with local users, carers and other key stakeholders to understand how best to make core information accessible, easily understandable and responsive to their needs. This engagement with users and interested parties is on-going to ensure that future development also reflects the experiences and preferences of those who will actually use the website.

Services4me has over 900 records covering a wide range of services, products and events. The directory can be easily accessed and all of its content is free. The listings within the online directory are managed and validated by the focus Services4Me team; they constantly review and assess the directory and look for opportunities to extend and improve it to provide information across the widest possible range of relevant services and activities.

Providers and suppliers are also encouraged to regularly review and update their listings so that information is relevant and accurate.

As well as encouraging users, carers and the wider public to access the website via their own technology (PC, tablets, phones etc.), we are also currently developing a range of ways to provide easy access to the website in public places. A suite of 20 iPad kiosks within all GP practices and growing community venues have now been implemented to support this.

- www.focusadultsocialwork.co.uk/where-are-we/services4me-kiosk-locations/

Key facts

- 116,117 unique sessions 204,171 page views
- 900+ providers registered
- 20+ iPad Kiosks launched in GP / community venues

services 4.me.uk

www.services4.me.uk

What is an e-market place and online Personal Budget Manager

As part of the range of tools being made available via Services4me, an online 'personal budget manager' is being developed as an innovative solution to provide the means to enable service users to embrace personal budgets, choice, control and independence. The Online Personal Budget Manager (OPBM) provides service users with a way to search for services/goods and engage with providers to secure services to meet their identified needs. It will allow the individual to:-

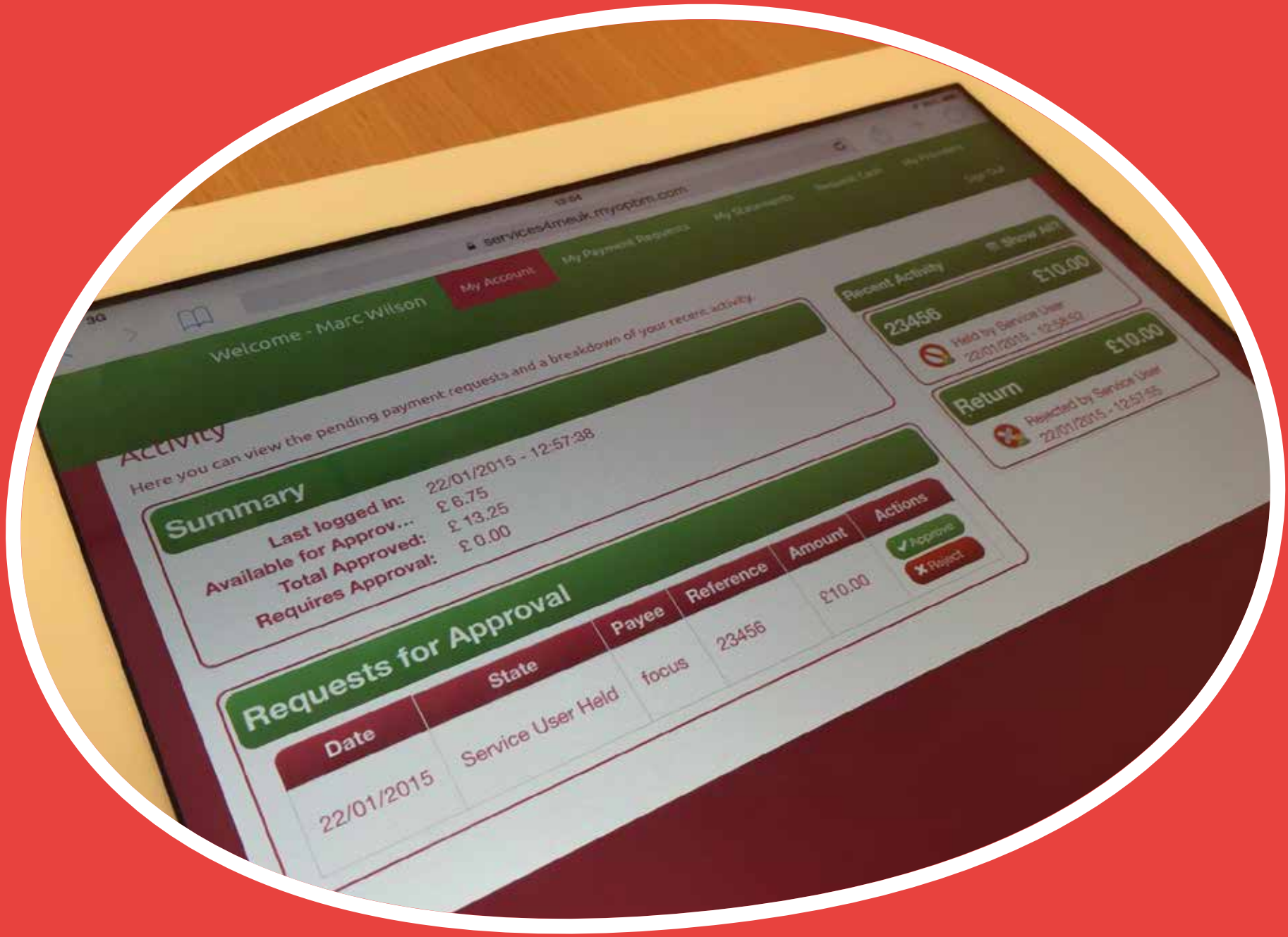
- Research available services and goods
- Request services direct with providers
- Track and manage their own budget (either themselves or by an approved person acting for them e.g. family, carer, social work or health professional etc.)
- Enable approval of services / virtual transactions

The OPBM also enables the organisations commissioning adult social care and health services to:-

- Provide better safeguards/ assurance of financial transactions (so better managing public monies)
- Provides an opportunity to streamline and modernise payments to providers.
- Increase competition in the market
- Provide information and intelligence to understand and shape the market

A major benefit for using an Online Personal Budget Manager is promoting and being part of an emerging local economy.

The tool is now availabe in a pilot phase and individuals have started to trial this through to September 2015.


Welcome - Marc Wilson
My Account
Activity
Here you can view the pending payment requests and a breakdown of your recent activity
Summary
Last logged in: 22/01/2015 - 12:57:38
Available for Approv... £ 6.75
Total Approved: £ 13.25
Requires Approval: £ 0.00
Requests for Approval
Date
State
Payee
Reference
Amount
Actions
22/01/2015
Service User Held
focus
23456
£10.00
Approve
Reject
Recent Activity
£10.00
23456
Held by Service User
22/01/2015 - 12:58:50
Return
£10.50
Rejected by Service User
22/01/2015 - 12:57:55

Appendices

Key Performance Indicators

The below performance tables are taken from the ASCOF results for 2014-15. You can find explanations of what each mean within the Glossary.

Enhancing Quality of Life for People with care and support needs

Description	2013/14	2014/15	
Social care-related quality of life	19.2%	19.2%	✓
Proportion of people who use services who have control over their daily life	77.6%	82.4%	✓
Proportion of people using social care who receive self-directed support	78.8%	91.4%	✓
Proportion of people receiving social care as a direct payment	26.5%	25%	-
Proportion of adults with learning disabilities in paid employment	17.6%	1.9%	-
Proportion of adults in contact with secondary mental health services who are in employment	10.1%	8%	-
Proportion of adults with learning disabilities known to adult social care who live on their own or with their family	75.8%	66.6%	-
Proportion of adults in contact with secondary mental health services living independently, with or without support	89%	74.2%	-

Delaying and reducing the need for care and support

Description	2013/14	2014/15	
Annual permanent admissions of people aged 18-64 to residential and nursing care homes per 100,000 population	11.5	13.6	-
Annual permanent admissions of people aged 65 and over to residential and nursing care homes per 100,000 population	698.8	563.9	✓
Delayed transfers of care from hospital per 100,000 population	7.8	7.1	✓
Delayed transfers of care from hospital per 100,000 population which are attributable to adult social care	3.3	2.1	✓
Percentage of older people still at home 91 days after being discharged from hospital with reablement/ rehabilitation services	94.4%	x	-

Ensuring people have a positive experience of care and support

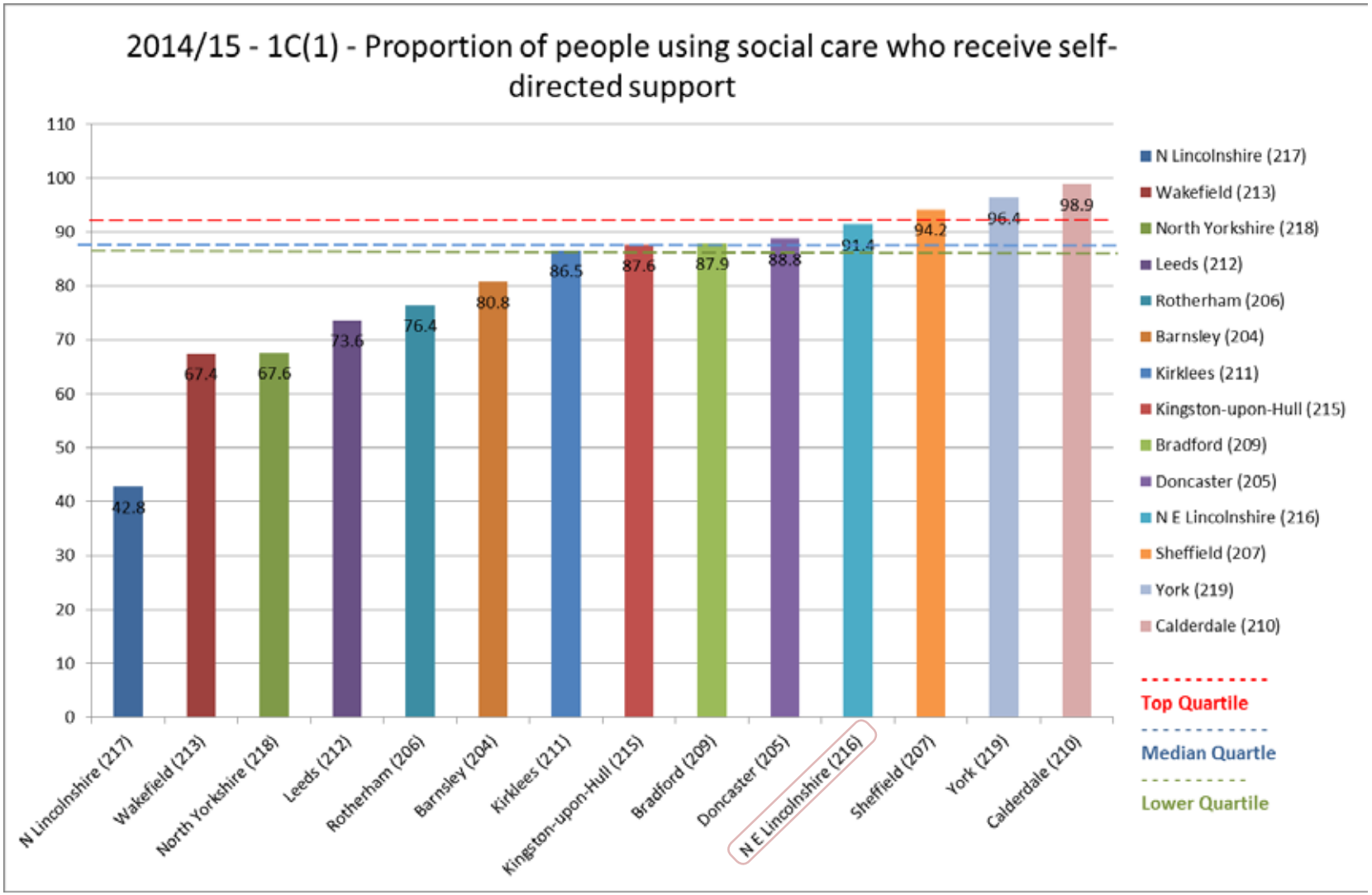
Description	2013/14	2014/15	
Overall satisfaction of people who use services with their care and support	67.2%	64%	✓

Safeguarding adults whose circumstances make them vulnerable and protecting them from harm

Description	2013/14	2014/15	
Proportion of people who use services who feel safe	65.2%	65.7%	✓
Proportion of people who use services who say that those services have made them feel safe and secure	87.9%	92.3%	✓

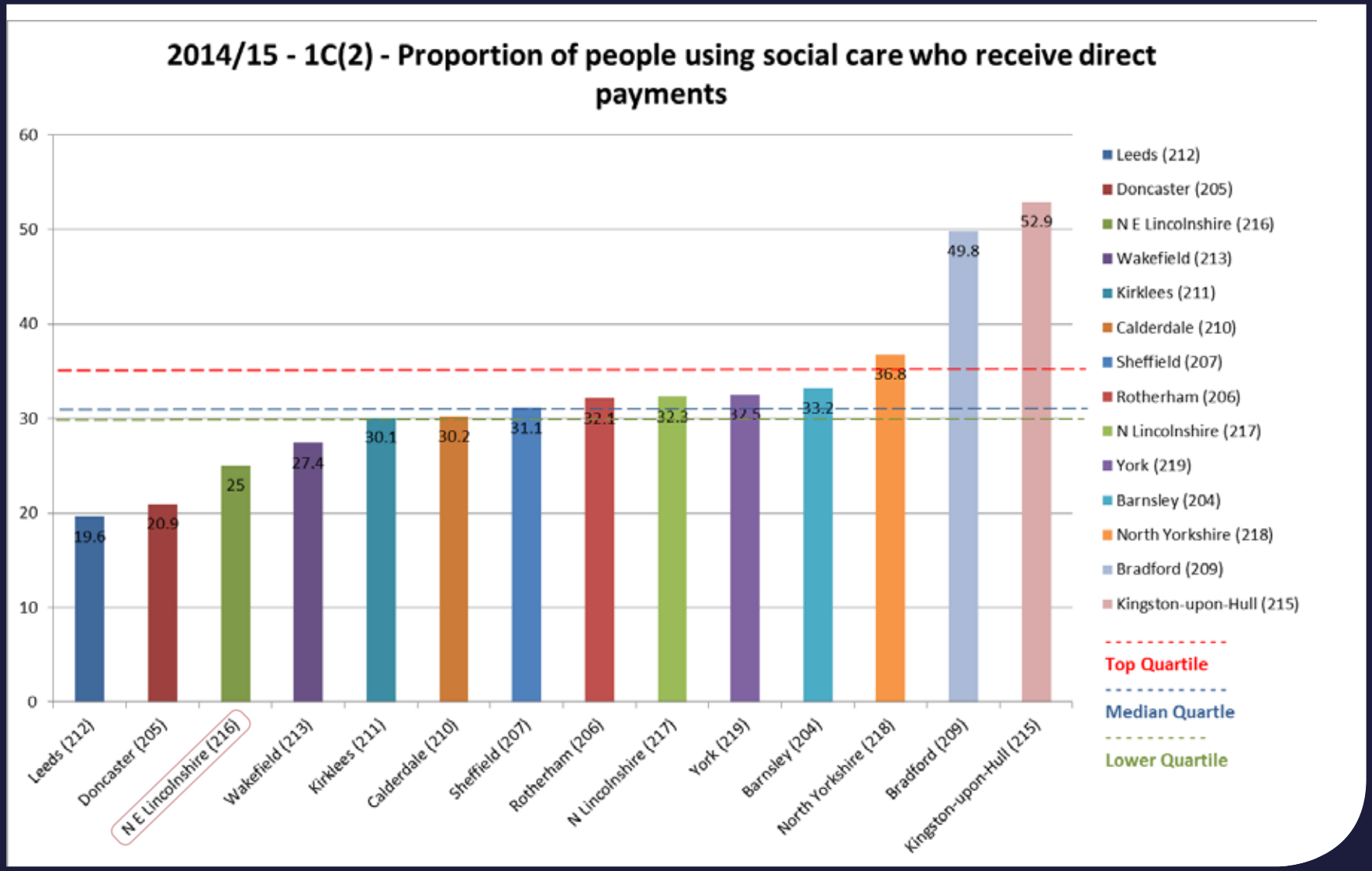
Personalisation

Those in receipt of a managed budget represent 91.4% of all those receiving support: A significant improvement on the previous year, we moved to 4th place regionally in 2014-15.



Direct Payments

The proportion of those using social care who received a direct payments to allow them to purchase case and support directly is 25%, this moves us to 12th place regionally in 2014-15.



Glossary

Abuse
Physical violence, verbal aggression, unwanted sexual contact, money or property taken without consent or under pressure, neglectful care or the deprivation of choice, privacy or social contact.

Carer
An individual who provides unpaid support to a family member or friend who cannot manage without this help.

Commissioning
Process the CCG uses to plan and buy services for adults with care and support needs.

Community based services
Care and support services provided in the community rather than in hospital or residential homes.

Community capacity building
Activities, resources and support that strengthen the skills and abilities of people and community groups; both to take effective action and take leading roles in the development of their communities.

Deprivation of Liberty Safeguards (DoLS)

Safeguards under the Mental Capacity Act (2005) that aim to protect people in care homes and hospitals from being inappropriately deprived of their liberty.

Direct payment
Money payment made to people who need care following an assessment, to help them buy their own care or support, and be in control of those services.

Extra Care Housing
Extra Care Housing is housing designed with the needs of frailer older people in mind; varying levels of care and support are available on site.

Health and Wellbeing Board
The health and wellbeing board is an NEL Council committee, which has responsibility to ensure that the health of the local population improves, and to ensure that health and social services are co-ordinated. These and other responsibilities of the board are set out in the Health and Social Care Act 2012.

Health Inequalities
Health inequalities are preventable and unjust differences in the health experienced by certain population groups. People in lower socio-economic groups are more likely to experience chronic ill-health and die earlier than those who are more advantaged. Health inequalities are not only apparent between people of different socio-economic groups they exist between different genders and different ethnic groups.

Hidden Carers
Many carers do not identify themselves as such, and are known as "hidden carers".

Home care
Help at home from paid carers for people with care and support needs.

Integrated
An integrated service acts as a service hub for the community by bringing together a range of services, usually under one roof, whose practitioners then work in a multi-agency way to deliver integrated support to children, young people and families, for example, extended services or sure start centres.

Intermediate Tier
Intermediate tier services are those provided on a time limited basis to help people discharged from hospital, or to prevent a hospital admission. Their aim is to re-enable people to regain their independence.

Key Ring Support Network
A supported living network made up of a number of ordinary homes for people who need support; a community volunteer lives in one of the homes and helps members. Paid workers are also available to give support.

Long Term Conditions
Long term conditions are health conditions that last a year or longer, impact on a person's life, and may require on-going care and support.

Managed budget
Where a person asks the council to directly provide them with services to the value of their personal budget.

Market Position Statement
A document containing intelligence, information and analysis of benefit to local adult social care providers.

Outcome
End result, change or benefit for an individual who uses social care and support services.

Personal Health Budget
A personal health budget is an amount of money to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team.

Preventative services
Services that involve early interventions to prevent long term dependency or ill health.

Personalisation
New approach to adult social care that is tailored to people's needs and puts them in control.

Personal budget
A money allocation available to someone who needs support; the money comes from the Council's social care funding.

Reablement
Helping people to regain the ability and confidence to do some or all of the things they used to, such as cooking for themselves, bathing without help or getting to the shops.

Rapid Response Service
A service that focuses on preventing avoidable hospital attendances and admission, treating and supporting individuals who have gone into crisis whether they have a health or social care need.

Rehabilitation
Treatment or treatments designed to facilitate the process of recovery from injury, illness, or disease to as normal a condition as possible.

Residential care
Care provided in a care home.

Safeguarding
Protecting vulnerable people from neglect or physical, financial, psychological, verbal or other forms of abuse.

Safeguarding Adults Board
The Safeguarding Adults Board focuses on the core safeguarding agenda - prevention, identification, investigation and treatment of the abuse of vulnerable adults. It develops safeguarding policies and procedures, participates in the planning of safeguarding services, gives guidance and direction to those responsible for service delivery and champions good practice.

Self-Directed Support
Self-directed support is about people being in control of the support they need to live the life they choose.

Social Enterprise
A business with primarily social objectives whose surpluses are principally reinvested for that purpose.

Solution
The most appropriate method of meeting an individual's needs.

Supported Living Schemes
Schemes that help adults to live as independently as possible in the community.

Think Local Act Personal
Think Local Act Personal is a group of over 30 national partners that are committed to real change in adult social care. Their goal is for people to have better lives through more choice and control over the support they use; often referred to as "personalisation".

Third Sector
Voluntary or not for profit sector.

Time Banking
Time banking is designed to support people who help others, and to offer support to those that need it. Every hour spent doing something for somebody, generates a time credit. Each time credit can then be exchanged for an hour of someone else's time.

Vulnerable adult
A person aged 18 or over who may be unable to take care of themselves, or protect themselves from harm or exploitation due to mental health problems, disability, sensory impairment, frailty or other conditions.

Wellbeing
Health and happiness.

Performance Measures Glossary

1A "Social Care –Related Quality of Life"
This is taken from the PSSASCS which asks people about how they view their quality of life.

1B "Proportion of people who use services who have control over their daily life"
This is taken from the PSSASCS which asks people if they feel they have control over their own life.

1C(1) "Proportion of People using social care who receive self-directed support."
This looks at the number of people who have received an assessment of need who have then been advised they can have a personal budget to meet their needs and advised as to how much this will be.

1C(2) "Proportion of People using social care who receive direct payments"
This looks at the number of people who choose to manage their own personal budget rather than ask Adult Social Care to arrange services.

1E "Proportion of People with learning disabilities in paid employment"
This looks at the number of people with a learning disability who have found employment and receive pay for this.

1F "Proportion of People in contact with secondary mental health services in paid employment"
This looks at the number of people in contact with secondary mental health services who have found employment and receive pay for this.

1G "Proportion of People with learning disabilities who live in their own home or with their family"
This looks at the number of people diagnosed with a learning disability who live independently rather than in a residential or nursing home.

1H "Proportion of People in contact with secondary mental health services who live independently with or without support"
This looks at the number of people who are receiving a service from the secondary mental health service who live independently rather than in a residential or nursing home.

2A(1) "Permanent admissions 18-64 to residential and nursing care homes, per 100,000 population"

2A(2) "Permanent admissions 65+ to residential and nursing care homes, per 100,000 population"

2B "Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation (effectiveness of the service.)"

2C(1) "Delayed transfers from hospital per 100,000 population"
This looks at the number of people who have been advised they are medically fit to leave hospital but have been unable to be discharged due to waiting for a specific service or piece of equipment.

2C(2) "Delayed transfers from hospital which are attributable to Adult Social Care, per 100,000 population
This looks at the number of people who have been advised they are medically fit to leave hospital but have been unable to be discharged due to waiting for an Adult Social Care service.

3A "Overall satisfaction of people who use services with their care and support"
This is taken from the PSSASCS which asks people how satisfied they are with the services that have been provided.

4A "Proportion of people who use services who feel safe"
This is taken from the PSSASCS which asks people how safe they feel where they are living.

4B "Proportion of people who use services who say those services have made them feel safe and secure"
This is taken from the PSSASCS which asks people if the services they receive have made them feel safe and secure where they are living.

LOC1 "Adult and older clients receiving a review as a percentage of those receiving a service."
This is a local indicator and asks if the person's support and care needs have been reviewed to identify any changes that are needed. This should be undertaken at least on a yearly basis.

LOC4 "Carers receiving needs assessment or review receiving a specific carer's service, or advice and information"
This is a local indicator which looks at the number of carers who have been assessed in their own right or have had their needs reviewed when they have a direct service to support them or have been provided with advice and information.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