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Adult Social Services Overview and Scrutiny Panel

Date: **Tuesday 3 November 2009**

Time: **10.00am**

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

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

Membership

Mr D Callaby
Miss C Casimir
Mrs M Chapman-Allen
Baron Chenery of Horsbrugh
Mr T Garrod
Mr P Hardy
Mr D Harrison
Ms D Irving
Mr J Joyce
Mr M Kiddle-Morris
Mr S Little
Ms J Mickleburgh
Mr J Mooney
Mr J Perry-Warnes
Mr N Shaw
Ms A Thomas
Mr A Wright

Non Voting Cabinet Member

Mr D Harwood

Non Voting Deputy Cabinet Member

Mr B Long

For further details and general enquiries about this Agenda please contact the Committee Administrator:
Tim Shaw on 01603 222948
or email timothy.shaw@norfolk.gov.uk

A g e n d a

Officer

1 To receive apologies and details of any substitute members attending

2 Minutes **(Page)**

To confirm the minutes of the meeting of the Overview and Scrutiny Panel held on 8 September 2009.

3 Members to Declare any Interests

Please indicate whether the interest is a personal one only or one which is prejudicial. A declaration of a personal interest should indicate the nature of the interest and the agenda item to which it relates. In the case of a personal interest, the member may speak and vote on the matter. Please note that if you are exempt from declaring a personal interest because it arises solely from your position on a body to which you were nominated by the County Council or a body exercising functions of a public nature (e.g. another local authority), you need only declare your interest if and when you intend to speak on a matter.

If a prejudicial interest is declared, the member should withdraw from the room whilst the matter is discussed unless members of the public are allowed to make representations, give evidence or answer questions about the matter, in which case you may attend the meeting for that purpose. You must immediately leave the room when you have finished or the meeting decides you have finished, if earlier. **These declarations apply to all those members present, whether the member is part of the meeting, attending to speak as a local member on an item or simply observing the meeting from the public seating area.**

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

5 Public Question Time

15 minutes for questions from members of the public of which due notice has been given.

Please note that all questions must be received by 5pm on Thursday, 29 October 2009. Please submit your question(s) to the person named on the front of this agenda. For guidance on submitting public questions, please use the link below:

www.norfolk.gov.uk/cabinetquestions

6 Local Member Issues/Member Questions

Please note that all questions must be received by 5pm on Thursday, 29 October 2009. Please submit your question(s) to the person named on the front of this agenda.

7	**Cabinet Member Feedback**		**(Page)**

Items for Scrutiny

8	**Compliments and Complaints Annual Report 1 April 2008- 31 March 2009**	Lesley Smith	**(Page)**
9	**Further Update Report- CareForce and the Provision of Home Care Services in Norwich**	Terry Cotton	**(Page)**
10	**Scrutiny**	Mike Gleeson	**(Page)**

Overview Items

11	**2009-10 Revenue and Capital Budget Monitoring Report**	Janice Dane	**(Page)**
12	**Service and Budget Planning 2010-13**	Jeremy Bone	**(Page)**
13	**Future Commissioning Models – Community Care In-House Day Services**	Maureen Begley	**(Page)**
14	**Norfolk County Council's Response to the Green Paper "Shaping the Future of Care Together"**	Harold Bodmer	**(Page)**
15	**Adult Social Services Capacity and Winter Planning**	James Bullion	**(Page)**

16 Carers' Services Hilary Mills **(Page)**

Group Meetings

Conservative	**9.00am**	**Colman Room**
Liberal Democrats	**9.00am**	**Room 504**

Chris Walton
Head of Democratic Services

County Hall
Martineau Lane
Norwich
NR1 2DH

Date Agenda Published: 26 October 2009

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Adult Social Services Overview and Scrutiny Panel

Minutes of the Meeting held on 8 September 2009

Present:

Miss C Casimir
Baron Chenery of Horsbrugh
Mr T Garrod
Mr D Harrison
Ms D Irving (Chairman)
Mr J Joyce
Mr M Kiddle-Morris
Mr S Little
Ms J Mickleburgh
Mr J Mooney
Mr N Shaw
Mrs A Thomas

Also Present:

Mr D Harwood, Non-Voting Cabinet Member
Mr B Long, Non-Voting Deputy Cabinet Member

Substitute Members –

Mr R Bearman for Mr P Hardy
Mrs D Clarke for Mr D Callaby

Officers/Others:

Harold Bodmer, Director of Adult Social Services
James Bullion, Assistant Director, Community Care, Adult Social Services
Janice Dane, Head of Finance, Adult Social Services
Catherine McWalter, Procedures and Quality Assurance Manager, Adult Social Services
Stephen Rogers, Partnership Funds Manager, Adult Social Services
Hilary Mills, Head of Commissioning and Partnerships, Adult Social Services
Carol Lock, ICT Development Manager, Adult Social Services
Mike Gleeson, Head of Democratic Support, Adult Social Services
Terry Cotton, Quality Assurance Officer, Domiciliary Care, Adult Social Services
Colin Sewell, Head of Policy and Performance, Adult Social Services
John Holden, Quality Assurance Officer, Adult Social Services
Peter Bland, Quality Assurance Officer, Adult Social Services
Janice James, Senior Project Manager, Transformation Programme, Adult Social Services
Kelly O' Donavan, Safeguarding Adults Co-ordinator, Adult Social Services

1 Apologies for Absence

Apologies for absence were received from Mr D Callaby, Mrs M Chapman-Allen, Mr P Hardy, Mr J Perry-Warnes and Mr A Wright.

2 Minutes

The Minutes of the previous meeting held on 21 July 2009 were confirmed by the Committee and signed by the Chairman.

3 Declarations of Interest

Ms D Irving declared a personal interest as a volunteer for the Norfolk and Waveney Mental Health NHS Foundation Trust.

Mrs D Clarke declared a personal interest as she had links with the Griffon Area Partnership.

Mrs A Thomas declared a personal interest because she was the South Norfolk District Council representative on Saffron Housing Trust.

Michael Chenery of Horsbrugh declared a personal interest because he had links with the Norfolk and Waveney Mental Health NHS Foundation Trust and he was also a Mental Health Practitioner.

4 Items of Urgent Business

There were no items of urgent business.

5 Public Question Time

There were no public questions.

6 Cabinet Member Feedback – Exemptions to Standing Orders Learning Difficulties Pooled Fund

The annexed report by the Cabinet Member for Adult Social Services was received.

The Panel noted a report from the Cabinet Member which gave feedback from Cabinet regarding two exemptions to contract standing orders in relation to the Learning Difficulties Pooled Fund; both of these issues related to services that fell within the sphere of NHS Health Services.

ITEMS FOR SCRUTINY

7 Community Meals Review – Developing a Community Meals Plus Service

The annexed report by the Director of Adult Social Services was received.

The Panel received an update report about the Community Meals Review.

During the course of discussion, the following key points were made:

- It was noted that the proposed model for delivering a community meals plus service would minimise dependence on Adult Social Services. The model involved the Department entering into contracts with service providers to deliver community meals direct to people's homes.

- Increased efficiencies should come from better use of contracts.

- The Department would be supporting service users to use their personal budgets to make their own arrangements with service providers.

- A Community Meals Consultative Council would be established to oversee the consultation process and monitor progress. It would include representatives from the Third Sector and service users. The Panel asked for the Community Meals Consultative Council to also include Member representation from Norfolk County Council and for the consultation form for service users (at Appendix 1 to the report) to be simplified.

- It was noted that the proposed model would safeguard the health and safety needs of service users and meet the needs of those who wanted an element of social inclusion.

- There would continue to be other means of delivering meals to the homes of service users, such as the teleshopping service.

- The number of people using the community meals service had decreased significantly in recent years and this had increased the cost of providing the service.

- A further report was needed when the review of the contract arrangements and the remodelling of the resources for the service had been completed.

- The review of the contract arrangements was expected to take up to six months to complete. During that period service users would be consulted on how they wanted to see the community meals service developed.

- The ambition was to provide the same level of service across the whole of Norfolk.

The Panel endorsed the following principles:

(a) A Community Meals Consultative Council should be established to oversee the phases of work and implementation of the Community Meals Review. The Panel asked for the Consultative Council to include Member as well as service user and Third Sector representation and for the service user consultation form at Appendix 1 to the report to be simplified.

(b) Phases 1 and 2 of the Community Meals Review should commence.

(c) A further report should be presented to the Panel on the achievement of savings and the prioritisation of investment in a community development approach to community meals and luncheon services, as part of the Community Meals Plus

Service.

8 Norfolk Learning Difficulties Pooled Fund Services for People with a Learning Disability

The annexed report by the Director of Adult Social Services was received.

The Panel received a report that explained the measures that had been put in place to manage the current financial pressures faced by the Norfolk Learning Difficulties Pooled Fund.

The Cabinet Member said that the Department had already achieved savings of £2m and was on target to achieve its financial recovery plan within the next two years.

The Panel noted that the pooled fund for learning difficulties was subject to considerable financial pressure as a result of rising demand and cost pressures.

The Panel:

(a) Noted the report and supported the strategic approach that officers were taking to continue to deliver the "Valuing People Now" policy within the budget available.

(b) Set up a Working Group to look at the Learning Difficulties budget in more detail and agreed the terms of reference for the Working Group as set out at Appendix B to the report.

(c) Noted that the membership of the Working Group would be agreed at the next Scrutiny Leads meeting.

9 Social Enterprise

The annexed report by the Director of Adult Social Services was received.

The Panel received a report that updated Members about the ongoing work regarding the development of social enterprise initiatives.

It was noted that the post of Social Enterprise Development Manager had been advertised. The postholder would be expected to work closely with the Economic Development Unit at County Hall and external bodies. It was pointed out that there would be opportunities to work with new and existing organisations to create social firms that supported the personalisation agenda.

Members said that it was important to ensure that there were no negative impacts for social enterprises run by other bodies in Norfolk.

The Panel noted the update regarding the development of social enterprise, the Department's continuing commitment in this area and the development of a framework proposing the way forward for the expansion of social enterprise across Norfolk. The Panel wished to be involved in this ongoing work by receiving regular updates in the Members' Briefing and an update report on the outcome of the recruitment process for the post of Social Enterprise Development Manager. Members also asked to receive

a report from the newly appointed Social Enterprise Development Manager in due course.

10 CareFirst Post Go Live – Progress

The annexed report by the Director of Adult Social Services was received.

The Panel received a report that updated Members about the implementation of the Modern Social Care project and progress with the CareFirst system following its implementation in November 2007 in both Adult Social Services and Children's Services.

The Panel noted that CareFirst continued to be embedded within both Adult Social Services and Children's Services and that no technical difficulties were currently being experienced with the system. The pilot had been extended by one month to 30 September 2009 to enable lessons to be learned from the introduction of wireless internet.

The Panel asked for a further report in November 2008 by which time a departmental policy on data quality should be produced.

11 Scrutiny

The annexed report by the Director of Adult Social Services was received.

The Panel received a report that summarised the scrutiny work programme and gave an update on progress.

The Panel noted the current status of scrutiny items, noted the programme of scrutiny meetings set out in the report, and agreed that the Member Working Group on Social Enterprise should be held in abeyance.

OVERVIEW ITEMS

12 Strategic Model of Care – Progress and Implementation

The annexed report by the Director of Adult Social Services was received.

The Panel received a progress report on the implementation of the strategic model of care for residential and housing with care services in Norfolk, outlining the general approach to the development and implementation of a new strategy.

During discussion, the following key points were made:

- The implementation of the strategic model of care required detailed proposals to be drawn up on a locality basis for the purpose of consultation and approval. The model would not preclude work on other opportunities as they arose being undertaken alongside the locality approach, in order to maximise the pace of change.

- The details of the tendering process were being worked up by NPS and would be presented to Cabinet at the same time as the results of the consultation.

- The strategy included the opportunity for the leasehold purchase of housing with care units and this would contribute to the capital costs of the work. Members were concerned that leasehold purchasing arrangements could cause difficulties when people moved homes and asked for careful consideration to be given to this matter.

- Members said that the proposals should include energy efficiency savings measures, dedicated areas being set aside for storage and charging of mobility vehicles, and the provision of guest accommodation.

The Panel noted that it was proposed to start the development of the detailed proposals in King's Lynn and West Norfolk and, following a more detailed report in February 2010, to consult with the residents in the four homes in this area and their relatives and other stakeholders. The Panel also noted the intention to seek Cabinet's agreement to develop other individual opportunities in addition to changes in King's Lynn should they arise.

13 2009-10 Revenue and Capital Budget Monitoring Report

The annexed report by the Director of Adult Social Services was received.

The Panel noted that at the end of July 2009 (period 4) the forecast revenue out-turn position for the financial year 2009-10 was a balanced budget and that the capital programme variance was nil.

The Panel discussed the various actions that the Department was taking to manage identified pressures of £+8m for 2009-10 and noted that the Department had a financial recovery plan with additional savings identified of £8m giving a forecast position of £0m.

The Panel noted that the financial recovery plan was necessary because it was not proving possible to achieve the savings attributed to learning difficulties and to purchase of care within 2009-10.

It was pointed out that the breakdown of expenditure for the purchase of care was as follows:

Reducing the amount of top-up payments; £100,000
Reducing purchasing through spot contracts for homecare; £1m
Reducing the number of planned/transitional beds purchased through block arrangements; £0.5m
Demand management; £2.5m
Continuing healthcare assessments (change in criteria); £400,000
Review of number of out of county placements and other contract arrangements; £80,000.

It was pointed out that the agenda for personal budgets did not fit neatly with the use of block contracts and management action was being taken to make better use of existing block contracts and reduce the use of spot purchases.

The Panel noted the report.

14 Adult Social Services Performance

The annexed report by the Director of Adult Social Services was received.

The Panel received and noted an update report on the 2008/09 performance assessment of the Department that presented the current performance activity for 2009/10.

15 Update Report – CareForce and the Provision of Homecare Services in Norwich

The annexed report by the Director of Adult Social Services was received.

The Panel received a report that provided an update on the performance of CareForce and its provisions of homecare to service users in the Norwich locality. The Panel also received on the table an update of the CareForce satisfaction figures as at 7 September 2009.

It was noted that the Department continued to seek the return of forms from those service users who had not yet responded.

The Panel asked for a further update to be presented to their next meeting.

16 Safeguarding Practice Audit

The annexed report by the Director of Adult Social Services was received.

The Panel noted that the safeguarding practice audit was the first practice audit to be carried out by the Procedures and Quality Assurance Team.

The meeting concluded at 12.45pm

Chairman

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Report to Adult Social Services Overview and Scrutiny Panel

3 November 2009
Item No 7a

Cabinet Member Feedback

Report by the Cabinet Member for Adult Social Services

Summary
This report gives feedback to Overview and Scrutiny Panel from Cabinet regarding the implementation of the Strategic Model of Care for residential and housing with care services in Norfolk, outlining the general approach to development and implementation.

Report	Strategic Model of Care – Progress and Implementation
Date Considered by O&S Panel:	January 2008 July 2008 September 2008
Panel Comments:	The Panel noted that the Cabinet would be asked to agree to undertake a consultation process and a feasibility study on the provision of care homes. Those consulted would include home providers and the NHS. It was too early to consider with any degree of accuracy the impact of the proposed changes on each of the local communities involved. The Panel resolved to recommend to the Cabinet that they approve the approach identified leading to the production of commissioning plans The Panel supported further investigatory work on an approach to determine the process to commission the new services.
Date Considered by Cabinet:	September 2009
Cabinet Feedback:	The Cabinet agreed to: 1. The development of a detailed proposal relating to West Norfolk and to consider a proposal for consultation in February 2010. 2. The development of other individual opportunities in addition to those in West Norfolk.
Action Required:	Review Panel are asked to note the feedback from Cabinet

Officer Contact(s) Harold Bodmer on: 01603 223175

Background Document(s) N/A

Report to Adult Social Services Overview and Scrutiny Panel

3 November 2009
Item No 7b

Cabinet Member Feedback

Report by the Cabinet Member for Adult Social Services

Summary
This report gives feedback to Overview and Scrutiny Panel from Cabinet regarding developments in the Safeguarding Adults work in Adult Social Services.
In August 2008 Adult Social Services commissioned an independent audit of its Safeguarding Services. The report 'Safeguarding Adults in Norfolk – A review of the contribution of Adult Social Services' has now been submitted with 17 recommendations for change to the Safeguarding Adults structures and processes. The report also reflected and made positive comments regarding the unique, dedicated work in Safeguarding Adults in Norfolk
Cabinet approval was sought for the appointment of an Independent Chair for Safeguarding Board. This is in line with recent good practice guidance issued by the Department of Health.

Report	Update on the Developments within the Safeguarding Adults Structure
Date Considered by O&S Panel:	Not reported to Panel
Panel Comments:	N/A
Date Considered by Cabinet:	October 2009
Cabinet Feedback:	The Cabinet: 1. Approved the appointment of an Independent Chair 2. Noted the results of the audit and progress made.
Action Required:	Review Panel are asked to note the feedback from Cabinet

Officer Contact(s) Harold Bodmer on: 01603 223175

Background Document(s) N/A

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Report to Adult Social Services Overview and Scrutiny Panel

3 November 2009
Item No 7c

Cabinet Member Feedback

Report by the Cabinet Member for Adult Social Services

Summary
This report gives feedback to Overview and Scrutiny Panel from Cabinet regarding Norfolk's proposed Draft Joint Commissioning Strategy for Dementia. Cabinet was invited to approve the proposals for public consultation..

Report	Norfolk's Draft Joint Dementia Commissioning Strategy
Date Considered by O&S Panel:	Not reported to Panel
Panel Comments:	N/A
Date Considered by Cabinet:	October 2009
Cabinet Feedback:	The Cabinet agreed that the draft Norfolk Dementia Strategy be released for a three month period of public consultation from the beginning of November 2009.
Action Required:	Review Panel are asked to note the feedback from Cabinet

Officer Contact(s) Harold Bodmer on: 01603 223175

Background Document(s) N/A

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Report to Adult Social Services Overview and Scrutiny Panel
3 November 2009
Item No 8

Compliments and Complaints Annual Report 1 April 2008 – 31 March 2009

Report by the Director of Adult Social Services

Summary

There is a statutory requirement for the Local Authority to compile an annual report regarding complaints received under the Local Authorities' Social Services Complaints (England) Regulations 2006. This is the Annual Report relating to the year ending 31 March 2009. There is no statutory requirement to report on the compliments received, however members have requested this information, and it has therefore been included in the annual report to give a balanced view.

This report also outlines the Adult Social Services Department's commitment to learning from complaints and our involvement in 2008 in a National Pilot for an Integrated Approach to Dealing with Complaints across Health and Social Care, which actively supports the personalisation agenda.

The Panel is asked note the content of the report and have the opportunity to comment

1 Introduction

1.1 On 1 September 2006 the Government introduced revised complaint regulations, the Local Authorities' Social Services Complaints (England) Regulations 2006. The procedure under the Act has three stages.

Stage One - Local Resolution

Stage Two - Formal stage

Stage Three - Complaints Review Panel

1.2 All complaints are brought to the attention of the relevant Locality Manager and Assistant Director/Head of Service so that they can be used as a quality assurance monitor.

2 Statistics for year ended 31 March 2009

2.1 To pursue a complaint, a person, or their representative, has to be eligible, i.e. in receipt of a service from the department, or has been refused a service to which they think they are entitled. There were 586 recorded complaints last year, of these 581 were resolved at the local resolution stage. Someone who does not wish to make a complaint will be recorded as making a comment. The department received 2 comments in the last year, which are not included in the overall 586 complaint figures.

2.2 The response to a complaint involves the Compliments and Complaints Manager: -

- Acknowledging receipt
- Establishing the focus of the concerns, this often entails further correspondence/communication with the complainant
- Communicating the concerns to the relevant Locality

Manager/Head of Service and requesting a formal response and/or a concerted attempt at conciliation

- Monitoring the action taken, and identifying lessons for the Department

2.3 For 2008/2009, 586 complaints were returned. The comparison with the previous year is as follows.

Service	2007/08	2008/09
Community Care	230	298
Mental Health	15	13
Finance	20	44
Learning Difficulties	29	49
Community Care//Finance	1	0
Physical Disabilities	0	46
Carer	3	0
Sensory Support Unit	2	0
Careforce	0	136
Total	**301**	**586**

2.4 In addition to the 586 Complaints received by the Compliments and Complaints Manager, 24 complaints were received and dealt with by the Occupational Therapy Equipment and Adaptation Service [Norse Commercial Services] they also received 84 compliments.

2.5 In 2008/09 the Director received a total of 111 letters from Members of Parliament. In the 2007/8 there were 141. Procedurally an Assistant Director or Head of Service responds to these letters. The Compliments and Complaints Team records contact information, for monitoring purposes. These letters are not necessarily one's of complaint, but MPs enquiring about a range of services on behalf of their constituents.

2.6 This year there has been an overall increase of 285 complaints, compared to 2007/8. Of the 285, 136 were Careforce complaints in last 2 months of the annual report year. There would have therefore been an increase of 149 complaints without the Careforce dimension. There was double increase in Finance complaints. The majority of the complaints concerned delay in service users receiving notification of their assessed charge. The delay was caused by the referral process to Finance. This has now been addressed and the financial referral now goes direct to Finance rather than through CMSS. The Finance team have also carried out Locality team training on finance issues. The Disability Related Expense had also caused a small increase in complaints. At that time decisions were being taken by Locality Managers, this has now been centralised to Finance, to ensure consistency of practice.

2.7 Members will note that there were 46 physical disability complaints recorded this year, but nil last year. 2007/8 complaints from service users with a physical disability were included in the generic title of 'community care'. To reflect these complaints it was felt important to highlight them in their own right. This year complaints regarding leaning difficulty have also doubled, these complaints were in response to the scrutiny of extensive care packages, and the realignment of the some long established services, these were responded to by way of a review. The majority of complaints regarding services to older persons concerned the efficiency of the home care service [external ands internal providers i.e. impact of delay i.e. timeliness of medication; carrying out assessed tasks], and the review of the service to those who had in been in receipt of long standing home care packages to establish if they met the critical/substantial criteria. There were complaints regarding the quality of care provided by residential care homes, the majority of these concerned external providers. Concerns ranged to sufficient staff on duty; delay in responding to call bells, not automatically calling GP following fall/expression of illness.

3 Formal Investigations - Stage Two

3.1 If a complaint is not resolved at the local resolution stage, to the complainant's satisfaction, then it becomes registered and subject to a formal detailed investigation by an officer independent of the Locality Service complained about. This task was originally undertaken by a Locality or Team Manager (or equivalent). However, the ability to release, at very short notice, the required time commitment (on average 50 hours within a 28 day period), resulted in the necessity to recruit external investigators to complete investigations on a sessional basis, when a manager is not readily available. Part of their approval was to attend a training day the department commissioned from the Local Government Ombudsman. This training ensures the standards in the 2006 Regulations are met. This action has been taken to attempt to avoid the situation in other Authorities where the Local Government Ombudsman has found maladministration in undue delay in processing complaints, which has been deemed to cause an injustice, and the Local Government Ombudsman has directed local authorities to make a payment for the maladministration, which caused injustice.

3.2 Members may find it helpful to be aware that each year the Local Government Ombudsman's office requests information from Adult Social Services Compliments & Complaints Team to enable them to respond to the members of the public who have approached them. Since 1991, implementation of the first statutory complaints procedure, the Local Government Ombudsman has not 'formally' investigated any Norfolk Adult Social Services complaint.

3.3 For this year, 2008/09, there were 5 Stage Two complaints investigations initiated, last year there were four. These concerned four Adult Care complaints and one Learning Difficulties complaint. One of the Adult Care investigations is ongoing.

3.4 All recommendations made by an Investigating Officer are responded to by an Adjudicating Officer (Regulations). In Norfolk, as in other Local Authorities, this is an Assistant Director/Head of Service. The Adjudicating Officer writes to the complainant as part of the conclusion of the formal stage enclosing the investigating officer's report, and setting out how and by whom any recommendations will be carried forward, and advising them of their right to request a Complaints Review Panel, should they remain dissatisfied with the Adjudicating Officer's response. In 2008/09 all the complainants accepted the Adjudicating Officers' actions based on the reports findings and recommendations to the Department.

4 Complaints Review Panels - Stage Three

4.1 The role of the Complaints Review Panel is to make findings and recommendations to the Director of Adult Social Services, who then has 28 days in which to respond to a complainant advising of how the Panel's findings and recommendations will be taken forward.

4.2 The Compliments and Complaints Manager monitors, approximately three to four months following the closure of the complaint, that the findings and recommendations have been acted on. This also applies at the 'formal' stage if a complainant accepts the Investigating Officer's findings and recommendations and does not proceed to Panel.

4.3 In 2008/9 no Complaint Review Panels were held.

5 Compliments

5.1 The Compliments and Complaints Manager received 106 Compliments in 2008/09 compared with 97 compliments in 2007/08. The Compliments and Complaints Manager is aware that individual Homes, Day Centres and Locality office staff receive directly many grateful and satisfied comments from clients and/or their relatives.

6 Learning from Complaints

6.1 **Complaint**
Complaint from service user, who as part of the complaint they were pursuing, had accessed their records under DPA, about the language and tone of some internal emails.

6.2 **Action**

- Staff were reminded that language in all forms of written/typed communication must be reasoned and measured.

6.3 **Complaint**
There have been a number of complaints regarding home carers arriving late. This has been in regard to in-house, and external providers.

6.4 **Action**

- In-house home carers have already been provided with mobile phones. Through Learning and Development training to re-inforce the good practice of contacting home care co-ordinators when delayed, so that they can contact next client, make alternative arrangements. For external providers Professional and Quality Assurance Officers to continue to promote the good practice of timely communication.

6.5 **Complaint**

Service users followed financial advice that was in an outdated booklet that had been revised, however the revised booklet did not give an indication that it replaced all previous booklets.

6.6 **Action**

- All booklets should now have a sentence informing service users that it replaces any previous information.

7 Early Adopter – Making Experiences Count

7.1 In the last annual report to members it was reported that Norfolk County Council had been part of a national pilot to create an integrated approach to the management of complaints across Health and Social Care. This initiative was part of the personalisation agenda and was at an invitation from the Department of Health, with the agreement of the Director of Adult Social Services. Adult Social Services joined with Norfolk and Norwich University Hospital; NHS Norfolk and the East Anglian Ambulance Service to become an Early Adopter site (EA). This meant that Adult Social Services was a national pilot site for the integrated complaints legislation under the 'Making Experiences Count' proposals. The Early Adopter sites reported back to the Department of Health in October 2008. NCC and NHS Norfolk were invited by Department of Health in March 2009 to launch the new legislation the EA sites had helped shape, at a conference held in London.

7.2 Learning from complaints is a key Government driver and as part of Adult Social Services' response to this, and building on the work of the Early Adopter pilot, the Compliments and Complaints Team were relocated to be managed within the HR & Organisational Development Service directly linking to organisational learning and improved customer service. The new Regulations

7.3 The revised regulations are titled 'The Local Authority Social Services and National Health Service [England] Regulations 2009'. There will be 2 stages – 'Local Resolution' and 'Referral to the Local Government Ombudsman' Within the 'Local Resolution' stage Complaints Panels have been deleted, and it will be for Local Authorities to determine how with the complainant they wish their complaint to be resolved. The time scales have also been abandoned. The detail of the legislation will be reported to members in next year's annual report.

8 Section 17, Crime and Disorder Act, Implications

8.1 Any complaint received which implies a crime or disorder is immediately referred through to either the Disciplinary or Vulnerable Adult procedures.

9 Resource Implications

9.1 To be met within existing resources

10 Equality Impact Assessment

10.1 The Complaints process has been Equality Impact assessed as part of the achievement of Level 3 Generic Equality Standard

11 Risk Implications/Assessment

11.1 None

12 Conclusions

12.1 The number of complaints received represents approximately 1% of total service users.

12.2 Complaints have increased numerically in comparison to last year, overall there were 285 more complaints – this is due in part to the introduction of the Careforce home care service in Norwich, where 136 complaints [included in 285] were received in February and March 2009. In the general body of the complaints compared to last year there were 149 more complaints.

12.3 The department continues to improve its approach to the management and learning of complaints, creating a new learning log and reporting complaints to the Adult Social Services Department Performance Board.

12.4 The department continues to record compliments received and takes part in the Outstanding Award Scheme

13 Action Required

13.1 For the Panel to note the content of the paper and have the opportunity to comment

Officer Contact:
Mrs Lesley Smith, Compliments and Complaints Manager, Tel: 01603 222102.
Dr Kathy Bonney PhD, Head of HR & Organisational Development, Tel: 01603 228952

If you need this report in large print, audio, Braille, alternative format or in a different language please contact Mike Gleeson, Tel: 0344 800 8020, Minicom: 01603 223242, and we will do our best to help.

Report to Adult Social Services Overview and Scrutiny Panel
3 November 2009
Item No 9

Further Update report –

CareForce and the provision of Home Care Services in Norwich

Report by the Director of Adult Social Services

Summary
This report provides a further update to the Overview and Scrutiny Panel on the performance of CareForce and its provision of home care to service users in the Norwich locality.

Members are asked to note and comment upon:

The continuing improvements in the overall performance of CareForce

The outcomes of the work being undertaken by CareForce and Adult Social Services in respect of those service users, whilst unhappy with the quality of service, wish to remain with CareForce as long as the service improves and those service users who no longer wish to remain with CareForce

The ongoing work with CareForce to ensure the quality of the service is sustained

1 Background

1.1 At its meeting of 21 July the Overview and Scrutiny Panel received a report from the Director of Adult Social Services setting out the results of a survey commissioned by the Department and undertaken by Age Concern following high levels of complaints regarding the quality of care being provided.

1.2 The survey indicated that a large number of service users had experienced problems and that complaints primarily related to missed calls, late calls, constant changes in care worker and poor communication.

1.3 The Chief Executive of CareForce also attended the Panel in July and answered questions from Members. He gave the Panel assurances in respect of CareForce's performance improvements in Norwich.

1.4 The Panel agreed that the Director of Adult Social Services consult with service users of CareForce in Norwich to assess their satisfaction with the service being provided by it and to review service options.

1.5 At its meeting of 8 September the Panel received a further report updating CareForce's performance in Norwich and setting out the results of written consultation undertaken by the Department with over 500 CareForce service users in the Norwich locality.

1.6 Just under 250 service users replied to the letter. The Panel noted that 33 service users were not happy with the service but were prepared to remain with CareForce as long as recent improvements were sustained and 49 service users had indicated a wish to move to another home care provider.

2 Monitoring the performance of CareForce

2.1 Officers from the Department's Purchasing and Quality Assurance Team and the Norwich Locality Social Work Management Team continue to meet with Senior and Operational Managers from CareForce, on a weekly basis to review CareForce's performance.

2.2 Its performance is reviewed against a number of key indicators, including missed and late visits, actual hours and visits provided, complaints received and resolved, staff training and development, recruitment, invoicing, equality and diversity issues and communication. Overall, CareForce's performance against these indicators continues to improve.

2.3 It is worth noting that, on average each week CareForce Care Workers provide almost 2,800 hours of care to over 520 service users and make just under 5,400 calls to service user's homes.

3 Departmental Letter to service users of CareForce in Norwich

3.1 As was reported to the last Overview and Scrutiny Panel, following the Age Concern survey conducted earlier in the year, which showed high levels of dis-satisfaction with CareForce, the Department wrote to all the Norwich service users asking if they were satisfied with the service provided by CareForce and if not whether they wished to remain CareForce. Those who wished to move would then be assessed by Adult Social Services to consider other service options, including direct payments, an individual budget or a move to another home care provider operating within Norwich.

3.2 At the time of the meeting of the September Panel 49 service users out of 250 who replied indicated a wish to move from CareForce.

3.3 Two Assistant Practitioners from the Norwich Locality Team were assigned to review all 49 service users who wanted to move. To date, 18 Service Users have moved from CareForce with the overall majority having moved to another home care provider in Norwich. 3 service users ceased their care. 7 service users are still being followed up.

3.4 Of those original 49, 21 to date have now decided to remain with CareForce as long as recent improvements in the service continue.

3.5 233 service users did not respond to the Departmental Letter. Between CareForce and the Norwich Locality Team those service users who were identified as vulnerable or did not have any other relatives/informal carers were contacted to establish whether they were satisfied with the service provided by CareForce. 170 commented that they wished to remain with CareForce as the service had improved. 6 indicated a wish to move from CareForce. Alternative service options are now being considered for those service users. 38 service users are still being followed up by Social Work staff from the Norwich Locality Team.

3.6 12 service users are now in residential care and 7 ceased their care package.

3.7 It is worth noting, as was reported to the last Overview and Scrutiny Panel, that many of the 170 service users who are happy to remain made compliments in respect of the calibre and commitment of their care workers. The overwhelming majority of complaints related to poor co-ordination from the office, lack of continuity of care worker and poor communication. All of these issues have been dealt with at the weekly performance review meeting.

4. New referrals to CareForce

4.1. As was reported, the Department agreed to a request from CareForce made on the 21 July that no new referrals be made for a period of 4 weeks. This was to allow for a period of consolidation, particularly in relation to the recruitment of permanent staff (this reducing the requirement for agency staff) and to concentrate on improvements that CareForce was determined to make.

4.2 The Department received a further request for a another 4 week extension on the 29 August 2009. After very careful consideration the Department agreed to this request but made it clear to CareForce that if it was unable to commence new referrals on 28 September then the Department would reconsider it contractual relationship with CareForce. During this time CareForce did accept 31 new referrals as there was pressing need identified

4.3 As from 28 September CareForce has accepted 66 new referrals. An update will be provided at this meeting of the Panel.

5 Equality Impact Assessment

5.1 There are no direct equality issues in this report.

6 Conclusion

6.1 The performance of CareForce continues to improve. Of 537 service users, 24 have or wish to move from CareForce. However, the Department is not complacent and it's Officers will continue to work closely with CareForce to ensure that a good quality service is maintained and enhanced.

7 Action Required

7.1 Members are asked to note and comment about:

- The continuing improvements in the overall performance of CareForce
- The outcomes of the work being undertaken by CareForce and Adult Social Services in respect of those service users, whilst unhappy with the quality of service, wish to remain with CareForce as long as the service improves and those service users who no longer wish to remain with CareForce
- The ongoing work with CareForce to ensure the quality of the service is sustained

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Quality Assurance Officer,
Domiciliary Care

Report to the Adult Social Services Overview and Scrutiny Panel
November 2009
Item No 10

Scrutiny

Report by the Director of Adult Social Services

Summary.
This report summarises the Scrutiny Work Programme, and updates the Panel on progress made

The Panel is invited to:

- Note the dates of future spokespersons meetings.
- Comment on the progress of the programme

1 Scrutiny Work Programme

1.1 **Aids, Adaptations and Equipment Services** - This item was agreed by the Panel in May 2008, and a report was presented in January 2009. Further updates will be scheduled.

Progress of the Social Enterprise Company – Whole Food Planet - This item was agreed by the Panel in May 2008, and a report was presented in November 2008. Further updates will be scheduled.

1.2 Three updates are presented at this Panel:

CareForce – Further update.

Complaints – Annual report

Carers Services.

1.3 **Member Working Groups**

Two Member Working Groups are currently established:

Proposals for the quality monitoring of the Home Support Service –Constitution of the group (post elections) was agreed at July's Panel.

Development of the Learning Difficulty Service - the Panel agreed this item in September 2009.

2 Spokespersons Meetings

2.1 Spokespersons meetings are planned for 2009/10:

- 25 November 2009
- 27 January 2010
- 7 April 2010.

All at 9.30 am in room 610

3 Section 17 – Crime and Disorder Act

3.1 The crime and disorder implications of the various scrutiny topics will be considered when the scrutiny takes place.

4 Equality Impact Assessment

4.1 This report is not directly relevant to equality, in that it is not making proposals that will have a direct impact on equality of access or outcomes for diverse groups.

5 Action Required

5.1 The Panel is invited to:

- Note the dates of future spokespersons meetings.
- Comment on the progress of the programme

Officer Contact

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If you need this report in large print, audio, Braille, alternative format or in a different language please contact Lesley Spicer, Tel: 0344 800 8020, Minicom: 01603 223242, and we will do our best to help.

Report to Adult Social Services Overview and Scrutiny Panel

3 November 2009

Item No 11

2009-10 Revenue and Capital Budget Monitoring Report

Report by the Director of Adult Social Services

Summary

As at the end of period six (September) the forecast revenue outturn position for the financial year 2009-10 is a balanced budget. Adult Social Services has identified pressures of £+7.985m for 2009-10 at the end of period six. The department is taking various actions to manage these pressures and has a financial recovery plan with additional savings identified of £-7.985m giving a forecast position at the year end of £0m.

The financial recovery plan is necessary because it is not proving possible to achieve all of the £-6.856m of savings attributed to Learning Difficulties and the Demand Management savings of £-3.922m attributed to Purchase of Care within the 2009-10 budget.

We are continually reviewing and monitoring the financial recovery plan, and we are concerned that we are not achieving the level of additional savings we would expect at this stage of the financial year in order to deliver a balanced budget. There are significant risks to delivering all £-7.985m of the savings. We will have a more accurate position available in December and we will provide a briefing note for Members of this Panel in December to provide them with the latest forecast.

There are considerable risks to the delivery of services in trying to achieve these savings.

At this point in the financial year slippage of £-0.260m has been identified on the capital programme. If there is slippage on a capital scheme at the year-end, ie the work has not been completed within the financial year or there are outstanding invoices to be paid, the money will be carried forward to 2010-11.

1 Introduction

1.1 This is the second budget monitoring report to Adult Social Services Overview and Scrutiny Panel for 2009-10.

2 Revenue Budget

2.1 The table below shows the forecast out-turn position by division of service:

R4R4R4Division of Service	Net Revenue Budget £m	Forecast Out-turn £m	Forecast +Over/- Underspend £m	Forecast +Over/- Underspend as % of budget %	Change in forecast from period four £m
Director and Finance	+2.401	-0.314	-2.715	-113.1	-0.075
Commissioning and Transformation	+10.834	+10.984	+0.150	+3.2	-0.181
Human Resources, Training and Organisational Development	+4.892	+4.466	-0.426	-8.7	-0.122
Community Care - Locality Managed Services	+105.848	+113.599	+7.751	+7.3	+0.464
Service Development	+18.766	+18.364	-0.402	-2.1	-0.323
Mental Health and Drug and Alcohol	+18.024	+17.728	-0.296	+1.6	-0.363
Supporting People	+0.495	+0.495	0	0	0
Total, excluding Learning Difficulties	**+161.260**	**+165.322**	**+4.062**	**+2.5**	**-0.600**
Learning Difficulties (Adult Social Services)	+51.473	+55.396	+3.923	+7.6	+0.585
Total, including Learning Difficulties	**+212.733**	**+220.718**	**+7.985**	**+3.8**	**-0.015**
Less: Financial Recovery Plan		**-7.985**	**-7.985**		**0**
Total	**+212.733**	**+212.733**	**0**	**0**	**0**

2.2 Within each division of service, the main reasons for the variances between the budget and the forecast position are set out below.

Director and Finance £-2.715m forecast underspend (budget £+2.401m)

2.3 The forecast outturn is analysed below:

Area	Budget £m	Forecast +Over/ -Under spend £m	Forecast +Over/- Under spend as % of the budget	Analysis
Finance Management	+3.333	-2.783	-83.5	Underspend due to contingency provision to offset various pressures elsewhere within the department.
Other	-0.932	+0.068	+7.3	Included in this is the recharge of overheads to the Learning Difficulties service.
Total	**+2.401**	**-2.715**	**-113.1**	

Commissioning and Transformation £+0.150m forecast overspend (budget £+10.834m)

2.4 The analysis of the forecast outturn is:

Area	Budget £m	Forecast +Over/ -Under spend £m	Forecast +Over/- Under spend as % of the budget	Analysis
Logistics - Building and Supplies, Building Other and Transport	+6.450	+0.178	+2.8	Forecast overspend due to changes in office accommodation during the year.
Other	+4.384	-0.028	-0.6	
Total	**+10.834**	**+0.150**	**+1.4**	

Human Resources, Training and Organisational Development £-0.426 underspend (budget £+4.892m)

2.5 The analysis of the forecast outturn is:

Area	Budget £m	Forecast +Over/ -Under spend £m	Forecast +Over/- Under spend as % of the budget	Analysis
Personnel	+1.581	-0.260	-16.4	Underspend due to a reduction in spend on recruitment and advertising.
Training and Other	+3.311	-0.166	-5.0	There is less spending forecast than originally anticipated on training.
Total	**+4.892**	**-0.426**	**-8.7**	

Locality Managed Community Care £+7.751m overspend (budget £+105.848m)

2.6 The forecast outturn position on Locality Managed Services is analysed in the following table:

Area	Budget £m	Forecast +Over/ -Under spend £m	Forecast +Over/- Under spend as % of the budget	Analysis
Purchase of Care - Older People	+46.513	+4.592	+9.9	Purchase of Care is the budget for the purchase of care from the independent sector, ie residential care, nursing care, domiciliary care, day care and supported living. As part of the 2009-10 budget the department had to include a saving of £-3.922m in Purchase of Care, representing a reduction in the number of packages we can provide. It is proving difficult to achieve these savings. The number of older people in residential and nursing placements at August 2009 was 3,023 compared to 2,997 at August 2008.
Purchase of Care - People with Physical	+13.193	+0.279	+2.1	There are some expensive packages pushing up expenditure for this group of service users.

Disabilities				This is caused by higher unit costs in this market, primarily as a result of demand exceeding supply. This is a national issue for this market and is not confined to Norfolk. The Department, in conjunction with Saffron Housing, is developing a Housing With Care scheme for people with physical disabilities. The department is also investigating the possibility of other housing schemes in the west of the county. The Department is rolling out the use of the cost analysis model as a tool for negotiation. The cost analysis model has been drawn up in conjunction with the regional Centre of Excellence using regional information, to understand what drives the costs of different packages. It enables the contracts team to compare a provider's proposed charge for a care package against a fair rate.
In-House Home Care - Older people and people with Physical Disabilities	+12.056	-0.161	+1.3	The start of the new home care contracts with external providers in February 2009 and the additional hours being provided externally, following the retendering exercise, has meant that there are now savings being made within the in-house home care service.
In-House Homes for Older People, Locality Managers, Housing With Care and Day Centres for Older People	+20.808	+1.351	+6.5	The pressure on this budget is mainly due to an increase in the staffing costs for In-House In-House Homes for Older People (£+1.089m overspend), including meeting CSCI (Commission for Social Care Inspection) requirements.
Hired Transport for Older People and people with Physical Disabilities	+1.350	+0.302	+22.4	Demand for these services continues to increase. There is a transport efficiency project in place looking at issues such as the efficient and effective use of vehicles and journeys made, which should result in savings to the department.

Other	+11.927	+1.388	+11.6	This overspend reflects that all of the £-1.562m efficiency savings from the review of Assessment and Care Management will not be realised this year.
Total	**+105.847**	**+7.751**	**+7.3**	

Service Development £-0.402m underspend (budget £+18.766m)

2.7 The forecast out-tum position for Service Development is as follows:

Area	**Budget** **£m**	**Forecast +Over/ -Under spend** **£m**	**Forecast +Over/- Under spend as % of the budget**	**Analysis**
Service Development	+18.766	-0.402	-2.1	Forecast overspends on areas such as the cost of equipment (aids and adaptations) and Norfolk Industries for the Blind are offset by underspends in other areas.

Mental Health and Drug and Alcohol £-0.296m underspend (budget £+18.024m)

2.8 The forecast outturn position for Mental Health and Drug and Alcohol is:

Area	**Budget** **£m**	**Forecast +Over/ Under spend** **£m**	**Forecast +Over/- Under spend as % of the budget**	**Analysis**
Purchase of Care - People with Mental Health problems and Drug and Alcohol.	+8.059	+0.082	+1.0	This includes £0.250m for cases being paid by Health as continuing care which may become NCC funded during this financial year.
Other Mental Health and Drug and Alcohol services	+9.965	-0.378	-3.8	This is largely due to a forecast underspend on Service Level Agreements resulting from agreements that have been ended.
Total	**+18.024**	**-0.296**	**-1.6**	

Learning Difficulties Pooled Fund £+3.923m (budget £+51.473 m)

2.9 The forecast outturn position is analysed below:

Area	Budget £m	Forecast +Over/ -Under spend £m	Forecast +Over/- Under spend as % of the budget	Analysis
Forecast -	+51.473	+5.313	+10.3	Care and Assessment (£+0.033m), Homes (£+0.071m), Day Care (£+0.108m), County Management (£-0.051m), Community Support Team (£+0.026m), Hired Transport (£+0.042m), In-House Home Care (£-0.003m), Purchase of Care (£+4.823m), Service Agreements (£0m) and Other (£+0.264m). There are pressures, particularly within the Purchase of Care budget in this area. As part of the 2009-10 budget the department had to include savings of £-6.856m in Learning Difficulties to ensure it operated within the financial constraints of the 5% growth agreed by the Learning Difficulties Pooled Fund Partners. It was highlighted that there are risks around achieving savings at this level given the pressure in demographic growth and increased need facing this area and it is proving difficult to achieve these savings.
Less: Priority Based Budgeting savings		-1.390		These are projected further savings from the Priority Based Budgeting exercise that are expected to be achieved in 2009-10, but have not been realised yet and are not therefore included in the budget monitoring above.
	+51.473	**+3.923**	**+7.6**	

Adult Social Services is a commissioning partner in the Learning Difficulties Pooled Fund, in partnership with NHS Norfolk and NHS Great Yarmouth and Waveney. This is an agreement between the County Council, NHS Norfolk and NHS Great Yarmouth and Waveney to provide a learning difficulties service in Norfolk. The original agreement came into effect on 1April 2002 and was with West Norfolk Primary Care Trust and Norfolk Health Authority. It has since been updated to reflect the abolition of the Health Authority and the reorganisation of the Primary Care Trusts.

Adult Social Services is the main provider of learning difficulties services to the Pooled Fund through the Norfolk Learning Difficulties Services (NLDS).

Adult Social Services carried out a Priority Based Budgeting (PBB) exercise in 2008-9 on its Learning Difficulties budget, in conjunction with NHS Norfolk and supported by external consultants. The purpose was to ensure that the pooled budget for Learning Difficulty services is used to maximum effect to support priorities. This helped to inform the budget setting process for 2009-10 and the savings identified are being implemented.

The Learning Difficulties Pooled Fund Commissioners have agreed a Medium Term Plan to ensure that annual growth for Learning Difficulties is managed within an affordable partner contribution uplift for 2009-10 and 2010-11.

Supporting People £0m (budget £+16.832m)

2.10 Supporting People is a government programme to provide good quality housing support to help people live as independently as possible. Housing support helps people set up or maintain their own homes. This can include activities and services such as: sheltered housing warden support; help to claim benefits or manage debts; help to move into accommodation with less support; refuge accommodation; help to identify and use other services. In Norfolk, Norfolk County Council manages the programme in partnership with seven District Councils, Health, the Probation Service, housing support organisations and people who use these services.

2.11 Norfolk County Council receives two grants for Supporting People: in 2009-10, a Programme Grant of £+16.337m to pay for the services and an Administration Grant of £+0.495m to pay for the management of the programme. Supporting People had a cumulative underspend of £4.475m at the end of 2008-9 on the Programme Grant which has been carried forward into 2009-10 and is fully committed. The underspend has accumulated over time to offset the considerable ongoing uncertainty about the future funding of the programme nationally and locally.

3	**Financial Recovery Plan**
3.1	The department has an action plan of £-7.985m for the remainder of the financial year which should result in a balanced position at the year end. The Financial Recovery Plan is shown below:

Action	**Amount £m**
Social Care Reform grant income utilised to maximum effect.	-1.000
Vacancy management of posts – temporary, agency, permanent and	-0.985

Action	Amount £m
increased hours – and a review of all current temporary posts.	
Purchase of Care - Reducing the amount of top up payments; - Reducing purchasing through spot contracts for home care; - Reducing the number of planning/transitional beds purchased through block arrangements; - Demand management; - Continuing Health Care Assessments; - Review of number of Out of County Placements and other contract arrangements.	-4.624
Review current placements with Children's Services where people will soon be moving to Adult Social Services.	-0.100
Reduction in expenditure on Mental Health Purchase of Care.	-0.476
Reduction in Learning Difficulties staff costs.	-0.200
Targeted reduction in staff travel for each team.	-0.200
Increase income to In-House homes from Other Local Authorities and Self-funders	-0.400
Total	**-7.985**

4 Capital Programme

4.1 The capital programme is summarised in Appendix One. Details of the budget and the outturn are given for each scheme. The capital programme for 2009-10 includes £5.512m of capital monies held on behalf of other organisations. There is £1.118m of funds NCC that is holding on behalf of Health following the resettlement of people with Learning Difficulties from Little Plumstead and which should be released to Wherry Housing; however negotiations are still ongoing between the legal representatives for Health and Wherry Housing. There is also £4.394m of grant funding to be handed over to Registered Social Landlords to help fund the purchase and conversion of accommodation suited to the needs of people with Learning Difficulties undergoing resettlement from the NHS Campus Closure. The funding was receipted from NHS Norfolk ahead of the scheduled phases of completion.

At this point in the financial year slippage of £-0.260m has been identified. If there is slippage on a capital scheme at the year-end, ie the work has not been completed within the financial year or there are outstanding invoices to be paid, the money will be carried forward to 2010-11.

Capital Programme	2009-10 Budget £m	2009-10 Outturn £m
Total	11.218	10.959

5 Bad Debt Fund

5.1 The Bad Debt Fund represents money set aside by Adult Social Services to pay for debts that, after lengthy investigation and, in many cases, legal action, are unlikely to be paid by the debtor. The department has a statutory duty to provide assessed care regardless of whether a person pays their contribution towards the cost of their care. The level of the Fund is based on the overall level and nature of debts owed to the Department and the forecast position is set out below.

Bad Debt Fund	**£m**
Fund as at 31 March 2009	+0.165
Plus: 2009-10 budget contribution	+0.250
Sub-total	+0.415
Less forecast write-offs during the financial year	-0.415
Balance as at 31 March 2010	0

5.2 More detail on the debt position at the end of September can be found in Appendix Two.

6 Equality Impact Assessment

5.1 An Equality Impact Assessment was carried out at the Budget Planning Stage. This report is not directly relevant to equality, in that it is not making proposals that will have a direct impact on equality of access or outcomes for diverse groups.

7 Section 17, Crime and Disorder Act, implications

7.1 Adult Social Services works in part with those people who are at risk of drifting into crime, and supports victims and vulnerable people. The action taken to deliver a balanced budget did not affect the planned work carried out with these people.

8 Conclusion

8.1 The Adult Social Services department is working hard to manage the budget position in 2009-10, given the inherent pressures on social services activity and the significant amount of savings it needs to achieve to balance the budget. The pressures on Purchase of Care and on the Learning Difficulties service are areas of concern, particularly with regard to the financial pressures in 2010-11 and future years, as demographic indicators and the increasing cost of packages indicate increasing demand and costs in this area.

We have a financial recovery plan with additional savings identified of £-7.985m to offset the pressures identified, through budget monitoring, giving a forecast position of £0m. There are considerable risks to the delivery of services in trying to achieve these savings.

We are continually reviewing and monitoring the financial recovery plan, and we are concerned that we are not achieving the level of additional savings we would expect at this stage of the financial year in order to deliver a balanced budget. There are significant risks to delivering all £-7.985m of the savings. We will have a more accurate position available in December and we will provide a briefing note for Members of this Panel in December to provide them with the latest forecast.

9 Action Required

9.1 Members are invited to discuss the contents of this report.

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If you need this report in large print, audio, Braille, alternative format or in a different language please contact Mike Gleeson, Tel: 01603 638129, Minicom: 01603 223242, and we will do our best to help.

Appendix One: Summary of Capital Programme

Scheme	2009-10 Budget £	2009-10 Outturn £	2009-10 Slippage (see Note One) £	Reasons for Variance or Comments
Projects				
Reprovision of Bishop Herbert House	5,680	5,680	0	The completed scheme was handed over on 28 February 2005. Scheme completed, including the work to the fire exit. There was an outstanding fee account at the end of the financial year 2008-9.
Learning Difficulties Day Care – Phase Two (2004-5)	-811	-811		Additional essential safety works.
Huntingfield Reprovision (2007-8)	114,486	114,486	0	The scheme is complete following delays due to the legal transfer of land. The final equipment and fee accounts were outstanding at the end of the financial year 2008-9.
Supported Living for People with Learning Difficulties (2006-7)	25,296	25,296	0	This money is earmarked for schemes in West Norfolk. The first scheme at Emneth was completed in June 2005. Further properties have been completed at Necton, Swaffham, West Winch and Kings Lynn. The final proposed property purchase has fallen through and alternative accommodation is now being sought in order to fulfil the final proposed support package.
Cranmer House, Fakenham Community Support Centre (2007-8)	334	334	0	The main contract was completed in January 2006 and the flooring works were completed in February 2006. Final fee accounts were outstanding at the previous financial year end. There was an underspend on final fixtures and fittings.
Thermostatic Blending Valves at In-House Homes for Older People (2007-8)	27,712	27,712	0	The programme of works within all areas accessible to residents has now been completed. The remaining amount is being used to fit thermostatic blending valves in sluice rooms and staff restrooms in line with the new hand washing hygiene legislation.

Scheme	2009-10 Budget £	2009-10 Outturn £	2009-10 Slippage (see Note One) £	Reasons for Variance or Comments
Department of Health - Extra Care Housing Fund (Learning Difficulties) (2006-7)	64,945	64,945	0	This is a five-year project to support adults with learning difficulties living independently in their own accommodation. Year three is now complete.
Ellacombe Home for Older People Refurbishments (2007-8)	1,931	1,931	0	Creation of 14 bedded Older Peoples Unit following the end of the lease to Norfolk and Waveney Mental Health Partnership Trust. There was slippage due to technical issues (eg asbestos) identified when minor enabling works started. The work has now been completed. Final payments to the contractor and fee accounts were outstanding at the 2008-9 year-end.
Ellacombe Home for Older People Refurbishments - Corporate Minor Works (2007-8)	57,739	57,739	0	See above.
High Haven – Windows (2007-8)	18,509	18,509	0	Part of the essential improvements for the in-house Homes for Older People. Delay due to granting of planning permission and need to programme works amongst other capital works at the home. Phase Two was completed April 2009 and accounts are outstanding.
Linden Court – Lighting	16,500	16,500	0	
Munhaven - Heating system (2007-8)	12,410	12,410	0	Part of the essential improvements for the in-house Homes for Older People. This work was integrated with the dementia care works so that the disturbance was minimised. The work is completed. Final accounts outstanding at the year end.

Scheme	2009-10 Budget £	2009-10 Outturn £	2009-10 Slippage (see Note One) £	Reasons for Variance or Comments
Munhaven – Windows (2007-8)	1,331	1,331	0	Part of the essential improvements for the in-house Homes for Older People. This work was integrated with the dementia care works so that the disturbance was minimised. The work is completed. Final Fee accounts outstanding at the 2008-9 year end.
Rebecca Court – Windows (2007-8)	8,674	8,674	0	Part of the essential improvements for the in-house Homes for Older People. Phases One and Two are complete. Phase Two accounts outstanding at the 2008-9 year end.
Somerley - Heating system	2,276	2,276	0	Part of the essential improvements for the in-house Homes for Older People. Final Fee accounts outstanding.
St Nicholas House - WC and bathroom facilities (2007-8)	6,007	6,007	0	Scheme part of Essential Improvements at In-House Homes for Older People Programme. The scheme is complete. There has been a reprofile of payments following essential asbestos removals causing delay. The final accounts remain outstanding.
Sydney House – Windows (2007-8)	65,155	65,155	0	Part of the essential improvements for the in-house Homes for Older People. Phase One is complete. A reprofile of payments in respect of Phase Two was due to the need to programme and interlink works with other major capital improvements planned at the home in order to ensure minimal disruption. The works are scheduled to be completed in 2009.
Sydney House – Lift (2007-8)	15,000	15,000	0	Part of the essential improvements for the in-house Homes for Older People. Reprofile of payments attributable to design issues and need to interlink with other planned works at the Home. The scheme was completed in May 2009.

Scheme	2009-10 Budget £	2009-10 Outturn £	2009-10 Slippage (see Note One) £	Reasons for Variance or Comments
Westfields – Lift (2007-8)	67,500	67,500	0	Part of the essential improvements for the in-house Homes for Older People. Reprofile of payments attributable to interlinking design issues with above scheme. We are measuring the success of scheme in Sydney House prior to commencement.
Westfields – Windows (2007-8)	9,733	9,733	0	Part of the essential improvements for the in-house Homes for Older People. Delays due to design stage, planning permission and need to programme works amongst other capital schemes at the home. Scheme completed. Final Fee accounts outstanding at the 2008-9 year end.
Westfields - Heating system (2007-8)	7,223	7,223	0	Part of the essential improvements for the in-house Homes for Older People. The work slipped because of the decision to delay the start of the works until the summer of 2008, as it is not possible to isolate different wings of the building. The scheme is completed. Final Fee accounts outstanding at the 2008-9 year end.
Woodlands - Dementia Care Unit Extension (2007-8)	34,699	34,699	0	Part of the essential improvements for the in-house Homes for Older People. Delays due to design stage, planning permission and need to programme works amongst other capital schemes at the home. The works are scheduled to be completed in summer 2009.
Munhaven - WC and bathroom facilities (2007-8)	4,867	4,867	0	The scheme was part of Essential Improvements at In-House Homes for Older People Programme. The scheme is complete. Final Accounts were outstanding at the 2008-9 year end.

Scheme	2009-10 Budget £	2009-10 Outturn £	2009-10 Slippage (see Note One) £	Reasons for Variance or Comments
In-House Homes for Older People- Essential equipment (2007-8)	20,106	20,106	0	This is part of the Essential Improvements at In-House Homes for Older People. Additional profile beds ordered. Accounts outstanding at the 2008-9 year end.
In-House Homes for Older People – Redecoration (2009-10)	120,000	120,000	0	
Replacement call systems – In-House Homes for Older People (2009-10)	75,000	75,000	0	
Pinewoods reprovision (2009-10)	168,000	168,000	0	Reprovision of Pinewoods, currently Supported Living, to make suitable for respite care following closure of Lothingland.
Magdalen House - WC and bathroom facilities (2007-8)	16,357	16,357	0	This is part of the Essential Improvements at In-House Homes for Older People. Reprofile of payments attributable to interlinking works amongst programme of Essential Improvements at the in-house homes and contractor availability. Scheme completed April 2009. Final accounts outstanding at the 2008-9 year end.

Scheme	2009-10 Budget £	2009-10 Outturn £	2009-10 Slippage (see Note One) £	Reasons for Variance or Comments
Improving Care Home Environment for Older People (2007-8)	10,987	10,987	0	The Department of Health provided a one-off grant in 2007-8 to enhance the physical environment in care homes registered to provide nursing or personal care where the majority of places are for older people. This was part of the Government's dignity campaign that aims to place dignity and respect at the heart of caring for older people. The grant was intended to safeguard and promote the welfare of older people for whom an Authority has made arrangements to provide or secure the provision of residential accommodation. The money was for independent homes and in-house homes. Work is still being completed at some independent homes but all work has been completed in NCC owned homes.
Dementia Care Norwich and North Norfolk (2007-8)	5,000	5,000	0	This relates to the work at Heathfield, Mountfield and Munhaven. The work has been completed. Additional requirements were identified to ensure registration ie garden areas, safety and security issues.
Southern Learning Difficulties Team office relocation at Attleborough	29,042	29,042	0	Move complete and waiting for final account.
Failure of Kitchen Appliances	617,818	617,818	0	Gas safety works around kitchen appliances. There has been a reprofiling of the payments at the design / survey stage.
Heathfield - Bathroom Facilities (2008-9)	33,655	33,655	0	This is part of the Essential Improvements at In-House Homes for Older People. The scheme was completed in May 2009.
Somerley - Bathroom Facilities (2008-9)	50,473	50,473	0	This is part of the Essential Improvements at In-House Homes for Older People. The project had to interlinked with the other projects in in-house homes and contract availability. The scheme was completed in May 2009.

Scheme	2009-10 Budget £	2009-10 Outturn £	2009-10 Slippage (see Note One) £	Reasons for Variance or Comments
Philadelphia House - Bathroom Facilities (2008-9)	42,858	42,858	0	This is part of the Essential Improvements at In-House Homes for Older People. The payments were reprofiled due to interlinking the scheme within programme and contractor availability. The scheme was completed in June 2009.
Springdale - Shower Facility (2008-9)	5,401	5,401	0	This is part of the Essential Improvements at In-House Homes for Older People. The payments were reprofiled due to interlinking the scheme within the programme and contractor availability. The scheme was completed in April 2009.
Rebecca Court Bathroom Facility (2008-9)	20,505	20,505	0	This is part of the Essential Improvements at In-House Homes for Older People. The payments were reprofiled due to interlinking the scheme within the programme and contractor availability. The scheme was completed in April 2009.
Westfields – Toilet and Bathroom Facilities (2008-9)	84,500	84,500	0	This is part of the Essential Improvements at In-House Homes for Older People. The payments were reprofiled due to interlinking the scheme within the programme and contractor availability.
St Edmunds - Shower Facility (2008-9)	7,606	7,606	0	This is part of the Essential Improvements at In-House Homes for Older People. The payments were reprofiled due to interlinking the scheme within the programme and contractor availability. The scheme was completed in April 2009.
High Haven - FF Bathroom Facilities (2008-9)	22,315	22,315	0	This is part of the Essential Improvements at In-House Homes for Older People. The payments were reprofiled due to interlinking the scheme within the programme and contractor availability. The scheme was completed in May 2009.

Scheme	2009-10 Budget £	2009-10 Outturn £	2009-10 Slippage (see Note One) £	Reasons for Variance or Comments
High Haven - Garden Areas (2007-8)	5,850	5,850	0	This is part of the Essential Improvements at In-House Homes for Older People. The scheme is completed.
Balance of LPSA Reward Grant 2008-9	125,903	125,903	0	This will be used in 2009-10 for alternative supported housing accommodation for the three tenants with Learning Difficulties who are vacating Pinewoods. .
Linden Court – Lift (2008-9)	82,500	0	82,500	This is part of the Essential Improvements at In-House Homes for Older People. The payments were reprofiled due to interlinking with other lift schemes in the in-house homes and departmental strategic planning.
Mildred Stone House – Lighting (2008-9)	16,500	16,500	0	This is part of the Essential Improvements at In-House Homes for Older People.
Sydney House – Lighting (2008-9)	13,200	13,200	0	This is part of the Essential Improvements at In-House Homes for Older People.
Beauchamp House - Dementia Unit (2008-9)	2,968	2,968	0	This is part of the Essential Improvements at In-House Homes for Older People. Additional schemes added to Essential Improvements at In-House Homes for Older People programme (Year 2 contingency funds).
Mountfield – Windows (2008-9)	8,000	8,000	0	This is part of the Essential Improvements at In-House Homes for Older People.
Harker House - FF Shower Facility	8,165	8,165	0	This is part of the Essential Improvements at In-House Homes for Older People.
Mountfield - Call System (2008-9)	6,895	6,895	0	This is part of the Essential Improvements at In-House Homes for Older People.
Sydney House - Door Locks (2008-9)	5,000	5,000	0	This is part of the Essential Improvements at In-House Homes for Older People.

Scheme	2009-10 Budget £	2009-10 Outturn £	2009-10 Slippage (see Note One) £	Reasons for Variance or Comments
Beauchamp House - WC and Bathroom Facilities (2008-9)	35,115	35,115	0	This is part of the Essential Improvements at In-House Homes for Older People.
Beauchamp House - Call System (2008-9)	47,000	47,000	0	This is part of the Essential Improvements at In-House Homes for Older People.
St Nicholas House – Lighting (2008-9)	16,500	16,500	0	This is part of the Essential Improvements at In-House Homes for Older People.
High Haven – Lighting (2008-9)	16,500	16,500	0	This is part of the Essential Improvements at In-House Homes for Older People.
Magdalen House - FF Refurbishments (2008-9)	85,000	85,000	0	This is part of the Essential Improvements at In-House Homes for Older People.
Ellacombe Windows (2008-9)	22,000	22,000	0	This is part of the Essential Improvements at In-House Homes for Older People. Reprofiling of payments due to the design stage and granting of planning permission.
Magdalen House – Windows (2008-9)	77,000	0	77,000	This is part of the Essential Improvements at In-House Homes for Older People. Reprofiling of payments due to interlinking with the strategic plan for Care Homes.
Sydney House – Heating (2008-9)	100,000	0	100,000	This is part of the Essential Improvements at In-House Homes for Older People. Reprofiling of payments due to interlinking with the strategic plan for Care Homes.
Woodlands – Windows (2008-9)	27,209	27,209	0	This is part of the Essential Improvements at In-House Homes for Older People. Reprofiling of payments due to the granting of planning permission, interlinking with other capital works at the home and interlinking with the strategic plan for Care Homes.
Accommodation for people with Learning Difficulties	100,000	100,000	0	Suitable accommodation has been identified. The agreement with the Housing Association is in place, planning permission has been obtained and the Building Regulation application has been submitted. Work will commence once building regulation approval is obtained, which is anticipated to be August 2009.

Scheme	2009-10 Budget £	2009-10 Outturn £	2009-10 Slippage (see Note One) £	Reasons for Variance or Comments
Deaf Welfare Centre (2008-9)	7,500	7,500	0	This was an additional scheme added to the 2008-9 programme. It is a revenue contribution relating to capital works.
Lawrence House – Learning Difficulties Office Set-up Costs (2008-9)	32,639	32,639	0	The office move is complete. Final accounts were outstanding at the year end.
Aegal House – Shower Room (2009-10)	15,000	15,000	0	This is part of the Essential Improvements at In-House Homes for Older People.
Rose Meadow – WC Upgrades (2009-10)	45,000	45,000	0	This is part of the Essential Improvements at In-House Homes for Older People.
Mildred Stone House – Shower Room (2009-10)	15,000	15,000	0	This is part of the Essential Improvements at In-House Homes for Older People.
Mountfield – Bathroom Upgrades (2009-10)	30,000	30,000	0	This is part of the Essential Improvements at In-House Homes for Older People.
Priorsmead – Shower Room (2009-10)	15,000	15,000	0	This is part of the Essential Improvements at In-House Homes for Older People.
Sub-Total for Projects	**2,858,263**	**2,598,763**	**259,500**	
Capital Monies that are earmarked but not committed for specific projects at the moment				
Other Housing With Care Schemes (2007-8)	84,000	84,000	0	To be used for future schemes as part of the Strategic Model of Care – Care Homes.
Mental Health Supplementary Credit Approval 2005-6	40,000	40,000	0	All grants had been paid except for £40k that was earmarked for the set up costs of an Integrated Mental Health Team bases in South Norfolk. Norfolk and Waveney Mental Health Care Trust is leading the search for premises for these bases but continues to incur difficulties in identifying suitable affordable premises.

Scheme	2009-10 Budget £	2009-10 Outturn £	2009-10 Slippage (see Note One) £	Reasons for Variance or Comments
Mental Health Supplementary Credit Approval 2006-7	206,204	206,204	0	This funding will be used to support the redesign of residential and day services over the next couple of years. It is likely to be used to develop supported housing for people with mental health problems.
Mental Health Supplementary Credit Approval 2007-8	263,602	263,602	0	
Mental Health Supplementary Credit Approval 2008-9	278,000	278,000	0	
Mental Health 2009-10	278,000	278,000	0	
Social Services Computer Projects (2003-4)	133,902	133,902	0	Work is in hand as part of the continued Modern Social Care project and the Transformation Programme to identify further IT and project investment needs.
Information Management Grant (2007-8)	309,279	309,279	0	
Adult Social Care IT Infrastructure (2008-9)	537,665	537,665	0	
Homes for Elderly People - Essential Improvements Year 1	24,777	24,777	0	Contingency funds set aside for schemes that will offer greatest benefit to residents in line with the strategic plan for all care Homes.
Homes for Elderly People - Essential Improvements Year 2	693,000	693,000	0	
Sub-Total - Capital Monies that are earmarked but not committed for specific projects at the moment	**2,848,429**	**2,848,429**	**0**	

Scheme	2009-10 Budget £	2009-10 Outturn £	2009-10 Slippage (see Note One) £	Reasons for Variance or Comments
Capital Monies held on behalf of other organisations				
Housing Grants to resettle clients from Little Plumstead Hospital	1,117,924	1,117,924	0	The people with Learning Difficulties have been resettled. This is funds which NCC is holding on behalf of Health and which should be released to Wherry Housing (previously Anglia Housing): negotiations are still ongoing between the legal representatives for Health and Wherry Housing. This matter is being followed up with Wherry Housing.
Learning Difficulties Community Homes Resettlement (2008-9)	4,393,793	4,393,793	0	Grant funding to be handed over to Registered Social Landlords to help fund the purchase and conversion of accommodation suited to the needs of people undergoing resettlement from the NHS Campus Closure. The funding was receipted from NHS Norfolk ahead of the scheduled phases of completion. NHS Norfolk is the lead agency on this project.
Sub-total - Capital Monies held on behalf of other organisations	**5,511,717**	**5,511,717**	**0**	
Total	**11,218,409**	**10,958,909**	**259,500**	

Note1: Where there is slippage on a scheme the money will be carried forward to 2010-11. Slippage is where the work has not been completed within the financial year or there are outstanding invoices to be paid. The year noted in the “Scheme” column is the year it started.

Appendix Two: Aged Debt Analysis as at 30 September 2009

	Adult Social Services Department service users at 30 September 2009 £	All other debts at 30 September 2009 £	Total NCC Debts at 30 September 2009 £		Adult Social Services Department Service Users at 31 July 2009 £	Total NCC Debts at 31 July 2009 £	
items referred to Head of Law	1,720,219	2,464,928	4,185,147	*1	1,361,575	5,949,285	
awaiting estate finalisation	1,206,868	0	1,206,868	*2	915,568	915,568	
secured debts	5,218,472	0	5,218,472	*3	5,998,529	5,998,529	
being paid by instalment	786,381	1,556,458	2,342,840		808,082	2,674,174	
items on hold/in dispute	595,434	1,388,049	1,983,483	*4	520,018	995,819	
items awaiting referral	0	0	0		0	0	
Items awaiting write-off	0	0	0		0	0	
Sub-total	9,527,374	5,409,435	14,936,810		9,603,772	16,533,375	
items outstanding							
under 30 days	2,815,668	7,745,849	10,561,517	*5	3,492,452	19,472,789	
31-60 days	290,279	2,005,000	2,295,279	*6	513,388	2,061,242	
61-90 days	417,343	625,767	1,043,109		149,117	538,179	
91-120 days	88,290	94,857	183,147		44,081	623,739	
121-150 days	39,781	50,517	90,298		57,335	100,301	
151-180	55,557	139,258	194,815		33,551	96,373	
over 180 days	64,913	44,091	109,004		51,527	78,344	
Total debt outstanding	13,299,206	16,114,773	29,413,979		13,945,224	39,504,342	

Key: *1 Debts subject to recovery by legal action.

*2 Debts subject to estate finalisation at death.

*3 Debts secured by legal charge on property or other security. Adult Social Services service users have certain rights regarding paying for residential care. If they declare an interest in a property, they can elect to defer payment (all or part) until the

property is sold. If the service user defers payment, the debt is secured by a deferred payment agreement and it may be some time before the debt can be collected.

*4 Debts disputed and referred back to service departments.

*5 New debts raised during the current month and unpaid at month end.

*6 Debts raised in the previous month and subject to normal recovery action.

Report to Adult Social Services Overview and Scrutiny Panel

3 November 2009

Item No 12

Service and Budget Planning 2010-13

Report by the Director of Adult Social Services and Head of Finance

Summary

This report sets out the main planning considerations for the services covered by this overview and scrutiny panel and the context in which they are set. This includes the financial position and the relevant performance and improvement considerations that relate to the council's delivery of its corporate objectives.

It also sets out the overall funding prospects and spending pressures for the service and the draft, potential savings options for the 2010/11 service budget.

The main issues and areas for consideration affecting the services covered by this panel include:

- Significant increases in demand brought about by demographic pressures
- The significant change Adult Social Services is undergoing through the Transformation Programme, and the drive through this to ensure a greater focus on personalised care and prevention
- Potential far-reaching legislative change in the future based on the Government's Green Paper 'Shaping the Future of Care Together'
- Identified corporate risks around managing increased demands against budgets, meeting savings targets, delivering integrated care and investment in preventative services
- Identified performance challenges around self-directed support, delayed transfers of care, waiting times for assessments and services, and services for carers
- The draft revenue proposals contained in section six and Appendix B of the report.

Overview and Scrutiny Panel members are asked to consider and comment on:

- the planning assumptions and how these are applied,
- the proposed spending pressures and savings set out in the appendices
- any specific issues on the proposed list of new and amended capital schemes to be evaluated within the capital prioritisation model as part of the review of the three- year capital programme.

1. Background

1.1. This discussion takes place in a financial climate for public services that has been widely described as 'dire' as a consequence of the economic downturn. Though we know our level of Government grant for 2010/11, we don't know what it will be for the following three years. For planning purposes, we are assuming there will be no increases in grant levels over this period because any incoming government will need to take drastic action to cut public spending to help to re-balance the country's finances.

1.2. In the light of such challenges, the Leader and Cabinet have agreed an organisational blueprint that describes how the council intends to change its operations over the coming four years to become a more responsive, efficient and streamlined organisation, focused on frontline services and increased value for money.

1.3. In addition, to help local people manage through the recession, the administration has assured Norfolk council tax payers that we will freeze the level of council tax for at least two of the next four years and, where we levy any increase, it will not be higher than the level of inflation.

1.4. Our planning for next year and the years to follow takes place within a clear framework and process agreed by Cabinet.

1.5. In August, Cabinet received and agreed a report[1] that set out the planning context, requirements and parameters services should use to steer their service planning. It confirmed as the authority's strategic intentions, the strategic ambitions, corporate objectives, values and key improvement areas set out in the County Council Plan 2008-11 and the outcomes we should focus on in our planning.

1.6. We deliver the County Council Plan through 34 detailed service plans which set out our service needs, outcomes, actions, targets, assessment of value for money and capacity. When we prepare them, we also consider the external and internal drivers for change, such as financial and economic predictions, performance and value for money, risks, customer needs and the impact of our services.

1.7. Cabinet asked that we prepare draft service and financial planning requirements and budget options for discussion by county councillors in the November Overview and Scrutiny Panels and public consultation.

1.8. This paper sets out the planning issues and requirements relevant to the services covered by this Overview and Scrutiny Panel, together with a summary of the relevant corporate assumptions that underpin them. It also puts forward from the Cabinet Member in association with

[1] Service and Financial Planning 2010/11 to 2012/13 – Report to Cabinet 10 August 2009

the service Chief Officer, some draft proposals for consultation based upon the financial parameters set by Cabinet in August.

The strategic and corporate context

1.9. The County Council Plan 2009-12 sets out our three Strategic Ambitions for Norfolk, which are closely aligned to the Norfolk County Strategic Partnership Vision, these are for Norfolk to be:

- An inspirational place with a clear sense of identity
- With a vibrant, strong and sustainable economy
- And aspirational people with high levels of achievement and skills;

It also sets out our nine Corporate Objectives (priorities) and the main areas where we want to improve, together with the targets set to help us know we have done so.

1.10. Each year we also assess the background and context for the County Council's work. Internal and external factors can affect our work positively or negatively and are factored into plans for how we provide our services and the implications for resources. Significant issues affecting County Council services during this planning period are outlined in Appendix A, but matters relevant to the corporate context include:

- **The impact of the recession**

1.11. Like many other organisations, the recession is biting in a number of ways. For example, from a financial point of view our plans must reflect, in particular, less investment income, due to lower interest rates. However, unlike some organisations, demand for services is higher than ever, particularly in the demand led services and our service plans will need to consider this. We report progress on the Council's response to the economic downturn on a regular basis to the Economic Development and Cultural Services Overview and Scrutiny Panel.

- **The new organisational blueprint for Norfolk County Council and its implementation programme - Norfolk Forward.**

1.12. A review of senior management structures is already underway and scheduled to report in December. The identified costs and savings associated with any agreed recommendations will be factored in to budget planning later in the process when the outcome is known.

1.13. As already reported to Cabinet in September, the costs of managing and operating the programme office, which will oversee the implementation of Norfolk Forward, are being contained within existing resources

- **Managing our performance**

1.14. Our planning must reflect the elements of the performance framework for local government, including the Local Area Agreement (LAA), the Comprehensive Area Assessment (CAA), the National Indicator Set and implications for increased partner working including shared resources.

1.15. Under the final round of the former Corporate Performance Assessment (CPA) inspection regime, (2008), the Audit Commission assessed the council as 'excellent' awarding us four out of four possible stars. This tells us that on the whole, we are delivering effective and good value services.

1.16. This year, the Comprehensive Area Assessment (CAA) has replaced CPA. CAA assesses how well public services are working together to meet the needs and aspirations of their communities and using their resources to meet identified needs and deliver the outcomes set in the Local Area Agreement for Norfolk. In reaching its judgement, the Audit Commission also draws upon those made by other inspectorates, such as Ofsted, to help reach its conclusions. The first CAA report for Norfolk will be published in December.

1.17. Inspection assessments on individual services and organisations will also continue and the Audit Commission will publish Performance and Organisational Assessment reports in December.

1.18. In addition, service and budget planning needs to take account of the challenging targets and outcomes agreed by partners in Norfolk Action, the Local Area Agreement (LAA) for Norfolk.

- **Modern Reward Strategy**

1.19. Previous budgets provided for the impact of implementing the Modern Reward Strategy Project, (MRS), which will introduce new pay scales and pay-related conditions of employment for approximately 16,000 County Council employees (teachers and fire-fighters are excluded).

1.20. Though MRS has been delayed as a result of the time taken to pursue a collective agreement with Unison nationally, the authority is keen to implement its proposals with effect from April 2010 and Members of the Personnel Committee asked that the necessary steps be taken to secure this.

- **Carbon Reduction Commitment**

1.21. The Carbon Reduction Commitment (CRC) is an obligatory emissions trading scheme covering both public and private sectors. We will need to comply with the new scheme, which commences in April 2010, including ensuring we have adequate resources to procure the trading allowances and deliver energy efficient solutions. We are assessing how much money we will need to set aside to purchase allowances

and budgeting for this corporately. The scheme will include an annual performance league table, with financial incentives and penalties based on our performance. If we are to compare well against other organisations, we need our plans to consider energy usage and include ways of exploiting options to reduce it.

2. Financial context 2010 - 2013

2.1. The detailed assessment of financial prospects for 2010-13 is set out in the August report to Cabinet. It is necessarily a funding forecast for planning purposes only and we will continue to review it.

2.2. The Government has indicated that the previously announced grant settlement for 2010/11 (an increase of £12.0m) will be honoured. However, the Comprehensive Spending Review 2010 scheduled to cover the three years from 2011/12 has been deferred until after the General Election. This means we cannot be clear about financial prospects beyond the end of the next financial year (2010/11). For planning purposes, we are assuming a grant freeze for 2011/12 and 2012/13.

2.3. In the light of the administration's pledge to keep tax increases within the level of inflation and freeze council tax in two of the next four years, for planning purposes we have assumed a council tax increase of 2% for 2010/11 and a tax freeze for 2011/12 and 2012/13.

2.4. Based on these assumptions our current net revenue budget of £559.9m, would increase by £18.9m in 2010/11 and then stay at that level for 2011/12 and 2012/13.

2.5. After allowing for funding of new external borrowing for the Capital Programme, Chief Officers were asked to approach their service and financial planning assuming a 2.5% budget increase in 2010/11 and no increase in 2011/12 and 2012/13. Following further consideration of the provision for pay inflation to be included in budgets for 2010/11, the Leader has requested this uplift to be adjusted to reflect an assumed pay freeze in 2010/11, for all awards still to be negotiated. For planning purposes only at this stage a provision of 2.25% pay increase remains for 2011/12 and 2012/13. Typically, additional cost pressures arising from inflation, demographic growth and new legal requirements total £50m each year. As a consequence, we require considerable and ongoing cost savings if we are to sustain services and budgets over the medium term.

3. Service specific - strategic context

3.1. The most significant service-specific driver for Adult Social Services is Norfolk's changing demography and its effect on demand for services.

Norfolk has a population that is significantly older than average. Population projection statistics from the Norfolk Data Observatory and

the Joint Strategic Needs Assessment show that people aged 60 or over make up 27.7% of Norfolk's population – significantly higher than the national average of 21.7%.

Norfolk's population is also getting older at a faster rate than the England average. The over-60 population across Norfolk is projected to increase by 58.1% between 2007 and 2031 years, compared to a 51.0% increase for England as a whole.

Significantly in terms of social care, the most significant increase in population is likely to be in the oldest age groups. Between 2007 and 2031 the Norfolk population aged 85 or over is projected to increase by just over 100%, again much higher than the England average.

In addition to age-driven demand increases, Norfolk also continues to experience significant increases in demand in other service areas. In the 9 year period from 1998 to 2007 the number of hospital admissions for mental and behavioural disorders doubled to an average of nearly 12,000 per year.

Increases in Learning Difficulties services reflect a national and ongoing trend and relate to a higher number of service users with learning difficulties who are living longer and requiring more care and a much larger cohort of young people with a severe disability reaching adulthood and requiring social care services. Once somebody has been assessed as meeting our criteria for social care (critical and substantial needs) we have a statutory duty to meet their needs.

3.2. There are service specific risks and pressures relating to the current recession. We have already identified increased demand in terms of welfare advice services and services around homelessness and the provision of temporary accommodation. A survey by the Association of Directors of Adult Social Services, reflecting on experience elsewhere in the country, suggests we must actively manage the possible risks of:

- Increased numbers of people unable to pay for their own care
- Increased safeguarding referrals
- Increased demand for mental health services and drug and alcohol misuse services
- Potential reductions in the number of suppliers for residential and home care.

3.3. The strategic Government documents Putting People First and Transforming Social Care provide the context of ongoing change in social care. These are backed up by the Social Care Reform Grant, a three year grant of money made available to help Adult Social Services departments achieve transformation.

Norfolk's Transformation Programme is a response to these drivers, along with the demand pressures described above and is funded through the Social Care Reform Grant. The programme consists of 22

planned or current service change projects affecting almost every aspect of the services we commission or deliver. These include the Assessment and Care Management Review (encompassing Personal Budgets and the New Front Door' project); the review of Day Opportunities for Older People and People with a Physical Disability or Sensory Impairments; the Strategic Model of Care for Care Homes; Community Meals; and the integration of Health and Social Care services.

The last year of the Social Care Reform Grant is 2010-2011. The Grant has been used to pay for project managers and associated costs required to drive forward the project, and the Prevention Fund. This has meant that the funding of this change programme has not shown as a budget pressure for the department or the authority. The future funding of the Prevention Fund is shown as a pressure in 2011-12, when the grant ends. The project managers are on fixed term contracts; however there will be no funding for the ongoing continuous improvement nor for the Prevention Fund.

3.4. The next year is likely to see the instigation of some off the most significant legislation chances to affect social care since the 1950s.

On 17 July 2009 the Government published its Green Paper 'Shaping the future of care together' which outlined their vision for social care in the future. The paper proposes the development of a National Care Service. Details of the proposals include:

- A vision for social care based around prevention, a new National Assessment for assessing peoples' needs, joined up services, better information and advice, personalised care and support, and fair funding

- Three options for the way social care will be funded in the future – considering a partnership model whereby the state pays a portion of everyone's care; a voluntary insurance model; and a comprehensive insurance model.

- Consideration of the way the amount of money available for individuals' support is decided – with a consideration of locally-driven and nationally-driven approaches

- Clear reinforcement of the role of local authorities as the bodies who channel funding and support; undertake assessments; provide information, advocacy and care management; provide and commission services and manage the market; and foster innovation in care and support

As a Green Paper, the proposals are currently under consultation. Depending on the result of this and other political considerations, the proposal may then become a White Paper and eventually legislation in the future. It is uncertain when this would happen. However, if implemented, either of the proposals would result in fundamental

changes to the way we are organised and the way we commission and deliver services.

4. Financial and service planning for next year (2010/2011)

4.1. Corporate assumptions

All the County Council's consultation proposals use a set of common, corporate assumptions as a means of balancing the budget for 2010/11.

These assumptions are set out below in the interests of fairness and consistency. We invite Members views on the assumptions and the principle that they should be applied corporately in each case, as part of their considerations of these service proposals.

- **Cash uplifts for services**

4.2. Services have been asked to plan on the basis of an assumed budget increase of 2.5%, less an adjustment for the revised assumptions for pay, within which increased costs and pressures should be managed.

For services covered by this overview and scrutiny panel, planned budget increases of £4.061m have been assumed. The proposals covering cost pressures and savings are not at this stage being met within this uplift. In 2009-10 there was a significant increase in the amount of savings Adult Social Services was required to make to balance its budget. In previous years the savings had been in the region of £6 to £7m each year, whereas in 2009-10 the department had to include savings in excess of £15m. The department is finding it difficult to make the necessary savings in 2009-10, especially in Learning Difficulties and the Demand Management saving in Purchase of Care for Older People, and based on the current forecast has pressures of £8m. As the pressures relate to packages of care they will continue into 2010-11 and future years. The department is therefore unable to put further savings of this nature, such as Demand Management, into the budget plan.

- **Planning for inflationary pressures**

4.3. A planning assumption has been made for inflation increases of 2% for general prices. This will apply to both expenditure and income budgets.
The exceptions to this are:

A proposed 4% cash uplift for home to school transport costs
A proposed 4% cash uplift for passenger transport services provide via the PTU for adult social services

- **Staff costs**

4.4. We are assuming a pay freeze for all staff in 2010-11 except for those groups of staff for whom pay settlements for all or part of 2010/11 have already been agreed via external bodies.

This should not affect the services being delivered by Adult Social Services but this does depend on whether this negatively affects the department's ability to recruit and retain staff. Also if a pay award is agreed for 2010-11, the department's budget will need to be increased to reflect this.

- **Inflation awards to independent and voluntary providers**

4.5. We are assuming a 0% inflationary award to such providers for 2010/11.

In 2009/10 we piloted increases based on quality ratings as part of our policy to commission quality services. The increases were between 0% for poor rated homes and an average of 3% for homes rated excellent. Unfortunately due to the financial pressures facing NCC and Adult Social Services it is not possible to repeat this in 2010-11.

This should not affect the quality of services provided but some providers may not feel there is an incentive to provide even better quality services.

- **Sharper commissioning**

4.6. We are assuming that commissioning arrangements will be reviewed where appropriate to ensure spending and services align with the council's priorities and deliver value for money. This may mean de-commissioning (ending) the automatic funding of some grants or services that are not directly aligned to the council's priorities for service users and so cannot be afforded as a priority.

Adult Social Services are proposing savings of £0.200m in 2010-11 from reviewing Service Level Agreements and decommissioning those that no longer fit with the objectives of the department or corporately.

- **Tough purchasing**

4.7. We are assuming that goods and services will be procured as efficiently as possible, driving down costs for Norfolk taxpayers whilst retaining quality.

Adult Social Services are proposing to save £0.500m in 2010-11 by

reviewing high cost packages and, where appropriate, negotiating down the cost of these.

- **Efficiency**

4.8. The efficiency target set by government for next year is 4%. This requires us to find £19m savings. No service specific targets have been set; we are assuming and expecting all services to contribute towards the achievement of the total.

- **Realistic charging**

4.9. We are assuming that subsidies, fees and other charges are reviewed where possible and relevant to reflect changed economic circumstances and expectations, other forms of grant or income or any significant changes in price, market or service.

Currently the only chargeable service that Adult Social Services provide but do not charge for is Day Care. The department is proposing to review this policy and has included savings in the budget plan for the financial years 2010-11 and 2011-12.

- **Capital**

4.10. In February, schemes and funding were considered within a three-year capital programme as part of the County Council Plan 2009-12 (Appendix C). We have not made assumptions about the allocation of capital at this stage, however, it is assumed that capital bids are identified following option appraisal and that these will be evaluated by the Corporate Capital and Asset Management Group (CCAMG). These will be evaluated alongside existing schemes using the capital prioritisation model and recommendations for any revision to the programme will be reported to January Overview and Scrutiny Panels.

New and amended schemes relevant to this overview and scrutiny panel are listed in Appendix D.

5. The principal challenges for this service

5.1. **The main challenges for the department**
The following identify the main risks and performance challenges for the department within the context of the relevant service objectives for the overarching Adult Social Services Service Plan.

- There are two corporate risks identified against the service objective '**Sustainably manage expenditure to ensure we can meet demand for social services'**.

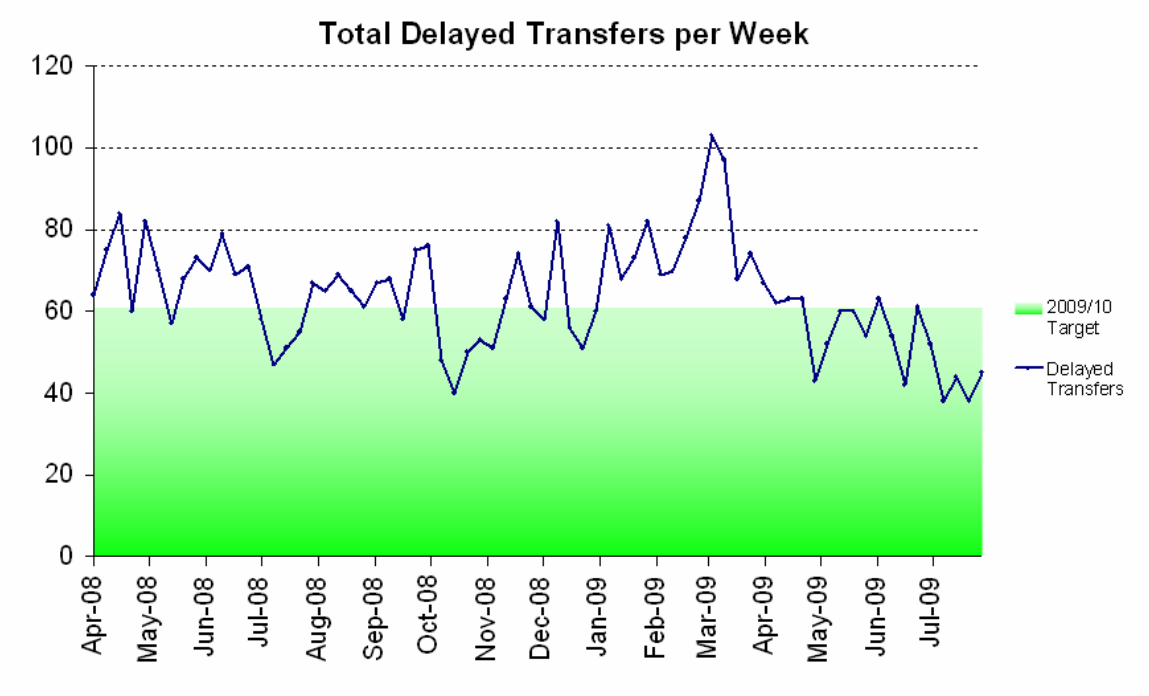
  The first is 'Failure to meet increased demand for Adult Social Services against available budgets'. The budget pressures

brought about by rising demands for services are covered elsewhere in this report – but nevertheless represent the single most significant long term challenge to the department.

The second is 'Inability to meet Learning Difficulties savings targets through the Priority Based Budgeting exercise and unpredictable service demand'. Whilst the Financial Recovery (or Priority Based Budgeting) Project in Learning Difficulties is forecast to realise savings of £3.2 million by the end of this financial year, 2009-10, this still leaves an estimated shortfall of £3.8million savings. In addition, given rising demand, there remains a significant longer term financial risk to the authority.

- One of the most important challenges to the department is the target, specified in the Local Area Agreement, to increase the proportion of service users in receipt of self directed support – for example those people receiving direct payments to pay for their own care needs. This relates to the service objective **Support people to arrange and manage their own support and meet their individual needs through self directed support so that half of all service users access services this way by 2011**. Whilst we have met our targets for self directed support in previous years – and are a leader in this area – the targets for future years are much more stretching. Significant work has been undertaken, and is planned, to help us meet this target, and the move towards self-directed support is a central tenet of the way we are transforming our services to improve choice and provide more personalised support.

- Our objective to **Deliver seamless integrated care between adult social services and health services** is impacted by the challenge of delayed transfers of care, which is identified as a performance issue and a Corporate Risk in the service plan. In performance terms there are historically high levels of delays, compounded by increases in hospital admissions year-on-year increasing pressures on services. Delays have been reduced as a result of better joint working between Adult Social Services and Norfolk's NHS organisations, and comparative performance figures show that we are now in line with other similar authorities. Overall numbers of delayed transfers over time are shown in the below graph.



However with demands for services continuing to increase sustaining this improvement remains a challenge.

Beyond delayed transfers of care, the establishment of the Integrated Care Pilots are a priority for the coming year and is central to meeting this objective. Six clusters of GP practices across the county are being reconfigured to improve joint working between health service and social care staff, as part of a national pilot programme.

Closely related to this objective, a further challenge relates to the way funding is allocated to the Learning Difficulties service from the health service. From 2011-12 Department of Health Funding for Learning Difficulties will no longer come via the NHS organisations' (NHS Norfolk and NHS Great Yarmouth and Waveney) contributions to the Learning Difficulties Pooled Fund. Instead the Department of Health funding will come direct to NCC. Currently work is ongoing with NHS Norfolk to agree the agreed transfer. However the agreed NHS contributions will then be pooled with the Department of Health (DoH) and allocated out to local authorities. At the moment it is not clear how the allocations will be made. There is a risk that NCC may receive less DoH funding for Learning Difficulties in future than currently. This will increase the budgetary pressures facing NCC and Adult Social Services.

- There are clear challenges around the service objective **Further develop and improve access to a range of preventative services with our partners to improve adult health, well-being and independence**. This is highlighted in the Corporate Risk 'Investment in preventative services'. Preventing people from

needing care services in the first place provides one of the best opportunities to ensure the well-being of Norfolk's growing number of older people. Improvements and increases in preventative services have been delivered as part of the Social Care Reform Grant, the last year of which is 2010-11. The funding of preventative services is identified as a pressure from 2011-12. Given the current growing demand for services, it will be a significant challenge for the council to ensure that sufficient investment continues to be made in preventative services to promote the longer-term well being of Norfolk's residents.

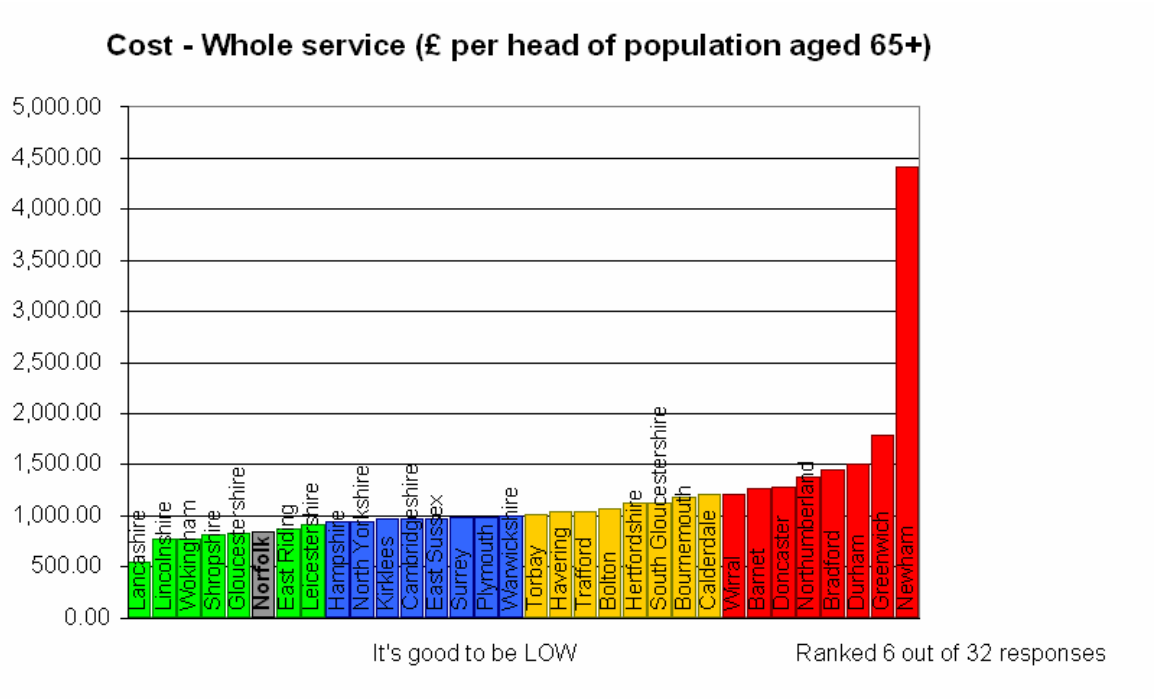
- Improving the timeliness of services and our systems is a priority, as reflected in the service objective **Maximise the benefits of care management systems and other care management improvements to ensure all cases meet the required quality standards and timescales**. Reducing waiting times – specifically the number of people receiving assessments, services and housing adaptions – is a clear improvement area for Norfolk, highlighted in our performance figures compared to other councils, and in feedback from our inspectorate. Work is already underway, through the Assessment and Care Management Review, to improve the systems and practices in Norfolk to improve performance.

- Feedback from both the Audit Commission and the Care Quality Commission also highlight challenges for Norfolk in terms of services to carers, relevant to our service objective **Increase the range and number of ser-vices for carers to support them in their role and ensure their own wellbeing**. A new Carer's Strategy will be developed, consulted upon and published showing how we will meet this objective.

5.2. **Delivering value for money**

There are a number of tools available to us to help us assess the extent to which we are delivering value for money compared to other councils.

PriceWaterhouseCooper's (PWC's) developing model for benchmarking services for older people shows that, of the participating councils, Norfolk had the 6th lowest whole service costs per head of population, as shown in the below graph:



The PWC older people's value for money tool also highlights performance against a range of indicators, again showing our performance against all of the participating authorities.

This shows an overall mixed picture of performance, with Norfolk performing particularly well in terms of:

- The number of clients receiving review
- Equipment and adaptions delivered on time
- The number of residents supported by the authority in nursing care.

And less well in terms of:

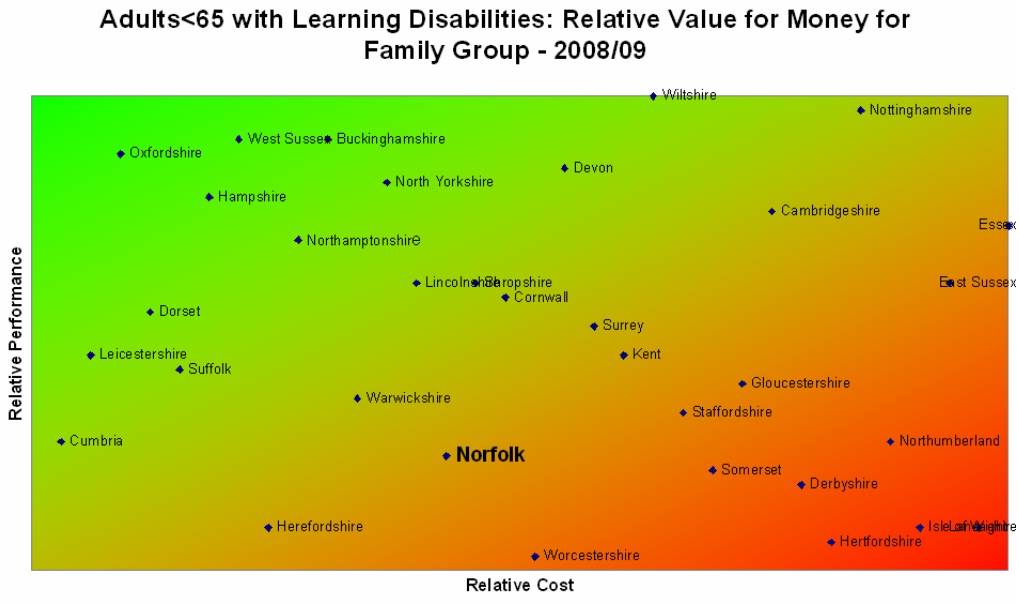
- Waiting times for care packages
- Day care/Day opportunities
- The number of residents supported by the authority in residential care
- Admission into nursing care.

Overall, therefore, this appears to show a picture of relatively good value for money, particularly given the low comparative costs per person. The picture is, however, much more complicated. Both the performance figures and the costs also reflect the size of Norfolk's service user base. We have the largest number of users in our official 'family group' of councils – those that are most similar to us. At the last comparable count, Norfolk had just over 32,000 service users, compared to an average of just under 23,000 for our family group as a whole. This has a significant impact on capacity (for example, the number of assessments we have to complete) and has implications for the cost of services per user.

Another tool, from the Society of County Treasurers, can also be used to help assess our relative value for money. The findings from this

analysis confirm the PWC findings for services to older people.

It also looks more broadly at some other service areas, showing for example that in comparing relative performance against relative cost, services for people with learning difficulties have around average costs per person, but have performance that is slightly below average.



Again, this partially reflects high numbers of service users, and doesn't account for some of the complexities of local service provision. However, through the Financial Recovery Project and the Priority Based Budgeting exercise in the Learning Difficulties service we are working to improve value for money and should improve our standing compared to other councils.

In summary, overall, there are clear areas where we are working to drive down the costs of services – for example in Learning Difficulties. In addition, the high level of demand experienced in Norfolk continues to put pressure on both our total costs and performance – and action is being taken to actively risk manage this. The more rounded and outcome-focused performance assessment provided by the Care Quality Commission currently gives Norfolk a three-star rating (an update is due shortly), the highest possible.

6. Draft revenue proposals for this overview and scrutiny panel 2010 – 2011

6.1. The following proposals are brought forward by the Cabinet Member in association with the service Chief Officer for consultation purposes and views are welcome. The proposals are listed in full in Appendix B.

No inflationary uplift to the independent and voluntary sectors in 2010-11 (£-1.400m). In 2009/10 we piloted increases based on quality

ratings as part of our policy to commission quality services. The increases were between 0% for poor rated homes and an average of 3% for homes rated excellent. Unfortunately due to the financial pressures facing NCC and Adult Social Services it is not possible to repeat this in 2010-11. This should not reduce the quality of services provided but some providers may feel there is no incentive to provide even better quality services.

NHS contribution to the Learning Difficulties Pooled Fund (£-2.137m). The NHS organisations in Norfolk have agreed to increase their contribution to the Learning Difficulties Pooled Fund in 2010-11 by the NHS agreed inflation rate, which is currently stated as 5%. If the NHS inflation rate varies then so will the NHS uplift to the Pooled Fund, and it could mean that their contribution is less than currently estimated. This would in turn increase the pressures for the department as it is the largest provider of services to the Pooled Fund.

Learning Difficulties Services – Priority Based Budget Savings (£-3.800m). This is an estimate of the amount of savings from the Priority Based Budgeting exercise that it will not be possible to deliver in 2009-10 but which will be delivered in 2010-11. This is based on current budget forecasts for 2009-10 and the monitoring of the projects to deliver savings.

Match funding from the NHS for the Prevention Projects (£-0.350m). Following the success of POPPs (Partnerships in Older Peoples Projects), where we piloted projects such as NightOwls and Swifts, Adult Social Services has invested £0.500m from the Social Care Reform Grant in a Prevention Fund to continue with these projects. The NHS in Norfolk contributed £0.150m to the Prevention Fund in 2009-10 and Supporting People also make a contribution. The Ibsen evaluation of POPPs was that for every £1 invested by Adult Social Services, we save approximately £1 and Health save approximately £1. If the NHS increased their contribution to the Prevention Fund to £0.500m, this would increase the amount of savings we make as well as NHS.

Reducing the cost of high cost packages (£-0.500m). Adult Social Services are proposing to save £0.500m in 2010-11 by reviewing high cost packages and, where appropriate, negotiating down the cost of these.

Ceasing the non-statutory HIV/AIDS service and ceasing the subsidy for the non-statutory bathing service (£-0.059m and £-0.054m). These proposals will not affect the department's ability to deliver its statutory services. The subsidy to the bathing service does contribute to the department's prevention programme.

Charging for day care (£-0.250m). Currently the only chargeable service that Adult Social Services provide but do not charge for is Day Care. The department proposes to review this policy. The amount of income generated from charging for day care would not be directly related to the number of people using the service as approximately two thirds of the people using the service already receive another service. They will therefore already have been financially assessed and will already be contributing towards the cost of their care if they assessed as being able to

and it may mean that we cannot charge them any more than they are already paying. Other issues include: charging people may mean people no longer wish to have day care but would then need other services; if people withdraw from day services this may lead to lower numbers and higher unit costs; and day services often provide the only respite for families and carers. We already charge people who use day care for their meals and transport.

Rationalisation of Learning Difficulties Day Centre Buildings (£-0.600m). Due to the increase in Community Based services in Learning Difficulties some of the buildings the day centres are based in are not fully utilised. The department proposes to review the buildings the services are provided in and rationalise them to make better use the buildings and improve the facilities available. The proposal will not result in a reduction in the services provided to people.

Due to the difficulties in delivering the required Demand Management savings in 2009-10 the department has not included savings of this nature in the budget plan for 2010-11 and future years.

For this panel, there is currently a shortfall of savings of £2.488m proposed when compared with the cash uplift. Work continues across all services to identify the scope for savings and these will be considered by Cabinet in the round and in light of the view of Scrutiny Panels and the outcome of public and stakeholder consultations. A further report will made to this panel in January prior to the Cabinet budget report on 25 January 2010.

7. Resource Implications

7.1. The implications to resources including, financial, staff, property and IT are set out in Sections 5 and 6 of this report and within the Appendices.

A number of the proposed measures have resource implications for our staff and those of partners. In taking forward the measures, we will ensure staff are properly consulted and engaged. More generally, our staff and those of partners continue to deliver high quality services throughout the County, and as a result of this, we have been able to maintain and improve our performance over the last four years

8. Other Implications (where appropriate)

8.1. **Legal Implications**: As the department is proposing to review its policy for charging for day care and is looking to rationalise day centre buildings for people with Learning Difficulties, people who use day centres and other stakeholders will be consulted and their views fed into the plans for change**.**

8.2. **Human Rights:** None.

8.3. **Equality Impact Assessment (EqIA)**. This report is not directly relevant to equality in that it is not making proposals that may have a direct impact on equality of access for statutory services or outcomes.

8.4. **Communications**: Communication Strategies will be put in place, where appropriate, for projects and actions resulting from these proposals.

9. Section 17 – Crime and Disorder Act

Adult Social Services commissions and/or provides a range of services, often in conjunction with partners, which support people who may be more susceptible to becoming victims and/or perpetrators of crime and disorder. The proposals are expected to enhance this further, because of the strong service development and transformation elements to them. As a result of this services will be better able to cope with future demands and expectations of service users.

10. Action Required

10.1. In light of the contextual issues presented and key challenges, overview and scrutiny panel members are asked to consider and comment on the planning assumptions and how these are applied, and the proposed spending pressures and savings set out in Appendix D, in order to inform Cabinet members' discussions.

10.2. Members are also asked to consider and identify any specific issues on the proposed list of new and amended capital schemes to be evaluated within the capital prioritisation model as part of the review of the three-year capital programme. The recommended capital programme will be reported to the January meeting of the Overview and Scrutiny Panel.

Officer Contact

If you have any questions about matters contained in this paper 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 Mike Gleeson on 01603 638129 or Textphone 0844 8008011 and we will do our best to help.

APPENDIX A

PLANNING CONTEXT – NEED TO CHANGE TO REFLECT UPDATED PLANNING CONTEXT

1. Key **demographic changes**, include:

   - Norfolk's population is growing faster than the regional average
   - We have increasing numbers of active older people – 81% of our over 85 year olds still live at home – raising implications for housing, independence and rising demand for the provision of care
   - Norfolk is becoming more diverse, with rapidly increasing black and ethnic minority populations – already around 100 languages are spoken
   - There are large and growing numbers of people from Europe living and working in areas of the county.

2. **Socio-economic factors**, such as:
   - Norfolk does have pockets of both rural and urban deprivation, and although the majority of people living in the county are not disadvantaged, 19% of children live in income deprived households
   - Generally good levels of health and higher than average life expectancy but there are people within our communities experiencing increasing inequalities in health and well-being, frequently correlating to areas of greatest deprivation in the county – for example teenage pregnancy
   - Obesity levels in the county continue to be of concern, with children's obesity being of particular concern; diseases normally seen in obese adults are becoming more common in children
   - Levels of adult participation in sport and active recreation in Norfolk remain much lower than in other parts of the country
   - Despite overall levels of crime falling in Norfolk, local people's perception of crime as an issue remains high.

3. Factors affecting **Norfolk's economy and skills**, including:

   - The current economic downturn is affecting employment and development nationally. Latest unemployment figures for Norfolk (as at mid August) show an increase in the number of people claiming job seekers allowance.
   - Norfolk already has one of the country's most significant financial service sectors, but our overall economic growth lags behind the regional average
   - Basic literacy levels in the county are below national and regional levels
   - Low wage and skills mean that that we need to create and attract more higher value jobs, such as jobs in knowledge-based industries
   - High and volatile price of crude oil impacts on the price of many oil derived materials

- It is expected that Norfolk will see 78,000 new homes built and 55,000 new jobs created by 2021, with significant numbers of people travelling to work by car.

4. **Environmental factors**, such as:

- Local Government has been identified as having a key role in tackling climate change and developing a strategy to support the UK Climate Change Programme, by cutting all greenhouse gases and carbon dioxide emissions – this presents us with a significant leadership challenge as well as delivery of improvements to our own operations
- Climate change and water resources are of major concern in the county, with challenges around issues of coastal erosion, storm damage and flooding – and increasing severity of emergencies caused by natural occurrences
- Moving towards paperless transactions in order to reduce the amount of waste going to landfill
- The Government intends to introduce five-year carbon budgets which may be set alongside other operational, funding and taxation policies and are likely to affect expectations of standards and targets as part of the assessment of services, to encourage investment in low-carbon fuels and technologies.

5. **Advances in the use of technology**, including:

- Convergence of voice and data services over broadband networks to support increasing use of mobile and home working facilities
- Increased use of mobile devices such as laptops
- Switchover from analogue to digital television in 2012 means that many more people could access services in diverse ways, such as via the internet using their television
- As part of the Waste Strategy for England 2007, we may have to make further progress with technologies relating to landfill diversion and increasing recycling at home.
- Maximising technologies available to enable safe independent living.

6. **National policy and government legislation**, such as:

- Putting People First – the Government's shared vision for the transformation of Adult Social Care – including establishing community based support systems for the health and wellbeing of local populations, through bringing together and re-designing (health and care) local systems around the needs of citizens
- Care Matters: Time to deliver for children in care and Children & Young Persons Bill – the Government's expectations of the right

quality care and support being in place for children in the care system

- Lifetime Homes, Lifetime Neighbourhoods – the Government's national strategy for dealing with housing in an aging society.

Appendix B

2010-13 Budget Proposals

Budget proposals for Adult Social Services

as at 22nd October 2009

Description of cost pressures or service improvement - shown against the key driver for the additional costs	2010-11 £k	2011-12 £k	2012-13 £k
Assumed funded budget increase for Planning Purposes	4,061	0	0
New non-specific funding - please provide comment - partner funding/LAA/indicative etc			
Total Additional Budget for planning purposes	**4,061**	**0**	**0**
COST PRESSURES AND SERVICE IMPROVEMENTS			
Basic Inflation - Pay (2010-11 - 0%; 2011-13 - 2.25%)	0	1,755	1,920
Basic Inflation - Prices (General 2%, School and social care passenger transport 4%)	2,488	2,539	2,591
Additional 0.7% contribution to Pensions (1% for 2011-13 years)	556	795	803

Description of cost pressures or service improvement - shown against the key driver for the additional costs	2010-11 £k	2011-12 £k	2012-13 £k
Additional 0.5% increase in NI Employers contributions in 2011-12 - estimate		308	
Reductions in inflation pressures			
No inflationary uplift to the independent and voluntary sectors	-2,200		
Sub Total Inflation	**844**	**5,397**	**5,314**
Government/Legislative requirements			
Reduction in preserved rights grant	201		
Sub Total Legislative	**201**	**0**	**0**
Demand/Demographic			
Demographic growth - Older People	2,000	2,300	
Increased Cost Packages - Older People	756	764	
Demographic growth - Physical Disability	36	21	
Increased Cost Packages - Physical Disability	118	119	
Demographic Growth - Mental Health	26	15	
Learning Difficulties Recurrent overspend from 2008-09, due to packages of care	3,800	0	
Learning Difficulties - one off savings made in 2009-10 (not recurrent)	246		
Transition of people with learning difficulties from children's services to adult social services	2,600	2,600	

Description of cost pressures or service improvement - shown against the key driver for the additional costs	2010-11 £k	2011-12 £k	2012-13 £k
Learning Difficulties Panel Decisions - new services less people leaving the service	2,720	2,720	
Learning Difficulties forecast growth above inflation	0	0	
Full year effect of previous year's Learning Difficulties Panel decisions	2,430	2,430	
Transition of people with physical disabilities from Children's Services to Adult Social Services - increase between years	168	168	
Sub Total Demographics	**14,900**	**11,137**	**0**
Costs specific to actions to meet County Council Plan targets			
Sub Total County Council Plan	**0**	**0**	**0**
Costs specific to meeting service strategies and improvements			
Prevention Fund - currently funded from Social Care Reform Grant - ending in 2011-12		500	
Sub Total Service Improvement	**0**	**500**	**0**
TOTAL COST PRESSURES AND SERVICE IMPROVEMENT	**15,945**	**17,034**	**5,314**

Proposed action	2010-11 Estimated Saving (£k)		2011-12 Estimated Saving (£k)		2012-13 Estimated Saving (£k)	
Non-policy issues						
NHS contribution to the Learning Difficulties Pooled Fund in excess of the Corporate inflation of 2% - estimated amount	2,137					
Savings from continued externalisation of home support services	719		627			
Estimating continuing health care for new service users with learning difficulties and people with learning difficulties transitioning from Children's Services	620		620			
Learning Difficulties Services - Priority Based Budget Savings	3,800					
Match funding from the NHS for the Prevention projects	350					
Alternative funding for the Domiciliary Care Apprentice Scheme	57					
Review Service Level Agreements with the Third Sector and cease those that no longer fit with corporate objectives	200					
Use of additional contract negotiation skills available corporately to drive down the cost of high packages - invest to save	500					
Modern Social Care Phase Two (part year, implementation of first of three modules	50					

Proposed action	2010-11 Estimated Saving (£k)		2011-12 Estimated Saving (£k)		2012-13 Estimated Saving (£k)	
Policy Issues						
Cease the non-statutory HIV/AIDS service	59					
Cease subsidy for the non-statutory bathing service	54					
Charging for day care - part year	250					
Rationalisation of Learning Difficulties Day Centres Buildings	600					
TOTAL SAVINGS	**9,396**		**1,247**		**0**	

Appendix C

Capital Budget Planning 2010-13

Schemes Previously Approved

Scheme Name	2010-11		2011-12		2012-13	
	NCC £000	Other £000	NCC £000	Other £000	NCC £000	Other £000
Replacement call systems at Homes for Older People	75	0	75	0	0	0

Appendix D

Capital Budget Planning 2010-13

Indicative and New Schemes

Indicative Schemes

Scheme Name	2010-11		2011-12		2012-13	
	NCC £000	Other £000	NCC £000	Other £000	NCC £000	Other £000
Mental Health ringfenced Supported Capital Expenditure (Revenue) - Note 1	0	278	0	278	0	0
Social Care Supported Capital Expenditure - Note 2	0	471	0	471	0	0

New Bids

Scheme Name	2010-11		2011-12		2012-13	
	NCC £000	Other £000	NCC £000	Other £000	NCC £000	Other £000
Respite Care for people with Learning Difficulties	1,000	0	0	0	0	0
Day Centre for people with Learning Difficulties	2,000	0	0	0	0	0
In-house Homes for Older People	150	0	0	0	0	0

Note 1: The funding will be used to support the redesign of residential and day services in the medium term.
Note 2: The funding will be used to support improvements to accommodation for service users and office accommodation.

Report to Adult Social Services Overview and Scrutiny Panel
November 2009
Item No 13

Future Commissioning Models – Community Care In House Day Services

Report by the Director of Adult Social Services

Summary
A comprehensive review of all community care day services has now been completed. This review was undertaken as part of the 'Making Your Day' project to decide on future commissioning and funding arrangements for all day services provision in the independent, voluntary and in-house sectors.

This report proposes a strategic plan regarding the future use of all in house day services for older people and younger people with physical and sensory impairments.

The proposed model for in house day services would replace current usage by providing two main services:

- Older people with dementia
- Re-ablement services based on social care needs

1. Background

1.1 A 'whole systems' review of day opportunities for older people and younger people with physical and sensory impairments commenced in 2008. This review has included all day services including the in-house, voluntary and independent sectors.

1.2 This review entitled the 'Making Your Day' project has formed part of the Department's transformation programme, and the introduction of greater 'personalisation' as part of the national programme 'Putting People First'. This means people will have more choice and control with the implementation of self directed support plans and allocation of a personal budget which, if people want to, can be taken as a direct payment. Personal budgets and direct payments will allow a person to purchase a wider range of services than those currently offered under the more traditional day services model.

1.3 The Commissioning Strategy for Day Opportunities for Older People and People with a Physical Disability or Sensory Impairments in Norfolk was based on what people told us about their preferences in our 'More Choices, Better Choices' consultation. This has led to the production of five locality plans, covering Southern, Western, Northern, Norwich and Eastern localities, which describe proposed changes in services. This was presented to the Overview and Scrutiny Committee in November 2008. A briefing report regarding the consultation was made available to the Overview and Scrutiny Committee in February 2009.

1.4 The locality plans produced a range of proposals to re-shape services that would widen choice for people by offering alternatives other than traditional day services in day centres.

1.5 In-house day services have been evaluated on similar principles and methodology as independent services and this included the following factors:

- the need to complement and not duplicate services in the voluntary and community sector
- strategic importance to the local area
- service user and carer satisfaction and outcomes
- value for money
- sustainability
- the impact of decisions on other services run by the provider.

2 Current provision of In-House Services

2.1 In-house services currently provide traditional services for physically or mentally frail older people who meet the Fair Access to Care Services (FACS) eligibility criteria. Traditional day services offer lunch and refreshments and activities including reminiscence, quizzes, bingo, gentle exercise classes, and occasional outings. This includes specialised day care for older people with dementia. There are fifteen centres located across the county. (See appendix 1A).

2.2 In-house services for older people with dementia are more specialised with use of life story books, reminiscence, diversional therapy, with one-to-one support. All in-house day service staff receive specialist training in the care of people with dementia needs.

2.3 Younger people with a physical and/or sensory impairment tend to use direct payments to allow access to more mainstream services using a personal assistant. Younger people are also demonstrating their preferences by attending groups in community buildings, and making use of education, training and employment opportunities. The outcome is that the Vauxhall Centre, which originally offered services for this client group, has evolved into a community centre. However the other day services provided by the department have not changed to the same extent.

2.4 At present ASSD provide approximately 1,364 day places weekly, in fifteen centres across Norfolk:

- Older People - 836 places
- Dementia day services - 408 places
- Physical and Sensory Impairment - 120 places (Vauxhall Centre, Norwich locality)

Total gross expenditure, which excludes any income and spend on transport, was £2,046,175 for 2008/09.

3. In-House Day Service Review – Evaluation findings

3.1 **Key findings from the evaluation include**:

- There was a significant amount of positive feedback from the people attending in-house day services regarding the quality of the services and much praise for the staff.

- Some buildings were found to be not fit for purpose. For example, in Norwich locality two buildings are disused church properties with limited parking, and storage space. One has no garden area for outside use the other has a small courtyard. Those two resources would need an estimated combined total of £69,000 to meet gas and other regulations to make the premises fit for purpose. Some buildings across the county offer little or no potential for improvement to meet higher levels of need as regards accessibility, specialist facilities e.g. hoists, bathing facilities, and no potential for 'dementia friendly' re-design.

- The reviews positively revealed that each in-house resource catered for frail older peoples' needs, and also met the needs of older people with low level dementia needs.

- In-house day service provision is sometimes more abundant in localities where there are gaps in provision from the independent and voluntary sectors i.e. Eastern Locality. However, strategically some buildings are not located in the right place to meet need, and occupancy can be as low as 50%, raising unit costs.

- In line with the 'Strategic Model of Care' three day centres, which currently occupy accommodation within a local authority care home will potentially at some time in the future need to be re-located. These are the Mousehold Day Centre (Norwich Locality), Riverview and Rosewood (Eastern Locality). The Crossroads centre (Western locality) is in the grounds of a care home and could be affected by plans for the home.

- Due to services being developed locally there is a lack of uniformity and strategic approach regarding location, capacity or type of service offered in the delivery of in-house provision across the county.

4. Strategic Context and Direction: Proposed Model

4.1 This review has allowed a strategic overview of in-house provision to take place. There is a need to take into consideration that day opportunities in the future, including in-house day provision, will have to meet local needs, provide a more personalised service and include prevention as part of the overall strategic direction, as outlined in the 'Commissioning Strategy for Day Opportunities for Older People and People with a Physical or Sensory Impairments in Norfolk'.

4.2 In the long term it is also necessary to commission and plan in-house services' future provision within the context of the Norfolk County Council's Strategic Model of Care' regarding residential and housing with care.

4.3 The in-house provision of day services also has to follow the strategic aim of Norfolk County Council being able to concentrate on better commissioning of services, market shaping, and being a provider where this provides best value for money.

4.4 To ensure that the future re-shaping of in house services complement the strategic direction outlined in strategies above this proposal outlines a five year interim market strategy to implement a model of in-house service provision that will provide services in two main areas:

- Dementia for those with high dependency needs regarding personal care
- Re-ablement Day Service for older people with social care needs.

Dementia day services.

4.5 All localities have identified a need for additional dementia provision because of increasing numbers of very old people, increased incidence of dementia and supporting people in their homes for longer than previous years. Re-assigning some current in-house day provision to dementia services will help make more appropriate use of scarce resources whilst we work to commission additional and more varied services from the third sector and to stimulate the market. Providing additional dementia services will support carers and delay admission of people with dementia to care homes.

Re-ablement day service for older people with social care needs

4.6 The model would be available for older people and for younger people with a physical or sensory impairment. A re-ablement day service would provide a centre or community based opportunity for people to learn or relearn skills to enable them to become as independent as possible and for them to achieve a sense of well being. The service would offer an individually designed programme over a certain period eg six weeks, with outreach services in place. Re-ablement based domiciliary care (Norfolk Home First) has proved very effective in maximising people's independence, whilst minimising the need for future social care spending

4.7 An individual's mental health needs could also be met by focusing on building confidence and helping people make social contacts, for example to address loneliness and isolation as well as improving the ability to manage day to day physical tasks. This would support progression from specialist mental health treatment services.

4.8 There is more work to be done to develop a re-ablement service to ensure services are designed to meet need and complement the re-ablement and rehabilitation services provided by Health, and ASSD Norfolk First Support service. Re-ablement services will be individually based rather than building based and could make greater use of existing community facilities.

4.9 Each centre has undergone the same process of option appraisal. There are fifteen day centres and proposals would include the following measures:

- Seven day centres providing dementia care would continue to do so for the next five years.
- Five day centres would re-assign their services from frail elderly care to dementia care or re-ablement or a combination of both.

- We will close three centre based services and redeploy the staff resource to support service development along the lines proposed. This will be in three day centres, two in Norwich locality and one in Southern locality, due to being accommodated in buildings not fit for purpose under the future model.

- In the longer term a fourth day centre in Eastern locality is to be considered for closure, dependent on the uptake on personal budgets and other provision offered by the independent or voluntary sector.

(See Appendix 2 for details of the centres and chosen options)

4.10 This proposal would necessitate the staged de-commissioning of day services for frail older people, and directing some current service and future service users either to the independent and voluntary sector for alternative places, or to new opportunities using a personal budget. At the same time the department will be working with in-house and external day care providers to develop a new specification based on choice and empowerment.

5. Strategic Partnerships

5.1 The final element of the new model will be to seek to work with strategic partners on the management and development of the in-house services.

5.2 Strategic partnerships will engage external partners to develop and deliver day opportunities that complement the commissioning strategy. Therefore there will be a need for early engagement with partners to explore new opportunities for partnership working.

5.3 Establishing strategic partnerships will also complement the shift towards the Council eventually becoming a commissioning organisation and not a direct provider of services.

5.4 Some of this work will be undertaken via a dementia services tender, which will offer an opportunity to include ASSD services in this process and seek strategic partners.

5.5 Existing strategic partnerships include:

5.5.2 Norfolk Adult Social Services and NHS Great Yarmouth and Waveney. Norfolk ASSD are working with NHS Great Yarmouth and Waveney to explore the possible provision of a dementia resource centre in the Eastern locality as part of the PCT's future strategy for the provision of dementia services. This would include potentially re-locating existing in-house day services

6.3.2 Norfolk Adult Social Services, NHS Norfolk and Norfolk & Waveney Mental Health NHS Foundation Trust. The re-location of the Mousehold Dementia Day resource currently located within a Norfolk County Council care home is a priority for Norwich Locality. Early negotiations are in place, discussing a possible re-location of this service, with the Norfolk & Waveney Mental Health NHS Foundation Trust and NHS Norfolk.

6. Younger People with Physical and Sensory Impairment

6.1 The Vauxhall Centre, in Norwich, is the only in-house service for younger people with a physical and or sensory impairment in Norfolk. The resource has evolved to become a community resource centre, offering a wide range of

activities including art, craft and information technology resources, and it now meets the needs of a wider range of people eg older people and adults with mental health problems. Many organisations, including Children's Services and Adult Education, are accommodated within the Vauxhall Centre.

6.2 This resource is outside the remit of the proposal above as it is a county resource accessible to people regardless of whether or not they meet our FACS criteria. The proposal is to include the introduction of a re-ablement service for the Norwich locality and to explore other strategic partnerships for its management.

7 Resource Implications

7.1 **Financial Implications:**

7.1.1 At this stage it is envisaged that overall the change will be cost neutral. The main costs in centre budgets are staff costs. If staff are redeployed within the service as the three identified buildings close, they will support service development by helping to provide the higher level of staffing required for dementia or re-ablement. This means there will not be any cashable revenue savings, but there will be efficiency savings as in-house services will be providing re-ablement services to reduce long term dependence and hence reducing demand for services. Dementia care is expensive to purchase externally, whilst lack of carer support can lead to care home admission. People currently attending the centres identified for closure will be supported to access other opportunities locally including day centres with spare capacity and community based services such as lunch clubs.

7.1.2 In addition some centres e.g. Mousehold, have no budgets for building costs, as that is held within the care home, so any re-provision would require additional funding. Any developments like this would have a full business case so that the full financial implications can be considered.

7.1.3 Savings that can be identified are:

i. Savings on buildings costs for centres and already identified refurbishment costs where the buildings will close.

ii. Dis-investing in services in buildings that are not needed for re-ablement or dementia and are not high quality, and are not located to meet local need, will also help meet efficiency savings.

iii. Sale of buildings.

7.1.4 Identified costs include:

i. Funding to train staff in re-ablement and dementia.

ii. Norfolk Property Services (NPS) costs re marketing/ sale of buildings.

iii. Security on empty buildings.

iv. Refurbishment and equipment costs to deliver a re-ablement service, and for security measures to ensure a secure environment for dementia resources.

7.2 **Staffing Implications**

7.2.1 Staff currently employed in services that are to be de-commissioned will need to be consulted and offered alternative posts as appropriate. Many staff have acquired skills and have undertaken training that can be transferred to other services e.g. dementia care.

7.2.2 Staff currently employed in day centres where there will be a change in service provision e.g. dementia or re-ablement, may need to undertake training or alternatively, staff may have the opportunity to be re-deployed in an alternative in-house resource that matches their skills and training.

7.3 **Property**

7.3.1 The Essex Rooms and the Silver Rooms are two in-house services that are to be de-commissioned, in the Norwich locality.

7.3.1 These buildings have been identified as requiring significant expenditure to meet gas regulations and these buildings are not suitable to offer either a dementia or a re-ablement service. (See appendix 2).

8 Other Implications

8.1 People using in-house day services:

- Implications for users of current services and their families – change and uncertainty can be minimised by having a staged approach in implementing changes in 2009/10 with minimal disruption to service users for those attending centres with a change in purpose being implemented.

- In view of the public consultation that has already taken place (see 1.1), it is proposed that a consultation exercise will take place with the service users in the day centres where a service will no longer be offered.

- There are alternative resources which have spare capacity for people currently attending in-house services (see appendix 1 and appendix 2).

- Hempnall Mill is leased from Hempnall Mill Trust and the day centre and the luncheon club share a cook. Further discussions will be required with the trustees to address any adverse impact of the proposed cessation of the day service at Hempnall Mill upon the luncheon club.

9 Equality Impact Assessment

9.1 An equality impact assessment has been completed for the:

- Commissioning Strategy for Day Opportunities for Older People and People with a Physical Disability or Sensory Impairments in Norfolk.

- Proposal for the future Commissioning Models – Community Care In House Day Services – there will be more services with people with dementia and support for their carers. Older people will be able to access re-ablement service to maximise their physical and mental well being

9.2 An equality impact assessment for this service model includes the following components:

- There will be a loss of in house services catering for frail elderly people, however alternative provision has been identified. The review and reassessment process will enable individual needs to be met.

- People will be able to remain in their own homes for longer by having access to the proposed services.

- Improved services and improved capacity for people with dementia – including provision in the evenings and at weekends with well trained staff.

9.3 At present in–house services are not equitably spread across the county. Future service commissioning of both dementia and re-ablement services will address this by taking a strategic view across areas, which includes both internally and externally provided services. This will also include market stimulation.

10. Section 17 – Crime and Disorder Act

10.1 Overall this proposed model for in-house day service provision will help to reduce crime and disorder by protecting vulnerable people who may be victims of crime and abuse. Safeguarding arrangements will be considered as part of the work on implementing this new model of service.

11. Risk Implications/Assessment

11.1 There is a potential risk that alternative provision is lacking for service users who do not fit the dementia and re-ablement model. However, this has been factored in through the wider strategic review.

11.2 Risks with de-commissioning of standard day services for older people include lack of clear evidence that this type of service will not be needed in the future by people with personal budgets. However 50% of older people on personal budgets are choosing less traditional services.

11.3 Re-deployment of staff will impact on staff morale.

11.4 There may be reduced capital income if buildings are sold, from the sale of buildings in the current economic climate.

11.5 There will be a need to stimulate the independent and voluntary sector to offer dementia and re-ablement services through the five year period as well as working with other organisations to form strategic partnerships. There is a risk that other organisations and providers are not able to take this work forward to identity future dementia and re-ablement services.

11.6 There is a need to co-ordinate the implementation of any changes to day services that are accommodated within a care home, so that one service changes does not impact on changes to another.

12. Alternative Options

12.1 **Option One - Status Quo – maintaining the status quo is not considered a viable option for all resources due to:**

- This would conflict with the need to develop more personalised services

and increase choice. However, there would be no disruption for people using these services.

- Some buildings are not located in the right place to meet need, and occupancy can be as low as 50%. As personal budgets are increasingly used, traditional day services are likely to face reducing demand, raising unit costs.

- Many buildings, which are not fit for purpose, are in urgent need of refurbishment.

- This would not help stimulate the market to provide these services in the future.

12.2 **Option 2 – De commission all in house services is not a viable option due to:**

- Lack of evidence that these types of services will not be at all needed in the future.

- There may be insufficient alternative resources, as the market is providing predominantly services for older people with low to moderate needs, and there is little specific re-ablement provision and an already identified shortfall of dementia provision in all localities. The implication is that this would de-stabilise the market, through demand outweighing availability.

13 Conclusion

13.1 This proposal strategically fits in with the need to redesign services that have low occupancy rates and to cease providing building based services that are accommodated in premises that are not fit for purpose. To inform these decisions, in-house services have been evaluated against external providers in each locality.

13.2 Strategically the re-ablement model would sit well with the prevention agenda, by avoiding inappropriate admission to hospital or delaying the need to need to be admitted into a care home. There will be a need to link in with the provision of short stay care as part of the Strategic Model of Care – Care Homes.

13.3 The aim is to maximise use of present services to meet gaps in current service provision. The need is to safeguard key day service provision for older people with dementia and introduce a new re-ablement service that will complement existing in-house services in the community and in care homes, for the next five years.

13.4 This proposal also reflects the strategic aim of Norfolk County Council being able to concentrate on better commissioning of services rather than being a direct provider of services. By initiating this proposal, a gradual shift from in-house provision towards independent and voluntary sector provision can be achieved over a five year period

14. Actions required

14.1 Members are requested to comment on the following proposals:

- To implement this proposal to re-focus in house services on dementia

care and re-ablement services and to limited centre closures over a five year interim period.

- To seek strategic partners, including partners to manage the services at the Vauxhall Centre.

Background Papers

Report to Cabinet 12th August 2008 – 'A Commissioning Strategy for Day Opportunities for Older People and People with a Physical Disability or Sensory Impairments in Norfolk'

Report to Cabinet – 13th October 2008 – 'Strategic Model of Care Strategy'.

Report to Cabinet – 13th October 2008 – Making Your Day: Locality Commissioning Plans for Day Opportunities for Older People and People with a Physical Disability or Sensory Impairments in Norfolk

Report to Adult Social Services Overview and Scrutiny Panel 17th November 2008 Locality Commissioning Plans for Day Opportunities –'Making Your Day' Project

Briefing Paper to Social Services Overview and Scrutiny Panel February 2009

'Making Your Day' Consultation Paper

Appendix One – Maps of current provision and alternative provision

Appendix Two – Locality Option Appraisals

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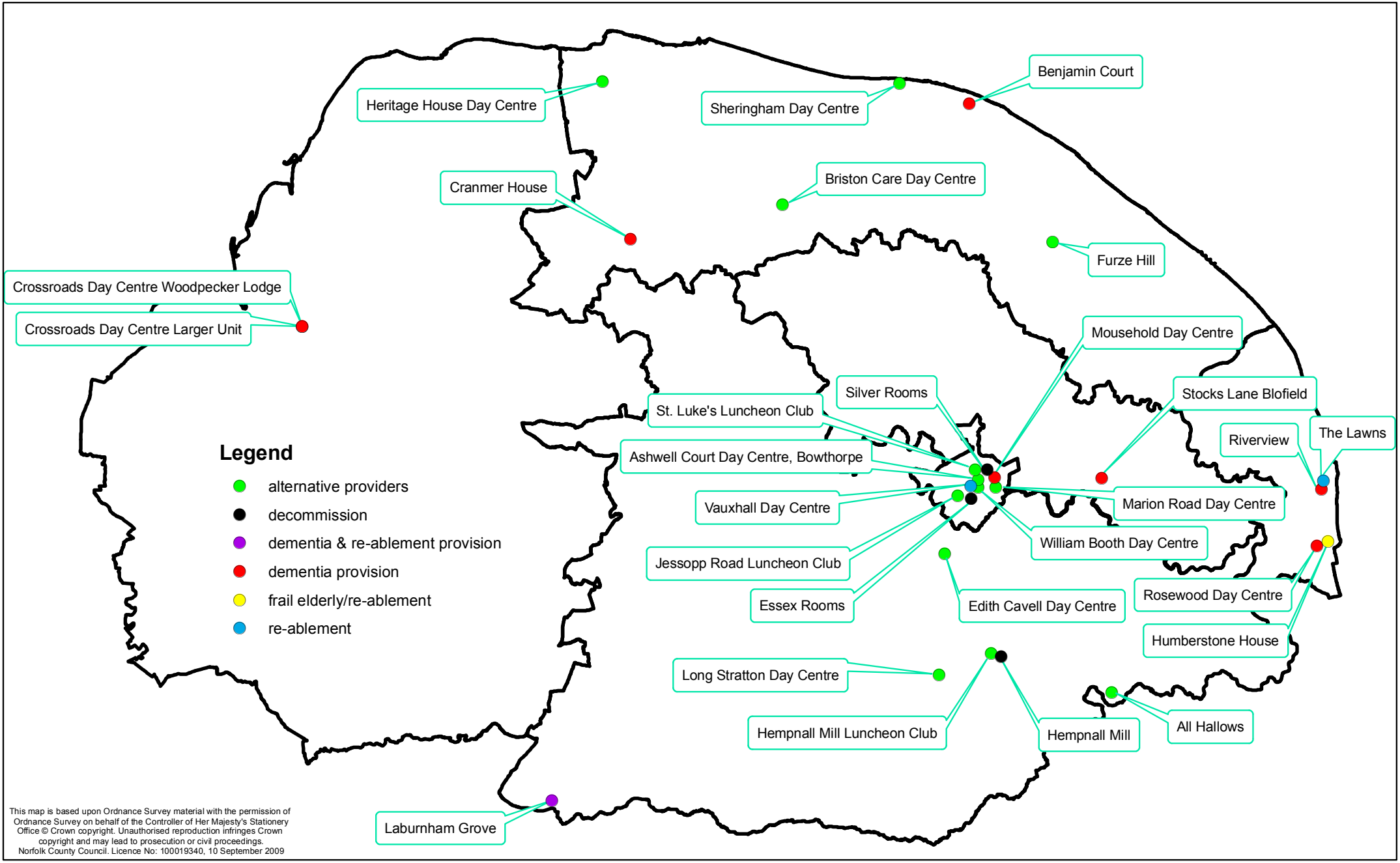

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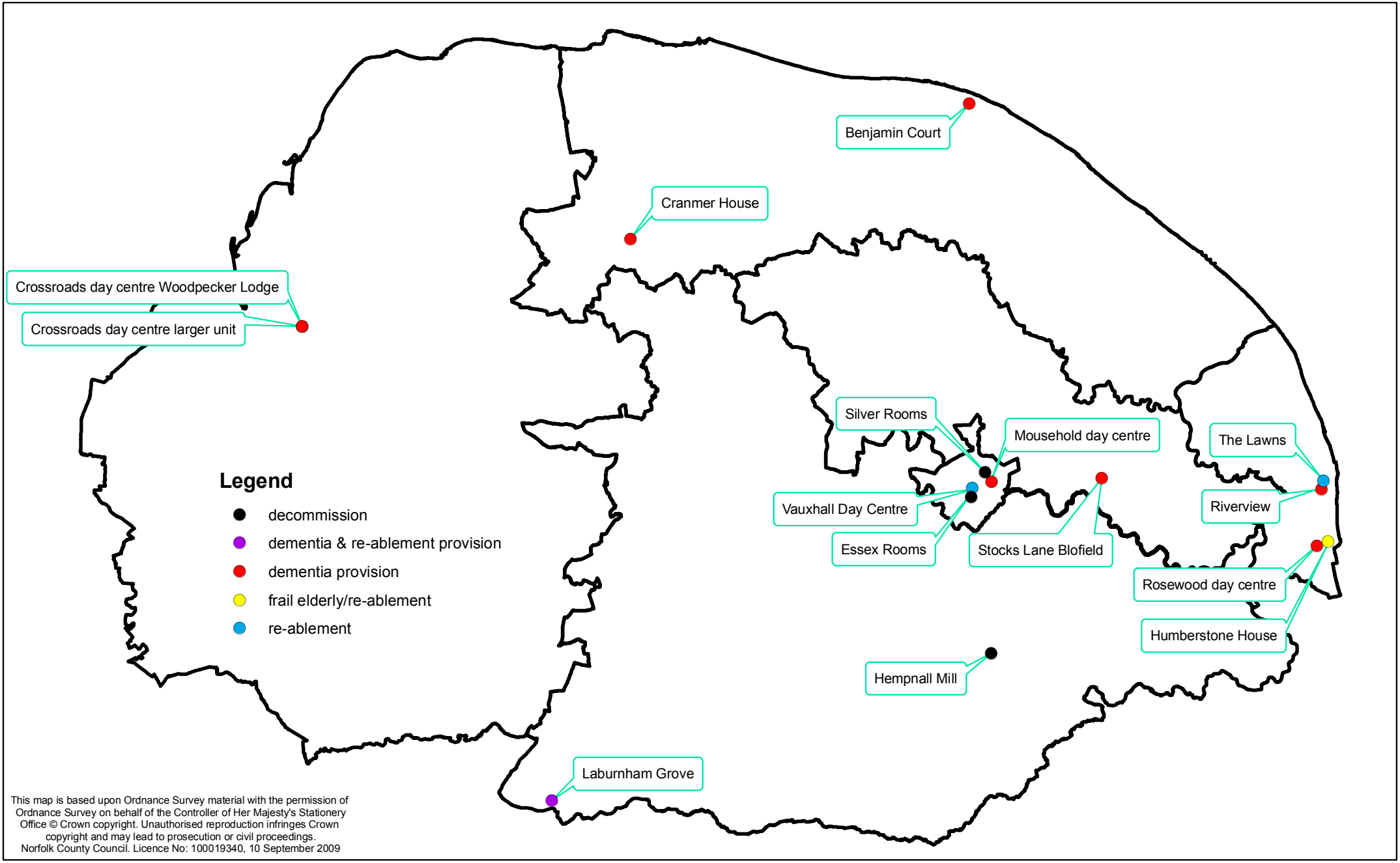

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Appendix Two: Future model of In House Day Services paper

Locality Option Appraisals

Re Future Model Of In-House Day Services

November 2009

Index

Introduction

Introduction

1. This is a detailed option appraisal for each of the five localities. Each option appraisal has considered a range of options for each service:

- Status Quo
- De-commission
- Re-design to dementia care
- Re-design to re-ablement care

2. Each locality was asked to consider the following factors:

- Link to needs analysis, gaps etc
- Adhere to commissioning framework and needs assessment and each individual Locality Plan
- To identify alternative provision for service users in the long term
- Outline potential savings
- Costings e.g. staff redeployment, redundancies and building maintenance implications if de-commission where possible
- Consider the content of an equality impact assessment
- Consider partnership-working

3. Prior to each option appraisal each locality has applied the commissioning tool based on a set of principles, which were included in the commissioning strategy. These have been developed into a commissioning/de-commissioning tool.

The factors considered include:

- strategic importance to the local area
- service user and carer satisfaction and outcomes,
- value for money,
- sustainability
- the impact of decisions on other services run by the provider

The tool has been used to ‘rate’ services, using information provided by providers and collected through site visits to all providers. The relationship between services of a similar nature, and across the area has, also been taken into account by the commissioning teams.

Note: The description of each centre gives occupancy rates – these are the average number of places taken up by registered users attending. This will be less than the number of users registered for each day due to illness, holidays etc and a centre may have all its places filled with registered users but not show 100% occupancy.

Option Appraisals Re Future Commissioning Model Of In House Day Services

Norwich Locality

Norwich has four in house day services

1. Vauxhall Centre

Description

The Vauxhall Centre has evolved into a community resource centre offering a wide range of services for members (people who pay to attend) and FACS eligible users referred through Adult Social Services. Services include an information service offering advice, information and signposting to other services. There is also a Children & Families resource within the centre. These places are available for FACS eligible people in addition to members who use the centre and who do not meet FACS eligibility criteria

The original purpose for this resource was a centre for younger people with a physical and/or sensory impairment, although it now caters for older people and people with mental health needs. It is essential to retain this service whilst exploring strategic partnerships to manage this service in the future. Ideally this resource would need to include re-ablement as the accommodation is highly suitable for re-ablement with equipment available.
.
Occupancy levels are high at 75%
Overall places available per week - 120 places
(See reference Overview and Scrutiny report page 6)

Chosen Option and Rationale

Re-ablement - This is an expensive resource, gross cost of £431,130 has further potential to provide services to the wider community including re-ablement. It is strategically located next door to the St. Raphael Club. The premises would not be suitable on a security basis for dementia care. To de-commission would deny the locality of a valuable resource which has potential to offer a wide range of services for the community. Therefore to be cost effective and to ensure this community resource is retained there is a need to engage with strategic partners for future delivery of services.

2. Essex Rooms

Description

This is an excellent service for physically and mentally frail older people. Staff are skilled and have gained expertise in providing a service for people with low level dementia care needs. However, the building which is a disused chapel is not suitable for a day resource for either re-ablement or dementia. There is no garden, no storage space and no parking facilities. There is public access around the perimeter of the building, which excludes the potential for upgrading the building. This resource is within walking distance to the Vauxhall Centre.

Occupancy levels are 75% approximately.
Overall places available per week – 150 places

Chosen Option and Rationale

De-commission - Due to the poor quality of the building for its purpose and the need to spend approximately £27,000 on this resource to update the kitchen this is not seen as a cost effective plan to continue to commission either for dementia or re-ablement.

3. Silver Rooms

Description

This is a high quality traditional day service for physically and mentally frail older people. The staff also skilled and have gained experience in the care of older people. Many activities are undertaken and innovative ideas have been adopted by arranging outings to places of interest. The building is a disused church and is therefore not purpose built with limited outside space for activities or parking.

Occupancy levels have been as low as 50%.
Overall places available per week = 150 places

Chosen Option and rationale

De-commission - The chosen option is to decommission as there is £46,000 expenditure needed to upgrade the kitchen facilities to meet regulations, which is not cost effective for the long term future. Occupancy levels are consistently low and at times have been only 50%.contribute to making this a not cost effective service.

4. Mousehold Day Centre

Description

This is a specialist dementia centre open 6 days a week for people with high level dementia needs. There are strong links with the Norwich Community Mental Health team. The service operates six days a week including Saturdays.

Occupancy levels are high at 80% or above.
Overall places available per week = 102 places

Chosen Option and rationale

Dementia Care - Decommissioning is not an option as this is a key resource for dementia care in the Norwich Locality and demand will grow. The proposal is for the service to continue as a dementia resource with relocation being considered with Health partners. The premises would not be suitable for re-ablement as they occupy the communal space for Heathfields care home, and re-ablement could be offered more appropriately at the Vauxhall Centre.

Southern Locality

Southern Locality has two in house day services

1. Laburnham Grove

Description

This resource is accommodated as part of a 'Housing with Care' Scheme and the purpose-built premises are set in a strategically significant area. The resource offers 80 day places per week for frail elderly and 15 for people with dementia.

Occupancy levels are moderate at 65%
Overall places available per week = 95 places

Chosen Option and rationale

Dementia care and Re-ablement - The recommended option is to continue to commission this service.

This resource is able to offer a flexible service creating a balance between dementia care and re-ablement over the five-day period. Current demand indicates a 1:4 day split between dementia and re-ablement, but projections of future needs would indicate a move to a 2:3 day split over the medium term.

By joint working with mental health pool expertise can offer more dementia places and possible improve services to include carer support groups and more partnership work with the local branch of the Alzheimer's Society etc with more robust links with the community mental health team being also sought.

Staff are all highly skilled – these skills may be lost if not appropriately re-deployed
No other services offering high level care of people with dementia in Thetford area.

Closure not an option due to paucity of comparable services in area + increasing demographic demand for dementia and re-ablement service. This leads to the conclusion that this service needs to be retained and re-focused.

Therefore the chosen option is to work towards a possible 'mixed use' re-ablement and dementia resource.

2. Hempnall Mill

Description

Hempnall Mill – premises owned by the Hempnall Mill Trust and leased to the County Council for two days each week. This is a resource for physically and mentally frail older people, taking people from a wide geographical area within Southern locality.

Occupancy levels are fairly high at around 75% or above.
Overall places available per week = 50 places

Chosen option and rationale

Decommission – this is the recommended option.

The premises, whilst suitable for physically frail older people, the traditional "village hall" design would not offer a suitable base from which to deliver a service for people with a significant dementia. It would be expensive to make the premises secure. There is no secure outside space and the premises are located on a relatively busy road.

Similar building constraints exist in connection with any proposal to provide a re-ablement service.

The geographical location in a relatively thinly populated part of the county would also result in significant transport costs inherent in providing a specialist service.

One implication for de-commissioning this service is the future employment of the cook who also caters for a luncheon club held at the same resource on another day. Once this service is de-commissioned the cook may not be able to continue the catering service for the luncheon club.

West Norfolk

West Norfolk has one in house service divided into two units. Both units provide dementia day services, and are located on the same site as a care home.

1. Crossroads Larger Unit

Description

This unit already provides short term/time limited support to aid re-ablement back into the community (6 weeks). This resource is open five days a week offering up to 25 places a day for people with early onset dementia.

Occupancy rates are high at about 80%
Overall places available per week = 125 places

Chosen option and rationale

Dementia and Re-ablement - the chosen option is to retain the dementia service and the reablement service currently in place. There is potential to develop re-ablement for people who have suffered a stroke working in partnership with the NHS Community health service rehabilitation team as some of the current clients have suffered strokes.

2. Crossroads Woodpecker Lodge smaller unit

Description

The small unit at Crossroads provides dementia services and acts as an assessment unit. The unit caters for people with dementia with moderate to high dependency need. The resource offers 15 places a day for moderate needs for three days a week and 12 places a day for high dependency needs available for two days a week. The centre is open five days a week.

Occupancy levels are about 70% - 75%
Overall places available per week = 69 places

Chosen option and rationale

Dementia Care -This chosen option is to retain this resource for dementia care.

As the adjacent residential home is part of the care place review, Crossroads could be considered in any new model of care (especially Housing with Care) as this would enhance services with the potential to provide a dementia centre offering all ranges of support to people in their own home.

Eastern Locality

Eastern has four in house day centres

The ratio of “in house” day centre places to the number of older people is higher than in other localities, but this is because there is only one voluntary sector provider in the locality, unlike other localities, where there are a wide range of voluntary sector providers to supplement the in house provision.

1. The Lawns

Description

The Lawns is a purpose built building attached to the Lawns Housing with Care Scheme. This resource currently provides services for physically frail older people and apart from Humberstone House and one small voluntary centre; this is the only provision for this user group in the locality. The service provides 30 places a day for five days a week

Occupancy levels are moderate and recorded at 62.6% but will be variable
Overall places available per week = 150.

Chosen Option and rationale

Status Quo – frail elderly - The chosen option is to retain the Lawns Day Centre for frail elderly people as there is very little alternative provision available in the locality and the Lawns is a purpose built building in a good locality with room to expand and develop into extended days, weekends etc.

The Lawns would be the most suitable venue for any re-ablement service, being situated within housing with care scheme - if required one of the residential units could be rented to support any re-ablement service provided in the day centre. However it needs to be borne in mind that some older people live in older properties with steep staircases, steps to front and rear of house and split levels and so outreach re-ablement and home visits would probably be better than renting a unit in the scheme so that older people could learn to manage within their own surroundings.

2. Humberstone House

Description

Humberstone House is in a stand alone adapted building that ASSD rents from a private landlord and is partway through an initial 15 year lease. The centre is open five days a week offering 18 places everyday except Wednesday when 21 places are available.

Occupancy levels have been recorded at 72% but will be variable
Overall places available per week = 93

Chosen Option and rationale

Frail elderly/Re-ablement - Retain the current use for frail older people at least in the short term but with more emphasis on individual activities and re-ablement type services.

While it is anticipated that personal budgets may reduce the demand for these places it is felt that the locality needs to retain some provision for frail older people at least until there is further evidence that older people are using their personal budgets to choose other services. If the demand does reduce as anticipated then the locality could reduce the overall number of places which could lead to the closure of one of the two services for frail elderly people. If this happens then Humberstone House is likely to be the centre most at risk as:

a. It is a smaller centre and so could more easily be incorporated in the Lawns
b. The premises are less suited to the provision of day care then those at the Lawns

If Humberstone was to close due to personal budgets then although there would be some savings there would be no savings on the full running costs of the centre as:

(a) Some of the staff and budget etc would be required to provide outreach services to help support people accessing other services with their personal budgets. This staff group could provide the outreach service from The Lawns
(b) Some of the transport budget would be required to transport the extra people to the Lawns

3. Riverview

Description

Riverview is a day service for older people with dementia accommodated in an adapted wing of in house residential care home (Mildred Stone House). It is a good service but the premises are not purpose built and better premises are required to develop the service and to meet future demands. The centre is open seven days a week offering 15 places each weekday and 11 places on Saturdays and 11 places on Sundays.

Occupancy levels are generally high at around 83.5%
Overall places available per week = 97

Chosen Option and rationale

Dementia care - There is a need to keep this service but the locality would like to develop a purpose built dementia centre that would incorporate day services to replace this and Rosewood. This proposal is being explored NHS Great Yarmouth and Waveney as part of the overall plans for dementia services in the PCT area.

As this service is provided in a wing of an in house care home any proposals regarding the future of in house care homes may have an impact on this service

Demand for more dementia places will grow and occupancy rates are high.

Currently there is no dedicated day service provision for people in early stage dementia, or neither for younger people with dementia nor for older people with functional mental health problems and so a ‘purpose built’ centre could help fill these gaps.

4. Rosewood

Description

Like Riverview, Rosewood is a day service for older people with dementia accommodated in an adapted wing of in house residential care home (Magdalen House). It is a good service but the premises are not purpose built and better premises are required to develop the service and to meet future demands. The centre is open seven days a week offering 15 places each weekday and 11 places on Saturdays and 11 places on Sundays.

Occupancy levels have been recorded at 76% but variable
Overall places available per week = 97

Chosen Option and Rationale

Dementia care - There is a need to keep this service but would like to develop a purpose built dementia centre that would incorporate day services to replace this and Riverview. This proposal is being explored NHS Great Yarmouth and Waveney as part of the overall plans for dementia services in the PCT area.

As this service is provided in a wing of an in house care home any proposals regarding the future of in house care homes may have an impact on this service

Demand for more dementia places will grow and occupancy rates are high.

Currently there is no dedicated day service provision for people in early stage dementia, nor for younger people with dementia, nor for older people with functional mental health problems and so a purpose built centre could help fill these gaps.

Northern Locality

1. Stocks Lane Day Centre

Description

Stocks Lane is a standalone specialist day centre for older people with dementia, situated in Blofield. The building is owned by Wherry Housing Ltd and approval has been granted for Adult Social Services to build an extension, increasing the day centre's capacity from 45 to 70 places per week. No meals are cooked on the premises. Meals are cooked at Springdale Care Home and are collected by the Day Centre Manager. The centre is open five days a week.

Occupancy levels are generally high at 89%
Overall places available per week = 45

Chosen Option and rationale

There is a significant need to retain Stocks Lane. It is currently operating at full capacity and has waiting lists for new referrals and people wanting additional days. Capital funding to build an extension on to Stocks Lane has been agreed and will better enable Stocks Lane to meet the growing current and future demand for specialist dementia day care, with an increase in capacity of 25 places per week with no additional staffing costs.

In addition, Stocks Lane provides valuable respite for Carers. There would be a significant impact on the local market, staff, people who access the service and their Carers if Stocks Lane was to close or cease to provide specialist dementia care as there are no affordable alternatives in the area.

2. Cranmer House Day Centre

Cranmer House is a day centre for older people, situated in Fakenham. The day centre is joined onto and has good links with Cranmer House, a short-term care home and re-ablement unit.

Occupancy levels are high at 91%
Overall places available per week = 100

Chosen Option and rationale

Dementia Care - The Northern Locality proposes to change Cranmer House Day Centre into a specialist dementia day centre for older people. This is in response to the current and anticipated future increase in demand for specialist dementia day services in the Fakenham area and the lack of affordable alternatives in the area.

This proposal will involve making the building and the garden secure and providing additional training to staff.

2. Benjamin Court Day Centre

Description

Benjamin Court is a day centre for older people, situated in Cromer. The day centre is joined onto Benjamin Court Housing with Care Scheme and Benjamin Court Community Hospital. While the day centre has made good links with the Housing with Care Scheme and the Community Hospital, these could be strengthened. The day centre's capacity could be increased by better-utilising the storage/staff room.

Occupancy levels are high at 88%
Overall places available per week = 125

Chosen Option and rational

Dementia care - Northern Locality proposes to change Benjamin Court Day Centre into a specialist dementia day centre for older people. This is in response to the current and anticipated future increase in demand for specialist dementia day services in the Cromer area and the lack of affordable alternatives in the area. This proposal will involve making the building and the garden secure and providing additional training to staff.

Summary In-House Day care places

Norwich Locality			
Name of Centre	**Current Number and type of places Per week**	**Proposal**	**Resource implications**
Mousehold	Dementia 102 places	Retain current service	No change
Silver Rooms	Frail elderly 150 places	De-commission	Alternative provision for 150 frail elderly places
Essex Rooms	Frail elderly 150 places	De-commisssion	Alternative provision for 150 frail elderly places
Vauxhall Centre	Younger people Physical and Sensory Impairment 120 places	Seek strategic partners with a view to a re-ablement services places number of places not yet identified	Younger people access mainstream services with the support of the development workers and various groups have emerged from this service – other resources include the Rainbow Club and resources with the Deaf Association in a building leased by ASSD within the Vauxhall Centre site.

Southern Locality			
Name of Centre	**Current Number and type of places Per week**	**Proposal**	**Resource implications**
Hempnall Mill	Frail elderly 50 places per week	De-commission	Alternative provision for 50 places for frail elderly
Laburnham Grove	Frail elderly 80 places & 15 Dementia places	Increase dementia places and replace older peoples' places with re-ablement service	Alternative provision needed for 80 places for frail elderly people Increase from 15 to 30 dementia places 60 re-ablement places

West Norfolk			
Name of Centre	**Current Number and type of places per week**	**Proposal**	**Resource implications**
Crossroads Larger unit:	Older people People with early on set Dementia 125 places	Retain current services	None
Crossroads small unit (Woodpecker Lodge)	Dementia – moderate needs 45 places Dementia – high dependency = 24 places total = 69 places Re-ablement Services for people with a physical or sensory impairment for the frail elderly who attend the centre.	Retain current services	None

Eastern			
Name of Centre	**Current Number and type of places per week**	**Proposal**	**Resource implications**
The Lawns	Frail elderly 150 places	Frail/Re-ablement 150 places	
Humberstone House	Frail elderly - 93 places	Retain service in short term may de-commission in long term/integrate into the Lawns facility depending on impact of personal budgets.	None
Rosewood	Dementia – 97 places	Retain service but relocate	Funding implications with NHS Gt. Yarmouth and Waveney
Riverview	Dementia – 97 places	Retain service but relocate	

Northern Locality			
Name of Centre	**Current Number and type of places per week**	**Proposal**	**Resource implications**
Stock's Lane Day Centre, Blofield, (Standalone)	Dementia – 45 places	Retain service – extend capacity by 25 places per week by funding new build extension	Increase in dementia places to 70 places per week
Cranmer House Day Centre, Fakenham (Part of short term care home)	Frail elderly 100 places	To provide dementia places only	Alternative provision for 100 places for frail elderly Increase of 100 places for dementia care
Benjamin Court, Cromer (Within Housing with Care Scheme)	Frail elderly 125	To provide dementia places only	Alternative provision for 125 places for frail elderly and increase of 125 places for dementia care

Summary

County totals under new service model proposal for in-house service provision

Category of Service	Norwich	Southern	West Norfolk	Eastern	Northern
Retain Physical and Sensory Impairment resource centre	120	0	0	0	0
Re-ablement	To be confirmed	60 places	Variable	To be confirmed in the longer term 0	0
Dementia	102	30	194	194	295
Retain frail elderly – with possible move to re-ablement	0	0	0	243	0
Totals	**202**	**90**	**194**	**437**	**295**

County Resource Implications:

- Dementia places will increase from 550 places to 815 places under this proposal

- Alternative provision needed for 748 frail elderly places in the independent and voluntary sectors

- Re-ablement places not confirmed in Norwich or Eastern locality as unable to confirm at present. No re-ablement services identified in Northern locality.

Report to Adult Social Services Overview and Scrutiny Panel

3 November 2009
Item No 14

Norfolk County Council's response to the Green Paper 'Shaping the future of care together'

Report by the Director of Adult Social Services

Summary

On the 14 July the Department of Health launched its Green Paper 'Shaping the future of care together'. This outlines the major challenges facing social care in the future, proposes a vision for a new National Care Service, and sets out three options for funding Social Care. The consultation period for this Green Paper finishes on the 13 November.

This paper proposes the formal Norfolk County Council response to the consultation. In developing this response we have consulted widely with staff, Members and stakeholders, including a member workshop.

The response takes each of the Department of Health's questions in turn.

In terms of the vision for the National Care Service:

- We broadly support for the vision for the National Care Service, and welcome the proposal for a consistent National Assessment.
- The vision needs to give a higher importance to prevention, the role of the voluntary sector, rurality and promoting a positive image for social care.

In terms of proposed approach to change:

- The overall approach is right
- There are existing barriers to making this work that must be accounted for, including organisations having different drivers, the need for greater clarity about choice, people needing advice and reassurance about self-directed support, issues of rurality and potentially complicated information and systems.

In terms of the best option for funding:

- That, on balance, the comprehensive model offers the best solution for Norfolk, particularly given its demographic profile and the number of older people living in deprived areas.
- That a part national/part local approach to the allocation of funding would work best, providing funding for social care was ring-fenced and that the agreed approach allowed local discretion.

After Overview and Scrutiny, this response will be discussed and approved by Cabinet before being submitted to the Department of Health.

This paper asks Overview and Scrutiny Panel to review and comment on Norfolk County Council's response, prior to it being discussed and approved by Cabinet on the 9 November.

1 Background

1.1 On the 14 July the Department of Health launched its Green Paper 'Shaping the future of care together'. This sets out the major challenges facing social care, focusing specifically on:

- The country's ageing population – with life expectancies increasing the absolute number of older people with poor health, long term health conditions, dementia and frailty
- The increasing life expectancy and expectations off adults with complex disabilities
- Significantly increased demands for adult social services as a result of these changes
- The un-sustainability of the current way social care is funded, with the proportion of the working-age population falling and increasing expectations about the quality of services
- Complicated and inconsistent approaches to eligibility and charging for health and care services
- The need to move more funding towards preventative services for everybody
- The need to recruit and retain excellent staff

Building on a national consultation process in 2008, the Green Paper proposes some of the most significant changes to social care since the 1940s. It proposes the development of a National Care Service, outlining a new vision for social care and suggesting options for a new way of funding care and support.

The proposals are wide-ranging and detailed. To see the full Green Paper go to the 'Big Care Debate' web site using the following link: http://careandsupport.direct.gov.uk/greenpaper/the-green-paper-and-supporting-documents/. For the purpose of this paper, a summary of the proposals is provided in Appendix A.

This debate is particularly important for Norfolk given the demographic challenges we face. Not only does Norfolk have a larger proportion of older people than average, but this proportion is growing at a faster rate than average. Furthermore, Norfolk has a relatively high proportion of older people living in its most deprived areas – making the Government's funding proposals particularly important.

The consultation for 'Shaping the future of care together' ends on the 13 November 2009.

2 Developing Norfolk County Council's response

2.1 In developing this response we have consulted widely, including:

- A staff questionnaire inviting responses
- Officer attendance at local Department of Health 'Big Care Debate' roadshows
- A member event to help develop this response, with involvement and presentations from the Norfolk County Strategic Partnership for Older People, the Norfolk Coalition of Disabled People and Voluntary Norfolk.

The views presented in this paper have been gathered through this consultation process and attempt to bring together a 'Norfolk view'.

After Overview and Scrutiny comment on the response presented here, it will be taken to Cabinet on the 9th November for further comment and approval.

3 Our response

The Green Paper requires us to respond to a series of questions. This paper now sets out our response to each of these in turn.

3.1 **Consultation question 1**

We want to build a National Care Service that is fair, simple and affordable. We think that in this new system there are six things that you should be able to expect: • prevention services • national assessment • a joined –up service • information and advice • personalised care and support • fair funding a) Is there anything missing from this approach? b) How should this work?

Norfolk County Council's response

With reference to the overall vision for the National Care Service:

- The six expectations set out for the National Care Service are right

- We welcome the proposal for a consistent national assessment process

Is there anything missing from the proposed approach?

- Prevention needs a higher profile and is underplayed in the current vision. Prevention is particularly important in areas such as Norfolk where demographic pressures are putting a significant strain on services and where it can be difficult to reach people in rural and/or deprived areas because of social isolation. We feel that the vision for the National Care Service and any subsequent plans to implement it should have a greater focus on prevention services and their links with the other elements of the vision (for example 'Information and advice' and 'National assessment'), with clearer guidance about how preventative work would be funded under the new approach.

- The role of the voluntary sector in delivering the new vision should be made clearer. We feel that the voluntary sector has an important role to play in delivering information, advice, advocacy and care services, and in particular for cost-effective preventative services, and that this expectation should be reflected in the vision for a new National Care Services.

- Rurality. Delivering services and support in rural areas provides particular challenges, not least in terms of costs, and this is not sufficiently covered in the vision for the National Care Service.

- The positive image of social care services. The introduction of a National Care Service provides a unique opportunity to address the poor image and esteem of adult care services in the public mind. The value of professional interventions and the recruitment of staff in the future – from a potential declining proportion of workforce, needs to be more positively addressed.

How should this work?

- We do not have detailed feedback on how these elements should work, but are clear that in delivering the new vision we must avoid developing complicated and costly processes, and should focus on individuals rather than organisational structures.

3.2 **Consultation question 2**

We think that in order to make the National Care Service work, we will need services that are joined up, give you choice around what kind of care and support you get, and are high quality? a) Do you agree? b) What would this look like in practice? c) What are the barriers to making this happen?

Do we agree with the approach?

- Yes, the overall approach is right
- For the integration of health and care services, a clearer expectation needs to be expressed on the 'choice' entitlements of the National Care Service and the National Health Service at a local level.
- Greater clarity about how personalised health and care services will work together is needed. A single framework for assessment and case management of people with complex care and health needs is needed at Primary Care Service Level, with much greater flexibility of payment incentives within local health systems. Too much emphasis is placed upon incentives for treatment in acute service settings.
- Practice Based Commissioning needs to become the default way of working for both local authorities and local health services.
- As long as organisations have different drivers and objectives, joined up working will remain difficult – and this is a barrier. In practice, different organisations must have the same national and local drivers and objectives, feeding from central government downwards.
- We support greater choice around the kind of care and support people get. Our experiences in Norfolk tell us that the move to more self-directed support requires great sensitivity. People need to be reassured and supported to make decisions about their care, and any further changes to encourage more self direct support must account for this. In practice this requires a focus on advice and advocacy services.
- Rurality can be a barrier to making the new approach work, and in particular when planning for more self-directed support. Accessing services in rural areas can be more difficult. Sometimes services aren't available, or are more expensive to access in rural areas. In addition, whilst the move to more imaginative and personalised support can benefit many people, where this means traditional services close others may lose out – a situation felt most keenly in rural areas where isolation is a threat for many.
- Making the National Care Service work also requires clear information to

be available to everyone. In the past confusing information and complicated systems have made it difficult for people to navigate social care and health services. In Norfolk we are moving to try and improve this through an improved "front door" so that people receive a consistent message about the options open to them. We believe that any model for change in social care must be clear about the role of information in helping people, and should specify that joined up working should mean joined up information.

3.3 **Consultation question 3**

The Government is suggesting three ways in which the National Care Service could be funded in the future: • Partnership – people will be supported by the Government for around a quarter to a third of the cost of their care and support, or more if they have a low income • Insurance – as well as providing a quarter to a third of the cost of people's care and support, the Government would also make it easier for people to take our insurance to cover their remaining costs • Comprehensive – Everyone gets care free when they need it in return for paying a contribution into a state insurance scheme, if they can afford it, whether or not they need care and support a) Which of these options do you prefer, and why? b) Should local government say how much money people get depending on the situation in their area, or should national government decide?

Which option is best for Norfolk?

- We believe that, on balance, the Comprehensive model offers the best solution for the people of Norfolk. We do recognise that, as with the current arrangements, people may want to enhance and individualise their services with additional services which may incur additional costs to them. The system should be flexible enough to cope with this.

- Norfolk experiences significant levels of income deprivation for older people than average, and the Comprehensive model is the only model which deals with the inequities in the current model.

- In addition, more than most places, Norfolk has a high number of people at or approaching retirement age and who would, for example, not have the opportunity to make regular payments into either voluntary or compulsory insurance schemes throughout their working lives. We feel that the certainties within the

comprehensive scheme best address these risks.

- During our discussions some participants felt that while the Comprehensive approach could be seen as an extension of national insurance, it offers the lowest overall cost per head of population. In addition, in the longer term it will reward people who are prudent and make provisions earlier by paying into it during their working life.

- Throughout our own consultations, we have received ongoing feedback about peoples' anxieties about a voluntary insurance scheme. The anticipation of low take-up of such a scheme, particularly in deprived areas, negates many of its likely benefits. There is also concern that any private insurance schemes, whilst taking some of the risk away from the public sector, might be too complicated and be difficult for some people to understand and manage.

- The partnership approach alone only appears to partially mitigate against the current issues. The guarantee of support for everyone is welcomed, but most respondents suggest that many people would be likely to continue to experience many of the problems they experience now – and as such is not a sustainable solution.

- With all options, there remains anxiety about how accommodation costs in residential care will be able to be effectively met.

Should local government say how much money people get depending on the situation in their area, or should national government decide?

- We feel that a part national, part local solution is required. However, in our discussions we agree that this should be managed in a particular way.

- A form of national funding allocation based on assessed local need (and accounting for issues such as rurality etc.) would be welcomed, providing allocation between regions is fair.

- However, we strongly believe that within this there should be some local discretion to ensure local circumstances and markets can be accounted for.

- The schools model, of providing a hypothecated or ring-fenced fund for a given area, was the most popular suggestion in our own discussions. There is particular conviction that these funds must be ring-fenced.

3.4 **Other feedback**

In developing our response we have identified some other important views that we should feed back:

- We welcome the proposed role for local government set out in the Green

Paper.

- It is clear that in planning any changes to the funding arrangements for social care, government must carefully consider the transition arrangements to ensure people understand changes, are not worried by them, and crucially are not disadvantaged by them unfairly.

- There is clearly a need to ensure that funds raised through any insurance systems are secure – some respondents expressed concern about this in the light of experiences of national insurance contributions and pensions. It is critical that this assurance is given and individuals are therefore clear about what they can expect, whatever scheme is finally settled on.

4 Resource Implications

4.1 There are no direct resource implications for the panel to consider

5 Equality Impact Assessment

5.1 The consultation process for the Green Paper nationally is being coordinated by the Department of Health, who report that it has undergone a rigorous Equality Impact Assessment.

5.2 In considering the Norfolk County Council response we have involved a range of stakeholders representing groups including the Norfolk Older People's Strategic Forum, the Norfolk Coalition of Disabled People and Voluntary Norfolk.

6 Section 17 - Crime and Disorder Act

6.1 There are no direct Crime and Disorder implications for the panel to consider.

7 Alternative Options

7.1 There are no alternative options presented.

8 Action Required

8.1 Overview and Scrutiny Panel are asked to comment on the proposed formal response to the Green Paper in preparation for the Cabinet discussion and submission to the Department of Health.

Background Papers

Appendix A – Shaping the future of care together summary

Officer Contact

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communication for all

If you need this report in large print, audio, Braille, alternative format or in a different language please contact Mike Gleeson, Tel: 0344 800 8014, Minicom: 01603 223242, and we will do our best to help.

Appendix A

Shaping the Future of Care Together Summary

What the green paper is about:

Trying to address issues with current adult social care system: unfairness of funding to people with assets, varying

Therefore proposes:

- New National Care Service for adults with six key elements:

    1. Better prevention services - rights for all to get up to 6 weeks reablement after leaving hospital
    2. A standard national assessment and eligibility criteria
    3. More joining up of services - one assessment for a range of care services
    4. Better info and advice for navigating the care system
    5. Ongoing personalisation approach
    6. Some state funding for ALL who qualify for basic care

Also proposes:

- Further integration of health and social care
- National social workforce development plan
- A national social care advisory service to advise on what works best and what is best value
- Integrating some disability benefits like Attendance Allowance with social care funding

Some given principles of national care service:

- All people meeting eligibility criteria will get state funded **basic** care and support.
- All will have the option of paying more for additional support.
- Option would be given to all to defer payment of food and accommodation costs (these not state funded) until death (i.e. would be recovered from estate)
- Continued role for local authorities in channelling state funding, assessments and care management, providing info and advocacy, commissioning and market management

What are the main points up for discussion?

How to fund the above?

Have already ruled out the option of funding wholly through taxation or wholly through people funding the costs themselves.

Therefore leaves three other options:

1. 'Partnership' – everyone meeting eligibility criteria entitled to have set proportion of care costs paid for (e.g. 1/4 or 1/3). Less well off would receive more – free for the poorest. Would apply to adults of all ages.
2. 'Insurance' – Building on 'partnership' principle, insurance could voluntarily be taken out to meet all remaining costs. Could be private insurance or state backed. To be paid either in instalments, as lump sum before retirement or after death. Risk - Relies on enough people getting insurance. Would apply to adults over 65. Most working age adults would be covered by state funding as on low incomes.
3. 'Comprehensive' – everyone over 65 with sufficient resources required to pay into state insurance scheme. All would then get free care. Payment could be varied according to what people could afford or set at a fixed level – e.g. £17-20k. Risk – some people would pay for a service they did not need. Would also be a free care system for people of working age alongside this funded by general taxation.

The Government favours 'Partnership' as a foundation for funding the new system with one of the other two models in addition to meet remaining costs.

Who sets the cost of care – national or local government?

Remember, as a given there would be:

- standard national assessment
- standard national eligibility criteria
- nationally determined proportion of **basic** care costs paid for by state

Two models are put forward for deciding how much money people then get:

1. 'Part-national/part-local' – Local authorities to set total funding to be allocated to an individual – **proportion** of costs met by state would be consistent nationally but not **total** funding provided to individuals. Care costs funded by council tax. Risk – May be seen as unfair. May not work with 'insurance' funding model.
2. 'Fully national' – Funding for each level of need set nationally. Care costs funded by national taxation. Risk – difficult for local authorities to respond to local circumstances.

Report to Adult Social Services Overview and Scrutiny Panel
3 November 2009
Item No 15

Adult Social Services Capacity and Winter Planning

Report by the Director of Adult Social Services

Summary
This report informs Members of the Adult Social Services approach to capacity planning in the forthcoming months in partnership with NHS Norfolk, Great Yarmouth & Waveney PCT and the Queen Elizabeth, James Paget and Norfolk & Norwich University Hospitals. It describes the systems that are put in place to meet anticipated increased demand, with additional emphasis on the impact of influenza.

Members are asked to discuss and endorse the plans.

1 Background

1.1 NHS Norfolk, Great Yarmouth & Waveney PCT, Queen Elizabeth Hospital, James Paget Hospital & Norfolk & Norwich University Hospital work in close partnership throughout the year to provide a good service to people who are in need of our services. In addition to ongoing work, the system is required to demonstrate preparation for "surges" that may occur- such as winter or an influenza epidemic. This report describes current initiatives and plans.

2 Report

2.1 The Health & Social Care systems continue to work well in partnership. Various initiatives mean that the system is able to cope with peaks of pressure.

2.2 These initiatives include:

- Tight escalation process in all organisations
- Increased capacity in community hospital beds and Health & Social Care procured beds and ability to spot purchase when required.
- Increased capacity in home support.
- Re-ablement schemes such as Norfolk First Support, Somerley and Beauchamp House.
- Joint Health & Social Care re-ablement scheme at Ogden Court.
- Dedicated team of Social Workers in each acute hospital and also alongside all planning beds.
- Rapid response teams.
- Focus on delayed transfers of care (resulting in decrease in number of delays)
- Regular management meetings to ensure plans are in place when needed.

Officer contact Lorrayne Barrett Head of Service 01603 222181

2.3 The system has produced a winter plan for 2009/10, which is attached in appendix 1; this is reviewed regularly and is the focus of fortnightly capacity planning meetings at NHS Norfolk & Great Yarmouth and Waveney PCT attended by Director/ Assistant Director level.

Officer Contact James Bullion Assistant Director for Community Care 01603 222996

2.4 This year the department has been required to focus efforts on planning for "Swine

Flu". A steering group has been meeting weekly to plan the department's management of, and response to, a further outbreak of Swine Flu and ensure that the delivery of critical services is maintained. Members will be informed in more detail via the newsletter.

Officer contact Ann Taylor Head of Service 01603 222206

3 Resource Implications

3.1 If demand increases in size or complexity then there may be demand for extra resource- either in staff time/expertise or in the procurement of a service. Senior officers consider need as it arises, prioritise and on occasion have to allocate additional resource. This can bring pressure onto budgets.

4 Other Implications

4.1 If demand is great then this can attract media interest- in particular regarding Delayed Transfers of Care and Swine Flu. An approach to media is agreed to ensure a measured approach.

Officer Contact Sarah Barsby 01603 223154

5 Equality Impact Assessment (EqIA)

5.1 The Capacity and Winter Planning includes all procedures which have already been Equality and Impact Assessed.

6 Section 17 - Crime and Disorder Act

6.1 Not Applicable

7 Risk Implications/Assessment

7.1 As outlined in plans

8 Conclusion

8.1 All partners continue to work well together to be prepared for seasonal surges. Internal and Joint plans mean we can be quick to respond as situations change - often very rapidly.

9 Action Required

9.1 Members are asked to discuss and endorse the plans.

Background Papers

Appendix 1- Winter Plan

Officer Contact

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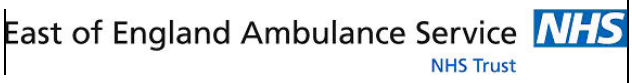

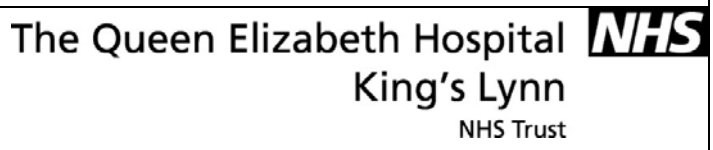

NORFOLK HEALTH AND SOCIAL CARE SYSTEM

WINTER PLANNING

2009/10

OCTOBER 2009

Document Control Form		
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1.1 NCH&C update	**4 September 2009**	NCH&C (VM)
1.2 N&N update	**9 September 2009**	N&N (KW)
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1.5 Ambulance Trust	**9 September 2009**	Ambulance Trust (DM)
1.6 Winter Planning meeting update	**9 September 2009**	ALL
1.7 Revised SHA template	**18 September 2009**	ALL
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1.15 Winter Planning Group	**7 October 2009**	All
1.16 Social Services update	**13 October 2009**	Social Services (LB)
2.00 Final draft	**15 October 2009**	All
2.10 Winter Planning Group	**21 October 2009**	All

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WINTER PLANNING 2009/10

1. INTRODUCTION

This document sets out the steps that are being taken across the Norfolk health system to ensure that appropriate arrangements are in place to provide high quality and responsive services over the winter period.

A capacity planning group was formed to deal with operational pressures ensuring that the whole system is aware of predictions and is planning to respond accordingly. A review of the escalation plans of each organisation has been undertaken and a revised plan is published at appendix 1. This has been signed off by the group and each organisation will ensure they adopt the triggers in their internal escalation policy. The membership of the group includes senior representation from NHS Norfolk, Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH), Queen Elizabeth Hospital Kings Lynn, NHS Trust (QEH), Norfolk Community Health and Care (NCH&C), Norfolk County Council Adult Social Services, Norfolk and Waveney Mental Health NHS Foundation Trust (NWMHFT) the East of England Ambulance Service NHS Trust and Out of Hours service. The membership is published in appendix 2 which also identifies the in hours and out of hours contact details for each organisations winter leads.

Winter Planning in previous years has focused on managing the peaks in demand over the Christmas and New Year period. The new challenge is the management of pressures throughout the year, particularly during October to March when additional pressures such as flu are more common. Without adequate system wide resilience plans, operational difficulties in parts of some systems, such as Delayed Transfers of Care (DTOC), waiting times in accident and emergency departments, ambulance delays and unplanned ward closures will occur.

This Winter Plan seeks to ensure:

- The clear identification of the escalation process
- Key organisational contacts are identified
- Potential risks have been identified and contingencies have been put in place
- That the provision of high quality patient services are maintained through periods of pressure
- That the impact of pressures on the levels of service, national targets and finance are managed
- That a process is in place to meet the winter reporting requirements of the SHA

2. WINTER 2009/10 – WINTER PLANS AND SYSTEM CAPACITY

Each organisation completed and submitted a winter plan risk management checklist. These checklists have been consolidated into one document which is included at appendix 3 and which provides detailed confirmation of preparedness across a number of areas.

A system wide bed capacity plan was agreed in September 2009 which includes a summary of a bed model used to estimate demand and commission supply during winter, an approach to internal and external communications and a summary of the integrated system management processes to manage patient flows.

Building on the Winter Planning process in 2008/9, the implementation of the bed model and system improvements will:

- Improve the patient experience
- Improve the management of capacity pressures
- .Reduce delayed transfers of care (DTOC)
- Co-ordinate patient flows
- Utilise intermediate care and acute facilities more effectively

A copy of the intermediate care bed plan is included as appendix 7.

There have been a number of other organisational specific initiatives implemented which are designed to strengthen the system and these are highlighted below:

2.1 Acute Hospital Capacity

2.1.1 QEH

The newly developed Clinical Decision Unit (CDU) opens on the 2 November. This will ensure Medical patients are admitted / assessed in a timely manner. It will also prevent Medical Diversions to A/E during peak times of activity & therefore will improve patient flow.

A modular ward will be operational from the 1 January 2010. The ward will be used as a decant / escalation ward during peak times of activity/Infection Control Outbreaks to ensure patient flow is not compromised.

A Trust wide project is in place to improve all aspects of discharge planning & includes input from the PCT & Social services.

New initiatives include the appointment of a Patient Flow Coordinator to manage the Ops centre and to review/amend current discharge policies/escalation plans.

The appointment of a second lead nurse for the Medical Directorate will improve patient pathways to include the development of nurse led discharge. Projects also commenced to decrease Length of Stay (LoS) by speciality. All patients LoS to be monitored and reviewed at day 5 to ensure management plans/EDD are effectively being implemented. Work is in progress to develop electronic monitoring of EDD. Interim solution of Traffic light (RAG system) will be implemented on all wards to proactively plan discharge.

Different ways of working are being implemented to include the expected Date of Discharge (EDD) entered on every patient's admission chart.

- Daily MDT meetings taking place on all wards at 08.30hrs
- Review of bleep holder's role to implement changes to operational site management
- MAU Consultants now in post and managing MAU and 14 short stay beds. LoS will be actively monitored
- Full time Occupational Therapist will join the Rapid Assessment Team in January 2010 to continue to improve admission avoidance
- Dedicated discharge vehicle (ambulance) is now operational from 14.00hrs – 22.00hrs Monday-Sunday and Bank Holidays
- Review of working hours of Discharge Lounge to be undertaken and changed as appropriate to meet the needs of the service
- The Trust has arrangements in place with the private hospital on site to access inpatient beds for surgical patients at periods of high demand

2.1.2 NNUH

A hospital wide "patient flow" project is in progress. A number of initiatives from that project are in place for the winter to improve discharge arrangements both from beds and pre-admission.

Rapid and Accessible Care by:

Review of site management and medical cover to improve speed of assessment, decision making and patient flow:

- Two additional Cardiology Registrars to support on-call out-of-hours medical patient assessments
- Investment proposal approved for two additional A&E consultants to extend the existing senior cover
- Operations Centre structure reviewed and additional resource identified and implemented

Admission Avoidance:

Preventing unnecessary admission for patients whilst ensuring timely but supportive, safe discharge:

- Additional Medicine for the Elderly (MfE) ward rounds in Emergency Assessment Unit (EAU) to support timely discharge or admission to the appropriate specialty ward
- Relocation of Early Intervention Team to emergency areas (and enhanced referral mechanisms) to improve patient access to community services to provide supportive discharge home

Patient Flow / Rapid Access to Diagnostics

Review of patient pathways to identify improvements to facilitate appropriate and timely assessment and admission for elective and emergency patients:

- Procurement of additional CT capacity for elective patients to reduce delays for in-patients
- Installation of additional CT scanner and relocation of plain X-ray machine to EAU to optimise patient access to diagnostics
- Introduction of an e-portering system Trust-wide and provision of dedicated portering supervision in emergency areas to ensure timely transfers
- Introduce MfE Enablement Project with an ethos of enablement from point of admission

Discharge

Review of discharge processes to enable better planning for patients:

- Implementation of an Expected Date of Discharge (EDD) identification system which identifies patients' discharge dates to enable patients, families, carers and the organisation to prepare for discharge
- Additional ward based pharmacy support to focus on discharge taking place earlier in the day

Introduction of a Discharge Lounge

- Development of a Discharge Planning Group to review and improve all discharge planning processes

2.1.3 Delayed Transfers of Care

There has been a whole system focus on reducing delayed transfers of care both from the Acute and Community Hospitals. Daily reporting to senior managers is well established and escalation is triggered when issues first occur. A single definition has been accepted across the system and work is progressing to establish a single point of access. Work is underway for complete service redesign across the system.

2.2 NORFOLK COMMUNITY HEALTH & CARE

An opportunity to use spare capacity in Beccles and Patrick Stead has also been agreed with the provider arm of GYW PCT and medical cover has been increased at Ogden Court, Dereham and Henderson wards to cover weekends.

Bed Based Services

In line with NHS Norfolk commissioning plans from 1 October 2009, eight additional beds have been opened at St Michael's Hospital, Aylsham and a further six additional beds have opened at Dereham Hospital for a period of six months. Also for the same time period weekend medical cover has been initiated in three of our nine community hospital units.

In mid-January 2010 a new complex which houses a 24 bedded specialist stroke rehabilitation ward and a 24 bedded generalist rehabilitation ward, (replacing beds currently supplied on Henderson Ward at the Julian site, Norwich) will be opened in Norwich on the Community Hospital site.

The specialist stroke rehabilitation ward incorporates an early supported discharge service supporting patients to return home earlier than has been possible in the past with an appropriate rehabilitation package.

Plans are currently in place to overlap the running of Henderson Ward for 3 months with the new rehabilitation unit outlined above.

Extensive work is being carried out in each community hospital using the Community Productive Ward to improve efficiencies in many areas, eg ALOS and delayed discharges, to improve the patient experience.

Community Teams

The management of Long Term Conditions and Admission Avoidance is a focus for our Integrated Community Teams.

We are part of a national pilot site for Integrated Care Organisations which demands a co-ordinated approach with general practice, social care and voluntary organisations. Currently we are formally planning projects, some of which will focus on admission avoidance and crisis management

2.3 Norfolk Social Services Capacity

Norfolk Adult Social Services has maintained the increase in capacity across the county. There has been a major re-tendering exercise of residential, nursing and domiciliary care resulting in an increased capacity. Capacity can be flexed additionally to meet demand. Transitional beds are used to supplement for planning when required. In-house residential homes are specialising in planning and reablement. The Ogden Court contract, which is a joint health and social services unit with therapy and nursing, has been extended for three years. The increased use of social services' own home care provision for intensive reablement is successful and offered to all patients requiring packages of care on discharge from hospital. Hospital discharge continues to be top priority for social services.

Daily monitoring of capacity and regular summits with all providers ensure that they understand priorities and can respond in a timely manner. A dedicated team supporting planning beds ensures flow through the system.

2.4 Ambulance Capacity

The East of England Ambulance Trust confirms the number of ambulances has remained constant when compared with last year. Flexibility to cope with increased demand will be provided through a variety of measures, including increased workforce capacity from reduced abstraction levels (e.g. training), use of clinically trained managers and Use of Non-Emergency Services and potentially private/voluntary ambulance services. The drive to improve ambulance turnaround at hospital will be closely monitored as part of daily Sit Rep reporting. Improved turnaround particularly at NNUH will increase ambulance capacity both to respond to emergencies as they occur but also in terms of ensuring prompt transfer to hospital where necessary. The ambulance capacity planning assumption is that no patient will wait more than 15 minutes for handover (including off-loading from ambulance trolley) at hospital in line with national guidance. The Ambulance Trust also has a key role in assisting with hospital flow by ensuring they bring urgent admissions in at the time agreed with the hospital requiring clear communication between the GP, the hospitals and the ambulance service.

2.4.1 Ambulance Handover

NHS Norfolk will agree an action plan and KPI reporting with the Acute Trusts and the Ambulance Trust using the South West model of best practice. Current NHS Norfolk Action Log against these recommendations can be seen at Appendix 5

2.5 Norfolk and Waveney Mental Health NHS Foundation Trust (NWMHFT)

NWMHFT will aim to support the maximum number of service users in the community.

The Crisis Resolution and Home Treatment Teams will provide a normal 24/7 service over the holiday period. For the bank holidays staffing levels will be based on those used at weekends. In Central and East Norfolk and in Waveney the integration of inpatient and Crisis Resolution teams will allow staff to be used flexibly, so that any reduction in bed occupancy will enable staff to be redeployed in the CRHT teams. The West Norfolk CRHT will work from 8.30am to midnight each day with support from the older person's intensive support team until 10pm weekdays and 9am-5pm weekends and bank holidays. .

The usual level of Community Mental Health Team provision will be available on the normal working days, but will not be available on weekends or bank holidays. This reflects normal working practice. In West Norfolk the Acute Treatment Team will provide any additional support required. However, some community services will be staffed over the bank holidays. Both the City and the County Assertive Outreach teams will have the usual number of staff available on the days between the Christmas and New Year holidays and will have a reduced number available over the weekends and bank holidays. The integrated acute services will run a normal service on the bank holidays.

The Child and Adolescent Mental Health Service in Central and East Norfolk will be staffed on the normal working days over the holiday period and will use their standard weekend on-call arrangements for the bank holidays. In West Norfolk the service will be staffed on normal working days and will have staff from the Intensive Support Team at weekends, but not on bank holidays.

The Alcohol and Drugs Service will be operating during normal office hours between Christmas and the New Year. Out of hours support will be provided by the Matthew Project with a 24-hour helpline, as happens at weekends throughout the rest of the year.

The Forensic Community Service will work normally between Christmas and New Year, but on the bank holidays calls will be referred to the service bleep holder who will decide on the appropriate response.

The liaison team at the Norfolk and Norwich hospital will be covering the normal hours on the days between the bank holidays, with the bank holiday cover being that for out of hours, provided by the CRHT for referral of acute presentation in A&E. At the Queen Elizabeth Hospital the 24/7 service provided by a Senior Nurse and an SHO will be provided as normal, also to include all CAMHS presentations to A&E. At the James Paget Hospital the Waveney and Gt Yarmouth Acute Teams will provide cover as normal.

In the Central Norfolk Localities, the Older People's Service will access the Intensive Support Team to provide out of hours support to service users considered high risk. Voluntary agencies and other statutory services will be also be approached to provide additional support as appropriate on a case-by-case basis. In West Norfolk there is a free-phone 0800 number available 24 hours a day, which is jointly managed by the Acute Treatment Team and the Emergency Duty Team. This offers advice and signposting to both service users and carers.

Past demand for services over Christmas/New Year has been reviewed and plans are in place to ensure service levels match demand. The review shows that the peak demand for mental health services is in January/February and not at Christmas. All of the acute wards will work to maximise the number of available beds by 24 December.

Trust staff will work with service users in the period up to 24 December to maximise their ability to cope over the Christmas period. Other measures will be put in place as appropriate, for example the Alcohol and Drugs Service will ensure that all prescriptions of methadone etc., will be delivered by hand to community pharmacies well in advance of the holiday to ensure that medication is available for collection when required.

2.6 Primary Care and OOHs

There will be at least 69 practices offering extended access to appointments across Norfolk by the end of November.

Additional capacity over and above predicted winter demand is being sought in response to the likely pandemic flu planning requirements.

Out-of-Hours Urgent & Emergency Primary Care Services; Capacity will be at the same level as for last year with predicted days of high demand being resourced appropriately. A winter pressures contingency plan, including flu pandemic, is in place. Discussions are ongoing with NHS Norfolk in regards to a joint approach to the management of the flu pandemic in regards to GP extended hours and the OOH service provision to ensure resources are used efficiently and effectively.

The treatment of patients with suspected swine flu creates higher level of home visits. Work is being progressed to identify clean and dirty areas to enable both urgent GMS patients and suspected swine flu patients to be treated in the primary care clinic setting but with no risk of cross-infection.

The service is currently reviewing efficiencies to improve performance, looking at alternative patient pathways, i.e. non-urgent repeat prescriptions being signposted to local community pharmacies.

2.7 Plans for Flu Vaccinations

Seasonal Flu Vaccination programmes will remain as previous years and be offered to all health and social care staff in an effort to improve resilience/business continuity and maintain delivery of service. It is the responsibility of each trust to make their own arrangements for seasonal flu vaccination and encourage uptake amongst staff as a priority.

Swine Flu vaccination will be offered to all front line key health and social care staff in accordance with national guidance. The focus should be given to those staff groups that administer treatment/care to patients and within the indentified priority groups:

- Individuals aged six months and up to 65 years in the current seasonal flu vaccine at-risk groups
- All pregnant women, subject to licensing conditions on trimesters
- Household contacts of individuals with reduced immune systems
- People aged 65 years and over in the current seasonal flu at-risk groups - this does not include otherwise healthy over 65s as they appear to have some natural immunity to the virus

2.7.1 Seasonal flu vaccine at-risk groups

Seasonal flu vaccine will be targeted at people with:

- chronic respiratory disease, such as chronic obstructive pulmonary disease (COPD)
- chronic heart disease, such as heart failure
- chronic kidney disease, such as kidney failure
- chronic liver disease, such as chronic hepatitis
- chronic neurological disease, such as Parkinson's disease
- diabetes requiring insulin or oral anti-diabetic drugs
- a suppressed immune system, due to disease or treatment

GP Practices are being funded to deliver the swine flu vaccine to their patients within the priority groups. All vaccine will be supplied by the DH with deliveries to acute hospitals, GP Practices and NHS Norfolk. It is the responsibility for all agencies to organise and fund administration of the vaccine to their key front line staff.

NHS Norfolk will coordinate the vaccination programme across the health and social care systems and ensure resupply via an audit management system

2.9 Summary

The joint working arrangements in place in the Norfolk system have been strengthened over the past 12 months. The established capacity planning group will continue to meet on a fortnightly basis throughout the winter both monitoring the operation of the system and predicting and reacting to pressure points before they occur. The escalation plan and policy will be closely monitored with system wide involvement at the

amber stage seeking to return to Green and senior management escalation at the Red stage. Escalating to Black alert will require a Director level decision to be taken in conjunction with NHS Norfolk Director on Call.

3. NORFOLK WHOLE SYSTEM ESCALATION PLAN

3.1 Summary

The new escalation policy and plan moves the system to three stages of alert i.e. Green, Amber and Red. The policy and plan covers both the NNUH and QEH and the alert stages are consistent although the trigger points are different due to the difference in scale of the two hospitals. It is recognised that there will be a small number of occasions where black may be appropriate and these have been identified in the policy. However, moving to "Black" alert will require a Director decision to be made in conjunction with NHS Norfolk. It will require a change in culture both at the NNUH and across the system and all agencies will need to ensure that they respond appropriately with action when the acute hospitals are on Amber and Red. This has been agreed by the Winter Planning leads in each organisation who will take the responsibility to manage the change in their own organisations. Both Acute hospitals must have clear guidance on what level of staff has the authority to escalate alert status (see Appendix 6 - NHS Norfolk Directors Action Card for Acute Hospitals request to escalate to BLACK alert status.)

This escalation plan has been drawn up from submissions received from Health and Social Care Partners across Norfolk.

The policy defines how each stage of the process is determined by measuring the increasing pressure on beds, and factors which will compound the ability of the Acute Trusts within Norfolk to admit patients to beds in a timely manner.

Each stage of escalation is described together with actions to be taken locally to address, contain or accommodate demand.

GREEN	Bed capacity within the Acute Trusts enable organisations to maintain both emergency and elective admissions, and deliver an emergency care service to all accident and emergency attendees in line with the Department of Health Emergency Care targets. All other organisations are able to manage demand.
AMBER	Pressures are increasing and the predicted or actual bed capacity may not meet demand. Constituent parts of the health economy are experiencing similar pressures. The actions to be taken will aim to bring the Trusts and the system back to a "green position".
RED	Despite measures undertaken pressures are continuing to increase. Demand within one or more organisation exceeds capacity. The Accident and Emergency departments are unable to provide an emergency care service in line with DOH emergency care targets and the Trusts maybe responding by cancelling some or all clinically urgent elective admissions or alerting ambulances to divert. The actions taken will aim to bring the Trusts and the system back to an "amber position".
BLACK Requires Director decision in conjunction with NHS Norfolk Director on Call	System Gridlock. A&E departments unable to safely provide emergency care service. Ambulances unable to offload. Elective work cancelled. Service Interruption (e.g. Diagnostics) which cannot be resolved in less than four hours and which requires emergency contingency measures.

ESCALATION POLICY AND PLAN

3.2 Introduction

This policy has been produced to assist in the management of health and social care capacity across Norfolk when the whole system, or one constituent part of the system, is unable to manage the presented demand being placed upon it. This escalation policy is separate from the Major Incident Policy, which deals with exceptional, immediately-presented demand for emergency care.

The underlying assumption of this policy is that sufficient capacity has been created by providers within accepted levels of tolerance, to provide emergency care services and planned elective activity in order to deliver agreed performance targets.

The health, social care and private sector organisations party to this policy are:

- NHS Norfolk
- Norfolk & Norwich NHS Foundation Trust
- Queen Elizabeth, Kings Lynn NHS Trust
- Norfolk Social Services
- Norwich Community Health and Care
- Norfolk and Waveney Mental Health NHS Foundation Trust
- East of England Ambulance Service NHS Trust
- Private Nursing Homes Representative

3.3 Principles

A set of principles underpin this policy and have been accepted by all the constituent agencies. These are set out below, with scenario examples of how these principles work:

- Capacity is managed as a co-ordinated system across separate organisations and within organisations
- No action will be taken by one constituent part of the system, without prior discussion which will undermine the ability of any other parts of the system to manage their core business, eg. the Acute Trusts would not close to all emergencies without discussion and agreement with partner organisations. NHS Norfolk will inform the SHA as and when required
- Managing patients at a time of increased escalation will require each organisation to manage additional risks, as individual decisions on patients' care are taken
- The escalation policy will be based upon an integrated, i.e. multi-organisation status report with differing levels of capacity availability and trigger indicators, i.e.

Green – the system is functioning and all organisations are able to manage demand

Amber – escalating pressure in one or more organisations within the system and need for aggressive action across the system to avoid gridlock

Red – Full implementation of escalation plan arrangements

Black - De-escalation will follow the reverse of the processes above

3.4 Delayed Discharges

A delayed transfer of care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when:

- A clinical decision has been made that the patient is ready for transfer
- A multi-disciplinary team decision has been made that the patient is ready for transfer
- The patients is safe to discharge/transfer

The measurement of DTOCs is to be taken at the end of each day for STEIS reporting by 10am the following day.

3.5 INFORMATION AND MANAGEMENT

3.5.1 QEHKL

Information and Management (The QEH)

8.30am (Monday – Friday): Daily bed meeting when the Trust status is assessed based on current bed state, forecast admissions and discharges and communicated by email Trust wide. The schedule for bed meetings throughout the day is agreed based on the status. This bed meeting is attended by bleep holders from each Division, EoE PTS, Pharmacy, PCT Discharge Liaison, and Rehabilitation Service. The West Norfolk's PTS Customer Services Manager also attends this meeting every day and advises of the daily transport status in terms of availability seats etc.

The last bed meeting of the day is at 4pm. This is chaired by the Senior Nurse On-call who is on site until 9pm Monday to Friday. Bed Management and A&E breaches are managed by the On-call Senior Nurse and Director after 5pm and at weekends.

Daily meeting in the Ops centre at 8.45am involves Discharge Liaison nurse (PCT) Social Services and patient Flow Coordinator to discuss all delayed discharges and the plan of action for the day. Operational issues in each team discussed & decision on necessity to escalate agreed. DTOC report also completed at this time.

New initiative to collate confirmed/predicted discharges earlier in the day to be available at 4pm bed meeting where any issues in terms of lack of capacity can be identified & rectified to ensure adequate capacity is available for next day's demand.

Daily breach/A/E Ambulance Turnaround meeting to discuss performance and any issues and to agree any actions. Monthly meeting with EEAT to discuss performance and agree any changes in practice/actions.

3.5.2. NNUH

The following operational meetings are held daily Monday to Friday:

8.45am: Medical bed capacity meeting

12.00hrs and 16:00hrs: Operational meeting to assess the Trust alert status based on current bed state, forecasted demand and discharges. This is attended by senior management staff representatives from each division.

If further meetings are required these are called by the Operations Centre Manager and/or the Assistant Director of Nursing/Divisional General Manager (Acute and Emergency Medicine).

Out of hours (after 5pm and at weekends) Patient Flow and A&E breaches are managed by the Site Nurse Practitioners, with support where necessary through the internal escalation process.

3.5.2 Ambulance Trust

Ambulance escalation procedures are attached in appendix 4.

3.5.4 Service closures

All providers should inform NHS Norfolk of any partial closures of any patient services, e.g. maternity/NICU. This should be communicated to the officers detailed in Appendix 2 as soon as possible during normal office hours.

3.6 Communications – Sit Rep Reporting

The IDT reports from NNUH and QEHKL are issued by 10am each day. These provide a report on patients fit for discharge and the attributed reason for their delay. The reports are shared with NHS Norfolk, NCH&C and Social Services are issued both to inform and as a prompt for escalation. NCH&C provide a community services capacity update at 3pm each day which is shared across the Norfolk Health and social care economy.

NHS Norfolk will be responsible for communication to Primary Care and out of hours providers as part of escalation actions.

Daily situation reporting will commence on the instruction of the East of England SHA by 10am each day. A report will be compiled in NHS Norfolk and a weekly dashboard will be distributed to MEX members and across the system.

3.6.1 Triggers

The triggers and actions are included in the attached risk matrix. It must be noted that one of the indicators in isolation does not determine the status. A substantial number, if not all, of the triggers must be the case for the status to be declared.

3.6.2 Escalation Points

Escalation/decision points are also detailed in the attached risk matrix. It must be noted that the escalation status is not attributed to one of the indicators. A substantial number of the indicators, if not all, must be met.

The escalation to black is only to be taken when system gridlock occurs. Decision can only be made in conjunction with NHS Norfolk who will test the decisions and actions against the escalation plan. NHS Norfolk will issue a situation report to the SHA.

3.6.3 Detailed Status identification and escalation procedures.

The following appendix classifies the alert status and de-escalation actions by key agencies.

3.7 System Wide communications

The Norfolk health and social care partners have agreed to co-ordinate communications and media handling. This will include a joint media protocol, communications plan for winter planning and winter health and protocol for handling any black alerts.

GREEN STATUS **Appendix 1** This situation reflects the normal position across the whole systems which is accepted as still being able to maintain capacity and demand. Beds are available to accommodate the elective activity, emergency admissions and discharges can be accommodated and patient waits in the A&E department are less than four hours			
The QEH	**NNUH**	**NHS Norfolk NCH&C Provider Services**	**Social Services**
At least 5 beds available on MAU at 9am. Critical care beds available to meet demand. 98% patients being seen in A&E within 4 hours and observation bay is open. Resus bays available on A&E. Beds becoming available from predicted / planned discharges, matches the forecast admissions for the next 24 hours. Patients requiring PTS ambulance transport have a provisional booking completed (tbc 24 hours prior to discharge). Patients requiring intermediate care assessment have had appropriate referrals and assessments completed/planned and 48 hour notification	Any combination of 3 indicators can trigger a change in the alert status. De-escalation will result from resolution of the below indicators: Emergency/Elective activity accommodated 45 surplus beds available across the Trust A minimum of 3 adult Critical Care beds available to meet demand No significant problems reported with Clinical Support Services e.g. IT, theatre, Pathology, Pharmacy, facilities etc No external influences present; infectious diseases, adverse weather . Patients requiring PTS ambulance transport have a provisional booking completed (tbc 24 hours prior to discharge). Agreed staffing levels in place 98% of patients are seen in A&E within 4 hours with less than 1 hour wait for first contact with assessing clinician	<u>Transfer from Acute Units</u> Discharge Liaison Team has the full list of patients assessed and ready for transfer into Community Bed Service. Appropriate transfer and discharge referrals have been completed. Supporting transfer from acute with 48 hour time frame and therefore no more than agreed numbers of health delays on the delayed discharge list for: NNUH 9 QEH 5 Patients requiring PTS ambulance transport have a provisional booking completed (tbc 24 hours prior to discharge). <u>Community Services</u> At least 10 beds available in Community Hospitals (general rehabilitation) throughout Norfolk. No more than 6 delays in discharge in Community beds	Staffing at full capacity. Effective and responsive assessment and planning processes in place. Good capacity in residential and nursing sector. Good capacity in domiciliary care. Multi-disciplinary teams communicating well, ease of information flow. Full use of IT systems. **Early warning signs of escalating pressures should include:** Staffing and sickness levels in any one constituent part. Increased pressure on planning bed occupancy. Increased pressure on domiciliary care capacity. Increase in requests for assessments. Increase in complexity of cases.

Discharge Facilitators have an up-to-date list of patients with completed assessments and, additionally, those patients in line for assessment. Scheduled ward rounds have taken place. Patients are discharged via the discharge lounge by 11am. There are less than 10 patients with discharge delays as reported on the daily IDT report. Ambulance handovers <15 mins.	7 cubicles available in Majors, 4 in resuscitation bay 11 beds available across EAU M&S No delays in ambulance handovers Beds becoming available from predicted discharges match forecasted admissions for the next 24 hours Scheduled ward rounds in progress Discharge facilitators have up to date information Patients are discharged via the discharge lounge by 11am Less than 15 medical boarders out of speciality There are less than 10 patients with discharge delays reported on the daily IDT 40 available mortuary spaces	Available updated list of patients fit for transfer and available list of potential others progressing to earlier discharge for all units. Health care home assessments completed where appropriate with any needs addressed; i.e. no equipment delays. Continuing Care assessments completed and transfer plans agreed. At least 5 or more patients identified for discharge from Community beds for the next 2 days. At least 5 slots available in Rapid Access, Health at Home/Outreach Teams throughout Norfolk. 12% of capacity in Community Team Services to receive patients (capacity 88%). <u>Staffing Capacity</u> Staffing levels to support - Inpatients - Community Teams - Discharge Liaison & Planning are uncompromised.	Delayed transfers of care begin to slow.

GREEN ACTIONS			
The QEH	**NNUH**	**NHS Norfolk – NCH&C Provider Services**	**Social Services**
Agree escalation status by 9 am. All stakeholders informed. Proactive management of patient discharge. Appropriate, accurate and timely information to inform decisions and further actions. Modern Matrons, Ward Sisters, Bed Managers, Discharge Facilitators to address warning signs in an effort to prevent escalation. High state of watchfulness. Tailor actions to address specific needs, i.e. redeployment of staff to vulnerable areas. Inform all clinical leads of potential problems. PCT Discharge liaison is maximising patient assessment and discharge to community hospital beds. Social Services are maximising patient discharge to Nursing/ Residential and Planning beds. **Early warning signs of escalating pressures:** Staffing & sickness levels in any one constituent part Decreasing performance of 4 hour waits in A&E. Increasing bed occupancy	The Operations Centre will monitor the operational issues across the site liaising with the following personnel: **In Hours Monday To Friday:** Hospital status communicated to EAAT and NSC CAMS Patient Flow Co-ordinators to actively manage current bed capacity and predicted discharges through virtual ops bed declaration system Senior Nurse Patient Management to liaise with Integrated Discharge Team (IDT) regarding current status of boarders and delayed discharges Senior Nurse/Medical Staff in emergency areas monitor situation in conjunction with Operations Centre Site Nurse Practitioners to monitor, act and escalate any operational issues Liaise with mortuary staff	Inpatients management team will agree escalation status by 9.30am. All stakeholders informed. Modern Matrons, Ward Sisters, Bed Managers, Discharge Facilitators to address warning signs in an effort to prevent escalation. **All Status (green, amber, red). Early warning signs of escalating pressures will include**: • Staffing & sickness levels in any one constituent part Increasing • Bed availability declining in one or more:- o community rehab beds o procured bed o planning beds • Increasing acuity of admitted patients • Ward closures due to infection control measures • Community intermediate care teams rising case loads • Reducing capacity in social home care packages • Worsening weather conditions • Increasing flu pandemic status • Delayed discharges on, or	Full staffing at key times. Spot purchase additional capacity as required. Attendance at delays meetings. Manages present and able to judge status. High state of watchfulness. Responsive communication with whole system. Minimise follow-up home visits.

Bed capacity constraints for observation bay in A&E, critical care beds, MAU beds. Lack of available nursing home beds or home care packages Ward closures due to infection control measures Reduced treatment areas available in A&E	**Out Of Hours and At Weekends:** The Site Nurse Practitioner will assume responsibility for site co-ordination resolving operational issues Reporting and escalating to the Duty Manager, Executive On Call and all other relevant personnel.	greater than targets in both acute trusts and community hospitals. **Trigger for change in Green Status** • Delayed discharges in acute trusts higher than green target PLUS • One or more indicators under heading community services higher than green target. • Unexpected reductions in staffing levels confined to one or two units/community teams.	

AMBER STATUS Escalating pressure in one or more part of the system and need for aggressive action across the system to avoid gridlock.			
The QEH	**NNUH**	**NHS Norfolk – NCH&C Provider Services**	**Social Services**
8.30 am Bed meeting identifies -5 beds Number of delayed discharges exceeds Previous 24 hour performance in A&E less than 98%. Medical outlier patients on surgical wards. No critical care beds. A&E observation bay closed due to staffing shortages. Ambulance handovers >15 mins but no greater than 30 mins.	Any combination of 3 indicators can trigger a change in the alert status. De-escalation will result from resolution of the below indicators: Elective surgical programme compromised "on hold" for more than an hour with 10 to 45 surplus available. No Critical Care adult beds available Problems reported with Clinical Support Services that cannot be rectified within 30 minutes Bed closures due to infection control measures Staffing levels are below agreed levels, patient safety becoming compromised Increasing referrals to A&E causing a reduction in the 4 hour wait performance. 2 hour wait for first contact with assessing clinician. 5 cubicles and 3 resuscitation bays available for use in A&E 6 beds available across EAU M&S Delays of more than 15 minutes ambulance handovers Predicted discharges do not match forecasted admissions for the next 24 hours	<u>Transfer from Acute Units</u> Discharge Liaison Team has reduced capacity/staffing levels to meet demand for discharge assessment. Unable to meet the transfer from acute with 48 hour time frame, therefore health delays on the delayed discharge list for: NNUH 15 QEH 9 <u>Community Services</u> At least 5 beds available in Community Hospitals (general rehabilitation) throughout Norfolk. 6 – 12 Delays in discharge in Community beds. 7% capacity in Community Team Services to receive patients. (95% capacity). Less than 3 patients identified for discharge from Community beds for the next 3 days. Continuing Care assessors have greater than 4 patients waiting for full assessment.	Some decrease in staffing (sickness/absence). Reduced capacity in residential and nursing sector. Reduced capacity in domiciliary care. IT systems not fully functioning. Difficulty meeting increased demand for assessments. Increase in delayed transfers of care.

	> than 15 but < 30 medical boarders out of speciality Between 16 to 39 mortuary spaces available	Waiting for equipment delays; more than 2 in the system. Increase in the pandemic flu status <u>Staffing Capacity</u> Staffing levels compromised - Inpatients in 3 – 5 units - Community Teams - in a range of community teams in some localities - Discharge Liaison & Planning	

AMBER ACTIONS Capacity is managed as a co-ordinated system across Norfolk. Pressures in any one constituent part of the system will impact on all other partners. Therefore, it will be necessary to meet and review pressures within the system at least twice daily.			
The QEH	**NNUH**	**NHS Norfolk NCH&C Provider Services**	**Social Services**
1. Increasing referrals to A&E causing a reduction in 4 hour wait performance or more than 10 patients attend in 2 consecutive hours – Implement A&E escalation plan (attached) **2.** Emergency Care Division Manager / Head of Nursing Contact consultants to undertake urgent work and feedback to the Emergency Care Systems Manager/1st on-call. Review all medical outlier patients and plan repatriation to medical beds Consider opening any closed beds within division. Liaise with PCT Discharge Liaison Team to ensure that patients are being assessed and discharged to community hospital beds. Liaise with Social Services to ensure that patients are being discharged in a timely way to placements and care packages. **3. Senior Nurses / Bleep holders** Support ward areas to	The Operations Centre will monitor the operational issues across the site liaising with the following personnel: **In Hours Monday To Friday:** **Intervention** Emergency Services/Divisional Operational Manager to liaise with Operations Centre Manager, Senior Nurse Patient Manager, Patient Flow Co-ordinators and Trust wide Divisional Operational Managers and General Managers to implement divisional escalation plan Assistant Directors/Senior Nurses to support ward areas by; expediting discharges, reviewing expected date of discharge, maximising the use of the discharge lounge and managing staff shortages. Providing feedback at the 12 midday Operations Centre meeting Senior Nurse Patient Management to liaise with IDT to reassess community capacity Identify potential discharges within the next 24 to 48 hours reviewing the elective programme	Coordination of the actions below will be taken by the Inpatient management team. <u>Transfer from Acute Units</u> Discharge Service Manager, Sister/Senior nurse in discharge liaison team will liaise with Community Hospitals and Community Teams to accelerate the "pull out" system of patient discharge. <u>Community Services</u> **Modern Matrons/Ward Sisters** Support ward areas to: maximise use of discharge areas within units where available; expedite transport facilities; ensure that discharge plans are updated appropriately; identify "simple discharges" and progress them as appropriate; identify potential weekend discharges and transfers; identify patients who could transfer to planning beds/PCT nursing home beds; problem solve any other issues. **Community Team Leaders/Community Matrons** Clinical leads to review patient	Increase staffing (evenings/weekends). Negotiation with independent sector re increasing capacity. Increase Manager presence. Escalate to Head of Service. Attend escalation / delays meetings. Joint communication strategy with system colleagues. Ensure 'Direction of Choice' being fully utilised.

maximise use of Discharge Lounge, expedite transport facilities, ensure that discharge plans are updated appropriately and problem solve any other issues. Support ward areas to identify "simple discharges" and put arrangements in place to plan the patient's discharge to their home or to access district nursing, community rehabilitation or home care packages. Potential weekend discharges and transfers to intermediate care to be available. Clinical leads to review patient caseloads, identifying further potential discharges. **Ambulance** Patients requiring ambulance transport have a booking completed as soon as it is known they can be discharged, and there is proactive discussion between the Acute Hospital Site Practitioner/Bed Manager and EEAST's Customer Services Manager to facilitate On the Day Discharge transport, making full use of the discharge lounge facility	Identify and prioritise operational issues e.g. clinical cleans, laboratory delays Site Nurse Practitioner and Patient Flow Co-ordinator to support A&E, EAU with Patient Flow/Discharge Consider utilising escalation areas Appraise and update mortuary capacity Communicate hospital status to EOE CAMS and EAAT **Out Of Hours And At Weekends:** The Site Nurse Practitioner will assume responsibility for site co-ordination resolving operational issues Reporting and escalating to the Duty Manager, Executive On Call and all other relevant personnel **Ambulance** Patients requiring ambulance transport have a booking completed as soon as it is known they can be discharged, and there is proactive discussion between the Acute Hospital Site Practitioner/Bed Manager and EEAST's Customer Services Manager to facilitate On the Day Discharge transport, making full use of the discharge lounge facility	caseloads, identifying further potential capacity. Consider increasing Continuing Care full assessment capacity. As appropriate, case managers to work with social care and the equipment store to highlight and expedite any equipment delay issues. Instigate appropriate escalation of the flu pandemic continuity plan. High state of watchfulness. Tailor actions to address specific needs, i.e. redeployment of staff to vulnerable areas. Inform all clinical leads of potential problems. **Triggers for change in Amber Status to Red** • Delayed discharges in acute trusts higher than amber target PLUS • One or more indicators under heading community services higher than amber target. • Unexpected reductions in staffing levels higher than amber target. **Triggers for change in Amber Status to Green** • Return to green target levels in both acute trusts and community hospitals Staffing levels uncompromised	

RED STATUS Gridlock and full implementation of escalation plan arrangements			
The QEH	**NNUH**	**NHS Norfolk Provider Services**	**Social Services**
Bed meeting identified -10 beds at 8.30am. Inadequate beds available for elective admissions Delayed discharges greater than 20 patients. Ambulance handovers >30 mins and more than 2 ambulances waiting to offload Previous 24 hour performance in A&E less than 95%. Resuscitation area full. A&E Observation area closed. Critical care beds over capacity and transfers being arranged.	Any combination of 3 indicators can trigger a change in the alert status. De-escalation will result from resolution of the below indicators: Elective surgical programme compromised; theatre start delayed or stopped, theatre recovery unable to decant post operative patients less than 10 beds available Inadequate beds available for elective admissions, patients deferred/cancelled on day of admission due to lack of beds Critical Care beds over capacity Problems with clinical support services that cannot be rectified within 2 hours Ward closures due to infection control measures Multiple areas below agreed staffing levels, patient safety becoming compromised Previous A&E 24hour performance below 95%, anticipated 4 hour breaches in A&E All treatment areas in A&E in use, less than 2 resuscitation bays available 3 hour wait for first contact with	Coordination of the actions below will be taken by the Inpatient management team. <u>Transfer from Acute Units</u> Discharge Liaison Team has reduced capacity/staffing levels to meet demand for discharge assessment. Unable to meet the transfer from acute with 48 hour time frame, therefore health delays on the delayed discharge list for: NNUH 20 QEH 15 <u>Community Services</u> No beds available in Community Hospitals (general rehabilitation) throughout Norfolk. 12 + Delays in discharge in Community beds. No capacity in Community Team Services to receive patients. No patients identified for discharge from Community beds for the next 3 days. No capacity in Community Nursing	Staffing severely compromised (sickness / absence). Severely restricted capacity in residential / nursing sector. Severely restricted capacity in domiciliary care. IT systems not fully functioning. Unable to meet demand of assessments. Delayed transfers of care high.

	assessing clinician EAU M&S over capacity Increasing risk to patients and staff as patients waiting for assessment increases Ambulances handovers > 30 minutes Beds available do not match forecast demand > 30 medical boarders out of speciality 1 to 15 mortuary spaces	services. Waiting for equipment delays; more than 5 in the system. Increase in the flu pandemic status **<u>Staffing Capacity</u>** Staffing levels compromised - Inpatients in 5 plus units - Community Teams - in a range of community teams in every locality Discharge Liaison & Planning Coordination of the actions below will be taken by the Inpatient management team.	

RED ACTIONS			
The QEH	**NNUH**	**NHS Norfolk – NCH&C Provider Services**	**Social Services**
Actions identified for Amber status have all been completed but pressure has not been relieved. Following 8.30am bed meeting, The QEH Chief Operating Officer (COO) to cascade status via email to NHS Norfolk COO Provider Services, Director of Planning Procurement & Performance 2. Divisional / Clinician Managers: • Request ON-CALL MEDICAL, SURGICAL & ORTHOPAEDIC TEAMS to screen GP referrals so that options for managing the patient without admission are explored. 3. A&E SHIFT LEADER / A&E Consultant: • Ensure patients are kept informed of delays and actions. • Support the rapid decision making process to prevent emergency pressures escalating. • Implement A&E escalation plan if necessary	Actions identified in Amber status have not relieved the pressure. **In Hours Monday To Friday:** **Intervention** Escalate change of alert status to Senior Management teams, Duty Manager, Divisional Directors, Executive On Call and Medical Director Director of Operations/Medicine/Executive On Call to inform external stakeholders e.g. PCTs, NHS Norfolk and Social Services NHS Norfolk Executives to liaise with respective Chief Executives to authorise out of area capacity with repatriation plan determining capacity and use for additional beds in the NHS and independent sector e.g. emergency community bed availability Operations Centre Manager/Site Nurse Practitioners to inform EOE CAMS and EAAT. Request support of Ambulance DOM/AGM and determine frequency of operational meetings. Senior Nurse Patient Flow to liaise with IDT to assess current position and transport provision	As in Amber status PLUS: Assistant Directors to review capacity levels in house with Service Managers and with equivalent managers in acute trusts, social services, private and voluntary organisations. Discharge all patients that have achieved 90% of their goals, if safe to do so. Increase Continuing Care capacity to undertake full assessments. If pressure continues and there is an increasing likelihood of “grid lock” the Associate Director of Adult Services will escalate this to the Executive Management Team and subsequently to NHS Norfolk. **Triggers for change in Red Status to Amber** • Return to amber target levels in both acute trusts and community hospitals • Staffing levels compromised at amber status levels.	Increase staffing (pull from other areas). Urgent negotiation with independent sector re increasing capacity (eg decorating/cleaning brought forward). Escalate to Assistant Director level. Attend escalation / delays meetings. Joint communication strategy. Agree restricted processes to facilitate speedy discharge (eg limited recording on system).

4. Emergency Care Divisional Manager / COO to liaise with Duty Executive at NHS Norfolk, Cambridgeshire and Lincolnshire PCTs to plan solutions. 5. Open any additional closed beds. 6. Divisional Managers to contact all consultants & ask to bring forward ALL ward rounds with the intention of accelerating discharge planning. Or ensure Doctor of the Day is available to discharge immediately Discharge all rehabilitation patients that have achieved 90% of their goals, if safe to do so. 8. If pressures continue, COO to hold conference call with NHS Norfolk COO Provider Services, NHS Norfolk Director of Planning Procurement & Performance and Norfolk Social Services Director to identify solutions i.e. potential to spot purchase additional residential / nursing home beds. **Ambulance** 9. Patients requiring ambulance transport in order to be discharged from hospital are prioritised and	Medical Director to contact Divisional Clinical Directors to request additional support for colleagues with caseloads of >30 boarders Divisional Clinical Directors to ensure junior medical staff undertake simple ward related tasks irrespective of whose firm the patient is affiliated to Assistant Directors/Senior Nurses to support ward areas by; expediting discharges, reviewing expected date of discharge, maximising the use of the discharge lounge Assistant Directors of Nursing/Senior Nurses to identify additional staff **or** arrange redeployment of existing staff in order to open escalation areas Divisional Directors/Operational Managers review elective programme for the next 24 to 48 hours in liaison with the Assistant Director of Nursing for Operations and the Operations Centre Manager Liaise with Serco to determine the ability to provide rapid response to clinical cleans and portering of patients Site Nurse Practitioners and Patient Flow Coordinators to liaise with Senior Nurse Emergency Area to review escalation status and support A&E and EAU with rapid decision making to prevent emergency pressures increasing Patient Flow Co-ordinators to ensure		

additional resources may be requested from EEAST/PAS	theatre and front door emergencies are managed on a one to one basis **Out Of Hours And At Weekends:** The Site Nurse Practitioner will assume responsibility for site co-ordination resolving operational issues Reporting and escalating to the Duty Manager, Executive On Call and all other relevant personnel **Ambulance** Patients requiring ambulance transport in order to be discharged from hospital are prioritised and additional resources may be requested from EEAST/PAS		

Appendix 2

Appendix 2 sets out the membership of the Winter Planning Group and the organisational contact leads during winter.

Winter Planning Group Membership:

NHS Norfolk		
David Matthews	(Chair) NHS Norfolk	
Dave Kerry	Emergency Planning Manager	
Tara Studholme-Lyons	Assistant director – Unplanned Care	
Wendy Hardicker	Assistant Director – End of Life & Long Term Conditions	
Norfolk and Norwich Hospital NHS Foundation Trust		
Anne Osborn	Director of Planning and Performance	
Cherry West	Divisional General Manager – Acute and General Medicine	
Karen Watts	Assistant Director of Nursing Acute & Emergency Medicine	
Queen Elizabeth Hospital NHS Trust		
Mark Henry	Director of Operations	
Maggie Carter	Emergency Care Division Manager	
Norwich Community Health Care		
Val Macqueen	Acting Associate Director of Adult Services	
Debbie Beresford	Acting Assistant Director of Inpatients	
Norfolk Adult Social Services		
James Bullion	Assistant Director	
Lorrayne Barrett	Head of Service	
John Sharples	Health & Social Care Forum	
Norfolk and Waveney Mental Health NHS Foundation Trust (NWMHFT)		
Roy Jones	Assistant Director	
Karen Rix	Business Manager	
East of England Ambulance Service NHS Trust		
Darren Maguire	A&E	Interim General Manager
Gail Thurston	OOHs	Locality Manager, Primary Care Services
Liz Joyce	NES	General Manager

KEY WINTER CONTACTS IN HOURS

WINTER LEADS	First Contact(s)	Second Contact
NHS Norfolk	David Matthews 07833 465 300 david.matthews@norfolk.nhs.uk Dave Kerry 07736374439 Dave.kerry@norfolk.nhs.uk	Steve Davies 07810 878 318 steve.davies@norfolk.nhs.uk
NNUH	Cherry West 01603 286286 cherry.west@nnuh.nhs.uk Karen Watts Karen.watts@nnuh.nhs.uk	Anne Osborn 01603 286286 anne.osborn@nnuh.nhs.uk
QEHKL	Maggie Carter 01553 613613 Maggie.carter@qehkl.nhs.uk	Mark Henry 01553 613613 Mark.henry@qehkl.nhs.uk
NCH&C	Debbie Beresford 01603 776774 deborah.beresford@norfolk-pct.nhs.uk	Val Macqueen 01603 697347 val.macqueen@norfolk.nhs.uk
Norfolk Social Services	Lorrayne Barrett 01603 222181 Lorrayne.barrett@norfolk.gov.uk	James Bullion 01603 222996 James.bullion@norfolk.gov.uk
NWMHFT	Roy Jones 01603 421421 roy.jones@nwmhp.nhs.uk	Karen Rix 01603 421421 karen.rix@nwmhp.nhs.uk
EoE Ambulance Service	Nick Smith (NNUH) In hours 07921028949 Nick.smith@eastamb.nhs.uk Ray McAllister (QEH) In hours 07834249879	Darren Maguire 01603 424255, 07753950736 Darren.Maguire@eastamb.nhs.uk
EOE Ambulance Service (A&E) – Non Emergency Services	Ray.mcallister@eastamb.nhs.uk Sue Woods (NNUH) In hours 01603 287208 Sue.woods@eastamb.nhs.uk	Liz Joyce 07834 249841 Liz.joyce@eastamb.nhs.uk

	Jonathan Edge (QEH) In hours 01553 773044 Jonathan.edge@eastamb.nhs.uk	
OOHs	Gail Thurston 01603 424255 Gail.thurston@eastamb.nhs.uk	Lyn Reynolds 01603 424255 Lyn.reynolds@eastamb.nhs.uk

Out Of Hours Escalation	**OUT OF HOURS**	
NHS Norfolk	Director on Call	01603 481208
NNUH	Exec on Call	01603 286286
QEHKL	Exec on Call	01553 613613
NCH&C	Manager on Call	01603 481262
Norfolk Social Services	Director on Call	07881 855987
NWMHFT	Manager on Call	01603 421421
EoE Ambulance Service	Exec on call (via control room)	01603 422741
Escalation to SHA - NHS Norfolk Use Only		
EoE Daily Winter Lead	In Hours	01223 597559
EoE On Call Manager	Out of Hours	01603 419800

Risk Management Checklist **Appendix 3**

	Area/Service	Yes/No	If no, please indicate reasons why		Any other comments
1.0	**Pandemic flu Business Continuity Planning**				
1.1	Has the PCT reviewed the business continuity plans for all trusts and provider units?	Yes		Amber	Awaiting BCM plans for the NNUH
1.2	Do trust Business Continuity plans reflect the scenario modelling provided by the SHA and / or the scenario modelling contained in the National Framework document for pandemic flu preparedness?	NHS N Yes		Green	Plans were based on previous DH modelling and future planning will be based on the 3rd September 2009 DH /Cabinet Office revised Swine Flu Planning Assumptions.
1.3	Has the PCT identified any gaps in the plans developed and agreed an action plan to address these gaps?	NHS N Yes		Green	Tested and lessons identified as a result of exercises; Winter Willow, Fancied Plum, Morbus, Peak Practice and Coldplay 2.
1.4	Do all trust business continuity plans include planning for recovery after the pandemic wave?	NHS N Yes		Green	All Trusts follow DH NHS Recovery Guidance principles and incorporate within individual trust plans.
1.5	Have all trusts engaged in robust planning with all partners in the Local Resilience Forum?	NHS N Yes		Green	Through NHS Norfolk as Lead PCT representing health at the NRF Strategic Coordinating Group
1.6	Have all trusts a board level director with responsibility for pandemic flu and business continuity planning?	NHS N Yes		Green	All Trusts have exec director representation at board level.
1.7	Have all trusts taken full account of the DH guidance, Pandemic Flu; Managing Demand and Capacity in Health Organisations (urge), version published 30 April 2009 to review and refine their business continuity plans?	NHS N Yes		Green	All trusts follow DH Surge Management Guidance which is demonstrated within their plans.
1.8	Have all trusts ensured that key clinical and managerial staff are fully aware of DH guidance, Pandemic Flu; Managing Demand and Capacity in Health Organisations (Surge), version published 30 April 2009 and understand its significance to their work?	NHS N Yes		Green	Evidenced within their plans and tested at regional and local exercises.

	Area/Service	Yes/No	If no, please indicate reasons why		Any other comments
2.0	**Acute hospital capacity**				
2.1	Have urgent and routine elective and emergency care services been planned and profiled appropriately across the Trust to meet waiting time targets and likely emergency demand allowing for anticipated pandemic flu pressures?	NHS N Yes		Green	QEH: The Trust has a plan for managing its elective workload while continuing to achieve the 18 wks RTT for admitted patients. Additional beds are being opened to accommodate increased demand in emergency medicine from 1 September 2008 and additional MAU trolley capacity is planned. Our main tactic is to plan bed capacity to prevent cancelled operations and A&E breaches. A modular escalation / decant ward will be available from 1st January to manage peaks in activity & to ensure elective activity is not compromised.
2.2	What systems are in place to resume electives earlier if emergency demand does not increase as expected?	Yes. QEH		Green	QEH: Elective activity is not being restricted, the Trust is opening more emergency capacity as outlined above. This is being created to enable demands to be met.
		Yes N&N		Green	N&N: Electives are already planned to start as early as feasible
2.3	Are there plans for a smooth but staggered restart of full in patient activity after the pandemic wave pressures?	Yes		Green	QEH: Pandemic Flu plan has been updated & approved by PCT & SHA. Business continuity plans have been updated. MAJAX & pandemic Flu exercise have been undertaken in 2009 to test the plans & amended as appropriate
		Yes N&N		Green	

	Area/Service	Yes/No	If no, please indicate reasons why	RAG Status	Any other comments
2.4	Have contingency arrangements been made (including with the private sector) to allow additional capacity to be introduced at short notice? e.g. if emergency demand exceeds anticipated winter pressures.	Yes QEH		Green	QEH: As above. The Trust has an arrangement with the private hospital on site to access inpatient beds for surgical patients at periods of high demand.
		Yes N&N		Green	N&N: We need to work with our partners as we did last year to secure additional community health and social care bed capacity. Early warning systems to be developed.
2.5	Is acute bed capacity the equivalent level to last year? Please explain any difference and likely impact on service.	No QEH - Improved	QEH: Modular ward will be on site from 1st January & will provide escalation capacity as appropriate. CDU will provide extra capacity for Medicine. 6 extra SAU beds	Green	QEH
		No N&N - Improved	N&N: There will be 18 additional beds through the development of the Same Day Admission Unit	Green	N&N

	Area/Service	Yes/No	If no, please indicate reasons why	RAG Status	Any other comments
2.6	What are your plans to flex capacity to meet peaks and troughs of unscheduled demand?			Green	QEH: Business continuity plans have been updated. Pandemic Flu plan is in place. Escalation plans are in place for each service and all of the above measures will be in place.
		Yes N&N	N&N	Green	N&N: We seek to accurately predict what is coming in the next few days in order to anticipate beds required. We are however under pressure to achieve both elective work to meet waiting time targets and emergency work. In reality this means managing patient flow as effectively as we can.
2.7	Are systems in place to ensure patient discharge is coordinated with partners in the Local Resilience Forum?	Yes		Green	
	Critical Care				
2.8	Has agreement been reached with the critical care network to ensure capacity is maintained or increased to deal with increased demand on the basis of the scenario modelling?	Yes		Amber	Both Acute Trusts agreed to double Critical Care Capacity and plans submitted to SHA. Further work is ongoing to complete additional training and procure the necessary additional equipment.
2.9	Have there been discussions between the critical care networks around mutual support during a pandemic? What arrangements have been made?	Yes		Green	SHA has held discussions with Critical Care Network and clinicians

	Area/Service	Yes/No	If no, please indicate reasons why	RAG Status	Any other comments
	Staffing				
2.10	Have hospital staff been trained to enable flexible deployment and rostering across disciplines (and where appropriate from the community to acute sector) to support times of peak pressure?	Yes QEH		Green	QEH: The Trust has flexible working in Critical Care, A&E and on the wards. Staff are used flexibly and improvements are being made to the nurse and medical staff bank arrangements. Staff survey has been undertaken to identify skill mix review in both clinical & non-clinical staff. This has been converted into a plan for utilisation of staff in the event of a Pandemic Flu.
		Yes N&N		Green	N&N: But not from the community
2.11	Are there plans in place to increase staffing levels in care areas experiencing increased demand for services?	Yes QEH	.	Green	
		Yes N&N	N&N	Green	N&N
2.12	When a pandemic flu specific vaccine is made available, has the trust developed a plan to provide the vaccine to prioritise staff groups – front line staff?	NHS N Yes		Amber	Principles of vaccination plans agreed. Recent received further guidance on vaccination deliveries will enable final planning to be completed a.s.a.p.
	Diagnostic services				
2.14	Are there arrangements in place to cover any increased demand for diagnostic tests as a result of the pandemic period?	Yes QEH		Green	QEH: The Trust has opened an additional CT scanner since last winter. Consultant on-call always on site in Radiology. Business continuity plans have been updated.
		Yes N&N	N&N	Green	N&N

	Area/Service	Yes/No	If no, please indicate reasons why	RAG Status	Any other comments
2.15	Are arrangements in place for access to urgent diagnostic tests and reporting during the pandemic flu period?	Yes QEH		Green	QEH: 7 day working is already in place for Radiology and Pathology and escalation plans will be in place for other diagnostic services. Business continuity plans have been updated. As per pandemic Flu plan.
		Yes N&N	N&N	Green	N&N
3.0	**Delayed Transfer of Care**				
3.1	Has a standard definition of a DTOC been put in place and agreed by PCT and provider?	Yes SS		Green	SS: Definitions agreed by all partners and monitored regularly
		Yes QEH		Green	QEH: Monitored at the daily Ops centre meeting with SS & PCT.
		Yes N&N	N&N	Green	N&N
		Yes NCH&C		Green	
3.2	Have performance standards been agreed for each part of the discharge pathway?	Yes SS		Green	SS: Performance standards agreed for majority of pathway and targets set
		No QEH			
		Yes N&N	N&N	Green	N&N
		Yes NCH&C		Green	
3.3	Are reporting arrangements in place against each standard?	Yes SS		Green	SS: Daily reporting to senior managers on daily basis with high level of detail
		Yes N&N	N&N	Green	N&N
		Yes NCH&C		Green	These will be put in place once standards agreed.
3.4	Are appropriate escalation measures in place where delays occur?	Yes SS		Green	SS: Joint escalation procedures have been reviewed and updated for each trigger point
		Yes		Green	QEH/N&N/NCH&C

	Area/Service	Yes/No	If no, please indicate reasons why	RAG Status	Any other comments
4.0	**Social Care (including housing & wider Local Government**				
4.1	Have social services ensured through contracts, line management and inspection that all the residential and nursing homes have effective protocols with primary care to avoid unnecessary admissions to hospital and facilitate timely return after an admission?	Yes SS		Green	SS: In house establishments- management focus to prevent avoidable admissions and facilitate timely discharge. With independent establishments- active support given to do same. Contracts beginning to reflect this area.
4.2	Has Social Service ensured that all residential and nursing homes have provided appropriate training and support to their staff to enable them to care for flu cases and avoid admission to hospital?	Yes		Green	All homes understand the need to avoid unnecessary admission to hospital. In CA homes all staff are fully trained with independent sector/NHS guidance shared and discussed re managing flu cases.
4.3	Is the bed capacity in social care system at an equivalent to last year? If there has been a reduction, why has this occurred and what arrangements have been made to ensure no detrimental effect to service?	Yes SS	.	Green	**It has increased** - additional capacity purchased throughout the County for the sole purpose of avoiding delayed discharges. The new residential and nursing block contracts are in place providing further capacity. Ability to increase and flex when required
4.4	Are there robust arrangements between social services and the local NHS to allow appropriate and timely discharge of patients from hospital care?	Yes SS		Green	SS: Increased focus of recent months in order to drive down delays and support timely discharge. Processes and relationships are good to support this. Further refinement and redesign is planned across the system to further improve arrangements.

	Area/Service	Yes/No	If no, please indicate reasons why	RAG Status	Any other comments
		Yes NCH&C		Green	NCH&C: Regular multidisciplinary team meetings including Social Services currently take place in all community units. Direction of choice policy needs to be reinforced before transfer from the Acute Trust and information leaflets provided to patients identifying the potential length of stay in community hospitals prior to discharge from the Acute Trust. Consistent social work involvement in all community hospitals is embedded. Continuing care patients placed without prejudice into transitional beds.
4.5	Are contingency plans in place should a private sec home become unable, at short notice, to provide ongoing care for residents?	Yes SS		Green	SS: There is capacity in the system to cope. Local experience has led to good practice and procedures to support when this occurs for whatever reason.
4.6	Have Social Services' plans in place to include provision for enhanced out of hours cover a pande period?	Yes SS		Green	SS: Adult Social Services and children's services provide 24 hour emergency cover over the whole holiday period- including emergency home support. Staff in the acute trusts work enhanced hours over the period and contracts with independent providers of home care reflect need to respond at that time.
4.7	Provision has been made to identify and support vulnerable people in the community during a pande flu at times of staff absence due to leave/illness?	Yes SS		Green	SS: Adult Social Services and children's services work with partners to identify and support vulnerable people. Contingency plans in place if emergency needs arise.
		Yes NCH		Green	Flu continuity plans in place
4.8	Have effective liaison and support systems been established with local nursing/residential homeown during the pandemic period?	Yes SS		Green	Regular meetings take place between social services and independent providers to discuss such issues and agree plans.

	Area/Service	Yes/No	If no, please indicate reasons why	RAG Status	Any other comments
4.9	Do mechanisms exist between health and social ca for the quick resolution of any issues arising from agreeing care packages?	Yes SS		Green	SS: Processes are quick and effective. In the unlikely event that issues arise, the escalation procedure ensures quick resolution.
		Yes NCH		Green	NCH&C: An escalation system has been developed and works effectively
5.0	**Ambulance Service**				
5.1	Are contingency plans in place to maintain agreed levels of response time performance during periods of significantly increased demand and low staffing levels?	Yes AMB		Green	The National Severe Weather Warning Service is provided by the Met Office and offers Emergency Services, the NHS and Local Authorities early notification of anticipated severe weather, providing emergency responders with time to plan actions. The EEAS will assess each warning and instigate escalation of staff and vehicles if appropriate. The EEAS also has a MOU with 4x4 Rescue should specialist vehicle be required. The NHS also has access to this service through the EAAS MOU. In the event of periods of high demand, contingency arrangements will enable the Trust to implement a 'Memorandum of Understanding' agreement with the Voluntary and Private Services should that be necessary. This agreement allows for a number of St John, Red Cross and Private Ambulance providers to be deployed to hospitals to operate under the direction of an EEAST Manager. They will also undertake Cat C and urgent calls as appropriate. Ambulance Car Service may also play a part in these arrangements, but their input cannot be guaranteed.

	Area/Service	Yes/No	If no, please indicate reasons why	RAG Status	Any other comments
5.2	Are protocols in place between Ambulance services/hospitals and A&E to ensure rapid turn around of vehicles?	Yes AMB		Green	Ambulance Control and Locality Managers are in regular discussion with Hospital operational managers at each location in order to ensure that any undue ambulance handover / turnaround delays are proactively managed. Recent Improvements in policy and electronic auditing of times should give advanced notification and enable more specific targeting at problem areas. No formal agreement with NNUH & QEHKL on escalation. Agreement with NNUH & QEHKL on formal escalation to be finalised by early November
5.3	Can Trusts and the Ambulance Service demonstrate robust and flexible discharge transport arrangements both in and out of hours have been agreed with each hospital.	Yes AMB		Green	EEAS Locality Managers are in discussion with Hospital Contract Managers at each location in order to ensure that firm discharge arrangements are in place both during normal office hours and also out of hours. In the event of periods of high demand, contingency arrangements will enable the Trust to implement a 'Memorandum of Understanding' agreement with the Voluntary and Private Services should that be necessary.
5.4	Has the ambulance service agreed to provide patient transfers at short notice? If not please comment on contingency plan.	Yes AMB		Green	Ambulance Control Managers will ensure that the Trust maintains its policy of treating transfers second only to 999 emergency calls, ensuring these calls are treated as emergency responses. An emergency ambulance would usually convey patients, who require immediate transfer from one hospital to another due to their clinical condition. Under these criteria, the patient will in most circumstances be transferred in agreed timescales with the acute.

	Area/Service	Yes/No	If no, please indicate reasons why	RAG Status	Any other comments
6.0	**Primary and Community Services**				
	Out of Hours Services				
6.1	Are PCTs confident that OOH arrangements are robust, and will be able to manage surges in demand?	Yes		Green	OOH operates summer and winter rosters with manning levels based on historic data / demand. They have an ability to bolster services at short notice from an additional staff pool that covers all required skill levels.
		Yes NCH&C		Green	Surge/business continuity plans in place
6.2	Are PCTs satisfied that adequate arrangements are in place to ensure adequate primary care services are available during a pandemic period?	Yes		Amber	As 5.1 above plus additional staff called in for historic peaks in demand across the bank holiday period.
6.3	Have PCTs ensured that all practices have pandemic flu plans and business continuity plans? Have practice been asked to activate the iQ planner that was provided to all practices?	Yes		Green	All GP's have access to and have submitted plans to the IQ system. IQ system also being utilised as communications tool.
6.4	Have PCTs activated their iQ Management Module for aggregation of practice data?	Yes		Green	PCT aggregation system operational.
6.5	Are arrangements in place to enable access to emergency dentistry and emergency contraception during the pandemic flu period?	Yes NHSN		Green	Emergency Contraception can be accessed via community pharmacies. Emergency Dental Services can be accessed via the NHSD dedicated dental line.0800 663246. Patients will then be triaged to A&E for Emergency Care or a duty dentist for urgent care. The Norfolk GP OOH service has an extensive drug formulary and can also offer emergency contraception during the evenings, weekend and bank holiday periods.

	Area/Service	Yes/No	If no, please indicate reasons why	RAG Status	Any other comments
6.6	Have pharmaceutical arrangements been agreed?	Yes NHSN		Green	In Norfolk there are 112 pharmacies, all of whom can provide essential winter medications. In addition, pharmacies have the ability to supply emergency prescription medicines when patients have either inadvertently ran out or are visitor to the area. Most pharmacies are open on Saturday and over 20 pharmacies are open on Sundays and Bank Holidays, with 4 pharmacies open from 10.00am until 8.00pm. A list of pharmacy Sunday and Bank Holiday opening times is listed on pharmacy windows. We do not list Saturday openings since almost 100% open. The Out of Hours service has a list of Sunday pharmacies. A new 100 hour pharmacy in Thetford is expected to open in September and this will certainly solve weekend access to pharmacies in this area. The Norfolk GP OOH service has an extensive drug formulary and can also offer emergency contraception during the evenings, weekend and bank holiday periods. The GP OOH services stocks a good range of medications on each of its primary care centres which patients can access during the evenings, weekend and bank holiday periods.
6.7	Have community pharmacies identified and begun to stockpile medicines and other flu related stock that will be in increased demand?	Yes		Green	Assurance received

	Area/Service	Yes/No	If no, please indicate reasons why	RAG Status	Any other comments
6.8	Have PCTs ensured that their local pharmacies have agreement from their head offices to act as ACPs?	Yes		Green	All agreed and successfully operating at present.
	Continuity of Care				
6.9	Is there a system in place for GPs, in liaison with other primary care and social service colleagues, to ensure the identification of high risk community based patients?	Yes NCH&C		Green	Each community team will hold their own live list which could be readily shared at times of crisis. This includes patients on home oxygen. Need to formalise a process of sharing information with regard to high risk community based patients across organisations i.e. health and social care. Links to 3.6
6.10	Are arrangements in place to support nursing and residential homes to avoid unnecessary hospital admissions?	NCH&C		Amber	NCH&C: There is no formal agreement in place. In those care homes that community teams already visit there are informal arrangements in place. Extra investment is needed in order for NCH&C to pick-up this function. Need to review GP cover in all NHS
6.11	Do PCTs have arrangements in place to support single handed GPs who may not have the infrastructure required to meet surges in demand?	N/A NHSN	NHS Norfolk do not have any single handed GPs	Green	
6.12	Are new arrangements in place to support patients requiring home oxygen services?	Yes NHSN		Green	NHS Norfolk home oxygen services are now provided by a single regional contractor BOC (Vitalair). We can confirm that they have in place plans to meet service needs (a contractual requirement) that covers the winter period, including specific bank holiday periods.

	Area/Service	Yes/No	If no, please indicate reasons why	RAG Status	Any other comments
	Staffing				
6.13	Are there plans in place to increase staffing levels in priority care areas when staff capacity overall is reduced?	Yes NCH&C		Green	Each service area has local plans to cover increased demands in staffing levels which feed into the organisations surge/business continuity plans.
	Flu campaign				
6.14	Have PCTs begun to develop plans for delivery of a pandemic specific flu vaccine to identified staff groups and to identified high risk patient groups when sufficient supplies of the vaccine become available?	Yes		Green	Final guidance received on delivery and GP engagement. Still awaiting comms package and training material from DH.
6.15	Have PCTs developed plans for the mass vaccination of the general population with a pandemic flu specific vaccine when available?	Yes		Amber	Agreement reached nationally with GP's to vaccinate patients within priority groups.
6.16	Do PCTs have arrangements in place to offer pandemic flu vaccine to all staff involved in the delivery and/or support to patients?	Yes NHSN		Green	All trusts have planning arrangements to administer seasonal flu vaccine to staff through an SLA. Occupational Health are organising a flu campaign with clinics across the PCT area for staff to access. Pay slip attachment to be sent and posters and leaflets will be distributed.
	Intermediate Care				
6.17	Are planned levels of capacity within intermediate care schemes sufficient to meet forecast demand for the pandemic flu period?	Yes NCH&C		Green	An increase in community intermediate care rehabilitation beds have been commissioned to meet the expected winter demand. Specialist stroke rehabilitation beds are expected to become live from January 2010 and reach full capacity over a 2 week period.
6.18	Are there contingency plans to increase the level of provision if demand is higher than planned?	Yes NCH&C		Green	

	Area/Service	Yes/No	If no, please indicate reasons why	RAG Status	Any other comments
6.19	Is there a single point of access for the full range of intermediate care services to ensure simplicity and clarity for users?	Yes NCH&C		Green	This is locality based and generally aliened to PBCs
6.20	Are services organised on a 24/7 basis?	In part NCH&C		Green	In line with NHS Norfolk current specification. Some community teams are 24/7 - District Nursing in the West and the Care at Home team in the South. All beds 24/7
6.21	Is there a clear communication plan to ensure that all potential users of intermediate care are fully aware of the availability of services and how to access them?	Yes NCH&C		Green	The communication plan is being led by NHS Norfolk and co-ordinated through the Strategic Capacity Planning Group
6.22	Are there robust multi-agency arrangements for planning, co-ordination and review of services before and throughout the pandemic flu period?	Yes NCH&C		Green	Led by NHS Norfolk - Strategic Capacity Planning Group. Led by NCH&C – Strategic Planning Group and Operational Capacity Planning Group meetings are scheduled in accordance to the level of alert.
6.23	Norfolk addition: Are there arrangements in place to specifically target flu vaccinations for people with learning difficulties	Yes		Green	Part of comprehensive communications plan
7.0	**Mental Health and Learning Disabilities**				
7.1	Are there plans in place for the care of inpatients who develop flu in all sectors of mental health inpatient care – open, low secure, medium secure and high secure units?	Yes		Green	All within a comprehensive NWMHFT Pandemic Flu Plan.

	Area/Service	Yes/No	If no, please indicate reasons why	RAG Status	Any other comments
7.2	Have arrangements been agreed to ensure access to services and primary care cover over the pandemic flu period and to identify and maintain vulnerable people in the community?	Yes NWMH FT		Green	The Crisis Resolution and Home Treatment Teams will provide a normal 24/7 service over the holiday period. For the bank holidays staffing levels will be based on those used at weekends. In Central and East Norfolk and in Waveney the integration of inpatient and Crisis Resolution teams will allow staff to be used flexibly, so that any reduction in bed occupancy will enable staff to be redeployed in the CRHT teams. The West Norfolk CRHT will work from 08.30 to midnight each day with support from the older person's intensive support team until 10pm weekdays and 9-5 weekends and bank holidays. The maximum number of service users will be supported in the community. Past demand for services over Christmas /New Year has been reviewed and plans are in place to ensure service levels match demand. The review shows that the peak demand for mental health services is in January/February and not at Christmas. . Trust staff will work with service users in the period up to 24th December to maximise their ability to cope over the Christmas period. Other measures will be put in place as appropriate, for example the Alcohol and Drugs Service will ensure that all prescriptions of methadone, etc will be delivered by hand to community pharmacies well in advance of the holiday to ensure that medication is available for collection when required

	Area/Service	Yes/No	If no, please indicate reasons why	RAG Status	Any other comments
7.3	Are arrangements in place for 24/7 rapid response support for mental health assessment of patients in A&E during a pandemic flu period?	Yes NWMH FT		Green	The liaison team at the NNUH will be covering normal working hours. Bank holiday cover is provided by the CRHT. At the QEH the 24/7 service will be provided by a Senior Nurse and an SHO.
7.4	Are arrangements in place to provide adolescent mental health cover the pandemic flu and Christmas and New Year period?	Yes NWMH FT		Green	The child and adolescent mental health service in Central and East Norfolk will be staffed on the normal working days over the holiday period and will use the standard weekend and bank holiday on call arrangements. In West Norfolk the service will be staffed on normal working days and will have staff from the Intensive Support Team at weekends but not on Bank Holidays, while CAMHS presentations to the QEH will be dealt with by the senior nurse and SHO.
8.0	**Escalation and Communication**				
8.1	Are key clinical and managerial staff within the health economy clear on the triggers, actions and responsibilities within the pandemic flu and business continuity plans of their trust?	Yes NCH&C		Green	
8.2	Is there a clear plan for communicating information to the public, publicising the services that are available?	Yes NHSN		Green	NHSN: Year round communication and media strategies in place to publicise services, including specific service guides, e-marketing tools and pr campaigns specific to winter periods. Communications systems established to get messages out to GPs, public etc, in urgent or emergency situations.

	Area/Service	Yes/No	If no, please indicate reasons why	RAG Status	Any other comments
8.3	Do the organisations have internal communications plans for keeping staff fully informed about preparations for pandemic flu?	Yes		Green	NHSN: Internal communication processes including newsletters, intranet, staff bulletins, staff briefing sheets and face to face team briefings.

Appendix 4

East of England Ambulance Service NHS
NHS Trust

EAST OF ENGLAND ESCALATION GUIDELINES

Purpose

The purpose of these guidelines is to provide support to Trust staff in the event of exceptional circumstances. The guidelines will provide a structured approach to escalation and will identify certain trigger points and actions in relation to a range of operational pressures.

The circumstances addressed by these guidelines are by no means an exhaustive list and staff should seek advice and/or support if they are uncertain of how to manage any adverse or exceptional situation that arises. These guidelines should also be read/utilised in conjunction with the Guidelines for On Call paper.

Operational Activity

The HEOC Duty Manager/Supervisor is responsible for identifying exceptional circumstances that place undue pressure on the ability of the organisation to deliver a service to patients. Some common exceptional circumstances and the trigger points for escalation are outlined below:

Emergency Activity

Trigger Point	**ANY** 999 calls outstanding with no resource to assign
Action Required	**Immediately** inform key personnel including Head of HEOC/Distribution Manager; Operational Managers; General Managers, LCOO, AD Distribution and Director of Ops. Also contact other HEOCs to request assistance.

Urgent Journey Activity:

Trigger Point	15 or more urgent journeys waiting for a vehicle to be assigned
Action Required	Inform key personnel including Head of HEOC/Distribution Manager; Operational Managers; General Managers, LCOO, AD Distribution and Director of Ops. Contact other HEOCs to request assistance.

Operational Downtime

This should not be solely the responsibility of the HEOC Manager and should be identified by operational managers in advance, where possible, and/or from the
HEOC status report.

Trigger Point	Greater than or equal to 5% of operational downtime
Action Required	Confirm HEOC status report has been distributed with the correct number of lost hours documented. Operational Managers should escalate to key personnel particularly General Managers and the LCOO responsible for those lost hours.

Hospital Delays:

Trigger Point	2 or more resources delayed at an acute unit for more than 30 minutes OR any resource delayed for greater than 60 minutes.
Action Required	Inform operational manager and copy in LCOO. Operational Manager to contact the appropriate person at the delaying unit to identify the extent of the problem and the potential for it to worsen.
Trigger Point	3 or more resources delayed at a receiving unit for more than 1 hour
Action Required	Inform key personnel including Head of HEOC/Distribution Manager; Senior Operations Team (Dir Ops, All LCOOs, AD Distribution, and AD Production). In hours it will be the responsibility of the LCOO to address the issue. If there is no commitment from the delaying unit to address the situation, or an apparent inability to address the situation, the Director on Call at the responsible PCT should be informed. The LCOO should inform the relevant Exec Director (depending on time of day) that it has been escalated to the PCT with a request for assistance and support. If there is no commitment from the PCT to provide support and address the situation with the acute trust, or an apparent inability to address the situation, then consideration should given to informing the On call Exec and the Ambulance Performance lead at the Strategic Health Authority (SHA). OOH this should be escalated to the Silver On-Call who will inform the Gold On-Call as necessary depending on the ability of the delaying unit to address the situation. In line with the On Call Guidelines it will be the decision of the Gold Commander to inform the Exec On-Call OOH.

It should be noted that the above are guidelines and is intended to support, not substitute the decision making ability of the HEOC Duty Managers/Supervisors. In all cases it is the responsibility of the LCOO to ensure that escalated issues for their area are managed appropriately.

Appendix 5

Ambulance Handover / Turnaround: List of recommendations and Action Plan

	Recommendation	Action	RAG
1	Acute Trusts, Ambulance Trusts and commissioners should identify an executive lead with responsibility for ensuring timely patient handover delays. Executive leads should commit to working together with other organisations in the local community.	NNUH Exec lead: Anne Osborn - Operational Lead: Cherry West/Karen Watts QEH Exec lead: Mark Henry - Operational lead: Maggie Carter EEAS Exec lead: Neil Storey – Operational lead: Darren Maguire NHS Norfolk Exec lead: David Matthews – Operational lead: Dave Kerry	Green
2	Acute Trusts and Ambulance Trusts should appoint a clinical lead to oversee the development and Implementation of clinical handover protocols for acute departments.	NNUH Clinical lead: Racheal Peacock, Senior Nurse & Bruce Finlayson, A&E Consultant and Clinical Director QEH Clinical lead: EAAS Clinical lead:	Red
3	Acute Trusts and Ambulance Trusts should review and agree protocols for handover, and how data is captured at each stage of the handover process with their ambulance trust for each location that patient handovers occur. Local variance between receiving departments in Trusts should be clearly identified and variances documented in local operational procedures.	Final protocols have been agreed as part of this action plan. Data capture systems for Handover and turnaround time implemented. Local variances in operating practices will be accommodated as part of the action plan but basic protocols should be consistent.	Green
4	Acute Trusts, Ambulance Trusts, Primary Care Trusts and Strategic Health Authorities have a responsibility to ensure that handover data definitions are consistently applied.	“Trolley Clear” can be categorised as when the patient is safely transferred on to a hospital trolley / bed or any other location that the A&E / Admissions unit clinical staff determine as appropriate and the patient's details / clinical information is communicated to the hospital clinical staff that are accepting responsibility for the on-going care of the patient and the ambulance crew and their stretcher are free to leave the department.	Green
5	Executive leads should communicate handover data definitions to all staff involved in the management of patient handovers.	Completed, SOP issued to all Ambulance staff.	Green
6	Ambulance Trusts and Acute Trusts should develop local processes to agree data and sign off collections – including joint reporting.	Data reporting capability in place. Daily and weekly data set sent by Ambulance Information Team to PCT and Acute Trusts.	Green
7	There should be a regular reconciliation process between the Acute Trust and the Ambulance Trust on the number of patient handover delays that have occurred, and to ensure consistency with reported returns.	Reconciliation occurs at the following levels: operational liaison / reporting at time of delay. Tactical meetings between Ambulance Trust and acute, strategic level meetings with PCT, Ambulance Trust and acute. Some minor issues regarding use of private ambulances to	Green

		resolve	
8	Acute Trusts and Ambulance Trusts should develop a system to categorise patient handover delays to ensure full operational understanding of all delays lasting more than 15 minutes.	Review undertaken (based on Bedfordshire lead) for delays over 60 minutes. No plans to review 15 min delays	Amber
9	Ambulance Trusts and Acute Trusts should develop a seven day breach analysis tool for patient handovers lasting more than 15 minutes.	EAAS producing and distributing daily and weekly information showing number of delays. Daily report will also shortly be available on delays pre and post handover (where recorded) Reports circulated to PCTs & acute Trusts.	Green
10	Executive leads should link patient handover delay improvement actions into other trust-wide operational management plans.	Ambulance handover is one of many initiatives being implemented at both hospitals and incorporated in existing escalation plans.	Green
11	Acute Trusts should develop an algorithm for detecting early signs of potential escalation status to allow time for local health community response to be prepared ahead of escalation.	Both Acute Trusts have agreed Escalation Plans that identify trigger points. Need to ensure that escalation plans do enable early notification to aid preparedness in the local health community.	Green
12	Local escalation plans should be jointly agreed and aligned with community wide plans. Escalation should be implemented as applicable and in accordance with the agreed plan.	NHS Norfolk Winter Planning 2009/10 includes jointly agreed escalation plans for the whole Norfolk health system.	Green
13	Commissioners should understand the detailed issues behind the delays and intervene if the key causes continually re-occur.	NHS Norfolk appointed manager to monitor delays and lead on formulation of agreed action plans in an effort to address any issues.	Green
14	The performance management arrangements for handover delays should be specified by primary care trusts and strategic health authorities.	Information is being received, shared and acted upon. This is a dynamic process that needs regular evaluation and sound communication links.	Green

Appendix 6

NHS Norfolk Director on call Action Card
Acute Hospital Escalation to BLACK

Acute Hospitals can only escalate to BLACK alert status following consultation and agreement between an Acute Hospital Director and an NHS Norfolk Director. It is the responsibility of NHS Norfolk to inform the EoE SHA of any escalation to BLACK alert status, giving an estimated duration of the escalation, confirming specifically what the events/triggers are that prompted the escalation and what actions are being taken to adequately address the problems identified.
EoE SHA normal working hours: **01223 597559**. Out of hours: Group pager **07699 732431**

BLACK alert state definition: System Gridlock. A&E departments unable to safely provide emergency care service. Ambulances unable to offload. Elective work cancelled. Service interruption (e.g. Diagnostics) which cannot be resolved under 4 hours and which requires emergency contingency measures

NHS Norfolk Director: …… Date:…… Time:……..

Acute Hospital:…… Director:…….. Contact No……..

Questions	**Yes/No**	**Comment**
1. All escalation actions for Red alert status implemented? **		
2. All treatment areas in A&E in use? **		
3. All possible escalation areas open? **		
4. > 3 Ambulances unable to offload for more than 1 hour? **		
5. Have Elective surgery admissions been cancelled? **		
6. Have Ambulance Diverts been requested? **		
7. Have all planned Electives been admitted?		
8. Delayed Transfers Of Care (DTOC):> 20 NNUH?> 15 QEH?		
9. Trolley-waits over 12 hours?		
10. > 4 hours A& E waits?		
11. Are additional Consultant led wards rounds taking place?		
12. Are there any Critical/Specialist care issues?		
13. Are any wards/beds closed and for what reason?		
14. Are there any significant staffing issues?		
15. Has there been any Media interest?		
What is the primary reason for requesting escalation to BLACK?	** All essential elements	

Escalation agreed: YES/NO – Time:……..hrs – Duration:……..hrs – Review time: ……hrs

Actions	**Yes/No**	**Comment**
Consider PCT Support for Ambulance Diverts requests if viable		
NCH&C DTOC Issues: **01603 776765** OOH**: 01603 481208**		
Social Services DTOC: **01603 222181** OOH: **07881 855987**		
Consider NHS Norfolk attendance at future bed meetings		
Authorise funding of viable additional initiatives / resources		
Consider communications message to Primary Care		
Inform EoE SHA: **01223 597559**: OOH pager **07699 732431**		
Inform East of England Ambulance: **01603 422741**		
Contact Acute Hospital Director at agreed review time		

Please use page 2 of this action card to log any additional information and forward this sheet to the NHS Norfolk Winter Planning lead for audit purposes

Date / Time	Action / Decision

Appendix 7

Intermediate Care Bed Capacity Plan for Winter 2009/10

Control

Title:	Intermediate Care Bed Capacity Plan for Winter 2009/10
Author:	David Matthews
Target Audience	Norfolk Health Organisations
Circulation Status:	
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Document Status:	Draft

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1 Introduction

The purpose of this paper is to set out NHS Norfolk's plans for Intermediate Care provision during winter 2009/10 following a system wide engagement and planning process.

The paper includes a summary of a bed model used to estimate demand, a summary of the additional capacity NHS Norfolk will commission, an approach to internal and external communications and a summary of the integrated system management processes to manage patient flows.

Building on the Winter Planning process in 2008/9, the implementation of the bed model and system improvements will:

- Improve the patient experience
- Improve the management of capacity pressures
- Reduce delayed transfers of care (DTOC)
- Co-ordinate patient flows
- Utilise intermediate care and acute facilities more effectively

One of the learning points from winter 2008/9 was to plan early and agree system wide solutions for capacity requirements at the earliest opportunity. It is testament to the engagement and commitment of all providers, PBC and social care colleagues that this agreed plan can be presented to Boards at this relatively early stage.

The bed model estimates the likely demand over the winter (to March 31 2010) and evaluates the consequence of commissioning actions on bed capacity, building on the initiatives discussed as part of the short term support to reduce DTOC at the Norfolk and Norwich University Hospitals Foundation Trust (N&NUH FT).

This bed plan will be referenced in the system wide Winter Plan which will be presented to Boards in October 2009.

2 Executive Summary

The Norfolk system has agreed a bed model which estimates the likely number of patients needing intermediate inpatient care, by month by location. This demand is converted into a monthly bed requirement and compared with the current planned availability of beds. This initial review identifies a shortfall in bed capacity in some areas during winter 2009/10. This initial position further deteriorates when additional capacity to reduce delayed transfers of care (DTOC) is built into the model. **(Appendix 1, Section 1-3)**

The model then evaluates the impact of additional bed purchases, additional community support and efficiency gains on existing bed capacity, building on the initiatives discussed as part of the short term support (Firebreak Plan) to reduce DTOC at the Norfolk and Norwich University Hospitals Foundation Trust (N&NUH FT). **(Appendix 1, Section 4-11)**

The assumptions used to generate the model have been discussed and generally accepted as realistic within the Norfolk health and social care system.

This early modelling has allowed time to secure additional capacity through community hospitals rather than nursing homes. This provides consistent high quality of care for patients and greater efficiency in terms of bed occupancy and length of stay (LOS).

The key commissioning issues from the review of the intermediate care system and the output of the model are:-

Model Outputs

- The 28 beds at Henderson should remain open until March 2010. (Double running with the new ward and stroke unit)
- The stroke beds (24) and the new ward (24 beds) are operational from mid-January 2010
- Additional beds in Dereham (6) and St Michael's (8) are commissioned from October 2009 for six months
- Additional nursing home beds (10) will be needed in central and south locations between November 2009 and January 2010
- Efficiency gains in both community and nursing homes have been factored into the model
- Additional weekend cover will be commissioned immediately to cover Henderson, Ogden Court and Dereham
- Additional community nursing support to nursing homes should be commissioned immediately to produce greater efficiency
- The model includes additional capacity to reduce DTOCs for health related patients
- Additional opportunities for efficiencies utilising spare capacity in the North may be available
- Additional beds in the South, based at Beccles and Patrick Stead or All Hallows, can be used

All of the outputs, including the additional resources needed, have been agreed by NHS Norfolk and contract variations have been issued to potential providers.

3 The Model

3.1 Demand assumptions

To arrive at the start position summarised in Appendix 1, Section 1, a model was developed which estimated the number of discharges per month per location at 8/9 activity levels and then converts this demand into a bed surplus/shortfall calculation.

Expected demand was calculated using the full year effect of 8/9 activity, using a monthly profile based on over 65 admissions to acute hospitals within certain specialties.

This demand has been estimated by month and by hospital/nursing home, summarised into a locality based total.

This detailed modelling includes an estimate of demand growth, which has been set at 3%.

To calculate the number of beds required to meet expected demand the historic average length of stay and occupancy rates has been used initially.

The assumption used to develop this initiate position includes the maintenance of 28 beds at Henderson until the end of March 2010 and the availability of new beds in the community ward and specialist stroke unit from mid January 2010.

3.2 Supply and efficiency changes to manage demand (Appendix 1)

The initial start position shows a shortfall in bed capacity in the South and Central locations, with spare bed capacity in the North.

The summary details and estimates the impacts of changes to this baseline position, the current list of possible interventions are detailed below:-

Commissioning Initiative	**Summary Reference**
Additional beds required to reduce Delayed Transfers of Care (DTOC)	Appendix 1, Section 2
Efficiency gains from reducing length of stay and occupancy rates at community hospitals, and reducing DTOCs	Appendix 1, Section 4
Commissioning additional beds at Dereham and St Michaels and providing weekend medical cover at Ogden Court, Dereham and Henderson	Appendix 1, Section 5
Improved discharge management in community hospitals	Appendix 1, Section 6
Enhanced efficiency in nursing homes by commissioning additional community support nurses	Appendix 1, Section 7
Commissioning additional beds at Beccles and Patrick Stead	Appendix 1, Section 8
Purchase of additional nursing home beds to cover the final locality shortfall	Appendix 1, Section 10

The overall impact of these actions provides sufficient capacity to meet expected demand across all localities. As expected the model shows excess capacity in the north with potential pressures in the south and west locations.

The option to encourage the use of spare capacity where this may not be the patients first choice has not been included in the estimations, but individual patients are now being able offered the option to choose an available bed, which will help to reduce DTOC and bed capacity issues.

4 Communications Plan

4.1 NHS Norfolk Lead

The Norfolk health system has agreed a co-coordinated approach to internal and external communications.

The NHS Norfolk team communications team will draft a communications strategy for winter, including an escalation protocol and media plan. This will be agreed through the Winter Capacity Planning Group (WCPG).

5 Winter Plan and Swine Flu Resilience

The escalation Plan for Winter 2009/10 is being completed by the system wide WCPG.

The plan includes:

- Norfolk whole system wide escalation plan, which includes all providers, social services and the ambulance trust.
- Escalation policy, including measures to judge green, red, amber and black alerts
- Names of key winter contacts, including on call arrangements
- SHA risk checklist, including pandemic flu preparedness
- Ambulance Trust escalation procedures

The plan will be completed in final draft by 30 September and be presented to Boards in October 2009.

6 Financials

The cost of implementing the actions and initiatives in the plan exceeds the current budget by £1m.

The recurrent nursing home spot purchase budget has been effectively reduced due to the ongoing costs of nursing home purchases made during the 2008/9 winter period.

7 Basis of assumptions and level of agreement

7.1 Initial Demand model

The detailed modelling is generally accepted as robust in calculating expected demand. The monthly percentage is based on over 65 year olds, non-elective admissions to general medicine, care of the elderly and orthopaedics over a two month period with zero lengths of stay removed. This gives a reasonable proxy for the expected number of admissions to community hospitals.

The level of growth (3%) has been subject to some debate, but reflects the planning assumptions in the internal NCH&C model and is consistent with the growth in the over 65 admissions for the relevant specialties above.

7.2 Additional capacity to reduce DTOC

The additional capacity included to reduce DTOC is the least robust of all the estimates as the number of variables and reasons for delays are numerous and complex.

Analysis shows that in total acute trusts have two health related DTOC added to the list per day. Individual case analysis could provide more information on the reason for delay and resultant level of addition could be refined, this could be piloted over a number of months to provide a more robust methodology in determining the additional beds needed to maintain DTOC at a minimal level.

7.3 Efficiency gains from community hospitals

Appendix 2 includes an assumption of efficiency gain to 90% occupancy (based on 95% availability) and 26 day LOS at all community hospitals. (8/9 performance was 88% occupancy and 27 day LOS).

This is viewed as achievable by NCH&C and recent data suggest the majority of hospitals are close to, or exceed, this target already.

7.4 Commissioning additional beds at Dereham and St Michael's

The option to commission an additional 6 beds at Dereham and 8 beds at St Michael's has been discussed with NCH&C. There is general agreement that beds could be made available from October 2009.

The beds at Dereham require some minor capital works (max. £15k) to purchase a new macerator.

A small gain from the commissioning of weekend medical cover at Henderson, Ogden and Dereham has also been included, allowing admissions and discharge over the full week.

7.5 Enhanced efficiency in nursing homes

The operating efficiency of nursing homes is historically poor, with minimal intervention by community support staff. The average occupancy rates are 78%.

By employing two dedicated community staff, there is general agreement that efficiency can be improved by 15%.

7.6 Additional capacity at Beccles and Patrick Stead

The provider arm of NHS GY&W has agreed to allow access to their available beds at Beccles and Patrick Stead. They are not willing to enter into a formal contract at this stage. Occupancy rates are low at 70% and therefore capacity should be available. The location of Beccles is very closes to the southern border of NHS Norfolk and therefore serves as a viable alternative to All Hallows.

7.7 Estimating the number of patients who would accept an available bed

A number of DTOCs result from patients waiting for a bed in a specific location. There is a general acceptance that a new protocol should be developed which seeks to use all available capacity. A new patient information leaflet is now in use which supports this approach.

This is some differing views on the assumptions that should be made on the use of spare capacity in the north of the patch. This model has assumed no benefit from this initiative.

A more detailed list of assumptions is included in the table at the end of this report.

8 Monthly Analysis of Bed Availability

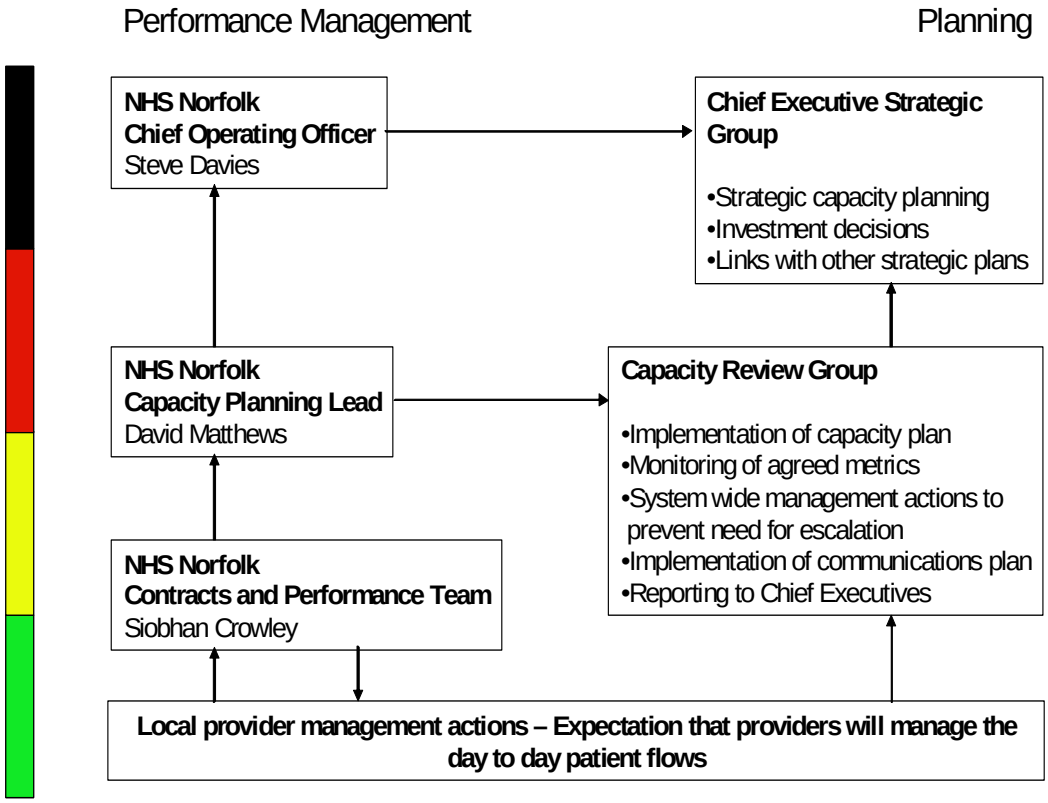
Appendix 2 shows the number of beds available in the system and demonstrates the move from using nursing home beds to community beds.

9 Performance Management and escalation

The winter plan will include details of day to day management of the system, based on approach where patient's flows, and DTOC, will normally be managed by providers on a day to day basis, with performance management by NHS Norfolk contracting team.

The winter plan will detail the escalation route, which is summarised below:

Escalation Route



Intermediate Care Bed Model

Assumptions and Calculations

Bed Model Field	How Calculated/Assumptions Made
Number of spells	All patients discharged in the year 2008/09 with the exception of zero lengths of stay at each community hospital (Data file supplied by NCH&C) Full year data for nursing homes are not available for individual patients. Part year (October-March) has therefore been used to calculate full year number of admissions
Average length of stay	Calculated from admission and discharge dates for all patients excepting zero lengths of stay Full year data for nursing homes are not available for individual patients. Part year (October-March) has therefore been used to calculate full year average length of stay
Occupancy rate	Number of actual occupied bed days divided by total number of potential bed days (number of beds x 365) Full year data for nursing homes are not available for individual patients. Part year (October-March) has therefore been used to calculate full year occupancy rate
Demand profile	An attempt to estimate demand rather than supply Over 65 year old, non-elective admissions to general medicine, care of the elderly and orthopaedics between April 2007 and March 2009 with zero lengths of stay removed
Activity uplift applied in 2009/10	3%
Stroke beds and new ward	Due to open 15 January 2010 Assumed that half of available beds will be used for half of January therefore 25% of total benefit assumed in the month (6 beds from 24)

Henderson ward	Assumed that Henderson ward will remain open with staffing and equipment to maintain current levels of patients and efficiency
Additional beds at Dereham and St. Michael's	Shown within 'Firebreak' section 6 beds at Dereham and 8 beds at St. Michael's at 90% occupancy Assumed that Dereham beds will go ahead subject to capital works being deliverable and affordable – will not compromise compliance with single sex accommodation rules
Additional medical cover at Dereham, Ogden Court and Henderson Ward	Assumed that medical cover will be in place by October and will give additional capacity of 2 beds, 1 in the central area, 1 in south
Out of area beds	Shown within OOA section Potential to secure 5 beds at Beccles
Beds required to reduce delayed transfers of care	Assumed that 10 beds will be required to accommodate delayed transfers of care Finnamore report used 16 beds including specialist hospitals
Efficiency	Assumed that community hospitals and nursing homes should reach a minimum efficiency level of 26 days length of stay and 90% occupancy. Efficiency is shown as the number of beds per locality that would be 'gained' if hospitals/nursing homes that are not currently achieving these levels were able to do so Where these levels are being achieved or bettered, no adjustment has been made Assumed that the efficiency gain is achievable with additional investment in nurses to manage nursing home discharges
Use of beds	Assumed that 0% of available community hospital beds in North Norfolk could be occupied by patients from other parts of the county if appropriate information, supported by transport schemes, is available

Number of additional nursing home beds to be commissioned	Efficiency from using available beds in the north is already factored in as detailed above so no further adjustment made Assumed that central and south Norfolk works as one system therefore the bed requirement for the two areas are added together Bed model does not demonstrate need for additional capacity in the west

NHS Norfolk Intermediate Care Bed Capacity Plan for Winter 2009/10
() = shortfall of beds

1		Community Beds					Nursing Home					Total				
	Mth	*North Total*	*Cent Total*	*South Total*	*West Total*	*Total*	*NthTotal*	*Cent Total*	*South Total*	*West Total*	*Total*	*North Total*	*Cent Total*	*South Total*	*West Total*	*Total*
Start position from detailed analysis	Sept	15	4	(0)	3	21	-	6	1	(2)	5	15	10	1	1	26
	Oct	4	(3)	(1)	1	1	-	(2)	(1)	(4)	(7)	4	(5)	(2)	(3)	(6)
	Nov	7	(0)	(1)	2	8	-	(8)	(10)	(4)	(22)	7	(9)	(11)	(2)	14)
	Dec	5	(2)	(1)	1	4	-	(8)	(10)	(4)	(22)	5	(10)	(11)	(2)	(17)
	Jan	(2)	2	(1)	1	1	-	(10)	(12)	(5)	(27)	(2)	(8)	(13)	(4)	(26)
	Feb	15	32	3	4	53	-	(9)	(12)	(5)	(26)	15	22	(9)	(1)	27
	Mar	8	27	3	3	41	-	(9)	(11)	(4)	(24)	8	19	(8)	(2)	16

DTOC 2		Community Beds					Nursing Home					Total				
	Mth	*North Total*	*Cent Total*	*South Total*	*West Total*	*Total*	*North Total*	*Cent Total*	*South Total*	*West Total*	*Total*	*North Total*	*Cent Total*	*South Total*	*West Total*	*Total*
Estimate of additional beds needed to reduce DTOC	Sept	-	(3)	(3)	-	(6)	-	-	-	-	-	-	(3)	(3)	-	6)
	Oct	-	(3)	(4)	-	(7)	-	-	-	-	-	-	(3)	(4)	-	(7)
	Nov	-	(3)	(4)	-	(7)	-	-	-	-	-	-	(3)	(4)	-	(7)
	Dec	-	(4)	(5)	-	(9)	-	-	-	-	-	-	(4)	(5)	-	(9)
	Jan	-	(5)	(6)	(1)	(12)	-	-	-	-	-	-	(5)	(6)	(1)	(12)
	Feb	(1)	(5)	(6)	(1)	(13)	-	-	-	-	-	(1)	(5)	(6)	(1)	(13)
	Mar	-	(5)	(6)	(1)	(12)	-	-	-	-	-	-	(5)	(6)	(1)	(12)

Sub Total 3		Community Beds					Nursing Home					Total				
	Mth	*North Total*	*Cent Total*	*South Total*	*West Total*	*Total*	*North Total*	*Cent Total*	*South Total*	*West Total*	*Total*	*North Total*	*Cent Total*	*South Total*	*West Total*	*Total*
Total of two boxes above showing total shortfall in beds after growth and DTOC capacity	Sept	15	1	(3)	3	15	-	6	1	(2)	5	15	7	(2)	1	20
	Oct	4	(6)	(5)	1	(6)	-	(2)	(1)	(4)	(7)	4	(8)	(6)	(3)	(13)
	Nov	7	(3)	(5)	2	1	-	(8)	(10)	(4)	(22)	7	(12)	(15)	(2)	(21)
	Dec	5	(6)	(6)	1	(5)	-	(8)	(10)	(4)	(22)	5	(14)	(16)	(2)	(26)
	Jan	(2)	(3)	(7)	(0)	(11)	-	(10)	(12)	(5)	(27)	(2)	(13)	(19)	(5)	(38)
	Feb	14	27	(3)	3	40	-	(9)	(12)	(5)	(26)	14	17	(15)	(2)	14
	Mar	8	22	(3)	2	29	-	(9)	(11)	(4)	(24)	8	14	(14)	(3)	4

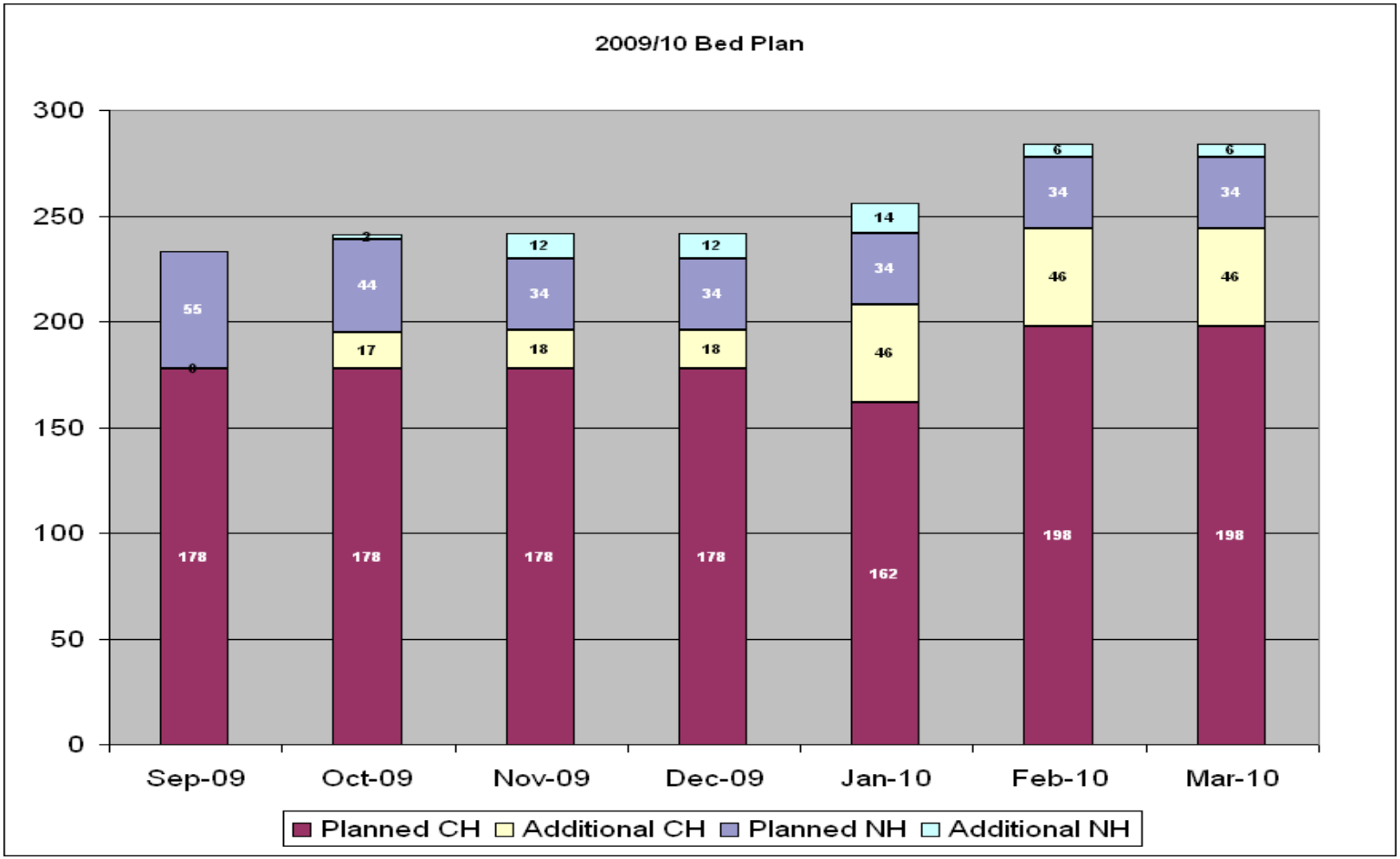
Efficiency 4		Community Beds					Nursing Home					Total				
	Mth	*North Total*	*Cent Total*	*South Total*	*West Total*	*Total*	*North Total*	*Cent Total*	*South Total*	*West Total*	*Total*	*North Total*	*Cent Total*	*South Total*	*West Total*	*Total*
Efficiency gain from community hospitals - 26 day LOS and 85% occupancy rate.	Sept	2	6	4	-	11	-	-	-	-	-	2	6	4	-	11
	Oct	2	6	4	-	11	-	-	-	-	-	2	6	4	-	11
	Nov	2	6	4	-	11	-	-	-	-	-	2	6	4	-	11
	Dec	2	6	4	-	11	-	-	-	-	-	2	6	4	-	11
	Jan	2	6	4	-	11	-	-	-	-	-	2	6	4	-	11
	Feb	2	6	4	-	11	-	-	-	-	-	2	6	4	-	11
	Mar	2	6	4	-	11	-	-	-	-	-	2	6	4	-	11

Firereak 5		Community Beds					Nursing Home					Total				
	Mth	*North Total*	*Cent Total*	*South Total*	*West Total*	*Total*	*North Total*	*Cent Total*	*South Total*	*West Total*	*Total*	*North Total*	*Cent Total*	*South Total*	*West Total*	*Total*
Commissioning additional 6 beds at Dereham, 8 beds at St Michaels at weekend medical cover	Sept	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Oct	7	6	-	-	14	-	-	-	-	-	7	6	-	-	14
	Nov	7	6	1	-	15	-	-	-	-	-	7	6	1	-	15
	Jan	7	6	1	-	15	-	-	-	-	-	7	6	1	-	15
	Feb	7	6	1	-	15	-	-	-	-	-	7	6	1	-	15
	Mar	7	6	1	-	15	-	-	-	-	-	7	6	1	-	15

Comm DTOC 6		Community Beds					Nursing Home					Total				
	Mth	*North Total*	*Cent Total*	*South Total*	*West Total*	*Total*	*North Total*	*Cent Total*	*South Total*	*West Total*	*Total*	*North Total*	*Cent Total*	*South Total*	*West Total*	*Total*

NHS Norfolk **Winter 2009/10 Bed Plan**

Name	Location	Sept 2009	Oct 2009	Nov 2009	Dec 2009	Jan 2010	Feb 2010	Mar 2110
All Hallows	Bungay	5	5	5	5	5	5	5
Lincoln House	Swanton Morley	10	10	10	10	10	10	10
Ford Place	Thetford	8	8	8	8	8	8	8
Various 8/9 contracts		21	10					
High Haven (NCC)	Downham Market	10	10	10	10	10	10	10
Westfields (NCC)	King's Lynn	1	1	1	1	1	1	1
Planned NH		55	44	34	34	34	34	34
Benjamin Court	Cromer	17	17	17	17	17	17	17
Cranmer House	Fakenham	13	13	13	13	13	13	13
North Walsham	North Walsham	16	16	16	16	16	16	16
Kelling - Pine Heath	Kelling	28	28	28	28	28	28	28
St Michaels	Aylsham	26	26	26	26	26	26	26
Henderson Ward	Norwich	28	28	28	28			
New Stroke Unit	Norwich					6	24	24
New Ward	Norwich					6	24	24
Ogden Court	Wymondham	8	8	8	8	8	8	8
Dereham	Dereham	24	24	24	24	24	24	24
Swaffham	Swaffham	18	18	18	18	18	18	18
Planned CH		178	178	178	178	162	198	198
	Total	**233**	**222**	**212**	**212**	**196**	**232**	**232**
Additional Procurements								
Dereham	Dereham		6	6	6	6	6	6
St Michaels	Alysham		8	8	8	8	8	8
Henderson						28	28	28
Beccles/ Patrick Stead	Beccles/ Halesworth		3	4	4	4	4	4
		0	**17**	**18**	**18**	**46**	**46**	
Nursing Homes								
	South/ Central	-	2	12	12	14	6	
Total additional bed purchases		**-**	**19**	**30**	**30**	**60**	**52**	
Total Bed Plan		**233**	**241**	**242**	**242**	**256**	**284**	


2009/10 Bed Plan
300
250
200
150
100
50
0
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Planned CH
Additional CH
Planned NH
Additional NH
178
0
55
178
17
44
2
178
18
34
12
178
18
34
12
162
46
34
14
198
46
34
6
198
46
34
6

Report to Adult Social Services Overview & Scrutiny Panel
3 November 2009
Item No 16

Carers' Services

Report by the Director of Adult Social Services

Summary
This report is intended to inform Overview and Scrutiny Panel of the current and proposed work that is taking place in the development of carers' services.

The Panel is asked to note the work in progress for carers and endorse future service development.

1 Background

1.1 In society today most people are living longer, many are developing long-term conditions and most people wish to maintain independence and control over their own lives. Consequently, the number of informal carers is likely to rise. It is estimated that across Norfolk there are some 80,000 carers supporting relatives and friends with some caring for over 50 hours per week.

1.2 Since 1999 following the first national carers strategy 'Caring about Carers', there has been an annual carers grant to all local authorities in England. The amount for Norfolk for 2009/2010 is £3.5 million.

1.3 Since then, other significant pieces of legislation include Carers and Disabled Children's Act 2000 and the Carers Act 2004.

1.4 In 2006, the community services White Paper 'Our health, our care, our say' announced a new deal for carers made up of four parts comprising of: a national information service; training programmes; emergency care cover and an updated strategy.

1.5 The vision for carers in this updated strategy 'Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own' published in 2008 is that - 'by 2018 carers will be universally recognised and valued as being fundamental to strong families and stable communities. Support will be tailored to meet individuals' needs, enabling carers to maintain a balance between their caring responsibilities and a life outside caring, whilst enabling the person they support to be a full and equal citizen.'

1.6 More recently, the government has committed additional funding to support emergency break provision, training and funding directly for young carers.

2 Support for Norfolk's Carers

2.1 Norfolk County Council recognises the need for carer support as a high priority and has invested in a number of initiatives to support carers.

2.2 **Review of Carers' Services**

2.2.1 Adult Social Services commissioned an external review of carers services and the role of Adult Social Services in the development of services.

2.2.2 This report is due to be finished in November 2009 and will inform the department and its partners on areas for improvement.

2.3 **Carers Council**

2.3.1 The Carers Council, established last year, is now supported by a post funded by the carers grant and employed and managed in the Third Sector.

2.3.2 Carers were involved in the tendering and recruitment process and the Council has a majority of carers with a carer as the chairperson. This has enabled the Council to develop and co produce with officers, representatives from health and the Third Sector working together in partnership.

2.3.3 The rationale behind the Council is that, as a user led group, a democratic countywide system to represent the views of carers and to be the lead and focus for carers' issues in Norfolk, is established.

2.3.4 Carers will be actively involved in developing and implementing the local carers' strategy and in the management of the carers grant.

2.4 **Joint Commissioning Group for Carers Services and Strategy Development**

2.4.1 A joint commissioning group across health and social care, including three representatives from the Carers Council, will commission services for carers.

2.4.2 The need for the type of service required by carers was identified in the consultation process for the development of a strategy. This consultation period ended at the beginning of September 2009.

2.4.3 The initial strategy work with carers and Third Sector representation took the form of an all day workshop and following the above consultation process; the group is developing the strategy's action plan for implementation.

2.4.4 The government allocated funding to Primary Care Trusts to increase breaks for carers. Guidelines stipulated that this funding should be spent in partnership with the local authority following the development of a joint plan for services. The Joint Commissioning Group for Carers Services is currently looking at possible models and will go on to commission services.

2.5 **Carers Emergency Respite**

2.5.1 The carer's emergency response system called 'In My Place' went live at the start of March. All carers complete an emergency plan, which is entered on to CareFirst. To date, approximately 500 carers have completed plans to go on the system.

2.5.2 The emergency support service has been commissioned from the Night Owls and Swifts services.

2.6 **ASSD Carers and Employees**

2.6.1 The issue of carers in employment has taken a more prominent position recently, and as an employer; Adult Social Services should lead by example and be seen to support employees who are also carers outside of the workplace.

2.6.2 There is a significant amount of legislation to support the development of principles in the way in which the department actively supports staff.

- The Work and Families Act 2006 extended the right to ask for flexible work to employees who care for adults.
- A recent UK court ruling gives carers protection against discrimination by association with disability.
- The National Carers Strategy *'Carers at the heart of 21st century families*

and communities' states that, "recognising the specific needs of carers can help retain experienced staff; avoid the cost of recruiting and training new employees and increase loyalty. Enabling carers to combine their caring role and paid employment is seen as a key to mitigating some of the adverse financial effects of caring."

- Adult Social Services Equality and Diversity Plan Section 3 - Action 8 aims to develop better awareness and support for staff with caring responsibilities.

2.6.3 A survey to identify employees that are carers within Adult Social Services and the issues that there are for them, resulted in carers being identified on the Norfolk Employee Well Being register. It is intended that this will be rolled out across the County Council.

2.7 **Information**

2.7.1 To ensure that information is easily and readily available, a part-time Information Officer has been appointed. This post sits within the Voluntary Sector located at the Carers Helpline managed by Crossroads Care.

2.7.2 The initial focus for this post is to develop a website for carers and to update and publish the information booklet 'Who Cares'.

2.8 **Carers Assessments**

2.8.1 Norfolk County Council Adult Social Services has exceeded the target set for the year on carer's assessments. The target for this year was 14.5% of carers in Norfolk should receive an assessment. So far, 19.7% have received a carer's assessment. Feedback from the Carers Council suggests that the quality of the assessment process can be improved upon and work is underway with operational staff to improve in this area.

2.9 **Individual Budgets**

2.9.1 Individual budget models for carers are being explored to enable greater choice and control for carers.

2.10 **Carers Grant**

2.10.1 There are clear guidelines for the management of the £3.5 million grant and it is spent as follows:

- Infrastructure - 5% of the grant is spent on infrastructure costs.
- Children's Services - 20% of the remaining grant is allocated to children's services. This supports services for young carers and parents of disabled children and is allocated at the start of the financial year.

2.10.2 There are regular meetings between Adult Social Services and Children's Services relating to carers services to ensure continuity and to avoid duplication.

2.10.3 The balance of the grant is spent with Adult Social Services Community Care and the Voluntary Sector.

2.11 **Voluntary Sector**

2.11.1 Adult Social Services commissions a number of services from the Voluntary Sector either by localities directly commissioning with organisations or by West Norfolk Carers Forum and Norwich and District Carers Forum using their grant allocation to fund and support carer's services.

2.12 **Training Programmes**

2.12.1 Adult Social Services Learning and Development Team have worked with carers to identify training needs and then to establish training programmes for informal carers that will meet their needs and where possible if the carer wishes help them to return to paid employment

3 Resource Implications

3.1 All services are funded from the £3.5 million carers grant.

4 Equality Impact Assessment

4.1 **Black and Minority Ethnic Groups**

4.1.1 These groups have not been traditionally well represented in carers' forums. The carers lead for Adult Social Services is actively seeking to address this issue and to ensure that the needs of these groups are delivered via the local strategy.

5 Section 17 - Crime and Disorder Act

5.1 Not applicable

6 Risk Implications/Assessment

6.1 Not required at this stage

7 Conclusion

7.1 Norfolk County Council Adult Social Services has achieved a significant step forward with the development of the Carers Council and the underpinning philosophy of co-production. The development of the local strategy in conjunction with health and the Joint Commissioning Group for Carers Services will facilitate the start of joint commissioning of services.

However it is acknowledged that there is still a lot to achieve on behalf of carers and further joint and integrated work across organisations is required.

8 Action Required

8.1 Overview and Scrutiny Panel are asked to note the work in progress for carers and endorse future service development.

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