Norfolk County Council

Adult Social Care Committee

Date: **Monday, 14 May 2018**

Time: **10:00**

Venue: **Edwards Room, County Hall,**
Martineau Lane, Norwich, Norfolk, NR1 2DH

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

Membership

Mr B Borrett (Chairman)

Mr Tim Adams	Mr W Richmond
Miss K Clipsham	Mr M Sands
Mrs S Gurney (Vice-Chair)	Mr M Storey
Mrs B Jones	Mr H Thirtle
Mr J Mooney	Mr B Watkins
Mr G Peck	Mrs 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 **Page 5**

To confirm the minutes of the meeting held on the 5 March 2018

3. Declarations of Interest

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

- your well being or financial position
- that of your family or close friends
- that of a club or society in which you have a management role
- that of another public body of which you are a member to a greater extent than others in your ward.

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

4. Any items of business the Chairman decides should be considered as a matter of urgency

5. Public QuestionTime

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 Wednesday 9 May 2018.**

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

the Constitution at www.norfolk.gov.uk.

6. Local Member Issues/ Member 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 on Wednesday 9 May 2018.**

7. Executive Director's Update

Verbal Update by the Executive Director of Adult Social Services

8. Chairman's Update

Verbal update by Cllr Borrett

9. Update from Members of the Committee regarding any internal and external bodies that they sit on.

Group Meetings

Conservative	9:00am	Leader's Office, 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: 04 May 2018

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Norfolk County Council

Adult Social Care Committee

Minutes of the Meeting Held on Monday, 05 March 2018 at 10:00am in the Edwards Room, County Hall, Norwich

Present:

Mr B Borrett (Chairman)
Mr Tim Adams
Miss K Clipsham
Mr P Duigan
Mrs S Gurney (Vice-Chair)
Mrs B Jones
Mr J Mooney
Mr G Peck
Mr W Richmond
Mr M Sands
Mr H Thirtle
Mr B Watkins
Mrs S Young

1. Apologies

1.1 Apologies were received from Mr M storey (Mr P Duigan substituting).

2. To confirm the minutes of the meeting held on 15 January 2018

2.1 The minutes of the meeting held on 15 January 2018 were agreed as an accurate record and signed by the Chairman.

3. Declarations of Interest

3.1 Mrs S Young declared a non-pecuniary interest as Chair of the West Norfolk Patient Partnership, as Chair of West Norfolk older persons' forum, and as member of the Fraud Prevention Strategy Board.

4. Urgent Business

4.1 There were no items of urgent business discussed.

5. Public Question Time

5.1 No public questions were received.

6. Local Member Questions / Issues

6.1 No local member questions were received.

7. Point of Order

7.1 The Chairman proposed to take item 9 next, "Executive Director's Update", followed by Item 8, "Update from Members of the Committee regarding internal and external bodies that they sit on", and then return to the running order of the agenda.

8. Executive Director's Update

8.1 The Executive Director of Adult Social Services discussed the recent severe snow and the difficulties it had caused for staff getting into work. He wished to thank staff in the care and health sector and district council colleagues for their response supporting vulnerable people and establishing emergency shelters for rough sleepers. He thanked colleagues at the Eastern Daily Press for positive coverage in the media. Services would continue to experience difficulty while readjusting from the challenges caused by the weather.

8.2 The Executive Director of Adult Social Services also updated members on:

- Recruitment to the 50 additional social work practitioner posts: 42 social workers had been recruited and would be in post by April 2018; there were 12 of these social worker and 5 social work manager vacancies remaining;
- Progress on researching assistive technologies: a paper was due to be brought to the Digital Innovation and Efficiency Committee on 6 March 2018; a further paper would be brought to Adult Social Care Committee at a later date;
- Consultation with the Adult Social Care Senior Management Team about restructure of the Adult Social Services team: formal consultation was due to begin; the new structure was designed to reflect revised integrated arrangements with the NHS. The Committee would be briefed when the outcome was known.

8.3.1 A letter had been received from a member of the public concerned that the decision made at the January 2018 Committee meeting about revised cost of care was discriminatory on care workers and put pressure on non-framework providers of care. The Executive Director of Adult Social Services clarified that the Council were aiming to incentivise a move away from block arrangements. There was no intention to discriminate against certain types of provider, but to incentivise those who could provide a greater capacity of care. The impact of changes would be monitored and providers had been corresponded with. Officers intended to meet with the care provider discussed in the gentleman's query. The Executive Director of Adult Social Services **agreed** to write to the Committee giving further detail about the cost of care framework.

8.3.2 The Vice-Chair noted that the Head of Quality Assurance and Market Development gave a detailed explanation of the situation at the January 2018 Committee meeting.

8.4 The Vice-Chair wished to note the support given by NCS (Norse Community Services) during the snow and in the setting up of night shelters for rough sleepers.

9. Update from Members of the Committee regarding any internal and external bodies that they sit on

9.1 Mr H Thirtle had attended a governors' meeting at the James Paget Hospital discussing recent unprecedented demand; he wished to share that the Hospital had expressed that the Council had been a great support to them during this time.

9.2 Ms B Jones had attended two Norfolk and Norwich Association for the Blind trustee meetings and related training.

9.3 The Vice-Chair updated members on:

- Her attendance at the Norfolk and Norwich University Hospital (NNUH) Governors' meeting;
- Her attendance at the Norfolk Care Awards celebration;

- Planning undertaken with the Assistant Director of Strategy & Transformation for a Making It Real meeting in May 2018, and a study day with Amazon Digital to arrange assisted technology for the Making It Real group to trial.

9.4 Mrs S Young updated members on:

- Her attendance at Board Meetings of the West Norfolk Clinical Commissioning Group and the Queen Elizabeth Hospital, both of which had recently recruited new Chief Executives;
- Her visit to the older persons Accident and Emergency department at the NNUH which had already been shown to provide relief to the existing Accident and Emergency department; this trial was planned to go on until May 2018;

10. Chairman's Update

10.1 The Chairman:

- Updated members on the Health and Wellbeing Board meeting due to be held the following day. Integration between the NHS and County Council would be discussed, looking at how commissioning of services could be aligned with NHS commissioning. The STP (Sustainability and Transformation Plan) process would also be discussed, with a focus on prevention services;
- Thanked voluntary, private and Council Adult Social Care staff and other Council staff who worked hard to get to people across Norfolk in the challenging weather;

10.2 A Member was concerned about levels of meaningful engagement with the public in the STP process; the Executive Director of Adult Social Services noted a public question and answer session held on the radio with the Chairman of the STP oversight board as an example of the effort towards better public engagement.

11. Adult Social Care Finance Monitoring Report Period 10 (January) 2017-18

11.1 The Committee considered the report outlining financial monitoring information based on information to the end of January 2018, variations from the budget, progress against planned savings and details of the use of the improved Better Care Fund.

11.2.1 Concerns were raised over pressures within the system and whether the downward trend on purchase of care would continue. The Finance Business Partner, Adult Social Services, clarified that the outturn position showed £9.5m more being spent in 2017-18 on purchase of care; the improved Better Care Fund (BCF) and plans with health partners had allowed Adult Social Services to put interventions in place to meet some of these pressures next year, 2018-19.

11.2.2 Concern was raised that the scale and pace of change may be too fast, putting pressure on staff and impacting on the most vulnerable people in Norfolk. The Chairman responded that the changes had been put in place by the previous administration some years ago.

11.2.3 Ms Clipsham asked whether mental health services would receive more funding in 2017-18; the Chairman **requested** a detailed response for Ms Clipsham.

11.2.4 It was queried what was being done to ensure people were helped to claim and made aware of disability disregard. The Finance Business Partner, Adult Social Services, reported that easy-read letters and forms were now available and staff who could

support people to apply for the disregard they were entitled to.

11.2.5 The Finance Business Partner, Adult Social Services, clarified that some BCF funding for 2017-18 was planned to carry forward to cover the impact of funding falling each year. Projects were implemented through BCF funding over a 2 or 3 year period to allow time for evaluation and to identify which to carry forward. Some unspent funding from 2017-18 was taken into the 2018-19 Social Care budget.

11.2.6 It was queried whether any assessment was being considered to look at a case for bringing care back in-house. The Chairman recalled that when homes were run by the Council they were of a lower standard and more expensive to run; NorseCare provided care at a reduced cost and increased standard.

11.2.7 Discussions regarding outstanding debt with health organisations and its recovery, delayed due to the weather, had been rearranged for later in the week. Following this an update would be given to Committee.

11.2.8 Some members felt that BCF funding put into reserves could have been used to mitigate cuts made to Building Resilience. The Chairman reiterated that these were the responsibility of the District Councils.

11.2.9 The Executive Director of Adult Social Services reported that 25 inadequate providers were being supported to improve by Norfolk County Council; these ratings were often not related to the rate paid to providers but other issues such as management.

11.3 Mr B Watkins proposed to take the recommendations separately seconded by Mrs B Jones. With 5 votes for and 8 against, the proposal was lost.

11.4 When the recommendations were taken together, with 8 votes for, 2 against and 3 abstentions the Committee **AGREED**:

a) The forecast outturn position at Period 10 for the 2017-18 Revenue Budget of £258.901m;
b) The planned use of reserves;
c) The forecast outturn position at Period 10 for the 2017-18 Capital Programme.

11.5 Mr M Sands wished to note that the Labour Party's objections were related to the planned use of reserves.

12. Performance Management Report

12.1 The Committee received the report setting out the latest performance position for Adult Social Services. The Assistant Director of Strategy & Transformation informed Members of a data crossover caused by the changeover between CareFirst and LiquidLogic (case recording systems).

12.2.1 Norfolk County Council's position in the league table for delayed transfers of care had declined; the Executive Director of Adult Social Services reported there had been a short term spike in admissions to hospital or Social Care caused by the poor weather. The social work model being implemented would mitigate this through a prevention based approach.

12.2.2 Although the same number of people had been assessed and discharged as in 2016-17, the speed of process had decreased. The flow of people through hospitals was not

as efficient as it could be, however, social workers were encouraged to take time to get to know people and find out what approach was best for them to reduce the chances of readmission; this would have a beneficial long term impact.

12.2.3 Ongoing discussions were being held with the NHS regarding issues related to batching of referrals to social care.

12.2.4 The Executive Director of Adult Social Services clarified that incentives were given to recognise higher costs of weekend discharge and other extraordinary costs to enable providers to take up referrals more quickly over peak periods, and acknowledge the additional pressures for carers at these times. The incentives paid so far amounted to less than £20,000.

12.2.5 It was raised that people returning to unfit home environments upon discharge from hospital may result in or impact on readmission to hospital or social care. The Assistant Director of Strategy & Transformation confirmed that the reablement service included staff to check that a person's home was suitable for their return. The "help to get home" service included assessors to identify issues at a person's home, such as unsafe stairs, and put in place strategies to support their return.

12.3 With 8 votes for and 5 abstentions, the Committee **AGREED** the overall performance position for adult social care as described in section 2 of the report.

13. Responding to the enquiry into long term sustainable funding for adult social care

13.1 The Committee received the report outlining the Council's response to the Government joint inquiry into long term sustainable funding of social care.

13.2.1 The Chairman confirmed that the submission reflected discussions held in Adult Social Care Committee over the past months.

13.2.2 Some members were concerned about the short notice for agreement of the enquiry response; the Chairman reported that the request for information from Government had been given at short notice, and reminded Members that the enquiry would be consulted on twice, at the Green Paper and White Paper stages. He invited members to suggest amendments to the presented submission.

13.2.3 Some Committee Members discussed their support for the presented submission.

13.2.4 Mr M Sands discussed that Westminster were cutting back the revenue support grant to Councils and felt there was provision through the submission to ask Westminster to reconsider. Mr M Sands **proposed** adding a statement to the submission asking "<u>whether Westminster, through the green paper, could reconsider the cutting back of revenue support grant to 0, and keep some of this grant for local authorities</u>".

13.2.5 The Executive Director of Adult Social Services felt paragraph 2.5.1a of the report could be changed to include a statement as per Cllr Sands proposal. The Chairman seconded the proposal; the Committee duly **AGREED** to include this information.

13.2.6 Mr P Duigan noted the demographic demand discussed at paragraph 2.41c of the report and asked if it took into account internal migration, noting the pressure on health and social care services caused by people returning or moving to Norfolk to retire. The

Finance Business Partner, Adult Social Services, confirmed that report data was based on population trends, however, the submission could be amended to give specific detail on internal migration and the older age profile. The Committee duly **AGREED** to include this information.

13.2.7 It was suggested that a task and finish group be set up to review the response to the Green Paper. The Chairman **agreed** to bring the Green Paper to Committee once published; it would be agreed how to proceed at this time.

13.3 With the 2 amendments discussed above, the Committee unanimously **AGREED**:

a) The structure of the submission shown at paragraph 1.6 of the report;
b) Options for funding that the government could investigate;
c) Key approaches that the government could adopt for supporting political and public consensus.

14. Adult Social Care Committee Plan

14.1 The Committee considered the report outlining the Adult Social Care three year forward plan and how its areas of responsibility would be shaped by the ambition of "Caring for our County: A vision for Norfolk in 2021" and principles of Norfolk County Council's new strategy, "Norfolk Futures".

14.2.1 The Vice-Chair suggested the aims and objectives needed more explanation, but that the plan was good overall.

14.2.2 Decision making processes under the proposed new Council governance system were queried; the Chairman advised that since it was not agreed whether to move to a new governance model or what the final structure would be, it was not possible to know the impact on decision making processes at that time.

14.2.3 In reference to p95 of the report, paragraph 1.1.4, specific queries were raised in relation to the Corporate Priorities. The Chairman noted that these were Council priorities and suggested that the Labour Group Leader raised these at Policy and Resources Committee.

14.3 When the recommendations were taken together, with 8 votes for, 4 against and 1 abstention, the Committee **RESOLVED** to:

a) **AGREE** the Adult Social Care Committee Plan at Appendix 1 of the report;
b) **NOTE** the Committee's contribution to, and responsibilities, for Norfolk Futures; Norfolk County Council's transformation plan at section 1 of the report;
c) **AGREE** metrics against which this Committee would report to Policy and Resources Committee for monitoring purposes at section 2 of the report.

The meeting finished at 12:00

Mr Bill Borrett, Chairman,
Adult Social Care Committee

Adult Social Care Committee

Item No……

Report title:	**Internal and External Appointments**
Date of meeting:	**14 May 2018**
Responsible Chief Officer:	**Wendy Thomson, Managing Director**

Strategic impact

Appointments to Outside Bodies are made for a number of reasons, not least that they add value in terms of contributing towards the Council's priorities and strategic objectives. The Council also makes appointments to a number of member level internal bodies such as Boards, Panels, and Steering Groups.

Responsibility for appointing to internal and external bodies lies with the Service Committees. The same applies to the positions of Member Champion.

Executive summary

Set out in the appendix to this report are the outside and internal appointments relevant to this Committee together with the current membership.

Recommendation

- **That Members review and where appropriate make appointments to those external bodies, internal bodies and Champions position as set out in Appendix A.**

1. Proposal

Outside Bodies

1.1 The appendix to this report sets out the outside bodies under the remit of this Committee. Members will note that the previous representative is shown against the relevant body. Members are asked to review Appendix A and decide whether to continue to make an appointment, and if so, to agree who the member should be.

Internal bodies

1.2 Set out in Appendix A are the internal bodies that come under the remit of this Committee. There is no requirement for there to be strict political balance as the bodies concerned do not have any executive authority. Appointments are not made on the basis of strict political proportionality, so the Committee may, if it wishes to retain a particular body, change the political makeup. The members shown in the appendix are those

serving on the body in the previous year. Any Member Champion appointments are also shown.

2. Financial Implications

The decisions members make will have a small financial implication for the members allowances budget, as attendance at an internal or external body is an approved duty under the scheme, for which members may claim travel expenses.

3. Issues, risks and innovation

4.1 There are no other relevant implications to be considered by members.

4. Background

4.1 The Council makes appointments to a significant number of internal bodies and external bodies. Under the Committee system, responsibility for these bodies lies with the Service Committees.

4.2 There is no requirement for a member of an internal body to be appointed from the "parent committee". In certain categories of outside bodies it will be most appropriate for the local member to be appointed; in others, Committees will wish to have the flexibility to appoint the most appropriate member regardless of their division or committee membership. In this way a "whole Council" approach can be taken to appointments.

Background Papers – There are no background papers relevant to the preparation of this report

Officer Contact

If you have any questions about matters contained or want to see copies of any assessments, e.g. equality impact assessment, please get in touch with:

Officer Name:	**Tel No:**	**Email address**:
Chris Walton	01603 222620	chris.walton@norfolk.gov.uk

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Adult Social Care Committee Boards, Panels, and Steering Groups 2017/18

1. Independence Matters Enterprise Development Board (2)

Chairman of the Adult Social Care Committee and Shelagh Gurney

This body was created to oversee the development of the Social Enterprise.

Adult Social Care Committee Outside Bodies

1. Norfolk Council on Ageing (1)

Mike Sands

The organisation's vision is that older people live well in Norfolk and its mission statement is to support older people in the County to enjoy the opportunities and meet the challenges of later life. The Council provides a wide variety of services to older people and their carers across the County.

2. Norfolk Safeguarding Adults Board (NSAB)

Greg Peck

Adult Social Care Committee Champions

Carers – Julie Brociek-Coulton
Older People – Mike Sands
Learning Difficulties – Sandra Squire
Physical Disability and Sensory Impairment – (also serves as Council representative on Norfolk and Norwich Association for the Blind) – Brenda Jones
Dementia – Colin Foulger

Adult Social Care Committee

Item No:

Report title:	**Norfolk's Better Care Fund and Integration Plan 2017-19: Progress Report for 2017-18**
Date of meeting:	**14 May 2018**
Responsible Chief Officer:	**James Bullion, Executive Director of Adult Social Services**

Strategic impact

Norfolk Health and Wellbeing Board (HWB) oversees Norfolk's work on integration that has been undertaken in accordance with Norfolk's Better Care Fund (BCF) and Integration Plan 2017-19. This report provides the Committee with information that was presented to the HWB on 2 May 2018. This report reviews progress during 21017-18, including information on how the Improved Better Care Funding (iBCF) and Disabled Facilities Grants (DFGs) have been used to support our integration work.

Executive summary

Norfolk has made good progress with its BCF and Integration Plan and the initiatives funded through BCF have made an important contribution to STP priorities.

A significant amount of iBCF funding has been invested into initiatives that contribute to addressing performance on Delayed Transfers of Care (DTOC) across the system, as this has been the only mandatory metric most at risk of not being delivered to target. The iBCF funding has been focused on areas in the recently developed High Impact Change Model (HICM) that social care can influence effectively, such as Trusted Assessors, Enhanced Home Support Services and Active Assessment Units (bed based reablement).

The complexity of the health and social care system in Norfolk means there is further work to do in order to achieve the priorities identified for system-wide change, which will be the ongoing focus of the BCF and Integration Plan.

Recommendations:

Committee is invited to review and agree the report, noting progress that has been made with integration in Norfolk.

1. Introduction

1.1 The Better Care Fund (BCF) initiative was established by Government to encourage closer working at local level between health, housing and adult social care through creation of a pooled fund.

1.2 Previously national guidance had been for these plans to be prepared for one year only, but for 2017 it was decided that they should be for two years to ensure longer planning timescales and should incorporate integration plans. Other key changes have been the in-year funding announcement of supplementary non-recurrent Improved Better Care Funding (iBCF) which has enabled quicker implementation of some initiatives and imposition of a national High Impact Change Model (HICM) designed to improve hospital discharge arrangements.

1.3 The local requirement for the Health and Wellbeing board to oversee the programme remains in place, as does quarterly reporting against four key targets for emergency

hospital admissions; delayed discharges from hospital; long-term admissions to care homes and success of reablement.

1.4 As a consequence of changes to the financial framework (the improved iBCF), final national guidance was delayed significantly, meaning that Norfolk's Better Care Fund and Integration Plan 2017-19 was not agreed by the Health and Wellbeing Board until September 2017 and not formally signed off by NHS England until December 2017. Please click here to see a copy of the Plan

1.5 The Plan sets the context for BCF and integration in Norfolk, so the detail of that will not be repeated here. However, it should be reiterated that the Plan is aligned closely with the Norfolk and Waveney Sustainability and Transformation Plan and reflects its guiding principles. It dovetails with Norfolk County Council's (NCC's) Promoting Independence Strategy and Clinical Commissioning Group (CCG) commissioning intentions for 2017-19. Also, it incorporates district council Prevention and Promoting Independence initiatives

2. Delivery of the Plan

2.1 Progress against the Plan for 2017-18

This report reviews progress that has been made during 2017 -18 in delivering the key elements identified in the 2017-19 Plan. These include:

a) Norfolk's five identified priorities
b) High Impact Change Model (HICM)
c) iBCF Initiatives
d) Performance against metrics

2.2 Norfolk's Five Priorities

Norfolk identified five priority areas to focus its BCF activity:

Priority 1: Locality Integrated Care Programme Infrastructure
Priority 2: Care Homes
Priority 3: The Home Environment
Priority 4: Out of Hospital Schemes
Priority 5: Crisis Response

2.2.1 **Priority 1**: Locality Integrated Care Programme Infrastructure

The Primary and Community Care workstream of the Norfolk and Waveney STP is progressing at pace with five Local Delivery Boards set up (one for each CCG footprint) with a focus on the development of New Models of Care. This will enable further integration between primary, community, social care, the voluntary sector and district councils. Areas of activity include:

a) Integrated social work and community health staff, based around GP surgeries
b) Engagement with Early Help Hubs
c) Risk stratification of patients
d) A well-developed multi-disciplinary team (MDT) approach is delivered through Integrated Care Teams
e) The Supported Care Service for North and South CCGs

All activities in this priority have been progressed as planned for this year. Next year will see more targeted work on risk stratification to embed a countywide approach.

Successes include a countywide approach to the role of Integrated Care Coordinators supporting multi-disciplinary teams and the introduction of the Supported Care Service. This latter service aims to enable adult patients, including frail older people and those with long-term conditions, to stay safe and well at home with over 80% of referrals to the service avoiding a hospital admission

2.2.2 **Priority 2**: Care Homes

The Norfolk system is engaged with the Enhanced Health Care in Care Homes framework as a basis for reducing admissions from care homes to hospital and is collaborating to support improvement in the quality of care offered. This is also a HICM priority.

This work has progressed well and all milestones have been achieved. Further investment has been agreed for the coming year to ensure the pace and impact of this work can be maintained.

Norfolk has developed the care homes dashboard to show admissions to hospital, use of 111 and quality ratings by care homes. It has been adopted by NHS England and is being presented and promoted as a model of good practice. It highlights a reduction in avoidable hospital admissions to hospital from care homes for 2017/18 compared to 2016/17 (based on data from the first half of each year).

- North Norfolk: 8.3%
- Norwich: 35.3%
- South Norfolk: 14.6%
- West: 15.8%

From 1 April 2018 the CCGs will be purchasing their business intelligence services from the Arden GEM Commissioning Support Unit (CSU) which should enable inclusion of GY&W data in the existing Norfolk dashboard, so providing data consistency across the STP area.

2.2.3 **Priority 3**: The Home Environment

This area of work covers interventions in the home that focus on housing as an enabler to improve health and wellbeing and, in particular, the use of Disabled Facilities Grant (DFG) funding.

The expenditure of nearly £7m for 2017-18 was overseen and distributed by seven district councils and spent primarily on statutory DFGs. However, work is ongoing with the districts to expand and diversify services provided to better support vulnerable people to return to their homes after a health incident.

A comprehensive report on progress and initiatives in localities is contained in **Appendix 1**.

2.2.4 **Priority 4**: Out of Hospital Schemes

Activities to support out of hospital schemes include:

a) Review of Information and Advice Services
b) Intermediate Care Strategy Planning
c) Delivery of the High Impact Change Model (HICM)
d) Social Prescribing

Use of the iBCF funding has enabled significant progress to be made on this priority, with the introduction of; active assessment units, enhanced home support services, and trusted assessment facilitators and the recruitment of six additional Discharge to Assess social workers to support hospital discharge. These schemes are expected to impact on the Delayed Transfer of Care (DToC) metric and contribute to an improvement in performance, as well as continuing to help maintain our rate of non-emergency admissions.

To progress work on social prescribing, Norfolk County Council is investing £1.9m from Adult Social Care and Public Health over the next 2 years to ensure that social prescribing is available across Norfolk. CCGs, district councils and voluntary sector 'umbrella' providers have been involved in developing the models which are being designed to reflect the local make up of services, needs, priorities and assets.

2.2.5 **Priority 5**: Crisis Response

Initiatives include:

a) Services for Carers
b) Early Intervention Vehicles (EIVs)
c) The Enhanced Home Support Service
d) Norwich Escalation Avoidance Team (NEAT):
e) West Norfolk Rapid Assessment Team

All milestones for this priority have been met. Further work will be undertaken in year two of the plan to analyse the impact of initiatives.

An example of effective work in this priority area is the new carer's support service 'Carers Matter Norfolk', which was launched in October 2017 and continues to support unpaid carers in Norfolk. Through the BCF part of a shared commitment it offers a 'carer-led' support service and telephone support, information and guidance to carers. Milestones for the service including the commencement date were all met.

2.3 **High Impact Change Model** (HICM)

2.3.1 The HICM aims to focus support on helping local system partners minimise unnecessary hospital stays and to encourage them to consider new interventions for future winters when pressures are greatest.

2.3.2 It offers a practical approach to supporting local health and care systems to manage patient flow and discharge. It can be used to self-assess how local care and health systems are working currently, and to reflect on, and plan for, action that can be taken to reduce delays throughout the year.

2.3.3 The model identifies eight system changes which will have the greatest impact on reducing delayed discharge:

1. Early discharge planning
2. Systems to monitor patient flow
3. Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector
4. Home first/discharge to assess
5. Seven-day services
6. Trusted assessors
7. Focus on choice
8. Enhancing health in care homes

2.3.4 As part of the BCF plan 2017 -19 Norfolk submitted a HICM plan (see **Appendix 2**) showing progress against the eight areas of the plan. Each has been rated as either green or amber. with all actions having been completed, though there was some slippage in timescales. Whilst plans are in place for all eight changes in the model, some are more established than others.

2.3.5 Most progress has been made on the areas of change where iBCF monies have been invested, such as Home First Discharge to Assess and Trusted assessors. With key iBCF initiatives now in place, impact is expected to accelerate and be demonstrated through improvements in transfers of care.

2.3 The main challenge to delivering the HICM has proved to be ensuring consistency across the three acute systems. Further work is planned to review the model and update the plans to maximise impact.

2.4 **iBCF Initiatives**

2.4.1 The Chancellor's Budget in March 2017 announced £2bn additional non-recurrent funding for social care, of which Norfolk received £18.561m in 17/18, followed by £11.901m in 2018/19 and £5.903m in 2019/20. The funding is paid as a direct grant to councils by the DCLG and as a condition of the grant, councils were required to pool the funding into their BCF.

2.4.2 The guidance received by DCLG requires that the funding is used by local authorities to provide stability and extra capacity in the local care system. Specifically, the grant conditions require that the funding is used for the purposes of:

a) Meeting social care needs
b) Reducing pressure on the NHS supporting people to be discharged from hospital when they are ready
c) Ensuring that the local social care provider market is stabilised

2.4.3 Plans for the use of the funding were reported to Adult Social Care Committee in July and were subsequently agreed with Norfolk's Clinical Commissioning Groups.

2.4.4 The plans included £9.1m earmarked to help support the local care provider market, rising to £10.8m in 2018-19. This was additional to budget plans already agreed for 2017-18, so in-year was targeted on managing the impact of new legislation on providers, managing the impact of market failures and amending pre-banded contracts for working age adults. The funding assigned for this purpose was not used in full and is part of the iBCF funding carried forward within reserves to ensure that it remains earmarked as planned. The iBCF will support the market through funding the 2018-19 impact of the residential and nursing care cost of care review, implementing the additional cost of the new home support framework, managing the impact of the national living wage on sleep in care provision and purchasing packages of care. By 2019-20 it is expected that £33m of the £34m iBCF funding will be spent on either sustaining the market through prices increases or protection of social care, which will mean buying an increased volume of care with the care provider market

2.9.4 The Adult Social Care Committee receives an update on the iBCF within the Adult Social Care Finance Monitoring Report. The latest published information for period 10 (Jan) 2017-18 is attached at **Appendix 3**

2.9.5 Funding has enabled us to:

a) Strengthen our Social Work capacity - By mid-February 40 appointments had been made to new roles in the service

b) Invest with Public Health in a countywide approach to social prescribing, enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services. This is being taken forward on CCG boundaries, working with Districts Council, CCGs & the voluntary sector. Locality plans have been developed with services commencing between January and June 2018
c) Appoint five Trusted Assessment Facilitators across the three acute hospitals. This role has been developed with care providers. The service commenced in January 2018 in the Norfolk & Norwich University Hospital, all three hospitals had this service in place by early March
d) Open new Active Assessment Units. This is an occupational therapy led service, designed to maximise people's independence and reduce permanent admissions to residential care, reduce hospital admissions and support safe and timely hospital discharge.
   A unit at Benjamin Court in Cromer has 18 beds available with services which commenced in February 2018. The East Norfolk scheme, provided by Burgh House, currently has four beds. The unit opened early January and by the end of February had already provided services to seven people. A West Norfolk unit will open later this year
e) Commission three independent flats within a 24-hour housing with care setting at Dell Rose Court in Norwich, supporting people who have been assessed as being medically fit for discharge from hospital, but unable to return to their home safely. Flats are fully contained and have been equipped to replicate a home from home environment. Referrals to the service commenced early February 2018
f) Establish the Enhanced Home Support Service, a small, flexible and enabling service which provides targeted home support to reduce delayed discharges from the three acute hospitals and unnecessary admissions from the community.
   This is a three-year pilot service, free to the service user for visits over a period of up to 72 hours and delivered in partnership by three Home Support providers: Carewatch, Allied Health Care and The Carers Trust.
   The service can offer support around meal preparation, personal care, shopping, welfare checks, medication monitoring and facilitation of the access to and the use of community resources and assistive technology solutions. It is suited to individuals with a low level of short term need. The service launched early February 2018 and by the end of the month had provided services to 30 individuals.
g) Open an additional six beds/flats commissioned as "step down" and admission avoidance from mental health hospitals jointly funded with NSFT with social care support to provide suitable discharge destinations. The service commenced in October 2017.

2.9.6 Where investment in social care is evidenced to provide wider system benefits the expectation is that financial support will be sought from across health and social care to enable new ways of working to continue beyond the project timescales. Where benefits cannot be evidenced or wider financial support from the health sector is not available, it is expected that the interventions will need to be stopped at the end of the projects.

2.10 **Metrics**

2.10.1 A BCF data dashboard is produced and monitored on a quarterly basis and a summary dashboard is included - **Appendix 4**.

The four main metrics that BCF activity is monitored against are:

- Reduction in non-elective admissions
- Rate of permanent admissions to residential care per 100,000 population (65+)
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Delayed Transfers of Care (delayed days)

For the 2017/18 Norfolk has been on track to meet target for three of the four metrics.

2.10.2 **Reduction in non-elective admissions**

- On track to meet target

The total figure for 2017/18 at January 2018 is approximately 77,838 (a rate of 10,7129 per 100,00 population); below the target for this period of approximately 78,934 (10,863 per 100,000).

Enhanced Care in Care Homes work is having a countywide impact on the reduction of non-elective admissions from Care Homes, along with a range of community initiatives such as the creation of the Norwich Emergency Avoidance Team (NEAT).

2.10.3 **Rate of permanent admissions to residential care per 100,000 population (65+)**

- On track to meet target

There is a continued reduction in permanent admissions based on improved practices and a focus on strength based social work practice, underpinned by good performance in reablement.

2.10.4 **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services**

a) On track to meet target

Performance in reablement services continues to have a positive impact on this metric. Up to January 2018 96% of older people (65 and over) were still at home 91 days after discharge from hospital into reablement / rehabilitation services. This is above the target of 90%.

It should be noted that due to the introduction of Liquid Logic the new social care system January's figures are unconfirmed. This is in line with reporting prior to the introduction of Liquid Logic.

2.10.5 **Delayed Transfers of Care (delayed days)**

Not on track to meet target.

Performance has not been on target and peaked in October 2017, performance improved during November and December but declined slightly in January. February's performance has seen an improvement there were 2242 total delayed days in February 2018, of which 890 were attributable to Social Care. This is a 17% decrease from January 2018, where there were 1078 Social Care delays.

3. Financial Implications

3.1 Funding for the plan is by a section 75 agreement and totals almost £70m for each of 2017-18 and 2018-19. This includes Disabled Faculties Grant capital funding of nearly £7m

3.2 Following the announcement of the one-off iBCF grants for 2017-18, 2018-19 and 2019-20, the use of the grant was agreed by NCC and health partners at the end of July 2017. A three-year plan was agreed that also took account of recurrent iBCF funding. The plan was focused on protection of social care, help to support the care market and initiatives to improve discharge from hospital.

3.3 Due to the timing of the grant announcement and finalisation of plans, it was not expected to be able to spend all the 2017-18 grant in year and carry forward has been agreed, both as part of the original plan and within monthly monitoring of progress. This has enabled initiatives to be planned in a structured way, with a clear commitment for pilot schemes to run for an agreed period to enable proper evaluation of benefits and assessment of the cost benefits for future funding. For example these include, social prescribing, enhanced home support and accommodation based reablement, which have mainly been implemented in Quarter 4 of 2017-18. The County Council has set the budget for 2018-19 to ensure that the funding is carried forward for the purposes agreed. At Period 10, the planned carry forward of iBCF funding to future years was £10.971m from a total grant of £18.561m.

4. Governance

4.1 The Health and Wellbeing Board oversees Norfolk's BCF programme, in line with its strategic oversight of the wider system and pursuit of an integrated, sustainable health and wellbeing system. Adult Social Care and CCG Chief Officers are responsible for ensuring the plan is delivered and appropriately reported to NHS England on a quarterly basis.

4.2 Feedback to NHS England on year one identified that two key successes observed in Norfolk toward driving integration in 2017/18 were:

a) Strong, system-wide governance and systems leadership, through the Health and Wellbeing Board partnership, including buy-in from elected representatives and health organisation leaders, plus regular meetings of senior CCG and NCC leaders
b) Empowering users to have choice and control through an asset based approach, shared decision making and co-production especially via Implementation of the three conversation model which promotes an asset-based approach to social care in innovation sites

4.3 Feedback to NHS England on year one identified that two key challenges observed in Norfolk toward driving integration in 2017/18 were:

a) Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors) particularly with the ageing population and providing services in rural areas resulting in unprecedented pressures on the local health and social care system
b) Integrated electronic records and sharing across the system with service users. The implementation of Liquid Logic has impacted on the availability of social care data between September 2017 and January 2018. The complexity of five CCGs (one half in county), three acute trusts and two community providers complicates joint planning and record sharing

4.4 The BCF risk register is monitored and reviewed regularly with the most significant risks being:

a) Inability to adequately reduce Delayed Transfers of Care across the system.

Mitigating actions include introduction of iBCF initiatives, appointment of a capacity manager, weekly monitoring of DTOC, and a system wide review

b) Workforce capacity and/or skill set insufficient to deliver quality services in some sectors

4.5 Mitigating actions include a STP workforce workstream, a Sector Skills plan and development of a European Social Fund bid to address capacity and skills issues

5. Conclusion and next steps

5.1 Norfolk's Better Care Fund and Integration Plan 2017-19 has made good progress in year one.

5.2 The five priority areas have delivered against the identified milestones. Priorities for year two include countywide development of risk stratification and analysis of the impact of a number of new initiatives that have been developed to support integration and keep people at home. These assist in continuing to prevent emergency admissions and are impacting on a reduction in delayed transfers of care

5.3 The iBCF has been used to support the BCF priorities and has enabled delivery of key elements of the HICM. System-wide delivery of HICM remains a challenge and this will be a focus for the next year

5.4 Initiatives continue to deliver performance that ensures most targets are met. Performance against DTOC is an area of concern, but with an increased focus on HICM, the implementation of iBCF initiatives, a planned review of health & social care DTOC and ongoing joint working, performance is expected to improve.

5.5 The Better Care Fund and Integration Plan 2017-19, has evidenced effective and innovative working through the delivery of, Supported Care, the Enhanced Care in Care Homes Initiative, Supported Care Programme, Social Prescribing, IEVs and use of the iBCF. Work is underway to address identified challenges and risks are being managed.

5.6 The progress review for 17/18 will be used to refresh and update the plan to ensure year two is targeted on the correct priorities and on supporting the delivery of the desired outcomes and impacts.

6. Recommendations

6.1 **Committee is invited to review and agree the report, noting progress that has been made with integration in Norfolk**

Officer Contact

If you have any questions about matters contained in this paper or want to see copies of any assessments, eg equality impact assessment, please get in touch with:

Officer Name:	**Tel No:**	**Email address**:
Sera Hall	01603 224378	sera.hall@norfolk.gov.uk

If you need this report in large print, audio, Braille, alternative format or in a different language please contact 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

Borough Council of King's Lynn & West Norfolk

Prevention and Promoting Independence -the District Council Contribution to the Better Care Fund Outcomes in Norfolk

Issue : 5

Martin Sands
10/04/18

Prevention and Promoting Independence
The district council contribution to the Better Care Fund Outcomes
1917/18 update

1. Introduction

This document is intended to show the activities and interventions of the District Councils in Norfolk that help residents to live independently at home, whether supporting them to continue living independently, enabling them to resume living independently after a stay in hospital or care home, or preventing the need for more serious interventions in the first place.

2. Document Overview

The document consists of a number of sections, the first section shows the activities and interventions that are common across all of the seven district councils in Norfolk. Then there are a further seven sections, one for each of the district councils, that show the activities and interventions that are specific to the individual councils. Those activities or interventions provided in the Better Care Fund/ Disabled facilities Grant Locality Plans are shown in *'italicised text'* to distinguish them from other activities or interventions provided.

Each of these sections contains a table that is split into three columns to indicate whether the activity or intervention is intended to help with "living well" (Prevent development of needs), "Maintain Independence" (Early Intervention), "Reablement at Home" (Reablement). Activities or interventions that fit into more than one heading are shown across multiple columns as appropriate.

The seven appendices are the specific BCF/DFG Locality plans produced by each of the seven district councils and integrated commissioners representing their Clinical Commissioning Group and Norfolk County Council. These contain the detailed descriptions of the activities and interventions being undertaken within these plans.

Prevention and Promoting Independence

The district council contribution to the Better Care Fund Outcomes 1917/18 update

Issue/Aim:	Living Well (Universal Pathway)	Maintaining Independence	Reablement at Home
Type of activity:	**Prevention**	**Early Intervention**	**Reablement**
Services/Initiatives Common to all District Councils	**Disabled Facilities Grant** Grant funded home adaptations recommended by and Occupational Therapist. Including improving access to bedroom and bathing facilities, cooking and food preparation, improving the safety within the resident's home.		
	Integrated Housing Adaptation Team – Continuous Improvement Plan *Review and amend existing processes to provide a more efficient and streamlined approach to providing Disabled Facilities adaptations. Agreed target for delivery is an average of 140 calendar days from initial enquiry to completion of the works.*		
	IHAT Housing Needs Reports – Produce housing needs reports to support Housing Options team to identify suitable properties for those people who need an adapted/adaptable property.		
	Housing standards Supporting residents to ensure that their homes are healthy and safe environments to live.		**Housing Options** Enabling moves to more suitable accommodation, where appropriate.
			Hospital Discharge *Working in partnership with hospitals to provide a common streamlined pathway for referral to ensure residents are able to return home or access suitable alternative accommodation prior to discharge from hospital.*

Prevention and Promoting Independence

The district council contribution to the Better Care Fund Outcomes 1917/18 update

Issue/Aim:	Living Well (Universal Pathway)	Maintaining Independence	Reablement at Home
Type of activity:	**Prevention**	**Early Intervention**	**Reablement**
Breckland District Council	***Discretionary Reable Grant*** *To broaden the eligibility criteria for the Breckland Discretionary Adaptation grant (Reable) to include a greater proportion of clients who can benefit from the streamlined service.*		
	Breckland Agency Service Establish a Breckland Agency service to extend the support offered to clients in the provision of adaptations.		
	Handyperson Service *Reintroduce a Handyperson Service for Breckland residents.*		
			Fast Track Hospital Discharge Process *Develop process to use the Discretionary Reable grant to fast track Hospital Discharge cases*
			Appointment at Triage *To introduce 'appointment at triage' stage to eliminate the waiting list for assessment.*

Prevention and Promoting Independence

The district council contribution to the Better Care Fund Outcomes 1917/18 update

Issue/Aim:	Living Well (Universal Pathway)	Maintaining Independence	Reablement at Home
activity:	Prevention	Early Intervention	Reablement
Broadland District Council	**Handyperson Plus -** Provides a small repair and maintenance programme, including the introduction of minor adaptions to help vulnerable residents remain safe in their homes. Assessment and support procedure provides information and guidance. Referral procedure to community services, and advocacy for benefit claims.		
	HIA interventions - Providing support for vulnerable people to stay healthy and independent in their own properties. Assistance with major/minor repairs and adaptations. Ensuring incomes are maximised; assistance with benefit and charity applications referrals to ancillary services and for financial assistance.		
	GP Clusters and MDTs - *Identification of those most at risk of hospital admission at a GP surgery. Co-operation between Integrated Care Co-ordinators and HIA enabling a focused personal intervention with the individuals providing access to the range of housing and benefit related support that the District provides. Referral to other agencies to assist vulnerable people to remain living independently in their own homes.*		
	Energy Advice: - to keep vulnerable residents warm in their own homes.- Provide energy advice on costs, suppliers, insulation and affordable options. Provide access to financial assistance for system repair and replacement where available.		
	Early Help Hub - A multi-agency team located at the Broadland District Council offices working in partnership to advise, support and assist individuals and families. The aim is to work with individuals and families as early as possible to prevent the need for more formal responses. Other council departments link into the hub;		
	Debt and Welfare Advice		
	Community at Heart (inc Community Projects Officer) Takes a whole council approach to getting more closely involved with our communities, building productive relationships and raising awareness of key initiatives between communities and ourselves. Also aims to build more trust and understanding for residents in terms of the role of the council and see first-hand the work of the councillors they voted for. Link to external community roles and groups including those relating to Health and Social Care; for example, NCC Development Workers, Integrated Care Coordinators and Adult Social Care's 3 Conversations Assistant Practitioners Provides Secretariat function to the Broadland Dementia Action Alliance		
	Falls Prevention Slipper Exchanges as part of Local Public Health Offer(LPHO) activity	**Smoking prevention -** LPHO activity-Smoke free parks and sports pitches signs requesting adults refrain from smoking in these areas.	
	LPHO Activity - Excess Winter Death Prevention Activities include: Energy team attending Aylsham Age Wise event, Thorpe St Andrew Heat and Eat Event – direct mailing to recipients of Guaranteed Pension Credit, Slow Cooker workshop (attendees receive free slow cooker), stands from other organisations		
	Community Groups and activities - Set up and/or enabled by BDC such the Marriott's Way 10k race; social physical activity groups; 3 parkruns and council produced cycling & walking leaflets	**Broadly Active -** A programme of physical activity and behaviour change therapy prescribed by a health professional to help manage and reduce the effects of chronic health problems such as coronary heart disease, diabetes, hypertension, anxiety, depression etc. Patients are referred at early stage and as part of a rehabilitation programme after hospital intervention	
	Active Norfolk Activity Pathway The development of outcome focused district level sport and physical activity locality plans co-produced between Active Norfolk, district councils and partner organisations		
	Why Weight A twelve week, tier 2, local weight management plan encouraging individuals to better understand their relationship with food. Education sessions combined with behaviour change therapy encourage lifestyle changes rather than short-term dieting. Suitable for anyone 16+ with a BMI of 25 or more so suitable for early intervention through to complementary treatment for the seriously ill returning home.		

Prevention and Promoting Independence

The district council contribution to the Better Care Fund Outcomes 1917/18 update

Issue/Aim:	Living Well (Universal Pathway)	Maintaining Independence	Reablement at Home
Type of activity:	**Prevention**	**Early Intervention**	**Reablement**
Great Yarmouth Borough Council	**Social Prescribing** Utilising the Connector roles mentioned below, the local VCS provision and GP surgeries to deliver a comprehensive offer that includes a range of advice and guidance plus personal development, support and navigation and community based self-help.		**Healthy Homes Assistance** Speedily undertakes works to a patient's property to facilitate safe hospital discharge or to prevent admission to hospital.
	Housing related Support Services Sheltered housing accommodation based service and outreach floating support service both keeping older people living at home independently safe & well.		**Assistive Technology – I'm Going Home** 24/7 hospital discharge service using temporary Yare Care community alarms and keysafe.
	Safe at Home HIA Services Providing housing repair and adaptation advice and support service. Includes full design service and support to seek funding. Also provide a Handyperson service.		**Great Yarmouth Community Housing** Comprehensive repair and adaption service for tenants of GY Community Housing.
	Early Help Hub - A multi-agency early intervention and collaboration hub where cases are discussed to avoid crisis interventions		
	Neighbourhoods that Work Building stronger communities and encouraging self-help using Community Connectors, Life Connectors, Skill Connectors and Community Development Workers		
	Yare Care Community Alarms - Utilising assistive technology to support independent living and provide 24/7 access to emergency help.		
	Making Every Adult Matter / Housing First Working collaboratively with a homeless hostel provider to provide housing first then combine it with supportive treatment services, education and employment		
	Sport and Leisure Providing accessible and affordable indoor leisure provision to encourage greater participation and promote healthy living		
	Tenancy Services The council is a stock owning authority providing quality accommodation at affordable rents and provides a comprehensive estate management service that supports & promotes wellbeing.		
	Emergency Repairs & Discretionary Loans Recycling existing loans when repaid to provide funding for emergency repair works for vulnerable households		

Prevention and Promoting Independence

The district council contribution to the Better Care Fund Outcomes 1917/18 update

<table>
<tr><th>Issue/Aim:</th><th>Living Well (Universal Pathway)</th><th>Maintaining Independence</th><th>Reablement at Home</th></tr>
<tr><th>Type of activity:</th><th>Prevention</th><th>Early Intervention</th><th>Reablement</th></tr>
<tr><td rowspan="11">Kings Lynn & West Norfolk Borough Council</td><td colspan="3">Handyperson Service - To provide a low level minor adaptations and repairs service focusing on prevention and early interventions</td></tr>
<tr><td colspan="3">Discretionary ADAPT grant- Raise limit from 6K to 12k</td></tr>
<tr><td colspan="3">Provision of Hardship Fund - To assist with client contributions where a client cannot raise the funds required.</td></tr>
<tr><td colspan="3">Provision of loan fund
To assist with cases where total costs exceed the maximum allowable £30K and the client cannot pay the costs above the 30K limit.</td></tr>
<tr><td colspan="2">Early Intervention Initiative –
Target identified cohorts of people with advice, information and low level initiatives such as a prevention home assessment, dementia assessment, home safety assessment, and energy tune up.</td><td>Fast Track Hospital Discharge Pilot:-
Development of Fast Track modular Ramping service and fast track stairlift service</td></tr>
<tr><td colspan="2">Lily
Ask LILY is a service focused on combatting loneliness and reducing isolation to support health and wellbeing. Available online, by telephone, via LILY Advisors at community locations or a home visit, adults can access advice, information and help to engage with social activities..</td><td>Handyman to assist Hospital Discharge:- Use of handyman service to support hospital with minor adaptations for Hospital discharge.</td></tr>
<tr><td colspan="2">Minor adaptation works grant
Introduce non-means tested minor adaptations grant for works under £1000</td><td>Lily:- Link into hospital teams to offer assistance to patients being discharged home.</td></tr>
<tr><td>Assistive Technology – (help people stay safely at home) - develop project to focus on key areas in partnership with Locality Social Care team.</td><td colspan="2">Relocation Grant
To help fund relocation costs in cases where adaptations cannot be made to the current property or moving is a more cost effective solution.</td></tr>
<tr><td>Energy Advice
To assist clients with general advice and funding information about heating problems.</td><td colspan="2">Partnership working with health and community teams
Identifying a streamlined pathway and referral template to enable community therapy teams to send in referrals for minor and major adaptations. To provide training workshops throughout the year to cross-train the multi-disciplinary teams in specialist areas</td></tr>
<tr><td colspan="2">Partnership working with Care Navigators
To work closely with other Organisations that provide support and co-ordinated care for over 75's in the west. To provide a stream lined process for referrals and to share relevant information about clients that may be accessing these services. To consider a hot desk arrangement within the IHAT</td><td>Non Means tested Hospital discharge Grant
To assist with a fast-track process for delivery of ramps and stair lift adaptations for hospital discharge</td></tr>
<tr><td colspan="2">Prevention Grant
To assist with the provision of minor adaptations for cases that are identified as in health need but have not yet reached care act eligibility</td><td>Amend Safe and Secure and Careline Grants
To provide discretionary assistance for minor repairs and Careline equipment.</td></tr>
<tr><td></td><td>Emergency Repair Grant
To assist with urgent minor repairs -</td><td>Assistive Technology – to assist with safe discharge from hospital - pilot project to focus on AT to help with safe discharge form hospital</td></tr>
</table>

Prevention and Promoting Independence

The district council contribution to the Better Care Fund Outcomes 1917/18 update

Issue/Aim:	Living Well (Universal Pathway)	Maintaining Independence	Reablement at Home
Type of activity:	**Prevention**	**Early Intervention**	**Reablement**
North Norfolk District Council	**Early Help** Hub collaboration meetings supporting timely interventions and Referral system between hub partners		**Hospital Discharge** Working in partnership with local hospitals to ensure residents are able to return home or access suitable alternative accommodation prior to discharge from hospital.
	Energy Advice Energy advice and signposting. Access to Norfolk Big Switch and Save.		
	Support of local implementation of national campaigns This includes but is not limited to promotions such as Stay Well This Winter, Flu Clinics etc		

Prevention and Promoting Independence

The district council contribution to the Better Care Fund Outcomes 1917/18 update

Issue/Aim:	Living Well (Universal Pathway)	Maintaining Independence	Reablement at Home
Type of activity:	**Prevention**	**Early Intervention**	**Reablement**
Norwich City Council	**Handyperson Scheme** Carrying out all general repairs, DIY, gardening, painting and decorating. Subsidised rates for older and vulnerable residents including up to two hours free labour on council tax reduction.		
	Discretionary Adaptations Grant *Discretionary grant of up to £5,000, for clients applying for a disabled facilities grant, toward the client contribution required by the means test.*		
	Preventing Admission to Hospital Grants *Non means tested grant of £10,000 and fast track adaptations and improvement service (28 days) to avoid admittance to hospitals.*		
	Domestic abuse outreach service Commissioned domestic abuse outreach service to provide adults, children and young people in Norwich who are currently in an abusive relationship with the necessary advice and support to help them and their children live more safely and independently.		***Hospital Discharge Grants (plus fast track service)*** *Non means tested grant of £10,000 and fast track adaptations service (28 days) to enable timely discharge of inpatients.*
	The Consortium - Commissioned service to deliver a range of social welfare advice, casework and representation services in order to reduce financial and social exclusion and inequalities.		
	Financial Assistance for Home Improvement for vulnerable home owners *Means tested grants and loans of up to £35k to carry out repairs to tackle or prevent hazards prejudicial to health in the home*		
	Social Prescribing - Working through Tuckswood and Gurney GP practices to help people address underlying issues early through linking into services within the community.	**Safe at Home Grants** Grants up to £2,500 to help people living with dementia and vulnerable home owners to maintain suitable and safe homes.	
	Energy Advice - Including loft clearance, insulation and heating grants and help to reduce energy bills.	**Tenancy Sustainment Team** Supporting tenants to remain in their own home	
	Support of local health and well-being initiatives Includes but not limited to Healthy Norwich, digital inclusion, promoting applications for free school meals and Healthy Start amongst new and expectant mothers.	**Norwich Early Help Hub** Working with partners to make sure individuals and families receive the most appropriate and effective support as soon as possible.	***Hospital Discharge Process-*** Working in partnership with NNUH, NCH&C, CCSRS and ASSD to update hospital discharge process to ensure residents are able to return to suitable accommodation (their own home or an alternative).
	Support of local implementation of national campaigns Including but not limited to Stay Well This Winter, Electrical Safety First.	**Money Advice Team** Providing money and debt advice to tenants.	

Prevention and Promoting Independence

The district council contribution to the Better Care Fund Outcomes 1917/18 update

Issue/Aim:	Living Well (Universal Pathway)	Maintaining Independence	Reablement at Home
Type of activity:	**Prevention**	**Early Intervention**	**Reablement**
South Norfolk Council	**Handyperson Scheme** Carrying out all general repairs, DIY, gardening, painting and decorating. Subsidised rates for our older and vulnerable residents including up to two hours free labour on a means-tested benefit.		
	Social Prescribing Working through South Norfolk's GP practices, Community Connectors help people address underlying issues early rather than continuing to use clinical or medical services unnecessarily through linking into services within the community.	**FIRST Officers** *Financial Independence, Resilience, Support and Training* is a multi-specialism support provision which will be able to provide a holistic package of support to residents of South Norfolk on a variety of issues	**Hospital Discharge (District Direct)** Working in partnership with NNUH to update the processes for Hospital discharge to ensure residents are able to return home or access suitable alternative accommodation prior to discharge from hospital.
	Energy Advice Including insulation and heating grants and help to reduce energy bills		**District Direct Hospital Discharge Grant** The District Direct Hospital Discharge Grant (max £3000) is intended to assist our residents who are able to return home from hospital, but are being prevented from doing so because there are factors at their home (that can be speedily remedied), that prevent them from doing so.
	Support of local implementation of national campaigns This includes but is not limited to promotions such as Stay Well This Winter, Flu Clinics etc.	**Early Help Flexible Fund** Available to support residents with one off small value solutions as part of a wider request for support from the Early Help Hub	
	Triage team Team based within the early help hub who identify and triage those residents on first enquiry about independent living	**Independent living team** Supporting residents to remain in their own home	

Appendix 1 – Breckland Locality Plan

Breckland Council Better Care Fund Locality Plan 2017/18-18/19	
Area covered:	**Breckland Council**
DFG Funding:	BCF Allocation – 2017/18 £1,003,721 2018/19 TBC

Overview:

One of the core purposes of the Council's Housing Team is 'If you want to stay at home, we'll support you to live more independently'

This purpose has been developed to reflect the statutory duty of the Council but also the current and future aspirations of the organisation.

The first objective is to fast track assessments for property adaptations at first contact. The Council has recently developed a Housing Support Hub with the capacity to triage and where appropriate deal with the majority of customer enquiries coming into the housing service, including requests for adaptation assessments. This team has been developed using intelligence which is based on the type and frequency of enquiries historically logged with the Housing Service. It is proposed that following the initial triage, appointments are scheduled at first point of contact based on level of complexity therefore working to a position of no waiting list.

This is particularly useful in terms of hospital discharge where it is proposed that through close engagement with the acute hospitals serviced by the Breckland area, the Housing Support Hub will become a key feature of the respective hospital's discharge process. By developing the multi-disciplined approach of the Hub a decision can be made at first point of what service would be most appropriate to successfully support an expedited discharge.

This way of working can also be exercised when considering elected surgeries and Breckland is committed to where possible preventing an admission but where this is unavoidable and where an adaptation is required will through the above process be in a position to carry out these works to aide a discharge and support the residents recuperation.

In addition, the service is currently considering the intelligence held by the Council to forecast those customers who may require an adaptation in the future and where possible prevent this from occurring. This includes the use of triggers and a collective approach from all Council departments to ensure that the organisation fully understands requests which are being made and what support in addition to what is being asked for is considered and where necessary put in place.

The Council is also reviewing the Reable Grant, Breckland's discretional property adaptations grant in order that this supports the above way of working.

Appendix 1 – Breckland Locality Plan

Delivery for 2017/18-18/19:

Activity in 2017/18 and proposed activity 2018/19

IHAT Continuous Improvement Plan – Breckland is committed to the common objectives of the IHAT continuous improvement plan and the goal to reduce end to end times to 140 days.

2017/18 update - Breckland has reduced the number of people on the waiting list to nil, in addition applicants are triaged and appointments made for initial assessment at first point of contact. The 140 days end to end objective has not been achieved, this is in part due to the clearing of and the associated historic waiting time accrued whilst waiting for the initial assessment.

2018/19 proposal - No Change

Hospital Discharge "Common Referral Pathway" – Work in partnership with hospitals to provide a common streamlined pathway for referral to ensure residents are able to return home or access suitable alternative accommodation prior to discharge from hospital. Breckland is unusual in so far as our catchment covers 3 key hospitals – N&N; Bury and Kings Lynn.

2017/18 update - Breckland has contributed to the successful pilot of District Direct, N&N hospital discharge process. The District has also been supportive and contributed to the proof of concept resulting in the NHS looking to finance the initiative on a permanent basis.

2018/19 proposal - No Change

Hospital Discharge "Fast Track Service" – Develop process to use the Discretionary Reable grant to fast track Hospital Discharge cases. This will require the acceptance of third party assessments of need and agreement of emergency timescales with contractors.

2017/18 update – See below

Discretionary Reable Grant - To broaden the eligibility criteria for the Breckland Discretionary Adaptation grant (Reable) to include a greater proportion of clients who can benefit from the streamline service. Subject to ratification, we will make Reable grants available to £14,000 (currently £7000)

2017/18 update – Reable grant currently at £7000

2018/19 proposal - It is still proposed that the discretional grant (Reable) will be reviewed to take into account the increase in general work costs and to ensure that the District can provide and maintain a fast-tracked adaptations service.

Handyperson Service – as part of the proposed agency service it is intended to reinstate a handyperson service to cover the Breckland area

2017/18 update – Breckland currently outsources its handyperson responsibilities to other neighbouring authorities.

2018/19 proposal - This remains an objective of the proposed new Home Improvement Company.

Appendix 1 – Breckland Locality Plan

Appointment at Triage - To introduce 'appointment at triage' stage to eliminate the waiting list for assessment. A private occupational therapist is currently being used to assist in reducing the current waiting list. Within 3 months (July 17) it is intended that appointments for assessment will be offered at the triage stage.

2017/18 update – Achieved – see above

2018/19 proposal – No Change

Breckland Agency Service - Establish a Breckland Agency service to extend the support offered to clients in the provision of adaptations. Options for the appropriate service delivery model are due to be considered by Breckland Councillors summer 2017

2017/18 update – The Council remains committed to provide a high quality works and expedited adaptation and grants service and are currently looking at options in terms of future delivery.

Appendix 2 – Broadland Locality Plan

Area covered:	**Broadland District Council**
DFG Funding:	**BCF Allocation – 2017/18 £766,244** **2018/19 TBC**
Expected demand for DFGs in 2018/19 and planned delivery:	
Expected Demand - 138 recommendations. Planned Delivery - 138	

In the following table, please include your proposal with innovative ideas and practice to support people to live independently at home.

Whilst putting together your proposal(s) please consider:

- the wider contribution of Districts
- how activity can contribute towards reduction in admissions to acute and care homes and support hospital discharge

Proposal 1 – Targeted approaches: Social Prescribing
Describe proposal in this box. Include: • The objective of the scheme: Further develop a programme where those most at risk of hospital admission and Adult Social Care cases are referred for wider support from the District Council as part of the prevention offer. • Some background (if relevant) on what has happened before. District Councils offer a range of housing and benefit related support to assist vulnerable people to remain living independently in their own homes. This could include adaptations, advice on appropriate benefits, energy efficiency advice, grants/loans for home repairs, a handy person service, community and 3rd sector support and general housing advice. The gateway to this support is through Home Improvement Agency Staff (HIA). Currently referrals are through an open process but a targeted approach has been developed at a single GP surgery in the Northern Locality for those most at risk of hospital admission. The scheme has moved the preventative approach forward for this cohort of people. The previous three month program has demonstrated considerable success to the satisfaction of the surgery involved and relative partners who operate through the survey. However some refinement of the process is required and further demonstration of the outcomes that are a result of the process. Therefore to move the procedure forward an intervention is proposed at an alternative GP surgery within Broadland District Council's boundary. • An overview of the scheme and activity that would take place The proposal is to develop and refine the provision of the wider support available from District Councils using the HIA as a conduit and establish a cost based approach that demonstrates financial benefits to the surgeries, adult social care and the NHS as a whole achieved by the

multidisciplinary approach taken by HIA officers.
Aimed at those who are at greatest risk of admission and a sample of certain initial demand into Adult Social Care to identify whether this support would aid them / their carer if not already in place.

The new procedure will be influenced by the evaluation of the original Aylsham pilot which is currently being developed in co-operation with the CCG's involved. If the approach evidences that such support further increases the independence of referred patients (if not already receiving such support), reduces admissions and demonstrates financial savings then a business case will be developed detailing the sustainability of the scheme.

Rationale/Evidence base

Detail your rationale/ evidence base here

Developing integrated approaches to ensure services are identifying and wrapping provision around those who are most at risk of hospital admission. The pilot at Aylsham has demonstrated that where the nature of the case allows, there are alternative ways of responding to demand into Adult Social Care rather than a full social care assessment.

Outcomes

Use this space to detail your expected outcomes

- Reduced emergency admissions within targeted cohort of people
- Dedicated prevention offer available to those most at risk
- Reduce reliance on care packages
- Reduced admission to care homes
- Potential for a reduction in carer breakdown
- Increased patient experience
- Potential for reduction in delayed transfers of care

Update

Two successful projects have been delivered involving two surgeries in the Northern locality area. A further intervention has been initiated in the North CCG locality. Evaluation is proceeding. No further intervention is anticipated at present as part of the locality procedure.

Proposal 2 – Targeted approaches: More than 2 adaptations

Describe proposal in this box.

Include:

- The objective of the scheme

Determine whether those who have been referred for more than 2 housing adaptations are known to MDTs – to avoid hospital admission. It is likely that this cohort would be known to

teams but it would be advantageous to be assured as this may highlight those that should be part of an MDT.

- An overview of the scheme and activity that would take place.

  This project would help inform those people who may be in need of an MDT approach, if not already identified. This may be a way of ensuring that those needs which may increase from a health and social care perspective are targeted as a priority, and enabled to maintain their independence via an MDT approach.

Rationale/Evidence base

Detail your rationale/ evidence base here

Developing integrated approaches to ensuring services are identifying and wrapping provision around those who are most at risk of hospital admission.

Outcomes

Use this space to detail your expected outcomes

- Reduced emergency admissions within targeted cohort of people
- Dedicated prevention offer available to those most at risk
- Potential for a reduction in carer breakdown
- Increased patient experience

Update

We shall initiate correspondence with Adult Social Care regarding the continued value of this process.

Proposal 3 – Improving End to End Times for the Adaptation Process

- The objective of the scheme

  To reduce the start to finish time for Disabled Facilities Grant aided adaptations to 140 days.

- Some background (if relevant) on what has happened before

  Previously, Integrated Housing Adaption Teams (IHAT's) consisting of collocated Occupational Therapists and District Council Staff were developed. This resulted in the start to finish times for adaptations to be provided reducing to an average across Norfolk of 243 days.

- An overview of the scheme and activity that would take place

  Demand will be assessed and approaches will be taken to remove waste from the system.

Rationale/Evidence base

Detail your rationale/ evidence base here

- Adaptations provided through DFG's have been proven to delay admission to residential care for an average of 4 years and to reduce the amount of formal and informal domiciliary care required. Therefore, the sooner such adaptations are provided the better in terms of this

preventative effect.

Outcomes

Reduction in the start to finish time for DFG adaptations to 140 days.

Update

Progress has been made and applicants are now generally seen within four weeks of an assessment which should be reflected in reduced start to finish times as this feeds through. We will continue to analyse the process and identify time efficiencies that can be implemented.

Proposal 4 – Provide Low level adaptions through the Handyperson+ Service (BCF funding increase dependant).

Describe proposal in this box.

Include:

- The objective of the scheme

To provide low level adaptions as part of a proactive response to residents who access the handy person scheme.
Broadlands Handy Person plus service currently provides a service for eligible residents to have small works done within their dwellings. The plus element of the service involves a **peas**

- If funding from BCF allows the Handy person will install low level adaptions as result of an initial assessment.

Rationale/Evidence base

Detail your rationale/ evidence base here

- Low level adaptations will be specifically based on accident prevention. They are therefore a preventative tool as opposed to higher level adaption that are preventative but also provide the opportunity for residents to stay in their own homes.

Outcomes

- These low level low cost adaptions are expected to reduce demand on GP surgeries and hospital emissions.

Update

33 low level grants have been approved to date. Subject to Cabinet approval the cap on this grant will be raised to £750

Appendix 2 – Broadland Locality Plan

Proposal 5 – DFG Top up Grants for contributions below £2000 (BCF funding increase dependant)

Describe proposal in this box.

Include:

An overview of the scheme and activity that would take place.

- Discretionary grant of up to £2,000 for clients applying for a disabled facilities grant. This will go towards the client contribution required by the means test.

Rationale/Evidence base

Detail your rationale/ evidence base here

The preventative element of DFG funding has been well documented relating to decreased pressure on care packages and care homes and a reduction in hospital emissions. Providing a top up fund is likely to increase the take up of these grants where a moderate contribution is required.

Outcomes

Widening affordability will increase the number of adaptions which will increase the preventative effect of the service.

Update

This proposal has not been moved forward and will be replaced with further proposals relevant to Better Care Fund.

Proposal 6 – Health Improvement Grants to upgrade inefficient heating systems (Max £4500)

A proposal to provide means tested boiler replacement for defective or non-condensing boilers or storage heaters for residents with health issues. The scheme will continue a current project and will be subject to cabinet approval and accessibility aligned to available funds.

Rationale/Evidence base

Detail your rationale/ evidence base here

Replacing an inefficient boiler enhances the efficiency of heating systems for vulnerable persons and therefore affects the affordability of staying warm with all the health benefits this provides.

Outcomes

Reduce demand for residents and health and care services

Appendix 2 – Broadland Locality Plan

Proposal 7 – Extended Financial Assistance
A new proposal to provide a top up grant or loan additional to £30K DFG. The proposal will be subject to cabinet approval and accessibility aligned to available funds.
Rationale/Evidence base
This proposal will provide further financial assistance where the current cap of £30K will not provide the funds necessary to complete the adaptions at a property.
Outcomes
Reduce demand for residents for health and care services.

Proposal 8 – Architect Grant
A new proposal to provide a means tested architect fee grant for complex cases. The proposal will be subject to cabinet approval and accessibility aligned to available funds.
Rationale/Evidence base
Complex cases are stalled where structural works require pricing prior to approval. The only option for the pricing procedure is for the applicant to finance the architect fee prior to approval hence the stall and sometimes abandonment of the procedure. A grant to cover these costs will help to ensure a smooth process for complex cases where structural works usually in the form of an extension are required.
Outcomes
Fluid procedure and reduced cancelation where complex works are required which will lead to reduced demand for residents for health and care services.

Proposal 9 – Get You Home Grant
A Get You Home Grant of up to £1000 to pay for essential maintenance works at residents' properties identified through the District Direct Service and other hospital referral routes. The proposal will be subject to cabinet approval and accessibility aligned to available funds.
Rationale/Evidence base
The grant would be used for trade services such as plumbing and electrical works and other works beyond the scope of the handy person plus service or one off capital expenses, such as purchasing necessary furniture or appliances or skip hire for decluttering.
Outcomes
Outcome aimed at reducing Hospital ward pressure and to assist resident to return to their homes at the earliest opportunity.

Appendix 3 – Great Yarmouth Locality Plan

Better Care Fund & Disabled Facilities Grant Locality Plan 2017/18 – 18/19 (Update February 2018)	
Area covered:	Great Yarmouth Borough Council
DFG Funding:	BCF Allocation - 2017/18 £1,021,403 2018/19 £TBC

Overview:

This locality plan has been jointly developed by Great Yarmouth Borough Council, Norfolk County Council and Great Yarmouth and Waveney CCG in response to the BCF/DFG allocation for 2017/18 and 2018/19 and in accordance with the BCF guidance which states:

The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives are required to be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

This document provides an overview of delivery up to the end of February 2017 and sets out the proposals and aims for the funding for 2018/19.

Key considerations

It is important to note the following which has been part of the conversation to develop this joint plan;

- Capital contribution by Great Yarmouth Borough Council: Should the Council require further financing to meet its statutory DFG function then approval to borrow would be sought. The Borough also provides discretionary loans as and when funds are available as a result of existing loans being repaid.
- The current funding of the Home Improvement Agency Service (Safe at Home) via the Clinical Commissioning Group: This helps to fund the caseworker role which not only supports vulnerable applicant through the DFG process but also provides Information and Advice to people who contact the HIA. It is recognised that if this was withdrawn, it would significantly impact on the capacity of the HIA to support the delivery of the outcomes associated with BCF/ DFG.
- As agreed the £36,251 underspend from 2016/17 has been rolled forward into 2017/18, helping to deliver the outcomes of this locality plan.
- Additional officers (1.86 fulltime equivalent) have been employed by Great Yarmouth Borough Council to deliver the projects set out in the plan and to help deliver similar project outcomes in Waveney for 2018/19. Capitalising revenue through the charging of fees for each job has generated insufficient income to maintain the additional officer posts and these rolls are now being supported by additional funding from Norfolk County Council, Suffolk County Council and Waveney District Council.

Expected demand and planned delivery for 2017/18:

Disabled Facilities Grant

The table below sets out the delivery associated with disabled facilities grants for 2014 to 2017

Year	Completions	Total Spend	Average Cost
2014/2015	118	£606,497	£5,139
2015/2016	118	£687,974	£5,830

2016/2017	115	£898,967	£7,817

Activity 2017/18

Type of work	No. applications received	No. applications approved	Value of approvals (£)	Value of payments made (£)	Completions	Outstanding commitment
Disabled Facilities Grant	101	100	£843,679	£888,194	117	£317,961

The 2016/17 Locality Plan set out parameters for utilising any underspend on DFG because there was a recognition that while there is significant demand for DFG it isn't always possible to covert that in a timely fashion into actual jobs.

Healthy Homes Assistance and **I'm Going Home** are two projects that have evolved out of the 2016/17 plan. These projects have used surplus BCF / DFG funding to enable people to return and / or remain at home. The projects have targeted delayed hospital discharge cases and admission prevention through A&E.

DFG Locality Plan for Great Yarmouth

Proposal 1:

Health Homes Assistance

The objective of this scheme is to ensure that any BCF surplus funding is used and targeted at specific people to either enable timely hospital discharge or provide a proactive prevention service that prevents hospital admission. This is done using grants for works up to £10,000

This surplus funding is to be used to target cohorts of people where improvements made to their home will deliver a clear benefit to their health and wellbeing and subsequently a reduction in demand for services.
The cohorts currently identified are;

- Hospital discharge cases
- Measures' to prevent hospital admission e.g. falls prevention

Works under £1,000 (Grant, not means tested)

Eligibility - Anyone identified as being in the target groups listed. Assistance restricted to three separate applications in any twelve month period.

Applicants must be referred by a health care professional using the Healthy Homes Referral Form. Social Work Duty, Out of Hospital Team, GPs, etc. – Key is that there is a health outcome.

Works over £1,000 (Grant, means tested, for works up to £10,000)

Eligibility - Anyone identified as being in the target groups listed. Assistance for works costing more than £1,000 is restricted to a single application in any twelve month period with a maximum of £10,000 in any 5 year period. However works under £1,000 can still be applied for separately. Where Healthy Homes Assistance is used in conjunction a Disabled Facilities Grant (DFG) application the maximum combined total grant available is £30,000 (less any means tested contribution).
Applicants must be referred by a health care professional using the Healthy Homes Referral Form. Social Work Duty, Out

of Hospital Team, GPs, etc. – Key is that there is a health outcome.

2017/18 Results

Progress and Delivery

A full-time technical officer and a part-time support officer were appointed at the end of November 2016 to develop and implement the locality plan. The Healthy Homes Assistance scheme was developed in conjunction with key partners in health and social care, the aims of the scheme and measures were agreed.

The officers took time to shadow key frontline staff from other organisations to learn about the issues they faced and how the Healthy Homes Assistance scheme could support their work. This informed the referral process which was developed to be quick and easy to use.

Officers attended promotional events to raise awareness of the Healthy Homes Assistance scheme and to network with other organisations, which has developed the knowledge of the officers and avoided duplication of work.

The Healthy Homes Assistance was ready to commence taking referrals on 3rd January 2017

The table below sets out the activity to date from 1st April 2017.

Type of work	No. applications received	No. applications approved	Value of approvals	Value of payments made (£)	Completions	Outstanding commitment
Healthy Homes Assistance	144	133	£134,327	£111,073	121	£26,198

Outcomes

Healthy Homes Assistance key outcome has been hospital admission prevention. To date 92% of completed cases in 2017/18 have featured work to prevent hospital admission.

Referrals for works under £1,000 are typically taking on average 21 days. The ***quickest turnaround to date has been 1 day*** and the longest 66 days. The 66 day case required the fabrication of a set of made to measure galvanised handrails.

The CCG report cost savings of £112,106 to the local NHS trusts as a direct result of the works undertaken by the project since 1st April 2017. Savings calculations for social care and the wider society are yet to be undertaken.

Client Feedback

- Mrs E no longer has painful shoulders as a result of struggling to managing her husband wheelchair over internal thresholds in the home and Mr E now feels comfortable asking his wife to help him get around the house as she is no longer in pain.
- Mrs B tells us she feels like her old self again as she feels clean because she can now bath herself safely again
- Mr M can sleep in his own bed again and is no longer at risk of falling when going upstairs

Practioner feedback

- Impressed with the speed at which the works can be delivered.

Appendix 3 – Great Yarmouth Locality Plan

Aims and objectives for 2018/19

So far Healthy Homes Assistance has made significant impact both in terms of savings through timely appropriate intervention and to the lives of people receiving the service.

The aims and objectives for 2018/19 will be around continuing the service with a view to making it both sustainable and integral to the overall wellbeing offer in Great Yarmouth

The service has attracted a lot of interest and there is a desire to expand the scheme. One of the aims is to explore linking up with GP surgeries around admission prevention and linking into the social prescribing service that is starting to be delivered in the borough.

A further aim will be to explore how this service aligns with other services and commissioning priorities locally. If the scheme is seen as being of value exploring how the money the system has to invest through the CCG and Adult Social Care can support and enhance what is being delivered.

Proposal 2:

I'm Going Home

For a very short period of time the patient is supported by a range of services working closely to ensure the patient reaches a point where they can remain at home without the further need for care and support or with a care and support package that is then charged for.
The package could comprise of:

- Yare Care Community Alarm
- Key safe
- Physical works to the patients home that facilitates hospital discharge and improved health
- Access to 24/7 monitoring for up to 6 weeks
- Wellbeing calls from the control centre
- Support from the Out of Hospital Team / swifts
- Potential to add in assistive technology

Benefit to Patients

- Patients feel more confident about leaving hospital knowing They are discharged with the knowledge that they have access to 24/7 emergency support and reassurance
- They have access to the out of hospital & swift team
- They have a health, care and support package that will enable them to get well at home.
- There's a coordinated & holistic approach to discharge, which takes into account medical need plus social needs and wellbeing.

Benefit to Organisations

- Timely and safe hospital discharge.
- Increased patient confidence on leaving hospital meaning they are less likely to be readmitted
- Cost benefits of enabling someone to return home more quickly.
- Coordinated approach to discharge – every organisation contributing to the package has full knowledge & understanding of patient requirements plus there is a shared responsibility and commitment to managing patient expectations.
- Encourages integrated working beyond health & social care

I'm Going Home started taking referrals on 1st February 2017

Appendix 3 – Great Yarmouth Locality Plan

2017/18 Results

Progress & Delivery

- 15 alarm units with roaming sim facility and temporary key safes are held by health and social care teams in a number of key locations ready for use.
- Training was provided to teams at the James Paget University Hospital and East of England Ambulance Service.
- A 24/7 referral process is in operation.

The table below sets out the activity to date from 1st April 2017.

Scheme	No. Referrals	No. Installations	Capital investment	No. calls received by the alarm centre	*No. of physical responses deployed	No. of clients taking on the paid service
I'm Going Home	68	68	£0	364	83	13

*Physical responses deployed include the out of hospital team, the swift response team and the ambulance service.

Outcomes

- ***158*** hospital bed days saved
- Equalling ***£32,655***** savings

**The savings have been calculated using local data sets agreed with the CCG.

Both client and practioner feedback has been very positive and the scheme is attracting a lot of local attention. Clients and their families have reported feeling safer leaving hospital with a temporary alarm, one daughter said ***'I would not have felt safe having dad home without the I'm Going Home package'***. Practioners involved in issuing the alarms have said '***the service is invaluable'*** and ***'it's brilliant it's made hospital discharge instantaneous'***

Aims and objectives for 2017/18 – 18/19

I'm Going Home has in 8 weeks of operation made significant impact both in terms of savings by facilitating hospital discharge and to the lives of people receiving the service.

The aims and objectives for 2017/18 and 18/19 will be around continuing the service with a view to making it sustainable and a service which is seen as integral to the overall wellbeing offer in Great Yarmouth

The service has attracted a lot of interest and there is a desire to expand the scheme. Discussions are due to take place with GP surgeries and with the voluntary sector to see how services can link more closely to improve the package of support on offer at the point of discharge and to prevent further hospital admissions.

There will be future evaluation of the scheme which will review progress and consider options for future delivery. This will be reported to partners in order to help inform the discussions on future funding beyond March 2019.

Appendix 4 – Kings Lynn and West Norfolk Locality Plan

Better Care Fund & Disabled Facilities Grant Locality Plan 2018/19	
Area covered:	**West Norfolk Borough**
DFG Funding:	**BCF Allocation - 2017/18 £1,352,170** **2018/19 £TBC**

Overview:

2016/17 allows for a budget of £1,748,225
2017/18 allows for a budget of £2,147,470
2018/19 allows for a budget of **£TBC**

This Plan shows the work that has taken place in 2017/18 and what the aims and proposals are for the next year.

Predicted spend is **- £2,050,508**

Expected demand and planned delivery for 2018/19:

Year	Completions	Total Spend	Average Cost
2015/2016 – Adaptation Works	162	£927,666	£4,614
2016/2017 – Adaptation Works Prevention Works	280 895	£1,391,701 £77,073.03	£4,970 £86.11
2017/2018 – Adaptation Works Prevention Works	367 472	£1,966,506 £52,259	£5358 £112
2018/19 – Adaptation Works Handy Person Works	TBC TBC		

Appendix 4 – Kings Lynn and West Norfolk Locality Plan

Activity in 2017/18;

- The hospital discharge pilot continues to see referrals into Care & Repair from the QEH, the Handy Person Service assisting with discharge, Lily Advisor service in the QEH on a regular basis and continued partnership working with the community and health teams.
- The number of those trained, marketing events and referrals continue to grow for Lily.
- Finalisation of the new Housing Assistance Policy is being implemented amending some grants and creating some new ones.
- Efficient and effective implementation for electronic triage, calls flow to CIC, a framework contract and further competency training during the last year. The new Assessment process is still being worked on.
- New Assistive Technology kit has been ordered and paperwork is being drawn up, there are 17 '3rings' kits available.

Proposals for 2018/19;

Hospital Discharge Pilot continuing to focus on;

- Fast track hospital discharge pilot
- Non means tested hospital discharge grant
- Handyperson to assist hospital discharge
- Ask LILY will further develop to support all adults to reduce social isolation and support health and wellbeing.
- Ask LILY will work with Community Action Norfolk to deliver social prescribing project.
- Partnership working with health and community teams

Early Intervention Initiative continuing to look at;

- Ask LILY
- Identifying cohorts of potential clients

Development of the Borough Councils Private Sector Housing Investment Policy;

- Finalisation of the new Private Sector Housing Investment Policy ready for approval and sign off
- Amending some existing grants, including;
  Discretionary ADAPT grant, provision of hardship fund, provision of loan fund, minor adaptation works grant, relocation grant and prevention grant

Progress the IHAT Continuous Improvement Plan;

- Continuing to look at productive and efficient ways to improve the service

Development of the new Assistive Technology proposal;

- 2 main areas focusing on helping people stay at home and assisting with safe discharge from hospital

Appendix 4 – Kings Lynn and West Norfolk Locality Plan

DFG Locality Plan for West Norfolk

Proposal 1:

Hospital Discharge Pilot

This objective is to establish a formalised approach with staff across Housing, Health and Social Care to join up provision of services and reach more people at an earlier point in the process of discharge from hospital or care.

Fast Track Hospital Discharge Pilot

The IHAT has worked with the local Queen Elizabeth Hospital to develop a fast track service for those clients in need of modular ramps or stair lift. This sees the development of a new referral system for this to happen through the Hospital Discharge teams sending referrals through to Care & Repair. For example when elective surgery is planned for amputees there is an automatic referral for the provision of modular ramps and / or stair lift.

Non means tested Hospital discharge grant

This has been written into the new Private Sector Housing Investment Policy to assist with a fast-track process for delivery of ramps and stair lift adaptations for hospital discharge.

Handyperson to assist Hospital discharge

This has seen one of the Borough Council's Handy Persons being able to assist the Queen Elizabeth Hospitals 'man in a van'. This has seen the Handy Person covering leave and completing environmental surveys, providing / dropping off equipment and fitting grab rails.

LILY Advisor Service

Link into hospital teams to offer assistance to patients being discharged home, offering advice and information. This has seen LILY being promoted throughout the Hospital and with relevant teams.

Partnership working with health and community teams

Identifying a streamlined pathway and referral template to enable community therapy teams to send in referrals for minor and major adaptations. To provide training workshops throughout the year to cross-train the multi-disciplinary teams in specialist areas.

2017/18 Results

Fast Track Hospital Discharge Pilot

- 22 hospital cases referred from the QEH in 2017/18 into IHAT, these are being monitored and

discussed with Lead QEH OT at regular meetings to look at the pathway and outcomes of these cases. They are a mix of bariatric, end of life, amputee and other type cases which is enabling us to look at amending the locality plan for 2018/19.

- Non means tested hospital discharge grant – this has been included within the new Housing Assistance policy going through panel and cabinet sign off currently.

Handyperson to assist hospital discharge

- This has continued throughout 2017/18 and we are monitoring the jobs specified to the HPS as a learning tool and discussing this feedback with the Lead QEH OT in regular meetings.

Ask LILY Advisor Service

- LILY Advisors in the Hospital 9 am – 5 pm, Monday to Friday
- No longer funded from February 2018 (funding now agreed)
- Awaiting outcome of Social Isolation funding bid (funding now agreed)
- Infopoint now installed at the QEH direct line to CIC LILY queue
- Marketing Assistant promoting council services once a month at the hospital

Partnership working with health and community teams

- 59 health referrals received since project initiation (7 in 2016/17 and 52 in 2017/18).
- Continued training workshops on the assessment template and process and manager meetings (health, IHAT & social care) throughout 2017/18 to discuss progress and outcomes of cases.
- The IHAT Team have tracked and evidenced the savings in time on various cases to show the benefits of this integrated process, this has been a very successful piece of work for the West in 2017/18.

All of the above will continue in 2018/19, an additional part of this proposal is the current plan to place a Housing specialist role based at the QEH (Monday to Friday) initially for a 12 month period. The role will be split between IHAT and Housing team funded by the district. This role will build on the existing work and relationships already in place but will include developing relationships within the Social Care / Social Worker team at the QEH to assist with the referral pathway and building knowledge / understanding between the two organisations.

Aims and objectives for 2018/19

- Housing specialist role based at the QEH (Monday to Friday) initially for a 12 month period.
- Continue closer working with the Community Health teams – making sure all colleagues have been trained in the IHAT process and providing on-going training. A third workshop / training session is planned for April 2018 – this will see another group of community therapists attending. Identifying other teams and organisations that this training may be relevant for and organising this in due course to make sure as many colleagues are using this referral route as possible.
- Continue to develop the work established between the Handy Person and the QEH.

- Continue the work around fast-track modular ramps and stair lift cases – make sure all colleagues are using this referral route.
- Continue the Ask LILY Advisors to be available in the hospital Monday to Friday 9 am – 5 pm to assist with advice and information.
- On-going hospital training planned for; Rapid Assessment Team, Rehab Team, West Newton Team, also considering hosting a stand and advertising LILY on the West Wing entrance.

Proposal 2:

Early Intervention Initiative

Target identified cohorts of people with advice, information and low level initiatives such as a prevention home assessment, dementia assessment, home safety assessment.

Ask LILY

Preventative service bringing together services, organisations and social activities adults. Accessed online, by telephone and via LILY Advisors at community locations or a home visit.

Identifying Cohorts

Handyperson Service – to provide a low level minor adaptations and repairs service focusing on prevention and early interventions.

Frequent callers – working with the call handling centre for the Careline alarms and local CCG to determine whether there are small cohorts of frequent callers who may need assistance from local services that may include other Assistive Technology and Care & Repair.

Care Navigators – plans are being established to develop the working relationship between the IHAT with the Care Navigators. A meeting has taken place to introduce the two teams and identify joint working between the two services.

Referral protocol – Care Navigators work in West Norfolk with patients who are high need. These are likely to be clients who need the services of IHAT / Careline / Handy Person Service. So working with this client base means we have an opportunity to speed up the IHAT process and get to people in need sooner.

Other areas of work with the Care Navigators is for them to access to health information databases used by IHAT, understanding the Care Navigators holistic assessments and training for the Care Navigators on DFG's / IHAT.

2017/18 Results

Identifying Cohorts of potential clients

The Handyperson Service has continued throughout 2017/18 to focus on providing a low level, minor adaptations / equipment prevention service. The service has delivered approximately 472

minor adaptation jobs. The new Housing Assistance policy has included a small menu of low level grants covering minor adaptations, dementia works and an emergency repair grants. We are piloting using contractors off the framework to complete minor jobs to see if this is value for money and to provide cover for sickness.

Frequent Callers

Contacting clients who have activated their alarm frequently due to anxiety, to date 114 clients have been contacted and referred to the following services:
12 x information
27 x LILY
23 x Handy Person Service
9 x Care & Repair

Future of LILY

Update on activities / work to date:
40 LILY Advisors
1902 entries on Ask LILY website plus 208 activities
676 staff and volunteers trained
50 Marketing and publicity events
417 organisations contacted
1102 community events attended
1078 onward referrals made
Additional BC funding allocated to support delivery until 31.03.2018

Aims and objectives for 2018/19

The Handy Person Service will continue in 2018/19, providing low level minor adaptations and repairs service focusing on prevention and early interventions.

To work with Community Action Norfolk to develop social prescribing.

To continue Ask LILY, expanding to 18 years.

Partnership working with Care Navigators to work closely with other organisations that provide support and co-ordinated care for over 75's in the West. To provide a stream lined process for referrals and to share relevant information about clients that may be accessing these services. To consider a hot desk arrangement within the IHAT.

LILY to increase activity in all areas, develop the service for the local area by using LILY Advisors and members of the public to shape the service into the future. Ask Lily has secured funding for the next 3 years from Norfolk County Council Combating Loneliness and Reducing Social Isolation (Western CCG area)

Appendix 4 – Kings Lynn and West Norfolk Locality Plan

Proposal 3:

PSHP (Private Sector Housing Investment Policy)

Within the IHAT team the aim is to develop and edit the current Private Sector Housing Investment Policy to make this work better and be much more accessible for the customer. Current considerations include;

Discretionary ADAPT grant

Raise limit from £6,000 to £12,000

Provision of Hardship Fund

To assist with client contributions where a client cannot raise the funds required

Provision of loan fund

To assist with cases where total costs exceed the maximum allowable £30,000 and the client cannot pay the costs above the £30,000 limit

Minor adaptation works grant

Introduce non-means tested minor adaptations grant for works under £1000

Relocation Grant

To help fund relocation costs in cases where adaptations cannot be made to the current property or moving is a more cost effective solution

Prevention Grant

To assist with the provision of minor adaptations for cases that are identified as in health need but have not yet reached care act eligibility

2017/18 Results

- Finalisation of the new 'Housing Assistance Policy' ready for approval and sign off
- Amending some existing grants, but also including; a Housing Review Panel as part of the process for complex cases, provision of a loan fund for top ups, minor adaptation works grant for works under £1000, relocation grant, prevention grant and Careline & an AT initiative.
- Policy was approved by Corporate Performance Panel 19th of February to progress to Cabinet in April.

Aims and objectives for 2018/19

- The new Housing Assistance Policy to go to Cabinet to be approved on 29th May 2018.
- Review the new Housing Assistance Policy and track a cohort of cases

Appendix 4 – Kings Lynn and West Norfolk Locality Plan

Proposal 4:

IHAT Continuous Improvement Plan

The overall goal of the Improvement Plan is to transform from a reactive to a more proactive service. In order to do this the IHAT service needs to be efficient and able to handle the demand in a timely fashion.

2017/18 Results

Continuing to look at productive and efficient ways to working to improve the service:-

- Electronic triage process has been implemented and streamlines the initial contact and triage of the enquiry / person.
- Calls transfer to CIC for both C & R and Careline – implemented and has created a smooth pathway for new enquiries allowing access to all services – LILY, Careline and IHAT / HPS.
- A Framework contract has been in place since April 2017, 20 contractors in total and a Schedule of Rates. We have included a technical survey within the SOR to utilise contractor skills / time instead of a Technical Officer – this helps manage demand and free the TO's up for more complex feasibilities.
- Competency training has covered stair lift assessments within the Client Officer and AP team and is including some access / ramp cases with guidance from the IHAT OT. A peer group meeting takes place each week with the IHAT OT for CO's / AP to have cases signed off. Handypersons also present cases to the Assessment team.
- The waiting list in West remains above 100 due to demand as the team itself has been constant but demand continues to rise. There has been a private OT join the team for a number of months in 2017/18 to help reduce the waiting list.
- Data / case reports for all client officers, AP and TO's have been created to allow for closer case management, The IHAT Co-ordinator will be building in the 7 stages targets into the reports to allow for early identification of a stage going over target and for officers to respond.
- New Assessment Process (using the district systems only and minimal input into Liquid Logic) – this is currently being worked on in some areas and will be implemented fully into 2018/19 once signed off by County managers. There will be an IHAT Peer group workshop across the County to implement the process.

Aims and objectives for 2018/19

- Implement New Assessment Process
- Continue seeking improvements with the goal being to reduce the average time taken to provide an adaptation (enquiry to completion of works) from 240 calendar days to 140 calendar days.
- Continued aim to reduce the waiting list to 56.

- Further developing competency training – ramps.
- Continued competency training including access – ramps and modular ramps.
- Look at the opportunities of mobile working for both the Client Officers and Technical Officers.

Proposal 5:
Assistive Technology (new proposal)

2017/18 –

- Working with NCC
- Joint recruitment explored, but not progressed.
- Last meeting with AT service manager on 09.01.2018, advised a further review of the AT team taking place.
- Offered "a desk" at Kings Court, still looking into training to reduce the number of visits required, but NCC not able to progress at the moment.
- Limited AT training available, awaiting the launch of the Telecare Service Association training portal.

Hospital –

- £100,000 allocated by BC.
- 1 x Additional Careline Officer recruited.
- A number of equipment demonstrations have taken place.
- Have met with Lead OT and RAT team twice and agreed that '3rings' and 'Pebbell' equipment will support HD.
- Ordered equipment, currently drawing up paperwork. 17 full '3rings' kits available, grant funded for 12 weeks.
- Starting with RAT team – likely to install 5 initially.
- '3rings' monitored by the clients relatives.
- Working on Pebbell / PNC compatibility so hope to monitor via Herefordshire Housing call centre.

Assistive Technology – (help people stay safely at home) – develop project to focus on key areas in partnership with Locality Social Care team.
Careline Community Service are working with the Norfolk County Council Assistive Technology team to look at;

- Training and development opportunities for Careline Officers.
- Completing straightforward AT installations (if possible, considering N-able in West Norfolk).
- AT assessors to carry community alarms for installation in West Norfolk / North Norfolk when required by a client.
- AT assessors to work from Kings Court with the Careline Community Service team.
- To work with NCC / CCG colleagues to identify cohorts of clients to enable AT to form part of early prevention initiatives to improve home safety.
- Research new technologies and develop a proposal around assistive technology which can support clients with long term medical conditions, reducing the requirement for GP / Hospital visits.

Appendix 4 – Kings Lynn and West Norfolk Locality Plan

Assistive Technology – to assist with safe discharge from hospital – pilot project to focus on AT to help with safe discharge form hospital.

- To identify cohorts of patients who would benefit from a community alarm / assistive technology at the point of discharge and imbed in the discharge process, enabled by amendments to the PSHP.
- To consider whether hospital volunteers can be trained in the installation of community alarms.
- Research new technologies and develop a proposal around the piloting of new technologies including telehealth and telecare, aiming to reduce the number of re-admissions within 90 days.

Aims and objectives for 2018/19

- AT Hospital Pilot.
- Complete TSA training to help develop joint working with NCC.
- As Above - Continue to develop the project and track progress

Appendix 5 – North Norfolk Locality Plan

Area covered:	**North Norfolk District Council**
DFG Funding:	**BCF Allocation - 2017/18 £1,030,087** **2018/19 £TBC**
Expected demand for DFGs in 2018/19 and planned delivery:	
Circa 150 grants at an average of £7,000	

In the following table, please include your proposal with innovative ideas and practice to support people to live independently at home.

Whilst putting together your proposal(s) please consider:

- the wider contribution of Districts
- how activity can contribute towards reduction in admissions to acute and care homes and support hospital discharge

Proposal 1 – Delivery of Disabled Facilities Grant

Describe proposal in this box.

Include:

- The objective of the scheme:

  To deliver adaptations as per the Council's statutory duty, employing best practice and innovation wherever possible.
- Some background (if relevant) on what has happened before

  The delivery of adaptations has been evolving since the implementation of the North Norfolk IHAT in November 2012 and will continue to evolve in line with the proposals made by the IHAT Managers Group and IHAT Strategy Group
- An overview of the scheme and activity that would take place

  It is expected that following the changes made within the North Norfolk IHAT (implementation of the Preventative Assessment, roll out of training for Community OTs to make direct recommendations, charging for technical and professional support, capitalisation of maintenance/extended warranties for equipment and closer working with the Early Help Hub and referral from the new social prescribing and loneliness and isolation services) will result in the full budget being spent. The Council continues to look at how it can reduce the length of time taken to deliver adaptations in line with the Government's request and will be working towards delivering adaptations in 140 days in line with the achievement of authorities in Warwickshire which employ a similar model to the IHAT.

Rationale/Evidence base

Detail your rationale/ evidence base here

Appendix 5 – North Norfolk Locality Plan

The Council has a statutory duty to deliver adaptations through Disabled Facilities Grant and the Government has requested that local housing authorities do everything they can to reduce the length of time taken to deliver adaptations and has increased the DFG allocation to enable this to happen.

Outcomes

Use this space to detail your expected outcomes

- Reduced emergency admissions in particular resulting from falls (steps and stairs, getting in and out of the bath)
- prevention offer
- Potential for a reduction in carer breakdown
- Improved customer journey/satisfaction.
- Potential for reduction in delayed transfers of care
- Improved health and wellbeing
- Increased independence and ability to access community facilities

Proposal 2 – Targeted approaches: GP Clusters and MDTs

Describe proposal in this box.

Include:

- The objective of the scheme:

  Determine whether those most at risk of hospital admission have been assessed for a housing adaptation as part of the prevention offer.
- Some background (if relevant) on what has happened before.

  Currently a referral for housing adaptations is an open process and is dependent on a request for an assessment for an adaptation being made. This approach ensures that a targeted response is considered to those most at risk of hospital admission thus furthering the preventative approach taken to this cohort of people.
- An overview of the scheme and activity that would take place

  Multi-Disciplinary Team working is in place for the top 2% of people identified most at risk of hospital admission. The proposal is to pilot within 2 GP practices (one in the East and one in the West of the district) a desk top review of this cohort interrogating IT systems (CareFirst/LAS and M3) to identify which have and which have not had an adaptation intervention and to consider whether an adaptation intervention or further assessment/review of the adaptation would assist in helping to manage health conditions to increase independence and reduce/delay potential hospital admission/residential care placement.

  Next steps are dependent on the output from the pilot(s). If this approach evidences that looking at a population group in this way further increases their independence (if not already had a housing adaptation assessment) then be rolled out across all GP surgeries and form part

of the MDT process.

Rationale/Evidence base

Detail your rationale/ evidence base here

Developing integrated approaches to ensuring services are identifying and wrapping provision around those who are most at risk of hospital admission.

Outcomes

Use this space to detail your expected outcomes

- Reduced emergency admissions within targeted cohort of people
- Dedicated prevention offer available to those most at risk.
- Potential for a reduction in carer breakdown
- Increased patient experience.
- Potential for reduction in delayed transfers of care

Proposal 3 – Targeted approaches: More than 2 adaptations

Describe proposal in this box.

Include:

- The objective of the scheme

Determine whether those who have been referred for 2 housing adaptation or more are known to MDTs – to avoid hospital admission. It is likely that this cohort would be known to teams but it would be advantageous to be assured as this might indicate those that should be part of an MDT.

- An overview of the scheme and activity that would take place.

This project would help inform those people who may be in need of an MDT approach, if not already identified. This may be a way of ensuring those needs who may increase from a health and social care perspective are targeted as a priority and enabled to maintain their independence via an MDT approach

Rationale/Evidence base

Detail your rationale/ evidence base here

Developing integrated approaches to ensuring services are identifying and wrapping provision around those who are most at risk of hospital admission

Outcomes

Use this space to detail your expected outcomes

- Reduced emergency admissions within targeted cohort of people
- Dedicated prevention offer available to those most at risk.

- Potential for a reduction in carer breakdown
- Increased patient experience.

Proposal 4 – Implement proposals that have already been tested with good outcomes

Describe proposal in this box.

Include:

- The objective of the scheme

Implement the roll out of use of the preventative assessment by trusted assessors. This is a county-wide initiative.
Some background (if relevant) on what has happened

- Before referrals for assessment would be received from Health OTs and the assessment undertaken by a Social Services OT/AP. This initiative negates the needs for a further assessment and uses the information gathered by Health OTs as trusted assessors thus speeding up the process, improving the customer journey and increasing capacity in the system An overview of the scheme and activity that would take place

It is estimated that this initiative will assist in moving closer to the 140 day target for provision of adaptations through DFG

Rationale/Evidence base

Detail your rationale/ evidence base here

The assessment process is impacting on the ability to progress with adaptations at pace.

Outcomes

- Reduced emergency admissions within targeted cohort of people
- Dedicated prevention offer available to those most at risk.
- Potential for a reduction in carer breakdown
- Increased service user experience.

Appendix 5 – North Norfolk Locality Plan

Proposal 5 – Options for use of any underspend

Describe proposal in this box.

Include:

- An overview of the scheme and activity that would take place

The DFG budget for North Norfolk was underspent in 2016/17 and there is potential for the budget to be underspent in 2018/19 if the number of recommendations is not generated to deliver the estimated number of completed DFGs. The Council would like to work with partners to utilise any potential underspend on capital schemes that will reduce the need for adaptations and support residents to live independently in the community and would like consideration to be given to the following;

- Improving dementia provision at Housing with Care schemes
- Subsidising the cost of new supported housing schemes (where required)
- Subsidising the cost of new build wheelchair accessible properties
- Funding the adaptation of properties within the current social housing stock that lend themselves to adaptation and which are not currently tenanted in order to meet the needs of those whose current property cannot be adapted (mainly households with children)
- Purchasing properties on the open market to meet the needs of households who needs are not currently being met and form whom there are no other solutions to meeting their needs

Rationale/Evidence base

Detail your rationale/ evidence base here

Utilisation of all available capital funds to meet shared strategic priorities

Outcomes

Use this space to detail your expected outcomes

- Dedicated prevention offer available to those most at risk.
- Increased service experience
- Reduction in delayed transfers of care
- Specific support available within the local community

Appendix 6 – Norwich Locality Plan

Better Care Fund & Disabled Facilities Grant Locality Plan 2018/19	
Area covered:	**Norwich City Council**
DFG Funding:	**BCF Allocation - 2017/18 £969,369** **2018/19 £TBC**

Overview

1. Within Norwich, the HIA/District Authority has is delivering the 2017/18 BCF DFG plan with a budget £969,369. This plan shows what the aims and proposals are for the next year.

Planned activity for 2018/19

2. Through the BCF, our Home Improvement Team will continue to deliver DFGs, discretionary DFG top up grants, and financial assistance for home improvement to vulnerable home owners on the following basis:
    a. DFGs of up to £30,000 for appropriate and necessary adaptations which are reasonable and practicable
    b. DFG discretionary top up of up to £35,000 for cases where major adaptations or relocations are required, and it is not possible to provide a cost-effective solution in the existing home of the client with a mandatory disabled facility grant
    c. Financial assistance of up to £35,000 for vulnerable people who own their own home outright or who have a mortgage, but cannot afford to pay for essential repairs. This is means tested, and is linked financial ability to pay for works, and the amount of equity in the home.
    d. Safe at home grants of up to £2,500 to provide dementia specific adaptations, emergency repairs or investigative works where disabled facilities grants are not suitable.

3. We will also deliver the following three proposals; two continue to be developed and one is a new proposal:
    a. Hospital discharge scheme – continued activity
    b. Adaptations assistance project – continued activity
    c. Preventing admission to hospitals – new activity

4. All the work of the Home improvement team supports people to live independently at home and provide health and wellbeing in the community. They provide a client-centred approach ranging from prevention and promotion of health and wellbeing to specific targeted interventions for people, for example, those living with dementia. It is expected that the proposals will maximise the potential for the physical environment to support vulnerable and disabled people, through access to adaptations and a range of housing options as well as ancillary services. The proposals will also contribute to the metrics of the better care fund:
    a. Non-elective admissions
    b. Admissions to residential care homes
    c. Effectiveness of reablement
    d. Delayed transfers of care

5. Compared to the total annual NHS budget, the cost savings to health and social care provided by the individual locality proposals are marginal. However, when considered in conjunction with our wider activities and interventions in regard to prevention and promoting independence (see Appendix 1), much can be achieved, particularly in terms of prevention and cost savings, from the cumulative effect of marginal gains.

Appendix 6 – Norwich Locality Plan

Proposal 1: Hospital discharge scheme & grant

6. Our hospital discharge scheme formed part of our previous set of plans and has been well received to date. In October 2016, we introduced a hospital discharge grant (non-means tested) of up to £10,000 to enable inpatients to access support and funding to tackle disrepair and adaptations in a timely manner. For straightforward adaptations and repairs, we aim to respond to the hospital discharge team by 3pm on the day of referral. Where more complex works are required, one of our case workers will visit the client in hospital to arrange access to the property and for works to be completed. We aim to complete these works in around 28 calendar days, compared with 144 calendar days for non-inpatient home improvement team referrals.

7. We carry out a follow up with clients three months after works are completed. This includes a customer satisfaction questionnaire and a follow up call, providing us with the ability to measure the value of the work carried out in terms of the client's health and well-being. Where key safes are fitted, a follow up call will be made a week after the works are complete to identify whether there are any other needs or services that we can help with, for example, income maximisation, handyperson service, living in fuel poverty, and onward referrals to other support agencies.

8. Over the course of these set of plans, evidence will be gathered to demonstrate a reduction in delayed transfer of care cases linked to housing related issues, and the cost savings to health and social care as a result of our interventions.

Aims and objectives for 2018/19

9. Further work is required to ensure that clinicians are aware of what activities local authorities' can provide to aid a timely discharge and that they are utilised in all cases where appropriate. In addition, it has been recognised that as local authorities, we need to work collaboratively to offer a single point of referral for health professionals to refer to for all local authority housing and home improvement related services.

10. A small task and finish group has been formed, made up of staff from districts across the county and the Norfolk and Norwich University Hospital (NNUH), to review the hospital discharge process, including the existing hospital discharge and homelessness prevention protocol[1]. The process will include discharge from all the hospitals in Norwich (NNUH, NCH&C , CCSRS and Hellesdon). There are a number of actions that will be carried out as part of this process which will enable a lean and efficient service to be delivered.

11. The first task is to produce a short list of simple questions that a patient can answer on admission that will highlight the need for any housing issues and wider needs to be addressed outside of the clinical setting. Draft questions will be based on the following:
    a. Where do you live when you're not in hospital?
    b. Do you own your home, or who do you pay your rent to?
    c. Do you find it difficult getting into and around your house, in/out of the bath, or up and down the stairs?
    d. Do you find it hard to carry out small repairs and odd jobs around the home and garden?
    e. Do you have contact with one or more people on a frequent basis?
    f. Do you often feel cold in your own home?

[1] Following the death of a homeless patient on the streets of Norwich some three years ago, the uncoordinated hospital discharge practice was highlighted by the Coroner's Office which led to the development of the NNUH hospital discharge and homeless prevention protocol.

g. Do you feel unable to pay your gas and electricity bill?

12. Unsafe housing can often be the reason why people are admitted into hospital in the first place, particularly through cold and trip hazards. These dangers have been estimated to cost the NHS over £600m every year in England[2]. By carrying out this '60 second' home health check, we can identify people to help and target BCF to make adaptations and improvements to their properties.

13. Further areas to focus on as part of the hospital discharge scheme include work with:
    a. the hospital discharge team to pilot a housing representative to be co-located in the discharge hub at the NNUH to support the ward co-ordinators in identifying at the earliest opportunity patients who will require district services to enable a timely discharge
    b. the network used for hospital discharge services in the community (including the Red Cross and Settle In service) to ensure that they are aware of the support and interventions available through the local housing authorities
    c. the hospital discharge team and public health to review the discharge data and identify pinch points on the process
    d. the homeless/housing outreach project based out of City Reach
    e. the East Anglian Ambulance Service to ensure that they are aware of the support and interventions available through the local housing authorities and identify the need for works to the property
    f. the pre-elective admissions team to produce a pathway where housing need can be identified before a patient is admitted creating a streamlined patient pathway.
    g. the wider partners including adult social care, CCGs and the community and voluntary sector to explore avenues of engagement (this links with our Community Pharmacy/Safe at Home proposal detailed further on in the plans).

Proposal 2: Adaptations assistance project

14. Applicants for disabled facilities grants are required to undertake a statutory means-test which determines what their contribution towards the works should be. This calculates a nominal loan value that the applicant could afford to support. The reality, however, is that many clients with small contributions have insufficient savings or the spare income to support a loan and this is reflected in a drop-out rate from applicants in that category which is has grown to around 25% (or approximately 40 cases a year at current demand levels).

15. The current mandatory means test is complex and tends to penalise those with housing costs that are higher than the standard amount specified or where the standard allowances for overall living costs are too low. It therefore works against the government's intentions to increase preventative spending on disabled adaptations. This means that a significant number of disabled residents in Norwich are not receiving appropriate and necessary adaptations which will enable them to live safely and independently in their homes despite government funding being made available for this purpose.

16. In order to ensure that applicants do not withdraw and that full use is made of the better care fund, we have recently introduced an adaptations assistance grant of up to £5,000 toward the contribution required by the means-test. The council can limit the risk of overspending the better care fund allocation by making the offer of the top-up grant dependent on available funds. If demand increases to a point where there is insufficient available capital to offer a top-up then the client would be offered a choice of proceeding with a disabled facilities grant only (including any contribution) or waiting for funding to become available. The council would not, therefore, be in breach of its statutory duty to approve a disabled facility grant to an eligible applicant. The offer of adaptations assistance grants would be suspended at the point at which the predicted year-end

[2] *https://www.hsj.co.uk/*

expenditure reached 90% of the available capital budget.

17. Applications for disabled facility grants cannot be placed on a waiting list due to the requirement to determine them within a six month period. However, there is the ability under the governing legislation to delay payment for up to six months to enable budgets to be managed across financial years. That mechanism, combined with the proposed suspension point should enable the capital funding to be kept within budget.

18. National research[3] has shown that people, who have an adaptation in their home and later move into care, do so some four years later than those who have not had adaptions carried out. With a residential care plan costing around £27,000 per year compared to the average disabled facilities grant costing less than £6,000, adaptations can have a major impact for social care budgets.

19. Since the introduction of the grant towards the end of January 2017 we have been able to process 12 additional referrals, subsequently helping those people who would ordinarily not have received the necessary adaptations to enable them to live safely and independently in their homes.

Aims and objectives for 2018/19

20. Although a formal evaluation will not be done until the end of year, initial evaluation of this scheme suggests that it is a success.

21. At the time of writing this report 35 families had accessed the assistance. It has not had a significant effect on the allocated budget but has resulted in adaptations going ahead when otherwise they may not have.

Proposal 3: Preventing Admission to Hospital Grant

22. Our hospital discharge scheme is limited to being reactive work dealing with issues as and when they arise. Using the extra £100k allocated to the city council from central government in January 2018, the city council implemented a preventing admission to hospital grant.

23. This grant is in effect a mirror of the Hospital Discharge Grant but with the purpose of avoiding unnecessary admittance to hospital caused by unsafe or unsuitable housing related issues.

24. The grant is a £10k non means tested grant with the only qualifying criteria being a referral from either the Norwich Escalation Avoidance team (NEAT) or the councils own environmental strategy team, through their cosy city initiative(who have been working to identify vulnerable people whose health is at risk due to poor heating and insulation).

Aims and objectives for 2018/19

25. It is our intention to continue to offer this type of financial assistance for the duration of this set of plans to enable us to make full use of the better care funding. An evaluation of the project will take place towards the end of 2018/19 to assess its success and the value of offering such assistance.

26. Further work is needed to build on our relationship with NEAT, which will be achieved by attending their weekly multi-disciplinary team meetings where prevention cases will be discussed and solutions identified.

[3] Linking Disabled Facilities Grants to Social Care Data, Foundations 2015

Appendix 6 – Norwich Locality Plan

27. The home improvement team will carry out a follow up with clients three months after works are completed. This will include a customer satisfaction questionnaire and if necessary a follow up call, providing us with the ability to measure the value of the work carried out in terms of the client's health and well-being.

Appendix 7 – South Norfolk Locality Plan

South Norfolk CCG Better Care Fund Locality Plan 2018/19 South Norfolk Council	
Area covered:	**The South Norfolk Council administrative area of the South Norfolk CCG**
DFG Funding:	**BCF Allocation - 2017/18 £780,666** **2018/19 £TBC**

Overview:

South Norfolk Council believe that a housing authority has much to offer health and social care. To us, housing is simple. A suitable, stable and secure home in the community supports people in being healthier and happier – which is the most important thing to everyone. But also, by embedding housing in the integration agenda we can be instrumental in helping health and social care reduce their costs.

The right home environment can protect and improve health and wellbeing and prevent physical and mental ill-health; it can enable people to manage their health and care needs, including long-term conditions, and ensure positive care experiences by integrating services in the home; it can allow people to remain in their own home for if they choose.

The right home environment is proven to delay and reduce the need for primary care and social care interventions, including admission to long-term care settings; prevent hospital admissions; enable timely discharge from hospital and prevent re-admissions to hospital and enable rapid recovery from periods of ill-health or planned admissions

Our approach to the home environment has been prepared in consultation with Norfolk Public Health, the South Norfolk Clinical Commissioning Group and the Norfolk Health and Wellbeing Board and is set out in the South Norfolk "Prevention and Promoting Independence" document. The activities described below comprise our main contributions to the Norfolk Better Care Fund Plan for 18/19 and 19/20.

Progress and performance will be reported to the South Norfolk Early Help Strategic Board.

Delivery for 2018/19

Proposed Activity in 2018/19

1. **Living Independently at home** – our aim is to reduce the average time taken from enquiry to completion to the Norfolk agreed target of 140 days. We will implement the improvements identified in our review of the system to ensure an effective delivery chain.

2. **Hospital Discharge (District Direct)** – in partnership with the Norfolk and Norwich University Hospital we will develop and embed the District Direct model to ensure barriers to discharge are identified at the earliest opportunity and a housing pathway agreed that ensures patients can return home at an appropriate time and are not put at risk by being discharged inappropriately.

3. **Care & Repair Service (Home Improvement Agency)** – we will continue to commission a home improvement agency to support vulnerable people to remain in their homes.

4. **District Direct Grants** – administered by the Care & Repair Service to support hospital discharge

5. **Handyperson Scheme** – we will continue to commission a Handyperson to support vulnerable people to remain in their homes.

6. **Social Prescribing** – we will pilot Social Prescribing services in GP practices to provide social and community based alternative for people presenting at the surgeries with non-medical issues

Activity 1 – Living Independently at Home (18/19)

Housing Adaptations – South Norfolk is committed to the Norfolk objective of reducing the average time for completion of non-priority case adaptations from 243 days to140 days and 55 days for priority cases.

Health Occupational Therapists (OT's) based in Community teams will undertake Disabled Facility Grant assessments, removing the need for two assessments.

Assistant Practitioners (AP's) and Home Improvement Agency Case Officers accredited to undertake stair lift assessments, releasing more time for OT's to deal with complex cases

Minor adaptations, repairs and home safety checks will be delivered through a Council managed Handyperson Service. Grants and discounts will be available to eligible residents.

Private sector housing residents will be assisted through the adaptation process

Poor housing, unsuitable housing and precarious housing circumstances affect our physical and mental health. The health of older people, children, disabled people and people with long-term illnesses is at greater risk from poor housing conditions. The home is a driver of health inequalities, and those living in poverty are more likely to live in poorer housing, precarious housing circumstances or lack accommodation altogether.

Activity 2 - Hospital Discharge

District Direct supports patients and hospital staff to identify and overcome barriers to discharge via a dedicated district resource within the integrated hospital discharge hub. The aim is to support residents to return home in a timely manner from hospital to an environment that meets their needs with the necessary support in place.
District Direct pilot includes:
• A dedicated District Direct officer based within the integrated hospital discharge hub
• Support to DISCOs to identify at an early stage patient vulnerable to delayed discharge,

developing and promoting the referral process and gaining patient consent
• Assessment and action plan to remove the barriers preventing patients from returning home
• Patient follow up to support sustainable independent living at home
We have raised concerns over the current allocation of places in Housing with Care schemes where high void levels have result in lost rent to landlords and underutilised care provision. Whilst a review of the schemes is being undertaken we are exploring interim alternative use of the accommodation including use as discharge beds.

Focus will be placed on identifying housing need at the earliest stage of the patient pathway including working through GP Practices to support patients assessed as needing elective medical interventions.

The protocol will be applicable to all the hospitals in Norwich (NNUH, NCH&C and CCSRS).

Future development

2.0/3.0 FTE employed by South Norfolk Council to be based within the NNUH Integrated Discharge Hub
Development of District Direct referral routes from A&E department
Support the hospital campaign to transfer people from being bed-based to day room facilities
Share best practice within mental health and community hospitals
Roll out to James Paget and Queen Elizabeth hospital

Activity 3 – South Norfolk Care & Repair Service (18/19 budget £tbc**)**

South Norfolk Care and Repair assists older, disabled and vulnerable people to live a good life for longer, offering reliable information and advice and supporting them to make modifications to their homes as their health and needs change, especially through later years. This model of providing low level early support has been consistently recommended by the DCLG and more recently in the Better Care Fund guidance from the DoH.

South Norfolk Council recognises the value of this service and despite Adult Social Care withdrawing support will continue to provide the service, prioritising vulnerable people in the private housing sector.

Activity 4 – District Direct Grants (18/19 £tbc)

The District Direct Hospital Discharge Grant (Appendix One) is intended to assist our residents who are able to return home from hospital, but are being prevented from doing so because there are factors at their home (that can be speedily remedied), that prevent them from doing so. Enabling that speedy discharge enables the hospitals to make better use of their resources, freeing up expensive bed space and increasing health service capacity and resilience. More importantly for some of our

residents, the speedy move back to their own homes improves their chances of recovery and lessens the likelihood of readmission and loss of life expectancy.
This grant is intended to compliment and not replace other support and assistance that may be available, either from the Council or other agencies.
It differs from the Disabled Facility Grant as it is addressing the immediate need which may be short term/temporary in nature, for example a resident returning home to recuperate. However, it could also be used to compliment a DFG by enabling a person with longer term needs to be able to return home with a support/care package whilst their longer-term needs could be addressed with a DFG, are fully assessed and understood.
We have set the maximum grant at £3000 to enable us to fund items that have been suggested by other agencies, however the experience from other parts of the country where such assistance is being provided indicates the average grant to be less than £500. With the most common works being installation of key-safes to allow carer access, and temporary ramping to doors to enable wheelchair access. This type of work could normally be undertaken by our Handyperson Service.
The type of work that could be funded has been included for example purposes not intended to be a definitive list. We have focussed on the intended outcome of the grant and the grant parameters in order to enable flexible responses and solutions to what will be invariably individual circumstances.

Activity 5 - Handyperson Scheme (18/19 £tbc)

South Norfolk has delivered a handyperson service since 2004. The scheme is designed to deliver small repairs and 'odd jobs' around the home to people who may find it difficult to carry out these jobs for themselves.

The scheme addresses property maintenance, minor adaptations, home-security, home safety and falls prevention all at the same time, as well as engaging with older people who are not currently in receipt of services, or who are suffering isolation. This is in line with the government's vision for efficient, holistic handyperson services. Unsafe housing can often be the reason why people are admitted into hospital in the first place, particularly through cold and trip hazards.

Referrals are received from partner agencies to for fitting key safes, grab rails etc to enable provision of care.

Activity 6 - Social Prescribing (18/19 £tbc)

Social prescribing aims to help people address underlying issues early - rather than using clinical or medical services unnecessarily. Social prescribing and building community capacity forms a central part of the Norfolk NHS Sustainability and Transformation Plan (STP) to address demand on health services.

South Norfolk Council employed Community Connectors are being embedded in South Norfolk's 13 GP practices (covering 18 sites) utilising district council, community and partners'

infrastructure and resources. Relationships are in place with practices to enable fast mobilisation. Early estimates indicate that the district wide provision could deliver £950k of savings to the health sector over 2 years.
Activity 7 – Triage team (18/19 £tbc)
Dedicated triage team within the early help hub to triage all independent living enquiries – identifying those residents who would benefit from smaller adaptations delivered through the handyperson or community support; completing ASC triage assessment for residents identified as benefiting from a Disabled Facilities Grant.

Appendix 2: High Impact Change Model Milestone Plan

		Norfok wide	Key dates
Change descriptor			
Early Discharge Planning. In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected dates of discharge to be set within 48 hours.	**Current Position**	All 3 acutes have a planned approach in place, but have identifed areas for improvement. Some will be at a local system level, others at County / whole system level	April 2017
	Planned Activity	Increased focus on supporting the red to green approach and board and ward round attendance. (Local) Increased focus use of ICCs & MDTMs in GP surgeries.(Local) Plan to be developed to improve discharge date planning across the system including community hospitals.(System wide) Appointment of a Capacity Manager post to understand, monitor and facilitate capacity across the system (System wide)	Work commenced July 17 Systemwide plan to be approved October 17 By October 17
Systems to Monitor Patient Flow. Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual.	**Current Position**	Silver systems in place at two acutes NNUH & QEH, with dashbords and information monitored daily. JPH takes Red & Green bed day approach.	April 2017
	Planned Activity	JPH A&E delivery board to review plans linking with NNUH and QEH. (Systemwide) Consider introduction of electronic patient flow systems (Local / Systemwide)	A&E Joint Delivery Board to have approved plan by Oct 17
Multi-disciplinary/Multi-Agency Discharge Teams, including the Voluntary and Community Sector. Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients	**Current Position**	Across the system plans are established to mature, with daily MTD meetings taking place. Involvemnt of voluntary sector and housing varies across the system. In NNUH; D2A in place with care providers, ASC and community health provider. CHC assessments increasingly undertaken outside hospital (D2A).	April 2017
	Planned Activity	Review involvement of voluntary sector and housing. (Local) Expand Social prescribing wider than GPs (Systemwide)	Plans shared with stakeholders Sept 17
Home First/Discharge to Assess. Providing short-term care and reablement in people's homes or using 'stepdown' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.	**Current Position**	Due to the varience in DTOC figures acrsoss the whole system each acute has a slightly different current model and future plan. Development of Intermediate Care Strategy Discharge to asses review undertaken with Emergency Care Improvement Programme (ECIP)	April 2017 June 2017 July 17
	Planned Activity	**Discharge to assess** Proposals to joint A & E Board for a programme of work to support Pathway 1 (System wide). Existing Pathway 3 work in East & Central being evaluated with support from Healthwatch to inform future investemnt in posts to support D2A (System wide) **Home First** Commissioning to support increased capacity and improve sustainability in the Home Care Sector (system wide) Crisis Homecare – To include; Home support wrap around service, Enhanced flexible dementia offer. (systemwide) Micro Commissioning to support Homecare (local) Bed Based Reablement – Delivery models being developed (system wide)	August 2017 September 2017 October 2017
Seven-Day Service. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs	**Current Position**	Plans are in place system wide for social care services, including availability of Care Arranging Services at weekends. Local schemes are in place such as Healthy Homes Project and Hospital Care at Home	April 2017
	Planned Activity	Further work is required at both system wide and local level to: Define the core level of services that are required at weekends. Clarify 7 day service not 7 day working. What this means for health services?	Ongoing

Trusted Assessor. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way	**Current Position**	No consistent system wide approach in place, some local examples of Trusted Assesor models at QEH	
	Planned Activity	**Systemwide model** Research of Trusted Assessor Models undertaken. Planning commenced at Health & Social Care Consultative Forum. Data analysis to inform demand. Meetings with all 3 Acutes. Meetings with representatives of the provider market to support co production. Link with Enhanced Health in Care Homes Project.	July 2017 August 2017 September 2017
Focus on Choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.	**Current Position**	Local arrangemnts in place including contracts with CHS Healthcare working within a Trust to expedite a range of patients – predominantly family choice / self-funders.	
	Planned Activity	Each acute is looking at their current system with a focus on how Discharge Coordinators link with Integrated Care Coordinators /GP surgeries / Local voluntary organisations. (Local)	Ongoing
Enhancing Health in Care Homes. Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.	**Current Position**	Well established project with a clear forward looking plan.	April 2017
	Planned Activity	Development of a robust care homes dashboard. Workforce development. Develop and introduce a falls prevention tool for care homes. Improve the pathway between hospital and care homes. Introduce a communication tool to support decision to support decision making by care home staff. Target support at care homes making most use of 999.	30th June 2017 30th Sept 2017 30th November 2017 31st December 2017 31st March 2018

Improved Better Care Fund – Summary March 2018

Appendix 3

Planning priority	Grant Condition	Description	2017/18 £m	2018/19 £m	2019/20 £m	Impact	Activity and progress
Protect	Meeting Social Care Needs	**iBCF1** Funding required to manage shortfall in recurrent pressures and protect social care services	1.9	11.9	22.2	Over the three-year period this funding will ensure that vital service provision such as homecare is maintained and people are supported to maintain their independence and stay out of hospital	Funding is part of budget planning for adult social care as a whole - over 80% of spend is with the market
Sustain	Reduce pressure on the NHS and stabilise Social Care provider market	**iBCF2** Support the care market and develop resilience against the impact of specific recurrent market pressures	9.1	10.8	10.8	Recent legislation on NMW and the cost of care presents additional pressures to the care sector that require supporting if provision is to remain sustainable. Market failure presents a risk to individuals but also the system overall funding here will support integrity of the care market	This is about sustaining the Market. In line with cost of care, legislation and market pressures – the aim is to develop a sustainable approach. Funding is targeted on specific needs such as legislative change, but some funding will be carried forward to 2018-19 where this enables funding to be targeted in a more sustainable way.
Sustain	Meeting Social Care Needs	**iBCF3** Managing recurrent capacity with DOLs when alternative funding finishes	0	0.2	0.2		To support delivery of this service from 2018-19 when current funding will no longer be available
Sustain	Reduce pressure on the NHS and meet social care need	**iBCF4** Managing capacity – strengthen social work to assist people at discharge and to prevent admissions	2.6	2.5	0.0	Social work is core to ensuring people's needs are met quickly and effectively. Supporting capacity of social work will strengthen the prevention offer, ensure people receive support that meets their needs and is fundamental to ensuring that people are able to leave formal care settings as soon as they are medically fit. Resources here will enable services to	As part of enhancing our capacity a recruitment campaign for 50 practitioners and 15 team managers is fully underway. By mid-February 40.25 fte appointments had been made to new roles in the service*:

Improved Better Care Fund – Summary March 2018

Appendix 3

Planning priority	Grant Condition	Description	2017/18 £m	2018/19 £m	2019/20 £m	Impact	Activity and progress
						be flexed according to pressure within the system. Investing in social work will reduce pressures on the NHS and supports the Promoting Independence agenda. The invest to save element will be realised through better management of needs and management of flow through the system. **Note**: of the £2.6m in 2017/18, £1m will need to be carried forward into 2018/19 to reflect recruitment timescales, therefore £3.5m will be spent in 2018/19. For 2019/20 it is the intention for the investment to remain at 2018/19 levels (£3.5m) but the additional capacity should be self-financing through savings delivered in the Purchase of Care budget.	There are currently 12.75 new capacity Social Worker vacancies to fill. Interviews took place early Feb, with 3 appointable candidates to allocate to a locality. The West is particularly difficult to recruit and a campaign is running specifically for this locality with 3 interviews for Social Workers and 1 for a Team Manager taking place at the end of February
Invest and Improve	Reduce pressure on the NHS	**iBCF5** Expansion of prevention schemes – social prescribing and community/care navigation schemes – Invest to save	0.7	0.7	0.0	Social prescribing has been evidenced to divert demand from formal care services, especially hospitals. Combined with an offer that builds on community resilience and capacity this initiative is designed to support demand management initiatives and enhance community ability to respond to need	Supporting the development of existing initiatives working with CCGs, Public Health and District Councils. This will be taken forward on CCG boundaries. Working with Districts, CCGs & voluntary sector. Locality plans have been developed services will commence between January and June 2018, when a formal launch of the whole service will take place.

Improved Better Care Fund – Summary March 2018

Appendix 3

Planning priority	Grant Condition	Description	2017/18 £m	2018/19 £m	2019/20 £m	Impact	Activity and progress
Invest and Improve	Reduce pressure on the NHS	**iBCF6** Respond to care pressures – micro commissioning invest to save pilot	0.1	0.1	0.0	Homecare is a key service in ensuring people can stay out of hospital and be discharged quickly when they are medically fit. Micro commissioning initiatives have been shown to have a positive impact on homecare capacity in similar rural areas. Increased capacity in the system is designed to be sustainable without additional funding after the first two years	Investment in support to micro enterprises to deliver Home Support. Community Catalyst have been engaged to support this work and initial scoping discussions undertaken to identify our approach to localised development.
Invest and Improve	Reduce pressure on the NHS	**iBCF7** Managing transfers of care – Trusted assessor	0.2	0.2	0.2	Managing transfers of care and implementing the HICM requires a number of joint initiatives between social care and health partners. Key elements of the pathway are trusted assessor and discharge to assess. The implementation of these will be supported by an enhanced, wrap around, home care offer and additional capacity in reablement beds – these initiatives will support the reduction of delayed transfers of care and provide a better quality of care for people in this pathway	The Trusted Assessment Facilitator role has been developed in tandem with providers who were involved in the recruitment into the new posts. Funding from the project has also supported the development of a bed capacity tracking system. There are 5 Trusted Assessment Facilitators across the 3 acutes, the service commenced on 22 January in NNUH. The full team will be in place by 28 February 2018. 1 Facilitator in QEH 2 Facilitators in NNUH 2 Facilitators in JPUH (1 funded by Suffolk CC)
Invest and Improve	Reduce pressure on the NHS	**iBCF8** Managing transfers of care – through invest to save programme for example discharge to assess; home	5.1	0.5	0.2	Many of these initiatives are to be run as pilots to evaluate outcomes and put in place sustainable funding based on the part of the system where benefits accrue. There will be a requirement to carry forward an element of the 2017/18	Recruitment for six discharge to assess social workers, was completed in December 2017. The service is now in place. Accommodation based reablement is implemented within the county,

Improved Better Care Fund – Summary March 2018

Appendix 3

Planning priority	Grant Condition	Description	2017/18 £m	2018/19 £m	2019/20 £m	Impact	Activity and progress
		support wrap around service; accommodation based reablement and active assessment beds				funding depending on the progress and timing of implementing each pilot.	with 14 units currently operational. The enhanced home support service is operational providing unplanned, short term same day home support for up to 72 hours across all five CCG areas in Norfolk.
Invest and Improve	Reduce pressure on the NHS	**iBCF9** Enhanced community offer for carers - 3 year invest to save pilot	0.1	0.1	0.1	Carers are key to supporting people to stay safe and independent. Additional funding here will work alongside newly commissioned carers service to ensure that carers are fully supported to have a good quality of life	Using the Home First model this is being linked with iBCF 8 and 9 to provide crisis management services
Invest and Improve	Reduce pressure on the NHS	**iBCF10** Enhanced flexible dementia offer - 3 year invest to save pilot	0.2	0.2	0.2	Providing support that enables people with dementia to stay in their own homes is a priority for both health and social care. This funding will enhance the existing offer and allow innovations in service to be implemented and tested for success. This service will support people with dementia to be discharged safely from formal care settings.	Using the Home First model this is being linked with iBCF 8 and 10 to provide crisis management services

Improved Better Care Fund – Summary March 2018

Appendix 3

Planning priority	Grant Condition	Description	2017/18 £m	2018/19 £m	2019/20 £m	Impact	Activity and progress
Invest and Improve	Reduce pressure on the NHS	**iBCF11** Reduce DTOC mental health services	0.4	0.4	0.4	Providing sufficient support when people with mental health problems leave formal care services is crucial in ensuring people can settle and establish their independence. We are working with mental health colleagues to formulate the most effective mechanisms that will support discharge from hospitals and formal care settings.	There are an additional six beds/flats commissioned as "step down" and admission avoidance from mental health hospitals jointly funded with NSFT with social care support to provide suitable discharge destinations. All units are fully occupied. Increased staff capacity, 4 additional staff includes; 1fte SW for OPMH 1fte Assistant practitioner for OPMH 1fte Assistant practitioner for Hosp SW Team 1fte AMHP for Duty Team
			20.4	**27.7**	**34.3**		
Funded by:	iBCF as per 2017 Spring Budget		-18.6	-11.9	-5.9	Non -recurrent funding	
	iBCF as per 2015 Spending Review		-1.9	-15.8	-28.4		
	Total		**-20.4**	**-27.7**	**-34.3**		

Better Care Fund Monitoring Dashboard

Meeting target | Within 5% of target | > 5% over target

Norfolk County Council	Better Care Fund - KPI Dashboard (March 2018)	Clinical Commisioning Groups NHS

Indicator	CCG	2017/18 Performance																
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4	YTD	Target
Total non-elective admissions in to hospital (general & acute), all ages, per 100,000 population	Great Yarmouth	917	974	932	929	878	876	939	974	990	1,037			2,823	2,683	2,903		9,446	-
	Norwich	1,616	1,749	1,717	1,693	1,586	1,658	1,739	1,829	1,805	1,754			5,082	4,937	5,373		17,146	-
	North Norfolk	1,322	1,340	1,348	1,329	1,343	1,295	1,377	1,445	1,547	1,547			4,010	3,967	4,369		13,893	-
	South Norfolk	1,535	1,677	1,687	1,651	1,637	1,708	1,768	1,724	1,844	1,863			4,899	4,996	5,336		17,094	-
	West Norfolk	1,969	2,185	2,038	2,036	1,914	1,936	1,953	1,990	2,052	2,186			6,192	5,886	5,995		20,259	-
	Norfolk Total	**7,359 (1,012.8)**	**7,925 (1,090.7)**	**7,722 (1,062.8)**	**7,638 (1,051.2)**	**7,358 (1,012.7)**	**7,473 (1,028.5)**	**7,776 (1,070.2)**	**7,962 (1,095.8)**	**8,238 (1,133.8)**	**8,387 (1,147.0)**			**23,006 (3,166.3)**	**22,469 (3,092.4)**	**23,976 (3,299.8)**		**77,838 (10,712.9)**	**78934 (10,863.8)**

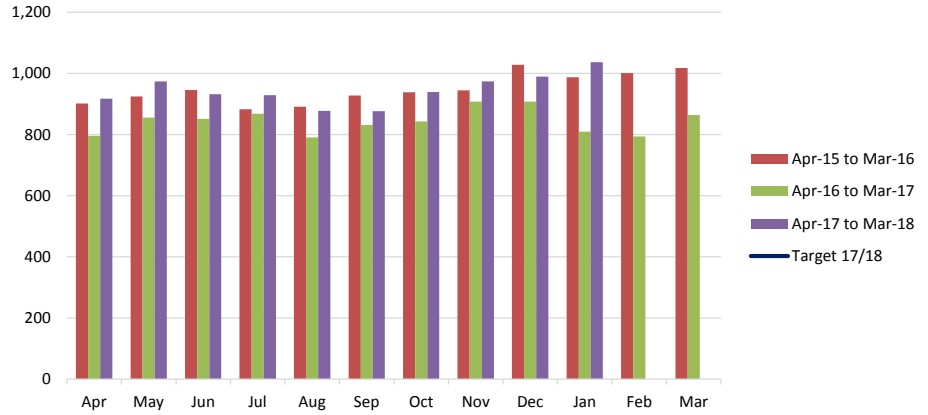
Overview of performance

Metric	Key issues and discussion points	Definition	Source notes
Total non-elective admissions in to hospital (general & acute), all ages, per 100,000 population	**Lower** is better.	A Non-Elective Admission is one that has not been arranged in advance. It may be an emergency admission, a maternity admission or a transfer from a Hospital Bed in another Health Care Provider.	NHS Digital Secondary Uses Service (SUS) data. Population taken from ONS 2014 based projections for 2017/18. Quarterly targets are apportioned equally between each of the three months. Roundwell Medical Practice moved from South Norfolk CCG to Norwich CCG on 1st Apr 2017, but has been assigned to Norwich for all three financial years to ensure figures are comparable.

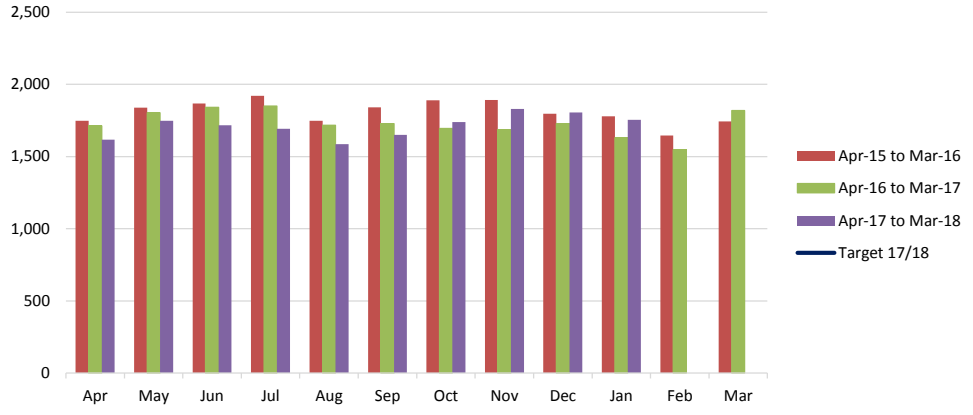
Better Care Fund Monitoring Dashboard

Non-elective admissions (general and acute) by CCG

Great Yarmouth



Norwich



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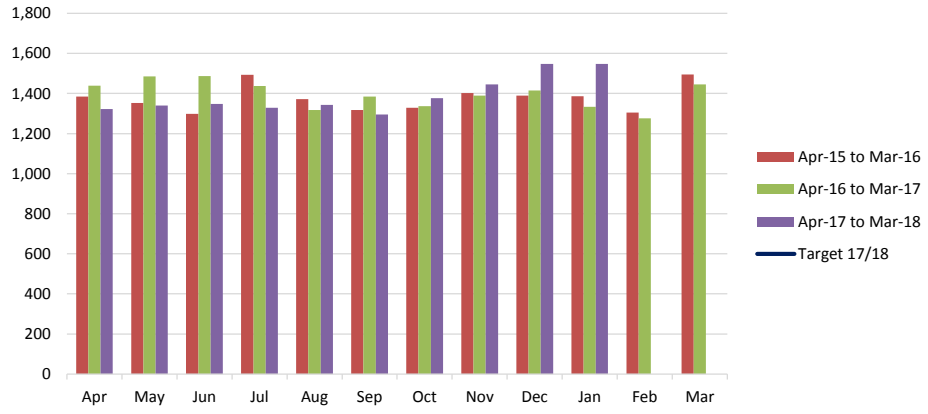
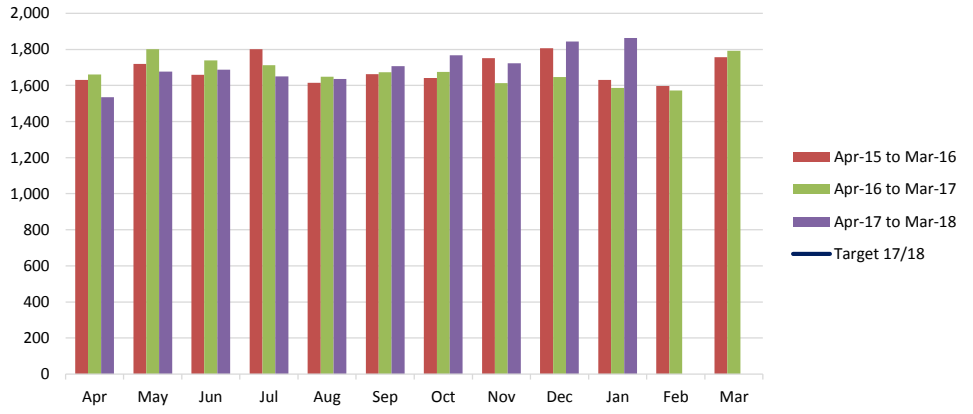


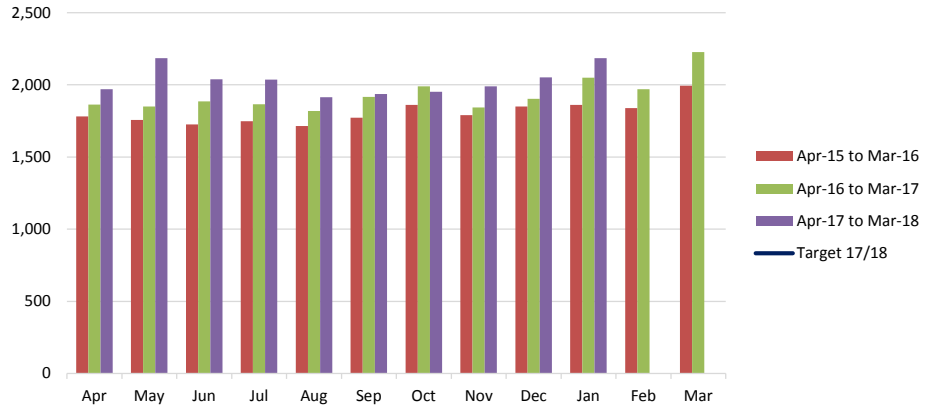
South Norfolk



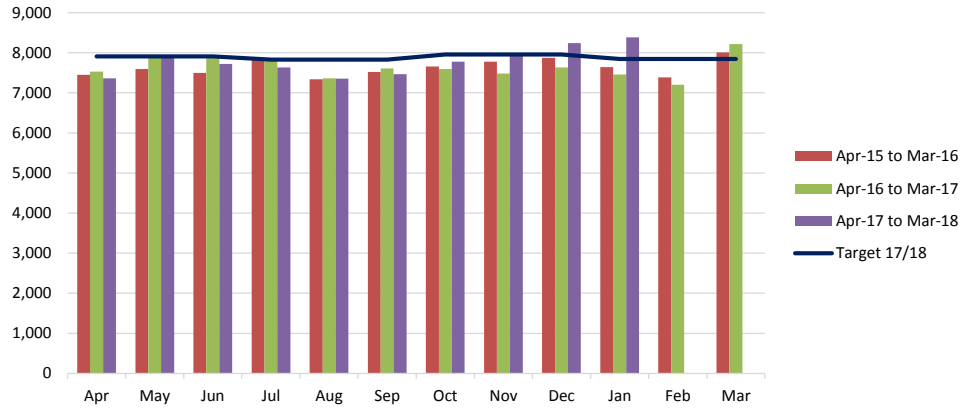
Better Care Fund Monitoring Dashboard

Non-elective admissions (general and acute) by CCG

West Norfolk



Norfolk Total



Better Care Fund Monitoring Dashboard

Meeting target | Within 5% of target | > 5% over target

Norfolk County Council		Better Care Fund - KPI Dashboard (March 2018)												Clinical Commisioning Groups NHS					
Indicator	Trust	2017/18 Performance																	
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4	YTD	Target
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+)	NNUH	1,110	933	847	844	820	955	1,637	1,215	936	1,268	887		2,890	2,619	3,788		8,562	-
	QEH	150	163	171	297	361	336	231	211	226	311	319		484	994	668		2,292	-
	JPH	86	119	181	113	84	37	115	324	181	108	121		386	234	620		1,083	-
	Norfolk Acute Total	**1,346**	**1,215**	**1,199**	**1,254**	**1,265**	**1,328**	**1,983**	**1,750**	**1,343**	**1,687**	**1,327**		**3,760**	**3,847**	**5,076**		**11,937**	-
	NSFT	528	460	458	340	318	373	499	442	320	277	197		1,446	1,031	1,261		2,766	-
	NCHC	447	577	643	668	433	530	549	573	528	518	534		1,667	1,631	1,650		4,333	-
	Norfolk Total	**2,489 (342.6)**	**2,467 (339.5)**	**2,521 (347.0)**	**2,513 (345.9)**	**2,254 (310.2)**	**2,430 (334.4)**	**3,192 (439.3)**	**2,940 (404.6)**	**2,406 (331.1)**	**2,688 (367.6)**	**2,242 (306.6)**		**7,477 (1,029.1)**	**7,197 (990.5)**	**8,538 (1,175.1)**		**20,665 (2,844.1)**	**15225 (2,095.4)**
(Responsible organisation)	NHS	1,260	1,237	1,274	1,321	1,413	1,413	1,622	1,607	1,103	1,562	1,280		3,771	4,147	4,332		**11,321**	9869
	Social Care	1,167	1,216	1,201	1,140	831	1,016	1,542	1,232	1,213	1,078	890		3,584	2,987	3,987		**8,942**	4993
	Both	62	14	46	52	10	1	28	101	90	48	72		122	63	219		**402**	362

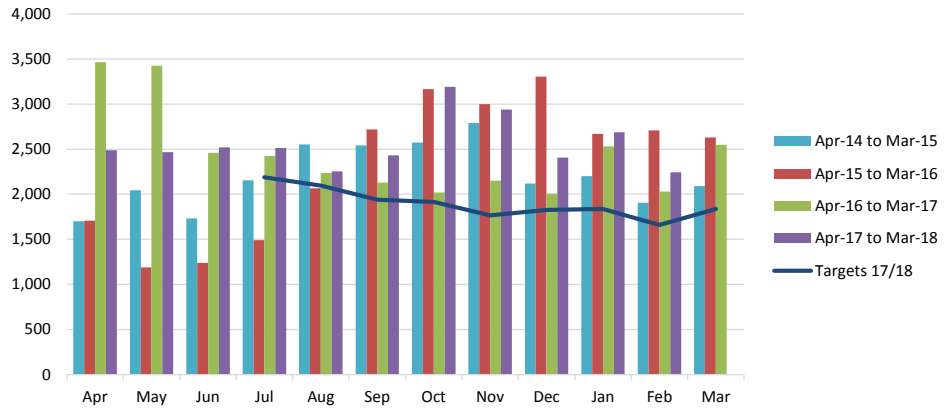
Overview of performance

Metric	Key issues and discussion points	Definition	Source notes
Delayed transfers of care from hospital per 100,000 population	**Lower** is better.	**Numerator**: Total number of delayed transfers of care for those aged 18+. **Denominator**: ONS 2014 based population projection for 2017.	NHS Monthly Situation Report data. Norfolk population taken from ONS 2014 based projections for 2017/18. Rates are not shown by Trust as populations are not available at hospital level. There was no target for Q1 2017/18.

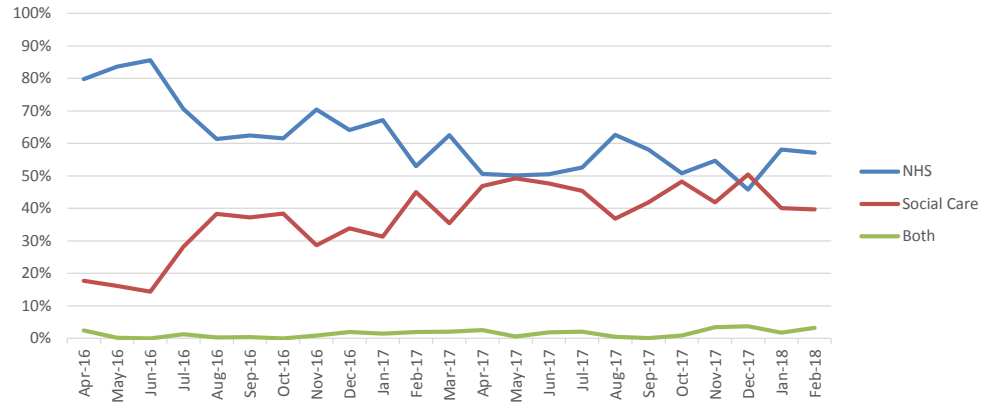
Better Care Fund Monitoring Dashboard

Delayed Transfers of Care

Norfolk Total



Responsible Organisation (Norfolk Total)



Better Care Fund Monitoring Dashboard

Supporting metrics

Meeting target | Within 5% of target | > 5% over target

Norfolk County Council		Better Care Fund - KPI Dashboard (March 2018)												Clinical Commisioning Groups NHS					
Indicator	CCG	2017/18 Performance																	
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4	YTD	Target
Local metric: 65+ Estimated diagnosis rate for people with dementia	GY & Waveney	61.7%	61.2%	61.1%	61.0%	62.1%	62.4%	62.5%	62.7%	62.7%	62.8%	64.7%	63.6%	61.3%	61.8%	62.6%	63.7%	63.6%	68.0%
	Norwich	62.3%	61.7%	61.3%	61.1%	60.7%	60.5%	60.6%	61.4%	61.1%	60.3%	60.7%	60.7%	61.8%	60.8%	61.0%	60.6%	60.7%	68.0%
	North Norfolk	61.4%	61.6%	61.3%	61.5%	61.3%	61.1%	60.8%	61.2%	61.0%	60.4%	62.1%	60.5%	61.4%	61.3%	61.0%	61.0%	60.5%	68.0%
	South Norfolk	62.5%	62.9%	63.2%	62.6%	63.6%	63.4%	63.6%	64.5%	64.5%	64.1%	58.3%	57.8%	62.9%	63.2%	64.2%	60.0%	57.8%	68.0%
	West Norfolk	64.8%	63.7%	63.6%	63.5%	62.9%	62.5%	62.6%	62.5%	61.5%	60.8%	62.9%	62.0%	64.0%	63.0%	62.2%	61.9%	62.0%	68.0%
	Norfolk Total	**62.4%**	**62.2%**	**62.1%**	**61.9%**	**62.2%**	**62.1%**	**62.1%**	**62.5%**	**62.2%**	**61.8%**	**61.7%**	**60.9%**	**62.2%**	**62.0%**	**62.3%**	**61.5%**	**60.9%**	**68.0%**
Long-term support needs of older people (aged 65+) met by admission to residential and nursing care homes, per 100,000 population	GY & Waveney	11	11	16	18	12	14	14	11	12	15			38	44	37		134	-
	Norwich	26	21	19	20	19	16	20	17	18	14			66	55	55		190	-
	North Norfolk	18	20	23	24	23	22	21	23	28	12			61	69	72		214	-
	South Norfolk	15	22	32	18	32	22	21	34	28	30			69	72	83		254	-
	West Norfolk	30	27	22	32	22	25	22	21	11	18			79	79	54		230	-
	Norfolk Total	**102 (47.2)**	**101 (46.7)**	**112 (51.8)**	**112 (51.8)**	**108 (49.9)**	**99 (45.8)**	**99 (45.8)**	**107 (49.5)**	**98 (45.3)**	**93 (42.3)**			**315 (145.7)**	**319 (147.5)**	**304 (140.6)**		**1,031 (476.8)**	**1247 (528.1)**
Proportion of older people (aged 65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	GY & Waveney	92.9%	95.1%	95.5%	94.5%	93.3%	90.9%							95.5%	90.9%			90.9%	90.0%
	Norwich	94.6%	92.2%	94.0%	94.2%	94.9%	93.5%							94.0%	93.5%			93.5%	90.0%
	North Norfolk	94.9%	95.9%	95.8%	95.5%	95.8%	94.0%							95.8%	94.0%			94.0%	90.0%
	South Norfolk	94.0%	95.7%	93.4%	91.0%	88.1%	93.2%							93.4%	93.2%			93.2%	90.0%
	West Norfolk	91.5%	91.9%	94.3%	95.8%	96.3%	96.3%							94.3%	96.3%			96.3%	90.0%
	Norfolk Total	**93.7%**	**94.0%**	**94.6%**	**94.2%**	**93.7%**	**94.1%**						**96%***	**94.6%**	**94.1%**		**96%***	**96%***	**90.0%**

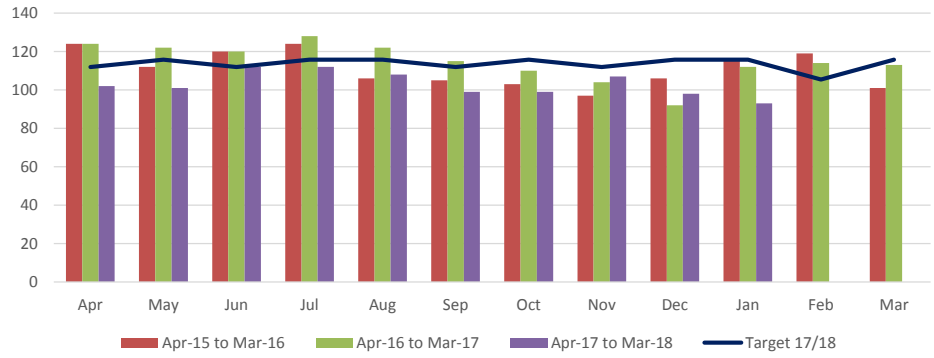
Better Care Fund Monitoring Dashboard

Overview of performance

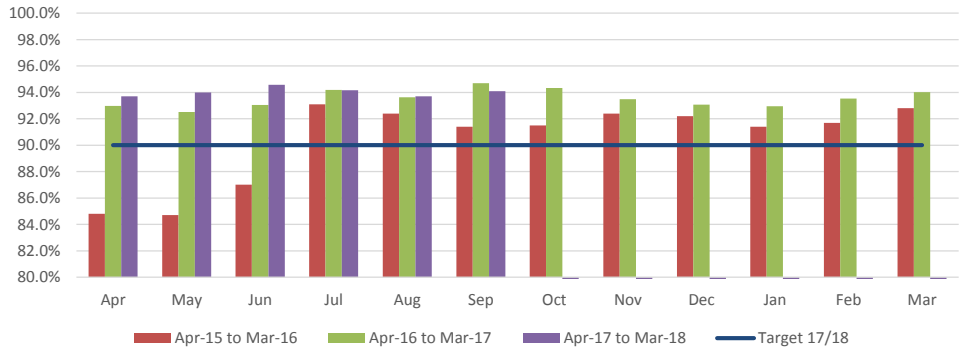
Metric	Key issues and discussion points	Definition	Source notes
Local metric: 65+ Estimated diagnosis rate for people with dementia	**Higher** is better.	The number of people detected in the population that have dementia as a % of prevalence. Same as the detection rate.	Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses
Long-term support needs of older people (aged 65+) met by admission to residential and nursing care homes, per 100,000 population	**Lower** is better.	**Numerator**: Number of council-supported permanent admissions of older people to residential/nursing care. **Denominator**: Number of older residents (aged 65+) in area.	Social Care data taken from CareFirst. Based on Adult Care Localities which are coterminous with the corresponding CCGs. Population taken from ONS 2014 based projections for 2017/18.
Proportion of older people (aged 65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	**Higher** is better.	**Numerator**: Number of older people discharged from hospital at home, in extra housing or an adult placement scheme setting three months after the date of their discharge from hospital. **Denominator**: Number of older people (aged 65+) offered rehabilitation services following discharge from acute or community hospital.	*** This is an unconfirmed figure because of the transition from CareFirst to LiquidLogic may mean there are differences in how the system counts. If there are changes needed to be made, we will issue a final confirmed figure in the next quarter.**

Supporting metrics

Permanent admission of older people (Norfolk Total)



Effectiveness of reablement (Norfolk Total)



Adult Social Care Committee

Item No ……

Report title:	**Adult Social Care Finance Outturn Report Year End 2017-18**
Date of meeting:	**14 May 2018**
Responsible Chief Officer:	**James Bullion, Executive Director of Adult Social Services**

Strategic impact

This report provides the Committee with a review of the budget position for the last financial year, based on information to the end of March 2018. It provides an analysis of variations from the revised budget, the use of additional funding received through the improved Better Care Fund, achievements against planned savings and use of reserves and capital.

Executive summary

The paper looks back at the financial position for Adult Social Services during 2017/18. At the end of financial year 2017-18, Adult Social Service's financial outturn position at March 2018 showed an underspend of £3.696m. The underspend equates to a 1.37% variance on the revised budget. The Period 13 position, which reflects the end of year position including final adjustments completed in April, represents a decrease of £1.196m on the position reported at the end of Period 10.

Expenditure Area	Budget 2017/18 £m	Outturn £m	Variance £m
Total Net Expenditure	269.241	265.545	(3.696)

The headline information and considerations include:

a) The outturn position for 2016-17 was a £4.399 overspend, which included some one-off funding. Investment was included in the 2017-18 budget to help manage the underlying pressure. This included £4.197m of one-off funding and internal plans for the service included savings targets to meet this pressure by April 2018
b) Norfolk County Council (the Council) in setting the budget recognised the additional business risks affecting the service, specifically in relation to the ongoing pressures from the cost of care exercise, increases in the National Living Wage, the continued growth in demand and the impact of savings not achieved in previous years. To support this, an additional £19.738m was added to the 2017/18 budget, over and above usual pay, price and growth increases
c) Key variations in the final periods included reductions in salary costs through delays in recruitment, lower home support costs than previously forecast through improved information availability and increased service user income compared to the forecast position
d) The service has delivered savings of £14.353m against a target of £14.213m. £10.728m of the savings have been delivered in line with the planned savings programme
e) £4.5m was used to create a Business Risk Reserve to support activities related to the savings programme for 2018/19 and beyond
f) Budget movements at year end reflected capital financing charges and had no impact on the outturn position

Adult Social Services reserves at 1 April 2017 stood at £2.074m. Plans were in place (and incorporated into the 2017/18 budget) to use these reserves to support projects and activities through the year.

In fact, during 2017/18 the service has added £22.535m to reserves (£15.670m of this related to the unspent element of the Improved Better Care Fund (iBCF), and £4.500m was used to create a Business Risk Reserve). This means the 2017-18 outturn position for reserves is £24.609m. Provisions totalled £4.157m at 1 April 2017, mainly for the provision for bad debts. Additional provision for doubtful debts has increased the balance to £6.454m.

Recommendations:

Members are invited to consider the contents of this report and to agree:

a) The outturn position for 2017-18 Revenue Budget of an underspend of £3.696m

b) The outturn position for the 2017-18 Capital Programme

1. Introduction

1.1 The Adult Social Care Committee has a key role in overseeing the financial position of the department including reviewing the revenue budget, reserves and capital programme.

1.2 This is the final monitoring report for 2017/18 and reflects the outturn position at the end of March 2018, Period 13.

1.3 The County Council in setting the budget recognised the additional business risks affecting the service, specifically in relation to the ongoing pressures from the cost of care exercise, increases in the National Living Wage, the continued growth in demand and the impact of savings not achieved in previous years. To support this, an additional £19.738m was added to the 2017/18 budget, over and above usual pay, price and growth increases.

2. Detailed Information

2.1 The table below summarises the outturn position as at the end of March 2018 (Period 13).

2016/17			2017/18				
Actual 2016/17	Over/ Under spend at Outturn	Expenditure Area	Budget 2017/18	Outturn	Variance to budget		Variance @ P10
£m	£m		£m	£m	£m	%	£m
10.392	(0.471)	Business Development	11.972	11.659	(0.313)	-2.61%	(0.309)
69.600	0.123	Commissioned Services	72.111	72.203	0.092	0.13%	(0.027)
5.492	(0.727)	Early Help & Prevention	7.938	7.845	(0.093)	-1.17%	(0.043)
168.243	12.971	Services to Users (net)	189.270	181.698	(7.573)	-4.00%	(5.586)
1.064	(7.497)	Management, Finance & HR	(12.012)	(7.822)	4.190	34.88%	3.465
254.791	**4.399**	**Total Net Expenditure**	**269.280**	**265.585**	**(3.696)**	**1.37%**	**(2.500)**

2.2 As at the end of Period 13 (March 2018) the revenue outturn position for 2017-18 is a £3.696m underspend. This includes the use of the Improved Better Care Fund (iBCF) and releases from reserves where appropriate to support planned activities. The unspent element of the iBCF was transferred into reserves to support agreed activities in future years, together with £4.500m to create a Business Risk Reserve to support the savings programme in 2018/19 and beyond.

2.3 The detailed position for each service area is shown at **Appendix A**, with further explanation of over and underspends at **Appendix B**.

2.4 The underspend is primarily due to the net cost of Services to Users (Purchase of Care and Hired Transport), and delays in recruiting to vacant posts.

2.5 There has been in-year movement in the budget between services to properly reflect the agreed areas supported by the Better Care Fund income. Key changes include reducing the income budget for both Management and Finance and Services to users with corresponding increase in income budget for Care and Assessment – which resulted in a reduction in net budget for these services, although did not affect the actual resources available.

2.6 **Services to Users**

2.6.1 The Purchase of Care budget outturn is set out in more detail below. This highlights that while overspends were recorded in each of the key areas, these were then offset by an over-recovery of income and an underspend on Hired Transport. Overall reductions have been recorded in year for the number of service users, reflecting the efforts made over recent years to manage demand.

2.6.2 The table below provides more detail on services to users, which is the largest budget within Adult Social Services:

2016/17			2017/18		
Actual 2016/17 £m	**Over/ Underspend at Outturn £m**	**Expenditure Area**	**Budget 2017/18 £m**	**Outturn £m**	**Variance £m**
111.914	8.238	Older People	111.169	114.650	3.481
23.246	1.207	Physical Disabilities	23.229	24.095	0.866
94.527	11.119	Learning Disabilities	99.202	100.865	1.663
13.174	0.267	Mental Health	14.116	14.616	0.500
6.746	3.074	Hired Transport	6.672	5.859	(0.813)
9.144	(1.194)	Care & Assessment & Other staff costs	11.752	10.181	(1.571)
258.751	**22.710**	**Total Expenditure**	**266.140**	**270.266**	**4.125**
(90.508)	(9.739)	Income	(76.870)	(88.568)	(11.698)
168.243	**12.971**	**Revised Net Expenditure**	**189.270**	**181.698**	**(7.573)**

2.6.3 Headlines:

a) There has been a continued decrease in the purchase of care net position in the second half of 2017-18. This includes a continued reduction in spending on Transport. The improvement against budget mainly relates to residential and nursing care for older people and residential respite, home support and supported living for people with learning disabilities. The latter relating primarily to adjustment of the forecast for growth. Improved information in relation to use of the home support block framework has enabled spend to be adjusted downwards. Income has continued to increase during the year, reflecting both variations to budgeted number of people in residential care, which has not decreased in line within initial plans, new approaches and protocols in place for transforming care programme (TCP) – although this will align with costs incurred. Initiatives such as accommodation based reablement have recently been implemented, which will provide more options for care provision post hospital discharge and reduce the likelihood of people requiring long term residential care
b) Permanent admissions to residential care –those without a planned end date – have been reducing since 2014/15 in both 18-64 and 65+ age groups. Over the past three years the rate of admissions for those aged 65+ has reduced significantly from a rate of 724 admissions per 100k population in 2014/15 to 611.9 per 100k population in 2016/17. Reductions have slowed over the last two years, but continue to fall. Figures for the end of March 2018 show a reduction in permanent admissions to 595.4 per 100k population, which is below our target of 603.1/100k. Admissions to permanent residential care per 100k population for people aged 18-64 has seen a small decrease during 2017-18. Total numbers during the year has changed by 15. Those that do go into residential care tend to be people with higher levels of need that require longer lengths of stay and more expensive care packages
c) Overall there are 455 fewer service users of adult social care at the end of March 2018, with service users reducing to 13,498. Some 392 relates to a reduction in older people requiring formal adult social care services. However, whilst service user numbers are decreasing in keeping with the Promoting Independence strategy, the mix and rate has not been sufficient to deliver all the planned savings.
d) The year on year position is not entirely comparable, partly due to one-off adjustments, but provides an indication of the expenditure trend. The outturn expenditure for Purchase of Care, excluding Care and Assessment is £10.478m higher than 2016/17. This reflects increases from demographic growth, ongoing work to ensure that suppliers are paid a fair price, increased costs around the legal rulings on sleep ins and the impact of the April 2017 increase to the National Living Wage, offset by delivery of savings. The Purchase of Care budgets included £6.134m of budget growth for demography, £4.5m for Cost of Care and £5.66m for pay and market pressures
e) Reducing the number of working age adults in residential placements in line with savings targets is challenging. Transition plans for individuals are continuing to be developed and implemented, but transition for most individuals will take time with increased resources often needed initially to support the transition process into more independent care settings
f) Services for people with learning disabilities has seen an increase in service users during the year. Although expenditure has increased above budget, this has been offset by additional income. The service has worked closely with health to develop shared care arrangements for some individuals where appropriate. However, this continues to be an area where there is high financial risk. As part of the learning disabilities work within the Promoting Independence programme, there has been an increase in operational and managerial resources to support the teams in development of strength based practice, targeted resource to undertake reviews of complex cases and actions to develop new service offers to help people gain independence

g) The net budget for mental health services (taking account of both expenditure and service user income) achieved a small overspend for 2017/18 of £0.088m. This is despite the service supporting an increase during the year of 65 service users, reflecting the ongoing trend in demand for the service. This increase includes transition of young adults from children services to adult service at 18, which was not included in growth pressures for the service last financial year. This pressure has been allocated to mental health services for 2018-19

h) Overall there was a reduction of £13.638m in budgeted income in 2017/18 compared to 2016/17 outturn. This primarily relates to one-off income items accounted for against Purchase of Care income in 2016/17 including:
   a) £10.155m from the Corporate Business Risk reserve for 2016/17 Cost of Care and National Living Wage pressures
   b) £0.948m from the Adult Social Care reserve to contribute to the costs mentioned above, as well as general growth pressures
   c) £1.2m transfer from Public Health

   In addition to some one-off income, there has been an £4.2m increase in service user income in 2017-18, reflecting a mix of service user wealth, the Council's charging policy and new approaches.

2.7 **Commissioned Services**

2.7.1

2016/17			2017/18		
Actual 2016/17 £m	**Variance at outturn £m**	**Expenditure Area**	**Budget 2017/18 £m**	**Forecast Outturn £m**	**Variance £m**
1.185	(0.289)	Commissioning Team	4.298	4.193	(0.105)
10.361	(0.795)	Service Level Agreements	12.759	12.444	(0.315)
2.184	(0.418)	Integrated Community Equipment Service	2.396	2.102	(0.294)
33.280	3.257	NorseCare	32.594	33.266	0.672
8.323	(1.172)	Supporting People	5.817	5.817	0.000
13.114	(0.244)	Independence Matters	12.857	13.077	0.220
1.153	(0.216)	Other Commissioning	1.390	1.304	(0.087)
69.600	**0.123**	**Total Expenditure**	**72.111**	**72.203**	**0.092**

2.7.2 Key points:

NorseCare

a) The variance has reduced from Period 10 to £0.672m. As part of the management of Norfolk County Council's overall 2016/17 underlying overspend for adult social services, one-off funding of £2m was used in 2017/18 to manage part of the variance between the previous budget and the NorseCare contract price. Despite on-going reductions in the real-terms contract costs (including NorseCare forgoing the inflationary increase for this year that the contract entitles it to) there remains a variation between the approved budget and the contract price

b) Savings targets set in the council's prior-year budgets were not able to be achieved within the 2017-18 contract price – this is mainly because of the 'legacy' costs that NorseCare carries in respect of staff terms and conditions and property maintenance

c) The reduction in the variance reflects work to maximise and reshape the contract and to ensure that income that relates to Norsecare block beds is reflected against the contract spend

Independence Matters

d) The service is working closely with Independence Matters to reshape the contract and service model to enable long term savings to be delivered. Savings related to the review of day services will not be fully delivered in 2017-18, however one-off efficiencies have been implemented.

2.8 **Achieved Savings**

2.8.1 The department's budget for 2017/18 included savings of £14.213m, the savings reported for the service totalled £11.213m, which reflects the impact of reversing previous savings of £3m for transport. In addition, the service recognised the need to target additional savings of £4.197m by April 2018 in order to manage the impact of the one-off adult social care support grant, which has been used to provide additional time to reduce the underlying overspend from 2016/17. The progress and risks associated with delivery of the savings have been reported regularly to the Adult Social Care Committee.

2.8.2 During the year the service refreshed the Promoting Independence strategy and savings programme, this was detailed in the report to this Committee in July 2017. As a result, whilst the savings were in line with the proposals agreed by County Council in February, the detail about how savings would be achieved was built up, with new projects.

2.8.3.1 In relation to the planned programme of savings, at Period 10 a savings delivery risk of £3.874m was reported, with £10.339m on track. The paper set out alternative savings totalling £1.587m.

The final planned programme savings achieved were £10.728m, of which risks totalling £3.485m were reflected in the forecast position. This represented an improved savings delivery of £0.329m when compared to the previously reported forecast. Throughout the year the service has been monitoring the overall position for the service and other savings areas have been identified and delivered. **This has result in achievement of total savings of £14.353m.**

Savings	Planned Saving 2017/18	Delivery 2017/18	Variance		Previously reported
	£m	£m	£m	%	£m
Savings not or partly achieved	6.646	3.041	-3.605	-54%	3.874
Savings on target	7.567	7.687	0.120	2%	0
Total Planned Savings	**14.213**	**10.728**	**-3.485**	**-25%**	**3.874**
Additional savings above target	0.000	3.625			
Total Savings	14.213	14.353	0.140	1%	

2.8.3.2 We have been relatively strict in our assessment of planned savings and have stuck to assessing the planned programme of savings in isolation. However, in reality a large scale programme of savings will include variation against original plans. In

recognising this, the service continually seeks and embraces opportunities to promote people's independence and maximise our income generation.

As with our period 10 forecast, the service has generated new savings opportunities and taken mitigating actions within the year. Examples of actions include:

- **Transport (delivery above budget £0.700m)** The service is seeing an impact of the transport policy coupled with the work being undertaken to continuously review routes and contracts. This will be an early achievement of the planned savings for 2018/19.
- **Service User income (delivery above budget £0.846m)** The Finance Exchequer Service has increased work with service users who make a nil contribution towards their care with a view to ensuring the service user is maximising their income and supporting them to claim all the benefits they are entitled to.
- **Shared Care income (delivery above budget £2.079m)** The service has focused on discussions with the NHS to share the costs of delivering on-going joint formal care services, in particular for those with Learning Disabilities and/or Mental Health needs

In addition to these specific actions, we continue to maximise our contracts and staffing establishments and have delivered one-off underspends on a number of base budgets.

The impact of an under-delivery of savings on future years budgets is dependent on the extent to which mitigating actions are recurrent in nature. Most of our income related mitigating savings will be recurrent and therefore the additional income generated will offset any shortfall.

2.8.3.3. Some of the under-delivery of planned savings is due to timing rather than not being able to deliver at all. But the impact on our "run-rate" must be considered. This term is used to describe our annual cost projection based on the volume and unit cost of the people being supported today. This is particularly important when a service is changing and the aim is to reduce levels of people being supported in complex settings. As our initiatives begin to have impact towards the latter half of the year, the ability to build delivered savings in that year are clearly limited by the time remaining in that financial year. This will however mean that the following year, assuming the levels remain at the lower level, the actual spend will be at level related to the lower volume (or unit cost).

2.8.3.4 Although our pattern of spending in relation to purchase of care was not as planned, it is changing and this is having an impact on our net expenditure. Key changes include:

a) Permanent admissions to residential care for older people is continuing to gradually reduce, but maintaining numbers has protected income that we receive
b) Reablement has continued to prove effective, with use increasing and is credited for the reduction in the need for home support
c) The social work approach is supporting cost avoidance. Whilst it is difficult to evidence directly there are signs of fewer referrals leading to an assessment, which indicates that the service is managing demand and is being effective at stemming the pattern over previous years of increased growth in the need for services

2.8.4 For those savings that did not deliver to target in full in 2017/18 a brief explanation is set out below.

2.8.5 **Younger adults and older people reviews (target £4.445m; delivery £2.546m; variance £1.899m)** The delivery is based on evidence of the actual impact from reviews completed earlier in the year. However, this is a difficult saving to accurately evidence and savings could still be achieved through other demand management interventions that will enable savings to be achieved across the workstream. Additional social workers have been

recruited and the Living Well programme has been launched, which will support approaches that will deliver increased independence for individuals.

Home care commissioning (target £0.183m; delivery £0.000m; variance £0.183m) A new framework is in place for the Northern, Central and Southern areas from April 2018. Investment into the framework is expected to improve stability in this market but is not able to achieve immediate savings. The new framework encourages provider collaboration to improve efficiency of home support rounds, which will improve the financial sustainability and support more cost effective commissioning of wider services, however it is expected that this will not result in savings in the short term.

Review of day services (target £1.000m; delivery £0.400m; variance £0.600m) Savings have been delivered through our independent purchase of care provision. In addition, the service is working closely with Independence Matters to reshape the contract and service model to enable long term savings to be delivered, however, part of the savings will require a further reduction in demand for day services and alternative approaches.

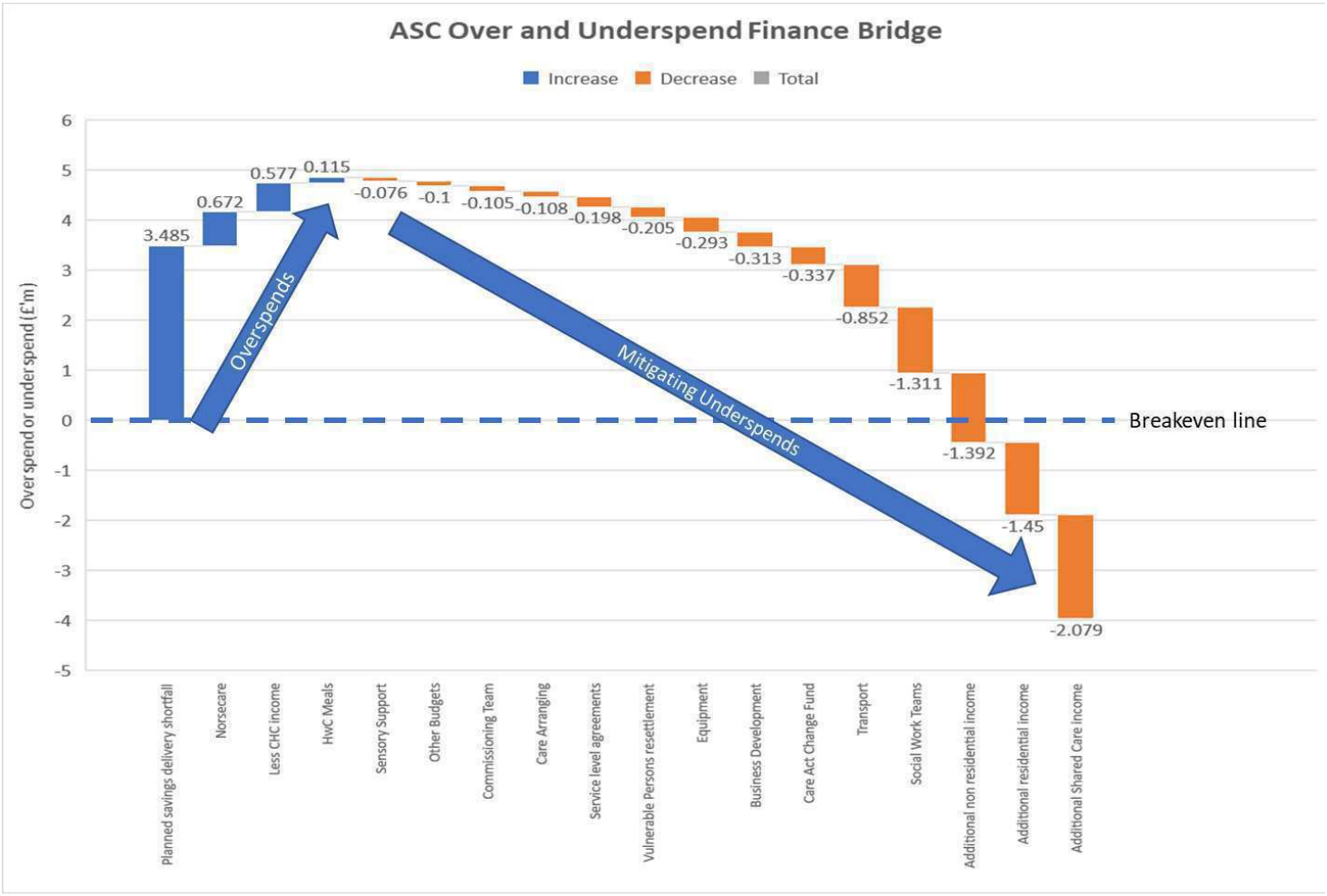
Review of the usage of short term planning beds (target £0.500m; delivery £0.080m; variance £0.420m) The service had targeted a reduction in its usage of planning beds but the decommissioning of these services has been delayed due to the requirement to source alternative capacity to ensure no detrimental impact on hospital discharge.

Review of various commissioning arrangements to identify more cost effective ways of providing services (target £1.159m; delivery £0.843m; variance £0.316m) Planned reduction and decommissioning of some contracts has not be achieved. This has been mitigated through revised usage of contracts to improve value for money.

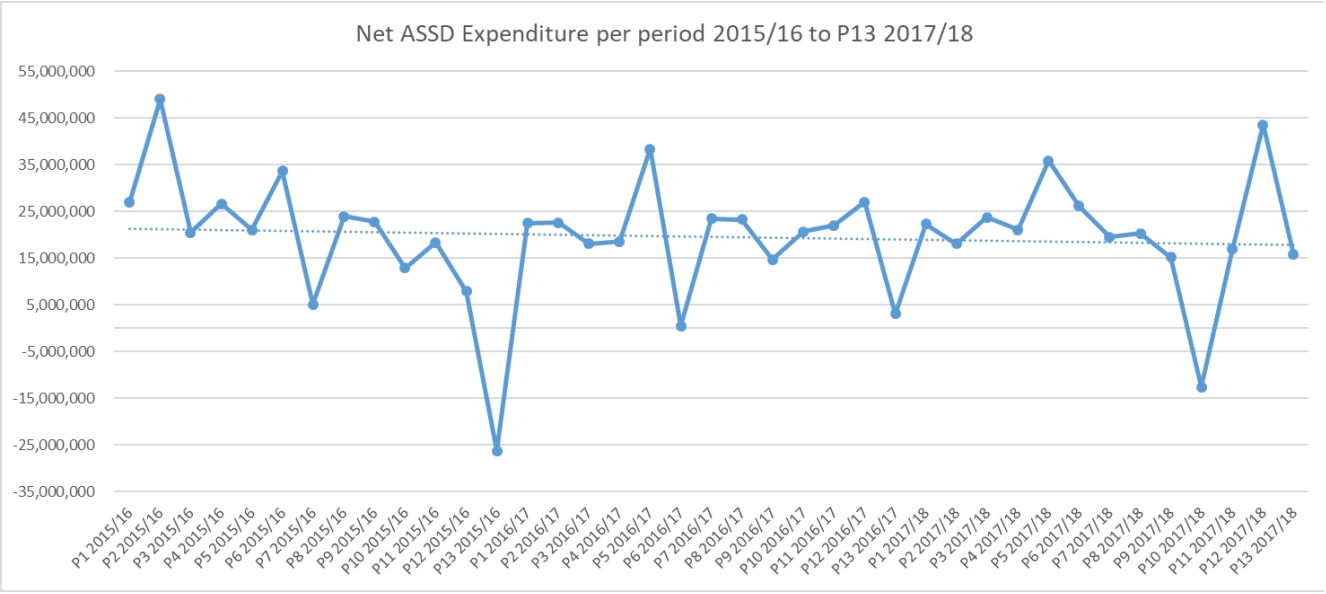
A consistent approach to specific laundry needs (target £0.055m; delivery £0.038m; variance £0.017m) Service contracts in the East and West of the county were decommissioned but the need has not been mitigated in the Norwich area.

Remodel contracts for support to mental health recovery (target £0.125m; delivery £0.035m; variance £0.090m) Service redesign has taken place and the remainder of the savings will be delivered in 2018/19.

2.8.6 Our Finance Bridge describes the overall picture taking into account budget performance across the overall department:



2.8.6 The departments net expenditure each period is prone to fluctuations, as evidenced by the below graphic, however, it continues to display a downward trajectory when compared to 2015/16. The spike in the period 5 2017/18 net expenditure is due to the month having two main payment runs – this is comparable to the peaks seen in similar periods of 2016/17 and 2015/16. The spike in P12 is primarily due to the transactions relating to capital accounting (no impact on bottom line) and movement required to transfer funding to reserves.



2.9 Improved Better Care Fund

2.9.1 The Chancellor's Budget in March 2017 announced £2bn additional non-recurrent funding for social care, of which Norfolk received £18.561m in 17/18, to be followed by £11.901m in 2018/19 and £5.903m in 2019/20. The funding is paid as a direct grant to councils by the

DCLG and as a condition of the grant, councils were required to pool the funding into their BCF.

2.9.2 The guidance received from DCLG requires that the funding is used by local authorities to provide stability and extra capacity in the local care system. Specifically, the grant conditions require that the funding is used for the purposes of:

a) Meeting social care needs
b) Reducing pressure on the NHS supporting people to be discharged from hospital when they are ready
c) Ensuring that the local social care provider market is stabilised

The table below shows the profile of the additional funding and the improved Better Care Fund.

£Ms	New funding (one-off)	Cumulative improved Better Care Fund (recurrent)	Total	Additional/Reduction in funding year on year
2017/18	18.561	1.885	20.446	20.446
2018/19	11.901	15.828	27.729	7.283
2019/20	5.903	28.372	34.275	6.546
2020/21		28.372	28.372	(5.903)

2.9.3 Plans for the use of the funding were reported to Adult Social Care Committee in July 2017 and were subsequently agreed with Norfolk's Clinical Commissioning Groups.

2.9.4 The Adult Social Care Committee has received regular updates on the iBCF within the Adult Social Care Finance Monitoring Report. The end of year summary is included within the report on progress on integration and BCF Plan 2017-19 elsewhere on this agenda.

2.9.5. In summary the funding has enabled us to:

a) Strengthen our Social Work capacity. By mid-February 40 appointments had been made to new roles in the service
b) Invest with Public Health in a countywide approach to social prescribing, enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services. This is being taken forward on CCG boundaries, working with Districts Council, CCGs & the voluntary sector. Locality plans have been developed, with services commencing between January and June 2018
c) Appoint five Trusted Assessment Facilitators across the three acute hospitals. This role has been developed with care providers. The service commenced in January 2018 in the Norfolk & Norwich University Hospital and all three hospitals had this service in place by early March
d) Open new Accommodation Based Reablement schemes. This is an occupational therapy-led service, designed to maximise people's independence and reduce permanent admissions to residential care, reduce hospital admissions and support safe and timely hospital discharge. A unit at Benjamin Court in Cromer has nine beds available with services having commenced in February and a further nine to be available later in 2018. The East Norfolk scheme, provided by Burgh House, currently has four beds. The unit opened early January and by the end of February

had already provided services to seven people. A West Norfolk unit will open later this year.

e) Commission three independent flats within a 24-hour housing with care setting at Dell Rose Court in Norwich, supporting people who have been assessed as being medically fit for discharge from hospital, but unable to return to their home safely. Flats are fully contained and have been equipped to replicate a home from home environment. Referrals to the service commenced early February 2018.
f) Implement the Enhanced Home Support Service, a small, flexible and enabling service which provides targeted home support to reduce delayed discharges from the three acute hospitals and unnecessary admissions from the community. This is a three-year pilot service, free to the service user for visits over a period of up to 72 hours and delivered in partnership with three Home Support providers. The service can offer support around meal preparation, personal care, shopping, welfare checks, medication monitoring and facilitation of the access to and the use of community resources and assistive technology solutions. It is suited to individuals with a low level of short term need. The service launched early February and by the end of the month had provided services to 30 individuals
g) Open an additional six beds/flats commissioned as "step down" and admission avoidance from mental health hospitals jointly funded with NSFT with social care support to provide suitable discharge destinations. The service commenced in July 2017

2.9.6 As reported throughout the year to Adult Social Care Committee the full grant funding has not been spent during this financial and members agreed early in the year to create a reserve to enable this funding to be carried forward in line with plans in 2018/19 and beyond. The reserves at 31st March 2018 include £15.670m for this purpose. There are three main reasons why the full allocation has not been spent to date.

a) The additional non-recurrent grant totalling £18.5m was announced in the March 2017 spring budget, which was after the County Council had agreed the budget for 2018-19. The full iBCF (BCF) guidance and sign-off process was not completed until July 2017
b) To jointly decide the best interventions to invest in to reduce pressures on the NHS, a more comprehensive understanding of the cause of delayed transfers of care (DTOC) relating to Social Care was required and data between health and social care has required ongoing development
c) The lead in time to develop, procure and contract services has meant many of the initiatives were not able to launch until Winter 2018. In recognising this we planned for a level of grant carry forward to fund services beyond the current financial year. This monthly expenditure will now increase significantly with the number of initiatives online

2.10 **Financial Accountability and Performance**

2.10.1 During the year the department has continued to closely monitor budget spend and income. Budget position, performance and variations are reviewed and monitored regularly within locality teams. Monthly performance and finance data is reviewed by senior management team in order to highlight key areas of focus for finance and performance board meetings. This is also a forum, which enables escalation by teams of blockages to progress and priority actions for the service. In addition, quarterly accountability meetings have been introduced, enabling scrutiny at team level and are led by the Executive Director of Adult Social Services. Teams continue to develop actions and follow up work to scrutinise variation to forecast.

2.10.2 The service implemented the new social care replacement system, LiquidLogic, on 22 November 2017, which included implementing a new financial system for social care. The system provides an improved management and reporting system for social care. The

implementation has been successful and teams are bedding in the new ways of working. The reporting tools are being implemented throughout 2018, which will improve reporting and data analysis.

2.11 **Reserves**

2.11.1 The department's reserves and provisions at 1 April 2017 were £6.230m. Reserves totalled £2.074m.

2.11.2 Plans were in place (and incorporated into the 2017/18 budget) to use these reserves to support projects and activities through the year.

2.11.3 During 2017/18 the service has added £22.535m to reserves (£15.670m of this related to the unspent element of the Improved Better Care Fund (iBCF), and £4.500m was used to create the Business Risk Reserve). This means the 2017-18 outturn position for reserves is £24.609m. Provisions totalled £4.157m at 1 April 2017, mainly for the provision for bad debts. Additional provision for doubtful debts has increased the balance to £6.454m. The projected use of reserves and provisions is shown at **Appendix C.**

2.12 **Capital Programme**

2.12.1 The department's three-year capital programme is £26.203m. The programme includes £6.782m relating to Department of Health capital grant for Better Care Fund (BCF) Disabled Facilities Grant (DFG), which is passported to District Councils within the BCF. Work has been undertaken with district councils as part of the BCF programme of work, to monitor progress, use and benefits from this funding. However, as this is passported directly to district councils this is not included within the programme for future years. The capital programme also includes £7.149m for the Social Care and Finance Replacement system in 2017/18 and beyond.

2.12.2 In setting the 2018-19 Budget, members agreed a proposal to capitalise spend on equipment to support service users, which will deliver revenue savings of £2.3m. Since reporting to members at the end of Period 10 and as part of year-end, it was put forward that it would be beneficial to NCC to capitalise this expenditure in 2017-18 enabling this to be supported through the unallocated capital grant within the service's capital programme. This change will not impact on the savings proposed for next financial year or affect the capital available for the service, which will be able to be sought through capital borrowing subject to business cases.

2.12.3 The year end capital programme includes slippage of the project for Elm Road. Following advice from the corporate property team, the service has been asked to explore alternative options for the site, which may enable a broader use of the site. As this will change the proposed usage and funding required, it is proposed that the £1.286m of funding is released for other purposes, while new proposals are developed. The impact on planned revenue savings is factored into savings risks and alternative savings will need to be identified.

2.12.4 The priority for use of capital is development of alternative housing models for young adults. There has been some reprofiling of the capital programme to reflect revised spending plans. Details of the current capital programme are shown in **Appendix D**.

3. Financial Implications

3.1 The outturn for Adult Social Services is set out within the paper and appendices. The impact for 2018/19 is set out below.

3.2 As set out in this report, the £3.696m underspend, is after placing £4.5m into a business risk reserve to help mitigate the budget risks to the department in 2018/19.

3.3 Throughout the year the service has been reporting the need to over deliver savings to address the loss in 2018-19 of £4.197m of one-off funding that was invested in 2017-18 and to help manage the impact of the 2016/17 overspend. The impact of this is included in the savings target of £27.290m for the service in 2018-19. Part of the year end analysis has been to examine the extent that the core underspend of £8.196m is ongoing and therefore will support delivery of planned savings or provide alternative means to mitigate savings and budget risks. It is calculated that £2.4m represents a recurrent underspend.

3.4 The service achieved overall delivery of savings of £14.353m against a target of £14.213m. Within this, £3.625m of savings were from delivery of alternative savings. The original savings will continue to be pursued, but as the many of the alternative savings are recurrent, all delivery of the original savings will make a positive contribution to the 2018-19 budget outturn position. The only exception is the transport savings, which are already reflected in the 2018-19, but were delivered sooner than expected and benefited the 2017-18 outturn position.

3.5 The position regarding spend of the improved Better Care Fund grant is set out at 2.10 of this paper. Members' decision to create a reserve in 2017-18 has enabled projects and spend to be progressed in a timely manner, and support delivery of the iBCF as planned. Many of these projects will support health and social care system benefits.

3.6 The Council has a high level of outstanding debt with health organisations. The level of debt (above 60 days) outstanding at 31 March with NHS bodies totalled some £7.1m, of which £4.4m is over 181 days. This predominately relates to purchase of care spending, which has been commissioned by the Council on behalf of health or where the Council is seeking full or part contribution towards costs. Discussions are in place with health, but non-recovery would increase cost pressures for the service in 2018/19. Income collection for non-health related debts is performing well. 85% of non -residential invoices are collected within 30 days and 83% of residential invoices. The level of unsecure debt is decreasing. Excluding grants and BCF, managed income across services totalled £95.310m in 2017-18.

4. 2018/19 Budget

4.1 The 2018/19 budget was set by County Council in February 2018. It includes the use of the one-off additional social care grant, amounting to £11.901m in 2018/19.

4.2 The 2018/19 budget, is broken down in the table below:

Actual 2017/18	Over/under spend 2017/18	Expenditure Area	Budget 2018/19
£m	£m		£m
11.620	(0.313)	Business Development	10.683
72.203	0.092	Commissioned Services	62.663
7.845	(0.093)	Early Help & Prevention	5.796
181.698	(7.573)	Services to Users (net)	199.070
114.650	*3.481*	*Older People*	*121.859*
24.095	*0.866*	*People with Physical Disabilities*	*24.592*
100.865	*1.663*	*People with Learning Disabilities*	*103.705*
14.616	*0.500*	*Mental Health*	*14.504*
5.859	*(0.813)*	*Hired Transport*	*6.105*
10.181	*(1.571)*	*Staffing and Support Costs*	*14.076*
(88.568)	*(11.698)*	*Income*	*(85.771)*
(7.822)	4.190	Management, Finance & HR	(23.974)
265.585	**(3.696)**	**Total Net Expenditure**	**252.466**

4.3 Areas to note include:

a) The increases in Older People and Learning Disabilities expenditure reflects demographic changes and increased costs
b) Early Help and Prevention budget for 2018/19 reflects increased contributions from the NHS compared to 2017/18
c) Staffing and Support Costs budget for 2018/19 is higher than the outturn for 2017/18. This is because of the additional social care posts created and to be funded from the Improved Better Care Fund
d) The net budget for Management, Finance & HR has reduced through the inclusion of the release from reserves to cover the Improved Better Care Fund which was committed in 2017/18 but not spent

4.4 The savings target for 2018-19 totals £27.290m and reflects a significant challenge for the service. As part of the evaluation of the 2018-19 budget delivery, the service has reviewed both savings and additional budget risk to assess the budget delivery position for 2018-19. The promoting independence strategy focuses largely on demand management, which accounts for some £17m of the total savings for 2018-19. Many of these savings have from the outset been recognised as challenging and will continue to be identified as high risk of delivery – this is based on achieving delivering in full and within the planned timeframe. However, although the full savings remain challenging within the timeframe, there are clear indications that the strategy is working and the service is implementing new ways of working to support delivery, including:

a) Implementing strengths based social work using the Living Well – three conversations model
b) 50 new social work practitioner posts
c) Dedicated discharge to assess social workers
d) An enhanced home support service
e) Implementing accommodation based reablement and expanded home based reablement services
f) Trusted assessment facilitators in hospitals
g) A new strategy and offer for people with learning disabilities
h) Developing social prescribing across the county
i) Developing technology enabled care
j) More step-down beds to support people with mental health needs leaving hospital

4.5 Not all potential costs can be included within the budget and the risks and mitigating actions are closely monitored throughout the year. Some of the key budget risks for Adult Social Care include:

a) Risk of market instability and lack of capacity
b) Increase in removal of continuing health care
c) Risk of additional costs associated with national living wage legislation
d) Continued risk of non-agreement of transforming care protocols
e) NHS financial position and increased level of debt

4.6 In February the Government announced a 2018-19 Adult Social Care Grant, providing £150m of one-off funding nationally. For Norfolk this equates to £2.6m. County Council agreed that this would be used to create an Adult Social Care Business Risk Reserve. The service has developed and signed off operational budget plans and has a strong programme of savings underway, however the service recognises the financial risks to be managed. This, together with the additional £4.5m business risk reserve and recurrent element of the 2017-18 underspend, described in Section 3, will help mitigate potential in-year implications arising for both the identified budget and savings risks for the service. All these elements will be part of the regular financial reports to this Committee during 2018-19.

5. Issues, risks and innovation

5.1 This report provides the outturn financial performance information on a wide range of services monitored by the Adult Social Care Committee. Many of these services have a potential impact on residents or staff from one or more protected groups. The Council pays due regard to the need to eliminate unlawful discrimination, promote equality of opportunity and foster good relations.

5.2 The financial monitoring reports through the year have outlined the risks that impact on the ability of Adult Social Services to deliver services within the budget available. Whilst some of these risks have been mitigated through the budget planning for 2018-19, many will continue into the new financial year and will be reported within the Period 2 monitoring report for this committee in July.

6. Background

6.1 The following background papers are relevant to the preparation of this report.

Finance Monitoring Report – Adult Social Care Committee March 2018 (p14)

Strategic and Financial Planning 2018-19 and 2021-22 and Revenue Budget 2018-19 – January 2018

Norfolk County Council Revenue Budget and Capital Budget 2018-21 - County Council February 2018 (p49)

Officer Contact

If you have any questions about matters contained in this paper or want to see copies of any assessments, e.g. equality impact assessment, please get in touch with:

Officer Name:	**Tel No:**	**Email address**:
Susanne Baldwin	01603 228843	susanne.baldwin@norfolk.gov.uk

IN TRAN communication for all

If you need this report in large print, audio, Braille, alternative format or in a different language please contact 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

Adult Social Care 2017-18: Budget Outturn Period 13 (March 2018)

Please see table 2.1 in the main report for the departmental summary.

Summary	Budget	Outturn	Variance to Budget		*Variance at Period 10*
	£m	£m	£m	%	*£m*
Services to users					
Purchase of Care					
Older People	111.169	114.650	3.481	3.13%	*3.896*
People with Physical Disabilities	23.229	24.095	0.866	3.73%	*0.317*
People with Learning Disabilities	99.202	100.865	1.663	1.68%	*1.092*
Mental Health, Drugs & Alcohol	14.116	14.616	0.500	3.54%	*1.047*
Total Purchase of Care	**247.716**	**254.226**	**6.510**	**2.63%**	***6.352***
Hired Transport	6.672	5.859	(0.813)	-12.19%	*(0.888)*
Staffing and support costs	11.752	10.181	(1.571)	-13.37%	*(1.186)*
Total Cost of Services to Users	**266.140**	**270.266**	**4.125**	**1.55%**	***4.278***
Service User Income	(76.870)	(88.568)	(11.698)	15.22%	*(9.864)*
Net Expenditure	**189.270**	**181.698**	**(7.573)**	**-4.00%**	***(5.586)***
Commissioned Services					
Commissioning	4.298	4.193	(0.105)	-2.44%	*(0.180)*
Service Level Agreements	12.759	12.444	(0.315)	-2.47%	*(0.444)*
ICES	2.396	2.102	(0.294)	-12.26%	*(0.281)*
NorseCare	32.594	33.266	0.672	2.06%	*0.826*
Supporting People	5.817	5.817	0.000	0.00%	*(0.000)*
Independence Matters	12.857	13.077	0.220	1.17%	*0.089*
Other	1.390	1.304	(0.087)	-13.37%	*(0.036)*
Commissioning Total	**72.111**	**72.203**	**0.092**	**0.13%**	***(0.027)***
Early Help & Prevention					
Norfolk Reablement First Support	3.824	3.782	(0.041)	-1.09%	*0.017*
Service Development	1.131	1.069	(0.061)	-5.42%	*(0.031)*
Other	2.984	2.994	0.010	0.335%	*(0.007)*
Prevention Total	**7.938**	**7.845**	**(0.093)**	**-1.17%**	***(0.043)***

Adult Social Care
2017-18 Budget Outturn Period 13
Explanation of variances

1. Business Development, underspend (£0.313m)

The main variances are:

Business Support vacancies, across multi teams These have been held and will be reviewed following the implementation of Liquid Logic.

2. Commissioned Services overspend £0.092m

The main variances are:

NorseCare, overspend of £0.672m. This relates to the budgeted reduction in contract value from previous years which has not been achieved. These have been offset by recharges for Continuing Health Care and Shared Care for eligible service users from the NHS. Changes have been made to reduce costs starting in 2017/18 and progress is expected to continue.

Service Level Agreements, underspend of (£0.315m). Reductions in planned costs following retendering and replacement of contracts.

Integrated Community Equipment Service (ICES), underspend of (£0.294m). This is following a change in the working practices to resolve backlogs which previously existed.

Independence Matters, overspend £0.220m, primarily due to savings that have not been delivered.

Commissioning, underspend (£0.105m), as a number of vacancies exist and other staff are not at the top of scale.

3. Services to Users, underspend (£7.573m)

The main variances are:

Purchase of Care (PoC), overspend £6.510m.

The key reasons for the differences between the outturn position and the 2017-18 budget are:

- The service has not been able to deliver all planned savings during the year, which has predominately impacted on the Purchase of Care budgets. The significant element of this reflects the variation against the planned strategy to move from Residential to Home Care packages
- Home Care costs have been less than planned
- Management of Direct Payments has ensured that reclaims were maximised

Service User Income, above budget (£11.698m). Residential income has been higher than budget as more service users are eligible for charging than expected, together with work to review those that were previously nil payers. There were also increases to NHS income for Shared Care and Continuing Health Care from the NHS.

Hired Transport, underspend (£0.813m). Reductions have been seen in both the Norse contract and in other providers, together with an unused creditor from 2016/17.

Staffing and Support Costs, underspend by (£1.571m). The majority of the underspend comes from delays in recruitment and maternity leave.

4. Early Help and Prevention, underspend (£0.093m)

The main variances are:

Reablement, underspend (£0.041m). Includes reduced costs for the new rostering system and slippage in recruiting to posts.

Service Development, underspend (£0.061m). The variance mainly relates to vacancies affecting the Sensory Support service.

5. Management, Finance and HR, overspend £4.190m

The main variances are:

Management and Finance, overspend £4.213. The overspend comes from the £4.500m contribution to the Business Risk Reserve, which is offset by savings in other parts of Adult Social Care. It is offset by unused funding for the NIPE.

Appendix C

Adult Social Services Reserves and Provisions 2017/18

	Balance	P13 Final Usage or addition	Balance
	01-Apr-17	2017/18	31-Mar-18
	£m	£m	£m
Doubtful Debts provision	4.157	2.297	6.454
Total Adult Social Care Provisions	**4.157**	**2.297**	**6.454**
Prevention Fund – General - As part of the 2012-13 budget planning Members set up a Prevention Fund of £2.5m to mitigate the risks in delivering the prevention savings. £0.131m remains of the funding, and it is being used for prevention projects: Ageing Well and Making It Real. 2013-14 funding for Strong and Well was carried forward within this reserve as agreed by Members. £0.122m remains of the funding, all of which has been allocated to external projects, and will be paid upon achievement of milestones. Market Development fund – carried forward committed funds	0.221	-0.138	0.082
Repairs and renewals	0.043	0.000	0.043
Adult Social Care Workforce Grant	0.255	0.014	0.269
HR Recruitment Costs	0.000	0.020	0.020
ICES Training post	0.000	0.080	0.080
Change Implementation – Commissioning Manager	0.000	0.025	0.025
IT Reserve - Slippage in revenue spending pattern in relation to social care information system reprocurement	0.361	0.373	0.734
Unspent Grants and Contributions - Mainly the Social Care Reform Grant which is being used to fund Transformation in Adult Social Care	1.196	0.114	1.310
Public Health grant to support the Social Prescribing Project	0.000	0.400	0.400

Funding to support Transformation projects in 2018/19	0.000	0.475	0.475
Supporting People (MEAM and Community Model)	0.000	0.251	0.251
Vulnerable Person's Resettlement Scheme and Controlling Migration Fund projects – funding to be carried forward to 2018/19	0.000	0.433	0.433
Funding for Mental Health Practitioners to carry out reviews	0.000	0.159	0.159
Funding for additional 15 NIPE students	0.000	0.150	0.150
AMPH Backfill	0.000	0.009	0.009
Adults Business Risk Reserve	0.000	4.500	4.500
Improved Better Care Fund – requirement to carry forward unspent grant for committed projects	0.000	15.670	15.670
Total Adult Social Care Reserves	**2.074**	**22.535**	**24.609**

Total Reserves & Provisions	**6.230**	**24.832**	**31.063**

Adult Social Services Capital Programme 2017/18

Summary	**2017/18**		**2018/19**	**2019/20**
Scheme Name	**Current Capital Budget**	**Outturn**	**Capital Budget**	**Draft Capital Budget**
	£000s	£000s	£000s	£000s
Supported Living for people with Learning Difficulties	0	0	15	0
Adult Social Care IT Infrastructure	211	211	5	0
Adult Care - Unallocated Capital Grant	0	0	2167	0
Strong and Well Partnership - Contribution to Capital Programme	73	73	47	0
Winterbourne Project	0	0	50	0
Care Act Implementation	0	0	871	0
Social Care and Finance Information System	3273	3273	3876	0
Elm Road Community Hub	37	37	1286	0
Better Care Fund Disabled Facilities Grant and Social Care Capital Grant – passported to District Councils	6782	6782	0	0
Teaching Partnership IT Equipment	46	46	22	0
Accommodation Based Reablement – Benjamin Court IT	84	84	0	0
County Resilience Team IT	21	21	1	0
WIFI Upgrade Integrated Sites	0	0	10	0
Miscellaneous capital projects (not greater than £5000)	4	4	0	0
ICES Equipment Costs	1902	1902	2334	2380
Netherwood Green	23	23	681	0
TOTAL	**12458**	**12458**	**11365**	**2380**

Adult Social Care Committee

Item No……

Report title:	**Performance management report**
Date of meeting:	**2 May 2018**
Responsible Director	**James Bullion, Executive Director of Adult Social Services**

Strategic impact

Robust performance management is key to ensuring that the organisation works both efficiently and effectively to develop and deliver services that represent good value for money and which meet identified need.

Executive summary

This report sets out the latest available performance position for Adult Social Services. The data has been drawn from the new Liquid Logic system. All front line teams continue to support a high number of people across all ages and with a range of needs, and points to the challenging impact of a high volume of activity over the winter period.

The report includes data about complaints, and a report detailing a finding against Adult Social Services from the Local Government Social Care Ombudsman.

Recommendations

The Committee is asked to:

a) **Discuss and agree the overall performance position for adult social care as described in section 2**
b) **Consider the findings of the Local Government Social Care Ombudsman's report included in full in Appendix 2.**

1. Introduction

1.1 This report sets out the latest available performance position for Adult Social Services. The data which is in this report has been drawn from the new Liquid Logic system; there is one indicator where the switch to the new system has not given a direct match, so at the time of writing we are not able to report confidently against the indicator measuring reviews which lead to reduced formal services.

2. Performance overview

2.1 All front line teams continue to support a high number of people across all ages and with a range of needs. Whilst there has been continued focus on helping people stay independent, it has been a challenge to sustain or improve performance against key indicators and not all the targets we set ourselves have been met. Our strategy continues to be to:

a) Strengthen and expand prevention – including through good advice, connecting people with help in their communities, strengths based social work – our Living Well approach

b) Intervene to keep people independent – through short-term support, often in partnership with the NHS, through reablement to help people regain skills and confidence so they can continue living independently in the community

c) Support people who need on-going help – providing as much choice and control as possible, including for carers; developing more housing options for people to live independently but with additional support if needed; enabling a vibrant care market with a skilled workforce

Please see Appendix 1 for detailed information on Report Cards.

2.2 **Cases that lead to assessments**

2.2.1 Leading practice in social care suggests that a quarter of contacts to social care should translate into a formal care act assessment. This is because the majority of people who initially contact the Council will be able to be supported with advice, information and prevention. We are reporting this measure for the first time out of the new Liquid Logic system. It shows an increase over the last period (November to March) which is likely to be a reflection of the pressure on adult social care during the winter period.

2.2.2 The roll out of our Living Well: 3 conversation approach to social work does suggest that an overall reduction in the number of formal assessments is achievable, as strengths based working is embedded across the department. Whilst still relatively early days, initial evaluation of the first Living Well sites has shown benefits for people using our services. These include:

a) People's needs are better understood and met (and expectations managed) because time has been taken to understand what is needed
b) Speed of response to people's support needs has improved which has prevented some issues from escalating
c) People have told staff they value being dealt with directly and not passed between departments ("handed off")
d) Staff knowledge about their local communities has grown and this has increased the range of services staff can offer to people
e) Staff themselves feedback that their overall wellbeing and morale has improved with the new approach, despite the intensity of the work

2.3 **Assessments which go on to services**

2.3.1 Our new model of social work which looks at the strengths of an individual, should lead to fewer full Care Act assessments taking place, as we work to support people earlier. However, where assessments do take place, good practice suggests that a greater proportion are likely to require formal services, since other sources of support will have been already sought.

2.3.2 This is the first time we have reported against this measure and it shows that we are not yet making an impact in line with the 3 conversations model. We have set a stretch target of 85%, but our current performance is at 50%. It is a new indictor and will largely be turned around through the implementation of Living Well model and through continued training and development. The focus at every point of any contact with customers on independence and non reliance on formal services combined with health's new focus on self care and prevention should promote further reduction in need for services.

2.4 **Effectiveness of reablement**

2.4.1 Reablement continues to be a major factor in promoting people's independence and preventing people from needing intensive on-going formal care. Adult Social Services and the CCGs now invest around £7.4m in reablement. Recent analysis suggests that approximately only 20% of people who have received reablement services from Norfolk First Support need ongoing local authority funded long term services. Furthermore, for those that do require services, we typically see a 24% reduction in the service requirement.

2.4.2 We have recently agreed with our CCG partners to further increase investment in home based reablement in 2018/19. This will mean the service can:

a) Enable more people to live at home as independently as possible by meeting the (inevitable) increase in number of referrals, which is the trend for the last few years –and is consistent with our focus on helping people to live in their own homes as independently as possible
b) Work with people receiving double ups (ie two carers at the same time) and their carers where there is the potential to reable the person and/or to reduce the number of carers to one. We sometimes have to decline referrals which are double up requests. Extra staff capacity would mean that these double up referrals could be accepted, where appropriate

2.4.3 The switch over from Care First to Liquid Logic has meant we have not been able to report confirmed figures for a couple of months. The rate of effectiveness for March shows an increase, after the dip of earlier months. As before there are two possible causes for this: a time lag in reporting; and discrepancies between how the data is captured between Care First and Liquid Logic.

2.5 **Holding lists**

2.5.1 The rate of reduction in the holding list this month has slowed; and is just above the target we set in October (2565 against a target of 2396). However, the reduction from a peak of 3109 in August represents a significant improvement. The special county team set up to support community teams in dealing with backlogs is fully recruited. The staff in the West were the most recent group to get up to strength allowing us to continue to take more cases from that locality which continues to have the largest waiting lists. In total, the dedicated team has taken around 800 cases; to date these have largely been more straight-forward cases, but as the team becomes more experienced they will be able to pick up a wider range of cases.

2.5.2 As well as the additional resources from the county team, individual localities have adopted bespoke approaches to reducing the backlog of work. This includes, temporary staff focused on those waiting; weekend working and overtime. All cases that are held continue to be monitored and prioritised if circumstances change.

2.6 **Delayed transfers of Care**

2.6.1 Staying unnecessarily long in acute hospital can have a detrimental effect on people's health and their experience of care. If they are not able to leave hospital to continue their recovery, older people particularly risk losing their mobility and ability to manage daily living tasks, increasing their level of care needs and impacting on their independence and quality of life. The joint focus of health and social care is to avoid unnecessary admissions to hospital, and ensure a timely discharge when it is safe and in the best interests of the person needing care.

2.6.2 Moving people swiftly out of hospital continues to be a major focus of interest for the Government. Stretching targets for all areas were set, and within that the target is broken down to delays caused by the NHS, and delays caused by social care.

2.6.3 Performance has not been on target and peaked in October 2017. Since then there has been an improvement and February's figure is the lowest it has been since December 2016. There were 2242 total delayed days in February 2018, of which 890 were attributable to Social Care. This is a 17% decrease from January 2018, where there were 1078 Social Care delays.

2.6.4 The main decrease in social care delays took place at the Norfolk and Norwich University Hospital (634 to 458 – January to February).

2.6.5 The proportion of Social Care delays occurring in acute care was 60%.

The latest published figures show that Norfolk (health and social care) is ranked 100 out of 151 local authorities for total delays per 100k population. Norfolk is ranked 123 out of 151 for Social Care delays per 100k population.

2.6.6 Throughout the year, we have grappled with capturing an accurate, verified picture of social care delays across the three acute hospitals and the many community units. Whilst clearly what ultimately matters is reducing the overall total, accurate recording – together with accurate reasons for the delays – is critical if effective improvement measures are to be put in place.

2.6.7 We want to work with trusts to address the practice where referrals to adult social care teams in hospitals come through in tranches and often with the minimum timescale set in the Care Act rather than supporting discharge planning from the point of admission. The impact of this is that our social work teams face peaks and troughs in their workload, are reactive to the demand and struggle to engage earlier in the discharge planning, which inevitably leads to delays which could be avoided.

2.6.8 In June, we will be working with the Better Care Fund Support Team to focus on the central system to give an independent view of the current arrangements and recommendations about how we can use the collective social services and NHS teams to best effect for people.

2.7 **Reviews that lead to reduced services**

2.7.1 It has not been possible to report a robust figure against this measure for this report. This is to do with how the data is captured on the new system. We will either have a confirmed figure for the next meeting, or alternative measures.

2.8 **Rate of permanent admissions**

2.8.1 The rate of permanent admissions for younger adults has been reducing slowly, reversing what had been an upward trend. March data shows a decrease from the January rate of 21.9/100K to 19.19/100K – keeping in line with performance in April 2017.Transformation of learning disability services is a priority for the department. We have brought in an external agency to accelerate reviews. This will ensure all individuals have an up to date strengths-based care act compliant review.

2.8.2 Additional capacity for front line operational and assessors for the service has been put in place to support teams in implementing a way of working which enables people to live independently – with appropriate support.

2.8.3 An example of this is Netherwood Green in the County Hall grounds which is being developed to offer two types of accommodation, a shared house for four people which will have the security of having staff on site, as well as eight, one bed self contained flats to be supported by staff from the house. Netherwood is seen as stepping stone to more independent living, so tenancies will be short term in the anticipation that people will build skills and confidence and move on to other types of accommodation.

2.9.1 Admissions for people over 65 are in line with our target. (The March data may increase because of a time lag in reporting.) Our strategy of early help, prevention reablement and strengths-based work is contributing to an overall reduction in the number of people in long-term care, as has a very determined focus on only using residential care as a last resort and not making permanent admissions from hospital. The rates have remained stable, with a small overall reduction, despite the well-documented pressures on demography and demand.

2.10 **Complaints**

2.10.1 In addition to the regular data on complaints, this report includes the outcome of a complaint upheld against Adult Social Services by the Local Government Social Care Ombudsman. The report requires consideration of the findings and actions by elected Members.

2.10.2 The complaint was that Norfolk County Council failed to properly explain to him how the complaint's mother's care home fees would be paid. As a result, the family chose a care home which, they later found out, would be unaffordable once his mother's capital reduced to £23,250. The full report is attached at Appendix 2

2.10.3 Norfolk County Council have accepted the recommendations, sent a written apology to the complainant and his family for the time, trouble and distress caused. Norfolk County Council also waived the top up fee and paid £300 to the family. (as recommended by the LGSCO).

2.10.4 Norfolk County Council is carrying out the remaining recommendations made by the LGSCO, including reviewing our policy and the processes we have in place to ensure people receive the financial information they need, that staff involved in needs and financial assessments know what information they need to provide and that appropriate information and training is provided to staff.

2.10.5 Residential charging policy and associated leaflets have been amended to ensure that people receive the financial information they need. A new process for first party top ups has been created with additional controls to ensure that service users or their representatives fully understand the implications of the financial arrangement. Additional training will start in June consisting of an initial team session, following by formal 3-hour training session for all staff (Adults and Finance) from 1st September 2018.

2.10.6 Also, as recommended by the LGSCO, Norfolk County Council is reviewing similar cases, in the last 12 months to check if the same error has been made.

2.10.7 An additional requirement by the LGSCO was publication of two public notices in local newspapers about the case. These public notices were placed in the Eastern Daily Press (EDP) and the Evening News on the 29th March 2018. The requirement to issue the notice above and a number of other recommendations made in this case is a change of approach by the LGSCO. We have been advised by Norfolk County Council Complaints Manager that the LGSCO intend to make greater use of his powers under

Section 26D of the Local Government Act 1974 and because of this we are seeing the LGSCO recommending more wide-ranging remedies.

3. Recommendations

3.1 **The Committee is asked to:**

a) **Discuss and agree the overall performance position for adult social care as described in section 2**
b) **Consider the findings of the Local Government Social Care Ombudsman's report included in full in Appendix 2.**

Officer Contact

If you have any questions about matters contained in this paper or want to see copies of any assessments, eg equality impact assessment, please get in touch with:

Officer name :	Tel No. :	Email address :
Debbie Bartlett	01603 223034	debbie.bartlett@norfolk.gov.uk

IN TRAN communication for all

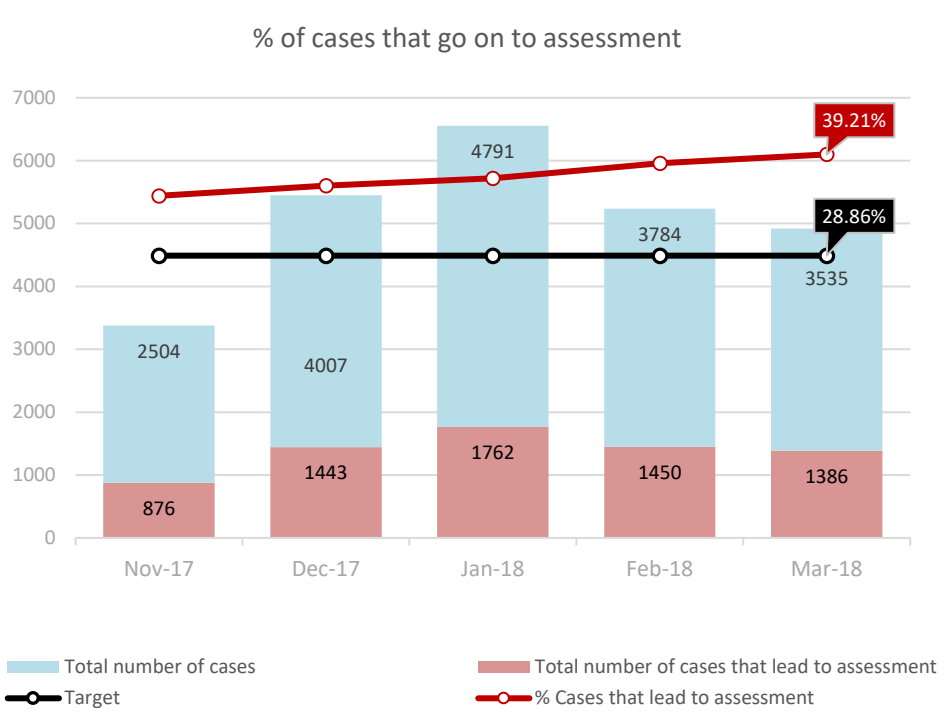
If you need this report in large print, audio, braille, alternative format or in a different language please contact 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

Percentage of requests that go on to assessment

Why is this important?

Leading practice in social care suggests that a quarter of contacts to social care should translate into a formal care act assessments. This highlights the need to expand and embed prevention and information strategies which connect people with support or advice so more people stay in control of their lives.

Performance



What is the background to current performance?

- Our early intervention, prevention and strengths=based working are all directed towards supporting people to be independent, resilient and well.
- The trend over the last four months has seen an increase in overall requests and a higher percentage leading to an assessment
- The figures do coincide with the peak period of pressure for the health and social care system, so we would expect to see an improvement in the next period.
- Early findings from Living Well: 'Three Conversations' approach to social work does show a benefit for people through connection to informal services
- As yet, the model is operating at 7 sites across Norfolk, so its impact is yet to feed through to this measure

What will success look like?

- Good performance will mean a reduction in the percentage of requests for support ending with an intention to carry out assessment. Performance is therefore driven by the extent to which other options – for example community-based support – have been explored; and by the amount of requests for support.

Action required

- Continued embedding of strength-based work
- Agree a roll-out plan for Living Well; 3 Conversations
- Continue to develop community-based support – including social prescribing, social isolation, tackling loneliness
- Management action at a team level, using locality level data to target improvement

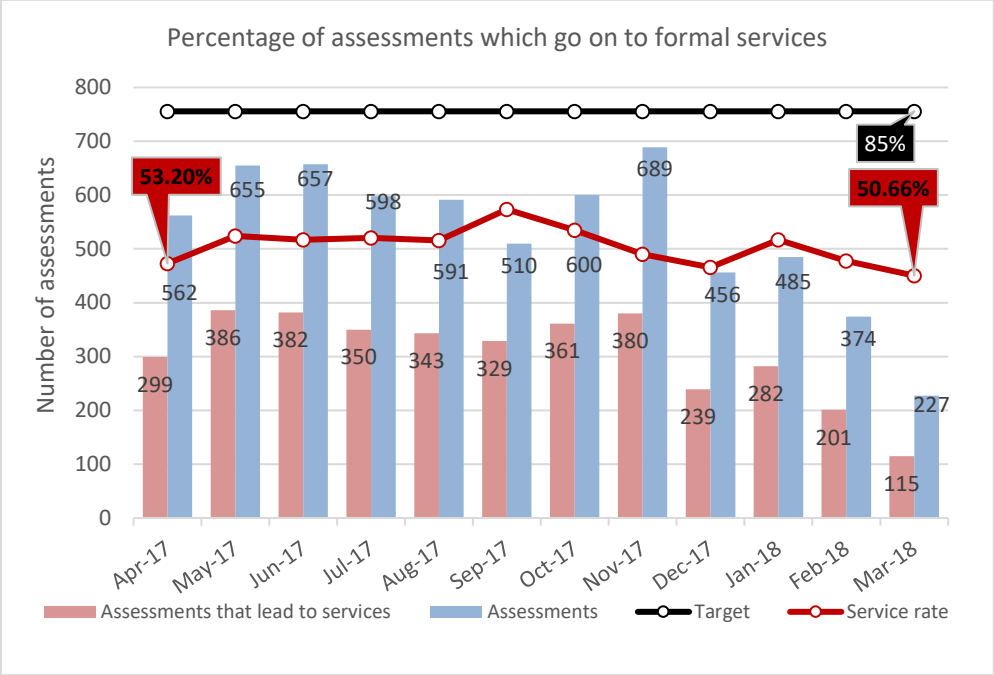
Responsible Officers	Lead: Lorna Bright, Assistant Director Social Work	Data: Intelligence and Analytics Service

Percentage of assessments which go on to formal services

Why is this important?

This indicator measures the effectiveness of arrangements for supporting and re-abling people, and of the process for determining which people need a Care Act Assessment. People that go on to receive information and advice as a result of an assessment, or who receive 'no further action', probably should not have received an assessment in the first place.

Performance



What is the background to current performance?

- This indicator should improve as we embed and sustain strengths-based working, and in particular roll out Living Well 3 conversations approach
- This will lead to an earlier engagement with people to link them and connect them informal support.
- We expect the number of formal assessments to reduce but those which do take place will be more likely to lead to formal services.
- The period reported has been a time of peak activity and pressure on community teams as they handle the winter period. This has meant they are dealing with people who are likely to have existing plans for care and support, so would require assessments.
- The last few months show a reduction in the absolute number of assessments, but a similar proportion leading to services.

What will success look like?

- People that go on to receive information and advice as a result of an assessment, or who receive 'no further action', probably should not have received an assessment in the first place.
- The increase suggested here may feel counter-intuitive in that it might suggest additional service provision. In fact this increase is predicated on an overall reduction in assessments in line with the principles of the 'Three Conversations' model.

Action required

- Locality level data from the new information system for this indicator will give teams better information to help target and address this
- Continued focus at every point of contact with people on independence
- Joint working with health to promote self-care and build resilience in communities
- Planned roll out across all teams of the Living Well model

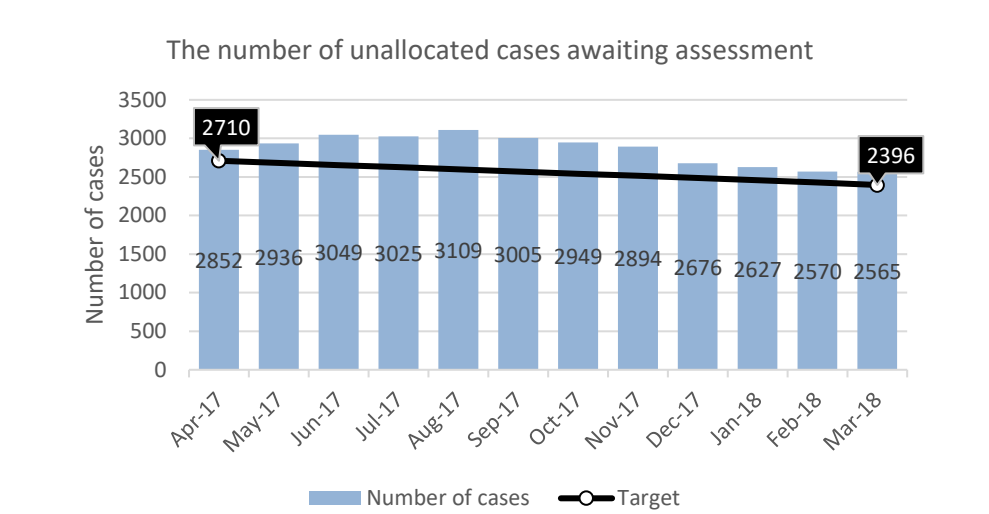
Responsible Officers	Lead: Lorna Bright, Assistant Director Social Work	Data: Intelligence and Analytics Service

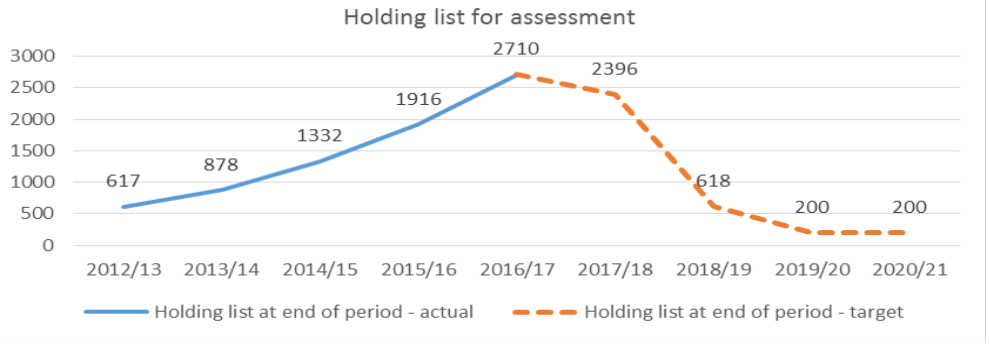
Holding List

Why is this important?

Carrying high backloads of work is having an impact of the pace of change we need to make. Delays in assessments can worsen the service users' condition, resulting in a greater need of care from the authority and potentially reducing their level independence. Monitoring of this will allow us to assess the impact of recruitment into newly created posts and allows us to monitor the performance of the 3 conversations model.

Performance





What is the background to current performance?

- In July it was reported that teams were carrying a significant amount of backlogs of work. The latest figure of just over 2500 is almost 500 lower than what was first reported on in July. However, the change from Care First to Liquid Logic may mean that there are changes in how the system counts unallocated cases, and we are keeping this under review.
- Given a current 16/17 rate of assessments of around 8,800 a year the holding list targets require an additional 4% of assessments in 2017/18. Some of this will be off-set by a reduced requirement for new assessments in line with other targets (e.g. reduced rates of requests for support to services).
- Delivery of target is dependent on recruitment to additional social work posts, and on improvements to productivity delivered through the Promoting Independence programme and through the Three Conversations model.
- A short term specialist team dedicated to addressing the holding list have been in post since December. The team works across all five localities prioritising areas with the largest list and the case which have waited longest
- Whilst the pace of reduction has slowed over the last few months, this has been at the time of most intense pressure for teams over winter
- The recruitment to additional posts to increase capacity has been positive. It has helped strength front line teams, giving them more capacity to address backlogs.

Action required

- Good performance will mean a reduction in the number of unallocated cases awaiting assessment. Performance is therefore driven by the success of the recruitment process to increase capacity and the further introduction of sites using the 3 conversations model.

- Continue with the roll out of strengths-based working – 3 conversation model. To date two sites have been run, with a further 4 due in March. The teams in those sites have demonstrated that capacity can be created to tackle waiting lists.
- Ensure recruitment to additional or vacant posts is monitored and positions are filled. Any failure to recruit to posts, and to fill existing and future vacancies, will compromise the council's ability to hit this target. Recruitment can be a challenge, so monitoring recruitment progress will be important.

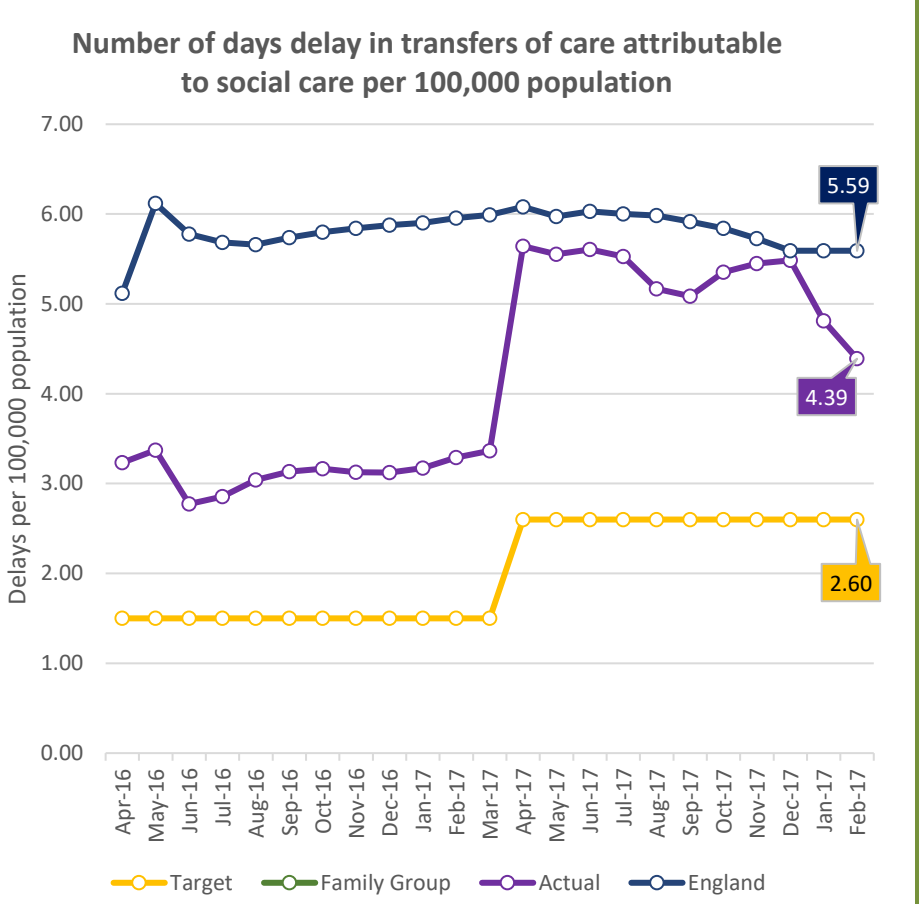
Responsible Officers	Lead: Lorrayne, Assistant Director Social Work	Data: Intelligence and Analytics Service

Delayed transfers of care

Why is this important?

Staying unnecessarily long in acute hospital can have a detrimental effect on people's health and their experience of care. Delayed transfers of care attributable to adult social services impact on the pressures in hospital capacity, and nationally are attributed to significant additional health services costs. Hospital discharges also place particular demands on social care, and pressures to quickly arrange care for people can increase the risk of inappropriate admissions to residential care, particularly when care in other settings is not available. Low levels of delayed transfers of care are critical to the overall performance of the health and social care system. This measure is a rolling average over the financial year, so smooths out individual month performance.

Performance



What explains current performance?

Winter is always pressured in the hospital services, but we put in place effective plans in preparation. Nationally and locally, hospitals saw unprecedented numbers of people attending.

As anticipated, it is after Christmas that pressures are often most acute and we experienced greater pressure later in January, coupled with the challenges of sickness. Delays performance improved consistently following the initial winter pressures.

- The number of social care delays in Feb 2018 was within the DoH Feb 2017 benchmark at all Norfolk trusts other than NNUHFT which exceeded this benchmark by 233. Despite this the total number of social care delays in Norfolk was within Feb 2017 benchmark for the first time since Aug 2017.
- We have worked closely with NCHC and NSFT to ensure that when there are delays they are accurately coded. This has led to a substantial reduction in the number of delays attributed to social care.
- NCC is not yet able to fully verify DTOC figures and is working with the NHS to adopt a best practice joint verification process.
- New resources funded through the improved Better Care Fund have come on line: trusted assessors, accommodation based reablement and enhanced home care all became available in late January.
- The Council put in place temporary measures have been put in place to support effective discharge over winter: additional social care assessment staffing, reprioritising workload, incentives to providers to take on cases swiftly and exceptional additional payments to secure care services.
- We have invited external support via the regional Better Care Fund Support Team to work with the system on hospital discharge so that we benefit from new perspectives.

What will success look like?

- Low, stable and below target, levels of delayed discharges from hospital care attributable to Adult Social Care, meaning people are able to access the care services they need in a timely manner once medically fit.

Action required

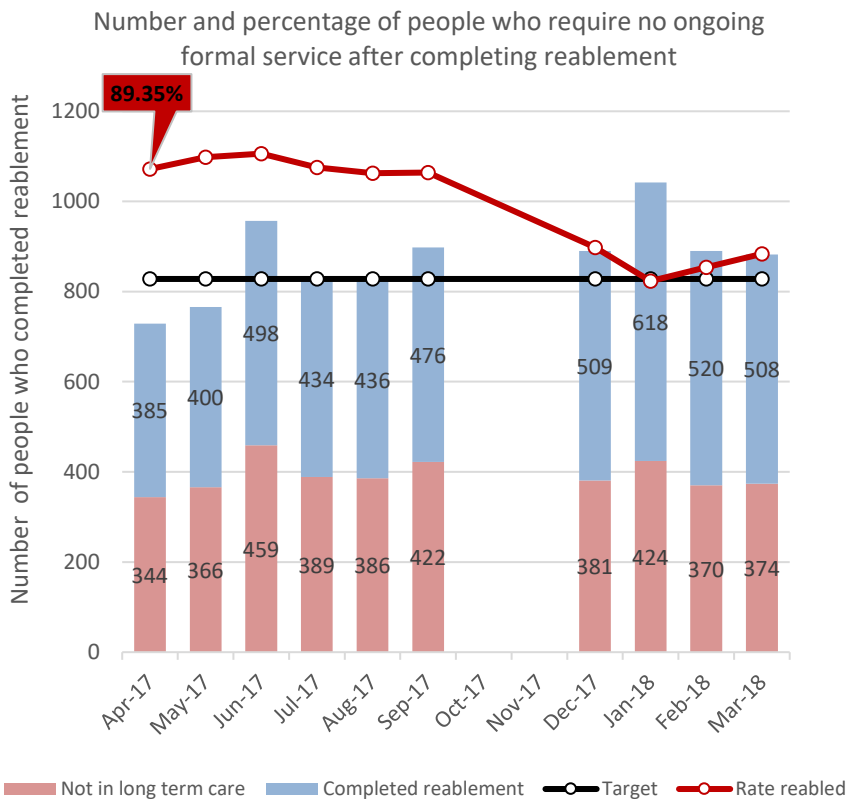
- Engage with external support to strengthen and change our integrated assessment processes for discharging people from the acute and community hospitals

The effectiveness of Reablement Services - % of people who do not require long term care after completing reablement

Why is this important?

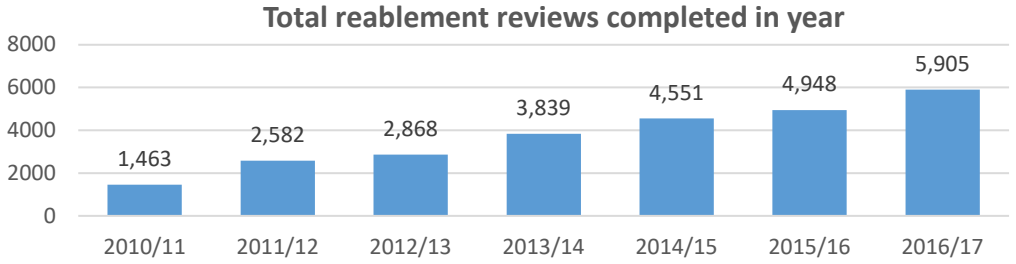
The Promoting Independence Strategy, as well as the Care Act 2014, requires that the council does all that it can to prevent or delay the need for formal or long-term care. Norfolk has provided reablement services for a number of years – that help people get back on their feet after a crisis – to people leaving hospital or that have just experienced a change in their wellbeing that might require some kind of care. The success of this is important for two reasons. First, people that do not require long-term support as a result of reablement are more independent and tend to experience better outcomes. Secondly, avoiding long term care saves the council money.

Performance



What is the background to current performance?

- Due to the migration from Care First to Liquid Logic there is a gap in the data available for October and November.
- The rate of people who require no ongoing formal service after completing reablement has dropped from 89% to 74% in March. We believe this could be due to one of two issues. First those people taken on by NFS in January and February are still being reabled and therefore are not shown as reabled yet. Secondly it is also a possibility that there is a time-lag in the process of inputting the data and that the parameters used on Care First data are slightly different to what is in Liquid Logic. Further investigation into this is ongoing.
- Benjamin Court, the new accommodation based reablement unit opened on 9 February. The unit is design for people who are medically fit but cannot go home safely to have the potential to be reabled.
- All people with a social care need are assessed for suitability for reablement before leaving hospital; most go on to receive some kind of reablement services, usually in their own home.
- Performance in this indicator is linked to the 'Sustainability of reablement' indicator and report card.



What will success look like?

Action required

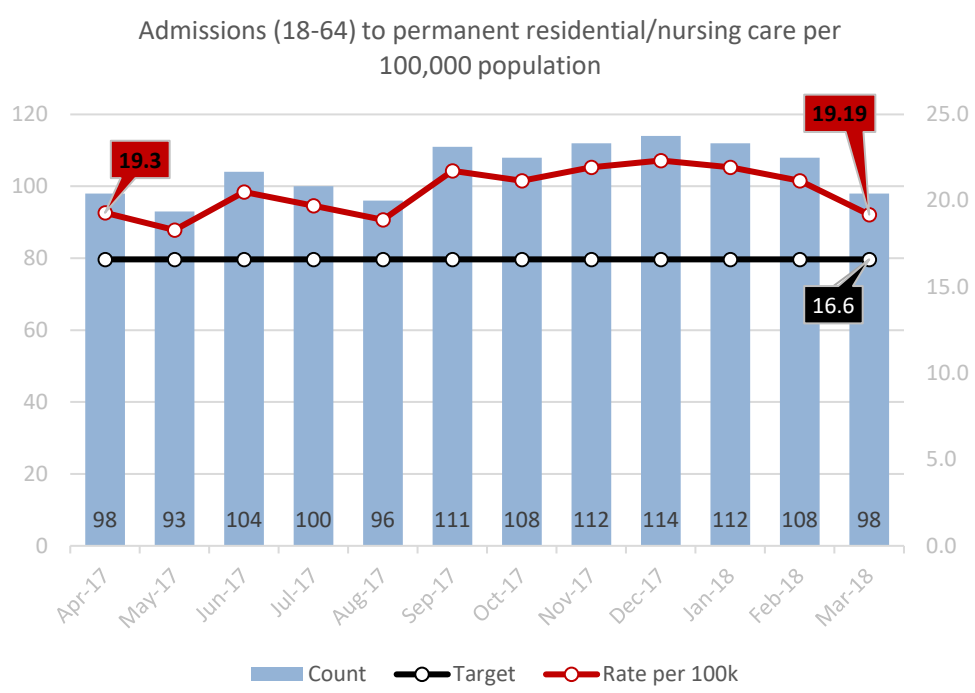
• The maximum proportion of people completing reablement not needing ongoing care. • The business case for additional investment in Norfolk First Support calculated that to reable everyone with the potential for reablement, and therefore maximise outcomes and savings, approximately 6,000 people a year should receive reablement (based on previous years). • The cost of reablement services to be significantly less than the likely cost of long term care.	• Continued monitoring of the impact of reablement against this indicator, and against the targets set out in the business case for additional investment in Norfolk First Support.
Responsible Officers	Lead: Janice Dane – Assistant Director Early Help and Prevention Data: Business Intelligence & Performance

More people aged 18-64 live in their own homes

Why is this important?

People that live in their own homes, including those with some kind of community-based social care, tend to have better outcomes than people cared-for in residential and nursing settings. In addition, it is usually cheaper to support people at home - meaning that the council can afford to support more people in this way. This measure shows the balance of people receiving care in community- and residential settings, and indicates the effectiveness of measures to keep people in their own homes.

Performance



What is the background to current performance?

- Historic admissions to residential care for people aged 18-64 were very high in Norfolk at nearly three times the family group average.
- Improvements have seen year-on-year reductions accelerate with admissions going from 31.0/100k in Mar 2015 to 16.4/100k in Dec 2016. The reduction from Apr 2016 onwards brought admissions per 100k below the target rate however the increase in Jan 2017 took admission rates (18.5/100k) worse than target for the first time in 9 months and rates have been increase gradually since.
- The submitted Department of Health result for 2016/17 showed a worse level of performance than in 2015/16. This is the first time year-on-year performance has declined since 2012/13.
- Performance since has varied, with fluctuations month-on-month.
- March data shows a decrease from the January rate of 21.9/100K to 19.19/100K – keeping in line with performance in April 2017.

What will success look like?

- Admissions for levels at or below the family group benchmarking average (around 13 per 100,000 population)
- Subsequent reductions in overall placements
- Availability of quality alternatives to residential care for those that need intensive long term support
- A commissioner-led approach to accommodation created with housing partners

Action required

- September 2017 – new approach to strengths based social work first innovation site goes live
- Development of “enablement centres” model for service users aged 18-64 to be helped to develop skills for independent living
- Reviewing how we strengthen and change our integrated assessment processes for discharging people from the acute and community hospitals will impact on this indicator

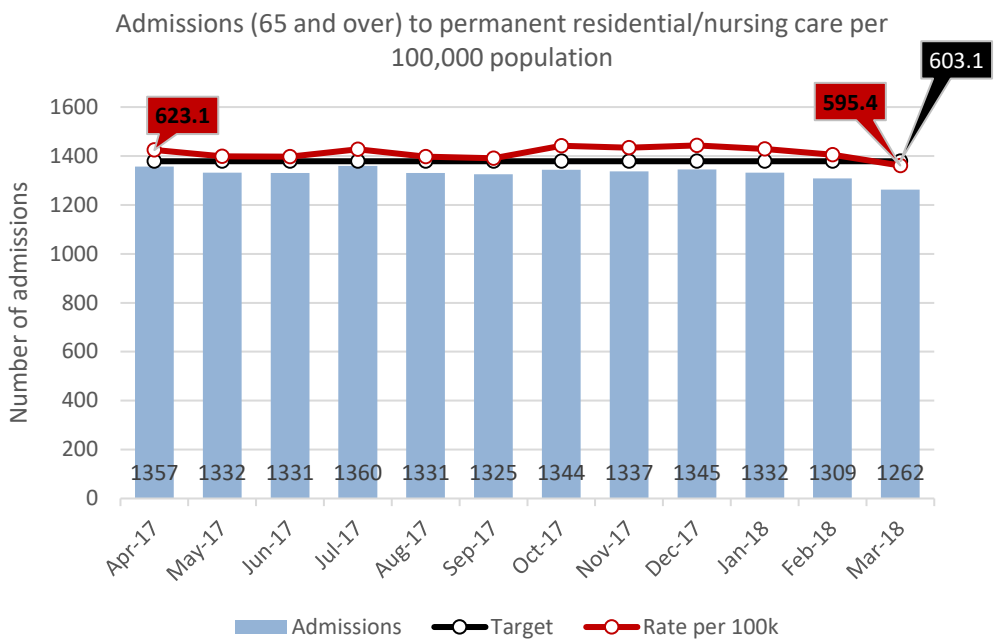
Responsible Officers	Lead: Lorna Bright, Assistant Director Social Work	Data: Intelligence and Analytics Service

More people aged 65+ live in their own homes for as long as possible

Why is this important?

People that live in their own homes, including those with some kind of community-based social care, tend to have better outcomes than people cared-for in residential and nursing settings. In addition, it is usually cheaper to support people at home - meaning that the council can afford to support more people in this way. This measure shows the balance of people receiving care in community- and residential settings, and indicates the effectiveness of measures to keep people in their own homes.

Performance



What is the background to current performance?

- Historically admissions to residential care have been higher than Norfolk's family group average.
- Over the past 3 years the rate of admissions in Norfolk has reduced significantly from a rate of 724.0 admissions per 100k population in 2014/15 to 611.9 admissions per 100k population in 2016/17.
- Monthly reporting of performance shows there has been a slowing down of improvement since March 2016.
- Nevertheless, rates of admissions continue to fall.
- March's figures show a reduction in permanent admissions – the rate is below our target of 603.1/100k.

What will success look like?

- Admissions to be sustained below the family group benchmarking average and in line with targets
- Subsequent sustained reductions in overall placements
- Sustainable reductions in service usage elsewhere in the social care system

Action required

- The Promoting Independence programme includes critical actions to improve this measure
- Close scrutiny at locality team level and use of strengths based approach to assessment
- Commissioning activity around accommodation to focus on effective interventions such as reablement, sustainable domiciliary care provision, crisis management and accommodation options for those aged 65+ will assist people to continue live independently
- Supported care model for North and South localities now operational – offering 24 hour support for up to 7 days for people in crisis to avoid admissions to hospital/residential care
- Measures to support the effective discharge of people from hospital as part of the Improved Better Care Fund programme.

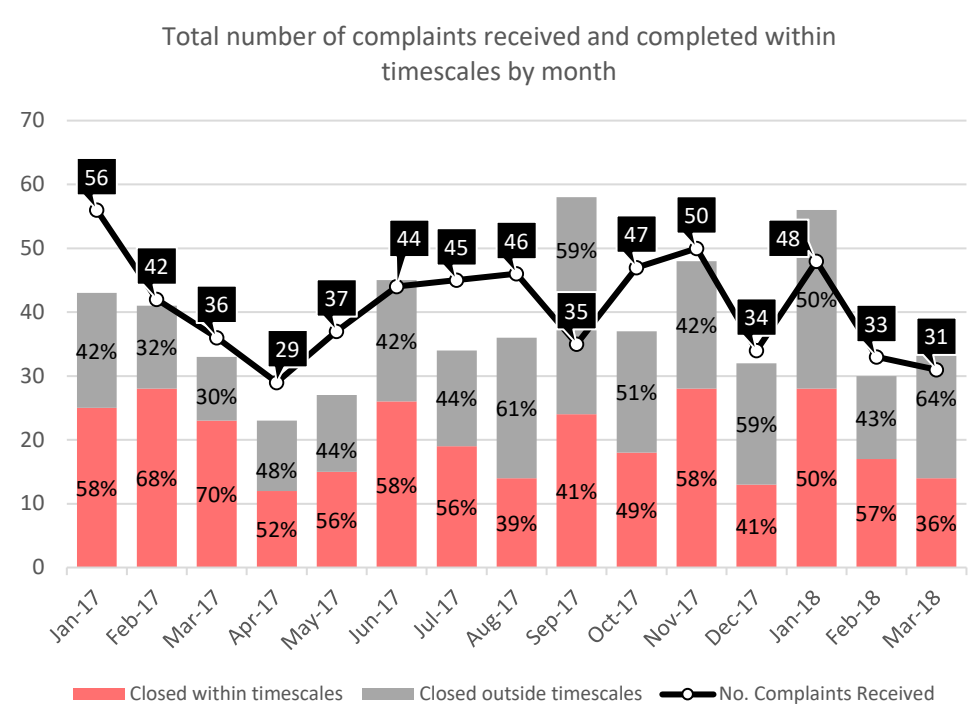
Responsible Officers	Lead: Lorrayne Barrett, Director of Integrated Care, and Lorna Bright, Assistant Director Social Work	Data: Intelligence and Analytics Service

Complaints

Why is this important?

Customer feedback is essential, not only can we gather valuable service user insights but it also gives the ability to identify service failures and gives thought on how to address them. The overall satisfaction or dissatisfaction of the service user will allow the service to monitor the effect/success of its strategic priorities.

Performance



What is the background to current performance?

- Over the calendar year 2017, Adult Social Services received just over 500 complaints. The main reasons for those complaints are process related, staff/employee related and financial complaints. These have largely stayed in the same proportion as previous years.
- There was an increase in the number of Social Work (other) complaints during April, May and June. 43% of complaints in regards to Social Work were around process issues, including service failures such as delays with assessments or dissatisfaction with outcomes such as changes to care plans. 29% were relating to staff-related issues, such as communication of information by social workers and delays in arranging respite/assessments/returning messages.
- Failure demand is demand caused by a failure to do something or do something right for the customer, which then prompts them to make contact several times. There have been a number of complaints logged incorrectly as they are not for the customer service centre but for allocated social workers who did not provide direct contact details to the service user. A large number of calls relating to finance have been recorded due to customers selecting the wrong telephone option.

What will success look like?

- A reduction in the number of complaints is not the main indicator for success. Understanding the types of complaints received and delivering actions to improve the performance of the service and monitor its performance against the strategic priorities should be the main indicator of success.

Action required

- To work closely with third party providers to ensure that appropriate standards of care are met.
- Improve Customer Journey. Review the telephone message options and work with web team to ensure information is clear and accessible.
- Improve communication with service users, agree on timescales and eligibility and charges for care and ensure they are understood before they commence. Ensure they have the correct contact details for allocated social workers etc.

Responsible Officers	Lead: Sarah Rank, Business Development Manager	Data: Customer Experience & Systems Team

Local Government & Social Care OMBUDSMAN

Report by the Local Government and Social Care Ombudsman

Investigation into a complaint against Norfolk County Council (reference number: 16 013 790)

27 February 2018

The Ombudsman's role

For 40 years the Ombudsman has independently and impartially investigated complaints. We effectively resolve disputes about councils and other bodies in our jurisdiction by recommending redress which is proportionate, appropriate and reasonable based on all the facts of the complaint. Our service is free of charge.

Each case which comes to the Ombudsman is different and we take the individual needs and circumstances of the person complaining to us into account when we make recommendations to remedy injustice caused by fault.

We have no legal power to force councils to follow our recommendations, but they almost always do. Some of the things we might ask a council to do are:

- apologise
- pay a financial remedy
- improve its procedures so similar problems don't happen again.

Section 30 of the 1974 Local Government Act says that a report should not normally name or identify any person. The people involved in this complaint are referred to by a letter or job role.

Key to names used

Mr C	The complainant
Mrs B	The service user (complainant's mother)

Report summary

Adult social care

Mr C complains the Council failed to properly explain to him how his mother's care home fees would be paid. As a result, the family chose a care home which, they later found out, would be unaffordable once his mother's capital has reduced to £23,250.

Finding

Fault found causing injustice and recommendations made.

Recommendations

The Council has accepted our recommendations. The Council must consider the report and confirm within three months the action it has taken or proposes to take. The Council should consider the report at its full Council, Cabinet, or other appropriately delegated committee of elected members, and we will require evidence of this.

In addition to the requirements set out above the Council has agreed to:

- apologise to Mr C, and his family, for the distress he is experiencing because he is worried his mother will be not be able to remain in the care home, once her capital has reduced;
- pay Mr C £300 for the time, trouble and distress the Council has caused him;
- inform the staff involved in needs and financial assessments of the correct approach with regard to people in similar situations;
- review the process it has in place, to ensure people receive the information they need (verbally and in writing), at the time they need it, to make informed decisions about finding an affordable care home;
- based on the review, ensure that staff involved in needs and financial assessments know what type of key information they need to provide (verbally and in writing), and at what stage, to enable people to make informed decisions about finding an affordable care home;
- remind staff involved in needs and financial assessments about the importance of keeping records that show what information they provide to clients about charging and when;
- review its policy on charging to ensure it contains sufficient detail about when the Council (should not) ask for a top-up; and
- review if there have been similar cases, in the last 12 months, where the Council has made the same errors, and ensure that any injustice arising from these will be remedied. The Council will need to produce a report for the Ombudsman that shows how it has carried out the review and summarises its findings.

Introduction

1. Mr C complains the Council failed to properly explain to him how his mother's care home fees will be paid. As a result, the family chose a care home which, they later found out, will not be affordable once his mother's capital has reduced to £23,250.

Legal and administrative background

The Ombudsman's role

2. We investigate complaints about 'maladministration' and 'service failure'. In this report, we have used the word fault to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. We refer to this as 'injustice'. If there has been fault which has caused an injustice, we may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1), as amended)***

Care Act 2014

3. The Care Act 2014 (section 9) says that, where it appears to the council that an adult may have care and support needs, the council must assess whether the adult does have such needs and (if so) the extent of his/her needs. Where such a needs assessment indicates that an adult is in need of care, the council has an obligation to assess whether those needs meet certain eligibility criteria; as set out in the Care and Support (Eligibility Criteria) Regulations 2015.

4. Once the council has carried out the needs assessment, and if an adult meets the eligibility criteria, section 17 of the Care Act states the council must carry out an assessment of his/her financial resources. This assessment is to find out what amount (if any) he/she could afford to pay towards their care. This is governed by the Care and Support (Charging and Assessment of Resources) Regulations 2014/2672 (the 2014 Regulations). These Regulations state that if an adult has more capital than £23,250 (the upper financial resource limit) the council is not permitted to pay towards the care costs and the adult must pay for their own care (see regulation 12). Alternatively, if his/her capital is under this limit, the council must carry out a financial assessment of the adult to establish what contribution he/she can afford to pay towards their care.

5. In accordance with regulation 18 and schedule 2 (paragraph 2) of the 2014 Regulations, the value of an adult's main home should be disregarded from an assessment of a permanent resident's capital for the first 12 weeks of them moving into a care home. If the effect of this is the adult's remaining capital is below the £23,250, the council needs to carry out a financial assessment to find out the amount the adult could afford to pay towards their own care (see section 17 of the 2014 Act). Furthermore, the council will have a duty to meet the adult's eligible care needs on the basis that condition 1 referred to in section 18(2) of the 2014 Act will have been satisfied, i.e. the adult has less than £23,250 of capital.

6. The Department of Health produced guidance for using the Care Act called 'Care and Support Statutory Guidance'. Paragraph 45 of Annex B to the Statutory Guidance outlines why the value of an adult's main home should be disregarded for the first 12 weeks. It says: "*An important aim of the charging framework is to prevent people being forced to sell their home at a time of crisis. The regulations under the Care Act 2014 therefore create space for people to make decisions as to how to meet their contribution to the cost of their eligible care needs. A council must therefore disregard the value of a person's main or only home for 12 weeks in the following circumstances: (a) when they first enter a care home as a permanent resident*". Further, paragraph 18 of Annex E to the Statutory Guidance states: "*At the end of 12 weeks, the value of the person's home is taken into account… This may result in the person becoming liable to pay for all of the costs of their care and choosing to enter into a private contract with the care home for the provision of their care on a permanent basis, rather than continuing to be provided with accommodation by their placing authority*".

7. Paragraph 11.7 of the Statutory Guidance makes clear that: "*Everyone whose needs are met by the council, whether those needs are eligible, or if the council has chosen to meet other needs, must receive a personal budget as part of the care and support plan, or support plan*". This is also reflected in section 24.1 and 26.1 of the 2014 Act. The personal budget must always be an amount enough to meet the person's care and support needs.

8. The Statutory Guidance makes clear that, as part of its obligation under section 18 to ensure Mrs B's care needs are met, the Council: "*must ensure that at least one option (in this case 'care home') is available that is affordable within a person's personal budget and should ensure that there is more than one. If no preference has been expressed and no suitable accommodation is available at the amount identified in a personal budget, the council must arrange care in a more expensive setting and adjust the budget accordingly to ensure that needs are met. In such circumstances, the local authority must not ask for the payment of a 'top-up' fee. Only when a person has chosen a more expensive accommodation can a 'top-up' payment be sought*."

9. The guidance also says councils should ensure there is enough information and advice available to ensure the person and/or their representative can understand any contributions they are asked to make.

10. The council should also support the person to identify options of how best to pay any charge. One such payment option can be a deferred payment agreement (DPA). A universal deferred payment scheme has been established, which means that people should not be forced to sell their home in their lifetime to pay for their care. By entering into a DPA, a person can 'defer' or delay paying the costs of their care and support until a later date. If somebody is eligible for a DPA, the council must explain to them how it works. This explanation should, at a minimum, include: an explanation of what happens when the agreement is terminated, and provide an overview of some potential advantages and disadvantages of taking out a DPA.

How we considered this complaint

11. We produced this report after examining relevant files and documents and interviewing the complainant and relevant employees of the Council.

12. We gave the complainant and the Council a confidential draft of this report and invited them to comment. We took their comments into account before finalising the report.

Investigation

13. At the beginning of June 2016, it was agreed between the Council and Mr C that his mother needed residential care and the family would look for a suitable home. His mother owned a property, which the Council would consider in the financial assessment.

14. Mrs B's social worker says:

    - when she met Mr C on 3 June 2016, she provided him with two brochures: "Care Select, Handbook for Relatives" and "Norfolk – your guide to care and support 2016"; and

    - she explained that, once Mrs B's capital falls below the £23,250 threshold, the Council will pay £460.71 a week; a top-up will be required for any difference.

15. Mr C said the social worker did not provide this information at this meeting. He says he also did not receive any handbooks or guides about charging from the Council. The record of this meeting does not say what (if any) information Mr C received about charging, verbally or in writing.

16. Mr C says that he subsequently went to try and find a suitable home for his mother, without being told what his mother's indicative personal budget was (eventually set at £460.71 a week).

17. A finance officer from the Council met Mr C on 9 June 2016, to carry out a financial assessment. Mr C says the officer explained that his mother's "assessed contribution" was £275 a week. The officer explained this was the amount that his mother would have to pay during the 12 week property disregard period. After this 12 week period, Mrs B would have to pay for the full cost of her care. However, Mr C says:

    - the officer failed to mention what his mother's indicative/personal budget would be and explain how the Council arrived at this figure;

    - the officer failed to explain the £275 was actually "a contribution towards" such a personal budget;

    - when he told the officer that he was looking for care homes of around £700 to £825 a week, the officer failed to explain to him that this could mean a top-up payment would be required; and

- if he had known the correct information he would not have placed his mother in a home that was not affordable.

18. The finance officer did not record what he discussed at this meeting.

19. Mr C says that, later, his mother's social worker told him "the Council will pay £460 per week". However, he says the social worker did not explain why the amount was £460 a week or that his mother's assessed charge is actually a "contribution towards that amount". Mr C says he therefore believed he could choose a care home with a weekly fee of around £802 (£460 + his mother's weekly income).

20. When Mr C told the social worker on 16 June 2016 that his mother had chosen the care home, the social worker did not ask about the rate the home would charge. The social worker contacted the home on 28 June, which told her that its weekly rate would be £725 per week. This rate was more than Mrs B's personal budget of £460. Even so, the social worker did not contact Mr C to discuss this with him.

21. The Council said:

- social workers usually give a copy of "*Norfolk – your guide to care and support 2016*" to clients at the time of the decision that somebody needs to move into permanent residential care. The Council also has a sheet "*Charges for people moving into a residential or nursing care home*", which social workers often give to people looking for a care home;

- the £460 a week is the amount at which the Council believes it is possible to find the residential care home Mrs B needed, for clients placed by the Council;

- Mrs B's capital, including her property, was above £23,250. This meant she is a privately funded resident. As such, the Council did not have an obligation to provide a care home that would not be more expensive than the amount identified in the personal budget. The Council has no control over the rates care homes charge privately funded residents. Care homes in the area do not accept the Council's (lower) rate (of £460 a week) for those who enter the home on a 12 weeks property disregard;

- Annex A, paragraph 12 of the Statutory Guidance does not apply, which says that: if the Council cannot offer any suitable accommodation at the amount identified in the personal budget, it: "*must arrange care in a more expensive setting and adjust the personal budget to ensure it meets the person's needs*". The Council has obtained its own legal advice, who have confirmed the above position;

- at the time the social worker dealt with Mrs B's case, she had not yet gained a lot of practical experience with residential care funding. The Council has already acknowledged to Mr C that it failed to explain to him, before his mother went into the home, that a top-up would be needed for the first 12 weeks. The Council has already provided an apology to Mr C for this oversight. It has also waived the top up-fee for the 12 weeks property disregard period; and

- the manager of the team that was involved has asked the finance team to do a presentation to the team's social workers about any faults identified.

22. The Council sent a Deferred Payments pack to the family on 17 June 2016. If Mr C had chosen to go ahead with the DPA, it would have started on 26 September; 12 weeks after Mrs B entered the care home. However, Mr C says that, by this time he had already found a buyer for Mrs B's home.

23. Mr C also said: if the Council had properly explained everything to him, the family would never have chosen a care home that is not affordable. The family is worried, because it will not be able to pay a third party top-up fee of £252 a week, once Mrs B's capital has reduced to £23,250. This will put his mother's placement at the care home at risk. The family is concerned this may result in a decision to move his mother to a different (cheaper) care home, which will be disruptive and upsetting for her.

24. The Council told Mr C in December 2016 that, once Mrs B's capital reduces to below £23,250: "It cannot guarantee that it will agree the funding needed for Mrs B to remain at this home indefinitely. However, it will carry out a review/assessment that will consider, among others, how long Mrs B had been at the home and how happy and settled she was there. In addition, it would consider if the home was still appropriate in meeting Mrs B's needs".

Conclusions

25. The Council says that Mrs B's capital, including her property, was above £23,250. It says this meant the Council did not have an obligation to offer a care home that will not need a top-up.

26. For the first 12 weeks of a placement in a residential care home, the charging rules require the Council to disregard the value of the person's main or only home. This means a Council must carry out a financial assessment assigning no capital value to the property to be disregarded. The Council did this and provided a personal budget.

27. If, as a result of that assessment, the adult's remaining financial resources do not exceed £23,250, the condition(s) provided for in section 18 of the 2014 Act will have been met (even if it is only for the initial 12 weeks period) and the Council will have a statutory duty to meet the adult's care needs during that period.

28. In this case, the result of disregarding the value of Mrs B's home meant that Mrs B's capital fell below £23,250 during the 12 weeks property disregard. To meet Mrs B's care needs, the Council was under a duty, in accordance with the 2014 Act and the Statutory Guidance, to offer at least one residential care home option that was affordable within Mrs B's personal budget for residential care homes (less any assessed contribution payable by Mrs B). The Council failed to offer this and did initially not accept that it had such a duty. This is fault. Insofar as the 12 weeks disregard period is concerned, the Council should not have asked for a top-up in this case.

29. After the 12 weeks period has elapsed, it will be open to a council to take a property into account and re-assess the financial resources available to the person. This assessment can, if needed and agreed with the person, take the form of a light touch financial assessment. If the adult's capital will then be above the £23,250 capital threshold, he/she will be responsible for meeting all of the costs of their own care. However, the fact that Mrs B's resources exceeded the upper financial limit at the end of the 12 weeks does not mean the Council does not owe a duty under section 18 during the 12 weeks period.

30. The Council has already told Mr C that his mother will not have to pay a top-up for the first 12 weeks. However, it made this decision not because of the reason provided above (see paragraph 27 and 28), but because it acknowledged that it did not tell the family about top-ups in a timely manner.

31. The Council has assured the family of the steps it will take once Mrs B's capital reduces to below £23,250 (see paragraph 24 above).

32. The Council failed to provide the information Mr C needed, at the time he needed it, to ensure he could make informed decisions to choose an affordable care home and decide how to pay for this. This is fault.

33. There was a delay in Mr C being told what Mrs B's indicative / personal budget would be, and how this amount was arrived at.

34. The Council failed to explain that the "assessed contribution", was a contribution towards Mrs B's personal budget of £460.71 a week.

35. The Council did not discuss top-ups, even though it had decided that Mrs B would have to pay a "first party top-up". In addition, the Council had also failed to ensure Mrs B had agreed to this before she went into the home. This is fault.

36. Furthermore, both the social worker and the finance officer failed to appropriately record the discussions they had with Mr C about charging. This is fault.

37. There was also a significant delay in Mr C receiving the Council's Finance Report, which he received in September 2016.

Recommendations

38. The Council must consider the report and confirm within three months the action it has taken or proposes to take. The Council should consider the report at its full Council, Cabinet, or other appropriately delegated committee of elected members, and we will require evidence of this.

39. In addition to the requirements set out above the Council has agreed to:

    - apologise to Mr C, and his family, for the distress he is experiencing because he is worried if his mother will be able to remain in the care home, once her capital has reduced;

- pay Mr C £300 for the time, trouble and distress the Council has caused him because of the above faults;
- inform the staff involved in needs and financial assessment of the correct approach (as outlined in paragraph 28 and 29) with regards to people in similar situations;
- review the process it has in place, to ensure people receive the information they need (verbally and in writing), at the time they need it, to make informed decisions about finding an affordable care home;
- based on the review, ensure that staff involved in needs and financial assessments know what type of key information they need to provide (verbally and in writing), and at what stage, to enable people to make informed decisions about finding an affordable care home;
- remind staff involved in needs and financial assessments about the importance of keeping records that show what information they provide to clients about charging and when;
- review its policy on charging to ensure it contains sufficient detail about when the Council (should not) ask for a top-up;
- review if there have been similar cases, in the last 12 months, where the Council has made the same errors, and ensure that any injustice arising from these will be remedied. The Council will need to produce a report for the Ombudsman that shows how it has carried out the review and summarises its findings.

Decision

40. We have completed our investigation into this complaint. The Council failed to act in accordance with the Care Act 2014; this caused injustice to the complainants. It caused the complainants distress and they had to spend additional time and trouble to obtain the correct information and pursue the complaint. We are satisfied the actions already taken by the Council and its agreement to the recommendations in paragraph 39, are sufficient to acknowledge the impact of that fault and to prevent future problems.

Adult Social Care Committee

Item No.

Report title:	**Risk Management**
Date of meeting:	**14 May 2018**
Responsible Chief Officer:	**James Bullion, Executive Director of Adult Social Services**

Strategic impact

Monitoring risk management and the departmental risk register helps the Committee undertake some of its key responsibilities and provides contextual information for many of the decisions that are taken.

Executive summary

As this is the first Adult Social Care committee meeting of 2018/19 this report presents the full departmental risk register for information on the department's risks. For future reports, we will continue to report by exception (in line with last year).

Risks are where events may impact on the Department and the County Council achieving its objectives and these are set out in the risk register together with tasks to mitigate each of the risks and progress updates.

Recommendations:

Committee Members are asked to:

a) **Consider the main changes since the first Risk Management report of 2017/18 and the last Risk Management report presented in January 2018 (Appendix A)**

b) **Discuss and agree the risk register as set out in Appendix B**

c) **Agree to the removal of risk RM14290 as set out at 1.3 below**

1 Proposal

1.1 The Adult Social Services departmental risk register has been refreshed for 2018/19 and this report provides the Committee with an update of the most recent changes. It also includes an overall view of risk management over the past year**. Appendix A**

1.2 This report provides the full departmental risk register, inclusive of corporate risks pertaining to Adult Social Services. The Department's risks can be seen at **Appendix B.** For future reports, we will continue to report by exception.

1.3 Risk RM14290 was added to the Risk Register in September 2015 as a result of a successful judicial review against the County Council. A cost of care exercise and consultation process took place and revised usual prices for care were agreed and implemented in April 2016. We now have a process in place and therefore it is recommended that this risk is removed from the register.

2 Evidence

2.1 The Adult Social Services departmental risk register reflects both corporate and departmental key business risks that need to be managed by the Senior Management Team and which, if not managed appropriately, could result in the service failing to

achieve one or more of its key objectives and/or suffering a financial loss or reputational damage. The risk register is a dynamic document that is regularly reviewed and updated in accordance with the Council's Risk Management Policy.

2.2 A clear focus on strong risk management is necessary as it provides an essential tool to ensure the successful delivery of our strategic and operational objectives. The Business Development Manager meets regularly with the Risk Management Officer to provide an update on each of the risks contained within the risk register.

3 Risk Register

3.1 Each risk score is expressed as a multiple of the impact and the likelihood of the event occurring:

a) Original risk score – the level of risk exposure before any action is taken to reduce the risk when the risk was entered on the risk register
b) Current risk score – the level of risk exposure at the time the risk is reviewed by the risk owner, taking into consideration the progress of the mitigation tasks
c) Target risk score – the level of risk exposure that we are prepared to tolerate following completion of all the mitigation tasks

3.2 In accordance with the Risk Matrix and Risk Tolerance Level set out within the current Norfolk County Council Risk Management procedure, five risks are reported as "High" (risk score 16–25), eleven as "Medium" (risk score 6–15) and three as "Low" (risk score 1-5). A copy of the Risk Matrix and Tolerance Levels appears at **Appendix C**.

3.3 The prospects of meeting target scores by the target dates are a reflection of how well mitigation tasks are controlling the risk. It is also an early indication that additional resources and tasks or escalation may be required to ensure that the risk can meet the target score by the target date. The position is visually displayed for ease in the "Prospects of meeting the target score by the target date" column as follows:

a) Green – the mitigation tasks are on schedule and the risk owner considers that the target score is achievable by the target date
b) Amber – one or more of the mitigation tasks are falling behind and there are some concerns that the target score may not be achievable by the target date unless the shortcomings are addressed
c) Red – significant mitigation tasks are falling behind and there are serious concerns that the target score will not be achieved by the target date and the shortcomings must be addresses and/or new tasks are introduced

3.4 The current risks are those identified against the departmental objectives for 2018/19 and have been reviewed for this report.

4 Attachments

4.1 **Appendix A** provides Committee members with the reconciliation report listing significant changes to the full departmental risk register including Adult Social Services corporate risks. It also includes an overall view of risk management over 2017/2018.

Appendix B provides Members with the latest departmental risks on a page, providing the full details of all of the current Adult Social Services departmental risks.

Appendix C provides Members with background information including the risk management matrix used to plot risks, risk tolerance levels.

5 Financial Implications

5.1 There are no financial implications other than those identified within the risk register.

6 Issues, risks and innovation

6.1 There are no other significant issues, risks and innovations arising from this Risk Management report.

Officer Contact

If you have any questions about matters contained in this paper or want to see copies of any assessments, e.g. equality impact assessment, please get in touch with:

Officer name :	Email address :	Tel No. :
Sarah Rank	sarah.rank@norfolk.gov.uk	01603 222054

IN TRAN communication for all

If you need this report in large print, audio, braille, alternative format or in a different language please contact 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

Risk Reconciliation Report **Appendix A**

Significant changes* to the Adults Social Service's departmental risk register since the first Adults Social Care Committee Risk Management report was presented in June 2017 and the last update in January 2018

1. For the financial year 2017/2018, the Adult's Social Services departmental risk register was first reported to the Adults Social Care Committee in June 2017.
   At that time there were 19 risks: four risks were reported as "High" (risk score 16–25), fourteen as "Medium" (risk score 6–15) and one as a "Low" (risk score 1-5).

   During 2017/2018 two risks were removed from the register and two new risks were added.

   Risks removed:

   RM020a - Failure to meet the long term needs of Norfolk citizens
   RM020b – Failure to meet the needs of citizens

   Risks added:

   RM023 - Failure to understand and act upon changes to demography, funding, and government policy, with particular regard to Adults Services.
   RM14314 - Delayed Transfers of Care (DTOC)

   As at January 2018 there were 19 risks on the register: five risks were reported as "High" (risk score 16–25), thirteen as "Medium" (risk score 6–15) and one as "Low" (risk score 1-5).

2. Since the Risk Management Report was presented to the last Committee meeting (in January 2018) there are two significant changes to report :

   RM014b - The savings to be made on Adult Social Services transport are not achieved

   The current score of this risk has been lowered from 9 to 4, with both the impact and likelihood scores being lowered from 3 to 2.

   RM14290 - Negative outcome of the Judicial Review into fee uplift to care providers

   As set out at 1.3 of the main report we are recommending this Risk is removed from the register.

3. The next review is due in September 2018.

* A significant change can be defined as any of the following;

- A new risk
- A closed risk
- A change to the risk score
- A change to the risk title or description (where significantly altered).

Appendix B

Risk Number	RM023	**Date of update**	23 April 2018
Risk Name	Failure to understand and act upon changes to demography, funding, and government policy, with particular regard to Adults Services.		
Risk Owner	James Bullion	**Date entered on risk register**	18 August 2017

Risk Description

There is a risk of failure to fully understand and act upon changes to demography, funding, and government policy. Cause: Changes to demography, funding, and government policy. Event: The Council fails to plan and adapt to change effectively for the future. Effect: Outcomes for Norfolk citizens may worsen.

Original			**Current**			**Tolerance Target**				
Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Target Date	Prospects of meeting Target Risk Score by Target Date
5	5	**25**	4	5	**20**	2	4	**8**	Mar-20	**Amber**

Tasks to mitigate the risk

1) Implementation of Promoting Independence Strategy. This strategy is shaped by the Care Act with its call to action across public services to prevent, reduce and delay the demand for social care. The strategy aims to ensure that demand is understood and managed, and there is a sustainable model for the future.
2) As part of the strategy, a shift of spend towards targeted prevention, reablement services, enablement, and strengthened interim care.
3) Implementation of Better Care Fund plans which promote integration with the NHS and protect, sustain and improve the social care system.
4) A new set of NCC corporate priorities which aims to address longer-term demand management in children's and adult services.

Progress update

1) Demand and demography modelling continues to be refined through the cost and demand model. Four main themes for transformation: Services for people with learning disability; maximising digital technology; embedding strength-based social work through Living Well; 3 conversations; health and social care integration.
2) Sector based plans for providers which model expected need and demand associated with demographic and social change.
3a) Strengthened investment in prevention, through additional reablement, social prescribing, local initiative's for reducing social isolation and loneliness.
3b) Workforce – continued recruitment campaign to increase front line social workers and occupational therapy staff.
3c) Better Care Fund targeted towards supporting people to stay independent, promoting and enabling closer integration and collaboration across health and social care.

Risk Number	RM019	**Date of update**	23 April 2018
Risk Name	Failure to deliver a new fit for purpose social care system on time and to budget.		
Risk Owner	James Bullion	**Date entered on risk register**	24 February 2016

Risk Description

A new Social Care system is critical to the delivery and efficiency of Adults and Children's Social Services. This is a complex project and the risk is the ability to deliver on time along with the restriction on making any system changes to the existing system (Carefirst)

Original			**Current**			**Tolerance Target**				
Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Target Date	Prospects of meeting Target Risk Score by Target Date
4	5	**20**	3	5	**15**	1	4	**4**	Sep-18	**Green**

Tasks to mitigate the risk

1) Ensure effective governance is in place
2) Set up a project team to manage the project.
3) Determine go live dates for Adults Services, Children's Services, and Finance.
4) Deliver implementation of the new system.
5) Complete User Acceptance and Data Migration Testing.
6) Deliver change and training.

Progress update

1a) Clear governance is in place. The Project Sponsors are Janice Dane (Adults), Debby McKechnie (Children's) and John Baldwin (Finance). This is overseen by CLT. A Programme Board was set up including the Directors of Adults, Children's and Finance and Commercial Services.
1b) There are weekly Joint Leadership Advisory Group (JLAG) meetings with the Project Sponsors and the Project Team and regular updates to Adults Committee and to CLT.
2) A core Project Team has been up and running since January 2016 (with strong practitioner involvement). A network of champions has been established in Adult Social Services and Children's Services.
3) Adults and Finance successfully went live on 22 November 2017. Children's and Finance were planned to go live in March 2018 however at the first Programme Board Go/No go decision point on the 16 January 2018 for the Children's and Finance systems it was forecast that implementation would not be ready by the w/c 19 March 2018. Therefore it was agreed to move the go live by a few weeks and to use an alternative go live date w/c 30 April 2018. Part of the contingency budget is funding the extension.
3b) Children's and Finance - at the last Go/No Go point on 12 April the SCSR Programme Board agreed to continue the go live process in line with the agreed plans. The next SCSR Programme Board on 1 May will decide whether to proceed to make the systems live for end users.
4) Delivery of implementation is proceeding in line with the plan. Considering the scale of the change that has happened, requiring some significant changes to behaviours in staff and managers, this process has been relatively smooth. Payment and billing runs have been made from the system and approximately 70 providers are using the Provider Portal. A support helpdesk is up and running in a central location.
6) Training of staff is in progress for Children's.

Risk Number	RM014b	**Date of update**	23 April 2018
Risk Name	The savings to be made on Adult Social Services transport are not achieved.		
Risk Owner	James Bullion	**Date entered on risk register**	04 November 2015

Risk Description

The risk that the budgeted savings of £1.7m to be delivered by 31 March 2020 will not be achieved.

Original			**Current**			**Tolerance Target**				
Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Target Date	Prospects of meeting Target Risk Score by Target Date
3	3	**9**	2	2	**4**	2	2	**4**	Mar-20	**Green**

Tasks to mitigate the risk

1) In 2017 the savings were reprofiled to future years (2018/19 and 2019/20).
2) A corporate review of transport is also taking place.
3) Transport Guidance has been updated in line with the revised transport policy
4)Under the Younger Adults of the Promoting Independence Workstream, we're developing a joint approach to disability and transition from Children's to Adults.
5) Exploring the use of an application to help with monitoring of the cost of transport. This application is currently being used by Children with Special Educational Needs.

Progress update

1)Adult Social Care Committee agreed on 4 September 2017 to amend the transport savings to £0.700m in 2018-19 (from £3m) and £1m in 2019-20 (from £0.800m) and that the difference of £2.1m in savings will be made through the purchase of care budget as a result of changes to patterns of care. The department achieved an underspend on Transport for 2017-18 of £0.813m - in effect the early delivery of the 2018-19 savings and some of the 2019-20 savings.
2) Travel Independence Training Across the Nation (Titan) training is being rolled out. Have recruited to ASS specific posts to enable more people to use public transport.
3) The revised Transport Guidance and Policy was agreed by ASC Committee on 6 March 2017 and shared with staff. This is being implemented for new service users now and for existing people at the point of review. This now links with the work on assessments and reviews as part of the Promoting Independence Programme. It appears that this is being embedded in working practices, given the forecast underspend on transport.
4) The department has been advised that there is potentially scope for the development of the Elm Road site on a bigger scale. In light of this, the review of Learning Difficultie
s day services and the potential new opportunities this could lead to, the department is reviewing the Elm Road project.
5) This is currently being developed. We have carried out the fieldwork to understand the current transition process from Children's services to Adult services. We have taken a joint approach and carried out 50 interviews with senior stakeholders from children's services, adult services and health, as well as meeting with transition workers, team managers and other key staff from children with disability teams, looked after care teams, leaving Care teams, Adult LD, Adult mental health and adult Physical disability team.
5b) IMT have developed the first version of a Transport application for use by Adult Social Services and Travel and Transport where you can see for each day centre where people are travelling from, whether they are travelling alone/with others and which day services other people charged to that budget code are going to. It is based on an application IMT developed for Children with Special Education Needs. The application looks useful, and provides a clearer picture of transport provision than analysing pages of reports. The department is checking the viewer application and it will be trialled with Business Support initially.

Appendix B

Risk Number	RM13926	**Date of update**	23 April 2018
Risk Name	Failure to meet budget savings		
Risk Owner	James Bullion	**Date entered on risk register**	30 April 2011

Risk Description

If we do not meet our budget savings targets over the next three years it would lead to significant overspends in a number of areas. This would result in significant financial pressures across the Council and mean we do not achieve the expected improvements to our services

Original			**Current**			**Tolerance Target**				
Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Target Date	Prospects of meeting Target Risk Score by Target Date
3	5	**15**	4	5	**20**	3	5	**15**	Mar-19	**Red**

Tasks to mitigate the risk

1) Efficiency and savings targets are being managed through the Promoting Independence Programme Board and the Finance and Performance Board.
2) Monthly monitoring, locality team meetings and continued development of forecast to ensure timely focus on key budgets and any emerging issues.
3) Norsecare Liaison Board to develop and monitor delivery of savings related to the Norsecare contract.
4) County Council agreed budget for 2018-19 included investment and carried forward of unspent iBCF funds.
5) Senior and concerted focus on transforming the LD service.
6) Norfolk Future's programme in place, including Promoting Independence for vulnerable adults, smarter information and advice, towards a Norfolk housing strategy, Digital Norfolk, Commercialisation and Local Service Strategy. The programme will provide further support for delivery of savings.

Progress update

1) Promoting Independence programme of work in place and delivery plan developed. Target demand model complete and focussed work on entry points, processes for older people and younger adults, cross-cutting Living Well project and commissioning projects. Savings totalling £27m in 2018-19 with £17m through demand management work.
2) Finance and Performance Board have moved to a panel style approach providing senior management scrutiny along with locality finance meetings. All managers are expected to take responsibility for budget savings via 1-1's, accountability meetings, appraisals etc.
3) Work continues with Norsecare to deliver savings.
4) Social care funding has been received and plans agreed by NCC and health partners. In addition to funding to support protection of social care and to support market stability, there are invest to save projects that will both support discharge from hospital and wider demand management.
5) Reshaped management of the LD service and dedicated younger adults workstream within the PI programme.
6) The service has delivered savings in 2017/18 of £14.353m against a target of £14.213m. £10.728m of the savings have been delivered in line with the planned savings programme.

Appendix B

Risk Number	RM14314	**Date of update**	23 April 2018
Risk Name	Delayed Transfers of Care (DTOC)		
Risk Owner	James Bullion	**Date entered on risk register**	05 December 2017

Risk Description

A significant increase in DTOC might jeopardise additional funding (iBCF) and have adverse consequences as well as for the quality of care This would further increase financial pressures on the health and social care system.

Original			**Current**			**Tolerance Target**				
Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Target Date	Prospects of meeting Target Risk Score by Target Date
4	4	**16**	4	5	**20**	3	4	**12**	Mar-19	**Amber**

Tasks to mitigate the risk

1) DTOC Improvement Plan is now in place
2) Improved Better Care Fund is targetted, in part, on reducing DTOC

Progress update

1) Performance reporting mechanism established.
1b) Daily capacity mapped and monitored and given high priority
1c) The DTOC Improvement Plan includes weekly meetings to monitor the figures and take action as required
1d) Senior NCC presence at A&E Delivery Board which hepls to ensure an integrated and coherent approach
1e) Ongoing work with providers to increase capacity in the market to support safe dischargesTrusted assessor and enhanced homecare now in place and full
1f) implementation of the High Imapact Change Model being pursued in partnership with health
1g) Multidisciplinary review of flow through the health and social care system happening in June – will support adoption of best practice

Appendix B

Risk Number	RM13931	**Date of update**	23 April 2018
Risk Name	A rise in acute hospital admissions and discharges and pressure on acute services.		
Risk Owner	James Bullion	**Date entered on risk register**	30/06/2011 revised

Risk Description

A significant rise in acute hospital admissions / services would certainly increase pressure and demand on Adult Social Care. Potential adverse impacts include rise in Delayed Transfers of Care (DTOCs), pressure on Purchase of Care spend, assessment staff capacity and NCC reputation.

Original			**Current**			**Tolerance Target**				
Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Target Date	Prospects of meeting Target Risk Score by Target Date
3	4	**12**	4	4	**16**	2	3	**6**	Mar-19	**Amber**

Tasks to mitigate the risk

1) Integrated structure between NCC and NCHC allows AD's to make quick decisions and to flex resources to minimise impact.
2) Integration programme developing new approaches to reduce delays and prevent admissions.
3) Daily participation in whole system escalation process.
4) DTOC Improvement Plan is now in place
5) Senior manager oversight of emerging issues.
6) Careful management of reputational risk.

Progress update

1) Daily Capacity mapped and monitored and given high priority.
2) Within Phase 3 (of the Integration Programme) we have concentrated on flow and capacity. We are also working closely with the Promoting Independence Programme Team to alter the role of the OT to focus on pre Care Act eligibility determination cases; bed based offer for short term placements, and the discharge to assess pathways to ensure people are not making life changing decisions in an acute setting.
2b) The introduction of accommodation based reablement beds across Norfolk will aid the flow from the acute and community hospitals and reduce strain on the Purchase of Care budget and assist the department to meet DTOC targets.
2c) Integrated managers taking an active role in developing new models with primary care to avoid admissions eg NEAT (Norwich Escalation Avoidance Team) in Norwich.
3) Work closely with health colleagues on silver calls (a silver call is daily whole system monitoring and action planning call).
4) The DTOC Improvement Plan includes weekly meetings to monitor the figures and to take action as required.
5) Director of Integrated Care coordinates senior manager oversight to effectively manage issues.
6) SMT presence at A&E delivery Board which helps to improve reputation.

Appendix B

Risk Number	RM14237	**Date of update**	23 April 2018
Risk Name	Deprivation of Liberty Safeguarding		
Risk Owner	Lorna Bright	**Date entered on risk register**	08 May 2015

Risk Description

Following the Cheshire West ruling it has been identified that we're not meeting our responsibilities around Deprivation of Liberty Safeguards (DoLS). This could lead to us being judicially reviewed.

Original			**Current**			**Tolerance Target**				
Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Target Date	Prospects of meeting Target Risk Score by Target Date
3	4	**12**	4	4	**16**	2	4	**8**	Mar-19	**Red**

Tasks to mitigate the risk

1) Reviewed staffing compliment
2) Reviewed processes and systems to ensure cases are dealt with in a timely manner.
3) Improved data quality and reporting to allow cases to be monitored.
4) Implementation of Liquid Logic may impact whilst staff become used to a new system.

Progress update

1) Limited DoH grant funds remain. SCCE are receiving e-dols, so inputting the referrals. Three temporary 12 month posts were advertised with iBCF money, however only been able to recruit into 1.5 FTE to start in August 2018.
1b) Independent BIA's are used for out of county reviews, relief BIA's are used regularly. Seven places have been made available for BIA training in September 18.
2) Currently unable to produce accurate figures of workload. Team are currently reviewing the process in order to streamline tasks – paper to be submitted to SMT (end May 18).
3)There is currently one legal challenge and two potential – but all are around objection to the DoLS and not NCC process.
4) Liquid Logic has impacted upon the team and management of workload due to required process. A Business Support Officer has been appointed for 12 weeks to cleanse the desktop.

Appendix B

Risk Number	RM14262	**Date of update**	23 April 2018
Risk Name	The potential risk of shortfall between funding and pressures through integration of capital and revenue funding between the Council, health organisations and district councils		
Risk Owner	James Bullion	**Date entered on risk register**	16 June 2016

Risk Description

The integrated health and social care agenda has seen pooling of capital and revenue resources through the Better Care Fund and further policy drive to manage the transfer of people with learning disabilities from inpatient settings to community settings. There is a risk that this will have a negative impact on available resources for delivery of adult social care

Original			**Current**			**Tolerance Target**				
Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Target Date	Prospects of meeting Target Risk Score by Target Date
3	5	**15**	3	5	**15**	2	4	**8**	Mar-19	**Amber**

Tasks to mitigate the risk

1) Section 75 agreements to manage forward planning and joint arrangements
2) Partnership Boards in place attended by NCC.
3) Transforming Care Plan project in place and NCC involvement on all workstreams.
4) Introduction of the Improved Better Care Fund including planned use for additional social care grant.
5) Regular monitoring and liaison with health partners on outstanding debt.

Progress update

1) Two year Section 75 agreements finalised in Autumn 2017.
2) BCF plans in place and signed off.
3) Transforming Care Plan programme in place and baseline completed. Progress achieved with moving people from inpatient settings to community placements and targets being met. Further work completed on joint protocols, which have not been agreed. Work is progressing to develop criteria in line with operational processes.
4) Three year iBCF plans in place (2017-20), which are being monitored through ASC committee, Health and Wellbeing Board and regular updates to Norfolk and Waveney Chief Officer Group. Some projects align with the STP programme of work. Evaluation criteria to enable sustainable funding places for new interventions are being developed, but securing on-going funding remains a risk.

Appendix B

Risk Number	RM14260	**Date of update**	23 April 2018
Risk Name	Failure of the care market (through the independent providers) due to difficulties in recruiting staff into the sector.		
Risk Owner	Sera Hall	**Date entered on risk register**	16 May 2016

Risk Description

The council invests over £54m through approximately 120 independent providers in provision of homecare to over 4000 vulnerable people at any one time. Failure of the care market (through the independent providers) due to problems recruiting staff into the sector may result in a risk to safeguarding of vulnerable people, delays in discharging people from hospital and inappropriate admissions to hospitals and care homes. Problems recruiting into and retaining care workers in the care sector are particularly acute in the west and north of the county but are experienced across the county as a whole.

Original			Current			Tolerance Target				
Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Target Date	Prospects of meeting Target Risk Score by Target Date
4	4	**16**	4	3	**12**	2	3	**6**	Jul-18	**Amber**

Tasks to mitigate the risk

1) A Quality Assurance Framework provides a risk based approach to the market of care services.
2) Ensure robust procurement processes that ensure providers cost provision adequately.
3) Work with providers, workforce professionals and other partners to develop and implement a workforce development plan and to ensure workforce terms and conditions are equitable.
4) Development of a care contingency network and emergency provision.
5) Clear communication needed with the market to publicise areas of need and future commissioning intentions.

Progress update

3) An executive board has been created to take responsibility for the promotion and delivery of a sector skills action plan and this includes a clear accountability structure with named leads for each priority.
3b) Inclusion of Unison Ethical Care Charter in all new Home Support contracts.
3c) Website for care workers which includes information and advice around the caring profession. There is also a recruitment portal for providers to advertise vacancies and a promotional campaign in order to make the profession more attractive.
4) Emergency capacity which provides additional funding for providers put in place over winter and periods of increased demand.
4b) Increase in capacity of in house resources.

Appendix B

Risk Number	RM13925	**Date of update**	23 April 2018
Risk Name	Lack of capacity in ICT systems		
Risk Owner	James Bullion	**Date entered on risk register**	30 April 2011

Risk Description

A lack of capacity in IT systems and services to support Adult Social Services delivery, in addition to the poor network capacity out into the County, could lead to a breakdown in services to the public or an inability of staff to process forms and financial information in for example Care First.

Original			**Current**			**Tolerance Target**				
Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Target Date	Prospects of meeting Target Risk Score by Target Date
4	4	**16**	3	4	**12**	3	2	**6**	Mar-19	**Amber**

Tasks to mitigate the risk

1) As part of the Business Continuity plan steps are in place to mitigate any system loss and downtime.
2) Discuss and IMT issues at the monthly IMT Programme Board.
3) Develop the technology strategy for ASSD.

Progress update

1) Recovery steps are outlined in the Business Continuity plan. These are always reviewed following any serious incidents and updated where necessary.
2) Any IMT issues are discussed at the IMT Programme Board.
3) A technology strategy for Adults has been developed and reviewed by SOCITM. We will now devise an implementation plan to deliver which will drive improvements in care and efficiencies.

Appendix B

Risk Number	RM14247	**Date of update**	23 April 2018
Risk Name	Failure in the care market		
Risk Owner	Sera Hall	**Date entered on risk register**	07 September 2015

Risk Description

The council contracts with independent care services for over £200m of care services. Risk of failure in care services would mean services are of inadequate quality or that the necessary supply is not available. The council has a duty under the Care Act to secure an adequate care market. If services fail the consequence may be risk to safeguarding of vulnerable people. Market failure may be faced due to provider financial problems, recruitment difficulties, decisions by providers to withdraw from provision, for example. Further reductions in funding for Adult Social Care significantly increases the risk of business failure.

Original			Current			Tolerance Target				
Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Target Date	Prospects of meeting Target Risk Score by Target Date
4	3	**12**	4	3	**12**	2	3	**6**	Jul-18	**Amber**

Tasks to mitigate the risk

1)A Quality Assurance Framework is in place which provides a risk based approach to the market of care services, collating intelligence from a range of sources and triangulating to identify services for targeted intervention.
2) Prioritising care workforce capacity within the learning and development programme.
3) Revision of a market failure protocol based on established good practice.
4) Liaison with Care Quality Commission to engage with their work with Norfolk care services.
5) Stabilise market for provision of care.
6) Procuring new domiciliary care contracts.
7) Appropriate investment in the care market.
8) Effective management of market failure.

Progress update

1)Real time quality (risk) dashboard produced and being utilised.
2) Working with the Local Enterprise Partnership and Norfolk and Suffolk Care and Support.
3) Care failure protocol's in place and market resilience strategy under development.
4) Refreshed working arrangements with CQC and active work with providers to improve CQC compliance.
5) New 'patch' based contracts in place.
5a) Provider engagement and dialogue included in the 'cost of care' exercise which will support accurate identification of costs of provision and ensure investment targeted appropriately.
5b) Proactive programme to settle increased fee rates as a result of NMW regulation in the area of sleep ins.
5c) Provider dialogue process in place to ensure inflationary uplifts are correctly assessed and implemented.
5d) New commissioning and market shaping framework agreed by members driven by new sector based plans and sector engagement.
5e) Supporting the establishment of a formal care association for Norfolk.

Appendix B

Risk Number	RM 14261	**Date of update**	23 April 2018
Risk Name	Staff behaviour and practice changes to deliver the Promoting Independence Strategy		
Risk Owner	James Bullion	**Date entered on risk register**	25 April 2016

Risk Description

A significant change in staff behaviour and social care practice is required to deliver the Promoting Independence Strategy. Failure to make the culture change needed across the workforce would greatly impact the transformation of the service and its ability to deliver associated budget savings'

Original			**Current**			**Tolerance Target**				
Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Target Date	Prospects of meeting Target Risk Score by Target Date
3	5	**15**	3	4	**12**	2	4	**8**	Mar-19	**Amber**

Tasks to mitigate the risk

1) Robust OD plan signed off by the PI Programme Board.
2) Reviewing staff supervision and process and training.
3) Management Development Programme for Team Managers and Practice Consultants will be rolled out throughout the year.

Progress update

1) Early evaluation survey of staff involved in innovation sites has been extremely positive, practitioners are engaged and responding positively to the new ways of working, which is also having a positive impact on staff morale and team engagement in the sites.
1b) 90% of additional capacity posts have been filled.
2)Implementation of new supervision procedure and roll out of new supervision training.
3) Manager Development programme continues which are being led by SMT- 5 cohorts have now completed.

Appendix B

Risk Number	RM14085	**Date of update**	23 April 2018
Risk Name	Failure to follow data protection procedures		
Risk Owner	Lorna Bright	**Date entered on risk register**	30 September 2011

Risk Description

Failure to follow data protection procedures can lead to loss or inappropriate disclosure of personal information resulting in a breach of the Data Protection Act and failure to safeguard service users and vulnerable staff, monetary penalties, prosecution and civil claims.

Original			**Current**			**Tolerance Target**				
Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Target Date	Prospects of meeting Target Risk Score by Target Date
3	5	**15**	3	4	**12**	1	3	**3**	Mar-19	**Green**

Tasks to mitigate the risk

1) New staff not allowed computing access until they have completed the data protection and information security e-learning courses.
2) Mandatory refresher training every two years and monitoring rates of completion of training.
3) An Information Compliance Group (with representation across each department) meet on a bi-monthly basis and reports back any issues to the Information Management Board.
4) Changes to Data Protection rules (GDPR) will come into effect on 25 May 2018 - we are working closely with Information Management to ensure all of our policies and procedures are compliant.

Progress update

2) Reminders to individual staff to complete Data Protection e-Learning courses are sent out and managers are informed of staff who have not completed the e-learning course. The refresher e-learning course has now moved from every three year's to two year's in line with guidance received from the ICO.
4) The Department has a Business Lead who is working closely with Information Managment to ensure all of our processes and procuedres are GDPR compliant from 25th May 2018.

Appendix B

Risk Number	RM13923	**Date of update**	23 April 2018
Risk Name	Risk of failing to deliver Promoting Independence, change programme for Adult Social Services in Norfolk		
Risk Owner	James Bullion	**Date entered on risk register**	30 April 2011

Risk Description

Promoting Independence Change Programme oversees and co-ordinates the linked change and transformation activities required to deliver the strategy. If we fail to deliver the programme this will lead to a failure in developing a sustainable model for adult social care and a failure to deliver a balanced budget

Original			Current			Tolerance Target				
Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Target Date	Prospects of meeting Target Risk Score by Target Date
4	3	**12**	3	4	**12**	2	4	**8**	Mar-19	**Amber**

Tasks to mitigate the risk

1) Robust programme management arrangements with properly resourced capacity and skills in place.
2) Defined suite of business cases which are prioritised and sequenced to maximise impact and make best use of resources.
3) Clear leadership from senior managers to sponsor and champion changes.
4) Strong performance framework to measure and monitor the impact of change activities and to take action to address any issues.

Progress update

1) Demand and demography modelling continues to be refined through the cost and demand model.
2) Four main themes for transformation: Services for people with learning disability; maximising digital technology; embedding strengths-based social work through Living Well; 3 conversations; health and social care integration.
3) Additional corporate scrutiny through Norfolk Futures programme.
4) Key indicators monitored through performance reporting to Adults committee and P&R Committee.

Appendix B

Risk Number	RM13936	**Date of update**	23 April 2018
Risk Name	Potential for integration to adversely affect delivery of statutory responsibilities or impact on reputation		
Risk Owner	James Bullion	**Date entered on risk register**	30/06/2011 - revised

Risk Description

Pressure on integrated staff could have an adverse impact on joint teams regarding capacity and take them away from departmental priorities impacting on reputation / ability to deliver.

Original			**Current**			**Tolerance Target**				
Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Target Date	Prospects of meeting Target Risk Score by Target Date
3	5	**15**	2	5	**10**	1	5	**5**	Mar-19	**Green**

Tasks to mitigate the risk

1) Pressure closely monitored by AD's and escalated to Director of Norfolk Adult Operations and Integration.
2) SMT monitor and consider the implications and costs across both organisations.
3) Issues can be escalated to S75 Monitoring Board (membership includes Director of Norfolk Adult Operations and Integration, Executive Director NCC and CEO of NCHC) for resolution.
4) Budget and performance metrics and holding to account sessions are kept separate and focussed.

Progress update

1) SMiT (Senior Managers Integration Team) regularly discuss capacity issues and take action.
3) Issues are escalated as and when necessary and also monitored through the Performance Board.

Appendix B

Risk Number	RM14287	**Date of update**	23 April 2018
Risk Name	Potential failure to meet the needs and safeguarding of adults in Norfolk.		
Risk Owner	Lorna Bright	**Date entered on risk register**	14 December 2016

Risk Description

There is a national risk that Adults Social Service do not provide adequate safeguarding controls.

Original			**Current**			**Tolerance Target**				
Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Target Date	Prospects of meeting Target Risk Score by Target Date
2	5	**10**	2	5	**10**	2	4	**8**	Mar-19	**Amber**

Tasks to mitigate the risk

1) Multiagency Safeguarding Policy & Local Procedures in place.
2) Adults Safeguarding Board in place.
3) Delivery of Safeguarding training to providers.
4) Appropriate checks / vetting of staff.
5) Serious case reviews actioned where appropriate.
6) Any recommendations made by Safeguarding Adults Review's (SAR's) are monitored by the Safeguarding Adults Review Group and also disseminated 1/4ly to all managers via the Quarterly Managers Forum (QMF).

Progress update

1) Multiagency safeguarding policy and procedure refreshed and updated by the Learning, Improvement and Policy sub group of the Norfolk Safeguarding Adults Board (NSAB). Now published on the NSAB and publicised among partners.
2) Board is well established and has an independent chair.
3) Specific training for providers is delivered (at a cost) via the commissioned training provider, St Thomas'. The NSAB can also signpost providers to safeguarding training.
4) Enhanced DBS checks are carried out for all customer-facing staff in ASSD.
5) ASSD has a representative on the multiagency Safeguarding Adult's Review (SAR) Group and the group is attended by NPLaw. There is a robust process in place for evaluating cases referred to the SAR Group against the SAR criteria. Claire Crawley (Senior Policy Advisor for the Department of Health) has visited the NSAB and has given advice on the interpretation of the SAR criteria and the importance of identifying and actioning learning.
6) The SAR Group holds and monitors action plans for each SAR and is developing a thematic approach. They also have a standing item on the NSAB agenda to update the board on progress with actions, and any forthcoming reviews. The Head of Service (for Safegaurding) presents learning from SARs and reviews this alongside the relevant locality Assistant Director/Head of Operations. The learning is used as a platform for a more detailed look at a particular theme for ASSD.

Appendix B

Risk Number	RM14238	**Date of update**	23 April 2018
Risk Name	Failure in our responsibilities towards carers.		
Risk Owner	Sera Hall	**Date entered on risk register**	27 May 2015

Risk Description

The failure of Adult Social Services to meet its statutory duties under the Care Act will result in poorer outcomes for service users and have a negative impact on our reputation. Funding reductions by health and other partners may adversely impact on provision of countywide carers services

Original			Current			Tolerance Target				
Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Target Date	Prospects of meeting Target Risk Score by Target Date
2	3	**6**	2	3	**6**	1	1	**1**	Mar-19	**Amber**

Tasks to mitigate the risk

1) Co-production with providers and users of services resulted in revised carers services specification.
2) Maintaining existing health investment in commissioned services.
3) Strong engagement and dialogue with the Carers Council.
4) Competitive procurement of a Carers Service delivered in Sept 2017.
5) Proposed investment as part of the improved Better Care Fund for enhanced support for carers.
6) Review of our offer to carers around respite, direct payments and commissioned services.

Progress update

1-5) The commissioned service has been operational since 1/10/17 and contract meetings take place to review performance as part of BAU.
6) A review of the respite policy has being considered by SMT and is now being developed further. The Commissioner links with the Operational Lead for Carers on developments in relation to this area.
7) A Carers Charter has been proposed by Members - a working group is now actively developing this. Commissioning forms part of this working group.
8) An operational post, with a focus on carers, has been advertised - no successful applicants. The Operational Lead for Carers is reconsidering the Job Description.

Appendix B

Risk Number	RM14149	**Date of update**	23 April 2018
Risk Name	Impact of the Care Act		
Risk Owner	Janice Dane	**Date entered on risk register**	27 November 2013

Risk Description

Impact of the Social Care Act/Changes in Social Care funding (significant increase in number of people eligible for funding, increase in volume of care - and social care - and financial assessments, potential increase in purchase of care expenditure, reduction in service user contributions)

Original			**Current**			**Tolerance Target**				
Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Target Date	Prospects of meeting Target Risk Score by Target Date
4	3	**12**	1	5	**5**	1	3	**3**	Mar-20	**Green**

Tasks to mitigate the risk

1) Project for Implementation of the Care Act. Ensure processes and resources in place to deliver Government requirements. Estimate financial implications.
2) Keep NCC Councillors informed of issues and risks.

Progress update

1) Project delivered necessary changes for April 2015 (part one of the Care Act). On 17 July 2015 the Government announced that Part Two of the Care Act is deferred until 2020.
2a) ASC Committee members agreed to keep this on the risk register until government guidance was clearer. A Green Paper is due in the summer of 2018 - the date is currently unspecified.
2b) We now have a Care Act Lead person who ensures all policy and procedure are Care Act compliant.

Appendix B

Risk Number	RM14290	**Date of update**	23 April 2018
Risk Name	Negative outcome of the Judicial Review into fee uplift to care providers		
Risk Owner	James Bullion	**Date entered on risk register**	07 September 2015

Risk Description

A successful Judicial Review being brought by a group of residential care providers may result in additional costs which were not anticipated in budget planning for the year.

Original			**Current**			**Tolerance Target**				
Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Target Date	Prospects of meeting Target Risk Score by Target Date
3	4	**12**	1	4	**4**	1	4	**4**	Mar-18	**Met**

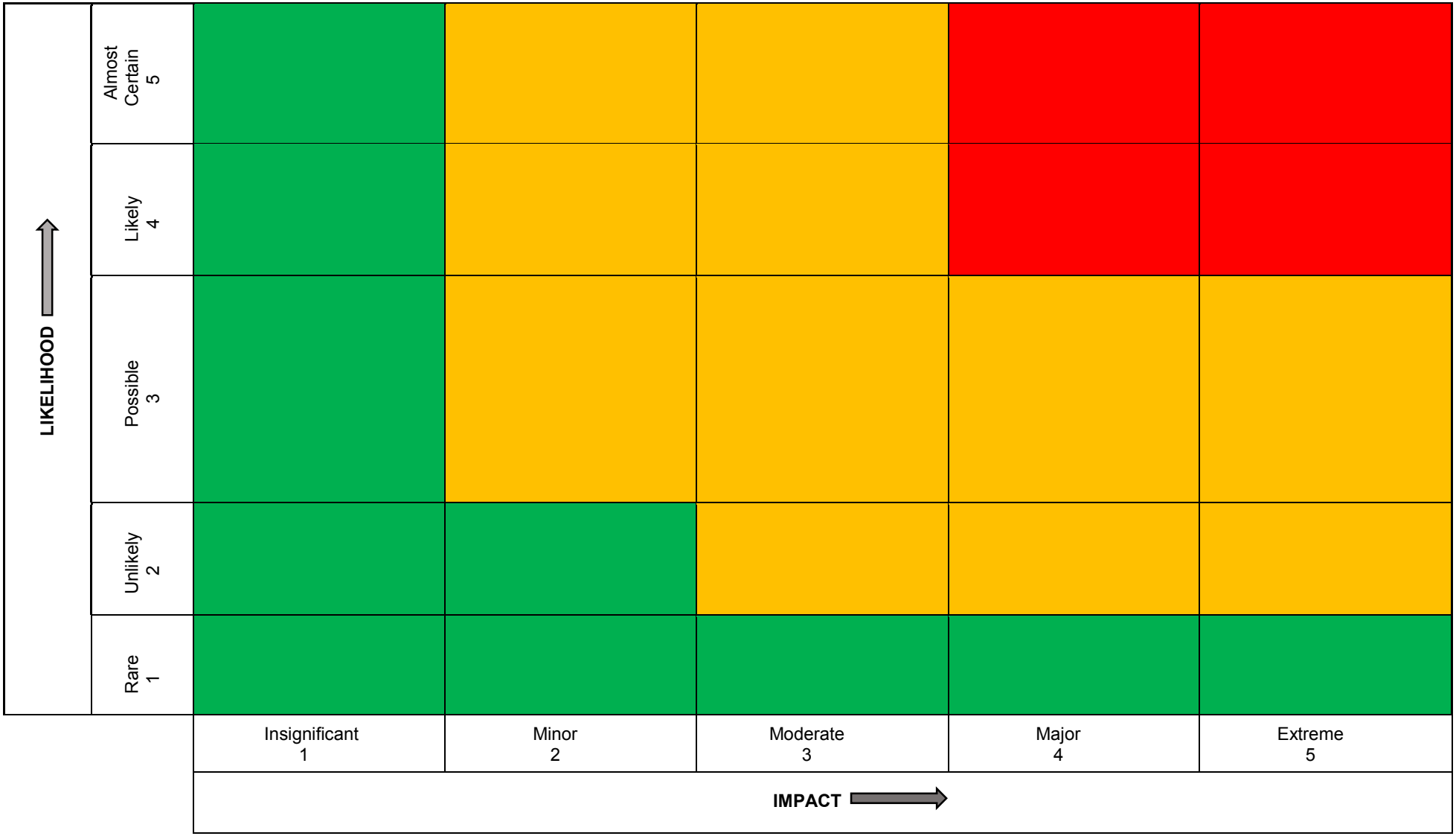
Tasks to mitigate the risk

1) Following the Older People residential and nursing care cost of care exercise and consultation process, the outcome and revised usual prices was recommended to the Adult Social Care Committee on 29th April 2016 and implemented.
2) Ongoing work with the market to discuss annual increases to fees

Progress update

1) Consultation has been completed.
2) Ongoing work continues with the care market to understand cost pressures as part of developing the annual fee uplifts.

Background Information



Above: the County Council's risk matrix template used to plot risk.

Tolerance Level Risk Treatment

High Risk (16-25)
Risks at this level are so significant that risk treatment is mandatory

Medium Risk (6-15)
Risks at this level require consideration of costs and benefits to determine what if any treatment is appropriate

Low Risk (1-5)
Risks at this level can be regarded as negligible or so small that no risk treatment is needed

The Council's risk scoring methodology

The prospects of meeting target scores by the target dates reflect how well mitigation tasks are controlling the risk. It is also an early indication that additional resources and tasks or escalation may be required to ensure that the risk can meet the target score by the target date. The position is visually displayed for ease in the "Prospects of meeting the target score by the target date" column as follows:

a) Green – the mitigation tasks are on schedule and the risk owner considers that the target score is achievable by the target date
b) Amber – one or more of the mitigation tasks are falling behind and there are some concerns that the target score may not be achievable by the target date unless the shortcomings are addressed
c) Red – significant mitigation tasks are falling behind and there are serious concerns that the target score will not be achieved by the target date and the shortcomings must be addressed and/or new tasks are introduced.

Adult Social Care Committee

Item No.

Report title:	**Norfolk Against Scams Partnership**
Date of meeting:	**14 May 2018**
Responsible Chief Officer:	**James Bullion, Executive Director of Adult Social Services**

Strategic impact

Caring for our County:

- **Good growth: Building communities we can be proud of**
- **Helping our population remain independent, resilient and well**

The National Trading Standards (NTS) Scams Team is keen to form a partnership with Norfolk County Council to protect people, to prevent them from becoming victims of financial abuse through mass marketing scams. This will be achieved by empowering communities to '*Take a Stand Against Scams'*.

The purpose of this report is to present a recommendation on the proposed formation of the **Norfolk Against Scams Partnership**; to support the National Trading Standards 'Friends Against Scams' initiative.

Executive summary

Mass marketing scams are a form of financial abuse which affect the lives of millions of people in the UK. The lonely and older people are most at risk, although anyone can fall victim to a scam, particularly when faced with circumstances with which they are unfamiliar such as applying for a student loan or banking online. It is estimated that between £5billion and £10billion is lost every year by UK consumers to this form of fraud.

The National Trading Standards (NTS) Scams Team has launched the 'Friends Against Scams' initiative; to raise the profile of the extent of this problem and to empower citizens and communities to 'Take a Stand Against Scams.' In order to further this initiative the NTS Scams Team is developing an '**Against Scams Partnership'** which they would like to take forward in Norfolk.

The formation of the **Norfolk Against Scams Partnership (NASP)** would involve a commitment from the Council to spread the message to '*Take a Stand Against Scams'* and Members would be invited to become Scambassadors as part of the Friends Against Scams network.

The NASP would be a community pledge asking the whole of Norfolk to take action in helping to protect people in the county from scams. Scams are fraud and fraud is a crime. Organisations and groups would be asked to sign up to a charter as partners and help deliver initiatives to 'take a stand against scams'. This problem is significant and it needs a multi-agency approach to tackle it to protect our communities; specifically consumers who are made vulnerable by their circumstances.

Recommendations:

a) **Members are asked to support the development of a Norfolk Against Scams Partnership (NASP) with the National Trading Standards (NTS) Scams Team and communities in our county**
b) **Members are asked to support Norfolk County Council becoming one of the flagship Friends Against Scams local authorities.**
c) **Members are invited to become a Norfolk "Scambassador" as part of the Friends Against Scams network**

1. Background

1.1 Friends Against Scams (FAS) is a NTS Scams Team initiative launched in 2016 to highlight the scourge of financial abuse in the UK and to protect and prevent people from becoming victims through scams. It is estimated that between £5billion and £10billion is lost every year by UK consumers, falling victim to this type of fraud.

1.2 For over 10 years the Trading Standards Service has sought to raise the awareness of scams in communities across Norfolk. The 'Friends Against Scams' initiative has enabled the Service to align with a nationally recognised brand delivered by a national organisation and by other local authorities; encouraging communities to take action to prevent and protect potential victims.

1.3 There are a number of ways both people and organisations can further the aims of the initiative by becoming:

a) A Friend
b) A Scamchampion
c) A Scambassador
d) A Friends Against Scam Organisation
e) An Friends Against Scams Partner

Definitions are given below.

1.4 Norfolk Trading Standards Service has taken forward the Friends Against Scams initiative by raising awareness in communities:

a) 615 people have registered to become a 'Friend Against Scams' by completing the face to face or online training. (The Service 2017/8 target is to train 600 by 31 March 2018)
b) 34 people have registered as Scamchampions and Chloe Smith MP and Clive Lewis MP are Scambassadors
c) One large Norfolk finance sector business has expressed an interest in the Friends Against Scams initiative and Trading Standards are exploring ways to take this forward

1.5 The Council supporting a Norfolk Against Scams Partnership (NASP) will:

a) inspire action by a wide range of agencies and organisations across the county
b) highlight the scale of the impact of scams on people's lives in Norfolk
c) positivity enhance the reputation of the council as taking a proactive stance against scams to protect the citizens of Norfolk
d) change the perceptions of why people fall for scams
e) help to make scams a community, local, regional and national topic
f) build on the work that Norfolk Trading Standards has led on to recruit over 600 Friends Against Scams in Norfolk
g) build on the excellent 'Uniting Norfolk Against Financial Abuse and Scams' conference held in Norwich on 14 September 2017 where over 90 organisations

came together to hear the work that academia, statutory and voluntary agencies and businesses are delivering on in Norfolk. A focus group was formed post-conference to work together to strengthen and develop our collaborative countywide response to the issue of safeguarding adults at risk of financial abuse and scams

1.6 **Definitions**

a) A Friend is someone who completes a scams awareness session and turns their knowledge into action
b) A Scamchampion delivers awareness sessions and recruits Friends
c) A Scambassador is someone who will use their influence to raise the profile of scams at a national level
d) A Friends Against Scams local authority (FAS LA) is a local authority that commits to spreading the message to Take a Stand Against Scams

1.7 To arrange a training session or access the online session you can visit; www.norfolk.gov.uk/friendsagainstscams.

2. Proposal

2.1 A core function of Adult Social Care is to build a safe, fair and legal marketplace for Norfolk, helping businesses to succeed and safeguarding communities. Our three priorities are:

a) Enabling economic growth by providing support for businesses and ensuring a level playing field by tackling the most serious illegal trading
b) Safeguarding communities and vulnerable people by engaging with communities and businesses to build resilience to scams and rogue traders
c) Protecting public safety, health and well-being and ensuring trading is legal, honest and fair

2.2 Adult Social Care staff provide information and support to Norfolk communities to protect them from scams by raising their awareness of them. While there is a level of awareness about scams and the impact these have on users of adult social care services among adult social care staff but is by no means universal.

2.3 Other departments with Norfolk County Council have also been taken forward this work. For example, Norfolk Trading Standards (NTS) have organised community events; delivering training; raising awareness through partners, media and organisations; and supporting the most vulnerable in our communities who have fallen victim to scams. This is often in conjunction with a Community Champion partner. In addition NTS provides a weekly email alert service for a number of years; whereby scam alerts are sent to a large database of both consumers and businesses.

2.4 The National Trading Standards (NTS) Scams Team is urging communities to '*Take a Stand Against Scams*.' This is achieved by people being equipped with the knowledge and skills to recognise scam communications, advertising and mailing. The community is then able to take local action to protect their more vulnerable members from becoming victims. The national launch of the Friends Against Scams initiative took place in 2016 and has been supported by Norfolk Trading Standards (NTS). NTS committed to this initiative in early 2017 through promoting and delivering the Friends Against Scams training, with the aim of 600 Norfolk people becoming a friend by the end of this current service year.

2.5 A number of the Members of Adult Social Care Committee have positively supported this work and helped to promote the Scam Awareness Popup Advice shops.

2.6 The objective of the Norfolk Against Scams Partnership (NASP) will be that the council will take the lead in bringing together organisations from the public and private sectors, the

voluntary sector, community groups, and individuals in the county; to raise a concerted heightened awareness of scams. This will increase the understanding by communities of the various types of mass marketing scams being experienced by many residents and will help to protect the people who are vulnerable to them. Each organisation will be asked to sign up to a Charter, indicating their willingness to work together in the partnership. The NASP will work with charter partners to share key messages and try to avoid duplication. In supporting this partnership working, the Council will encourage Friends Against Scams training across all NCC employees and the council will support its Members to (voluntarily) become Scambassadors in their divisions.

2.7 The formation of a Norfolk Against Scams Partnership (NASP) would be a decisive step in Norfolk Taking a Stand Against Scams and would demonstrate the Council's commitment to the Friends Against Scams initiative.

3. Evidence

3.1 Financial abuse through mass marketing scams is well documented as a form of fraud which targets the most vulnerable in society. Academia has looked into this scourge, in particular Bournemouth University. Further information is provided in the NTS Scambassador pack (**Appendix 1** to this report).

3.2 From this literature it is evident that in the UK:

a) Financial abuse through scamming is an under-reported crime. Currently it is estimated that only 5% of this type of fraud is recorded
b) More than 53% of people aged 65 or over have been targeted by scams
c) The average age of a scam victim is 75 but victims can be as young as 19
d) Older people are more susceptible to becoming victims due to lower levels of cognitive function. This is a concern because of our ageing population
e) Victims have lost £1,000 or more before they realise they have been scammed

3.3 Norfolk Trading Standards' experience of working with victims of scams confirms these figures. A West Norfolk victim, aged over 80, whom the service is currently helping, has lost over £85,000.

4. Financial Implications

4.1 There are no direct financial implications of the Council becoming a Partner with the National Trading Standards Scams Team or the formation of the Norfolk Against Scams Partnership. The Trading Standards Service will lead this partnership and the delivery by the Service will be met from current resources. Other services, particularly the Norfolk Safeguarding Adult Board, will support the delivery of this partnership but this will again be met from existing resources.

4.2 There is strong evidence that an older victim of a scam is considerably more likely to lose their independence and draw on the services of the Council and other community partners because of the negative impact on their confidence, financial integrity, and health and wellbeing.

5. Issues, risks and innovation

5.1 The formation of a Norfolk Against Scams Partnership (NASP) will support the priorities of Adult Social Services care to support residents to be independent, resilient and well; to prevent, reduce and delay the need for formal services, and to safeguard vulnerable people from harm. This will be achieved through:

a) raising awareness of safeguarding vulnerable people by engaging with communities and businesses to build resilience to scams and rogue traders.

b) reducing the deprivation of an individual's assets which will support them to use their funds on their choice of care and support.
c) reducing the known impact following an incident of scamming which commonly includes loss of confidence and need for a greater level of support

5.2 NASP will build on the 'Uniting Norfolk Against Financial Abuse and Scams' conference, jointly organised by the Norfolk Safeguarding Adults Board (NSAB) and Trading Standards, held in Norwich on 14 September 2017. Over 230 delegates from 90 organisations came together to hear the work that academia, statutory and voluntary agencies and businesses are delivering to safeguard people in the UK from scams.

5.3 Section 42(3) of the Care Act 2014 clearly states that abuse includes financial abuse and, for that purpose, "financial abuse" includes:

(a) having money or other property stolen
(b) being defrauded,
(c) being put under pressure in relation to money or other property, and
(d) having money or other property misused

5.4 Added to this, the most recent edition of the "Statutory Guidance to support Local Authorities implement the Care Act 2014" recognises that Trading Standards has a valuable contribution to make in ensuring adults are safeguarded, saying:

14.29 In all cases this is financial abuse and the adult at risk can be persuaded to part with large sums of money and in some cases their life savings. These instances should always be reported to the local police service and local authority Trading Standards Services for investigation. The Safeguarding Adults Board will need to consider how to involve local Trading Standards in its work.

5.5 For further information please see The Scams Team Smart Guide: Scams, Adult Social Care and The Care Act (**Appendix 2** to this report).

5.6 The formation of the NASP will continue to reduce the risk of people becoming victims of scams and help make Norfolk a scam free county. This initiative also complements the council's ongoing support of 'Dementia Friends' and 'In Good Company'.

The risks associated with the NASP are:

a) Failure to deliver the Partnership effectively as a result of reduced resources for the Trading Standards Service and/or other services in the Council; which would lead to a potential increase in the number of scam victims and reputational damage to the Council.

b) Reluctance of Members to embrace the spirit of this Partnership by choosing not to act as Scambassadors; which would lead to reputational damage to the Council.

c) Reluctance of the Council's employees to undertake the Friends Against Scams training and as a result fail to identify and support a victim of scams; leading to victims failing to get support and reputational damage to the Council

6. Recommendations

6.1
a) Members are asked to support the development of a Norfolk Against Scams Partnership (NASP) with the National Trading Standards (NTS) Scams Team and communities in our county
b) Members are asked to support Norfolk County Council becoming one of the flagship Friends Against Scams local authorities.
c) Members are invited to become a Norfolk "Scambassador" as part of the Friends Against Scams network

Officer Contact

If you have any questions about matters contained in this paper or want to see copies of any assessments, e.g. equality impact assessment, please get in touch with:

Officer name :	Email address :	Tel No. :
Walter Lloyd Smith	walter.lloyd-smith@norfolk.gov.uk	01603 223422

If you need this report in large print, audio, braille, alternative format or in a different language please contact 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

Friends Against SCAMS

STAND AGAINST SCAMS

Scams are the scourge of our communities. They are operated by criminals with the sole purpose of identifying and exploiting often vulnerable, elderly and mentally impaired people.

Trading standards, a function of local government, is focused on combating criminals and protecting these vulnerable individuals.

The average victim loses about **£1,000** to scams but some have lost their homes, their life savings and many thousands of pounds.

Financial loss is not the only cost. Feelings of **vulnerability** can have an overwhelming impact on many victims.

Elderly victims are **2.4 times more likely** to die or go into a care home than those who are not scammed.

Many other public services are required to help pick up the pieces and all this has a cost.

WHO ARE THE NATIONAL TRADING STANDARDS SCAMS TEAM?

The NTS Scams Team is funded by National Trading Standards and is hosted by East Sussex Trading Standards. The team was founded in 2012 to tackle the problem of postal, telephone and doorstep scams, and related crimes. The team works across England and Wales with trading standards and partner agencies to investigate scams, and to identify and support those who fall victim to them.

Together with the NTS Scams Team we are creating a cross-party network to protect everyone from scams and the damage they cause. This is the **#SCAMbassador** network.

WHAT IS FRIENDS AGAINST SCAMS?

Friends Against Scams is a National Trading Standards Scams Team initiative which aims to protect and prevent people from becoming victims of scams by empowering communities to… 'Take a Stand Against Scams.'.

Scams affect the lives of millions of people across the UK. People who are scammed often experience, loneliness, shame and social isolation.

Friends Against Scams aims to inspire action, highlight the scale of the problem, change the perceptions of why people fall victim to scams and make scams a local, regional and national topic.

By attending a Friends Against Scams awareness session or completing the online learning, anyone can learn about the different types of scams and how to spot and support a victim. With increased knowledge and awareness, people can make scams part of everyday conversation with their family, friends and neighbours, which will enable them to protect themselves and others.

Within the initiative there are:

Friends
People from all walks of life who attend a short training session, commit to talking to others about scams and potentially identify victims.

SCAMchampions
Friends who attend a further training session to enable them to recruit new Friends Against Scams.

SCAMbassadors
MPs, senior officials or someone who will use their influence to raise the profile of scams.

CONTACT US TO SIGN UP TODAY
SCAMBASSADORS@TSI.ORG.UK

Friends Against SCAMS

STAND AGAINST SCAMS

SO WHAT ARE SCAMS?

If someone is persuaded to part with money as a result of **postal**, **telephone** or **electronic communication** received into the home they have been scammed. This can often take place on an industrial scale through:

- **Fictitious prize draws**
- **False investment opportunities**
- **Pension fraud or bogus equity release schemes**
- **Clairvoyant or dating scams**
- **Fake lotteries**

These scams often use techniques such as sales scripts, data collection and targeted mail. They may play on the aspirations as well as the vulnerability of the victim. Victims' details are often passed around criminal groups, leading to repeat victimisation.

Several forms of this crime take place on the doorstep. Victims are cold called at their homes and persuaded to part with money. The most common form is charging an extortionate price for unnecessary work not completed.

THE TIP OF THE ICEBERG

For all that is known about scams it is believed that there is a great deal of information yet to be discovered.

- **Victims don't report being scammed because of shame or intimidation**
- **With diminishing funding for local trading standards services there are fewer opportunities to follow up on suspicious activity**
- **Developing technology enables scammers to access victims in new ways**

When it was founded the NTS Scams Team had uncovered **106,000** potential victims on captured criminal target lists also known as 'suckers lists'. Further investigations have suggested that there are **750,000** victims in circulation with many more anticipated.

Only 5% of scams are reported

WHAT ARE LOCAL AUTHORITIES DOING ABOUT SCAMS?

Combating scams is rarely easy. Many criminals operate overseas out of the reach of UK authorities, hide under company identities or intimidate their victims into silence. Trading standards have seen staff numbers fall by half over the last five years. Criminals know this and are targeting consumers because of this.

Local authority trading standards step in when they are aware of a victim, disrupting the criminals and where possible attempting to bring them to justice.

Officers work with victims to prevent future scams, using innovations such as call blockers to safeguard individuals. When a call blocker is installed it shows the targeting of the vulnerable.

Local authority trading standards have piloted call blocking software to help tackle scam calls up and down the country. In partnership with trueCall we have found that:

Over 100 **trading standards**, **charity**, **social services**, **adult safeguarding** and **police teams** have been involved in successful call blocking projects all across the UK

nuisance calls blocked

of all calls received were nuisance calls

of nuisance and scam calls blocked

Residents were receiving **53 nuisance calls** per month – **6 times** the national average

MANY INTERVENTIONS ARE GUIDED BY THE WORK OF THE NTS SCAMS TEAM

Aims of the National Trading Standards Scams Team are:

- To **IDENTIFY** victims of scams
- To **INTERVENE** and protect victims from further victimisation
- To **INVESTIGATE** criminal activity
- To **INFORM** local authorities and agencies on how to work with and support scam victims
- To **INFLUENCE** people at local, regional and national levels to **TAKE A STAND AGAINST SCAMS**

The NTS Scams Team is fighting for a scam free nation by 'Taking a Stand Against Scams.'

The team shares its data with local authority trading standards services who are then able to intervene with victims on a one-to-one basis. Partner agencies are advised to make face-to-face visits to ensure that the victim receives the best possible care and support.

Local trading standards work tirelessly to ensure a long term support network is established. Where possible local teams will also link victims with other support mechanisms and befriending services such as those run by the charity Age UK.

Successes of the NTS Scams Team

- **177 local authorities are signed up to the NTS Scams Team initiative**
- **20,464 victims identified throughout the UK**
- **£1,469.88 average savings per person as a result of trading standards work**

3,628
postmen and postwomen trained by trading standards

110,000
items of mail seized

150,000
cheques seized

750,000
victims have been identified on so-called 'suckers lists'

STAND AGAINST SCAMS

Average financial detriment per person

Highest detriment surrounding one scam victim

Cost of fraud to the UK Economy each year

What some victims aged 70+ have had to do to cover their debt

Estimated total consumer detriment by mass marketing scams annually

Estimated total consumer detriment from doorstep crime

One victim's details sold on over 200 times by scam companies

Report being victim of a scam

ANYONE CAN BE THE VICTIM OF A SCAM

yet it is the elderly and vulnerable who are often systematically targeted by scammers

53% of people aged 65+ have been targeted by scammers (Action Fraud)

75 is the average age of scam victims*

19 youngest reported scam victim*

*based on 'suckers list' intelligence

RESEARCH HAS CONFIRMED

older people are more susceptible to becoming victims due to lower levels of cognitive function. This is a concern because the ageing population is on the rise:

11.4 million (17.7% population) were aged over 65 in mid-2014

Set to rise to 20 million by 2050

Number of people with dementia set to rise by 40% by 2025

HOW TO HELP A SCAM VICTIM?

By signing up to the initiative, as both a new #SCAMbassador and as a prominent figurehead of the community, the cases of local scams victims and their families will inevitably surface and require action.

It is important to remember that victims are all unique. There are, however, some common things to remember for every victim:

- Experts have described victims of scams and financial abuse as being groomed by scammers
- Because of this they may not accept that they have been a victim of crime, believing the criminals even over their own family
- Their family may have made several attempts to stop repeat victimisation only to find that their family member cannot accept that they are being defrauded
- Many victims suffer from dementia and other debilitating mental conditions which contributes to the difficulty to accept a crime has taken place

Trading standards becoming involved will bring safeguarding support to victims and help to investigate criminal activity.

If you or a constituent wishes to report a potential scam contact the Citizens Advice consumer helpline.

03454 04 05 06

or

03454 04 05 05

(Welsh speaking line)

If you would like any further information on the issues around scams, trading standards and what happens to an issue once it is reported please get in touch with CTSI

SCAMBASSADORS@TSI.ORG.UK

WWW.FRIENDSAGAINSTSCAMS.ORG.UK

PRINT OUT FOR FUTURE REFERENCE

JOIN THE FIGHT

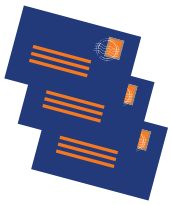
CTSI and the NTS Scams Team will support you every step of the way in becoming an effective #SCAMbassador for your community. We will provide media support and can help give you ideas for local community actions that might work well in your area.

Some initiatives that have worked well in the past include:

WRITING to your local newspaper/magazine. Include a column on the latest scams reported in the area, warn constituents to be aware, provide info and keep us updated.

Use social media to raise awareness of issues **#FRIENDSAGAINSTSCAMS**. Become a **#SCAMbassador** today!

Co-ordinate a **MAIL COLLECT** in your constituency – this is a great way to get scam mail out of your constituent's homes and into the hands of the trading standards teams who will be able to investigate it fully. Send findings over to the NTS Scams team.



YOUR COMMITMENT TO US:

BY SIGNING UP AS A #SCAMBASSADOR YOU ARE COMMITTING TO:

- **Help us to raise the profile of the problem of fraud and financial scams at a national level**
- **Raise the issue of scams as a key topic of concern in parliament**
- **Encourage your local authority to sign up to the NTS Scams Team and start taking information on scam victims**

As the #SCAMbassador network grows we hope to be able to bring increased national attention to the issues

CONTACT THE TEAM TO SIGN UP TODAY

SCAMBASSADORS@TSI.ORG.UK

Friends Against SCAMS

FOR MORE INFORMATION CONTACT THE POLICY TEAM

tel 01268 582250 or email
scambassadors@tsi.org.uk

Published by Chartered Trading Standards Institute

Scams Team Smart Guides

Scams, Adult Social Care and The Care Act

The Introduction

Victims of scams, whether that is mass marketing fraud or doorstep crime, are victims of financial abuse. As a result, the Care Act 2014 puts all local authorities under a duty to take steps to prevent individuals being subjected to financial abuse. This paper outlines succinctly the legislative basis that requires local authorities to take responsibility for tackling scams and undertake activities which could prevent people being financially abused.

The Facts

Section 42 of the Act states that where a local authority has reasonable cause to suspect that an adult in its area —

(a) has needs for care and support (whether or not the authority is meeting any of those needs),
(b) is experiencing, or is at risk of, abuse or neglect, and
(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

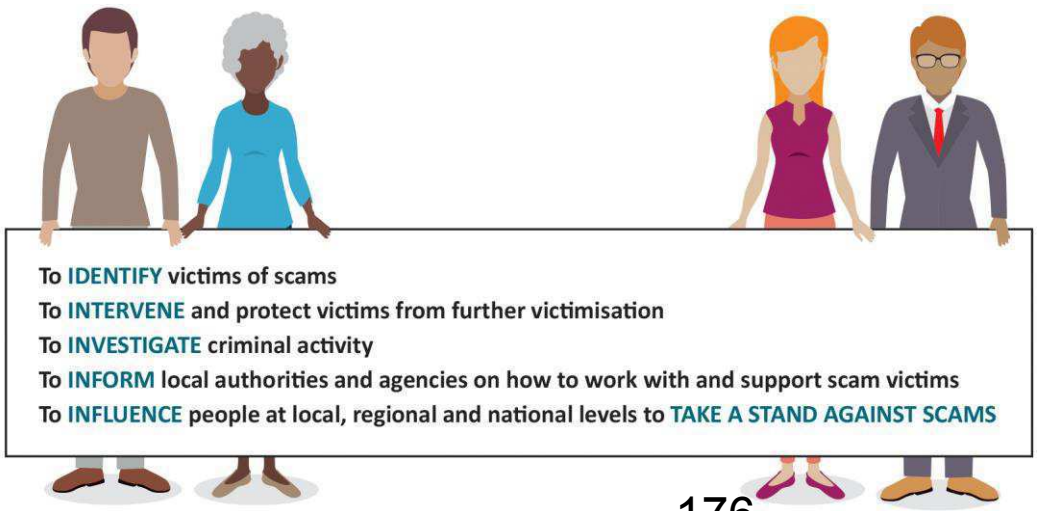
The local authority then must make whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.

Section 42(3) clearly states that abuse includes financial abuse; and for that purpose "financial abuse" includes –

(a) having money or other property stolen,
(b) being defrauded,
(c) being put under pressure in relation to money or other property, and
(d) having money or other property misused

Added to this the most recent edition of the, "Statutory Guidance to support Local Authorities implement the Care Act 2014" recognises that trading standards have a valuable contribution to make in ensuring adults are safeguarded, saying:

14.29 In all cases this is financial abuse and the adult at risk can be persuaded to part with large sums of money and in some cases their life savings. These instances should always be reported to the local police service and local authority Trading Standards Services for investigation. The Safeguarding Adults Board will need to consider how to involve local Trading Standards in its work.



NATIONAL TRADING STANDARDS
Scams Team

14.30 These scams and crimes can seriously affect the health, including mental health, of an adult at risk. Agencies working together can better protect adults at risk. Failure to do so can result in an increased cost to the state, especially if the adult at risk loses their income and independence.

The Act also introduced statutory Safeguarding Adults Reviews (SAR). The Safeguarding Adults Board must conduct a SAR if there is reasonable cause for concern about how the Board, members of it or others worked together to safeguard the adult and death or serious harm arose from actual or suspected abuse.

Safeguarding adults with care needs who are subject to financial abuse via scams therefore need to be considered as part of a whole council approach. Furthermore, Section 2 also states local authorities must make provision for services that prevent or delay the need for care and support.

The Challenge

Adult Social Care teams may not recognise that responding to scams constitutes financial abuse and that steps need to be taken to protect these individuals. Adult Social Care managers and Directors may not recognise the scale of the problem and the need to resource dealing with this aspect of safeguarding as part of a whole council approach.

Local trading standards services are at the forefront of tackling financial abuse through their excellent work in visiting and supporting victims of scams. A recent survey we conducted showed that whilst 81% are engaged with adult social care to the extent that they can discuss/action concerns re financial abuse, only 26% have a place on their Safeguarding Adults Board.

It is beneficial to engage with your local Safeguarding Adults Board to ensure the needs of financial abuse victims are addressed through a co-ordinated range of activities, including:-

- To recognise the signs of financial abuse when council employees come into contact with vulnerable members of the public, especially when in their own homes.
- To be proactive in responding to information and intelligence which indicates an individual may be subject to financial abuse.
- To ensure that there is adequate intervention, prevention and support.
- To evaluate what the most appropriate method of intervention and support is, whether that is within the local authority or by using partners, including the voluntary sector.

The Help

The NTS Scams team are currently working with the Association of Directors of Adults Social Services (ADASS) to enhance understanding at a national level of the importance of tackling scams and supporting victims covered within the Care Act.

The team is also happy to support you with advice and guidance as necessary to increase the profile of scams within your authority. Furthermore, it has developed the Friends Against Scams initiative which, amongst other things, will provide an on-line training tool to help carers and others who visit people in their homes to identify financial abuse and report it.

It is essential that the signs of financial abuse are not missed or overlooked and recently we have been actively supporting the care sector and other professionals who particularly visit adults in their own homes to look out for and report any suspicions of abuse.

We want to engage with local authorities further in discussions about how we can forge greater working relationships and explore working practices so that together we can further improve safeguarding in this area.

Adult Social Care Committee

Item No:

Report title:	**Integrated Community Equipment Service (ICES) provision into Waveney Health & Social Care**
Date of meeting:	**14 May 2018**
Responsible Chief Officer:	**James Bullion, Executive Director of Adult Social Services**

Strategic impact

Expanding the provision of community equipment to Waveney aligns with the Sustainable Transformation Partnership's Norfolk and Waveney footprint. Providing community equipment is a statutory requirement under the Care Act and supports our Promoting Independence and prevention agendas, in keeping people supported at home for as long as possible. Norfolk Integrated Community Equipment Service (ICES) is also an enabling service which supports discharges from acute and community hospitals. Norfolk County Council's agreement to accept the delegation of powers from Suffolk County Council to provide community equipment for social care prescribers in the Waveney area is necessary in order to achieve the expansion of ICES services into Waveney.

Executive summary

ICES, currently commissioned by Norfolk County Council on behalf of NCC and five Norfolk Clinical Commissioning Groups, delivers community equipment to people in Norfolk. In January 2018 the ICES Management Board agreed that expansion of the service to support those in Waveney offered benefits for both customers and commissioners.

Waveney health prescribers already use the same equipment provider as Norfolk ICES, Nottingham Rehabilitation Services (NRS), and inclusion of this service into the Norfolk contract is straightforward and easily achieved by Great Yarmouth & Waveney Clinical Commissioning Group (GY&WCCG) being a partner to the current Norfolk ICES contract. However, the current contract references GY&WCCG regarding provision to Great Yarmouth (and not Waveney), so this proposal would also include the acceptance of Waveney health into the contract.

Waveney social care prescribers currently use a different provider for community equipment. Suffolk County Council are keen to join Norfolk ICES. Given the current model used with the CCGs, it is therefore proposed that Suffolk County Council delegate their powers for the purchase of community equipment for social care in relation to the Waveney area to Norfolk County Council. The recommendations in this Committee report reflect the two governance systems and the actions that need to be undertaken to join Waveney to the Norfolk ICES Contract. Suffolk County Council are meeting to discuss this proposal on 15 May 2018 and Norfolk County Council's acceptance of the delegation is subject to this agreement.

Following acceptance of this delegation by Norfolk County Council, the parties will enter into a formal delegation agreement. It is proposed that the agreement will be drafted to allow Suffolk County Council to benefit from the governance arrangements already in place and to allow funds for the purchase of social care equipment to be pooled with monies already allocated for the service. In addition to this, additional income of £26.4k will be provided by Suffolk County Council to fund administration of the contract.

Recommendations:
Committee are asked to approve that:

a) **Norfolk County Council to accept the delegation of powers from Suffolk County Council for the purchase of community equipment for social care in relation to the Waveney area**
b) **Norfolk County Council to accept the inclusion of Waveney health into the contract and for Norfolk County Council to extend its purchase of community equipment for health in relation to the Waveney area**
c) **The delegation in 1 and agreement in 2 shall be subject to the execution of the relevant agreements which shall include the contributions that Suffolk County Council and Great Yarmouth & Waveney CCG will make towards the contractual and management costs of the wider ICES arrangements. The completion of this agreement shall be delegated to the Head of Integrated Commissioning (Norwich)**

1. Proposal

1.1 The ICES service is an integrated equipment service in Norfolk, delivered by Nottingham Rehabilitation Service (NRS), commissioned by Norfolk County Council on behalf of itself and all five Norfolk CCGs. Norfolk County Council's Integrated Commissioning Team have developed and held responsibility for this contract for service since 2012, following the completion of a s.75 agreement whereby the five Norfolk CCGs delegated their commissioning powers to Norfolk County Council and the necessary procurement exercise.

1.2 The ICES service currently delivers to Norfolk County Council's footprint. Great Yarmouth and Waveney CCG have a mirror contract with NRS for the Waveney health component and are party to the existing s.75 agreement for the provision of community equipment to Great Yarmouth. Suffolk County Council currently commission the Waveney social care equipment services from another provider.

1.3 **Creating a Coherent Community Equipment Service for Norfolk and Waveney**

Colleagues from Waveney health and adult social care have been keen to purchase from the Norfolk ICES contract for services. The benefits of this approach are:

a) Service delivery of integrated equipment is across the STP Norfolk & Waveney footprint
b) Clinicians from Great Yarmouth & Waveney will no longer have to use two systems to prescribe community equipment
c) ICES Norfolk is considered to have robust management and Waveney wish to come under this umbrella
d) There are opportunities for economies of scale and increased funds from Waveney health and social care into the Norfolk ICES Management Team
e) Increased management fees to the ICES Management Team would enable a greater emphasis on improving service quality, service standardisation and engagement into pertinent issues such as reducing Delayed Transfers of Care (DTOC) from acute and community hospitals for the whole of Norfolk and Waveney

For clarity the Waveney area is co-terminus with Waveney District Council and includes all service users who are registered with a Great Yarmouth & Waveney CCG GP surgery.

1.4 **Governance Process to Achieve the Norfolk and Waveney Service**

To be able to expand Norfolk ICES into Waveney the following governance process applies:

a) Norfolk ICES Management Board approve a decision to expand the reach of ICES into Waveney health and social care – **Approved on 24 January 2018**
b) Suffolk County Council ask Norfolk County Council offer the delegation of powers from Suffolk County Council to purchase community equipment for social care in relation to the Waveney area – **SCC Cabinet Decision 15 May 2018**
c) Norfolk County Council accept the delegation of powers referred to in point 2 at Adult Social Care Committee – **Decision to be made on 14 May 2018**
d) Norfolk County Council and Suffolk County Council enter into the relevant agreement which shall include the contributions that Suffolk County Council will make towards the contractual and management costs of the wider ICES arrangements. Great Yarmouth & Waveney CCG add include their contributions regarding the Waveney health component. The completion of this agreement shall be delegated to the Head of Integrated Commissioning (Norwich) – **Decision to be made on 14 May 2018**
e) Norfolk ICES Management Board shall be reshaped to include a member from Suffolk County Council – **Decision at the next Management Board Meeting**

2. Evidence

2.1 **System-wide Benefits**

The main benefits of expanding the reach of the current Norfolk ICES into Waveney health and social care are system-wide benefits and end user benefits. Norfolk ICES has a robust clinical foundation, with standard operating procedures, good quality practice, a direct relationship with the provider, NRS (via a jointly funded NRS-NCC Occupational Therapist) and nearly five years of operating as an integrated system.

2.2 **Enabling Prescribers to Work More Efficiently**

Waveney Health currently operate under a similar contract for services, commissioned by GY&WCCG and provided by NRS, which is performing well. Currently clinicians in Waveney have to use two different providers for community equipment with separate patient record systems, service levels and equipment catalogues which reduces the effectiveness of the system overall.

2.2.1 Bringing Waveney Health and Social Care community equipment under the reach of the Norfolk ICES provides standardised and equitable practices across the STP footprint.

3. Financial Implications

3.1 The financial implication for Norfolk County Council in accepting Suffolk County Council's delegation of power to purchase community equipment for social care and Great Yarmouth & Waveney CCG's inclusion into the contract is that Norfolk County Council will receive and manage the monies from Suffolk County Council and GY&WCCG to provide the service. It is proposed that the delegation agreement would allow Suffolk County Council to benefit from the governance arrangements already in place.

3.2 In addition to this, income of £26.4k from Suffolk County Council will add to the management fee of ICES, this will be utilised by the Management Team to enable a greater emphasis on improving service quality for beneficiaries, service standardisation

and engagement into pertinent issues such as reducing Delayed Transfers of Care (DTOC) from acute and community hospitals for the whole of Norfolk and Waveney.

4. Issues, risks and innovation

4.1 The procurement implications from a health and social care perspective have been examined with no issues arising from either system in adding Waveney into the Norfolk ICES.

4.2 The inclusion of additional commissioners will involve agreeing a contribution to the ICES management fee. The additional management fee will be utilised to ensure that administration of the contract is sufficient given that the prescribing footprint will expand. It is considered this will be necessary to maintain/improve the level of service.

4.3 The Management Team hosted by Norfolk County Council already have innovative initiatives in place and plan to deliver more in 2018-19 to improve the quality of the use of community equipment by prescribers and to support domiciliary care providers in using equipment.

4.4 The extension of the delivery of ICES into Waveney is anticipated from June 2018 and there is a mobilisation team from Norfolk County Council, GY&WCCG and Suffolk County Council working together towards this goal. The team is also ready to continue working to a later go live date, if this is deemed necessary, and has contingency measures in readiness.

5. Recommendations

5.1 **Committee are asked to approve that:**

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- **c) The delegation in 1 and agreement in 2 shall be subject to the execution of the relevant agreements which shall include the contributions that Suffolk County Council and Great Yarmouth & Waveney CCG will make towards the contractual and management costs of the wider ICES arrangements. The completion of this agreement shall be delegated to the Head of Integrated Commissioning (Norwich)**

Officer Contact

If you have any questions about matters contained in this paper or want to see copies of any assessments, eg equality impact assessment, please get in touch with:

Officer Name:	**Tel No:**	**Email address**:
Sera Hall	01603 224378	sera.hall@norfolk.gov.uk

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If you need this report in large print, audio, Braille, alternative format or in a different language please contact 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.