Adult Social Care Committee

Item No……

Report title:	**Performance management report**
Date of meeting:	**6 March 2017**
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 presents current performance against the committee's vital signs indicators, based upon the revised performance management system which was implemented as of 1 April 2016.

A full list of indicators is presented in the committee's performance dashboard.

Detailed performance information is available by exception for indicators that are off-target, are deteriorating consistently, or that present performance that affects the council's ability to meet its budget, or adversely affects one of the council's corporate risks. The following indicators are reported as exceptions on this occasion:

a. Number of days delay in transfers of care per 100,000 population (attributable to social care) (off target)
b. % People receiving Learning Disabilities services in paid employment (off target)
c. % People receiving Mental Health services in paid employment (off target)
d. Decreasing the rate of admissions of people to residential and nursing care per 100,000 population (65+ years) (off target)

The report also includes benchmarking information which compares Norfolk's performance to that of our "family group" – a collection of 15 other local councils that the Care Quality Commission (CQC) considers to have similar characteristics to Norfolk and are therefore our best comparators for performance. The annual benchmarking report is included in **Appendix 2**.

Recommendations

With reference to section 3, for each vital sign that has been reported on an exceptions basis, Committee Members are asked to

a. Review and comment on the performance data, information and analysis presented in the vital sign report cards and in the Benchmarking report presented in Appendix 2
b. Determine whether the recommended actions identified in the vital signs report cards are appropriate or whether another course of action is required.

In support of this, Appendix 1 provides:

a. A set of prompts for performance discussions
b. Suggested options for further actions where the committee requires additional information or work to be undertaken

1 Introduction

1.1 This performance monitoring report provides the most up to date performance data available, to the end of period 9 (December 2016).

2 Performance dashboard

2.1 The performance dashboard provides a quick overview of Red/Amber/Green rated performance across all vital signs over a rolling 12 month period. This complements our approach to exception reporting, and enables committee members to check that key performance issues are not being missed.

2.2 The dashboard is presented below.

2.3 Adult Social Services Dashboard

Note: results without alerts/colouring denote where targets have not yet been set – in this case because new indicators have been developed.

Monthly	Bigger or Smaller is better	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Target
% of people who require no ongoing formal service after completing reablement	Bigger	86.2%	86.5%	86.3%	87.2%	91.8%	89.9%	89.1%	89.4%	91.6%	92.9%	91.0%	91.9%		
Decreasing the rate of admissions of people to residential and nursing care per 100,000 population (18-64 years)	Smaller	22.5	22.5	21.7	21.1	19.7	18.7	17.7	18.3	17.0	16.6	16.6			**18.2**
Decreasing the rate of admissions of people to residential and nursing care per 100,000 population (65+ years)	Smaller	622	617	623	616	622	614	613	613	621	630	637			**590**
Decreasing the rate of people in residential and nursing care per 100,000 people	Smaller	567	564	565	567	568	562	558	558	555	558	563	562		
Increasing the proportion of people in community-based care	Bigger	66.5%	66.7%	66.8%	66.7%	66.7%	66.9%	67.1%	67.1%	67.2%	67.1%	66.7%	66.4%		
Decreasing the rate of Council service users per 100,000 population (18-64 years)	Smaller	928	929	936	935	937	940	939	937	938	941	937	935		
Decreasing the rate of Council service users per 100,000 population (65+ years)	Smaller	3,495	3,505	3,523	3,516	3,531	3,497	3,496	3,494	3,479	3,486	3,479	3,433		
% of people still at home 91 days after completing reablement	Bigger	91.4%	91.7%	90.7%	92.2%	91.9%	93.3%	94.3%	93.2%	94.5%	94.1%	93.0%			**90.0%**

Number of days delay in transfers of care per 100,000 population (attributable to social care)	Smaller	1.5	1.5	1.5	2.9	2.6	2.4	2.6	3.0	3.1	3.1	3.1			**1.5**
% People receiving Learning Disabilities services in paid employment	Bigger	3.6%	3.6%	3.7%	3.3%	3.3%	3.2%	3.2%	3.3%	3.3%	3.3%	3.3%	3.3%		**3.8%**
% People receiving Mental Health services in paid employment	Bigger	1.9%	1.8%	2.1%	1.9%	2.1%	2.3%	2.3%	2.3%	2.3%	2.3%	2.3%	2.3%		**3.2%**
% Enquiries resolved at point of contact / clinic with information, advice	Bigger	37.2%	39.6%	42.3%	34.0%	36.2%	35.5%	37.4%	33.3%	37.2%	37.1%	37.3%	36.5%		
Rate of carers supported within a community setting per 100,000 population	Bigger	658	662	647	604	602	607	598	598	589	586	591	588		
% of CQC ratings of all registered commissioned care rated good or above	Bigger	56.9%	56.7%	56.9%	60.6%	61.2%	62.9%	65.0%	68.0%	69.2%	69.7%				
% Social care assessments resulting in solely information and guidance	Bigger	10.9%	13.4%	11.1%	13.0%	9.0%	14.2%	9.7%	14.2%	9.2%					

*Because targets are 'profiled' over the year, and so change every month to reflect the change that is required over time, it is possible for the performance alert to change without the result changing

3 Report cards

3.1 A report card has been produced for each vital sign. These provide a succinct overview of performance and outlines what actions are being taken to maintain or improve performance. The report card follows a standard format that is common to all committees.

3.2 Each vital sign has a lead officer, who is directly accountable for performance, and a data owner, who is responsible for collating and analysing the data on a monthly basis. The names and positions of these people are clearly specified on the report cards.

3.3 Vital signs are to be reported to committee on an exceptions basis, with indicators being reported in detail when they meet one or more criteria. The exception reporting criteria are as follows:

- Performance is off-target (Red RAG rating or variance of 5% or more)
- Performance has deteriorated for three consecutive months/quarters/years
- Performance is adversely affecting the council's ability to achieve its budget
- Performance is adversely affecting one of the council's corporate risks

3.4 The report cards for those vital signs that do not meet the exception criteria on this occasion, and so are not formally reported, will be made available to view through Members Insight. To give further transparency to information on performance, for future meetings it is intended to make these available in the public domain through the Council's website.

3.5 These will then be updated on a quarterly basis. In this way, officers, members and the public can review performance across all of the vital signs at any time.

3.6 The four report cards highlighted in this report are presented below (with the reason they are presented here 'by exception' in brackets):

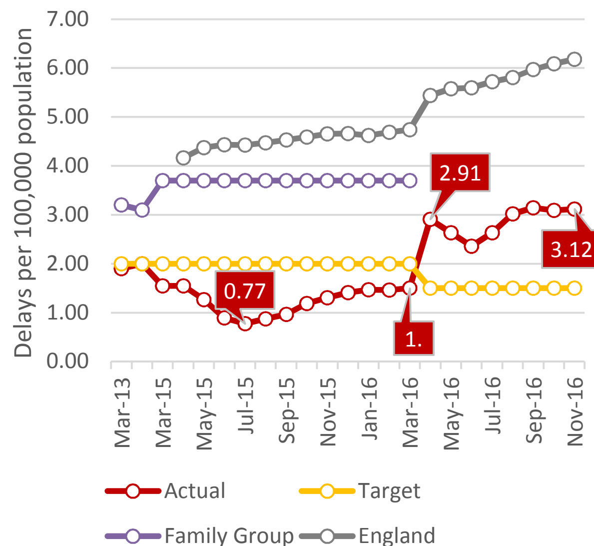
a. Number of days delay in transfers of care per 100,000 population (attributable to social care) (off target)
b. % People receiving Learning Disabilities services in paid employment (off target)
c. % People receiving Mental Health services in paid employment (off target)
d. Decreasing the rate of admissions of people to residential and nursing care per 100,000 population (65+ years) (off target)

3.7 Number of days delay in transfers of care per 100,000 population (attributable to social care)

Why is this important?

Staying unnecessarily long in acute hospital can have a detrimental effect on people's health and their experience of care. Delayed transfers of care attributable to adult social services impact on the pressures in hospital capacity, and nationally are attributed to significant additional health services costs. Hospital discharges also place particular demands on social care, and pressures to quickly arrange care for people can increase the risk of inappropriate admissions to residential care, particularly when care in other settings is not available. Continuing Norfolk's low level of delayed transfers of care into appropriate settings is vital to maintaining good outcomes for individuals and is critical to the overall performance of the health and social care system. This measure will be reviewed as part of Better Care Fund monitoring.

Performance



What explains current performance?

- In April 2016 the number of delays per 100,000 of population nearly doubled when compared to the previous month, dropping off slightly in the subsequent months and then rising to a record high in September 2016 (3.14) before levelling off
- The rise appears to have largely been driven by a sharp jump in delays attributable to social care from the Norfolk & Norwich University Hospital – from a baseline of zero prior to April, to over 200 in April, May and July. June delays returned to zero before rising to 261 in September, dropping to 139 in November
- Since April 16 the NNUHFT has been conducting significant changes to its internal pathways to reduce pressure on their A&E department and to recover the '4 hour target'. These changes have increased the pace of discharge resulting in an increase in referrals to social services
- The NNUHFT has increased its number of Continuing Health Care Nurses to increase the number of CHC reviews completed and reduce CHC related delays. Due to this, the number of CHC cases requiring support from a Social Worker has increased and has placed increased pressure on the social work team based at the NNUHFT and may be contributing to higher DTOC
- The NNUHFT regularly, but unpredictably, escalates to BLACK alert in response to pressure within the hospital. This results in a spike of referrals to the social services discharge team. This spike can take a short while to reduce and can cause some patients to be delayed
- The NNUHFT has set up a discharge hub and employed a new team to support their discharge process. It has taken a short while for this team to learn the process and has resulted in recording errors. A daily process to validate delays is now in place
- The NNUHFT has conducted a quality improvement programme known as Red2Green which aims to improve patient flow through the hospital. As a result, the hospital is identifying patients suitable for discharge at a higher rate than before

What will success look like?

- Low, stable and below target, levels of delayed discharges from hospital care attributable to Adult Social Care, meaning people are able to access the care services they need in a timely manner once medically fit

Action required

- Continue priority actions in partnership with health services to ensure timely discharges from hospitals into appropriate care settings through integrated discharge arrangements: whilst ensuring cost effective and appropriate solutions are found
- Trialling a change in practice where discharges can happen while the Free Nursing Care (FNC) decision is ratified and processed, rather than current process which is to wait until afterwards. This should have a positive impact on DTOC
- ICT changes and upgrades at inpatient units allow Social Workers to complete records and paperwork on site, making the inpatient units fully integrated sites and help staff to be fully mobile. ICT upgrade to connection has happened with full access expected by December 2016.this assists overall flow and capacity
- Review and re-enforce re-enablement first following acute care pathways and no permanent placements from hospital

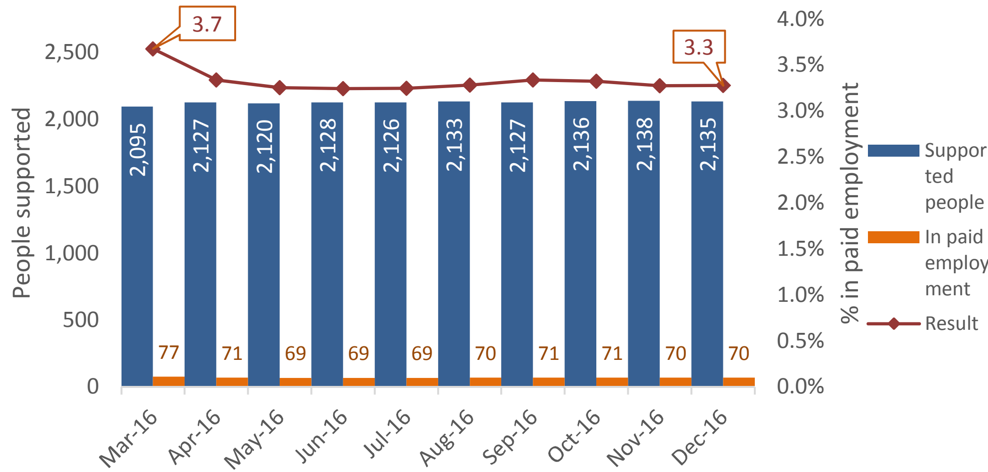
Lead: Lorrayne Barrett, Director of Integrated Care Data: Business Intelligence & Performance Team

3.8 % People receiving Learning Disabilities services in paid employment

Why is this important?

Research and best practice shows that having a job is likely to significantly improve the life chances and independence of people with learning disabilities, offering independence and choice over future outcomes. Furthermore this indicator has been identified within the County Council Plan as being vital to outcomes around both the economy and Norfolk's vulnerable people. Norfolk has a low rate compared to other councils.

Performance



Month	In voluntary employment
Jul-16	56
Aug-16	63
Sep-16	72
Oct-16	76
Nov-16	81
Dec-16	82

What is the background to current performance?

- Historically Norfolk's performance kept pace with the family group average, even during the recession, but poor performance means Norfolk is now significantly below the family group average percentage of 5.1% (Feb 16)
- We know that there is a "ceiling" of people who could possibly be in employment of around 9% since about 91% of people receiving LD services are classed as "not seeking work/retired"
- Current data shows 160 service users recorded as seeking work. Further analysis shows that some service users are being supported to seek employment, and others are volunteering. Some individuals would like to be in employment but will need a higher level of support to achieve this
- Some service users are not looking for employment and records therefore need to be updated

What will success look like?

- Meet targets to exceed the previous highest rate (2013/14), with 'steeper' improvement in 17/18 and 18/19 to reflect the timing of the planned review of day services
- Targets of 5% by end of 16/17, 5.3% by 17/18 and 7.5% by 18/19

Action required

- Providers contacted to ensure those seeking work are supported to meet this objective-work underway and is near completion
- Review of day service providers underway to ensure that providers who say they provide support for people to find work do so This will take 3-6 months. Following this review we will ensure effective contractual arrangements support targets with providers offering employment / work related / volunteering.
- OWLs (Opportunity, Work and Learning) project now has the full support of CLT and is progressing
- The NCC employment support service for LD, Match, is working to identify the barriers to finding employment
- NCH&C looking at how they can offer work experience / shadowing / apprenticeships / employment to people with a learning disability, building on successful approaches used elsewhere in the NHS and the Trust will seek to work with local voluntary organisations. NHS Employers have agreed to provide some support to the Trust to run this project
- Build on success of approaching employers directly rather than applying on the open market. Build a community approach-hold local events to encourage employers to pledge work experience/voluntary work
- Continued emphasis on using strengths based practice at reviews and during transition to emphasise the importance of accessing employment/work based activities. Share good practice in teams
- Further work needed to ensure literacy and maths requirements are not a barrier to accessing apprenticeships

Responsible Officers

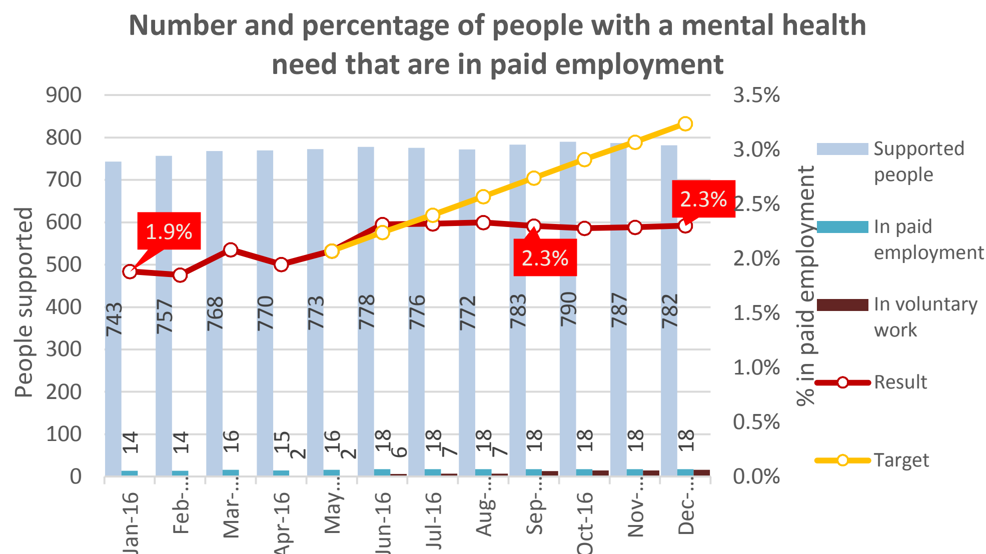
Lead: Lorrayne Barrett, Director of Integrated Care Data: Business Intelligence & Performance Team

3.9 % People receiving Mental Health services in paid employment

Why is this important?

Research and best practice shows that having a job is likely to significantly improve outcomes for people with mental health needs, offering independence and improving mental wellbeing.

Performance



What is the background to current performance?

- The number of people receiving mental health services who are in paid employment has remained static at 18 (2.3%) since June 2016
- An ambitious target has been agreed which increases each month and reaches 3.74% (32 people) by the end of March 2017
- The Mental Health service is seeing an overall reduction in service users receiving a funded service
- Service users seeking work may no longer meet Care Act eligibility. They may progress onto work but this is not captured in service performance figures
- The number of people in voluntary work or training and work related activities has been recorded since April 2016. Since then, numbers have almost doubled. There are now 25 people engaged in these activities. Volunteering, training and work related activities can be a precursor to opportunities in paid work

What will success look like?

- People receiving mental health services who want to work will be in employment, using funded or non-funded services to achieve their goals
- People who take part in meaningful activities and the structure gained from work related activities, training or volunteering will benefit from an improvement in their well being and require less formal social care support
- Market development will be stimulated to provide more choice into employment for people receiving mental health services

Action required

- Team managers carry out monthly checks to ensure that each service user has an employment status recorded on their record. This includes volunteering, training and work related activity
- Personal budgets are being scrutinised at assessment / review to ensure that if someone wants to work their personal budget reflects this and that support is commissioned to support this outcome
- Links are being made across organisations, such as with the Worklessness Development Officer who identifies employment and training opportunities within community resources and networks
- Information arising from reviews of personal budgets will be used to commission new schemes to help people into work or training
- A recent small sample of case closures identified that 1 person out of 10 had gained employment and no longer wished to receive care and support
- Closer links are being forged with the local NHS mental health trust to promote recovery through employment. A course is under development which will impact on the statutory return of service users subject to CPA and gaining employment

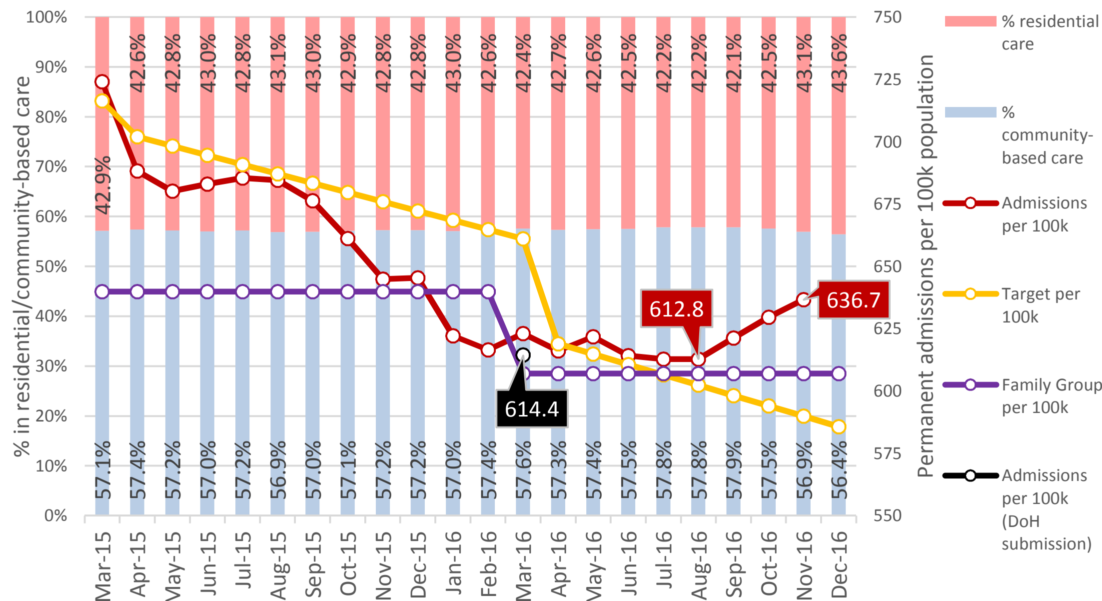
Responsible Officers	Lead: Alison Simpkin	Data: Business Intelligence & Performance Team

3.10 Decreasing the rate of admissions of people to residential and nursing care per 100,000 population (65+ years)

Why is this important?

People that live in their own homes, including those with some kind of community-based social care, tend to have better outcomes than people cared-for in residential and nursing settings. In addition, it is usually cheaper to support people at home - meaning that the council can afford to support more people in this way. This measure shows the balance of people receiving care in community- and residential settings, and indicates the effectiveness of measures to keep people in their own homes.

Performance



What is the background to current performance?

- Historically admissions to residential care have been higher than Norfolk's family group average, however we are expecting to be more in line based on improved year-on-year reductions
- Significant improvements in the last four years has seen the rate of admissions per 100k reduce from 823 in 2012/13 to a low of 613 (August 2016). The subsequent increase took admissions per 100k to the highest point (636.7) since December 2015 and has diverged from the target, which is moving downwards
- Some increases in admissions per 100k are driven by pressures on acute hospitals, particularly regarding delayed transfers of care.
- This has had an impact on overall placements, with the residential care population increasing from 42.1% in September 2016 to 43.6% now (December 2016)
- Reductions had been driven by improvements to:
  - Reablement services
  - Improvements to the hospital discharge pathway
  - Improved 'strength based' social care assessments
- Reductions in % residential care placements don't keep pace with admissions because the average length of stay of someone aged 65+ is around 2.3 years

What will success look like?

- Admissions to be sustained below the family group benchmarking average
- Subsequent sustained reductions in overall placements
- Sustainable reductions in service usage elsewhere in the social care system (see 'Reduced service use' Vital Signs Report Card)

Action required

- Reductions in admissions for 65+ must be sustained through good social care practice
- Commissioning activity around accommodation to focus on effective preventative interventions such as reablement, sustainable domiciliary care provision, and improved Housing With Care options for those aged 65+
- Monitor admission levels to identify if the recent increase becomes a trend
- Review use of Planning beds and implement actions to reduce conversion to long term placement
- Re-enforce reablement and therapy first processes to prevent unnecessary admission to long term residential care

Responsible Officers	Lead: Lorrayne Barrett, Director of Integrated Care, and Lorna Bright, Assistant Director Social Work	Data: Business Intelligence & Performance

The impact of ‘whole system’ pressures on performance in delayed transfers of care and residential admissions for people aged 65+

3.11 The specific details and actions to address performance levels for Delayed Transfers of Care and residential care admissions are covered in the report cards in sections 3.7 and 3.10.

In addition, it is important to highlight that the levels of performance described in the report cards are linked, and are driven to a significant extent, by pressures in the overall health and social care system and market, and in particular in acute hospitals.

3.12 Current winter pressures, specifically unplanned hospital admissions, are well documented and understood, with a developing narrative based around record Accident & Emergency admissions and waits, hospital capacity and “bed blocking” dominating national news coverage.

3.13 These explanations reflect Norfolk’s experience. Above-target rates of hospital admissions and whole-system delayed discharges (so those attributable to health as well as to social care) have meant that local acute hospitals have been operating at-or-around capacity, and at ‘black alert’ level on a number of occasions, in recent months.

3.14 Pressures within hospitals and within the wider social care market can lead to excess admissions to residential and nursing care.

The need to free up hospital beds puts social care teams under pressure to find the right support for people who are ready to be discharged but who have an eligible social care need.

Finding the right care package can be challenging. To ensure the best outcomes for people in the long term it is usually best to arrange care, where appropriate, in their own homes. However a lack of availability of home care, particularly in some rural areas, means that it can be difficult to guarantee a safe and supported discharge home quickly. When this happens pressure builds to discharge people into whatever safe setting is available, which in Norfolk tends to mean residential care.

It is possible to put in place measures to allow for a more considered approach to ensuring people get the right care package, particularly when residential care is not the ideal long term solution. In Norfolk this takes the form of ‘planning beds’, usually within temporary residential settings outside of hospitals, that give patients more time to recover, and more time for services to be put in place. However, these are not an ideal solution: depending on individual circumstances, planning beds can increase the likelihood of people losing their strength, and thus reducing their chances of recovery. Overall, people who go from hospital into a planning bed are more likely to go on to receive permanent residential care than those who are able to be discharged into their home.

3.15 These factors are reflected in Norfolk's experiences and data.

Winter pressures have had a significant impact on overall long term admissions to residential and nursing care. In the last two years, quarter 3 (September – December) long term admissions to residential and nursing care have risen significantly, with planning bed usage in the same periods increasing at an even faster rate.

Looking more closely at the data that make up these figures we can see that:

- The Northern Locality, where the availability of homecare is known as a particular problem, accounts for over half of all planning beds commissioned by locality teams, over a quarter of all planning beds county-wide, and around a quarter of all long term residential and nursing care placements across the system.
- Hospitals teams account for around 40% of all commissioned planning beds; and the NNUH, where delayed transfers of care have grown the most, account for the majority of planning beds commissioned by hospital teams.

It's important to note that these factors don't account for all of the increases in residential care placements: there are increases in placements throughout all localities, including those less affected by hospital pressures and market issues. Nevertheless it is clear pressures are felt more acutely in areas where there are pressures caused by delayed discharges and the reduced availability of non-residential care packages.

3.16 When considering the council's approach to these issues, a skilful balance needs to be struck based on the needs of the patient/service user and the system as a whole. On one hand unnecessarily prolonged hospital stays lead to poor outcomes for people, and reduce the likelihood of recovery; and on the other, inappropriate admissions to residential care tend to result in similarly poor outcomes in the longer term, with a significantly higher risk of dependence on formal social care services. In terms of the system as a whole an unnecessary delayed discharge costs hospitals capacity and money, just as unnecessary residential placement places a financial burden on Adult Social Services.

3.17 In recognition of these challenges, the council works with hospitals and care providers on a daily basis to balance the needs of patients, service users and the system as a whole to try and ensure good outcomes and a fair distribution of risks and costs. Our strong and growing reablement offer helps us to get people back on their feet and home whilst reducing the risk of readmission. In addition we are working with colleagues throughout the NHS and the care market locally to develop new ways to help people to move swiftly on from hospital, and are trialling new methods of quickly assessing and discharging people (called 'Discharge to Assess'). Where people receive these provisions we know that results are good – for example those receiving reablement have a high chance of remaining independent. However we also know, through the increased use of planning beds during autumn and winter, that sometimes there is not enough reablement capacity or other provisions to manage spikes in demand.

3.18 In considering our immediate actions, it is important to highlight that performance improvements in one of these areas may require a trade-off in the other. The council's current spike in residential and nursing home admissions reflects significant pressures from acute hospitals, and on the care market as a whole, and is contributing to significant budget pressures. However, any short term efforts to reduce these risk increasing delayed discharges. Equally a focused approach to reducing delayed discharges may result in increased admissions to planning beds, or to short or long term residential care. Improvement efforts will continue to take a whole-system approach to balancing pressures, working in partnership with NHS colleagues and care providers.

Benchmarking

3.19 Appendix 2 contains the 2015/16 benchmarking report for Adult Social Care. This report presents benchmarking information for Norfolk Adult Social Care for the year 2015/16 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.

3.20 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.

3.21 **Key findings: services for 18-64 year olds**

By comparing ourselves to other similar councils, we can see that Norfolk has a comparatively high rate of referrals into short term care from hospital for those aged 18-64 (our rate per 100,000 population is the second highest in our family group). Consequently, we can also see when we compare our performance to our family group that Norfolk has a comparatively high rate of people in receipt of long term support aged 18-64 (our rate per 100,000 population is the second highest in our family group).

Norfolk also has the joint highest number of people in this age range being admitted to permanent residential or nursing care which accounts for some of the large number of people supported in long term care. In assessing our benchmarked position for this indicator it is important to note that, whilst Norfolk continues to have significant room for improvement, its relative position compared to its comparator councils has improved markedly in recent year. 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 groups. The rate reduced to 44.9 in 2013/15 and to 30.7 in 2014/15, and within this context Norfolk's rate of 18 in 2015/16 represents a continued reduction that should see us move towards our stated ambition of achieving at most our family group average rate.

3.22 **Key findings: services for 65+**

When compared to the rest of England and our family group, Norfolk has very high levels of short term support but lower levels of long term support. This suggests that the short term support we are providing to maximise independence is working by reducing the need for long term support. Our rate of people aged 65+ admitted to permanent residential or nursing care, although still comparatively high, has continued to decrease since 2013/14 and we are closer to our family group average than we have been, having decreased our figure by 15% when compared to 2014/15. We are performing comparatively well in the effectiveness of reablement for those aged 65+, and we are now top of our family group and performing significantly above the national average for the percentage of people still at home 91 days after discharge from hospital.

3.23 **Key findings: enhancing quality of life**

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

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

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 gone down by 2%, but remains above the family group, regional and national averages.

The second reports on the people stating whether they feel they have control over their daily life. Norfolk's result of 78.2% of people who feel they have control over their daily life represents a continued fall from 85.2% in 2013/14 and 80.8% in 2014/15. Nevertheless this reduction has accompanied a nationwide reduction in scores meaning that, as with the previous measure, Norfolk's lower score remains above its family group, regional and national averages.

The third reports on overall satisfaction of people who use services with their care and support, and shows that 67.6% of respondents were satisfied. Again performance has reduced, by 0.7% compared to 2014/15, but again this continues to place Norfolk above family group, regional and national averages.

The remaining indicators within the 'Quality of life' section measure the percentage of service users with a learning disability in paid employment, and the percentage of service users with a learning disability living in their own home or with family. Our comparative performance in both areas has worsened and has seen a drop in Norfolk's rankings, meaning that we're below the national and family group averages in both measures.

3.24 **Key findings: other indicators**

Some other key headlines from the report are:

- An increase in the percentage of people who use services who feel safe, albeit at a level below regional, national and family group averages;
- A reduction, from an already comparatively low result last year, in the percentage of people who say that Adult Social Care services make them feel safe and secure
- A further reduction, from a below-average positon, in the proportion of people that find it easy to find information about services.

3.25 The full benchmarking report is available in appendix 2.

4 Financial Implications

4.1 There are no significant financial implications arising from the development of the revised performance management system or the performance monitoring report.

5 Issues, risks and innovation

5.1 There are no significant issues, risks and innovations arising from the development of the revised performance management system or the performance monitoring report.

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:

Officer name :	**Tel No. :**	**Email address :**
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Jeremy Bone	01603 224215	jeremy.bone@norfolk.gov.uk

If you need this report in large print, audio, braille, alternative format or in a different language please contact 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

Appendix 1

Performance discussions and actions

Reflecting good performance management practice, there are some helpful prompts that can help scrutinise performance, and guide future actions. These are set out below.

Suggested prompts for performance improvement discussion

In reviewing the vital signs that have met the exception reporting criteria and so included in this report, there are a number of performance improvement questions that can be worked through to aid the performance discussion, as below:

1. Why are we not meeting our target?
2. What is the impact of not meeting our target?
3. What performance is predicted?
4. How can performance be improved?
5. When will performance be back on track?
6. What can we learn for the future?

In doing so, committee members are asked to consider the actions that have been identified by the vital sign lead officer.

Performance improvement – recommended actions

A standard list of suggested actions have been developed. This provides members with options for next steps where reported performance levels require follow-up and additional work.

All actions, whether from this list or not, will be followed up and reported back to the committee.

Suggested follow-up actions

	Action	Description
1	Approve actions	Approve actions identified in the report card and set a date for reporting back to the committee
2	Identify alternative/additional actions	Identify alternative/additional actions to those in the report card and set a date for reporting back to the committee
3	Refer to Departmental Management Team	DMT to work through the performance issues identified at the committee meeting and develop an action plan for improvement and report back to committee
4	Refer to committee task and finish group	Member-led task and finish group to work through the performance issues identified at the committee meeting and develop an action plan for improvement and report back to committee
5	Escalate to County Leadership Team	Identify key actions for performance improvement (that require a change in policy and/or additional funding) and escalate to CLT for action
6	Escalate to Policy and Resources Committee	Identify key actions for performance improvement (that require a change in policy and/or additional funding) and escalate to the Policy and Resources committee for action.