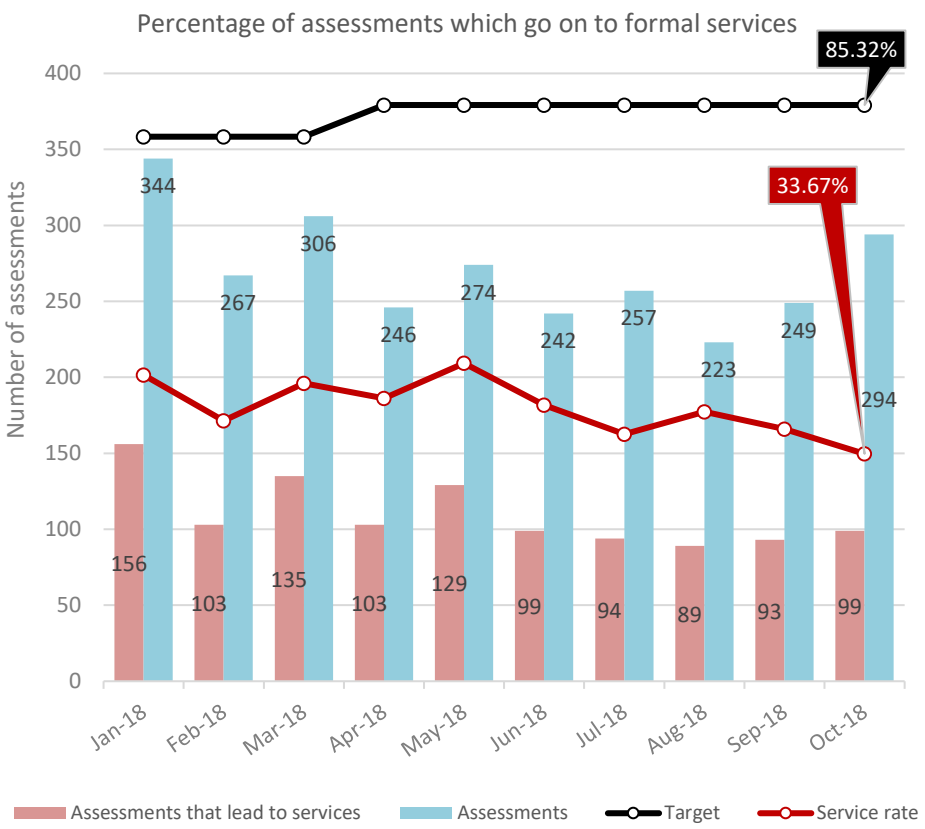
Percentage of assessments which go on to formal services

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?

- We have recognised that we need to review this target as part of the implementation of Living Well; 3 conversations. The target was based on demand management work carried out nationally and may not reflect the practice we are seeking to implement in Norfolk.
- The indicator is based on seeing a high 'conversion' rate from assessments to formal services, based on the presumption that all other forms of informal support would have been exhausted in earlier conversations.
- Further work with social care teams is needed to understand more about practice at the front line affecting this indicator. It may be that the outcome of assessments – whilst not a formal service – is still supporting people appropriately.
- Our more local performance data also shows differences between localities, possibly reflecting the extent to which 3 conversations is embedded.

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

- Continue to review and act on locality level data at monthly performance and finance board.
- 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

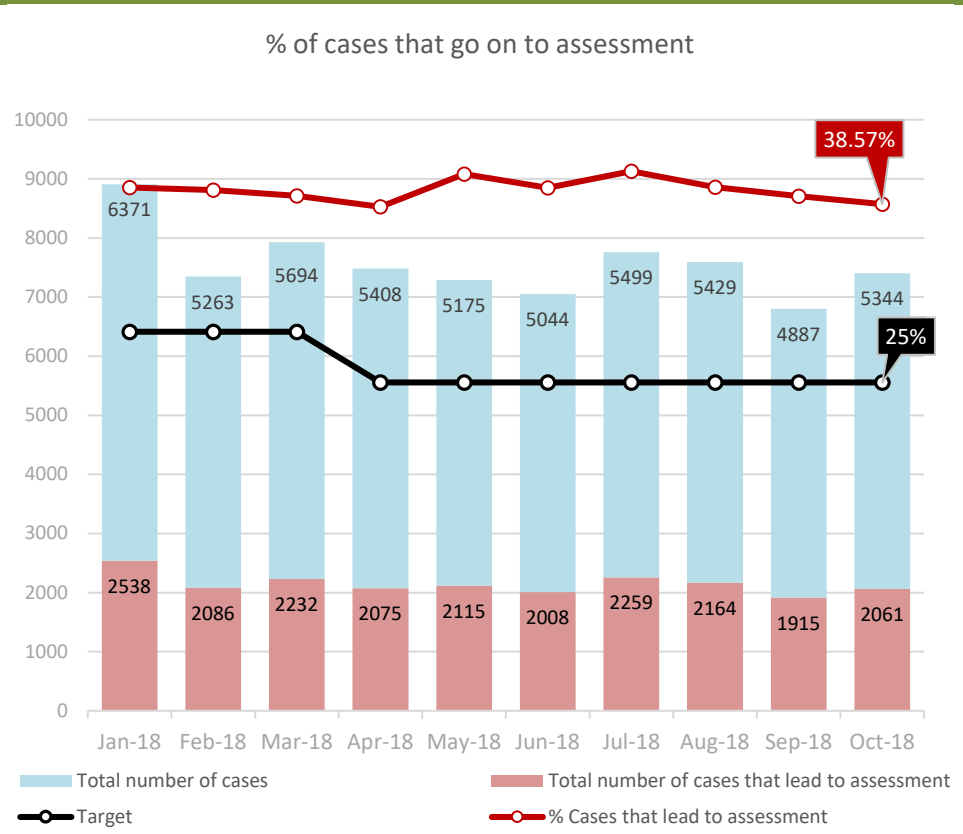
Responsible Officers	Lead: Craig Chalmers, Director of Community Social Work	Data: Intelligence and Analytics Service

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 assessment. 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?

- There are now a suite of prevention and early intervention approaches which should be contributing towards keeping people connected to their communities and self-help. Data continues to show an improvement against this measure, suggesting early intervention, prevention and strengths-based working are all directed towards supporting people to be independent, resilient and well. The challenge will be maintaining continued improvement against this target during more intensive months of activity
- Norfolk is piloting a county-wide offer for Social Prescribing which is funded through Norfolk County Council and Public Health for two years until April 2020. Locality models are all live and have been accepting referrals from 1st August 2018
- Data up until 31st October 2018 shows 1117 referrals across the county, with the South locality being the busiest (this is expected as these services has been running significantly longer). There are high number of referrals coming through GP practices but at the time of writing fewer referrals from NCC Customer Services Centre (however training only took place in November 2018). The primary referral reason data identified 'benefit advice', 'social isolation', 'mental health' and 'financial advice' as the highest needs.
- Living Well 3 conversation model will be implemented from January onwards and rolled out to all locality teams over a 3 month period.

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

- Thorough and effective implementation of Living Well: 3 conversations, ensuring that the fundamental drivers of the approach are not diluted by the widespread roll-out
- Effective targeting of preventive work, through a risk-stratification model
- Strengthened communication around prevention and early help services, so that teams maximise the benefits of the expanded offer.

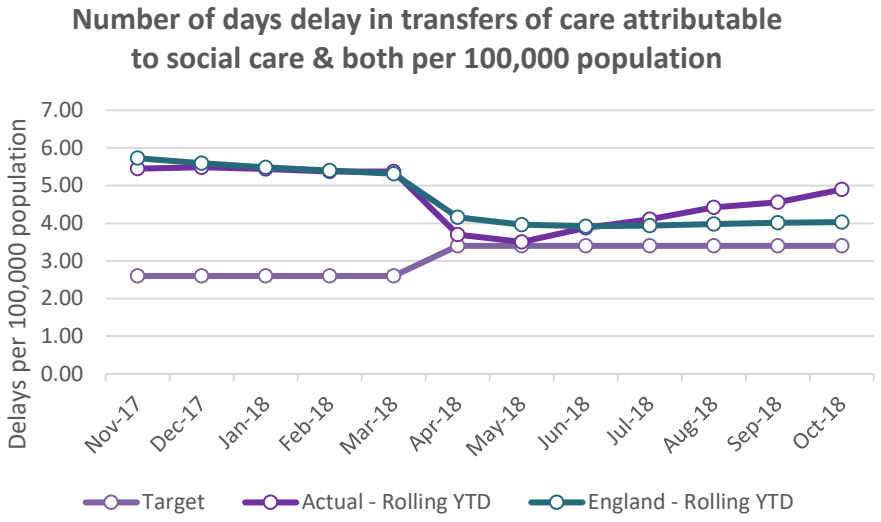
Responsible Officers	Lead: Craig Chalmers, Director of Community Social Work	Data: Intelligence and Analytics Service

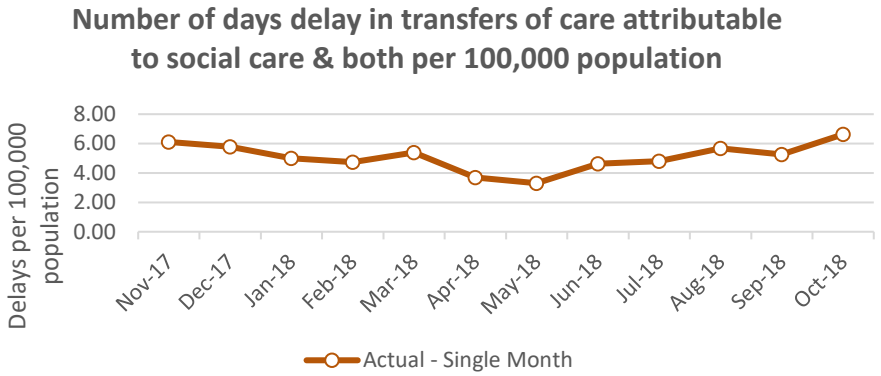
Delayed transfers of care

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 will be reviewed as part of Better Care Fund monitoring.

Performance





What explains current performance?

- There were 2709 total delayed days in October 2018, of which 1491 were attributable to Social Care. This is an increase from September 2018, where there were 1051 Social Care delays
- 55.0% of delays were attributable to Social Care, 41.4% were attributable to the NHS with 3.6% attributable to both NHS and Social Care.
- The main reason for Social Care delays was "Awaiting Residential Home Availability or Placement". This accounted for 768 delayed days (42.6% of all Social Care delays).
- The proportion of Social Care delays occurring in acute care was 63.9%.
- Delays were verified for NCHC, NSFT & 2 out of 4 out of county trusts only. NNUH, JPUH and QEH delays were agreed at ward level. NNUH published data was not as expected from local tracking and reporting. QEH delays were at expected levels. JPUH submitted delays as expected.
- New guidance jointly from NHS England and the Association of Directors of Adult Social Care has confirmed the need for local authorities to verify numbers attributed to them before they are submitted to the national system.
- At the time of writing, there are steps to strengthen sign-off since there have been discrepancies between numbers agreed locally, and those submitted and published nationally.

What will success look like?

Action required

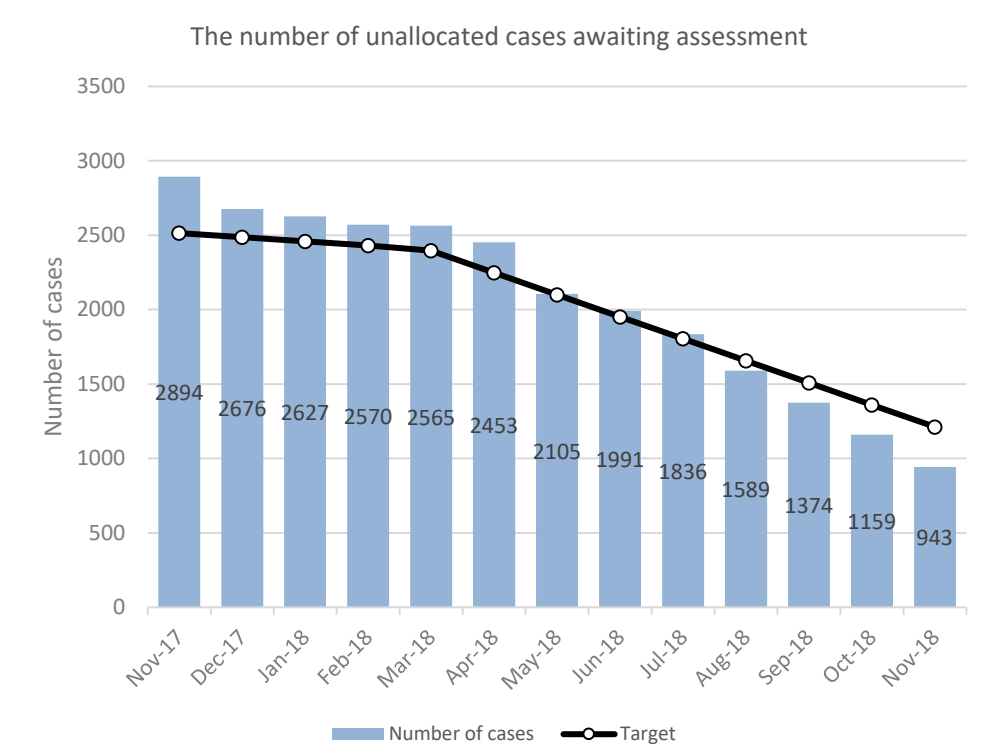
• Low, stable and below target, levels of delayed discharges from hospital care attributable to Adult Social Care, meaning people are able to access the care services they need in a timely manner once medically fit.	• Deliver against the winter resilience plan, including the use of additional monies • Strengthen and formalise the role of the Head of Hospital Discharge in the formal verification of numbers attributable to adult social services • Monitor, review and act on daily, weekly and monthly intelligence
Responsible Officers	Lead: Craig Chalmers, Director of Community Social Work and Lorrayne Barrett, Director of Community Health and Social Care. Data: Intelligence & Analytics

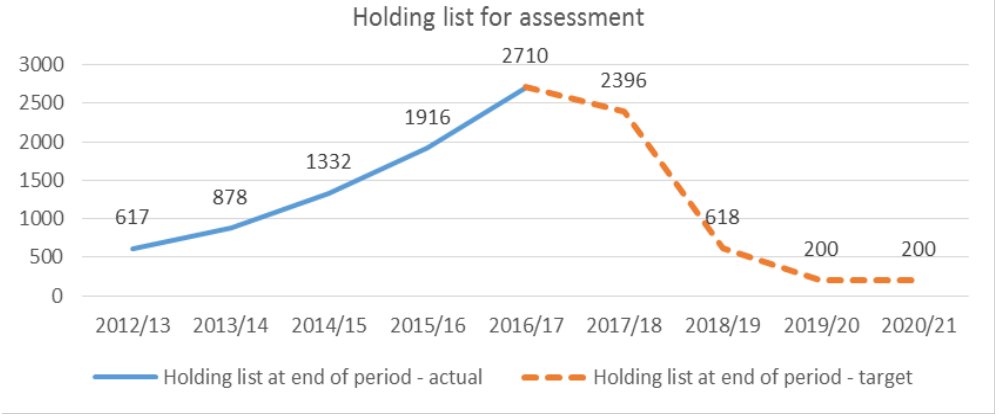
Holding List

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?

- Our 'holding' lists peaked over a year ago; since then they have been reducing
- A further reduction is reported over the last three months.
- This is a combination of different approaches by locality teams, and support across the county from the dedicated Community Care Resilience Team
- All workers are trained in strengths based practice, have an ethos in line with the Three Conversations and OT first, and have achieved their competencies to allocate low level equipment
- Early indications from Living Well innovation sites show that it is possible to minimise any holding list; the Community Care Resilience Team have been working in a three conversations model
- 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

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	• Celebrate success and share good practice and practical support for locality teams through cross-departmental learning opportunities • Continue to be innovative around recruitment – in the CCRT team, and in locality teams • Consider the best skillmix and set-up of teams as part of the implementation of Living Well: 3 conversations to sustain the decrease in the holding list.

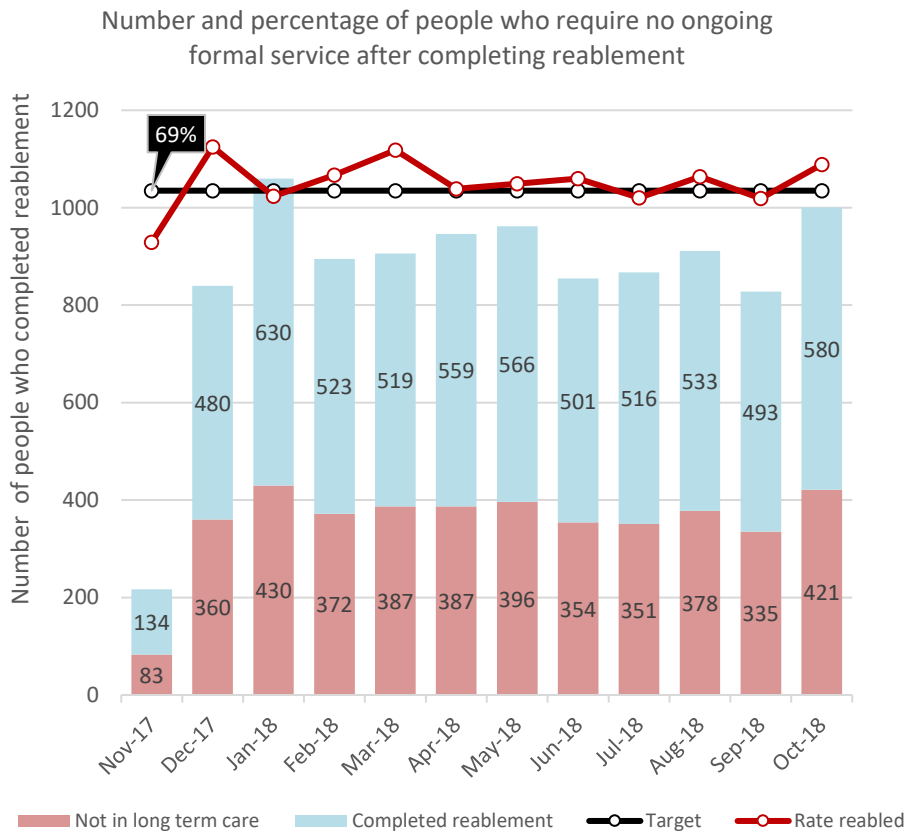
Responsible Officers	Lead: Lorrayne Barrett, Director of Adult Ops and Integration – NCC and NCHC	Data: Intelligence and Analytics Service

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

Why is this important?

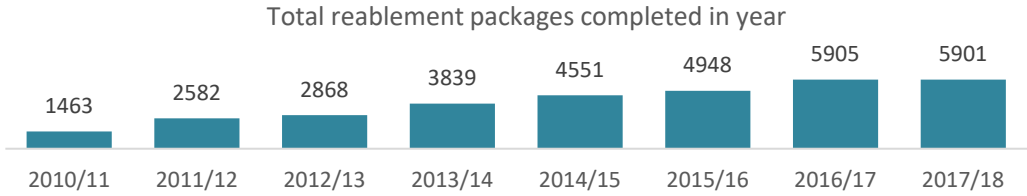
The Promoting Independence Strategy, as well as the Care Act 2014, requires that the council does all that it can to prevent or delay the need for formal or long-term care. Norfolk has provided reablement services for a number of years that help people get back on their feet after a crisis – to people leaving hospital or that have just experienced a change in their wellbeing that might require care. The success of this is important for two reasons. First, people that do not require long-term support because 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 LiquidLogic there is a gap in the data available for October, November & December 2017
- Unlike in Care First, it is not possible in LiquidLogic to see those that have been passed to NFR with long term conditions that will always require a service, such as those with palliative care needs. These people do not have the potential 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, which will have an impact on the overall figure, ie the percentage reabled will appear lower than when the data was taken from Care First
- A sister indicator to this one is the number of people who have been through reablement who remain at home after 91 days. This is currently proving difficult to extract from the new system; Norfolk performs strongly on this indicator – last year consistently at 93%.
- There is a challenge for NFS in recruiting and retaining staff, as with many providers in the Health and Social Care system. NFS has looked at what else it can do attract and retain staff. The initial changes are making a difference: 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
- The first nine beds in Benjamin Court were opened in February 2018. Benjamin Court is the accommodation based reablement unit in Cromer run by NFS. 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. 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 went home with home based reablement; 13% needed no further services; 18% needed to go back to

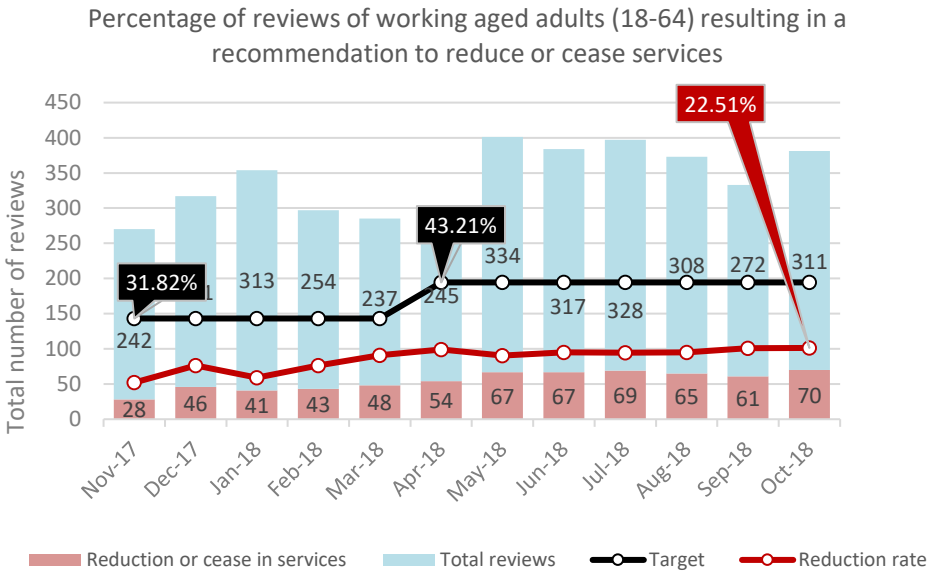
	hospital; 1.5% went into Housing with Care; 5% moved to permanent residential care; 5% went home with their existing home care provider.
What will success look like?	**Action required**
• The maximum proportion of people completing home based reablement not needing ongoing care • The business case agreed by NCC and the CCGs in April 2018 for additional investment in Norfolk First Support home based reablement was based on delivering 15% more referrals. It looks as if the service is delivering this, however the service is checking the data as it appears to not include all referrals. The cost of reablement services to be significantly less than the likely cost of long term care	• Continued monitoring of the impact of reablement, 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

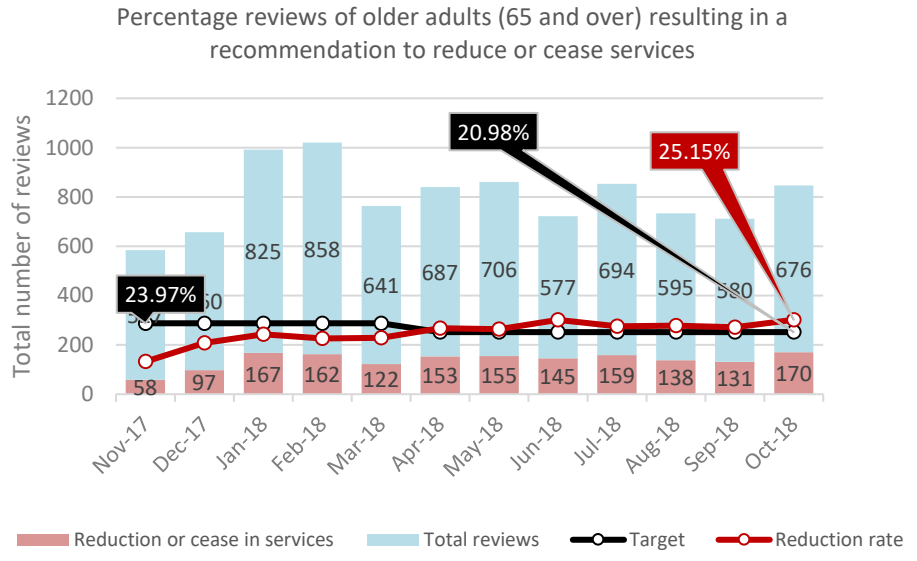
Percentage of reviews that lead to a recommendation to reduce or cease services

Why is this important?

People's needs change and, under the Care Act, a review of needs has to be undertaken if there is a change in need, or if not, an annual review is required. We are currently carrying a backlog of work, much of which is made up of reviews. We have two targets associated with this measure reflecting two key groups of people – people aged 18-64, and older people (65 plus)

Performance





What is the background to current performance?

- It is important for the service to address what is a backlog of reviews – particularly for people with learning disabilities
- To do this, we engaged a specialist agency; however, they withdrew from the work because they were unable to recruit to the levels and skills of staff required to complete complex case reviews to the required quality
- To mitigate this, we have established a temporary Assistant Practitioner team to take on more review work. We are strengthening the oversight and supervision of the temporary Assistant Practitioner team so they can cover the more complex work
- Since May 2018, this team has undertaken 262 reviews
- High quality reviews for people with complex needs can take considerable time, and making changes for people often requires intensive support for the individual, and close working with providers of care
- Work by the Community Care Resilience Team on the holding list has included undertaking reviews of older people. Combined with the work undertaken by locality teams, this has helped to keep this measure in line with our target

What will success look like?	Action required
• For older people, many of whom have entered service with long term and deteriorating health needs, there may be fewer opportunities for greater independence and reduced care packages. If long term care packages reduce in line with Promoting Independence and three Conversations principles, those remaining in long term care may have more complex needs – making the target more difficult to hit • For people aged 18-64, performance in this area has been relatively low – below that of reviews of people aged 65+ - and the proposed targets represent a significant change in practice and performance. This will be challenging	• Further analysis of why reviews lead to changes in service configuration • Additional capacity amongst practitioner teams to undertake targeted reviews of complex cases • Continued improved communication to front-line teams about the choices available for community based services

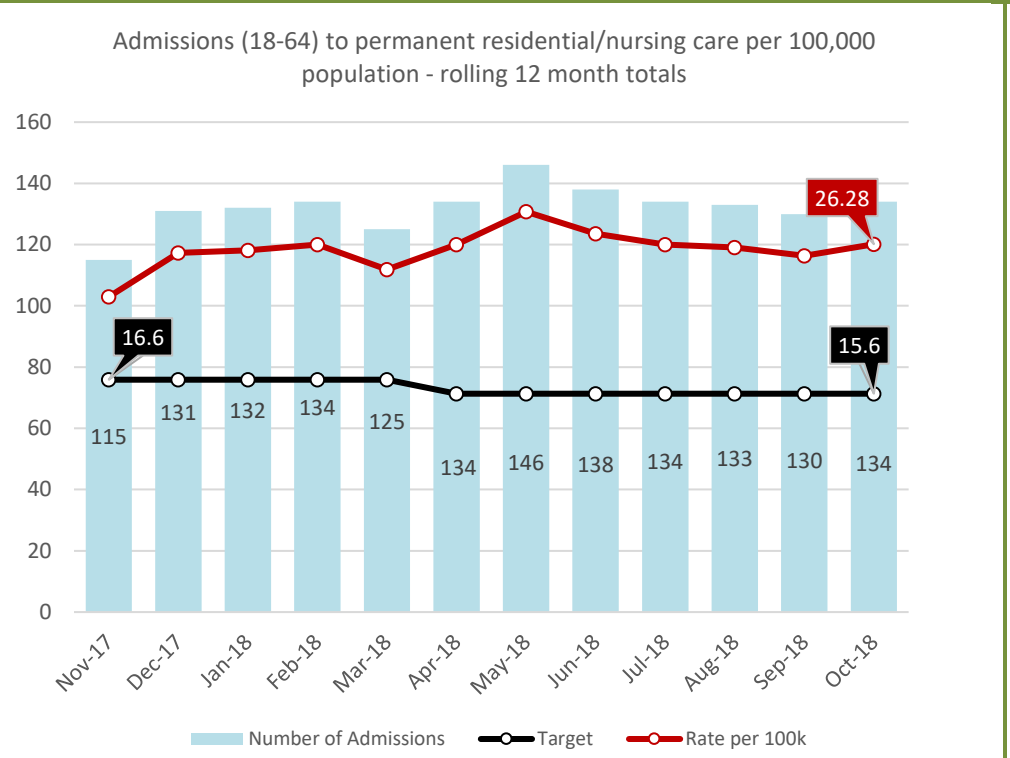
Responsible Officers	Lead: Craig Chalmers, Director of Community Social Work	Data: Intelligence and Analytics Service

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 but most recently, the rate has remained largely static
- Our priority focus has been to transform services for people with learning disabilities. This should see fewer people with learning disabilities in permanent residential and nursing care, because of wider choices of accommodation
- In addition, we are shifting to an enablement approach which helps people build independent living skills – cooking, managing money, building friendships
- These changes are in flight but may take some time to show impact on this indicator
- In parallel to this work, we have recognised the need to review the options that we have available for people with physical disabilities, and see what alternatives to residential care might be possible to develop

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

- Development of “enablement centres” model for service users aged 18-64 to be helped to develop skills for independent living
- Development of a Preparing for Adult Life services, across adults, children’s, education and health to support transition between children’s and adults services

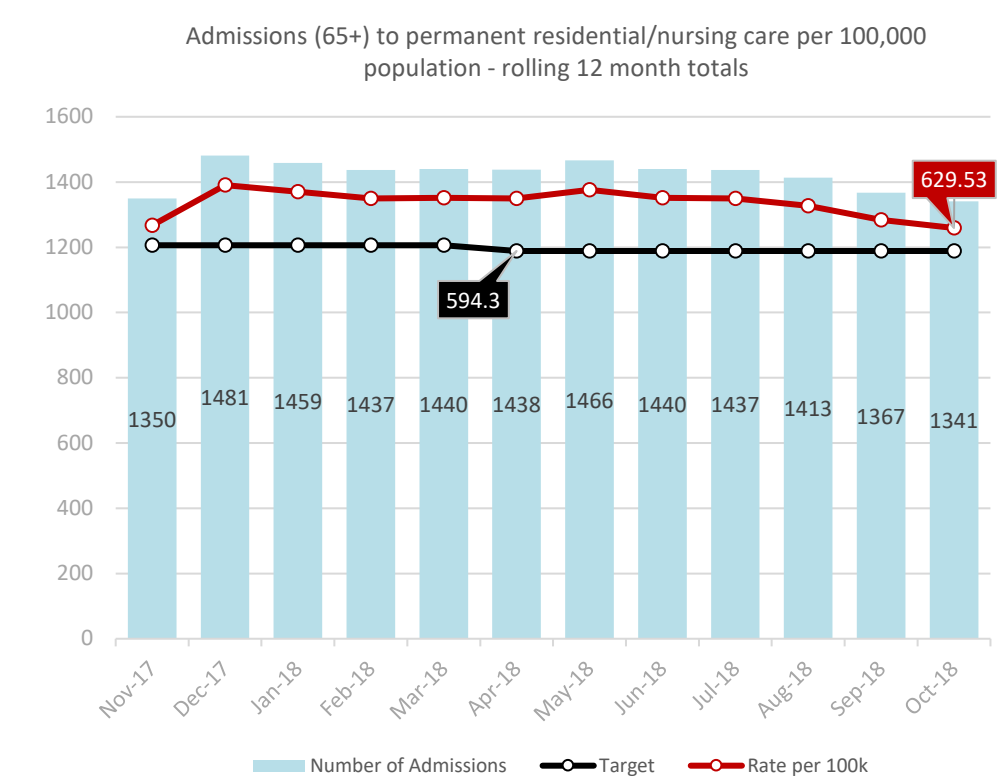
Responsible Officers	Lead: Craig Chalmers, Director of Community Social Work	Data: Intelligence and Analytics Service

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 three years the rate of admissions in Norfolk has decreased although monthly reporting of performance shows there has been a slowing down of improvement since March 2016
- The figures from Liquid Logic here need to be treated with some caution, given the trends we are seeing in high numbers of short and long-term placements as evidenced through finance and activity data
- The figures here – a rolling annual average – may look better than it is because of a known discrepancy in the transfer of information earlier in the year between old and new systems
- Work over the last three months has analysed our use of short-term placements – many of which were becoming by default permanent admissions. This is a trend which other areas of the country are reporting
- Our analysis identified 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

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 extra care accommodation options for those aged 65+ will assist people to continue live independently
- Measures to support the effective discharge of people from hospital as part of the Improved Better Care Fund programme
- Evaluation of new process to strengthen the appropriate use of short-term beds

Responsible Officers	Lead: Lorrayne Barrett, Director of Integrated Care, and Craig Chalmers, Director of Community Social Work	Data: Intelligence and Analytics Service