Adult Social Care Committee

Item No……

Report title:	**Performance Management**
Date of meeting:	**14 January 2019**
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 point to sustained high volumes of activity, continued complexity of needs, and pressures on the wider care market, particularly for home care and nursing care.

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 71)

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 LiquidLogic system and reflects performance up until the end of October 2018, although it should be noted that it can take some months to complete all care and support recording.

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 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, and assessment leading to formal services**

2.2.1 The overall trend is a reducing number of contacts going onto assessment, in line with the strategy of supporting more people earlier, connecting them with informal community support. Since the beginning of the year, there has been considerable expansion of prevention and early help work for adults in the community – a strength noted in the recent Peer Review. However, this will take time to embed, and time to deliver results for people.

2.2.2 The 'sister' measure (assessments which go onto formal services) is reducing, when best practice suggests that a higher proportion of assessments would be expected to result in formal services. We are exploring the drivers behind this; it could be that practice still favours capturing and recording people's needs in an assessment, even if the outcome involves supporting people through informal support. The full implementation of Living Well may require us to review the balance between these two related indicators to ensure that the targets reflect the practice we want to achieve.

2.4 **Effectiveness of reablement**

2.4.1 Norfolk First Support (NFS) continues to support increasing numbers of people through reablement – at home and in Benjamin Court. The expansion of the service – agreed in April 2018 – has enabled more people to live at home by meeting the increase in referrals. NFS has responded to the widespread challenge of recruiting and retaining staff, and at the end of October there has been a significant improvement in the number of vacancies, only 8 fte reablement support worker vacancies (out of 225 ftes) across the county.

2.4.2 There are now 33 accommodation based reablement beds in five locations across Norfolk. Accommodation based reablement is for people who are well enough to leave hospital but need extra support before they can go home safely and for people who live

at home but need extra support to prevent them going into residential care. Overall, data shows that around 70% of people are reabled to return home.

2.4.3 The first nine beds in Benjamin Court were opened in February 2018, and a further nine have followed. Benjamin Court is the accommodation based reablement unit in Cromer run by NFS. The service aims to help people stay as independent as possible in their own homes and not need permanent residential care prematurely, giving better outcomes for people and saving Adult Social Services money. At the end of October, 137 people had been taken into Benjamin Court: 53% then returned to their home with home based reablement; 13% needed no further services; 18% needed to go back to hospital; 1.5% went into Housing With Care; 5% moved to permanent residential care; 5% went home with their existing home care provider.

2.5 Holding lists

2.5.1 Continued focus by the community care resilience team, and by locality teams has seen the drop in the number of unallocated cases on the holding list reduce again over this period. The reduction is due to a combination of targeted work by the resilience team – recognised through the Council's outstanding staff contribution awards (OSCA) for their work – and different approaches across locality teams. This includes the west locality which, through allocating a dedicated team, was able to eradicate its holding list for social work and occupational therapy. This was achieved within existing resources by re-shaping the mix of teams, creating a dedicated fixed-term team to pick up cases on the holding list. It is critical that teams move into the winter period with the minimum number of cases on their holding lists so they are able to respond effectively to people who need support either coming out of hospital, or to enable them to stay supported in their own homes. It is also critical to reduce holding lists to as low a level as possible as we move into the full implementation of Living Well.

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 The October publication of figures shows Norfolk Adult Social services as still above its stretching DToC target. (6.63% against the target of 3.4%). As reported to Committee last month, winter resilience has been strengthened through a range of measures including strengthened operational leadership for the three acute hospital discharges; brokering and care arranging to ensure swift processes and decision making; strengthened communication with care providers; expansion of reablement; a suite of prevention and early intervention services in communities.

2.6.3 Our tracking of November and December figures, whilst yet to be confirmed, suggests a slight improvement, principally through earlier engagement in decision making on the wards. At the time of writing, we are finalising actions with the NNUH to agree a shared approach to sign-off of delays, ensuring we are capturing the right reason and the right attribution, so that we can use the information to target improvements for people.

2.7 Reviews that lead to reduced services

2.7.1 We have re-calculated this measure as we realised we were not taking into account a tranche of reviews which were being recorded differently in the new LiquidLogic

System. For adults of working age this has demonstrated that we have been working at a more realistic higher rate of around 22% of reviews leading to a reduction in service. There is now a dedicated team in the learning disability service focusing on reviews, and since they began in May, they have completed 262 reviews. There are good examples of a reablement approach being successful; a recent example was of a 24 year old woman who had been in a specialist residential home since the age of 19. Her review showed increased level of independence and a drive to live more independently. Over a period of around nine months, she was able – with support from social workers and staff in her residential home – to gain skills and confidence to move into her own tenancy in supported living. Follow up shows her to be settled, enjoying new independence, accessing the community and having more family contact.

2.8 **Rate of permanent admissions**

2.8.1 The rate of permanent admissions for younger adults continues to remain largely steady, with small fluctuations month by month. The Learning Disability Strategy is moving forward on a number of fronts designed to increase the independence of people with learning disabilities by developing more choices for housing, and more opportunities to build independent living skills – cooking, managing money, building friendships. These changes are in progress but, as outlined earlier in this report, may take some time to impact on this particular indicator. Work is underway with LD teams to shape how a Living Well: 3 conversation model of working could be implemented across the service.

2.8.2 For older people, the measure captures a rolling annual average of the number of new admissions to permanent care. This takes out any short-term placements or temporary placements – something which we know is currently driving up our costs and activity. As we reported to Committee in October 2018, a recent sample study undertaken by the intelligence and analytics team within the Council has reconfirmed our understanding of the drivers of this demand. Dementia, a fall or the breakdown of existing support arrangements are still amongst the main/primary life changes that may lead to a residential placement. As a result of this we are beginning to see a shift between standard residential care and enhanced (dementia related) care.

2.8.3 We have followed up the original analysis work by a further close reading of the use of short-term beds. This was identified because of the number of people who, following a stay in a short-term bed, were going on to need permanent care – often in the same setting. The work highlighted the effectiveness of our short-term beds which were centrally managed and supported and used appropriately to avoid people making long-term decisions in a crisis. This was in contrast to 'spot purchased' short-term placements. As a result we have changed our process to ensure the best use of short-term and reablement beds across the system.

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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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.