Adult Social Care in North East Lincolnshire

# Local Account 2011/2012

North East Lincolnshire Council and North East Lincolnshire Care Trust Plus

# Contents





# Foreword

I am pleased to introduce our first local account, which covers adult social care in North East Lincolnshire. Of course, one of the unique things about North East Lincolnshire is that, since 2007, the local council and the local NHS have planned and delivered health and adult social care together through the creation of the Care Trust Plus (CTP). It is interesting to note that the integration of health and social care is now being talked about by Government as the key to delivering efficient and quality care, so it's good to know that we have already taken this step and are beginning to see the benefits.

Since the ratification of the Health and Social Care Act in 2012, we are now required to become a Clinical Commissioning Group (CCG). I'm pleased to say that we are well on the way to becoming fully authorised as one of the first CCG's in the country and probably the only one to be an integrated CCG with responsibility for adult social care. We hope you find this document a useful reference and guide to how we have set about improving and developing integrated care in partnership with the people of North East Lincolnshire. We are committed to producing a similar document annually to chart our progress in the coming years.

***Yours sincerely***
***Peter Melton, chief accountable officer NEL Clinical Commissioning Group***

In this, our first local account, we are trying to inform people about how our adult social care services operate in North East Lincolnshire. Locally we have a unique partnership arrangement with the NHS which helps to deliver health and social care services in a joined up way. As you will see from the account we are able to provide support for a variety of different needs.

People will be aware that there are major challenges relating to increased numbers of people needing care and support, against a backdrop of reduced resources. At the same time there are changing expectation about the way in which care is provided. We are no longer simply providing services, our approach is to work with people to shape what and how support will be delivered to them in the most effective and efficient way. Our aim is to ensure that the care provided is in line with what people want.

The local account shows that we are making good progress in some areas but we are very conscious that there is a good deal more to do.

As this is our first local account, we are looking for your feedback as to how we can improve this document.

***Jack Blackmore, strategic director for people and communities, North East Lincolnshire Council.***

## 1 Why are we writing this report?

By writing this local account of social services in North East Lincolnshire we aim to give the community clear information about the role that these services play in meeting the needs of some of the most vulnerable residents in the borough. These include services for older people, those with learning disabilities, mental health needs or physical disabilities. The report reflects our performance for the period April 2011 to March 2012. Looking back at how we have performed will help us to plan and make improvements in the future.

We aim to give an honest account of how these services are performing and how we are developing them to ensure that as many people as possible can live independently and retain choice and control over how their support needs are met.

We are also setting out some of the challenges we face as an area in continuing to meet the needs of an increasing older population at a time of unprecedented financial restraint in the public sector, coupled with the significant changes being brought about by the government in terms of the welfare system.

All of this means that we need to change the way in which we have traditionally offered support to older and vulnerable people by:

1. Encouraging and promoting a healthier community by investing in prevention and wellbeing.

2. Continuing to ensure high quality care for those most vulnerable.

3. Putting people in control of their own care through personalisation and self-directed support.

4. Creating a financially sustainable care system through accessibility, expert assessment, developing supported housing options as well as careful financial management.

This report outlines how we are aiming to achieve all of these things. We hope to demonstrate our progress, whilst at the same time giving an honest account of areas where we need to improve.

### 1.1 What's different about living in North East Lincolnshire?

In 2007, North East Lincolnshire Council and North East Lincolnshire Primary Care Trust formed a unique organisation called the Care Trust Plus. Traditionally social services are delivered by local councils but it was recognised here that people have many needs and that health and social care needs are linked. The aim of the Care Trust Plus is to ensure that health and social services work much more closely together to better meet the needs of those they support – this is known as "integrated commissioning and integrated service delivery".

Working well, this should mean that local people get the support they need based on a single assessment or conversation with services.

In North East Lincolnshire, community care is mainly provided by a community social enterprise company called Care Plus. A social enterprise is an organisation that exists to help communities with profits being reinvested back into the businesswhich, in turn, further benefits the community. Another community social enterprise called NAViGO provides mental health services. Both these organisations work closely with the community and produce their own quality account, which is available on their respective websites.

**What happens if you contact social services and need help, support or advice?**

1. If you have complex needs (for example you need support in a number of ways) we will ensure that a comprehensive package of care is developed with you to ensure it meets your needs and aspirations. In doing this we will work with all the people who are involved in your life – your family, your carers and other health and social care staff to maximise the control that you have over what is arranged. In an increasing number of cases, people have decided to design and plan their care arrangements by using personal budgets and/or direct payments.

2. If you have an urgent need, for example you experience a fall with the risk that independent living will be more difficult in the future, you will be able to access a period of intermediate care or re-enablement support. We have worked hard to develop these services in a way that integrates fully with the health service so there is no gap for people to fall through. Our aim is to work with you to get you back on your feet as quickly as possible and allow you to return home so you are able to enjoy many more years of independent living. We know that often people just need a helping hand, perhaps with shopping, attending a lunch club, perhaps a friendly face to talk to occasionally or maybe some advice about equipment. So if you need this kind of support (which will also slow down any future increases in need), we will help you to find support in your local community. We are working hard with the independent and voluntary sector (such as the Alzheimer's Society and others) to ensure that these types of services are available right across North East Lincolnshire, and that they include a wide range of options at a reasonable cost.

**Case studies: how short term and intensive "intermediate care" actually works...**

Daisy is 75 years old and has a learning disability. Whilst living in a local shared house, she fell and injured herself which meant she couldn't get around as before. This also led to a loss of confidence and could have meant that long-term residential care might have been considered. Our local rapid response team arranged for a social worker and nurse to attend and assess the situation and to work out the best way of helping Daisy get back on her feet – physically and emotionally. The rapid response team and the intermediate care at home team talked to Daisy and agreed it was best that she temporarily moved into intermediate residential support where she could be helped to regain her mobility and confidence by specially trained staff. During this time the team worked intensively with Daisy and, after a short period of time, her mobility improved, her confidence returned and she was ready to return home within weeks of the fall.

Mr P lives with his wife of 50 years. He has recently been diagnosed with dementia and Mr P's wife was beginning to find it hard to cope. Mr P contracted a urinary tract infection and was suffering from vomiting and diarrhoea when the crisis response team – part of our intermediate tier of services, became involved. The team has a range of specialisms and within a short space of time, the medical issues were resolved and Mr P and his wife were supported to manage Mr P's dementia at home, with support from the right people, at the right time. Often this type of incident leads to a permanent residential admission if services are not co-ordinated. This is a good example of the responsive and flexible range of service we are developing in NEL. We will need to do more of this in the future if we are going to support a growing number of people who will be living with dementia in our community.



### 1.2 Ensuring access to services and providing professional assessment

To help us make sure that we provide the right care at the right time by the right professional, we place great importance on assessing people's needs.

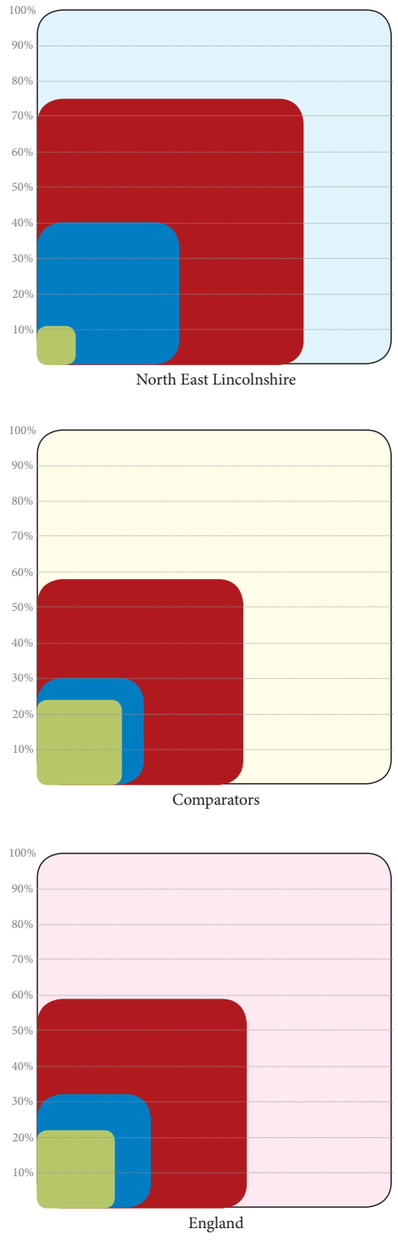
When someone comes to social services for help, they expect and need a straightforward and prompt response. To enable local people to access information, advice and guidance the 'A3' service was developed, which stands for Advise, Assess, Attend. The number of people contacting the A3 service continues to grow and we monitor the contribution it makes to ensuring a prompt and appropriate response. By the start of this year, about 90 people a week were receiving some form of initial assessment from the A3 service.

Many of these contacts result in a full assessment, and we expect to conduct these promptly. North East Lincolnshire completes 40 per cent of these reviews within 2 days compared to only 30 per cent in similar authorities up and down the country[1] This is shown in Figure 1.

As well as providing a professional assessment, it is also important to review people's needs on a regular basis. During 2011/12 4,577 people received a review (almost exactly the same as the previous year), which represents 67 per cent of people receiving a service. This is slightly below the level achieved by other similar authorities. North East Lincolnshire has set a target to achieve 88 per cent in 2012/13.

[1]Similar Authorities are defined by the National Adult Social Care Intelligence Service (NASCIS) as Darlington, Derby, Hartlepool, N Tyneside, Plymouth, Redcar & Cleveland, Rotherham, St Helens, Stockton on Tees, Stoke on Trent, Tameside, Walsall & Wirral. The source of the data is the NASCIS003 Referrals, Assessment and Packages If Care 2011/12 Comparator Report for NE Lincolnshire.

**Figure 1 The percentage of people who receive assessments promptly**




It is important for people to get the right advice as quickly as possible so we are constantly looking to improve our advice, access and assessment services. These are some of the improvements that will take place in 2012/13. We will:

- Increase and improve the training of our staff to enable us to speed up telephone queries and signposting. This will include solution-focussed training so we are better able to resolve issues and concerns earlier.
- Implement a new Integrated Care Record called SystmOne to improve the speed of data recording and reduce paper work. This will be an integrated health and social care record system and we will be one of very few areas in the country to have this.
- Develop a "Multi Discipline Triage Team" which will speed up the initial assessment process and ensure people get the right advice and support.
- Continue to develop the Services4Me website and its online self-referral tool to assist in managing demand electronically.

### 1.3 Care and support

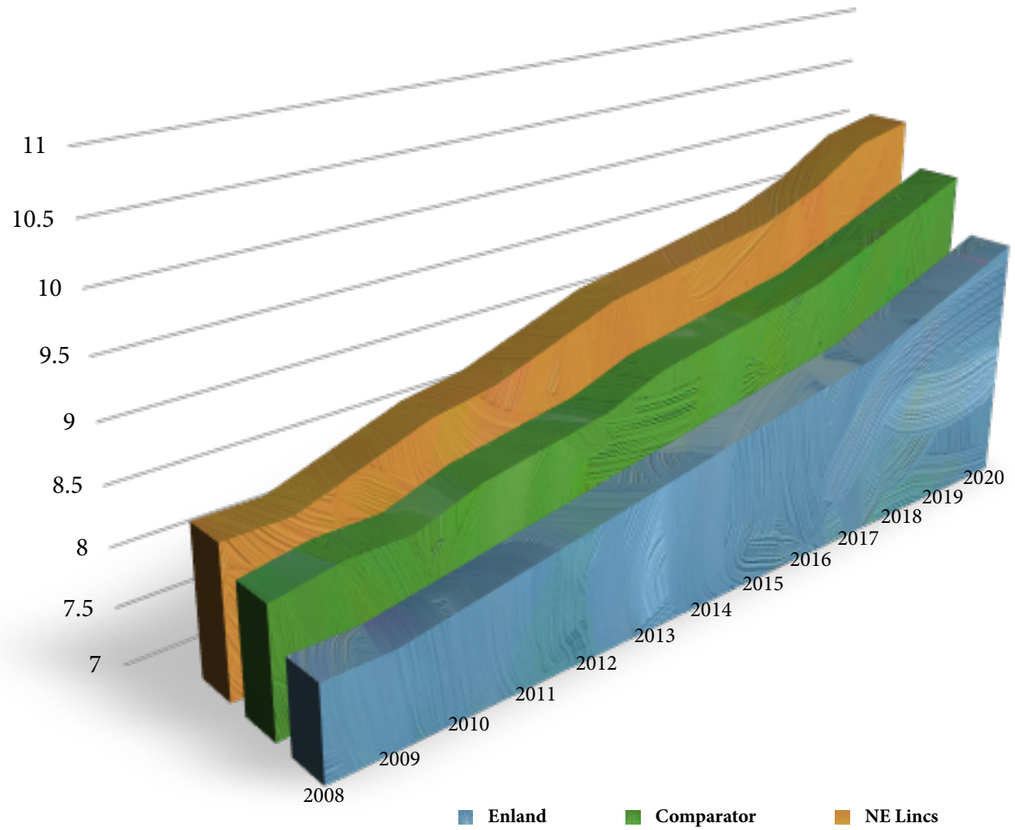
The adult population in North East Lincolnshire is approximately 120,000. Between April 2011 and March 2012 the council provided support to approximately 28,000 people. About two thirds of these were people with physical needs, including older people, but over 7,000 were people with mental health needs and about 1,700 had a learning disability. This shows the range of needs that we are responding to in the local population and is illustrated in percentage terms in Figure 2 below.

**Figure 2 The number of people with different needs that social services supported during 2011/12**[2]


[2] The source for this data is the local data return (RAP) to the Department of Health for 2011/12. No comparative information for this is available at the time of the writing of this report.

The number of people supported last year in North East Lincolnshire is about 9% higher than is the case in similar authorities up and down the Country. This is partly because of North East Lincolnshire has a higher proportion of over 75-year -olds in their population than other Authorities (see Figure 3). Whilst many people over the age of 75 continue to live well it is from within this age group that needs begin to arise. The reason for this is partly because some people choose to retire here but also because many people of working age find it necessary to leave the area for work.

**Figure 3 The percentage of people over the age of 75 in North East Lincolnshire compared to elsewhere**[3]




[3] The source for this data is the Office for National Statistics (ONS) population projections. The comparator locations are the same as those used by the National Adult Social Care Information Centre (NASCIS) comparator locations referred to under footnote 1.

### 1.4 Planning for the future

As we plan for the future there are two important trends that we have to address, that are due to improvements in health care over recent decades.

- The first is the increase in the number of children who are surviving life threatening conditions and then continue to have needs that social services will need to support.
- The second is the fact we are all living longer and therefore we have a higher number of older people in the population, as can be seen in Figure 3.

However, the good news is that we are able to support many of these people to live as independently as possible, and that for older people the time during which they can expect to be in good health is increasing. Providing support to help people live independently and continuing to invest in prevention and wellbeing to extend the years of healthy life expectancy beyond the age of 65 will be a key feature of our strategy going forward. We will describe how we are doing this later in the document.





## 2 Working in partnership

Meeting the social care needs of local people can never be done in isolation. This section describes how we work in partnership with local people, the health service and with those who provide care and support, including carers.

### 2.1 Working with local people

Many of our commissioning decisions (decisions about which services we buy on behalf of the people of NEL) are taken with the involvement of community members. In addition, we also involve local people who are often "experts by experience" in the planning of services. ACCORD community membership is open to every resident of North East Lincolnshire, including staff members, so by becoming a member of ACCORD people can help shape health and care services now and for the future. Details of how to get involved are given at the back of this report.

**Case study: How these services made a difference.**

Mary was referred to the specialist unit from an existing care home with behaviour that was described as "challenging". The new environment and the enhanced level of care and support offered to Mary in this new provision resulted in a much more stable placement where staff were able to work closely with Mary to understand her needs in a much more satisfactory way. Six months after the move to the Haverstoe Unit, Mary is enjoying more social interaction, is more relaxed and is able to make day-to-day decisions for herself.

**Case study: How local people are playing a role in deciding what services are commissioned and provided.**

During 2011/12 our local dementia forum was involved in discussions as to what our local dementia services should look like. Specifically, there was a workstream identified around the quality of care for people with dementia in residential homes. The commissioning of specialist "enhanced dementia beds" was in part a result of this process and became a key part of our local dementia strategy. The local dementia forum, made up of people who have the illness, their carers' and other professionals were involved in drafting the service specification (the document that explains what we require of a provider) and even in selecting the preferred providers.

### 2.2 Working with the NHS

Our unique arrangement of integrated health and social care commissioning and provision means that there is less chance that the money we spend on social care duplicates or competes with health spending, or that there are gaps in what is needed locally.

Decisions on how we will spend social care money have increasingly been made at the same time as decisions on how health service money has been spent. Examples of this have included decisions about intermediate care services which have been made jointlyby health and social care. For example, when someone leaves hospital, community health and social care services will offer re-enablement services to get people back on their feet. These services will be delivered by health and social care staff, working in one organisation and working across traditional boundaries.

A number of local residents enjoy the benefits and flexibility of controlling their own care finances

through a social care personal budget. Personal budgets and direct payments allow people to recruit their own carers and put together their own package of care as they see fit. The benefits of our close working relationship and integration with the health service means that in North East Lincolnshire people who become eligible for Continuing Health Care can now transfer their package and continue to control their own resources through a personal health budget.

This is an area that we will continue to work on over the coming year so that where appropriate individuals are able to use a personal budget to tailor the care they receive.

**Case study: Integrated working between health and social care.**

Following two strokes, Bob's state of health meant that he qualified for NHS Continuing Health Care (CHC). Prior to his second stroke, Bob's care had been funded by adult social care through a personal budget and had used it to employ two personal assistants who he had built a good relationship with. When Bob became eligible for CHC he worked with one of our nursing staff to develop a plan that allowed him to continue working with the personal assistants he had already appointed, who were given extra training to adapt to his additional health care needs. This would not have been possible in areas that did not offer a personal health budget and Bob's care would have been disrupted and interrupted.

### 2.3 Working with our health and social care providers

In North East Lincolnshire we have developed two new provider organisations as described earlier (NAVIGO and Care Plus). Both have been able to integrate health and social care and are now well established providers who have built a strong local identity and good reputation. Being a social enterprise allows both staff within the organisations and the people who use the services ownership and input into how they are organised and run. This status also allows them to generate new income through commercial activity and charitable income.

The improvements we have seen in the care and support for people in North East Lincolnshire are partly a result of these organisational changes. However, in the future we want to make sure that it is the people who need care and support that influence how these services are delivered. The way this will be achieved is by giving people much greater say in how they spend the money that is allocated to their care.

### 2.4 Supporting people who provide care

Someone of any age who looks after a child, relative, partner or friend in need of help because they have an illness, disability, frailty or a substance misuse problem are a 'carer'. The support the carer may provide could be personal, emotional or supervisory and is unpaid.

Our vision is to ensure that carers are identified, recognised, valued and supported to carry out their caring role while having a life of their own outside of caring.

Within North East Lincolnshire, just fewer than 10 per cent of the population are carers (15,337 carers), a quarter of whom provide more than 50 hours of care per week. The numbers are likely to be even greater as we know that many carers do not identify themselves as carers.

As an integrated health and social care organisation, the Clare Trust Plus has a history of developing and providing services to support carers, including working in partnership with other local organisations and agencies as part of the local carers' strategy. Social Services has a responsibility to inform carers who are providing regular and substantial amounts of care of their right to request a carer's assessment. During 2011/12 about 1,800 carers had been assessed or reviewed, all of whom had received advice and information. The vast majority had also utilised carers support services to meet their needs. It is acknowledged that further work is required to ensure more carers are identified and supported.

In the future we want to ensure that carers have a stronger voice in the support and services they and the person they care for receive. In order to do this we have ensured that services such as the North East Lincolnshire carers' centre, part of the George Hardwick Foundation, become carer led over the next two years, by putting carers at the forefront of decision making. We have also re-launched the North East Lincolnshire carers' forum which is chaired and vice-chaired by carers to act as a local voice for carers.

**Case studies: Supporting the carer.**

Carers often find themselves under practical, financial and emotional pressures. In North East Lincolnshire we are able to offer the following:

**Carers Assessments**
**Direct payments and Personal Budget**
**Sitting Services**
**Emotional Support**
**Carers Alert Cards**
**Access to Carers Centres that provide a range of carers support**
**Help and Advice**

Carers tell us that without this support their families would not have been able to cope and the caring arrangements might have broken down.

One of the many examples included a woman who was concerned about her father. He was caring for his wife, who suffered from dementia. Her father was reluctant to accept support but had reached crisis point, admitting that he was considering taking his own life. By referring the family to the Admiral Nurses support service via the carers centre, guidance and support was provided to help them through this crisis. Respite care was arranged to provide a much needed break.

**Quote:** *"I know that without me caring for them, both my mother and brother would almost certainly be in full time residential care. However with the support I am receiving, we as a family are able to stay together at home."*





## 3 Our financial account

North East Lincolnshire Council funds a wide range of local services as well as adult social care including children & education, housing, highways and environmental, planning and cultural services. It receives income from council tax, rates, the government and other grants, totalling £373.6M in 2011/12. £48.7M of this was allocated to adult social care. When you include users' contributions this rises to £50.2M for 2011/12[4].

Due to population changes, demand for social services has increased year on year but demand has been contained within the budget allocated by making better use of our resources. As well as prioritising the needs that are presented to social services, as outlined earlier, we are also looking at the following ways of changing our service delivery to ensure that we can continue to meet needs at a time of unprecedented financial restraint in public services.

These include:

- Demand management – continue to develop the A3 service as described earlier to ensure we are able to give the right support at the right time by the right professional. We know that reacting quickly, and getting our response right, results in better use of resources and avoids long term care packages in many cases.
- Promoting "Prevention and Wellbeing" through developing community based support – for example, befriending and good neighbour schemes that tackle loneliness and lessen the likelihood people will need expensive on-going support.
- Getting better value for money by working differently with providers of care. For example, we will allow our home care services to respond appropriately to the people they care for rather than simply delivering set hours regardless if the person needs it or not.
- Developing less traditional models of care aimed at avoiding expensive long-term residential care. We will help people to live at home for longer and develop extra care housing that will be a real high quality alternative to residential care.
- We will develop our community equipment provision, which will further help people live at home for longer. We will also keep up-to-date with the latest technologies to ensure people can access the latest solutions to care needs.
- We will look again at our charging policies to ensure we protect the most vulnerable but ask those who can afford it to pay for the care they receive.

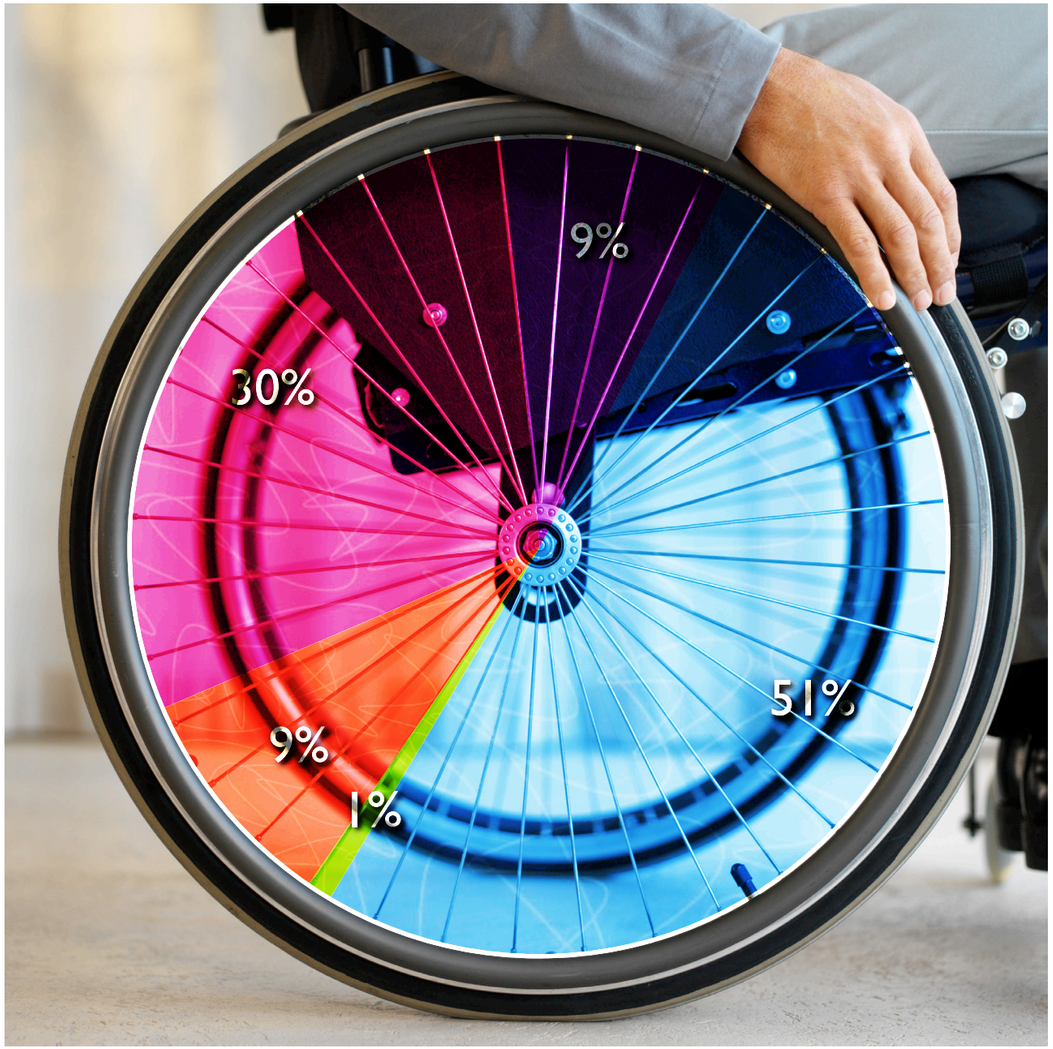
We then have a responsibility to spend this money wisely, which includes ensuring that there is a fair way to charge for some of these services where people can afford to do so. During 2011/12 a new fairer contributions policy was approved that supports the overall objectives of fairness and good stewardship of our resources. Figure 4 shows how adult social care spending is split[5]. Compared to other areas:

- North East Lincolnshire spends £1,356 per head of population aged 65 or over, which is the 2nd highest compared to similar councils
- Our spend on people with a learning disability is 14th highest compared to similar councils;
- Our spend on people with a mental illness is 3rd highest compared to similar councils;
- We are the 10th highest on the amount we spend on people who are physically disabled.

[4] Utilisation of NELC adult social care funding report (August 2012) undertaken by the East Coast Audit Consortium.

[5] The source for this information is the official PSSEX1 data for 2011/12 submitted to the DH as part of the Authorities statutory returns.

**Figure 4 The proportion of spend on different social care needs**[6]




- Physical disability or sensory impairment 9%
- Other adult social care 0%
- Older people (aged 65 or over) 51%
- Mental health needs 9%
- Social care strategy 1%
- Learning disabilities 30%

[6] The source for this information, and that in the remainder of this section, is an external audit report produced by the East Coast aaudit cconsortium and published in August 2012.



| Older People | Physical Disability | Learning Disabilities | Mental Health |
|---|---|---|---|
| £24.8M | £4.4M | £14.6M | £4.4M |

**Table 1 Spend on the main client groups (net of client contributions and using the breakdown in Figure 4)**

To reflect our overall objectives of improved outcomes and greater efficiency across all client groups it is important to note that:

- £3.3 million is being spent on direct payments where the service user has direct control over what support is purchased for them (up from £1.5 million four years ago);
- Management costs have been reduced in recent years by over £0.2 million with plans in place to reduce this by a further £0.6 million in the coming years;
- £0.79 million was spent on services directly for carers;
- The split of funding between care provided at home compared to care provided in a residential home has shifted from 20/80 to nearly 30/70 over recent years reflecting a much stronger emphasis on support at home;
- The shift in spend from bed based to home based services for people with dementia has been particularly pronounced and is in the order of £2.5 million.

## 4 How well are we doing?

For a long time now it has been recognised that our performance should be judged on the basis of outcomes rather than inputs or just financial efficiency. Outcomes measure whether people are any better off as a result of the support they receive or not. The adult social care outcomes framework (ASCOF) is a national framework that makes it possible to compare how we are doing with others. They cover four areas that are key to the role and function of adult social care:

1. Personalisation – enhancing the quality of life for people who need care and support.
2. Prevention is better than cure – avoiding the development of unnecessary dependence on Social Services.
3. Positive experiences – ensuring that whenever there is a need for care and support people get a positive experience.
4. Protecting people from harm – meeting our statutory responsibility to safeguard the most vulnerable in society.

### 4.1 A personalised and high quality service

Personalisation means that services should fit around the person, not the other way around. All our staff and providers are required to embed these principles into every aspect of their work. If however, this cannot meet the individual needs then people in NEL are able to plan and arrange their own care through either the use of a personal budget or a direct payment.

**Case study: Enabling choice and personalisation**

Eighteen-year-old Amanda has a severe skin condition and requires assistance to change her dressings several times a day. Through the integration of social care and health care direct payments, Amanda now has the ability to employ the carers of her choice and to arrange the time of the visits to suit her lifestyle. Previously, Amanda had to wait at home more or less the whole day to fit in with her previous assistants' rotas. Amanda now has the flexibility to get on with her life as she has planned her care and support around college and having fun.

This principle of personalisation covers all of the support we think a person needs, but we have different ways of helping people to achieve it:

- We will provide an opportunity for as many people as possible to influence what is provided for them. We call this 'self-directed support';
- For some people we will offer a personal budget which actually puts people in control of the money to purchase care flexibly and in line with their assessed needs. A personal budget can be managed by us or a third party on your behalf.
- A direct payment can be made directly to your bank account if you would like to fully control the money that has been allocated to you.

There are a lot of ways that we can measure if we are achieving this goal. Some of these are listed below:

1. By measuring how many people make decisions about the care they receive through self-directed support and personal budgets we can see how successful we are being at enabling personalisation and choice.

   **Performance:** In 2011/12 about 2,400 people (36 per cent of those that we supported) had either self-directed support or a personal budget. This is a slight improvement on the previous year but is below the average for other similar councils. Our target for 2012/13 is 60 per cent. This is a challenging target as the more people opt to take a personal budget, the more resources we have to free up from our existing contracts with our existing providers. We also need to make sure we have the best possible processes and mechanisms in place to ensure everyone is offered the choice of self-directed support, a personal budget or a direct payment.

2. The number of people with a learning disability or mental health need in paid employment is one measure that tells us how successful we are in supporting people to achieve and maintain their independence.

   **Performance:** In North East Lincolnshire 17 per cent (or 74 people) with a Learning Disability and 10.5 per cent of those with significant mental health needs achieved this goal. Although this is slightly lower than the previous year it is higher than most other similar authorities up and down the country. In 2012/13 we are looking to maintain these levels or improve on them by working closely with our existing providers and new providers who can offer people support and encouragement in finding employment.

3. By recording how many people with a learning disability or mental health need are living independently because of the support they receive, we can measure how successful we are in ensuring services are personalised and people have choice and control on where they live and receive their care and support.

   **Performance:** In 2011/12 72 per cent (310 people) with a learning disability and 89 per cent of those with mental health needs were living independently. This is slightly higher than in the previous year. For people with a learning disability this is about average compared to similar local authority areas whilst for those with mental health needs it is significantly above average. In 2012/13 we are looking to maintain these levels or improve them slightly by continuing to work with registered social landlords and care providers to open and build new appropriate accommodation.

We continually strive to ensure that all our services in North East Lincolnshire are encouraged to work with people as individuals and to allow the maximum amount of choice and control over their care and support. However, there is still room for improvement, particularly in the overall number of people who take up self-directed support. This continues to be a priority for us in adult social care and we are reviewing all our processes and systems to ensure we are able to offer this to the biggest number of people possible. In order to facilitate choice, we realise that we need to increase the number and variety of services on offer in North East Lincolnshire.

### 4.2 Prevention is better than cure

Maintaining independence requires a preventative approach. This means across NEL we are encouraging all our services to work with people to prevent ill-health, accidents and dependence. Some examples of this are the work we do around preventing falls and supporting people who live alone to take an active part in the community rather than becoming isolated. We have also developed our intermediate care services to ensure people who experience a period of ill-health and immobility are supported to get back on their feet as quickly as possible. The prevention and wellbeing agenda therefore is an approach that applies to all our work at whatever level of need people come to us with. The principle is we support people to get better, to support themselves staying fit and healthy rather than to encourage long term dependence.

**Case study: overcoming social isolation**

Bob was referred to adult social care because he felt lonely, isolated and was beginning to have memory difficulties. He had moved from a house in Grimsby to sheltered accommodation in Cleethorpes. An ooccupational therapist undertook an assessment concluding that Bob needed to familiarise himself with the local area and explore appropriate groups and activities. He began to attend a local group to build confidence and also the local memory café which offers a supporting environment and is provided by the Alzheimer's society. He also had one-to-one sessions with a worker and started to walk around local routes and attractions. Bob is now living happily at home and is still attending the memory café on a regular basis where he has made a number of friends. He got the right level of support as well as advice and guidance about his illness and options going forward.





By adopting a preventative approach as outlined above, we are able to reduce the number of people who are admitted to long-term residential care. To measure the success of our preventative approaches we monitor the number of people admitted to long term residential care.

> **Performance:** In 2011/12 140 people over the age of 65 and 8 people under the age of 65 were admitted permanently to a care home. This is 13 higher than the previous year but significantly lower than 3 years ago. It is also significantly lower than the rate of admission for comparable authorities up and down the country taking into account differences in population size. Despite the slightly increased numbers admitted, costs are not rising because people are supported at home for longer making their stay in a care home shorter. This continues the trend over recent years, which we plan to improve through a continued emphasis on support at home and new developments in extra care housing.

1. By counting the number of people who are still at home three months after a discharge from hospital we can measure the effectiveness of intermediate care services.

> **Performance:** In 2011/12 71 people were still at home 3 months after being discharged from hospital through intermediate care. This has increased from 59 in the previous year and is 99 per cent of all those discharged in this way. Nationally this figure is approximately 85 per cent.

The investment in the intermediate tier over recent years has meant that our performance in this area is good. There is still room for improvement by increasing access to intermediate care services but this performance suggests that once people access this support the outcomes are good.

**Case study: Helping people get control of their lives**

The Rapid Response Team received a referral from an elderly lady suffering from diabetes and heart problems. The assessment revealed that she was not eating, drinking or taking medication. She lived with her husband and was spending all her time in a chair in their home, it was evident that she was suffering from depression. They had previously refused services. Following a mental health assessment she agreed to try anti-depressants, with weekly follow up visits. She is now eating, drinking and taking all necessary medication. Her mood has improved, she has a better quality of life, and has agreed to further services to assist her.

### 4.3 A positive experience

It is important that we understand what users think of the services that we provide. We carry out satisfaction surveys for users and carers and try to find out whether the information we provide is easy to use and understand.

**Case study: Memory Cafe advice and support**

Joan accessed the Memory Café with her husband Brian. Joan had been diagnosed with Alzheimer's and Brian had noticed that she was beginning to decline, becoming withdrawn and introverted. The Memory Café offered an opportunity for social interaction in a friendly group that understood the illness. The café also provided support to Brian, gave him information about the illness and suggested ways of looking after and motivating Joan.Brian thinks that the Memory Café has been positive for Joan and himself.

1. We can measure the overall satisfaction of people who use social services. The way this is calculated is by taking a range of indicators and calculating what is effectively an 'index' of satisfaction.

   **Performance:** In 2011/12 North East Lincolnshire achieved the level of 59 per cent using this index, which is lower than the average of other similar authorities elsewhere in the Country. We have analysed this data and made improvements to our "front end" as described earlier.

2. In a similar way we can also measure the proportion of people who use services, and their carers who find it easy to find information about support.

   **Performance:** In 2011/12 North East Lincolnshire achieved the level of 74 per cent using this index, which is very close to the average of other similar authorities elsewhere in the Country, which is 75 per cent.

### 4.4 Protecting people from harm - Safeguarding Adults in North East Lincolnshire

The term safeguarding adults refers to the local arrangements that have been put in place to safeguard 'vulnerable adults' from abuse in North East Lincolnshire.

In North East Lincolnshire the safeguarding adults board (SAB) govern the arrangements that are in place locally to safeguard those individuals who may be at risk of abuse.

The key emphasis for safeguarding adults is the prevention of abuse and the ethos that safeguarding is everybody's business. Therefore a key area for the safeguarding adults strategy is raising awareness and communication. This includes engagement with staff within the health and social care services, but also with other organisations and the wider community including community groups.

The community voice has been established as part of the safeguarding adults governance structure, and is a group of community members who are passionate about safeguarding. The group have undertook to arrange a number of public awareness market stall events that have focused on issues such as isolation, doorstep crime and keeping safe at home. They have also actively promoted other local initiatives such as winter planning. The community voice were key agents in the development and implementation of the local keep safe scheme, which is a scheme that identifies a number of local business who are willing to act as 'safe havens' that vulnerable people can access if they feel threatened or fearful when they are out and about in the community.

The safeguarding adults team has a number of roles, the key ones being: the provision of advice, responding to concerns, the facilitation of safeguarding adults and Mental Capacity Act awareness training.

Since the development of the team, general safeguarding adults awareness has been raised, and referral rates to the team have increased significantly. This is illustrated in the graph below. As a result, considerable effort has been made to improve the quality of referrals coming into the team by the issuing of guidance notes and advice to referrers. This can be seen in the reduction of referral rate during the second two quarters of 2011/12.

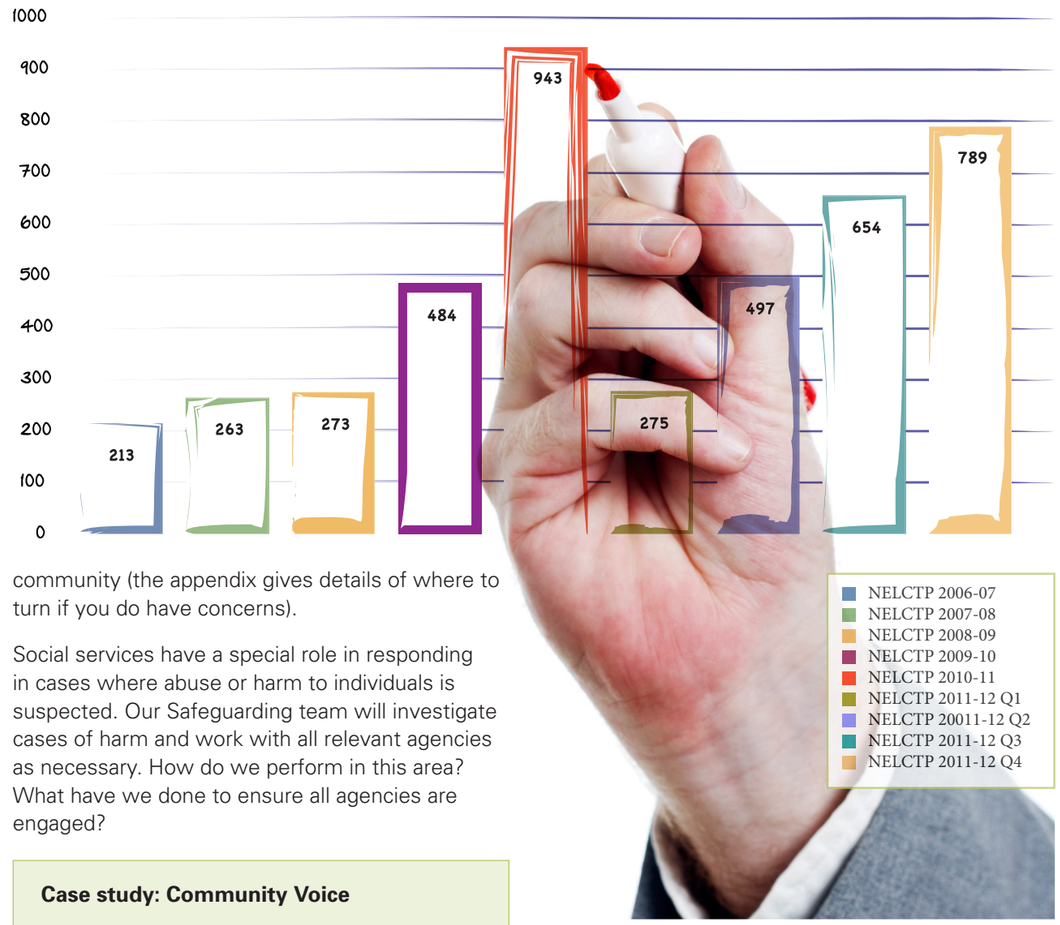
Although the high numbers of referrals can initially appear alarming, the referral rate does reflect that an increasing number people are looking out for concerns and sharing them appropriately so that any problems can be addressed. This is viewed positively. Not all of the cases referred went on to an investigation as the response to concerns needs to be both proportionate, and the least intrusive for the vulnerable person taking into account their views and wishes.

It is everybody's duty to be aware of people who are potentially vulnerable to harm in their





**Number of Safeguarding Incidents 2006-2012**




community (the appendix gives details of where to turn if you do have concerns).

Social services have a special role in responding in cases where abuse or harm to individuals is suspected. Our Safeguarding team will investigate cases of harm and work with all relevant agencies as necessary. How do we perform in this area? What have we done to ensure all agencies are engaged?

**Case study: Community Voice**

'Community Voice' work alongside public and voluntary sector agencies to address community issues and protect vulnerable people and are involved in our local safeguarding arrangements. Previously they have promoted awareness of social isolation and doorstep crime. They have also supported and promoted the winter planning campaign and the keep safe scheme. The community voice is currently planning the next event focusing on keeping safe at home, alongside offering advice and information about local organisations.

1. Measuring a sense of safety is clearly a difficult and subjective thing. However, we do ask people who use our services whether the provision of this support has made them feel safe and secure.

   **Performance:** In 2011/12 79 per cent of people answered this question positively, which is above the average for similar authorities elsewhere in the country.

## 5 Planning for the future

Because of the population changes we outlined earlier and government policy changes we need to plan for the future needs of the population. This means we need to:

- Understand the changing needs of the local population;
- Listen carefully to what people say helps them to stay independent;
- Work with our partners to continue to ensure an efficient and effective local system of care and support;
- Stimulate or commission new services that will act as catalysts for improved health and wellbeing.

We are addressing this through an approach called transformation which has a number of elements outlined below together with the actions we continue to take during the current year.

| What we need to do | Examples of how we are doing this |
|---|---|
| Invest in intermediate care services that help in rehabilitation and reablement | New recuperation beds have been opened to help the transition between hospital and the community where people need a little more time to recover |
| Support providers to improve quality and value for money | Contracting and performance management will continue to have quality and value for money at their heart |
| Enable people to have choice through personalisation | The emphasis on personal budgets and self directed support will continue |
| Support to self care | Working with the third sector and increasing the take-up of self directed support this important element of care will be enhanced |
| Developing the third sector | A strategy is being developed to enable the third sector to grow its business in North East Lincolnshire in line with local needs |
| Ensuring safety | We have well developed systems in place to ensure we are able to receive and investigate safeguarding reports and take the necessary action. |
| Enabling supported living | People with a learning disability continue to be given the choice to move into more independent living situations, with appropriate support. |
| Managing demand | Providing increased access to prevention services, particularly through A3 assessment and sign-posting activity, will help to manage demand.<br><br>We are also working hard to promote the development of Extra Care Housing across NEL to ensure there is a real alternative to residential care |
| Supporting local neighbourhood responses | Social services are selecting a community provider to work alongside them in stimulating local responses to need |
| Ensuring robust financial and performance management | A regular quarterly performance report is to be made available that integrates activity and financial information as they relate to achieving the transformation to a long term and sustainable local care and support system |
| Understanding and managing the system | Continued effort is being put into support for managers to understand the impact of the commissioning activity they undertake |

**Case studies: A picture of the future....**

Daniel is a young man with complex learning disabilities. He began receiving support from The Trust during the transition from children's to adult services. Through the Market Reshaping Programme they were able to find Daniel a place to live and staff to support him through the transition. The Trust began their work with Daniel while he was under the care of children's services, which allowed them to be gradually introduced to Daniel and learn about how staff worked with him. There were some issues while the changes were taking place, due to Daniel not coping well with change. However Daniel has now been living in his home for a year and has made huge advances. Support from staff has been reduced due to Daniel gaining independence, such as being able to prepare his own food and drinks, and this change has been well received by Daniel.

**Quote:** *"Before moving into his new home he had not visited his family home for over three years. He now visits his parents once a week and stays for about an hour and a half."*

**As we continue to work to deliver the care and support needed by the people of North East Lincolnshire there are opportunities for everyone to get involved. A list of contact details is contained in the appendix.**

## Appendix 1: List of engagement activity facilitated by North East Lincolnshire Care Trust Plus involving Accord members and the wider community

| Project | Activity | Engagement |
|---|---|---|
| A&E pilot | A new way of working was piloted in the Accident & Emergency Department at the local hospital and a patient questionnaire was used to gather feedback on the efficiency of the new service and also to find out if the new approach has improved things for local people. The aim is to reduce inappropriate admissions in the Accident & Emergency Department by effective referral to the most appropriate services. | To provide independence to the approach Accord members made calls to patients to gather their views. |
| Respect & dignity for hospital patients | Newly admitted patients to the B Wards at the local hospital were invited to take part in a survey to gather information around their experiences of in-patient care. | 4 Accord members involved in planning and implementation of the survey over two 3month periods.<br><br>83 patients completed surveys<br><br>A Patient Experience Sub-Group has now been established to take this work forward and an Accord representative is a member of this group. |
| Carers Health and Wellbeing Outreach Campaign | Outreach consultations | Over 1,000 accord members and 30 local organisations and groups including those with protected characteristics were informed of these events.<br><br>Feedback from the events helped to develop the Carers strategy and action plan |
| Access to primary care | Mystery shopping of GP practices in North east Lincolnshire | 6 Accord members made mystery calls to check consistency of service at all NEL GP surgeries.<br><br>The GPs and managers welcomed the survey and found the report very useful. Following this the report has been included in the recent round of contract review meetings with the expectation that where issues have been raised, practices will provide development plans that will address any matters identified.<br><br>More mystery shopping is planned in the future. |
| Healthy Lives Healthy people | Public Health Consultation on The Government's public health white paper | 100 Accord members were given the opportunity to attend the consultation and have a say on proposals outlined in the NHS white paper Equity and Excellence: Liberating the NHS |
| Safeguarding Vulnerable Adults | Monthly Meetings open to the public<br><br>Community events focussing on current issues affecting vulnerable people<br><br>Supporting local community projects<br><br>Raising awareness of safeguarding adults out in the community | 15 – 25 Accord members plus general public regularly attend monthly meetings. Invitations sent to local organisations and groups including those with protected characteristics.<br><br>All residents are invited to attend events organised by Community Voice, which are well advertised, posters distributed throughout local area.<br><br>Accord members regularly attend public events to raise awareness of safeguarding adults |
| Tendering process for care beds for people with dementia | Active Participation in a restricted tender exercise in N E Lincolnshire in order to contract with existing providers for the supply of Enhanced Care Beds, Shared Care and Assessment Beds and a Day Care Unit for people with dementia.. | 2 Accord members actively involved in the week long tendering process, viewing care homes, listening to provider presentations, and providing feedback on views.<br><br>The members' input was invaluable in providing an unbiased, objective assessment at each stage of the exercise.<br><br>Two contracts have been awarded based on the decisions of the panel. |
| Recruitment for 3 directors at Care Plus | Active Participation in Care Plus staff interviews | 2 Accord members on interview panel alongside staff members. Decisions made based on the opinions of all those involved. |
| Services4me | Supporting the development of a one stop information website. | 2 Accord members joined the steering group during the website development stage. 12 Accord members reviewed new information leaflets for the website and provided feedback. |
| Paediatric Cardiac services<br><br>Northern Lincolnshire | National consultation on the future of paediatric cardiac services. Regional event held in Leeds. Local event held across Northern Lincolnshire to raise awareness to the consultation and give the opportunity for local people to ask questions prior to responding to the consultation. | Accord members who expressed an interest in children's' services plus other community members from North and North East Lincolnshire were invited to attend a consultation event.<br><br>Relevant groups and organisations were also invited.<br><br>On 4 July 2012 the Joint Committee of Primary Care Trusts announced that the new congential heart networks would be introduced across England and Wales. This will result in the development of 7 surgical centres across the country. |
| West Marsh Lifestyle | Lifestyle survey in the West Marsh area<br><br>Workshop to gather information about the lifestyles of West Marsh residents | Public Health invited 100 Accord members to take part in a survey and to share information about their lifestyles by attending a workshop discussion. |
| Social Model of Disability | A series of workshops were organised to gather public opinion by talking to disabled individuals about the changes required to enable disabled people to participate in their community. | Over 100 Accord members invited to get involved and 3 Accord members took part in the Social Model of Disability Workshops which offered an alternative way of understanding issues in the 'disabling world.' |
| Stroke | A small working of stroke survivors and carers was established to support the Stroke Service Review. | As part of the work, an updated Stroke Information Pack was developed to help support stroke survivors and the carers. |