Norfolk County Council

Adult Social Care Committee

Date: **Monday, 19 June 2017**

Time: **10:00**

Venue: **Edwards Room, County Hall, Martineau Lane, Norwich, Norfolk, NR1 2DH**

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

Membership

Mr B Borrett (Chairman)

Mr Tim Adams	Mr W Richmond
Ms K Clipsham	Mr T Smith
Mrs S Gurney (Vice-Chair)	Mr H Thirtle
Ms B Jones	Mr M Sands
Mr J Mooney	Mr M Storey
Mr G Peck	Mr B Watkins

For further details and general enquiries about this Agenda please contact the Committee Officer:

Hollie Adams on 01603 223029
or email committees@norfolk.gov.uk

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Agenda

1. To receive apologies and details of any substitute members attending

2. Minutes **Page 5**

To confirm the minutes of the meeting held on 6 March 2017

3. Declarations of Interest

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is on your Register of Interests you must not speak or vote on the matter.

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is not on your Register of Interests you must declare that interest at the meeting and not speak or vote on the matter

In either case you may remain in the room where the meeting is taking place. If you consider that it would be inappropriate in the circumstances to remain in the room, you may leave the room while the matter is dealt with.

If you do not have a Disclosable Pecuniary Interest you may nevertheless have an **Other Interest** in a matter to be discussed if it affects
- your well being or financial position
- that of your family or close friends
- that of a club or society in which you have a management role
- that of another public body of which you are a member to a greater extent than others in your ward.

If that is the case then you must declare such an interest but can speak and vote on the matter.

4. Any items of business the Chairman decides should be considered as a matter of urgency

5. Public QuestionTime

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

Please note that all questions must be received by the Committee Team (committees@norfolk.gov.uk) by **5pm Wednesday 14 June 2017.** For guidance on submitting public question, please visit www.norfolk.gov.uk/what-we-do-and-how-we-work/councillors-meetings-decisions-and-elections/committees-agendas-and-recent-decisions/ask-a-question-to-a-committee or view the Consitution at www.norfolk.gov.uk.

6. Local Member Issues/ Member Questions

Fifteen minutes for local member to raise issues of concern of which due notice has been given.

Please note that all questions must be received by the Committee Team (committees@norfolk.gov.uk) by **5pm on Wednesday 14 June 2017.**

7. Chairman's Update

Verbal update by the Chairman of the Committee

8. Update from Members of the Committee regarding any internal and external bodies that they sit on.

9. Executive Director's Update

Verbal Update by the Executive Director of Adult Social Services

10. Internal and External Appointments **Page 14**

A report by the Managing Director of Norfolk County Council

11. Norfolk Adult Social Services – a review of the current position and issues **Page 18**

A report by the Executive Director of Adult Social Services

12. Adult Social Care Finance Outturn Report Year End 2016-17 **Page 27**

A report by the Executive Director of Adult Social Services

13. Performance Management report **Page 44**

A report by the Executive Director of Adult Social Services

14. Risk Management **Page 62**

A report by the Executive Director of Adult Social Services

15.	**Adult Social Care Annual Quality Report 2016/17**	**Page 73**
	A report by the Executive Director of Adult Social Services	

Group Meetings

Conservative	9:00am	Conservative Group Room, Ground Floor
Labour	9:00am	Labour Group Room, Ground Floor
Liberal Democrats	9:00am	Liberal democrats Group Room, Ground Floor

Chris Walton
Head of Democratic Services
County Hall
Martineau Lane
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NR1 2DH

Date Agenda Published: 09 June 2017

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Norfolk County Council

Adult Social Care Committee

Minutes of the Meeting Held on Monday, 06 March 2017
at 10:00am in the Edwards Room, County Hall, Norwich

Present:

Mrs J Brociek –Coulton	Mr R Parkinson-Hare
Mr M Chenery of Horsbrugh	Mr J Perkins
Mr D Crawford	Mr M Sands
Mr A Dearnley	Mr E Seward
Mrs S Gurney	Mr M Storey
Mr T Garrod	Mr B Spratt
Mrs J Leggett	Mr B Watkins
Mr J Mooney	Ms S Whitaker
Ms E Morgan	

1. Apologies

1.1 Apologies were received from Mr B Borrett, Mr W Richmond, and Mrs M Stone.

1.2.1 The Chairman and Vice-Chair of the Committee had sent their apologies so it was necessary to elect a Member to Chair the meeting.

1.2.2 Ms Whitaker was duly elected to Chair the meeting.

1.2.3 Ms M Whitaker in the Chair.

2. To confirm the minutes of the meeting held on 23 January 2017

2.1 The minutes of the meeting held on 23 January 2017 were agreed as an accurate record and signed by the Chair subject to an amendment to change "Mrs Whitaker" to "Ms Whitaker" and "Mrs Morgan" to "Ms Morgan" throughout the minutes.

2.2 The Committee expressed their best wishes for Chairman Mr B Borrett for a speedy recovery.

3. Declarations of Interest

3.1 There were no declarations of interest.

4. Urgent Business

4.1 There were no items of urgent business.

5. Public Question Time

5.1 Two public questions were received and the answers circulated; see Appendix A.

5.2.1 Mr Chapman asked a supplementary question: he asked whether the Council could offer reassurance that stroke survivors would be able to access services mentioned in the response to his question, which relied on using a phone or visiting a location and may be difficult for some stroke survivors to access.

5.2.2 The Executive Director of Adult Social Services replied that it was the intention for all stroke survivors to be able to access these services; if this was not suitable for them, provision would be made for them to be assessed by Social Services and access services in a different way.

5.3.1 Ms Czarnowska asked a supplementary question: she noted that the response to her question made no reference to the fact that the key policy proposed making people use their nearest centre removed all choice for individuals, that residential settings were expected to cover costs for transport and day 'activities', and once accommodation was funded there was often no budget left for additional services. She asked how service users would be able to drive changes in how services were organised.

5.3.2 The Executive Director of Adult Social Care responded that he didn't expect there to be a blanket policy to constrain a user to a service; he expected a case by case service, taking service users' preferences, skills and abilities and personal budgets into account, adopting a flexible approach.

6. Local Member Questions / Issues

6.1 No Member questions were received.

7. Chairman's Update

7.1 There was no update to give to the Committee.

8. Update from Members of the Committee regarding any internal and external bodies that they sit on

8.1 Mr Watkins updated members about:

- His attendance at the Health and Wellbeing Board, where the Sustainability and Transformation Plan (STP) was discussed;
  - The Board were in support of the STP but queried whether joint working was embedded;
  - The oversight committee had met with Chairs of providers and Clinical Commissioning Groups (CCGs) and representatives from Norfolk County Council;
  - There were concerns over integration and development of primary care.
- The NNUH;
  - The NNUH was now removed from financial special measures;
  - There was a £20m deficit for the current financial year, 2016-17;
  - It was hoped the Bodram Institute would open in spring 2018.

8.2 Mrs Brociek-Coulton had attended a meeting of the Governor's Council of James Paget University Hospital NHS Foundation Trust.

8.3 Ms Morgan had attended a meeting of the “Making it Real” group; they had found it beneficial to have a County Councillor on the group, and hoped another Councillor would join after May 2017.

8.4 The Chair had attended meetings as Partner Governor for the Mental Health Trust:

- Nominations Committee meeting where an updated job description for the non-executive member was discussed and agreed;
- Education and Members group, where a strategy to attract more members to the trust was discussed;
- A Workshop on mental health, alcohol and drug use; service users and carers attended, and topics such as housing and substance misuse were covered;
- A new member would be sought for the Partner Governor for the Mental Health Trust in May; the Chair recommended this as a beneficial role.

8.5 Mrs Gurney and the Committee thanked Ms Whitaker for her work for Adult Social Care and the County. The Committee also thanked Ms Morgan and other Members who would not be returning to the Council in May 2017.

8.6 Mr Watkins confirmed the NNUH deficit related to PFI (Private Funding Initiative) funding This was an issue faced by all NHS trusts.

9. Executive Director’s Update

9.1 Norfolk County Council had met with Norfolk’s 3 acute hospitals in February 2017 to discuss pressures for NHS hospitals, highlighting the need for integration work.

9.2 On 27 February a website was launched to attract more people into care, particularly home care: www.norfolkcarecareers.co.uk

9.3 On the 23 February the Norfolk care awards took place. An Outstanding Achievement Award was awarded posthumously to Harold Bodmer.

9.4 The Executive Director for Adult Social Services referred to coverage in the press over the number of home-care safeguarding issues nationally in the past three years; Norfolk had complied with the FOI (freedom of information) request. A briefing note would be sent to Committee Members to put this into context.

10. Adult Social Care Finance Monitoring Report Period 10 (January) 2016-17

10. 1.1 The Committee received the report providing financial monitoring information based on information to the end of January 2017. The report contained analysis of variations from the budget and actions being taken to reduce the overspend.

10.1.2 In table 1, page 19 of the report, the Budget “revised net expenditure” should read £247.273m. The forecast outturn for “Management finance and HR” on page 21 should read £1.426m.

10.2.1 A section 75 agreement was in place with the CCGs; they were due to repay the Better Care Fund (BCF) corporate reserve in 2017-18, and 2018-19.

10.2.2 The Executive Director for Adult Social Services was asked what could be done to tackle the Adult Social Care overspend:

- He noted positive progress related to purchase of care expenditure;
- He highlighted a need to continue to invest in prevention, reablement and technology and change the approach to social work to prevent and delay need;
- Strong social work leadership would ensure Social Workers felt supported;
- Reducing NHS referrals would reduce pressure on social care;
- 60% of care was provided via by spot purchase contracts; investing in block contracts would allow expenditure to be planned and reduce cost;
- He spoke about lobbying for further investment in Social Care.

10.2.3 It was noted that the £13m allocated to Independence Matters should reduce as services were reshaped.

10.2.4 Work was underway with NHS to recover outstanding debts from CCGs.

10.2.5 The Business Development Manager for Adult Social Care clarified that the Business Support underspend was due to secondment and vacancies across the service which were being addressed; the structure of Business Support was being reviewed.

10.2.6 A report on day opportunities, including information on Independence Matters, would be brought to a future meeting of the Adult Social Care Committee.

10.2.7 The Finance Business Partner for Adult Social Services clarified that approximately 15/20 people per month dropped below the threshold for self-funding. In these cases, if care met a person's assessed needs but the rate was above that paid by Norfolk

- the family could top-up the fees;
- the person could move to a more affordable home;
- it was most appropriate for the individual, they could remain in their current care home.

10.3 The Committee **NOTED**:

a) The forecast outturn position at Period 10 for the 2016-17 Revenue Budget of an overspend of £9.629m;
b) The planned actions being taken by the service to reduce the overspend;
c) The planned use of reserves;
d) The forecast outturn position at Period 10 for the 2016-17 Capital Programme.

11. Performance Management report

11.1 The Committee received the report outlining current performance against the Committee's Vital Signs Indicators.

11.2.1 Pressure caused by escalation to Opal 4 drove referrals to Adult Social Care, therefore investment in reablement to increase capacity to action referrals was important.

11.2.2 The Norfolk First Support model was in place to prevent admissions with a focus on reablement. Use of planning beds would be reviewed under the older people's planning stream.

11.2.3 A query was raised over the effects of the closure of Henderson ward. Flexibility in the use of community units had been seen across the County; discussion was underway over how these beds would be used.

11.2.4 Data which appeared to be “missing” from the dashboard was queried; the Delivery Manager clarified that this related to the cut-off time for data prior to a Committee meeting and differences in administration time for the indicators.

11.2.5 It was planned that a full set of targets would be in place for the May 2017 meeting of the Adult Social Care Committee.

11.2.6 Promoting community centres to take on more voluntary employees was discussed.

11.2.7 Communications and working relationships were in place between Social workers and Suffolk Health Service and West Suffolk Hospital for areas of Norfolk covered by Suffolk Health Service e.g. Thetford.

11.2.8 Some members commented that appendix 1 and the benchmarking report were not easy to view on an IPad.

11.2.9 The Delivery Manager reported that in 2016/17 Norfolk continued to do better in 18-64 residential care admissions compared to statistical neighbours. However, older people’s care admission figures were likely to be higher than before. The Delivery Manager **agreed** to put copies of the benchmarking report in Group Rooms.

11.23 With reference to section 3 of the report, for each Vital Sign that had been reported on an exceptions basis, the Committee:

a. **REVIEWED** the performance data, information and analysis presented in the vital sign report cards and in the Benchmarking report presented in Appendix 2 of the report;
b. **AGREED** that the recommended actions identified in the Vital Signs report cards were appropriate.

12. Moving Forward Integrated Health and Care

12.1.1 The Committee received the report providing information on the integration of health and care services by 2020, and recommendations on how to progress based on existing integrated commissioning and provider arrangements.

12.1.2 It was noted recommendation e) should read “…principles proposed at section 1.6…”

12.2 The Director for Health and Integration had no concern over any specific area regarding integration; she felt that reflection, rather than hasty decisions, on work with hospitals was needed due to the pressures.

12.3 The Committee **ASKED** officers to progress the development of integrated health and care in Norfolk by working with partners to:

a) Review and revise integrated arrangements to ensure they meet Care Act and Sustainability and Transformation Plan requirements;
b) Review the social models of care and support that are required for good quality sustainable services;
c) Review our arrangements for both hospital and community-based Learning Disability social work;
d) Agree a Member workshop on integration;
e) Agree the principles proposed at section 1.6 of this report;

13. Transport Update

13. 1 The Committee received the report outlining work being carried out to deliver savings from Adult Social Services transport.

13.2.1 Clarity was requested over the wording in paragraph 1.1: “a **legal** duty to provide…”, and paragraph 1.2: “there is **no statutory duty** to provide…” The Assistant Director of Social Work clarified the Council’s duty under the Care Act 2014 to promote independence through personal abilities, friends and family, the local community, public transport etc. before stepping in. “No statutory duty” related to where a person had no eligible Social Care need, in which case there was no separate statutory duty to provide transport. This would be amended to read “no <u>separate</u> statutory duty”.

13.2.2 Safeguarding courses for taxi drivers offered by Broadland and Breckland District Councils and Norwich City Council were noted; the Assistant Director of Social Work **agreed** to consider including this in the transport policy.

13.2.3 The Executive Director for Adult Social Services **agreed** to find out more information about disabled bus passes not being eligible for use before 9.30 am.

13.2.4 It was clarified that an ‘appropriate day service’ would be defined in conversation with service users, their carer and social worker.

13.2.5 The Executive Director for Adult Social Services **agreed** to find out about progress towards refurbishment of the Thetford Day Services Centre.

13.3 Mr B Spratt left the meeting at 12:08 PM.

13.4.1 The wording at paragraph 3.12 was queried over the use of “normally” and “appropriate”. The Executive Director for Adult Social Services **agreed** that this would be amended”.

13.4.2 The Finance Business Partner for Adult Social Services clarified that the recognised savings related to Transport went back to 2014; an investment of £3m had been agreed so that savings could be delayed until 2018/19 and 2019/20.

13.5 Mr R Parkinson-Hare left the meeting at 12:28 PM

13.6.1 Mrs Gurney **proposed**, seconded by Mr Mooney, that a less in-depth report be brought to Committee every meeting, with an extensive report every six months.

13.6.2 After discussion, Mrs Gurney withdrew her motion. It was **agreed** that it would be decided by the next Committee how to proceed with this item.

13.7 Ms Morgan raised concerns over the impact of the Care Act 2014 and budget cuts on individuals.

13.8 With 9 votes in favour, 2 votes against and 4 abstentions, the Committee **AGREED** the approach to Transport and the revised Transport Policy and Guidance attached to the report. The Guidance would help social care staff work with service users to promote their independence and reduce the funding required for transport.

14. Update on progress with recommendations of the SCIE review

14.3.1 Recommendations from a review on workload and a staff survey would be taken to senior management to inform staffing levels and capacity. Work with stakeholders and service users was underway to look at ways of working together.

14.3.2 The Executive Director for Adult Social Services would seek input from Mrs Brociek-Coulton on the Carers Agenda.

14.4 The Committee **NOTED** the progress in implementing the recommendations of the SCIE review.

The meeting finished at 12:55 PM

CHAIR

PUBLIC QUESTIONS TO ADULT SOCIAL CARE COMMITTEE

MONDAY 6 MARCH 2017

1a. Question Neil Chapman, Area Manager – East of England, the Stroke Association

What do Norfolk County Council propose to do to support Stroke survivors and carers in Gt Yarmouth now that Gt Yarmouth and Waveney CCG have decided to decommission the Stroke Association's Information Advice and support service which has been supporting up to 350 stroke survivors and carers a year? Part of their reasoning is that the service is providing many social care outcomes which are not the responsibility of the CCG to provide.

1b. Response from Chair

The Stroke Information and support service provided advice and support to patients and their families in the Great Yarmouth and Waveney area and is being decommissioned by Great Yarmouth and Waveney CCG from 1 April 2017.

NCC are working closely with the CCG to understand the implications of the decision and will continue to work with the stroke team at the James Paget Hospital to see what steps can be taken to further improve the support which patients receive after discharge. As part of this the CCG will be contacting the Stroke Association to carry out a short piece of engagement work with patients around what information and support would be required going forward.

NCC fund a number of support and advice networks which are able to provide information on benefits, financial support and access to care. These include the Equal Lives information and advice service for people with disabilities, Age UK information and advice for older people and Citizens Advice. We will continue to work with the Borough Council and the CCG to support people to get the information they need.

If people require advice about their health they should contact their GP or ring NHS111 which is a free to call telephone number for people wanting to access urgent healthcare but not needing to call 999.

2a. Question Roz Czarnowska – NANSA

How does NCC plan to ensure that the policy of expecting residential settings (residential care, supported living schemes) to provide the full range of support needs including transport and day services will:

A) not leave vulnerable adults effectively institutionalised within a single setting (as at Winterbourne View).

B) support the LA's strategy of Promoting Independence, given the limited options residential settings can offer for daytime support

C) not lead to closures of day service provisions (due to service users only being able to access the nearest provision, regardless of choice) and the potential collapse of a market which will affect a large number of adults with physical and learning disabilities?

2b. Response from Chair

The Care Act 2014 requires us to make sure that we meet eligible need using national criteria, and to ensure that support plans are consistent with meeting those needs. We will continue to do that and promote independence in a way that tries to prevent, reduce or delay levels of need. Our social workers work with a method called 'Signs of Wellbeing' which seeks to ensure that service users and carers capabilities, expectations and assets are taken into account in how needs are met, and how care is organised. The Care Act Guidance expects councils to meet a person's outcomes in the most effective and cost effective way. We would expect that service users and carers will therefore drive the changes of how services are organised, and that social workers will review outcomes including reviewing cases and ensuring the safeguarding of people. We would therefore expect people to make a choice within the constraint of their personal budget about which services they want to use, but which gives them a meaningful daytime opportunity. We do not expect to have a 'blanket policy' which limits service users to one provider. This could be in the same setting as a person's residential care or a separate setting.

Adult Social Care Committee

Item No……

Report title:	**Internal and External Appointments**
Date of meeting:	**19 June 2017**
Responsible Chief Officer:	**Wendy Thomson, Managing Director**

Strategic impact

Appointments to Outside Bodies are made for a number of reasons, not least that they add value in terms of contributing towards the Council's priorities and strategic objectives. The Council also makes appointments to a number of member level internal bodies such as Boards, Panels, and Steering Groups.

Responsibility for appointing to internal and external bodies lies with the Service Committees. The same applies to the positions of Member Champion.

Executive summary

In the previous Council, Service Committees undertook a fundamental review of the Outside Bodies to which the Council appoints. The views of members who have served on these bodies together with those bodies themselves and Chief Officers were sought and reported back to Committees.

Set out in the appendix to this report are the outside and internal appointments relevant to this Committee together with the current membership.

Recommendation

- **That Members review and where appropriate make appointments to those external bodies, internal bodies and Champions position as set out in Appendix A.**

1. Proposal

Outside Bodies

1.1 In the previous Council, all organisations and the current member representatives were invited to provide feedback on the value to the Council and the organisation of continued representation and to make a recommendation to that effect. In addition, Chief Officers were consulted.

1.2 Organisations were asked a number of questions about the role of the Councillor representative. Councillor representatives were asked questions such as how the body aligned with the Council's priorities and challenges and what the benefits are to the people of Norfolk from continued representation. Finally, both were asked whether they supported continued representation. Committees considered this information and made decisions on appointments. The appendix to this report sets out the outside bodies under the remit of this Committee. Members will note that the most recent representative is shown against the relevant body. Members are asked to review Appendix A and decide whether to continue to make an appointment, and if so, to agree who the member should be.

Internal bodies

1.3 Set out in Appendix A are the internal bodies that come under the remit of this Committee. There is no requirement for there to be strict political balance as the bodies concerned do not have any executive authority. The current appointments are not made on the basis of strict political proportionality, so the Committee may, if it wishes to retain a particular body, change the political makeup. The members shown in the appendix are those most recently serving on the body in the previous Council.

2. Evidence

2.1 The views of the Councillor representative, the organisation and Chief Officer were reported to the Committee when it undertook its fundamental review of appointments in the previous Council.

3. Financial Implications

The decisions members make will have a small financial implication for the members allowances budget, as attendance at an internal or external body is an approved duty under the scheme, for which members may claim travel expenses.

4. Issues, risks and innovation

4.1 There are no other relevant implications to be considered by members.

5. Background

5.1 The Council makes appointments to a significant number of internal bodies and external bodies. Under the Committee system, responsibility for these bodies lies with the Service Committees.

5.2 There is no requirement for a member of an internal body to be appointed from the "parent committee". In certain categories of outside bodies it will be most appropriate for the local member to be appointed; in others, Committees will wish to have the flexibility to appoint the most appropriate member regardless of their division or committee membership. In this way a "whole Council" approach can be taken to appointments.

Background Papers – There are no background papers relevant to the preparation of this report.

Officer Contact

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

Officer Name:	Tel No:	Email address:
Chris Walton	01603 222620	chris.walton@norfolk.gov.uk

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APPENDIX A

Adult Social Care Committee Boards, Panels, and Steering Groups (2016/17 Appointments shown)

1. Independence Matters Enterprise Development Board (2)

Chairman of the Adult Social Care Committee and Margaret Stone

This body was created to oversee the development of the Social Enterprise.

Adult Social Care Committee Outside Bodies (2016/17 Appointments shown)

1. Norfolk Council on Ageing (1)

Sue Whitaker

The organisation's vision is that older people live well in Norfolk and its mission statement is to support older people in the County to enjoy the opportunities and meet the challenges of later life. The Council provides a wide variety of services to older people and their carers across the County.

Adult Social Care Committee Champions (2016/17 Appointments shown)

Carers – Julie Brociek-Coulton
Older People –Denis Crawford
Learning Difficulties –Elizabeth Morgan
Physical Disability and Sensory Impairment – Jonathan Childs

Adult Social Care Committee

Item No:

Report title:	**Norfolk Adult Social Services – a review of the current position and issues**
Date of meeting:	**Monday 19 June 2017**
Responsible Chief Officer:	**James Bullion, Executive Director of Adult Social Services**

Strategic impact

Adult Social Services accounts for the largest proportion of spend for Norfolk County Council, and the largest proportion of savings for the council over the next three years. A clear understanding of the legislative framework, the national and local drivers of demand and cost pressures provide the background for the vision and strategy for a sustainable adult social care model.

Executive summary

This report sets out the current 'as is' position for Adult Social Services. It focuses on the main underlying issues that influence and drive demand and costs, and also highlights some other pressing issues that shape the direction of travel for the service for the medium term. The issues covered are:

a) Demography – particularly the implications of Norfolk's 85+ population
b) Demand – what drives increasing need for services, and the implications for costs of delivering care
c) Cost pressures – the balancing of the statutory role to develop and manage the market, with the need to ensure best use of money when purchasing care in the independent sector
d) NHS and integration – the potential impact of far-reaching changes in the NHS, particularly around system-wide leadership

The report summarises the budget for 2017/18, including previously agreed savings.

It briefly explains the key elements of the strategy Promoting Independence, highlighting how the strategy is a positive response to challenges facing social care. It sets out that a more detailed report about Promoting Independence will be brought to the July meeting.

The report concludes that Adult Social Services faces a continued challenge to deliver a sustainable model of services for the future, which is affordable and helps people achieve and maintain independence and a good quality of life. The vision, strategy and priorities set a clear course for change but the pressures and demands which are evident across the whole health and social care system are likely to increase. A critical success factor will be strengths-based social work which supports people to be as independent as possible.

The Department has strengthened its understanding of need and demand; the Promoting Independence strategy will support demand management, with the aim of reducing demand for services over a number of years, by shifting spend away from the more costly intensive spending such as residential care, towards earlier intervention and prevention. The additional investment in the service has provided a sound basis on which to transform the service but the savings targets remain extremely challenging.

Recommendation:

The Committee discusses and agrees:

a) **the analysis and conclusions set out in section 5**
b) **the priorities Adult Social Care Committee and the vision in section 4**

1. Adult Social Services – National context

1.1 Social care has the power to transform lives. It provides care, support, and safeguards for those who have the highest level of need, and for their carers. Nearly two million people in England rely on these essential services and around 6.5 million carers provide support alongside and beyond formal social care. Social care contributes £43 billion to the national economy in direct and indirect costs.

1.2 Local authorities in England in 2015/16 spend £16.8bn on social care for adults, which is equivalent to 14% of the health care budget. Over half (52%) of social care funding is spent on those aged 65 years and older. The number of people in this age group is growing rapidly, increasing by almost a million in England from 2010 to 2015, and will grow by a further million by 2020.

1.3 The remaining 48% of funding is spent on supporting younger adults with disabilities. Need for social care services among younger adults will rise as medical advances increase survival rates for people with serious health conditions, people who have had accidents, and for premature babies.

1.4 The key legislative framework for Adult Social Services is the **Care Act 2014** which represented the most significant change in social care law for 60 years. The Act's wellbeing principle spells out the local authority's duty to ensure people's wellbeing is at the centre of all it does. It places much greater emphasis than previously on outcomes for people – rather than services – and helping people to connect with their local community. For the first time, the Act sets a national eligibility criteria for services.

1.5 Nationally it is acknowledged that social care has been underfunded. Additional funding has been, since the Council agreed its budget in February, directed towards adult social care by the Government, including through the ability to increase council tax to support social care. However, there is still a need for a more sustainable footing for the future, and during the coming months there will be further debate about the best way to finance and deliver social care services.

2 Adult Social Services – Norfolk context

This section aims to set out the issues that underpin planning and delivery of social care in Norfolk, and inform the priorities for the department for the year ahead.

2.1 Demographic changes and demand for social care

2.1.1 In common with many other areas, Norfolk is having to re-think fundamentally its approach to delivering public services. Many of our services were designed in a very different era and policy framework. The basis of how we work is rooted in the times when government transferred far more grant to fund local services. Funding regimes now do not account fully for demographic change or socio-economic changes, instead the drive is for local government to become self-sufficient through council tax and increased revenue from locally raised business rates.

2.1.2 At the same time as funding has been reduced, our population continues to grow and the pattern of family life has changed. Medical advances are huge – people live longer and have access to many more medical specialists than in the past. More profoundly disabled young people with increasingly complex needs are coming into adulthood every year.

People move around more for jobs than in previous generations, so families cannot always be near to older relatives to help and care.

2.1.3 The impact of this has been that funding has not kept pace with people's need for services, and while the overall amount of money adult social services spends has increased year on year, savings still have to be made.

2.1.4 A growing 'older' population affects Norfolk more than most other places – it has, and will continue to have, a higher proportion of older people compared to the average for the Eastern Region and for Norfolk's 'family group' of similar councils.

2.1.5 **Key demographic trends for Norfolk are**:

a) Norfolk generally has an older population that is projected to increase at a greater rate than the rest of England

b) Across Norfolk the average life expectancy is about 80 years for men and about 84 years for women. The average number of years a man can expect to live in good health is about 64 and for women it is about 66

c) The number of people aged 65 and over in Norfolk is due to increase from 209,700 in 2015 to 274,800 in 2030

d) This is a 31% increase in 15 years, and will mean that the number of people aged 65 and over, as a proportion of Norfolk's total population, will increase from 23.8% to 28.3%

e) About 77,700 people are limited a lot in their day to day activities and about 23,200 provide more than 50 hours of care per week

f) There are an estimated 19,000 who are blind, and 110,000 with a hearing impairment

g) With the population aged 18 to 64, there are estimated to be:

- 12,300 with a serious physical disability
- 4,500 with a serious personal care disability
- 2,800 with a moderate or severe learning disability
- 81,400 with a common mental health disorder

2.1.6 In Norfolk, as in many areas, budgets for services for people aged 18-64 with a learning disability or a physical disability are consistently the most challenging to meet. This is driven, in a very positive way, from some less well discussed demographic changes. In short, people with learning disabilities or physical are, through improvements to the medicine and care available to support their long term conditions, surviving to a much older age.

2.2 Drivers of demand

2.2.1 Understanding the drivers of demand is critical for future planning of adult social services, since a more refined understanding allows the Council to see where it can influence demand through behaviours and practices. However, demand for social care is a complex matter and predicting and managing demand is not an exact science. Whilst the growth in the older population is significant, a simple projection of the population does not equate to a commensurate increase in demand.

2.2.2 Key considerations that inform our predictions are:

a) Critically, the 85+ age group is Norfolk's fastest growing, and it is this age group which has most impact on demand. Between 2015 and 2030 this age group will increase by 77%

b) Whilst people over 85 are clearly more likely to be physically frail and to find it more difficult to undertake day-to-day tasks, they are also more likely to have dementia. Norfolk's dementia prevalence is high – being third highest in the region behind Suffolk and Southend. Dementia is likely to be one of the most important drivers of social care need in older people in Norfolk in the next twenty years

c) People with learning disabilities are living to a much older age. Whereas once relatively few people with a learning disability would live beyond the age of 65, around 12% of people being supported by a learning disability team are now over 65

d) Wider social factors are also significant in influencing demand. These include people's general health and wellbeing, their income, particularly given that social care is subject to financial eligibility; and loneliness and isolation – evidence suggests that people that are at risk of loneliness may be more likely to seek care

e) Importantly, given Norfolk's predominantly rural nature, population density and rural/urban split does not seem to have an impact on the provision of care. Put another way – people in rural areas are on average no more or less likely to receive services overall. However, Norfolk's rurality is a challenge, not due to need but because delivery in rural areas poses greater challenges than that in urban areas

2.2.3 There are other potential drivers of social care demand about which there is less research but these are still important factors:

a) Availability of informal care. We know that in Norfolk at the last census there were 91,000 people who said they provided informal care. Changes and fluctuations in the amount of informal care that people provide to family members and friends, can have an impact on the amount of formal care people seek

b) Attitudes to and expectations of care change continually. It is anticipated that the baby boomer generation will become increasingly demanding customers of social care, expecting high quality as well as choice and autonomy

c) The impact of inward migration to Norfolk – particularly to coastal areas where people retire for the landscape and quality of life that Norfolk has to offer. As they become more frail, their independence is diminished, and some become more dependent on social services

2.2.4 For 2017/18, the following amounts have been built into the budget to mitigate some of the pressures set out above:

a) £6.134m has been agreed to manage the estimate increase in the number of people with eligible needs
b) £0.202m has been included within the budget to manage the vulnerable persons resettlement scheme

2.3 **Cost pressures and managing the market**

2.3.1 Adult social services spends the vast proportion of its monies with independent providers of care. Whilst social workers assess what strengths people have and agree with individuals what additional support they need to be able to stay as independently as possible, any care is then purchased from the care market. This is predominately home care, but also includes residential care, nursing care. Although more packages of care are for home care, the majority of cost is spent within the residential and nursing care market.

2.3.2. Inflation, pay costs and rising prices all put pressure on the cost to adult social services for that care.

2.3.3 In line with other local authorities, the amount of money the Council pays for each 'unit' of care is increasing. These increased costs are being driven by a range of factors including:

a) Increases to the National Minimum Wage
b) A very challenging labour market, with significant ongoing staff turnover, particularly in home care
c) An 'ageing' care estate of often older care homes and nursing homes

2.3.4 Adult social services has a statutory responsibility to support and develop the market for care – not just for those eligible for adult social care, but for all citizens in Norfolk. At the same time, it is also our responsibility to purchase care in the most cost effective way for council tax payers.

2.3.5 We have a programme of support and development for providers and we publish our direction of travel to help them plan for the future. Collaborative exercises with providers support determination of a fair price for care and support a sustainable market. In 2017/18, we took the decision to pass on the costs of the national living wage in order to help stabilise what was potentially a difficult financial period for many care providers.

2.3.6 Investment **totalling £14.7m** was agreed by the Committee and Full Council to support price increases and inflation; the increase of residential and nursing care prices, and uplifts to help providers with the impact of the National Living Wage.

2.4 Integration and the NHS

2.4.1 Adult social services has well-established arrangements for integration of commissioning and service delivery with partners in the NHS.

2.4.2 The NHS sustainability and transformation plans (STPs) assume that closer working and closer integration with adult social care is essential to manage the future for health and social care.

2.4.3 The Council is committed to sustaining and accelerating integration so that artificial boundaries become increasingly less relevant, and individuals and communities are the starting point for planning services.

2.4.4 Since 2014, integration with the NHS has been underpinned by the Better Care Fund (BCF). This national programme has required the creation of a pooled budget between Clinical Commissioning Groups (CCGs) and Local Authorities, in order to support integration between health and care.

2.4.5 The principle we have taken is that where people have complex needs, the health and care services they receive should act as seamless services to provide person-centred co-ordinated care. Key performance indicators in the BCF are:

a) Unplanned admissions to hospital
b) Residential care admissions
c) Successful reablement
d) Delayed transfers of care from hospital

2.4.6 The BCF for 2017/18 requires us to implement eight 'high impact changes' to tackle delayed transfers of care, so we will be working with our acute hospitals and other NHS bodies to ensure we have effective ways to managed discharge from hospital. It is critical however that we also focus our attention on how to avoid admissions wherever this is possible and this is a primary focus of the STP.

2.4.7 Priority areas of focus between health and care under the STP are:

a) The reduction of admissions to hospital (20%) and reduction of length of stays in hospital (20%) by 2019

b) An integrated approach to intermediate care provision: services which prevent admission to care or hospital and services which help people to return home

c) End of life and palliative care services

d) Working with care homes to improve their ability to manage the complex needs of residents, particularly to avoid unnecessary admission to hospital

e) Social prescribing: a means of enabling GPs, nurses and other professionals to refer people to a range of local, non-clinical services e.g. welfare advice, social groups

2.4.8 The Council has a joint management arrangement with Norfolk Community Health and Care so that social worker services and community nursing come under a combined senior management team. There are also joint management arrangements with East Coast Health Care in Great Yarmouth. This has allowed for the improved collaboration and co-ordination across these services at local level, and closer working with GPs to focus on more active support to people with complex health and care needs.

2.4.9 We have an integrated commissioning arrangement with the CCGs, meaning our commissioning team works across health and care to plan and secure services. For example, we jointly commission our community equipment service.

2.4.10 During 2017/18 we will be reviewing our integration arrangements for commissioning and service provision, as we progress our priorities for adult social care within the framework of the STP.

3 2017/18 Budget summary

3.1 In setting the 2017-18 budget, Norfolk County Council raised council tax by 4.8%, incorporating a 3% rise for the social care precept and a 1.8% general increase. This decision was driven by a priority to protect front line services, taking account of the significant pressures faced in social care and other areas. In addition, a number of savings previously agreed were removed or deferred in recognition of budget pressures.

3.2 The total adult social care precept will raise £16.644m in 2017-18. Norfolk County Council previously froze council tax for five years between 2010-11 and 2015-16, and raised it by 3.99% (including 2% for the adult social care precept) in 2016-17. The County Council's medium term financial plan is based on increasing the adult social care precept by 3% in 2018-19.

3.3 In summary, decisions by Full Council in February 2017, saw significant investment in adult social services. This comprised:

a) £6.134m for demographic growth pressures
b) £4.500 for cost of care pressures
c) £5.660 for pay and price market pressures
d) £9.578m to address an underlying overspend

3.4 On top of this, we have re-profiled £20m of savings from 2016-18 to 2019-21. The original value of savings remain, but experience to date has confirmed that whilst savings are achievable, the level of demand management required will take longer to achieve.

3.5 Adults' gross budget for 2017/18 is £369.422m; income (from fees and charges) is £107.969m, giving a net budget of £261.453m. Two thirds of the gross budget will be spent with the independent sector purchasing care to meet their assessed needs.

3.6 The service has £2.074m reserves at the start of the 2017-18 financial year and provisions of £4.157m, which is entirely for doubtful debts. Mostly reserves relate to committed expenditure including £0.361m for the Social Care replacement system, £0.279m for deprivation of liberty safeguards and £0.400m for transformation.

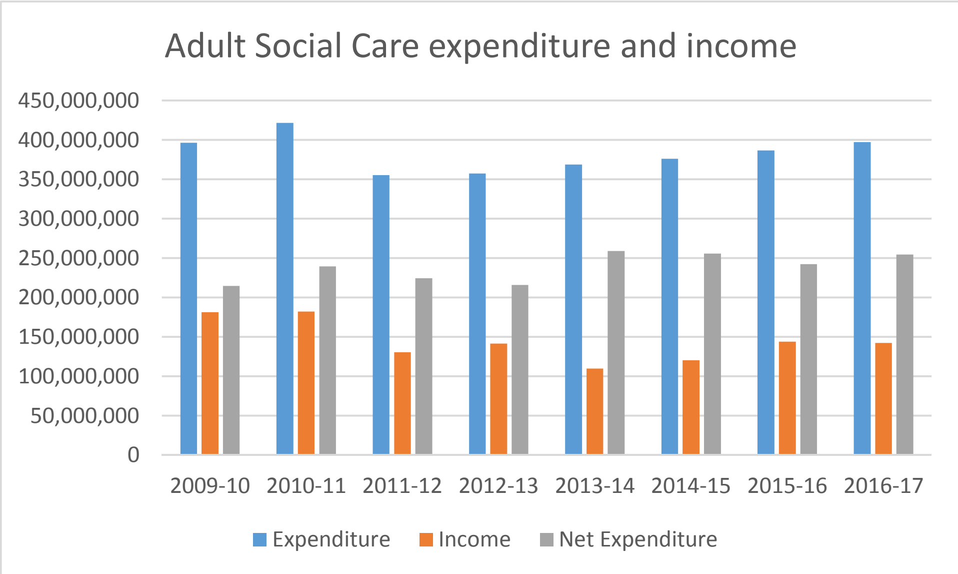
3.7 The Adult Social Care capital programme totals £16m. This includes £7.2m for the social care and finance system. Funding for specific building projects totals £2.1m. £4.2 is unallocated capital grant. Since 2016/17 the disabled facilities grant that is received by the County Council must be passported in full to district councils.

3.8 A table setting out the expenditure over the last eight years is included below (Chart 1). Whilst the overall spending for adult social services increases year on year, savings still have to be achieved to keep pace with the demand for services and the increasing costs of providing them.

a) In 2016/17, adults made savings of £7.2m in 2016/17 against a target of £10.926m

b) In 2017/18, it is required to deliver savings of £14m, and a further £4m to replace one-off government funding, which will be removed from the budget in 2018-19; this is the most it has ever had to achieve

Chart 1



3.9 The savings are planned to be realised through reducing the number of people who need formal services and in particular working age adults within long-term residential care, and the cost of packages, and through changes to how we commission key services – including home support, day services, and following through on savings decisions including reducing spend on housing related support, remodelling contracts for support to mental health recovery and aligning our charging policy to more closely reflect actual disability related expenditure.

3.10 Since the budget was agreed, additional one-off funding from the Government has been allocated to all councils for adult social services. This comes with requirements as to how it is spent, particularly, in support of the NHS and the need to allow people to come out of hospital quickly. It will not be able to offset savings already agreed.

3.11 This additional funding will be considered in detail at the July Committee meeting.

4 Promoting Independence – our strategy for a sustainable future

4.1 Adult Social Services has developed a vision for the future – **to support people to be independent, resilient and well.**

4.2 To achieve our vision, we have a **strategy – Promoting Independence** – which is shaped by the Care Act with its call to action across public services to prevent, reduce and delay the demand for social care. It is also a positive response towards managing what is a difficult financial climate for public services. It does not see a retreat to a statutory minimum but ensures that we manage demand and have a sustainable model for the future, at the core of which is quality social work which builds on the strengths of individuals.

4.3 Promoting Independence aims to shift our spending away from the more costly intensive spending such as residential care, towards earlier intervention and prevention. The strategy for the service will support demand management, with the aim of reducing demand for services over a number of years.

4.4 The strategy has these main elements:

4.4.1 **Prevention and early help** – Empowering and enabling people to live independently for as long as possible through giving people good quality information and advice which supports their wellbeing and stops people become isolated and lonely. We will help people stay connected with others in their communities, tapping into help and support already around them – from friends, families, local voluntary and community groups. For our younger adults with disabilities, we want them to have access to work, housing and social activities which contribute to a good quality of life and wellbeing. Carers make a critically important contribution towards keeping people independent. Through supporting carers, we are supporting those they care for; service development includes looking at strengthening support for carers, recognising their expertise and working in partnership with them to shape services.

4.4.2 **Staying independent for longer** – for people who are most likely to develop particular needs, we will try and intervene earlier. Certain events, such as bereavement or the early stages of an illness like dementia can be a trigger for a rapid decline in someone's wellbeing, but with some early support we can stop things getting worse and avoid people losing their independence and becoming reliant on formal services. Our social care teams will look at what extra input could help people's quality of life and independence – this might be some smart technology, some adaptations to their homes to prevent falls, or access via telephone or on-line to specialist tailored advice. When people do need a service from us, we want those services to help people gain or re-gain skills so they can live their lives as independently as possible. This could mean a spell of intensive reablement after a stay in hospital to increase confidence and ability to do as many day to day tasks as possible.

4.4.3 **Living with complex needs** – for some people, there will be a need for longer term support. This might mean the security of knowing help is on tap for people with conditions like dementia, and that carers can have support. We will look at how we can minimise the effect of disability so people can retain independence and control after say a stroke or period of mental illness. For some people, moving into residential care or to housing where there are staff close by will be the right choice at the right time, but such decisions should be made with good information and not in a crisis.

4.4.4 The changes we have to make for Promoting Independence are not ones we can achieve on our own. Critical to success will be integration with the NHS, and joint working with other public services and third sector to develop vibrant, supportive networks in communities.

4.5 **To deliver our strategy, we have the following priorities:**

4.5.1 a) Strengthen social work so that it prevents, reduces and delays need - Great social work, in all its forms, is at the heart of delivering our vision, and is at the heart of our statutory role as outlined in the Care Act. Day in day out, our care teams support and enable thousands of people. Without their skills to listen, support, motivate and change lives, we cannot achieve our vision

b) Be strong partners for integrated working to support a good life in communities – working with partners, sharing information, joining up services will help us avoid duplication and plan health and social care so it is organised around how individuals want to live their lives, not around organisational structures

c) Increased focus on quality and safeguarding – during a period of change, the need to be relentless on quality and safeguarding becomes even more important. We will test, examine and improve our own practice, and aim to ensure that 80% of our providers are judged good or better by CQC

d) Strong financial and performance accountability – the council has prioritised spending on adult social care and made some tough decisions to ensure that we are on a sound financial footing. This has included asking residents to pay more in council tax specifically to support adult social care. Residents can rightly expect us to have a continuous focus on efficiency, driving out waste and unnecessary cost, and ensuring every pound we invest represents the best possible value

5 Conclusion

5.1 Adult Social Services faces a continued challenge to deliver a sustainable model of services for the future, which is affordable and helps people achieve and maintain independence and a good quality of life. The vision, strategy and priorities set a clear course for change but the pressures and demands which are evident across the whole health and social care system are likely to increase. Critical will be strengths-based social work which relies on social care staff having conversations which support people to live as independently as possible, enabling them to overcome crises, and reducing the need for dependence on formal services.

5.2 The Department has strengthened its understanding of demand; the Promoting Independence strategy will support demand management, with the aim of reducing demand for services over a number of years, by shifting spend away from the more costly intensive spending such as residential care, towards earlier intervention and prevention. The additional investment in the service has provided a sound basis on which to transform the service but the savings targets remain extremely challenging.

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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Adult Social Care Committee

Item No ……

Report title:	**Adult Social Care Finance Outturn Report Year End 2016-17**
Date of meeting:	**19 June 2017**
Responsible Chief Officer:	**James Bullion, Executive Director of Adult Social Services**

Strategic impact

This report provides the Committee with a review of the budget position for the last financial year, based on information to the end of March 2017. It provides an analysis of variations from the revised budget, recovery actions taken in year to reduce the overspend and the use of Adult Social Care reserves.

Executive summary

The paper looks back at the financial position for Adult Social Services during the previous financial year. At the end of financial year 2016-17, Adult Social Service's financial outturn position at March 2017 showed an overspend of £4.399m, after the application of previously identified use of reserves, including the Corporate Business Risk Reserve, work across teams to deliver recovery actions and £1.2m funding to support priorities from Public Health. The overspend equates to a 1.76% variance on the revised budget. The Period 13 position, which reflects the end of year position including final adjustments completed in April, represents a decrease of £5.230m on the position reported at the end of Period 10.

Expenditure Area	Budget 2016/17 £m	Forecast Outturn £m	Variance £m
Total Net Expenditure	250.392	264.946	14.554
Agreed use of Corporate Business Risk Reserve	0.000	(10.155)	(10.155)
Revised Net Expenditure	250.392	254.791	4.399

The headline information and considerations include:

a) The outturn position for 2015-16 was a £3.168m overspend and this underlying pressure continued into 2016-17
b) Norfolk County Council (the Council) in setting the budget recognised the additional business risks affecting the service, specifically in relation to the cost of care exercise that concluded in April, the additional cost in 2016-17 for the introduction of the national living wage and the uncertainty of health funding to maintain social care as part of the Better Care Fund. A corporate business risk reserve was set up as part of the 2016-17 budget to help manage this risk. The use of £5.155m was agreed for cost of care and national living wage pressures and £5m towards protecting social care following the reduction in health funding towards social care in 2016-17 within the Better Care Fund
c) Public Health funding of £1.2m has been transferred to Adult Social Care to support homelessness schemes
d) Care Act implementation funding of £0.492m that remained unspent at the end of the year was able to be used to reduce the overall overspend.

e) Key variations in the final periods included lower home support costs due to improved contract management, an increase in direct payment reclaims due to targeted work, and increase in service user income compared to the forecast position and lower than forecast transport costs
f) The service has delivered savings of £7.2m in 2016/17 against a target of £10.926m
g) Previous agreement of £0.651m of reserves and further agreement to utilise £0.948m of uncommitted reserves to help reduce the 2016/17 forecast overspend
h) Budget movements at year end reflected capital financing charges and had no impact on the outturn position

Adult Social Services reserves at 1 April 2016 stood at £2.848m. At the point that the budget was set in February 2016, the Council agreed to £1.073m use of Adult Social Services reserves in 2016/17. The year end position on reserves was £0.838m higher than at budget.

Excluding the use of the Corporate Business Risk Reserve, during 2016/17 the service has made use net use of £0.774m of reserves and has increased provisions by £1.030m. The 2016-17 outturn position for reserves is £2.074m, which includes some increases due to specific commitments to projects that will now not be spent until the new financial year. Provisions totalled £3.127m at 1 April 2016, mainly for the provision for bad debts. Additional provision for doubtful debts has increased the balance to £4.157m

Recommendations:

Members are invited to consider the contents of this report and to agree:
a) The outturn position for 2016-17 Revenue Budget of an overspend of £4.399m
b) The outturn position for the 2016-17 Capital Programme

1. Introduction

1.1 The Adult Social Care Committee has a key role in overseeing the financial position of the department including reviewing the revenue budget, reserves and capital programme.

1.2 This is the final monitoring report for 2016/17 and reflects the outturn position at the end of March 2017, Period 13.

1.3 The County Council in setting the budget for 2016/17, recognised the significant business risks facing the service, including the review of cost of care and the implications of national living wage and the continuation of funding from Clinical Commissioning Groups (CCGs) to maintain social care within the Better Care Fund scheme. As part of the 2016-17 budget setting, the Council put in a place a Corporate Business Risk Reserve. The outturn position includes the approved use of £10.155m to manage the actual costs incurred by the service.

2. Detailed Information

2.1 The table below summarises the outturn position as at the end of March 2017 (Period 13).

Actual 2015/16	Over/ Under spend at Outturn	Expenditure Area	Budget 2016/17	Outturn	Variance to budget		Variance @ P10
£m	£m		£m	£m	£m	%	£m
8.325	(0.312)	Business Development	10.863	10.392	(0.471)	-4.3%	(0.323)
70.665	0.804	Commissioned Services	69.477	69.600	0.123	0.2%	1.753
5.442	0.142	Early Help & Prevention	6.219	5.492	(0.727)	-11.7%	(0.704)
164.760	9.653	Services to Users (net)	155.272	168.243	12.971	8.4%	15.962
(6.710)	(7.119)	Management, Finance & HR	8.561	1.064	(7.497)	-87.6%	(7.083)
242.482	3.168	Total Net Expenditure	250.392	254.791	4.399	1.76	**9.629**

2.2 As at the end of Period 13 (March 2017) the revenue outturn position for 2016-17 is a £4.399m overspend. This includes the release of (£6.557m) of Care Act funding that was not allocated to specific budgets at the beginning of the year. It also includes use of reserves, including the planned use of £10.155m from the Corporate Business Risk reserve to manage the impact from the cost of care review and introduction of the National Living Wage and also the agreed use of £0.948m from Adult Social Care reserve, previously allocated for business transformation costs.

2.3 The detailed position for each service area is shown at **Appendix A**, with further explanation of over and underspends at **Appendix B**.

2.4 The overspend is primarily due to the net cost of Services to Users (purchase of care and hired transport), and shortfall in delivery of planned recurrent savings, resulting in an overspend of £12.971m.

2.5 There has been in-year movement in the budget between services to properly reflect the agreed areas supported by the Better Care Fund income. Key changes include reducing the income budget for both Management and Finance, and Services to users with corresponding increase in income budget for Care and Assessment, and Reablement services – which resulted in a reduction in net budget for these services, although did not affect the actual resources available.

2.6 **Additional pressures for 2016/17**

2.6.1 As previously reported the outturn position for the service includes the additional costs arising from the cost of care review and the implications of the national living wage within the 2016/17 uplift to prices. These costs have been built into the 2017-18 budget pressures for the relevant services, so will not be an additional pressure on spending plans in the current financial year.

2.7 Services to Users

2.7.1 The Purchase of Care budget outturn is set out in more detail below. This highlights that the key areas of overspend in 2016/17 were in relation to services for people with learning disabilities and older people. Mental Health services were provided within the net budget. The Older People overspend of £8.625m is particularly impacted by the cost of care review for older people residential and nursing implemented in 2016-17 and the introduction of national living wage. Whilst the teams continue to have significant challenges in managing demand and market pressures, in overall terms £6.1m savings were achieved against purchase of care and teams have largely stabilised spend and in some cases reduced spending year on year.

2.7.1 The table below provides more detail on services to users, which is the largest budget within Adult Social Services:

Actual 2015/16 £m	Over/ Underspend at Outturn £m	Expenditure Area	Budget 2016/17 £m	Outturn £m	Variance £m
111.417	3.579	Older People	103.677	111.914	8.238
24.750	0.412	Physical Disabilities	22.039	23.246	1.207
90.218	9.863	Learning Disabilities	83.408	94.527	11.119
13.519	1.839	Mental Health	12.907	13.174	0.267
6.909	2.328	Hired Transport	3.672	6.746	3.074
14.436	(1.150)	Care & Assessment & Other staff costs	10.338	9.144	(1.194)
261.249	**16.871**	**Total Expenditure**	**236.041**	**258.751**	**22.710**
(96.490)	(7.218)	Service User Income	(80.769)	(90.508)	(9.739)
164.760	**9.653**	**Revised Net Expenditure**	**155.272**	**168.243**	**12.971**

2.7.2 Headlines:

a) Permanent admissions to residential care – so those without a planned end date – have been consistently reducing for the last three years in both 18-64 and 65+ age groups, and reductions had accelerated in the last year in response to the provisions put in place in response to Promoting Independence. However, over the second half of the year there had been some increase in permanent residential placements – due to a mix of reasons including increased pressure from hospital discharge, self-funders that had dropped below the threshold for self-funding and assessed needs. At April 2015 the rolling 12 months admissions for people aged 65+ was 688 per 100,000 population. This had reduced to 613 by August 2016, but then increased in the following periods, to 633 by March 2017, which means that there has been a small increase in 2016/17 when compared with the rate of 623 at the beginning of the year. For people aged 18-64 there is a more marked reduction, with 33 people per 100,000 population admitted into permanent residential care in April 2015, reducing in most periods to 17 per 100,000 population by November 2016. Again there has been an increase in the last quarter of the year to 19.3 admissions per 100,000 population. However, whilst total numbers have reduced, those that do go into residential care tend to be people with higher levels of need that require longer lengths of stay and more expensive care packages, meaning that spend has not reduced proportionally

b) Overall there are 513 less service users of adult social care reducing to 13,698 users at the end of March 2017. Some 423 relates to a reduction in older people requiring formal adult social care services. However, whilst service user numbers are decreasing in keeping with the Promoting Independence strategy, the mix and rate has not been sufficient to deliver all the savings required.

c) The year on year position is not entirely comparable due to such as one-off adjustments, but provides an indication of the expenditure trend. The outturn expenditure for purchase of care, excluding care and assessment is £2.9m more than the 2015/16 outturn. The 2015/16 expenditure included £1.1m one-off expenditure, which was offset by income. However, the 2016/17 expenditure includes the increase in spend due to the cost of care exercise and implementation of the national living wage, which totalled £5.155m. This highlights that despite rising costs and demands, the service is delivering change within the service, resulting in savings that are helping to stabilise spending. After taking account of additional costs and adjustments, demand management savings to support the purchase of care totalled just over £6m in 2016/17

d) Reducing the number of working age adults in residential placements in line with savings targets is challenging. Transition plans for individuals are continuing to be developed and implemented, but transition for most individuals will take time with increased resources often needed initially to support the transition process into more independent care settings

e) Savings against services for people with learning disabilities were not fully delivered and expenditure has continued to rise. The service has seen an increase of 27 service users during the year. This continues to be an area where there is high financial risk. Mitigating actions have been taken to address the risk. These include: strengthening the social care focus at all levels of management; the appointment of a Business Lead role to help drive through the comprehensive list of actions developed in line with the Promoting Independence Programme; focussed operational resource to address waiting lists and prevent 'drift' in casework; and a wholesale review of day services and supported living provision

f) The net budget for mental health services (taking account of both expenditure and service user income) achieved a small underspend for 2016/17. This is despite the service supporting an increase during the year of 49 service users to a total of 1139 service users at year end – reflecting the continuing increase in demand for the service

g) Overall there was a reduction of £16m in budgeted income in 2016/17 compared to 2015/16 outturn, with an expectation that service user income would remain similar. This primarily relates to one-off income items accounted for against purchase of care income in 2015/16 including:
   a) £4.6m from reserves for 2015/16 cost of care pressures and approved use of reserves when setting the 2015/16 budget;
   b) £0.415m transfer from Public Health;
   c) £3.6m to adjust for Continuing Health Care agreements which reflects packages that are funded by health where people have been assessed with ongoing health needs
   d) £1.1m in relation to additional invoices raised, but which were offset by additional costs

2.7.3 It also reflected reallocation of Better Care Fund (BCF) income to the areas of agreed budget spend, particularly Care and Assessment and Reablement. The outturn includes the additional income from the Corporate Risk Reserve of £5.155m in relation to cost of care and national living wage. The actual service user income was £0.484m more than previously forecast.

2.8 **Commissioned Services**

2.8.1

Actual 2015/16 £m	Variance at outturn £m	Expenditure Area	Budget 2016/17 £m	Forecast Outturn £m	Variance £m
1.219	(0.182)	Commissioning Team	1.474	1.185	(0.289)
10.925	(0.219)	Service Level Agreements	11.157	10.361	(0.795)
2.620	0.021	Integrated Community Equipment Service	2.602	2.184	(0.418)
32.496	1.645	NorseCare	30.024	33.280	3.257
9.141	(0.141)	Housing related support	9.494	8.323	(1.172)
12.930	(0.265)	Independence Matters	13.345	13.114	(0.244)
1.334	(0.055)	Other Commissioning	1.369	1.153	(0.216)
70.665	**0.804**	**Total Expenditure**	**69.477**	**69.600**	**0.123**

2.8.2 Key points:

a) A joint and medium term plan is being developed with Norse Care for delivery of current and future savings. While some planned savings have been made during 2016/17 and actions implemented, the targeted reductions in the contract price will take longer to achieve in full

b) Changes within the work of the integrated community and equipment service and locality teams has led to an increase in use of equipment but less use of high cost specialist stock along with further work to enable more cost effective options for the same treatment

c) SLA underspend relates to small underspends on multi contracts

d) The position for housing related support reflects one-off public health funding to support homelessness schemes in 2016/17, which has increased the income to the service and therefore reduced the net expenditure. It does not reflect any reduction in spending in 2016/17

2.9 **Achieved Savings**

2.9.1 The department's budget for 2016/17 included savings of £10.926m. The progress and risks associated with delivery of the savings have been reported regularly to the Adult Social Care Committee. In particular a revised forecast was reported to Committee, following a review undertaken with iMPOWER consultants of the Promoting Independence programme of work. The review concluded that the Council is pursuing the right strategy, but there are other interventions that can be used to enhance delivery of the strategy and that the timeline for the strategy was too challenging to successfully be delivered in three years. This led to re-profiling of the targets for future years. However, the original budgeted targets for 2016-17 remained.

2.9.2 At Period 10 risks totalling £4.510m were reflected in the forecast position and throughout the year work has continued on recovery plans and alternative savings where possible.

The final savings achieved reflect an improved position since the Period 10 forecast with savings delivered in 2016/17 totalling £7.189m, of which £6.012m is attributable to savings to purchase of care.

2.9.3

Savings	**Saving 2016/17 £m**	**Outturn £m**		**Variance £m**
Savings not or partly achieved (Red or Amber)	(9.458)	(5.721)		3.737
Savings on target	(1.468)	(1.468)		0.000
Total Savings	**(10.926)**	**(7.189)**		**3.737**

For those savings that did not deliver to target a brief explanation is set out below.

2.9.4 **Integrated Community Equipment Service (target £0.500m, outturn £0.436m, variance £0.064m)**

The savings were planned focusing on a mix of preventative and efficiency savings. The service is working to increase the access to equipment to reduce or delay the need for formal packages of care and review the way that equipment is recalled. Changes within the work of the integrated community and equipment service and locality teams has led to an increase in use of equipment but less use of high cost specialist stock along with further work to enable more cost effective options for the same treatment. In addition, focus will be on increasing the review and recall of equipment and reviewing where improved access to equipment can reduce the need for some service users to require two care workers (known as double-ups). Posts were recruited to during Quarter 4 of 2016/17, which will achieve further savings in 2017/18.

2.9.5 **Changing how we provide care for people with learning disabilities or physical disabilities (target £1.500m, outturn £0.600m, variance £0.900m)**

The saving involves re-assessing the needs of existing service users and where appropriate providing alternative and more cost effective accommodation, or means of supporting them in their current accommodation. As previously reported, while it is considered that savings can be achieved over time, the lead in times for the work have been longer than originally planned. The future direction for this work is part of the refresh of the promoting independence programme.

2.9.6 **Promoting Independence - Reablement - expand Reablement Service to deal with 100% of demand and develop service for working age adults (target £3.158m, outturn £2.067m, variance £1.091m)**

Recruitment to posts was completed during 2016/17 and the service has managed an increased number of referrals. The target number of additional referrals was 1464 and 1342 has been achieved. Referral rates and service declines are monitored closely and capacity is being increased where there is not adequate provision for demand. The referral rates are continuing to increase, supported by the strength based approach to assessments and work with hospitals on discharge and therefore savings are expected to be delivered in full during 2017/18.

2.9.7 **Transport Savings (target £1.050m, outturn £0.246m, variance £0.804m)**

A full report was presented to committee in July and September 2016 and further updates provided in November and March. Various strands of work have and are being carried out including the reduction in the allocation for funding for transport in peoples' Personal Budgets; discussing with people at their annual review how they can meet their transport needs in a more cost effective way; and charging self-funders. As reported the budgeted savings have not been possible to deliver in the current framework and this led to the re-profiling of savings for future years. As reported to Committee in March, the transport policy has been revised to help support teams and service users. In addition savings on routes are continuing to be made, with a small reduction in transport expenditure in 2016/17 compared to 2015/16.

2.9.8 **NorseCare Savings (target £0.750m, outturn £0.405m, variance £0.345m)**

The proposed savings with the NorseCare contract were not achieved in full in 2016/17. The savings include the rebate, which includes some recurrent savings from the reduction in the number of beds that will be purchased through the block contract from Ellacombe. This saving will continue to increase over the next few years as beds are decommissioned within the contract. In addition NorseCare has made changes to the terms and conditions for new staff that join the company, which will start to reduce costs in 2017/18.

2.9.9 The below table provides an overview of the full programme of savings and outturn position for 2016-17.

Saving	Action	2016/17		
		Budget £m	Outturn £m	Variance £m
Promoting Independence – Customer Pathway (ASC006)	Strengths based approach rolled out; preventative assessment introduced; OT/AP first approach piloted and rolled out across most of the county.	1.258	1.258	0.000
Promoting Independence – Move service mix to average of comparator family group (ASC011)	As above	0.120	0.120	0.000
Promoting Independence – expanding reablement service (ASC007)	Additional staff in place and increased referrals. Unachieved savings are expected to be delivered in full in 2017-18.	3.158	2.067	(1.091)
Changing how we provide care for people with learning disabilities or physical disabilities (COM034)	Just Checking work completed; contract reviews; void management. Increased focus on re-assessments.	1.500	0.600	(0.900)
Transport – reduce the number of service users we provide transport for and payment of transport out of personal budgets (COM040 and ASC003)	Policy confirmed and new transport review agreed. .	1.050	0.246	(0.804)
Reducing the cost of business travel (GET016)	Complete	0.090	0.090	0.000
Reduce funding within personal budgets to focus on eligible unmet needs (COM033)	Impact from reassessments and strength based approach	2.500	1.967	(0.533)`
Promoting Independence – expand use of Integrated Community Equipment Service (ASC009)	Service redesign and new practice agreed	0.500	0.436	(0.064)

Review of NorseCare agreement for the provision of residential care (COM042)	Joint action plan – Savings planned as Ellacombe placements reduce; external income from placements and NorseCare rebate.	0.750	0.405	(0.345)
	Totals	**10.926**	**7.189**	**(3.737)**

2.10 **Overspend Action Plan**

2.10.1 During the year the department took recovery action to manage and reduce in year spending as far as possible. All localities prepared recovery plans which were reviewed and monitored by Finance and Performance Board and Senior Management Team. This has supported identification of key areas to stabilise and reduce spend, which are now incorporated within the Promoting Independence Programme. This work has helped to stabilise and reduce some areas of spend, focus attention on key areas such as using of Occupational Therapists and Assistant Practitioners to look at preventative measures including use of equipment; consistent use of the Care Arranging Service for brokerage of care packages; reviewing and amending hospital discharge policies; and capacity planning to review workloads across social work teams.

2.11 **Reserves**

2.11.1 The department's reserves and provisions at 1 April 2016 were £5.975m. Reserves totalled £2.848m.

2.11.2 At the point that the budget was set in February 2016, the Council agreed to £1.073m use of Adult Social Services reserves in 2016/17. The year end position on reserves was £0.838m higher than at budget. Following agreement of the Policy and Resources committee, the Period 10 forecast included both the originally agreed £1.073m and use of £0.651m. Both these amounts did not assume use of reserves to offset general overspend. The forecast also included the subsequent agreement from Policy and Resources committee to utilise an additional £0.948m. This was following the recommendation from this Committee, which in light of the overspend, utilised reserves previously earmarked for transformation in adult social care, to offset the overspend position. The 2016-17 outturn position for reserves is £2.074m, which includes some increases due to specific commitments to projects that will now not be spent until the new financial year. Provisions totalled £3.127m at 1 April 2016, mainly for the provision for bad debts. Additional provision for doubtful debts has increased the balance to £4.157m

The projected use of reserves and provisions is shown at **Appendix D.**

2.12 **Capital Programme**

2.12.1 The department's three year capital programme is £24.360m. The programme includes £8.368m relating to Department of Health capital grant for Better Care Fund (BCF) Disabled Facilities Grant (DFG), which is passported to District Councils within the BCF. Work has been undertaken with district councils as part of the BCF programme of work, to monitor progress, use and benefits from this funding. The capital programme also includes £7.926m for the social care and finance replacement system. The priority for use of capital is development of alternative housing models for young adults. There has been some reprofiling of the capital programme to reflect revised spending plans. Details of the current capital programme are shown in **Appendix D**.

3. Financial Implications

3.1 The outturn for Adult Social Services is set out within the paper and appendices. The impact for 2017/18 is set out below.

3.2 As part of the 2017/18 budget planning process, the committee proposed a robust budget plan for the service, which has now been agreed by County Council. This included the reprofiling of savings across the following four years and additional investment to enable effective management of the 2016/17 overspend. Within this investment £4.197m is from one-off funding. This means that the service will need to deliver savings in 2017-18 above the 2017/18 headline amount in order to reduce spending to a level that will ensure that this is addressed before April 2018. These savings will continue to be pursued from areas previously agreed and wherever possible, further efficiencies. The 2017-18 budget was allocated within service teams based on service user commitments at January 2017. The position at year end, suggests that while there are a few variations, there is not a significant change in actual service users at the beginning of the new financial year, which could have changed cost pressures.

3.3 The 2017/18 agreed growth pressures included £9.578m to manage the 2016/17 overspend for the service, some of which has been included on a one-off basis as set out above. The additional investment will support the service to manage the underlying cost pressures affecting predominately the purchase of care budget. The variance to the outturn position for the service reflects some one-off income, including one-off funding from public health to support homelessness services.

3.4 The Council has a high level of outstanding debt with health organisations, however, there was an improved position in quarter 4 with aged debt reducing by £1.245m. The level of debt (above 30 days) outstanding at 31 March with NHS bodies totalled some £5.920m, of which £3.52m is over 181 days. This predominately relates to purchase of care spending, which has been commissioned by the Council on behalf of health or where the Council is seeking full or part contribution towards costs. Discussions are in place with health, but non-recovery would increase cost pressures for the service in 2017/18.

4. 2017/18 Budget

4.1 The 2017/18 budget was set by County Council in February 2017. This was prior to receiving notification of one-off additional social care grant, amounting to £18.561m in 2017/18; £11.901m in 2018/19 and £5.903m in 2019/20. A separate paper setting out proposals for the use of this funding will be presented to the Adult Social Care Committee meeting in July.

4.2 The 2017/18 budget is broken down in the table below:

Actual 2016/17	Over/under spend 16/17	Expenditure Area	Budget 2017/18
£m	£m		£m
10.392	-0.471	Business Development	4.010
69.600	0.123	Commissioned Services	68.381
5.492	-0.727	Early Help & Prevention	8.133
168.243	12.971	Services to Users (net)	188.747
111.914	*8.238*	*Older People*	*111.219*
23.246	*1.207*	*People with Physical Disabilities*	*23.175*
94.527	*11.119*	*People with Learning Disabilities*	*96.395*
13.174	*0.267*	*Mental Health*	*13.548*
6.746	*3.074*	*Hired Transport*	*6.672*
9.144	*-1.194*	*Staffing and Support Costs*	*18.370*
-90.508	*-9.739*	*Income*	*-80.633*
1.064	-7.497	Management, Finance & HR	-7.818
254.791	4.399	**Total Net Expenditure**	**261.453**

4.3 Areas to note include:

a) The Business Development expenditure is expected to be similar to 2016-17, the variation between the 2016/17 outturn and the new year budget is due to year-end adjustments for capital related to the Disabled Facilities Grant
b) Early Help and Prevention budget for 2017/18 is higher than the 2016/17 outturn through the inclusion of additional expenditure for Reablement and removal of the Better Care Fund income
c) Staffing and Support Costs budget for 2017/18 is higher than the outturn for 2016/17. This is because these areas were allocated significant sums from the Better Care Fund to cover their activities in 2016/17, which has the effect of reducing the net budget
d) The net budget for Management, Finance & HR has reduced through the inclusion of additional income through the Improved Better Care Fund and the one-off Adult Social Care Support Grant

5. Issues, risks and innovation

5.1 This report provides the outturn financial performance information on a wide range of services monitored by the Adult Social Care Committee. Many of these services have a potential impact on residents or staff from one or more protected groups. The Council pays due regard to the need to eliminate unlawful discrimination, promote equality of opportunity and foster good relations.

5.2 The financial monitoring reports through the year have outlined a number of risks that impact on the ability of Adult Social Services to deliver services within the budget available. Whilst some of these risks have been mitigated through the budget planning for 2017-18, many will continue into the new financial year and will be reported within the Period 2 monitoring report for this committee in July.

6. Background

6.1 The following background papers are relevant to the preparation of this report.

Finance Monitoring Report – Adult Social Care Committee March 2017 – p19

2017/18 Budget and Medium Term Financial Planning 2017-18 to 2019-20 – Adult Social Care Committee January 2017 – p17

Norfolk County Council Revenue Budget and Capital Budget 2017-20 - County Council February 2017 – p22

Officer Contact

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

Officer Name:	Tel No:	Email address:
Susanne Baldwin	01603 228843	susanne.baldwin@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.

Adult Social Care 2016-17: Budget Outturn Period 13 (March 2017)

Please see table 2.1 in the main report for the departmental summary.

Summary	Budget	Outturn	Variance to Budget		*Variance at Period 10*
	£m	£m	£m	%	*£m*
Services to users					
Purchase of Care					
Older People	103.677	111.914	8.328	7.95%	8.625
People with Physical Disabilities	22.039	23.246	1.207	5.48%	1.266
People with Learning Disabilities	83.408	94.527	11.119	13.33%	9.338
Mental Health, Drugs & Alcohol	12.907	13.174	0.267	2.07%	0.562
Total Purchase of Care	**222.032**	**242.862**	**20.830**	**9.38%**	**19.790**
Hired Transport	3.672	6.746	3.074	83.71%	3.433
Staffing and support costs	10.338	9.144	(1.194)	-11.55%	(0.894)
Total Cost of Services to Users	**236.041**	**258.751**	**22.710**	**9.62%**	**22.330**
Service User Income	(80.769)	(90.508)	(9.739)	12.06%	(6.368)
Net Expenditure	**155.272**	**168.243**	**12.971**	**8.35%**	**15.962**
Commissioned Services					
Commissioning	1.474	1.185	(0.289)	-19.63%	(0.289)
Service Level Agreements	11.157	10.361	(0.795)	-7.13%	(0.889)
ICES	2.602	2.184	(0.418)	-16.07%	(0.242)
NorseCare	30.024	33.280	3.257	10.85%	3.464
Housing related support	9.494	8.323	(1.172)	-12.34%	(0.001)
Independence Matters	13.358	13.114	(0.244)	-1.82%	(0.127)
Other	1.369	1.153	(0.216)	-15.77%	(0.113)
Commissioning Total	**69.477**	**69.600**	**0.123**	**0.18%**	**1.829**
Early Help & Prevention					
Housing With Care Tenant Meals	0.698	0.660	(0.038)	-5.50%	(0.073)
Norfolk Reablement First Support	1.213	0.952	(0.261)	-21.50%	(0.270)
Service Development	1.075	0.998	(0.077)	-7.17%	(0.047)
Other	3.232	2.882	(0.350)	-10.84%	(0.313)
Prevention Total	**6.219**	**5.492**	**(0.727)**	**-11.69%**	**(0.704)**

Adult Social Care
2016-17 Budget Outturn Period 13
Explanation of variances

1. Business Development, underspend (£0.471m) – (4.3%)

The main variances are:

Business Support vacancies, across multi teams.
Logistics, building and supplies actual costs for telephone rental and calls and postage costs were lower than forecast.

2. Commissioned Services overspend £0.123m – 0.2%

The main variances are:

NorseCare, overspend of £3.257m. This relates to the previous year shortfall on the budgeted reduction in contract value and previously reported contractual requirements that meant that 2015-16 savings could not be achieved. As reported savings include the rebate, which includes some recurrent savings from the reduction in the number of beds that will be purchased through the block contract from Ellacombe. This saving will continue to increase over the next few years as beds are decommissioned within the contract. In addition NorseCare has made changes to the terms and conditions for new staff that join the company, which will start to reduce costs in 2017/18.

Service Level Agreements, underspend of £0.795m. Reductions in planned costs and additional Continuing Health Care income.

Integrated Community Equipment Service (ICES), underspend (£0.418m)

Housing related support, underspend (£1.172m), primarily due to £1.2m one-off contribution from Public Health to support homelessness services.

3. Services to Users, overspend £12.971m

The main variances are:

Purchase of Care (PoC), overspend £20.830m.

The key reasons for the differences between the outturn position and the 2016-17 budget are:

- The impact of the budget gap – the service managed underlying unfunded pressures (reflected in the overspend at the end of 2015/16). The budget was set reflecting commitments (cost of placements) at January 2016, but the pressures from commitments at April compared to actual budget showed a £3.5m underlying pressure
- The service has not been able to deliver all planned savings during the year, which has predominately impacted on the purchase of care budgets. This relates to reablement and review of packages of care, which is set out in section 2.9 of this report
- The 2016/17 financial cost of both the cost of care exercise and the impact to care providers from the national living wage was not included in the adult social care budget when it was set in February. Additional costs totalling £5.155m are included in the 2016/17 spend. This is offset by the use of the corporate business risk reserve which is included within the income for services to users. This reduces the actual underlying

overspend for purchase of care, most significantly £4m for older people purchase of care and £0.500m for learning disabilities

- The purchase of care spend includes a reduction in overall commitments, including long term residential care and home support, but with a notable increase in spending on residential respite for older people. This reflects continuing pressure from hospital discharges leading to temporary care packages that may not best support the Promoting Independence strategy and lead to increase spend.
- Tightened controls to manage home support contracts has resulted in a reduction in spend.
- Management of direct payments has ensured that reclaims were maximised, which has helped to reduce the overspend in the final quarter of the year.

Service User Income, over-recovery (£9.739m). The outturn includes the additional income from the Corporate Risk Reserve of £5.155m in relation to cost of care and national living wage. There is also increase against budget for income from service users of mental health, physical disabilities and learning disability services, reflecting more people being eligible for charging than previously forecast. Excluding movement for NHS income affecting shared care and continuing health care, the actual income from service users was £0.484m higher than forecast at Period 10.

Hired Transport, overspend £3.074m. The savings from transport have not been realised, with savings of £0.246m achieved, through application of the policy, route changes and contract reductions. The forecast includes expected delay in 2016/17 savings. Reports providing an update on the Transport savings and project were reported regularly to Committee during 2016-17.

4. Early Help and Prevention, underspend (£0.727m)

The main variances are:

Reablement, underspend (£0.261m). Includes reduced spending on standby payments and travel and temporary long-term sickness cover that is no longer required.

Other services, underspend (£0.350m). The variance mainly relates to vacancies affecting the care arranging service, development workers and transformation.

5. Management, Finance and HR, underspend (£7.497m)

The main variances are:

Management and Finance, underspend (£7.475m). As part of the budget setting, funding relating to the Care Act was held with the Management and Finance budget, in order to focus on the savings delivery and to enable this money to be allocated longer term once spending is at a sustainable level. The outturn includes the release of (£6.8m) of Care Act funding that was not allocated to specific budgets at the beginning of the year and reserve usage of (£0.948m) from unspent grants and contributions earmarked for transformation. It is offset by £0.301m to support the proportion of in-year savings that were not delivered in the financial year, arising from the reduction in Better Care Fund allocation.

Adult Social Services Reserves and Provisions 2016/17

	Balance	P13 Final Usage or addition	Balance
	01-Apr-16	2016/17	31-Mar-17
	£m	£m	£m
Doubtful Debts provision	3.121	1.036	4.157
Redundancy provision	0.006	-0.006	0.000
Total Adult Social Care Provisions	**3.127**	**1.030**	**4.157**
Prevention Fund – General - As part of the 2012-13 budget planning Members set up a Prevention Fund of £2.5m to mitigate the risks in delivering the prevention savings. £0.131m remains of the funding, and it is being used for prevention projects: Ageing Well and Making it Real. 2013-14 funding for Strong and Well was carried forward within this reserve as agreed by Members. £0.122m remains of the funding, all of which has been allocated to external projects, and will be paid upon achievement of milestones. Market Development fund – carried forward committed funds	0.253	-0.032	0.221
Repairs and renewals	0.043	0.000	0.043
Adult Social Care Workforce Grant	0.070	0.185	0.255
IT Reserve - Slippage in revenue spending pattern in relation to social care information system reprocurement	0.000	0.361	0.361
Unspent Grants and Contributions - Mainly the Social Care Reform Grant which is being used to fund Transformation in Adult Social Care	2.482	-1.287	1.195
Total Adult Social Care Reserves	**2.848**	**-0.774**	**2.074**

Corporate Business Risk Reserve	**10.157**	**-10.157**	**0.000**

Total Reserves & Provisions	**16.132**	**-9.901**	**6.231**

Adult Social Services Capital Programme 2016/17

Summary	2016/17		2017/18	2018/19
Scheme Name	**Current Capital Budget**	**Outturn**	**Capital Budget**	**Draft Capital Budget**
	£m	£m	£m	£m
Failure of kitchen appliances	0.001	0.001	0.030	0.000
Supported Living for people with Learning Difficulties	0.003	0.003	0.015	0.000
Adult Social Care IT Infrastructure	0.000	0.000	0.141	0.000
Progress Housing - formerly Honey Pot Farm	0.310	0.310	0.000	0.000
Adult Care - Unallocated Capital Grant	0.000	0.000	4.198	0.000
Strong and Well Partnership - Contribution to Capital Programme	0.008	0.008	0.121	0.000
Bishops Court - King's Lynn	0.000	0.000	0.085	0.000
Cromer Road Sheringham (Independence Matters	0.169	0.169	0.000	0.000
Winterbourne Project	0.000	0.000	0.050	0.000
Great Yarmouth Dementia Day Care	0.033	0.033	0.000	0.000
Care Act Implementation	0.000	0.000	0.871	0.000
Social Care and Finance Information System	0.776	0.776	5.328	1.912
Elm Road Community Hub	0.076	0.076	1.215	0.109
Better Care Fund Disabled Facilities Grant and Social Care Capital Grant – passported to District Councils	6.368	6.368	2.000	0.000
Bowthorpe Scheme	-0.023	-0.023	0.000	0.000
Netherwood Green	0.005	0.005	0.650	0.000
TOTAL	**7.726**	**7.726**	**14.613**	**2.021**

Adult Social Care Committee

Item No……

Report title:	**Performance management report**
Date of meeting:	**19 June 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.

The report reviews the whole of the last year's performance, detailing areas of sustained good performance, areas of improvement, areas of deteriorating performance, and areas where performance remains challenging. It highlights Norfolk's strong performance in providing service users with choice, and in supporting people to get back on their feet through reablement; and improved performance in admissions for residential care for working aged adults, in the quality of commissioned services, and in reducing the overall number of older people requiring formal care services.

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. % people in residential and community based care, and permanent admissions to residential care (65+ years) (off target)
e. % people in residential and community based care, and permanent admissions to residential care (18-64 years) (off target)

Recommendations

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

a. Discuss and agree the performance data
b. Agree the actions to address performance in the vital signs report cards
c. Agree to delegate to the Director the submission of data for statutory returns
d. Agree to receive a report in September showing targets for 2017/20

1 Introduction

1.1 This performance monitoring report provides the most up to date performance data available, to the end of period 12 (March 2017). As such this represents an end-of-year report for the financial and reporting year 2016/17, with section 3 and 4 presenting performance in the Committee's Vital Signs key performance indicators, and section 5 presenting provisional results for our annual statutory Adult Social Care Outcome Framework (ASCOF) indicators that we submit to Central Government.

2 Summary of performance 2016/17

2.1 An overview of performance in both Vital Signs and ASCOF indicators presents mixed performance, with some areas of strong and sustained performance, some areas of improvement, some areas where performance has deteriorated, and a small number of difficult areas where we have not yet turned around more sustained performance issues.

2.2 **Sustained good performance**

Norfolk continues to perform well in the following areas:

a) **Giving people who use services choice**. The proportion of both service users and carers who use services who receive self-directed support, the rate of carers receiving Direct Payment, remains above target, and are likely to remain above key benchmarks. Only the indicator relating to Direct Payments for service users missed target, through remains above benchmarks

b) **Helping people get back on their feet following a crisis**. Performance in key reablement services and short term services is good – exceeding targets and key benchmarks, with the proportion of people aged 65+ at home 91 days after discharge into reablement services continuing to be over 90%

2.3 **Areas where we have improved**

The following areas have seen significant improvements over the year:

a) **The number of people aged 18-64 permanently admitted to residential or nursing care.** Historically Norfolk admitted far too many younger adults into permanent residential or nursing care, with admissions in 2013/14 at a rate of over three times our family group average. The last four years have seen sustained and significant improvements, moving from a rate of 52 admissions per 100,000 population aged 18-64 in 2012/13 to just 15.8 in 2016/17. Nevertheless, continued improvement is required. Whilst Norfolk's reduction in admissions is significant, the 2016/17 result is likely to mean it remains one of the highest 'placers' in its family group

b) **The quality of social care providers**. The Care Quality Commission assesses all registered care providers in the county, and the proportion of providers rated 'good' or above has increased significantly from 56.9% in March 2016 to 72.8% in December (the latest available data)

c) **The number of older people requiring formal social care services**. The number of older people requiring formal care services decreased from 3,524 per 100,000 population aged 65+ in March 2016 to 3,404 a year later – a reduction of nearly 3.5% - showing that improved reablement services, and more "strength-based" social care practice, is improving the independence of more older people

2.4 **Areas where performance has worsened**

The following areas have seen a deterioration in performance over the year:

a) **Delayed transfers from hospitals into Adult Social Care.** After a very good performance in the previous three years, Norfolk's Delayed Transfers of Care Attributable to Social Care increased from a rate of around 1.5 to 3.6 in 2016/17. Most of this increase is attributable to delays from the Norfolk & Norwich University Hospital, where significant pressures – particularly over the winter months – and some changes to recording practices have resulted in over double the rate of delays. These increases are mirrored nationally and reflect overall pressures on the health and social care system. Overall Norfolk's rate is likely to remain below the Family Group average

b) **The number of people aged 65+ permanently admitted to residential or nursing care.** After a number of years of consistent reductions, admissions increased slightly in 2016/17. The increase reflects the same pressures that are driving increased delayed transfers of care, along with reported issues with finding appropriate alternatives to residential care in some areas

2.5 **Areas where performance remains challenging**

The following areas have low performance that has not significantly improved over the year:

a) **The % of people receiving learning disabilities services in paid employment.** Performance has remained below target, and below significant benchmarks, throughout the year. This is mitigated to some extent by an increase in voluntary employment which, whilst not contributing to the ASCOF indicator, demonstrates improved outcomes for an increased number of people

b) **The % of people receiving mental health services in paid employment.** We have only gathered this indicator during the last year. Targets aim for consistent improvement, however performance has remained low and stable throughout the year

2.6 The remainder of the report looks at the detail behind these headlines, with section 3 and 4 presenting performance in the Committee's Vital Signs key performance indicators, and section 5 presenting provisional results for our annual statutory Adult Social Care Outcome Framework (ASCOF) indicators that we submit to Central Government.

3 Performance dashboard

3.1 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.

3.2 The dashboard is presented below.

3.3 Adult Social Services Dashboard

Monthly	Bigger or Smaller is better	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Target
% of people who require no ongoing formal service after completing reablement	Bigger	86.3% 334 / 387	87.2% 387 / 444	91.8% 367 / 400	89.9% 357 / 397	89.1% 342 / 384	89.4% 371 / 415	91.6% 380 / 415	92.9% 352 / 379	91.0% 365 / 401	91.9% 340 / 370	84.2% 362 / 430	85.8% 387 / 451	88.6% 413 / 466	
Decreasing the rate of admissions of people to residential and nursing care per 100,000 population (18-64 years)	Smaller	21.7	21.1	19.7	18.7	17.7	18.3	17.0	16.6	16.6	16.4	18.5	18.1	19.3	**16.5**
Decreasing the rate of admissions of people to residential and nursing care per 100,000 population (65+ years)	Smaller	623	616	622	614	613	613	621	630	637	628	627	625	633	**573**
Decreasing the rate of people in residential and nursing care per 100,000 people	Smaller	565	567	568	562	558	558	555	558	563	562	554	557	557	
Increasing the proportion of people in community-based care	Bigger	66.8% 8203 / 12277	66.7% 8173 / 12259	66.7% 8204 / 12299	66.9% 8190 / 12243	67.1% 8208 / 12233	67.1% 8200 / 12223	67.2% 8197 / 12196	67.1% 8198 / 12222	66.7% 8128 / 12190	66.4% 8028 / 12082	66.7% 8011 / 12005	66.6% 8020 / 12036	66.6% 8015 / 12034	
Decreasing the rate of Council service users per 100,000 population (18-64 years)	Smaller	936	935	937	940	939	937	938	941	937	935	934	931	938	
Decreasing the rate of Council service users per 100,000 population (65+ years)	Smaller	3,523	3,516	3,531	3,497	3,496	3,494	3,479	3,486	3,479	3,433	3,399	3,422	3,404	

Monthly	Bigger or Smaller is better	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Target
% of people still at home 91 days after completing reablement	Bigger	90.7% 675 / 744	92.2% 650 / 705	91.9% 682 / 742	93.3% 699 / 749	94.3% 779 / 826	93.2% 744 / 798	94.5% 750 / 794	94.1% 732 / 778	93.0% 771 / 829	93.1% 828 / 889	93.1% 825 / 886	93.5% 839 / 897	94.2% 861 / 914	**90.0%**
Number of days delay in transfers of care per 100,000 population (attributable to social care)	Smaller	1.5	2.9	2.6	2.4	2.6	3.0	3.1	3.1	3.1	3.2	3.4	3.5	3.56	**1.5**
% People receiving Learning Disabilities services in paid employment	Bigger	3.7% 77 / 2095	3.3% 71 / 2127	3.3% 69 / 2120	3.2% 69 / 2128	3.2% 69 / 2126	3.3% 70 / 2133	3.3% 71 / 2127	3.3% 71 / 2136	3.3% 70 / 2138	3.3% 70 / 2135	3.3% 69 / 2122	3.3% 69 / 2113	3.3% 69 / 2122	**4.0%**
% People receiving Mental Health services in paid employment	Bigger	2.1% 16 / 768	1.9% 15 / 770	2.1% 16 / 773	2.3% 18 / 778	2.3% 18 / 776	2.3% 18 / 772	2.3% 18 / 783	2.3% 18 / 790	2.3% 18 / 787	2.3% 18 / 782	2.1% 17 / 798	2.0% 16 / 806	2.0% 17 / 832	**3.7%**
% Enquiries resolved at point of contact / clinic with information, advice	Bigger	42.3% 2097 / 4955	34.0% 1575 / 4636	36.2% 1579 / 4367	35.5% 1621 / 4562	37.4% 1720 / 4602	33.3% 1532 / 4599	37.2% 1716 / 4613	37.1% 1606 / 4326	37.3% 1668 / 4476	36.5% 1400 / 3831	37.9% 1779 / 4698	38.2% 1485 / 3888	40.0% 1931 / 4825	
Rate of carers supported within a community setting per 100,000 population	Bigger	647	604	602	607	598	598	589	586	591	588	583	576	581	
% of CQC ratings of all registered commissioned care rated good or above	Bigger	56.9% 99 / 174	60.6% 123 / 203	61.2% 131 / 214	62.9% 154 / 245	65.2% 174 / 267	68.2% 210 / 308	69.5% 228 / 328	69.7% 264 / 379	72.8% 286 / 393	72.8% 302 / 415	/	/	/	

Monthly	Bigger or Smaller is better	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Target
% Social care assessments resulting in solely information and guidance	Bigger	11.1% 113 / 1019	13.0% 127 / 975	9.0% 79 / 877	14.2% 107 / 752	9.7% 70 / 719	14.2% 97 / 681	9.2% 65 / 709	13.5% 88 / 653	11.5% 82 / 715	11.3% 62 / 551	8.1% 53 / 655	/	/	

Notes: results without alerts/colouring denote where targets have not yet been set. Missing data is due to time lags in data being available to report on – the dashboard contains the most up to date information available at the time of writing.

*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

4 Report cards

4.1 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.

4.2 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.

4.3 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

4.4 The report cards for vital signs that do not meet the exception criteria on this occasion, and so are not included in this report, are 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.

4.5 These are 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.

4.6 The five 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. % people in residential and community based care, and permanent admissions to residential care (65+ years) (off target)
e. % people in residential and community based care, and permanent admissions to residential care (18-64 years) (off target)

4.7 **Key actions being undertaken to address performance issues**

Actions to address performance issues include:

Delayed transfers of care:

a) Undertake priority actions in partnership with health services to ensure timely discharges from hospitals into appropriate care settings through integrated discharge arrangements
b) Review and re-enforce reablement first following acute care pathways and no permanent placements from hospital.
c) Closer working between performance leads at acute hospitals and NCC

Learning disabilities/employment:

a) Review of day service providers to ensure that providers who say they provide support for people to find work do so. Following review, ensure effective contractual arrangements support targets with providers offering employment / work related / volunteering
b) Progression of OWL (Opportunity, Work, Learning) project

c) Work with the NCC employment support service for people with Learning Disabilities, called Match, to identify the barriers to employment
d) NCH&C to consider 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

Mental health/employment:

a) 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
b) 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
c) Monthly checks by team managers to ensure that each service user has an employment status recorded on their record. This includes volunteering, training and work related activity

Permanent admissions to residential care (18-64)

a) Find people aged 18-64 alternative long term accommodation arrangements where appropriate through the review process
b) Focus commissioning activity around accommodation on improved multi-tenant options for people aged 18-64 and accommodation-based enablement
c) Engage partners in providing appropriate care to keep people in their own home

Permanent admissions to residential care (65+)

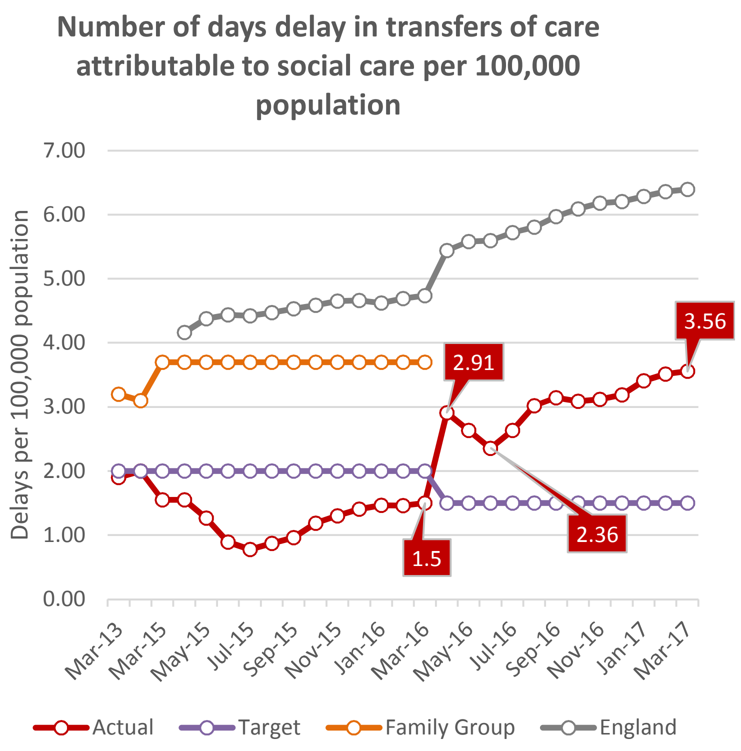
a) Focus commissioning activity around accommodation on reablement, sustainable domiciliary care provision, crisis management and accommodation options for those aged 65+ to assist people to continue live independently
b) Monitor admission levels to identify if the recent increase becomes a trend
c) Review use of planning beds and implement actions to reduce conversion to long term placement
d) Re-enforce reablement/therapy first to prevent unnecessary admission to long term residential care

4.7 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 days delay per 100,000 of population nearly doubled when compared to the previous month, dropping off slightly in the subsequent months and then persistently rising to a record high in March 2017 (3.56).
- The increase appears to have 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 4 of the 5 subsequent months. There was a decrease between August and December (299 to 125) which has since risen to 225 (Feb17). Over the same period social care delays from NCH&C have risen from 268 (Aug16) to 344 (Feb17) and count for approximately 50% of Norfolk's social care delays since April 16.
- Since April 16 the NNUHFT has conducted 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 regularly, but unpredictably, escalates to OPEL Status in response to pressure within the hospital. This results in a spike of referrals to the social services discharge team and can take a short while to reduce.
- The NNUHFT has set up a discharge hub and team to support their discharge process. A daily process to validate delays is now in place and the teams will co-locate within a month.
- 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. This is now being implemented in community units, with Phase 3 of the Integration Programme also including a work-stream looking at social care offer to the units.
- The focus on community units has created additional demand and pressure on social care, however the length of stay has significantly reduced. The increased focus on the continuing care process and Discharge to Assess pathway has also caused additional, but expected pressure.

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.
- Review and re-enforce re-enablement first following acute care pathways and no permanent placements from hospital.
- Performance leads at acute hospitals and NCC to work together to achieve "one version of the truth".

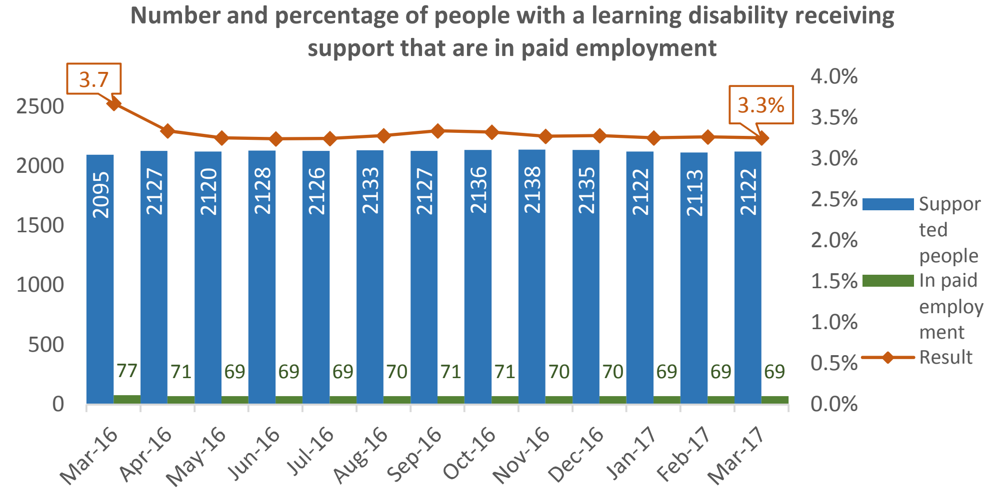
Lead: Lorrayne Barrett, Director of Integrated Care   Data: Business Intelligence & Performance Team

4.8 % of people with learning disabilities 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
Jan-17	89
Feb-17	91
Mar-17	95

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 17).
- 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 Learning Disabilities (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.

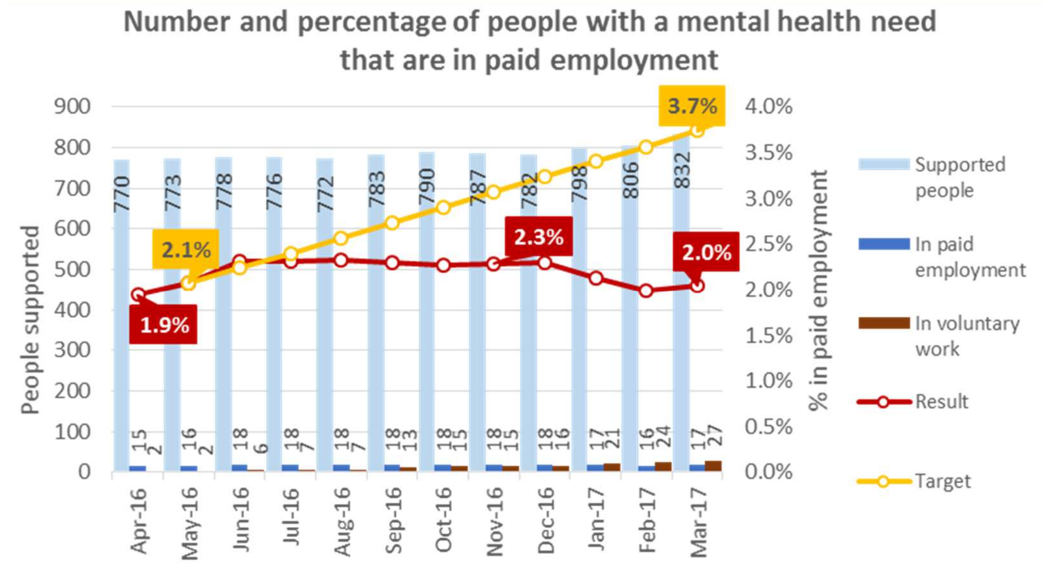
Responsible Officers Lead: Lorrayne Barrett, Director of Integrated Care Data: Business Intelligence & Performance Team

4.9 Number and % of 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 broadly similar, from a low of 15 people in Apr 2016 to 17 people in Mar 2017.
- To meet the ambitious increasing target, 32 of the 835 people supported needed to be in paid employment by the end of March 2017.
- Service users seeking work may no longer meet Care Act eligibility. They are not captured in service performance figures if they progress onto work but are no longer eligible for a funded service.
- The number of people in voluntary work or training and work related activities has been recorded since April 2016. The numbers have risen each month from 2 people at the start to 27 people now 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 support then 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.

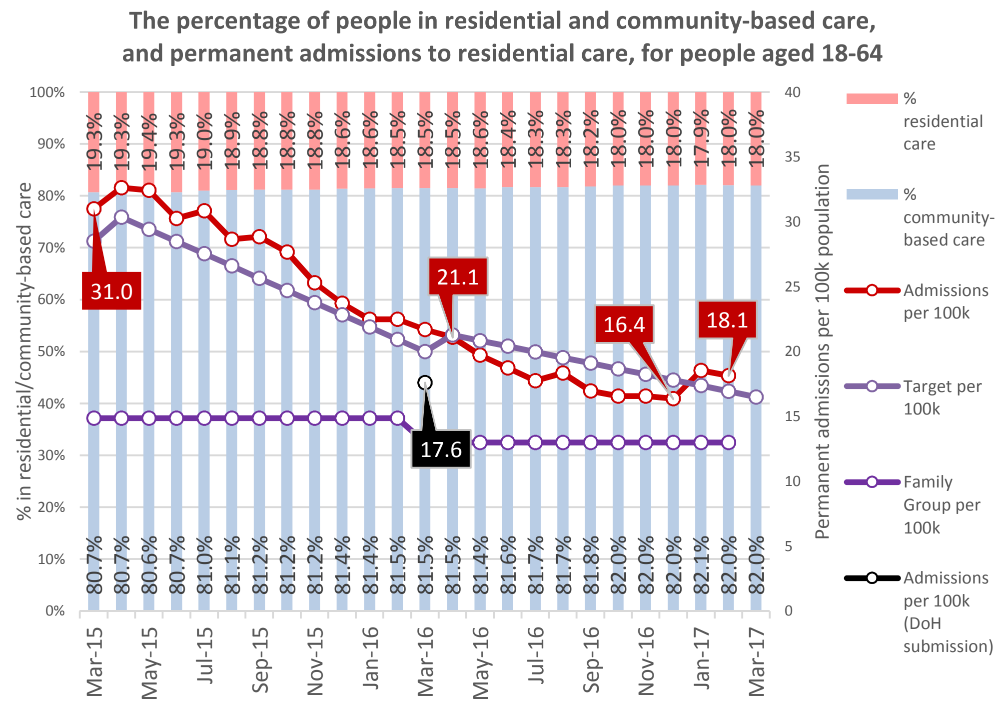
Responsible Officers | Lead: Alison Simpkin | Data: Business Intelligence & Performance Team

4.10 % people in residential and community based care, and permanent admissions to residential care (18-64 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?

- The percentage of people receiving community based care has increased from 80.7% in March 2015 to 82.0% in March 2017 where it has remained static since December 2016.
- Historic admissions to residential care for people aged 18-64 were very high in Norfolk at nearly three times the family group average.
- Improvements have seen year-on-year reductions accelerate with admissions going from 31.0/100k in Mar 2015 to 16.4/100k in Dec 2016. The reduction from Apr 2016 onwards brought admissions per 100k below the target rate however the increase in Jan 2017 took admission rates (18.5/100k) above target for the first time in 9 months.
- Reductions have been achieved through a combination of focussing social work practice on residential reviews, and approving temporary only admissions to residential care for a maximum of 6 months – agreed by panels.
- Placements are made in specialist mental health care homes using recovery approaches, and specialist housing with care for people who would previously have been placed in residential care.
- There has been a greater focus on filling supported living voids as an alternative to residential care.
- Learning Disabilities admissions account for almost half of admissions. Rates in Mental Health have been reducing steadily over a 2 year period and now account for less than 25% of admissions.

What will success look like?

- Admissions for levels at or below the family group benchmarking average (around 13 per 100,000 population)
- Subsequent reductions in overall placements
- Availability of quality alternatives to residential care for those that need intensive long term support
- A commissioner-led approach to accommodation created with housing partners

Action required

- Further reductions required through good practice
- A focus on specialisms where rates continue to be high
- Reviews must also seek to find people aged 18-64 alternative long term accommodation arrangements where appropriate
- Commissioning activity around accommodation to focus on improved multi-tenant options for people aged 18-64 and accommodation-based enablement
- Engage partners in providing appropriate care to keep people in their own homes

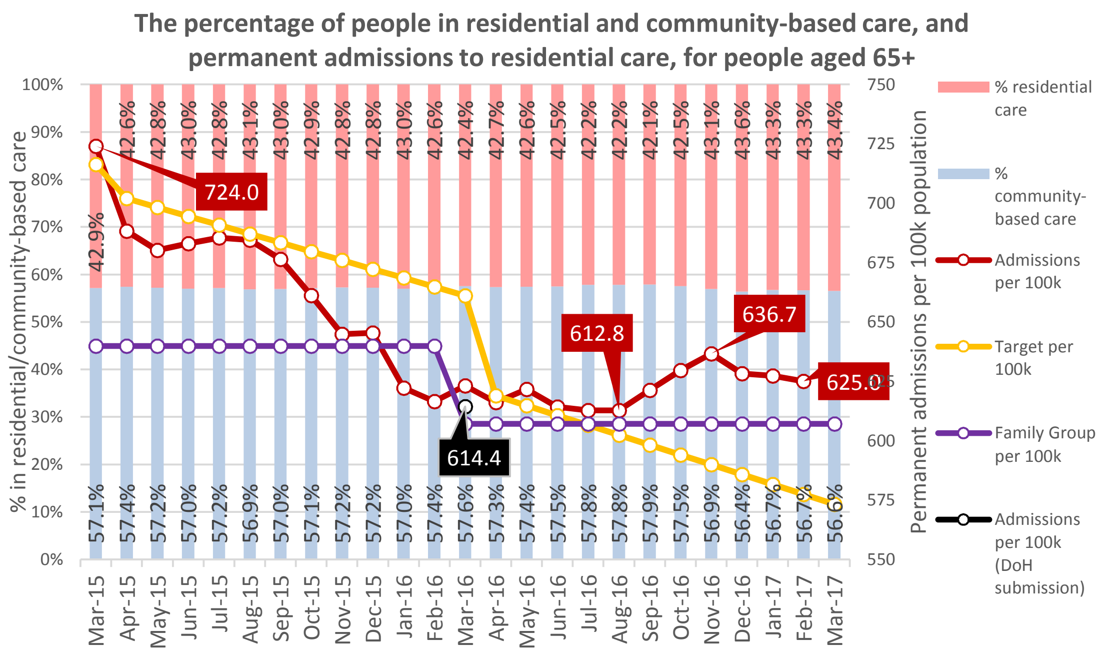
Responsible Officers	Lead: Lorrayne Barrett, Director of Integrated Care, and Lorna Bright, Assistant Director Social Work	Data: Business Intelligence & Performance

4.11 % people in residential and community based care, and permanent admissions to residential care (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 two years has seen the rate of admissions per 100k reduce from 724 in March 2015 to a low of 613 (August 2016). The subsequent increase took admissions per 100k to the highest point (636.7) since December 2015 before reducing slightly from December 2016 onwards. Admissions continue to diverge from the downwards moving target.
- 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 43.4% now (March 2017).
- Reductions had been driven by improvements to:
  - Reablement services
  - Improvements to the hospital discharge pathway
  - Improved 'strength based' social care assessments
- Reductions in 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 interventions such as reablement, sustainable domiciliary care provision, crisis management and accommodation options for those aged 65+ will assist people to continue live independently
- 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

5 Norfolk's statutory performance returns 2016-17

5.1 Every year the council submits a series of significant data 'returns' to the Department of Health – this is information we return to central government about the services we provide as a Local Authority. Returns include data about the volumes of people in short and long term services, surveys asking about the views of people using adult social care services, and details of the safeguarding activities that the department has undertaken with its partners. Officers have recently submitted the Short and Long Term Support (SALT) return and two returns reporting on our statutory surveys of service users and carers. The data submitted is currently classified as 'provisional' as it has not been checked and validated by the Department of Health.

5.2 The Short and Long Term Support (SALT) return is designed to provide outcome and pathway information for service users, showing not just numbers of events and services, but what happened after these events, service movements in year and the factors prompting these movements.

Unlike the returns from several years ago, the SALT returns does not contain specific event information (i.e. number of assessments, reviews and referrals).

5.3 Returns contribute to a range of publications and data releases throughout the year, and allow us, for example, to compile benchmarking reports. Crucially they determine the council's results against the Government's Adult Social Care Outcome Framework (ASCOF). Accepting that the results are provisional and may change subject to the Department of Health's validation process, Norfolk's ASCOF figures are currently as follows.

Provisional ASCOF Results 2016/17

Indicator Reference	Indicator Name	Good is	Numerator	Denominator	Current Target	Norfolk Provisional 2016/17 Result	Provisional Performance vs Norfolk Result 2015/16	Family Group 2015/16	Eastern Region 2015/16	England 2015/16
SALT indicators										
1C(1A)	The proportion of people who use services who receive self-directed support	High	7,244	7,968	70	**90.9**	88.2	84.1	85.1	86.9
1C(1B)	The proportion of carers who receive self-directed support	High	1,315	1,531	70	**85.9**	88.1	60.4	89.2	77.7
1C(2A)	The proportion of people who use services who receive direct payments	High	2,427	7,968	35	**30.5**	33.0	30.4	29.2	28.1
1C(2B)	The proportion of carers who receive direct payments	High	1,305	1,531	35	**85.2**	87.7	55.0	83.1	67.4
1E	The proportion of adults with a learning disability in paid employment	High	74	2,178	4	**3.4**	3.7	5.1	7.1	5.8
1G	The proportion of adults with a learning disability who live in their own home or with their family	High	1,622	2,178	75	**74.5**	74.0	76.7	74.0	75.4
2A(1)	Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 pop'n	Low	80	507,180	16.5	**15.8**	17.5	13.0	15.8	13.3
2A(2)	Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 pop'n	Low	1,321	213,765	573.3	**618.0**	616.4	607.0	570.3	628.2
2B(1)	The proportion of older people (aged 65 and over) still at home 91 days after discharge from hospital into reablement/rehab services	High	722	772	90	**93.5**	91.7	83.2	82.6	82.7
2D	The outcome of short-term services: sequel to service	High	2,552	3,028	82.5	**84.3**	73.9	76.7	81.5	75.8

Indicator Reference	Indicator Name	Good is	Numerator	Denominator	Current Target	Norfolk Provisional 2016/17 Result	Provisional Performance vs Norfolk	Family	Eastern	England
Adult Social Care Survey (ASCS) Indicators										
1A	Social care related quality of life	High	249,678	12,951		**19.3**	19.2	19.2	19	19.1
1B	The proportion of people who use services who have control over their daily life	High	10,269	12,951		**79.0%**	78.2%	78.0%	77.4%	76.6%
1I1	The proportion of people who use services who reported that they had as much social contact as they would like	High	6,381	12,951		**49.0%**	47.5%	45.6%	44.8%	45.4%
3A	Overall satisfaction of people who use services with their care and support	High	8,387	12,951		**65.0%**	67.6%	65.3%	64.5%	64.4%
3D1	The proportion of people who use services who find it easy to find information about services	High	9,473	12,951		**73.0%**	71.2%	72.8%	72.7%	73.5%
4A	The proportion of people who use services who feel safe	High	9,101	12,951		**70.0%**	67.8%	70.1%	68.7%	69.2%
4B	The proportion of people who use services who say that those services have made them feel safe and secure	High	10,786	12,951		**83.0%**	81.0%	86.0%	82.4%	85.4%
Health indicators										
2C1	Delayed transfers of care from hospital per 100,000 population (all delays)	Low	996			**11.5**	10.8	12.2	15	N/A
2C2	Delayed transfers of care from hospital per 100,000 population (attributable to social care)	Low	299			**3.6**	1.5	4.7	6.4	N/A
Survey of Adult Carers in England (SACE) indicators							Norfolk Result 2014/15	Family Group 2014/15	Eastern Region 2014/15	England 2014/15
1D	Carer reported quality of life	High	3,921	522		**7.5**	7.5	7.8	7.9	7.9
1I2	Proportion of carers who reported that they had as much social contact as they would like	High	176	550		**32.0%**	32.2%	35.8%	41.3%	38.5%
3B	Overall satisfaction of carers with social services	High	172	463		**37.1%**	41.5%	41.4%	40.6%	41.2%
3C	Proportion of carers who report that they have been included or consulted in discussions about the person they cared for	High	277	388		**71.4%**	69.0%	N/A	72.7%	72.3%
3D2	The proportion of carers who find it easy to find information about services	High	231	369		**62.6%**	67.0%	64.0%	64.9%	65.5%

6	**Targets for 2017-20**
6.1	Targets are being developed in line with the developing Promoting Independence Strategy action plans, and to reflect the volumes of services and outcomes required by this and the department's emerging Cost and Demand Model. Targets will be proposed to Committee for discussion, amendment and sign-off, as part of the next performance management paper.
7	**Financial Implications**
7.1	There are no significant financial implications arising from the development of the performance management framework or the performance monitoring report.
8	**Issues, risks and innovation**
8.1	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:

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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.

Adult Social Care Committee

Item No.

Report title:	**Risk Management**
Date of meeting:	**19 June 2017**
Responsible Chief Officer:	**James Bullion, Executive Director of Adult Social Services**

Strategic impact

Monitoring risk management and the departmental risk register helps the Committee undertake some of its key responsibilities and provides contextual information for many of the decisions that are taken.

Executive summary

As this is the first Adult Social Care committee meeting of 2017/18 this report presents the full departmental risk register for information on the department's risks. For future reports, it is proposed to report by exception. Further details can be seen in paragraph 1.2.

Risks are where events may impact on the Department and the County Council achieving its objectives and these are set out in the risk register together with tasks to mitigate each of the risks and progress updates.

Recommendations:

Committee Members are asked to:

a) **Discuss and agree the risk register as set out in Appendix A.**

1 Proposal

1.1 The Adult Social Care departmental risk register has been refreshed for 2017/18 and this report provides the Committee with an update of the most recent changes.

1.2 This report provides the full departmental risk register, inclusive of corporate risks pertaining to Adult Social Care. The Department's risks can be seen at **Appendix A.** For future reports, it is proposed to report by exception, providing full details of risks that have a score of 12 or more, with a prospects score (of meeting the target score by the target date) of red or amber. A summary of all risks on the departmental risk register will be provided to future committees.

2 Evidence

2.1 The Adult Social Services departmental risk register reflects both corporate and departmental key business risks that need to be managed by the Senior Management Team and which, if not managed appropriately, could result in the service failing to achieve one or more of its key objectives and/or suffering a financial loss or reputational damage. The risk register is a dynamic document that is regularly reviewed and updated in accordance with the Council's "Well Managed Risk – Management of Risk Framework".

2.2 A clear focus on strong risk management is necessary as it provides an essential tool to ensure the successful delivery of our strategic and operational objectives. The Business

Development Manager meets regularly with the Risk Management Officer to provide an update on each of the risks contained within the risk register.

3 Risk Register

3.1 Each risk score is expressed as a multiple of the impact and the likelihood of the event occurring:

a) Original risk score – the level of risk exposure before any action is taken to reduce the risk when the risk was entered on the risk register
b) Current risk score – the level of risk exposure at the time the risk is reviewed by the risk owner, taking into consideration the progress of the mitigation tasks
c) Target risk score – the level of risk exposure that we are prepared to tolerate following completion of all the mitigation tasks

3.2 In accordance with the Risk Matrix and Risk Tolerance Level set out within the current Norfolk County Council "Well Managed Risk - Management of Risk Framework", four risks are reported as "High" (risk score 16–25) and 14 as "Medium" (risk score 6–15) and one as "Low" (risk score 1-5). A copy of the Risk Matrix and Tolerance Levels appears at **Appendix B**.

3.3 The prospects of meeting target scores by the target dates are a reflection of how well mitigation tasks are controlling the risk. It is also an early indication that additional resources and tasks or escalation may be required to ensure that the risk can meet the target score by the target date. The position is visually displayed for ease in the "Prospects of meeting the target score by the target date" column as follows:

a) Green – the mitigation tasks are on schedule and the risk owner considers that the target score is achievable by the target date
b) Amber – one or more of the mitigation tasks are falling behind and there are some concerns that the target score may not be achievable by the target date unless the shortcomings are addressed
c) Red – significant mitigation tasks are falling behind and there are serious concerns that the target score will not be achieved by the target date and the shortcomings must be addresses and/or new tasks are introduced

3.4 The current risks are those identified against the departmental objectives for 2017/18 and have been reviewed for this report.

4 Attachments

4.1 **Appendix A** provides Committee members with the full departmental risk register including Adult Social Care corporate risks.

Appendix B provides Members with a Risk Matrix, showing where the risks sit on the risk spectrum from 1 (lowest possible score) to 25 (highest possible score).

Appendix C provides Committee members with a definition of key changes which will be reported to the Committee.

5 Financial Implications

3.1 There are no financial implications other than those identified within the risk register.

4 Issues, risks and innovation

4.1 There are no other significant issues, risks and innovations arising from this Risk Management report.

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

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Risk Register - Norfolk County Council

Risk Register Name	**Adult Social Care Departmental Risk Register**
Prepared by	**Sarah Rank and SMT**
Date updated	**May 2017**
Next update due	**September 2017**

Risk score key	Prospects key
High	Red
Med	Amber
Low	Green
	Met

	Service	Risk number	Risk name	Risk Description	Date entered on risk register	Original Likelihood	Original Impact	Original Risk Score	Current Likelihood	Current Impact	Current Risk Score	Tasks to mitigate the risk	Progress update	Target Likelihood	Target Impact	Target Risk Score	Target Date	Prospects of meeting Target Risk Score by Target Date	Risk Owner	Reviewed and/or updated by	Date of review and/or update
C	Adult Social Care Committee	RM14079 and RM020a	Failure to meet the long term needs of Norfolk citizens	If the Council is unable to invest sufficiently to meet the increased demand for services it could result in worsening outcomes for service users, promote legal challenges and negatively impact on our reputation. With regard to the long term risk, bearing in mind the current demographic pressures and budgetary restraints, the Local Government Association modelling shows a projection suggesting local authorities may only have sufficient funding for Adult's and Children's care.	11/10/2012	5	5	25	4	5	20	1) Implementation of Promoting Independence Strategy. This strategy is shaped by the Care Act with its call to action across public services to prevent, reduce and delay the demand for social care. The strategy aims to ensure that demand is understood and managed, and there is a sustainable model for the future. 2) As part of the strategy, a shift of spend towards targeted prevention, reablement services, enablement, and strengthened interim care. 3) Implementation of Better Care Fund plans which promote integration with the NHS and protect, sustain and improve the social care system.	1) Promoting Independence change programme established. First set of change activities prioritised and agreed; robust and extended (to 5 years) target demand model in place to model scenarios and set volume and saving targets. 2) Business cases for change prioritised to address key shifts which need to be made; underpinned by and aligned to commissioning and de-commissioning. Critical enabler is embedding strengths-based practice. 3) Initial plans for investment of additional Better Care Fund monies discussed with Health and Wellbeing Board; clear alignment with Promoting Independence and STP expectations. Significant delays in publication of national guidance on BCF which has delayed production of a local two year BCF Plan. When finalised this will include an Integration Plan with objectives linked to STP. 3b) Performance management arrangements for the BCF to provide additional assurance and progress on shared BCF targets including reablement, and reductions in residential care.	2	4	8	31/03/2030	Amber	James Bullion	Debbie Bartlett	31/05/2017
C	Adult Services (Lead Director) Shared Re-procurement of social care system for Adults, Children's and Finance Departments -	RM019	Failure to deliver a new fit for purpose social care system on time and to budget.	A new Social Care system is critical to the delivery and efficiency of Adults and Children's Social Services. This is a complex project and the risk is the ability to deliver on time along with the restriction on making any system changes to the existing system (Carefirst)	24/02/2016	4	5	20	3	5	15	1) Ensure effective governance is in place 2) Set up a project team to manage the project. 3) Determine go live dates for Adults Services, Children's Services, and Finance. 4) Deliver implementation of the new system 5) Complete User Acceptance and Data Migration Testing 6) Deliver change and training	1) Clear governance is in place. The Project Sponsors are Janice Dane (Adults), Don Evans (Children's) and John Baldwin (Finance). This is overseen by CLT. 1b)There are weekly Joint Leadership Advisory Group (JLAG) sessions with the Project Sponsors and the Project Team; a monthly update provided to Adults SMT and regular updates to Adults Committee and to CLT. 2) A core Project Team has been up and running since January 2016 (with strong practitioner involvement) and the team is now almost fully recruited to. The two Adult Social Services Subject Matter Experts, the Change Managers and the Training Manager are now in post. A network of 110 champions has been established in Adult Social Services and briefing sessions have taken place. The original user reference group continues to advise the project on social care practice affecting data mapping and system configuration. 3) Adults and Finance are planned to go live on 20 November 2017 and Children's and Finance in April 2018. 4) Delivery of implementation is proceeding in line with the plan. New draft process models and form/plan designs for Adult Social Services (ASS) have been developed, consulted upon and approved. Finance System - and Case management system configuration workshops with the supplier have been completed. 5) The first of four rounds of User acceptance and data migration testing has been completed. Generally the first round completed successfully. User Acceptance Testing (UAT) 2 started on 15 May. 6)Training preparation is well under way and a training programme is in place.	1	4	4	30/04/2018	Green	James Bullion	Janice Dane	31/05/2017
C	Adult's Services	RM014b	The savings to be made on Adult Social Services transport are not achieved.	The risk that the budgeted savings of £3.8m to be delivered by 31 March 2020 will not be achieved.	04/11/2015	3	3	9	4	3	12	1) Whilst we have managed to achieve £0.487m of the budgeted savings, as we were unable to achieve the savings in full, the savings have been reprofiled to future years (2017/18 and 2019/20). 2) A review of transport is also taking place. 3) Transport Guidance has been updated in line with the revised transport policy 4) Refurbishment of a site in Thetford to provide day services and respite care to prevent people from having to travel long distances. 5) Under the Younger Adults workstream of the Promoting Independence Straetgy, we are developing a joint approach to both disability and transition where the youn adult has been receving services from Children's and is now moving to Adults. 6) Exploring the use of an application to help with monitoring of the cost of transport. This application is currently being used by Children with Special Educational Needs.	1) P&R agreed to the reprofiling of savings to future years (2017/18 and 2019/20). The target date of the risk has been amended accordingly. 2) Titan training will be rolled out. Currently recruiting to enable more people to use public transport. 3) The revised Transport Guidance and Policy was agreed by ASC Committee on 6 March 2017 and shared with staff. This is being implemented for new service users now and for existing people at the point of review. This now links with the work on assessments and reviews as part of the Promoting Independence Programme. 4) NPS (on our behalf) are preparing to submit a planning application and we will then follow a framework agreement when we come to source the contractor. 5) Joint approach being developed. 6) This is currently being considered.	2	3	6	31/03/2020	Red	James Bullion	Janice Dane	31/05/2017

C	Adult Social Care Committee	RM14079 and RM020a	Failure to meet the long term needs of Norfolk citizens	If the Council is unable to invest sufficiently to meet the increased demand for services it could result in worsening outcomes for service users, promote legal challenges and negatively impact on our reputation. With regard to the long term risk, bearing in mind the current demographic pressures and budgetary restraints, the Local Government Association modelling shows a projection suggesting local authorities may only have sufficient funding for Adult's and Children's care.	11/10/2012	5	5	25	4	5	20	1) Implementation of Promoting Independence Strategy. This strategy is shaped by the Care Act with its call to action across public services to prevent, reduce and delay the demand for social care. The strategy aims to ensure that demand is understood and managed, and there is a sustainable model for the future. 2) As part of the strategy, a shift of spend towards targeted prevention, reablement services, enablement, and strengthened interim care. 3) Implementation of Better Care Fund plans which promote integration with the NHS and protect, sustain and improve the social care system.	1) Promoting Independence change programme established. First set of change activities prioritised and agreed; robust and extended (to 5 years) target demand model in place to model scenarios and set volume and saving targets. 2) Business cases for change prioritised to address key shifts which need to be made; underpinned by and aligned to commissioning and de-commissioning. Critical enabler is embedding strengths-based practice. 3) Initial plans for investment of additional Better Care Fund monies discussed with Health and Wellbeing Board; clear alignment with Promoting Independence and STP expectations. Significant delays in publication of national guidance on BCF which has delayed production of a local two year BCF Plan. When finalised this will include an Integration Plan with objectives linked to STP. 3b) Performance management arrangements for the BCF to provide additional assurance and progress on shared BCF targets including reablement, and reductions in residential care.	2	4	8	31/03/2030	Amber	James Bullion	Debbie Bartlett	31/05/2017
C	Adult's Services	RM0207 and RM020b	Failure to meet the needs of Norfolk citizens	If the Council is unable to invest sufficiently to meet the increased demand for services arising from the increase in the population of people in Norfolk it could result in worsening outcomes for service users, promote legal challenges and negatively impact on our reputation.	01/04/2011	3	4	12	3	4	12	1) Implementation of Promoting Independence Strategy. This strategy is shaped by the Care Act with its call to action across public services to prevent, reduce and delay the demand for social care. The strategy aims to ensure that demand is understood and managed, and there is a sustainable model for the future. 2) As part of the strategy, a shift of spend towards targeted prevention, reablement services, enablement, and strengthened interim care. 3) Implementation of Better Care Fund plans which promote integration with the NHS and protect, sustain and improve the social care system.	1) Promoting Independence change programme established. First set of change activities prioritised and agreed; robust and extended (to 5 years) target demand model in place to model scenarios and set volume and saving targets. 2) Business cases for change prioritised to address key shifts which need to be made; underpinned by and aligned to commissioning and de-commissioning. Critical enabler is embedding strengths-based practice. 3) Initial plans for investment of additional Better Care Fund monies discussed with Health and Wellbeing Board; clear alignment with Promoting Independence and STP expectations. Significant delays in publication of national guidance on BCF which has delayed production of a local two year BCF Plan. When finalised this will include an Integration Plan with objectives linked to STP. 3b) Performance management arrangements for the BCF to provide additional assurance and progress on shared BCF targets including reablement, and reductions in residential care.	2	4	8	31/03/2018	Amber	James Bullion	Debbie Bartlett	31/05/2017
D	Finance	RM13926	Failure to meet budget savings	If we do not meet our budget savings targets over the next three years it would lead to significant overspends in a number of areas. This would result in significant financial pressures across the Council and mean we do not achieve the expected improvements to our services	30/04/2011 -	3	5	15	4	5	20	1) Efficiency and savings targets are being managed through the Promoting Independence Programme Board and the Finance and Performance Board. 2) Monthly monitoring, locality team meetings and continued development of forecast to ensure timely focus on key budgets and any emerging issues 3) Norsecare Liaison Board to develop and monitor delivery of savings related to the Norsecare contract 4) P&R agreed to the recommendation of the re-profiling of savings totalling £3m for 16/17 and also for savings from the Promoting Independence programme of £10m from 2017-18 to 2019-20. 5) Senior and concerted focus on transforming the LD service.	1) Promoting Independence programme of work refreshed and delivery plan developed. Target demand model complete and focussed work on entry points, processes for older people and younger adults, cross-cutting behavioural change and commissioning projects. Reprofiled savings have been approved by P&R Committee. 2) Finance and Performance Board have moved to a panel style approach providing senior management scrutiny along with locality finance meetings. Production of financial recovery plans by all teams and assessment plans to reduce the backlog. Mid year close down undertaken to improve accuracy of forecast. 3) Work continues with Norsecare to deliver savings. 4) 2017-18 budget signed off by all RBOs . Additional social care funding has been received. Plans to be agreed with members including invest to save pieces of work which will support delivery of savings particularly in future years. 5) Reshaped management of the LD service and dedicated younger adults workstream within the PI programme	3	5	15	31/03/2018	Red	James Bullion	Susanne Baldwin	31/05/2017
D	Locality and hospital teams	RM13931	A rise in acute hospital admissions and discharges and pressure on acute services.	A significant rise in acute hospital admissions / services would certainly increase pressure and demand on Adult Social Care. Potential adverse impacts include rise in Delayed Transfers of Care (DTOCs), pressure on Purchase of Care spend, assessment staff capacity and NCC reputation.	30/06/2011 - revised 21/04/2016 -	3	4	12	4	4	16	1) Integrated structure between NCC and NCHC allows AD's to make quick decisions and to flex resources to minimise impact. 2) Integration programme developing new approaches to reduce delays and prevent admissions 3) Daily participation in whole system escalation process. 4) Senior manager oversight of emerging issues. 5) Careful management of reputational risk.	1) Daily Capacity mapped and monitored and given high priority. 2) Phase 2 of the Integration Programme delivered integrated arrangements at NNUH and we're looking to roll this out across other acutes. 3) Work closely with health colleagues on silver calls. 4) Director of Integrated Care coordinates senior manager oversight to effectively manage issues. 5) SMT presence at A&E delivery Board which helps to improve reputation.	2	3	6	31/03/2018	Amber	James Bullion	Lorrayne Barrett	31/05/2017
D	SMT	RM14237	Deprivation of Liberty Safeguarding	Following the Cheshire West ruling it has been identified that we're not meeting our responsibilities around Deprivation of Liberty Safeguards (DoLS). This could lead to us being judicially reviewed.	08/05/2015	3	4	12	4	4	16	1) Reviewed staffing compliment 2) Reviewed processes and systems to ensure cases are dealt with in a timely manner. 3) Improved data quality and reporting to allow cases to be monitored. 4) The Law Commission made recommendations for a new DoLS framework in March. New legislation due late 2017 for implementation in 2018. 5) We are linking in with DoLS managers across the Eastern region to ensure we are working in similar ways.	1) Temporary staffing been extended to deal with this - specific team to deal with the increased demand. 2) Processes and systems in place to manage priority workload. 3) Receiving data to report on issues 4) Awaiting for legislation to be issued. 5) Continuous working together.	2	4	8	31/03/2018	Red	Lorna Bright	Alison Simpkin	31/05/2017

C	Adult Social Care Committee	RM14079 and RM020a	Failure to meet the long term needs of Norfolk citizens	If the Council is unable to invest sufficiently to meet the increased demand for services it could result in worsening outcomes for service users, promote legal challenges and negatively impact on our reputation. With regard to the long term risk, bearing in mind the current demographic pressures and budgetary restraints, the Local Government Association modelling shows a projection suggesting local authorities may only have sufficient funding for Adult's and Children's care.	11/10/2012	5	5	25	4	5	20	1) Implementation of Promoting Independence Strategy. This strategy is shaped by the Care Act with its call to action across public services to prevent, reduce and delay the demand for social care. The strategy aims to ensure that demand is understood and managed, and there is a sustainable model for the future. 2) As part of the strategy, a shift of spend towards targeted prevention, reablement services, enablement, and strengthened interim care. 3) Implementation of Better Care Fund plans which promote integration with the NHS and protect, sustain and improve the social care system.	1) Promoting Independence change programme established. First set of change activities prioritised and agreed; robust and extended (to 5 years) target demand model in place to model scenarios and set volume and saving targets. 2) Business cases for change prioritised to address key shifts which need to be made; underpinned by and aligned to commissioning and de-commissioning. Critical enabler is embedding strengths-based practice. 3) Initial plans for investment of additional Better Care Fund monies discussed with Health and Wellbeing Board; clear alignment with Promoting Independence and STP expectations. Significant delays in publication of national guidance on BCF which has delayed production of a local two year BCF Plan. When finalised this will include an Integration Plan with objectives linked to STP. 3b) Performance management arrangements for the BCF to provide additional assurance and progress on shared BCF targets including reablement, and reductions in residential care.	2	4	8	31/03/2030	Amber	James Bullion	Debbie Bartlett	31/05/2017
D	Finance	RM14262	The potential risk of shortfall between funding and pressures through integration of capital and revenue funding between the Council, health organisations and district councils	The integrated health and social care agenda has seen pooling of capital and revenue resources through the Better Care Fund and further policy drive to manage the transfer of people with learning disabilities from inpatient settings to community settings. There is a risk that this will have a negative impact on available resources for delivery of adult social care	16/06/2016	3	5	15	3	5	15	1) Section 75 agreements to manage forward planning and joint arrangements 2) Partnership Boards in place attended by NCC. 3) Transforming Care Plan project in place and NCC involvement on all workstreams. 4) Introduction of the Improved Better Care Fund including planned use for additional social care grant.	1) Section 75 agreements to be renewed for 17/18 once final allocations and detailed BCF guidance is received. 2) Consolidated Better Care Fund Programme Board is in place. Final guidance affecting 2017-18 and 2018-19 is now unlikely to be received until late June 2017. 3) Transforming Care Plan programme in place and baseline completed. Developing forward plan for individuals who are currently hospital inpatients (ie a low secure setting) who may be able to move to community settings. Further work completed on joint protocols has not been agreed by all parties and target has been set for June 2017. 4) The introduction of the Improved BCF from April 2017, including additional one-off funding for social care. The overall plans will need to be agreed by the Health and Wellbeing Board and spending plans for the additional funding, will need to be agreed by ASC Committee.	2	4	8	31/03/2019	Amber	James Bullion	Susanne Baldwin	31/05/2017
D	Transformation	RM13923	Risk of failing to deliver Promoting Independence, change programme for Adult Social Services in Norfolk	Promoting Independence Change Programme oversees and co-ordinates the linked change and transformation activities required to deliver the strategy. If we fail to deliver the programme this will lead to a failure in developing a sustainable model for adult social care and a failure to deliver a balanced budget	30/04/2011	4	3	12	3	4	12	1) Robust programme management arrangements with properly resourced capacity and skills in place 2) Defined suite of business cases which are prioritised and sequenced to maximise impact and make best use of resources 3) Clear leadership from senior managers to sponsor and champion changes 4) Strong performance framework to measure and monitor the impact of change activities and to take action to address any issues	1) Programme arrangements agreed and resourced. Programme manager appointed; start date to be negotiated. One out of 4 project managers appointed; external recruitment underway; interim project management to be brought in short-term to ensure pace and continuity 2) Initial business cases for first tranche of activities agreed; now subject to critical review, particularly around metrics – due for final sign-off at May Programme Board. 3) Workstream sponsors engaged and owning priorities. Temporary business lead roles appointed for two of the workstreams. 4) Initial set of high level measures agreed – effectively a set of 'vital signs' for the programme. Requires targets to be set against these, and metrics disaggregated to workstream and project level.	2	4	8	31/03/2018	Amber	James Bullion	Debbie Bartlett	31/05/2017
D	Adult Social Services Department	RM 14261	Staff behaviour and practice changes to deliver the Promoting Independence Strategy	A significant change in staff behaviour and social care practice is required to deliver the Promoting Independence Strategy. Failure to make the culture change needed across the workforce would greatly impact the transformation of the service and its ability to deliver associated budget savings'	25/04/2016	3	5	15	3	4	12	1) Robust OD plan signed off by the PI Programme Board. 2) Reviewing staff supervision and process and training. 3) Management Development Programme for Team Managers and Practice Consultants will be rolled out throughout the year.	1) Mandatory Strengths Based Assessment and Signs of Wellbeing approach has been rolled out to staff. 2) Review complete - will come back to SMT to agree actions mid May. 3) Programme is currently being developed.	2	4	8	31/03/2018	Amber	James Bullion	Lucy Hohnen	31/05/2017
D	Support & Development	RM13925	Lack of capacity in ICT systems	A lack of capacity in IT systems and services to support Adult Social Services delivery, in addition to the poor network capacity out into the County, could lead to a breakdown in services to the public or an inability of staff to process forms and financial information in for example Care First.	30/04/2011	4	4	16	3	4	12	1) As part of the Business Continuity plan steps are in place to mitigate any system loss and downtime. 2) To ensure effective Integration, staff must have access to the relevant systems regardless of where they are located. Please also refer to Risk RM019	1) Recovery steps are outlined in the Business Continuity plan. These are always reviewed following any serious incidents and updated where necessary. 2) ICT Capacity and solutions for integrated working are discussed at the Integration Programme Board. Issues are being progressed as a key priority. NCHC staff now have access to NCC Outlook calendars. We are working with NCHC to arrange NCC staff having access to NCHC Outlook calendars.	3	2	6	31/03/2018	Amber	James Bullion	Sarah Rank	31/05/2017
D	Information Management	RM14085	Failure to follow data protection procedures	Failure to follow data protection procedures can lead to loss or inappropriate disclosure of personal information resulting in a breach of the Data Protection Act and failure to safeguard service users and vulnerable staff, monetary penalties, prosecution and civil claims.	30/09/2011	3	5	15	3	4	12	1) New staff not allowed computing access until they have completed the data protection and information security e-learning courses. 2) Mandatory refresher training and monitoring rates of completion of training. 3) Monthly reports to CLT around data breaches 4) An Information Compliance Group (with representation across each department) meet on a bi-monthly basis and reports back any issues to the Information Management Board.	2) Reminders to individual staff to complete Data Protection e-Learning courses are sent out and managers are informed of staff who have not completed the e-learning course. The refresher e-learning course will shortly be moving from every three year's to two year's in line with guidance received from the ICO. 4) The ICO has recently carried out an audit on how NCC is complying with data protection. The ICO has concluded that "there is a reasonable level of assurance that processes and procedures are in place and delivering data protection compliance". As a result of the ICO audit, Norfolk Audit Services have carried out a council wide QA audit. Once this is received we will review and implement any recommendations.	1	3	3	31/03/2018	Green	Lorna Bright	Sarah Rank	31/05/2017
D	Adult Social Services Commissioning	RM14290	Negative outcome of the Judicial Review into fee uplift to care providers	A successful Judicial Review being brought by a group of residential care providers may result in additional costs for 2015/16 which were not anticipated in budget planning for the year.	07/09/2015	3	4	12	3	4	12	1) Following the Older People residential and nursing care cost of care exercise and consultation process, the outcome and revised usual prices was recommended to the Adult Social Care Committee on 29th April 2016. 2) Work is continuing with the market to discuss annual increases to fees	1) The 2016/17 uplifts were recommended to Committee and agreed following consultation 2) Project in place to review working age adults fee framework	1	4	4	31/03/2018	Amber	James Bullion	Susanne Baldwin	31/05/2017

C	Adult Social Care Committee	RM14079 and RM020a	Failure to meet the long term needs of Norfolk citizens	If the Council is unable to invest sufficiently to meet the increased demand for services it could result in worsening outcomes for service users, promote legal challenges and negatively impact on our reputation. With regard to the long term risk, bearing in mind the current demographic pressures and budgetary restraints, the Local Government Association modelling shows a projection suggesting local authorities may only have sufficient funding for Adult's and Children's care.	11/10/2012	5	5	25	4	5	20	1) Implementation of Promoting Independence Strategy. This strategy is shaped by the Care Act with its call to action across public services to prevent, reduce and delay the demand for social care. The strategy aims to ensure that demand is understood and managed, and there is a sustainable model for the future. 2) As part of the strategy, a shift of spend towards targeted prevention, reablement services, enablement, and strengthened interim care. 3) Implementation of Better Care Fund plans which promote integration with the NHS and protect, sustain and improve the social care system.	1) Promoting Independence change programme established. First set of change activities prioritised and agreed; robust and extended (to 5 years) target demand model in place to model scenarios and set volume and saving targets. 2) Business cases for change prioritised to address key shifts which need to be made; underpinned by and aligned to commissioning and de-commissioning. Critical enabler is embedding strengths-based practice. 3) Initial plans for investment of additional Better Care Fund monies discussed with Health and Wellbeing Board; clear alignment with Promoting Independence and STP expectations. Significant delays in publication of national guidance on BCF which has delayed production of a local two year BCF Plan. When finalised this will include an Integration Plan with objectives linked to STP. 3b) Performance management arrangements for the BCF to provide additional assurance and progress on shared BCF targets including reablement, and reductions in residential care.	2	4	8	31/03/2030	Amber	James Bullion	Debbie Bartlett	31/05/2017
D	Adult Social Services Commissioning	RM14247	Failure in the care market	The council contracts with independent care services for over £200m of care services. Risk of failure in care services would mean services are of inadequate quality or that the necessary supply is not available. The council has a duty under the Care Act to secure an adequate care market. If services fail the consequence may be risk to safeguarding of vulnerable people. Market failure may be faced due to provider financial problems, recruitment difficulties, decisions by providers to withdraw from provision, for example. Further reductions in funding for Adult Social Care significantly increases the risk of business failure.	07/09/2015	4	3	12	4	3	12	1)A Quality Assurance Framework in in place which provides a risk based approach to the market of care services, collating intelligence from a range of sources and triangulating to identify services for targeted intervention 2) Prioritising care workforce capacity within the learning and development programme 3) Revision of a market failure protocol based on established good practice 4) Liaison with Care Quality Commission to engage with their work with Norfolk care services 5) Procuring new domiciliary care contracts 6) Appropriate investment in the care market 7) Effective management of market failure	2) A recruitment and retention project is underway which was launched in March 17. 2b) New real time quality (risk) dashboard produced 3) Market resilience strategy under development 4) Refreshed working arrangements with CQC 4b)Revised and improved carers service that will support informal carers - being procured for delivery in Sept 17. 5) New 'patch' based contracts procured in the North, East and West of the county with a roll out to Norwich and South during 2017. 5) We are in the process of procuring new domiciliary care contracts. 6) Stabilisation of provider market and channelling of investment proposed as part of the improved Better Care Fund. 7) Provider engagement and dialogue included in the 'cost of care' exercise which will support accurate identification of costs of provision and ensure investment targeted appropriately	2	3	6	31/03/2018	Amber	Sera Hall	Steve Holland	31/05/2017
D	Adult Social Services Commissioning	RM 14260	Failure of the care market (through the independent providers) due to difficulties in recruiting staff into the sector.	The council invests over £54m through approximately 120 independent providers in provision of homecare to over 4000 vulnerable people at any one time. Failure of the care market (through the independent providers) due to problems recruiting staff into the sector may result in a risk to safeguarding of vulnerable people, delays in discharging people from hospital and inappropriate admissions to hospitals and care homes. Problems recruiting into and retaining care workers in the care sector are particularly acute in the west and north of the county but are experienced across the county as a whole.	16/05/2016	4	4	16	4	3	12	1) A Quality Assurance Framework provides a risk based approach to the market of care services 2) Ensure robust procurement processes that ensure providers cost provision adequately 3) Work with providers, workforce professionals and other partners to develop and implement a workforce development plan and to ensure workforce terms and conditions are equitable 4) Development of a care contingency network and emergency provision 5) Clear communication needed with the market to publicise areas of need and future commissioning intentions	2) Market testing conducted using open technique (providers set bid price) 3) An xecutive board has been created to take responsibility for the promotion and delivery of a sector skills action plan and this includes a clear accountability structure with named leads for each priority 3b)Inclusion of Unison Ethical Care Charter in all new Home support contracts 3c) We have a website for care workers which includes information and advice around the caring profession. There is also a recruitment portal for providers to advertise vacancies and a promotional campaign in order to make the profession more attractive. 4) Plans to develop and implement resilience measures including emergency provision are being developed and will be proposed to SMT 5) Market Position Statement for 2017/18 will be finalised in June 2017.	2	3	6	31/03/2018	Amber	Sera Hall	Steve Holland	31/05/2017
D	Integration	RM13936	Potential for integration to adversely affect delivery of statutory responsibilities or impact on reputation	Pressure on integrated staff could have an adverse impact on joint teams regarding capacity and take them away from departmental priorities impacting on reputation / ability to deliver.	30/06/2011 - revised 18/04/2016	3	5	15	2	5	10	1) Pressure closely monitored by AD's and escalated to Director Integrated Services. 2) Integration Programme Board monitors and considers implications and costs across both organisations. 3) Issues can be escalated to S75 Monitoring Board (membership includes Committee Chair and Executive Director) for resolution.	1) SMiT (Senior Managers Integration Team) regularly discuss capacity issues and take action. 2) The Integration Board (in May) discussed costs and benefits of Integration for each Organisation. 2b) NAS have recently carried out an audit on Management accountability to social care. We are currently waiting for the report. 3) Issues are escalated as and when necessary.	1	5	5	31/03/2018	Green	James Bullion	Lorrayne Barrett	31/05/2017
D	Adult Social Services Department - Commissioning	RM14238	Failure in our responsibilities towards carers.	The failure of Adult Social Services to meet its statutory duties under the Care Act will result in poorer outcomes for service users and have a negative impact on our reputation. Funding reductions by health and other partners may adversely impact on provision of countywide carers services	27/05/2015	2	3	6	2	3	6	1) Co-production with providers and users of service resulted in revised carers services specification 2) Maintaining existing health investment in commissioned services 3) Strong engagement and dialogue with Carers Council 4) Competitive procurement of Carers Service to deliver in Sept 2017 5) Proposed investment as part of the improved Better Care Fund for enhanced support for carers. 6) Review of our offer to carers around respite, direct payments and commissioned services.	1) Revised carers services specification agreed by SMT 2) We have secured continued health investment in commissioned services 3) Continue to have a strong dialogue wth the Carers Council 4) Competitive procurement of Carers Service has commenced. 5) This is currently being proposed. 6) Work has now commenced on this and the revised offer should be known within the next month.	1	1	1	31/03/2018	Amber	Sera Hall	Emma Bugg	31/05/2017
D	Transformation	RM14149	Impact of the Care Act	Impact of the Social Care Act/Changes in Social Care funding (significant increase in number of people eligible for funding, increase in volume of care - and social care - and financial assessments, potential increase in purchase of care expenditure, reduction in service user contributions)	27/11/2013	4	3	12	1	5	5	1) Project for Implementation of the Care Act. Ensure processes and resources in place to deliver Government requirements. Estimate financial implications. 2) Keep NCC Councillors informed of issues and risks.	1) Project delivered necessary changes for April 2015 (part one of the Care Act). On 17 July 2015 the Government announced that Part Two of the Care Act is deferred until 2020. 2) ASC Committee members agreed to keep this on the risk register until government guidance was clearer. No further information has been received from Government.	1	3	3	31/03/2020	Green	Janice Dane	Janice Dane	31/05/2017

C	Adult Social Care Committee	RM14079 and RM020a	Failure to meet the long term needs of Norfolk citizens	If the Council is unable to invest sufficiently to meet the increased demand for services it could result in worsening outcomes for service users, promote legal challenges and negatively impact on our reputation. With regard to the long term risk, bearing in mind the current demographic pressures and budgetary restraints, the Local Government Association modelling shows a projection suggesting local authorities may only have sufficient funding for Adult's and Children's care.	11/10/2012	5	5	25	4	5	20	1) Implementation of Promoting Independence Strategy. This strategy is shaped by the Care Act with its call to action across public services to prevent, reduce and delay the demand for social care. The strategy aims to ensure that demand is understood and managed, and there is a sustainable model for the future. 2) As part of the strategy, a shift of spend towards targeted prevention, reablement services, enablement, and strengthened interim care. 3) Implementation of Better Care Fund plans which promote integration with the NHS and protect, sustain and improve the social care system.	1) Promoting Independence change programme established. First set of change activities prioritised and agreed; robust and extended (to 5 years) target demand model in place to model scenarios and set volume and saving targets. 2) Business cases for change prioritised to address key shifts which need to be made; underpinned by and aligned to commissioning and de-commissioning. Critical enabler is embedding strengths-based practice. 3) Initial plans for investment of additional Better Care Fund monies discussed with Health and Wellbeing Board; clear alignment with Promoting Independence and STP expectations. Significant delays in publication of national guidance on BCF which has delayed production of a local two year BCF Plan. When finalised this will include an Integration Plan with objectives linked to STP. 3b) Performance management arrangements for the BCF to provide additional assurance and progress on shared BCF targets including reablement, and reductions in residential care.	2	4	8	31/03/2030	**Amber**	James Bullion	Debbie Bartlett	31/05/2017
D	Safeguarding	RM14287	Potential failure to meet the needs and safeguarding of adults in Norfolk.	There is a national risk that Adults Social Service do not provide adequate safeguarding controls.	14/12/2016	2	5	10	2	5	10	1) Multiagency Safeguarding Policy & Local Procedures in place. 2) Adults Safeguarding Board in place. 3) Delivery of Safeguarding training to providers. 4) Appropriate checks / vetting of staff. 5) Serious case reviews actioned where appropriate. 6) Any recommendations made by Safeguarding Adults Review's (SAR's) are monitored by the Safeguarding Adults Review Group and also disseminated 1/4ly to all managers via the Quarterly Managers Forum (QMF).	1) Multiagency safeguarding policy and procedure refreshed and updated by the Learning, Improvement and Policy sub group of the Norfolk Safeguarding Adults Board (NSAB). Now published on the NSAB and publicised among partners. 2) Board is well established and has an independent chair. 3) Specific training for providers is delivered (at a cost) via the commissioned training provider, St Thomas'. The NSAB can also signpost providers to safeguarding training. 4) Enhanced DBS checks are carried out for all customer-facing staff in ASSD. 5) ASSD has a representative on the multiagency Safeguarding Adult's Review (SAR) Group and the group is attended by NPLaw. There is a robust process in place for evaluating cases referred to the SAR Group against the SAR criteria. Claire Crawley (Senior Policy Advisor for the Department of Health) has visited the NSAB and has given advice on the interpretation of the SAR criteria and the importance of identifying and actioning learning. 6) The SAR Group holds and monitors action plans for each SAR and is developing a thematic approach. They also have a standing item on the NSAB agenda to update the board on progress with actions, and any forthcoming reviews. The Head of Service (for Safeguarding) presents learning from SARs and reviews this alongside the relevant locality Assistant Director/Head of Operations. The learning is used as a platform for a more detailed look at a particular theme for ASSD.	2	4	8	31/03/2018	Green	Lorna Bright	Helen Thacker	31/05/2017

Risk Matrix and Tolerance Levels

Impact / Likelihood	Extreme 5	Major 4	Moderate 3	Minor 2	Insignificant 1
Almost Certain 5	25	20	15	10	5
Likely 4	20	16	12	8	4
Possible 3	15	12	9	6	3
Unlikely 2	10	8	6	4	2
Rare 1	5	4	3	2	1

Tolerance Level	Risk Treatment
High Risk (16-25)	Risks at this level are so significant that risk treatment is mandatory
Medium Risk (6-15)	Risks at this level require consideration of costs and benefits in order to determine what if any treatment is appropriate
Low Risk (1-5)	Risks at this level can be regarded as negligible or so small that no risk treatment is needed

The Council's risk scoring methodology

Each risk score is expressed as a multiple of the impact and the likelihood of the event occurring:

a) Original risk score – the level of risk exposure before any action is taken to reduce the risk when the risk was entered on the risk register
b) Current risk score – the level of risk exposure at the time the risk is reviewed by the risk owner, taking into consideration the progress of the mitigation tasks
c) Target risk score – the level of risk exposure that we are prepared to tolerate following completion of all the mitigation tasks

In accordance with the Risk Matrix and Risk Tolerance Level set out within the current Norfolk County Council "Well Managed Risk - Management of Risk Framework", three risks are reported as "High" (risk score 16–25) and 11 as "Medium" (risk score 6–15).

The prospects of meeting target scores by the target dates are a reflection of how well mitigation tasks are controlling the risk. It is also an early indication that additional resources and tasks or escalation may be required to ensure that the risk can meet the target score by the target date. The position is visually displayed for ease in the "Prospects of meeting the target score by the target date" column as follows:

a) Green – the mitigation tasks are on schedule and the risk owner considers that the target score is achievable by the target date
b) Amber – one or more of the mitigation tasks are falling behind and there are some concerns that the target score may not be achievable by the target date unless the shortcomings are addressed
c) Red – significant mitigation tasks are falling behind and there are serious concerns that the target score will not be achieved by the target date and the shortcomings must be addresses and/or new tasks are introduced

Appendix C – Risk Reconciliation Report

Significant changes* to the Adults Social Service's departmental risk register since the last Adults Social Care Committee Risk Management report was presented in January 2017.

The Adult's Social Services departmental risk register was last reported to the Adults Social Care Committee in January 2017.

Since the last Committee meeting the risk register has been reviewed by the Senior Management Team and the Risk Management Officer. It was agreed that there have been no significant changes to report.

The next review is due in September 2017.

* A significant change can be defined as any of the following;

- A new risk
- A closed risk
- A change to the risk score
- A change to the risk title or description (where significantly altered).

Adult Social Care Committee

Item No:

Report title:	**Adult Social Care Annual Quality Report 2016/17**
Date of meeting:	**19 June 2017**
Responsible Chief Officer:	**James Bullion, Executive Director of Adult Social Services**

Strategic impact

The Council invests more than £260m a year in purchasing adult social care services from the market. The Council has legal duties under the Care Act 2014 to promote the effective and efficient operation of a care market securing a choice of high quality services.

Executive summary

Ensuring that the social care and support services that adults in Norfolk may require to meet their needs and to help them to live as independent a life as possible is a key priority for Norfolk County Council (the Council). The Care Act placed this priority on a statutory footing through new duties requiring it to seek continuous improvements in quality and choice of services in its promotion of the market. The Adult Social Care Committee (the Committee) approved and adopted a new quality framework in January 2015 and this report updates the committee on its implementation and includes the second annual quality report for the Committee's consideration. Overall there has been a significant improvement in quality particularly in home care however Norfolk still lags behind most other local authorities. The annual quality report (Appendix 1 to this report) sets out the detail and the strategy for further improvement.

Key Findings:

a) **The Council invests £260m annually in the care market to support more than 15,000 adults**
b) **There is a formal care market of 730 providers of which 520 are subject to CQC assessments**
c) **Across the sector CQC inspections indicate that 73% of providers have been rated as good, 25% as requires improvement and <2% rated as inadequate**
d) **Significant improvements in quality have been achieved in 2016 across all sectors – from 57% meeting required standard to 73%**
e) **Homecare has improved from 57% meeting the required standard to 84%**
f) **Residential care has improved from 61% meeting required standard to 70%**
g) **The Council implemented a new programme of targeted interventions to support overall sector improvement in 2016 which is delivering good outcomes and supporting providers to improve quality of services**
h) **The Council has implemented the Approved Public Protection programme (APP) across the sector which will support risk analysis and provide a comprehensive understanding of the quality and operation of the care market**
i) **There is still work to do, while improvements in quality are evidenced, Norfolk remains at the bottom of the regional league table for CQC results and is 93rd out of 152 local authorities across all care types**
j) **The Quality Assurance team continue to provide a targeted programme of interventions which support the development and improvement of a good quality care market. These approaches are enhanced by the Market Development Fund which supports providers to develop effective training and recruitment programmes**

Recommendations:

The Committee is recommended to:

a) **Consider the findings presented and agree to publish the annual quality report**
b) **Agree to a further detailed briefing on the care market**

1. Proposal

1.1 Since the adoption of the quality framework in January 2015 considerable progress has been made in taking forward key actions that are set out in the annual report attached as Appendix 1 to this report. The governance proposals within the framework provide an opportunity for the Committee to thoroughly consider the quality of adult social care in Norfolk, the actions taken by the Council to secure quality and proposals for future actions to improve quality in adult social care.

2. Evidence

2.1 **Care Act 2014**

2.2 The Care Act places significant duties on local authorities to facilitate and shape their market for adult care and support as a whole, so that it meets the needs of all people in their area who need care and support, whether arranged or funded by the state, by the individual themselves, or in other ways.

2.3 The ambition is for local authorities to influence and drive the pace of change for their whole market leading to a sustainable and diverse range of care and support providers, continuously improving quality and choice, and delivering better, innovative and cost-effective outcomes that promote the wellbeing of people who need care and support.

2.4 Poor quality services are not effective in supporting people to achieve their wellbeing outcomes. It is essential, therefore, that we ensure we know that all the services we pay for are high quality and effective. This requires regular ongoing proactive monitoring of provider performance across the board and effective interventions to restore high quality services if things are beginning to go wrong. The quality framework supports this.

2.5 **Annual Quality Report**

2.5.1 The committee originally approved and adopted the quality framework at its meeting in January 2015. Since that time considerable progress has been made in the implementation of the framework supported by some additional financial investment in quality assurance staff and systems.

2.5.2 It is critical that the Council gains a thorough understanding of quality in the care market and a key feature of the framework lies in its governance, review and reporting arrangements that are intended to ensure that the quality of care is understood throughout the department and the committee. To this end the framework requires the production of an annual quality report (the Report) for consideration by the committee.

2.5.3 The Report is intended to be a public document and thus serves the purpose of helping the Council as a whole, key commissioning partners, stakeholders and the public understand the quality of care in Norfolk. The Report for 2016/17 is the second of its kind and is attached at Appendix 1. (The Report will be available through the Council's website following consideration by the Committee). This provides the first opportunity to identify trends with the 2015/16 Report acting as the baseline. Elected members also have the opportunity to track key aspects of quality through the regular performance reports provided to the Committee.

2.6 **Quality Improvement Strategy**

2.6.1 The Report sets out the current quality picture in Norfolk and details the various initiatives and actions that have been taken to tackle poor quality services. These initiatives and actions, some supported by the Market Development Fund, have been evaluated together with practice elsewhere to support the formulation of a quality improvement strategy for 2017/18 which is set out in the Report itself.

3. Financial Implications

3.1 There are no direct financial implications arising from the implementation of the quality framework.

4. Issues, risks and innovation

4.1 The quality framework places the Council in a strong position to effectively discharge its duties in securing high quality adult social care and support services in Norfolk. The current quality picture, whilst showing improvement compared to the previous year, continues to present significant challenges to the Council and it will be important to keep the position under review taking such steps as are necessary and proportionate to secure high quality care services.

5. Background

5.1 The quality framework itself can be accessed via the link below

www.norfolk.gov.uk/care-providers

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**:
Steve Holland	01603 638353	Steve.holland@norfolk.gov.uk

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Norfolk County Council

Adult Social Care Annual Quality Report 2016/17

1 Introduction

1.1 The Care Act

1.1.1 The Care 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. People will of course always require care and support for a number of reasons including lifelong disabilities or an event in their lives as well as simply ageing.

1.1.2 Norfolk County Council (the Council) has responded 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 often 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 for example 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 In order 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 second such report since the Act came into force and the framework was adopted.

1.2 The Quality Framework

1.2.1 The quality 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:

- Supports a whole systems approach to promoting individual wellbeing and independence
- Supports the development and implementation of quality standards that set out what good looks like
- Sets out how high quality care provision will be secured from the market
- Sets out how provider performance will be monitored and how the effective and efficient operation of the market will be promoted
- 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 large and complex 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 Council's Market Position Statement 2016). (An updated market position statement will be published in July 2017).

1.3.2 The Council currently invests over £260m annually in this market to support more than 15,000 adults mainly through contracts with almost a thousand different care providers most of whom are independent businesses. The diagram below shows how many accredited providers there are in each of the main sectors 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.

1.3.3 **The Size of the Norfolk Care Market – Number of Accredited Providers - December 2016**

1.3.4 There are 520 providers subject to CQC assessment and a further 210 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 730 providers.

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 £500,000 annually.

1.3.6 The Council itself still provides some formal social care directly through its rehabilitation service but over 98% 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 fail.

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 Care 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:

- Is the service safe?
- Is the service effective?
- Is the service caring?
- Is the service responsive?
- 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

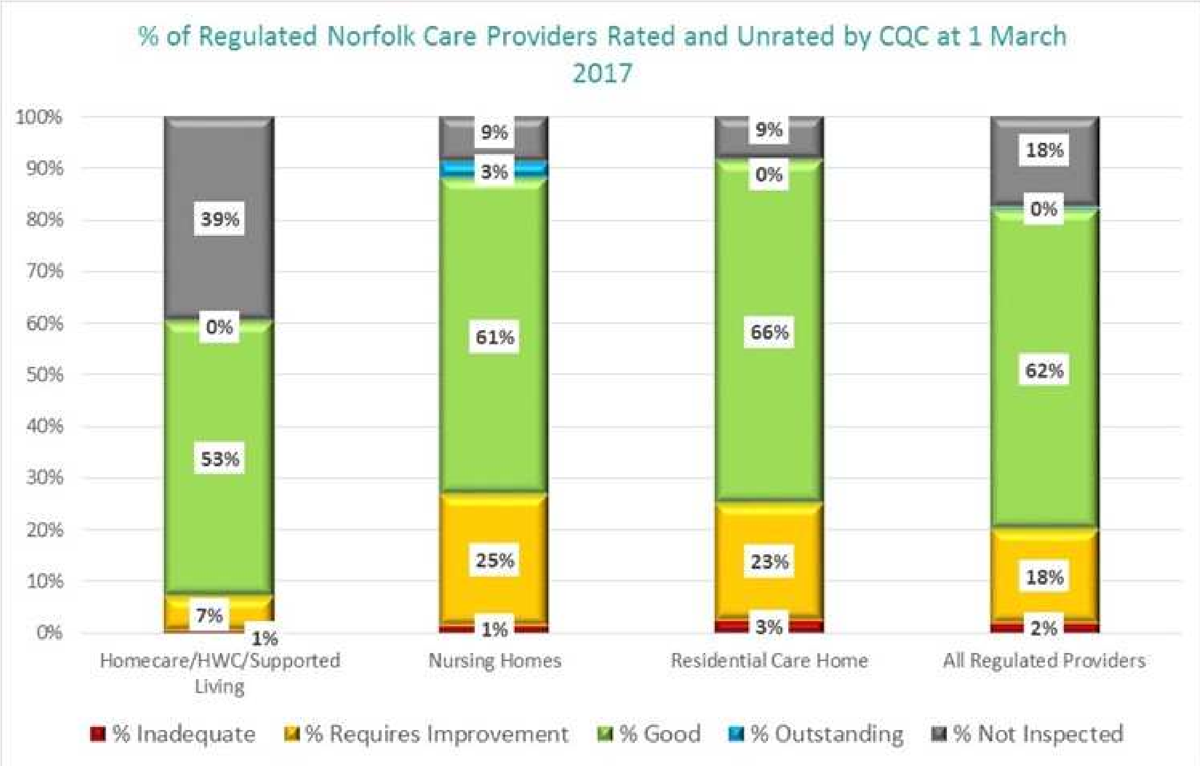
- Inadequate.
- Requires improvement.
- Good.
- Outstanding

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 1 March 2017 426 registered providers in Norfolk had been inspected and rated. This is 82% of all registered providers. The diagram below shows the extent of the inspections carried out by CQC by care sector and the proportions of ratings awarded in each category.

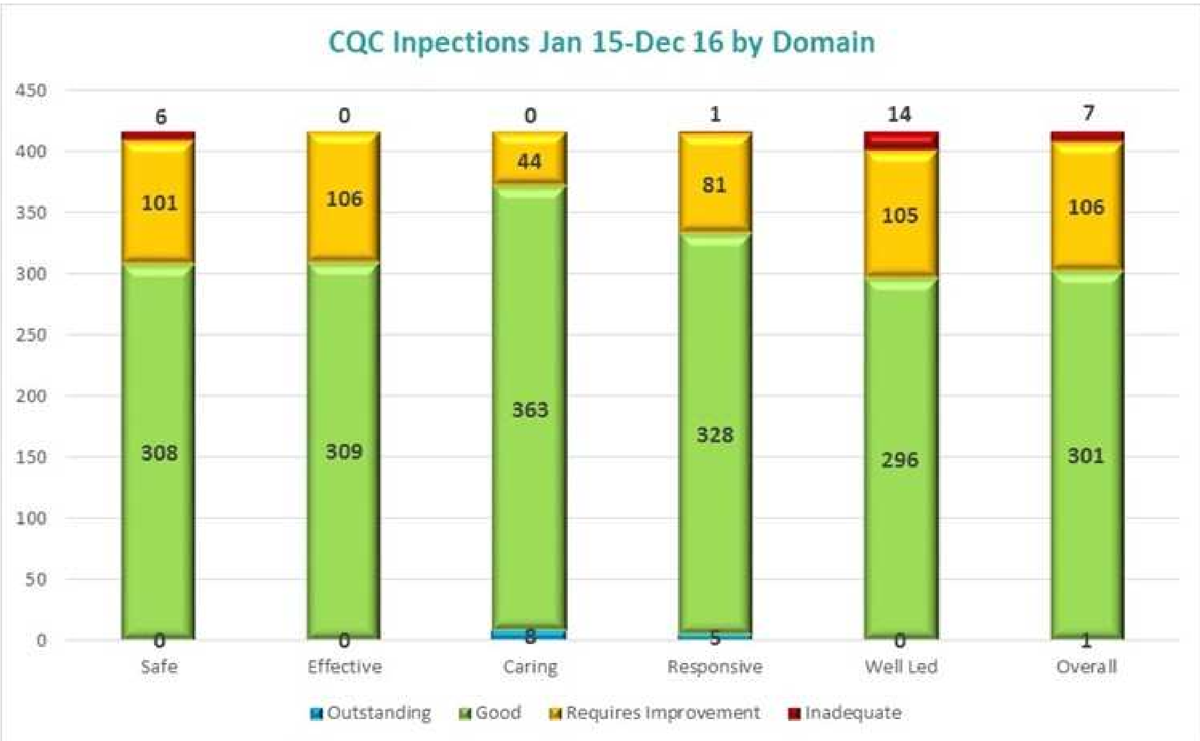
2.2.2



2.2.3 As at 1 March 2017 94 providers had yet to be assessed of whom 33 were care homes. Nevertheless over 80% of providers have been assessed (some more than once) providing a clear picture of care quality as measured against the national standards.

2.2.4 An analysis of the domain ratings shows that there is a strong correlation between the rating awarded in the Well Led domain and the Safe domain and the overall rating that is likely to be awarded. Scoring highly in the Caring domain is not as good an indicator of the final rating likely to be awarded. The diagram below shows how Norfolk providers fared against the five domains.

2.2.5



2.2.6 This seems to indicate that whilst Norfolk providers score well in the Caring domain there are issues in relation to leadership and safety that are having a significant effect on overall ratings.

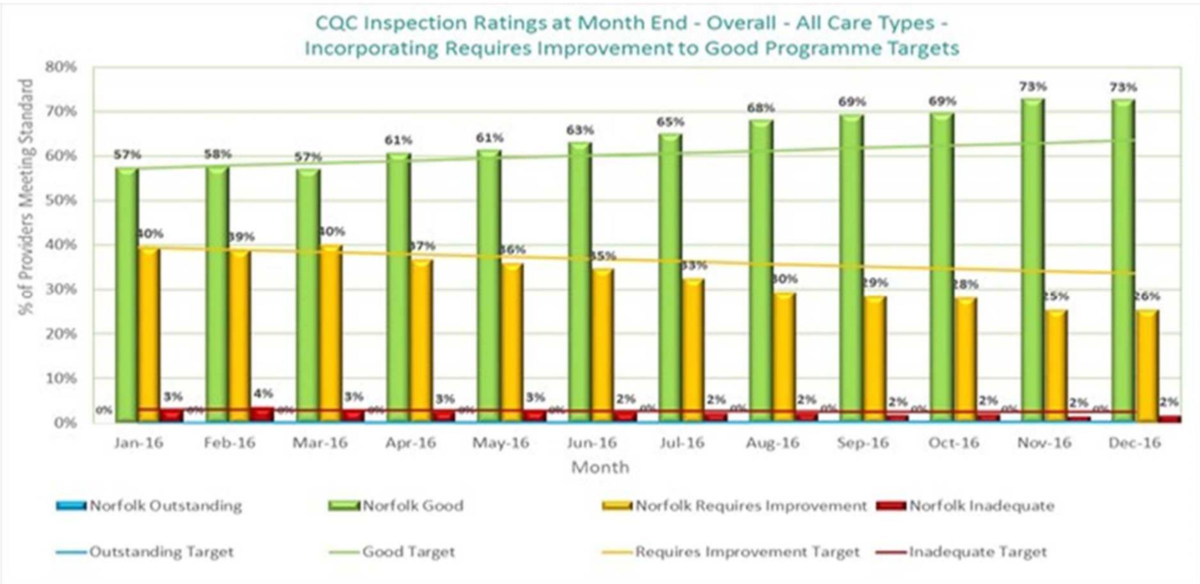
2.3 Requires improvement to good programme (RIG)

2.3.1 A new programme of targeted interventions 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.

2.3.2 The target lines on the diagram show the RIG trajectory required if at least 80% of providers were to achieve a good or better rating by the end of the 2018/19 year. It can be seen that the target trajectory is being exceeded and that the proportion of providers rated as good has risen from just 57% in January 2016 to 73% by December 2016. Conversely the proportion of providers rated as requires improvement has reduced from 40% at the beginning of 2016 to 26% by the end of that year. The diagram below shows the trend in the proportion of ratings awarded overall in the 2016 calendar year.

2.4 Overall ratings whole market

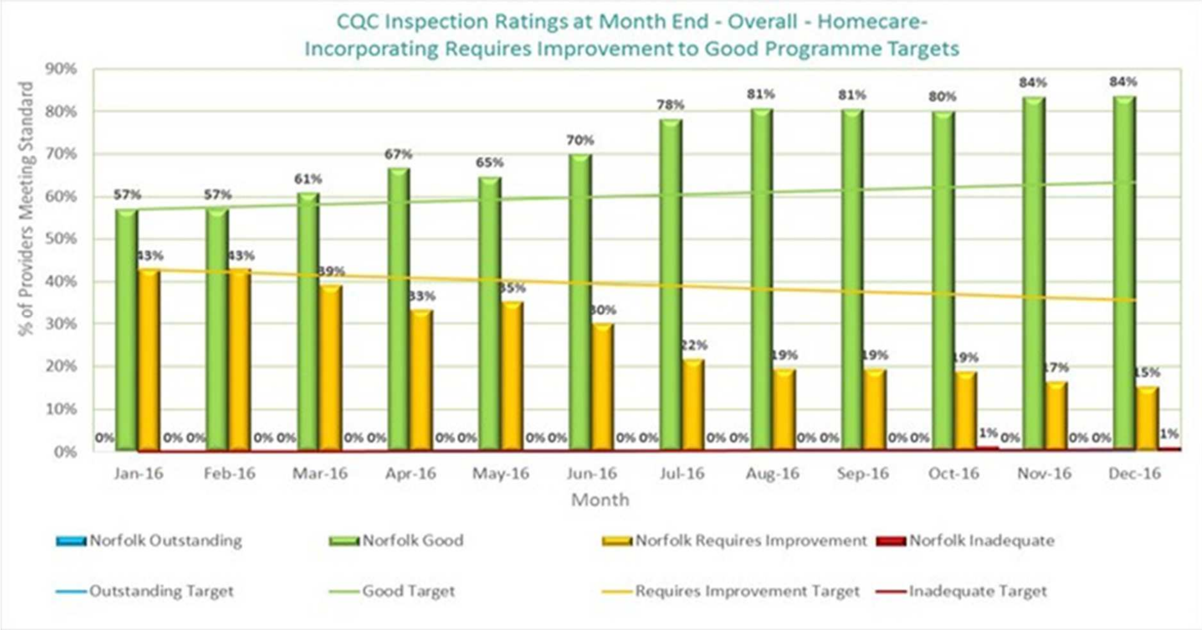
2.4.1



2.4.2 At the end December 2016 a total of 415 providers across all care sectors had been assessed by CQC, 1 had been rated as outstanding, 301 had been rated as good, 106 had been rated as requires improvement and seven had been rated as inadequate.

2.5 Ratings for home care

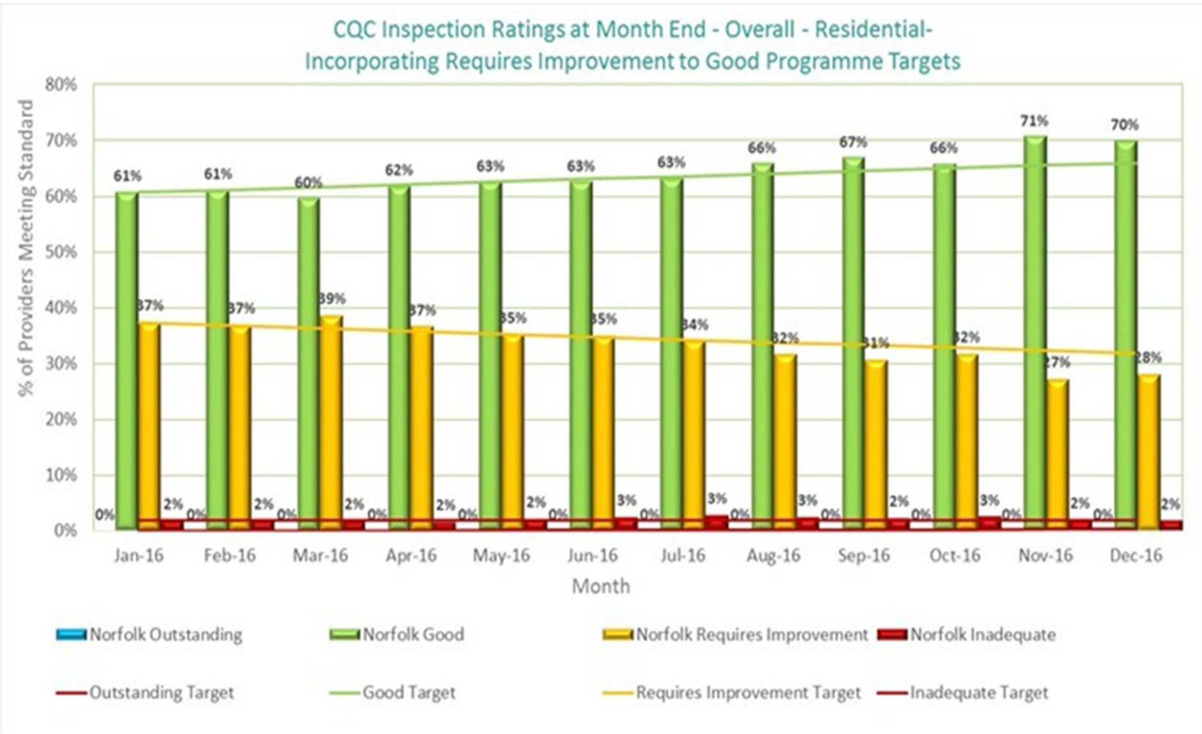
2.5.1 The diagram below shows the same data but by care sector starting with home care.



2.5.2 It can be seen that the RIG target had already been exceeded by August with a dramatic improvement from 57% rated as good to 81% rated as good and continued improvement to 84% by the end of the year. Across all sectors this is the best performance in Norfolk. The picture is less encouraging in the care home sector.

2.6 Ratings for residential care

2.6.1

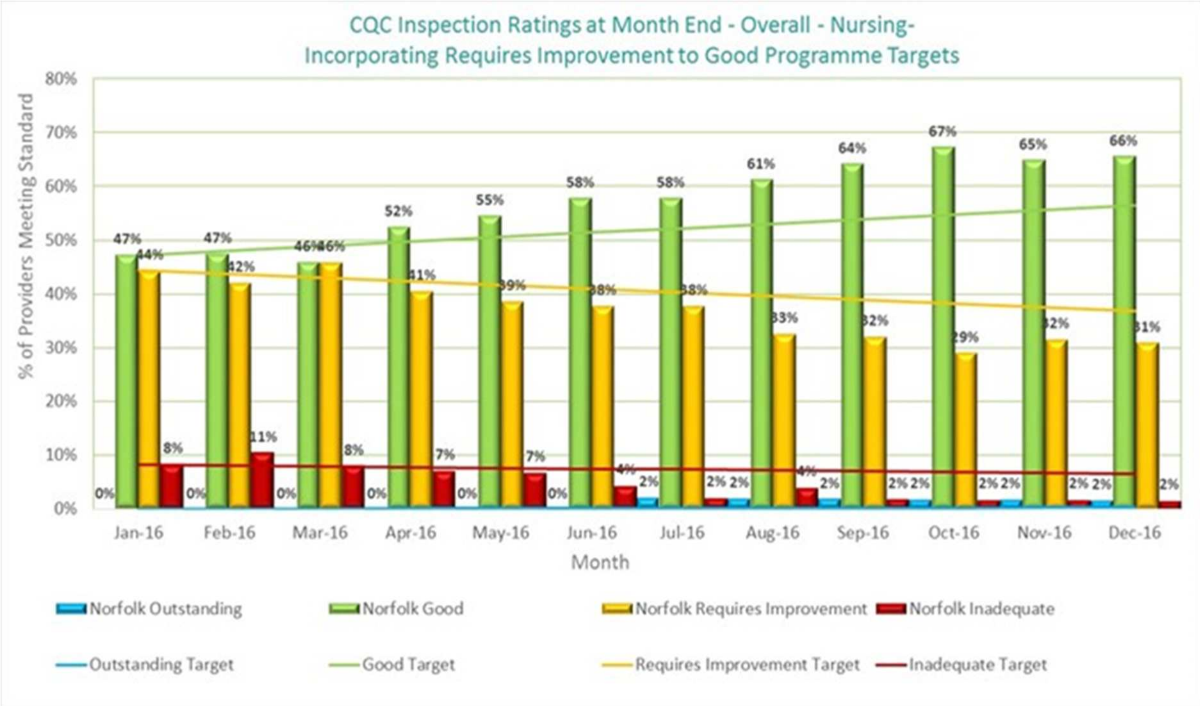


2.6.2 It can be seen that whilst the RIG target trajectory is being met 28% of residential care homes still require improvement. This equates to about 84 care homes.

2.7 Ratings for nursing care

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

2.7.2



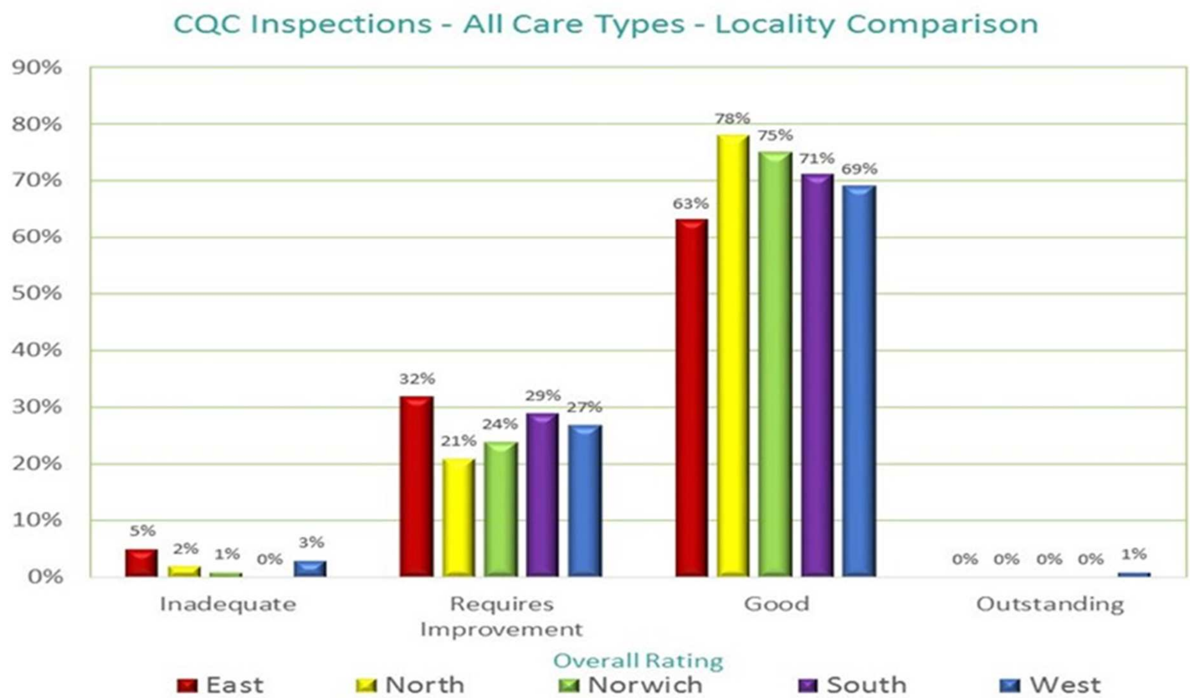
2.7.3 The RIG target is being exceeded and there has been a significant improvement from a bad start, however, 31% of nursing homes require improvement which equates to about 22 homes.

2.7.4 Having said that, two nursing homes became the only providers in Norfolk to have been assessed as outstanding thus far (one at the end of December 2016).

2.8 Ratings for all care types by location

2.8.1 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.

2.8.2

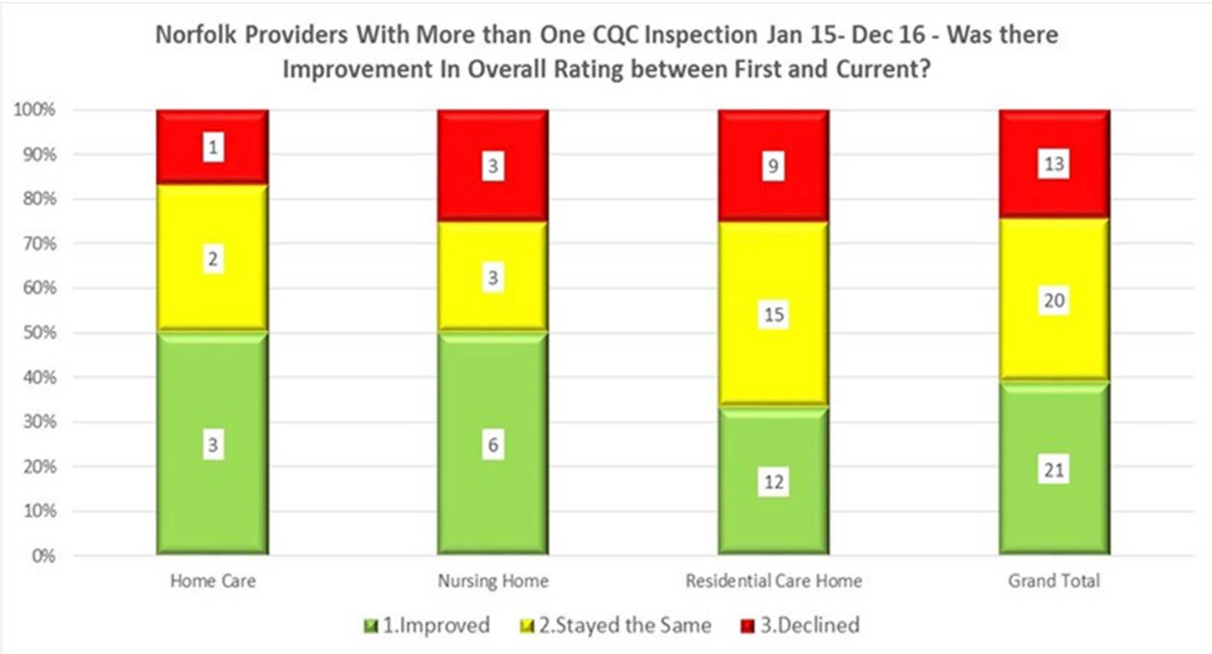


2.9 Persistently underperforming providers

2.9.1 During the year a small “hard core” of 21 underperforming providers were identified who despite a total of 61 inspections from CQC and support from the Council’s own quality assurance team had not been able to improve to a rating of good. One of these providers was a home care provider whose contract with the Council was terminated by mutual agreement. 16 were residential care homes and four were nursing homes. In a number of cases the Council has stopped placing people until improvements have been made and it is likely that some providers will exit the market altogether.

2.9.2 During the 2016 calendar year 54 providers were reinspected. All of these providers had been rated as requires improvement or inadequate. The table below shows how these providers performed upon reinspection during the year.

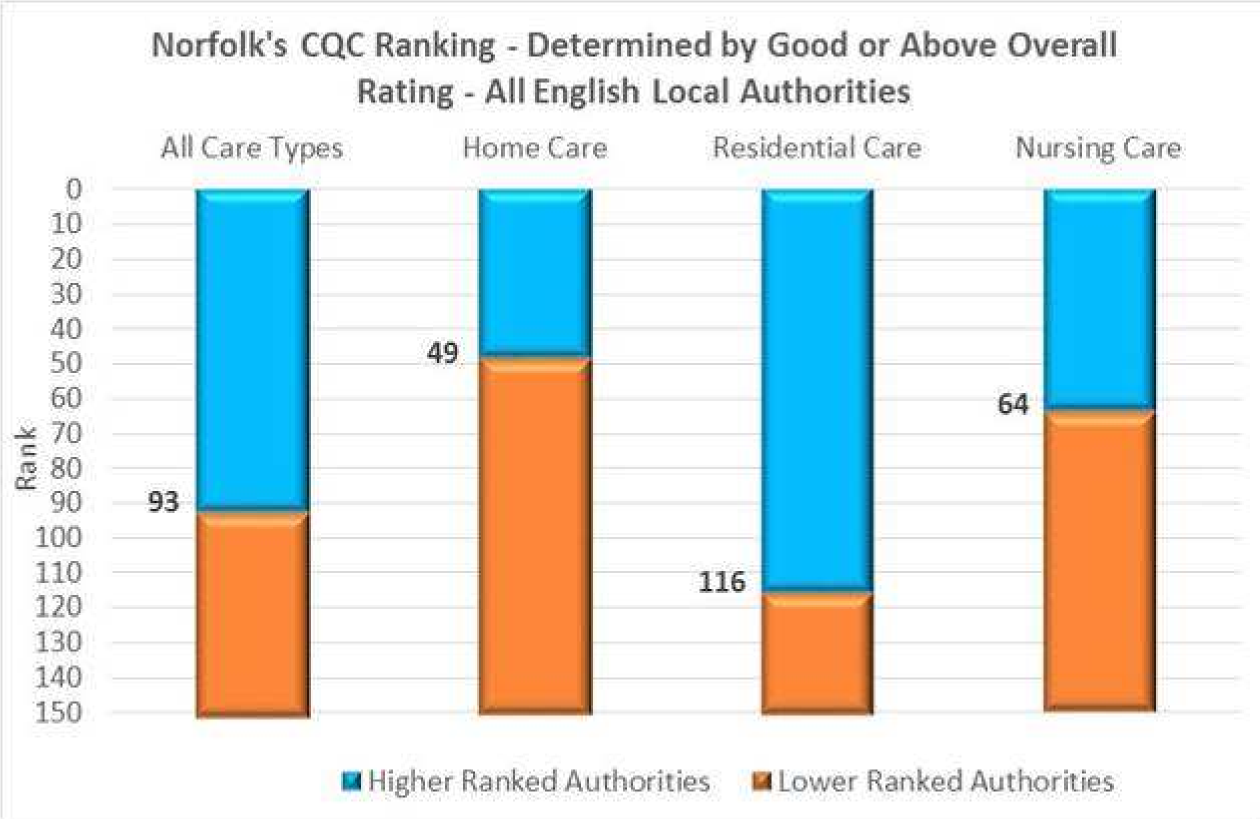
2.9.3



2.9.4 48 of the providers (89%) were care homes of which 18 improved their rating (37.5%). The remaining care homes are the subject of ongoing improvement actions by both CQC and the Council’s quality assurance team.

2.10 Norfolk ranking against other adult social care local authorities

2.10.1 There are 152 local authorities with adult social care resonsibilities in England. The diagram below shows the current Norfolk ranking across all care types and in the home care, residential care and nursing care sectors.



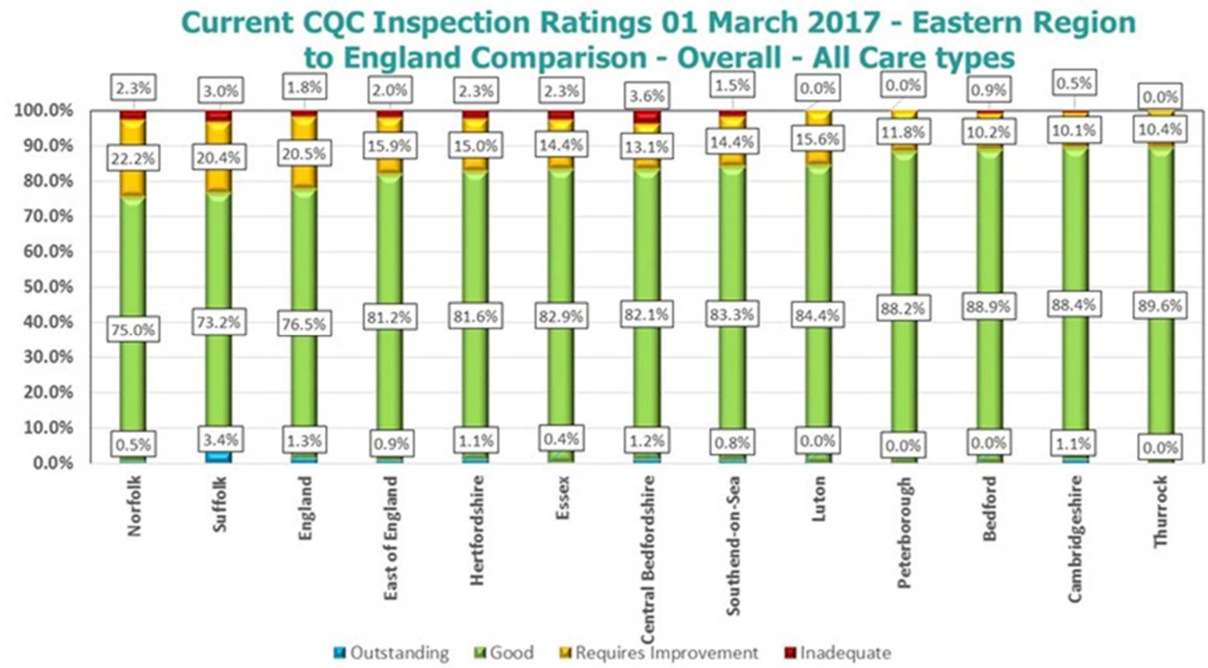
To be in the top quartile Norfolk would need to rank at 38 or better. Currently Norfolk is outside the top quartile in all three sectors and is in the lowest quartile for residential care.

2.11 Norfolk comparison with the East of England

2.11.1 The current picture shows a marked improvement across the board in Norfolk especially in home care and shows that the RIG trajectory is being matched even in the poorer performing sector, namely care homes. It is important, however, to understand Norfolk's performance in the context of the other adult social care authorities in our region.

2.11.2 The diagram below shows Norfolk's position against the other 10 adult social care authorities in the East of England, the East of England average and the all England average.

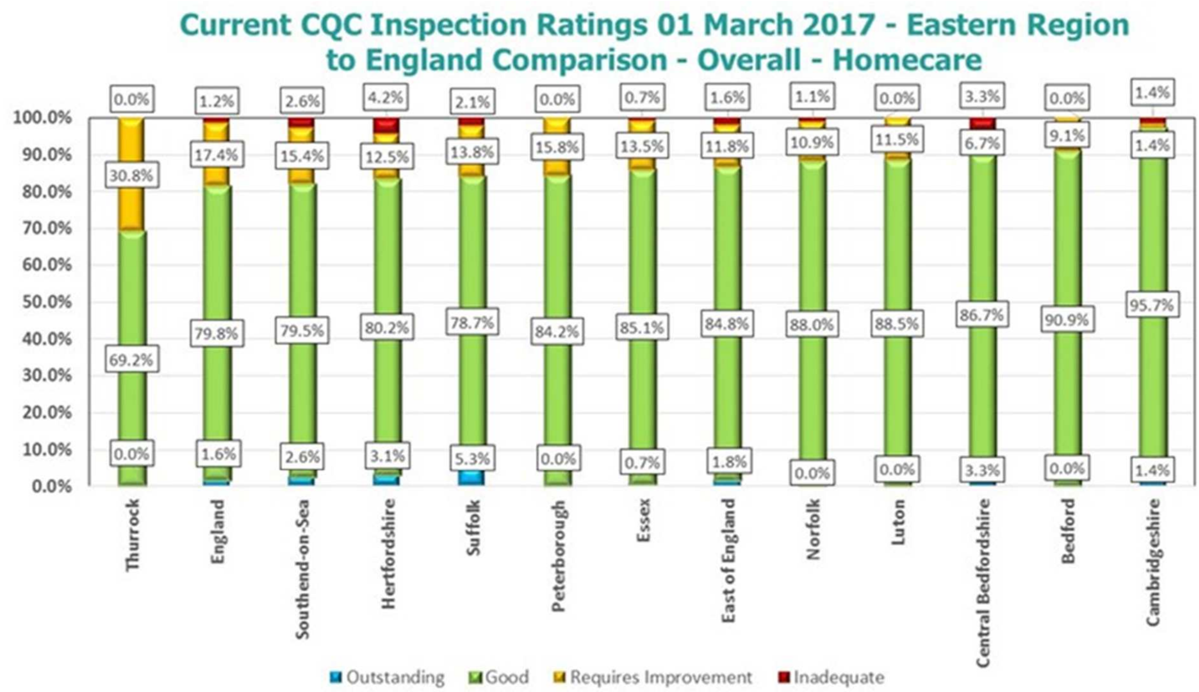
2.11.3



2.11.4 Norfolk remains at the bottom of the league table for the second year running. In comparison to the previous year Norfolk have improved at a higher rate than any other council in the East of England region so the gap is closing. Norfolk is below its own RIG target and it can be seen that nine out of the 11 councils have already achieved or bettered Norfolk's RIG target.

2.12 Home care

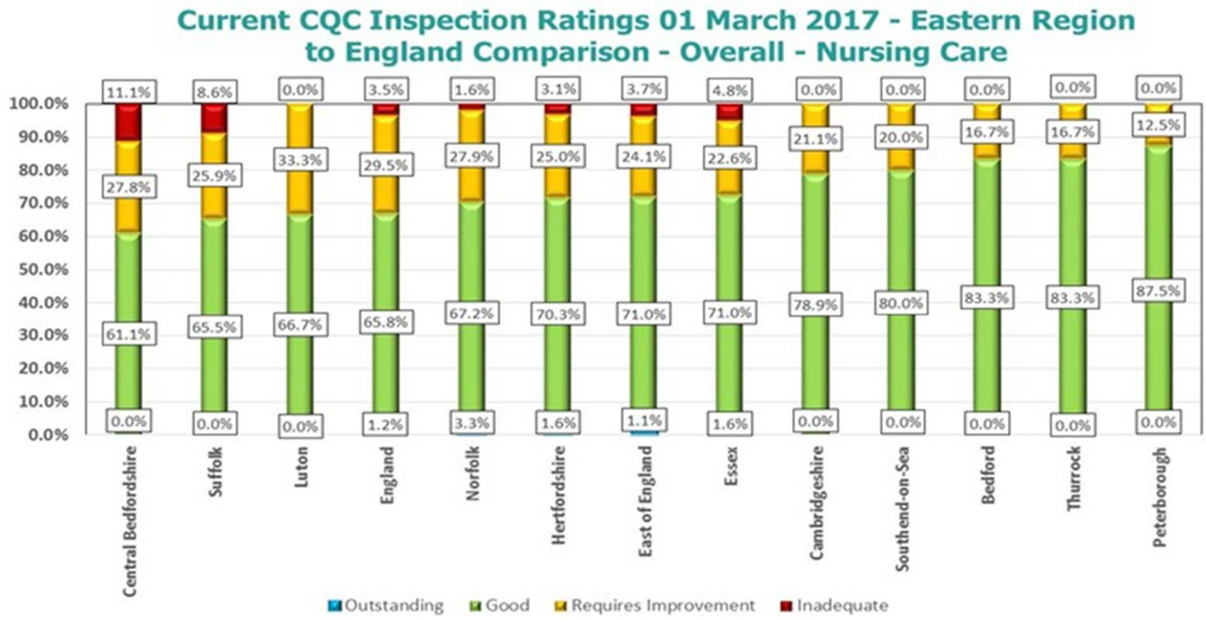
2.12.1



2.12.2 Norfolk is the fifth best performer out of the 11 councils in the region in home care exceeding both the East of England and all England averages. Norfolk comfortably exceeds its own RIG target in this sector as do all but one of the 11 councils in the region.

2.13 Nursing care

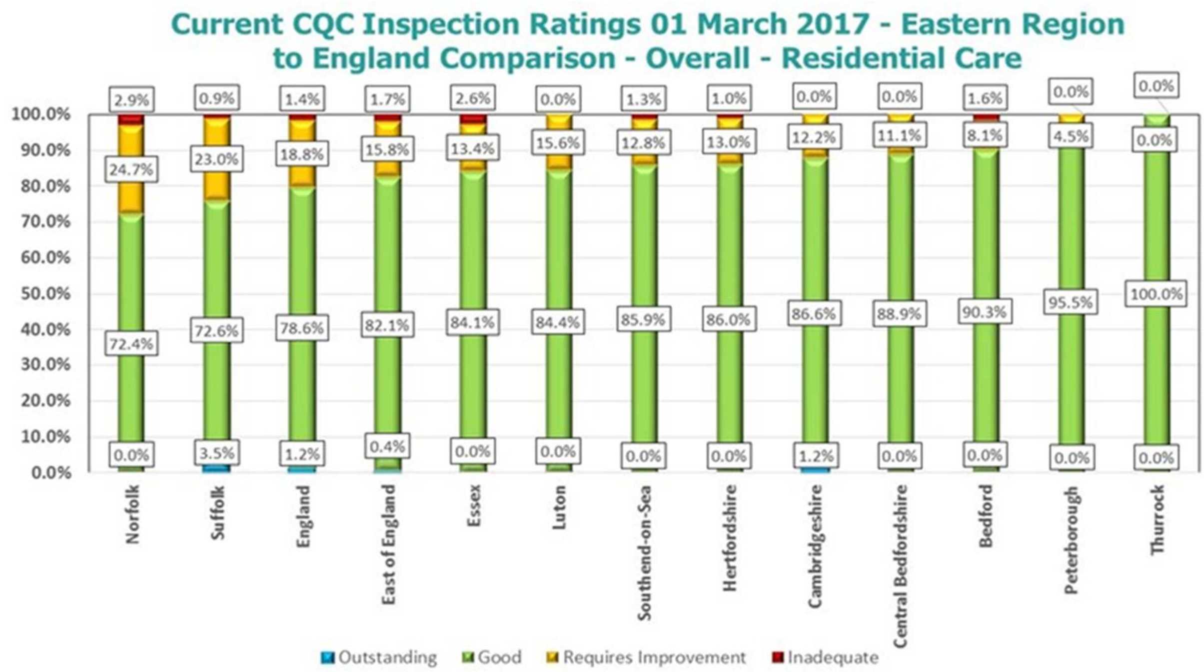
2.13.1



2.13.2 Norfolk is the eighth best performer out of the 11 councils in the region and above the all England average but below the East of England average. Norfolk is well below its RIG target as are all but four of the councils in the region.

2.14 Residential care

2.14.1



2.14.2 Norfolk is the worst performer out of the 11 councils in the region in the residential care sector and is well below its own RIG target as is one other council in the region. It is in the residential care sector where there is the most marked difference in performance and it is this sector in particular where performance on quality is at its worst.

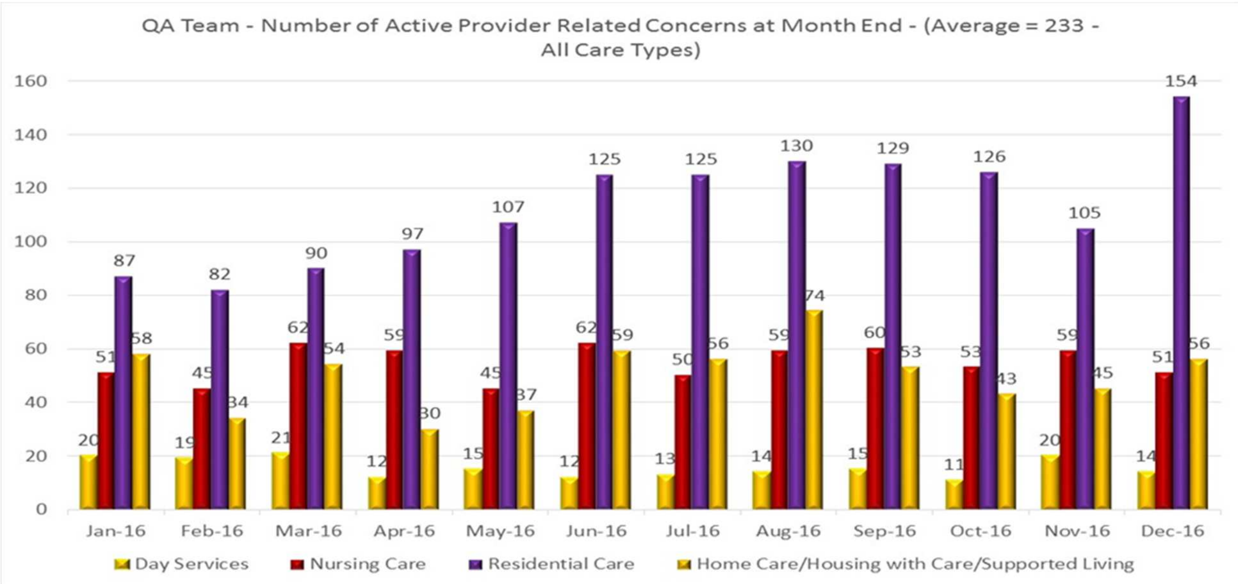
3. Securing quality at local level

3.1 The Quality Assurance Team

3.1.1 The Council has a small quality assurance team consisting of a quality manager and six quality assurance officers (5.3 full time equivalents) and two market assurance officers. This team deals with all provider related complaints and concerns including provider related safeguarding issues as well as supporting CQC. The team works closely with social care practitioners and commissioners at the local level and supports the reprovision of care in the event of provider failure. The team produces detailed quality dashboards on a monthly basis at both local level and countywide in accordance with the Quality Framework through its information analyst.

3.1.2 The table below shows the number of active cases being dealt with by the team at month end during 2016.

3.1.3



3.1.4 The workload has increased in year by over 23% and is over 30% higher than the previous year. Each quality assurance officer is on average carrying an active case load of about 44 cases. The increase is mostly down to problems in the care home market in which active cases in residential care have increased by 48% in just one year.

3.1.5 The team has averaged 60 visits a month to providers over the past 12 months and has been involved with 40% of all accredited providers. Within this 40% the proportion of providers in each sector with whom the team have been involved was:

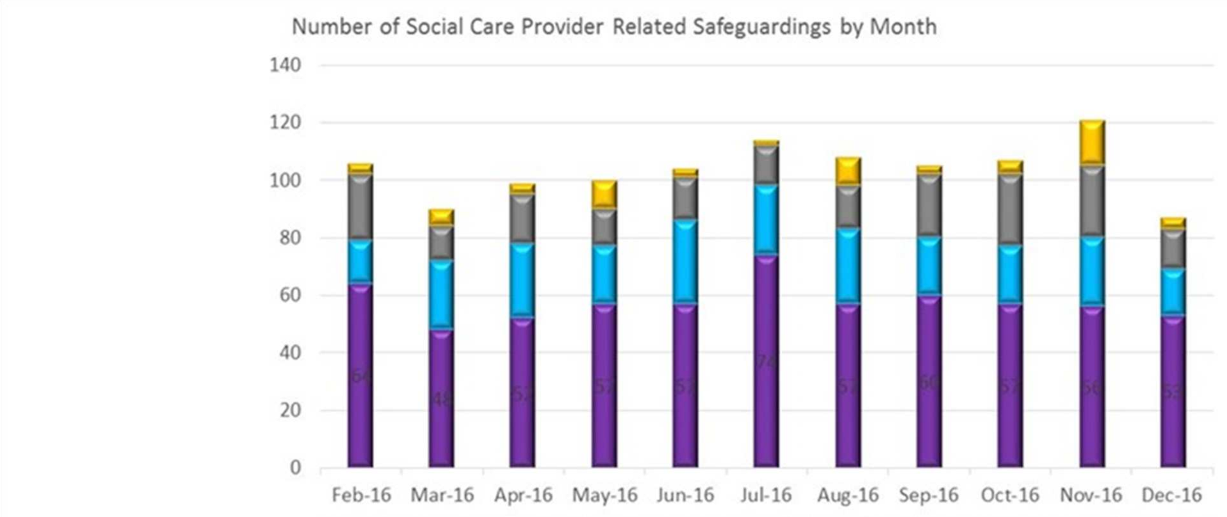
- 75% of all nursing homes
- 60% of all residential homes
- 25% of homecare agencies
- 20% of day services

3.2 Safeguarding

3.2.1 The provision of safe care is paramount and about 45% of all complaints and concerns have a safeguarding element. The table below shows the number of safeguarding related referrals to the quality team in each month from February to December 2016.

The team do not need to act on every referral, however, the information is used to help build up the risk profile of the providers concerned.

3.2.2

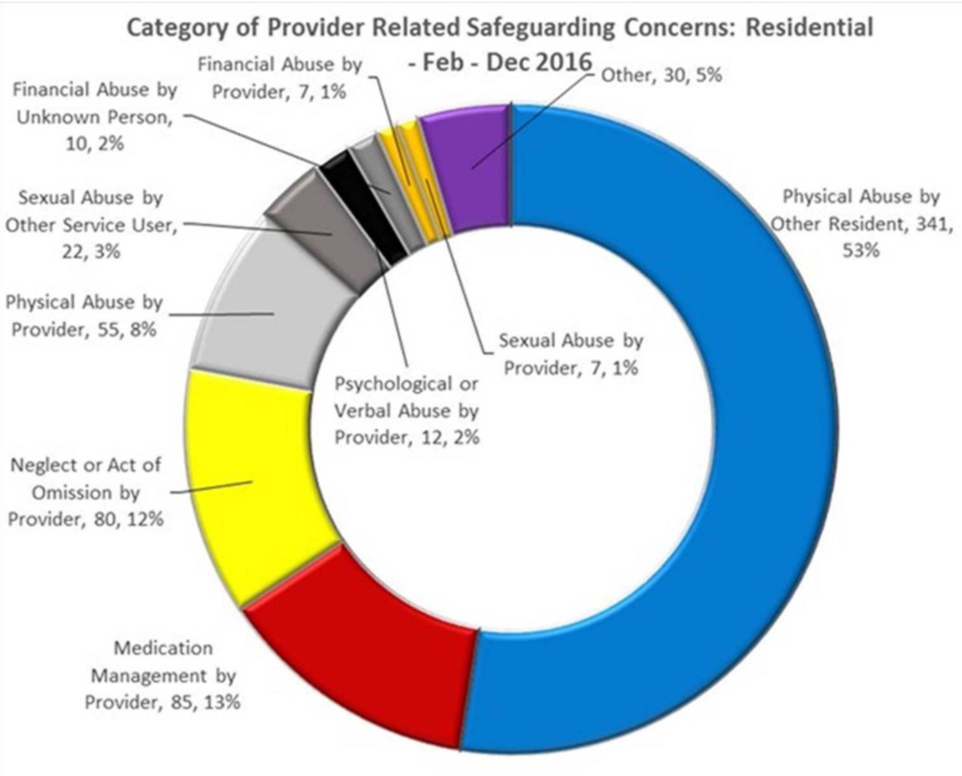


	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Day Services	4	6	4	10	3	2	10	3	5	16	4
Home Care/HWC/Supported Living	23	12	17	13	15	14	15	22	25	25	14
Nursing	15	24	26	20	29	24	26	20	20	24	16
Residential	64	48	52	57	57	74	57	60	57	56	53

3.2.3 The majority of provider related safeguarding concerns are in the care homes sector. The types of abuse or neglect vary significantly from sector to sector as shown in the diagrams below.

3.3 Residential care

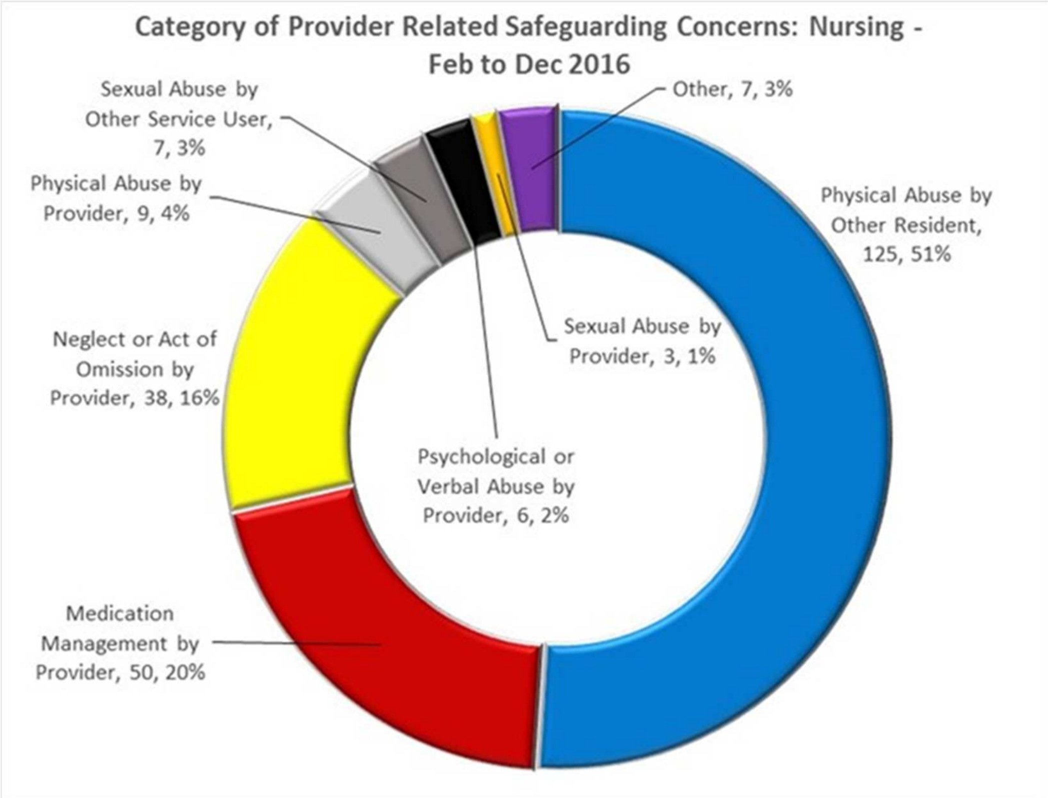
3.3.1



3.3.2 53% of all concerns relate to abuse by one resident to another with a further 25% relating to medication errors or neglect on the part of providers.

3.4 Nursing care

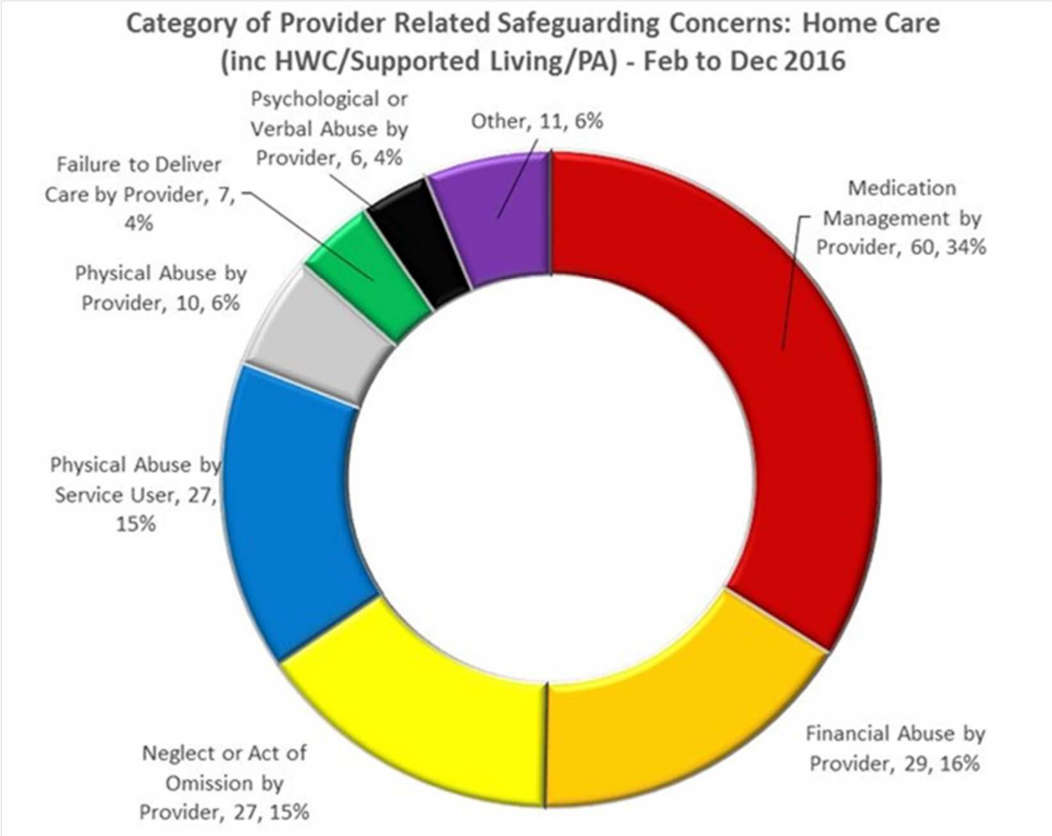
3.4.1



3.4.2 51% of concerns relate to abuse by one resident to another with 36% of concerns relating to medication management or neglect.

3.5 Home care

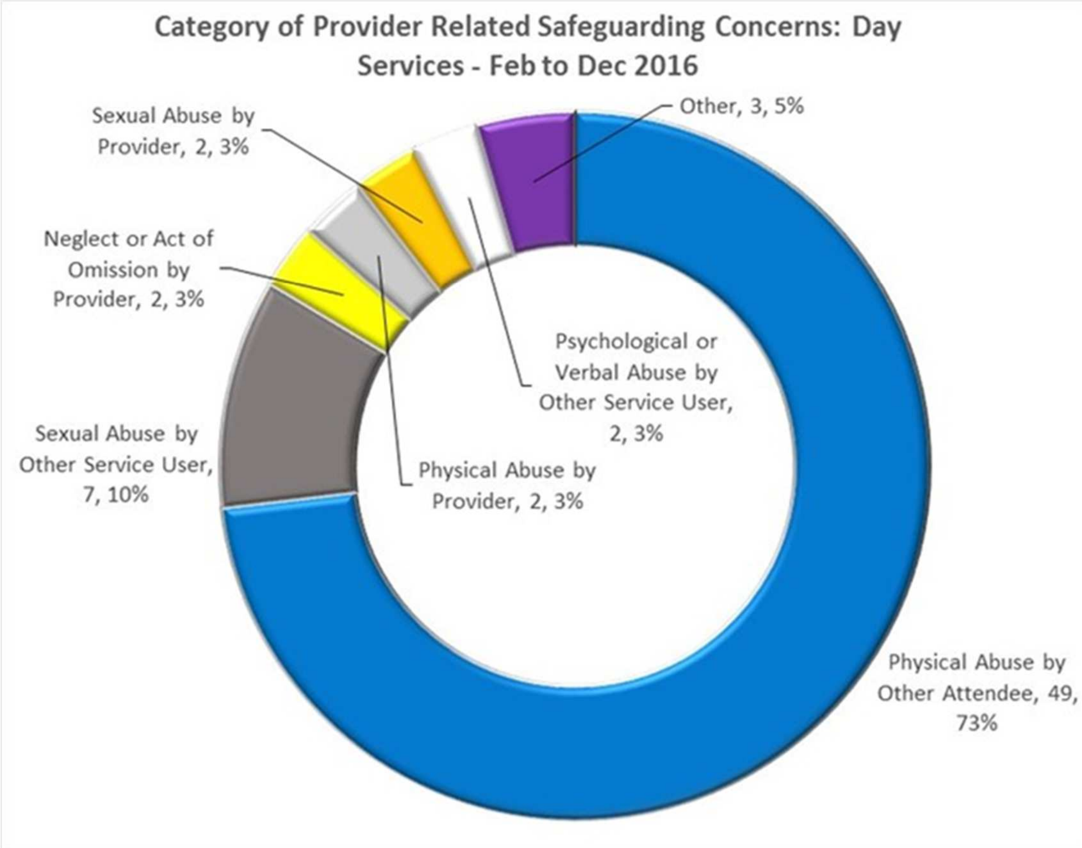
3.5.1



3.5.2 60% of concerns relate to medication management with significant concerns relating to financial abuse and neglect. 15% of concerns relate to abuse by the service user.

3.6 Day care

3.6.1



3.6.2 73% of all concerns relate to abuse by one attendee on another attendee with a further 10% of concerns relating to sexual abuse by one attendee on another attendee.

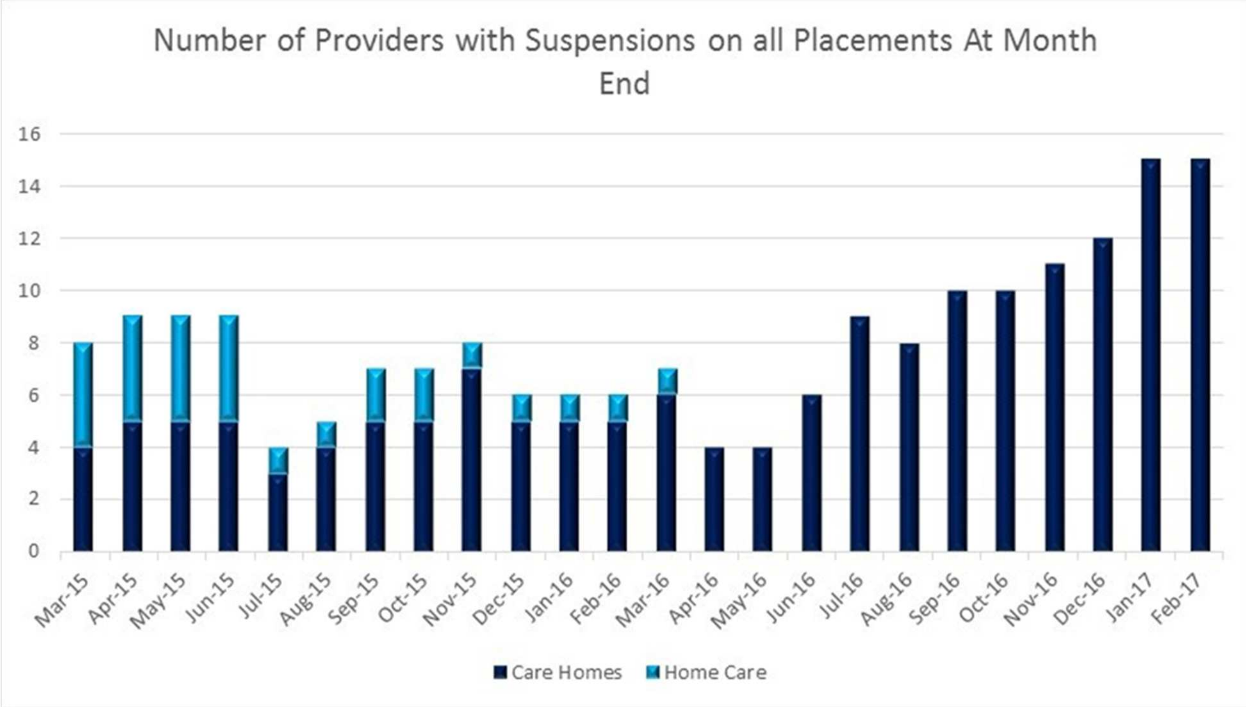
3.6.3 In summary the diagrams indicate that:

- Incidents of physical assault between service users are most frequently occurring in residential, nursing care and day services
- Medication errors are most frequently occurring in home care but also common in residential and nursing
- Neglect is a significant concern in all provider types apart from day services.
- Financial abuse of service users occurs more in homecare than in other care types
- Physical abuse of residents by care staff occurs more in residential homes but is noticeable in nursing homes and homecare

3.7 Suspension on placements

3.7.1 In more serious cases the quality team will impose sanctions on providers by activating suspension powers under the Council's contracts. The table below shows the prevalence of suspensions for March 2015 to February 2017.

3.7.2



3.7.3 It can be seen that through the period March 2015 to March 2016 there were serious issues with a small number of care home providers and home care agencies. In the period April 2016 to February 2017 the problems have been in the care home sector with an increase from four suspended services to 15.

3.7.4 Effective work by the QA team, commissioners and contract management has reduced the number of homecare providers with restriction on all placements. The decrease in these suspensions is a good news story and reflects the hard work of the QA team in working with providers to improve the quality of the care that they provide and reduce the risk they pose to their service users.

3.7.5 The number of care homes with suspensions on all placements has more than doubled during the last year. The QA team are actively involved with these providers to improve their services but the increase reflects the difficulties in this area. This is also demonstrated by the CQC ratings for residential and nursing which have fewer good or above ratings than homecare.

3.8 Targeting high risk providers

3.8.1

- The team have continued to develop and implement the APP system which is used by many trading standards and environmental health authorities for public protection purposes. The system includes a database of all regulated and accredited social care providers in Norfolk and enables all intelligence about the performance of those providers to be logged. Typically this information will include :
  - Concerns investigated by the Quality Assurance Team
  - Response visits and routine monitoring visits undertaken by the QA team
  - Provider Safeguardings
  - CQC Inspection Results
  - Public Health Infection Prevention and Control Inspections
  - Customer satisfaction surveys

Restrictions on placements and performance notices the provider is subject to.:

3.8.2 Analysis of this intelligence enables a risk score for each provider to be developed and kept up to date on an ongoing basis.

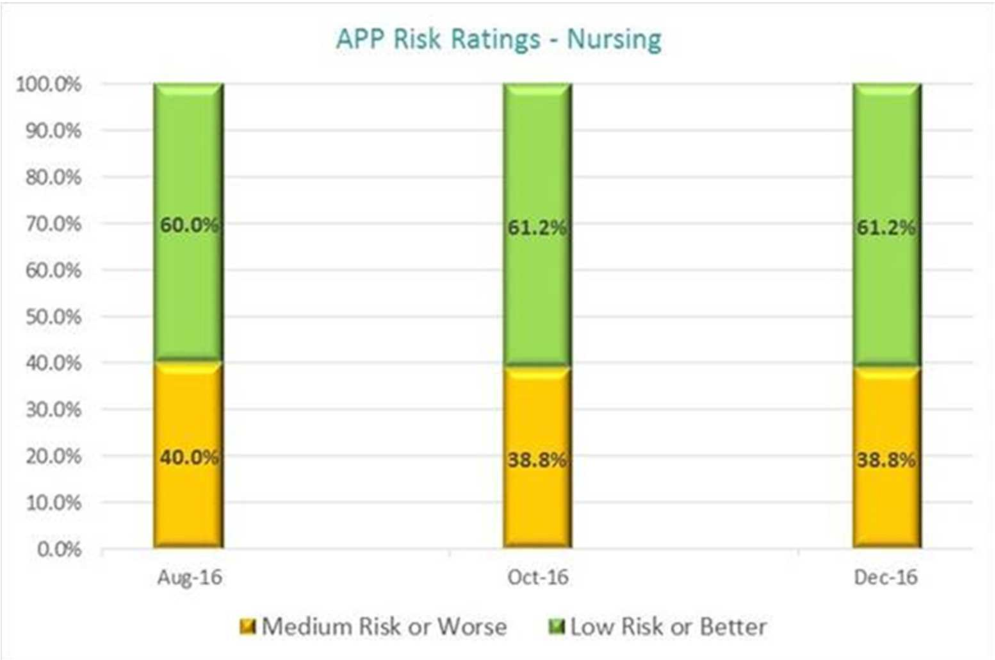
3.8.3 The system also acts as a case management and performance management tool enabling the quality manager to ensure that workloads are balanced and prioritised.

3.9 Current APP ratings

3.9.1 The current APP ratings correlate well to CQC ratings and provide an objective assessment of non regulated services including day care. The diagrams below show the ratings as at August, October and December 2016. The quality team would expect to be actively involved with all providers rated medium risk or worse.

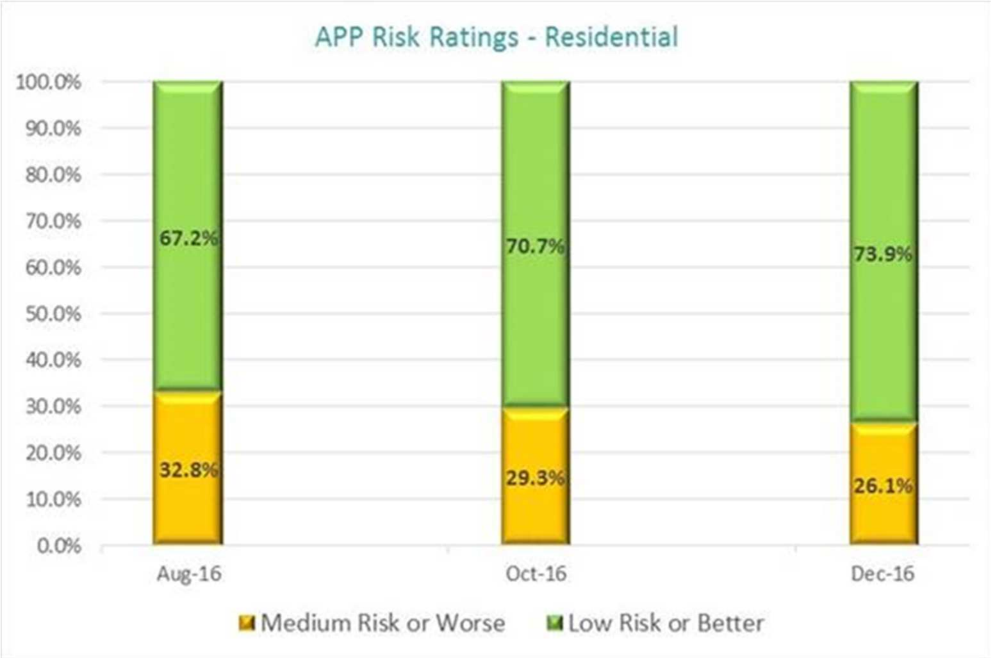
3.10 Nursing homes

3.10.1



3.11 Residential care homes

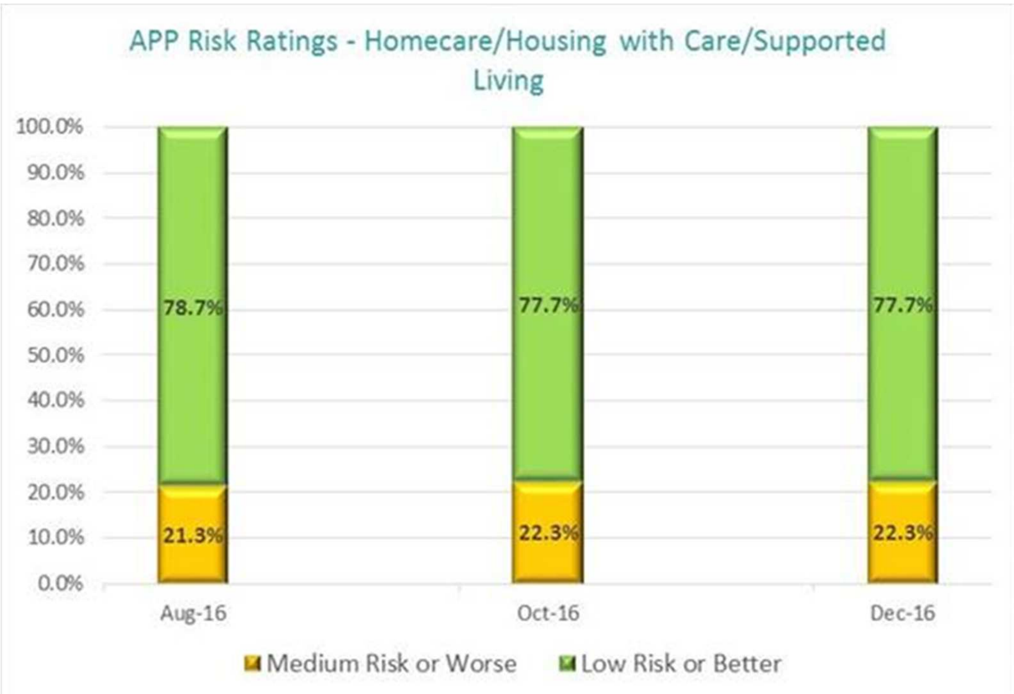
3.11.1



3.11.2 The diagrams evidence the fact that there is a significant proportion of the care home market that presents real concerns about quality care. Some improvement has been achieved but the level of risk remains stubbornly high in this sector. Poor quality in care homes contributes to otherwise avoidable admissions to hospital putting greater strain on the health system and compromising the outcomes that residents should expect.

3.12 Home care

3.12.1



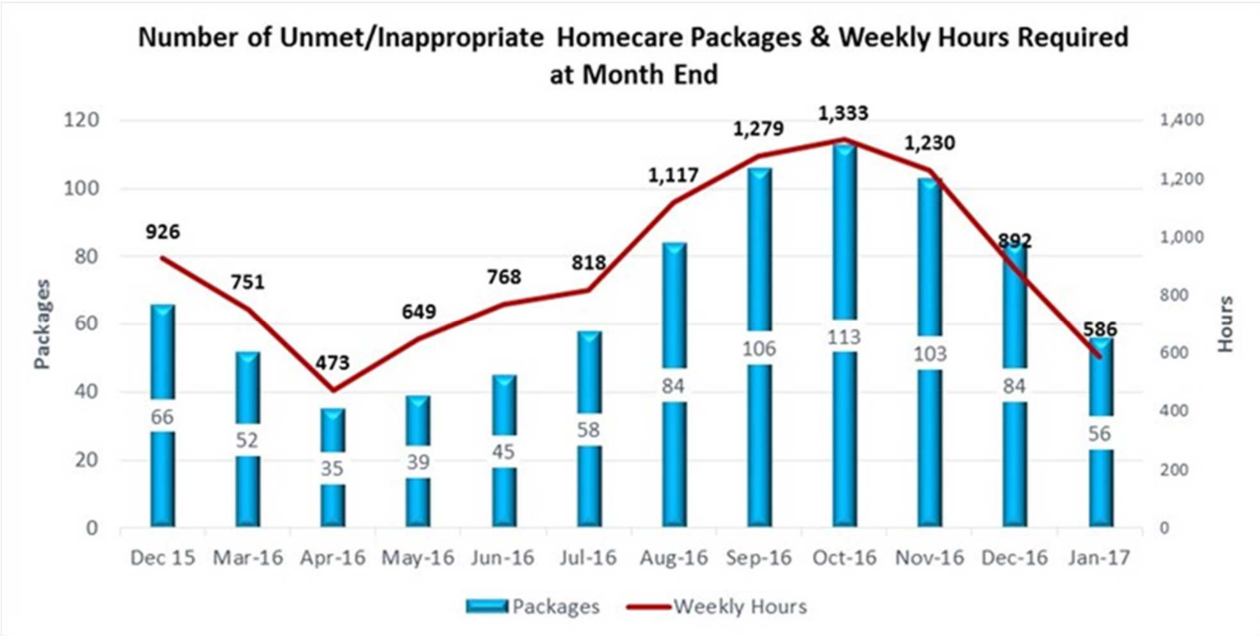
3.12.2 About 1 in 5 home care providers are giving rise to quality concerns some of which is due to the inability of the market to respond to demand. This means that some people are waiting at home for care which is not available, or cannot be discharged from hospital to go home, or are in temporary residential or nursing care waiting to be able to go home. In addition some people have successfully completed their rehabilitation through the Council's own service and continue to be looked after by that team until home care becomes available.

3.12.3 As well as compromising the outcomes that would otherwise be achieved the inability of to market to respond drives significantly higher costs for both the Council and the health system.

3.12.4 The QA team produces a monthly analysis of unmet or inappropriately met need for home care to support targeted interventions. Northern locality has the greatest problems with unmet homecare need, and this is not only in rural areas but also in the more built up northern fringes of Norwich and in market towns. The situation is being actively tackled by commissioners through focused market engagement to ensure that providers can pick up individual hard to place care packages and innovative procurement intended to better balance demand and supply.

3.12.5 The diagram below shows the scale of the problem

3.12.6



3.13 Quality Dashboards

3.13.1 The Quality Framework requires the production of data to enable the department to understand the quality of care being provided. The QA team supported by market development colleagues produces six quality dashboards per month, one covering Norfolk and one for each of the five localities. This equates to 72 dashboards per year. The last year has seen constant revisions to all dashboards to better evaluate quality in the care market and better reflect the needs of the dashboard customers. The dashboards evaluate quality in the care market through analysis of CQC results, provider related safeguardings, provider risk scores and analysis of unmet homecare need.

4. Quality improvement strategy 2017/18

4.1 This report sets out a comprehensive picture of the quality of adult social care in the formal care market in Norfolk in 2016/17. The report shows the scale of the interventions carried out by the Council to help providers who have fallen below the minimum quality standards required. The Quality Framework supports the continuous improvement of quality and the next section of this report sets out the Council's quality improvement strategy.

4.2 Care homes

4.2.1 The evidence clearly shows that the need for improvement is at its greatest in the care home sector and consequently a major improvement programme is planned across the health and social care system as a whole which includes the following key components:

4.2.2

Care element	Sub-element
1. Enhanced primary care support	Access to consistent, named GP and wider primary care service
	Medicine reviews
	Hydration and nutrition support
	Access to out-of-hours/urgent care when needed
2. Multi-disciplinary team (MDT) support including coordinated health and social care	Expert advice and care for those with the most complex needs
	Helping professionals, carers and individuals with needs navigate the health and care system
3. Reablement and rehabilitation	Rehabilitation/reablement services
	Developing community assets to support resilience and independence
4. High quality end-of-life care and dementia care	End-of-life care
	Dementia care
5. Joined-up commissioning and collaboration between health and social care	Co-production with providers and networked care homes
	Shared contractual mechanisms to promote integration (including Continuing Healthcare)
	Access to appropriate housing options
6. Workforce development	Training and development for social care provider staff
	Joint workforce planning across all sectors
7. Data, IT and technology	Linked health and social care data sets
	Access to the care record and secure email
	Better use of technology in care homes

4.2.3 This programme of work is intended to significantly increase the proportion of care homes rated as at least good by CQC as well as reducing admissions from care homes to hospital.

4.2.4 The QA team will work with the wider quality community in the CCGs and community health providers as well as integrated commissioners to deliver a series of workshops aimed at care home providers to better understand the root causes of poor quality and agree, develop and implement tailored improvement programmes.

4.2.5 The Council's quality team will continue to work with specialists funded through the Market Development Fund to tackle the worst performers through the RIG programme.

4.2.6 In addition work will commence to replace the current Council accredited list for care homes with a new framework and contract that will have a strengthened focus on quality.

4.3 Using market intelligence to target quality improvement - APP system

4.3.1 The quality team will continue to use its APP system to target providers throughout the care market using a range of proportionate and effective interventions where quality has been compromised. The team will also develop a range of tools and resources including tailored self audit tools to enable providers to better manage and sustain high quality services.

4.4 Delivering the "requires improvement" to "good" programme. (RIG)

4.4.1 The current CQC ratings position is clearly not acceptable and so we will use our Market Development Fund to commission a new programme of work aimed at securing better CQC ratings. We will develop and implement a programme focused on ensuring that providers with a "requires improvement" rating from CQC are supported to achieve a "good" rating at next inspection.

4.5 Promoting the Harwood Care Charter

4.5.1 The Harwood Care Charter is the Council's own quality standard focusing on putting service users in control of the care they receive. We will re-promote the Harwood Care Charter to providers encouraging them to demonstrate their commitment to person centred care by registering as adherents to the scheme and its principles. We will use the Councils website to ensure that people can see which providers have committed to person centred care in this way.

4.6 Using service user feedback to drive quality improvement

4.6.1 We want real insight into whether the services that the Council pays for are actually helping people achieve the outcomes that they want. We will therefore continue to roll out and develop our customer outcomes satisfaction surveys in the home care market to test the extent to which services are promoting wellbeing and independence in line with our Promoting Independence strategy.

4.7 Delivering a sector skills plan to support the workforce

4.7.1 We will build on the work carried out in the past year to promote care as a career including the creation of a new website to connect care workers with potential employers.

4.8 Investing in and engaging with the market

4.8.1 We will build on the successful provider dialogue process we established last year that will enable the Council to work with provider representatives from all the major care sectors to gain a thorough understanding of the cost of providing care so that in setting and agreeing prices the Council can be confident that those costs are properly recognised.

4.8.2 We will also work with providers throughout the year to develop and establish effective arrangements at both the strategic and operational level so that the Council can tackle issues including care quality improvement alongside providers themselves. This will include the implementation of our market engagement plan co produced with providers.

4.9 Innovative commissioning and Integrated approaches

4.9.1 We will develop innovative approaches for securing sustainable high quality services through our commissioning and procurement activity with a particular focus in the coming year on the home care and residential care markets.

4.9.2 Work commenced in 2016 that brings together the quality leads from the five clinical commissioning groups in Norfolk and the local authority in a collaborative approach to support quality improvement in the care home sector. The ambition is to roll out this collaborative approach across all sectors as integrated working matures and delivers quality outcomes.

4.10 Care conference

4.10.1 We will continue to invest in an annual care conference at which we can work directly with care consumers and providers to agree how best working together we can secure sustainable good value for money quality services.

4.11 Norfolk care awards

4.11.1 We will continue our support of the Norfolk Care Awards event as a valuable investment in identifying, promoting and celebrating best practice in care quality.

4.12 Capacity review

4.12.1 We will carry out an external review of the Council's quality assurance capacity and arrangements to ensure that the Council has the most effective and efficient arrangements in place.