## Adult Social Care

# Local Account for 2016/17

## How did we do?

NORTH LINCOLNSHIRE COUNCIL

www.northlincs.gov.uk

# Foreword

**Welcome to the Adult Social Care Local Account. This document is intended to help you understand more about the services the council provides to adults living in our area. It shows you how services make a difference to someone's life and how we support people and communities in ways that engage and give them choice and control in the way they want to live their lives. We will tell you how we are performing, the challenges we have faced, changes we have made and our priorities for the future.**

People remain at the centre of everything we do in North Lincolnshire and we are working to ensure those in need of support and care live safe, fulfilling and transformed lives. It is essential to work with our partners and to listen to what you tell us to ensure the creation of our plans and services meet the needs of the people we support and the wellbeing of our communities.

Your views are important to us as they help shape our services. Page 00 contains details of how you can contact us.

**Cllr Julie Reed**
Cabinet Member for Adults and Health

**Karen Pavey**
Director for Adults and Community Wellbeing

Finally, may we thank the people who use our services, their families, and all the staff, partners and providers involved in the changes that have taken place during 2016/17, and look forward to your continued support for the future – Supporting us to keep our pledge – *'Nothing about you without you.'*

# Introduction

**This local account explains how the Adult Social Care and our partners are supporting the people of North Lincolnshire. It will set out our achievements in 2016/17 and what we plan to do in 2017/18.**

The service enables adults with care and support needs to maintain independence and control, be safe, have choices and remain engaged in the activities and relationships that are important to them. We do this by working with people who use our services, their family members and carers, our partners and provider agencies.

We continue to transform the way we do business to ensure we provide the best support to people, focusing on enabling people to remain in their own home and communities, tailoring support that is meaningful and meets a person's individual needs.

# Main Messages

- More people have been supported to regain the skills they need to remain living in their own homes, strengthening the rehabilitation and reablement service.
- The Community Wellbeing Hubs are continuing to increase the number of people attending activities. This has a positive impact on preventing or delaying the need for long term care.
- The implementation of the Care Networks has improved joint working with health services to improve health and wellbeing outcomes for the people of North Lincolnshire.
- Supporting people to learn or re-establish daily living skills, supply telecare equipment, support access to employment, housing and to community activities that promote healthy living and keep people involved in their community.
- The number of carers receiving self-directed support and/or a direct payment continues to increase.
- The 'Bespoke Care Solutions' model has been introduced across the service resulting in outcomes that are meaningful and specific to individuals.
- The number of people who told us they have more choice and control over their daily life has increased.
- The principle of 'Making Safeguarding Personal' has been implemented across our services.
- The volume of people supported has increased by 14% compared with last year.
- The All Age Carers online training has been launched and this was quickly adopted by other local authorities to train their staff.
- Remained in budget and at the same time increased the number of people we support.
- Developed resources to try out different accommodation choices to help people make informed decisions about their future living needs.
- Implemented the Community Responder Service to provide 24 hour response to people with care needs living in their own home enabling them to remain as independent as possible.
- Implemented the Discharge to Assess and Trusted Assessment project to support a person return home as soon as it is safe and their acute medical needs have been met.

# Who did we support?

1,824 People with caring responsibilities

**14,672 People Supported**

2,618 people with eligible care needs

297 people with housing related support

204 aged 18-64 with a physical disability

340 people living with a learning disability

450 people living with a mental health need

6 people with other support needs

1,618 people with aging frailty

897 people supported by care homes

10,884 people in receipt of a blue badge

609 people receiving short term breaks

126 people in receipt of telecare equipment

1,721 people receiving home care

1,153 Carers received preventative services

855 people 18-64 helped to live independently

866 people 65+ supported to live independently

1,229 people received a direct payment or personal budget

320 new registrations at the Community Wellbeing Hubs

4,128 people provided with Occupational Therapy equipment and adaptations

# What we do

**We provide care and support to people over the age of 18 to enable them to remain as independent as possible and have choice and control over how they live their lives.**

This includes people who experience frailty due to later life, people living with learning disability, physical or sensory impairment/s, long term health conditions, mental ill health issues.

We support people who are caring for a family member, friend or neighbour and work to ensure they have the right information, advice and support to continue to care for their loved one.

With our partners, we provide 'Rehabilitation and Reablement' support which is designed to enable people who have experienced changes to their health, as a result of illness, injury, a surgical procedure or general decline in health, to regain independence. We do this by providing social care support and therapy to develop or regain the life skills needed to maintain independence and remain in control of how they want to live their lives.

The main focus of our service, across all areas of support, is to provide the best possible opportunities for people to remain in their own home or to develop skills to increase their choices and independence. This approach helps people to achieve their full potential and live as independently as possible.

We work with partners and Children's Services to understand the needs and aspirations of young disabled people who will be moving into adulthood, ensuring a safe and smooth transition.

Our 'Preventative' services support people to maintain their health and general wellbeing. Anyone can access the Community Wellbeing Hubs where we provide social and fitness activities, information and support to help people stay physically and mentally well.

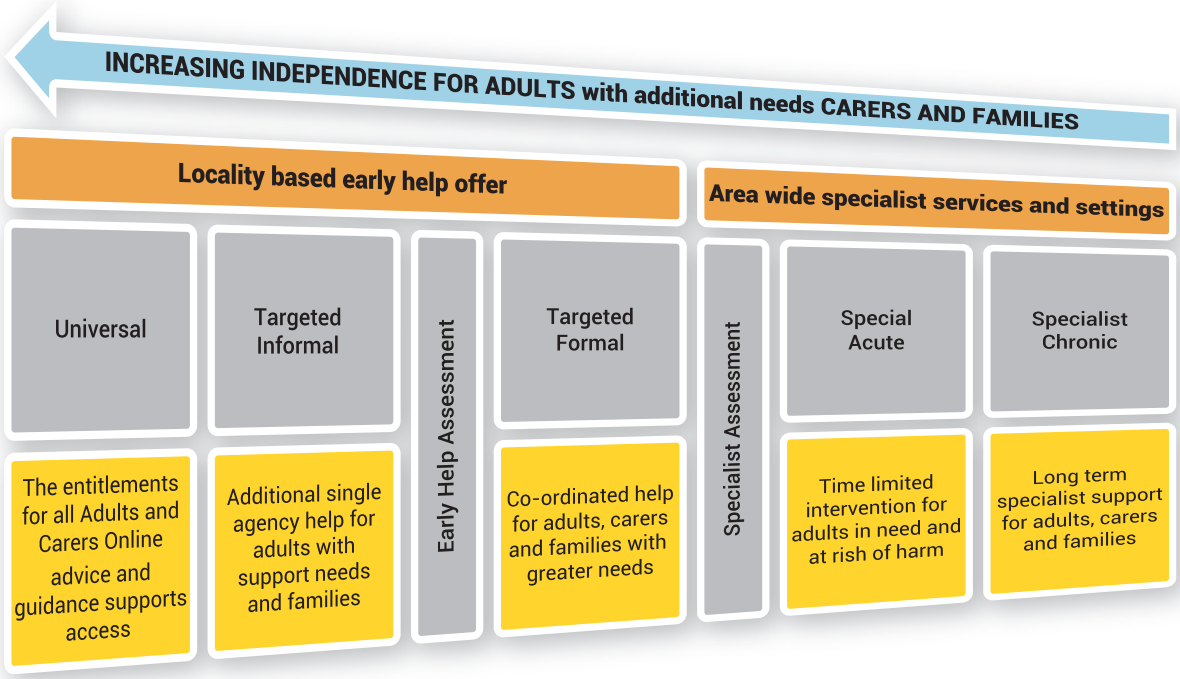
The number of people living with multiple long term conditions is increasing and we need to provide services that meet people's needs - maintain an individual's independence, promoting choices that enable a person to remain in control of their lives. This can be through 'Telecare' equipment, support to regain or learn daily living skills, activities to keep healthy and involved in community life or a personal budget to buy their own care and support.

> A personal budget is an allocation of money given to a person to use to enable them to decide what care solutions would best suit the way they want to live their life.

We commission other organisations to provide services on our behalf. For example, support to live at home or to live in a care home, advocacy services, support with housing and support at work or in a voluntary placement. We contract for these services and monitor the quality of them to ensure they are achieving the high standards of care we expect and the outcomes that have been set out in a person's care plan.

We support organisations that provide residential and nursing care services, through training, advice and monitoring to provide the best outcomes they can for anyone living in their

**Services are organised on levels of need, they are:**




At the heart of every service, whether it is for short or longer term, we aim to support people to live well for longer, have choice and control, and be involved in their community with the opportunity to appropriately access life chances including, education, volunteering, employment, leisure and other social activities/opportunities as independently as possible.

Our partnership with health services enables us to improve the health and wellbeing of our communities. We have worked together on a number of projects over the year to enhance and improve the experiences of people of North Lincolnshire.

# What we do

**How much did we spend in 2016/17 and what did we spend it on?**

**£55.584m**
Gross Expenditure

Personalised Longer Term Care:
**£36.417m**

Voluntary Organisations:
**£598,000**

Assessment and Targeted Services:
**£18.569m**

| | |
|---|---|
| **£9,354,000** | Contributions from people |
| **£8,217,000** | Income from NHS, Grants, other sources of income |
| **£38,013,000** | Net Total Expenditure 2016/17 |

# The Focus for 2016/17

**The Focus for 2016/17 was:**

**People live well for longer:** Implement the three 'Care Networks' where health and social care professionals work together locally to improve health and wellbeing outcomes for the residents in their area.

**People are enabled to be involved in community life:** Strengthening supported employment.

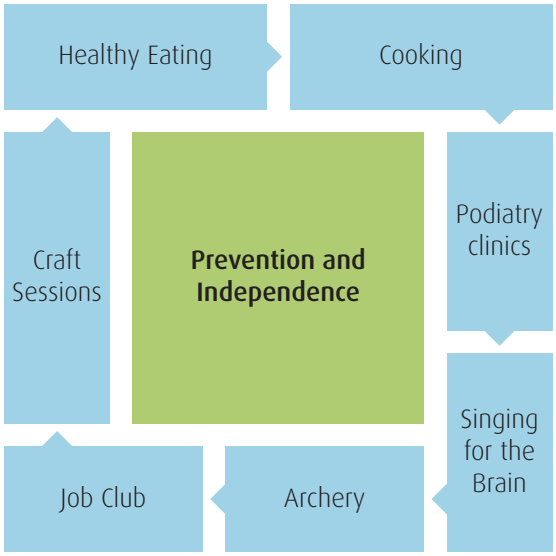
**People have choice and control:** Embed the 'bespoke care solution' model of support to encourage people to explore how their support needs can be met in a way that is creative, meaningful and personal to them and can obtain the best value for their personal budget.

**Safeguarding:** adults at risk of harm are able to decide what steps they can take to change their situation and to be involved throughout the safeguarding investigation. Experts by Experience improve the quality of provision across the area.

# People live well for longer

**Activities at the Community Wellbeing Hubs**

The Community Wellbeing Hubs provide an opportunity for members of the public, adults with care and support needs and carers to take part in health and social activities to keep well and stay in touch with their local community.




People can access a range of activities including social and sports activities, such as archery and trampolining, different kinds of crafts, singing for the brain, the dementia café, mother and baby groups, as well as health related services, for example, podiatry clinics and Livingwise weight loss programmes.

The Hubs also provide people with information, advice and guidance to maintain their independence and prevent them from needing long term care and support.

**My Story**

My son has many different care needs and was only happy going to places where he had been before. This made it difficult for him when he needed to go somewhere different and would make him very stressed and unhappy. Staff at the hubs, and his care workers, have helped him access the community hubs which has really improved his confidence. He now has more friends and has built his confidence so much he is able to go to the pods. He looks forward to going out now.

Celebrations for the Queen's 90th birthday took place in many of our Community Wellbeing Hubs, with activities and quizzes, singing and plenty of food.

There are seven Community Wellbeing Hubs across North Lincolnshire. More people have attended the hubs during 2016/17 and we are aiming to reach even more.

Health partners, provider agencies and community groups are now using the hubs to deliver their own activities, clubs and information services.

Why not find out what's going on in your local hub.

# Expert Patient Programme

| Expert Patient Courses | |
|---|---|
| No. of Courses | No. of people attended |
| 7 | 65 |

The Expert Patient Programme is a free six-week course for people living with a long term health condition. The course can help people take control of their health by learning new skills to manage their conditions on a daily basis. The majority of the courses are led by volunteers who themselves have long term health conditions.

*I was really impressed with the course and the way it was delivered. I am hoping that I can become a champion for the programme or maybe a tutor!*

You do not need a health professional to refer you for a place on this course, go on-line and complete an application form or give us a call on 01724 298421.

**My Story**
My partner and I were living with anxiety issues and had difficulty interacting with others. We both agreed to go on the programme and to support each other.

By the end of the programme I was able to take a trip to the local shop for the first time in 25 years. The Expert Patient Programme had given me the skills and the confidence to get out more.

# Working together

We spoke in the last local account about a project to work more closely with our health colleagues within the community. This was called the creation of the 'Care Networks'. Our ambition to relocate our services to three networks across North Lincolnshire has been implemented, although we will continue to develop our systems and ways of working to benefit the communities of these areas.

Care Networks are made up of social care and health professionals, working together locally to improve the health and wellbeing outcomes for the residents in their area.

Each Care Network is able to tailor its services to meet the needs of the area it supports and its particular local circumstances. Joint working has enabled us to use available health and council resources to reduce the need for hospital admissions and support people to live in their own homes for longer.

We continue to work on processes for sharing basic information so that people who need health and social care support only need to tell their story once.

# Doing things differently

During the summer of 2016 we worked with health teams, doctors and social care providers to understand what a Gold Standard of health and social care should look like. Over a period of 14 days we worked together to understand where the blocks to providing the Gold Standard of service are and how we can improve what we do. People were able to join in the conversation using #nlperfect14.

A number of changes to how we can work together to improve outcomes for people were identified:

- We have established multi-disciplinary meetings within each network, ensuring the health and social care needs of individuals can be discussed and resolved efficiently without the need for lengthy communications.
- Social Care Link Workers have been established to link with GP surgeries and social care providers to ensure communication streams and working practices can continue to explore how we can work together to support people to live well in our communities.
- The Care Home Assessment Team, a multidisciplinary team, was created to support people living in care homes. They work to prevent hospital admissions by giving care homes direct access to emergency care practitioners, social care, nurses, therapists and doctors. This supports people to live well in care homes and reduce unnecessary admissions to hospital.

# Hurry home!

When a person, who is vulnerable because of frailty or a disability, finds themselves in hospital because of an illness or accident, it can be a frightening time. People experience uncertainty about how long they will be in hospital, what their future will hold and how they will cope when they get home. A lengthy stay in hospital can lead to muscle wasting and loss of confidence, which means they can struggle to regain the independence and quality of life they had before. It is therefore important to support a person to build their confidence to return to an appropriate level of independent living as quickly as possible.

The Discharge to Assess and Trusted Assessment projects are designed to support a person return home as soon as their acute medical needs have been met, removing the potential for delays while different professionals carry out their assessments at the hospital bedside.

One assessment, in partnership with health and social care professionals, is carried out in the person's own home – this way we can more accurately identify their care needs and rehabilitation requirements. The person involved only has to tell their story once and together we can ensure a person's particular needs and circumstances are understood and solutions to their support are meaningful for them, maintaining their choice and control over the way they live their life.

If a person goes to Accident and Emergency (A&E) we support them to get home rather than go into a hospital bed. We provide support until an assessment in their home is completed. This element of Discharge to Assess supports people at A&E, 24 hours a day, seven days a week and means we are able to reduce the numbers of people admitted to wards, ensuring people are able to go home safely until a full assessment is completed.

This project aims to reduce the number of hospital admissions, enabling effective use of hospital resources.

| **2016/17 Facts and Figures** | | |
|---|---|---|
| Key Performance Indicator | North Lincs. 2016/17 | North Lincs. 2015/16 |
| Delayed transfers of care from hospital attributable to adult social care | 2.6 | 2.0 |

*N.B. A low figure means the council is performing well.*

| **2016/17 Facts and Figures** | | |
|---|---|---|
| Key Performance Indicator | North Lincs. Council 2016/17 | North Lincs. Council 2015/16 |
| Percentage of older people still at home 91 days after discharge from hospital into R & R services | 92.3% | 91.1% |
| Percentage of older people offered reablement on discharge from hospital | 3.5% | 2.6% |

**91.7%** of people who received a short-term reablement service went on to need no further support.

# The right home for you

We understand that it can be difficult to envisage what it would be like to live independently again for someone who has lived in a care home or had a long stay in hospital. A short stay in our extra care housing accommodation can allow people to see if living in a supported care environment would better fit their care needs.

The flat has been used to help people who are currently living in their own property to see what supported living is like and also people who are living in care homes to see if they could improve their independence. The flat has also assisted people who are moving between properties, provide respite for carers and also provided a space of safety for people who are vulnerable from safeguarding issues.

The flat is fully equipped and furnished to provide people with a safe experience of independent living. As well as the facilities within the flat, people can take advantage of the services provided within the complex, for example, guest lounges, hobby room, restaurant, hairdressing and laundry.

People have been enabled to make informed decisions about the type of housing and support they need to meet their care needs, supporting them to remain as independent as possible.

# Experts by Experience

We are committed to our policy of 'nothing about you without you'. To support this, and to ensure that we are able to listen to the views of people who use our services, we have recruited a number of Experts by Experience. An Expert by Experience is someone who has experience of using health and care services or is, or has been, a carer of someone who has care needs.

There are now 14 people recruited to support us to develop and test our services and information.

The team get involved in many different projects and this year they have:

- Worked with the Local Safeguarding Adults Board (LSAB) to co-produce their new webpages, contribute to their leaflet content and design and support with the production of their promotional materials.
- Worked with Yorkshire and Humberside Local Government Regional Group to carryout mystery shopping.
- Helped produce care and support leaflets.
- Proof read and provided feedback on strategies and policies.
- Provided feedback and comment on the new trusted assessment for referral to Intermediate Care.
- Been involved in the creation of the process and guidance for commissioning home care support.

They also work as 'Quality Ambassadors' by gathering peoples' views on the support they are provided when they are living in a care home or receiving care in their own home.

Last year the team attended the Safeguarding Adults Board conference and were able to contribute to the improvement and shaping of policies and services.

The team took part in the Learning Disability Week, Interactive Market Stall event held at the Ironstone Centre. They used this opportunity to promote their work and recruit new team members.

*I have got so much out of being an Expert by Experience. I have built new friendships, received support and kindness and been able to influence services to ensure people remain at the centre.*

The Experts by Experience meet monthly to look at forthcoming projects and invite officers and council members to attend their meetings to discuss ways of including our citizen's voices in future information and service developments.

*People often tell us things they would not say to others, this helps us to get meaningful feedback on services.*

# Living independently

The Intermediate Care Service is a time-limited, short-term service that provides rehabilitation and reablement which aims to get people back home after an injury or illness, enabling them to live well within their home as independently as possible.

**My Story**
After suffering a stroke I was supported by the Intermediate Care Service to get back home. I was very low. I couldn't get around and I had lost the use of one hand.

Staff supported me with therapy and the skills I needed to look after myself again and helped me to get access to the internet to stay in touch with people.

They helped me find a new flat that had easier access and I am now working towards getting back to work.

We provide personalised programmes of:

- Rehabilitation to help people regain physical strength
- Reablement to help people regain daily living skills and confidence to live at home.

Our programmes can be provided:

- Within a person's own home by the Community Support Team (CST), or
- As a short stay in The Intermediate Care Centre, based within Sir John Mason House.

We always aim to provide care in a person's own home wherever possible.

**My Story**
I spent some time in the Intermediate Care Centre because I recently had a leg amputated. When I arrived I was very depressed and I needed a lot of help to get mobile again.

Once I had a prosthetic limb I was supported to learn to use it. The service provided me with an exercise bike to use during my stay and this helped me to get fit again.

Staff also helped me stay in touch with people by supporting me to use the computer and IPads. They helped me to make sure my home was ready to return to and I was able to go home without needing any further support.

# Staying active

Staying active is an essential part of getting well again. For those people who need rehabilitation in the Intermediate Care Centre we are focused on enabling them to "Get Up, Get Dressed and Get Moving" in order to prevent further loss of muscle tone. This is important because a person over 80 who spends 10 days in a hospital or community bed will lose 10% of muscle mass. This could be the difference between going home and going to a care home. We are promoting awareness of this through posters and information and also through twitter #nlsnoozeulooze.

Throughout 2017/18 we will be implementing #nlsnoozeulooze. This is a simple concept that recognises a person's time is the most important currency in health and social care and defines each day a person spends in the Intermediate Care Centre as either a red or a green day.

'Red days' are defined as those days that fail to contribute to improving a person's independence and getting them home. By working better together, we can reduce red days and increase the number of valuable 'green days'.

Green days are where a person receives support or therapy, or takes part in activities, that moves them towards regaining their independence and getting back home.

We will analyse why a person has a red day and work with our partners to remove and reduce the things that cause delays in getting people back to their independent lives. If you would like to learn more go to Red2Green or 1000days, or you can join in the conversation at #red2green and #nlsnoozeulooze.

# People are enabled to be involved in community life

## Young adults living with a learning disability

Young adults who are living with a learning disability and still studying are currently having some of their sessions at our Wellbeing Hubs a few times a week. The students work with their tutors for part of their day, continuing with normal studies, and then are able to take part in community activities that are going on in the hubs.

These activities support students to be confident in taking part in sport or social events within the community, develop new skills and build friendships and natural ways of getting support. Students start to develop a sense of belonging and can start the journey of contributing to their community.

## Dance through the decades

Initially created for people living with dementia, Dance Through the Decades has proved so popular that a wide range of people now join in.

The 'dancing' can be as energetic or gentle as you can manage. The sessions combine memorable music and fun movements that can be done seated or standing.

The activity is fun and sociable and also helps keep people healthy and active. The sessions are held at the Scunthorpe Wellbeing Hub every Thursday from 11-12 noon.

## Getting into work

We work with people who are experiencing difficulties organising daily living needs. It may be they have lost their confidence and struggle to make daily living decisions or are having trouble managing their finances. We work to enable people to have control over their day to day life by participating in work, education, training and universal services.

*A young person with a learning disability told us they wanted to get back into work. The person had worked before and we discussed the type of work they wanted and what skills they had.*

*We worked with them to find voluntary work that would fit their skills and experience.*

*They are now working part time and volunteering in a coffee shop. This has meant that they are involved in their community and experience the independence, pride and freedom that comes with being employed.*

We have supported people living with mental ill health to gain the confidence and first steps needed to get back into employment in a number of ways. One of which is a craft and joinery workshop where people can go to learn new skills and meet others who are facing similar issues. The six week courses provide a foundation for people to build self-confidence and to gain skills which may support their recovery and possibly lead to employment.

# Tailored support – everyone is different!

Last year we talked about a pilot, Bespoke Care Solutions, to find different ways of working with individuals and their family or carers to explore how they would like their support needs met in a creative and meaningful way to them, helping them get the best value for their personal budget. The pilot was successful and the benefits of working in this way across the Care Networks were clear.

Each network has a lead enabling people to access meaningful opportunities to support their care needs. This might mean reducing or replacing the traditional kinds of support, for example, day care and home support visits and finding creative and unique ways to be supported in the home and out in the community.

We do this by understanding what a person sees as important to them, help them design their own support package, and look at ways they can remain as independent as possible, helping them regain daily living skills they may have lost.

*A young man with learning disabilities had recently lost his father and was missing the activities they used to do together. We supported him to look at ways in which these activities could continue.*

*We helped him employ a Personal Assistant who was be able to go with him to go to the local pub for a game of snooker, to the cinema or to music concerts.*

*An employment advisor supported him to find and apply for jobs.*

*By looking at the services he was already receiving together we were able to redesign them so he was able to use them to do things that were important to him, like choosing his own shopping and activities outside of 'traditional' day services.*

*He has now developed a network of friends and has more control of how he lives his life.*

# Strengthening supported employment

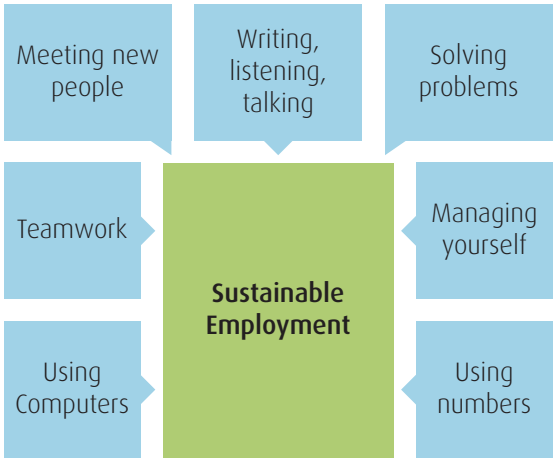
We are working with people, partners and employers to develop more employment opportunities for people living with a learning disability or mental ill health.

A mapping exercise has taken place of all organisations and services available in North Lincolnshire to support people to get into employment. We understand that services to encourage and support the skills needed to maintain a job are key to long term employment.

**My Story**
I was feeling lonely and I wanted to get a job. My support worker helped me find work with a local charity.

I am enjoying getting out and about and like getting the money at the end of the month.

We have worked alongside partners, including Education and providers of Post-16 Training, in the development of seven skills needed to help people get a job, these are:




To support people to achieve these seven employability skills we have developed a 'Journey to Employment' journal. The journal helps people work with their family, carers and support workers to track their progress against the seven skills.

We are currently working with potential employers to develop more employment opportunities and ensure that employment is sustainable for people and employers.

Supporting people living with mental ill health or a learning disability to get into paid or voluntary work offers many challenges and we are working hard to understand the barriers people face when returning or finding work. We will work hard to support people to manage their long term health conditions, improve their confidence, gain new skills, and find an appropriate job with the right support.

We need to explore how we provide enough information and support to employers and voluntary organisations to generate opportunities for employment and we will work with partner organisations to support these ambitions.

## Hub Club

The Hub Club is open to 16-25 year olds living with a learning disability. These sessions are led by the young people who decide what activities they would like to take part in.

Communicating and mixing with others can sometimes be difficult for someone who has a learning disability.

The Hub Club is a place where people can be creative, active social or just chill out. It can also build independence, social skills, autonomy and self-esteem.

Members of the Hub Club officially opened the new community kitchen at Scunthorpe Community Hub.

# People have choice and control

## Carers Advisory Partnership

The Carers Advisory Partnership is made up of people who have been, or are, carers. They work to develop and raise the profile of carers with service providers in North Lincolnshire. The partnership ensures the voices of carers are listened to and helps to develop services that give carers choice and control.

The partnership has worked on a number of projects with us over the last year. We have together created a new Carers Guide. The guide provides information on how to access advice, information and guidance on staying healthy, the assessment process, finance, housing and useful contacts.

Personal Budget Information packs were created and have been piloted in the Care Networks. The information from the pilot is being collated and will inform any amendments needed before the packs are launched formally.

The Carers Advisory Partnership has also been actively involved in many other projects locally and regionally, some of which are:

- the creation of an 'All Age Carers e-learning Package',
- the design of our Home Care Contract, and
- presentations and talks at conferences and events to raise the profile of carers in our community.

National estimates suggest there may be **19,000** carers in North Lincolnshire with approximately **7,000** carers providing **20** or more hours of care per week.

## All Age Carers Training

The All Age Carers Commissioning Strategy identified the need for developing training on carer's issues for both professionals and carers of all ages. In partnership with young carers, adult carers and the Carers Partnership Board we have developed an e-learning programme that can be completed online. The course supports professionals and carers to learn about the issues caring responsibilities can bring and understand where people can access information and support. The course covers:

- Information about different carer groups
- Detail about hidden carers
- The rights of adult and young carers
- Key statistics about carers in the UK
- Case studies on young and adult carers including their outcomes after they have received help from the council
- How to access further information and support.

Other local authorities have requested to use this training for their carer communities and we have been able to share this with them.

The course is free and you can access it by contacting our Health and Social Care Workforce Training Team on 01724 298409 and asking for access to the All Age Carers E-Learning package.

| 2016/17 Facts and Figures | | |
|---|---|---|
| Carer Survey Results | North Lincs. Council 2016/17 | North Lincs. Council 2015/16 |
| Percentage of carers who said they were satisfied with the service received. | 50.2% | 44.6% |
| Percentage of carers who said they were included/consulted in care conditions | 82% | 72.5% |

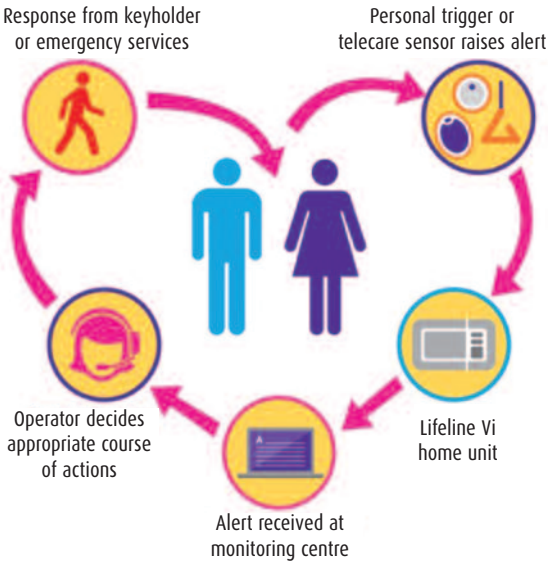
**My Story**

I needed to go into hospital for an operation but I was worried about how my husband would be cared for whilst I was away.

The Family Carer Team worked with my husband and I to find the right support for us so that I can have my operation without worrying about my husband's care.

They have also supported my daughter with training so she can help me care for my husband and this has given her the confidence to return to work.

## Telecare




To support people to remain in their home for longer we use 'Telecare' systems. This is the name given to electronic equipment which can support people to remain independent. The equipment may be an alarm or sensor that can be worn by the person or placed around the home. For example if someone has had a fall a sensor that is worn around the wrist or neck will alert our call centre who can then seek help for that person.

**126** people received telecare equipment to promote and support independence at home

Telecare systems can also monitor if a door is opened, or whether someone has gone to, or got out of bed. These types of sensors help carers and care providers to monitor activities to ensure the most appropriate support is provided.

**My Story**
I had been in residential care for some time and I wanted to live independently again. My support worker helped me to choose the right Telecare equipment to help me live safely in my new home. I feel so much safer now and my confidence has improved. I know there is always someone there if I need them.

## Access to Continuing Health Care

NHS Continuing Health Care (CHC) is free care outside of hospital that is arranged and funded by the NHS to meet a person's primary healthcare needs. We worked with our health partners to create and deliver training to our staff, voluntary organisations and private providers so they can support people who are eligible for CHC to receive the appropriate funding, in a timely manner, to enable them to have choice and control over their care and support needs.

By training front line staff to understand the eligibility criteria and application process we have improved the ability of the workforce to gather evidence and present a comprehensive application for Continuing Health Care funding. This has resulted in the number of people being considered eligible for this funding rising by 21% during 2016/17.

## Transition to adulthood

Young people face plenty of challenges when moving into the adult world, and young people with learning or physical care needs can face many additional challenges.

We start building relationships with young people and their families from the age of 14 so that together we can plan for future care needs and understand their aspirations for how they would like to live their adult life.

This ensures together we plan for further education and independent living, people are supported to gain the necessary life skills needed and young people and their families are informed about the support that is available to them as adults.

We have worked with universities to understand what support and facilities will be required to enable the young people we support access the universities of their choice.

# Sports Activities – Mental Health

Physical activity can play a key role in recovery from mental health issues like anxiety and depression and help people to stay well in the long term.

Feelings of low self-confidence, exhaustion or fear of crowded places can create significant obstacles that prevent people from taking part in sport or physical activities.

We have worked with Leisure Services to create a programme of activities and taster sessions at the Pods for people living with mental ill health issues to enable them to make sport a part of their lives and recovery.

After only a short while we found that people had gained in confidence and were able to attend the Pods on their own. They were taking part in other activities at the Pods and were making arrangements to meet outside of the health sessions. Friendships and informal support groups were made and people were able to feel more confident in taking part in activities in their own communities.

# People are Safe

## What is Safeguarding?

Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect.

We work with partner organisations, for example, health services, police and other government departments to investigate allegations of abuse and support people to remain safe from harm.

**Our four priorities are:**

- To keep adults safe at home
- To keep adults safe in care and health settings
- To raise awareness of keeping people safe
- To ensure the Safeguarding Board leads multi-agency safeguarding effectively

## Safeguarding Facts

The Government issued new guidance about when a safeguarding concern should be counted as a safeguarding incident under Section 42 of the Care Act 2014. In light of this guidance there has been a change in the way we record safeguarding incidents and so this has led to an increase in figures when compared to the year 2015/16.

**382 concluded Section 24 safeguarding enquiries**

| | |
|---|---|
| 295 risk identified and action taken to make person safe | 34 no risk identified and no further action needed |
| 29 no risk identified but actions and advice provided | 18 people were happy with advice and able to resolve issues themselves |
| 5 safeguarding unproved – action and advice provided | |

Analysis of information for North Lincolnshire shows that:

- Physical abuse, neglect and financial harm remain the highest categories for safeguarding investigations.
- Women over 65 and people in care homes are amongst the highest population who receive support through a safeguarding investigation.
- There has been an increase in the numbers of people requesting an investigation be stopped. This might be for a number of reasons, for example, they may feel their issues are resolved before the investigation is complete.

- A review of feedback shows that people are happy with the outcomes of investigations and actions taken to support them to be safe.

**80%** of Care Homes in North Lincolnshire are rated by the Care Quality Commission as Good or Outstanding

## Young Adult Exploitation

As children, victims of child sexual exploitation may already be in receipt of services through Children's Service. We recognise that just because they turn 18 their need for support does not disappear. We have developed clear pathways to support vulnerable children into adulthood, to keep them safe after they reach 18 and support them in the challenges they face in recovery.

**97%** of Home Care providers in North Lincolnshire have an overall rating of Good by the Care Quality Commission Outstanding

## Training to keep communities safe

We provide a wide range of courses for adults, carers, partners and provider organisations to develop the knowledge and capacity of care providers across North Lincolnshire.

These courses are delivered through e-learning or workshops and together aim to ensure that adults and their carers are able to have choice and control over how they live their lives and all people who work within the social care environment are trained to a high standard.

82 workshops and e-learning Courses

237 workshop training sessions

5,461 people trained by workshops and e-learning

## Community Responders

Community responders provide a flexible and speedy response when care call alarms have been activated by a person. They may have had a fall or perhaps living with dementia and have become confused. The community responders go to the person's home and will remain with them until medical professionals arrive or a family carer arrives. A responder may just need to give some reassurance if someone has become confused and help them settle again.

The service operates 24 hours a day, 365 days a year. Over the last year the reasons for people calling the responders have been varied, but the core aim remains the same – To provide a flexible response to falls or other concerns in a person's home, ensuring that people can remain safely and independently in their own homes.

# Quality: Monitoring and Evaluation

**We monitor the performance of services provided to adults with care and support needs by collecting data and asking people directly about the services they are receiving.**

During 2016/17 we collected information on 28 key performance indicators. These are called Adult Social Care Outcome Framework (ASCOF) Indicators and are measures that are collected nationally. This allows us to see how we are performing against the priorities we have set, against our regional neighbours, authorities that are similar in size to us and how we are doing nationally. More information on the ASCOF indicators at Appendix 1.

## In The Pink

In the Pink is a survey sent to residents of Care Homes and forms part of an annual quality assurance process of Residential Care Home providers in North Lincolnshire.

The survey gives people the opportunity to give their views and write comments; it is these views, comments and ratings that we use to evaluate how people feel about the care they are receiving in their residential home.

## Care Homes

We work to help people to stay in their own home for as long as possible but there may be reasons why living in a residential home is necessary. This could be a short term stay to regain daily living skills or a more permanent solution to care needs.

We work with care home providers to monitor the quality of services provided through our 'In the Pink' surveys and by using our Experts by Experience in their Quality Ambassador role to talk to people living in care homes about the quality of their care.

The quality of care homes in our area is good. Out of 58 care homes 80% are rated by the Care Quality Commission as 'Good' or 'Outstanding'. For more information, you can visit the Care Quality Commission website where individual care home ratings are available.

## POET (Personal Outcome Evaluation Tool)

'POET is a national survey of people who receive a personal budget to purchase services to meet their care needs. This survey focuses on the impact that personal budgets are having on people's lives.

| POET survey showed North Lincolnshire above national average in many areas | | |
|---|---|---|
| 90% said the amount of support they received was good or very good | | 86% said services made them feel safe |
| 83% said they had choice and control on how they spend their personal budget | | 84% said services improve the quality of their life |
| 93% people said they were treated with dignity | 43% said they take part in the community | 85% said their views were included in their support plan |

# Complaints

The number of complaints received has increased during the year 2016/17, but remain a low percentage of the number of people who use our services at just 1.9%. The number of complaints upheld, or partially upheld, has only increased by 3%.

| **2016/17 Facts and Figures** | | |
|---|---|---|
| Year of complaint | Number of received | Number upheld (in part or in full) |
| 2015/16 | 28 | 16 |
| 2016/17 | 38 | 18 |

Analysis of complaints informs our learning and service planning going forward. Complaints are often made on behalf of a person by a relative. People in need of care may be reluctant to make a complaint about a service on which they rely and they may need support in order to raise concerns. Often this support is provided by the people closest to them.

We would always wish to know someone has a worry or a problem with a service so that we have the opportunity to take action. We therefore ensure that information about the complaints procedure is easily available; that people have advice about their right to complain and that the procedure is easy to access.

# Our Partners

Organisations working together in partnership are able to deliver better outcomes for individuals and communities. In North Lincolnshire we have a range of partnerships, the following are examples:

## Health and Wellbeing Board

**What is the Health and Wellbeing Board and what does it do?**

The North Lincolnshire Health and Wellbeing Board is a partnership of organisations responsible for the health and wellbeing of everyone living in North Lincolnshire. It brings together a range of local partners involved in a wide range of health and social care related activities. The Board is responsible for:

- Developing and publishing the Joint Strategic Needs Assessment (JSNA), an assessment of the current and future social care and health needs of our communities.
- Developing and publishing the Joint Health and Wellbeing Strategy (JHWS), a document which identifies areas where joint working would deliver better services for the people of North Lincolnshire. This document sets out the key priorities for health and social care services in North Lincolnshire.
- Identifying ways in which agencies and partners can commission services, looking at where services can be bought jointly and promote integrated working.

## Adults Partnership

**What is the Adults Partnership and what does it do?**

The Adults Partnership brings together adults and young people who are receiving or have received support and representatives from organisations that provide services and support to adults. The partnership develop, monitor and reviews the Vulnerable Adult Strategy for North Lincolnshire and ensures that adults with care needs, their families and carers are central to the delivery and development of our services. The ambitions developed in the strategy are:

- Vulnerable adults live well for longer
- Vulnerable adults are enabled to be involved in community life
- Vulnerable adults have choice and control

The principles in the strategy link to the 'Think Local Act Personal' initiative which focuses on personalised, community based support.

## Strategic Commissioning Group

**What is the Strategic Commissioning Group and what does it do?**

The Strategic Commissioning Group develops joint commissioning arrangements and a joint commissioning plan to support the Health and Wellbeing Board to deliver effective joint commissioning.

The key roles for the Strategic Commissioning Group are:

- To increase the use of joint commissioning and pooled budgets
- To ensure the commissioning of services meets the vision of the Joint Health and Wellbeing Strategy
- To ensure effective use of resources for the purposes of joint arrangements (i.e. Better Care Fund, CAMHS Transformation)

# Safeguarding Adults Board

**What is the Safeguarding Adults Board and what does it do?**

The Safeguarding Adults Board is a statutory partnership of organisations that work together to ensure that systems and services protect vulnerable people from abuse.

The board sets procedures, creates an annual strategic plan, reports on its achievements and priorities annually and reviews cases if required.

The Priorities of the Safeguarding Adults Board are:

- To keep adults safe at home
- To raise awareness of keeping people safe
- To keep adults safe in care and health settings
- To ensure the Safeguard Adults Board leads multi- agency safeguarding effectively

# North Lincolnshire First

**What is 'North Lincolnshire First' (Accountable Care Partnership) Operational Group and what does it do?**

This board is a partnership with membership from the North Lincolnshire Clinical Commissioning Group/Council/Northern Lincolnshire & Goole Foundation Trust/Rotherham Doncaster & South Humber Foundation Trust and has oversight of delivery of the Better Care Plan for North Lincolnshire.

The board is responsible, across partner organisations, to support the delivery of integration in North Lincolnshire health and care economy. The operational group's aims are:

- to enable a consistent and collaborative approach to integration and transformation,
- Operational delivery in relation to the Better Care Fund and other similar initiatives,
- support the New Models of Care project work programme

# Cross Sector Provider Partnership

The Cross Sector Provider Partnership (CSPP) is a group of care providers from across the public, private and third sector, who meet to share expertise, development strategies, learning, innovation, information and best practice to develop services for adults with care needs in North Lincolnshire. This Partnership has helped shape the provider events held during 2016/17 to develop and strengthen community capacity.

# Strategic Care Home Partnership

The Strategic Care Home Partnership is a group consisting of residential and nursing care home providers, health and adult care representatives.

The group meet to share information and best practice, drive up standards across the care home sector, and work together to look at how people can be supported.

The partnership is supported by the Health and Social Care Standards Board.

# Nothing about you without you

We are committed to including service user voices at an individual level in the way we support people to achieve the care and support they need. We also need to include the voice of service users at a service and strategic level. To achieve both levels of involvement we have developed the 'Collaboration and Engagement Pledge, Nothing About You Without You'. This document sets out how we include the voices of people who use our services throughout service design and delivery.

## Citizenship partnerships

Citizenship partnerships are groups which focus on carers, people with learning disabilities and people with autism. These groups are attended by people who use our services and their carers/families as well as people from other organisations. At these groups people can talk about the things that matter to them.


## The Learning Disability Partnership (LDP)

The Learning Disability Partnership (LDP) was set up to bring people living with a learning disability, carers and public, private, community and voluntary organisations together.

The group works to ensure that communication to people with learning disabilities from all organisations is available in 'Easy Read' format, the team are working with doctors surgeries to help create letters, and other information, in easy read format for people with a learning disability. The partnership also meets to discuss employment issues and other projects that enable people living with a learning disability to be involved with their local communities.

## Carers Advisory Partnership

The Carer's Advisory Partnership is led by carers and meets once a month with members of North Lincolnshire Council and the NHS to create and monitor the North Lincolnshire Carer's Strategy. The group also identifies projects that aim to improve services and support to carers and adults with care and support needs and works with health and care partners to complete these projects.

## Senior Citizens Forum

The Senior Citizen Forums are led by members of the community and are an independent advocate for older people. They provide information and representation on issues affecting older people, arrange opportunities for older people to network with service providers, monitor new services and developments that affect older people and provide statutory, voluntary and private organisations with the views of older people about existing and proposed services.

## Autism Partnership

The Autism Partnership monitors and directs the development of services to people with Autistic Spectrum conditions. The partnership board also looks at ways to raise awareness about autism.

# Priorities for 2017/18

## People live well for longer

Improve health and wellbeing outcomes for people by continuing to develop partnership working and enable people to leave hospital and have an assessment out of the hospital environment working to support the ambition that **people live well for longer**.

## People are enabled to be involved in community life

Strengthening the supported employment offer and support to working carers – to support the ambition that **people are enabled to be involved in community life.**

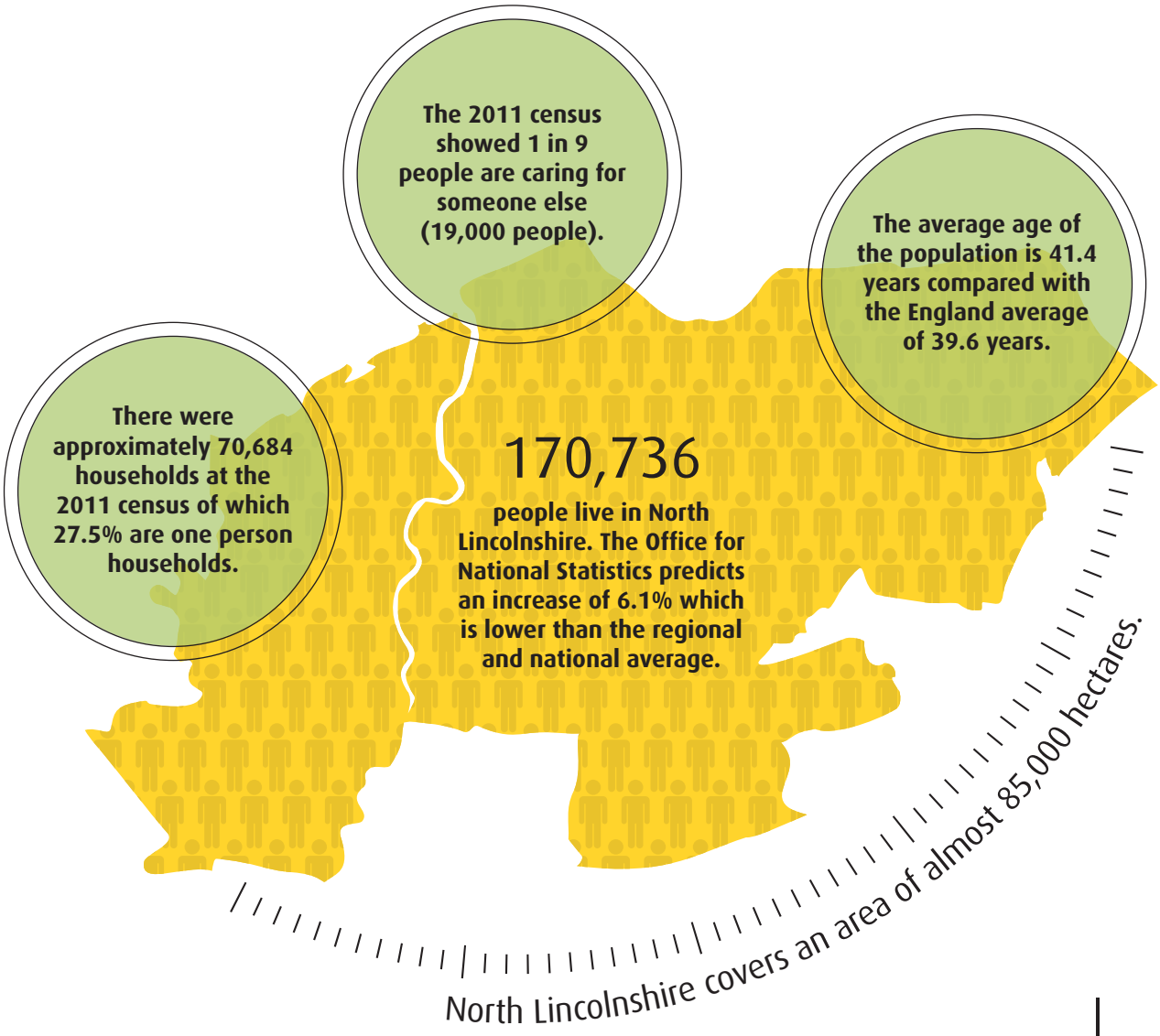
## People have choice and control

Implement #nlsnoozeulooze within the Intermediate Care Service to recognise a person's time as being the most important currency and work with partners to make every day a 'green day', to support the ambition that **people have choice and control.**

## Safeguarding

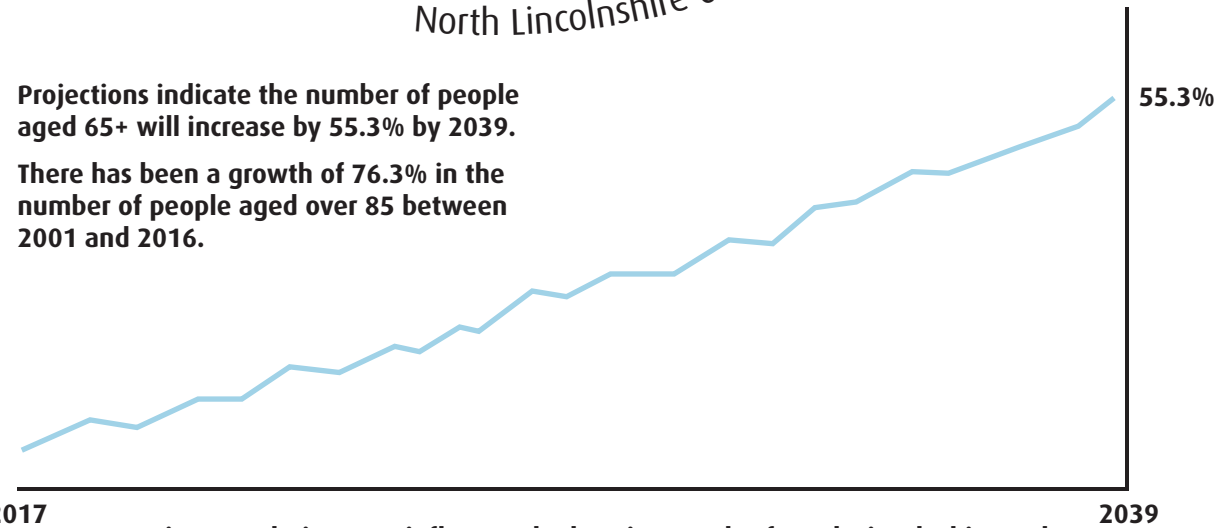
**Safeguarding;** adults at risk of harm are able to decide what steps they can take to change their situation and to be involved throughout the safeguarding investigation. Experts by Experience improve the quality of provision across the area.

# Our people and places




**Projections indicate the number of people aged 65+ will increase by 55.3% by 2039.**

**There has been a growth of 76.3% in the number of people aged over 85 between 2001 and 2016.**




**An aging population may influence the housing needs of North Lincolnshire and require more single person and single storey/accessible housing options.**

# Help us improve

Thank you for taking the time to read this local account. We are keen to hear about your personal experience of care in North Lincolnshire.

It is important that we understand the views of the people who use our services to ensure our standards remain high and we are able to continue to improve things that are important to you.

It is always good to know when people have had a positive experience of our services and this helps us to understand what works well. Receiving your comments and suggestions gives us the opportunity to identify good practice and processes and spread this knowledge across our service and wider council.

We also want to hear from you if you have a complaint or if you have any concerns about the service we have provided. We want to ensure that our services work well for people, but we recognise that from time to time people may not receive the standard they expect. When this happens we want to know so that we can put things right.

If you would like to give us your views either about the service you receive, or this local account, you can get in touch in the following ways:

Email:
servicedevelopmentteam@northlincs.gov.uk

Telephone: 01724 298405

Post:
Service Development Team,
North Lincolnshire Council,
Hewson House,
Station Road,
Brigg,
DN20 8XJ.

**APPENDIX 1**

# North Lincolnshire Performance Assessment – 2016/17

The council is committed to listening to the people of North Lincolnshire, and ensuring the services meet current and future needs of people in the area. The Adult Social Care Outcomes Framework (ASCOF) is a set of nationally agreed measures that help the council to compare performance against other councils.

The table below shows how North Lincolnshire's performance for 2016/17 compares to the previous year 2015/17. There are 28 measures relevant to this year. Of these measures, we have improved or remained the same in overall performance in 15 of the 28 measures, 24 out of the 28 measures are better than the England 2015/16 outturn.

## Highlights

We have been able to provide rehabilitation and reablement services to a greater number of people and in addition to this the effectiveness of rehabilitation and reablement services has improved from 91.1% last year to 92.3% during 2016/17. This means that of all the people using these services 92.3% were still independent three months later.

## What people tell us

The number of people who have improved their social contact has increased for both carers and the people who use services. Both measures remained above the England outturn for 2015/16. An increased number of people who use our services or who are carers have told us they are satisfied with our services. The number of people who use our services who say information is easy to find has decreased from 2014/15, however, carers have told us they are find information about services easy to find. This may be a reflection of the new information available through the carers guide and the All Age Carers e-learning module.

You can explore in more depth the data for North Lincolnshire on the NHS Digital website.

| Outcome Measure | Definition of Outcome Measure (Summary) | 2015/16 Outturn | 2016/17 Outturn | Direction of Travel (2016/17 Outturn vs 2015/16) |
|---|---|---|---|---|
| All Delayed Transfers of Care across NHS and Social care (DTOC) (ASCOF 2C Part 1) | Delayed transfers of care from hospital taken on a particular day (Thursdays) over the year, per 100,000 population | 6.6 | 6.0 | ↑ Low Number = Good Performance |
| Delayed Transfers of Care Attributable to Adult Social Care ONLY (DTOC) (ASCOF 2C Part 2) | Delayed transfers of care from hospital taken on a particular day (Thursdays) over the year, which are attributable to adult social care, per 100,000 population | 2.0 | 2.6 | ↓ Low Number = Good Performance |
| Effectiveness of Reablement/Rehabilitation (R&R) Service (ASCOF 2B Part 1) | Proportion of older people (aged 65 and over) who were at home 91 days after discharge from hospital into R&R services | 91.1% | 92.3% | ↑ |
| Availability of Reablement/ Rehabilitation (R&R) Service (ASCOF 2B Part 2) | Proportion of older people (aged 65 and over) offered R&R services as a percentage of all older people discharged | 2.6% | 3.4% | ↑ |
| The Outcome of Short-Term Services: Sequel to Service (ASCOF 2D) | Percentage of those that received a short-term service during the year where the sequel was either no on-going support or support of a lower level. | 90.6% | 91.7% | ↑ |
| Self-Directed Support – Service Users (ASCOF 1C Part 1a) | Service users receiving self-directed support measured against all service users receiving long term support (snap-shot) | 100% | 100% | ↔ |

| Outcome Measure | Definition of Outcome Measure (Summary) | 2015/16 Outturn | 2016/17 Outturn | Direction of Travel (2016/17 Outturn vs 2015/16) |
|---|---|---|---|---|
| Direct Payments – Service Users (ASCOF 1C Part 2a) | Service users receiving direct payments measured against all service users receiving long term support (snap-shot) | 32.0% | 25.8% | ↓ |
| Long-Term Support Needs met by admission of younger adults to residential and nursing care homes, Per 100,000 population (ASCOF 2A Part 1) | New permanent admissions of younger adults, aged 18-64, to residential and nursing care homes per 100,000 age group population | 13.9 | 14.9 | ↓ Low Number = Good Performance |
| Long-Term Support Needs met by admission of older people to residential and nursing care homes, per 100,000 population (ASCOF 2A Part 2) | New permanent admissions of older people, aged 65 and over, to residential and nursing care homes per 100,000 age group population | 575.3 | 597.3 | ↓ Low Number = Good Performance |
| Self-Directed Support – Carers (ASCOF 1C Part 1b) | Carers receiving self-directed support measured against all carers receiving specific carer services | 95.2% | 95.8% | ↑ |
| Direct Payments – Carers (ASCOF 1C Part 2b) | Carers receiving direct payments measured against all carers receiving specific carer services | 76.3% | 80.2% | ↑ |
| Learning Disability Paid Employment (ASCOF 1E) | Service users with a learning disability in paid employment measured against service users with a learning disability in receipt of a long-term service | 5.3% | 5.0% | ↓ |
| Learning Disability Living Independently (ASCOF 1G) | Proportion of service users with a learning disability who live on their own or with their family | 77.2%. | 76.8% | ↓ |
| Mental Health Paid Employment (ASCOF 1F) | Service users with a mental health issue on a Care Programme Approach (CPA) in paid employment measured against service users with a mental health issue in receipt of a long-term service | 8.2% | 6.0% | ↓ |
| Mental Health Living Independently (ASCOF 1H) | Proportion of service users with a mental health issue who live independently with or without support | 71.7% | 89.6% | ↑ |

# What local people say about North Lincolnshire

| Outcome Measure | Definition of Outcome Measure (Summary) | 2015/16 Outturn | 2016/17 Outturn | Direction of Travel (2016/17 Outturn vs 2015/16) |
|---|---|---|---|---|
| People who use Services who have Control over their Daily Life (ASCOF 1B) | Service user survey response about control over life | 79.3% | 81.2% | ↑ |
| Social Care Related Quality of Life (Service User) (ASCOF 1A) | Service user survey composite measure of various quality of life issues out of an overall weighted score of 24 | 19.6 | 19.6 | ↔ |
| Social Care Related Quality of Life (Carer) (ASCOF 1D) | Carer survey composite measure of various quality of life issues out of an overall weighted score of 12 | 8.2 | 8.6 | ↑ |
| Social Contact Service Users, (ASCOF 1I Part 1) | Service user survey response about social contact | 50.5% | 51.4% | ↑ |
| Social Contact Carers (ASCOF 1I, Part 2) | Carer survey response about social contact | 38.1% (2014/15) | 47.3% | ↑ |
| Quality of Life (ASCOF 1J) | Impact of Adult Social Services on peoples quality of life | - | 0.411 | - |
| Overall satisfaction - Service Users (ASCOF 3A) | Service user survey response to satisfaction of social care services | 67.3% | 67.5% | ↑ |
| Overall satisfaction with care and support (carers) | Carer survey response to whether the support and care received was satisfactory. | 44.6% (2014/15) | 50.2% | ↑ |
| Information and Advice – Service Users (ASCOF 3D Part 1) | Service user survey response to how easy it is to find information | 81.5% | 78.6% | ↓ |
| Information about services is easy to find - Carers (ASCOF 3D, Part 2) | Carer survey response to how easy it is to find information | 72.6% | 79.0% | ↑ |
| Feeling Safe (ASCOF 4A) | Service user survey response to feeling safe | 76.2% | 75.3% | ↓ |
| Feeling Safe as a Result of Services (ASCOF 4B) | Service user survey response to feeling safe as a result of social care services | 89.1% | 86.8% | ↓ |
| Carer included/consulted in discussion about person in need of care (ASCOF 3C) | Carer survey response to whether they were included/consulted in care discussions. | 72.5% (2014/15) | 82.0% | ↑ |

# Glossary of Terms

**Advocacy services:** Advocacy is when a person, called an advocate, speaks or acts on your behalf and would be independent of the council. Advocacy means having someone who will express your views and wishes, secure your rights and represent your interests

**Autistic:** A developmental disability that impacts how an individual communicates and understands other people. Autism influences how people interpret the world around them. To find out more, please visit Autism.org.

**Bespoke Care Solutions:** a model of support that finds different ways of working with people and their carers to explore how they would like their support needs met in a creative and meaningful way to them.

**The Better Care Fund:** is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible. For more information, please visit the Local Government website.

**Care Networks:** health and social care professionals working together locally to improve health and wellbeing outcomes for the residents in their area.

**Carer:** A person who provides unpaid support to a partner, family member, friend or neighbour who is in need of care and support and could not manage without this help. This is distinct from a care worker, who is paid to support people.

**Care Quality Commission:** A public body that inspects and regulates health and social care services in England. The responsibility of the CQC is to ensure hospitals, care homes, dental and GP surgeries, along with all other care services in England, provide people with safe, effective and quality care.

**Clinical Commissioning Group (CCG):** The local North Lincolnshire Clinical Commissioning Group in is led by local GPs who are responsible for ensuring the people have access to the healthcare services they need. If you would like to find out more, please visit the website at: North Lincolnshire Clinical Commissioning Group.

**Community Wellbeing Hubs:** There are seven hubs across North Lincolnshire that provide opportunities for members of the public, adults with care and support needs and carers to take part in health and social activities.

**Continuing Health Care:** free care outside of hospital that meets a person's primary healthcare needs. More information can be found on the NHS Choices website.

**Direct Payment:** A Direct Payment is money paid directly to you, by the council, to buy your own care services from a person or agency. This is available for most people who have been assessed as being in need of eligible community services.

**Expert Patient Programme:** a free six week course to support people living with a long term health condition to learn new skills to help manage their conditions on a daily basis.

**Experts by Experience:** Someone who has experience of using health and care services or is, or has been, a carer of someone who has care needs. They support us to test and develop our services and information.

**#nlsnoozeulooze/Red2Green:** the movement and way of working that recognises a person's time is important and works to support people to get back to independent living as soon as possible.

**Personal Assistant:** A person who is employed directly by an individual to support them with care or support needs.

**Personal Budgets:** An allocation of money given to a person to use to enable them to decide what type of care would best suit the way they want to live their life.

**POET:** POET is a national survey of people who receive a personal budget to purchase services to meet their care needs. This survey focuses on the impact that personal budgets are having on people's lives

**Re-ablement:** Is a programme to support people to regain and develop the confidence and skills to safely and independently, live at home.

**Rehabilitation:** is a programme of support to help people regain physical strength and dexterity to live independently.

**Safeguarding:** to protect people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect.

**Self-Directed Support (SDS):** SDS is the process of working with people and their carers to identify their care and support needs and agree how best these can be met through a support plan.

**Telecare:** Telecare services use technology to help people live more independently at home. The services include personal alarms and health-monitoring devices.