Adult Social Care Committee

Item No:

Report title:	**Annual review of progress against priorities**
Date of meeting:	**4 March 2019**
Responsible Chief Officer:	**James Bullion, Executive Director of Adult Social Services**

Strategic impact

Promoting Independence is the overarching strategy for Adult Social Services. Within the context of that strategy – and in line with the Council's Norfolk Futures – the Committee agreed a set of priorities for the year. This report sets progress against those priorities, and priorities for the coming year 2019/20.

Summary

In March 2017, the Committee agreed the Adults Committee Plan which set out the priorities and key annual actions for the year ahead. This report sets out progress against those actions.

It highlights significant focus on embedding a strengths-based approach to social care, through Norfolk-wide roll out of Living Well: 3 conversations. Alongside this for staff will be new mobile devices – which have been piloted and tested by front line teams.

Reablement has continued to expand, with the introduction of accommodation based reablement to support out of hospital care and avoid unnecessarily long stays in acute and community hospitals. This has been complemented by better use of short-term beds, early help and prevention services, and the establishment of escalation avoidance teams in all five localities.

Building blocks for key changes in learning disability services have been put in place, supporting an enablement approach from our own teams and providers, testing and piloting new day activities and reviewing all supported living schemes to ensure they are meeting peoples' needs.

A comprehensive refresh of safeguarding practice has been completed, and a systematic approach to identifying and working with 'at risk' providers has been put in place. Additional monies for the cost of care has seen quality improve, although some care homes have closed.

Technological improvements have continued through the exploitation of the new social care system – LiquidLogic; assistive technology capacity has increased to match demand, and we are in the process of recruiting additional team members to expand further.

Challenges remain – notably to see an impact of investment in short-term care on the numbers of delayed discharges of care; a further scale up of technology enabled care to support prevention and early help; continued strong leadership to support the market to change and adapt for future patterns of care; to embed a strengths-based approach to social work across all teams, and to ensure high quality support for people with learning disabilities as we move into changes in their day activities.

Recommendations:
Committee is recommended to:

a) **Discuss and note progress against the 2018/19 priorities**
b) **Agree the priorities for Adult Social Care for 2019/20**

Appendix A – Norfolk Adult Social Services Strategic Context (p85)

1. Background

1.1 Promoting Independence remains the overarching strategy for Norfolk Adult Social Services. The three main elements of the strategy are:

Prevention and early help – empowering and enabling people to live independently for as long as possible through giving people good quality information and advice which supports their wellbeing and stops people becoming isolated and lonely. We will help people stay connected with others in their communities, tapping into help and support already around them – from friends, families, local voluntary and community groups. For our younger adults with disabilities, we want them to have access to work, housing and social activities which contribute to a good quality of life and wellbeing.
Staying independent for longer – for people who are most likely to develop particular needs, we will try and intervene earlier. Certain events, such bereavement or the early stages of an illness like dementia can be a trigger for a rapid decline in someone's wellbeing, but with some early support we can stop things getting worse and avoid people losing their independence and becoming reliant on formal services.
Living with complex needs – for some people, there will be a need for longer term support. This might mean the security of knowing help is on tap for people with conditions like dementia, and that carers can have support. We will look at how we can minimise the effect of disability so people can retain independence and control after say a stroke or period of mental illness. For some people, moving into residential care or to housing where there are staff close by will be the right choice at the right time, but such decisions should be made with good information and not in a crisis.

1.2 Revised and updated summary is attached at **Appendix A.**

1.3 Implementing Promoting Independence is requiring some fundamental changes to how Adult Social Services – and its partners – work together, some of which will take a minimum of three to four years to fully embed. These are:

a) Building up community capacity and resilience, and low-level prevention services so that there is strong network of formal and informal help and support for people to draw on
b) A strengths-based approach to social work – a way of working and a culture of looking at what people can do, rather than what they can't do
c) A shift to reablement and enablement – an approach which always seeks to help individuals achieve or recover as much of their independence as possible
d) Joined-up services with community health teams, district councils, which help prevent frail people from falling into a crisis
e) Modern, fit for purpose, housing options for people who need on-going support, in addition to a high quality residential and nursing care market

2. Adult Social Services Committee Plan Priorities

2.1 This time last year, the Committee – through its Committee Plan – agreed a set of departmental priorities and annual actions for 2018/19. These were:

2.1.1 **Priorities**

a) Strengthen social work to prevent, reduce and delay need
b) Be strong partners for integration working
c) Accelerate technology-enabled care
d) Improve quality and safeguard people
e) Strong management of finance and performance

2.1.2 **Annual Actions for 2018/19**

1) Implement a learning disability enablement model – connecting people to activities, building skills, and developing housing which is ambitious and supports people to live well and progress
2) Roll out Living Well, to embed strengths-based social work and community development which transforms lives by helping people and those who care for them to live independently
3) Commission the right mix of good quality affordable care – and address the need for more dementia care so people stay living independently, with dignity
4) Deliver all integrated short-term care services – avoiding hospital admissions, responding to a crisis and helping people to get home when they are well enough
5) Develop more technology enabled care – so we target people in need, support people to connect with one another, monitor people at risk and have more face to face engagement
6) Continually strive to improve the quality of service and safeguard people at risk of harm

3. Reviewing actions for 2018/19

3.1 **Annual Action 1 - Learning Disability Enablement approach**

3.1.1 The Learning Disability Strategy, 'My Life, My Ambition, My Future' was co-produced with people with disabilities published December 2018. Its ten priority areas now provide the over-arching framework for change. There are a range of change projects to implement the strategy, all of which are designed to promote independence, and provide alternative ways to help people with learning disabilities live the lives they want to lead, with less reliance on long-term services. Key progress:

3.1.2 **Establishment of a preparing for adult life service** - Children's and Adults' services are working closely together to strengthen transition arrangements, and this will be made more formal through a joint service – Preparing for Adult Life. It will focus on young people's needs from 14 years old, facilitating stronger relationships with families, ensuring a smooth transition into adulthood. For an individual, this means their contact with the service starts much earlier, their expectations and needs are then explored earlier making the move from Children's Services to Adult Services more seamless. Also, for those not eligible for Adult Services alternatives can be explored and put in place prior to their 18th birthday.

3.1.3 **Housing and accommodation** - an accommodation strategy and plan is being developed to look ahead and ensure there is a 'pipeline' of housing options for people. A new requirement is that that all accommodation must be enablement focussed – by which we mean an approach which helps to build skills, confidence and independence for individuals.

3.1.4 Building work at **Netherwood Green,** on the County Hall campus is complete. Potential tenants are being assessed, and these will include people who have previously been in long-term residential care. An open day for new tenants was held in February 2019. We anticipate that tenants will stay at Netherwood for up to two years.

3.1.5 **Review of all Supported Living schemes** over the next two years. This reflects the steer we had from people with learning disabilities who wish to live their lives as independently as possible. Each review will be focussed to ensure that tenants of the scheme are receiving the most appropriate package of care and support, that there is a demand for the scheme and that services being provided are of the high quality expected by Norfolk County Council.

3.1.6 **Employment and volunteering - w**e do not have a good track record on the number of people with learning disabilities in paid employment. Our rate is 3%, against a national

average of 6%. We fully recognise that not all people with learning disabilities will be able to work, but, as a county, we should be offering more opportunities. The LD Strategy has a key theme around employment and when consulted, 65% of people said it was a priority for them to access employment.
We have designed an improved way to co-ordinate advice and practical support for people with learning disabilities (and other working age adults) so that more can find and keep employment. A new service is due to start in June which will have a two-pronged approach:

a) Co-ordinators working directly with individuals to help them hone their skills and CVs to find training or work
b) Working with employers to create and open opportunities for people with LD, and ensuring front line staff make local connections with employers, matching people to roles

3.1.7 **Day opportunities** - a redesign of day opportunities is underway, which gives people more opportunities to take part in different social activities in their communities - as well as continuing to provide buildings-based services for people with more complex needs.
We have:

a) Met with current and potential providers to discuss the enablement approach we want to embed across all our commissioned services, and to share commissioning intentions for day opportunities
b) Developed a new service specification – which takes as its starting point, the priorities people told us were important to them as part of the learning disabilities strategy
c) Run a six-month pilot to test and learn how we can help support people into employment and other voluntary activity. From the 110 individuals who started the pilot 6 months ago 85% are currently in some form of voluntary or work experience position; 5% are currently in paid employment, with providers confident this will increase significantly with more time

3.1.8 **Backlog** - as previously reported, there is a backlog of work, including reviews. A dedicated team has been appointed to focus on reviews. To date they have completed 324 and, working in a strengths-based way with the individual, have been able to reduce the amount of input from formal services for some people.

3.2 **Annual Action 2 - Community care - Strengths-based social work**

3.2.1 Underpinning much of the change we need to make is the new model of social work – **Living Well: 3 conversations**. We have:

a) Concluded seven innovations sites across the County, and used the data and evaluation to shape a consistent county wide approach
b) Transferred ‘front door’ first point of contact back into Adult’s department (from the Customer Service Centre) to maximise their skills and knowledge as part of Living well
c) Started the roll out of the new way of working in the West locality and with the Social Care Centre of Expertise (SCCE). Go live for the rest of the locality teams will be April 2019
d) We are part way through an induction and training programme for 400 practitioners and 70 managers in preparation for Go Live

3.2.2 **Recruitment** - We have recruited more staff, recognising the need to reduce individual caseloads and give people more time for the 3 conversations approach.

3.2.3 **Reduction in the holding list** – this had peaked at almost 3000 pieces of work in November 2017, when carrying such a high backload of work was having an impact on the pace of change. The latest figure stands at 1200.

3.3 **Annual Action 3 - Commissioning the right mix of good quality affordable care**

3.3.1 A range of actions have been taken to strengthen and support the market. These include:

a) An additional £15.5m was put into the market for rising costs and market pressures, and a further £18m has been agreed for 2019/20. The balance between residential and nursing care – particularly for people with dementia – has remained difficult to achieve. The Council has a diminishing need for standard residential care, and more need for enhanced nursing care
b) Market engagement with residential and nursing home care providers to develop a new contract specification which reflects the Norfolk market conditions
c) Strengthened support for workforce development and training, including £75,000 secured from Skills for Care to deliver free enhanced care training courses for social care staff in Norfolk
d) Home care framework – Members agreed a new home support framework in 2017 (agreed banding delayed until April 2018) with pricing designed to recognise the higher cost of providing service in rural areas. This has been implemented at a cost of £2m. This has seen greater collaboration between different providers, however there are still significant challenges with capacity in parts of Norfolk, particularly North Norfolk. Overall, the number of people using homecare has decreased, although the cost of individual packages has increased for younger adults, suggesting on average that where home care is used, it is more intensive. For older people there has been a reduction in people using homecare and a small reduction in the cost of individual packages, which reflects the increased use of reablement and accommodation based reablement to help people regain their independence after a crisis, such as a period in hospital
e) Development of a robust plan and business case to develop 2842 new extra care housing units over the next 10 years, including securing financial and staffing resource to deliver, with the go-ahead to support the first scheme to be discussed at Policy and Resources Committee in March 2019
f) Set up a new service targeting people at risk of social isolation and loneliness
g) Collaboration with NHS, through the Sustainable Transformation Programme, to review dementia support across health and social care. Extensive engagement has included 22 focus groups; preliminary recommendations for action to be considered initially through the STP in late February

3.4 **Annual Action 4 - Integrated short-term care**

3.4.1 A range of work has been undertaken in the period under review. Key actions are:

a) **Home-based reablement** – expansion of capacity by 15%, jointly funded by the Council and Clinical Commissioning Groups (CCGs), has meant around an additional 900 people supported, although demand continues to increase
b) **Accommodation based reablement** – complements the home based reablement service and was initiated in 2018. There is now a total of 40 beds across the county available and in use. Benjamin Court, the largest scheme, is running at capacity
c) **Escalation avoidance teams** - established in all five localities to bring together health and social care multi-disciplinary teams to support people in crisis who might otherwise be admitted to hospital, and to help people home from hospital
d) **Short-term beds** - We established a dedicated team to make the best use of 47 short-term beds to provide short-term care for people who are in crisis, or who are discharged from hospital. This will ensure we maximise individuals opportunity for independence and that people to do not remain in Short term beds any longer than they need to

e) **Healthy Ageing frailty toolkit** – developed and implemented across health, social care and the voluntary sector to intervene sooner with people who are frail and at risk of more serious health issues. This resource is designed for anybody who is supporting older people in the community, including families, carers and older people themselves. The toolkit has lots of practical guidance about how to recognise frailty and/or dementia at an early stage with links to information, advice and local services that can enable older people to live safe and well at home. The toolkit has been used more than 2,000 times since December 2018 and approximately 500 people have used the toolkit more than once
f) **Carers** – the Council's Carers' Charter was developed with carers, for carers, aimed at raising the profile of informal carers, and holding the council to account for a series of actions
g) **Social work model in acute hospitals** – a new model has been delivered at the James Paget hospital allowing us to more actively contribute towards Discharge2Assess processes by assessing some people at home rather than on the ward, which supports improved patient flow and better outcomes for individuals. Evaluation of changes has been positive and intention is to replicate this at the other acute hospitals
h) **Joint Occupational Therapy (OT) triage and allocation in Norwich** – all therapy referrals for Norwich health and social care OTs are now managed together, significantly reducing duplication, creating productivity gains and better care for individuals

3.5 **Annual Action 5 - Technology-enabled care**

3.5.1 Assistive technology (AT) – expanded the service to tackle the growing demand. AT is already reaching around 7000 homes. We have reviewed our AT offer and identified some improvements to ensure that the benefits of AT are maximised to prevent, reduce and delay the need for formal care and support and that consideration of assistive technology is fully integrated into practice across all areas of the Department. Our visions for Assistive Technology is that:

a) Technology plays a major role in supporting people to live independently for as long as possible, and in helping carers to continue caring for as long as they are able and willing to do so
b) Assistive technology will be widely accessible, easy to use, and available for people when it can make most difference to maintaining independence
c) Our own staff are champions for assistive technology and use it widely to prevent people needing formal care services
d) Providers embrace technology to help people stay independent in all types of settings and maximise the efficiencies it can bring.
e) Innovation – through a 'hackathon' where the council presented to a set of Norfolk digital entrepreneurs its challenges in supporting isolated older adults and lone workers. The event identified a possible cost-effective way to connect sensors to support people living alone
f) Opened a 'smart flat' in Norwich to show how technology practically works in someone's home, and opened the campus innovation centre
g) Exploiting and maximising LiquidLogic
h) preparation completed for a new portal to go live in April which will give people contacting adult social services, a web-based inquiry form. The information will be directed automatically to the relevant locality team, without the need for an additional intervention by phone, which is the current process
i) Piloted mobile devices for front-line social care staff, so they can connect to the LiquidLogic system and work on the go. The pilot (for 75) showed clear productivity gains for staff. A further 625 devices will be rolled out, with training and support, from May onwards

j) E-brokerage – will provide the ability to match care needs and care providers electronically and enable citizens to identify and purchase care provision online. This will go live for residential care providers in June 2019
k) Bed-tracker - An enhanced bedtracker – developed by our in-house Information Technology team – has supported quicker decision making for health and social care teams, by providing a 'live' view of care home vacancies across the county

3.6 **Annual Action 6 quality and safeguarding**

3.6.1
a) During 2018, 7 care homes in Norfolk closed. This was made up of three nursing homes (loss of 79 residential and nursing beds) and four residential homes (loss of 91 beds). Overall there are around 9780 beds in Norfolk, so the closures represent a reduction 1.5%
b) Safe transfer of care provision from Allied Health Care to Home Support Matters
c) A shift of focus to proactively target care homes, agencies and supported living schemes which are at risk of delivering poor quality service
d) In collaboration with LD Commissioning, pilot of an inspection regime of supported living schemes, for roll out in 2019
e) Introduction of Provider Assessment Market Management System (common to the 11 East of England Local/Unitary Authorities), a quality audit and public reporting tool identifying poor practice, formulating improvement plans and directing specific support and monitoring of the achievement of the improvements required
f) Greater collaboration with health to improve the quality of residential and nursing home provision through the Enhanced Care in Care Homes project
g) Sought feedback to shape a new Care Association for Norfolk through a survey of 300 providers
h) Recruited two additional social work specialists in safeguarding to deliver a programme of training and skills development for team managers and practice consultants. The programme of work also includes strengthening understanding and awareness of safeguarding with key independent providers and partners
i) Safeguarding resources pulled in a single place for social care staff
j) Easy to access information for managers to ensure that staff training on safeguarding is up to date and timely

4. Looking ahead – priorities and annual actions for 2019/20

4.1 The focus on the annual actions has led to good progress and impact in all areas, however, challenges still remain. The main challenges are:

a) Reducing delayed discharges of care – the short-term integrated care changes are yet to have a significant impact on delays
b) A further scale up of technology enabled care to support prevention and early help
c) Continued strong leadership to support the market to change and adapt for future patterns of care
d) Embedding a strengths-based approach to social work across all teams
e) Ensure high quality support for people with learning disabilities as we move into changes in their day activities
f) The Sustainability and Transformation Partnership and NHS Long Term Plan will have major implications for social care in Norfolk & Waveney. This will bring opportunities but also challenges to implement the extensive changes we need to make to our practice and commissioned services whilst simultaneously ensuring a strong social care influence on the shape of future
g) The continued financial challenge and uncertainty around the Green Paper

4.2 Taking progress and challenges into account, we are proposing the following set of annual actions for 2019/20:

4.2.1
a) To implement market development activities which address and correct capacity in the provider market and support providers to develop new models in line with Promoting Independence
b) To re-shape integrated community teams to align delivery with the 20 primary care networks across Norfolk and Waveney, and to accelerate delivery of Promoting Independence
c) To re-shape integrated commissioning arrangements in the light of changes envisaged as part of the Norfolk and Waveney Integrated Care System, so they accelerate delivery of Promoting Independence
d) To develop an integrated health and social care model for mental health
e) Implement a learning disability enablement model – connecting people to activities, building skills, and developing housing which is ambitious and supports people to live well and progress
f) To develop and implement a programme of cultural change for Adult Social Services to underpin service transformation and the delivery of Promoting Independence

4.3 In addition, we are proposing amendments to the three-year priorities. Those highlighted * are either additions or slight amendments.

4.3.1
a) Strengthen social work so that it prevents, reduces and delays need
b) *Strengthen the Council's relationship with the NHS playing a full part in delivering an integrated care system
c) *Be a strong partner with the provider market
d) *Accelerate the use of technology
e) Improve quality and safeguard people
f) *Embed a positive working culture which promotes people's independence and uses public resources fairly
g) Strong management of finance and performance

5. Measuring progress

5.1 Since 2017, we have been reporting progress to Committee against a set of eight vital signs. These were developed in response to changing systems (LiquidLogic (LAS)) and associated shortage in data. Latest data against these was reported to the January meeting, and final end of year position will be reported, once the financial year is completed, although this will be under the new governance framework for the Council.

The table below proposes a revised suite of vital signs which have been developed with input from front-line managers and aim to give a wider, which give better coverage of the main issues we need to grip.

Pathway element	Outcome	**KPI title**	Rationale	Timing	Good is…
People coming into contact with the council	People with substantive adult social care needs are being responded to quickly and effectively	**Holding list**	Carrying high backloads of work is having an impact of the pace of change we need to make. Delays in assessments can worsen the service users' condition, resulting in a reduced level of independence for the person and a greater of care from the authority	Snapshot	Low
People being supported to get back on their feet, and to stay independent for as long as possible	People who are referred to us are having their needs assessed in a way which promotes their independence	**The number of Living Well 'Conversation 3's as a % of all Living Well conversations**	The Living Well model uses three types of conversation. 'Conversation 1' aims to link people to support within their community, 'Conversation 2' aims to get people on their feet after a crisis, and 'Conversation 3' aims to help those people with long term support needs to be as independent as possible. Promoting Independence aims to reduce the number of people requiring long term support, and this indicator measures the extent to which C1 & C2 are successful in avoiding C3s.	Monthly	Low
	People are independent and free from formal care following reablement	**% People receiving reablement that don't go on to require formal long-term care**	Reablement helps people get back on their feet after a crisis, people leaving hospital with increased care and support needs, or those who have experienced a change in their wellbeing that might require care. Effective reablement supports people to be more independent. This is also more cost-effective than long-term services.	Monthly	High

Pathway element	Outcome	KPI title	Rationale	Timing	Good is…
	People leaving hospital with social care needs are supported in a timely and effective way	**Delayed transfers of care attributable to Adult Social Care per 100,000 population**	Staying unnecessarily long in acute hospital can have a detrimental effect on people's health and their experience of care. Hospital discharges also place particular demands on social care, and pressures to quickly arrange care for people can increase the risk of inappropriate admissions to residential care, particularly when care in other settings is not available.	Monthly	Low
Enabling people with longer term care needs to make choices	People are being provided opportunities to improve their own independence in a way which is important to them	**% Living well conversations that are person-centred**	Living Well places people, and their strengths and choices, at the heart of efforts to maximise their independence. This indicator measures the proportion of cases where there is evidence that conversations have taken account of the choices of, and circumstances around, individuals.	Quarterly,	High
	People are receiving timely and regular reviews of their care and support needs	**% People receiving a review within timescales**	Timely and regular reviews of people's care ensure their support is still appropriate and effective.	Snapshot	High
	People with longer-term needs are being supported towards greater independence.	**% Reviews that result in a ceasing, or reduction in the costs of, services**	We should treat every review as an opportunity to identify if there are alternative ways that we could meet a person's care needs. There is also an expectation that for some people, their level of support will be reduced as they re-gain independence	Monthly,	High
Living with complex needs	People are living independently without the need for formal care and support	**Total number of people receiving formal care services per 100,000 population**	Promoting Independence aims to reduce the number of people requiring long term support, and this measure tracks this. As a rate of population, it also allows us to differentiate between demand caused by performance level, and that caused by demographic growth.	Snapshot	Low

Pathway element	Outcome	**KPI title**	Rationale	Timing	Good is…
	Our spend per population represents value for money for the people of Norfolk	**Net spend on formal care services per 100,000 population**	This measure will help benchmark the cost effectiveness of our services. Alongside our measure of service user numbers, it shows whether efforts to improve reablement and reduce people in care have an impact on overall expenditure.	Snapshot	Low
	Our spend represents value for money for the people of Norfolk	**% Variance of purchase of care spend from budget and previous year**	Compliance with budget indicates our ability to deliver savings and the Promoting Independence strategy, and provides an early warning when we might be off-track.	Monthly,	Low
	People in formal care settings are receiving a good level of service from their provider	**% Registered providers rated as 'outstanding' or 'good' by the Care Quality Commission**	We are committed to improving and sustaining quality of care across the sector. Regular reporting against this will enable us to map progress.	Snapshot	High
Safeguarding	We are safeguarding our citizens by responding to possible safeguarding concerns in a timely manner	**% Safeguarding strategy meetings that take place within 3 days of referral**	To keep people safe, it is important that our response to safeguarding concerns is timely, and this indicator shows whether we comply with good practice in ensuring response within 3 days of referrals.	Monthly,	High
	People are being kept safe by our safeguarding interventions	**% Safeguarding cases that are re-referrals from within the last 6 months**	Safeguarding interventions should address the issues putting people at risk of abuse or neglect. This indicator measures the proportion of cases where this has not been entirely effective, and where risks result in re-referral.	Monthly,	Low

6. Recommendations

6.1 **Committee is recommended to:**

a) Discuss and note progress against the 2018/19 priorities
b) Agree the priorities for Adult Social Care for 2019/20

Officer Contact

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

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