Norfolk County Council

People and Communities Select Committee

Date: **13 March 2020**

Time: **10am**

Venue: **Edwards Room, County Hall, Norwich**

Persons attending the meeting are requested to turn off mobile phones.

Membership:

Cllr S Gurney (Chairman)
Cllr F Eagle (Vice-Chairman)

Cllr T Adams
Cllr D Bills
Cllr P Carpenter
Cllr E Connolly
Cllr D Harrison
Cllr B Jones
Cllr C Rumsby
Cllr T Smith
Cllr M Smith-Clare
Cllr F Whymark
Cllr S Young

For further details and general enquiries about this Agenda please contact the Committee Officer:
Hollie Adams on 01603 223029
or email committees@norfolk.gov.uk

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A g e n d a

1 To receive apologies and details of any substitute members attending

2 Minutes

To agree the minutes of the meeting held on 31 January 2020 **Page 5**

3 Members to Declare any Interests

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is on your Register of Interests you must not speak or vote on the matter.

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is not on your Register of Interests you must declare that interest at the meeting and not speak or vote on the matter

In either case you may remain in the room where the meeting is taking place. If you consider that it would be inappropriate in the circumstances to remain in the room, you may leave the room while the matter is dealt with.

If you do not have a Disclosable Pecuniary Interest you may nevertheless have an **Other Interest** in a matter to be discussed if it affects, to a greater extent than others in your division

- Your wellbeing or financial position, or
- that of your family or close friends
- Any body -
    - Exercising functions of a public nature.
    - Directed to charitable purposes; or
    - One of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union);

Of which you are in a position of general control or management.

If that is the case then you must declare such an interest but can speak and vote on the matter.

4 To receive any items of business which the Chairman decides should be considered as a matter of urgency

5 Public Question Time

Fifteen minutes for questions from members of the public of which due notice has been given. Please note that all questions must be received by the Committee Team (committees@norfolk.gov.uk) by **5pm Tuesday 10 March 2020**

For guidance on submitting a public question, please visit www.norfolk.gov.uk/what-we-do-and-how-we-work/councillors-meetingsdecisions-and-elections/committees-agendas-and-recent-decisions/ask-aquestion-to-a-committee

6 Local Member Issues/Questions

Fifteen minutes for local member to raise issues of concern of which due notice has been given. Please note that all questions must be received by the Committee Team (committees@norfolk.gov.uk) by **5pm Tuesday 10 March 2020**

7 Children's Services Transformation – Impact to date Page **22**

Report by the Executive Director of Children's Services

8 Norfolk County Council and Norfolk Community Health and Care Section 75 agreement for Community Health and Social Care Page **33**

Report by the Executive Director of Adult Social Services

9 Developing an Engagement Strategy for Adult Social Care Page **56**

Report by the Executive Director of Adults Social Services

10 Carers Charter Task and Finish Group Page **88**

Report by the Executive Director of Adults Social Services

11 Care Quality and the Market Position Task and Finish Group *To Follow*

Report by the Executive Director of Adults Social Services

12 Development of Public Health Vision and Long Term Plan 2021-25 Page **93**

Report by the Executive Director, Community and Environmental Services

13 Forward Work Programme Page **97**

Report by the Executive Director of Adults Social Services

Group Meetings

Conservative	9:00am	Conservative Group Room, Ground Floor
Labour	9:00am	Labour Group Room, Ground Floor
Liberal Democrats	9:00am	Liberal Democrats Group Room, Ground Floor

Chris Walton
Head of Democratic Services
County Hall
Martineau Lane
Norwich

NR1 2DH

Date Agenda Published: 23 January 2020

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Norfolk County Council

People and Communities Select Committee
Minutes of the Meeting Held on 31 January 2020 at 10am in the Council Chamber, County Hall

Present:
Cllr S Gurney (Chairman)
Cllr Fabian Eagle (Vice-Chairman)

Cllr Tim Adams
Cllr David Bills
Cllr Ed Connolly
Cllr David Harrison
Cllr Brenda Jones
Cllr Chrissie Rumsby
Cllr Thomas Smith
Cllr Mike Smith-Clare
Cllr Sheila Young

Substitute Members Present
Cllr Phillip Duigan for Cllr Fran Whymark

Officers Present:

Suzanne Baldwin	Finance Business Partner (Adult Social Services)
James Bullion	Executive Director of Adult Social Services
Janice Dane	Assistant Director Early Help and Prevention (Adult Social Services)
Gary Heathcote	Director of Commissioning (Adult Social Services)

1. Apologies for Absence

1.1 Apologies were received from Cllr Penny Carpenter and Cllr Fran Whymark (Cllr Phillip Duigan substituting)

2. Minutes

The minutes of the meeting held on 15 November 2020 were agreed as an accurate record and signed by the Chairman

3. Declarations of Interest

3.1 The following interests were declared:
- Cllr Sheila Young declared an interest as a carer
- Cllr Thomas Smith declared an interest as he had a family member receiving care and a care plan from Norfolk County Council

4. Items received as urgent business

4.1 There were no items of urgent business.

5. Public Questions

5.1 No public questions were received

6. Member Questions and Issues

6.1 No Member questions were received

7. Adult Social Services Norfolk Care Market

7.1.1 The Committee received the report summarises some of the main challenges facing the Council and providers in developing a vibrant care market.

7.1.2 The Director of Commissioning (Adult Social Services) introduced the report and gave a presentation; see appendix A:

- Norfolk's population had higher than the national average of older people
- Increase in private funders and homes focussing on private funded care was putting pressure on the council's ability to provide care
- Norfolk was third highest in the region for number of registered nurses from the European Union at 26%
- The county was 10th out of 11 in the eastern region and 11th out of 11 in the group of comparative local authorities for quality in the market
- Quality and resilience nurses were working within the council's quality and resilience team to support with improving market quality
- Employment in adult social care was higher in Norfolk than employment in agriculture and transport at 28,840 employees

7.2 The following points were discussed and noted:

- Concern was raised about high labour turnover, quality improvements required, and the amount of beds lost from the care market and it was suggested that a deep dive should be carried out to look into improvements
- The Chairman assured Members that the Cabinet Member for Adult Social Care, Public Health and Prevention, Cllr Bill Borrett, and Cabinet Member for Children's Services, Cllr John Fisher, had both been invited to attend the meeting but unfortunately were unavailable. The Chairman met regularly with Cabinet members to discuss and update them on topics on the agenda
- The Chairman was concerned about reported issues related to new-build care homes and felt further discussion was needed, possibly via a task and finish group
- Risks to the care market had been discussed by Corporate Board and Cabinet; these risks were impacted by national issues including the increase in living wage and pension which affected companies' ability to expand. Officers continued to lobby for improved funding in Adult Social Care
- One issue which needed addressing was the wider perception of the care workforce, who were not regarded with as high value or recognition as NHS nurses despite the value and difficulty of their role.
- A lot of turnover in the care market related to workers moving between companies; improving the working relationship with the care market to support care companies to make improvements in quality, workers terms and conditions, and make long term investments in staff and training would be important.
- The national care sector was calling for money to stabilise the market as well as a plan for long term improvement in the system

- The high number of providers and lack of consolidation across the market was noted as a concern; consolidation and capacity of the market was an area commissioners wanted to explore further
- The commissioning team could be approached for information to inform district planning projects; officers had worked with planning teams to include housing for vulnerable people in neighbourhood plans
- The challenges of finding placements or ensuring continuing healthcare for people with advanced dementia were discussed; officers were looking at funding for continuing healthcare with the Director of Community Social Work
- The difficulty of finding appropriate care for younger people with dementia was noted as an issue
- A Member raised concerns that many staff working in Social Care felt they were not treated well by their employer. The Executive Director of Adult Social Services recognised the difficulties for staff in the sector and assured Members that work was ongoing with health and social care to try and improve the challenging situations
- the projected increase in unpaid carers and mechanisms in place to support them was queried; the report at item 8, “Support for Carers through the Life Chances Fund”, discussed support for carers
- The Director of Commissioning (Adult Social Services) agreed to circulate information on the location of struggling care homes including what support they were being provided with
- The Director of Commissioning (Adult Social Services) confirmed that the capital towards new Extra care housing was NCC’s contribution; further funding would be sought from other source such as Homes England
- Officers confirmed that care organisations could not be contracted to ensure the use of funding provided to them towards paying staff the living wage was correctly allocated, however, as it was a legal requirement to pay staff the living wage, homes could be audited to ensure they were compliant with the law
- The Director of Commissioning (Adult Social Services) agreed to circulate information on whether the 15 inadequate care homes were the same or different to the 15 inadequate care homes reported in 2018-29; he believed that through support to improve from the quality team, and some homes leaving the market it was likely that only a portion would be the same
- The Council was responsible for continuity of care so when care homes closed at short notice, it was responsible for supporting people to find new packages of care
- People were encouraged to have personal assistants, however, due to cut in Minimum Income Guarantee it was noted that some people would not be able to afford one; the Executive Director of Adult Social Services clarified that in cases where a personal assistant was required, they would often be provided through the care package or personal budget, which was different funding to the Minimum Income Guarantee
- It was suggested it would be useful for Committee Members to visit care homes
- Cllr Tim Adams, seconded by Cllr Brenda Jones, **PROPOSED** that the Committee set up a task and finish group to carry out a deep dive into how care quality and the market position could be improved; the Committee **AGREED** this proposal
- The Chairman noted that, under the remit of the Select Committee, the task and finish group should look at outcomes that could be achieved via changes to policy
- It was **agreed** that in discussion with Cllr Adams and the Chairman, Officers would come up with draft terms of reference to bring back to the next meeting for agreement
- The Vice Chairman suggested that an apprenticeship scheme could be set up

through Norse and a mentor scheme could be set up using retired care nurses
- the issue of burnout in the care industry was noted

7.3 The Select Committee:
- **CONSIDERED** and **DISCUSSED** the context for the care sector in Norfolk, and note the actions planned in response to the challenges
- **AGREED** to set up a task and finish group to look at policy change to impact on how care quality and the market position could be improved, with a report setting out the terms of reference to be brought to the meeting in March 2020

8. Support for Carers through the Life Chances Fund

8.1.1 The Select Committee received the report

8.1.2 The Director of Commissioning (Adult Social Services) introduced the report
- If the life chances fund bid was successful it would bring contracts together to provide an outcome focussed approach, protecting funding for 5 years, with the opportunity to attract additional funding through the life chances fund. It would also allow the Council to support carers more effectively and raise awareness of carers
- The outcome of the bid would be known in March 2020

8.2 The following points were discussed and noted
- Officers confirmed that the investment model of the Life Chances Fund was outcomes-based. The Council would have a 5-year contract in place with the investment company and therefore, the Council would have no risk of loss of service in the event of a financial loss to the investor
- Support given to people new to caring and in a care-crisis was queried; officers were planning to work with GPs as part of the Life Chances project as well as looking at schemes to help prevent care breakdown, develop signposting, focussed action planning, and higher end support where appropriate, using existing services to ensure that there was a cohesive service in place for carers
- There was not much empirical evidence around carer investment at that time therefore gathering evidence as part of this project would be beneficial for the Council moving forward as well as for other Councils
- Concerns were raised about lack of capacity to carry out repeat carer assessments; the Executive Director of Adult Social Services confirmed that poor performance issues needed addressing and would be picked up under this piece of work
- The Finance Business Partner (Adult Social Services) confirmed that officers would look at performance through the Life Chances project work including seeking feedback from carers
- The importance of effective respite for carers was discussed
- The Executive Director of Adult Social Services was optimistic that the application would be successful, however noted that regardless of the outcome of the bid, Norfolk needed a strategy to support carers
- Support for carers was being promoted through the work of the carers' charter and the Member Champion for carers
- The chairman hoped that evidence gained through the project would be presented in future papers related to policies being updated based on this learning

8.3 The Select Committee

a) **DISCUSSED** and **CONTRIBUTED** ways of supporting a new offer for carers under the auspices of the Life Chances Fund

b) **NOTED** and **DISCUSSED** the work underway to strengthen support for carers through an enhanced service offer

8.4 The Committee adjourned for 10 minutes to look at the marketplace presentation stands in the foyer presenting information on technology initiatives in adult social care

8.5 The Committee adjourned 11.52 and reconvened at 12:12

9. Adult Social Services Technology Enabled Care Strategy

9.1 The Select Committee considered the report giving information on the Adult Social Services Technology Enabled Care Strategy, critical to the Promoting Independence Strategy, and heard a presentation by the Executive Director of Adult Social Services and the Assistant Director Early Help and Prevention (Adult Social Services); see appendix B

- Technology would be used to save the service money by reducing demand and providing support differently, with a target of saving £6.5m over three years
- Some schemes were already in place, and more initiatives were planned for delivery over the coming years
- Work was underway to eliminate paperwork heavy tasks
- Assistive technology was intended to support people to be as independent as possible in their own homes
- Work was taking place in partnership with the University of East Anglia (UEA) and the Alzheimer's Society to promote schemes available

9.2 The following points were discussed and noted

- The Chairman asked for feedback on Amazon Echo devices
- The new devices distributed to social care staff had been seen to have better internet access
- A film was shown during the presentation to Members; this was a promotional video as part of the roll out of Llama (LiquidLogic Adults Mobile App) to staff, highlighting its benefits
- The term "empowered citizens" was queried; the Executive Director of Adult Social Services reported that there was an aim to allow people to manage and be in control of their own care where this was possible, noting that this approach did not suit everybody
- Following an assessment to identify appropriate assistive technology training in the equipment provided by either the Assistive Technology Practitioner or N-Able staff
- It was estimated that by using assistive technology, approximately £4,000 per year was saved per person by reducing or delaying care packages

9.3 The Select Committee **CONSIDERED** and **DISCUSSED** the progress of the Technology Enabled Care Strategy for Adult Social Services

The Meeting Closed at 12:40

Cllr S Gurney, Chairman,
People and Communities Select Committee

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Norfolk Care Market

People and Communities Select Committee
January 31 2020

Gary Heathcote
Director Commissioning
Adult Social Services

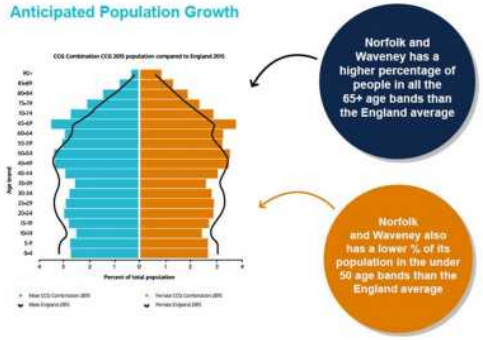
Norfolk County Council

National Context

- Spending Review – short term funding but no sign yet of a sustainable model of funding social care
- Brexit
- Demographic pressures from ageing population who are living longer with increased complexity of multiple comorbidities including Dementia
- Workforce – recruitment and retention, parity of esteem with NHS roles, perception of sector
- Market Failure / Financialisation of the market – private for profit business models – risks around collapse of large national providers
- Delayed Transfer of Care (DTOC) Pressures
- NHS Long Term Plan

Demographics in Norfolk Driving Demand for Care Services

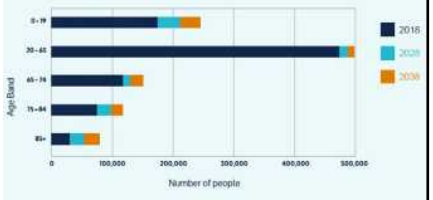
Anticipated Population Growth



Norfolk and Waveney has a higher percentage of people in all the 65+ age bands than the England average

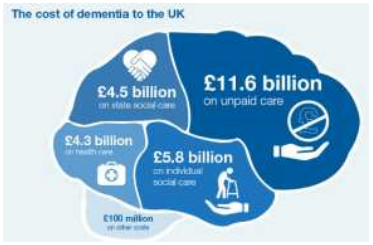
Norfolk and Waveney also has a lower % of its population in the under 50 age bands than the England average

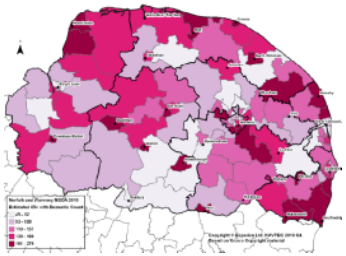
The estimated Norfolk population is 902,033 rising to 1,011,073 in 2038. The Norfolk population is generally older than average for England and the largest increase in population between 2015 and 2038 is anticipated to be in the older age bands (age 75+).



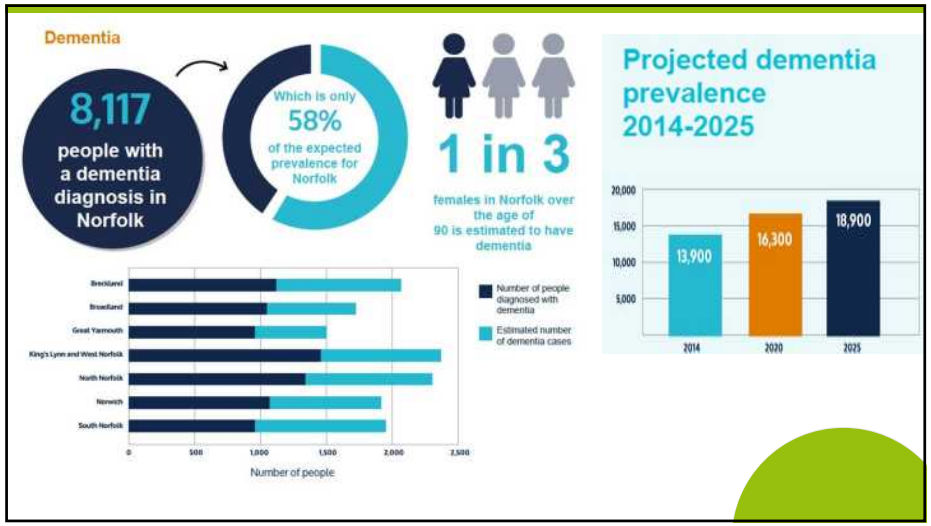
The bars in the above graphic represent the Norfolk and Waveney population by age bands (blue male, orange female). The black line represents where these bars would be if Norfolk and Waveney matched the England average

Dementia – Costs To Society





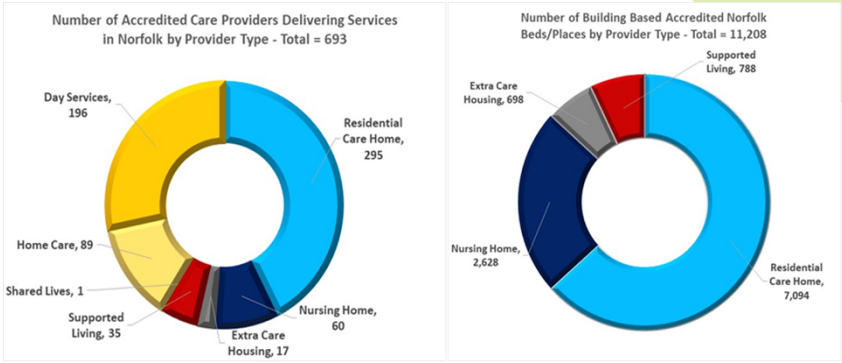
- Increasing challenges for health and social services to deal with dementia rates
- Ideally live longer and healthier at home
- Majority of care for people with dementia provided by unpaid carers



Norfolk Care Market

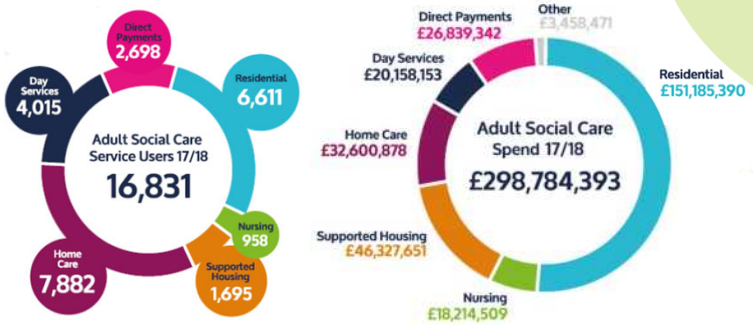
- Accommodation based market is dominated by residential and nursing homes (**87%**) with much smaller alternative housing based provision (**13%**)
- **497** providers operating from **693** sites subject to CQC regulation
- **196** day care providers not subject to CQC regulation required to pass NCC's quality criteria prior to purchasing any care from them
- Sector employs **27,000** care workers and relies upon extensive bed based care estate
- **100,000** people providing informal social care together with volunteer organsiations and community based groups whose contributions are estimated to be worth at least **£500M** annually
- NCC provides some formal social care through the Reablement and First Response Services
- NCC operates Norse Care and Independence Matters as arms length companies

Norfolk Care Market - Size – April 2019



(Supported living comprised 235 individual schemes and floating support providers run by 35 care companies)

Norfolk Care Market – Gross Spend and Service Users – 2017-18



In 2018-19 the Purchase of Care spend detailed above increased to £328,087,984, with only a nominal increase in service users to 17,500

The factors likely to have contributed to the increase in spend without a substantial increase in service user numbers:

- Above inflation increases to the fees that the Council pays care providers, a significant factor being the increase to the National Living Wage
- Perception that people supported are more likely to have a higher level of need and will therefore have more expensive care packages
- Promoting Independence and Living Well appear to be moderating predicted increases in the people requiring care at the moment

Fee Uplift

2020-21 envelope £12m + £1.035m for second phase cost of care			
Core price inflation	National Living Wage (1p roughly equates to £0.2m cost)	Supply & market shaping	Legislation

In 2020-21 Core inflation increases total £12.011m (covering price inflation and NLW)	
Sector	2020/21
Home Support spot/framework Band 1	4.61%
Residential and Nursing older people	4.55%
Residential and Nursing working age adults (including physical disabilities)	4.40%
Day Care	3.99%
Supported Living	3.63%
Supported Accommodation	3.63%
Direct Payments (PA element – 7.13%)	4.00%
Carers	4.61%
Other	2.00%

- In 2019-20 a further £2.9m (75%)cost of care for OP residential and nursing remaining £1.035m (25%) in 2020-21 enabling total increases for usual price of between 5.44% and 6.79% incl. inflation.
- Challenges ahead– continued increase in NLW; fragility of the market and reason closures; workforce and unmet need in parts of the county
- National living wage is estimated to cost up to £7.9m next year – now the biggest cost driver for adult social care. For comparison 2% ASC precept = £8.135m

Norfolk Care Market – Quality (1)

- The responsibility for maintaining good quality lies with the providers themselves although the Council remans accountable for quality of care in the market under the Care Act.
- Demands on the quality assurance team rose significantly during the year driven by increases in safeguarding referrals and market failures.
- Proactive improvement programme introduced this year targeting up to 40 struggling care homes. We plan to build on this programme in 2019/20 with increased capacity within the team and improved performance in commissioning, procurement and contract management activities
- Cost pressures beginning to be evidenced by reducing staffing levels in some homes, impact on quality
- Providers either leaving market or focusing on private funding market – higher rates
- Trend for new builds being for private funders

Norfolk Care Market - Quality (2)

Key Findings in 2018/19 include

- The Council paid £328m for care for 17,000 adults
- 85 providers out of 465 inspected by CQC were rated *Requires Improvement* (18%) This was a 3% improvement on the previous year
- 15 providers were rated as *Inadequate* (3%) the same as the previous year
- 9 providers were rated as *Outstanding* up from 5 the previous year
- The poorest performing sector is nursing homes at 70.5% rated good or outstanding a drop from 72.5% at the beginning of the year
- Staff turnover rates are very high in the independent market approaching 50% in nurses in nursing homes and over 40% in home care
- 12 care home providers and 5 home care providers left the market

Social Care Workforce – Recruitment and Retention

Turnover and vacancy rate and recruitment from within adult social care

Region	Local authority	Turnover rate
Eastern	Peterborough	51%
	Thurrock	50%
	Hertfordshire	46%
	Suffolk	40%
	Southend on Sea	39%
	Cambridgeshire	39%
	Norfolk	37%
	Central Bedfordshire	36%
	Essex	33%
	Bedford	33%
	Luton	29%

Annual turnover rates of **direct care workers** are at concerning levels, though not as high as in some other East of England authorities

Turnover and vacancy rate and recruitment from within adult social care

Region	Local authority	Turnover rate
Eastern	Southend on Sea	44%
	Luton	40%
	Norfolk	39%
	Suffolk	37%
	Bedford	30%
	Peterborough	29%
	Cambridgeshire	29%
	Essex	27%
	Hertfordshire	21%
	Central Bedfordshire	21%

Turnover rates of **registered nurses** are at concerning levels, and higher than most other East of England authorities

Turnover and vacancy rate and recruitment from within adult social care

Region	Local authority	Turnover rate
Eastern	Peterborough	19%
	Southend on Sea	18%
	Hertfordshire	18%
	Cambridgeshire	17%
	Essex	16%
	Suffolk	16%
	Norfolk	15%
	Luton	14%
	Bedford	14%
	Central Bedfordshire	13%
	Thurrock	11%

Turnover rates of **managers** appear comparable with levels in East of England generally. The loss of a registered manager at a care provider can cause significant disruption that can lead to decline in standards of care and safety

Social Care Workforce – Demographics of Direct Care Workers

Percentage of workers that are...

Region	Local authority	Aged 55 and over
Eastern	Hertfordshire	23%
	Cambridgeshire	23%
	Southend on Sea	23%
	Norfolk	23%
	Essex	22%
	Central Bedfordshire	22%
	Bedford	21%
	Suffolk	20%
	Thurrock	19%
	Luton	18%
	Peterborough	18%

Norfolk has a high percentage of **direct care workers** who are aged 55 or over, with the likelihood of the care industry losing these workers in the next 5-10 years

Percentage of workers that are...

Region	Local authority	Female
Eastern	Thurrock	89%
	Luton	88%
	Hertfordshire	85%
	Suffolk	85%
	Essex	85%
	Southend on Sea	85%
	Central Bedfordshire	84%
	Norfolk	83%
	Bedford	82%
	Cambridgeshire	82%
	Peterborough	82%

Norfolk, like the rest of the East of England, has a high percentage of **direct care workers** who are female. Females can be more likely to take up informal caring roles for family members and leave the care profession. A high percentage of female care staff can also generate shortages in care environments when "male only carers" are required

Percentage of workers that are...

Region	Local authority	EU nationality
Eastern	Cambridgeshire	18%
	Central Bedfordshire	14%
	Hertfordshire	12%
	Peterborough	12%
	Bedford	11%
	Norfolk	11%
	Luton	8%
	Suffolk	8%
	Essex	8%
	Southend on Sea	6%
	Thurrock	4%

With 11% of **direct care workers** from the EU, Norfolk has a degree of expose to the consequences of the UK leaving the EU

Social Care Workforce – Demographics of Registered Nurses in Care Homes

Percentage of workers that are...

Region	Local authority	Aged 55 and over
Eastern	Luton	41%
	Central Bedfordshire	38%
	Norfolk	36%
	Suffolk	35%
	Essex	31%
	Hertfordshire	30%
	Southend on Sea	28%
	Bedford	28%
	Thurrock	27%
	Cambridgeshire	25%
	Peterborough	18%

Norfolk has a high percentage of **registered nurses** that are aged 55 or over, with the likelihood of the care industry losing these nurses in the next 5-10 years

Percentage of workers that are...

Region	Local authority	Female
Eastern	Peterborough	91%
	Thurrock	89%
	Bedford	89%
	Hertfordshire	88%
	Essex	88%
	Suffolk	88%
	Central Bedfordshire	87%
	Southend on Sea	85%
	Luton	85%
	Norfolk	85%
	Cambridgeshire	83%

Norfolk, like the rest of the East of England, has a high percentage of **registered nurses** who are female. Females can be more likely to take up informal caring roles for family members and leave the care profession

Percentage of workers that are...

Region	Local authority	EU nationality
Eastern	Hertfordshire	32%
	Peterborough	32%
	Norfolk	26%
	Cambridgeshire	25%
	Central Bedfordshire	23%
	Essex	20%
	Thurrock	19%
	Bedford	19%
	Luton	18%
	Suffolk	14%
	Southend on Sea	12%

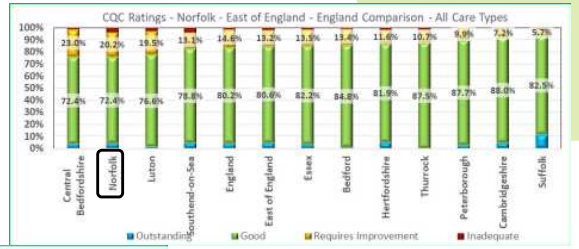
With 26% of **registered nurses** from the EU, Norfolk has a high level of expose to the effects of the UK leaving the EU

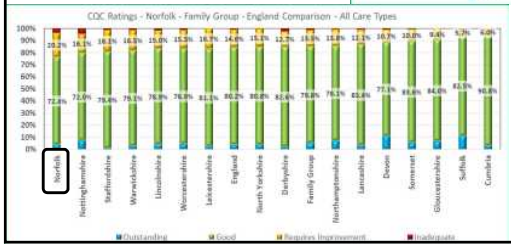
Quality Issues in the Care Market

Despite moderate improvements in 2018-19, the percentage of Norfolk's care providers rated good or outstanding by CQC (76%) has declined since

Norfolk does not compare well in this measure against the other local authorities in the East of England

At the end of August 2019 Norfolk was ranked 10/11





Norfolk does not compare well in this measure against the other local authorities that are similar demographically (large rural counties)

At the end of August 2019 Norfolk was ranked 11/11

Care Home Closures

In 2018-19 in Norfolk

- 12 care homes were closed with a total loss of 173 beds (61 nursing beds). This often followed serious quality/safety concerns
- 121 of the lost beds (70%) were in older people's care homes (this was 86% in 2017-18 which is a more typical figure)
- 4 new care homes were opened with the creation of 16 new beds
- The new homes are very small and cater for people with learning disabilities and mental health issues not older people
- The net loss of beds in 2018-19 was therefore 157 (173 minus 16)
- 1 nursing home deregistered its nursing, an estimated 11 nursing beds were lost which became residential beds. There are concerns that more nursing homes will do the same

There are currently new care homes for older people in planning and development, the Council have several concerns over these:

- Will new care homes provide enough new beds that accept NCC fees?
- Will the number of new beds compensate for the number of beds that are being lost annually?
- Will the care homes be built in places where there is a need for Council funded placements?

Commissioning and Market Development are working to influence this through our Older People's Care Home Project

Part of the project is sharing our analysis of demand and need with the care market and stating to care home owners our requirements (types of beds, numbers of beds and where required)

Cost of Market Failure

- Over the last year we estimate that the cost of market failure has been in the region of **£1m**, including the opportunity cost of NCC staff time.
- In addition to the impact of the Allied Healthcare failure, we have seen **18** market failures affecting **370** people.
- The additional costs to the council, due to higher care costs and transition costs have totalled **£0.570m**.
- Quality Assurance team costs have totalled in the region of **£0.115m**
- Remainder relates to social work time, covering reassessments and working with providers and families to find alternative care; commissioning; communications and procurement team resources.
- There has also been a related cost from the need to divert other social work professionals away from other pieces of work, including transformation work to deliver savings, in order to manage these cases and support locality teams.
- Although the direct costs are accurate, the opportunity cost is only an estimate – but reflects the wide range of teams that have been needed to be involved with this work.

Commissioning Response

- **Restructure of NCC's Commissioning Service**
  - More capacity in Quality Team to increase inspections and provide market support
  - New AD role which brings together Quality, Workforce and Markets in the one role to work much more closely with the social care market.
  - Opportunities to work with CCG on market quality
  - Increased commissioning focus on key markets
  - Market Position and Intentions statement
- **Commissioning Intentions**
  - Prevention and early help
  - Keeping people independent for longer
  - Support for people living with complex needs
  - Stronger assessment of commissioning strategy effect on market stability
  - Focus on key service areas
  - Commissioning 3 year plan Inc. market engagement

Response to Pressures

- **Focus on Housing and Prevention**
  - Extra Care Housing - NCC committed £30m to facilitate the development of 3,000 units of extra care housing across the county. A first site in Fakenham will be open in 2021, with more expected to be confirmed over the next few years.
- **New Norfolk Care Association**
  - Focus on establishing a strong, supportive relationship with providers through the new Norfolk Care Association which will represent the market and strengthen the relationship with NCC and other commissioners
- **Increased Support for Unpaid Carers**
- **Focus on NCC's Care Companies**
- **Focus on Technology for provider market (AT & Digital)**
- **E- Brokerage – market insights**

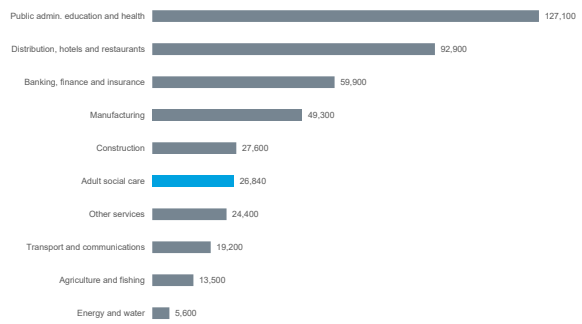
Response to Pressures (2)

- **Workforce**
  - Recently successful in our European Social Fund bid for the '**Developing Skills in Health and Social Care Programme**' which together with match funding from partnership organisations will support a total skills project value **of £7,580,000** for Norfolk and Suffolk
  - As well as support to individuals in the workforce, we expect the higher take up of qualifications to lead to better recruitment and retention rates, better quality of care, and improved leadership and management skills to help sustainability within the care market.
  - National Social Care Recruitment campaign – NCC appointed a Recruitment Coordinator to support providers in Norfolk and Waveney take full advantage of the campaign
  - TNA Partnership – Inclusion of social care participants from care homes in joint health and social care Trainee Nursing Associate apprenticeship programme
  - Training and Development Programmes delivered to the social care workforce through NCC funded Norfolk and Suffolk Care Support
  - Norfolk Care Careers website established & maintained by NCC for providers – jobs board

Economic contribution of Social Care Sector

- Adult social care employers contribute £46 billion to the UK economy per year (Skills for Care report)
- Economic Contribution based on 3 measures of Gross Value Added (GVA) ;
  - Direct (wages paid to workers)
  - Indirect (created by the sector in its supply chain by purchasing services from other sectors of the economy that might include cleaning services or food suppliers)
  - Induced (impact of those who are employed directly in the sector and those employed indirectly spending their wages in other sectors of the economy
- Norfolk's social care sector contributes **GVA £439** million per year
- Highlights the importance of social care not only as a provider of services to citizens when they need it, but our sector's importance as a provider of jobs in local economies across the county where much of the money is spent.

Employment in norfolk by broad sector

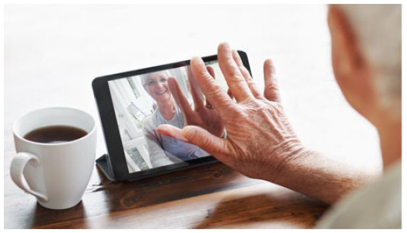


Conclusion

- DASS has responsibility under the Care Act to ensure market is sustainable – includes providers we don't commission.
- Norfolk's social care market is fragile & impact of market failure on NCC services is considerable
- Brexit – greatest risks of impact in nursing care
- Looking to increase our engagement with LEP, and Economic Development colleagues to help them recognise that the growing social care sector is one of the largest employers and makes significant economic contribution to Norfolk. Social Care employs more people than NHS in Norfolk
- New commissioning structure will address workforce, quality & market development

ASSD Technology Enabled Care

People and Communities Select Committee –
31 January 2020



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Digitally enabled adult social care strategy

Our Vision

- Technology will be integral to good, quality care.
- It will enable professionals to work efficiently, for services to work smartly and for people to live independently at home for longer, reducing the need for formal, intensive adult social care intervention.

Three core areas	What this will look like
Productive **workforce**	• Practitioners make maximum use of their time by using the Mobile App to work 'offline' and wherever necessary by appointments being scheduled • Ensuring staff have the right technology to enable them to work effectively and only print where necessary • Wifi is available in the core sites and Mobile data is available to front line workers • Practitioners are confident in their use of technology in many situations as well as how it can be used to support people to live independently
Providers	• We will be able to identify those who are likely to need services in the future at a much earlier stage • Information on who is using the services, at what point and the outcomes are easily available and accessible • Ability to cease payments as soon as a person stops receiving care • Procurement exercises are reduced or avoided by the choice of care options available in the marketplace easily viewable and directly accessible by all
Empowered citizens	• Digital technology will be recognised as an enabler for promoting independence and will be accessed early / at the start of a persons journey • Digital technology will be used for a wide range of challenges and situations

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Adults Digital Savings Target

	Recurrent Net Target (£m)				
	2018-19	2019-20	2020-21	2021-22	TOTAL
TOTAL	0.049	1.251	1.500	3.700	6.500

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Adult Social Care Technology Enabled Care (ASTEC)

The ASTEC Officer Steering Group has cross departmental representation and provides:

- development and direction of the programme of ASTEC projects and initiatives, providing leadership, advice and support
- Assurance of effective delivery by providing governance and control, monitoring finance and performance, and by addressing the risks and issues that have been escalated
- Consideration and challenge for longer term views of technology development

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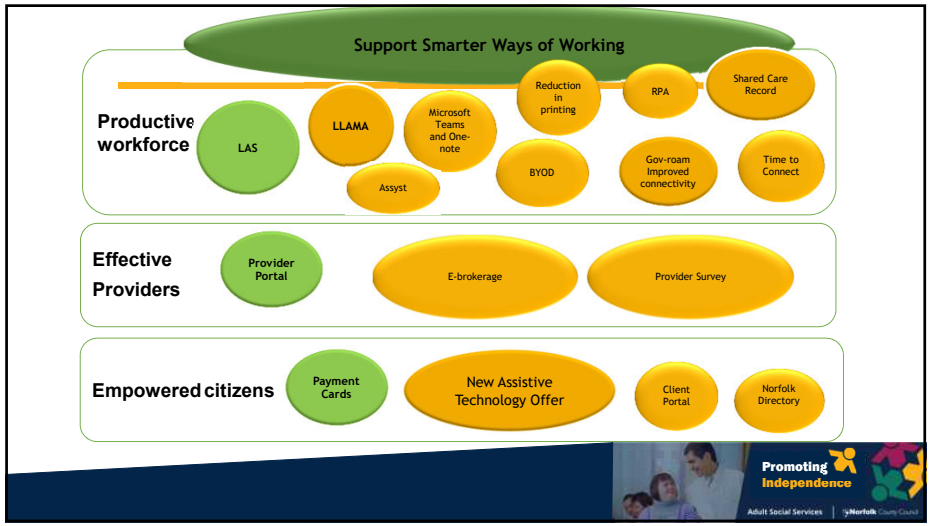
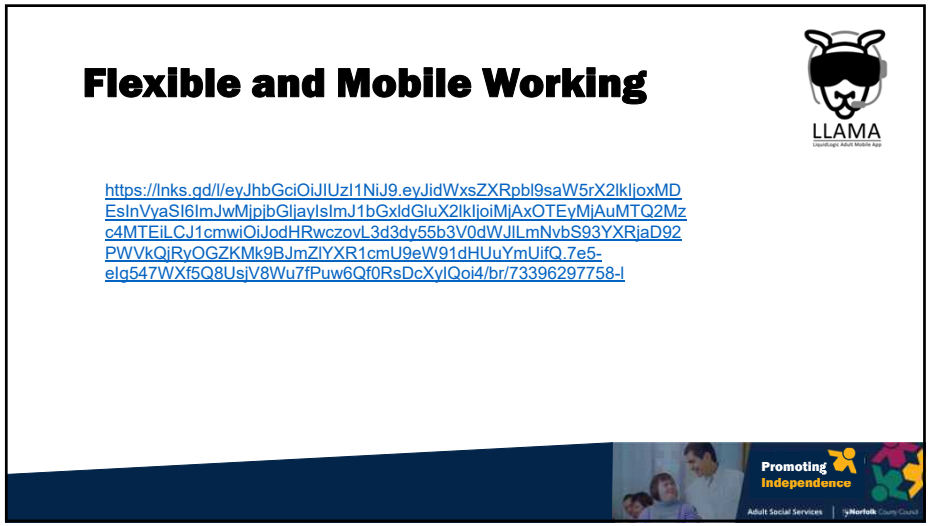

Support Smarter Ways of Working
Productive workforce
LAS
LLAMA
Microsoft Teams and One-note
Assyst
Reduction in printing
BYOD
RPA
Gov-roam Improved connectivity
Shared Care Record
Time to Connect
Effective Providers
Provider Portal
E-brokerage
Provider Survey
Empowered citizens
Payment Cards
New Assistive Technology Offer
Client Portal
Norfolk Directory
Promoting Independence
Adult Social Services


Flexible and Mobile Working
LLAMA
https://lnks.gd/l/eyJhbGciOiJIUzI1NiJ9.eyJidWxsZXRpbl9saW5rX2lkIjoxMDEsInVyaSI6ImJwMjpjbGljayIsImJ1bGxldGluX2lkIjoiMjAxOTEyMjAuMTQ2Mzc4MTEiLCJ1cmwiOiJodHRwczovL3d3dy55b3V0dWJlLmNvbS93YXRjaD92PWVkQjRyOGZKMk9BJmZlYXR1cmU9eW91dHUuYmUifQ.7e5-eIq547WXf5Q8UsjV8Wu7fPuw6Qf0RsDcXyIQoi4/br/73396297758-l
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Time to Connect
1
Improve the quality, range and efficiency of care and support provision for our service users
2
Maximising Face to Face time with Service Users
3
Support and enhances the delivery of Mobile Working & Living Well
4
Understand capacity and demand to enable ongoing delivery of services
5
Support smarter ways of working to improve productivity and to alleviate funding reduction
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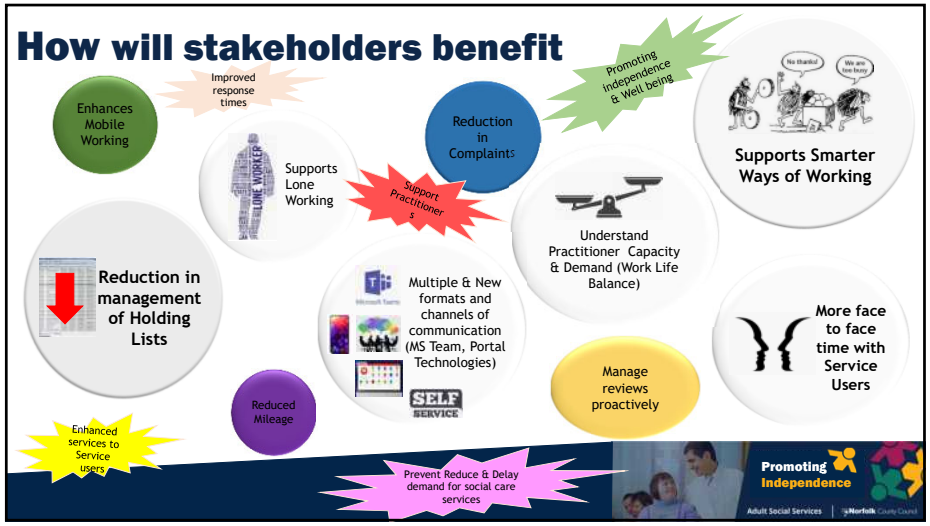

How will stakeholders benefit
Enhances Mobile Working
Improved response times
Supports Lone Working
Reduction in Complaints
Promoting Independence & Well being
Supports Smarter Ways of Working
Support Practitioners
Understand Practitioner Capacity & Demand (Work Life Balance)
Reduction in management of Holding Lists
Multiple & New formats and channels of communication (MS Team, Portal Technologies)
SELF SERVICE
More face to face time with Service Users
Manage reviews proactively
Reduced Mileage
Enhanced services to Service users
Prevent Reduce & Delay demand for social care services
Promoting Independence
Adult Social Services

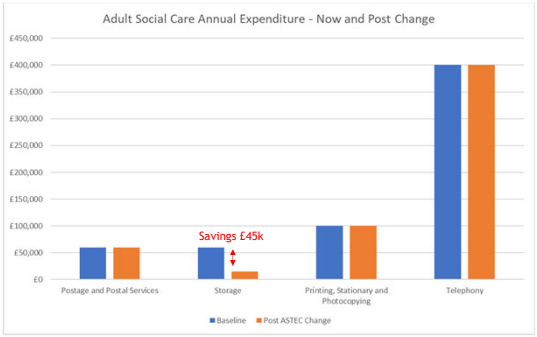
Back Office Project

Printing:
- 3.2m pages printed by ASC
- 2.7m B/W and 0.5m Colour
- Tech solution for our Reablement in-house provider who is largest printer
- Culture and Tech change for other staff

Postage:
- ASC shares a proportion of 750,000 items posted by NCC each year

Archiving:
- ASC shares a proportion of 39,000 items stored by NCC

Please Note:
Telephony, Printing and Postage costs are being reviewed but as part of wider corporate initiatives such as "Bring Your Own Device"



We are presently tied into a corporate printing contract until April 2022 so cannot realise any savings there until after that point – we will target a significant impact on our existing level of spend post that

Assistive Technology

- Assistive Technology (AT) has a key role to play in supporting people to live independently for as long as possible and providing support to family carers to enable them to continue caring for as long as they are able and willing to do so.

- Have a vision for Assistive Technology which includes citizens, workforce and providers:
  - Technology plays a major role in supporting people to live independently for as long as possible, and in helping carers to continue caring for as long as they are able and willing to do so
  - Assistive technology will be widely accessible, easy to use, and available for people when it can make most difference to maintaining independence
  - Our own staff are champions for assistive technology and use it widely to prevent people needing formal care services
  - Providers embrace technology to help people stay independent in all types of settings, and maximise the efficiencies it can bring.

Assistive Technology continued

The AT Team continue to pro-actively look at opportunities for innovation utilising new technologies and to work with and learn from other organisations to improve the AT offer, including:

- The launch of the pilot to allows Occupational Therapist's to send prescriptive referrals for some low-level AT equipment through to the AT team.
- The development and strengthening of a working partnership with UEA.
- Delivery of a wide range of training/awareness raising events including.
- Planned work with the Alzheimer's Society to develop a user and carer focus group to advise on technology, test and review equipment and provide product design and manufacturer feedback.

Trialled the use of Amazon Echo with the Making it Real group. Positive feedback on the use includes:

"Looking up the weather, trying to search things and finding out spellings….you don't have to read so well and it's fun hearing jokes. …"

"Listening to radio stations
Listening to music stored on my PC,
Spoke to someone on Drop-in,
Check the news,
Asked what is in my calendar today
Created a group with my existing Echo speaker so it would play music on both at the same time…"

"I used the amazon echo to set reminders for my mum, so she remembers the things that she has planned such as appointments and her tables …. **the amazon echo tells us what we got planned for the day but also can tell us that we have planned for the week ahead**"

"I thought it worked really well. It didn't understand everything I said, but again I was in a rush, but I feel it's one I could certainly get on with. …"

On-line access for citizens (Client Portal)

- Much improved customer offer.
- Residents being able to use an online wellbeing questionnaire to either be signposted to services in the Norfolk Community Directory or to refer themselves via online forms that come straight into Liquid Logic.
- Service users being enabled to have a registered portal account which allows messages and documents to be sent between us and them.
- Can give family members access to some of their information if the service user chooses.

Finding the right care - eBrokerage

Marketplace Admin

- eBrokerage is an online system that will enable a two-way exchange of information between Norfolk County Council and our care providers to help obtain the most suitable package of care for our service users.
- It helps the Council to find a match for a service user's specific needs quickly without having to phone around providers.
- Providers are able to submit offers online, enabling the council to select the best offer for the client.
- The eBrokerage project is a multi phase project covering Adults Residential, Adults Non-Residential and Health Integration
  - Residential and Nursing homes went live on 29 October 2019
  - Adults - Non Residential – Timescale TBC (aiming for June 2020)
  - Norfolk Continuing Care Partnership – Timescale TBC (aiming for June 2020).

Adults and Digital Norfolk

- Our digital transformation activity across NCC is all connected and our priorities anchor everything that we do.
- We have been on a digital transformation journey with our staff and customers for a while – we are continuing that in the way we work.
- We are shifting to digital channels, making it simpler and easier for customers to access our services.
- We are driving an improved customer and colleagues experience.
- We are driving business efficiency.

National engagement

Socitm Advisory : "Overall, NCC has made significant progress over the last 2 years. ASC are of course on a digital journey, and there are many opportunities to progress further, however we would consider NCC as one of the more mature digital programmes"

Local Government Association (LGA) /Association of Director's of Adult Social Services (ADASS): We've been invited by the LGA/ADASS to contribute to a national report "Evidencing Outcomes and Financial Opportunities in Social Care Digital Transformation

Share digital 20 and Kings Fund : We've been asked to host a table at the Share Digital 20 event and a workshop at the International Digital Health and Care Congress 2020 – we'll be covering our progress on the e-Brokerage roll out and in particular around our work with residential and nursing care providers.


Any
Questions
Promoting
Independence
Adult Social Services

People and Communities Select Committee

Item No. 7

Report title:	**Children's Services Transformation – Impact to date**
Date of meeting:	**13 March 2020**
Responsible Cabinet Member:	**Cllr John Fisher (Cabinet Member for Children's Services)**
Responsible Director:	**Sara Tough Executive Director of Children's Services**

Introduction from Cabinet Member

This paper provides an overview of the Children's Services Transformation programme. It is provided to ensure the Committee are sighted on the breadth and depth of this work, can see the impact to date and steer the future direction over the longer term.

Executive Summary

Norfolk County Council's Children's Services has established a major programme of transformational change, known as the Safer Children and Resilient Families (SCARF) Programme. The Programme aims to create a sustainable model of over the long term, reducing pressure on demand-led budgets. It takes a whole-system approach where need is met earlier and more effectively, improving outcomes for families before statutory intervention is required.

The programme of work was established in 2018 and has now developed a significant track record of success across several areas of work. In particular;

- The new 'front door' model has been real success – we are now providing the right response to families first time and we have reduced unnecessary referrals to our teams
- We are now supporting more families to stay together through effective intervention – the number of children in care is reducing month on month
- We are changing the mix of placements of children in care – reducing the reliance on external agencies and residential settings

However, we are still only about 18 months into a 5-year programme, there is a significant distance still to travel and the pressure on Children's Services finances remains. Priorities looking ahead include the delivery of a major partnership transformation of the children's mental health system, the creation of a new model of inclusion for children with special educational needs and implementation of the 'No Wrong Door' Model for adolescents with complex needs.

Actions required

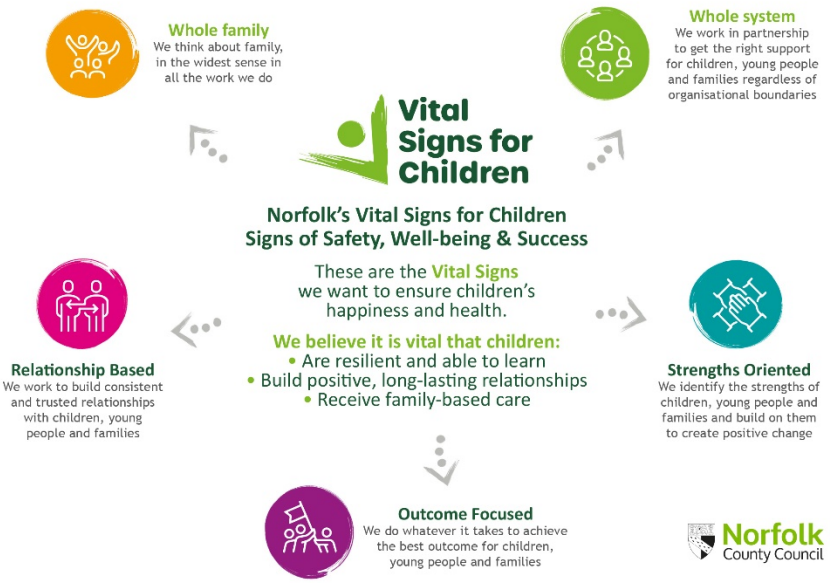
It is recommended that the Committee note the contents of the report and provide comments to steer the direction of the work.

1. Background and Purpose

1.1. Children's Services in Norfolk continue to operate in a challenging context. As is the case for almost all local authorities, we are experiencing high and increasing levels of need across numerous areas of service and, in particular, in relation to children with special educational needs and children at risk of harm.

1.2. Although this is a challenging context, Norfolk County Council and its Children's Services are responding in a bold, positive and ambitious way. That began with the launch of the Norfolk Futures Transformation programme in the summer of 2017 and in particular for Children's Services in September 2017 when the business case for a major investment in transformational change was agreed at Policy and Resources Committee. That high-level business case committed an allocation of £12-15million of up-front investment in Children's Services to enable the development of new service models that can respond to the changing needs in communities and allow us to continue to achieve positive outcomes for children and families. During 2018 the Safer Children and Resilient Families (SCARF) Transformation Programme and team to support the implementation was established.

1.3. Children's Service has developed a clear direction of travel for the department through our Vital Signs for Children vision:



This articulates the practice model we want to embed and sets out five key principles for practice which guide how we want to work across the operating model and our transformation agenda.

1.4. The original case for change is outlined below:

- To create a sustainable model of over the long term, reducing pressure on demand-led budgets
- Develop a whole system where need is met earlier and more effectively, improving outcomes for families before statutory intervention is required
- To enable more direct work with families
- Changing our placement mix for children in our care to better meet need, to be more local and to be more cost effective
- To address increasing unit costs through smarter commissioning
- Creating the right education provision for children with special education needs
- Promote inclusion and increase the proportion of children educated in mainstream schools rather than specialist settings

1.5. The formal targets for the Programme, agreed via the Norfolk Futures Steering Group are currently:

a) Reduce the number of referrals in to social work teams to 6650 and the number of social work assessments to 6451 completed per year **by 2021/22**

b) Reduce children in care rate per 10k to 62.5 **by 2021/22** (equivalent to 1111 Children in Care)

c) To change the mix of placement for children in care, reducing the number of children living in residential care (to 85 children), external semi-independent provision and independent fostering (to 340 children) and increase the number of in-house fostering placements (to 519 children) **by 2021/22**

d) To achieve total in year savings (net of demographic growth) of £7.430m by 2021/22 as per the current Medium-Term Plan; current budget planning assumptions projects a total of £14.1m **by 2023/24**

e) To increase the % of EHCP's completed within the 20-week timescale to 88% **by Nov 2020**

2. Transformation Approach

2.1. The overarching ambition for the programme is described as supporting 'Safer Children, and Resilient Families'. At its heart the programme is about identifying the children and families who need extra help as quickly as possible and working alongside them to build their resilience to challenges – so that, ultimately, they can achieve positive outcomes without the need for lots of ongoing involvement from the local authority. It's a strengths-based early intervention model which aims reduce the number of children and families whose needs escalate to the point of crisis or the point at which they require high cost interventions or full-time local authority care. This kind of successful preventative and early intervention work can achieve better

outcomes for children, families and communities whilst simultaneously reducing the costs to the County Council.

2.2. Alongside the focus on effective early intervention we are also delivering a number of major change initiatives aimed at transforming the provision we make for the children and young people who do need to come into local authority care or require specialist education support. Rather than relying only on the traditional placement models that the market provide we are instead taking a much more proactive approach – investing in our own provision, developing new types of care arrangement and putting much more creative packages of support in place for our children and young people.

2.3. We want to create a coherent model, with all of our proposals and innovations aligned to this overarching vision and direction and so we have developed a number of strategic themes under which to drive our work. The figure below provides a high-level overview.

Fig 1 - Overview of Themes and Projects in Children's Services Transformation Programme

Inclusion

- Investing in Specialist Resource Bases
- Additional direct inclusion work
- Increasing the proportion of children with SEN who are supported to stay in mainstream settings
- Investing in independence – enabled by technology

Prevention and Early Intervention

- Transformed model at the front door enabling more demand to be managed preventatively and the social work teams to focus only on appropriate cases
- Enhancing Early Help – with a focus on building capacity in the partnership system

Effective Practice Model

- Creating a new multi-disciplinary social work model
- Driving quality interventions through signs of safety and restorative practice
- New case discussion meetings deploying resources earlier rather than at the point of crisis
- Wrapping specialist help around practitioner plans e.g. substance misuse, mental health and domestic abuse

Edge of Care Support and Alternatives to Care

- New therapeutic service for families with children at the edge of care (SIB)
- Turnaround short breaks alternatives to care provision
- A focus on family finding and building support networks from extended families

Managing the care market & creating the capacity we need

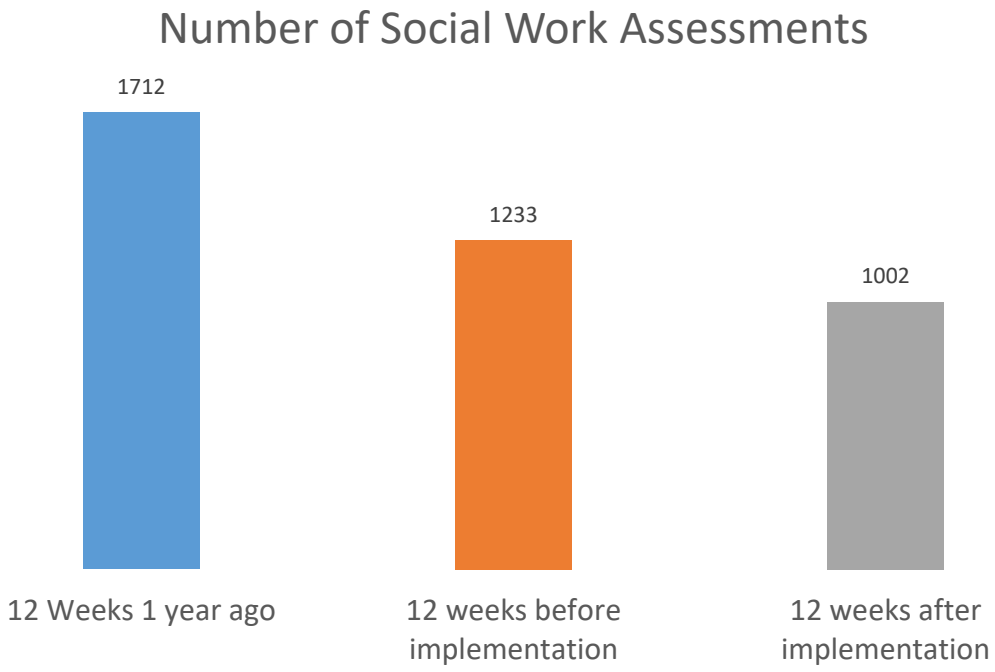
- Step-change investment in Special Schools
- Creating high-quality semi-independent provision
- Family Values - using behavioural science to redesign our approach to recruiting foster carers
- Enhanced fostering model – building a network of capacity around foster carers to work with higher needs
- Valuing Care Model – robust needs analysis and outcome-based commissioning of care

2.4. The transformation programme will impact on each area of Children's Services, on how we work with families, with each other within the Council and with our Partners. As part of this work we will be reshaping our policies and approaches to reflect our changed principles and ways of working. For example, last July we discussed the new "No Wrong Door" to transform the way we approach working with young people on the edge of care as well as those who become accommodated.

3. Impact to date of transformation

3.1. We are now starting to see the impact of the transformation programme against the targets agreed by the Norfolk Futures Steering Group. This section will outline some of the high-level impacts against our original targets.

3.2. **Getting the "front door" right -** We deliberately prioritised and focused on the front door to Children's Services as the first building block of the transformed system. In October 2018 we launched a new model for the Children's Advice and Duty Service with a highly experienced team of social workers fielding call from professionals and probing the issues to identify the level and nature of needs and to ensure the right response if provided first time. This has been a big step forward from the previous approach based on written referrals which frequently led to unnecessary referrals and assessments, particularly by social work teams. Since the new model has been introduced the number of assessments being completed has fallen significantly and our social work teams report they are now "doing the right work". This has been sustained in the 15 months since the new service went live.



The new model was inspected by Ofsted in October 2019 and received glowing feedback – that positive external endorsement was really gratifying and gives us further confidence in our capacity to deliver transformational change which achieves quality and outcomes. Feedback from Ofsted included:

- “Since the previous inspection ……..the front door has been transformed”
- “The children’s advice and duty service (CADS) has significantly improved the way in which information is shared, analysed and recorded at the first point of contact”
- “With appropriate checks and balances, and effective leadership and management oversight, staff in the CADS work well together to identify the kind of help and protection that children and families need.”
- “The quality of decision-making is consistently strong. Throughput is timely.”

3.3. The number of children in care is falling overall

At the core of the transformation agenda is our aspiration to support families to stay together wherever possible – thereby reducing the number of children in local authority care. Numbers of children entering and in care had been rising steadily over several years – but now we are seeing that trend reverse as our new operating model and ways of working take effect.

This graph shows the number of children that are looked after by Norfolk County Council. The overall figure is broken down to reflect the of Unaccompanied Asylum Seeking Children (UASC) as part of the national protocol to support these young people. Our aim is to keep more families together and we are targeting looking after 1139 children (exc. UASC) by March 2020.

We attribute this initial success to several factors

- The new social care operating model which is delivering higher quality relationship-based practice
- The reduced level of referrals meaning teams are able to work each case more effectively
- A strengthen process at the ‘edge of care’ with greater exploration of alternatives to care
- The new family networking model starting to embed – with teams bringing extended family members into their thinking and empowering families to support themselves

3.4. Moving towards in-county, in-house, family-based care

These graphs demonstrate how we are changing how we meet the needs of children in care. As part of our Family Values we are using behavioural insight to re-shape our recruitment and support strategy, to dramatically increase the number of enquires and then convert these to more carers with equal focus on retention, support and use of existing carers to drive availability of placements. The graph above highlights how we are reducing our reliance on the external market driving improved outcomes for children and contributing to reducing our expenditure.

The graph is showing an overall reduction in the number of children placed in residential accommodation. We have seen a positive impact from semi-independent and enhanced fostering projects contributing to this reduction, as well as the impact of fewer children coming into care. However, we do have concerns about individual placements where children have complex needs and we do not have sufficient placements in Norfolk. We are exploring how we can increase our sufficiency for this cohort by looking to build solo / dual placement homes.

3.5. Creating a new alliance between Children's Services and mental health services in Norfolk

Children's Services is a key partner in the Children and Young People's Mental Health Service's transformation of the existing CAMHS services, which will create a system based on the THRIVE framework, a nationally-recognised best practice approach.

In order to improve outcomes for children, young people and young adults, the system needs to change how it currently delivers services. Instead of moving the child or young person around the system, we aim to move the system around the child. There is an opportunity to reshape how statutory and early intervention

services work together to reduce inefficiencies, increase the contact time spent supporting children, young people and young adults, improve access and choice of services, improve transition and develop new and improved ways of working between partners.

The THRIVE framework provides a set of principles for creating coherent and resource-efficient communities of mental health and wellbeing support for children, young people and families. It uses common language that everyone understands, and is need-led as defined by children, young people and families, alongside professionals through shared decision making. It will function as a single service, delivered by a core partnership of providers.

The focus of the transformation is to increase efficiency in order to cope with the expected increase in demand, alongside a shift in focus to prevention, early intervention and shared system outcomes and resource. This shift will help us achieve far better outcomes for children, young people, young adults and families, which remains our highest priority.

In the future, the new service model should meet the needs of looked after children, as it will for other children and young people. However, we need to work together to design points of integration and joint working for the future, including more thinking at senior level. We also need to identify all possible sources of shared system resource to achieve the best outcomes for children looked after.

In order to support the development of integrated services, we have appointed a new Joint Director post with the Clinical Commissioning Group, which will focus on integrated commissioning and service design for children and young people.

4. Financial Implications

4.1. The transformation has proved successful during the last 18 months, with savings delivered in 18/19 of £0.6m (full year effect £0.9m), anticipated for 19/20 at £3.2m, and forecast for 20/21 at £5.1m.

4.2. However, the overall financial position for CS remains difficult, with the significant overspend forecast for 19/20 due to additional pressures, despite the impact of the transformation programme. If the transformation programme had not been in place and having an effect, we expect that the department would be now forecasting a significantly higher overspend.

4.3. Despite ongoing demand and increasing complexity of need there has been a sustained reduction in children looked after numbers this year, which has driven a sustained reduction in annualised children looked after placement costs as a result of volume.

4.4. Financial pressures remain due to the legacy costs of previous years' increase in demand, the flow of young people with complex needs leaving care and becoming care leavers, and the societal changes and challenges (particularly for vulnerable adolescents and contextual safeguarding)

5. Looking ahead

5.1. As part of strengthening our edge of care offer to support children and young people to stay with their families the No Wrong Door Model (which we are introducing as part of the national DfE Strengthening Families & Protecting Children Programme) developed by North Yorkshire County Council will be adopted by NCC. The No Wrong Door Model aligns perfectly with our Vital Signs Vision and will allow us to deliver for the young people with the most complex needs. We also see the No Wrong Door culture influencing practice well beyond the residential hubs at the core of the model.

5.2. No Wrong Door is a non-traditional approach to working with adolescents experiencing complex journeys – with an innovative residential 'Hub' at the heart of the service. It will lead to systemic change across the whole of Children's Services. Norfolk County Council entered the No Wrong Door programme in January 2020 and we are working to enable the first young people to be supported by the new hubs by November 2020.

No Wrong Door will provide:

- short term placements and edge of care support (in and out of care);
- a range of services, support and accommodation options;
- embedded specialist roles working together (shared practice framework);
- an integrated service with a defined culture and practice model;
- an integrated team that 'sticks with' young people on their journey.

And it will support us to make a significant difference for vulnerable young people, including:

- Reduced risk of exploitation and reduced number of missing episodes;
- Improved emotional and mental wellbeing;
- Reduction in family breakdown;
- Improvement in the young person's life prospects and ambition for the future;
- Safer communities.

5.3. As part of our overall offer for vulnerable adolescents, the No Wrong Door Model (described above) will play a large part in reshaping how we support some young people who fall within this cohort. Over and above this we are also exploring how we can complement the No Wrong Door Model through an enhanced offer that helps to support young people at risk of extra familial harm and exploitation.

The outcomes we are looking to achieve are:

- Reduced risk of exploitation and reduced number of missing episodes
- Improved emotional and mental wellbeing
- Reduction in family breakdown
- Improvement in young person's life prospects and ambition for the future
- Safer communities

This work is currently in the design phase.

6. Actions required

6.1. 1. It is recommended that the Committee note the contents of the report and provide comments to steer the direction of the work.

7. Background Papers

7.1. The original business case for this Transformation Programme was agreed at Policy and Resources Committee in September 2017. The papers are available here

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People and Communities Select Committee

Item No. 8

Report title:	**Review of NCH&C and NCC Section 75 Agreement for Community Services**
Date of meeting:	**13 March 2020**
Responsible Cabinet Member:	**Councillor Bill Borrett - Cabinet Member for Adult Social Care, Public Health and Prevention**
Responsible Director:	**James Bullion – Executive Director of Adult Social Services**

Foreword and Executive Summary

A recent paper by the health think tank The King's Fund entitled "Leading for integrated Care" has as its strapline "If you think that competition is hard, you should try collaboration" and maybe it should be added "and if you think that's harder, try integration". Over the last five years the roles of the Assistant Directors and Heads of Service in the S75 service have been tough: managing teams from different professional backgrounds; reporting into two separate organisations with completely different cultures, drivers and processes; against a backdrop of national austerity and funding pressures; in an environment where demand for health and social care services has been steadily increasing. Although this report concludes with a range of recommendations for improvement, it should not be forgotten that significant progress has been made over the five years that the integration management arrangements for social care and community health have been in place.

The infrastructure for supporting services covered by the S75 has not been without its difficulties. Staff have had to live with frustrations of IT firewalls and failure to resolve conflicting estate and other organisational policies, meaning that they have needed to operate duplicate policies. Moreover, during the five years, Norfolk County Council (NCC) adult social care ASCOF indicators have worsened compared to other areas. Yet consultation evidence shows that the care experience for patients/ service users has improved through better join-up and this must be an overriding consideration.

Looking forward, if Norfolk is going to deliver on the national aspiration to shift the focus of health policy away from acute hospitals, there's a broad consensus that good quality and well-targeted community health and social services are required. The ambition of the integrated service must be centred on preventative community services that keep people living independently at home, yet it seems unlikely in the current climate we'll be able to shift from the reactive approach centred on managing delayed transfers of care (DToC) from hospitals. This focus on the immediate needs of acute care is probably the main reason why the balance of the teams' work has been on health rather than social care and this must be addressed.

Yet the changes provided by the NHS Long Term Plan provide some cause for optimism. The combination of a new strategic approach at a Norfolk and Waveney system level, with a new single health Clinical Commissioning Group (CCG) and development of 17 "neighbourhood" primary care networks, should in time change the health and social care landscape and offers the prospect of much greater emphasis on person-centred care in the community. This is why it's been agreed that NCC and Norfolk Community Health & Care (NCH&C) put on hold any major structural changes to the current S75 agreement until it's clearer how the local

arrangements will play out. Alliances may involve new partners in different types of partnerships, in which the needs of patients/ service users are put centre stage. The experience of the S75 arrangements will mean that both organisations are well placed to understand the benefits and difficulties of this type of approach. Until then, consideration should be given to implementation of the recommendations included in Section 4 of Appendix 1, based on the experiences of those closest to the service.

Recommendations
The review concludes that the current integration operational arrangements for community health and social care are the most appropriate model for the service delivery. Principally, this is because closer working under a single management structure provides better support for patients and service users. For example, there can be no attempts made to hand-off responsibility from one organisation to another.

There are a number of improvements that can and should be made to the integrated services. Many of these relate to more joined up support services of the two organisations, including estates, IT and HR processes. Plans are already in place to make on taking forward further integration. Other improvements relate to capacity of the senior team. It is envisaged that the new staffing structure now being implemented will largely resolve these, in particular it will allow the new Locality Operations Directors scope to become more engaged in locality strategic planning with other health partners.

A new three plus two-year S75 contract with NCH&C is proposed commencing in October 2020, with sufficient flexibility included to allow other provider partners to join the arrangement during its course.

Actions required:

a) Committee is asked to consider and discuss the recommendations contained in Section 4 of Appendix 1, including the proposal to enter into a new long-term contractual arrangement with NCH&C

1. Background and Purpose

1.1. The NHSE Long Term Plan (LTP) envisages fundamental changes in the way that the NHS works. This includes development of Integrated Care Systems from Sustainability and Transformation Partnerships (STPs), which for Norfolk will be based on a Norfolk and Waveney footprint. GP practices are already working more closely together in new Primary Care Networks and the five Norfolk (CCGs) are merging into a single Norfolk and Waveney CCG, with legacy Local Delivery Groups based on the geography of the former CCGs. There is an underlying assumption in the LTP and locally that social care will be fully engaged in these system-wide changes at a strategic and operational level. It is within this context that the future of the integrated operational community health and social care service has taken place and that views of the committee are sought.

2. Proposals

2.1. The proposals are included in Appendix 1.

3. Impact of the Proposal

3.1. Implementation will ensure that the integrated arrangements between NCC and NCH&C remain focused on providing high quality services to patients and service users in the context of changing health system structures and processes. A number of

recommendations have been made aimed at ensuring that integration and effectiveness will be enhanced.

4. Evidence and Reasons for Decision

4.1. These are provided in the Appendix 1. Consultation has been undertaken with patients/ services users, operational staff and the senior managers engaged in providing services, directors and other key stakeholders of both organisations and health commissioners.

5. Alternative Options

5.1. Alternative options were explored as part of the review, which included research undertaken of good practice models elsewhere. An outline of these is provided in Section 3 of Appendix 1.

6. Financial Implications

6.1. None relating to the staffing restructure other than those referred to in the resourcing section below.

7. Resource Implications

7.1. **Staff:**

7.1.1 A delivery plan will be required which will have set out resource implications, once final recommendations have been agreed. Additional resource will be needed should proposals on developing a more robust performance management framework be agreed. Project Manager resource will be required to take forward many other of the recommendations.

7.2. **Property:**

7.2.1 Co-location is considered important in assisting better integration. NCC and NCH&C staff are already meeting to discuss some of the impediments that have inhibited this over the previous six years.

7.3. **IT:**

7.3.1 Staff of both organisations are meeting to develop greater interoperability of IT systems.

8. Other Implications

8.1. **Legal Implications:**

8.1.1 None at present, though there will be legal implications when the current agreement ends in September 2020, depending on whether additional partners are involved or likely to become so during the course of a future agreement.

8.2. **Human Rights implications**

8.2.1 None identified

8.3. **Equality Impact Assessment (EqIA) (this must be included)**

8.3.1 None identified,

8.4. **Health and Safety implications** (where appropriate)

8.4.1 None identified

8.5. **Sustainability implications** (where appropriate)

8.5.1 None identified

8.6. **Any other implications**

8.7. None identified

9. Risk Implications/Assessment

9.1. The option recommended in the review focuses on developing the existing service model and consequently risks associated with this approach should be minimal. The Joint Monitoring Board of NCC and NCH&C which oversees the operation of the S75 agreement will meet more frequently to discuss progress on agreed developments.

10. Action required

10.1. **a) Committee is asked to consider and discuss the review outcomes contained in Section 4 of Appendix 1, including the proposal to enter into a new long-term contractual arrangement with NCH&C**

11. Background Papers

11.1. NHSE Long Term Plan

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Review of NCH&C and NCC Section 75 Agreement for Community Services

Foreword and Executive Summary

A recent paper by the health think tank The King's Fund entitled "Leading for integrated Care" has as its strapline "If you think that competition is hard, you should try collaboration" and maybe it should be added "and if you think that's harder, try integration". Over the last five years the roles of the Assistant Directors and Heads of Service in the S75 service have been tough: managing teams from different professional backgrounds; reporting into two separate organisations with completely different cultures, drivers and processes; against a backdrop of national austerity and funding pressures; in an environment where demand for health and social care services has been steadily increasing. Although this report concludes with a range of recommendations for improvement, it should not be forgotten that significant progress has been made over the five years that the integration management arrangements for social care and community health have been in place.

The infrastructure for supporting services covered by the S75 has not been without its difficulties. Staff have had to live with frustrations of IT firewalls and failure to resolve conflicting estate and other organisational policies, meaning that they have needed to operate duplicate policies. Moreover, during the five years, NCC adult social care ASCOF indicators have worsened compared to other areas. Yet consultation evidence shows that the care experience for patients/ service users has improved through better join-up and this must be an overriding consideration.

Looking forward, if Norfolk is going to deliver on the national aspiration to shift the focus of health policy away from acute hospitals, there's a broad consensus that good quality and well-targeted community health and social services are required. The ambition of the integrated service must be centred on preventative community services that keep people living independently at home, yet it seems unlikely in the current climate we'll be able to shift from the reactive approach centred on managing delayed transfers of care (DToC) from hospitals. This focus on the immediate needs of acute care is probably the main reason why the balance of the teams' work has been on health rather than social care and this must be addressed.

Yet the changes provided by the NHS Long Term Plan provide some cause for optimism. The combination of a new strategic approach at a Norfolk and Waveney system level, with a new single health CCG and development of 17 "neighbourhood" primary care networks, should in time change the health and social care landscape and offers the prospect of much greater emphasis on person-centred care in the community. This is why it's been agreed that NCC and NCH&C put on hold any major structural changes to the current S75 agreement until it's clearer how the local arrangements will play out. Alliances may involve new partners in different types of partnerships, in which the needs of patients/ service users are put centre stage. The experience of the S75 arrangements will mean that both organisations are well placed to understand the benefits and difficulties of this type of approach. Until then, consideration should be given to implementation of the recommendations included in Section 4 of this report, based on the experiences of those closest to the service.

1 Introduction

1.1 The Service

A five-year arrangement to integrate the senior management structures of Norfolk Community Health and Care (NCH&C) community health and Norfolk County Council (NCC) social work operational teams was established in October 2014. This legal arrangement is contained in an agreement set up in accordance with Section 75 of the NHS Act 2006, hereafter referred to as the "S75". So far as we are aware, this remains a unique integrated

arrangement described by the Executive Director of Adult Social Services as “Norfolk’s best kept secret”. The agreement has been extended for a further year until 30 September 2020 to allow for a review of the arrangements and to determine what changes are needed to improve services based on the five-year experience of working with an integrated management structure and local changes being driven by national policy.

The S75 agreement covers a wide range of services. The NCH&C community health and NCC adult social care services are structured to be coterminous with the geographic areas covered by the four Clinical Commissioning groups North, Norwich, South and West. The intention at inception was to appoint one integrated Assistant Director (AD) and one Head of Service (HoS) in each locality reporting to a Director and Deputy Director i.e. integration is at the most senior operational level only. The S75 and staff establishment provides for an AD and a HoS for each of these four areas, with a health professional in one post and a social care professional in the other, balanced to ensure two of each for both organisations. There was too, a stated intention to consider further integration of staff at lower levels in the structure, to pool locality resources and to operate in an integrated way.

For reasons outlined above, the integrated management structure originally envisaged under the S75, did not proceed much beyond these original arrangements and instead an opportunistic, pragmatic approach was taken rather than wholescale change.

1.2 Drivers for Change

The publication by NHS England (NHSE) of the NHS 10 Long Term Plan (LTP) introduces wide-ranging changes that are already having significant implications for the way the local health system operates. The five Norfolk and Waveney Clinical Commissioning Groups (CCGs) are combining to form a single CCG, though their former boundaries will continue to be the focus for health planning in the form of Local Delivery Groups (LDGs). The Norfolk and Waveney Sustainable and Transformation Partnership (STP) is accelerating its action programmes with an aspiration to become an Integrated Care System (ICS) and newly established Primary Care Networks (PCNs) are developing quickly. The new Government plans to legislate to enshrine these arrangements though in practice implementation is well advanced. It will be important that community health and social work services locally can respond flexibly to these new local commissioning requirements.

At the time of writing, the national picture on social care remains unclear. One of the first statements of the Prime Minister when he came into office, was that he would scrap plans to produce the long-promised green paper on social care and intended instead to accelerate matters by producing a white paper. Since the general election, the Minister for Health and Social Care has announced plans to engage in cross-party discussions and representative groups and to finalise an agreed policy by the end of the current parliament.

1.3 Review Scope

This service review looks at how well the integrated service has performed over the last five years, whether it has succeeded in meeting the expected outcomes stated when the S75 was established and how it has tackled other issues that have arisen over the period of the agreement. It looks forward to how services could be arranged in future: the degree of integration between community health and social care that can provide the most effective services; the fitness for purpose in the context of LTP expectations and those of local commissioners; and what we could implement locally from learning how services have been integrated in other areas of the country. Finally, it will provide options and recommendations for local integration moving forwards.

It’s important to remember that integration shouldn’t become an end in itself. It should be pursued to achieve clearly identified outcomes and the benefits should be tangible. For example, clearly, it’s beneficial if integration delivers efficiencies, particularly at a time when health and social care budgets are stretched, and these are relatively easy to measure.

However, at least as important, should be that it provides improvement to how people experience services at a time when they need care and support and these outcomes are more difficult to discern. This is articulated well in a recent Care Quality Commission report:

> *"Older people often need to move between different kinds of care. When they do, all services involved in their care have a role in keeping them safe and helping them move smoothly between different aspects of their care – so they must work together."* CQC: Beyond Barriers: How older people move between health and social care in England July 2018

The Social Care Institute of Excellence (SCIE) has produced a "Logic Model for Integrated Care" and this provides a useful reference point particularly for evaluating outcomes, but also for its identification of "enablers" and integration and "components of integrated care".

1.4 Informing the Review

Interviews or surveys were undertaken with four groups of stakeholders: Patients and Service users; staff working in the integrated service; integrated Assistant Directors (ADs) and Heads of Service (HoS) and other senior staff. All people who were involved were told that their views would be anonymised. A review of literature and conversations with people working in areas of designated good practice was also undertaken.

1.4.1 Patient and Service User Interviews

Nine patients/ service users who had recently received a health and a social care service were interviewed at length. They were not necessarily aware, or are unable to recall, which organisation, team or services provide their support, care or treatment. A positive experience of integrated working may not be understood as such by those who receive care, support or treatment.

"*[I] knew some staff were health and some were social care as [they] have different colour coats but it didn't matter to me – they talked to each other and gave me what I needed which were the important things". Patient/ Service user interviewee*

The questions were designed to test whether the SCIE Logic Model ambitions for 'peoples experience' were being achieved:

- **SCIE outcome 1 (living as full a life as possible):** Service users / patients reported physical (e.g. greater mobility) and mental (e.g. increased wellbeing) improvements to their lives after care, support or treatment
- **SCIE outcome 2 (information access and use):** Service users / patients were satisfied with the information provided: workers' details for future contact were routinely provided
- **SCIE outcome 3 (participation in decision making):** All interviewees said they (or their family members / carers) were involved in deciding what care was required and they felt listened to although some repetition of 'telling their story' more than once was noted
- **SCIE outcome 4 (knowing what happens next):** Awareness of plans for subsequent stages of care, support or treatment were mixed
- **SCIE outcome 5 (range of support):** The majority of interviewees felt they had access to support which enabled them to live the life they wanted but some unmet need remained
- **SCIE outcome 6 (carers feel supported):** Although assessing this outcome was not part of the original remit, one carer was interviewed. The carer felt she had sufficient information and felt supported, she also had confidence in staff who listened and included her and her husband's views when developing plans: however, she did have to repeat

information about her husband to staff. One interviewee requested support for his wife who was feeling isolated in her caring role

1.4.2 Staff Survey

A previous largely positive survey was undertaken in 2015. Staff working in integrated environments were asked to complete a survey comprising a limited number of largely free format questions. This was to aid understanding of whether working for integrated senior staff employed by different organisations and from different professional backgrounds helped or hindered their work. They were also asked to provide their views on how improvements could be made. There were 73 respondents, with over half based in the Norwich locality. The key findings are:

- Staff see many benefits of integrated working to patients / service users and also professionally: there is widespread understanding of the benefits of working closely with colleagues in health and / or social care
- Integrated senior managers are generally seen as positive because of their overview of NCC and NCH&C, but there is also concern about the ability (and availability) of integrated senior managers with a health background to advise social care professionals and vice versa
- Over half of respondents said having an integrated senior manager has no impact on their performance
- The main benefits of integrated working to service users / patients are cited as a more 'person focused' approach because of better information sharing and a reduction in the number of times the patient / service user needs to 'tell their story' to professionals
- Co-location is perceived as a (potentially) positive way of promoting integrated working by breaking down professional barriers, encouraging productive working relationships and making it easier to share information, but practical issues of noise levels and space, and organisational and/or cultural issues mean that the full range of benefits are not yet realised
- A mix of positive and negative effects of the current arrangement of having a co-located team under an integrated manager (compared to working in a co-located team with separate health and social care managers) were expressed but no clear preference emerged

1.4.3 Examples of Good Practice

A literature search was undertaken to examine how other community health and social care services have been integrated and particularly to examine good practice being carried out elsewhere. In some cases, conversations were held with senior staff in other organisations to better understand their best practice, local relationships or to gain more detail about their ways of working.

2 Evaluating the Section 75 Agreement

2.1 Expected Outcomes

The S75 articulates the outcomes expected after five years and achievement of these expectations is evaluated below:

Outcomes	Comments
Collocation of health and social care teams	Teams have been collocated wherever possible, but the lack of a joined-up estates strategy and IT compatibility have hindered full collocation of teams. Operational staff of organisations continue to strive to collocate, as it's considered that this adds significant benefit.
Creation of a joint senior management structure to ensure a single approach across both organisations	Achieved.
Engagement in multi-disciplinary teams (MDTs) discussing cases with GPs at their practices	A recent audit demonstrated that MDTs are held in almost every surgery. However, the quality, success and frequency of these varies and so there is now work being undertaken on a best practice document which it is hoped will drive up standards. Implementation will require GP buy-in.
Further development of Integrated Care Liaison officer roles - now called Integrated Care Co-ordinators (ICC)	The number of ICCs varies by locality, but has expanded, particularly recently to 32, including two supervisors. They have proved popular with surgeries and, as the expansion of ICCs has been funded largely by CCGs, their future roles are likely to be guided by GPs. In Norwich, dedicated ICCs are now working in the Norfolk and Norwich University Hospital (NNUH) and in North Norfolk and Norwich in the Norfolk Emergency Admissions Teams (NEATs). There is disparity between localities in the way that ICCs operate and again, work is being undertaken to understand and promote best practice.
Ability for all staff to view health and social care records, with use of NHS number. Both organisations will work towards greater sharing of information between them	NCC had previously explored commissioning of joint software for Learning Disability teams and it had proved unsuccessful. Both NCC and NCH&C systems were re-procured early into the S75 period, but both organisations declined to move to the same system as their needs were very different and because it would have proved overly expensive. Consequently, the ambition for the S75 was tempered and instead there developed a mantra that staff should not have to record information more than once, through having access to each other's systems. Access to both systems, but not single recording, has been achieved. Similarly, each organisation has its own email and calendar system and the capability for staff to view those of the other organisation to has been sporadic. This has proved problematic and a major cause of frustration. This was mentioned by almost all those interviewed. More recently, sharing of calendars has been achieved. A Data Sharing Agreement is renewed every year.

Development of shared protocols for ICT, referral process and case management, complaints, health and safety & operational management for joint teams	Despite best efforts, there has been little progress in achieving development of the protocols. This is a source of frustration for managers – one interviewee noted that they needed to be able to follow two different complaint procedures. The most notable achievements are implementation of a common approach to appraisal and establishment of a recruitment and selection protocol, though in both cases there are separate formats.
Performance indicators against a 'balanced scorecard' of: • Number of non-elective admissions to acute hospitals • Number of delayed transfers of care • Number of care home admissions • Percentage of people receiving reablement not readmitted to hospital after 91 days.	These are the mandatory Better Care Fund indicators and there has been no regular use of these in evaluating how the S75 has performed. These were intended as a stop-gap solution, chosen pending development of an intended performance management agreement, as they are readily available statistics.

2.2 Key Elements

There are key ambitions stated in the S75 agreement and an assessment of these is provided in the table below:

Partners intend to develop the integrated management structure to encompass further parts of the staffing structure of both partners	It was intended to move quickly to integrate further management tiers starting with team managers. However, a decision was taken not proceed from Head of Service to Team Manager level. The main reasons were the unprecedented overspend in the adult social care budget with an associated overriding corporate need for NCC to focus on that and similarly the difficulties NCH&C experienced year on year in achieving its Cost Improvement Programme (CIP) requirements, resulting in staff reductions and thus capacity to innovate. Simultaneously, the national integration model demonstrated that integration does not produce savings, providing less of an incentive to make changes. For these and other reasons, proposals were put on hold, and so no changes were made to the teams to allow team managers or clinical operational managers to meaningfully deputise for each other. Later, there became an almost overriding emphasis for teams on alleviating Delayed Transfers of Care (DToCs) from hospitals. Other limited integration has occurred in an almost ad hoc and opportunistic way. There has been previous consideration of combining health and social care occupational therapy teams, but this seems to have foundered because an appropriate team manager

	hasn't been found in the locality and because of opposition from some staff who cite professional accountability as a difficulty. However, an integrated therapy team has been established in the Norwich locality and evidence shows that this is working well. An integrated team is now planned for the South locality. Also, two integrated quality posts have been appointed in West locality and integrated discharge managers have been appointed for NNUH and Queen Elizabeth Hospital (QEH).
A change control process is to be followed for any agreed changes	This procedure has been followed. Any changes go to the S75 Integration Board and then the S75 has been amended accordingly. Five of the changes made relate mainly to posts the agreement already encompasses and to the split of funding for staff i.e. adding people or amending the agreement.
Each partner shall make their premises available, and otherwise make assets available to either partner. Premises and office accommodation will be met by the partner providing the relevant office and are not subject to contributions from the other partner.	This is a laudable ambition but has been difficult to establish and maintain in practice, because of conflict with corporate rules. There are over 100 staff based at the other partner's sites, but there remain ongoing issues for estates. A memorandum of understanding has been in development since 2016 based on the supposition that it's simpler than separate agreements for each site. However, confusion arises every time operational managers wish to move staff. There are further issues for payment of meeting rooms and parking. There is renewed endeavour by the Director of Integration to resolve these difficulties over the coming year.
Each employee will use the ICT equipment of their employing organisation.	This arrangement hasn't always been adhered to. ICT generally has proved to be a real inhibitor to integration, again partly because of adherence to corporate policies that can mitigate against an integrated approach. There is renewed endeavour by the Director of Integration to resolve these difficulties over the coming year.
It is not intended that TUPE or secondment will apply to staffing arrangements	This has been adhered to.
A S75 Board is to meet quarterly to review progress. The Director will submit a monthly report to this Joint Monitoring Board.	The stipulation to hold quarterly meetings was subject of a change control agreement made during 2018. The Joint Monitoring Board (JMB) is now required to meet six-monthly. The Director regularly submits a report to the Board. There is some question about how effective the Monitoring Board has been in managing the contract.
An annual review of the contract is required reporting on: • Performance against aims and outcomes of agreement • Performance of individual services against service levels and other targets	There has been no formal annual review undertaken, though the Director of Integration and Programme Manager reported every quarter on most of the aspects that would have been in an annual report. Greater gravitas was provided when the lead council member for social care and a non-executive member of the NCH&C Board attended JMB meetings, but this arrangement has lapsed. Taken together with the lack of a suite of appropriate indicators to measure

• Plans to address underperformance • Review of plans and performance levels for the next year • Plans to respond to any changes in policy or legislation • Change control enacted within the year.	performance, and the move to six-monthly meetings, this has contributed to a less formal approach to JMB meetings. Regular reports have been made by the Director of Integration to NCC members and NCH&C Board Members.
Staff in the integrated management structure shall be subject to a 50/50 background of health and social care professionals.	This was requirement was adhered for most of the five years. Currently, these arrangements are out of kilter because of temporary appointments and acting up arrangements. This would be rectified under the draft NCH&C proposal, currently out to consultation.
Reporting against the performance framework identified in the S75 Contract as follows: • Budgetary performance • User satisfaction • Carer satisfaction • GP satisfaction • Staff sickness • Staff turnover • Staff satisfaction	The envisaged performance dashboard was developed but lapsed in 2017.

2.3 Issues arising during the course of the contract

A change of focus as the contract has progressed	The focus has changed for various reasons including: the national message changed – the Five Year Forward View (Oct 2014) and the Long Term Plan (Jan 2019); greater emphasis on DToC; new evidence on integration savings (NAO report 2017); new CEO and Exec Director appointed; significant financial challenges in each organisation and the outcome of the NCH&C CQC Inspection report (March 2018).
The scope to make savings from integrated delivery alone	It was demonstrated nationally that creation of integration structures alone is unlikely to produce savings (NAO report 2017). For Norfolk, some staff savings were made in the first two years for both organisations but after that none were achieved. Thereafter, the JMB was content that indirect savings and efficiencies were demonstrated.
The share of time taken by integrated managers in focusing on each organisation's requirements	Most of the Assistant Directors (ADs) and Heads of Service consider that they spend a higher percentage of their time on health-related work than social care related work. There seem to be several reasons for this: the immediacy of many of the health-related challenges; the greater robustness of NCH&C accountability meetings; the wider range of health activity and the greater numbers of health staff are all mentioned as factors.

The financial grasp of managers from each organisation's perspective	There was an internal NCC audit exercise undertaken to test this and it was found that all integrated managers were suitably focused on NCC budgets.
Duplication of governance requirements e.g. performance boards, separate HR systems	This proved to be an issue of concern from the outset and has remained so.
Managing or being managed by staff from a different organisation	The staff survey indicates that this has not proved to be a particular problem.

3. Models of Integration

3.1 Using Learning from Elsewhere

The LTP calls for greater system working and locally this will be arranged on the Norfolk and Waveney footprint. Whatever is agreed by NCC and NCH&C will need to fit in with aspirations of commissioners and other provider organisations. There's wide availability of information on a range of good practice options, including learning from the NHSE funded Vanguard sites, but almost all are based on an underlying premise of greater organisational integration. However, in its 2018 review of 20 case studies, "Beyond Barriers" CQC argues that none of those studied has matured into a joined up integrated system.

On integrating services, The King's Fund states:

> "*There is no single model of provision; the range and configuration of services varies depending on the local population, geography and nature of other local services, and local legacy in terms of how services have developed and evolved."* The King's Fund: Reimagining Services 2018

In addition, the Health Foundation report "The Spread Challenge" identifies the difficulties posed by the "replicability problem" of transferring identified best practice from one area to another. Doing the "same" thing in a new place will not look the same or produce the same outcomes as the original. We also know that apparently successful approaches don't necessarily stand the test of time e.g. Torbay – an approach much heralded ten years ago, but which ultimately bankrupted the social care system. So whilst there is learning to gained from understanding how other systems are being developed, there will be no single "best" model either for system or service integration that can, or should, be used as a blueprint. The arrangements described below in Section 3.4 are theoretical archetypes, with actual examples provided that closely match the description.

3.2 Assessment of Structural Options for Community Services and Social Care

The year-long extension to the S75 has provided NCH&C and NCC time to undertake this review, to better understand the developing approaches at system and PCN levels and to explore prospects of greater engagement with other health providers. NCH&C and NCC are already amending the existing arrangements for senior staff in the S75. This entails the four locality teams being extended to include a Clinical Quality Director (NCH&C funded), an upgraded Locality Operations Director post (replacing the current Assistant Director post) and an additional Head of Service now titled Head of Integrated Care – Primary Care Networks. The post of Deputy Director is to be removed and a new Associate Director for Special Projects (NCH&C funded) included. NCH&C is also in discussion with Norfolk and Suffolk Foundation Trust (NSFT) on developing mutually beneficial closer working relationships, initially on shared support services.

3.3 Forms of Agreement

A Section 75 agreement, legally provided by the NHS Act 2006, delegates the legal responsibility for a function from one authority to another. It is not a contract or service and therefore not a procurable relationship. For NCH&C and NCC the costs of named senior management posts and support costs are shared and a partnership of equal control and accountability to manage delegated functions of both partners has been created. However, there has been no pooling of budgets

Elsewhere, there exist integrated arrangements termed "alliances". These are likely to be another term for one or more contracts for services, with one or more organisations, which could also be consortiums. There also exist "strategic partnerships", or some that are

covered by a memorandum of understanding. These are rarely legally binding and therefore less robust arrangements.

3.4 NCC and NCH&C possible working arrangements

3.4.1 Separate working

Theoretically, both NCC and NCHC could operate in isolation, but all guidance and best practice indicates that this provides fragmented services with poorer outcomes for patients/ service users (e.g. CQC's "Beyond barriers: How older people move between health and social care in England"). A fragmented health and social care system can often mean that staff in one organisation are unfamiliar with the detail of services in another, or that a defensive corporate approach can be adopted to decisions on "hand-off" decisions, particularly at a time when finances and/or performance are under scrutiny.

To implement this in Norfolk would mean disaggregating the existing model. The evidence gathered for this report from patients/ service users, staff and stakeholders demonstrates that benefits of integration, not least for patients/ service users significantly outweigh those of organisations acting separately. Each contribution from different professionals brings value to the outcomes for people. In an integrated structure, there is range of services under single management and so it's more likely that a more holistic care and support solution can be provided. A local senior manager has nowhere to transfer responsibility. "You can't argue with yourself" as one put it. Another pointed out that discussions on delayed transfers of care from acute hospitals to home are very different from those for community hospitals to home, as there is no vested organisational interest involved.

3.4.2 Working alongside each other in an aligned way.

Alignment is the most common way that joined up community health and social care services operates across the country, with the degree of collaboration varying considerably. There are numerous examples of good practice e.g. in NE Hampshire and Farnham and the South Somerset Symphony Programme (both NHSE Vanguards). Closer to home, ECCH works in this way alongside NCC Adult Social Care. A variant of this arrangement is co-location of aligned services e.g the Leeds model described in NHSE & SCIE publication "Better Integration". It's clear that additional benefits of the Norfolk model have accrued where co-location of services has been achieved, so resolving the issues that have prohibited further co-location should be an ambition for future joint working.

3.4.3 Bilateral integration

3.4.3.1 Selective integration

This model would restrict integrated working to those aspects of service where there is a common caseload, rather than more broadly to frailty, and where integration offers most value to service users. This would include collective work to relieve pressures on acute services - urgent care (including NEATs), ICCs, supported care teams, hospital teams, reablement etc. The rationale for adopting this approach would be based on early analysis which showed that there was no significant overlap between caseloads of social care and community nursing. Adopting this model would alleviate NCC concerns about shift in the balance of resources to health. However, in comparison with the Norfolk model, it is difficult to conceive how the management of these integrated services would interface as well with the non-integrated services. Some of the identified benefits of the current integrated approach are based on a single management team holding responsibility for all frail people within a locality and this would be lost.

3.4.3.2 Integration of senior staff (the existing model)

The consultation undertaken indicates that the existing system, unique to Norfolk has proved largely successful. Most staff consider the current model is in the best interest of patients/ service users. One interviewee commented that "the gain has been worth the pain".

However, there have been several impediments to effective working described in Section 2 above, that need to be overcome, principally concerning the supporting infrastructure. Also, the existing structure lacks capacity and it's questionable whether that it will be fit for purpose as new systemwide developments are implemented.

3.4.3.3 Development of the existing model

The NCH&C and NCC restructuring plans provide more senior management capacity by providing an additional Head of Service per locality, relieving pressure on the enhanced Locality Operations Directors, allowing them to develop a more strategic role within their localities. Also, it's clear that the infrastructure difficulties need resolution and the new Director of Integration titled Director of Community Health and Social Care Operations has already put in place a process to progress most aspects of these.

With the changeable environment within which the service is operating, there are clear advantages in adopting a flexible approach to further structural developments - looking for opportunities for further integration where evidenced benefits can be realised e.g. single management of OT services within localities. However, there were good reasons for not pursuing the original intention of progressive integration within the service, so the current principle of integrating only where demonstrable benefits can be realised showed be retained.

There are many more specific suggestions for refining the existing model in Section 4 on recommendations below.

3.4.3.4 Locate services within one organisation

There are several areas where social care staff have been transferred into an NHS community health organisation, including the Wirral Foundation Trust and the Northumberland Accountable Care Organisation Vanguard, where social care is sited within Northumbria Foundation Trust. This was among the rejected options considered by the consultants who made recommendations for setting up the Norfolk service initially. The time and effort needed to transfer staff between organisations is significant (so-called "TUPE arrangements") and so this is not considered to be a viable option.

3.5. Multi-lateral arrangements

The renewed emphasis on system-wide working infers closer future working between the main health and social care provider organisations. Principally for Norfolk, in addition to NCC and NCH&C, this means NSFT and East Coast Community Health (ECCH), though could include Norse, private sector and voluntary sector organisations. As described above, NCH&C has already been working on developing a much closer relationship with NSFT, which ultimately could result in a merger between the two organisations. There are ongoing discussions with the new Primary Care Networks on how NCC and NCH&C services can be flexed to meet their needs, including with a pilot exercise planned in mid-Norfolk.

In Great Yarmouth and Waveney, NCC is working collaboratively with all partners including local councils, East Coast Community Health, the James Paget Hospital, NSFT, the voluntary and independent sectors on an integrated approach. Funding has been obtained for

Stepping Out to develop a business case and options appraisal for possible forms of arrangement to underpin this work. It could range from a mini ICS or public mutual, to use of a memorandum of understanding, with various options in between. It will be helpful to understand how this proposal progresses and well worth considering whether there are elements of this work that could be applied to future collaborations in the rest of Norfolk.

Until the implications of these developments unfold, it would be unwise to agree a new S75 and this is the reason that the existing agreement was extended for an additional year. It may be necessary to extend it beyond September 2020 if system-wide and locality arrangements remain unresolved. Alternatively, a new more flexible arrangement could be agreed which allowed other partners to be included.

4 Recommendations Summary

4.1 Integration model options

1. It is recommended for the present that NCC and NCH&C continue with the current S75 arrangement whilst system-wide needs and requirements are clarified, but this shouldn't preclude some proposed changes. This includes implementation of the new place-based model, with authority delegated to Locality Operations Directors to adapt this to needs of developing PCNs. A clear timetable including all agreed recommendations from this review should be developed. It is considered that the new arrangement should be for three years with an option to extend for a further two
2. New proposals for the S75 must be in line with commissioning aspirations for Norfolk and Waveney and it is recommended that explicit agreement is sought from the newly merged CCG
3. It is implicit that there is a need to work actively with other potential provider partners to understand their intentions for collaborative working
4. There is a need to keep in step, and aligned, with good practice to understand how other areas are tackling increasing expectations of service integration
5. It is recommended that combining the best aspects of both organisations should continue to be actively pursued

4.2 Governance and forms of agreement

1. There is a need to ensure that a flexible partnership arrangement is created so that further changes can be made as needed, to include other partners joining, development of service plans, engagement with PCNs, conflict avoidance, changes resulting from inspection, commissioning or regulation etc
2. A tighter S75 Joint Monitoring Board (JMB) model should be developed with clear lines of responsibility and accountability including bi-monthly meetings, shared metrics and an activity matrix
3. The S75 JMB should ensure commitment of resources to the development of more meaningful performance indicators for the services managed by the integrated management team and development of a single performance board
4. The S75 JMB should ensure a reduction in bureaucracy, so far as due diligence and accountability will permit, by developing a single financial reporting framework
5. More regular meetings of finance managers should be held during each year to discuss and agree integrated team shared costs e.g. clearer invoicing
6. Greater clarity is needed on what services and activities are included in the S75, so that there's a better understanding of portfolios and a basis for rectifying any imbalance

4.3 Infrastructure

1. Clear benefits accrue from co-location of staff and an estates strategy should be developed to further progress this
2. There needs to be corporate commitment to resolve the IT interoperability difficulties
3. There needs to be a proportionate and appropriate response for integrated services to access each other's IT systems, with read-only access available and use governed by Caldicott principles, in the way already established for Integrated Care Co-ordinators
4. Further research should be undertaken e.g. on what was achieved by the NHS Vanguard sites for improved IT systems, and a strategy developed focusing on which new technological ways of working can best support teams working in the community and the acute hospitals
5. It is recommended that NCC and NCH&C become involved in system-wide planning to facilitate achievement of the national aspirations for record sharing
6.

4.4 Processes

1. The Data Sharing Protocol needs to be reviewed and renewed annually as required
2. The JMB should take a view on each of the shared protocols referred to in the S75, based on whether the extra burden caused by duplication of processes is irresolvable and whether existing protocols are irreconcilable
3. HR leads should meet regularly to discuss and agree single processes that are currently duplicated
4. Variations will be required for the Joint Operational Protocol and the financial contributions section of the S75 once the restructuring proposals have been agreed
5. Consideration should be given to extending NCC's e-brokerage sourcing to NCH&C e.g. for Continuing Health Care

4.5 Structure

1. There should be more explicit adherence to the balance of NCH&C / NCC staffing of senior posts
2. A mechanism for oversight of senior staff workload should be devised and established to ensure a balance of development activity, performance and financial management across health and social care
3. There is a need to ensure that there remains a strong social care voice in localities where two of the locality management teams will comprise three health professionals including a clinical quality director and one social care HoS
4. It will be important to ensure that the additional Head of Integrated Care post in each locality doesn't result in a diminution of integration, with each within a locality reverting to their professional discipline
5. It would be advisable to keep the proposed abolition of the deputy director role under review, as this post was not included in the original structure, but was subsequently needed, both to reduce pressure on the director and to aid professional balance within the structure

4.6 Development of future initiatives

The following initiatives should be worked up as outcome requirements for the S75 work programme.

4.6.1 Working with Primary Care Networks

1. Time-focused "huddle working" should be considered as a mode of operation in primary care either with a practice or PCN focus
2. Consideration should be given to enhancing the role of ICCs and increasing their numbers
3. It's recommended that NCC's capacity to comply with Care Act requirements will be considered alongside the social care offer to PCNs
4. It is recommended that there should be a direct referral route for professionals working in the community to draw on specialist mental health and learning difficulty support
5. The Home First initiative should comply fully with the Primary Care Home model, developed National Association of Primary Care (NAPC) and endorsed by NHSE

4.6.2 MDTs

1. For social care there is a need to assess capacity to determine how to resource expected requests for PCN focused service delivery and options are being tested in various parts of the county. There are several initiatives planned that should assist
2. At present social workers can sit through a long MDT in order to comment on a single case. Social workers should be integral members of MDTs and there to provide guidance and insights across the social care spectrum
3. More integrated MDT working on wards should be a focus for acute hospital working, along the lines of the South Tyneside Vanguard model. There should be earlier

engagement and involvement of social workers in the patient journey through the acute system to enable them to focus on better outcomes and earlier discharge

4.6.3 Enhanced integration of community health and social care

1. It is recommended that the integrated OT model in Norwich is extended to Southern locality, with an ambition for West and North localities to follow suit
2. Consideration should be given to exploring whether there are elements of the Suffolk REACT model that might be used to further improve the NEAT model
3. It is recommended that an evaluation is undertaken of Supported Care and Community FICS (Fully Integrated Care and Support) to determine the effectiveness of each service
4. It will be advisable to keep abreast of the different ways of community health and social care working in East Norfolk

4.6.4 Engagement

1. It is recommended that NCH&C and NCC further their efforts to engage with the VCSE (Voluntary Community and Social Enterprise Sector) and review progress on the work of Community Catalysts pilot locally
2. It is recommended that there is greater collaboration on best practice for engaging with Healthwatch, Making it Real and other representative groups, and for cross-fertilisation of ideas for future collaborative work with patients/ service users
3. It is recommended that the Patient Participation Groups (PPGs) initiative established in East Norfolk is considered for the rest of the STP footprint, as it provides ready-made access to feedback from patients/ service-users

4.6.5 Staff Development

1. Self-care and health coaching techniques, including the NCC Living Well model, are a vital part of managing demand on health and social care. Integration should continue to support and develop these models
2. It is recommended that joint training opportunities are developed to ensure this whole person approach is embedded e.g. through reflective practice
3. There was substantial support for the setup of the integrated service. It is important to recognise that new staff joining the new structure will need to receive a robust induction. This, together with updates for existing staff will ensure improved understanding of both organisations within the S75 to make them more effective in their integrated role
4. It is recommended that HR leads meet to: consider a range of learning and training proposals and initiatives and determine appropriate actions

Abbreviations and Glossary

ADASS	Association of Directors of Adult Social Services
APs	Assistant Practitioners working in adult social care teams
CCGs	Clinical Commissioning Groups. Five are merging to form the Norfolk and Waveney CCG covering the STP footprint
CQC	Care Quality Commission. The independent organisation that regulates all health and social care services in England
DoH	Department of Health. The Government department that provides the mandate for NHSE and oversees social care
DTOC	Delayed Transfers of Care from hospitals
ECCH	East Coast Community Health. The community interest company that provides community health in Great Yarmouth and Waveney
GPs	General Practitioners in primary care
Healthwatch	Part of a a national network of independent champions for people who use health and social care services
HWB	The Health and Wellbeing Board - in Norfolk based on the County Council footprint
HICM	High Impact Change Model. A comprehensive self-assessment tool produced by LGA, DoH, ADASS and NHSE for managing transfers of care between hospital and home
ICCs	Integrated Care Co-ordinators working across health and social care
ICS	Integrated Care System. System-wide planning arrangements which all areas should have place by 2021
Joint Monitoring Board	The Board overseeing the S75 arrangements comprising the Chief Executive of NCH&C, NCC's Executive Director of adult Social Care and the Director of Community Health and Social Care Operations
King's Fund	An independent health think tank
LAS	The IT system used for social care case recording by NCC.
LDGs	Local Delivery Groups. Health and care 'place' based planning for areas of the five former CCG areas (coterminous with NCH&C and NCC service provision arrangements)
LGA	Local Government Association
Liquid Logic	The provider of the IT system used for social care case recording by NCC.
LTP	Long Term Plan. The NHSE 10 year plan published in Jan 2019
Making it Real	Making it Real is a partnership between Norfolk adult social care and health services and the people who use services and carers.
MDTs	Multi-disciplinary Teams that co-ordinate health and social care decision-making in hospitals and the community
NEATs	Norfolk Emergency Avoidance Teams They provide a single point of access for urgent, unplanned health and social care needs.
NCH&C	Norfolk Community Health and Care. The NHS community health provider for all of Norfolk except for the Great Yarmouth area
NHSE/I	National Health Service England and National Health Service Improvement
NNUH	Norfolk and Norwich University Hospital
NFS	Norfolk First Support – the NCC in-house reablement service
NSFT	Norfolk and Suffolk Foundation Trust. The local NHS mental health provider trust
OTs	Occupational Therapists (working in both health and social care)
PCNs	Primary Care Networks. Networks of GP practices first proposed in the LTP, typically with 30,000 – 50,000 patients. There are 17 being developed in Norfolk and Waveney and will be used for 'neighbourhood' based planning.
QEH	Queen Elizabeth Hospital, King's Lynn
SCIE	Social Care Institute of Excellence. A UK charity and improvement agency

SystmOne	The most widely used IT system for case recording in primary care
STP	Sustainability and Transformation Partnership. System-wide planning arrangements (Norfolk and Waveney locally) – the forerunners of ICSs
Vanguards	'Vanguard' areas were funded by NHSE between 2015 and 2018 to develop good practice for New Models of Care outlined in the Five Year Forward View, the strategy which preceded the LTP
VHSE	Voluntary, Community and Social Enterprise sector

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Report to People & Communities Select Committee

Item No 9.

Report title:	**Developing an Engagement Strategy for Adult Social Care**
Date of meeting:	**13 March 2020**
Responsible Cabinet Member	**Councillor Bill Borrett - Cabinet Member for Adult Social Care, Public Health and Prevention**
Responsible Director:	**James Bullion – Executive Director of Adult Social Services**

Executive Summary/Introduction from Cabinet Member

Listening to and engaging with people who use our services, and people who might use our services in the future is critical, if we are to make the very best use of resources we have and achieve the best possible outcomes for individuals.

There are already wide and varied examples on engagement with people who use our services, or groups which represent them. However, this has not been brought together in a single plan or approach. This developing strategy aims to set out a clear framework for engagement – encompassing co-production, involvement, consultation and informing – and to set some principles by which the department can be held to account.

Actions Required

a) **Members are asked to comment on the approach and principles set out in this paper**

1 Background

1.1 On any day in Norfolk, Adult Social Services is supporting over 14,000 people, and spending over £1 million a day on services for people across the county.

With a growing and changing population, we constantly need to improve, adapt, change and make ourselves as efficient as we can, given the public sector funding challenges.

Listening to and engaging with people who use our services, and people who might use our services in the future is critical, if we are to make the very best use of resources we have, and achieve the best possible outcomes for individuals

Whilst we have pockets of good engagement across many areas of service, we do not have a single consistent strategy and standards to guide our work.

This paper sets out some principles and objectives which will form the basis of an engagement strategy and annual plan.

2 Our drivers for engagement

2.1 We recognise that good quality engagement can achieve these benefits:

Trust and accountability – through engaging with both people who use our services and citizens who pay for them through council tax, we can build a better understanding of the work of Adult Social Services and the context in which we work

Stronger services which fit people's lives – by listening and working with people to shape and influence our services we will improve outcomes for people

Early action – through dialogue and engagement some problems can be anticipated and avoided

Inclusive – by using different approaches to engage with people, we can ensure that less heard voices have an opportunity to influence

Innovation and problem solving – different views and perspectives can unlock practical and effective solutions to long-standing problems

2.2 Our approach

2.2.1 We use 'engagement' as an umbrella term to cover the range of ways Adult Social Services engages with people who use our services, the wider public, people who provide services, and other organisations who have an interest in our work.

2.2.2 Within that umbrella term of engagement, we recognise that there are different levels of engagement and we have adopted a simplified 'ladder of engagement' to frame our on-going engagement. The idea behind the ladder is that it become progressively more participative the higher up the ladder you go. The 'ladder' has four 'rungs'

Inform – as a minimum we would strive to keep a range of people and organisations informed about the work of adult social services. Where there are changes in how we are working, or updates about our practice, or general information about our progress and performance, we would seek to make this information as accessible and understandable as possible

Consult – this is where we would want to get feedback and views about proposals. As a result of that feedback we may change or amend proposals

Involve – this is where we would want people who use services, or other partners and stakeholders to help shape thinking and the shape the design of services. This would be over a period of time and would help ensure that the concerns and aspirations of people are consistently heard and understood

Co-production – this is the gold standard of engagement. Coproduction is about developing equal working partnerships between people who have experience of using care services, carers and paid staff, bringing together different ways of seeing things, knowledge and experience to design and help make services better. Working with people who use services, carers and paid staff to plan and improve services.

2.2.3 At any one time in Adult Social Services, we are working along all rungs of our 'ladder'. A current picture of the main areas under each of those headings are:

Type of engagement	Current examples, not exhaustive
Co-production	As experts by lived experience, our Making it Real Board advise us on co-production best practice. This year we have agreed with the Board two areas of co-production. These are: • Coproduced training for our social care staff around personalisation and direct payments

	• Together we are also attending a set of Self-Directed Learning sessions led by Think Local Act Personal to help support national co-production developments
	• Other service developments that have, or continue to be, co-produced are:
	  o Transitions for young people though our new Preparing for Adult Life Service
	  o Our Peer Support project
	  o The tender, pilot and implementation of Life Opportunities in Learning disabilities
	  o The County Council's Carers Charter, Carer Support Day and development of a new carers 'offer' - particularly around plan ned breaks for carers (respite)
	  o The new Peer Support role as part of the Employment Service

Engage	Attendance at our user-led and partner forums provide protected time for key service developments to be discussed and shaped. We have been increasing our engagement activity through: • Joint recruitment with people who use our services for new staff in Mental Health Teams and for our Preparing for Adult Life service • Our Physical Disability Reference Group which brings together officers and people with lived experience to improve our social work practice and choices for people with physical disability • Engaging our Provider Forum on the new Framework and Transforming Care Market • A new Direct Payment Support Services Advisory Group which was borne out of initial issues and concerns around direct payments; the group is now shaping on-going improvements to the service • Interactive Better Working Together sessions planned for 2020 with professionals from Health, Education, Childrens and Adults and Family Voice to improve working together
Consult	The County Council leads consultation on major change issues relating primarily to the budget setting process. As part of these, we will endeavour to ensure maximum reach and clarity in the consultation. More recently, as a department we have also consulted people with lived experience, and delivery partners on these issues: • Integration – we have asked people about their experiences of integrated health and social care to help shape the next Section 75 agreement., • Care Association – we have consulted widely with providers of care about the remit, shape and direction for a new Care Association for Norfolk • We asked advice from carers about the information and advice for carers on our website, and used their feedback to make changes • We consulted with Family Voice about how the new Preparing for Adult Life Service will work, and have built their feedback into our planning

Inform	Regular Senior officer input and practical and financial support for key user voice partnerships and groups, for example, Carers Voice Making it Real Learning Disability Partnership Board Autism Board Older People's Strategic Partnership Regular updates led by the Executive Director with voluntary sector representatives One-off briefings for key groups on changes to policies or ways of working which will affect different people who use our services, for example welfare right information sessions for Age UK; Money Support Services sessions for Independence Matters, Carer's Forums, Job Centre, St Giles Trust and the Citizen's Advice Bureau to raise awareness of their support offer Direct Payment Champions from within our social work teams have attended and met with schools, job centres and other charitable groups to raise awareness Our Social Care Teams have been proactively communicating our Living Well approach to their local GP surgeries Another significant element of informing people is the information we produce about services, our internet which we are systematically reviewing and updating to make as relevant and helpful as possible

2.4 **Our principles**

We are proposing a set of principles to guide our engagement approach. These are:

Clear – we will be clear about why we are engaging, and we will be clear about the nature of the engagement – informing, consulting, involving or co-producing

Open – we will be open and transparent about our engagement. We will publish a rolling programme of engagement, highlighting key pieces of engagement activity and being honest about any constraints we face

Feedback – we will communicate the outcomes of engagement to those who took part and more widely, whilst respecting the privacy of people who may have shared their lived experience with us

On-going dialogue – we will aim to have an on-going dialogue with people who use our services, partners and stakeholders, rather than 'one-off' events or discussions

Valuing people's time – we will ensure that we reimburse people for their time when engaging with us in a fair and equitable way

2.5 Over the coming months, we intend test our initial approach and principles set out here with user representative organisations, in particular with our Norfolk Making it Real group. Attached at Appendix 1 are a set of "I and We Statements" produced by the national co-production group Think Local, Act Personal.

2.6 The principles set out at 2.4 are not set in stone, and we are open to adding, amending, changing. We also aim to work with organisations to jointly shape a work plan for the year, which we will then publish and monitor.

3. Resource Implications

3.1 Engagement does require financial resource, and more importantly time and capacity of officers and others involved. Whilst some on-going engagement can be funded from within existing resources, we will need to develop a costed annual plan to ensure the commitments we give can be met and are transparent.

4. Equality Impact Assessment (EqIA)

4.1 An Equality Impact Assessment for the engagement strategy will be carried out as the work is developed.

5. Recommendation or Action Required

5.1 **a) Members are asked to comment on the approach and principles set out in this paper**

Officer Contact

If you have any questions about matters contained in this paper, please get in touch with:

Officer Name:	Telephone Number:	Email address:
Debbie Bartlett	**01603 222475**	**debbie.bartlett@norfolk.gov.uk**

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Making it Real for everyone

The I and We sentences for good care and support

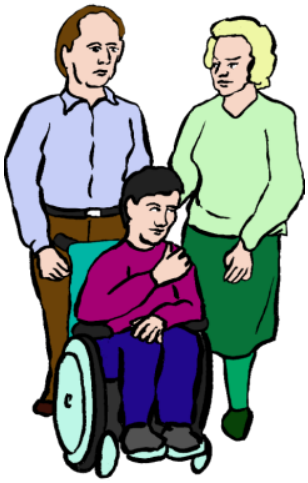
Making it Real—Living the life I want, keeping safe and well.

I can do the things that are important to me.

I am treated with respect.

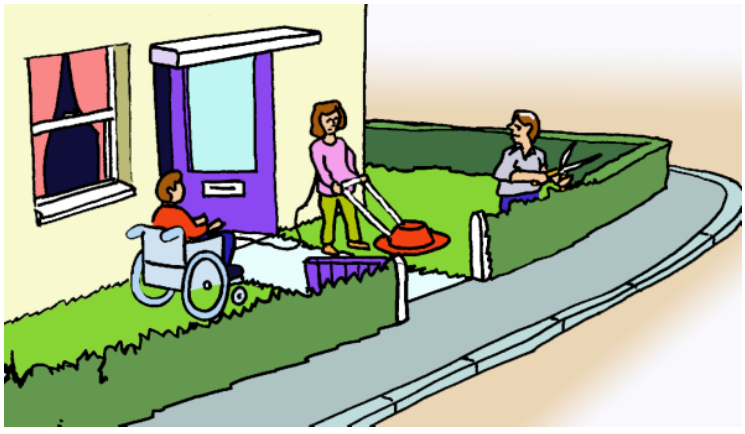
I feel safe. I know about things that can be dangerous.

I have support with my health.

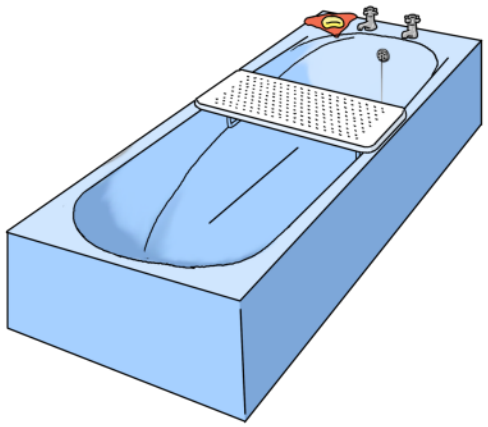


I have people who care about me like family and friends.

I do things to help other people.



The place I live in feels like home.



My home has been changed to suit me.

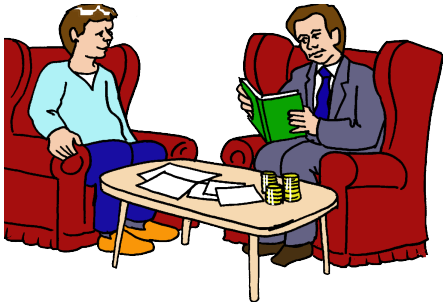
We talk with people about what they want from life.

We think about their care, support and homes.

We make sure that people's plans talk about being healthy and happy.

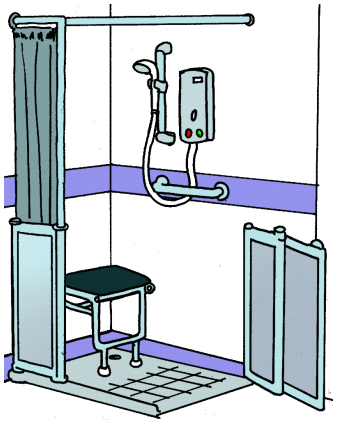
We keep people safe without stopping them from doing things that are important to them.

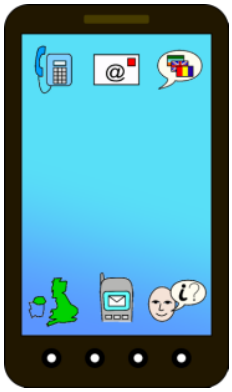
We help people to get together in groups to share their stories and ideas.



We welcome ideas about using personal budgets in new and different ways.

We find ways for people to do things with their community and help other people.





We make sure people have the right equipment and technology to feel safe and happy in their own home.

We talk with people about where and who they live with and their support.

We know this is important for people's health and happiness.

Making it Real—Having the information I need, when I need it.

I can get information and advice about how I can have a good life.

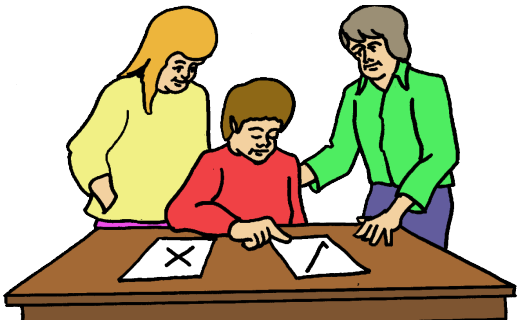
I can get information and advice about how I can be healthy.

This means being well in my body, my mind and my feelings.

I can get information and advice that I can understand.

I know about things that are happening in my area and groups I can join.

I know my rights and what choices I have about my health, support and where I live.



I can see the information that people have about me.

I can say who else can see that information.

We give free information and advice to everyone, including people who ort out or pay for their own care and support.

We give information that is up-to-date and in different ways like face-to-face if that's what people need.

We talk to people to find out how much information they want.

We give people the information they need about their health, social care and housing and don't take away any of their choices.

We give people information and advice that follow the law and national guidelines.

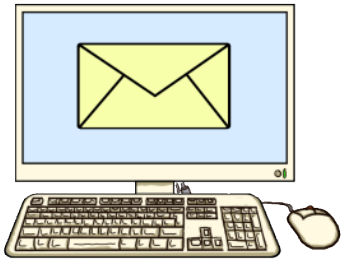
We make sure that people know how to find their local health, social care and housing services.

We tell people how to get more information or advice if they need it.

We make sure that people know their rights and what they are responsible for

We make sure people have the information, advice and support they need to think about what is best for them. This includes information about person-centred plans.

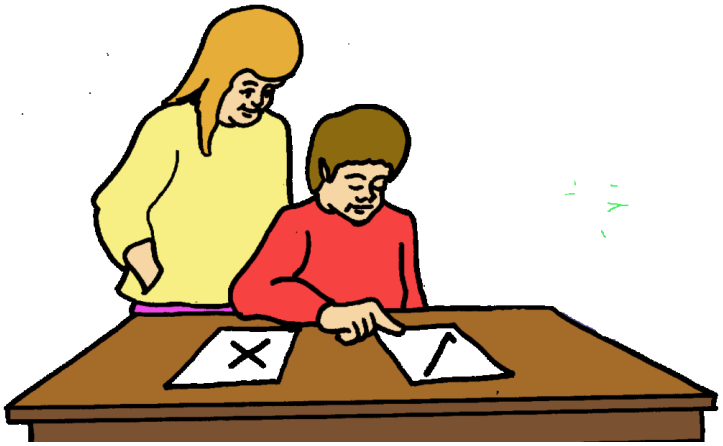
We give people information about what's happening in their local area and how they can join in.



We always include a name, telephone number and email address of who to contact when giving people information by email or text message.

We make sure that other local organisations know what we do and how people can contact us.

We tell people they have the right to see their health and social care records and can ask for any mistakes to be put right.



We check with people before sharing their personal information to make sure they agree.

Making it Real—Keeping family, friends and connections.

I have people who support me. They might be my family or my friends.

I can meet people who like the same things as me.

I can go to local groups and activities and feel safe.

If I want to, I can learn new things like how to volunteer or work.

I can see my family, my friends and other people who are important to me.

I have a plan that was written with me.

It includes how I can do things in my local community.

We make sure that people can keep in touch with family, friends and people in their area who are important to them.

We make sure that people can make new friends and relationships.

We work with local organisations to make our area friendly and welcoming to everyone.

We work with local organisations to give people chances to volunteer, work and learn.

We know about all the local groups and things that are happening in our area and tell people about them.

We help local groups of people by giving them a place to meet or the chance to learn new things.

We make sure that people's support plans are written with them and say how they can join in local activities that are important to them.

Making it Real—My support, my own way.

I can live the life I want. The people who support me see who I am and what I'm good at.

I can plan the care and support I need with people who know and care about me.

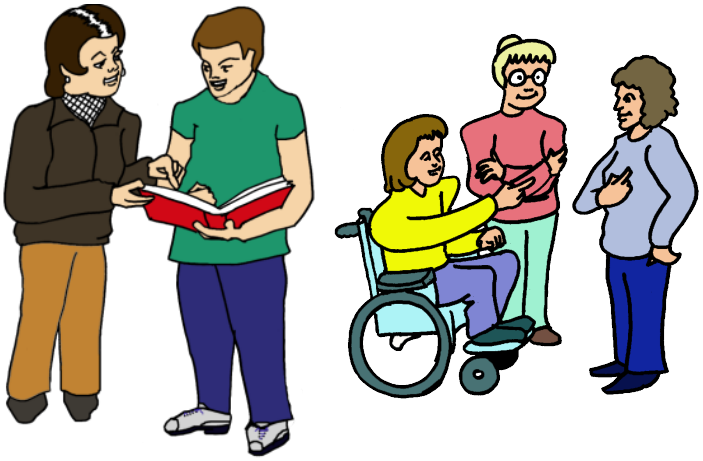
I know how much money there is to pay for my care and support.

I can say how the money is spent.

I have care and support from people who work well together.

I say who supports me, how, when and where.

I get help to understand how I can make the best use of the money that pays for my care and support.

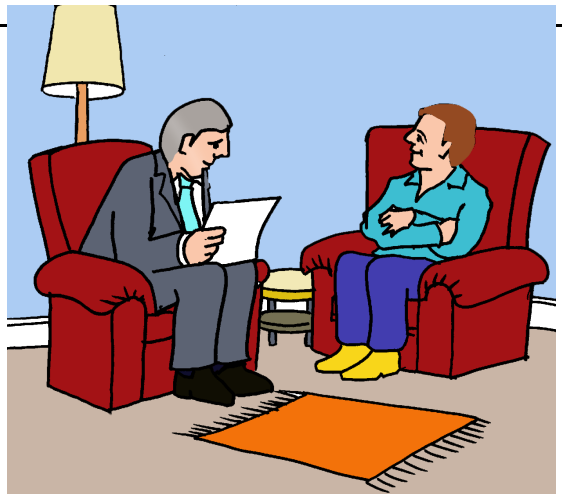


I can get help to manage the people who support me.

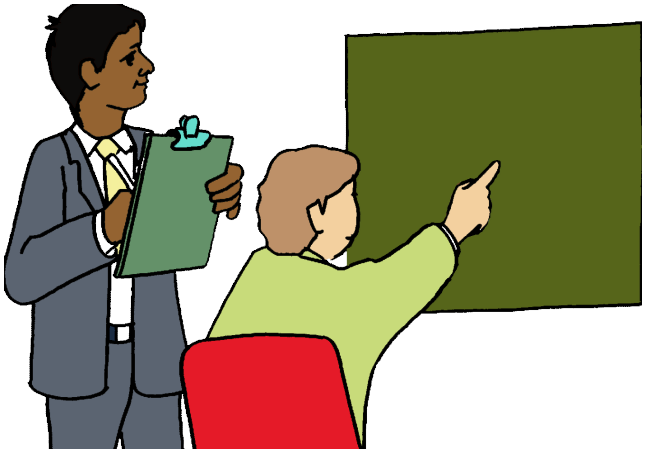
We work with other organisations so that everything works well for people.

We work with other organisations to make sure people have one plan.

We give people the name of one person to contact for all their support.



We talk with people to find out what they're good at and what they want to do, and include them in their support plan.



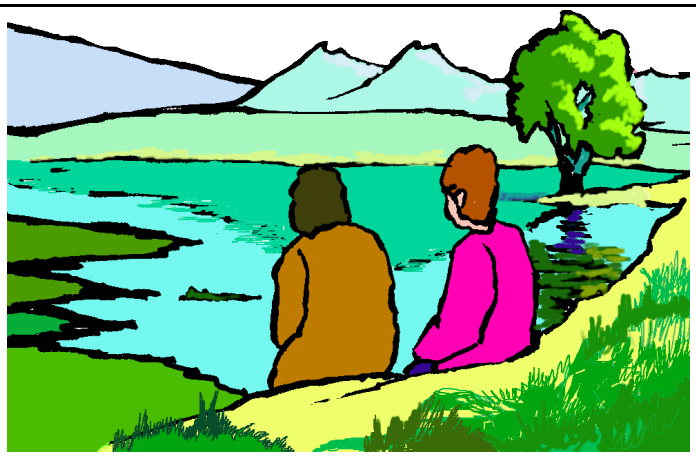
We work with people as equals.
We all share what we know to help us make decisions together.

We tell people about their rights to advocacy which is when someone speaks up for them.

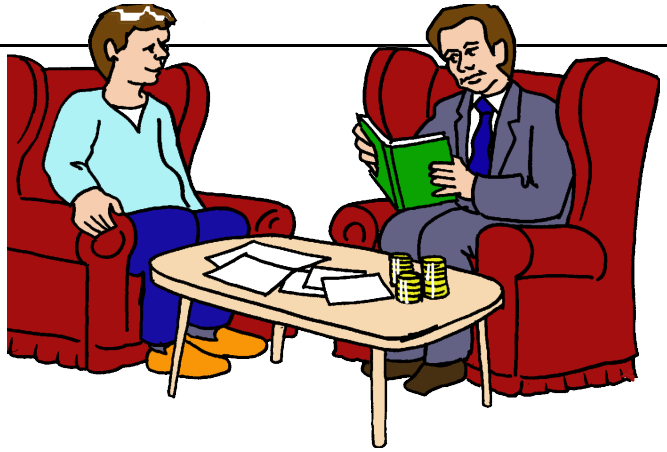
We make sure there are people who can do this.

We make sure people are supported to create their own support plan.

We make sure there are people who know about person-centred planning to help them.



We make sure that people get support when it's best for them, by people who take time to get to know them and are reliable.



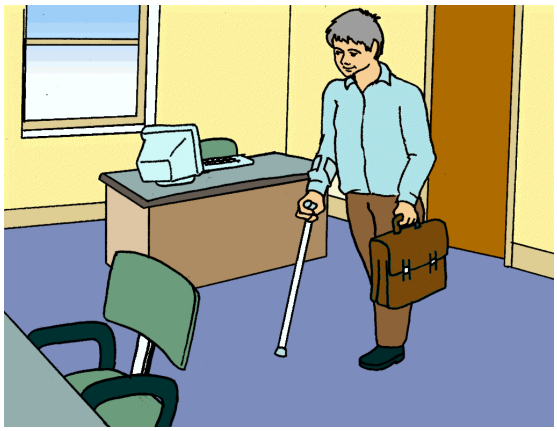
We support people to use their personal budgets in the way that makes sense to them and change the support when they ask us to.

We check people's support plans regularly and see if people are doing the things that are important to them.

We make sure that the way we do things follows the law and we don't stop people from having choice and control.

Making it Real—Staying in control

I have help to plan for any changes in my life.

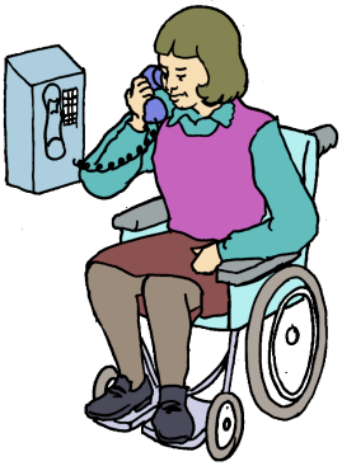


I have a plan for when I move or there are big changes in my life. I know everything will be ready in time.

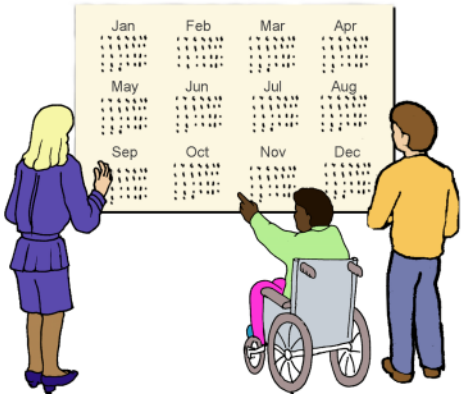
I know that the people who care about me are listened to if I move to another place.

If my medicine has to change, I know why and can say what I think about it.

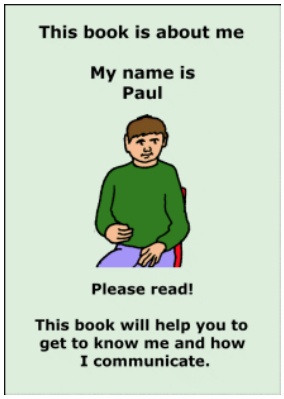
I can stay in control in an emergency and trust people will follow my plan.



I know who to contact and how to contact them if things are going wrong or I'm feeling ill.



We support people to plan for big changes in their lives, so they have enough information and time to decide what they want to do.



We make sure staff in new places, or places where someone will be for a short time, know what support people need and want.

We talk to people when there are big changes in their life, to find out if they need their care, support or housing to be different.

We talk with people about changes in treatment or medication. We talk about what the changes mean for how they want to live.

We write plans with people for emergencies and make sure everyone who supports the person knows what to do and who to contact.

We make sure that any people or animals are looked after.

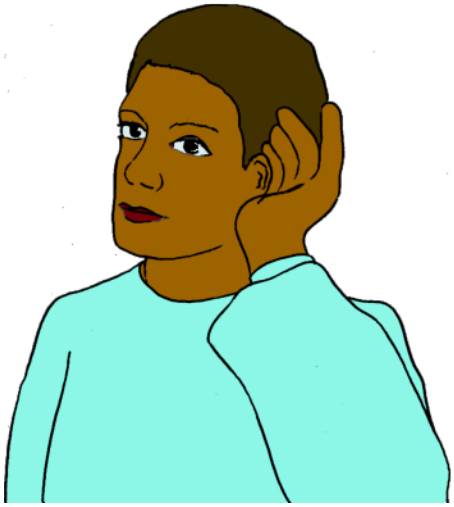
We make sure that people, and everyone who supports them, know what to do if they are getting poorly or something is going wrong.

We respond quickly if anyone is worried.

Making it Real—The people who support me

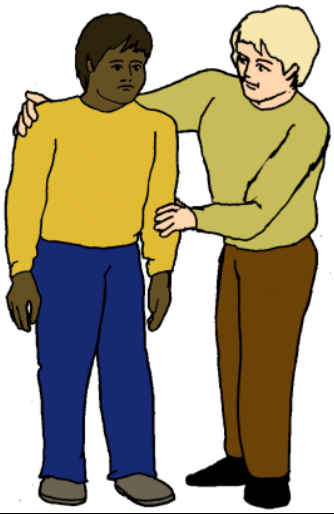
I am supported by people who value me for who I am. They know what I'm good at and what's important to me.

I am supported to make decisions by people who see things from my point of view.



I am supported by people who listen to me so they know how I want to live my life.

They think about what's important for me to be well in my body, mind and feelings.



I am supported by people who know what they are doing, who listen to me and are kind and caring.

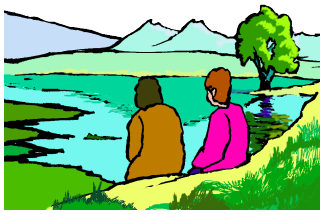
We don't make guesses about what people can or cannot do.

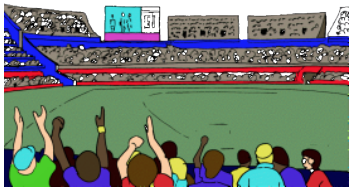
We don't stop them from having choices.

We see people as individuals who can do things that they want to do and that are important to them.

We value people for who they are.

We talk to people to find out what they want to do, where they want to live, how they can be healthy, happy and safe, and how they can join in things that are important to them.





We know what is important to people and make sure those things happen.

We keep up to date with what's happening locally – events, groups and chances to learn – and we tell people about these things so they can join in.

People and Communities Select Committee

Item No. 10

Report title:	**Carers Charter Working Group**
Date of meeting:	**13 March 2020**
Responsible Cabinet Member:	**Councillor Bill Borrett - Cabinet Member for Adult Social Care, Public Health and Prevention**
Responsible Director:	**James Bullion – Executive Director of Adult Social Services**

Introduction from Cabinet Member

In October 2018 the Council launched the Norfolk Carers Charter, adopting a policy to raise the profile of the 100,000 unpaid cares who play a key role in the health and wellbeing of our county, and improving the support available to them through partnership work and promoting carer friendly communities.

The Charter was produced by Members and carers working as a task and finish group. Since the Charter's launch the Council has worked towards its pledges and undertaken work to promote it principles with organisations across the county.

With its original objective accomplished, we propose turning the task and finish group into a working group of the People and Communities Selection Committee and approving a new Terms of Reference (ToR) which confirm the important role the working group has to play in implementing this policy, promoting the Charter's principles and monitoring the progress of the work.

Executive Summary

This report sets out a proposal to update the Terms of Reference for the Carers Charter Working Group to make it a formal working group of the People and Communities Select Committee that will oversee the pledges made within the Charter and promote the principles of the Charter.

Actions required

a) **To recommend to Cabinet that the Carers Charter Task and Finish Group be made a working group of the People and Communities Select Committee for the purpose of overseeing the pledges made within the Charter and promoting the principles of the Charter across Norfolk, as set out in Appendix A**

1. Background and Purpose

1.1. In October 2018 the Council launched the Norfolk Carers Charter, adopting a policy to raise the profile of the 100,000 unpaid cares who play a key role in the health and wellbeing of our county and improving the support available to them through partnership work and promoting carer friendly communities. The Charter was produced by Members and Carers working as a task and finish group.

1.2. The creation of the Charter was a major step forward in raising awareness of unpaid carers in Norfolk. Since its publication the Council has worked towards the pledges it

made in the Charter and undertaken extensive work promoting the charter's principles with organisations across Norfolk

1.3. Over the course of 2019 the Council undertook campaign and engagement activity to promote the Charter's principles with organisations across the county, encouraging the adoption of carer friendly practices within educational settings and employers.

2. Proposals

2.1. The task and finish group continues to meet, recognising the important role they have to play in realised the policy aim of promoting the Charter's principles and monitoring the progress of the work. Having achieved its original objective of producing the charter as set out in its Terms of Reference, the task and finish group ask that its Terms of Reference be revised to reflect this new purpose.

2.2. A revised ToR is enclosed in Appendix A which sets out that the overall purpose of the Working Group will be to oversee the delivery of the Council's policy of raising the profile of the 100,000 unpaid cares who play a key role in the health and wellbeing of our county and improving the support available to them through partnership work and promoting carer friendly communities.

2.3. The working group members are also mindful that since the original Terms of Refence were produced the Council has moved to a cabinet structure, meaning parts of the old Terms of Refence are outdated.

3. Impact of the Proposal

3.1. The proposal will formally recognise and endorse the focus of the working group on promoting the Norfolk Carers Charter and the importance of this work in promoting the health and wellbeing of unpaid carers.

4. Financial Implications

4.1. None

5. Resource Implications

5.1. **Staff:** None

5.2. **Property:** None

5.3. **IT:** None

6. Other Implications

6.1. **Legal Implications:** None

6.2. **Human Rights implications:** None

6.3. **Equality Impact Assessment (EqIA) (this must be included):** N/A as the decision sought is to formalise the committee governance of a piece of existing work

6.4. **Any other implications:** None

7. Actions required

7.1. To recommend to Cabinet that the Carers Charter Task and Finish Group be made a working group of the People and Communities Select Committee for the purpose of overseeing the pledges made within the Charter and promoting the principles of the Charter across Norfolk, as set out in Appendix A.

Officer Contact

If you have any questions about matters contained in this paper, please get in touch with:

Officer name:	Debbie Bartlett	**Tel No.:**	01603 973838
Email address:	debbie.bartlett@norfolk.gov.uk		

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Norfolk County Council Carers Charter Working Group

Terms of Reference

Purpose

The overall purpose of this Working Group is to oversee the delivery of the Norfolk Carers Charter by monitoring the commitments that have been made by the Council in the charter and promoting the principles of the charter in partnership with the organisations represented by the group's membership.

Scope

The Carers Charter is a statement of principles, rights that we ask other organisations to support and pledges that Norfolk County Council have made to support carers in work; young carers and young adult carers in education; and carers in the community.

The charter was developed and delivered by a Task and Finish Group which will now become a working group of the People and Communities Select Committee in order to monitor the Council's performance against its pledges and make recommendations about promoting the charter's principles through partnership working.

Ways of working

The working group will be supported by officers, and can draw on a range of different inputs to help shape the development of the Charter. This could include:

- Data and evidence about carers and their lives in Norfolk
- Testimonies based on experiences of carers themselves
- Review of the current council support for carers
- Research on best practice elsewhere
- National policy context.

A schedule of three meetings per year has been agreed. They will be held at County Hall.

Papers will be distributed in advance, ensuring the group's members have sufficient time to prepare.

Meetings will last no longer than two hours

Membership

The Task & Finish Group's membership is as follows:

- Independent Chair – William Armstrong
- People and Communities Select Committee Chair
- County Council Carers Champion
- Three county councillors
- Six carer representatives
- A representative from Cares Voice

- A representative from Caring Together

Continuity of membership for the meetings will be important, however, it is recognised that for carers attendance can be difficult, so substitutes will be able to attend by arrangement with the Chairman.

People and Communities Select Committee

Item No. 12

Report title:	**Development of Public Health Vision and Long Term Plan 2021-25**
Date of meeting:	**13th March 2020**
Responsible Cabinet Member:	**Cllr Bill Borrett (Cabinet Member for Adult Social Care, Public Health and Prevention)**
Responsible Director:	**Tom McCabe (Executive Director, Community and Environmental Services)**

Introduction

The Public Health Vision and Long-Term Plan will set out our ambitions for transforming the population health outcomes of Norfolk. Through the delivery of our Vision and Long-Term Plan, we will lead action, mobilise and work with partners, to achieve measurable improvements to public health. This Long-Term Plan will serve as our compass over the coming years

Effective public health interventions address both individual factors and environmental, place-based wider determinants that affect our health, and so in our Long-Term Plan we propose both types of interventions. This plan will set out, at a high level, the priorities and actions to improve the public's health.

Executive Summary

The Vision and Long Term Plan will be aligned to the Council's County Plan and reflect and support system priorities. It will be firmly based on the latest performance & population health data and include diagnostic & predictive analysis, placing prevention at the heart of everything we do. It will highlight the links between income deprivation and poorer health outcomes (adults and children) and the influence that external & home environment can have on health outcomes (adults and children). It will also focus on the health behaviour factors that can influence healthy life expectancy (adults) and those that contribute to achieving the best start in life (children).

It will describe a vision for Norfolk to be a place where people are enabled to live longer, healthier lives, a place where it is easier for individuals to make healthier choices. It will set out an overall aim to increase healthy life expectancy by 1 year over the next 10 years.

After a period of stakeholder engagement, we hope to present the proposed vision and long term plan to Cabinet on 6th July 2020.

Actions required

1. **To review the key elements of the proposed public health vision & long term plan and to note and comment on:**
    a. **Overall aim and vision**
    b. **Priorities – aligned to the County Plan**

1. Background and Purpose

1.1. Much has been achieved since we published the first public health strategy for Norfolk in 2016. The team has moved away from a medical model of public health and engaged with councillors, specialists and staff across a wide range of local government functions. We are developing a public health approach to community safety, road safety and resilience, helping us to understand how social, physical and economic environments can have a greater impact than medical care on how long and how well people live.

1.2. Many of the so-called 'health determinants' are in fact economic determinants. The goals of inclusive growth, improving the health of the local population and thriving communities, are interdependent. Our new long term plan outlines how public health can play an important role in collating and interpreting relevant population-level data and supporting place-based partnerships in understanding and acting on the health impact of economic strategies

1.3. We do not underestimate the challenges, but we believe that we have real opportunities to deliver tangible improvements for the people of Norfolk. We know that a preventative intervention can be more effective and better value for money than trying to address a problem further down the line. That is why we have placed prevention at the heart of our new plan. We must look to utilise and maximise our collective assets, develop and nurture close collaborations between partners across the system and focus on developing a joint approach to ensure that our prevention services are directed to where they can have the most impact

1.4. Many of the actions we are going to take in the first couple of years of our plan we are already starting to put into practice, but some of our ambitions and goals will take longer, particularly addressing the long-standing health inequalities we have; the causes of which are varied and complex. We will review this plan every year, adding to it and amending it where we need to.

2. Proposals

2.1. To develop a revised public health vision and long term plan that reflects developments in council priorities, a renewed focus on prevention across the council, the latest public health outcomes and service performance data, best practice from elsewhere and the changing strategic and partnership landscape.

2.2. It will describe a vision for Norfolk to be a place where people are enabled to live longer, healthier lives, a place where it is easier for individuals to make healthier choices. It will set out an overall aim to increase healthy life expectancy by 1 year over the next 10 years.

2.3. Supporting the Council's Together for Norfolk plan, we will invest in the following priorities to deliver on our public health ambitions:

Thriving People	1	**Providing the best start in life** We will strive to ensure all children in Norfolk have the best start in life.

Strong Communities	2	**Reducing the risk of developing a long-term condition** We will implement strategies to prevent people from developing physical and mental ill health in collaboration with partners in health, social care and communities
	3	**Tackling crime and causes of crime** We will tackle challenges to community safety including reducing violence and tackling drug and alcohol misuse by working across the criminal justice & community safety system.
	4	**Protecting Norfolk from risks to services and health** We will ensure that Norfolk is prepared for the full range of possible emergencies by supporting the Norfolk Resilience Forum, and the Local Health Resilience Partnership.

3. Impact of the Proposal

3.1. The vision and long term plan will clearly set out our long-term ambitions for improving the population and public health of Norfolk aligned to the County Plan.

4. Financial Implications

4.1. Actions and interventions outlined within the long term plan are aligned with our medium term financial strategy and savings plan.

5. Resource Implications

5.1. **Staff:**

No additional staff resources are required to develop the Vision and Long Term Plan. It is our intention to deliver the proposed priorities using existing staffing resources.

5.2. **Property:**

Not applicable

5.3. **IT:**

Not applicable

6. Other Implications

6.1. **Legal Implications**

None at this stage

6.2. **Human Rights implications**

None at this stage

6.3. **Equality Impact Assessment (EqIA) (this must be included)**

An Equality Impact Assessment for the Vision and Long Term Plan will be carried out as the work is developed

6.4. **Health and Safety implications (where appropriate)**

Not appropriate

6.5. **Sustainability implications (where appropriate)**
Not appropriate

6.6. **Any other implications**

None

7. Actions required

7.1. **1. To review the key elements of the proposed public health vision and long term plan and to note and comment on:**
a. Overall aim and vision
b. Priorities – aligned to the County Plan

8. Background Papers

8.1. None

Officer Contact

If you have any questions about matters contained in this paper, please get in touch with:

Officer name:	**Sally Newby**	**Tel No.:**	**01603 973749**
Email address:	**sally.newby@norfolk.gov.uk**		

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People and Communities Select Committee

Item No. 13

Report title:	**Forward Work Programme**
Date of meeting:	**13th March 2020**
Responsible Cabinet Member:	**N/A**
Responsible Director:	**James Bullion – Executive Director of Adult Social Services**

Executive Summary

This report sets out the Forward Work Programme for the Committee.

Actions required

1. To review and agree the Forward Work Programme for the Select Committee.

1. Forward Work Programme

1.1. The existing Forward Work Programme for the Select Committee is set out in Appendix A, for the Committee to use to shape future meeting agendas and items for consideration.

2. Financial Implications

2.1. None

3. Resource Implications

3.1. **Staff:** None.

3.2. **Property:** None.

3.3. **IT:** None.

4. Other Implications

4.1. **Legal Implications:** None.

4.2. **Human Rights implications:** None.

4.3. **Equality Impact Assessment (EqIA):** N/A.

4.4. **Health and Safety implications:** N/A

4.5. **Sustainability implications:** N/A

4.6. **Any other implications:** None.

5. Actions required

5.1. **1. To review and agree the Forward Work Programme for the Select Committee.**

6. Background Papers

6.1. None

Officer Contact

If you have any questions about matters contained in this paper, please get in touch with:

Officer name:	Sally Newby	**Tel No.:**	01603 973749
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Appendix A: People & Communities Select Committee Forward Plan

Meeting Date	Report title	Service	Lead Officer	Deadline for reports	Pre- agenda meeting
31st May 2020	Joint Prevention Strategy - update	Adult Social Care, Children's Services and Public Health			
	Vulnerable Adolescents 'No Wrong Door' update	Children's Services			
17th July 2020					
18th September 2020					