Adult Social Care Committee

Item No……

Report title:	**Performance Management**
Date of meeting:	**3 September 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 LiquidLogic 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 sustained high volumes of activity.

Recommendations

The Committee is asked to:

a) **Discuss and agree the overall performance position for adult social care as described in section 2 of this report**

Appendix 1 – Performance management report cards (page 61)

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 LiquidLogic system and reflects performance up until the end of July 2018.

1.2 Members should note that because the report draws on more up to date data, final positions may change as work is completed and as social workers complete the reporting on the system.

2. Performance overview

2.1 Promoting Independence is the department's strategy for accelerating the delivery of improved outcomes for people who require adult social care within the ongoing challenging financial context. The Committee has previously (October 2017) agreed six key measures that align with to the intervention points of Promoting Independence. The measures are:

a) Reducing the 'conversion' of requests for support to formal assessment by connecting people effectively with good quality information and support
b) Ensuring an appropriate proportion of assessments go on to require ongoing social care involvement
c) Reablement cases where the person does not require additional social care

d) Increasing the rate at which review backlogs are handled, and increasing the rate of reviews that lead to a reduction or cease in service
e) Reducing permanent admissions into residential care for people aged 18-64
f) Reducing permanent admissions into residential and nursing care for people aged 65 and over

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 ongoing 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

The following section gives an update against each of the measures, and by extension an update on the key changes under Promoting Independence.
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. Since we reported, the number of contacts overall per month has decreased, as would be expected during summer. There has also been a trend in the last three months which has seen fewer of these contacts translating into a formal care act assessment, which is encouraging.

2.2.2 There is work led by other departments which makes a significant contribution towards connecting people with information, advice and other informal support. New in this period of reporting is the new Norfolk Community Directory which was launched May 2018 https://communitydirectory.norfolk.gov.uk/ replacing the previous Norfolk Directory.
The Directory contains activities, services and groups to help all Norfolk residents live healthy, active and fulfilling lives. It draws on information from other areas – not duplicating or replacing – but making connections to other similar directories.

2.2.3 The new Directory will be a valuable resource for our social work teams, for Integrated Care coordinators, our development workers and for social prescribing teams and should considerably enhance the quality and breadth of information we are able to draw on for the people we work with. Work is underway to increase the content where there are known gaps – for example information for people who fund their own care.

2.2.4 During July and August, our new social prescribing service will be up and running, based around groups of GPs, covering all parts of the county. Social prescribing is in line with our strengths-based approach; it aims to help people take greater control of their health and wellbeing, connecting them to a range of informal support and activities. Common to schemes in all areas of Norfolk are Connectors who will work with individuals for a short period of time. Social prescribing is funded through the Improved Better Care Fund (iBCF) and through public health. The further increased investment in prevention is anticipated to be an invest to save, since it is expected to reduce demand on both adult social services and primary care.

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 and in different ways. 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 The average since March has been that 43% of assessments result in no formal services; to meet our stretch target, we would need to see that figure come down to 15%. We need to understand more about this trend and will then look into the data which lies behind it. We believe it will take some time to make an impact and will be turned around as part of the new model of social work, sustained prevention activity, including reablement.

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 ongoing formal care. The total number of people benefitting from reablement increases year on year, and the outcomes for those people remain good.

2.4.2 Unlike in Care First, it is not possible in LiquidLogic to see those that have been passed to Norfolk First Support (reablement) with long term conditions that will always require a service, such as those with palliative care needs. These people do not have the potential to be reabled but the service sometimes has a duty to provide support and care if there are no other providers able to do this at that time. This means that since November 2017 the measure is now looking at all cases taken on by the reablement service, regardless of whether the person has the potential to be reabled, which will have an impact on the overall figure, ie make the percentage reabled lower than when the data was taken from Care First.

2.4.3 It nonetheless remains a good level of performance. We are still pursuing excluding the people who do not have the potential to be reabled from it to give an accurate figure.

2.4.4 Initial analysis from accommodation based reablement at Benjamin Court points to a strong 'invest to save' business case. Of the first 38 people to use the service, 23 went home with further support from Norfolk First Support; six with no services; one went home with support from their previous provider; three moved into housing with care and five returned to hospital. There are similarly positive outcomes for people accessing accommodation based reablement in the East locality.

2.5 Holding lists

2.5.1 The holding list has continued to fall, and is now at 1,836 at the end of July, from a high of 3109 a year ago.

2.5.2 Key to this reduction has been the Community Care Resilience Team (CCRT) introduced in December last year to address the current unallocated and overdue work in localities. In the first six months the team has completed 1,300 cases and as result of this, and the additional staffing capacity in our locality teams beginning to take effect, holding lists for localities have been reducing. There has been a recent increase which has been a combination of pressure from hospital due to the hot weather, the peak leave period and staff sickness.

2.5.3 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 Despite the summer months, pressure has continued to be felt on NHS services and while delays attributed to Adult Social Care have come down steadily since October 2017, performance across the system still requires significant improvement. In June NCC was 27.3% above target for social care delays with 930 delayed days. This accounted for 43% of total delays in Norfolk. The main reason for social care delays was "Awaiting Residential Home Availability or Placement". Norfolk was ranked 88 out of 151 in June for total delays per population and 127 out of 151 for social care delays per population.

2.6.3 We have a set of improvement actions, which will form part of a formal winter plan including better liaison with care providers; clear processes for identifying care home vacancies and earlier involvement in discussions on wards.

2.6.4 New targets have been allocated by the Department of Health and Local Government Association with an expectation of achievement by the end of September and beyond.

2.6.5 For Norfolk (NHS and Adult Social Services) this target is 66.6 delayed days per day; for Adult Social services the target is 24.3 days, per day. In other words, to be within target on any one day, there can only be 24.3 delayed days across Norfolk attributed to Adult Social Services. (Equivalent to about 729 total delays attributable to adult social care in a month)

2.6.4 The Executive Director has written to all front line staff, acknowledging the stretch in the new target, but with a clear expectation that we will work towards achieving it.

2.6.5 In July 2018, Adult Social Services organised a two-day system-wide event to look at what more can be done by health and social care to ensure people ready to leave hospital can do so without unnecessary delay. Over 80 representatives from the Norfolk and Waveney system were joined by experts from the Local Government Association (LGA) in partnership with the Better Care Support Team, National Health Service England (NHSE) and National Health Service Improvement (NHSI). Key findings from the event were:

a) A need to break away from 'linear' ways of working which are driven by processes and not people
b) A need to work at all levels with a culture of 'home first' so that all professionals involved are working towards getting people home
c) Better communications at all levels – between different professionals, with care providers and particularly residential and nursing homes, and with individuals and families

2.7 **Reviews that lead to reduced services**

2.7.1 This is the first time we have been able to report against this measure. People's needs change and, under the Care Act, a review of needs should be undertaken if there is a change in need, or if not, an annual review is required. As reported elsewhere, there is a backlog of work which includes reviews, and we are making progress against that backlog. We have set a highly stretching target for younger adults against this measure and the first tranche of data shows we are currently well below that target. Just over 11% of reviews are leading to reduced service, against our high aspiration of 43%. For older people, we are closer to target with 15.07% of reviews resulting in a step down of formal service, against a target of 21%.

2.8 **Rate of permanent admissions**

2.8.1 The rate of permanent admissions for younger adults continues to remain largely steady, although there are fluctuations month by month. Transformation of learning disability services is a priority for the department. Focus is on developing alternatives to permanent care which help people to 'step down' into more independent living.

2.8.2 Admissions for people over 65 are in line with our target and staying largely steady. To understand better events prior to people moving in permanently to residential care, we looked at 1,200 people's experience to see what patterns there were about the triggers and causes of admission to care.

2.9 **Key findings from this work show:**

a) Over half of people (53%) didn't have any NCC funded home care prior to residential care which raises the question of how many people are coming to our services through less traditional routes, which could be described as crises pathways
b) 44% of people had NCC funded home care immediately prior to residential care, whilst 3% had NCC funded housing with care/sheltered accommodation
c) Of people who did have home care, the average duration was 11 hours
d) The top three reasons for people requiring home care were personal care (including washing and dressing), eating and drinking (including the prep, encouraging to eat and feeding) and medication administration
e) Reasons why people were admitted to residential care were recorded and more than one contributory reason could be recorded by each person. People were most likely to be admitted to residential care due to dementia or mental health issues. The second most frequent reason people were admitted to residential care was due to falls
f) Average length of stay in Norfolk is 2 years and 9 months whereas in the north it is significantly higher at 2 years and 11 months

2.9.1 A piece of linked analysis has also shown that just over half of people who took up a temporary stay in residential setting stayed there permanently and did not return to their previous home. A further significant finding is that 80% of those stayed permanently in the same home.

2.9.2 Whilst this work cannot give us definitive answers, it does highlight lines of inquiry which we will follow up to ensure that our activities are targeted where they can make most difference. The areas we will look into further are:

a) Support for people to return home after a stay in hospital, particularly whether there is more we could do to help people in short-term, temporary care re-gain skills or confidence – with support – to return to their home
b) Preventive work around falls which are a significant factor in nearly a third of admissions to residential care. Elsewhere our statutory survey responses highlight that people fear falls more than anything when considering their safety
c) Whilst personal care is, expectedly, the most cited reason for people needing home care, 'food and drink' and 'medication' are the second and third reasons respectively
d) Differences in length of stay in residential and nursing care across Norfolk – the breakdown shows that the stay is longer than average for Norfolk in North Norfolk

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 of this report

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:

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