Adult Social Care Committee

Item No……

Report title:	**Performance management report**
Date of meeting:	**5 March 2018**
Responsible Director	**James Bullion, Executive Director of Adult Social Services**

Strategic impact

Robust performance management is key to ensuring that the organisation works both efficiently and effectively to develop and deliver services that represent good value for money and which meet identified need.

Executive summary

This report sets out the latest available performance position for Adult Social Services. The report comes at the time of transition between the former CareFirst system, and the new social care recording system LiquidLogic, so there is only limited information against the suite of Promoting Independence measures. For this reason the report focuses on other important aspects of performance, including the annual benchmarking report.

Key performance messages

Adult Social Services has been under a high degree of pressure over the winter period; achievement of our centrally imposed target for delayed discharge of transfer cannot be met within the timescale set.

Holding lists have started to reduce with the introduction of a resilience team, and concerted targeted work by locality teams.

Early indications of data from the new system show that reablement has continued to benefit a high number of people, and provide critical support to the NHS over the winter period.

Despite pressures, our social work teams have continued to follow the aims of Promoting Independence, connecting people to informal support, enabling and reabling people so they can re-gain skills and a level of independence.

Permanent admissions to residential care for older people have continued to reduce, while permanent admission for adults aged 18-64 have remained broadly constant.

Our annual benchmarking review shows a steady picture of performance for the year 2016/17 compared with our family group. There are no significant fluctuations; reablement and short-term support continues to be above average; overall satisfaction dipped, although the proportion of people feeling safe using our services improved.

Six report cards are included at Appendix 1
The full presentation about the annual benchmarking report is included in Appendix 2

Recommendation

The Committee is asked to:

Discuss and agree the overall performance position for adult social care as described in section 2

1. Introduction

1.1 This report sets out the latest available performance position for Adult Social Services. The report comes at the time of transition between the former CareFirst system, and the new social care recording system LiquidLogic, so there is only limited information against the suite of PI measures. For this reason the report focuses on other important aspects of performance, including the annual benchmarking report.

2. Performance overview

2.1 Pressure across the health and social care in Norfolk has intensified during December, January and February.

2.2 Latest information shows that occupancy rates for all Norfolk acute hospitals have consistently running above 85% for the whole of January. New referrals to Adult Social Care were up 57% year-on-year for January and new referrals from hospital teams continued to increase by 50% from December 2017 through to January 2018 (151 to 226).

2.3 In response, we have

a) expanded re-ablement – directly into people's homes, and as a 'step down' from hospital
b) Improved liaison with care homes through trusted assessors in all 3 hospitals
c) Added dedicated social care staff to manage flow in hospitals
d) Provided 7 self-contained flats with on-site support for adults with MH needs to prevent delays
e) Introduced new expanded home care using highly trained care workers that can support the high acuity of older people being discharged –and prevent admission

2.4 These are on top of our additional spending with the care market to reflect costs including the national living wage, and the recruitment of additional social workers and occupational health staff to strengthen social work to assist people at discharge and to prevent admissions.

2.5 At the periods of most intense pressure, we have

a) Increased overtime and weekend working in our hospitals
b) Increased overtime and weekend working in Norfolk First Support – our in-house reablement services
c) Introduced financial incentives rates for homecare where agencies can take people within 12 hours – this has been for defined periods of time, triggered by extreme pressures
d) Introduced incentive payments for residential care – again to speed up assessment; only for a defined window of time
e) Pulled in social workers and occupational health staff from localities to increase the number of assessments we can do in hospitals
f) Appointed an assistant director to oversee discharge, and located other senior social work managers in hospital teams at peak periods of pressure

2.6 Despite all of the above, the published figures for December show that Norfolk (health and social care) is ranked 100 out of 151 local authorities for total delays per 100k population. Norfolk is ranked 123 out of 151 for Social Care delays per 100k population.

2.7 To understand and to introduce sustainable improvement across the health and care system, we have invited the Better Care Fund Support Team to work with the whole system on hospital discharge so that we benefit from new perspectives. This will give us an independent view of the current arrangements and recommendations about how we can use the collective social services and NHS teams to best effect for people in Norfolk.

3. Holding lists

3.1 We first reported in July that teams were carrying significant backlogs of work. Latest figures show we now have just under 2700 people on our holding list. This is around 400 lower than when we last reported. However, the change from CareFirst to LiquidLogic may mean there are slight changes in how the system counts.
We have three strands to address the backlog:

a) A short-term specialist team dedicated to addressing the holding list have been in place since December. The team works across all five localities prioritising areas with the largest list and the cases which have waited longest
b) Additional capacity – as previously reported the recruitment to additional posts has been positive. It has helped strengthen front line teams to give them more day to day capacity to address the backlogs
c) Strengths-based working - 3 conversation model – as previously reported to the Committee we are introducing a new model of social work. To date we have run two sites; a further four will be running by March. Whilst it is early days, the teams in those sites have demonstrated that capacity can be created to tackle waiting lists and prevent the long waits for customers associated with the older, care management approach. However, there will always be peaks of intensive activity – for example – at times of acute winter pressure

4. Reablement and Norfolk First Support (NFS)

4.1 Adult Social Services has provided reablement services in people's own homes for a number of years. Norfolk First Support (NFS), an in-house service, provides reablement. Reablement helps people get back on their feet after they have been in hospital or that have experienced a change in their wellbeing that might require some kind of care. This means that people are more independent and tend to experience better outcomes. Also by avoiding long term care the Council saves money.

4.2 Due to the migration of our social care database from CareFirst to our new social care system, LiquidLogic, there is no data available for October and November 2017. However, the early data for December and January indicates that NFS have taken more reablement referrals than usual. The service has offered overtime to staff over the last three months to try to increase the amount of people the service could work with.

4.3 Early data from Liquidlogic also appears to show that the rate of people reabled has decreased in December and January. We think the reasons behind this are two-fold:

a) people referred to NFS in January are still receiving reablement services and therefore are not showing as reabled yet
b) the change of systems from CareFirst to LiquidLogic means there is a time-lag in the process of inputting the data and that the parameters used on CareFirst data are slightly different to in LiquidLogic. Whilst the volume of work over the winter period may have caused a slight dip, we expect the overall trend of high

performance to continue. We will update Members next time, when we expect the final outcomes for people will be reflected in the data

4.4 Benjamin Court, the new accommodation based reablement unit in Cromer, opened on 9 February 2018. This complements our existing home based reablement service and is aimed at people who:

a) are medically fit but unable to return to their home safely (including due to physical/function ability and concerns about night time)
b) have the potential to be reabled
c) and would benefit from reablement

4.5 This new service is an important part of the social care and health system response to maximising the independence of people in Norfolk, reducing the number of people going into residential care and preventing people going into hospital.

5. Rate of permanent admissions

5.1 Whilst our front line teams report that they are dealing with high volumes of work, this is not translating into increased rates of admissions to permanent residential care for people aged over 65 which have reduced to below our target for the first time. This would suggest that our strategy of promoting independence, focusing on short-term support to re-able people and help maintain independence is having an impact. For younger adults (aged 18-64), the rate has stayed broadly the same.

5.2 The change to the LiquidLogic system meant a reporting hiatus between September and January. In CareFirst there was usually a 'reporting lag' of around three months, meaning that delays in recording cases led to figures only being correct around three months in arrears. This should not be the case with LiquidLogic in the future – however we will closely monitor any changes in the data and report back to Committee if the numbers go up retrospectively.

6. Complaints

6.1 Over the calendar year 2017, Adult Social Services received just over 500 complaints. Whilst a direct comparison on the same period for 2016 is not possible, a nine month comparison points to a reduction in the number of complaints in 2017.

6.2 In April to December 2016 there were 448 stage one complaints compared with 367 in the same period for 2017. The main reasons for those complaints are set out in the report card and these have largely stayed in the same proportion.

6.3 Detailed analysis each quarter is considered by senior managers; this looks at complaints by locality area as well as by specialty. Consistently, this shows that the main focus for improvement needs to be on good communication between our teams and people using our services.

7. Benchmarking

7.1 Appendix 2 contains the **2016/17** benchmarking report for Adult Social Care. This report presents benchmarking information for Norfolk Adult Social Care for the year 2016/17 and is designed to help members and managers to compare the performance of Norfolk with other councils that have social care responsibilities and to identify areas for improvement.

7.2 Norfolk's "family group" – a collection of 15 local councils that the Care Quality Commission (CQC) considers to have similar characteristics to Norfolk and are therefore our best comparators for performance – consists of the following County Councils: Lincolnshire, Gloucestershire, Cumbria, Lancashire, Devon, Worcestershire, Suffolk, Staffordshire, Northamptonshire, Somerset, North Yorkshire, Nottinghamshire, Warwickshire, Leicestershire, and Derbyshire.

8. Key findings: services for 18-64 year olds

8.1 By comparing ourselves to other similar councils, we can see that Norfolk has a below average rate of requests for support relating to people aged 18-64.

8.2 Norfolk also has a lower than average rate of people aged 18-64 receiving short term support – which describes support and services that have a planned end date. Conversely, Norfolk has a very high rate of people aged 18-64 receiving long term services without a planned end date – the second highest rate it its family group. Whilst it is not possible to say definitely that relatively low short term services and relatively high long term services are linked, it is likely. High levels of long term services suggest that preventative 'upstream' interventions, either in the form or short-term or 'reablement' services, are not in place or are not effective. This observation strongly informs Norfolk's strategy for working aged adults, and in its strategy for improving support for people with a learning disability. Efforts are increasingly focused on developing appropriate short term and enablement services that maximise people's independence, and reduce the need for long term formal care.

8.3 A significant factor in Norfolk's high rates of long term care is its historically high rates of admissions to residential and nursing care. Whilst Norfolk's placement rate to residential and nursing care remains high – it has the 6th highest rate in its family group - its relative position compared to its comparator councils has improved markedly in recent years. In 2012/13 Norfolk's rate of 51.7 permanent admissions for people aged 18-64 per 100,000 population meant we were placing nearly three times more people than our comparator group average. The rate reduced to 44.9 in 2013/14; 30.7 in 2014/15; and 17.5 in 2015/16, and within this context Norfolk's rate of 15.7 in 2016/17 represents a continued reduction that sees it move towards our stated target of achieving a rate in line with the family group average.

9. Key findings: services for 65+

9.1 When compared with the rest of England and our family group, Norfolk has very high levels of short term support, and high levels of reablement, but lower levels of long term support.

9.2 This suggests that the reablement services and short term support we are providing to maximise independence are working and are reducing the need for long term support. This is shown in measures of both the outcomes of reablement and admissions to long term care. Norfolk has the second highest rate of people living at home after a period of reablement, and permanent admissions to residential and nursing care continue to fall. Norfolk has previously reported above average rates of admissions to residential and nursing care, even whilst having below average rates of overall long term services, suggesting an over-dependency on high cost services. However Norfolk's residential and nursing care rates are now much closer to the family group average and continue to fall.

10. Key findings: enhancing quality of life

10.1 Norfolk's performance for indicators measuring quality of life is mixed when compared to its family group councils.

10.2 Four of the measures are taken from the annual User Experience survey conducted by every council.

10.3 The first assesses people's overall social care related quality of life, and uses an index which takes into account responses relating to factors such as control over daily life, personal care, food and nutrition, accommodation, safety, social participation, occupation and dignity. In this area Norfolk's score has improved slightly since last year, and is in line with family group, regional and national averages.

10.4 The second reports on the people stating whether they feel they have control over their daily life. Again, Norfolk's result of 79.3% is a slight increase on the 2015/16 score of 78.2%, and means that we are in line with our family group average.

10.5 The third reports on overall satisfaction of people who use services with their care and support, and shows that 64.8% of respondents were satisfied with their care and support, significantly lower than the 2015/16 score of 67.6%. This reduction means that Norfolk has moved from being significantly above average up to last year to being the second lowest performer in our family group. There is no clear indication within the data about the cause of this reduction, although it is important to note that Norfolk's score is actually in line with the East of England average (65.4%) suggesting that Norfolk's satisfaction is falling into line with regional levels. It will clearly be important to closely monitor this as we receive initial 2017/18 scores in the summer. The survey does not provide any commentary from respondents, so any further reductions or variance from family group and regional averages may require some more in depth investigation to understand what is driving changed perceptions.

10.6 The fourth indicator from the survey is new, and has been introduced across the Eastern Region as part of a voluntary agreement with the Department of Health. It looks at how well people providing care and support work together, and aims to assess the success of efforts to integrate health and social care services. This shows that 80% of people that responded in Norfolk agree strongly that people and services do work well together. We will revisit this again in our analysis next year to assess whether this has changed.

10.7 The two remaining indicators in this section look at how well people with a learning disability are supported to remain independent. These show a slight increase in people with a learning disability living in their own home or with family, and a slight decrease in people with a learning disability in paid employment. In both indicators Norfolk's scores place it below the family group average.

11. Key findings: Supporting those who are caring for others

11.1 Every two years, as part of the Adult Social Care Outcome Framework, we are required to survey carers to understand their satisfaction with support and outcomes. Overall satisfaction of carers is slightly below that of the Eastern Region average, and significantly below the Family Group average. The story is similar around carer's reported quality of life. The proportion of carers who find it easy to find information about support is more in line with the Eastern Region average, but remains below the Family Group average.

12. Key findings: Safety

12.1 The percentage of respondents in Norfolk who use services who feel safe is in line with the Family Group average.

12.2 An additional question was also added across the Eastern Region to ask people what concerned them about their safety. The responses to this are both enlightening and challenging. Only 1% of respondents stated that they were concerned about being harmed by someone who cares for them, and 2% feared being harmed by other residents in a care home. The highest reported concerns were around falling over inside the house (19%), falling over outside (15%) and uneven, dangerous pavements (12%). In short, those factors most obviously relating to formal safeguarding procedures were of least concern to most people, with more general issues around everyday life and personal independence causing most worry. Whilst this should not suggest a lower priority for essential formal safeguarding provisions, this provides a broader challenge across Adult Social Care to respond to some clear messages around falls and care arrangements.

12.3 The full benchmarking report is available in Appendix 2.

13. Recommendations

13.1 **The Committee is asked to:**

Discuss and agree the overall performance position for adult social care as described in section 2

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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