Norfolk County Council

Adult Social Care Annual Quality Report 2017/18

1 Introduction

1.1 The Care Act

1.1.1 The Care Act (the Act) requires councils with adult social care responsibilities to promote the wellbeing of their adult residents and to prevent, reduce or delay the need for social care services.

1.1.2 Norfolk County Council (the Council) is responding to its Care Act duties through its Promoting Independence strategy, which will help people maintain their independence for as long as possible obviating the need for formal funded care. When people do need social care and support, it is almost always provided through the care market consisting of hundreds of care businesses.

1.1.3 The Act also requires councils to promote the effective and efficient operation of its care market in which there is a choice of high quality services. The majority of the services provided are subject to national statutory quality standards which are assessed by the Care Quality Commission (CQC) who publish quality ratings. These published ratings and other intelligence gathered about the quality of services from complaints and concerns, enable the Council to target providers who are not performing well enough, as it remains the duty of the Council to ensure that the quality of services is good.

1.1.4 To ensure that the Council was well placed to secure quality services as required by the Act, a formal Quality Framework was adopted by the Adult Social Care Committee (the Committee) in January 2015. The framework requires the production of an Annual Quality Report and this report is the third such report since the Act came into force and the framework was adopted.

1.2 The Quality Framework

1.2.1 The Quality Framework (the framework) itself is a published document and can be accessed through the following link www.norfolk.gov.uk/careproviders The framework is based on a set of principles which are set out below:

a) Supports a whole systems approach to promoting individual wellbeing and independence
b) Supports the development and implementation of quality standards that set out what 'good' looks like
c) Sets out how high-quality care provision will be secured from the market
d) Sets out how provider performance will be monitored and how the effective and efficient operation of the market will be promoted
e) Sets out governance, review and oversight arrangements that will enable the Council to judge the extent to which it is discharging its responsibilities properly

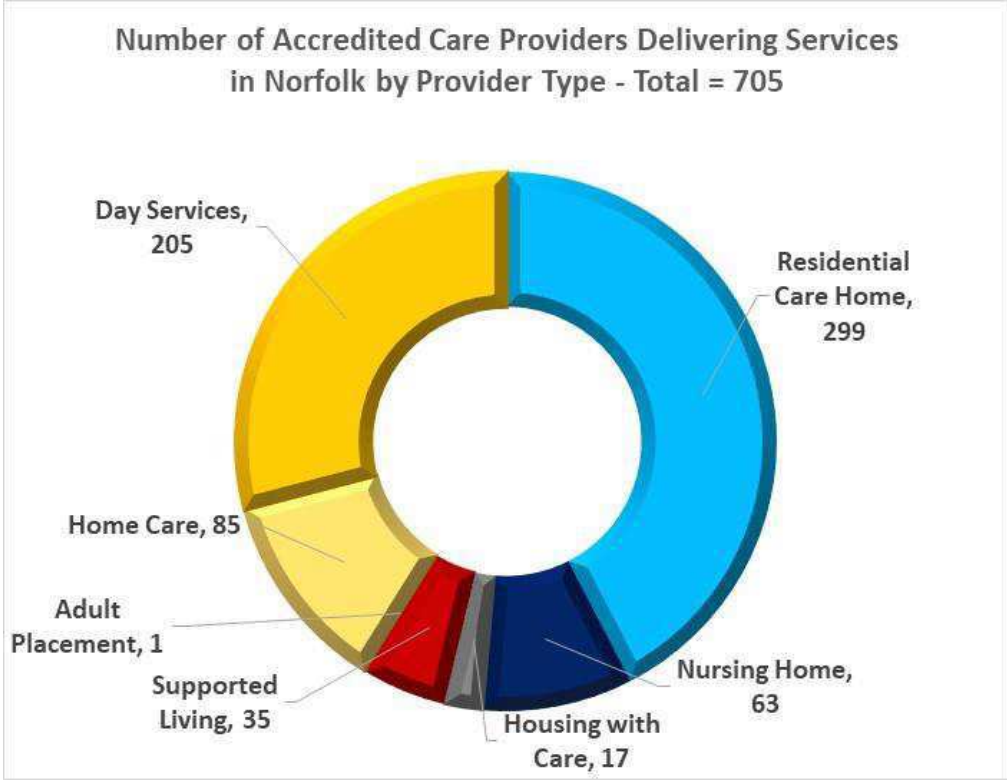
1.2.2 At the heart of the framework is the development of a systematic approach to quality assurance involving standard setting, securing quality, monitoring quality and intervention, and finally governance, review and reporting.

1.3 The Care Market in Norfolk

1.3.1 The care market in Norfolk is the second largest in the Eastern region, providing a vast range of services to thousands of adults whose needs vary significantly and whose expectations as to quality and choice continue to rise. (For a comprehensive overview of this market please refer to the Market Position Statement 2017. An updated market position statement will be published in September 2018)

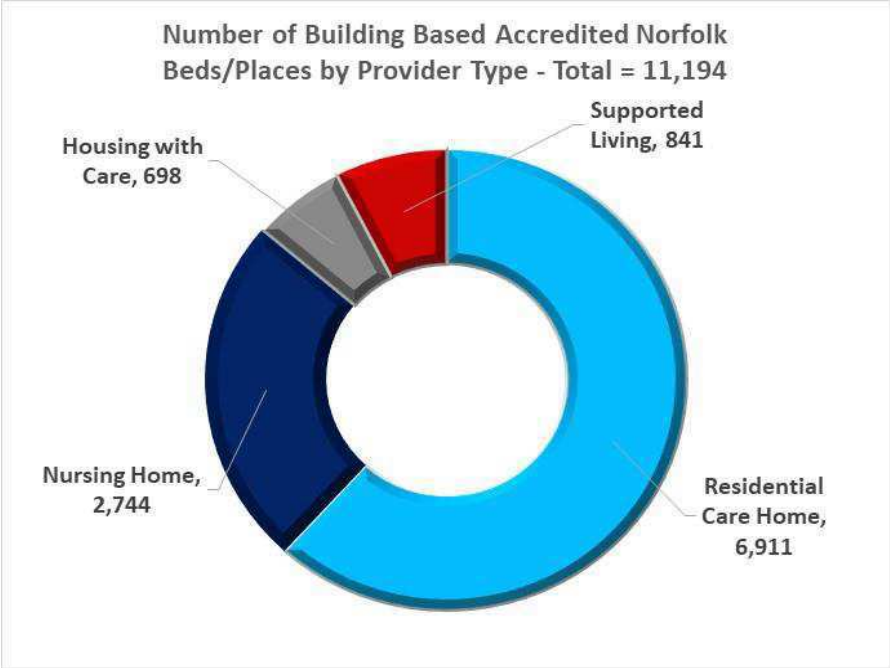
1.3.2 The Council currently invests over £320m annually in this market to support more than 15,000 adults, mainly through contracts with over 700 different care providers most of whom are independent businesses. The diagram below shows how many accredited providers there are in each of the main segments of the market. Even this, however, is not the full picture as there are increasing numbers of personal care providers directly employed by individuals using direct payments from personal budgets, not to mention community organisations, groups and more than 90,000 informal carers.

1.3.3 **The Size of the Norfolk Care Market – Number of Accredited Providers - 2018**



1.3.4 There are 500 providers operating from 700 sites subject to CQC assessment and a further 205 day care providers, not subject to CQC inspection, but required to pass the Council's quality criteria to be accepted on the accredited list. This makes a formal care market of just over 700 providers.

The sector employs over 27,000 care workers and relies upon an extensive bed-based care estate. The diagram below shows the distribution and number of care beds in Norfolk, which shows that the market is dominated by care homes with much lower housing based provision.



1.3.5 This formal care market is needed when informal social care is not available. Over 94,000 people are providing informal social care in Norfolk, together with numerous organisations and community based groups whose contributions are estimated to be worth at least £700m annually.

1.3.6 The Council itself still provides some formal social care directly through its reablement and first response services and operates Norse Care and Independence Matters as arm's length care companies. Nevertheless, almost 90% of formal social care is sourced through the formal care market. This makes it even more important that the Council has a systematic and effective approach so that it can be confident that it is investing in quality care. This means care that is effective in supporting the outcomes that people want and is fully compliant with national standards, irrespective of whether they fund the care themselves, or the Council does.

2 Setting standards and assessing quality

2.1 Care Quality Commission

2.1.1 The Quality Framework begins with standards of quality. The starting point is the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which include regulations which are the fundamental standards of care below which no registered provider should fall.

2.1.2 The CQC is responsible for the registration, inspection and assessment of all registered providers. It is important to understand, however, that the Act places the duty of securing the quality of care in Norfolk on the Council itself.

2.1.3 The CQC assessment process asks five key questions about the service:

a) Is the service safe?
b) Is the service effective?
c) Is the service caring?
d) Is the service responsive?
e) Is the service well led?

2.1.4 Each area of enquiry is known as a domain and each of these is rated as either:

a) Inadequate
b) Requires improvement
c) Good
d) Outstanding

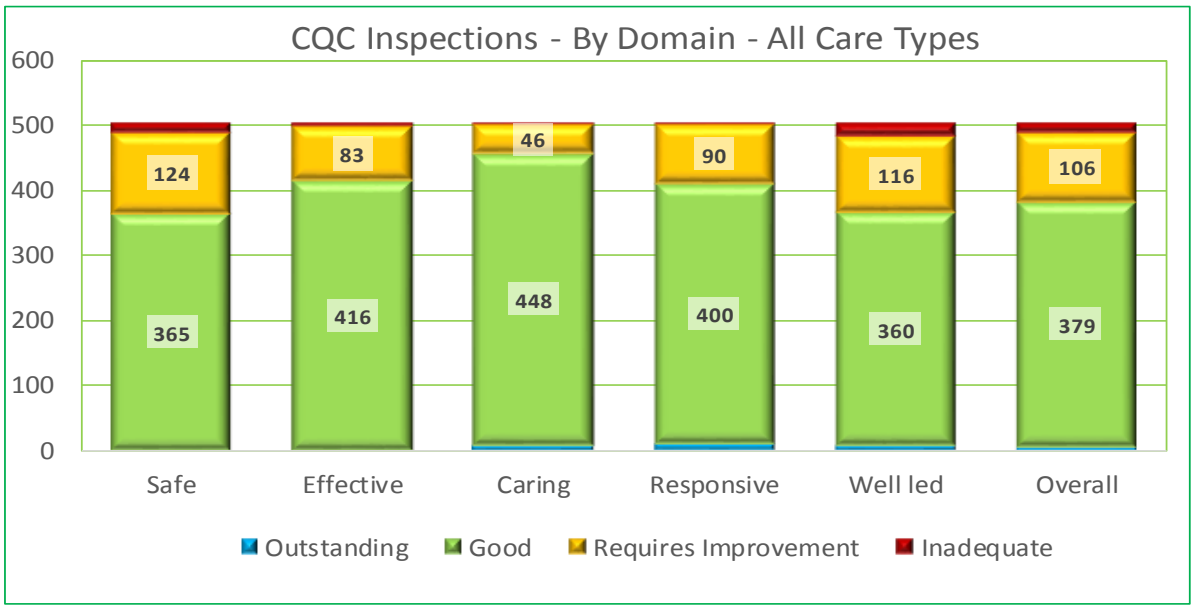
2.1.5 These domain ratings are published along with an overall rating. Some care needs to be taken as there is a delay between the assessment and publication of the assessment and there are occasions when improvements have already been made by the time of publication.

2.2 How are providers in Norfolk doing against CQC ratings?

2.2.1 As at 31 March 2018, 505 registered providers in Norfolk had been inspected and rated. The tables and diagrams below show how all provider types performed against the five domains:

Current CQC Ratings by Domain - All Care Types

Domain	Outstanding	Good	Requires Improvement	Inadequate	Total
Safe	0	365	124	16	**505**
Effective	0	416	83	6	**505**
Caring	9	448	46	2	**505**
Responsive	11	400	90	4	**505**
Well led	7	360	116	22	**505**
Overall	5	379	106	15	**505**

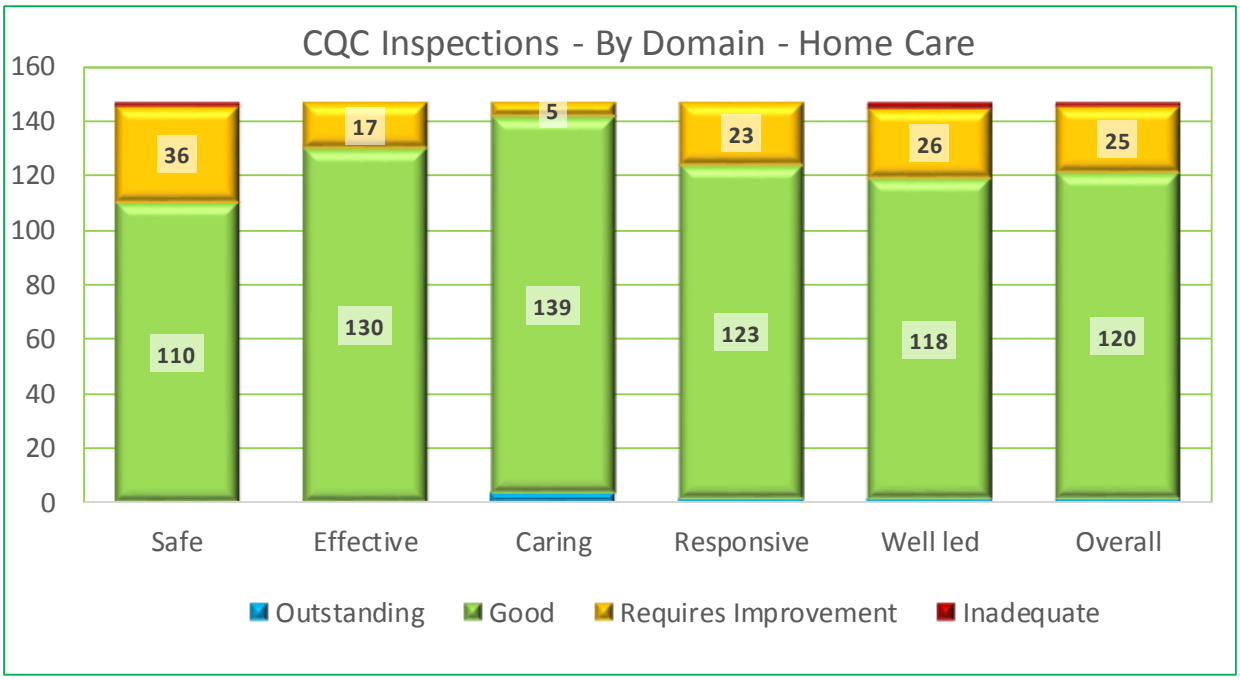


At year end, 106 providers (21%) were rated as 'requires improvement' and 15 providers (3%) were rated 'inadequate'. The domains in which providers are doing less well are the 'Well Led' and 'Safe' domains. Providers perform best against the 'Caring' domain. The following diagrams show how providers are performing by care sector:

2.2.2

Current CQC Ratings by Domain - Home Care

Domain	Outstanding	Good	Requires Improvement	Inadequate	Total
Safe	0	110	36	1	**147**
Effective	0	130	17	0	**147**
Caring	3	139	5	0	**147**
Responsive	1	123	23	0	**147**
Well led	1	118	26	2	**147**
Overall	1	120	25	1	**147**

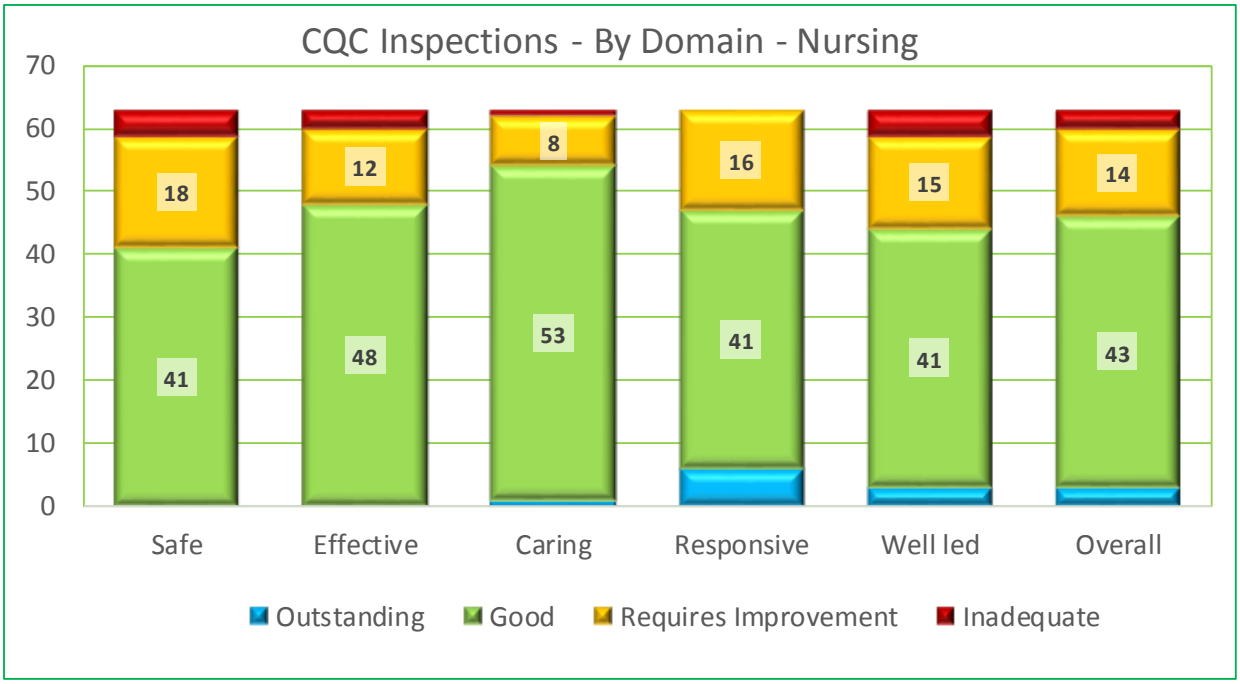


25 providers (17%) were rated as 'requires improvement' and one provider was rated as 'inadequate'. One provider was rated as 'outstanding'.

2.2.3

Current CQC Ratings by Domain - Nursing

Domain	Outstanding	Good	Requires Improvement	Inadequate	Total
Safe	0	41	18	4	**63**
Effective	0	48	12	3	**63**
Caring	1	53	8	1	**63**
Responsive	6	41	16	0	**63**
Well led	3	41	15	4	**63**
Overall	3	43	14	3	**63**

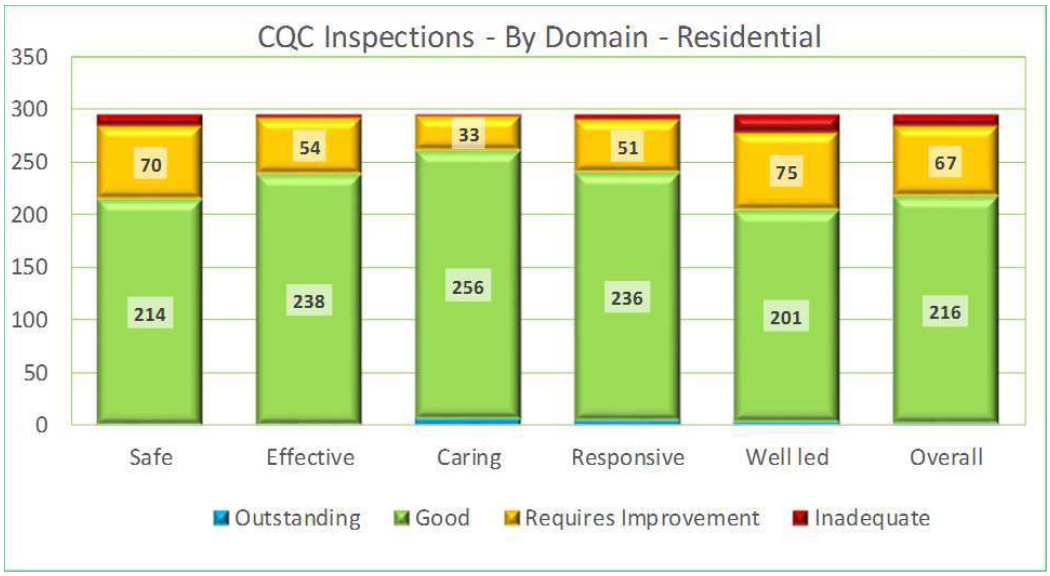


14 homes (20.6%) were rated as 'requires improvement' and three homes (4.4%) were rated as 'inadequate'. Three homes were rated as 'outstanding'.

2.2.4

Current CQC Ratings by Domain - Residential

Domain	Outstanding	Good	Requires Improvement	Inadequate	Total
Safe	0	214	70	11	**295**
Effective	0	238	54	3	**295**
Caring	5	256	33	1	**295**
Responsive	4	236	51	4	**295**
Well led	3	201	75	16	**295**
Overall	1	216	67	11	**295**



67 homes (22.7%) were rated as 'requires improvement' and 11 homes (3.7%) were rated as 'inadequate'. One home was rated as 'outstanding'.

2.2.5 Our analysis demonstrates that providers in residential and nursing care who do not achieve a rating of 'good' in the well led and safe domains are highly likely to have an overall rating of' requires improvement' or even 'inadequate'. In home care the key domain indicators are well led and responsive. Our improvement programmes described in more detail below are therefore targetted at these particular areas.

2.3 Requires Improvement to Good programme (RIG)

2.3.1 As part of the quality improvement strategy a targeted programme called Requires Improvement to Good (RIG) was introduced during 2016/17 in which targets were set so that no more than 20% of providers would be rated as 'requires improvement' and conversely at least 80% would be rated as 'good' by the end of the 2018/19 year. We have just completed the middle year of the three-year programme.

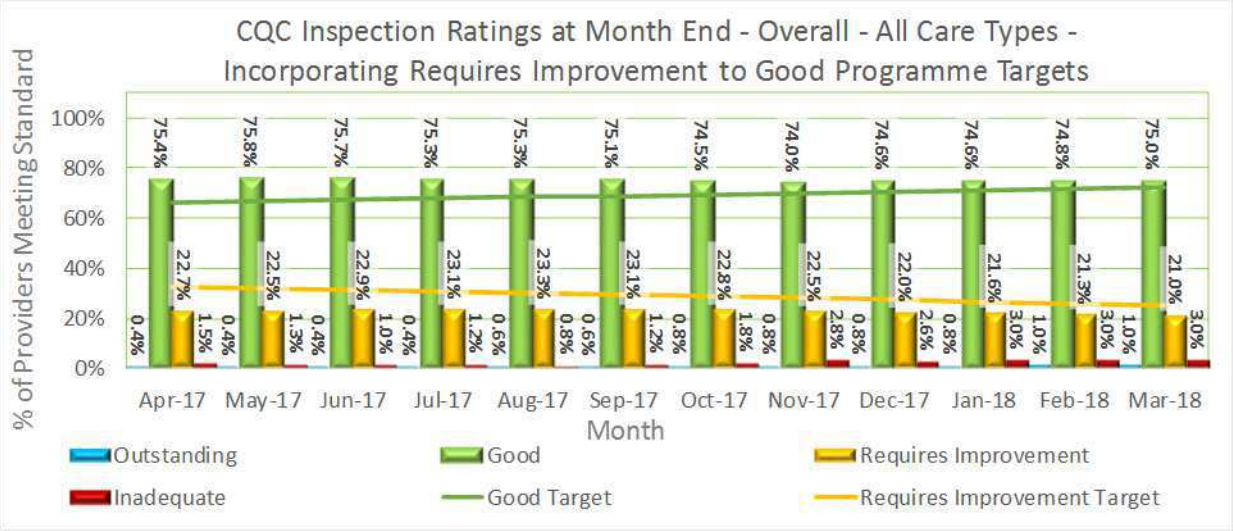
2.3.2 In the first year, targeted support resulted in significant progress from a low base in which the proportion of providers in all care types rated as 'good' or better increasing from 57% to 73% by December 2016. The diagrams below show how the programme faired in 2017/18.

2.4 Overall ratings whole market

2.4.1 The tables and diagrams below show how the market in Norfolk has performed against the RIG target.

Current CQC Ratings - Overall - All Care Types

Month	Outstanding	Good	Requires Improvement	Inadequate
Apr-17	0.4%	75.4%	22.7%	1.5%
May-17	0.4%	75.8%	22.5%	1.3%
Jun-17	0.4%	75.7%	22.9%	1.0%
Jul-17	0.4%	75.3%	23.1%	1.2%
Aug-17	0.6%	75.3%	23.3%	0.8%
Sep-17	0.6%	75.1%	23.1%	1.2%
Oct-17	0.8%	74.5%	22.8%	1.8%
Nov-17	0.8%	74.0%	22.5%	2.8%
Dec-17	0.8%	74.6%	22.0%	2.6%
Jan-18	0.8%	74.6%	21.6%	3.0%
Feb-18	1.0%	74.8%	21.3%	3.0%
Mar-18	1.0%	75.0%	21.0%	3.0%

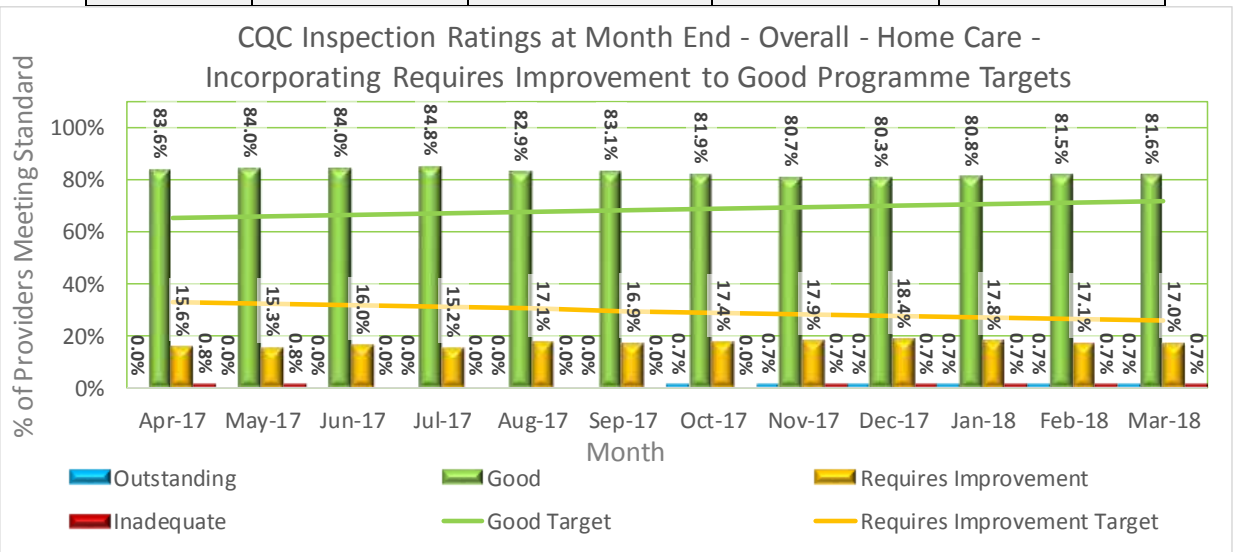


Whilst the programme is still on target, the rate of improvement has slowed. At the end of the 2017/18 year a total of 106 providers were rated as requires improvement and 15 were rated as 'inadequate'. This is almost exactly the same as at the end of the previous year although it includes more providers inspected and rated by CQC

2.4.2 Ratings for home care

Current CQC Ratings - Overall - Home Care

Month	Outstanding	Good	Requires Improvement	Inadequate
Apr-17	0.0%	83.6%	15.6%	0.8%
May-17	0.0%	84.0%	15.3%	0.8%
Jun-17	0.0%	84.0%	16.0%	0.0%
Jul-17	0.0%	84.8%	15.2%	0.0%
Aug-17	0.0%	82.9%	17.1%	0.0%
Sep-17	0.0%	83.1%	16.9%	0.0%
Oct-17	0.7%	81.9%	17.4%	0.0%
Nov-17	0.7%	80.7%	17.9%	0.7%
Dec-17	0.7%	80.3%	18.4%	0.7%
Jan-18	0.7%	80.8%	17.8%	0.7%
Feb-18	0.7%	81.5%	17.1%	0.7%
Mar-18	0.7%	81.6%	17.0%	0.7%

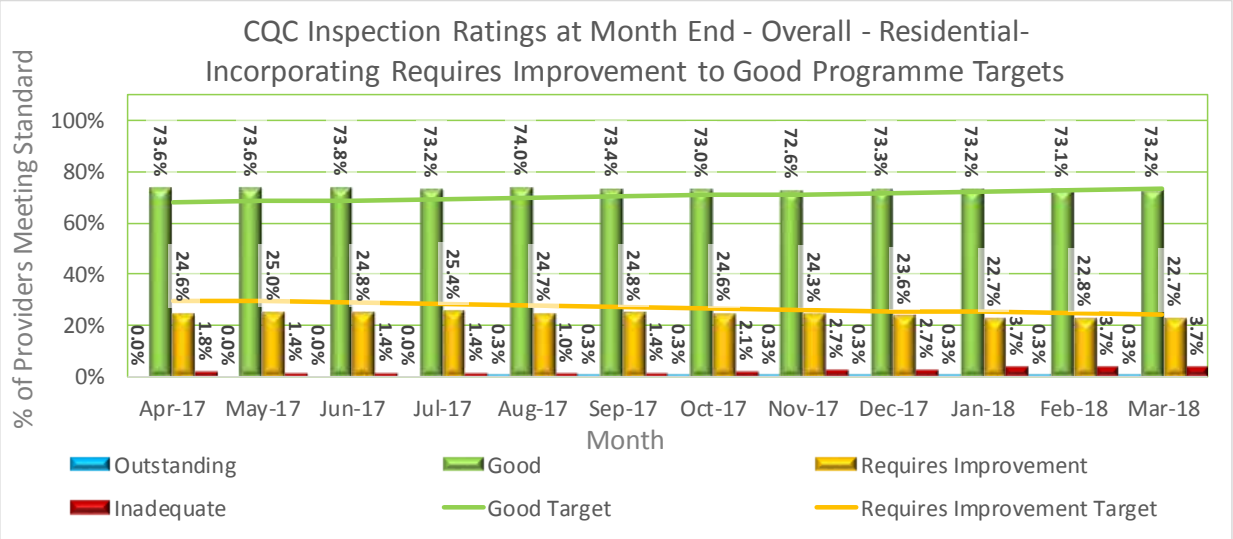


There has been further improvement exceeding the RIG target, however the rate of improvement has slowed compared to the previous year.

2.4.3 Ratings for residential care

Current CQC ratings - Overall – Residential

Month	Outstanding	Good	Requires Improvement	Inadequate
Apr-17	0.0%	73.6%	24.6%	1.8%
May-17	0.0%	73.6%	25.0%	1.4%
Jun-17	0.0%	73.8%	24.8%	1.4%
Jul-17	0.0%	73.2%	25.4%	1.4%
Aug-17	0.3%	74.0%	24.7%	1.0%
Sep-17	0.3%	73.4%	24.8%	1.4%
Oct-17	0.3%	73.0%	24.6%	2.1%
Nov-17	0.3%	72.6%	24.3%	2.7%
Dec-17	0.3%	73.3%	23.6%	2.7%
Jan-18	0.3%	73.2%	22.7%	3.7%
Feb-18	0.3%	73.1%	22.8%	3.7%
Mar-18	0.3%	73.2%	22.7%	3.7%



While still on target, performance in the residential care sector has remained broadly static. By the end of the 2017/18-year 67 residential care homes were rated as 'requires improvement' and 11 were rated as 'inadequate'. This is a slight improvement on 2016/17 when 84 homes required improvement.

2.4.4 Ratings for nursing care

The diagram below shows the picture in the nursing home sector.

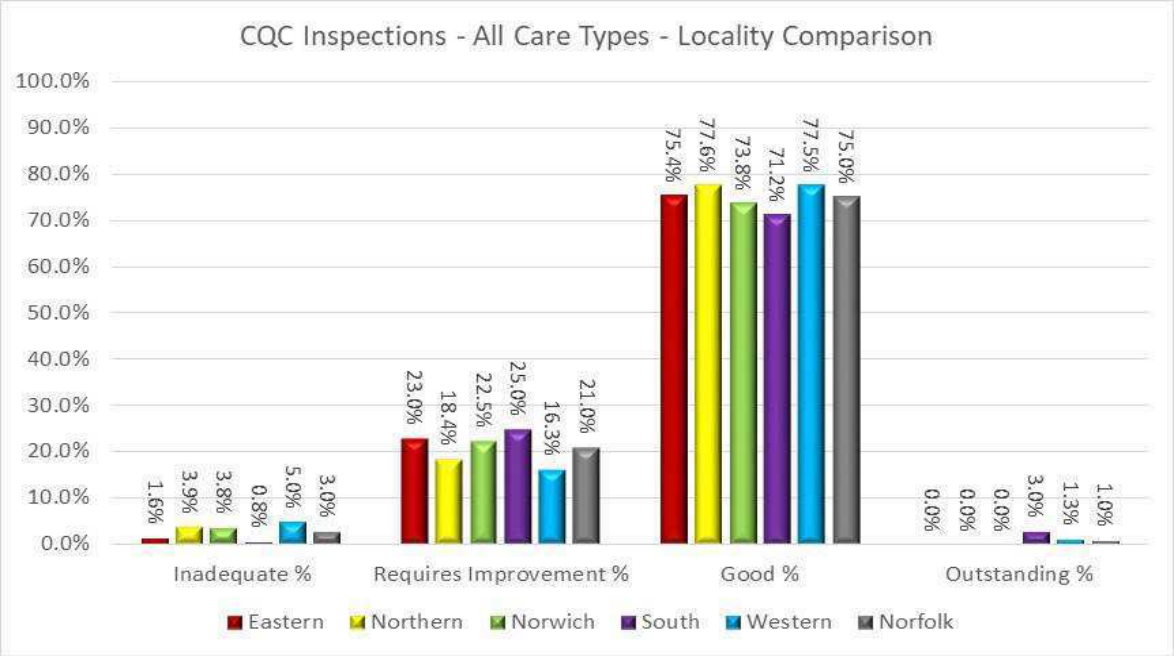
Current CQC ratings - Overall - Nursing

Month	Outstanding	Good	Requires Improvement	Inadequate
Apr-17	3.1%	67.2%	28.1%	1.6%
May-17	3.1%	68.8%	26.6%	1.6%
Jun-17	3.1%	67.2%	28.1%	1.6%
Jul-17	3.0%	65.2%	28.8%	3.0%
Aug-17	3.0%	65.2%	30.3%	1.5%
Sep-17	3.0%	65.2%	28.8%	3.0%
Oct-17	3.0%	65.2%	27.3%	4.5%
Nov-17	3.0%	65.2%	24.2%	7.6%
Dec-17	3.1%	67.7%	23.1%	6.2%
Jan-18	3.2%	66.7%	25.4%	4.8%
Feb-18	4.8%	66.7%	23.8%	4.8%
Mar-18	4.8%	68.3%	22.2%	4.8%

There has been a noticeable improvement in the nursing home market but again the rate of progress has slowed.

2.5 Ratings for all care types by location

2.5.1 There are variations in ratings between the five locality areas that correspond broadly to the Clinical Commissioning Groups (CCGs) as shown in the diagram below.



North and West localities do best with South and Norwich localities fairing less well. East locality performs just above the Norfolk average. Compared to the previous year there has been a noticeable improvement in all localities.

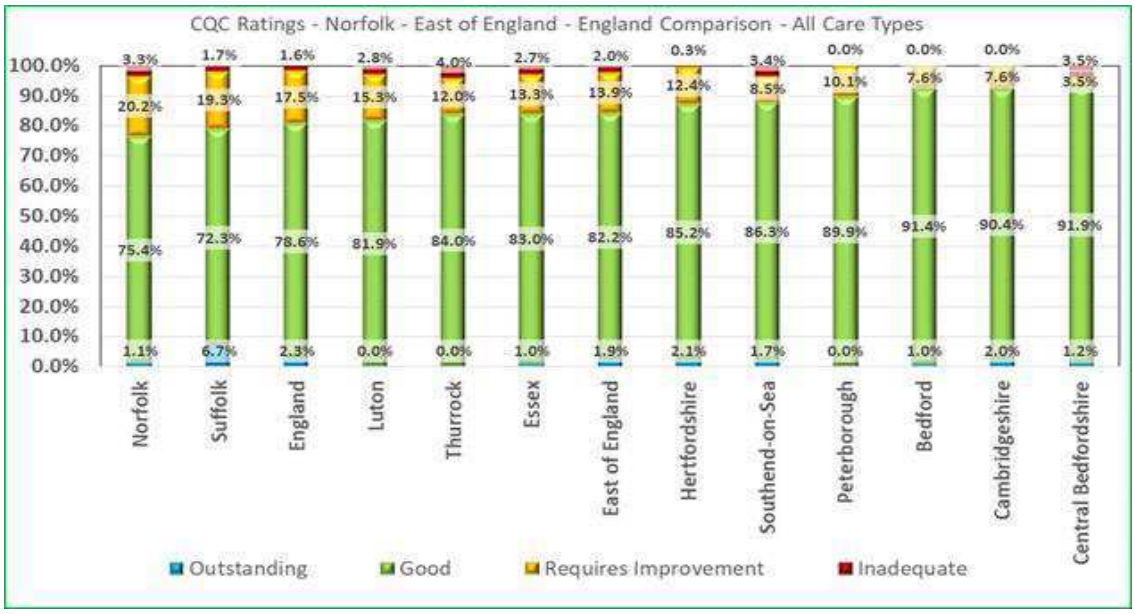
2.6 Norfolk ranking against other adult social care local authorities

2.6.1 There are 152 local authorities with adult social care responsibilities in England. Looking at Norfolk in isolation tells us how we are progressing in relation to securing good quality care. It is clearly important however that we understand our market performance against other council areas. The following diagrams show how Norfolk is performing when compared to councils in the East of England and the all England average as well as our family group of similar types of local authorities.

2.7 Norfolk comparison with the East of England and all England averages

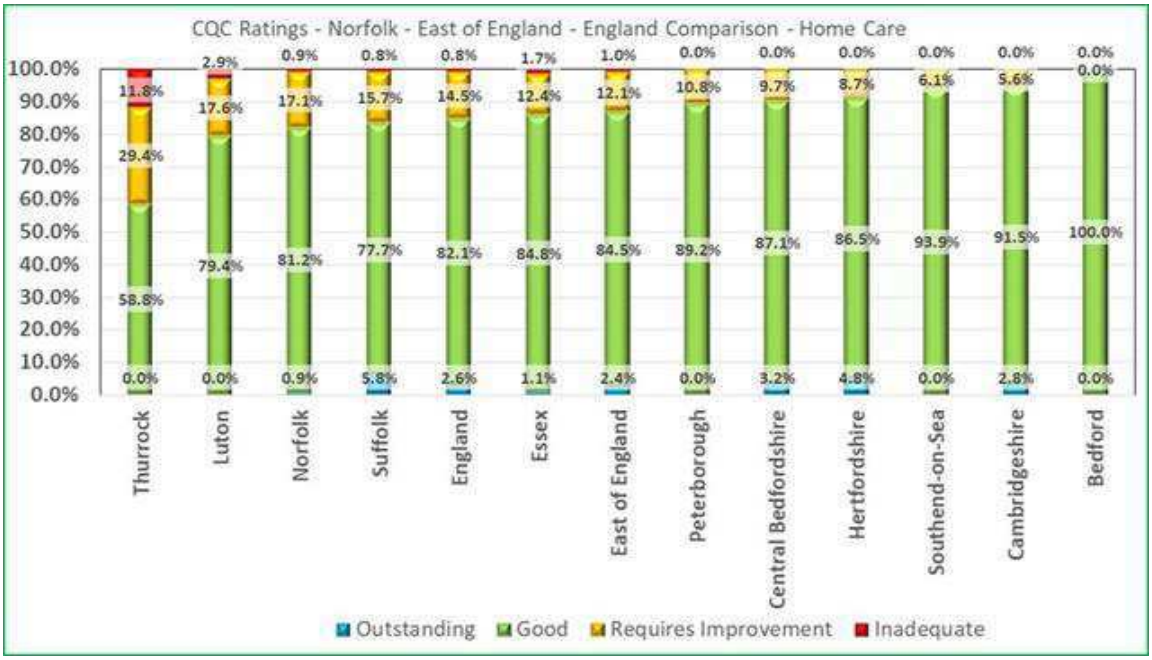
2.7.1 The diagram below shows Norfolk's position against the other ten adult social care authorities in the East of England, the East of England average and the all England average.

2.7.2 Regional comparison all care types



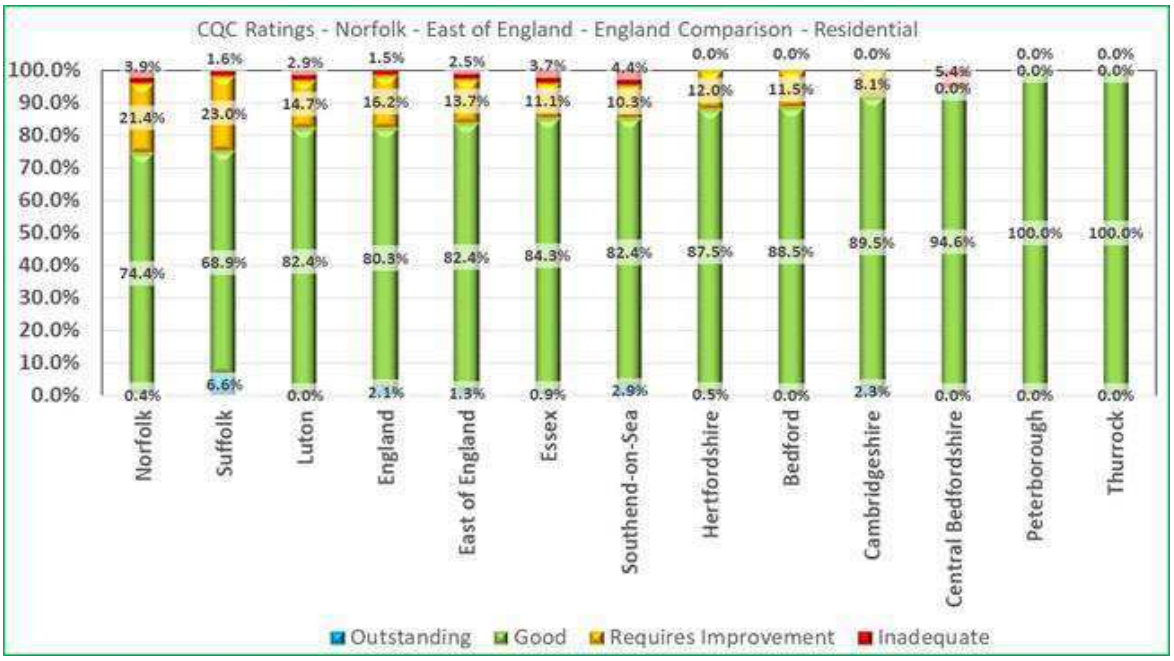
With 76.5% of providers rated as 'good' or 'outstanding', Norfolk is at the bottom of the regional league table as they were in the previous year. The all England average is 80.9% and the East of England average is 84.1%. The highest performer is Central Bedfordshire at 93.1%.

2.7.3 Regional comparison home care



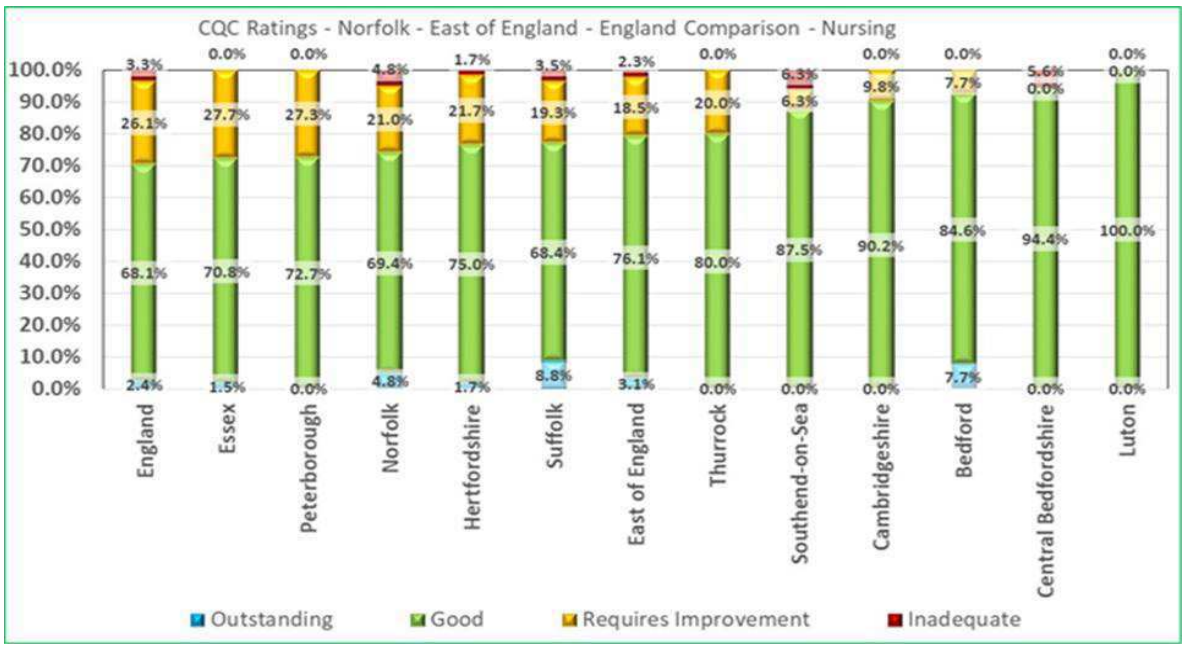
With 82.1% of home care providers rated as good or outstanding, Norfolk is third bottom in the regional league table. The all England average is 84.7% and the East of England average is 86.9%. In the previous year Norfolk were placed fifth with a rating of 88% so there has been a decline in performance.

2.7.4 Regional comparison residential care



With 74.8% of providers rated as 'good' or better, Norfolk is bottom of the league table for residential care quality as they were in the previous year in spite of a 2.4% improvement. The all England average is 82.4% and the East of England average is 83.7%. Both Thurrock and Peterborough score 100%.

2.7.5 Regional comparison nursing care

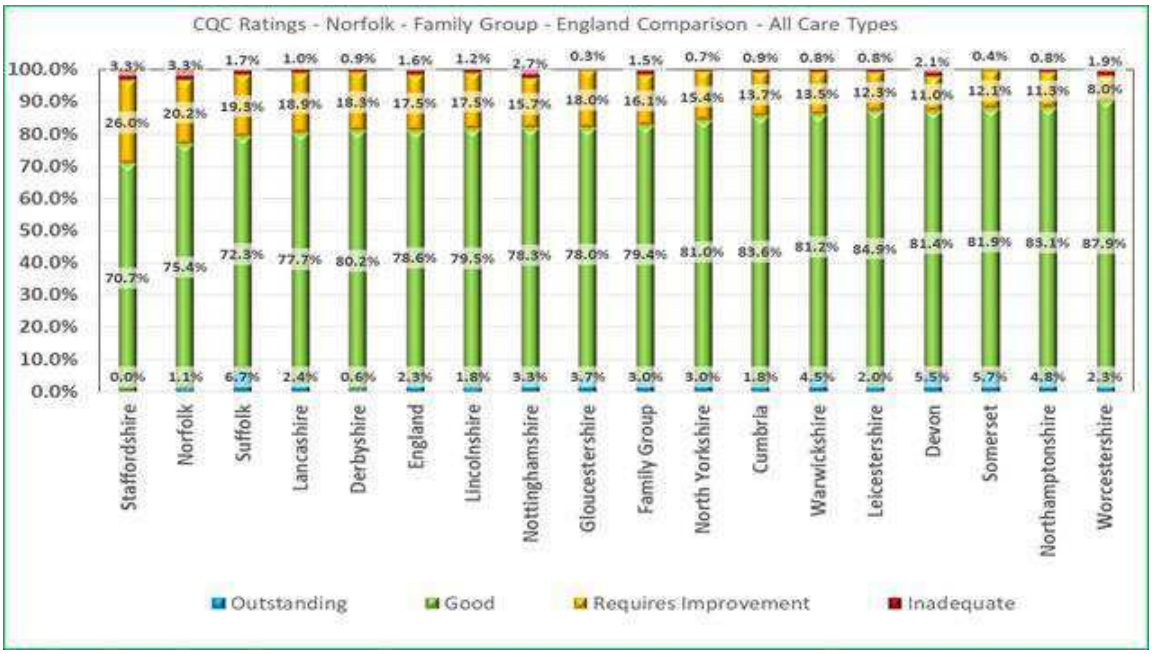


With 74.2% of providers rated as good or outstanding, Norfolk is ninth out of eleven local authorities. The all England average is 70.5% and the East of England average is 79.2%. Norfolk improved from the previous year performance of 70.5% with a number of homes gaining a rating of 'outstanding'.

2.7.6 Family group comparison

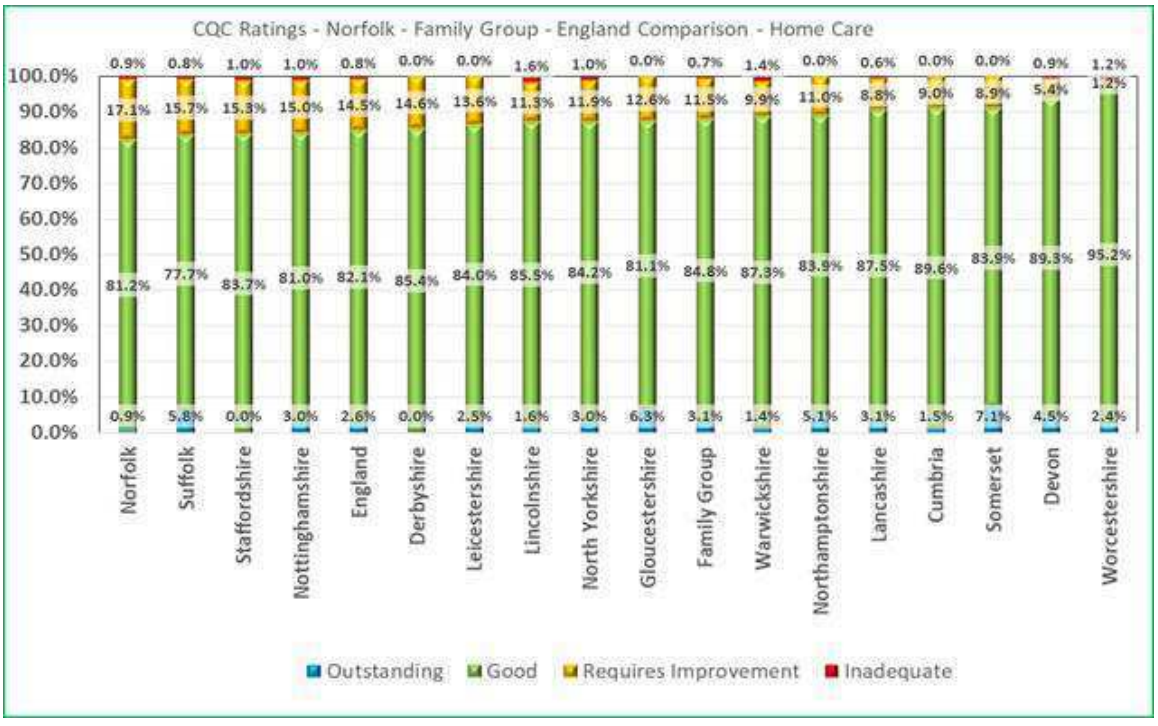
For the first time the quality report sets out comparisons with similar types of local authorities.

All care types



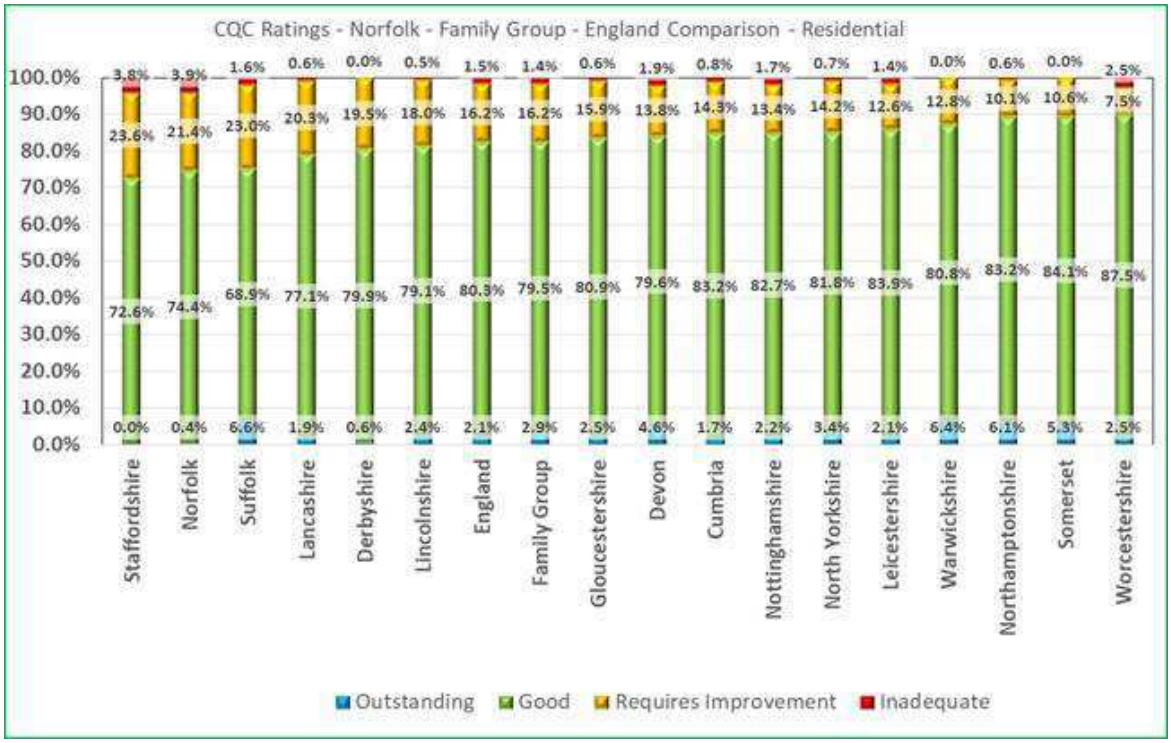
Norfolk is placed 17 out of 18 similar authorities across all care types. The median score is 83.7% meaning that there is a 7.2% gap to make up to match median performance.

Home care



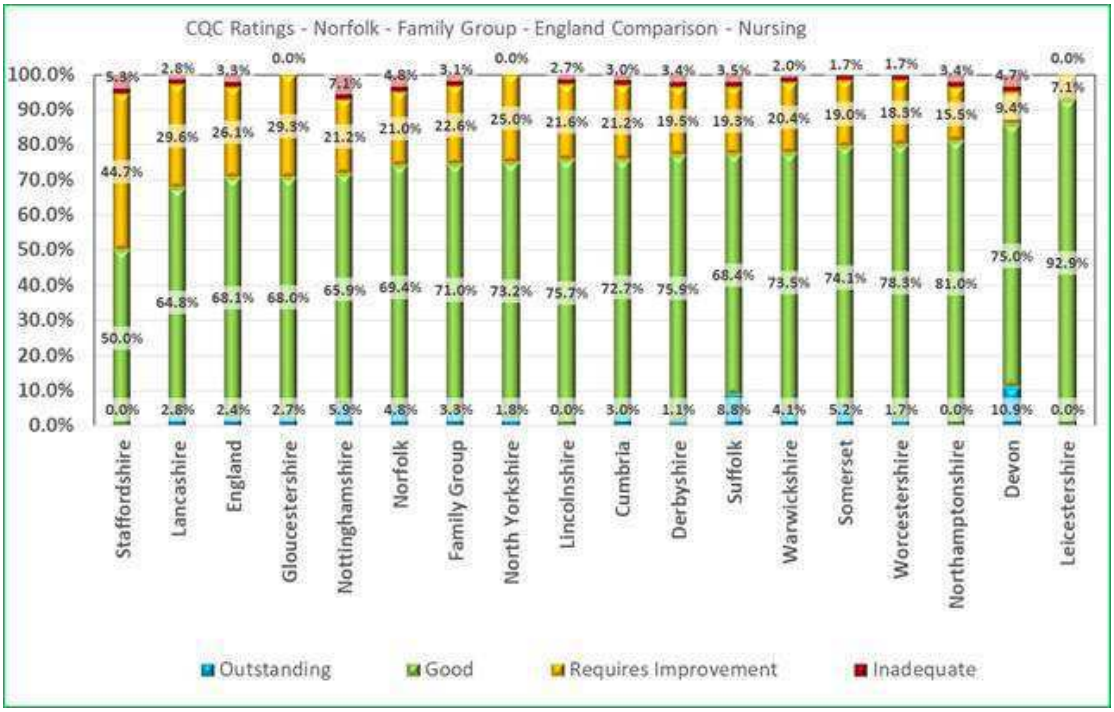
Norfolk is placed 18 out of 18 similar authorities. The median score is 87.2% compared to Norfolk at 82.1%.

Residential care



Norfolk is placed 17 out of 18 similar authorities. The median score is 83.4% compared to Norfolk at 74.8%.

Nursing care



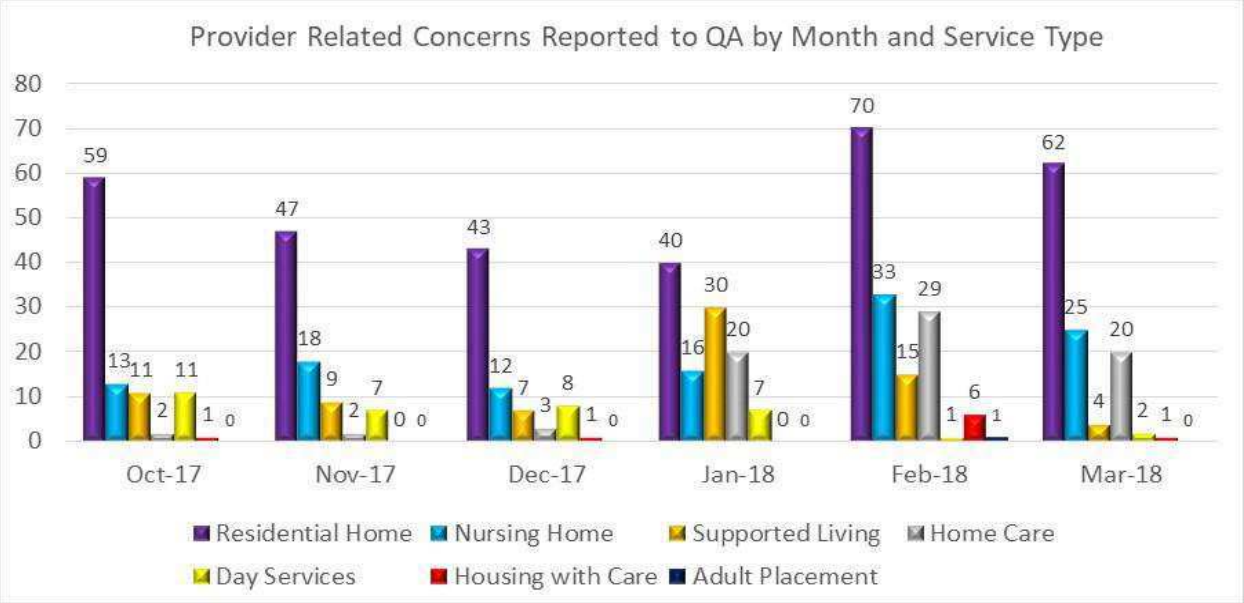
Norfolk is placed 13 out of 18 similar authorities. The median score is 75.7% compared to Norfolk at 74.2%

3 Complaints concerns and safeguarding 2017/18

3.1 CQC ratings alone only paint part of the quality picture. The Quality Assurance (QA) team receives intelligence from the public, recipients of care and providers concerning provider performance which is always assessed and acted upon in accordance with risk. It is essential that issues arising during the year that are serious enough to warrant intervention are dealt with on an ongoing basis as they occur. A failure to react would result in further down rating of providers, dissatisfaction on the part of complainants and people with concerns and reputational damage to the Council and in the most serious cases, risk of legal challenge.

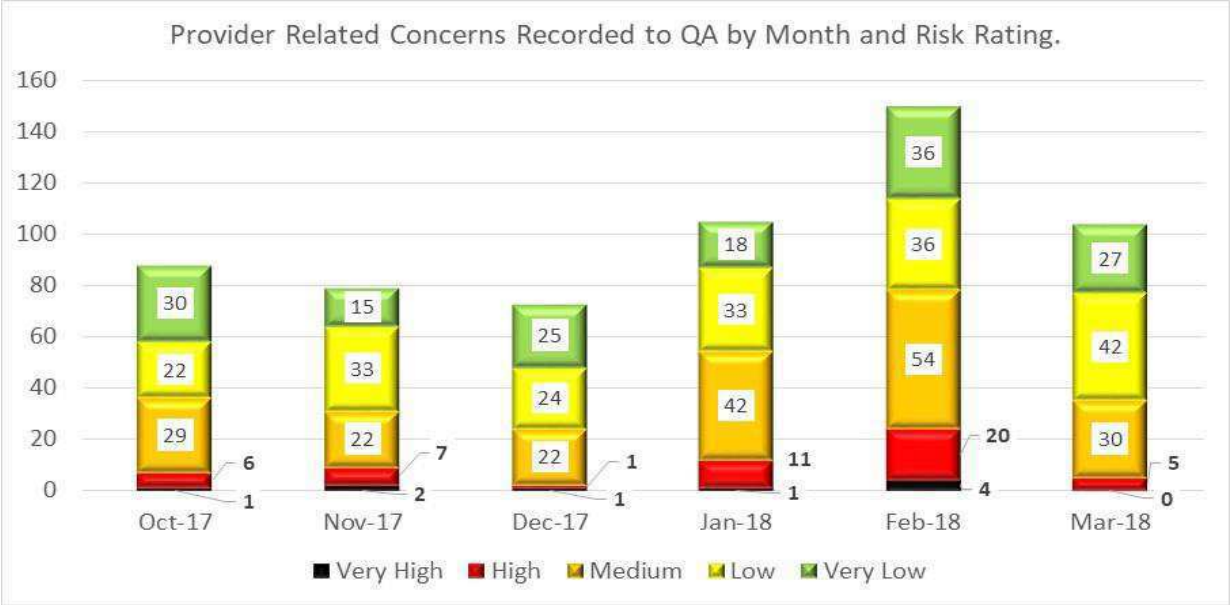
3.2 The next part of the report describes and quantifies the workload of the QA team as regards this reactive activity. The picture painted is one of increased demand for reactive interventions when compared to the previous year and little capacity being available, as hoped, for proactive improvement programmes.

3.3 The diagram below shows the number of active cases being dealt with by the QA team at month end for the last six months of the 2017/18 year.



3.4 Issues in care homes account for the majority of the concerns that come into the QA team. Home care and supported living also contribute significant work to the QA team. Not every issue is currently recorded on the Authority Public Protection (APP) system that is used for this purpose and it is estimated that 200-250 provider related concerns are reported to the team monthly.

3.5 Concerns are risk rated to ensure that the team focuses on the higher risk concerns. The diagram below shows the ratings for all recorded concerns coming in to the team.

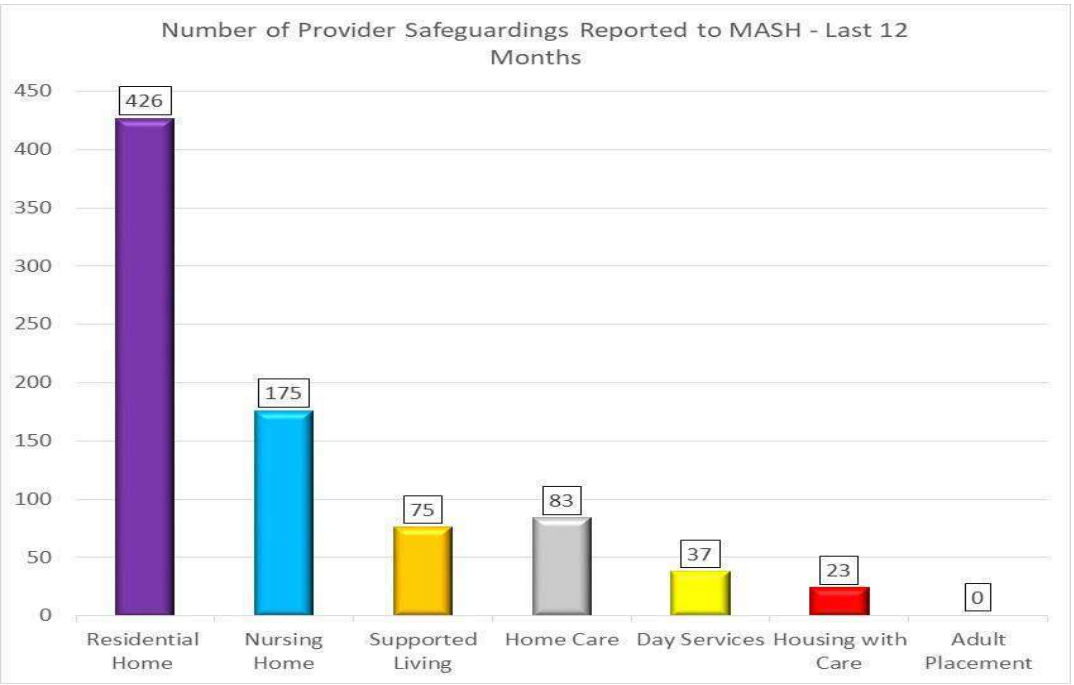


3.6 There have been 258 recorded concerns rated as medium, high or very high risk during the six month period. These concerns typically involve lengthy and complex investigation and support to providers. The team is required to always respond to concerns in these categories and set response times have to be achieved. The response rate target is 90% and the team achieved 92%.

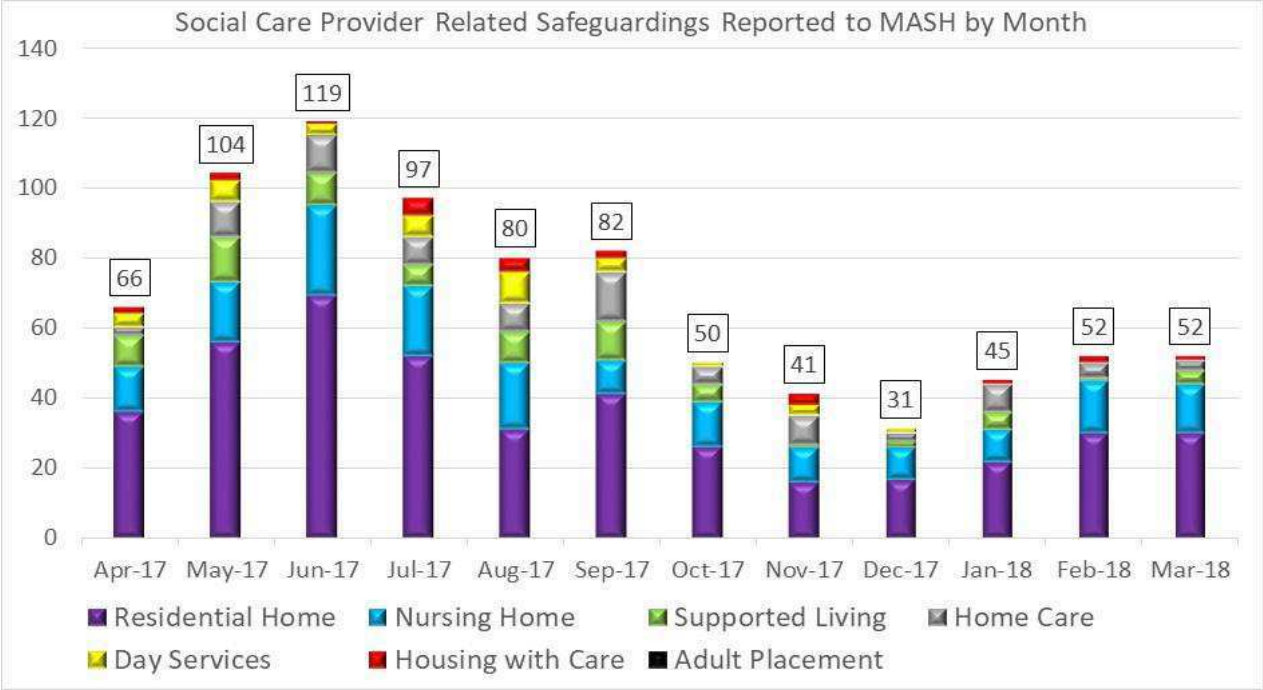
3.7 This volume of work means that there is little capacity to carry out proactive quality improvement work.

3.8 **Safeguarding**

3.8.1 About half of the QA team's work originates from safeguarding concerns where a care provider is involved. The following diagram shows the number of safeguardings reported to the Multi Agency Safeguarding Hub (MASH) which relate to providers:

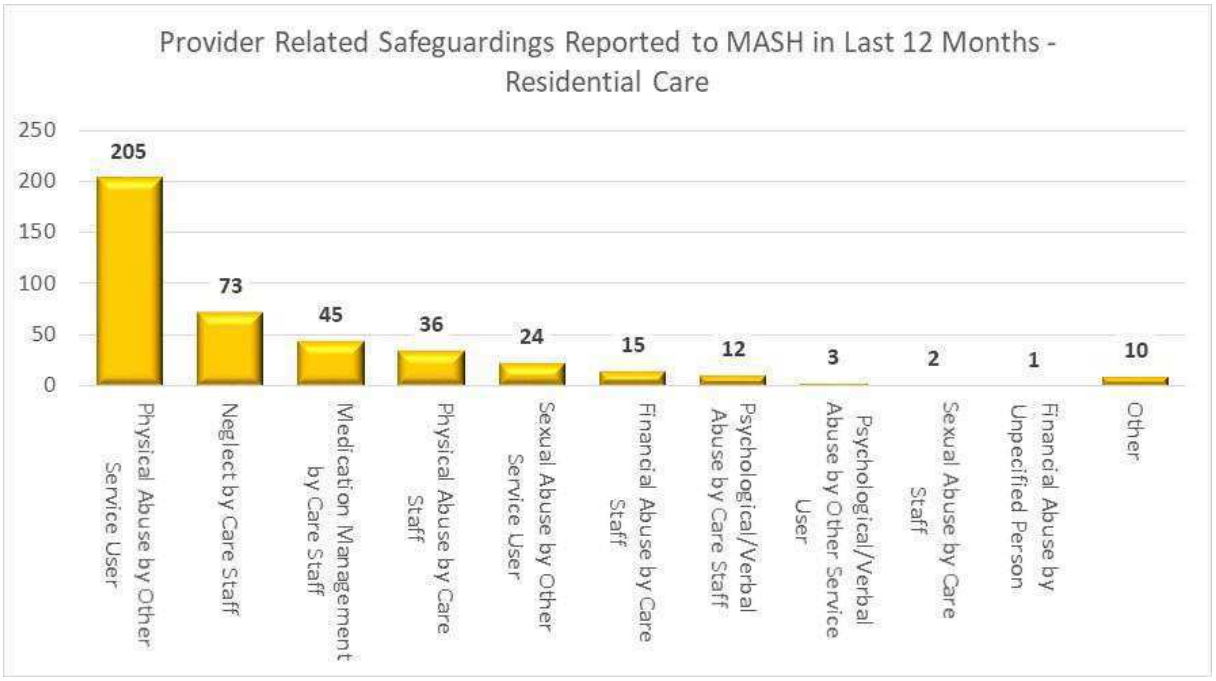


3.8.2 There is a distinct cyclical pattern which can be seen in the diagram below:



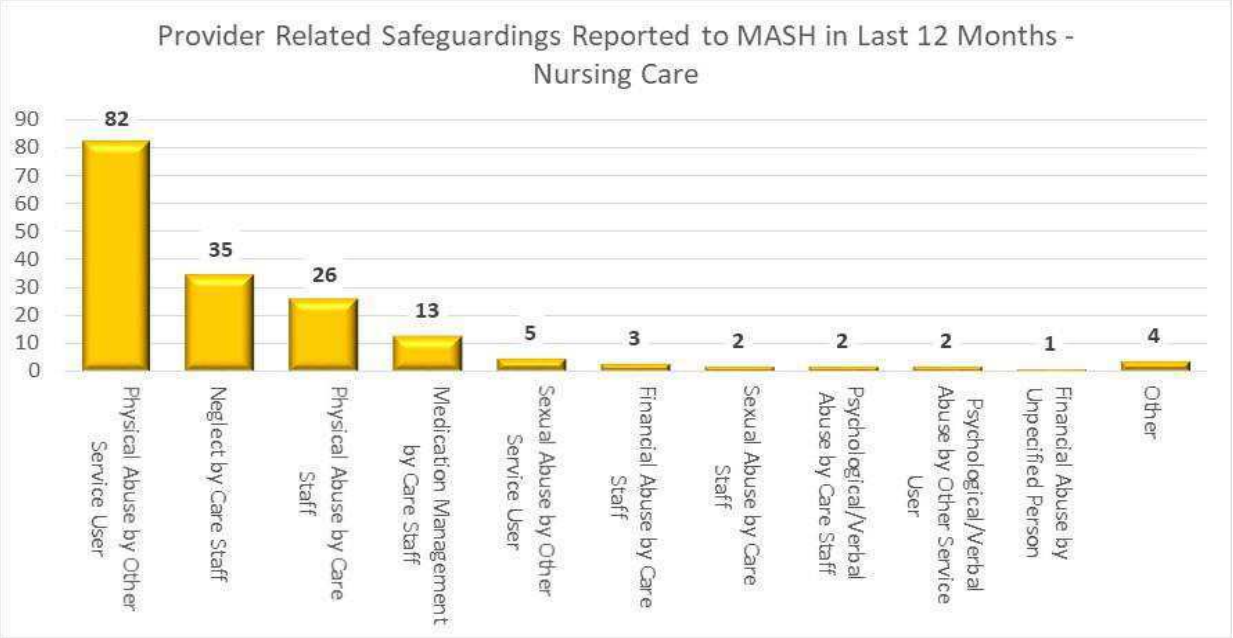
3.8.3 The following diagrams show the principle reasons for safeguarding concerns in the key market sectors:

Residential care home



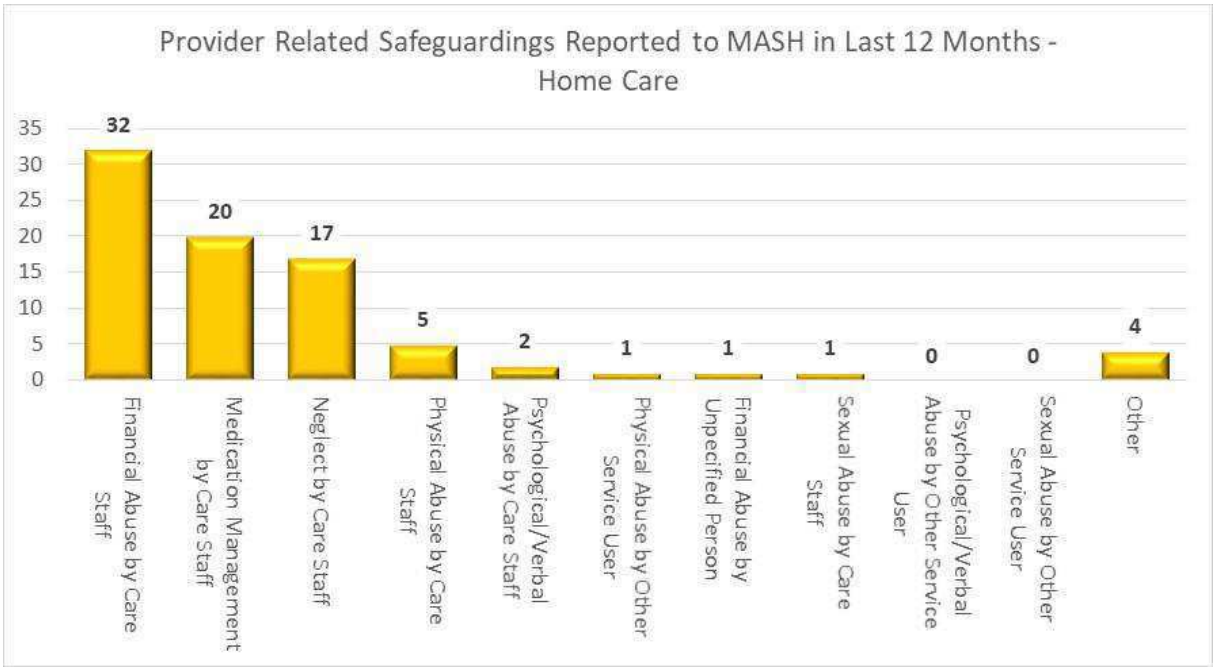
By far the greatest reason for provider related safeguardings is resident on resident abuse.

3.8.4 **Nursing care home**



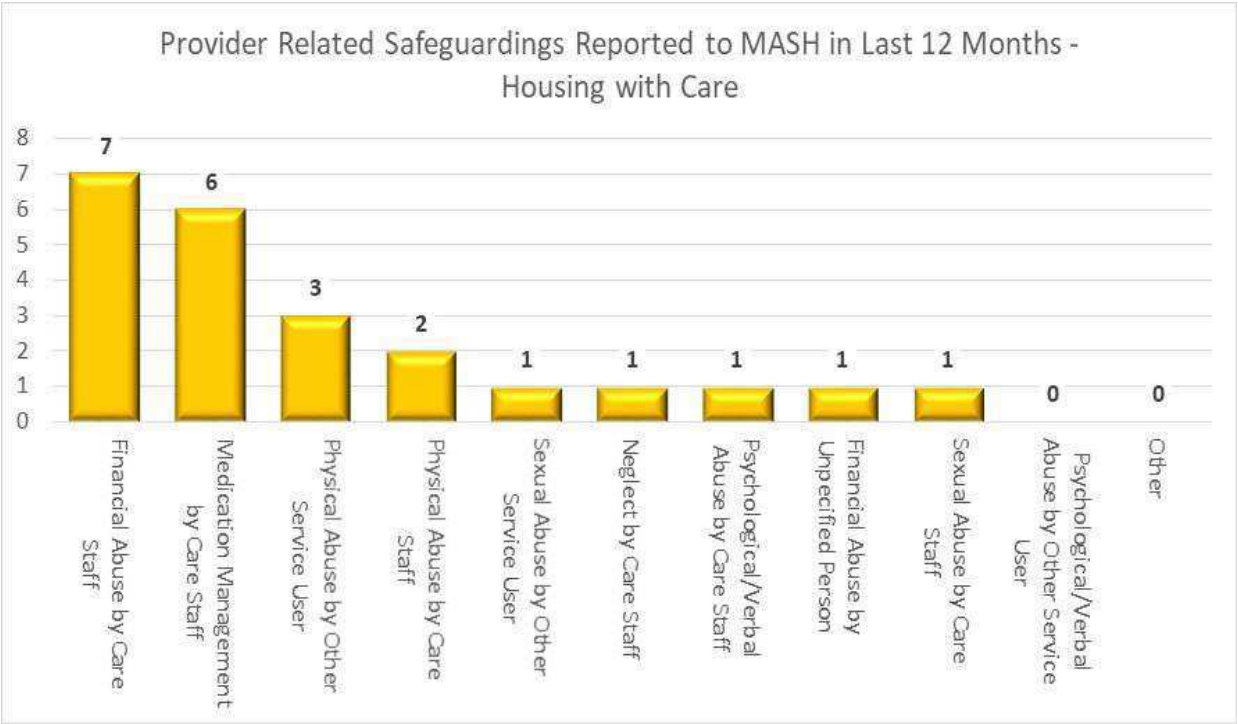
Again the most common safeguarding referral concerns resident on resident abuse

3.8.5 **Home care**



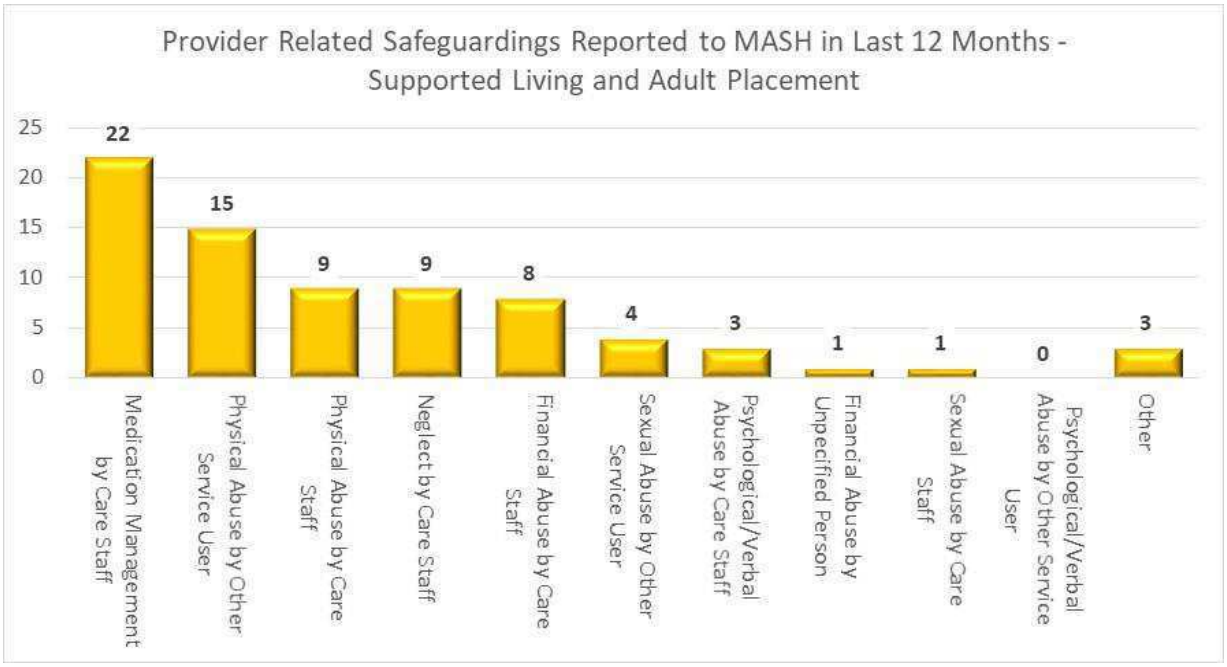
It can be seen that the biggest risks in the home care sector are in financial abuse by care workers and poor medication management.

3.8.6 **Housing with care**



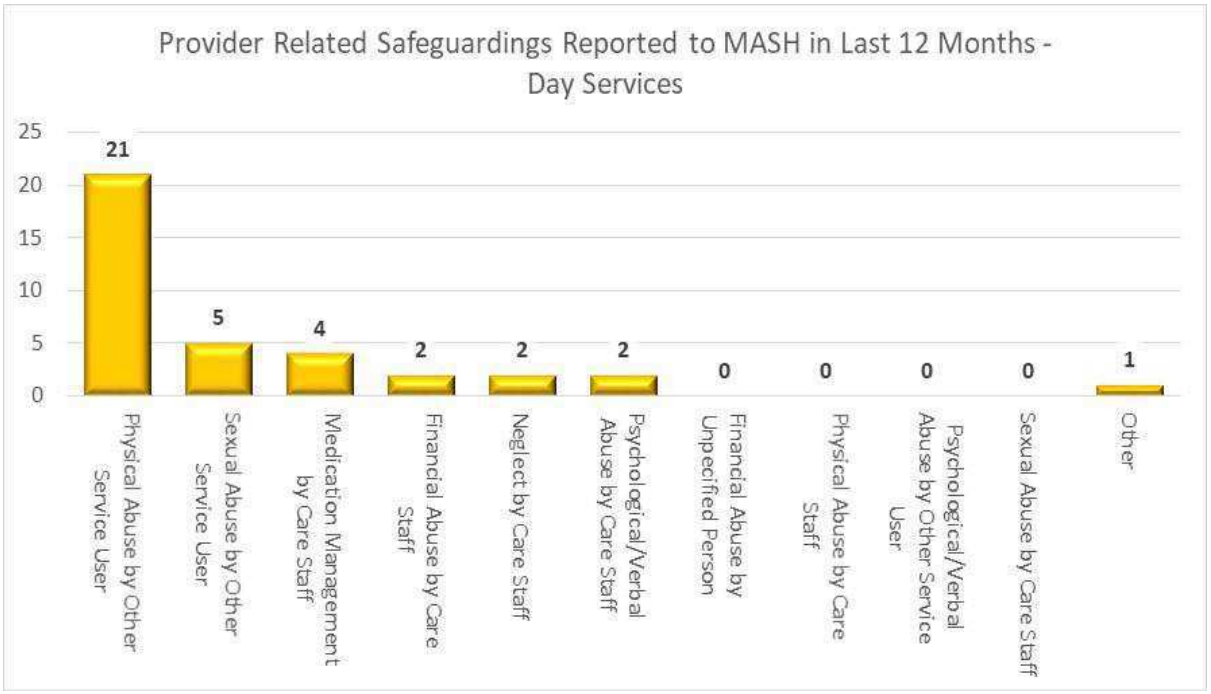
The position is similar to home care but also includes resident on resident abuse within the housing scheme.

3.8.7 **Supported living**



Medication management and physical abuse by other service user are the most common concerns in supported living together with physical abuse or neglect by care workers in supported living schemes.

3.8.8 **Day care**



Abuse by service users on other service users is the greatest concern in day services

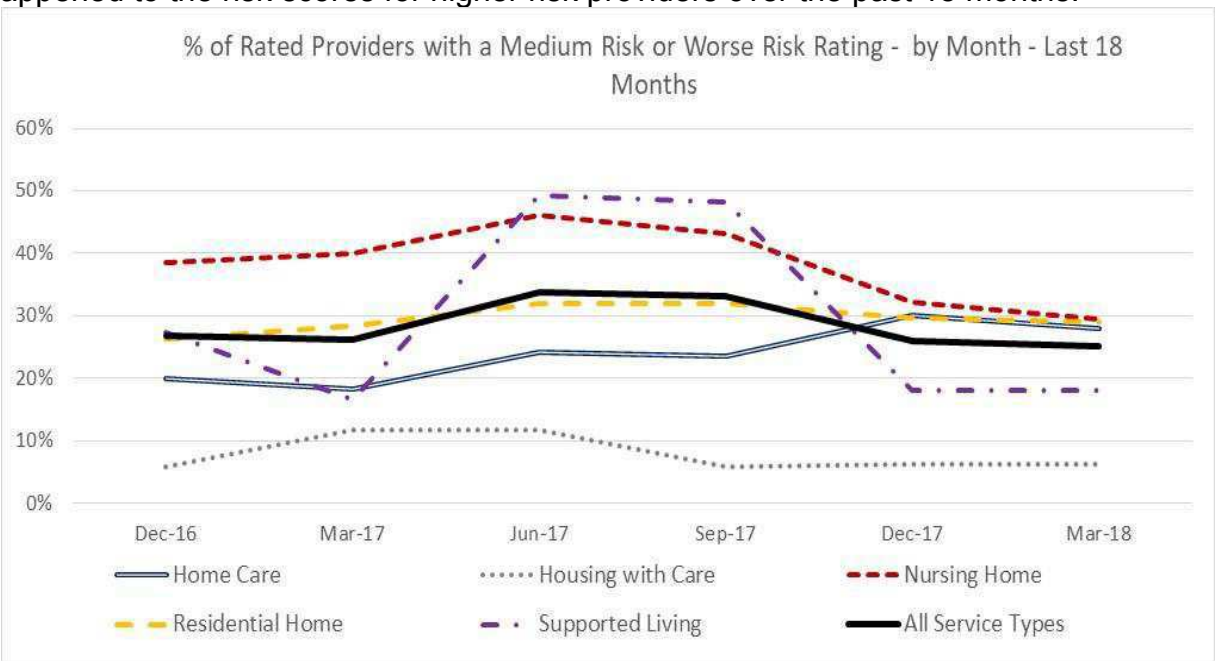
3.9 **Non safeguarding concerns**

3.9.1 The QA team also supported contract managers, commissioners and social work teams throughout the year working with a major home care provider under performance notice, supporting multiple provider failures, supporting procurement colleagues in setting quality standards for tenders and assessing tender bids. All these activities eat into the time available for proactive provider support programmes.

3.10 **Overall provider risk ratings**

3.10.1 The QA team operate the APP system that enables all intelligence about providers to be analysed to produce an overall risk score. The diagram below shows what has happened to the risk scores for higher risk providers over the past 18 months.

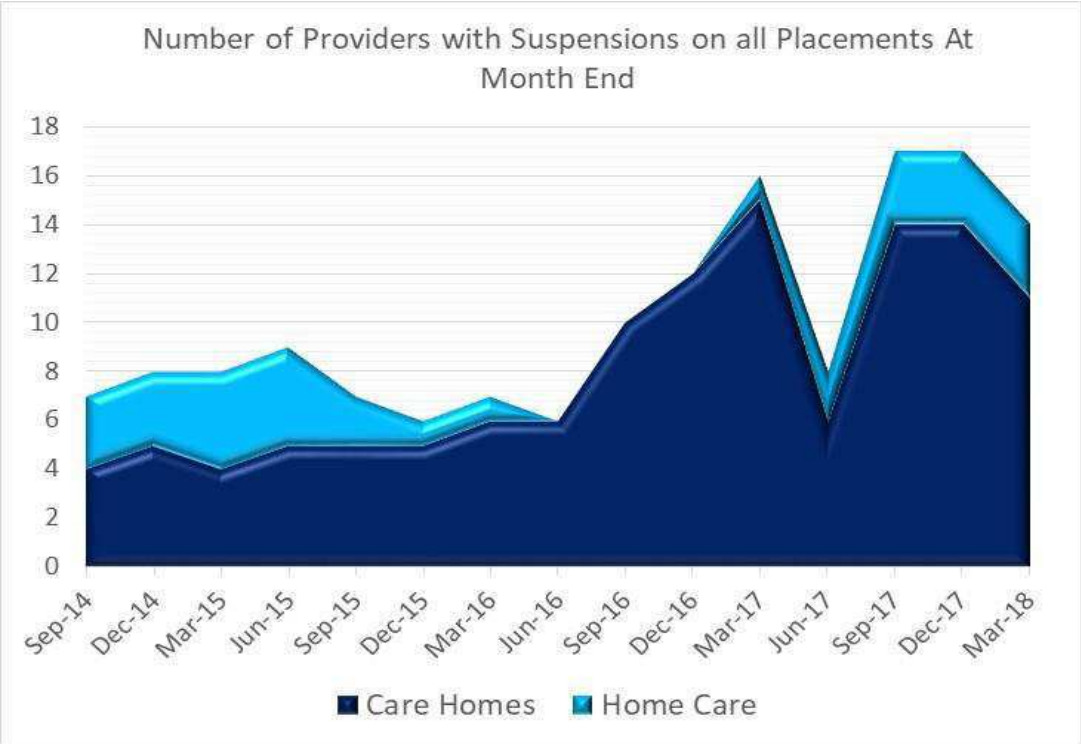
3.10.2



3.10.3 It can be seen that overall risk in the nursing home sector has reduced significantly with a very slight increase in residential care homes. Risk in home care has increased significantly and risk in supported living has fluctuated but settled at a lower rate than the beginning of the year. This performance suggests that the team is just about managing risks through its reactive programmes but has not been able to achieve significant improvement across the market that only comes through proactive work at scale.

3.11 **Suspension of placements**

3.11.1 In more serious cases the QA team will put a stop on placements. The diagram below shows the pattern of suspension on placements at month end over the past three and a half years.



3.11.2 A restriction on all placements is when the Council cannot place a service user with a care provider, usually because of serious concerns with the safety and quality of the service delivered by the provider

3.11.3 For the last 18 months there have regularly been between 10 to 15 care homes where the Council has placed a restriction on all placements.

3.11.4 The QA team works closely with providers to enable them to make the improvements required for placements to start again. Unfortunately, when one home comes off restriction another often replaces it. The continued number of care homes with suspensions on all placements requires a considerable amount of QA worker time.

3.12 **Provider loss**

3.12.1 Provider loss is an issue in the care home sector and requires QA and Operational team time when it occurs. The QA team has well tested arrangements in the event of closure and has managed ten closures over the last year with the loss of 235 beds. At the same time the private sector has built a number of new care homes, however these are all aimed at the self-funding market.

3.12.2 There has been a marked incidence of dual registered homes de-registering their nursing care and only catering for residential service users.

3.12.3 A study undertaken by the QA and Market Development team in January 2018 shows that:

Since December 2015 in Norfolk:

a) three nursing homes have closed with the loss of 69 nursing beds
b) two care homes have de-registered their nursing beds with the loss of 53 nursing beds
c) four care homes are considering or are in active discussions with the Council about de-registering their nursing beds, with the potential loss of 120 nursing beds
d) during the same period the number of people with the Council's funded nursing care has increased from 502 to 539
e) the above followed a 13-month period where five homes de-registered their nursing

Reasons given for closure/de-registration/potential de-registration included:

a) fee levels paid for nursing care not allowing financial viability/delivery of a safe nursing service
b) difficulty in recruiting nursing/care staff resulting in reliance on (expensive) agency staff.
c) high bed vacancy levels (sometimes following quality issues/restrictions on placements) causing financial viability issues

3.12.4 In nursing homes, Norfolk has significantly higher annual staff turnover than regional and national averages.

Care Workers:	Norfolk - 50%	East of England - 39%	England - 35%
Registered Nurses:	Norfolk - 40%	East of England - 32%	England - 32%

3.12.5 Collaboration with health colleagues on the quality of clinical provision happens in a number of forums; notably within the Enhanced Health in Care Homes project.
In addition, the team is entering into a Memoranda of Understanding with clinically led quality assurance colleagues to support information sharing, joint visiting and risk management.

3.13 **Securing quality at local level 2017/18**

3.13.1 As explained earlier in this report the scope for carrying out proactive work with providers has been limited and we believe that it is this work with providers that really makes the difference in quality improvement. The reactive work serves in the main to preventing further deterioration in quality.

3.13.2 The picture painted in this report is of a market which is struggling to secure further improvements in quality ratings and a market that is improving more slowly than comparable Local Authorities across the board. There continue to be particular quality issues in the care home market and there has been a decline in the rate of improvement in the home care market. The Council's RIG target of 80% of providers rated as 'good' or better appears unambitious, when compared to similar Local Authorities who are already exceeding that level of performance. A target of 85% is now needed to get Norfolk to median performance.

3.13.3 Concerns, compliance and safeguarding referrals involving care providers are running at over 2,000 per year. Proactive support to providers, who we know are struggling

through our market intelligence, has been provided by using the Market Development Fund.

3.13.4 Compared to other Local Authorities with social care responsibilities in the East of England region, Norfolk has a significantly higher number of providers resulting in higher case loads and surveillance for officers. The implementation of the regional quality tool and a review of the QA function for the market will result in a more structured approach to quality within the market and greater capacity for proactive quality work and provider performance.

4 Quality improvement programme 2017/18

A quality improvement strategy for 2017/18 was set out in the 2016/17 Annual Quality Report and the following initiatives were delivered:

4.1 Care homes

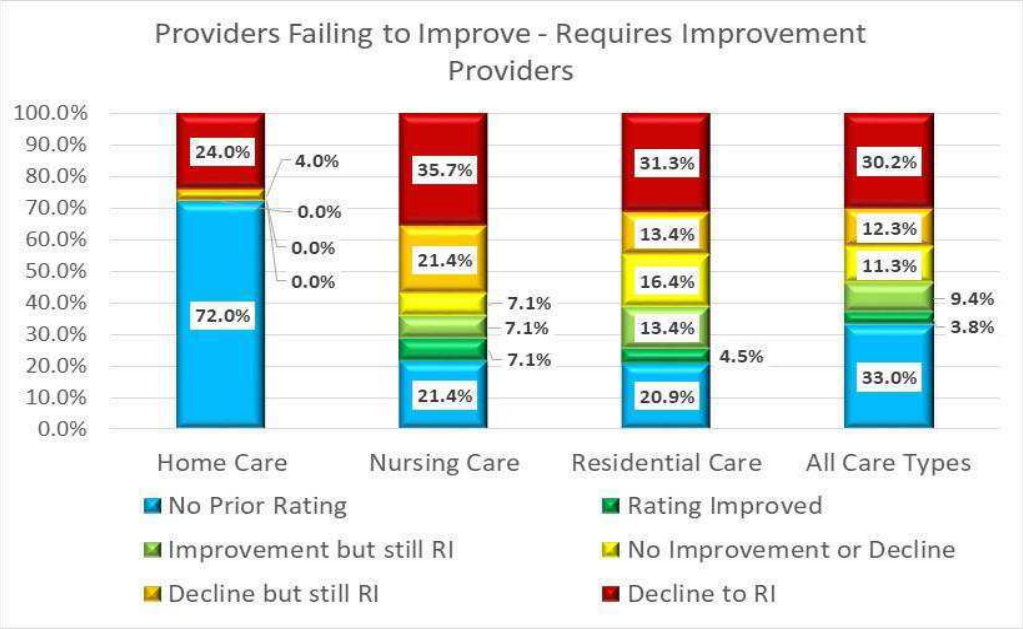
The embedding of the the Enhanced Health Care in Care Homes (EHCCH) programme has been a priority for Norfolk as part of the Better Care Fund. Significant reductions have been acheived in admissions from care homes, indicating an improvement in quality of care, however this is yet to be reflected in CQC ratings. This programme will be enhanced and expanded by additional resource deployed in 2018/19.

4.2 Using market intelligence to target quality improvement

The team was able to use its APP system to target high risk care homes. During the year, the team helped in the development of a self assessment tool that will be used as part of the 2018/19 programme.

4.3 Delivering the 'requires improvement' to 'good' (RIG) programme

The team had a modest RIG programme resourced through the Market Developmnent Fund operating throughout the year, focusing on 20 care homes who were struggling to achieve or maintain good quality. At the time of writing we are waiting for the formal evaluation of the programme and the full results. We can say, however, that there were improvements in 65% of providers who were reinspected by CQC across all five domains but this did not result in overall improvement to 'good' in all cases, we however, are expecting mixed results in line with our analysis of the shift in ratings in the market as a whole. The diagram below shows the shift in ratings over the past year:



30.2% of providers rated during the year across all care types who started the year rated good were downgraded to requires improvement. This trend is most noticeable in residential and nursing care but is beginning to happen in the home care sector also.

32.6% of providers rated during the year who began the year rated as' requires improvement', failed to improve to a 'good' rating. Only 3.8% of providers rated during the year improved their rating.

4.4 **Promoting the Harwood Care Charter**

The team has re-promoted the use of the charter card and highlighted the charter at the Care Convention. Take up by providers has, however, remained low and we will need to re-think the effectiveness of this particular way of promoting person centred care with a proposal to embedding the principles in future contracts

4.5 **Using service user feedback**

We introduced customer satisfaction surveys in some of the home care market during 2016/17. At the time of writing early results are being evaluated.

4.6 **Delivering a sector skills plan to support the workforce**

A sector skills plan has been developed together with a free to use website that links people who want to work in the care market with providers who have vacancies. It is clear, however, that more will need to be done to tackle the very challenging recruitment and retention picture in the market.

4.7 **Investing in and engaging with the care market**

Good progress had been made in implementing our market engagement strategy as well as engaging providers in developing cost models for use in the home care market. The provider dialogue process in which we work with providers to agree inflationary pressures has worked well and has underpinned our fee uplift proposals, ensuring that providers are sustained and able to focus on provision of quality services.

4.8 **Innovative commissioning, market shaping and integration approaches**

Commissioners increasingly take a quality based approach to the procurement of new services; sourcing services solely on price does not support quality in the market for social care.

Management of the market to support an optimum number of quality providers is proactively being taken in the home care market and is currently being explored in the residential and day care market. This approach is expected to yield an improvement in the quality of overall provision but it is too early in the cycle to tell at this time.

4.9 **Care Convention**

A new style Care Convention was successfully held in November 2017, bringing together providers and consumers of care for the first time. Quality of care was to the fore in the speeches and discussions that took place throughout the day.

In 2018/19 the organisation and promotion of care and carers is increasingly being managed by care providers themselves, which again promotes awareness of the importance of this sector and the quality of provision.

4.10 **Norfolk care awards**

The Council supported the celebration of high quality care at the annual Care Awards event that took place in February 2018. This event showcases the very best practice in the market and enables the Council to promote best practice and recognise top quality care.

4.11 **Review of QA function**

An external review of the QA function was carried out during the year. This review will feed into a fundamental review of QA arrangements and capacity as part of the overall review of the commissioning function which is expected to be completed later in the year.

5. Quality improvement programme 2018/19

5.1 The Council must continue to respond to ongoing complaints, concerns and safeguarding referrals in a proportionate and effective manner to avoid deterioration in quality, address the concerns of individuals, minimise reputational damage, and in the most serious cases minimise the risk of legal challenge. It is clear from evaluating other Councils in the region and seeking advice through the regional networks that the most effective way to improve quality is through a structured risk-driven proactive inspection programme that drives improvement planning and implementation.

We are realigning the team to focus on delivering a programme supported by the use of the regional quality improvement tool known as Provider Assessment and Market Management System (PAMMS).

5.1.1 **PAMMS proactive inspections**

Within existing resources the QA team will use its two Market Assurance Officer posts to focus exclusively on a proactive risk driven programme targeting and working with providers to help them improve CQC ratings. Additional resources will be focused on securing further 1.5 full time equivalent Market Assurance Officer posts for 12 months to focus exclusively on proactive inspections.

These staffing resources will be used to target providers identified at greatest risk of poor quality scores. They will use the regional PAMMS quality inspection and rating tool to proactively work with providers focusing in on the precise areas that need improvement. The officers will rate providers both before and after the support that we will provide. In a full year we estimate that up to 140 providers can be supported.

The Market Assurance Officers will focus on 40 care homes who are at greatest risk of failing to improve from their current ‘improvement’ rating to a rating of ‘good’ and some homes who are at risk of slipping back to a ‘requires improvement’ rating from a rating of ‘good’.

While the new proactive inspection team represents the most radical change in direction regarding quality improvement the following improvement initiatives are also planned for 2018/19:

5.1.2 **Enhanced health care in care homes programme (EHCCH)**

The EHCCH programme has demonstrated excellent results in driving down admissions to hospital from care homes; this improvement demonstrates the improvements in care that occurred. We will continue with the EHCCH programme to further support the care home sector and support them to demonstrate these improvements.

5.1.3 **Skills for Care registered managers networks**

We know that good leadership through registered managers is key to achieving and maintaining high quality services. Skills for Care provide support to registered managers through a networking programme that enables these key leaders to share best practice and provide mutual support. We have negotiated a very favourable rate with Skills for Care that will enable all registered managers to benefit from this support at no charge to providers.

5.1.4 **Customer feedback programme**

We will carry out surveys of all service users in receipt of care services in a new customer feedback programme focussing initially on home care and care homes and use this to help identify areas for improvement and to target providers who are not performing well.

5.1.5 **Care Association**

We are working with key organisations in the market to establish a Care Association for Norfolk which is intended, among other things, to help members improve quality and sustainability. A formal Care Association will help promote and develop the highest standards of care.

5.1.6 **Reshaping the care market**

The nature of the care market in Norfolk itself provides challenges of a different nature and scale compared to many other local authority areas.

For example, Norfolk has a residential and nursing care market which is dominated by a very large number of non-purpose-built care homes (90% of all provision) that can be difficult or economically non-viable to improve to modern standards and this can reflect in CQC ratings.

Carer turnover rates are higher in Norfolk than anywhere else in the Eastern region and this impacts on continuity of care which impacts on CQC ratings. We are working with New Anglia, the Local Enterprise Partnership to implement our workforce and skills plan as well as developing a broader long-term strategy to tackle the need for significant investment in a new care estate in Norfolk.

5.1.7 **Commissioning and market shaping framework**

The Committee has already approved the commissioning and market shaping framework and we are now in the process of implementing the framework through a three-year prioritised programme of market shaping. The process will focus on the outcomes that people want, the achievement of which is key to how care consumers perceive quality. In addition to this, using the best market intelligence, the process will result in a better balance of supply and demand and right-sizing all key market segments, so that we do not have an excessive number of regulated providers and without infringing our duties regarding choice.

5.2 **In addition to these actions the following will be continue as business as usual:**

Using market intelligence to target quality improvement
Promoting the Harwood Charter through the contracting process
Driving up focus on workforce through the realigning of the team
Investing in and engaging with the care market