Adult Social Care Committee

Item No:

Report title:	**Peer Review**
Date of meeting:	**14 January 2019**
Responsible Chief Officer:	**James Bullion, Executive Director of Adult Social Services**

Strategic impact

The Peer Review of Adult Social Services has helped shape our programme of activity for Promoting Independence. There was strong engagement throughout the Review from key partners, including CCGs, which has also led to influence over Sustainability and Transformation Partnership and emerging Integrated Care System for Norfolk and Waveney. The recommendations and actions identified in this report reflect this.

Executive summary

A Peer Review of Adult Social Care was undertaken 18-21 September. This focused on how well health and social care work together to support older people, with particular reference to supporting people to live independently in their own homes, assisting them in crisis and to step down from crisis. As much of the Peer Review considered the interface between health and care, partners from across the system were heavily involved in the review.

A final report of the key findings and recommendations has recently been received and in response an Action Plan has been developed. The final report is attached at Appendix One.

Recommendations:

Committee is asked to review the key findings and recommendations from the Peer Review and agree the Action Plan to be taken forward in response.

Appendix One - Peer Challenge Report - Older People (page 19)
Appendix Two - High level narrative for Norfolk (page 38)

1. Background to the Review

1.1 A Local Government Association Peer Review took place 18-21 September. This focused on how well health and social care work together to provide support for older people. Norfolk-wide strategies were considered but there was a focus on impact and evidence from the Central Norfolk System.

1.2 The benchmark for this Peer Review was the Care Quality Commission's local systems review framework, considering how our system functions at the interface across:

a) Keeping people's wellbeing in their usual place of residence
b) Crisis management
c) Step down after crisis, including return to usual place of residence

1.3 It followed ten key lines of enquiry that related to the system being well-led; safe; effective; responsive; and person-centred.

1.4 A Self-Assessment and portfolio of evidence were compiled in advance for the Review Team.

1.5 The Peer Review Team comprised:

a) Director of Adult Social Services and Housing from Southend-on-Sea
b) Leader of Warwickshire County Council
c) Head of Mental Health and Principal Social Worker from Southend-on-Sea
d) Director of Nursing, Quality and Patient Safety from Northumberland Clinical Commissioning Group
e) Independent Health and Care Improvement Consultant and Coach
f) Advisor, Health and Care Improvement from the Local Government Association
g) Peer Review Manager from the Local Government Association

1.6 Whilst on site the team reviewed over 80 documents, held 40 meetings and met and spoke with over 100 people, collectively spending more than 360 hours to determine their findings. Activities included:

a) Interviews and discussions with councillors, officers, partners and service providers
b) Focus groups with front line staff, managers, service users and carers
c) Collecting information from those who use services in Norfolk
d) Site visits to experience a number of services in practice
e) Reading a range of documents provided by the Council

2 Input from Partners

2.1 Being a strong partner to health colleagues is a key principle for Adult Social Services. For the Peer Review partner input was also crucial given the focus on delivery at the interface between health and social care.

2.2 Key partners including Clinical Commissioning Groups, Norfolk Community Health and Care, Norfolk and Suffolk Foundation Trust, GPs, care providers and the voluntary sector, actively played a role in the Peer Review. This includes input into our self-assessment, the initial presentation to the Peer Review Team, active participation in interviews and engagement in the final presentation of findings.

2.3 The Final Report identifies:

a) It was clearly demonstrated to the team that there is a partnership in place to deliver health and social care in Norfolk. At all levels across the Sustainability and Transformation Partnership the team found examples of strong, collaborative leadership that was able to make brave decisions to ensure that appropriate services were delivered
b) There were examples of good outcomes and improvements that had been achieved through partnership working. This included well established, integrated working in the west, where there were examples of good practice in admission avoidance and early supported discharge. The team was impressed with the work of the Norfolk Escalation Avoidance Team (NEAT) where specialists from a variety of organisations and disciplines 'huddle' together to keep people safe in their own homes
c) It was also clear that effective partnership working is inconsistent across the Sustainability and Transformation Partnership footprint, with some partners playing a more active and engaged role than others. More work would be required to demonstrate the level of engagement in acute trusts and the ambulance service

3. Key Findings, Recommendations and Actions

3.1 Findings from the Peer Review have helped shape our programme of activity being delivered as part of Promoting Independence as well as influencing the direction of

travel for some Sustainability and Transformation Partnership Boards, including Communications and Engagement and the Primary and Community Group.

3.2

Key Findings and recommendations from the review	How this is being taken forward	Who's responsible
Integrated Models of Care: **Finding:** There is a strong practice of piloting new ways of working but pilots need robust evaluation, improvement measures and opportunities to share learning. One example is Norwich Escalation Avoidance Team (NEAT) model for unplanned care, which was identified as particularly innovative and positive practice. **Recommendation**: Roll out the NEAT Model countywide and test out the degree to which new models of practice are embedded.	• NEAT model being rolled out in all localities, jointly overseen by CCGs, Social Care and Norfolk Community Health & Care • Work closely with Local Delivery Groups to develop new models of care, fully evaluating delivery of pilots and sharing learning	• Director of Integrated Care • Reported through SMIT and Integration Board
Working with Primary Care: **Finding:** There is strong evidence that the ambition to shift focus from acute to primary care and promoting independence is happening. Integrated Care Coordinators work closely with GPs helping enable effective Multi-Disciplinary Team working and tracking of individuals at risk. There is some inconsistency in approach across Norfolk. **Recommendation:** Create greater consistency in the coordination and approach to risk stratification at Primary Care level.	• Engagement with Primary Care Networks, supporting them to develop effective models of care for local populations • Director of Adult Social Services chairs the Primary and Community Group for the STP • Delivery of the Healthy Ageing Project to enable older people and their carers/family to enjoy the best possible quality of life and remain safe and well at home • Further develop the role of Integrated Care Coordinators in Norfolk to effectively support risk stratification and Multi-Disciplinary Team working	• Executive Director of Adult Social Care • Reported to Promoting Independence Board • Overseen by Local Delivery Groups
Engagement: **Finding:** The vision for older people is generally understood, but there are inconsistent levels of engagement with service users and carers.	• Develop and implement a communication and engagement plan for Adult Social Services which aligns with the STP vision In Good Health, and the Health	• Assistant Director Strategy and Transformation • Director of Social Work

Recommendation: Develop a clear narrative around the STP that can be customised dependent on audience, ensure that the ambition and plans to achieve this are understood by all those involved and affected by delivery.	and Wellbeing Board strategy • Review and strengthen engagement mechanisms with service users and representative groups	• Reports to Promoting Independence Board
<u>Culture</u> **Finding:** A culture shift across the health and social care workforce is needed. Under pressure staff rely on familiar ways of working rather than new models of care. Staff need to be supported so they are more resilient and fully conversant with preferred models of practice. **Recommendation**: Develop an organisational development plan that enables a culture of doing and learning together. Make strengths-based practice a reality.	• Work with partners as part of the STP to develop a Home First Campaign for Norfolk and Waveney to engage with patients, families and staff • Delivering Living Well, Norfolk's new social work model of strengths-based practice. This includes a comprehensive programme of staff support and training. The roll out across Locality teams commences in February 2019	• Director of Social work. • Reports into the Promoting Independence Living Well Board • Assistant Director Strategy and Transformation
<u>Technology:</u> **Finding:** There was evidence of NCC's ambition to drive forward with the use of technology to deliver health and social care preventatively – for example through Assistive Technology. However, the digital maturity of the STP footprint overall is low. **Recommendation:** Work is required to improve the interface and sharing of information between health and social care.	• Create a digitally enabled workforce by rolling out mobile working to all teams during 2019 • Work across the system as part of the STP to create a shared care record that brings together patient level data from different recording systems	• Head of Business & Technology • Adult Social Technology Enabled Care (ASTEC) Board
<u>Market Development:</u> **Finding:** There is evidence that market development is underway and willingness from the wider health and social care partnership to become more involved. **Recommendation:** Utilise Council resource in shaping the market in the best way and	• Use the Joint Strategic Commissioning Committee to agree joint market shaping strategies	• Director of Integrated Commissioning

engage the wider partnership in development activities.		
<u>Mental Health:</u> **Finding:** The pathway to support older people with mental health needs, including dementia, is an area that needs further development. There is inconsistency of pathways across Norfolk. **Recommendation:** New pathways being piloted need to be fully evaluated and communicated with opportunities for learning and roll out across Norfolk.	• Continue to play an influential role in the N&W STP Dementia Review Group • Undertake a stocktake of existing dementia provision • Develop an action plan for Adult Social Services which is based on integrated pathways, and the findings of our own stocktake.	• Director of Integrated Care • Reported through to the Community Alliance
<u>Delayed Transfers of Care (DTOC)</u> **Finding:** There is a lack of single understanding how DTOC are recorded, managed and challenged. **Recommendation:** Develop a clear and agreed approach to DTOC that is understood by all partners, and one where robust challenge is both sought and welcomed.	• Appointed an integrated lead officer for patient flow and hospital systems • Revising the social work model of delivery that supports the acute trusts, starting with the James Paget which went live in November 2018, moving on to Norfolk and Norwich University Hospital and the Queen Elizabeth during 2019 • Creating a stronger multi-disciplinary team approach to discharge, with decisions taken jointly by a range of professionals in Discharge Hubs • Established one Winter Room for Norfolk to oversee DTOC during the winter period • Shift focus to early discharge planning for both elective and emergency admissions • Revise NCC's Direction of Choice policy • Work with the acute trusts to ensure the correct method of recording DTOC is implemented • Implement a bed tracker system to provide more	• A&E Delivery Boards • NCC weekly DTOC meeting • Senior Integrated Management Team

	accurate data on bed availability	
<u>Over-provision of Care:</u> **Finding:** There can be an over prescription of care packages, particularly at the point of discharge, and there is not always capacity for robust and timely review. There is a culture of risk averseness across the system. **Recommendation:** The partnership should consider how the system can more easily recognise and select alternative options to residential care. Raise the system-wide understanding and approach to managing risk.	• Implement Living Well, NCC's new model of strengths based social work, which includes taking no decisions about permanent care in a hospital • Implement as a system Discharge to Assess • Develop a Home First communications and culture change campaign • Deliver more Accommodation Based Reablement for people who are medically fit but need extra help to build their skills and confidence to return home from hospital • Improve the provision of short term bed placements – including how they are booked and the speed at which people in them are reviewed to increase the number of people able to return home after a hospital stay	• Director of Social Work • Promoting Independence Board

4. Financial Implications

4.1 The Peer Review has been a useful tool to ensure we effectively target our existing resources and the work of our transformation programme Promoting Independence. The Action Plan in 3.2 reflects a refocusing on key priorities, with delivery reporting into existing governance structures. There are no implications for the agreed Annual Budget.

5. Issues, risks and innovation

5.1 Further collaboration and joint working with partners is an essential element of responding to both the Peer Review findings and direction of travel with the Sustainability and Transformation Partnership as we move towards an Integrated Care System for Norfolk and Waveney. In developing new models of care all proposals will be considered thoroughly in terms of financial risk and liability on part of the Council. This includes consideration of implications for estates management and provision of ICT services.

5.2 It is also recognised that several health partners are in challenging positions currently. To be an effective partner we will ensure that NCC's position is fully represented and that there is clarity on our Social Care Offer.

5.3 Although this primarily affects Adult Social Services there are implications for other parts of the Council including Public Health and Children's Services from a contracts and commissioning perspective.

6. Background Papers

6.1 High level narrative for Norfolk (attached as Appendix Two)

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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