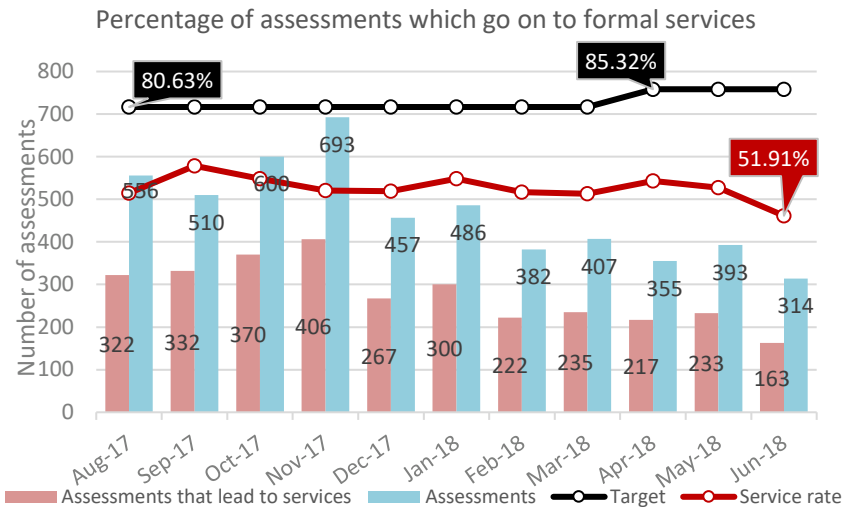
Percentage of assessments which go on to formal services

Why is this important?

This indicator measures the effectiveness of arrangements for supporting and re-abling people, and of the process for determining which people need a Care Act Assessment. People that go on to receive information and advice as a result of an assessment, or who receive 'no further action', probably should not have received an assessment in the first place.

Performance



What is the background to current performance?

- This indicator should improve as we embed and sustain strengths-based working, and, in particular, roll out Living Well 3 conversations approach
- This will lead to an earlier engagement with people to link them and connect them informal support.
- We expect the number of formal assessments to reduce but those which do take place will be more likely to lead to formal services.
- Further work with social care teams is needed to understand more about practice at the front line affecting this indicator
- A discharge to assess pathway is currently being developed within the service.
- The resilience team are now using the Living Well 3 Conversations approach, with a site about to launch at the NNUH.
- There is also work looking into exploring links with health coaching within the integrated services.

What will success look like?

- People that go on to receive information and advice as a result of an assessment, or who receive 'no further action', probably should not have received an assessment in the first place.
- The increase suggested here may feel counter-intuitive in that it might suggest additional service provision. In fact this increase is predicated on an overall reduction in assessments in line with the principles of the 'Three Conversations' model.

Action required

- Locality level data from the new information system for this indicator will give teams better information to help target and address this
- Continued focus at every point of contact with people on independence
- Joint working with health to promote self-care and build resilience in communities
- Planned roll out across all teams of the Living Well model

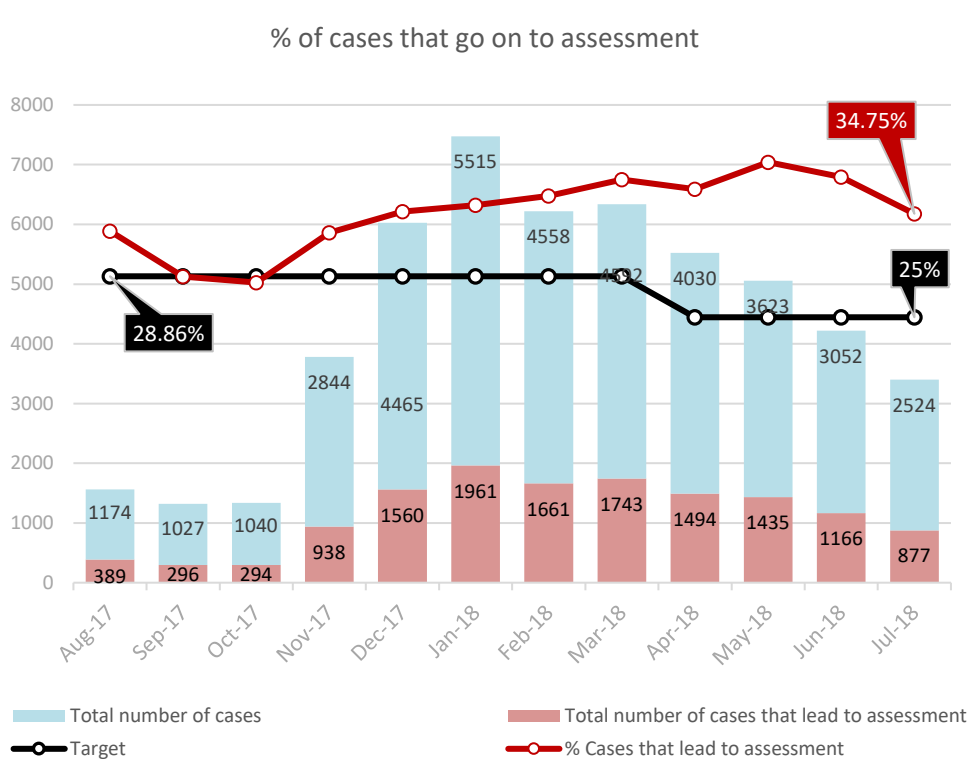
Responsible Officers	Lead: Craig Chalmers, Director of Community Social Work	Data: Intelligence and Analytics Service

Percentage of requests that go on to assessment

Why is this important?

Leading practice in social care suggests that a quarter of contacts to social care should translate into a formal care act assessment. This highlights the need to expand and embed prevention and information strategies which connect people with support or advice so more people stay in control of their lives.

Performance



What is the background to current performance?

- The most recent trend points to an improvement against this measure, suggesting early intervention, prevention and strengths-based working are all directed towards supporting people to be independent, resilient and well.
- There are now a suite of prevention and early intervention approaches which should be contributing towards keeping people connected to their communities and self-help. These include:
- Early findings from Living Well: 'Three Conversations' approach to social work does show a benefit for people through connection to informal services
- Coverage of Living Well is expanding – in the East and in the West
- Social prescribing which is xxxx is now up and running across al 7 district areas of Norfolk
- Norfolk Community Directory has been launched – with the aim of providing comprehensive information on community support for residents and for professionals.
- The challenge will be maintaining continued improvement against this target during more intensive months of activity.

What will success look like?

- Good performance will mean a reduction in the percentage of requests for support ending with an intention to carry out assessment. Performance is therefore driven by the extent to which other options – for example community-based support – have been explored; and by the amount of requests for support.

Action required

- Thorough and effective implementation of Living Well: 3 conversations, ensuring that the fundamental drivers of the approach are not diluted by the widespread roll-out
- Effective targeting of preventive work, through a risk-stratification model
- Management action at a team level, using locality level data to target improvement

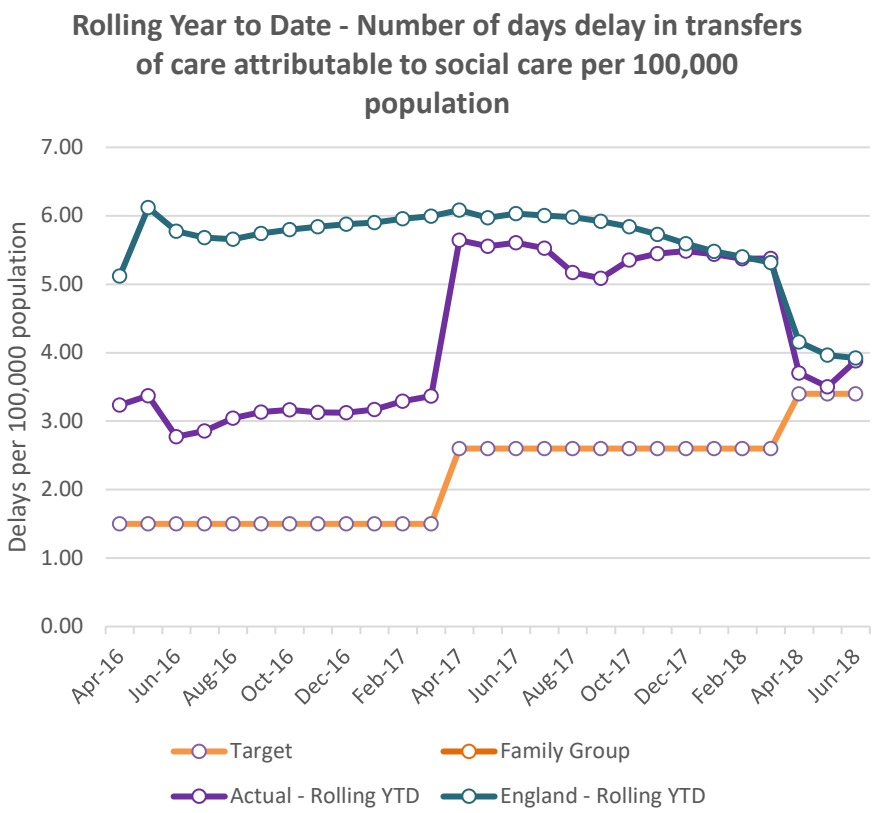
Responsible Officers	Lead: Craig Chalmers, Director of Community Social Work	Data: Intelligence and Analytics Service

Delayed transfers of care

Why is this important?

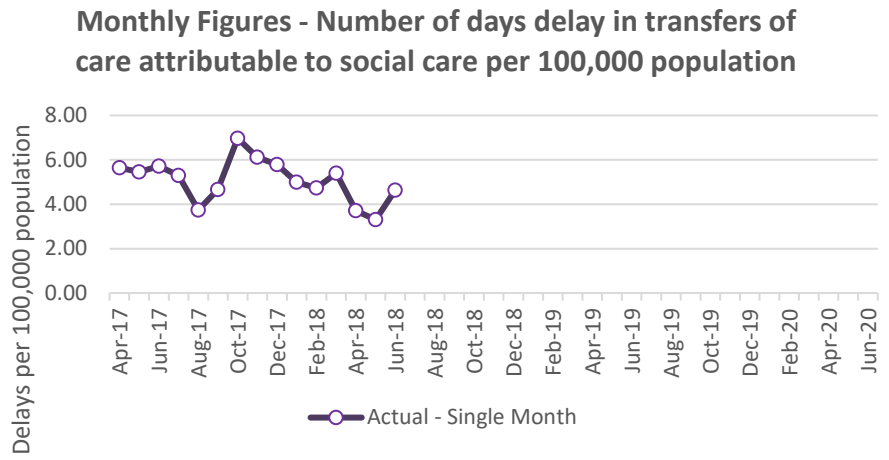
Staying unnecessarily long in acute hospital can have a detrimental effect on people's health and their experience of care. Delayed transfers of care attributable to adult social services impact on the pressures in hospital capacity, and nationally are attributed to significant additional health services 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. Low levels of delayed transfers of care are 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?

- Delays attributed to Adult Social Care have come down steadily since October 2017 – see graph bottom left.
- However, performance across the system still requires significant improvement
- New targets have been set by the Department of Health and Ministry of Housing and Local Government. For Adult Social Services this means that on any one day, there can be no more than 24.3 delayed days per day attributed to adults.
- In June NCC was 27.3% above target for social care delays with 930 delayed days. This accounted for 43% of total delays in Norfolk.
- The main reason for social care delays was "Awaiting Residential Home Availability or Placement".
- Norfolk was ranked 88 out of 151 in June for total delays per population and 127 out of 151 for social care delays per population.
- We have a set of improvement actions, which will form part of a formal winter plan which includes better liaison with care providers; clear processes for identifying care home vacancies; earlier involvement in discussions on wards.



What will success look like?	Action required
• 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.	• Engage with external support to strengthen and change our integrated assessment processes for discharging people from the acute and community hospitals

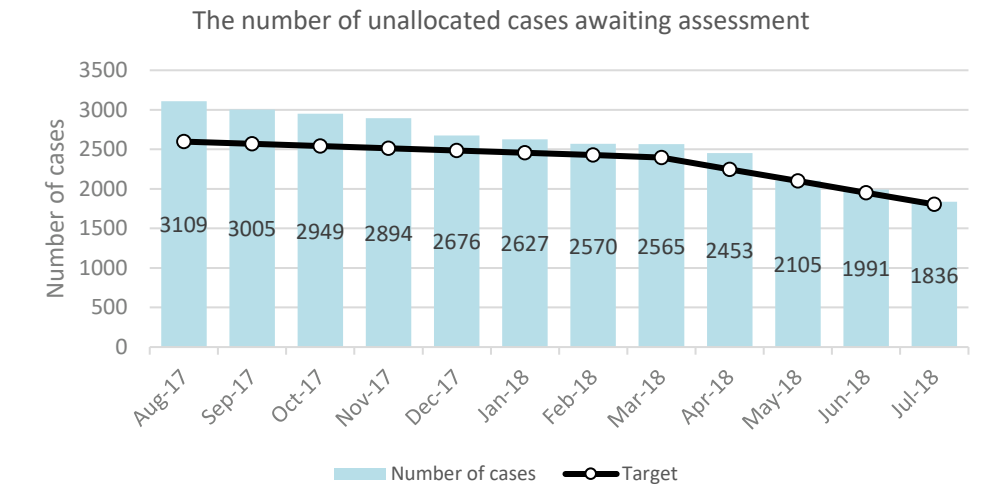
Lead: Craig Chalmers, Director of Community Social Work and Lorrayne Barrett, Director of Community Health and Social Care. Data: Intelligence & Analytics

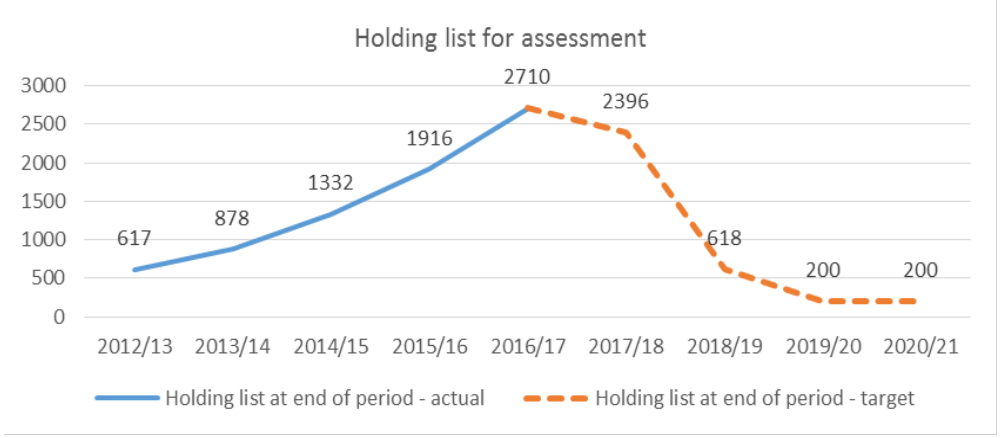
Holding List

Why is this important?

Carrying high backloads of work is having an impact of the pace of change we need to make. Delays in assessments can worsen the service users' condition, resulting in a greater need of care from the authority and potentially reducing their level independence. Monitoring of this will allow us to assess the impact of recruitment into newly created posts and allows us to monitor the performance of the 3 conversations model.

Performance





What is the background to current performance?

- Our 'holding' lists peaked over a year ago; since then they have been reducing
- The Community Care Resilience Team has been operating since December to support locality teams in bringing down the holding lists
- In a six month period (to June 21st 2018) the team's work spread across all localities. (see below)
- All workers are trained in strengths based practice, have an ethos in line with the Three Conversations and OT first, and have achieved their competencies to allocate low level equipment.
- In addition, all locality teams actively manage their holding lists, and have different approaches to bringing them down
- To sustain continued reduction and to keep the number on the holding list also requires changed ways of working.
- Early indications from Living Well innovation sites show that it is possible to minimise any holding list

Locality	Cases
South	372
North	312
West	252
Norwich	173
East	123
Total	**1,252**

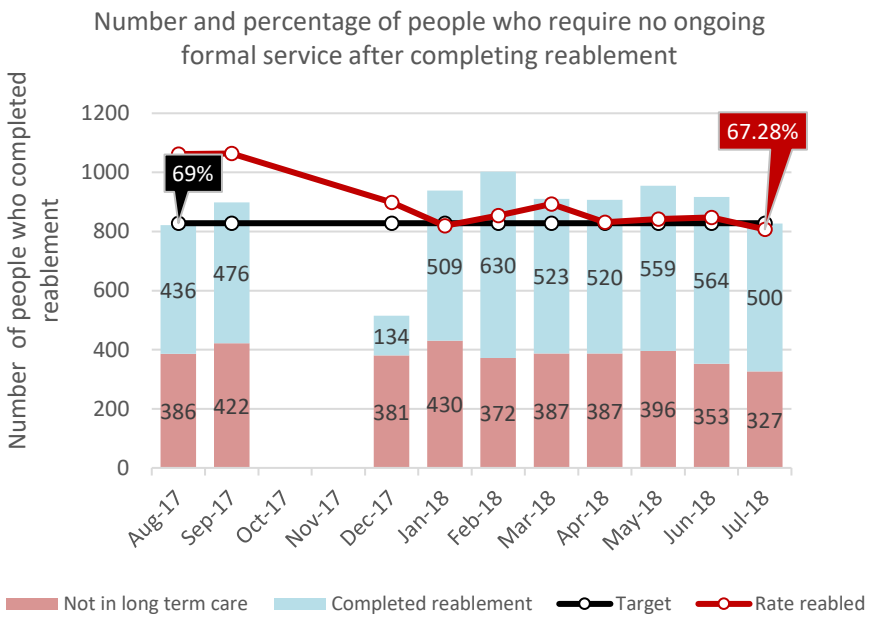
Action required		
• Good performance will mean a reduction in the number of unallocated cases awaiting assessment. Performance is therefore driven by the success of the recruitment process to increase capacity and the further introduction of sites using the 3 conversations model.	• Continue with the roll out of strengths-based working – 3 conversation model. To date two sites have been run, with a further 4 due in March. The teams in those sites have demonstrated that capacity can be created to tackle waiting lists. • Ensure recruitment to additional or vacant posts is monitored and positions are filled. Any failure to recruit to posts, and to fill existing and future vacancies, will compromise the council's ability to hit this target. Recruitment can be a challenge, so monitoring recruitment progress will be important.	
Responsible Officers	Lead: Lorrayne Barrett, Director of Adult Ops and Integration – NCC and NCHC	Data: Intelligence and Analytics Service

The effectiveness of Reablement Services - % of people who do not require long term care after completing reablement

Why is this important?

The Promoting Independence Strategy, as well as the Care Act 2014, requires that the council does all that it can to prevent or delay the need for formal or long-term care. Norfolk has provided reablement services for a number of years that help people get back on their feet after a crisis – to people leaving hospital or that have just experienced a change in their wellbeing that might require some kind of care. The success of this is important for two reasons. First, people that do not require long-term support as a result of reablement are more independent and tend to experience better outcomes. Secondly, avoiding long term care saves the council money.

Performance



What is the background to current performance?

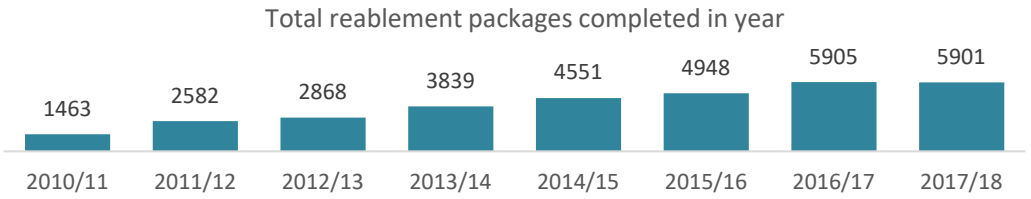
- Due to the migration from Care First to Liquid Logic there is a gap in the data available for October, November & December.
- Unlike in Care First, it is not possible in Liquid Logic to see those that have been passed to NFR with long term conditions that will always require a service, such as those with palliative care needs. These people do not have the potential be reabled but the service sometimes has a duty to provide support and care, if there are no other providers able to do this at that time. This means that since November 2017 the measure is now looking at all cases taken on by the reablement service, which will have an impact on the overall figure, ie the percentage reabled will appear lower than when the data was taken from Care First.
- A sister indicator to this one is the number of people who have been through reablement who remain at home after 91 days.
- This is currently proving difficult to extract from the new system; Norfolk performs strongly on this indicator – last year consistently at 93%
- There is a challenge for NFS in recruiting and retaining staff, as with many providers in the Health and Social Care system.
- A further recruitment drive is underway and the service is looking at what else it can do attract and retain staff.

What will success look like?

- The maximum proportion of people completing reablement not needing ongoing care.
- The business case for additional investment in Norfolk First Support calculated that to reable everyone with the potential for reablement, and therefore maximise outcomes and savings, approximately 6,000 people a year should receive reablement (based on previous years).
- The cost of reablement services to be significantly less than the likely cost of long term care.

Action required

- Continued monitoring of the impact of reablement against this indicator, and against the targets set out in the business case for additional investment in Norfolk First Support.



Responsible Officers

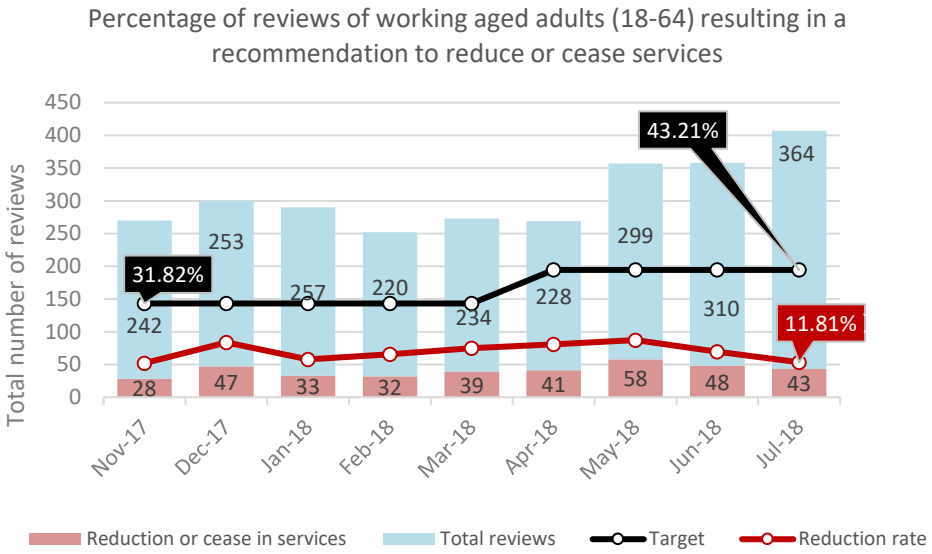
Lead: Janice Dane – Assistant Director Early Help and Prevention Data: Business Intelligence & Performance

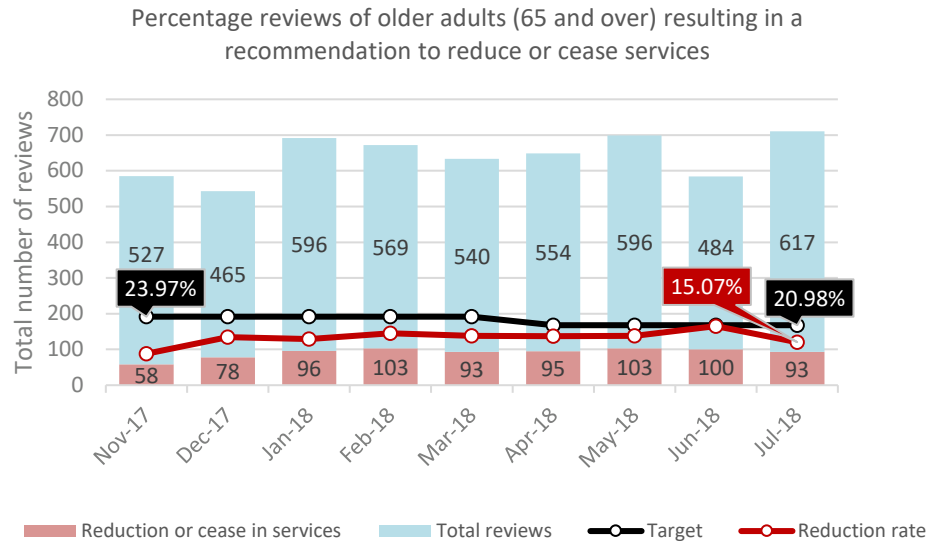
Percentage of reviews that lead to a recommendation to reduce or cease services

Why is this important?

People's needs change and, under the Care Act, a review of needs has to be undertaken if there is a change in need, or if not, an annual review is required. We are currently carrying a backlog of work, much of which is made up of reviews. We have two targets associated with this measure reflecting two key groups of people – people aged 18-64, and older people (65 plus)

Performance





What is the background to current performance?

- It is important for the service to address what is a backlog of reviews – particularly for people with learning disabilities
- To do this, we engaged a specialist agency; however, they withdrew from the work because they were unable to recruit to the levels and skills of staff required to complete complex case reviews to the required quality
- To mitigate this, we have established a temporary Assistant Practitioner team to take on more review work. We are strengthening the oversight and supervision of the temporary Assistant Practitioner team so they can cover the more complex work

The work is complex and takes time to get right

What will success look like?

Action required

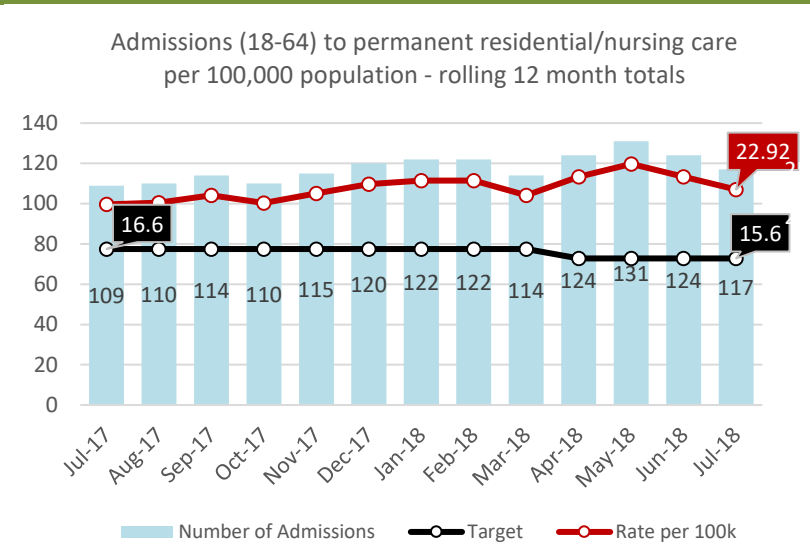
• For older people, many of whom have entered service with long term and deteriorating health needs, there may be fewer opportunities for greater independence and reduced care packages. If long term care packages reduce in line with Promoting Independence and three Conversations principles, those remaining in long term care may have more complex needs – making the target more difficult to hit. • For people aged 18-64, performance in this area has been relatively low – below that of reviews of people aged 65+ - and the proposed targets represent a significant change in practice and performance. This will be challenging.	• Further analysis of why reviews lead to changes in service configuration • Additional capacity amongst practitioner teams to undertake targeted reviews of complex cases	
Responsible Officers	Lead: Craig Chalmers, Director of Community Social Work	Data: Intelligence and Analytics Service

More people aged 18-64 live in their own homes

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?

- 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 but most recently, the rate has remained largely static
- Our priority focus has been to transform services for people with learning disabilities. This should see fewer people with learning disabilities in permanent residential and nursing care, because of wider choices of accommodation.
- In addition, we are shifting to an enablement approach which helps people build independent living skills – cooking, managing money, building friendships.
- These changes are in flight but may take some time to show impact on this indicator
- In parallel to this work, we have recognised the need to review the options that we have available for people with physical disabilities, and see what alternatives to residential care might be possible to develop

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

- September 2017 – new approach to strengths based social work first innovation site goes live
- Development of “enablement centres” model for service users aged 18-64 to be helped to develop skills for independent living
- Reviewing how we strengthen and change our integrated assessment processes for discharging people from the acute and community hospitals will impact on this indicator

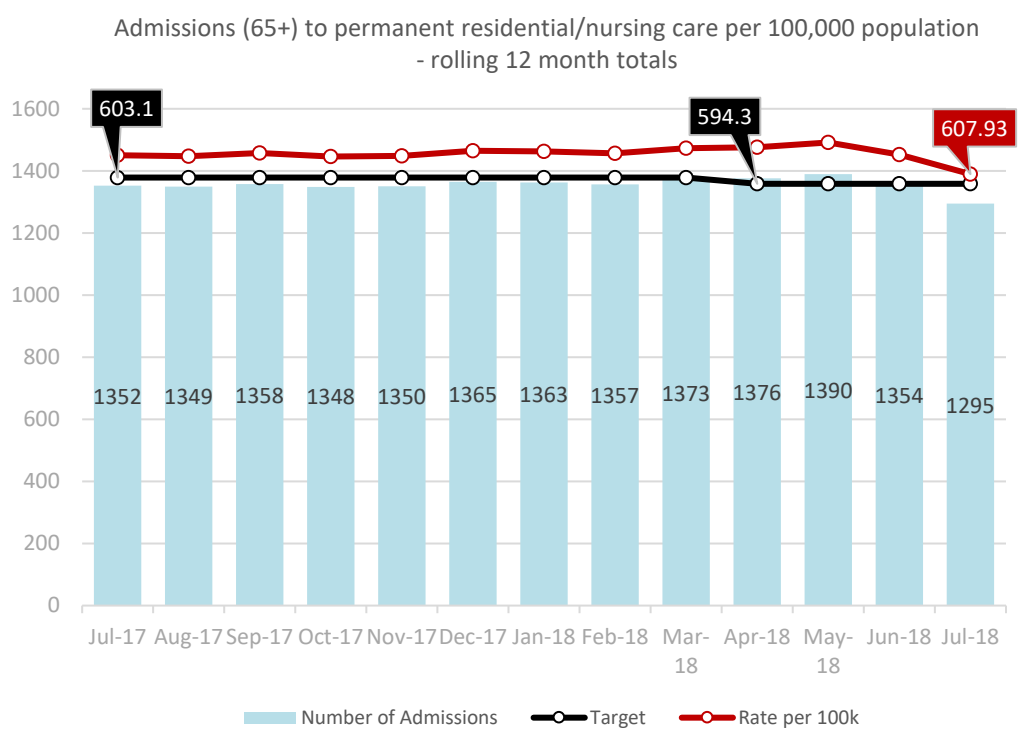
Responsible Officers	Lead: Craig Chalmers, Director of Community Social Work	Data: Intelligence and Analytics Service

More people aged 65+ live in their own homes for as long as possible

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.
- Over the past 3 years the rate of admissions in Norfolk has although monthly reporting of performance shows there has been a slowing down of improvement since March 2016.
- In depth analysis of individual cases, carried out by the Information and analytics team has identified lines of inquiry which we will follow up to ensure that our prevention and reablement activities are targeted where they can make most difference. These are:
- Support for people to return home after a stay in hospital, particularly whether there is more we could do to help people in short-term, temporary care re-gain skills or confidence – with support – to return to their home.
- Preventive work around falls which are a significant factor in nearly a third of admissions to residential care.
- Whilst personal care is, expectedly, the most cited reason for people needing home care, 'food and drink' and 'medication' are the second and third reasons respectively.
- Differences in length of stay in residential and nursing care across Norfolk

What will success look like?

- Admissions to be sustained below the family group benchmarking average and in line with targets
- Subsequent sustained reductions in overall placements
- Sustainable reductions in service usage elsewhere in the social care system

Action required

- The Promoting Independence programme includes critical actions to improve this measure
- Close scrutiny at locality team level and use of strengths based approach to assessment
- Commissioning activity around accommodation to focus on effective interventions such as reablement, sustainable domiciliary care provision, crisis management and extra care accommodation options for those aged 65+ will assist people to continue live independently
- Supported care model for North and South localities now operational – offering 24 hour support for up to 7 days for people in crisis to avoid admissions to hospital/residential care
- Measures to support the effective discharge of people from hospital as part of the Improved Better Care Fund programme.

Responsible Officers	Lead: Lorrayne Barrett, Director of Integrated Care, and Craig Chalmers, Director of Community Social Work	Data: Intelligence and Analytics Service