Norfolk County Council

Adult Social Care Committee

Date: **Monday, 06 March 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)

Mrs J Brociek-Coulton	Mr J Perkins
Mr D Crawford	Mr W Richmond
Mr A Dearnley	Mr M Sands
Mr T Garrod	Mr E Seward
Mrs S Gurney	Mrs M Stone (Vice-Chairman)
Mr J Mooney	Mr M Storey
Ms E Morgan	Mr B Watkins
Mr R Parkinson-Hare	Ms S Whitaker

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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A g e n d a

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

2. Minutes **Page 5**

To confirm the minutes of the meeting held on the 23 January 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 on Wednesday 1st March 2017.** For guidance on submitting public question, please view the Constitution at www.norfolk.gov.uk, or 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.

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 1st March 2017.**

7. Chairman's Update

Verbal update by Cllr Bill Borrett

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. Adult Social Care Finance Monitoring Report Period 10 (January) 2016-17 **Page 19**

A report by the Executive Director of Adult Social Services

11. Performance Management report **Page 37**

A report by the Executive Director of Adult Social Services

12. Moving Forward Integrated Health and Care **Page 90**

A report by the Executive Director of Adult Social Services

13. Transport update **Page 98**

A report by the Executive Director of Adult Social Services

14. Update on progress with recommendation of the SCIE review **Page 116**

A report by the Executive Director of Adult Social Services

Group Meetings

Conservative	9:00am	Conservative Group Room, Ground Floor
UK Independence Party	9:00am	UKIP Group Room, Ground Floor
Labour	9:00am	Labour Group Room, Ground Floor
Liberal Democrats	9:00am	Liberal democrats Group Room, Ground Floor

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Date Agenda Published: 24 February 2017

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Norfolk County Council

Adult Social Care Committee

Minutes of the Meeting Held on Monday, 23 January 2017 at 10:00am in the Edwards Room, County Hall, Norwich

Present:

Mr B Borrett (Chairman)
Mrs J Brociek–Coulton
Mr J Childs
Mr A Dearnley
Mr T Garrod
Mr J Mooney
Ms E Morgan
Mr R Parkinson-Hare
Mr J Perkins
Mr W Richmond
Mr M Sands
Mr E Seward
Mr B Spratt
Mr M Storey
Mrs M Stone
Mr B Watkins
Ms S Whitaker

1. Apologies

1.1 Apologies were received from Mr D Crawford (Mr J Childs substituting) and Mrs S Gurney (Mr B Spratt substituting).

2. To confirm the minutes of the meeting held on 07 November 2016

2.1 The minutes were agreed as an accurate record subject to the following amendments:

- To amend paragraph 3.2 to read that "Mr B Spratt wished to commend services for support given to his Mother-in-Law";
- In paragraph 7.2, to amend "Social Services Conference" to read "Annual National Social Services Conference" and to note that Mrs Whitaker also attended the meeting and endorsed the Chairman's comments.

3. Declarations of Interest

3.1 Mr Seward declared an "other interest" as he had a family member who worked for About With Friends.

4. Urgent Business

4.1 There were no items of urgent business.

5. Public Question Time

5.1 Four public questions were received and circulated; see Appendix A.

5.2.1 Ms Rutland asked a supplementary question: she queried the response given to question 1 indicating there would be a £4.5m spend; she felt this implied a decision had been made related to homelessness spend and services. The Executive Director of Adult Social Care replied that the Council had not yet made a decision on the budget proposals. He clarified that the Committee would recommend proposals to the full council to make the final decision on the budget.

5.2.2 Ms Smith asked a supplementary question: she queried how Officers felt a 32% cut to crisis accommodation fulfilled the definition of crisis prevention and queried an additional £1m reduction not set out in the proposal. The Chairman replied that this would be answered during the Committee's discussions during the meeting.

5.2.3 Mr Moore asked a supplementary question: he was concerned that if housing services were cut to the extent indicated that this would had a knock on effect on mental health and suicide rates, and queried whether the Council had considered this as part of their assessment of their proposal. The Executive Director of Adult Social Care replied that as part of consultation and Equality Impact Assessment, balance between future spend on lower level issues and targeted services had been considered. Proposals related to prioritising spend to higher level need, for example targeting homelessness and people with mental health problems.

6. Local Member Questions / Issues

6.1 No member questions were received.

7. Notice of Motions

7.1.1 Mr J Mooney, *seconded by Mr B Borrett* **proposed**: "that this Committee supports the Motor Neurone Disease (MND) Charter, which sets out the care and support that people living with MND and their carers deserve and should expect. I also recommend that full council be asked to consider supporting the above proposal."

7.1.2 Mr Mooney and the Chairman welcomed representatives from the Norwich, Waveney and Wymondham branch of the Motor Neurone Disease Association. Briefing packs were provided to the Committee with information about MND and the Charter, and Mr Mooney noted the statement from Mrs Heal and briefing paper within the pack. Mr Mooney spoke about Sue Heal's story which had persuaded him to bring the proposal to the Committee, and read out an email received from Mrs Franklin in Caister-on-sea supporting the motion.

7.2 After debate the motion was put to a vote and was duly **CARRIED**.

8. Chairman's Update

8.1 There was nothing to update.

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

9.1.1 Mrs E Morgan discussed her attendance at:

- A learning disabilities partnership board meeting in early December 2017;
- A Norfolk Safeguarding Adults Board meeting in January 2017.

9.1.2 Mrs Brociek-Coulton discussed her attendance at:

- A Clinical Commissioning Group meeting discussing plans over the next 6 months; a report was due to come to Adult Social Care Committee on this;
- A Carers Council meeting;

9.1.3 Mrs S Whitaker discussed her attendance at:

- A council of governors meeting for the Mental Health Trust;
- A meeting of the Mental Health Trust Nominations Committee;
- A meeting of Age UK Norfolk.

9.1.4 Mr B Watkins discussed his attendance at:

- A meeting of the Health and Wellbeing Board
  - o An informal meeting was held at the John Innes Conference Centre with Local Authorities and the Voluntary sector to look at the STP (Sustainability and Transformation Plan) process, also attended by Mrs M Stone;
  - o Presentations were given on the 4 main workstreams: acute care, primary and community care, prevention and wellbeing and mental health, which was a dedicated workstream;
  - o The Health and Wellbeing Board had concerns over the integration of health and social care, district council contribution and investment in primary care and communication, and felt a clearer vision and consistent core message was needed

9.1.5 Mrs M Stone discussed her attendance at:

- The Norwich and Great Yarmouth and Waveney CCG meetings;
- A visit to an Independence Matters day centre in Dereham;
- The judging of the Norfolk Care Awards as a Member judge;
- A Promoting Independence Programme Board meeting;
- A Norse Liaison Board meeting;
- A meeting of the Enterprise Development Board
- A meeting of the Section 75 Care Board

9.1.6 Mr J Perkins discussed his attendance at:

- A meeting of the Queen Elizabeth Hospital Trust.

9.1.7 Mr M Sands discussed his attendance at:

- A meeting of the Norfolk County Community Safety Partnership Scrutiny Sub Panel where issues such as domestic abuse and County Lines were discussed; he recommended that Committee Members read the agenda.

9.2 The Chairman reported that achieving a common STP was challenging due to the high number of organisations involved. Mr Watkins confirmed that this was to be discussed at the

next Health and Wellbeing Board.

10. Executive Director's Update

10.1 The Executive Director of Adult Social Care reported that Catherine Underwood would focus corporately on ensuring the Council's demands from integration were articulated.

10.2 NHS leaders, the Managing Director and Executive Director of Adult Social care had met to take the STP plan forward strategically.

10.3 Work continued with colleagues in the GP sector, however it had not been possible to prevent escalation to Opel 4, formerly black alert, despite minimising numbers of delayed transfers of care. Opel stood for "operational escalation". The definition of the black alert had become uneven throughout the Country therefore had been changed to impose consistency across the Country

10.4 In the recent threat of flood, action was taken in Great Yarmouth and other coastal areas; luckily the storm surge was not as big as predicted. Evacuation of care-homes and other precautions were taken to ensure safety of residents

10.5 Support arrangements and a specialist team were in place to support incoming Syrian refugees; the Executive Director for Adult Social Care **agreed** to find out the dates of the arrival of the second group of Syrian refugees.

11. Appointment of Member Representative to the Governor's Council of James Paget University Hospital NHS Foundation Trust

11.1.1 The Committee received the report asking them to consider a Member representative for the Governor's Council of James Paget University Hospital NHS Foundation Trust.

11.1.2 The Trust had requested a representative who could commit long term therefore Mrs Whitaker **proposed** that this item was deferred until after the elections in May 2017.

11.2.1 Mrs Brociek-Coulton **agreed** to remain on the Trust until May 2017 however could not commit to attending every meeting.

11.2.2 It was **agreed** that for meetings she was unable to attend, Mrs Brociek-Coulton could arrange for Norfolk County Council members attending as representatives of their constituent areas to provide written feedback for her to bring to the Committee.

11.2.3 The Committee **AGREED** that Julie Brociek-Coulton remain as Member representative of the Governor's Council of James Paget University Hospital NHS Foundation Trust until May 2017 and **AGREED** to defer appointment of a replacement representative until the next round of appointments after the elections in May 2017.

12. Strategic and Financial planning 2017-18 to 2019-20 and revenue budget 2017-18.

12.1.1 The Committee received the report outlining proposals to inform the Council's decisions on council tax and contribute towards setting a legal budget for 2017-18.

12.1.2 The Executive Director of Adult Social Services introduced the report as a reflection of national debate regarding social care and NHS funding. The proposals in the report included £25.872m to support the Adult Social Care budget, with an overall strategy focussed on enabling people to remain independent for as long as possible, but recognising the costs of provision of service and considering prioritising eligible social care need for those with substantial need, over support for the wider population.

12.2.1 During discussion the following points were raised:

12.2.2 Concerns were raised over the proposed changes to advice and advocacy services, that if generic advice services were provided, people may not receive the right support at the right time and the impact proposed changes may had on other areas such as homelessness, mental health and admissions to A&E.

12.2.3 It was clarified that funding was received directly from the NHS for pursuing NHS complaints advocacy, as indicated on page 116 of the report.

12.2.4 Discussion was held over concerns that proposed cuts to "Building Resilient Lives" may increase expenditure long term, and the possible impact this may had on young people entering adult social care.

12.2.5 A suggestion was raised that supplied equipment could be investigated as an avenue for savings through capitalisation; the Finance Business Partner for Adult Social Services clarified that equipment was supplied through a contracted service, therefore Norfolk County Council did not own the assets in order to capitalise them.

12.2.6 The Finance Business Partner for Adult Social Services clarified that the spend on day care services through the purchase of care budget was ~ £19m and the Independence Matters contract was ~£13.2m, of which a proportion was for day care services. Proposed savings to day care services would involve reviewing contracts and new ways to offer day services in the community.

12.2.7 The Executive Director of Adult Social Care clarified that work on changes to day care services would take up to 2 years through the Promoting Independence Pathway. The shape of savings shown in the report reflected the time it would take to develop savings.

12.2.8 In relation to the proposal for building resilient lives, meetings had been held with District Councils and providers, and work was underway with stakeholders to co–produce services.

12.2.9 It was suggested that Norse services could be reviewed to look for further budget savings.

12.2.10 The Finance Business Partner for Adult Social Services clarified that a recurrent £4.5m investment was proposed to support "building resilient lives", which was included within the consultation. As previously reported to members, the total reduction in spending included £1m due to the reduction in funding allocated to the Council through the Better Care Fund (BCF) in 2016/17, reflecting a total reduction of £5.5m. The Executive Director for Adult Social Care clarified that savings reported in-year due to changes to BCF had been reflected in the 17-18 budget.

12.2.11 Discussion was held on the adjustment to the charging policy regarding the Disability Related Expenditure (DRE) disregard. As part of the financial assessment of service users of non- residential adult social care services, the Council automatically applied a disregard

of £15 per week to allow for DRE for all service users, whether or not they required or incurred those costs. It was estimated that people in receipt of the disregard spent between £5 and £7 per week on additional DRE. It was proposed to reduce the standard disregard to £7.50 and, as now, individuals with higher DRE could evidence additional DRE that should be taken into account.

12.2.12 This consultation would commence should the Committee agree the proposals. The proposals had arisen due to the need for the Council to propose further savings following the autumn statement, therefore it had not been possible to include in the autumn budget consultation. The consultation timetable would allow time for review of responses and submission of a report for the 20 February 2017 Council meeting.

12.2.13 Regarding the proposal for "building resilient lives", the Executive Director of Adult Social Care clarified that the consultation and agreement between partners on what should be prioritised going forward were distinct activities. As the proposed expenditure of £4.5m would be targeted at those at highest risk with an eligible social care need, he did not expect to see an increase in financial risk to the service.

12.2.14 The Acting Director of Integrated Commissioning clarified that sheltered housing currently supported around 6000 people in Norfolk, of whom 4300 were supported by NCC. The proposals in the report would leave 27 separate accommodation bases, with a £2m continued spend on housing and £1.2m on housing for young people aged 16-24.

12.2.15 The Executive Director of Adult Social Care reported that a large amount of the £25.872m investment would cover the cost of care, rather than increasing the spread of care. The investment would address demographic growth, cost of care pressures, increase to the national living wage and existing overspend; the overspend would be met partly through the use of the one-off Adult Social Care support grant, which would impact in next year's budget 2018/19.

12.2.16 It was clarified that from April to June 2016, 3031 people received floating support. Discussion was held over the potential impact of reducing these services.

12.2.17 Over 4000 people were receiving warden support; concerns were raised that the proposed cuts may cause people to move into residential care. The Executive Director of Adult Social Care recognised the value of the services, however, that Promoting Independence involved connecting people with their community, family, and personal skills to enable them to be independent for as long as possible; it was important to work alongside district council stakeholders and GPs to ensure the right level of support was in place for people when they needed it.

12.2.18 Mr J Childs wished to raise a proposal to charge peppercorn rents for empty Council buildings to support voluntary services to expand and extend their services. The Chairman felt this was an important proposal, however, it was not in the remit of the Adult Social Care Committee. The Executive Director of Adult Social Care agreed to take this proposal to the County Leadership Team to be directed to the correct Committee.

12.2.19 The Executive Director of Adult Social Services confirmed that through work with colleagues from Children's Services on a commissioning level it was felt that the proposed changes would not impact on the number of looked after children.

12.2.20 The Acting Director of Integrated Commissioning reported that the role and cost of

wardens varied, ranging from £2.50 / £3 per week for less intensive schemes, such as a weekly phone-call, to £8 per week for more intensive schemes. Discussions would be ongoing with district councils and housing providers to plan the reductions.

12.3.1 Mrs S Whitaker felt discussions still needed to be held on how to achieve the proposed savings and that a clear plan should be in place first. Therefore she **PROPOSED**:

- to defer the savings for "Building Resilient Lives" with the proviso that ongoing discussions were held with organisations and partners so that detailed proposals could be brought to Committee with next year's budget (2018/19), and to find the £2.1m savings elsewhere in the budget.

12.3.2 Mr B Watkins seconded this proposal.

12.3.3 The Chairman asked if Mrs Whitaker had an alternative savings proposal for the £2.1m of savings. Mrs Whitaker said she did not and the Chairman replied that without an alternative savings proposal he could not support her proposal because it may put the budget at risk.

12.4.1 The Chairman moved to a vote on Mrs Whitaker's proposal:

12.4.2 With 8 votes for, 8 votes against and 1 abstention, the Chairman used his casting vote to **REJECT** the proposal.

12.5.1 With 9 votes for and 8 against:

a) The Committee **AGREED** the Committee's specific budget proposals for 2017-18 to 2019-20, including the findings of public consultation set out in Appendices 2 to 7 in respect of:

i. The budget proposals set out in Appendix 1;

ii. The new and additional savings proposals to contribute to the supplementary target of £4.000m for the Council as identified to Policy and Resources Committee in November 2016;

iii. The scope for a general Council Tax increase of up to 1.99%, within the Council Tax referendum limit of 2% for 2017-18, noting that the Council's budget planning was based on an increase of 1.8% reflecting the fact that there was no Council Tax Freeze Grant being offered, and that central government's assumption was that Councils would increase Council Tax by CPI every year. The Council also proposes to raise the Adult Social Care Precept by 3% of Council Tax as recommended by the Executive Director of Finance and Commercial Services. Bringing forward increased in the Social Care Precept would mean that the 2% increase planned for 2019-20 would not occur.

iv. The scope for raising the Adult Social Care Council Tax precept by the maximum amount available (3%) in 2017-18 and in the subsequent year of the Medium Term Financial Strategy, 2018-19, but with no increase in 2019-20, as recommended by the Executive Director of Finance and Commercial Services

v. The use of new one-off Adult Social Care Support Grant totalling £4.197m for Norfolk

12.5.2 With 9 votes for, 7 against and 1 abstention:

b) The Committee **CONSIDERED** the findings of equality and rural assessments, attached at Appendix 8 to this report, and in doing so, **NOTED** the Council's duty under the Equality Act 2010 to had due regard to the need to:

i. Eliminate discrimination, harassment, victimisation and any other conduct that was prohibited by or under the Act

ii. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who did not share it
iii. Foster good relations between persons who share a relevant protected characteristic and persons who did not share it

12.5.3 With 8 votes for, 0 against and 9 abstentions:
c) The Committee **AGREED** any mitigating actions proposed in the equality and rural impact assessments.

12.5.4 With 9 votes for, 8 against and 0 abstentions:
d) The Committee **AGREED** and **RECOMMENDED** the draft Adult Social Care Committee Revenue Budget as set out in Appendix 1 for consideration by Policy and Resources Committee on 6 February 2017, to enable Policy and Resources Committee to recommend a sound, whole-Council budget to Full Council on 20 February 2017 including all of the savings for 2017-18 to 2019-20 as set out;

12.5.5 With 8 votes for, 0 against and 9 abstentions:
e) The Committee **AGREED** and **RECOMMENDED** the Capital Programmes and schemes relevant to this Committee as set out in Appendix 9 to Policy and Resources Committee for consideration on 6 February 2017, to enable Policy and Resources Committee.

12.5.6 The Recommendations were duly **AGREED**.

The Committee took a break from 11:53am until 12:02pm

13. Adult Social Care Finance Monitoring Report Period 8 (November) 2016-17

13.1 The Committee received the report giving financial monitoring information, based on information to the end of November 2016 and an analysis of variations from the budget and the actions being taken by the service to reduce the overspend.

13.2.1 During discussion the following points were raised:

13.2.2 The Finance Business Partner for Adult Social Services clarified that the Norse Joint Liaison Board would identify actions to reduce the contract value with Norse Care working within the Promoting Independence strategy; updates would be brought to the Committee.

13.2.3 It was clarified that the increased overspend in the older people's budget had been looked at in detail with locality teams; a number of different factors involved had been identified and a strategy was in place to address the overspend.

13.2.4 The Finance Business Partner for Adult Social Services confirmed that over half of the increase seen in relation to spending on older people was related to cost of care and National Living Wage implementation.

13.2.5 It was reported that maintenance of social care funding from NHS covered aspects of reablement and there would be no funding from Health towards 'Swifts'; it was proposed that NCC would continue to pick up this cost in 2017/18 while looking into ways to increase efficiency of the service. It was **agreed** that an update on the work of the 'Swifts' and 'Nightowls' and impact of their work would be brought to the Committee.

13.2.6 A discussion was held over reablement and enabling people to stay in their own home if possible. There were currently many models in place which may conflict with each other; a **report** would be brought to the Committee on the approach to reablement and prevention.

13.2.7 An overspend of ~£10m in the learning disabilities budget was noted; the Executive Director for Adult Social Care reported a strategy and plan would be in place to address this.

13.2.8 The delayed discharge at the James Paget Hospital in Lowestoft of 2.5years was noted, and highlighted as an opportunity for lessons to be learned.

13.3 The Committee **NOTED**:

a) The forecast outturn position at Period 8 for the 2016-17 Revenue Budget of an overspend of £11.982m;

b) The planned actions being taken by the service to reduce the overspend

c) The planned use of reserves and to propose to Policy and Resources Committee that County Council approve the use of additional reserves of £0.948m in 2016-17 as set out in Section 2.11, which would reduce the overspend to £11.034m;

d) The forecast outturn position at Period 8 for the 2016-17 Capital Programme;

14. Fee levels for adult social care providers 2017/18.

14.1 The Committee received the report providing background on the Care Act and purchase of adult social care services by Norfolk County Council, and setting out a recommended approach for setting and maintaining appropriate fee levels for 2017/18.

14.2.1 It was queried whether increasing the charges would help sustainability of the market. The Acting Director of Integrated Commissioning for Adult Social Services reported that the proposed fee levels were based on analysis of the cost of providing residential and home based care for over 65s, therefore would ensure providers were as well supported as possible. Analysis carried out with home support providers on spot contracts indicated their costs were higher than the National UK Home Care Association indicated.

14.2.2 The Finance Business Partner for Adult Social Services clarified that the £16.60 per hour paid to providers at that time included carer's wages, travel, overheads and other business costs.

14.2.3 The Finance Business Partner for Adult Social Services **agreed** to clarify and circulate figures to Committee regarding the recent trend in number and proportion of self-funders.

14.3.1 Mrs Whitaker proposed that the Committee accept the recommendations, which was duly **AGREED.**

14.3.2 The Committee **AGREED** the approach to fee uplifts for the 2017/18 financial year as set out below:

a) In respect of contracts where an inflation index or indices were referenced an uplift was implemented to match any changes in the relevant index or indices;

b) In respect of contracts where there was a fixed price for the duration of the contract, no additional uplift in contract prices takes place

c) In other contracts, where the Council had discretion in relation to inflationary uplifts, that uplifts were considered in line with those set out in this report;

d) In the case of residential and nursing care any final uplift including other adjustments

was subject to formal consultation with implementation being through the use of Chief Officer delegated powers following that process.

15. Risk Management

15.1.1 The Committee received the report outlining the review to the format of the Adults Risk Register, update to the register since the last update in October 2016, and a new national risk which had been added.

15.2.1 The new national risk "rm487" would be added to the risk register. The Business and Development Manager for Adult Social Services clarified that this risk related to adult social services not providing adequate safeguarding controls which would be mitigated through actions including providing regular safeguarding updates to Adult Social Care Committee and ensuring adequate multi agency safeguarding procedures were in place.

15.2.2 The Business and Development Manager recommended that Risk 14149 (Impact of the Care Act) was removed from the risk register; the Executive Director of Adult Social Services reported that the Government intended to implement the second part of the Care Act, with guidance expected this year, 2017. Mrs S Whitaker was concerned about the risk related to the Care Act being removed from the risk register.

15.3 After discussion Mrs Whitaker's suggestion that risk 14149 was <u>not</u> removed from the risk register was put to a vote and duly **AGREED.**

15.4 The Risk rm13931 related to risks in hospital admissions; the integration programme was at phase 2 and to mitigate the risks involved, new approaches were being developed to reduce delays and prevent admissions.

15.5 The Committee:

a) **NOTED** the new format of the combined risk register;
b) **NOTED** the merging of risks RM14079 and RM020a and RM0207 and RM020b;
c) **NOTED** the progress updates on the risks as detailed at 2.4.1;
d) **AGREED** to the removal of risk RM14259;
e) **NOTED** the new risk RM4287.

16. Safeguarding Children and Adults with care and support needs: Summary of roles and responsibilities within the Council.

16.1.1 The Committee received the report outlining the roles and responsibilities for safeguarding children and adults with care and support needs.

16.2.1 As the Member responsible for safeguarding for Adult Social Services, Mrs Morgan **suggested** that support was given in future for the Member taking on this role. The Chairman agreed and felt the Member should be given a briefing on their remit.

16.2.2 Concern was raised regarding paragraph 5.7, related to increasing figures of multi-agencies. The Chairman **agreed** to take this to Children's Services.

16.2.3 At the April 2017 meeting of the Health and Wellbeing Board, a range of issues related to health and equality would be discussed including safeguarding.

16.2.4 It was highlighted that new councillors in May 2017, and Members on other committees than Childrens Services Committee and Adult Social Services Committee may be less aware of their responsibilities as councillors with respect to safeguarding, and **suggested** that Resources worked with Members to raise awareness and understanding of their responsibilities; the Executive Director of Adult Social Care suggested this could be incorporated into the Members' induction.

16.2.5 Attendance at safeguarding board meetings was queried, regarding who organised them and periodic briefings being brought to the Committee. Mrs Morgan agreed to take this up with the Adult Safeguarding Lead Manager.

16.3 The Committee:

- **ACKNOWLEDGED** and **SUPPORTED** the roles and responsibilities set out in this report;
- **APPROVED** the Council Corporate Safeguarding Policy and statement for the public around the Council's commitment to safeguarding.

17. Transport Update

17.1.1 The Committee received the report providing an update regarding the work being carried out to deliver savings from Adult Social Services transport, including the reviewed.

17.2.1 Concerns were raised over the length of time being taken to identify savings in this area, and that the report was not as in depth as expected.

17.2.2 The Assistant Director for Early Help and Prevention for Adult Social Services clarified that Norse Care provided a lot of transport services however approximately 50% was provided by other transport providers.

17.2.3 It was clarified that the transport costs had not doubled in a year, however the savings had not been met which was why a significant overspend was indicated compared to the budget.

17.2.4 The Chairman was concerned that the proposal to identify ways to deliver transport savings had originally been reported as part of a budget proposal at least 2 years before; if savings could not in fact be met he requested that this be reported to the Committee. The Executive Director of Adult Social Care felt that with the reductions in the cost of care, the cost of transport should also decrease in line with this.

17.2.5 The Chairman proposed that an item regarding this was brought to each Adult Social Services Committee meeting until a conclusion was reached

17.2.6 Discussion was held on the progress of refurbishment of a building in Thetford for day service provision; the Assistant Director for Early Help and Prevention clarified that an update on this was included at paragraph 5.1.1 of the report.

17.3.1 The Committee:

- **DID NOT AGREE** that the department look at the current policies of other local authorities and brings to Adult Social Care Committee a proposed transport policy that meets the minimum legal requirements regarding transport and could help social care staff work with service users to reduce the funding required for transport;

17.3.2 but instead:

- **AGREED** that a transport update was brought to each Adult Social Services Committee meeting until a conclusion was reached.

The meeting finished at 13:03 PM

CHAIR

PUBLIC QUESTIONS TO ADULT SOCIAL CARE COMMITTEE

MONDAY 23 JANUARY 2017

1a. Question Alison Thorpe, Orwell Housing.

"In light of the extensive feedback about the reduction in funding to Housing Related Support Services, does the council accept the detrimental impact this will cause our most vulnerable citizens, and therefore is it acceptable to proceed with these reductions?"

1b. Response from Chairman

The feedback we have had as a result of the consultation and engagement has helped shape where we will propose to spend the £4.5 million of housing related support going forward. We have listened, and the proposals for changing how that money is now spent going forward continues to support the most vulnerable groups - crisis housing for young people and those who are homeless, an outreach service for older people and those at risk of homelessness.

We would, of course, prefer not to have to make any reductions, but the demands and pressure on adults social services mean we have to make changes. With a reduced amount of funding available, our considered view is that a move away from generic, and broader support, towards targeted interventions will protect the most vulnerable and make the biggest difference to quality of life.

2a. Question from Kayleigh Rutland, Home Group

The Gunning Principles (1985) 84 LGR 168 at 169, (i) state consultation must take place when a proposal is still at formative stage and the product of consultation must be conscientiously taken into account. The point of Gunning principle (i) is that the decision-maker cannot consult on a decision that it has already made. Otherwise, the consultation unfair. Has NCC has breached the Gunning Principles by agreeing to the funding cut on 10th October 2016 before the consultation commenced?

2b. Response from Chairman

No we have not breached the Gunning principles. In October, adult social services committee proposed the change but was clear we were going out to consult – no final decisions has been made by members. Adult Social Care will take account of the consultation findings, amongst other things, in discussions at today's meeting (Monday January 23rd) whilst deciding what recommendations they will make. Ultimately the final decisions is taken by all members at Full Council on 20 February. At this stage members could reject the proposal if they so wished.

3a. Question from Darryl Smith, Operations Manager, YMCA

Ref: ASC016/19

The Equality Assessment (p123) states that 30% of those housed in 16-24 accommodation are 16/17s, many of whom will be Care Leavers or enabled to stay out of the care system through the support afforded by the funding under threat.

In the context of a 5% increase in LAC numbers in the last 4 months, what does the Committee expect to be the increased cost of additional Care placements for 16/17s as a result of the funding cuts and is this higher than the value of the cuts proposed today?

3b. Response from Chairman

We are clear that there won't be an increase in care placement for 16/17 year olds because we are prioritising and protecting crisis accommodation for young people and homeless people and we are working closely with children's services to ensure that they are not impacted.

4a. Question from Jonathan Moore, Chair of Trustees Equal Lives

With regard to homelessness have the Council considered the effect of cutting services on the people who have become homeless as a result of substance misuse and mental health issues?'

4b. Response from Chairman

We have considered the effect on people with mental health and substance misuse problems. NCC will continue to prioritise investment in accommodation services for homeless people. NCC is also proposing to invest an outreach service that would include this client group.

Adult Social Care Committee

Item No ……

Report title:	**Adult Social Care Finance Monitoring Report Period 10 (January) 2016-17**
Date of meeting:	**6 March 2017**
Responsible Chief Officer:	**James Bullion, Executive Director of Adult Social Services**

Strategic impact

This report provides Adult Social Care Committee (the Committee) with financial monitoring information, based on information to the end of January 2017. It provides an analysis of variations from the budget and the actions being taken by the service to reduce the overspend.

Executive summary

As at the end of January 2017 (Period 10), Adult Social Services is forecasting an overspend of £9.629m, with the application of previously identified use of the Corporate Business Risk Reserve. The overspend equates to a 3.8% variance on the revised budget and represents a decrease of £2.353m on the position reported at the end of Period 8. This is following review of risks and recommendations for application of funding, which is set out below. The paper also highlights the recovery actions being taken by the service.

Expenditure Area	Budget 2016/17 £m	Forecast Outturn £m	Variance £m
Total Net Expenditure	247.273	267.057	19.784
Agreed use of Corporate Business Risk Reserve	0.000	(10.155)	(10.155)
Revised Net Expenditure	247.369	256.902	9.629

The headline information and considerations include:

a) The outturn position for 2015-16 was a £3.168m overspend and this underlying pressure continues 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 has previously been 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) The forecast recognises the increase in commitments between when the budget was set at the end of January 2016 and the actual commitments at April 2016
d) The service is continuing to improve its information and accuracy of forecasting. Inclusion of improved information about how our home care and day contracts are being used, information about waiting lists and service level agreements has improved the accuracy of forecasting, but resulted in the need to recognise a higher budget pressure for the service
e) The forecast at Period 10 includes a reduction in commitments for Older People and People with Learning Disabilities

f) Following work with iMPOWER consultants the forecast includes a revised savings estimates, reflecting re-profiling of some savings
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

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. Following agreement of the Policy and Resources committee the Period 10 forecast includes both the originally agreed £1.073m and additional use of £1.599m.

The 2016-17 forecast outturn position for reserves is £1.374m. Provisions totalled £3.127m at 1 April 2016, mainly for the provision for bad debts.

Recommendations:

Members are invited to discuss the contents of this report and in particular to note:

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

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 monitoring report is based on the Period 10 (January 2017) forecast including assumptions about the implementation and achievement of savings before the end of the financial year.

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 forecast includes the approved use of £10.155m to manage the actual costs that have now arisen for the service.

2. Detailed Information

2.1 The table below summarises the forecast outturn position as at the end of January (Period 10).

Actual 2015/16 £m	Over/ Underspend at Outturn £m	Expenditure Area	Budget 2016/17 £m	Forecast Outturn £m	Variance @ P10 £m
8.325	(0.312)	Business Development	7.544	7.221	(0.323)
70.665	0.804	Commissioned Services	69.540	71.293	1.753
5.442	0.142	Early Help & Prevention	6.220	5.516	(0.704)
164.760	9.653	Services to Users (net)	155.485	171.447	15.962
(6.710)	(7.119)	Management, Finance & HR	8.485	1.402	(7.083)
242.482	**3.168**	**Total Net Expenditure**	**247.273**	**256.902**	**9.629**

2.2 As at the end of Period 10 (January 2017) the revenue outturn position for 2016-17 is £9.629m, the forecast includes the release of (£6.079m) of Care Act funding that was not allocated to specific budgets at the beginning of the year.

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 risks associated with the delivery of recurrent savings, resulting in a forecast overspend of £15.962m.

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 results in a reduction in net budget for these services.

2.6 **Additional pressures for 2016/17**

2.6.1 As previously reported the forecast 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.

2.7 **Services to Users**

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	Forecast Outturn £m	Variance £m
111.417	3.579	Older People	103.677	112.302	8.625
24.750	0.412	Physical Disabilities	22.039	23.305	1.266
90.218	9.863	Learning Disabilities	83.408	92.746	9.338
13.519	1.839	Mental Health	12.907	13.469	0.562
6.909	2.328	Hired Transport	3.672	7.105	3.433
14.436	(1.150)	Care & Assessment & Other staff costs	10.338	9.443	(0.894)
261.249	**16.871**	**Total Expenditure**	**236.041**	**258.370**	**22.329**
(96.490)	(7.218)	Service User Income	(80.556)	(86.923)	(6.368)
164.760	**9.653**	**Revised Net Expenditure**	**155.485**	**171.447**	**15.962**

2.7.2 Key points:

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. Over quarter three, there had been some increase in permanent residential placements – the key reasons were improved timeliness of recording, but teams also reported increased pressure from hospital discharge and a number of previous self-funders that had dropped below the threshold for self-funding. 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 each of the following periods, to 637 by November 2016. 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. 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) The forecast expenditure for purchase of care, excluding care and assessment is £2.9m less 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

c) 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

d) The Learning Disability and Physical Disability savings for 2016-17 are not expected to be fully delivered. This is reflected in the savings forecast and actions identified within the recovery action plan

e) Overall there is a reduction of £16m in budgeted income in 2016/17 compared to 2015/16 outturn, however service user income has remained the same. This primarily relates to one-off income items accounted for against purchase of care income in 2015/16 including £4.6m from reserves for 2015/16 cost of care pressures and approved use of reserves when setting the 2015/16 budget; £0.415m transfer from Public Health; £3.6m to adjust for Continuing Health Care agreements and £1.1m in relation to additional invoices raised, but which were offset by additional costs. It also reflects reallocation of Better Care Fund (BCF) income to the areas of agreed budget spend, particularly Care and Assessment and Reablement. The forecast includes the additional income from the Corporate Risk Reserve of £5.155m in relation to cost of care and national living wage

f) The purchase of care forecast 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. The forecasts are built on the accuracy and timeliness of the recorded information on each service user and therefore can be subject to operational pressures

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	1.211	(0.263)
10.925	(0.219)	Service Level Agreements	11.157	10.268	(0.889)
2.620	0.021	Integrated Community Equipment Service	2.678	2.359	(0.318)
32.496	1.645	NorseCare	30.024	33.487	3.464
9.141	(0.141)	Supporting People	9.494	9.494	(0.001)
12.930	(0.265)	Independence Matters	13.345	13.218	(0.127)
1.334	(0.055)	Other Commissioning	1.369	1.256	(0.113)
70.665	**0.804**	**Total Expenditure**	**69.540**	**71.293**	**1.753**

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 however, this is not expected to reduce the shortfall in 2016/17

2.9 **Savings Forecast and risks affecting 2017/18 budget planning**

2.9.1 The department's budget for 2016/17 includes savings of £10.926m. A revised forecast was previously 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, that there are other interventions that can be

used to enhance delivery of the strategy and that the timeline for the strategy is challenging with the consultants questioning whether the savings can realistically be delivered in three years.

2.9.2 The risks within the programme were reported to Committee in November and following recommendations from this committee, Policy and Resources Committee approved the revised profile of savings to be included within the Council's budget planning for 2017-20. Following the latest assessment of the programme, and re profiling of 2017-18 targets, the table below reflects the revised position. This creates higher risk in 2018-19. More detail regarding the implications for forward planning are included in the Strategic and Financial Planning paper elsewhere on this agenda.

2.9.3 Risks totalling £4.510m have been reflected in the forecast position and alternative savings are being identified.

Savings	**Saving 2016/17 £m**	**Forecast £m**	**Variance £m**
Savings off target (explanation below)	4.510		4.510
Savings on target	6.416	6.416	0.000
Total Savings	**10.926**	**6.416**	**4.165**

For those savings that are off target a brief explanation is provided below of the reasons why they are off target and any planned recovery action that is in place.

2.9.4 **Integrated Community Equipment Service (target £0.500m, forecast £0.043m, variance £0.457m)**

The savings were planned focusing on a mix of preventative and efficiency savings. The service is aiming 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. Feasibility plans have identified that these savings will need to be re-profiled due to the time needed to set up new teams and processes. The 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 have now been recruited to.

2.9.5 **Changing how we provide care for people with learning disabilities or physical disabilities (target £1.500m, forecast £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. In addition actions have been needed to review the implementation of the changes. 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, forecast £1.200m, variance £1.958m)**

Recruitment to posts is completed and the service is managing an increased number of referrals. The savings are expected to be delivered, but have required re-profiling in year one, which will reduce the levels of savings that can be achieved in 2016/17.

2.9.7 **Transport Savings (target £1.050m, forecast £0.200m, variance £0.850m)**

A full report was presented to committee in July and September 2016 and an update in November. An update report with more detail is also included on this agenda. 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. However the savings from transport are taking longer to deliver than originally anticipated due to; the information available from travel systems; being able to make changes to travel arrangements for all individuals on a route to enable transport to be stopped and savings realised; and cultural change. It does appear that in the current framework it is not possible to achieve the budgeted savings. (Please see separate report for more detail).

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

The proposed savings with the NorseCare contract will not be achieved in full in 2016/17. The forecast reflects the expected 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 current position for 2016-17. Proposals for the 2017-21 programme are included in the strategic and financial planning report elsewhere on this agenda.

Saving	Action	2016/17		
		Budget £m	Forecast £m	Variance £m
Promoting Independence – Customer Pathway (ASC006)	Strengths based approach rolled out; community hub piloted; preventative assessment piloted and being rolled out. Additional interventions identified including information advice and guidance	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. This should achieve the estimated full year savings in 2017-18.	3.158	1.200	(1.958)
Changing how we provide care for people with learning disabilities or physical disabilities (COM034)	Just Checking work piloted and being embedded; 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. See separate report for full update.	1.050	0.200	(0.850)
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	2.500	0.000
Promoting Independence – expand use of Integrated Community Equipment Service (ASC009)	Service redesign and new practice agreed	0.500	0.043	(0.457)
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**	**6.416**	**(4.510)**

2.10 **Overspend Action Plan and 2017-19 Savings programme**

2.10.1 The department is taking recovery action to manage and reduce in year spending as far as possible. All localities have prepared recovery plans which include ongoing actions and new areas. These have been reviewed by Finance and Performance Board and Senior Management Team and key areas to stabilise and reduce the in-year budget position have been identified. The actions are incorporated in the operational priorities of the department and the revised Promoting Independence programme of work. A high level view of the revised programme of work is shown at Appendix C. The actions and performance are incorporated into the work of the Finance and Performance Board and the Promoting Independence Programme Board to provide a framework for regular monitoring and assurance.

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 includes 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 includes 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 current overspend, utilises reserves previously earmarked for transformation in adult social care, to offset the overspend position. The 2016-17 forecast outturn position for reserves is currently £1.374m, which includes some carry forward of Learning and Development funding for committed projects. Provisions totalled £3.127m at 1 April 2016, mainly for the provision for bad debts. 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 £23.387m. 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 £6.931m 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 E**.

3. Financial Implications

3.1 The forecast outturn for Adult Social Services is set out within the paper and appendices.

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 current 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. Any eventual movement in the outturn position for 2016/17 compared to the previous forecasts, will impact directly on the additional savings required in 2017-18.

3.3 The Council has a high level of outstanding debt with health organisations. The level of debt (above 30 days) outstanding at 31st January with NHS bodies totalled some £7.165m, of which £3.561m 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.

4. Issues, risks and innovation

4.1 This report provides 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.

4.2 This report outlines a number of risks that impact on the ability of Adult Social Services to deliver services within the budget available. These risks include the following:

a) Pressure on services from a need led service where number of service users continues to increase. In particular the number of older people age 85+ is increasing at a greater rate compared to other age bands, with the same group becoming increasingly frail and suffering from multiple health conditions. A key part of transformation is about managing demand to reduce the impact of this risk through helping to meet people's needs in other ways where possible
b) The ability to deliver the forecast savings, in addition to continuing to need to implement some recurrent savings from previous years to help reduce the overspend
c) The cost of transition cases, those service users moving into adulthood, might increase due to additional cases that have not previously been identified
d) The impact of pressures within the health system, through both increased levels of demand from acute hospitals and the impact of decisions due to current financial deficits in health provider and commissioning organisations
e) The Council is incurring increased levels of outstanding debt in relation to health organisations, which could lead to increased pressures if debt is not recovered.
f) Increasing waiting lists and delays in recording could result in additional packages and placements incurring costs that have not been included in the forecast
g) In any forecast there are assumptions made about the risk and future patterns of expenditure. These risks reduce and the patterns of expenditure become more defined as the financial year progresses and as a result of the reduced risk the forecast becomes more accurate
h) The ability to be able to commission appropriate home support packages due to market provision, resulting in additional costs through the need to purchase increased individual spot contracts rather than blocks

i) The continuing pressure from the provider market to review prices and risk of challenge
j) The impact of health and social care integration including Transforming Care Plans, which aims to move people with learning disabilities who are currently inpatients within the health service to community settings

5. Background

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

Finance Monitoring Report – Adult Social Care Committee January 2017 – p142

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:

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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 Monitoring Period 10 (January 2017)

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

Summary	Budget	Forecast Outturn	Variance to Budget		*Variance at Period 8*
	£m	£m	£m	%	*£m*
Services to users					
Purchase of Care					
Older People	103.677	112.302	8.625	8.32%	9.352
People with Physical Disabilities	22.039	23.305	1.266	5.74%	1.154
People with Learning Disabilities	83.408	92.746	9.338	11.20%	9.053
Mental Health, Drugs & Alcohol	12.907	13.469	0.562	4.35%	0.368
Total Purchase of Care	**222.032**	**241.822**	**19.790**	**8.91%**	**19.926**
Hired Transport	3.672	7.105	3.433	93.50%	3.433
Staffing and support costs	10.338	9.443	(0.894)	-8.65%	(0.728)
Total Cost of Services to Users	**236.041**	**258.370**	**22.329**	**9.46%**	**22.632**
Service User Income	(80.556)	(86.923)	(6.368)	7.90%	(5.209)
Net Expenditure	**155.485**	**171.447**	**15.962**	**10.27%**	**17.423**
Commissioned Services					
Commissioning	1.474	1.211	(0.263)	-17.86%	(0.204)
Service Level Agreements	11.157	10.268	(0.889)	-7.97%	(0.602)
ICES	2.678	2.359	(0.318)	-11.89%	(0.198)
NorseCare	30.024	33.487	3.464	11.54%	3.119
Supporting People	9.494	9.494	(0.001)	-0.01%	(0.011)
Independence Matters	13.345	13.218	(0.127)	-0.95%	(0.127)
Other	1.369	1.256	(0.113)	-8.22%	(0.006)
Commissioning Total	**69.540**	**71.293**	**1.753**	**2.52%**	**1.970**
Early Help & Prevention					
Housing With Care Tenant Meals	0.698	0.626	(0.073)	-10.44%	(0.112)
Norfolk Reablement First Support	1.213	0.943	(0.270)	-22.28%	(0.241)
Service Development	1.076	1.028	(0.048)	-4.43%	(0.071)
Other	3.232	2.919	(0.313)	-9.69%	(0.195)
Prevention Total	**6.220**	**5.516**	**(0.704)**	**-11.32%**	**(0.619)**

Adult Social Care
2016-17 Budget Monitoring Forecast Outturn Period 10
Explanation of variances

1. Business Development, forecast underspend (£0.323m)

Business Support vacancies, especially in the Central and West teams.

2. Commissioned Services forecast overspend £1.753m

The main variances are:

NorseCare, forecast overspend of £3.464m. 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. The reasons for the additional variance in Period 10 is set out at para 2.9.8 of this report. NorseCare and NCC are developing a joint savings plan that will enable a medium term plan for delivering opportunities for further savings but it is not expected that additional savings can be delivered in this financial year.

Service Level Agreements, forecast underspend of £0.889m. Further review of budgets has identified reductions in planned costs and additional Continuing Health Care income.

3. Services to Users, forecast overspend £15.962m

The main variances are:

Purchase of Care (PoC), forecast overspend £19.790m.

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

- The impact of the budget gap – the service is managing 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 shows a £3.5m underlying pressure
- Since setting the budget, improved information gained at year-end on the use of home care packages and waiting lists, has enabled estimates to be improved. However, this has meant that forecast expenditure should be increased by £2.9m to reflect that home care commitments are being used more fully than previously and inclusion of expected commitments arising from people that are on waiting lists
- A revision in the level of 2016/17 savings that can be delivered has increased the forecast outturn. This relates to reablement and review of packages of care, which is set out in section 2.8 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. Costs totalling £5.155m are included in the 2016/17 forecast. This is offset by the use of the corporate business risk reserve which is included within the income forecast 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 forecast 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. The forecasts are built on the accuracy and timeliness of the recorded information on each service user and therefore can be subject to operational pressures

Service User Income, forecast over-recovery (£6.368m). The forecast 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.

Hired Transport, forecast overspend £3.433m. The savings from transport have not been realised. The forecast includes expected delay in 2016/17 savings. Reports providing an update on the Transport savings and project were reported to Committee in July 2016 and September 2016 and following review a further update is included elsewhere on this agenda.

4. Early Help and Prevention, forecast underspend (£0.704m)

The main variances are:

Housing with Care tenant meals, forecast underspend (£0.073m). This reflects a change in the arrangement where service users now pay the new provider directly for meals. The respective income forecast (under Service User Income) also reflects a reduction in income. However, overall there is a small net cost to the service's budget as costs per meal increased (in excess of income) whilst the previous service wass wound up.

Reablement, forecast underspend (£0.270m). Includes reduced spending on standby payments and travel and temporary long-term sickness cover that is no longer required.

5. Management, Finance and HR, forecast underspend (£7.083m)

The main variances are:

Management and Finance, forecast underspend (£7.073m). 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 forecast includes the release of (£6.079m) 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 will not be delivered in this financial year, arising from the reduction in Better Care Fund allocation.

The forecast at Period 4 overstated the use of the Business Risk Reserve by £0.500m. A part of the corporate reserve has been used to reprofile the saving COM033 - Reduction in funding within personal budgets to focus on eligible unmet needs within the budget setting process. The service will continue to benefit from the use of the Business Risk Reserve of £10.157m in 2016/17, however this pressure will need to be met within the service. This had previously been reflected within the Management and Finance budget, but is now shown within the Purchase of Care budget, in order to more accurately reflect the area of spend.

2016/17 Revised Action Plan

The revised plan sets out the priority actions for the service, in additional to business as usual focus on targets for placements, contract management and continued reinforcement of policy and practice. The below is predominately management actions and new projects. The plan has been updated to reflect the progress at Period 10 and the management and governance framework for taking forward actions into 2017-18.

	Action	**Progress Impact planned and benefits achieved**	**Management and governance 2017-18**
1	Full rollout of preventative assessments	The rollout is completed and localities are reporting a reduction in number of Care Act assessments required	Business as usual – continued to be monitored via Finance and Performance Board
2	Full rollout of occupational Therapist/Assistant Practitioner approach	The rollout is completed and localities have reported savings from the approach. It is currently not possible to quantify the reduction in spend, as the service is seeing a mix of reduced spend and cost avoidance through use of preventative approaches.	Business as usual – continued to be monitored via Finance and Performance Board
3	First point of contact to improve triage of referrals and consistency of practice. Business case setting out use and impact and recommended interventions	The scoping and principles are agreed together with analysis of all entry points to the service. Aim is for reduction in number of Care Act assessments required, leading to reduction in need for formal packages of care through improved signposting, information and advice	Promoting Independence - Entry points workstream
4	Implement enhanced service around transitions from Children's Services. Initial action to widen scope of initial business case	Aim is for improved outcomes through development of plans to work towards greater independence and less high cost packages of care. Savings not expected until 2017/18.	Promoting Independence – Younger adults workstream

	Action	Progress Impact planned and benefits achieved	Management and governance 2017-18
5	Improved offer for carer support – focusing on signposting and early help. Detailed and costed business case required.	A more effective pathway for carers will be implemented in September 17 which will improve the overall service provided to carers and ensure better join up of the wide ranging services provided. Focus will be on ensuring people can access the right support at the right time minimising the risk of carer breakdown. Carer breakdown is cited as one of the main reasons for people requiring new and increased packages of care. Action is needed to help reduce demand. Savings not expected until 2017/18.	Promoting Independence – cross cutting
6	Compulsory use of the Care Arranging Service for brokerage of all packages of care. Ensure capacity and knowledge to meet all service requirements within CAS	Directive in place and support identified, in order to help reduce prices for care and reduce the number of top-up arrangements require. Aim to support front line staff manage workloads. Further opportunities for improvement to ways of working through use of IT.	Monitoring through Finance and Performance Board and improvements to be implemented through Promoting Independence programme
7	Review of policy for hospital discharge and assessment to ensure the right long term care package is in place	Improved consistency and improved timetabling for assessment to avoid the risk of adverse longer term packages based on someone's need too soon after discharge. Avoidance of purchase of care spend. Protocols for each hospital for continuing health care being developed. Further opportunities through further development of integrated care models through STP	Business as usual – continue to be monitored through Finance and Performance Board
8	Capacity planning, prioritisation and reallocation of social work resources to support the area of current highest needs in the service – this will focus mainly on services for people with learning disabilities but include other high cost packages of care and low level packages of care	Plans are in place and a full review of capacity is completed, which will support workforce planning. To provide increased support to manage any tasks that can be undertaken by non- social work teams. To increase the number of reassessment of packages of care undertaken in order to increase impact of strength based approach to social care.	Business as usual – continue to be monitored through Finance and Performance Board

	Action	Progress Impact planned and benefits achieved	Management and governance 2017-18
9	Implement Learning Disability service programme.	To ensure that the Promoting Independence strategy can be delivered within the service in line with Older People and Mental Health – helping to reduce the demand for services and provide solutions to meet eligible needs in line with national best practice.	Promoting Independence – Younger adults workstream
10	Audit review of financial controls	Assurance report on financial controls within Care and Assessment Teams. Field work commenced in January.	Business as usual – monitored through Finance and Performance Board

Appendix D

Adult Social Services Reserves and Provisions 2016/17

		Period 10	
	Balance	Planned Usage post P&R decisions	Balance
	01-Apr-16	2016/17	31-Mar-17
	£m	£m	£m
Doubtful Debts provision	3.121	0	3.121
Redundancy provision	0.006	-0.006	0
Total Adult Social Care Provisions	**3.127**	**-0.006**	**3.121**
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 was brought-forward on 1st April 16, 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 was brought-forward on 1st April 16, all of which has been allocated to external projects and will be paid upon achievement of milestones.	0.253	-0.146	0.107
Repairs and renewals	0.043	0	0.043
Adult Social Care Workforce Grant	0.07	0.079	0.107
Unspent Grants and Contributions	2.482	-1.407	1.075
Total Adult Social Care Reserves	**2.848**	**-1.475**	**1.374**

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

Total Reserves & Provisions	**16.132**	**-11.638**	**4.495**

Adult Social Services Capital Programme 2016/17

Summary	**2016/17**		**2017/18**	**2018/19**
Scheme Name	**Current Capital Budget**	**Forecast outturn at Year end**	**Draft Capital Budget**	**Draft Capital Budget**
	£m	£m	£m	£m
Failure of kitchen appliances	0.031	0.031	0.000	0.000
Supported Living for people with Learning Difficulties	0.003	0.003	0.014	0.000
Adult Social Care IT Infrastructure	0.000	0.000	0.141	0.000
Progress Housing - formerly Honey Pot Farm	0.318	0.318	0.000	0.000
Adult Care - Unallocated Capital Grant	0.266	0.266	3.904	0.000
Strong and Well Partnership - Contribution to Capital Programme	0.124	0.124	0.000	0.000
Bishops Court - King's Lynn	0.085	0.085	0.000	0.000
Cromer Road Sheringham (Independence Matters	0.197	0.197	0.000	0.000
Winterbourne Project	0.000	0.000	0.050	0.000
Great Yarmouth Dementia Day Care	0.030	0.030	0.000	0.000
Care Act Implementation	0.000	0.000	0.871	0.000
Social Care and Finance Information System	1.897	1.897	5.034	0.000
Elm Road Community Hub	0.082	0.082	1.209	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
Netherwood Green	0.005	0.005	0.650	0.000
TOTAL	**9.406**	**9.406**	**13.873**	**0.109**

Adult Social Care Committee

Item No……

Report title:	**Performance management report**
Date of meeting:	**6 March 2017**
Responsible Director	**James Bullion, Executive Director of Adult Social Services**

Strategic impact

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

Executive summary

This report presents current performance against the committee's vital signs indicators, based upon the revised performance management system which was implemented as of 1 April 2016.

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

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

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

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

Recommendations

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

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

In support of this, Appendix 1 provides:

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

1 Introduction

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

2 Performance dashboard

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

2.2 The dashboard is presented below.

2.3 Adult Social Services Dashboard

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

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

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

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

3 Report cards

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

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

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

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

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

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

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

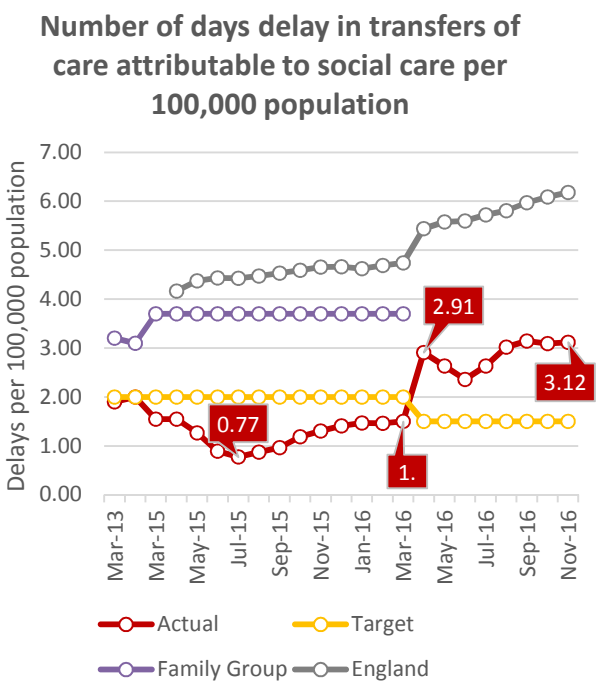
a. Number of days delay in transfers of care per 100,000 population (attributable to social care) (off target)
b. % People receiving Learning Disabilities services in paid employment (off target)
c. % People receiving Mental Health services in paid employment (off target)
d. Decreasing the rate of admissions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

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

Why is this important?

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

Performance



What explains current performance?

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

What will success look like?

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

Action required

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

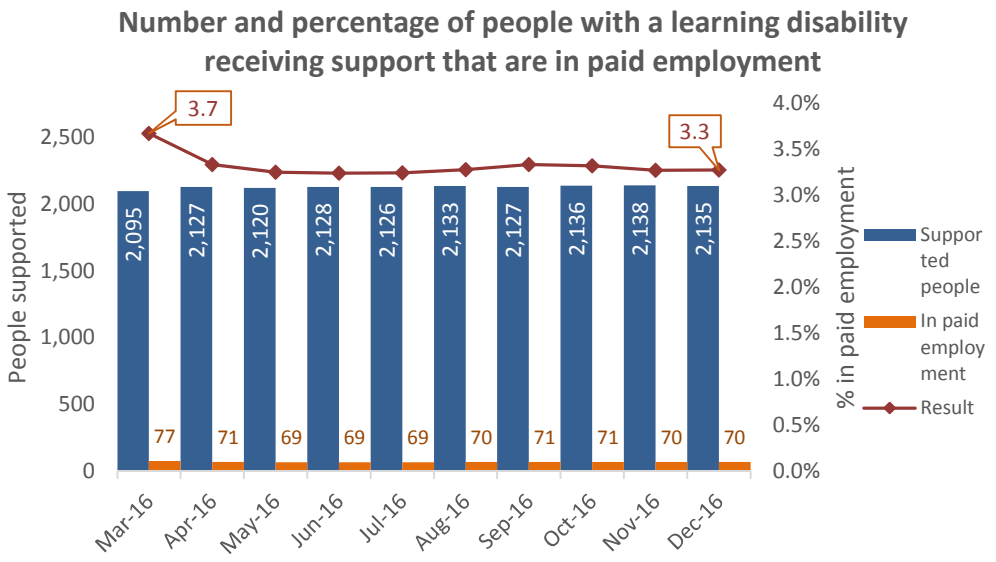
Lead: Lorrayne Barrett, Director of Integrated Care Data: Business Intelligence & Performance Team

3.8 % People receiving Learning Disabilities services in paid employment

Why is this important?

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

Performance



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

What is the background to current performance?

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

What will success look like?

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

Action required

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

Responsible Officers

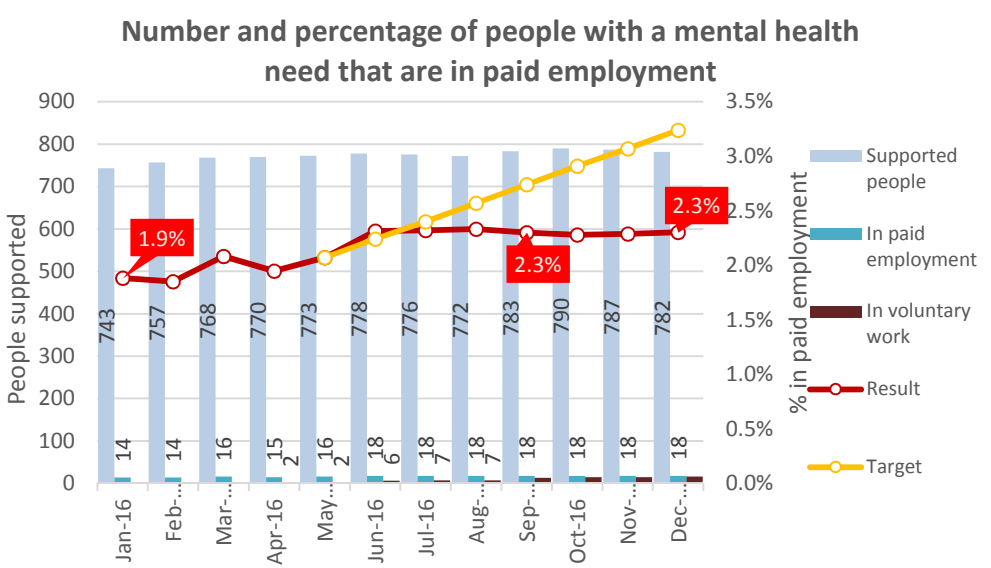
Lead: Lorrayne Barrett, Director of Integrated Care Data: Business Intelligence & Performance Team

3.9 % People receiving Mental Health services in paid employment

Why is this important?

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

Performance



What is the background to current performance?

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

What will success look like?

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

Action required

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

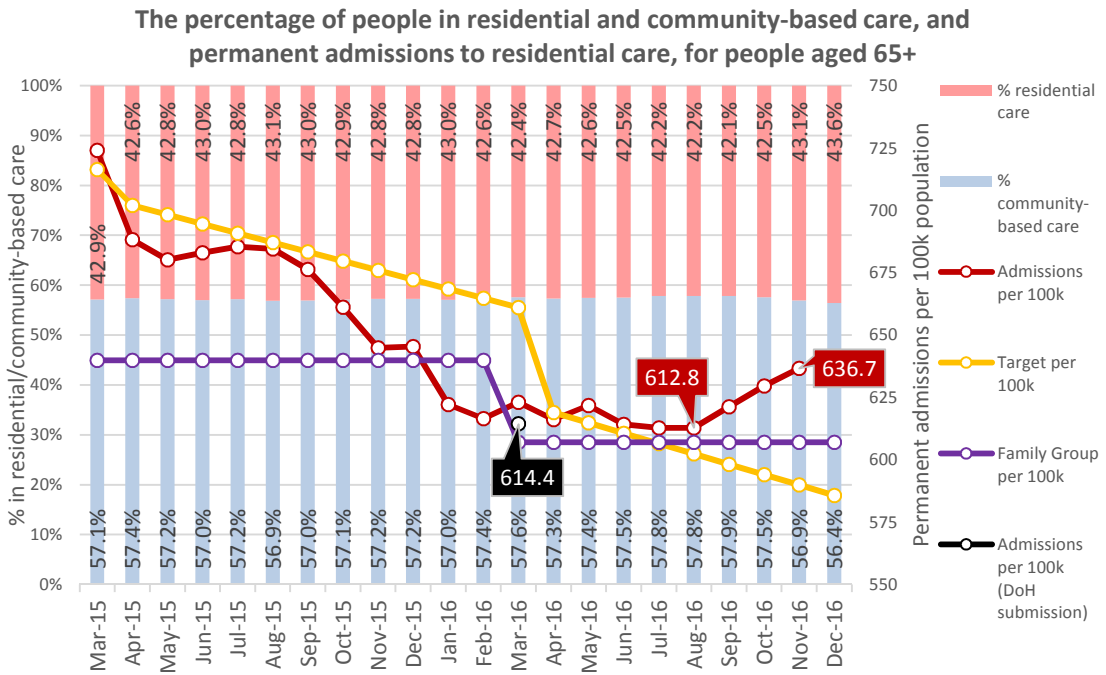
Responsible Officers	Lead: Alison Simpkin	Data: Business Intelligence & Performance Team

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

Why is this important?

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

Performance



What is the background to current performance?

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

What will success look like?

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

Action required

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Benchmarking

3.19 Appendix 2 contains the 2015/16 benchmarking report for Adult Social Care. This report presents benchmarking information for Norfolk Adult Social Care for the year 2015/16 and is designed to help members and managers to compare the performance of Norfolk with other councils that have social care responsibilities and to identify areas for improvement.

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

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

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

Norfolk also has the joint highest number of people in this age range being admitted to permanent residential or nursing care which accounts for some of the large number of people supported in long term care. In assessing our benchmarked position for this indicator it is important to note that, whilst Norfolk continues to have significant room for improvement, its relative position compared to its comparator councils has improved markedly in recent year. In 2012/13 Norfolk's rate of 51.7 permanent admissions for people aged 18-64 per 100,000 population meant we were placing nearly three times more people than our comparator groups. The rate reduced to 44.9 in 2013/15 and to 30.7 in 2014/15, and within this context Norfolk's rate of 18 in 2015/16 represents a continued reduction that should see us move towards our stated ambition of achieving at most our family group average rate.

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

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

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

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

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

The first assesses people's overall social care related quality of life, and uses an index which takes into account responses relating to factors such as control over daily life, personal care, food and nutrition, accommodation, safety, social participation, occupation and dignity. In this area Norfolk's score has gone down by 2%, but remains above the family group, regional and national averages.

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

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

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

3.24 **Key findings: other indicators**

Some other key headlines from the report are:

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

3.25 The full benchmarking report is available in appendix 2.

4 Financial Implications

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

5 Issues, risks and innovation

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

Officer Contact

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

Officer name :	Tel No. :	Email address :
Lorna Bright	01603 223960	lorna.bright@norfolk.gov.uk
Jeremy Bone	01603 224215	jeremy.bone@norfolk.gov.uk

IN TRAN
communication for all

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

Appendix 1

Performance discussions and actions

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

Suggested prompts for performance improvement discussion

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

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

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

Performance improvement – recommended actions

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

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

Suggested follow-up actions

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

Norfolk County Council

Adult Social Care

Benchmarking

Report

2015/16

Norfolk County Council

Contents

Norfolk County Council

1 Introduction

Who is this report for?

This report presents benchmarking information for Norfolk Adult Social Care for the year 2015/16 and is designed to help managers and elected members compare the performance of Norfolk with other councils that have social care responsibilities and identify areas for improvement. It is not designed for use by the public.

What is benchmarking?

'Benchmarking' is a widely used term within all sectors, describing when an organisation compares what it does against others. Organisations can benchmark their business processes, performance, finance, quality etc. to understand strengths and weaknesses and respond accordingly. Essentially 'benchmarking' provides a snapshot of how a 'business' is performing in relation to a particular standard. We use benchmarking in a variety of ways in order to inform how we are doing and help us determine what our priorities are. It enables us to position ourselves amongst others, letting us know where our issues are as well as informing the target setting process. Benchmarking is not an exact science and should be treated with some caution. It is important that the information is used properly and within context.

Warnings to consider:

Where possible, this report has tried to overlay performance against population but there are some warnings to consider when using benchmarking information. Broadly these include:

- Not all councils were able to provide a full set of data for the social care indicator values and estimates have not been made for those with missing data. England and regional totals are based on councils that have provided the complete data.
- The disparity between the size, demography, structure, budget etc. of councils, even amongst our 'family group', can sometimes impact on the results.

This does not negate the benefits of benchmarking but understanding what it is telling you is vital; resist simplistic interpretations by sourcing some contextual understanding.

2 What is this report measuring?

What is this report measuring?

This report presents benchmarking information for Norfolk Adult Social Services for the year 2015/16.

Where does the data come from?

Every social services department must submit a range of returns each year relating to Short and Long Term care (SALT), the Adult Social Care Survey (plus the Carers' Survey every other year) and Adult Social Care Finance Return (ASC-FR). The results of these returns are collected together by the National Adult Social Care Intelligence Service (NASCIS) and made available to the Council online. Most of the data in this report has been taken from the SALT return and the ASCOF data set. The source of data is listed on each page.

What time period does the report look at?

Most of the data presented relates directly to the year 2015/16. Where the latest reportable data relates to another financial year, details are always provided with the data on the relevant page of the report. When there is data available to compare against previous years, the year is stated on the page. In some cases this may be as far back as 2010/11, for others it may be more recent.

Important Notes

All data included in this report can be subject to change as the Department of Health can retrospectively republish data of councils if issues or amendments are identified.

3 Which councils are being compared?

Our results are mostly compared to Norfolk's 'family group' - a collection of 15 other councils that the Care Quality Commission considers to have similar characteristics to Norfolk and are therefore a valid comparison for performance. Our 'family group' consists of:

Lincolnshire County Council

Gloucestershire County Council

Cumbria County Council

Lancashire County Council

Devon County Council

worcestershire county council

Suffolk County Council

Staffordshire County Council

Northamptonshire County Council

Somerset County Council

North Yorkshire County Council

Nottinghamshire County Council

Warwickshire County Council

Leicestershire County Council

Derbyshire County Council

Where financial information is being compared with other councils the comparator group is based on Area Cost Adjustment (ACA) factors. The ACA factors are derived from the relative cost of providing services within a council's geographic area. For comparison of expenditure data, Norfolk was placed into one of four ACA groupings with 49 other councils with similar ACA factors in 2007/08.

4 How to use this report

1

In this report, information is presented in several different ways. In many case, traditional bar charts or line graphs and pie charts are used. In some other cases, pictographs (or picture icons) are used to provide a visual demonstration of how Norfolk figures compare to other councils. The size of these pictographs is adjusted to provide an approximate reflection of the figures represented. The method used for sizing pictographs is not consistent throughout the report so icons on different pages may appear to be different sizes even though they represent the same figure. The figure represented is always provided inside or next to the icon.

2

Data relating to people is sometimes represented with a stick person icon.

Data relating to living accommodation is sometimes represented with a house icon.

Data relating to satisfaction is sometimes represented with a smiley face icon.

3

- A key is provided on each page but in most cases the following colours indicate the following things:

England | Family Group | Norfolk | East England

4

- Grey boxes also indicate how the data has been counted. This is normally per 100,000 population but may also be by a %.

Per 100,000 population

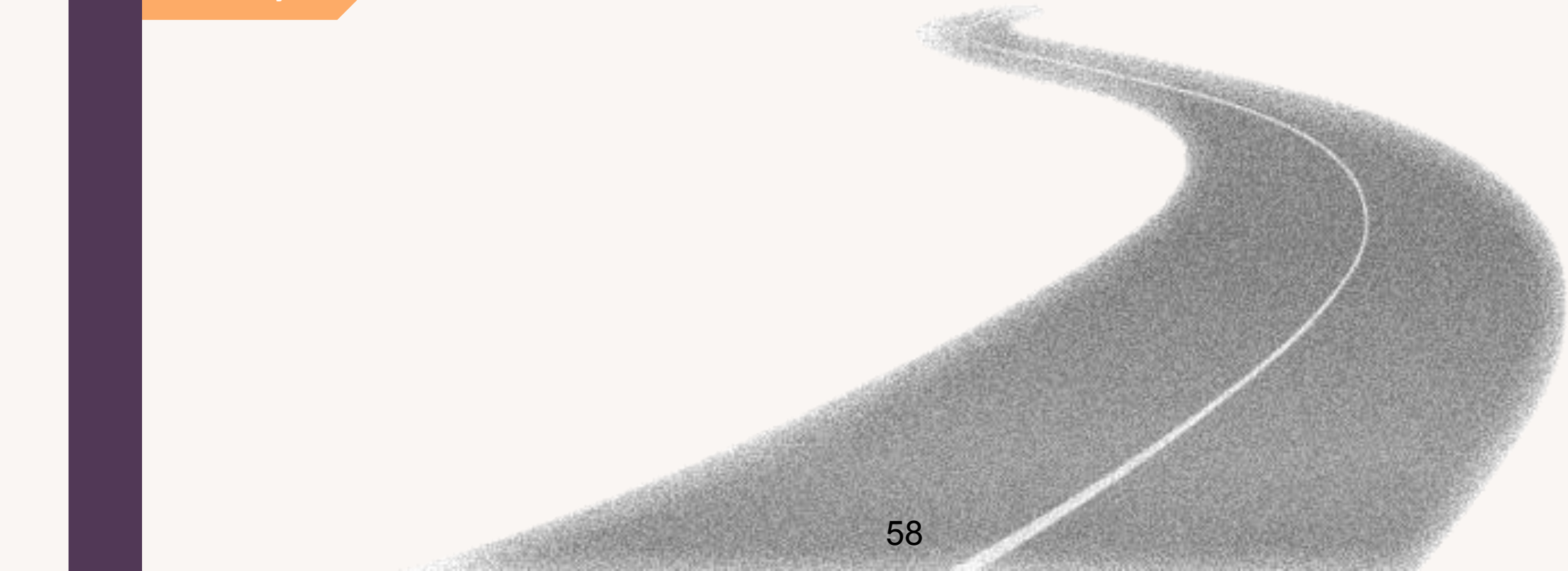
- An information icon is used to mark important information about the data.

18 - 64

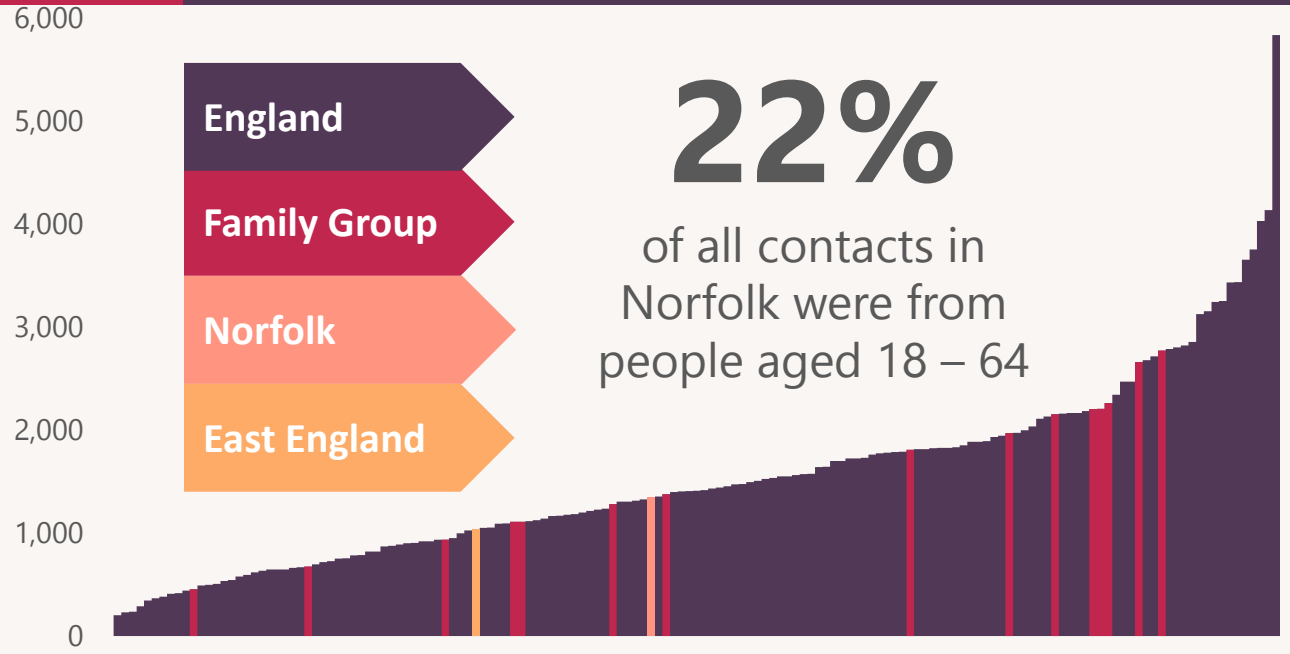
Adult

Social Care

Pathway



6 Number of requests for support for people aged 18 – 64



22%

of all contacts in Norfolk were from people aged 18 – 64

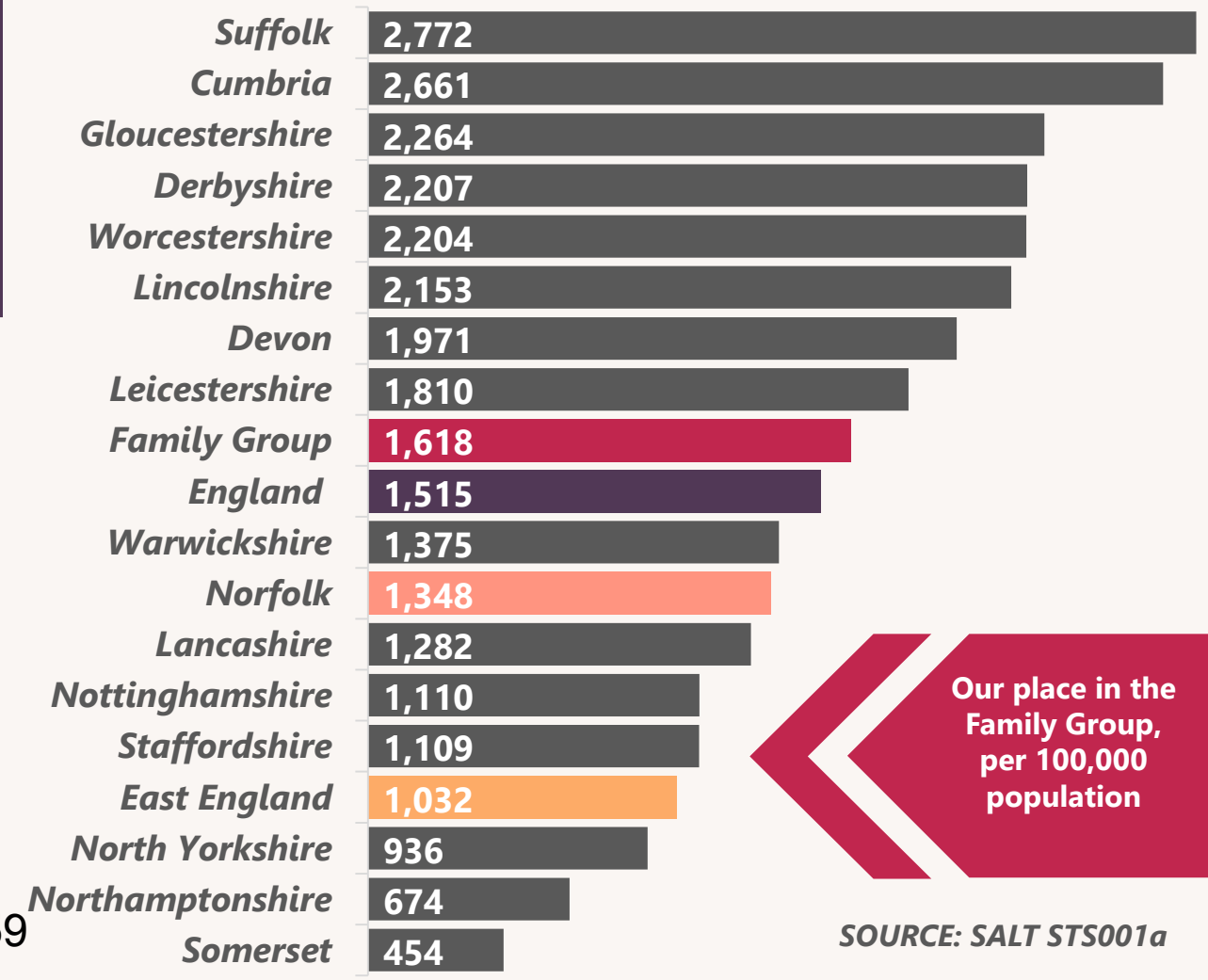
What this measures:

The number of contacts from people aged 18-64 requesting support per 100,000 population. It does not include requests from people already in a long term service. The figures for England, Eastern and the family group are based on averages.

What does this tell us?

Norfolk is around the middle for both family group and all authorities – but missing Blue Badge recording means the figures are certainly lower than they should be. Difference between this and previous very high contacts results possibly indicates suppressed figures, but also high levels of mis-directed re-referrals coming through the front door – particularly given that people already in services aren't included in these figures.

This measure is significantly different to the 'contacts' measure reported previously in the RAP return. Norfolk's figure is artificially low because we don't capture Blue Badge requests in the right way – other councils may have been able to include these.



Our place in the Family Group, per 100,000 population

SOURCE: SALT STS001a

7 What happened next in Norfolk for those aged 18-64?

What this measures: This shows us what happened following a new request for support from somebody not already receiving a service. This is split by the route of access for each request, and by percentage split to each service classification. The classification of short term support is for people who receive a short period of reablement after leaving hospital to help them regain their independence, or are helped by an emergency intervention, such as assistance after pressing their community alarm.

What does this tell us? People who are not eligible for a service are usually given tailored advice and information on other organisations who could help. The majority of people that contact us are signposted onto other services

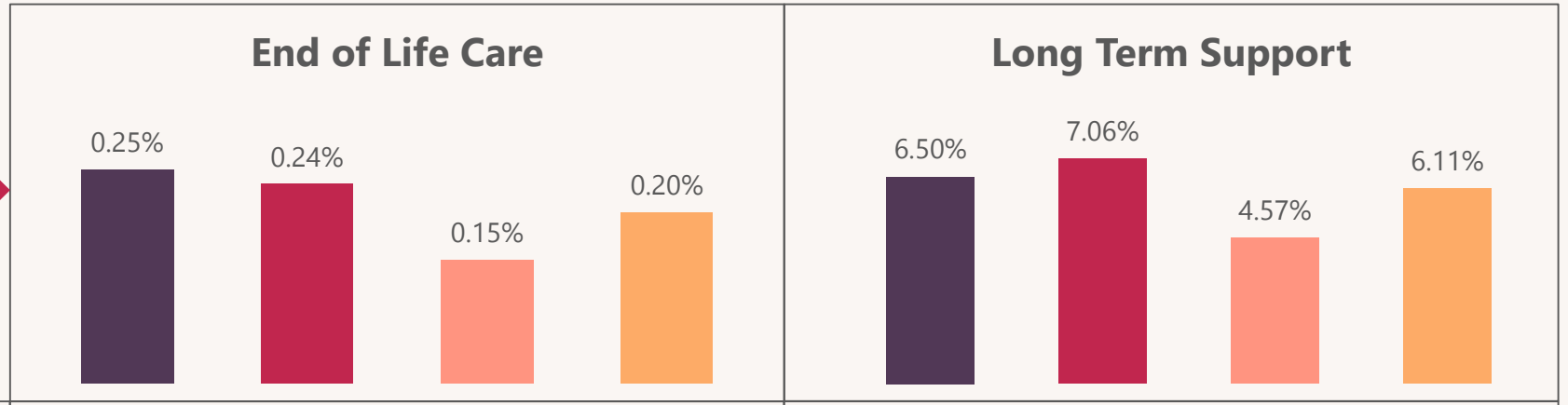
SOURCE: SALT STS001a

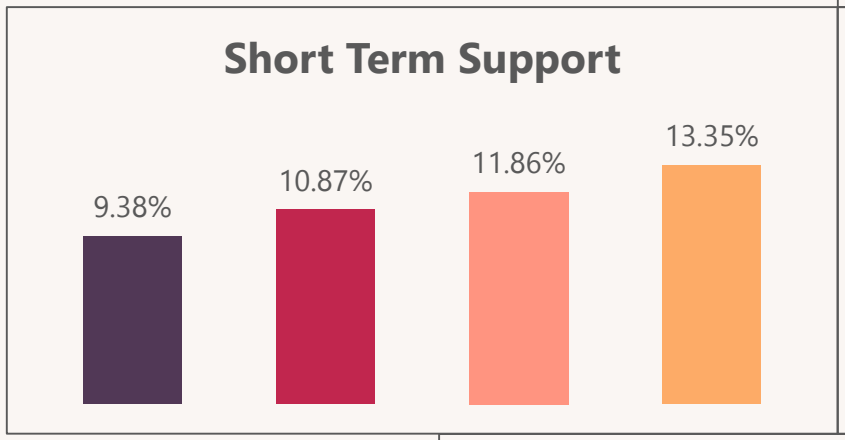
		Route of Access			
		Moving from Children's Services **0.52%**	Discharge from Hospital **10.10%**	Preventing Hospital Admission **1.25%**	Other Route **88.14%**
11.86%	Short Term Support	**0%**	**34.31%**	**35.29%**	**9.03%**
4.42%	Long Term Community Care	**14.29%**	**8.76%**	**5.88%**	**3.85%**
0.07%	Long Term Nursing Care	**0%**	**0.73%**	**0%**	**0%**
0.07%	Long Term Residential Care	**0%**	**0%**	**0%**	**0.08%**
0.15%	End of Life Care	**0%**	**0.73%**	**0%**	**0.08%**
13.49%	Ongoing Low Level Support *eg. Equipment/adaptations*	**85.71%**	**2.92%**	**5.88%**	**14.88%**
69.42%	Universal Services/ Signposted to other services	**0%**	**51.09%**	**52.95%**	**71.66%**
0.52%	No Services Provided	**0%**	**1.46%**	**0%**	**0.42%**

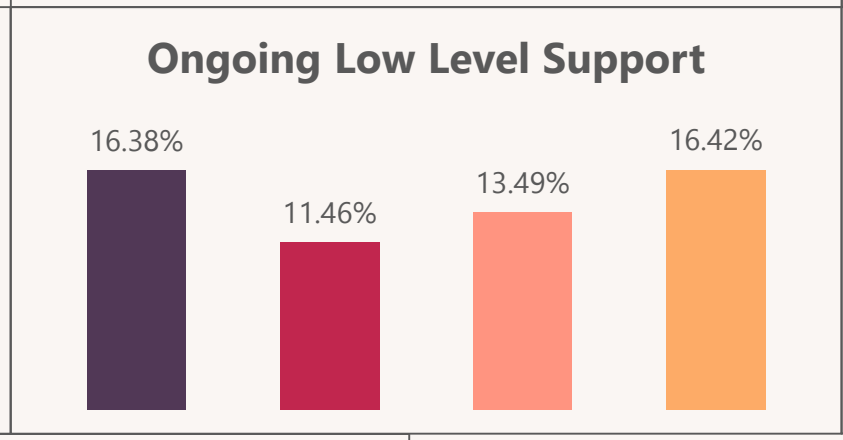
8 How does Norfolk compare for those aged 18-64?

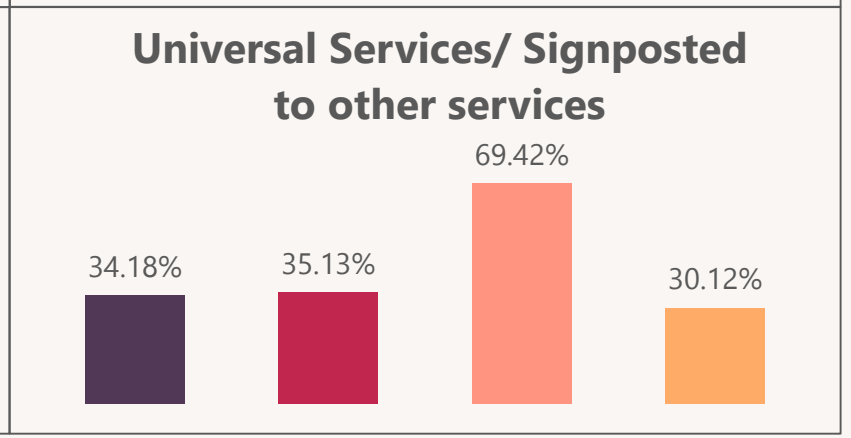
What this measures:
This looks at the percentage of people whose request for support resulted in each of the 6 types of sequel described on the previous page, compared against England, our family group and East England

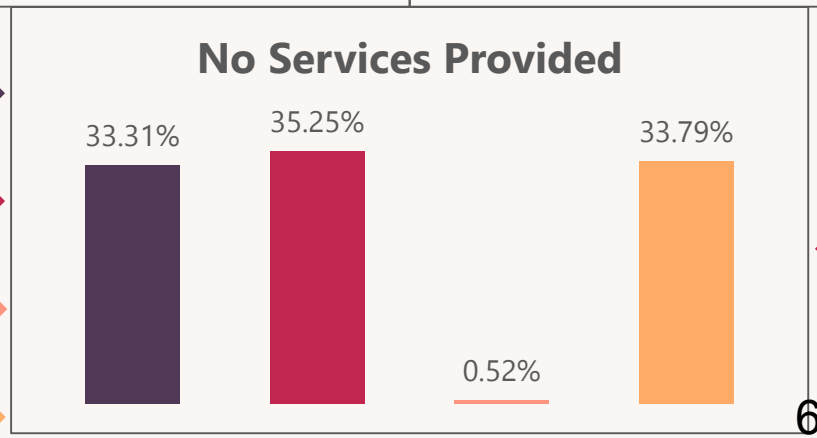
SOURCE: SALT STS001a











England

Family Group

Norfolk

East England

What does this tell us? Norfolk has extremely low numbers of people that receive no services but has extremely high numbers of people that receive universal services and are signposted to other services. This is because where people are not eligible for a service we give them tailored advice and information about other possible ways to get help. For all other sequels, we are fairly comparable with our family group and the rest of England.

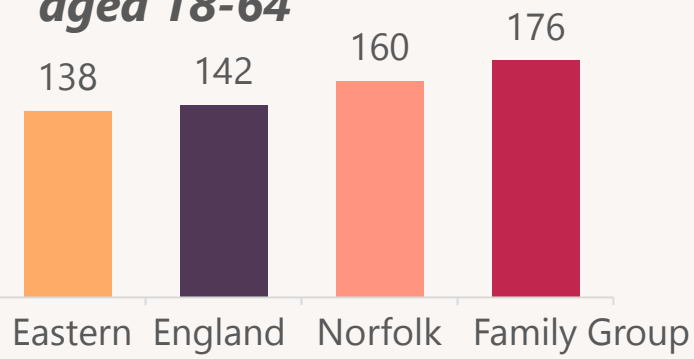
9 People in receipt of short term support aged 18-64

Short Term Support refers to people who have a short period of reablement after leaving hospital to help them regain their independence, or are helped by an emergency intervention, such as assistance after pressing their community alarm.

What this measures: This measures the number of people aged 18-64 receiving short term support per 100,000 population. The graph shows the percentage split across our family group between reablement and emergency intervention.

SOURCE: SALT STS001a

Per 100,000 population aged 18-64



Per 100,000 population, short term support for those aged 18-64 in Norfolk has increased by

18%

compared to 2014/15

What does this tell us?

All four comparator groups have more people receiving short term support per 100,000 population compared to 2014/15. The split between the two types of short term support, has also increased by 3% more weighted to emergency intervention compared to 2014/15. Norfolk is around the middle of our comparator groups for both emergency intervention and reablement and has more of an equal split between the different types of short term support

England

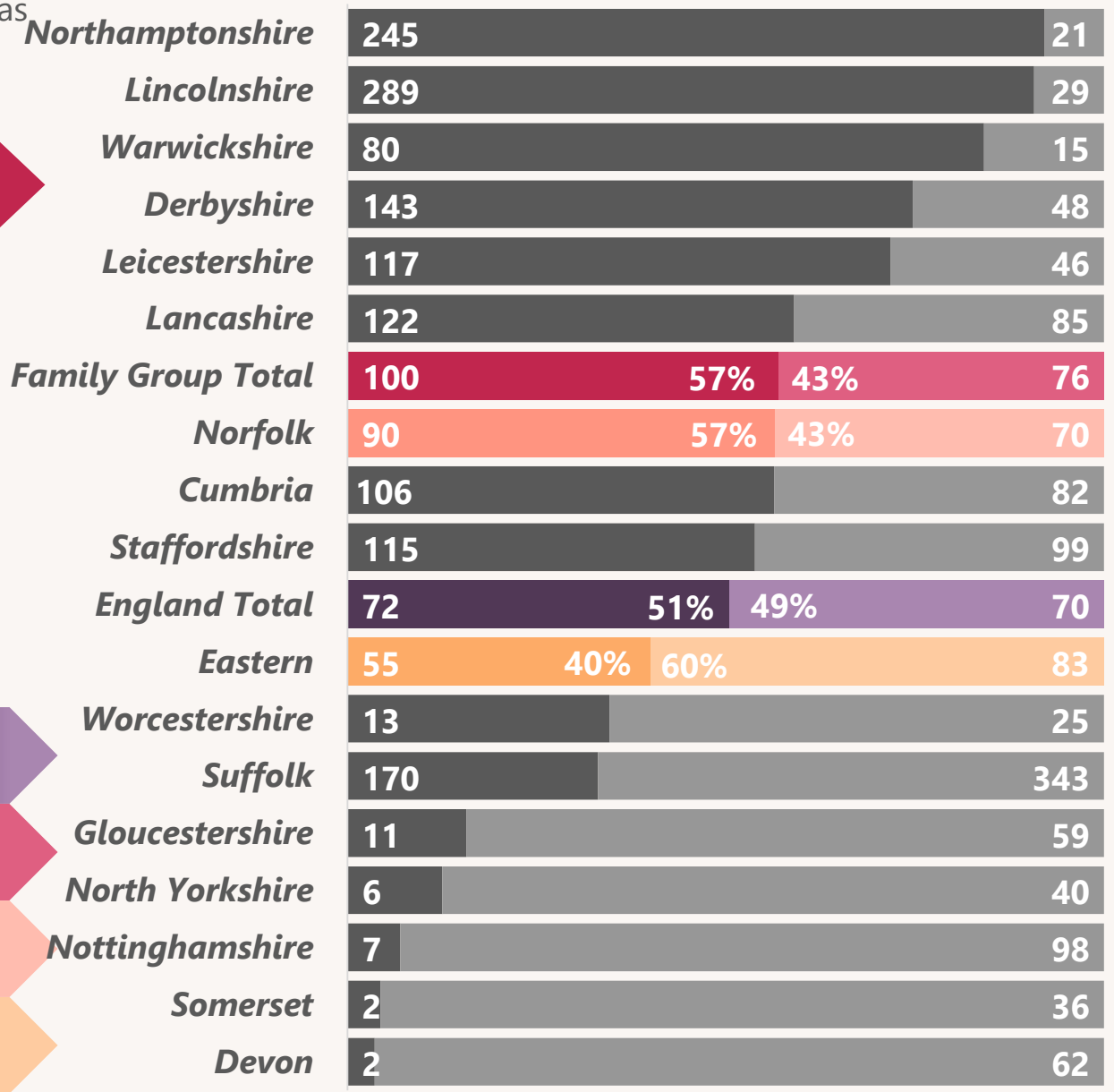
Family Group

Norfolk

East Engla

Emergency Intervention ***Reablement***

per 100,000 population aged 18-64



10 Referrals into short term care from hospital for those aged 18-64

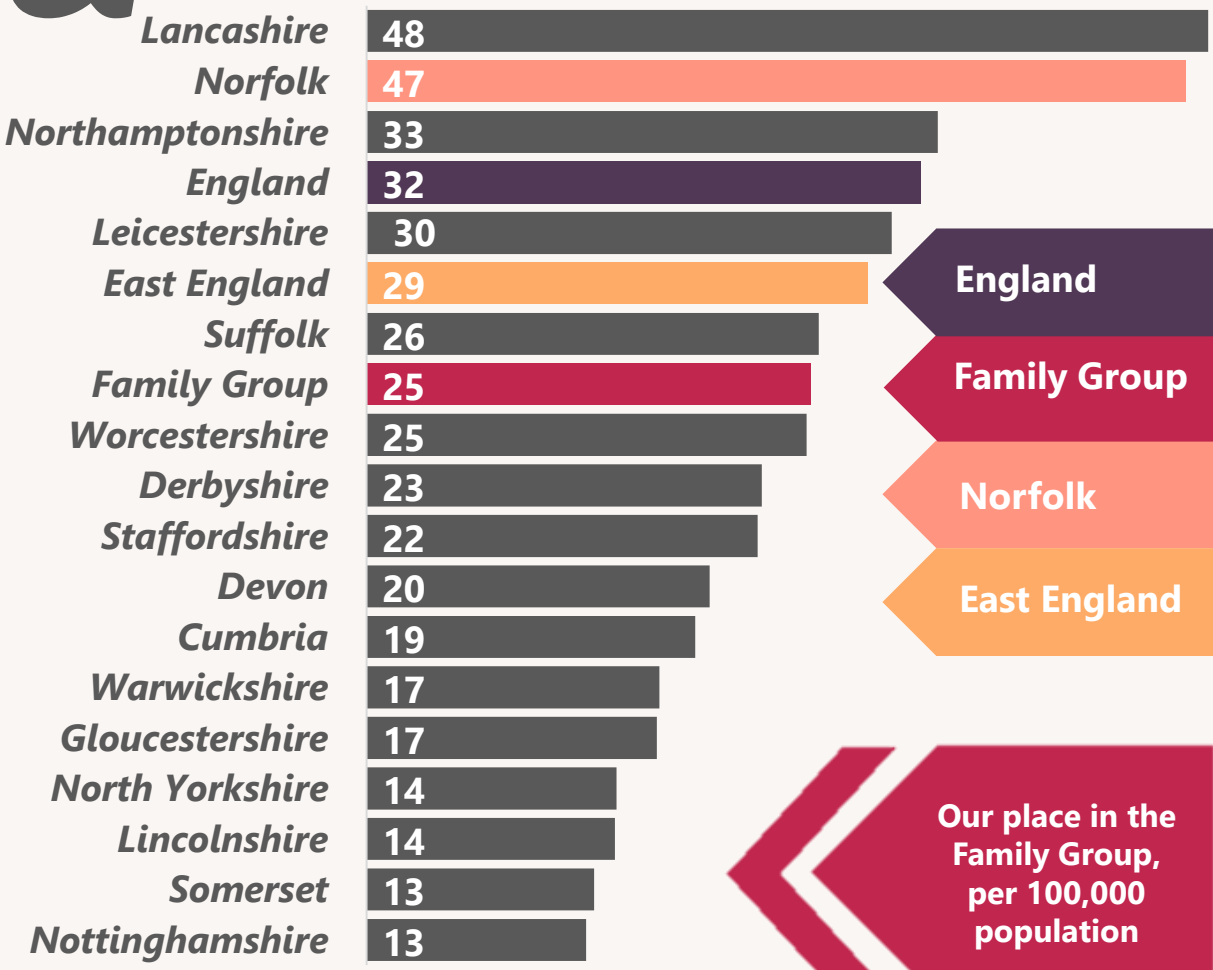
The national picture...

What does this tell us? Norfolk is the second highest in our family group, which supports the emerging hypothesis that this explains some of the high levels of long term care in the age group. This is likely as requests for support and other sequels are around the mid-point of councils but referrals into short term care are disproportionately higher.

SOURCE: SALT STS001a

What this measures:
The number of people aged 18 – 64 being referred into short term social care from hospitals per 100,000 population aged 18-64.

& our place in the family group



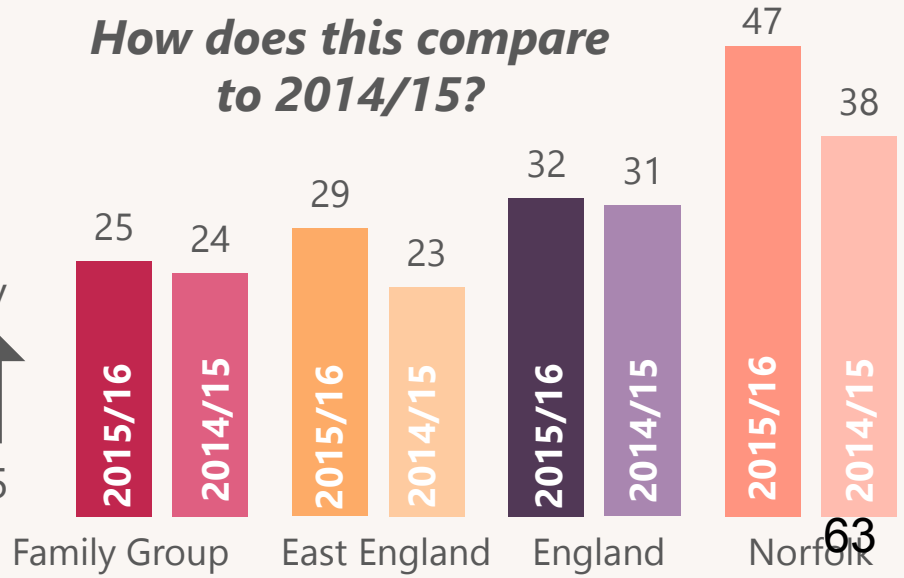
Our place in the Family Group, per 100,000 population

All four comparator groups have seen an increase of referrals into short term care from hospital. Norfolk's has risen by

24%

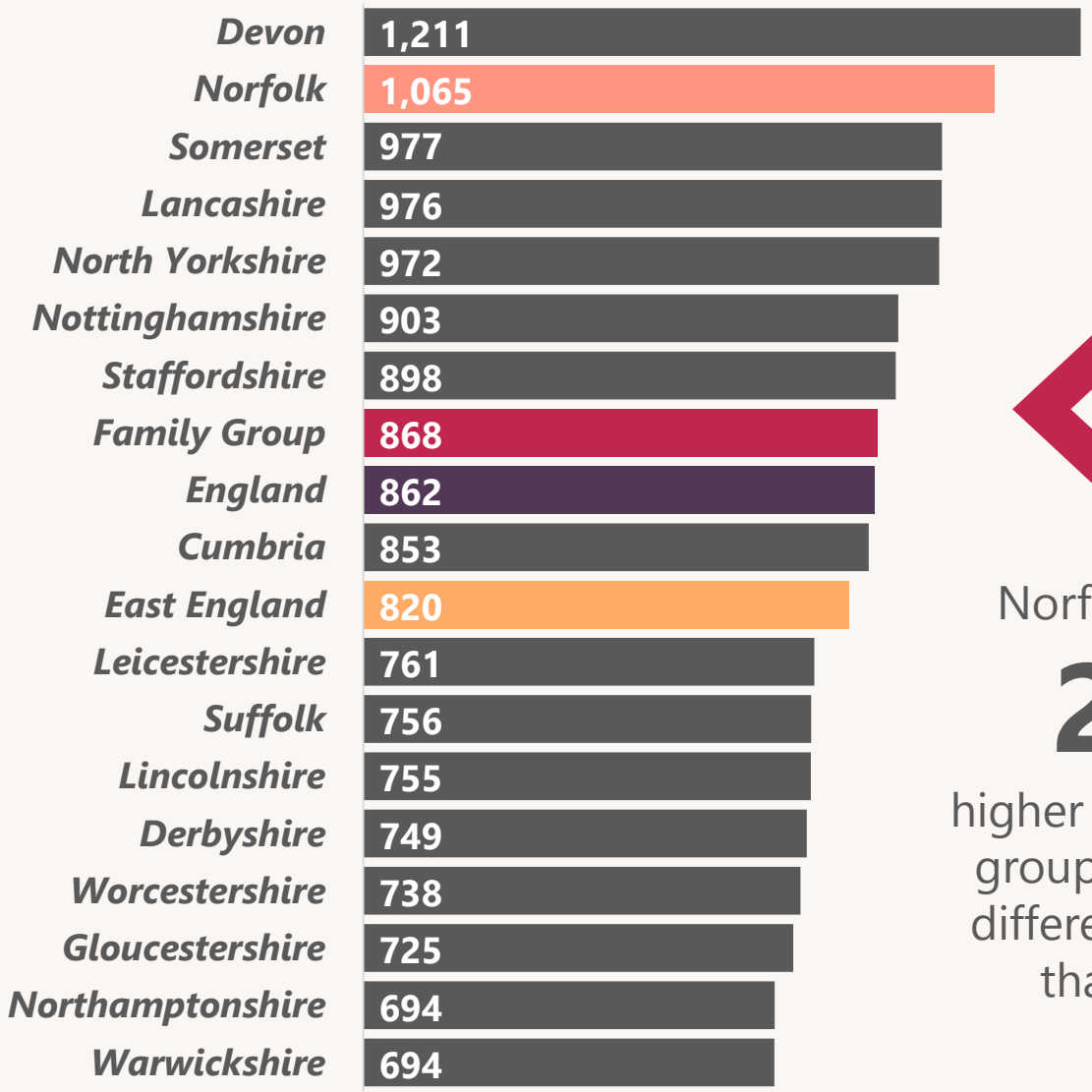
compared to 2014/15

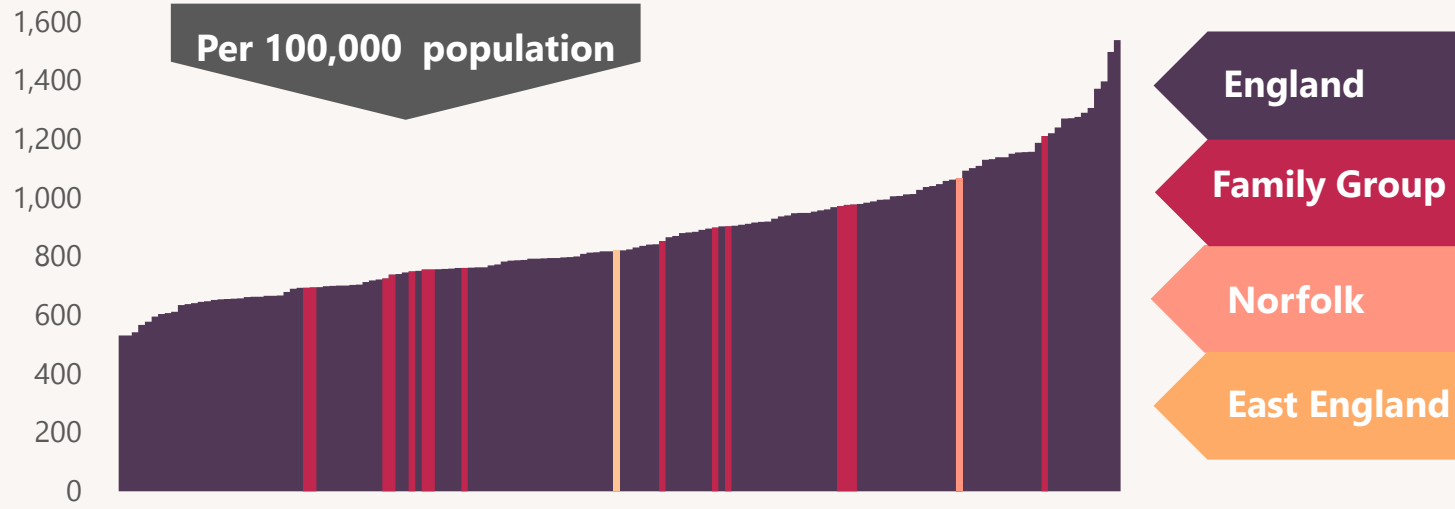
How does this compare to 2014/15?



11 People in receipt of long term support aged 18-64

What this measures:
The number of people aged 18 – 64 receiving long term support per 100,000 population aged 18 – 64.





What does this tell us? ***SOURCE: SALT LTS001a***

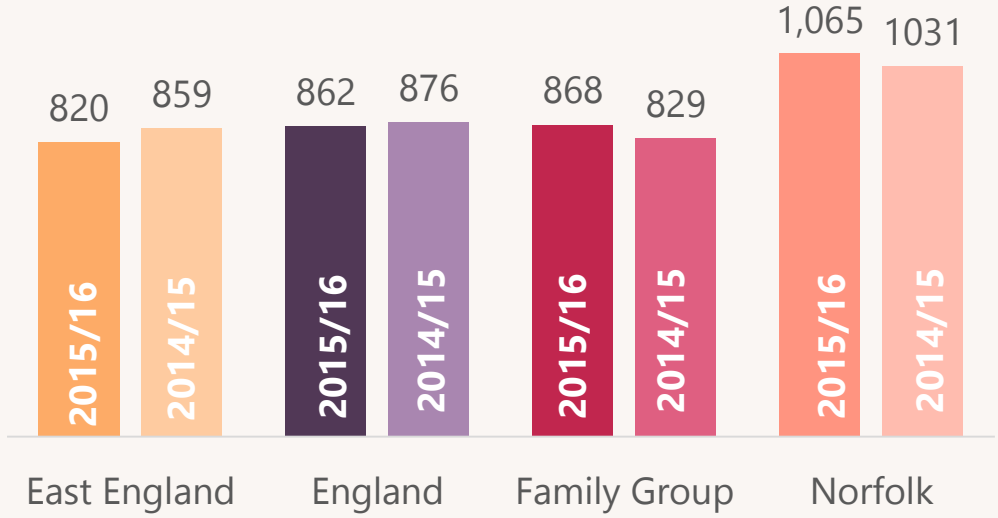
Norfolk is the second highest in our family group for long term support for this age range. So whilst there is an 'average' position up to the allocation of reablement/short term services, the picture changes dramatically thereon.

Norfolk's figure is

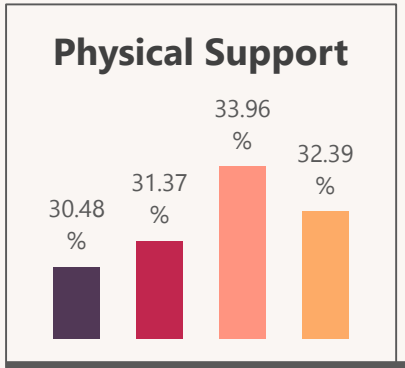
23%

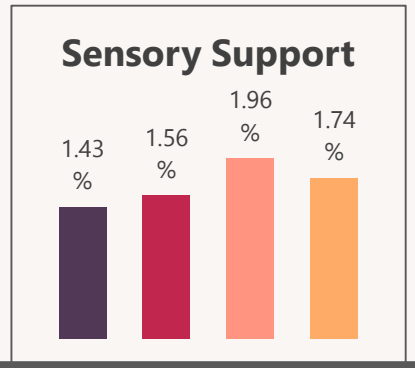
higher than the family group average. This difference is 1% less than 2014/15

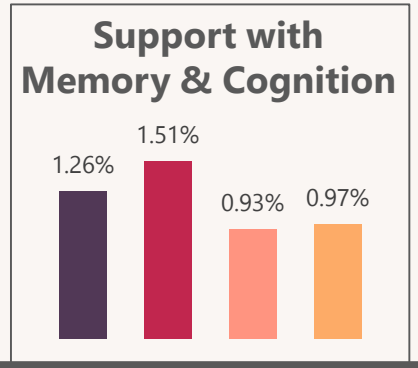
How does this compare to 2014/15?

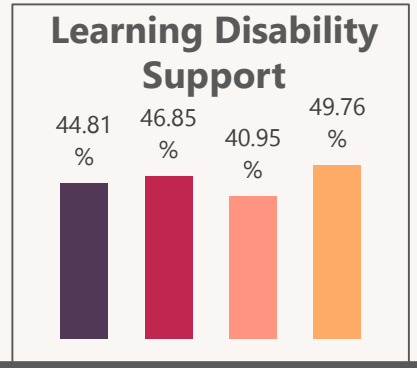


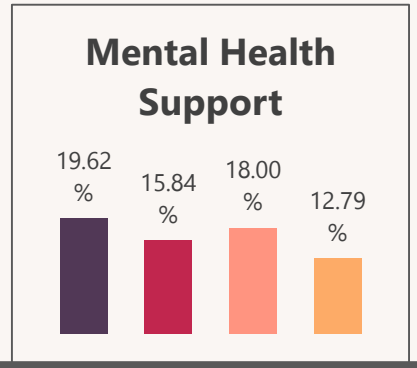
12 What do we mean by 'long term support' for those aged 18-64?

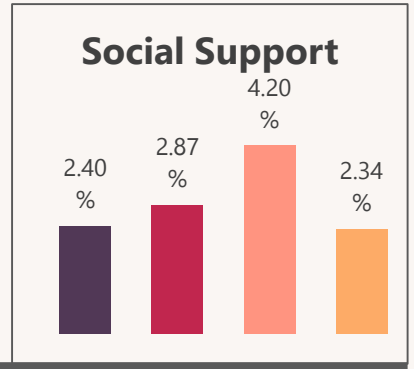












The breakdown of long term support in Norfolk

Physical Support 33.96%

- Personal Care **10.07%**
- Access & Mobility **23.89%**

Aged 18-64

SOURCE: SALT LTS001a

Sensory Support 1.96%

- Visual Impairment **1.22%**
- Hearing Impairment **0.37%**
- Dual Impairment **0.37%**

Support with Memory & Cognition 0.93%

Learning Disability Support 40.94%

Mental Health Support 18.01%

Social Support 4.20%

- Substance Misuse **0.47%**
- Asylum Seeker Support **0%**
- Social Isolation/ Other **3.73%**

What does this measure?

The six bar charts show the main reason for support for people receiving 'long term support', and how we compare against our family group, the East of England and the rest of the country. The flow diagram shows Norfolk's figures for each classification of long term support.

What does this tell us?

For this age range, Norfolk's figures are very similar to our family group and the national average, across all categories.

England → **Family Group** → **Norfolk** → **East England**

**Key just for reference to bar charts, not flow diagram.*

13 People admitted to permanent residential or nursing care

What this measures: *SOURCE: ASCOF 2A(1)*

The number of people aged 18-64 being permanently admitted to residential or nursing care per 100,000 population aged 18-64.

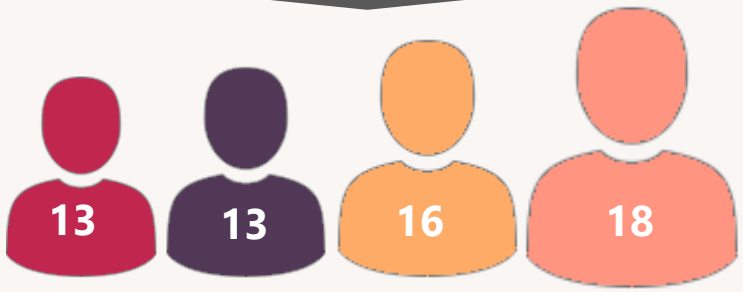
England

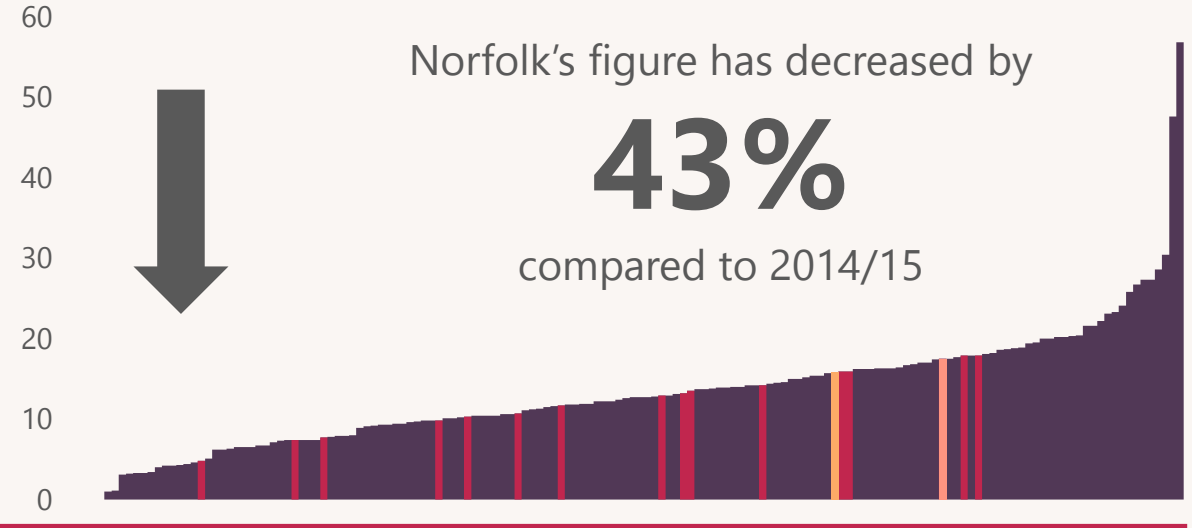
Family Group

Norfolk

East England

Per 100,000 population





Norfolk's figure has decreased by

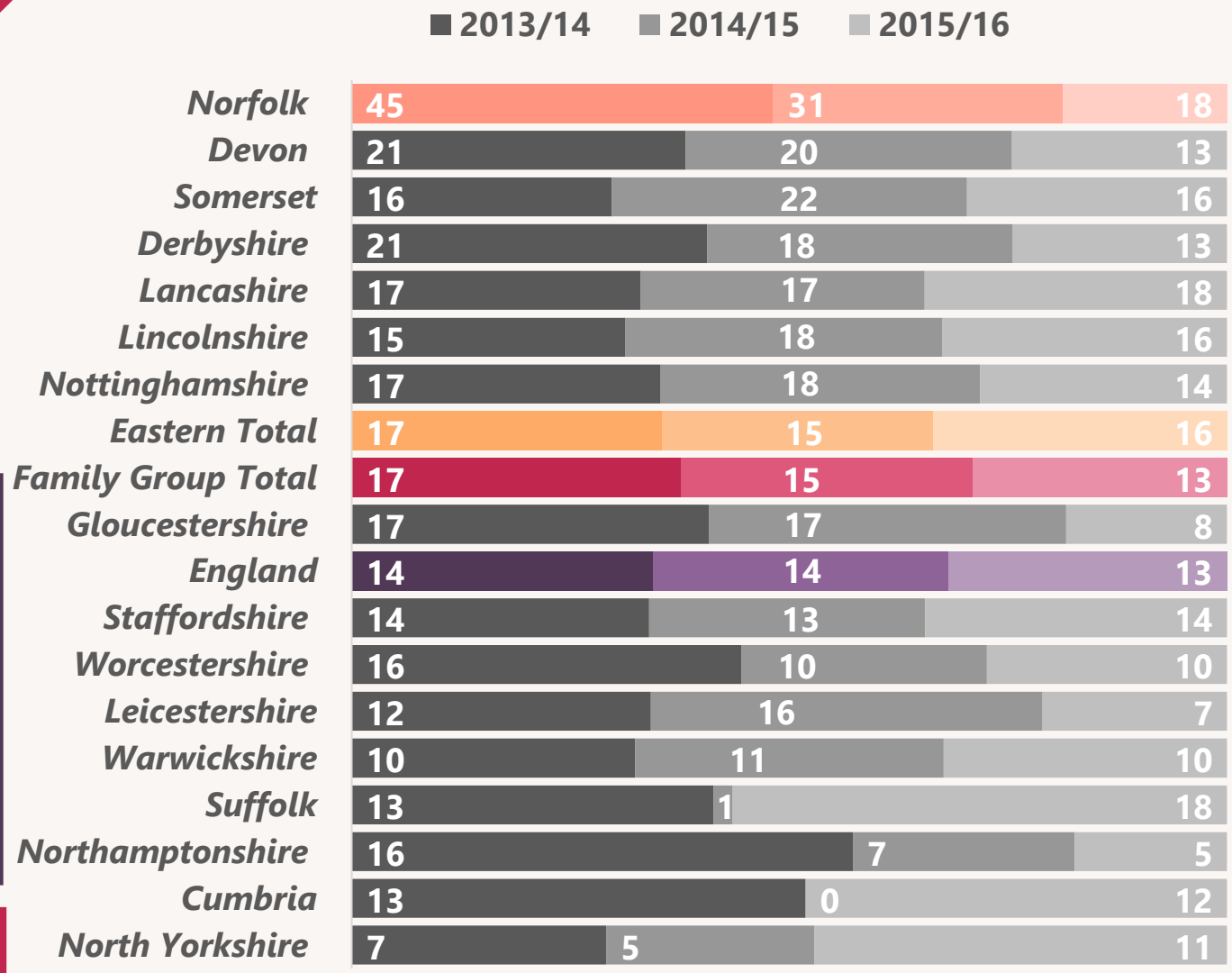
43%

compared to 2014/15

What does this tell us?

Norfolk has the highest number of people in this age range being admitted to permanent or nursing care in its family group. This accounts for the large number of long term services we provide.

Our place in the family group and how this has changed over time



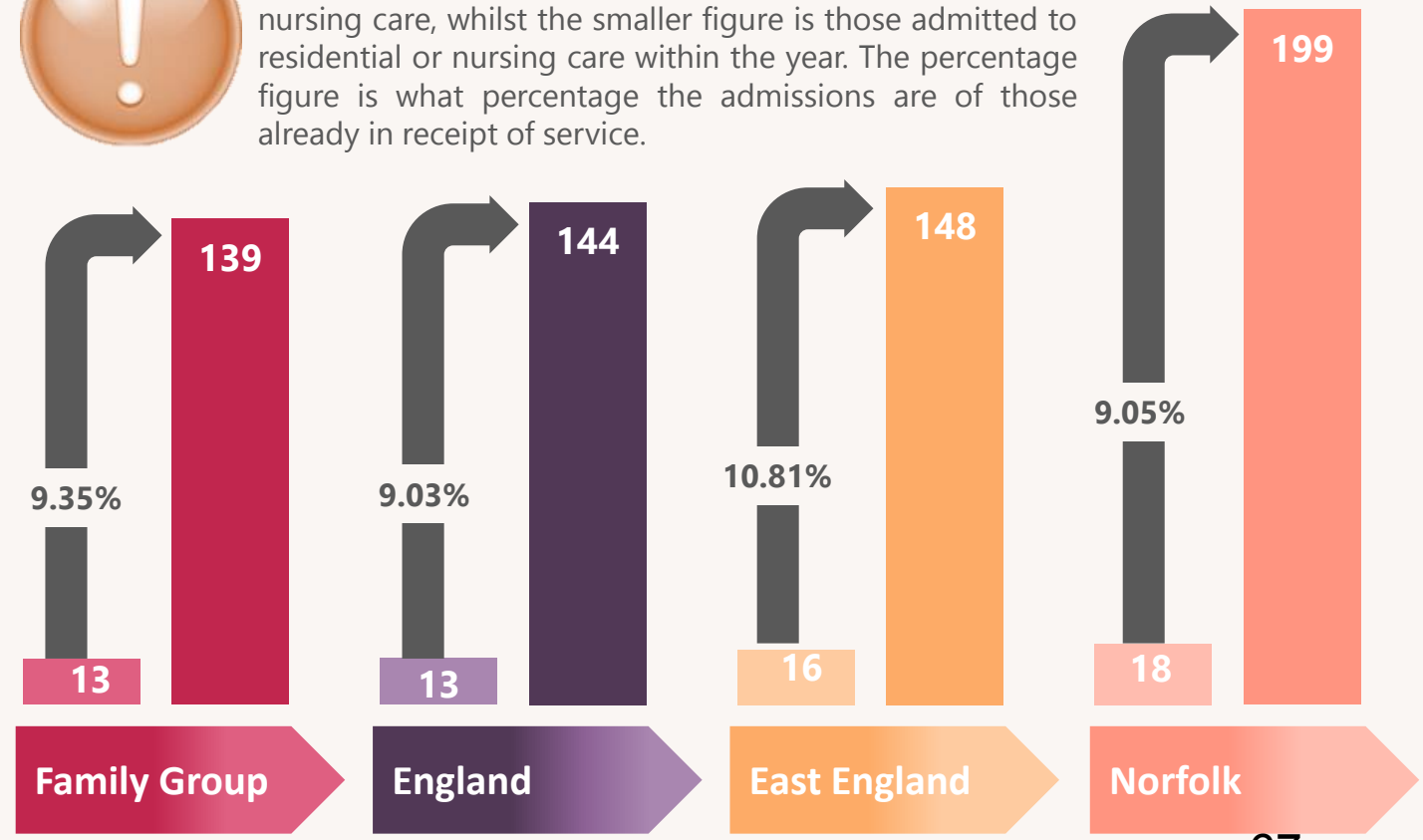
For 2014/15 Cumbria did not provided any results to they have not been included in the family group average.

14 Residential Admissions compared to those already in receipt of care

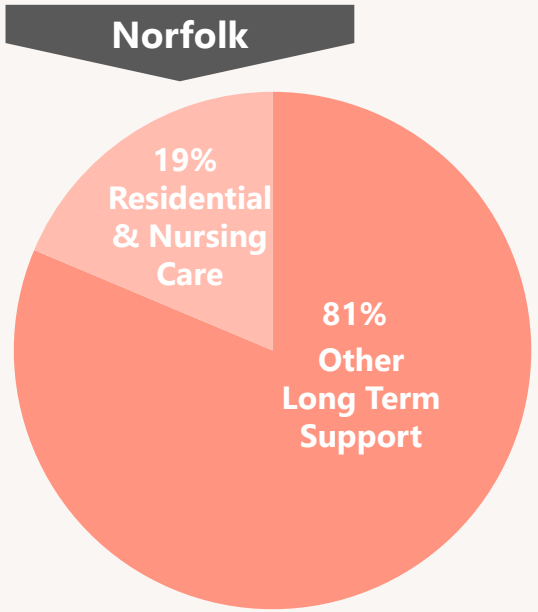
What this measures:
This compares the number of people aged 18-64 being permanently admitted to residential or nursing care (per 100,000 population) in year, against the number of people aged 18-64, who were in receipt of residential or nursing care per 100,000 population.

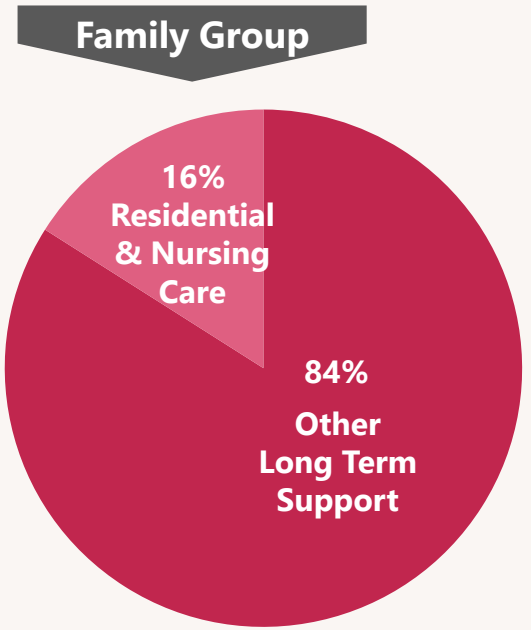
Per 100,000 population

The larger of the two numbers for each comparator groups is people aged 18-64 in receipt of residential or nursing care, whilst the smaller figure is those admitted to residential or nursing care within the year. The percentage figure is what percentage the admissions are of those already in receipt of service.



What % of Long Term Support is Residential and Nursing Care?





What do we mean by 'Other Long Term Support'?

Other long term support includes direct payments, part direct payments, personal budgets and other commissioned support.

What does this tell us?
Norfolk's rate of existing service users in residential care is higher than our comparator groups. However when we look at the proportion of new admissions, this figure is relatively consistent with everyone else.

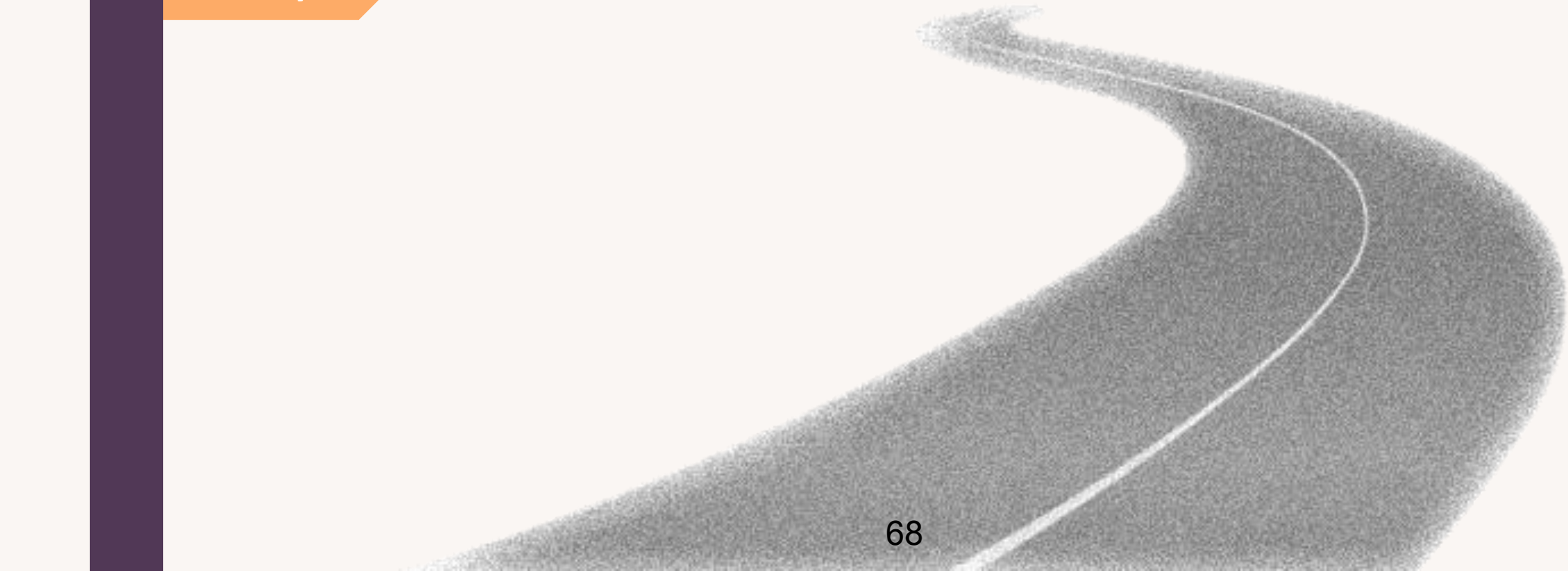
SOURCE: Residential Admissions ASCOF 2A (1) & People in receipt of long term care SALT LTS001a

65+

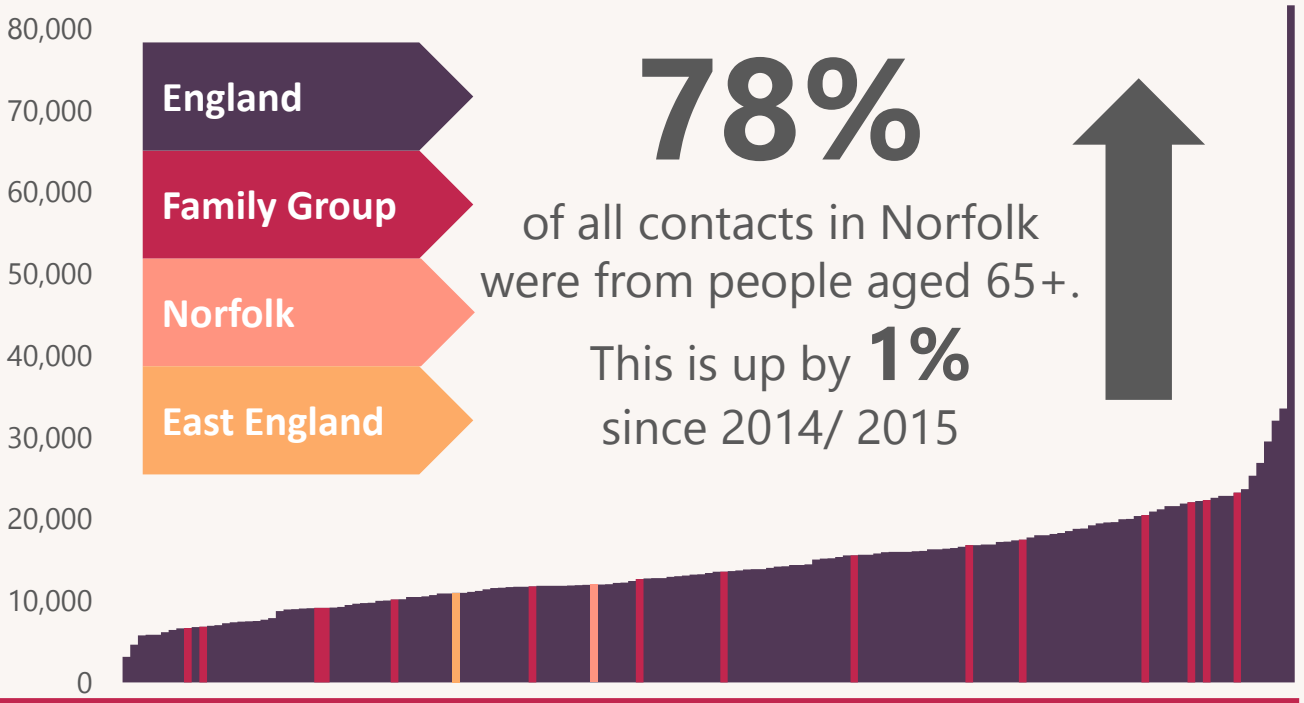
Adult

Social Care

Pathway



16 Number of requests for support for people aged 65+



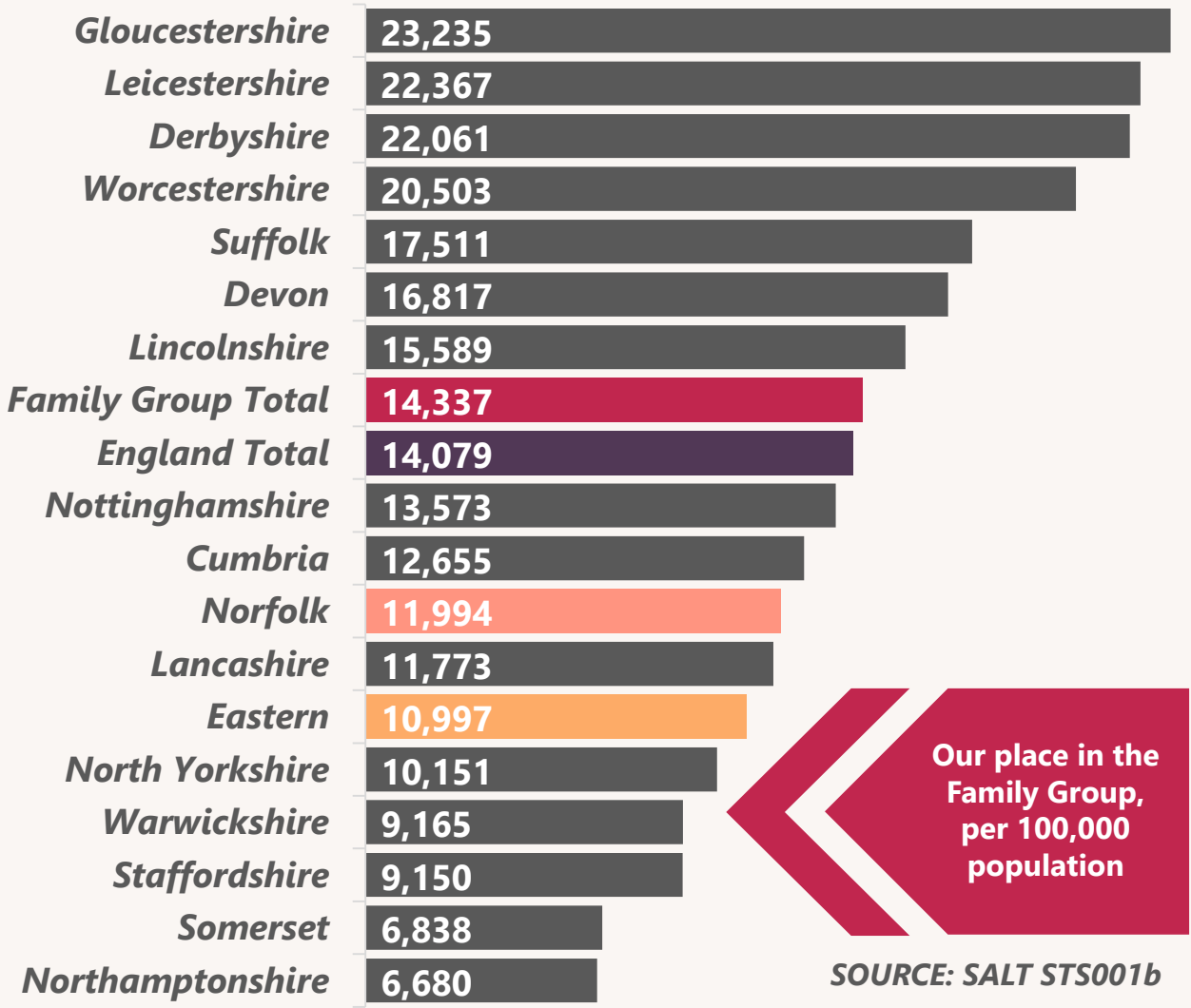
78%

of all contacts in Norfolk were from people aged 65+.

This is up by **1%** since 2014/ 2015

What this measures:

The number of contacts from people aged 65+ requesting support per 100,000 population. It does not include requests from people already in a long term service.



Our place in the Family Group, per 100,000 population

What does this tell us?

Norfolk is significantly below average compared to our family group and England – but missing Blue Badge recording means the figures are certainly lower than they should be. Difference between this and previous very high contacts results possibly indicates suppressed figures, but also high levels of mis-directed re-referrals coming through the front door – particularly given that people already in services aren't included in these figures.

This measure is significantly different to the 'contacts' measure reported previously in the RAP return. Norfolk's figure is artificially low because we don't capture Blue Badge requests in the right way – other councils may have been able to include these.

SOURCE: SALT STS001b

17 What happened next in Norfolk for those aged 65+?

What this measures:
This shows us what happened following a new request for support from somebody not already receiving a service. This is split by the route of access for each request, and then by percentage split to each service classification i.e Short Term Support.

What does this tell us? Compared to 2014/15 the percentage split by the route of access has not really seen any significant changes. However, there has been a decrease in ongoing low level support, end of life care and an increase in short term support, which supports Norfolk's promoting independence strategy.

SOURCE: SALT STS001b

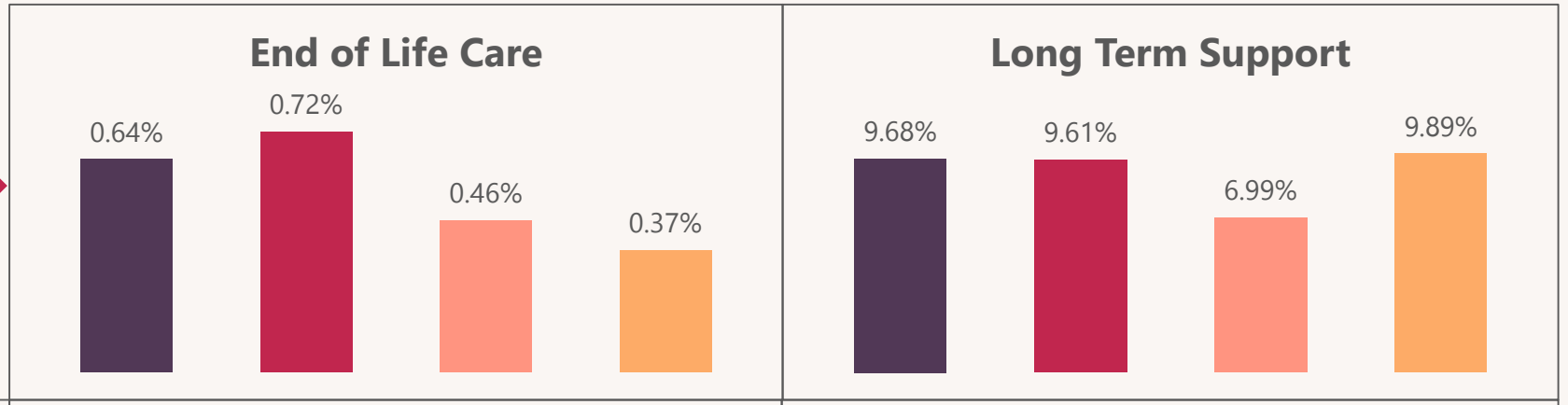
The 'No Services Provided' category includes people whose assessment is terminated, usually because they go in to hospital or die before it is completed. This is why the percentage in this category is higher than for younger people.

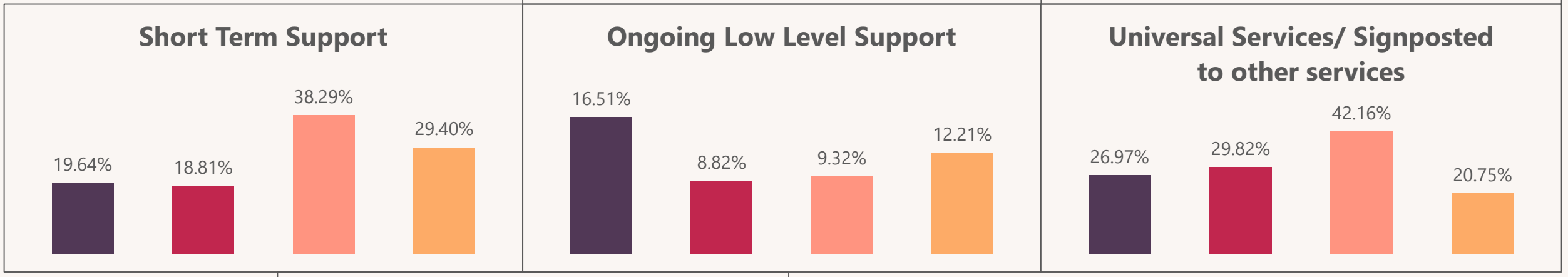
		Route of Access		
		Discharge from Hospital 25.31%	Preventing Hospital Admission 2.71%	Other Route 71.98%
38.29%	Short Term Support	48.77%	63.84%	33.65%
5.95%	Long Term Community Care	11.68%	3.08%	4.05%
0.29%	Long Term Nursing Care	0.90%	0%	0.09%
0.75%	Long Term Residential Care	1.81%	0%	0.40%
0.46%	End of Life Care	0.41%	0%	0.49%
9.32%	Ongoing Low Level Support eg. Equipment/adaptations	2.22%	2.31%	12.09%
42.17%	Universal Services/ Signposted to other services	30.26%	29.23%	46.83%
2.77%	No Services Provided	3.95%	1.54%	2.40%

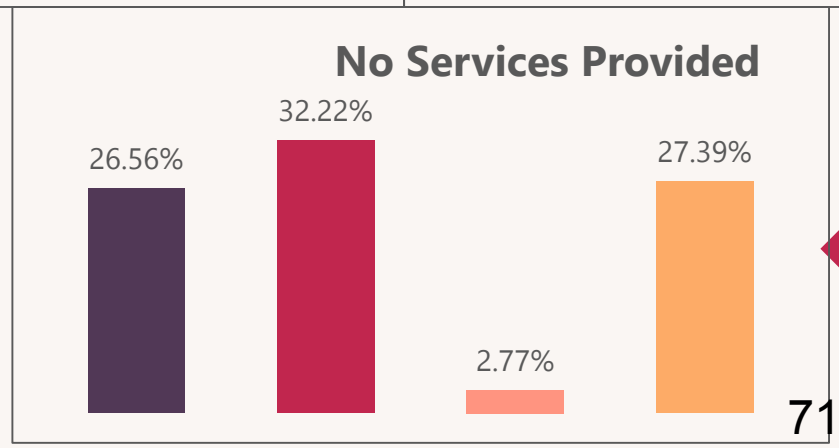
18 How does Norfolk compare for those aged 65+?

What this measures:
This looks at the percentage of people whose request for support resulted in each of the 6 types of sequel described on the previous page, compared against England, our family group and East England

SOURCE: SALT STS001b







England

Family Group

Norfolk

East England

What does this tell us?
When compared to the rest of England and our family group, Norfolk has very high levels of short term support but lower levels of long term support. This suggests that the short term support to maximise independence is working by reducing the need for long term support. Long term support has decreased since 2014/15, whilst short term support has increased.

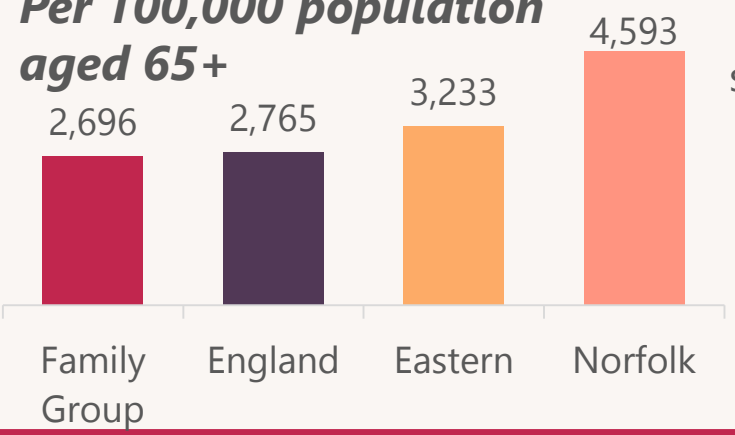
19 People in receipt of short term support aged 65+

Short Term Support are people who have a short period of reablement after leaving hospital to help them regain their independence, or are helped by an emergency intervention, such as assistance after pressing their community alarm.

What this measures: This measures the number of people aged 65+ receiving short term support per 100,000 population. The graph shows the percentage split across our family group between reablement and emergency intervention.

SOURCE: SALT STS001b

Per 100,000 population aged 65+



Per 100,000 population, short term support for those aged 65+ in Norfolk has increased by

21%

compared to 2014/15

What does this tell us?

Norfolk is the third highest in the family group and higher than all our comparator group averages for short term emergency intervention. This suggests we are providing large amounts of short term support compared to other councils. As with short term support for those ages 18-64, we are providing more short term support per 100,000 population compared to 2014/15.

England

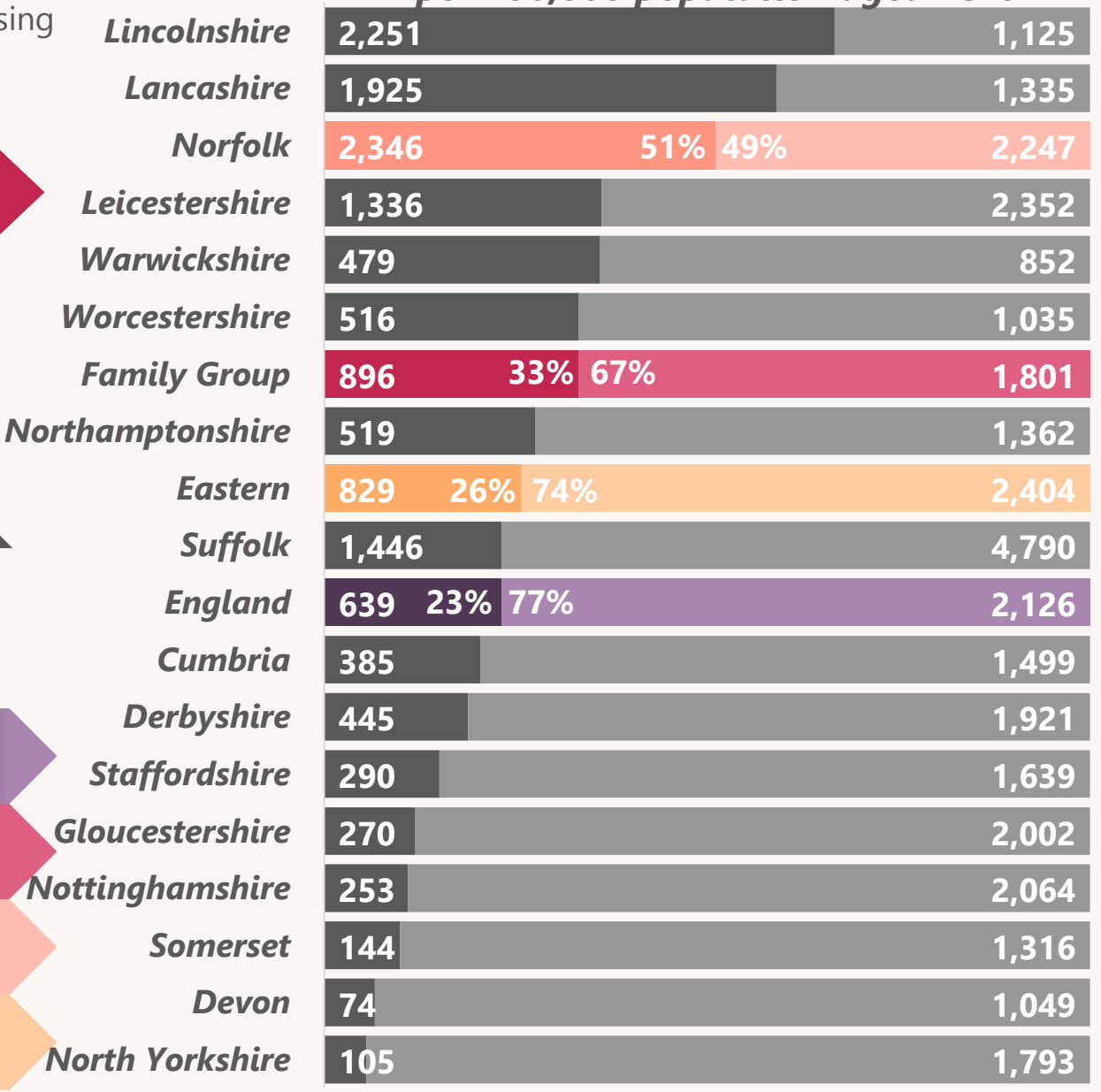
Family Group

Norfolk

East Englan

Emergency Intervention ***Reablement***

per 100,000 population aged 18-64



20 Referrals into short term care from hospital for those aged 65+

The national picture...

What does this tell us?

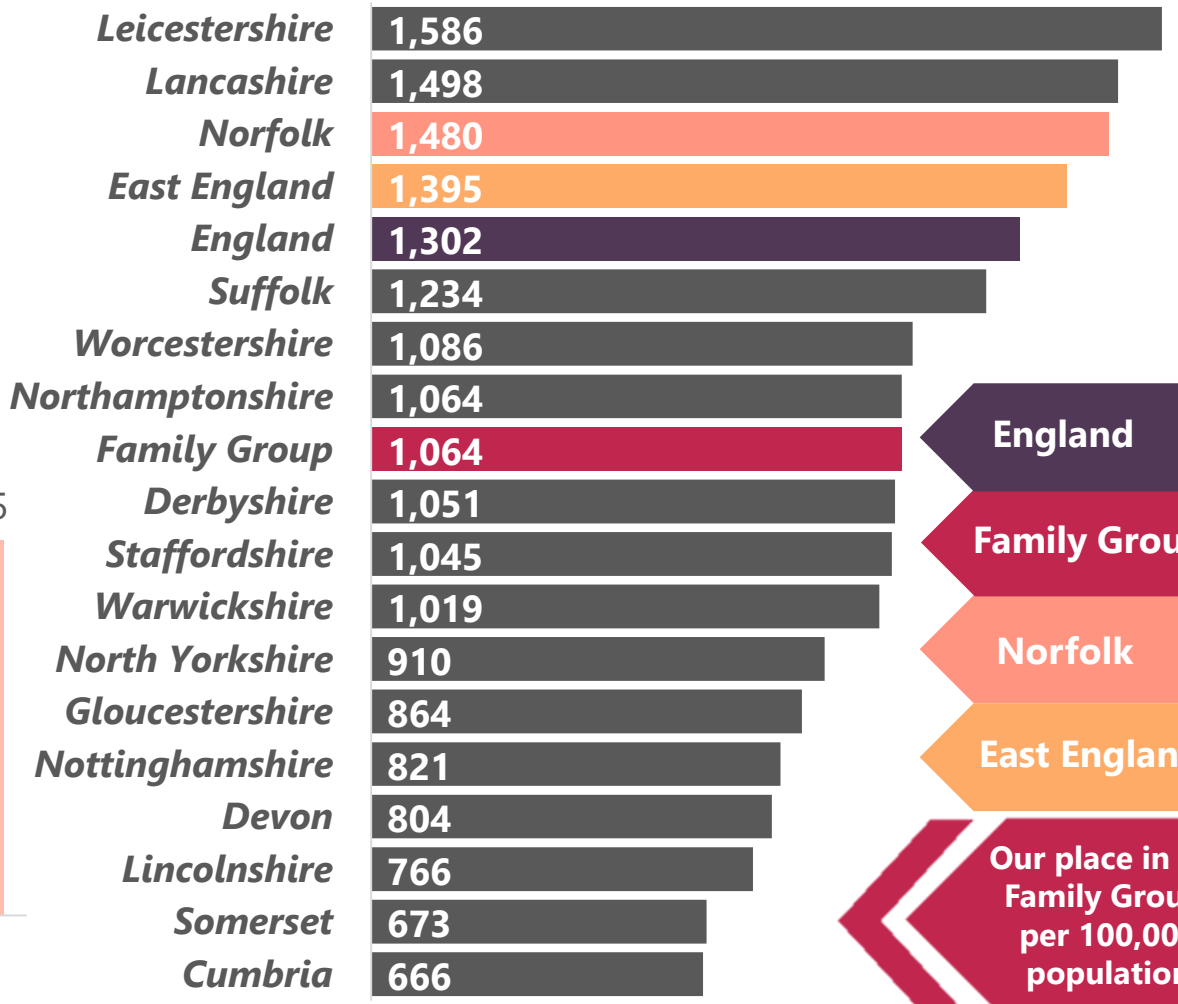
When compared to our family group, Norfolk's figures are quite high. However, looking nationally, our figures are around the mid-point.

SOURCE: SALT STS001b

What this measures:

The number of people aged 65+ being referred into short term social care from hospitals per 100,000 population aged 65+.

& our place in the family group

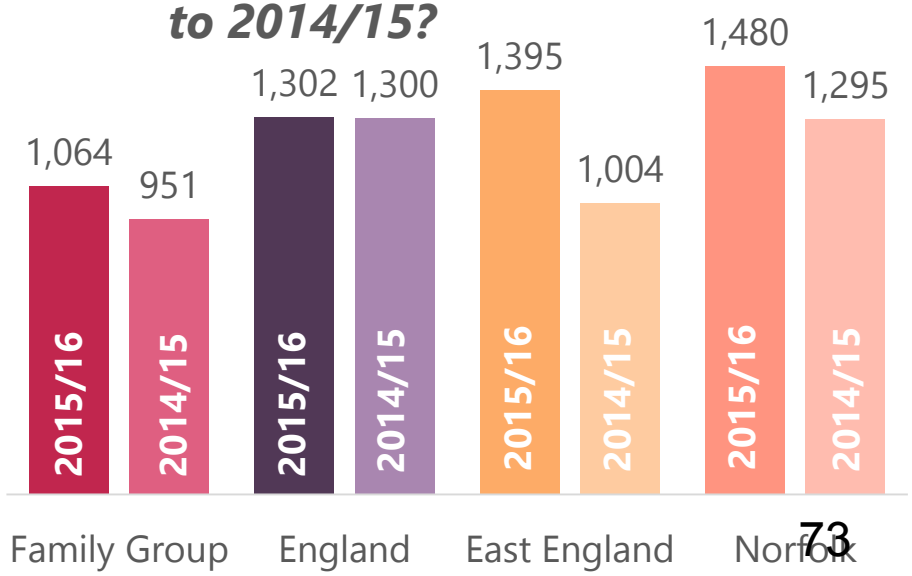


All four comparator groups have seen an increase of referrals into short term care from hospital. Norfolk's has risen by

14% ↑

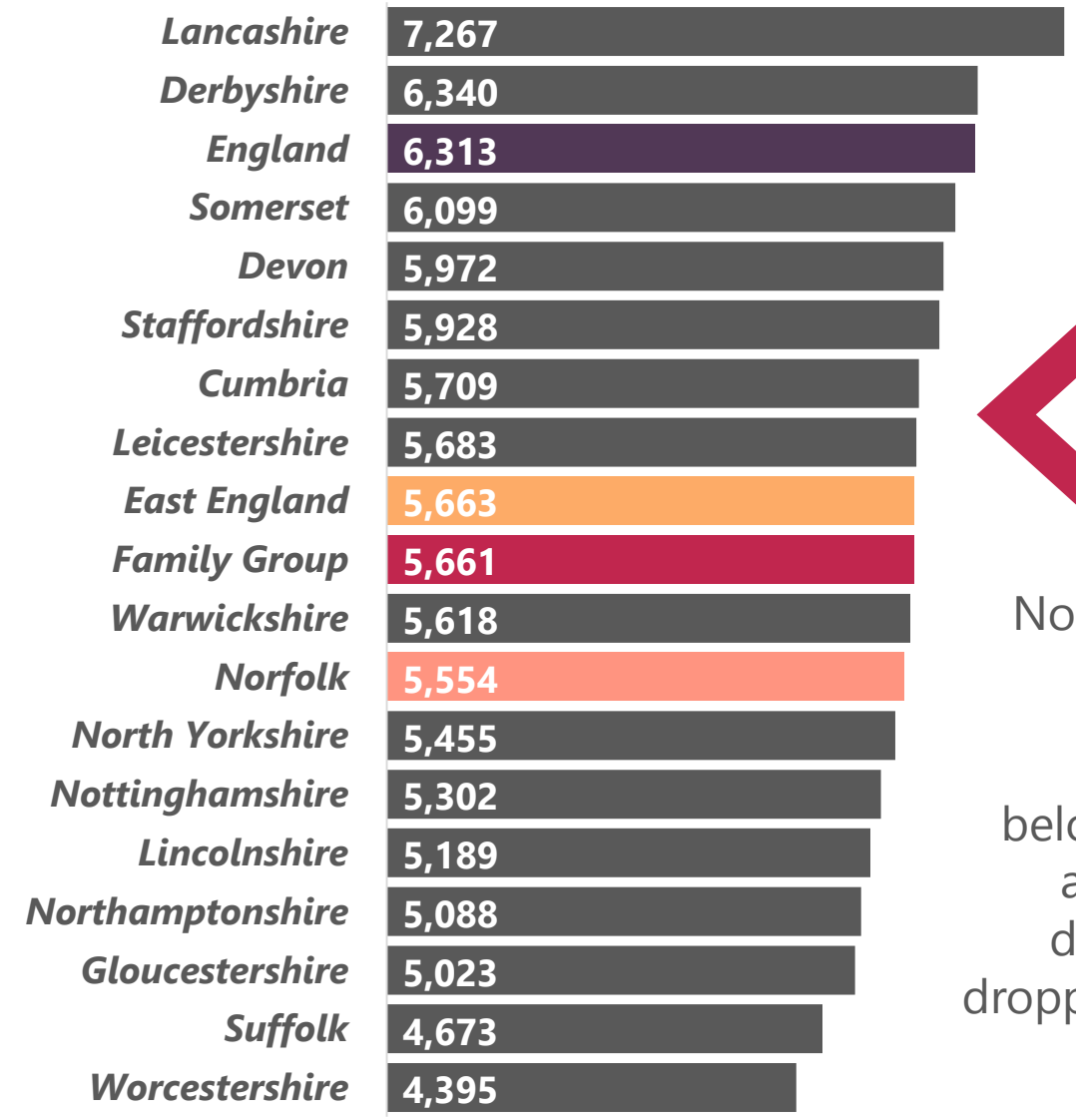
compared to 2014/15

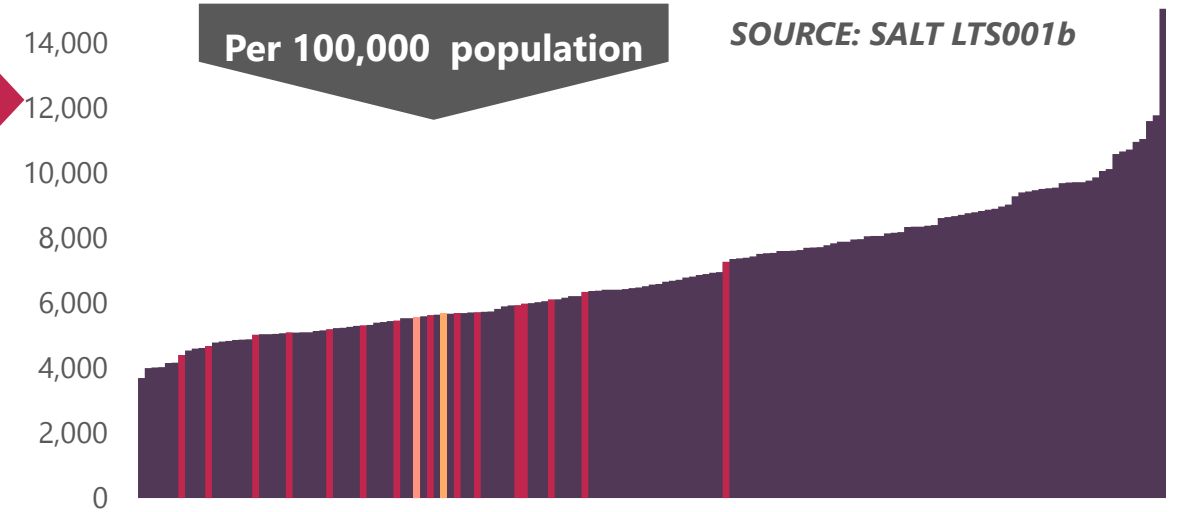
How does this compare to 2014/15?



21 People in receipt of long term support aged 65+

What this measures:
The number of people aged 65+ receiving long term support per 100,000 population aged 65+.





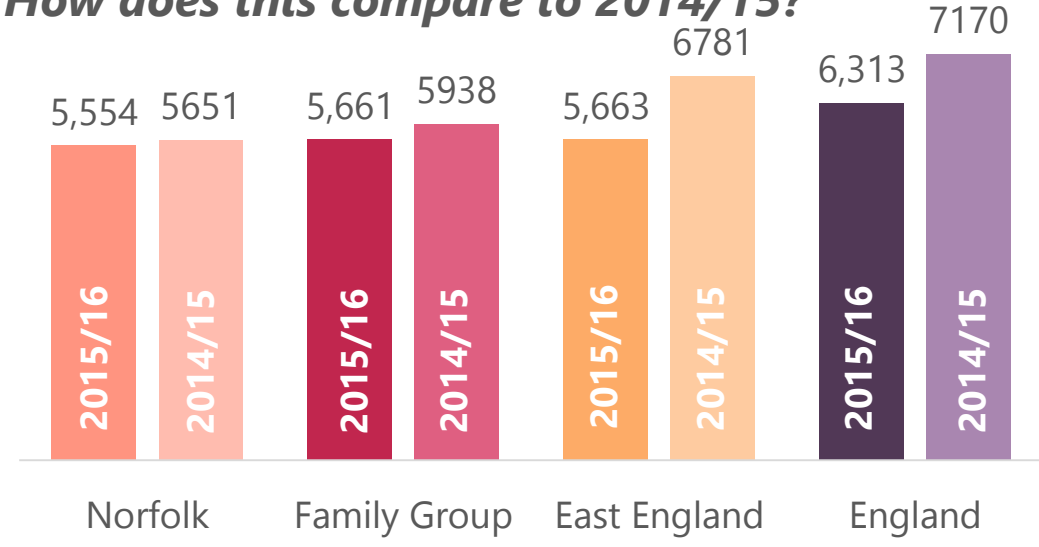
What does this tell us? Norfolk has moved from being the second highest in our family group, to now being eighth in our family group. This decrease suggests that the short term support to maximise independence is working by reducing the need for long term support.

Norfolk's figure is

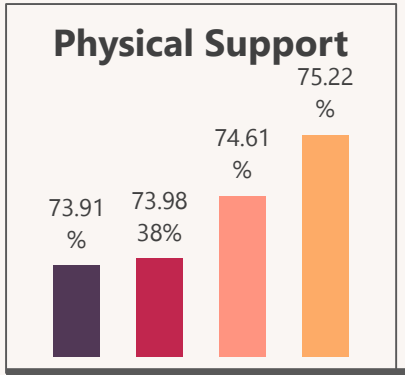
12%

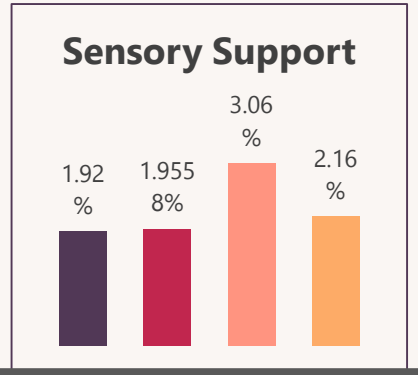
below the national average. This difference has dropped by 10% since 2014/15

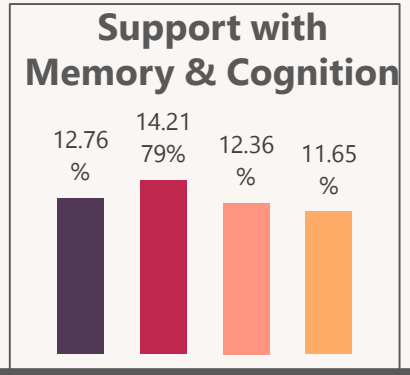
How does this compare to 2014/15?

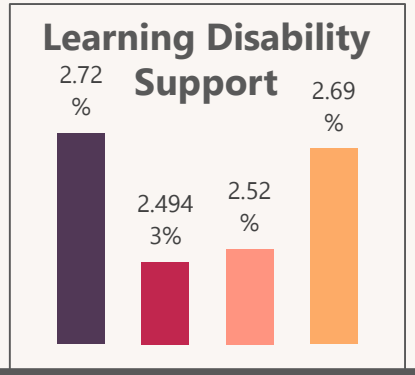


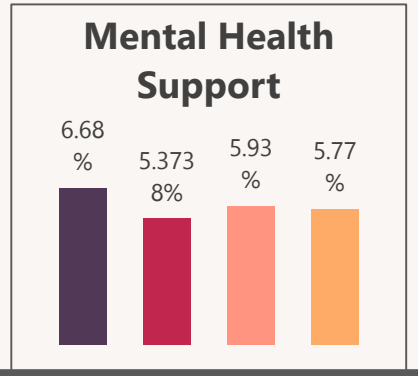
22 What do we mean by 'long term support' for those aged 65+?

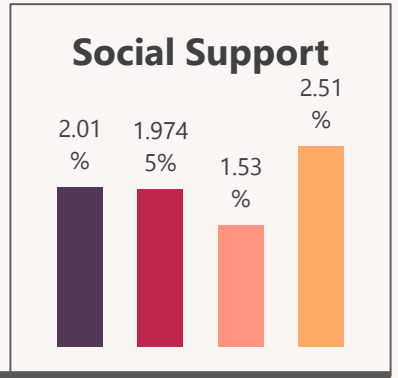












The breakdown of long term support in Norfolk

Physical Support 74.60%

Sensory Support 3.06%

Support with Memory & Cognition 12.36%

Learning Disability Support 2.52%

Mental Health Support 5.93%

Social Support 1.53%

Personal Care **56.31%**

Access & Mobility **18.29%**

Aged 65+

SOURCE: SALT LTS001b

Visual Impairment **2.02%**

Hearing Impairment **0.63%**

Dual Impairment **0.41%**

What does this measure?

The six bar charts show the main reason for support for people receiving long term support, and how we compare against our family group, the East of England and the rest of the country. The flow diagram shows Norfolk's figures for each classification of long term support.

What does this tell us?

Unlike the 18 – 64 age range, there is a marked difference. Norfolk supports more people with physical and mental needs than it does with social support. This is similar to figures from 2014/15.

Substance Misuse 0.18%

Asylum Seeker Support 0%

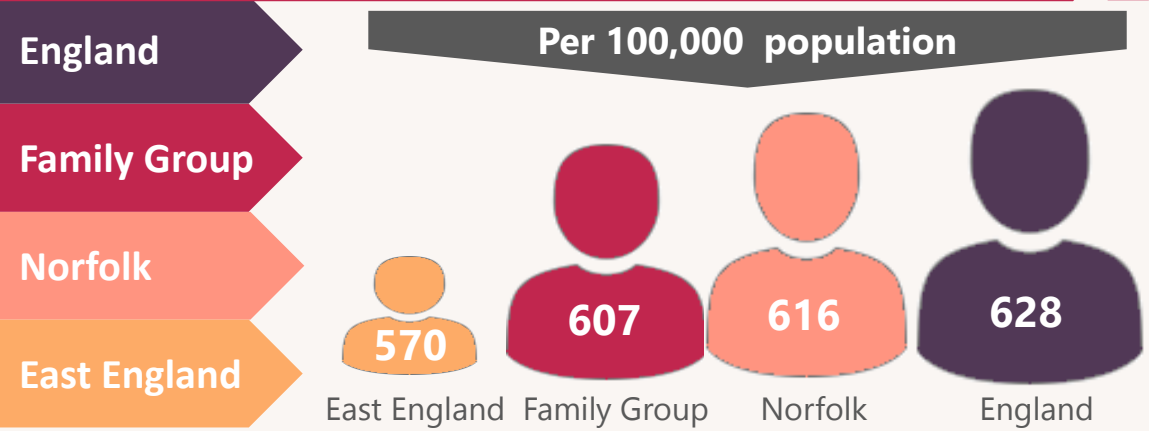
Social Isolation/ Other 1.35%

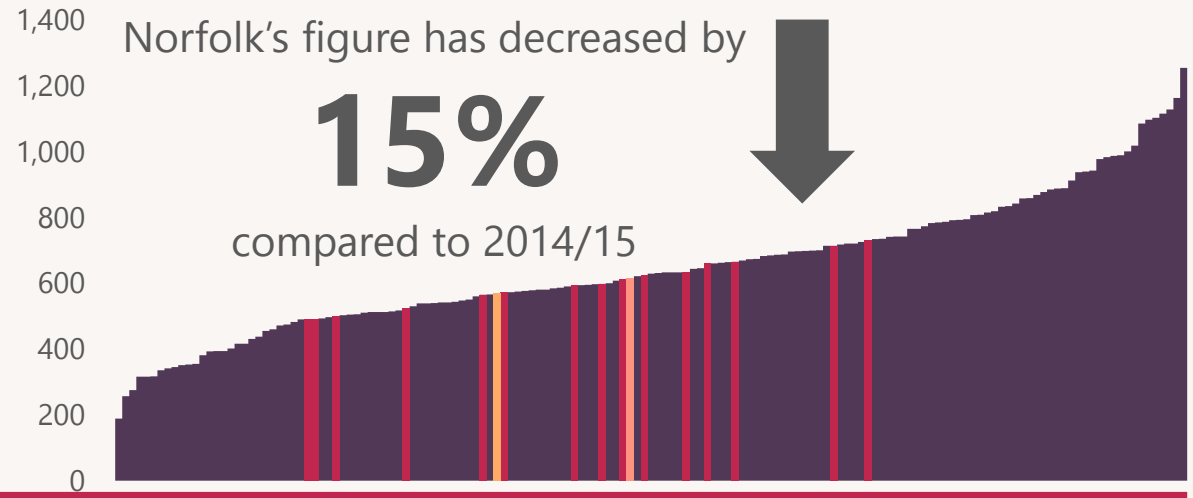
England → **Family Group** → **Norfolk** → **East England**

**Key just for reference to bar charts, not flow diagram.*

23 People admitted to permanent residential or nursing care

What this measures:
The number of people aged 65+ being permanently admitted to residential or nursing care per 100,000 population aged 65+.





What does this tell us?
Norfolk's rate is still high, despite a continued decrease from 2013/14. We are the closest we have been to our family group since 2013/14.

SOURCE: ASCOF 2A(2)

Our place in the family group and how this has changed over time

	2013/14	2014/15	2015/16
Gloucestershire	800	710	665
Lancashire	796	794	715
Norfolk	777	724	616
Northamptonshire	750	545	491
Leicestershire	731	734	594
Derbyshire	716	751	731
Family Group Total	656	640	607
Staffordshire	655	669	625
Lincolnshire	654	600	614
England	651	696	628
Eastern Total	649	566	570
Nottinghamshire	632	724	599
Suffolk	628	123	661
Worcestershire	609	638	635
Cumbria	594	0	491
Somerset	572	771	566
Devon	541	616	501
Warwickshire	539	504	573
North Yorkshire	511	695	525

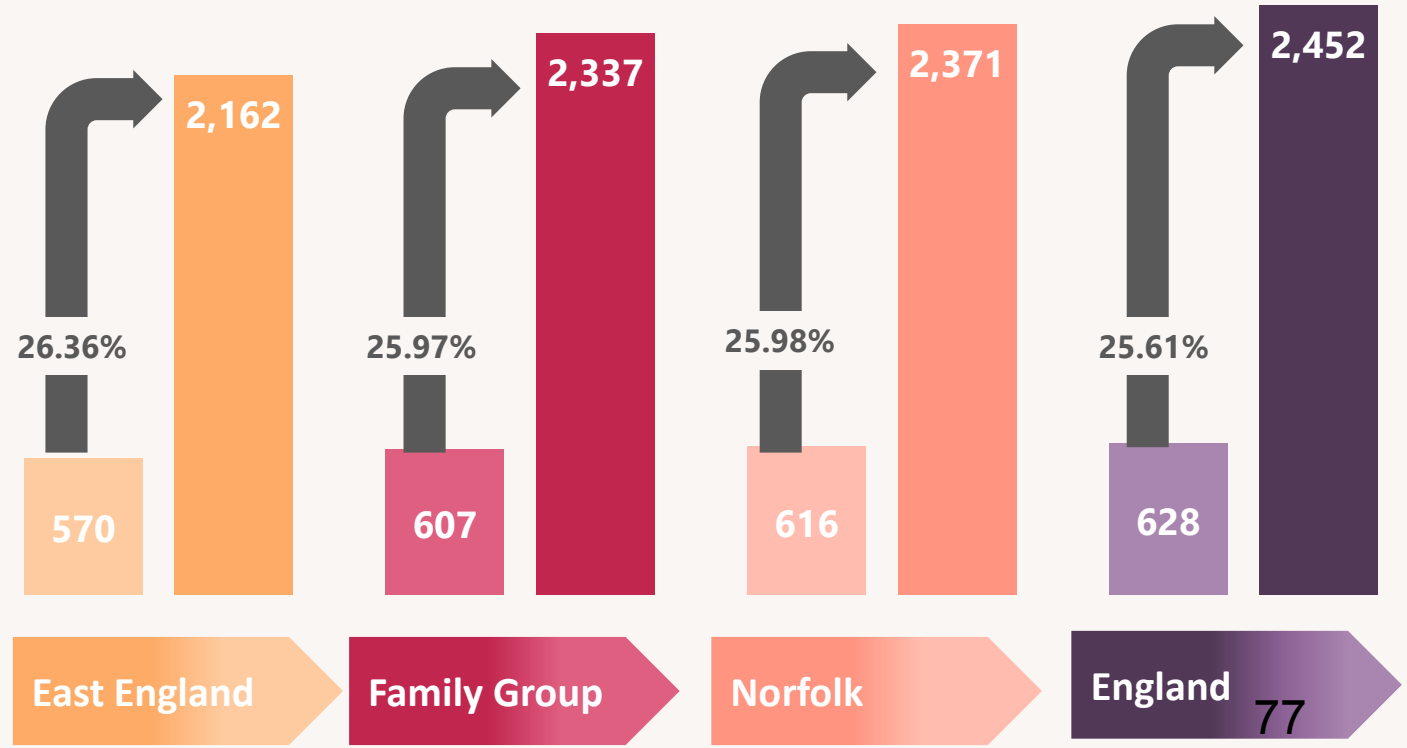
For 2014/15 Cumbria did not provided any results to they have not been included in the family group average.

24 Residential Admissions compared to those already in receipt of care

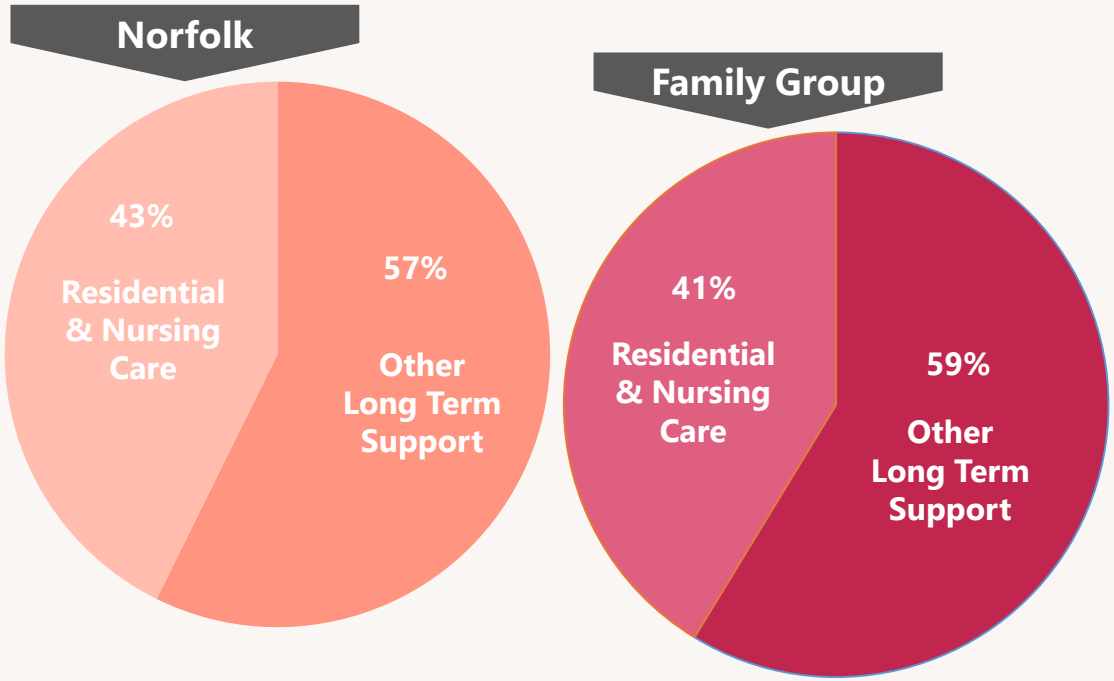
What this measures:
This compares the number of people aged 65+ being permanently admitted to residential or nursing care (per 100,000 population) in year, against the number of people aged 65+, who were in receipt of residential or nursing care per 100,000 population.

Per 100,000 population

The larger of the two numbers for each comparator groups is people aged 65+ in receipt of residential or nursing care, whilst the smaller figure is those admitted to residential or nursing care within the year. The percentage figure is what percentage the admissions are of those already in receipt of service.



What % of Long Term Support is Residential and Nursing Care?



What do we mean by 'Other Long Term Support'?

Other long term support includes direct payments, part direct payments, personal budgets and other commissioned support.

What does this tell us?
As expected, unlike the 18-64 age range, the split between residential and other long term support is more equal. Norfolk's figures are slightly above our family group figures, however Norfolk is still below the national figures per 100,000, however the percentage split is higher.

SOURCE: Residential Admissions ASCOF 2A (2) & People in receipt of long term care SALT LTS001b

25 Effectiveness of reablement for those aged 65+

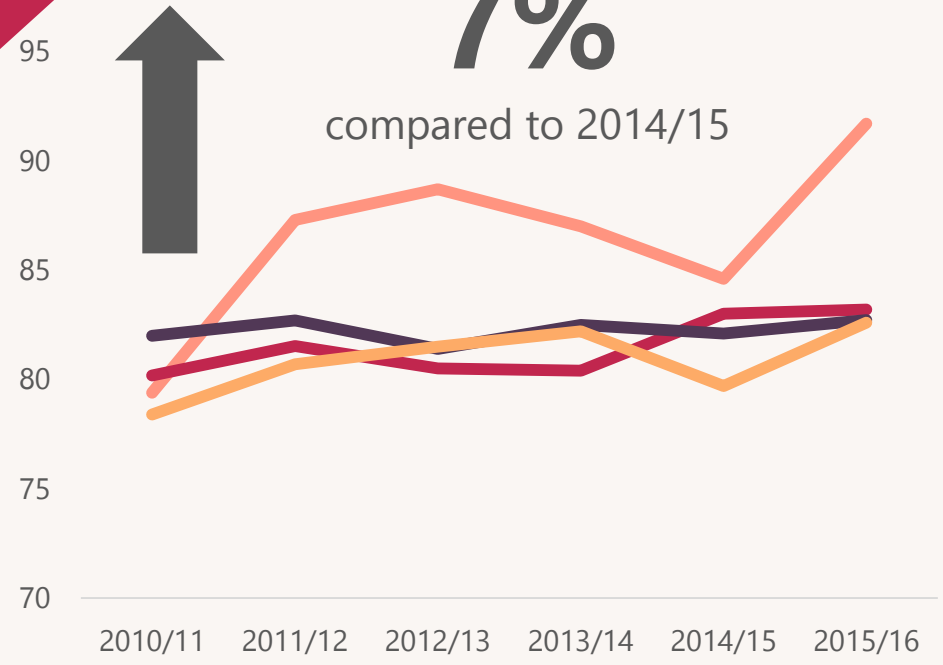
What this measures:
This measures the percentage of people still at home 91 days after discharge. It measures the effectiveness of our reablement services.

How has this changed over time?

Norfolk's figure has increased by

7%

compared to 2014/15



England

Family Group

Norfolk

East England

Our place in the family group by % of people still at home 91 days after discharge:

Norfolk	91.70%
Somerset	91.40%
Nottinghamshire	91.30%
Staffordshire	87.80%
Worcestershire	87.70%
Leicestershire	87.50%
Devon	87.10%
Cumbria	85.60%
Warwickshire	84.00%
Family Group Total	83.20%
Lancashire	83.20%
England Total	82.71%
Eastern Total	82.60%
North Yorkshire	82.50%
Gloucestershire	81.40%
Suffolk	77.80%
Derbyshire	77.00%
Lincolnshire	76.00%
Northamptonshire	72.90%

What does this tell us?
Norfolk has the highest percentage of people that are still at home 91 days after discharge. Norfolk has gone from just above average for this measure, to significantly above the national average for this measure.

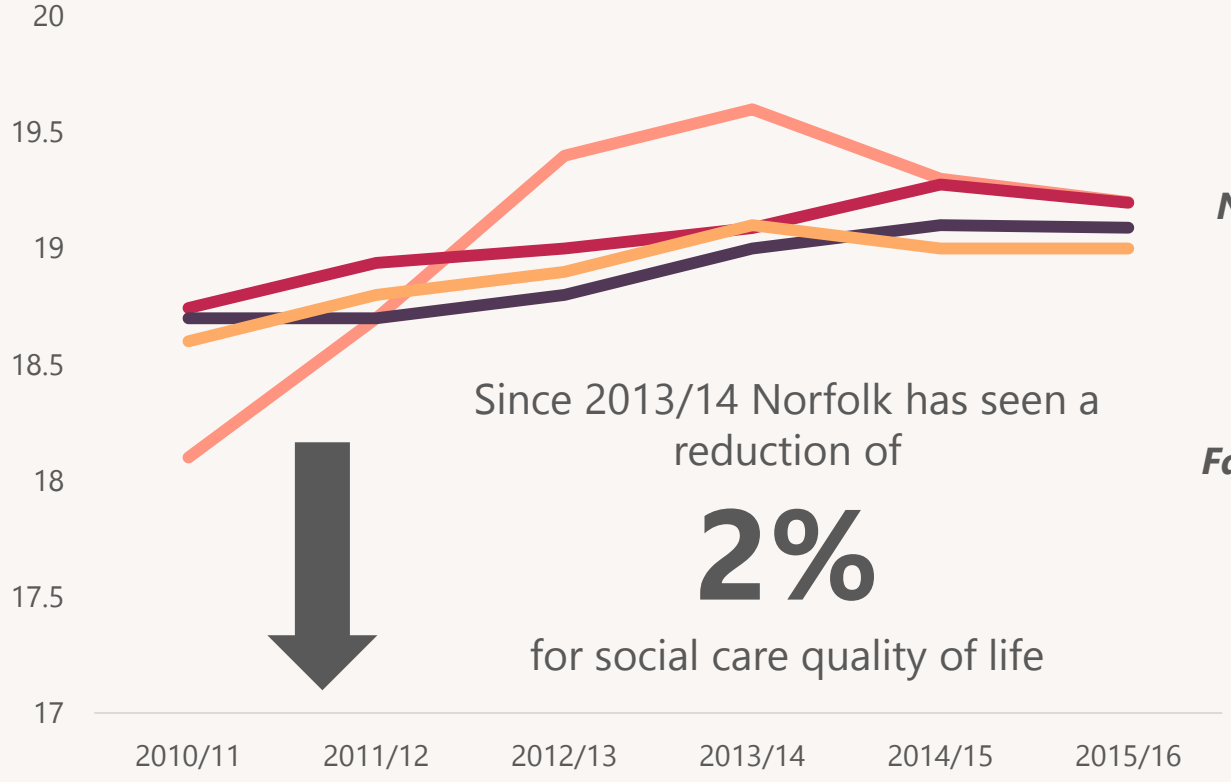
SOURCE: ASCOF 2B(1)

Enhancing Quality of Life for people with Care and support needs

'People are able to find employment when they want, maintain a family and social life and contribute to community life'

27 Social Care related quality of life

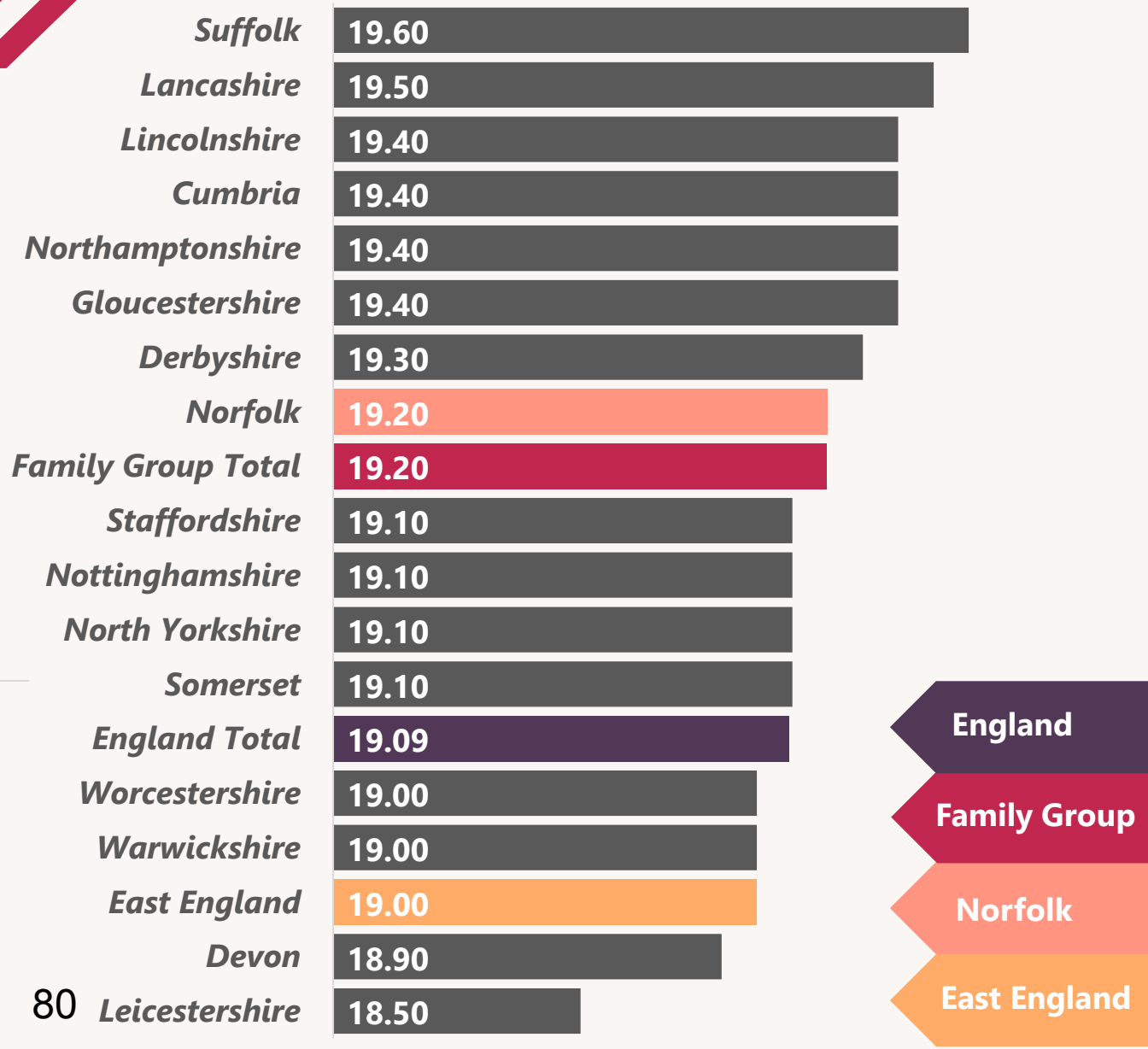
What this measures:
This measures the average score for social care-related quality of life. This is taken from the annual Adult Social Care Survey.



What does this tell us?
Norfolk is above the national average for this indicator, however our figures have dropped down to the same as our family group average. The national average has also seen a slight reduction, whilst our family group and the East of England have all seen an increase in satisfaction.

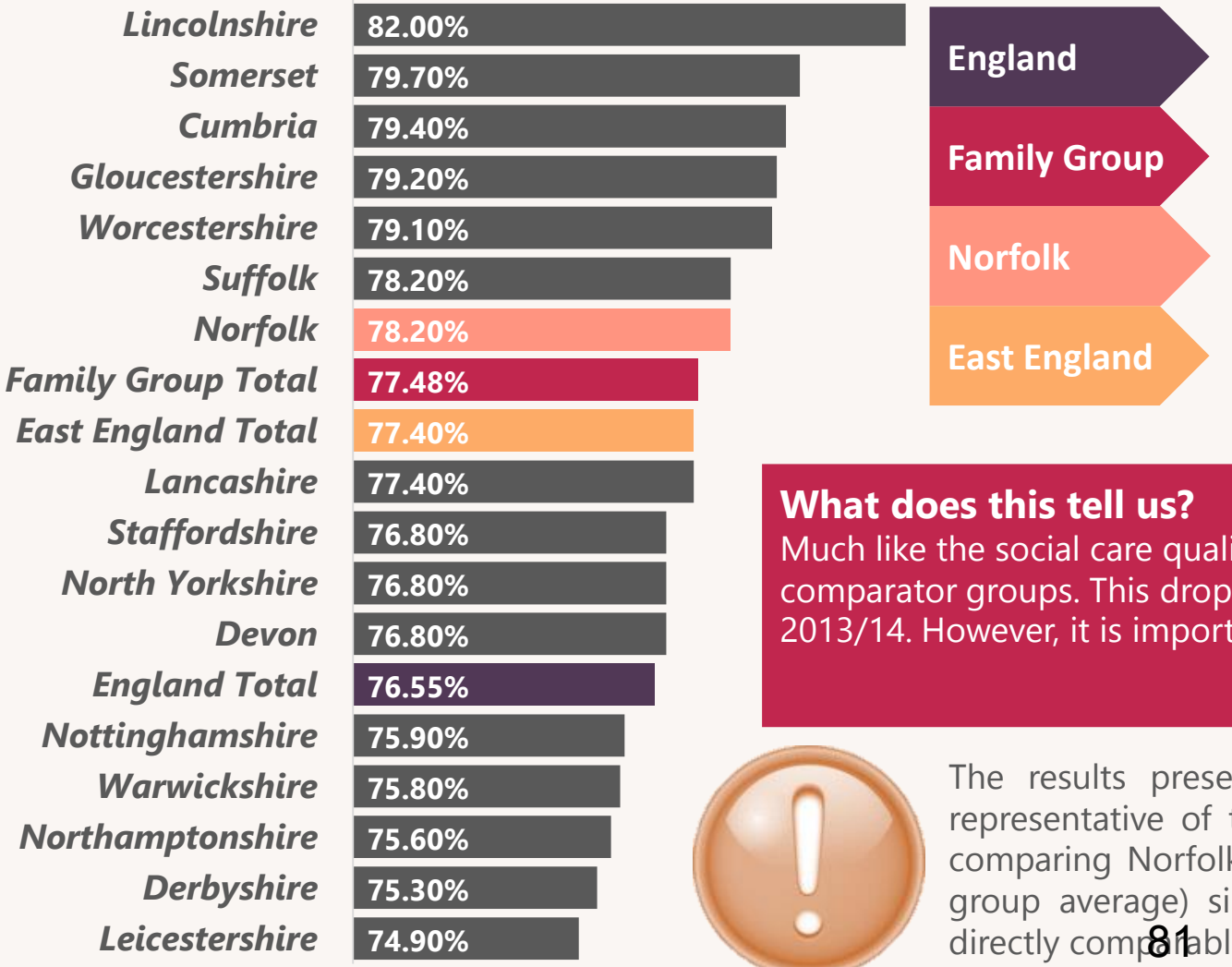
SOURCE: ASCOF 1A

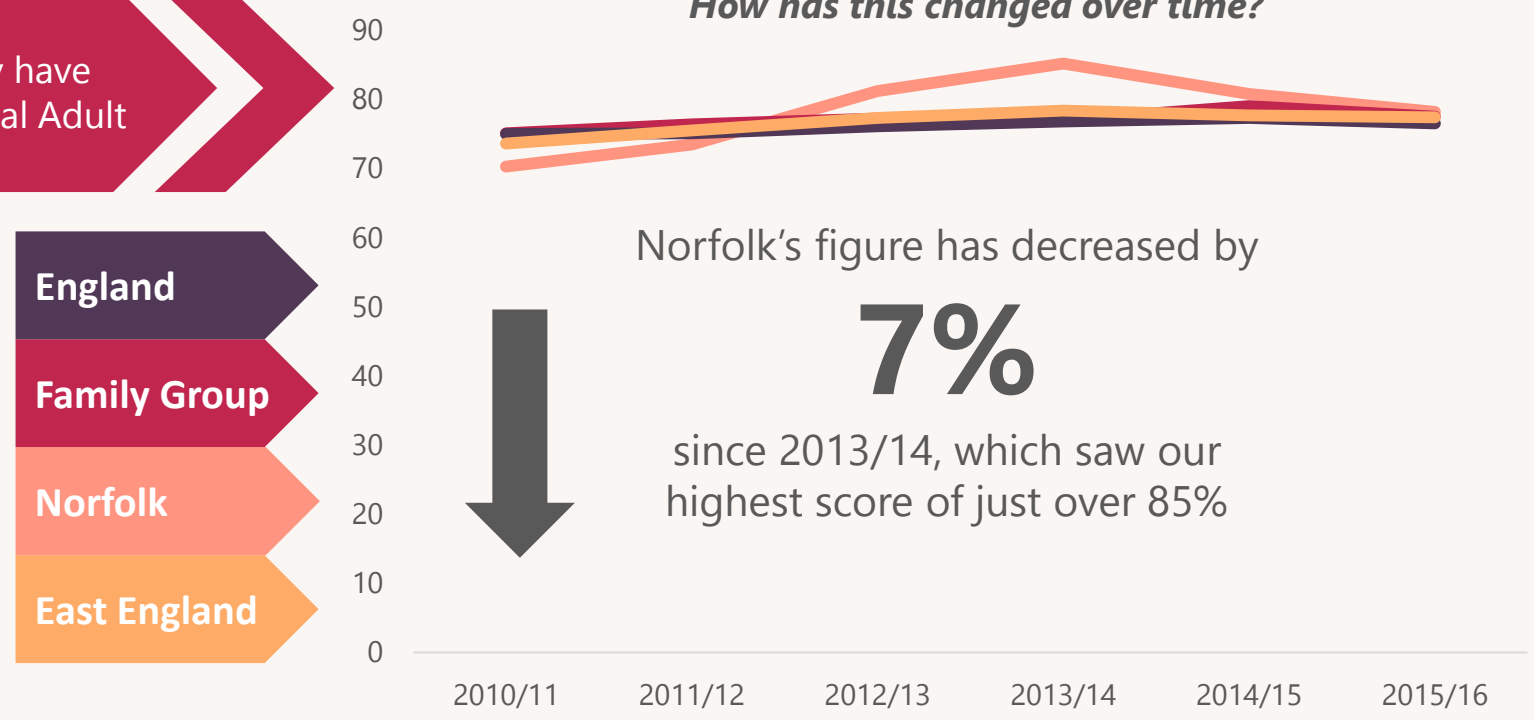
Our place in the family group for social care quality of life



28 People using services who have control over their daily life

What this measures:
This measures the % of people using services who feel they have control over their daily life. This is also taken from the annual Adult Social Care Survey.





How has this changed over time?

Norfolk's figure has decreased by

7%

since 2013/14, which saw our highest score of just over 85%

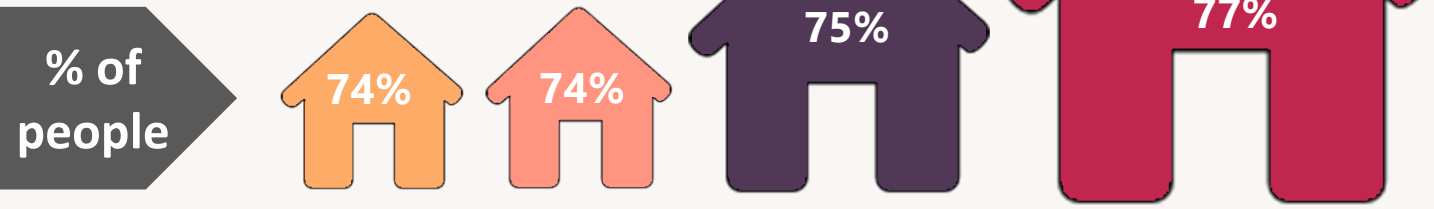
What does this tell us?
Much like the social care quality of life indicator, Norfolk has dropped down and is now just above our comparator groups. This drop is significant when you look back to our highest score of 85% in 2013/14. However, it is important to note we are still above the national average for this indicator.

SOURCE: ASCOF 1B

The results presented here have been weighted to make the survey results more representative of total local populations. This means that caution must be taken when comparing Norfolk's performance with the results from other areas (and with the family group average) since variations in population characteristics mean our results are not directly comparable with anything but our own historic performance.

29 People with learning disabilities living in their own home or with family

What this measures:
This measures the % of people with learning difficulties living in their own home or with family.

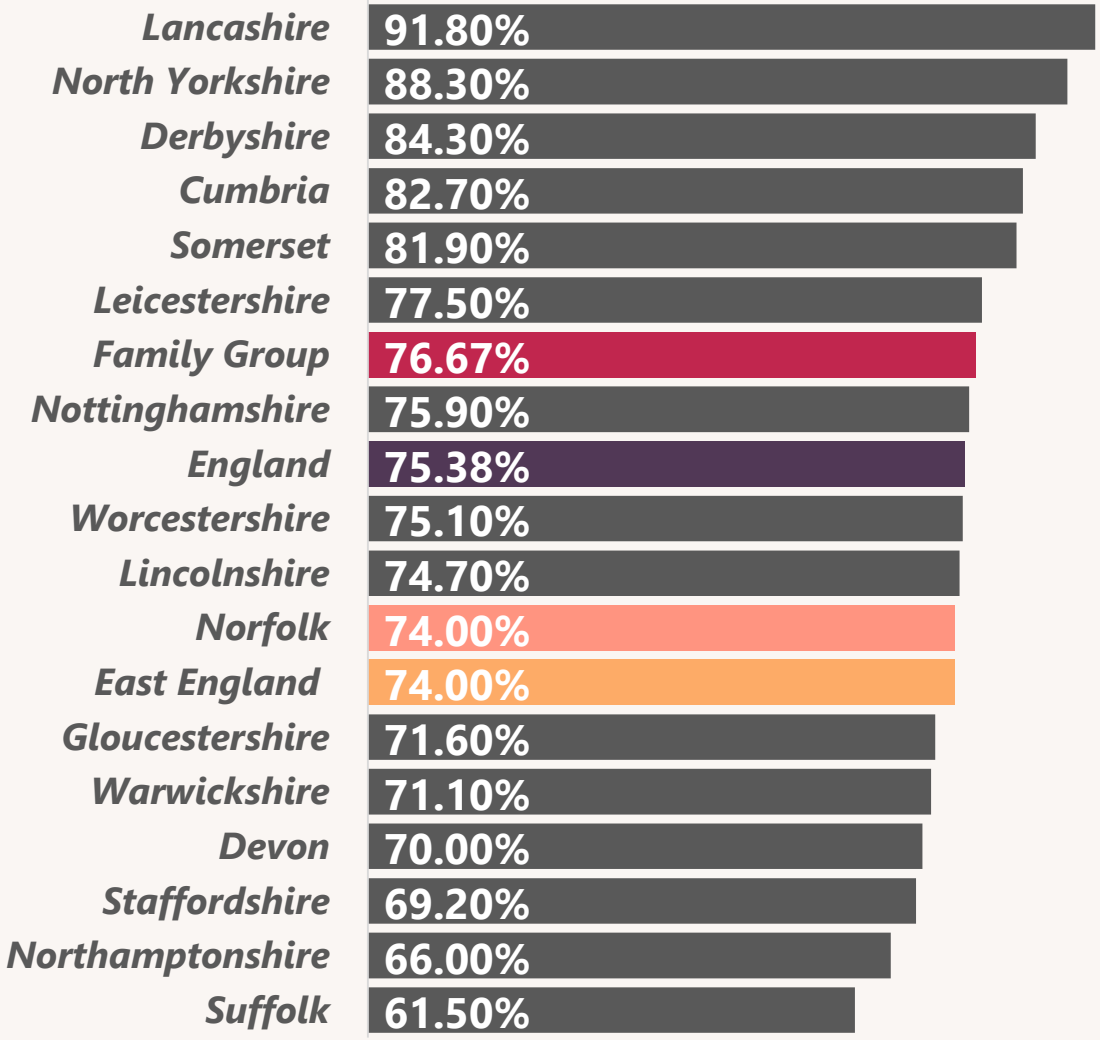


	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
England	59	70	73.5	74.9	73.3	75.4 ↑
Family Group	56.9	66.9	73.9	75.3	73.9	76.7 ↑
Norfolk	70.2	71.9	72.1	73.4	74.20	74.0 ↓
East England	54.5	66.3	73.1	73.9	69.2	74.0 ↓

What does this tell us?
For the first time in six years, Norfolk has seen a reduction in figures. However, this is a slight reduction of 0.20%. This feels significant because both nationally and within our family group the figures have increased, so our ranking has decreased.

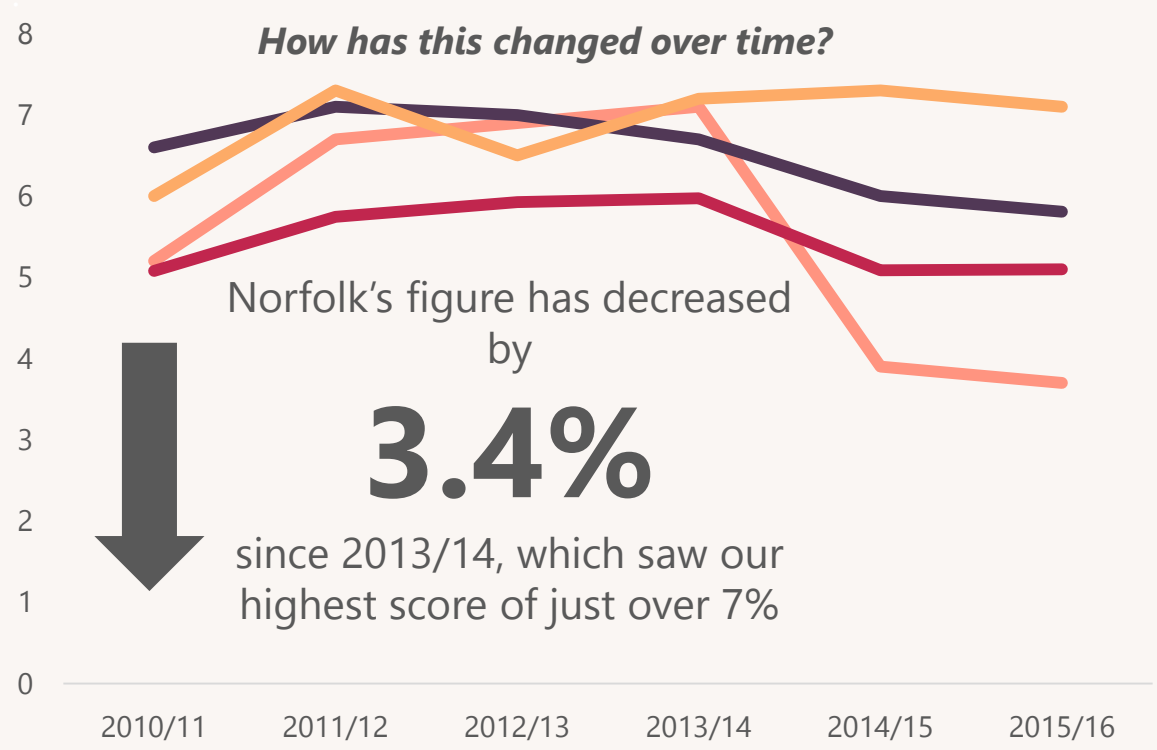
SOURCE: ASCOF 1G

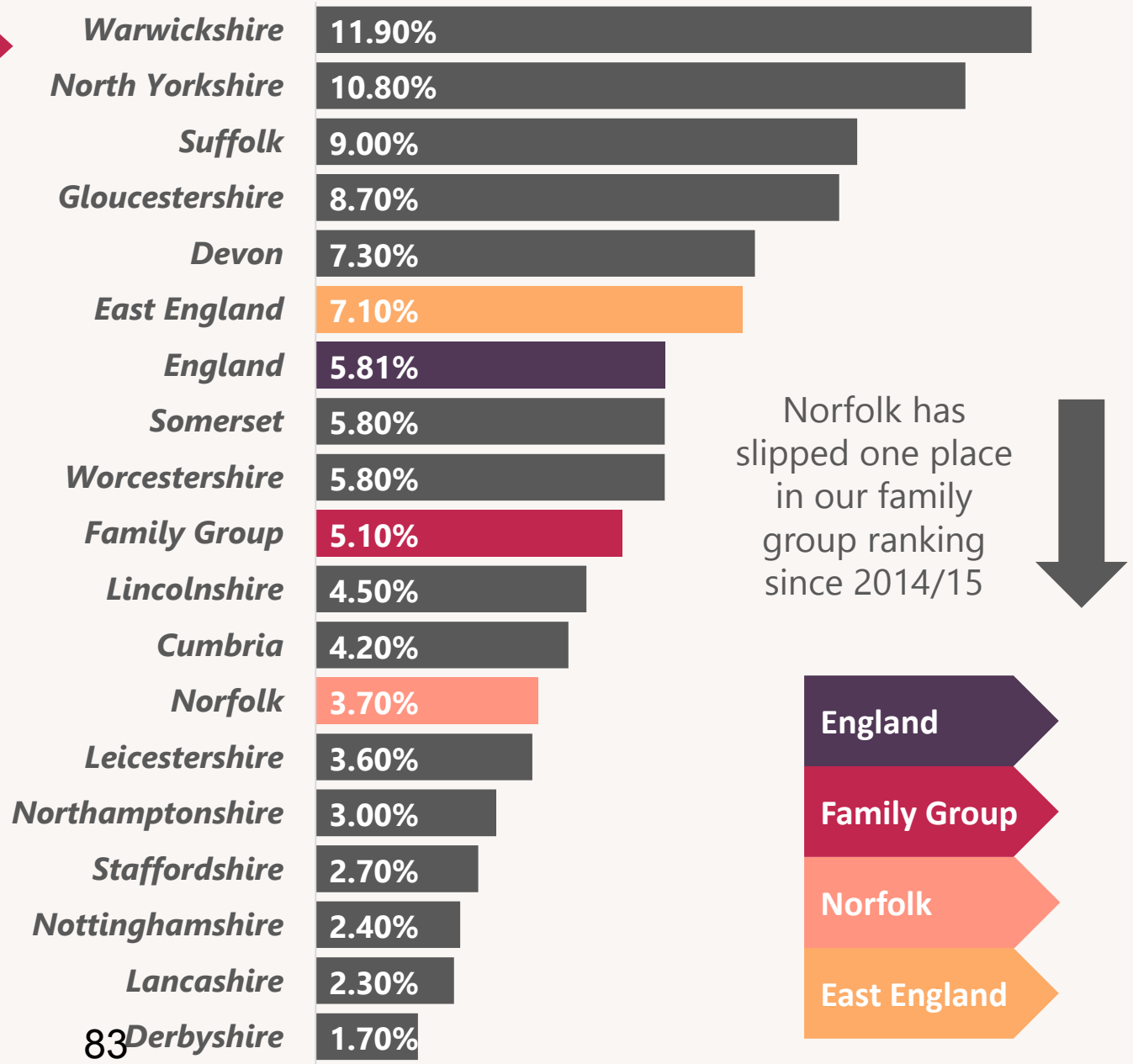
Even though Norfolk has only had a **0.20%** reduction since 2014/15, we have dropped from **7th place** in our family group to **12th place.**



30 People with Learning Disabilities in paid employment

What this measures:
This measures the % of people with learning disabilities who are in paid employment.





What does this tell us?
For the second year in a row, Norfolk's figures for this indicator have fallen. Although the figure is not as significant as 2014/15, when combined together the decrease over two years is a significant 3.4%. Norfolk, is one of five within our family group to see a decrease in this figure since 2014/15.

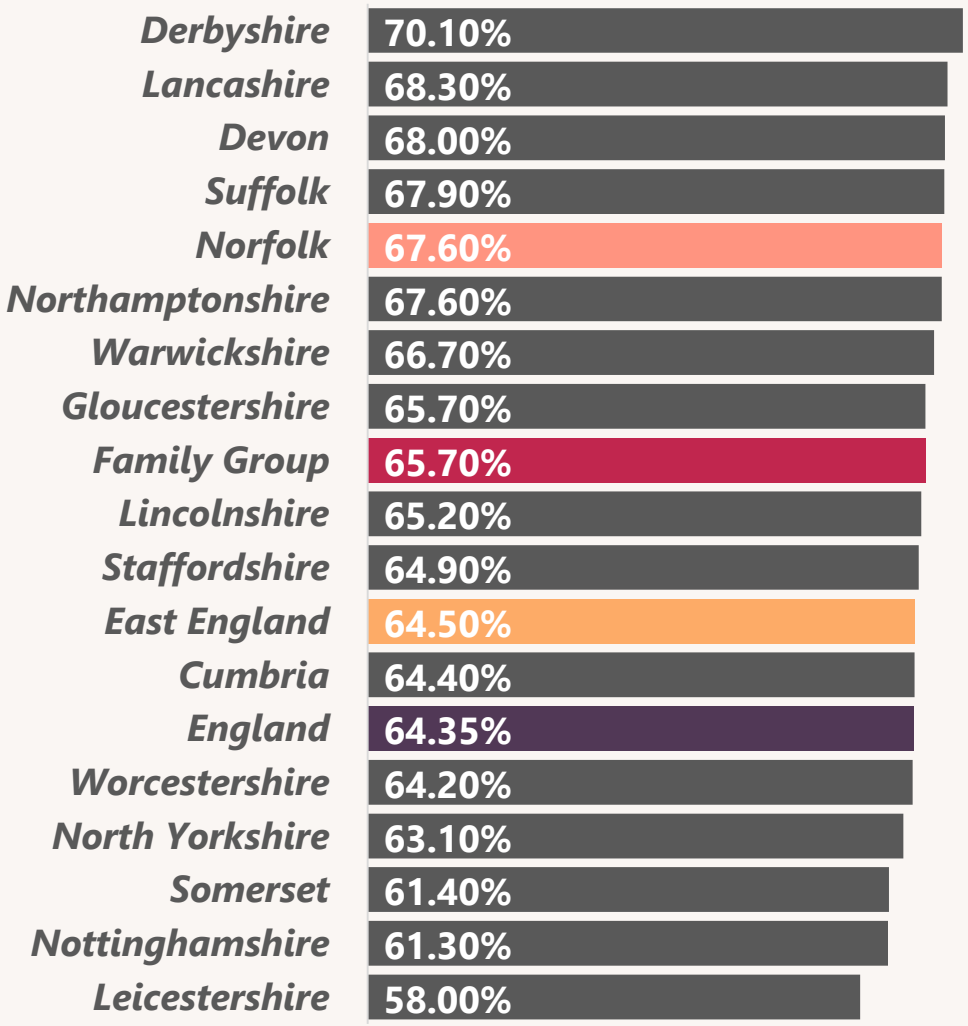
SOURCE: ASCOF 1E

31 Overall satisfaction of people who use services with their care and support

What this measures:
This measures the overall satisfaction of people who use services with their care and support.

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
England	62.1	62.8	64.1	64.8	64.7	64.4 ↓
Family Group	63.2	63.6	65.8	65.9	66.5	64.5 ↓
Norfolk	55.1	60.8	68.7	70.1	66.9	65.7 ↓
East England	58.7	60.5	62.3	65.6	63.6	67.6 ↑

Even though Norfolk has only had a **0.70%** reduction since 2014/15, **we have moved** from **8th** to **5th** position in our family group.



What does this tell us?
Norfolk's figures follow both the national trend and the trend within our own family group, of a decrease in satisfaction. The East of England as a whole has seen as an increase in satisfaction. This data was also taken from the Adult Social Care Survey so caution must be taken when looking at this data.

SOURCE: ASCOF 3A

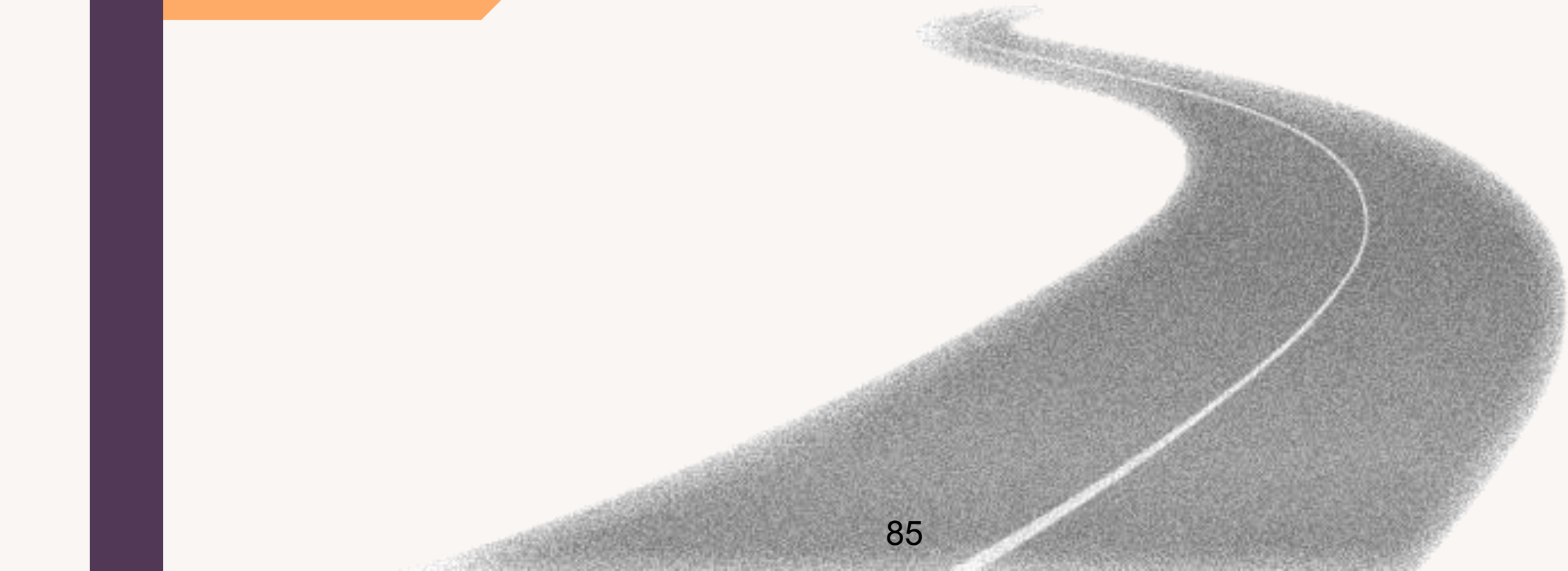
Safeguarding

those who are

vulnerable from

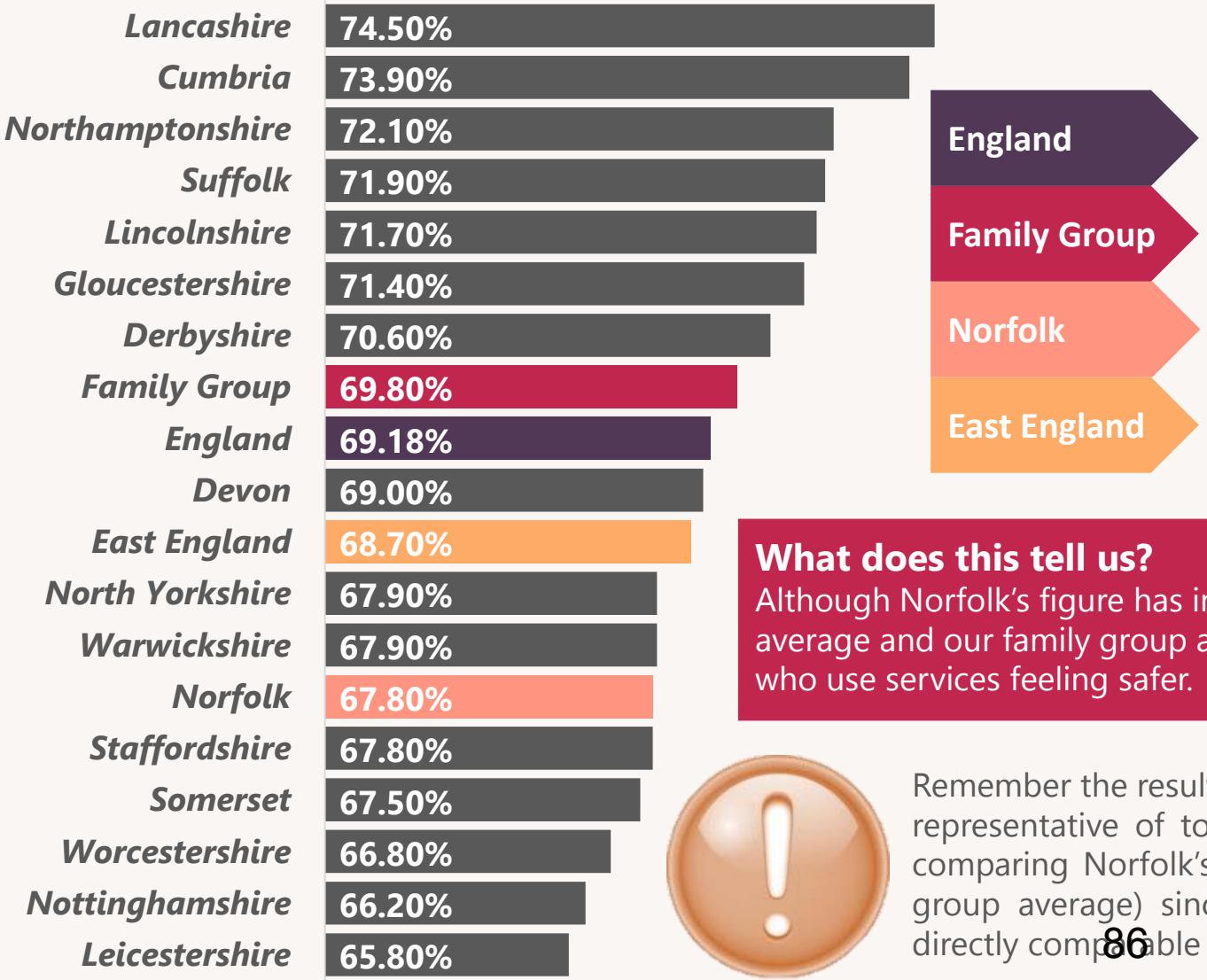
abuse or harm

'Everyone enjoys physical safety and feels secure'

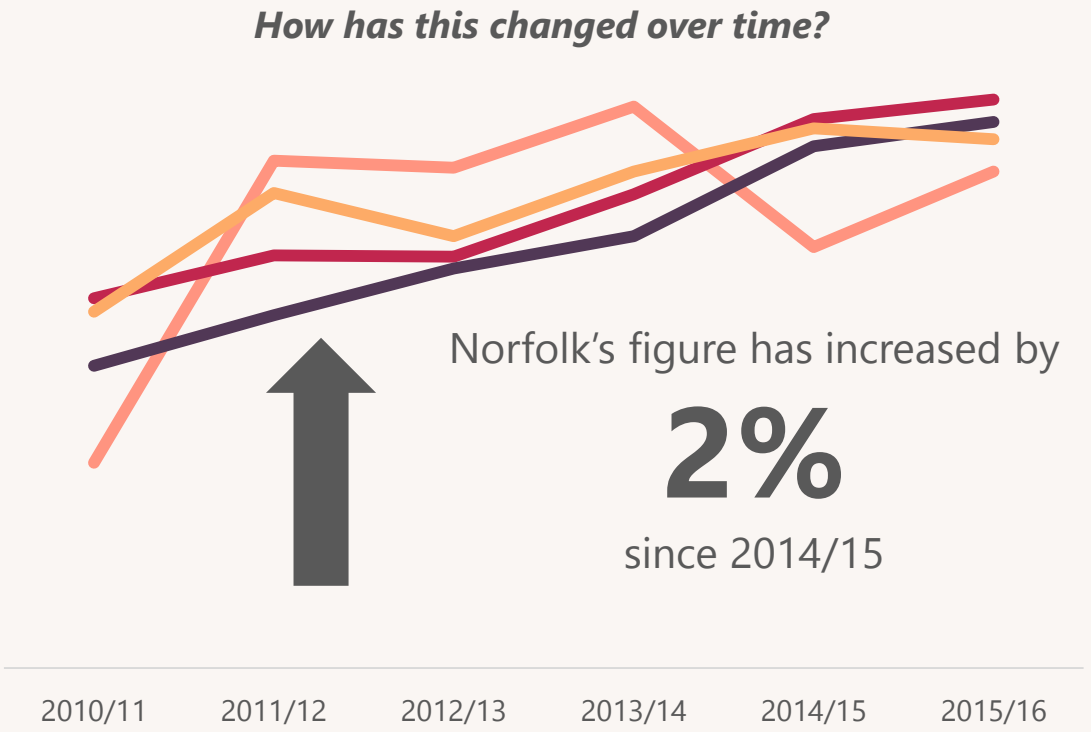


33 People who use services who feel safe

What this measures:
This measures the % of people who use services who say that they feel safe.



How has this changed over time?



Norfolk's figure has increased by

2%

since 2014/15

What does this tell us?
Although Norfolk's figure has increased since 2014/15, it is still significantly below the national average and our family group average. Our family group has followed the national trend of people who use services feeling safer.

SOURCE: ASCOF 4A

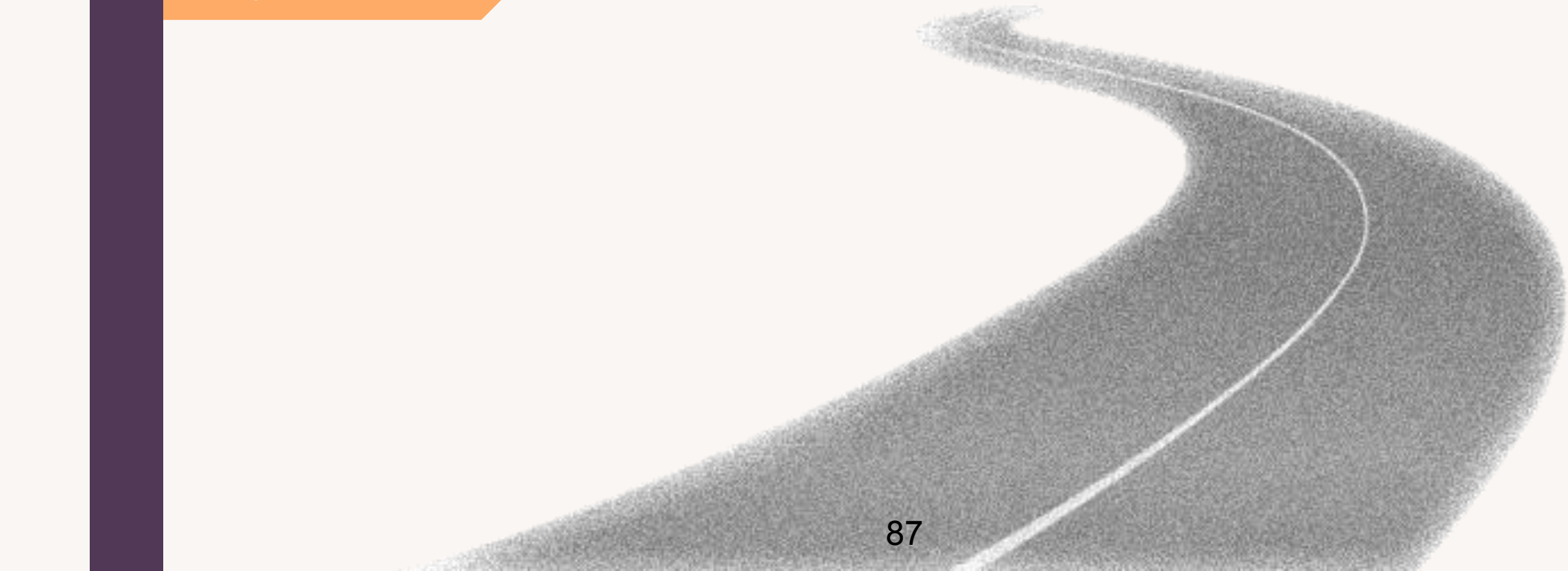
Remember the results presented here have been weighted to make the survey results more representative of total local populations. This means that caution must be taken when comparing Norfolk's performance with the results from other areas (and with the family group average) since variations in population characteristics mean our results are not directly comparable with anything but our own historic performance.

ASCOF

Summary

Tables

2015/16



35 ASCOF Summary Table

What this measures:
This table summarises Norfolk's ASCOF scores for 2015/16, and how this compares to the previous year. It also shows how Norfolk compares to the Family Group average and our ranking within the Family Group. 1 is the best and 16 is the worst.

			2015/16	2014/15	Family Group Average	Ranking 1= Best 16 = Worst
Enhancing quality of life for people with care and support needs						
1A	Social care-related quality of life score	▼	19.20	19.30	19.19	8
1B	The proportion of people who use services who have control over their daily life	▼	78.20	80.80	77.57	6
1C (1A)	The proportion of people who use services who receive self-directed support	▼	88.20	88.70	85.25	10
1C (1B)	The proportion of carers who receive self-directed support	▲	88.10	72.60	70.72	8
1C (2A)	The proportion of people who use services who receive direct payments	▼	33.00	34.80	30.27	4
1C (2B)	The proportion of carers who receive direct payments	▲	87.70	43.50	64.45	7
1E	The proportion of adults with a learning disability in paid employment	▼	3.70	3.90	5.46	10
1F	The proportion of adults in contact with secondary mental health services in paid employment	▲	5.40	3.90	18.36	15
1G	The proportion of adults with a learning disability who live in their own home or with their family	▼	74.00	74.20	75.98	10
1H	The proportion of adults in contact with secondary mental health services living independently, with or without support	▼	36.30	62.30	58.86	3
1I (1)	The proportion of people who use services who reported that they had as much social contact as they would like	▼	47.50	48.70	45.14	3
Delaying and reducing the need for care and support						
2A (1)	Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 population	▼	17.50	30.70	12.58	14
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 population	▼	616.40	707.00	600.01	10
2B(1)	The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	▲	91.70	84.60	84.06	1
2B (2)	The proportion of older people (aged 65 and over) who received reablement/rehabilitation services after discharge from hospital	▼	2.10	2.70	2.44	10
2C(1)	Delayed transfers of care from hospital, per 100,000 population	▲	21.70	10.50	28.56	6
2C(2)	Delayed transfers of care from hospital that are attributable to adult social care, per 100,000 population	▲	3.00	1.60	11.24	2
2D	The outcome of short-term services: sequel to service	▼	73.90	82.50	75.24	8
Ensuring that people have a positive experience of care and support						
3A	Overall satisfaction of people who use services with their care and support	▲	67.60	66.90	65.28	5
3D (1)	The proportion of people who use services who find it easy to find information about support	▼	71.20	74.80	72.96	10
Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm						
4A	The proportion of people who use services who feel safe	▲	67.80	65.70	69.55	11
4B	The proportion of people who use services who say that those services have made them feel safe and secure	▼	81.00	83.40	87.66	15

Adult Social Care Benchmarking Report 2015/16

Report produced by Business Intelligence

3rd Floor, County Hall, Martineau Lane, Norwich NR1 2DH

Email: bi@norfolk.gov.uk

Source acknowledgements: *National Adult Social Care Intelligence Service*

Adult Social Care Committee

Item No:

Report title:	**Moving forward integrated health and care**
Date of meeting:	**6 March 2017**
Responsible Chief Officer:	**James Bullion, Executive Director of Adult Social Services**

Strategic impact

Integration between health and care is fundamentally about supporting vulnerable people by better organising services to provide the outcomes people need. Integration of health and care by 2020 is a policy requirement signalled since 2010 and set out in the 2015 spending review and the Better Care Fund. Integration and system redesign will mean significant changes in the local health and care system and will be determined at a local level. This is work that the Council needs to progress with partners in the NHS. It will be central to the configuration of our future social care services. This is an opportunity to shape the future health and social care system to support the Council's strategic priorities, particularly in relation to supporting vulnerable people within the available resources. See **Appendix 1** for the National Policy Perspective.

Executive summary

Integration is about organising services so that they can achieve the best outcomes for local people, overcoming the organisational, professional, technical and legal barriers to achieving this.

This report responds to national policy relating to integration of health and care services by 2020 and makes recommendations about how to progress on the basis of our existing integrated commissioning and provider arrangements. This will be key in determining how social care will be provided in the future.

Under the Sustainability and Transformation Plan, development of locally integrated health and care provision is proposed, bringing together community health and care services with primary care to address the needs of a local population.

Alongside this, it is proposed that integrated commissioning arrangements with Clinical Commissioning Groups will be reviewed with a view to proposing future integrated arrangements.

Taking stock of the learning from the national Vanguard schemes, good practice examples and local experience, this paper provides a review of existing integration and sets out a proposed framework for progressing the agenda. It considers the opportunities and the risks as they relate to the citizen and to the County Council's strategic outcomes.

Recommendations:

That Committee asks 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 and sustainable services**
c) **Review our arrangements for hospital social work and community based learning disability social work**
d) **Agree a Member workshop on integration**
e) **Agree the principles proposed at section 1.9 of this report**

1. Taking stock of integration in Norfolk:

1.1 From review of our integration to date and learning emerging from around the country, it is proposed that our integration continues to be founded on the two existing elements: integrated commissioning and integrated service provision.

1.2 **Integrated commissioning**

1.2.1 There are a number of potential benefits of commissioning health and care services in an integrated way:

a) Being able to plan pathways for citizens and patients regardless of whether it is a health or care service they require e.g. planning for dementia
b) Being able to make the most effective investment with the available funding rather than separate investment decisions e.g. reducing gaps and duplication
c) Reducing the burden on suppliers, particularly smaller organisations, of being commissioned by multiple agencies
d) Being better able to influence local markets and avoid unintended impact e.g. by paying different rates for services
e) Making best use of our shared commissioning officer resource by reducing duplication

1.2.2 We have had integrated commissioning in Norfolk since the inception of the CCGs in 2013 and all of the Council's social care commissioning takes place within an integrated team led by the Council's Director of Integrated Commissioning. All posts are jointly funded with the CCGs and have a remit to work across health and care. There is a small team people based within each CCG which has a strong local focus and a team at County Hall which tends to handle the larger scale commissioning and support the local teams. The CCGs lead the commissioning of key health providers.

1.2.3 Commissioning may involve planning and procurement of large scale services but in social care it is increasingly about shaping our markets and working creatively with providers and communities to achieve outcomes with the available resources.

1.2.4 The Clinical Commissioning Groups (CCGs) have been developing how they work together as commissioning organisations and 2016 saw the publication for the first time of commissioning intentions across Norfolk for health and care. It is anticipated that as we shape a more integrated health and care system this can be better facilitated through integrated commissioning.

1.2.5 It is proposed that integrated commissioning is reviewed and proposals developed with the CCGs seeking to maximise the benefits in terms of service outcomes and efficiency.

1.2.6 We will also seek to maximise the opportunities for efficiency in the support to commissioning, such as shared data and analysis, procurement and contract management.

1.3 **Integrated provision**

1.3.1 Adult Social Services has a well-established integrated management arrangement with Norfolk Community Health and Care (NCHC) under a section 75 agreement and has integrated management with East Coast Community Healthcare (ECCH) for the Great Yarmouth area. These arrangements have enabled development of more integrated approaches across community health and care, for example aligning the work of occupational therapists, co-locating teams and contact points, creating integrated care co-ordinator roles.

1.3.2 This has allowed for services to be better co-ordinated around individual need. A recent survey of people who had received the integrated services has provided positive feedback in terms of the elements which patients and service users had originally told us most mattered to them:

a) **92%** of patients/service users **either strongly agreed or agreed** that the professionals involved in their care **communicated effectively and directly with themselves and their families**

b) **78%** of patients/service users either strongly agreed or agreed that professionals involved in their care **communicated effectively** with each other

c) 76% of patients/ service users **strongly agreed or agreed** that their **care was well co-ordinated**

d) **90%** of patients/service users either **strongly agreed or agreed** that they were seen by the right **professionals who knew and understood their care needs**

e) **79%** of patients/service users either **strongly agreed or agreed** that professionals involved in their care knew their story and **did not need to repeat themselves**

1.3.3 Implementing the new models of care from the Five Year Forward View will shape the future of the social care teams which are integrated with NCHC and ECCH. At this stage, we envisage developing multi-specialty community provider model with primary care in order that there is a team focused on the health and care of each locality population. This could mean our social work teams being aligned with GP practices and community health care colleagues to work as a team focusing on ensuring that people with health and care needs get co-ordinated specialist care. Alongside this, they would work with District Councils and voluntary and care providers to ensure people are connected effectively to local prevention services. The aim is to be the best we can at helping people to be healthy and well at home wherever possible.

1.3.4 It is proposed that we work with our partners in primary care and the health providers, along with local voluntary services and district councils, to develop the future model for integrated community care.

1.4 **Learning disability and mental health services**

1.4.1 Our learning disability teams are currently joint teams with the commissioned service from NCHC, bringing together social workers, nurses and other specialists. The current arrangement is secured under contract, so this provides us with an opportunity to work with our partners to shape a future service which does the very best we can to help people with a learning disability to live active and fulfilled lives in their local communities. An integrated approach to this will continue to be an essential underpinning, as will strong engagement with local communities.

1.4.2 Similarly an integrated and community-based approach is core in supporting adults with mental health needs. Whilst our services are not formally integrated we will continue to work with CCGs and mental health partners to ensure a seamless approach as we develop our services. For younger adults, these developments will align closely with the existing Promoting Independence activities.

1.5 **Aligned and pooled budgets**

1.5.1 Aligned and pooled budgets can act as an enabler to integrated health and care. At present pooling of budgets has been limited to particular areas:

a. the integrated community equipment service where NCC holds a contract on behalf of NCC and all CCGs (total value c. £7m)
b. the pooled fund with each CCG for the Better Care Fund, most of which is mandated, totals £60.087m revenue funding in 2016/17 and £6.368m capital funding, alongside a joint agreement for the additional funding for the maintenance of social care totalling £7.9m

1.5.2 Funding within a pooled arrangement can reduce unnecessary and costly transactions, support integrated service provision and ultimately our ability to make best use of health and care resources. There is potential to progress this on a staged basis. For example, aligning funding for a local population to support a population-based approach or pooling our resources for an area of service to support an integrated service area such as rehabilitation and reablement. As such options are explored the Council will want to ensure it has appropriate governance and management of risk.

1.6 **Principles to take forwards into the design**

1.6.1
a) A shared commitment to improving local people's health and wellbeing using approaches which focus on what is the best outcome for citizens and communities
b) Services and the system are designed around the individual and the outcomes important to them, and developed with people who use or provide services and their communities
c) Everyone – leaders, practitioners and citizens – is committed to making changes and taking responsibility for their own contribution to improving health and wellbeing
d) A shared and demonstrable commitment to a preventative approach, which focuses on promoting good health and wellbeing for all citizens

1.6.2 As we progress with integration it will be important to move forwards into a world where the artificial boundaries between health and care become increasingly less relevant as the focus becomes increasingly about shaping services around individuals and communities. However, it will remain vital that the Council is able to assure itself of the value it delivers on behalf of its citizens.

1.6.3 Arrangements must reflect our new model of social work and Promoting Independence programme and indeed furthers these goals. Integration must not compromise our ability to deliver our key duties under the Care Act 2014 within available resources, including strengths-based assessment, review and care and support planning.

1.6.4 Integration should be focused first on achieving outcomes for individuals or service improvements. Consideration of organisational form will follow rather than lead the thinking.

2. Financial Implications

2.1 There are key financial considerations in furthering integrated care. Due to the inherently integrated nature of health and care services, changes in the NHS are highly likely to have implications for the local authority adult care services. For example, increased admissions to hospital will tend to lead to an increase in people who when discharged will need some form of care service. Working together on such key areas, for example through increasing the opportunities for reablement and home based care, may mitigate the risk of this impact.

2.2 Any funding agreements should consider the need for formalised risk agreement. There is no nationally recommended approach and as yet very few areas have tested full pooling of resources between health and social care. Given the severe pressures in the system of increased complexity and demand, the Council and health partners will want to consider how to secure their respective responsibilities. For example, Torbay Council,

whilst heralded as an exemplar of integration across health and care, has recently acknowledged the council's exposure to financial impact due to a risk agreement under which the council is responsible for a percentage of the amount over the control total agreed with NHS England. We would want to ensure we learn from such experience.

2.3 However, the opportunity in integration is also to remove the artificial distinctions between health and social care and the associated funding, creating more seamless services, removing costly and time-consuming bureaucracy and potentially allowing increased funding for social care. The Better Care Fund for example has coordinated existing health and social care revenue and capital funding totalling £66m with £31m supporting adult social services in 2016-17. More funding will be coming from central government into the Better Care Fund in 2018/19 and 2019/20.

2.4 Officers will make use of national and regional networks to inform detailed proposals for the development of joint funding arrangements.

3. Issues, risks and innovation

3.1 Integration offers opportunities for innovation to improve outcomes and whilst there is considerable best practice evidence there is no conclusive blueprint for success. What is clear is that solutions need to both draw on evidence but also be tailored to local application.

3.2 There will be implications for staff, certainly in terms of ways of working, but potentially as we further our integration there may be changes in terms of job roles. For example, we may seek to develop more roles which work across health and care. We have existing strong engagement with our staff and Trade Unions and will ensure staff are engaged and supported in any change and that our existing human resources procedures are followed.

3.3 There is evidence that co-location can facilitate integration and we have already taken several opportunities to co-locate staff. Better use of public estate is one of the opportunities in integration and we will continue to identify how we can do this within the priorities, and governance, of the Council's estates strategy.

3.4 Financial risks have been highlighted above, but current NHS control totals at an organisational level challenge a whole system approach. The STP is developing the financial system overview to support better medium and long term planning and potential reallocation of resources.

3.5 Our existing integration is underpinned by legal agreement and we will continue to ensure proper appraisal of and governance of future arrangements.

3.6 The risk in not progressing with integration is firstly that we fail to meet explicit policy directions, but primarily that we fail to realise the opportunities to secure improved experience and outcomes for people in Norfolk.

4. Background documents

4.1 Stepping up to the Place: the key to successful health and care integration

Five Year Forward View, NHS England

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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National Policy Perspective

Our focus in integration is to improve the way services are organised in order to better meet the health and wellbeing outcomes of local people. This is reflected in national policy which requires the development of integration between health and social services. The 2015 spending review and subsequently the Better Care Fund has set out the requirement that by April 2017 areas have a plan for the integration of health and care by 2020. This is reflected in Norfolk's Sustainability and Transformation Plan, "In Good Health" which makes integration a priority in the future configuration of health and care systems. A major focus is the reduction in avoidable hospital admissions, by strengthening the community-based health and care, particularly for older people and people with a range of long term health conditions.

Taking stock of integration at a national level:

'Stepping Up to the Place: the key to successful health and care integration', is a joint publication from the Local Government Association, Association of Directors of Adult Social Services, Clinical Commissioners and the NHS Confederation. It set out a vision for integrated care which sets health and care firmly within communities and focused on outcomes for citizens:

"Services that are organised and delivered to get the best possible health and wellbeing outcomes for citizens of all ages and communities.

They will be in the right place – which is in our neighbourhoods, making the most of the strengths and resources in the community as well as meeting their needs. Care, information and advice will be available at the right time, provided proactively to avoid escalating ill health, and with the emphasis on wellness. Services will be designed with citizens and centred on the needs of the individual, with easy and equitable access for all and making best use of community and voluntary sector provision. And they will be provided by the right people – those skilled to work as partners and citizens, and who enable them to be able to look after their own health and wellbeing.

Leaders – local and national – will together do what is best for their citizens and communities ahead of institutional needs. It means directing all of the resources in a place – not just health and care – to improving citizen's wellbeing, and increasing investment on community provision. It also means sharing responsibility for difficult decisions, particularly in securing sustainable and transformed services."

The report reviewed the ingredients for successful integration and proposed the following essential characteristics:

1. **Shared commitments:**
    a) A shared commitment to improving local people's health and wellbeing using approaches which focus on what is the best outcome for citizens and communities
    b) Services and the system are designed around the individual and the outcomes important to them, and developed with people who use or provide services and their communities
    c) Everyone – leaders, practitioners and citizens – is committed to making changes and taking responsibility for their own contribution to improving health and wellbeing
    d) A shared and demonstrable commitment to a preventative approach, which focuses on promoting good health and wellbeing for all citizens

2. **Shared leadership and accountability:**
    a) Locally accountable governance arrangements encompassing community, political, clinical and professional leadership which transcend organisational boundaries are collaborative, and where decisions are taken at the most appropriate local level

b) Locally appropriate governance arrangements which, by local agreement by all partners and through health and wellbeing boards, take account of other governance such as combined authorities, devolved arrangements or NHS planning
c) A clear vision, over the longer term, for achieving better health and wellbeing for all, alongside integrated activity, for which leadership can be held to account by citizens

3. Shared systems:

a) Common information and technology – at individual and population level – shared between all relevant agencies and individuals, and use of digital technologies
b) Long-term payment and commissioning models – including jointly identifying and sharing risk, with a focus on independence and wellbeing for people and sector sustainability
c) Integrated workforce planning and development, based on the needs and assets of the community, and supporting multi-disciplinary approaches

These characteristics are reflected in the areas we will want to address as we progress local integration.

STP and the NHS England Five Year Forward View

A key factor in the design of future services is the national requirement on the NHS to address the new models of care set out in NHS England Five Year Forward View, in particular population-based models of either Multi-Specialty Community Provider (MCP) or Primary and Acute Provider Service (PACS) model.

The planning assumptions are place- and population-based. The underlying premise of both models is that a provider, or group of providers, take responsibility for managing the health of the population in an area and the funding is allocated as associated with the population rather than against specific services. The drive is to focus on the outcomes for the population rather than an organisationally focused approach, and that this encourages new ways of working.

MCP is a model which brings together such components as primary care, community nursing, therapy, and potentially social care and the voluntary sector. Elements of services which happen in the acute hospital could be included, such as some diagnostics.

PACS explicitly includes acute services as part of a vertical integration model so the responsibilities for hospital and community services for a population are held in one place.

In addition to these two models, the Five Year Forward View also sets out how care homes must be supported to be better connected to health services in playing their part to avoid unnecessary admissions to hospital.

Adult Social Care Committee

Item No:

Report title:	**Transport Update**
Date of meeting:	**6 March 2017**
Responsible Chief Officer:	**James Bullion, Executive Director of Adult Social Services**

Strategic impact

The Council has responded to the financial challenges facing all local authorities through the development of a new strategy which sets out a direction for the Council to radically change its role and the way it delivers services. This commits the Authority to delivering the Council's vision and priorities, working effectively across the whole public sector on a local basis, and will ensure that the Council's budget of £1.4bn is spent to the best effect for Norfolk people. Adult Social Care is contributing to this vision through the Promoting Independence strategy where people are able to achieve their outcomes through the most independent means possible helping individuals and families to connect easily to the support of their communities and targeting Council's resources where additional support is needed. The aim is to develop a sustainable approach to social care in Norfolk, by working with local communities and changing the mix of service provided we aim to reduce the level of long term packages of care; help people to stay at home longer and provide better use of all resources available to reduce the cost of care packages.

The Care Act, the biggest legislative change for 60 years, shapes and informs this new approach by giving us clear and new responsibilities across the whole population of Norfolk to prevent, reduce and delay demand for social care.

Part of these includes changes to transport and savings in this area.

Executive summary

This is an update regarding the work being carried out in relation to delivering the savings from Adult Social Services transport. It needs to be read in conjunction with the reports to Adult Social Care Committee on 4 July, 5 September 2016 and 23 January 2017 and the update on in November 2016.

Local Authorities are responsible for preventing, reducing and delaying the need for statutory support. The implementation of the Care Act gives us a responsibility to the whole population of Norfolk, including carers, to provide good information about what is available. For those requiring social care our vision is for short term interventions that support people to gain skills and confidence to be able to undertake personal care and the activities of daily living and be active within their communities within individual capabilities. This includes transport.

Adult Social Services is reframing its transport offer in line with the Care Act and the department's Promoting Independence strategy.

Recommendations:

Adult Social Services Committee Members are asked to agree the approach to Transport and the revised Transport Policy and Guidance attached to this report to help social care staff work with service users to promote their independence and also reduce the funding required for transport.

1 The Care Act

1.1 Adult Social Services has a legal duty to provide transport to service users who are eligible for social care support in certain circumstances. The Care Act 2014 states:

"Local authorities should consider the adult's ability to get around in the community safely and consider their ability to use such facilities as public transport, shops or recreational facilities when considering the impact on their wellbeing."

1.2 Transport is a means of accessing other services or support. The overriding principle is that the decision to provide transport is based on a person's individual circumstances including: needs; risks; outcomes; and promoting independence. There is no statutory duty for Councils to provide transport nor funding for it.

1.3 Norfolk County Council's role should be to:

a) help our customers to access services by the most suitable transport available
b) help people live as independently as possible
c) help people to develop new skills, and take risks that are positively managed, thereby building confidence
d) promote the development and use of local services which result in a reduction in distances travelled and time spent travelling
e) improve health and well-being through community and social inclusion
f) ensure the efficient use of resources
g) reduce the numbers of people using council funded transport to services where they are capable of travelling more independently
h) provide guidance and support to individuals to look at their transport needs as part of their support plan

1.4 There is an expectation that service users will meet their own needs for transport to access and take advantage of services, or support to facilitate them.

2 Expenditure and Budget Savings

2.1 The County Council currently spends approx. £7.1m (based on the latest forecast) each year on transport for adult social care service users to access day - and respite services. This spend is for approximately 450,000 journeys per year at an average cost of £15 per journey. This does not include other expenditure by the Council on transport such as: Blue Badges; Community Transport; bus subsidies etc.

2.2 Adult Social Services funds the transport of about 2,000 people enabling them to access their social care/community activities. Approximately 1,500 of these have transport arranged and commissioned by Travel and Transport (Community and Environmental Services).

2.3 Included in the 2014-18 budgets agreed by Council were Adult Social Services transport savings totalling £3.8m.

Financial Year	**£m**	**£m**	**£m**
2014-15	1.800		1.800
2015-16	0.150		0.150
2016-17	0.150	0.900	1.050
2017-18		0.800	0.800
Total	**2.100**	**1.700**	**3.800**

2.4 At this point in time there has been a net reduction of approximately £0.487m in spend over the last two-three years. Although the department has not made the significant savings yet that it needs to make on transport, it does appear to be managing demand in this area, as expenditure has not increased despite overall there being an increasing demand for services.

2.5 Following a review of the achievability of savings in the timescales the Council has delayed £3.000m of the transport savings to 2018-19 and £0.800m to 2019-20.

3 Work to Date

3.1 In line with the budgets agreed by Council to deliver the transport savings the department has:

a) reduced the funding allocated for transport in the Resource Allocation System (RAS) from 1 April 2014. The RAS calculates the indicative personal budget allocation. The reduction was implemented with immediate effect for new service users and from time of annual review for people who were already service users
b) Started using a new policy from 1 April 2015, assessing all new service users under new criteria. The department re-assessed existing service users, who use their personal budget to buy transport or who have their transport paid for by the department, at their annual review:
   i. Making sure people are using their Motability vehicle or mobility allowance for their transport
   ii. Asking people to use public transport or community transport where we assess that they are able to do this
   iii. Asking people to use the service that is closest to them if this will meet their needs, for example, their local day centre. If they don't want to use the local service as they prefer to use a service that is further away, we will not pay for them to travel there
   iv. If we cannot find a service that meets people's needs in their local area we would not automatically pay for them to travel a long way to get the service elsewhere. Instead we would work with the person who needs the service and their carer/s to come up with a more creative solution that involves less travel
   v. The project team have reviewed information and have identified potential savings from transport packages for individuals that seem expensive and not good value for money. This information has been shared with the locality teams to help inform their reviews/reassessments of people
c) Ensured it is charging people who fund their own social care but where NCC provides the transport
d) Is working with independent providers and TITAN Travel Training in Children's to pilot this in Adult Social Services, to enable people to use public transport rather than having transport provided
e) Thetford Day Services for people with Learning Difficulties. The project team identified that there were a number of younger people with complex needs being transported from the Thetford area to a service in Norwich. The department has now got approval and funding to refurbish a building to provide day services locally in this area and is working with the Corporate Property team and NPS to get ready to go to tender
f) Review of lease cars. Some of the original lease periods have expired and the vehicles are effectively now on a rolling yearly lease. The project team is starting to work with teams so that the use of these and the need for them are reviewed on an individual basis

3.2 Although the funding available in peoples' Personal Budgets for transport has been reduced we are not making the savings needed. As reported last time we looked at 150 cases from the latest set of current transport packages supplied by Travel and Transport. This is approximately 10% of the people Transport and Travel arrange the transport for. It is time-consuming as we have to look at each person's Carefirst notes in detail.

Of the 150 cases:

a) 110 (74%) had no change in their transport packages
b) 5 (3%) cases had increased their transport
c) 35 (23%) their transport had decreased or had actually ceased. This is mainly people due to moving house or where day centres have closed and some people have chosen not to continue having day care and others have decided to relocate to an alternative centre that is closer

3.3 It is important to note that not all increases or decreases in transport packages alter the overall costs of transport. Where someone is travelling on a vehicle with other people and they stop travelling or reduce the number of days they travel, the transport contract cost may remain the same or only have a small reduction in cost as the route may not significantly alter, but a smaller number of passengers will be transported. Although the unit cost changes for each person, the overall cost of the journey remains similar.

3.4 Norfolk appears to spend more on Adult Social Services transport than other authorities. For example:

a) Nottinghamshire County Council spends approximately £3.9m pa. They transport 991 service users and have a county population of about 800,000. This excludes Nottingham City as it is a unitary authority
b) Hertfordshire spends about £4.9m on adult social care transport budget of £4.5m and they transport 1,600 people

4 Current and Future Work

4.1 Adult Social Services is reframing its transport offer and arrangements in line with the Care Act and the department's Promoting Independence strategy, and to enable it to focus on statutory priorities.

4.2 The department has looked at the current policies and guidance of other local authorities and has drawn up a proposed transport policy and revised guidance for social care staff working with service users to implement the Care Act, help deliver the Promoting Independence Strategy and ensure the best use of the funding available for transport. These are attached at **Appendix One and Appendix Two.**

4.3 For new people eligible for adult social services this policy will come into effect on an agreed date. For existing people getting adult social services funding, this policy will be introduced in a gradual manner as part of their annual review and reassessment and will be part of the reassessments and reviews carried out under the Working Age and Older People projects under the Promoting Independence programme.

4.4 Alongside this the department will :

a) put a Transport Offer on the NCC website to provide details of what resources are available and to clarify the Council's responsibility to the people of Norfolk (see section five below)
b) continue working with independent providers and TITAN Travel Training in Children's to pilot this in Adult Social Services, to enable people to use public transport

c) work to get Thetford Day Services for people with Learning Difficulties refurbished and ready for use
d) review the lease cars used by service users
e) work with others in the Council to develop an Adults Transport app similar to the SEN (Special Educational Needs) Transport app, to provide improved information of where people are travelling from and to

5 Transport Offer

5.1 NCC needs to provide good information about transport to help prevent reduce and delay the need for ongoing statutory support. NCC will do this as part of its transport offer to the resident population and the offer will be clearly defined on the website, helping to clarify and strengthening the Council's responsibility to the wider resident population including carers and war veterans. A Transport offer is one of the products required from the improved web offer for the population of Norfolk as part of the new Entry Points workstream, part of the Adult Social Services Promoting Independence programme.

5.2 The Transport offer will include information about:

- Buses and Trains – including timetables, cost, wheelchair and disability access
- Concessionary fares - eg what times of day they are
- Where to apply for a senior bus pass or railcard, if a person meets the local criteria.
- a disabled persons bus pass or railcard
- Shop mobility
- Taxi services – including that NCC registers regulates and licences companies to provide safe, reliable services and details of these
- Norfolk Community Transport
- Blue Badges
- Motability Cars and Mobility allowances
- Car Tax Exemption
- When the NHS provides help with travel and transport costs.
- Travel Training

It will also describe to people, what happens if they are deemed to have a need as outlined in the policy and their needs cannot be met by the above.

6 Assessments, reassessments and reviews

6.1 For existing people getting adult social services funding, the reframed policy will be introduced in a gradual manner as part of their annual review and reassessment. This will be part of the reassessments and reviews carried out under the Working Age and Older People projects and the Review of Day Services under the Promoting Independence programme.

6.2 Signs of Wellbeing is Adult Social Services' approach to achieving a strengths based approach to assessment, review and support planning. Our social care staff have been provided with processes, tools and training to help them hold Signs of Wellbeing conversations with people.

6.3 In the context of transport, this means that practitioners should consider a person's own strengths, resources and networks to enable them to access activities that help them achieve greater wellbeing and meet the eligible needs for care and support under the Care Act.

6.4 In practice, this might mean encouraging the person to use the mobility component of their benefits or their mobility vehicle, accessing voluntary or community transport schemes, or using public transport – for which we can provide 'transport training' if this is required. Our aim is to promote the person's independence and help equip them to take an active part in the life of their own communities.

6.5 Examples of what the changes might mean for people and Adult Social Services, based on previous case studies, are shown in **Appendix Three**.

7 Conclusion

7.1 The department has carried out actions in line with the budgets agreed by Council to deliver the transport savings however this has not resulted in the level of transport savings required. The department does appear to be managing demand in this area, as expenditure has not increased despite overall there being an increasing demand for services. Following a review of the achievability of savings in the timescales the Council has delayed £3.000m of the transport savings to 2018-19 and £0.800m to 2019-20.

7.2 The Transport project is being reviewed as part of the refreshing of the Promoting Independence programme, including a Transport Offer on the NCC website, a Transport policy and reframed guidance for staff.

8 Financial Implications

8.1 The department needs to achieve savings from transport of £3.000m by 2018-19 and £0.800m by 2019-20. These will continue to be closely monitored and if further actions are identified that are needed, in addition to those that are in place and have already been taken, these will be implemented.

9 Issues, risks and innovation.

9.1 The savings on Transport rests upon a general assumption and expectation that service users will meet their own needs for transport to access and take advantage of existing services or support, including public transport. Funded transport should only be provided if, in the opinion of the assessor, it is the only reasonable means of ensuring that the service user can be safely transported to an assessed and eligible service. The overriding principle is that the decision to provide transport is based on needs, risks and outcomes and on promoting independence. This is a cultural shift and it is taking time to embed.

9.2 Even if two people make alternative travel arrangements and no longer travel on an NCC funded minibus, there might still be four people travelling which means the minibus is still required and therefore no overall savings are achieved until more people have different transport. With travel training and reassessments/reviews it will be necessary to look at people in groups, eg where they travel on the same bus to a day service.

10 Recommendation

10.1 **Adult Social Services Committee Members are asked to agree the approach to Transport and the revised Transport Policy and Guidance attached to this report to help social care staff work with service users to promote their independence and also reduce the funding required for transport.**

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 One: Adult Social Services Transport Policy

1 Background

1.1 Norfolk Adult Social Services provides transport through a variety of options to people with social care needs. This policy outlines how the Council will move towards a consistent and equitable way of supporting older people, adults with disabilities and/or mental health problems in the provision of transport funded by Norfolk County Council.

1.2 This policy should be read in conjunction with the national eligibility criteria set out in the Care Act 2014.

1.3 The provision of adult social care is aimed at promoting the maximum possible independence for the person. The ability to travel within the community is an important part of helping people to remain as independent as possible. However it is not always the responsibility of Norfolk County Council to provide the transport. We can provide advice, information and support to access other transport solutions.

1.4 Norfolk County Council's role should be to:

- help our customers to access services by the most suitable transport available
- provide guidance and support to individuals to look at their transport needs as part of their support plan.
- help people live as independently as possible
- help people to develop new skills, and take risks that are positively managed, thereby building confidence
- promote the development and use of local services which result in a reduction in distances travelled and time spent travelling
- improve health and well-being through community and social inclusion.
- ensure the efficient use of resources
- reduce the numbers of people using council funded transport to services where they are capable of travelling more independently

2 Introduction

2.1 It is good news that people in Norfolk are living longer and healthier lives. However this places greater demand on care services at a time when we also have reducing funding. We need to make the best use of the resources that we have.

Adult Social Care has a legal duty to provide transport to service users who are eligible for social care support in certain circumstances. The Care Act 2014 sets out that duty as follows:
"The national eligibility criteria set a minimum threshold for adult care and support needs and carer support needs which local authorities must meet. All local authorities must comply with this national threshold."

The Act details that: "Local authorities should consider the adult's ability to get around in the community safely and consider their ability to use such facilities as public transport, shops or recreational facilities when considering the impact on their wellbeing."

The responsibilities of local authorities are clearly set out with regard to carers and their assessment.

2.2 We need to move away from a position where the Council has funded and provided transport for many service users receiving community care. We need to work with people to identify their transport needs and agree suitable alternatives to current provision.

2.3 Transport is a means of accessing other services or support. The overriding principle is that the decision to provide transport is based on a person's individual circumstances including: needs; risks; outcomes; and promoting independence. There is no statutory duty for Councils to provide transport nor funding for it.

2.4 There is an expectation that service users will meet their own needs for transport to access and take advantage of services, or support to facilitate them.

2.5 This will mean the Adult Social Services will only fund transport in exceptional circumstances where there is no suitable or appropriate alternative.

2.6 The provision of transport will only be considered in relation to meeting the needs of:

- adults aged 18 years and over, and who are not in full time education
- who have been assessed as eligible for services and/or support from Adult Social Services
- are ordinarily resident in Norfolk

2.7 Funded transport should only be provided if, in the opinion of the assessor, there is no alternative and appropriate transport available (be it personal, with the assistance of family / friends, or public transport) and it is the only reasonable means of ensuring that the service user can be safely transported to an assessed and eligible service.

2.8 This policy comes into effect on the *(date to be inserted)* to any new people eligible for adult social services and also to existing people, in a gradual manner as part of their annual review and reassessment.

2.9 For those existing individuals who could lose their eligibility for transport under this policy, their situation will be considered sympathetically and personal circumstances will be taken into account to ensure there is not a detrimental effect on the person's access to eligible services. Transitional arrangements can be put in place for a limited period of time to make alternative arrangements, if deemed necessary.

3 Policy

3.1 There is an expectation that service users will meet their own needs for transport to access and take advantage of services, or support to facilitate them.

3.2 Transport is a means of accessing other services or support. The overriding principle is that the decision to provide transport is based on a person's individual circumstances including: needs, risks, outcomes and on promoting independence. There is no statutory duty for Councils to provide transport nor funding for it.

3.3 As part of the Assessment and Care Planning process, the need to attend a community service and/or to pursue other activities away from the service user's home may be identified. The need for transport to any community service or activity service must be part of the assessment of a persons' needs and any subsequent review(s) and can only be provided where the person is eligible for a service in accordance with the national eligibility criteria set out in the Care Act 2014.

3.4 Although a person may attend a specific community service or activity to meet their assessed needs, they will not be eligible automatically for transport to and from the service/activity.

3.5 The transport provided will be appropriate for that need, will provide value for money and be cost effective.

3.6 Transport may be provided on a temporary basis and reviewed when the person is able to use an alternative method of transport, for example, public transport.

3.7 The assumption is that service users will travel independently except where assessment shows that this is not possible. The test used in the assessment should be: **"If Adult Social Services does not provide transport, would this result in an eligible need for services going unmet?"** i.e. are there other ways in which the service user can reasonably be expected to attend services and/or support making his/her own arrangements to get there?

3.8 Where an individual is provided with a Personal Budget or requests a Direct Payment to meet their assessed needs for care, the same principles will apply as to those people opting to receive support directly from Adult Social Services.

3.9 If a person has been assessed as able to make their own transport arrangements but declines to do so and as a result is unable to attend the service for which they have an assessed eligible need this will be viewed as the person declining services. Where a person has declined a service which they are eligible for, the assessor will evaluate whether the person has the capacity to make this decision.

3.10 For those existing individuals who could lose their eligibility for transport under this policy, their situation will be considered sympathetically and personal circumstances will be taken into account to ensure there is not a detrimental effect on the person's access to eligible services. Transitional arrangements can be put in place for a limited period of time to make alternative arrangements, if deemed necessary.

3.11 We will link with the Children Service and work closely to ensure the transport needs of children and young people are assessed whilst at school, so that options to promote independence and use mainstream transport have been explored before they go to college or an adult community activity. This will assist to overcome the expectation from their families that the Adult Social Services will provide transport in all circumstances. All young people requiring adult social services will require an assessment of their needs.

3.12 Adult Social Services would not normally provide Council funded transport for a person:

1. Who is able to access services using their own, public or community transport.

2. Who is able to arrange their transport themselves. For example, if the person uses public or community transport independently at any other time, it should be assumed that they will use public or community transport to access services where this is available.

3. Who chooses to attend a service which is not their nearest appropriate service.

4. Who has Concessionary Travel Passes - People who qualify for concessionary travel will be expected to apply and use this as and when appropriate according to assessed needs.

5. Who is in receipt of a Motability vehicle or mobility payment.

6. Who has a Mobility Scooter and their day services is only a short distance from their home and can be safely accessed by them using their mobility scooter.

7. Who lives in a setting funded by the Adult Social Services, eg Residential Care, supported living schemes - The cost of the placement will meet the full range of support needs, including transport.

8. Where a person contributes towards a Shared Community Vehicle.

9. Who funds their own social care - Where a self-funder is unable to arrange their own transport and there is no-one who can help them, then we can support them to access appropriate transport to their day services but the person will have to pay the transport provider direct.

10. Who is on a short stay break to return to their day service provision in their local area (unless the cost of their day service provision together with the cost of transport to and from that provision is less than would be charged for them remaining in respite for the day).

11. To attend health service appointments, including GPs, chiropodists, dentists, hospitals.

12. To attend social clubs and other activities that are not part of their Support Plan.

Appendix Two: Adult Social Services Transport Guidance

1 Background

1.1 The ability to travel within the community is an important part of helping people to remain as independent as possible. However it is not always the responsibility of Norfolk County Council to provide the transport. We can provide advice, information and support to access other transport solutions.

1.2 Our role should be to:

- help our customers to access services by the most suitable transport available
- provide guidance and support to individuals to look at their transport needs as part of their support plan.
- help people live as independently as possible
- help people to develop new skills, and take risks that are positively managed, thereby building confidence
- promote the development and use of local services which result in a reduction in distances travelled and time spent travelling
- improve health and well-being through community and social inclusion.
- ensure the efficient use of resources
- reduce the numbers of people using council funded transport to services where they are capable of travelling more independently

2 Introduction

2.1 It is good news that people in Norfolk are living longer and healthier lives. However this places greater demand on care services at a time when we also have reducing funding. We need to make the best use of the resources that we have and we need to deliver the £3.8m of savings from transport by 2019-20.

2.2 We need to move away from a position where the Council has funded and provided transport for many service users receiving community care. We need to work with people to identify their transport needs and agree suitable alternatives to current provision.

2.3 Transport is a means of accessing other services or support. The overriding principle is that the decision to provide transport is based on a person's individual circumstances including: needs; risks; outcomes; and promoting independence. There is no statutory duty for Councils to provide transport nor funding for it.

2.4 There is an expectation that service users will meet their own needs for transport to access and take advantage of services, or support to facilitate them.

2.5 This will mean the Adult Social Services will only fund transport in exceptional circumstances where there is no suitable or appropriate alternative.

2.6 Funded transport should only be provided if, in the opinion of the assessor, there is no alternative and appropriate transport available (be it personal, with the assistance of family / friends, or public transport) and it is the only reasonable means of ensuring that the service user can be safely transported to an assessed and eligible service.

2.7 The provision of transport will only be considered in relation to meeting the needs of:

- adults aged 18 years and over, and who are not in full time education
- who have been assessed as eligible for services and/or support from Adult Social Services.
- Are ordinarily resident in Norfolk.

3 Guidance

3.1 This guidance comes into effect on the *(date to be inserted)* to any new people eligible for adult social services and also to existing people, in a gradual manner as part of their annual review and reassessment.

3.2 As part of the Assessment and Care Planning process, the need to attend a community service and/or to pursue other activities away from the service user's home may be identified. The need for transport to any community service or activity service must be part of the assessment of a persons' needs and any subsequent review(s) and can only be provided where the person is eligible for a service in accordance with the national eligibility criteria set out in the Care Act 2014.

3.3 Adult Social Services will only arrange or provide transport where it has been assessed as a separate eligible social care need under the Care Act 2014. Although a person may attend a specific community service or activity to meet their assessed needs, they will not be eligible automatically for transport to and from the service/activity.

3.4 The need for and purpose of transport should be clearly stated on an individual's Care and Support Plan. The transport provided will be appropriate for that need, will provide value for money and be cost effective.

3.5 Transport may be provided on a temporary basis and reviewed when the person is able to use an alternative method of transport, for example, public transport.

3.6 The assumption is that service users will travel independently except where assessment shows that this is not possible. The test used in the assessment should be: **"If Adult Social Services does not provide transport, would this result in an eligible need for services going unmet?"** i.e. are there other ways in which the service user can reasonably be expected to attend services and/or support making his/her own arrangements to get there?

3.7 Where an individual is provided with a Personal Budget or requests a Direct Payment to meet their assessed needs for care, the same principles will apply as to those people opting to receive support directly from Adult Social Services. The cost of transport will only be included in the Personal Budget or Direct Payment where no other suitable alternative is available and it is considered that the service user is eligible for this support. The transport provided will be appropriate for that need, will provide value for money and be cost effective.

3.8 People who receive higher rate disability allowance and those who qualify for concessionary travel assistance such as: bus passes, Blue Badges and Motability Vehicles will be expected to apply and use these as and when appropriate according to assessed needs.

3.9 Individual support plans must include outcomes that relate to, and state the reasons why, there is a need for transport funded by Adult Social Services. Transport provision should be viewed as an independent item on a person's care plan and a clear record kept of the decision making process against eligibility criteria, together with the cost of the ASS commissioned transport.

3.10 If a person has been assessed as able to make their own transport arrangements but declines to do so and as a result is unable to attend the service for which they have an assessed eligible need this will be viewed as the person declining services.
Where a person has declined a service which they are eligible for, the assessor will evaluate whether the person has the capacity to make this decision

3.11 For those existing individuals who could lose their eligibility for transport under this policy, their situation will be considered sympathetically and personal circumstances will be taken into account to ensure there is not a detrimental effect on the person's access to eligible services. Transitional arrangements can be put in place for a limited period of time to make alternative arrangements, if deemed necessary.

3.12 We will link with the Children Service and work closely to ensure the transport needs of children and young people are assessed whilst at school, so that options to promote independence and use mainstream transport have been explored before they go to college or an adult community activity. This will assist to overcome the expectation from their families that the Adult Social Services will provide transport in all circumstances. All young people requiring adult social services will require an assessment of their needs.

Please see Annex 1 for when we would not normally provide Council funded transport.

4 Lease cars.

Although we have provided lease cars in the past these are often not the most cost-effective way of providing transport and therefore should not be provided under any circumstances without prior approval from the appropriate Team Manager, and if necessary approval by the appropriate Funding Panel and should be recorded on a separate service agreement on CareFirst, including costs.

5 Costing up transport to go in support plan

In those exceptional cases where we do agree to fund transport the cost of this needs to be included in the person's support plan.

Each of the journeys will need to be costed and the cost of the routes need to be considered to ensure that they do not exceed the personal budget.

If the identified needs cannot be met within the personal budget, you must discuss this with your line manager.

6 Extra expense for transport related to a disability

Where people incur extra expense for transport related to their disability this will be considered in their financial assessment process and allowances made if appropriate.

7 Requests for Transport journey bookings

All requests for transport journey bookings must be made by the social care teams via the Care Arranging Service (CAS) and the costs for all transport must be recorded on a separate service agreement on the individual's CareFirst record.

Providers, e.g. of day care services, should not ask Travel and Transport to arrange journeys for people or to change journeys or to arrange lease cars. All requests to Travel and Transport for Adult Social Services transport should be made via CAS.

8 Where someone chooses to take all of their personal budget as a direct payment

This guidance applies to people who choose to take their personal budget as a direct payment. The cost of transport will only be included in the Personal Budget or Direct Payment where no other suitable alternative is available and it is considered that the service user is eligible for this

support. If a person takes all of their personal budget as a direct payment and it is agreed that they can use some of this for transport, they should arrange and pay for their transport direct. We will not commission or arrange transport on their behalf. If the person wishes us to arrange and pay for their transport, the amount they receive as a direct payment should be reduced to take into account the total transport costs (weekly zonal cost X 50 weeks = £reduction to DP) and this will be shown on their CareFirst record.

Annex 1: When transport and funding for transport would not be provided

Adult Social Services would not normally provide Council funded transport for a person:

1 Who is able to access services using their own, public or community transport

- If the person has their own car, which they drive, we expect this to be used.
- In rural areas of the county, consideration should be given as to whether the cost of public transport (as opposed to commissioned transport) will jeopardise a person's ability to meet their other financial commitments.

2 Who is able to arrange their transport themselves

For example, if the person uses public or community transport independently at any other time, it should be assumed that they will use public or community transport to access services where this is available. Independent travel must be promoted whenever possible. This may need to include travel training and we can offer this support through TITAN travel training.

3 Who chooses to attend a service which is not their nearest appropriate service

We will only provide transport to the nearest day service that meets the person's need. If a person chooses to attend a day service which is further away from their nearest appropriate day service, then they will be expected to pay the whole cost of their transport: it will be the actual cost which may be higher than the zonal charge.

4 Who has Concessionary Travel Passes

People who qualify for concessionary travel will be expected to apply and use this as and when appropriate according to assessed needs.

5 In receipt of a Motability vehicle or mobility payment

- If someone has their own "Motability" vehicle which they drive themselves we expect the person will use that vehicle in order to travel to the location of the day opportunity. If an individual or carer makes the decision that the Motability vehicle will not be used for the intended purpose, the onus must be on the individual and/or carer to make alternative appropriate arrangements
- If someone has a Motability vehicle but they do not use it to transport them to day services, e.g. there is no-one available to drive it, we can support them to move from a Motability vehicle to a mobility payment - via Welfare Rights Officers and Voluntary Advice Organisations. A person can have several people on the insurance to drive the vehicle
- Where there is conflict between the individual and the carer, regarding Motability cars, we need to consider the possibility of reverting to a mobility payment from the Department for Work and Pensions, if the individual so wishes. This would promote independence and allow the individual to take control of their own transport requirements. Consideration should be given to the impact of this option on individual-carer relationships and the need to avoid creating unnecessary conflict. In some circumstances, support from an independent advocacy service should be sought for the individual and, if necessary, the carer
- Assessing officers must also ensure that a carer's reluctance or inability to assist with transport does not prevent an individual form accessing a service that meets their assessed needs and the individual/carer will need to make alternative arrangements
- Where a person uses their own vehicle or Motability car no petrol costs or other expenses will be considered

6 Who has a Mobility Scooter

If the person has a mobility scooter and their day services is only a short distance from their home and can be safely accessed by them using their mobility scooter.

7 People living in settings funded by the Adult Social Services, eg Residential Care, supported living schemes

The cost of the placement will meet the full range of support needs, including transport, to attend community activities including college.

8 Shared Community Vehicle

Where a person contributes towards the provision of a shared community vehicle, this should be used to transport them to community activities including college, assuming it is available to do so.

9 Self-funders

Transport should not be commissioned for those self-funders who are able to arrange and pay for their own transport or where a family member/carer is able to arrange this for them. Where a self-funder is unable to arrange their own transport and there is no-one who can help them, then we can support them to access appropriate transport to their day services but the person will have to pay the transport provider direct.

10 Other instances

Other instances where we should not arrange transport are:

- for a person on a **short stay break** to return to their day service provision in their local area (unless the cost of their day service provision together with the cost of transport to and from that provision is less than would be charged for them remaining in respite for the day);
- for a person to attend **health service appointments**, including GPs, chiropodists, dentists, hospitals etc;
- for a person to attend **social clubs and other activities that are not part of their Support Plan.**

Where you think there are exceptional circumstances which would warrant providing transport in any the above cases, you must discuss the case with your line manager.

Appendix Three: Case Studies

Examples of what the changes might mean for people and Adult Social Services, based on previous case studies, are shown below.

Person A

Adult Social Services (ASS) have commissioned transport to a day centre for one day per week for a number of years. Following their annual review and a discussion about their circumstances and the support available, the person uses Norwich Door to Door transport that they pay for. The person's family will also occasionally provide the transport. ASS stopped the commissioned transport a few weeks after the review once the new arrangements were in place. NCC helps grant fund Norwich Door to Door transport.

Person B

The person attends day services four days per week but following a discussion at their review moves to a different day centre. Previously ASS provided transport each day (approx. 10 miles each day). By moving to a different day centre the person can now travel independently and no longer needs NCC commissioned transport. The person travelled on a 16 seater vehicle with 12 other people, so in order to change the size of the vehicle or decommission the route the department will also need to work with the other people on the bus to see if they can make other travel arrangements.

Person C

The person goes to a day centre three days per week, NCC commissioned transport took the person to their day service and their family picked them up from the day service each day. Another day service was identified that can meet the person's need and is closer to their home. To enable the person to carry on going to the day centre that was further away, the family agreed to take over all transport.

Person D

The person goes to day services three and a half days a week. The family has a Motability vehicle, but the person's parent gets too stressed to drive in traffic at peak times. Following a the review the family have agreed to pick the person on the half day when the traffic is less and to return the Motability Vehicle at the end of its lease in 2017 and convert to a Mobility Allowance that will be used to help fund the person's transport. There is a financial penalty that the family cannot afford if the Motability vehicle is returned before end of lease.

Adult Social Care Committee

Item No:

Report title:	**Update on progress with recommendations of the SCIE review**
Date of meeting:	**6 March 2017**
Responsible Chief Officer:	**James Bullion, Executive Director of Adult Social Services**

Strategic impact

In June 2016 the Social Care Institute for Excellence (SCIE) published its review of the council's progress in implementing the Care Act. It contained a number of recommendations to ensure the council was meeting its statutory duties. The purpose of this report is to update Members on progress with implementing the recommendations.

Executive summary

Of the 22 recommendations in the SCIE review, work has been completed on 13, and work is underway on the remaining nine.

A series of co-production workshops have been held with stakeholders, and these are continuing. The report sets out those actions currently underway.

Recommendation:

The Committee is invited to note the progress in implementing the recommendations of the SCIE review.

1. Background

1.1 In September 2016 the Adult Social Care Committee considered the findings of the SCIE review of the implementation of the Care Act in Norfolk. The review contained 22 recommendations.

1.2 Norfolk County Council (the Council) committed to working with stakeholders to implement the findings of the review and a planning workshop was held in July 2016. Two further co-production workshops have followed to build on the shared desire to improve outcomes for people with care and support needs and their carers.

2. Evidence

2.1 Since the publication of the review the Council has been working with its stakeholders to progress actions in response to the recommendations. Where it was possible to make internal changes to comply with specific recommendations, this work has been progressed. In other cases, the aim has been to involve stakeholders in creating solutions through a series of co-production workshops.

2.2 Progress to date can be summarised as follows:

a) All administrative recommendations have been implemented. These relate to terminology changes on internal forms and guidance documents to ensure the correct Care Act terminology is used

b) An investigation into workloads is nearing completion. This has consisted of a detailed data analysis to understand the relationship between caseload numbers and complexity of cases and a practitioner survey to gain feedback from staff about their areas of concern
c) A quality assurance audit of supervision has been completed with recommendations being accepted by the department's Senior Management Team
d) A new Personal Budget Questionnaire has been co-produced and the Resource Allocation System will be amended as a result. The new process is planned to be introduced with the new social care computer system in November 2017
e) Two co-production workshops have been held (in October 2016 and January 2017) with a further one planned for April 2017. These were attended by individuals who use services, representatives from user led organisations, service providers and operational staff. These workshops have focused on the following tasks:
    i. Involving people who use services and carers in training and development to ensure the service user's voice is clearly represented and staff have an opportunity to gain a better understanding of the lives of people with care and support needs and the people who care for them
    ii. Developing an engagement agreement, setting out the expectations on all sides of what constitutes effective engagement. Broad principles of an agreement have been suggested and a smaller working group will be working on the detail of an agreement
    iii. Revising information the Council gives to people prior to assessment, setting out what they can expect from us and how they can get the most from the process, and improving the guidance given to staff about preparing for assessments to ensure the person remains at the heart of the conversation

3. Financial Implications

3.1 Any changes as a result of the SCIE recommendations will be delivered within existing budgets.

4. Issues, risks and innovation

4.1 If the Council fails to comply with its duties under the Care Act 2014 it could leave itself open to legal challenge. By progressing with the recommendations of the SCIE review, the Council can gain assurance that it working in a Care Act compliant way.

4.2 Improving engagement with stakeholders and involving them in the development of strengths based approaches will help ensure that the wellbeing of people with care and support needs remain central to the process of assessment and care and support planning.

5. Background Papers

5.1 Report to Adult Social Care Committee 5 September 2016: Norfolk's implementation of the Care Act

External Care Act Implementation Review in Norfolk County Council (June 2016) Social Care Institute for Excellence

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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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.