Vulnerable Adults Strategy
2015 to 2020

Safe vulnerable adults
Supported families and carers
Transformed lives
Foreword

I am delighted to present the Vulnerable Adults Strategy 2015-2020 which outlines the ambitions we want to achieve over the next 5 years for our local residents. Here in North Lincolnshire we are proud of the way we work with the people who use our services, their families and our partners. We share the same desire to do everything we can to help people to help themselves and to be independent.

As the Chair of the Adults Partnership, I am confident that we can continue to work together to provide the care and support to individuals with the skill, compassion and commitment to really make a difference.

Moving forward, we will work hard to continue to listen to our residents and involve the people who use our services to improve and develop them further. People have told us that they want to stay independent for as long as possible and this strategy focuses on what we can do together with our communities to make this happen.

Cllr Julie Reed
Cabinet Member Adult Services
Chair of the Adults Partnership
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1. Introduction

Welcome to the North Lincolnshire Vulnerable Adults Strategy 2015 to 2020 which sets out the high level ambitions the partnership wants to achieve in order to improve outcomes for vulnerable adults. The Adults Partnership is committed to promoting integrated ways of working in order to achieve these ambitions.

Our aim is to have the right services, in the right place, at the right time. The transformation journey is moving at a pace and there is a positive story in relation to working together to improve outcomes for vulnerable adults and their families/carers.

In North Lincolnshire there is a positive track record of partnership working. Some examples of what the partners have done through working together:

- Developed greater involvement with voluntary and community groups, for example the Carers Advisory Partnership.
- Informed the development of activities through the community wellbeing hubs across the localities as a key vehicle for delivering the wellbeing offer.
- Enhanced integrated health and social care presence at the hospital providing 24/7 working including GP input, single point of contact, clinical decision unit and implementation of ambulatory care models supported by adults social care presence ensuring increased access to assessment and decision making.
- Improved user engagement and collaboration and created opportunities for stakeholders to be involved in shaping strategy and services for example support to Seniors Forum to promote Older People’s week.

Moving into the future, the Care Act 2014 and the NHS Five Year Forward puts an emphasis on greater integration of services between health and social care and the community. Personalisation is confirmed in statute and the promotion of individual wellbeing is an essential feature of the care and support system. The Care Act also places a responsibility on local authorities to ensure that people in the area receive services that prevent, reduce and delay their care needs from becoming more serious, can get the information they need to make good decisions about care and support and have a good range of providers to choose from. This document incorporates our prevention strategy and early help offer.

The strategy demonstrates a commitment by North Lincolnshire partners to the personalisation agenda that is promoted at a national partnership level ‘Think Local Act Personal’ (TLAP). The national level partnership spans central and local government, the NHS, private sector and people with care and support needs and their carers. TLAP’s definition of personalisation is about better lives and is rooted in the power of co-production with people, carers and families to deliver better outcomes for all. The TLAP programme includes resources and support for organisations to implement the changes needed to ensure people have greater independence and enhanced wellbeing within stronger, more resilient communities.
2. Why we have a strategy

This strategy sets in place the vision for how North Lincolnshire’s vulnerable adults will be supported in future, including the overall ambitions and actions required to provide better outcomes for vulnerable adults as well as strengthening the partnership between key stakeholders. A key to this strategy having the desired impact is our focus on prevention and early help, which is a key theme within our ambitions.

The strategy sets out how we — the Council, the NHS, partners, providers, communities and citizens — will address the priority needs of North Lincolnshire’s vulnerable adults in a financially sustainable way. It brings together existing aims and objectives from North Lincolnshire’s plans and strategies, such as the Health and Wellbeing Strategy and Safeguarding Adults Business Plan, combined with the emerging changes in national policy. Bringing these into one place, the strategy sets out a route map for transformational change over the next three to four years.

The strategy has been developed in partnership with citizens and stakeholders at the Adults Partnership (membership details in Appendix 4) and sets out a framework which embraces the contribution that all partners can make to ensure that we achieve our ambitions and improve outcomes for vulnerable adults in North Lincolnshire.
3. Definition of a Vulnerable Adult

A Vulnerable Adult for the purposes of this strategy is a citizen aged over 18 who may be at risk of losing their independence or those people who may need additional help and support to prevent, reduce or delay the need for statutory services.

As such, this definition and this strategy encompasses the broad spectrum of need of all vulnerable adults in North Lincolnshire including (but not limited to):

- older people with long-term conditions, degenerative chronic or neurological diseases, adults with learning disabilities, mental health difficulties and physical and sensory impairment;
- people who are at risk of losing their independence due to issues relating to health, age or disability;
- people who act as carers;
- people affected by broader issues relating to social exclusion and homelessness including those with co-existing needs (e.g. mental health, alcohol and substance misuse, mild learning disabilities);
- refugees and asylum seekers;
- the long-term unemployed and those living in poverty; and
- victims of crime and anti-social behaviour.

And promotes our shared beliefs that vulnerable adults and their carers have the right:

- to feel safe and be safe
- to a stable life
- for their circumstances, background and culture to be recognised, respected and valued
- to be able to discover their strengths and reach their potential
- to contribute positively to their local community
- to services and support that meet their needs
- to have a voice and be consulted on plans, interventions and services that directly affect them
4. Our Vision and Guiding Principles

**VISION:**
Safe vulnerable adults
Supported families and carers
Transformed lives

**Principles:**
Collectively we will achieve our vision and ambitions by working to the following guiding principles. These have been summarized under the ‘Think Local Act Personal’ headings.

<table>
<thead>
<tr>
<th>Early Help, Prevention and building Community Capacity</th>
<th>Enabling Choice and Control</th>
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<tbody>
<tr>
<td>• we identify needs early and provide support at the earliest point</td>
<td>• we actively collaborate and engage with service users - ‘nothing about you without you’</td>
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<tr>
<td>• we build on strengths of individuals and families to promote self designed solutions to develop resilience</td>
<td>• we recognise and make use of citizen insights i.e. experience led commissioning</td>
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<td>• we work towards whole system integration whilst delivering value for money</td>
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<tr>
<th>Tailoring Support</th>
<th>Co-ordinating Care and Support</th>
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<tr>
<td>• we target services to meet assessed need</td>
<td>• our approaches and services are person centred and designed around the needs of the individual</td>
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<tr>
<td>• we work collaboratively with service users and their carers</td>
<td>• we share actions to reduce inequalities</td>
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<tr>
<td>• we are outcome focused</td>
<td>• we support the workforce to deliver the integrated responses to identified need</td>
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We are working towards the commitments outlined in Making it Real - marking progress towards personalisation and community based support.
5. Vulnerable Adults in North Lincolnshire – Local Needs Assessment

This strategy brings together the needs of all vulnerable adults under one over-arching framework, prompted by the need to ensure we respond effectively to national policy and to local priorities around greater individual choice and control, the development of personalisation and the greater integration of health and social care.

The scope and content of the strategy is informed by national and local drivers, including the changing demographics and the needs of North Lincolnshire’s populations.

National Drivers
A summary of key national drivers is detailed in Appendix 2.

Particular focus of this strategy sets out how North Lincolnshire can contribute to the Think Local Act Personal (TLAP) framework for working together for personalised, community based care and support.

Community Capacity
Choice and Control
Tailored Support
Co-ordinated Care

Independence
Wellbeing
Citizenship

Care Act 2014
The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life. The Care Act 2014 guidance sets out how a local authority should go about performing its care and support responsibilities. Underpinning all of these individual “care and support functions” is the need to ensure that doing so focuses on the needs and goals of the person concerned. The sections of the care act which is of particular significance for a partnership approach includes:

- Have wellbeing at the heart of their care and support - the ‘wellbeing principle’
- Can get the information and advice they need to make good decisions about care and support
- Have a range of high-quality care providers to choose from
- Receive services that prevent their care needs from becoming more serious, or delay the impact of their needs
Local Drivers

Our population
The latest midyear population estimates for North Lincolnshire (2013, ONS) suggest there are currently 168,700 people resident in the area. This represents more than a 10% growth since 2001. The largest growth has been amongst our older population and the greater net gain has been in our market towns and rural settlements.

Vulnerable Adults

- Population of North Lincs 168,760
- Population over 16 years 137,474 Est.
- Adults over 65 32,522 Est.
- Adults over 85 28,580 Est.
- Adults living with mental illness 68,760
- Adults with serious physical disabilities and mobility issues 8,636
- 4,684 carers providing over 50 hours
- Adults with learning difficulties 3,155 Est.
- Adults with dementia (over 65) 2303

Joint Strategic Needs Assessment
A statutory function of the Health and Wellbeing Board is to undertake a Joint Strategic Needs Assessment to inform the development of strategy and commissioning plans. The full summaries can be found on the North Lincolnshire Strategic Assessment website. Relevant sections are highlighted below.
Living and Working Well

- Lifestyle issues, such as smoking, obesity and physical inactivity, are having a negative impact on the health of the working age population of North Lincolnshire. Interventions that support people to change behaviours, targeted at areas most in need, is key.
- Mental illness remains the largest single cause of disability and sickness absence in North Lincolnshire.
- People with serious mental illness have a life expectancy which is 10-20 years lower than average. There is a strong link between mental and physical ill health.
- The health needs of these and other vulnerable groups need to be better targeted and monitored.
- Mental health promotion is everyone’s business, requiring universal as well as targeted intervention.

Ageing Well

- An increasing number of people aged 65+ continue to work in some form of paid or unpaid (usually part time) employment. This will rise between now and 2018, as the state pension age increases for both men and women.
- Targeting communities and GP practices for public health interventions in areas where lifestyle risk factors are high and disease detection rates are low, will need to form part of a long term strategy to improve the health and wellbeing of this older age group.
- The number of care home beds per 100 people aged 75+ in North Lincolnshire, was above the national average in May 2014.
- 84% of people aged 85+ live independently and wish to do so for as long as possible.
- Age friendly environments, including access to suitable housing, transport and public spaces will be required to underpin the prevention agenda.

Challenging Trends

- The number of people developing late onset dementia is increasing incrementally, and at a faster rate than nationally. There are approximately 2,260 residents of North Lincolnshire living with dementia. This will rise to 2,730 by 2020, a rise of 20%.
- Detection rates of chronic conditions such as chronic lung disease and dementia are improving, but remain below the national average. The focus on preventing and delaying the onset of these conditions in older age will need to be maintained and strengthened.
- These trends will also have implications for the health and wellbeing of unpaid carers, as an increasing number of older working age people will need to combine work with unpaid caring responsibilities.
- Tackling loneliness and isolation amongst the older population is a local and national priority and will prevent challenges in some of our more rural areas.
User voice

North Lincolnshire service users are far more likely to express satisfaction with care and support services than nationally. Recent local consultations with residents suggest that future services should focus on providing:

- Care as close to home as possible, including more integrated health and social care support.
- More education and support about how to manage long term conditions and stay healthy.
- More outpatient appointments delivered closer to home.
- More opportunities to stay active and mobile. This is a specific issue for people living in care homes and people living in rural areas where transport may be less accessible.
- More opportunities to stay connected socially whether through paid work, social or voluntary activity. This includes mentoring befriending and peer support opportunities, especially for those living in care homes.
- A wider range of supported housing provision in older age, including, step up and step down provision to help people to maintain their independence for as long as possible.
- More flexibility from employers to enable people in their middle years and older to combine caring responsibilities with paid work.
- For those in receipt of home based care, more consistency in the provision of care, and more flexibility in the times at which this is made available.
- More forward planning for service users and their carers in the event of an out of hours emergency.

Dying Well

- Life expectancy continues to rise in North Lincolnshire, but still lags behind improvements in other parts of the country, and for both men and women remains below the national average, of 79.4 years and 83.1 years.
- Early deaths from smoking related diseases remain above the national average and are rising amongst local women, with rates above the national average.
- These diseases also contribute to the 8 and 9 year gap in life expectancy between North Lincolnshire’s most and least deprived men and women.
End of life
Experience Led Commissioning project highlighted a need to strengthen and develop:

- Anticipatory end of life care planning for people with terminal illnesses other than cancer, including people with dementia.
- Consistent and systematic approaches to enable people to articulate their wishes at end of life.
- Communication between primary secondary and tertiary health and social care.

The Joint Strategic Needs Assessment informs the Health and Wellbeing (HWB) Strategy. The Vulnerable Adults Strategy is informed by the HWB strategic priorities:

- **Safeguard and Protect** so that North Lincolnshire is a place where every vulnerable adult feels able to exercise their rights to independence safely where ever they are.

- **Support independent living** so that North Lincolnshire is a place that supports people to exercise their human right to living ordinary lives with a quality of life.

- **Enhance mental wellbeing** so that North Lincolnshire is a place that recognises and supports the emotional wellbeing of its residents and where people with mental illness can access the same level of care and support as those with other conditions.

- **Raise aspirations** so that North Lincolnshire is a place where every vulnerable adult and carers wants to be the best they can be and achieve their potential.

- **Close the gaps** so that North Lincolnshire is a place where there is equality of opportunity for all and no vulnerable adults or their carers are disadvantaged.

- **Prevention of early deaths** so that vulnerable adults in North Lincolnshire are supported to live well, age well and die well in the place of choice.
6. Ambitions for action

The partnership co-ordinates activity in relation to areas that impact on vulnerable adults and their carers to deliver against the strategic priorities. We have identified three ambitions which are:

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As a partnership, there is a commitment to taking collaborative partnership action to make progress against the ambitions and make a difference for our vulnerable adults. In order that the partnership can be responsive it is recognised that the actions to be taken will inevitably be fluid, however the headline actions are outlined below.

6.1 Ambition 1 — Vulnerable adults live well for longer

Action

Together we:

- Take responsibility for and provide early help
- Develop an inclusive network of well being activities
- Ensure that public information is easy to read
- Share and maintain ONE directory (Connect2Support) of information
- Promote economic wellbeing

**CASE STUDY - Ellie** is 44 and has a physical disability. She lives with mum who is 88 and quite frail and tired and is struggling to care for Ellie and look after her at home. Ellie and her mum spoke to Ellie’s social worker about the options for the future. The plan they had considered was to move near family but if they did this, they would have to live apart, Ellie in a nursing home and mum in a flat. This was not what they wanted, but it seemed to be the only option to enable them both to receive the support they needed. Ellie was supported to say what she wanted and that this was to be with mum and to stay in Scunthorpe. A flat became available in an extra care housing scheme and they moved in together. Ellie is being supported to increase her skills around the home and her personal budget has decreased as she is doing more for herself. Ellie has employed a Personal Assistant to help her get out and about, develop her computer skills, do art and craft and her own personal shopping.
6.2 Ambition 2 — Vulnerable adults are enabled to be involved in community life

Action

Together we:
• Create North Lincolnshire as a dementia friendly place
• Support vulnerable adults to engage in volunteering and befriending.
• Facilitate the voice of vulnerable adults through citizen groups and stakeholder groups.
• Encourage participation of vulnerable groups in community level consultations.
• Develop circles of support linked to well being hubs.

CASE STUDY - Michael is 75 years old and lives alone in sheltered accommodation. A care agency provides support three times a day, five days a week. He was also referred for extra support. During conversation with Michael it became apparent that he was not paying his bills and never seemed to have any money left for his living expenses. It was established that there may be financial abuse taking place and a safeguarding alert was raised. After working closely with Michael, the police, his care agency and care practitioner, the financial abuse has stopped and he is now financially secure and debt free.

CASE STUDY - Mrs Jones cares for her husband who has dementia. Like many carers, she provided all of his care herself until one day she fell and injured her back, which meant she was unable to look after him on her own. Mrs Jones’ doctor referred her to Adult Services and one of the Family Carers’ team went to see her and discuss what support and advice she needed. Mrs Jones wanted assistance until she was well enough to look after her husband again and it was agreed that a direct payment would be paid to her to purchase care and support for him as she needed it until she was fit again. Once she was well, she discontinued the care and support services for her husband, though she has stayed in touch with the Family Carers’ Team so that if she needs further support and advice, she knows where to get it.
**6.3 Ambition 3 — Vulnerable adults have choice and control**

**Action**

Together we:

- Sign up to ‘every contact counts’
- Implement a single assessment and support planning framework
- Champion personal health and social care budgets
- Champion the rights of vulnerable people to die in a place they choose
- Ensure that vulnerable people and their carers are central to the quality assurance of services.

**CASE STUDY - Enid** is 74 years old and lives with her daughter. Enid does have carer support from a local care agency who come in twice a day (Monday to Friday). Enid is happy with this service and has built up a good relationship with the carers. Enid’s daughter finds caring for Enid very tiring and stressful even with the assistance of this paid support. Enid is aware of this and understands that her daughter needs a break from her caring role. Enid’s care manager has identified that Enid is eligible for access to short breaks and that she could use her allocation in different ways i.e. more carers could come into her home rather than her going into residential care. Enid and her daughter were keen on the suggestion of having more carers in the home and it was arranged that when Enid’s daughter went away, the carers would make additional calls in the week and also at the weekend. As Enid was made aware of her entitlements and the means to access them, this gave Enid a greater choice and flexibility over the type of services she received. It also helped to keep Enid independent and safe in her own home.

**CASE STUDY - Peter** is a young man of 24 with a learning disability. Peter was made aware that he would be given a direct payment to manage his short break needs to enable his family to continue to offer support. It would be up to Peter and his family to use the money to access services that would benefit them all and that the services would be enjoyable for him. Peter decided that he would like to go on two assisted adventure holidays. The family had already done some research into this previously and Peter was keen to go on holiday by himself without his parents. By recognising that Peter and his family were the ‘experts’ in their own lives and by enabling Peter to go on these assisted holidays, he remains independent and in control of the services he receives. His self confidence has improved and in turn, this has helped the way Peter behaves at home. Whilst Peter is away, the family are able to have a break from their caring roles and they feel happy that he is doing something he really wants to do and that he is safe and being looked after.
7. One Vision One Workforce

To achieve our vision and ambition, the Adults Partnership believes that the health and social care workforce should be:

- Ambitious for every vulnerable person
- Excellent in our practice
- Committed to partnership working
- and people working together to improve services and outcomes
- Respected and valued as professionals

As such, partners are committed to working together to ensure the health and social care workforce in North Lincolnshire are highly skilled and follow a consistent approach to provide better outcomes for vulnerable adults.

Priority actions for the workforce are:

- Commit to developing a Health and Social Care workforce strategy for North Lincolnshire
- Develop a workforce to treat the individual as the expert in understanding their needs and collaborative planning.
- Enable staff to become dementia friends and identify dementia champions.
- Upskill the workforce to ensure vulnerable people are aware of their benefit entitlements, rights and support them to access them.
- Endorse a partnership approach and collective understanding to dignity and respect (for our customers and as professionals).
- Roll out Making Every Contact Count training
- Ensure that staff are equipped to provide kind, enabling and coaching support and care to people.
- Ensure we build in questions regarding people’s views and values in relation to dignity and respect in recruitment processes.
- Ensure the risk principles are embedded across the partnership.

To support integrated working, the workforce has access to the Integration Suite of Documents, which provides a range of tools for staff.
8. Nothing about you without you

Delivery of the Vulnerable Adults Strategy will consider the pledge made as part of the Integration Statement agreed by the Health and Wellbeing Board. As partners we have agreed that we will work together to make sure that the support and services that we offer are based on what service users need. People who use our service would like:

- **Vigilance** — to have people notice when things are troubling them and/or when things aren’t going well
- **Understanding and action** — to understand what is happening, to be heard and understood and to have that understanding acted upon
- **Stability** — to be able to develop an ongoing stable relationship of trust with those helping and supporting them
- **Respect** — to be treated with the expectation that they are competent rather than not and as adults that they are the experts in their own lives
- **Information and engagement** — to be informed about and involved in everything that affects them i.e. procedures, assessments, decisions, concerns, plans
- **Explanation** — to be informed out the outcomes of assessments and decisions and reasons when their views have not met with a positive response
- **Support** — to be provided with relevant support, in their own right as well as a member of their family
- **Advocacy** — to have access to advocacy to assist them in putting forward their views (where appropriate)

9. Safeguarding Adults

We also have priorities relating to safeguarding vulnerable adults at risk from harm, which align to the strategic priority outcomes. Our safeguarding arrangements are overseen by the Local Safeguarding Adults Board (LSAB) who has identified four priority actions:

- Keep vulnerable adults safe in the community
- Raise awareness with friends and families how to keep vulnerable adults safe
- Keep vulnerable adults safeguarded in placement
- Ensure the Board has robust systems and structures in place

The responsibility for this work is shared out across agencies and partners and the LSAB assumes collective responsibility. However, the Adults Partnership will play a role in the delivery of these priority actions with all partners continually examining and challenging their approach to keeping vulnerable adults safe.
### 10. Impact — What will success look like?

We will know that we have achieved our ambitions when vulnerable adults say:

| • I will remain independent for as long as possible. | • I understand how care and support works and what my entitlements and responsibilities are. |
| • I am happy with the quality of my care and support. | • I know that the person giving me care and support will treat me with dignity and respect. |
| • I am in control of my care and support. |

We will also know we are successful when vulnerable adults say that:

| • We listened to them and understood what they needed | • We provided support and services that made thing better for them |
| • We treated them respectfully and explained things clearly | • They were happy with the way we treated them |
| • We acted quickly to provide what they needed |

Success will also be measured through a range of key performance indicators and outcome measures taken from the Adult Social Care Outcomes Framework and Public Health Outcomes Framework.
11. Right Service, Right Place, Right Time

The success of the Vulnerable Adults Strategy will be determined by ensuring people have access to ‘The Right Service, at the Right Time, in the Right Place’. Partners across North Lincolnshire are signed up to a single organisational model and whole system integration as set out within the Integration Statement and Suite of Documents. The single organisational model is a framework to describe the level of need that individuals and their families/carers may have and the nature of services that are available at each level. The level of need and service provision will be designed to meet need.

In order to effectively manage the resources available to North Lincolnshire health and social care economy, our aim is to actively focus on prevention and work to ensure vulnerable adults and their families/carers are as independent as possible with the lowest level of support required.

Universal Prevention Services (Early Help)
Vulnerable adults are encouraged and supported to seek help at the earliest opportunity, in order for the appropriate support to be provided.

There is a wide range of activities within North Lincolnshire communities that vulnerable adults are accessing. This includes things such as church groups, sport and leisure clubs, luncheon clubs, community centre based groups. In order to provide opportunities for those people who may not be accessing these activities an opportunity to participate, perhaps with a short period of support, the wellbeing offer has been introduced, delivered through community wellbeing hubs.
The wellbeing offer includes:

- Information, advice and support
- Social activity including drop ins, art and craft workshops, reading groups, volunteer befriending.
- Healthy and safe lifestyles e.g. eating well, physical activity, footcare and sexual health.
- The facilitation of community meals
- Well being checks for those aged 75+
- To raise awareness of keeping safe e.g. adult safeguarding, relationship abuse, sexual exploitation etc

Where people are identified as requiring additional support for a period of time, this could be from the G.P. from the hospital social work team, from Reablement services, from contact through single point of access or as a result of a wellbeing check a more detailed assessment will undertaken to determine what support is required. This could include:

- Activities and support for family carers
- Time limited intervention on a 1to1 basis e.g. recently bereaved, discharged from more specialist service, befriending into sessions.
- Supported employment opportunities
- The facilitation of and access to services for those with specific needs e.g. learning disability, mental ill health, and for those who are considered frail and elderly

The Early Help and Wellbeing Offer Pathway is included in Appendix 3

**Targeted Prevention Services and Reablement**

Regulated and support services provide a range of services that are aimed at supporting people to:

- Stay at home while recovering from injury or illness
- Leave hospital more quickly following treatment
- In some cases prevent the need to be admitted to hospital

Most of these services are directly provided by the council integrated with the NHS but some are commissioned and they can be provided either:

- In peoples’ own home or
- As a short stay in our rehabilitation unit at Sir John Mason House.
Specialist Services (Adult Protection and Safeguarding services)

The Care Act 2014 set out responsibilities in respect of assessing people’s needs and their eligibility for publicly funded care and support. This includes:

- Carry out an assessment of anyone who appears to require care and support, regardless of their likely eligibility for state-funded care
- Focus the assessment on the person’s needs and how they impact on their wellbeing, and the outcomes they want to achieve
- Involve the person in the assessment and, where appropriate, their carer or someone else they nominate
- Provide access to an independent advocate to support the person’s involvement in the assessment if required
- Consider other things besides care services that can contribute to the desired outcomes (e.g. preventive services, community support)
- Use the new national minimum threshold to judge eligibility for publicly funded care and support.

The national eligibility criteria require that in order for needs to be eligible, they must relate to an impairment or illness, mean a person cannot achieve at least two outcomes in their day-to-day life, and that as a result there is a significant impact on their wellbeing. The eligibility determination must be made without regard to whether a carer might be meeting those needs at the given time.
12. Stakeholder Engagement and Partnership Arrangements

The Adults Partnership
The Adults Partnership is a stakeholder/reference group which brings together representative partners from all adult workforce sectors as well as adult representatives. It focuses on the collaborative work of agencies and services, helps to secure the added value of integrated working and in partnership with adult representatives helps to ensure improved outcomes and reduced inequalities for vulnerable adults, and their families and carers in North Lincolnshire.

The Adults Partnership ensures that all partners remain committed to the successful implementation of the strategy and provides the service user view and perspective to inform and shape delivery of the strategy. The partnership is responsible for ensuring that vulnerable adults and their carers are at the centre of all that we do and partners represented on the partnership are responsible for ensuring that agencies are compliant with the values, principles and strategic commitments outlined in this strategy.

Health and Wellbeing Board
The Health and Wellbeing Board (HWB) is a statutory partnership of professionals who are responsible for improving the health and wellbeing outcomes of the people of North Lincolnshire across all life stages and to reduce inequalities. The HWB works within agreed governance and accountability framework and it is responsible for the development of the Joint Strategic Needs Assessment and the implementation of the Joint Health and Wellbeing Strategy. The HWB encourages a joint commissioning approach and promotion of integrated working.

The Adults Partnership provides a stakeholder view on the HWB strategic plans to ensure that the views and needs of vulnerable adults are visible.

Local Safeguarding Adults Board
The Local Safeguarding Adults Board (SAB) is a statutory partnership of professionals from key agencies who work together to ensure that systems and services are effective in protecting vulnerable people from abuse. The main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area. The SAB has a strategic role that is greater than the sum of the operational duties of the core partners. It oversees and leads adult safeguarding across North Lincolnshire and is interested in a range of matters that contribute to the prevention of abuse and neglect. These include the safety of patients in our local health services, quality of local care and support services, effectiveness of prisons and approved premises in safeguarding offenders and awareness and responsiveness of further education services.

The Adults Partnership provides a mechanism for the SAB, through the partnership networks, a citizen and stakeholder view regarding the effectiveness of strategies for the prevention of abuse and neglect.
Joint Board Health and Social Care (Frail and Frail Elderly)
The requirements of the Better Care Fund are to establish a pooled budget and formal partnership arrangement under section 75 of the NHS Act 2006 to deliver integrated services to improve outcomes for the frail and frail elderly in North Lincolnshire.

The joint board is made up of members from the North Lincolnshire Council, North Lincolnshire Clinical Commissioning Group, Northern Lincolnshire and Goole Hospital Trust and Rotherham and Doncaster Hospital Trust to oversee the implementation of the Better Care Fund Plan.

The Adults Partnership provides a platform for consultation in respect of health and social care integration and transformation.

Citizen Partnerships
Service user and citizen engagement and participation arrangements across North Lincolnshire provide a significant contribution to joint working. Citizen partnerships are supported to provide a collective focus to improve services for the whole community so individuals and communities are able to live healthier lives, reduce health inequalities and have a better experience of the health and care system.

The Citizen Partnerships lie at the heart of the arrangements for improving the health and well being of the population, though its relationship with the relevant organisations, community groups and citizens of North Lincolnshire the partnerships will support, challenge and influence its activities.

The Citizen Partnerships form the core membership of the Adults Partnership as well as linking into other statutory partnership and governance arrangements such as the Local Safeguarding Adults Board and Health and Wellbeing Board. They will also shape and influence the underpinning workstreams.

The following citizen partnerships are represented on the Adults Partnership, to provide feedback and views from their members and to champion their specific issues and outcomes.

- Learning Disability Partnership
- Seniors Forum
- Carers Advisory Partnership
Cross Sector Provider Partnership

The Cross Sector Provider Partnership invites providers from all sectors, public, private and third sector to work together to achieve the best outcomes.

Objectives

The Cross Sector Provider Partnership will:

- Enable providers and partners in North Lincolnshire Council, Adult Services to have a greater understanding of the market in North Lincolnshire
- Be a positive forum to share, expertise, development, learning, innovation, information and best practice to understand and respond to the emerging customer market
- Provide Market Position Statement updates
- Enable providers to build networks and identify ways of working together
- Identify solutions to overcome common barriers and to identify areas for joint development
- Explore workforce development opportunities
- Share challenges ahead and develop joint solutions
- Consider diversity in all aspects of the Partnership
- Develop opportunities to work in collaborative and constructive partnerships
- Invite speakers who can give an insight into current initiatives

The Adults Partnership provides a wider forum for providers to inform and shape services for vulnerable adults across North Lincolnshire.

13. Monitoring and Review

The delivery of actions will be monitored through the partnership through highlight and exception reporting.

The partnership will identify champions for each ambition who will ensure that individual agencies articulate their contribution to achievement against the ambition. The council will be the lead for delivery and implementation with reporting through the Cabinet Member for Adult Services.

The turning the curve methodology will be used to monitor the difference the strategy is making for vulnerable adults. Each ambition will have some key indicators taken from the Adult Social Care Outcomes Framework, Public Health Outcomes Framework or NHS Outcomes Framework. This will be summarised in a ‘scorecard’.

There will be an annual review of the strategy to ensure that it is relevant and fit for purpose and therefore effective.
APPENDIX 1 — Local Strategic Planning Documents

JOINT STRATEGIC NEEDS ASSESSMENT — is a process through which North Lincolnshire Council services (both the People and Places directorates) work together with health services (North Lincolnshire Clinical Commissioning Group) to assess the health and social needs of the North Lincolnshire population and determine priorities for commissioning services and is part of the overall North Lincolnshire Strategic Assessment.

http://nldo.northlincs.gov.uk/IAS_Live/

JOINT HEALTH AND WELLBEING STRATEGY — the Health and Social Care Act 2012, provides the statutory basis for the development and responsibilities of HWBs. A key role for the HWB is to assess local needs (via preparation of the JSNA) and to develop a Joint Health and Wellbeing Strategy to address identified need. This strategy is one of the ways that we will work together to make sure services meet the health and wellbeing needs of people in North Lincolnshire.


BETTER CARE FUND PLAN (BCF) — has been developed jointly between the CCG and the Council and was jointly agreed by both organisations and endorsed by the Health and Wellbeing Board. The plan reflects and builds upon a number of existing programmes (e.g. the Frail and Elderly Implementation Plan, Healthy Lives Healthy Futures) and sets out the timescales and milestones in relation to deliver all aspects of the BCF.

FRAIL AND ELDERLY IMPLEMENTATION PLAN — sets out the vision to transform services to provide sustainable person centred co-ordinated care and support that is delivered closer to home and in communities.

LOCAL SAFEGUARDING ADULT BOARD BUSINESS PLAN - has been agreed by all agencies responsible for safeguarding vulnerable adults and describes the visions for safeguarding vulnerable adults in the area. It also sets out the priorities for the next two years and how partners intend to work together to deliver the priorities.

http://www.northlincs.gov.uk/people-health-and-care/information-for-professionals/safeguarding-procedures/safeguarding-adults-board/

JOINED UP COMMISSIONING STRATEGIES — there is a suite of commissioning strategies which have been developed across the partnership (and by individual partners) with detailed underpinning implementation plans. Examples include the CCG Strategic Plan and the People Joint Commissioning Plan, all of which have been develop in collaboration with the Integrated Commissioning Partnership and citizen groups and networks.

ADULT SERVICES SERVICE PLAN — sets out the vision for adult social care and highlights how the local authority adult services will deliver against its priorities and how these contribute to wider partnership outcomes.

LOCAL ACCOUNT — brings together information as to what has been achieved and how adult social care has performed against set priorities. It also outlines what the priorities are for the year ahead and how these decisions were made. There is a significant focus on the views of local people and how these have been used to shape decision making.

Services for vulnerable adults are bound by Government guidelines and legislation, and we, as partners across the Adults Partnership, work within these boundaries that shape and influence what we have to do, how we manage our services and our workforce.

## APPENDIX 2 – National Drivers

<table>
<thead>
<tr>
<th>Source</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A Narrative for Person Centred Care</strong></td>
<td>National Voices, a national coalition of health and care charities have developed a person centred narrative on integration. It provides a guide to the sort of things that integrated care will achieve and some clarity over what local areas should be aiming to achieve practically, in their efforts to integrate services.</td>
</tr>
</tbody>
</table>
| **Care Act 2014**                                           | Sets out new legal parameters relating to care and support for adults and the law relating to support for carers, makes provision about safeguarding adults from abuse or neglect, makes provision about care standards, establishes and makes provision about Health Education England, establishes and makes provision about the Health Research Authority and for connected purposes. (Comes into force in October 2014). The Care Act guidance provides information to ensure compliance in relation to the following areas:  
  - General responsibilities and universal services  
  - First contact and identifying needs  
  - Charging and financial assessment  
  - Person centre care and support planning  
  - Adult safeguarding  
  - Integration and partnership working  
  - Moving between areas: inter-local authority and cross border issues |
| **Dilnot Commission Report on Social Care 2011**           | Outlines the recommendations on the Commission on Funding of Care and Support focusing on how to deliver a fair, affordable and sustainable funding system for social care in England. It outlines proposals on how best to deal with funding a growing ageing society and recommends the cap of individuals lifetime contributions towards their social care costs. It also recommends that the current means tested threshold of assets should be increased and that there should be national eligibility criteria and portable assessments to ensure greater consistency. In order to support the call for more choice and control for service users, the report highlights that people must have different options for meeting their contributions (either through income, savings, releasing housing assets or through a specific financial product). |
| **Health and Social Care Act 2012**                        | Sets out the transfer of Public Health responsibility and ring fenced budget from PCTs to LAs. Establishes the Health and Wellbeing Board as a statutory committee of the Council to link to Clinical Commissioning Groups, with a responsibility for promoting closer integration of commissioning and service delivery. The core tasks include developing the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Well being Strategy (JHWS). |
| **Putting People First 2007**                              | A shared vision and commitment to transforming adult social care which was accompanied by a three year transformation grant.                                                                                                                                                                                                                                                                                       |
| **Integrated Care and Support – Our Shared Commitment 2013** | Sets out how local areas can use existing structures such as Health and Wellbeing Boards to bring together local authorities, the NHS, care and support providers, education, housing services, public health and others to make further steps towards integration.                                                                                                                                                                                                                   |
### APPENDIX 2 – National Drivers CONT

| **Think Local Act Personal (TLAP) 2011** | TLAP is a sector wide national commitment to moving forward with personalisation and community based support. A programme grant funded by the Department of Health has been delivered in partnership with the organisations who signed the original agreement. TLAP sets out a framework for working together for personalised, community based care and support:  
  - Community Capacity Independence  
  - Choice and Control  
  - Tailored Support  
  - Co-ordinated Care  
  - Independence  
  - Wellbeing  
  - Citizenship |
| **Transforming Care: A National Response to Winterbourne View Hospital 2012** | Sets our clear, timetabled actions for health and local authority commissioners working together to transform care and support for people with learning disabilities or autism who also have mental health conditions of behaviours viewed as challenging. It sets out a programme of action to transform services so that people no longer live inappropriately in hospitals but are cared for in line with best practice, based on their individual needs, and that their wishes and those of their families are listened to and are at the heart of planning and delivering their care. |
| **Better Care Fund (BCF)** | The Comprehensive Spending Review 2013 announced the transfer of ring-fenced funding from the NHS to Social Care to create an Integration Transformation Fund, now renamed as Better Care Fund. The BCF is described as a single pooled budget for health and social care services to work more closely together in local areas, based on a plan between the NHS and local authorities. Locally, the BCF plan has been through relevant assurance processes, including the Health and Wellbeing Board, and the plan sets out how improved outcomes and wellbeing for people in North Lincolnshire will be achieved, with effective protection of social care and integrated activity to reduce emergency and urgent health demand. The plan including the following national performance metrics and targets:  
  - Reduce residential and nursing home admissions  
  - Increase effectiveness of reablement  
  - Increase access to reablement  
  - Reduce delayed transfers of care attributable to health and social care or both  
  - Patient/user experience |
| **NHS 5 Year Forward View** | The 'Forward View' sets out a clear direction for the NHS — showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. The document identifies three key areas that can drive change:  
  1. Prevention and public health  
  2. Greater control for patients in their own care  
  3. How care is provided (G.P’s, hospitals, community, physical, mental, social) |
APPENDIX 3 – Early Help and Wellbeing Offer Pathway

Access to Universal Prevention Services — Request from Professional or Agency

Vulnerable adults are encouraged and supported to seek help at the earliest opportunity, in order for the appropriate support to be provided. The Adults Service Care Pathway encourages access to Prevention Services.

Request from GP/Health Professional/ Social Worker Received by Access Team where a decision is made regarding level of service i.e. to pass to hub or offer other service. Referral/Contact form completed.

- Can be supported without 1-1 support? yes
- Over 75 wellbeing check if eligible
- Flexible support to meet needs — includes targeted support in hub and workshops — does not need home intervention at this time

- Access team requests service from nearest Community Wellbeing Hub coordinator who undertakes visit/meeting jointly with person already involved where this is possible and appropriate. Contact assessment undertaken filed on Carefirst
- Possible 1-1, specific intervention required? yes
- Arrange for home visit to gather information and complete assessment — electronic record started
- Assessment completed. Target 1 to 1 work required Y/N
- Decision making for most appropriate support discussed with relevant Co-Ordinator — support plan agreed with Service User.
- Targeted support — 1-1 intervention to prevent further needs emerging Review plan at 6-8 weeks
- Agree with Co-ordinator and Service User to continue support, amend plan further action or return to universal activities.

Universal Services

Safeguarding concerns at any point in process follow procedures — and immediate reporting to Line Manager and duty
APPENDIX 3 — Early Help and Wellbeing Offer Pathway

Access to Universal Prevention Services — Request for services by individual service user

Vulnerable adults are encouraged and supported to seek help at the earliest opportunity, in order for the appropriate support to be provided.
The Adults Service Care Pathway encourages access to Prevention Services.

- **Self referral — (telephone/walking into Centre)** can be advertised drop in or ad hoc asking for support. Contact form completed by worker and Care First checks undertaken.

  - **Over 75 wellbeing check if eligible**
  - **Can be supported without 1-1 support? yes**

  - **Flexible support to meet needs — includes targeted support in hub and workshops — does not need home intervention at this time.**

  - **Access team requests service from nearest Community Wellbeing Hub coordinator who undertakes visit/meeting jointly with person already involved where this is possible and appropriate. Contact assessment undertaken filed on Carefirst.**

  - **Possible 1-1, specific intervention required? yes**

  - **Arrange for home visit to gather information and complete assessment — electronic record started.**

  - **Assessment completed. Target 1 to 1 work required Y/N**

  - **Decision making for most appropriate support discussed with relevant Co-Ordinator — support plan agreed with Service User.**

  - **Targeted support — 1-1 intervention to prevent further needs emerging Review plan at 6-8 weeks**

  - **Agree with Co-ordinator and Service User to continue support, amend plan further action or return to universal activities.**

- **Universal Services**

- **Access team requests service from nearest Community Wellbeing Hub coordinator who undertakes visit/meeting jointly with person already involved where this is possible and appropriate. Contact assessment undertaken filed on Carefirst.**

- **Safeguarding concerns at any point in process follow procedures — and immediate reporting to Line Manager and duty.**
### Appendix 4 - North Lincolnshire 
**Adult Partnership Membership and Representation** (as at April 2015)

<table>
<thead>
<tr>
<th>Core Members</th>
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<tbody>
<tr>
<td><strong>Member Agency</strong></td>
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<tr>
<td>North Lincolnshire Council</td>
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<tr>
<td>North Lincolnshire Clinical Commissioning Group (CCG)</td>
</tr>
<tr>
<td>General Practitioner representatives</td>
</tr>
<tr>
<td>North Lincolnshire and Goole NHS Trust</td>
</tr>
<tr>
<td>Rotherham and Doncaster South Humber NHS Foundation Trust</td>
</tr>
<tr>
<td>East Midlands Ambulance Service</td>
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<tr>
<td>Humberside Police</td>
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<tr>
<td>National Probation Service</td>
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<tr>
<td>Community Rehabilitation Company</td>
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<tr>
<td>Humberside Fire and Rescue Service</td>
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<tr>
<td>Job Centre Plus</td>
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<tr>
<td>North Lincolnshire Homes</td>
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<tr>
<td>Social Care Providers</td>
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<tr>
<td>Healthwatch</td>
</tr>
<tr>
<td>Voluntary Sector representatives</td>
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<tr>
<td>Citizen representatives</td>
</tr>
</tbody>
</table>
# Appendix 4 - North Lincolnshire

## Adult Partnership Membership and Representation (as at April 2015)

<table>
<thead>
<tr>
<th>Agency</th>
<th>Role</th>
</tr>
</thead>
</table>
| North Lincolnshire Council    | • Assistant Director Prevention and Commissioning  
|                               | • Head of Integrated Commissioning, Partnerships and Health Improvement  
|                               | • Head of Universal and Prevention Services Adults and Children  
|                               | • Governance and Partnership Manager  
|                               | • Principal Manager Social Work  
|                               | • LSAB Service Manager  
|                               | • Scrutiny Officer  
| LSAB Independent Chair        | • Independent Chair  
