Adult Social Care Committee

Item No……

Report title:	**Performance management report**
Date of meeting:	**9 October 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 covers these aspects of Adult Social Care performance:

a) It introduces the most critical measures against our strategy Promoting Independence, and proposes targets against those measures for regular and detailed review by this Adult Social Care Committee (the Committee)
b) It proposes three additional measures for regular and detailed review, and includes targets against two of these

Taken together it is proposed that these measures are the subject of regular detailed reporting to the Committee. The measures and associated targets for the next three years, have been selected because they are the best indicators we have of whether the changes we aim to make are having impact.

Recommendations

The Committee is asked to:

a) Discuss the overall performance position for adult social care as described in section 2
b) Agree targets against the measures as set out in the table at section 4

1 Introduction

1.1 This report covers these aspects of Adult Social Care performance:

a) It introduces the most critical measures against our strategy Promoting Independence, and proposes targets against those measures for regular and detailed review by this Committee
b) It proposes three additional measures for regular and detailed review, and includes targets against two of these
c) It provides a link to the fuller suite of measures (vital signs) which have been regularly reported to this Committee

2 Performance overview

2.1 Adult Social Services teams continue to handle a high number of requests for support which is in line with well-understood changes in population and people's increasingly complex needs. Our strategy continues to be to connect people with support in their communities, building on strengths and assets already in people's lives. The last 12 months of available data shows that Norfolk County Council (the Council) is receiving between 3,500 and 4,800 enquiries a month depending on seasonal trends, and over this period between 33% and 40% of these enquiries were resolved immediately with information, advice and guidance.

2.2 Locality teams are reporting increased pressure on them, particularly as a result of the focus by the health and social care system to reduce the length of time people stay unnecessarily in hospital. Each area, working closely with primary care, has new approaches in place to avoid unnecessary admissions to hospital and to helping people to come home as soon as they can.

2.3 The Department of Health (DoH) has made clear its expectations to health and social care systems to hit stretching targets for delayed discharges of care, set through the Improved Better Care Fund process. For Norfolk and Waveney this means that overall delayed transfers of care must reduce by 16% between July 2017 and March 2018, and that delays attributable to Adult Social Services must reduce by 21% over the same period.

2.4 Additional monies from the Government for adults is being directed towards this priority. This includes the additional social work capacity, new types of reablement, strengthening of homecare, and targeted prevention work to address the triggers which can lead to people being admitted to hospital. For adults, it is important to establish new services outside of hospital where people can re-gain as much independence as possible before making long-term decisions about their future care. There is a risk that people moved swiftly out of hospital make long-term decisions in a state of crisis which are life-changing.

2.5 The number of people benefitting from reablement continues to be high which helps people to achieve the best possible levels of independence. There has been an overall increase in the number of people admitted to permanent residential and nursing care – a relatively high proportion of these have been following a stay in hospital. This will be a trend we need to monitor carefully, since it also brings budget pressures and works against our overall strategy.

2.6 We reported in July that teams were carrying significant backlogs of work. Since then, the position overall has slightly worsened, although some teams have begun to make reductions. Recruitment to additional capacity is underway, and the first wave has had a promising response. For further details please see **Appendix D**.

3. Promoting Independence – measuring impact and progress

3.1 Promoting Independence (PI) is the department's strategy for accelerating the delivery of improved outcomes for people who require adult social care and for meeting the financial targets set by Councillors for the next three years. We must ensure that our performance indicators align to the workstreams and milestones we have set as part of Promoting Independence. They must also align to and reflect other priorities, including the Better Care Fund (BCF) and the Sustainability and Transformation Plan (STP).

3.2 At the meeting of this committee in July 2017, a paper was received (Promoting Independence progress and actions for 2017/18) which set out six key measures that had been identified as aligning to the key intervention points of Promoting Independence workstreams, where we expect impact to be made.

The measures are:

a) Reducing the 'conversion' of requests for support to formal assessment by connecting people effectively with good quality information and support
b) Ensuring an appropriate proportion of assessments go on to require ongoing social care involvement
c) Reablement cases where the person does not require additional social care
d) Increasing the rate at which review backlogs are handled, and increasing the rate of reviews that lead to a reduction or cease in service
e) Reducing permanent admissions into residential care for people aged 18-64
f) Reducing permanent admissions into residential and nursing care for people aged 65 and over

3.3 The three-year targets proposed for these measures have been developed through using our cost and demand model. This is a modelling 'tool' which tracks the number of people at different stages throughout their involvement with adult social services. The model adds in changes for demography and increased demand, and estimates what impact the changes underway can reasonably be expected to have an impact.

3.4 Overlaid on this, we have looked at current benchmarking of our own 'family group' of authorities, national best practice, and our own internal expertise in data analysis and performance management. We propose reviewing the targets each year.

3.5 The proposed targets are described in detail in the report cards in **Appendix B**. What follows is here is a summary of each, together with an overview of current performance.

3.5.1 **Requests for support which go on to assessment (Appendix B – PI1)**

3.5.1.1 In 2016/17 the Council received around 61,000 requests for support, with 20,000 – or around 33% –ending with an intention to assess. Current performance shows this has reduced to just below 32%. However, leading practice in social care suggests that a quarter of contacts to social care should translate into a formal care act assessment. This highlights the need to expand and embed prevention and information strategies which connect people with support or advice so more people stay in control of their lives. We have modelled to achieve the best practice of 25% by the end of 2018/19, which would mean the figure for assessments reducing to 15,200. We would then aim to maintain that level going forward. Maintaining that rate will continue to be stretching, if, as we anticipate, more people are finding good sources of information and advice independently, without the need to even contact the Council.

3.5.1.2 If all remains equal the target would see the number ending with an intention to assess reduce from around 20,000 to 15,200 by March 2019.

3.5.1.3 Activities and interventions to effect this target include our 3 conversations model of social work; improved, targeted information and advice, and early offers of assistive technology.

3.5.2 **Assessments that lead to services (Appendix B – PI2)**

3.5.2.1 In 2016/17 we carried out around 8,800 assessments. Our target is modelled on this overall number reducing to around 7,400 with around 6,680 going on to some kind of service. Whilst this is an increase in the % of assessments that lead to services, the overall number going on to services does not increase, and it represents an improvement in practice because those assessments which do take place are appropriate.

3.5.2.2 Activities and interventions to impact this target include all those highlighted for the previous target together with additional social work capacity to address the holding list, and embed Living Well - our 3 conversations model.

3.5.3 **Reablement cases where the person does not require additional social care (Appendix B – PI3)**

3.5.3.1 Reablement is already having a positive benefit for people's lives in Norfolk. The number of people who are able to stay at home after reablement is amongst the best in the country and makes a substantial contribution to avoiding people going to into hospital unnecessarily. In 2016/17, 5,799 people received reablement services, with just under 4,000 requiring no additional social care intervention.

3.5.3.2 The target we are modelling is based on sustaining high performance even though we are likely to be putting forward people with more complex problems for reablement.

3.5.3.3 The proposed targets maintain this rate – although any increase in the amount of reablement will require a proportional increase in those cases requiring no intervention.

3.5.3.4 Activities which impact this target include the sustained investment and scale of our in-house service Norfolk First Support, the establishment later this year an accommodation based reablement service, and increasingly the attempt to shift towards home care which has a reablement focus.

3.5.4 **Increasing the rate at which assessment backlogs are handled, and increasing the rate of reviews that lead to a reduction or cease in service (Appendix B – PI4)**

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

3.5.4.2 We have set ourselves a deliberately challenging target for reviews which lead to a reduction in service for people aged 18-64. Our target sees the figure increase from 686 at March 2017 to 2,200 at March 2021. This reflects that Norfolk makes one of the highest rates of placements in long term care for this age group. Our strategy, currently being co-designed with people with learning disabilities, will be ambitious, looking at ways to enable people to live independent lives in a way that gives them control and opportunities.

3.5.4.3 For older people our target is less stretching, reflecting that we intend to reduce the number of older people requiring long term care (through better reablement and short term interventions), and that those that do receive long term services are likely to be people with the highest and most complex levels of need, with less likelihood of reducing need.

3.5.4.4 Activities which impact on this targets include the re-shaping of learning disability services, and enablement approach for social work for people aged 18-64, reablement and enhanced home care, and our 3 conversations model of social work.

3.5.5 **Reducing permanent admissions into residential care for people aged 18-64 (Appendix B – PI5)**

3.5.5.1 For the reasons set out above, this target is highly challenging and will require a step change in our performance which has been historically poor, although last year we did see an improvement. In 2016/17 there was around 80 permanent admissions to residential and nursing care for people aged 18-64 (note: this figure does not include temporary placements) The target, that also accounts for population growth, means that around 70 people would be permanently placed in residential and nursing care in 2020/2.

3.5.5.2 Although a stretching target, it is based on what other Councils are able to do, and it also reflects the ambition we have for improving choice and opportunities for people with learning disabilities.

3.5.5.3 Activities which impact on this target include the full range of transformation in learning disability services.

3.5.6 **Reducing permanent admissions into residential and nursing care for people aged 65 and over (Appendix B – PI6)**

3.5.6.1 Our target for this represents a significant improvement from being around the median to being one of the lowest 'placing' Councils in Norfolk's family group. Many factors influence people's decisions to move into permanent residential care; for some it feels safer after an incident such as a fall or a period in hospital; there may not be the right type or amount of home care where they live; their needs may be complex and cannot be met in their own homes. This measure also counts those people whose private funding has run out, and who are then eligible for adult social care. In 2016/17 there was around 1,320 permanent admissions to residential and nursing care for people aged 65+ (note: this figure does not include temporary placements). The target, that also account for population growth, mean that around 1,220 people would be permanently placed in residential and nursing care in 2020/21.

3.5.6.2 There had been a long term reduction in the rate of admission to permanent care for older people but this has started to fluctuate in the last year, with some increases in the most recent months.

4. Additional measures for the Committee

4.1 In addition to the six Promoting Independence indicators set out above, there are a further three measures which we propose to report regularly and in some detail to committee. These are

a) Delayed discharges of care
b) Reduction of holding list
c) Measuring our support for carers – the precise measure to be determined

4.2 Report cards for delayed discharges of care and the reduction of the holding list are appended with more detail, and the main performance issues are set out below. We have further identified a gap in close monitoring of our support for carers, and propose to include this going forward. We will bring an update to the Committee about this.

4.2.1 **Delayed discharges of care (DToC) (Appendix A)**

4.2.1.1 Moving people swiftly out of hospital is a major focus of interest for the Government. Stretching targets for all areas have been set (for us this is Norfolk and Waveney), and within that the target is broken down to delays caused by the NHS, and delays caused by social care.

4.2.1.2 This is not a new measure for Adult Social Services, although a target has recently been set down for us. This means we are working towards a reduction in social care delayed days from 744 patient days in June to 566 in November. The Norfolk and Waveney NHS is required to make a reduction from 1393 patient days to 1155 patient days. Our target will be very difficult to achieve in that space of time, but we are committed to doing everything we can with our NHS partners to ensure that as few people as possible stay unnecessarily in hospital.

4.2.1.3 Timely hospital discharges matter. Delays in discharging people from hospital when they are ready can have a negative impact on health outcomes and the wellbeing of individuals. If they are not able to leave hospital to continue their recovery, older people particularly risk losing their mobility and ability to manage daily living tasks, increasing their level of care needs and impacting on their independence and quality of life. It has been estimated that 10 days unnecessary stay in hospital for an older person will lead to the equivalent of 10 years loss of muscle strength and associated loss of functioning. Ensuring services are available to support timely discharge is vital to avoiding this kind of impact.

4.2.1.4 There is an expectation that additional monies from the Government announced earlier this year will help Councils to reduce delayed discharges. We are targeting that investment towards strengthening the social care market, investing in extra social work capacity to meet increasing numbers of people needing social care support, and specific targeted work to avoid people getting into hospital in the first place, and then getting them either home or somewhere intermediate to regain as much independence as possible.

4.2.1.5 Whole system working is critical to avoid one part of the health and social care system meeting its target at the expense of another. For adults, it is important to establish new services outside of hospital where people can re-gain as much independence as possible before making long-term decisions about their future care. There is a risk that people moved swiftly out of hospital make long-term decisions in a state of crisis which are life-changing.

4.2.1.6 We are working closely with acute hospitals on implementing new ways of working, and in ensuring that we have a shared picture of how we are measuring and recording numbers associated with delayed discharges so we can jointly make an impact for the people we support.

4.2.1.7 A report card, giving trends and further detail is attached at **Appendix A**

4.2.2 **Reduction in holding list (Appendix C)**

4.2.2.1 We reported in July that our teams were carrying high backloads of work which was impacting on the pace of change we need to make. We have modelled the reduction in this which sees the most significant reduction in 2018/19 and 2019/20 through a combination of change. This includes additional social workers, our new model of social care – Living Well: 3 conversations. Latest figures for this month show the backlog has risen overall. It may be that a dedicated team is required for a short period

of time to focus solely on the holding list, should the recruitment of new capacity not be swift enough.

5. Summary of targets

5.1

	Performance			Targets		
Indicator	**2016/17**	**Most recent**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
% requests for support where the intention is that the person will go on to receive a care act assessment	32.72%	31.94% (Jul-17)	28.86%	25.00%	25.00%	25.00%
Holding list – number of unallocated cases awaiting assessment	2,710	3,109 (Aug-17)	2,396	618	200	200
% Reablement cases where the outcome is recorded as not requiring any further social care support	68.89%	68.4% (Aug-17)	69%	69%	69%	69%
% Assessments which are closed with the intention of supporting the person with services	75.95%	78.99% (Aug-17)	80.63%	85.32%	90.00%	90.00%
Number of permanent admissions to residential and nursing care for people aged 18-64 per 100k population	18.3	19.7 (Jun-17)	16.6	15.6	14.4	13.6
Number of permanent admissions to residential and nursing care for people aged 65+ per 100k population	611.9	611.4 (Jun-17)	603.1	594.3	563.3	534.0
% Reviews of people aged 18-64 where the intention is to cease or reduce services	20.42%	21.69% (Jul-17)	31.82%	43.21%	54.61%	66.00%
% Reviews of people aged 65+ where the intention is to cease or reduce services	26.96%	24.59% (Jul-17)	23.97%	20.98%	17.99%	15.00%

5.2 It is intended that the measures described in detail here form the consistent basis of performance reports for the remainder of the year. The department monitors a much wider set of measures and these will be regularly published for the Committee. Should there be any issues of significance from that wider suite, we will bring detailed information to the Committee. The full list of those suite of measures is on the performance dashboard which can be accessed by clicking here.

5.3 In addition to this, the introduction of the Liquid Logic system should provide much improved opportunities for monitoring performance in the areas described above, and in particular better information about people moving from one part of the system to another (for example from hospital to care, or from reablement to particular services). This may allow us to report, and set targets against, more precise measures. If so, we will update the Committee through regular reporting, and any additional or amended targets will be presented as part of end-of-financial-year reporting after March next year.

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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