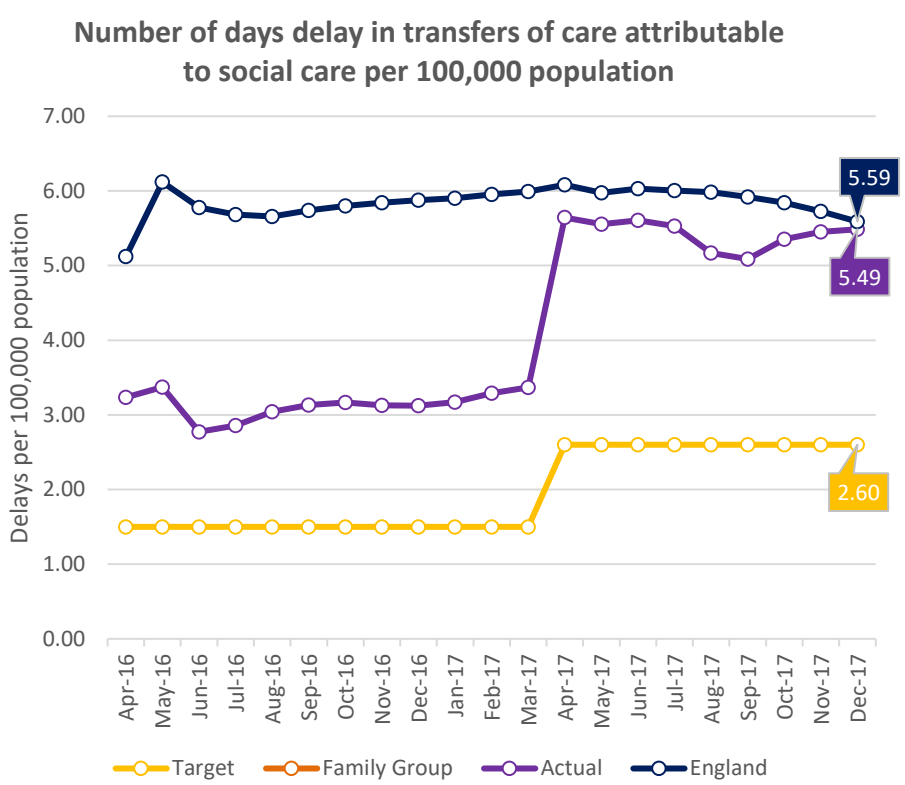
Delayed transfers of care

Why is this important?

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

Performance



What explains current performance?

Winter is always pressured in the hospital services, but we put in place effective plans in preparation. Nationally and locally, hospitals saw unprecedented numbers of people attending.

As anticipated, it is after Christmas that pressures are often most acute and we experienced greater pressure later in January, coupled with the challenges of sickness.

- The number of social care delays is within the DoH Feb 2017 benchmark at:
  - Queen Elizabeth Kings Lynn
  - James Paget Great Yarmouth
  - Norfolk and Suffolk Foundation Trust
- The number of social care delays at NNUHFT exceeds this benchmark by 315 delays and 135 at NCHC.
- We have worked closely with NCHC and NSFT to ensure that when there are delays they are accurately coded. This has led to a substantial reduction in the number of delays attributed to social care.
- NCC is not yet able to fully verify DTOC figures and is working with the NHS to adopt a best practice joint verification process.
- New resources funded through the improved Better Care Fund have come on line: trusted assessors, accommodation based reablement and enhanced home care all became available in late January.
- The Council put in place temporary measures have been put in place to support effective discharge over winter: additional social care assessment staffing, reprioritising workload, incentives to providers to take on cases swiftly and exceptional additional payments to secure care services.
- We have invited external support via the regional Better Care Fund Support Team to work with the system on hospital discharge so that we benefit from new perspectives.

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

- Engage with external support to strengthen and change our integrated assessment processes for discharging people from the acute and community hospitals

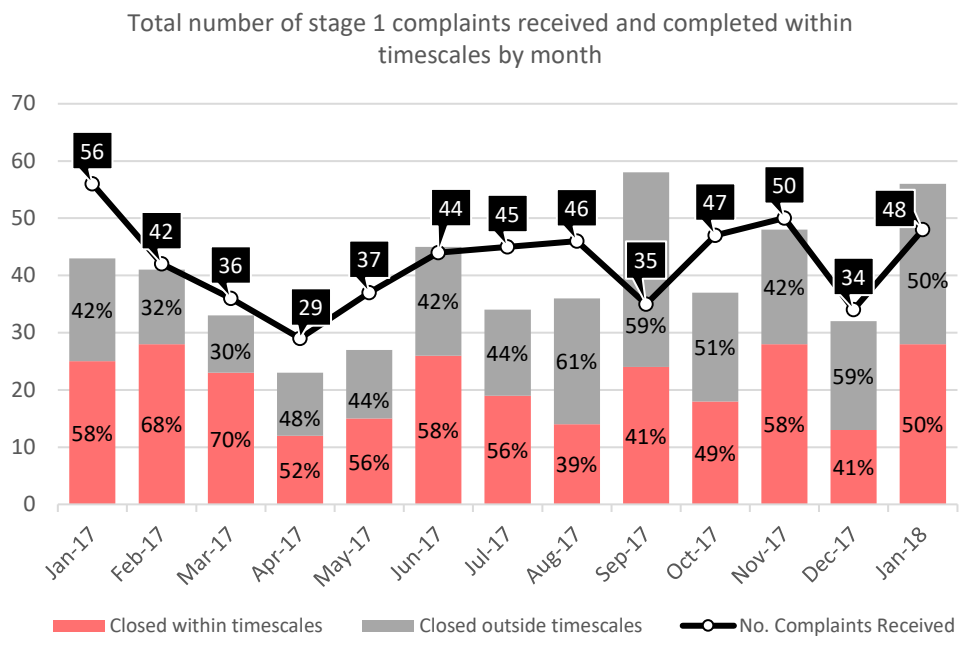
Lead: Catherine Underwood, Director for Health and Integration Data: Intelligence & Analytics

Complaints

Why is this important?

Customer feedback is essential, not only can we gather valuable service user insights but it also gives the ability to identify service failures and gives thought on how to address them. The overall satisfaction or dissatisfaction of the service user will allow the service to monitor the effect/success of its strategic priorities.

Performance



What is the background to current performance?

- Over the calendar year 2017, Adult Social Services received just over 500 complaints.
- The department provides services to around 20,000 people in a year
- A different system of recording complaints was introduced in April 2016 which makes a direct comparison difficult; however, comparing the period April to December 2016 with the same period in 2017 shows a drop in complaints: 367 in 2017, compared with 448 in 2016
- The main reasons for those complaints are process related, staff/employee related and financial complaints. These have largely stayed in the same proportion as previous years.
- During April, May and June, 43% of the complaints were around process issues, including service failures such as delays with assessments or dissatisfaction with outcomes such as changes to care plans. 29% were relating to staff-related issues, such as communication of information by social workers and delays in arranging respite/assessments/returning messages.
- Failure demand is demand caused by a failure to do something or do something right for the customer, which then prompts them to make contact several times.

What will success look like?

- A reduction in the number of complaints is not the main indicator for success. Understanding the types of complaints received and delivering actions to improve the performance of the service and monitor its performance against the strategic priorities should be the main indicator of success.
- Ensure learning from complaints is used to inform future service delivery.

Action required

- We have prime responsibility for the quality of care even when we commission the delivery to a third party. Therefore we need to work closely with Commissioners and third party providers to ensure that this is reflected in our formal contracts and appropriate standards of care are met.
- Ensure recommendations arising from complaints result in actual service improvements to reduce similar complaints arising.

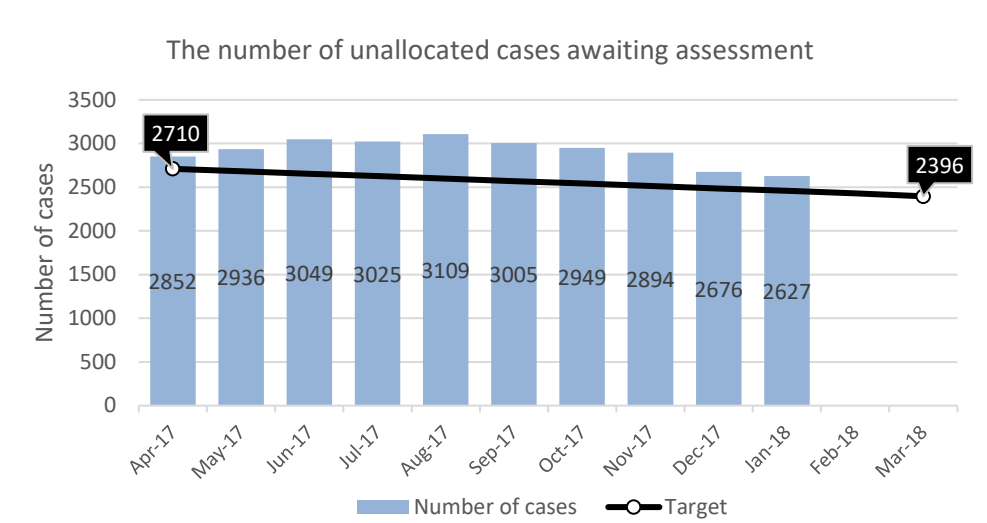
Responsible Officers	Lead: Sarah Rank, Business Development Manager	Data: Customer Experience & Systems Team

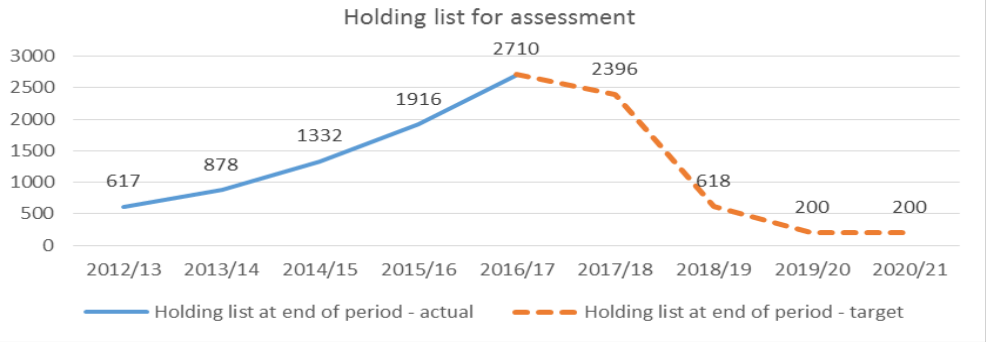
Holding List

Why is this important?

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

Performance





What is the background to current performance?

- In July it was reported that teams were carrying a significant amount of backlogs of work. The latest figure of just over 2600 is almost 400 lower than what was first reported on in July. However, the change from Care First to Liquid Logic may mean that there are slight changes in how the system counts unallocated cases.
- Given a current 16/17 rate of assessments of around 8,800 a year the holding list targets require an additional 4% of assessments in 2017/18. Some of this will be off-set by a reduced requirement for new assessments in line with other targets (e.g. reduced rates of requests for support to services).
- Delivery of target is dependent on recruitment to additional social work posts, and on improvements to productivity delivered through the Promoting Independence programme and through the Three Conversations model.
- A short term specialist team dedicated to addressing the holding list have been in post since December. The team works across all five localities prioritising areas with the largest list and the case which have waited longest
- The recruitment to additional posts to increase capacity has been positive. It has helped strength front line teams, giving them more capacity to address backlogs.

Action required

- Good performance will mean a reduction in the number of unallocated cases awaiting assessment. Performance is therefore driven by the success of the recruitment process to increase capacity and the further introduction of sites using the 3 conversations model.

- Continue with the roll out of strengths-based working – 3 conversation model. To date two sites have been run, with a further 4 due in March. The teams in those sites have demonstrated that capacity can be created to tackle waiting lists.
- Ensure recruitment to additional or vacant posts is monitored and positions are filled. Any failure to recruit to posts, and to fill existing and future vacancies, will compromise the council's ability to hit this target. Recruitment can be a challenge, so monitoring recruitment progress will be important.

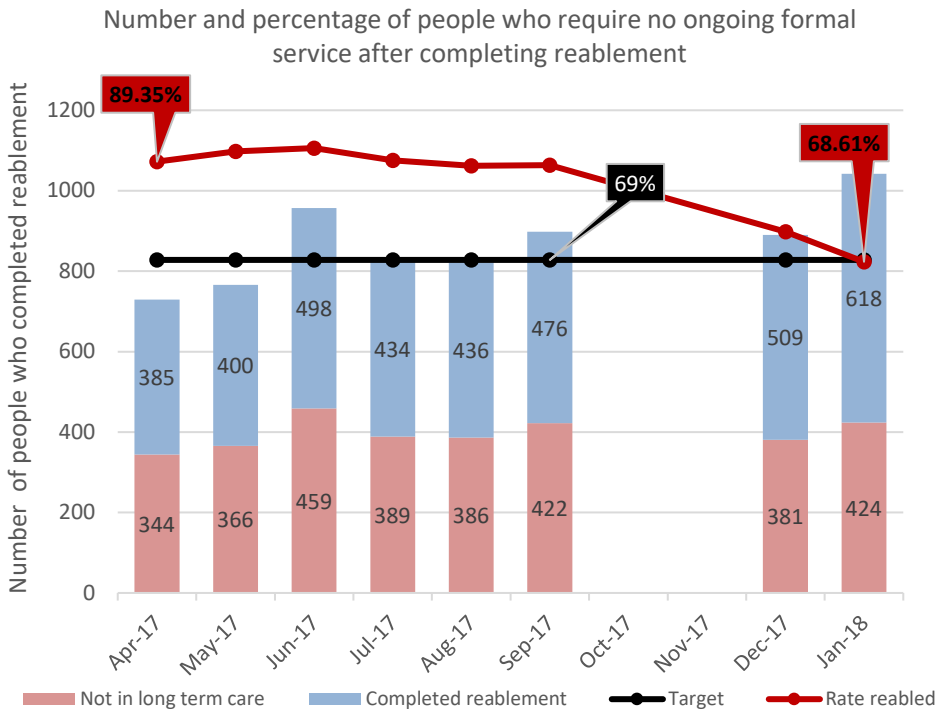
Responsible Officers	Lead: Lorna Bright, Assistant Director Social Work	Data: Intelligence and Analytics Service

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

Why is this important?

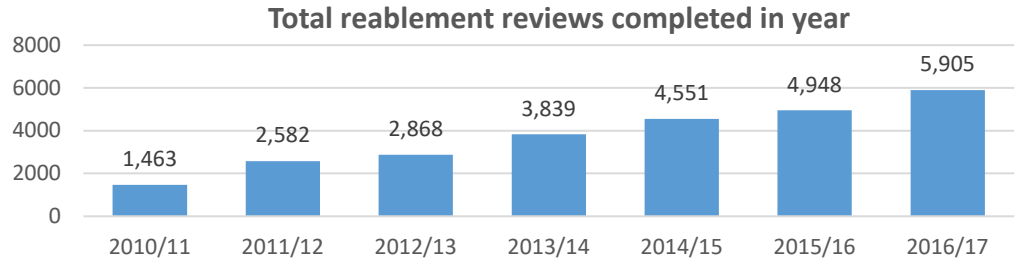
The Promoting Independence Strategy, as well as the Care Act 2014, requires that the council does all that it can to prevent or delay the need for formal or long-term care. Norfolk has provided reablement services for a number of years – that help people get back on their feet after a crisis – to people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

Performance



What is the background to current performance?

- Due to the migration from Care First to Liquid Logic there is a gap in the data available for October and November.
- Early data for December and January indicates that NFS have taken more reablement referrals than usual. The service has offered overtime to staff over the last three months to try and increase the amount of people the service could work with.
- This early data shows the rate reabled has dropped from 89% to 69% in December. We believe this is because of two issues. First those currently being serviced by NFS in January and December are still being reabled and therefore are not shown as reabled yet. Secondly it is also a possibility that due to the change of systems from Care First to Liquid Logic that there is a time-lag in the process of inputting the data and that the parameters used on Care First data are slightly different to what is in Liquid Logic. Further investigation into this is ongoing.
- Benjamin Court, the new accommodation based reablement unit open on 9 February. The unit is design for people who are medically fit but cannot go home safely to have the potential to be reabled.
- All people with a social care need are assessed for suitability for reablement before leaving hospital; most go on to receive some kind of reablement services, usually in their own home.
- Performance in this indicator is linked to the 'Sustainability of reablement' indicator and report card.



What will success look like?

Action required

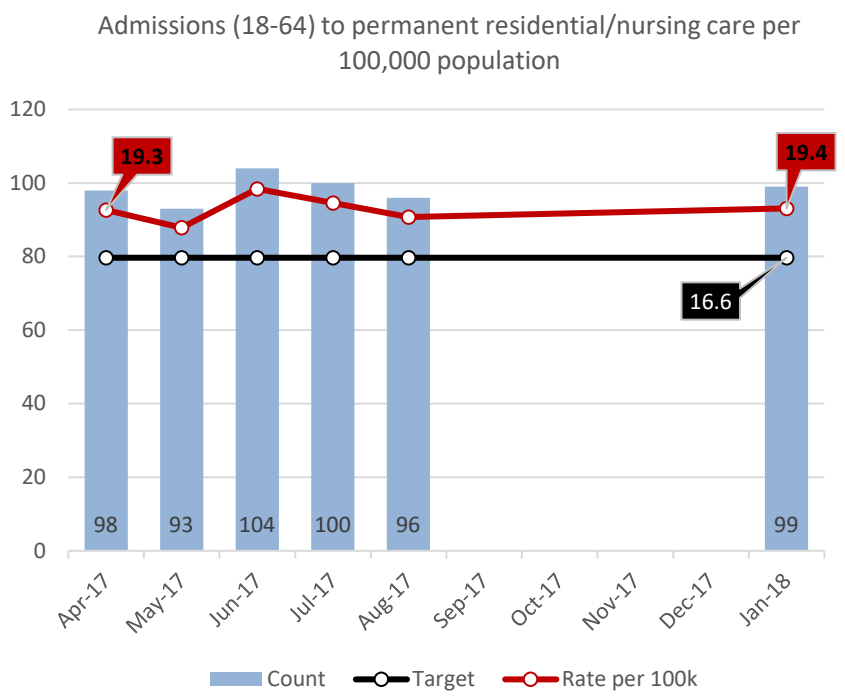
• The maximum proportion of people completing reablement not needing ongoing care. • The business case for additional investment in Norfolk First Support calculated that to reable everyone with the potential for reablement, and therefore maximise outcomes and savings, approximately 6,000 people a year should receive reablement (based on previous years). • The cost of reablement services to be significantly less than the likely cost of long term care.	• Continued monitoring of the impact of reablement against this indicator, and against the targets set out in the business case for additional investment in Norfolk First Support.
Responsible Officers	Lead: Janice Dane – Assistant Director Early Help and Prevention Data: Business Intelligence & Performance

More people aged 18-64 live in their own homes

Why is this important?

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

Performance



What is the background to current performance?

- Historic admissions to residential care for people aged 18-64 were very high in Norfolk at nearly three times the family group average.
- Improvements have seen year-on-year reductions accelerate with admissions going from 31.0/100k in Mar 2015 to 16.4/100k in Dec 2016. The reduction from April 2016 onwards brought admissions per 100k below the target rate however the increase in Jan 2017 took admission rates (18.5/100k) worse than target for the first time in 9 months and rates have been increase gradually since.
- The movement to the Liquid Logic system meant that data was missing from September to December. January's data shows a continued rate of admission, slightly above our target.
- Reaching our rate of admission per 100k population target would need a reduction to 85 (rolling annual total); the most recent figure was 99.
- There is a significant body of work underway to develop our learning disability services, to move towards alternatives to permanent residential care
- Current support draws heavily on traditional formal adult care services, and the intention is to modernise our offer to be more ambitious for service users, enhance independence and improve overall wellbeing.

What will success look like?

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

Action required

- March 2018 – new approach to strengths based social work (Thre conversations) first innovation site goes live
- Development of "enablement centres" model for service users aged 18-64 to be helped to develop skills for independent living
- Reviewing how we strengthen and change our integrated assessment processes for discharging people from the acute and community hospitals will impact on this indicator

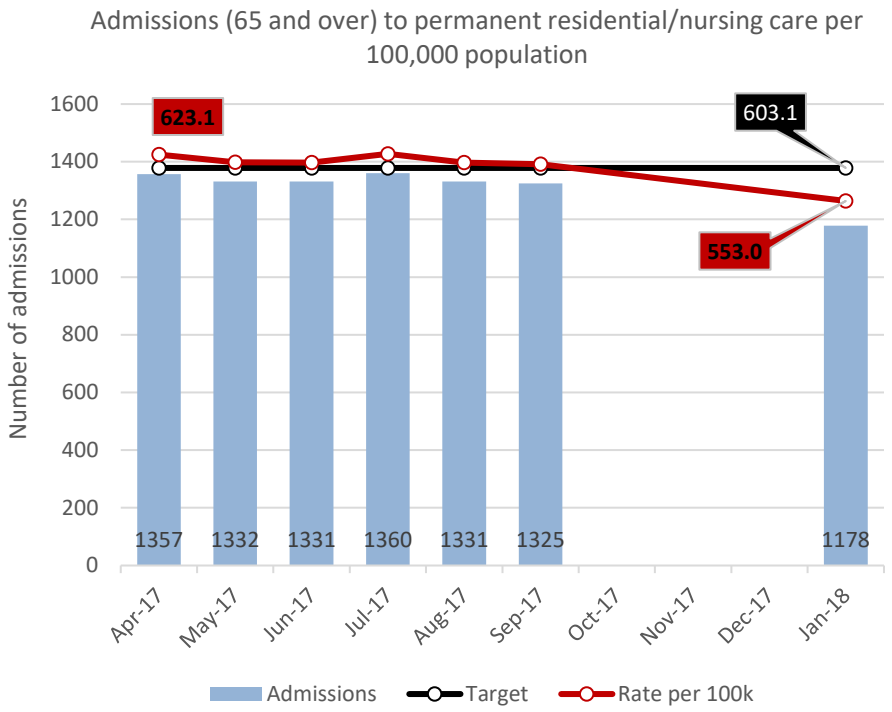
Responsible Officers	Lead: Lorna Bright, Assistant Director Social Work	Data: Intelligence and Analytics Service

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

Why is this important?

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

Performance



What is the background to current performance?

- Historically admissions to residential care have been higher than Norfolk's family group average.
- Over the past 3 years the rate of admissions in Norfolk has reduced significantly from a rate of 724.0 admissions per 100k population in 2014/15 to 611.9 admissions per 100k population in 2016/17.
- Monthly reporting of performance shows there has been a slowing down of improvement since March 2016.
- Nevertheless, rates of admissions continue to fall.
- The change to the Liquid Logic system meant a reporting hiatus between September and January. January's figures show a significant reduction in permanent admissions. Further work is ongoing to determine whether these were offset by an increase in short term placements or other services.
- In addition, in CareFirst there was usually a 'reporting lag' of around three months, meaning that delays in recording cases led to figures only being correct around three months in arrears. This should not be the case with Liquid Logic in the future – however we will closely monitor any changes in the data and report back to committee if the numbers go up retrospectively.

What will success look like?

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

Action required

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

Responsible Officers	Lead: Lorrayne Barrett, Director of Integrated Care, and Lorna Bright, Assistant Director Social Work	Data: Intelligence and Analytics Service