CQC ANNUAL PERFORMANCE ASSESSMENT (APA) ACTION PLAN FOR 2009-10.

KEY

COMPLETE	**BLUE**
Good performance - on track to meet action plan targets	**GREEN**
Some progress made – some progress towards action plan targets but not meeting all deadlines.	**ORANGE**
Limited / no progress made against action plan targets and deadlines.	**RED**

Abbreviations:

ASSMT	Adult Support Services Management Team
ATT	Assistive Technology Team
BME	Black & minority ethnic groups
Cambs DPSS	Cambridgeshire Direct Payments Support Service
CAS	Community & Adult Service
CCC	Cambridgeshire County Council
CCS NHST/CCS	Cambridgeshire Community Service NHS Trust
CEDF	Cambridge Ethnic Diversity Forum
CPFT	Cambridge & Peterborough NHS Foundation Trust
DOLS	Deprivation of Liberty
ECHG	English Churches Housing Group
ESCR	Electronic Social Care Record
LD	Learning Disability
LDP	Learning Disability Partnership
LOS	Length of Stay
MCA	Mental Capacity Act
NHSC	NHS Cambridgeshire (the Primary Care Trust)
OP	Older People
OT	Occupational Therapy

OPMH	Older people with mental health issues
PD	Physical Disability
PPC	Preferred Priorities of Care
RAS	Resource Allocation System
SDS	Self Directed Support
SOC 388	Form used to collect information on individuals for whom safeguarding concerns have been raised
SOVA	Safeguarding of Vulnerable Adults
ULO	User Led Organisation

N.B. Please note that the Action Plan is set out in accordance with the Areas for Development under each of the 7 Outcomes, as set out by CQC in the APA documentation. Actions and outcomes provided below will contribute to more than one of the 7 Outcomes.

SUMMARY OF PROGRESS

Area for Development Number	Area for Development	Overall Status of Recommendation
OUTCOME 1: INCREASED HEALTH AND WELLBEING		
1	**Further improvement is needed to increase the number of reviews for people in receipt of services.**	**Orange**
	Action Plan in place in Disability Services: • Targets for teams - weekly targets are in place and monitored. • Regular monitoring - monthly meeting of senior care manager/social worker staff. • Dedicated staff – Localities / teams have dedicated review staff, as well as care managers & social workers carrying out reviews.	
	Action Plan in place to increase number of reviews undertaken by Older People's integrated teams, streamlining processes and establishing Officer time to conduct reviews. Targets set in teams.	
	• Ensuring OT reviews **and major adaptation reviews are counted appropriately**	

Update on progress	**Disability Service** • Target met last two years. Close to target in current year (09/10). • Weekly monitoring of targets. • Dedicated staff – but all practitioners carry out reviews. • Grouping of reviews being implemented. • Increased staff allocated to support review process during transformation process. **OP/OT Service** • Increased performance for reassessments and reviews • Service provisions in time achieving over 93% • ATT reviews linked with social care reviews • End of year reporting currently shows reviews at 73%
Outcome	• Undertaking regular reviews ensure that people's views and needs are identified and addressed. A gentleman with acquired head injury living at a residential unit was demonstrating suicidal tendencies and had very low self esteem. The review identified this was linked to his feelings of failure and the confining environment. A reassessment enabled support to return to his home with a care package, and negotiations with his previous employer and with the 'Access to work' scheme resulted in him returning to work on less demanding duties. His care package is no longer needed as his confidence and skills have improved sufficiently for him to live independently.

Area for Development Number	Area for Development	Overall Status of Recommendation
2	**There needs to be a continued focus on reducing delayed discharges from hospital, particularly those attributable to social care.**	**Orange**
	• Joint Strategic Discharge Management Group and Discharge and >40 Day LOS Review Group established for Addenbrookes • Re-utilisation of reimbursement funds and the pooled budget to extend community pathways. • Development of set of performance indicators to facilitate monitoring. • Streamlining of panel process • Implementation of range of investments, including OPMH nursing home placements, domiciliary care for hard to reach patients, discharge cars, double-up cars and 'hard to reach' cars, increased social care workers to improve the assessment and discharge processes, interim care placements / arrangements, new Home-Finder post for self-funders and a mental health nurse within the discharge planning team. • Active management of delayed discharges. • Undertaking 'Root Cause' and Case note Analyses of delayed discharges. Development of a 16 point discharge action plan, operating across the local health system.	
Update on progress	The Executive Director of CAS and Chief Executive of NHS Cambridgeshire continue to meet with senior managers of acute and community providers to manage the reduction of delayed transfers of care. This work has been supported by GO East who have confirmed that pressure in the system is contributed to by (i) Addenbrookes have a high level of conversions from A&E attendances to admissions, (ii) the difficult winter impact on health care and emergency care admissions; (iii) the successful reduction of length of stay in acute hospitals, from 26 days average to 11 days) which has led to people being discharged with a higher degree of volatility. Objectives agreed to prevent admissions, maximise intermediate care and reablement, and improve management of long term conditions, readmissions, support for carers and end of life issues (outcome example highlighted below).	

Outcome	• CCS's Discharge Planning Specialist Nurses have been working with ward staff, community based colleagues, continuing care and equipment services to streamline the process to fast track the discharge of terminally ill patients who wish to die at home to enable these patients to leave hospital as quickly as while possible while ensuring that their complex needs are met. In the period January to March 2010 69 patients achieved their preferred place of death using this approach compared to 31 patients in the same period last year. • The CCS NHST specialist palliative care service has introduced Preferred Priorities of Care (PPC) documentation. This has been an extremely useful and effective document for the patient as it provides them with an opportunity to think about, talk about and write down what they feel is important in the planning of their end of life care. It is not a document that is used for legally binding decisions and patients are encouraged to discuss this with their doctors and complete Advance Directives. The PPC enhances the communication between patient, relatives and professionals. Often just filling in the paperwork can trigger conversations between patients and their relatives because patients are encouraged to share the information they have written. A lot of patients can find it very difficult to discuss future care plans with family and friends as it can often be very painful and emotional. o One woman described how she had promised her husband that he could stay at home because this is where he had expressed a wish to be cared for informed by some bad experiences of being in hospital. When he completed the document he confirmed that he wanted to be cared for at home, but also highlighted concern for how his wife would manage and his fear that his pain would not be controlled. He shared the document with his wife and they were able to talk openly about their concerns. Her husband's condition deteriorated and they had support to help them manage at home until his symptoms became unmanageable and he was admitted to the local hospice. When completing the document the husband had stated that although he would prefer to be at home, he would accept admission to the hospice for end of life care so that his wife could be supported and so that he could receive adequate symptom management. He died a couple of days after he was admitted. His wife shared with staff that if they had not been given the opportunity to establish his priorities / preferences then she would never have been able to forgive herself for admitting him to the hospice because she had promised him that he would die at home. She said that she felt relieved and reassured because his wishes had been met and his end of life care had been managed in a way that meant her husband had not needed a hospital admission.

Area for Development Number	Area for Development	Overall Status of Recommendation
3	**Ensure that people can access staff who are trained to support people with dementia, and that the access is equitable across the county** Dementia training strategy developed in partnership with relevant parties • Identify Target Staff Groups for Dementia Training. • Map current provision of training for each identified target staff group. • Develop Dementia Training Strategy in partnership with training providers, including vol orgs, to address gaps identified and differentiate appropriate training programmes for each target staff group. • Develop & deliver relevant training programme for each of identified staff groups: community services; specialist mental health services; local acute hospitals; local authority services; care / nursing homes; young-onset dementia staff; carers. • Disseminate information at Training Consortium Meetings involving Independent Training Providers • Outcomes from training captured.	**Blue**
Update on progress	• Provision of mental health, particularly Dementia training, to care home and day care staff continues to be delivered in specific areas, aligned with what's funded. It's not available to Hunts, Peterborough or Fens areas. • Outcome of training is always collected at end of each session and collated centrally. • Some training have been provided specifically at request, e.g. Cambridge Home Improvement Agency. • Training for Dementia ward staff at Addenbrookes will be commencing very soon. • OPMH in process of setting up e-learning package • OPMH implementing Dementia Care Mapping across different areas in OPMH division.	

Outcome	• Training has raised awareness on the use of MCA assessments for people with dementia: Mrs T is a 66 year old with dementia. Some of her family members raised SOVA/ DOL concerns concerning Mrs T's daughter. Social workers from CCS and CPFT worked together to complete the complex capacity assessment and worked with the DOLs assessor and the residential home manager and family members to resolve the concerns. • Training has also raised awareness of how Court of Protection can be used to benefit people with dementia: an older woman suffering from dementia was referred to have her finances managed through our Deputyship service because she was heavily in debt, but as there was on going financial abuse investigations regarding family members it was not appropriate for them to manage finances on her behalf. Whilst the application was going through the Court, Mrs B's bank accounts were frozen money and her then day to day finances were managed through the locality team's imprest account. After a great deal of work, the Deputyship Officer managed to establish that Mrs B had debts in the region of £9000 with banks, loans, credit cards, utility bills & car insurance. The Deputyship Order granted in December 2009 and there after, letters were sent out to all companies that had financial connections to Mrs B explaining the situation and that an application for a Deputyship Order had been granted by the Court of Protection. It took nearly four months before most of the debts were sorted out. The Deputy Officer managed to get two of the debts written off, two others were given repayment plans and the majority paid off out of Mrs B's funds.

OUTCOME 2: IMPROVED QUALITY OF LIFE		
Area for Development Number	**Area for Development**	**Overall Status of Recommendation**
4	**Ensure that requests for reassessments are dealt with promptly ensuring that people receive services that meet their needs.**	**Blue**
	• Confirm with CCS colleagues that reassessments are covered in the action plan for OT services	
	• Effective workload management of requests for reassessment and new referrals	
Update on progress	• Communications to staff to reinforce the need to prioritise requests for reassessments • Requests for reassessments prioritised according to need. • Often carried out at a review or as a result of a review.	
Outcomes	• Following a hip fracture an elderly woman returned to the home she shared with her daughter but found that the layout of the property was overly restrictive, even with equipment and simple adaptations. Her daughter was at work all day and she was becoming socially isolated and very lonely. A reassessment led to her being considered an urgent case for re-housing within Extra Care. She moved to a spacious level access flat which she can easily move around within, and was able to toilet without the use of a commode. She immediately joined in with the majority of the social activities on offer. She was able to move herself in her wheelchair to the dining room and independently transfer from her wheelchair to a dining chair to retain her independence. She has forged many friendships and often now receives visitors to her home. She has benefited from living within a building which has level access throughout, also from having social interaction with others over lunch and at social functions. When her daughter visits she now has quality time with her Mother. She is fiercely independent and by living within Extra Care she is able to retain that independence but have access to the support and care she may need now or in the future.	
5	**Increase awareness of assistive technology equipment amongst people who use services and carers, providing them with information about support that can increase independence.**	**Blue**
	• Further publicity in CCC & CCS publications • Continued training to teams • Continued training and awareness raising with independent sector	

Update on progress	• Comprehensive information on Cambridgeshire Community Services website including service description, self referral routes, equipment loan conditions and range of assistive technologies available • Open days and display stands for public & professionals at Addenbrookes concourse, Hinchingbrooke concourse & Chinese community development day • Quarterly newsletter circulated to all health & social care colleagues. Circulation lists reviewed and expanded • Monthly training events in the smart flat open to health, housing, social care and voluntary sector staff working in Cambs. Other training provided on request at a range of venues • Training plannned for Call Advisors at Contact Centre, Independent Care Agencies • Leaflets on the service available & have been produced in other languages These are sent out directly from the Contact Centre to referrers Assistive technology champions identified in partner organsiations. Quarterly meetings to support and update champions
Outcomes	• See SAS pages 10 – 12 • Assistive Technology equipment has supported the security of people who use services & carers living in their own homes. In one instance, a vulnerable older person with a personal alarm pressed the alarm when a burglary was taking place in her home. The call handler had the presence of mind not to talk when he become aware of what was happening. They called the police and made a recording of the burglary that has been provided to support the police investigation.

OUTCOME 3: MAKING A POSITIVE CONTRIBUTION		
Area for Development Number	**Area for Development**	**Overall Status of Recommendation**
6 & 13	**6. Continue to focus on engaging with people from minority and underrepresented communities.** **13. Engage as planned with representatives from Indian and Chinese communities.**	**Green**
	• Continued discussions at 'Voices for Change' meetings. • Continued development of 'Voices for Change', including development of work programme. • Develop communication links between Voices for Change, Partnership Boards & ASSMT. • Continued discussion at Partnership Boards • . Development of work with communities as part of Transformation agenda & as part of Community Engagement strategy. • Implementation of Council's Single Equality Strategy. • Continuation of Community Outreach programme to engage with BME & underrepresented groups.	

Update on progress	• Voices for Change now has a new Chairperson - Julie Cartwright Finch (CEO Dhiverse) who is very keen to progress the work of the group. In order to do this a subgroup has been formed to consider some of the issues faced by the group these include:- - Increasing the frequency of meetings, - Improving communication links with the boards - Consideration of minorities within the Partnership Boards. • The conclusions from the subgroup have led to the decision to form Partnership Board for minority groups. • Ormiston Trust have agreed to send a representative for the Gypsy Traveller Community to the next full meeting • Discussions have been held with Cambridge Ethnic Diversity Forum about how to promote Safeguarding information to ethnic minority groups. It was agreed that the CEDF Development officer would highlight the support available from Adult Support Services to develop safeguarding polices, a positive first step to increasing knowledge about how to safeguard vulnerable people in minority communities. • Visits to the Chinese and Indian communities went ahead as planned and both were well attended. The visit to the Chinese Community took the form of a workshop. Officers from different areas of Adult Support Services (ASS) attended and explained about different areas ASS. The workshop was attended by over 30 of the community's older people. • During visits to community groups, Community Leaders identified a number of different issues which make it diffiicult for people from BME communities to engage with statutory organisations. Ways of developing options to build on the work completed to date and that would address the issues identified by community leaders are being currently being researched

Outcomes	• The Indian Community visit resulted in one person referring themselves to carer services even though the leader of the community explained to officers that the community provided its own support. • Greater understanding of religious and cultural needs has had a positive impact for Mrs S, an 87 year old Indian lady. She is a devoutly religious person requiring a strict regime of sleep, prayer, washing and dressing. A care manager intervened when they became aware that Mrs S was unhappy with care provided by her care agency. The care manager involved Mrs S, her family and the care agency management to resolve issues concerning religious requirements and visit times. • Close working with the Traveller's Liaison Worker ensures that referrals are made and acted on in response to identified need. A lady from the traveller community who was caring for her disabled husband who was incontinent and her 4 children was awarded a carer grant to purchase a washer dryer. She is now more able to maintain her caring role without having to hand wash clothes and bedding. • Discussions with BME groups raised the need to develop a sustainable method of providing information to BME communities. After exploring a number of options with BME groups it was subsequently agreed to run a (BME) Outreach Pilot. This pilot involves commissioning 3 'umbrella' community organisations (in Huntingdon, Cambridge and Wisbech) to provide a staff member for 2 hours a month at a drop in centre or at a recognised base for a 6 month period. They would inform people of services offered by Adult Support Services and support them to make a referral. As part of the pilot the following actions are currently being implemented. (i)The community organisations are currently in discussions with Adult Support services to devise a training programme for those staff,(ii) the communication links with the Contact Centre, and (iii)recording and reporting systems

Area for Development Number	Area for Development	Overall Status of Recommendation
7	**Ensure that issues raised through the user led organisation, Life Unlimited Partnership, are responded to.** • Identify the actions required to address the issues and ensure these are embedded within existing action plans • Provide feedback to the Life Unlimited Partnership on the progress made against the actions	**Green**
Update on progress	Actions embedded in the following areas of work led by CCC: • Information & advice project – improved access to information • Development & roll out of SDS, including the involvement of the Reference Group – improved choice & control & involvement in service development • Ongoing work with Partnership Boards – involvement with service development Funding from CCC has been extended to enable the ULO to engage a development worker to address: (i) The key areas of accessibility of information, peer support, increasing connections between disabled people, supporting people to challenge the quality of services & offer suggestions for improvement, and to support people to get involved in running the Life Unlimited Partnership. (ii) Develop 2 projects in Huntingdonshire and Fenland focusing on peer mentorship to support people in using SDS.	
Outcomes	• See SAS Outcome 3 Making a Positive Contribution & Outcome 4 Increased Choice & Control	

OUTCOME 4: INCREASED CHOICE & CONTROL		
Area for Development Number	**Area for Development**	**Overall Status of Recommendation**
8 & 9	**8. Ensure that the number of social care clients receiving self directed support, increases in line with comparator councils.** **9. Continue with the planned introduction of self directed support ensuring that all staff teams receive training to support introduction across the county.** • Implement the self directed support system that is outcomes-focused, and provides support for individuals to make informed choices and take control of how their social care needs are met. • Detailed project plan in place • Continued rollout of training plan & other workforce development activity including: e-learning; care management forums; action learning sets; administrators forum	**Blue**
Update on progress	Extensive work undertaken to prepare for the launch of formal roll out on 20 April 2009, including development of support questionnaires and RAS, training and communications. All work has involved key partners and service user and carer representatives, including representation on the project board and in delivering training. Managers Briefings undertaken ahead of staff training. All teams received two days of training prior to rollout within their team. The first day of training covers the vision and aims of Transformation, and the second day concerns the implementation. Members of the Transformation team based within the teams for the first days of implementation and have been going back to teams after six months to check on any issues that might have arisen. Roll out timetable adjusted around Christmas 2009 to ensure adequate support available for teams, but all LD, PD, OP and OPMH teams had "gone live" by April 2010. Work continues as planned for people with mental health issues, where a pilot is being used to develop SDS to fit with the recovery model.	

Outcomes	• Joyce is an older lady who lives on her own and who enjoys using the bus to go into her local town, to get her hair done once a week, and to go dancing which she likes to do despite experiencing episodes of dizziness. For Joyce it is imperative that she is able to get out and about. Her family is very important to Joyce. On a Saturday her son-in-law takes her shopping and she looks forward to this as it means she gets out of the house and has some company. Her son-in-law also helps Joyce with any lifting in the house and opening items she finds difficult. Joyce requires some help with her personal care and needs someone to help her to get in the shower and to be on hand while she takes her shower to offer reassurance. Joyce's care package has been meeting her needs well but now she has her Personal Budget she wants to reduce the package that she receives so that she can arrange for a private cleaning service. • Like many young men, Alan planned to share a house with a friend after leaving college. But, in his third and final year, he decided that he didn't want to finish his course and came home to live with his family in a small village south of Cambridge. Alan's family talked to him about what he wanted from his life. He didn't like the idea of going to a day centre and he didn't want to do another college course. He wanted to do things he enjoys, like going to the gym, going bowling, going shopping and doing activities like cooking, writing and photography. After finding out about personal budgets, the family put all of Alan's interests into a weekly plan. The plan was agreed with Alan's mother acting as his agent and managing the personal budget on his behalf. She keeps the books, manages the payroll and expenses and together with Alan recruits his personal assistants (PAs). One year into his personal budget Alan is really making the most of the opportunities it has given him, and his week is full of the things he likes to do as well as the things that he needs to do. He goes to the local gym, shopping and bowling, and spends time at home when he cleans his room and cooks his lunches. He makes decisions about how he wants to be supported and the role he wants his PAs to take. Alan's mother says: 'Alan is gaining confidence by the day, his general health has improved and he is now a very fit young man. He has taken up running and swims at the local pool three times a week. He has plans to go back to college one day a week to take a pottery course, he is also looking for work experience as one of his goals is to have a job.' Alan is well known in the village where he lives, and his PAs are local people who know Alan and are interested in being with him and helping him to make the most of his interests. With his new found confidence, Alan is now thinking about a home of his own again – although not just yet!

	• Ania is 23 and has physical disabilities. She moved to Cambridgeshire from Poland and lives with her mum. She received her Personal Budget in July 2009 and developed her Support Plan with her Mum and Care Manager. Ania enjoys socialising and likes going to the theatre, cinema and shopping. She goes to the gym to keep herself as mobile as possible. Ania needs support to prepare her evening meal and wants support to go out independently so she doesn't always have to go out with her Mum. With plans to get a job in administration, continuing her education is important and Ania, who speaks English, plans to go to language school to improve her languages and to university. Ania has taken her Personal Budget as a Direct Payment managed by Cambridgeshire Direct Payments Support Service (Cambs DPSS)*. She has someone she knows who she employs to provide her support. This is important to Ania as she will be able to establish a relationship with her carer and not have lots of different people looking after her. It also means her plan and her support can be flexible to accommodate her different needs when she is at university and during non-term time. During term time, Ania will need to support to go to and from university and most of her Personal Budget will be used on this support. When she is not at university she plans to use her budget to get support at meal times and to go out once a week to socialise. • Jimmy is an energetic young man with autism and learning disability. It is important that he receives the right type of support to enable him to do one-to-one basic learning exercises as well as undertaking a mixture of activities that develop important life skills and give him the daily exercise he needs. Prior to getting his personal budget, Jimmy attended generic college courses but these were not specific to his individual needs. Jimmy has had a personal budget since 2007. His family organise his support plan and have been able to tailor this to meet Jimmy's individual needs. The flexibility of a personal budget has helped with this, and it has been easy to modify Jimmy's plan to reflect his changing interests. Jimmy's father says: 'Jimmy's personal budget has had a significant impact on his life. It has allowed him to participate in regular activities such as rowing, trampolining, going to the gym, visiting social clubs for disabled people and walking the dogs. He has developed an interest in photography, and attends cooking and woodwork classes with his helpers. It has also enabled him to employ four different support workers, as he needs the variety that they give him.' Since having a personal budget Jimmy has moved into independent living accommodation and has been able to transfer the skills he has learnt in his classes into his own home. His support plan contains elements of learning (in particular basic reading, writing and counting) as well as more domestic tasks such as making the bed, cooking and cleaning. It also includes one-to-one tuition, which, unlike his old generic college courses, is helping him to excel in his life skills. His father says: 'We have found it easier to plan for Jimmy's future because we are aware of the budget available to support him upfront. His personal budget has enabled Jimmy to flourish. He is much happier in his living circumstances and with his daily routine. He is much calmer, and this has had a knock-on effect on the whole family.'

Area for Development Number	Area for Development	Overall Status of Recommendation
10	**Complete the introduction and use of the electronic social care record.** • Phased programme of rollout of ESCR in line with project plan.	**Blue**
Update on progress	ESCR rolled out to all teams as planned and the project formally closes in May 2010. Roll out for OT is being linked to work to develop an integrated approach with physiotherapy, and for adult mental health further work is being undertaken to explore how ESCR might work with Lorenzo, the main system used by the mental health service.	
Outcomes	Staff in Discharge Planning Teams report the positive impact of having instant access to individual's files, rather than wating for information to be FAXed, which helps them to respond in a more timely fashion when people are ready for discharge.	
11	**Ensure that complaints procedures and processes are known and promoted to people who use services, and continue to capture changes that have been made as a direct result of complaints received.** • Promote the distribution of the Complaints Leaflet through Locality Teams • Publicise information on the complaints procedure through existing networks e.g. Carers Newsletter, voluntary sector organisations • Continue to collate evidence of complaints influencing practice and share this information widely across the service	**Blue**
Update on progress	• Communication with staff to reinforce that they speak to service users about their right to complain and reinforcing that leaflets should be routinely given out. • Capacity in the Customer Care Team being increased with a second 21 hour post being recruited to – new post holder starts June 2010. Meetings with staff to discuss learning from complaints	

Outcomes	• Two linked and complex complaints that involved 2 siblings with severe learning disabilities were investigated by an independent investigator who identified a number of management and practice issues that could be improved within the team. The Service Director who responded to the investigator's report has worked with the Locality Manager to support the team in improving practice and this learning is being spread throughout the service. • A complex complaint from the daughter of an older person living in a residential home demonstrated the need for improved communication between staff in CCC and CCS. Managers have identified where the key weaknesses were and have set expectations for staff to address these.

OUTCOME 5: FREEDOM FROM DISCRIMINATION AND HARRASSMENT		
Area for Development Number	**Area for Development**	**Overall Status of Recommendation**
12	**The council needs to monitor the number and type of referrals received through Home Shield scheme and use information to gauge if alternative access routes are needed to support people from hard to reach groups within the community.**	**Green**
	• Regular monitoring of Home Shield referrals through Home Shield Steering Group. • Identification of key themes and of any gaps in services raised at Project Board • Discuss with Voices for Change and action any adjustments required for people from minority groups. • Publicise the scheme through a range of existing networks, e.g., Carers newsletter, Parish Councils.	
Update on progress	The Cambridgeshire Home Shield Scheme was launched in April 2009. The County Counci's Trading Standards section initiated the scheme and Age Concern Cambridgeshire was selected to co-ordiante and manage the scheme on a day to day basis. Following the launch the initial focus was on: - Ensuring there were sound arrangements in place to manage referrals into the scheme; - Establishing a steering group comprising representatives from key partner/referring agencies; - Increasing the number of organisations signed up as referring agencies - Organising training events for partner agencies (July 2009) - Developing monitoring arrangements to provide a profile of rererrals to the scheme. Steering Group meets on a quarterly basis. Information relating to number and type of referall is presented at these meetings, but no specific trends have emerged so far from the analysis. This will continue into 2010, as numbers of referals increase. Steering Group has increased the partners involved to ensure access into the scheme is available to all. A successful Partnership event was held on 5th February.	

Outcomes	Cambridgeshire's innovative Homeshield scheme, is providing positive outcomes for older and vulnerable people in the community who are not always known to services. The scheme is an outreach referral service, for older and vulnerable people. The scheme was officially launched in April 2009 and, at that time, there were eight partner organisations. This has now increased to 29 organisations. The scheme ensures support is received from a range of organisations helping people to stay safe, healthy and happy in their own homes. The support helps with: reducing hospital admissions; identifying problems before they become acute; referring people with unmet needs to the right support services; checking that people are receiving all the income and benefits to which they are entitled; daily living tasks such as; ensuring the client gets regular hot meals; advice on how to keep their houses warm and to have access to hot water and toilet facilities; helping the person to enjoy regular social contact; security and safety including finding ways to help the person to be able to secure their house; ensuring there is a working smoke alarm; checking for any fire or trip hazards in the home. Over the first year of the project the total number of referrals into the scheme was 219 and this was from 22 different referral sources. Of these 219 people were not known to social services and therefore not receiving any formal packages of care. The greatest number of onward referrals was to Cambridgeshire Fire and Rescue Service for fire safety checks (include the fitting of smoke alarms). There were 70 referrals to the Pension Service, of which 39 were eligible for follow-up for benefit checks, 13 of whom were found not to be claiming their full entitlement. During the year the total value of benefits gained is £48,224.00 per year. A 92 year old woman living alone in her bungalow was referred to the Homeshield scheme by a Fire Officer who visited to assist following reports of a number of small fires, for instance, caused by a toaster setting bread alight, and found that she had no heating and hot water in her home Support from Homeshield and a referral to a local charity have enabled the lady to have her heating and hot water problems resolved, and her garden has also been renovated.

OUTCOME 6: ECONOMIC WELLBEING		
Area for Development Number	**Area for Development**	**Overall Status of Recommendation**
14	**Further increase pathways to employment for people who have learning disabilities to enable more people to move into paid work and into voluntary work.** • Plans within LDP teams, and with partners in training organisations & with employment service, to increase work opportunities for people with learning disabilities • Work with partners in employment training organisations to review services & to develop outcomes for service users. • CCC to lead work on being exemplar employer.	**Green**
Update on progress	• Targets have been achieved in last two years but this year (09/10) has proved difficult due to economic downturn. • A working group set up in County Council on employing people with a learning disability. • LDP is working with partners to improve opportunities.	
Outcomes	• Red2Green, worked with a service user who liked cutting grass. “I enjoy going up and down and making the stripes in it. I enjoy it the most when I am using the ride-on mower". She started doing gardening for people in her local village and began to think about self-employment and was supported to approach the Prince's Trust. She is also applying for gardening jobs as they become available. • H had spent a few years working at day and social training services and wanted to move on. Unfortunately, two previous part-time voluntary positions she had taken in local cafes had fallen through when the establishments had failed because the economic climate. H needed help with taking the bus so a worker travelled to Ely and Newmarket with H using her bus pass. She quickly gained confidence with this and started going into town on her own. H and the worker approached a café in Newmarket and she was offered a voluntary position for a few hours a week. She has now progressed to clearing tables and serving customers. Working there has given H so much confidence in her ability that she approached Starbucks and now has a small but paid part-time position. • Care providers are also actively supporting service users to gain employment. One care provider working in supported living services for people with learning disabilities have employed a service user. It was identified that he enjoyed cleaning activities at home and so noted as an area of support in his support plan and the staff team there worked with him to increase his skills in this area. There was a vacancy for a cleaner at the Regional Office, for which he applied and was employed. He is paid £7.50 an hour and is being appropriately trained and supported.	

15	**Increase and further publicise support available to carers to assist in maintaining or returning to employment across the county.** • Raise employers' awareness of Carers in the workforce by running workshops in commercial and statutory sector. • Support carers who work to reduce the number leaving employment to care. • CCC to lead with carer friendly policies. • Support carers back into employment. • Include carer friendly policy in contracts with independent organisations	**Green**
Update on progress	• The new Jobcentre-plus Care Partnership Manager for Carers has attended the Carers Partnership Board, and Carers Support Team Meetings. Jobcentre-plus frontline staff have now received training on 'Carer Awareness'. The Carers Support Team has used these links to provide more than 100 Carers identified through Jobcentre Plus with a copy of the local Carers Support Directory. • CCC has joined 'Employers for Carers'. Membership has given access to advice and support in improving carer friendly policy and practice and retaining skilled workers. • An awareness raising article on combining caring and employment is going out in 'Countywide' magazine in March 2010. Countywide magazine is sent to approximately 18,000 employees in a paper or electronic version. • Provision of Carers Assessments - target of 21% achieved - through training for Care Managers to promote a 'partnership approach' with Family Carers. This supports and enables a dialogue about Carers' needs and preferences which impacts on their ability to maintain their own employment. • Carers Standards have been drafted – work is ongoing with CCC Contracts Team and Carers Partnership Board for sign up across CCC and Partners	

Outcomes	• Carers are supported via carers assessments to look at their own employment needs and what support they would require to enable them to continue or regain employment. Implementation of the Cambridgeshire Carers Strategy includes a standard on Economic Wellbeing to support carers to ensure they are informed and assisted to access benefits and grants to which they are entitled; able to take advantage of opportunities for work if they wish to do so; and working carers are supported to remain in employment through carer-friendly employment practices. For instance, a young person with a learning disability was offered a college course that only covered three and half days a week .The team supported this young person via their support plan to find other activities and support to enable mum to continue to work full time. • C damaged her back following an injury at work. Following discharge from hospital, her husband struggled to provide care as he was unable to take any further time off work. To allow him to continue to work care support was provided 4 times a day. The arranged provision is now meeting the need of both services user and carer • Low level preventative work and close working with the 3rd sector maximises flexibility and speed of response to pick up and address issues quickly. For example My Fantastic life (MFL), a person centred planning and youth activity service, noted that a single mum with a young Down syndrome son (L) had been struggling since a marital breakup. When the situation came to a head and mum had "had enough" of being off work sick and getting regularly assaulted by her son, confused over the breakup, they were able to respond. Using MFL staff they offered 2 nights out that week to give Mum some of her own time. L now has a direct payment to employ his own PA to do things like cooking, shopping or bowling and accesses a number of respite nights. L no longer vents his anxiety on his mother and has had some very positive experiences with his supporter during holidays and breaks so Mum can continue to go to work.

OUTCOME 7: FREEDOM FROM DISCRIMINATION AND HARRASSMENT		
Area for Development Number	**Area for Development**	**Overall Status of Recommendation**
16	**The council needs to work with partner agencies to increase safeguarding awareness amongst NHS staff and housing staff.** • Continue to work with NHS and Housing organisations to ensure that safeguarding awareness training is included in induction. • Continue to provide support for NHS and housing organisations in the development and delivery of safeguarding awareness training. • Monitor the quality and effectiveness of the training provided by NHS and housing organisations to their staff.	**Green**
Update on progress	• We have updated the County Council Adult Safeguarding website • A new training brochure has been developed along with updated course flyers which have been sent to all our partners. • Addenbrookes hospital is using the CCC e-learning safeguarding pack which they have modified to use within the hospital environment • Hinchinbrook hospital has just employed a safeguarding lead and will be rolling out training very shortly • Cambridgeshire Community Services NHS Trust (CCS) has established a safeguarding board, supported by the CCC Safeguarding lead, to raise the profile of safeguarding and the improve practice across social care and NHS staff employed within CCS • Bespoke training for housing providers has been developed and delivered to a number of housing agencies(e.g. ECHG and Jimmies Nightshelter) • Work with registered social landlords is supported by a lead safeguarding manager from one of the larger housing associations who has been trained on one of our train the trainer courses and uses the comprehensive training pack to help trainees engage with safeguarding. • The Board has a district council housing representative who supports the need for training within this sector. • A steering group has been established that involves housing providers in Cambridge who support homeless people. • Cambridgeshire and Peterborough NHS Foundation Trust has introduced the CCC e-learning pack as part of its commitment to safeguarding training.	

Outcomes	See SAS page 34.

17	**The council needs to adequately manage and use systems for recording the status of safeguarding referrals.** • Continue recording the status of safeguarding referrals on SWIFT • Revision of Annual Report to give data over a 3 year period.	**Blue**
Update on progress	• Revised SOC 388 form has been developed to effectively collect information for the Information Centre for Health and Social Care vulnerable adults data collection, this will enable all adult safeguarding information to be loaded onto the swift data base. • All safeguarding information being loaded onto WISDOM our electronic social care records database.	
Outcomes	Accurate recording for end of year returns.	