Torbay Care Trust

(Now Torbay and Southern Devon Health and Care NHS Trust)

Your Local Account of Adult Social Care Services

July 2012

Right Care, Right Place, Right Time

www.tsdhc.nhs.uk

Introduction from Councillor Christine Scouler Executive Lead for Adult Social Care

Dear Resident

In November 2011 the Government published its consultation paper "Transparency in Outcomes, a framework for adult social care" The results of the consultation indicated that Councils were in favour of producing local accounts, replacing annual publications, assessments and rating by the Care Quality Commission. This offers Councils the opportunity to share a common approach with a more tailored local focus responsive to the needs of citizens.

Therefore I am pleased to present this first edition of your **Local Account**. This first Local Account provides information on Adult Social Care in Torbay and is a key way through which residents can hold the Trust to account on how well we are supporting people with social care needs. Your Local Account covers the period 01 April 2011 to 31 March 2012.

The Council and the NHS to date have successfully used the idea of "Mrs Smith" as an example of an elderly person and her family in the Bay needing some health and social care support. This metaphor has helped focus Councillors, NHS Board members, managers and front line staff on the purpose of our services, 'doing the right thing' for the individual in our community as part of our shared values. The draft commitment statement continues that journey for Mrs Smith in the new context of changing public sector reform and reducing public resources but maintains our core shared value on doing the right thing for the person in our community.

We will actively seek to gather information on the needs of people of all ages across our community to ensure that their voices are heard by the people responsible for purchasing and providing care services.

Wherever possible we want people to be able to help themselves; however when they do require support, advice or services we are working to ensure it's the right care in the right place, at the right time and at the right cost.

Adult Social Care in Torbay
The Outcomes the Trust is tasked to deliver

Outcome 1	• Improving Health and Emotional Wellbeing
Outcome 2	• Improved Quality of Life
Outcome 3	• Making a Positive Contribution
Outcome 4	• Increased Choice and Control
Outcome 5	• Freedom from Discrimination or Harassment
Outcome 6	• Economic Wellbeing
Outcome 7	• Maintaining Personal Dignity and Respect
Outcome 8	• Leadership
Outcome 9	• Commissioning and Use of Resources

Mrs Smith in the heart of her Community —
Statement by Torbay Council

We will always aim to help people continue to live in their neighbourhood and community, where this is feasible and affordable. We will seek to reduce admissions of people to residential care where we can safely meet their assessed needs in a community based setting. We will always ensure that the assessment is offering more than just a response to a current crisis and that each person is getting the right health, housing and other support alongside their social care. If a person is now in residential care and an assessment indicates that they may be able to live in the community we will give them the opportunity to try that option.

We will ensure that the interventions we offer people will focus on how we can promote their independence. This means we will always seek to use community based solutions including assistive technology where these will enable people to remain safe and meet their care needs. All the domiciliary care that we offer will be based on the principles of re-ablement. This means we will work with people to see how we can assist them in doing more for themselves. Over time we would expect some packages of care to decrease as people meet their own defined outcomes in achieving greater independence.

We will use residential care where we have explored other options and have found that this is the only way to meet someone's care and support needs in a safe way. In many cases, people who have the most complex needs also have longer term health conditions which also mean they may be entitled to additional personal health budgets to meet their needs.

Resources focused on critical and substantial needs for Mrs Smith
Our interventions will offer the right level of support according to a person's assessed needs. Assessments will be carried out over a reasonable period of time to ensure that we have not made long-term decisions about people before we have had a chance to work with them through a recovery or recuperative plan.

We recognise that the solutions that many people have to meet their care needs can be found within their own families, their communities and within themselves. We will work with each person and their network to find these solutions. We will continue to support the number of carers in the Bay. Where people have lost their support networks we will work in partnership to rebuild them. We will encourage our service users, our partners and our staff to help find creative solutions to meet the outcomes that they wish to achieve. We will always look for solutions that offer value for money (quality in delivering the agreed outcomes against the cost to the public purse).

Mrs Smith and risk
The essence of our work will be to ensure that we are balancing risk to empower and safeguard our service users. We will never take responsibility away from someone unless we have a court order, which indicates that the person does not have capacity to manage their own affairs. If we are concerned about the decisions a person is making for themselves, but they still have capacity to make a decision, then we will talk through the risks and work with them to ensure that, as far as possible, they understand the risks they are taking. This may mean that some people make the wrong decisions but that will be their choice based on as full an understanding as possible of the risks. We will look to offer guidance and support but not to take over control.

Work with Providers for the benefit of Mrs Smith
We will work with our providers to build a philosophy of care that focuses on outcomes – where service users can determine with their assessors and their providers the aspirations they have from the service. We will ensure that people have a suitable level of service (preferably through a Direct Payment) that will meet their currently assessed needs and support their objectives towards independence. We will always work with those who are providing services to ensure that they are delivering value for money from the public purse; we will look to achieve this in partnership through a dialogue between service users, providers and the council. We will set a main performance contracts through the ASA for all our services that are provided or commissioned by the Council and these will focus on the desired outcomes for the service users.

We will invest in providers who can demonstrate creative, innovative service provision and disinvest in providers who do not provide a person centred, value for money service. If Mrs Smith has learning disabilities we will work with her to develop as much independence and quality of life choices as possible.

We will develop community based services that encourage good neighbourliness, assist in meeting the challenges of social isolation and social exclusion as well as services that enable people to take more control over their own lives. We will support user-led organisations, social enterprises and other groups who can meet our aspirations for social care.

We will also work with other public sector bodies, our contractors and companies based in the Bay to offer real opportunities for people whose disability may have traditionally disadvantaged them within the employment markets.

Managing demand for services with a growing number of Mrs and Mr Smiths

With the combination of growing demand and reduced resources available to the council, we need to ensure that money is spent in a fair and equitable way. It is possible that some of our current service users and their carers may see a reduction in the amount of money that is available to them. The decision as to how any reduced money will be used will always be done in full consultation with the user and their carers. In particular we will manage reductions in a clear, transparent and negotiated way.

We will focus on achieving value for money for every service that we procure on behalf of service users. We will focus on finding the most affordable price that can deliver us the degree of quality that our service users require.

In a world of personal budgets we will take a balanced view between procuring services on behalf of local people to achieve good value and through encouraging service users to develop their own creative solutions to meeting their needs.

We will ensure that there are services available for service users and their carers to meet their needs within the resources that will be made available to them through personal budgets. We will work with local and regional providers of care to support the delivery of this policy.

Our commissioning strategy will be developed jointly with our health partners and in consultation with our service users and carers and we will learn lessons from elsewhere. We will build models of care and support which help us to deliver the outcomes that we have outlined above.

Knowledgeable and Informed Workforce

We will develop a workforce who can work within this vision. This includes staff both within the council and those who work for organisations who provide services on our behalf. We will ensure that all staff understand how to work with service users in ways that promote their independence and support their recovery. We will support staff to work within multi-disciplinary teams. We will help staff develop their practice in ways which will assist them to empower our service users to make the best use of their personal budgets to ensure a relentless focus on promoting independence rather than creating dependency.

Valuing Carers

Many people with social care needs will have these met mainly through the carers with whom they live. We will ensure that carers are informed of their right to have a carers assessment which they can have either together with their cared for person or separately and we will work to identify the carers in the bay that are not currently aware of the support that is available to them.

Mrs Smith and suitable housing for her long term quality of life

We will continue to develop housing schemes with partners with suitably adapted accommodation and to offer care and support in the community wherever that is feasible to meet someone's needs (as opposed to residential care). In an age of digital technology we will continue to explore how new technological solutions, such as Telecare can give citizens better care, ensure their safety and assist our staff in carrying out their daily tasks.

Safeguarding Mrs Smith
We will continue to take a multi-agency approach to safeguarding adults and ensure through good communications that members of our community know what to do if they are concerned for Mrs Smith. We will continue to be reflective that we have the right balance and quality systems in place and we will continue to learn from best practice.

Ms Smith to Mrs Smith- child to adult
We will expect that younger adults who have sufficient ability are supported into work environments. We will support younger adults and their families through the move from children's services into the adult world. We will support young carers to ensure that their needs are also being met. We will use personal budgets to ensure that the people requiring longer term care can take as much control over their lives as their needs allow. We will continue to increase the number of people who are in receipt of a direct payment.

An integrated health and social care system for Mrs Smith
We need to maintain an integrated and outcome-focused approach to our work with all our health partners, in the context of major NHS reforms. This will mean working with the new CCG (Clinical Commissioning Group) who will commission health services for Mrs Smith on how health and social care jointly improve outcomes, and with an NHS Foundation Trust how we further build on the innovative work we have done with the Trust to find new provider based innovations for solutions for Mrs Smith.
We will maintain shared health and social care assessments and a single plan that will help people to retain independence in the community.
We will work with NHS partners to develop the expert patient programmes which enable people to take more responsibility for how they manage their longer term conditions. This will both help them as the patient and reduce the cost to the council and the NHS.

We will develop our commissioning strategy jointly with the NHS, (and adjacent local authorities where it is sensible to do so) with a wide range of Stakeholders including health partners, providers, community groups, users and carers taking a whole systems approach to the design and development of services. In this way we can maintain a sustainable approach to social care for Mrs Smith for the years ahead.

To include signature of DASS

What you said you wanted in this year's Local Account

- To make sure people are always treated with Dignity and respect
- Better outcomes for carers and carers health. Carers should be recognised, valued and supported
- Community equipment available when required
- Improved Service User experience

These themes were also identified in the Quality Account for 2011/12.

Outcome 1 Improving Health and Emotional Wellbeing

Activity Priorities:

- To ensure that adult social care issues are included in the development of wider integrated care opportunities
- To work in partnership to close the gap in health inequalities through the development of a neighbourhood management pathfinder and assist with its development in other deprived areas subject to successful evaluation of improved outcomes in the pathfinder area
- To play a full role in developing and implementing the ASC contribution to an Active Ageing Strategy.
- To develop an integrated prevention strategy to safeguard vulnerable adults in partnership with the Crime Reduction Partnership.

Quantitative Target Priorities

Performance Framework	Definition	2010/2011 Targets	2011/2012 Targets	2011/12 Result
NI 125	Achieving independence for older people through rehabilitation/ intermediate care	75%	78%	82%
NI 131	Delayed transfers of care	17.5	9	1.7
New Target	Emergency readmission rate for over 65s within 28 days	Not reported in 2010/11	10% Reduction Proposed Target 348	557
New Target	Emergency bed days for over 75s with 2+ admis-sions to acute hospital	Not reported in 2010/11	5% Reduction Proposed. Target 11,368	13,580
New Target	Falls to over 65 patients living in a care home which result in a hospital admission		5% Reduction Proposed Target 731	764

Outcome 1 Improving Health and Emotional Wellbeing

Community safety and relationships

Our independent sector partners have been active in establishing funding from the Home Office to tackle the issues of 'hate crime' and 'mate crime'. They have been keen to share information about this with people who have learning disabilities, and with the agencies working with them. Support in relation to the independent reporting of crime and revitalising the 'Safe Place' scheme will be further developed this year.

Dave Hingsburger, a Canadian psychologist and civil rights supporter, visited us recently for a well-attended workshop on 'building community'. It was very thought-provoking and established some clear thinking about the barriers in our community that may exist for people who have a learning disability and what we can do to encourage greater inclusion. The Trust has also been working with speech and language therapists to improve communication in community services such as libraries and leisure centres.

Hele Project—Neighbourhood Management Pathfinder

The pilot scheme was set-up 3 years ago with the hope that the scheme would act as a catalyst for further schemes in other areas suffering from socio-economic disadvantage and health inequalities within Torbay.

The scheme was designed to "*bring residents and service providers together to improve the quality of life for the people in the most disadvantaged neighbourhoods and ensure public service providers are more responsive to neighbourhood needs and to improve their delivery".*

The Neighbourhood Team comprises a Neighbourhood Manager, residents and estate based workers such as Street Wardens, Police Community Support Officers, Housing Officers and Health Trainers working to a specified Neighbourhood
Management Action Plan.

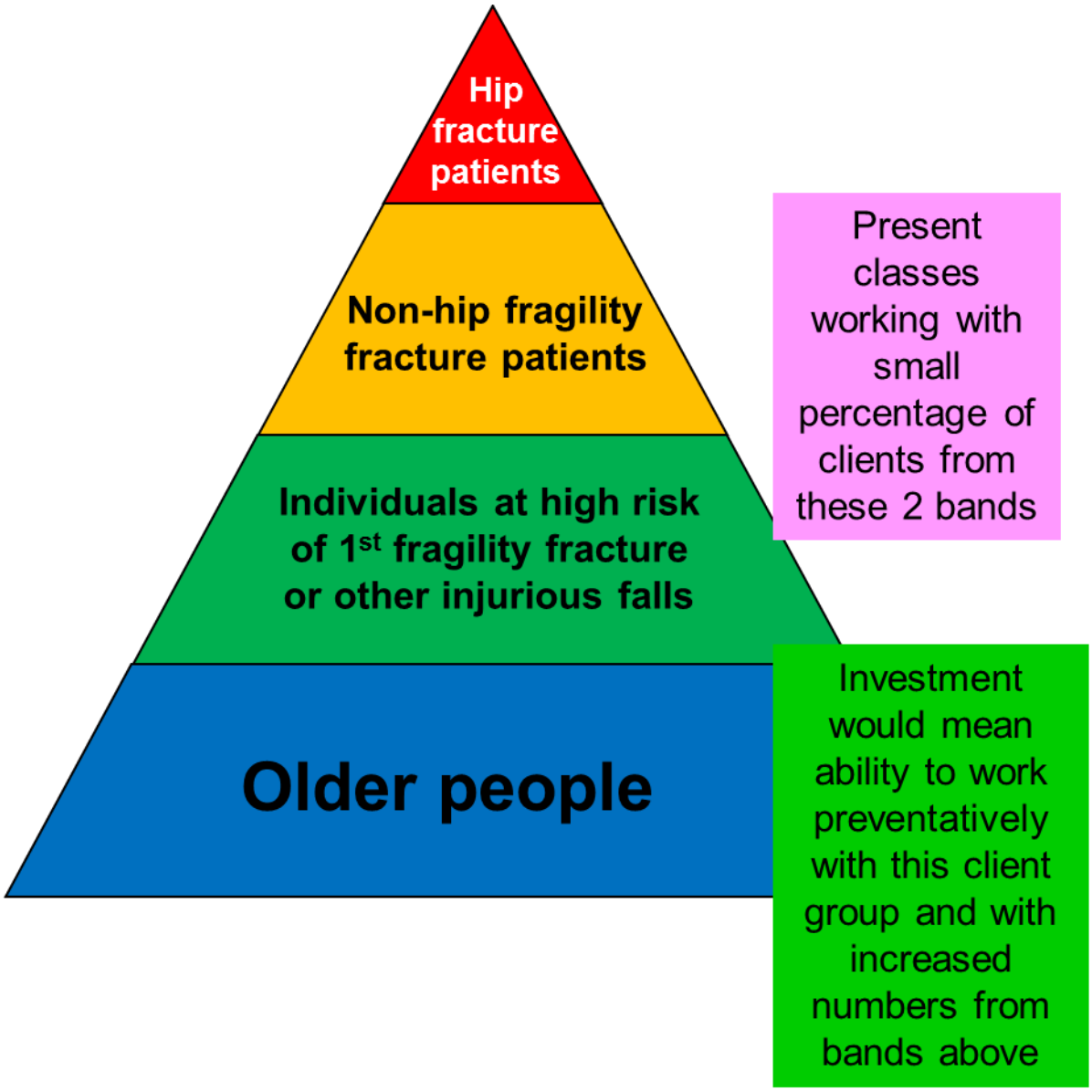
Hele provides a suitable backdrop for the Neighbourhood Management Pathfinder and as part of the *phased delivery* plan will act as a catalyst for a series of similar initiatives throughout Torbay.

The scheme is now well established—Hele's Angels is established in the area with initial outcomes based on reduced crime, activities for young people (under 11), improved work prospects and environmental improvement.

The initial project is now under the leadership of a Community Board under the leadership of a Management Team. Hele's Angels has been established as a Social Enterprise based in new premises together with the creation of a commercial aspect/charity shop.

FALLS PREVENTION

DEPARTMENT OF HEALTH SYSTEMATIC APPROACH TO FALLS AND FRACTURE CARE & PREVENTION: FOUR KEY OBJECTIVES



Falls Prevention

June 24th 2011 saw a successful Active For Life day held in Brixham.

Over 300 people were invited along to the drop in day where they could quiz professionals about their issues from foot health, visual problems, how to exercise and lose weight, how to prevent falls and maintain their bone health and independence. There were opportunities to try out various dance and exercise forms to maintain or improve their level of activity and talks to educate older people about falls prevention, exercise, foot health, healthy vision and bone health.

The feedback from the day was very positive with staff and the public going away challenged and well -armed with information. On evaluation 87% had been challenged about their activity levels, 67% about their bone health, 62% about their diet, 24% about their vision, 69% about falls prevention and 30% about volunteering.

Feedback from Falls —Active for Life day

I thought the event in Brixham was excellent ... from the moment I walked into the hall, to the minute I left, there was a real buzz in the place.

You are to be commended on involving so many people both from professional groups

I cannot recommend the Strength and Balance Class highly enough. I attended Jane Reddaway's class about two years ago and, since then, have literally gone from strength to strength!

Previously I was unfit and kept tripping. I thoroughly enjoyed the sessions, improved my stamina and stopped tripping!

After completing 20 sessions I then joined the Fit-Bay Scheme. This was another 20 sessions and, on completion, I was eligible to join Lifestyle Health and Fitness Club at the Riviera International Centre on a discounted subscription. I now attend the gym regularly

In 2010/11 The Trust spent £2095 on an initial pilot scheme training 3 Instructors and providing equipment

In 2011/12 The Trust spent £17,797 for 3 Instructors to provide more weekly sessions to improve the falls prevention service

Balance and Strength 12 week Course at Romalyen Gardens

I have just completed the above course and I felt that I must write to say how amazed I was to find how greatly I had improved.

I can now stand for over 1 min not holding on, (and no sticks) which means getting money out of my purse to pay at tills also doing my coat up, pulling up trousers without having to lean against something.
I had difficulty in putting collars straight on coats & blouses, but now I can reach across my shoulders no bother.
I have a mobility scooter, which I would be lost without, I found to twist from the hips to look L or R to see if traffic was coming, was a bit limited, but now I have no bother.
You don't realise how much you have improved, & then suddenly you reach for something, & find you didn't have to push your arm up, or you are doing things in the kitchen & not leaning on worktops. There are lots more things I can do, which it is not until I go to do them that I realise how much I have improved.

Many thanks, Jane Keep breathing!

Outcome 2 Improved Quality of Life

Activity Priorities:

In line with Care Quality Commission's recommendations the Trust should

- Improve performance on the provision of telecare; telehealth and community equipment within agreed budgets.
- Implement the Dementia Strategy for Torbay

Quantitative Targets Priorities

Performance Framework	Definition	2010/2011 Targets	2011/2012 Targets	2011/12 Result
NI 136	People supported to live independently through social services (all adults)	2,701	2,911	2,661
New Indicator	Number of people supported through telecare and telehealth	Not reported in 2010/11	1,100	1,000

Hospital Care for people with dementia Is this too health focused?

- Our community hospitals have all completed the national audit on their environment and interface with patients with dementia, (information available re dementia etc). This has been a very useful process, all have an action plan in place which is being monitored and some will be involved in a peer audit across the south west which is due to take place in the autumn.

The Torbay Dementia Alliance

- This has been set up and has begun to meet to consider how the community can work better together to support those living with dementia within our community. It is joint chaired by Norman McNamara, a service user with dementia and the deputy Mayor . The Mayor has agreed to support the 'Dementia friendly communities ' initiative and has provided a formal note of support to the Dementia Alliance: "It is great that Torbay is aiming to be the first dementia friendly community in the UK. It is wonderful that individuals, such as Norman McNamara, and local groups are working extremely hard towards achieving this status. Norman and others transform the lives of those affected by dementia in Torbay. This includes supporting their independence and reducing pressure on the NHS and social care system."

  We look forward to supporting this initiative

Supporting Care Homes

- The Trust are working closely with Devon Partnership Trust to consider how we might better support people with dementia living in care homes in Torbay, and also to help individuals and their families work with their care homes to plan their future and state their aspirations for care and treatment. The South of England NHS strategic Health Authority has identified £10 million to be used to help kick start
  projects and service innovations for people with dementia. Initial applications are invited from each Clinical Commissioning Group in July with full submissions due in September.

- The Department of Health scrutiny committee will consider these and inform applicants in October. It is anticipated that a number of submissions will relate to improving the care of people with dementia and in support of carers.

Hospital Care for people with dementia:

- Our community hospitals have all completed the national audit on their environment and how we engage patients with dementia and carers. This has been a very useful process, all hospitals have an action plan to make improvements, these will be monitored and reported to the Trust Board. The SHA are leading a peer review of hospital standards of dementia care across the South West which is due to take place in the autumn.

Adult Social Care and Primary Care

- We have recently reviewed our systems in Torbay to consider with staff and people with dementia and their families how we might best support them. Changes have been made and implemented. The mental health team for older people links with all our zones to aid communications and with each GP practice. All GP practices have received an education session about dementia and are required to keep a record of all the people they have on their lists with dementia. Each practice has also nominated a lead GP for dementia.

Memory Cafes

- These are now well established in Torbay. We currently have 3 cafes, one in each of our towns run by the Alzheimer's society. All Cafes run weekly and are very well attended. The Alzheimer's society has also started other initiatives including a 'Singing for the brain' group and a group for peer support for those with an early diagnosis.

Memory clinics

- A good clinic for assessment of those with suspected dementia is well established in Torbay.

Telecare , Telehealth and assistive technology

- In order to maximise an individual's independence, whether they live in a residential home or their own accommodation, our health and social care teams will talk to people about the range of equipment and devices that are available to support them in their daily lives. We want more people to benefit from these types of support so we will educate our staff to consider tele-options as part of the normal care planning process.

Health checks for people with a Learning Disability

- We offer health checks to people with a Learning Disability living in Torbay and this year we were the best in England. We will continue to keep up this high standard to ensure that everyone has access to good quality health and social care.

Aids to daily living

- We have developed a prescription-based service for simple aids and equipment. People who need these can chose where to get them from and can "top-up" if they wish to buy a more expensive piece of equipment.

Outcome 3 Making a Positive Contribution

Activity Priorities:

- To ensure a systematic approach to knowing and understanding service users and carers experiences and levels of satisfaction and to develop a collaborative approach with the Council and other partners to engaging them in the commissioning and monitoring of services. Develop self-assessment mechanisms to ensure the delivery of more personalised services. To foster the agenda symbolised by the Governments Big Society intentions – specifically voluntary and community activity.

- Introduce an outcomes-based accountability approach to transforming social care to ensure the intended positive effects are realised, through goal setting and review of personal care plans. To

Quantitative Target Priorities

Performance Framework	Definition	2010/2011 Targets	2011/2012 Targets	2011/12 Result
New Indicator	Number of people on Carers' Register	Not reported in 10/11	2,759	3,396
Young Adult Carers	Number of Young Adult Carers in contact with the Trust	Not reported in 10/11	25	55

Carers Support

Understanding carers experience of services has directly led to service developments such as creating a Carers Support Worker post within the Hospital Discharge Team at Torbay Hospital, a new telephone befriending scheme (Carers 4 Carers) staffed by volunteers, and a service for Young Adult Carers (age 16 – 25). Carers and former Carers have been directly involved in monitoring services as Carer Evaluators, interviewing carers as part of service evaluation. This brings a new level of involvement and feedback. Torbay Carers Register has grown by 20% each year for the past two years, and now means that over 3,000 local carers can be asked for their views on services.

The development of Torbay Carers Forum (www.torbaycarersforum.co.uk) means there is an independent website, run by local Carers, where they can exchange views and issues and debate common concerns. Systematic consultation with Carers has led to them directly influencing the commissioning of new services e.g. a new service supporting Carers of People with Substance Misuse Problems and a project for early identification of Carers of people with dementia.

Carers Support (continued..)

Our focus on early identification of carers (many people who are caring do not see themselves as carers and so don't access support) has been very successful as a result of the direct involvement of Carers in publicity campaigns, such as the work with Sainsburys supermarkets. Carers play a key role in monitoring services by sitting on management and steering groups and their ideas are frequently the basis of new innovation e.g. Carers Discount Scheme. The publication of joint plans for carers support, (Measure Up Interagency Carers Strategy for Torbay) and details the expenditure on Carers services enables carers to comment on planning and service delivery. An annual review of Measure Up 2012 – 14 will be published. By focussing attention on Carers experience we have identified an area for improvement in community based support immediately following discharges from Hospital. This will be the subject of an improvement target (CQUIn) for the Trust. We will also be undertaking a consultation with Carers of people with Mental Health problems, age 18 – 64, during 2012 in order to review these services.

Susan and Peter's Story:

Peter was diagnosed with terminal cancer. Susan also had an on-going long term medical condition.

Following admission to hospital Peter desperately wanted to be able return home to spend his last few weeks.

Social Work Team – liaising with Torbay Hospital were able to determine his needs and ensure an appropriate care package was put in place together with carer support for Susan, who wanted to be able to have Peter at home but recognised she needed support to achieve this. The District Nursing Team and the SW Team worked through the Continuing Healthcare Check-list together, producing a Health Needs Assessment . The case was taken to the Resource Allocation Meeting to get agreement to Continuing Healthcare Funding.

The District Nursing Team visited daily and were also able to arrange Marie Curie night services.

The Zone Occupational Therapy Team involvement ensured Peter had appropriate equipment in place before his admission to hospital. The hospital OT also put some extra equipment in place to ensure Peter could be safely discharged home.

The outcome was that Peter died at home as he wished and Susan expressed her thanks for all the support provided from the zone to Peter and her.

Outcome 4 Increased Choice and Control

Activity Priorities:

- Review and re-commission appropriate models of Information, Advice and Advocacy to support the preventative and independence agenda including further website development and the further development of information and advice consortia.
- To successfully complete the review of Learning Disabilities Services and begin implementation of subsequently approved recommendations.
- To take forward in partnership, the development of extra-care housing in Torbay with an associated wide range of enablement services. To extend the scope of care to a Virtual Extra Care model supported by community hubs offering care and support by piloting this approach in Shiphay.
- Continue to improve partnership working with Children's Services to improve transitions from Children's to adult services.
- To ensure the development of a thriving third sector through better joint commissioning that adopts the principles outlined by the Office of the Third Sector.
- Improve current rating of performing adequately to performing well through the effective mainstreaming of personalisation across Paignton, supported by more widespread use of assistive technology (including Telecare) and the development of social capital, incorporating the paragraph above.

Performance Framework	Definition	2010/2011 Targets	2011/2012 Targets	2011/12 Result
NI 130	Social Care Clients receiving self directed support per 100,000 population	30%	40%	45%
NI 132	Timelines of social care assessment (all adults)	79	75%	73%
NI 133	Timelines of social care packages following assessment	90%	85%	99%
NI 135	Carers receiving needs assessment or review and a specific carer's service, or advice and information	38%	35%	38%
NI 145	Adults with learning disabilities in settled accommodation	39%	45%	68%

Outcome 4 Increased Choice and Control

Performance Framework	Definition	2010/2011 Targets	2011/2012 Targets	2011/12 Result
NI 149 Devon Partnership Trust Provision	Adults receiving secondary mental health services in settled accommodation	29%	35%	72% DPT
New Indicator	No. of people aged 65 or over living in residential or nursing homes	602	570	600
New Indicator	No. of LD and MH <65 people living in residential or nursing homes	188	180	130
PAF D39	People receiving a Statement of Needs	93%	95%	96%
PAF D40	Clients receiving a Review	85%	85%	83%

Advice and information access for all

- We are working with organisations across Torbay, including local libraries, to develop an internet access point for information on a range of services, activities and support in the bay. Where people are asking about things which we don't have in the bay at present, we want to be able to capture this information so that we can encourage the development of new business and activities in Torbay.

Extra—Care Housing

- We have been developing accommodation for individuals and their families who need support in order to remain living in their own homes. Dunboyne in Plainmoor has been successfully rebuilt and a number of people are now housed in accommodation which provides them with services on their doorstep to maintain their independent lives.
- We are going to develop extra-care at other sites in Torbay like Hayes Road in Paignton. We intend these new homes to have practical solutions such as Telecare and assistive technologies, in order to use all the modern resources available to meet peoples needs.

Personalising Social Care

- We have been developing new ways of working to enable individuals who receive social care and their families to have a better understanding and more control over the options available to meet their assessed care needs.

- **Resource Allocation—a fair slice of the cake**

  We have been using the national resource allocation system (RAS) to assist us in determining how much money an individual may need to meet their assessed needs. We have one RAS so that no group of individuals is discriminated against as the allocation of a budget for care is based on an individuals needs not a care label. There are people living with complex illnesses and disabilities which may be expensive and we recognise that the RAS will not always determine the full extent of money these people need for their care. We are working with other colleagues to ensure the RAS will calculate a budget for more expensive care.

  Personal budgets

- We have been telling people how much money is available to spend on their care—their "personal budget". By the end of 2013 we want everyone to know their budget and to have the choice to manage their budget personally. We already have many people who do this through a "direct payment" whereby money is put into a nominated account to pay for care and services chosen by the client.

Partnership Working

Staff from Children's Integrated Services (Disabilities) have regular meetings and undertake some joint working with our Adult Learning Disability Colleagues which has started to improve the transitional experience of young people with Learning Disabilities. Adult Services also occasionally facilitate young people continuing with the befrienders and other carers that they know well. We work with third sector organizations to improve the transitions experience and we commission some services that go across the transitions age in order to enable young people to continue to meet with their peers and learn life skills. There is currently some project work underway to produce a parent/carer and young persons guide to transition and these will contain useful information and guidance to support the transition process across health, education and social care.

Improved choices

In the last year we have worked hard to further improve the services available to a person with a learning disability. In 2011/12, we increased the choice of approved providers for people who use services in their own home. This has proved to be really useful for people who have complex needs. We have also extended choice of day services for people. This is something that we plan to build upon in 2012/13, ensuring that day activities are closely linked to a person's needs.

Examples of Torbay citizens accessing personal budgets

Female carer in 50's receiving one off payment for the purchase of greenhouse and starter kit to allow her to 'escape' / step outside of her caring role to provide some respite and an interest.

Single person had a stroke many years ago. Lives alone. Had a series of serious falls within the home which instigated frequent GP and ambulance call outs and visit. Received physiotherapy and intermediate care but a severe fall resulted in a referral by GP for a residential stay. In the home, mobility difficulties continued and required further input from physiotherapy services. The client wanted to regain independence in the community. Previous rented accommodation had been relinquished due to unsuitability leading to increased risk of falls. Now officially homeless, options appeared to be limited to residential care. With social worker support client explored alternative property options and secured more appropriate accommodation to maximise independence whilst minimising risk of falls and social isolation. To receive a supportive package of care for personal care and household tasks. Residential placement @ £550 per week, package of care £175 per week

Client with mental health problems, poor mobility suffering from depression received a one off payment to purchase gardening tools and materials to enable use of an allotment. Contact made through local voluntary agency to identify additional sources of funding to assist with making allotment wheelchair accessible and easier to maintain. Social life enhanced by allotment social group. No further support/care needs identified by client.

Older client on a waiting list for a stair lift funded by a disabled facilities grant, further delays would be experienced by the process of agreement and planning.

An Occupational Therapist in multi-disciplinary team advised clients key worker of a widower who wanted to get rid of their late spouses 18 months old stair lift. An engineer (OT provided details) was willing to do a survey for free to establish if the stair lift was suitable for the client/property. It was and the engineer agreed to remove and re-fit for £300. CCW raised a £300 carers support payment for her husband and carer in order to fund this work.

76 year old single client living in nursing home for several years following stroke. During annual review with key worker client discussed intense dissatisfaction with institutionalised care and a strong desire to return to independent living in the community. The stroke has caused limb paralysis, leaving only one functioning limb. Intermediate Care therapists worked to stabilise mobility and maximise independent living skills. Social worker assisted exploration of suitable accommodation and family assisted with move. Varied support plan includes technology to reduce risks indoors and day opportunities to promote social inclusion.

New client 80 years old opted for taxi to hair dresser and church rather than original referral for day care. Using Attendance Allowance to fund this and no further services required

Outcome 5: Freedom from discrimination or harassment

Activity Priorities:

- People independently funding their own residential care will receive discretionary care management support services only if they are in need of protection or other exceptional circumstances exist. This is to balance the need for independence and autonomy whilst offering protection to those who may require it. This is to be reviewed as part of the Transformation in Social Care.
- Ensure that people from black and minority ethnic groups and other equality groups have appropriate access to assessment.
- To develop and then apply a more direct source of customer feedback to provide meaningful data and assurance.

Quantitative Target Priorities:

Performance Framework	Definition	2010/2011 Targets	2011/2012 Targets	2011/12 Result
PAF E47	Ethnicity of older people receiving assessments	1.25%	1.25%	1.38%
PAF E48	Ethnicity of older people with services	1%	1%	1.13%

As part of the referral process prior to a social care assessment, any language or cultural needs would be identified and recorded. This might include the need for interpretation or translation services or providing same gender care wherever possible. **The role of Community Development Workers is to work together with the Black and Minority Ethnic (BME) communities to improve access, experience of, and outcomes for using Health Services.** Currently there is no data available to measure what proportion of the local population is classified as being from BME communities. There are many support groups for various ethnic groups in Torbay which include:

Polish (Kubush), French and Japanese Clubs : they each meet monthly, bring people together to promote their culture and organise open days for people in Torbay.

One World BME Family Support Group: is a multi-cultural community group, meets every week, offers art and craft activities for children and a con-fidential place for parents/families to talk about challenges they are facing or activities they are engaged in, to ask how and where to get help and enjoy time with each other.

Imagine: is a multicultural organisation which promotes understanding of culturally diverse communities or groups living in Torbay and also provides a social and support group network for people from minority ethnic communities and the wider community within Torbay.

In addition to supporting the various support groups listed above Sevil has also been able to apply for funding to help set up additional activities requested by communities such as the sewing club which has been running for 5 weeks and has been attended by 16 people from the BME community

.Sevil Fertinger (our CDW) has supported these communities by helping them access health and mental health services, encourages and has supported individuals to report experiences of racial and domestic abuse.

In developing partnerships with services such as the Peri-natal mental health service, maternity Services, Depression and Anxiety service, Devon Partnership Trust and sexual health services, Sevil has been able to educate health professionals of the needs and experiences of the BME population. By developing these partnerships Sevil has been able to support individuals to access or gain confidence to engage with local services.

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Where necessary Sevil has challenged services to provide an assessment of individuals ability to communicate in English and provide interpretation services in order to ensure the BME community receive the quality of care and support they require. Sevil has been involved in the initial stages of informing the Equality delivery system and will continue to help evidence and support the development of this piece of work.

Sevil's future role will be to work closely with Healthwatch in order to inform commissioners of the experiences and health needs of the local BME population in order to inform service provision and service development.

Outcome 5: Freedom from discrimination or harassment

The Experts by Experience Group of former patient and carers linked to safeguarding are currently reviewing safeguarding pathways for services users with learning disabilities , shortly to be followed by older people. It is hoped that in 2012/13 as part of the communities staff change to using electronic patient records in the community, staff will be able to take survey data on visits with them to provide greater assurance, communities hospitals will be improving their questionnaires at point of discharge and the BME Community Development worker within the Lifestyles Team is working with the Local Involvement Network to identify access issues within the BME community. Feedback to the Trust is expected in the autumn of 2012 and actions will be taken following this as part of the Equality Delivery System.

In 2011/12 the Trust undertook the first stages of the Equality Delivery System, a peer, community and employee assessment of how the organisation measures up against national equalities targets. The work was carried out in partnership with the emerging Clinical Commissioning Group and South Devon Healthcare Foundation Trust. The first stage of this work has involved a number of opportunities for the public and voluntary and community sector, (VCS), to comment the first two, of four goals, *Better Health Outcomes for All,* and *Improved Patient Access and Experience.* In both areas the Trust was scored by the local community and VCS as 'developing'. The involvement of the Torbay Local Involvement Network, (LINk), primary dental care for people with disabilities, short breaks for children and young carers with complex needs and chaplaincy and pastoral care being provided in community hospitals, were all cited as positive experiences.

The Trust's score of 'developing' means that residents can expect improvements in functions linked to equality and diversity issues and further opportunities for public engagement and assessment. Improvements include the establishment of a perinatal infant mental health service, complaints literature targeted at children and young people, service user reviews of safeguarding pathways for learning disabilities clients and older people,

Outcome 6: Economic Wellbeing

Activity Priorities:

- The Trust will work to maximise benefits income of its customers and to use this to support the costs of care required.
- To work with the Council and other employers to improve access to employment for the disabled and other vulnerable groups by reviewing recruitment policies and procedures and agreeing mutual targets for supported work placements.
- To work with the council and other partners to foster the development of community and social enterprises and the use of apprentices. In particular to support opportunities for older people to remain active, retain economic independence, in care and support and for the intrinsic health benefits of this.

Quantitative Target Priorities:

Performance Framework	Definition	2010/2011 Targets	2011/2012 Targets	2011/12 Result
NI 146 ** Note shared target across all public agencies to improve	Adults with learning disabilities in employment PSA 18	3.40%	5	4.2%
NI 150 DPT Provision	Adults receiving secondary mental health services in employment	5	5	6.3%

Nine candidates successfully completed the Health and Social Care Apprenticeship Level 3 programme in 2010/11. One candidate in particular was not only successful in completing this award but felt it did contribute to her success in applying for another role within health and social care. The establishment where they worked for the Trust was sadly closing, so the candidate was going through redeployment and offered jobs to apply for. The candidate commented that doing the apprenticeship programme gave her more confidence in her abilities and applying for different roles in health and social care within the Trust. Their manager stated that the candidate worked to a high standard of care and had a person centred approach to her service users, this was reflected not only in the work she produced in her portfolio but more importantly in the observations of practice by her assessor.

The candidate commented, as did others on the programme- since doing the award she reflected more on her work practice and how she could improve the care she gave. She commented that it made her think more about how she would feel if it were her receiving the care. They also used this process to challenge staff if she felt the standard of care was not acceptable; it enabled them to be more confident in their role.

One of the components in the apprenticeship programme is Maths and English. The candidate was not very confident with the maths and failed the exam. She said she wanted to achieve it so arranged extra support and tuition from the college (who we worked in partnership with on the award) in her own time. This was testament to their level of commitment not only to the course but also to her working role, as she knew having this award would improve her work practice and the care she gave her service users.

Helping people access benefits

The Trust has a small number of staff who actively support clients, living with illness and disability, and their carers to claim additional benefits they may be entitled to. These officers in the Disability Information Service and the Financial assessment and Benefit team liaise with colleagues in the Department of Work and Pensions, Independent Living Fund and other organisations on behalf of clients who may find this difficult. Having extra money enables many people to buy care and support independently. For those who are eligible and who require assistance from social care, they are assessed to see how much money they can contribute towards the total package of support they require.

Outcome 7: Maintaining Personal Dignity and Respect

Activity Priorities

- Seek ways to continue to raise the standards to meet the Dignity in Care agenda.
- To ensure that the findings of the independent safeguarding review are incorporated into commissioning and operational practice and improve joint working with children's safeguarding.
- The Trust will pursue its policy of not commissioning care services from poorly rated providers.
- Performance data from Adult Safeguarding activity will appear in Trust Board reports and Council reports. The annual Safeguarding Adults Board report will be reported to both the Trust Board and the Council. A dashboard of Safeguarding Performance Measures is to be approved by the SAB in January 2011 and will be attached to the Annual Strategic Agreement.

Quantitative Target Priorities:

Performance Framework	Definition	2010/2011 Targets	2011/2012 Targets	2011/12 Result
LAA	End of life care – access to appropriate care enabling people to be able to choose to die at home	22%	27%	
New Indicator LI703	Proportion of safeguarding calls triaged in less than 48 hours	Oct to Dec 57%	80%	90%
New Indicator LI704c	Proportion of safeguarding strategy meetings held within 5 working days	Oct to Dec 71%	75%	80%
New Indicator LI706	Proportion of safeguarding case conferences held within 20 working days of strategy meeting	Oct to Dec 2%	70% (from end July 2011)	74%
New Indicator LI708	Number of repeat safeguarding referrals in last 12 months	10/11 baseline to be determined by April 11	10% reduction on 10/11 outturn = 13	7

Ensuring the safety and wellbeing of patients and service users is of the highest priority for us, with robust procedures in place to ensure that everyone in our care is protected from harm. As part of providing integrated care, the Trust is the lead organisation for safeguarding adults in Torbay and is part of the Safeguarding Adults Board (SAB). The SAB leads and manages multi-agency safeguarding work across Torbay and has senior representation from all organisations involved in safeguarding adults, as well as from service users, care-led organisations and independent care providers. In 2011, we received 408 safeguarding alerts, of which 158 progressed to referral. Initial meetings were held within five days of referral in 79 per cent of cases. Last year, there was one safeguarding case review (SCR) circumstances that led up to an incident and the role that all the services played. The SCR was an opportunity for us and other agencies to share learning and to make improvements to services and procedures In 2011, we used the findings of an external audit report to further improve safeguarding; as a result, we have worked hard to ensure that strategy meetings and conferences are held in a timely manner, that our case files are audited on a regular basis and that there is regular review and improvement to procedures. Last year, safeguarding was part of Commissioning for Quality and Innovation (CQUIN), an incentive scheme where care homes earn payments for meeting a number of quality standards. A third of the homes in Torbay took part in the new scheme. The Trust and the SAB work closely with other local authorities across the region, with the Chair of the Torbay SAB leading regional meetings with other SAB chairs to ensure integrated working and learning across the South West. The Torbay safeguarding team are also playing their part in a piece of work to develop shared policies and practice standards across the region.






Outcome 8: Leadership

Activity Priorities

- Work to raise the profile of Adult Social Care, its importance and contribution to the fabric of Torbay and work to ensure sustainability for plans and personalisation that will provide high quality services and choice for people. This should include the engagement of all elected members to promote understanding in the work of adult social care services and joint working initiatives as a result of the Trust's arrangements.
- To work with Torbay Council to explore further integrated working to improve outcomes and efficiency. To engage with the Torbay Strategic Partnership and the development of the pathfinder Health and Wellbeing Board in the context of the emerging South Devon provider. model.

Training for Care Homes in personal profiles

- In 2012 we will begin to work with care homes to develop a single page profile of each of their residents. This is a person-centred way of focusing on what important to the individual as well as what is important for them.

Following the election of the new Mayor and appointment of a new Executive Lead for Adult Social Care, the council has strengthened its engagement and its future planning arrangements for ASC. A stronger focus on understanding demand pressures, improvement opportunities and resource planning has been evident both internally within the corporate functions of the Council and in the Council's management of its arrangement with Torbay Care Trust.

Despite the complexities of the NHS Reforms, the Council and the NHS have continued to emphasise the importance of retaining the level of integration and impact that Health and Social Care integration has had to the benefit of Torbay residents.

The separation of Commissioner and Provider responsibilities previously vested with Torbay Care Trust has caused an adjustment to the effect that the DASS role moved from the Chief Executive of the (former) PCT to the Council's Deputy Chief Executive in April 2012 as the former Care Trust became an NHS Trust.

Outcome 9: Commissioning and use of resources

Activity Priorities:

- To ensure a maximisation of benefits of joint commissioning and investigate ways in which this can be further consolidated.
- The Trust will undertake a robust monitoring of its contracts to ensure safe and effective service delivery as appropriate. Links with Commissioning Strategy, and links with the regional

- The Trust provided Adult Social Care to around 6,350 people in 2011/12 (this includes 830 people over 65 with mental health issues).
- The Trust have offered a local payroll system to people who take a budget for their own Personal Assistants.
- 49.61% of people were offered a Personal Budget in 2011.

The Council and the Care Trust have retained the partnership and pooled budget arrangements in place. This facilitates flexible resource use to meet patient needs. Both NHS and Local Authority Commissioners understand the benefits that this has brought for service users and for the Health and Care system as a whole.

In common with the rest of the country, the care home sector is showing signs of vulnerability. Several homes have ceased trading and others are known to be facing longer term viability issues. Nonetheless both quality and value for money indicators have remained strong despite the continued downward trend of about 4% per annum reduction in publicly funded placements. This is in line with the shared local strategy of developing services to support carers and customers in their own homes.

The jointly funded and jointly provided function of assessment/care management and care coordination continues to attract external attention for its ability to impact positively on whole system performance.

A small proportion (about 25%) of the Council's spend on Learning Disability continues to be provided in-house. This component of our Learning Disability strategy has progressed more slowly than others and will receive fresh impetus during 12/13 when a consolidation of day services sites from three to two will be implemented as the last directly provided residential home will, with full family involvement, be re-procured with a new partner contracted to redevelop the facility into supported living.

The domiciliary care market continues to be difficult to balance between the reliability of the four large block contractors, a range of other independent sector providers and the emerging picture of direct payments and personalised care plans further diversifying the picture. A small residual in-house service, focused on post discharge care at present is changing focus to intensive rehabilitation to reduce long-term care package dependency.

If you would be interested in joining our panel of social care users and family carers, to provide us with feedback on planned developments, please contact us.

E-mail: communications.torbaycaretrust@nhs.net

Tel: 01803 219700

Please also let us know if you have any ideas for what we should include in our Local Account for 2012 - 2013

This booklet is available on request on audio tape, CD, Large Print, Braille or alternative language.

If you would like either of these, need translation into a specific language, require further copies or would like to comment on the Local Account, please contact the Trust Communications Department. Tel: 01803 210500

For Information about social care contact| Tel: 01803 219700