Adult Social Care **Local Account**

2015/16

Gloucestershire
COUNTY COUNCIL

Contents

1.0 What is the Adult Social Care Local Account?

A document sharing the performance of adult social care services in Gloucestershire. It covers our performance over the last financial year and our challenges and future plans to address these. It also invites feedback from those who have used or experienced adult social care services. Real life examples are included (we have changed names and details to protect confidentiality).

1.1 Message from Cllr Dorcas Binns – Cabinet Member for Older People

Welcome to this year's Adult Social Care local account for Gloucestershire County Council. This is an opportunity for us to take a step back and reflect on what's gone well, where our challenges are and share our plans for the future with you.

Resources continue to be tight and at the same time people are living longer with complex needs resulting in increasing demand for social care services. Through the combined hard work of our staff, partners, volunteers and family and friends who act as carers, we continue to come together to ensure that the most vulnerable people living in our communities are given the support they need.

As you read through our Local Account you'll see some great examples of where we're making progress and seeing our plans coming to fruition. For example, i've been pleased to see an increased number of people with disabilities and challenging behaviour given the chance to live a more fulfilling life in their community. We really can see the transformation in services for people with disabilities starting to happen.

You'll also see we've been upfront with you about our challenges, including responding to the increasing numbers of older people needing services from us after leaving hospital. I'm confident, working jointly with our partners, we are taking the right steps to manage these challenges, including our focus on prevention, for example through our community hubs, helping to maintain peoples' wellbeing for longer. We'll be working even more closely with our partners to transform services for older people.

So, yes, although these are difficult times, we continually look at how we can deliver the best services with the resources we have.

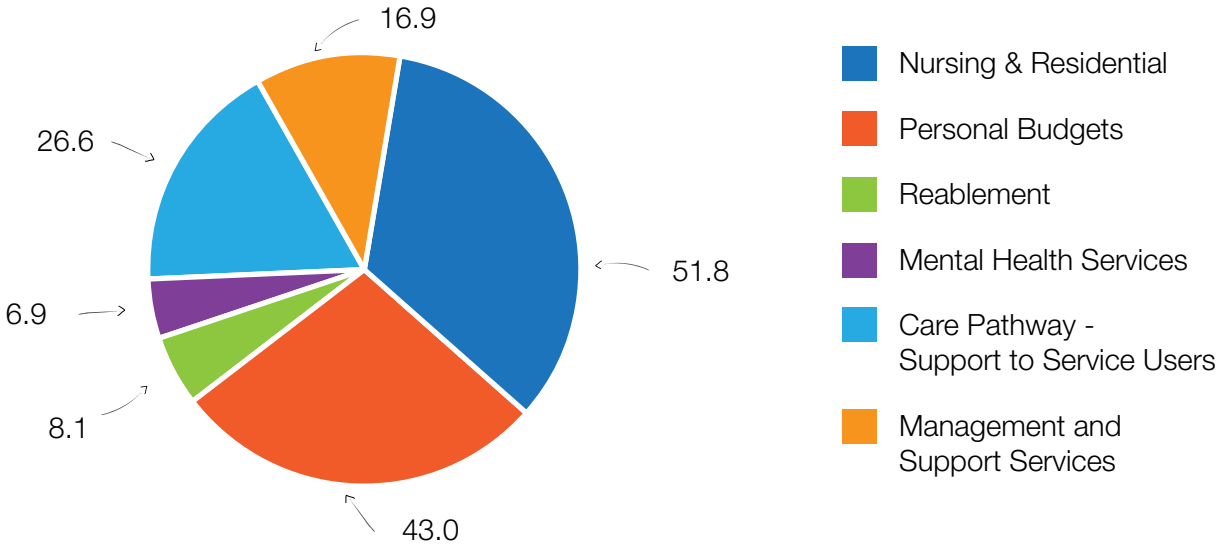
I hope you find our Local Account a useful read and welcome your views on how you think we're doing and our plans for the future.

1.2 The Facts

Budget…

- For 2015/16 spend was £154.7m against a final budget of £151.5m
- For 2016/17 we have set our budget at £153.4m, which is 36.5% of the county council's overall budget, with a breakdown below. (note: numbers here & in pie chart below rounded to nearest hundred thousand)

Adult Social Care Budget for 16/17 by type of service (£m)



Geography…

- Gloucestershire has a mixture of rural and urban areas including two large urban centres, Gloucester and Cheltenham. The more rural areas such as the Cotswolds and Forest of Dean have an older population over a wider area, making delivering services more challenging.

Did you know?...

- Gloucestershire is one of the healthiest counties in England with approximately half of our citizens aged over 65 in good health. Statistics show Gloucestershire's older population is growing at a faster rate than the UK average. The number of people over 90 is predicted to increase by 75% between 2016 and 2031, and research has shown people over 90 typically require twice as much care as 70 year olds.

People…

- Gloucestershire has a population of approximately 620,000 as of 2015, and has grown by an average of 4,000 people a year in the past 10 years. There are around 8,000 people receiving long term social care services funded by Gloucestershire County Council each year. We also help a large number of people contacting us with advice, information and guidance. Gloucestershire has about 63,000 people who provide unpaid care for a family member, friend or neighbour.

Our partners…

We work closely with our key partners to deliver adult social care services including:

Gloucestershire Care Services NHS Trust: to provide short term intensive support.

2gether NHS Foundation Trust: to provide social and healthcare services to people with mental health needs.

Health partners: the Gloucestershire Clinical Commissioning Group and GPs to ensure we deliver joined up health and social care services designed to meet people's care and wellbeing needs.

Hospitals: to make sure people can return home from hospital as soon as they are ready, and where they need care and support, making sure this is in place.

1.3 What are the future challenges?

People are living longer with more complex needs and in order to meet this increasing demand with the resources we have, we need to change the way we deliver services, whilst maintaining our responsibility to be there for those in need of social care services.

Here's a summary of the changes in social care needs we expect to see over the coming years:

- On the whole, people are living longer and making a valuable contribution to their community. However the number of people aged 75 and over (the ages at which Gloucestershire County Council funded services are most likely to be required), is projected to increase by an annual average of 2,300 between 2014 and 2039, meaning demand for adult social care will increase.

  The number of people over the age of 85 will see the fastest rate of growth during this period. Added to this, the number of older people living alone is projected to rise from 35,000 to 44,000 between 2015 and 2025, which we expect will mean that more people will need our help.
- We are also seeing an increase in the number of people with dementia, who may require specialist care. In Gloucestershire, there are estimated to be 9,000 people aged over 65 living with dementia and that number is expected to reach 15,000 over the next 15 years.
- At the same time it is expected the number of unpaid carers aged over 65 will rise from the current 18,000 to 25,000 by 2030, meaning there will be more elderly carers who may need support themselves.
- Gloucestershire has an estimated 11,000 adults with a learning disability, which is much higher than the national average and partially due to people with disabilities moving to the county for the specialist education facilities. We expect this to continue increasing by 1,200 people by 2030.
- We are also predicting other areas of increased demand with more children with complex needs going on to need services when they become adults and an increase in young people with mental health needs.
- It is forecast that the new national living wage will have a significant impact on adult social care contractual costs, which could cost the council around £3m a year.

We want feedback from people receiving adult social care services and ideas on what improvements or changes they would like to see.

1.4 Listening to you

You told us in our budget consultation last year that we should focus on supporting the most vulnerable, working with communities and individuals to help them to do more for themselves. You also supported the council's proposals to raise council tax particularly in order to invest in services for people who need them most.

2.0 Active Individuals

We want to help people stay healthy for longer so they can enjoy remaining independent and active into old age.

We know from what people tell us that they want to stay living at home for as long as possible. We need to focus on encouraging people to follow healthy lifestyles to prevent avoidable health problems later in life.

Good information and advice to encourage participation in local activities, clubs and voluntary groups can help people stay connected with their community.

2.1 How are we doing?

We continue to do well with the support we give to people with learning disabilities to help them live an active life in their communities.

There's been a big transformation this year as we've seen more people move from traditional residential care to community living, including those with complex needs and challenging behaviour, and as part of this we've seen many more people accessing preventative services. To support this change we've been refurbishing community accommodation.

We continue to improve the way we work, and now have specialist staff in our disabilities brokerage team including a dedicated housing broker to help ensure we are giving people choice and control over their care.

The schemes we fund, that help people with learning disabilities develop lifeskills and find meaningful employment, continue to be successful, and results show us above other similar areas of the country. Our performance on helping users stay living at home is line with other councils.

We also fund employment support for people with disabilities, who although not in need of ongoing social care support, benefit from some support to help them find paid employment and remain independent. Our local data shows this preventative approach is very successful in helping them to find paid employment.

The work of the Forwards Employment Team we fund to increase employment opportunities for people with a learning disability was 'highly commended' at the 'Municipal Journal' public sector awards ceremony.

One way we help to keep people independent is through our drop-ins. These have been revamped and can now be used by people with any disability. We're working with service users on plans to have these run by local disability groups.

In the last year we've also succeeded in combining services for children and young adults with learning disabilities into one service for 0-25 year olds to ensure a smoother transition for children entering adulthood who continue to need support.

We've seen good outcomes for people with mental health issues through the focus of preventative services we fund helping them to develop life, work and wellbeing skills. We perform better than other similar parts of the country on how many people with mental health issues we help into employment and to live at home.

The 2gether Mental Health Trust received an overall rating of 'good' from the Care Quality Commission. Two service areas - acute wards for adults of working age and psychiatric intensive care units and mental health crisis services and health based places of safety – were rated as 'outstanding'. 2gether was the only mental health trust in the country to have achieved outstanding ratings in these areas.

Case Study
Enabling people to live in their community

The Council and our health partners have worked together to transform Coombe End residential home in Hucclecote Road into 8 new independent purpose-built flats to support people with severe learning difficulties and behavioural challenges.

Cllr Kathy Williams, Gloucestershire County Council's cabinet member for long term care said; "This is a fantastic new facility which will support people with learning disabilities. There is a growing need for this type of accommodation which helps people to live in the community."

Case Study
Helping people with complex and challenging behaviour to live in their community

Paul aged 29

Paul has challenging behaviour and after attending a special school went into a residential home. He wasn't happy in the home and his behaviour was worsening and Paul ended up in hospital for a year. He wanted to leave but the right sort of support wasn't available.

Paul then moved out of Gloucestershire for a few years into a flat but still had to be escorted by staff if he wanted to go out. Being indoors and bored made his behaviour worse, including causing damage to his home and lashing out at staff, and on top of this he didn't see his family very often.

A few years ago Paul moved back to Gloucestershire into his own home. Although he still had some challenging behaviour and sometimes struck out at the staff, with the right support he felt more stable and secure, and his behaviour improved and Paul started to enjoy life more.

He now has chickens and rabbits to look after, is closer to his family and has been on camping holidays. Paul cooks his own dinners, has his own front-door key and says his life is very different now.

Case Study
Support into employment

Christian aged 22

Christian has Cerebral Palsy and a Visual Impairment. When Christian was referred to the 'Forwards' employment team he wasn't sure about his future prospects, having experienced the disappointment of a college course being withdrawn and so was uncertain on what to do next.

A job broker from the Council met with Christian and his mother to work out a plan. At first, the goal was to get out of the house, be busy and meet people. Then, further down the line, set up his own business to help other people with difficulties. So, with the broker's support, Christian created a CV and worked out steps to achieving his life goals.

Christian started a 6 month traineeship at the local college, and then he had the idea of creating a modern and up to date accessibility guide for Gloucester. Our broker helped him prepare for an interview with Marketing Gloucester, including working out the details of producing such a guide.

He got the traineeship, is really enjoying it and learning new skills. The broker keeps in touch and will support Christian onto the next stage of his life-plan when he finishes his traineeship, either into a paid apprenticeship or his own business where he can offer his marketing skills to other towns looking for similar guides.

2.2 Future plans

We'll be creating a joint team with our health partners to enable more people like Paul with complex and challenging behaviour to move from traditional residential care or hospital to live supported in their community.

Helping more people like Christian into employment is at the heart of our plans for the future to transform the lives of people with disabilities in Gloucestershire.

3.0 Active Communities

Being part of an active community can play a huge part in helping people stay independent for longer.

We know many carers, families, friends and neighbours are contributing to 'active communities' in their areas. There are also over 2,000 voluntary organisations working across Gloucestershire providing community run activities including financial advice, holding lunch clubs and running youth clubs.

3.1 How are we doing?

Carers make a massive contribution in helping friends, relatives and neighbours to live at home.

Our local data shows that Carers Gloucestershire are continuing to improve on assessing and supporting more carers and this is reflected in improved and high satisfaction levels. However our local data also shows that we need to increase the number of carers with a personal budget or direct payment, and we expect to see a continued improvement on this in the coming year.

For older people, we've continued to establish the Gloucestershire Community Hubs, where facilities in residential homes have been utilised and opened up to the wider community to offer flexible drop in opportunities for activities. As a result we're seeing a great community feeling as residents join together socially with people who attend from the community.

Steady progress has continued in relation to improving information, advice and advocacy. A new independent Care Act Advocacy service is in place to help people understand the information and decisions around their care and support. Also a new financial advice telephone line is in place now resulting in more users receiving this type of advice.

Case Study
Community Hubs

Research shows that as some people get older they are at risk of becoming socially isolated, as they leave their social groups, for example that they had at work, and at the same time participate in less activities. Other factors leading to isolation can include living in a rural area with less transport, reduced mobility and a shortage of friends to go out with. Eventually this can lead to people needing social care services.

One part of our preventative strategy to address this is through the roll out of Community Hubs for older people and we now have 21. These are purpose built in extra care housing schemes, or traditional sheltered housing schemes, village halls and day centres. There are flexible 'drop in' options which give carers a break at the same time as a social and stimulating time for the people they care for. A big range of social activities are on offer ranging from 'Zumba' to theatre trips or just tea and a chat.

We've had very positive feedback from users about the many benefits, with some quotes below, and our survey results show high satisfaction.

- "I've been able to come off my blood pressure tablets"
- "After knee replacement my surgeon commented that my recovery was advanced due to my exercise regime"
- "Regular exercise at 85 has caused me to lose weight around my middle"
- "I can only manage going local so it is great we have things going on at the hub"
- "I don't get out very often – coming to the hub is the only time I see people and I was lonely"
- "After 18 months I feel confident enough to walk without my stick"
- "I've got more confidence to do more for myself"
- "Only used to see my family when they visited – now I have my own friends at the hub"
- "I've finally found new friends and I feel so much more alive"
- "Friendship, support and information at the hub has made me feel more connected"
- "I now feel confident enough to think about volunteering".
- "The hub is my lifeline – meeting others like myself helps me feel involved"
- "My health problems are the same but not so scary for me any more"
- "Attendance at the hub has given me more confidence in myself"
- "It improves my mental health as well as keeping the body supple"
- "I get great enjoyment from getting together, having a laugh, sharing "life" problems! It's good to socialise"

Our evaluation of the hubs supports this with evidence of improved mental health, self-confidence, reduced anxiety and increased optimism. We also see that as people do these activities they become more sociable which in turn reduces social isolation and loneliness. Working with our partners we'll continue to ensure the hubs thrive.

3.2 Future plans

We'll continue with our plans to support active communities and a key part of this will be reviewing how we can best deliver an effective 'community connector' role.

This means each community having a 'connector person', aware of local people who are at risk of becoming socially isolated, but who can, with some information and encouragement, enjoy activities and feeling part of a community, and so avoiding a potential loss of independence.

Alongside this we'll work with our partners to create more opportunities for people to take part in activities that help them stay healthy, and mentally and physically active. Underpinning al this will be on-line information about activities and matching people to volunteering opportunities.

Another strand of this strategy will be reviewing housing support for vulnerable people, for example those who live in supported tenancies and sheltered housing. This includes increasing the availability of community activities in areas where people are receiving support, ensuring accommodation is of a suitable standard and providing information and advice early on to those at risk of a crisis. We know how important it is to provide timely, good quality information and advice, particularly when people first contact us about support. The annual Service User Survey results show we perform better than other councils for providing accessible information for service users.

However, there is still more for us to do in regard to improving information, advice and advocacy and we'll be reviewing and re-tendering all our advocacy services for adults and children to increase access and standards. We also want to improve on-line information, including revamping our 'your circle' website, providing user-friendly on-line advice about the care and support available.

4.0 Back to independence

Social services have a responsibility to help people who need it to get back on their feet, for example following a stay in hospital, so they can carry on living in their home safely.By getting this support to people quickly we can avoid some of them going into hospital or a care home.

4.1 How are we doing?

When people are ready to leave hospital we know how important it is for them not to be kept waiting when they could go home. Our social care staff in hospitals work to get patients ready to leave and make sure support is ready if they need it when they get home.

They work closely with hospital staff such as physiotherapists as well as voluntary groups who help for example with transport home. The effectiveness of this joined up support is reflected in our performance figures which continue to show us as one of the top councils nationally for minimising the number of people delayed in hospital when they are ready to return home.

Our reablement service has been effective in helping us prevent unnecessary delays when people are ready to leave hospital, and this is reflected in our improved performance helping people stay at home for at least 3 months after leaving hospital, where we are now at a similar level to other areas of the country. We also perform better than other similar parts of the country for people not requiring further support after reablement.

We know how effective this type of short intensive support can be to help clients to remain living at home in their community and reduce preventable admissions to care homes, and we'd hoped to have seen more benefiting.

However we've faced the challenge of coping with the high demand from people leaving hospital and as a result fewer clients receiving reablement support than in the previous year, and although staff are spending more of their time working directly with service users, this is still below where we want it to be. To address this we've made changes so that we now target this support at those most likely to benefit after their discharge from hospital and also undertaking an assessment identifying what type of support will best meet their needs.

Our telecare and equipment services are also an effective way of keeping people independent. This is where we install equipment such as falls detectors, linked smoke detectors, epilepsy sensors, medication dispensers and 'lifelines' (where in an emergency care staff are notified.) Whilst we are doing well in making the latest technology available we want to see more people benefiting from this type of support and reducing the need for long term social care support.

We know that people value meals on wheels as it helps them remain living independently at home as well as reducing feelings of isolation. A new contract is now in place to ensure better choice, access and flexibility which are key things users of the service told us they value. Cllr Dorcas Binns, cabinet member for older people, said: "We know that many older people want to stay in their own homes and communities for as long as possible, and by continuing to provide community meals, we can help them to do that."

Case Study
Telecare in action

We provide a range of the latest 'telecare' equipment to help people remain living at home, and for many who are prone to falls this technology is vital for them to stay independent. The equipment is linked to a monitoring centre with trained staff and we also use Gloucestershire Fire and Rescue Service (GFRS) 'responders' to go into homes should users of this equipment have an emergency. Here is one of many examples we have of our clients benefiting.

Freda lives alone in her bungalow and enjoys being sociable and frequently goes to her local day centre. She has two daughters who visit every week but no regular carers, and lives independently.

Freda developed dementia affecting her memory and concentration, she is also hard of hearing. She could struggle to hear alarms such as a smoke alarm and needed help to get out of bed or into a chair. Freda and her family wanted her to carry on living at home, with some support to make sure she was safe.

After an assessment, Gloucestershire Telecare set Freda up with an automatic fall detector, as well as linked gas, heat and smoke detectors. So, in the event of a fall or a potential emergency, the detector is triggered and help called for, and if Freda can't get out of her home, responders are alerted to come and help. We also provided her with equipment to help her find her way around the bungalow as she was prone to wandering.

When Freda has had a fall the responders get there quickly, helping her back onto her feet. After one fall she had some back pain and the responders got the paramedics in. If they hadn't responded so quickly, things could have quickly got worse, potentially with Freda ending up in hospital or a care home.

Freda's daughter told us she'd seen a 'marked change' in her mother and that the responders made all the difference as she didn't live locally so wasn't always on hand should there be an emergency. Through using remote technology, linked to our monitoring centre, together with responders, we want to help more people like Freda live at home safely and independently for as long as possible.

4.2 Future plans

We expect to see a reduction in care home admissions as a result of our new reablement model, allowing resources to be focussed on those who will benefit most after leaving hospital.

We'll be working with our health partners to see how we can better manage the increasing numbers of admissions to hospital and the resulting higher demand for social care services. By targeting our shared community resources at people earlier on we hope to ease this demand on hospital discharges to focus our resources on reducing avoidable admissions to care homes. Alongside this we'll increase the number of people receiving telecare through improving access and getting equipment to clients quickly, for example after they have had a crisis such as a fall. We'll invest in the latest telecare technology available, for example to help the increasing numbers of people we see with dementia. Finally, we'll review our service that supplies more general equipment such as wheelchairs, to better integrate it with reablement and telecare services.

5.0 Long Term Care

Although help may be available from families, friends, neighbours and communities, we know there will always be some people who will also require social care services.

5.1 How are we doing?

From our annual survey of service users, we know we continue to do well in helping them maintain quality of life, choice and control, with similar levels of satisfaction as in other similar parts of the country.

Active individuals and communities playing their part will mean we can be there for the people who need us most. For some, this may mean going into a residential or nursing home, but we will focus increasingly on providing support in the community to help people stay within their own home as this is what people tell us they want. That way, even when they need ongoing assistance from us, they can still continue to benefit from the informal help they receive from the community around them. We will give people a personal budget wherever we can and work together with them on a support plan that best meets their needs.

Although we have seen a reduction in the number of people going into care homes, we still have more than other parts of the country and haven't achieved the levels we'd hoped for. Although the numbers of people requiring support to live at home are steady, there's been an increase in those with more complex needs. The number of people receiving their support through a personal budget is better than last year. However the number of users with direct payments (where people are in direct control of their care budget so they can buy services themselves that best meet their needs) is still behind other parts of the country. In response we've brought in specialist staff to focus solely on direct payments, support planning and purchasing services, and already there are positive signs of improved choice and control for service users.

As we have coped with the demands from people leaving hospital, that we talked about in the last chapter, we've not been able to make the improvements we wanted to the timeliness of people's assessments for social care support.

Good progress has been made with improving the choice and quality of homecare services available (support with peoples' everyday tasks such as getting dressed, washing and eating). This has been achieved through re-tendering the contracts and focussing on achieving outcomes, as well as setting out consistent standards.

The challenge now is ensuring we have enough provision to cover the varied geographical mix of urban and rural areas across the county. Although we're struggling to meet demand at the moment as the new arrangements bed down, we're confident the changes place us well for the future. Another way we're ensuring consistent standards from our providers is through the electronic call monitoring system we've put in place, which now gives us better information about the amount and quality of care from providers.

Protecting all adults in Gloucestershire with care and support needs who are experiencing or are at risk of abuse and neglect, runs through everything we do. Our local data shows that we had fewer safeguarding concerns (a 23% decrease on last year), and out of those concerns that were investigated and closed within 2015/16, the risk was removed or reduced in three quarters of them. There's been an improvement in the percentage of people, who said in our annual survey, that the services they use have made them feel safe and secure, placing us slightly above other similar parts of the country. Lastly, we continue to listen to our service users. Over the course of the year, the number of complaints received has increased marginally from 211 last year to 223 in 2015/16, but there has been a significant reduction in those upheld from 83 last year to 64 in 2015/16. We have also received more compliments, with 273 in 2015/16 compared to 236 last year.

As part of our plans to increase service user engagement a Physical Disabilities Partnership Board has been set helping us to ensure we listen and understand peoples' needs. This builds on our existing forums, for example for carers, older people and people with a learning disability as well as for those with mental health issues.

Case Studies
Supporting people to remain living in their own home

Elsie's family called us as they were getting worried about her safety and wellbeing, and felt she needed to go into a care home. Elsie is an older lady who suffers from dementia which was leading to her not being able to look after herself and wandering from home. After talking to Elsie it was clear that the dementia meant she couldn't make decisions about her own care. We then came up with a plan to see if between us and her family we could help her manage the risks and still enjoy living at home.

This support included telecare to reduce the risk of Elsie falling or wandering, homecare for support around the house including personal care and making meals and Elsie's family helping with shopping and managing her finances. Working with her family we came up with a weekly timetable of local activities, such as social stimulation which can help reduce the risk of wandering.

Elsie is continuing to live at home through this support, with her family happy and re-assured that she doesn't need to go into a care home.

James: James is in his mid thirties and was living in a residential care home. The social worker felt that James had the potential to live a more independent life in his community and that a shared care scheme would be the ideal way to give him a supportive environment in which to achieve this.

The social worker and the shared care staff worked together to support James's move into his new accommodation. When James first moved in he wasn't confident about what he could do, and didn't believe he could make friends and got out on his own, and his parents felt the same way.

Staff were able to help James build his capabilities resulting in him being able to go out on his own. He now goes to college, the gym and has joined numerous social clubs. James gets support from staff when he needs it – for example to go to some social events – but this is gradually decreasing as he builds on these successful experiences.

James and his parents are now really positive about what he can do and James now has the ambition to move into his own home.

5.2 Future Plans

We will continue with our plans to improve the way we deliver services for older people to achieve the best value for taxpayers to meet the needs of people using those services.

The new reablement model, that we talked about in the last chapter, should help us reduce care home admissions through being more responsive and targeted at those who will benefit the most. At the same time we want reablement, telecare and equipment services to be more smoothly joined up. Also we'll ensure the new homecare contracts improve quality and encourage new providers into the market.

We'll be setting out in a Market Strategy the services we need from providers in the future to make sure we meet the changing needs of the population. This includes more specialist services for people with dementia who represent an increasing proportion of service users. Additionally, the type of housing we need, as well as ensuring a fair price for residential and nursing care. Also, we'll be having joint health and social care staff commissioning services building on our close working relationship with health colleagues. We'll also be encouraging more providers to enter the market so we have more services for people with challenging behaviour as currently there is a shortage of this type of care.

Last year we brought back into the council the management of adult social work services for older people and those with a physical disability. This highlighted that we had a shortage of staff to cope with increasing demand, which is also an issue councils across the country face. To address this we will be investing money from the council tax rise to recruit more good quality staff. This will enable us to cope better with increasing demand and improve on areas such as the timeliness of assessments.

From our investment in specialist brokerage staff we expect to see better choice and value for money for service users from their personal budgets. We'll also bring in 'pre-paid' cards to make it easier for those who want to have a direct payment.

6.0 Final Thoughts

In our Local Account you'll have read about a lot of good work we're doing with some exciting examples, whilst at the same time we're not hiding from the areas where we need to improve.

This year we've made progress implementing the plans we talked about last year. We know we can only make our vision a reality through listening and working together with our communities and partners. Whilst acknowledging these are challenging time we're continuing to head in the right direction.

7.0 How we are performing

Comparator data from the Health & Social Care Information Centre.

Measure	Glos 14/15	Glos 15/16	Glos Annual Trend	Family Group 15/16	England 15/16
ASCOF 1A: Social care related quality of life score (comparators range was 18.8 - 19.7 with max score possible of 24)	19.3	19.4	⟷	19.1	19.1
ASCOF 1B: Proportion of people who use services who have control over their daily life	78%	79.2%	↑	77.2%	76.6%
ASCOF: 1C pt 1A: Proportion of people using social care who receive self-directed support	85%	90.6%	↑	83%	83.7%
ASCOF 1C pt 2A: Proportion of people using social care who receive direct payments	19.3%	22.2%	↑	31.2%	26.8%
*ASCOF 1C(1B): Proportion of carers receiving self-directed support	n/a	10.2%	n/a	93.4%	77.7%
*ASCOF 1C(2B): Proportion of carers receiving direct payments for support direct to carer.	n/a	10.2%	n/a	31.2%	67.4%
Local figure: % of carers with flexible budgets (following assessment)	48%	43.4%	↓		
ASCOF 1D: Carer-reported quality of life score (comparators range was 7.3 – 8.3 with max score possible of 12)	7.4%	n/a	new	7.8% (14/15)	7.9% (14/15)
ASCOF 1E: Adults with learning disabilities in paid employment	8.3%	8.7%	↑	6.2%	6%
*Local figure including those people with learning disabilities helped by the council to find employment who have not received a funded service	18.5%	19.9%		n/a	n/a
ASCOF 1F: Adults in contact with secondary mental health services in paid employment	10.7%	12.2%	↑	9.4%	6.8%
ASCOF 1G: Adults with learning disabilities who live in their own home or with family	70.6%	71.6%	↑	73.3%	75.4%

Comparator data from the Health & Social Care Information Centre. The 2015/16 data was supplied by authorities in June 2016.

Key: Green = either better / same / less than 1 % below comparators
Yellow = more than 1% below comparators.

Measure	Glos 14/15	Glos 15/16	Glos Annual Trend	Family Group 15/16	England 15/16
ASCOF 1H: Adults in contact with secondary mental health services living independently, with or without support	79.1%	75.9%		55%	58.6%
ASCOF 1I pt1: Proportion of people who use services who reported that they had as much social contact as they would like	47.2%	48.2%		44.5%	44.8%
ASCOF 1I pt2: Proportion of carers who reported that they had as much social contact as they would like	26.8%	n/a	new	36.1% (14/15)	38.5% (14/15)
ASCOF 2A pt 1: Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 population (less is better)	15.9	7.7		12.8	13.3
ASCOF 2A pt 2: Long-term support needs of older adults (aged 65+) met by admission to residential and nursing care homes, per 100,000 population (less is better)	694.7	665.4		563.0	628.8
ASCOF 2B pt 1: Older people (65 and over) who were still at home 91 days after discharge from hospital into reablement rehabilitation services, expressed as a percentage	74.7%	81.4%		83.1%	82.7%
ASCOF 2Bpt 2: Older people (65 and over) who were offered reablement services after hospital discharge	3.0	3.4		2.4	2.9
ASCOF 2Cpt 1: Delayed transfers of care from hospital, per 100,000 population (less is better)	3.1	3.9		14.1	12.1
ASCOF 2Cpt 2: Delayed transfers of care from hospital which are attributable to adult social care, per 100,000 population (less is better)	0.9	1.0		5.7	4.7
ASCOF 2D: Proportion of those that received short term service within yr where the sequel to that service was either no ongoing support or support of a lower level	90.2%	89.2%		76.4%	75.8%

Measure	Glos 14/15	Glos 15/16	Glos Annual Trend	Family Group 15/16	England 15/16
ASCOF 3A: Overall satisfaction of people who use services with their care and support	66.9%	65.7%		64.3%	64.4%
ASCOF 3B: Overall satisfaction of carers with social services	38.5%	n/a	new	40.8% (14/15)	41.2% (14/15)
ASCOF 3C: Proportion of carers who report that they have been included or consulted in discussion about the person they care for	68.1%	n/a	new	72.5% (14/15)	72.3% (14/15)
ASCOF 3Dpt 1: Proportion of people who use services who find it easy to find information about services	77.3%	77.3%		72.6%	73.5%
ASCOF 3D pt2: Proportion of carers who find it easy to find information about services	64.6%	n/a	new	64.4% (14/15)	65.5% (14/15)
ASCOF 4A: Proportion of people who use services who feel safe	67.7%	71.4%		68.6%	69.2%
ASCOF 4B: Proportion of people who use services who say that those services have made them feel safe and secure	90.9%	91%		86.0%	85.4%

8.0 Glossary of commonly used terms in adult social care

Adult social care services	These are services for adults who need additional support to manage their everyday lives and to be independent, including people with a disability or long-term illness, people with mental health problems, people with a learning disability and carers. This includes for example residential care, home care, care assistants, aids and adaptations and personal budgets.
Advocacy	Advocates are independent of the council and can help you find services, ensure your views are heard and help you with important decisions.
ASCOF	Advocates are independent of the council and can help you find services, ensure your views are heard and help you with important decisions.
Assessment	By looking at your needs we can assess what support you may require. Someone from our social care team will contact you and your carer or family member. We will talk to you about your needs and work with you to find out what services will best help you to live a more independent life. Your assessment helps us to determine how much your budget will be, based on your assessed needs. If you are assessed as not needing social care, we may still be able to offer guidance and information about sources of support that you can access or provide for yourself.
Carer	A carer is a person who cares for a relative, friend, or neighbour – who through illness or disability, is unable to look after themselves. Becoming a carer can happen to anyone at any time of life. A carer is not someone who is paid to look after others, like a nurse or care worker, or a volunteer working for a voluntary organisation.
Co-production	Co-production means making something happen together. It is the way decision makers and the important people in someone's life will work with people with disabilities, carers and equality groups to improve their lives.
Community hospital	We have seven community hospitals across Gloucestershire which provide a range of health services for people of all ages 365 days a year.
Community hubs	Community hubs are situated in extra care housing schemes, or traditional sheltered housing schemes, village halls and day centres. There are flexible 'drop in' options which give carers a break at the same time as a social and stimulating time for the people they care for. A big range of social activities are on offer ranging from 'Zumba' to theatre trips or just tea and a chat.
Dementia	Dementia includes problems with: memory loss, thinking speed, mental agility, language, understanding, judgement
Direct Payments	A direct payment is money the county council can give you directly to enable you to choose where you want to buy the services or equipment that you, or the person you care for, have been assessed as needing.
Domiciliary care	Home care (also known as domiciliary care) is help which is provided in your own home to help you with everyday tasks and is provided by personal assistants.
Extra Care Housing	For frail older people extra care housing provides them with their own home in the community together with varying levels of care and support on-site.
Independent Living	Getting the assistance and support you need so you are able to live the life you want, for example through taking part in your community and doing things for yourself.

Integrated Community Team	These bring together occupational therapists, physiotherapists, social workers, reablement workers and community nurses to work as one team to serve a local area.
Learning Disability Enablement Team	The enablement service is for adults with learning disabilities who have the potential to go out and about independently. The service aims to support you to find out more about activities in your area, help you with making friends and build on social networks where you live.
Mental Health	Mental illness refers to conditions that significantly interfere with an individual's, thinking, emotional or social abilities e.g. depression, anxiety, schizophrenia.
Occupational Therapy	The Occupational Therapy (OT) service supports people who have a permanent disability to live independently in their own homes. They can also advise on smaller pieces of equipment to help with day-to-day tasks such as bathing and preparing meals.
Older People	This term is used to refer to people over the age of 65.
Outcomes	An aim or a need you want to achieve, such as continuing to live in your own home or being able to go out and about. You should be able to say which outcomes are the most important to you, and receive support to achieve them.
Personal Budget/ Self directed support	A personal budget is the total amount of money available for your care. Using your assessed needs we can calculate how much money is available for your care and manage this budget for you.
Physiotherapy	Physiotherapists work to help restore your movement and function to as near normal as possible when this has been affected by injury, illness or by developmental or other disability.
Physical Inclusion Network Gloucestershire (PING) http://pinglos.org.uk/	PING is a network, linking physically disabled people and services in Gloucestershire. PING's website includes a directory of services and information relevant to physically disabled people. They organise events, carry out quality checking services and create inclusive networks for people with physical disabilities.
Preventative	Services you may receive to prevent more serious problems developing. These services include things like reablement, Telecare, befriending schemes and falls prevention services. The aim is to help you stay independent and maintain your quality of life, as well as to save money in the long term and avoid admissions to hospital or residential care.
Public health	Public Health responsibilities to help keep people healthy includes. • Weighing and measuring children. • Health Check Assessments for adults. • Sexual Health services. • Stop Smoking Services. • Alcohol and drug misuse services. • Public Health Services for children and young people aged 5-19 (including school nurses). • Obesity and weight management services and increasing physical activity.

Short term intensive support/Reablement	Short term intensive support means help with the change back to independence after a period of ill health, a hospital stay, a residential care stay, or simply a fall or accident. Anyone over the age of 18 who meets the criteria may have access to this support for up to six weeks, for which there will be no charge.
Residential care	Care homes provide accommodation with trained staff on hand to look after your needs day and night. There are two types of care home: • Care homes with trained staff who can offer you the same care that you would receive from relatives and friends. • Nursing homes which provide the same level of care as care homes but also have trained nurses on duty to provide skilled nursing care when you need it.
Review	This is when you have a re-assessment of your needs to look at how well the services you are receiving are meeting your needs and helping you achieve your chosen outcomes.
Safeguarding	Safeguarding vulnerable adults is a key responsibility of the local authority. We work with our partners to help keep vulnerable people safe from harm and abuse. Abuse is a violation of an individual's human and civil rights by any other person or persons.
Signposting	Signposting means letting you know where you can find information that you will find useful about social care.
Support Plan	Once you have had your assessment and had your funding agreed the next stage is a support plan. Your support plan will: • help identify your needs and priorities and outline how these will be met • help you build your circle of trusted support, both formal and informal • outline how you intend to spend your personal budget to meet those identified or assessed needs.
Telecare	Telecare provides a range of equipment to help you live safely and independently in your own home. This can include: fall detectors, epilepsy sensors and pull cords, bogus caller buttons and video door entry. We install a Telecare base unit in your home which is connected to your phone line. This links to a 24/7 contact centre. A series of sensors are linked wirelessly to the base unit and if one of the sensors is triggered e.g. if you have a fall, an alarm is activated. (For people in need of the emergency response service who don't have a landline they can use a mobile phone).
User led organisation	A ULO is an organisation that is run by people who use support services and their families and carers.
Village agents	Village and Community Agents work with the over 50s in Gloucestershire, providing easy access to a wide range of information that will enable them to make informed choices about their present and future needs.
Vulnerable people	A vulnerable adult is someone aged 18 or over who is or may be: • In need of community care services because of a disability, age or illness and is • Unable to take care of themselves, or unable to protect themselves against significant harm or exploitation.

What do you think?

We want to hear from you.

Please let us know your experiences and ideas about how we could do things differently. Let us know your thoughts:

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If once you have read this document you have any further questions, or if you would like to receive a copy of it in a larger font, another language or in Braille, please contact

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Gloucestershire COUNTY COUNCIL