Norfolk County Council

Adult Social Care Annual Quality Report 2016/17

1 Introduction

1.1 The Care Act

1.1.1 The Care Act requires councils with adult social care responsibilities to promote the wellbeing of their adult residents and to prevent, reduce or delay the need for social care services. People will of course always require care and support for a number of reasons including lifelong disabilities or an event in their lives as well as simply ageing.

1.1.2 Norfolk County Council (the Council) has responded to its Care Act duties through its Promoting Independence strategy which will help people maintain their independence for as long as possible obviating the need for formal funded care. When people do need social care and support it is often provided through the care market consisting of hundreds of care businesses.

1.1.3 The Act also requires councils to promote the effective and efficient operation of its care market in which there is a choice of high quality services. The majority of the services provided are subject to national statutory quality standards which are assessed by the Care Quality Commission (CQC) who publish quality ratings. These published ratings and other intelligence gathered about the quality of services from complaints and concerns for example enable the Council to target providers who are not performing well enough as it remains the duty of the Council to ensure that the quality of services is good.

1.1.4 In order to ensure that the Council was well placed to secure quality services as required by the Act a formal Quality Framework was adopted by the Adult Social Care Committee (the Committee) in January 2015. The framework requires the production of an annual quality report and this report is the second such report since the Act came into force and the framework was adopted.

1.2 The Quality Framework

1.2.1 The quality framework itself is a published document and can be accessed through the following link www.norfolk.gov.uk/careproviders. The framework is based on a set of principles which are set out below:

- Supports a whole systems approach to promoting individual wellbeing and independence
- Supports the development and implementation of quality standards that set out what good looks like
- Sets out how high quality care provision will be secured from the market
- Sets out how provider performance will be monitored and how the effective and efficient operation of the market will be promoted
- Sets out governance, review and oversight arrangements that will enable the Council to judge the extent to which it is discharging its responsibilities properly

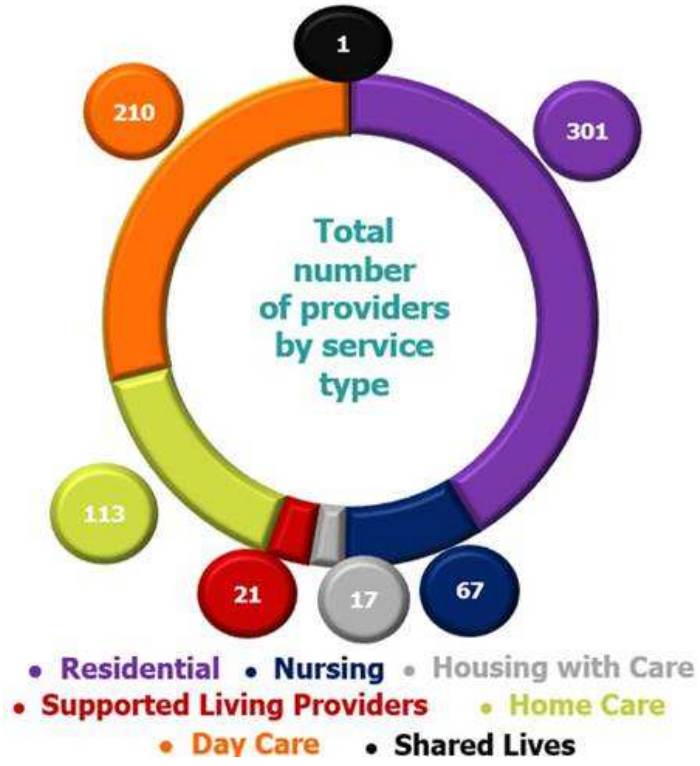
1.2.2 At the heart of the framework is the development of a systematic approach to quality assurance involving standard setting, securing quality, monitoring quality and intervention and finally governance, review and reporting.

1.3 The Care Market in Norfolk

1.3.1 The care market in Norfolk is large and complex providing a vast range of services to thousands of adults whose needs vary significantly and whose expectations as to quality and choice continue to rise. (For a comprehensive overview of this market please refer to the Council's Market Position Statement 2016). (An updated market position statement will be published in July 2017).

1.3.2 The Council currently invests over £260m annually in this market to support more than 15,000 adults mainly through contracts with almost a thousand different care providers most of whom are independent businesses. The diagram below shows how many accredited providers there are in each of the main sectors of the market. Even this, however, is not the full picture as there are increasing numbers of personal care providers directly employed by individuals using direct payments from personal budgets.

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



1.3.4 There are 520 providers subject to CQC assessment and a further 210 day care providers not subject to CQC inspection but required to pass the Council's quality criteria to be accepted on the accredited list. This makes a formal care market of 730 providers.

1.3.5 This formal care market is needed when informal social care is not available. Over 94,000 people are providing informal social care in Norfolk together with numerous

organisations and community based groups whose contributions are estimated to be worth at least £500,000 annually.

1.3.6 The Council itself still provides some formal social care directly through its rehabilitation service but over 98% of formal social care is sourced through the formal care market. This makes it even more important that the Council has a systematic and effective approach so that it can be confident that it is investing in quality care. This means care that is effective in supporting the outcomes that people want and is fully compliant with national standards irrespective of whether they fund the care themselves or the Council does.

2. Setting standards and assessing quality

2.1 Care Quality Commission

2.1.1 The quality framework begins with standards of quality. The starting point is the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which include regulations which are the fundamental standards of care below which no registered provider should fail.

2.1.2 The CQC is responsible for the registration, inspection and assessment of all registered providers. It is important to understand, however, that the Care Act places the duty of securing the quality of care in Norfolk on the Council itself.

2.1.3 The CQC assessment process asks five key questions about the service:

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

2.1.4 Each area of enquiry is known as a domain and each of these is rated as either

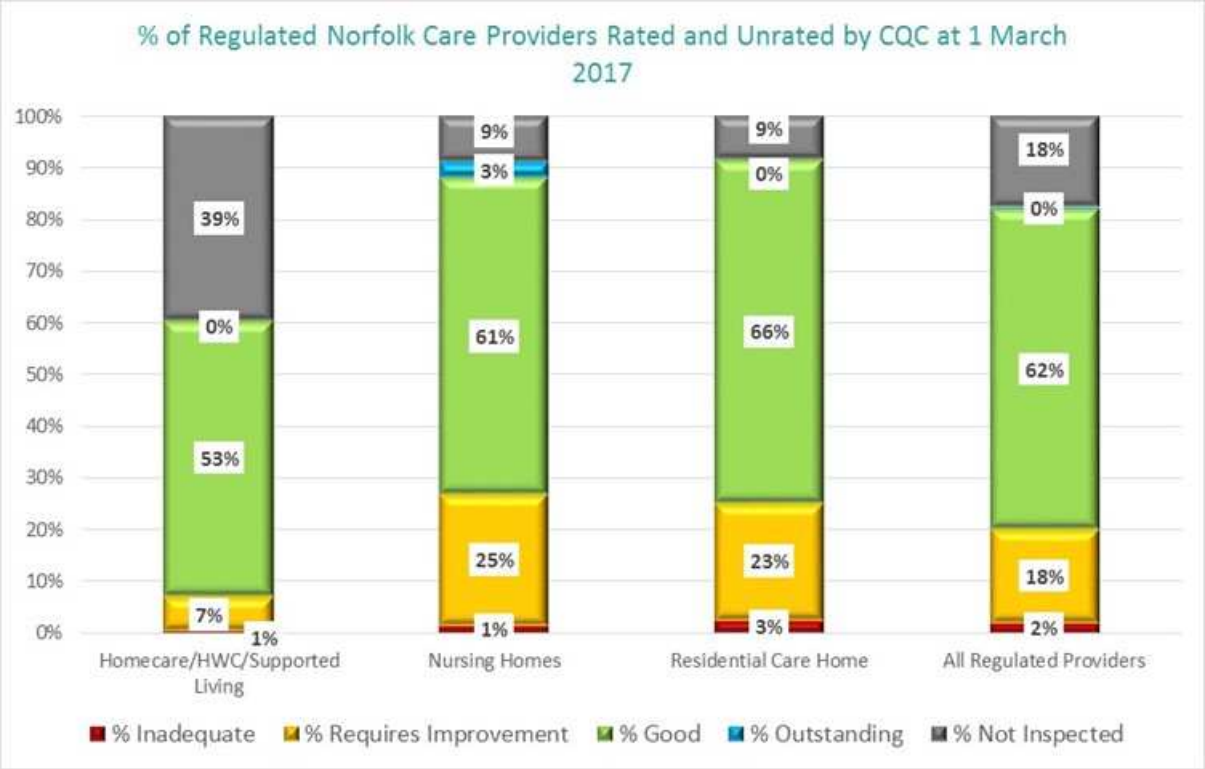
- Inadequate.
- Requires improvement.
- Good.
- Outstanding

2.1.5 These domain ratings are published along with an overall rating.
Some care needs to be taken as there is a delay between the assessment and publication of the assessment and there are occasions when improvements have already been made by the time of publication.

2.2 How are providers in Norfolk doing against CQC ratings?

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

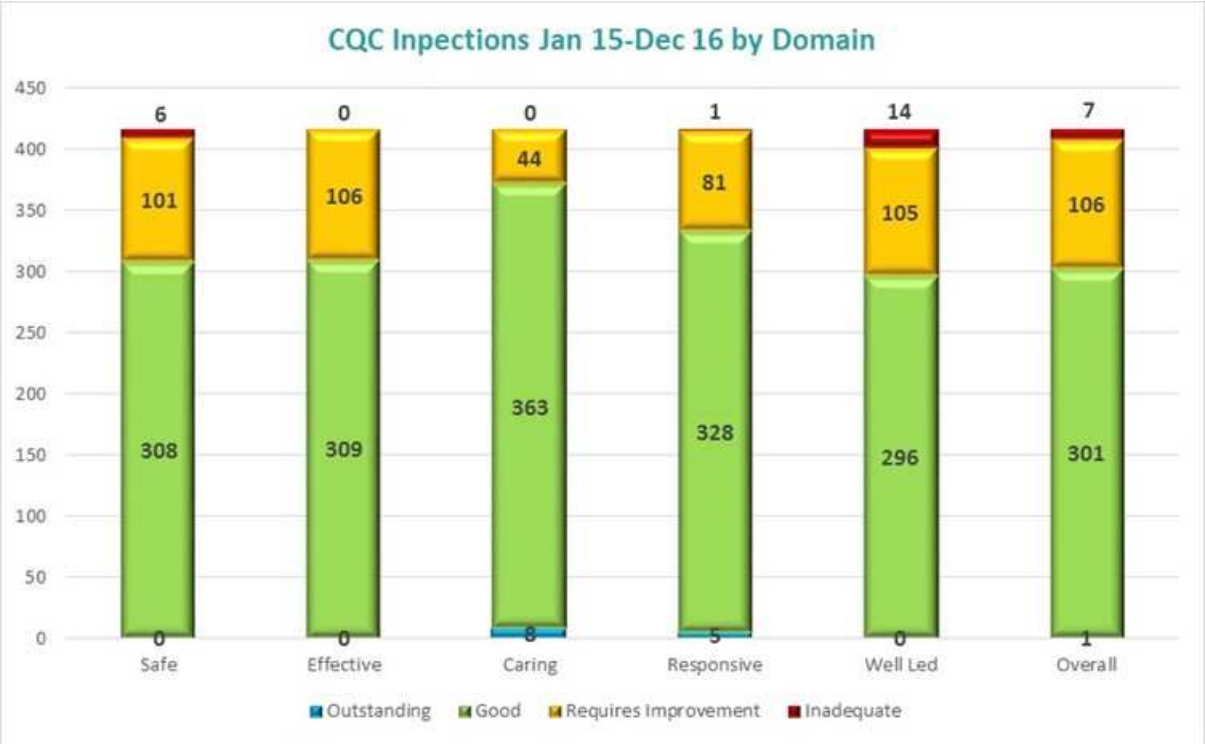
2.2.2



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

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

2.2.5



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

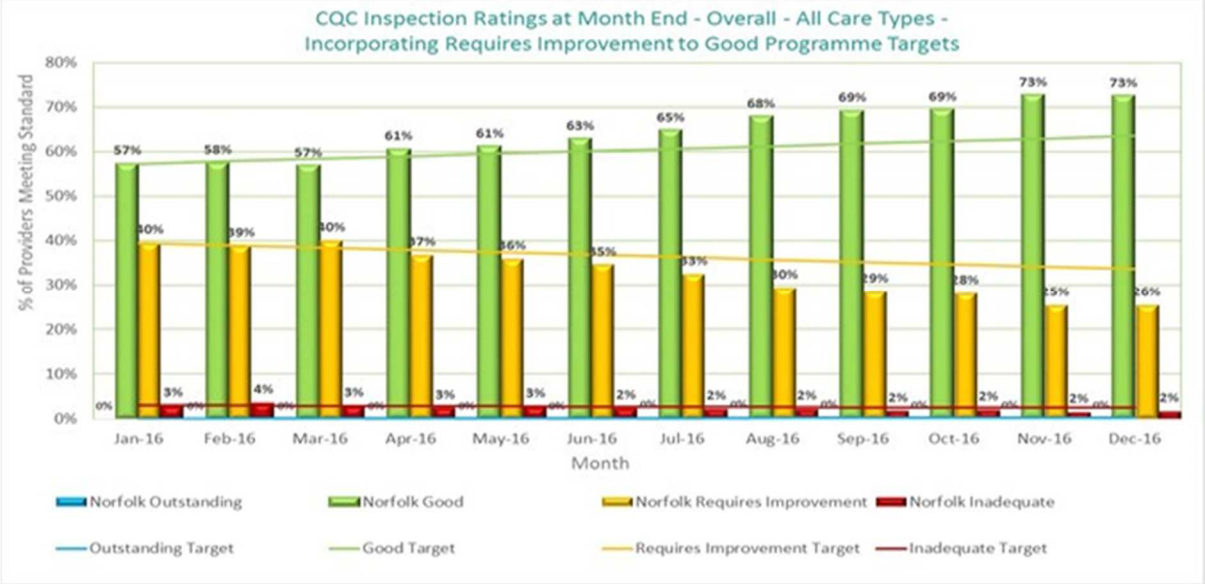
2.3 Requires improvement to good programme (RIG)

2.3.1 A new programme of targeted interventions called Requires Improvement to Good (RIG) was introduced during 2016/17 in which targets were set so that no more than 20% of providers would be rated as requires improvement and conversely at least 80% would be rated as good by the end of the 2018/19 year.

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

2.4 Overall ratings whole market

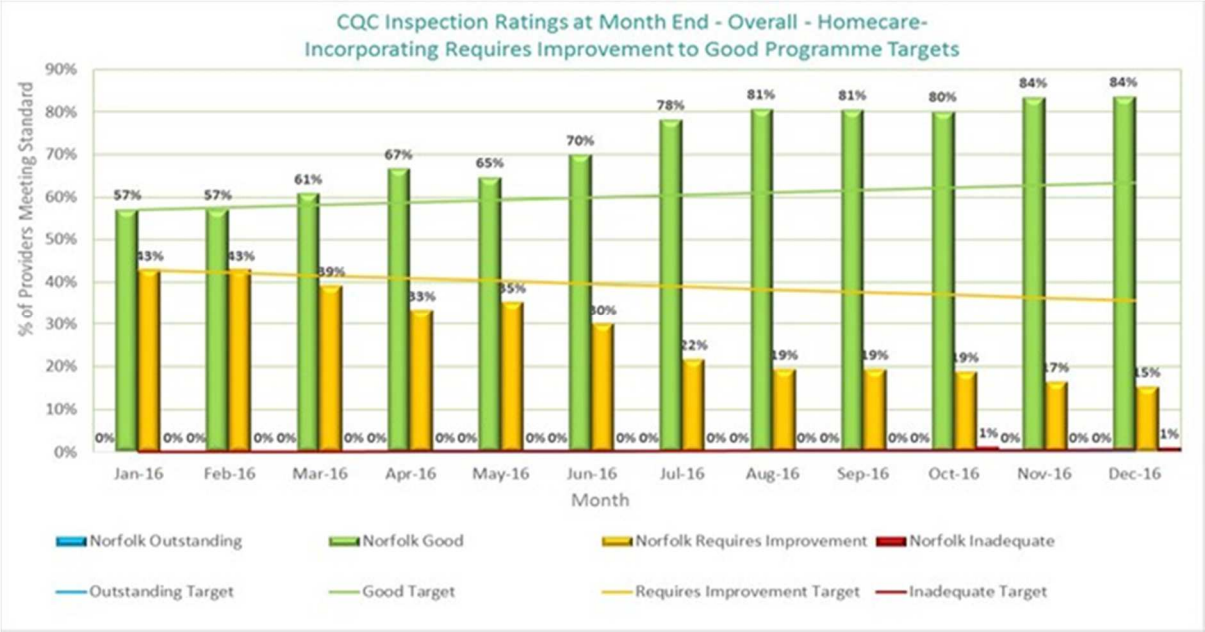
2.4.1



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

2.5 Ratings for home care

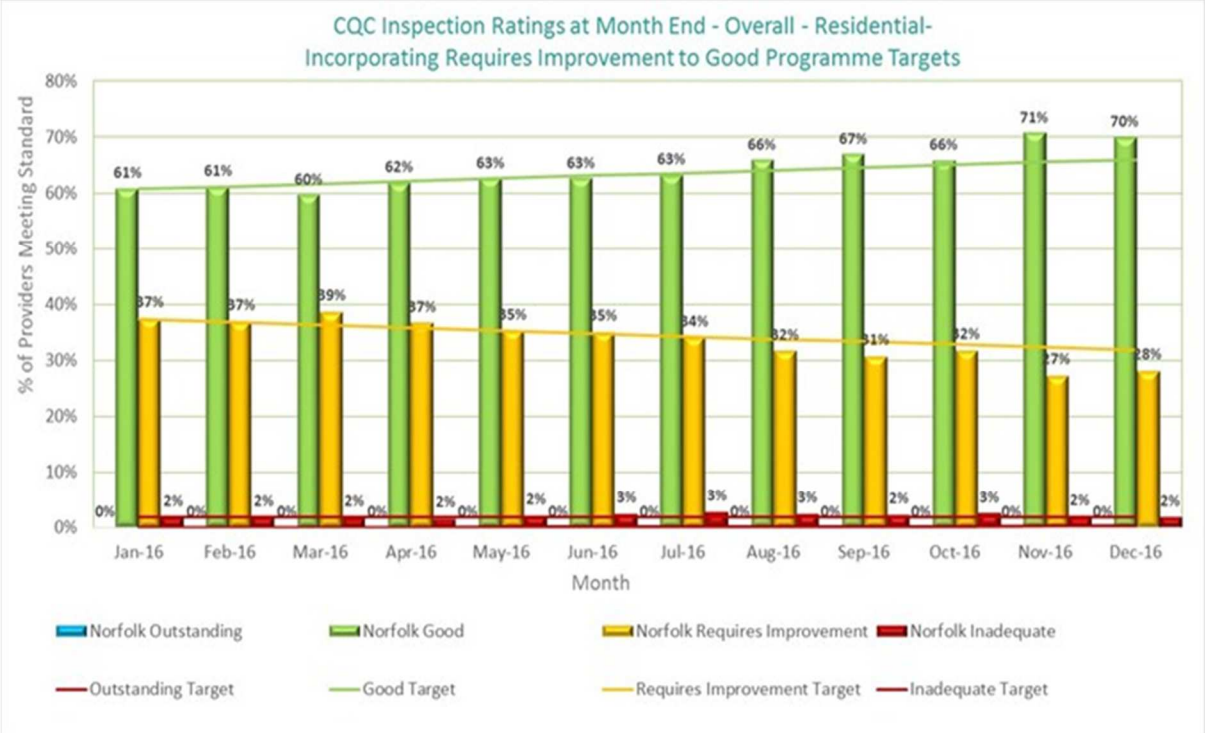
2.5.1 The diagram below shows the same data but by care sector starting with home care.



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

2.6 Ratings for residential care

2.6.1

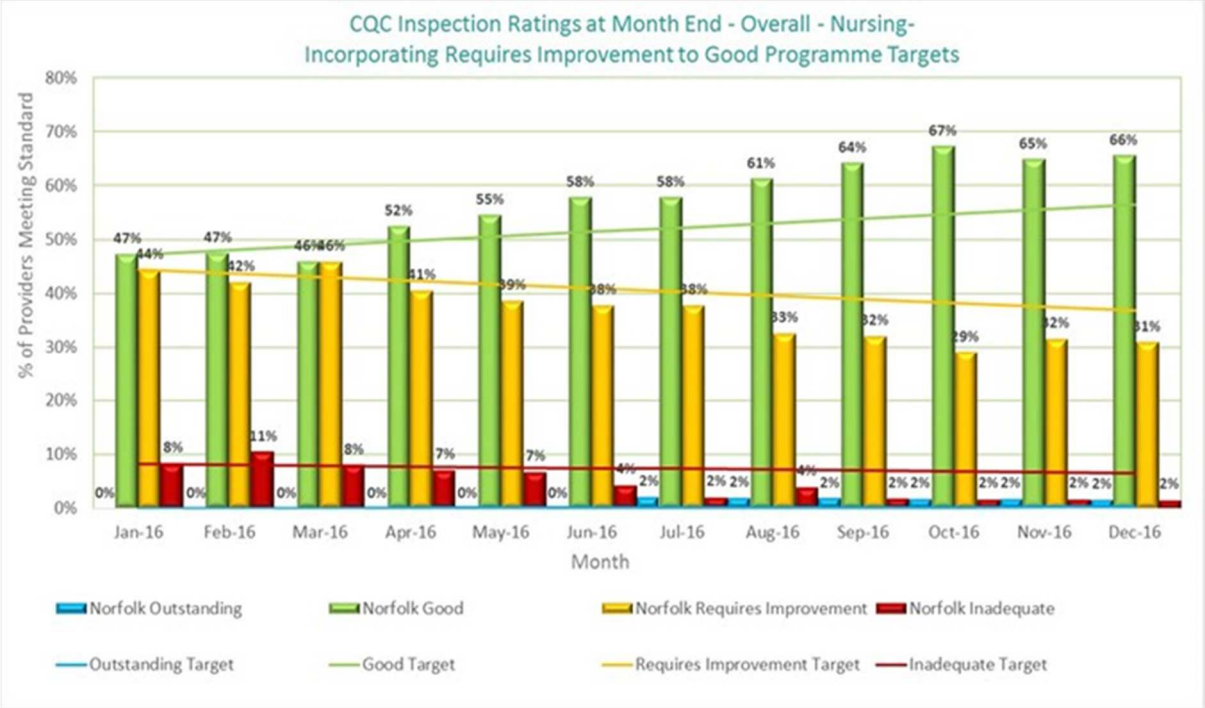


2.6.2 It can be seen that whilst the RIG target trajectory is being met 28% of residential care homes still require improvement. This equates to about 84 care homes.

2.7 Ratings for nursing care

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

2.7.2



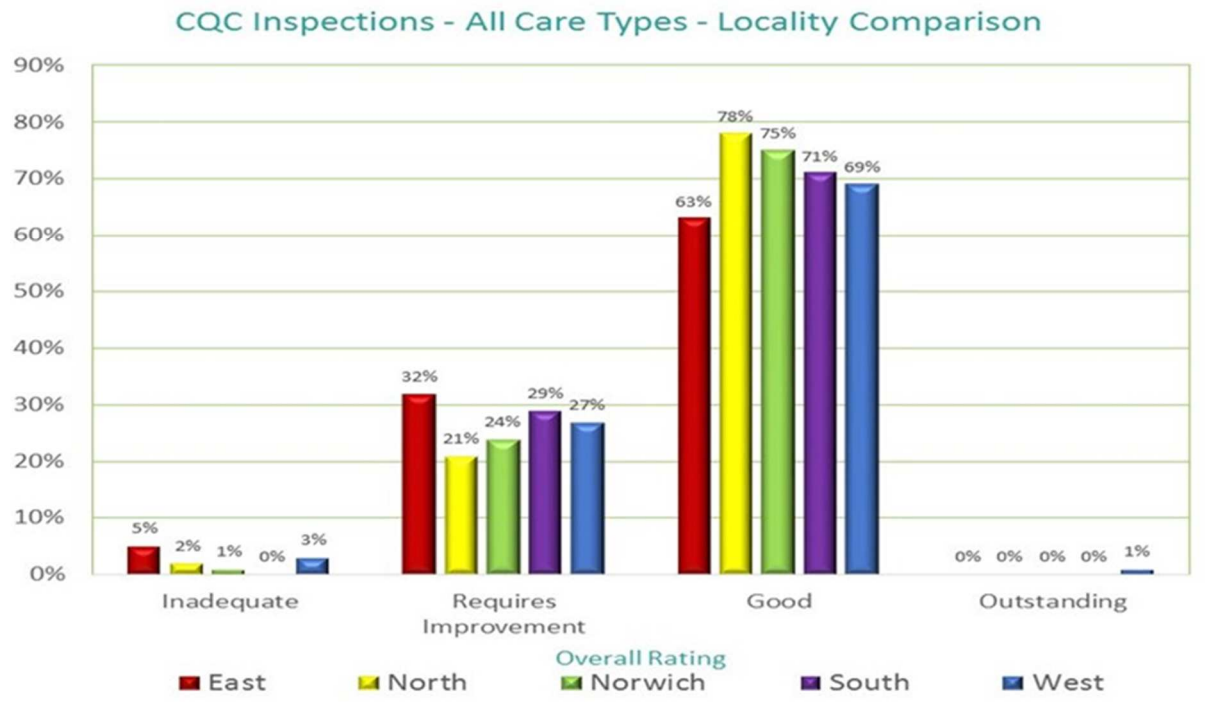
2.7.3 The RIG target is being exceeded and there has been a significant improvement from a bad start, however, 31% of nursing homes require improvement which equates to about 22 homes.

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

2.8 Ratings for all care types by location

2.8.1 There are variations in ratings between the five locality areas that correspond broadly to the Clinical Commissioning Groups (CCGs) as shown in the diagram below.

2.8.2

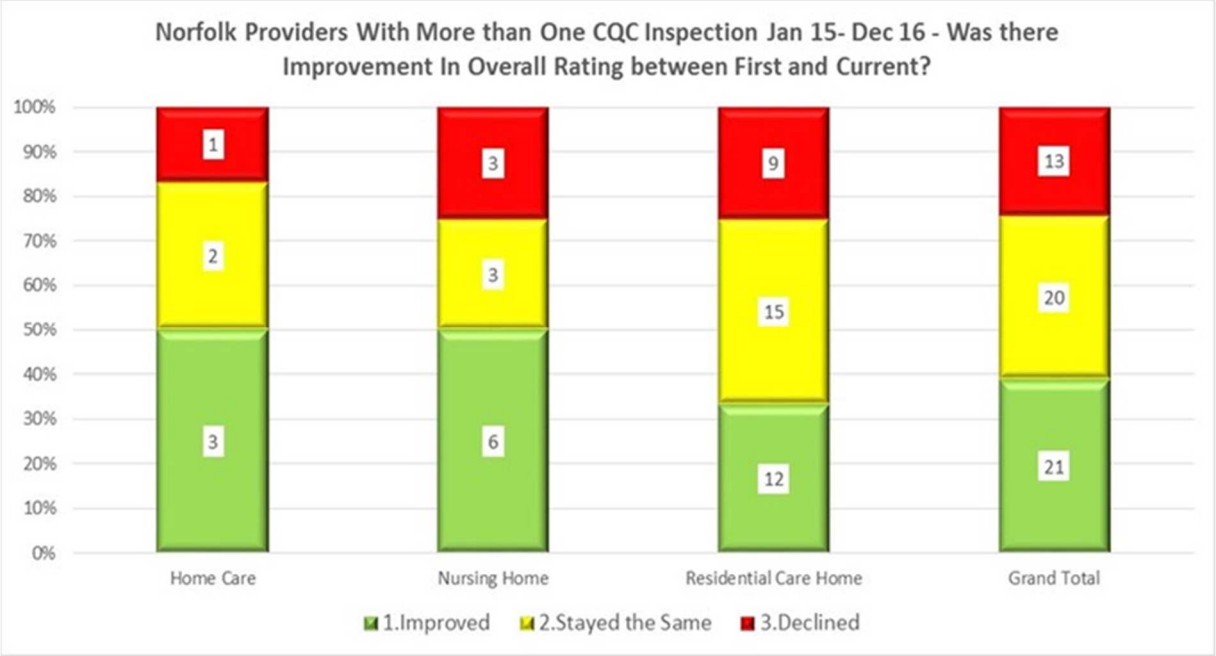


2.9 Persistently underperforming providers

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

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

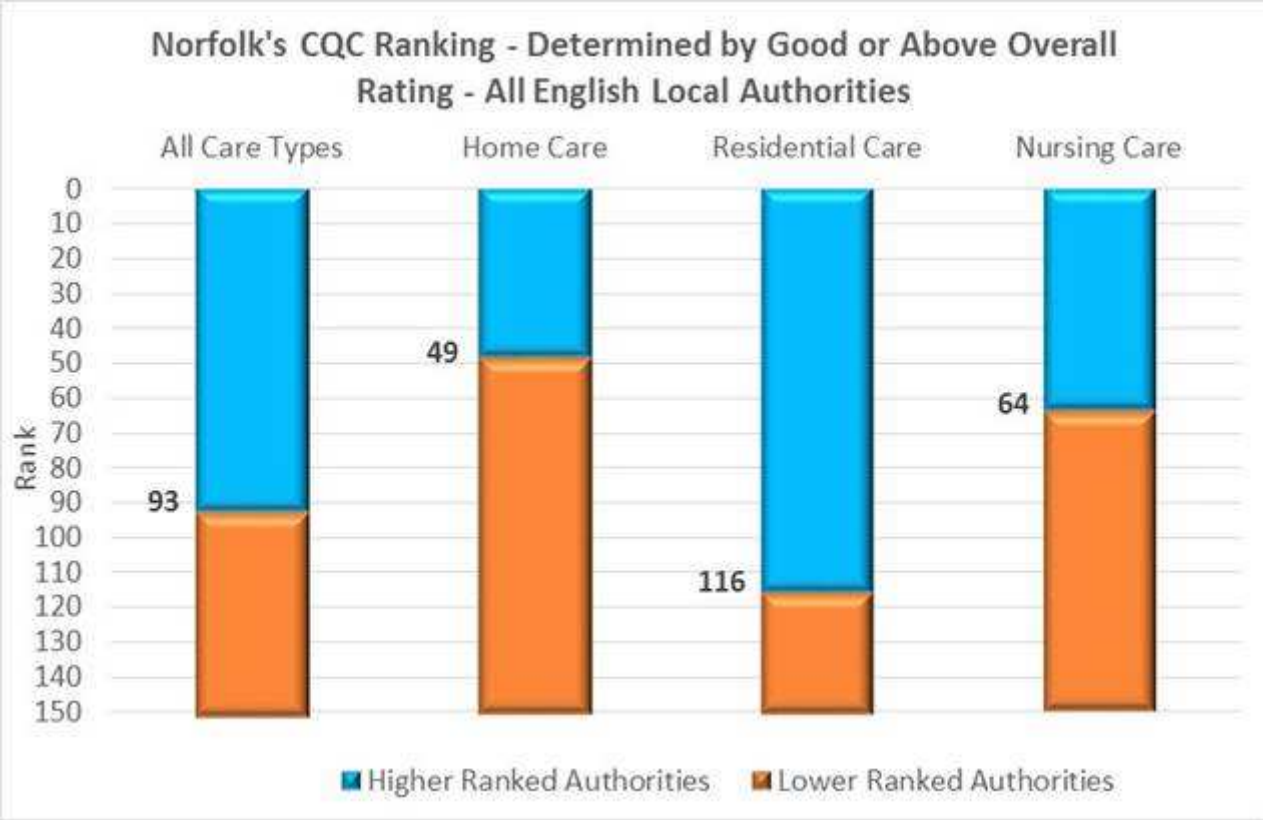
2.9.3



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

2.10 Norfolk ranking against other adult social care local authorities

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



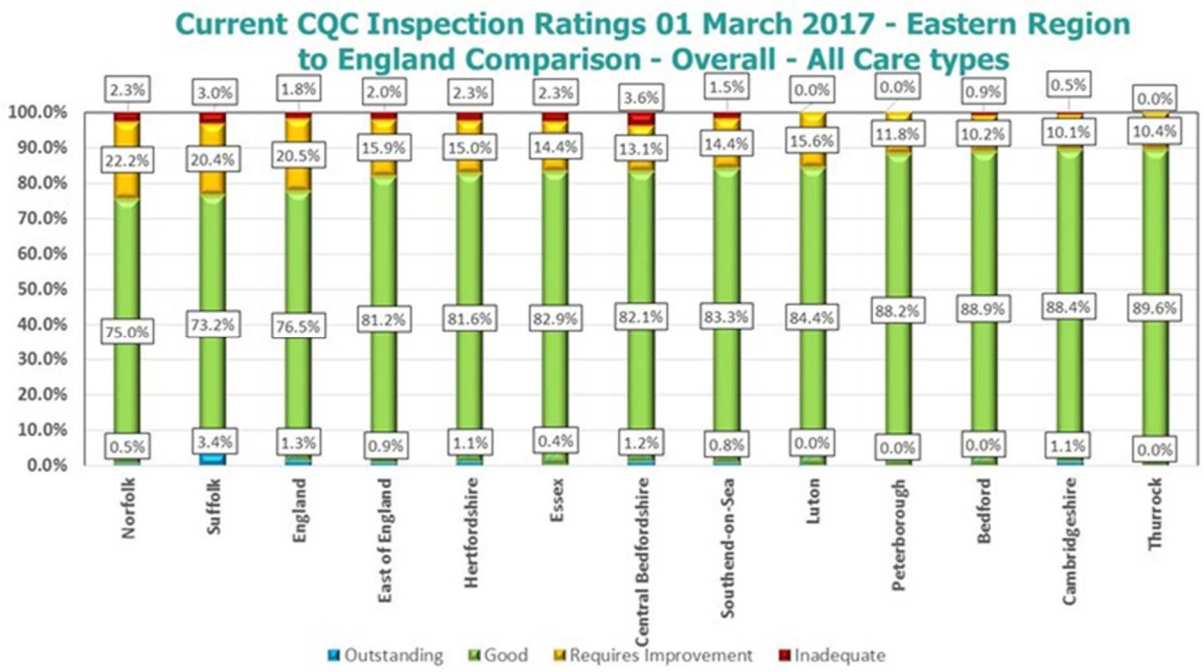
To be in the top quartile Norfolk would need to rank at 38 or better. Currently Norfolk is outside the top quartile in all three sectors and is in the lowest quartile for residential care.

2.11 Norfolk comparison with the East of England

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

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

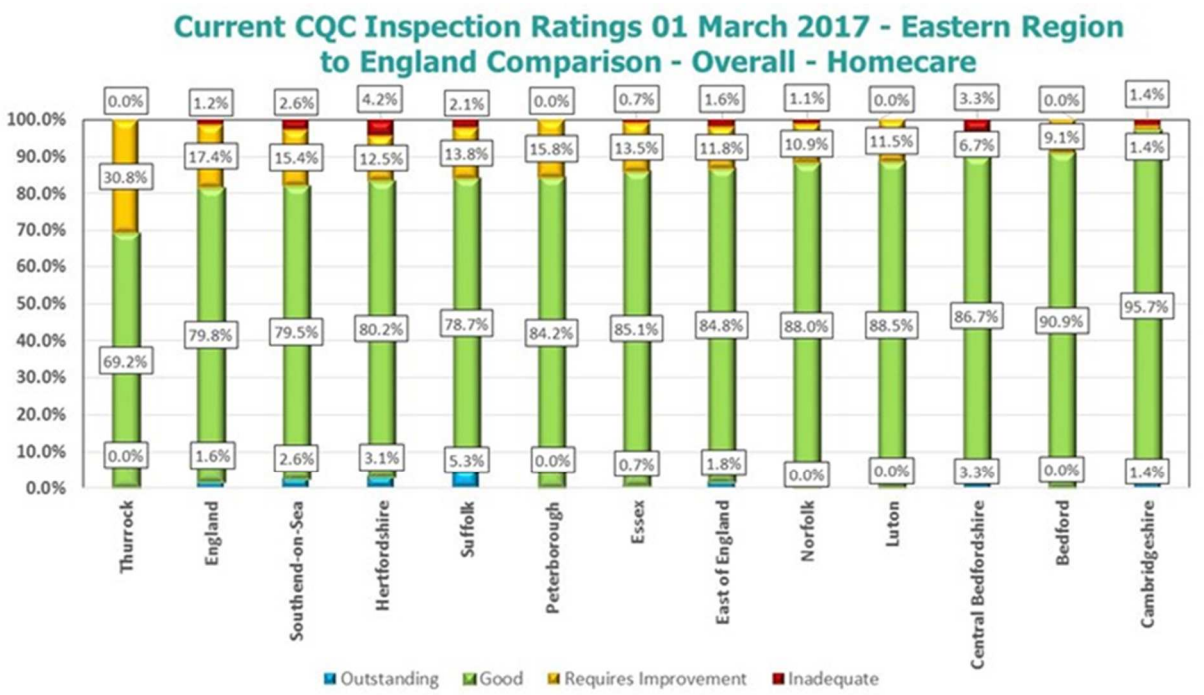
2.11.3



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

2.12 Home care

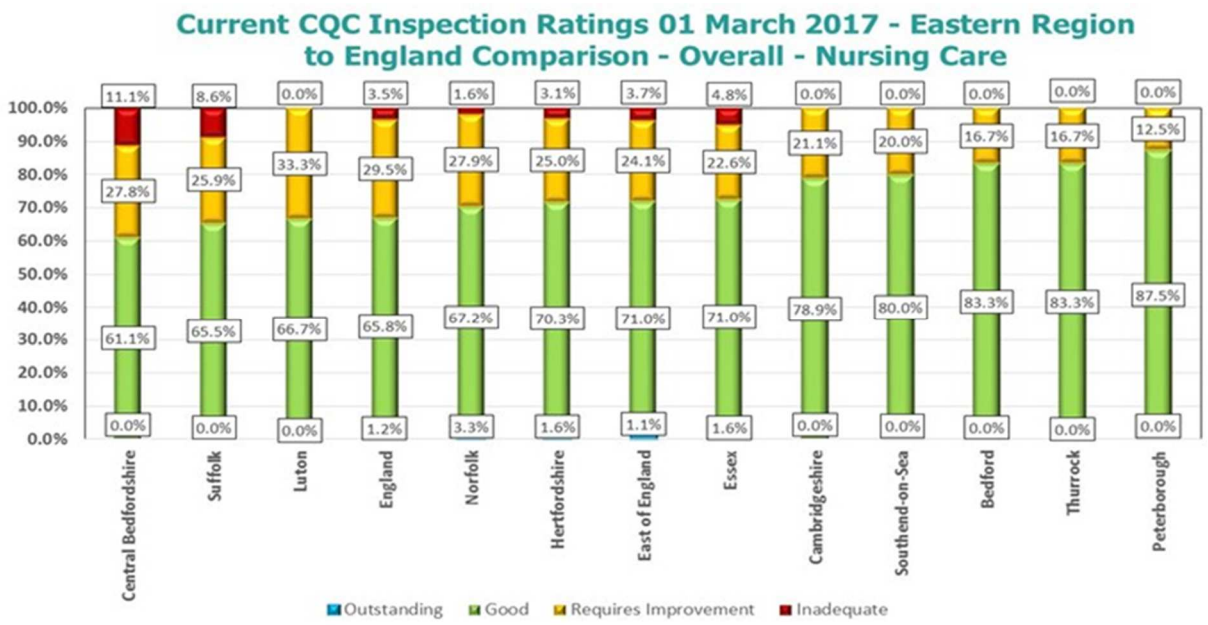
2.12.1



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

2.13 Nursing care

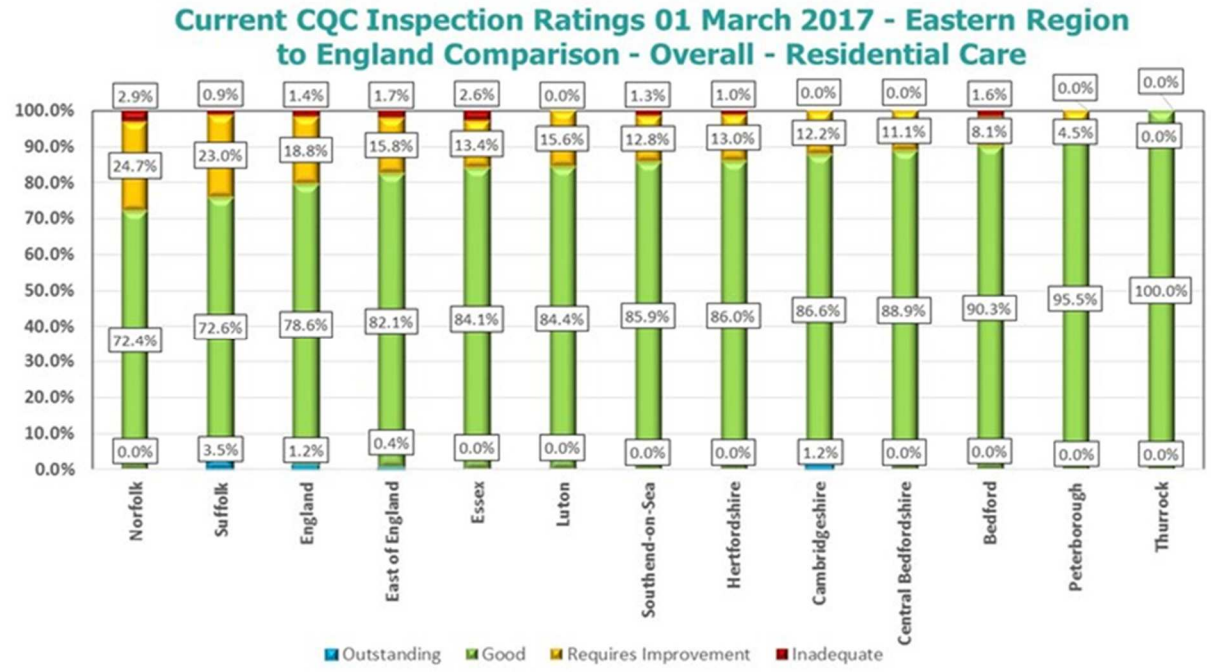
2.13.1



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

2.14 Residential care

2.14.1



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

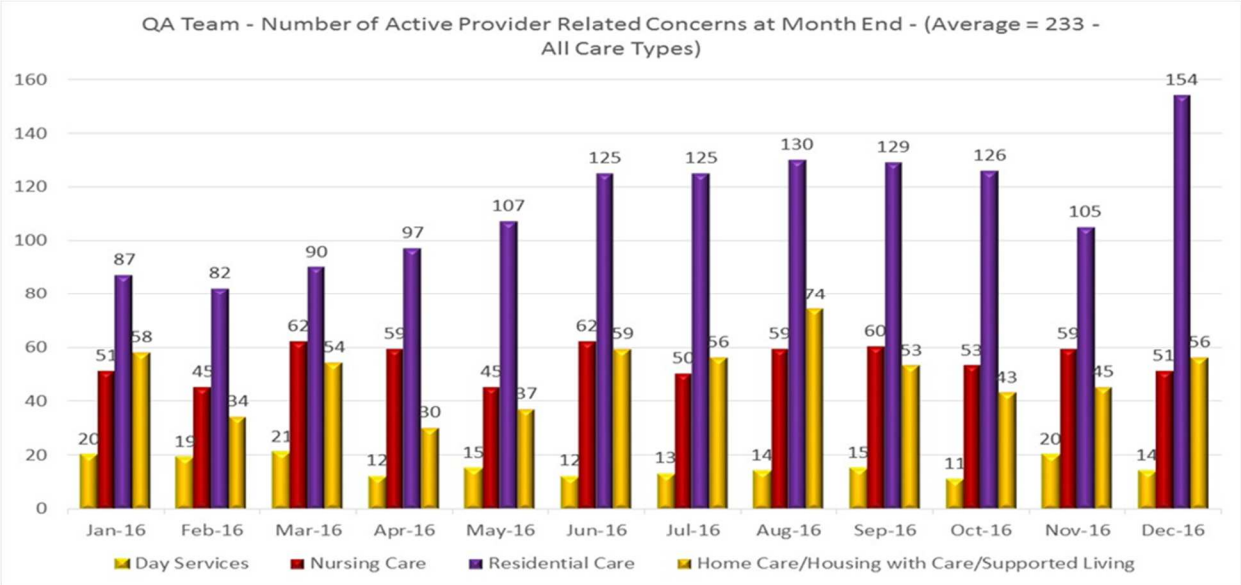
3. Securing quality at local level

3.1 The Quality Assurance Team

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

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

3.1.3



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

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

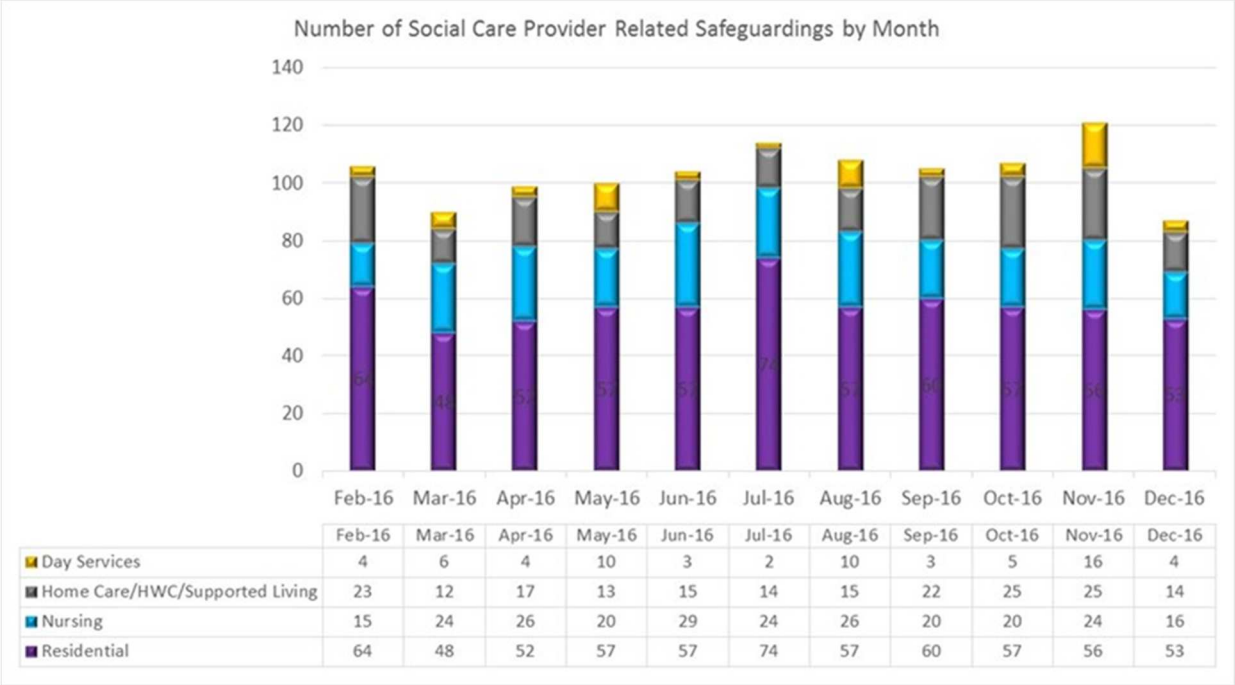
- 75% of all nursing homes
- 60% of all residential homes
- 25% of homecare agencies
- 20% of day services

3.2 Safeguarding

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

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

3.2.2

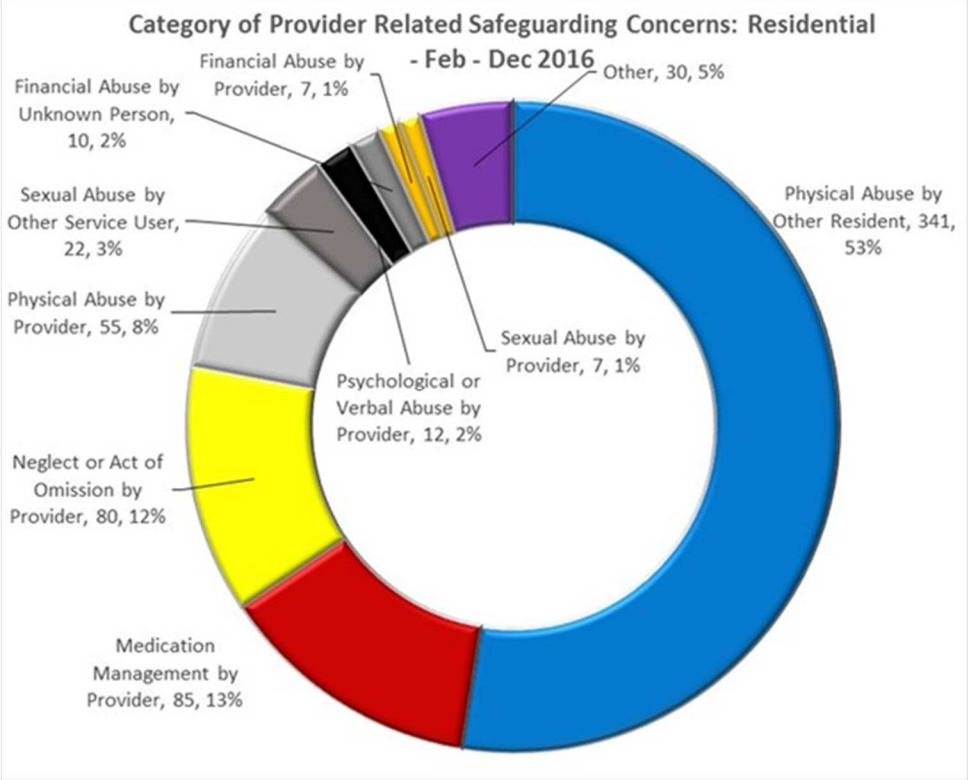


	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Day Services	4	6	4	10	3	2	10	3	5	16	4
Home Care/HWC/Supported Living	23	12	17	13	15	14	15	22	25	25	14
Nursing	15	24	26	20	29	24	26	20	20	24	16
Residential	64	48	52	57	57	74	57	60	57	56	53

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

3.3 Residential care

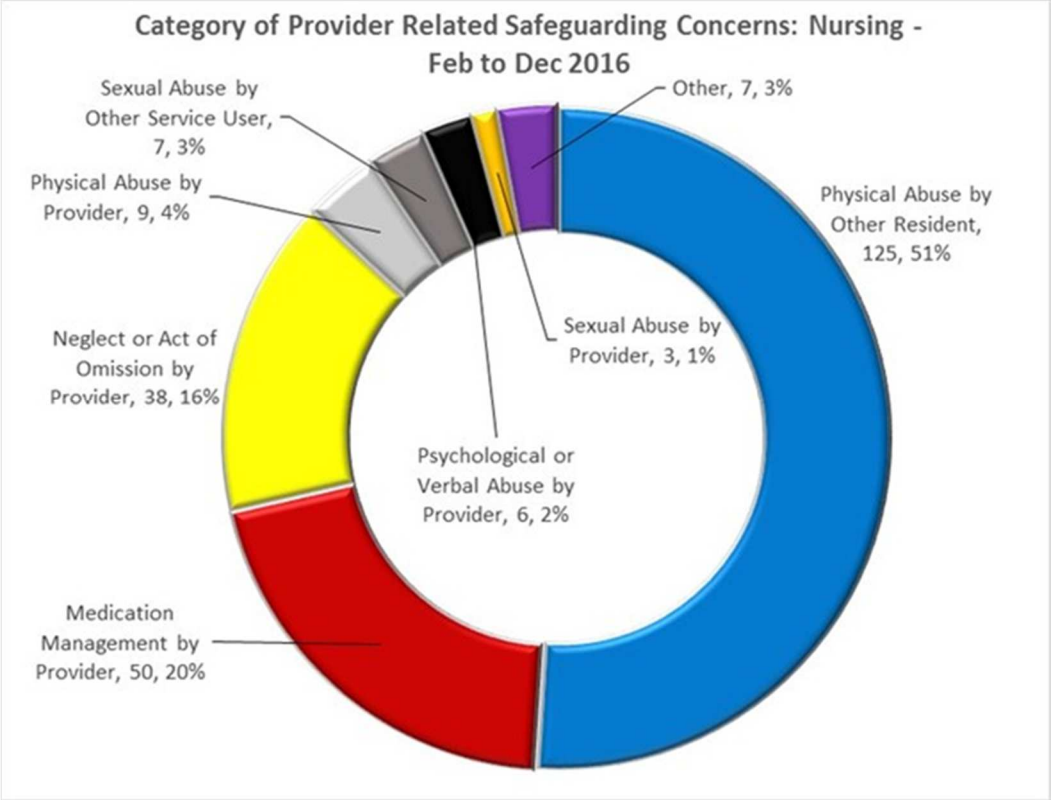
3.3.1



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

3.4 Nursing care

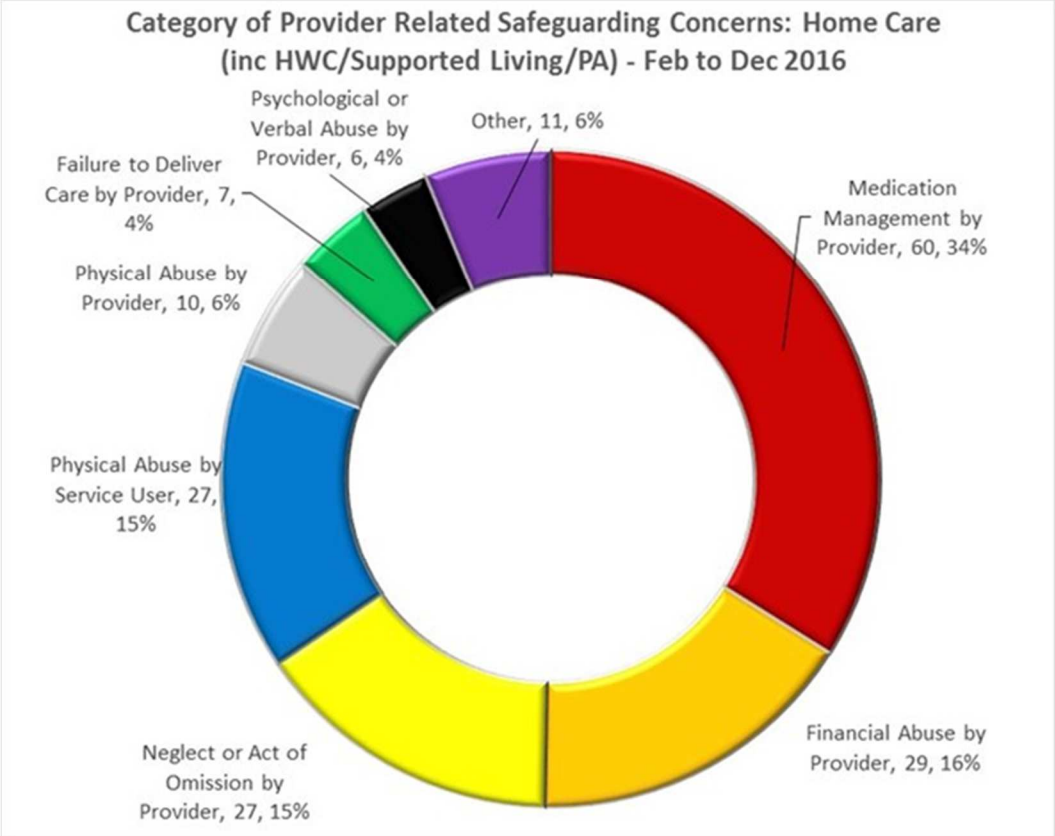
3.4.1



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

3.5 Home care

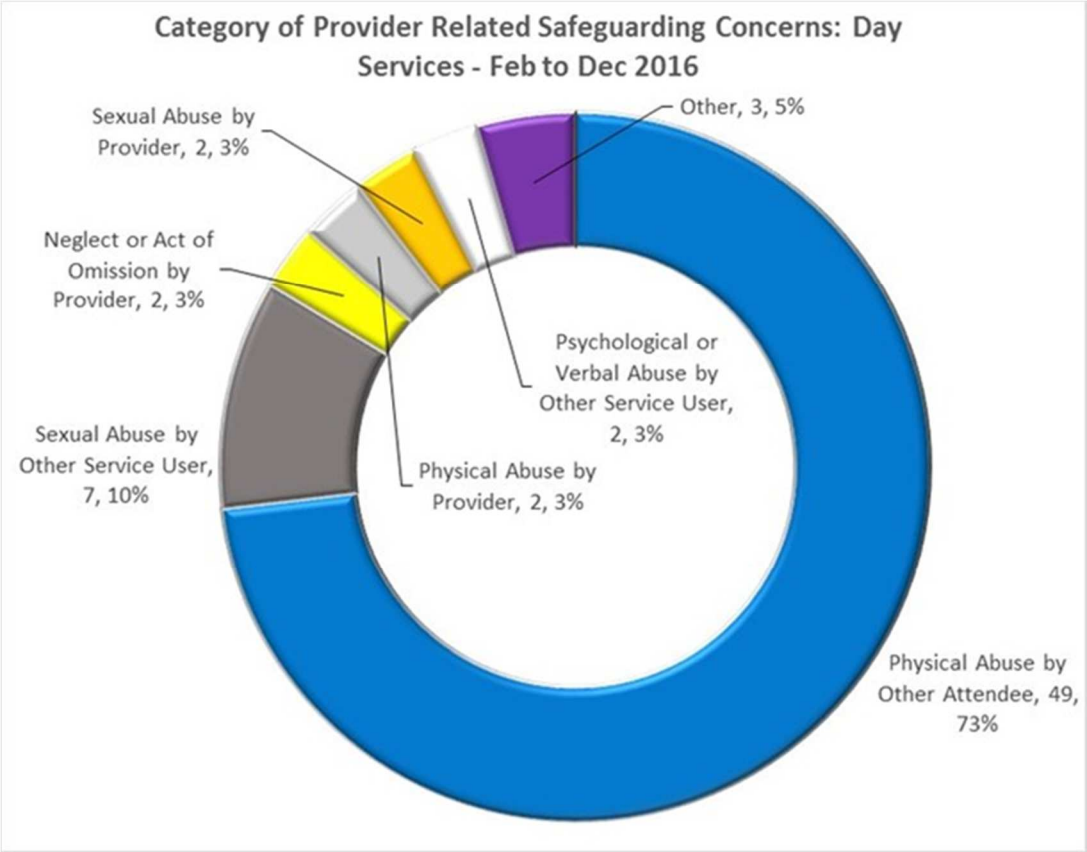
3.5.1



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

3.6 Day care

3.6.1



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

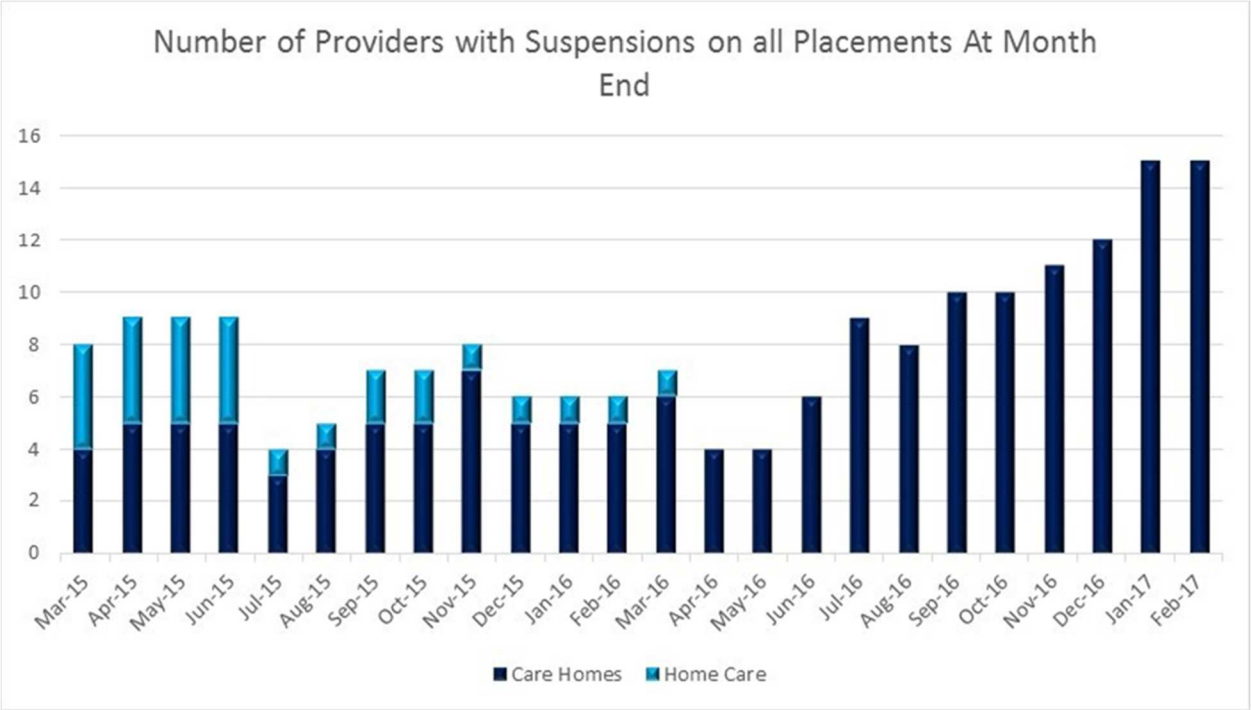
3.6.3 In summary the diagrams indicate that:

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

3.7 Suspension on placements

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

3.7.2



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

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

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

3.8 Targeting high risk providers

3.8.1

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

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

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

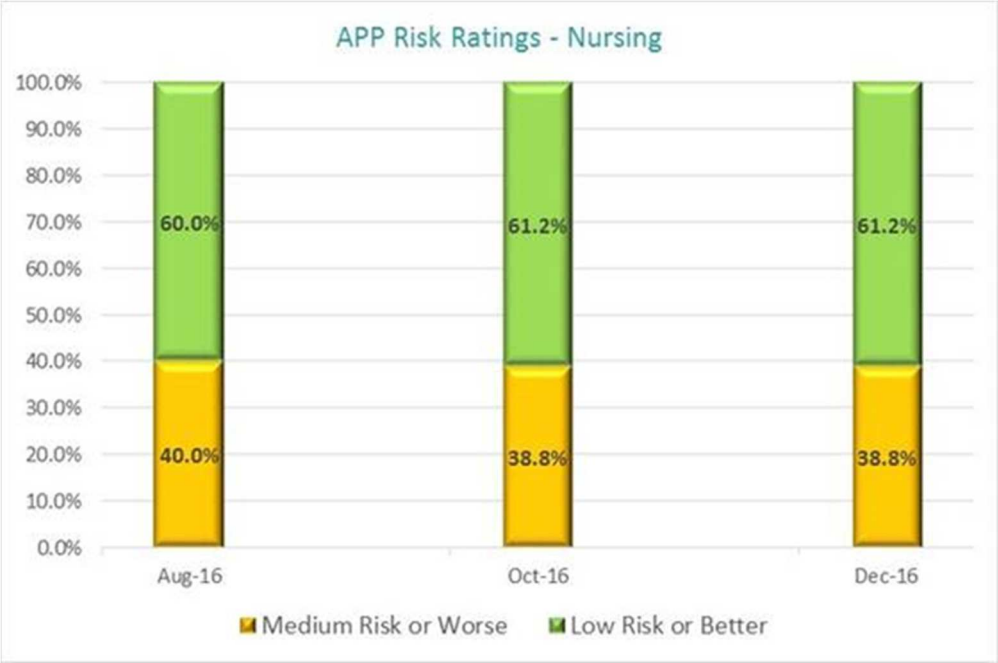
3.8.3 The system also acts as a case management and performance management tool enabling the quality manager to ensure that workloads are balanced and prioritised.

3.9 Current APP ratings

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

3.10 Nursing homes

3.10.1



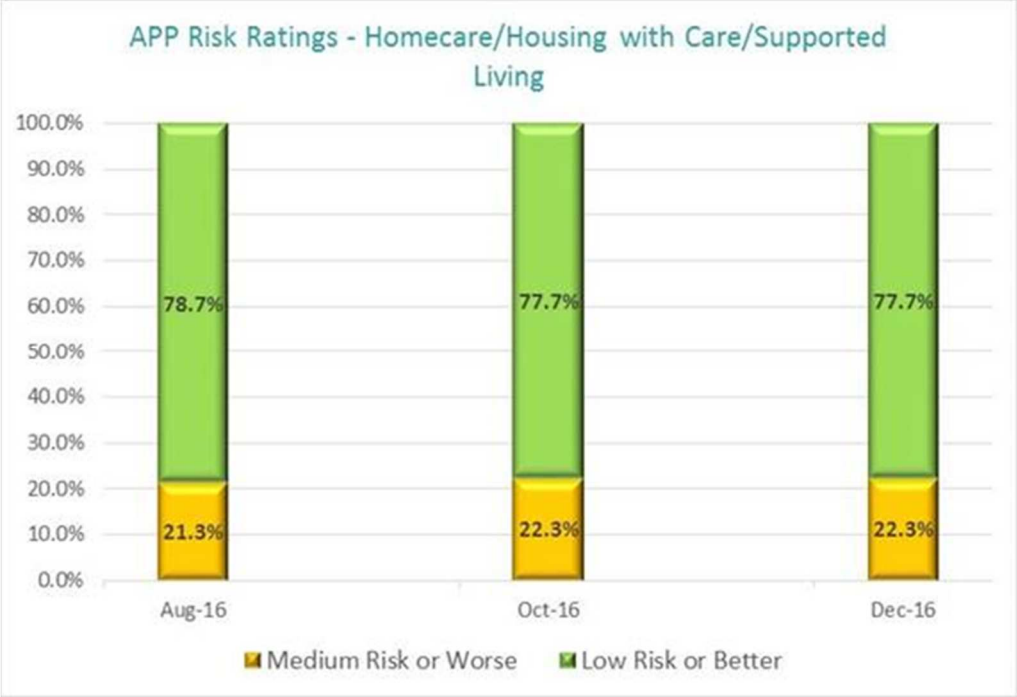
3.11 Residential care homes

3.11.1

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

3.12 Home care

3.12.1



3.12.2 About 1 in 5 home care providers are giving rise to quality concerns some of which is due to the inability of the market to respond to demand. This means that some people are waiting at home for care which is not available, or cannot be discharged from hospital to go home, or are in temporary residential or nursing care waiting to be able

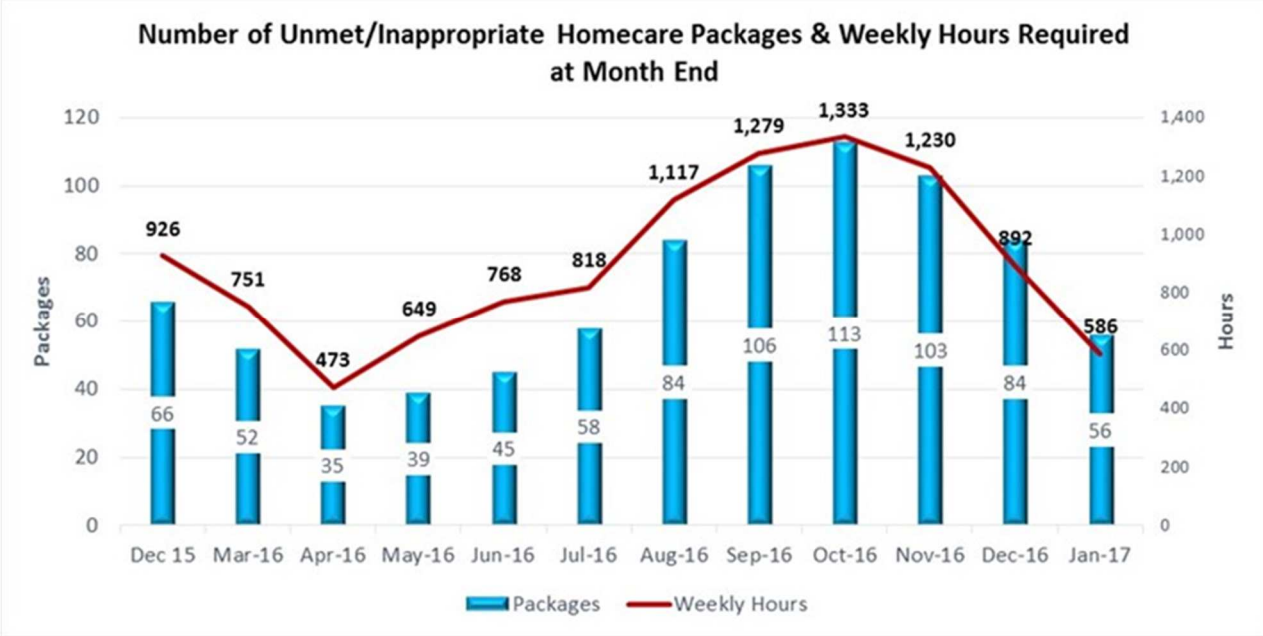
to go home. In addition some people have successfully completed their rehabilitation through the Council's own service and continue to be looked after by that team until home care becomes available.

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

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

3.12.5 The diagram below shows the scale of the problem

3.12.6



3.13 Quality Dashboards

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

4. Quality improvement strategy 2017/18

4.1 This report sets out a comprehensive picture of the quality of adult social care in the formal care market in Norfolk in 2016/17. The report shows the scale of the interventions carried out by the Council to help providers who have fallen below the

minimum quality standards required. The Quality Framework supports the continuous improvement of quality and the next section of this report sets out the Council's quality improvement strategy.

4.2 Care homes

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

4.2.2

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

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

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

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

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

4.3 Using market intelligence to target quality improvement - APP system

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

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

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

4.5 Promoting the Harwood Care Charter

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

4.6 Using service user feedback to drive quality improvement

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

4.7 Delivering a sector skills plan to support the workforce

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

4.8 Investing in and engaging with the market

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

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

4.9 Innovative commissioning and Integrated approaches

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

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

4.10 Care conference

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

4.11 Norfolk care awards

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

4.12 Capacity review

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